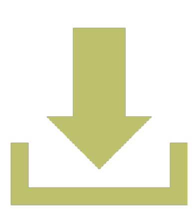
Improving Injury Outcomes: Understanding Health Equity from a Systems Perspective

Technical Tips

Audio is broadcast through computer speakers



Download resources in the File Share pod (above the slides)

If you experience audio issues, dial **(866) 835-7973** and **mute computer speakers**

Use the Q & A (bottom left) to ask questions at any time

You are muted

This session is being recorded

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under the Child and Adolescent Injury and Violence Prevention Resource Centers Cooperative Agreement (U49MC28422) for $5,000,000 with 0 percent financed with non-governmental sources. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

Presenters

Sasha Mintz, MPH

Child Fatality Prevention System Epidemiologist
Colorado Department of Public Health and Environment

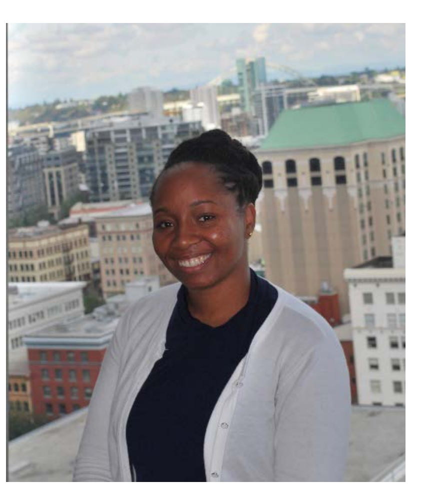
Jessica Ehule, MS, MSPH

Senior Public Health
Project Coordinator
CityMatCH

Abby Collier, MS

Executive Director
National Center for Fatality Review and Prevention

CityMatCH
Applying an Equity Lens to Bring Transformative Change to Our Work



Jessica Ehule, MS, MSPH

Senior Public Health Project Coordinator, CityMatCH

What is Equity?

World Health Organization (WHO) defines Equity as:

"...the **absence** of **avoidable** or **remediable differences among groups of people**, whether those groups are defined socially, economically, demographically, or geographically."

Health Equity

Health Equity means that everyone has a fair opportunity to lead a long and healthy life. That requires removing obstacles to health such as poverty, discrimination, and their consequences—including powerlessness, lack of access to good jobs, fair pay, education, housing, environments, and health care for all who live in America.

Conversely, WHO Describes Health Inequities as:

"…more than inequality with respect to health determinants, access to the resources needed to improve and maintain health or health outcomes. They also entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms."

Social Determinants of Health (SDoH)

Examples of Social Determinants of Health

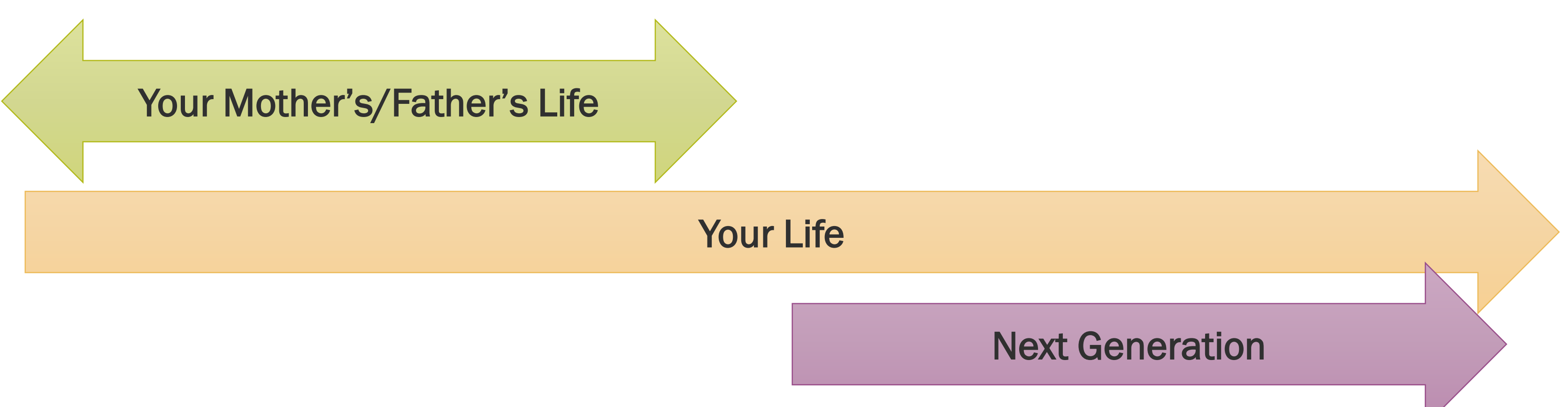
- The economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole
- According to the WHO, the conditions in which people grow, live, work, and age.
- They include, but are not limited to:
  - Access to Safe & Affordable Housing
  - Living Wage
  - Job Security
  - Quality Education
  - Social Connection & Safety
  - Access to Transportation
  - Food Security

