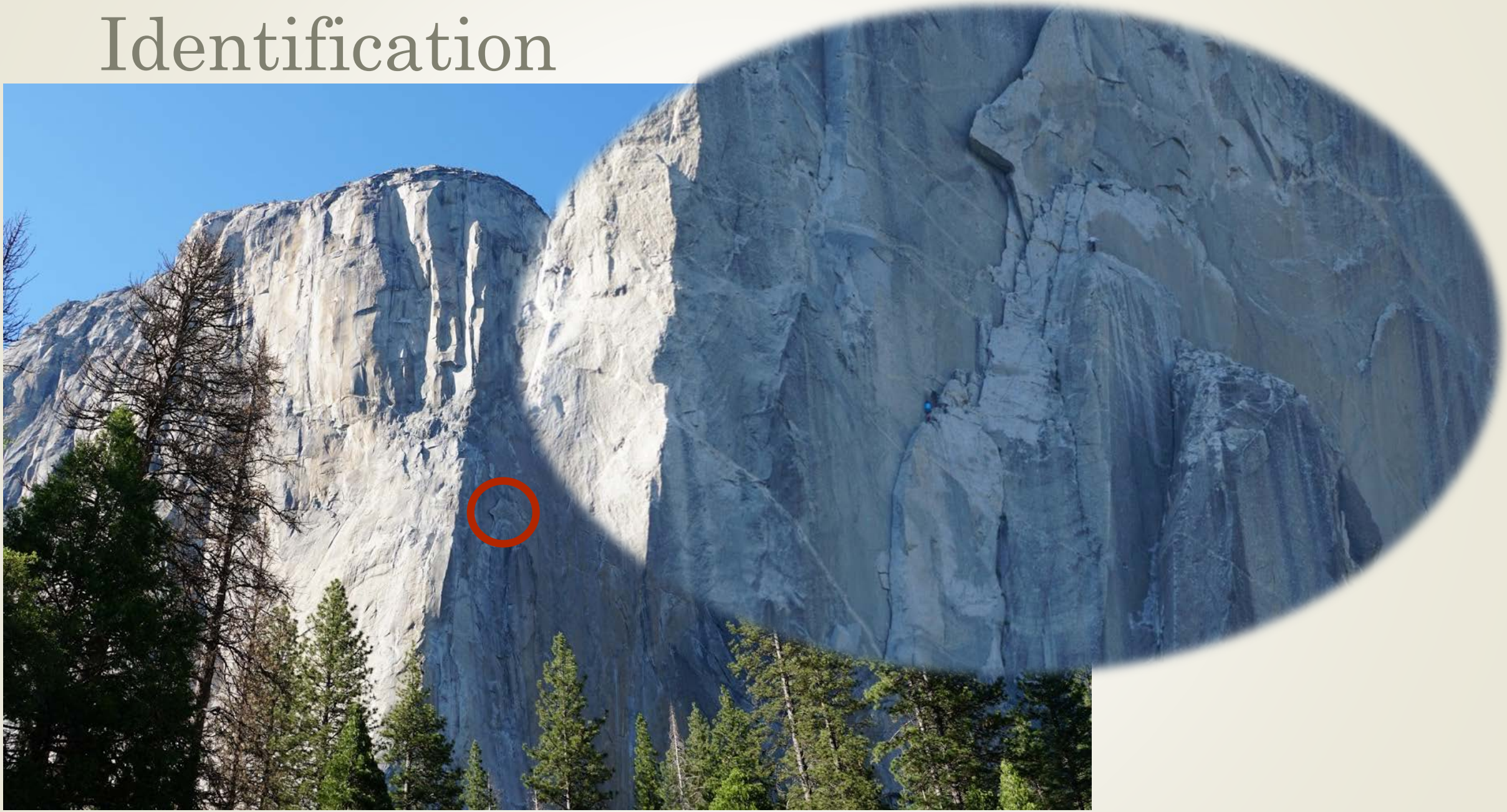
# Maternal and Child Death Review

Annual Meeting 2017

# 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

