CSN Children's Safety Network

EDC Education Development Center

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Partnering for Child Safety: Fatality Review Teams and State Title V Programs

Moderator

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Impact Research Inc.

Funding Sponsor

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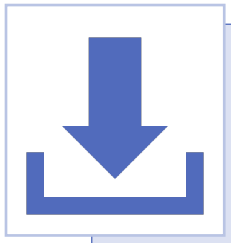
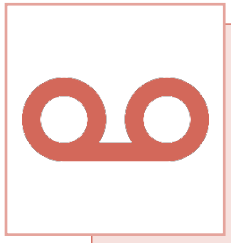


Download resources in the File Share pod (above the slides)

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



This session is being recorded

Speakers

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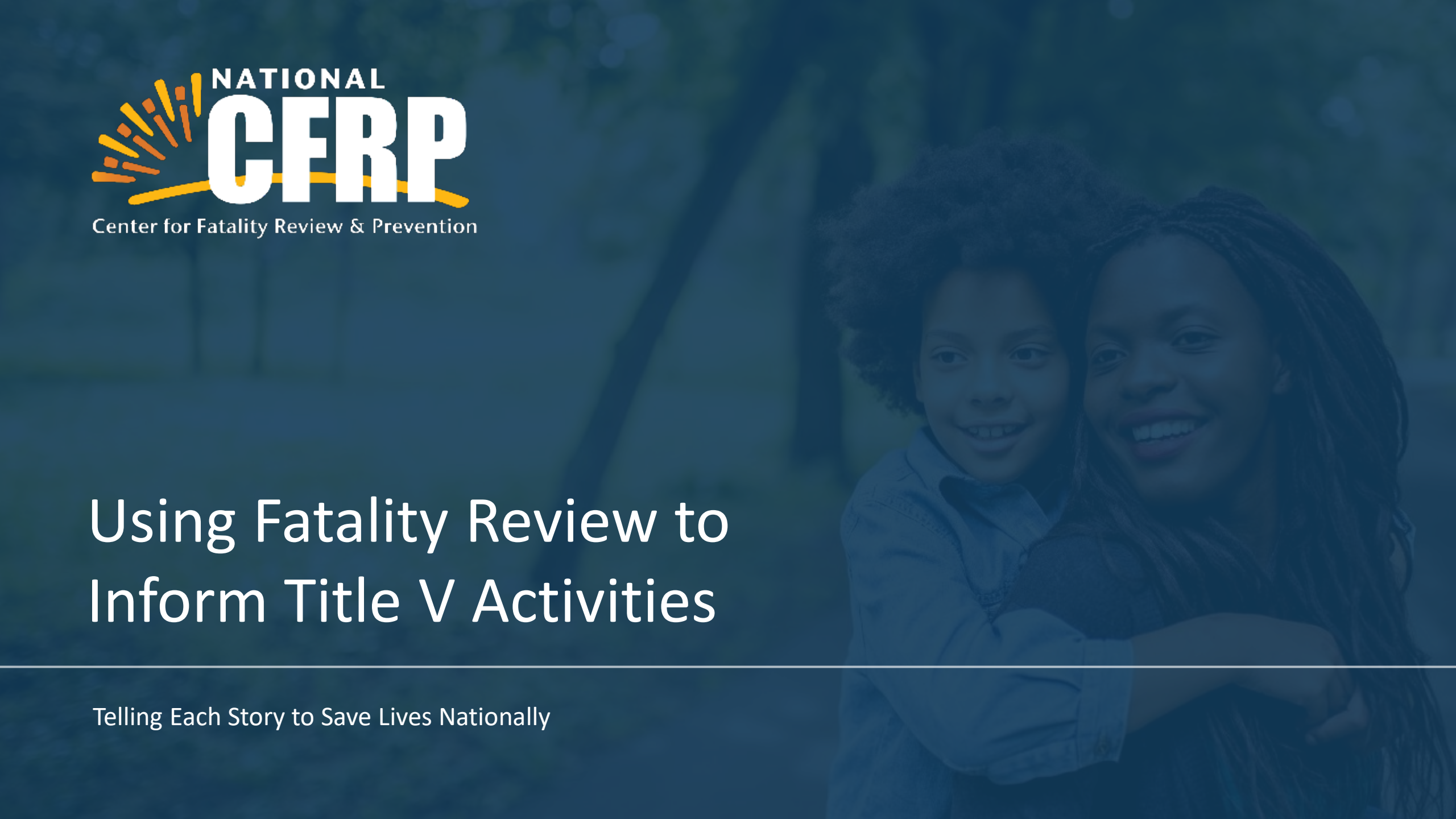
Karen Nash, MBA

Project Manager

Children's Health Alliance of Wisconsin

NATIONAL CFRP

Center for Fatality Review & Prevention



Using Fatality Review to Inform Title V Activities

Telling Each Story to Save Lives Nationally

KEY FUNDING PARTNER

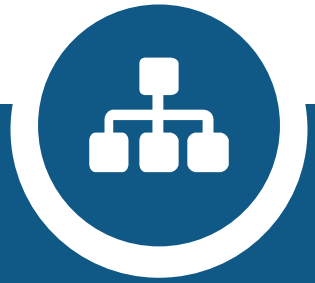
FEDERAL ACKNOWLEDGEMENT

The National Center is funded in part by Cooperative Agreement Numbers UG7MC28482 and UG7MC31831 from the US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) as part of an award totaling $1,099,997 annually with 0 percent financed with non-governmental sources. Its contents are solely the responsibility of the authors 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.

