Report to the General Assembly

Workgroup Study:
Fetal and Infant Mortality Review Team (FIMRT)
HB1950 of 2021

Office of the Chief Medical Examiner
Virginia Department of Health

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Questions or Comments:
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Executive Summary

From 2015-2020 there were a total of 5,182 fetal deaths in Virginia. Using data from the Virginia Office of Health Statistics, the rate of fetal death in Virginia in 2019 was 7.6 fetal deaths per every 1,000 live births (Statistical Reports and Tables, 2021), which is the lowest it has been since 2015. From 2016-2020 there were a total of 2,723 infant deaths in Virginia. The Centers for Disease Control estimates the infant mortality rate in Virginia to be 5.8 infant deaths per 1,000 live births as of 2019 (Centers for Disease Control, 2021), with similar rates over a 5 year time span. Despite lower numbers of fetal deaths and stable rates of infant deaths, Virginia continues to struggle to decrease mortality in these populations. According to the Centers for Disease Control, Virginia falls in the lower 50 percent when compared to other states and has been there for some time. Previous efforts aimed at reducing fetal and infant death have fallen short and resulted in the ending of fetal and infant death review through Regional Perinatal Councils in 2012.

Acknowledging the need to address fetal and infant death in the state of Virginia, the 2021 House Committee on Health, Welfare and Institutions requested the Virginia Department of Health's Office of the Chief Medical Examiner (OCME) convene a work group to (1) study the feasibility and execution of a Fetal and Infant Mortality Review Team (FIMRT); and (2) address the following items, as able:

1. Methods for collecting information about fetal and infant death in the Commonwealth;
2. The definition of a fetal death for the purpose of review;
3. Criteria for the selection of deaths for review;
4. Criteria for the selection of deaths for which additional voluntary qualitative interviews will be conducted;
5. Procedures for maintaining confidentiality; and
6. A five-year implementation plan.

Using a thematic approach, the workgroup identified three plausible review team options for Virginia. These included: (1) Using existing child and maternal mortality statuary provisions as the framework for a fetal and infant mortality review team and implementing a team that mirrors the other teams in the state; (2) Implementing a large scale, multi-region, state program;

or (3) Implementing a team to review fetal deaths and natural infant deaths that do not fall under the Child Fatality Review Team. Both Option 1 and Option 3 are similar, but the distinguishing factors between them are that Option 3 would avoid duplicating the review of cases that are already reviewed under existing child fatality statute. Currently only non-natural deaths are reviewed under current child fatality statute, as natural deaths are deaths that do not fall under the jurisdiction of the OCME thus are not include in the child fatality review process. This would meet a greater need and provide a more direct focus that could aid in reducing fetal and infant deaths in Virginia.

After careful study, review, and discussion the workgroup decided that implementing Option 3, a team that reviews fetal deaths and natural infant deaths would address the needs of Virginia and complement the work that is already being done by the other review teams. This report highlights the need, background, discussion, and results of the workgroup and also identifies the necessary steps needed in order to move forward with this much needed fatality review team.

Introduction

The 2021 House Committee on Health, Welfare and Institutions requested the Virginia Department of Health's Office of the Chief Medical Examiner (OCME) convene a work group to (1) study the feasibility and execution of a Fetal and Infant Mortality Review Team (FIMRT); and (2) address the following items, as able:

1. Methods for collecting information about fetal and infant death in the Commonwealth;
2. The definition of a fetal death for the purpose of review;
3. Criteria for the selection of deaths for review;
4. Criteria for the selection of deaths for which additional voluntary qualitative interviews will be conducted;
5. Procedures for maintaining confidentiality; and
6. A five-year implementation plan.

The Chief Medical Examiner and Director of the Division of Death Prevention convened the Fetal and Infant Mortality Review Team (FIMRT) Workgroup ("the workgroup") to make recommendations to implement a plan for the identification, data collection, and review of fetal and infant deaths. A list of the workgroup members and organizations represented can be found in Appendix A.

Fetal and Infant Mortality Review Teams History (Virginia)

In 1980, improvements to the Commonwealth's perinatal health-care system began when the Virginia General Assembly authorized the Perinatal Services Advisory Board to develop the first Statewide Perinatal Services Plan. Subsequently, in 1983, the Perinatal Services Advisory Board not only issued recommendations for improving Virginia's system of providing perinatal health care but also identified seven regions by using information about the concentration of births across the Commonwealth. The board revised the Statewide Perinatal Services Plan in 1988 and included specific health-care responsibilities for each of the regional perinatal centers. In 1990, the division of Maternal and Child Health—through a recommendation from the Perinatal Services Advisory Board—awarded a contract to the National Perinatal Information Center to study the effectiveness of perinatal regionalization.

The Center's primary recommendation was the formation of regional perinatal councils in Virginia. In 1992–1993, the VDH used funds from the Maternal and Child Health Block Grant (Title V) to establish a regional perinatal coordinating council (RPCC) in each of the Commonwealth's seven perinatal regions (see Appendix A). The purpose was to create a collaborative network among providers of perinatal services with the goal of providing risk-appropriate care to all perinatal clients in Virginia. The long-term responsibility of each RPCC was to decide how each region would address issues and problems such as access to care, perinatal education, collection and analysis of data, and identification of potential resources. During their first year, the RPCCs completed a needs assessment, and, at a state-level meeting of lead agencies, officials identified infant mortality as an issue requiring statewide attention. In 1996, the regional perinatal coordinating councils were renamed the "regional perinatal councils" (RPCs). The RPCs were required to devise a plan to incorporate the FIMRT program in a self-selected area in their region and to begin the program in 1997.

In 1997, VDH contracted with the Commonwealth's seven regional perinatal councils to begin the establishment of statewide, regional FIMRs. They piloted the program in Norfolk. Sponsored by a local perinatal study group and with additional financial support and cooperation from Eastern Virginia Medical School, Sentara Norfolk General Hospital, and the Children's Hospital of The King's Daughters, the pilot project reviewed 40 cases of fetal and infant deaths in Norfolk. The project generated strong interest in establishing an ongoing FIMR program in the state. The Healthy Start grant which is named Loving Steps, is a comprehensive community based program using various health care professionals to provide care management and care coordination for pregnant and interconception women. Healthy Start funds were utilized to establish the FIMR sites, develop a statewide database, and implement a FIMR evaluation plan.

In 2012, funding was cut to the RPCs and the RPCs disbanded. Concerns over the efficacy of FIMRTs in Virginia, fragmented programs and policies, and a lack of measurable outcomes led to the loss of funding and the loss of FIMRTs in Virginia. Since then, fetal deaths have not been reviewed and infant deaths are only reviewed by the State and Regional Child Fatality Review teams.

Fetal and Infant Death Model (1992-2012)

Modeled on the National FIMR Program, the Virginia FIMR Program was a community-based process that begins when a fetal or infant death occurs. Data (e.g., death certificate information and medical records related to the pregnancy, as well as pediatric records, if available) were collected and abstracted following the National FIMR Program guidelines (https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/FIMRManual.pdf). All identifying information was removed during the abstraction. After all the necessary records were collected, the RPCs would review the cases to identify gaps in care or education, determine needs, and make recommendations. Additionally, using a standardized interview tool during a home visit, a trained professional recorded the mother's experience with community resources and care received during the prenatal, intrapartum, and postnatal periods. Mothers were also referred to appropriate support groups and/or community resources if such a need is identified during the home visit. These interviews were also used as part of the review.

Key Features of Fetal and Infant Mortality Review Teams (FIMRT)

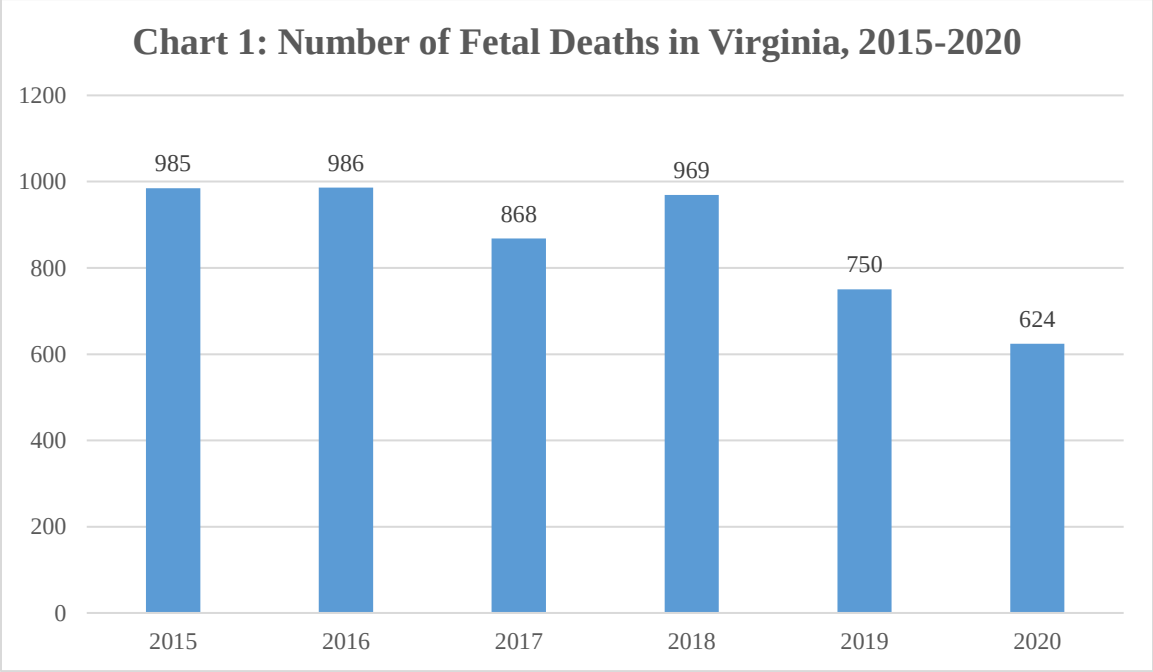
As summarized by Kootz, Buckley, and Ruderman (2004), key FIMR concepts are the following:

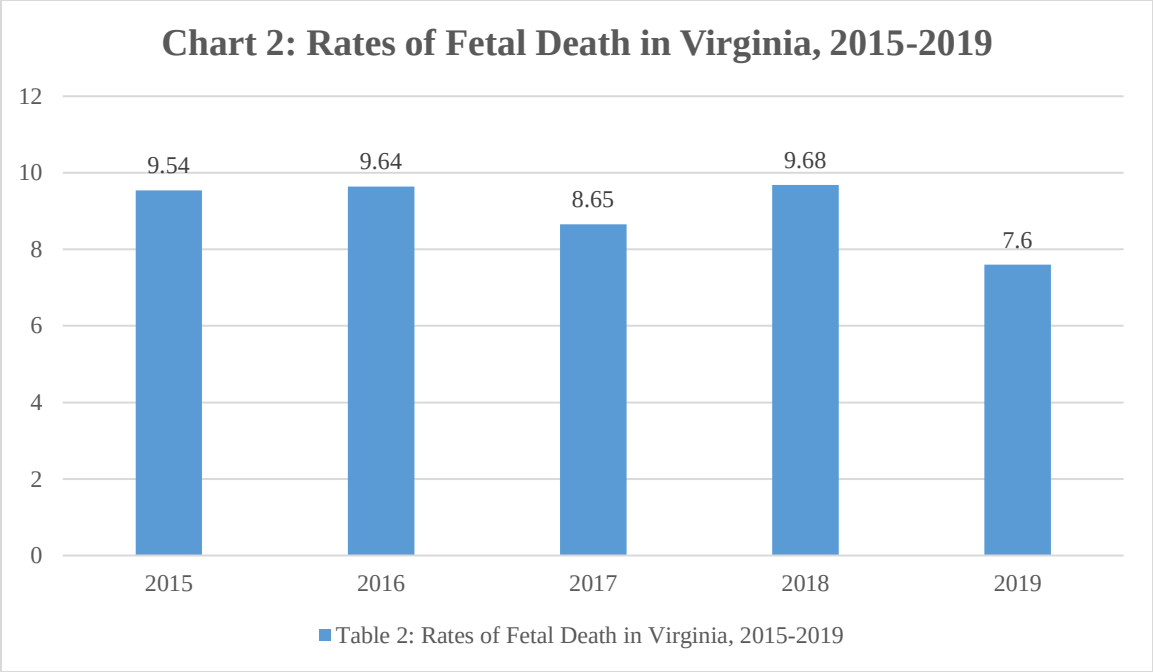
- Systematic evaluation of individual cases (case review).
- Identification of a broad range of factors contributing to adverse outcomes (environmental, system, socioeconomic).
- Inclusion of information not available through routine quantitative methods such as the interview with the mother.
- Cases viewed as sentinel events illustrating system and resource issues.
- Avoidance of preventable/non-preventable classifications of death because the intent of the case review is to identify opportunities for change.
- Avoidance of blame (anonymous cases and confidential process, explicitly not a medical audit, examination of associated factors rather than causes).
- Population-oriented focusing on a specific geographic area.
- Two-tiered process that promotes separate teams being responsible for the analytic function and the action function.

- Multidisciplinary involvement not only with health professionals but also with various community partners.
- Promotion of joint sponsorship by medical society and health department to bolster physician and community support while maintaining a public health perspective.
- Adaptability to varying local conditions and resources.
- Complementary method to other maternal child health improvement methods. Integral components of an ongoing needs assessment, program planning, implementation, and evaluation cycle, which are essential functions in public health practice.

Fetal and Infant Death in Virginia (2015-2020)

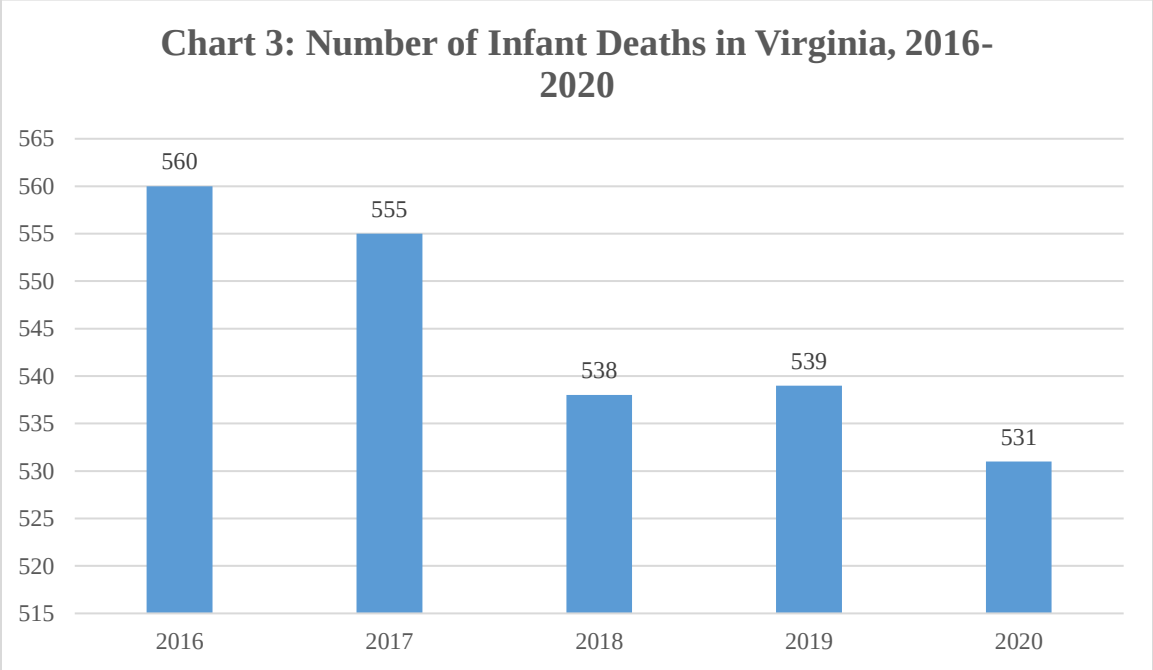
From 2015-2020 there were a total of 5,182 fetal deaths in Virginia. Using data from the Virginia Division of Health Statistics, the rate of fetal death in Virginia in 2019 was 7.6 fetal deaths per every 1,000 live births (Statistical Reports and Tables, 2021), which is the lowest it has been since 2015.

