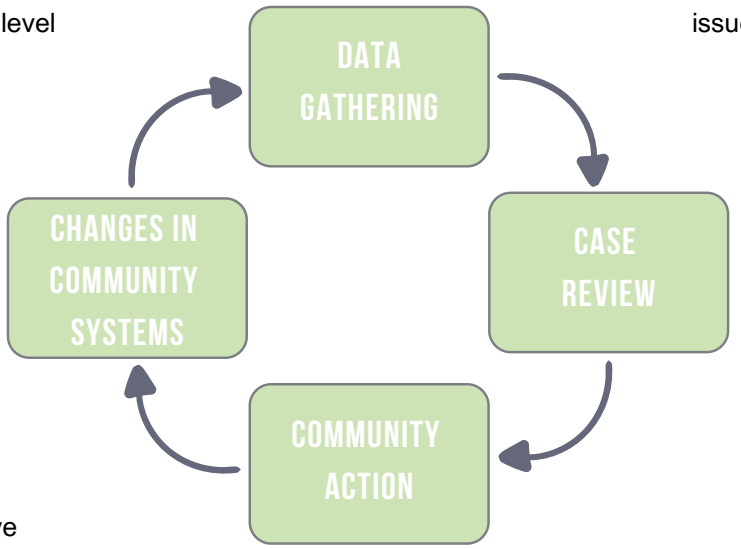
Florida Healthy Start
Broward Healthy Start Coalition

# FETAL AND INFANT MORTALITY REVIEW PROGRAM
# 2022 ANNUAL REPORT

## ABOUT THE FETAL AND INFANT MORTALITY REVIEW PROGRAM

Fetal and Infant Mortality Review (FIMR) is a community-based, action-oriented process to review fetal and infant deaths and make recommendations to spark systemic changes to prevent future similar deaths. All FIMR teams operate at the local level (usually the county) to examine medical, non-medical, and systems-related factors and circumstances contributing to fetal and infant deaths.




The purpose of FIMR's Case Review team is to conduct comprehensive multidisciplinary review of fetal and infant deaths to understand how a wide array of local social, economic, public health, educational, environmental and safety issues relate to the tragedy of infant loss; and use the findings to take action that can prevent other infant deaths and to improve the systems of care and resources for women, infants and families.

Among the various types of fatality reviews, the FIMR approach is unique because cases are de-identified; they may include a family interview to determine the family's perspective on factors that may have contributed to the infant's life and death; and many of the teams have a Community Action Group (CAG) that, after completion of the review, works to take the case review team's recommendations to action.

Fetal and infant mortality are important indicators of the health of a community. Fetal and infant deaths are sentinel events that illustrate system and resource issues. Understanding and addressing infant mortality in our community can be challenging, however it is one of the most important things that can be done to improve the overall health of our population.

# CASE SELECTION AND METHODOLOGY

In 2022, there were a total of 279 deaths in Broward County-166 fetal deaths and 113 infant deaths. 31 deaths, representing 11% of total, were systematically chosen, based on the review of cause of death, where the family lives, and maternal characteristics. Of these: 20 infant deaths were selected, and 11 fetal deaths. Nine(9) maternal/family interviews were completed. These interviews enriched the Case Review Teams ability to process the family's pregnancy and birth experience directly from their perspective.

"Aggregate mortality and population data are necessary, but insufficient to catalyze services and systems level changes. Strategic and skilled storytelling in fatality review processes can humanize data and help shift prevailing narratives - e.g., that mothers and babies die because of personal behaviors - toward upstream solutions. Greater inclusion of the voices of parents and families who have experienced losses honors their lived experiences and elevates their stories, for stronger solutions."

