CSCoIIN

Child Safety

Collaborative Innovation & Improvement Network

EDC Learning transforms lives.

Safe Kids and Fatality Review: Connecting and Partnering

Populations and Settings

Call (866) 835-7973 to join

Tips

We want to hear you!
Call (866) 835-7973

Mute yourself when you're not talking

This webinar is being recorded

Ask questions in the chat at any time or use the hand raise feature

Download resources from File Share pod

Staff & Participants

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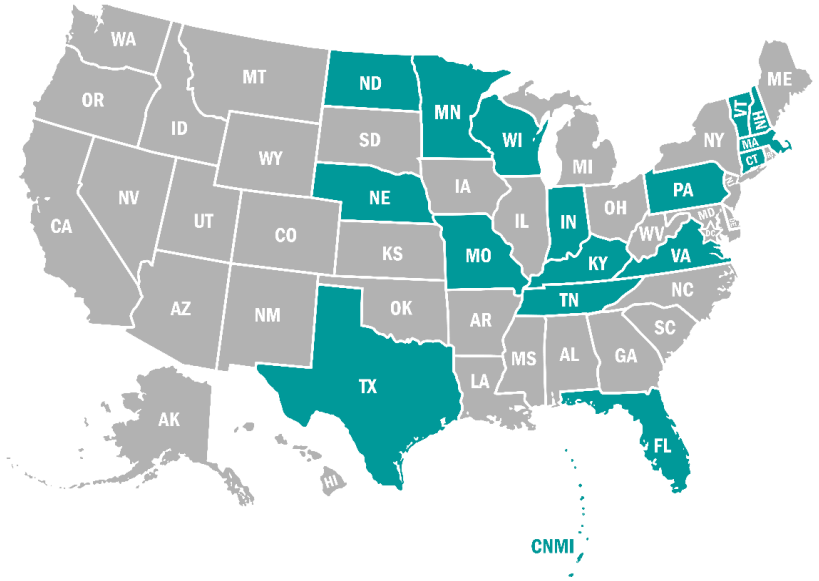
Coordinator

Rebecca Willmer
Tech Guru



Interpersonal Violence Prevention	Child Passenger Safety	Teen Driver Safety	Suicide and Self-Harm Prevention	Falls Prevention (Home-based and Recreational Injuries)
• Florida • Indiana • Minnesota • Missouri • Nebraska • Northern Mariana Islands • Pennsylvania • Tennessee	• Florida • Indiana • Kentucky • Missouri • Northern Mariana Islands • Texas • Vermont	• Florida • Kentucky • Nebraska • New Hampshire • North Dakota • Tennessee • Texas • Wisconsin	• Connecticut • Florida • Kentucky • Massachusetts • Missouri • Texas • Vermont • Virginia	• Florida • Massachusetts • Pennsylvania • Tennessee

Agenda

- Safe Kids Coalitions
- Fetal and Infant Mortality & Child Death Review
- Questions and Discussion

"Creating a better world requires teamwork, partnerships, and collaboration. . ."

-Simon Mainwaring

Connecting and Partnering with Safe Kids Coalitions

Morag MacKay, Director of Research

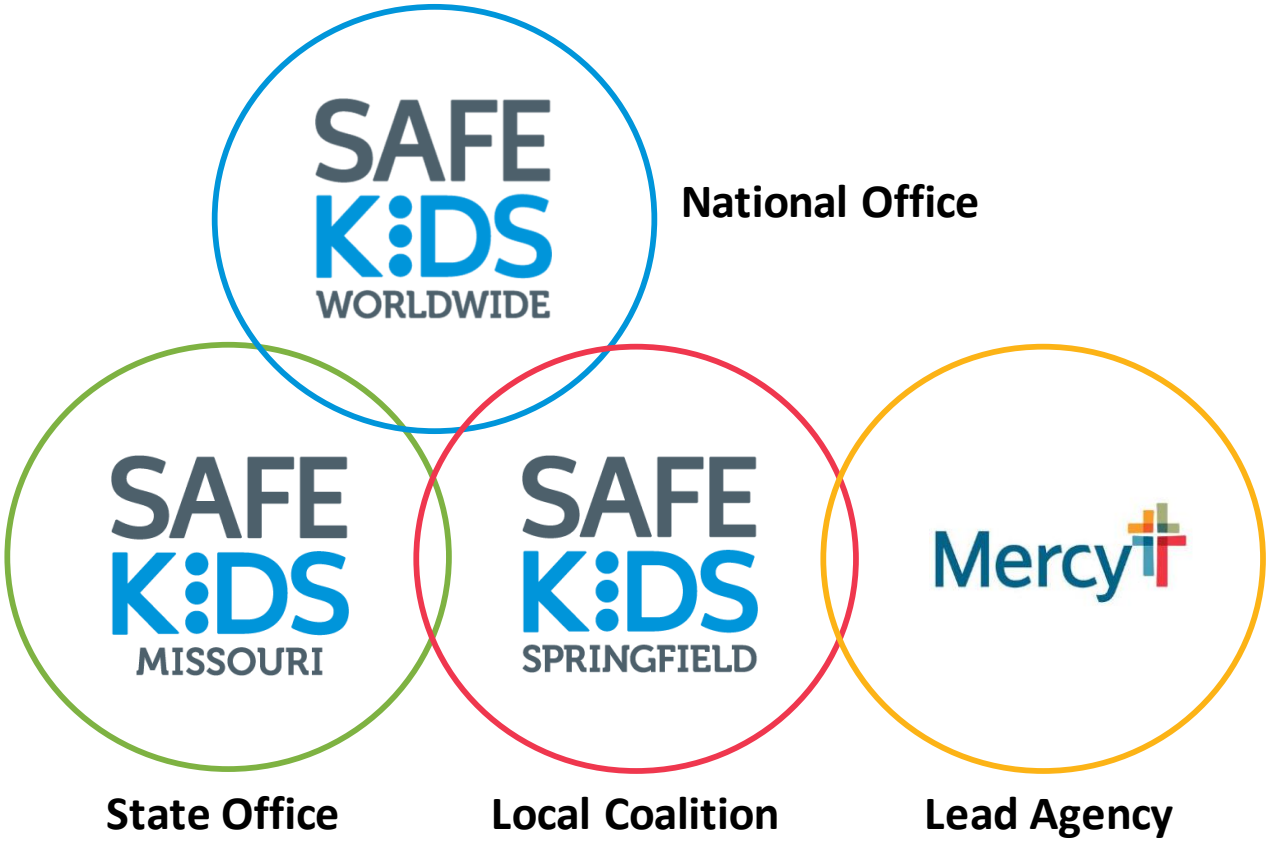
CS CoIIN Topic Call: Populations and Settings – June 27, 2017

SAFE KIDS WORLDWIDE

- Overview of Safe Kids Worldwide
- Possible benefits of partnering with local Safe Kids coalitions
- Where to go to get more information and to start building a partnership if you don't have one