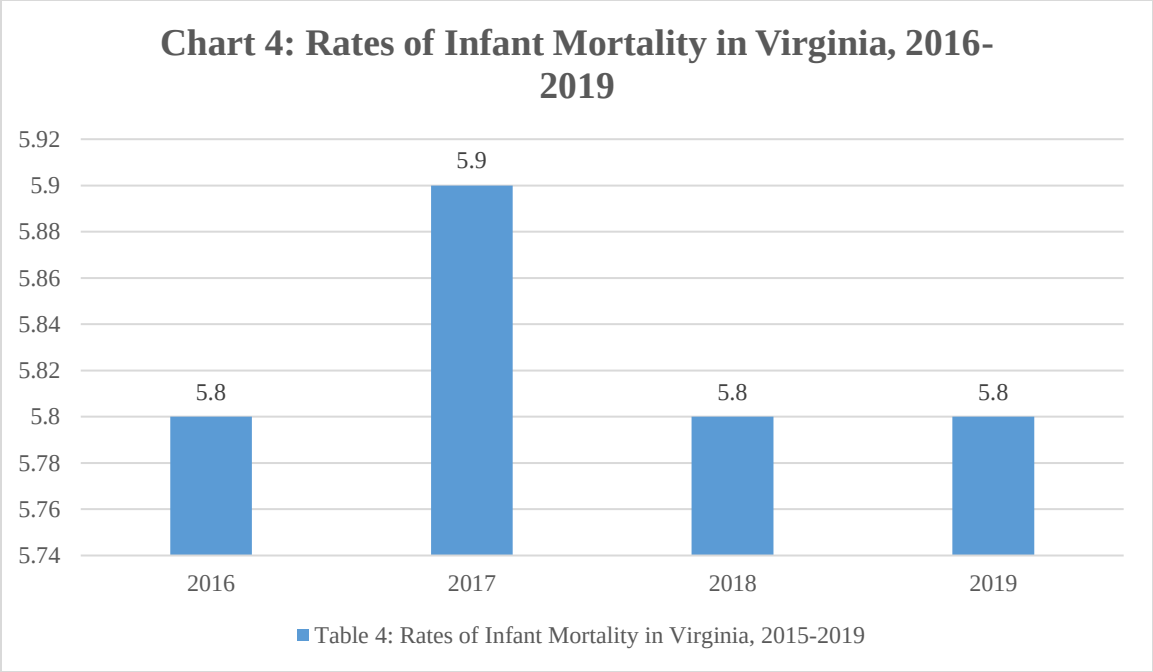




Data from 2020 is still being calculated and not available for rate calculations.

From 2016-2020 there were at a total of 2,723 infant deaths in Virginia. The Centers for Disease Control estimates the infant mortality rate in Virginia to be 5.8 infant deaths per 1,000 live births as of 2019 (Centers for Disease Control, 2021).





Data from 2020 is still being calculated and not available for rate calculations.

Despite lower numbers of fetal deaths and stable rates of infant deaths, Virginia continues to struggle to decrease mortality in these populations, especially for non-White women and infants. According to the data, infant death disproportionally affects Black women compared to White, Hispanic, or Asian/Pacific Islander women. From 2016-2018 the infant mortality rate for Black infants in Virginia was 9.5 per 1,000 live births as compared to White infants at 4.8 per 1,000 live births (March of Dimes, 2021).

Conversely, non-White and non-Black women experience higher rates of natural fetal loss in Virginia according to the Virginia Division of Health Statistics. Non-White and non-Black women experience rates of fetal death approximately 1.5 times higher than their counterparts.

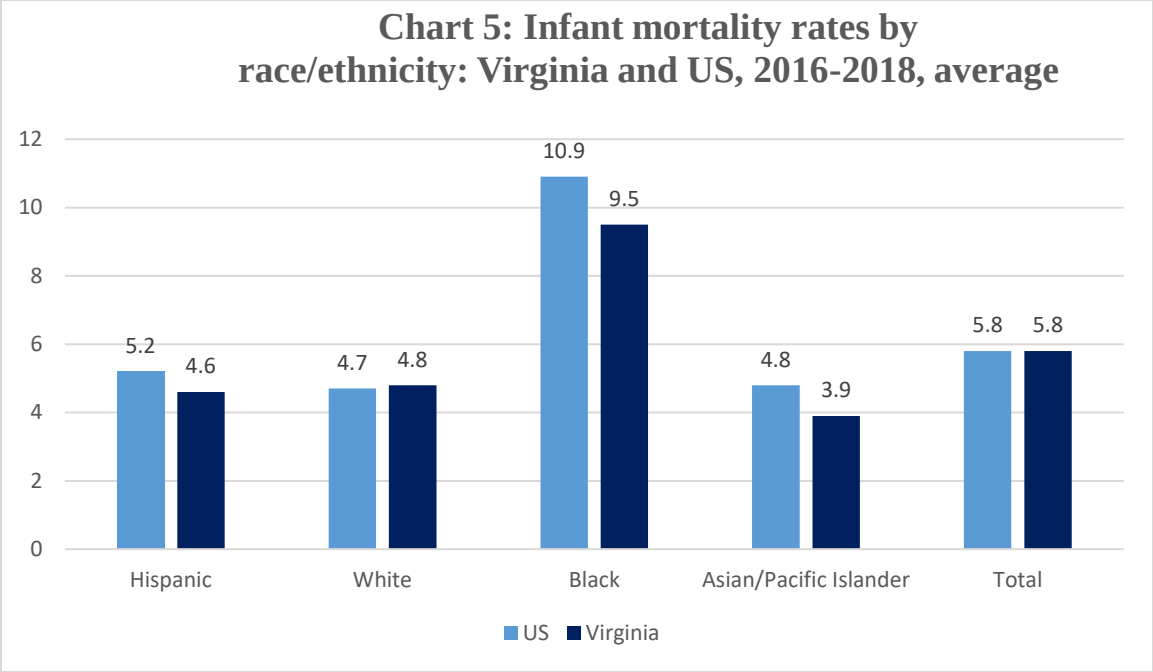


Chart 5: Infant mortality rates by race/ethnicity: Virginia and US, 2016-2018, average
12
10
8
6
4
2
0
5.2
4.6
4.7
4.8
10.9
9.5
4.8
3.9
5.8
5.8
Hispanic
White
Black
Asian/Pacific Islander
Total
US
Virginia

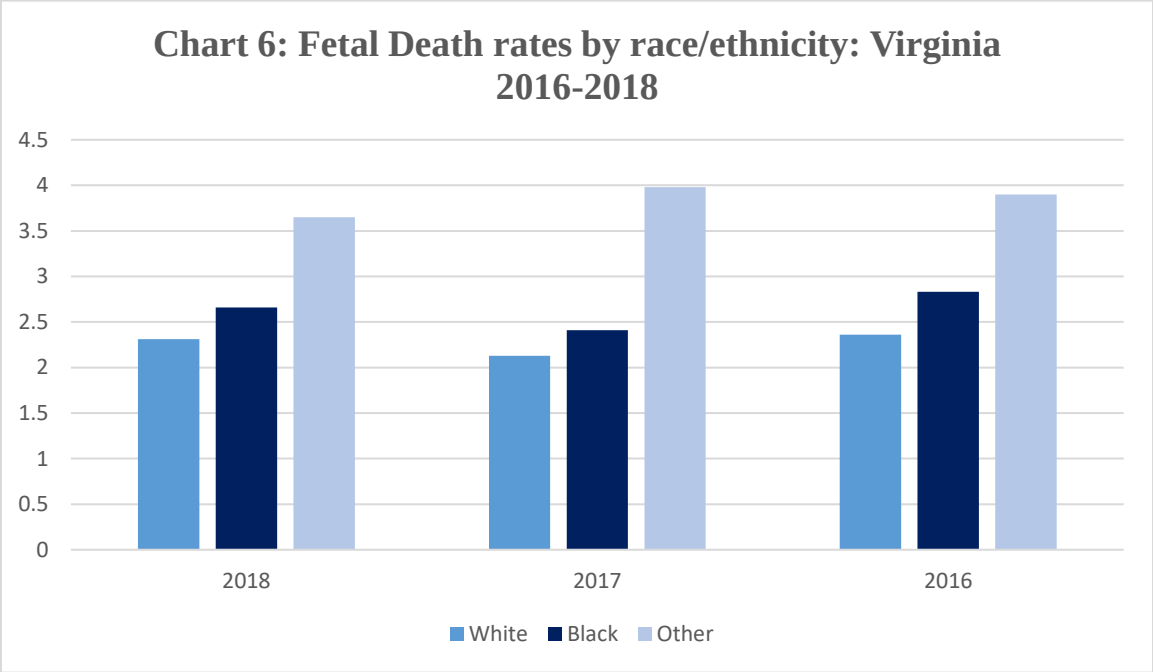


Chart 6: Fetal Death rates by race/ethnicity: Virginia 2016-2018
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
2018
2017
2016
White
Black
Other

Definitions

Fatality Review: Fatality review is a retrospective process and is a theory and method grounded in public health, designed to identify and understand risk factors for death. It involves examination of relevant records relating to the decedent by a multidisciplinary team of professionals. The purpose is to improve understanding of how and why people die and to make recommendations for education, training, and prevention efforts.

Fetal Death: Refers to the spontaneous intrauterine death of a fetus at any time during pregnancy. In the state of Virginia, fetal death occurs at any point in pregnancy, when the pregnancy does not result in a live birth. For the purpose of Virginia FIMRT, fetal death is any death of a fetus, in Virginia, whose mother is a resident of Virginia.

Natural Infant Death: Any death of a person, aged 12 months or less, that died of a natural cause. Deaths can be those that fall in and outside the jurisdiction of the Medical Examiner's Office. For the purpose of Virginia FIMRT, infants will be those that are residents of Virginia at the time of their death and who died in Virginia.

Surveillance: The systematic collection, analysis and dissemination of health data for the planning, implementation and evaluation of public health programs.

