



# More First Birthdays

A Report on the Status of Fetal & Infant Mortality Review in the United States, 2020  
*October 2021*

Grateful acknowledgement and thank you to the many local FIMR programs and state FIMR coordinators who contributed this information. Special gratitude is extended to the parents and families who have shared their stories and experiences with loss to prevent future fetal and infant deaths for other families. Their dedication and commitment to their communities improves the health of families.

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***The National Center for Fatality Review and Prevention State Profile Database:***  
Reports from Fetal and Infant Mortality Review programs

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Michigan Public Health Institute, October 2021

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### Introduction

In the United States, every year, about 23,000 liveborn babies do not survive until their first birthday. An almost equal number of babies are stillborn, without signs of life at delivery. While fetal and infant mortality in the United States has improved in recent years, disparities persist between whites and persons of color, especially African Americans, Latinos and Native Americans.

**Fetal and Infant Mortality Review (FIMR) is a community-based, action-oriented process to review fetal and infant deaths and make recommendations that spark systems-level changes and prevent future deaths.** The National Center for Fatality Review and Prevention (National Center) is funded by the Maternal Child Health Bureau (MCHB) within the Health Resources and Services Administrations (HRSA) of the United States Department of Health and Human Services to provide technical assistance, training, and data support to FIMR programs across the country.

FIMR programs differ in their scope and composition of state and local teams, level of state support, administrative leadership, supporting legislation, case selection methods, and reporting systems used. To better understand these similar but diverse programs, the National Center conducts a bi-annual survey of FIMR program leaders to collect additional team-specific profile data to assess the status of programs. **The following report summarizes 160 FIMR programs that were actively reviewing cases in 2020. Of these, 136 local and 14 state and territorial coordinator responses from 26 states, the District of Columbia, Puerto Rico, and the Commonwealth of the Northern Mariana Islands responded to the profile survey.** If an active team's response was received in a previous year's survey, but not the survey for activities in 2020, the most recent response is reported.

**The purpose of this report is to provide a summary of the status of FIMR programs across the United States:** how they are situated within states and communities; what agencies participate and fund them; the legal bounds in which they function; how these factors guide case selection within states and local jurisdictions; how data are collected and used; and how these teams work to decrease fetal and infant fatalities. The National Center provides this report with the hope that it informs review teams, their partners, their local, state, and federal governments, and other concerned parties about the breadth, diversity, and impact of the FIMR process. Policymakers can use this report to develop policy agendas and help shape the debate around eliminating the disparities in maternal and infant mortality.

The information in the following report is not static, as sites often make changes to their programs, adopt new legislation to support FIMR, or build new and expand existing teams. The following information provides a comprehensive snapshot of the status of FIMR in the United States. More complete information and links to individual programs can be found on the National Center website (URL: [www.ncfrp.org](http://www.ncfrp.org)).

# FIMR in 2020: Effects of COVID-19

Health departments lead the majority of FIMR programs, and all of them rely on multidisciplinary teams meeting together to review cases. Prior to the pandemic, many teams were prohibited from meeting virtually due to confidentiality concerns and requirements. It was very rare for a team to do anything other than meet as a group in person. During the pandemic, states and local agencies were impacted in different ways, and FIMR programs responded differently.

**While in-person review meetings continued in some jurisdictions, most teams responded by *meeting remotely or temporarily halting reviews*.**

In addition to stay-home orders and new remote work requirements, some state and local teams faced reassignment of key staff in support of the COVID-19 response to activities such as surveillance, contact tracing, or COVID testing. Even after the worst of the pandemic had passed, some staff continued to be reassigned to supporting mass vaccination efforts. In many jurisdictions, teams' ability to conduct reviews was a moving target throughout the year. Some were early adopters of virtual platforms; COVID-19 did not impact each jurisdiction the same way, and state policies related to COVID-19 varied.

*State and local programs displayed creativity and resilience in the face of the challenges of 2020. They shared effective strategies in regional networking opportunities and through the National Center's listserv.*

Despite ongoing data entry, there were fewer cases entered into the National Fatality Review-Case Reporting System in 2020 compared to the previous year. **In 2019, FIMR programs entered 147 cases per month on average; in 2020, they entered 140 cases per month on average. This 5% decrease in entered cases occurred despite new teams participating in the NFR-CRS in 2020.**

Even when FIMR teams continued to review cases or resumed reviews, the pandemic presented challenges to completing case reviews, including:

- *Team member/staff deployments*
- *Lag in access to death certificates*
- *Delay in receiving records from other agencies*
- *Building capacity for remote meetings*
- *Challenges with case identification*
- *Records had less information than usual*

# Report Highlight Summary, 2020

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Fetal and Infant Mortality Review (FIMR) is a multidisciplinary, community-based, action-oriented process where teams meet to discuss case information to better understand fetal and infant deaths.

There were 162 active FIMR teams in 27 states, Washington, D.C., Puerto Rico, and the Commonwealth of the Mariana Islands.



**80%**

of these teams are coordinated by state or local health departments. Others are led by hospitals, Federally Qualified Health Centers (FQHCs), and Healthy Start programs.

**58%** of FIMRs have an active Community Action Team to implement recommendations.

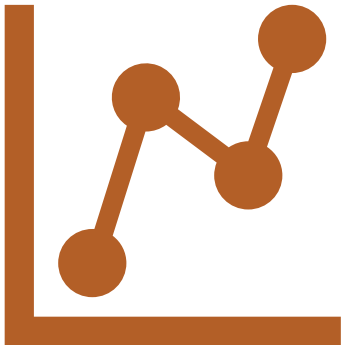
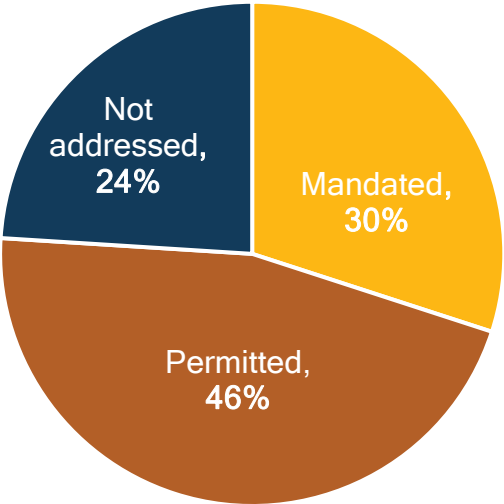
**66%** of FIMRs reviewed cases from within their own county of residence.