Who We Are and Where We Work

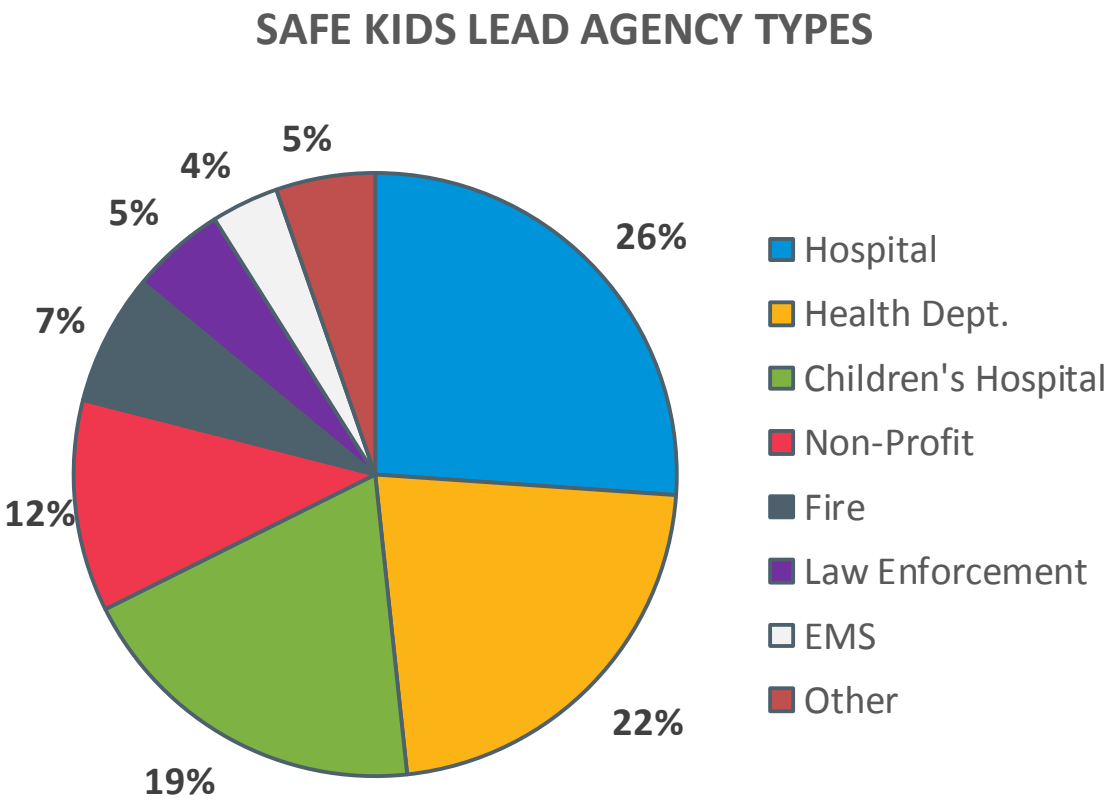
U.S. Coalition Network Structure



What is a Local Coalition?

A **grassroots collaboration of individuals and organizations supported** by a **"lead agency"** in a community that conducts multifaceted childhood injury prevention efforts.

Safe Kids Worldwide has **400+ coalitions** in the United States and **27 State Offices.**



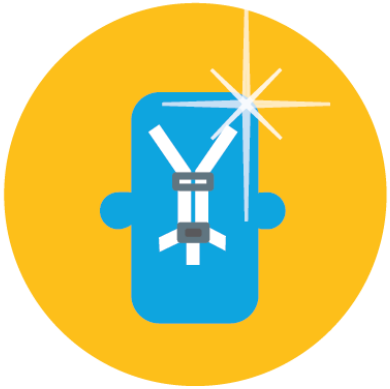
How We Work

RESEARCH

Data analyses

Synthesis of evidence

Inform other activities



PROGRAMS

Reach parents, caregivers, children and educators

AWARENESS

Deliver consistent, compelling messaging

ADVOCACY

Advocate for new and improved laws

Programming

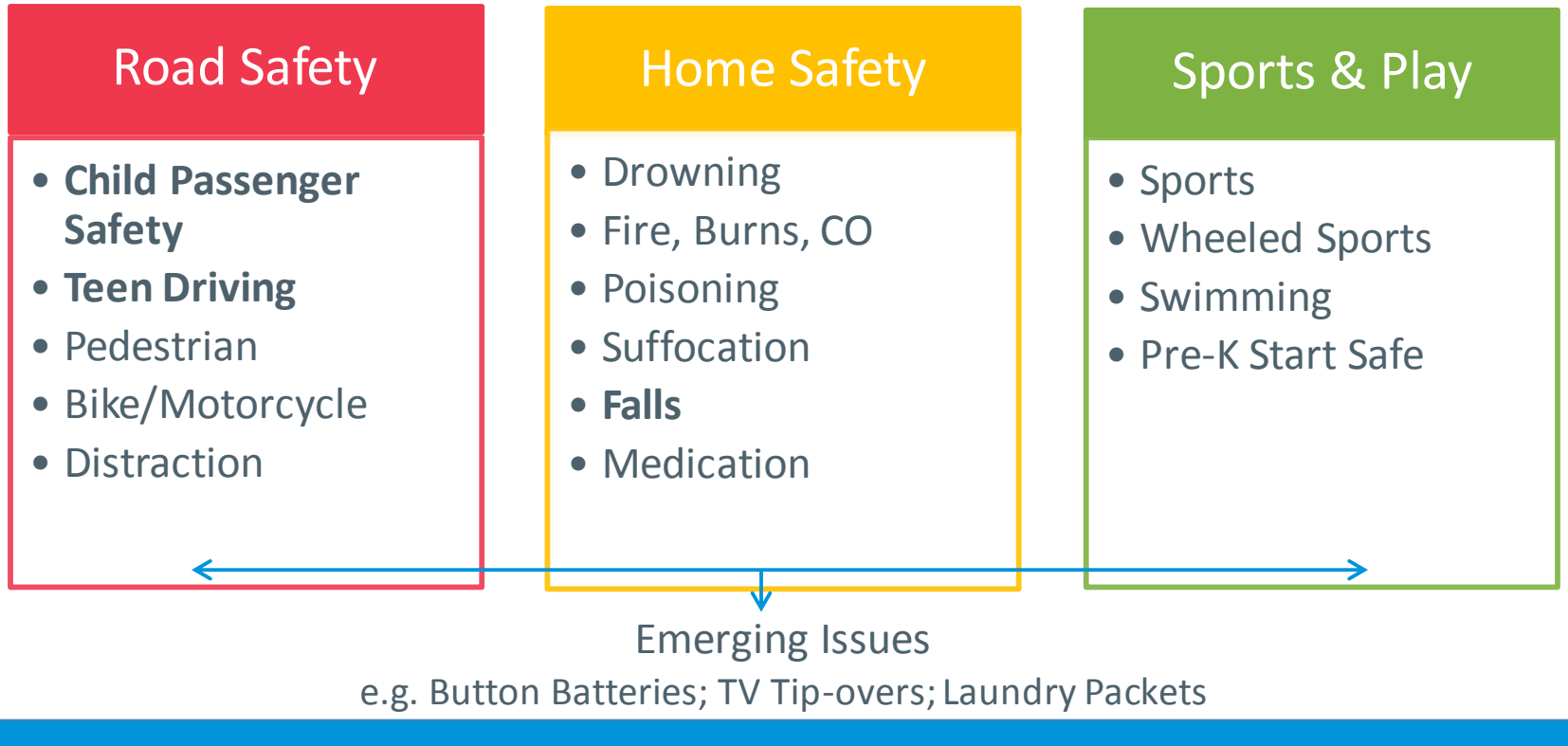
What We Do

- Develop evidence-informed/based programs and initiatives that engage communities in child injury prevention through education, awareness and environmental changes.

- Collaborate with Safe Kids coalitions and other partners to implement programs that address the leading causes of unintentional child injury and death.

Areas of Focus

Safe Kids Worldwide provides resources to **deliver community programs**.



