



**Montgomery County, Maryland
Fetal & Infant Mortality Review Board Community Action Team
Fiscal Year 2018 Annual Report**



A poor pregnancy outcome or infant death is a loss for our entire community. The Montgomery County, Maryland Fetal & Infant Mortality Review Board process helps us to understand the reasons behind fetal loss or the death of an infant, and recommends actions designed to improve pregnancy outcomes. Our goal in Montgomery County is to see all babies born healthy.





TABLE OF CONTENTS

MESSAGE FROM HEALTH OFFICER.....	3
LETTER FROM CO-CHAIRS OF FIMR BOARD and CAT.....	4
ACKNOWLEDGEMENTS.....	6
FIMR BOARD and COMMUNITY ACTION TEAM MEMBERS.....	7
FIMR BOARD and COMMUNITY ACTION TEAM VISION, MISSION & GOALS.....	8
CASE REVIEWS and EMERGING TRENDS IN FETAL / INFANT LOSS.....	9
RECOMMENDING CHANGE AND TAKING ACTION.....	15
PRIORITIES FOR FISCAL YEAR 2019.....	16
APPENDIX A.....	17
APPENDIX B.....	20

**MESSAGE FROM MONTGOMERY COUNTY HEALTH OFFICER
TRAVIS GAYLES, MD PhD**



It is often said that the health of a community can be summarized by the number of infants born there who reach their first birthday.

Montgomery County is no exception, and it is through the work of the Fetal & Infant Mortality Review (FIMR) Board and its Community Action Team (CAT) that key issues related to fetal / infant mortality and racial disparities are identified and addressed.

This Annual Report was created as a way to share highlights of these efforts during Fiscal Year 2018.

I would like to extend my sincere appreciation to the FIMR Board and CAT members, and to all community members who share our goal of reducing fetal and infant loss. Thank you for your expertise and steadfast commitment to improving the lives of women and infants in our community.

The FIMR Board and CAT rely on health care providers, hospitals, community agencies, public and private institutions, and individuals who provide ongoing support.

During the past year, our teams worked with a variety of community partners to increase awareness of fetal and infant mortality, identify factors that contribute to these losses, and advocate for needed changes.

Montgomery County has seen steady improvement in reducing its overall infant mortality rate, which declined to a rate of 5.1 in 2012-2016 from 5.3 a decade ago. While we recognize the progress made so far, much remains to be done.

We continue to face persistent racial disparities in Montgomery County, with Black / African American women more than twice as likely to experience fetal or infant loss than women of other races.

If significant and lasting change is to be accomplished, we must continue to engage in activities to improve birth outcomes and give all infants of all races the best possible start in life.

Thank you for joining us on this journey, and we look forward to continuing this important work together in the year ahead.



LETTER FROM THE CO-CHAIRS OF THE FIMR BOARD and COMMUNITY ACTION TEAM

August 30, 2018

On behalf of the Montgomery County Fetal and Infant Mortality Review (FIMR) Board and its Community Action Team (CAT), we are pleased to share the Fiscal Year 2018 FIMR/CAT Annual Report. We are grateful for the many hours given by expert volunteers under the leadership of DHHS Program Manager Sheilah O'Connor.

The death of a baby or a pregnancy loss is a trauma to the mother, the family and in many ways, the entire community. Often, there are few clues to determine exactly what happened. The FIMR process provides an evidence-based and action-oriented community process that looks closely at trends in infant and fetal losses, maternal characteristics and pre-conception health factors. We also seek to understand the long-standing racial disparity which has disproportionately affected the Black/African-American community.

The March of Dimes recently issued a statement stating: *"We believe that environmental factors like stress can play a role in pregnancy outcomes..."*. The idea of stress, arising from factors that include long-standing racism, depression or financial insecurity, has been discussed in our FIMR/ CAT meetings, and we will continue this important dialogue. This type of critical thinking is key to understanding the disparity problem.

In spite of the fact that Montgomery is one of the healthiest counties in the nation, significant disparities in birth outcomes continue, with Black/African-American rates of infant mortality more than twice that of their white counterparts. But unlike many other jurisdictions in Maryland and across the United States, many of the mothers who experience loss in this County are educated (have completed high school and/or college), are insured and started prenatal care early in their pregnancies.

The top risk factors seen consistently during FIMR reviews are obesity, advanced maternal age, and oftentimes a history of a prior pregnancy loss or pre-term birth. For reasons not entirely understood, a significant and overlooked risk factor is simply being Black/African-American.