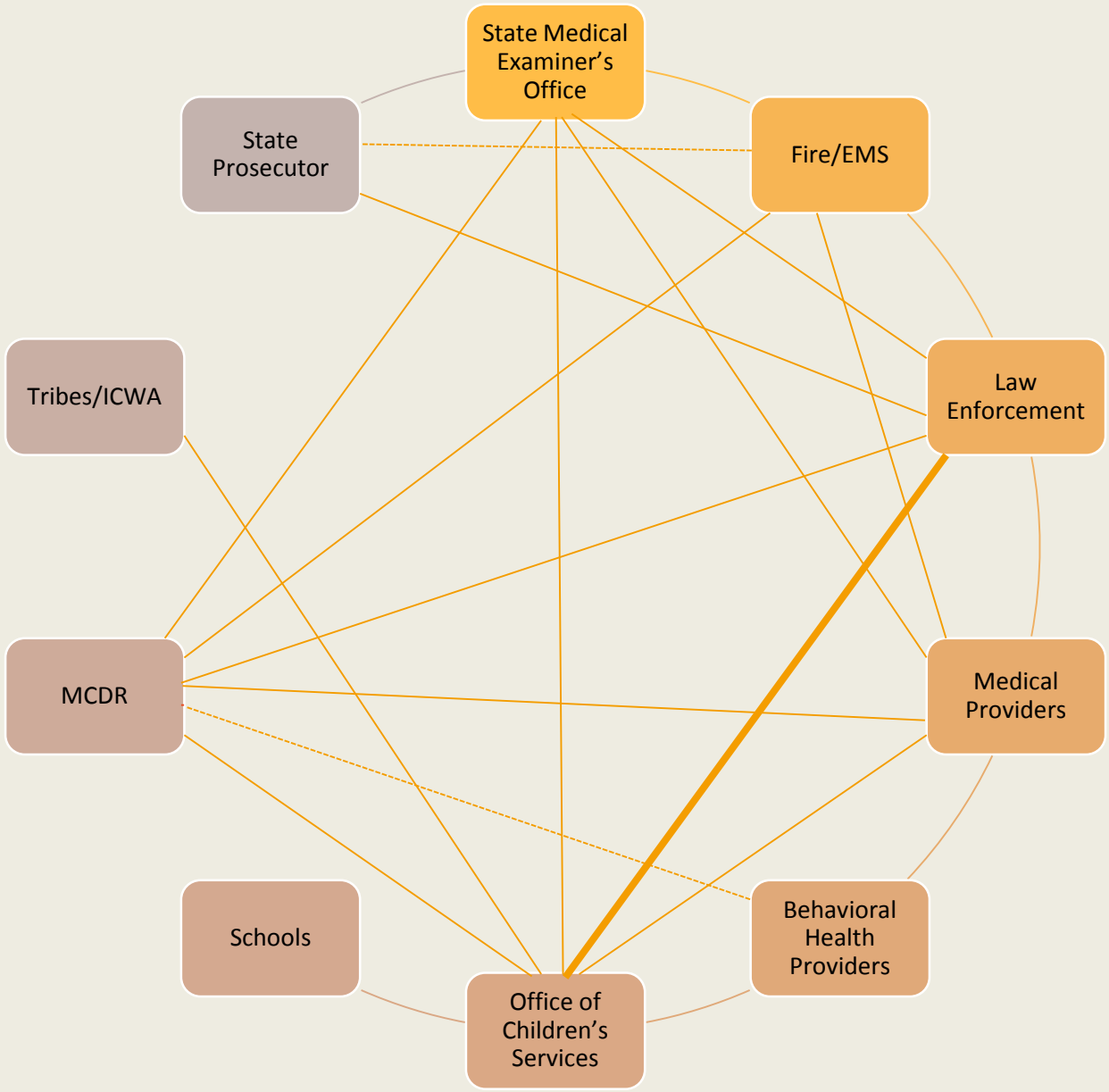


# Data is used to identify patterns

- 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.

