MATERNAL AND CHILD DEATH REVIEW PROGRAM

2018 ANNUAL SUMMIT

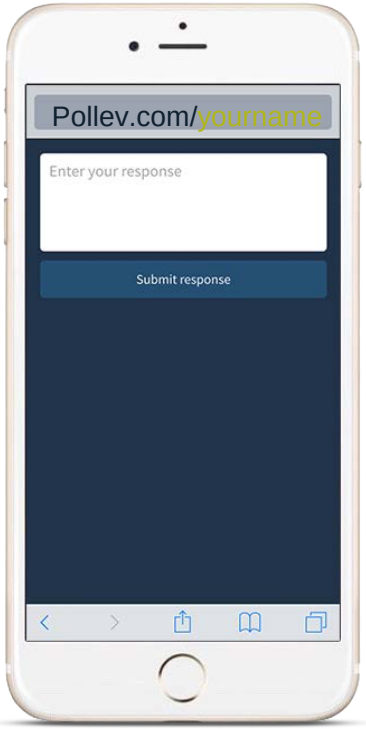
STATE of ALASKA
Department of Health and Social Services

Protection Promotion Prevention
ALASKA DIVISION OF Public Health

AGENDA

9:00 to 9:15 am	Welcome & Introductions
9:15 to 9:30 am	MCDR Program Updates
9:30 to 10:15 am	MCDR Data Presentation
10:15 to 10:30 am	Break
10:30 to 11:30 pm	Group Table Discussion
11:30 to 12:15 pm	Table Report Out
12:15 to 1:30 pm	Lunch Provided
1:30 to 2:30 pm	Group Table Discussion
2:30 to 3:15 pm	Table Report Out
3:15 to 3:30 pm	Break
3:30 to 4:15 pm	Moving Forward Activity
4:15 to 4:30 pm	Closing Remarks

Responding with Poll Everywhere



Web voting

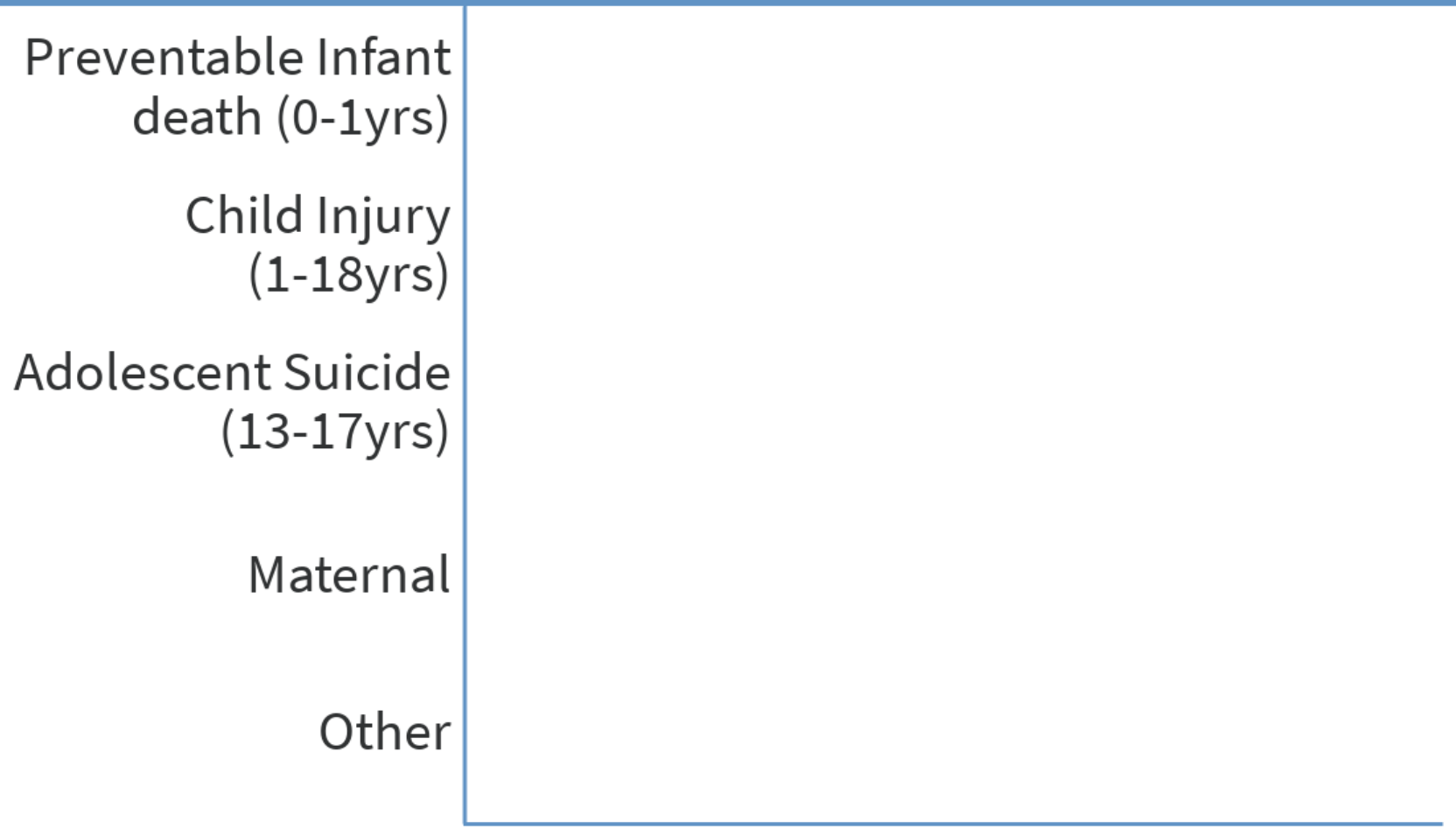
Text voting

What's the word that best describes the agency you work for?

PRIOR ANNUAL MEETINGS

- 2015: 2-day review (nearly 100 deaths reviewed resulting in >20 recommendations)
- 2016: ½ day review, ½ day discussion (Focused on Drowning, SUID, Suicide, Maternal Opioid deaths)
- 2017: 1 day of partner agency presentations to reduce myths, barriers, and miscommunications between systems.

Is there a manner of death you would like prevention activities to be focused on (statewide/in your own practice)?



MCDR PROGRAM UPDATES

DANIELLA DELOZIER, MSPH

MCDR PROGRAM MANAGER

SOA, DHSS, DPH, WOMEN'S
CHILDREN'S & FAMILY HEALTH

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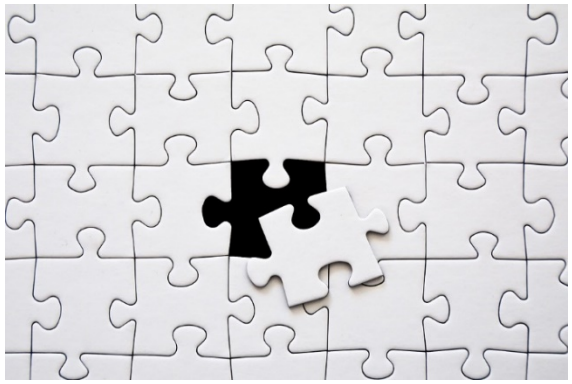
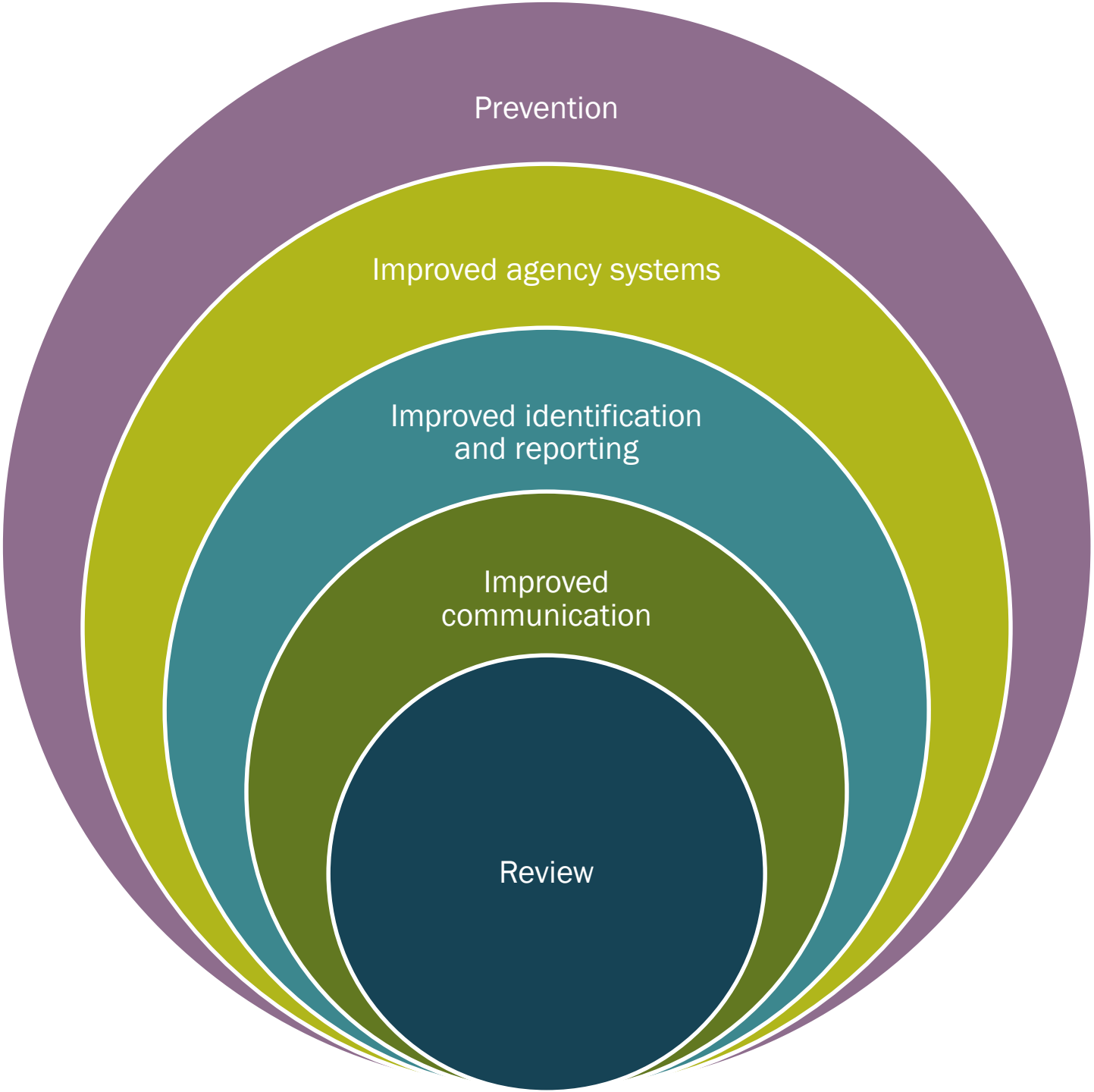
SECTION OF WOMEN'S, CHILDREN'S, AND
FAMILY HEALTH, MCH-EPIDEMIOLOGY UNIT

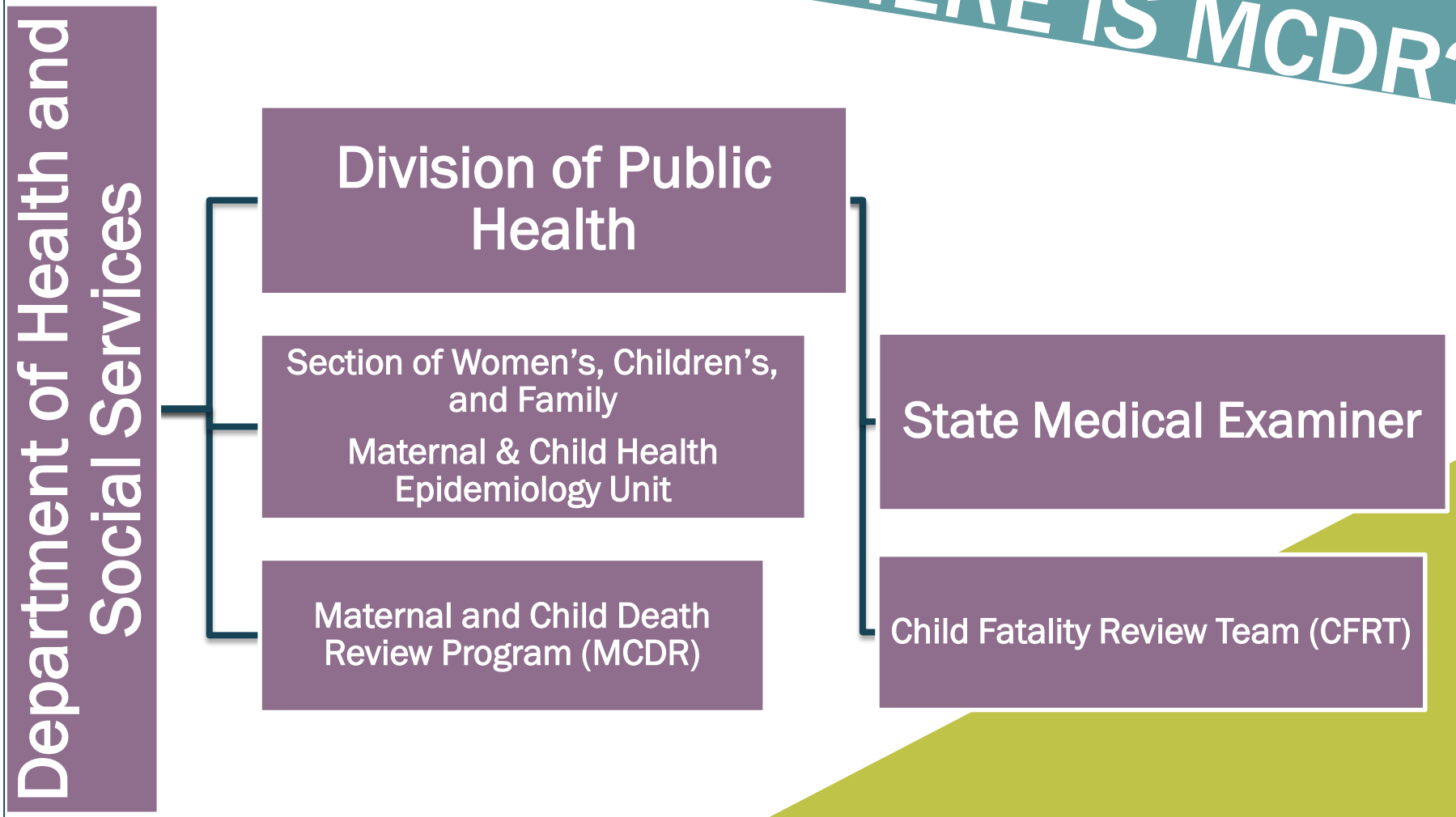
WHAT IS MCDR?

MCDR is an engaged, multidisciplinary community, telling a child's story, one child at a time, to understand the causal pathway that leads to a child's death to identify pre-existing vulnerabilities and circumstances- in order to identify how to interrupt the pathway for other children.




Prevention
Improved agency systems
Improved identification and reporting
Improved communication
Review

WHERE IS MCDR?

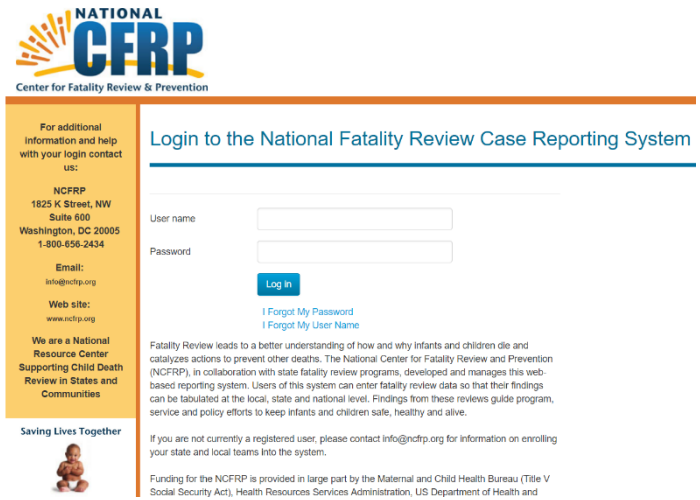


MCDR

- 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.**

DATA COLLECTION PROCESS

- MCDR is notified of a death.
  - HAVRS file (once a month)
  - CFRT (once a month)
  - Medical Examiner's database (weekly)
- **Records collected for each case**
  - Law Enforcement, medical, OCS, DJJ, Social Media, etc.
- **MCDR staff inputs data elements into the CRS and writes summary for each case.**



