



Central Oklahoma
FIMR Project

FETAL AND INFANT MORTALITY REVIEW

2009 Report



“The death of a baby is like a stone cast into the stillness of a quiet pool; the concentric ripples of despair sweep out in all directions, affecting many, many people.”

-John DeFraín, Ph.D., 1991

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Dear Reader,

I am so proud to present to you the first report for the Central Oklahoma Fetal and Infant Mortality Review (FIMR) project. The issue of infant mortality has been near and dear to my heart since I was a Peace Corps volunteer in Togo, West Africa. Early in my service I trained a group of village health workers as health educators. One day, a village woman who had gone through the training told me that she had to drop out of the program to take care of her sister’s baby, a little girl named Jacqueline. When I saw her several weeks later in the market; Jacqueline was having trouble eating and I could tell that she had not gotten any bigger. A few days later I learned that Jacqueline had died.

You may read that sad story and think, yes, I know infant mortality is a problem in developing countries such as Togo. However, infant mortality is not a problem unique to developing countries. Oklahoma has one of the highest rates of infant mortality in the United States and on average, two babies die every week in Oklahoma County. As alarming as this is, infant mortality rates are much higher in the African American community than in other racial and ethnic groups.

When I tell people what I do in my job, many will ask me, “Isn’t that hard? Doesn’t it make you sad?” The answer is, simply, yes. But I am inspired by the families who so graciously and generously participate in the FIMR interview and tell me, “If anything I say will help another family not go through this, I will tell you my story.” I am moved, thinking about all the babies who have died who, like little lights, were dimmed before really getting an opportunity to shine brightly for the world to see. The potential for improving services and conditions so that more babies may live motivates me and everybody connected with FIMR to try to do something about it.

At its core, FIMR is about weaving together threads of experience in order to tell a story, and to use that story to improve the health and support systems for women, children and families. It is about learning from the past to improve the future. Together with its community partners, FIMR is working towards a future when every baby can celebrate his or her first birthday.

Thank you for reading this report, and if you are motivated to join us in our mission to prevent infant mortality for central Oklahoma families, please contact me at (405) 425-4406 or Marybeth_cox@occhd.org to learn how to get involved.

Best regards,

Mary Beth Cox, MSW, MPH
FIMR Project Coordinator

Infant Mortality in Central Oklahoma

Overview of Infant Mortality

- Infant death (also known as infant mortality) is when a live-born baby dies before he or she is a year old.
- The infant death rate, or infant mortality rate, is measured as the number of infant deaths per 1,000 live births.
- Infant mortality is a key indicator often used to help measure the health and well being of a community.
- Risk for infant death is complex and includes biological and socio-economic factors before, during and after the mother's pregnancy
- The United States ranks 38th in the world in infant deaths¹, and Oklahoma ranks 38th in the nation², with the first ranking having the lowest rate; only 12 states have higher infant mortality rates than Oklahoma.

Oklahoma County has a higher infant death rate than state and national rates (**Figure 1**). In addition, there are disparities in infant mortality among racial and ethnic groups. African American babies in Oklahoma County die at much higher rates compared to babies from other racial and ethnic groups (**Figure 2**).

Zip codes in Oklahoma County that have a higher rate of infant deaths include:

73106	73108	73109
73110	73111	73115
73117	73118	73119
73121	73129	73149

The three leading rankable causes of infant death in Oklahoma County, in order of prevalence, are congenital abnormalities, preterm birth (also known as prematurity) and Sudden Infant Death Syndrome (SIDS).^{*} It is important to note that for African American babies, preterm birth is the leading cause of death.

Oklahoma ranks poorly in many indicators of women's health. Many of these indicators are also risk factors for poor birth outcomes, including prematurity and infant death. For example, 27% of reproductive-age women in Oklahoma (ages 15-44) are uninsured, 27% are obese, 26% smoke and 19% live in poverty (www.peristats.com, 2007 data).