In a recent speech, the Chief Medical Officer for Planned Parenthood Federation of America, Dr. Raegan McDonald-Mosley said that the disparity "tells you that you (the patient) can't educate your way out of this problem. There's something inherently wrong with the system that's not valuing the lives of black women equally to white women."

In FY18 our Health Officer, Dr. Travis Gayles, assigned a project to Preventive Medicine Resident Dr. Elizabeth Erickson of the Uniformed Services University at Walter Reed National Medical Center to study maternal mortality and severe maternal morbidity. Dr. Erickson found that while maternal mortality is quite low in our county, severe maternal morbidity was higher than the national rate (2014 data), with all of its potential for prolonged hospitalizations, high medical costs and long-term health consequences.

Similar to infant mortality trends, disparities exist with Black/African-American and Hispanic women being 61% and 46%, respectively, more likely to experience severe maternal morbidity than white women. The national literature suggests that severe maternal morbidity may serve as a proxy measure for quality of maternal care. Dr. Gayles also convened a Focus Group on Infant/Maternal Mortality and Severe Maternal Morbidity. This group will continue to meet as needed to discuss possible solutions and innovative approaches.

FIMR/CAT recently forged an academic partnership with the University of Maryland School of Public Health Science. Their students conducted a survey to determine the level of awareness in the Black/African-American community about disparity and infant mortality.

Most respondents did not know that just being Black/African-American puts one at increased risk for poor pregnancy outcomes. This survey demonstrated an unmet service need in Public Health.

This past year, Ms. O'Connor conducted maternal interviews on the vast majority of cases presented to the FIMR Board. These interviews are an important component of the FIMR process, as they often give voice to the disenfranchised and the mothers lost in grief, providing a rare opportunity for community providers to hear from the consumer.

A recent Opinion Summary issued by the American College of Obstetrics and Gynecology (ACOG) recommends low-dose aspirin use during pregnancy for those women at high risk for preeclampsia. A summary can be found in the appendix of this document. While the ACOG opinion does not directly mention the racial disparity risk, it defines high risk conditions that include diabetes, high blood pressure and obesity, all of which are more prevalent in the Black/African-American community. Advances such as this may help to reduce the disparity.

It will also take dedicated resources at the local level to encourage community engagement, with regular and ongoing outreach to raise awareness in affected populations and among medical providers. This is a call to action to encourage the community and physicians to take an active role in resolving this long-standing health disparity.

FIMR/CAT would like to thank the Montgomery County Department of Health and Human Services Director, Ms. Uma Ahluwalia, and the Health Officer, Dr. Travis Gayles, for their interest and support of our mission and goals. We strongly recommend that staff and budget be earmarked for increased outreach and education in the Black/African-American community, and that targeted case management of Black/African-American pregnant women be considered a top priority for Public Health.

In addition, we strongly recommend a strategy for education and outreach to providers regarding the disparity crisis and the need for emphasis on pre-conception health for all female patients of childbearing age. In closing, we are pleased that Public Health Services received funding for the next three years from the State's Babies Born Healthy Initiative to support efforts to reduce infant mortality in the county.

The Fiscal Year 2018 Annual FIMR Board/CAT Report follows.



ACKNOWLEDGEMENTS

Our sincere thanks to the FIMR Board & Community Action Team Co-Chairs and Members for your efforts during Fiscal Year 2018. We remain grateful to our Members for sharing their professional expertise & perspective, and for their steadfast dedication to reducing fetal & infant mortality and related racial disparities in Montgomery County. Your commitment has improved the lives of women and infants throughout our community.

FIMR BOARD CO-CHAIRS

Richard Margolis, MD
Obstetrician / Gynecologist

Carol Garvey, MD, MPH
Community Advocate
Health Officer, Ret.

Arva Jackson, MSW
Community Advocate

COMMUNITY ACTION TEAM CO-CHAIRS

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Jeanine McGrath, RN, CD (DONA)

By Your Side Doula Services



MONTGOMERY COUNTY, MD FIMR BOARD & COMMUNITY ACTION TEAM (CAT)

OUR VISION

All infants of all races are born healthy in Montgomery County.

OUR MISSION

To increase healthy pregnancy outcomes and address related racial disparities by improving healthcare delivery systems and community resources in Montgomery County.

WHO WE ARE

The **Fetal & Infant Mortality Review (FIMR) Board** is made up of a wide range of health care providers and includes obstetricians, neonatologists and other physicians, hospital nurses, public health nurses and program managers, mental health providers, social workers and insurers.

