

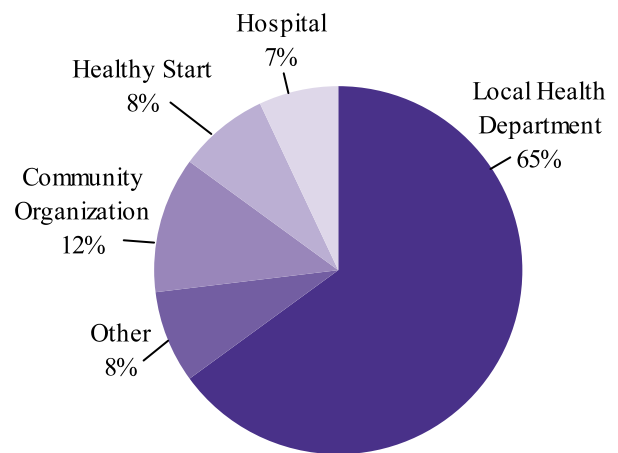
FIMR Program Structure, Organization and Process

As part of the national evaluation of Fetal and Infant Mortality Review (FIMR) programs, in-depth telephone interviews were conducted with 74 FIMR directors across the country. Descriptive information about the structure and operations of the FIMRs was obtained in the interviews and is provided here. A companion document, *The Evaluation of FIMR Programs Nationwide: Early Findings*, presents analytic information, including findings from 193 interviews with local health department officials.

Administrative Homes of FIMR

The most common location for the FIMR was within the local health department, with 65% of all FIMRs located there.

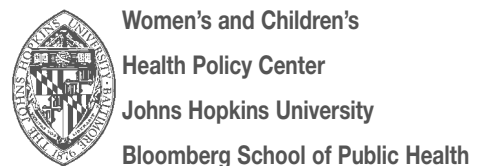
The FIMR programs in the evaluation had been in existence for an average of 6 years, ranging from 1 to 22 years. Over half of FIMRs were begun as a component of another health program (55%). Currently, 61 percent are “stand-alone” initiatives, including some that began as components of other programs. This does not preclude the FIMR program being “located” within an agency such as the local health department.



FIMR Attributes and Roles

In 1997, the National FIMR Program (NFIMR) and a Technical Advisory Group for the evaluation identified a set of “key attributes” to describe FIMR. Attributes reported by at least 80 percent of the FIMR directors in the sample are listed below.

% of FIMRs (n=74)	Attributes of FIMR Programs
91%	Used an anonymous confidential case review format
91%	Engaged in data collection and assessment
88%	Considered social and behavioral aspects of perinatal health
85%	Identified otherwise unrecognized health care gaps
84%	Brought together professionals with different orientations toward perinatal health
82%	Provided a human face to health care system problems
81%	Provided a forum for discussion between clinicians and public health professionals
80%	Investigated perinatal and infant health problems in depth
80%	Served as a base for advocacy



Nearly half of the FIMR programs (45%) also participated in child fatality reviews, 15% participated in maternal mortality reviews, and 30% participated in any combined review. FIMR coordinators were also asked about a number of different roles that FIMR programs play with regard to perinatal health. Over 70% of all FIMR coordinators reported that the FIMR program played the following roles:

% of FIMRs (n=74)	Roles of FIMR Programs
82%	Assessed perinatal health needs or health status
81%	Facilitated communication among providers of perinatal health care
77%	Educated the community about perinatal health
73%	Served as an advocate for mothers and newborns
72%	Identified perinatal data needs

