[2:21] **Hospital Administrator**

>> Was there an interpreter used?

[2:23] **Chair**

>> No I didn't see any mention of an interpreter used in her office notes from this particular pregnancy either at her intake or the postpartum visit. They gave her Depo-Provera at that postpartum visit and then talk about potential Essure or something more permanent, but that was left open-ended at that time. In terms of her 2005 delivery or her 2006 termination I don't have any more information about that.

 [3:28] **Nurse Midwife**

>> I think Dr. Goldsmith is right. In terms of the initial failure, failure with contraception I think subsequent of that there seems like there was a failure of prenatal care in terms of, you know a woman who sounds like she has a history of peripartum cardiomyopathy although, you know as in anything there's always a question of what exactly is the etiology of her heart failure especially with this family history of heart failure, but she sounds mostly like peripartum cardiomyopathy who sort of, who wasn't cared for like somebody who has peripartum cardiomyopathy and potentially wasn't counseled appropriately for her risk of occurrence of that event and postpartum period.

 [4:36] **Cardiologist**

>> So I think from my experience, looking at cardiac cases in maternal mortality this is a prototype case. This is a prototype case for cardiomyopathy of any kind, but this particular like you mentioned earlier with the family history, brother dying at the age 19, makes me think of a familial type of cardiomyopathy, but it doesn't matter at this point. I think the important thing is that she had cardiomyopathy, was in congestive heart failure prior with a prior delivery and then there was a loss of follow up, kind of no medical care, now she presents late into prenatal care with that history. I think that is a point where you could have helped or there was an opportunity not only to get all those records in a timely manner, but consult her right there and then and then from there on she had more than one emergency room visits. So I think this is again a failure, there is several points where you could have intercepted, helped, prevented this unfortunate event.

[5:46] **Patient Advocate**

>> I was stunned when I saw that her first visit at 35 weeks, so she's presented very late, she's saying she had congestive heart failure and there was no referral.

>> And I think, you know, you know what I was imagining was no translator, you know a woman that the providers were having a very hard time communicating with, at that point knowing that she hadn't come in until 35 weeks, she needed a whole host of things happening on the medical side of things, but also on, I don't know when the, they learned about the Intimate Partner Violence, but in terms of social work getting involved and a home visiting service like to make, because she has this history of not following through.

[6:36] **Chair**

>> She went to a private OB/GYN's office and so you know there's a nursing intake and then there's three visits with the provider and patients, you know even if they, anybody that, it's not normal for a 30 year old to tell you that they have a heart condition, you know? You know, and if they say that, especially if they know something as specific as congestive heart failure, I probably wouldn't spend a lot of time thinking about gee I wonder if that's really true or not true. You know, especially time is of the essence at 35 weeks and you know you can probably at least get an echocardiogram. Sometimes it can be hard maybe depending on where you practiced to get a referral in or this or that, but at least if you get the echocardiogram in and realize kind of what you're dealing with if it's markedly abnormal, then at least you have some, you know you're going to manage, I think her labor differently in terms of fluids and all of that sort of a deal.

[7:32] **Cardiologist**

>> Absolutely. I think --

>> In this case it was starting from the inter conception period, before she presented to we have areas to improve and when she presents for prenatal care there's another opportunity to look into it and after she delivers she had this history and now she delivered with this history of cardiomyopathy and we know that these patients, cardiac patients may get worse. Not necessarily during delivery, but after delivery so that was another opportunity particularly she had complained of cough after she delivered. So that was a red flag right there and then --

[8:12] **Chair**

>> If you look at her I's and O's (intake and output) too she was positive three liters at the first 24 hours.

[8:17] **Pathologist/ME**

>> But some point you think she's having, she had the post appointment. So is there, when are you out of the woods? Because she delivered in '05 and that was just four years later. So at what point --

[8:32] **Cardiologist**

>> Well typically in a patient that has postpartum cardiomyopathy, if they recover they usually recover in the first six months. So if she had a follow up echocardiogram within the first year and her ejection fraction was not normal and she was off of medications, she falls into a separate group, which is a better prognosis than somebody who has persistent LV (left ventricle) function, which I suspect this patient was because she practically was symptomatic at the time of delivery. >> So that is a group of women where the mortality approaches 20-25%. So this is the group of patients whose pregnancy is contraindicated, that's why she had that termination in 2006 and if she gets pregnant again with LV dysfunction you have to again, discuss pregnancy termination and follow in a multidisciplinary fashion.

