Maternal Infant Mortality Review and Child Death Review
Section of Women's Children's and Family Health
Alaska Division of Public Health

Recommendations Report *January 2016*

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Background

Established in 1989, the Alaska Maternal Infant Mortality Review and Child Death Review (MIMR-CDR) program conducts monthly multi-disciplinary retrospective child death reviews to 1) improve comprehensive epidemiologic surveillance of demographic and etiologic risk, and 2) develop public health policy and prevention recommendations.[1] Historically deaths have been reviewed 2-3 years after they occur. This lag in review timing can impact the direct relevance of policy and prevention recommendations made. The Section of Women's Children's and Family Health (WCFH), which coordinates MIMR-CDR, conducted an audit of the program in 2014-2015 and initiated efforts to ensure more timely reviews and to improve the development and relevancy of recommendations.

As a result of this audit, in May of 2015 MIMR-CDR pioneered a new methodology for conducting death reviews using a "blitz" approach. This method was designed with technical assistance from the National Center for the Review and Prevention of Child Deaths (NCRPCD) and the University of North Carolina Injury Prevention Research Center (UNC-IPRC). Unlike monthly reviews that cover only a few cases with a subset of committee members present, the "blitz" consisted of a two-day meeting, during which multi-disciplinary teams reviewed approximately 100 cases of deaths occurring during 2009-2015. This extensive and highly condensed process exposed 43 reviewers to the diverse events that may lead to maternal, infant, and child deaths in Alaska, and culminated in the creation of 22 individual recommendations. A list of represented agencies can be found at the end of this document.

These recommendations, unmatched in detail and breadth by any prior set of recommendations produced by MIMR-CDR over the past two decades, were compiled by MIMR-CDR staff in conjunction with the NCRPCD director. WCFH identified itself as the lead agency and began implementation of several key recommendations. Due to staffing changes, limited resources, and programming priorities, addressing the comprehensive set of recommendations has taken longer than desired. WCFH recently hired a new MIMR-CDR program manager, who will be reaching out to stakeholders and partner agencies to develop timelines, designate champions, and provide data and technical support. Where applicable, established lead agencies, timelines, and progress as of December 2015 are included in the table below.

Moving forward, MIMR-CDR will continue to track and assess the impact of implemented recommendations, hold monthly review meetings to review sentinel conditions within a few months of occurrence, convene an annual "blitz" to review and revise recommendations, and identify priorities and emerging issues. As WCFH institutionalizes and expands the "blitz" process, we hope to identify programmatic champions willing to lead the implementation of recommendations that are beyond the scope of WCFH. With resources dedicated to this effort, collaborative input and prioritization, and increased data sharing, we are confident that together we can continue to make Alaska the safest place for mothers and children to live and grow.

[1] http://dhss.alaska.gov/dph/wcfh/Pages/mchepi/mimr/default.aspx

Recommendations

Recommendations are grouped by the major categories of Sudden Unexplained Infant Death, Injury/Homicide, and Maternal/Perinatal/Congenital Anomalies and Other Natural Causes. A list of acronyms used can be found at the end of this document.

Sudden Unexplained Infant Death:

The teams that reviewed Sudden Infant Death Syndrome, Sudden Unexplained Infant Death, and Asphyxia (SIDS/SUID/Asphyxia) cases developed 8 recommendations that focused on substance abuse, response and reporting, or creating a safe sleep environment.

Focus: Substance Abuse

Recommendation 1	DHSS, DPS, Law, and tribal entities will facilitate regional train-the-trainer events to increase capacity to raise awareness about drug endangered children using an Alaska-specific adaptation of the National Alliance for Drug Endangered Children core curriculum. These events will be for mandatory reporters including: clinicians, investigators, home healthcare workers, and home visitors. They will help mandatory reporters to better recognize substance use and abuse (including alcohol, tobacco, and marijuana) and to understand screening, education, referral, and treatment.
Lead Agency	
Recommendation 2	DV/SV agencies will develop a roadmap for community safety plans for kids.
Lead Agency	