**61%** conducted parental interviews.





Most FIMR teams were enabled or mandated by statutes or administrative rules that support records access and case review.



**268** Approved users of the National Fatality Review-Case Reporting System (NFR-CRS) by the end of 2020.

**18** participating states.

Over **6500** FIMR cases in the NFR-CRS.



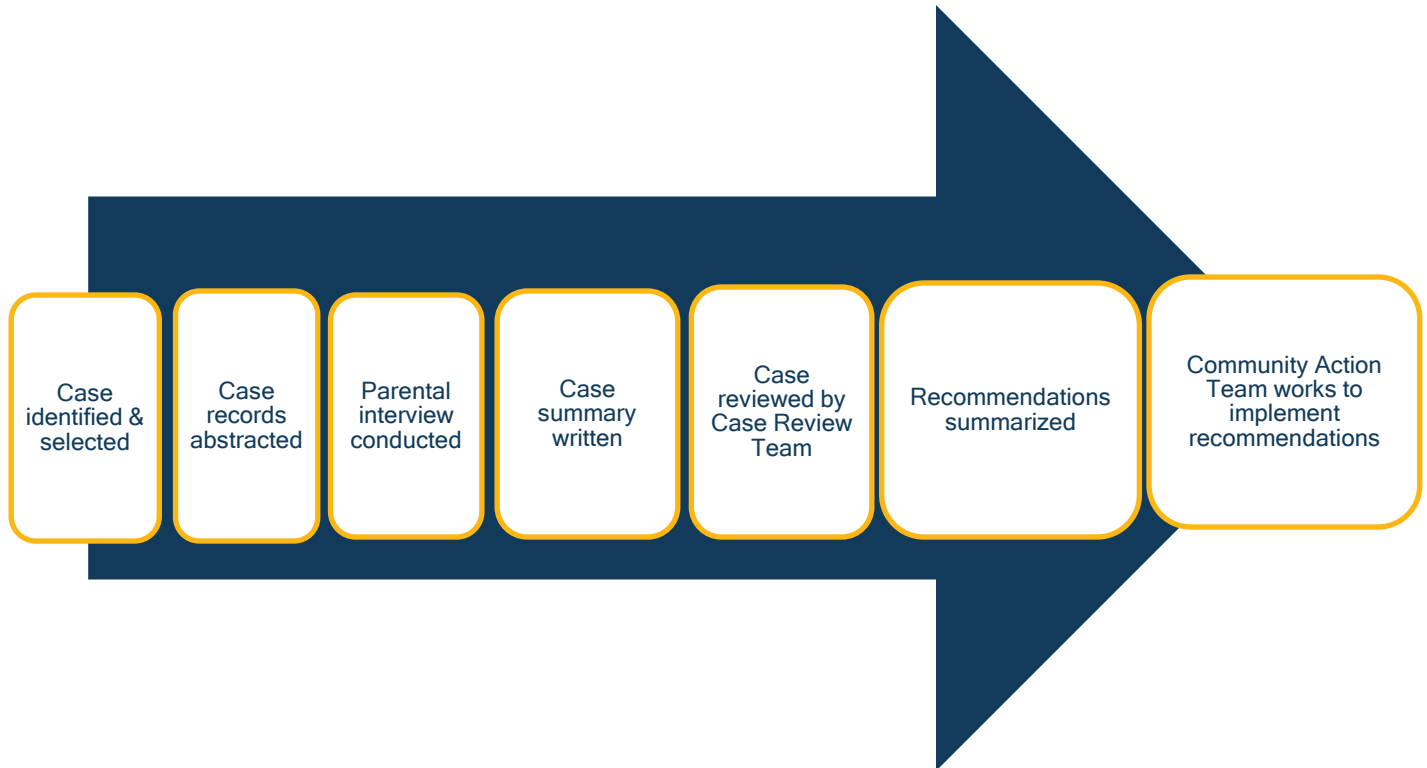
FIMR teams commonly collaborate with other review processes and public health programs, including:

- *Child Death Review*
- *Healthy Start*
- *Maternal Mortality Review*
- *Maternal Child Health programs*

# Review Process



Fetal and infant case reviews have great potential to stimulate and subsequently reflect community improvement. The process itself is considered continuous quality improvement (CQI) for systems that impact maternal and infant populations. To assess the case in the level of detail required to make meaningful case findings and recommendations, a significant amount of work must be done in preparation for the review itself, and special attention given to the de-identified nature of records and of the review.



The FIMR methodology strikes a balance between having a standardized process and enough flexibility to adapt to each local FIMR's regulatory, funding, and public structure. Having guidance and protocols for the fatality review process leads to better data, and more effective prevention and systems-improvement efforts. The number of states with statutes or regulations that cover protocols for FIMR review continues to stay steady, and they determine or require:

- *Confidentiality and de-identification of cases*
- *Access to records*
- *Privacy of review meetings*
- *Protection of reviews from subpoenas/discovery and FOIA*
- *Program reports*
- *Designation of required state and local team members*
- *Required review protocols*

***Each of these provisions is important to the integrity of the FIMR process.***

## Partners



The unique, multidisciplinary nature of fatality review is what makes it most effective. In particular, the impact of teams' prevention work is increased through strategic partnerships with maternal child health programs like home visiting, the federally funded Healthy Start programs, Title V maternal child health programs, and medical care providers.