[9:24] **Hospital Administrator**

>> And so the point that I wanted to make with respect to the interpreter because I've seen this happen a lot times with patients is they might memorize, they might memorize a buzz word, but it doesn't necessarily mean that they understand it. when looking at the face and go like this, families translating for them, I mean there's a reason why you have to have an appropriate interpreters because they're not going to be able to convey the medical terms and in looking at how poor the postpartum discharge instructions were when you're thinking about the acuity after delivery, it just feels like such a recipe for disaster.

[10:00] **Executive Director of a Maternal and Child Health Stakeholder Organization**

>> There was and I think just to tag along on your postpartum instructions, when you look to see that there were no special problems noted, nor were there any postpartum instructions, special instructions provided. Huge missed opportunity because even if there wasn't as much recognition, I don't know that there wasn't any recognition of her history with the cardiac disease, but to know that should you have an increase in any of these symptoms that you need to come back immediately prior to the two week visit whenever that happens it's important not only for her, but also for her family to recognize that to assist so I think there was a big --

[10:46] **Cardiologist**

>> And expanding on the same part, she actually did present in the emergency department more than once --

>> And then --

>> And we didn't treat her right.

[10:55] **Executive Director of a Maternal and Child Health Stakeholder Organization**

>> So did she share with them that she had been pregnant, so did they know the recent pregnancy or did the provider know to even ask that question?

[11:05] **Cardiologist**

>> So that is the part of the cardiovascular tool kit that we worked on, pregnancy within the last year Emergency Department knows that if they delivered and they come in with shortness of breath, cough, asthma, those are the triggers to look for.

[11:22] **Nurse Midwife**

>> Can I ask Dr. Hameed just a quick question about sort of the actual cause of death. I mean, I was a little bit confused just in terms of how the MI (myocardial infarction) plays into this whole picture. I mean, in some of the documentation they say like she had an MI that resulted in, you know, her cardiomyopathy result to her death which doesn't seem correct, you know, with all these-- seems like the other way around.

[11:45] **Cardiologist**

>> Yeah.

>> I agree, I think if ejection fraction (EF) falls down to 20%, for those of you who are not familiar EF is 55% in a normal person. So, when it falls down to 50%, that's when look for a transplant. Those are transplant candidates when you get to 20%, these are women-- or patients who are really symptomatic. They're on multiple medications at this percent of cardiac death. So, they are the super high risk. So, the sequence of events that seems to happen here is, she went into heart failure and she was in cariogenic shock, which was the extreme. The only way she would have gotten out of it is if she responded to intra-aortic balloon pump or she was left ventricular assist device or transplant. Otherwise, there's very little chance. And particularly with malignant arrhythmias these patients don't do well. In terms of the coronary, I think those are-- I won't-- I agree with you. I don't think those are the primary reasons because initially, she had the troponins done, her EF fraction, there was no initial evidence of myocardial damage. So, even though that, again, happen in peripartum cardiomyopathy. So, there was no big myocardial infarction that put her in-- For you to have cardiogenic shock with myocardial infarction, would only be if literally, all three or two of the big vessels get blocked and there's no perfusion to the heart. And your troponins would be sky high and it would be a different picture. So, this is primarily cardiomyopathy.

 [13:23] **Anesthesiologist**

>> And what are the recommendations for anticoagulation for these women? She did have two little clots in her left circumference

[13:30] **Cardiologist**

>> Absolutely. So, when the ejection fraction goes below 30%, your cardiac output is not that great. So, you tend to have stasis, you tend to have not only venous thromboembolism, you also have a thrombus inside the heart, which is the LV thrombus. So, the recommendation is to give them anticoagulation to prevent those complications. All right. In this particular case, I don't think that primarily led to the demise but, yeah, I think that is what was lacking in terms of her care.

[14:02] **Patient Advocate**

>> So, my question as the non-medical person here is, we know that she died from this cardiac set of events but was it that-- is it that what killed her or was it the system failure to properly treat her? So that, if when she got there at 35 weeks with no prenatal-- well, one would hope, that there would have been follow up before that with this woman. But, getting to prenatal care at 35 weeks if, like at that point, the physician has referred her to a tertiary care hospital and a team came in and—[14:36]

[15:02] **Anesthesiologist**

>> And what are the legal requirements for translation services?

>> It's required.

[15:08] **Hospital Administrator**

>> It's required in a hospital facility, you're supposed to provide one. That's why I kept asking.

>> Is it federal, is it--

>> Yeah, yeah, medically trained.

>> Yes.

>> Yes. Medical trained, it can't be the family.

>> Right.

>> It's not supposed to be the family.

>> And what’s the standard of service that has to be achieved?

