

A Report on the Status of
Fetal and Infant Mortality
Review in the United States
2016



Source of Information:

The National Center for Fatality Review and Prevention
Reports from Fetal and Infant Mortality Review Programs



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Acknowledgement and thank you to the many local FIMR programs and state FIMR coordinators who contributed this information. Their dedication and commitment to the community is what improves the health of families.

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Introduction

The beginnings of Fetal and Infant Mortality Review (FIMR) date back to the mid-1980s, when concern over high infant mortality rates intensified nationwide. The Maternal and Child Health Bureau (MCHB) conceptualized Infant Mortality Review (IMR), the forerunner of FIMR, as a promising method to improve understanding of local factors contributing to infant mortality and to motivate community response. FIMR is a community-based, action-oriented process to review fetal and infant deaths and make recommendations to spark systemic changes to prevent future similar deaths. Most FIMR teams operate at the local level (usually the county) to examine medical, non-medical, and systems-related factors and circumstances contributing to fetal and infant deaths.

Among the various types of fatality reviews, the FIMR approach is unique because cases are de-identified; they may include a family interview to determine the family's perspective on factors that may have contributed to the infant's life and death; and many of the teams have a Community Action Team (CAT) that, after completion of the review, works to take the case review team's recommendations to action. From the very beginning, the FIMR model strongly emphasized the importance of a community-based two tiered process that promoted the use of separate groups to carry out an analytic function and a subsequent action function. The Community Review Team has the role of reviewing cases and drafting recommendations, while the Community Action Team helps to disseminate findings, and facilitates implementation of recommended policies and interventions.

For many years, HRSA funded a National Center for Child Death Review as a resource center for FIMR programs. In 2015, HRSA released a Funding Opportunity Announcement for a new Center that would combine FIMR and Child Death Review training, technical assistance, and data services. The result is the National Center for Fatality Review and Prevention at the Michigan Public Health Institute, which came into being on July 1, 2015. In the first grant year, the National Center contracted with the American College of Obstetricians and Gynecologists to provide the FIMR technical assistance and training. In year two, the Michigan Public Health Institute (MPHI) brought its FIMR support services in-house.

The Center provides training and technical assistance to the field, is creating a web-based FIMR database; facilitates collaboration between FIMR and CDR; is developing a website and portal where FIMR teams may post their outcomes; and has developed a regional network of FIMR programs.

In late 2016, the National Center surveyed 175 FIMR teams in 29 states were surveyed about their structure, process, and activities during 2016. Figure 1 is a map showing the states and number of FIMR programs in each state. One hundred and thirty-six programs in 25 states and Puerto Rico responded to the survey. Of the 136 respondents, 128 (94%) were from local FIMR programs, and 8 (6%) were state FIMR coordinators. Both local and state program responses are represented together in aggregate. Figure 2 provides an overview of the respondents.

Trends in Fetal and Infant Mortality Review

FIMR PROGRAM STRUCTURE

Many FIMR teams are well established in their communities. Almost three-quarters of respondents stated that their health department (whether state, county or city) is the lead agency for FIMR in their jurisdiction. Healthy Start is the lead for another 11% of responding programs, and the rest are led by a variety of agencies, such as perinatal coalitions/networks and hospitals. The majority (96.6%) of reviews are conducted at the local level. Only 4.4% of FIMR programs conduct state level reviews: Puerto Rico, Utah, and West Virginia.

Funding sources vary among the responding programs. For 71.4% of programs, the primary sources of funding are state and federal Maternal Child Health/Title V block grant funding through local health

departments and other state funding. Federal funding, including federal Healthy Start funding, accounts for 34.7% of programs; and local foundations and charities such as United Way fund 10.2% of programs, with 28.6% of respondents indicating “other” sources of funding. Figure 2 illustrates the breakdown of how respondents answered the question on funding source for their FIMR.

The authority to access medical records and conduct FIMR reviews varies greatly across states and local jurisdictions. About half of FIMR programs who responded (47.4%) operate under state statute or language in the Public Health Code that enables or permits the local FIMR to operate. In 36% of the sites that responded, there is a state law or mandate to conduct FIMR.

Most communities select cases for review based on risk and/or population factors such as vital statistics data and other information about the causes of infant mortality and how these statistics change over time. Many communities attempt to review all cases of fetal and infant death to give them a better picture overall of the community and its services and resources. Of the respondents, 54.2% report that they review cases of fetal and infant death of residents of their county. Some programs focus on known high risk areas such as a city (2.4%) or residents of certain zip codes (7.2%) In more rural settings, a FIMR program may include multiple counties for case selection and review (25.3%). In 2016, state and local FIMR teams reviewed a total of 2,335 (n=113) infant deaths, babies born alive who did not survive until their first birthday, and 2,315 (n=113) stillborn infants.

The selected de-identified cases are then abstracted by an individual, usually a nurse. In many teams, the case abstractor interviews the mother or other family member about the circumstances of the death, which can yield valuable information about social and environmental aspects surrounding the fetal or infant death. This information is included in the case abstract. The abstracts are then shared and discussed with the multidisciplinary case review team (CRT), which then makes recommendations for improvements in care and systems change. Many teams also utilize a second tier of review, the Community Action Team (CAT), which usually includes other community leaders. The CAT works to take the CRT recommendations to action.

COMMUNITY ACTION TEAMS

As stated above, a unique feature of FIMR programs is the use of a Community Action Team as a second tier of review and action. While there may be some overlap in membership, the role of each team is quite distinct. The CRT acts as the information processor, reviews and analyzes the information collected in interviews and case abstractions, identifies gaps in care, and makes recommendations for how to improve systems and delivery of care. The CAT translates the CRT recommendations into strategies for action and participates in implementing interventions designed to address the identified problem. Based on the survey responses, over two-thirds of teams (67.4%) have a two-tiered structure (CRT and CAT). Some have CATs developed solely for the FIMR program, and many have CATs that are part of existing community coalitions.

The membership on CRT and CAT teams varies among teams: the professions that are included on half or more of the teams are local health departments, social workers, obstetric/pediatric nurses; pediatricians; obstetricians; nurse home visitors; mental health professionals; child welfare workers; and educators.

MATERNAL INTERVIEWS

A unique feature of the core FIMR model is its focus on obtaining a family interview as part of the review process, which provides their perspective of their baby’s death and allows them to describe their experiences in their own words. The maternal/family interview is emerging as a major strategy for helping teams understand mothers’/families’ experiences of racism and other inequities, and how those experiences may have impacted maternal and child outcomes. Most family interviews are conducted with the birth mother, but teams report that the father of the infant, grandparent, or other caregiver may also be included. The interviews yield information not usually captured in routinely collected health records. Over three quarters of responding teams (78%) report that they typically include information from an interview with a family member as part of their reviews. The mean response of respondents who reported

the percentage of reviews which include a maternal interview is 29.4% (n=88). Of the respondents, 12.5% report that they get completed interviews for 75 – 100% of their cases, 6.8% report having interviews for 51 – 75% of their cases, 18.2% report having interviews for 26 – 50% of their cases, and 62.5% of respondents report that they have maternal interviews for less than 25% of their cases reviewed. There are many barriers that FIMR teams identify to obtaining maternal/family interviews. Both respondents who use the family interviews and those who do not described reasons for their difficulties obtaining the interviews. The majority of FIMR teams (58.3%) identified challenges locating and finding the mother or other family member as the primary reason for low number of interviews. Lack of funding to allow staff to do maternal interviews was identified as a barrier for 47.6% of respondents, and a significant number of programs (17.9%) identify lack of staff training/comfort level with grief as a barrier to obtaining maternal interviews. An additional 11.9% identify that FIMR staff are uncomfortable with the interview process. These findings suggest that the maternal/family interview should be a major focus of technical assistance for FIMR teams in the coming year.

COLLABORATION WITH MATERNAL AND CHILD HEALTH INITIATIVES

The Healthy Start Program is an initiative to eliminate disparities in perinatal outcomes through grants to project areas with high infant mortality. There are 100 Health Resources and Services Administration (HRSA), funded Healthy Start programs in 35 states. One third of respondents (33.8%) indicated that there is collaboration between Healthy Start and FIMR.

Respondents described a number of ways FIMR and Healthy Start collaborate including: FIMR findings may spur a community to apply for a Healthy Start grant; Healthy Start may fund FIMR in whole or part; Healthy Start members may serve on the FIMR Community Review Team (CRT) and/or Community Action Team; FIMR may ask a Healthy Start Community Action Network (CAN) to act as its FIMR Community Action Team. Frequently, Healthy Start may be the vehicle through which FIMR recommendations are implemented in communities. In 50% of the FIMR communities there is no federally funded Healthy Start, and an additional 15.4% of FIMR respondents described that there is a Healthy start in the community but there is no documented collaboration.

One of HRSA's areas of focus for the new Center is increasing collaboration between and among different types of fatality reviews. FIMR programs were asked to identify which fatality review processes operate in their communities and whether they collaborate with them. Of the 103 programs that responded to this question, 92.2% of respondents indicated they participate in Child Fatality Reviews. 15.5% of respondents indicated they participate in Maternal Mortality Reviews.

Many of the programs that participate in Child Fatality Reviews described their collaboration to be shared staff work on CDR and FIMR processes and/or attendance at each other's meetings. Other means of collaboration listed by the teams are leadership of both in one organization and joint prevention messages.

In addition to collaboration with other death review processes, FIMRs were asked if they play a role in collaborating with and informing their Title V programs. The Title V Maternal Child Health Services Block Grant Program is authorized under Title V of the Social Security Act to ensure the health and well-being of women, mothers, infants, children (including children with special health care needs), adolescents and their families. Of the 126 respondents to this question, 72.2% reported collaboration with State MCH or Title V.

DATA

FIMR teams use a variety of data systems to enter information about their reviews and actions. Some use systems created by their state and/or community. Some use the non-web-based system developed by the National Fetal and Infant Mortality Review program (NFIMR). Others use a web-based database pilot developed in 2015 by the American College of Obstetrics and Gynecologists, the State of Michigan, and the Michigan Public Health Institute (MPHI). Still others use an Infant Enhancement Module that is also part of the existing MPHI web-based National Child Death Review-Case Reporting System (CDR-CRS). HRSA's goal is one web-based system used by all FIMRs and all CDRs, for consistency and aggregate

data, and to facilitate national reports. To that end, a workgroup of FIMR coordinators from around the country has been working with the National Center to develop a FIMR module to be integrated with the existing CDR-CRS system. The new module is expected to launch in January, 2018. Figure 14 details the breakdown of the current type of reporting system being used by respondents, and Figure 15 indicates the high number of FIMR programs (89.3%) that are interested in a standard and uniform data reporting systems for both CDR and FIMR.

PREVENTION INITIATIVES

The hallmark of FIMR, is the way in which team and communities use their findings and translate them into meaningful actions. Teams are very active in seeking solutions to prevent the types of deaths they review. Their responses are a rich repository of prevention initiatives, as indicated in the tables and charts below in Section E. The following are specific examples of successful interventions.

- In Alabama, FIMR reviews found that many cases of infant deaths due to prematurity were linked to physical abuse of the mother. FIMR personnel provided educational trainings to emergency room staff so they are equipped and confident to identify and refer pregnant women who are victims of domestic violence to appropriate community shelters and resources.
- The Alameda County, California FIMR Program found that the mothers in a high number of their reviews had not been routinely screened or referred for mental health conditions, so that maternal depression often went undiagnosed and unaddressed, contributing to poor pregnancy outcomes. The team obtained maternal depression screening and referral at all County Public Health WIC sites for pregnant and postpartum WIC clients.
- Weld County, Colorado's FIMR program, the only one in the state, began in 2012 after a local physician became concerned about the county's high infant mortality. Despite many challenges, there has been an increased awareness of the issue of infant mortality in the community and a subtle shift in individual agencies to make changes that will enhance maternal health and infant survival. The Weld County Safe Sleep Campaign (2013, 2014, 2016) involved creating tool kits and presentations for providers, proclamations by city and county government, attendance at community events, parades, fairs, press conference, public showing of a PBS documentary. Increased public awareness of infant mortality issues via newspaper articles, community forums, attendance at health fairs, and networking of agencies involved in FIMR process has drawn much attention from the State Health Department and within the community. FIMR is proud that the infant mortality rate in Weld County has decreased from 7.5 in 2011 to 4.7 in 2015.
- Baltimore's FIMR program findings pointed to a high number of mothers with a previous pre-term birth who gave birth to a subsequent baby born too early and too little to survive. They researched the efficacy of the use of 17-P ((alpha-hydroxyprogesterone caproate - a buffered steroid) and found there was a profound increase in survival of infants born to mothers who had a history of previous loss in early pregnancy when used as a weekly injection during a subsequent pregnancy beginning around 12 to 14 weeks gestational age. The FIMR team also partnered with a local hospital and the Maryland Society for Maternal-Fetal Medicine physicians to sponsor interdisciplinary OB/GYN Grand Rounds for all OB/GYN providers. As a result, the use of 17-P has increased, leading to greater survival among infants and shorter hospital stays.

Another important prevention tool for FIMRs is disseminating findings from reviews. Many programs (68%) report that they use an annual report for enhancing the credibility and visibility of issues related to women, infants and families within the broader community. Getting the annual report to the right people is also important, as reflected in Figure 18.

Looking Forward to 2017

DATA

In 2015, the National Child Death Review Case Reporting System (NCDR-CRS) was updated to Version 4.0, and work is now underway on Version 5.0. Since the merger of the centers, NCFRP is the national data center for both CDR and FIMR. Version 5.0 will add a FIMR module for the approximately 175 FIMR teams in 29 states to enter data about their reviews.

The purpose of the Case Reporting System is to learn from the data to prevent further deaths. In the coming year, NCFRP will begin publishing a series of reports summarizing and analyzing the data about specific types of death. The purposes of the reports are to broaden availability of summary data from fetal, infant, and child death reviews and to inform prevention policies and activities in the states and nationally.

The Center is also working in partnership with the U.S. Centers for Disease Control and Prevention (CDC) in a pilot of a Sudden and Unexplained Infant Death Case Registry in 18 states, and is partnering with CDC and the National Institutes of Health on a Sudden Death in the Young Case Registry in 10 states. The states use the NCDR-CRS as the foundation for reporting into the registries.

SUPPORT FOR THE FIMR PROCESS

The National Center, working closely with HRSA, will continue to support the Fetal Infant Mortality Review Program and will be working with all Healthy Start grantees to make sure that they work closely with existing FIMR programs in their communities. A priority in this next calendar year will be to reach out to Healthy Start grantees with no FIMR program and to assist them in establishing a FIMR program in collaboration with their state/local/ or city health departments.

With HRSA's strong focus on outcomes, the National Center will roll out a new website in 2017 with a portal where FIMR (and CDR) programs will be encouraged to post their prevention activities and outcomes. The Center will also create a prevention playbook resource, including case studies of teams moving from reviews to action.

Respondents were asked to identify what they want from the Center. The most frequent responses were the new database; training, either in-person or through webinars; regional activities; regional and/or national meetings; increasing capacity for family interviews; and technical assistance regarding obtaining medical records and death notices, taking recommendations to action, and updating the abstraction tool.

PREVENTION

In 2017, the Center will also continue its focus on prevention activities. FIMR teams are working hard to craft better recommendations and implement evidence-based and promising practices that can prevent fetal and infant deaths. NCFRP is proud of and excited by the prevention activities taking place around the country as a result of FIMR activities and will continue to provide states with links to resources to support their prevention work and to showcase programs that have moved from reviews to improvements in systems and services for women, infants, and families.

NATIONAL PARTNERS

Many national organizations and agencies are working to reduce infant mortality. The Center is a member of several national coalitions to help translate FIMR work into prevention at the national policy level, and Center staff present, attend, exhibit, and network at numerous conferences and meetings of these organizations. FIMR programs also report important partnerships with a variety of partners in their communities and states.

Tables/Charts Describing the Status of FIMR in the U.S.

