FIMR (Fetal Infant Mortality Review) Testimony

Ohio Joint Medicaid Oversight Committee, Ohio General Assembly

July 13, 2023

Chair Holmes, Vice-Chair Romanchuk, Ranking Member Ingram, and members of the Ohio Joint Medicaid Oversight Committee, thank you for the opportunity to provide an overview of the Franklin County Fetal Infant Mortality Review Program. I am Jenessa Teague, the Family Health Administrator at Columbus Public Health where I oversee WIC, Dental and Maternal & Child Health programming. The Fetal Infant Mortality Review Program falls under my purview, and I am pleased to provide you an overview of this valuable program today.

Columbus Public Health houses several reviews, including the Fetal Infant Mortality Review which is an action-oriented quality improvement process that assesses, monitors and works to improve service systems and community resources for women, infants and families. Ohio Revised Code 3701.049 establishes that the Ohio Department of Health Director sets forth the procedure for local creations of the Fetal Infant Mortality Review, as well as the procedures of conducting reviews of fetal or infant deaths. The code also requires the Director to establish specifications of the data and other relevant information that boards must use as defined under ORC 3707.71. The Fetal Infant Mortality Review process is an effective tool to inform public health interventions. In fact, the Fetal Infant Mortality Review Case Review Team reviews a subset of the roughly 280 cases of fetal and infant deaths and shares its findings with the Community Action Team annually for intervention planning and implementation.

The Fetal Infant Mortality Review is different from other reviews in several ways. First, it's the only review which includes fetal losses. Fetal loss, also called pregnancy loss, is defined by the Centers for Disease Control and Prevention as the spontaneous intrauterine death of a fetus at any time during pregnancy. Franklin County has about 130 fetal losses reported each year. These losses, combined with the county's average of 150 infant deaths each year, is equivalent to 14 kindergarten classes of students who don't make it to their first birthday. Ohio also mandates the reporting of all fetal deaths 20 weeks gestation or greater (also called stillbirths or intrauterine fetal demise) so we have good data on these later losses. Losses or miscarriages occurring before 20 weeks are reported voluntarily, so the actual number of fetal losses in Franklin County each year is likely much higher.

The second way the Fetal Infant Mortality Review is different is that it is based on an in-depth review of a subset of all fetal and infant losses. Each community determines which deaths to review based on the needs of that community. The reviewed deaths typically have some common set of characteristics. At Columbus Public Health, we utilize predefined selection criteria to choose cases to review.

And the third difference is that Fetal Infant Mortality Review explicitly seeks to include the voices of families affected by fetal and infant loss in the review process. The voluntary family interview, which is done respectfully by a social worker, provides invaluable information on the family's history and experience of the pregnancy, delivery and loss.

It's important to note that the Fetal Infant Mortality Review focuses on the circumstances affecting the mother and the family before, during, and after the loss. It is NOT focused on the cause of death or determining "preventability."

The Fetal Infant Mortality Review process involves four Parts: Case Identification, a Case Abstraction & Family Interview, the Case Review Team, and the Community Action Team.

First, cases are selected based on a set of pre-determined criteria. All families experiencing a loss receive a condolence card, grief resource guide, and documentation to provide to WIC (if they use this program) and their medical providers. Cases selected for review are contacted for a family interview and referrals are made based on needed resources.

Medical, legal and social service records are then abstracted and de-identified for review by the Case Review Team. Data are combined with information from the family's interview to create a narrative that provides valuable insight into the family's life course milestones and experience with community service systems.

The Case Review Team meets monthly to review the abstracted cases (12 per quarter or 48 per year). Team members are medical doctors, social workers, chaplains, public health professionals, and others who have expertise in bereavement support, child welfare, family violence, father engagement, high-risk pregnancy case management, housing, labor and delivery, maternal mental health, neonatology, nutrition, obstetrics, prenatal home visiting, prenatal care, public health, and refugee health. Their purpose is to identify service system gaps and trends, develop recommendations for system improvements, and report findings to the Community Action Team.

The action-based Community Action Team then prioritizes identified issues, designs and implements interventions, and ultimately guides future Fetal Infant Mortality Review case selection criteria.

