

# **Why Fetal and Infant Mortality Review (FIMR)?**

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# Annual Wisconsin Infant and Child Deaths

	n	% of all deaths
All deaths (0<age<18yrs)	748	100
Infant deaths (0≤age<1yrs)	465	62
Child deaths (1≤age<18yrs)	283	38

Based on 5 year average from 2005–2009 WISH data

Estimates are rounded- may not add up 100%

# Annual Wisconsin Infant and Child Injury Deaths

	n	% of all injury deaths
All injury deaths (0<age<18yrs)	203	100
Infant injury deaths (0≤age<1yrs)	41	20
Child injury deaths (1≤age<18yrs)	162	80

Based on 5 year average from 2005–2009 WISH data

Estimates are rounded- may not add up 100%

# Annual Wisconsin Infant and Child Deaths by Type of Injury

	Unintentional n (%)	Suicide n (%)	Homicide n (%)
<b>All (0&lt;age&lt;18yrs)</b>	<b>147 (100)</b>	<b>22 (100)</b>	<b>29 (100)</b>
<b>Infant (0≤age&lt;1yrs)</b>	<b>30 (20)</b>	<b>0 (0)</b>	<b>9 (31)</b>
<b>Child (1≤age&lt;18yrs)</b>	<b>117 (80)</b>	<b>22 (100)</b>	<b>20 (69)</b>

Based on 5 year average from 2005–2009 WISH data

Estimates are rounded- may not add up 100%

# Annual Wisconsin Infant Deaths by Cause

	n (%)
<b>All Causes</b>	<b>465 (100)</b>
<b>“SIDS”</b>	<b>37 (8)</b>
<b>Unintentional injury</b>	<b>30 (6)</b>
<b>Homicide</b>	<b>9 (2)</b>
<b>Disorders related to short gestation and low birthweight, NEC</b>	<b>91 (20)</b>
<b>Congenital malformations/ deformations/ chromosomal abnormalities</b>	<b>96 (21)</b>
<b>Complications of placenta, cord, membranes</b>	<b>18 (4)</b>
<b>Respiratory distress of newborn</b>	<b>15 (3)</b>
<b>Maternal complications of pregnancy</b>	<b>22 (5)</b>
<b>Other</b>	<b>147 (32)</b>

Based on 5 year average from 2005–2009 WISH data  
Estimates are rounded- may not add up 100%

# Proportion of Infants Deaths Among all Child Deaths by County

County of Residence	Percent <1 year	County of Residence	Percent <1yr
ADAMS	54%	DODGE	56%
ASHLAND	44%	DOOR	89%
BARRON	43%	DOUGLAS	68%
BAYFIELD	63%	DUNN	44%
BROWN	62%	EAU CLAIRE	67%
BUFFALO		FLORENCE	
BURNETT		FOND DU LAC	56%
CALUMET	48%	FOREST	42%
CHIPPEWA	54%	GRANT	44%
CLARK	44%	GREEN	57%
COLUMBIA	58%	GREEN LAKE	50%
CRAWFORD		IOWA	82%
DANE	66%	IRON	

Based on 5 year average from 2005–2009 WISH data; Estimates are rounded- may not add up 100%

# Proportion of Infants Deaths Among all Child Deaths by County

County of Residence	Percent <1yr
JACKSON	50%
JEFFERSON	59%
JUNEAU	63%
KENOSHA	50%
KEWAUNEE	50%
LA CROSSE	53%
LAFAYETTE	
LANGLADE	63%
LINCOLN	53%
MANITOWOC	64%
MARATHON	60%
MARINETTE	36%
MARQUETTE	38%

County of Residence	Percent <1yr
MENOMINEE	63%
MILWAUKEE	73%
MONROE	59%
OCONTO	
ONEIDA	45%
OUTAGAMIE	64%
OZAUKEE	51%
PEPIN	
PIERCE	78%
POLK	48%
PORTAGE	46%
PRICE	56%
RACINE	73%

Based on 5 year average from 2005–2009 WISH data; Estimates are rounded- may not add up 100%

# Proportion of Infants Deaths Among all Child Deaths by County

County of Residence	Percent <1yr
<b>RICHLAND</b>	<b>50%</b>
<b>ROCK</b>	<b>61%</b>
<b>RUSK</b>	
<b>ST. CROIX</b>	<b>57%</b>
<b>SAUK</b>	<b>62%</b>
<b>SAWYER</b>	<b>45%</b>
<b>SHAWANO</b>	<b>48%</b>
<b>SHEBOYGAN</b>	<b>50%</b>
<b>TAYLOR</b>	<b>80%</b>
<b>TREMPEALEAU</b>	<b>56%</b>
<b>VERNON</b>	<b>56%</b>
<b>VILAS</b>	<b>42%</b>
<b>WALWORTH</b>	<b>65%</b>

