Restructuring Maternal Child Death Review:

A Path to Enhanced Impact and Action

Grace Jackson and Margaret Young
AKPQC and MCDR Annual Summit
March 28, 2025

Agenda

Programmatic updates and summary of recent activities

1. MCDR Staff
2. Programmatic Updates
3. MCDR Restructuring and Committee Changes
4. Outreach and collaboration

Data trends and high-level findings

1. Maternal Mortality
2. SUID
3. Child

2024 Recommendations Highlights

ANTHC Partnership

MCDR Staff

Grace Jackson, Program Manager

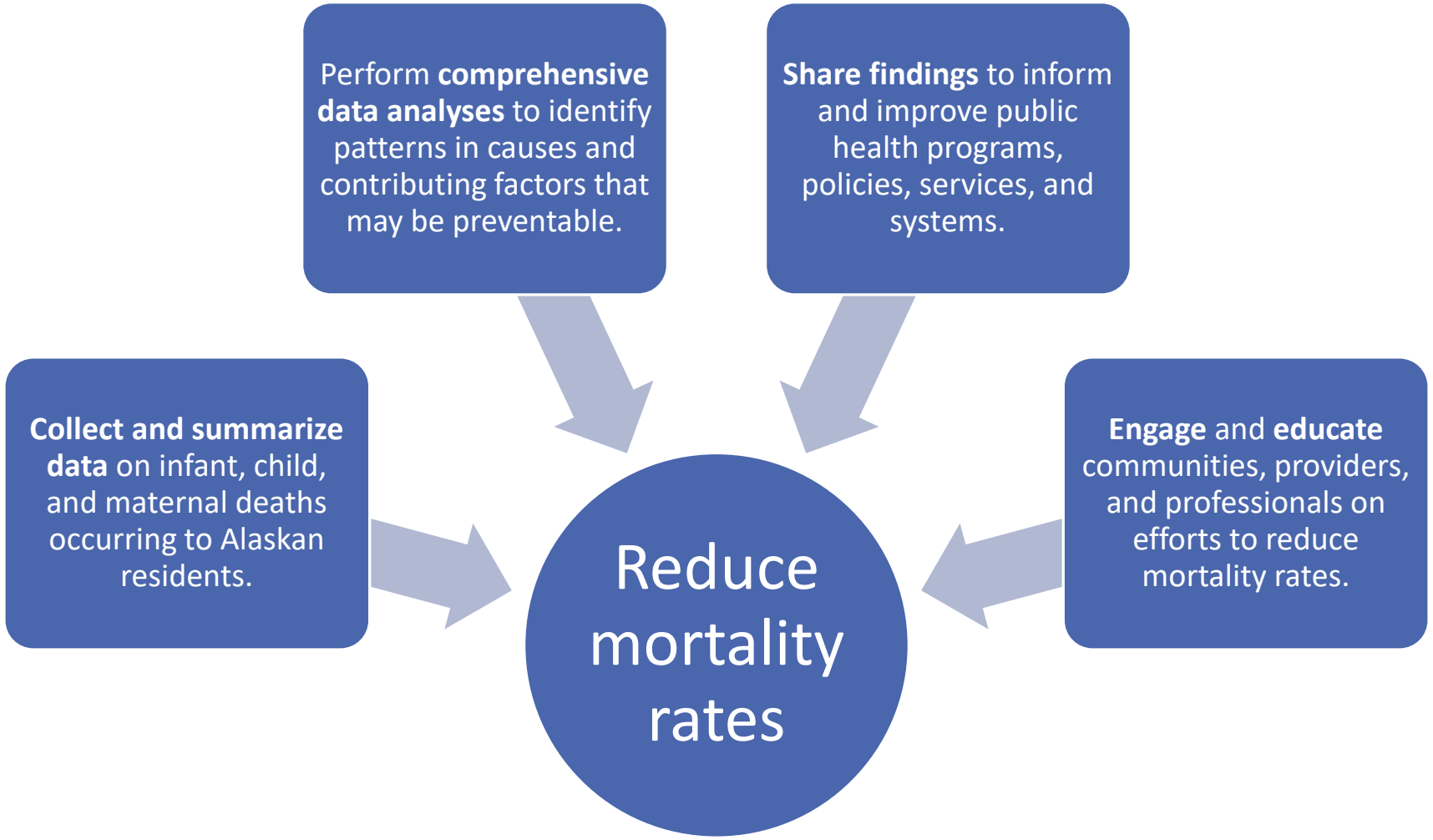
Kimberly Schmid, Health Program Associate

Marley Elconin, Research Analyst

Amanda Roedl, Contract Abstractor

Margaret Young, MCH EPI Unit Manager

MCDR Program Goal and Objectives



Funding Sources

CDC

- **ERASE MM (Enhancing Reviews and Surveillance to Eliminate Maternal Mortality)**
- **SUID (Sudden Unexplained Infant Deaths) Case Registry**