The **Community Action Team (CAT)** is an advisory / advocacy group that includes dedicated representatives from community non-profits, local and state agencies, youth & parenting groups, bereavement support programs, and a host of other public and private organizations.

HISTORY OF FIMR & CAT

- Established in 1988 by the federal HHS Health Resources & Services Administration in 5 states to identify factors that contribute to fetal / infant loss and to improve local healthcare delivery systems.
- Maryland obtained federal funds to begin its FIMR Program in 1997. The Montgomery County FIMR Board and its Community Action Team were created the following year, in 1998.

FIMR & CAT GOALS

- The Montgomery County, MD FIMR Board is responsible for conducting de-identified reviews of fetal / infant loss among County residents to identify non-clinical factors contributing to poor pregnancy outcomes. The Board then recommends changes to healthcare delivery and community resources. Our goals are to reduce fetal / infant mortality overall, address racial disparities in pregnancy outcomes and promote good preconception health.
- Recommendations are not for individual cases, and FIMR CAT provide no case management or other direct services.
- FIMR Board Reviews include:
 - + Social Determinants that Likely Impacted the Pregnancy
 - + Healthcare System Successes & Failures
 - + Key Recommendations



FIMR reviews are never about naming names or assigning blame. We do not identify the infant, mother, father or other relatives, nor do we name her physician or other providers, hospitals or other healthcare facilities. The review process is designed to identify system-wide issues that need to be addressed, and to recommend changes that will accomplish this. There are typically between 100-130 fetal & infant losses each year in Montgomery County. Fetal losses typically account for somewhere between half and two-thirds of all losses.

The FIMR Board meets quarterly. For each case reviewed, the Board look at factors that include:

- + Whether and how the mother was able to access health care, or what barriers made that difficult;
- + Whether she had other children and /or any previous losses;
- + Chronic health issues the mother had prior to becoming pregnant, including mental health issues;
- + The role of the father in this pregnancy;
- + Family or other social supports available to the mother.

Systems successes include aspects of the pregnancy or the six-week period immediately following birth that worked well. Examples of this include cases in which the woman was identified as high risk and referred to services she needed, had adequate social support, or received excellent follow-up care after giving birth.

System failures are often linked to a lack of programs or resources to meet specific needs, to communication issues or a failure to address chronic health conditions that impact pregnancy, including obesity and hypertension.

The FIMR Board recommendations are then forwarded to the Montgomery County, MD Community Action Team (CAT), an advisory / advocacy group that is responsible for prioritizing FIMR Board recommendations and developing ways to make changes “on the ground.”

DEVELOPING CASE REVIEWS

- All fetal loss and infant birth and death certificates are sent from the Maryland Vital Statistics Administration.
- Each record is reviewed, and de-identified information is entered into a spreadsheet to track total numbers & identify emerging trends.
- Cases are selected for presentation to the FIMR Board based on State priorities for the year.
- All related prenatal care and postpartum records are reviewed, including those from obstetricians, maternal-fetal medicine specialists and other providers, and hospital records.
- Maternal interviews are conducted to better understand the mother’s story and concerns, and to identify factors possibly contributing to the adverse outcome.
- Information about support groups and other resources is provided.
- Case summaries are prepared and presented to the FIMR Board.

The maternal interview is a key part of any case review. It allows the mother to share her story and express concerns she had during or after the pregnancy. Information about grief support groups and other bereavement resources is provided, and we are continually updating the list of support groups. In a number of case reviews, fathers were also interviewed and their comments are extremely valuable to the review.



EMERGING TRENDS IN FETAL & INFANT LOSS

Overview of Mothers with Fetal / Infant Loss in 2017



FETAL ONLY:

White: 26%
 Black /African American: 36%
 Hispanic (of any race): 16%
 Asian: 13%
 Other: 7%

INFANT ONLY:

White: 13 %
 Black /African American: 41%
 Hispanic (of any race): 26%
 Asian: 15%
 Other: 5%

FETAL & INFANT COMBINED:

White: 20%
 Black /African American: 38%
 Hispanic (any race): 20%
 Asian: 14% Other: 6%

Grade 8 or <: 7%	Some High School: 7%	
HS Diploma: 25%	Some College: 24%	
BA: 15%	Advanced Degree: 15%	Unknown: 7%

Private insurance: 47%	Medicaid: 38%
Self-pay: 4%	Unknown / missing: 11%

The Maryland Vital Statistics Administration often receives information from hospitals several months after the calendar year ends. It can take up to 2 years to publish final reports, due to residents who give birth out of state.