Coalition Engagement

- Small Grants
- Educational Sessions
- Community Events
- Coalition Resources
  - Webinars
  - Educational materials in multiple languages
  - Interactive activities & displays
  - Media tools
- Media Outreach
- Partner Outreach

Advocacy

What We Do

- State Based Advocacy
  - Support SK state and local coalitions in their advocacy efforts
  - Research and track bills
- Raise Awareness
  - When legislation is proposed
  - When new laws are passed or go into effect
- Federal Advocacy
  - Build and maintain relationships with agencies
  - Join with other organizations to work on policy matters
  - Work with Congress on child safety policies

Poll Question

Safe Kids Overlap with CS-CoIIN

State	SK State Office	Number of SK Coalitions (2017)	Proportion Working on CPS (2015)	Proportion Working on Falls (2015)	Proportion Working on Teen Driving (2015)
Florida	Yes	14	14/14	11/14	7/14
Indiana	Yes	16	14/14		
Kentucky	No	3	2/2		2/2
Massachusetts	Yes	2		2/2	
Missouri	Yes	10	10/10		
Nebraska	Yes	9			4/9
New Hampshire	No	1			1/1
North Dakota	No	2			1/2
Pennsylvania	Yes	16		11/16	
Tennessee	Yes	6		2/3	2/3
Texas	No	9	9/9		1/9
Vermont	No	2	1/1		
Wisconsin	Yes	13			6/13

Benefits to Partnering with SK Coalitions

- Local coalitions:
  - often involve stakeholders from other sectors (e.g., local DoT, police)
  - know the local community
  - may already have mechanisms for reaching hard to reach populations
  - may already have educational materials and resources, so you don't have to recreate the wheel

Benefits to Partnering with SK Coalitions

- may already be working on some of the change ideas you've selected
- may be interested in working on some of the change ideas you've selected

Example - Child Passenger Safety

- Basic awareness training
- Safe Kids CPS Certification
- Educational materials & resources – Ultimate Car Seat Guide
- Mobile Check-up Events / Permanent Inspection Stations – access to their own data
- Access to technical updates
- Access to car seats for low income families

How Do I Start Building a Partnership with a Local Safe Kids Coalition?

- Contact Sheel Pandya, Director of Global Networks at spandya@safekids.org


SAFE KIDS WORLDWIDE™
PREVCON
SAVE THE DATE!
July 26 - 29, 2017 Baltimore, Maryland, USA
Childhood Injury Prevention Convention
Bringing together injury prevention professionals from across the globe to share research and best practices for protecting children on the move, at home, and at play.
www.prevcon.org

Make **every** kid a **safe** kid.

THANK YOU!

www.SafeKids.org
mmackay@safekids.org

SAFE KIDS WORLDWIDE™

Fetal and Infant Mortality Review & Child Death Review in the US in 2016

Abby Collier

Senior Program Coordinator

National Center for Fatality Review and Prevention

NATIONAL CFRP

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The National Center for Fatality Review and Prevention

Facebook and Twitter

MCHB Vision for the Integrated Fatality Review and Prevention Center

- One coordinated data and technical support center that builds upon data collection and coordinated strategies to prevent fetal, infant, and child deaths while preserving unique components of these two diverse processes.
- Improvement in the quality and effectiveness of the CDR and FIMR processes and data collected.
- State and community CDR and FIMR programs use their data to design and propose changes to policy and practice which can reduce adverse maternal, infant, child, and adolescent outcomes.
- Dissemination of results nationally and increased availability and use of data to inform prevention efforts.

Objectives of the Funding Opportunity Announcement

1. Expand and support standardized data collection and quality improvement.
2. Provide leadership, training, and technical support to the FIMR and CDR programs.
3. Develop a centralized national network to coordinate and disseminate information and findings related to FIMR and CDR.
4. Facilitate the translation of recommendations from CDR and FIMR programs into action and practice.

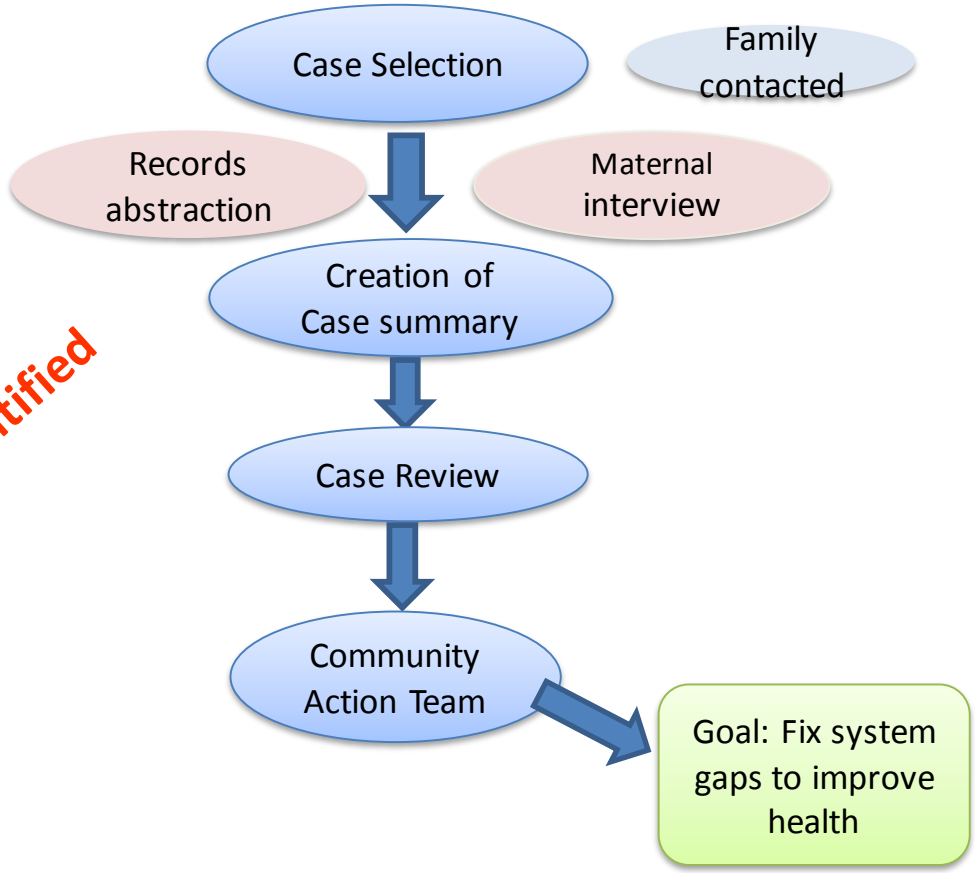
Essential Elements of Review

- Multi-disciplinary.
- Telling a story through the sharing of case information from multiple sources.
- Focused on improving systems and prevention of deaths; not culpability.
- Balance between individual cases and use of population data for trends.

