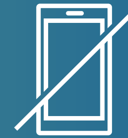
Welcome!

We are so glad you are here!

We will get started shortly.
In the meantime, we invite you to intentionally enter this space.


Silence your cell phone

Stretch

Close the door

Take a few deep breaths

Close browser windows

Emotionally release your to-do list

Check your audio and video

Take a bio break

2021 Healthy Start Virtual Grantees' Meeting

Fetal and Infant Mortality Review (FIMR) & Healthy Start: Synergy for Greater Health Equity

Wednesday, November 3, 2021 || 3 pm to 4:20 pm ET

Fetal and Infant Mortality Review (FIMR) & Healthy Start: Synergy for Greater Health Equity

Breakout Session

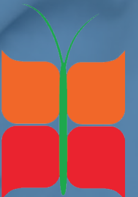
Wednesday, November 3, 2021

3:00pm – 4:20pm ET

The Healthy Start TA & Support Center is operated by the National Institute for Children's Health Quality (NICHQ). This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number 1 UF5MC327500100 titled Supporting Healthy Start Performance Project.

NICHQ
National Institute for Children's Health Quality

HEALTHY start
TA & SUPPORT CENTER



Agenda

Housekeeping	**Miriam Campbell**, National Healthy Start Association
Welcome & Introduction	**Miriam Campbell**, NHSA
FIMR & Healthy Start: Synergy for Greater Health Equity	**Rosemary Fournier**, National Center for Fatality Review and Prevention
Q&A	**All**
Closing	**Miriam Campbell**, NHSA

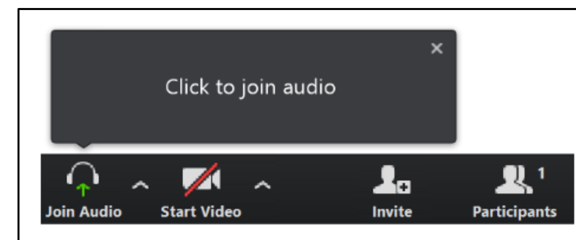
This session is being recorded.

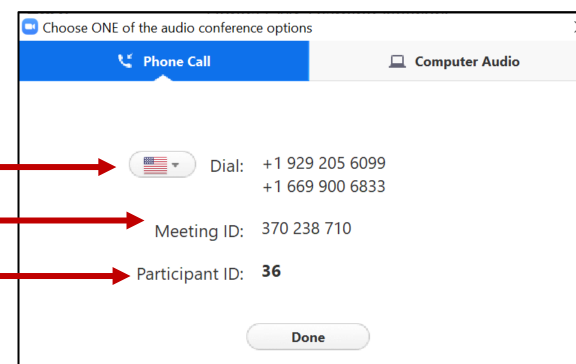
All participants are muted upon entry. We ask that you remain muted to limit background noise.

Participants are encouraged to share comments via the Chat module and ask questions via the Q&A module in Whova (on the mobile app or browser).

Audio

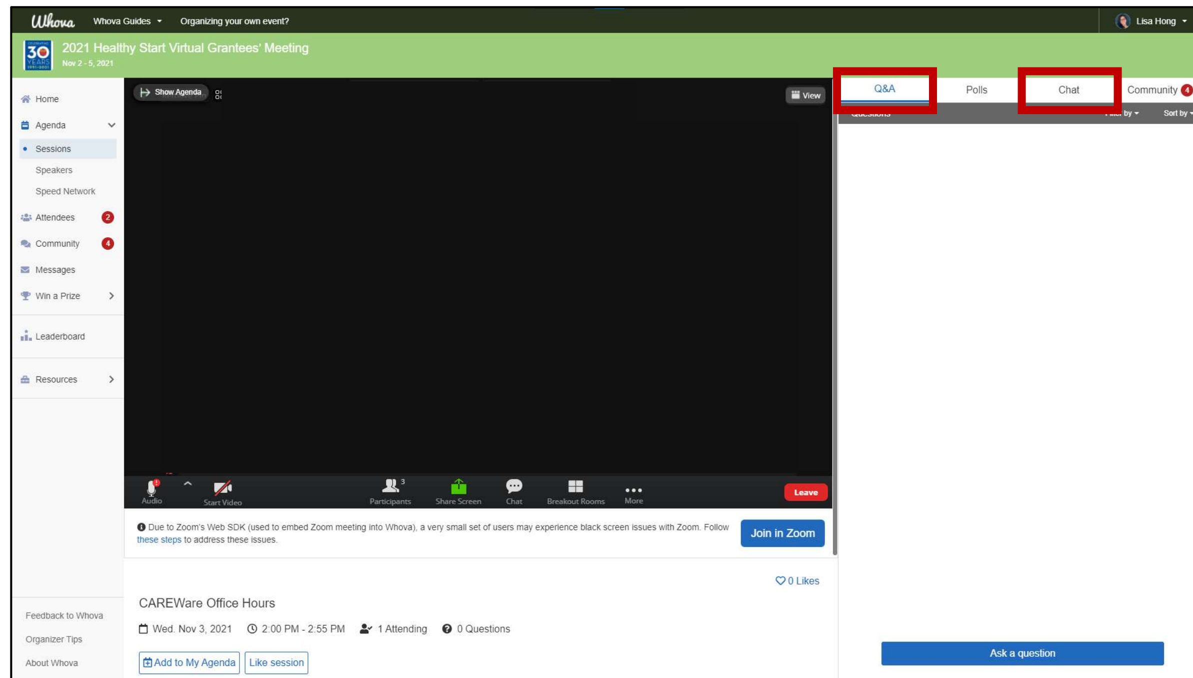
- After you join the Zoom session, an audio conference box may appear.
  - If you do not see the box, click **'Join Audio'**
- From the audio conference box, select **'Phone Call'** or **'Computer Audio'**
  - If using the phone:
    - Dial one of the given numbers next to **'Dial'**
    - You will be prompted to enter the **Meeting ID**
    - Then you will be prompted to enter the **Participant ID**



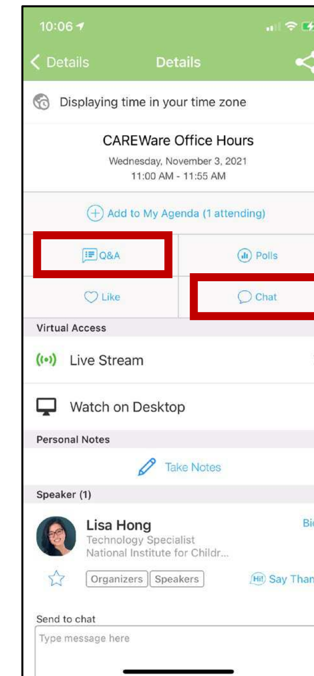


Chat and Q&A modules in Whova

Chrome Browser



Mobile Application



NICHQ National Institute for Children's Health Quality

HEALTHY start TA & SUPPORT CENTER

Like what you see?

The Healthy Start TA & Support Center is now active on social media!

