

The Coordination & Integration of Fatality Reviews:

Improving Health & Safety Outcomes Across the Life Course

**Findings from the National Invitational Meeting
December 7-8, 2011**

*A Report to the Maternal and Child Health Bureau,
Health Resources Services Administration, U.S. Department of Health and Human Services*



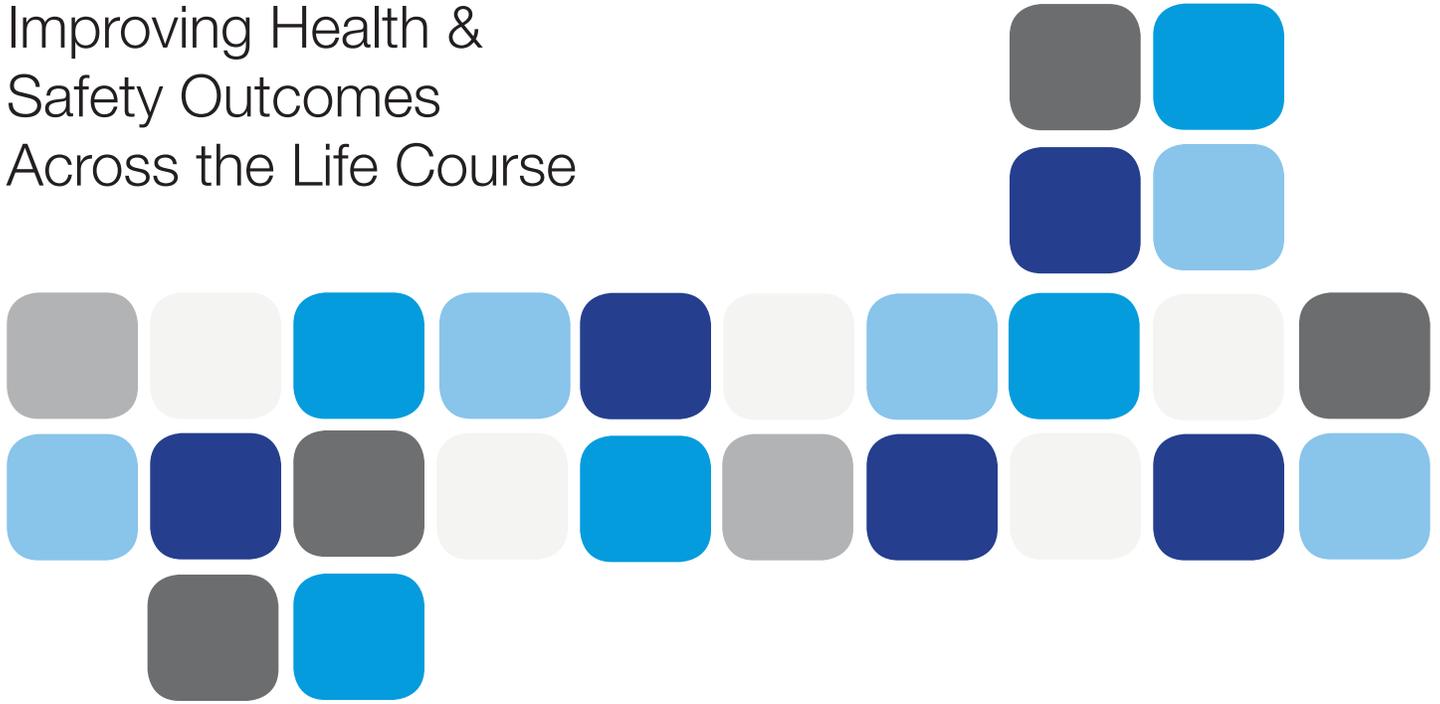
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Prepared by:
The National Center for the Review and Prevention of Child Deaths
at the Michigan Public Health Institute

Executive Summary

Unexpected and untimely deaths of infants, children, adolescents and adults are opportunities to turn tragedies into lessons to prevent other deaths.

Understanding the circumstances of and taking action to prevent these deaths is the work of fatality review programs. These programs help to uncover the reasons why each year in the United States:

- At least half of the 55,000 children who die before age 19 die from preventable causes;
- At least 1,770 children die from child abuse and neglect, including approximately 1,000 infants¹;
- There are more than 1,800 domestic violence related homicides, of which 80 percent or more are women, representing approximately one-third of all female murders²; and
- Four percent of all persons over the age of 60 experience abuse, neglect, and/or self-neglect, some dying from this maltreatment.³

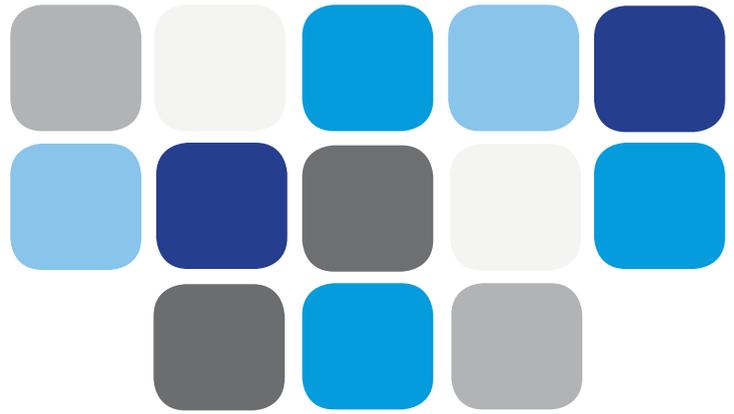
Throughout the U.S., fatality review programs have been established in all states and in thousands of communities. These programs support multi-disciplinary team case reviews during which individual deaths are closely studied. Beginning with the first reviews of maternal and infant health in the early 20th century through to the development of elder abuse fatality reviews in the first part of the 21st century, teams across the country have been examining individual deaths to understand and evaluate the death investigations, the causes of deaths, the systems that touched the life of the deceased, the relevant risk and protective factors, and the actions that should be taken to improve systems and catalyze prevention. Today in the United States, there are active networks of

A fatality review team is a multidisciplinary group of professionals that meets to discuss the circumstances leading to and causing deaths in order to improve agency systems and to take action to prevent other deaths.

The unifying feature of these different types of fatality reviews is that they are wide angle, multidisciplinary case studies conducted in a climate that promotes open discovery of information. Review teams obtain information on deaths from multiple sources for their discussions on the often extremely complex death events. Teams

are comprised of individuals with expertise relevant to the deaths and from agencies and services representing death investigation, public health, medicine, law enforcement, social services, mental health, education and many others. The teams examine records; discuss the events leading up to and causing the death; and work to identify what could be done differently to prevent other deaths. They make recommendations to agencies and other decision makers for prevention activities and/or changes to service systems. The ultimate purpose of the reviews is catalyzing action for prevention rather than merely counting and calculating death rates.