In 2020, **67% of local teams** reported formal coordination with their Title V Maternal Child Health Services Block Grant Program.

The Title V Maternal and Child Health Services Block Grant of the Social Security Act of 1935, United States Code 701-710, Subchapter V, Chapter 7, Title 42 (Title V), is to create federal/state partnerships that enable each state or jurisdiction to address the health services needs of its mothers, infants, and children, including children and youth with special healthcare needs and their families. Title V is a key source for promoting and improving the health of America's mothers and children.

### Coordination with other programs

#### FIMR commonly coordinates with:

- State Maternal Child Health programs
- Child Death Review
- Healthy Start programs
- Maternal Mortality Review
- Child Protective Services

Fetal and Infant Mortality Review programs effectively coordinate and collaborate with other types of fatality review processes and public health programs. Notably, there is an enhanced alignment with federally funded Healthy Start programs, as both programs receive funding from the Division of Perinatal Services within the MCHB. Twenty-seven local teams indicated that there was a local Healthy Start in their community and that the FIMR was coordinating with it in some way. For example, FIMR findings may spur a community to apply for Healthy Start funding. A Healthy Start Community Action Network may also serve as the

FIMR Community Action Team. FIMR aligns with the four overarching Healthy Start Goals:

- 1. Reduce differences in access to and use of health services**
- 2. Improve the quality of the local health care system**
- 3. Empower women and their families**
- 4. Increase consumer and community participation in health care decisions**

Commonly, a case that falls under the purview of FIMR may also be selected for review in a different fatality review process, such as Child Death Review (CDR). Coordination between FIMR and other fatality reviews is considered a best practice. Examples of different ways that FIMR teams report collaborating with CDR include:

- *Assigning one agency to coordinate/administer CDR and FIMR*
- *Consolidating staff resources*
- *Partnering on grant applications*
- *Coordinating trainings*
- *Establishing a dedicated staff member who participates in both CDR and FIMR*



Of the 14 state or territorial coordinators who responded, ten reported coordinating with their local CDR. In addition to coordination with these programs, many FIMR programs benefit from specialized analyses by epidemiologists who support them in case selection, including the perinatal periods of risk analysis (PPOR).

# Teams

The FIMR process is a two-tiered model. A Case Review Team conducts an analytic function, and a Community Action Team performs an implementation function. While the majority of reviews occur at the local level, some programs are supported by state-level coordination or reviews.

## Structure

### Case Review Teams

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**Case reviews are conducted by a Case Review Team (CRT).** Team participants are often frontline providers, bringing relevant content and procedural expertise to case review meetings, providing institutional and professional context to help create the full picture of how and why a baby died. Teams conduct root cause analyses to identify risk factors, protective factors, and systems gaps. This information is used to create recommendations that are then delivered to a Community Action Team (CAT) whose role is to implement these findings-based recommendations in the community.

**There were 162 active FIMR teams in 27 states the District of Columbia, Puerto Rico, and the Commonwealth of the Northern Mariana Islands (CNMI) in 2020.** Thirteen jurisdictions have a single team; the remaining jurisdictions range from having 2 to 30 teams.

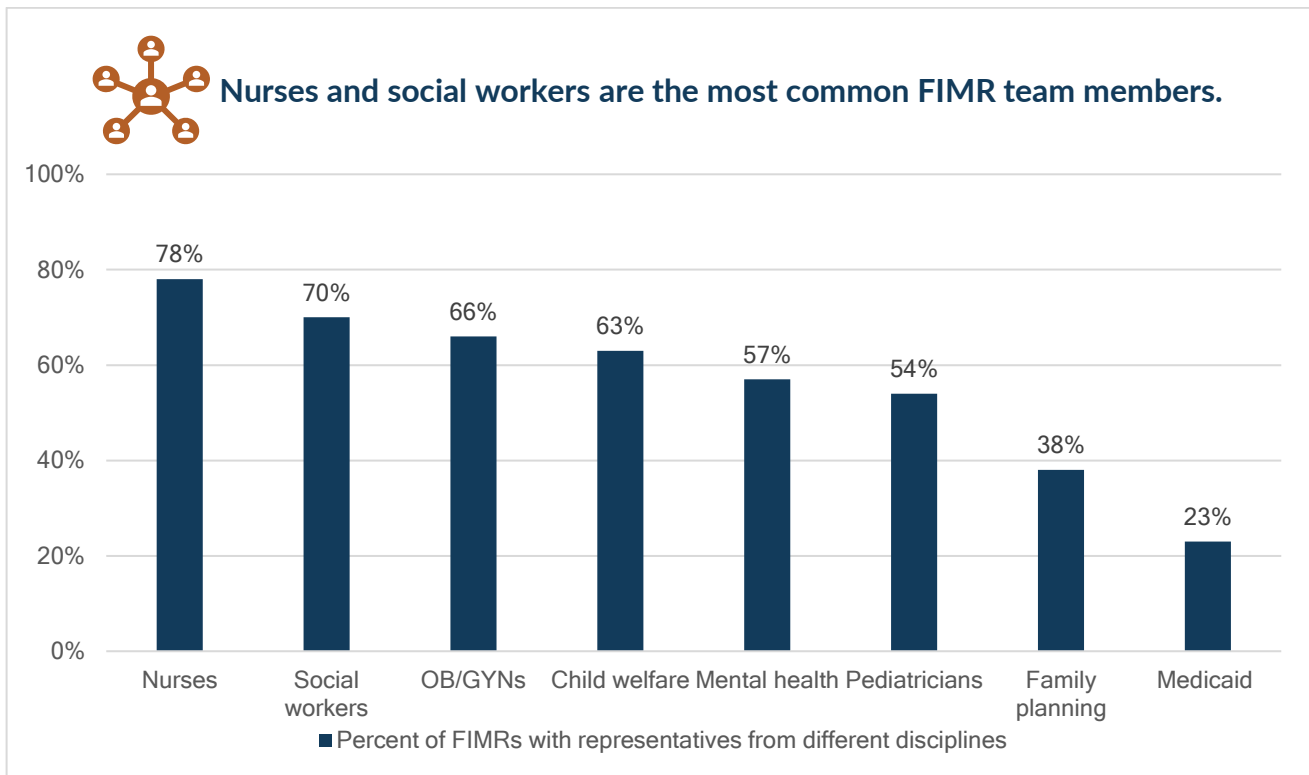
Jurisdiction	Number of teams	Jurisdiction	Number of teams
Alabama	6	Montana	30
California	15	Nebraska	1
Colorado	1	Nevada	1
Commonwealth of the Northern Mariana Islands	1	New Jersey	3
Delaware	2	Ohio	9
Florida	18	Oklahoma	2
Illinois	1	Pennsylvania	1
Indiana	19	Puerto Rico	1
Kansas	3	Tennessee	4
Kentucky	1	Texas	3
Maine	1	Utah	1
Maryland	13	Washington, D.C.	1
Michigan	11	West Virginia	1
Mississippi	2	Wisconsin	7
Missouri	2	Wyoming	1