1. Take a picture or a screenshot
2. Share on Instagram or Twitter!
3. Don't forget to tag @HS_TASC and @NICHQ and include hashtags #HealthyStartVGM2021 and #HealthyStartStrong

Technical Issues

If you experience any technical challenges with Whova, please email support@whova.com.

Welcome & Introduction

Miriam Campbell

National Healthy Start Association

Welcome to the VGM!

We hope you have been enjoying today's sessions so far!

In this breakout, you will:

- Learn how FIMR and Healthy Start working together can benefit communities and improve maternal, infant, and family outcomes.
- Learn how FIMR aligns with the four Healthy Start approaches
- Gain knowledge and understanding about how to use and leverage powerful stories and strategic storytelling in their FIMR practices and processes, for greater impact.

#HealthyStartVGM2021
#HealthyStartStrong
@HS_TASC @NICHQ

FIMR & Healthy Start: Synergy for Greater Health Equity
Hosted by the Healthy Start TA & Support Center at NICHQ on November 3, 2021

NICHQ
National Institute for Children's Health Quality

Our Speaker

Rosemary Fournier, RN, BSN
FIMR Director
National Center for Fatality Review and Prevention
Michigan Public Health Institute

Questions during the session?

Use the Q&A module in the Whova platform and make sure to identify the speaker to whom you are directing your question(s).

Questions will be answered during the session if time permits. Otherwise, questions will be addressed post-session.

Fetal and Infant Mortality Review (FIMR)

Healthy Start Virtual Grantees' Meeting

November 3, 2021

Telling Stories to Save Lives

KEY FUNDING PARTNER

FEDERAL ACKNOWLEDGEMENT

The National Center is funded in part by Cooperative Agreement Numbers UG7MC28482 and UG7MC31831 from the US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) as part of an award totaling $1,099,997 annually with 0 percent financed with non-governmental sources. Its contents are solely the responsibility of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

ABOUT THE NATIONAL CENTER

Technical Assistance and Training

On-site, virtual and/or recorded assistance, customized for each jurisdiction, is provided to CDR and FIMR teams.

National Fatality Review-Case Reporting System

Support the NFR-CRS which is used in 45 states and provides jurisdictions with real-time access to their fatality review data.

Resources

Training modules, webinars, written products, newsletters, list-serv, website and more.

Communication with Fatality Review Teams

Regular communication via listserv, newsletters and regional coalitions.

Follow Us on Social Media

@NationalCFRP on Twitter and Facebook.

Session Agenda

- Update on the scope of the problem: Fetal and Infant Mortality in the US
- Description of the FIMR Methodology
- Discussion on how FIMR aligns with the four Healthy Start Strategic approaches
- Exploration of the current FIMR interview practice and use of storytelling for greater impact

Zoom Polls

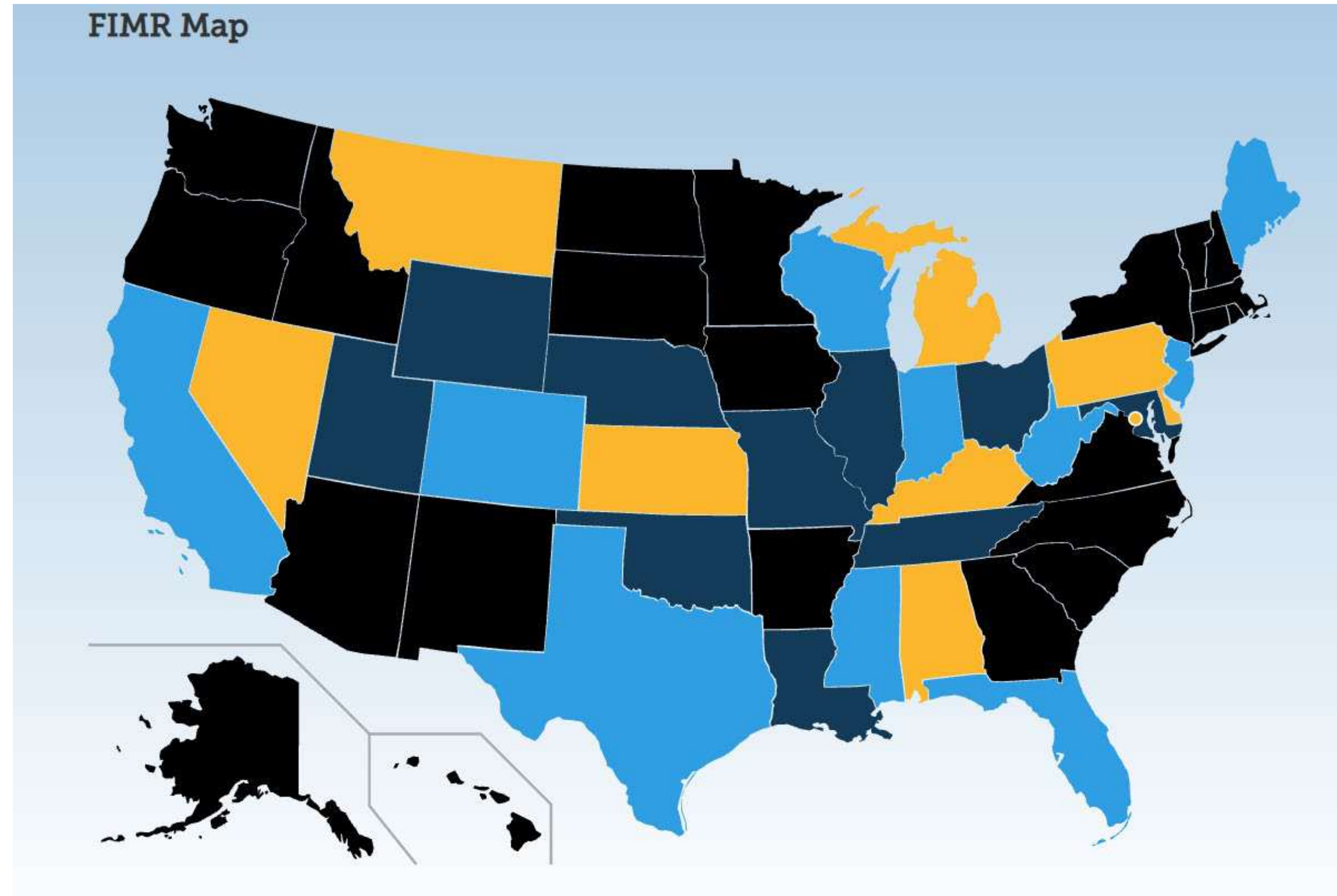
There is a FIMR in my community. Yes/No/I don't know

Have you participated in a FIMR case review meeting? Yes/No

Have you participated in a FIMR Community Action Team meeting? Yes/No

Find States and Jurisdictions with Active FIMR Programs

https://ncfrp.org/fimr-map/

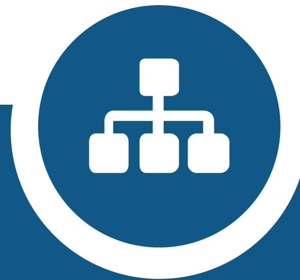


Brief History of FIMR

Maternal Child Health Bureau conceptualized IMR, the forerunner of FIMR

1988: 10 pilot programs funded

MA, SC, CT, NY, AL, UT, AR, IN, KS were among the original pilot sites



1990: ACOG funded as the TA and resource Center

Transitions to **FIMR** in 1991 when stillbirth review was added

1997–2004: MCHB funded 12 state FIMR Support Programs

2004: National Evaluation of FIMR by Johns Hopkins University Women's and Children's Health