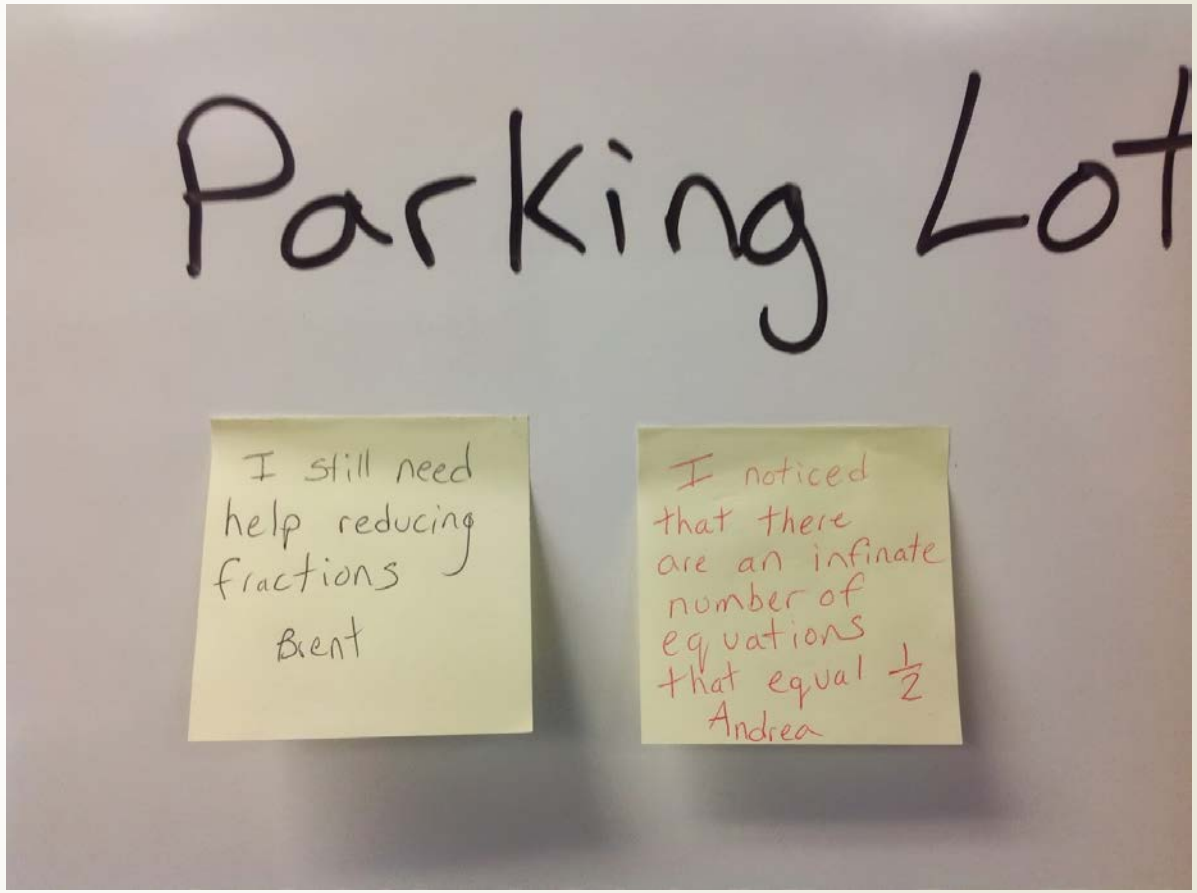
# Networks:

- 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.