**Case Review Teams are made up of professionals who commonly deliver services to maternal and infant populations.** They provide their expertise on how systems interact with families, maternal and infant medicine, social service programs, and other important perspectives to help teams get a clear picture of deaths and their contexts. The composition of these teams varies, but standard participating organizations for the case review process include:

- *Obstetrician/Gynecologists*
- *Pediatricians*
- *Maternal/Fetal Medicines*
- *Child Welfare*
- *Family Planning*
- *Women, Infant, & Children (WIC)*
- *Medical Examiners or Coroners*
- *Managed Care Plan Representatives*
- *Law Enforcement*
- *Maternal Child Health Professionals*
- *Mental Health Professionals*
- *Community Advocates*

- 162 active FIMR teams
- 27 states, Washington, DC, Puerto Rico, and CNMI

More than half of FIMR teams included mental health professionals, pediatricians, child welfare representatives, and OB/GYNs. Two-thirds of teams had nurses, and 70% had social workers. Another 38% had representation from family planning programs, and 23% included a Medicaid representative.



## Community Action Teams

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**Community Action Teams (CAT) are most effective when comprised of community decision makers.** This allows them to implement community improvements recommended by CRTs. These teams develop creative solutions to improve services and resources for families and work with the community to implement interventions to improve services and resources. Among responding local programs, 91 (58%) indicated they had a two-tiered system, including a CAT in 2020.

**FIMR teams reported 91 local Community Action Teams.**

Successful CATs include two types of members: those who have the political will and fiscal resources to implement large-scale systems change and those who can best define a community perspective on how to create the desired change in the community. Some FIMR programs have integrated “consumers” into their CAT, individuals who live, work, worship, and play in the FIMR catchment area and use its services and resources. Examples of CAT membership may also include members of the city council, CEOs of local hospitals, the director of the local medical society, those who sit on housing and redevelopment authorities, social services, schools, the CEO of the managed care organization, clergy, local March of Dimes chapter members, and representatives from the Chamber of Commerce.

## State vs. local models

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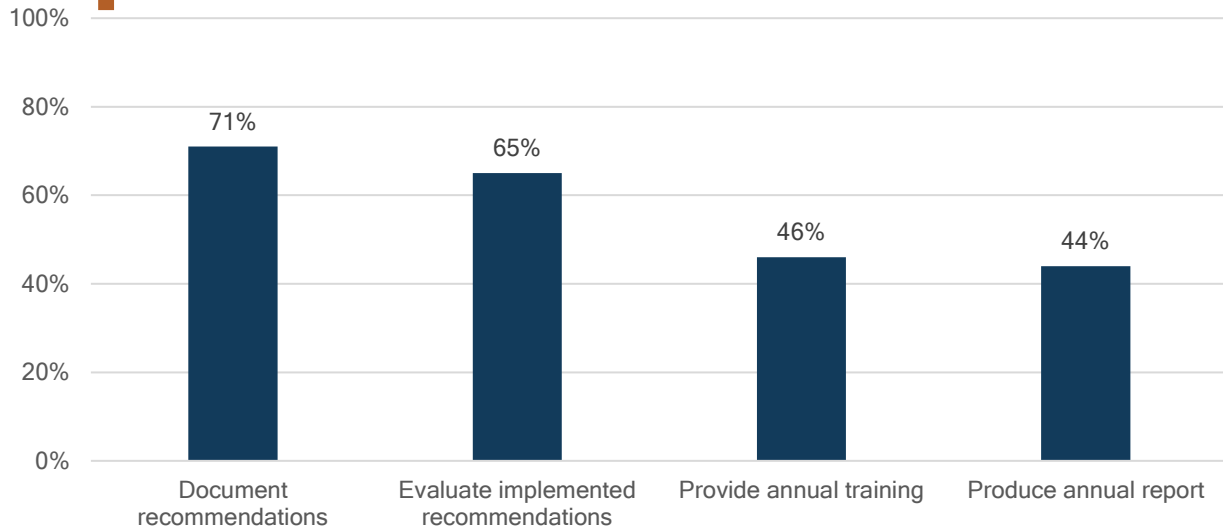
**The majority of FIMR teams review cases in their local communities.** Local teams commonly review deaths from within a specific county; occasionally, they are from a more specific area of the community. Some states with multiple local FIMR teams have a state coordinator; fourteen responded to this survey. In states with several FIMR teams, case review data funnels up to a state program or agency, contributing to a larger, state-level dataset to support broader prevention efforts. Some state programs select certain cases to review for quality assurance or to inform the state team and contextualize the data from local programs. States’ approaches vary based on a number of factors, including infant mortality rates and rates of disparities, state statues, geography, population size and density, funding, and program staffing.