FIMR Programs Today

152 FIMR programs in 27 states, Puerto Rico and CNMI are reviewing fetal and infant deaths

States with FIMR Programs

The Need the FIMR Program meets

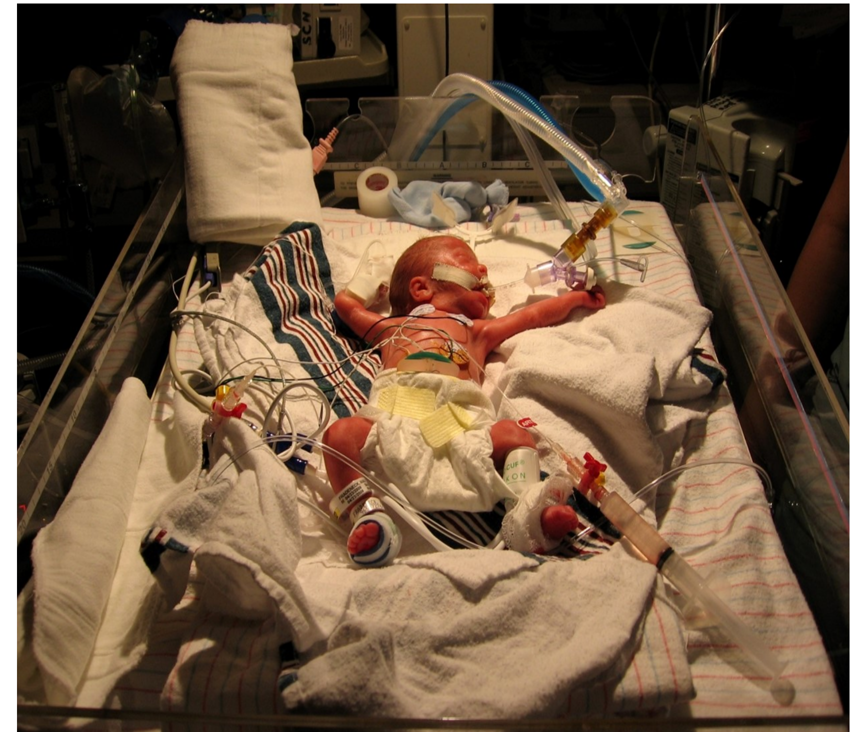
Addressing the burden of Infant Mortality in the US

- 3,747,540 live births in 2019

  8.3% were low birth weight (less than 5.5 pounds)

  10.23% preterm, (born less than 37 weeks gestation
- 20,911 infant deaths
- Rate of 5.58 deaths per 1,000 live births

https://www.cdc.gov/nchs/fastats/infant-health.htm



How does the United States compare to the world?

The United States ranks 33rd out of 36 countries similar in size and wealth which are members of the OECD.

Disparities Persist

With a rate of 10.75 deaths /1,000 live births, African Americans have the highest death rates among all ethnic and population groups. American Indians & Alaskan Natives have an infant death of 9.4.

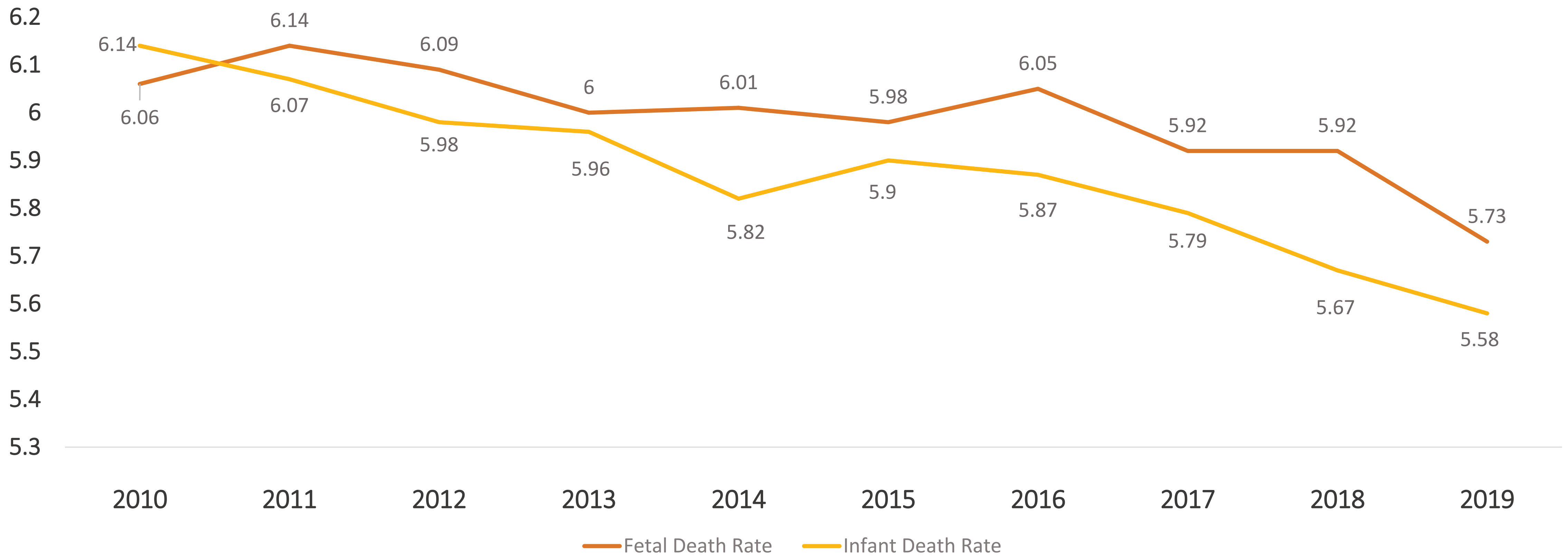
Leading Causes of Infant Death

In 2019, the leading causes of infant death were congenital anomalies, disorders related to prematurity (short gestation & unspecified low birthweight), injuries (suffocation) SIDS, and maternal complications.

