Child Death Review Findings:

A Road Map for MCH Injury & Violence Prevention

Supported by the Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services.

MCH and CDR teams

- Learn about key causes of injuries
- Assist in developing recommendations to address injuries
- Play a role in implementing IVP recommendations

Today's webinar

CDR: Injury and violence prevention

- Sara Rich, NC CDR

Developing action-oriented recommendations

- Steve Wirtz , CA DPH

Using recommendations to influence change

- Jacqueline Johnson, TN MCH
- Heidi Hilliard, MPHI

Child Death Review: Avenues to Prevention

Sara Rich, MPA

National Center for CDR

The National Center for Child Death Review Policy and Practice and Children's Safety Network are supported in part by the Maternal and Child Health Bureau, Health Resources and Services Administration, Department of Health and Human Services.

CDR Process

Investigation → Services → Prevention

Law enforcement
Medical Examiner/Coroner
Child Protection
Legal
EMS

Public Health
Social Services
EMS
Education
Mental Health
Health care

Local health department/MCH
Injury and violence
Child Abuse
Community Groups
SIDS/OID Programs

CDR Cruising to Prevention

- **Healthy People 2010 Objective 15.6:**

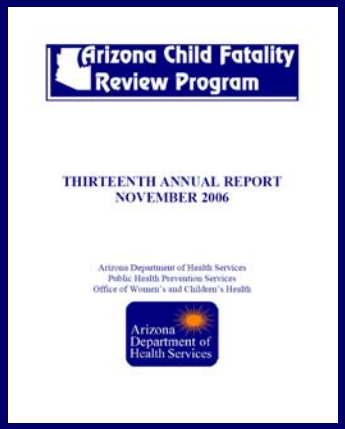
  Extend the number of States to 50 and the District of Columbia, where 100% of deaths to children aged 17 years and younger that are due to external causes and 100% of all sudden and unexpected infant deaths are reviewed by a child fatality review team."

- **Half of states CDR are located in health departments**
- **Two out three states have local CDR review teams**
- **Nearly all states review deaths under age 18**
- **Half of all states review all causes of death**

Rubber Meets the Road

80% of states publish an annual report with recommendations

Two of three states report recommendations have led to state legislation, policy changes, and/or prevention programs



Developing Effective Recommendations Taking Findings To … Action

Steve Wirtz, PhD
Epidemiology and Prevention for Injury Control (EPIC) Branch
California Department of Public Health

Children's Safety Network Webinar:

Child Death Review Findings: A Road Map for MCH Injury and Violence Prevention Actions

August 20, 2007

Acknowledgements

- Valodi Foster, MPH, After School Programs Office, California Department of Education

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Purpose

- Focus is on PREVENTION
  - Translating Child Death Review Team (CDRT) findings into ACTION!
  - Partnering with Maternal Child Health (MCH)
- Developing and writing effective recommendations for action
- Brief review:
  - California CDRT recommendation study
  - Guidelines for writing effective recommendations
  - Implications for MCH practice

Child Death Review Teams (CDRTs)

- Multi-disciplinary, multi-agency review of circumstances surrounding child deaths
- Function at state and local levels
- Serve multiple functions:
  - Identification of causes and circumstances
  - Investigation of CAN & questionable deaths
  - Review community responses and services
  - Surveillance - monitoring and reporting
  - Prevention of future child deaths

Role of State and Local MCH

- CDRT Membership
- Information sharing
  - Case specific
  - Broader public health perspective
- Leadership
- Integrate CDRT processes into MCH activities
  - Using data & findings from CDRT/FIMR
  - Helping to shape recommendations
  - Acting on recommendations