Office of the Assistant Secretary for Health

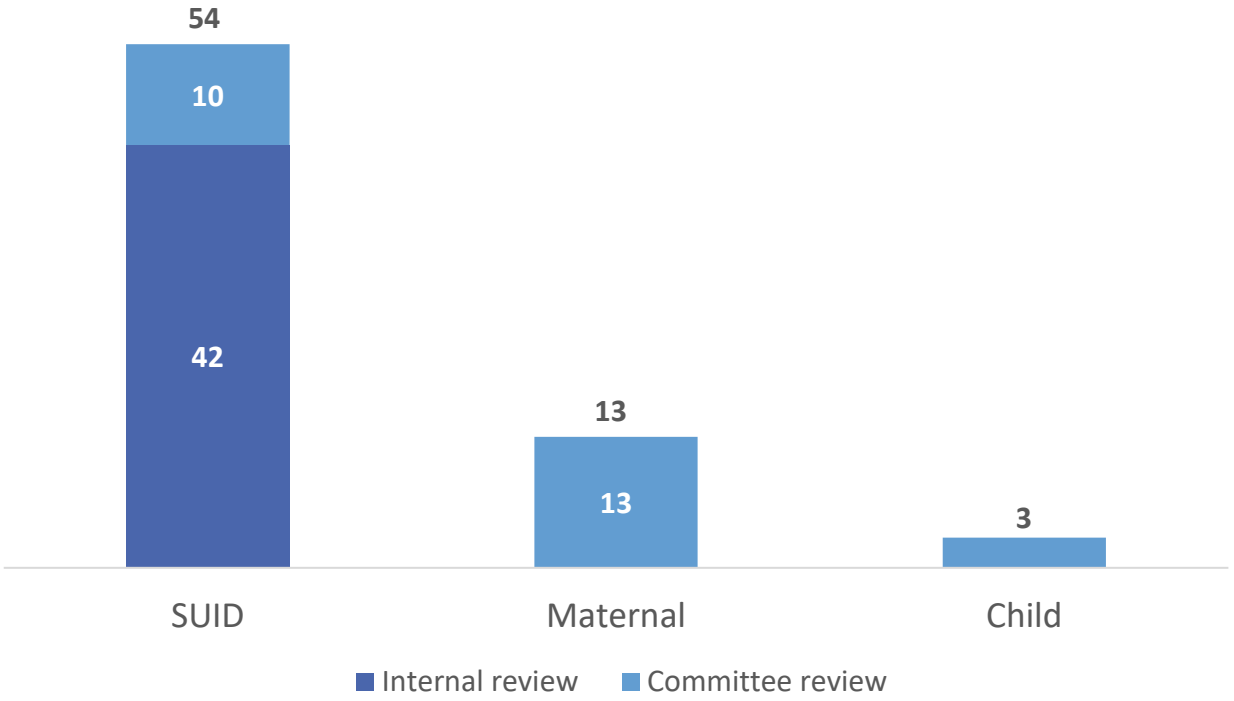
- **Partnership Programs to Reduce Maternal Deaths due to Violence**

Health Resources and Services Administration

- **Title V MCH Block Grant**

Cases Reviewed in 2024

In total, 70 cases were reviewed in 2024.



SUID committee reviews: February, June, August

SUID internal reviews: April, June

Maternal committee reviews: March, July, September, December

Child review: November

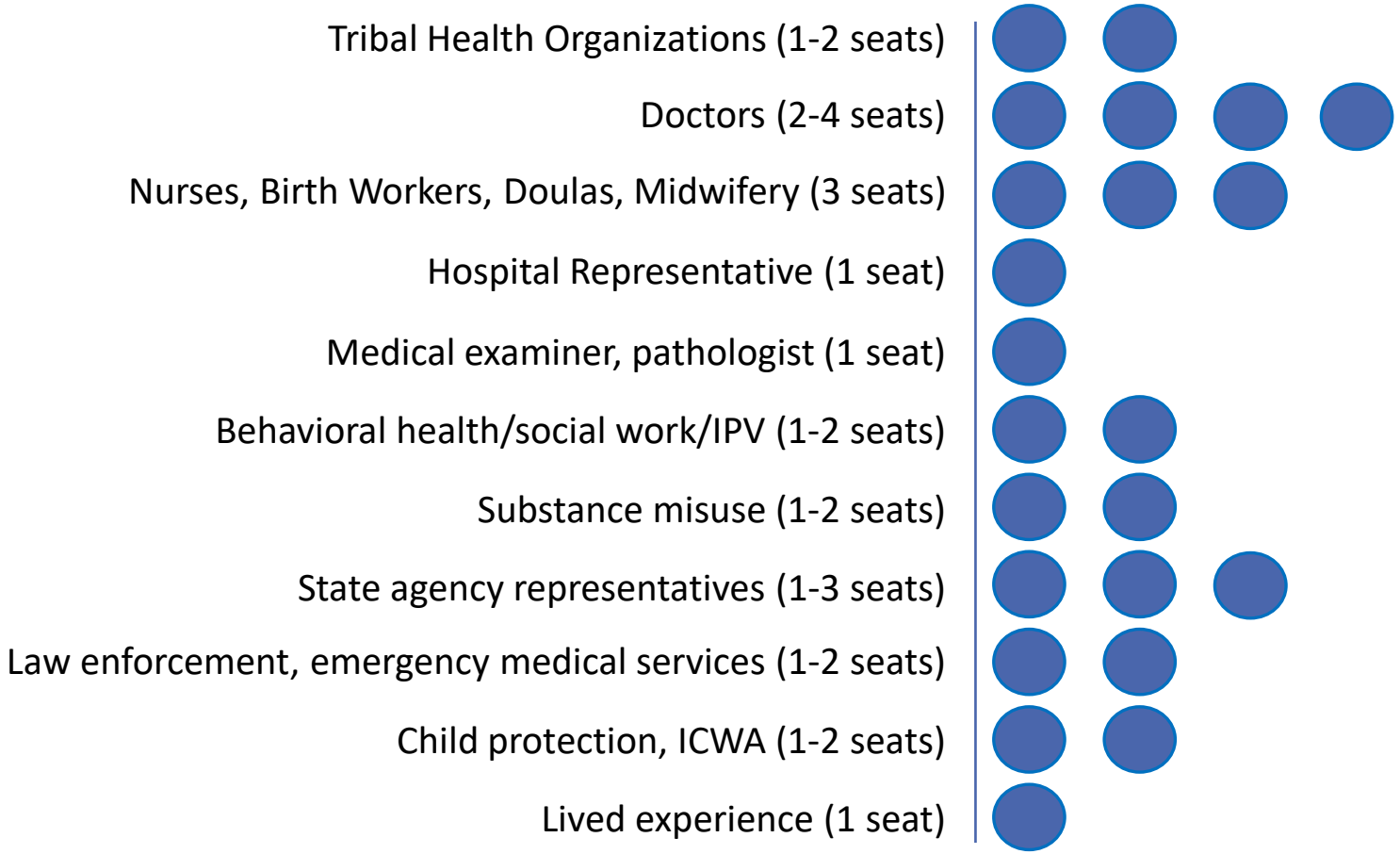
Focus for 2025

- ❑ All maternal deaths (deaths during pregnancy or within 1 year postpartum)
- ❑ All Sudden Unexplained Infant Deaths (SUID)
- ❑ Additional child/youth deaths may be reviewed as capacity allows.

Two separate sub committees-

- ❑ One focusing on maternal deaths.
- ❑ One focusing on infant mortality (and child deaths if capacity permits).