Life Course Perspective

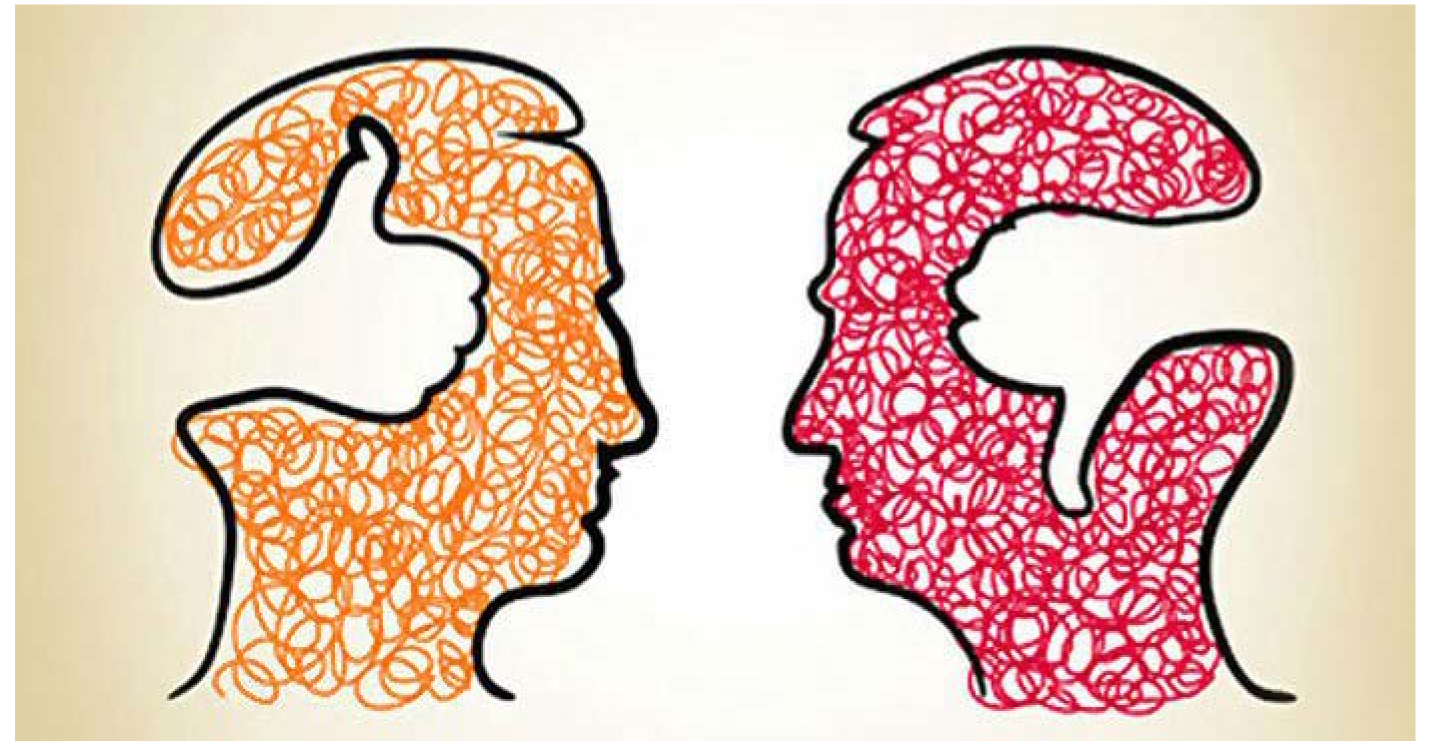
- The Life Course Perspective is a complex interplay of various factors including:
  - Biological
  - Behavioral
  - Psychological
  - Social
- Protective and risk factors contribute to the health outcome across the span of a person's life

What is the life course perspective?

- Looking at health through a life course perspective hopes to address three key areas:
  - Your health as an **individual**
  - Your health before your conception (i.e. your mom's health **pre-conception**)
  - Your children's health (**intergenerational** component).



Implicit/Explicit Bias



History of Inequities

- Creation of false hierarchy of human value led to establishment of inequitable policies, practices, and procedures.

History of Inequities

In the most recent century, there have been significant policies established that impact the ability of families and communities to access:

- Safe Housing
- Transportation
- Quality Health Care
- Jobs with Livable Wage
- Quality Education

Our Health Outcomes Are Multifactorial

Society
- Inadequate national health system
- Institutionalised inequalities
- Weak legal protections against abuse
- Recent or ongoing conflict or natural disaster
- Poor national record on human rights

Community
- Institution or detention
- Conspiracy of silence around abuse
- Negative cultural practices and beliefs
- High levels of inequality/ unemployment/ poverty
- Belief that rights do not apply in an African context
- Nomadic

Relationship
- Unemployment within family
- Drug/alcohol dependencies within family
- Absence of responsible adults
- Too many children for parent/s to manage/support

Individual
- Young
- Ethnic minority
- Disabled
- Homeless
- Refugee
- Uneducated about own rights
- Orphan

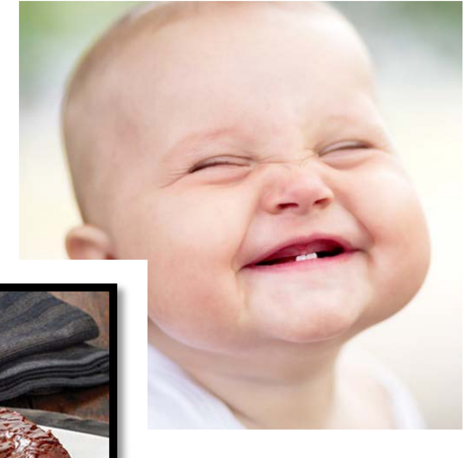
Equity in Our Work

Equality

Equity

Rwgf.org

Equity is about Meeting the Needs



Equity Requires an Analysis

- Equity requires an investigation of current conditions and the **legacy** of past actions.
- Equity requires an **analysis of systemic oppression:** the role of history, culture, bias, privilege, internalized oppression, institutional policies and practices, power, and economics.

Changing the Narrative

- A narrative of our communities has been shaped by the history and the biases of the dominant voice.
- Making significant changes requires doing work differently. This includes changing the way we think by asking deeper questions.

Changing the Narrative

- How do we get kids to stop bullying?
  - What are the lived experiences and possible traumas experienced by children that lead them to bullying their peers?
- Why do lower income families have higher rates of child injuries?
  - What are the social conditions in which low income families are living that may predispose their children to injuries?