FIMR IS…

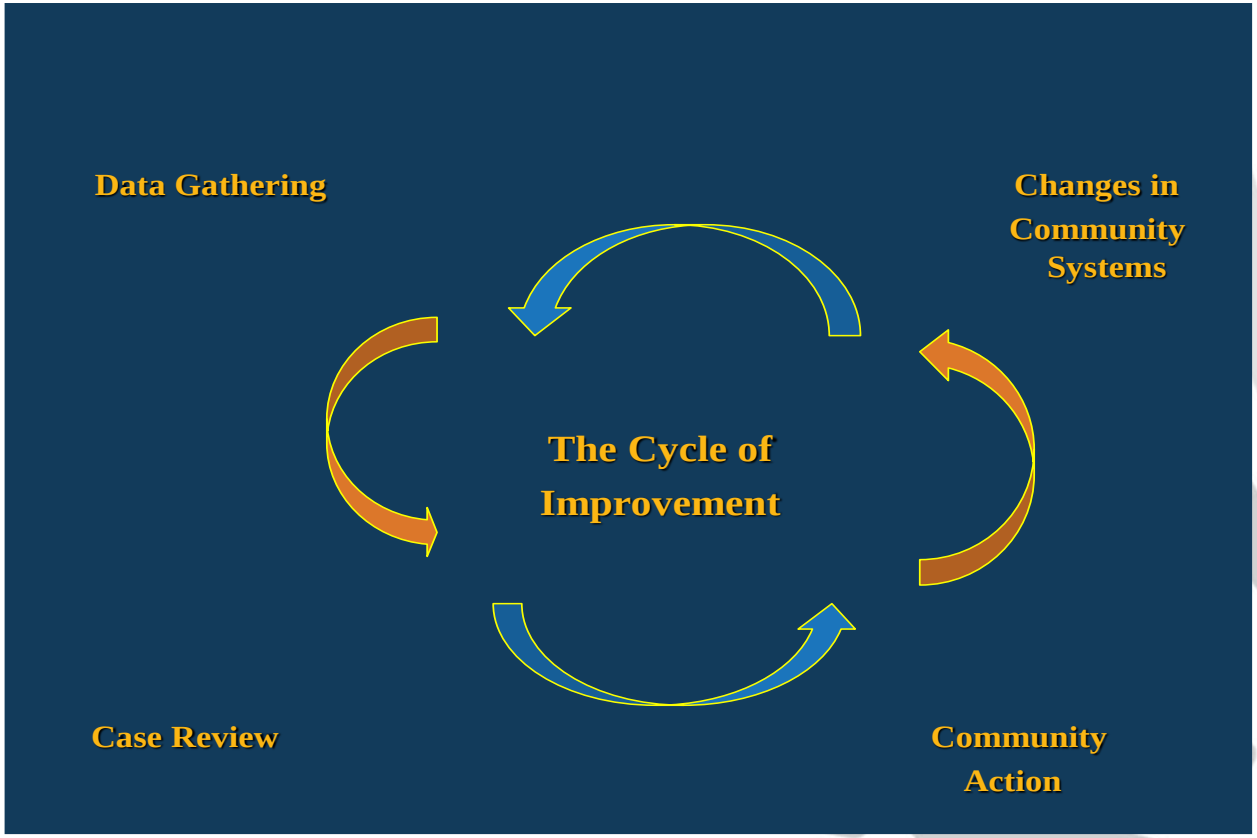
An Approach for Examining Infant Death and Fetal Loss to develop an action-oriented community process that continually assesses, monitors, and works to improve service systems and community resources for women, infants, and families.

De-identified

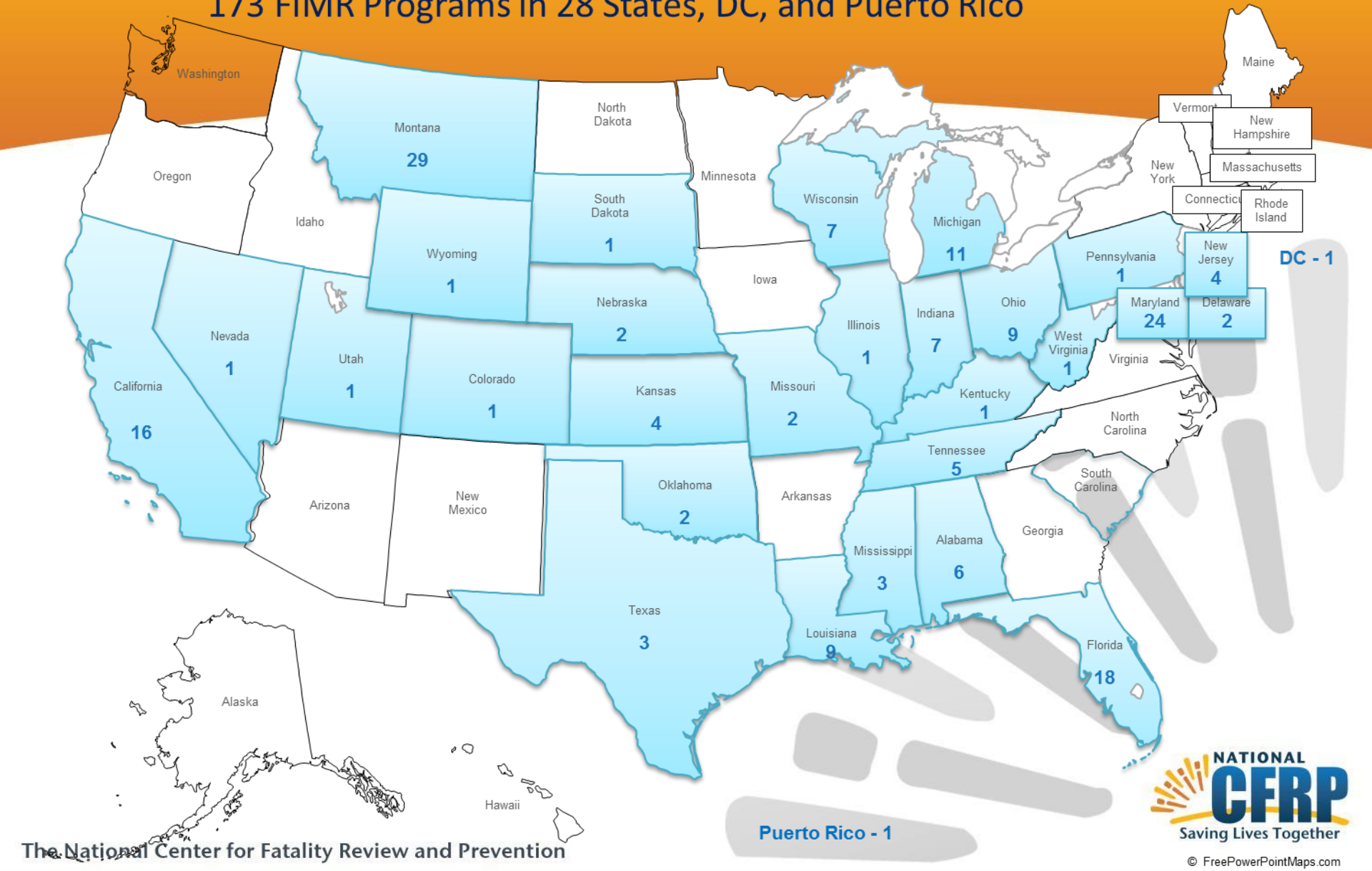


FIMR PROCESS: Continuous Quality Improvement (CQI)