DISPARITIES

In examining the race of mothers who experienced fetal or infant loss during 2017, it's clear that a persistent racial disparity in pregnancy outcomes continues. Black / African American women accounted for more than one-third of fetal losses, and nearly half of all infant losses in 2017.

Black / African American women are at higher risk for poor pregnancy outcomes regardless of their education, income or frequency of prenatal care.

EDUCATION

While 14% of women who experienced fetal or infant loss last year had less than a high school education, more than half of the mothers had attended college. Educational levels do not appear to have a protective effect on pregnancy outcomes, and we continue to see highly educated women experience fetal and infant loss.

INSURANCE STATUS

The vast majority of the mothers who experienced a loss in 2017 had some form of health insurance.



Maternal Characteristics Related to Fetal / Infant Loss

1 or More Risk Factors in Pregnancy: 49%
Most common risk factors were **Overweight/ Obesity, Advanced Maternal Age & Prior Loss**

Normal weight: 33% Overweight: 25% Obese: 29%
Unknown: 11%

< 20 years: < 1% Age range: 18- 46 years old
20-29 years: 32%
30-39 years: 50%
40 years: 15%

No prior Loss: 78%
1 Prior Loss: 10%
2 Prior Losses: 11%
3 or more Prior Losses: < 1%

PNC Starting in 1st Trimester: 69%
2nd Trimester: 13% 3rd Trimester: 4%
No Prenatal Care: 7% Unknown / missing: 7%



RISK FACTORS

Almost half of all women who had a loss last year began the pregnancy with 1 or more risk factors. The most frequently seen risk factors were overweight / obesity, advanced maternal age and history of prior fetal or infant loss.

OBESITY

More than half - 54% - of all women who experienced a fetal or infant loss were overweight or obese at the start of their pregnancy. Obesity during pregnancy is frequently linked to gestational diabetes or cardiovascular conditions.

MATERNAL AGE

Montgomery County is home to many of the oldest first-time mothers in the state. The majority of women who experienced fetal or infant loss last year were between 30-39 years old. Maternal ages ranged from 18 to 46 years old.

PRIOR LOSS

A relatively small number of women who had a fetal or infant demise in 2017 had experienced an earlier loss. For more than three-quarters of the women, the loss in 2017 marked their first such experience. Some 11% had experienced 2 prior losses, and less than 1% had 3 or more prior losses.

PRENATAL CARE

The vast majority of women who experienced a loss last year received early prenatal care. More than 69% began their prenatal care in the 1st trimester, and another 13% began care in the second semester.



Overview of Fathers in 2017

Paternal Age ranged from 18 to 61 years old.

< 20 years: 2%
20-29 years old: 15%
30-39 years old: 45%
40-49 years old: 11%
> 50 years old: 7% Unknown: 20%

White: 25%
Black / African American: 36%
Hispanic (of any race): 25%
Asian: 7%
Other: 2% Unknown: 4%

Grade 8 or less: 2%
Some High School: 9%
HS Diploma: 31%
Some College: 13% College 4yrs: 13%
Advanced Degree: 16% Unknown: 15%



PATERNAL AGE

Nearly two-thirds of all fathers who experienced a loss in 2017 were at least 30 years old, with almost 7% older than 50 years of age. The age of fathers ranged from 18 to 61 years old. Paternal information continues to be incomplete, with the father's age or other information unknown in a substantial number of cases.