* Elder abuse teams may also include reviews of vulnerable adults of all ages. There are also review teams that focus on specific types of deaths including deaths in the workplace, deaths of persons with asthma, disabilities, and suicides and homicides.



maternal mortality reviews (MMR), fetal and infant mortality reviews (FIMR), child death reviews (CDR), specialized child maltreatment reviews through citizens review panels (CRP), domestic violence fatality reviews (DVFR), and elder abuse fatality reviews (EAFR).*



Although each review process developed and operates independently of the others, there is growing interest in improving the coordination of the different review programs at both the community and state level. In fact, many states are putting systems in place to improve coordination. Coordinating review processes can be important for a number of reasons:

- Deaths across the age span often have intertwined risk factors. Coordination can help review teams share information and findings, thereby contributing to our understanding of the link between infant, child, maternal, spousal/partner and elder deaths. Some teams currently conduct joint meetings as a way to share information. For example, in a situation where a family has died as a result of domestic violence, CDR, DVRF, and CRP teams meet together for one review.
- Second, collaboration can help to discover that different types of deaths are associated with similar issues within the same service agencies or across agencies and encourage further collaboration among agencies. Some programs have combined all the review programs under one agency to help ensure that systems findings are better coordinated.
- Third, coordination can also minimize duplication of efforts and create economies of scale. Some programs utilize one coordinator to manage several review programs, identify cases for reviews and/or collect case information. Some programs use one data analyst to manage data collection, analysis and reporting for all reviews.

- Fourth, and most importantly, when review programs coordinate their findings and recommendations for action, the potential for adoption and implementation of recommendations to prevent deaths exponentially increases. In several states, the different review programs and teams are beginning to issue one report instead of several, giving greater power to their recommendations.

The Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) has supported fetal and infant mortality reviews and child death reviews for more than a decade through support of two resource centers. MCHB has also supported efforts to improve coordination across reviews, including a meeting in 1998 and funding of an initiative to improve coordination between MMR, FIMR and CDR in a number of states from 1999-2001. Through its 2011 funding to the National Center for the Review and Prevention of Child Deaths, MCHB supported further efforts at coordination leading to the December 2011 national meeting: *Improving Outcomes across the Life Course through Fatality Reviews*. This meeting was convened in Washington DC to identify opportunities and challenges associated with enhancing collaboration between reviews for the purpose of improving outcomes. Thirty-seven state and national leaders of CDR, FIMR, MMR, DVFR, CRP, and EAFR programs gathered with twelve federal partners to affirm the importance of joint reviews and to develop guidance for states to enhance coordination across review processes. Using the life course perspective as the framework, the participants shared and examined commonalities as well as unique elements of each type of review, identified barriers to coordination, and worked to develop strategies to promote and support collaborative review activities.

The meeting led to affirmation among participants that collaboration is important and can be a catalyst for moving from reviews to prevention. While not all participants believed extensive coordination across all reviews is feasible, most participants acknowledged that substantial benefits for improving prevention outcomes from reviews could be realized through improving coordination.

The Life Course Perspective is a framework used to understand how chronological age, life transitions, socioeconomic circumstances and social change shape people's lives from birth to death.

Throughout the day and a half meeting, participants reiterated a number of key recommendations and examples for enhancing collaboration and improving outcomes. These included the following:

1. Consolidate the management and administration of review programs

- Assign one agency to coordinate/administer all teams;
- Consolidate staff resources and money; and
- Conduct joint trainings.

2. Improve communication during the case review process

- Educate each other about review approaches and underlying philosophies;
- Establish formal liaisons between review teams and have members serve on multiple teams;
- Work together to identify common case findings and processes for case reviews; and
- Cluster reviews by types of deaths, hold joint reviews, or collaborate on reviews where there are areas of overlap.

3. Standardize and/or link data collected from reviews

- Develop unified data collection instruments that standardize questions and data elements for all types of deaths and reviews;
- Consolidate or link databases;
- Compile and aggregate raw data across reviews into a centralized data clearinghouse; and
- Share data with other teams.

4. Coordinate recommendations, reports and interventions to prevent deaths

- Create joint reports and identify topics that cross disciplines;
- Share the work to identify best practice interventions and strategies for prevention that affect all age groups and causes of deaths across reviews;
- Bring together multiple review teams to discuss findings, recommendations, and actions; and
- Consolidate recommendations that will prevent deaths across the life course, and work collaboratively to ensure these are implemented.

5. Continue efforts at the national level to foster coordination between and among fatality reviews

- Establish an interagency task force of federal partners working with fatality reviews;
- Support communication structures, such as a listserv or website, for state and local programs to facilitate exchange of information among reviews;
- Support national meetings of program leaders from all review systems; and
- Model innovations in review coordination at the national level.





A number of challenges to improving coordination were identified throughout the meeting. These included limited resources to support efforts at collaboration; overcoming possible perceptions in the field that one type of review or another is the preferred approach; and addressing concerns that the integrity of a specific review model may be compromised through collaboration. Some of the unique characteristics of reviews that may hinder collaboration include access to records, identification of protected information and case identities, statutory protection of confidentiality of the reviews and records, and family involvement in the process.

At the conclusion of the meeting, each participant shared with the entire group what he or she planned to do back home to promote coordination. Attendees working in fatality reviews across the country were remarkably consistent in valuing the importance of collaborative work and in their resolve to assume leadership in their home states to bring about the fruits of fatality review coordination. The power and success of the meeting was evident in the enthusiasm and commitment to coordination that participants displayed in their final remarks. For example, one person planned to convene a first time meeting of all five of her state's major review program managers. Another state leader planned to work on consolidating databases from her state's different review programs and encourage one state report rather than three.