A. FIMR PROGRAMS

1. Map of FIMR Programs in the U.S.
2. Overview of Survey Respondents
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4. Funding Source

B. CASE SELECTION AND REVIEW STRUCTURE

5. Catchment Areas
6. Statute/Rules/Grant of Authority
7. Two-Tiered Team with a Functioning Community Action Team (CAT)
8. Maternal Interviews Conducted
9. Cases with a Maternal Interview
10. Barriers to Maternal Interviews

C. COLLABORATION WITH OTHER MATERNAL AND CHILD HEALTH INITIATIVES

11. Coordination with Federal Healthy Start
12. Coordination with Other Death Review Programs
13. Coordination with Maternal and Child Health

D. FIMR REPORTING

14. Type of Reporting System
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E. FIMR PROGRAM ACTIVITIES

16. FIMR Action Categories
17. Action Categories by Percent of Responses
18. Annual Reports Produced
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SECTION A
FIMR PROGRAMS

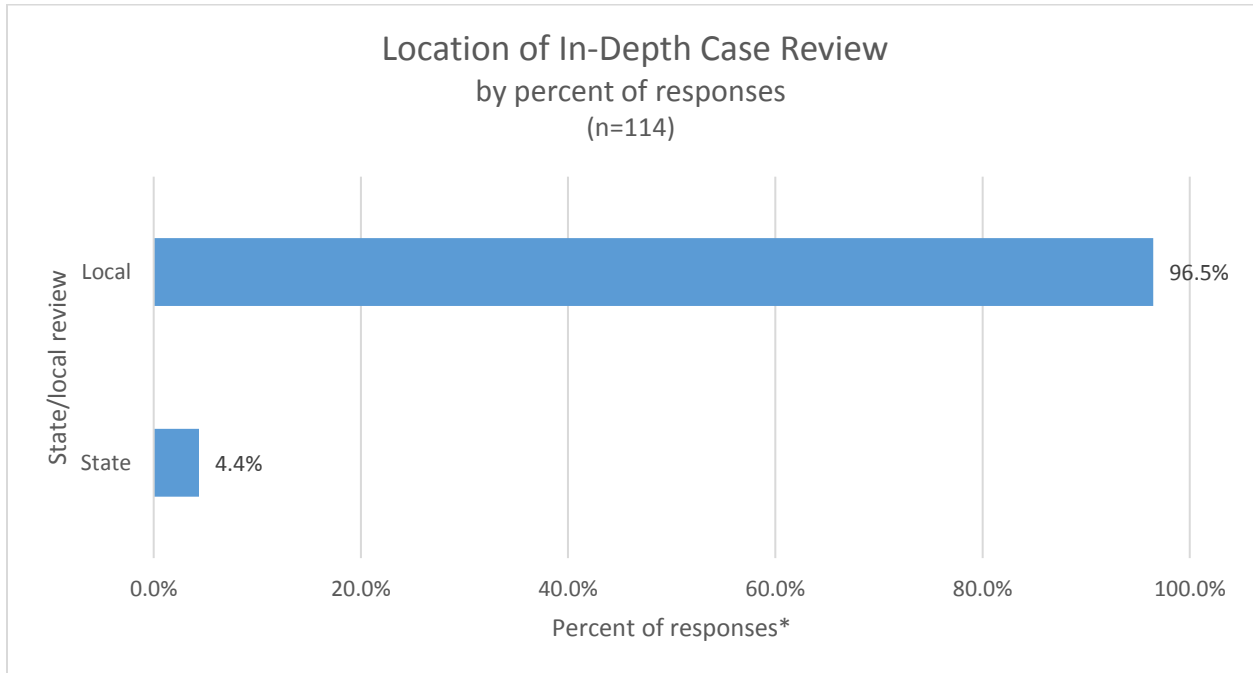
1. Map of FIMR Programs in the U.S.



2. Overview of Survey Respondents

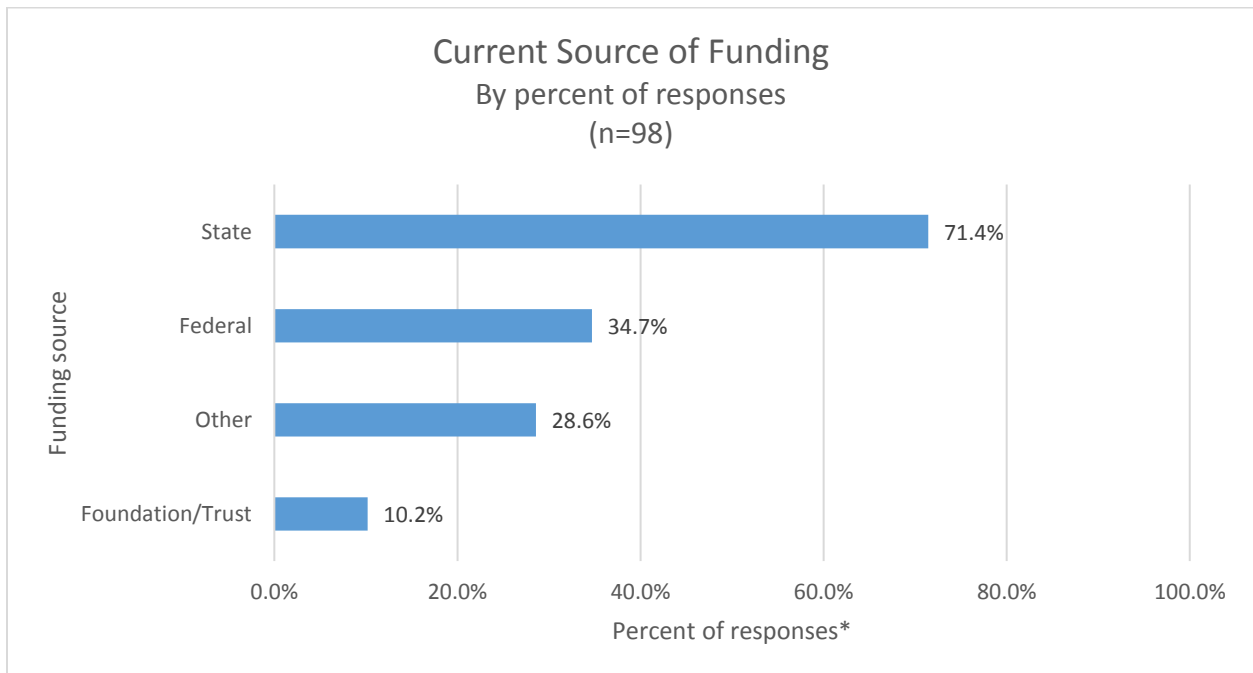
| State | Number of respondents | State | Number of respondents |
|---|-----------------------|------------------------------|-----------------------|
| Alabama* | 3 | Missouri* | 3 |
| California | 13 | Montana* | 19 |
| Colorado | 1 | Nebraska | 1 |
| Delaware* | 2 | Nevada | 1 |
| Florida | 12 | New Jersey* | 3 |
| Illinois | 1 | Ohio* | 10 |
| Indiana | 6 | Oklahoma | 2 |
| Kansas | 3 | Tennessee* | 6 |
| Kentucky | 1 | Texas | 3 |
| Louisiana* | 7 | Utah | 1 |
| Maryland | 20 | West Virginia | 1 |
| Michigan | 10 | Wisconsin | 3 |
| Mississippi | 3 | Puerto Rico | 1 |
| * Indicates that a state coordinator responded to the survey in addition to local program coordinators. | | Number of states | 25 and Puerto Rico |
| | | Number of respondents | 136 |

3. Location of In-Depth Case Review



*Responses are not mutually exclusive.

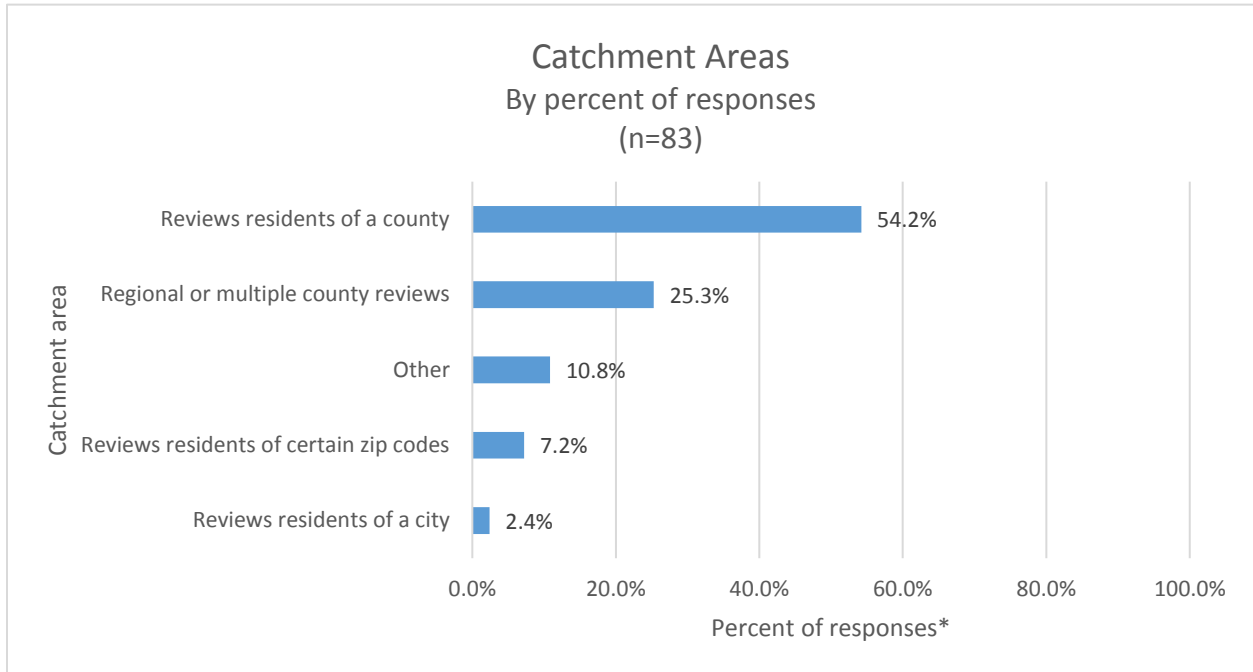
4. Current Source of Funding



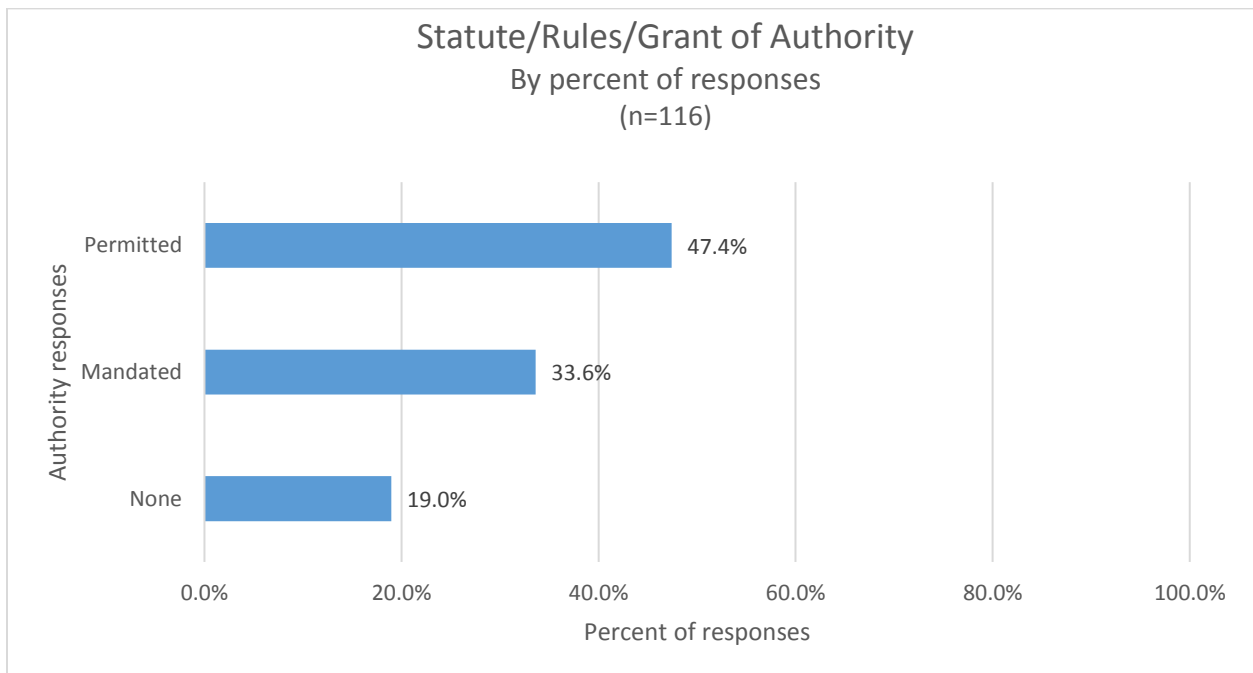
*Responses are not mutually exclusive.