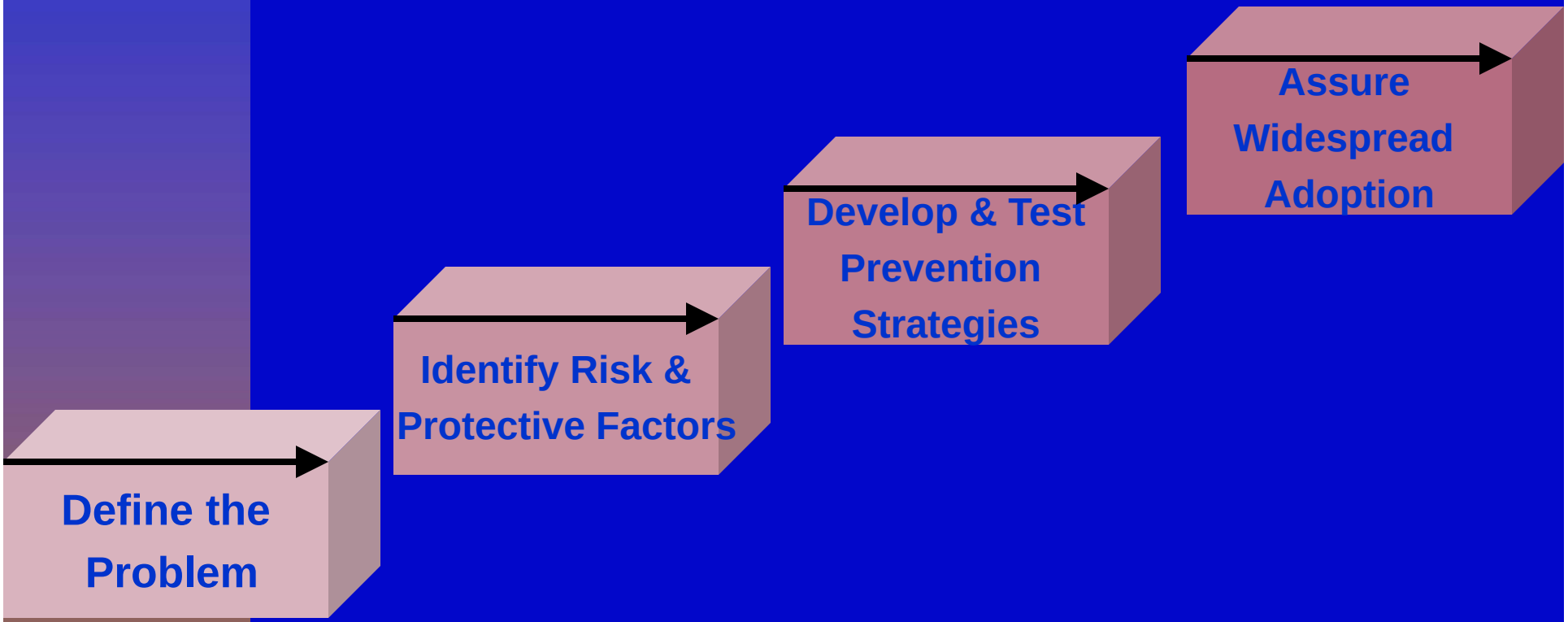
CDRT Recommendations Project

- Questions about the value of CDRTs
- Variability in the functioning of CDRTs
  - Reviewing cases
  - Collecting data
  - Making recommendations
  - Writing reports
- Questions about the effectiveness of team recommendations
- Need for more information

CDRT Recommendations Project

- Based our study on public health planning model
- Sampled written reports from 75 CDRTs throughout the United States
- Developed “Guidelines for Writing Effective Recommendations”
- Reviewed and assessed over 1,000 recommendations

The Public Health Approach to Prevention



Role of Effective Recommendations

- Recommendations come after
  - Defining the Problem and
  - Identifying Risk and Protective Factors
- But Before
  - Developing and Testing Interventions
- They are part of developing solutions

Framework for Developing Guidelines for Writing Effective Recommendations

- Clarifying roles and engaging members in prevention
- Using data to help define problems
- Identifying risk and protective factors
- **Developing solutions**
- Proposing strategies, policies, and interventions
- Monitoring implementation of interventions
- Promoting accountability through evaluation of impact/outcomes

Writing Effective Recommendations

- Problem Assessment
- Written Recommendation
- Action on Recommendation

Problem Assessment

- Problem Statement
  - Includes problem definition; local, state & national data; risk and protective factors
- Best Practices
  - Demonstrates knowledge of “best” or “promising” practices for addressing the problem

Problem Assessment (Cont'd)

- Capacity
  - Demonstrates knowledge of existing local efforts, resources, capacities, "political will", and/or takes advantage of serendipitous opportunities

Written Recommendation

- Intervention Actor
  - Identifies the persons and organizations (doers) to take action in a manner consistent with the problem assessment
- Intervention Focus
  - Identifies the recipient (e.g., person, agency, policy, law) of the intended action in a manner consistent with the problem assessment

