An Overview of Case Trends and Recommendations for Action identified by the Sedgwick County Fetal Infant Mortality Review Case Review Team (2016)

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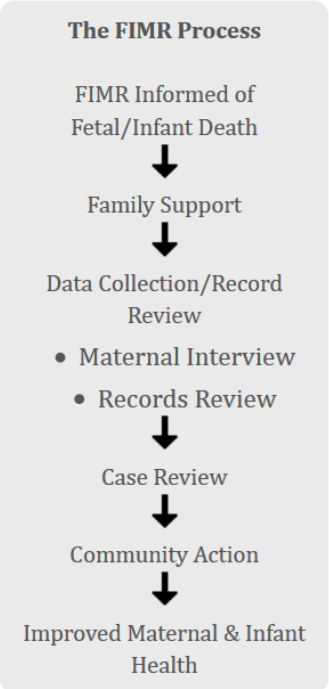
FIMR Overview

Fetal and Infant Mortality Review (FIMR) is an action-oriented community process that continually assesses, monitors and works to improve service systems and community resources for women, infants and families. Prior research demonstrates FIMR is an effective perinatal systems intervention. The national FIMR process consists of five components: grief and bereavement support, maternal interview, records review, case review and community action[1]. This process begins when the FIMR program is notified that a fetal or infant death has occurred. In the first phase[2], FIMR staff provides bereavement support, information and referrals to other services that assist parents and families. Next[3], following the initiation of family support, a maternal interview is conducted, which provides the mother an opportunity to share her experiences before, during and after pregnancy. In the third phase[4], the FIMR program reviews and gathers information from a variety of sources including medical records, birth and certificates, coroner's reports and records from health and social service agencies. Next, a de-identified case summary is prepared using information from the maternal interview and the records review.

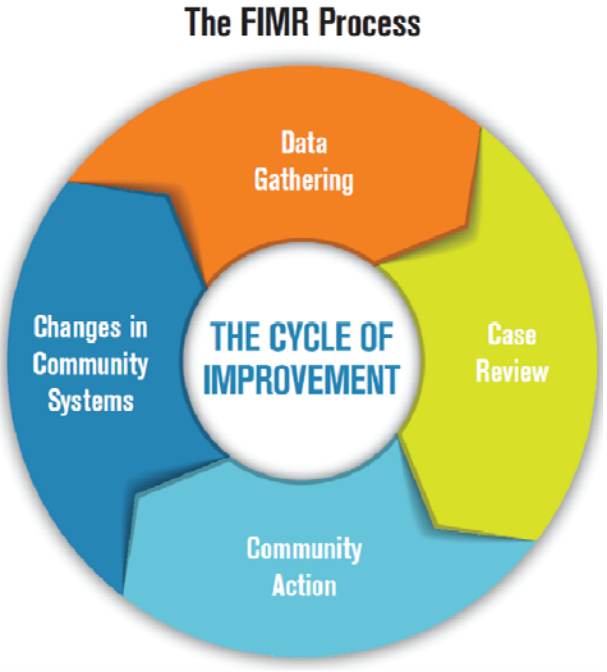
The Case Review Team (CRT), which consists of individuals representing academic and medical institutions, community organizations and public or private agencies that provide services or resources for women, infants and families, reviews the case summaries. Their objective is to (a) identify social, economic, health, educational, environmental and safety factors associated with the deaths and (b) identify problems with the health care that require change and make recommendations for how to improve policies and services that affect families. Finally, the Community Action Team is responsible for turning CRT recommendations into action. Issue-specific task force groups are formed to implement interventions designed to address the problems identified by the CRT. For more information about FIMR visit the national website, http://nfimr.org.



[1] Source:
[2] The KIDS Network, Inc. staff is currently responsible for this phase of the process.
[3] The KIDS Network, Inc. staff is currently responsible for this phase of the process.
[4] The SCHD Chart Abstractor is currently responsible for this phase of the process

Introduction

The purpose of this report is to provide an overview of the FIMR activity in 2016, including the trends in FIMR cases and resulting recommendations identified by the Sedgwick County Case Review Team. This report also highlights recent process improvements intended to enhance the functioning of the Sedgwick County FIMR.



Case Review Activity

In 2016, a total of 24 cases were reviewed and 13 maternal interviews were conducted.