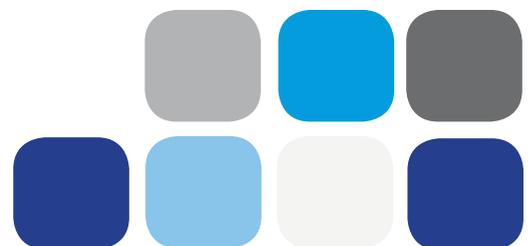
Likewise, the federal partners reiterated their intention to continue to support coordination efforts. For example, a current ACF-funded project is conducting site visits to states to elicit promising practices for collaboration and improved outcomes

Recommendations to Improve Coordination of Fatality Reviews:

1. Consolidate the management and administration of review programs
2. Improve communication during the case review process
3. Standardize and/or link data collected from reviews
4. Coordinate recommendations, reports and interventions to prevent deaths
5. Continue efforts at the national level to foster coordination between and among fatality reviews

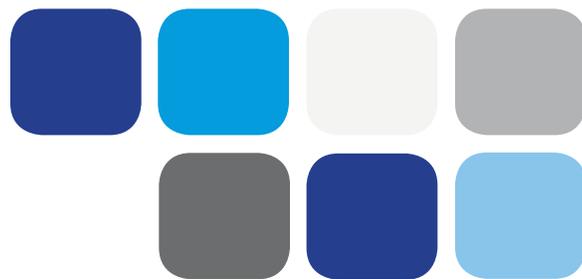
from CDR, FIMR, CRP and DVFR. This project will conclude with another national meeting in Summer 2012 to further encourage cross-review collaboration.

This report is only a first step in informing federal, state and local decision makers about the potential benefits, challenges and possible approaches for coordinating review activities in states and communities across the country. It is critical that the review processes continue to seek ways to work together to prevent the premature deaths of America's infants, children, domestic violence victims, and vulnerable older adults.



Part One: Background

Descriptions of Review Processes: Their Differences and Commonalities



Fatality review is a process in which multidisciplinary groups of professionals meet to discuss the circumstances leading to and causing deaths in order to improve agency systems and to take action to prevent other deaths. Beginning with the first reviews of maternal and infant health in the early 20th century through to the development of elder abuse fatality reviews in the first part of the 21st century, teams across the country examine individual deaths to understand and evaluate the:

- Death investigations.
- Causes of deaths.
- Systems and services that touched the life of the deceased.
- Relevant risk and protective factors.
- Actions that should be taken to improve systems and catalyze prevention.

Today in the United States, there are active networks of maternal mortality reviews (MMR), fetal and infant mortality reviews (FIMR), child death reviews (CDR), specialized child maltreatment reviews through citizens review panels (CRP), domestic violence fatality reviews (DVFR), and elder abuse fatality reviews (EAFR).*

The following is a short description of the different types of death reviews. Appendix C includes a fuller description and a matrix comparing the various components of the review processes. It is important to recognize that there is not only variation among reviews but also within each review type based on the particularities of the state and/or community. These variations include legislation, administrative

homes, organizational structures, team membership, data collection and reporting. There are also differences such as whether the decedent is de-identified for the purposes of the review, whether family interviews are conducted, and whether there is state legislation protecting the confidentiality of review proceedings. Almost all review types have some level of state oversight and staffing to support state and local reviews.

* Elder abuse teams may also include reviews of vulnerable adults of all ages. There are also review teams that focus on specific types of deaths including deaths in the workplace, deaths of persons with asthma, disabilities, and suicides and homicides.





Maternal Mortality Review (MMR) was the first type of formal death review in the U.S., with most states having reviews in the early 1900s. Its purpose is to identify pregnancy-related and/or pregnancy associated deaths, and review the factors that led to those deaths to prevent other deaths. A distinguishing characteristic of MMRs is that they typically utilize a medical model for review with extensive reviews of maternal medical histories. Membership is primarily comprised of medical and public health professionals, with a heavy emphasis on professionals with expertise in perinatal specialties. Because maternal mortality is a rare event, most MMRs in the U.S. are state-level rather than local. They are based in state medical societies, public health or academic institutions. There are no national standardized protocols for MMRs. The U.S. Centers for Disease Control and Prevention (CDC) has developed a data abstraction tool and a number of administrative tools for teams. There is no national resource center for MMR, although the CDC provides guidance to state MMR teams and also conducts MMR reviews at the national level. The CDC also published a report in 2006 describing the experiences of MMR in nine states.



Fetal and Infant Mortality Reviews (FIMR) were established in the 1980s as a pilot project in five urban communities and then became for a time a requirement of federally funded Healthy Start programs in communities with high infant mortality rates. The primary purpose of FIMR is to improve systems of care for women and infants to reduce deaths. Several key components of the FIMR model distinguish it from other reviews: the infant and mother are always de-identified, a complete abstract of the mother's and infant's medical history is completed and used at reviews, and a home interview is often conducted with the mother. FIMR membership for case review is primarily composed of maternal and infant health professionals. The FIMR model encourages two tiers of review: a case review committee and a community action team. The community action team receives the findings of the case reviews and develops the plan for systems improvements and other prevention actions. There are about 220 community-based FIMR teams in 40 states. State public health departments often provide training and coordination. There are national standards on the FIMR methodology and a standardized data system that teams can use. Nationally aggregated data is not collected. Training and technical assistance for FIMR teams is provided by the National Fetal and Infant Mortality Review Program, a collaboration between the American Congress of Obstetricians and Gynecologists and MCHB, with funding from MCHB.

Across the Life Course in Louisiana: Coordinating Fetal and Infant Mortality and Child Death Reviews

Wonderful Work Down on the Bayou

The State of Louisiana had a very robust system of child death review, operated out of its injury prevention program. Every parish in the state had a designated child injury prevention coordinator, who also served as the local CDR team coordinator. The state also supported regional FIMR teams, coordinated by public health nurses. Last year, a state budget crisis forced a downsizing of the injury prevention program and the state had to eliminate its local injury prevention coordinators. The state health department could have decided this also meant the end of CDR. Instead, it reached out to the FIMR program and asked the FIMR nurses to take on the role of managing the local CDR teams. Most of the staff agreed, and many had to take on extra hours of work. But they all came together for strategic planning and training from the National Center for the Review and Prevention of Child Deaths. They now meet regularly to continue exploring the best path towards a system that is effective, efficient and meets the needs in their communities. One of their most promising outcomes is that they are merging their separate processes for moving from reviews to systems improvements and prevention into a single community action team in each parish. These teams will review findings from all deaths of all ages. They are also using their teams' experience in injury prevention to help improve their infant death review outcomes. □

Oklahoma-You're OK!

