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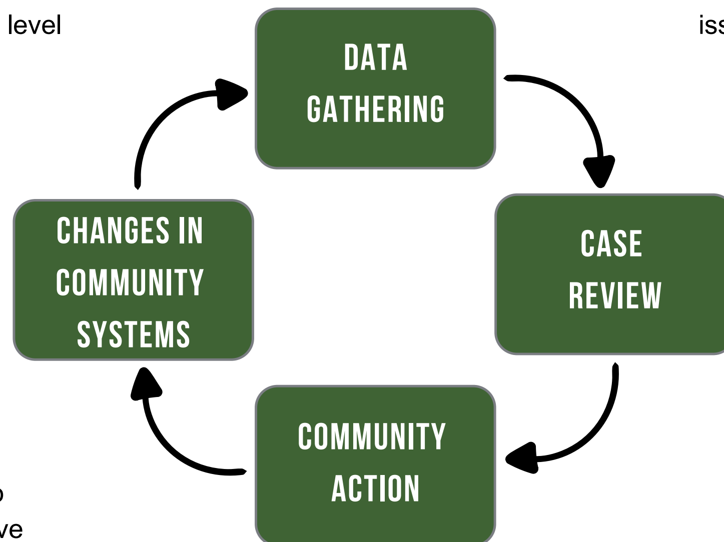
Broward Healthy Start Coalition

FETAL AND INFANT MORTALITY REVIEW PROGRAM 2023 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.

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.



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.

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

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In 2023, Broward County recorded 247 deaths—146 fetal and 101 infant. Of these, 53 deaths (21% of the total) were selected for review based on cause of death, family residence, and maternal factors. This includes 29 infant deaths and 24 fetal deaths. Of the 53 reviewed, the case review team determined 25 as "Probably Preventable," 18 "Probably Not Preventable," and 9 "Unable to Determine"- due to insufficient records or lack of thorough documentation. 37% (9) of fetal deaths and 52% (15) of infant deaths were considered "Probably Preventable" by the CRT.

Seven maternal/family interviews were conducted, providing the CRT with valuable insights into the family's pregnancy and birth experience.

"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

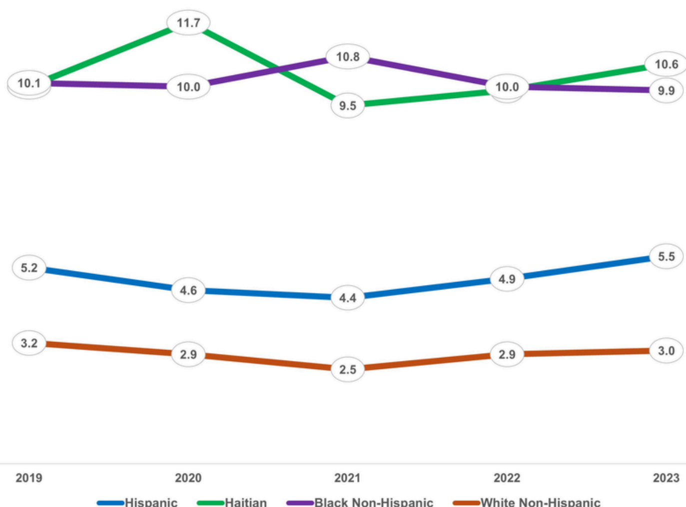
"I saw a specialist and they found what was called an "angioma", a tumor on the umbilical cord. The specialist and OB never seemed to be on the same page and the specialist never explained to me what exactly they saw. I heard the doctor say to the nurse, "I don't know what's going on. We're going to call it a tumor for now". **I wish they would have paid closer attention to it and looped my OBGYN into the situation. The whole pregnancy I felt like none of the doctors were on the same page.** I would go to the doctor and most times would have to wait around two hours to only have a visit that was maybe 10 minutes long. They never told me what happened but that it could have been the cord. They told me I would have to pay for the autopsy and I couldn't afford it."
-N.R., Lauderhill

"The postpartum nurses were wonderful and made me a memory box. There were also people that came in and gave me information about a bereavement support group. **I attend the group every week and it is very helpful, especially to connect to other moms going through the same things."**
-M.N., Lauderhill

