Welcome:

- Prior annual meetings:
  - 1st year 2-day review (nearly 100 deaths reviewed resulting in >20 recommendations).
  - 2nd year ½ day review, ½ day discussion (Focused on Drowning, SUID, Suicide, Maternal Opioid deaths).
  - This year about bringing people together to better understand each other.
Identification
Data is used to identify patterns

- Risk Factors/at risk populations: Substance use, mental health, stressors, historical trauma, low parental education/age, household dysfunction, low SES, prior criminal, Juvenile, Child welfare history, poor maternal health, marital status, sleep position, crowding...

- Protective Factors: supportive family/community, access to services, social connections, social and emotional competence of children, improved sanitation, vaccinations/immunizations...

- Systems: less tangible
  - Last year identified patterns during reviews related to agency-to-agency interactions that if improved likely could have prevented deaths.

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Networks:

- Built primarily to be reactionary/supportive
- Some networks are stronger than others
- Some are unidirectional (or function as such)
- In nearly all cases, connections need to be improved
Learn from each other

– We all come from different backgrounds.
– We all have important experiences (positive and negative) with the system serving/supporting children and families.
– Today selected agency representatives will describe what they do, who they serve, some challenges they face, and identify needs to be successful.
– Two boards for thoughts that come up:
  – Challenges you’ve faced working between agencies that hinder optimized care
  – Successes you’ve experienced working between agencies that supported care
Today is about strengthening connections

– Committee members indicate that the connections they form during reviews are one of the most important thing they gain from MCDR participation.

– Please use the breaks and lunch to meet people and strengthen or form new connections.

– Today is about zooming in on the systems issues we all have encountered.

– All ideas and thoughts welcome...in the parking lot.

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Maternal and Child Death Review (MCDR)

- Established in 1989 under a medical review statute (AS 18.23.020).
  - Formerly known as Maternal and Infant Mortality Review-Child Death Review (MIMR-CDR).
- Began by reviewing maternal deaths, but has since expanded.
- Committee required to be at least 75% medical professionals as defined by statute.
  - Generally physicians and nurses.
  - Currently 82% of our committee members are medical professionals.
  - Other members include specialists in injury prevention, suicide prevention, children’s services, etc.
Current MCDR Membership

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MCDR Updates

- No backlog for most cases!
  - We are reviewing cases as soon as we receive records. (Exception: neonatal cases).

- Expanded scope of review: now reviewing all decedents under 18, plus maternal cases.
  - 2016: Started reviewing ages 15-18
    - Captures the majority of youth suicides.
  - 2017: Started reviewing in-hospital neonatal deaths in a separate neonatal review process (started with 2014 cases).

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MCDR: % of Deaths Reviewed 2015-2016

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2017 MCDR Review Categories

Maternal Cases
- Full review
- Quarterly/Semi-annual Reviews

In Hospital Infants
- Medical Review (Can be referred to full review)
- Semi/Annual Reviews

Out of Hospital Infants
- Full Review
- Monthly Reviews

Children 1-18
- Full Review
- Monthly Reviews

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MCDR Administrative Changes

- Maternal cases are now held for quarterly or semi-annual review at a dedicated meeting.
  - Pending case availability
  - Allows specialists to attend when cases relevant to their field are reviewed.
- We started using the National Center for Fatality Review & Prevention’s Case Reporting System for infant and child deaths in 2015.
- We are in the process of switching over to the CDC’s Maternal Mortality Review Information Application (MMRIA)
  - Both of these databases make it far easier to abstract and analyze data systematically and consistently, and to share data across state lines.
MCDR Goals

– Review all pregnancy-associated, infant, and child deaths that occur within the state of Alaska, or among Alaskan residents.
– Identify which deaths are preventable.
– Find points of possible intervention.
– Use this information to prevent similar deaths.
Systems Challenges