U.S. total: 5.67

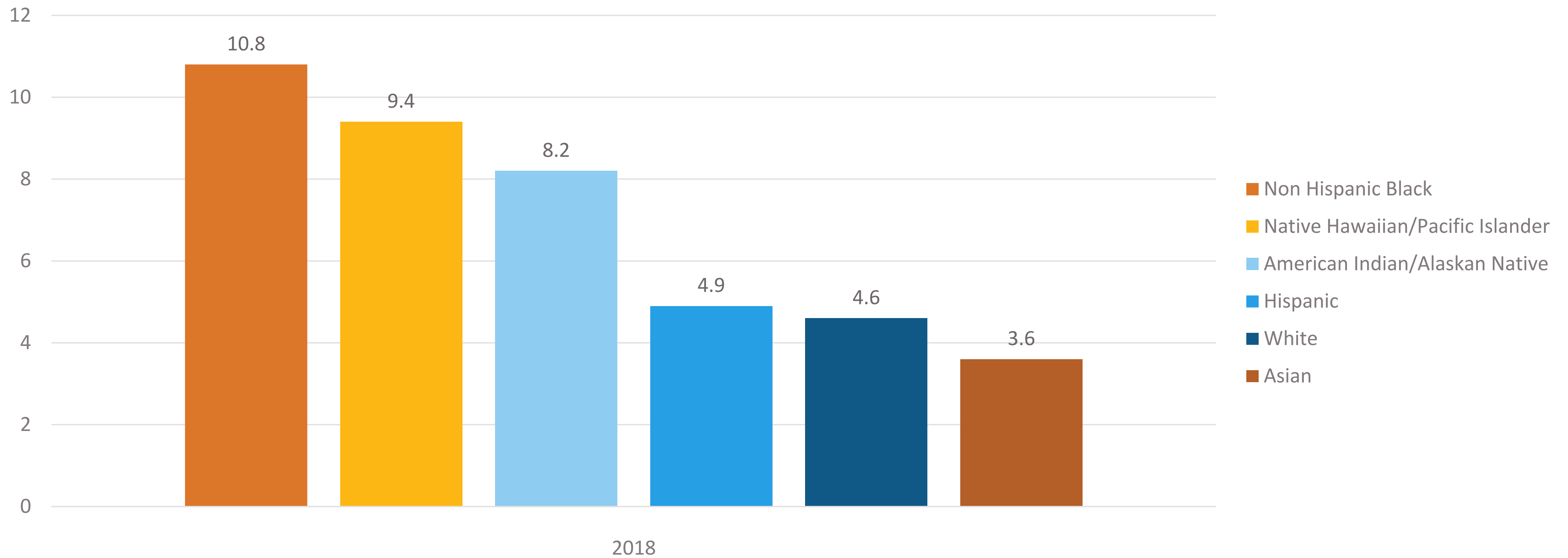
- Less than 4.00
- 4.00–4.99
- 5.00–5.99
- 6.00–6.99
- 7.00–7.99
- 8.00–8.99

United States Fetal and Infant Mortality Rates



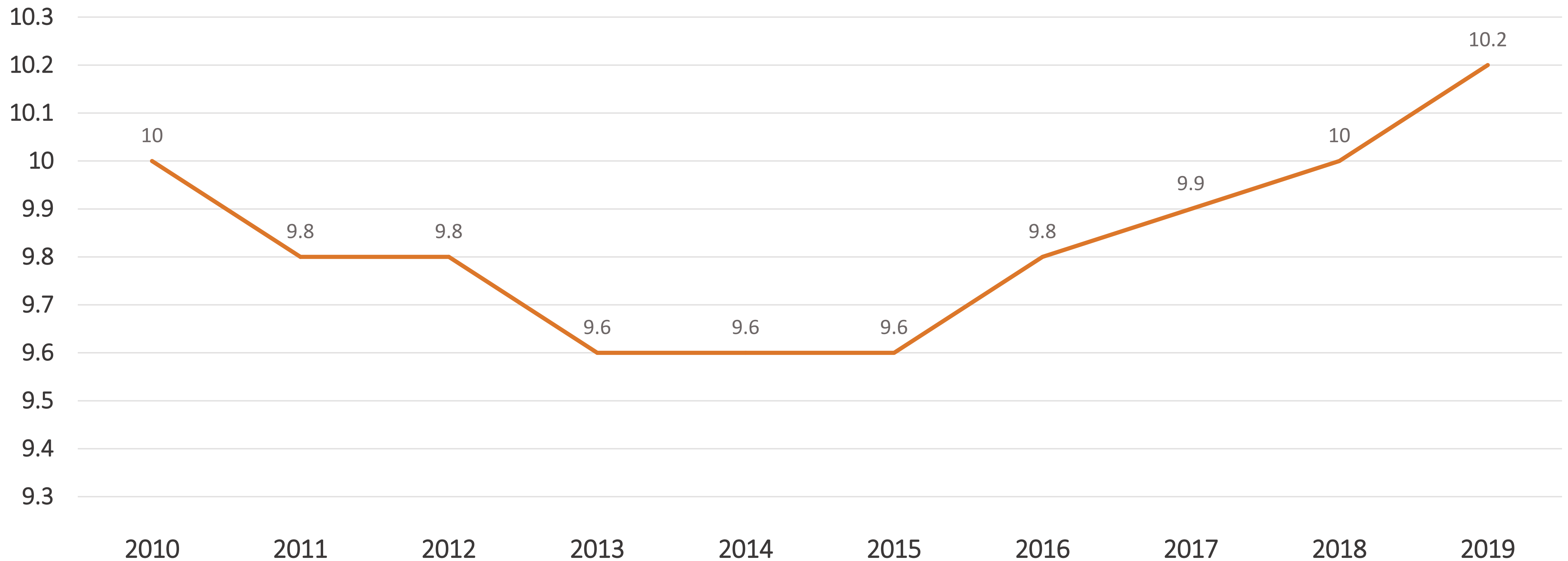
Source: CDC WONDER On-line Database, http://wonder.cdc.gov/lbd-current.html