MCDR PROGRAM

UPDATES

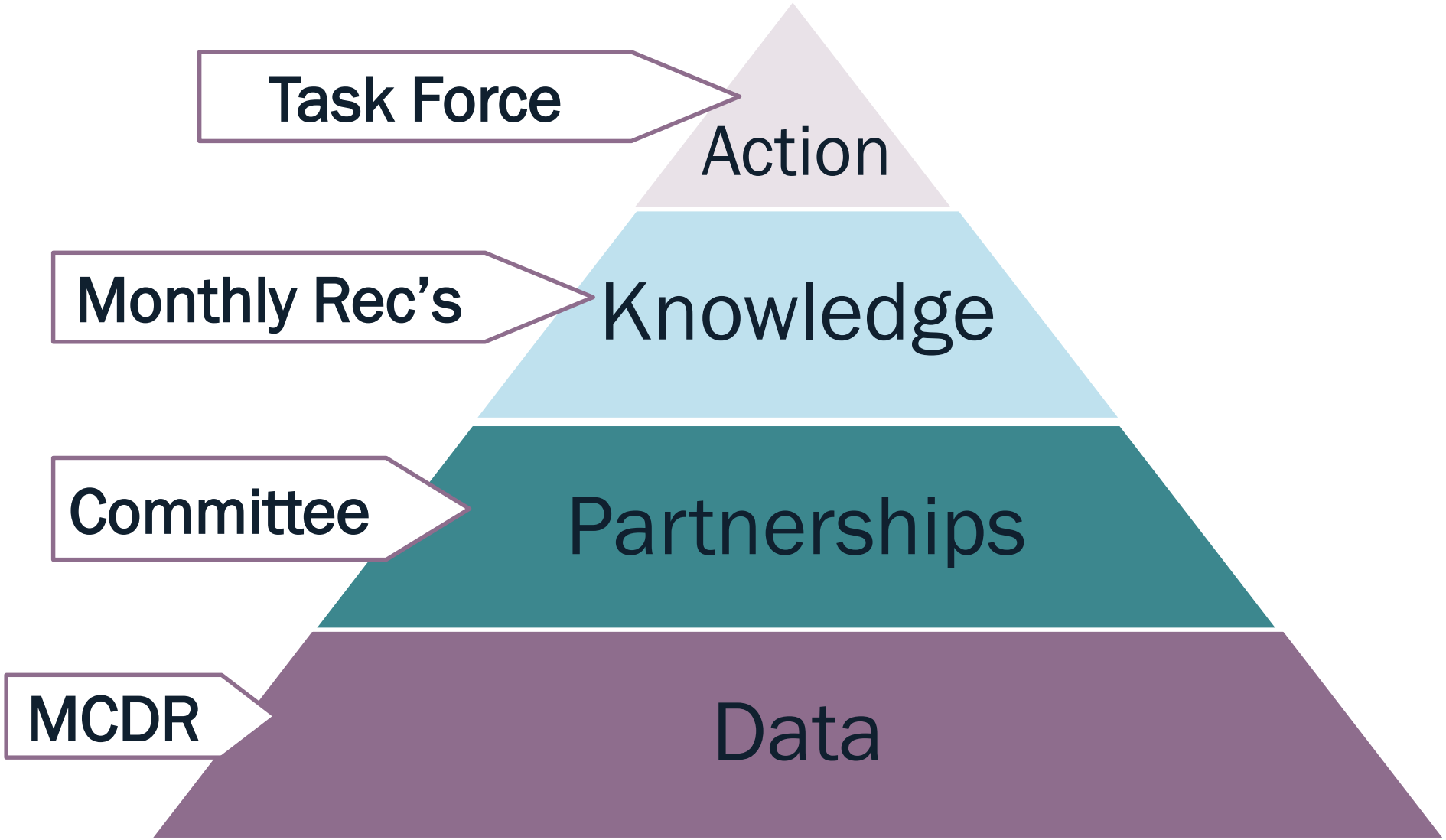
- Restructured program in May 2018
- Hired new Epidemiology Specialist in September 2018
- Created MCDR Listserv
- Annual Maternal Death Review

PLANS

- Develop custom questions for Case Reporting System
- Start tracking case “strengths” at monthly reviews
- Increase data accessibility
- MCDR Task Force
- Strengthen prevention partnerships

MCDR NEEDS

- Rural and Tribal representation on committee
- Behavioral health/Psychiatric provider representation
- School & Behavioral Health Records
- MCDR Recommendation Task Force


Task Force
Action
Monthly Rec's
Knowledge
Committee
Partnerships
MCDR
Data

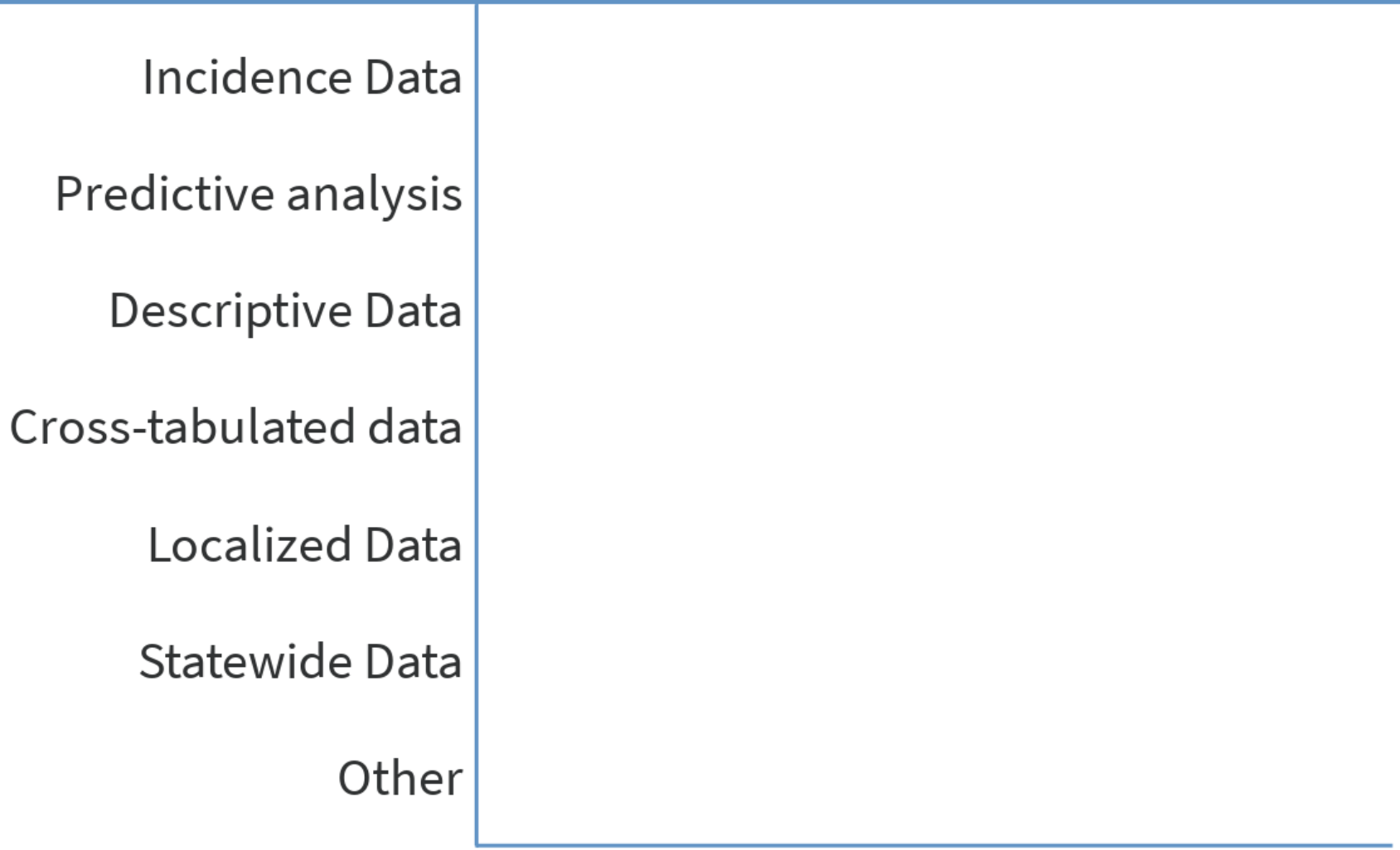
MCDR DATA

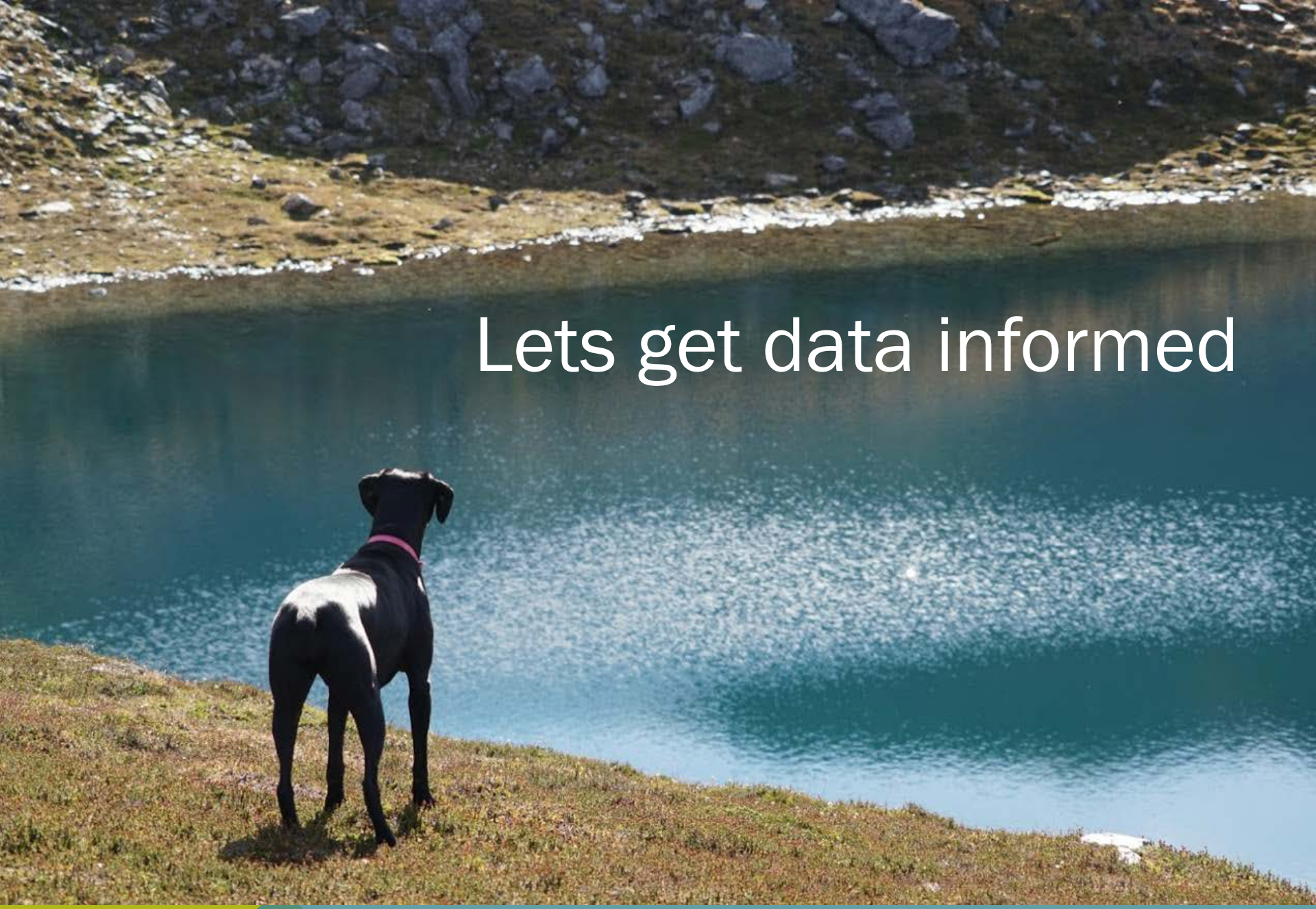
SECTION OF WOMEN'S, CHILDREN'S, AND FAMILY HEALTH, MCH-EPIDEMIOLOGY UNIT

JARED PARRISH, PHD- JARED.PARRISH@ALASKA.GOV

MARGARET YOUNG, MPH – MARGARET.YOUNG@ALASKA.GOV

What type of MCDR data is most useful to you?




Lets get data informed

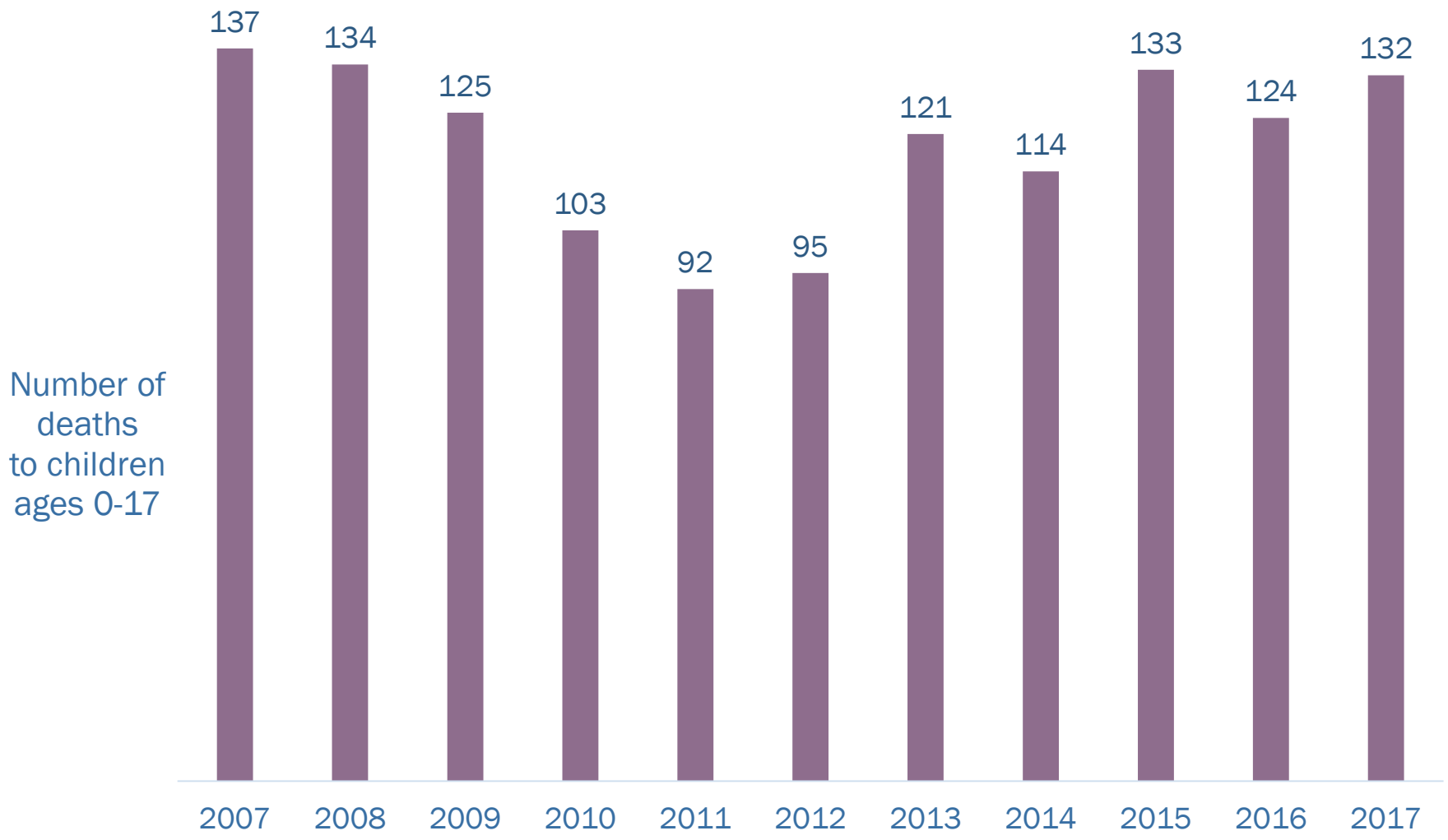
Disclaimer statement

These data, unless otherwise indicated are not for public distribution but were extracted from the Case Reporting System (CRS) for initial provisional analysis to inform the annual MCDR meeting attendees. The information contained herein is subject to change without notice and caution should be used with interpretation until such data are verified.

The MCH-Epidemiology unit, MCDR program is working to develop a public report and increase accessibility to these data. Please contact the MCDR program for the status and availability of verified and finalized MCDR data from the CRS system.