*- Excerpt from Connecting Fatality Review Teams Across The Life Course Through Strategic Storytelling.*

## *Family Voice and Experience*

"The hospital was not letting me back to see my son. I was getting emotional. Someone came to escort me somewhere else, and I knew something was horribly wrong. When the doctor came to speak with me, they just said that they had been trying for an hour and that he was gone. **It felt so dismissive and there was no empathy.** I was never able to understand what happened." – F.M., Margate

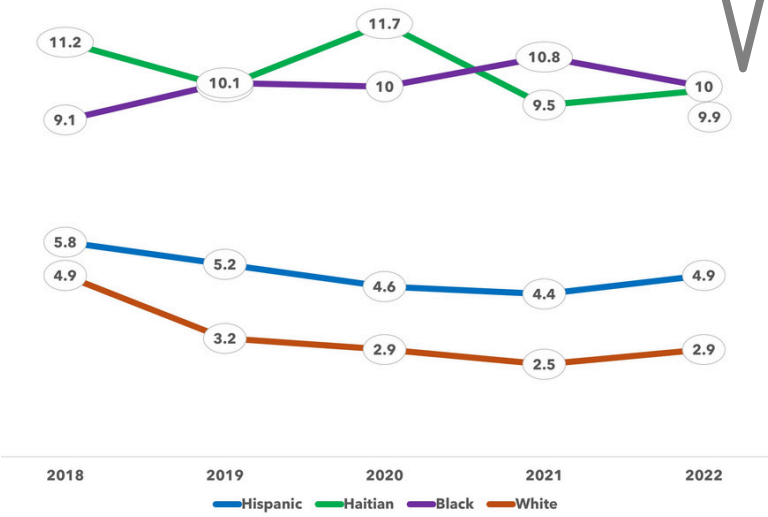
"My work was understanding, and I felt supported by them. They allowed for me to have a month off during my pregnancy. After my son passed away, **my work provided bereavement support for me and my husband. I am so grateful for them**." – H.F., Fort Lauderdale

"I was at my ultrasound appointment and got told over the phone by a doctor I had never spoken to before that the baby had no heartbeat and wasn't alive. It didn't feel real until I saw that the ultrasound technician was crying. **I was just screaming and didn't know what to do, it was truly the shock of my life**." – C.D., Lauderdale Lakes

"I don't think my voice was heard during my pregnancy. It is 2022 and I think women need to be taken more seriously when we express our concerns about our health. **I was in a lot of pain during my pregnancy and my doctor didn't listen to me.** I trusted the doctors even when I knew something was wrong. I have a degree, and I work at a hospital. I followed all of the doctors' recommendations and attended every appointment. After the baby died the doctor said to me "at least I saved your life you can get pregnant again. What do you want me to tell you?". **I felt like no one listened to me because I am young, and I am Black.**" – S.J., Fort Lauderdale

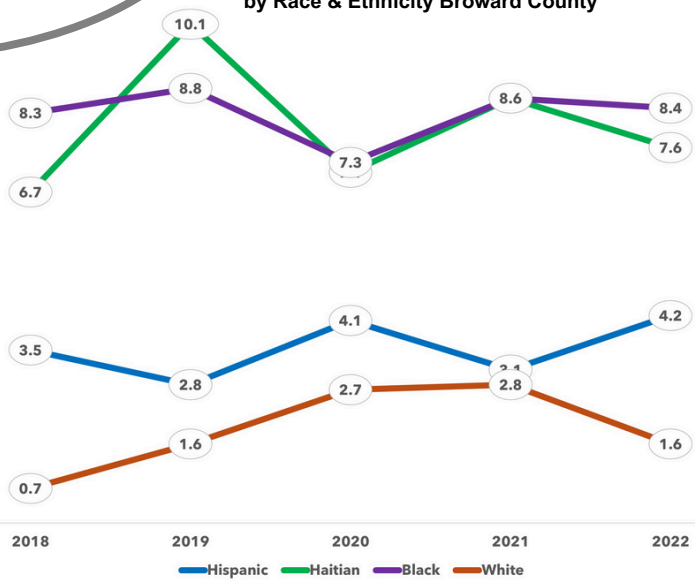
**Over the past 5 years, the fetal and infant mortality data shows a persistent disparity between the white, Hispanic and their Black and Haitian counterparts in Broward County. This indicates that renewed efforts reflecting innovative strategies focusing on upstream factors must be applied to positively impact birth outcome rates.**