United States Infant Mortality Rates



Source: CDC WONDER On-line Database, http://wonder.cdc.gov/lbd-current.html

United States Preterm Birth Rates

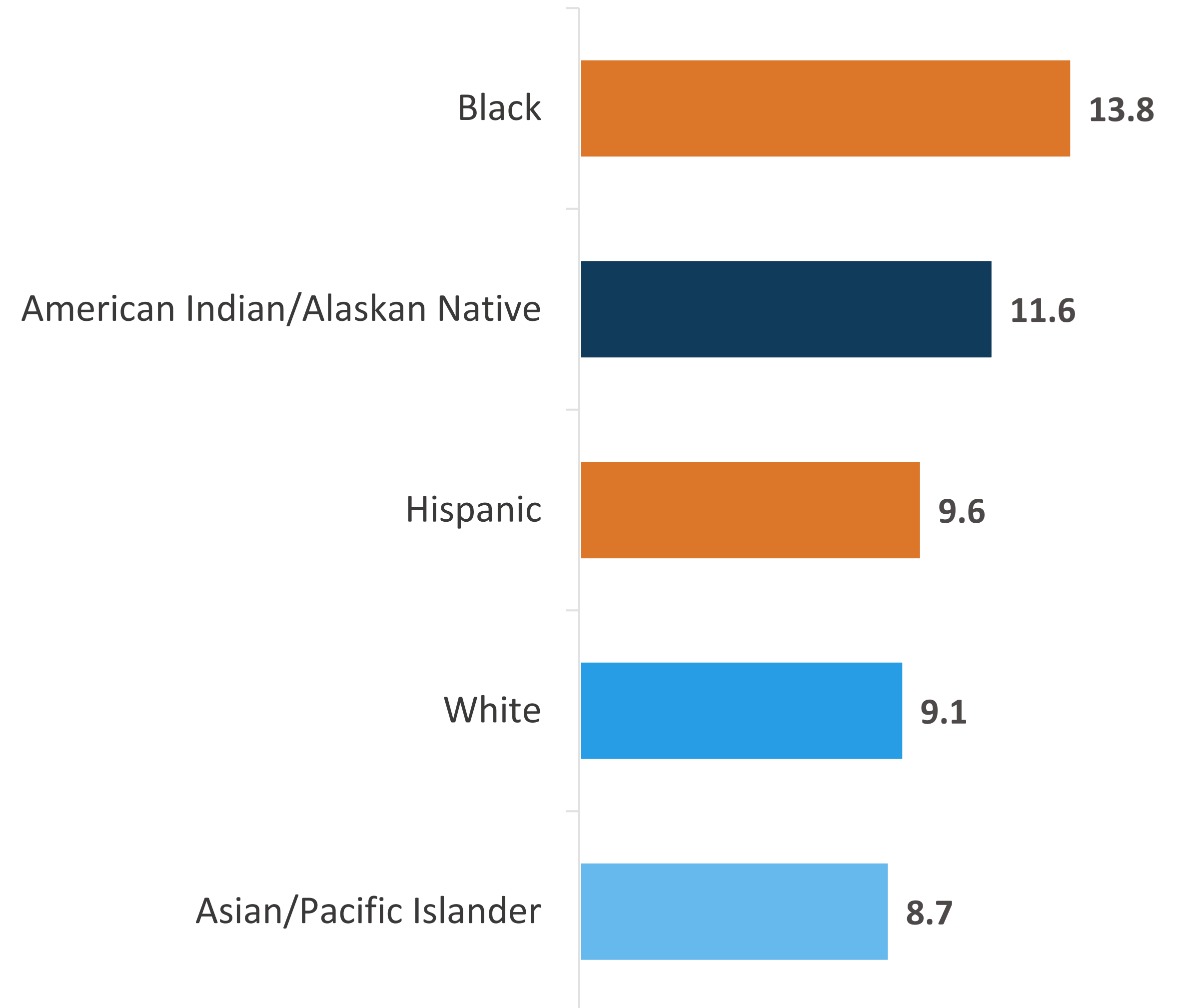


Source: https://www.marchofdimes.org/peristats/Peristats.aspx

United States Preterm Birth Rate by Race and Ethnicity

Percentage of live births in 2016 – 2018 born premature

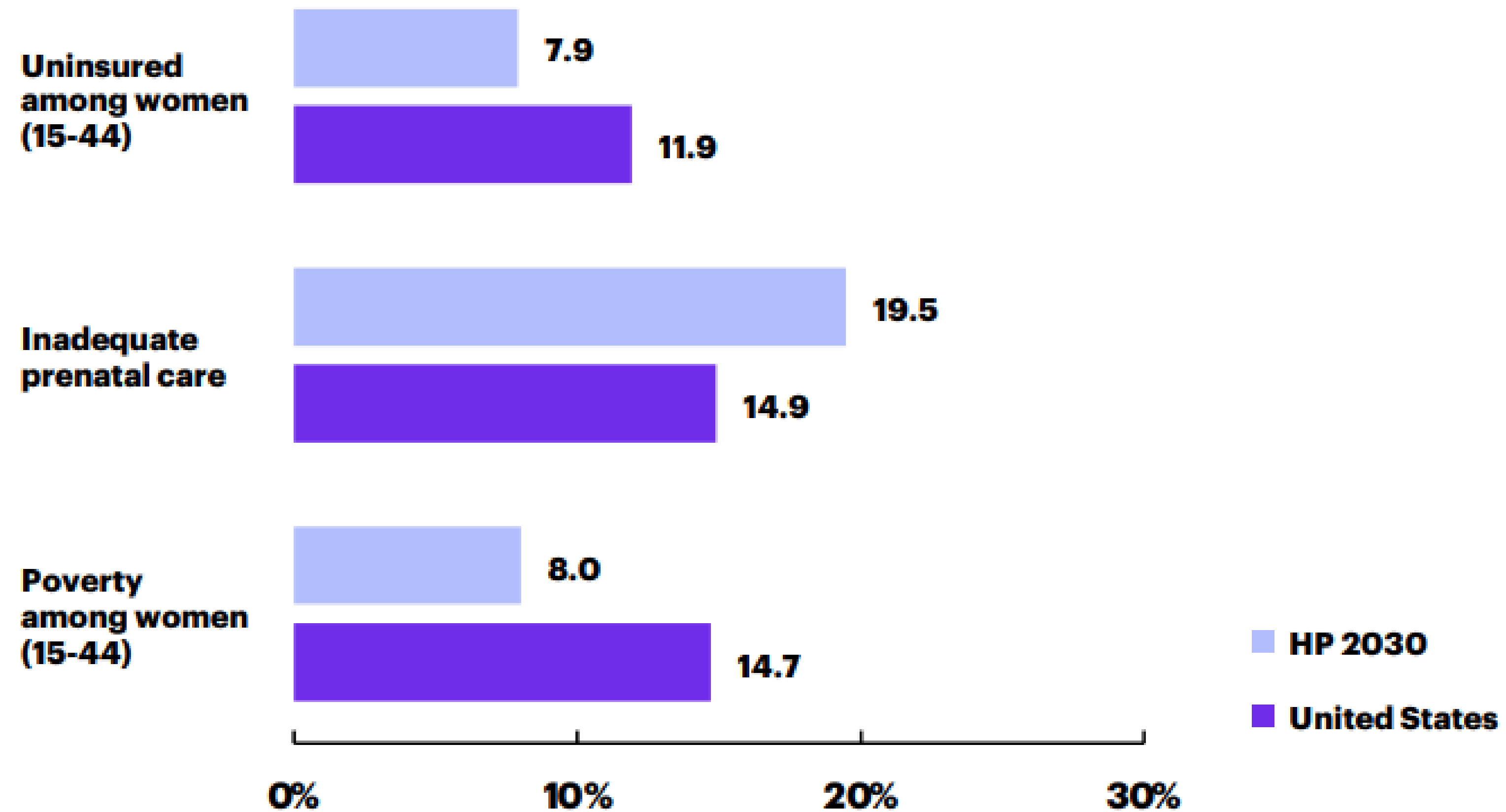
In the United States, the preterm birth rate among ***Black women is 50% higher*** *than the rate among all other women..*



Source: https://www.marchofdimes.org/peristats/Peristats.aspx

United States Maternal and Infant Health

Selected Social Determinants of Health



Source: *https://www.marchofdimes.org/peristats/Peristats.aspx*

Fetal and Infant Mortality Review (FIMR)

When Vital Statistics alone cannot tell us the story . . . Communities turn to FIMR to tell us how and why babies are dying

Information obtained through the FIMR process goes far beyond what we can learn from vital statistics or other population data. FIMR data can complement local population-based fetal and infant mortality data.

What is FIMR?