County of Residence	Percent <1yr
<b>WASHBURN</b>	<b>83%</b>
<b>WASHINGTON</b>	<b>52%</b>
<b>WAUKESHA</b>	<b>66%</b>
<b>WAUPACA</b>	<b>48%</b>
<b>WAUSHARA</b>	<b>33%</b>
<b>WINNEBAGO</b>	<b>77%</b>
<b>WOOD</b>	<b>58%</b>

Based on 5 year average from 2005–2009 WISH data; Estimates are rounded- may not add up 100%

# What Is FIMR?

- **Fetal and Infant Mortality Review**
  - Action-oriented community process
  - Assesses, monitors, and works to improve service systems and community resources for women, infants, and families
  - Develop solutions to improve future birth outcomes
  - Fetal or infant death treated as sentinel event and begins the process

# What are the Objectives of FIMR?

- **Examine/identify the health, social, economic, cultural, safety and education systems' factors associated with fetal/infant mortality through review of individual cases**
- **Plan interventions/policies addressing these factors to improve service systems and community resources**
- **Participate in implementation of community-based interventions/policies**
- **Assess the progress of the community-based interventions**

# What Cases are Reviewed by a FIMR Team?

- **Fetal death**
  - Baby who dies before birth, but after at least 20 weeks pregnancy OR weighs at least 350 g
- **Infant Death**
  - Baby born alive but who dies within 1<sup>st</sup> year of life

# Annual Wisconsin Fetal and Infant Deaths

	n (%)
<b>All Infant Deaths</b>	<b>466 (58)</b>
Neonatal (<28 days)	281 (35)
Post-neonatal ( $\geq$ 28 days–1 year)	185 (23)
<b>All Fetal Deaths</b>	<b>340 (42)</b>
<b>Total</b>	<b>806 (100)</b>

# How Does FIMR Work?

- **Fetal/Infant death identified**
- **Data collection**
  - **Maternal interview**
  - **Record review**
    - **Public health data**
    - **Maternal/infant medical records**
    - **Additional health/social services agency records**
- **Case Review**
- **Community Action**

# How Does Data Collection for FIMR Differ From CDR?

## FIMR

- Maternal/infant record abstraction completed prior to case review
- Data de-identified (confidential and anonymous)
- Maternal interview

## CDR

- Each agencies bring individual case records to the case review
- Data not de-identified (confidential but not anonymous)
- No maternal / family interview

# Common FIMR Data Elements

- **Maternal medical care**
  - Prenatal care
  - Labor and delivery
- **Fetal/Infant medical care**
  - NICU
  - Emergency Department
  - Outpatient
  - Pediatric ICU
- **Payment for medical services**
- **Problems with prenatal or pediatric care**
- **Substance abuse**
- **Social support**
- **Home / sleep environment**
- **Poverty**
- **Mental health / stress**
- **Family violence / neglect**
- **Culture**
- **Transportation**
- **Provision / design of services**
- **Environmental / occupational hazards**
- **Family planning**

# Maternal Interview

- **Learn about mother's experiences before and during pregnancy**
- **Learn about events during the infant's life and around the time of death**
- **Identify community assets / deficits affecting mother's life during the pregnancy, birth and death of her infant**
- **Summarize and convey the mother's story of her encounters with local service systems**
- **Assess family's needs and provide culturally appropriate referrals as needed**
- **Facilitate the bereavement process and provide appropriate referrals**

# How do FIMR and CDR Case Review Teams Differ?

## FIMR Case Review Team Members (example)

- Medical examiner / coroner
- Public health
- Pediatrician / family health provider
- Obstetrics / gynecology
- Family planning providers
- Community health educators
- WIC nutrition specialists
- Drug treatment center representatives
- Pastoral counselors
- Minority rights advocates

## CDR Case Review Team Members (example)

- Medical examiner / coroner
- Public health
- Pediatrician / family health provider
- Emergency medical services
- Child care licensing
- School district
- Family court
- Law enforcement
- Child protective services
- Prosecutor / district attorney

# **FIMR Community Action Team**

- **Members with the political will and fiscal resources to create large-scale system change**
- **Members who can define a community perspective on how best to create the desired change in the community.**