Presentation Goals

Overview of CDR, FIMR, and NFR-CRS

Explain CDR and FIMR processes, goals, membership, data collection, and role of family interviews



Resources Promoting Collaboration

Explain how

Wisconsin Example

Overview of how Wisconsin has built collaboration between fatality review and Title V

Technical Assistance and Training

On-site, virtual and/or recorded assistance, customized for each jurisdiction, is provided to CDR and FIMR teams.

National Fatality Review-Case Reporting System

Support the NFR-CRS which is used in 48 states and provides jurisdictions with real-time access to their fatality review data.

Resources

Training modules, webinars, written products, newsletters, list-serv, website and more.

Communication with Fatality Review Teams

Regular communication via listserv, newsletters and regional coalitions.

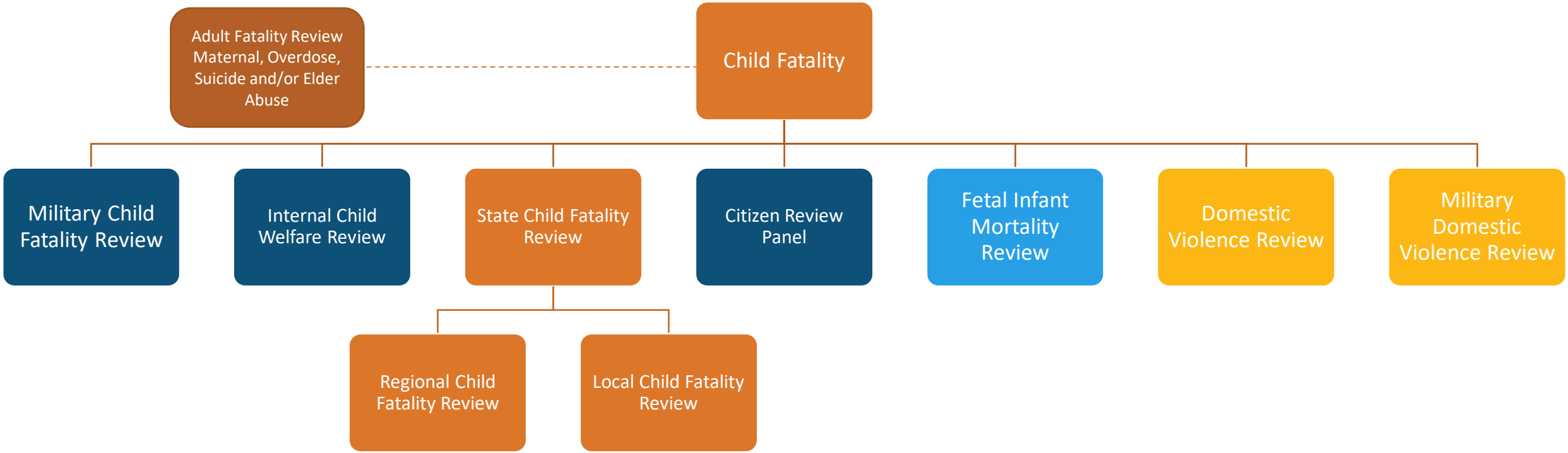
Follow Us on Social Media

@NationalCFRP on Twitter and Facebook.

ABOUT THE NATIONAL CENTER

The Web of Reviews

Intentional Connections to Improve Health and Safety



OVERVIEW OF CDR, FIMR, AND National Fatality Review-Case Reporting System

Identification of Deaths

Ensure the accurate identification and uniform, consistent reporting of the cause and manner of death

Agency Communications

Improve agency communications and linkages that enhance coordination

Agency Responses

Improve agency investigations, responses to protect siblings and investigations

Findings and Recommendations

Identify opportunities for improving systems including identifying barriers, risk factors and trends

Advocate for Change

Advocate for changes in policy, practice and legislation that improves the health and safety of the community

ESSENTIAL ELEMENTS

FOCUS ON PREVENTION

MULTIDISCIPLINARY

Engage a broad, yet targeted, group of stakeholders to tell the child's story with a focus on identifying systems gaps

STAY FOCUSED ON PREVENTION

Identify findings and use them to write recommendations while finding the balance between taking action on individual cases and using data

WHAT IS CDR?