Written Recommendation (Cont'd)

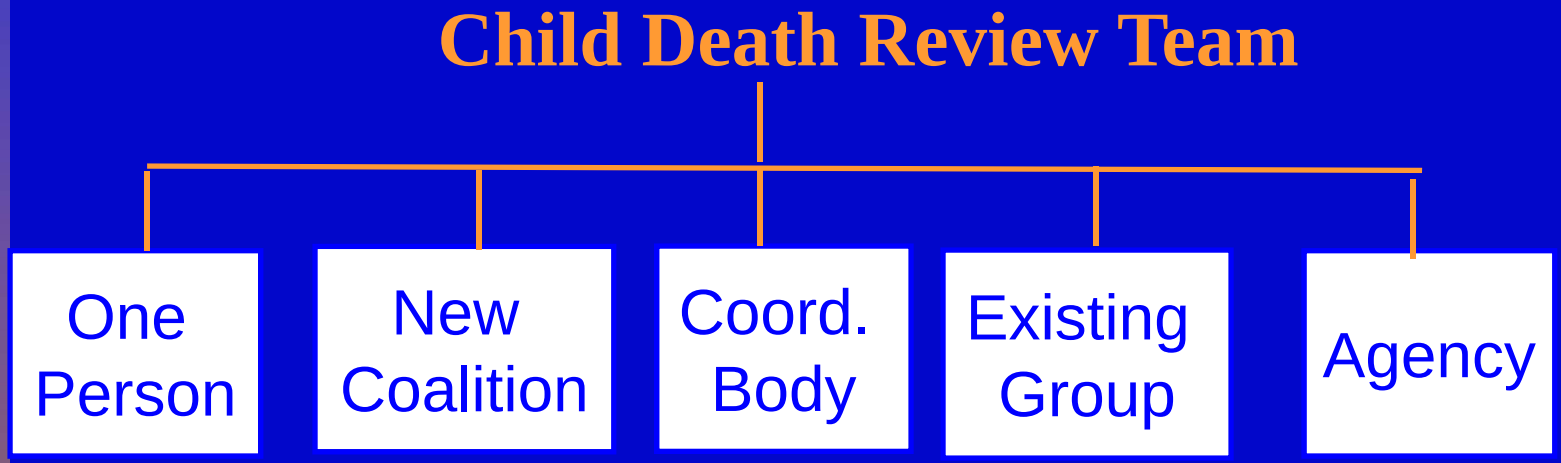
- Specificity
  - The plan of action described in sufficient detail to allow follow up consistent with:
    - Issues identified in problem assessment
    - Actions appropriate for recipient
    - Places/institutions identified where changes will occur
    - Timeframe for action identified

Written Recommendation (Cont'd)

- Accountability
  - Assigns and obtains buy-in of someone (i.e., team member or other individual) to be accountable for follow up and tracking of progress on actions taken within timeframe identified
- Spectrum of Prevention
  - Demonstrates awareness of levels of intervention and identifies appropriate level(s) given issues identified in problem assessment

Spectrum of Prevention

Refer Recommendations



A recommendation is not complete until responsibility for follow-up has been assigned

Action on Recommendation

- **Dissemination**
  - specifically states who will receive the recommendation, and includes not only the potential actors and recipients but also appropriate decision makers, funders, and potential supporters.

Action on Recommendation (Cont'd)

- **Outcomes/Impacts**
  - identifies a mechanism/procedure to document the impacts and outcomes that result from action on team recommendations.

Findings from CDRT Recommendations Project

- Quality of recommendations varied widely
- CDRTs did best on front end
  - Problem statement
  - Best practices
- CDRTs scored lowest on follow up activities
- Written recommendations showed moderate specificity and awareness of Spectrum levels, but lacked clarity on who was to take action

Writing Effective Recommendations

- Practical considerations
  - Small number of cases
  - Recommendations for single cases
  - Knowing what works
    - Involve “experts” (e.g., injury professionals)
    - Best or promising (or even reasonable) practices
    - Local conditions
  - Resources for taking action - capacity
    - How to start on action – e.g., can start small
    - Existing capacity for action
    - Setting priorities
    - Who can take lead (or champion) the action
    - “Political will” for action
    - How to get follow through

Qualities of Teams

- Multi-disciplinary, power in our diversity
- Potential for a unified voice
- Politically connected
- Offer support
- Provide recognition
- Make a difference!

