Fetal Infant Mortality Review Implementation in Washoe County

Making an Imprint on Nevada’s Future
National Fetal and Infant Mortality Review (NFIMR)

- NFIMR is a collaborative effort between:
  - American College of Obstetricians and Gynecologists (ACOG)
  - Federal Maternal and Child Health Bureau, Health Resources and Services Administration (MCHB)
Introduction to FIMR and Why it is Needed

The FIMR process
- Cycle of Improvement
- Data Collection
- Home Interview
- Case Review Team (CRT)
- Community Action Team (CAT)

Implementing FIMR (CRT/CAT)

2015 Annual Report

CAT plan
FIMR GOALS

- Understand What Issues Relate to Fetal/Infant Loss
- Utilize Information to Reduce Fetal and Infant Mortality
- Enhance Delivery Systems and Resources
WHY FIMR?

- Fetal mortality is often an overlooked public health problem although nationally nearly as many fetal deaths as infant deaths occur each year.

- “Infant mortality is viewed as a sentinel event that serves as a measure of a community’s general health status as well as its social and economic well-being” (NFIMR, 2008)
Fetal vs Infant death

Case Classification

- Fetal (greater than 20 weeks): 42, 51%
- Neonatal (birth to 28 days): 31, 37%
- Postneonatal (29 days to one year): 8, 10%
- Unknown: 2, 2%
WHY FIMR?

- Washoe County’s Infant Mortality Rate is among the highest in the state (2010-2012)

- National average: 5.1
- Nevada: 5.3
- Clark County: 5.2
- Washoe County: 6.0
FIMR Does Not

- Manage cases
- Review infant abuse and neglect cases
- Review cases in litigation
- Assign blame to providers or institutions
- Attempt to classify death as preventable
- Conduct research on etiology of infant/fetal death
The FIMR Process

Overview of FIMR Process

- Referrals received from hospitals and vital statistics
- Data Abstraction Team reviews all medical records
- Home interviewer contacts parents and conducts maternal interview with family’s consent
- If parents decline the home interview, summaries are still presented to CRT
THE FIMR PROCESS

- De-identified information is entered into FIMR database
- De-identified cases may be reviewed with medical experts
- Cases are summarized and information is presented to Case Review Team (CRT)
- Identified problems and recommendations from CRT are presented to Community Action Team (CAT)
CRT

Case Review Team:

- Meets every month
- Meetings last 2 hours (3-5 cases to review)
- Closed to the public, confidential
- Each member signs confidentiality pledge annually
- De-identified summaries are sent to members 5-7 days prior to the meeting
- Develops recommendations based on cases reviewed with emphasis on information from the home interview
Case Summary

- Maintain confidentiality of our clients and providers
- Observe what information is gleaned from the data and home interview
- Discuss possible concerns and ideas for change that can be generated
Some Guidelines for CRT discussion

- Did the family receive the services or community resources they needed?
- Were the systems & services culturally and linguistically appropriate?
- What gaps in or duplication of services are apparent or suggested?
- What does this case tell us about how families are able to access the existing services and resources?
Community Stakeholders

- Child Death Review Board
- Grief/Bereavement Resources
- Governor Sandoval
- JTNN
- Insurance providers
- Life Change Center
- Local Hospitals

- Local Physicians
- March of Dimes
- NEIS
- PILSOS
- REMSA
- State of Nevada DPBH
- WC Vital Statistics
- WIC
- WC Social Services
Community Action Team:

- FIMR Coordinator gives brief update quarterly based on CRT recommendations
- Members may have political will and fiscal resources to help make changes
- Members have a community perspective on how to best create change
FIMR and CHILD DEATH REVIEW BOARD (CDRB)

**Coordinating Fetal Infant Mortality Review and Child Death Review**

- Identification of deaths
  - Vital Statistics, Hospital, or Health Care Provider Referral

- Cases triaged for review process

**FIMR**
- All fetal 20 weeks+ gestation
- Select neonatal deaths (birth to 28 days)
- Select postneonatal deaths (28 days to 1 year)

- Maternal interview

- Database entry
  - Case preparation

- Case Review Team (CRT)

**CDR**
- Select cases birth to one year
  - all deaths ages 1 to 18 years

- Case Preparation

- Child Death Review (CDR)
  - Optional: FIMR coordinator presents recommendations on shared cases

**CDR Results**

**FIMR Results**

**Community Action Team (CAT)**
- Optional: CDR leader presents actions on shared cases
Where we are now

- CRT has been meeting monthly to review up to 6 cases each time.
- CAT has met quarterly and has presented brief updates at other MCH meetings
- Developed and Implemented REDCap data collection and reports
- Annual Report Completed
Data abstraction on 83 cases in 11 months

20 were non Washoe County residents, but received care there

No clear consistent trends but several issues became apparent:

- Premature births
- Lack of timely prenatal care
- Overweight/obesity
- Questions regarding tobacco, alcohol and substance use
- Incidence of Hispanic deaths
Contributing Factors

Gestation

- < 25 weeks: 43, 52%
- 25-36 weeks: 25, 30%
- > 37 weeks: 10, 12%
- Unknown: 5, 6%
Initial CRT Findings

- Contributing factors to fetal and infant deaths:
  - Lack of on-time prenatal care
  - Substance abuse.
  - Obesity
  - Lack of Education/Understanding
  - Infections
Initial CRT recommendations

- Update a community directory
- Community outreach
- Improve communication between various providers
- Education and treatment centers for substance abuse
CAT Plan

- Public Awareness campaign for early or on-time prenatal care
- CAT members have chosen to move forward with Go Before You Show campaign
- Members are working to get financial commitment and/or resources from organizations.
- Developing timeline and contract with media buyer
Current CAT Plan

- Research information regarding substance use among women in Nevada.
  - CAT members continue to gather more information regarding ways to address this issue in Nevada.
  - Moving towards providing education and increasing awareness among providers and patients.
Unanticipated results:

- As a result of the various FIMR meetings there has been increased conversations between physicians, nurses, Cribs for Kids, REMSA, FQHC’s, state and county public health, and insurance companies.
- “Individually, we are one drop. Together we are an ocean.” -Ryunosuko Satorio
The WC FIMR Team:

- Contact us with questions and/or suggestions

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Questions
Washoe County FIMR

THANK YOU