A multidisciplinary, community process that examines cases of fetal & infant deaths that is: Comprehensive, de-identified, confidential, and **gives voice to parents/families' experiences**. FIMR is **Continuous Quality Improvement**

Changes in Community Systems

As the physical, health care and social environment for childbearing families improves, outcomes, over time, will be better.

Data Gathering

Information is collected from a variety of sources, including family/parental interview, medical records, pre-natal care, home visits, WIC, and other social services.

Case Review

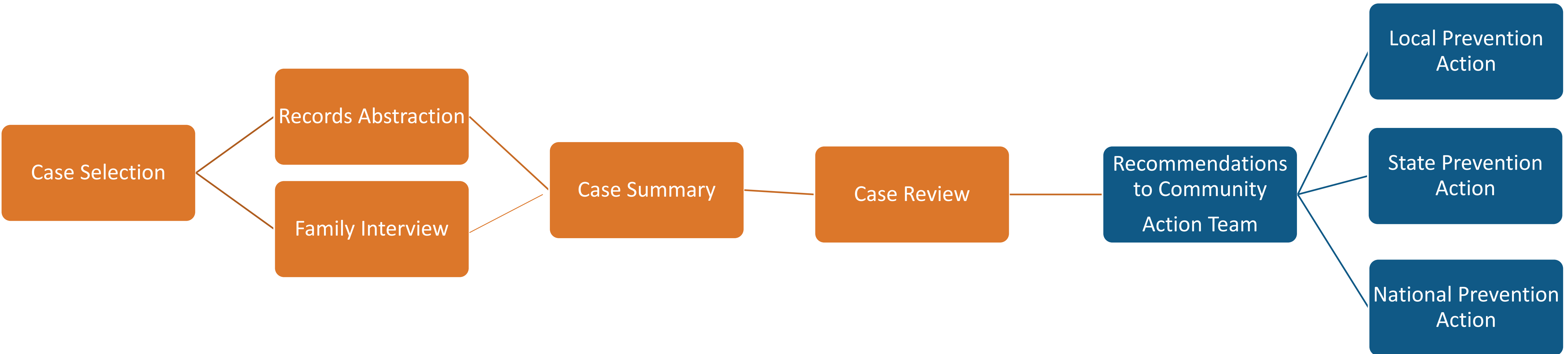
The multidisciplinary team reviews the case to identify barriers to care and trends in service delivery and ideas to improve policies and services that affect families.

Community Action

The Community Action team receives the recommendations from the review team and is charged with developing and implementing plans leading to positive change within the community.

FIMR Process

Best Practices in Reviews



A Two-Tiered Process

Case Review Team (CRT)

- **Reviews the story**: What happened to this baby and family from the time his/her mother got pregnant until the time of death?
- Identifies the issues: Were there clinical, community or health system factors that contributed to the death?
- Makes recommendations

Community Action Team (CAT)

- Composed of those who have the political will and fiscal resources to create large scale systems change
- Responsible for taking recommendations to **ACTION**

  -Creative solutions to improve services and resources

  -Prioritize and implement interventions

How does FIMR benefit the community?

- Identifies gaps in current services, a key part of needs assessment, and cooperate to fill those gaps
- Expands available services through cooperative programming and joint funding
- Fosters interagency networking and communication
- Develops a greater understanding of maternal and child health community needs by seeing the whole picture, not just a part

FIMR Focuses on Systems

Each FIMR case review provides an opportunity to improve communication among medical, public health, and human service providers and to develop strategies and resources for women, infant, and families.

FIMR is not about blaming individual providers, agencies, or families for outcomes. FIMR emphasizes systems improvement over personal responsibility.

FIMR includes a Family Perspective: A home interview with the parents who have suffered a loss and the families' story is conveyed to the FIMR team members

What we have learned from interviews:

-Felt she did not receive the services she needed
-When she called with symptoms, she was dismissed
-(Providers) did not listen to her concerns
-Felt she was not treated kindly
-Communication was less than desired
-Staff believed her pain wasn't real
-Death was accidental, but family felt treated like it was their fault

FIMR promotes broad community participation

FIMR is a community coalition that can represent all ethnic and cultural community views and becomes a model of respect and understanding

FIMR is Action Oriented

FIMR leads to multiple creative community actions to improve resources and service systems for women, infants and families.

Undoing the Damage

Racial Health Inequities

Infant mortality inequity can be undone with deliberate action on many levels.

–Arthur R. James, MD, FACOG

FIMRs have the fundamental opportunity to build internal capacity in their communities by prioritizing health equity in:

- Data collection (including family interviews)
- Data analysis
- Recommendations and **response**

A guiding principle of the FIMR process is to provide as much ***context*** on the life of the parents, family, and the death of the infant. Social factors such as geography, access to education, experience with discrimination, trauma (including historical trauma), and access to physical and behavioral healthcare can contribute to poor pregnancy outcomes and fetal and infant mortality.

Equity in FIMR

Team composition, training and orientation

Data Gathering: gathering the right records to help teams understand mothers'/families' experiences of racism and how those experiences may have impacted maternal and child outcomes.

Data to Action: ensure that once we have the findings, teams are making and implementing meaningful recommendations that address disparities

Changing the Frame

The shift from personal responsibility to social responsibility

In the current frame, teams often ask, “What biological and behavioral risk factors place mothers and families at risk for fetal and infant death?”

Instead, challenge teams to use a different frame, asking instead, “How do we eliminate the social injustices that produce inequities in health outcomes?”

Personal Responsibility vs Social Responsibility

Factors that may have contributed to the death	Personal Responsibility	Social Responsibility
Domestic Violence	The mother should have left the father in earlier instances of abuse.	Wage inequality makes women/ children fully dependent on a spouse, creating vulnerability in abusive relationships. Isolation and residential segregation limits social networks.
Opioid Abuse	Mother's friend group encouraged her relapse after treatment.	State refusal to expand Medicaid leaves working families without health insurance. Women with chronic pain self-prescribe and are vulnerable to addiction in their childbearing years.

Upstream & Downstream?

Upstream Strategies

Prevention Vehicles

Downstream Strategies

Used with permission, Lynne Le, CityMatCH

Upstream & Downstream?

Upstream Strategies
Racism, education, housing, labor, justice, transportation, agriculture, environment, etc.

Prevention Vehicles
Home Visiting, Medical Homes and Neighborhoods, Case Management, WIC, Centering, Baby-friendly Hospitals and Birthing Clinics, Doula Care, etc.

Downstream Strategies
Family Planning, Maternal Stress Prevention and Management, Tobacco, Alcohol, other Drug Cessation, Progesterone, Kangaroo Care, Safe Sleep, etc.

Used with permission, Lynne Le, CityMatCH

FIMR ESSENTIAL ELEMENTS

FOCUS ON PREVENTION

MULTIDISCIPLINARY

Engage a broad, yet targeted, group of community collaborators to tell the infant's story with a focus on identifying systems gaps

REVIEW FINDINS MAY INCLUDE

Trends over time

Sentinel events

Incidental findings

Synergy across Fatality Review Programs

Telling stories to save lives

FETAL AND INFANT MORTALITY REVIEW

152 local FIMRs in 27 States, the District of Columbia., Puerto Rico, CNMI

CHILD DEATH REVIEW

All 50 states have CDR program, some state level ~1,350 local review teams throughout the U.S.