1. UNICEF. The State of the World's Children 2008. Retrieved July 24, 2009 from <http://www.unicef.org/sowc08/statistics/tables.php>

2. Kaiser State Health Facts, 2002-2005. Infant Mortality Rate (Deaths per 1,000 Live Births), Linked Files, 2003-2005. Retrieved July 24, 2009 from <http://www.statehealthfacts.org/>

3, 4. Oklahoma State Department of Health, OK2Share, Vital Statistics (Death Data). Retrieved July 24, 2009 from <http://www.health.state.ok.us/ok2share/index2.html>

^{*} Although SIDS is a leading cause of infant death, the number of other sleep and possible sleep-related infant deaths in Oklahoma is at least 50% higher than the number of SIDS deaths (*Oklahoma Child Death Review Board, 2004-2007*). This is not reflected in typical vital statistics because many of these deaths are coded as "undetermined." The most common ways that babies die due to unsafe sleep are wedging (getting stuck between items such as pillows) and overlay (another person lying on the baby).

Figure 1. Infant Mortality Rates in the U.S., Oklahoma and Oklahoma County, 1999-2006³

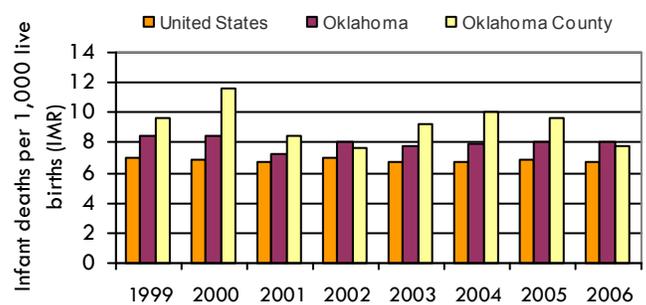
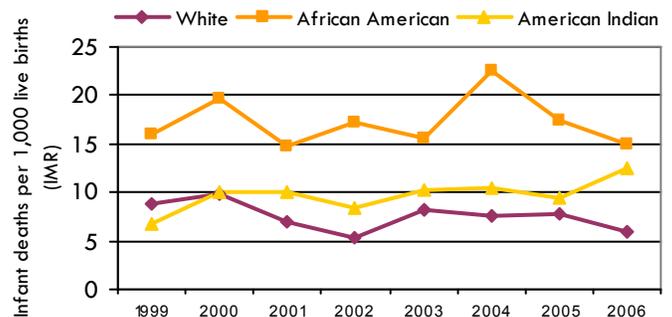