Lessons Learned

- Make prevention a priority
- Value the recommendation process
- Be realistic – take small steps
- Identify existing partners & champions
- Keep track of what you recommend
- Follow-up
- Let people know what happens
- Celebrate successes

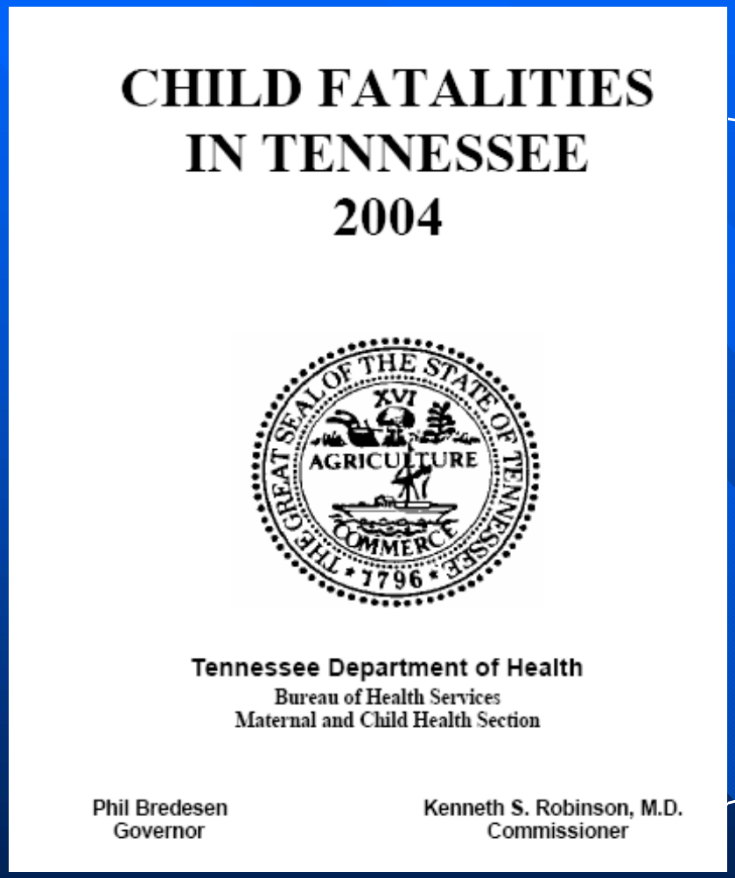
Keys to Success

- Guide to Effective Reviews
- Spectrum of Prevention
- Writing Effective Recommendations
- Champions
- Follow-Up

Tennessee
Child Fatality Review Program

Child Fatality Review (CFR) Program was established in 1995 and housed out of the Tennessee State Department of Health- Maternal and Child Health

Tennessee Child Fatality Review Program

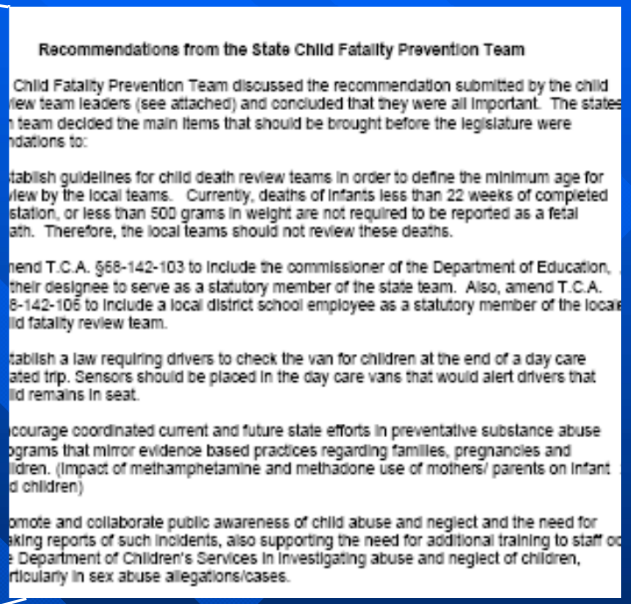


CHILD FATALITIES IN TENNESSEE 2004

Tennessee Department of Health
Bureau of Health Services
Maternal and Child Health Section

