FETAL–INFANT MORTALITY REVIEW IN BALTIMORE CITY

January 2016 | FY 2015 Report

Although infant mortality is decreasing over time, babies in Baltimore City still die at an alarming rate. Baltimore City's Fetal–Infant Mortality Review process helps our community understand why babies are dying and how we can take action. Recommendations for change for policymakers, health care systems and service providers, communities, and families are inside.

B'more for Healthy Babies
Every baby counts on you

Fetal–Infant Mortality Review in Baltimore City

FY 2015 REPORT

WHAT IS FETAL–INFANT MORTALITY REVIEW?

A community's infant mortality rate is considered to be one of the most sensitive signs of the overall health of the community. In Baltimore City, there are typically about 200 total fetal deaths (also referred to as stillbirths) and infant deaths every year. Baltimore's infant mortality rate has traditionally been one of the highest in the country and is a serious public health problem.

Fetal–Infant Mortality Review (FIMR) is a process a community can undertake to better understand why babies in the community die and what steps can be taken to prevent fetal and infant deaths. Through the Baltimore City FIMR process—which enables us to take an in-depth look at the circumstances around a baby's death—we examine the social, economic, health, and health care factors associated with fetal and infant mortality. Then we take action as a community to make education, policy, and systems changes that will improve the health and care of mothers, families, and babies in Baltimore City.

FIMR began in Baltimore City in 1993, just three years after the National FIMR program was established by the American College of Obstetricians and Gynecologists and the U.S. Maternal and Child Health Bureau. Today, there are more than 220 state and local FIMR programs in 40 states.

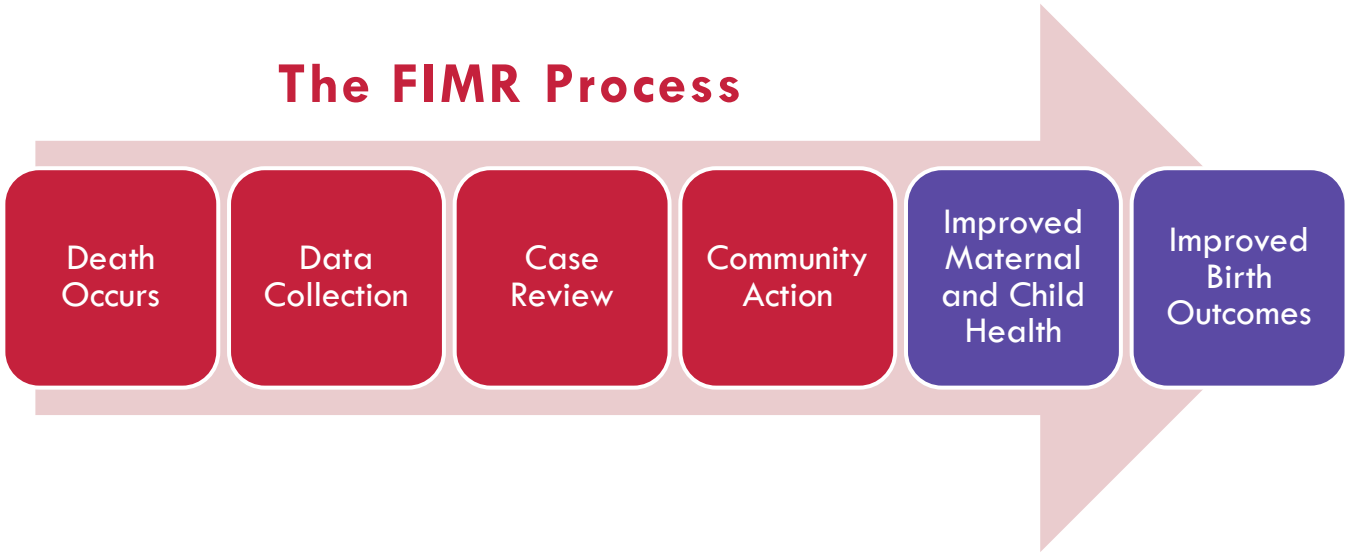
FIMR asks the basic question, "Why did this baby die, and what can we do to prevent it from happening again?"

HOW THE FIMR PROCESS WORKS

The FIMR process begins when a fetal or infant death occurs in Baltimore City. Information is gathered about the death from medical, public health, and social services records. A public health nurse conducts a voluntary interview with the baby's mother to record her experiences with her pregnancy and the health care and support services that were available to her and her family.