# MCDR Program

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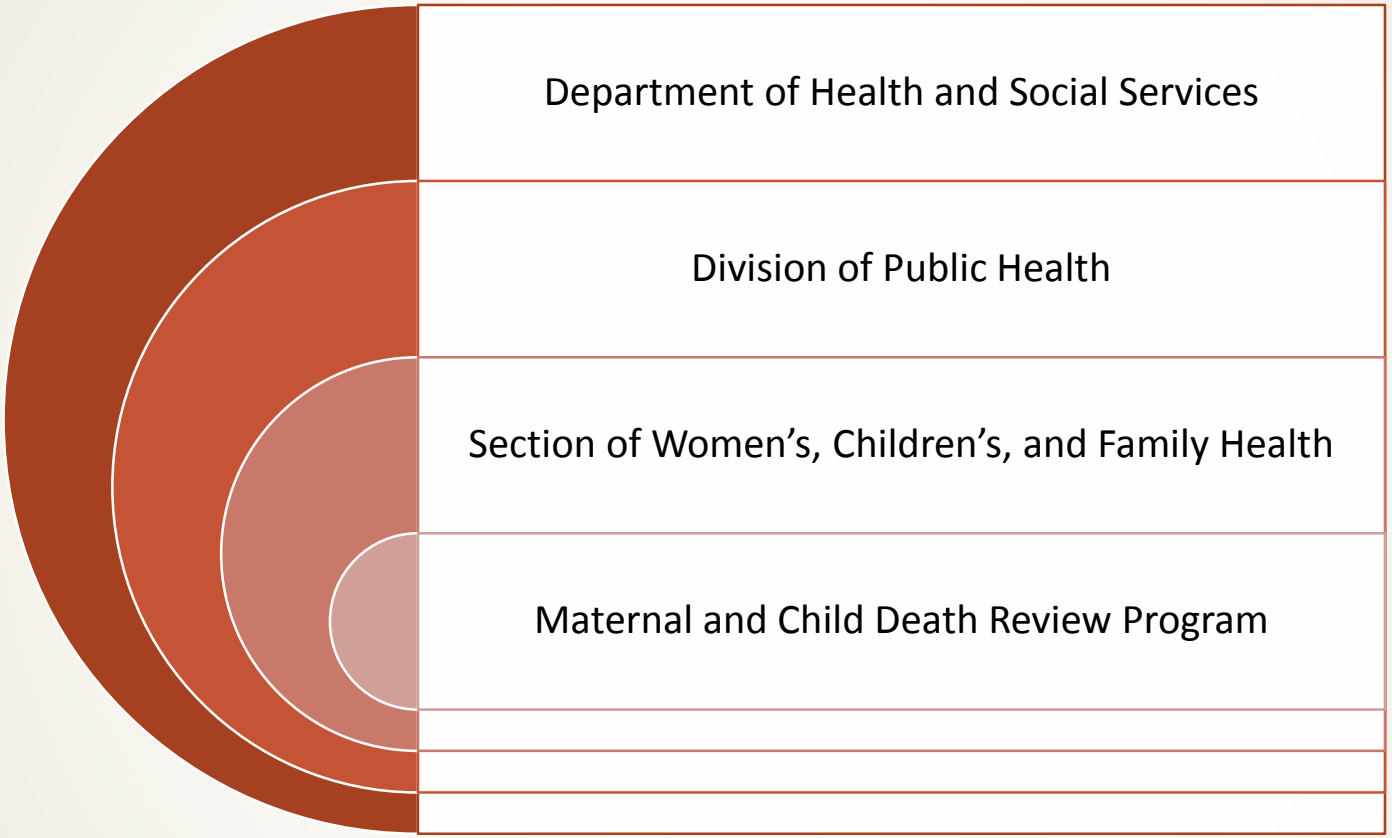
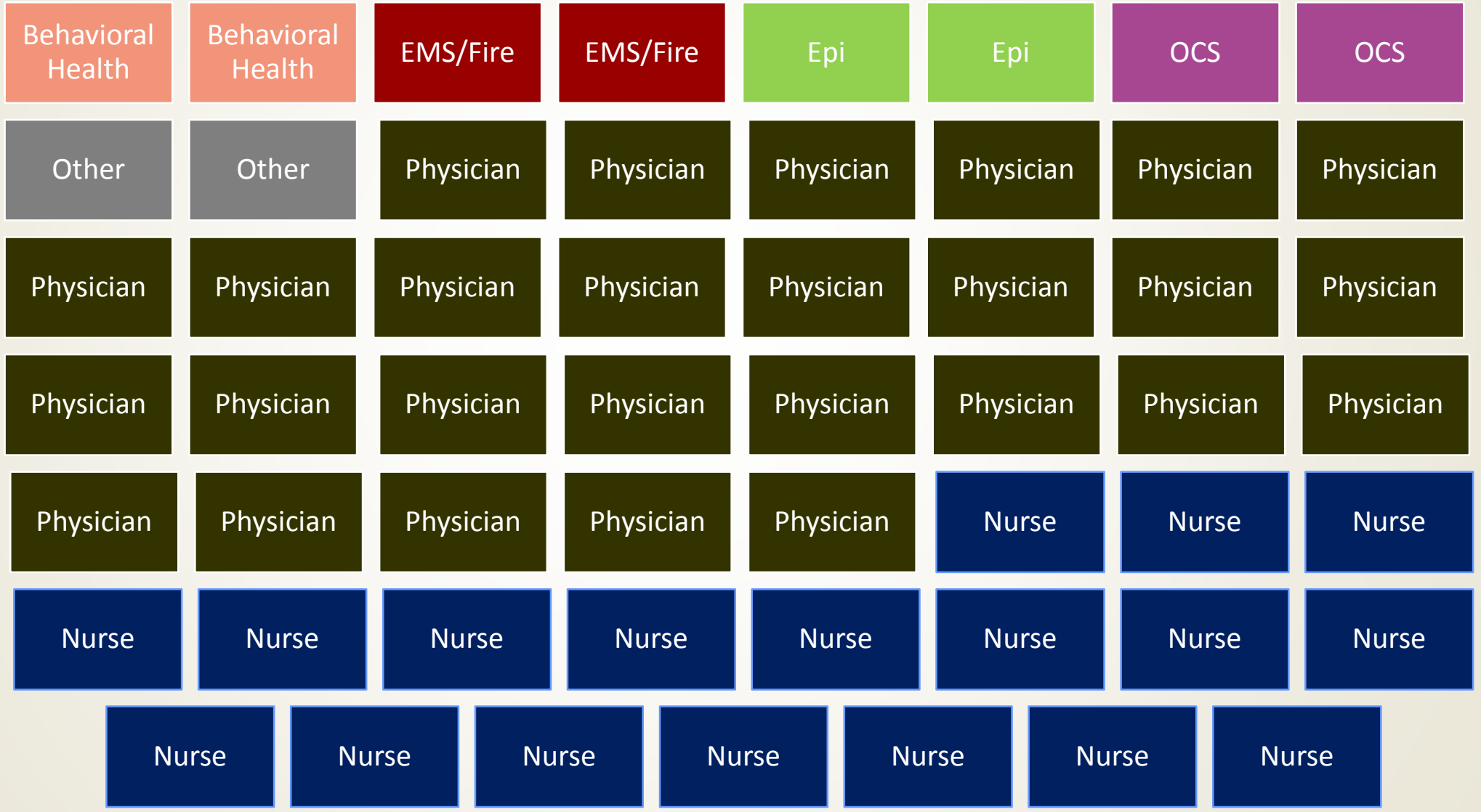

