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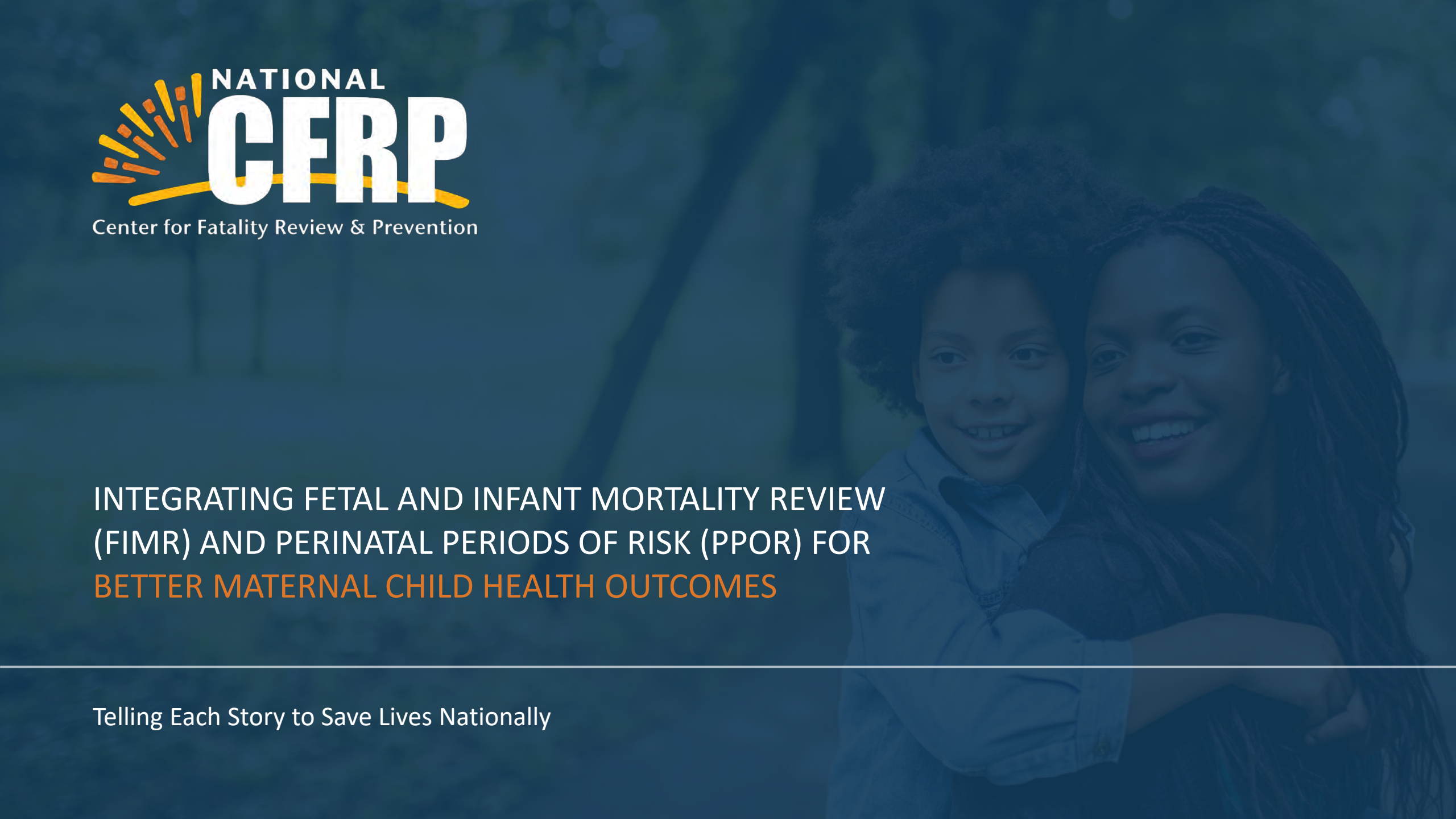

INTEGRATING FETAL AND INFANT MORTALITY REVIEW (FIMR) AND PERINATAL PERIODS OF RISK (PPOR) FOR BETTER MATERNAL CHILD HEALTH OUTCOMES

Telling Each Story to Save Lives Nationally

KEY FUNDING PARTNER

FEDERAL ACKNOWLEDGEMENT

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HOUSEKEEPING

Before we get started

- This webinar is being recorded and will be available on the National Center's webpage (URL: **www.ncfrp.org**).
- Participants are muted. Use the question and answer box to ask questions.
- Due to the large number of participants, the speakers may be unable to answer all questions. Unanswered questions will be answered and posted with the recording.
- Contact the National Center (email: **info@ncfrp.org**) for any tech problems.

EVALUATION

https://www.surveymonkey.com/r/32BRMMX

Diane Pilkey, RN, MPH

Welcome and Introductions

Senior Nurse Consultant

Division of Child, Adolescent and Family Health

Maternal and Child Health Bureau

Health Resources and Service Administration

HRSA'S VISION FOR THE NATIONAL CENTER

IMPROVING SYSTEMS OF CARE AND OUTCOMES FOR MOTHERS, INFANTS, CHILDREN, AND FAMILIES

Assist state and community programs in:

- Understanding how CDR and FIMR reviews can be used to address issues related to adverse maternal, infant, child, and adolescent outcomes
- Improving the quality and effectiveness of CDR/FIMR processes
- Increasing the availability and use of data to inform prevention efforts and for national dissemination

PRESENTATION GOALS

Describe FIMR

Summarize the community-owned, action-oriented FIMR process.

Describe PPOR

Summarize the prevention-focused PPOR analysis.

Explore FIMR and PPOR strengths and limitations

Describe the appropriate way to use the FIMR process and PPOR analysis to support MCH outcomes

Highlight opportunities for integration of PPOR and FIMR

Describe ways that PPOR can be used to support the FIMR process.

Explore the utility of FIMR and PPOR at the local level

Illustrate how FIMR and PPOR can support public health decision making, processes, and outcomes

Speakers

Rosemary Fournier, RN, BSN
FIMR Director
National Center for
Fatality Review and Prevention

Carol Gilbert, MS, ABD
Senior Health Data Analyst
CityMatCH

Kelli McNeal, BA
FIMR and Maternal Child Health
Outreach Program Supervisor
Oklahoma City-County Health
Department

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FIMR's relationship to Public Health **Surveillance**

- The ongoing, systematic collection and *analysis* of data about a health problem that can lead to action to control or prevent the problem.
- An infant death is a sentinel event that triggers surveillance and prevention activities.

Definitions

Understanding fetal and infant mortality

FETAL MORTALITY (Stillbirth)

An infant born without signs of life, generally after 20 weeks of gestation

INFANT MORTALITY

The death of any live born infant prior to his/her first birthday.

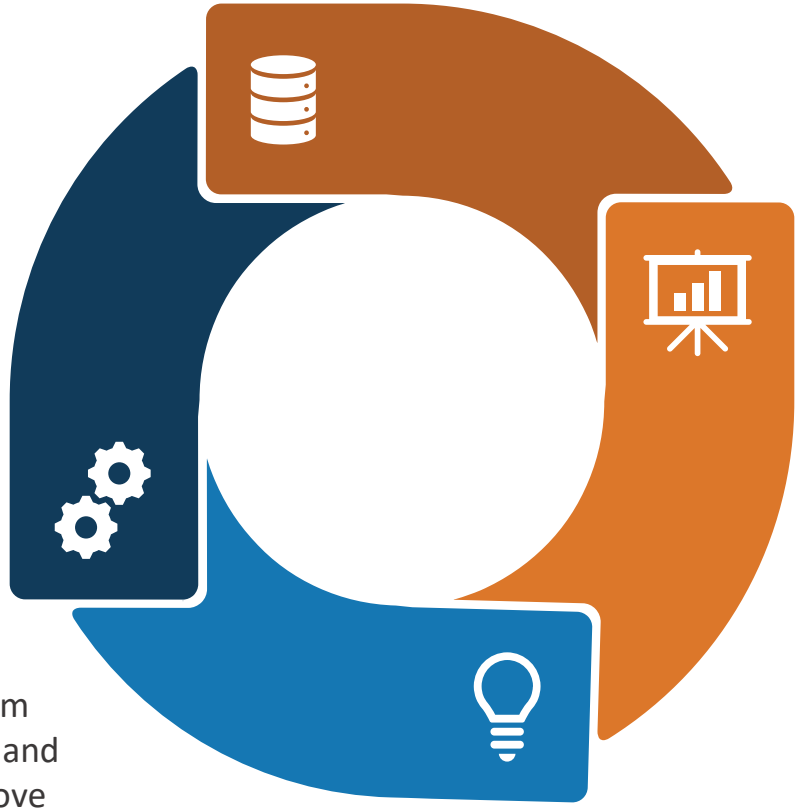
FIMR: The Cycle of Improvement

A multidisciplinary, community process that examines cases of fetal & infant deaths that is:

Comprehensive, de-identified, confidential, and **gives voice to parents/families' experiences**.

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.



Improvements in Systems of Care

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

Case Review

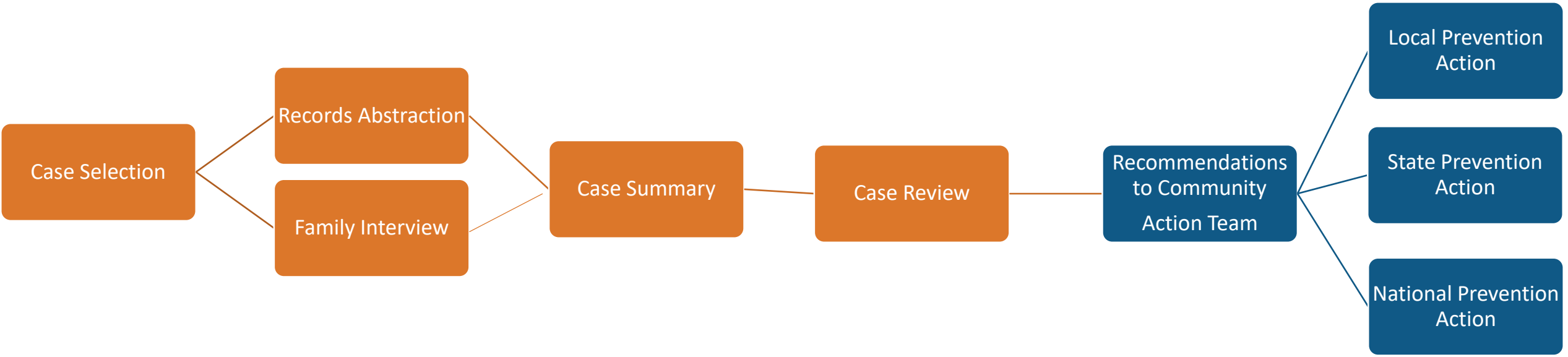
The multidisciplinary Case Review Team team reviews the case to identify barriers to care and trends in service delivery and ideas to improve policies and services that affect families.

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



FIMR

A TWO-TIERED PROCESS

CASE REVIEW TEAM (CRT)

- Reviews the story
- Identifies the issues
- Makes recommendations

COMMUNITY ACTION TEAM (CAT)

- Composed of those who have the political will and fiscal resources to implement change
- Responsible for taking CRT recommendations to **ACTION**

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

FIMR's benefit to the Community

- Identifies **gaps** in current services, a key part of needs assessment, and cooperates to fill those gaps
- Provides **context** through case review and data collection
- Fosters interagency networking and communication, diverse **partnerships**
- Develops a greater understanding of maternal and child health community needs by seeing the **whole picture**, not just a part
- Health Disparities: Illuminates **inequities** and identifies populations at the most significant risk for a poor outcomes
- Provides ***community-specific*** information about changing health care systems

Integrating Fetal and Infant Mortality Review (FIMR) and Perinatal Periods of Risk (PPOR) for better Maternal Child Health Outcomes

Carol Gilbert

CityMatCH

Contents

- What is PPOR
- How PPOR and FIMR are complementary
- Ways to use them together

Perinatal Periods Of Risk (the PPOR approach)

- a simple analytic framework and steps for investigating feto-infant mortality at a local level
- an epidemiological tool to be used as a part of a larger urban community planning process

What IS NEEDED to do PPOR?