Multidisciplinary Representation



Changes to committee membership

- Formal application and appointed process
- Schedule provided in advance
- Meetings will be held virtually
- Preparation required
- Training
- Term Limits

2024 statue revision

Removed statement from AS 18.23.070(5)(c) that “At least 75 percent of the committee members must be health care providers”

*** Sec. 3.** AS 18.23.070(3) is amended to read:

(3) "health care provider" means **a person licensed, certified, or otherwise permitted by law to provide health care services in the ordinary course of business or practice of a profession,** [AN ACUPUNCTURIST LICENSED UNDER AS 08.06; A CHIROPRACTOR LICENSED UNDER AS 08.20; A DENTAL HYGIENIST LICENSED UNDER AS 08.32; A DENTIST LICENSED UNDER AS 08.36; A NURSE LICENSED UNDER AS 08.68; A DISPENSING OPTICIAN LICENSED UNDER AS 08.71; AN OPTOMETRIST LICENSED UNDER AS 08.72; A PHARMACIST LICENSED UNDER AS 08.80; A PHYSICAL THERAPIST OR OCCUPATIONAL THERAPIST LICENSED UNDER AS 08.84; A PHYSICIAN LICENSED UNDER AS 08.64; A PODIATRIST; A PSYCHOLOGIST AND A PSYCHOLOGICAL ASSOCIATE LICENSED UNDER AS 08.86;] a hospital as defined in AS 47.32.900, including a governmentally owned or operated hospital**,** [;] and an employee of a health care provider acting within the course and scope of employment;

Changes to approval mechanism

(C) a committee established by the commissioner of health and approved by the **chief medical officer in the Department of Health** [STATE MEDICAL BOARD] to review public health issues regarding morbidity or mortality [; AT LEAST 75 PERCENT OF THE COMMITTEE MEMBERS MUST BE HEALTH CARE PROVIDERS];

Outreach and collaboration

MCDR Surveillance update

What are pregnancy-associated deaths?

Death from any cause during pregnancy and up to one-year post-partum

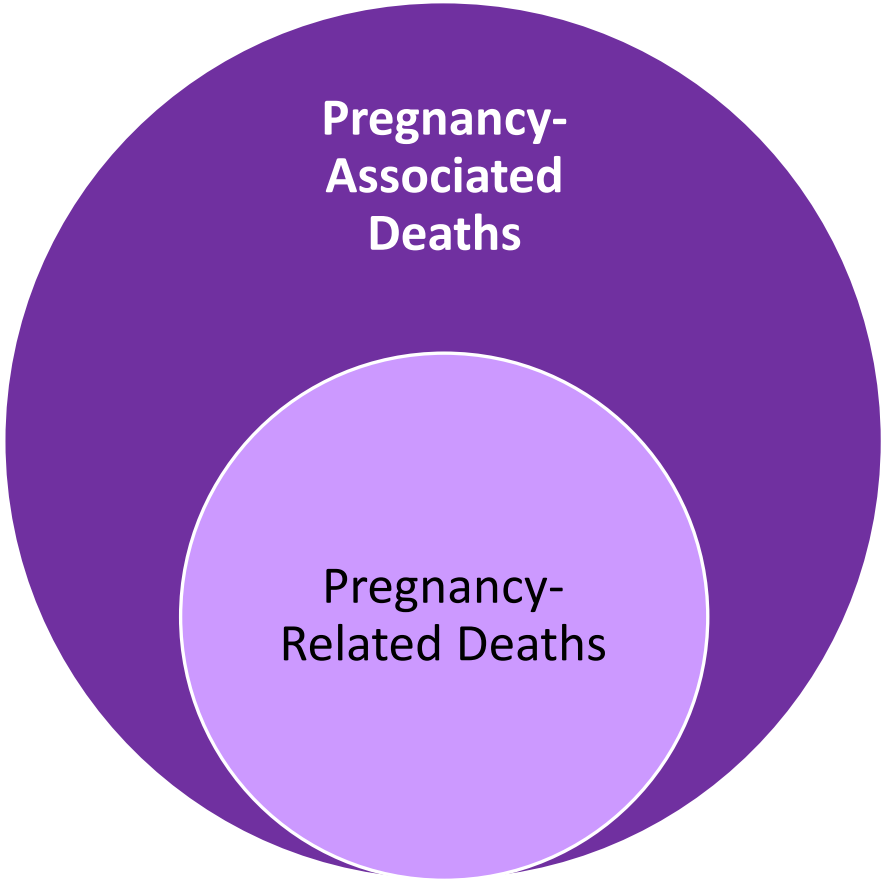
Casts a wide net

Includes all pregnancy-related deaths

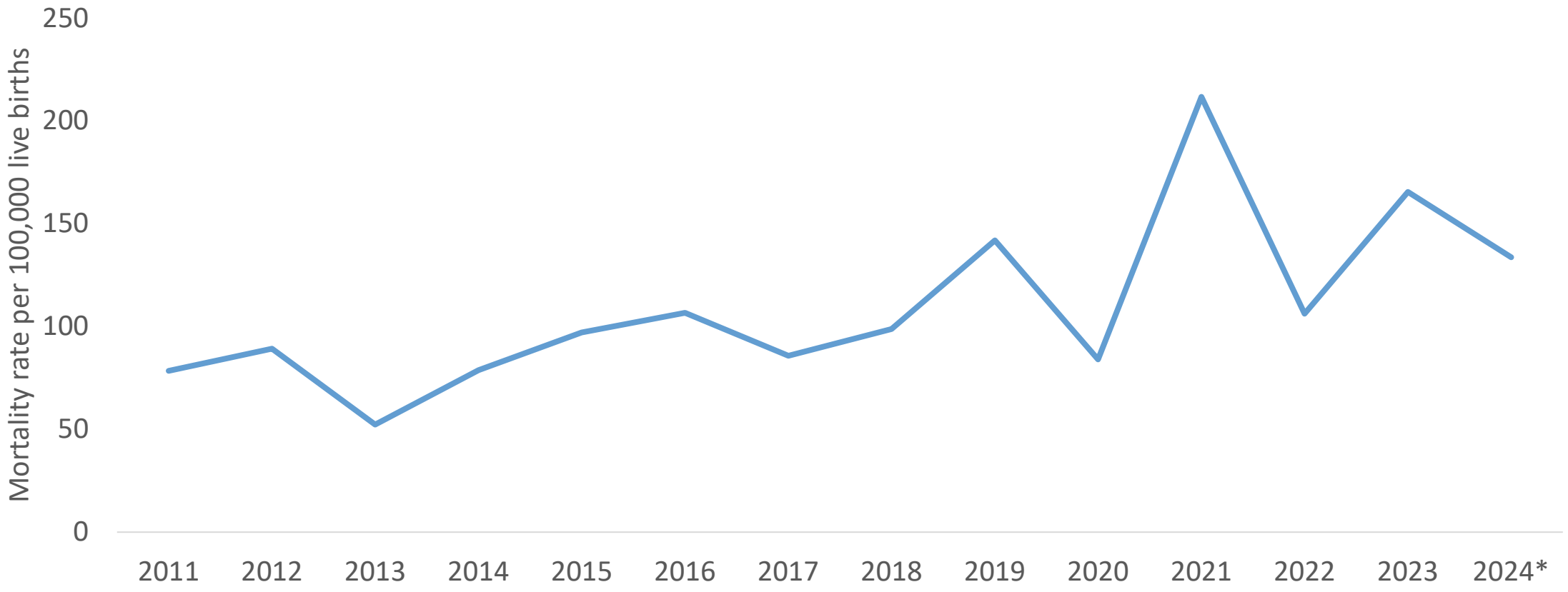
- Death while pregnant or within 1 year of the end of the pregnancy from any cause related to or aggravated by the pregnancy