Importance of Internal Equity

Equity in Our Workplace

CityMatCH Journey Toward Internal Equity

The Wheel of Change

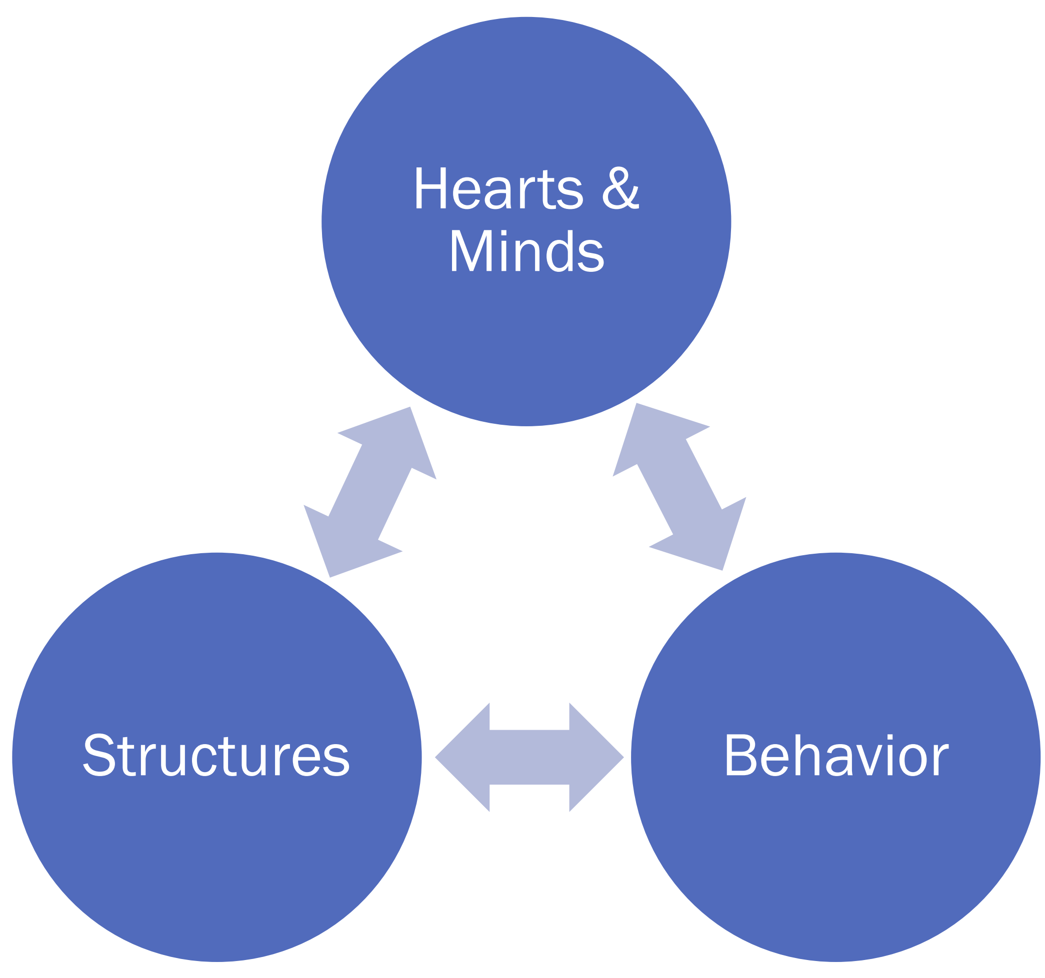


Image based on stproject.org diagram

Process to Initiate Change

External Trainings

- Technique for addressing stereotypes (*OUCH That Stereotype Hurts!*)
- Implicit Bias Training (Consult Me, LLC)
- Racial Healing Circle
- Racial Equity Institute
- Cultural Improvement Strategic Planning

Process to Initiate Change

- Intentional Organizational Dialogue
  - Training/conversations led by staff members within organizations
  - Book Club*
- Review progress and refine plan of action
  - Progress on strategic plan
  - Working with consultant to develop better ways to measure equity
  - Revising oppressive policies/practices normalized by dominant culture

Lead from Where You Are

Leadership

- You can lead from any level within your organization
- Keys to Leading This Effort
  - Awareness
  - Effective Communication Skills
  - Building Relationships
  - Honesty/Integrity
  - Organization & Planning

Reflection

- How are my organization's policies, practices, and procedures contributing to inequities?
- How do we intentionally apply an equity lens to our work?
    - What assumptions are we making?
    - Turn to wonder. Ask why.
- Intentionally Change the Narrative

Questions?

Please enter your questions in the Q & A pod

Jessica Ehule, MS, MSPH
jessica.ehule@unmc.edu

Poll

Are you or your organization doing any work to promote health equity?

Colorado Child Fatality Prevention System (CFPS): Considering Equity in Prevention and Data

Sasha Mintz, MPH

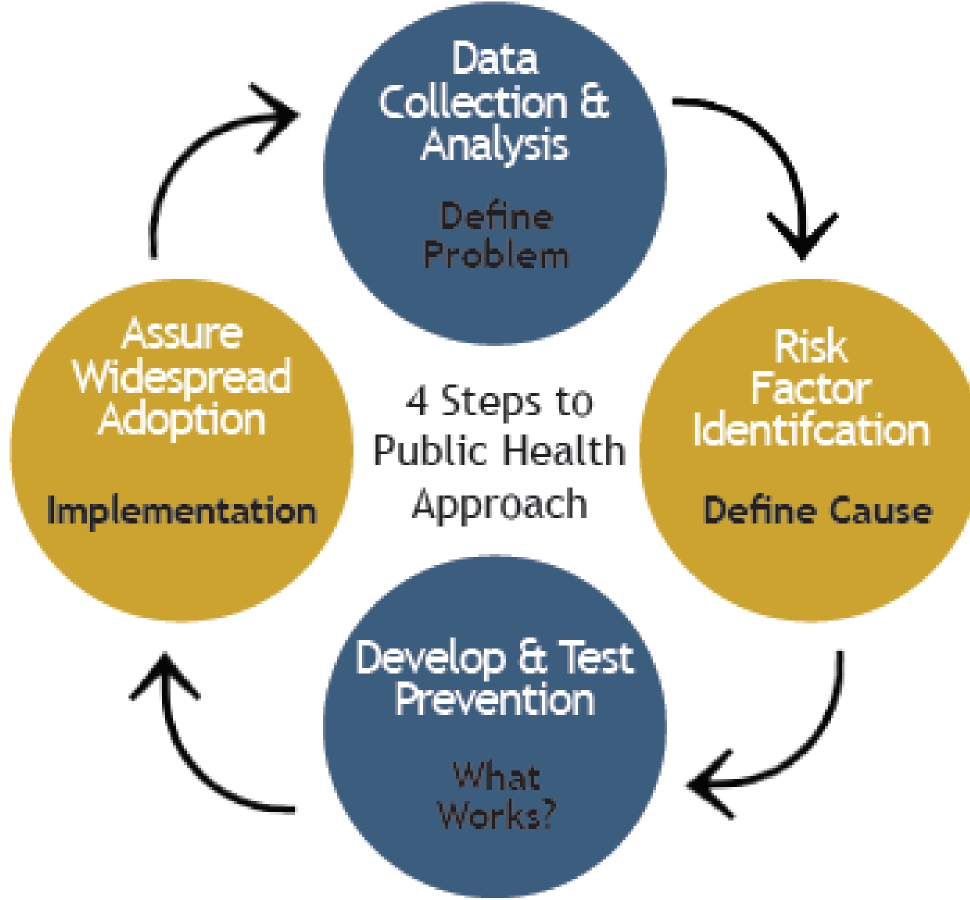
Child Fatality Prevention System Epidemiologist

