B'more for Healthy Babies
Every baby counts on you

Tackling Baltimore City's Black-White Disparity in Infant Mortality

Recommendations from Baltimore City Fetal-Infant Mortality Review (FIMR)

Case Review:

Reviewed 29 cases in which the mother had hypertension (chronic, gestational, preeclampsia) and very preterm delivery, the most significant drivers of the racial disparity

Findings:

Entering pregnancy:	During pregnancy:	Delivery and postpartum:
•Mothers with high stress levels •Chronic hypertension, obesity, and mental health •Racial residential segregation (isolation segregation) •Lack of primary care •Previous preterm birth	•Poor quality of care •Suspected provider bias based on race •Missing Prenatal Risk Assessments •Declined home visiting •Unclaimed nutrition and income benefits •Self-care challenges	•Insensitive treatment of mothers •Poor linkage back into primary care •Missing HOPE Project referrals

Priority Recommendations:

Recommendation and Actions	Lead	Timeline
1. Obstetric provider training on implicit bias		
Pass state legislation for 2020 session	RHEAM	April 2020
Pilot training partnership with March of Dimes	Johns Hopkins	July 2020
2. Group-based programming for social support		
Seek funds to expand existing BHB programming	BCHD, Family League	June 2021
Increase access through care coordination	BCHD, HCAM	January 2021
3. Robust prenatal care coordination		
Increase pregnancy engagement specialist capacity	BCHD, HCAM	June 2021
Implement community hub model	BCHD, HCAM, City Schools	June 2021
4. Improved quality obstetric care		
Hold FIMR Summit training	BCHD	February 2020
Survey hospitals on use of safety bundles	Johns Hopkins	June 2020
5. Community hypertension screening and education		
Sustain BHB programming in Upton/Druid Heights	UMSSW	June 2020
Seek funds for communications and outreach	BCHD, Family League	June 2021
6. Housing policy advocacy		
Advocate for local fair housing policies	Healthy Start	June 2020

January 2020

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Preventing Infant and Toddler Fatalities

Recommendations from Baltimore City Child Fatality Review (CFR)

Case Review:

78 infants and toddlers died suddenly and unexpectedly from 2016 to 2018:

- 36 sleep-related infant deaths
- 16 accidental deaths (fire, drowning, motor vehicle, other)
- 13 homicides (child abuse)
- 8 natural deaths (infections, congenital heart problems, other)
- 5 undetermined deaths (suspected child abuse)

Findings:

- Unsafe sleep (co-sleeping, unsafe bedding, smoke exposure, unusual sleeping places)
- Highly chaotic family environments, caregiver substance use, and exposure to trauma
- Insufficient investigations with lack of coordination across agencies

Priority Recommendations:

Recommendation and Actions	Lead	Timeline
1. Promote safe sleep environments for infants		
Pass legislation for mandatory hospital education	BCHD	April 2020
Seek funds to expand BHB SLEEP SAFE Campaign	BCHD, Family League	January 2021
Conduct special outreach to NICUs and homeless, domestic violence, and opioid treatment providers	BCHD	January 2021
2. Robust prenatal care coordination		
Increase PRA and PIMR submission rates	BCHD	Ongoing
Increase pregnancy engagement specialist capacity	BCHD, HCAM	June 2021
Implement community hub model	BCHD, HCAM, City Schools	June 2021
3. Multidisciplinary investigation protocol		
Obtain model policies and protocols	BCHD	February 2020
Convene investigative agencies to create protocol	BCDSS	June 2020
4. Policy for conducting CPS investigations of fatalities		
Develop and implement policy	BCDSS	June 2020
5. Closing of loopholes in Maryland Birth Match law		
Pass legislation to address loopholes	BCHD	April 2020
6. Support for substance-exposed newborns		
Crosstrain home visitors and child welfare workers	MDH	Complete
Convene local cross-agency response team	BCDSS	June 2020
7. FAN training for child-serving agencies		
Seek funds for training	BCHD, UMSSW	March 2020

January 2020