Violent deaths can be pregnancy-related

- Suicide related to postpartum depression
- Some homicides related to intimate partner violence/IPV (Austin et al., 2016)

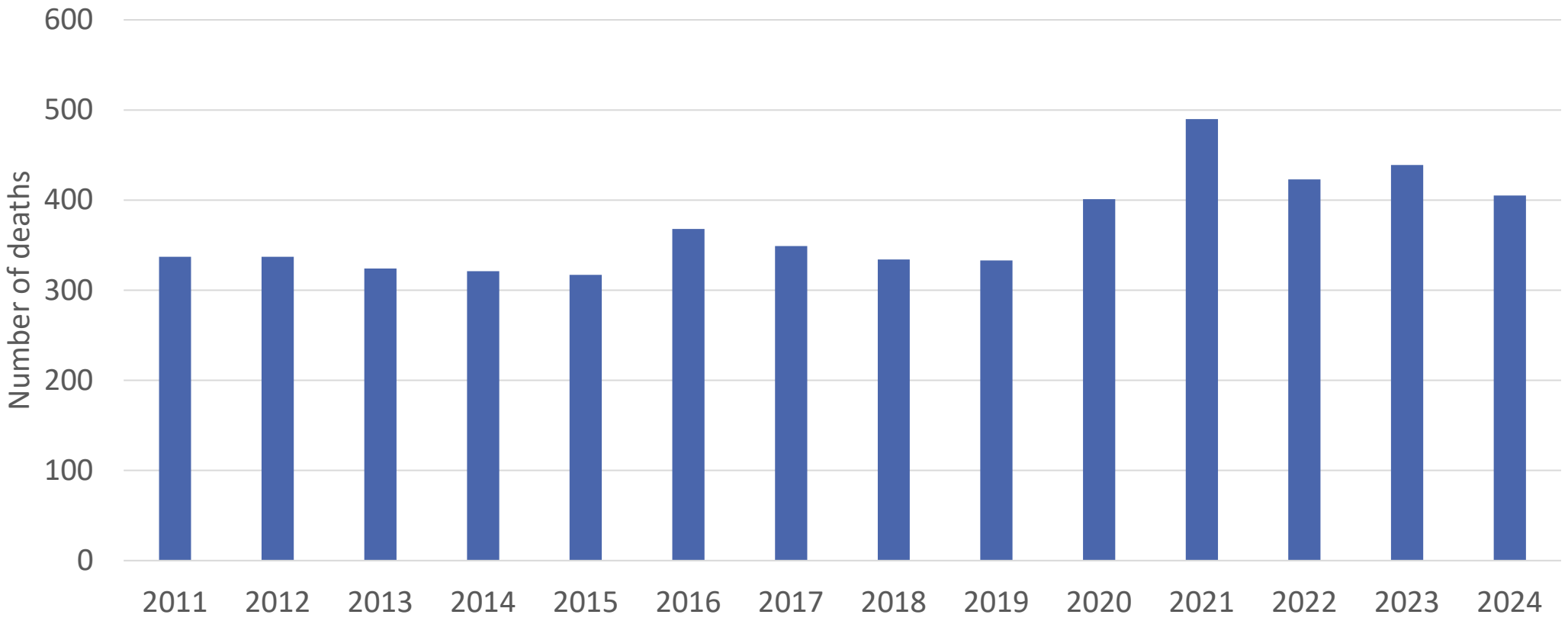


Observed increase in Alaska's pregnancy-associated mortality rates



*2024 data is provisional. Full case ascertainment for 2023 and 2024 has not yet occurred.

Similar trend in overall annual number of deaths among Alaska resident females ages 15-54