Virginia's FIMRT Workgroup (HB1950)

Methodology

General Meeting Procedure

The Office of the Chief Medical Examiner (OCME) sent invitation letters (Appendix B) to each required workgroup member identified in HB1950. The letter solicited their or their designees' participation. This process also allowed for the identification of additional workgroup members such as doulas, community-based providers, and stakeholders by other members, who were then invited through the same process as those required.

Starting in March 2021, OCME convened the FIMRT Workgroup and met on the 4th Tuesday of each month to discuss topics and make decisions based on group discussion. The agendas for these meetings can be found in Appendix C. The meetings were facilitated by the Director, Division of Death Prevention who has a background in qualitative interviewing and group facilitation, in addition to familiarity with fatality review.

Following each workgroup meeting, notes and minutes were compiled and using a thematic approach, the discussions were analyzed and this analysis was used to plan and facilitate the subsequent meeting. This approach was also used to determine the most feasible options to carry forward, if a team was codified.

Legislative Recommendation

A thematic approach was used to identify three FIMRT options for legislative recommendation. The options were presented to the workgroup in a regularly scheduled meeting. Each option included a discussion of items to consider, including the strengths and weakness of each identified option. After the presentation the group discussed the options, before voting. An anonymous, systematic polling system was used to cast votes in the workgroup.

Virginia Fetal and Infant Mortality Review Team

Using the meeting notes and minutes, the following options were identified:

1. Implement a Fetal and Infant Morality Review Team, built on the existing Maternal and Child Fatality Review Team statutes.
2. Implement Regional Councils, as done in the past, but instead of operating as before with each regional council being their own entity, have there be state oversight of each regional council, with mandatory reporting requirements and programs within the community.
3. Implement a Fetal and Infant Mortality Review Team, where only fetal deaths and certain natural infant deaths are reviewed, since the State of Virginia already has an active Child Fatality Review Team that encompasses infant deaths.

As stated in a previous section, both Option 1 and Option 3 are similar, but the distinguishing factors between them are that Option 3 would avoid duplicating the review of cases that are already reviewed under existing child fatality statute. Currently only non-natural deaths are reviewed under current child fatality statute, as natural deaths are deaths that do not fall under the jurisdiction of the OCME thus are not include in the child fatality review process. Option 3 would enhance the definition of infant death in Virginia for review purposes and allow

for the review of natural cases of infant death. The workgroup members identified and thoroughly discussed each option and the results of the discussions are below.

Implement a Fetal and Infant Morality Review Team, built on the previous Maternal and Child Fatality Review Team statutes.

The State of Virginia has two active state led fatality review teams; the Child Fatality Review Team (CFRT) under (§ 32.1-283.1.) and the Maternal Mortality Review Team (MMRT) under (§ 32.1-283.8.). The CFRT was the first team, implemented in 2002 and the MMRT was codified in 2019, but has been active since 2000. Both teams operate out of the Office the Chief Medical Examiner and are staffed with a Program Manager with a doctorate degree and a Research Assistant. Both teams conduct fatality review team meetings six times per year, reviewing approximately 30 cases per year. The teams are chaired by the Chief Medical Examiner (CFRT) and the Chief Medical Examiner in partnership with the Office of Family Health Services (VDH) (MMRT). Each team operates under a two-armed approach: Fatality Review and Surveillance.

Cases for review are identified through the surveillance process which includes using the Office of the Chief Medical Examiner's VMEDs database, cross referenced with the Virginia Violent Death Reporting System and the Office of Vital Records. Using this approach ensures that with almost 100% certainty, all cases that meet case criteria for the review are identified. Once cases are identified, the Program Manager and their staff collect records from social, medical, medical examiner, law enforcement, and other sources to develop cases summaries about the decedent. Once all the data is abstracted, compiled, and summarized, it is presented to the teams. The teams are comprised of multidisciplinary professionals and community-based members who review the case, identify the risk factors that led to the death, determine preventability, and based on the preventability score, determine recommendations for policy or program to reduce similar deaths in the future.

Surveillance is where data is abstracted from similar files used in the fatality review process and entered into a web-based database. This database is used to conduct analysis for reports, briefs, and presentations, given to stakeholders, the Centers for Disease Control, and other entities which use data to understand a problem or set of problems related to the child or

maternal death. This data is housed in perpetuity and can also be used to identify trends and highlight outcomes.

There are several strengths and weaknesses for this model. Strengths of this model include:

Cost: This model is cost effective and would provide the oversight, review, and surveillance necessary to understand issues surrounding fetal and infant death in Virginia. The cost of this model is estimated to be about $200,000 per year, which is in line with the CFRT and MMRT in Virginia. These models are slightly smaller in scope for both fatality review and surveillance, due to the much lower case numbers, which factors into the cost of the teams.

Model: The model is evidence-based and has been working in Virginia since the early 2000s. This model has been verified, is familiar, and effective in producing fatality review data.

Surveillance: Surveillance is already embedded into this process and a separate surveillance program would not need to be developed.

Statewide Team: The team is comprised of agencies and stakeholders at the state and community level who are involved in policy change and program implementation. This fact allows for vetting of recommendations and also, support for development and implementation.

Even with several strengths, there are several weaknesses of this model to consider. Those weaknesses include:

Targeted Reviews: Due to the high number of cases, the reviews would need to be targeted since the team can only review approximately 30 cases per year. Limited and strongly targeted reviews can create gaps in policy and program implementation, create silos amongst agencies, and limit the ability to implement programs and policies.

Family Interviews: Interviews with family members, particularly mothers, are one of distinguishing features of a Fetal and Infant Mortality Review Team. Family/parental interviews allow for a deeper understanding of the issues that may have led to a fetal demise or infant death. This model would not allow for family/parental interviews.

Recommendations: Recommendations are a feature of the fatality review process. Using a thematic approach, vetting procedures, and collaborative processes recommendations are drafted

from each child fatality or maternal mortality review. Recommendations are designed to be carried out by an identified entity. One of the weaknesses of fatality review is the lack of a feedback loop to assess the implementation or evaluate the implemented outcomes due to the structure of fatality review teams in Virginia. The team is not responsible for implementing the recommendations, but instead support and advocate for them. This lack of implementation or carry through produces very few measurable outcomes.

Duplication of Efforts: If a FIMRT is enacted using the same model as the CFRT and MMRT there is a high risk for duplication of efforts of the FIMRT and CFRT. The Child Fatality Review Team reviews and/or collects surveillance data on all child cases that fall under the jurisdiction of the OCME, aged 0 to 17 years. Infants must be born alive to be identified as an infant for the purposes of CFRT. Since infant death is defined as the death of anyone under the age of 12 months, this means that many of the cases identified in the CFRT could be also reviewed in the FIMRT, which means that there would be a duplication of efforts that may not produce change.

Implement Regional Councils, as done in the past, but instead of operating as before with each regional council being their own entity, have there be state oversight of each regional council, with mandatory reporting requirements and programs within the community.

One option to consider was the implementation of FIMRT, using the previous model used until 2012, with some model changes. Those changes include state oversight, coordinated policy and program implementation, and mandatory reporting requirements. Strengths of this model include:

Local: Teams are local and changes are implemented at the local level, benefiting the population at the community level and thus better able to produce measurable outcomes and reduce rates of fetal and infant death.

Oversight: One of the criticisms of the previous FIMRT team model was that there was minimal oversight at a higher level. Each team operated as their own entity, doing their own reviews, and submitting their own reports. While this has benefits, it created a very fragmented system, where outcomes were difficult to identify and evaluate. Oversight by a state team would provide

systematic approaches to review, standardized policies and procedures, and a reporting structure to maintain accountability.

Regional Teams: Regional teams have been a cornerstone of FIMRT in the past which lead to rich review, as those that are most educated about the community are reviewing the cases. Those that work or have a stake in the community, who understand the social and cultural norms, are beneficial to review as it gives more targeted policy and program recommendations.

Family Interviews: As stated above, family/parental interviews is a large part of fetal and infant death review. Family/parental interviews give insight to the issues, allow for further understanding through asking clarifying questions, allow for problem solving, and gives those that suffered a loss, a voice. This process uses a thematic analysis to understand the problems and potential solutions and is grounded in qualitative research theory, which legitimizes the work.

Natural and unnatural fetal and infant death review: This review option would allow for the review of both natural and unnatural deaths since the cases would be split among the regions. Each region would be responsible for identifying their cases, with the support of the OCME and Office of Vital Records, and reviewing those cases using the established protocol. From these reviews, the teams would enter data into a database for larger use, but also as a way to document their findings. Recommendations would be based on their own reviews.

As before, there are several weaknesses of this plan. Those weaknesses are identified as:

Cost: It is estimated, using previous budget data, coupled with financial data used among other teams, that it would cost approximately $2.5M to $2.75M to implement this level of a fatality review team. A program of this size would require many staff members to develop, implement, and provide administrative and management support of the local and regional teams, local team support to include coordination and management, higher travel costs, and the cost of developing a surveillance system. This estimation also includes administrative costs such as office space, supplies, technology, analysis and database software, and contract services.