"When I was discharged from the hospital, a few days later I had extremely high blood pressure readings. I went back to the hospital and was admitted for postpartum preeclampsia. **I am aware of this being a risk especially for Black women so that is why I was so consistent about checking my blood pressure** and making sure I went back to the hospital."
-L.S., Pembroke Pines

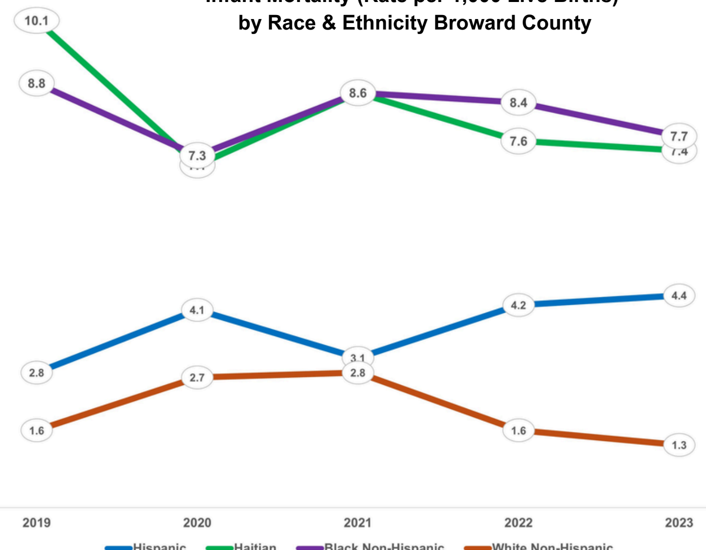
"I was in early labor and needed an emergency C-Section because my baby was breech. The OBGYN said they were going to deliver the baby vaginally because, "you've had other children vaginally so this one will be easy." I said I wanted to have a C-Section because the baby was breech and that every pregnancy and delivery should be treated differently. I pushed and delivered the baby's legs and body, but the baby's head was stuck for more than 15 minutes. After the baby was fully delivered the doctor left the room immediately and did not tell me what was going on. NICU nurses and doctors were in the room and took the baby after he was delivered to work on him but were unable to save him. **There was no empathy or compassion from any of the doctors or nurses about how my child had just died."**
-D.Z., Coral Springs