- Access to and the ability to analyze vital records data
- Every population studied must have at least 60 feto-infant deaths in at most 5 years (>100 for full analysis)
- A team of community collaborators & champions

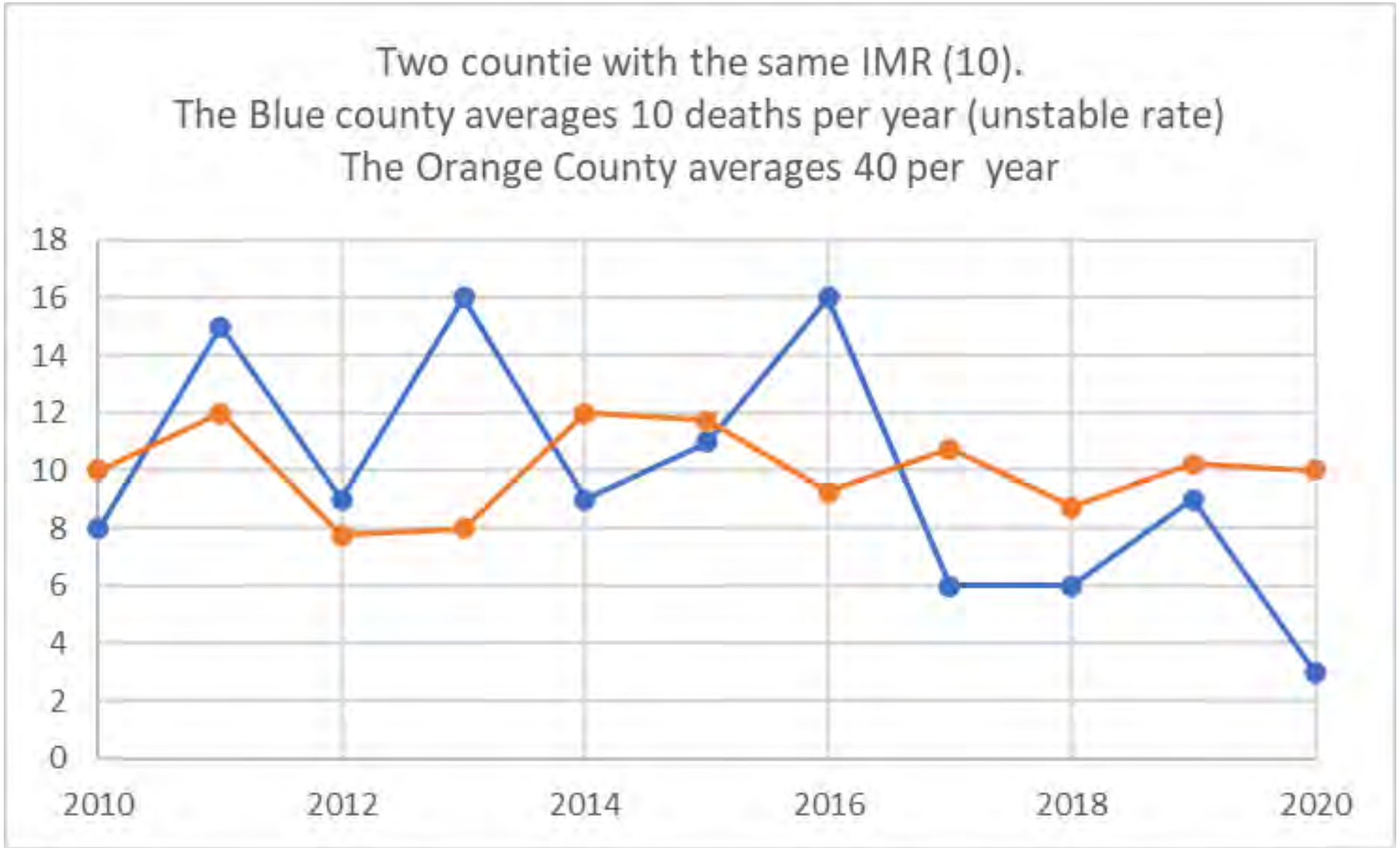
Three vital records data files – *every* live birth and fetal death is included

- Live birth certificate files
- Fetal death certificate files
- Infant death certificate files linked to birth certificate information

ALL are produced in every state.

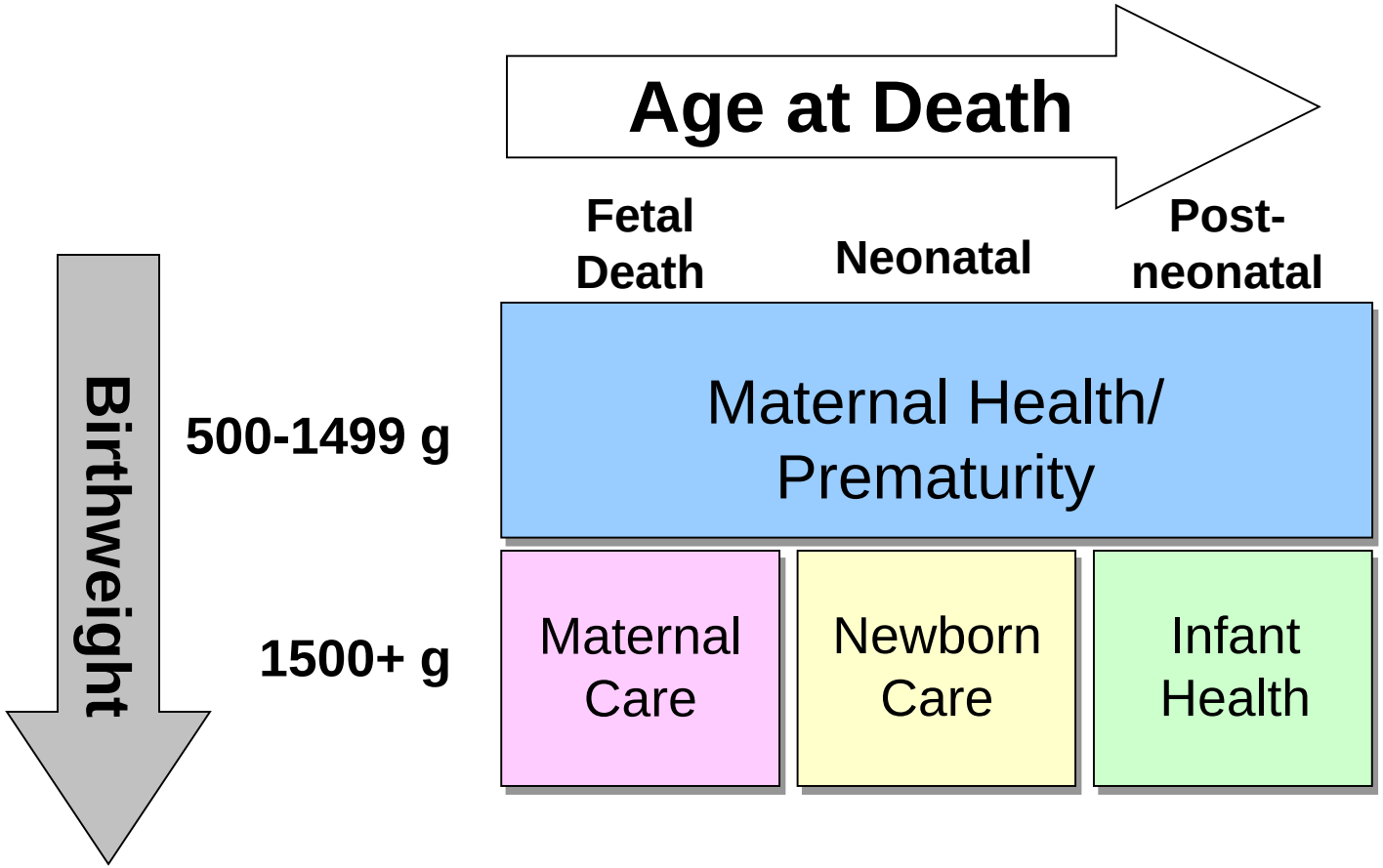
Smaller populations still need 60 deaths

- Subpopulations within an urban county
  - Immigrant communities
  - Urban Native Americans
  - African-Americans
- Combine similar counties
  - Public health systems
  - Health care systems
  - Cultures and traditions
- Combine years

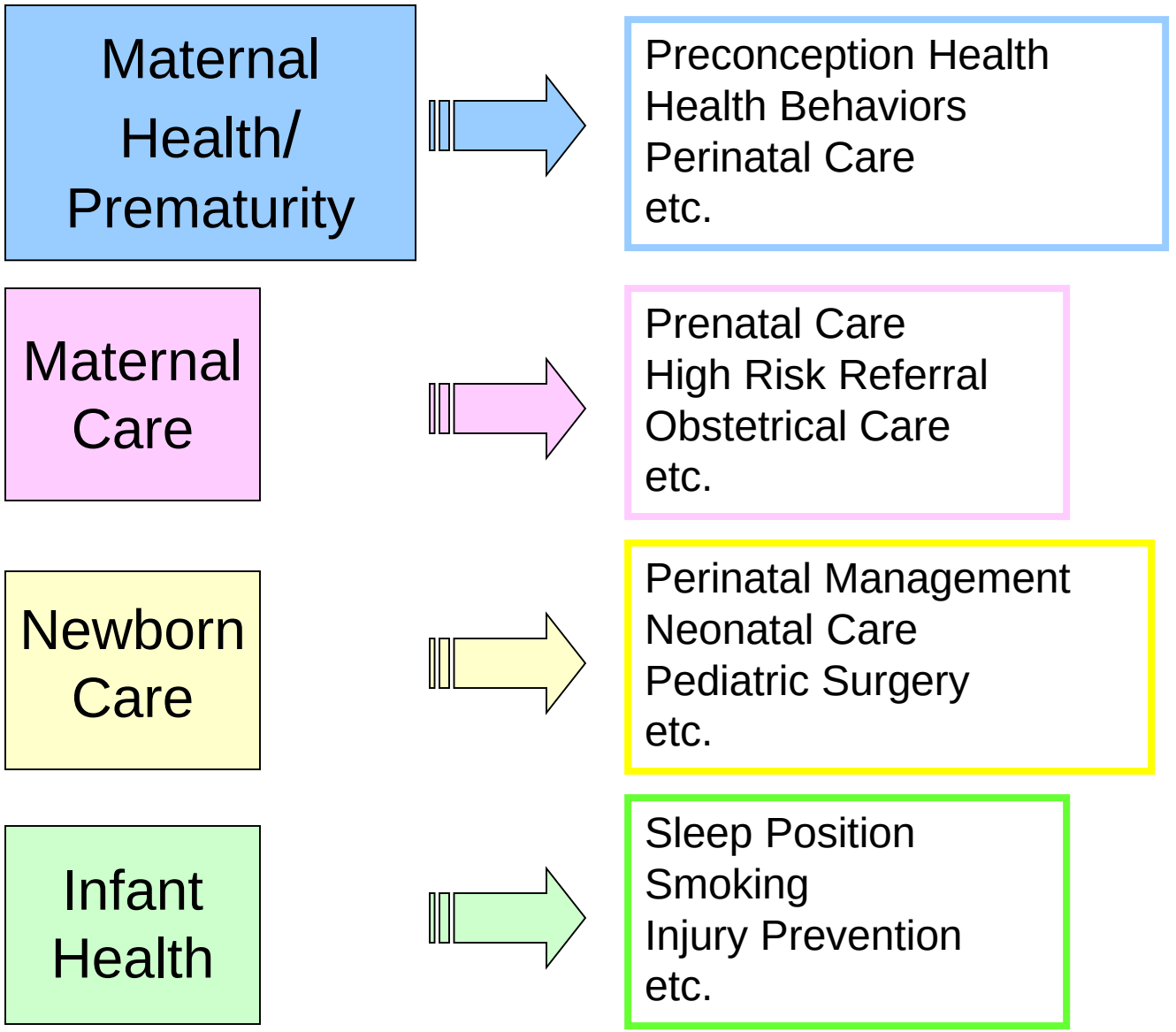

Two countie with the same IMR (10).
The Blue county averages 10 deaths per year (unstable rate)
The Orange County averages 40 per year
18
16
14
12
10
8
6
4
2
0
2010
2012
2014
2016
2018
2020

PPOR PHASE 1

Fetal and infant deaths are sorted into four periods of risk, and a mortality rate is calculated for each period.



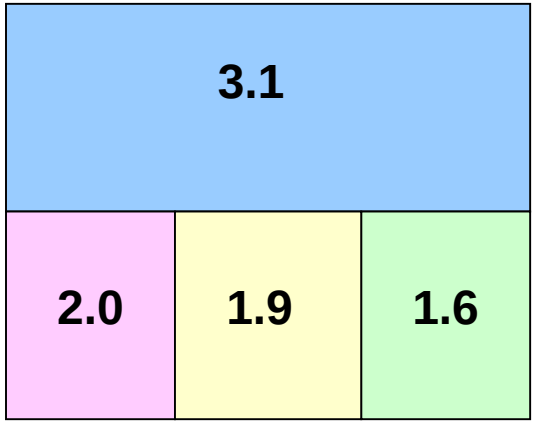
Phase 1 Narrows the Choices of Action



Urban County: Comparing Different Subpopulations

White Fetal-Infant
Rate = 8.6

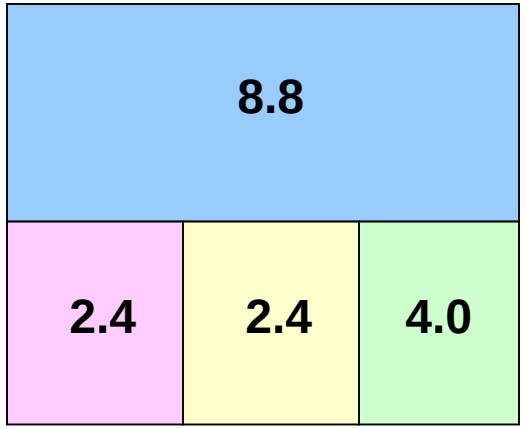
(Denom.=16,045)



White non-Hispanic

Black Fetal-Infant
Rate =17.6

(Denom.=3,291)