Focus: Response and Reporting

Recommendation 3	Law, DPS, ME, OCS, and tribal entities will develop a statewide protocol (reference SART) to respond to child deaths that can be used by each community team. Evaluation of the protocol should be suggested to the UAA MPH program as a potential master's project. The protocol should involve law enforcement (VPSO, VP, State Troopers, Muni Police), OCS, ME, Health Aids, PHN, tribal agencies, CACs, Law, Animal Control.
Lead Agency	
Recommendation 4	MCH-Epi will work with the CDC and ME to incorporate statewide statistical information and grief support training into the SUIDI trainings. Trainings should be made available to a wider audience (Law, OCS, ME, Health Aides, PHN, tribal agencies, CACs).
Lead Agency	
Recommendation 5	OCS, tribal entities, law enforcement, schools, community leadership, and Parents as Teachers (RurAL CAP) should work together to establish a number of "safe sober homes" in communities where children can go or be dropped off under defined criteria/circumstances. The goal is to develop pilot programs in 3 communities and to understand the process clearer and measure impact. Additional potential partners are Temporary Assistance for Needy Families (TANF) and the Nome Children's Home.
Lead Agency	

Sudden Unexplained Infant Deaths (Continued)

Focus: Safe Sleep Environment

Recommendation 6	Existing state safe sleep posters and pamphlets should be distributed and exhibited at retail places that sell cribs and baby supplies. The Alaska CoIIN work group should talk to the UAA School of Nursing or the MPH program about accomplishing this.
Lead Agency	Section of WCFH, through the Alaska CoIIN safe sleep work group
Recommendation 7	The Alaska CoIIN work group should continue work with hospitals and providers to ensure that they are providing a consistent and universal message about safe sleep to their patients. Particular emphasis should be placed on Prenatal/OB providers and delivery hospitals.
Lead Agency	Section of WCFH, through the Alaska CoIIN safe sleep work group
Timeline	Current / Ongoing
Update: 12/15	The Alaska CoIIN work group has presented safe sleep information to providers via Pediatric Grand Rounds in Fairbanks and Anchorage, as well as via webinar to Alaska Public Health Nursing.
Recommendation 8	The Alaska CoIIN work group should help current home visiting programs in Alaska operate in an evidence-based manner with outcome evaluation.
Lead Agency	Section of WCFH, through the Alaska CoIIN safe sleep work group and MCHIEV Home Visiting Program
Timeline	Current / Ongoing
Update: 12/15	The Alaska CoIIN work group has presented safe sleep trainings and information to all nurses currently working with the MCHIEV Home Visiting Program.

Injury/Homicide:

The team that reviewed Injury and Homicide cases developed 2 recommendations that focused on leveraging existing injury data within the state.

Recommendation 1	MCH-Epi and PHN will try to leverage the existing DPH injury prevention workgroup to analyze injury data by location and type. The target audiences of the analyses are related subject matter experts.
Lead Agency	WCFH / MCH-Epi
Timeline	Work began in September 2015
Recommendation 2	WCFH/MCH-Epi, PHN, law enforcement, and OCS will establish a 5 member workgroup of subject matter experts to utilize data to engage communities. Community identification and strategies will be data driven using the injury data. Injury prevention strategy identification will use a community-based participatory research, and key informant methodology. By the end of 2016, data from the designated communities will be gathered and reported back at the annual MIMR-CDR statewide review.
Lead Agency	WCFH/MCH-Epi
Timeline	October 2015 – End of 2016

Maternal / Perinatal/Congenital Anomalies & Other Natural Causes:

The teams that reviewed maternal, perinatal, congenital anomalies and other natural causes developed 10 recommendations that focus on case management, data validation, grief management, and adolescent health.

Focus: Case Management

Recommendation 1	YKHC will expand the existing Centering Pregnancy program to encompass pediatric preventative care with a goal of improving neonatal and pediatric health outcomes and establishing a model for other providers to adopt.
Lead Agency	YKHC
Timeline	Implementation by June 30th 2016
Recommendation 2	Direct Entry midwives and other providers working in birth centers should begin to implement and enforce already established regulations on the transfer of high risk pregnancy patients to hospitals for "high risk" prenatal care and/or delivery by December of 2016. The goal is to improve perinatal outcomes and coordination of care. Alaska State Medical Boards, Alaska State Hospital and Nursing Home Association, Alaska Birth Network, and the Board of Certified Direct-Entry Midwifes will be partners/champions in this endeavor.
Lead Agency	
Timeline	
Update: 12/15	MCH-Epi has established a partnership with one midwifery clinic in Wasilla and will be sharing and obtaining data with this clinic. The midwives at this clinic are engaged and will contribute to better understanding the impact of midwifery on birth outcomes in Alaska.
Recommendation 3	MIMR-CDR will invite direct entry midwives to participate in reviews by working with the Alaska Birth Network.
Lead Agency	MCH-Epi, through MIMR-CDR
Timeline	Fall 2015 – Spring 2016
Update: 12/15	Work has been initiated on inviting midwives in Alaska to participate in MIMR-CDR. We are developing relationships with all levels of midwives and are looking to engage them as partners. We now have one certified midwife attending review meetings and are looking to expand.
Recommendation 4	DHSS should develop and implement a regulatory change to require all facilities and providers to screen all delivery patients for drug use, alcohol use, domestic violence, and mental health issues by December 2017.
Lead Agency	