Child Fatality Prevention System

<u>Causes of child deaths reviewed:</u>

- Motor vehicle/other transport
- Sudden unexpected infant deaths
- Child maltreatment
- Suicide
- Homicide
- Overdose and poisoning deaths
- Unintentional injury (fires, drowning, falls)
- Undetermined causes

Public Health Approach to Child Fatality Prevention



Shared Protective Factors

CONNECTED-NESS

ECONOMIC STABILITY & SUPPORTS

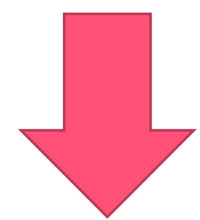
BEHAVIORAL HEALTH

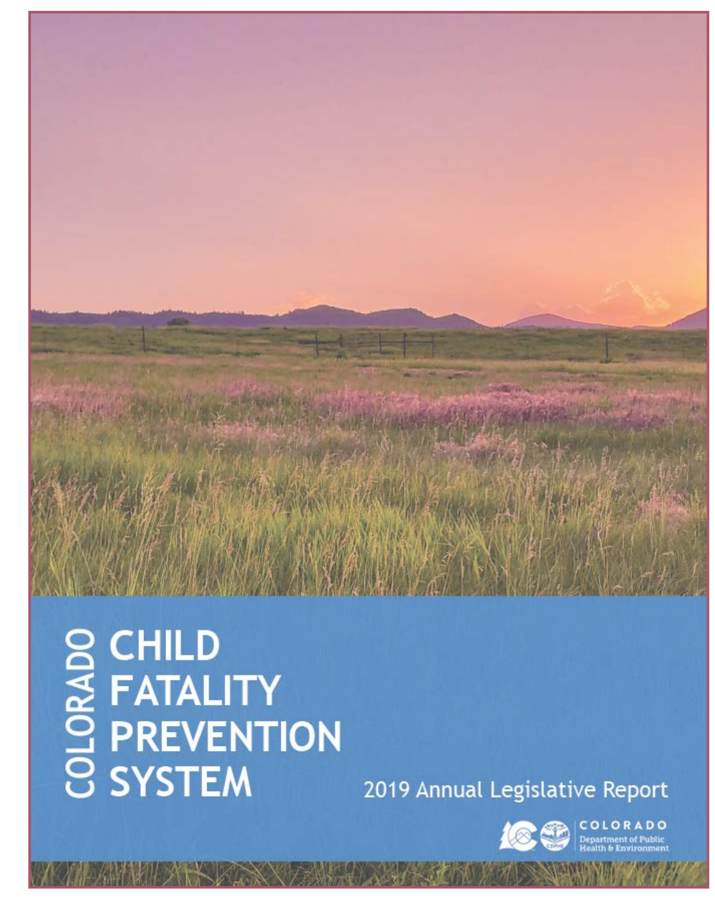
SOCIAL NORMS

Protective factors: characteristics or situations that mitigate the risk of experiencing violence and/or injury, and help to build resilience to thrive when faced with adversity

