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.

FETAL INFANT MORTALITY REVIEW

June 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	8	5
Cases reviewed by Public Health's Core FIMR Team	Cases reviewed by Pre-FIMR Team	Cases reviewed by FIMR Case Review Team

Stillbirth: 11 Infant: 3

Records & Timeline

General timeliness is crucial to case review 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 June case review, the deaths happened during 2023-2024. This does not necessarily mean the pregnancy and birth occurred in the same year.

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.

One or more maternal health issue (10)

Adverse birth situation: C-section, emergency, D&E (10)

Reproductive choice considerations and factors (8)

First pregnancy (6)

Mental health concerns across perinatal course (6)

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Public Health Madison & Dane County coordinates the Fetal and Infant Mortality Review process for Dane County.

Major Case Review Discussion Points

During both Pre-FIMR and Case Review Team meetings, 28 partners participated in comprehensive case review. These points reflect both major discussions and commonalities between cases.

Insurance type impacted care.
Comparing cases with similar outcomes but different insurance types, people with BadgerCare/Medicaid generally had more emergency visits, limited referral options, inability to seek desired care (i.e., second opinion), delayed mental health connections, and minimally addressed nutrition challenges.

Reproductive choice was an emerging theme that impacted more than half the cases.

- This included prior abortion, variations with between pregnancy (interconception) counseling, postpartum contraception issues, and completion of Wisconsin abortion paperwork in setting of medical emergency.
- In two cases, mothers/birthing people were not able to access their postpartum contraception of choice due to cost and/or postpartum BadgerCare coverage expired by the time they saw their provider.
- Two stillbirth cases had "recommended termination due to medical necessity" and were classified as medical abortion. Historically, similar FIMR cases have not included this classification and instead were documented as "induced".

Five cases involved nutrition challenges, yet only one had a nutrition consult and one had WIC.
Unaddressed nutrition challenges could contribute to inappropriate weight gain or loss, poorly controlled diabetes and other conditions, and food insecurity.

LanguageLine is available 24/7 but is not inclusive of all languages, dialects, nor cultural and religious contexts.

- Certain medical terms do not translate directly to any other language, as they may only exist in English. This highlights how difficult in general it is to understand medical jargon; there is added difficulty when hearing the information through interpretation.
- Discussion centered on the importance of questioning "how much of what is being interpreted is actually understood by the mother/birthing person?"

Anticipatory grief may occur prenatally and is exacerbated postpartum, which highlights the need for wraparound support across the perinatal course.
Three particular areas of concern: 1) When a fetal anomaly is diagnosed early, 2) impact of prior loss or birth trauma on both parents, and 3) need for whole family support.

Mental health concerns continue to be one of the most common themes across FIMR cases.
1 in 5 Black women report postpartum depression compared to less than 1 in 10 mothers/birthing people in Dane County overall (Wisconsin PRAMS, 2017-2021).

Edinburgh Postnatal Depression Scale (EPDS) is used consistently to screen for perinatal depression.

- Two additional assessments are common: Patient Health Questionnaire (PHQ-9) and Generalized Anxiety Disorder Questionnaire (GAD-7).
- Discussion revealed that providers are "stuck" with negligible immediate local mental health services, long waitlists, limited perinatal-specific options, and few BIPOC providers.

FIMR Action Network Topic

Based on these discussions, this quarter's FIMR Action Network (FAN) will focus on **healthcare provider awareness of community-based resources to increase referrals to services outside of clinical care.**

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.

FETAL INFANT MORTALITY REVIEW

September 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.

9	4	4
Cases reviewed by Public Health's Core FIMR Team	Cases reviewed by Pre-FIMR Team	Cases reviewed by FIMR Case Review Team

Stillbirth: 3 Infant: 6

Records & Timeline

General timeliness is crucial for case review 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 September case review cycle, the deaths reviewed happened during 2022-2024.This does not necessarily mean the pregnancy and birth occurred in the same year.

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.

- Limited bereavement support (8)
- One or more maternal health issues (7)
- One or zero postpartum appointments (6)
- Inconsistent or limited prenatal care (5)
- Mental health concerns across perinatal course (5)

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Major Case Review Discussion Points

During both Pre-FIMR and Case Review Team meetings, 28 partners participated in comprehensive case review. These points reflect both major discussions and commonalities between cases.

Person-centered and wraparound care must meet at the intersection of harm reduction and trauma-informed approaches.

- These approaches prioritize respect, compassion, and collaboration to foster support and trust. Discussion emphasized that this multi-faceted, individualized approach is crucial to caring for people and families in complex situations.
- Group consensus about difficulty screening for environmental factors and social determinants of health led to discussion on the importance of building a trusted relationship as the foundation to initiate conversations around challenges. The level of trust may be more realistic for certain types of providers and settings.

Three of the cases involved a caregiver with current or historical substance use.

- Specific considerations: 1) generational or whole-family substance use, 2) perinatal recovery planning, and 3) impact on environment and home dynamics.
- Discussion highlighted the importance of substance use screening during all perinatal periods and the need for whole family resources.

Considerations for birthing people and families with prior pregnancy and infant loss, especially extensive loss histories.

Discussion revealed the potential long-term impact of loss on future pregnancies, relationships, mental health, stress, and behaviors.

Significant and varied impact on children who experience the loss of their infant sibling.

