FETAL INFANT MORTALITY REVIEW

March 2024 Quarterly Meeting Summary

What We Do

The Dane County Fetal and Infant Mortality Review (FIMR) aims to prevent pregnancy loss and infant deaths in Dane County.

FIMR is an evidence-based, community level prevention strategy. The purpose of case review is to identify systems-level problems and advocate for solutions.

14	7	4
Cases reviewed by Public Health's Core FIMR Team	Cases reviewed by Pre-FIMR Team	Cases reviewed by FIMR Case Review Team

Stillbirth: 7 Infant: 7

Records & Timeline

General timeliness is crucial to identify and illustrate themes, trends, and factors facing individuals and systems in our community. FIMR case review timeliness varies, and we review cases as timely as records are available. The cases reviewed are not a comprehensive record of **all** deaths that occurred during a specific timeframe. During the March review, all the deaths happened during 2023. This does not necessarily mean the pregnancy and birth were in 2023.

Themes

Themes are factors that influence health outcomes and certain themes were consistent in several cases. The number of cases for each theme is in parentheses.

Maternal health issues including gestational diabetes and hypertension (10)

One or less postpartum appointment (9)

At least one prior loss: miscarriage, stillbirth (7)

Bereavement support limited or declined (7)

Mental health concerns across perinatal course (7)

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Major Case Review Discussion Points

During both Pre-FIMR and Case Review Team meetings, 23 partners participated in comprehensive case review. These points reflect both major discussions and commonalities between cases.

Social determinants of health (SDOH) documentation varied.
SDOH screening evaluates stressors and needs including housing, paying for basic needs, and having enough food. Comparing prenatal records, SDOH screening documentation varied between no information, one general question about basic needs, or up to 12 questions.

Many families only received or were offered grief support during their birth hospitalization. Postpartum bereavement follow-up was uncommon.

- During hospitalization, grief support typically involves a chaplain, social work, local service, and printed information. It is more common for a family to receive grief support postpartum if their infant is in the NICU or they are already connected to support (i.e., doula, mental health).
- A particular area of concern is with twins: The balance between supporting the family with the living twin and grief support for the lost twin needs further discussion.

Documentation of referral completion is limited. It's more common for a birthing person to be told to contact the referral than for the referral source to coordinate or provide a "warm hand off."

- Types of referrals are generally documented. Specific referral sources varied, and further discussion is needed on how resources are framed for pregnant individuals.
- A common unmet need prenatally is dental care, often because the birthing person had to problem solve to access care. In cases with documented substance use, there was inconsistency with timing and frequency of offering substance use services, whether that be at the first prenatal appointment or halfway through pregnancy.

"Nonadherence" to medical recommendations should be redefined, reconsidered, and viewed through cultural context.
Discussion on cases where a birthing person was labeled as "nonadherent" highlighted how not understanding provider instructions can be a barrier to care. Health education and medical information—written using plain language with limited jargon—could be tailored to the mother or birthing person to improve likelihood of understanding and ultimately, adherence.

Common barriers to consistent prenatal and postpartum care included limited transportation, financial, and mental health.

- In certain cases, prenatally this resulted in limited ultrasounds, late or no referrals, and repeated advocacy by the birthing person.
- In majority of cases, the birthing person was responsible for scheduling postpartum. This most often resulted in one or no postpartum appointment.

It is difficult to get a complete picture of someone's full care team and formal supports because documentation of external (non-hospital) care team members varied.

- Discussion highlighted that in order to fully understand wraparound gaps for families, there needs to be consistent documentation of all the services and supports.
- A person may be connected to a doula their entire pregnancy, yet it is only noted during their birth hospitalization. This point ties directly to the FAN topic.

FIMR Action Network Topic

Based on these discussions, this quarter's FIMR Action Network (FAN) will focus on **standardizing documentation of birthing people utilizing doula services.**

Fetal and Infant Mortality Review is an important way to honor families that have experienced fetal and infant death. FIMR is a needed process that works toward preventing tragedies, but we also want to acknowledge the heaviness of this work. We thank every FIMR support and participant for being engaged in this difficult work.