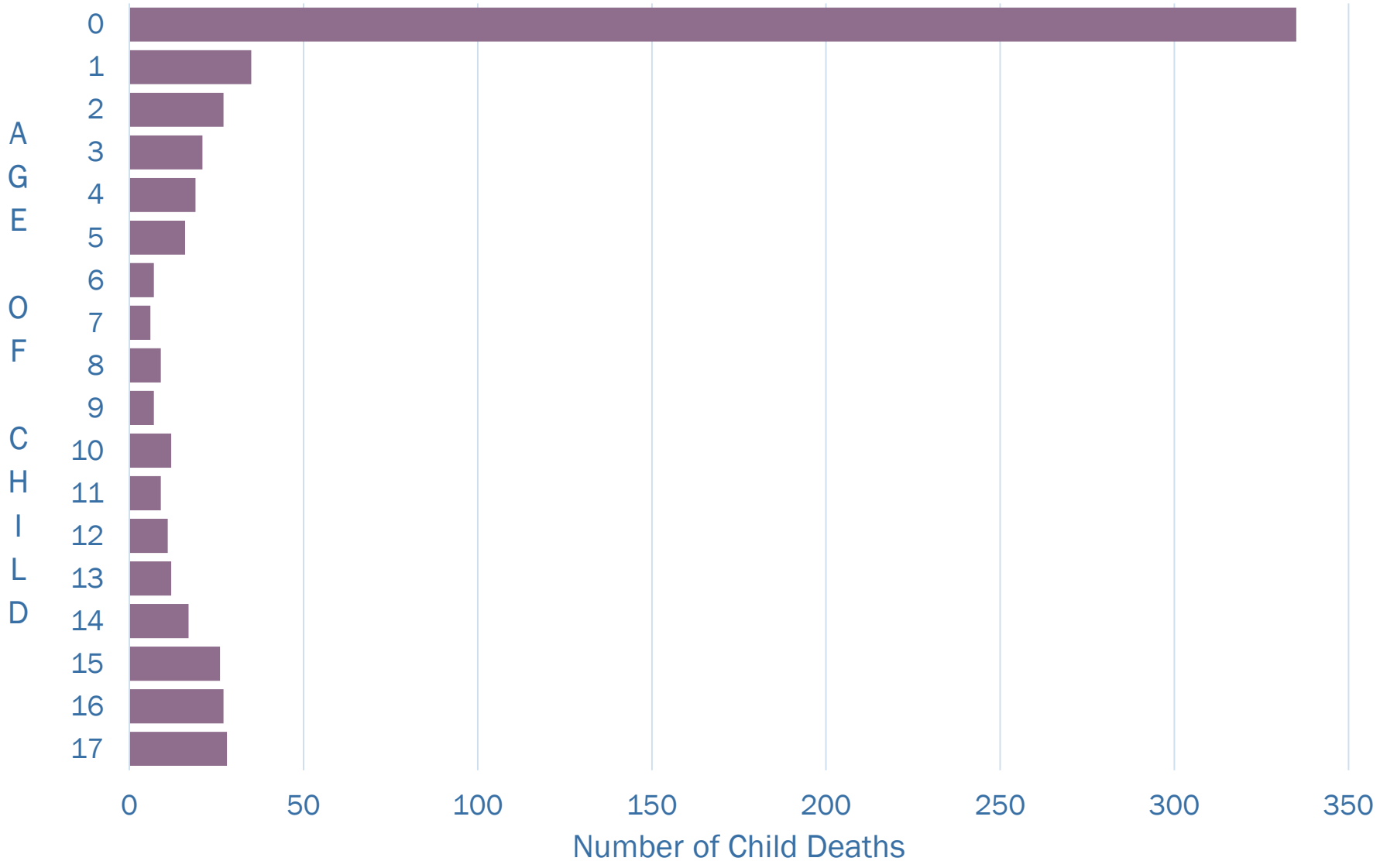
CHILD DEATHS IN ALASKA, 2007-2017

DATA SOURCE: ALASKA SECTION OF HEALTH ANALYTICS AND VITAL RECORDS



CHILD DEATHS IN ALASKA BY AGE, 2013-2017

DATA SOURCE: ALASKA SECTION OF HEALTH ANALYTICS AND VITAL RECORDS



CHILD DEATHS IN ALASKA BY AGE, 2013-2017

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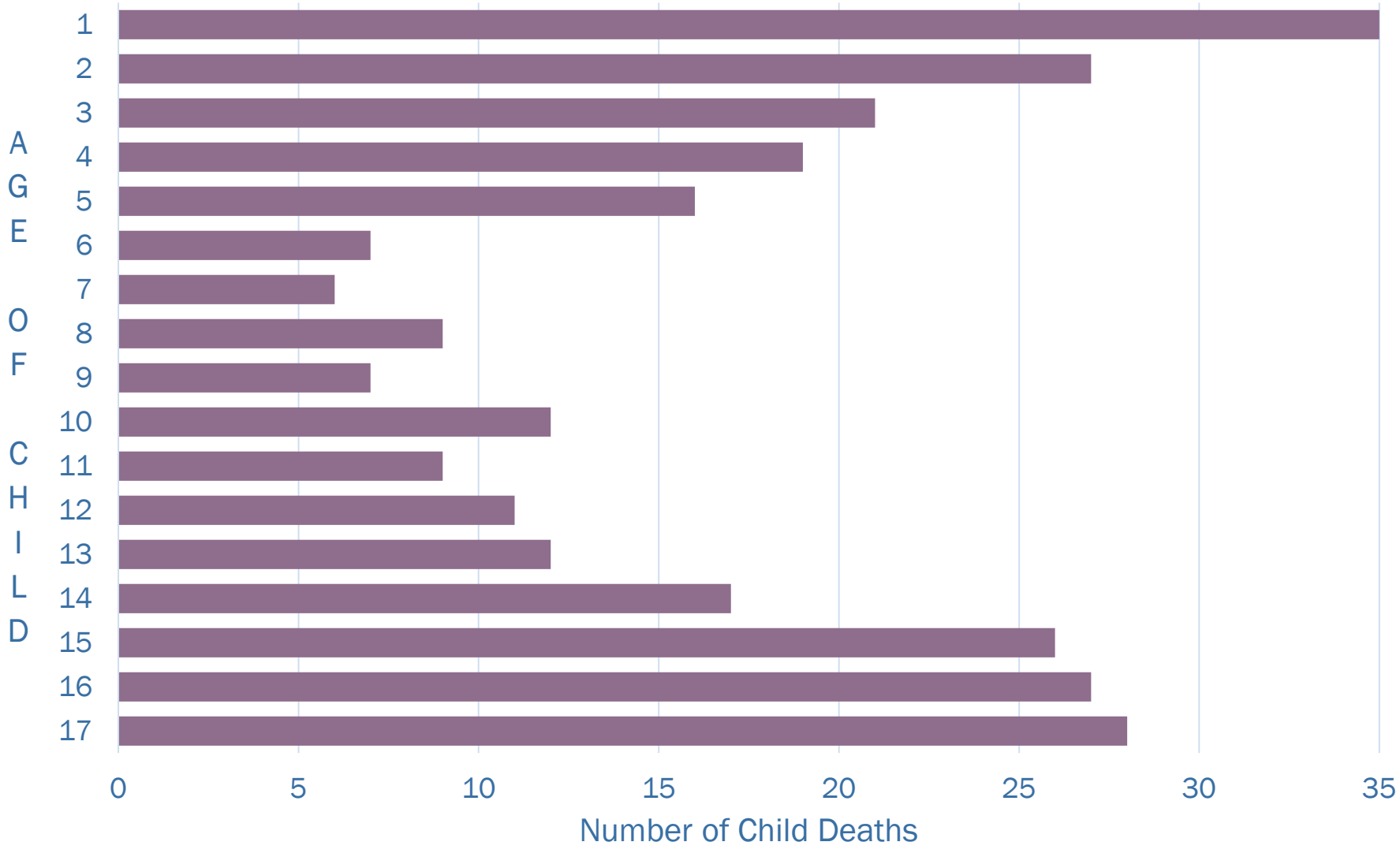
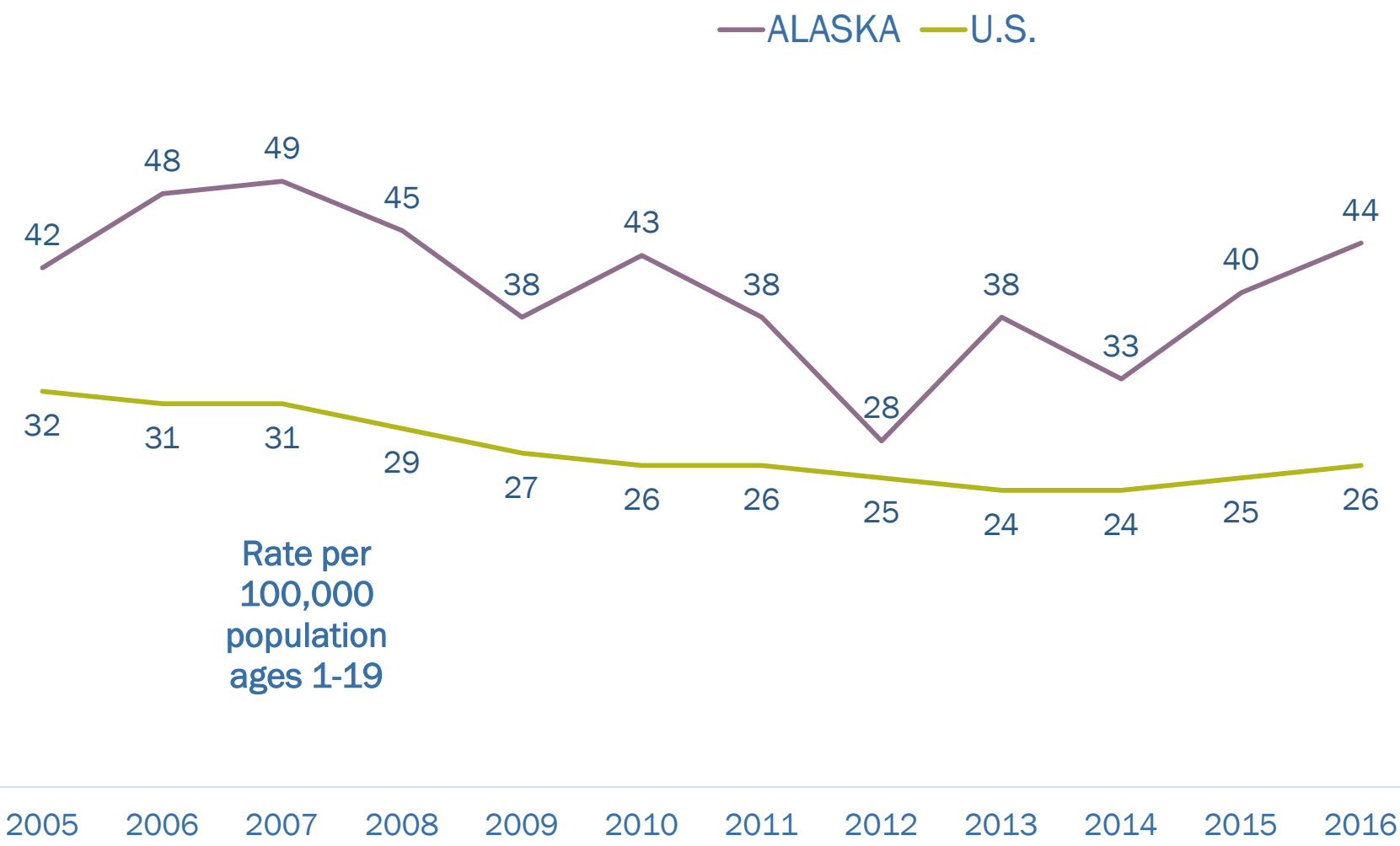


CHILD DEATH RATES IN ALASKA & U.S, 2005-2016

PUBLISHED ON KIDS COUNT DATA CENTER

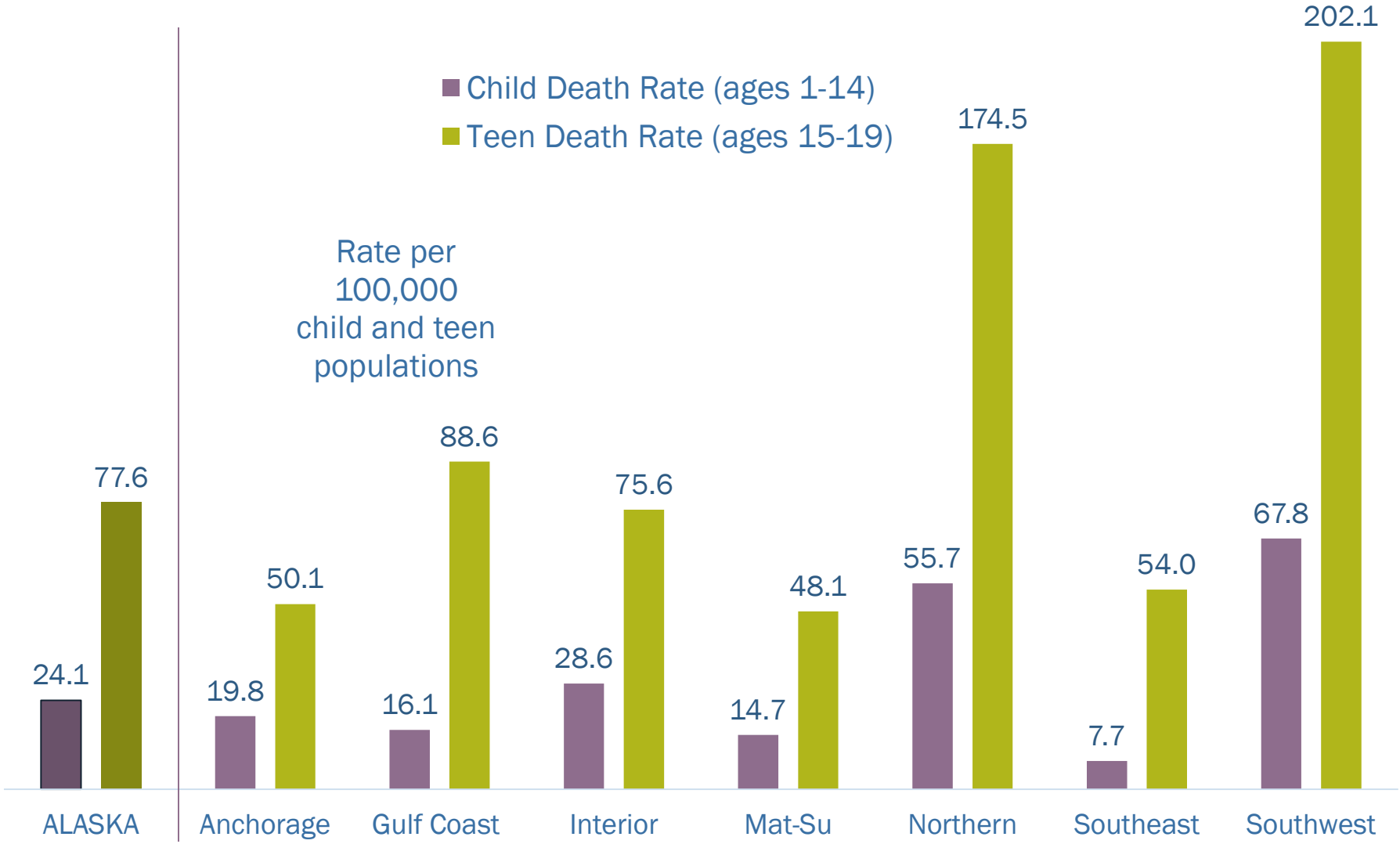
DATA SOURCE: U.S. CENTERS OF DISEASE CONTROL AND PREVENTION (CDC) & NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)



CHILD AND TEEN DEATH RATES IN ALASKA BY REGION, 2012-2016

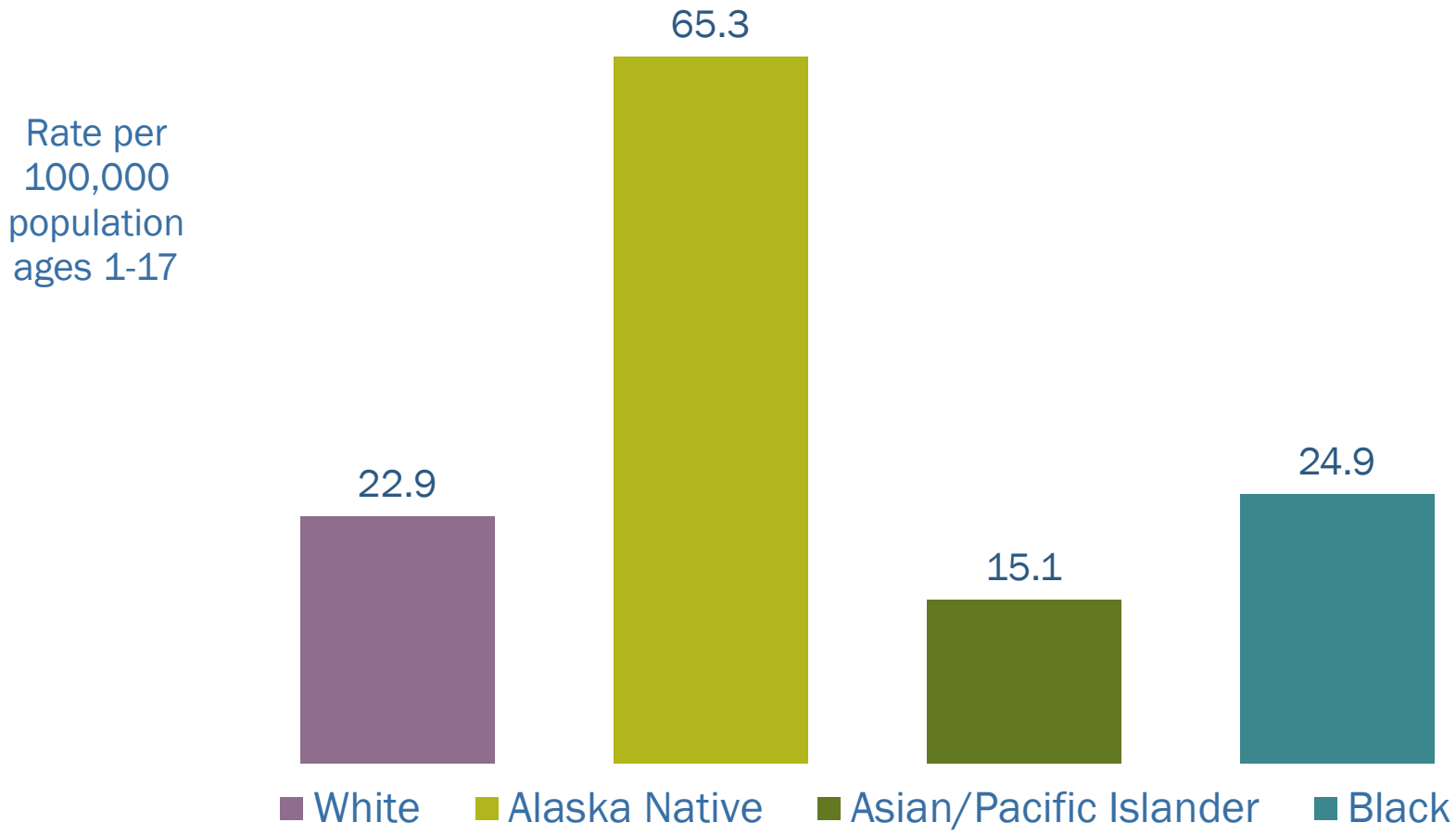
PUBLISHED ON KIDS COUNT DATA CENTER

DATA SOURCE: ALASKA SECTION OF HEALTH ANALYTICS AND VITAL RECORDS & ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT



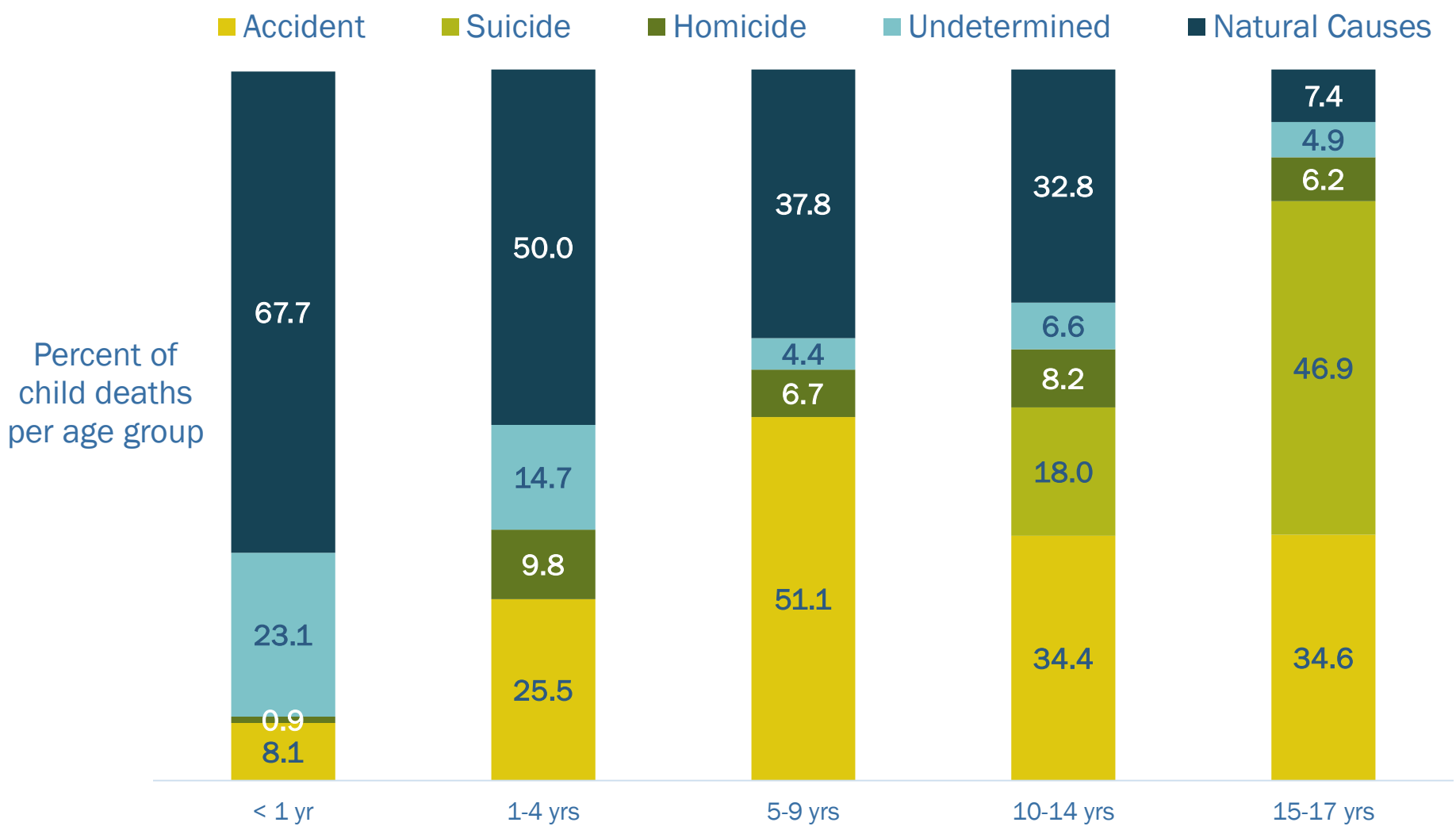
CHILD DEATH RATES IN ALASKA BY RACE, 2013-2017

DATA SOURCE: ALASKA SECTION OF HEALTH ANALYTICS AND VITAL RECORDS & ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT



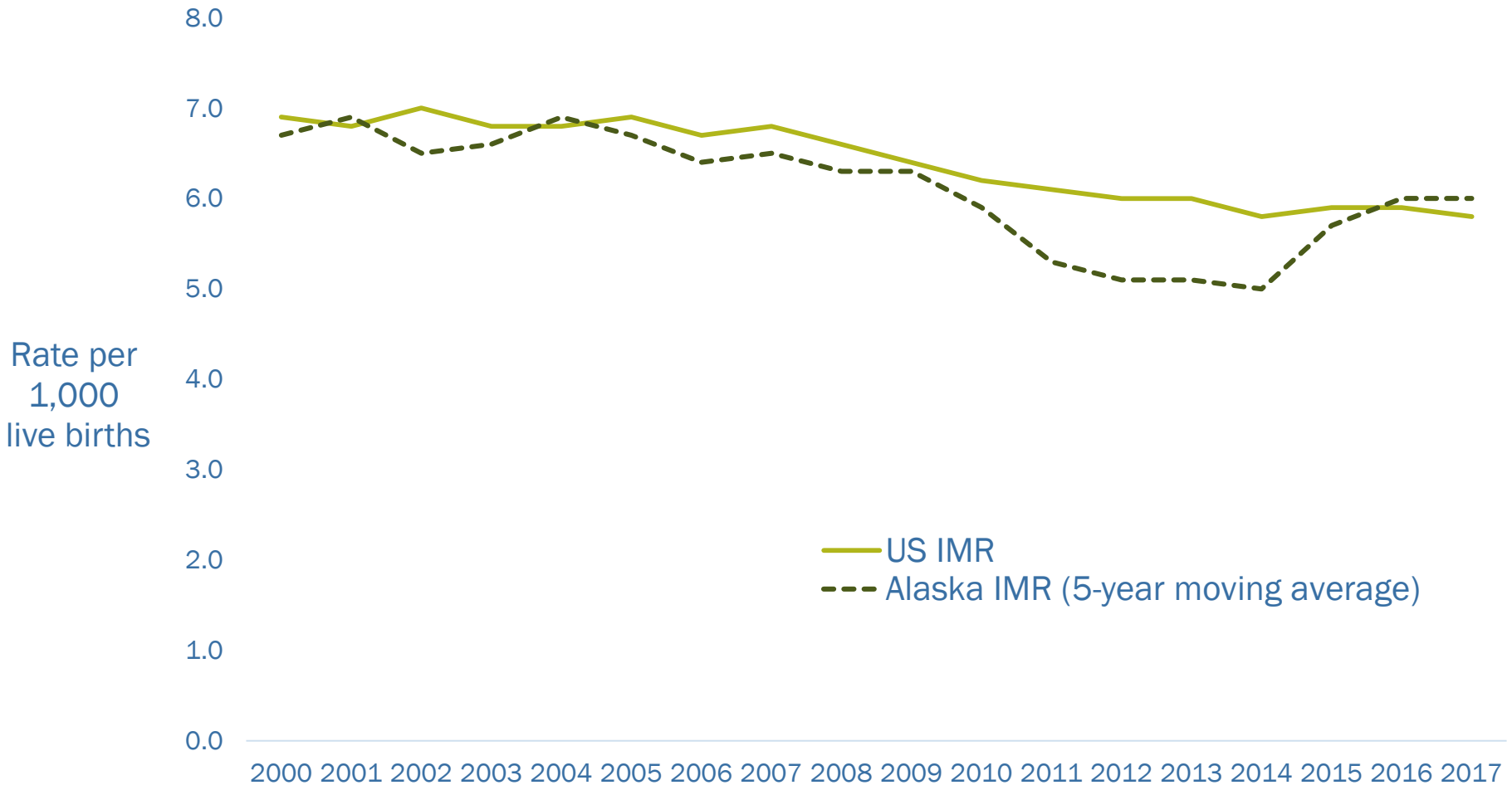
MANNER OF DEATH: PERCENTAGE BY AGE GROUP, 2013-2017

DATA SOURCE: ALASKA SECTION OF HEALTH ANALYTICS AND VITAL RECORDS



INFANT MORTALITY RATES: ALASKA AND U.S., 2000-2017

DATA SOURCE: ALASKA SECTION OF HEALTH ANALYTICS AND VITAL RECORDS & NATIONAL VITAL STATISTICS SYSTEM, NATIONAL CENTER FOR HEALTH STATISTICS (NCHS), U.S. CENTERS OF DISEASE CONTROL AND PREVENTION (CDC)



INFANT MORTALITY RATES (IMR) BY REGION, 2012-2016

Region	# deaths	IMR
Northern	32	**11.2**
Southwest	43	**10.0**
Anchorage	136	5.9
Interior	53	5.6
Southeast	23	5.5
Mat-Su	30	4.2
Gulf Coast	22	4.1

Alaska Overall Rate: 6.0 (2012-2016)

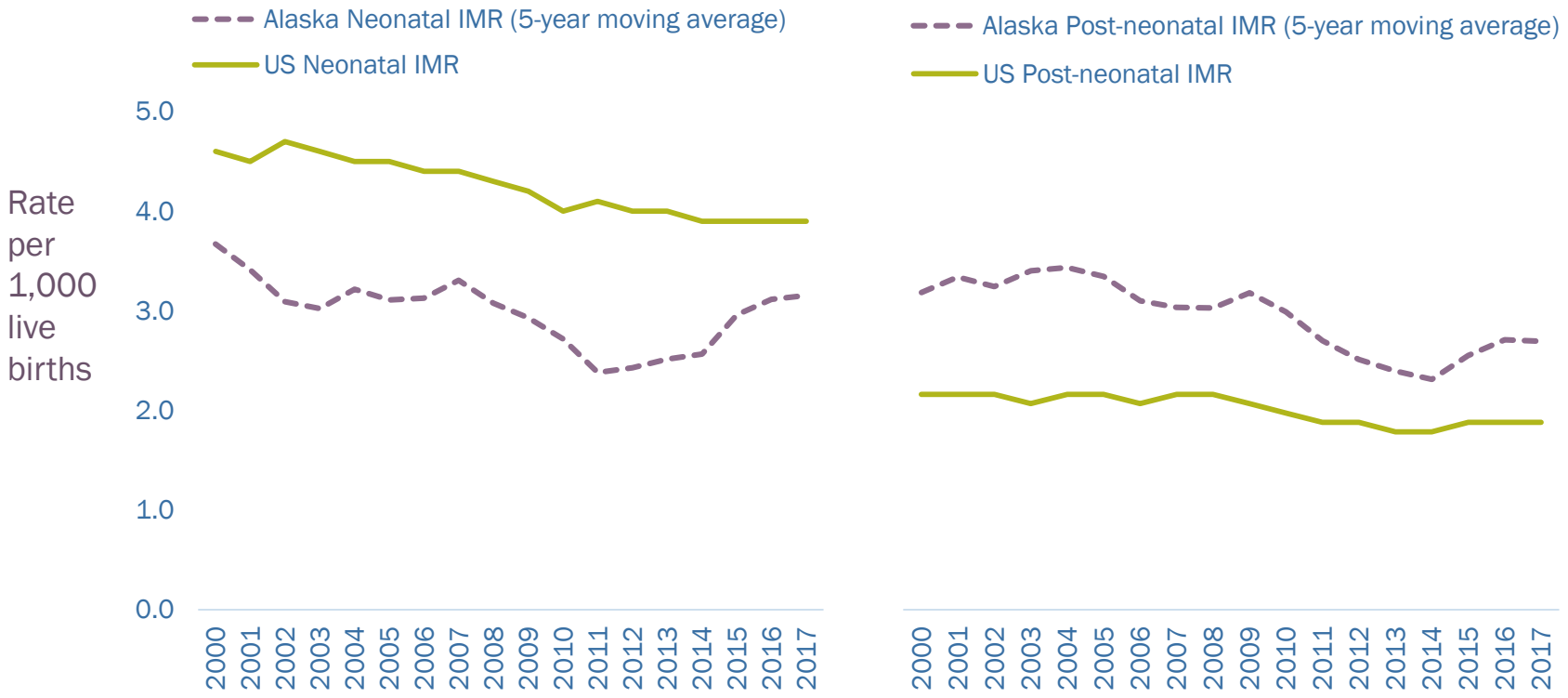
Definitions: The number of deaths among infants under 1 year, per 1,000 live births. This is a 5-year average. Region for denominator is determined by maternal residence, not site of delivery. Region for numerator is child's place of residence, not place of death.

Data Source: Alaska Section of Health Analytics and Vital Records, Kids Count Data Center

Footnotes: Five years of data were combined to minimize the unreliability of measurement due to the small number of actual events. The reported values are a moving average across five years.

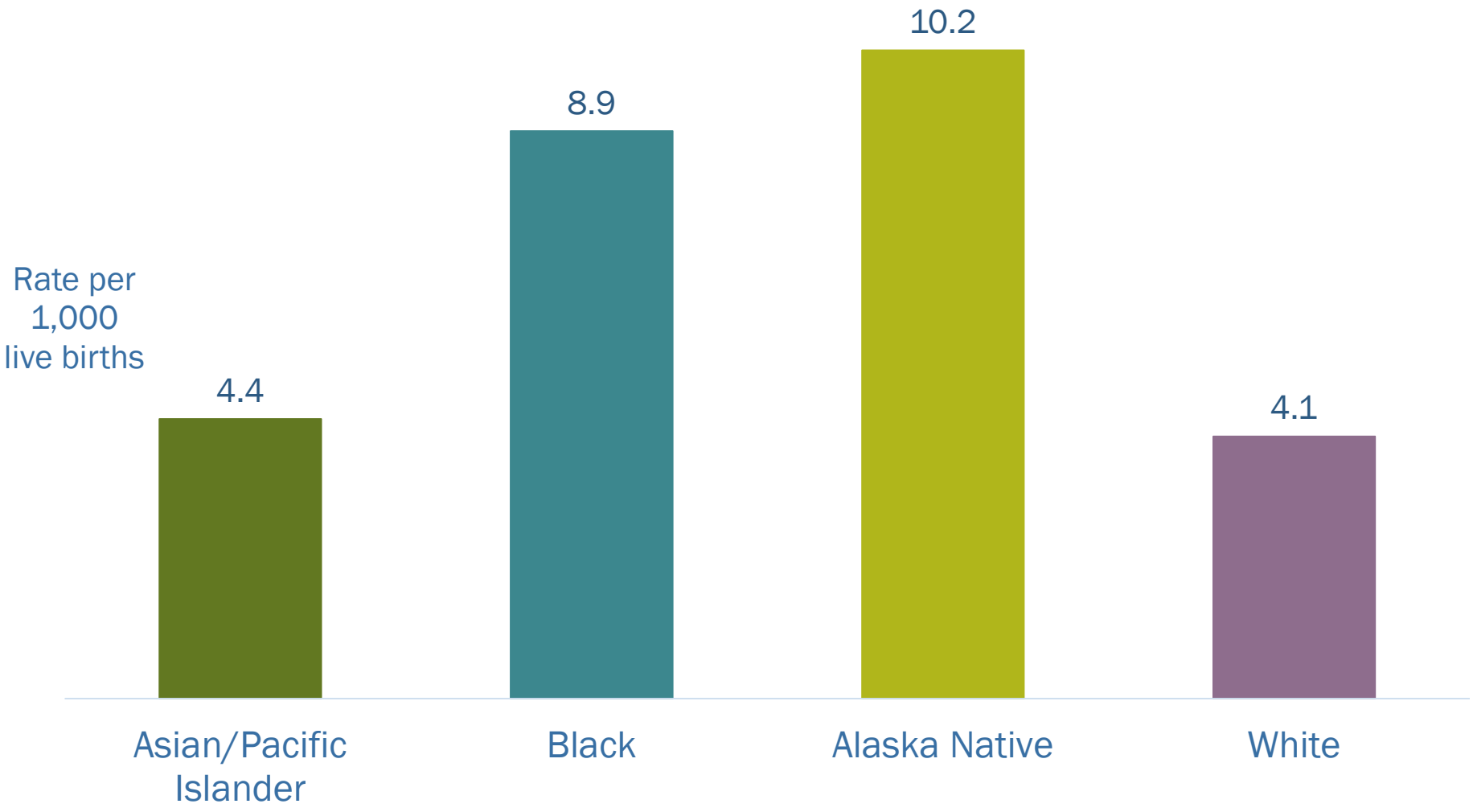
NEONATAL AND POST-NEONATAL INFANT MORTALITY RATES: ALASKA & U.S., 2000-2017

DATA SOURCES: ALASKA SECTION OF HEALTH ANALYTICS AND VITAL RECORDS & NATIONAL VITAL STATISTICS SYSTEM, NATIONAL CENTER FOR HEALTH STATISTICS (NCHS), U.S. CENTERS OF DISEASE CONTROL AND PREVENTION (CDC)



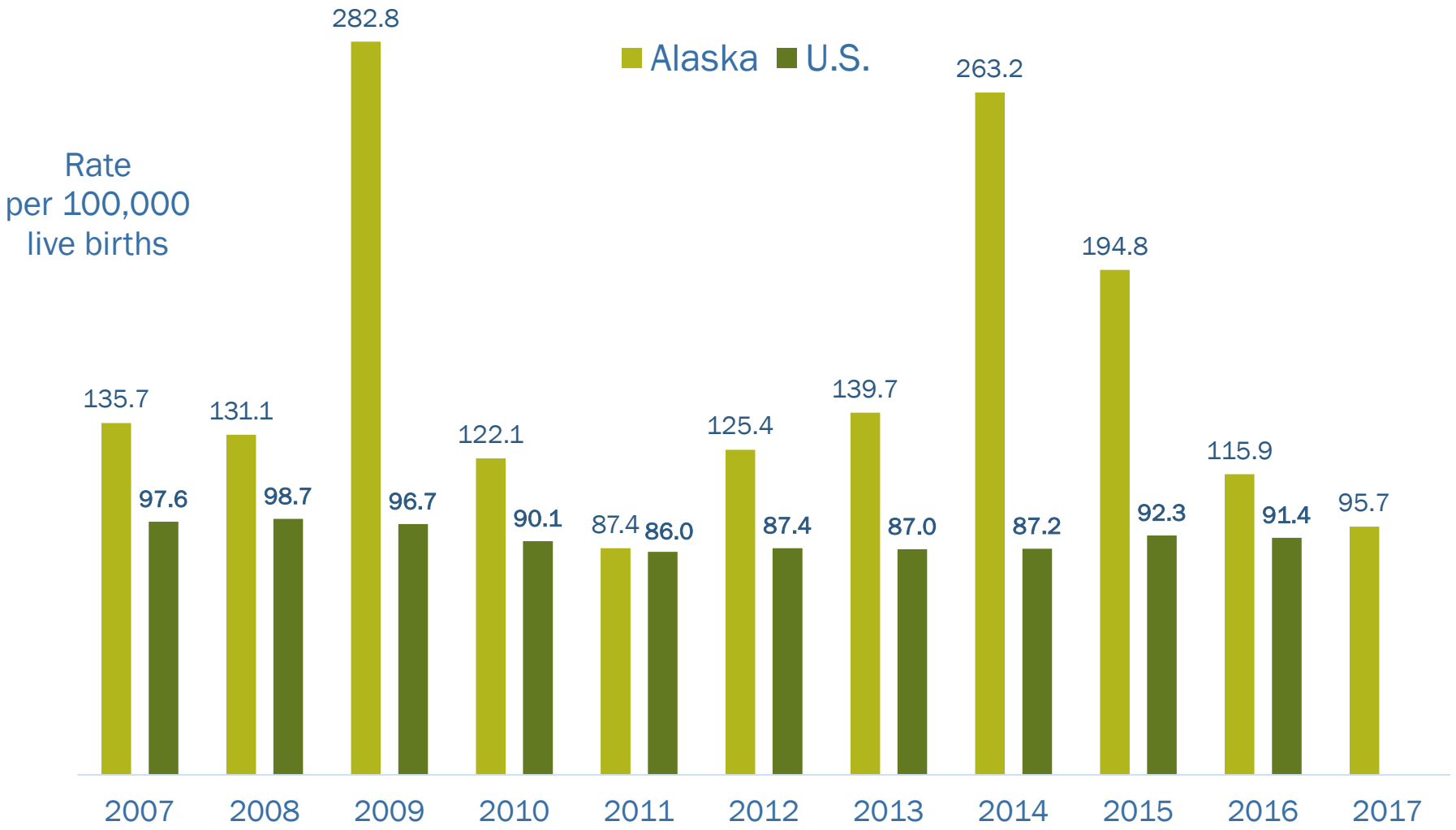
INFANT MORTALITY RATES IN ALASKA BY RACE, 2013-2017