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, 2019-2023

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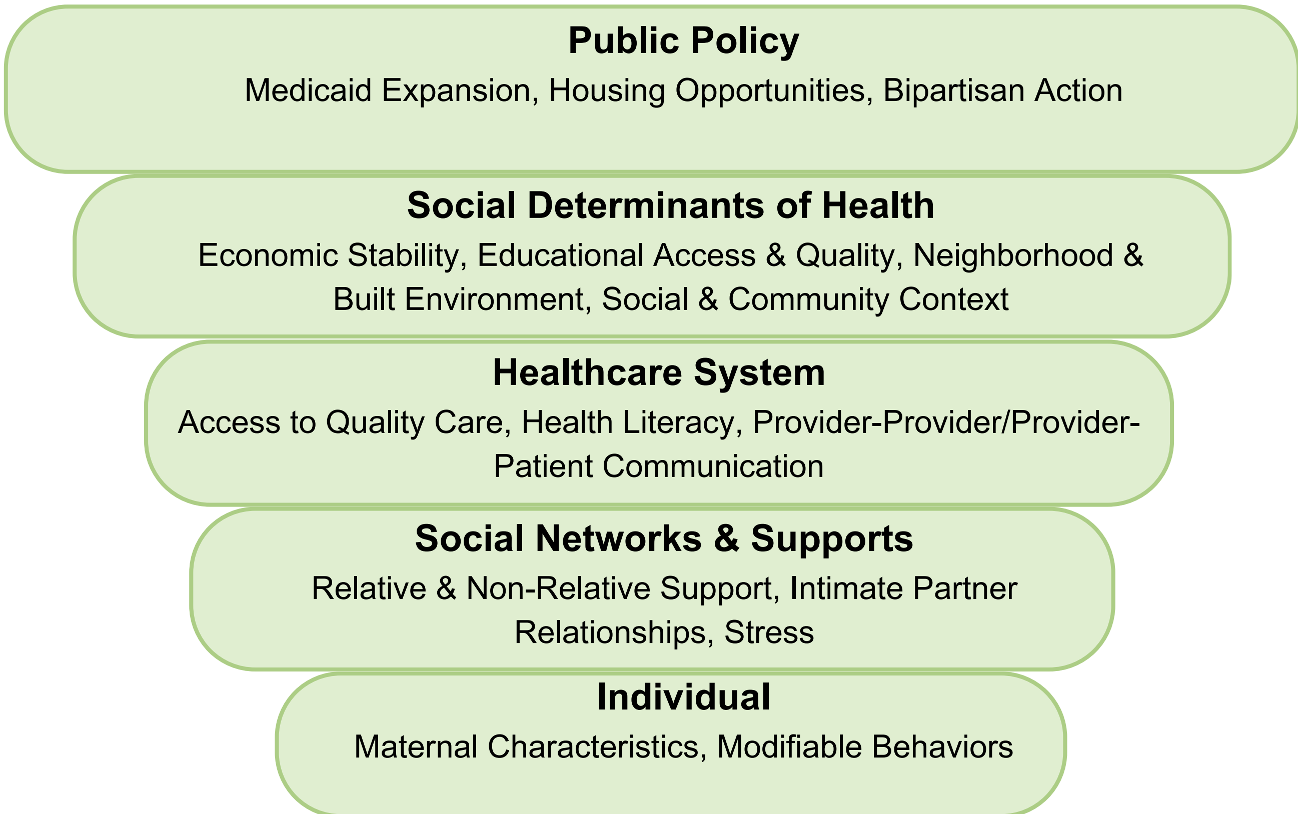
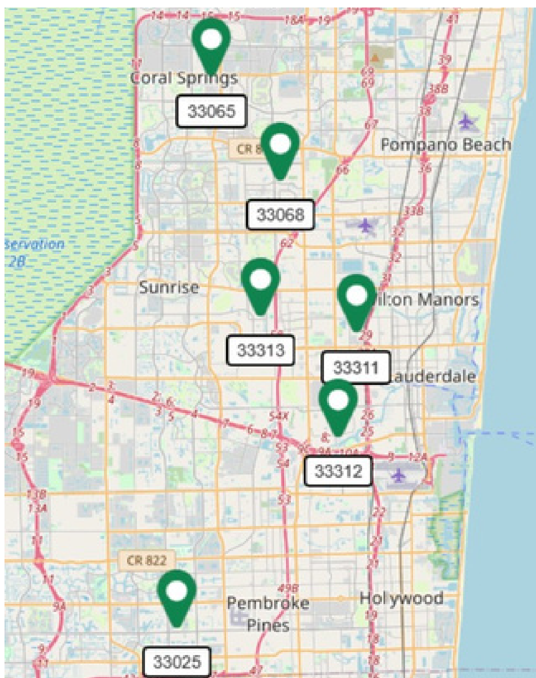
The 5-Level Socio Ecological Model (SEM): Individuals, communities, and the impact of systems

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



These 6 zip codes represent those with the highest rates and counts of fetal death, infant death, and preterm birth in 2023 in Broward County.



	Fetal Mortality		Infant Mortality		Preterm Birth	
Zip Code	*Count*	*Rate*	*Count*	*Rate*	*Count*	*Rate*
33025	13	14.4	5	5.6	121	13.6%
33065	8	12.0	4	6.1	76	11.6%
33068	6	8.6	5	7.2	89	12.9%
33311	13	12.8	7	7.0	151	15.1%
33312	5	7.1	5	7.1	64	9.1%
33313	12	13.8	8	9.3	126	14.7%