Understanding Fatalities to Improve Safety

- Multidisciplinary, community-oriented process that brings together professionals to understand how and why children die.
- Illuminates where systems are successful in working together as well as opportunities for improvement.
- Uncovers disparities in how families are offered resources, access services and navigate systems.
- Prevention-focused program that seeks to keep kids alive.

CDR Process

Best Practices in Reviews

What is FIMR?

A multidisciplinary, community process that examines cases of fetal & infant deaths that is: Comprehensive, de-identified, confidential, and **gives voice to parents/families' experiences**. FIMR is **Continuous Quality Improvement**

Changes in Community Systems

As the physical, health care and social environment for childbearing families improves, outcomes, over time, will be better.

Data Gathering

Information is collected from a variety of sources, including family/parental interview, medical records, pre-natal care, home visits, WIC, and other social services.

Community Action

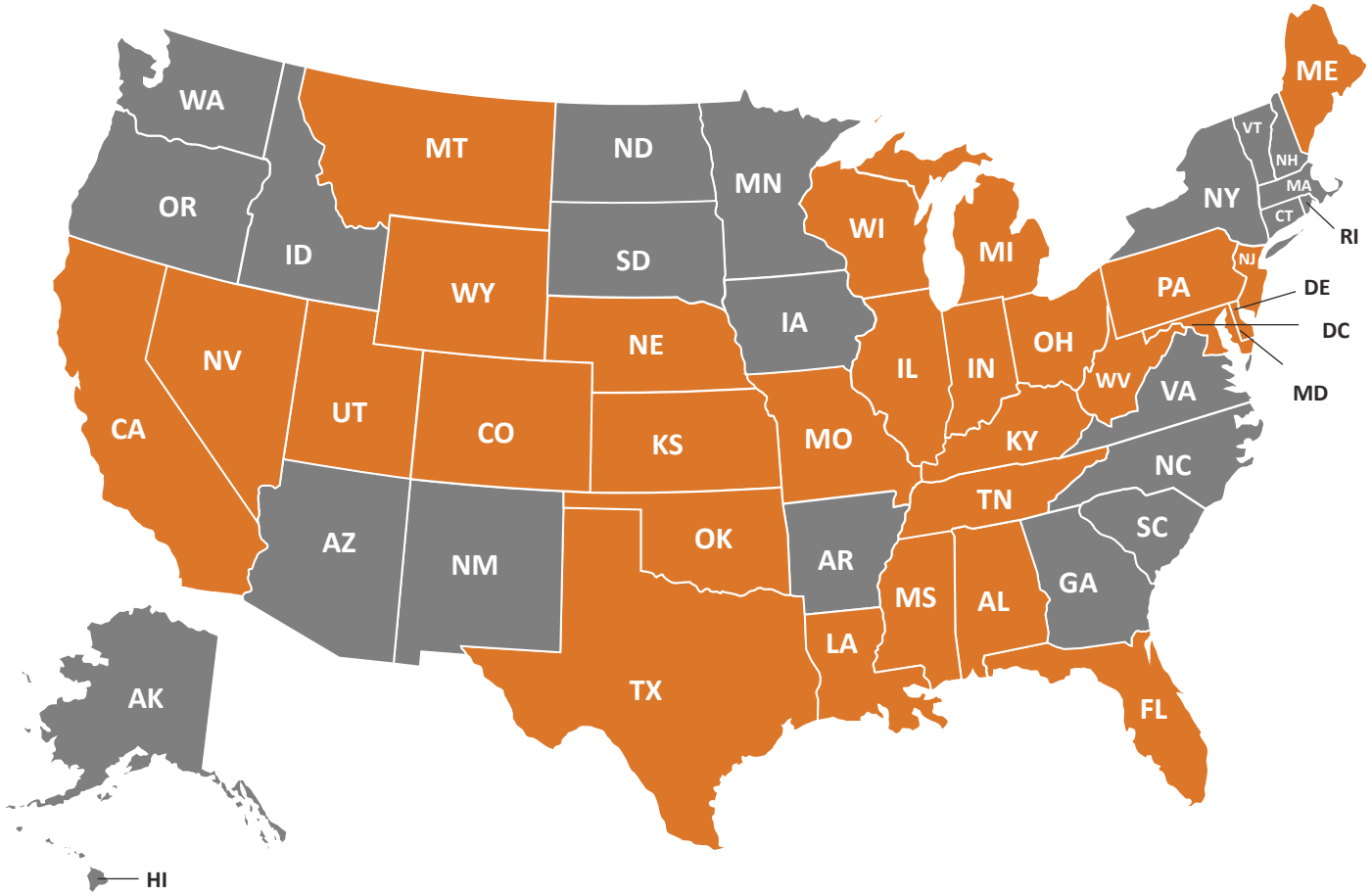
The Community Action team receives the recommendations from the review team and is charged with developing and implementing plans leading to positive change within the community.