– A recurring theme we’ve noticed is that some children and mothers fall through the cracks between our various systems.
– If everybody who came in contact with the decedent had everybody else’s information, the individual might not have died.
  – This is an impractical goal, so how do we coordinate efforts most effectively?
Falling Through the Cracks: Infant

- Infant born premature and drug-exposed.
- Physicians stabilize infant, but have grave concerns about parents’ (in)ability to care for child.
- Physicians notify OCS.
- OCS places infant with sober relative.
- Relative fails to provide proper medical care to infant.
- Infant dies in a sleep-related death while co-sleeping.
Falling Through the Cracks: Child/Teen

- Child reports SA by non-caregiver adult in home to school counselor.
- Counselor makes report to OCS.
- Parents remove perpetrator from home, starts child in therapy.
- Child makes suicidal comments at school.
- School staff alerts parents, but believe that child is no longer actively suicidal.
- Parents make appointment with therapist for that afternoon.
- Child makes suicidal texts to friend who is out of range.
- Friend reports texts when (s)he sees them, but child has already gone home and died by suicide.
Falling Through the Cracks: Maternal

- Woman with a child begins dating new partner.
- Over time she gradually withdraws from social circle.
- Partner shows signs of being emotionally abusive in a prenatal visit.
- OB asks about DV; woman denies.
- Woman shows non-specific signs of stress at subsequent appointments.
- Friend meets woman by chance after birth of child, and is startled at how different she seems.
- Partner kills woman within one year of child’s birth.
- Partner had no criminal history in Alaska before this death, but is found after the fact to be polysubstance abuser.

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Patching Cracks

– In many such cases, the MCDR reviewers feel strongly that the deaths could have been prevented.

– The difficulty may lie in the fact that no single agency did anything inappropriate, yet they did not coordinate efforts effectively.

– Our goal is to explore ways for different stakeholders to combine efforts to keep these fatalities from occurring.

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What MCDR Offers:

– We serve as a single point where many data sources converge.
– We strive to provide the most complete picture possible of a child’s or mother’s situation before a fatality.
– Our meetings serve as a gathering place for different partners, and a place where stakeholders can see other agencies’ perspectives.
– We collect and analyze data over time.
Blue: Provides Records to MCDR

Green: Represented in monthly MCDR meetings

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MCDR Drawbacks:

- We are small.
  - Sam
  - Katey (shared with ABDR)
  - Zoe (part-time, works for CUBS)
- We are only as good as the data provided to us.
- We lack/have to wait for important data sources.
  - Law Enforcement (generally have to wait until a case has been prosecuted).
    - Limited release
    - Personnel turnover
  - School Records
  - Out of State Records (sometimes).
  - Out of Country Records

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MCDR Drawbacks:

- We lack much rural representation, and we need more Alaska Native representation.
- We have tried teleconferencing local providers
  - Limited success due to technology limitations.
- We are exploring other avenues and actively welcome suggestions.
MCDR Needs

– MCDR struggles to translate recommendations into concrete action.
– We can reach out to, and provide data for, partners who have the capability to enact changes, but lack the capacity to directly implement most changes.
– We always seek partners in prevention and implementation.
  – Kids Don’t Float
  – Injury Prevention
  – Suicide Prevention
  – OCS
  – Medical Providers

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MCDR Goals for Annual Meeting:

– Start a conversation about how each responder to child/maternal fatalities can work to patch cracks in the system of care.
  – Often at the interface between organizations.
  – Facilitate partnerships that work to bolster other agencies’ work.
  – Identify places where the system truly lacks an ability to provide effective services.
Agenda

– 9:30-10:30: Presentations (Medical Providers)
– 10:30-10:45: Break
– 10:45-12:45: Presentations (Medical cont., Medical Examiner, AK Cares, OCS)
– 12:45-1:15: Lunch
– 1:15-2:45: Presentations (Law Enforcement)
– 2:45-3:00: Break
– 3:00-4:30: Presentations (Fire and EMS)
– 4:30-5:00: Closing Remarks (Dr. Butler, DPH)

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