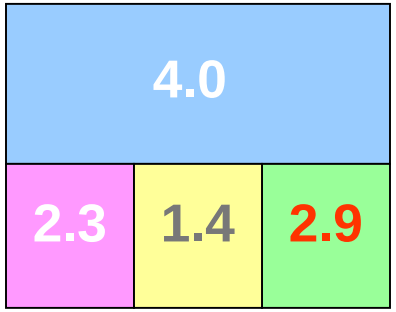
Black non-Hispanic

Map of Feto-Infant Mortality Rates

1993-2006

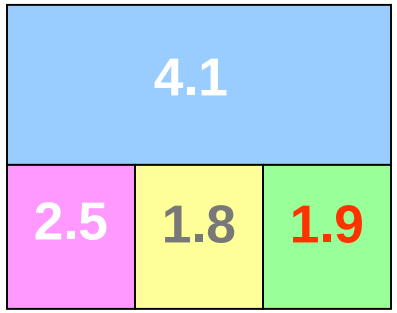
Douglas County, NE, All Races

Feto-Infant Rate = 10.7



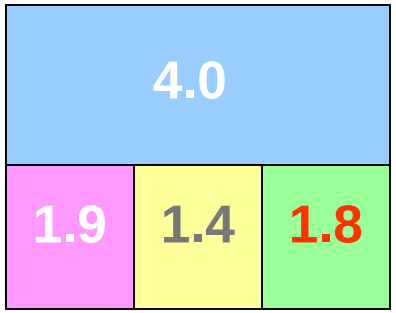
1993-1996

Feto-Infant Rate = 10.3



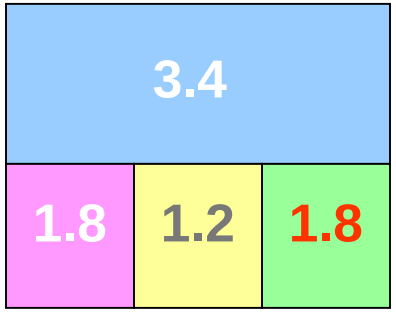
1997-2000

Feto-Infant Rate = 9.1



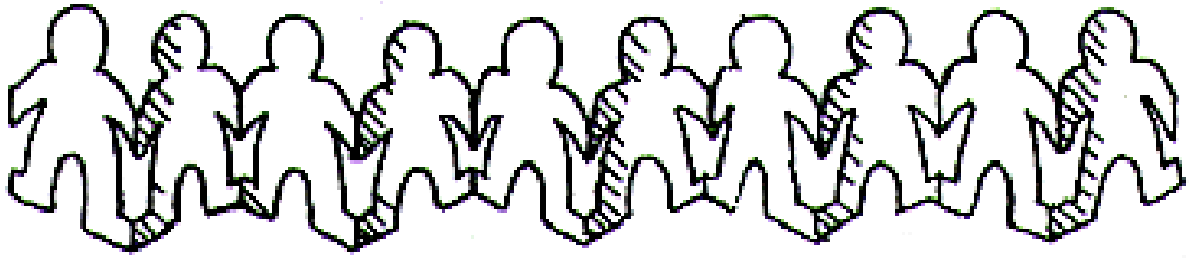
2001-2004

Feto-Infant Rate = 8.2



2003-2006

PPOR mortality rates are also calculated for a reference population to answer the question “What rates should we *expect* to see in each Period of Risk?”



The reference group is selected based on maternal demographics, not behaviors or health conditions.

PPOR Phase 1

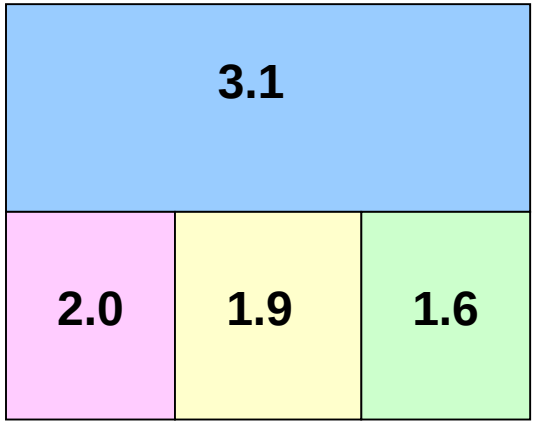
- The reference group provides a baseline, an expected mortality rate under ideal conditions
- If a death rate exceeds the baseline rate, we know there are deaths that could have been ***prevented***.
- PPOR Phase 1 tells the team which periods of risk and populations have ***preventable*** deaths,

i.e. **“Where are the gaps?”**

Urban County: Comparing Different Subpopulations

White Fetal-Infant
Rate = 8.6

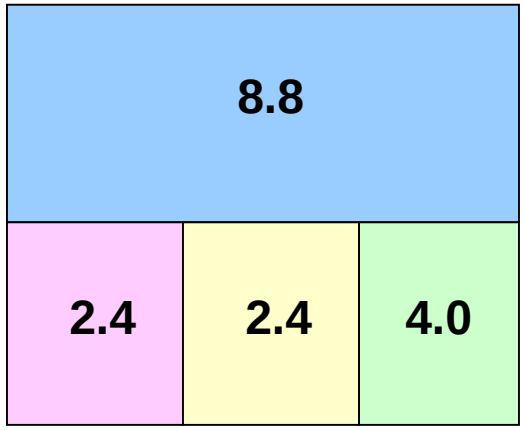
(Denom.=16,045)



White non-Hispanic

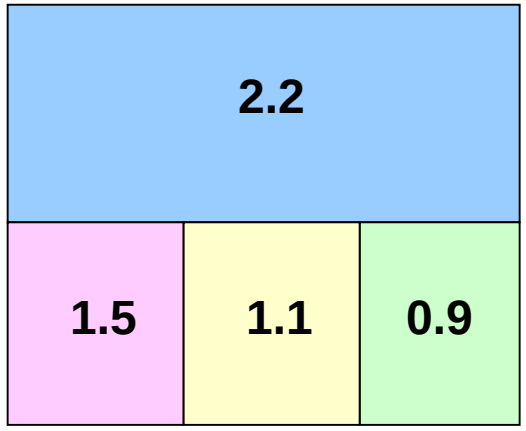
Black Fetal-Infant
Rate =17.6

(Denom.=3,291)



Black non-Hispanic

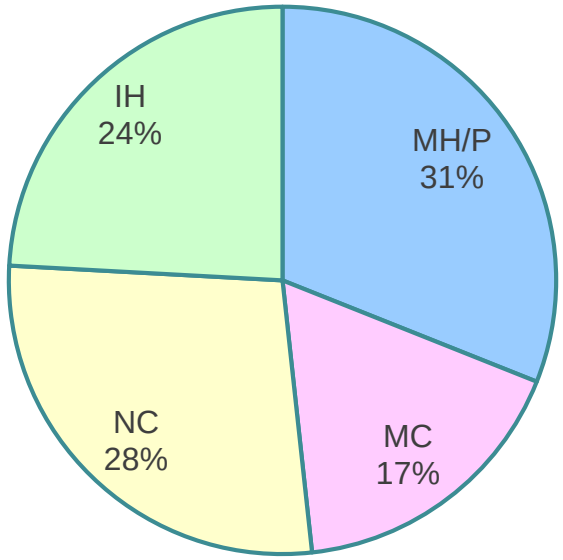
Reference Group
=5.7
(National)



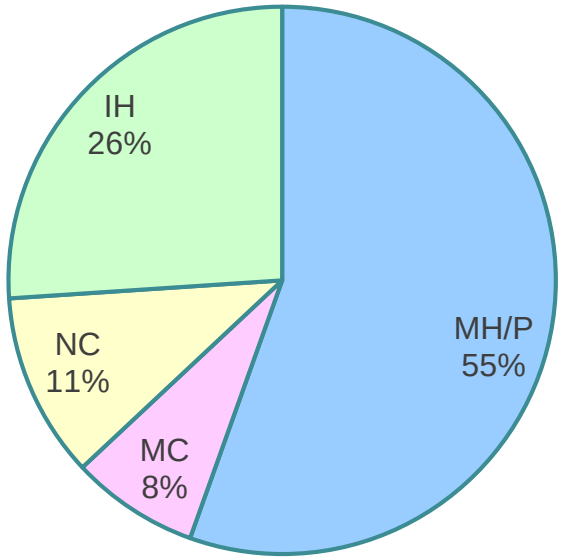
White, 13 years education
Age >=20

The gaps (Phase 1 results)

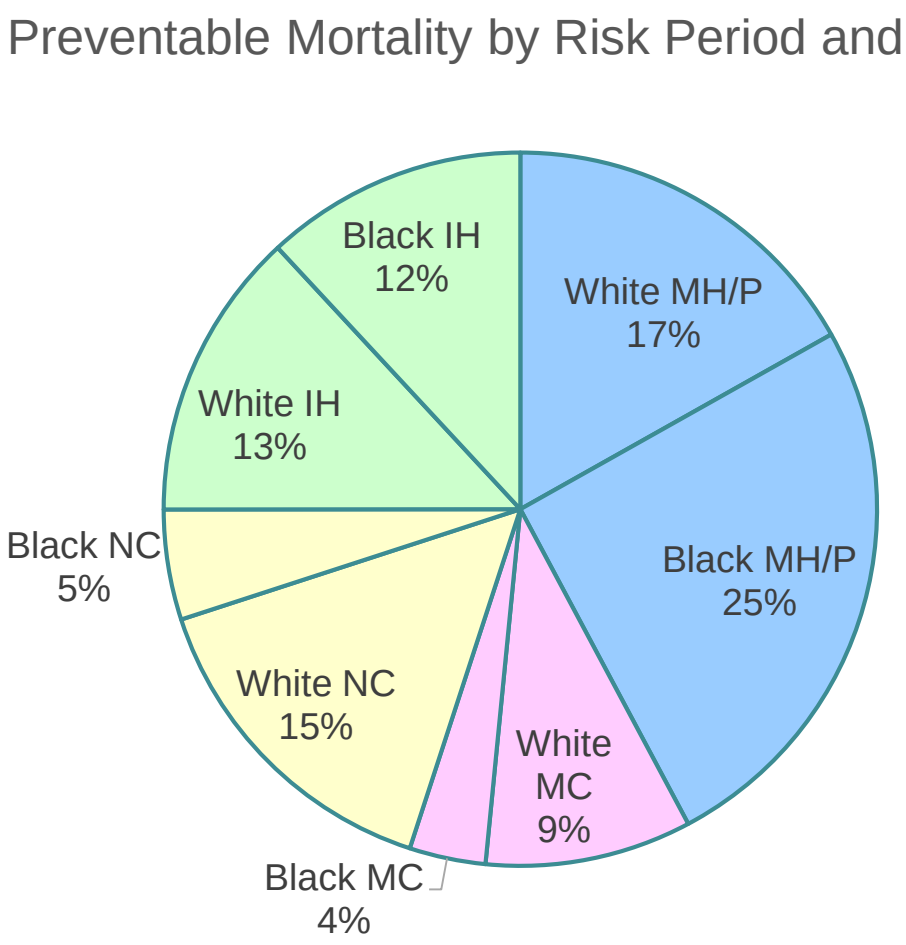
Preventable White Mortality



Preventable Black Mortality



The gaps (Phase 1 results)

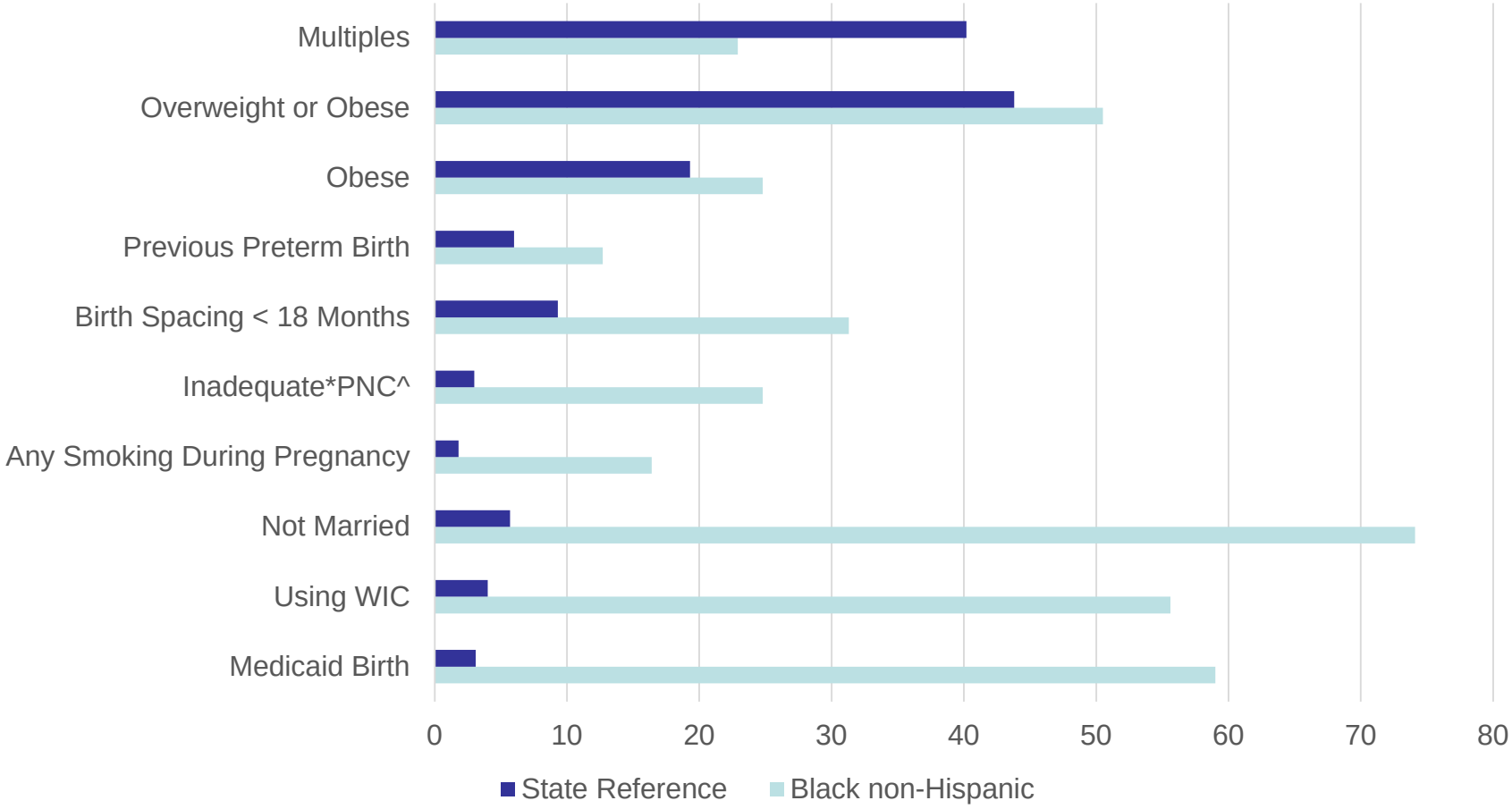


PPOR Phase 2

Focus on the populations and periods of risk with the largest gaps.