Case Review

The multidisciplinary team reviews the case to identify barriers to care and trends in service delivery and ideas to improve policies and services that affect families.

FIMR Programs

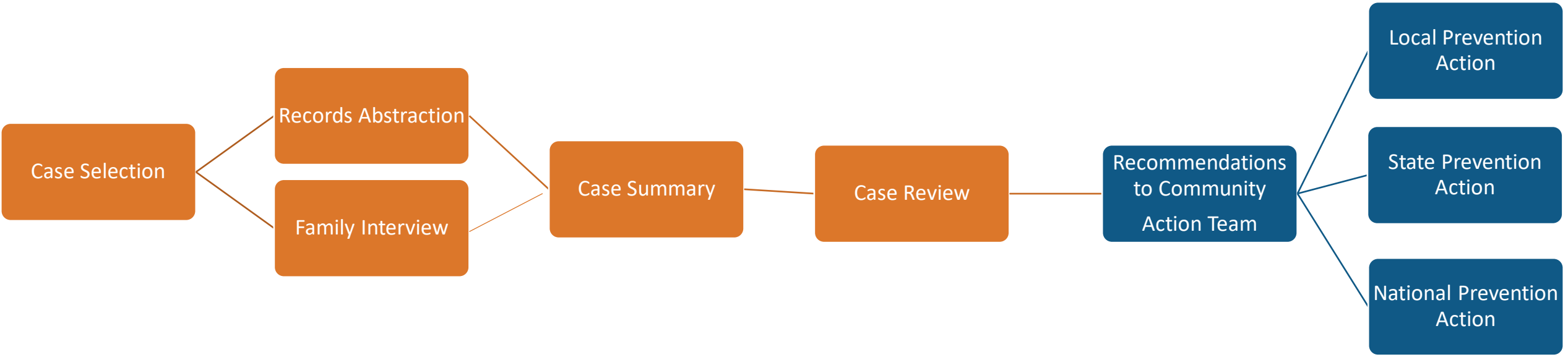
161 FIMR programs in 28 states, Puerto Rico and CNMI are reviewing fetal and infant deaths