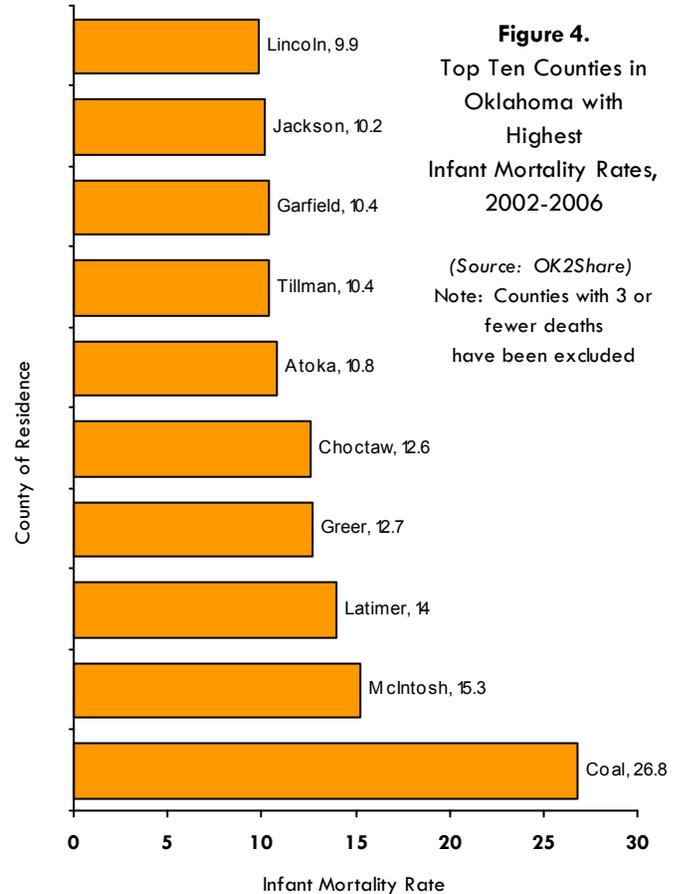
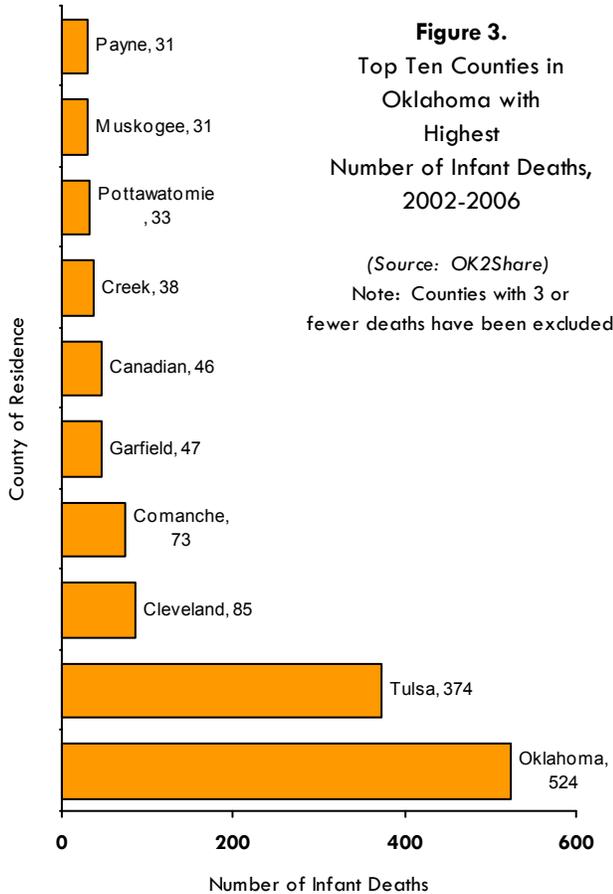
Figure 2. Infant Mortality Rate by Race Category, Oklahoma County, 1999-2006⁴



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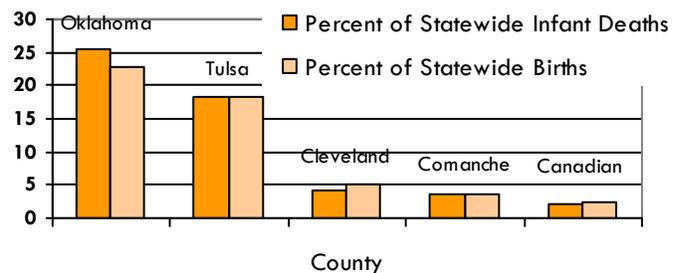
How does Oklahoma County compare?

During the 5-year period of 2002-2006, 2,059 infants died in Oklahoma. More infants died in Oklahoma County than in any other county (524 infants, representing 25.5% of the total infant deaths in the state). However, compared to other counties' infant mortality rates, or the number of infants dying per 1,000 live births, Oklahoma County's rate was 8.9 and ranked 23rd in the state. The statewide infant mortality rate during this time was 8.0 including Oklahoma County, and 7.7 excluding Oklahoma County.



From 2002-2006 Oklahoma County had 25.5% of statewide infant deaths, but 22.8% of statewide infant births. Compared with other highly populated counties in Oklahoma, Oklahoma County appears to carry a disproportionate share of infant deaths (see Figure 5).

Figure 5. Percent of Statewide Infant Deaths and Births, Top Five Counties with Highest Births, Oklahoma 2002-2006 (Source: OK2Share)



About FIMR

Infant mortality is an important indicator of community health and well-being. In the late 1980's, the Fetal and Infant Mortality Review process was developed in a collaboration between the U.S. Department of Health and Human Services, Maternal and Child Health Bureau and American College of Obstetrics and Gynecology (ACOG) as a method for communities to understand and impact infant mortality in their population. Today, there are over 200 FIMR projects nationwide.

