# FIMR Action Networks:

## Taking Action to Reduce Infant and Fetal Mortality in Dane County

FIMR team: Ali Blackmore, Patricia Frazak, Crystal Gibson, Natalie Girin, Katarina Grande, Hannah Huset, Rachel Kulikoff, Rebecca LeBeau, Merta Maaneb de Macedo, Kimberley Neuschel, Daniel Stattelman-Scanlan, Caroline Weber, Joanne Weber.

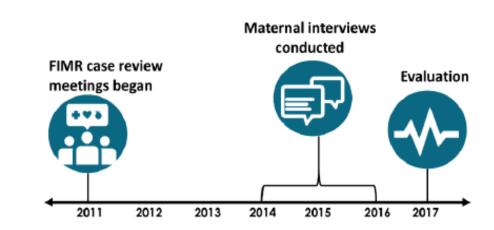


Healthy people. Healthy places.

### Background



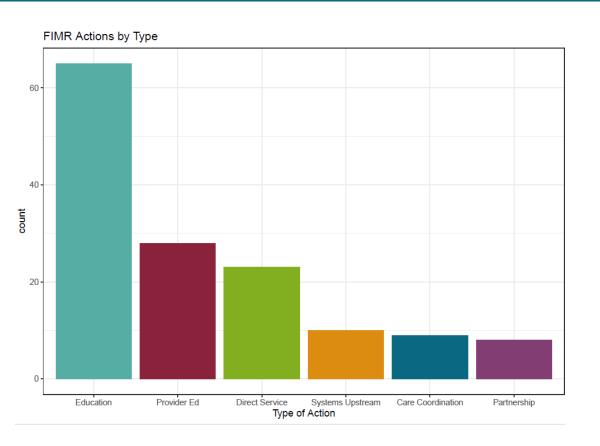
- The Fetal and Infant Mortality Review (**FIMR**) is a national model that examines fetal and infant deaths in order to prevent future loss through taking action to improve services, resources, and systems for women, infants, and families.
- In Dane County, the FIMR Case Review Team (**CRT**) meets quarterly, reviewing 3-5 infant or fetal deaths each quarter. A wide variety of partners attend the meetings, including physicians, midwives, doulas, social workers, home-visitors, Epic representatives, and community members.
- In 2017, FIMR was evaluated using a Ripple Effects Mapping technique. One key finding was the desire for a structured way to continue taking FIMR data to **action**.



• In 2019, we created FIMR Action Networks (FANs) to address this need.

## History & Development

• We reviewed and analyzed reported actions of other FIMR action arms (often called Community Action Teams) around the USA to gain an understanding of what action could look like.



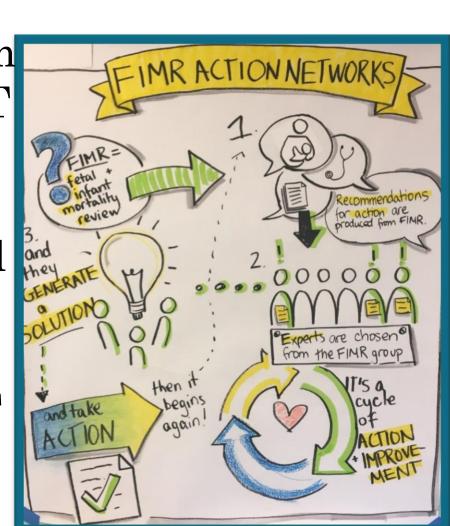


- We conducted key informant interviews with members of our Case Review Team as well as community members involved in preventing fetal and infant mortality. We asked to see how they saw the potential of taking action around FIMR findings and topics of focus for action.
- In a qualitative analysis, we found common themes: a consistent desire for FIMR to take action, the value of FIMR to act as a convener, the importance of improving communication and visibility of issues being worked on, and an eagerness to work on upstream issues.



### FIMR Action Network Structure

- FANs are designed to act as short term "sprints" to be completed between CRT meetings to address a specific issue that comes up in case reviews.
- FANs activate experts on the CRT and in the community interested in that issue to engage in action.
- We report on actions taken to the CRT at the next meeting.



### FIMR Themes for Action

- After each Case Review Team Meeting, we analyze the topics from the discussion of cases.
- We use these themes, as well as any specific recommendations for action, to determine what action to focus on and who we need to invite to the table to pursue that action.