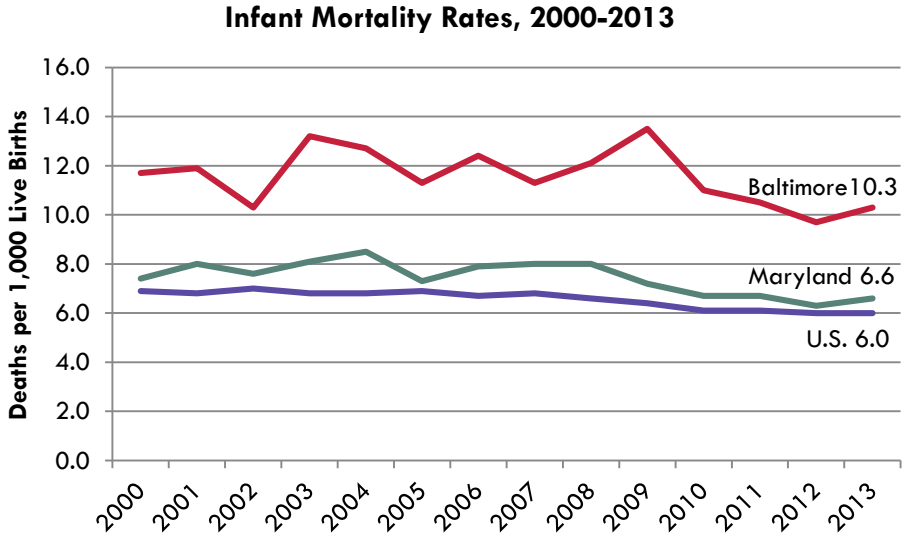
Every month, the FIMR Case Review Team meets to review the information gathered from records and interviews with mothers. The Case Review Team is made up of health care providers and representatives from community agencies who volunteer their time to meet and review the cases. The meetings are confidential, and no identifying information about the mother or her service providers is shared with team members. After reviewing the cases, the team begins to identify health system and community factors that may have contributed to the deaths and make recommendations for change.

Finally, FIMR's Community Action Team, composed of leaders of the city's B'more for Healthy Babies initiative who have the ability to create change in public and community agencies and health care systems, as well as its two Neighborhood Action Teams, translate those recommendations into action. Improved policies, systems, and public education lead to improved maternal health and more babies who make it to their first birthdays.



FETAL AND INFANT MORTALITY IN BALTIMORE CITY

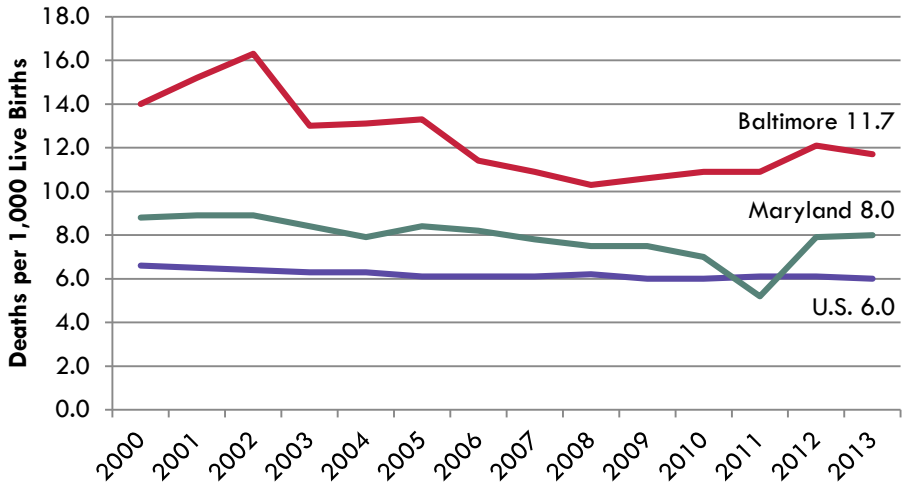
Baltimore babies die at a rate that is among the worst in the nation. In 2009, the year in which the City launched the B'more for Healthy Babies initiative, the City had the fourth highest infant mortality rate (IMR) in the United States. Although the City's IMR has since fallen by 24%—from 13.5 deaths per 1,000 live births in 2009 to 10.4 in 2014[1]—the rates continue to be much higher than the overall rates in Maryland[2] and the United States[3] (shown below through 2013, the latest year for which data is available for the United States).



Infant deaths are those that occur from the baby's first breath to the first birthday. In 2011, the IMR in Baltimore was 1.6 times the IMR in Maryland and 1.7 times IMR in the United States.

Baltimore City also has a very high fetal mortality rate (FMR) at 11.7 per 1,000 live births in 2013,[4] higher than Baltimore's IMR. Although the FMR has dropped over the last decade, this rate too is much higher than those of Maryland[5] and the United States.[6] Although fetal mortality has traditionally been an overlooked public health problem, there is a growing awareness of the impact of stillbirth on families in Baltimore and around the country.

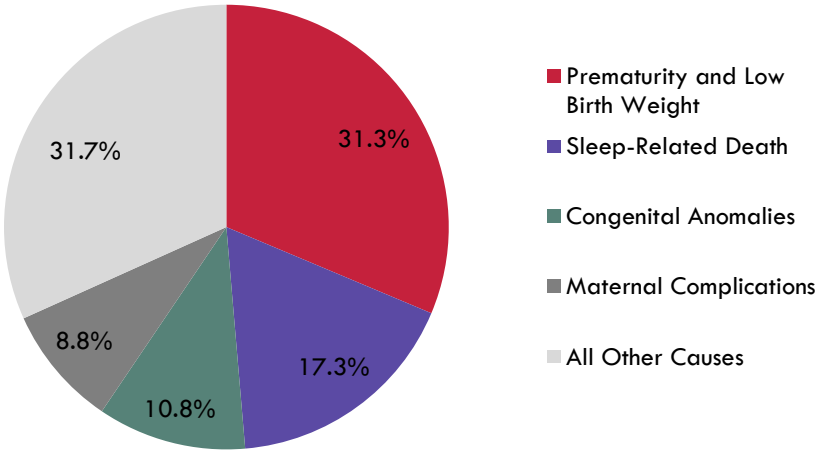
Fetal Mortality Rates, 2000-2013



Fetal deaths are stillbirths that occur after the 20th week of pregnancy. In 2011, the FMR in Baltimore was 1.5 times the FMR in Maryland and nearly 2.0 times the FMR in the United States.