>> Well, that's why you would require a medical--

>> …cause she speaks French and there’s not so many French speakers…

>> But if the person doesn't necessarily we have to be-- the person doesn't have to be solely be there in person. You could do it through like Skype-wise or telephone. There's different options. Ideally, if it's during the delivery, you would want to have somebody there in person but that's not always the case. There's a lot of technology now to make it happen. And if she had a planned induction, then you had enough time to coordinate all those services.

[15:52] **Chair**

>> Well, French isn't a difficult language. I mean, we have in our, you know, in Columbus, you know, like Fulani language. There's one Fulani interpreter in the entire city, you know. So, that requires, you know, a lot more.

>> And that's part of—

>> what about a private doctor's office? Is that different from a hospital? My understanding is even if you're in a private doctor's office, you still have to meet those understands in terms of interpretation.

>> You still have duty… [16:15]

[16:24]

>> So, from the legal standpoint, what-- how do you determine that this patient needs an interpreter versus not?

[16:30]

>> So, if you're-- so, I'm going to play devil's advocate. A couple of people mentioned how many times she talked about congestive heart failure, right? But yet, the way that she treated her pregnancy and the lack of follow up can lead you to believe that she didn't have a full understanding of exactly how to manage this.

>> And how can you say that you properly educated the patient when you don't speak her language and you didn't have anybody there to be able to say, "Hey, I communicated with her in French." You don't have any documentation of that all.

[19:17] **Chair**

>> We better pause here because it's a great discussion we, you know. But we have another case to do. So, we should probably take a look and I think what we're going to do is go to our audience and let them vote and then we'll make our deliberation then we see the comparison.

 [19:37] **Coordinator**

>> So, I'm hoping too that everyone is feeling like that this is much richer than just administrative data, right? OK. So, make sure that you're-- if you have a clicker, not everyone has one because we only have 40. Make sure that your clicker is on, turn it on. This is going to take us just a few seconds. So, one of the key decisions that the committee needs to make next is whether or not this death was pregnancy-related. Is there anything more you want to know about that definition? Do we need a reminder?

 [08:45] **Nurse Abstractor**

>> It's on your paper. It's at the bottom of your paper. So, remember, it would be a death that you could attribute to the pregnancy. One of the things that we say in your teams a lot times is if you're not sure, would this women have died if she had not been pregnant? And that's like a key clue to how might determine.

[21:30] **Coordinator**

91 percent thought that this was indeed-pregnancy related.

So we've got one other poll question. Was this death preventable?

[21:38] **Chair**

>> In other words, was there-- A good way to think about it is, was there a chance to alter outcome? [21:43] Yeah.

[22:39] What about an opportunity to alter outcome? Yeah. Strong.

OK. So, we agreed with our audience so that's good. So, in the interest of time, I'll just say, I think, do we all agree with the cause of death being secondary to cardiomyopathy? No one who didn't? OK.

So, what about recommendations? We'll take a couple minutes just to say, what would-- what would our recommendations be?

[23:05] **Pathologist/ME**

>> Translation services.

>> Access to interpretive services.

[24:09] **Anesthesiologist**

>> Adding a screening question for pregnancy for ED visits would be helpful

[24:14] **Hospital Administrator**

With the EMR's is that that chart could have been flagged. She's had various visits to the ER. So, it could have been part of the problem list. History of so and so. That would have-- didn't matter if I never saw the patient before, it would have popped up. And it would have become, hopefully, part of your assessment and plan of care.

[24:38] **Chair**

>> So, there were really, if you look at these kind of things on three levels. You know, at the patient level, at the clinical level and at the systems level. At the very, you know, we saw certainly a lot of clinical issues that we've identified. Not just among the obstetrical providers but also other disciplines. Anesthesiology, you know, they had an opportunity of labor and delivery to intervene as well as the emergency department. But also, systems issues, you know, in terms of translation services and maybe accessibility of records. I will say for the group that this lady, all her deliveries were at the same hospital. So, the records from 2005, 2006 were at the hospital. So, it shouldn't been that hard to make a records request. And the cardiologist who saw her during the second ED visit at the primary hospital was her cardiologist. She was known to him. He knew her as soon as, you know.

[25:35]

**Health Department Medical Director**

>> Another major issue is just family planning and access to long-acting universal contraception.

>> Right.

>> We don't know what her intent was for pregnancy. We don't know what her relationship was with her husband at that time, whether she's allowed to-- if she had-- with interpreters, if she understood the gravity of the situation, if she chose, she didn't want to get pregnant again, I mean--

>>Right.

>> -- all this is preventable.

[25:54] **Chair**

>> And I will mention the-- just bring up again the intimate partner violence. I mean, she had a restraining order against him. So, we could only assume that was not a great relationship.