States with FIMR Programs

FIMR Process

Best Practices in Reviews



National Fatality Review-Case Reporting System

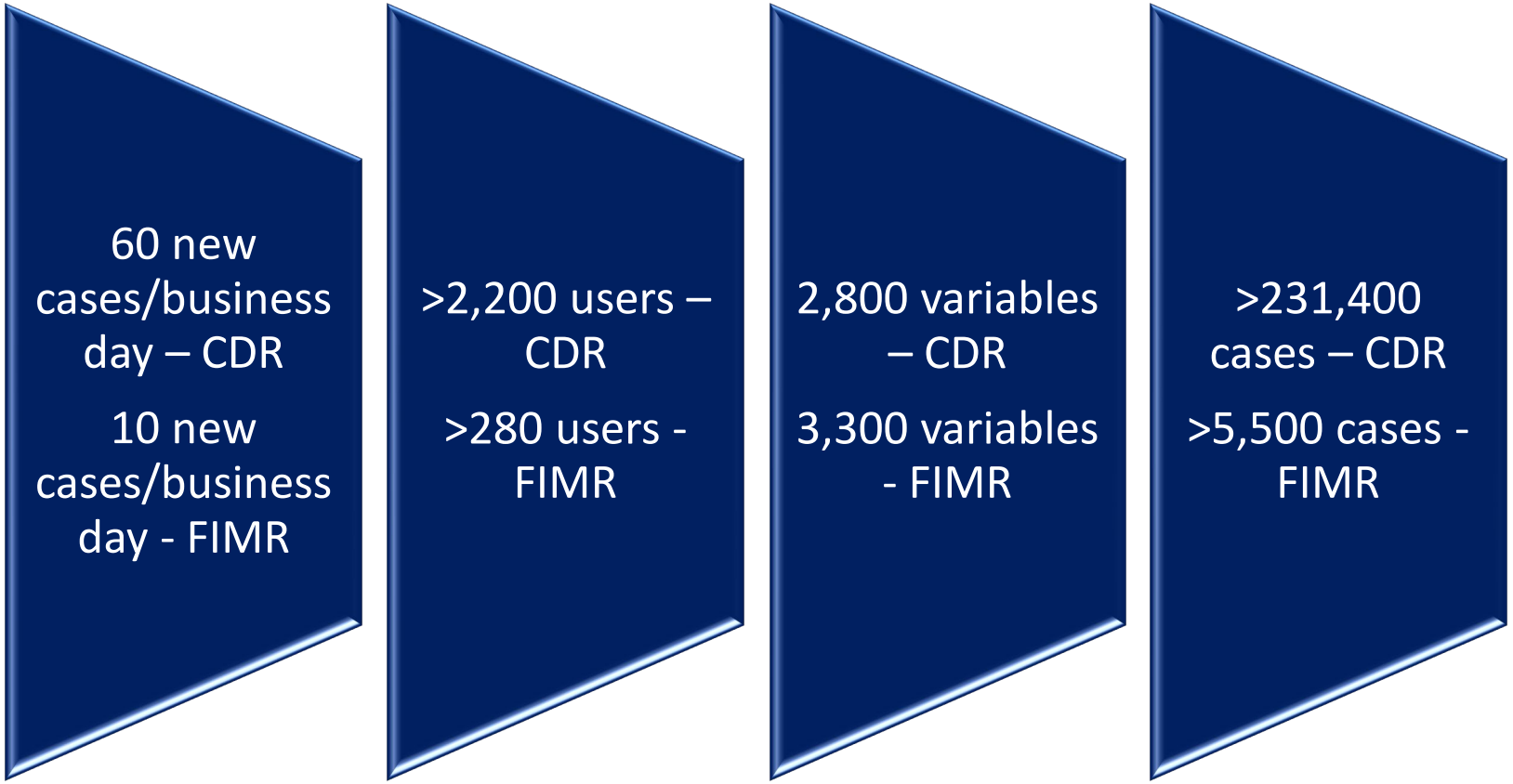
A National Tool for CDR and FIMR Teams

The purpose of NFR-CRS is to systematically collect, analyze, and report comprehensive fatality review data that includes:

- Information about the fetal, infant or child and their family, supervisor at the time of the incident and person responsible (when applicable)
- Services needed, provided, or referred
- Risk and protective factors
- Findings and recommendations
- Factors affecting the quality of the review meeting