The Oklahoma CDR program operates out of the Oklahoma Commission on Children and Youth (OCCY), an independent government commission, and supports a state team and 4 regional teams. The state's DV fatality review program is based in the State Attorney General's Office and supports one state team. Both teams recognized that their own case reviews included deaths of children and/or women who were victims of family violence. Three years ago, the two state teams decided to explore the possibility of conducting joint reviews of these cases. But they faced a number of challenges related to the perceptions each team had of the other. The CDR team felt that the DV team's focus was too limited to seeking justice through the courts for the victims. The DV team was troubled by its perception that CDR team members did not understand the complex difficulties of mothers' trying to protect their children while also living in fear of their violent partners. The programs decided to face these challenges head on. The two state teams went on a two-day retreat together. The CDR members were also provided training on domestic violence. While there are still challenges in working together, both teams are working hard to understand each other's perceptions, and they now do joint reviews. They also collaborated together with the state welfare agency on a recently published state protocol manual that provides guidance to CPS staff working cases of child maltreatment in which domestic violence is also present in the home. □

Child Death Review (CDR) gained momentum in the early 1990s when the U.S. Administration on Children and Families (ACF) and the U.S. Department of Justice (DOJ) supported national trainings and developed model legislation and standardized protocols to encourage CDR as an approach to better identify child maltreatment deaths. By the late 1990s, the focus expanded in most states to reviews of all preventable deaths using a public health model, and all states now have CDR. The primary purpose of CDR is to improve investigations, services to children and families, and agency systems, and to implement prevention policies and programs. Teams typically have a core team membership that includes social services, law enforcement, prosecution, medical examiner/coroner, and public health, but most teams include a much broader array of professionals. The state administrative home for CDR is usually in public health or social services. Thirty-five states have state advisory panels that review findings of local teams and make recommendations. Today 44 states have legislation requiring CDR reviews such that 36 states have teams at the local level. All states but one review deaths to at least age 18. There is a national standardized CDR protocol and a national CDR Case Reporting System. Forty states submit their case review data into the Case Reporting System. From this system, local, state and nationally aggregated data is available. Training and technical assistance is provided to CDR programs by the National Center for the Review and Prevention of Child Deaths, based at the Michigan Public Health Institute, with funding from HRSA, MCHB.

Citizens Review Panels (CRP) were established in 1996, when Congress reauthorized the Child Abuse Protection and Treatment Act (CAPTA). In order for states to receive CAPTA funds, they are required to establish at least three CRPs that meet at least quarterly and produce an annual report available to the public. States are required to include maltreatment fatalities and near fatalities as a component of their reviews. The primary purpose of CRP is to determine whether state and local agencies are meeting their federally mandated child protection responsibilities and to make recommendations for improvements in the state's child welfare system. Membership includes persons across a wide spectrum of citizens and agencies working in child welfare and human services. There is a mix across the U.S. of state and/or local review panels. Twenty-eight states have local citizens review panels, 33 have state panels and 12 states have both although not all currently review fatalities. Twenty states use their state CDR team as their fatality CRP. All CRPs are administered by state social services. There is no standardized protocol for CRP reviews and no national reporting tools. Training and technical assistance is provided by the National CRP Resource Center at the University of Kentucky, with partial funding from the Children's Bureau at ACF.

Domestic Violence Fatality Review (DVFR):

Following a national DOJ summit in 1998 to introduce and encourage DVFR, there was a rapid expansion throughout the U.S. The primary purpose of DVFR is to preserve the safety of battered victims, hold accountable both the perpetrators of domestic violence and the multiple agencies and organizations that come into contact with the parties, and prevent other deaths. DVFR teams review the murders of persons that occurred during domestic disputes or in relation to ongoing family violence. Most of the reviews are of the deaths of women and/or their children, and many are paired with suicides of the perpetrator. One unique component of domestic violence review is analysis of the protections afforded victims prior to their deaths. Teams tend to have more representation from law enforcement, the court systems, and victim advocates than other reviews. The administrative home varies by state but most teams are based out of the attorney general or state court offices. Twenty-three states have local DVFR teams; 18 have state teams. Five of these states have both local and state level reviews. There are standardized protocols for DVFR but no national reporting tool. Most states with DVFR have case report instruments and issue state level reports, but no nationally aggregated data is compiled from the reviews. Training and technical assistance is provided by the National Domestic Violence Death Review Initiative with partial funding from the Office on Violence Against Women at the U.S. Department of Justice (DOJ).

Across the Life Course in New Hampshire: Coordinating Domestic Violence and Elder Abuse Reviews

The Granite State Rocks

The State of New Hampshire was one of the early starters in child death review, starting its CDR team in 1991. Since then, the state has established a total of five review programs: CDR, DV, Suicide, Elder and Incapacitated Adults (EAIAR), and most recently a maternal mortality review (MMR) program. Three of the six (CDR, DV and EAIAR) are managed out of the Office of Victims Assistance (OVA) in the State Attorney General's Office, and staff from the OVA participate on all the reviews except MMR. NH realized early on that it was neither effective nor efficient for each review team to conduct reviews of the same case and very helpful if teams talked together. As a result NH routinely conducts joint reviews. For example, both teams come together and conduct one review of the death of a child in a home where domestic violence was prevalent. Recently, the state conducted one remarkable review bringing three teams together, totaling more than 40 people, to review the deaths of a mother with mental illness who killed her children, tried to kill herself, and whose husband then killed her and tried to kill himself. The integrated review highlighted numerous mental health systems issues across many agencies. NH also developed a recommendation/prevention planning tool that is used by all the OVA review teams. □

Elder Abuse Fatality Reviews (EAFR) were established in the states of Maine and California in the 1990s and are beginning to expand to other states. The purpose is to identify systems improvements and prevention action to prevent elder abuse fatalities. Some EAFRs examine dependent adult deaths as well as elder abuse deaths. All examine both home and institutional deaths. In their reviews, the teams examine information about the victim, the perpetrator, and the victim's contact with various public systems. Membership on teams typically includes the same types of member agencies as CDR and DVFR, but also includes financial exploitation experts. Although the Elder Abuse Fatality Review Team concept is still relatively new, there are now teams in at least 13 states. A recent survey found that Florida has six teams, Texas two, New Hampshire one, Illinois four, and California has thirty-three. New York will soon have two teams. There are no national standards or reporting tools, although the American Bar Association and Office for Victims of Crime published *Elder Abuse Fatality Review Teams: A Replication Manual* in 2005. This comprehensive guide provides information on establishing and maintaining review teams.⁴ Currently there is no national resource center supporting Elder Abuse teams, but the National Adult Protective Services Resource Center at National Adult Protective Services Association is partnering with the National Center for the Review and Prevention of Child Deaths to develop a plan to provide technical assistance and promote development of teams.

