



# MASSACHUSETTS MEDICAL SOCIETY

*Every physician matters, each patient counts.*

**TESTIMONY IN SUPPORT OF H.2187/S.1414  
AN ACT RELATIVE TO CONDUCTING FETAL AND INFANT MORTALITY REVIEW  
BEFORE THE JOINT COMMITTEE ON PUBLIC HEALTH**

**November 15, 2023**

**The Massachusetts Medical Society (MMS) wishes to be recorded in support of H.2187/S.1414, *An Act relative to conducting fetal and infant mortality review.***

The Massachusetts Medical Society (MMS) is a professional association of over 25,000 physicians, residents, and medical students across all clinical disciplines, organizations, and practice settings. The Medical Society is committed to advocating on behalf of patients, for a better health care system, and on behalf of physicians, to help them provide the best care possible. The Medical Society is committed to the elimination of racial and ethnic disparities in maternal and child health outcomes and supports the timely, systematic monitoring of fetal and infant mortality in Massachusetts.

Infant mortality is a strong indicator of the health and well-being of a community or state because the same biological, social, economic, and environmental risk factors that contribute to infant health also affect the health of the broader population. According to the Centers for Disease Control and Prevention (CDC), Massachusetts had the second-lowest infant mortality rate (IMR) of 3.23 deaths per thousand live births in 2021.<sup>1</sup> But the state's overall success in this area belies pervasive disparities that exist across the Commonwealth. Low-income communities and communities of color have infant mortality rates that are nearly double the statewide average and above the 5.0 target Healthy People 2030 goal rate set by the U.S. Department of Health and Human Services. In fact, rates of infant mortality among Black infants (9.5) were more than two times that of Whites, while Hispanic infant mortality rates (2.7) were 1.5 times higher than Whites, geographically, according to the most recent data available from the Massachusetts Department of Public Health (DPH).<sup>2</sup>

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<sup>1</sup> Centers for Disease Control and Prevention, Stats of the states – infant mortality.

<https://www.cdc.gov/nchs/pressroom/states/massachusetts/ma.htm>

<sup>2</sup> Massachusetts State Health Assessment, Maternal, Infant, and Child Health. <https://www.mass.gov/doc/chapter-2-maternal-infant-and-child-health/download>

Communities have struggled to consider and understand the potential causes of the disparities in local infant mortality rates. Many have expressed a desire for more timely data and more opportunity to dig deeper into the individual stories in a timely and compassionate way that will allow them to hear directly from families, not merely through the filter of medical chart audits. One way to identify and help address disparate rates of fetal and infant death is through Fetal Infant Mortality Reviews (FIMRs), a public health, multi-part process that supplements state records with detailed information from individual record reviews by a multi-disciplinary case review team and in-home interviews with mothers and other family members about their experiences. FIMR is a community-based, action-oriented process that brings together key stakeholders to examine fetal and infant deaths, determine preventability, and engage communities to take action. It is critical to provide a platform for families' perspectives on accessing care and facing the grief of a loss, as well as for community perspectives, which can help inform local or state policymakers. This platform is a unique element to the review that brings voice to the personal experience of the death and provides important insights to uncover actionable opportunities to strive toward improved, equitable health outcomes by expanding access to services and care, systems, and resources for women and birthing individuals, infants, and families. We know systemic racism is the driver of racial inequities in maternal and child health outcomes; establishing local FIMRs can begin to address these systemic issues by identifying whether quality services and community resources are available, accessible, culturally appropriate and responsive to a community and if not, developing recommendations make them so.

At present, no community conducts a process aligned with federal FIMR guidelines. This legislation would: (1) require timely data sharing from DPH to local public health departments. DPH would establish a process and criteria for local public health entities to request and receive information on infant and fetal deaths in a timely manner; (2) empower local public health departments that desire to access Vital Statistics data and other relevant data from multiple sources, which may include physician and hospital records in addition to relevant community program records; and (3) enable an established and proven tool to address community issues through FIMR. Notably, this legislation does not require any community to establish or conduct FIMR nor does it change any reporting requirements for fetal deaths.

While the MMS supports this legislation, we urge the inclusion of language to promote privacy for families electing to be involved in the FIMR process by requiring that all data and records created or maintained pursuant to this section to not be confidential. Last session, the Joint Committee on Public Health reported favorably on a version of this legislation that included such language.<sup>3</sup> We respectfully

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<sup>3</sup> See H.2371, *An Act relative to conducting fetal and infant mortality review*: <https://malegislature.gov/Bills/192/H2371>

request the committee's consideration of the reintegration of these privacy protections into H.2187/S.1414.

Massachusetts excels in the practice of precision public health, using data and technology to inform policy and improve practice. Unfortunately, data from the state regarding fetal and infant deaths are typically not available until two years after any loss. This delay hinders the ability to conduct the family interviews and obtain critical information that can improve practices and impact outcomes. Allowing Massachusetts communities to carry out FIMR processes in line with best practices will bring new insight to help us lower the infant mortality rate in communities whose rates now exceed the state average.

For these reasons, the Massachusetts Medical Society urges favorable action on H.2187/S.1414, *An Act relative to conducting fetal and infant mortality review*. Thank you for your consideration of this legislation.