SECTION B
CASE SELECTION AND REVIEW
STRUCTURE

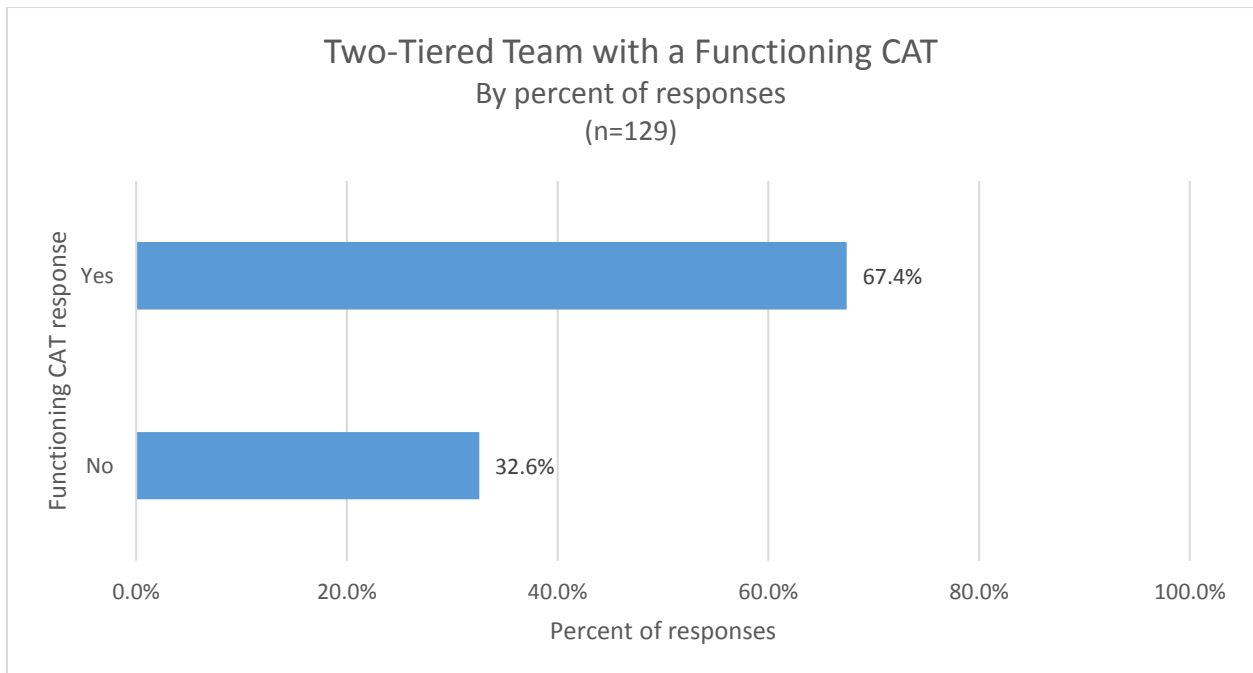
5. Catchment Areas



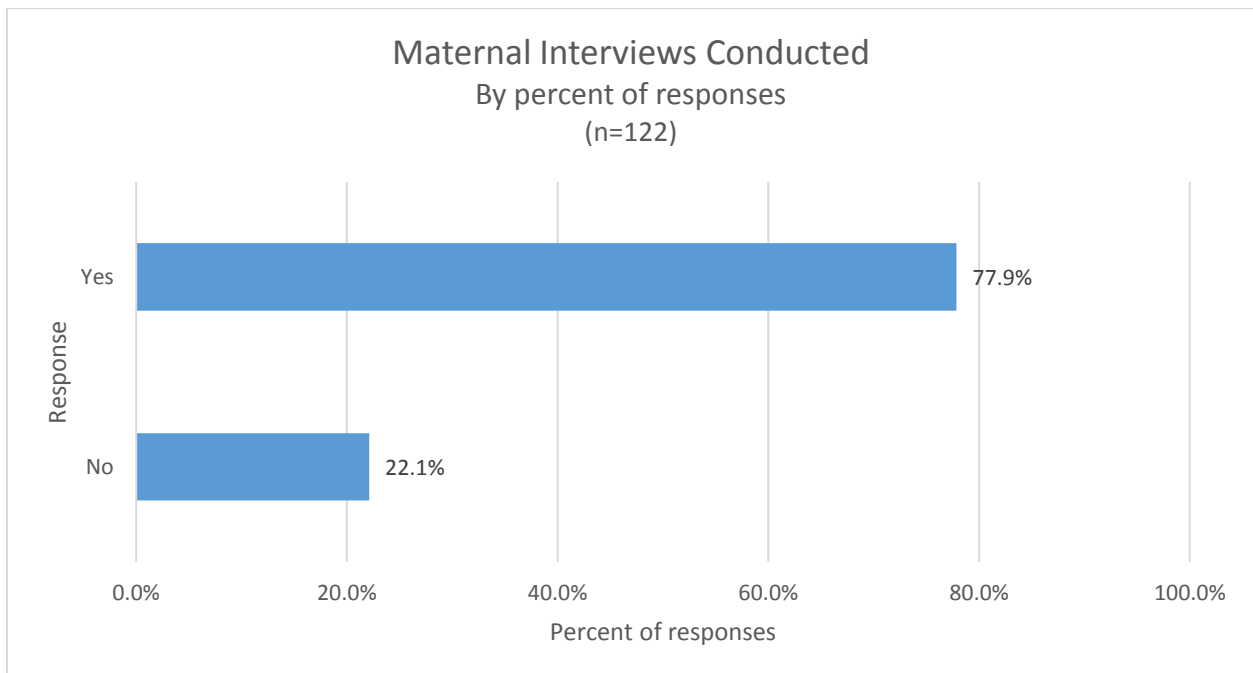
6. Statute/Rules/Grant of Authority



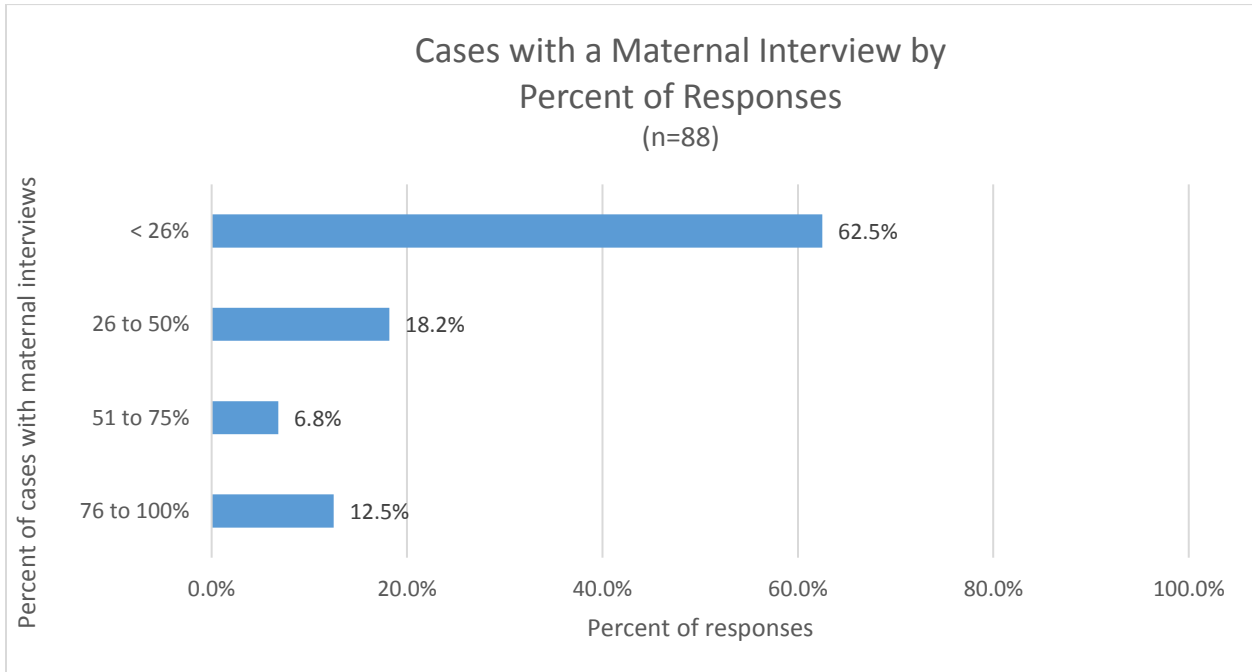
7. Two-Tiered Team with a Functioning Community Action Team (CAT)



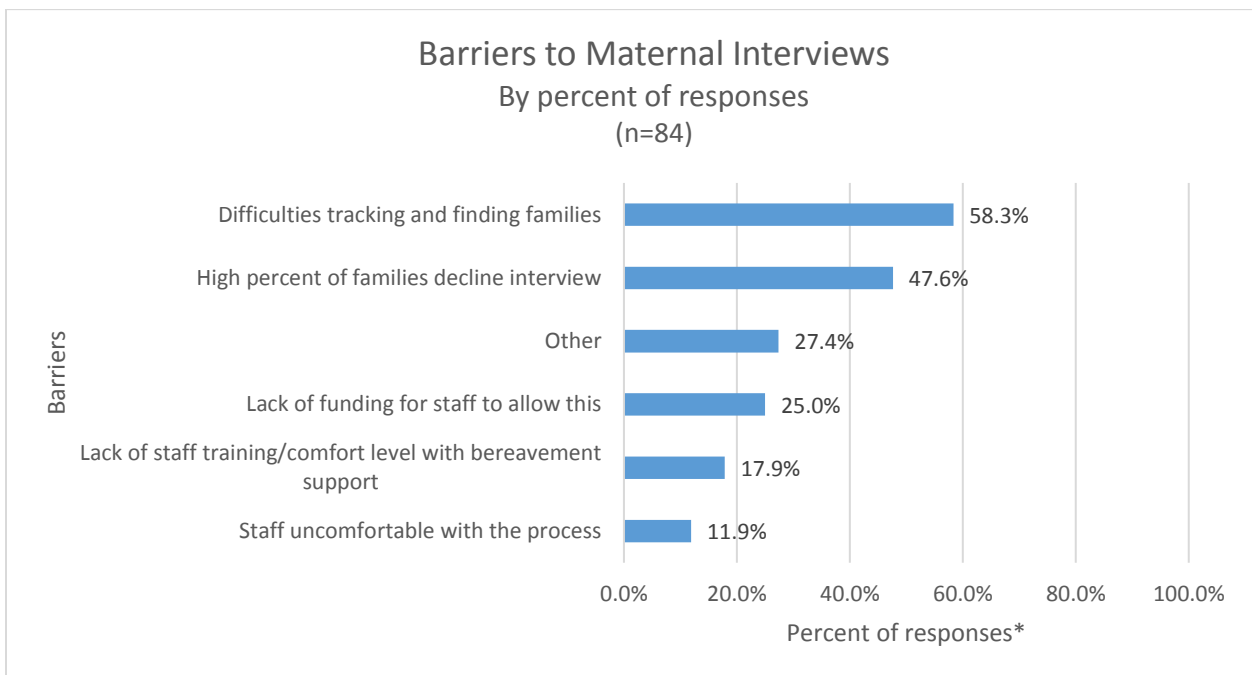
8. Maternal Interviews Conducted



9. Cases with a Maternal Interview



10. Barriers to Maternal Interviews

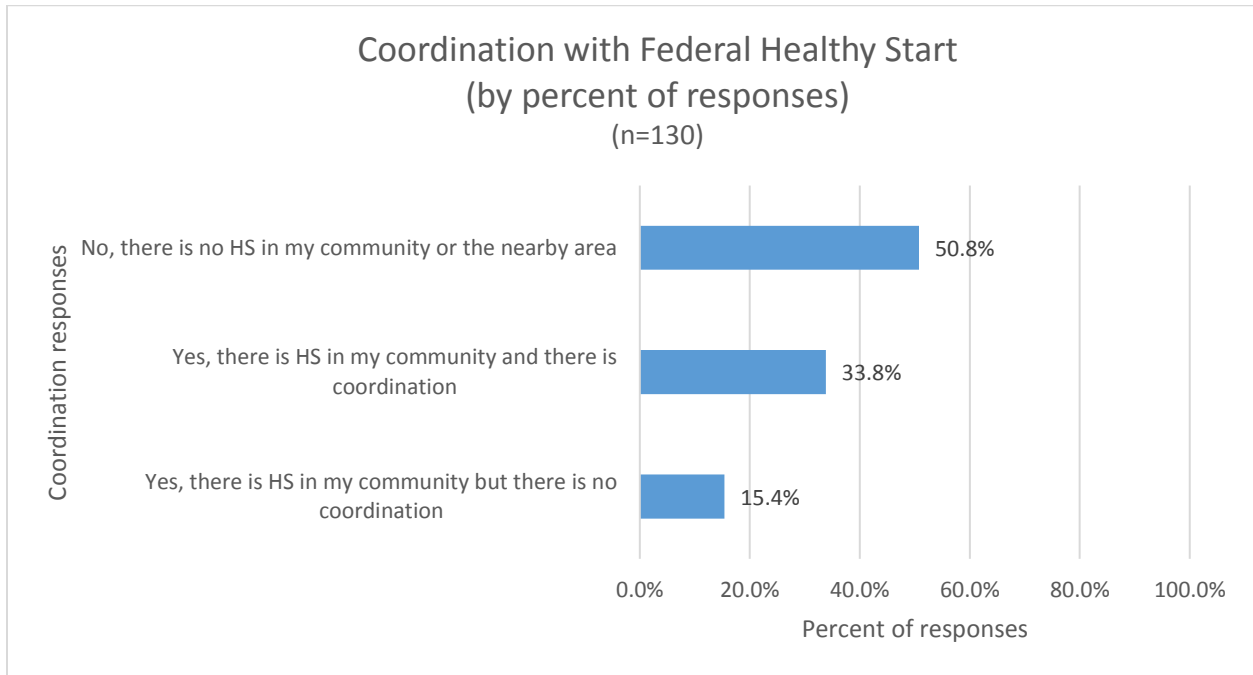


*Responses are not mutually exclusive.