Phil Bredesen
Governor

Kenneth S. Robinson, M.D.
Commissioner



Recommendations from the State Child Fatality Prevention Team

Child Fatality Prevention Team discussed the recommendation submitted by the child
iew team leaders (see attached) and concluded that they were all important. The states
n team decided the main items that should be brought before the legislature were
ndations to:

tablish guidelines for child death review teams in order to define the minimum age for
iew by the local teams. Currently, deaths of infants less than 22 weeks of completed
station, or less than 500 grams in weight are not required to be reported as a fetal
ath. Therefore, the local teams should not review these deaths.

nend T.C.A. §68-142-103 to include the commissioner of the Department of Education,
their designee to serve as a statutory member of the state team. Also, amend T.C.A.
8-142-106 to include a local district school employee as a statutory member of the local
ld fatality review team.

tablish a law requiring drivers to check the van for children at the end of a day care
ated trip. Sensors should be placed in the day care vans that would alert drivers that
ld remains in seat.

courage coordinated current and future state efforts in preventative substance abuse
ograms that mirror evidence based practices regarding families, pregnancies and
ldren. (Impact of methamphetamine and methadone use of mothers/ parents on infant
d children)

omote and collaborate public awareness of child abuse and neglect and the need for
aking reports of such incidents, also supporting the need for additional training to staff o
e Department of Children's Services in investigating abuse and neglect of children,
rticularly in sex abuse allegations/cases.

ATV Background

- 1982-2001
  - » 164 deaths
- Youth ATV deaths in 2004 (n=7)
  - » 5.2% of all vehicle deaths.