Not surprisingly, percentages of programs conducting training and producing annual reports declined significantly in 2020 compared to the most recent reporting year.

- **46%** of local programs received annual FIMR training in 2020, down from **62%** in 2018.
- **44%** produced annual reports, down from **89%** in 2018.



## Local FIMR programs provided broad programmatic support to team members in 2020.



## Staffing



Programs have diverse levels of funding and staffing to support state FIMR activities. These are significantly impacted by state budgets and competing priorities. At the local level, it is very common for FIMR staff to also hold other roles or responsibilities in their local communities. In addition to having a program or team coordinator, many communities also have a parental interviewer. In some communities, the coordinator serves in both roles. The reported median FTE for local programs was .56 in 2020, up slightly from .5 in 2018. There was, however, skipped by 64% of responding programs in

2020, which may have been influenced by reallocation of FTE due to COVID-19.

The amount of staffing and financial support drives program capacity and, ultimately, success in obtaining parental interviews, caseloads, and case selection criteria. The most common source of funding that states allocate to support FIMR is Title V Block Grants—or Maternal Child Health (MCH) Block Grant funds.

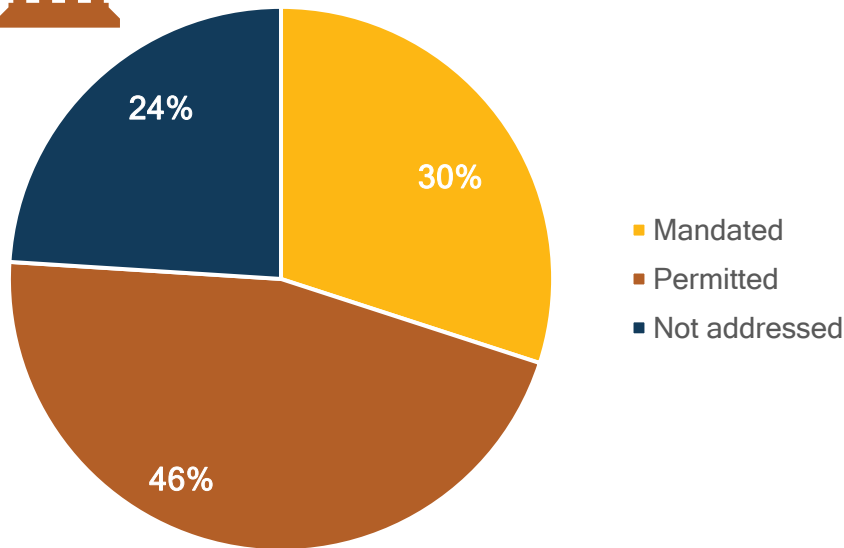


## Statutes and rules that apply to FIMR

Some states have legislation or administrative rules that mandate FIMR. More commonly, FIMR is enabled or permitted by state statute or public health code, code that allows entities to share personal health information for the conduct of “public health surveillance, public health investigations, and public health interventions.”<sup>1</sup> These protections may make it easier for teams to access case records for review, create a reporting mechanism for teams to inform specific agencies, the Governor, or legislature of their findings and recommendations, or require agencies to respond or act on FIMR recommendations. Forty-six percent of FIMRs indicated they had permitting language enabling the process, up from 38% of reporting teams



**In 2020, 76% of reviewing programs had language in statute or public health code that enabled or permitted FIMR, up 68% from 2018.**



in 2018. Teams reporting that enabling language for FIMR is *not addressed* in statute or public health code decreased from 32% to 24% of teams in the same timeframe. In general, whether mandated language or permissive language, a higher level of specificity in legislative language can sometimes limit program flexibility.

## Lead Agency

While local health departments coordinated most FIMR programs in

2020, others were coordinated by Healthy Start programs, other perinatal coalitions, or hospitals.

**81% of state local FIMR teams were coordinated by health departments in 2020.**

## Regions

Fatality review is a unique function within states and communities, and coordinators often do not have local colleagues who can share lessons learned, provide input, or give advice from a place of in-depth programmatic understanding. **The National Center supports five regional collaboratives for local and state FIMR program participation, divided into West, Midwest, Southern, Central, and North Atlantic.** Local and state coordinators and other FIMR personnel

<sup>1</sup> HIPAA Section 164.512(b) Public Health Disclosures





# Case Selection



The selection of cases to bring to case review also varies by program.

***Most communities select cases for review based on risk and/or population factors such as vital statistics data.***

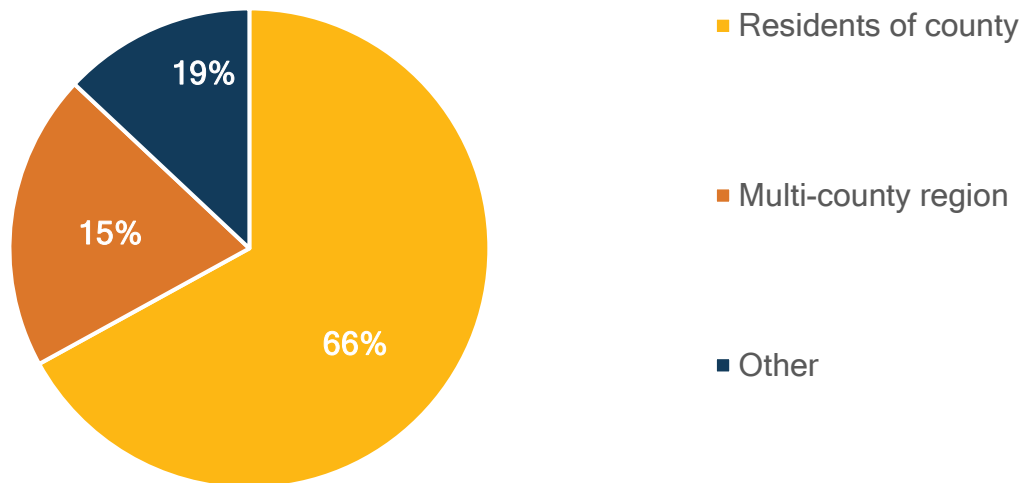
They also consider information about the causes of infant mortality and how these statistics change over time. Many communities attempt to review all cases of fetal and infant death that occur in a calendar year to give them a better picture of the risk and protective factors in the community and its services and resources overall.