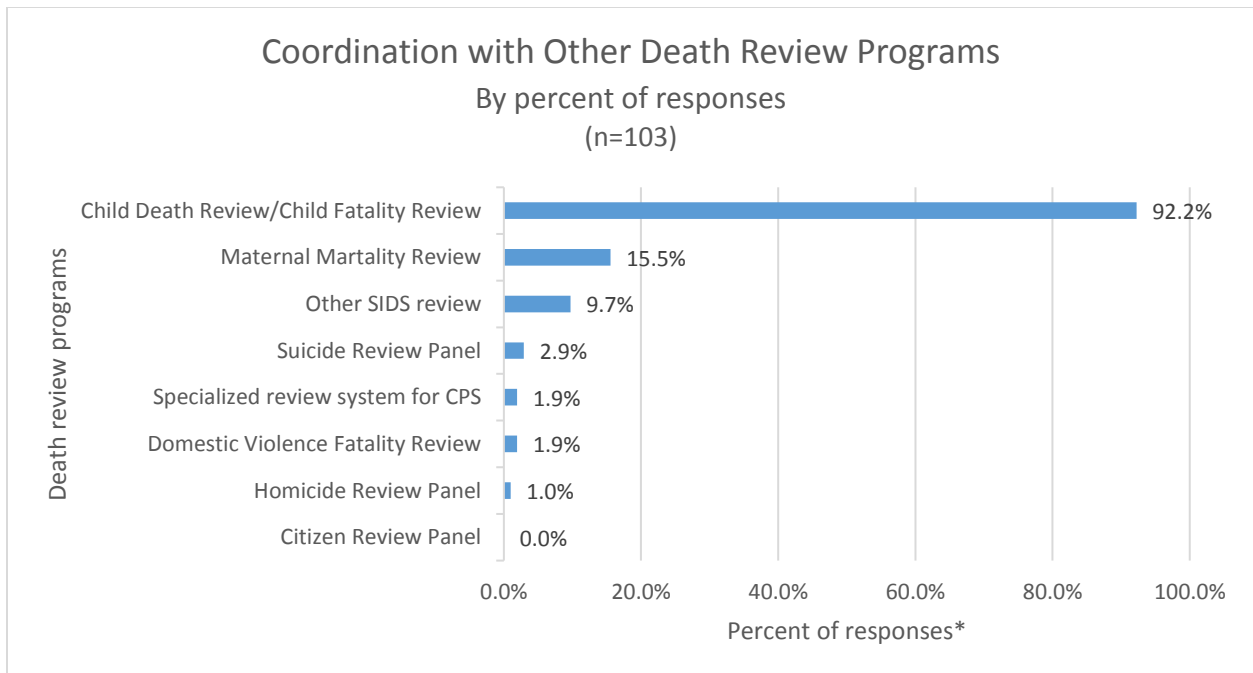
SECTION C

Collaboration with Other Maternal and Child Health Initiatives

11. Coordination with Federal Healthy Start (HS)

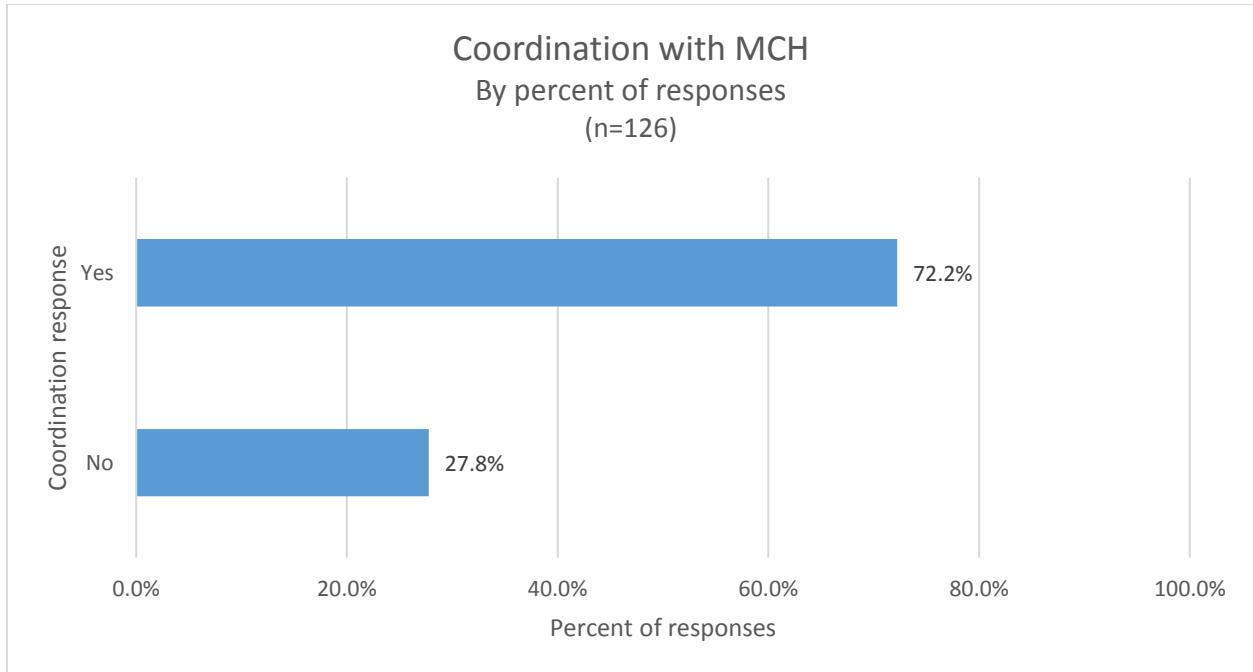


12. Coordination with Other Death Review Programs



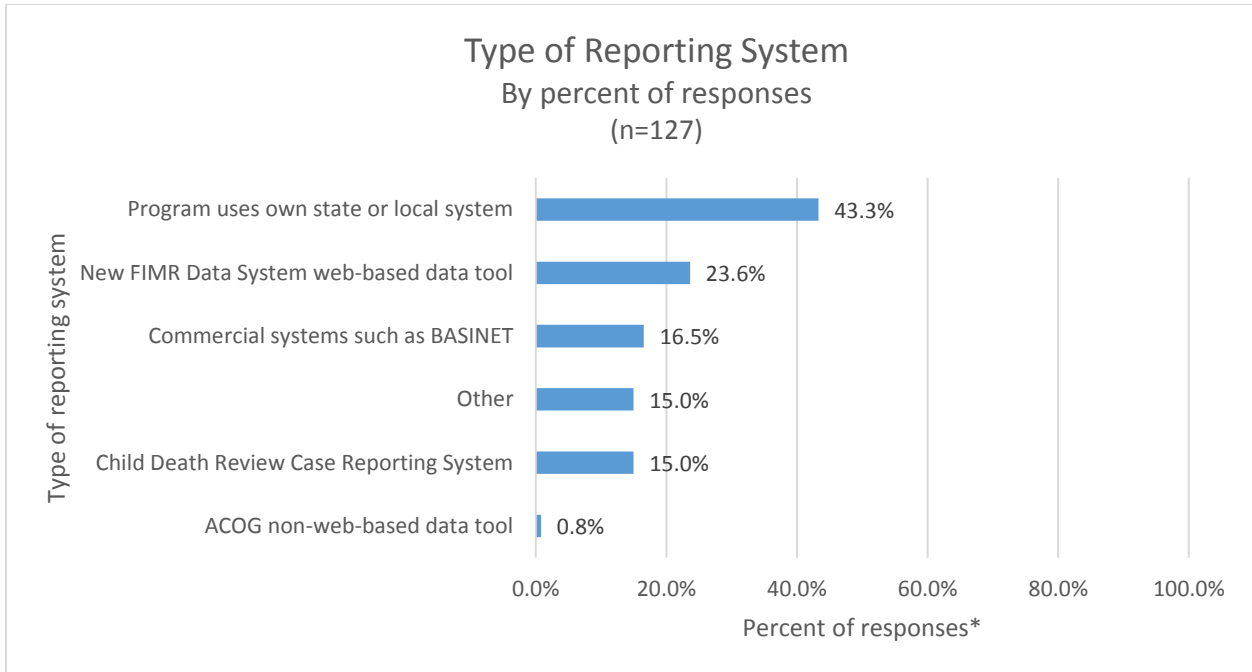
* Responses are not mutually exclusive.

13. Coordination with Maternal Child Health (MCH)



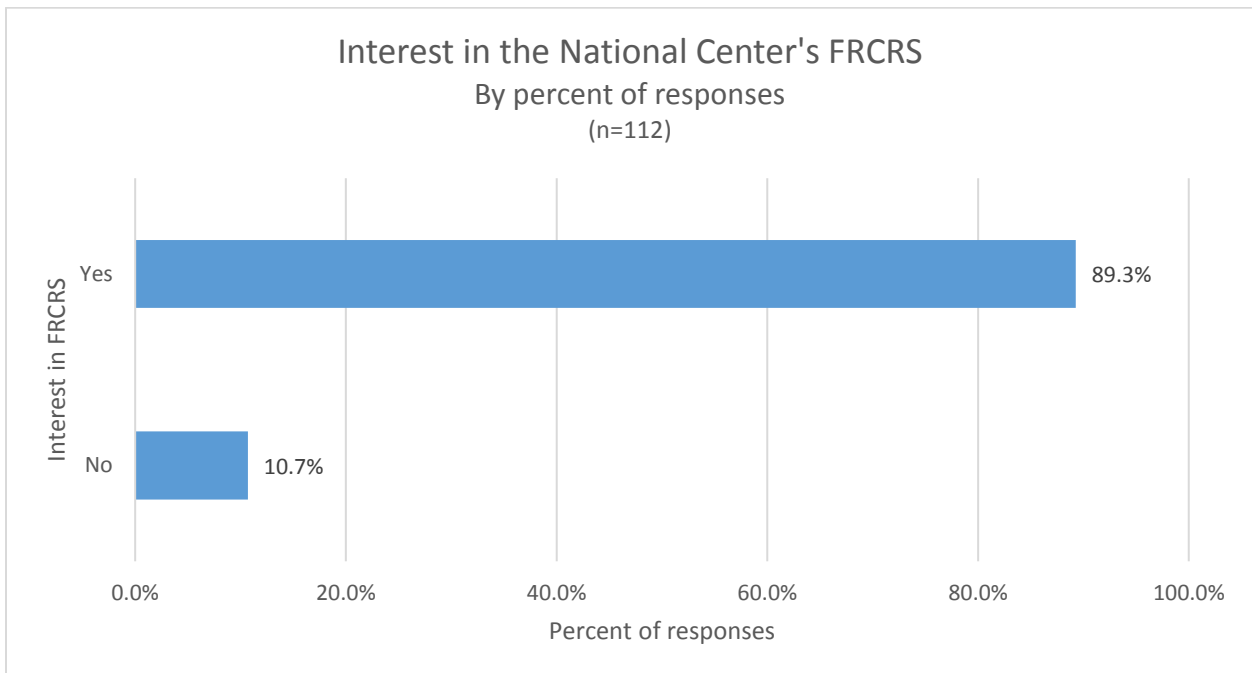
SECTION D
FIMR REPORTING

14. Type of Reporting System



*Responses are not mutually exclusive.

15. Interest in the National Center's Fatality Review Case Reporting System (FRCRS)

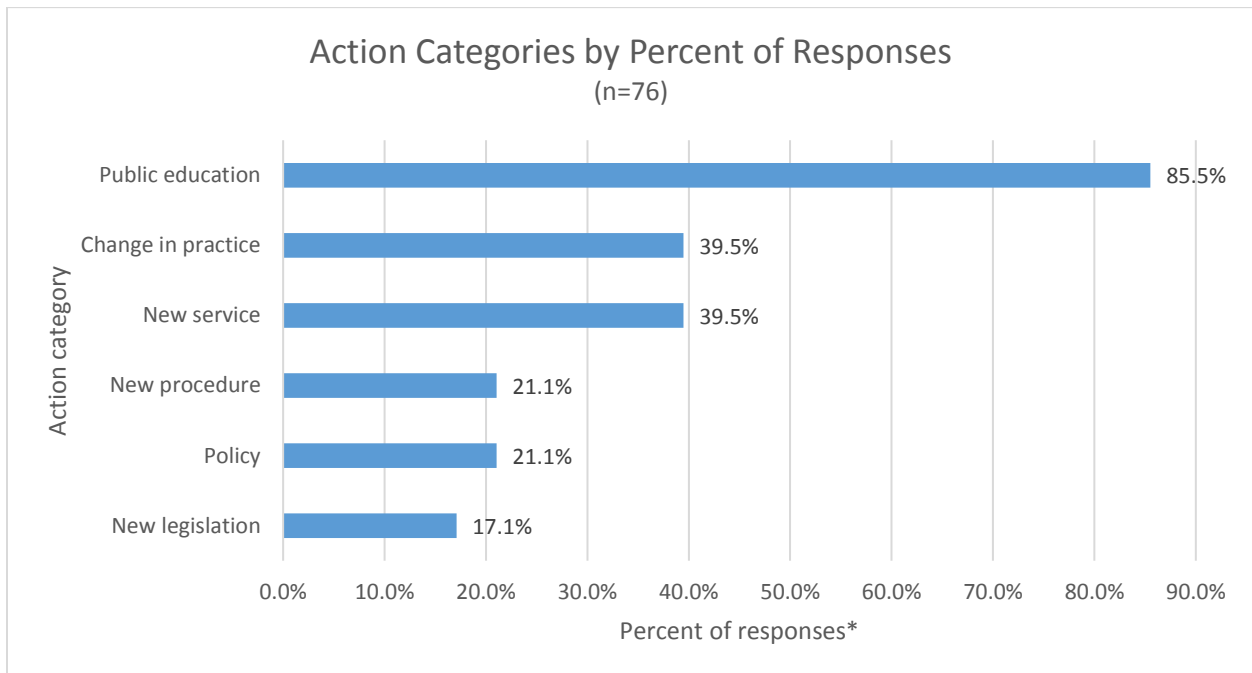


SECTION E
FIMR PROGRAM ACTIVITIES

16. FIMR Action Categories

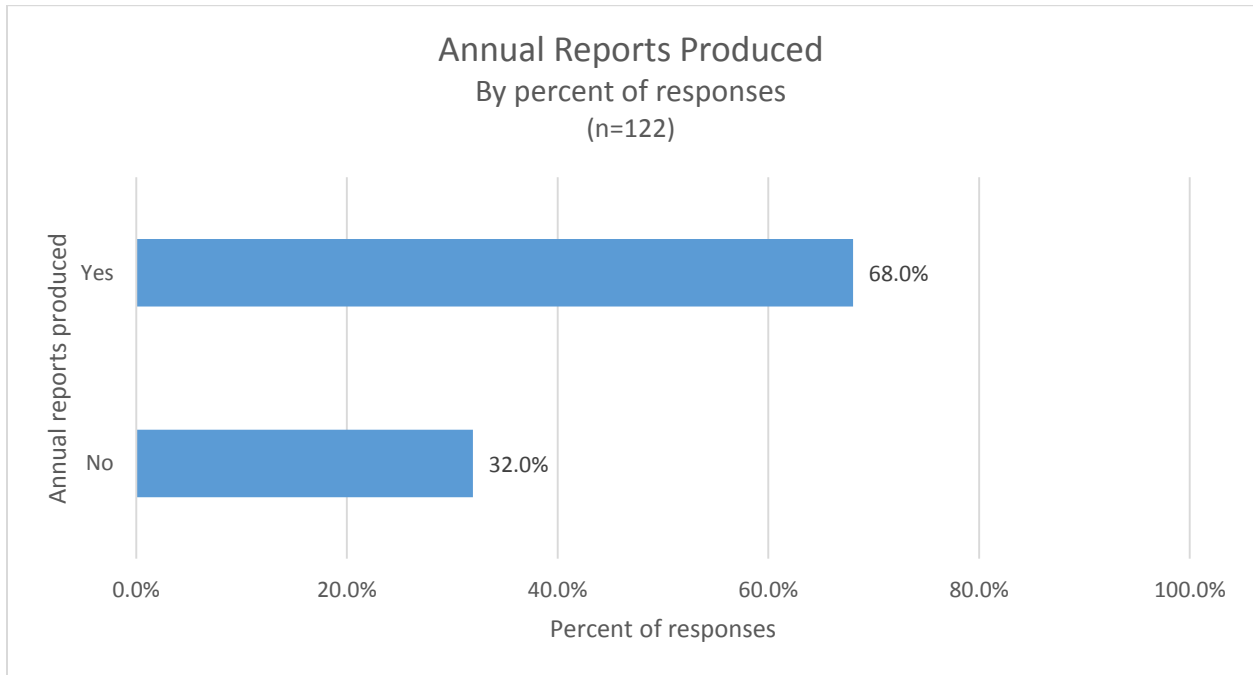
| Action Category | Number of Respondents implementing this type of action |
|-----------------------------|--|
| Public Education | 65 |
| New Service | 30 |
| Change in Practice | 30 |
| Policy | 16 |
| New Procedure | 16 |
| Legislation/Policy/Advocacy | 13 |

17. Action Categories by Percent of Responses

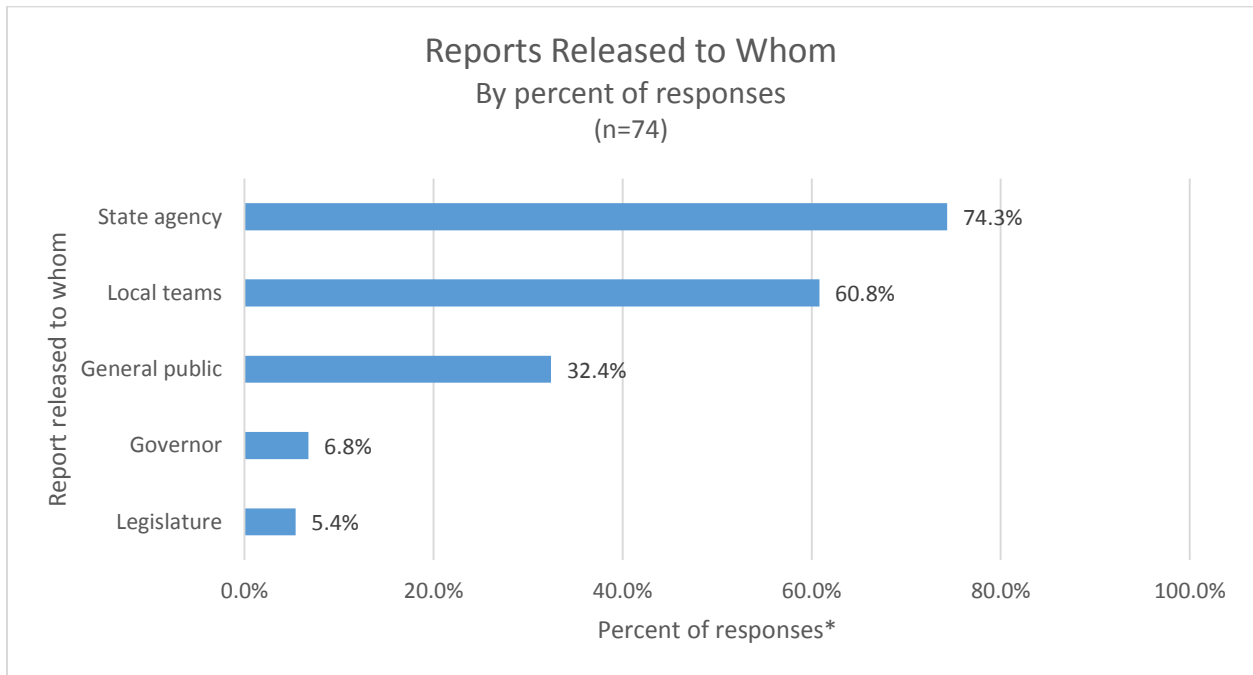


*Responses are not mutually exclusive.

18. Annual Reports Produced



19. Annual Reports Released to Whom



*Responses are not mutually

Actions Taken Because of FIMR in Selected States/Counties, 2016

Alabama

Contact: Amy Stratton; Amy.Stratton@adph.state.al.us

Problem: many cases of infant deaths due to prematurity were linked to physical abuse of the mom.

Recommendation: Provider education and universal screening of women in emergency room settings for physical abuse

Action: FIMR personnel provided educational trainings to emergency room staff so they are equipped and confident in identifying and referring pregnant women who are victims of domestic violence to appropriate community shelters and resources.

Problem: pre-existing health conditions of the mother greatly affect the outcomes of many pregnancies.

Recommendation: increase access to pre and interconception counseling

Action: a well-women program is being piloted in select health departments to improve access to care, continuity of care, and ultimately over-time improve the outcomes of pregnancy.

Problem: Infant deaths due to unsafe sleep in Alabama continue to be a leading cause of preventable infant death.