MATERNAL MORTALITY REVIEW

47 States, the District of Columbia, New York City, and Philadelphia a formal MMRC

CDR, FIMR, and MMR: Differences and Similarities

Review Elements	FIMR	CDR	MMR
Case Selection	Stillbirths (fetal deaths) and live born infants who die before reaching their first birthday	Children 1 – 19 year of age	Birthday persons who die during or within one year of pregnancy, regardless of age
Team Structure	Two-tiered, Case Review Team and Community Action Team. Most teams are at the local level	Most teams consist of one review board that conducts case reviews, usually includes agency professionals directly involved in the case. Can be at the state or local level	Generally , a single multidisciplinary statewide team that convenes periodically.
Case Preparation	Cases are abstracted from a variety of medical and social service records: a de-identified case summary is prepared in advance for team members	Team members bring their records to the review and share information from them. The process is confidential but not de-identified.	Generally, a full case presentation is prepared with patient hospital record. abstraction. Case information is de-identified.
Family Involvement	Yes. A voluntary interview is conducted with consenting families and is included in the case review	No	No

Fatality Review Collaboration Goals

Recognize that each fatality review system has distinct but complimentary processes

Preserve the integrity and methodology of each program and the unique perspective it brings

Capitalize on opportunities for shared resources: leverage funding and use of data to drive prevention initiatives

Advocate for changes in policy, practice and legislation that improves the health and safety of the community

National Fatality Review- Case Reporting System

Started as the Child Death Review Case Reporting System, 2005

Expanded to FIMR in 2018

The purpose of NFR-CRS is to systematically collect, analyze, and report comprehensive fatality review data that includes:

- Social/demographic information on child, family, and supervisor
- Death investigation information
- Risk factors for specific mechanisms of injury death

New Data Elements

Life Stressors and Impacts of COVID-19

Life Stressors in NFR-CRS

Added in April 2020, Version 5.1 of NFR-CRS (https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/CDR_CRS_v5-1.pdf)

I7. LIFE STRESSORS Please indicate all stressors that were present for this child around the time of death.

a. Life stressors - Social/economic

- ☐ None listed below
- ☐ Racism
- ☐ Discrimination
- ☐ Poverty
- ☐ Neighborhood discord
- ☐ Job problems
- ☐ Money problems
- ☐ Food insecurity
- ☐ Housing instability
- ☐ Witnessed violence
- ☐ Pregnancy
- ☐ Pregnancy scare

b. Life stressors - Relationships (age 5 and over)

- ☐ None listed below
- ☐ Family discord
- ☐ Argument with parents/caregivers
- ☐ Parents' divorce/separation
- ☐ Parents' incarceration
- ☐ Argument with significant other
- ☐ Breakup with significant other
- ☐ Social discord
- ☐ Argument with friends
- ☐ Bullying as a victim
- ☐ Bullying as a perpetrator
- ☐ Cyberbullying as a victim
- ☐ Cyberbullying as a perpetrator
- ☐ Peer violence as a victim
- ☐ Peer violence as a perpetrator
- ☐ Isolation
- ☐ Stress due to sexual orientation
- ☐ Stress due to gender identity

c. Life stressors - School (age 5 and over)

- ☐ None listed below
- ☐ School failure
- ☐ Pressure to succeed
- ☐ Extracurricular activities
- ☐ New school
- ☐ Other school problems

d. Life stressors - Technology (age 5+)

Stress/negative consequences due to:

- ☐ None listed below
- ☐ Electronic gaming
- ☐ Texting
- ☐ Restriction of technology
- ☐ Social media

e. Life stressors - Transitions (age 5 and over)

- ☐ None listed below
- ☐ Release from hospital
- ☐ Transition from any level of mental health care to another (e.g. inpatient to outpatient, inpatient to residential, outpatient to inpatient, etc.)
- ☐ Release from juvenile justice facility
- ☐ End of school year/school break
- ☐ Transition to/from child welfare system
- ☐ Release from immigrant detention center

f. Life stressors - Trauma (age 5 and over)

- ☐ None listed below
- ☐ Rape/sexual assault
- ☐ Previous abuse (emotional/physical)
- ☐ Family/domestic violence

g. Life stressors - Describe any other life stressors: (age 5 and over)

LIFE STRESSORS DATA

How Teams May Use Life Stressors Data

Impact Health Inequities

By addressing underlying health inequities, communities are healthier, safer environments for children and families.

Drive Prevention

Use data and discussions to drive prevention work at the community, state, and national level.

Discussion

By adding life stressors to NFR-CRS, the National Center is hoping that fatality review teams begin/deepen their discussion of these issues.

Data Collection

By collecting these data, teams can document risk and protective factors occurring in their community.

COVID-Related Questions in NFR-CRS

Section I8: *COVID-19 Related Deaths, added in April 2021*

I8. COVID-19-RELATED DEATHS

a. For the 12 months before the child's death, did the family experience any disruptions or significant changes to the following?
Check all that apply:
- ☐ None listed below
- ☐ School
- ☐ Daycare
- ☐ Employment
- ☐ Social services (such as unemployment assistance, TANF, WIC)
- ☐ Living environment
- ☐ Medical care
- ☐ Mental health or substance use/abuse care
- ☐ Home-based services (non-child welfare)
- ☐ Child welfare services
- ☐ Legal proceedings within criminal, civil, or family courts
- ☐ Other
- ☐ U/K

Describe:

b. For the 12 months before the child's death, did the child's family live in an area with an official stay at home order?
○ Yes ○ No ○ U/K
If yes, was the stay at home order in place at the time of the child's death?
○ Yes ○ No ○ U/K

c. Was the child exposed to COVID-19 within 14 days of death?
○ Yes ○ No ○ U/K
If yes, describe:

d. Select the one option that best describes the impact of COVID-19 on this child's death:
- ○ COVID-19 was the immediate or underlying cause of death
- ○ COVID-19 was diagnosed at autopsy or the child was suspected to have COVID-19
- ○ COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death
- ○ The birthing parent contracted COVID-19 during pregnancy
- ○ Other, specify:
- ○ COVID-19 had no impact on this child's death
- ○ U/K

e. Did COVID-19 impact the team's ability to conduct this fatality review?
○ Yes ○ No ○ U/K
If yes, check all that apply:
- ☐ Unable to obtain records
- ☐ Team members unable to attend review
- ☐ Remote reviews negatively impacted review process
- ☐ Team leaders redirected to COVID-19 response

Impact of COVID-19

Identify the Most Significant Impact of COVID-19 on the Death

Most Significant

Least Significant

d. Select the one option that best describes the impact of COVID-19 on this child's death:

- ◯ COVID-19 was the immediate or underlying cause of death
- ◯ COVID-19 was diagnosed at autopsy or the child was suspected to have COVID-19
- ◯ COVID-19 indirectly contributed to the death but was not the immediate or underlying cause of death
- ◯ The birthing parent contracted COVID-19 during pregnancy
- ◯ Other, specify:
- ◯ COVID-19 had no impact on this child's death
- ◯ U/K

FIMR and Healthy Start

Improving the way systems respond to maternal child health needs, addresses inequities, and aligns and strengthens prevention activities.