By the Numbers: NFR-CRS

How NFR-CRS is Used in the Field



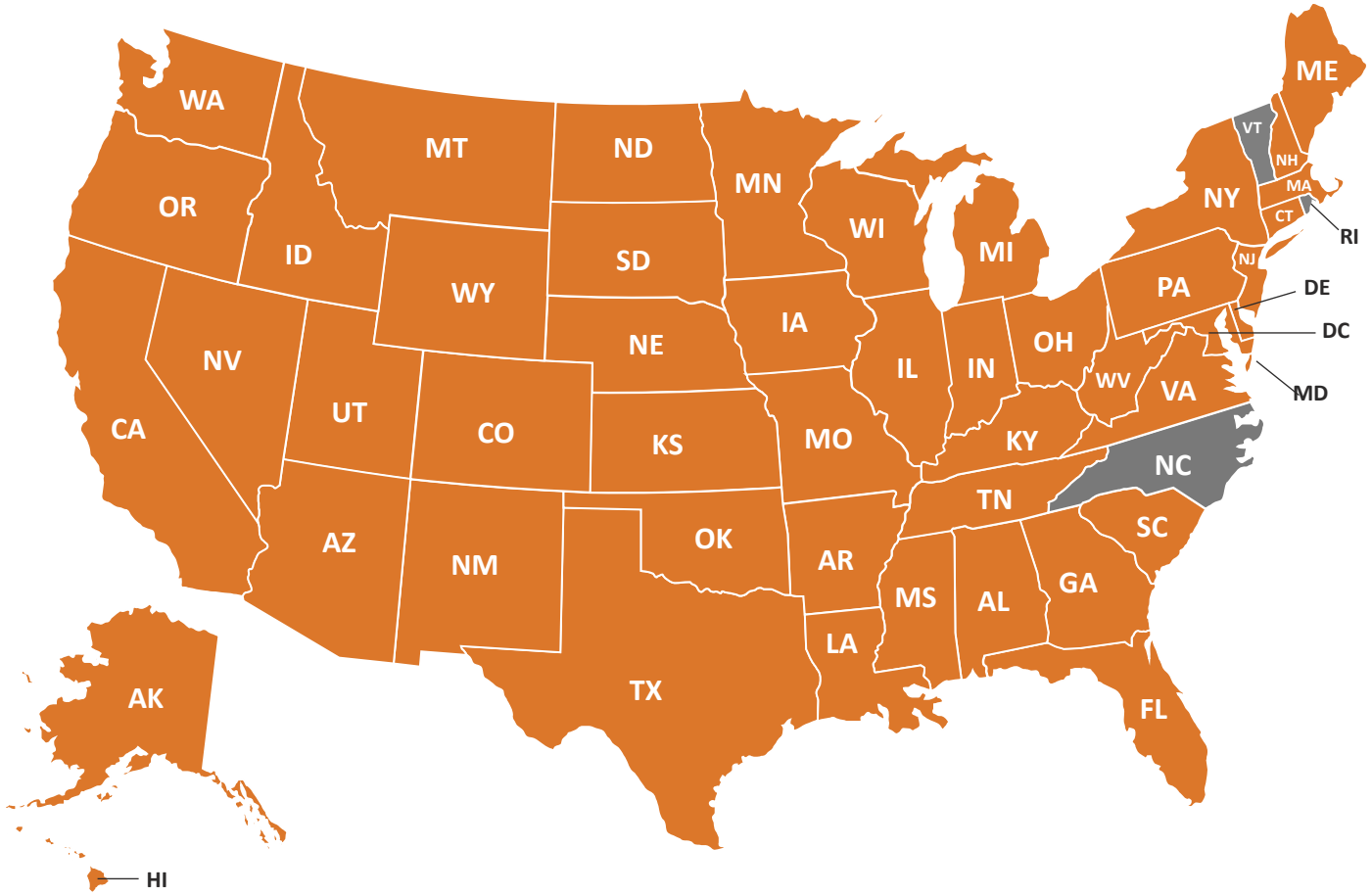
States Using NFR-CRS

There are currently 48 states using NFR-CRS

47 use NFR-CRS for CDR
19 use NFR-CRS for FIMR

Each state uses NFR-CRS differently. Some have comprehensive reviews whereas others may only use NFR-CRS in one jurisdiction.

NFR-CRS data are used at the national level to describe how and why children die. Example in recently released Quick-Look on Sleep-Related Infant Deaths URL: https://www.ncfrp.org/wp-content/uploads/Sleep-related-Quick-Look_print.pdf



States Using NFR-CRS

RESOURCES FOR BUILDING COLLABORATION

Examples in Maternal Smoking, Infant Safe Sleep, and Adolescent Mental Health

Fatality Review Adds Value

Title V Programs can Benefit from Fatality Review Data, Findings, and Recommendations

Providing Context through Review and Data Collection: Identifies how systems worked together and exposes structural barriers and gaps.

Prevention: Collects unique data collection provides an additional layer of understanding.

Community Engagement & Partnerships: Cultivates diverse stakeholders who develop findings that reach across systems.

Health Disparities: Illuminates disparities and identify populations at the most significant risk for a poor outcome.

Adolescent Mental Health

For this report, the youth were divided into three categories:

1. *Youth whose manner of death was listed as accident or homicide on death certificates AND the youth had no documented mental health history. There were 3,224 youth in this category.* [15]

2. *Youth whose manner of death was listed as accident or homicide on death certificates AND the youth had a documented mental health history. There were 1,375 youth in this category.*

3. *Youth whose manner of death on death certificates was listed as a suicide. There were 6,732 youth in this category.*

According to the American Academy of Pediatrics stages of adolescence, the three existing groups were further divided into two subcategories: early adolescence (ages 10-13) and middle adolescence (ages 14-17).[16]

Adolescent Mental Health: Race/Ethnicity

Data Source: NFR-CRS, Excludes Missing and Unknown Data

	Manner of Death was Accident or Homicide AND No Mental Health History Documented		Manner of Death was Accident or Homicide AND Mental Health History Documented		Manner of Death was Suicide	
	Early Adolescence ages 10-13	Middle Adolescence ages 14-17	Early Adolescence ages 10-13	Middle Adolescence ages 14-17	Early Adolescence ages 10-13	Middle Adolescences ages 14-17
Ethnicity/Race						
Hispanic	17%	18%	13%	15%	15%	16%
Non-Hispanic White	52%	49%	54%	48%	60%	68%
Non-Hispanic Black	25%	27%	27%	32%	18%	9%
Other Race	6%	5%	5%	4%	7%	8%
Sex						
Female	38%	29%	24%	28%	35%	28%
Male	62%	71%	77%	72%	65%	72%

Adolescent Mental Health: Child Maltreatment

Data Source: NFR-CRS, Excludes Missing and Unknown Data

	Manner of Death was Accident or Homicide AND No Mental Health History Documented		Manner of Death was Accident or Homicide AND Mental Health History Documented		Manner of Death was Suicide	
	Early Adolescence ages 10-13	Middle Adolescence ages 14-17	Early Adolescence ages 10-13	Middle Adolescence ages 14-17	Early Adolescence ages 10-13	Middle Adolescences ages 14-17
Maltreatment						
History as a Victim of Maltreatment	23%	21%	63%	59%	35%	34%
Family had Open CPS Case at Time of Death	4%	3%	19%	16%	7%	6%
Child Placed Outside of Home Prior to Death	6%	6%	33%	35%	12%	13%
CPS Record Check Conducted as a Result of the Death	60%	50%	66%	58%	67%	54%
Abuse, Neglect, Poor Supervi-sion, or Exposure to Hazards Contributed to Death	41%	19%	47%	32%	17%	15%
School						
Child Had History of Problems in School	10%	23%	73%	84%	60%	57%