Surveillance: To understand fetal and infant death, not only is a fatality review team needed, but there is also the need for a coordinating surveillance program to collect data. The data collected in the surveillance program provides data to teams, creates trends, identifies risk factors and

other variables, and is the quantitative part of the process. A large regional based initiative would require a substantial surveillance program not only requiring a large database, but also the staff to collect, enter, and analyze the data. The surveillance team would also partner with the regional councils and coordinate fatality review data and also develop data dissemination plans.

Implement a Fetal and Infant Mortality Review Team, where only fetal deaths and certain natural infant deaths are reviewed, since the State of Virginia already has an active Child Fatality Review Team that encompasses infant deaths.

Since the State of Virginia already has a CFRT, which reviews deaths of children 0-17 years of age that fall under the jurisdiction of the OCME, another option is to implement a FIMRT where fetal deaths are reviewed, but also infant deaths that do not fall under the purview of the OCME and meet certain case criteria such as deaths due to early prematurity or medical conditions that lead to early death. Strengths of this model include:

Collaboration with MMRT and CFRT: Preconception, prenatal, and postnatal care are all necessary for healthy pregnancies and infancies. Implementing a fetal and infant review team that fills the gaps between MMRT and CFRT, would create a more complete picture of fatalities in Virginia that would be beneficial to multiple stakeholders. The FIMRT would review deaths that do not meet the case criteria for MMRT or CFRT, also reducing duplication. The collaborative nature of this option would allow for the in-depth review of fetal and natural infant death, which could be shared and used by the MMRT and CFRT in order to develop more comprehensive recommendations that could transcend all related topics.

Cost: Modeling after the CFRT and MMRT, with some additions, this model is cost effective and would provide the oversight, review, and surveillance necessary to understand issues surrounding fetal and infant death in Virginia. The estimated cost of a Virginia FIMRT is approximately, $350,000 per year. This cost is higher than the CFRT and MMRT due to the higher caseloads, larger surveillance need, and the addition of qualitative interviews with families.

Model: The model is evidence-based and has been working in Virginia since the early 2000s. This model has been verified, is familiar, and effective in producing fatality review data.

Surveillance: Surveillance is already embedded into this process and a separate surveillance program would not need to be developed.

Family Interviews: As stated above, family/parental interviews are a large part of fetal and infant death review. Family/parental interviews give insight to the issues, allow for further understanding through asking clarifying questions, allow for problem solving, and give those that suffered a loss, a voice. This process uses a thematic analysis to understand the problems and potential solutions and is grounded in qualitative research theory, which legitimizes the work.

Advisory Group: Historically, review team members develop recommendations and share data with stakeholders and community members as needed and spread this information through formal and informal networks. This proposed option would allow for the development of an advisory group that would support the team by advocating for change, but also adding input to case review topics. This group would also assist with sustainability and holding the team accountable. It is anticipated that the advisory group would meet one to two times a year to discuss data trends, recommendations, and provide insight. This group would be different than the review team and could include family members, public health officials, medical personnel, etc.

The weaknesses of this plan are identified as:

Targeted Reviews: Due to the high numbers of cases, the reviews would need to be much targeted since the team can only review approximately 30 cases per year. Limited and strongly targeted reviews can create gaps in policy and program implementation, create silos amongst agencies, and limit the ability to implement programs and policies.

Recommendations: Recommendations are a feature of the fatality review process. Using a thematic approach, vetting procedures, and collaborative processes recommendations are drafted from each child fatality or maternal mortality review. Recommendations are designed to be carried out by an identified entity. One of the weaknesses of fatality review is the lack of a feedback loop to assess the implementation or evaluate the implemented outcomes due to the structure of fatality review teams in Virginia. The team is not responsible for implementing the recommendations, but instead support and advocate for them with other community

stakeholders. This lack of implementation or carry through produces very few measurable outcomes.

Decision of the Fetal and Infant Mortality Workgroup

After in-depth discussion of each option, the workgroup voted on the model they determined would be most beneficial in the state, taking into consideration time, cost, definitions, etc. The results of the poll identified that Option 3: Implement a Fetal and Infant Mortality Review Team, where only fetal deaths and certain natural infant deaths are reviewed, since the State of Virginia already has an active Child Fatality Review Team that encompasses infant deaths as the recommendation for legislation. Eighty-two percent of the FIMRT Workgroup identified this option as the most viable option. The rest of this report will focus on the development, implementation, and evaluation of FIMRT where the focus will be fetal and natural infant death.

Team Development, Implementation, and Evaluation

In order to fully execute a Team, several items must be considered. Those include the draft legislation, proposed budget, reporting, and the follow-up on the implementation and evaluation of recommendations, which come from the report(s). Other considerations such as timelines for implementation, case selection, and other items must be considered by the General Assembly prior to codifying this team.

Methods for collecting information about fetal and infant death in the Commonwealth

Epidemiological surveillance is the systematic collection, analysis and dissemination of health data for the planning, implementation and evaluation of public health programs. Surveillance data is broader than fatality review data and can be used in a variety of ways. Most commonly the data is shared with stakeholders, community members and used in reports and articles to describe special topics or a topic in general. Fetal and infant mortality data for this project will be collected using a validated tool developed by the OCME, Division of Death Prevention. An example is available upon request due to the size of the file. The tool will be modeled after the tool used by the child fatality and maternal mortality review teams.

Initial data will be drawn from the Virginia Office of Vital Records. This will include identifying cases that meet the case criteria for FIMR. This will include all fetal deaths and

natural infant deaths, of Virginia residents who died in Virginia. The Office of Vital Records is the entity that houses this data and will provide the fetal, birth, and death records. Upon receiving the records, using the tool, the OCME will request records and/or other documents available to complete the tool. Data will then be entered into Redcap or another similar database for use. Data will also be uploaded into the OCME Dashboard as appropriate. This database will also be used to house additional data that comes from the reviews or to identify cases for review.

Definition of a fetal death for the purpose of review

The workgroup decided that for the purposes of this fatality review process, the definition of fetal death is any fetal death, regardless of gestational age, where a record is available in the Office of Vital Records. The justification for this definition is that there can be systematic, health, or other reasons for a fetal demise, even in the early weeks of pregnancy that could be useful to review. Early pregnancy loss can be associated with many factors, including a lack of preconception care, substance use, or injury that could be beneficial to understand.

Criteria for the selection of deaths for review

There are approximately 1,000 fetal and infant deaths per year. The large number of cases make it impossible to review every case, in every review cycle. A team can only review approximately 30-40 cases per year. Due to this inability to review all cases, the workgroup decided that all fetal and natural infant deaths will be surveilled, but only certain cases will be reviewed. Using data trends found in the surveillance data or using national trends, criteria will be developed and only those cases that meet criteria will be reviewed. For example, if the data is showing a high rate of premature birth in women who live in a particular region, then those cases will be reviewed in that FIMRT review cycle and all others will be excluded. A review cycle is approximately two to three years based on the complexity of the cases being reviewed.

Before identifying a case for review, the data that is produced by the FIMRT Program at the OCME will be shared with the Advisory Group. The group will discuss the data, the need for a particular review, or other items that will assist in the development of the topic for the review cycle. The model is designed to allow not only for statistical data, but also for personal and professional experiences to be used to develop the topic for review. This will ideally ensure that the review is useful at the local level and takes into consideration cultural, societal, and professional input.

Criteria for the selection of deaths for which additional voluntary qualitative interviews will be conducted

Family interviews are part of the review process that sets the FIMRT apart from other fatality teams. This unique process is designed to reveal the mother's (although fathers and other guardians can participate) perspective on the fetal or infant death. It is designed to shed light on the factors of the death and provides community-specific information that can often not be found in Vital Records or other data points, such as medical or social service records.

The workgroup decided that family interviews should be a part of the process, but not all deaths will require or be offered an interview. Cases where there is incomplete data or extenuating circumstances that warrant an interview, will be offered an interview. When an interview is offered, a trained interviewer will speak to the mother (or other family member), and collect data. Interviewers will be trained using trainings from the National Fetal and Infant Mortality Center as well as be trained in trauma informed interviewing.

Additionally, if needed, interviewers will be able to connect families to resources in their community. The interview may bring up memories and trauma or create new issues and the interviewer will be prepared to offer resource support as needed. The hope is that interviewers will be able to make partnerships with community-based groups and agencies that would be able to provide support to the mother or other family members, including other children.

A five-year implementation plan

Unfortunately, the workgroup was unable to reach a consensus on an implementation plan, given the many unknown factors associated with this work. The workgroup did acknowledge that the first one to two years of implementation will include hiring staff, developing review team policies, developing the surveillance system, identifying cases for surveillance, surveilling those cases, building partnerships, and identifying team members and advisory team members and bringing those groups together for training. It is anticipated that the first review cycle will not begin until late 2024 at the earliest, if this was passed during the 2022 General Assembly session, with the first review team report available in 2027. Status reports will be available each year, starting in 2023.