Local Healthy Start projects have an impact on not just the individual, but also the overall community by conducting activities such as:

- **Health care services**
  - Prenatal, post-partum, well-baby, reproductive life planning, and women's health
  - Screening and referral to services for depression, substance use, and interpersonal violence
- **Services that increase access to health care and improve health outcomes**
  - Outreach & case management
  - Screening & referrals for healthcare, insurance, and social services such as WIC, home visiting, and doula services
- **Public Health Services**
  - Immunization and health education (smoking cessation, breastfeeding & nutrition)
- **Provider training**
  - Continuing education & training on best practices for Healthy Start staff and community partners

Healthy Start Strategic Approaches

Improving women's health

Activities to improve coverage, access to care, and health promotion and prevention, and health for women before, during, and after pregnancy.

Improve family health and wellness

System coordination/integration, health promotion and prevention, and social support services that protect and advance parental and infant/child health and wellbeing.

Promoted systems change

Catalyst for community action to address social determinants of health and integration among health and social services, other providers, and key leaders in the community.

Assure impact and effectiveness

- workforce development
- data collection
- quality improvement
- performance monitoring and evaluation.

Important Point to Remember

The national evaluation suggests that a community where FIMR and Perinatal Initiatives were both present could achieve as much as **nine times** more progress in systems improvement!

The shortest distance between two people is a story.

(multiple authors)

HEADLINE NEWS: What's Your 6-Word Story?

Create a '6-word story' or headline, responding to one (or both) of these questions:

WHAT BROUGHT YOU TO THE WORK OF HEALTHY START THE BEGINNING?

WHAT MAKES YOU KEEP GOING EVERY DAY IN THIS WORK, ESPECIALLY NOW?

Where you woke up today

Where are you joining us from today?

Who you serve in your HS work?

What community or communities do you serve in your Healthy Start work?

How you want to be called ?

How would you like us to know you? Share your name. Consider sharing your pronouns.

Your 6-word story

Respond to the question of what brought you to, or what sustains you in, your work in Healthy Start.

Then call on someone, after you finish

When you are done sharing, call on another person in your breakout room.

Breakout Instructions

A story communicates fear, hope, and anxiety, and because we can feel it, we get the moral not just as a concept, but as a teaching of our hearts… That's the power of story.

-Marshall Ganz, Community Organizer and Professor, Harvard University

Why Storytelling is Important

Putting a Face to the Data

Persuade

Inspire

Teach

Influence

AIM

Adapt, apply and integrate the science and best practices of Storytelling with existing community-based death review processes.

Design Team Convened

To inform the design and implementation of a pilot program, to orient and train selected FIMR Teams on harnessing the power of stories for social change, with focus on improving perinatal outcomes. Foundation document created.

Host four 90-minute fall sessions

Design Team + 4 to 5 FIMR sites, 3 – 4 people per site

Story Circle

Learning Collaborative across sites/teams to continue learning and working together after the Fall Sessions… to translate what is learned to what is possible locally.

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Sites

Baltimore City, MD; Broward County, FL; Kalamazoo, MI; Kansas City, MO; and Washoe County, NV

Fall 2020
FIMR Story Telling Project

collaboration
give them a voice
loss
doesn't
let
hear your story
every baby matters
you're fine
lost
one
babies
passion for children
too often
stories
come from care for black women
motivate intentional action
golden rule
it could've been me.
kids are still dying
to save babies
always
no
education
assignment
data doesn't tell the story
no more moms without their babies
no cash no care another loss
something is very wrong
preventable
data
today
all babies deserve to thrive
no parent should lose a child
empathy
hear your voice
life
telling
need
true systems change
heard
too many
too long
honoring families
why should my skin color protect me
be heard
save
justice
everyone
one story too many moms
skin color should not tell my story
care another
need a voice
counts
every child deserves a first birthday
death
possibility
families
family-centered empowerment
field
dedication
make changes
every family has a story
every
promotion
baby
future & families
deserved better
changing systems
worth
background
deeply inspired
not seen not heard not valued
matters
safer babies
compassion

"A woman knows her body. Listening and acting upon her concerns during or after pregnancy could save her life."

— Dr. Wanda Barfield, Director of CDC's Division of Reproductive Health

Fatality Review Outcomes

The Spectrum of Success

Greater Prevention Impact

Improved Communication

Kalamazoo, Michigan FIMR

Team Findings: Family interviews (obtained for over 50% of FIMR cases reviewed) have consistently revealed that there is a profound disconnect between medical records documentation of patient education /decision making and the families' report of their experiences. Having both providers and home visitor CHWs on the review team has confirmed both realities and the disconnect they represent, and lead to brainstorming solutions and recommendations together.

Improved Investigations and Data Collection

Baltimore City, Maryland, FIMR

Finding: About half of pregnant women supported through Medicaid who experienced a fetal or infant death did not receive the mandated Maryland Prenatal Risk Assessment (PRA) from their obstetric care provider at the first prenatal care visit, meaning that these women did not receive outreach, care coordination, and linkage to supportive community services such as home visiting. FIMR reviews uncovered that one of the reasons for the low rates of submission was due to providers not being able to fill out an electronic form.

Washoe County (Reno) Nevada FIMR

Improving Agency Systems

In 2020, the team found that delayed and/or interrupted prenatal care due to COVID-19 was a serious risk factor for poor pregnancy outcomes. Case reviews identified that reasons for delayed health-seeking were lockdowns, lack of understanding of guidelines or resources, and fear of contracting COVID-19 infection.

Prevention

St. Joseph County (South Bend) Indiana FIMR

Created an OB Navigator program that connects mothers who apply for or have Medicaid insurance during pregnancy to support through several local community-based programs.

Allowed teens who are pregnant to access prenatal care without parental consent if the parent is not supportive of the mother receiving care. FIMR team members provided information to the State Senate

PARTING THOUGHTS & QUESTIONS

Rosemary Fournier

rfournie@mphi.org

www.ncfrp.org

CONTACT INFORMATION

2395 Jolly Rd., Suite 120
Okemos, MI 48864

Phone: 800-656-2434

info@ncfrp.com

www.ncfrp.org

Q&A

Please submit questions using the Q&A module in the Whova platform.

#HealthyStartVGM2021
#HealthyStartStrong
@HS_TASC @NICHQ

FIMR & Healthy Start: Synergy for Greater Health Equity
Hosted by the Healthy Start TA & Support Center at NICHQ on November 3, 2021

If you need any support…

Please email healthystart@nichq.org

Upcoming Session: 4:30 pm ET

Collaborative Approaches to Addressing Maternal and Infant Health Disparities

FIMR & Healthy Start: Synergy for Greater Health Equity
Hosted by the Healthy Start TA & Support Center at NICHQ on November 3, 2021

NICHQ
National Institute for Children's Health Quality

HEALTHY start
TA & SUPPORT CENTER

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