- Questions:
  - What are the likely causes of this gap?
  - What interventions are most likely to work?
- Activities:
  - Further epidemiologic study (Phase 2 PPOR)
  - Review scientific evidence
  - Community health and health systems assessments
  - Fetal Infant Mortality Reviews (FIMR)

Phase 2 analysis (partial)
MHP (Blue Box) too many VLBW Babies



Summarize factor importance using PAR

	Percent of Population with Risk Factor	Risk Ratio (risk of those exposed to the factor compared to those not exposed)	Population Attributable Risk Percent (potential impact of factor on very preterm birth rate)
Twins or More	3.2%	11.4	24.9%
Not Married	44.4%	1.5	17.7%
<=High School Education	48.3%	1.4	16.5%
Birth Spacing < 18 Months	13.7%	2.2	14.0%
Previous Preterm Birth	5.4%	4.0	13.9%
Delivery Paid by Medicaid	27.4%	1.4	9.4%
Overweight or obese	48.3%	1.1	6.6%
Smoking during pregnancy	15.7%	1.4	5.6%
Previous Poor Birth Outcome	1.1%	5.3	4.6%
Obese	24.0%	1.1	1.7%
Teen Mom (19 or less)	10.9%	1.1	0.9%
WIC	42.7%	0.9 Protective	Protective

Example of Phase 2 conclusions

Too many VLBW births contributes 75% of preventable “blue box” deaths, 31% of all excess mortality. What are the important factors?

Likely important causes *or markers* in our community

- Not married
- High school or less
- Short birth spacing
- Previous preterm birth

Not likely

- Multiples (twins/triplets)
- Teen births
- Obesity/overweight
- Low educational attainment
- Inadequate prenatal care
- Smoking
- Other previous poor outcomes

PPOR Phase 2 fosters *integration* with other key efforts

- Assessments and studies (CHIP, CHA etc.)
- Surveillance systems such as PRAMS, BRFSS, YRBS
- Policy and program evaluations
- **Fetal Infant Mortality Review**

PPOR & FIMR

– USE FIMR information in Phase 2, to help interpret findings and to understand true causes of excess mortality

e.g. late prenatal care ***because of what?***

– lack of trust
– insurance limitations or barriers
– transportation or childcare

Role of FIMR

- Aggregate info on contributing factors can help identify specific needs, risks
- FIMR info can be used to formulate, tailor interventions
- FIMR findings can be used to monitor impact of new interventions

Carol Brady, 2005

FIMR can help address some Limitations of PPOR

- PPOR can’t be used in communities or subpopulations with less than 60 deaths in 5 years.
- Observational data cannot prove cause and effect, whereas case studies can reveal actual causes.
- Vital records and other population-based data sources only collect data on a very limited number of factors known to affect birth outcomes. FIMR is unlimited and can identify NEW factors.

PPOR can help FIMR programs operate efficiently

- FIMR can use PPOR data to focus limited case review resources on areas where there is the most opportunity (the gaps), and to provide context for findings to improve recommendations

PPOR can help organize FIMR findings

- FIMR can use PPOR data to focus limited case review resources on areas where there is the most opportunity (the gaps), and to provide context for findings to improve recommendations

Integrating PPOR & FIMR

(contributing factors by risk period)

MATERNAL HEALTH

(n=31)

- Maternal infections other than STDs - 45%
- Preterm labor - 45%
- PROM - 39%
- Hx of fetal or infant loss - 39%
- Anemia - 32%
- Lack of family planning - 32%
- Substance use - 29%
- Pre-pregnancy medical condition -29%

MATERNAL CARE

(n= 18)

- Obesity - 50%
- Pre-pregnancy medical conditions - 39%
- Maternal infections other than STDs - 33%
- Parental education (kick counts, s/s of preterm labor) -33%
- Late entry into prenatal care - 33%

Carol Brady, 2005

Integrating PPOR & FIMR

(contributing factors by risk period)

NEWBORN CARE

(n=9)

- STDs - 56%
- Pre-pregnancy health - 44%
- Maternal infection other than STD - 44%
- PROM - 44%
- Hx of previous loss - 44%
- Maternal age<21 - 44%
- Substance use - 33%

INFANT HEALTH

(n= 9)

- Poor follow-up for medically-complex child - 78%
- Poverty -68%
- Lack of Healthy Start screening - 56%
- Poor communication between providers - 56%
- Late entry into care - 56%
- SIDS prevention - 44%

Carol Brady, 2005

Another limitation that PPOR can address:

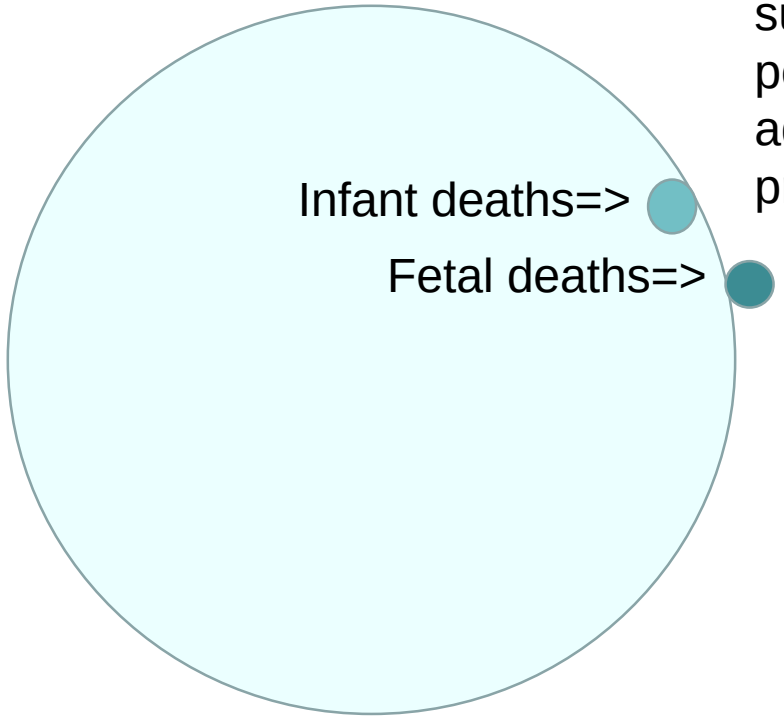
what cases is our FIMR program reviewing?

- In order to understand risks in the community, information about *babies that don't die* is also needed.

  Why?

  All are at risk of becoming a death

Deaths are a much smaller group than the population at risk.
They have different characteristics

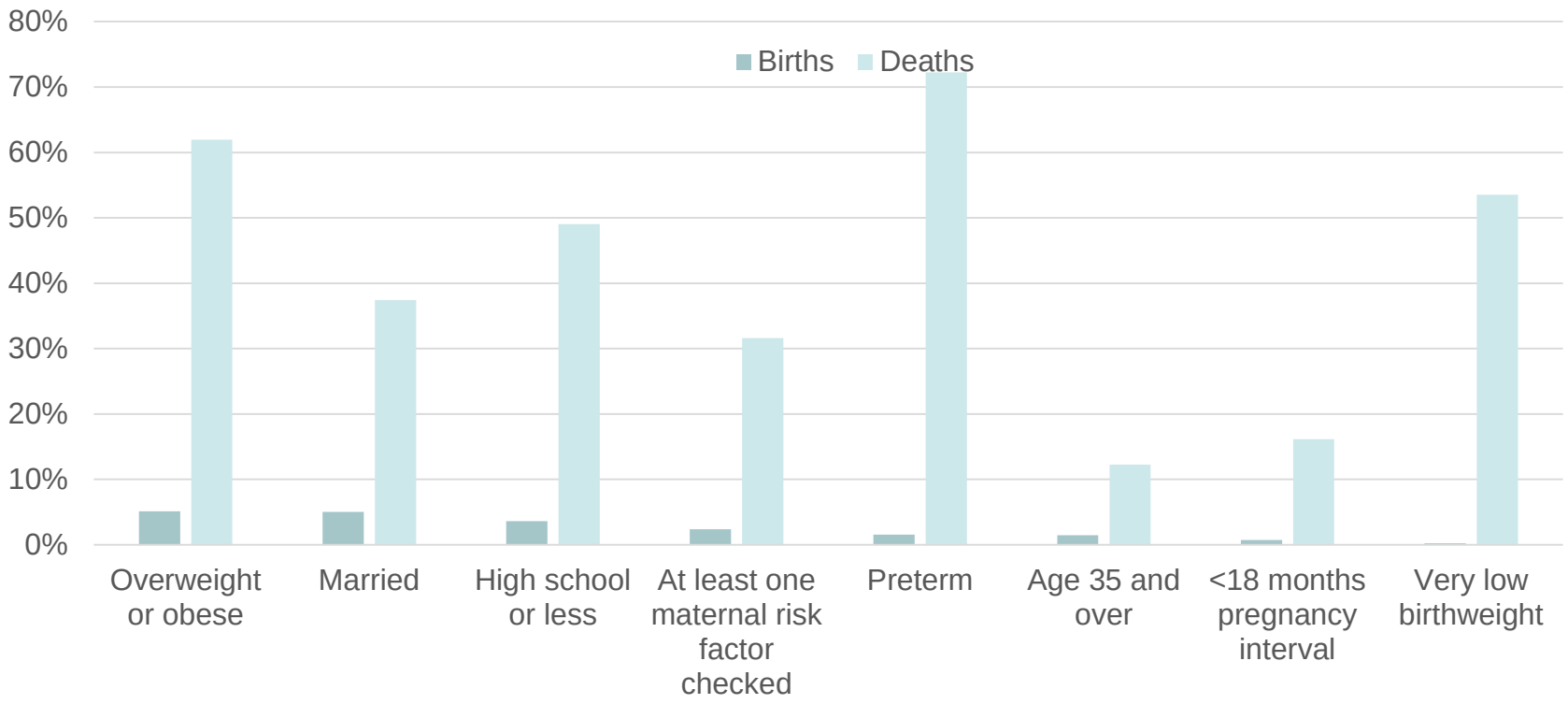


Deaths are a very small subset of the population we would address with prevention activities

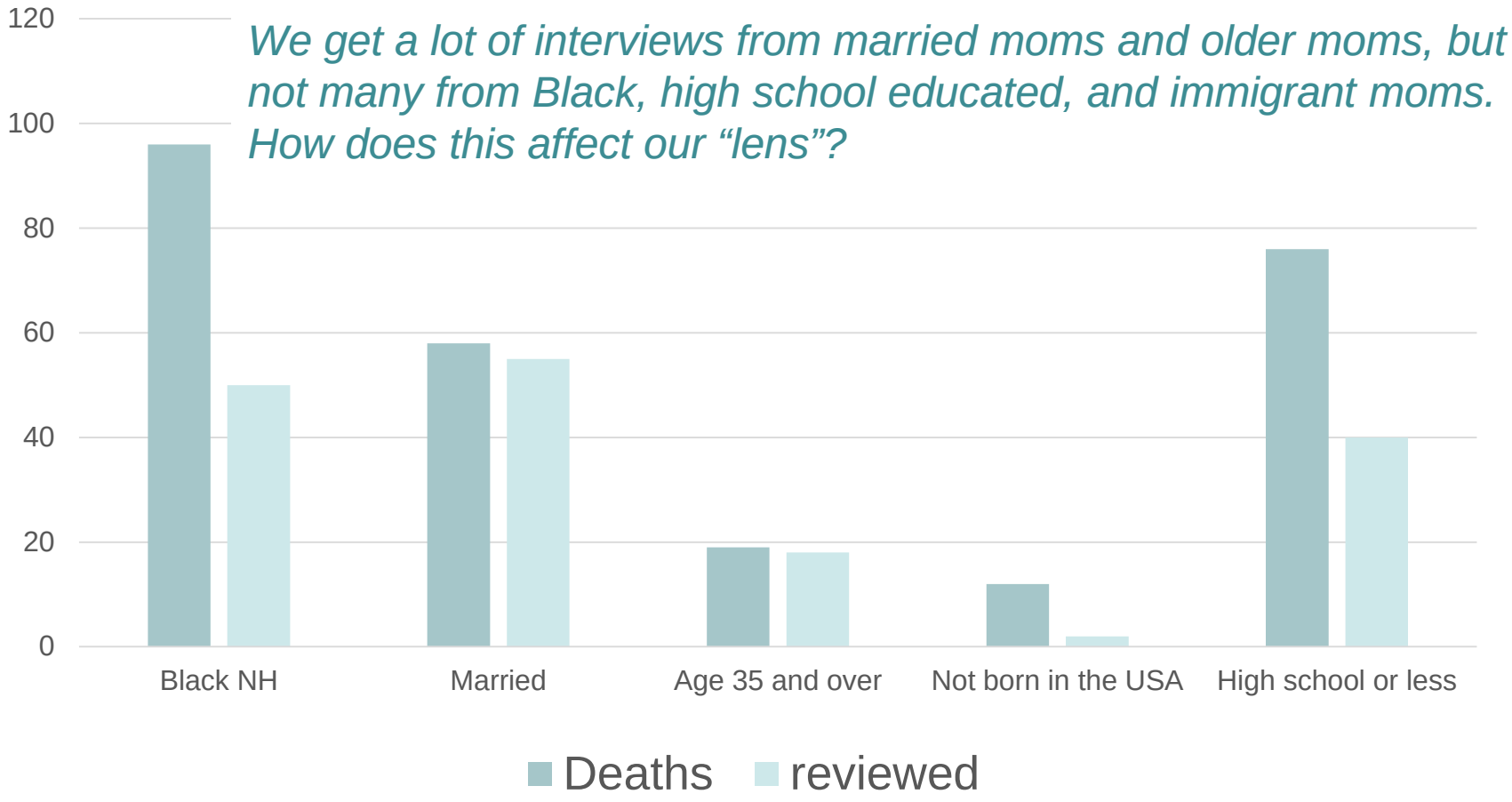
… not a random or representative sample, either. Much higher prevalence of risk factors.