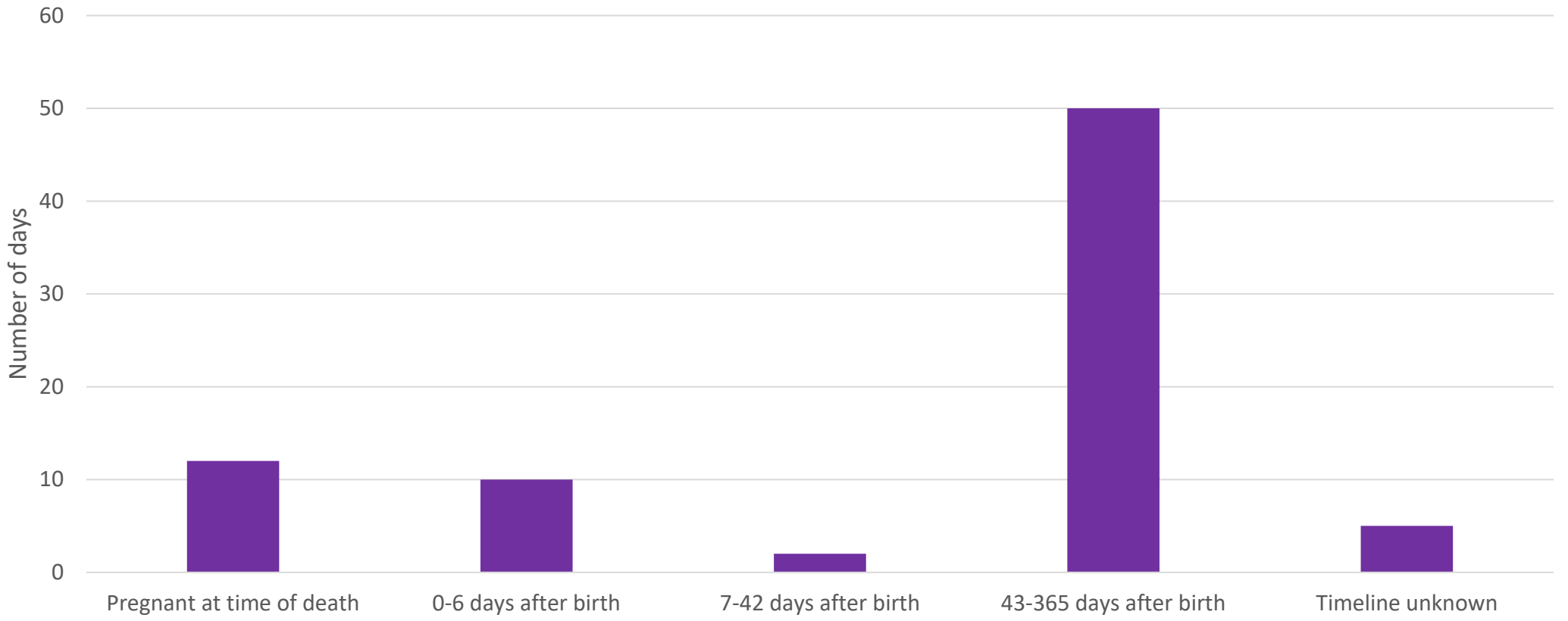
MCDR case review status

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
# deaths	11	12	9	10	14	8	20	10	*15*	*12**
% reviewed					100%	88%	65%	50%	0%	0%

Among the 79 cases during 2019-2024 (in the MMRIA data system)

- **39 (49%) have been reviewed**
- 13 are ready for review
- MCDR staff abstracting or collecting records on remaining 27

Timing of identified pregnancy-associated deaths among Alaska residents, 2019-2024



Committee pregnancy-related determinations (among 39 reviewed cases from 2019-2022)

11 pregnancy-associated but not –related

14 pregnancy-associated but unable to determine pregnancy-relatedness

14 pregnancy-related

- 9 had **mental health conditions** as the primary underlying cause of death
- Other underlying causes of death for pregnancy-related deaths were hemorrhage, infection, hypertensive disorder of pregnancy, injury, and cardiovascular conditions

Committee Determinations of Contributing Factors and Violence (among 39 reviewed cases)

Determination	Yes	Probably	Unknown	Percent yes/probably
Did mental health conditions contribute?	17	7	8	61%
Did substance use disorder contribute?	20	3	4	59%
Did discrimination contribute?	11	7	6	46%
Did obesity contribute?	2	1	2	5%
Was this death a suicide?	7	0	5	18%
Was this death a homicide?	7	0	0	18%

2024 MCDR Review Recommendations:

Maternal

Prenatal providers should **screen** for substance misuse, provide non-stigmatizing **education**, and make early **referrals** for birthing parents when attending routine prenatal visits to **increase access to and awareness of medication-assisted therapies** (MAT) and other treatment options available during pregnancy.

State programs need to increase and improve outreach measures related to perinatal mental health care to private practitioners, hospitals, and all providers ensuring development of and **access to appropriate behavioral health and substance use recovery services**.

Facilities and licensing boards should encourage the normalization of talking about vicarious trauma and compassion fatigue among staff. Initiatives could include providing supervision time and space to talk about compassion fatigue for staff, and providing routine training and access to wellness resources, including Employee Assistance Programs.

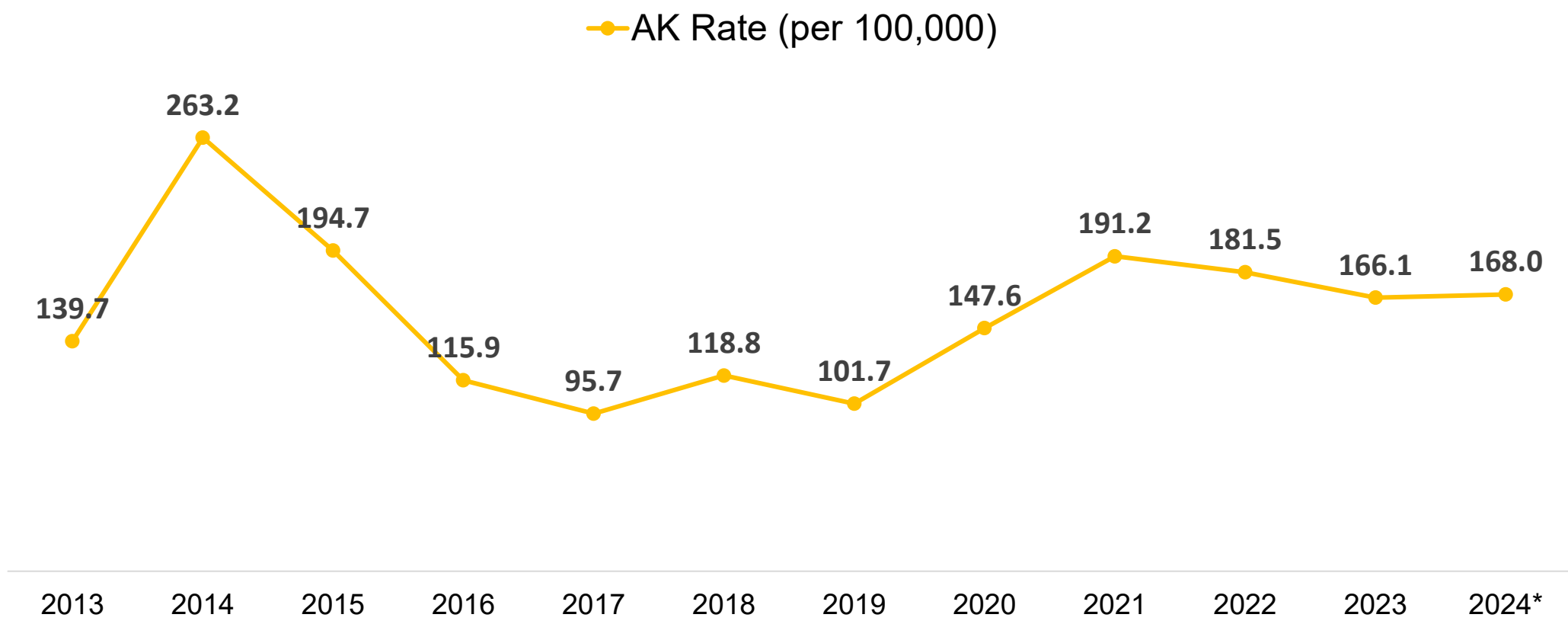
Providers should make referrals to local organizations to ensure **culturally appropriate support during the perinatal period**, e.g. Alaska Native Birthworkers Community.

