Meeting Results:
By the end of the meeting the CRT will:

- Discuss updates and new information gathered since the Sept. 18 meeting
- 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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<tr>
<th>Name</th>
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<tr>
<td>Ellen Steinburg</td>
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<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>Julie Swindler</td>
<td>Families First</td>
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<td>Dr. Allan Dinnerstein</td>
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<td>Rich Ellis</td>
<td>PBC Fire Rescue</td>
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<td>Lauren Young</td>
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<td>Amy McGuire</td>
<td>Saint Mary’s Medical Center</td>
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Program Staff

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Review Sept. 18 Meeting Notes and Discuss Updates

Updates to Recommended Community Actions from Sept. 18 CRT Meeting:

1. **Have an early system of screening that will generate community referrals for follow up.**
   - **Update language:** Improve training around the system of screening that generates referrals to the Healthy Beginnings system.
   - **Clarification:** If the screening is accurate, it automatically links to services within the Healthy Beginnings system, but not necessarily to other community resources. Team was seeking improvement of the early screening in order for the families to be funneled into the HB system.
   - Educate the patient appropriately in order for them to be informed that they will be receiving care throughout their pregnancy regardless of their status or coverage.
   - Making the value of the services known to the general public. Patients decline services and screens due to them not quite understanding what is being offered to them and how it will benefit them.
• There is a difference between giving the screening material to the patients for them to fill out vs. having someone administer them. The professional who administers has a better chance to capture the scenarios in the patient’s life and can prompt for details. This would mean better understanding and utilization of services.
• There might be a shortage of professionals (i.e. at HMHB) who go to the private doctors’ offices to administer the tests/screens. The front desk personnel might not take the time to assist the families in completing the screens/surveys.

2. Are there bereavement checklists and how can abstractors obtain them? Are they completed and are they efficient? Can they be improved?
• Better connection between hospitals and hospice in order to have a more elaborate and efficient bereavement process. This will improve the bereavement support system.
• Funding might have recently been restored at the hospice to cater to families needing counseling after losing a child. There was a discussion about how to bring this information to the public.

3. Develop or share an existing checklist for pregnant women (kick counts, where to access prenatal care, locations of birthing centers, etc.)
• The prenatal checklist is very important but the results are not communicated with the patients. They might not be aware of the use of the checklist. This process should be explained to the patients and they must know about the resources available to them beyond that checklist (i.e. Ensure providers are utilizing CSC’s pregnancy guide for patient education).
• The pregnancy resource guide should be distributed during each 1st prenatal visit and explained.

Collective Case Deliberation/Review Notes

Case #00003:
Gaps in Service Delivery or Community Resource Systems:
• Was there information about the patient prior to them entering RIMPC?
• How can we educate the population on two-vessel cord problems?
• Concern about some patients not getting the full scope of care available due to their ability to pay at RIMPC.

Personal Strengths or Service Delivery Systems of Support:
• Discussed the importance of fetal movement

Preventability: The group found that the preventability of this case was undeterminable. It is unknown as to whether there were cardiac anomalies and there was no autopsy performed on the baby.

Recommendations:
• More stress testing should have been done for this mother.
• Suggestion to explore making two-vessel cord an indication for early delivery.
• Identify how bereavement services can be improved.

Case #00004:
Gaps in Service Delivery or Community Resource Systems:
• Was there genetic counseling done for this family?
• If mother had done the amniocentesis, would she have received genetic counseling?
• Were certified interpreters provided to the family? It is noted that the husband served as translator, but it is unknown if medical information was clearly conveyed to the mother.
Personal Strengths or Service Delivery Systems of Support:
- Mother was encouraged to eat nutritiously and take prenatal vitamins

Preventability: The group determined that this death was not preventable due to cause of death (genetic abnormality)

Recommendations:
- Identify when genetic counseling is offered and if mothers with a history of genetic abnormalities automatically receive this.
- Identify health clinic and hospital protocols for providing families with qualified interpreters to ensure medical information is accurately relayed to the patient.
- Mother declined Prenatal Plus Program—identify why patients are not enrolling in free services and how better to communicate the benefits of these programs.

Case #00005:
Gaps in Service Delivery or Community Resource Systems:
- Was there postpartum care for the family? Family planning, home visits, etc.? (This information was not available from the health department clinic)
- Patients sometimes complain of the long wait before they are able to access care at the health department clinics and that deters them from making appointments when a medical issue comes up. They go to the emergency room.
- Unknown if palliative care or grief support was provided.

Personal Strengths or Service Delivery Systems of Support:
- Access to health insurance (Medicaid)

Preventability: The group determined that this death was not preventable due to cause of death (genetic abnormality)

Recommendations:
- Education should be made around advanced maternal age as well as family planning (which is available through Medicaid).
- Review/revisit case selection protocol (eliminate cases with cause of death as genetic abnormalities to prioritize preventable causes of death).

Next Steps:
- CRT members to complete the following action commitments for the next meeting:
  1. Bereavement Services: Identify resources available through hospice organizations
  2. Checklist: Bring copy of CSC’s pregnancy resource guide
  3. Bring copy of prenatal risk screen scoring questionnaire
  4. Identify the availability of services based on payer source (specifically undocumented)
- CRT members interested in attending the Oct. 17 PBC-FIMR Community Action Group Meeting can RSVP to FGlasgow@flhealthinnovation.org
- Save the date for the next CRT Meeting:
  Tuesday, Nov. 13; 6-8pm
  Quantum Building Community Room
  2701 N. Australian Ave., West Palm Beach 33407