PATERNAL RACE

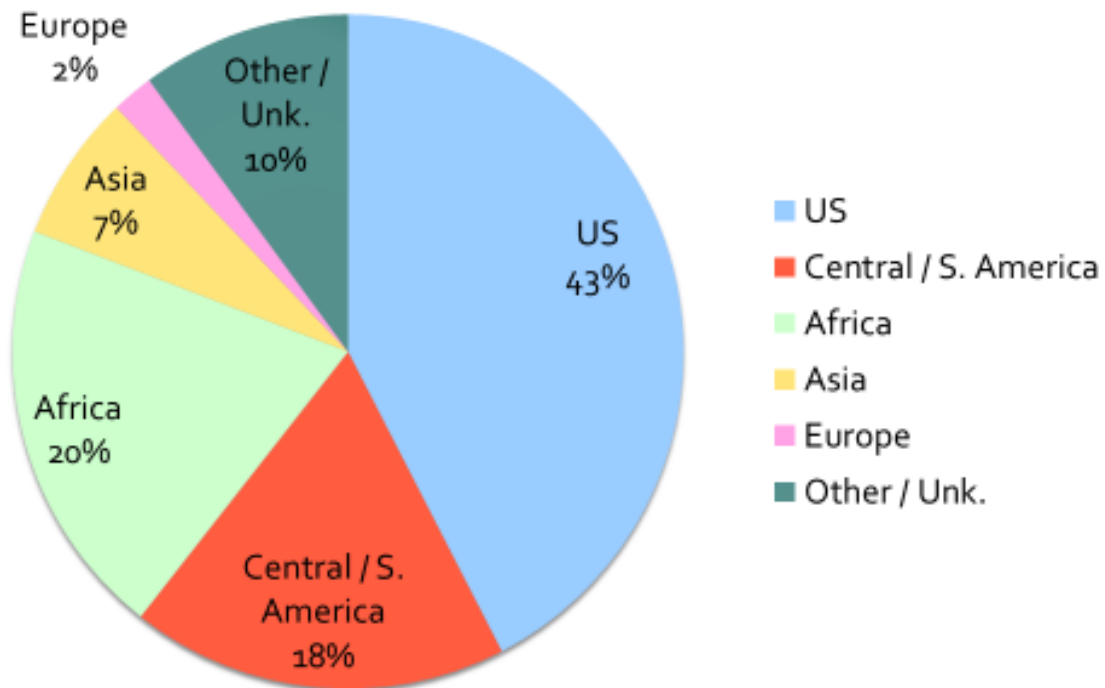
Some 36% of fathers who experienced a loss last year were Black /African American, while white fathers and Hispanic fathers (of any race) each accounted for 25%.

EDUCATION

Education levels among fathers who had a loss continues to rise. Last year, the number of fathers who graduated from high school nearly doubled, reaching 31% in 2017. An increase was also noted in the number of fathers who had earned a 4-year college degree, while the number of fathers with an advanced degree declined somewhat to 16%.



Region of Birth for Mothers Who Had a F / I Loss in 2017



U.S. BORN MOTHERS

In 2017, the share of mothers experiencing loss who were born in the U.S. stood at 43%. For the last several years, U.S. born mothers have represented less than half of all women experiencing fetal or infant loss.

MOTHERS BORN IN OTHER COUNTRIES

Women from Central America, South America and Caribbean countries accounted for 18% of losses during 2017.

Mothers born in African nations represented 20% of all fetal and infant losses in 2017. Asian and European mothers continued to represent a relatively small share of all losses.

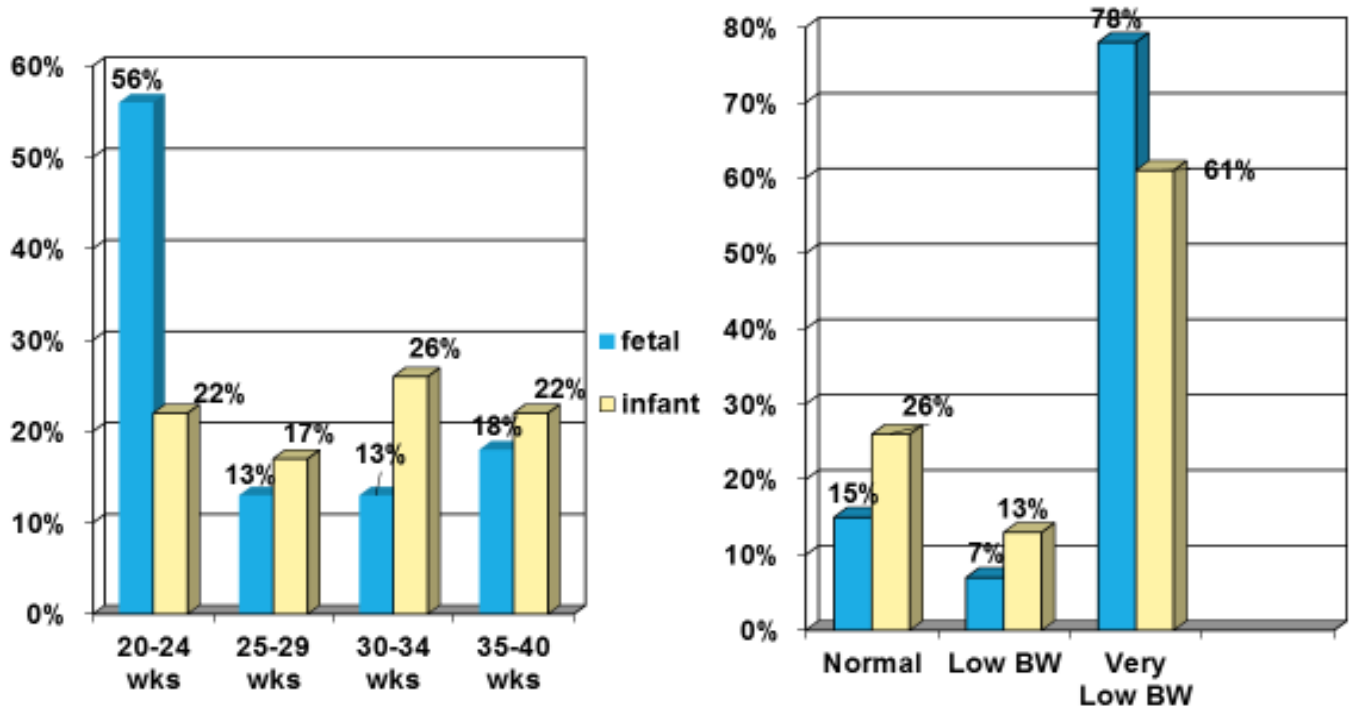
Just over 10% of the records did not cite the maternal country of origin. The paternal region of birth closely resembled that of the mothers.