Emergency personnel should ask all women accessing care if they are pregnant or have given birth within the last year, to identify periods of increased risk and **optimize access to timely behavioral health interventions**.

Infant Mortality

Focusing on SUID (Sudden Unexplained Infant Death)

Sudden Unexplained Infant Death (SUID) mortality rates from death certificate data



*provisional

SUID case review status

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
# deaths (DC)	22	13	10	12	10	14	18	17	15	15
# confirmed SUID (CRS)	25	15	19	19	16	18	24	23	21	20
% categorized	96%	100%	100%	100%	100%	100%	100%	100%	100%	10%

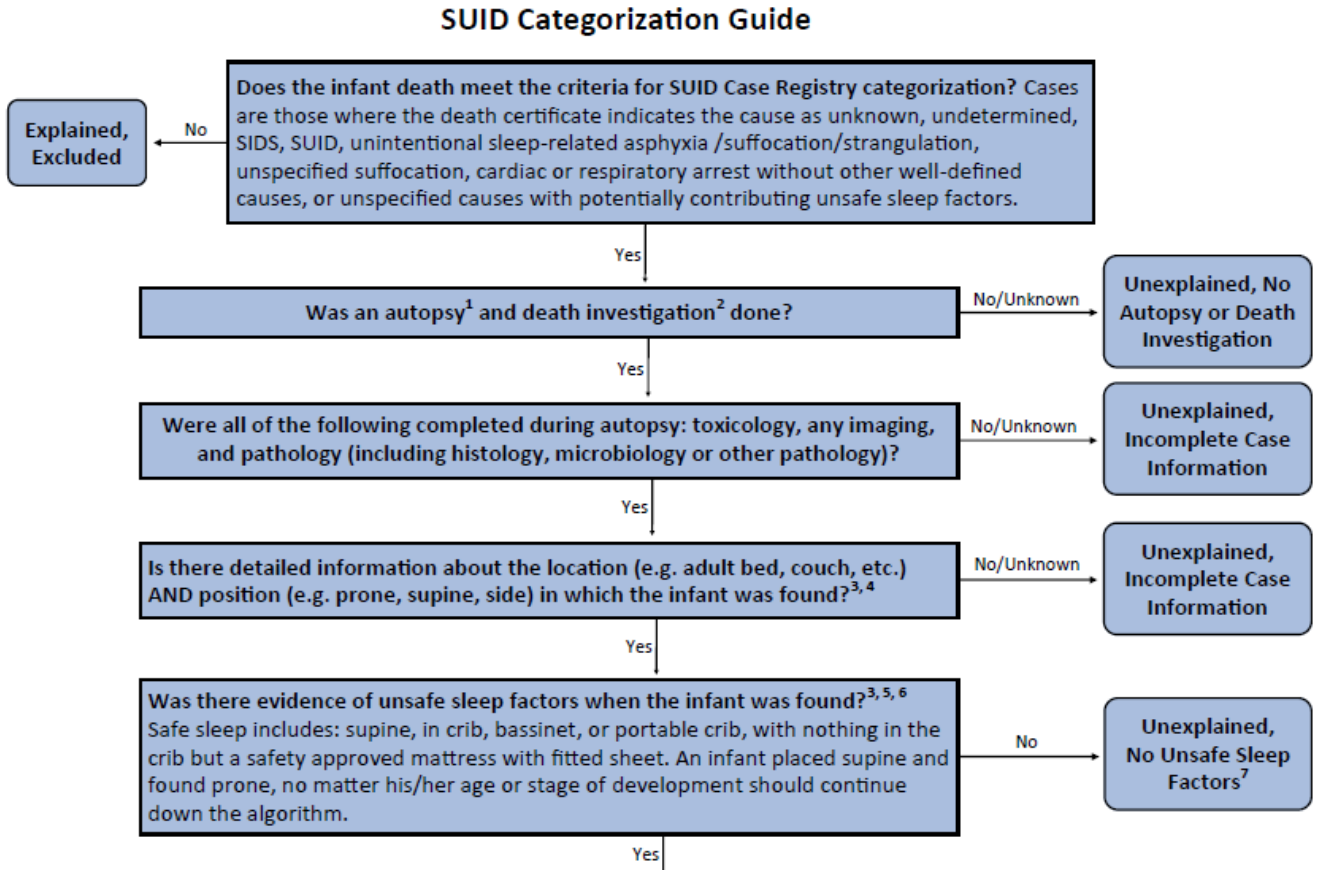
Among the 193 cases during 2015-2024 (in the CRS data system)