Recommendation: Public Awareness Campaign

Action: FIMR personnel applied for a grant from Association of Maternal Child Health Programs (AMCHP) that allowed Alabama to conduct Public Service announcements recorded by the State Health Officer, place floor stickers in retail stores with high rates of infant unsafe sleep deaths, collaborate with public transit to place bus wraps with safe sleep messages, and provided a train-the-trainer conference to provide the Direct On Scene Education Program to first responders.

Problem: there was a lack of bereavement resources/ support for women experiencing a loss.

Recommendation: Enhance available services for grieving families;

Action: FIMR team developed a Facebook page 'Healing Heart for Baby Loss of North AL' where families can share, get links to resources and information on grief. The FIMR team also developed and implemented an annual Perinatal Loss event held in October each year for families with a loss.

California

Alameda County:

Contact: Carole McGregor; Carole.McGregor@acgov.org

Problem: the Alameda County FIMR Program found that in a high number of their reviews, women were not routinely offered screened or referred for mental health conditions. Thus, maternal depression often went undiagnosed and unaddressed, contributing to poor pregnancy outcomes.

Action: the team implemented maternal depression screening and referral at all County Public Health WIC sites for pregnant and postpartum WIC clients.

Problem: infants were abandoned by moms who could not care for them, and died as a consequence.

Recommendation: launch a Public Information Campaign regarding Safe Surrender Law* in California.

Action: The team developed posters and obtained a donation from the Bench Ad company to post info about the Safe Surrender Law. Also established collaboration with Social Services to increase surveillance and track the number of infants safely surrendered.

* <http://www.cdss.ca.gov/inforesources/Safely-Surrendered-Baby>

Problem: many moms had trouble accessing care due to the lengthy Medicaid application process. Delays were in inability to access prenatal or infant care.

Recommendation: Improve performance of Medicaid; find ways to increase access to care for women and infants experience delays in activation of their Medicaid.

Action: FIMR established collaboration with Family Health Line and CHOP; team members developed postcards for distribution to clients who may experience delays, informing them of how to utilize Family Health Line and CHOP to increase access.

Contra Costa County

Contact: Natalie Berbick; Natalie.Berbick@hsd.cccounty.us

The Contra Costa FIMR Program's Perinatal Palliative Care Team is creating a grief and bereavement support training for local health services providers to be completed spring 2017.

Problem: Late to prenatal care trend and lack of tracking health care services for moms between multiple providers.

Recommendation: Create a product that a mother can keep with her to track her health care

Action: Prenatal health care card (pocket-sized). Patient can share this card with providers if she goes to multiple clinics to receive care.

Problem: Fetal birth defects that can be mitigated through better nutrition for reproductive age women.

Recommendation: Improve public awareness of the benefits of folic acid in preconception and interconception health.

Action: Folic Acid Campaign – raised awareness of folic acid and its role in preventing birth defects of the brain and spine. The campaign included collaborative efforts, media, incentives and educational materials, and regional trainings.

Problem: Perinatal health disparities with African American maternal and infant health outcomes.

Recommendation: Increase public awareness of issue, and provide an annual convening and support for pregnant African American Women.

Action: African American Baby Shower (2010) – a community baby shower for African American pregnant women that included educational sessions on preterm labor, breastfeeding and stress. The baby shower was put together in partnership with other public health programs and community partners.

Humboldt County

Contact: Allison Tans; atans@co.humboldt.ca.us

Problem: Infant and child deaths due to drowning were associated with lack of supervision at time of death

Recommendation: FIMR team will rejoin Northwestern Water Safety Coalition to strengthen prevention efforts.

Action: FIMR Coordinator joined Coalition and assisted with Public Service Announcements and obtained funding for Personal Flotation Devices

Problem: Maternal Depression and self-medicating with Cannabis Use

Recommendation: discourage Cannabis use and increase awareness of detrimental effects.

Action: Team with Health Educators and Healthy Moms Program to develop brochure and promote Public Health Breastfeeding Statement

Kern County

Contact: Elaine Anthony; anthony@co.kern.ca.us

Problem: Multiple infant deaths r/t Unsafe Sleeping Environment.

Recommendation: Provide safe sleeping environments to families who are being case managed by Public Health staff and do not have the means to afford a pack and play.

Action:

- Safer Sleeping Education Project was initiated to provide gift cards from Wal-Mart and K-Mart to be distributed to perinatal women who are at least 38 weeks gestation and are being case managed by Public Health Nurse or Aide so that they can purchase a pack and play.
- Safe Sleep Public Services Announcements throughout Bakersfield using electronic billboards for two months; social media using Facebook, YouTube, and Twitter; and PSAs at the Maya Cinema for two months.

Expanded services to the Lincoln House by providing Safer Sleeping Education. Lincoln House is a facility that houses perinatal women who have difficulty with substance abuse.

Problem: increasing number of fetal and infant deaths r/t perinatal substance abuse.

Recommendation: Community partners i.e. Mental Health, Managed Care, FQHC staff, DHS etc. would collaborate on substance abuse prevention education for the public, especially women of child-bearing age.

Action: The Perinatal Substance Abuse Prevention Partnership (PSAPP) was initiated. PSAPP meets every other month to discuss ways to reduce perinatal substance abuse in Kern County.

Placer County

Contact: Sue Seaters; sseaters@placer.ca.gov

Problem: Death of infants < 4 mos of age to pertussis, no Tdap given during last trimester of pregnancy

Recommendation: Survey OB provider offices to determine whether Tdap was being offered and administered to pregnant moms in 3rd trimester- offer support/assistance to providers to increase the # of women vaccinated in during pregnancy.

Action: local Immunization coordinator contacted all OB offices to survey who administered the Tdap in pregnancy. Few providers were offering vaccine, but referring patients to their Primary Care Provider (an additional medical appt). Ongoing assistance with provider offices to determine what the barriers are for them to house and offer Tdap vaccine in office.

Problem: Death of infants < 4 mos of age to pertussis, family members and other in-home caregivers were not current on their Tdap vaccines.

Recommendation: Offer in home Tdap vaccines to family members of pregnant women who were being case managed by home visiting Public Health Nurses to facilitate cocooning the newborn.

Action: Funding was secured through the work of the Immunization coordinator and Public Health to provide in-home vaccines to anyone not current for Tdap living in a home with a pregnant woman or newborn

Problem: A sentinel Case: positional asphyxia related to a “boat bed” that had a lidded toy box in the “bow”, child fell in, lid fell- pinning the child, unable to escape and died.

Recommendation: FIMR/CDRT Coordinator contacted Consumer Product Safety Commission with information on the case.

Action: A thorough investigation was completed by CPSC resulting in an international recall on the bed
San Francisco

Contact: Aline Armstrong; aline.armstrong@sfdph.org

In 2010, SF FIMR CRT recommended a safe sleeping policy for newborns due to unsafe sleeping cases reviewed. To address SIDS prevention and unsafe sleeping, recommendations were made for SF FIMR to become a partner of the “Cribs for Kids Program” in Pennsylvania. In partnership with Cribs for Kids, we were able to adapt their educational forms and purchase Pack N Play cribs to be disseminated through SF MCAH home visiting programs. In 2016, a new component to the procedure for dispensing cribs was added to include providing a well-fitted sheet with the crib.

The San Francisco FIMR program received a two-year UCSF Preterm Birth Initiative award to strengthen the local public health surveillance system for preterm birth, so that it can be used to inform tailored, targeted interventions to prevent preterm birth and address Social Determinants of Health. This project is an expansion of FIMR.

Problem: Infant deaths were associated with chronic maternal health conditions, including hypertension, gestational diabetes, obesity, and mental health illness. More than half of the women with chronic conditions had a pregnancy that was unplanned, and needed a medical home.

Recommendation: Encourage preconception and interconception counseling for women, so they can plan for optimal pregnancy outcomes.

Action: a) We will designate 1 FTE Public Health Nurse to address young women’s health during preconception and interconception.

b) To address mental health, SF Nurse Family Partnership Home Visiting Program has already collaborated with Project LAUNCH/P500. These services will include mental health consultation and resources for pregnant women and their children. Field Public Health Home Visiting Program will be included in this model in the upcoming New Year.

Ventura County

Contact: Claudia Benton; claudia.benton@ventura.org

Problem: Late access to prenatal care

Recommendation: Coordinate to promote access to health care

Action: Requested to survey WIC clients. Request unsuccessful. Developed a Prenatal Website in collaboration with MCAH and other agencies such as First 5

Problem: substance use in pregnancy

Recommendation: More advocacy for MDs education.

Action: FIMR team sponsored a conference for physicians related to Marijuana use in pregnancy

Colorado

Weld County

Contact: Melanie Cyphers; mcyphers@co.weld.co.us

Problem: fragmentation of care in our community

Recommendation: Create and implement a survey to find out what is actually occurring in our community among prenatal providers in terms of education, guidelines, and policies

Action: Survey of prenatal providers on various prenatal practices

Problem: need for improved grief support in our community

Recommendation: develop written materials on grief support to give to women at the hospital for miscarriage or infant loss

Action: A group of individuals in the community came together to create a community grief center that will among many functions, house a support group for parents who have lost infants.

Problem: need for more healthy lifestyle education in pregnant women

Recommendation: utilize methods like “test4baby”, include more education in high school classes regarding preconception health, work with programs like the Tobacco education group to distribute educational materials and develop awareness campaigns, present findings to prenatal providers to enhance awareness of areas of increased patient education

Action: Tobacco program including education to pregnant women in their work plan; plans to present findings to prenatal providers in development stage

Safe Sleep Campaign in 2013, 2014, 2016 (involved creating tool kits and presentations for providers, proclamations by city and county government, attendance at community events, parades, fairs, press conference, public showing of a PBS documentary) ; Increased Public awareness of infant mortality issues via newspaper articles, community forums, attendance at health fairs, networking of agencies involved in FIMR process

The Weld County FIMR program began in 2012 after a local physician became concerned about the high IMR in our county. It is the only one in our state so we have had to develop most of our materials and action plan alone using guidance from existing FIMR materials. This has been a very challenging program to work with since we have no budget, a staff of 1 (10 hours per week also working on CDR), little support, challenges in getting referrals (HIPPA) and then in getting their records. Despite these challenges, there has been an increased awareness of the issue of infant mortality in our community and a subtle shift in individual agencies to make changes that will enhance maternal health and infant survival. Our safe sleep campaigns have drawn much attention even from the State Health Department, and within our community, this program has name recognition. The most impressive result of our involvement in FIMR is that our IMR decreased from 7.5 in 2011 to 4.7 in 2015.

Delaware

Contact: Joan Kelley; Joan.kelley@state.de.us

Problem: Need to expand access to and reimbursement for LARCs (long acting reversible contraception) in both the public and private clinics statewide.

Recommendation: The CRTs recommended that birth control be provided in the immediate postpartum period. LARCs are more likely to result in effective contraception, because once they have been placed, their effectiveness is not dependent upon daily decisions by women to assure that they are being used properly. Increasing access and insurance coverage of LARC will provide more options to women for making family planning choices that fit their preferences and lives.

Action: There was a resurgence of interest in LARC and discussion of increasing access to these contraceptive options. DE Medicaid has approved the reimbursement of postpartum LARC insertion outside the bundled services for delivery admission, making the procedure more economically feasible for providers and hospitals.

Problem: The CRTs noted that it was important that home visiting representatives notify a woman’s OB provider when she is enrolled in an evidenced based home visiting program and provide regular clinical and/or psychosocial updates to facilitate interagency communication and continuity of care.

Recommendation: improve communication between the prenatal care providers and home visiting providers to help increase provider awareness of the content and benefits of such services. This may in turn, result in providers' more apt to screen and refer high risk mother for home visiting services.

Action: The DE Home Visiting Community Advisory Board has developed templates for a provider feedback form, an enrollment letter and a referral letter to standardize and efficiently communicate information between home visiting and healthcare providers.

Problem: The CRTs suggested mothers receive education on the importance of early and consistent prenatal care for those women who had no PNC, limited PNC or late PNC.

Recommendation: For those women who present to ERs/OB triage units the opportunity may present itself to obtain a social work assessment to evaluate what services are available for the mother and what appropriate referrals can be initiated.

Action: The CRT members felt that the feasibility of getting a SW assessment varies based on the location of the clinical facility and the time of day. Even in larger hospitals the SW staff is busy during the day and pregnant women "may not be a priority. At night, there may only be one SW on call covering multiple sites so access is limited. Other smaller hospitals or free-standing emergency rooms usually do not have a SW on call.

Florida:

Escambia

Contact: Meghan Emmons; meghan@healthystart.info

Problem: Lack of bereavement services available to women when fetus is diagnosed with a lethal anomaly in utero or after the loss of a baby.

Recommendation: Increase awareness of bereavement services available to women through Healthy Start, local counselors, and grief support groups.

Action: Resolve Through Sharing (RTS) bereavement training was held and highly attended to combat the absence of bereavement services that specialize in perinatal loss.

Problem: Transportation is a significant barrier to women receiving early and consistent prenatal care.

Recommendation: Develop a pilot project that will include the use of transportation network company (TNC) such as Uber to address the issue of transportation.

Action: The Infant Mortality Task Force, comprised of local and state civic leaders, OB and pediatric providers, and public health officials is charged with this project.

Hardee, Highlands and Polk Counties

Contact: Tonya Akwetey; takwetey@healthystarthhp.org

Problem: There was a high rate of deaths associated with unsafe sleep practices.

Recommendation: Investigate the reason for the deaths associated with unsafe sleep.

Action: Created a tri-county program called The Beds for Babies Project. This project provides safe sleep pack n plays, halo sleep sacks, fitted sheets, and a book about safe sleep for our local communities.

Problem: There was high rate of preterm/early labor associated with maternal dehydration.

Recommendation: Committee members spoke with providers to ask what they thought the reason was for moms going into early labor.

Action: There was a water bottle created for all moms in the tri-county area with the slogan make it 6-8 a day to encourage water intake prenatally and postnatally.

Problem: There was a high infant mortality rate in African American and Hispanic populations.

Recommendation: Educate the African American and Hispanic populations about the importance of prenatal care, folic acid, and Healthy Start services.

Action: There was a church fan created for local churches in both Spanish and English distributed in the African American and Hispanic communities that listed information about prenatal care, folic acid, and Healthy Start services.

Baker, Clay, Duval, Nassau, St. Johns Counties

Contact: Tracy Claveau; tclaveau@nefhsc.org

Problem: Unsafe sleep practices continue despite providing safe places to sleep and education

Recommendation: survey of general public about “what safe sleep means”.

Action: revised educational materials to specify what safe sleep really means.

Problem: Lack of contraception post-partum often linked to inability to obtain contraception prior to hospital discharge.

Recommendation: Determine method to provide long acting reversible contraception prior to discharge. However this is not a paid service by Medicaid prior to discharge in Florida.

Action: In partnership with other projects, approached Medicaid and have been given approval to pilot the administration of long acting reversible contraception to Medicaid clients prior to discharge as a covered benefit.

Leon, Wakulla, Gadsden, Jefferson, Maddison, Taylor Counties

Contact: Faye Gardner; faye@capitalareahealthystart.org

Problem: here is a high number of fetal and infant deaths associated with maternal obesity

Recommendation: Primary Care Physicians (PCP) should discuss preconception health to women of childbearing age, including the importance of a normal BMI Pre-pregnancy.

Action: Our CAT is working to educate Primary Care Providers in the area.

Pinellas County

Contact: Michelle Schaefer; mtschaefer@healthystartpinellas.org

Problem: Several families do not have a safe place for their babies to sleep that can also be placed next to the parent’s bed or be easily moved from one residence to the next. Also, parents continue to use loose blankets to place the baby to sleep.

Recommendation: Provide pack and plays and sleep sacks at no cost.

Action: A pack and play and a HALO sack is provided to families in need that reside in the Pinellas County in Florida. Education about recommended safe sleep guidelines by the American Academy of Pediatrics is provided along with instructions on how to use pack and play and sleep sack.

Problem: Obese rates continue to rise, and are highly associated with poor pregnancy outcomes

Recommendation: Discuss appropriate weight gain during first appointment/first trimester and offer exercise classes at no cost.