**Fetal Mortality (Rate per 1,000 Deliveries) by Race & Ethnicity Broward County**




**Fetal mortality or still birth is the death of a fetus at 20 weeks' gestation or more. The HP2030 goal for fetal mortality is 5.7 per 1,000 deliveries.**

**Infant Mortality (Rate per 1,000 Live Births) by Race & Ethnicity Broward County**




**Infant mortality are deaths that occur between 0 and 364 days. The HP2030 goal for infant mortality is 5.0 deaths per 1,000 live births.**

Source: Florida Health Charts, Florida Department of Health, 2018-2022

## The 5-Level Socio Ecological Model (SEM): Individuals, communities, and the impact of systems

*Invested community stakeholders work to develop strategies that promote well-being and improve community health.*

**Public Policy**
Medicaid Expansion, Housing Opportunities, Creating Race Explicit Policies, Bipartisan Action, Racism

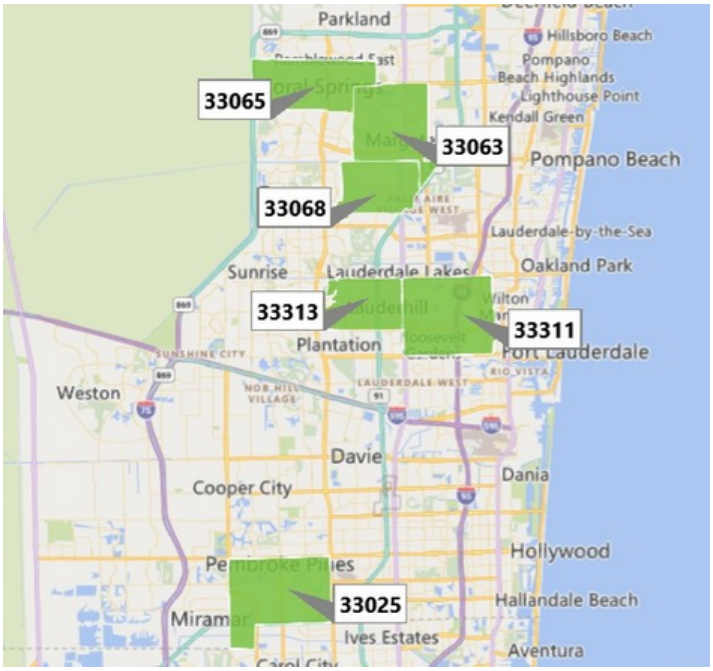
**Social Determinants of Health**
Economic Stability, Educational Access & Quality, Neighborhood & Built Environment, Social & Community Context, Racism

**Healthcare System**
Access to Quality Care, Health Literacy, Patient-Provider Communication, Implicit Bias & Racism

**Social Networks & Supports**
Relative & Non-Relative Support, Intimate Partner Relationships, Stress, Racism

**Individual**
Maternal Characteristics, Modifiable Behaviors, Racism

**These 6 zip codes represent those with the highest rates and counts of fetal death, infant death, and preterm birth in 2022 in Broward County.**