Deaths and births are very different populations

(prevalence of risk factors in Jefferson County, AL)



FIMR case review samples (especially maternal interviews) are not usually 100% and those that respond are not *representative* of the population of *deaths.*



PPOR and FIMR PROCESSES ALIGN

PPOR Steps	Parallel Components	FIMR Steps
Community Engagement and Readiness.		Building Community Support
Data and Assessment (Analysis)		Collect Data (including parental interviews) and Review Cases (CRT)
Strategy, Planning and Implementation		Community Action Team (CAT) Translates Recommendations into Action
Monitoring and Evaluating		Monitor Implementation and Evaluate Results (CAT)

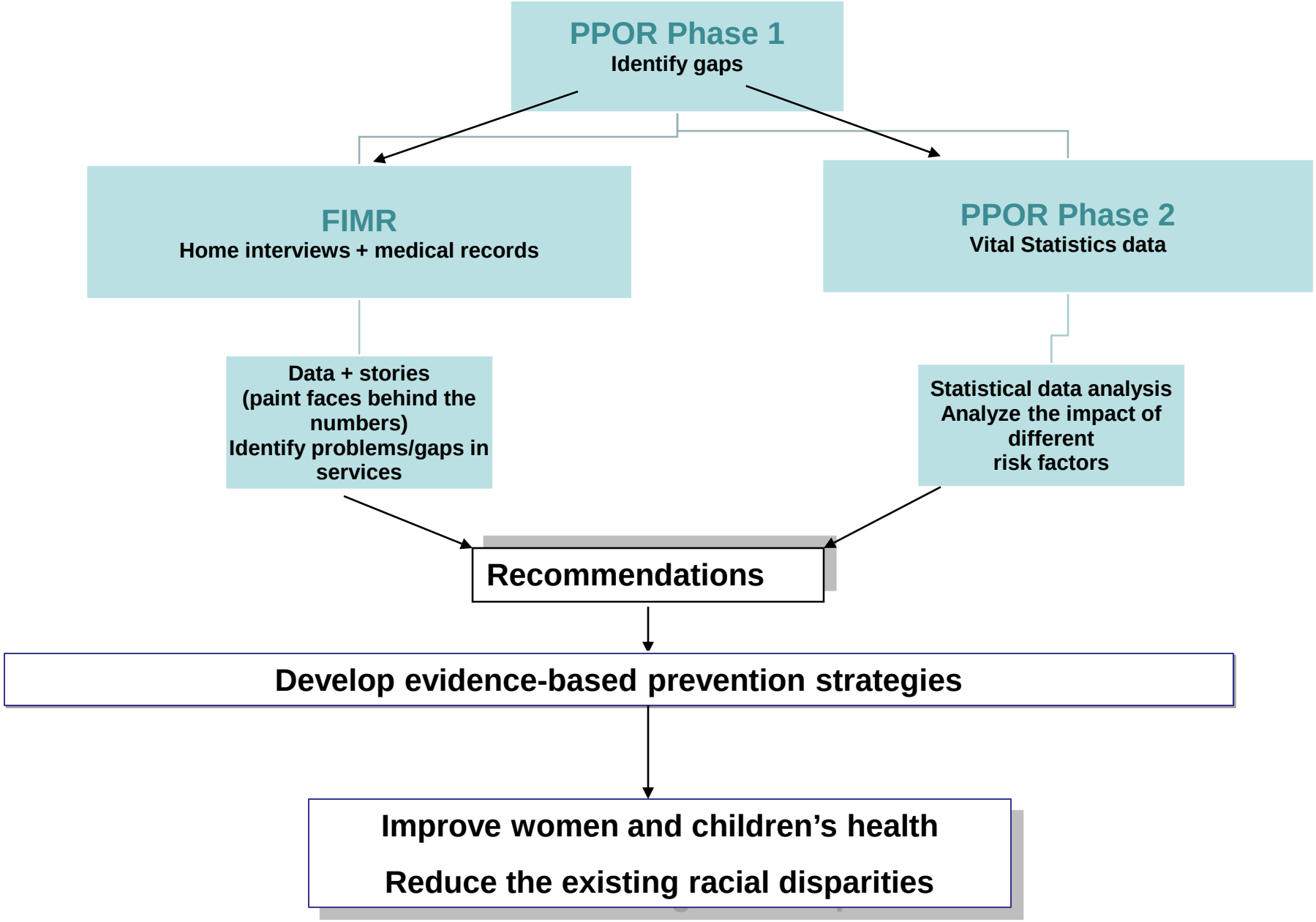
The Community Action Team is the PPOR Community group

- *“Many communities already have a functioning group that has the characteristics necessary to fulfill the role of the CAT. … It is most important not to form a new and separate FIMR CAT unless no other comparable group exists in the community …”*

  --Fetal and Infant Mortality Review Manual: A Guide For Communities

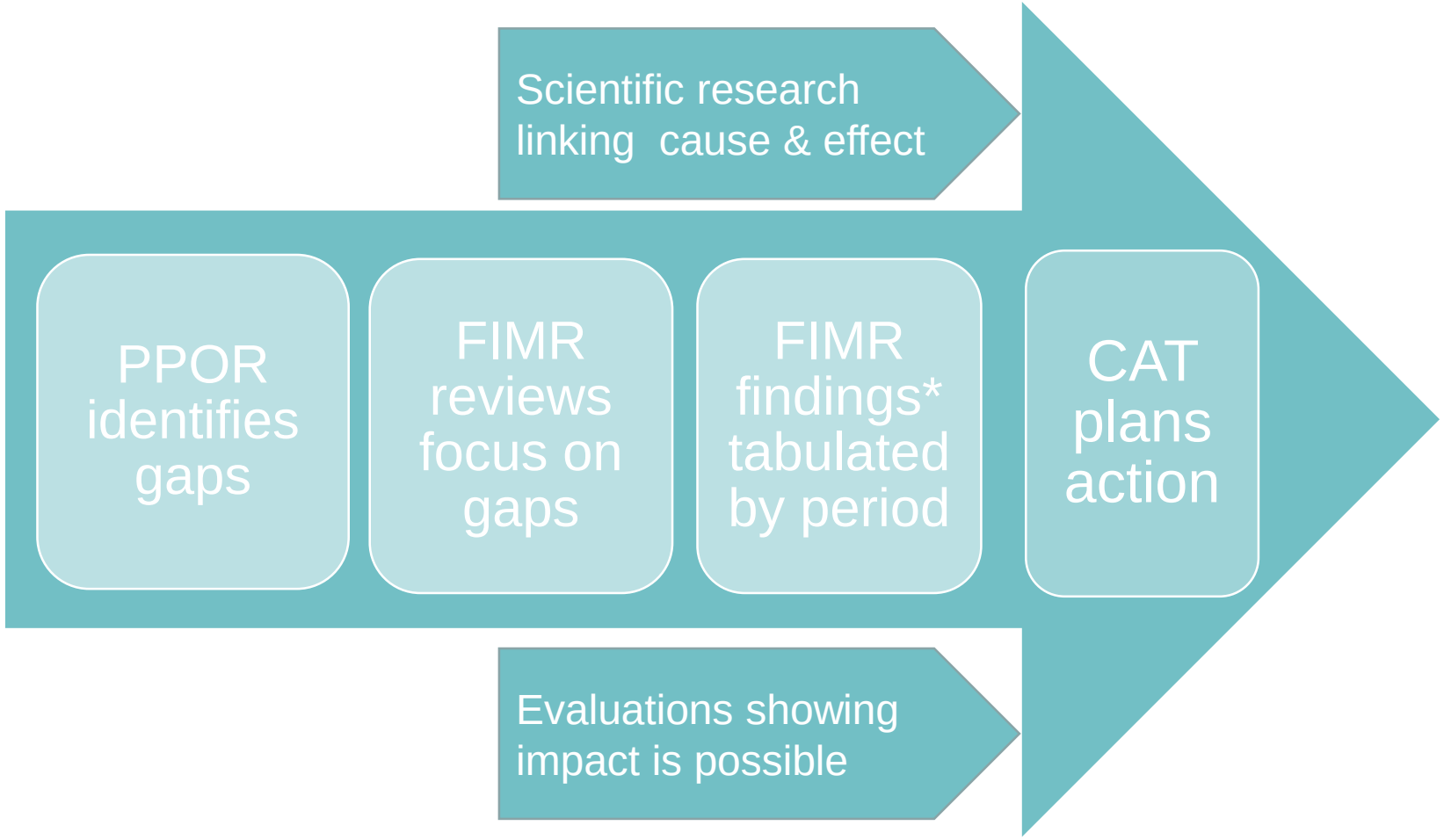
  Kathy Buckley

Integrating PPOR, FIMR, and MCH Services



Adapted from Grigorescu, Louisville KY

Integrating PPOR and FIMR (common model for smaller populations)



*findings are contributing factors

FIMR and PPOR have complimentary strengths

- Each process can add value to the other.
- Each adds information to the community's efforts to prevent infant deaths.

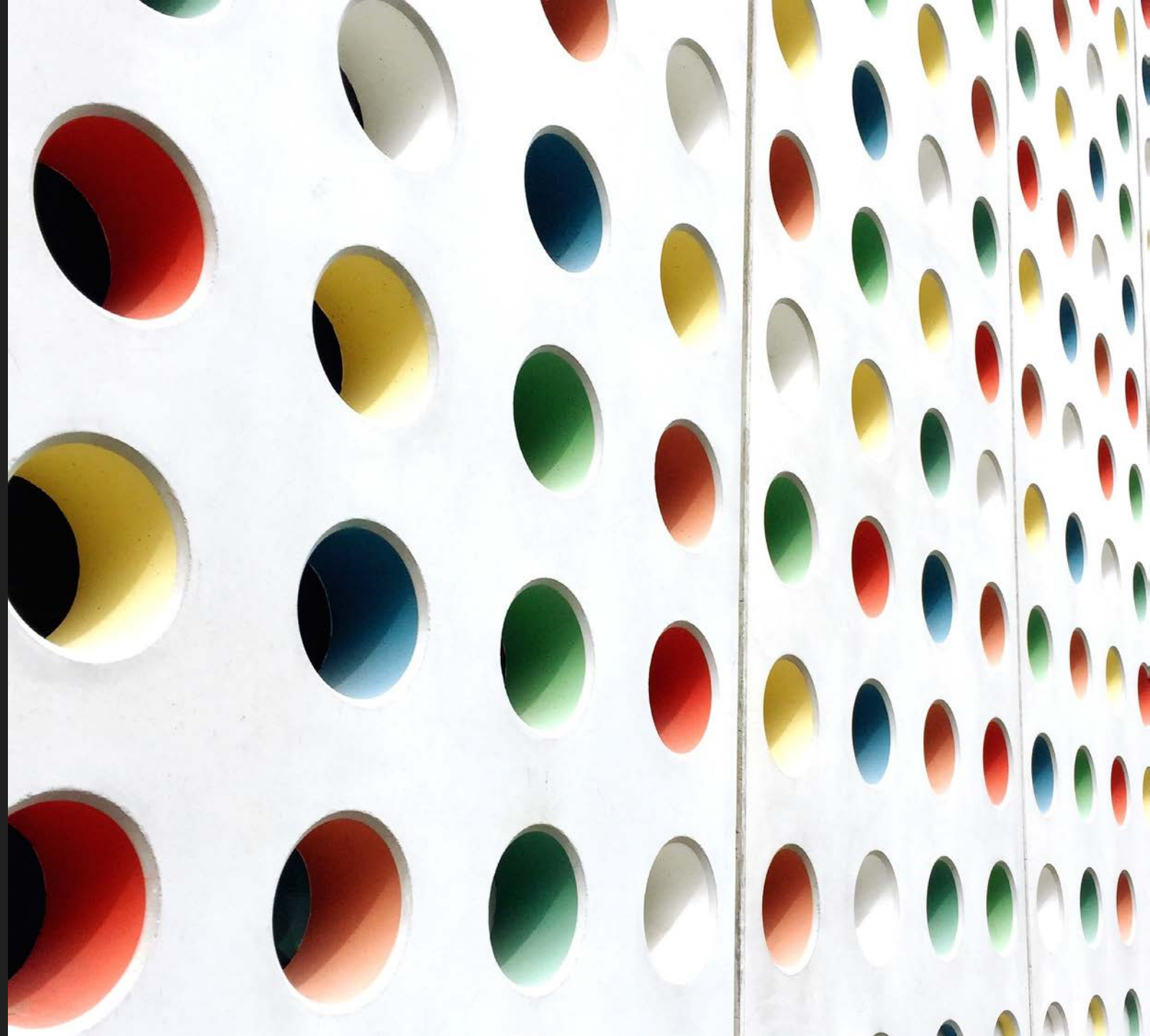
PPOR and FIMR each provide needed pieces of the puzzle.