2019 Annual Legislative Report

You can access this report and past legislative reports on the CFPS website

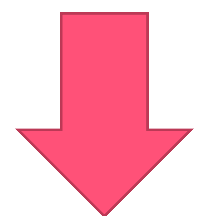


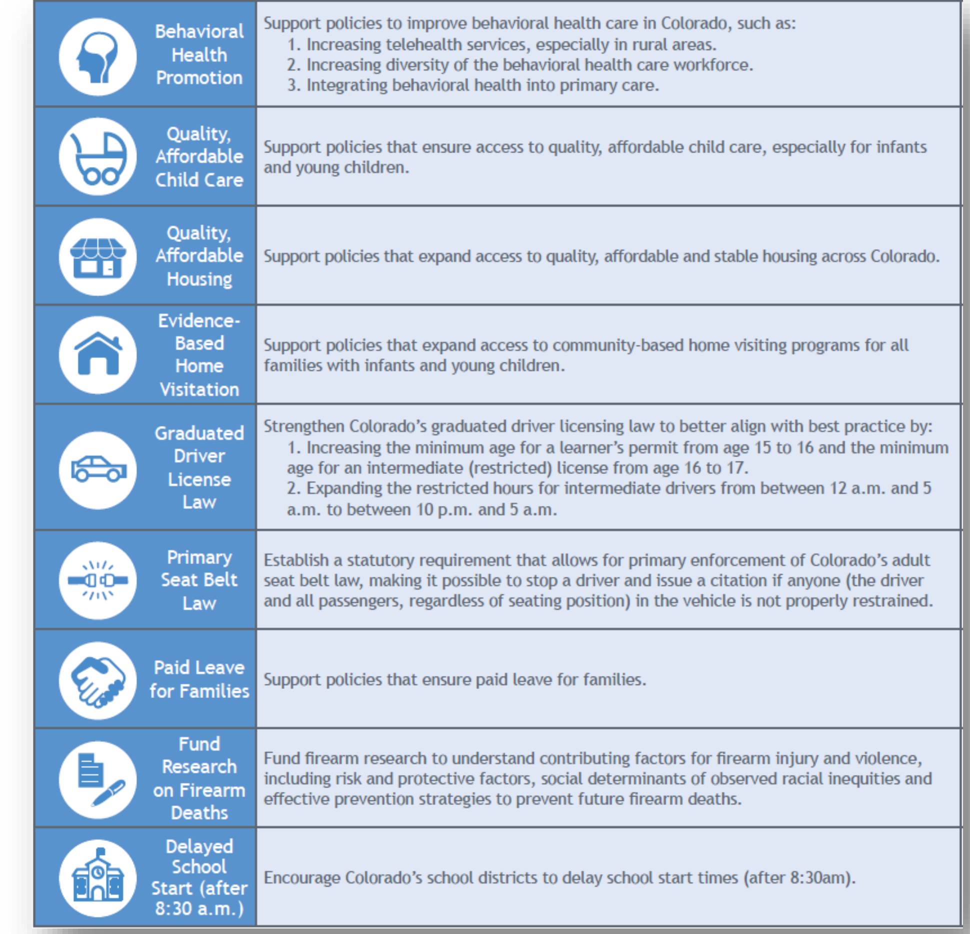


www.cochildfatalityprevention.com/p/reports.html

2019 Prevention Recommendations

Two pagers on each recommendation are available on the CFPS website





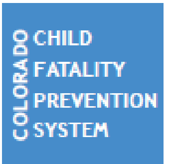
Behavioral Health Promotion	Support policies to improve behavioral health care in Colorado, such as: 1. Increasing telehealth services, especially in rural areas. 2. Increasing diversity of the behavioral health care workforce. 3. Integrating behavioral health into primary care.
Quality, Affordable Child Care	Support policies that ensure access to quality, affordable child care, especially for infants and young children.
Quality, Affordable Housing	Support policies that expand access to quality, affordable and stable housing across Colorado.
Evidence-Based Home Visitation	Support policies that expand access to community-based home visiting programs for all families with infants and young children.
Graduated Driver License Law	Strengthen Colorado's graduated driver licensing law to better align with best practice by: 1. Increasing the minimum age for a learner's permit from age 15 to 16 and the minimum age for an intermediate (restricted) license from age 16 to 17. 2. Expanding the restricted hours for intermediate drivers from between 12 a.m. and 5 a.m. to between 10 p.m. and 5 a.m.
Primary Seat Belt Law	Establish a statutory requirement that allows for primary enforcement of Colorado's adult seat belt law, making it possible to stop a driver and issue a citation if anyone (the driver and all passengers, regardless of seating position) in the vehicle is not properly restrained.
Paid Leave for Families	Support policies that ensure paid leave for families.
Fund Research on Firearm Deaths	Fund firearm research to understand contributing factors for firearm injury and violence, including risk and protective factors, social determinants of observed racial inequities and effective prevention strategies to prevent future firearm deaths.
Delayed School Start (after 8:30 a.m.)	Encourage Colorado's school districts to delay school start times (after 8:30am).

www.cochildfatalityprevention.com/p/reports.html

2013-2017 CFPS Inequity Examples *

- Overall, male infants, children and youth are more likely to die than females (20.1 compared to 12.0).
- Infants, children and youth residing in a frontier county are nearly twice as likely to die as those living in an urban county (29.8 compared to 15.5).
- Black infants and children are more than four times as likely to experience child maltreatment (abuse and neglect) than white infants and children (10.7 compared to 2.6).

*All rates expressed per 100,000



QUALITY, AFFORDABLE HOUSING

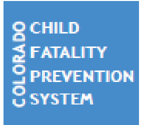
Prevention Recommendation:

SUPPORT POLICIES THAT EXPAND ACCESS TO QUALITY, AFFORDABLE AND STABLE HOUSING ACROSS COLORADO.

Equity considerations:

- Policies must consider affordability and the impacts of gentrification on communities of color and low-income communities.

- While systemic supports like rental assistance can help families access safe, stable, and affordable housing, families must also interact with various systems to access public assistance. Policymakers and agencies should ensure that families do not face undue barriers to accessing vital supports.



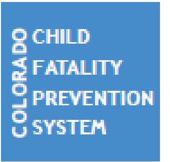
Prevention Recommendation:

STRENGTHEN COLORADO'S GRADUATED DRIVER LICENSING LAW TO BETTER ALIGN WITH BEST PRACTICE BY:

1. Increasing the minimum age for a learner's permit from age 15 to 16 and the minimum age for an intermediate (restricted) license from age 16 to 17.
2. Expanding the restricted hours for intermediate drivers from between 12 a.m. and 5 a.m. to between 10 p.m. and 5 a.m.

Equity considerations:

- There is not equitable access to driver's education in Colorado. Low income families may have difficulty paying for driver's education. Youth living in rural areas may have to travel long distances to access the nearest driving school and may not have broadband internet to access online options.
- Colorado's GDL law requirements are complex, so state agencies and motor vehicle safety partners must write educational materials in plain language and translate them into multiple languages.

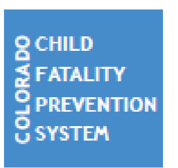


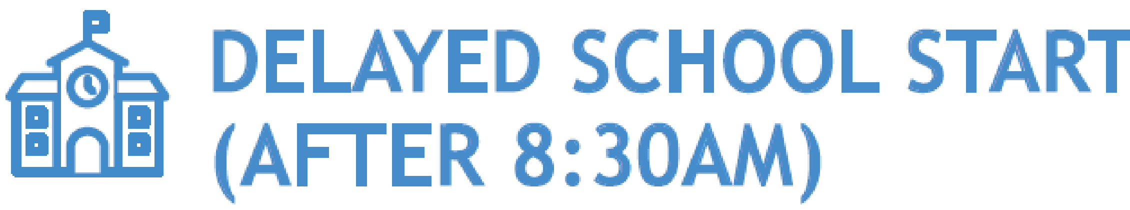
Prevention Recommendation:

SUPPORT POLICIES THAT ENSURE PAID LEAVE FOR FAMILIES.

<u>Equity considerations:</u>

- Paid leave should be accessible to everyone, but is especially important for low-wage workers and caregivers of color, who are less likely to have access to paid leave and are disproportionately impacted by financial pressures associated with unpaid leave.





Prevention Recommendation:

ENCOURAGE COLORADO'S SCHOOL DISTRICTS TO DELAY SCHOOL START TIMES (AFTER 8:30AM).