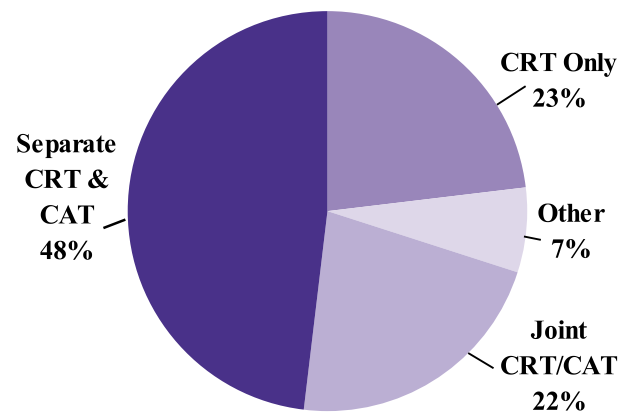
FIMR Team Organization and Participants

Three general team structures were identified among the 74 FIMRs interviewed: Case Review Team (CRT) and Community Action Team (CAT) as separate teams, CRT only, and CRT and CAT combined/joint team. Of the 74 FIMRs, all but two reported the existence of a formal CRT, which may or may not have been combined with a CAT. Approximately half of the FIMRs reported having a separate Case Review Team and Community Action Team.

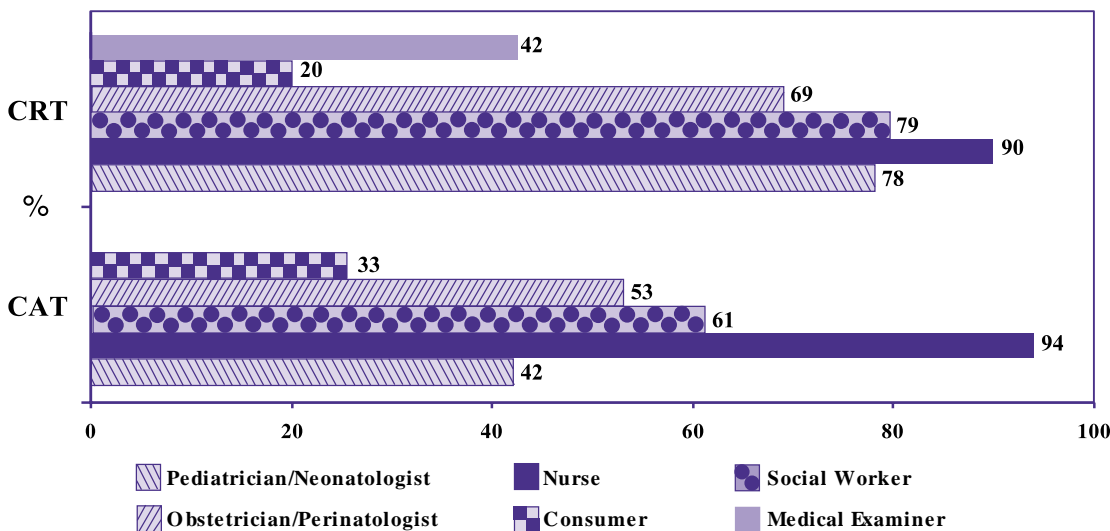
With the exception of the consumers and medical examiners, almost half of the CRTs (47%) and slightly more than one-quarter of the CATs (28%) had at least one member from each of the professional groups listed in the figure below.

Approximately one-third of the CRT's (36%) included at least one representative each from the local health department, local hospital, social welfare services agency, and a community health clinic/practice. Nearly one-half of the CATs (47%) included at least one representative from each of these groups. Managed care organizations were infrequently represented on CRTs (13%) but more often included in CATs (36%). It should be noted, however, that some communities may have only a small proportion of the population served by managed care providers.

FIMR Program Organization



CRT and CAT Professional Composition



About FIMR Case Reviews¹

Nearly all FIMR directors (90%) reported using maternal or parent interviews as part of the case review process. Our telephone survey did not assess the proportion of reviewed cases in which a parental interview could be obtained. However, based on case studies conducted with 10 selected FIMRs, programs may be experiencing some difficulty in obtaining maternal or parental interviews. On average, across the case study sites, 50-60 percent of case reviews included a parental interview. Moreover, difficulty in completing parental interviews was frequently reported by FIMR directors as a barrier to conducting case reviews and developing recommendations. Some case reviews in the 10 sites studied are consequently conducted without the benefit of information from parent interviews.

The majority of CRTs met at least 6 times per year, with half of CRTs meeting at least once per month. The median time between the death of a fetus or infant and the review of the case was 4 months.