Areas of concern: 1) during death investigations, 2) direct witness of traumatic death, 3) trauma and grief support, and 4) provider education of on age-appropriate responses to trauma.

If the infant death required investigation at multiple levels, this commonly took a year or longer.

- Communication with the family on cause and manner of death were seemingly delayed in the cases, and when they did receive communication, it commonly caused frustration or confusion.
- Communication between investigative systems and families significantly varied.

There are opportunities to talk with families about safe sleep that are realistic and relevant to their lives, but sleep education is stigmatized and commonly punitive.

Discussion highlighted barriers to individualized sleep education using a lens of harm reduction: how to bring in protective factors for sleep, based on a family's situational context, structure, and their environment.

Grouped Case Review

The FIMR model involves grouped review with cases that have similar causes of death, situationally alike, or specific factors. Grouped case review allows for comparison across similar cases to identify commonalities related to upstream themes and areas of intervention.

Dane County FIMR has not facilitated grouped case review in recent years, until this September case review cycle. The theme was infant deaths with Medical Examiner autopsies that had cause and manner of death classifications. Three cases were classified as injury-related and one was classified as Sudden Unexpected Infant Death (SUID).

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.

FETAL INFANT MORTALITY REVIEW

December 2024

Quarterly Meeting Summary

What We Do

The Dane County Fetal and Infant Mortality Review (FIMR) aims to prevent pregnancy loss[1] and infant deaths[2] 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.

9	8	4
Cases reviewed by Public Health's Core FIMR Team	Cases reviewed by Pre-FIMR Team	Cases reviewed by FIMR Case Review Team

Stillbirth: 4 Infant: 5

Records & Timeline

General timeliness is crucial for case review 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 December case review cycle, the deaths reviewed happened during 2022 and 2024. For infant deaths, the pregnancy and/or birth may have occurred in the calendar year prior to the year of death.

Themes

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

Variations in postpartum appointments (8)

One or more maternal health issue (7)

Environment concerns including sleep, housing, stress (7)

Adverse birth situation (5)

Mental health concerns across perinatal course (5)

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Case Review Discussion Points

During both Pre-FIMR and Case Review Team meetings, 32 partners participated in comprehensive case review. These points reflect both major discussions and commonalities between cases.

The current postpartum care model is one contact 1-3 weeks after delivery, followed by an appointment at 6 weeks. The American College of Obstetricians and Gynecologists recommendation is to expand the postpartum appointment timeframe to 12 weeks (ACOG, 2018).

- Postpartum care was not consistent across cases: In four cases, the birthing person had no care after 7 weeks postpartum. In four cases, the birthing person had no care before 6 weeks postpartum.
- Type of insurance (private versus BadgerCare/ Medicaid) impacted longevity of care, number of appointments, and types of appointments.

Several gaps exist in postpartum care, especially for a parent who could benefit from ongoing support beyond the initial six weeks.

- There are extremely limited options for bereavement support that are culturally concordant or congruent and in languages other than English.
- Discussion generated ideas about opportunities for continuity of care: 1) OB support transition to primary care, 2) referral to specialized doula or community health worker, 3) warm hand off between providers, and 4) standard interconception guidance.

Dental needs during pregnancy has been a steady theme across FIMR cases over time.

Five cases this quarter needed dental care during pregnancy. Access to dental care is impacted by limited options for folks with BadgerCare/Medicaid.

Five cases had BadgerCare/Medicaid. Some were uninsured before accessing prenatal care.

- Discussion identified possible barriers: 1) confusion about BadgerCare/Medicaid eligibility, 2) don't know how or when to enroll, and 3) unclear how to access care.
- One potential factor is language access: Are resources on insurance and accessing medical care in Spanish, and are these reaching Spanish-speaking communities?
- One particular area of concern is challenges to insurance enrollment for folks who recently immigrated.

Technical sleep education is 'one size fits all'. Adaptive sleep education uses harm-reduction to facilitate conversations about sleep.

- Three cases involved sleep setting, which highlighted gaps in sleep education for non-birth parent caregivers and how to contextualize caregiver impact on sleep environment.
- Discussion centered on the importance of conversations and public messaging about factors that might impact a baby's sleep, especially during respiratory illness season.

Mental health screening is consistently done, but substance use screening or any documented conversation about it is not.

Specific considerations: 1) periodic and standard substance use screening, 2) screening or asking about mental health and substance use at all postpartum appointments, 3) dual treatment as preventative medicine, and 4) need for dual diagnosis support with any history of substance use in a family.

Year in Review: 2024

Four quarter cycles of FIMR were completed in 2024.

⇒ In total, 46 cases were reviewed → 17 of those were reviewed by the Case Review Team.

⇒ With every case, 38 themes were tracked, in addition to social determinants of health.

⇒ On average, 28 partners participated per quarter.

Fetal and Infant Mortality Review is an important way to honor families who have experienced pregnancy and infant loss. While FIMR is an essential process that works toward preventing tragedies, we also acknowledge how heavy and challenging this work can be.

Thank you to every FIMR support and participant for being engaged in this difficult work.

[1]*Pregnancy loss (fetal death)* is defined as an intrauterine death at least 20 weeks gestation or a delivery weight of at least 350 grams (WI statute).

[2]*Infant death* is defined as a death of a liveborn child before one year of life (CDC).