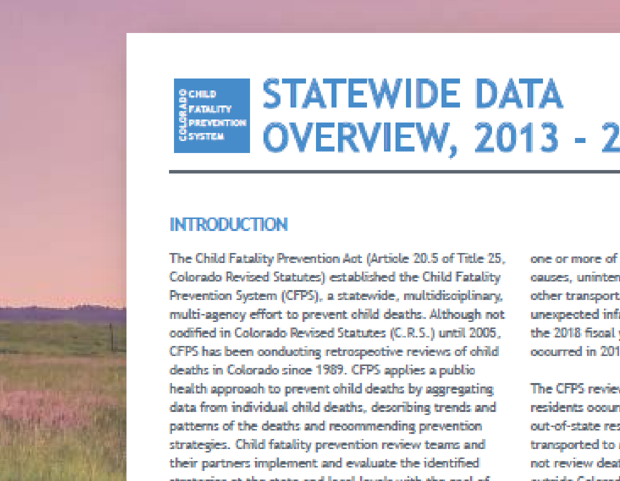
Equity considerations:

- Schools will need to modify bus schedules to accommodate changes in school start times, which may impact school resources.
- For youth who work after school, later start times may also make it challenging to get to an after-school job. Later start times may also create challenges for caregivers who must drop off and pick up students.
- School districts and policymakers need to meaningfully engage families to make sure they are on board with the changes to the school schedule.
- Policymakers need to consider transportation budget to meet changing needs if school start times change.

2013-2017 Data Reports

Statewide and topic-specific reports:

- Sudden unexpected infant death (SUID)
- Motor vehicle
- Suicide
- Child maltreatment
- Firearm deaths
- Drowning
- Unintentional poisoning
- Homicide



COLORADO CHILD FATALITY PREVENTION SYSTEM

STATEWIDE DATA OVERVIEW, 2013 - 2017

INTRODUCTION

The Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) established the Child Fatality Prevention System (CFPS), a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Although not codified in Colorado Revised Statutes (C.R.S.) until 2005, CFPS has been conducting retrospective reviews of child deaths in Colorado since 1989. CFPS applies a public health approach to prevent child deaths by aggregating data from individual child deaths, describing trends and patterns of the deaths and recommending prevention strategies. Child fatality prevention review teams and their partners implement and evaluate the identified strategies at the state and local levels with the goal of preventing similar deaths in the future.

The data presented within this data summary come from comprehensive, statutorily-mandated reviews of deaths among those under 18 years of age occurring in Colorado between 2013 and 2017. Local child fatality prevention review teams are responsible for conducting individual, case-specific reviews of deaths of children meeting the statutory criteria. Reviewable child deaths result from one or more of the following causes: undetermined causes, unintentional injury, violence, motor vehicle and other transportation-related, child maltreatment, sudden unexpected infant death (SUID) and suicide. During the 2018 fiscal year, local teams reviewed deaths that occurred in 2017.

The CFPS review process includes deaths of Colorado residents occurring in Colorado, as well as deaths of out-of-state residents who died in Colorado or were transported to a Colorado hospital and died. CFPS does not review deaths of Colorado residents that occur outside Colorado. These criteria are different from other reports of child fatality data and many other Colorado government data sources. As a result, the data presented in this topic-specific data brief may not match other statistics reported at both the state and national levels. This data brief provides an overview of the state-level data from CFPS. Additional CFPS data is available in cause-specific data briefs and an interactive data dashboard at: www.cochildfatalityprevention.com/p/reports.html.

STRUCTURAL INEQUITY

CDPHE acknowledges that generations-long social, economic and environmental inequities result in adverse health outcomes. They affect communities differently and have a greater influence on health outcomes than either individual choices or one's ability to access health care. Reducing health disparities through policies, practices and organizational systems can help improve opportunities for all Coloradans.[1]

Some families lose infants, children and youth to the types of deaths reviewed by CFPS not as the result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds can also contribute to a child's death.[2] In the United States, most residents grew up and continue to live in racially and economically segregated neighborhoods, which can lead to marginalization.[3,4] This marginalization of groups into segregated neighborhoods further impacts access to high-quality education,[5] employment opportunities,[6] healthy foods[7] and health care.[8] Combined, the economic injustices associated with residential, educational and occupational segregation have lasting health impacts that include adverse birth outcomes,

2 Statewide Data Overview, 2013 - 2017

www.cochildfatalityprevention.com/p/reports.html

STRUCTURAL INEQUITY

CDPHE acknowledges that generations-long social, economic and environmental inequities result in adverse health outcomes. They affect communities differently and have a greater influence on health outcomes than either individual choices or one's ability to access health care. Reducing health disparities through policies, practices and organizational systems can help improve opportunities for all Coloradans.[1]

Some families lose infants, children and youth to the types of deaths reviewed by CFPS not as the result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds can also contribute to a child's death.[2] In the United States, most residents grew up and continue to live in racially and economically segregated neighborhoods, which can lead to marginalization.[3,4] This marginalization of groups into segregated neighborhoods further impacts access to high-quality education,[5] employment opportunities,[6] healthy foods[7] and health care.[8] Combined, the economic injustices associated with residential, educational and occupational segregation have lasting health impacts that include adverse birth outcomes, infant mortality,[9] high rates of homicide and gun violence[10] and increased motor vehicle deaths.[11]

> A note about terminology: While "Latinx" is becoming the preferred way to identify people of Latin descent, this report uses "Hispanic" throughout the data section to reflect how CFPS data is collected and to align with terminology used in cited literature and research.[12]

When interpreting the data, it is critical not to lose sight of these systemic, avoidable and unjust factors. These factors perpetuate the inequities that we observe in child deaths across populations in Colorado. Research is making progress in understanding how race and ethnicity, economic status, sexual orientation and gender identity correlate with health. It is critical that data systems like CFPS identify and understand the life-long inequities that persist across groups in order to eradicate them.

Structural Inequity.

Some families lose infants, children and youth to the types of deaths reviewed by CFPS not as the result of the actions or behaviors of those who died, or their parents or caregivers.