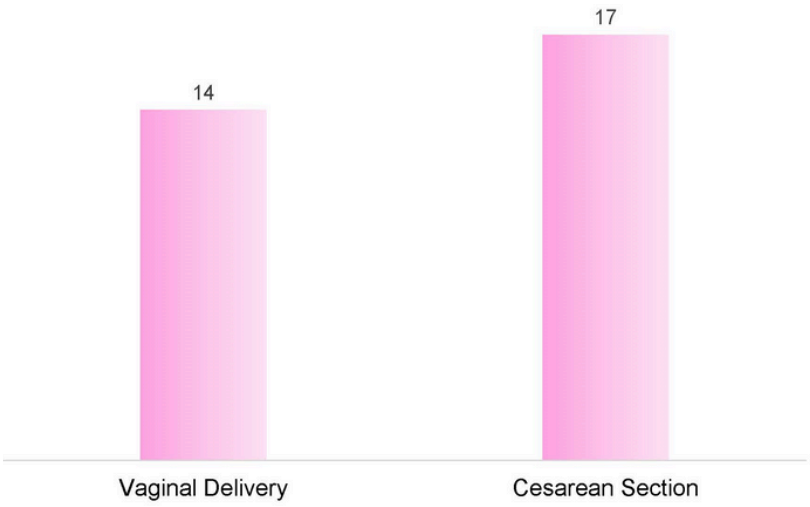



| | Fetal Mortality | | Infant Mortality | | Preterm Births | |
|---|---|---|---|---|---|---|
| *Zip Code* | *Count* | *Rate* | *Count* | *Rate* | *Count* | *Rate* |
| 33311 | 13 | 11.7 | 9 | 8.2 | 202 | 8.8% |
| 33313 | 14 | 14.7 | 5 | 5.3 | 142 | 6.2% |
| 33068 | 8 | 10.7 | 11 | 14.8 | 93 | 4.0% |
| 33025 | 6 | 6.4 | 6 | 6.5 | 94 | 4.1% |
| 33065 | 6 | 8.1 | 4 | 5.4 | 90 | 3.9% |
| 33063 | 5 | 8.7 | 5 | 8.8 | 83 | 3.6% |

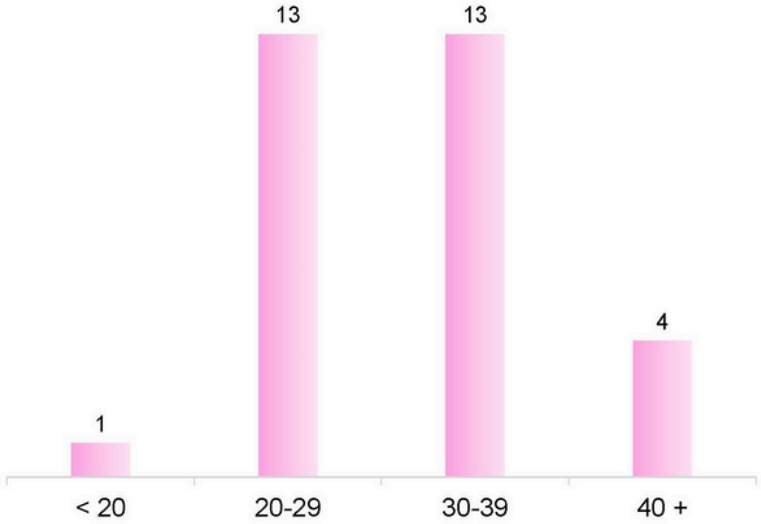
*Fetal Mortality rate is per 1,000 deliveries *Infant Mortality rate is per 1,000 live deliveries *Preterm Birth rate is percentage of births in zip code