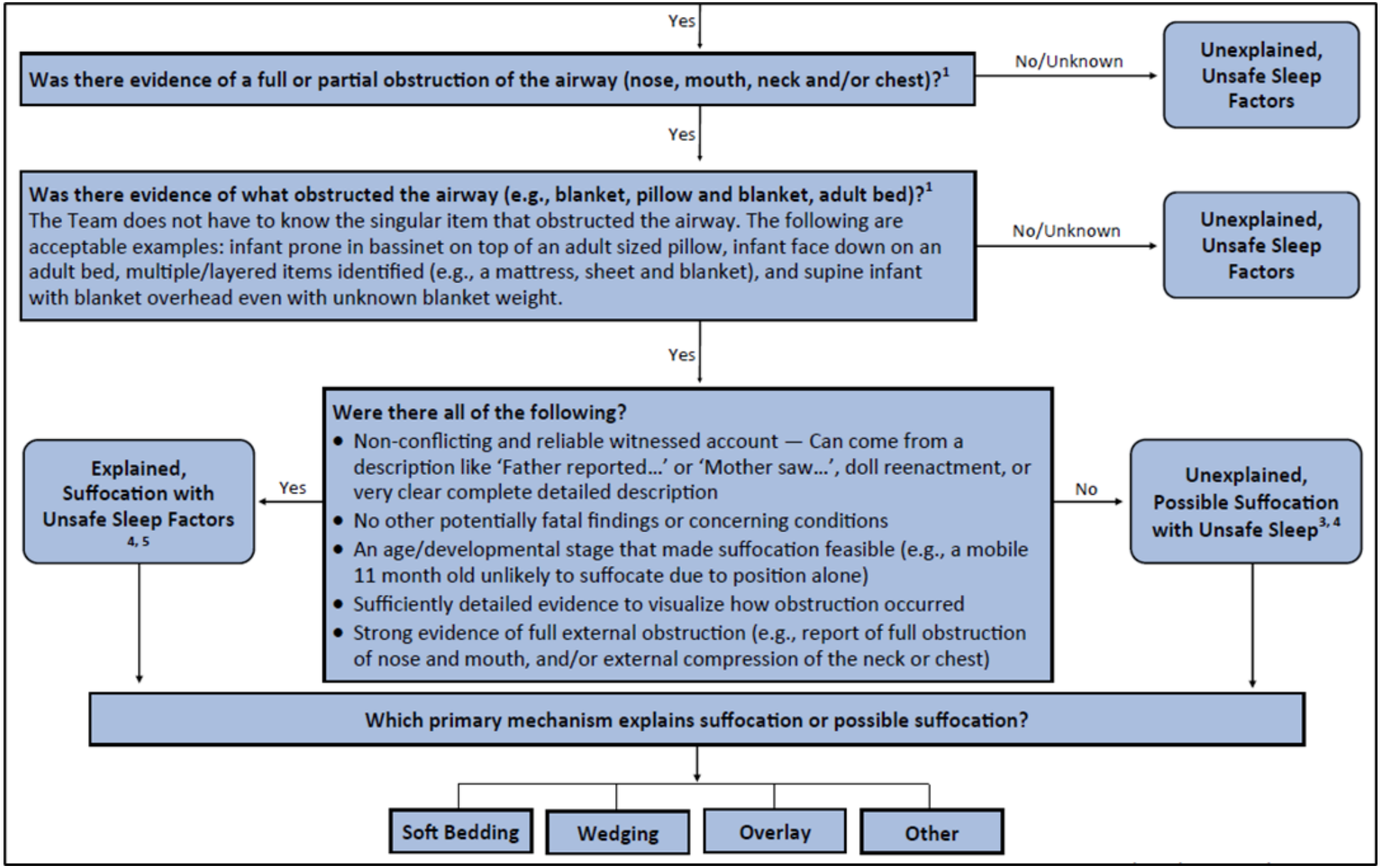
- **179 (90%) have been categorized**
- 8 cases from 2024 are ready for abstract and review

SUID Categorization Process

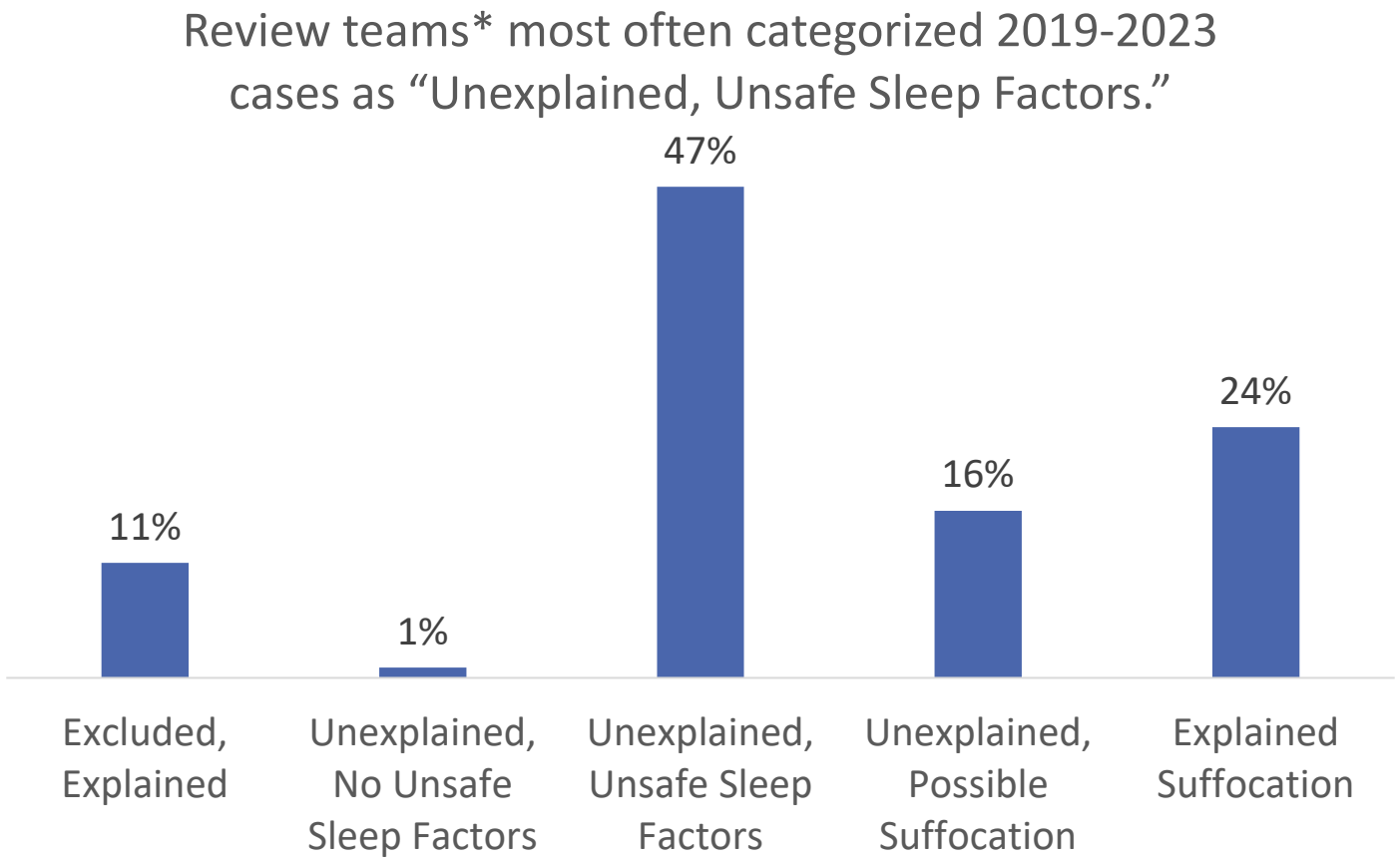
Categories:

- Excluded, explained
- Unexplained, no autopsy or death scene investigation
- Unexplained, incomplete case information
- Unexplained, no unsafe sleep factors
- Unexplained, unsafe sleep factors
- Possible suffocation with unsafe sleep
- Explained, suffocation with unsafe sleep factors



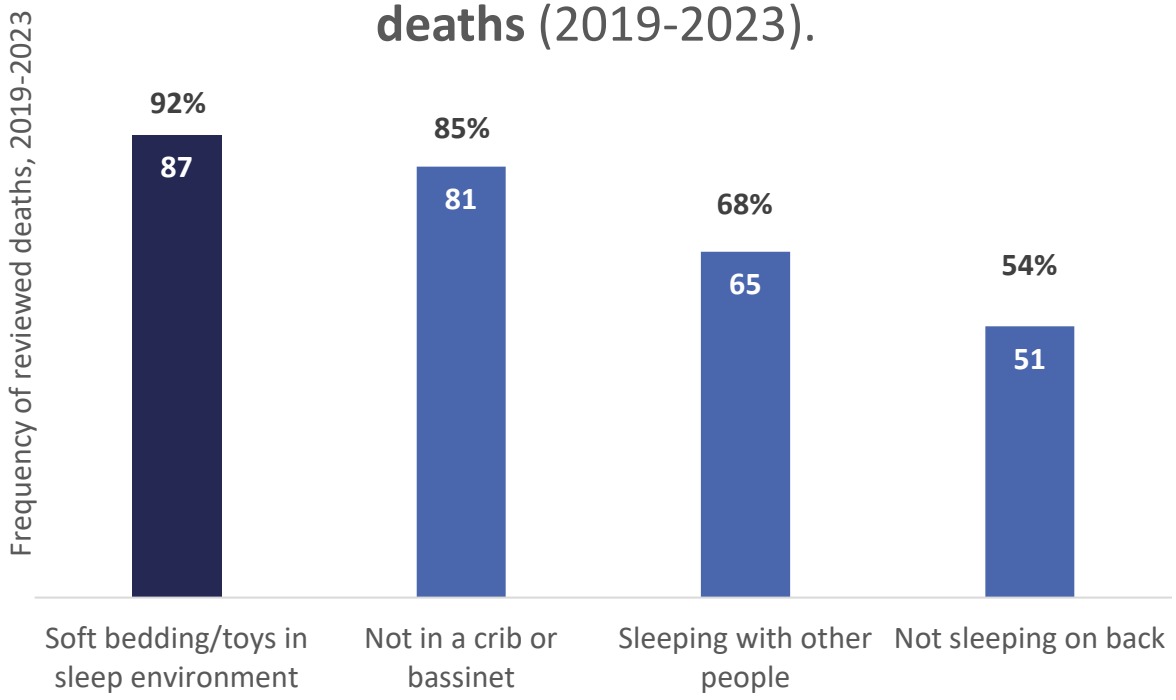

Yes
Was there evidence of a full or partial obstruction of the airway (nose, mouth, neck and/or chest)?[1]
No/Unknown
Unexplained, Unsafe Sleep Factors
Yes
Was there evidence of what obstructed the airway (e.g., blanket, pillow and blanket, adult bed)?[1]
The Team does not have to know the singular item that obstructed the airway. The following are acceptable examples: infant prone in bassinet on top of an adult sized pillow, infant face down on an adult bed, multiple/layered items identified (e.g., a mattress, sheet and blanket), and supine infant with blanket overhead even with unknown blanket weight.
No/Unknown
Unexplained, Unsafe Sleep Factors
Yes
Were there all of the following?
• Non-conflicting and reliable witnessed account — Can come from a description like 'Father reported…' or 'Mother saw…', doll reenactment, or very clear complete detailed description
• No other potentially fatal findings or concerning conditions
• An age/developmental stage that made suffocation feasible (e.g., a mobile 11 month old unlikely to suffocate due to position alone)
• Sufficiently detailed evidence to visualize how obstruction occurred
• Strong evidence of full external obstruction (e.g., report of full obstruction of nose and mouth, and/or external compression of the neck or chest)
Yes
Explained, Suffocation with Unsafe Sleep Factors
4, 5
No
Unexplained, Possible Suffocation with Unsafe Sleep[3, 4]
Which primary mechanism explains suffocation or possible suffocation?
Soft Bedding
Wedging
Overlay
Other

How are SUID deaths commonly categorized?



Safe Sleep Factors, 2019-2023

Soft bedding/toys in the sleep environment were a factor in **92% of SUID deaths** (2019-2023).



- 76% (n=72) were prenatally exposed to non-prescribed substances.
- 66% (n=63) were postneonatal (more than 28 days old).

*Preliminary data

2024 MCDR Review Recommendations:

Infant/Child

The Division of Public Health and Tribal Health organizations should develop an **education program** for all individuals (with virtual options for individuals in rural communities) who interact with families of newborns, including hospitals and social workers that emphasizes **discussions about safe sleep including harm reduction** for families that co-sleep and culturally appropriate strategies.

State **Medical, Nursing and Direct Entry Midwives Boards** should write regulations requiring a minimum of 1 hour per licensing cycle **training** for birthing professionals to include newborn care pertaining to **high-risk protocols** for maternal opioid use and Neonatal Opioid Withdrawal Syndrome (NOWS).

The State of Alaska should invest in **early intervention programs** such as Nurse Family Partnership, Head Start, and family/parent friendly substance use treatment options to address risk factors for child deaths.

Partnership with ANTHC

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Partnership Activities:

- Assisting with recruitment for MCDR Committee
- Providing stipends for AN/AI committee members
- Disseminating recommendations to tribal health organizations
- Participating in maternal reviews in an advisory capacity
- Partnering with MCDR on community outreach projects/events

ALASKA NATIVE TRIBAL HEALTH CONSORTIUM

Thank you!

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Prevention Promotion Protection

ALASKA DIVISION OF Public Health