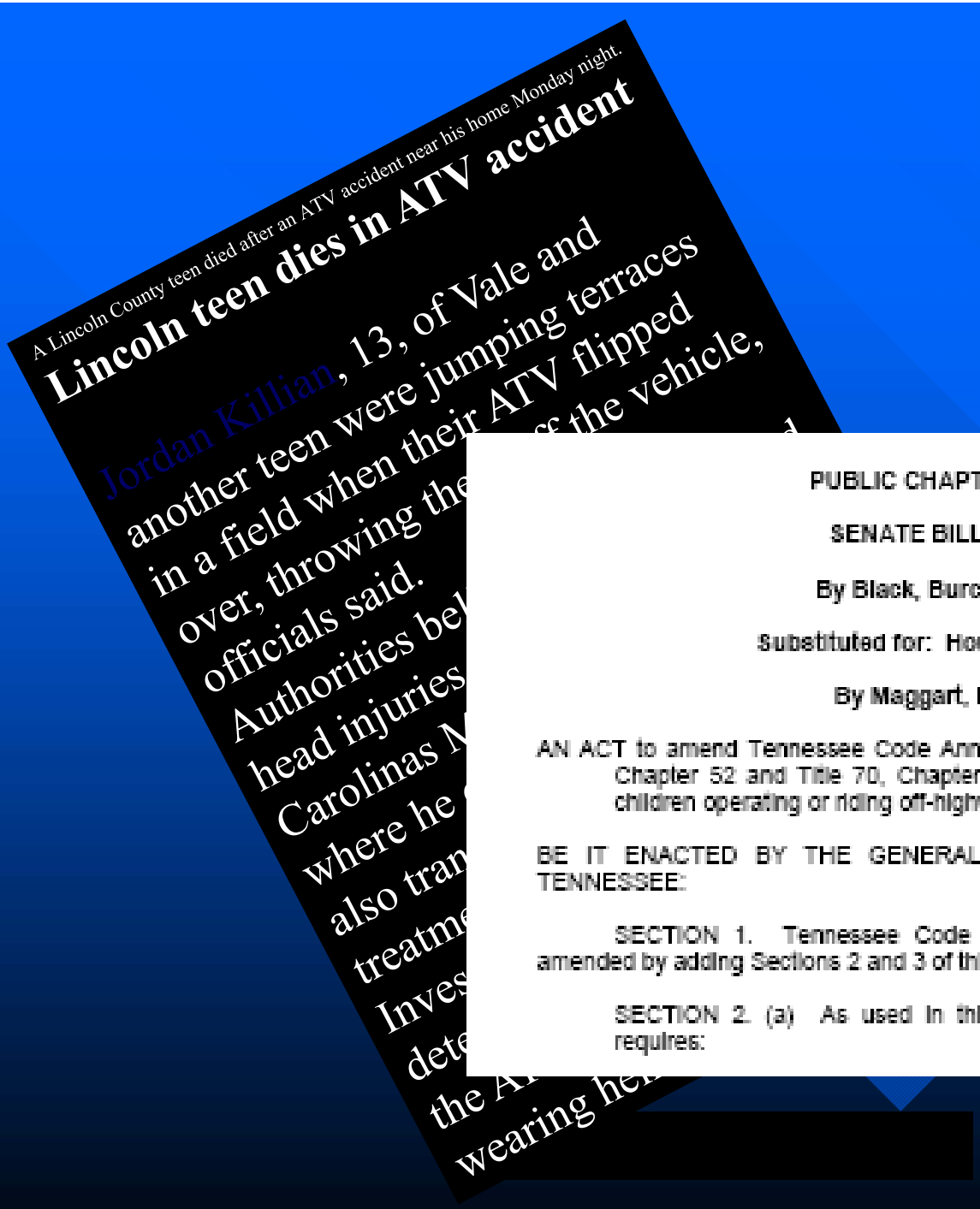
Recommendation → Policy

Develop or promote legislation to regulate all terrain vehicles (ATV) usage. Establish a minimum age requirement, safety gear, parental requirements, seller requirements and pre-training prior to driving.

CDR Recommendation

State Policy

Public Chapter 481 June 21, 2007 Requires helmet for operators and passengers 18 or younger of off-highway motor vehicles – parents will receive fines ups to $50 and $10 court cost.


A Lincoln County teen died after an ATV accident near his home Monday night.

Lincoln teen dies in ATV accident

Jordan Killian, 13, of Vale and another teen were jumping terraces in a field when their ATV flipped over, throwing the

officials said.

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PUBLIC CHAPTER NO. 481

SENATE BILL NO. 1994

By Black, Burchett, Kurita

Substituted for: House Bill No. 1974

By Maggart, Hardaway

AN ACT to amend Tennessee Code Annotated, Title 55, Chapter 10; Title 55, Chapter 52 and Title 70, Chapter 9, relative to the use of helmets by children operating or riding off-highway motor vehicles.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. Tennessee Code Annotated, Title 55, Chapter 52, is amended by adding Sections 2 and 3 of this act as a new Part 2:

SECTION 2. (a) As used in this part, unless the context otherwise requires:

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Phon 0368
x: 61
l:
Jacqueline.Johnson@state.tn.us

Michigan Child Death Review

Michigan Child Death Review

- Started in 1995 by state MCH director and over 6,400 child deaths reviewed since 1995.
  - In 2004, 93% of all external deaths to children were reviewed by local teams. (n=833)
  - 83 counties / 74 teams/1,200 local team members
  - 25-member State Advisory Committee including MCH

MVC - Mecosta County

Findings from local CDR meetings:

- 8 deaths involving young drivers in 4 months.
- Ask teens about their experience in learning to drive, the team was told:
  - Teens don't always get all 50 hours driving with parent; variety of conditions not required.
  - Parents not completely understanding their responsibilities.
  - Teens/parents not actually required by the State to turn in log book of 50 supervised hours.

MVC - Mecosta County

Actions:

- CDR team organized Teen Driver Task Force, including local teens and officials from three high schools in the county
  - **Task Force designed a more detailed log book.**
  - **Schools agreed to require a parent orientation, and the new log books be completed.**
  - **Team met with state leaders to ask them to tighten certain requirements/close loop-holes in the GDL.**

Community Support

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http://www.keepingkidsalive.org

Take home messages

CDR: Seek out MCH & IVP participation

MCH: Connect with CDR teams

Effective reviews and recommendations lead to change

Contact us…

- Help forge collaboration between MCH and CDR
- Assist in writing action-oriented IVP recommendations
- Assist in implementing IVP recommendations

www.ChildrensSafetyNetwork.org

- Building CDR Capacity
- Training for State and local teams
- Networking State CDR coordinators
- Linking to prevention resources and tools
- Coordinating with other review processes
- CDR Case Reporting System

(800) 656-2434
www.childdeathreview.org

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