# CASE REVIEW TEAM FINDINGS n=31

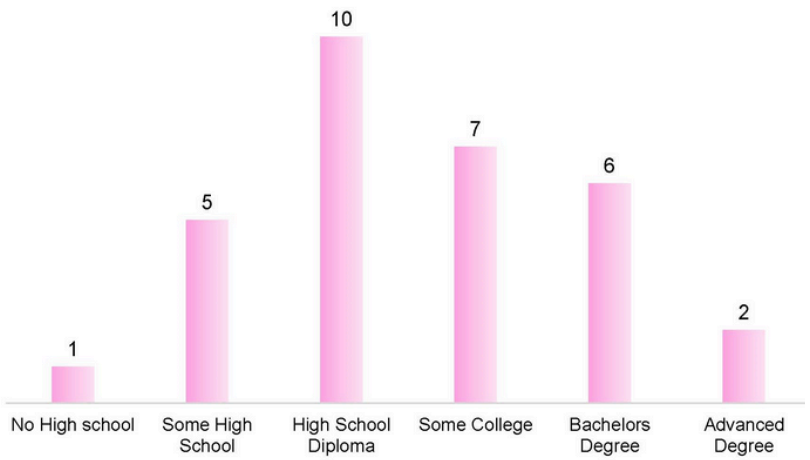
## Method of Delivery



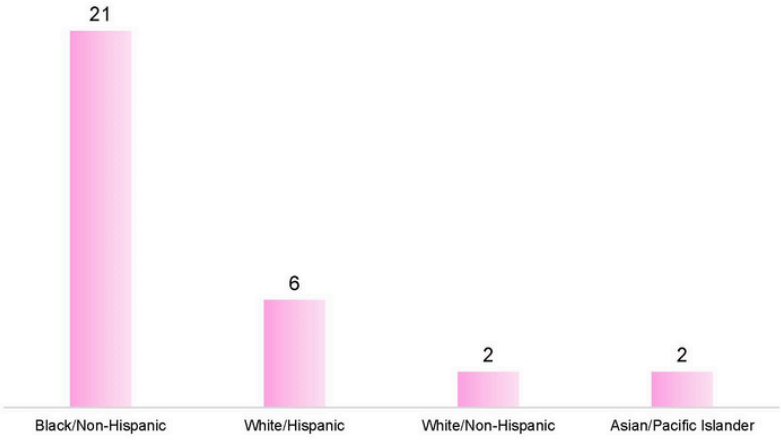

## Age of Birthing Person



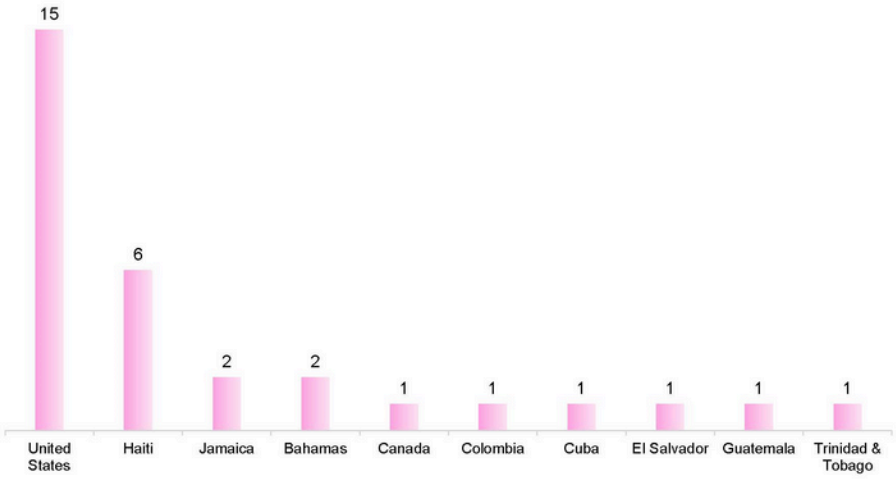

## Education



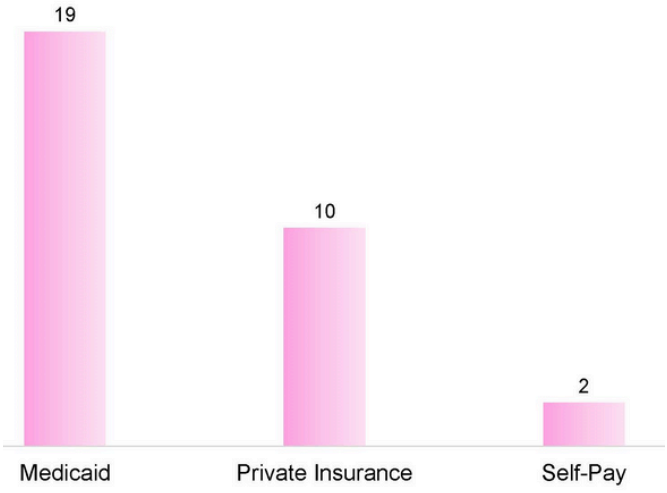

## Race/Ethnicity




## Nativity

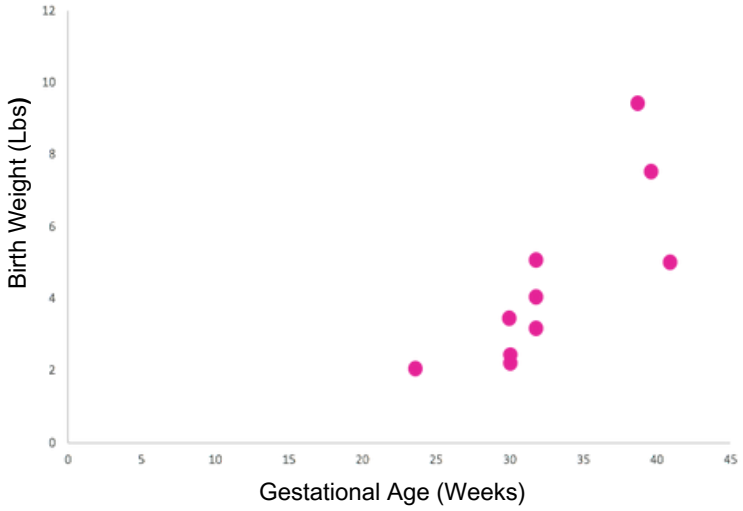



## Insurance

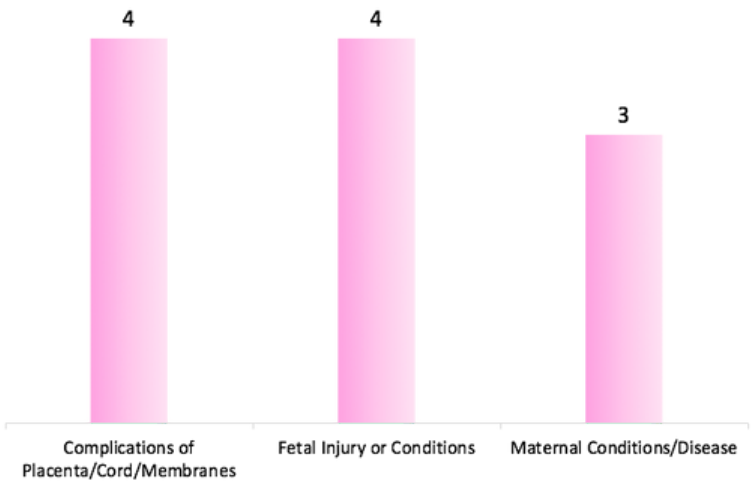


# CASE REVIEW TEAM FINDINGS

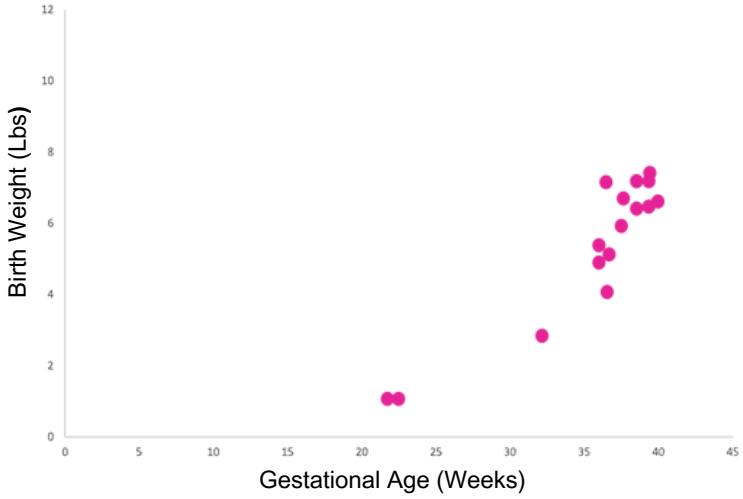
## Gestational Age & Birthweight: Fetal



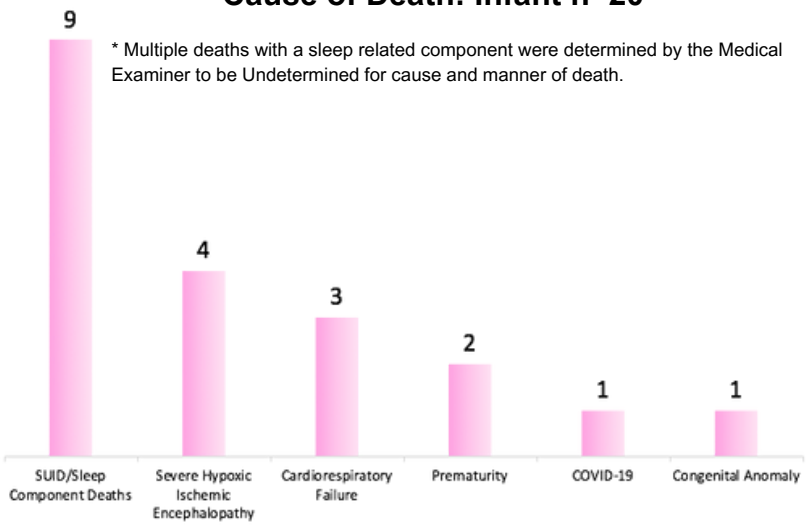

## Cause of Death: Fetal n=11




## Gestational Age & Birthweight: Infant

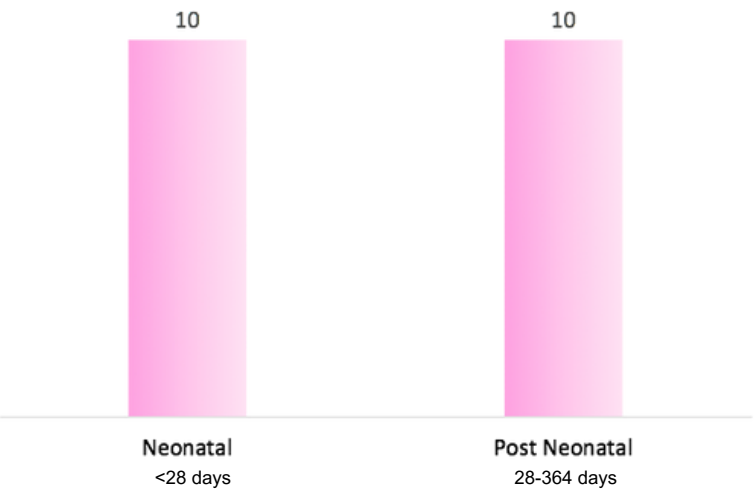



## Cause of Death: Infant n=20

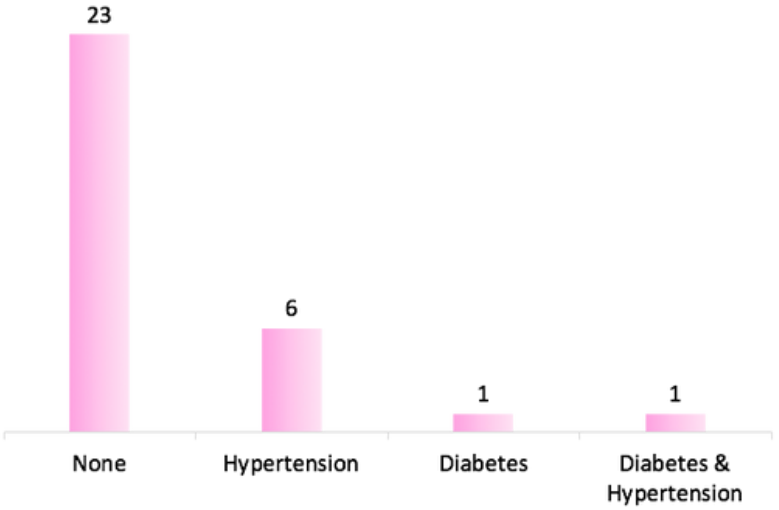



* Multiple deaths with a sleep related component were determined by the Medical Examiner to be Undetermined for cause and manner of death.

## Age at Infant Death




## Medical Conditions



# RECOMMENDATIONS FROM THE CRT

| Respectful Maternal Care | Social Determinants of Health | Cultural Humility | Education and Engagement |
|---|---|---|---|
