Palm Beach County Fetal and Infant Mortality Review
Case Review Team Meeting Notes
Tuesday, September 18, 2018

Meeting Results:
By the end of the meeting the CRT will:
- Review each case presented by the Palm Beach County FIMR team
- Individually and in assigned groups identify the factors/causes contributing to the case
- Review the case collectively during the FIMR Abstractor team presentation
- Following the presentation, deliberate collectively on the contributing factors, strengths and suggestions
- Collectively determine if the death was preventable
- Formulate recommendations to be shared with the Community Action Group (CAG)

Meeting Participants:

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<th>Name</th>
<th>Organization</th>
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<tr>
<td>Jeff Goodman</td>
<td>Children’s Services Council of PBC</td>
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<td>Lisa Greenwood</td>
<td>Healthy Mothers, Healthy Babies</td>
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<td>Christine Walsh</td>
<td>Children’s Services Council of PBC</td>
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<td>Julie Swindler</td>
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<td>FDOH, Healthy Start Coalition</td>
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<td>Zoraime Ramos Cortes</td>
<td>WIC</td>
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Program Staff

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<td>Dr. Roderick King</td>
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<td>Martine Jolicoeur</td>
<td>FDOH, PBC-FIMR Qualitative Abstractor</td>
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Collective Case Deliberation/Review Notes

Case #1 Significant Issues

Preconception
- Obesity
- Diabetes (Discrepancy in how condition was listed in medical records and on death certificate; prenatal record stated mother had pre-gestational diabetes; throughout the pregnancy and on death certificate stated gestational diabetes. Records did not specify Type 1 or Type 2 Diabetes)

Prenatal
- Late prenatal care (started at 16 weeks)
- Loss of insurance coverage (records did not specify type of Medicaid insurance)
- Prenatal Risk Screen scoring issues (hospital/clinic scoring different from HMHB scoring)
  - Scored a 3, but should have scored a 5 on prenatal risk screen
- Interoperability: Providers are not getting the information being collected by CSC/Healthy Beginnings (HB)
Lack of follow-up with patient in between prenatal care appointments

- Referral was not made to HB home visiting nurses (disconnect between provider and HB services)
- Possible language barriers preventing full understanding of the health education provided

Was this death preventable? No

Service delivery gaps:
- Physician education and data sharing

Personal strengths:
- Mother was employed
- Received WIC and Medicaid services
- Mother’s Education-GED

Improved linkages:
- Prenatal risk screen
- Medicaid/loss of insurance
- Palliative care/bereavement support

**Case #2 Significant Issues**

**Preconception and Prenatal**
- Late prenatal care
- Wanted to be pregnant later (stress of unplanned pregnancy and not being able to pay bills)
- Didn’t feel the baby kick (lack of education or understanding around counting kicks)

Service delivery gaps:
- HMHB staff is not a medical staff
- HB Prenatal Risk Screening information is simply “Self Report”
- 1st score on Prenatal Risk Screen is the only one counted regardless of the subsequent scores that may be recorded.
- Language barriers may contribute to skewed responses and interactions between staff and the patients.
- Suggestion that motivational interviewing techniques can be improved.

Improved linkages:
- Education of prenatal risk scoring and referrals
  - “Wanted to be pregnant later” should generate a certain referral within the HB system
- Sharing of information between CSC, RIPCC, DOH
- F/U where to get information about labor signs
- Provide mother with information about pre-eclampsia

**Summary of Proposed CRT Actions and Recommendations to the CAG**

**Proposed CRT Actions:**
- Show abstractors where the bereavement services are documented in the medical chart

*Research and report on the following for next meeting (Oct. 9):*
- If prenatal risk assessment is done early in pregnancy, what happens if she does not continue services with HMHB to get second scoring? How do we transfer the information from one office/clinic/hospital to the other?
Healthy Start information does not reach the RIPCC doctors or providers. Where does it go when it is sent to the hospital or the clinics?

How will RIPCC clinic, DOH, and CSC share information about the patients? Can we start working on a plan?

Lisa (HMHB) will be bringing a blank scoring questionnaire and has offered to also share the information on cases selected.

Could the bereavement services from hospice org be used for FIMR?

**Recommended Community Actions:**

1. Have an early system of screening that will generate community referrals for follow up.
2. Home visits to check on patient during and after pregnancy (or death of child).
3. Communication with patient: they still can continue receiving care at the RIPCC clinic whether they have insurance or not.
4. Communication between providers: there should be some way for all providers to be on the same page about the patients. The electronic medical records should all be synced.
5. Communication between the CSC data and Electronic medical files of the clients in order for all providers (CSC and medical) to be informed of the patients’ situation.
6. Discussion about the March of Dimes $$
7. Are there bereavement checklists and how can abstractors obtain them? Are they completed and are they efficient? Can they be improved?
8. Develop or share an existing checklist for pregnant women (kick counts, where to access prenatal care, locations of birthing centers, etc.)

**CRT Meeting Process Feedback**

**What worked well?**

1. Getting cases early
2. Great format
3. Great summaries
4. Small diverse group to facilitate discussions

**Improvements:**

1. Add zip codes to the narratives to check for patterns
2. Make sure prior pregnancy history is included in the narrative
3. Show risk screens done for every mother
4. Share Infographic on Healthy Beginnings System/Services

**Next Steps:**

Complete CRT Meeting Feedback Survey: https://www.surveymonkey.com/r/?sm=k92hljflUfDkVlGLOaqxQa98Ph6BKqbz0QgDBmqaVZ4_3D

**Next CRT Meeting:**
Tuesday, Oct. 9, 2018; 6:00-8:00 p.m.
Quantum Building Community Room
2701 N. Australian Ave., West Palm Beach 33407