Coordination Among Review Processes



The Value in Coordinating Reviews

Although each review process developed and operates independently of the others, there is growing interest in improving the coordination of the different review programs at both the community and state level. In fact, many states are putting systems in place to improve coordination. Coordinating review processes can be important for a number of reasons:

Deaths across the age span often have intertwined risk factors. For example, in a number of the deaths reviewed by all of the processes, violence is an underlying and intersecting thread woven through the families of the persons who have died. Infant mortality is highly associated with family violence: the FIMR program in Saginaw, Michigan found that 20% of women who had an infant death had prior domestic violence reports in the year leading up to the infant's birth, and five percent were beaten during their pregnancies.⁵ Child abuse is highly associated with domestic violence: more than 70% of youth who reported that they had been sexually abused by a known adult had also witnessed domestic violence in their home, and children who have witnessed family violence are three to nine times more likely to be maltreated than those who do not witness violence.⁶ In the U.S. each year approximately 3,300 children lose a parent to domestic homicides⁷ and a significant number of children also die within the context of domestic violence.⁸ Many cases of elder and vulnerable adult abuse are in fact domestic violence. Unlike the intimate partner abuse traditionally thought of as domestic violence, however, many of the abusers in these cases are the victim's adult children. In addition, a higher percentage of victims are men, although women still represent the majority of victims (roughly three out of four).⁹

More than 70% of youth who reported that they had been sexually abused by a known adult had also witnessed domestic violence in their home.



Coordination can help review teams share information and findings on these intertwined risk factors, thereby contributing to our understanding of the relationships between infant, child, maternal, spousal/partner and elder deaths. Some teams currently conduct joint meetings as a way to share information. For example, in a situation where a family has died as a result of domestic violence, CDR, DVRF, and CRP teams may meet together for one review.

Second, collaboration can reveal that different types of deaths are associated with similar issues within the same service agency or across agencies and encourage further collaboration among agencies.

Some programs have combined all the review programs under one agency to help ensure these systems findings are better coordinated.

Third, coordination can also minimize duplication of efforts and create economies of scale. Some programs utilize one coordinator to manage several review programs, identify cases for reviews and/or collect case information. Some programs use one data analyst to manage data collection, analysis and reporting for all reviews. Many of the review programs face the same process issues, such as ensuring confidentiality, identifying and selecting cases for review, sustaining membership, reporting

on findings and developing and implementing recommendations. All deal with the timing of reviews relative to case disposition in the criminal justice system. Many of these issues can be resolved more effectively and efficiently if the review programs work together to identify policy and practice solutions.

Fourth, and most importantly, when review programs coordinate their findings and recommendations for action, the potential for [adoption and implementation of recommendations to prevent deaths exponentially increases](#). In several states, the different review programs and teams are beginning to issue one report instead of several, giving greater power to their recommendations. They are also working as a united front to gain political and agency acceptance of their recommendations, thus increasing the odds that actions will be taken to prevent other deaths.

HRSA, MCHB and Other Federal Efforts to Promote Coordination

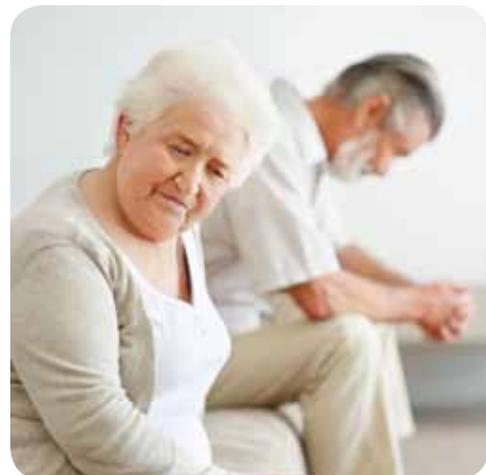
For more than a decade, the Maternal and Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA) has supported fetal and infant mortality reviews and child death reviews through its funding of the CDR and FIMR resource centers. MCHB has also supported efforts to improve coordination across reviews. In 1998, MCHB convened the first national invitational meeting on death review coordination. CDR, FIMR, and Sudden Infant Death (SIDS) program experts met together to develop recommendations for coordinating reviews. Following the meeting, a report of the meeting proceedings with suggestions for improved coordination was distributed widely to review programs.¹⁰ MCHB and the American College of Obstetrics and Gynecology issued a bulletin in 2002 on opportunities for collaboration between FIMR and CDR.¹¹ MCHB also published a paper in 2004 on the opportunities for coordination between FIMR and CDR.¹²

MCHB funded a *State Morbidity and Mortality Review Program* in four states in two cycles from 1998-2001 and 2001-2004 in order to identify models for

improved integration and/or coordination of review programs. For example, Virginia's project was designed to improve coordination, limit redundancy and develop a network of collaborations across the state's mortality review processes. As a result of this funding, Virginia convened a state level mortality review advisory group; re-established its MMR program, administered MMR, CDR and FIMR under the state medical examiner's office; established processes for streamlining acquisition of records for reviews; and conducted joint trainings.¹³

The CDR national resource center has language in its federal cooperative agreement with HRSA, MCHB requiring coordination. It has worked with NFIMR to conduct joint trainings, and many national review experts and staff at the resource centers attend and present on coordination at each other's conferences. The National CDR Program Manual includes a chapter on coordinating with other reviews.¹⁴

It should be also noted that the U.S. Administration on Children and Families (ACF) funded a one-year effort in 2012 that will build on the outcomes from this meeting. The recipient of these funds, Walter R. McDonald and Associates, is working in partnership with NCRPCD to conduct an expansive literature review and study of fatality review recommendations and outcomes, with an emphasis on coordination among reviews. Site visits will be conducted in 2012 to selected states demonstrating effectiveness in coordinating across reviews. Throughout 2012,



recommendations for improved coordination and integration will be further refined based on the findings generated from the meeting described in this report, from the review of state recommendations and outcomes, from the literature review and from the site visits. The project will culminate in another national meeting in Summer 2012, expanded to include one to three review program representatives from every state. The purpose of this meeting is to share findings and further promote coordination and integration across reviews.

Current Coordination of Reviews in States

Many states and communities are aware of the common issues and purposes of the different review types and are looking for opportunities to blend review processes, coordinate activities, and/or enhance communication among reviews. For example, CDR teams coordinate reviews with CRP in 17 states, with FIMR in 20 states, and with DVFR in 14 states.¹⁵ A number of state CDR teams also report coordinating with community-based homicide reviews, elder abuse reviews and suicide reviews. States utilize different models for coordination. The most prevalent models currently in use are as follows:

1. Two or more of the review processes are administered by the same agency and a single cluster of staff provide the training and support to teams. Examples include:

- The Delaware Child Death, Near Death, and Stillbirth Commission, which conducts CDR and FIMR reviews, is required by law to share review findings on abuse cases as a CRP function.
- The Michigan Public Health Institute manages CDR, FIMR, and CRP under one program office.
- The District of Columbia Office of Fatality Review in the Medical Examiner's Office manages CDR, DVFR, and FIMR.
- The West Virginia Medical Examiner manages both DVFR and CDR.
- Children's Hospital of Wisconsin manages both CDR and FIMR.