The Fetal and Infant Mortality Review Project (FIMR) of Central Oklahoma has been working to prevent families from experiencing the loss of their baby since late 2006. The FIMR project reviews fetal and infant deaths in Oklahoma County, identifies common factors and trends, and develops and implements systems-oriented solutions in the community to improve fetal and infant outcomes.

FIMR's mission is to reduce the number of infant deaths in Oklahoma County by examining issues surrounding fetal and infant death and promoting maternal and infant health through community-based approaches.

The goals of the project are to reduce the rate of fetal and infant deaths in Oklahoma County and to eliminate racial and ethnic disparities. The project's vision is that each woman in Oklahoma County will be healthy when she gets pregnant and will have a healthy pregnancy and healthy baby who will live to celebrate his or her first birthday.

FIMR can be thought of as a three step process:

Step 1.

FIMR Project staff work to collect and abstract medical records on selected infant deaths and conduct home interviews with the mothers to listen to their story about what happened.

Step 2.

The Case Review Team (CRT) reviews case summary information and recommends how services could be improved to help families by identifying trends, gaps in service delivery systems, and community needs.

Step 3.

The Community Action Team (CAT), comprised of influential community leaders, develops the recommendations into new and creative solutions to improve services and resources for infants and families in the community.

FIMR complements and partners with other efforts in Central Oklahoma to improve maternal and child health including:

- Central Oklahoma Healthy Start Initiative
- Oklahoma Child Death Review Board
- Central Oklahoma Perinatal Coalition
- Perinatal Advisory Task Force
- Oklahoma Healthy Mothers Healthy Babies Coalition

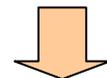
HOW DOES FIMR WORK?

Death Occurs



Data Collection – Maternal Interview and Records Abstraction

- FIMR receives monthly records of recorded infant deaths from the Oklahoma State Department of Health Bureau of Vital Statistics
- FIMR reviews cases of infant deaths to mothers residing in Oklahoma County
- Homicide deaths are excluded
- Infants who died more than 6 months ago are excluded



Multidisciplinary Case Review



Community Actions / Interventions



Improved Maternal and Infant Health

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Activities and Findings

Summary

- Between 2006-2008, depending on FIMR staff capacity, FIMR reviewed every third case, every other case or every case that met selection criteria
- FIMR completed 43 home interviews with families, usually the infant's mother (Note: All cases are reviewed even if the home interview is not completed)
- Altogether, FIMR opened and reviewed 134 cases, representing approximately one-half of all infants deaths during this time

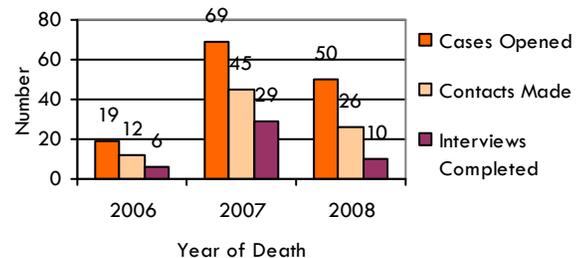


Home Interview Summary, FIMR Cases Opened from 2006-2008

	Number	% of Cases
Contacts Attempted	134	100.0
Interviews Completed	43	31.9
Interviews Not Completed	92	68.1

Reasons Interviews Not Completed	Number	% of Cases Reviewed Without Interviews
Could not locate mother	19	20.7
Mother declined interview	27	29.3
Mother did not respond	35	38.0
Mother did not show	4	4.3
Unknown / Missing	7	7.6

Figure 6. FIMR Home Interview Summary, 2006-2008



Demographics, FIMR Cases 2006-2008

Maternal Age

<20 Years	16.4%
20-35 Years	79.9%
>35 Years	3.7%

Marital Status

*excludes 1 unknown	
Married	42.1%
Unmarried	45.1%
Other	12.8%

Maternal Race

*excludes 7 unknown	
African American	35.4%
Asian	2.4%
Caucasian	58.3%
Native American	2.4%
Multiracial	1.6%

