

## Infant Mortality

**About Technical Assistance Briefs.** The MCH Evidence Center provides ongoing technical assistance (TA) to Title V agencies related to the emerging evidence base, strategies, and measures related to many topics interconnected with National Performance Measures and other critical topics in MCH. *Technical Assistance Briefs* are an outcome of these TA sessions that are designed to act as *conversation starters* in thinking about programs that can be developed to address issues that affect women, infants, children, adolescents, youth, families, and communities. These briefs are not meant to be comprehensive; full analyses of the NPM topic areas are provided in [Evidence Analysis Reports](#).

The Center makes these customized briefs available during TA and on the program website to identify evidence-based/informed strategies, promising practices, examples of ESMs from the field and peer-reviewed resources. Please [contact us](#) if you would like us to develop a similar report for topics that you are working on.

**Initial Query for this Brief.** Identify measures and best practices around Infant Mortality.

### Evidence-Based Strategy Measures

**ESM: Program Integration.** These ESMs have been chosen by other states. You can review the ESMs to see if any resonate with your goals. Evidence Center staff are available to talk through how you could modify select ESMs to serve your needs.

State	ESMs
AL	<b>ESM 5.2:</b> Number of sleep-related infant deaths
AK	<b>ESM 7.1.1:</b> Percent of preventable child deaths due to injury reviewed by the MCDR with at least one prevention recommendation that is specific and actionable (including a "who, what, when") and targets systems above the individual level.
IN	<b>ESM 7.1.2:</b> Percent of child deaths reviewed by Child Fatality Review teams.
KY	<b>ESM 7.1.1:</b> Number of community members receiving training or technical assistance about preventable child injuries or death and promoting injury prevention activities including child maltreatment, child passenger, gun, water, fire, pedestrian, ATV, or more.
MT	<b>ESM 5.1:</b> Percent of activity goals to decrease infant deaths due to unsafe sleep conditions which are met by county public health departments using MCHBG funding for the work.
OR	<b>ESM 7.1.1:</b> Injury death rate among children 0 - 9 years of age
OR	<b>ESM 7.1.2:</b> Transportation injury death rate among children 0 - 9 years of age
OR	<b>ESM 7.1.3:</b> Drowning death rate among children 0 - 9 years of age
SC	<b>ESM 5.1:</b> Number of culturally appropriate translations of material created for populations at risk of infant mortality.
SD	<b>ESM 5.1:</b> % of Child Death Review (CDR) team members who scored above 80% on a post-test

## Evidence-Based Strategies – What Works for Health

The following programs have been identified as effective models related to Infant Mortality:

Title	Link	Category
Computerized clinical decision support systems	<a href="https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/computerized-clinical-decision-support-systems-cdss">https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/computerized-clinical-decision-support-systems-cdss</a>	Scientifically Supported
Early childhood home visiting programs	<a href="https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/early-childhood-home-visiting-programs">https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/early-childhood-home-visiting-programs</a>	Scientifically Supported
Nurse-Family Partnership (NFP)	<a href="https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/nurse-family-partnership-nfp">https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/nurse-family-partnership-nfp</a>	Scientifically Supported
Public reporting of health care quality performance	<a href="https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/public-reporting-of-health-care-quality-performance">https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/public-reporting-of-health-care-quality-performance</a>	Some Evidence
Value-based performance (VBP)	<a href="https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/value-based-purchasing-vbp">https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/value-based-purchasing-vbp</a>	Some Evidence

## Evidence-Based Strategies – Innovation Hub

The following programs have been identified as effective models related to behavioral health

Title	Link	Category
Reducing the Risk of SIDS and Other Sleep-related Infant Deaths through the Design and Deployment of Free Educational Apps for Mobile Phones	<a href="https://amchp.org/wp-content/uploads/2021/05/SIDS_Practice-Handout-Emerging.pdf">https://amchp.org/wp-content/uploads/2021/05/SIDS_Practice-Handout-Emerging.pdf</a>	Emerging
Mississippi Interpregnancy Care Project: The MIME and DIME Studies	<a href="https://amchp.org/wp-content/uploads/2021/05/MIME-DIME_2015.pdf">https://amchp.org/wp-content/uploads/2021/05/MIME-DIME_2015.pdf</a>	Emerging

## Resources for Increasing Workforce Capacity around Infant Mortality

MCH Library Infant Mortality Toolkit: <https://www.mchlibrary.org/toolkits/infant-mortality.php>

CityMatCH Infant Mortality Webinar Series: <https://www.citymatch.org/region-v-infant-mortality-webinar-series/>

Infant mortality by maternal prepregnancy body mass index: United States, 201-2018. This report presents 2017–2018 infant mortality rates in the United States by maternal prepregnancy body mass index, and by infant age at death, maternal age, and maternal race and Hispanic origin.

<https://www.cdc.gov/nchs/data/nvsr/nvsr63/NVSR-69-09-508.pdf>

Evidence-based and evidence-informed safe sleep practices: A literature review to inform the Missouri Safe Sleep Strategic Plan. This review examines and compiles literature and analyses of current evidence-based safe sleep practice guidelines, policies and initiatives that provide health care provider training and modeling, increase infant caregiver knowledge and education, and promote safe sleep polices at the local, state and federal level. This review includes: current Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID) U.S. and Missouri data; evidence-based guidelines, specifically from the American Academy of Pediatrics (AAP); examples of evidence-based or evidence-informed interventions and educational programs; and, of importance, specific evidence regarding the impact of poverty, race and ethnicity on SIDS, SUID and infant mortality.

[https://www.nichq.org/sites/default/files/resource-file/Lit%20Review\\_MO\\_SSSP\\_Final%20for%20Web.pdf](https://www.nichq.org/sites/default/files/resource-file/Lit%20Review_MO_SSSP_Final%20for%20Web.pdf)

**Promising practices for safe sleep to inform the Missouri Safe Sleep Strategic Plan.** This document describes promising practices for improving infant safe sleep and reducing infant mortality caused by Sudden Infant Death Syndrome (SIDS) and Sudden Unexplained Infant Death (SUID) in these areas: (1) active endorsements of American Academy of Pediatrics guidelines; (2) infant caregiver knowledge, skills, and self-efficacy; (3) community champions; and (4) supportive policies for safe sleep practices.

[https://www.nichq.org/sites/default/files/resource-file/PromisingPractices.MO\\_SafeSleepStratgicPlan\\_Final%20for%20Web.pdf](https://www.nichq.org/sites/default/files/resource-file/PromisingPractices.MO_SafeSleepStratgicPlan_Final%20for%20Web.pdf)

**Guidance for review deaths of infants/children with disabilities and/or special healthcare needs.**

This document provides guidance to Child Death Review (CDR) and Fetal Infant Mortality Review (FIMR) teams on conducting effective reviews of the deaths of infants and children who had a disability or chronic illness. Contents include definitions of disability and special health care needs; preparing for the review meeting; background and questions for discussion at the review; medical death or natural causes; maltreatment as a factor; death in foster care, group home, institution, or jail/detention facility; mental health services for children in care; death at school or on a school bus; injury deaths; and risk factors. A structure for identifying and addressing gaps in services, policies, or protocols and model recommendations is included.

<https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/NCFRP-Webinar-020817-Disabilities-Guidance.pdf>

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**Infant Mortality: Technical Assistance Brief**

Last Updated: July, 2022

Access other resources at <https://www.mchevidence.org>

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U02MC31613, Strengthen the Evidence for Maternal and Child Health Programs, \$3.5 M. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.