Together they can improve community prevention efforts.

Fetal & Infant Mortality Review (FIMR) and the Perinatal Period of Risk (PPOR)

Kelli Mcneal

OKC-COUNTY HEALTH DEPARTMENT



Goal

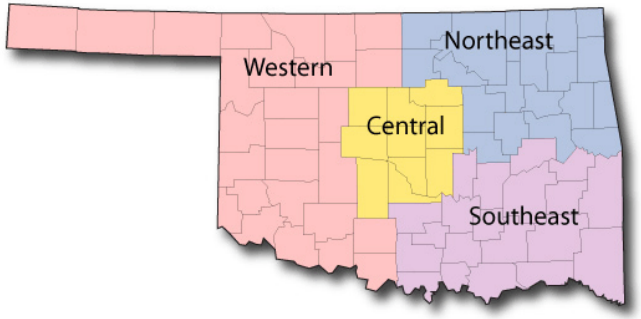
FIMR: Continuous Quality Improvement

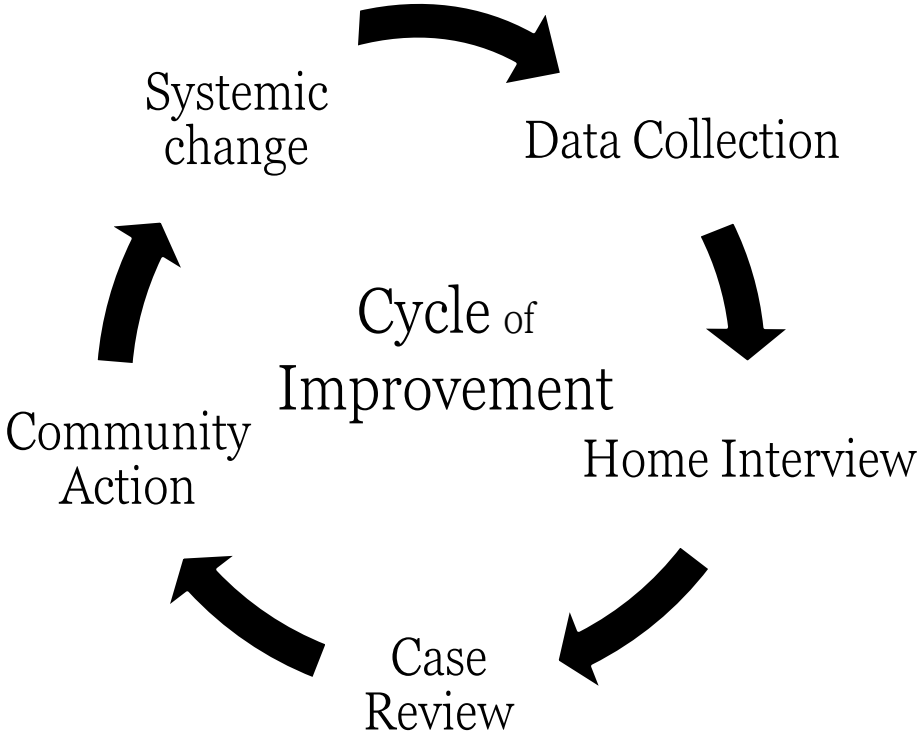
Perinatal Period of Risk (PPOR) Model

Our Process

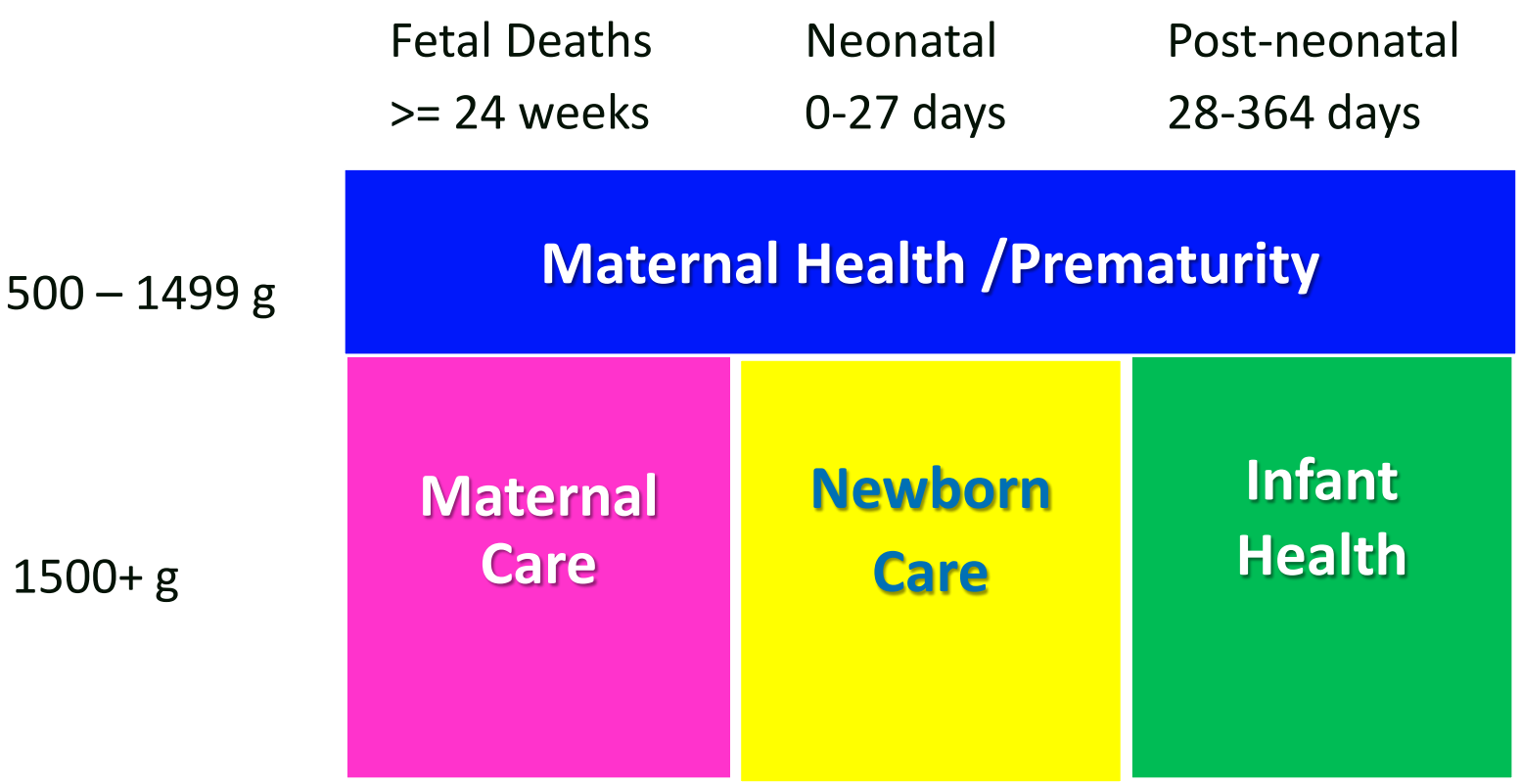
Outcomes

FIMR Model and Case Criteria

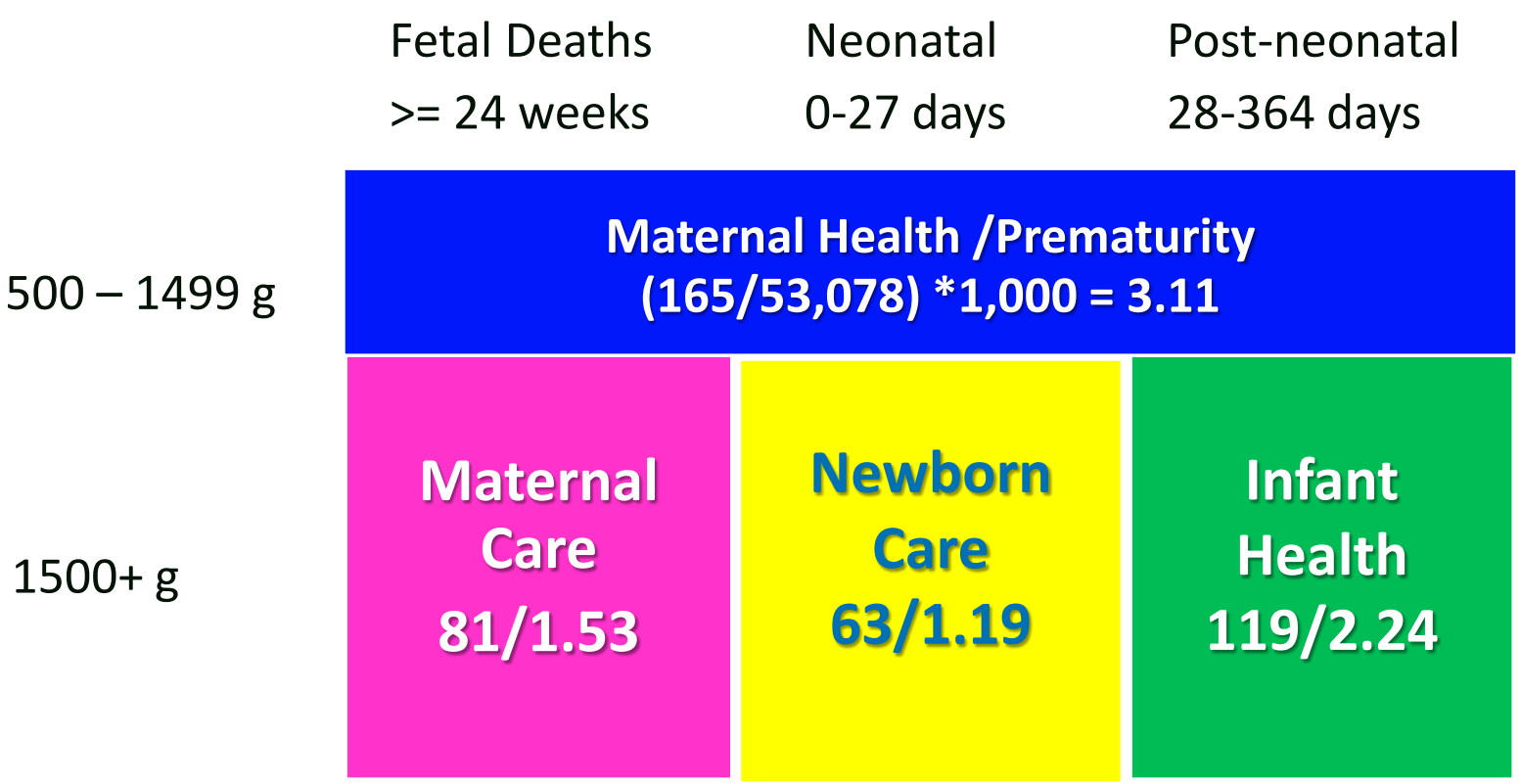




- Resident of Oklahoma, Cleveland, Canadian, Logan, or Pottawatomie Counties
- Fetal Demise or Live birth ≥ 24 Weeks Gestation
- Birth Weight ≥ 500 grams
- Infant passing away prior to 1 year of age
- No litigation associated with case



Perinatal Period of Risk (PPOR) Maps Feto-Infant Deaths



PPOR Maps Feto-Infant Deaths: All Races (2016-2018)

Reference Group

2014-2018 internal ref group

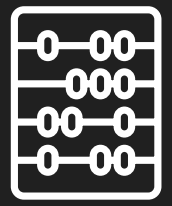
- Women with at least some college education
- 20-34 years of age
- Any race/ethnicity
- Resident of Canadian, Cleveland, Logan, Oklahoma or Pottawatomie County at the time of baby's birth

MH/P (2.68), **MC** (1.54), **NC** (0.95), **IH** (1.25)