Maternal Ethnicity

*excludes 13 unknown	
Hispanic	14.9%
Non-Hispanic	85.1%

Maternal Education

*excludes 2 unknown	
Less than high school	30.3%
High school and beyond	69.7%

Payor, Prenatal Care

*excludes 1 unknown	
Medicaid	53.4%
Private Insurance	33.1%
Self Pay	7.5%
Mixed methods	6.0%

Gestational Age at Birth

20-24 weeks	29.1%
25-32 weeks	27.6%
33-36 weeks	14.9%
37-40 weeks*	28.4%
* full term	

Birth Weight

*excludes 3 unknown	
<750 g	38.2%
750-1499 g	11.5%
1500-2499 g	22.1%
2500 g or more**	28.2%
**normal birth weight	

Select Findings

Infant Age at Death

- 59.7% of FIMR infant cases died in the neonatal period (0-28 days)
- 71.9% of neonatal deaths occurred in the 0-7 day period and 28.1% occurred in the 8-28 day period

Prematurity

- 71.6% of FIMR infant cases were born premature (<37 weeks gestation)
- Of the infants born premature, 79.2% were very premature (<32 weeks gestation)
- Nearly one in five (19%) FIMR infants were born prematurely to mothers who had a previous premature birth

Maternal Health Disparities

- When compared with identified Caucasian mothers, a higher percentage of African American mothers had late prenatal care, maternal infections and pre-pregnancy obesity. However, smoking during pregnancy was higher in the Caucasian population than among African Americans (45.7% vs. 26.3%; 35.5% overall). (Note: FIMR had limited data to adequately examine other factors)

Safe Sleep

- There was only 1 selected and reviewed FIMR case where the cause of death was ruled* as Sudden Infant Death Syndrome (SIDS)
- There were 10 selected and reviewed FIMR cases where the cause of death was “undetermined” or “asphyxia” with significant conditions associated with sleeping, such as wedging between mattresses or overlay by another person in the sleep space
- FIMR case data reflects statewide data, in that infant deaths associated with unsafe sleep conditions appear to outnumber SIDS cases by at least 50% (*Child Death Review Board data, 2004-2007*)

*Cause of death as ruled by the State Medical Examiner’s (ME) Office

Figure 7. Infant Age at Death by Gestational Age at Birth, FIMR Cases 2006-2008 (N=134)

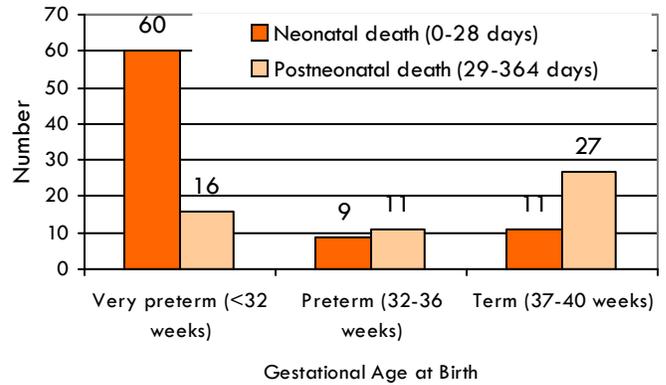


Figure 8. Premature Status of FIMR Cases and Prior Infants, 2006-2008 (N=134)

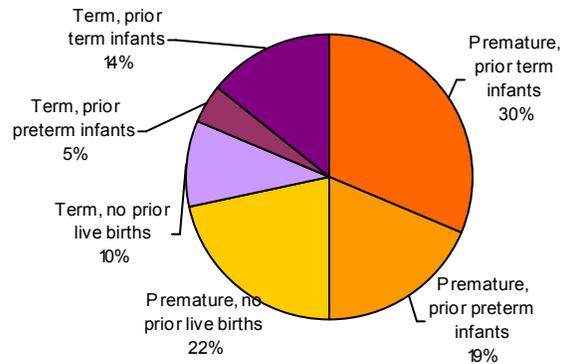


Figure 9. Maternal Health Disparities, FIMR cases 2006-2008 (N=127; data not available on 7 cases)