In the United States as a whole, the leading cause of infant mortality is congenital anomalies, also known as birth defects. In Baltimore City, however, the leading cause of infant mortality is babies born too soon and too small: prematurity and low birth weight.[7] Maternal risk factors for prematurity and low birth weight include poor health, smoking and substance use, hypertension, diabetes, under- and overweight, family history, exposure to pollutants, domestic violence, depression, lack of social support, poverty, and high stress levels.[8]

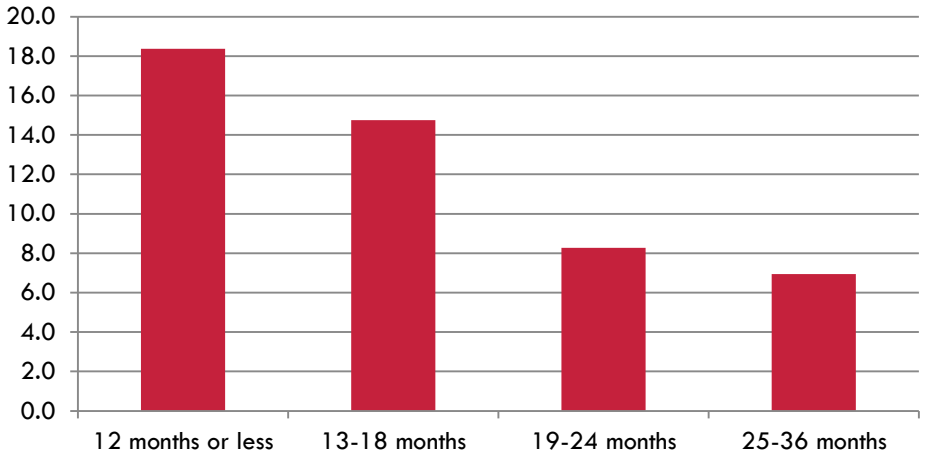
Causes of Infant Death, 2009-2013



Preterm births occur before 37 weeks of pregnancy. Low birth weight babies are those born under 5.5 pounds. In 2013, 12.2% of all babies were born preterm and 11.9% had a low birth weight.

IMR varies widely based on the length of time a woman waits following a previous birth before becoming pregnant again, which is known as birth spacing.[9] Those with short spacing are at greater risk of having preterm and low birth weight babies, placental abruption (the placenta peeling away from the uterus), and placental previa (the placenta covering the cervix).[10] Women with short birth spacing often do not have time to recover from the physical stress of pregnancy, including the depletion of nutrients from their bodies.

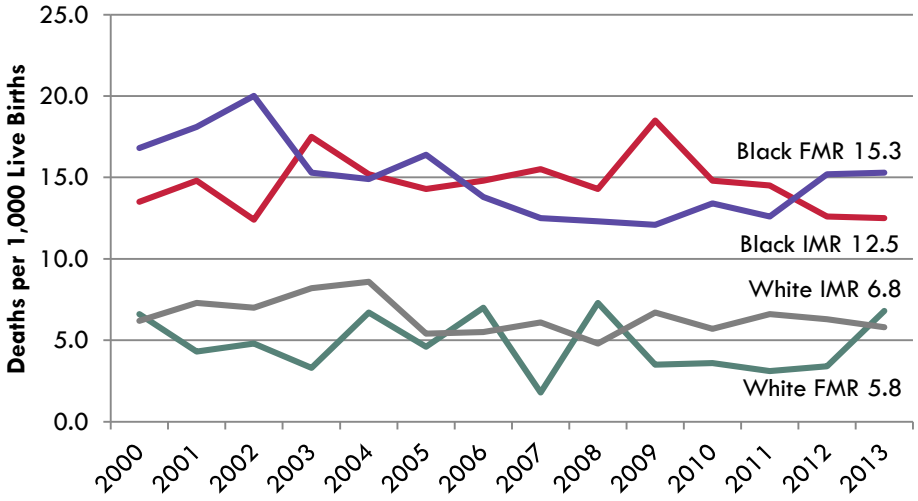
IMR by Birth Spacing Interval (Birth to Birth), 2009–2013



The IMR in Baltimore decreases steadily for babies based on when their last sibling was born. The IMR for babies born 12 months or fewer from their last sibling was 18.4.