Adolescent Mental Health: Historical Information

Data Source: NFR-CRS, Excludes Missing and Unknown Data

	Manner of Death was Accident or Homicide AND No Mental Health History Documented		Manner of Death was Accident or Homicide AND Mental Health History Documented		Manner of Death was Suicide	
	Early Adolescence ages 10-13	Middle Adolescence ages 14-17	Early Adolescence ages 10-13	Middle Adolescence ages 14-17	Early Adolescence ages 10-13	Middle Adolescences ages 14-17
Mental Health and Substance Use History						
History as a Victim of Maltreatment	23%	21%	63%	59%	35%	34%
Family had Open CPS Case at Time of Death	4%	3%	19%	16%	7%	6%
Child Placed Outside of Home Prior to Death	6%	6%	33%	35%	12%	13%
CPS Record Check Conducted as a Result of the Death	60%	50%	66%	58%	67%	54%
Abuse, Neglect, Poor Supervision, or Exposure to Hazards Contributed to Death	41%	19%	47%	32%	17%	15%
Criminal or Delinquent History						
History of criminal and/or delinquent activities	3%	19%	12%	61%	8%	23%

Smoking During Pregnancy (NPM 14.1)

A Tool for Title V Programs

- 91 percent of mothers received health education **between 1st prenatal visit and delivery**; only 37 percent reported education on tobacco use
- 94 percent of families received health education **between hospital admission and discharge**; only 19 percent reported education on tobacco use
- 52 percent of families were **referred to social services**; only 7 percent had documented referrals to smoking cessation
- Mothers who smoked during pregnancy **reported higher rates of**:
  - Financial problems
  - Involvement in physical fight
  - Someone close to them having a substance use problem
  - Experiencing physical abuse
- In cases where a parental interview was conducted, **52 percent mothers who smoked during pregnancy reported experiencing ACEs** whereas 24 percent of nonsmoking mothers reported ACES.

CONTACT INFORMATION

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Questions?

Please enter your questions in the Q & A pod

Partnering with the Department of Health Services to Promote Fatality Review

Karen Nash
Project Manager
Children's Health Alliance of Wisconsin

Children's Health Alliance of Wisconsin

WISCONSIN ASTHMA COALITION
Children's Health Alliance of Wisconsin

EMSC Emergency Medical Services for Children WISCONSIN
Children's Health Alliance of Wisconsin

Infant Death Center
Children's Health Alliance of Wisconsin

Keeping Kids Alive IN WISCONSIN
Children's Health Alliance of Wisconsin

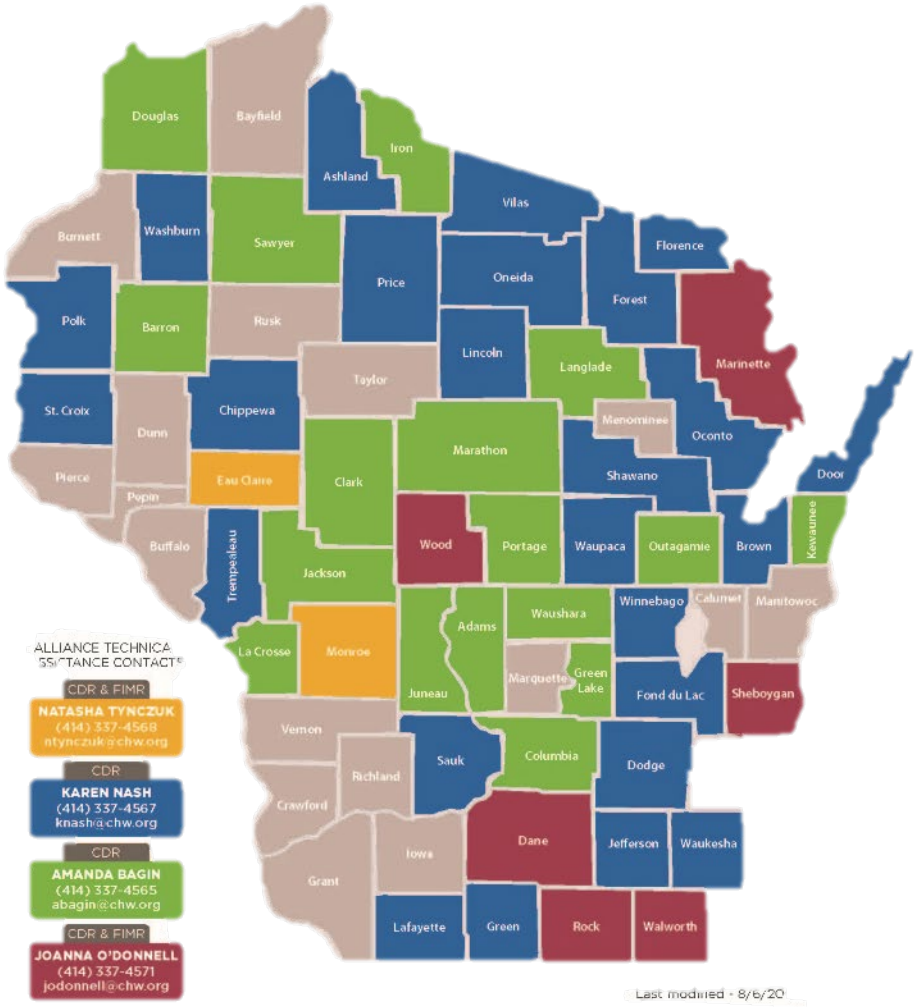
WISCONSIN Medical Home
Children's Health Alliance of Wisconsin