Fetal Infant Mortality Review



173 FIMR Programs in 28 States, DC, and Puerto Rico



The National Center for Fatality Review and Prevention

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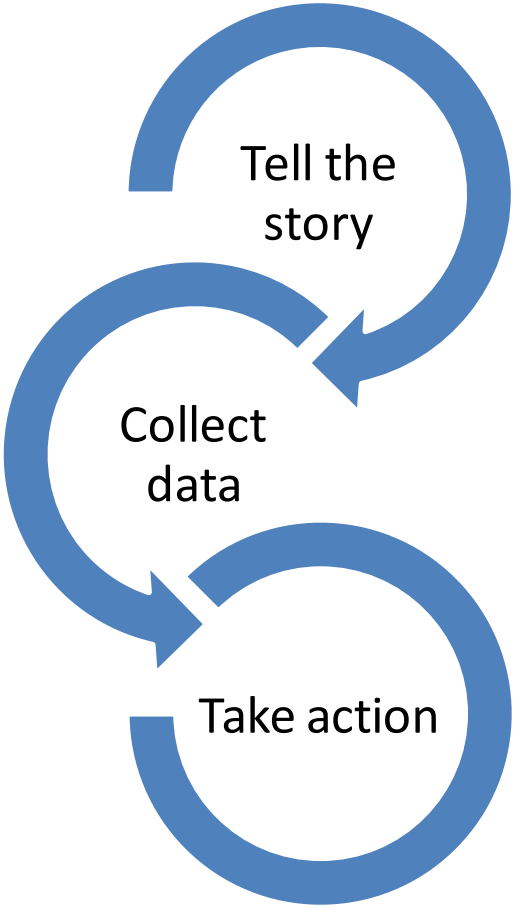
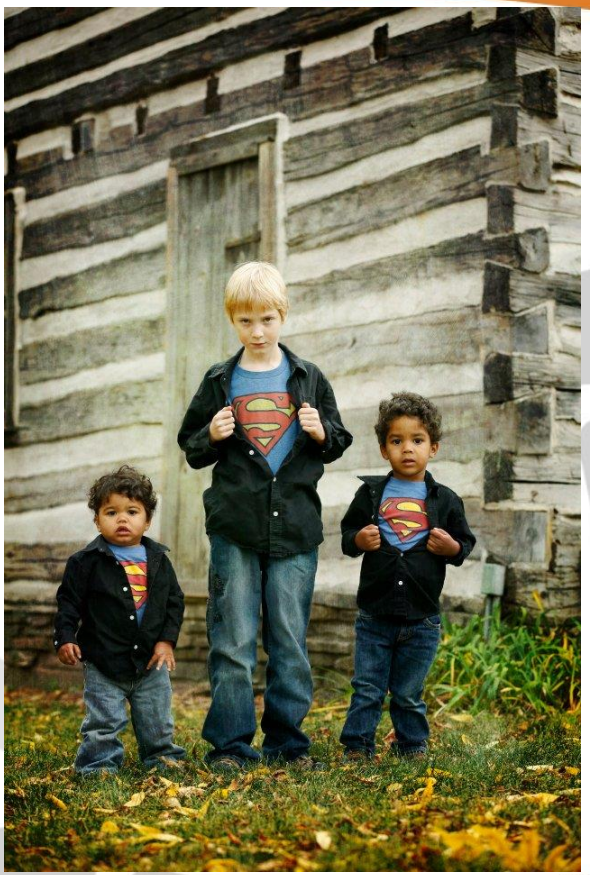
CDR IS…

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….

CDR: Where the Good Shift Happens





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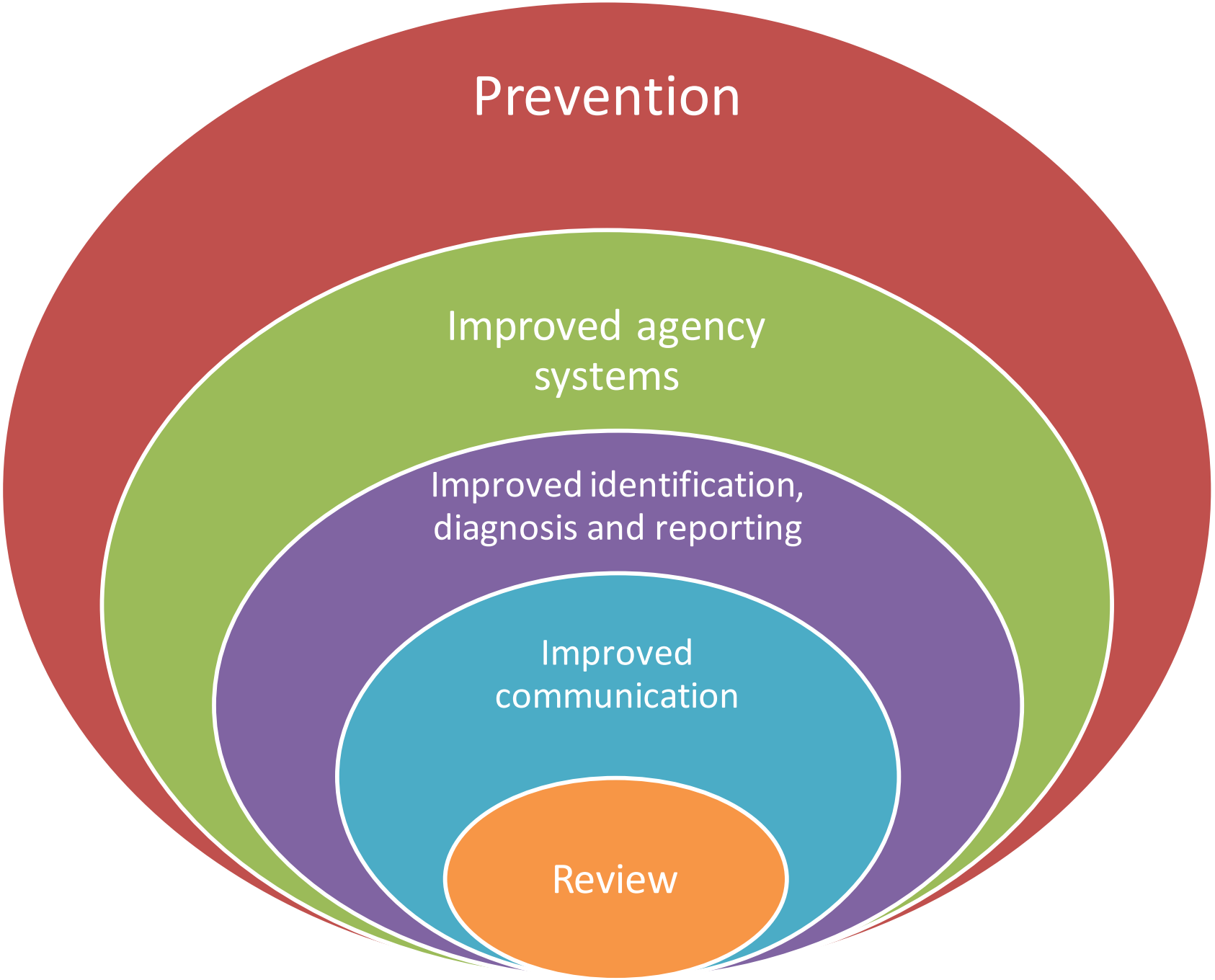
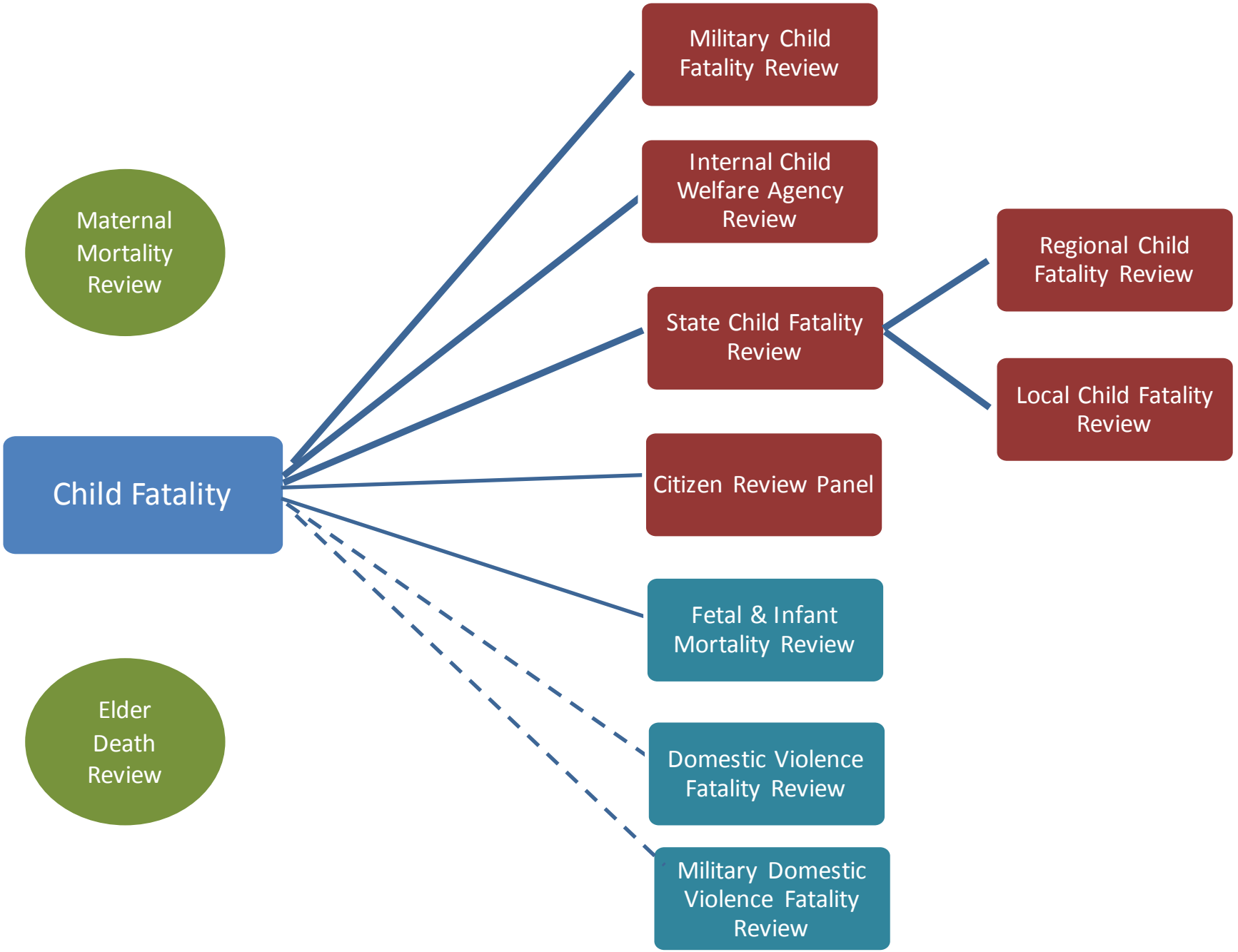
Child Death Review