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

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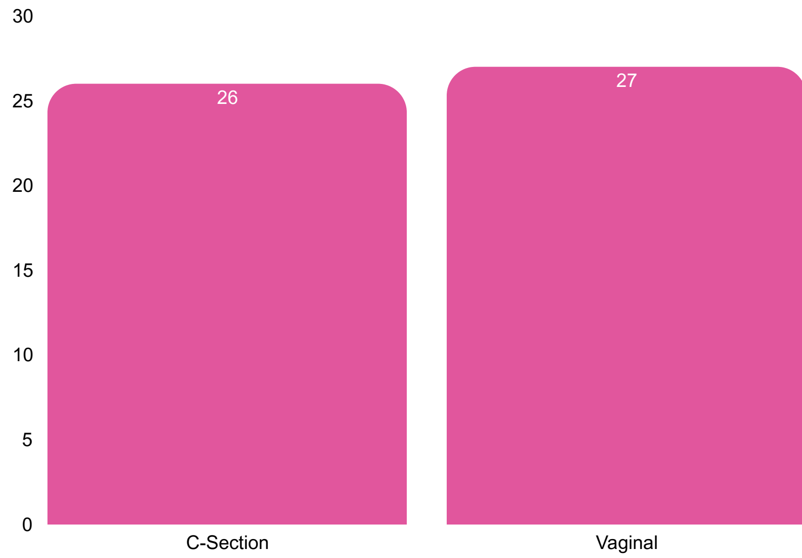