Department of Health and Social Services
Division of Public Health
Section of Women's, Children's, and Family Health
Maternal and Child Death Review Program

# Maternal and Child Death Review (MCDR)

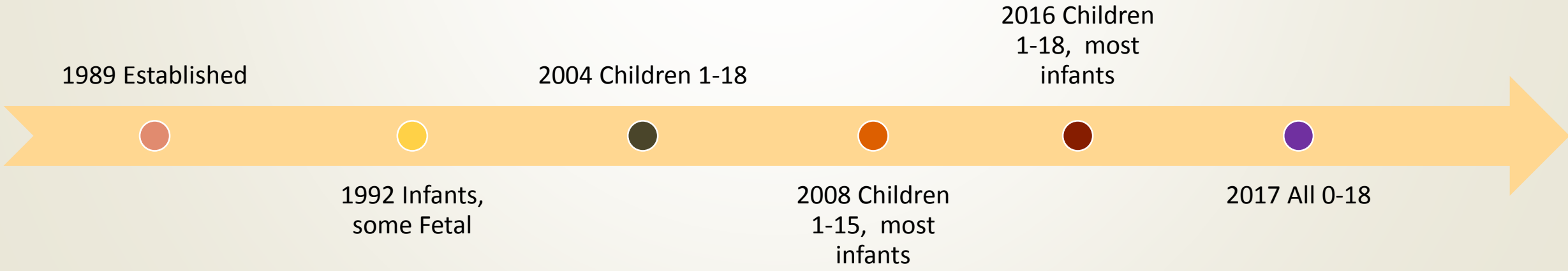
- Established in 1989 under a medical review statute (AS 18.23.020).
  - Formerly known as Maternal and Infant Mortality Review-Child Death Review (MIMR-CDR).
- Began by reviewing maternal deaths, but has since expanded.
- Committee required to be at least 75% medical professionals as defined by statute.
  - 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