Action: Contract created with a fun and upbeat exercise instructor that provides classes at local gyms. Healthy Start participants with high BMI’s are referred to classes. Instructor receives referral information, calls the client and gets them interested in the classes and pumped up about participating.

Problem: Specialized bereavement services are expensive and women referred are not participating.

Recommendation: Fund counseling sessions and train all involved parties to correctly refer to service.

Action: Purchase agreement created to cover cost and release news and referral instructions to all involved parties.

Sarasota County

Contact: Terri Roberts; river4@digitalbungee.com

The FIMR team created a separate Safe Sleep Sarasota Initiative focusing on community partnerships, support, referrals, and education. Implemented multi-agency plan and updated practice.

Problem: High need for bereavement support for those who have experienced fetal/infant loss.

Recommendation: Development of support groups, and focus on ways to reach the community for education and support.

Action: Support groups and curriculum identified, grants written to fund, will implement upon funding allocation.

Problem: High number of maternal infections contributing to poor birth outcomes.

Recommendation: Research innovative ways to share prenatal health information to community.

Action: Located several free apps and texting programs (Text4Baby, Lamaze, etc.) with excellent parental health information. Shared information with agencies, organizations, clients, and healthcare providers in the area.

Broward County

Contact: Sandra Despagne; sdespagne@hmhbbroward.org

Problem: Community is experiencing a high number of sleep related deaths that are 100% preventable.

Recommendation: All caregivers should be educated on infant safe sleep practices.

Action: Conduct a County wide safe sleep awareness campaign to decrease the number of sleep related deaths in the community, target education with specific entities and professionals.

Problem: Women are unhealthy and sometime have chronic illnesses contributing to poor outcomes.

Recommendation: Launch a preconception/interconception campaign to educate the community on the importance of being healthy before pregnancy.

Action: Healthcare provider toolkits are being developed surrounding the issue of preconception/interconception health to help provide resources and information needed for them to discuss and share with their patients.

Hillsborough County

Contact: Leisa Stanley; lstanley@hstart.org

Problem: SUID deaths, lack of parenting education.

Recommendation: Parenting Education.

Action: Safe baby program.

Problem: Poor baby spacing.

Recommendation: Increased Interconception care services.

Action: Care coordination services in NICU.

Problem: Poor maternal health/chronic health conditions.

Recommendation: Pregnancy Medical Home.

Action: Receipt of Strong Start for Mothers and Newborns, CMS grant to implement Pregnancy Medical Home mode.

Illinois
Chicago

Contact: Virginia Julion; lstanley@hstart.org

Problem: Need for a local support group for families who have experienced neonatal/infant loss.

Recommendation: Start monthly support group.

Action: Monthly support group started, two annual activities for recognizing loss.

Problem: Inability to access medication to prevent preterm labor.

Recommendation: Raising awareness with medical providers regarding women being able to receive Progesterone medication regardless of their ability to pay.

Action: Women who needed this service were able to receive medication free or at a reduced rate.

Indiana
Elkhart County

Contact: Marti Liechty-Conrad; mconrad@elkhartcounty.com

Problem: Babies dying related to co-sleeping with adults

Recommendation: Increase educational efforts re: dangers of co-sleeping.

Action: Make sure ALL providers working with pregnant moms and infants have up-to-date and readily available information on Safe Sleep Guidelines, make sure ALL providers working with pregnant moms and infants have information on referral process to Cribs for Kids free Pack and Plays.

Problem: Issues re: Fetal Movement

Recommendation: Increase educational efforts re: the importance of being aware of Fetal Movement and how to track.

Action: Make sure ALL providers working with pregnant moms have up-to-date information on the importance of Fetal Movement Tracking beginning at 28 weeks GA.

Problem: Access to early OB care.

Recommendation: Increase community Awareness regarding the importance of obtaining early, consistent OB care.

Action: Make sure ALL providers working with pregnant moms have up-to-date information on how to refer for Prenatal Care Coordination / navigation for Medicaid access.

Marion County

Contact: Teri Conard; TConard@MarionHealth.org

Problem: Increase in Maternal Substance Use in Pregnancy.

Recommendation: Better understanding of Maternal Substance Use Barriers to Care.

Action: Involvement with state efforts to impact maternal substance use and improve care, Poster presentation at the 2013 National American Public Health Association.

Problem: Impact of Maternal Obesity in Infant Mortality.

Recommendation: The general public does not understand how obesity affects fetal health.

Action: Public/Profession education at the local Healthy Babies Consortium meeting on the impact of Obesity.

Problem: Maternal Diabetes impacting pregnancy outcomes.

Recommendation: Education on the effect of Maternal Diabetes on pregnancy and infant health.

Action: Presentation at local consortium of FIMR findings APHA 2015 oral presentation on FIMR findings at national APHA meeting.

Vanderburgh

Contact: Lynn Herr; lherr@vanderburghcounty.in.gov

Problem: High nitrate levels in well water potentially associated with fetal loss.

Recommendation: To look at correlations, monitor water reports and follow up with the Indiana State Department of Health

Action: taking to CAT this week... more to come.

Problem: No assigned PCP to follow up at risk newborn

Recommendation: Develop a policy for hospitals to follow-up with newborn care if not assigned PCP at discharge (weekend discharge).

Action: Local hospitals to develop a plan and inform the team.

Problem: Increase number of safe sleep deaths for 2016.

Recommendation: More community awareness, standardized education and modeling.

Action: Pull together a community coalition to address safe sleep with standardized messages. Working with local hospitals, universities and community partners.

Kansas

Junction City

Contact: Dani Holliday; dholliday@gcphd.org

Problem: Pregnant mother that are new to the area, one visiting and one moved to the community, are not aware of services or programs available. Medical records incomplete or not available. The review of records of the case note care was given with limited information regarding the pregnancy history. One mother was a new patient to the medical community the other mother was visiting the area.

Recommendation: Develop a travel brochure for use by mothers. Distribute brochures to area doctor offices. Survey clinics for use and effectiveness of product.

Action: Pregnancy passport brochure developed in coordination with local clinics and agencies.

Brochure distributed to clinics. Clinics surveyed for use of the brochure and perceived effectiveness.

The product was well received and continues to be utilized in the community, to include military installation.

Kansas City

Contact: Jennifer Allen-Caudle; jallen@wycokck.org

Problem: Lack of grief and bereavement support services for families experiencing an infant or fetal loss

Recommendation: Enhance services in the community

Action: Developed a community grief support group and created an annual Pregnancy and Infant Loss Awareness Vigil

Kentucky

Louisville

Contact: Mary Jolly; Mary.Jolly@louisvilleky.gov

Problem: post-partum grief support specifically for stillbirth loss for the families is lacking

Recommendation: assess the community resources available

Action: create a list of available resources for the families and refer as necessary. Hospitals are willing to offer the space for these groups as well as looking into churches in the neighborhood

Louisiana

Orleans, St. Bernard, Plaquemines, and Jefferson

Contact: Rosa Bustamante-Forest; Rosa.Bustamante-Forest@la.gov

Problem: Fatalities related to unsafe sleep environments.

Recommendation: Better investigation of these deaths.

Action: Statewide trainings for coroner's and investigators.

Problem: Fatalities related to unsafe sleep environments.

Recommendation: Move beyond the ABC of safe sleep to conversation with parents and problem solving, risk reduction strategies that are culturally congruent.

Action: no action as of now.

Problem: Stillbirths with unknown cause of death.

Recommendation: Need greater detail in examination of the placenta when no autopsy is done.

Action: no action as of now.

Lafayette, Evangeline, Saint Landry, Acadia, Saint Martin

Contact: Christine Cornell; christine.cornell@la.gov

Problem: Increase number of drug exposed infant births.

Recommendation: increase community education around the dangers of substance abuse in pregnancy

Action: 1. NAS Project of Acadian group formed. One day community in-service presented by Dr. Barry Lester offered 2. Awareness of NAS shared with La. Perinatal Commission.

Problem: Increase cases of STD/HIV, including congenital syphilis.

Recommendation: Increase community awareness.

Action: Statewide task force to increase community awareness and resources available via media.

Vernon, Sabine, Natchitoches, Winn, Grant, Rapides, LaSalle

Contact: Lisa Norman; lisa.norman@la.gov

Problem: Infants are dying from unsafe sleep practices

Recommendation: Broad community education on safe sleep practices

Action: After giving a safe sleep presentation to a local Kiwanis Club, the group offered to provide a small amount of money for a safe sleep community project. The MCH Coordinator connected them with a local hospital which was looking for funding a safe sleep display in the hospital lobby. The Kiwanis Club donation provided a crib, doll, clothing and sheets for the lobby display and a pack-n-play, doll and sheets for a second display inside the nursery by the viewing window. The hospital marketing department created an attractive AAP recommended safe sleep messaging for both displays. The Joint Commission was very impressed with the project noting it was a great example of "best practices".

Problem: Infants are dying from unsafe sleep practices

Recommendation: Broad community education on safe sleep practices.

Action: The Rapides Parish Coroner's Office funded a 30 second safe sleep PSA featuring the well-known coroner sharing points for safe sleep. The MCH Coordinator collaborated with the Communication,

Innovation and Action department within the Bureau of Family Health to target the script to parents with young families (primarily Africa-American parents in their 20s).

Problem: Infants are dying from unsafe sleep practices.

Recommendation: Broad community education on safe sleep practices.

Action: The Rapides Parish Coroner's Office funded a 30 second safe sleep PSA featuring the well-known coroner sharing points for safe sleep. The two large hospitals in Rapides Parish were encouraged to use the PSA for "in house" promotion of the safe sleep messaging in the emergency department and throughout the hospital. It was also proposed to the hospitals that they could use the script prepared by the Communication, Innovation and Action department of the Bureau of Family Health to market the safe sleep message using a person of their own choice and branding the message with their hospital logo.

Washington, Saint Tammany, Saint Helena, and Tangipahoa

Contact: Martha Hennegan; Martha.Hennegan@la.gov

Problem: Babies are dying in unsafe sleep environment

Recommendation: Provide safe sleep education to all delivering parents at regional hospitals

Action: Regional coordinator met with each MCH nursing director and led staff, provided data, resources and support for review and revision of safe sleep practices within and discharge planning for all new parents. Admit assessment revised to include questions about planned sleep environment for new born, revised discharge check list. Additionally, hospital parenting centers provide safe sleep education with all expectant parent orientation.

Problem: Babies at additional risk for dying in unsafe sleep environments during natural disasters

Recommendation: Provide safe sleep education (Bi-lingual) specific to families in temporary housing

Action: Flyer distributed with written and pictures demonstrating safe sleep recommendations during temporary re-location. Pack and plays, baby boxes provided through local non-profit in connection with WIC, Red Cross, United Way and staff at shelters. Local coroner holds press conference reminding families about the importance of safe sleep for babies during disaster, avoiding co-sleeping and providing recommendations on parish website for resources.

Problem: Families struggle with adequate food supply and activities during summer months.

Recommendation: Develop a resource directory for DCFS, Head start, local food banks.

Action: Held a summer program resource fair, developed a directory distributed to Medicaid, Head start, faith based organizations, food banks and as a result of publicity, large big box retail chain provided over \$60,000.00 to regional food banks and supplies as well as 15 employee volunteers to get out the word and assist with distribution (food, school supplies, clothing, etc.).

Maryland

District of Columbia

Contact: Lisa Helms-Guba; hdhelm00@aacounty.org

Problem: Infant Deaths related to unsafe sleep conditions

Recommendation: Prevent SIDS/SUID Deaths

Action: We developed a Stork's Nest with one of our partners. Between Healthy Start, DSS Family Support Center and Stork's Nest- we issue pack and plays to families that do not have a crib for their babies. We also have a Healthy Babies website and safe sleep materials. www.aahealthybabies.org. We have educated pediatricians and birthing hospitals on infant safe sleep. We have also done ongoing Infant Safe Sleep Advertising- bus shelter signs, billboards, and radio and newspaper ads.

Problem: Substance Abuse in Pregnancy

Recommendation: Prevent and reduce substance abuse in pregnancy

Action: Birthing hospitals in our county test at delivery for illicit substances.

Developed a brochure for OBs/Healthy Start/Department of Social Services to hand out to pregnant mothers- <http://aahealthybabies.org/pdf/marijuana-pregnancy-facts.pdf>

Problem: lack of bereavement services to FIMR families

Recommendation: Provide Bereavement resources to families with an infant or fetal loss

Action: We developed a pamphlet that the birthing hospitals give out for infant/fetal losses-

<http://www.aahealthybabies.org/pdf/bereavement.pdf>

Baltimore County

Contact: Mary Beckenholdt; mbeckenholdt@baltimorecountymd.gov

Problem: Recent increase in mental health disorders and drug addiction among pregnant women, especially in eastern Baltimore County.

Recommendation: OB/GYN Grand Rounds at obstetric hospital in eastern Baltimore County highlighting mental health and drug addiction services available to these patients through the Baltimore County Department of Health.

Action: Held OB/GYN Grand Rounds in Eastern Baltimore County hospital highlighting the services available to providers through Baltimore County Department of Health who manage pregnant women who are either drug addicted or have mental health problems, or both.

Problem: Increase in pregnant women in Eastern Baltimore County with a positive risk factor for smoking.

Recommendation: Hold OB/GYN Grand Rounds with expert speaker who specializes in smoking cessation techniques.

Action: Held OB/GYN Grand Rounds in eastern Baltimore County Hospital where our speaker gave presentation on various techniques and treatments available to help pregnant women who are smoking.

Problem: Literature revealed use of Magnesium Sulfate as neuroprotection in pregnant women who would imminently be delivering preterm infants.

Recommendation: Hold OB/GYN Grand Rounds with speaker who is an expert in the use of this medication, dosage, statistics supporting this, etc.

Action: Held OB/GYN Grand Rounds in all three Baltimore County hospitals where our expert speaker presented findings on the use of Magnesium Sulfate for neuroprotection among preterm infants, decreasing their chances of developing developmental delays, if they survive.

Calvert County

Contact: Betsy Bridgett; betsy.bridgett@maryland.gov

Problem: Lack of contraception offered postpartum to high risk women.

Recommendation: Increase usage of LARC

Action: Wrote and received a grant based on FIMR findings targeting women with substance use disorders. Increased access to the most reliable means of contraception.

Cecil County

Contact: Tina Bell; tina.bell@maryland.gov

Problem: Sleep-related deaths

Recommendation: Safe Sleep Campaign

Action: Safe Sleep Campaign t-shirt with message, bottle bag and educational materials are provided to sites to distribute to the pregnant and post-natal women for whom they provide services.

Problem: Pregnant women are unaware of decrease in fetal movement

Recommendation: Develop educational material for distribution to pregnant women.

Action: "Kick Counts" flyer was developed by FIMR Board and distributed to sites which provide services to pregnant women.

Problem: History of smoking during pregnancy

Recommendation: Increase smoking cessation education of pregnant women

Action: Brochure regarding the effects of tobacco on the fetus is placed in Safe Sleep Campaign educational bags. Second hand smoke presentations are conducted in the community for pregnant women and families. Obstetricians can participate in Cecil County Health Department Nicotine Replacement and Chantix™ Program, by prescribing nicotine patches and giving payment vouchers for the medication at participating pharmacies. These vouchers are provided by a grant funded by the Pregnancy and Tobacco Cessation Help (PATCH) grant awarded to the Cecil County Health Department. The Maryland Quit Line is promoted and providers are taught how to conduct a short smoking cessation session. Anti-smoking policies in community agencies and organizations are promoted.

Charles County

Contact: Lois Beverage; Lois.Beverage@maryland.gov

Problem: need to decrease the chance of children being left in cars

Recommendation: partnership with child care providers to call families if children are not dropped off as expected

Action: Regional program developed and implemented asking for a pledge from child care providers to contact families if children do not show up as expected.

Problem: Need to increase parent education regarding safe sleep environment

Recommendation: Distribute widely a DVD produced by the state on this subject.

Action: DVD's are being produced and distributed by the FIMR Outreach Worker to medical providers, hospital, civic groups, outreach events, and individual families.