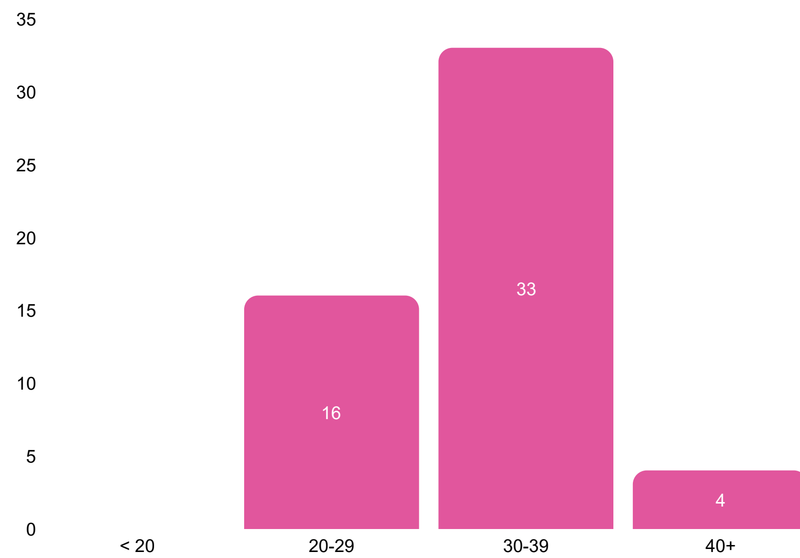

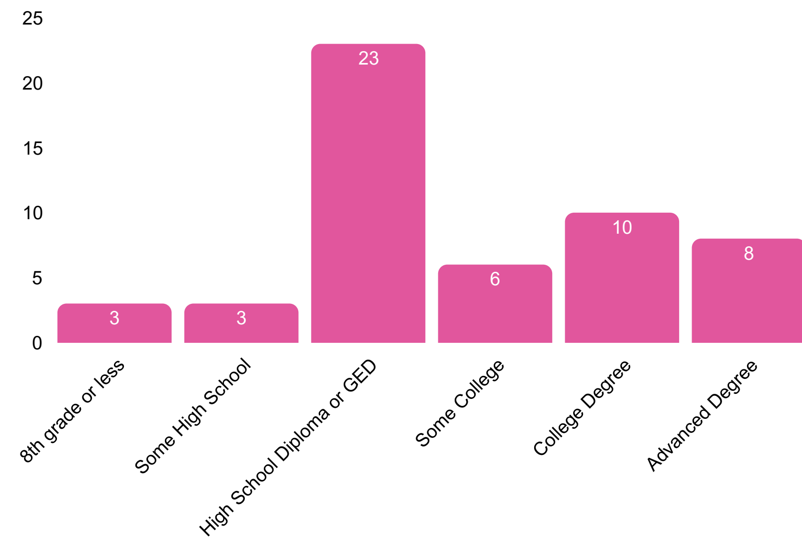

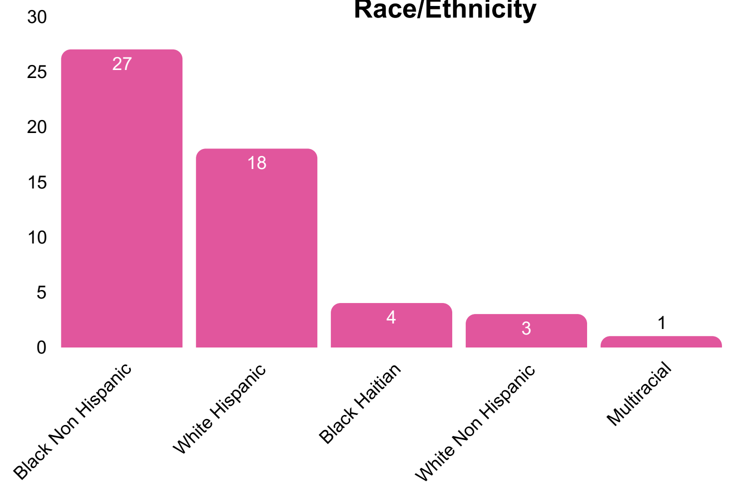

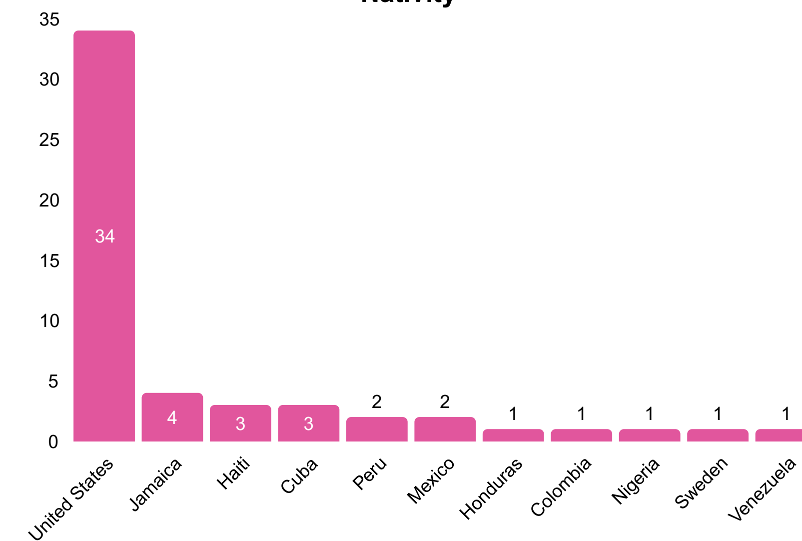

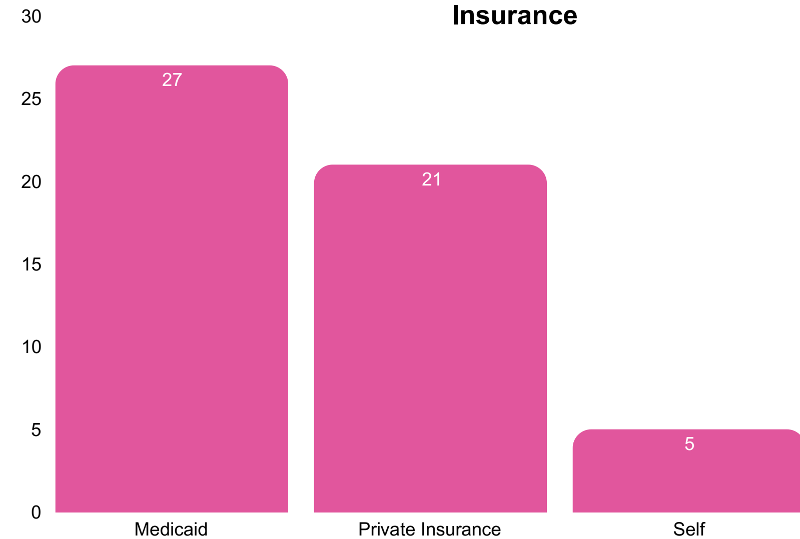