Draft Legislation (including procedures for maintaining confidentiality)

The workgroup drafted legislation and identified the following keys aspects of the code: definition of fetal death, operating procedures of the team, team memberships, confidentiality measures and reporting requirements. The workgroup also identified key aspects such as the advisory panel and family interviews. A copy of the draft legislation can be found in Appendix D.

Estimated Budget

The estimated budget for this Team includes salaries, fringe benefits, travel for meetings and training, costs associated with family interviews, and administrative costs such as computers, software, and dashboard development for the housing of data. The estimated budget to implement and sustain this team is $353,197.00 per year. These costs are similar to the costs associated with the Child and Maternal Mortality Review teams. The following is a narrative of the associated costs. For a line item budget, refer to Appendix E.

Salaries

This team will require three FTEs for a Program Manager, Research Associate, and one Research Assistant. The Program Manager is responsible for project oversight and review team facilitation, as well as data analysis, reporting, and evaluation. The Program Manager will also facilitate the advisory group and conduct family interviews and provide support to stakeholders and community members. The Program Manager is a high level position, in which the incumbent holds a Doctorate degree or a Master's degree with five to seven years of related experience.

The Research Associate is responsible for coordinating the surveillance efforts of the team, which includes data collection, data entry, data analysis, assisting with reporting, and other related duties. Due to the topic of this team, the Research Associate must have a high level of clinical knowledge, as well as research experience and will need a clinical or science related degree and one to three years of experience coordinating research projects.

The Research Assistant will be responsible for data collection, entering data, review team administration, note taking, and general duties as assigned. The Research Assistant is an entry level position and would need a Bachelor's degree in a related field.

Fringe Benefits

As classified employees of the Commonwealth, fringe benefits for these positions include: FICA, retirement, group life, retiree medical benefits, long term disability, health care premiums, and deferred compensation match.

Travel

Travel is a routine function of review team members, staff, and interviewers. The travel funds for this project include travel to conduct family interviews and/or support review team members' travel to participate in review team meetings. Depending on travel location, review team members are reimbursed for hotel, per diem, mileage, and/or parking expenses.

Data Dashboard

The OCME Data Dashboard is currently in development. This public, forward-facing, web-based, interactive dashboard will house all the data from the review team and the surveillance program. This data will be made available to stakeholders and community members for their own use. Data sharing is a routine part of review team and surveillance functions and this allows those that want data to access data efficiently and as needed, without needing to request it from the program manager. Additionally, data in the dashboard will be shared with the advisory group that will be developed.

Other

Other expenses include computers and analysis software such as SPSS, ArcGIS, and NVivo. This software is necessary to analyze surveillance data, identify themes from interviews, and provide reports. Transcription is necessary as interviews are qualitative and need to be transcribed in order for the data gleaned from the interviews to be used.

Recommendations

Despite the data that indicates the need for a FIMRT, and the national push for FIMRT and related projects (MMRT and CFRT) there are several considerations when deciding on codifying, developing, and implementing a fetal and infant mortality review team in Virginia.

Sustainability

Creating a team, with adequate staff and financial resources is necessary, but the sustainability of the team must be considered. Sustainable teams are those teams that grow, adapt, and change as the "science" changes. The OCME has a long history of creating sustainable teams. The CFRT and MMRT have been in existence for almost two decades and have reviewed hundreds of cases. The coordinating surveillance work has become one of the go-to programs for data in the Commonwealth and the program managers are the subject matter experts, with a presence in the community, locally and nationally. While the teams have been sustainable, they would not be without adequate funding. A FIMRT is a costly team, with several large line items. While the work is necessary, it cannot be conducted without adequate financial support. Leveraging funding and appropriate levels of funding secure the necessary workforce and team support to sustain the team and creates longevity.

It is recommended that the team receive full funding and not partial or an unfunded mandate, as the work that is necessary will not be able to be completed. For example, if partial funding only allows for a program manager, the surveillance data will not be collected as the program manager will not have the capacity to do both the work needed to facilitate a team (record requests, reviews, summaries, meeting, data analysis, etc.) and collect, enter, and analyze data. Due to the nature of this work, there is no way to collect all the necessary surveillance data without a dedicated person.

Additionally, if this mandate was unfunded, no work would be done on this topic. Without funding, staff, and other necessary budgetary needs, a team cannot operate. The OCME does not have the financial or staffing capacity to support the work without additional funding. All OCME staff are already assigned to other projects, with full FTEs and the needs of their projects preclude them from assisting with this effort. Dedicated funding is also needed, since

funding sources such as grants and other streams are not guaranteed and it would be detrimental to start this work and not be able to conduct or finish it due to funding.

One way to sustain the team is to leverage funding, if there is funding available, but at this time, there is no funding available. Talks with other agencies and departments have not generated the funds to implement or sustain this work. While some funding could be available, it is not at the necessary level and could also be removed, based on the other entities funding needs or changes to their funding requirements. It would be best if the funding for this project came from General Funds. While those funds can change, they are more stable than grant funds or pass through funding.

Partnerships

One area of concern with previous FIMRT work is that there was not a connection between the teams and evaluation data showing the work improved outcomes. This is also a pervasive problem within other review teams. Based on how teams operate, they are not programmatic and their sole purpose is to review cases, report findings, and make recommendations. The teams are not programmatic, which means the implementation of all recommendations falls on those identified in the recommendations.

It is recommended that the FIMRT partner with a programmatic entity (e.g. VDH Office of Family Health Services or the Virginia Neonatal Perinatal Collaborative) to implement the recommendations or partner with identified individuals or agencies to implement the recommendations. As a programmatic entity, they would be better suited to support and implement the recommendation, but they would also be poised to collect evaluation data to analyze to determine the impact on outcomes. Additionally, they would be able to conduct evaluations that would allow them to change the program or recommend other policy, based on needs of the community or the agency. The most common is Plan-Do-Study-Act (PDSA) evaluations, which is a rapid-cycle evaluation process aimed at identifying the problem, implementing change, evaluating change, and making change in a cyclical pattern.

Partnerships will also be needed to provide support, if needed, to individuals and/or families who need support following a family interview. The goal of this partnership is to be able to directly link families to the resources and not just provide possible avenues of support.

The goal is a "warm handoff" to a person, program, or agency, who can then support the individual or family as needed. The development of these partnerships will be ongoing.

Regional and Local FIMRTs

A state FIMRT team is needed and would be beneficial, but an additional need is the development of local and regional FIMRTs, similar to the regional child fatality, domestic violence, or overdose review teams currently in statute. Local and Regional teams are beneficial in that it brings together those that were directly involved in the case to the review process. The personal insight allows for better review and recommendation development because those at the table know the culture, norms, and other aspects of the community that would lead to successful recommendation development and implementation. State teams have value, but they do not know the "ins and outs" of particular communities that could impact the success of programs in the community. While they can create larger, overarching recommendations that could benefit all, local and regional teams are concerned with their community and thus, their recommendations are directly tied to the needs of their community, which often produces outcomes that create greater change.

In addition, these local and regional teams would support an expansion of the state team, which is in line with the traditional FIMRT model and the model that was present in Virginia until 2012. Regional and local teams could also conduct family interviews as they are members of the community and can build better rapport with families, and this would be a way to increase the number of family interviews conducted. Local and regional teams would also be poised to implement state recommendations in their community, with caveats that take into consideration their community, creating a more holistic and larger reaching program than a state team alone.

Conclusion

The importance of a Fetal and Infant Mortality Review is great and necessary in the state. Despite several potential challenges, it is the recommendation of the FIMRT Workgroup to implement a state level FIMRT in Virginia that would focus on fetal and natural deaths, as these are populations that are not currently being reviewed by the Child Fatality and Maternal Mortality review teams. Coupled with a robust epidemiological surveillance program, a FIMRT could broaden the scope of fatality review and also have the ability to make meaningful change

with the right partnerships and support to be sustainable. The work of the FIMRT would also cross boundaries and support other fatality review teams, support the development of local and regional efforts and support local communities affected by higher rates of fetal and natural infant death. The purpose of fatality review is to take the tragedy of death and dying and make positive and meaningful change and a FIMRT would be an asset to this public health prevention model.

