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

- Review each case prepared 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 review, 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>
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<tbody>
<tr>
<td>Jennifer Boutin</td>
<td>Nutritious Lifestyles</td>
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<td>Kristin Thomas</td>
<td>HomeSafe</td>
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<td>Lisa Greenwood</td>
<td>Healthy Mothers Healthy Babies of PBC</td>
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<td>Dr. Patrick Bernet</td>
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<td>Julie Swindler</td>
<td>Families First</td>
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<td>Jeff Goodman</td>
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<td>Lauren Young</td>
<td>PBC Fire Rescue</td>
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<td>Danick Joseph</td>
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<td>Fay Glasgow</td>
<td>FIHI, PBC FIMR Site Coordinator</td>
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Case #34:

Significant Issues/Present and Contributing Factors:

1. Preconception/Medical History of Mother
   - Overall Health (fibroids, cancer)
   - Obesity
   - Language barrier/lack of insight
   - Unemployed
   - Less than high school
   - Financial stressors
   - Insurance issues
   - Dental problems
   - Preterm labor
   - Acute Chorionitis
   - PPROM (prolonged premature rupture of membranes)
   - Pre-existing dental issues
   - Multiple stressors

2. Medical: Fetal/Infant
   - VLBW (<1500 grams)
   - Prematurity
   - Respiratory Distress Syndrome
   - Sepsis

Strengths:

- Early prenatal care entry
- HMHB involvement
- Referred to perinatologist
- Nutritional assessment
- Postpartum visit kept
- Family support
- Medicaid + WIC + birthing classes
- Followed plan of care
- Planned pregnancy

Gaps in Service Delivery or Community Resource Systems:

- Language barrier at hospital level; Lack of trust between provider and patient; lack of medical case management involvement; Breast cancer not followed adequately; Mom’s previous health conditions may have contributed to the sepsis.

Recommendations:

- Link HMHB medical case management to hospital medical case management services
- Follow-up with high risk pregnant patients weekly
• Provide appropriate mental health services with appropriate language interpretation to ensure continuation of care after loss
• Refer to ICC (interconceptional care)
• Ensure patient is healthy before next pregnancy

Was this death preventable? Yes

Case #35:

Significant Issues/Present and Contributing Factors:

2. Preconception/Medical History of Mother
   • Advance maternal age
   • Chronic Hep B
   • Lack of prenatal teaching
   • Non-compliance with plan of care
   • Language barrier
   • Waiting > 24 hours before following-up about lack of fetal movement
   • CMV infection/ Parvovirus
   • Missed appointments
   • Lack of home visiting (eligible)
   • Missing data
   • No documentation of bereavement support

2. Prenatal
   • Oligohydraminios

Strengths:
   • Married
   • Early entry to PNC
   • Private insurance
   • Referred to perinatology

Gaps in Service Delivery or Community Resource Systems:
   • Not enough information to determine gap in delivery services

Recommendations:
   • Medicaid case manager/ medical case manager
   • Financial assistance for moms on bedrest
   • Link to community/social services (not just a referral but follow-up)
   • Better access to documentation/medical records

Was this death preventable? Unable to determine due to lack of engagement and information
Case #36:

Significant Issues/Present and Contributing Factors:

3. Preconception/Medical History of Mother
   - Patient not comfortable to communicate concerns/info with midwife
   - Obese
   - History of asthma
   - Unintended pregnancy
   - Mild acute chorioamnionitis
   - Placental problems
   - Lack of consistent PNC visits
   - Recent move after pregnancy
   - Lack of home visit (eligible)
   - Significant weight loss during pregnancy
   - Multiple stressors
   - Concern about enough money

2. Prenatal
   - Multiple providers/site
   - Standard of care not met

Strengths:
   - Father of baby involved/married
   - Employed part-time/student
   - Referred to perinatology
   - Early entry to PNC
   - Mom continuing her education
   - Medicaid
   - Financial planning for baby’s arrival
   - Family support
   - Mom advocated for herself

Gaps in Service Delivery or Community Resource Systems:
   - Inconsistent care due availability of provider; Mom did not get connected to resources due to mother not responding to outreach efforts.

Recommendations:
   - Offer more case management services in hospitals to ensure patients receive wrap around services after discharge
   - Provide culturally diverse training to all hospital staff to ensure staff is appropriately addressing patients’ needs and concerns and not making inappropriate comments
   - Encourage hospitals to provide appropriate training and incentives to address compassion fatigue issues
   - Conduct a complete psychosocial assessment on all pregnant patients during hospital stay
Was this death preventable? Unable to determine

**Case #38:**

Significant Issues/Present and Contributing Factors:

1. Preconception/Medical History of Mother
   - Mental health issues
   - Multiple drug use
   - Obese
   - Bipolar
   - Non-compliance with plan of care (appointments & medication)
   - Home chaos
   - No mandated services in the home after mom discharge from hospital
   - Unsafe sleep environment

2. Prenatal
   - Multiple gestation
   - Chronic hypertension
   - Preeclampsia
   - Discharge from OB practice

3. Medical: Fetal/Infant
   - Prematurity
   - Positive screen for NAS (neonatal abstinence screen)

**Strengths:**

- Father of baby involved/married
- DCF involvement
- Financially stable
- Private
- Established pediatric care

**Gaps in Service Delivery or Community Resource Systems:**

- DCF should have required mandated services to family instead of recommending voluntary services.

**Recommendations:**

- Regular mandated drug testing
- Drug treatment
- Mandated services from DCF
- Provide ongoing mental health counseling for surviving siblings

Was this death preventable? Yes