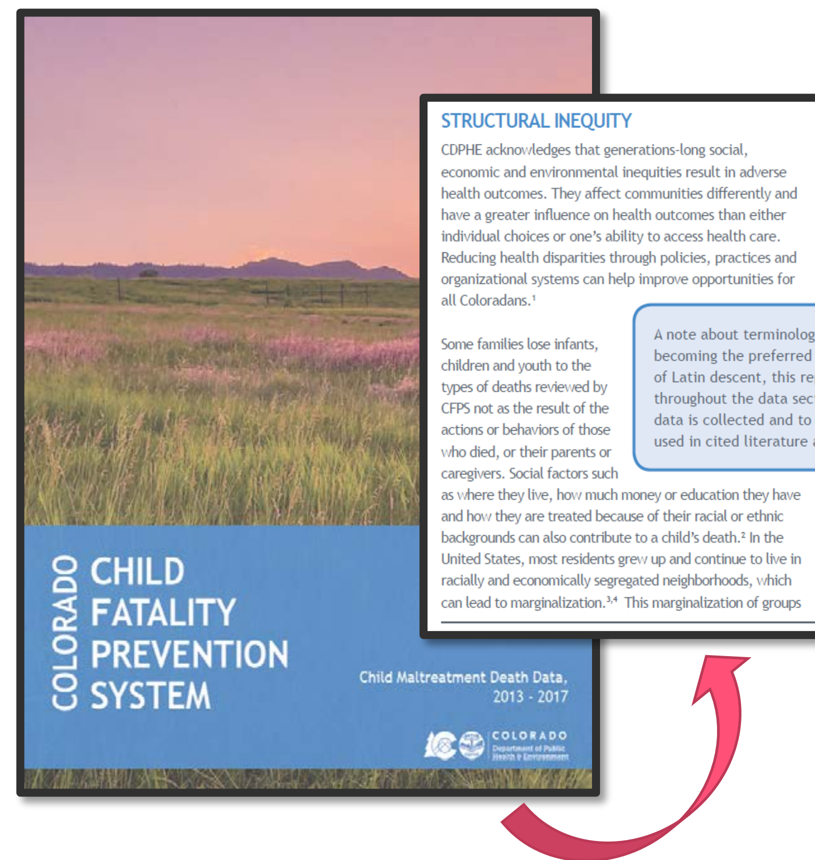
Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds can also contribute to a child's death.

Residential segregation impacts access to high-quality education, employment opportunities, healthy foods and health care.

Combined, the economic injustices associated with residential, educational and occupational segregation have lasting health impacts that include adverse birth outcomes, infant mortality, high rates of homicide and gun violence and increased motor vehicle deaths.

2013-2017 Racial & Ethnic Inequities: Child Maltreatment

The rate of death due to child maltreatment among non-Hispanic black infants, children and youth was *4.1x* higher than for non-Hispanic whites.



STRUCTURAL INEQUITY

CDPHE acknowledges that generations-long social, economic and environmental inequities result in adverse health outcomes. They affect communities differently and have a greater influence on health outcomes than either individual choices or one's ability to access health care. Reducing health disparities through policies, practices and organizational systems can help improve opportunities for all Coloradans.[1]

Some families lose infants, children and youth to the types of deaths reviewed by CFPS not as the result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of their racial or ethnic backgrounds can also contribute to a child's death.[2] In the United States, most residents grew up and continue to live in racially and economically segregated neighborhoods, which can lead to marginalization.[3,4] This marginalization of groups

into segregated neighborhoods further impacts access to
high-quality education,[5] employment op
foods[7] and health care.[8] Combined, the
associated with residential, educational
segregation have lasting health impacts
birth outcomes, infant mortality,[9] high r
gun violence[10] and increased motor vehi

> A note about terminology: While "Latinx" is becoming the preferred way to identify people of Latin descent, this report uses "Hispanic" throughout the data section to reflect how CFPS data is collected and to align with terminology used in cited literature and research.[12]

When in
data, it
to lose s
systemic
unjust f
factors p
inequitie
in child
populations in Colorado. Research is
understanding how race and ethnicit
sexual orientation and gender identit
health. It is critical that data system
and understand the life-long inequiti
across groups in order to eradicate t

RACIAL AND ETHNIC INEQUITIES

There is a significant inequity in the rate of child maltreatment deaths by race and ethnicity in Colorado. The rate of child maltreatment deaths among non-Hispanic black infants, children and youth was 4.1 times higher (10.7 per 100,000 population) than for non-Hispanic whites (2.6 per 100,000 population). The rate of child maltreatment deaths among Hispanic infants, children and youth was 1.2 times higher (3.1 per 100,000 population) than for non-Hispanic whites, although this difference was not statistically significant.

Traditionally, individual level factors of caregivers have been shown to contribute to the racial differences in deadly child maltreatment, including low educational attainment, low income, inadequate employment, intimate partner violence and history of abuse as a child.[13] However, studies examining these individual-level factors have failed to fully explain the racial differences. Instead, research highlights the role that social determinants and contextual factors, particularly community and environmental inequities, play in child maltreatment prevention.[14]

Racialized residential segregation can lead to the racial and ethnic inequities in various child fatalities including child maltreatment deaths. These inequities are largely driven by discriminatory federal, state and local policies, such as redlining, that create unjust geographic divisions among racial and ethnic groups.[15] Racial segregation leads to neighborhood disadvantage by concentrating neighborhood poverty, increasing exposure to environmental stressors such as air pollutants, creating barriers to and fewer opportunities for a healthy lifestyle, limiting access to health services and increasing housing and food insecurity.[16] The consequences of residential segregation resulting from historical practices like redlining are still reverberating throughout communities of color today. In the United States, Hispanic families are significantly more likely to reside in segregated neighborhoods with higher rates of social isolation and lack of access to resources.[17,18] Similarly, black families are likely to live in communities that are highly segregated with limited access to basic needs assistance, mental health and substance abuse treatment and opportunity for employment.[19] Data show 19.9 percent of black and 19.3 percent of Hispanic Coloradoans live below the poverty level, compared to 8.5 percent of non-Hispanic white Coloradans.[20,21] This structural injustice which many black and Hispanic families unjustly experience may partly explain the inequities around child maltreatment deaths.

A significant amount of research has documented that racial and ethnic minority populations are overrepresented in the child welfare system, compared with the general population. Studies have consistently found that black infants, children and youth are more likely to be the subject of child maltreatment reports and substantiations than non-Hispanic whites.[22] Possible explanations for this have included 1) disparate needs of children and families of color, particularly due to higher rates of poverty, 2) racial bias and discrimination by caseworkers, mandatory reporters and the general public and 3) lack of resources for families of color in the child welfare system and other similar factors.[23] Studies have found no relationship between race and incidents of child maltreatment after controlling for poverty.[24] Instead, child abuse and neglect is strongly associated with poverty and other measures of economic well-being.[25]

Families of color inequitably and disproportionately experience poverty in the United States, manifesting the higher prevalence of abuse and neglect compared to non-Hispanic white families. Experiencing poverty may also amplify exposure to the social service system (e.g. financial or housing assistance) and increase exposure to mandatory reporters, an idea referred to as visibility or exposure bias.[26] This research urges an emphasis on social factors such as poverty, rather than a focus on bias within the child welfare system.

