Palm Beach County Fetal and Infant Mortality Review
Case Review Team Meeting Notes
Tuesday, Feb. 12, 2019

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

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jeff Goodman</td>
<td>Children’s Services Council of PBC</td>
</tr>
<tr>
<td>Christine Walsh</td>
<td>Children’s Services Council of PBC</td>
</tr>
<tr>
<td>Rich Ellis</td>
<td>PBC Fire Rescue</td>
</tr>
<tr>
<td>Lauren Young</td>
<td>PBC Fire Rescue</td>
</tr>
<tr>
<td>Dr. Allan Dinnerstein</td>
<td>Helix</td>
</tr>
<tr>
<td>Jennifer Boutin</td>
<td>Nutritious Lifestyles</td>
</tr>
<tr>
<td>Kristin Dean</td>
<td>HomeSafe</td>
</tr>
<tr>
<td>Dr. Janis Jones</td>
<td>T. Leroy Jefferson Medical Society</td>
</tr>
<tr>
<td>Dr. John Caravello</td>
<td>ObGyn Specialists of the Palm Beaches</td>
</tr>
<tr>
<td>Julie Swindler</td>
<td>Families First</td>
</tr>
<tr>
<td>Zoraime Ramos-Cortes</td>
<td>WIC</td>
</tr>
<tr>
<td>Safiya Young</td>
<td>WIC</td>
</tr>
</tbody>
</table>

Program Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. Roderick King</td>
<td>Florida Institute for Health Innovation (FIHI), PBC-FIMR Program Director</td>
</tr>
<tr>
<td>Martine Jolicoeur</td>
<td>DOH, PBC-FIMR Qualitative Abstractor</td>
</tr>
<tr>
<td>Debra Oliver</td>
<td>DOH, PBC-FIMR Quantitative Abstractor</td>
</tr>
<tr>
<td>Fay Glasgow</td>
<td>FIHI, PBC-FIMR Site Coordinator</td>
</tr>
<tr>
<td>Danielle Lewald</td>
<td>FIHI, PBC-FIMR Program Manager</td>
</tr>
</tbody>
</table>

Collective Case Deliberation/Review Notes

Case #00012:

Significant Issues:

* Misdiagnosis of hypothyroidism=>incorrectly listed in medical chart
* Question as to whether the appropriate care was provided

Strengths:

* Sought help
* OB was detailed
* Family support
* Consistent medical care
* Mother was employed
* Good nursing staff
Gaps in Service Delivery or Community Resource Systems:

- Better interconception care needed
- Inconsistency in definition of interconception care between WIC (2 years) and FLDOH (18 months)
- Accepted navigation (WIC) but not nurse home visiting program=>why?
- Are private providers reopening cases to push for home visiting nurse through Healthy Mothers, Healthy Babies (HMHB)?

Recommendations:

- Improve patient follow-up by establishing a HMHB contact person available for providers to call
- Dig deeper to figure out why patients are noncompliant and declining services

Was this death preventable? YES

Case #00013:

Strengths:

- Utilized WIC services
- Medicaid insurance
- Mother took prenatal vitamins
- Mother was employed

Gaps/Significant Issues:

- Patient did not respond to outreach to engage in services
- No one intervened after initial contact through HMHB encounter

Recommendations:

- Build an additional layer of outreach/follow-up to patients that decline services (current program recently launched by Families First)

Was this death preventable? Unknown; do not know all underlying issues to be able to determine preventability.

Case #00014:

Strengths:

- Good prenatal care
- Some education (high school)
- Married
- Health insurance

Gaps/Significant Issues:

- Patient waited 2 hours in ED
- Information gaps in medical record
- Cultural disconnect related to bereavement services offered
- Lack of education during prenatal period
- Lack of nutritional services given high BMI
- Timing of bereavement services=>were offered during delivery of baby

Recommendations:

- Improve coordination and alignment between L&D services and ED services
- Ensure that all providers offer patient education on kick counts, signs of pre-eclampsia, and labor symptoms
- More culturally competent services, including culturally sensitive staff that are ethnically similar to the community served
- Nutritional services to help mothers maintain a healthy BMI and education to address maternal obesity
- More education for all staff on question 21 of the prenatal risk screen: Does patient have an illness that requires ongoing medical care?
- Improve approach and timing of bereavement care services offered

**Was this death preventable?** Medically, not preventable; other factors were viewed as preventable.

**Next Steps**
Save the Dates for Upcoming Meetings and Events:
- Next CRT Meeting: Thursday, March 14, 2019; 6-8pm; Quantum Building
- Upcoming CAG Meeting: Wednesday, March 27, 2019; 10:30am-1pm; Quantum Building
- The Florida Perinatal Quality Collaborative will be hosting its annual conference April 4-5 in Tampa
  (REGISTER HERE)