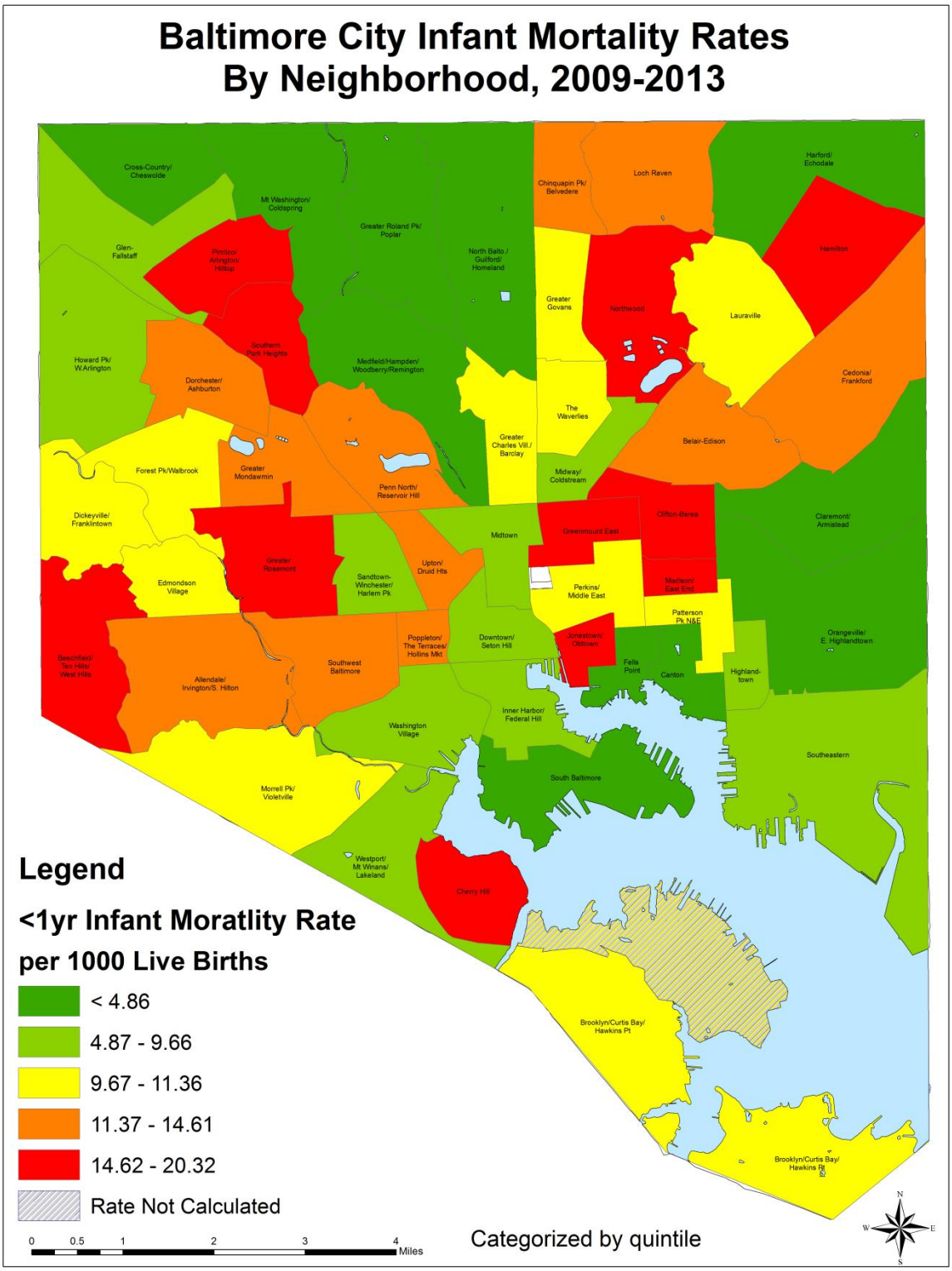
Although Baltimore City's IMR and FMR have decreased over time, there remain alarming racial disparities. In 2013, 91 infants died, and 69 of them were Black; the IMR for White infants was 6.8 and for Black infants was 12.5. That year, 104 fetal deaths occurred, and 86 of those were to Black mothers, with an FMR for White infants of 5.8 and for Black infants of 15.3.[11] If Black mothers in Baltimore City had had the same IMR and FMR as White mothers that same year, 32 infant deaths and 54 fetal deaths, or 86 total deaths, would have been averted. In 2013, 14.6% of Black babies were born preterm, and 14.5% were born with low birth weight, compared with 7.8% of White babies born preterm and 7.2% with low birth weight.[12]

Black–White Disparities in IMR and FMR, 2000–2013



In 2013, Black babies in Baltimore died at a rate more 1.8 times that of White infants, and Black mothers experienced 2.6 times the rate of fetal deaths experienced by White mothers.

Some communities in Baltimore City experience a greater burden of fetal and infant loss than do others. Neighborhoods with high IMRs and FMRs have higher poverty rates and populations of people of color.



Source: DHMH Vital Statistics Records 2009-2013
Prepared by the Baltimore City Health Department
Bureau of Maternal & Child Health

CASES REVIEWED BY BALTIMORE CITY FIMR IN FY 2015

The Baltimore City Case Review Team conducted in-depth reviews of 32 cases of fetal and infant deaths (7 occurring in 2013 and 25 occurring in 2014) from July 2014 through June 2015. Maternal interviews were conducted with eight mothers. These cases were selected because they were all deliveries in which the fetus or infant had a very low birth weight (less than 3.3 pounds). An analysis of Baltimore City's fetal and infant deaths conducted in 2014 showed that the majority of fetal–infant mortality, as well as the greatest racial disparities in fetal–infant mortality, is being driven by very low birth weight deliveries. The team prioritized these cases to better understand the risk factors and circumstances surrounding very low birth weight. The team also prioritized for review cases in which pregnant women were publicly insured through Medical Assistance and had an education of high school diploma/GED or below based on analyses showing higher rates of fetal–infant mortality among these groups.