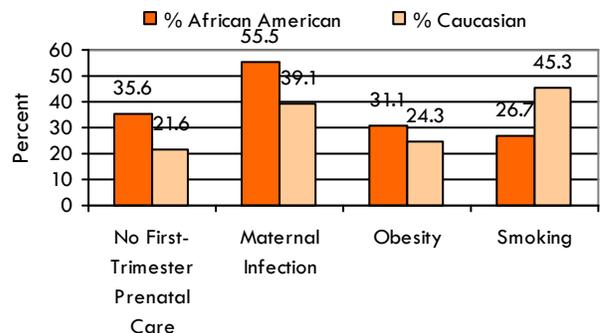
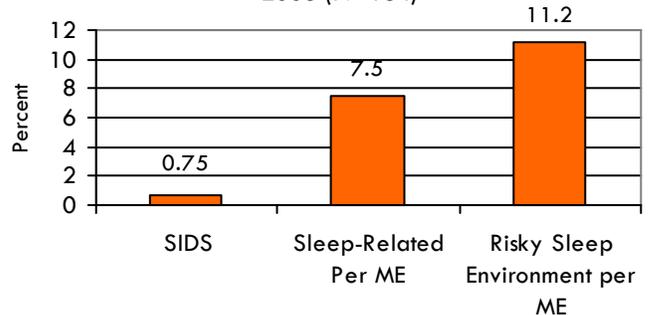


Figure 10. SIDS, Sleep-Related and Possible Sleep-Related Infant Deaths, FIMR Cases 2006-2008 (N=134)



General Recommendations from FIMR Case Review

The FIMR Case Review Team reviewed 134 cases of infants who died between 2006 and 2008. These cases represent approximately 50% of all infant deaths during this time period. The team identified salient issues and made the following general recommendations, listed in order beginning with the most prevalent.

Over 60% of pregnant women in Oklahoma and identified FIMR cases have Medicaid/ SoonerCare as their health insurance provider. SoonerCare offers many services and options for pregnant and postpartum women that will help address many of the recommendations listed here. **Sadly, these benefits are underused in the current health care system in Oklahoma County.**

Reimbursed services include smoking cessation counseling, dental care, maternal and infant health social work services, genetic counseling, high-risk obstetric care and lactation consultation. For more information about perinatal SoonerCare benefits, visit:

<http://www.ohca.state.ok.us/>.

1 Improve Preconception, Interconception, and Women's Overall Health

The evidence is clear that being healthy prior to getting pregnant improves a woman's chances for a healthy pregnancy and healthy infant. Improving preconception health, interconception health and the health of all women of reproductive age, regardless of pregnancy intention, are the best strategies to improve outcomes for women and their future babies.

2 Help Women Quit Smoking

Quitting smoking is perhaps the single most important thing a woman can do to reduce her and her baby's risk for potentially life-threatening health complications prior to, during and after pregnancy. Nearly one in five women in central Oklahoma smoke cigarettes prior to getting pregnant and research shows that smoking before pregnancy has not changed in Oklahoma since 2000.¹ Both patients and providers should know about and take advantage of available smoking cessation benefits including reimbursement for 5 A's counseling for Medicaid providers and accessing the free statewide Quitline, 1-800-QUIT-NOW.

3 Help Women Achieve a Healthy Body Weight

Over 57% of women who experienced an infant loss were obese or overweight prior to becoming pregnant, and over 5% were underweight. Being overweight or obese not only increases a pregnant woman's risks for health complications, it puts her baby at risk for being born preterm, low birth weight, or having congenital abnormalities - all risk factors for infant death.