A variety of steps were taken to ensure the confidentiality of the case review process such as:

% of FIMRs (n=72)	Steps Taken
81%	Followed NFIMR confidentiality guidelines
79%	Asked CRT members to sign a confidentiality form
56%	Had approval from the local or state health department IRB
38%	Had approval from agency's IRB

Two-thirds (66%) of FIMRs directly offered bereavement services to mothers or parents of infants who had died. Around the same proportion (64%) reported that the agency in which they were located offered these services.

FIMR CRTs reported using several sources of data for the technical case reviews.

% of FIMRs (n=72)	Sources of Data for Technical Case Review
93%	Hospital medical records
93%	Birth or death certificates
90%	Coroner or medical examiner's records or death site reports
89%	Maternal or parent interviews
83%	Health department medical records
79%	Private physician's medical records
69%	Social Service reports
29%	Other (e.g. Healthy Start)

The **four** most frequently reported barriers to the CRT process were:

- 1) Difficulty locating parents/mothers for interviews. (reported by 71% of FIMRs)
- 2) Incomplete information from medical records (69%)
- 3) Limited participation of some agencies or providers on the team (61%)
- 4) Timeliness of obtaining data (49%)

Findings from the case reviews were disseminated to a number of outside groups. Nearly all FIMR programs disseminated findings from case reviews to their local and state health departments. On average, findings were disseminated to 4 different groups. Approximately three-quarters (78%) of the FIMRs reported that the CRT makes recommendations based on the FIMR case review findings.

% of FIMRs (n=72)	Case Review Findings Disseminated to:
94%	Local health department
88%	State health department
69%	Hospitals or hospital associations
67%	CAT or policy team
50%	Perinatal board, committee or task force
36%	Local professional societies

¹ Two of the 74 FIMRs did not report conducting case reviews and therefore 72 was used as the denominator for these responses.

Development and Dissemination of FIMR Recommendations²

Most FIMRs (81%) that developed recommendations used several sources of information, beyond case review findings. The sources used by those FIMRs are listed below.

% of FIMRs (n=58)	Sources Of Information, Beyond Case Review Findings, To Develop Recommendations
95%	Local or state health department policies
95%	Recent vital statistics data
95%	Assessments of community resources
86%	Policies or protocols of local facilities providing perinatal care
83%	Epidemiological research on infant mortality or perinatal health
79%	The preventability of the death

As with findings from the case reviews, nearly all of the FIMRs disseminated recommendations to their local and state health department. There was broader dissemination of the recommendations to other groups as compared with case review findings.

% of FIMRs (n=58)	Recommendations Disseminated To...
98%	Local health department
95%	State health department
80%	Hospitals or hospital associations
68%	Advocacy groups
63%	Consumers
54%	Perinatal board, committee, or task force
45%	Local professional societies
41%	Mayor's or county executive's office
38%	City or county council
23%	Governor's office

The FIMR Evaluation Team wishes to acknowledge the many individuals who were instrumental in the conceptualization of the evaluation design and its implementation. In this regard, we are especially grateful for the efforts of the FIMR Evaluation Technical Advisory Group (TAG). Additionally, we would like to thank the State and local public health officials and FIMR and PI coordinators who participated in the evaluation. Their willingness to share information with us through written, telephone and in-person interviews about the important work they are doing required significant commitment of time, expertise, and effort – we remain in their debt.

The Evaluation of FIMR Programs Nationwide: FIMR Program Structure, Organization and Process

Prepared by the FIMR Evaluation Team: Adam Allston, MSW, MPH, Katherine M. Baldwin, MSW, Holly Grason, MA, Mira Liao, MHS, Karen McDonnell, PhD, Dawn Misra, PhD, Donna Strobino, PhD. July 2001.

Development of this document was supported by a Cooperative Agreement (Grant #U93 MC 00101) from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services.

This document can be viewed on the Women's and Children's Health Policy Center's web site at <<http://www.med.jhu.edu/wchpc>>.

² Fourteen of the 72 FIMRs conducting case reviews did not report using additional information to develop recommendations and were not included in this analysis.