- The Philadelphia Medical Examiner's Office manages CDR, FIMR, and DVFR.

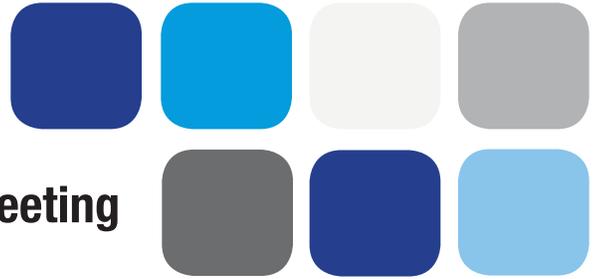
2. The review team at the state and/or local level serves a dual purpose, conducting one or more types of reviews. For example, seventeen state CDR team/advisory boards also serve as their state CRP for child deaths. Numerous local teams throughout the U.S. conduct infant death reviews, child death and domestic violence reviews – often during the same meeting. One model used by a number of communities is to have a core team membership attending a full meeting, with other expert members coming in only for specific cases. For example, a neonatologist will only attend the infant death case review; the DV shelter staff will come for the DV review.

3. A state or community will have separate review teams but the individual team coordinators will meet regularly to triage cases prior to reviews; identify overlap in cases such as a child killed during a DV incident; and identify common or joint recommendations. Often they will attend each other's meetings as regular practice. In some places, recommendations from separate teams will be shared with a broadly representative community-action team representing all review type members for further development and implementation. A model was developed by the National Center for the Review and Prevention of Child Deaths to encourage this type of coordination, described in Appendix D.

4. Some states conduct joint training. For example, Hawaii conducted a joint DVFR and CDR training in 2008.

5. A state or community will have separate review processes but will merge their findings and recommendations into one report. For example, Michigan includes both CDR and FIMR review findings and recommendations in the state's annual child death report.





Part Two:

Proceedings of the National Invitational Meeting

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The meeting, “Improving Outcomes across the Life Course through Fatality Reviews,” was held December 7–8, 2011 to identify opportunities and challenges associated with enhancing collaboration among the various forms of fatality reviews for the ultimate purpose of improving outcomes and preventing deaths. It was sponsored by the National Center for the Review and Prevention of Child Deaths (NCRPCD) and funded by the Health Resources and Services Administration, Maternal and Child Health Bureau. The meeting was planned by a committee representing staff and key leaders from the national resource centers for CDR, FIMR, CRP, and DVFR as well as senior staff from the HRSA, MCHB Division of Child and Family Health’s Emergency Medical Services for Children and Injury and Violence Prevention (EMSC-IVP) Branch. The committee developed the agenda, list of invitees, and resource materials for the meeting. The meeting was facilitated by Anderson Benson Consulting.

The purpose of the meeting was to identify opportunities for, and challenges to, improving outcomes through collaboration among the various types of fatality reviews—particularly those conducting reviews of fetal, infant, child, maternal, domestic violence and elder abuse deaths.

The specific objectives of the meeting were to:

- Identify unique components of each individual review process that could be adapted to enhance other review processes.
- Share state and local experiences in working with more than one review process.
- Identify opportunities for, and limitations of, review process intersection, integration and/or coordination.
- Begin development of a framework to facilitate fatality review coordination to improve outcomes across the life course.

Attendees included 37 national, state and local representatives already known to be working on coordination and integration across reviews, and federal leaders from MCHB, CDC, DOJ, Administration on Aging and the Indian Health Service, some of whom serve as the project officers for the federally funded resource centers. Appendix A includes a roster of the planning team and attendees and Appendix B includes the agenda.



Meeting Proceedings



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The meeting opened with a presentation by Beth Edgerton, Branch Chief for EMSC-IVP at HRSA, MCHB. She stressed the value of cross-fertilization among fatality review teams while respecting each team’s unique niche and characteristics. Teri Covington, Director of NCRPCD, next provided a historical overview of fatality reviews and charged the group with finding the key intersections in their work.

The Life Course Perspective

Katie Brandert, the Acting Associate Director of Programs for CityMatCH, outlined the “Life Course Perspective” and its importance to the work of all the review teams. As described in *Making a Paradigm Shift in Maternal and Child Health*, the Life Course Perspective “offers a new way of looking at health not as disconnected stages (infancy, latency, adolescence, child-bearing years, and old age) unrelated to each other, but as an integrated continuum. This perspective suggests that a complex interplay of biological, behavioral, psychological, social, and environmental factors contribute to health outcomes across the course of a person’s life.”¹⁶ She then introduced *The Life Course Game*,¹⁷ which is a board game, modeled on the board game *Life*. The game was created by CityMatCH to illustrate in an interactive way the protective and risk factors that occur along the lifespan. Attendees played the board game and many remarked that the activity highlighted both the relevance of and the possibilities inherent in collaborating among reviews.

National Resource Centers

Representatives of the several national fatality review resource centers made brief presentations outlining the key features of each type of fatality review. See Appendix C for an overview of the components of



each review process. In addition to a description of their review processes, the representatives addressed opportunities for coordination of their reviews with others, and made the following points:

The representatives for Maternal Mortality Review, David Goodman, and for Fetal and Infant Mortality Review, Kathy Buckley, each stressed the importance of home interviews for informing the process and, in the case of FIMR, providing an opportunity for home assessments and a pathway to needed services. They also noted that bringing obstetricians and pediatricians to the same table is an important step in conducting reviews, but that it is a challenge to do so. Ms. Buckley stressed that the de-identification of FIMR reviews and the fact that only FIMR conducts family interviews complicates coordination with other reviews.

The Child Death Review representative, Teri Covington, in describing the national CDR Case reporting system, emphasized the value of finding ways for fatality reviews to coordinate case identification and findings, reports of findings and recommendations and outcomes. She urged attendees to work through barriers to find common means to prevent child deaths.



Blake Jones, the Citizens Review Panel Resource Center representative, stated that most, but not all, of the CRPs that review fatalities are already linked to CDRs. He also suggested that attendance at the national CRP conference by CDR staff would facilitate cross-fertilization of ideas and outcomes.