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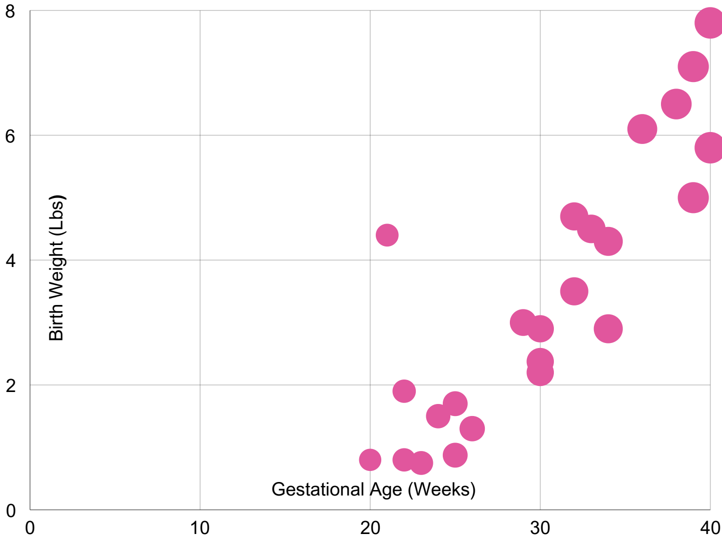
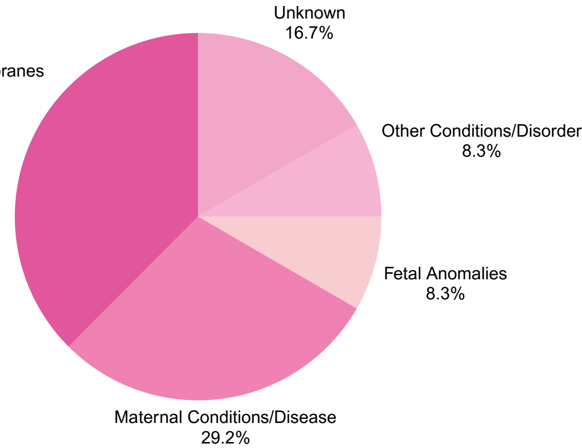
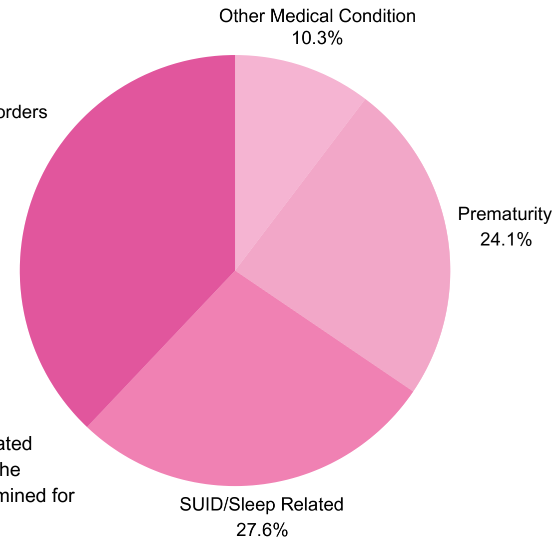
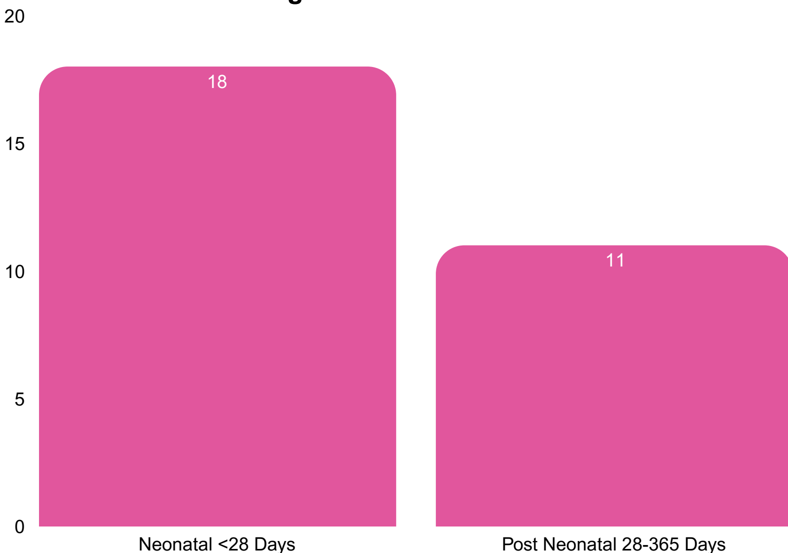
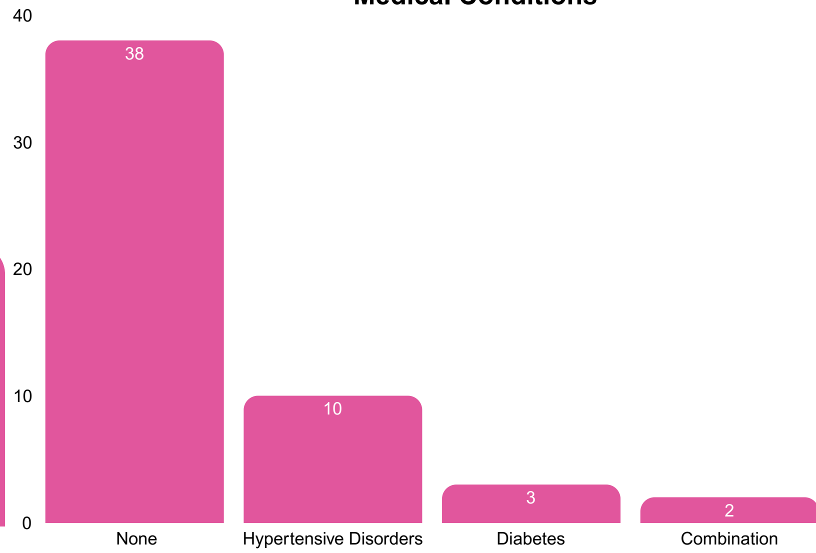