***Of the FIMR program respondents, almost two-thirds (66%) report reviewing cases of fetal and infant death of residents from their county.***

Some programs select cases from known high-risk areas such as a city or residents of specific zip codes. Especially in more rural settings, a FIMR program may include multiple counties for case selection and review, creating a regional team. Thirteen percent of teams reported using a regional approach.



**Cachment area for case reviews is most commonly at the county level.**



Case selection criteria are influenced by multiple factors in addition to geographic catchment area, including:

- *Lead agency*
- *Public health priorities*
- *Program capacity*
- *Residency of mother*
- *Cause/manner of death*
- *Observed disparities in outcomes*
- *Fetal/Infant age*

**This diversity of case selection criteria creates important context when examining FIMR data from the state level or aggregated at the national level.** While few communities are able to review 100% of their cases or review a completely representative sample of cases, limiting the use of FIMR data at the population level, the details and qualitative information provided through FIMR reviews give context to and enrich examinations of population-level statistics in fetal and infant death cases.

# Parental Interviews

FIMR aims to identify the gap between institutional-policy intent and actual end-user experience; FIMR parental interviews are vital to fulfilling this aim. With stakeholders from multiple sectors providing case-specific information, FIMR teams are uniquely positioned to see the system at work: how many medical appointments the mother had, how well her baby was growing, whether she enrolled in WIC, if she received safe sleep education, and much more. With the sheer amount of administrative record information assembled in case summaries (medical, mental health, public health, social service records, to name a few), teams can get the sense that they have a complete picture of what happened and why based solely upon these records. However, without a parental interview, the picture is cripplingly incomplete.

**Ninety-seven local teams**

reported conducting  
parental interviews in  
2020.

Of those sharing  
completion rates, teams  
completed interviews in  
**15% of cases on average,**  
down from **28%** in 2018.

*No matter how well documented, case summaries that rely exclusively upon administrative records show only one side of the story.*

*That side is the institutional one: the side with the power and the resources. Without the family side, which is way too often alone and disenfranchised, this picture is incomplete. With an incomplete picture, teams will face significant challenges in identifying true system gaps.*

Parental interviews are essential if teams are to get a complete view of the case. As the people most profoundly impacted by this loss, families not only tell us what happened to them, they tell us what it felt like, what they understood and didn't understand, what made things better, and what made them worse. More importantly, they shed light on the circumstances

behind their choices: why they missed the appointment, why they quit taking the medication, why they fell asleep with the baby on their chest. Such circumstances are often the places where the system has failed, where the gap can be found between well-meaning but ill-informed policies and families' reality.

*The value of parental interviews is well-recognized by FIMR teams, with 6 out of 10 FIMR respondents (61%) reporting they conduct them.*

While not necessarily the primary goal of the interview, participation can help the families themselves in multiple ways: giving them an opportunity to tell their story, the knowledge that they are helping identify system problems that may save other families from such tragedy, facilitating their grief process, and linking them to bereavement or community resources.

Testifying to the challenges inherent in securing these interviews, FIMR respondents who conduct parental interviews report that, on average, just 15% of all possible interviews were conducted in 2020. This decreased significantly from 2018 and may have been influenced by pandemic-related adjustments. Obstacles cited by both FIMR respondents who conduct

parental interviews as well as those who do not highlighted a decrease in the identified barriers respondents were asked to choose from. Their responses are outlined below.

- *41% of local FIMR respondents, down from 50% in 2018 cited obtaining accurate contact information and finding the parent or other family member as a barrier to completing interviews.*
- *13% of local FIMR respondents, down from 18% in 2018 identified a lack of funding for staff to do parental interviews.*
- *6% of local FIMR respondents, down from 11% in 2018 identified discomfort of staff with the interview process itself.*
- *5% of local FIMR respondents, down from 9% in 2018 identified inadequate or absent staff training, and resulting discomfort with their ability to address parental grief.*

Notably, of 52 sites that indicated "other" barriers to conducting interviews, 25 sites specified obstacles directly related to COVID-19.

In attempts to address these challenges, FIMR teams have partnered with evidenced-based home visitation programs for developing the interview process as well as conducting the interviews themselves. This can counter limitations in funding and staff capacity. Other teams have extended their abstractions to include contact data so that they have the most updated and comprehensive contact information possible. Trainings, materials, and technical assistance at the state and national level have proven invaluable for increasing FIMR staff skill sets and comfort levels. Clearly, more is needed, however, to raise interview numbers and to empower FIMR staff so they have the time, the skill, and the knowledge to reach parents and families.

***In sum, parental interviews are essential for effectively identifying gaps and informing potential solutions, the very essence of FIMR programming. COVID-19 impacted teams' ability to conduct interviews.***

**The interviews can be a means for helping heal the very families suffering these terrible losses, and they have the potential to lift up the voices of people who have been silenced by racial or social discrimination.<sup>2</sup> They further have the potential to inform FIMR teams about the ways families were impacted by the pandemic. Finally, parental words and shared experiences can reach the heart, mind, and soul of FIMR team members, motivating not just their understanding but also their action.**

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<sup>2</sup> Taylor Jamilya, Novoa Cristina, Hamm Katie, Phadke Shilpa. Eliminating Racial Disparities in Maternal and Infant Mortality. Center for American Progress. May, 2019.