The Domestic Violence Fatality Review representative, Matthew Dale, discussed the importance of maintaining confidentiality and assembling diverse review teams, including policy makers on teams, and moving reviews from case discussions to prevention and systems improvements. Mr. Dale also discussed how adding non-traditional representatives to DVF reviews, such as a person from the Department of Motor Vehicles, can help facilitate implementation of certain types of recommendations.

Kathleen Quinn and Andrew Capehart, both representatives of national elder abuse fatality reviews, discussed that although EAFR is the most undeveloped of the review types and that although there is no national resource center dedicated to elder fatality reviews at this time, they are working to build teams and support efforts for coordination among reviews.

Descriptions of Structures for and Challenges to Coordination in Nine States

Representatives of nine states already coordinating reviews in some fashion described the structure of their coordination, gave suggestions on building and maintaining infrastructures for coordination, and identified the practical challenges they encountered in their coordination efforts. The purpose of these presentations was to give attendees ideas of possible ways they too can coordinate reviews.

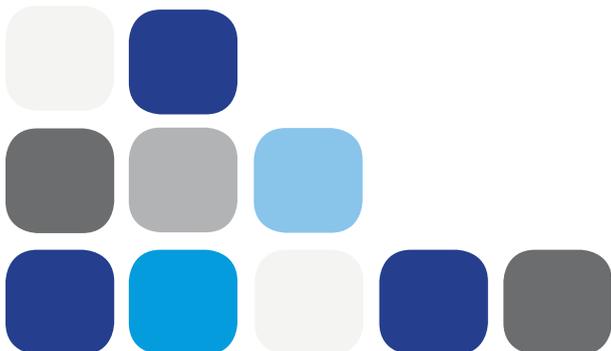
It was clear from the reports of the nine states that there are numerous ways in which review processes can work together, many of which require no significant changes to infrastructure and could easily be implemented by teams if they want to coordinate their efforts.



The following chart highlights the key points made with respect to how the nine states currently coordinate reviews as well as some of the challenges the states faced:

New Hampshire	<ul style="list-style-type: none"> • Attorney General's office coordinates three teams: CDR, DV, and elder/incapacitated adults. Reviews are done jointly, usually involving two teams. The first three-team review will begin in January 2012 and plans are to add a fourth team: suicide. • Recommendations and action steps are developed jointly, and each action step is returned to the committee responsible for that action step. Committees must report back, even if only to say they have no funds to pursue the action. • There is also a suicide team that reviews suicide cases not captured by the other teams. • Because the AG's office already coordinates the review teams, it is easier to bring the team leaders together to look for overlapping issues and cases.
Delaware	<ul style="list-style-type: none"> • 2004 legislation mandated CDR and FIMR panels; 2008 legislation added MMR and DV panels. • The coordinating agency for CDR, DV, FIMR, and MMR is housed under the judiciary, with subpoena power, so that it will be nonbiased and outside state agencies. The agency is a center for sharing money, resources, and infrastructure. This is necessary because the state is so small. • Each CDR review has a DV specialist in attendance. Child abuse cases are reviewed before prosecution. • Multiple review processes meet together twice yearly to look at most recent recommendations to determine what systems need improvement and where further training is warranted. • CDR and FIMR report together.
Michigan	<ul style="list-style-type: none"> • Michigan Public Health Institute (MPHI) provides oversight of CDR, CRP, and FIMR and technical assistance for other fatality review panels. The three coordinators meet together regularly. • All team members are volunteers, making it especially important to cultivate relationships, identify all participants at the outset, and get all to agree to the process. • MPHI used the CDR protocol to develop protocols for the CRP team and the CDR program is assisting in building an elder abuse program. • MPHI makes it efficient for the state to put money into one entity. • At the local level, teams have autonomy. Reviews are done separately, but teams come together to make recommendations. MPHI looks for commonalities among reviews. Multiple teams making the same recommendations "adds weight." • Joint and cross-training is important and the reviews often train together and attend each other's trainings. • State policy allows CDR and FIMR coordinators to share certain information with each other, expediting the case abstraction process. • Cases that might have been dually reviewed may now be done together or findings shared. Some members of each team participate on the other team. The teams also share consultants. • Teams meet with non-traditional partners (e.g., WIC, the federal nutrition program for women, infants, and children) and educate them on how fatality review information can help them. • One significant barrier is that state agencies are not required to respond to recommendations.
Ohio	<ul style="list-style-type: none"> • The State Department of Health is required to review all infant deaths, except those under investigation or being prosecuted. • There is interest in expanding FIMR statewide, but some question whether both CDR and FIMR are needed. CDRs do not include maternal interviews, so the process is different (with respect to where the data come from) but not necessarily the outcome. • In smaller communities the CDR team does the FIMR; in larger cities there are separate teams, and cases get reviewed and reported twice.

Oklahoma	<ul style="list-style-type: none"> • Their legislation mandates that the domestic violence team is housed in the Attorney General's Office. • CDR and DV have worked together and a two-year pilot proved the efficacy of these joint DV and CDR reviews. • Programs are data-based and coordinated across the state. • A strategic action plan is attached to every report.
Virginia	<ul style="list-style-type: none"> • The Office of the Medical Examiner (OME) coordinates CDR, FIMR and DVR. • Prosecutors and law enforcement want elder deaths recorded as "undefined" instead of "natural" so suspicious deaths can still be investigated as in cases of sudden infant death syndrome. • There is value in doing FIMR as well as CDR because FIMR captures data on the mother's well-being.
West Virginia	<ul style="list-style-type: none"> • The Office of the Medical Examiner coordinates CDR and DV teams. Although reviews are done separately, the OME has access to key data (homicides, suicides, undetermined deaths). About half the teams' memberships overlap.
Wisconsin	<ul style="list-style-type: none"> • The coordinating agency for both CDR and FIMR is housed in the largest children's hospital in the state and Title V (Maternal and Child Health Block Grant) funds both programs. Being a neutral entity has helped improve coordination. • Building coordination between CDRs and FIMRs has been challenging because of their different structures, but coordination and partnerships have worked well. A key consideration in coordination has been compromising on elements of each review process. Staff and members are able to work across disciplines and seek compromise. • Wisconsin has a tiered system: In rural areas, there is more overlap with CDR and FIMR between teams because there are not enough people to do both separately. The CDR framework is the mechanism for the review. In large cities, cases may be reviewed twice by both CDR and FIMR.
Wyoming	<ul style="list-style-type: none"> • The CDR team is in the midst of redevelopment. In addition to actual case reviews, the new structure will look at trends in child deaths across the state. The hope is to expand to include adult protection reviews and to get the departments of transportation and health involved. • There is no statutory authority for either child or adult death reviews. • Bringing teams together across a big state has not been easy due to time and travel challenges.