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Appendix A: Members of the FIMRT Workgroup

William T. Gormley, MD, PhD

Chief Medical Examiner

Office of the Chief Medical Examiner
Virginia Department of Health

Ansley Perkins

Child Fatality Specialist (former)

Department of Social Services

Ryan Diduk-Smith, PhD, MPH

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Shannon Pursell, MPH

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Virginia Neonatal Perinatal Collaborative
Virginia Commonwealth University Health

Keshia Singleton

State Project Manager

Office of the Chief Medical Examiner
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Jennifer MacDonald, MPH

Director for Division of Maternal and Child Health

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Melanie Rouse, PhD

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Certified Professional Midwife

EVa Home Birth

Dane De Silva, PhD

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Amara Minnus

Doula

Amara's Childbirth Education and Doula Services

Alexis Aplasca, MD

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Misty Ward, CPM

Certified Professional Midwife

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Barbara L. Kahler, MD, FAAP

Pediatrician

Virginia Chapter of the American Academy of Pediatrics

Katie Page

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Christian Chisholm, MD

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Kelly Cannon

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Kenda Sutton-El

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Birth in Color RVA

Nicole Lawter

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Sydney Wooten, MS

FIMRT Workgroup Research Assistant

Office of the Chief Medical Examiner
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Alison Hicks, MPH

Maternal Health Program Manager

Virginia Hospital & Healthcare Association

Appendix B: Invitation Letter

Dear

I am writing on behalf of Dr. Gormley, Virginia's Chief Medical Examiner. House Bill 1950 (HB1950) was presented during the 2021 General Assembly session and passed. The Bill mandates that the Office of the Chief Medical Examiner (OCME) coordinate a work group to study the feasibility of implementing a Fetal and Infant Mortality Review Team (FIMRT). Therefore, the OCME is hosting a meeting for key stakeholders to discuss the possibility of instituting a FIMRT in Virginia. The Bill is attached for your reference.

HB1950 directs the OCME to convene a work group to develop a plan for the establishment of a FIMRT and to report such plan to the Chairmen of the House Committees on Appropriations and Health, Welfare and Institutions and the Senate Committees on Finance and Appropriations and Education and Health by December 1, 2021. The OCME is further directed to address the following items, as able:

1. Methods for collecting information about fetal and infant death in the Commonwealth;
2. The definition of a fetal death for the purpose of review;
3. Criteria for the selection of deaths for review;
4. Criteria for the selection of deaths for which additional voluntary qualitative interviews will be conducted;
5. Procedures for maintaining confidentiality; and
6. A five-year implementation plan.

The meeting is scheduled for Monday, March 29, 2021 from 10:00am to 1:00pm. The meeting will be hosted on Zoom. Please follow this link to register for the meeting: https://us02web.zoom.us/meeting/register/tZIuf-mhrDovHdKk2zNrFca9yantFmFDPhH1

Some questions that we would like you to think about and come prepared to discuss:

1. What do you know about Fetal and Infant Mortality Review Teams?
2. Is your agency impacted by fetal and/or infant deaths and how so?
3. How do you define fetal death in your agency?
4. Are you or your agency poised to support a FIMR team and how so?
5. Do you foresee any immediate challenges implementing a FIMR team?
6. Are there other stakeholders who should be included in this meeting (please see below)?
    a. Office of the Chief Medical Examiner (VDH)
    b. Office of Family Health Services (VDH)
    c. Office of Vital Records (VDH)
    d. Behavioral Health and Developmental Services
    e. Department of Social Services
    f. Department of Criminal Justice Services
    g. Virginia Hospital and Health Care Association

h. Virginia Chapter of the American College of Obstetrics and Gynecology
i. The Virginia Chapter of the American Association of Pediatrics
j. Virginia Affiliate of the American College of Nurse-Midwives
k. Virginia Neonatal Perinatal Collaborative

Can you let me know who from your organization will attend this meeting? Also, if there are additional stakeholders that you feel should be considered for this meeting, please let me know.

For planning purposes, the deadline to register is Thursday, March 25. Thank you for your attention to this important matter and I look forward to meeting with you or your designee on March 29. Please don't hesitate to contact me should you have additional questions or concerns.

Sincerely,

Ryan Marie Diduk-Smith, PhD, MPH
Director, Division of Death Prevention
Office of the Chief Medical Examiner
Virginia Department of Health

Appendix C: Workgroup Agendas

HB1950

Fetal and Infant Mortality Review Team Workgroup

March 29, 2021 10:00am – 1:00pm

Agenda

I. Introductions and Review of Agenda

II. Provide overview of the issue

III. Fatality Review in Virginia

a. Maternal Mortality (Dr. Melanie Rouse)
b. Infant and Child Fatality (Dr. Dane De Silva)

IV. Overview of FIMRT

a. National Initiatives
b. Operating Principles
c. Purpose
d. Approach

V. Discussion questions

a. What do you know about Fetal and Infant Mortality Review Teams?
b. Is your agency impacted by fetal and/or infant deaths and how so?
c. How do you define fetal death in your agency?
d. Are you or your agency poised to support a FIMRT and how so?
e. Do you foresee any immediate challenges implementing a FIMRT?
f. Do you work with any other fatality review teams?
    i. How do you foresee these teams working together?

VI. Establish further actions needed and future meetings

VII. Adjourn

HB1950

Fetal and Infant Mortality Review Team Workgroup

April 27, 2021 10:00am – 1:00pm

Agenda

I. Introductions and Review of Agenda

II. Overview of Meeting Ground Rules

III. Approval of Meeting Minutes from March 29, 2021

IV. History of FIMRT in Virginia (Shannon Pursell)
See attached materials for further information on the history of FIRMT in Virginia

V. Discussion questions

a. From what we have learned about FIMRT in Virginia, what are the biggest challenges we face?
b. From what we have learned about FIMRT in Virginia, what are the strengths that we can learn from and use in a FIMRT?
c. How should we define fetal death in Virginia?
d. What data sources do we have available to the FIMRT team?
e. What data sources do we need, if they are not available to us?

VI. Establish actions or steps for future meetings

a. Meeting dates (last Tuesday of the month, 10am-1pm)
i. May 25
ii. June 29
iii. July 27

VII. **Adjourn**

VIII. **Attachments:**

a. Perinatal Council Evaluation Report
b. FIMR Historical Report
c. FIMR Commissioner Packet
d. Meeting Minutes from March 29, 2021

HB1950

Fetal and Infant Mortality Review Team Workgroup

May 25, 2021 10:00am – 1:00pm

Agenda

I. Introductions and Review of Agenda

II. Questions or follow-up from the last meeting

III. Approval of Meeting Minutes from April 27, 2021

IV. Overview of Vital Statistics Data

V. Breakout Discussion Groups (1 hour)

Groups may not get to all topics within the hour. Any remaining questions will be addressed in the next meeting.

a. Moderators:
   i. Breakout Group 1: Shannon Pursell
   ii. Breakout Group 2: Ryan Diduk-Smith
   iii. Breakout Group 3: Melanie Rouse

b. Discussion questions
   i. In the first year of FIMRT what should be the priorities?
      1. What would the timeline entail?
   ii. How do we fund FIMRT and how do we ensure sustainability?
   iii. As a state team how should we work with the localities?
      1. What would be their role?
      2. Which localities needs to be brought to the table?

   iv. Who should be interviewed?
      1. Who does the interviews?
      2. What are the needs of interviewers?
      3. What are the needs of families or how do we meet the needs of the families who are interviewed? Especially if there is past trauma and grief that rises?
   v. What cases do we review?
      1. How far back?
      2. How do we decide which cases to review?
   vi. How often should reports be generated?
      1. Annually?

2. Biannually?
3. Triennially?
4. What kind of reports? All data or special topics?

vii. What is needed or how should the state team translate the findings and recommendations in the report to action?
1. What support is needed?

VI. Presentation from Breakout Groups and Group Discussion

VII. Establish actions or steps for future meetings

a. Meeting dates (last Tuesday of the month, 10am-1pm)
i. June 29
ii. July 27
iii. August 31

VIII. Adjourn

IX. Attachments

a. Meeting minutes from 04/27/2021
b. Fetal and Infant Death in VA slide
c. Fetal and Infant Death in VA excel file
d. Vital Statistics Fetal Death Record

HB1950

Fetal and Infant Mortality Review Team Workgroup

July 27, 2021 10:00am – 1:00pm

Agenda

I. Introduction: Sydney Wooten, FIMRT Workgroup Research Assistant

II. Questions

III. Timeline

IV. Overview of implementation options and vote

V. Establish actions or steps for future meetings
   a. Meeting dates (last Tuesday of the month, 10am-1pm)
      i. August 31
      ii. October 26 (skip September)

VI. Adjourn

VII. Attachments
   a. Agenda
   b. FIMRT Matrix of FIMRT in US
   c. Meeting PowerPoint

Appendix D: Fetal and Infant Mortality Review Team; duties; membership; confidentiality; penalties; report; etc.

A. This chapter does not apply to the review of a fetal death that is the result of a voluntary or therapeutic termination of pregnancy. As used in this section, "fetal death" shall be defined as it is defined in VA Code 32.1-258.1. An Infant is any child under the age of 12 months.