- Multi-disciplinary
- Telling a story through the sharing of case information from multiple sources
- Focused on improving systems and prevention of deaths; not culpability
- Balance between individual cases and accumulation of fatal and non-fatal data for trends


Prevention
Improved agency systems
Improved identification, diagnosis and reporting
Improved communication
Review


Maternal Mortality Review
Elder Death Review
Child Fatality
Military Child Fatality Review
Internal Child Welfare Agency Review
State Child Fatality Review
Regional Child Fatality Review
Local Child Fatality Review
Citizen Review Panel
Fetal & Infant Mortality Review
Domestic Violence Fatality Review
Military Domestic Violence Fatality Review

Why collaborate?

- Minimize duplication and create economies of scale
- Increase the potential for prevention activities
- Deaths across the age span often have intertwined risk factors
- Identify broad system gaps

Healthy People 2020

IVP-4 Increase the number of states and the District of Columbia where 90% of deaths to children aged 17 years and under that are due to external causes are reviewed by a child fatality team.

- 27 (of 41 reporting) met goal in 2011
- Nationwide, teams reviewed 59% of all external deaths in 2007

Healthy People 2020

IVP-5 Increase the number of States and the District of Columbia where 90 % of sudden and unexpected deaths to infants are reviewed by a child fatality review team.

- 30 states met this standard in 2011
- 25 of those reviewed 100%
- Teams reviewed 69% of all U.S. SUID deaths in 2007.

Key Center Activities in 2016

- Significant training and technical assistance: on-site or web-based, many multiple times:
  - CDR: 21 states
  - FIMR: 10 states
- Work Groups to develop resources:
  - Completed Guidances on Zika-related reviews, Children with special health care needs reviews, Reviews and Vicarious Trauma
  - Near completion: Guidances on coordination of reviews, coordination with military reviews, using reviews to inform Title V programs and services.
  - New: suicide reviews

Key Center Activities in 2016

- HRSA's FIMR CoIN with the Pacific Basin and Caribbean nations
- Monthly webinars for the field
- CDR regional coalitions and building of FIMR regional groups
- The National Case Reporting System and the FIMR Reporting System-Version 5 Development

CDR Outcomes: 2005-2015

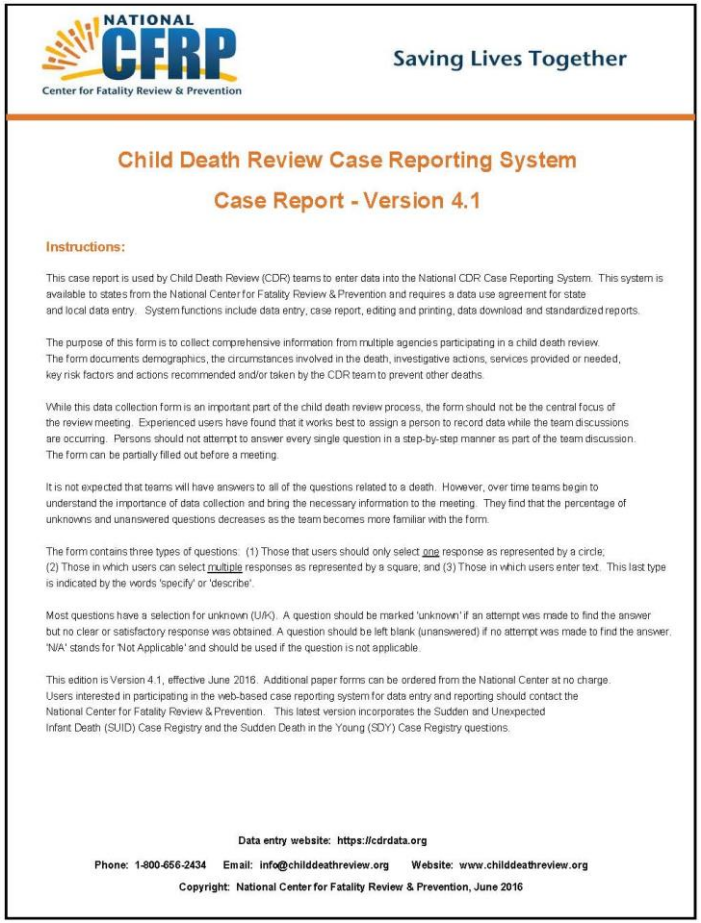
Prevention Initiatives (Recommendation/Planning/Implementation)*

	Frequency	Percent
Parent education	6850	21.7
Media campaign	4535	14.4
Community safety project	3912	12.4
Agency policy/services	3818	12.1
Provider education	3106	9.8
School campaign	2858	9.1
Other education	1778	5.6
Public forum	1252	4.0
Other	3457	11.0
Total	**31566**	**100.0**

*Not mutually exclusive

Fatality Review Data Collection

National CDR Case Reporting System since 2005, that allows for data to be aggregated across programs at the local, state and national level.