[26:02] **Patient Advocate**

>> I think that one of the reasons to have a community-based origination on your team is that we also have to look outside the walls of the hospital. And there are two really big systems issues here. One is the education of, you know, private providers in terms of how does a city or whatever area that is that this took place in get all of their providers to know that if this presents, you need to get the person someplace else. And then, I think the domestic violence, we don't know. One of the things that in our committee we would have talked about was what were the services that would have been available for this woman? Do we need to look at, you know, for example services for women who don't-- who only speak French. Do we have that available in our city?

>> Yes. Exactly. So--

[26:52] **Epidemiologist**

>> And I think that's very important to our assessment and referring to her as not compliant based on the medical records, we don't know if she was prevented from going to prenatal care earlier than this.

>> Right.

>> Or what the other circumstances were. These are, I think, that sort of a perspective is important.

>> She got that tag but there was-- it was probably a lot more complex than that, so.

[27:14] **Nurse Abstractor**

>> And I just want to point on thing out really quick before we move on.

>> Yeah.

>> So, just because we're kind of a little bit rushed and we jumped ahead of a really key point is really identifying by the team what was the underlying cause of death for this woman? So, do we have a consensus as to what we think was the underlying cause of death?

>> Peripartum--

>> Peripartum CARDIOMYOPATHY. And so, I want to point out to everybody. In your packet, there are the PMSS-MM, because with of the maternal mortality because-- so, I highly recommend that if you're not using them that you take a look at them because it's a great way for data to be collected uniformly among many states. OK. So, there would be a--

[27:51] **Chair**

>> So there would be a comparing. If we all compared all of our cases with each other around the table and we'll do that. And I also will put in a plug when we think about recommendations, a tool that the-- like California is putting together can be very beneficial to just about any state, you know.

[28:09] **Executive Director of a Maternal and Child Health Stakeholder Organization**

>> I would go back to those postpartum discharge instructions.

>> Yes.

>> Making sure that something and it is written so they can take that home. So, in this case, someone else could possible identify, you know…

>> Yeah. OK.

[28:27] **Psychiatrist**

>> Just one other issue, this was this case. She had-- her sister had adopted out-- she had adopted out two of her children and was supposed to adopt out this third child to this woman as well. You know, and you-- just looking at the whole systems failure--

>> OK.

>> -- there's something really significant going on here.

>> Yeah.

>> Why is she having this baby? Is she having them for herself or is she having them for her sister?

>> That's a good point.

 [28:52] **Coordinator**

>> Can I break in here? So, we have people chomping at the bit to ask questions so, I want us to take just a few minutes to fill some questions in the audience. The committee’s all warmed-up; I know that you all would have probably have gone much, much longer on this case.

[29:11] **Chair**

>> And I'll be honest, this happens in real life, you know. We're at a meeting, you know, eventually you have to, if you're facilitating, you have to say "OK".

>> We got to be done. We got to vote. We got to, you know.

[29:51] **Chair**

>> Well, in our review, we would say, you know, we would try to do this in 20 minutes. This case may have taken a little bit longer, you know, but yeah. [29:59]

[30:37] **Health Department Medical Director**

>> In Philadelphia we schedule about five or six cases for a two-hour meeting and also, you can never predict that sometimes the more we do pregnancy-related as long as those not related. And sometimes you assume that a pregnancy-related is going to take the majority of time and we do that in 10 minutes. And then, something totally not related, we'll spend like 30 minutes talking on. And it's up to the facilitator to keep it all in time.

[30:57] **Chair**

>> And we send the cases out to identify to the members ahead. So they've read it. So, it's not like a cold thing, they had a chance to think about it. [31:04]

[31:50] ultimately the goal for us at the end of every year. Is, again, what are our recommendations legislatively or to physicians.

[32:03] **Health Department Medical Director**

Also, something to keep in mind with any-- if you looked at FIMR before, fetal infant mortality review, where you can do interview of the mother. In this case, the person who died-- the person we're reviewing is dead. And we won't know the story, we're trying to get to the bottom of the truth and there's always so many questions. And sometimes, when we review our cases, sometimes, and we'll try to ask the doctors to keep anonymity, in Philadelphia, there's only six labor and delivery hospitals, and so we have all the all the chairs there and so, they'll know the cases and we'll talk to them before we review it at the group. So, they can give us feedback, stuff that you don't get out of the abstraction of the medical records. And sometimes, the medical records will say one thing, you know, that someone transcribed, you know, because of “noncompliance” but maybe it's not as simple as that and it's hard. I mean, we don't do follow back. You can't do follow back. But, so, you're trying the best you can.