Problem: Pregnant women not feeling supported in their workplace

Recommendation: Approaching the local Chamber of Commerce regarding the issue and the State's Attorney.

Action: This is a very new concern and efforts are just in the beginning stages.

Frederick County

Contact: Jan Sparks; jsparks@frederickcountymd.gov

Problem: Delayed entry into prenatal care for Hispanic women

Recommendation: create bi-lingual resources

Action: developed pamphlets in Spanish about early care, video spotlights in Spanish

Problem: Decreased referrals to maternal fetal medicine

Recommendation/Action: Information about perinatology and "who should see a specialist" to be placed in OB offices and a bookmark for community agencies to hand to clients.

Problem: decreased sensitivity of OB office staff when there is a loss

Recommendation: tips for making an OB office more comforting sent to all OB offices along with bereavement resource brochure.

Action: Info sent during October "perinatal loss month".

Garrett County

Contact: Michelle Ford; michelle.ford@maryland.gov

Problem: Child died of SIDS when she was napping while mother was staying with friends

Recommendation: Safe Sleep information given at hospital and through home visiting. This safe sleep information related to safe sleep when the child is sleeping somewhere other than home.

Action: Information now given at hospital and through local health departments.

Problem: Unsure if hospital staff aware of all the resources available to families, ex. Now I lay me down to sleep photography.

Recommendation/Action: Hospital to make staff aware of all resources.

Howard County

Contact: Colleen Nester; cnester@howardcountymd.gov

Problem: Disparity in preterm birth rate and IMR amongst African American women in the community.

Recommendation: Broad-based education & outreach to providers, community groups, etc.

Action: Broad-based education & outreach to providers, community groups, etc.

EMPOWER Initiative, stands for Eliminating Premature Outcomes with Education and Resources; multi-system approach that is engaging OB providers, faith-based community groups, social organizations, and women in the community to empower themselves to take action for better health outcomes. Also includes an action/resource component.

Montgomery County

Contact: Sheilah O'Connor; Sheilah.o'connor@montgomerycountymd.gov

Problem: A number of pregnant African American women who experienced a fetal loss would have benefited from nurse home visiting or other case management.

Recommendation: Refer all Black / African American pregnant women to the Montgomery County SMILE (Start More Infants Living Equally Healthy) Program, which serves these populations during pregnancy and for one year after childbirth.

Action: FIMR / CAT ensured (via presentations and follow-up calls) that staff in the County's Community Health Services, Medicaid Unit and other Service Eligibility Units, School Health Services, and Infant & Toddlers Services are aware of the SMILE Program and how to make referrals to it. FIMR / CAT presented to hospital staff, Women, Infants & Children (WIC) Program staff, civic groups and to University of Maryland students.

Problem: Women who experience fetal / infant loss often began pregnancy with unaddressed chronic health issues that include obesity, diabetes & hypertension.

Recommendation: Promote optimal health prior to pregnancy.

Action: FIMR / CAT created a brochure "My Reproductive Life Plan" aimed at younger women, that includes a checklist of health issues to be aware of, and how to address issues before becoming pregnant. The brochure is printed in English, Spanish and French.

Problem: Some women who express interest in grief support don't attend peer or professional support groups due to lack of transportation, limited English skills, other children to care for or depression.

Recommendation: Identify bereavement support that can be offered over the phone, and in languages other than English.

Action: FIMR / CAT located several peer counselors who offer telephonic grief support, and also located services for Spanish speakers.

Prince Georges County

Contact: Kristen Newman; knnewman@co.pg.md.us

Problem: Prenatal education deficits-possible maternal lack of knowledge.

Recommendation: Create standardized prenatal education throughout the county.

Action: OB Toolkit (in process).

Problem: Public lack of knowledge; increase in sleep related deaths.

Recommendation: Media, Ad Campaign.

Action: Safe Sleep Campaign (in development).

Problem: Lack of knowledge in community regarding women's reproductive health.

Recommendation: Women's Reproductive Health Conference.

Action: Women's Reproductive Health Conference (under way for May 2017).

Somerset County

Contact: Lee Ann Ennis; LeeAnn@dhmh.state.md.us

Problem: Trend with infant deaths related to safe sleep.

Recommendation: Education Campaign.

Action: Safe Sleep Campaign.

Problem: Trend with pregnant women seeking services through the Emergency Department multiple times and not yet enrolled in local prenatal care.

Recommendation: Develop a process to ensure one point person is informed to coordinate and follow through to ensure pregnant women access prenatal care.

Action: Social Worker to refer to the local health department to assist these women with entrance into care.

Talbot County

Contact: Tracey Leeson; tracey.leeson@maryland.gov

Action: We educate continually on Safe Sleep, Car seats, and Kicks Count.

Washington County

Contact: Patricia Murphy; patti.murphy@maryland.gov

Problem: unsafe sleep practices

Recommendation: increase education

Action: safe sleep taught in schools, education provided in pediatrician and family practice offices.

Problem: increase in babies born with NAS.

Recommendation: Educate parents re the danger of drug use in pregnancy.

Action: pocket sized card generated with all the resources in the county for addiction.

Wicomico County

Contact: April Webster; April.webster@maryland.gov

Problem: Trend with infant deaths related to safe sleep issues.

Recommendation: Public education campaign.

Action: Safe sleep campaign that included billboards and messaging on buses.

Problem: Trend with pregnant women seeking services through the emergency department multiple times who had not yet enrolled in local prenatal care.

Recommendation: Develop a process to assure one point person is informed to coordinate and follow through to assure pregnant women are enrolled in local prenatal care.

Action: Local birthing hospital to implement change that if a pregnant women seeks services through the emergency department or labor/deliver and she has not enrolled in local prenatal care, she will be referred to the hospital social worker. The social worker is to refer to the local health department to assist the woman to enroll into care and enroll in other eligible services such as WIC.

Problem: A woman had an addiction intake completed mandated by the court who was uninsured and she was not aware that she was pregnant until she experienced the loss. If she was aware, insurance coverage would have been expedited for her to enter treatment.

Recommendation: Early identification of pregnancy for women entering addiction services.

Action: Implemented pregnancy testing for women entering addictions services through Worcester County Health Department who are not currently on a reliable method of contraception, such as Nexplanon or IUC.

Worcester County

Contact: Debora Farlow; Debora.Farlow@maryland.gov

Problem: Trend with infant deaths related to safe sleep issues.

Recommendation: Public education campaign.

Action: Safe sleep campaign that included billboards and messaging on buses.

Problem: Trend with pregnant women seeking services through the emergency department multiple times who had not yet enrolled in local prenatal care.

Recommendation: Develop a process to assure one point person is informed to coordinate and follow through to assure pregnant women are enrolled in local prenatal care.

Action: Local birthing hospital to implement change that if a pregnant women seeks services through the emergency department or labor/deliver and she has not enrolled in local prenatal care, she will be referred to the hospital social worker. The social worker is to refer to the local health department to assist the woman to enroll into care and enroll in other eligible services such as WIC.

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Recommendation: Early identification of pregnancy for women entering addiction services.

Action: Implemented pregnancy testing for women entering addictions services through Worcester County Health Department who are not currently on a reliable method of contraception, such as Nexplanon or IUC.

Michigan

Detroit

Contact: Yolanda Hill-Ashford; hillashford@detroitmi.gov

Problem: HIV/AIDS medications were not available immediately after birth to new mothers.

Recommendation: Provide Medicaid prescription coverage for HIV/AIDS medications to new mothers after they deliver.

Action: State Medicaid policy was changed to permit Medicaid prescription coverage for HIV/AIDS medications to mothers immediately after having given birth.

Problem: Family Planning

Recommendation: Provide birth control in the hospital when a woman indicates she does not want to become pregnant.

Action: Inform local hospital.

Problem: Frequent late entry into prenatal care.

Recommendation: Administer personal check-list assessment at doctors' offices for childbearing-age women

Action: Inform emergency room, doctors' offices.

ITC: Native American Infants throughout the State

Contact: Raeanne Madison; rmadison@itcmi.org

Problem: Few families received referrals and/or follow-up care for grief and bereavement counseling, either from a traditional American Indian or medical perspective.

Recommendation: We recommend that families have improved access to bereavement services including traditional and medical approaches.

Action: We applied for and received funding to support the first statewide bereavement support network for American Indians in the state of Michigan. Our team will be trained on nursing care and traditional Native protocols for providing bereavement support to grieving families.

Problem: A significant proportion of neonatal infant deaths had unsafe sleep factors that were present or contributed to the death.

Recommendation: Our families and entire communities need better education and support to practice safe sleep at all times.

Action: We implemented a massive statewide education campaign to promote infant safe sleep to families, health care professionals, elders, childcare providers, and early childhood providers in all Michigan tribes. This effort has been ongoing for the past two years, and has turned into a well-known campaign that includes traditional teachings along with the APP safe sleep recommendations.

Problem: A high proportion of cases had positive screens for domestic violence and/or family chaos in the home at present or in the past

Recommendation: Improve access to domestic violence services. Have our home visiting staff be trauma-informed and prepared to assist women who experience domestic violence.

Action: We held a training for all tribal home visiting staff to conduct domestic violence assessments in the home. They also learned how to make safety plans and respond to positive screens for DV. 100% of tribal home visiting participants have received domestic violence screens since the training was conducted.

Jackson County

Contact: Mary Kops; MKops@co.jackson.mi.us

Problem: Need for more meaningful referrals- that follow up.

Recommendation: To make sure referral happens.

Action: Pathways system implemented in 211 for pregnant moms – dedicated one employee to make and follow up on the referrals.

Kent County

Contact: Sarah E. MacDonald; sarah.macdonald@spectrumhealth.org

Problem: 75% of African American mothers are being drug screened prenatally while only 25% of white mothers are being drug screened

Recommendation: Universal screening and testing for substance use of all women during pregnancy

Action: Established the Coalition on Universal Screening and Testing for Substance Use during Pregnancy, working to create a community standard, created a brochure: “How to Stop Smoking Marijuana,” updated Substance Abuse and Mental Health Decision Trees. Plans: To send out survey to OB/GYNs on screening and testing practices, and present case for Universal screening to OB/GYN groups.

Problem: Continuing to have sleep-related infant deaths – 16.4% of infant deaths in 2015

Recommendation: Continue getting the safe sleep message out to community and health care providers

Action: Baby Buggy Walk in the Park, MDHHS Grant received, Super DADS – Dads against Dangerous Sleep, Community Resource cards for DOSE packet, TV and Radio Interviews: Maranda Show and WJRW, Infant Safe Sleep magnets and framed posters in English and Spanish, and New display board in Spanish. Plans: Safe Sleep education in the faith-based organizations and videos to refresh DOSE training.

Cities of Pontiac and Southfield

Contact: Lisa Hahn; hahnl@oakgov.com

Problem: Infants die of unsafe sleep

Recommendation: Promotion of safe sleep

Action: Billboards, bus signs and safe sleep posters, safe sleep education with foster parents, DHHS workers.

Saginaw County

Contact: Deb Rhodes; drhodes@saginawcounty.com

Problem: Premature births related to Bacterial Vaginosis infection.

Recommendation: Early screenings and follow up

Action: Education and resources on screening taken to area OB’s.

Mississippi

District 8 (Southeast Public Health, Covington, Jones, Wayne, Jefferson Davis, Marion, Lamar, Forrest, Perry and Greene Counties)

Contact: Gail Jones; gail.jones@msdh.ms.gov

Problem: need for infant CPR to be taught to family

Recommendation: include this as part of discharge teaching at hospitals

Action: this has been incorporated in the teaching at discharge

Problem: need for safe sleep environment to be taught to all caregivers

Recommendation: include this as part of discharge teaching at hospitals, prenatal care appointments, and pediatric appointments.

Action: teaching material and information has been provided at case review meetings and community action meetings to all attendees.

Problem: need for smoking cessation to be encouraged to childbearing aged women and pregnant women.

Recommendation: provide this education to patients at clinic visits. Make use of community resources to assist in this by referrals to appropriate sources, i.e. miss. Tobacco free coalition and the quit line.

Action: teaching material and information has been provided at case review meetings and community action meetings to all attendees.

District 9 (Coastal Plains Public Health, Pearle River, Stone, George, Hancock, Harrison, and Jackson Counties)

Contact: Cheryl Coleman; cherylcolemandoyle@gmail.com

Problem: Parents unable to perform infant CPR

Recommendation: CPR to be taught in hospitals to all families before discharge

Action: Done

Problem: Grandmothers not believing in ABCs of infant safe sleep

Recommendation: To be taught in hospitals; startup of Grand parenting classes

Action: Done

Problem: 40% smokers

Recommendation: Smoking Cessation classes offered on discharge

Action: Done

Delta Region

Contact: Arletha Howard; ahoward@tougaloo.edu

Problem: Follow up regarding grief services

Recommendation: Follow up regarding grief services

Action: Follow up regarding referrals

Missouri

Kansas City

Contact: Jennifer Allen-Caudle; jallen@wycokck.org

Problem: After reviewing the number of unsafe sleep deaths, a Safe Sleep Task Force was created, chaired by CRT, Child Death Review and SIDS Resources.

Recommendation: Procure Pak and play cribs and give them out to Medicaid moms for a safe sleep environment for their babies.

Action: Apply for grants, partner with home visitation agency, train them to teach safe sleep, give them cribs for their families, ask that at least one person from their agency sit in on the SSTF meetings (for their education and feedback to us from the community). There are 7 (soon to be 8) agency partners in Wyandotte Co Kansas (WYCO has the highest black infant mortality rate in the USA). There are 3 (soon to be 6) agency partners in Kansas City MO.

St. Louis

Contact: Catherine Carter; ccarter@generatehealthstl.org

Problem: Babies dying in unsafe sleep environments

Recommendation: Standing recommendation for SIDS Resources.

Action: Maintained relationship with SIDS Resources. Their director sits on the Case Review Team, and whenever issues or questions arise around safe sleep, Generate Health refers and defers to SIDS Resources, who offers safe sleep education and grief support services.

Problem: Smoking

Recommendation: Decrease prevalence of smoking among pregnant women and new mothers.

Action: Held training sessions for providers on best practices for smoking cessation.

Problem: High prevalence of Gestational and Type 2 Diabetes.

Recommendation: Improved preconception and prenatal diabetes coordination.

Action: A white paper was written about weight management and diabetes (specifically focusing on the preconception and prenatal periods). The white paper and recommendation for improved preconception and prenatal diabetes coordination was taken to the St. Louis Diabetes Coalition.

Montana

Contact: Kari Tutwiler; ktutwiler@mt.gov

Problem: One county determined expanded education was needed on safe car seats for infants.

Recommendation: Secure a business partner and host a community day to provide free car seats and demonstrate proper installation.

Action: Partnered with an insurance company that provided free infant car seats, demonstrated safe installation, and performed safety checks for people who stopped by. It is now an annual event.

Problem: Opioid abuse is a problem throughout the state and one county educated local providers on this issue.

Recommendation: Provide area doctors with specific information to help combat this issue.

Action: A member of a county FICMMR team produced and distributed a powerful letter to area doctors that contained a comprehensive listing of red flag behaviors common to people who abuse prescription drugs along with a link to training.

Problem: No one in their entire county was certified as a child passenger safety technician.

Recommendation: Someone on the FICMMR team needed to step up, if not us, then who?

Action: The FICMMR team leader took a week-long training and became certified. The training was essential allowing the county to continue participating in the Safe Seat/Safe Sleep Program (to receive free cribs & car seats to qualified families). At their first event, the team partnered with the local fire department for Child Passenger Safety Week and inspected 20 car seats, only one of which was installed correctly.

Flathead City-County

Contact: Brynne Leftridge; bleftridge@flathead.mt.gov

Action: Flathead Best Beginnings Community Council – an inclusive effort to bring together all community-based organizations that serve young children and families.

Action: Collaboration of local WIC office and Community Health Immunization Clinic – Immunization clinic reviews WIC clients (ages 0-5) immunization record before client's visit. If parent chooses to do so the child is able to be immunized that day at the immunization clinic as it is located in the same building.