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Child Death Review Case Reporting System

Case Report - Version 4.1

Instructions:

This case report is used by Child Death Review (CDR) teams to enter data into the National CDR Case Reporting System. This system is available to states from the National Center for Fatality Review & Prevention and requires a data use agreement for state and local data entry. System functions include data entry, case report, editing and printing, data download and standardized reports.

The purpose of this form is to collect comprehensive information from multiple agencies participating in a child death review. The form documents demographics, the circumstances involved in the death, investigative actions, services provided or needed, key risk factors and actions recommended and/or taken by the CDR team to prevent other deaths.

While this data collection form is an important part of the child death review process, the form should not be the central focus of the review meeting. Experienced users have found that it works best to assign a person to record data while the team discussions are occurring. Persons should not attempt to answer every single question in a step-by-step manner as part of the team discussion. The form can be partially filled out before a meeting.

It is not expected that teams will have answers to all of the questions related to a death. However, over time teams begin to understand the importance of data collection and bring the necessary information to the meeting. They find that the percentage of unknowns and unanswered questions decreases as the team becomes more familiar with the form.

The form contains three types of questions: (1) Those that users should only select one response as represented by a circle; (2) Those in which users can select multiple responses as represented by a square; and (3) Those in which users enter text. This last type is indicated by the words 'specify' or 'describe'.

Most questions have a selection for unknown (U/K). A question should be marked 'unknown' if an attempt was made to find the answer but no clear or satisfactory response was obtained. A question should be left blank (unanswered) if no attempt was made to find the answer. 'N/A' stands for 'Not Applicable' and should be used if the question is not applicable.

This edition is Version 4.1, effective June 2016. Additional paper forms can be ordered from the National Center at no charge. Users interested in participating in the web-based case reporting system for data entry and reporting should contact the National Center for Fatality Review & Prevention. This latest version incorporates the Sudden and Unexpected Infant Death (SUID) Case Registry and the Sudden Death in the Young (SDY) Case Registry questions.

Data entry website: https://cdrdata.org

Phone: 1-800-656-2434 Email: info@childdeathreview.org Website: www.childdeathreview.org

The Case Reporting System: By the Numbers

Poll

45 states using the System

Over 2000 authorized users

Over 1300 CDR teams have recorded a death in the System

More than 190,000 deaths have been entered

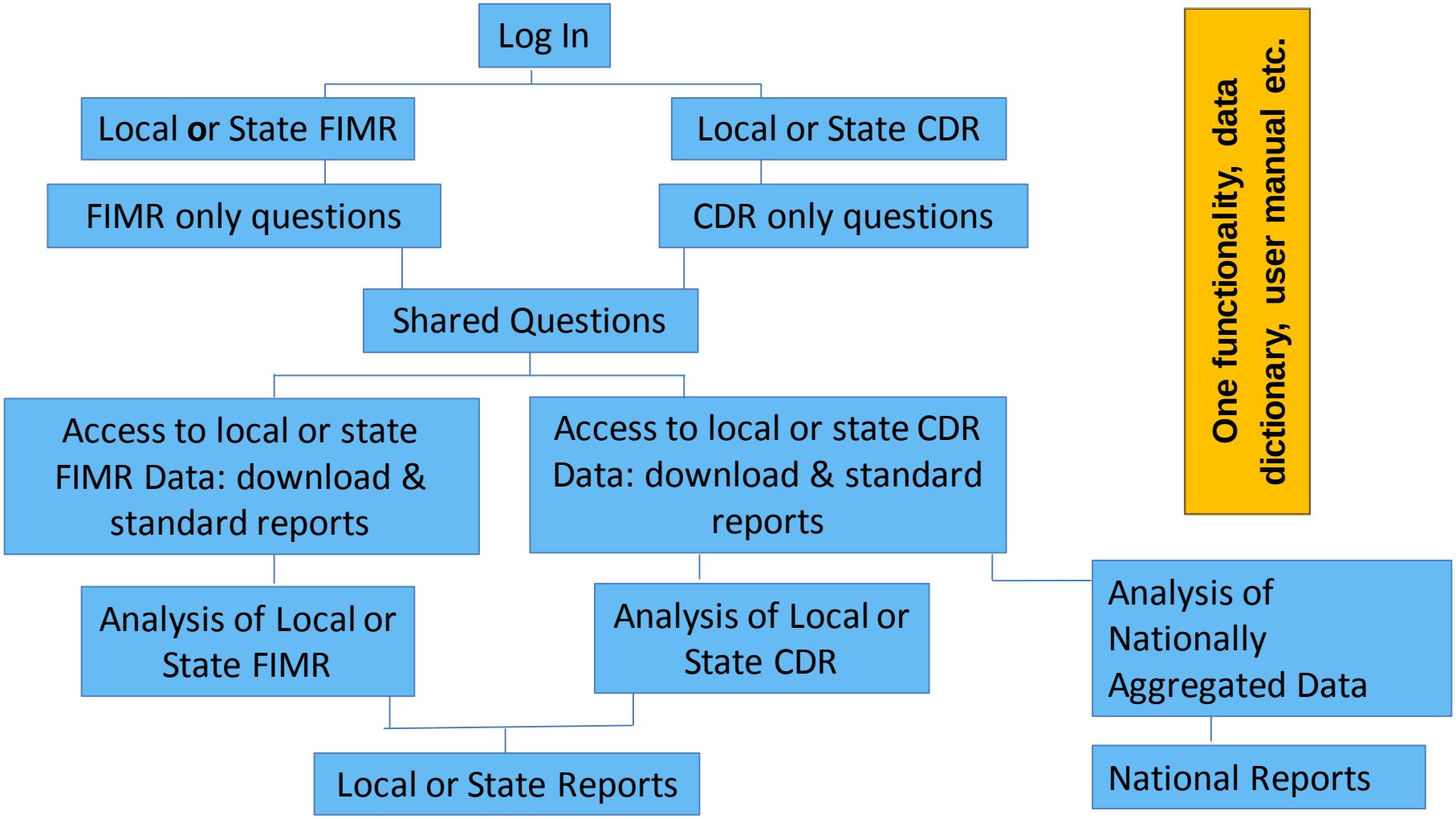
- 99% deaths
- 54% infants
- 76% cases from 2005-2014
- 58% males
- 50% natural deaths; 24% accidents

NATIONAL CFRP Saving Lives Together

Version 5.0 NCFRP-CRS

- Seamless integration of CDR and FIMR reporting.
- FIMR questions developed over past two years with local and state FIMR partner workgroup.
- Protects the sections for the SUID and SDY Registries, e.g. in depth medical history information and categorization questions.
- Basinet will help manage data migration for their users.
- Improves information on child abuse and neglect
- Ready early 2018