Where we are at

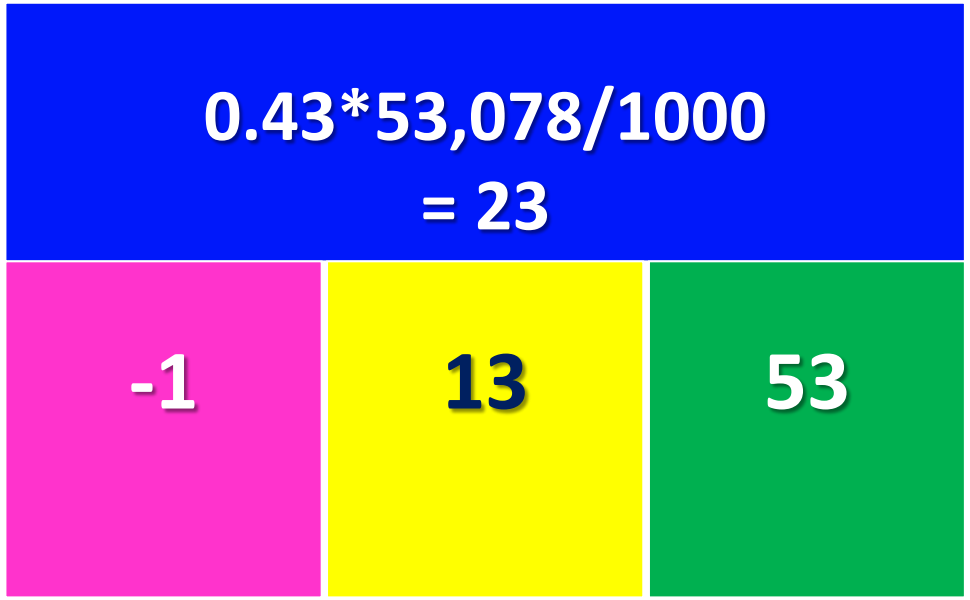
– Where we want to be

Number of babies we might have been able to save

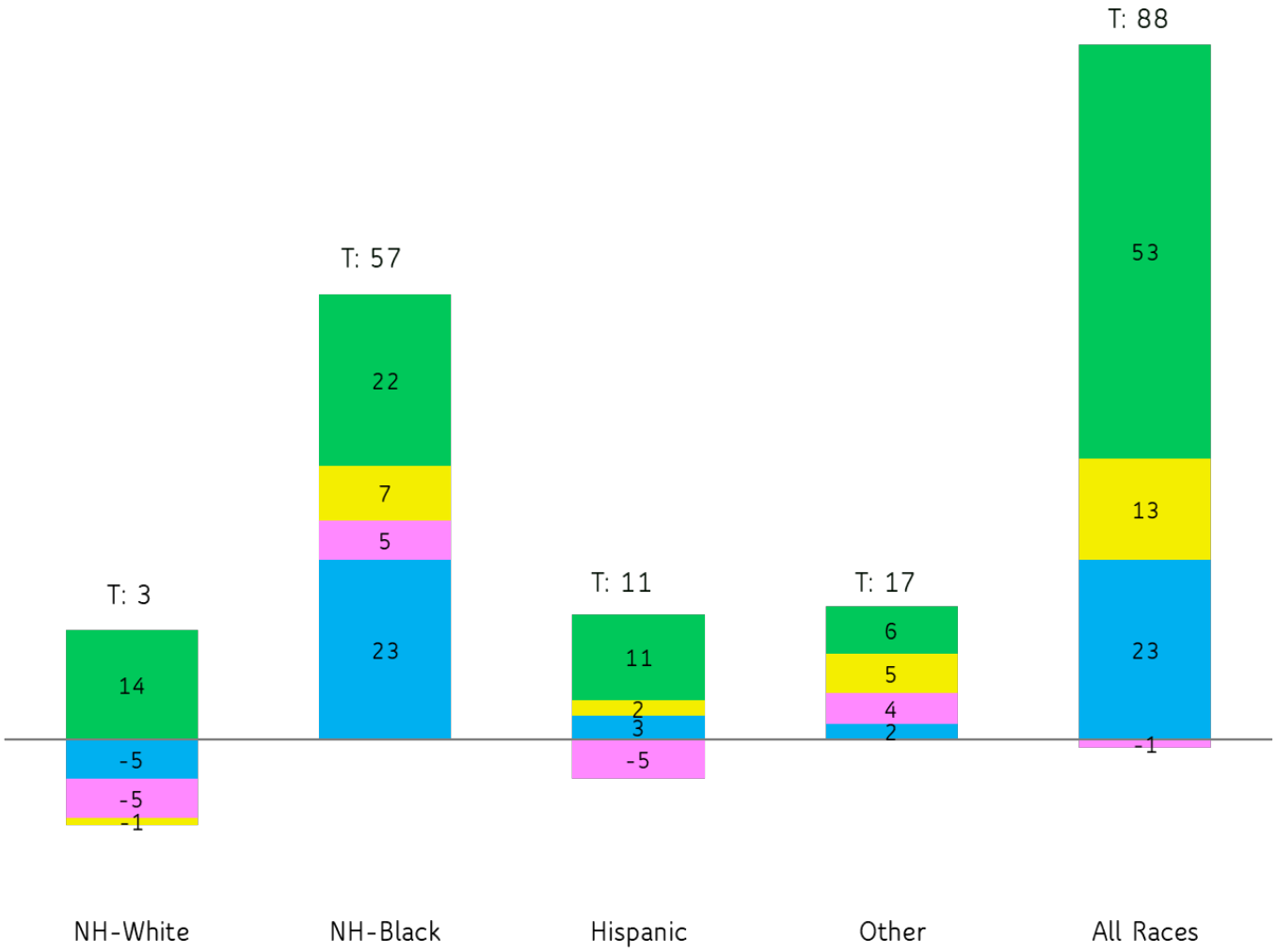


Number of Cases – Baseline = Excess Mortality

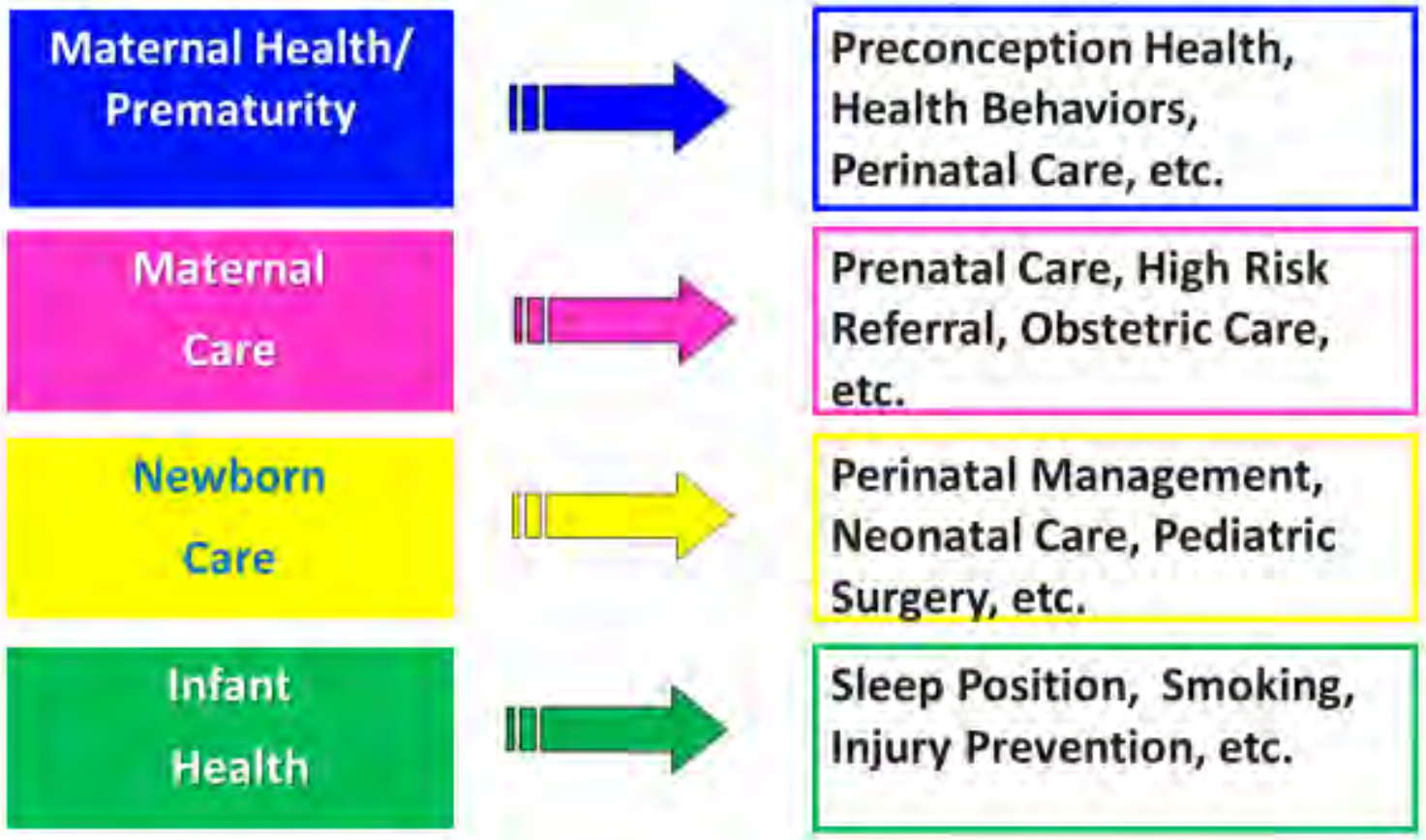
Estimated Excess Number of Deaths: All Races, 2016-2018



Overall estimated number of deaths (23-1+13+53)= **88**



Estimated Excess Number of Deaths by Race/Ethnicity 2016-2018



Data to Potential Action

2016 CRT Recommendations

- Primary and specialist address pregnancy issue with every patient (Chronic Health)
- Education for women with a history of pre-term labor/delivery on the need for progesterone in future pregnancies.
- Contraception counseling
- Social worker in OB/MFM offices
- More/additional preconception health education
- More education on importance of prenatal screening
- Change the media message/approach when educating according to age group/different interests, i.e folic acid
- More education and awareness on tobacco cessation for pregnant women Improve mental health and substance abuse services and interventions
- Improve access to mental health services for pregnant women
- Warning to women on the possibility of their infant having NAS if they use drugs/narcotics during pregnancy
- Increase referrals to high-risk OB
- Funding for Perinatal Hospice
- Need for Perinatal hospice and grief counseling Access to genetic counseling
- Increase referrals to genetic counseling services
- Extend and expand Sooner Ride
- More social workers in OB practice
- Appropriate translation services in clinics and hospitals
- Life Share to develop a more consistently compassionate approach when talking with families about organ donation · Support groups including online
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- More support on establishing and scheduling appointments with Pediatricians
- Safe Sleep awareness to include cribs for family members
- Car seat education on safe sleep
- Utilize more home visitation programs
- Safe sleep education to caregivers
- Free crib programs
- Ability to make a referral to OCCY on cases that may warrant further action
- Substance abuse testing at crime scene
- Drill down root causes of anomalies
- Greater need for mental health and substance abuse services

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Primary and specialist address pregnancy issue with every patient (Chronic Health)	Education for women with a history of pre-term labor/delivery on the need for progesterone in future pregnancies.	Contraception counseling	Social worker in OB/MFM offices	More/additional preconception health education	More education on importance of prenatal screening
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2017 CRT Recommendations

- Better preconception health/family planning services
- Increase preconception education on chronic health conditions and medications taken by pregnant women
- Preconception education / birth spacing
- More education and awareness on tobacco cessation for pregnant women
- Improved mental health referrals/management for pregnant women
- Increase referrals to Children First /Home visitation programs
- Increase promotion/education to hospitals and providers on resources for home visitation programs such as Parent Pro
- Improved mental health referrals/management for pregnant women
- More substance abuse treatment for pregnant women
- Increase education about substance use while caretaking of an infant
- Funding for Perinatal Hospice
- Need for Perinatal Hospice and grief counseling
- Car safety for pregnant women
- Giving general safety education about pregnancy, ie wearing your seatbelt, substances to avoid, etc.
- Education on emergency action/services/911
- Midwife scope of practice in line with ACOG
- More pregnancy centered models
- Expand Transitions Network to provide more services for families leaving the hospital
- Improve follow up to those families going home after bereavement/critically ill child
- Infant CPR prenatal
- Safe sleep education to include Foster families (re-education with death or near miss)
- Infant safe sleep education-Revised addition (changing the way we message)
- Continue to educate on Unsafe sleep practices
- Working on cause of death on autopsy (unknown/undetermined)
- Zip codes versus specific anomalies
- Increase use of SUIDI form
- Officer training in SUIDI/Case Review presence or training

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2018 CRT Recommendations

- Increased education about tobacco cessation
- Availability of more patient advocate services
- Increase available home health services
- Improve access to early prenatal care
- Increased screening and referrals for mental health issues
- Continue to promote safe sleep messages
- Revise safe sleep education, resources and messaging
- Continue to advocate for all police department to utilize the SUIDI form
- Create policy and /or education on joint response between DHS and Police when death occurs
- Better utilization/referrals for home visitation programs
- Recruiting more people to go into the nursing field to fill under staffing issues

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NOW WHAT?

Time for our Community Action Team to put it all together!

- ☑ FIMR Data
- ☑ FIMR Recommendations
- ☑ PPOR Data
- ☑ PPOR Analysis
- ☑ Leaders understand the current environment
- ☑ Work Begins

Prematurity
Work Group

Prematurity Domain includes both fetal and infant deaths that are between 500 and 1499 grams

Prematurity is one of the top three leading causes of infant mortality.

A baby born before 37 weeks is considered premature. According to the March of Dimes, about one in every ten babies is born prematurely in the U.S. Premature babies typically have more health problems than an infant born full term and may need a longer hospital stay. Additionally, infants born prematurely may have long-term health problems that can affect their whole lives.