DATA SOURCE: ALASKA SECTION OF HEALTH ANALYTICS AND VITAL RECORDS & ALASKA DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT



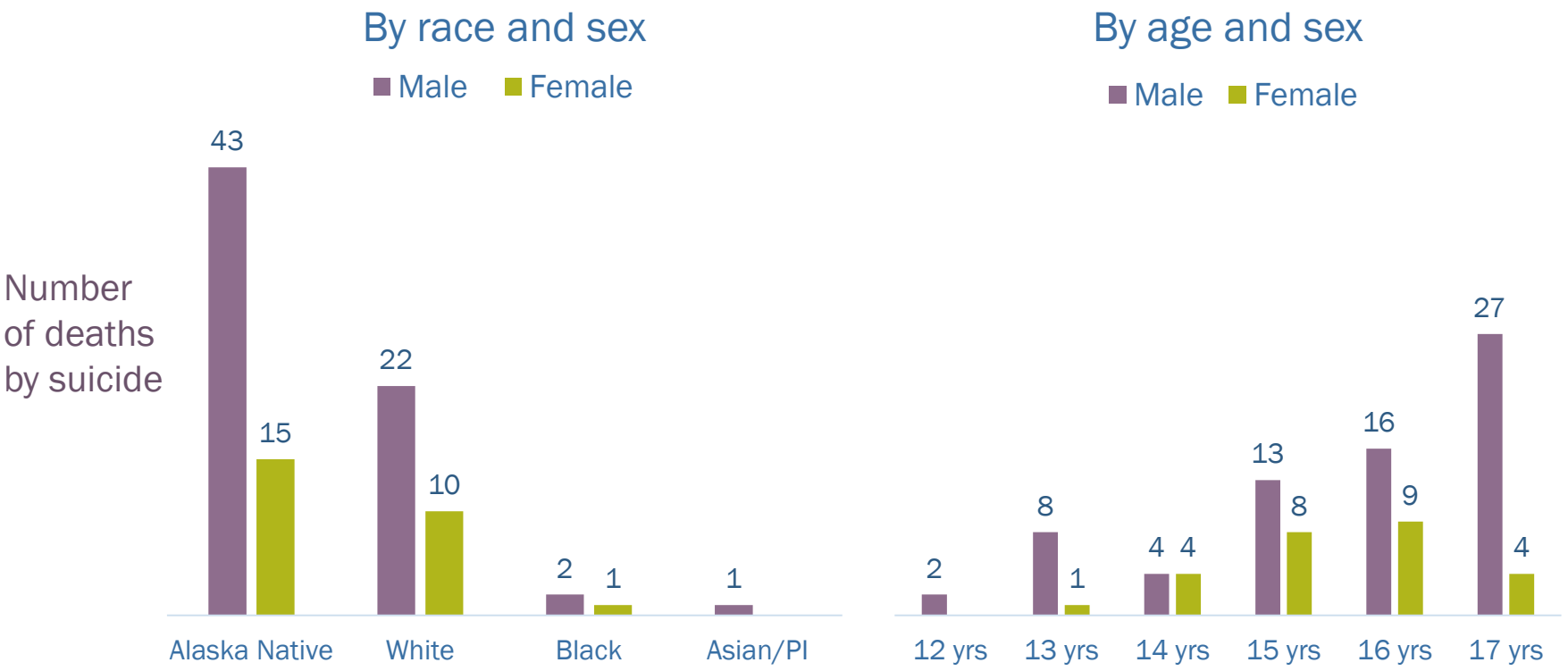
SUDDEN UNEXPLAINED INFANT DEATH (SUID) RATES: ALASKA AND U.S., 2000-2017

DATA SOURCE: ALASKA SECTION OF HEALTH ANALYTICS AND VITAL RECORDS & U.S. CENTERS OF DISEASE CONTROL AND PREVENTION (CDC), NATIONAL CENTER FOR HEALTH STATISTICS (NCHS)



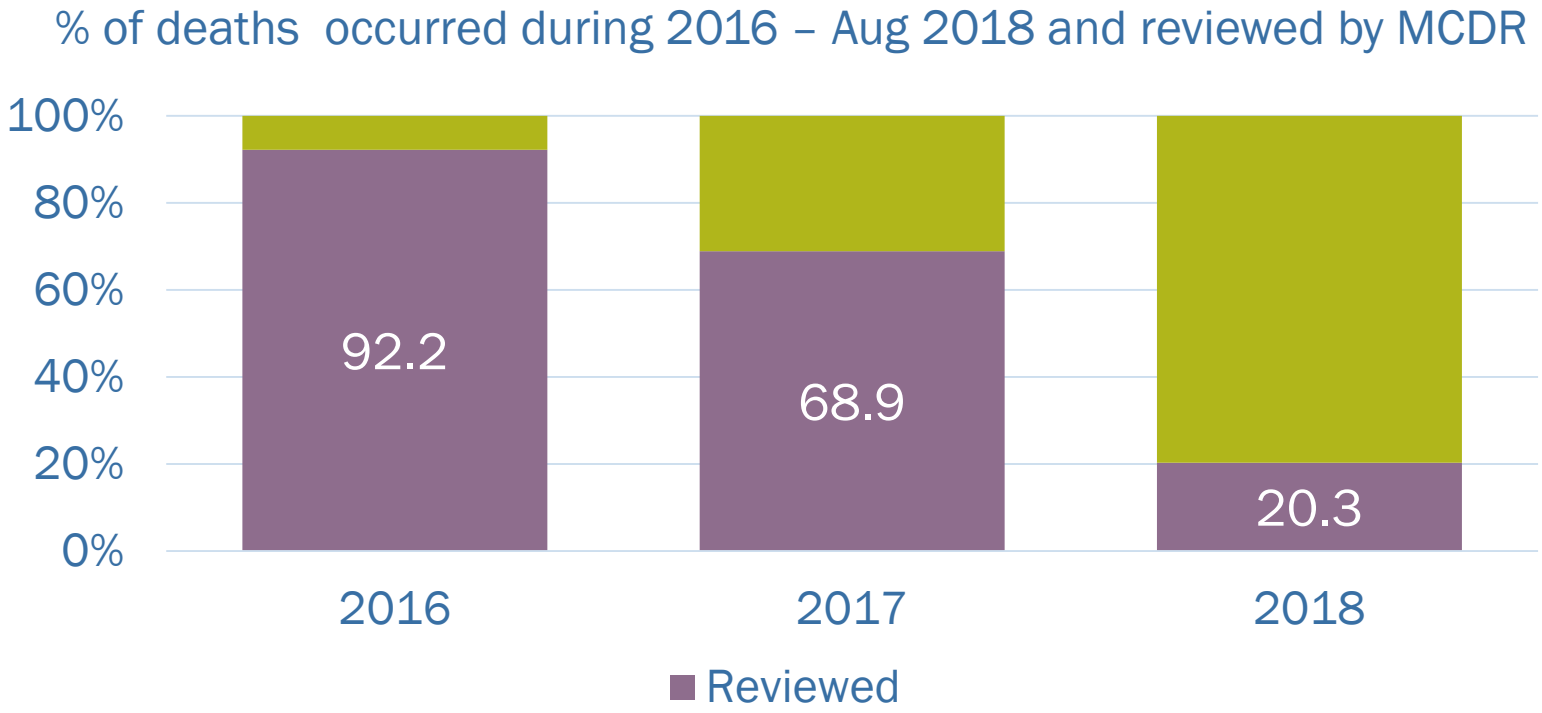
CHILD SUICIDE IN ALASKA, 2007-2017

DATA SOURCE: ALASKA SECTION OF HEALTH ANALYTICS AND VITAL RECORDS



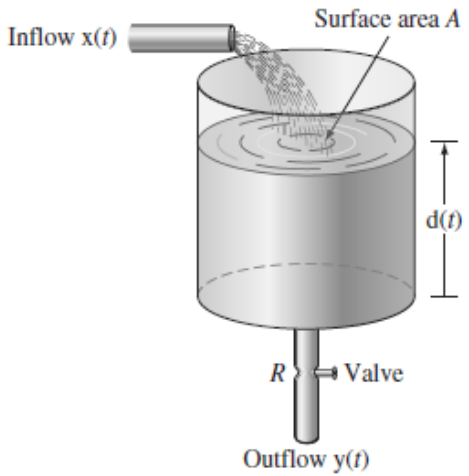

NATIONAL
CFRP
Center for Fatality Review & Prevention
System Codebook
National Fatality Review
Case Reporting System
Version 5.0
SAVING LIVES TOGETHER

MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)



- 329 deaths occurred
  - MCDR has reviewed 67.8% of these deaths
    - 2016: N = 128, 118 reviewed
    - 2017: N = 132, 91 reviewed
    - 2018: N = 69, 14 reviewed

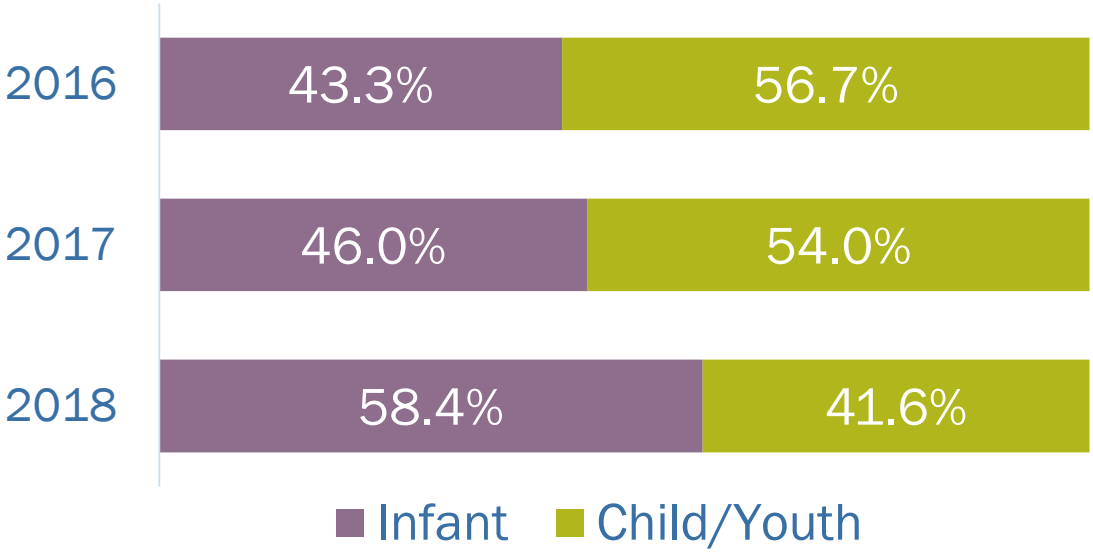
MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)



During 2016 – Aug 2018

- MCDR reviewed 371 deaths

Reviewed during:



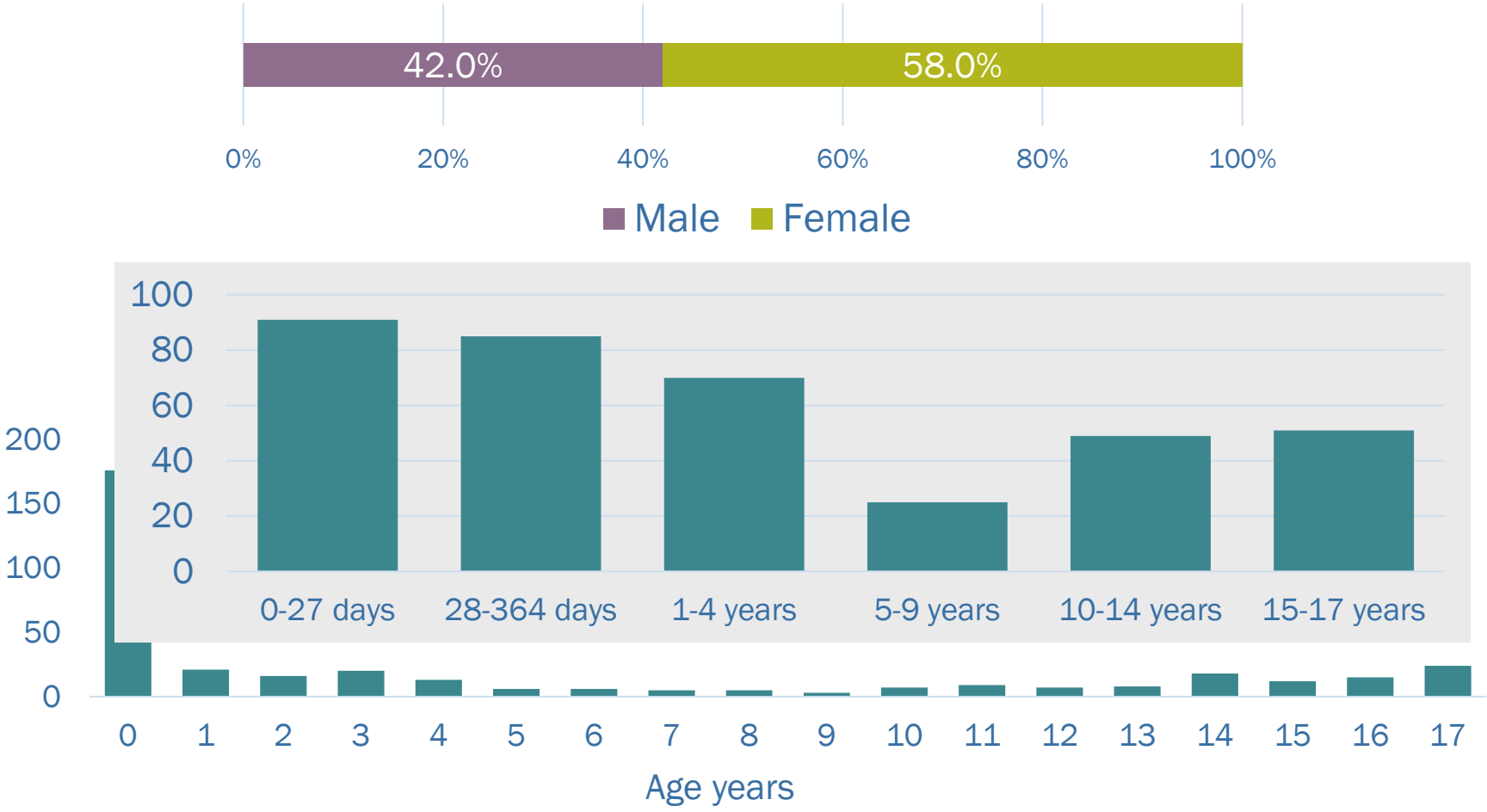
Death years 2010:2016 (N=157)

Death years 2014:2017 (N=137)

Death years 2015:2018 (N=77)

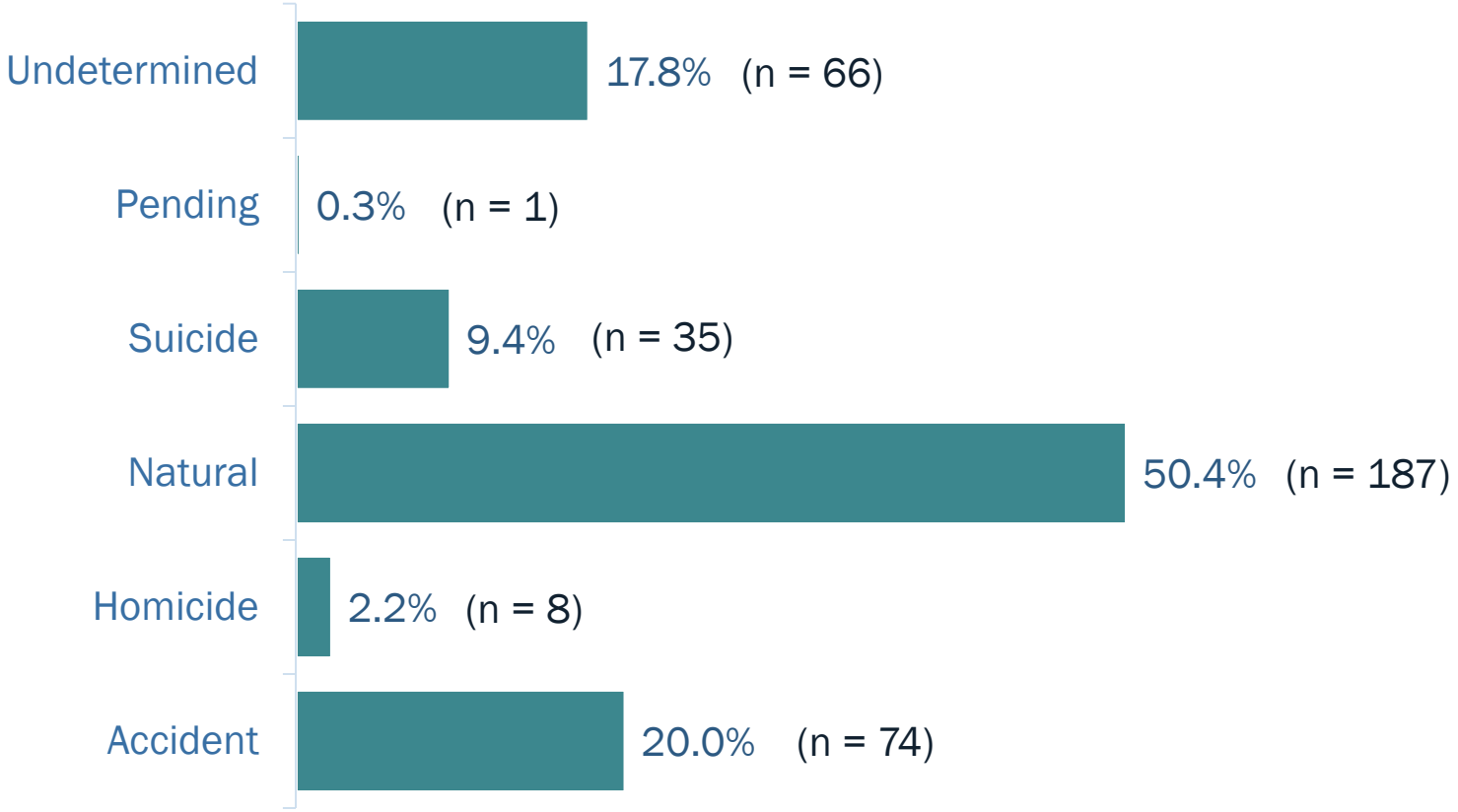
MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed 371 deaths (During 2016 – Aug 2018)



MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed 371 deaths (During 2016 – Aug 2018)
Manner of Death



CHARACTERISTICS OF THESE FATALITIES

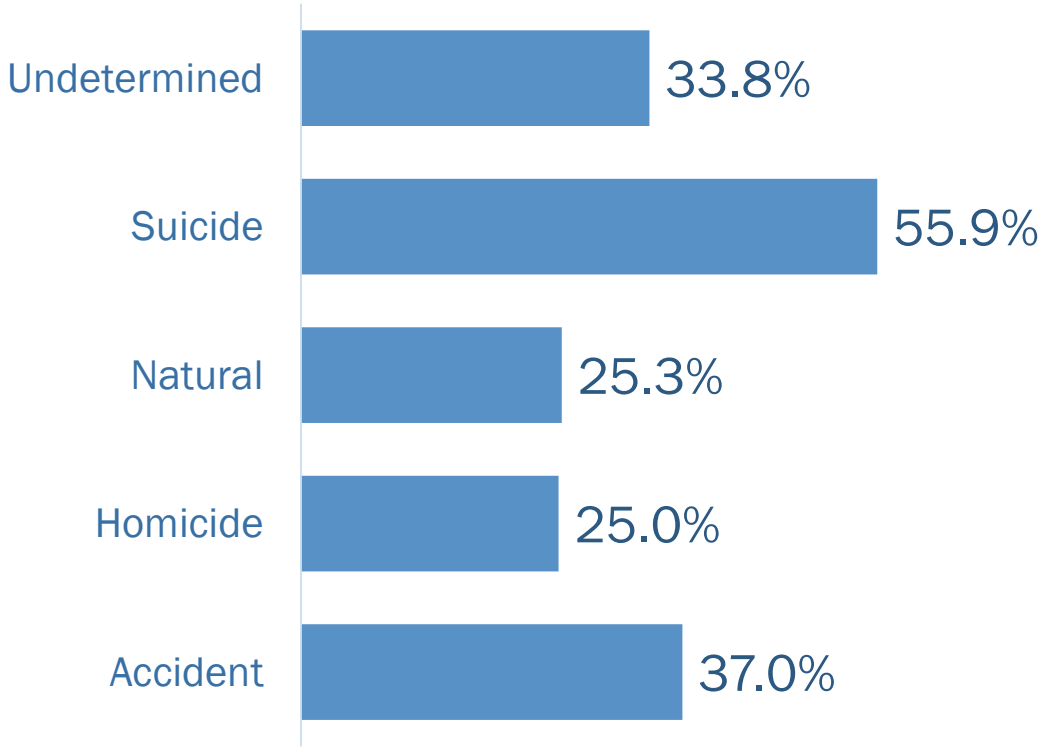
MCDR reviewed 371 deaths (During 2016 – Aug 2018)
CRS data for reviewed cases

Caution
All CRS estimates should be interpreted as a minimum as detection of specific elements through the available records may (likely) result in incomplete ascertainment

MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed 371 deaths (During 2016 – Aug 2018)

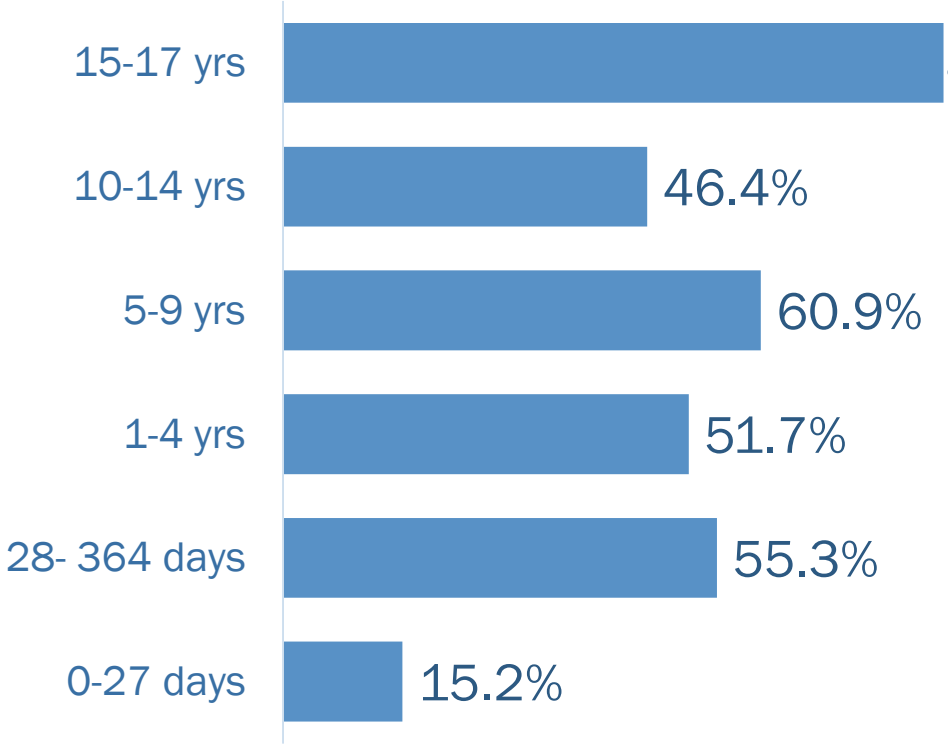
Child had history of child maltreatment (as victim)



MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed 371 deaths (During 2016 – Aug 2018)

CAN, poor supervision, exposure to hazard cased/contributed to death



44.8% total*

(n=126)

- 10.3% Abuse
- 35.0% Neglect
- 24.6% poor supervision
- 31.0% exposure to hazard

MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed deaths (During 2016 – Aug 2018)

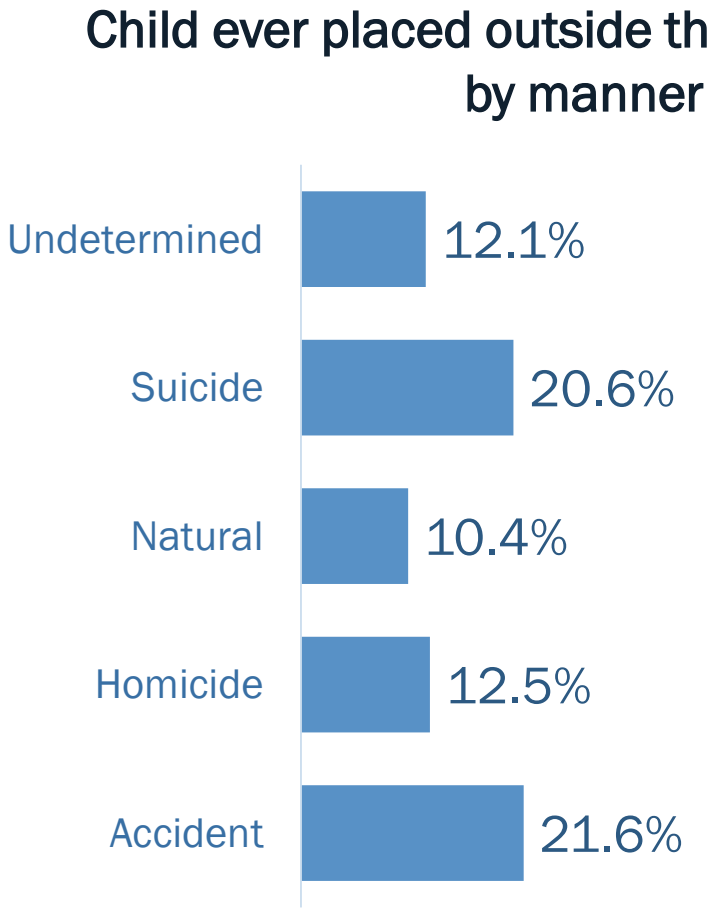
Hazards

Among the 45 deaths that indicated a specific hazard:

- 39 sleep environment
- 3 firearms
- 2 Motor vehicle
- 1 Medication/poison

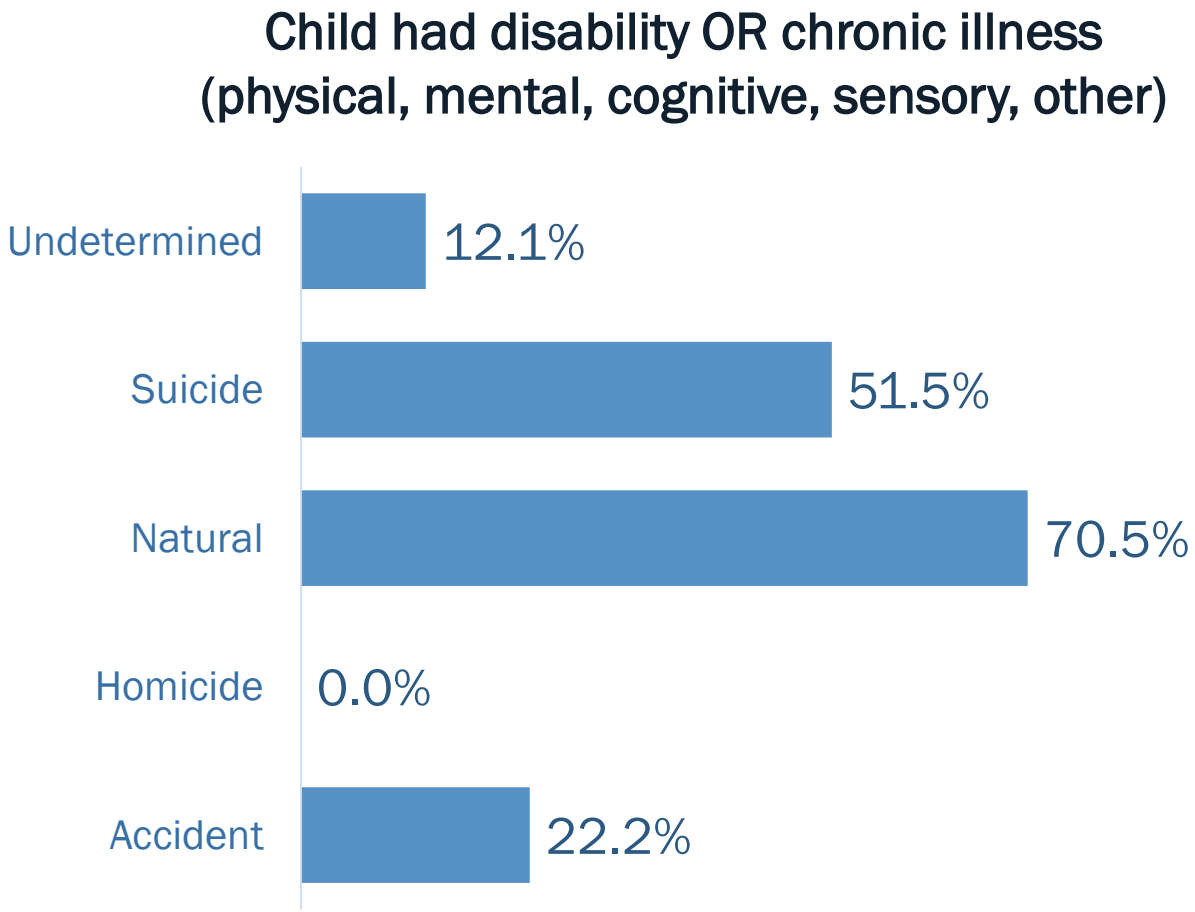
MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed 371 deaths (During 2016 – Aug 2018)



MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed 371 deaths (During 2016 – Aug 2018)



MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed 371 deaths (During 2016 – Aug 2018)

- Primary Caregiver

	0-27 dys (N=91)	28-364 dys (N=85)	1-4 yrs (N=70)	5-9 yrs (N=25)	10-14 yrs (N=49)	15-17 yrs (N=51)
Hx of drug abuse	30.6%	44.0%	43.5%	32.0%	18.8%	26.0%
Hx of maltreatment (Vic)	18.2%	23.8%	21.4%	12.0%	6.3%	4.0%
Hx of maltreatment (Perp)	22.7%	42.2%	34.3%	56.0%	30.6%	38.0%
Children ever removed	9.7%	22.3%	20.8%	0%	13.3%	20.6%
Prior death of child	4.5%	8.2%	2.9%	4.0%	4.2%	0%
Hx of IPV	15.4%	24.7%	22.9%	20.0%	16.3%	29.4%
Delinquent/criminal Hx	24.7%	47.1%	35.7%	24.0%	27.7%	26.0%

MCDR REVIEWED DEATHS (INFANT/CHILD)

MCDR reviewed 186 deaths (During 2016 – Aug 2018)

- Caregiver: Primary

0-27days (N=91; 63)	28-364 days (N=85; 78)	1-4 years (n=70; 69)	5-9 years (n=25; 24)
Bio Mother (54)	Bio Mother (58)	Bio Mother (38)	Bio Mother (13)
Bio Father (6)	Bio Father (9)	Bio Father (12)	Sibling (3)
Hospital Staff (2)	Grandparent (2)	Adoptive parent (5)	Grandparent (2)
Foster parent (1)	Other relative (2)	Grandparent (5)	Other relative (2)
	Foster parent (2)	Other relative (2)	Bio Father (1)
	Adoptive parent (1)	Foster parent (1)	Adoptive parent (1)
	Sibling (1)	Sibling (1)	Foster parent (1)
	Hospital staff (1)	Friend (1)	Hospital staff (1)
	Licensed child care worker (1)	Institutional staff (1)	
	Other (1)	Babysitter (1)	
		Unknown (2)	

MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed 371 deaths (During 2016 – Aug 2018)

- Supervision

	0-27 dys (N=91; 63)	28-364 dys (N=85; 79)	1-4 yrs (N=70)	5-9 yrs (N=25)	10-14 yrs (N=49; 34)	15-17 yrs (N=51; 16)
Child supervised at time of incident	96.8%	92.4%	77.1%	68.0%	83.6%	88.0%
Supervisor Hx of drug abuse	35.0%	46.1%	46.2%	34.8%	12.9%	12.5%
Supervisor Impaired at time of incident*	4.8%	25.3%	24.3%	32.0%	29.4%	31.3%

*Post neonates, 1-4yrs, and 5-9yrs caregiver impairment most often indicated as distraction and/or alcohol

MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed 371 deaths (During 2016 – Aug 2018)

- **Incident/Investigation**

	0-27 dys (N=91; 60)	28-364 dys (N=85; 79)	1-4 yrs (N=67)	5-9 yrs (N=25)	10-14 yrs (N=49; 34)	15-17 yrs (N=51; 49)
911 called	22.0%	77.9%	67.2%	69.6%	75.5%	95.9%
Resuscitation attempted	66.6%	80.5%	65.7%	40.0%	34.7%	52.0%
Drug Impaired	0%	0%	0%	0%	16.2%	30.0%
Investigation conducted	13.8%	70.6%	52.2%	65.2%	78.3%	92.0%
Referred to ME	18.0%	72.9%	67.1%	68.0%	67.3%	96.0%
Autopsy conducted	31.5%	76.5%	55.1%	52.0%	46.9%	68.0%
Death Scene conducted	13.8%	70.2%	52.9%	65.2%	75.6%	92.0%

MCDR REVIEWED DEATHS (INFANT)

MCDR reviewed 176 deaths (During 2016 – Aug 2018)

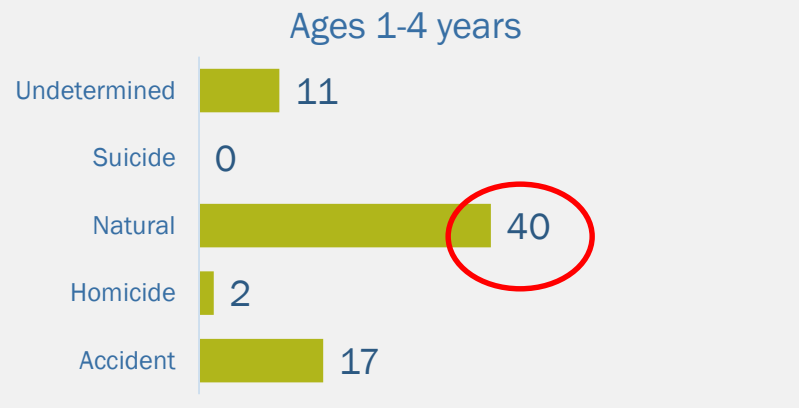
	NeoNates (0-27 days) N=91	PostNeo (28-364 days) N=85
Low birth wt. (<2500g)	35.5%	22.1%
Access or compliance issues with prenatal care	34.8%	29.4%
Infant born drug exposed	26.7%*	35.0%*
Mother smoked 3mo prior to pregnancy	25.8%	42.4%
Mother smoked during pregnancy	20.2%	40.0%
Abnormal metabolic newborn screen	21.7% (20% CPT1-A)	20.7% (58% CPT1-A)