While we have made progress in understanding the overrepresentation of children and youth of color within the child welfare system,[27,28,29] it remains critical to identify, understand, and eradicate the life-long inequities that persist across racial and ethnic groups that contribute to child maltreatment.[30]

6 Child Maltreatment Death Data, 2013 - 2017

RACIAL AND ETHNIC INEQUITIES

There is a significant inequity in the rate of child maltreatment deaths by race and ethnicity in Colorado. The rate of child maltreatment deaths among non-Hispanic black infants, children and youth was 4.1 times higher (10.7 per 100,000 population) than for non-Hispanic whites (2.6 per 100,000 population). The rate of child maltreatment deaths among Hispanic infants, children and youth was 1.2 times higher (3.1 per 100,000 population) than for non-Hispanic whites, although this difference was not statistically significant.

Traditionally, individual level factors of caregivers have been shown to contribute to the racial differences in deadly child maltreatment, including low educational attainment, low income, inadequate employment, intimate partner violence and history of abuse as a child.[13] However, studies examining these individual-level factors have failed to fully explain the racial differences. Instead, research highlights the role that social determinants and contextual factors, particularly community and environmental inequities, play in child maltreatment prevention.[14]

Racialized residential segregation can lead to the racial and ethnic inequities in various child fatalities including child maltreatment deaths. These inequities are largely driven by discriminatory federal, state and local policies, such as redlining, that create unjust geographic divisions among racial and ethnic groups.[15] Racial segregation leads to neighborhood disadvantage by concentrating neighborhood poverty, increasing exposure to environmental stressors such as air pollutants, creating barriers to and fewer opportunities for a healthy lifestyle, limiting access to health services and increasing housing and food insecurity.[16] The consequences of residential segregation resulting from historical practices like redlining are still reverberating throughout communities of color today. In the United States, Hispanic families are significantly more likely to reside in segregated neighborhoods with higher rates of social isolation and lack of access to resources.[17,18] Similarly, black families are likely to live in communities that are highly segregated with limited access to basic needs assistance, mental health and substance abuse treatment and opportunity for employment.[19] Data show 19.9 percent of black and 19.3 percent of Hispanic Coloradoans live below the poverty level, compared to 8.5 percent of non-Hispanic white Coloradans.[20,21] This structural injustice which many black and Hispanic families unjustly experience may partly explain the inequities around child maltreatment deaths.

A significant amount of research has documented that racial and ethnic minority populations are overrepresented in the child welfare system, compared with the general population. Studies have consistently found that black infants, children and youth are more likely to be the subject of child maltreatment reports and substantiations than non-Hispanic whites.[22] Possible explanations for this have included 1) disparate needs of children and families of color, particularly due to higher rates of poverty, 2) racial bias and discrimination by caseworkers, mandatory reporters and the general public and 3) lack of resources for families of color in the child welfare system and other similar factors.[23] Studies have found no relationship between race and incidents of child maltreatment after controlling for poverty.[24] Instead, child abuse and neglect is strongly associated with poverty and other measures of economic well-being.[25]

Families of color inequitably and disproportionately experience poverty in the United States, manifesting the higher prevalence of abuse and neglect compared to non-Hispanic white families. Experiencing poverty may also amplify exposure to the social service system (e.g. financial or housing assistance) and increase exposure to mandatory reporters, an idea referred to as visibility or exposure bias.[26] This research urges an emphasis on social factors such as poverty, rather than a focus on bias within the child welfare system.

While we have made progress in understanding the overrepresentation of children and youth of color within the child welfare system,[27,28,29] it remains critical to identify, understand, and eradicate the life-long inequities that persist across racial and ethnic groups that contribute to child maltreatment.[30]

1. State the inequity.
2. Point out structural factors that contribute to the inequity.
3. Supplement CFPS data with other data sources. For example:
   - American Community Survey (ACS)
   - Behavioral Risk Factor Surveillance System (BRFSS)
   - Pregnancy Risk Assessment Monitoring System (PRAMS)
   - Youth Risk Behavior Surveillance System (YRBSS)

Room for Growth

- Embedding equity considerations into prevention recommendations rather than listing at the end
- Additional context for racial and ethnic inequities
  - This year we focused on residential segregation, but did not include much information on the chronic stress of experiencing racism and discrimination over a lifetime and how that contributes to the inequities we observe in our data.
- Urban/Rural inequities
- LGBTQ+ inequities
  - Youth suicide, motor vehicle deaths, homicide

LGBTQ+ Inequities

- Creating inclusive spaces with the use of third-person pronouns during meetings with internal and external partners
- Improving data collection on sexual orientation and gender identity (SOGI) during child fatality reviews
  - Added SOGI questions to the National Center for Fatality Review and Prevention's Case Reporting System
  - Developed a guidance document for local child fatality review teams to use when discussing SOGI during child fatality reviews.

Child Fatality Guidance

Guidance to use when discussing Sexual Orientation and Gender Identity within Child Fatality Reviews

Lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+) youth experience inequities related to several of the leading causes of death reviewed by the Colorado Child Fatality Prevention System (CFPS), including suicide and motor vehicle deaths. These inequities in deaths by sexual orientation and gender identity exist because our culture and systems are dominated by heterosexual and cisgender norms. This social context results in LGBTQ+ people experiencing discrimination, stigma, and bias, including rejection from family, friends, and community, as well as limited access to LGBTQ+ informed healthcare. **In order to better understand these inequities and address the unique needs of LGBTQ+ people, it is critical to gather complete and standardized data about sexual orientation and gender identity.**

Questions?

Please enter your questions in the Q & A pod

Sasha.Mintz@state.co.us
303-692-2306

Thank you!

Please fill out our evaluation: https://go.edc.org/CSNA-Webinar-Feedback

Visit our website:

www.ChildrensSafetyNetwork.org