Focus: Data Validation

Recommendation 5	MCH-Epi will work with BVS and ANTHC Epi Center to determine accuracy and completeness of birth and death certificate fields. This analysis should be conducted on an annual basis beginning in 2016. This will help improve quality of the data we use for action / decision making.
Lead Agency	MCH-Epi
Timeline	Analysis beginning in early 2016
Recommendation 6	MCH-Epi, BVS and ANTHC Epi Center should use the results of the analysis above to inform guidelines for complete and accurate birth and death certificate completion.
Lead Agency	MCH-Epi

Maternal / Perinatal/Congenital Anomalies & Other Natural Causes (Continued)

Focus: Historical Trauma

Recommendation 7	Compile a resource list of programs or activities available to communities to address historical trauma and the transmission of violence in communities. This includes creating a "working" document and online resource repository for communities seeking to address historical trauma. The document will describe local programs such as Pathways to Hope, Family Wellness Warriors, Home Visiting, Triple-P, bystander interventions, and other national programs, as well as information on the strength of evidence supporting the programs.
Lead Agency	

Focus: Adolescent Health

Recommendation 8	The WCFH Adolescent Health Program should increase by 10 the number of schools instituting the 4th R curriculum, targeting Juvenile Justice schools.
Lead Agency	WCFH
Timeline	2016-2017 academic year
Recommendation 9	The Department of Education and Early Development (EED), in collaboration with WCFH, should evaluate and recommend evidence-based comprehensive health curricula for schools and districts.
Lead Agency	
Recommendation 10	EED and DHSS should establish a coalition to advocate for mandatory, comprehensive health education requirements for graduation.
Lead Agency	

Represented Agencies (Alphabetical)

Alaska CARES, Agence de Medicine Preventive, Alaska Native Tribal Health Consortium, Anchorage Police Department, Bartlett Regional Hospital, Fairbanks Medical Hospital, Justice for Native Kids, Mat-Su Regional Medical Center, National Center for the Review and Prevention of Child Deaths, Norton Sound Health Corporation, Providence Alaska Medical Center, Seldovia Village Tribal Health Center, South Central Foundation, State of Alaska Child Protective Services, State of Alaska Department of Health and Social Services, State of Alaska Medical Examiner's Office, State of Alaska Public Health Nursing, State of Alaska Section of Women's, Children's, and Family Health, University of Alaska, Yukon Kuskokwim Health Corporation.

Acronyms used in this report

ANTHC	Alaska Native Tribal Health Consortium
BVS	Bureau of Vital Statistics
CAC	Child Advocacy Center
CDC	Centers for Disease Control and Prevention
CoIIN	Alaska Collaborative Innovation Improvement Network to Reduce Infant Mortality
DHSS	Department of Health and Social Services
DPS	Division of Public Safety
DV/SA	Domestic Violence/Sexual Assault
EED	Department of Education and Early Development
Law	Department of Law
MCH-Epi	Maternal and Child Health Epidemiology Unit
MCHIEV	Maternal, Infant, and Early Childhood Home Visiting
ME	Medical Examiner
MIMR-CDR	Maternal and Infant Mortality Review and Child Death Review
NCRPCD	National Center for the Review and Prevention of Child Deaths
OCS	Office of Children's Services
PHN	Public Health Nursing
SART	Sexual Assault Response Training
SCF	Southcentral Foundation
SUIDI	Sudden Unexpected Infant Death Investigation
UAA	University of Alaska Anchorage
UNC-IPCR	University of North Carolina Injury Prevention Research Center
VP	Village Police
VPSO	Village Public Safety Official
WCFH	Section of Women's, Children's, and Family Health
YKHC	Yukon-Kuskokwim Health Corporation