* Multiple deaths with a sleep related component were determined by the Medical Examiner to be Undetermined for cause and manner of death.





RECOMMENDATIONS FROM THE CRT

Respectful Maternal Care

Policy
- Training and implementation of the FPQC Respectful Maternal Care initiative systemwide.

Healthcare System
- Host listening sessions at the neighborhood level to understand patient experience.
- Promote preconception & inter-pregnancy care.
- Ongoing professional development.

Provider
- Improved provider to provider/provider to patient communication.
- Thorough documentation.
- Bereavement service referrals.
- Ongoing chronic disease education.

Individual/Community
- Education, awareness and distribution through grassroots methods and social media of legal rights before, during and after pregnancy and beyond.

Social Determinants of Health

Policy
- Engage partners on provision of healthcare services.
- Address the need for OBGYNs in deserts, and that contract with Medicaid.

Healthcare System
- Promote early and adequate prenatal care.
- Identify, collaborate, and respond to challenges related to social determinants of health.

Provider
- Effective coordination of care that includes the priority of addressing all social determinants of health for families.

Individual/Community
- Education, awareness, and distribution through grassroots methods and social media of available concrete supports and mutual aid, and Medicaid extended benefits.

Cultural Humility

Policy
- Policy that supports increased access to doulas and midwives.

Healthcare System
- Increase access to high quality interpreters.
- Adopt a strengths-based and supportive approach to safe sleep messaging.
- Adopt a culture of shared decision-making.

Provider
- Accountability in responding to patients' needs, rights, and preferences.
- Work toward a trauma responsive system of care.

Individual/Community
- Education, awareness, and distribution through grassroots methods and social media of available social supports; doulas, recovery communities, and faith-based partners.

Education and Engagement

Policy
- Strengthen the practice of existing state policy, that all patients are provided with Florida's Universal Prenatal and Infant Screening.

Healthcare System
- Prioritize screening, referral to treatment, and follow up for substance use, mental health and all behavioral health conditions.

Provider
- Pediatricians to be equipped to screen parents for mental health symptoms.
- Conversations with caregivers on topics of health and safety.

Individual/Community
- Education, awareness, and distribution through grassroots methods and social media of the American Academy of Pediatric Safe Sleep Recommendations.

Community Action Group Members

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The FIMR Program is funded by the Florida Department of Health and administered by Broward Healthy Start Coalition.

For more information on the FIMR Program visit us at www.browardhsc.org