Oral Health
Children's Health Alliance of Wisconsin

Keeping Kids Alive N Wisconsin
Children's Health Alliance of Wisconsin

DEATH REVIEW TEAMS

ALLIANCE STAFF TECHNICAL ASSISTANCE CONTACTS BY COUNTY



Local Teams Need Support

- Must have technical assistance
- Must have champions to re-enforce the collective good statewide
- Must have backbone support to ensure continuity and integrity of the process

Benefits of CDR

- Encourages collaboration with key community partners
- Promotes systems level changes
- Raises awareness about important issues
- Utilizes data to highlight the burden of injury
- Drives action

Influences Prevention

- Information is shared among partners
- Data is transformed and analyzed
- Identify protective factors to prevent similar deaths

sleep baby safe

Children's Health Alliance of Wisconsin

Sleep Baby Safe

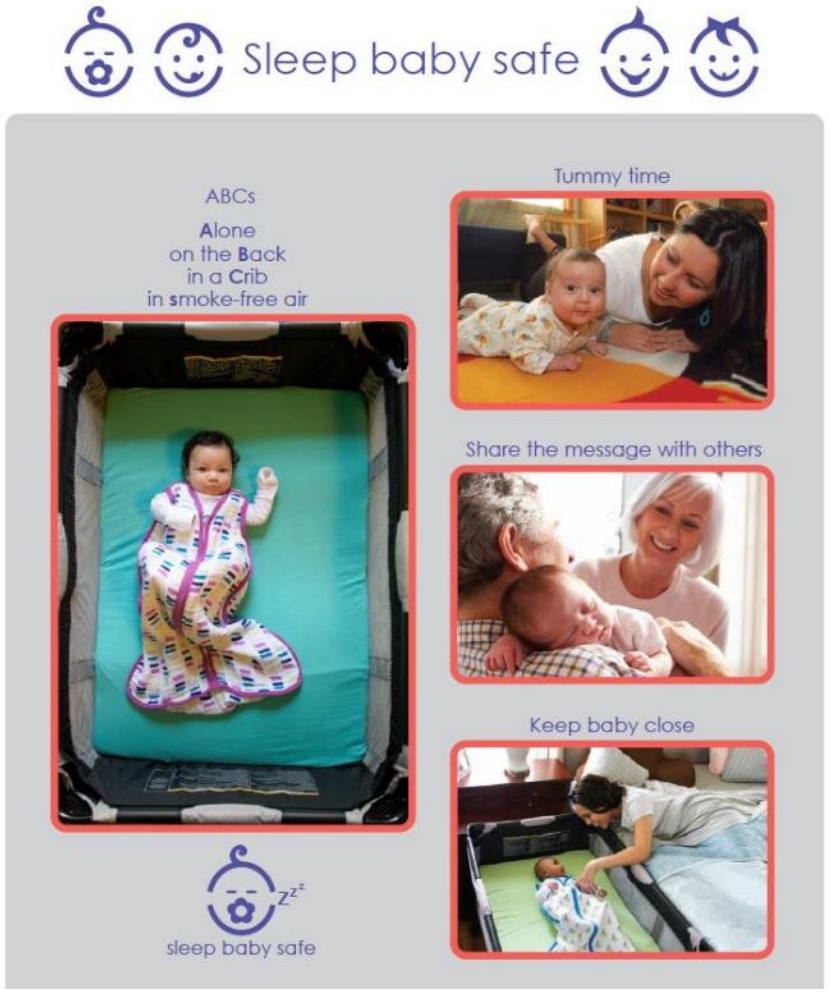
A training for professionals working with families

(guiding conversations with families to ensure their babies thrive)

Objectives

- **Why it matters:** Understand research and "why" behind safe sleep recommendations
- **Play it safe:** Know and share safe sleep recommendations from American Academy of Pediatrics (AAP)
- **Let's talk:** Engage in conversations with caregivers about baby's sleep environment

Sleep Baby Safe Resources



- Grief and bereavement support
- Established in 1980
- Notification of SUID cases by MEs and coroners

Questions and thank you

Karen Nash
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Follow the Alliance on Facebook and Twitter @CHAWisconsin

Questions?

Please enter your questions in the Q & A pod

Upcoming Webinar

Farm Safety for Children and Youth: Risks and Rewards will be held on Thursday, March 4, at 3:00 PM ET.

Register here: https://go.edc.org/Register-FarmSafety

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at Education Development Center

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