Our team consists of 3 FTEs. A Fetal Infant Mortality Review Coordinator is responsible for program oversight and management. The Health Information Technician is responsible for case abstraction by accessing and synthesizing the records. And, a Community Clinical Counselor is a social worker responsible for conducting and abstracting maternal/family interviews.

Our funding comes from the Ohio Equity Institute grant, administered to Columbus Public Health through the Ohio Department of Health, for $36,875, which is <1FTE. The rest of our funding is subsidized from City of Columbus general funds.

All Ohio Equity Institute counties are required to have a Fetal Infant Mortality Review, and there are now 10 counties in Ohio with reviews. Lorain County is the newest. Because Columbus Public Health's Fetal Infant Mortality Review model has been so successful, we were selected to mentor the Lorain County program by the National Center for Fatality Review and Prevention and National Healthy Start.

The *F*IMR Case Review Team Findings for the 2021 Report demonstrated several common themes with recommendations to improve various systems of care. These recommendations include:

- Enrolling more high-risk pregnant people in perinatal home visiting services to help them get and stay involved in their prenatal care, improve compliance with their plans of care, increase awareness about birth spacing, and support them in navigating a complex medical system.
- Adequately assessing patients' non-medical needs like income, employment, insurance, housing, transportation, food, nutrition, and childcare to underscore the fact that pregnancy is not just a medical condition.
- Eliminating barriers to prenatal care, including transportation problems, lack of insurance, difficulty scheduling appointments, and mitigating bias in health care.
- And, addressing patient trauma and mental health before, during and after pregnancy to decrease their lifelong potential for serious health problems and engagement in health-risk behaviors.

When the 2022 Fetal Infant Mortality Review Report is released in the near future, there also will be specific action recommendations geared to Managed Care Organizations such as: developing a guide to help patients navigate their insurance plans or the healthcare system; drafting a sample letter for patients to send to insurance companies for reimbursement/coverage; developing and disseminating information on Medicaid enrollment and reenrollment; providing training for staff on how to help clients navigate Medicaid unwinding and manual renewal requirements; ensuring staff are aware of navigator access resources; developing/obtaining a tool that describes general MCO plan benefits; and, establishing wraparound care experiences for patients, including prenatal, postpartum and primary care with co-located social services for a true one-stop shop to address the social determinants of health.

There are several areas of support that would enable continued success. As I mentioned early, Columbus Public Health currently only receives about $36,000 in funding that supports three FTEs in this work. To best support this work and our community, we are anxious to implement additional elements to our programming, including offering additional outreach and support for families who have experienced loss, proactively providing mental health counseling support for families in our home visiting programs, launching a grief support group for parents who have suffered a fetal or infant loss, and implementing a Franklin County Maternal Mortality Review to help our community understand and mitigate the circumstances leading to the untimely demise of women during and immediately following pregnancy.

We also would like to see a simpler and more accessible process to help families in Ohio sign up for and continue their Medicaid coverage, as well as continued improvement of MCO-supported transportation to ensure that transportation for medical appointments is not a barrier to families. Additionally, we would endorse the support of increased access to mental health services for Medicaid participants and an increased number of Medicaid-eligible mental health providers in Franklin County to ensure the health and well-being of families.

Additionally, we know that implementing a universal screening process for home visiting during prenatal appointments would increase the number of families served and supported by home visitation services, which would help decrease infant mortality. The continuation of financial support and Medicaid reimbursement for home visiting services to expand and be evaluated for efficacy will ensure that Ohio families have access to quality services and support to provide a healthy life for themselves and their families.

And finally, to prevent homelessness during pregnancy and postpartum, we urge funding for affordable family housing and support for housing programs like Healthy Beginnings at Home which are instrumental to the health and well-being of infants, children, pregnant women, and families. We currently work closely with the Healthy Beginnings at Home initiative and a loss of funding leaves a gap in resources for families experiencing homelessness or non-stable housing.

Overall, the Fetal Infant Mortality Review is a critical program that improves service systems and community resources for women, infants and families so they can lead the healthiest lives possible. Columbus Public Health is proud to work with all of our partners on behalf of our community.

Thank you for giving me this opportunity to share more about our Fetal Infant Mortality Review. Our team has joined us here today, and we are happy to answer any questions you may have.