Problem: The Perinatal Periods of Risk (PPOR) data reported that 64% of women who lost their infants during the Prematurity domain reported maternal infection during pregnancy.

Issue: At least 40% of preterm births are associated with intrauterine infection. In individual cases it is often difficult to determine whether infection is the cause or consequence of the processes leading to preterm delivery. However, there is abundant evidence that infection and the inflammation generated by infection, whether within the gestational tissues or elsewhere, are a primary cause of a substantial proportion of preterm births.

Source: Lamont RF. Infection in the prediction and antibiotics in the prevention of spontaneous preterm labour and preterm birth. BJOG. 2003;110(Suppl 20):71–5. [PubMed]

Strategy: Screen women for sexually transmitted infections (STI) when they receive a positive pregnancy test in order to reduce risk of preterm birth.

Problem:
The Perinatal Periods of Risk (PPOR) data reported that 17.4% of women who suffered a loss during the prematurity period had a previous preterm birth.

Issue: Women who have experienced a previous preterm delivery are at higher risk to have a subsequent preterm birth. Accessing services early in a pregnancy can be beneficial to detecting some underlying issues. However, far too often women experience a delay in access to services early in their pregnancy.

Strategy:
Empower women who have had a previous preterm birth to advocate for access to early services and educate them on related risk factors.

Maternal Care
Work Group

Maternal Care Domain includes fetal deaths that are stillborn weighing 1500 grams or greater

The excess fetal deaths in the Perinatal Periods of Risk (PPOR) data in the Maternal care period highlight the importance of improving the access to utilization of prenatal care services and referral for high-risk pregnancies. In addition, interventions should target overall health behaviors and birth spacing.

Problem: The PPOR data has identified individual, social, economic and environmental factors effecting women in this domain. These included:

- 18%–Sexually transmitted infections
- 15%–Maternal education less than high school diploma
- 38%–Pre-pregnancy obesity
- 26%–No or late prenatal care
- 28%–Tobacco use
- 15%–Drug use

Issue: A women's life circumstances play a major role in determining the health of her baby. Known as "social determinants of health" these circumstances include factors such as income and education level, social supports, physical environment and working conditions. For example, pregnant women with low income and education and few social supports may have poorer birth outcomes than pregnant women with higher incomes, education levels and strong social supports. *(http://www.aimcoemsalookahealthstats.org/topics/pregnancy-and-before/parental-characteristics/social-determinants)*

Strategy: Support and increase the availability of social work services for pregnant women and their families.

Problem: The data reveals that the number of pregnancies spaced at less than 18 months apart were significantly higher for every population group (Caucasian, African American and Hispanic) than the reference group.

Issue: According to the March of Dimes, birth spacing refers to the time from one child's birth until the next pregnancy. Pregnancies that start less than 18 months after a previous birth are associated with delayed prenatal care and adverse birth outcomes, including preterm birth, neonatal morbidity, and low birthweight. In the United States, between 2006 and 2010, about 33% of pregnancies among women with a previous live birth began less than 18 months after the prior birth, placing mothers and infants at risk for adverse health outcomes.

Strategy: Educate families on the importance of planning and spacing their pregnancies.

Newborn Care
Work Group

Newborn care domain includes infants that are born weighing 1500 grams or greater and live between 0-27 days.

Problem: Congenital anomalies are considered to be one of the top three leading causes of infant mortality. Data from the PPOR shows that 72% of newborns within this domain were diagnosed with a birth defect.

Issue: Half of all pregnancies in the U.S. are unplanned. This makes addressing pre-conception health very difficult. Although, the healthier a woman is when becoming pregnant, the better chance she has for a healthy birth outcome. Given that Folic acid has been proven to decrease the incidence of certain birth defects, any woman of child-bearing age should be taking the supplement on a daily basis.

Strategy: Increase the number of child-bearing aged women taking daily vitamins including at least 400 mcg of Folic acid to reduce birth defects.

Problem: Data from the PPOR shows that over 13% of the newborns within this domain were exposed to illicit drugs prenatally. This does not account for the regular, prescribed use of opioid medications during pregnancy.

Issue: Studies have consistently shown prescription opioids are among the most commonly prescribed medications and the prevalence of use is increasing among pregnant women. Potential harms associated with prescription opioid use, during pregnancy, include poor fetal growth, preterm birth, birth defects, and neonatal abstinence syndrome.

Strategy: Decrease the number of women taking prescription opioids during pregnancy in order to reduce associated risks to the newborn including Neonatal Abstinence Syndrome.

Infant Health
Work Group

Infant Health Domain includes infants that are born weighing 1499 grams or greater and live between 28 -364 days of life.

Problem: The data reveals that 63% of the infants that fall within this domain, unsafe sleep factors were sleep-related deaths.

Issue: Educating families on the risks associated with creating an infant safe sleep environment has been challenging. Over the last several years, FIMR and many of our partners have been successful in educating a wide array of professionals on the importance of infant safe sleep. However, there remains a disconnect for families ability to identify infant safe sleep as a risk for their newborn.

Strategy: Develop new education and awareness campaigns with targeted messages on the risks associated with sleep-related deaths.

Problem:
Tobacco usage is the single most preventable risk factor associated with infant loss and is identified in every domain of the PPOR data.

Issue: There is no risk-free level of exposure to second-hand smoke. Second hand smoke can contribute to numerous health problems in infants including respiratory infections, asthma, ear infections, and is a leading factor in the risk for SIDS/SUID. FIMR data showed that 61% of infants who succumbed to a sleep related death, were exposed to second-hand smoke. According to the CDC chemicals in tobacco smoke appear to affect the brain in ways that regulate an infant's breathing. As well, infants who died from SIDS/SUID had higher levels of nicotine in the lungs and blood as infants who died from other causes.

Strategy:
Reduce the number of infants who are exposed to second and third hand smoke.

You Guessed It!
Work Groups Established by PPOR

Perinatal Period of Risk (PPOR) Priorities Developed

Prematurity:

- Screen women for sexually transmitted infections (STI) when they receive a positive pregnancy test in order to reduce risk of preterm birth.
- Empower women who have had a previous preterm birth to advocate for access to early services and educate them on related risk factors.

Maternal Care

- Support and increase the availability of social work services for pregnant women and their families.
- Educate families on the importance of planning and spacing their pregnancies.

Newborn Care

- Increase the number of child-bearing aged women taking daily vitamins including at least 400 mcg of Folic acid to reduce birth defects
- Decrease the number of women taking prescription opioids during pregnancy in order to reduce associated risks to the newborn including Neonatal Abstinence Syndrome.

Infant Health

- Develop new education and awareness campaigns with targeted messages on the risks associated with sleep-related deaths.
- Reduce the number of infants who are exposed to second and third hand smoke.

FIMR Priorities

SCREENING WORK GROUP

- Screen women for sexually transmitted infections (STI) when they receive a positive pregnancy test to reduce risk of preterm birth.

EDUCATION WORK GROUP

- Empower women who have had a previous preterm birth to advocate for access to early services and educate them on related risk factors.
- Educate families on the importance of planning and spacing their pregnancies.
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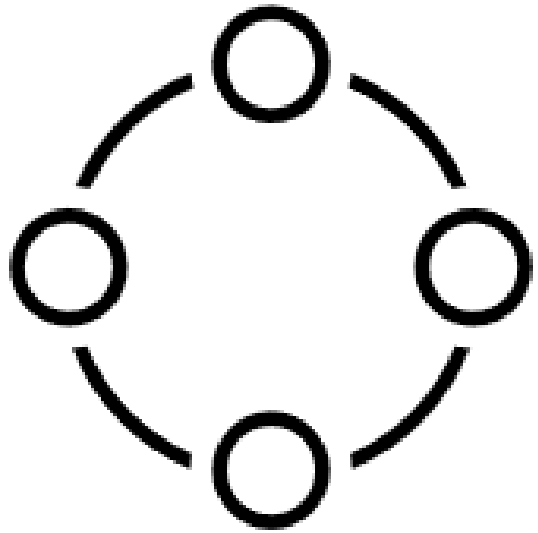
SAFE SLEEP WORK GROUP

- Develop new education and awareness campaigns with targeted messages on the risks associated with sleep-related deaths.
- Reduce the number of infants who are exposed to second and third hand smoke.



Statewide Issues

- Support and increase the availability of social work services for pregnant women and their families.
- Decrease the number of women taking prescription opioids during pregnancy to reduce associated risks to the newborn including Neonatal Abstinence Syndrome.

Outcomes

- Screen women for sexually transmitted infections (STI) when they receive a positive pregnancy test to reduce risk of preterm birth.
    - Statewide task force
    - Approval to go into clinics when reopen after COVID

Outcomes

- Empower women who have had a previous preterm birth to advocate for access to early services and educate them on related risk factors.
- Educate families on the importance of planning and spacing their pregnancies.
- Increase the number of child-bearing aged women taking daily vitamins including at least 400 mcg of Folic acid to reduce birth defects

Outcomes

SAFE SLEEP WORK GROUP

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Outcomes

Infant Mortality Alliance
www.infantmortalityalliance.org

QUESTIONS

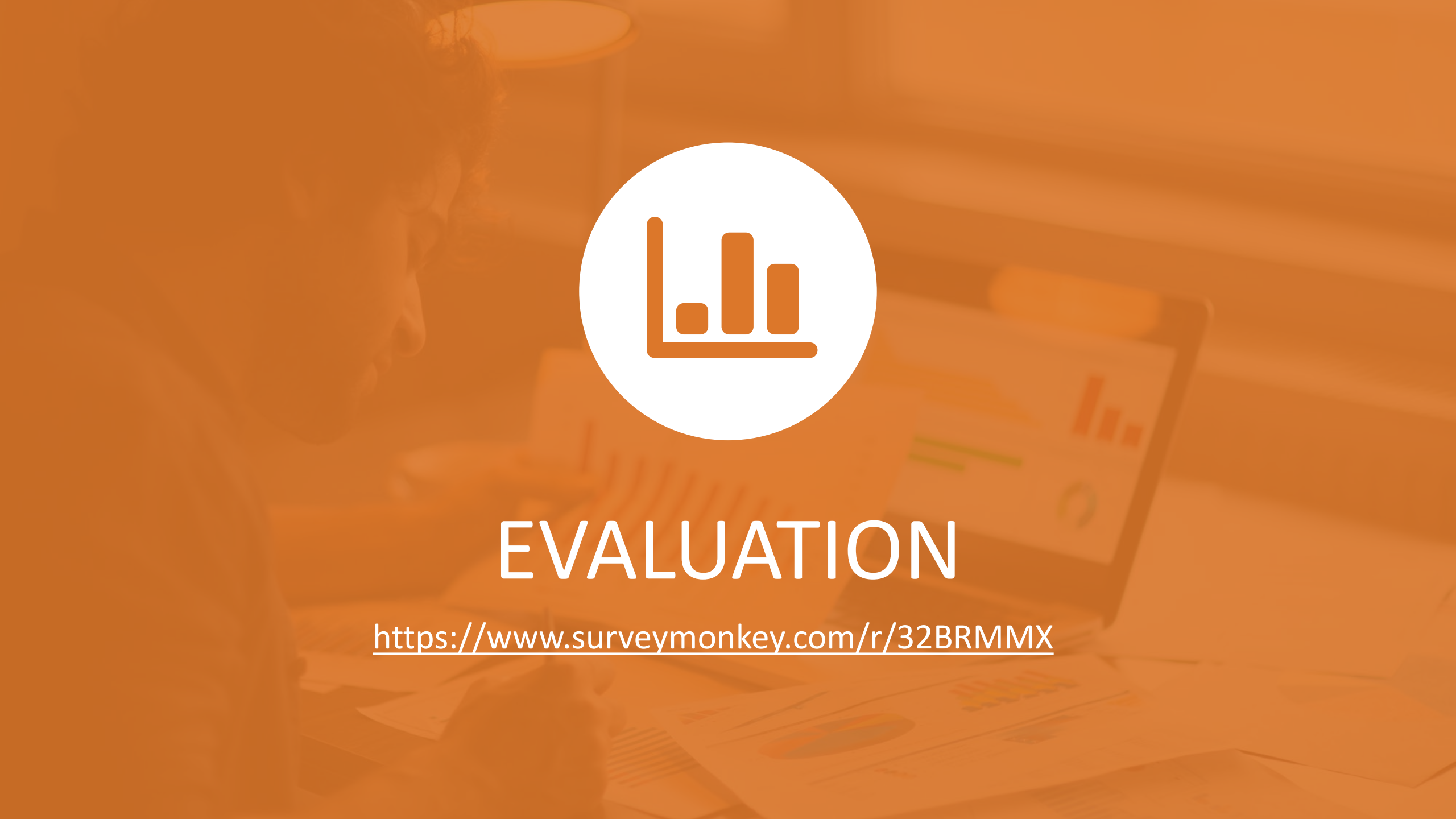
WHAT ADDITIONAL INFORMATION WOULD BE HELPFUL?

USE THE QUESTION AND ANSWER BOX

The box is located at the bottom of the screen

UNANWSERED QUESTIONS

All unanswered questions will be answered and posted on the National Center's website (URL: **www.ncfrp.org**).



EVALUATION

https://www.surveymonkey.com/r/32BRMMX

CONTACT INFORMATION

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THANK YOU FOR YOUR TIME!
www.ncfrp.com