Because cases were not selected at random, some characteristics described below may be over- or underrepresented when compared with characteristics of all fetal and infant deaths in Baltimore City. The characteristics were documented through review of health and social services records. Because these records may have omitted some data and include data that is self-reported (e.g., smoking during pregnancy), some of the proportions below may differ from the actual.

Maternal Characteristics

Maternal Age

<20	20-24	25-29	30-34	35+
9%	22%	31%	9%	28%

Maternal Race

Black	White	Hispanic
85%	15%	5%

Maternal Education

<Grade 8	Grade 9-12 No Diploma	High School/GED	Some College	Associate's Degree	College Degree	Unknown
0%	22%	50%	16%	0%	6%	6%

Age at First Pregnancy

<20	20-24	25-29	30-34	35+
59%	22%	9%	0%	9%

Number of Prior Pregnancies

None	1-3	4-6	7 or More
25%	38%	28%	9%

History of Previous Preterm Birth Among Women with Prior Pregnancies

Previous Preterm Birth	No Previous Preterm Birth
38%	62%

History of Abortion Among Women with Prior Pregnancies

Previous Abortion	No Previous Abortion
50%	50%

Pre-Pregnancy Body Mass Index (BMI)

Underweight	Normal Weight	Overweight	Obese	Unknown
3%	28%	13%	53%	3%

Chronic Medical Condition Prior to Pregnancy

Diabetes	Hypertension	Other Condition
3%	13%	47%

Mental Health Disorder Prior to Pregnancy

Mental Health Disorder	No Mental Health Disorder
34%	66%

Smoked During Pregnancy

Smoked	Did Not Smoke
31%	69%

History of Illicit Drug Use

History of Drug Use	No History of Drug Use
31%	69%

History of Trauma (e.g., domestic violence, abuse as a child)

History Documented	No History Documented
44%	56%

History of Criminal Charges Prior to Pregnancy

History Documented	No History Documented
31%	69%

Maternal Services and Supports

Health Insurance

Medical Assistance	Private Insurance	Uninsured
84%	6%	9%

Prenatal Care Entry

1st Trimester	2nd Trimester	3rd Trimester	None
50%	34%	6%	9%

Received a Maryland Prenatal Risk Assessment (PRA) by Prenatal Care Provider*

Received	Did Not Receive
50%	50%

*PRAs are required to be completed for pregnant women insured through Medical Assistance on the first prenatal care visit. Women with private insurance or women who did not enter prenatal care would not be expected to receive a PRA. Based on this, pregnant women in 24 of the 32 cases were expected to receive a PRA. The percentages reflect findings for these 24 cases.

Enrolled in Women, Infants & Children (WIC)

Enrolled	Not Enrolled
81%	19%

Enrolled in a Home Visiting Program

Enrolled	Not Enrolled
6%	94%

Baby's Father Involved During Pregnancy/Delivery

Documented Involvement	No Involvement Documented
53%	47%

Postpartum Social Work Consult Offered

Offered	Not Offered
53%	47%

Family Planning Counseling at Postpartum Discharge

Counseling Documented	No Counseling Documented
34%	66%

Postpartum Appointment

Appointment Kept	Appointment Not Kept
56%	44%

Autopsy Conducted

Autopsy Conducted	No Autopsy Conducted
31%	69%

Major Findings of the Case Review Team

- In most cases reviewed, the mother experienced her first pregnancy as a teen. In 19 of 32 cases (59%), the mother had her first pregnancy at 19 years old or younger. Teen childbearing is associated with lower educational attainment and poverty in adulthood, both of which are significant risk factors for poor birth outcomes.[13] Starting early may be physically and emotionally taxing, leading to subsequent pregnancies of higher risk.

- The health of pregnant women before pregnancy is compromised. Higher weight, hypertension, diabetes, and other health conditions raise the risk of very low birth weight and fetal and infant mortality.[14] More than half of women had a chronic medical condition prior to pregnancy, and more than half of women were obese prior to pregnancy. Many women giving birth in Baltimore City, especially those who live in the inner city, do not have access to healthy foods or safe places in which to exercise and experience other challenges managing chronic health conditions.

- Trauma history, mental health conditions, and substance use are prevalent. Nearly half of women had documented exposure to trauma, and a third of women had a diagnosed mental health condition. About a third of women smoked during pregnancy and a third of women had history of illicit drug use. Chronic stress, mental health problems such as depression and anxiety, and substance use during pregnancy, including smoking, contribute to poor preconception health and poor birth outcomes.[15,16,17] There were few documented behavioral health referrals and supports despite evidence of high need.

- Pregnant women often did not receive the required Prenatal Risk Assessment (PRA). At the first prenatal care visit for women with Medical Assistance, the provider is required by law to complete and submit a PRA to HealthCare Access Maryland, which then initiates short-term care coordination services that connect women to needed services including home visiting, safe sleep education, cribs and car seats for those in financial need, mental health care, and substance use disorder treatment. In only 12 of the 24 cases (50%) in which a PRA was mandated did the pregnant women receive a PRA. Numerous pregnant women who qualified for free, evidence-based home visiting services demonstrated to improve birth outcomes missed the opportunity to enroll.