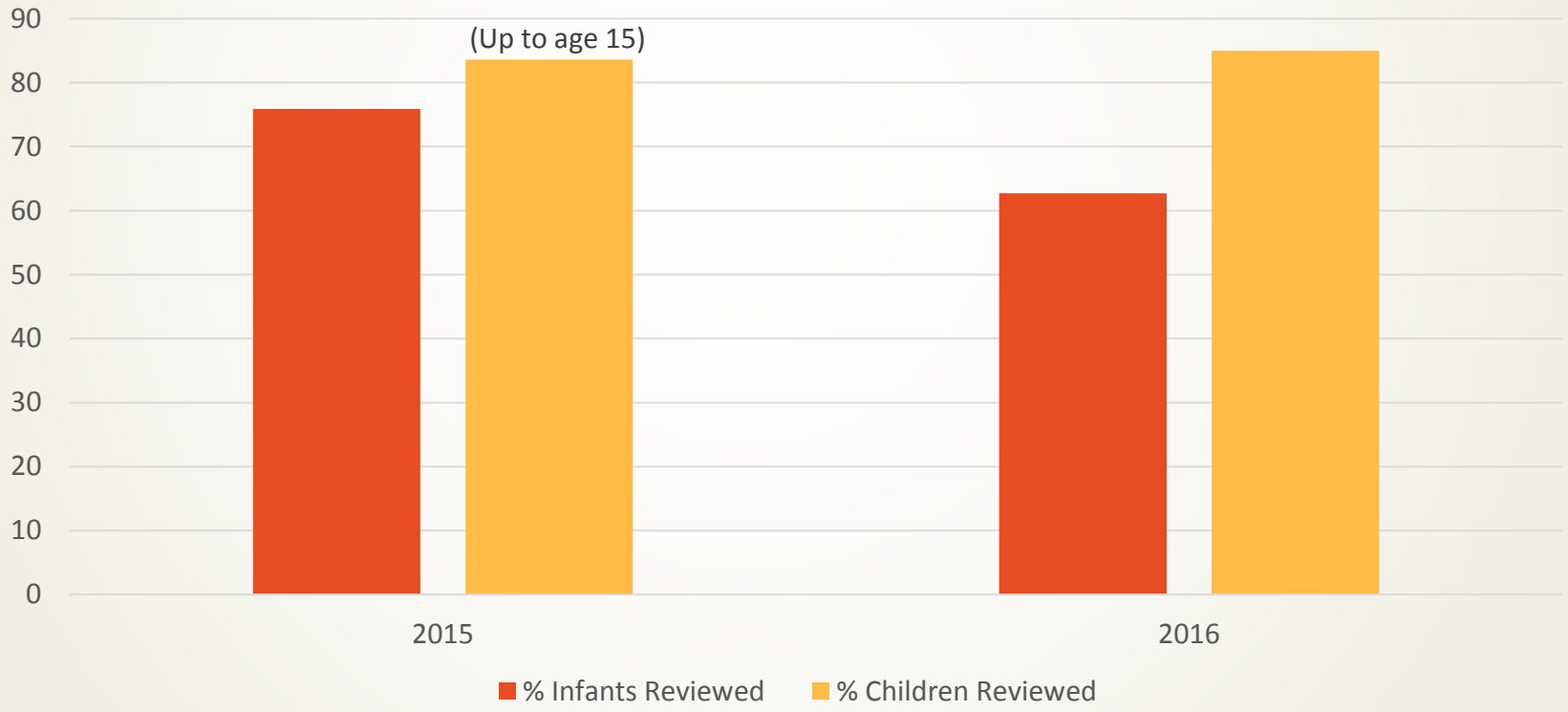


# MCDR Updates

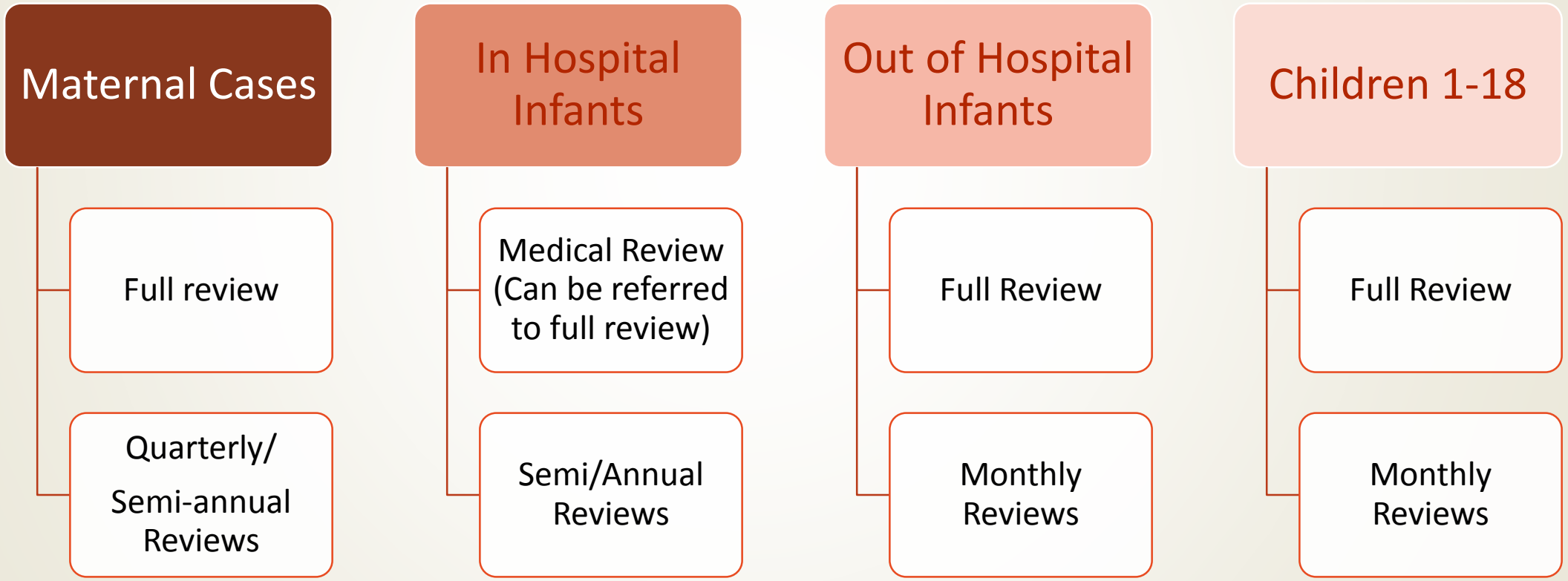
- No backlog for most cases!
  - We are reviewing cases as soon as we receive records. (Exception: neonatal cases).
- Expanded scope of review: now reviewing all decedents under 18, plus maternal cases.
  - 2016: Started reviewing ages 15-18
    - Captures the majority of youth suicides.
  - 2017: Started reviewing in-hospital neonatal deaths in a separate neonatal review process (started with 2014 cases).