B. There is hereby created the Fetal and Infant Mortality Review Team (the Team), which may develop and implement procedures to analyze fetal and natural infant deaths using public health and epidemiological methods for fatality review with the purpose to decrease the incidence of preventable fetal and natural infant deaths through the development of policy and programmatic recommendations. The Team shall coordinate with the State Child Fatality Review and Maternal Mortality Review teams to avoid duplicative work. The Team may review fetal and natural infant deaths filed with the Virginia Department of Health's Office of Vital Records, excluding those fetal deaths resulting from a voluntary or therapeutic termination of pregnancy. The Team shall not initiate a fetal or natural infant death review until the conclusion of any law-enforcement investigation or criminal prosecution. The Team shall (i) develop and revise as necessary operating procedures for fetal and natural infant death reviews, including identification and defining sets or subsets of cases to be reviewed and procedures for coordinating among the agencies and professionals involved; (ii) improve the identification of and data collection and record keeping related to causes of fetal and natural infant deaths; (iii) recommend components of programs to increase awareness and prevention of and education about fetal and infant deaths; and (iv) recommend training to improve the review of fetal and natural infant deaths; (iv) develop recommendations to better assess the service systems and broad community resources that support and promote the health and well-being of women, infants, and families; (v) recommend plans for implementing state service and program changes, as well as changes to the groups, professions, agencies, and entities that serve families, children, and pregnant women; (vi) develop plans for evaluating state service and program changes, as well as changes to the groups, professions, agencies, and entities that serve families, children, and pregnant women that result of the Team; (vii) provide aggregate data, trends, and patterns regarding fetal and infant deaths to stakeholders, as requested. Such operating procedures shall be exempt from the Administrative Process Act (§ 2.2-4000 et seq.) pursuant to subdivision B 17 of § 2.2-4002.

C. The Team shall consist of the following persons or their designees: the Chief Medical Examiner, the Director of the Office of Family Health Services, the State Registrar of Vital Records, the Commissioner of Behavioral Health and Developmental Services, the Commissioner of the Department of Social Services, and the Director of the Department of Criminal Justice Services or their designees, and (a) the Presidents of the Virginia Hospital and Healthcare Association, the Virginia Chapter of the American College of Obstetrics and Gynecology, the Virginia Chapter of the American Association of Pediatrics, and the Virginia Affiliate of the American College of Nurse-Midwives, or their designees; (b) the Director of the Virginia Neonatal Perinatal Collaborative or their designee; (c) representatives of community stakeholders such as doulas, local nonprofit organizations, mental health treatment providers, and other community stakeholders; (d) representatives of medical professionals with experience in fetal, infant, or maternal health; and (e) staff and members of such state agencies as may be appropriate. The Chief Medical Examiner shall serve as the chair of the Team. As chair of the Team, the Chief Medical Examiner may appoint a co-chair of the Team.

D. Upon the request of the Chief Medical Examiner in his capacity as chair of the Team, made after the conclusion of any law-enforcement investigation or prosecution, the Chief Medical Examiner or his designee may request copies or inspect and copy information and records regarding a fetal or infant death, including (i) any report of the circumstances of the death maintained by any state or local law-enforcement agency or medical examiner, and (ii) information or records about the mother and family maintained by any social services agency, attorney for the Commonwealth, or court, (iii) any presentence report prepared pursuant to § 19.2-299 for any person convicted of a crime that led to the death of the fetus or infant, (iv) any report or records from any healthcare provider, including mental health, pediatric, and prenatal records regarding the fetus or infant in the Commonwealth.

E. With the consent of the mother, father, or other legal guardian when deemed appropriate, trained interviewers on behalf of the Chief Medical Examiner may conduct interviews of any person deemed necessary to the investigative work of the Team. Any record of the interview or interviews shall be treated the same as any other record related to the work of the team under subsection F of this section.

F. An advisory panel shall be convened at a minimum of one time per fiscal year to discuss data trends, recommendations, case selection, and other items related to fetal and natural infant death. Upon invitation by the chair or co-chair, the panel will consist of grassroots organizations, community members, parents who have experienced a fetal or natural loss, state agencies not involved in the review team, emergency medical personnel, mental health, and other professionals with knowledge and a vested interest in fetal and infant death.

F. All information and records obtained or created by the Team or on behalf of the Team regarding a review shall be confidential and excluded from the Virginia Freedom of Information Act (§ 2.2-3700 et seq.) pursuant to subdivision 7 of § 2.2-3705.5. All such information and records shall be used by the Team only in the exercise of its proper purpose and function and shall not be disclosed. In preparing information and records for review by the Team, the Department shall remove any individually identifiable information or information identifying a health care provider, as those terms are defined in 45 C.F.R. § 160.103. Such information shall not be subject to subpoena, subpoena duces tecum, or discovery, be admissible in any civil or criminal proceeding, or be used as evidence in any disciplinary proceeding or regulatory or licensure action of the Department of Health Professions or any health regulatory board. If available from other sources, however, such information and records shall not be immune from subpoena, discovery, or introduction into evidence when obtained through such other sources solely because the information and records were presented to the Team during a fetal or infant death review. The findings of the Team may be disclosed or published in statistical or other form, but shall not identify any individual. Upon conclusion of the fetal or infant death review, all information and records concerning the case shall be shredded or otherwise destroyed by the Office of the Chief Medical Examiner in order to ensure confidentiality.

The portions of meetings in which individual fetal or natural infant deaths are discussed by the Team shall be closed pursuant to subdivision A 21 of § 2.2-3711. In addition to the requirements of § 2.2-3712, all Team members shall execute a sworn statement to (i) honor the confidentiality of the information, records, discussions, and opinions disclosed during meetings at which the Team reviews a specific infant or fetal death and (ii) not use any such information, records, discussions, or opinions disclosed during meetings at which the Team reviews a specific fetal or

infant death for any purpose other than the exercise of the proper purpose and function of the Team. Violations of this subsection are punishable as a Class 3 misdemeanor.

G. Upon notification of a fetal or infant death, any state or local government agency maintaining records on the woman or the woman's family that are periodically purged shall retain such records for the longer of 12 months or until such time as the Team has completed its review of the case.

H. The Team shall (1) compile a triennial statistical data report and may include policy recommendations where appropriate consistent with the goals of the team as specified in 32.1-283.9.(B) and (2) compile a brief annual report containing data, recommendations, and/or team related updates, which shall be made available to the Governor and the General Assembly. Any reports prepared by the Team shall be public record and shall not contain any personal identifying information.

I. Members of the Team, as well as their agents and employees, shall be immune from civil liability for any act or omission made in connection with participation in a review by the Team, unless such act or omission was the result of gross negligence or willful misconduct. Any organization, institution, or person furnishing information, data, testimony, reports, or records to the Team as part of such review shall be immune from civil liability for any act or omission in furnishing such information, unless such act or omission was the result of gross negligence or willful misconduct.

J. Upon inclusion in a general appropriation act adopted by the General Assembly of funds for such purpose, the Department of Health shall hire such contract staff as may be necessary to assist the Team created pursuant to § 1 of this act.

Appendix E
Commonwealth of Virginia
Virginia Department of Health
Office of Chief Medical Examiner

Summary of Amount Requested **$353,197**

Fetal and Infant Mortality Review Team

A.	**Personnel**				**$0**
					$196,500
		Annual	**Time**	**Months**	**Amount Requested**
	Position Title: FIMRT Projects Coordinator	$75,000	100%	12	$75,000
	Position Title: FIMRT Research Assistant	$45,000	100%	12	$45,000
	Position Title: FIMRT Research Assistant	$45,000	100%	12	$45,000
B.	**Fringe Benefits**				**$125,793**
	Salaries:				
	FICA @ .0765				$15,032
	Retirement @ .0876				$17,213
	Group Life @ .0119				$2,338
	Retiree Medical Health Benefit @ .01				$1,965
	Long Term Disability @ .0047				$924
	Health Care Premiums @ $1800/month * 12 months *4				$86,400
	Deferred Compensation Match @ $40/month				$1,920

C.	**Travel: All travel calculations based on current and average rates for Virginia.**	**$4,200**
	(1) Mileage for family interviews (2500 miles per year*.56/per mile)	$1,400
	(2) Mileage for routine meetings and review team members (5000 miles per year*.56/per mile)	$2,800
D.	**Equipment**	**$0**
E.	**Office Supplies**	**$1,500**
F.	**Contractual Costs**	**$18,304**
	(1) Transcription services for family interviews	$1,500
	(1) Dashboard Provider	$10,000
	(2) Full Service PC Desktop is $189 per month * 12 months * 3	$6,804
G.	**Construction**	**$0**
H.	**Other**	**$6,900**
	(1) SPSS for 4 staff ($800/year*3)	$2,400
	(2) Arc GIS	$2,000
	(3) NVivo	$2,500
I	**Total Costs for FIMRT (estimated)**	**$353,197**

Acknowledgements

HB1950 was introduced by Delegate Ayala. Proponents of the legislation were Birth in Color RVA and NARAL. https://lis.virginia.gov/cgi-bin/legp604.exe?212+sum+HB1950

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