An Integrated CRS



CDR and FIMR Data: Scratching the Surface to Reveal Possibilities

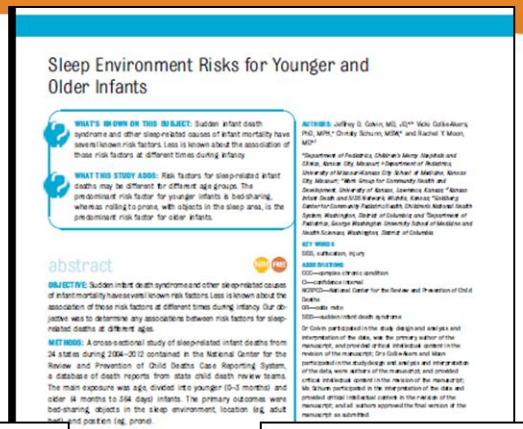
Poll

- Rich information on circumstances by cause.
- Questions were developed with attention to known risk and protective factors.
- High level of missing information but missing permutations can be performed.
- Data reflects national vital stats

Selected Journal Articles, Reports, and Posters Using CDR-CRS Data

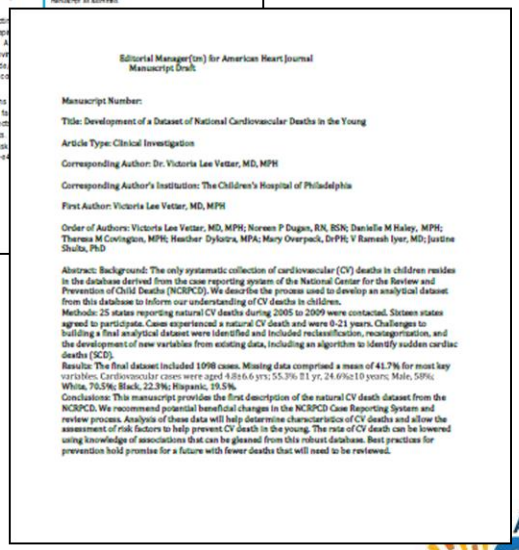

Child Abuse & Neglect

Child maltreatment deaths in the U.S. National Child Death Review Case Reporting System


Sleep Environment Risks for Younger and Older Infants


RESEARCH AND PRACTICE

Sudden Unexpected Infant Deaths: Sleep Environment and Circumstances


Editorial Manager(tm) for American Heart Journal
Manuscript Draft

Manuscript Number:

Title: Development of a Dataset of National Cardiovascular Deaths in the Young

Article Type: Clinical Investigation

Corresponding Author: Dr. Victoria Lee Vetter, MD, MPH

Corresponding Author's Institution: The Children's Hospital of Philadelphia

First Author: Victoria Lee Vetter, MD, MPH

Order of Authors: Victoria Lee Vetter, MD, MPH; Noreen P Dugan, RN, BSN; Danielle M Haley, MPH; Theresa M Covington, MPH; Heather Dykstra, MPA; Mary Overpeck, DrPH; V Ramesh Iyer, MD; Justine Shults, PhD

Abstract: Background: The only systematic collection of cardiovascular (CV) deaths in children resides in the database derived from the case reporting system of the National Center for the Review and Prevention of Child Deaths (NCRPCD). We describe the process used to develop an analytical dataset from this database to inform our understanding of CV deaths in children.
Methods: 25 states reporting natural CV deaths during 2005 to 2009 were contacted. Sixteen states agreed to participate. Cases experienced a natural CV death and were 0-21 years. Challenges to building a final analytical dataset were identified and included reclassification, recategorization, and the development of new variables from existing data, including an algorithm to identify sudden cardiac deaths (SCD).
Results: The final dataset included 1098 cases. Missing data comprised a mean of 41.7% for most key variables. Cardiovascular cases were aged 4.8±6.6 yrs; 55.3% ≥1 yr, 24.6%≥10 years; Male, 58%; White, 70.5%; Black, 22.3%; Hispanic, 19.5%.
Conclusions: This manuscript provides the first description of the natural CV death dataset from the NCRPCD. We recommend potential beneficial changes in the NCRPCD Case Reporting System and review process. Analysis of these data will help determine characteristics of CV deaths and allow the assessment of risk factors to help prevent CV death in the young. The rate of CV death can be lowered using knowledge of associations that can be gleaned from this robust database. Best practices for prevention hold promise for a future with fewer deaths that will need to be reviewed.

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Outcomes from the Field

- Developed a joint committee with the Child Protection Accountability Commission on substance exposed infant training committee after seeing an increase in Opiate using Mothers in FIMR and CDR and MMR
- Tracked ACE scores in 2016 on all FIMR, CDR and MMR
- Partnered with a national restaurant chain who donated proceeds from calendar sales to purchase 112 car seats to be given away
- Improved media awareness of MVA due to a high number of deaths
- Coordinated with Highway Safety Coalition and promoted cross-attendance at reviews
- Distributed safety kits via first responders/EMS
- Passed laws requiring passengers in the backseat to be restrained

Opportunities for Collaboration

- Attend meetings
- Share data
- Partner on prevention activities
- Participate in webinars
- Share resources

For More Information

Abby Collier

(517) 614-0379

acollier@mphi.org

SUGGESTIONS OR QUESTIONS?

Upcoming Deliverables & Calls

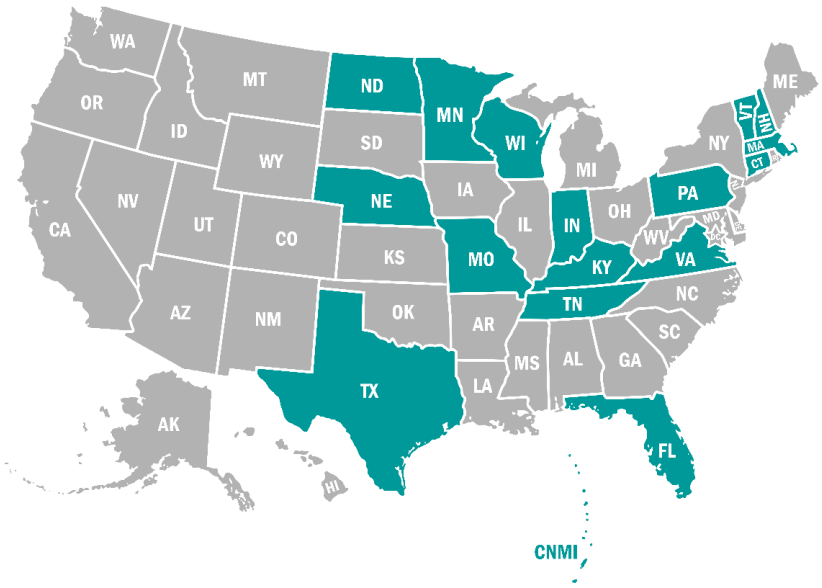
- ❗ Submit your Driver Diagram
- ☑ Monthly Reports about June are due on July 11th

- 🗓 **Teen Driver Safety:** July 18th, 1pm ET
- 🗓 **Suicide and Self-Harm Prevention:** July 19th, 1pm ET
- 🗓 **Interpersonal Violence Prevention:** July 20th, 3pm ET
- 🗓 **Child Passenger Safety:** July 25th, 1pm ET
- 🗓 **Falls Prevention:** July 27th, 10am ET

Thank you for participating!

Please complete this brief evaluation:

https://www.surveymonkey.com/r/TNGZFPM



Questions or Comments? Contact:
RThomas@edc.org
617-618-2178

For more information, visit:
https://www.childrenssafetynetwork.org/cscoiin