- Family planning services are lacking for women after a fetal or infant death. Family planning counseling, which should be routine following a loss, is infrequently documented in women's medical records. In records in which counseling is documented, women often express desire for a contraceptive method but are not provided with one before they leave the hospital. Without effective contraception or inadequate grief support following a loss, women may become pregnant again quickly. Poor birth spacing puts these women at high risk for another loss.[18]

- Poor patient-provider communication leads to lack of trust. In interviews, mothers reported experiencing insensitivity, as well as poor or inattentive treatment, by their health care providers. In addition, the team discussed that providers may have implicit biases that lead mothers of color and lower socioeconomic status to experience differential treatment. Poor communication has led to significant heartache and distrust, which may impact future care-seeking including attendance at the postpartum appointment, a key opportunity to address health concerns and provide family planning.

- Autopsy results are difficult to obtain. In interviews, mothers reported not understanding why their babies died and not being able to access autopsy results. Records also appear to be difficult for physicians to obtain and were often not available for the FIMR team's review.

FY 2013–2015 FIMR RECOMMENDATIONS

The Baltimore City Case Review Team made more than 125 recommendations to improve systems, services, and family health during FY 2013–2015. This is a condensed list of key recommendations, many of which are in active implementation.	Policymakers	Service Providers	Communities	Families
Preconception and Pregnancy Health				
Provide more opportunities for stress reduction and social support for women before and during pregnancy		■	■	■
Create consistent messaging, screening, and referral procedures for mental health care before and during pregnancy	■	■		
Provide culturally appropriate nutrition education to pregnant women using a harm reduction approach		■	■	■
Educate providers and pregnant women about alternative ways to purchase healthy food		■	■	■
Promote healthy eating and options for using WIC and food stamp benefits at farmer's markets	■	■	■	■
Expand the Shopping Matters program to teach families how to buy healthy food on a budget		■	■	■
Create more opportunities and safe places for physical fitness	■		■	
Educate women and girls about the dangers of smoking	■	■	■	■
Implement evidence-based strategies for smoking cessation		■	■	■
Train service providers and community programs to become MDQuit Fax to Assist providers to increase women's utilization of the Quitline	■	■	■	
Avoid smoking around pregnant women and infants			■	■
Complete a comprehensive substance use assessment when women have a positive toxicology screen during pregnancy		■		
Evaluate pregnant women with previous preterm deliveries for progesterone therapy and ensure that therapy is covered by insurance	■	■		
Prenatal Risk Assessment and Outreach				
Identify and outreach providers who are not completing the PRA	■	■		
Aggressively outreach pregnant women who are unable to be located after a PRA is submitted, enlisting WIC and the Department of Social Services as partners		■	■	
Conduct a needs assessment to better understand the circumstances of women who are unable to be located during prenatal outreach		■		

FY 2013-2015 FIMR Recommendations (continued)	Policymakers	Service Providers	Communities	Families
Prenatal Risk Assessment and Outreach (cont.)				
Work with hospital emergency departments to ensure that women are referred for pregnancy-related services when a pregnancy is detected		■		
Enact universal PRAs for all women regardless of Medicaid status	■			
Implement an electronic version of the PRA	■			
Screen pregnant women for life course risk factors (e.g., childhood abuse and exposure to violence) to identify women with potential high risk	■	■		
Refer all pregnant women to Baby Basics prenatal education programs		■	■	
Home Visiting System				
Educate prenatal care providers and pregnant women on the benefits of home visiting services to increase acceptance of services		■	■	■
Implement a shared referral database among home visiting programs		■		
Standardize outreach procedures and timeframes across all programs		■		
Accommodate the schedules of mother who work during the day through creative scheduling		■		
Enable paraprofessional home visitors to access consulting nurses		■		
Care Coordination and Provision				
Improve coordination between hospital emergency departments and prenatal care clinics to ensure follow up to emergency visits	■	■		
Increase use of underutilized services of managed care organizations for follow up after missed prenatal care and specialist appointments		■		
Increase appropriate Postpartum Maternal and Infant Referrals (PIMRs) by hospitals prior to postpartum discharge		■		
Increase sensitivity of patient-provider communication		■		
Train health care providers on implicit bias and cultural competence	■	■		
Improve care coordination and self-management education for pregnant women with hypertension and diabetes		■		
Improve coordination of care for women experiencing homelessness	■	■	■	

FY 2013-2015 FIMR Recommendations (continued)	Policymakers	Service Providers	Communities	Families
Care Coordination and Provision (cont.)				
Identify and develop resources for women with intellectual disabilities	■	■	■	
Improve coordination of care for youth and young adults in foster care	■	■	■	
Increase prenatal care providers' use of Baby Basics to promote improved communication and care provision		■		
Family Planning				
Counsel women at postpartum discharge on family planning options and document that counseling	■	■		
Lead with the most effective methods instead of the most familiar methods when providing family planning counseling	■	■		
Provide women who desire a contraceptive method with that method prior to postpartum discharge	■	■		
Educate providers on the availability and indications for long-acting reversible contraceptives (e.g., IUDs) to increase their use		■		
Expand access to long-acting reversible contraceptives by increasing capacity of health clinics to administer and get reimbursed for them	■	■		
Provide family planning counseling during treatment of sexually transmitted infections to ensure dual protection	■	■		
Provide regular family planning counseling to women with high risk conditions including hypertension and diabetes		■		
Plan pregnancies to achieve adequate birth spacing and prevent unintended pregnancy			■	■
Teen Pregnancy				
Work with Baltimore City teens to understand the barriers to acknowledging pregnancy and entering prenatal care			■	■
Better promote the services and pregnancy testing options at school-based health centers		■	■	■
Enable schools without health centers to offer pregnancy tests	■	■		
Coordinate teen pregnancy prevention efforts with Baltimore City's Community Resources Schools	■	■		
Strengthen systems for referring teens to prenatal care and social services programs	■	■	■	