Deaths by Gestational Age

Deaths by Birthweight

(LBW = < 2,500 g; VLBW = <1,500g)



CAUSE of DEATH

The top cause of death for fetal losses in 2017 was listed as: Unknown, Cord Complications / Premature Rupture of Membranes, and Intrauterine Growth Restriction. For infants, the most frequently seen cause of death included Extreme Prematurity, Congenital Anomalies, and Unknown.

EARLY PREGNANCY LOSS

The majority of fetal losses in 2017 took place at the gestational age of 20-24 weeks. There were fewer fetal losses at 35-40 weeks gestational age last year, and in 2017 they accounted for 18% of the total. Some 13% of infant losses were at less than 20 weeks gestational age. In each of these cases, an infant was born alive at 19 weeks gestational age and died shortly after.

BIRTH WEIGHT

More than two-thirds of all fetal losses (78%) involved very low birth weights of less than 3 pounds, 4 ounces. Another 7% were considered low birth weight, at less than 5 pounds, 8 ounces.

AUTOPSIES

Encouraging parents to consider an autopsy following fetal or infant loss is a frequent FIMR Board recommendation. Autopsies were conducted in 26% of infant deaths and 9% of fetal loss cases in 2017.



RECOMMENDING CHANGE & TAKING ACTION

Top FIMR Board Recommendations

- + Refer Black / African American women to SMILE nurse case management program in any future pregnancy.
- + Increase awareness among physicians & Black / AA women of their higher risk for fetal / infant loss.
- + Use community health workers to educate pregnant & postpartum women.
- + Encourage providers to summarize patient condition in writing and check for understanding.
- + Provide referrals to nutritionist.
- + Review "kicks count" fetal movements at every PNC appointment.
- + Increase awareness of family planning services.
- + Address chronic health conditions prior to pregnancy and encourage good preconception health.
- + Wait at least 18 months before starting new pregnancy after loss.

Please see Appendix B for a list of activities based on FIMR Recommendations and carried out by the Community Action Team during FY18.



PRIORITIES FOR FISCAL YEAR 2019 (July 1, 2018 to June 30, 2019)

Looking ahead...



- + A 7-year Perinatal Periods of Risk analysis conducted by MDH suggests that the preconception health of mothers is driving fetal & infant loss.
- + Leading risk factors across the state include marital status (social support), maternal education, pre-pregnancy hypertension & obesity, and teen pregnancy.
- + In Montgomery County, the top risk factors also include prior preterm birth.
- + Our FIMR Board in the year ahead will prioritize its reviews & highlight cases where the mother had a prior preterm birth, was unmarried, had low educational attainment, and / or pre-existing hypertension or obesity.

Appendix A



Women's Health Care Physicians



The American College of
Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS



Society for
Maternal-Fetal
Medicine
High-risk pregnancy experts

ACOG COMMITTEE OPINION

Number 743

For a comprehensive overview, the full-text version of this Committee opinion is available at <http://dx.doi.org/10.1097/AOG.0000000000002708>

Committee on Obstetric Practice

Society for Maternal-Fetal Medicine

This Committee Opinion was developed by the Committee on Obstetric Practice in collaboration with committee member T. Flint Porter, MD, and the Society for Maternal-Fetal Medicine in collaboration with members Cynthia Gyamfi-Bannerman, MD, MS, and Tracy Manuck, MD.