Figure 1

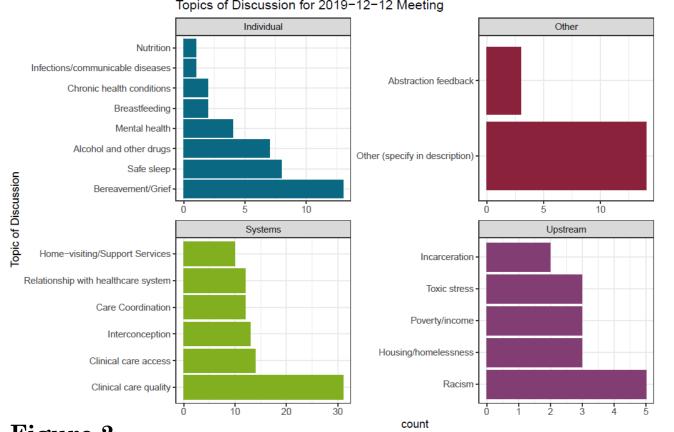
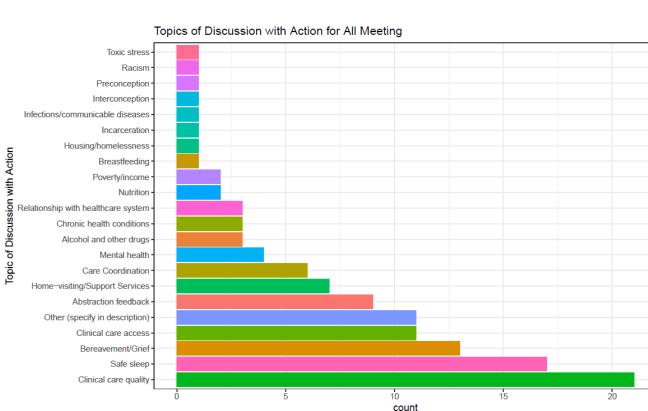


Figure 2



- We quantify what topics come up in each case review (fig.1); we're also interested in the overall picture of discussion since we started the FAN processes (fig.2).
- This allows us to stay accountable to the data and to what CRT members think important.
- Themes that often come up include clinical care access and quality, safe sleep, bereavement, care coordination, and mental health.
- In choosing FAN focus areas, we also consider health equity, feasibility within a three month time frame, and what action other organizations and groups are taking around the topic area.

## FAN Working Groups

### Healthy Women, Healthy Babies Letter of Support

- The Governor proposed a budget that extended Medicaid to one year post partum and provided funding for doulas, things that aligned with the mission of FIMR.
- We convened a FAN to draft a letter in support of the budget from the perspective of FIMR case reviews and sent the letter to all members of the joint finance committee and Dane County legislators.

"This proposal aligns with the efforts of FIMR to decrease infant mortality and eliminate inequities in infant mortality, and provides a platform to amplify our work alongside the collective action of countless community partners urgently working to close the gaps in maternal health and birth outcomes. We urge you to support Governor Evers's Healthy Women, Healthy Babies budget to ensure all families, including communities of color, thrive in Dane County and Wisconsin."

#### Bereavement Systems Mapping

- Many FIMR cases highlighted the lack of bereavement resources for families of color after a pregnancy or infant loss. There were also questions from FIMR members about what resources existed.
- FIMR team members convened a group of hospital and clinic staff to map out the resources available in hospitals. They also connected with local bereavement organizations, including one led by a woman of color.
- The FAN summarized available bereavement resources, made recommendations for improvement, and developed relationships with several local organizations offering support to families.

#### Safe Sleep Dialogues

- From 2007 2011: **31** sleep-related deaths in Dane County.
- Data on self-reported sleep practices vary widely between statewide survey data, health records, and public health client records.



- FIMR team members collaborated with Nurse Family Partnership nurses to facilitate a dialogue about nuaned safe sleep messaging with doctors from Wingra Clinic to generate conversation and break down silos.
- We participated in a role-playing activity to strategize on messaging in common scenarios, such as a parent co-sleeping on a couch because they were told not to co-sleep on a bed.
- After the dialogues, several doctors said that they had never thought about some of scenarios that we presented, and would consider making changes to the way they talk about safe sleep to patients.