Action: The Flathead County Immunization Coalition is a public-private partnership dedicated to improving vaccination rates in Flathead County residents to create a healthier community. The coalition meets quarterly to discuss current trends and challenges regarding increasing vaccination rates in Flathead County.

Lake County

Contact: Leigh Estvold; lestvold@mt.gov

Problem: Infant deaths were resulting from unsafe sleep practices, particularly bed sharing.

Recommendation: Education regarding safe sleep.

Action: We identified 2 sources where we are able to obtain Safe Sleep packages, including a Pack N' Play, and provide these to families when needed.

Madison County

Contact: Melissa Brummel; mcphd.melissa@madison.mt.gov

Problem: Physical Abuse

Recommendation: Provide education regarding abuse

Action: Provided community education through bulletin board/handout regarding physical abuse.

Nevada

Washoe County

Contact: Jan Houk; jhouk@washoecounty.us

Problem: On average, only 50% of women received prenatal care in the first trimester

Recommendation: Develop a program to ensure women are aware of the importance of on-time prenatal care.

Action: Secured funding for the Go before You Show campaign, which will be launched this year.

Problem: Inconsistencies exist in reporting fetal vs Infant Death

Recommendation: Medical professionals could benefit from clarification of Legal definition for delivery of an Infant vs Stillbirth

Action: Member of the State Department of Public and Behavioral Health agreed to disseminate this information.

Problem: There is a high correlation between Obesity and Fetal/Infant mortality, often with prematurity.

Recommendation: CRT will make recommendations to CAT for action.

Action: In progress

New Jersey

Atlantic City

Contact: Judith Stark; jstark@snjpc.org

Problem: Lack of parental education on fetal movement monitoring

Recommendation: Improve proportion of women who receive this education

Action: Provided materials to PNC sites

Problem: High proportion of fetal loss cases with obesity associated with loss and little individualized nutrition counseling at PNC site

Recommendation: Bring education to women at care site

Action: Worked with our local SNAP-Education providers to do waiting room education at FQHC's PNC clinics

Problem: Large proportion of cases with no autopsy or Standardized stillbirth evaluation

Recommendation: Increase proportion of autopsy or standard stillbirth evaluation

Action: Worked with project area delivery facilities to formulate consistent stillbirth evaluation and education to nursing staff on importance of such evaluation so they could advocate for this.

Ohio

Butler County

Contact: Karen Carr; carrke@butlercountyohio.org

Problem: need for contraception education for families seen by Children Services.

Recommendation: possibility of having the community health worker students be involved with providing contraception education to families in need.

Action: In Progress.

Cuyahoga County

Contact: Lorrie Considine; lconsidine@ccbh.net

Problem: No countywide listing of grief resources

Recommendation: Develop grief resource brochure for the county

Action: Grief resource brochure developed & mailed with a letter about the FIMR program to all families with a fetal or infant loss.

Problem: Families with fetal losses were upset that they could not get a birth certificate

Recommendation: Investigate what options are available to families with a fetal loss

Action: We found that a stillbirth commemorative "birth" certificate was available to parents free of charge. We now include this information in the FIMR letter we send to parents with a fetal loss.

Problem: Team not aware of what interventions/resources were available to families at the 8 birthing hospitals in our jurisdiction & what the hospitals knew about the FIMR program.

Recommendation: Plan & implement a round table discussion with birthing hospital representatives to look at grief support for families in the hospital & in the community.

Action: The round table meeting was well received & provided the opportunity to share knowledge & resources to benefit grieving families. The group wants to continue to meet.

Mahoning County

Contact: Tracy Styka; tstyka@mahoninghealth.org

Problem: lack of social support during pregnancy

Recommendation: Increase opportunities for social support to encourage prenatal care and continued care throughout the pregnancy

Action: implement Centering Pregnancy

Problem: lack of adequate birth spacing

Recommendation: Increased education to providers and community about proper birth spacing

Action: providing multiple avenues of education to providers and community

Oklahoma

Oklahoma City

Contact: Kelli McNeal; Kelli_McNeal@occhd.org

Problem: High disparities in Black and White Infant Mortality

Recommendation: Addressing health disparities in the African American community

Action: The Advisory Council has been supportive of addressing the infant mortality disparity issues in the African American community. As such, members have been instrumental in the development of the new Infant Mortality Alliance. The activities of the Alliance are included in Council meetings and will continue to be supported by the FIMR process. (Link to Infant Mortality Alliance strategic plan at https://www.occhd.org/application/files/6314/5938/0818/T1066_FIMR_Infant_Mortality.pdf)

Problem: many infant deaths associated with moms with mental health issues and substance use/abuse

Recommendation: Improve mental health and substance abuse services and interventions

Actions:

August: Blue Cross Blue Shield and coverage through the Affordable Care Act. This presentation included description of mental health and substance abuse coverage. In addition, Norman Regional HealthPlex shared about their newly implemented program on universal umbilical cord testing for drug use.

Action: The Council decided to develop a substance abuse work group.

Personnel from the Oklahoma Narcotics Bureau Drug Endangered Children Division discussed the desire to create a law enforcing prosecution for pregnant women who are abusing drugs. After a rather heated debate the group decided there was a greater need to communicate across disciplines to understand the underlying causes and coordinate greater solutions with multiple agencies and organizations.

Action: Council members are concerned that a proposed law will deter women seeking prenatal health care and want more information on the state plan.

Oklahoma Department of Mental Health and Substance Abuse Services updated the Council on what is happening at the state level on substance abuse services and that the new state plan did not currently including any language on pregnant women.

Action: Council began working with OSDH on finding language to be included in the new state plan. Staff will contact OSDH to coordinate.

Problem: Babies dying in un-safe sleep environments

Recommendation: Continue to educate/promote Safe Sleep for infants.

Action: The development of a train-the-trainer series to help more direct service providers educate the families they serve with safe sleep awareness, resources, and materials. Four trainings have been held with 136 participants have been trained in this series.

Outcome: Evaluations from the train-the-trainer series included the desire to have continuing education credits for participants. FIMR staff and work group members applied and received accreditation for providing continuing education credits for child care providers through the Center for Early Childhood Professional Development and nurses now receive credit through the Colorado Nurses Association for approval to award contact hours. The Colorado Nurses Association is accredited as an approver of continuing Nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

Problem: Tobacco use among pregnant women is a contributor to pre-term and low birth weight births

Recommendation: Tobacco Cessation for pregnant women and families, increased education and awareness on tobacco cessation for pregnant women

Actions:

A focus group with men who smoke was conducted in efforts to understand and develop strategic messaging aimed at second and third-hand smoking.

Outcome: Men have the perception that their smoking only affects them and not their family. Most do not understand the effects of second and third-hand smoke.

The Tobacco workgroup conducted an additional focus group with families participating with Family Expectations. The group is adding this information along with earlier focus group information to help identify new priority areas of focus. Data has also been requested from FIMR matrix and will be added to the discussion and will help in the development of evidence-based strategies. The area of most concentration currently centers on second and third-hand smoke.

Outcome: Development of strategic plan to create messages that educate on second and third-hand smoke. The plan includes creating a video and materials on second and third-hand smoke, increasing the Oklahoma Helpline visibility to pregnant Medicaid members and providing NRT (Nicotine Replacement Therapy).

FIMR has worked with the Healthy Living Grant at Oklahoma City County Health Department (OCCHD). This partnership was a huge benefit to the tobacco cessation work group as the Health Living grant provided items to create 2,000 smoking cessation quit kits.

Outcome: These kits will be given to pregnant women and their families that have indicated their desire to quit smoking.

The FIMR tobacco cessation work group has been hard at work developing new strategies to educate pregnant women and their families on the effects of second and third hand smoke. During one of the planning sessions it was recommended to include the 1-800 QUIT Now number on the back of Medicaid cards.

Outcome: Oklahoma Health Care Authority announced that they will be making that change for all new Medicaid cards distributed.

TennesseeKnox County

Contact: Katherine Larsen; Katherine.Larsen@knoxcounty.org

Problem: Need for large scale messaging around early prenatal care, full-term pregnancy and other healthy behaviors to improve birth outcomes.

Recommendation: Implement a media campaign and website for parents and caregivers.

Action: Launched Strong Baby media campaign in May 2016.

Problem: Need for education to women in addiction on NAS and birth control options.

Recommendation: Strategic partnership to reach women in recovery.

Action: FIMR program and Women's Health nurse practitioners to education and outreach to women enrolled in local recovery programs.

Nashville

Contact: Lillian Maddox-Whitehead; Lillian.Maddox-Whitehead@nashville.gov

Problem: Families were receiving messages from MCOs, magazines, formula companies and websites that would trigger grief of loss.

Recommendation: Need to prevent post loss families from receiving messages generated by birth Certificate from Welcome Baby and similar programs.

Action: FIMR Community Action Team Mental Health Action Team sensitivity toolkit action plan strategy development for calendar year 2016.

Problem: Smoking during pregnancy, lack of cessation services

Recommendation: Prenatal smoking cessation support is needed beyond just referral to TN Quit line.

Action: To date 17 instructors have been trained for the Baby & Me Tobacco Free Course. It has already been implemented in 88 counties in TN. Currently being restructured at MPH. Goal is to offer the course at all MPH sites. Expectant moms and their partner/family member are eligible.

Problem: Safe sleep death of infant, use of boppy pillow.

Recommendation: The Davidson County Child Fatality Review should review its authority to make review its authority to make recommendations to manufacturers of baby products (specifically, the boppy pillows) to include a stronger warning label about the danger of using with sleeping infants.

Action: A presentation re: Boppy Pillows was made at CDR August 2016 – the medical examiner will now refer all infant deaths that involve a product to CPSC.

Shelby County

Contact: Z. Leilani Spence; Leilani.Spence@shelbycountyttn.gov

Problem: Infants with Unsafe Sleep Environments/Service Linkage and Support Systems for Families

Recommendation: Outreach and Education – Social Marketing

Action: A robust social marketing plan was developed – to include bus wraps, FaceBook, Twitter, Health Department’s website, gas toppers, radio and television spots, billboards, movie theater announcements, blogs to encourage a unified safe sleep message (ABCs) of safe sleep. Additionally, families in need and WITHOUT an infant safe sleep environment are provided such resources at no cost (pack n plays are provided). Collaborations exist with birthing hospitals and home visitation programs regarding the availability of the resources.

Action: The program conducted a DOSE educational program (Direct on Scene Education) to for first responders (fire fighters). The DOSE program was developed by Captain James Carroll and is well recognized. The FIMR program has plans to enhance this education to include staff members employed by the local housing and apartment sectors. The program partnered with internal programs that provide case management/home visitation services to provide safe sleep education. For example, training was provided to the Infectious Disease/TB section—for the staff members that provide outreach and education. Also, when families present for the mandated Newborn Screening Activities, families are asked concerning their infant’s sleep environment- if family reports a need> a pack n play is made available. Most importantly, safe sleep resources are available to women and families served not only at the primary/main health department location, but, at the (6) public health clinics, as well. Transportation is a barrier for many families and by providing the resources at various locations – there exist “no wrong door” for access to such services.

Problem: Too few women breastfeeding, leading to poor infant outcomes

Recommendation: To educate women on the importance of breastfeeding

Action: Supplemental funding identified to promote peer and professional breastfeeding education. Also, social marketing was implemented to help increase initiation and duration breastfeeding rates. Program partnered with an Empower hospital regarding this topic and in collaboration with Clinical

Services, WIC program- provided breastfeeding support groups. Staff members, to include home visitation staff members, received workforce development opportunities to attend the Certified Lactation Course (CLC). The end result that the agency increased its depth with the number of CLC's on staff- not only in the WIC program, but available in the Maternal Child Health, home visitation programs, as well.

Problem: Need for Data to support program.

Recommendation: Hiring of a Data Analyst.

Action: Staff person was hired to provide epidemiological support for the program. Focus Groups/Listening Tours were scheduled to provide the consumers an opportunity to share input as to the barriers that exist related to maternal, child care.

Texas

Dallas

Contact: Alexea Collins; Alexea.Collins@phhs.org

Recommendation: Increase community and provider knowledge on insurance coverage/rights

Recommendation: Increase community and provider knowledge on insurance coverage/rights.

Recommendation: Focus on management of high risk pregnancies.

San Antonio

Contact: John Kwame Duah; john.duah@sanantonio.gov

Problem: Incomplete certification of death certificates.

Action: Data, which are entered by physicians into the death certificate, need more detail and accuracy to improve local and state health agencies' ability to assess and address trends in morbidity and mortality. The same holds true for fetal and infant deaths in Bexar County.

Problem: Premature birth and congenitally acquired anomalies are major associations with fetal and infant mortality outcomes. Evaluation of state data reveals that Bexar County has a high premature birth rate

Recommendation: Families need better education on signs of premature labor. All moms should have a medical home to help in the provision of risk appropriate care.

Action: We need to evaluate healthcare access and utilization for minority and low-income families.

Problem: Maternal age and chronic health conditions significantly affect the rates of prematurity and congenitally acquired malformations. We note a specific high trend for maternal conditions including obesity and diabetes.

Recommendation: Preconception health counseling is recommended for mothers intending to be pregnant. Screening for specific risk factors are recommended.

Action: Case management for high risk moms needs proper evaluation.

Tarrant County

Contact: Patti Shearin; pashearin@tarrantcounty.com

Problem: Few resources to support women after a fetal or infant loss

Recommendation: Increase capacity to support women and families after a loss

Action: Obtain list of current community resources, costs, and outreach practices of agencies that offer support and/or grief counseling to identify gaps.

Problem: Clergy lacks knowledge of the unique aspects of grief experienced by individuals following a pregnancy or infant loss.

Recommendation: Strengthen ability of clergy to minister to families after a fetal or infant loss.

Action: Offer training to hospital chaplains and the faith community to increase understanding of grief following a pregnancy or infant loss.

Problem: Lack of public understanding of on the importance of inter-conception health for optimal pregnancy outcomes.

Recommendation: Determine what is defined as inter-conception health to gauge current understanding.

Action: Focus groups held though out the county to include women of different demographics to determine current level of understanding and identify gaps.

Wisconsin

Central Racine City

Contact: Margaret Gesner; mgesner@crchd.com

Problem: Safe Sleep Messaging.

Recommendation: Campaign.

Action: Education to daycares; possible press release.

Problem: Infection during pregnancy.

Recommendation: Education during OB/GYN visits and STD clinics.

Action: Implemented education at STD clinics.

Problem: Prescription drop boxes.

Recommendation: Implement across the County.

Action: 9 boxes/sites implemented plus 4 one-day medication collection events.

Wood County

Contact: Ty Zastava; tzastava@co.wood.wi.us

Problem: Increased maternal BMI increases risk of stillbirth.

Recommendation: Increased attention to maternal BMI and preconception health.

Action: Recommendation letter created and sent to health care providers in the county and surrounding counties.

Problem: Accurate and thorough documentation not complete.

Recommendation: Providers strive to provide the best documentation for all patients. Providers are encouraged to document bereavement services that were provided.

Action: Recommendation letter created and sent to health care providers in the county and surrounding counties.

Problem: Importance of fetal movement monitoring.

Recommendation/Action: public education on kick counts and frequent patient education.

Puerto Rico

Contact: Cindy Calderon; ccalderon@salud.pr.gov

Problem: Obesity in Mothers as a risk factor for premature labor.

Recommendation: Increase prenatal nutrition education.

Action: Increase Nutritionist available in WIC centers.

Problem: Management of premature infants in inappropriate hospital level.

Recommendation: Evaluation of hospital levels and promotion of adequate referral.

Action: Regional Perinatal evaluation Task Force.

Problem: Lack of support in Hospitals to grieving parents of either a maternal loss, fetal loss or neonatal death.

Recommendation: Requiring hospitals to establish protocols to support grieving parents of either a maternal loss, fetal loss or neonatal death.

Action: Law 184 of 2016 requiring all hospitals to adopt a protocol to support grieving parents of either a maternal loss, fetal loss or neonatal death.