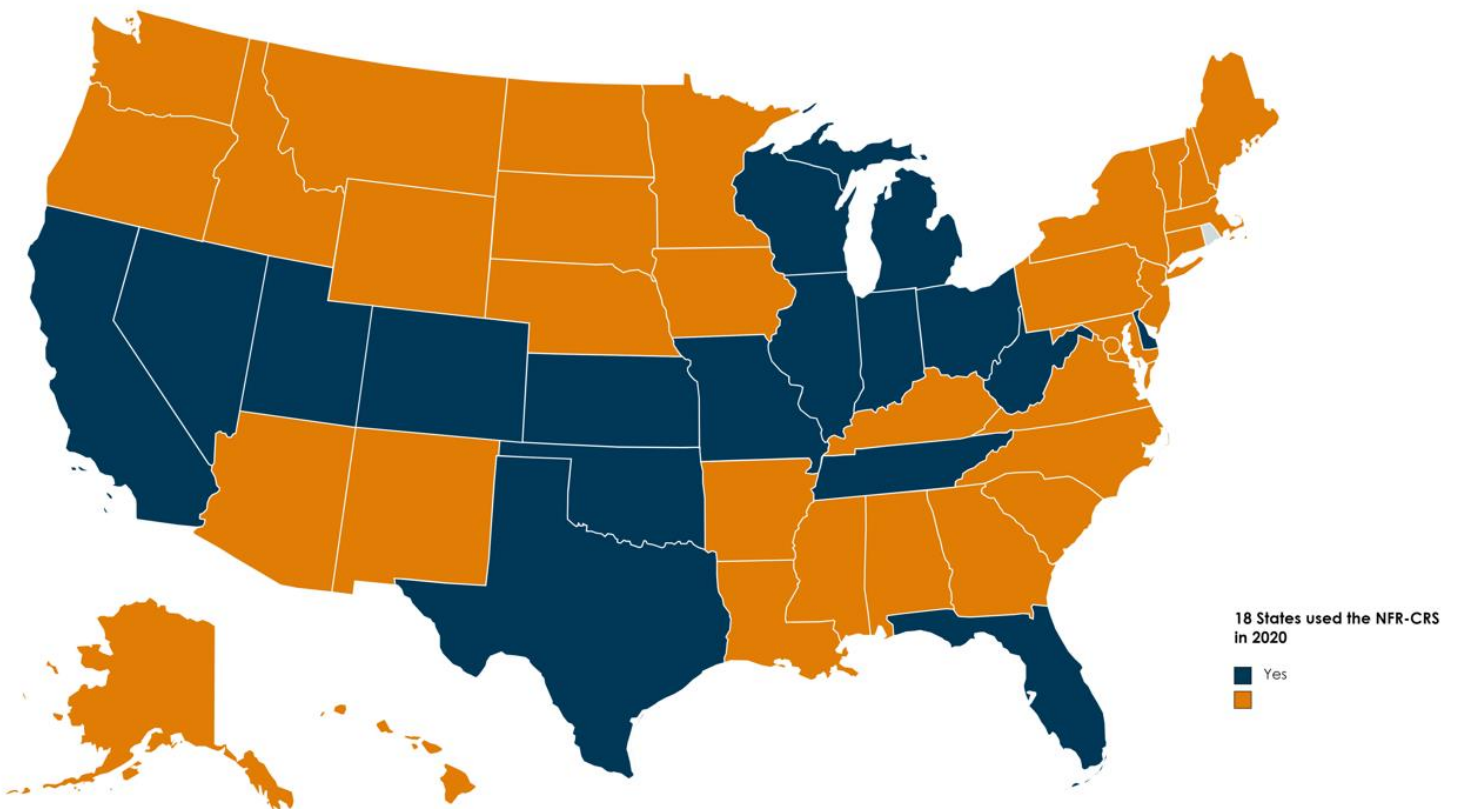


# The National Fatality Review-Case Reporting System



In 2005, the National Center initiated its web-based National Fatality Review Case Reporting System (NFR-CRS) and made it available at no cost to all local and state Child Death Review teams. In April 2018, the system was expanded to include data collected by FIMR teams across the country. Since that time, more and more teams have executed data use agreements with the National Center to join and use the NFR-CRS. By the conclusion of 2020, there were 268 approved FIMR users of the system from 18 states, with over 6500 FIMR cases entered.

*The nature of in-depth multidisciplinary case review through record sharing and deliberation provides more contextual data, family history, data on underlying health disparities, risk and protective factors, and community systems to inform robust policy recommendations, service delivery improvements, and prevention and programmatic planning.*





By the end of 2020, there were **268 local FIMR users** of the NFR-CRS from **18 states**. Together they had entered over **6500 cases** into the system.

The system is designed to systematically collect, analyze, and report comprehensive data on the deaths of each infant and child, including risk factors by cause of death, services needed, provided, or referred, and recommendations for and actions taken to prevent deaths.

*The integration of FIMR into the system was an important step to facilitate standardized data collection and enhanced ability to analyze and use review findings to inform communities and the greater MCH field.*

To make this rich data resource available for further analysis and study by maternal child health researchers, the National Center developed a data dissemination policy and procedures through which researchers can apply to use the data. An external committee of scientists, fatality review coordinators, and federal partners review research applications. In the future, articles by researchers who used data from the NFR-CRS may be a powerful tool to help inform policy and practice, and to understand how and why babies die. Data from FIMR case reviews will be available for research requests in 2022.

# Prevention

A hallmark of FIMR is the way teams and communities use their findings by translating them into meaningful actions. Teams are effective in seeking solutions to prevent the types of deaths they review and have a strong focus on primary and secondary prevention and systems-level improvements. They are encouraged not to focus on individual-level responsibility or blame-finding when reviewing cases but rather to focus on broader issues that communities can improve and that impact the most people.

