Palm Beach County Fetal and Infant Mortality Review
Case Review Team Meeting Notes
Wednesday, Dec. 12, 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>
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<tr>
<td>Jeff Goodman</td>
<td>Children’s Services Council of PBC</td>
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<tr>
<td>Lisa Greenwood</td>
<td>Healthy Mothers, Healthy Babies</td>
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<tr>
<td>Christine Walsh</td>
<td>Children’s Services Council of PBC</td>
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<tr>
<td>Julie Hayden</td>
<td>Department of Health (DOH)</td>
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<tr>
<td>Rich Ellis</td>
<td>PBC Fire Rescue</td>
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<td>Lauren Young</td>
<td>PBC Fire Rescue</td>
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<td>Kristin Dean</td>
<td>HomeSafe</td>
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Program Staff

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<tr>
<td>Dr. Roderick King</td>
<td>Florida Institute for Health Innovation (FIHI), PBC-FIMR Program Director</td>
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<tr>
<td>Martine Jolicoeur</td>
<td>DOH, PBC-FIMR Qualitative Abstractor</td>
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<tr>
<td>Debra Oliver</td>
<td>DOH, PBC-FIMR Quantitative Abstractor</td>
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<tr>
<td>Danielle Lewald</td>
<td>FIHI, PBC-FIMR Program Manager</td>
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<td>Fay Glasgow</td>
<td>FIHI, PBC-FIMR Site Coordinator</td>
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Collective Case Deliberation/Review Notes

Case #00006:

Was this death preventable?

- Not clear
- Many missed things at clinic that could have been caught in case management
- Not clear if there was anyone case managing to see the roadblocks she encountered
- If the providers listened to her original concerns, outcome would have been different

Significant Issues:

- Lack of case management
- Lack of social services during prenatal period
- Gap in clinical processes- many missteps given gestational diabetes
- Lots of mistrust possibly due to cultural issues that could prevent her from seeking out medical care in the future
- She was angry about not receiving postnatal services....she wanted more and didn’t get it
- Obesity
- Not using appropriate medical interpretation services (spouse served as translator)
• Healthy start risk screen (Unclear as to why she didn’t get services; may have been screened and declined or lost to follow-up)

Gaps in Service Delivery or Community Resource Systems:
• Case management definitely needed (community-based case management via social worker/CHW)
• Constant issues with accessing medications, services, etc.
• She would have qualified for the home visiting program (Healthy Families)
• Hospital liaisons would not complete an infant risk screen on an infant that died, which leads to lack of postnatal services for mom

Recommendations:
• Educating providers and family to complete prenatal risk screen and explain services family is eligible for (ensure they get services)
• High risk clinic could have community-based case manager assigned to high risk moms (E.g Bayview hospital)
• Increase access to post-partum care after infant demise
• Improve connection between mom and hospice and other services available to bereaved mothers (TrustBridge and VITAS)

Case #00007:
Was this death preventable?
• Unclear...no prior information about the mom since she came from outside of the country
• Made assumptions since data was missing
• This was a unique situation due to possible impact of stressors from hurricane

Significant Issues:
• History with chronic issues and would do better when treated with trauma informed care
• Language barriers

Strengths:
• Medicaid insurance
• Evacuated home country due to hurricane; sought out help
• Received bereavement packet

Recommendations:
• Can we develop a trauma informed care approach for moms post loss?
• Note in the medical record if a referral was made in the hospital, instead of just giving a bereavement packet to family (more follow-up is needed)
• Ensure bereavement resources are available in other languages
• Standardize bereavement care (closure and grieving services) and postpartum trauma informed care
• Improve postnatal care for parents (provide support after the loss and help family deal with next pregnancy)

Case #00008:
Significant Issues:
• For high risk mothers being hospitalized should we be monitoring 24/7?
• Why are moms with private insurance getting better care than our Medicaid patients?
• Providers stating...Why should we waste taxpayer dollars on Medicaid patients to order extra labs? (Dealing with a two tiered system)
• Lack of family planning services and birth control counseling
Recommendations:
- Address inequities in care provided to patients based on payor source (i.e. private insurance vs. Medicaid)
- Improve postnatal care services including bereavement support, family planning and birth control counseling

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 payor source (specifically undocumented)
- Save the date for next meeting:
  Tuesday, January 15, 2019; 6-8pm; Quantum Building, WPB