| **Policy**<br>• Training and implementation of the FPQC Respectful Maternal Care initiative systemwide. | **Policy**<br>• Engage immigration partners on provision of healthcare services.<br>• Address the need for OBGYNs in deserts. | **Policy**<br>• Policy that supports increased access to doulas and midwives. | **Policy**<br>• Strengthen the practice of existing state policy, that all patients are provided with Florida's Universal Prenatal and Infant Screening. |
| **Healthcare System**<br>• Host listening sessions at the neighborhood level to understand patient experience.<br>• Promote preconception & inter-pregnancy care.<br>• Ongoing antiracism and implicit bias training. | **Healthcare System**<br>• Promote early and adequate prenatal care.<br>• Identify, collaborate, and respond to challenges related to social determinants of health. | **Healthcare System**<br>• Increase access to high quality interpreters.<br>• Culturally and linguistically appropriate safe sleep messaging.<br>• Adopt a culture of shared decision-making. | **Healthcare System**<br>• Prioritize screening, referral to treatment, and follow up for substance use, mental health and all behavioral health conditions. |
| **Provider**<br>• Improved provider to provider/provider to patient communication.<br>• Thorough documentation.<br>• Bereavement service referrals.<br>• Ongoing chronic disease education. | **Provider**<br>• Effective coordination of care that includes the priority of addressing all social determinants of health for families. | **Provider**<br>• Accountability in responding to patients' cultural norms and preferences.<br>• Work toward a trauma responsive system of care. | **Provider**<br>• Pediatricians to be equipped to screen parents for mental health symptoms.<br>• Conversations with caregivers on topics of health and safety. |
| **Individual/Community**<br>• Education, awareness and distribution through grassroots methods and social media of legal rights before, during and after pregnancy and beyond. | **Individual/Community**<br>• Education, awareness, and distribution through grassroots methods and social media of available concrete supports and mutual aid, and Medicaid extended benefits. | **Individual/Community**<br>• Education, awareness, and distribution through grassroots methods and social media of available social supports; doulas, recovery communities, and faith-based partners. | **Individual/Community**<br>• Education, awareness, and distribution through grassroots methods and social media of the American Academy of Pediatric Safe Sleep Recommendations. |

## Community Action Group Members

- Chair: Dr. Sharetta Remikie
- Zoe Werner
- Samantha Silver
- Monica Figueroa King
- Regine Kanzki
- Robin Grunfelder
- L'Mara Thomas
- Alima Harley
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- Michelle Monsalve
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- Jean Robert Menard
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- Esther March Singleton
- Ieesha Crawford
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## Case Review Team Members

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- Grace Dible
- Carolyn O'Dell
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- Anissa Yarbrough
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- Tijee Williams
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**For more information on the FIMR Program visit** us at www.browardhsc.org