## Examples

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### St. Joseph County, Indiana



In 2020, Indiana had 19 active FIMR sites, including one in St. Joseph County (South Bend) that had been active since 2015. St. Joseph County collaborates closely with the state-level Title V program. The state of Indiana's FIMR program has provided information and data from FIMR to support improvement of birth outcomes at the policy level.

Informed by these efforts, the Governor set a goal in 2018 of Indiana becoming *Best in the Midwest* for infant mortality by 2024. In 2019, the General Assembly passed legislation to create an OB Navigator program to connect Medicaid-eligible mothers and others who apply to relevant community-based programs. They also passed legislation removing barriers to allow pregnant teens to access prenatal care without parental consent if the parent or guardians are not supportive of the mother receiving care.

In 2020, State Representative Vanessa Summers launched the state Maternal Health Caucus to focus on policies that will help reduce disparities in maternal and infant mortality. Caucus priorities included support for data collection, safety protocols, and cultural competency training for healthcare professionals. The caucus will also focus on eliminating barriers for reimbursement for innovative care services for women in minority communities, including direct reimbursement for doula care. They also intend to develop a statewide plan to expand postpartum Medicaid insurance coverage from 60 days to one year after delivery.<sup>3</sup>

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<sup>3</sup> Summers Launches Maternal Health Caucus." Indiana House Democratic Caucus, <https://indianahousedemocrats.org/news-media/summers-launches-maternal-health-caucus>, accessed 7/15/21

## Baltimore, Maryland

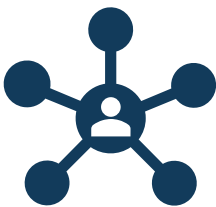


The FIMR team in Baltimore, Maryland, identified that about half of pregnant women with Medicaid coverage who experienced a fetal or infant death did not receive the mandated Maryland Prenatal Risk Assessment (PRA) from their obstetric care provider at the first prenatal care visit, eliminating their opportunity to receive outreach, care coordination, and linkage to supportive community services like home visiting. FIMR reviews revealed that one of the reasons for the low submission rates was the inability for the PRA to be filled out electronically by providers.

The FIMR team made the following recommendation: *Increase submission rates for the Maryland PRA to 100% through outreaching and conducting quality improvement with clinics and obstetric care providers and enabling electronic completion and submission. Make a version of the PRA electronic to increase provider submission.*

Extensive action has been taken based on the recommendation to reach out to obstetric care providers, including email newsletters, development and mailing of a PRA Best Practices Guide, in-person meetings at large clinics, and in-person distribution of materials to all obstetric care clinics in the city. Following the outreach, Baltimore is piloting the completion of the PRA through electronic health records with three prenatal care clinics.

## Kalamazoo, Michigan



Family interviews from the Kalamazoo, Michigan FIMR have consistently revealed a profound disconnect between medical records' documentation of patient education and decision making when compared to the families' reports of their own experiences. Having both providers and home visiting community health workers on the review team has confirmed both realities and the disconnect they represent. This has led to brainstorming solutions and recommendations together. The FIMR team

recommended that efforts be taken to improve provider/patient relationships and communication, including:

- Develop provider skills (relationship building, respect, communication)
- Implement a team approach to care
- Ensure consistency of information (across shifts, multidisciplinary)

Based on this recommendation, the first important step was building awareness in the provider community. The Kalamazoo FIMR team has been disseminating these findings and the FIMR recommendations to provider groups within the local community and healthcare systems. As awareness and understanding have grown, the providers and systems themselves have looked to different models of care to fill these gaps. All four major obstetric clinics have integrated community health workers into their clinical processes, starting at the first prenatal visit. The two largest clinics have adopted *Centering Pregnancy* models, and one has piloted a program integrating doula care on the labor and delivery floor.

Clinical partners are also exploring different ways to share information. One clinic has created a patient binder where they can add printed information and resources at each prenatal visit. Another made patient one-pagers that provide tips on self-care during the postpartum period. Within the community, the care coordination team brings in subject matter experts to educate the perinatal and early childhood home visitors and community health workers on available resources, including housing and prenatal care and services and how to access them.

## *Washoe County, Nevada*



In 2020, the Washoe County FIMR team in Reno, Nevada, 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 included lockdowns, lack of understanding of guidelines or resources, and fear of contracting COVID-19 infection. The Community Action Team recommended increased activities to advocate for pregnant women during the coronavirus pandemic. To do this, they promoted access to information for providers and patients to prevent delays in care or lack of care due to concerns about COVID-19 or misinformation about safety procedures. The Northern Nevada Maternal Child Health Coalition, the acting FIMR CAT, provided two presentations about COVID-19 to maternal child health professionals and community members. The Nevada Division of Health and Human Services Division of Public and Behavioral Health added more easily accessible information to the COVID-19 informational web page. Additionally, provider offices ran public service announcements encouraging women to continue to seek prenatal care during the pandemic.

## Conclusion

The FIMR field was actively engaged in 2020, despite significant challenges related to COVID-19 and the pandemic response at the local level. Despite moving to remote meetings, having FIMR staff detailed to contact tracing or vaccination efforts, or in some cases postponing reviews altogether, teams made actionable recommendations to prevent future fetal and infant deaths and collaborated across programs to achieve this goal. The diversity of various aspects of these programs reflects the diversity among the communities in which they operate. Despite their differences, they faced the shared challenges of 2020 and an ongoing commitment to addressing community-level challenges related to fetal and infant mortality.

The information from the bi-annual state profile surveys provides an opportunity for FIMR programs to learn from the structure, methods, and experiences of other programs to support ongoing efforts to review fetal and infant fatality cases to inform prevention efforts, make communities safer for families, and ultimately save lives.

For more information about FIMR in the United States, please contact the National Center for Fatality Review and Prevention at [info@ncfrp.org](mailto:info@ncfrp.org).