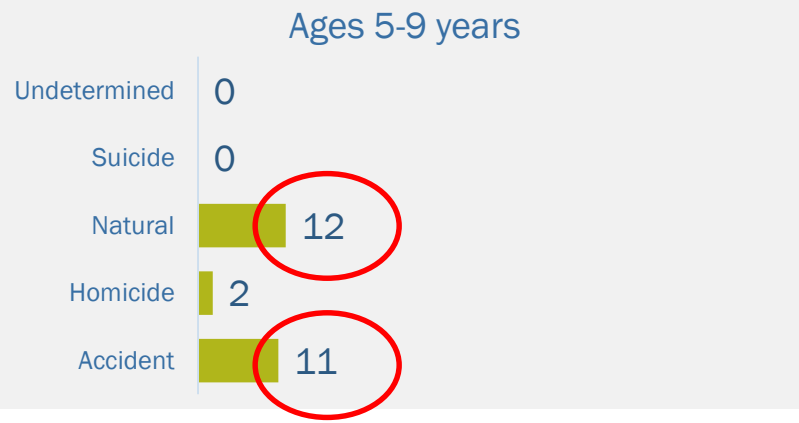
*based on 30 reviewed cases (neo) and 20 reviewed cases (post-neo)

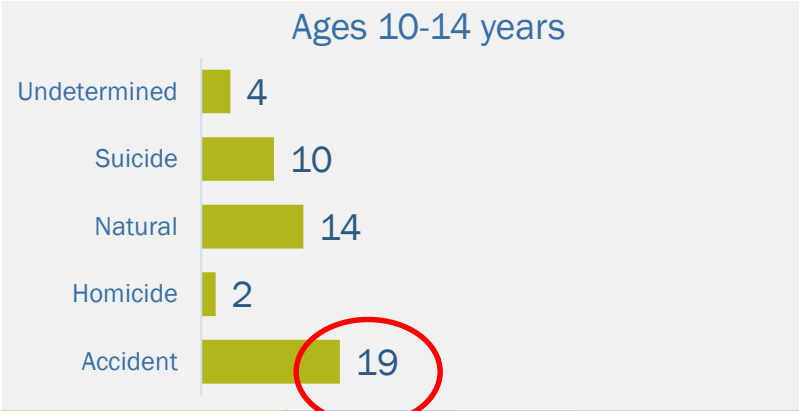
MCDR REVIEWED DEATHS (CHILD/ADOLESCENT)

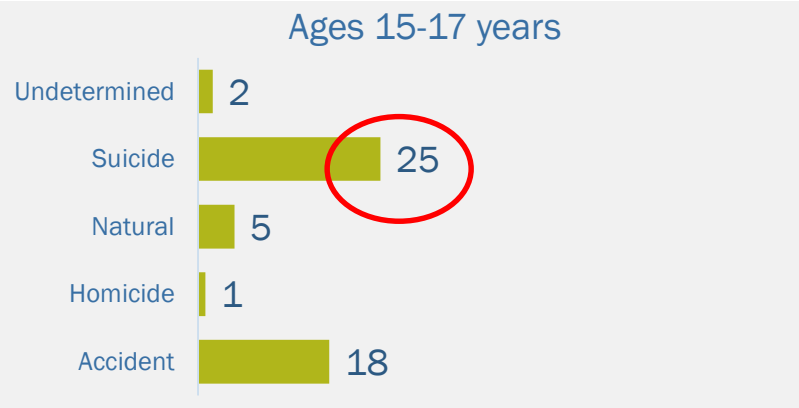
MCDR reviewed 195 deaths (During 2016 – Aug 2018)

Manner of Death by age group





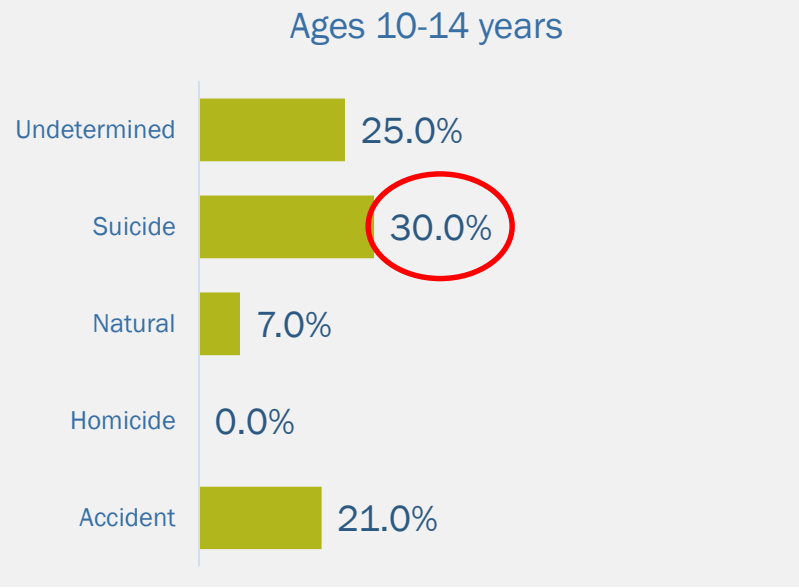


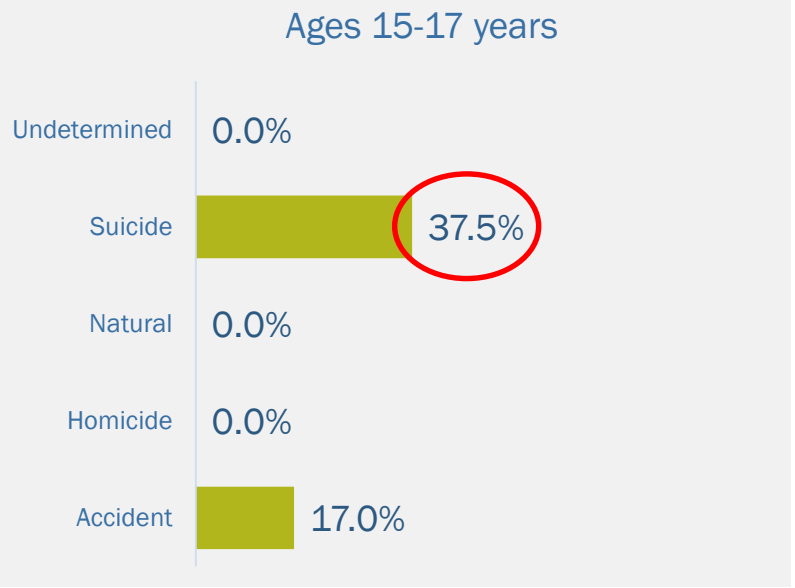


MCDR REVIEWED DEATHS (CHILD/ADOLESCENT)

MCDR reviewed 195 deaths (During 2016 – Aug 2018)

Child had Problems in School
(academic, truancy, suspensions, behavioral, expulsion)

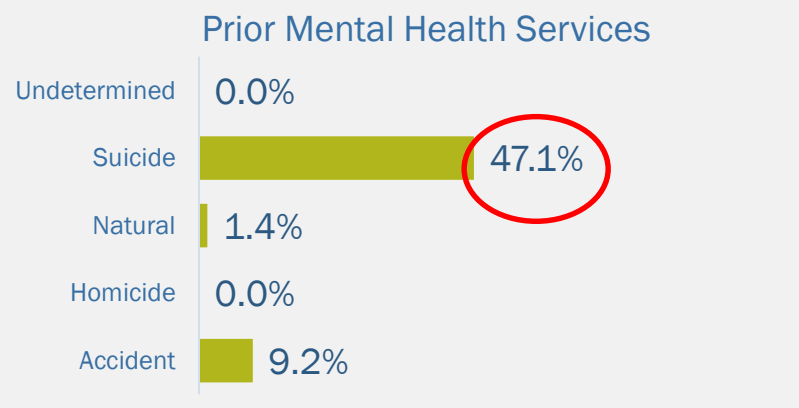


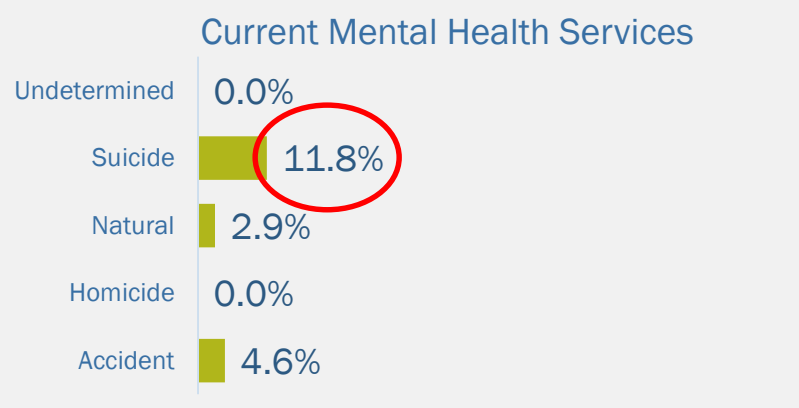


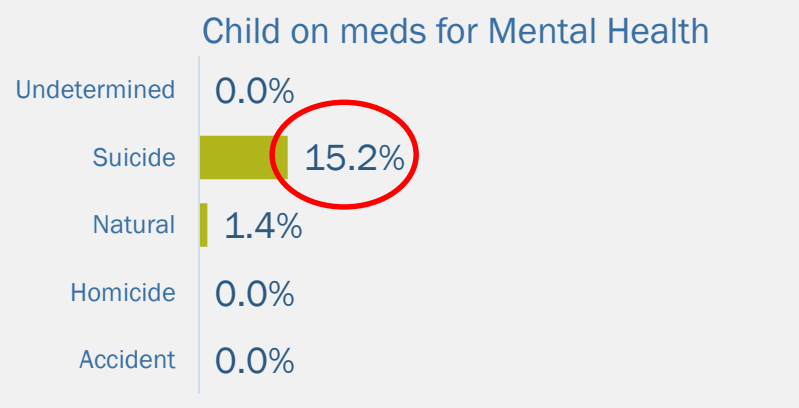
MCDR REVIEWED DEATHS (CHILD/ADOLESCENT)

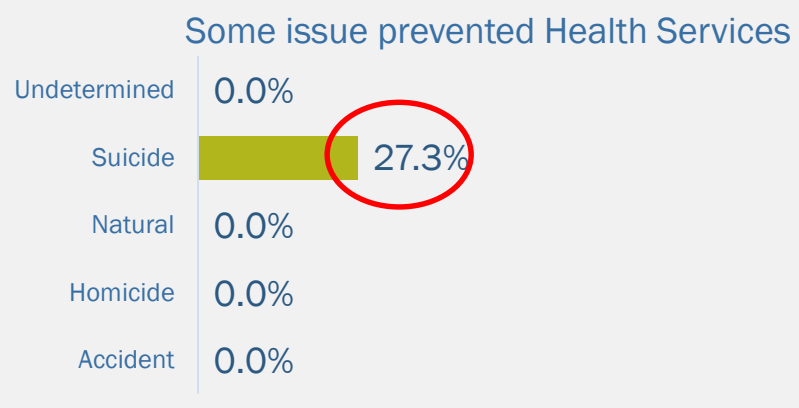
MCDR reviewed 195 deaths (During 2016 – Aug 2018)

Mental Health





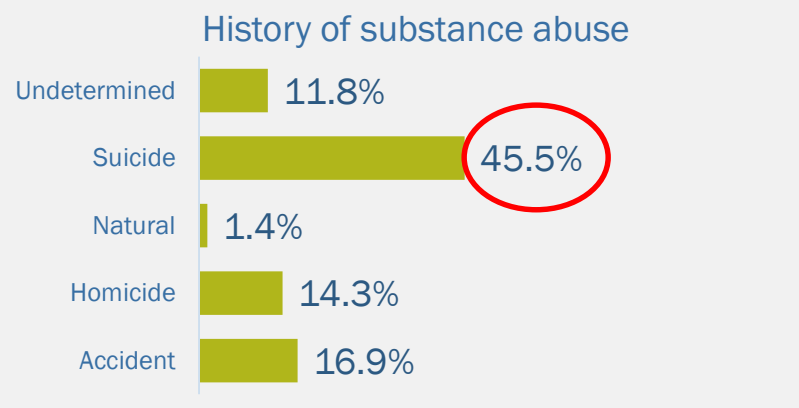


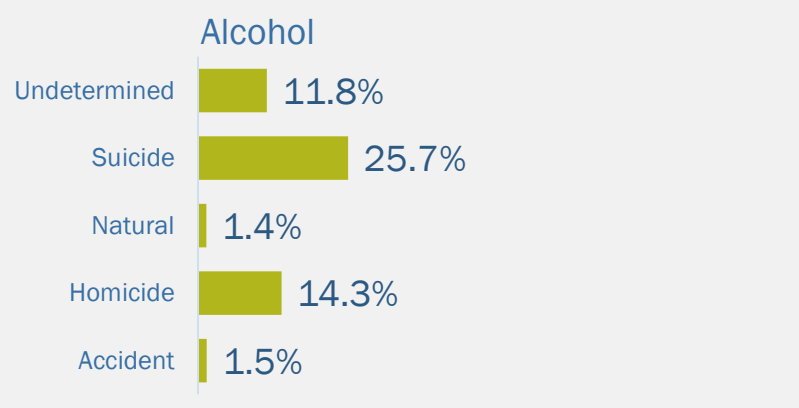


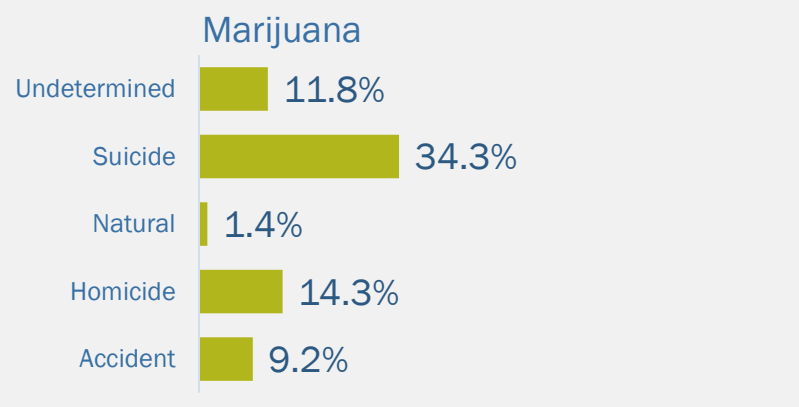
MCDR REVIEWED DEATHS (CHILD/ADOLESCENT)

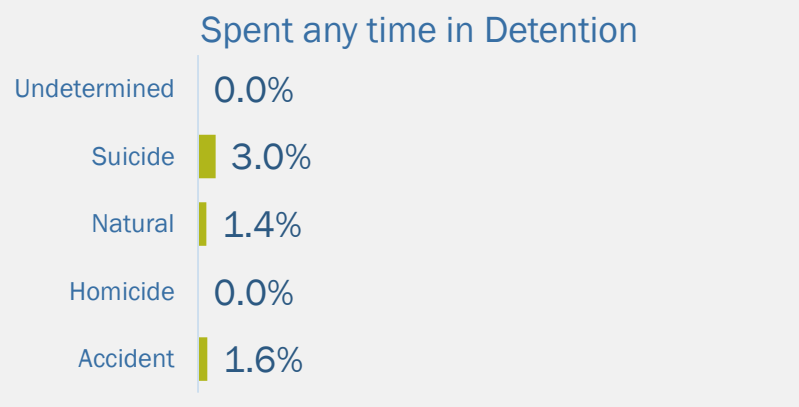
MCDR reviewed 195 deaths (During 2016 – Aug 2018)

Substance abuse/DJJ



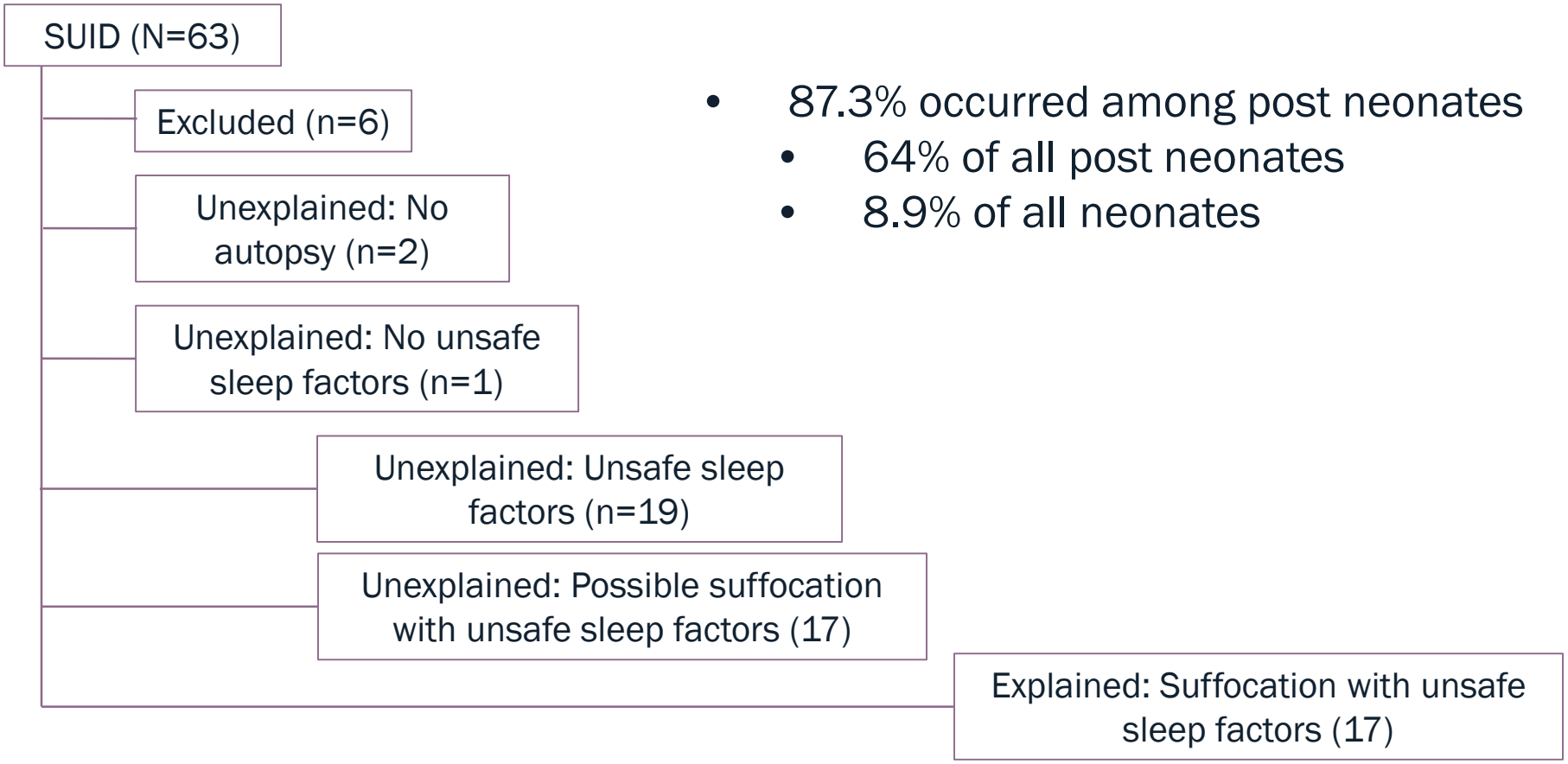






MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed SUID deaths (N=63, 36% of Infant deaths) (During 2016 – Aug 2018)



- 87.3% occurred among post neonates
  - 64% of all post neonates
  - 8.9% of all neonates

MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed **Motor Vehicle Crash** deaths (N = 23)
(During 2016 – Aug 2018)

1-4 years (n=70; 2)	5-9 years (n=25; 3)	10-14 years (n=49; 9)	15-17 years (n=51; 9)
Pedestrian (2)	Pedestrian (1) Car (1) ATV (1)	Airplane (5) Pedestrian (1) SUV (1) Motorcycle (1) ATV (1)	ATV (3) Pedestrian (1) Car (1) SUV (2) Truck (1) Snowmobile (1)

MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed **Fire deaths** (N=12)
(During 2016 – Aug 2018)

Sources of ignition	Structure type
Cigarette lighter	Single home
Cooking stove	Duplex
Electrical wiring	Trailer/mobile home
Hot liquid	
Other	

*Only 1 of the home fire fatalities occurred in a home with a working smoke detector.

MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed **Drowning deaths** (N=20)
(During 2016 – Aug 2018)

Activity before event

Playing near water (7)
Swimming (3)
Boating (2)
Bathing (1)
Tubing (1)
Sleeping (2)
Unknown/other (5)

Location

Open water (15)
- River (5)
- Creek (3)
- Lake (3)
- Pond (2)
- Ocean (2)

Bathtub (3)
Pool/hot tub (1)
Well/septic (1)
Other (1)

*Only 1 of the drowning deaths occurred where a life jacket was worn

MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed **Suicide deaths** (N=35)
(During 2016 – Aug 2018)

- **62.3% talked about suicide**
- 45.7% prior suicide threats
- 42.9% left a note
- 34.2% Hx of self mutilation
- 22.9% Hx of being bullied
- 22.9% totally unexpected
- 20.0% recent breakup with boyfriend/girlfriend
- 11.4% recent argument with boyfriend/girlfriend
- 14.3% prior attempts

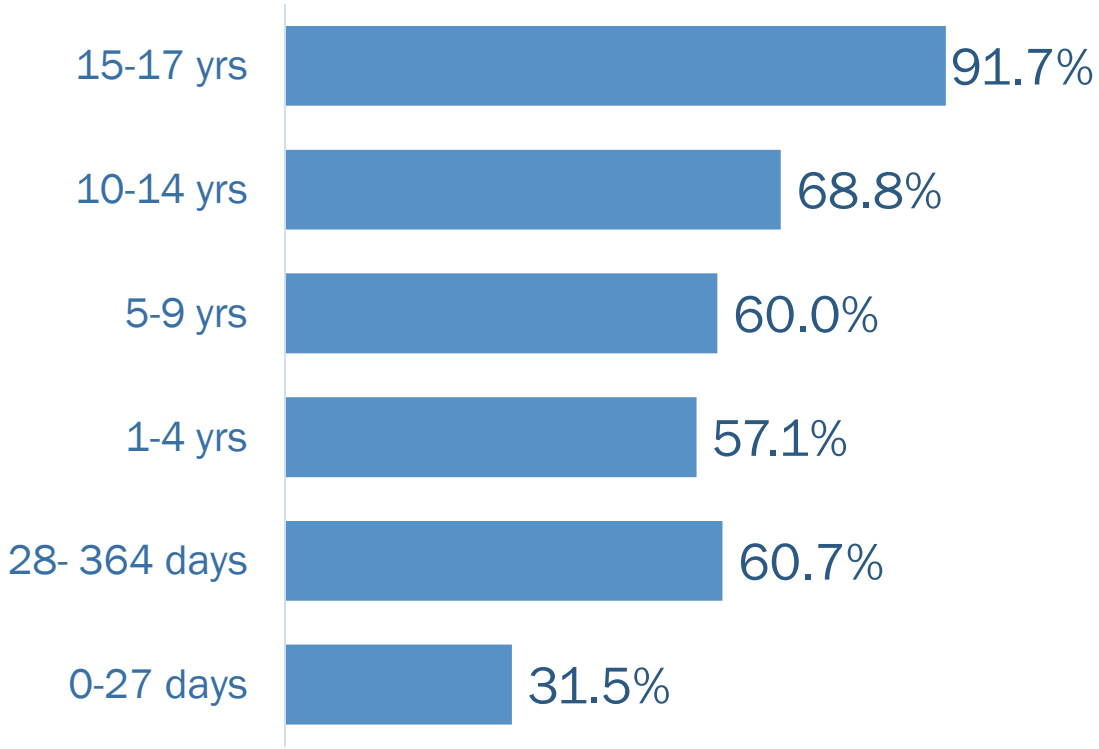
MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed Suicide deaths (N=35)
(During 2016 – Aug 2018)

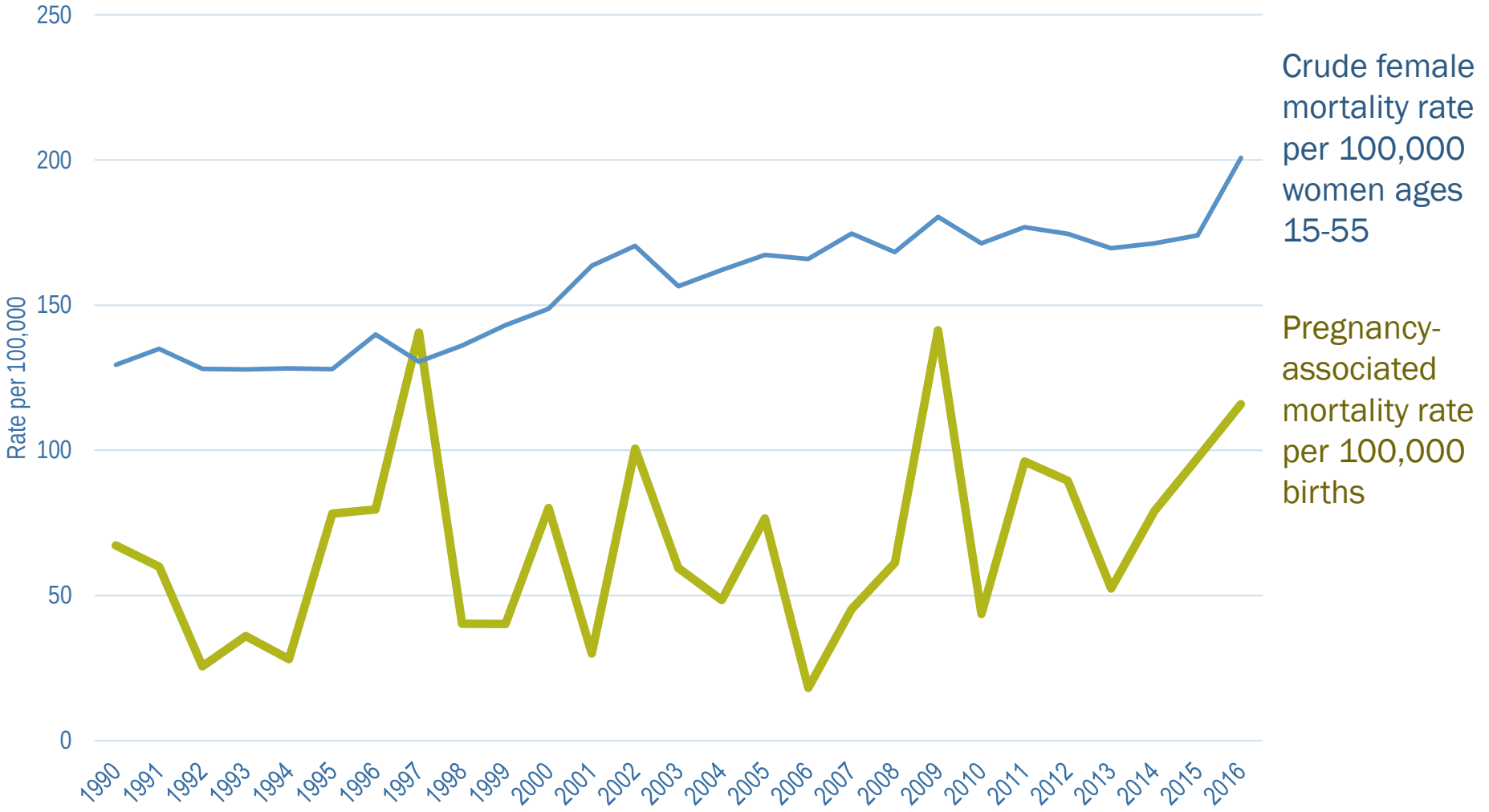
	Female (n=7)	Male (n=28)
Talked about suicide	**85.7%**	57.1%
Prior suicide threats	**71.4%**	39.3%
Left a note	57.1%	39.3%
Hx of self mutilation	**85.7%**	21.4%
Hx of being bullied	**42.9%**	17.9%
Totally unexpected	0%	28.6%
Recent break up with boyfriend/girlfriend	**28.6%**	17.9%
Recent argument with boyfriend/girlfriend	14.3%	10.7%
Prior attempts	**28.6%**	10.7%

MCDR REVIEWED DEATHS (INFANT/CHILD/ADOLESCENT)

MCDR reviewed 371 deaths **<Preventable>**
(During 2016 – Aug 2018)



ALASKA'S PREGNANCY-ASSOCIATED MORTALITY RATE HAS RECENTLY INCREASED ...SO HAS ALL FEMALE MORTALITY AGES 15-55



Data Sources: Alaska Section of Health Analytics and Vital Records (birth and death certificate data), Alaska Department of Labor and Workforce Development (population data)

PREGNANCY-RELATED DEATHS

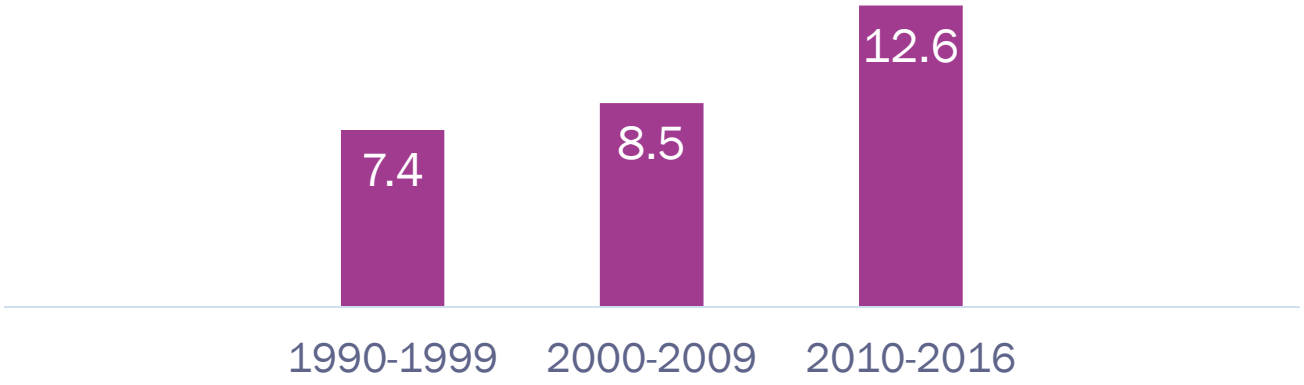
1990-1999: 8 deaths

2000-2009: 9 deaths

2010-2016: 10 deaths

Pregnancy-related mortality rates per 100,000 births
(Alaska 1990-2016)

US 2014 Rate, 18.0



3 OF THE 6 PREGNANCY-RELATED DEATHS DURING 2012-2016 WERE DEFINITELY OR PROBABLY PREVENTABLE

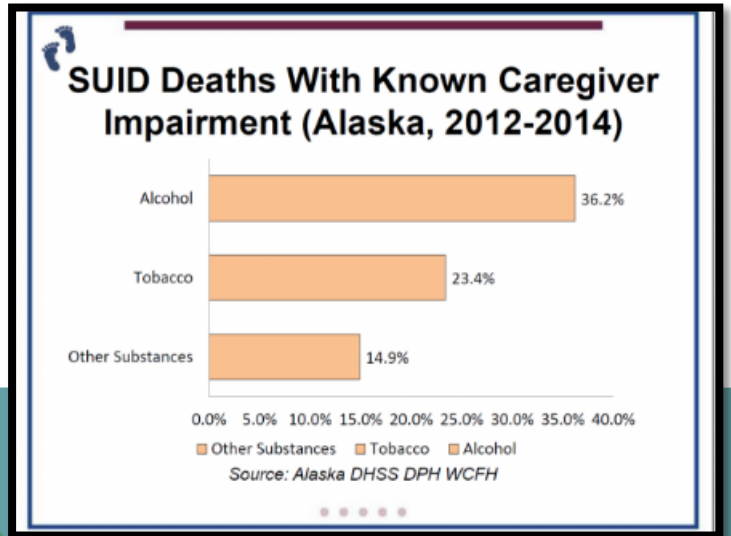
MCDR Committee Recommendations

- Improved blood pressure control
- Earlier referral to higher level of care
- Appropriate treatment of maternal infections
- Patient compliance with taking prescribed medications
- Improved access and treatment of substance abuse

HOW DO WE MOVE DATA TO ACTION?

SECTION OF WOMEN'S, CHILDREN'S, AND
FAMILY HEALTH, MCH-EPIDEMIOLOGY UNIT

MCDR DATA IN ACTION – SAFE SLEEP ROADSHOW 2018



BREAK

Please rank the recommendation you would like for the MCDR Program and prevention partners to focus on over the next year related to Sudden Unexpected Infant Death (SUID)

Recommendation 1

Recommendation 2

Recommendation 3

Recommendation 4

Recommendation 5

Recommendation 6

Recommendation 7

Please rank the recommendation you would like for the MCDR Program and prevention partners to focus on over the next year related to Maternal deaths

When poll is active, respond at **PollEv.com/mch2018**

Recommendation 16

Recommendation 17

Recommendation 8

Recommendation 19

Recommendation 20

Recommendation 21

Recommendation 22

CASE SUMMARIES 1 & 2

TABLE DISCUSSION

1. As a group, choose the recommendation you would like to work on and share out (you can do both if you finish early!)
2. Self-Reflection: Take a minute to jot down some ideas of your own for questions 1 and 2 on the “Group Discussion Worksheet”
3. Complete the worksheet as a table.
4. Decide what will be shared for Table Report Out question 1.
5. Wait for instructions on Table Report Out question 2

Thanks to today's lunch sponsor

Trust

Alaska Mental Health Trust Authority

www.mhtrust.org





Please rank the recommendation you would like for the MCDR Program and prevention partners to focus on over the next year related to Child injury deaths

Recommendation 8

Recommendation 9

Recommendation 10

Recommendation 11

Please rank the recommendation you would like for the MCDR Program and prevention partners to focus on over the next year related to Adolescent suicide

Recommendation 12

Recommendation 13

Recommendation 14

Recommendation 15

CASE SUMMARIES 3 & 4

TABLE DISCUSSION

1. As a group, choose the recommendation you would like to work on and share out (you can do both if you finish early!)
2. Self-Reflection: Take a minute to jot down some ideas of your own for questions 1 and 2 on the “Group Discussion Worksheet”
3. Complete the worksheet as a table.
4. Decide what will be shared for Table Report Out question 1.
5. Wait for instructions on Table Report Out question 2

BREAK

MOVING FORWARD ACTIVITY

On an index card, write the next step this group should take to create prevention task force

SIGN UP OR NOMINATE SOMEONE!

MCDR TASK FORCE & PREVENTION TEAM

PLEASE COMPLETE THE FOLLOWING:

Name: _____ Title: _____

Organization: _____

Each month the Maternal Child Death Review committee generates recommendations for prevention and identifies common risk factors based on individual case reviews. Often these reviews also identify gaps in systems, policies, death investigation process, and healthcare access and services. However it has been difficult for MCDR to use this information in a meaningful way to prevent deaths and improve data to action initiatives.

If you would be interested in forming a MCDR task force and prevention team to move these and future recommendations from the MCDR committee into action please check the boxes for the teams you would be interested in joining.

- ☐ **GENERAL MCDR TASK FORCE AND PREVENTION TEAM**
- ☐ **MATERNAL DEATHS**
- ☐ **PREVENTABLE INFANT DEATHS (0-1YR)**
- ☐ **CHILD UNINTENTIONAL INJURY (1-12YR)**
- ☐ **ADOLESCENT SUICIDE (13-17YR)**
- ☐ **OTHER –WRITE IN-_____**

Time commitment: Each team above will receive an e-mail after every monthly MCDR Committee Review with corresponding prevention recommendations. At the team's request, MCDR staff will facilitate a group meeting to discuss moving recommendations to action.

Is there someone you would like to nominate for a team?

- Nominee name and contact info:

THANK YOU!