Figure 1. CRT Case Review

2016 CRT	Jan	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec	TOTAL
Attendees	20	NA*	11	14	13	16	NA**	22	17	19	17	21	**148**
Cases Reviewed	NA*	NA*	3	3	3	3	NA**	3	3	3	3	N/A	**24**
Maternal Review	NA*	NA*	1	1	2	2	NA**	2	1	2	2	N/A	**13**

Methods

In 2016 total of 8 CRT Review Charts were abstracted and reviewed for analysis.

Theme Identification

The purpose of the review chart is to help identify factors that may have contributed to the fetal or infant death. The objective of this analysis was to identify appropriate categories that helped to facilitate this process. First, data from the overall findings in the case review charts were extracted and listed in a separate file. The overall findings were then reviewed and then coded to form seven themes. The seven thematic categories that the overall findings were placed into are:

- Hospital Policy-
    - Potential for improvement of discharge checklists, culturally appropriate practices, and post-partum education
- Culturally Appropriate Patient Education-
    - Cases reflected a potential miscommunication or disconnect of best practices regarding infant and child health between mothers and providers
- Community Awareness for Social Determinants of Poor Birth Outcomes-
    - General lack of community awareness of this issue and environmental influences that impact fetal and infant mortality including social determinants of health
- Quality Assurance of Care-
    - Differences or challenges with charting and documentation during reviews; no clear referral practices for high risk patients
- Access to Healthcare-
    - Potential insurance barriers or access to family planning services
- Access to Mental Healthcare-
    - Mental health a factor in several cases including stress management and addiction
- Behavioral Risk Factors-
    - Other contributing factors were likely nutrition, physical activity, substance use, and mothers' weight

Analysis of Content

After all the overall findings were entered, they were coded into what would eventually become the seven thematic categories discussed in the previous section. Some entries were omitted due to vagueness of content.

Resulting Recommendations for CAT

An important component of the FIMR 'Cycle of Improvement' is sharing findings from the case review process to shape policy and system level change that affect the health of mothers and infants. On December 15, 2016, the CRT convened and reviewed the findings highlighted in this report. After review and discussion, the CRT identified recommendations for action which will guide the work of the CAT. The six recommendations were:

1. Establish a process for referrals to those moms who are identified as having increased need.
2. Explore the development of implementation of a central "library" of resources for providers and patients that considers cultural learning to communication.
3. Explore opportunities for cultural learning and communication training for nursing staff.
4. Locate and group social media experts together to inform community.
5. Engage medical students to begin planning/implementing QI practices for care.
6. Educate community regarding birth spacing and benefits of LARC.

Community Action Activity

In 2016 the Project Imprint Community Action Team (CAT) focused their efforts on three of the recommendations passed over from CRT from the 2015 chart reviews. The recommendations were as follows:

- Increase education and improve screening for domestic violence
- Mental health
- Tobacco

Progress on 2016 Recommendations

Domestic Violence and Mental Health- A brief 13 question clinician assessment was developed and disseminated to gain information on what policies and procedures were already in place surrounding domestic violence and mental health for pregnant women. The goal was to have physicians from four selected OB practices complete the survey. Due to inadequate feedback, the CAT has decided to re-distribute the survey in hopes to receive a better response rate. After receiving the completed surveys, we will look at the results to determine whether or not a toolkit or education/training is needed on where and how to direct child bearing women who are facing domestic violence and/or mental health issues.

Tobacco- The strategy for the smoking task force was to provide cessation training for the KU School of Medicine residents, as well as Wesley medical providers. In 2016, two hundred and twenty five healthcare providers attended a tobacco cessation training held by the Maternal Smoking Taskforce. The taskforce will continue providing education and technical assistance to healthcare providers and practices. Additionally, the Maternal Smoking Taskforce will provide

the Kansas Tobacco Quitline with resources for pregnant women, and anyone interested in quitting through community partners, events and media promotion.

Adoption of 2017 Recommendations

The Community Action Team is currently in the process of voting on the recommendations that they will adopt and take action on for 2017. CAT currently operates as a collective group for recommendations, however, this year they will decide whether or not they would like to continue with the current structure, or break off into task forces.

References

1. Kerr DB, Huchins E. Sustaining the FIMR Program: A Toolkit. Washington, DC: National Fetal and Infant Mortality Review Program; 1999.
2. National Fetal and Infant Mortality Review Program. *FIMR Manual: A Guide for Communities (2nd Edition)*. Washington, DC: National Fetal and Infant Mortality Review Program; 2008.