Low-Dose Aspirin Use During Pregnancy

ABSTRACT: Low-dose aspirin has been used during pregnancy, most commonly to prevent or delay the onset of preeclampsia. The American College of Obstetricians and Gynecologists issued the Hypertension in Pregnancy Task Force Report recommending daily low-dose aspirin beginning in the late first trimester for women with a history of early-onset preeclampsia and preterm delivery at less than 34 0/7 weeks of gestation, or for women with more than one prior pregnancy complicated by preeclampsia. The U.S. Preventive Services Task Force published a similar guideline, although the list of indications for low-dose aspirin use was more expansive. Daily low-dose aspirin use in pregnancy is considered safe and is associated with a low likelihood of serious maternal, or fetal complications, or both, related to use. The American College of Obstetricians and Gynecologists and the Society for Maternal-Fetal Medicine support the U.S. Preventive Services Task Force guideline criteria for prevention of preeclampsia. Low-dose aspirin (81 mg/day) prophylaxis is recommended in women at high risk of preeclampsia and should be initiated between 12 weeks and 28 weeks of gestation (optimally before 16 weeks) and continued daily until delivery. Low-dose aspirin prophylaxis should be considered for women with more than one of several moderate risk factors for preeclampsia. Women at risk of preeclampsia are defined based on the presence of one or more high-risk factors (history of preeclampsia, multifetal gestation, renal disease, autoimmune disease, type 1 or type 2 diabetes, and chronic hypertension) or more than one of several moderate-risk factors (first pregnancy, maternal age of 35 years or older, a body mass index greater than 30, family history of preeclampsia, sociodemographic characteristics, and personal history factors). In the absence of high risk factors for preeclampsia, current evidence does not support the use of prophylactic low-dose aspirin for the prevention of early pregnancy loss, fetal growth restriction, stillbirth, or preterm birth.

Recommendations

The American College of Obstetricians and Gynecologists (ACOG) and the Society for Maternal-Fetal Medicine make the following recommendations:

Low-dose aspirin (81 mg/day) prophylaxis is recommended in women at high risk of preeclampsia and should be initiated between 12 weeks and 28 weeks of gestation (optimally before 16 weeks) and continued daily until delivery.

Low-dose aspirin prophylaxis should be considered for women with more than one of several moderate risk factors for preeclampsia.

Low-dose aspirin prophylaxis is not recommended solely for the indication of prior unexplained stillbirth, in the absence of risk factors for preeclampsia.

Low-dose aspirin prophylaxis is not recommended for prevention of fetal growth restriction, in the absence of risk factors for preeclampsia.

Low-dose aspirin prophylaxis is not recommended for the prevention of spontaneous preterm birth, in the absence of risk factors for preeclampsia.

Low-dose aspirin prophylaxis is not recommended for the prevention of early pregnancy loss.

Table 1. Clinical Risk Assessment for Preeclampsia*

Risk Level	Risk Factors	Recommendation
High [†]	<ul style="list-style-type: none"> • History of preeclampsia, especially when accompanied by an adverse outcome • Multifetal gestation • Chronic hypertension • Type 1 or 2 diabetes • Renal disease • Autoimmune disease (systemic lupus erythematosus, antiphospholipid syndrome) 	Recommend low-dose aspirin if the patient has one or more of these high-risk factors
Moderate [‡]	<ul style="list-style-type: none"> • Nulliparity • Obesity (body mass index greater than 30) • Family history of preeclampsia (mother or sister) • Sociodemographic characteristics (African American race, low socioeconomic status) • Age 35 years or older • Personal history factors (eg, low birthweight or small for gestational age, previous adverse pregnancy outcome, more than 10-year pregnancy interval) 	Consider low-dose aspirin if the patient has more than one of these moderate-risk factors [§]
Low	<ul style="list-style-type: none"> • Previous uncomplicated full-term delivery 	Do not recommend low-dose aspirin

*Includes only risk factors that can be obtained from the patient's medical history. Clinical measures, such as uterine artery Doppler ultrasonography, are not included.

[†]Single risk factors that are consistently associated with the greatest risk of preeclampsia. The preeclampsia incidence rate would be approximately 8% or more in a pregnant woman with one or more of these risk factors.

[‡]A combination of multiple moderate-risk factors may be used by clinicians to identify women at high risk of preeclampsia. These risk factors are independently associated with moderate risk of preeclampsia, some more consistently than others.

[§]Moderate-risk factors vary in their association with increased risk of preeclampsia.

Modified from LeFevre, ML. U.S. Preventive Services Task Force. Low-dose aspirin use for the prevention of morbidity and mortality from preeclampsia: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med* 2014;161:819–26.