FY 2013-2015 FIMR Recommendations (continued)	Policymakers	Service Providers	Communities	Families
Teen Pregnancy (cont.)				
Offer comprehensive reproductive health education in schools	■	■		
Care, Referral, and Outreach Following a Loss				
Refer all women with a loss for HOPE Project interconception care group and home visiting services		■	■	
Offer HOPE Project services in Spanish		■		
Educate providers and women with a loss on the benefits of interconception care to increase acceptance of services		■	■	■
Provide social work consultation and referrals for all women with a loss prior to postpartum discharge		■		
Educate women following a loss about self-care practices and delaying pregnancy until their bodies have had a chance to heal		■	■	■
Help women with a loss to understand why the baby died and explain results of tests using clear, sensitive language		■		
Ensure there is a clear process for families to obtain autopsy results		■		
Train hospital providers and managed care organizations on perinatal bereavement best practices		■		
Schedule postpartum appointments for women who have a loss 2 weeks post-delivery rather than 6-8 weeks post-delivery		■		
Notify managed care organizations of losses so they can provide follow up coordination and ensure the postpartum appointment is kept		■		
Keep postpartum appointments following a loss			■	■
Develop an electronic perinatal bereavement toolkit for hospitals		■		
Data Quality				
Increase the accuracy of birth and death certificates	■	■		
Improve the completeness and accuracy of medical records	■	■		
Improve documentation of counseling and teaching in medical records	■	■		

TAKING COMMUNITY ACTION

In 2009, Baltimore City launched B'more for Healthy Babies (BHB) to ensure that all babies are born full term at a healthy weight and ready to thrive in healthy families.

B'more for Healthy Babies™
Every baby counts on you

A 10-year-plus citywide initiative led by the Baltimore City Health Department's Bureau of Maternal and Child Health and with key implementation partners Family League of Baltimore and HealthCare Access Maryland, BHB is sponsored by the Office of Mayor Stephanie Rawlings-Blake and supported by CareFirst BlueCross Blue Shield and other public and private funds.

Community Action Team

The BHB Steering Committee and Core Implementation Team serve as the Community Action Team for Baltimore City's FIMR process. The trends and recommendations developed by the FIMR Case Review Team go semi-annually to the BHB Core Implementation Team, a group that has met weekly since 2009 to design and implement interventions to improve service systems and resources for mothers, babies, and families in Baltimore City. The BHB Steering Committee, which is anchored in the Mayor's Office and made up of a diverse group of Cabinet members and community leaders, oversees the Core Implementation Team.

Neighborhood Action Teams

In Baltimore City, Neighborhood Actions Teams in two communities—Upton/Druid Heights and Patterson Park North & East—work to implement FIMR recommendations within their communities. They conduct neighborhood outreach and education on safe sleep, secondhand smoke and smoking cessation, family planning, nutrition, exercise, and a host of other important issues. These communities offer Baby Basics Moms Clubs (pictured below), which is a group-based prenatal education program, and serve as sites for the B'more Fit for Healthy Babies program, a weight reduction and fitness program for postpartum mothers.

BHB Working Groups and Campaigns

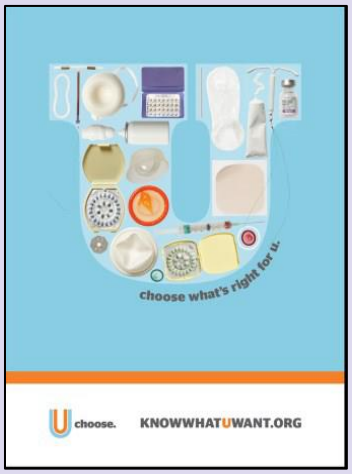
Since 2009, BHB has organized several working groups around key issues in fetal and infant mortality and family health. BHB working groups bring together stakeholders and create action plans at the policy, services, community, and family levels to create change in Baltimore City, using FIMR recommendations to develop strategies for intervention. Working groups include:

- Infant Safe Sleep
- BabyStat Home Visiting Collaborative
- Preventing Substance-Exposed Pregnancies (PSEP) Collaborative
- B'more Fit for Healthy Babies Coalition
- Teen Pregnancy Prevention Initiative (TPPI) Coalition
- Equity in Birth Outcomes Workgroup
- Family Literacy Coalition
- Baby Basics Coalition
- Youth Advisory Council (YAC)

In partnership with the Johns Hopkins University Center for Communications Programs and Mission Media, BHB operates citywide social marketing campaigns on safe infant sleep, reduction of secondhand smoke exposure, and prevention of teen pregnancies. The campaigns utilize video, social media, outdoor media, ads on radio and in public transportation venues, posters, and brochures to create positive change in Baltimore.

