“Infant mortality is not a health problem. Infant mortality is a social problem with health consequences.”

- M. Wagner
Every year 400 infants die before their first birthday in Oklahoma. One out of every four of those families experiencing the death of their infant resides in the Oklahoma City metropolitan area. That means each week two families in Central Oklahoma are affected by the loss of their baby.

Infant mortality is an important indicator of community health and well-being. The infant mortality rate (number of babies who die per 1,000 live births) has historically been greater in Central Oklahoma than both the state and national rates. The Central Oklahoma Fetal and Infant Mortality Review (FIMR) program was launched to address the very complex issues that lead to infant mortality.

FIMR is an action-oriented, community-based process that examines the factors and issues that impact fetal and infant mortality in our community. FIMR works to identify and create systemic change that result in the reduction of infant mortality.

**Getting Involved in FIMR**

**Health care providers, hospital administrators, medical records staff and law enforcement** can be involved in FIMR by paving the way for expedient and efficient data collection.

**Community members, health care professionals, public and private partnerships and local organizations** that provide services for women, infant and families can be involved with FIMR by joining the Case Review Team.

**Policy makers, professionals and community leaders** that are in a position to mobilize, direct and affect large-scale changes in the community can join the FIMR Advisory Council.

**Families** who have experienced a pregnancy loss or death of an infant can join FIMR by providing critical feedback and invaluable insight needed to improve the system of care for mothers and babies.
The FIMR Process

The four fundamental steps in the FIMR process include data collection, home interview, case review, and community action. The cyclical nature of the FIMR process, often referred to as the Cycle of Improvement provides feedback to determine whether recommendations and subsequent actions have made progress in improving systems of care for families.

The first step in the FIMR process begins with data collection. Once a fetal or infant death has occurred FIMR staff begins by abstracting information from various sources including birth and death certificates, law enforcement reports, autopsy reports, and medical records. The information is summarized and de-identified to protect the confidentiality of families, providers and institutions before going to case review.

As part of the data collection process FIMR also conducts an interview with families that have suffered from a fetal or infant loss. This gives family members an opportunity to share their experiences and allows their voice to be heard in the community.

The Case Review Team (CRT) is a multi-disciplinary team that reviews each case of fetal or infant loss and identifies risk factors, barriers to care, gaps in service and delivery systems, and other contributing factors associated with the death. Based on their case review the CRT begins making recommendations for improvement.

The Advisory Council is a community action team that prioritizes the recommendations from the CRT, reviews data and trends, and then develops and implements strategies to improve services, systems and community resources designed to reduce infant mortality.
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