Full-text document published online on June 25, 2018.

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Low-dose aspirin use during pregnancy. ACOG Committee Opinion No. 743. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2018;132:e44–52.



Appendix B

SELECT COMMUNITY ACTION TEAM (CAT) ACTIONS BASED ON TOP FIMR RECOMMENDATIONS

FISCAL YEAR 2018 (July 1, 2017 – June 30, 2018)

RECOMMENDATION:

Refer Black / African American women to SMILE nurse case management program for any future pregnancy. Increase awareness among physicians and Black / African American women of their higher risk for fetal or infant loss.

ACTIONS:

Developed a letter signed by our Deputy Health Officer that was sent to obstetricians in 3 Montgomery County zip codes with the highest number of fetal / infant losses. The letter encouraged obstetricians to treat all pregnant Black / African American women as high risk due to persistent racial disparities in infant mortality.

FIMR CAT staff presented on infant mortality, racial disparities and target populations for CAT initiatives as part of a panel at the African American Health Program "Health Literacy & Infant Mortality" conference.

CAT Chair Carol Jordan delivered a presentation on infant mortality and racial disparities to OB, Labor & Delivery and Mother-Baby Unit nurses at Shady Grove Medical Center.

FIMR Board Co-Chair Dr. Carol Garvey co-presented with African American Health Program Manager Arlee Wallace on efforts to address infant mortality & racial disparities at a Montgomery County Medical Society Board meeting.

Dr. Garvey presented on improving pregnancy outcomes at a Montgomery Cares Advisory Board meeting.

CAT Co-Chair Pat Keating was a guest on FIMR CAT member Dr. Jennifer Todd's "Women Transcending" podcast. Pat spoke in a 30-minute interview about changes in childbirth practices during the last several decades.

The CAT created subgroups in FY18 to advance specific efforts:

- The Social Media subgroup was created to increase awareness of infant mortality & related racial disparities via the Montgomery County Department of Health & Human Services Twitter account and Facebook page. Brief items on infant mortality & disparities were also provided to the Montgomery County Medical Society for its weekly e-newsletter.
- The Legislative Subgroup was created to track legislative proposals that impact maternal and infant health, including mental health, at the State and local level.
- The Grants Subgroup was created to explore funding for stress management peer support groups for Black/African American pregnant women.

RECOMMENDATION:

Promote use of Community Health Workers for health education to pregnant and postpartum women

ACTIONS:

FIMR CAT staff distributed information about community health services & other programs available to teens via School Health Nurses in October 2017.



RECOMMENDATION:

Review Kicks Counts at every prenatal appointment

ACTION:

Identified available materials from “Count the Kicks” organization and developed flyer for possible distribution.

RECOMMENDATION:

Distribute Signs of Preterm Labor refrigerator magnets & Reproductive Life Plan brochures

ACTION:

Signs of Preterm Labor refrigerator magnets and Reproductive Life Plan brochures (printed in English, Spanish & French) were distributed during the following meetings / events:

- African American Health Program "Health Literacy & Infant Mortality" conference September 2017
- School Health Nurses fall training/meeting October 2017
- OB, Labor & Delivery and Mother-Baby Unit nurse meeting at Shady Grove Medical Center October 2017
- Medical Society of Montgomery County Board meeting December 2017
- Montgomery Cares Advisory Board meeting December 2017
- KenGar Baptist Church presentation March 2018
- African American Health Program Community Day April 2018
- Annual FIMR CAT & CFR Data Meeting May 2018

OTHER KEY ACTIONS:

Recruited student from University of Maryland to update a FIMR CAT spreadsheet of all perinatal programs available in Montgomery County. This spreadsheet is designed to identify possible gaps in services or duplication of services for pregnant and postpartum women, and is used as a planning tool by CAT.

FIMR CAT staff organized educational visits to learn more about the role of community partners in improving pregnancy outcomes. Visits were made to:

- Mamatoto Village in Washington DC;
- Crossway Community in Kensington, MD; and
- Holy Cross Hospital Labor & Delivery unit and clinic in Germantown, MD

Analyzed fetal and infant mortality data for calendar year 2017 and prepared a data report highlighting emerging trends. Data report was presented at the FIMR CAT Annual Data Meeting in May 2018.



Montgomery County, Maryland Fetal & Infant Mortality Review Board Community Action Team

To view a copy of this report online, go to:

<https://www.montgomerycountymd.gov/hhs/pubsdeptdata/pubsdeptdataindex.html>

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