SLEEP SAFE

JUST HOLD OFF



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MAJOR SUCCESSES IN FY 2015

Utilizing FIMR findings and recommendations from FY 2013-2015 as well as recommendations gathered from needs assessments and community members, BHB took extensive action to reduce fetal and infant mortality in FY 2015. Highlights include:

- Home visiting. Several of Baltimore City's home visiting programs completed three years of implementation of the evidence-based Nurse–Family Partnership and Healthy Families America models. In collaboration with Baltimore Healthy Start and the Early Head Start program, these home visiting programs in Baltimore provide services to more than 1,800 high-risk mothers and babies each year. Baltimore's centralized intake and triage system for linking women to home visiting was featured as an innovative national model in the Pew Charitable Trusts report, *Bringing Up Baltimore*.

- Prenatal outreach. BHB advocated with the Maryland Department of Health and Mental Hygiene (DHMH) and major health systems to increase prenatal care providers' completion of the PRA, leading to enforcement action from DHMH. Partners on the BabyStat collaborative have aggressively outreached pregnant women, located women who are transient and traditionally difficult to reach, and linked women to services.

- Community outreach. The two lead BHB communities in Upton/Druid Heights and Patterson Park North & East have hosted dozens of community events; outreached families, schools, and businesses with health messages; and provided education at local health fairs. The communities worked with local pastors to engage the faith-based community and held a roundtable on infant mortality.

- Sleep-related infant deaths. In 2014, Baltimore City had the lowest number of sleep-related deaths ever on record (13). BHB expanded its SLEEP SAFE campaign, trained hundreds of providers on safe sleep practices, and released a new phase of the campaign focusing on the importance of smoke-free homes with online and radio ads, outdoor media, posters, rack cards, and more.

- Teen pregnancy prevention. BHB's TPPI Coalition implemented the innovative Know What U Want campaign to prevent unplanned pregnancies, using Facebook and other social media, street blitzes, youth advocate outreach, and posters and cards in clinics through the City. TPPI convened trainings on long-acting reversible contraception for teens and effected policy and systems change to ensure teens have access to the resources they need to prevent pregnancy. TPPI collaborated with Baltimore City Public Schools and other partners to win a 5-year, $9 million grant from the federal Office for Adolescent Health to fund comprehensive health and reproductive health education in all public middle and high schools.

- Smoking and substance use. BHB's PSEP Coalition worked to integrate the Screening, Brief Intervention, Referral, and Treatment (SBIRT) program for women who have or are at risk for substance use disorders into family planning clinics and other organizations across the City and is incorporating family planning services into substance use disorder treatment centers. Through a state Pregnancy and Tobacco Cessation Help (PATCH) grant, PSEP expanded access to the Maryland Quitline for pregnant women and trained partners to refer women to the Quitline. In addition, BHB began a new partnership with CVS pharmacies in Baltimore City to train pharmacists to counsel customers to quit smoking.

- Obesity reduction. More than 600 postpartum have enrolled in the B'more Fit for Healthy Babies program and have collectively lost almost 6,000 pounds through free support groups and workouts.
- Breastfeeding. BHB trained a dozen community health workers and lay people in lactation counseling to provide breastfeeding support to new mothers and launched three free community support groups open to mothers throughout the City.
- Mental health. BHB partnered with the University of Maryland School of Medicine to conduct 285 interviews with pregnant women and mothers with children under 5 years old in high-risk Baltimore neighborhoods to better understand needs for and barriers to mental health services. Results will be used to improve screening, referral, and services.
- Interconception care. BHB continued to expand the Healing Ourselves through Peer Empowerment (HOPE) Project for mothers who have experienced a fetal or infant loss. Four cycles of the group program were held in FY 2015. BHB developed a new HOPE Project home visiting program, and Roberta's House, a family grief center in Baltimore, won the award to begin implementation in FY2016.
- Equity in fetal and infant mortality. BHB graduated in the first cohort of the two-year CityMatCH Institute for Equity in Birth Outcomes. Achieving equity has become a primary goal for BHB in all facets of our work.

ENSURING A VITAL FIMR PROCESS IN FY 2016

In order to continuously improve Baltimore City's FIMR process, the FIMR Case Review Team has set several goals for the coming year:

- Behavioral health. The Case Review Team will examine in detail the behavioral health factors affecting women's health and pregnancy with a focus on understanding how preconception mental health concerns may be contributing to women's ability to access health care and engage in self-care and how the health system responds to women with mental health and substance use concerns.
- Perinatal Periods of Risk (PPOR) analysis. We will refresh our in-depth analysis of fetal and infant mortality in Baltimore City using PPOR methodology, which was developed to help urban areas with high infant mortality pinpoint areas for intervention.
- Membership. Baltimore City FIMR has had difficulty maintaining membership from all birthing hospitals in the city as required by the Maryland Perinatal Systems Standards and will work to re-engage all hospitals on the team. The team will also focus on recruiting community members from non-health sectors to ensure a wide range of perspectives.
- Maternal interviews and bereavement support. The Case Review Team will continue to offer bereavement support and maternal interviews to ensure that mothers have the resources and referrals they need following a loss.

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Endnotes

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