4 Improve Grief Support and Bereavement Services

FIMR has found that while grief support services exist in Oklahoma County, some families are not made aware of these services, especially those families whose infant dies at home. In addition, multiple mothers have said that they would prefer for someone to contact them rather than to have to initiate contact themselves.

5 Help Women Access Early and Adequate Prenatal Care

Over 26% of women who experienced an infant loss did not access prenatal care in their first trimester, with 36% of African American mothers compared to 22% of white mothers not accessing first trimester prenatal care. Accessing early and regular prenatal care is important in order to perform necessary tests and address health behaviors, particularly for mothers with known risk factors or poor health status.

6 Identify and Treat Maternal Infections

Over 48% of women who experienced an infant loss had at least one infection during pregnancy. There was an apparent disparity, with over 55% of African American women having an infection compared to 39% of white women. Maternal infections increase a woman's chance of pregnancy complications which include premature rupture of membranes and preterm labor.

1. Tong V et al. [Trends in Smoking Before, During, and After Pregnancy --- Pregnancy Risk Assessment Monitoring System \(PRAMS\), United States, 31 Sites, 2000--2005](#). Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Surveillance Summaries. May 29, 2009 / 58(SS04);1-29. Available at <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5804a1.htm>



7 Improved Safe Sleep Education for Families

While Sudden infant Death Syndrome is the third leading cause of death for infants, it is not the only way that infants can die while they are asleep. Among FIMR cases, 8% of infants died due to being placed in an unsafe sleep environment, and 11% died while sleeping in an unsafe manner. Only one FIMR case had SIDS as the cause of death (or 0.7% of cases). Parents, extended families and anybody who cares for infants should be given accurate information about the risks for sleep-related death and be encouraged and empowered to adopt healthy behaviors in their own households and other places where the infant may sleep.

8 Improve Efforts to Help Families Plan for Pregnancy

When a pregnancy is planned, the chance that both mother and baby have a healthier experience increases significantly.

9 Provide Risk-Appropriate Genetic Counseling

Genetic counseling can help families understand their risk for certain conditions and empower them to make informed decisions. Referral to and availability of genetic counseling is important in the perinatal period (i.e., around the time of birth) due to a known genetic condition in the infant, in the preconception period (i.e., prior to pregnancy) due to a positive family history of genetic condition and in the interconception period (i.e., between pregnancies) due to having a prior infant with a genetic condition.

10 Encourage and Empower Women to Comply with Medical Recommendations

Part of staying healthy in pregnancy is taking personal responsibility for adopting healthy behaviors. Women who receive advice from their health care provider should act in the best of interest of themselves and their unborn child. In addition, health care providers should ensure that women understand the advice they are given and should assist patients in finding and accessing additional resources they may need to adopt and maintain healthier choices.

11 Improve Care Coordination and Referral Systems

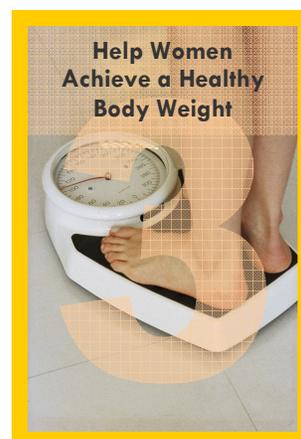
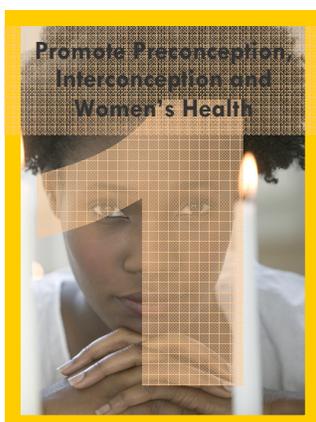
No single health care provider can meet all the needs of patients with complex health and social issues. Every effort should be made to connect women with community resources to meet their needs and reduce their risk for adverse outcomes. Many evidence-based programs are available in Oklahoma County that have a proven impact on pregnancy outcomes, such as Healthy Start and Children First, Oklahoma's Nurse-Family Partnership. Providers need to learn about these community programs and refer patients as appropriate.