# MCDR: % of Deaths Reviewed 2015-2016



# 2017 MCDR Review Categories



# 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.

# Patching Cracks

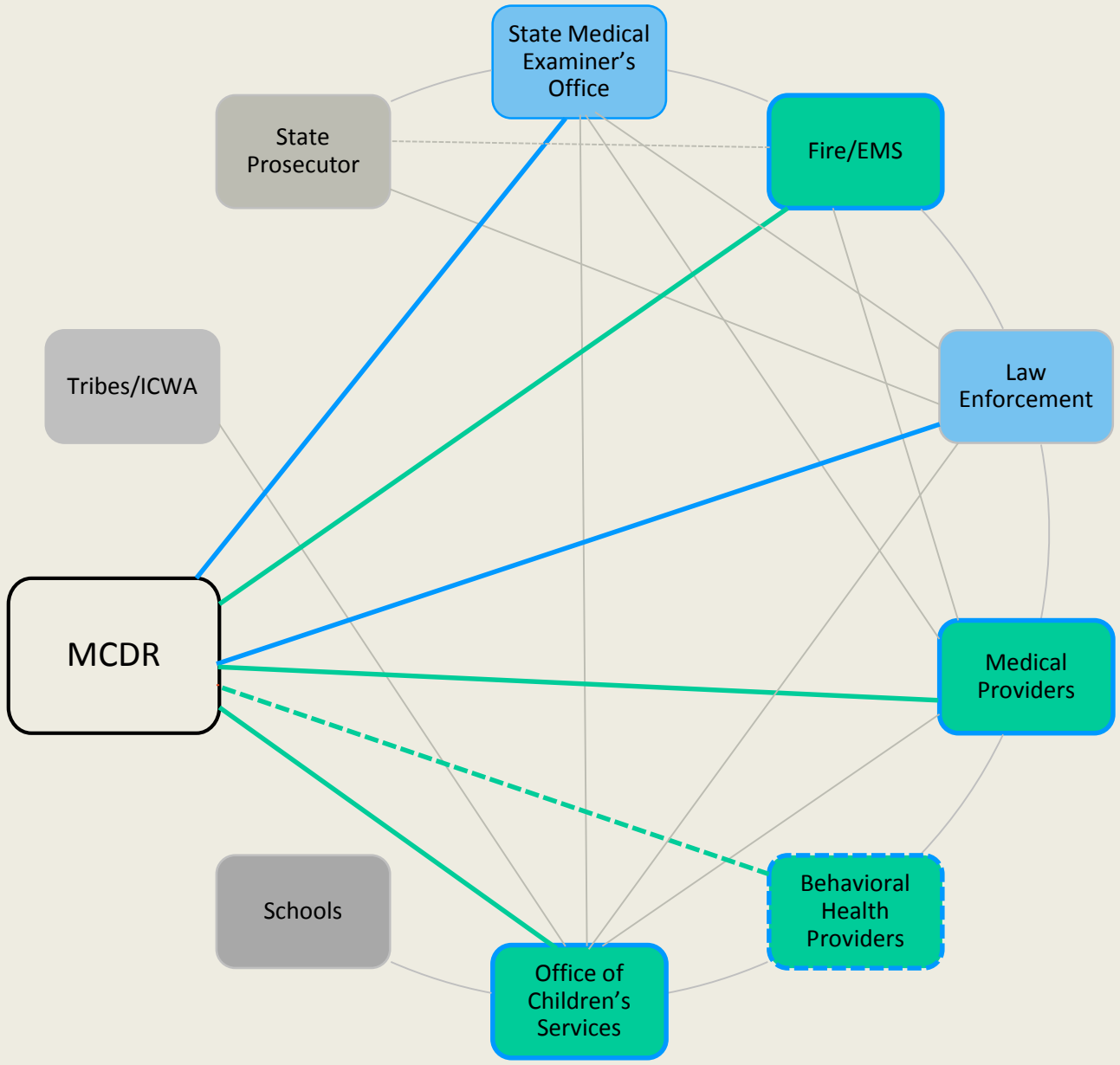
- In many such cases, the MCDR reviewers feel strongly that the deaths could have been prevented.
- The difficulty may lie in the fact that no single agency did anything inappropriate, yet they did not coordinate efforts effectively.
- Our goal is to explore ways for different stakeholders to combine efforts to keep these fatalities from occurring.

# 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



# 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

# 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

# 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)