12 Improve Access to Mental Health Services

Poor mental health can compound health or social circumstances in pregnancy, and can have a direct or indirect impact on the pregnancy outcome.

13 Ensure Timely, Appropriate Referral to a High-Risk Obstetric Provider

In Oklahoma County we are fortunate to have facilities and providers that specialize in high-risk obstetric care. Providers need to make sound assessments about the risk of their patients, given their health history and current health conditions, and consult with a high-risk provider when appropriate so the providers and the patient can formulate a plan of care that best meets the patient's special needs.



CENTRAL OKLAHOMA FETAL AND INFANT MORTALITY REVIEW

FIMR Accomplishments

Accomplishments

From October 2006 to June 2009, the FIMR project staff have:

- Selected, abstracted and facilitated the review of 134 cases of infant death
- Had full cooperation from local hospitals and physician practices in the case abstraction process
- Recruited 44 community leaders and professionals as CRT and CAT members
- Facilitated 31 meetings of the CRT and CAT
- Developed relationships with community partners, attended and made presentations at professional meetings, developed several publications and guided the direction of FIMR

The Community Action Team has:

- Gone through the process of exploring and understanding the important role they play
- Researched the role of maternal infections and other data elements in special sub-committees
- Explored the idea of piloting a prenatal health card in community clinics
- Repurposed their work through revising the mission, vision and goals of FIMR and the CAT
- Developed three work groups following the Ecological Model, focusing on Individual and Family issues, Community and Provider issues, and Policy and Environment issues
- Begun to partner with community-based organizations to implement impactful projects



Future Directions

The FIMR project is unique in that it links together information about the mother's and baby's medical and social services and the mother's own words about what happened. FIMR is the finger on the pulse of what mothers and their babies are experiencing now, in our community, at this point in time. FIMR can make a real difference.

Growth and Expansion: Health does not stop at the county line. In the near future, FIMR plans to expand its services to surrounding counties, beginning with Canadian and Cleveland counties. In addition, it plans to build new partnerships and enrich existing ones, beginning with similar organizations so we can multiply our efforts by working together.

More Action: The CRT will strive to craft recommendations that give better direction to the CAT, providing the blueprints for action and changing the discussion from "what do we do?" to "how do we do this?" The CAT has begun to put projects in place, but will continue looking for opportunities to improve systems. The best projects often improve existing services and linkages which, though little funding is required, requires manpower and know-how. To this end, FIMR will expand CRT and CAT membership to increase manpower.

Evaluation: FIMR will work to evaluate the impact of its activities. Evaluation is a key element if we are to be sure that FIMR is making a difference for Central Oklahoma families.

Acknowledgements

Many thanks to the professionals and community members who have dedicated their time, energy, expertise and passion to the FIMR process in Central Oklahoma. Here is a list of FIMR's current Case Review and Community Action Team members.

Case Review Team

Don L. Anderson, ACSW, LCSW
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Stork's Nest

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Rita L. Williams, MSN, RN, Nursing Instructor
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What do team members say about their participation in FIMR?

"FIMR work may be difficult but it is extremely important and valuable in trying to make improvements for Oklahoma's families."

-Lisa Rhoades

"There is potential for creating great change within this group."

-Bonnie K. Bellah

"I am much more aware of the coalitions working on issues as well as resources that will benefit families."

-Brooke Townsend

"It is a great opportunity to interact with a motivated sector of our community, to see how different systems depend on one another, and to have some impact on issues that need to be addressed."

-Sheryl Glover

"We now participate in Child Abuse Prevention month by sharing important information with our congregation. We also incorporated 2-1-1 into our resource book in getting assistance information to Oklahoma citizens who need help."

-Alice Richardson

FIMR Project Staff

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CENTRAL OKLAHOMA FETAL AND INFANT MORTALITY REVIEW

Inspiring Change
For Babies
One Story at a Time

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A special thanks to Suzanna Dooley, Chief, Maternal and Child Health Service, for her continuing support and guidance to the FIMR project.