State and Local Input on Key Elements of Successful Team Collaboration

Following the reports from the state representatives, all the state and local participants participated in a brainstorming session to identify other suggestions for the successful coordination of findings, recommendations, and outcomes.

Key elements determined by the group included the following:

- Even before formal coordination structures are in place, teams can share recommendations among all review teams.
- Teams can also coordinate their findings with other groups to strengthen the impact of the findings.
- Teams planning to coordinate should do a strategic plan to define and develop their collaboration activities.
- Teams will be even more effective if they also align themselves with and collaborate with other groups such as family planning and home visiting programs.
- A beginning step for coordinating teams would be for each committee to explicitly state the purpose of each committee and for the teams to identify where they overlap.
- Coordinating teams should also take the step of sharing best practices they utilize and sharing data to increase the usefulness and impact of the data.
- Another preliminary step could be to invite other review coordinators to serve on a panel or attend meetings.

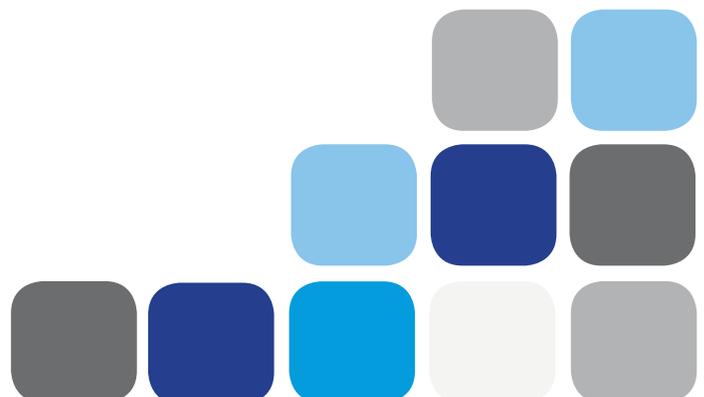
Most meeting participants did not recommend promoting one specific model of coordination. Most agreed that structures can be expected to develop differently from state to state, and there is no information or research available evaluating which model is best. The group did note that major differences among reviews in statutory requirements, confidentiality of proceedings, case identification of the decedent and family involvement may require time to resolve before real coordination can occur. Most participants agreed that these issues will be less of a challenge if review processes begin working together to explore models for coordination.

Group Discussion of Key Collaboration Questions

Small breakout groups were tasked with considering several key questions related to collaboration across fatality review types and improving outcomes. The breakout groups reported back to the full group in response to each question.

Q1: What unique components of individual review processes could be adapted to enhance other review processes?

The FIMR model has important, potentially adaptable features. The maternal interview could be generalized to other teams and to special populations, such as HIV, and possibly extended to other family members. The community action plan and cultural competence



tool kit could also be used by other teams. All review teams should have access to child and maternal health records as do many FIMR teams. Some felt the CDR and FIMR reviews should be sequenced to maintain the integrity of each process (e.g., do the CDR first, and then use that information but de-identified in the FIMR).

The CDR model uses a nationally standardized data collection system. Forty states currently use this system and obtain training and support through NCRPCD. The groups support using this system as a model for other review programs' reporting. Most states have legislation mandating or enabling CDR. Other reviews could adapt the CDR language or work legislatively to come under the umbrella of these statutes.

The CRP model is focused on identifying agency systems issues and problems and tailoring recommendations to improve these systems. The groups endorsed the CRP model of standardizing the recommendation process and requiring responses from public agencies to the recommendations and recommended that this strategic approach be adapted by other review processes.

The groups recognized that a strength of the DVFR model is the involvement of family members and victims to help catalyze the translation of findings into prevention actions. They felt that other reviews should borrow from this approach.

The groups suggested looking at states and communities with successes in collaboration. This

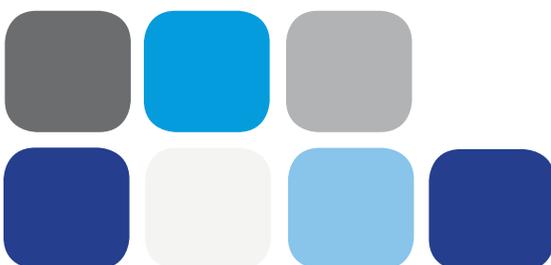
includes learning from states with strong legal authority for reviews, being strategic when selecting team members and identifying those stakeholders who can make change happen. There was some difference of opinion on the value of mandating membership on review teams. There was support for including family and victim perspectives and involving them as is done on some FIMR and DVF reviews. It was also suggested that multiple teams could do some reviews jointly, particularly those involving violent and/or criminal deaths.

Q2: What are the suggested approaches to integrate review processes? What are the challenges, barriers, and opportunities?

The groups suggested multiple ways in which review teams could integrate reviews or move toward integration through closer collaboration. The following summarizes the recommendations and suggestions from the groups with respect to this question.

Team membership and process

- Educate each other about review approaches and underlying philosophies;
- Establish formal liaisons between teams and have members serve on multiple teams;





- With all teams at the table, determine common case findings and processes for case triage (and possibly facilitate joint reviews);
- To bring more stakeholders and expertise to the table, cluster reviews by types of deaths, hold joint reviews, or collaborate on reviews where there are areas of overlap;
- Use existing systems to enhance opportunities for collaboration. For example, CRPs that are active in the community may already have connections in other areas, such as adult protective services; CRPs could be required to review some adult as well as child protective service cases;
- Create a joint action team to develop actionable recommendations based on all reviews and develop a collaborative plan to implement the joint actions; and
- Consider integrating all review processes.

Data

- Consolidate or link databases;
- Compile/aggregate raw data and create a centralized clearinghouse;
- Share data with other teams (e.g., for use in multiple reviews of same incident);
- Avoid duplication; and
- Determine how to share data and maintain

confidentiality, with appropriate caveats for essential protection of confidential or sensitive information. All information would not have to be available to everyone, but the person building the case abstract should have access to the information.

Organization

- Assign one agency to coordinate/administer all teams;
- Consolidate staff resources and money;
- Learn about military systems of review which may offer other promising practices; and
- Be aware of turf, status, and money issues that may be barriers to or limit collaboration.

Reporting and Outcomes

- Create joint reports and identify topics that cross disciplines;
- Disseminate information on lessons learned including a statement reflecting the life course perspective; and
- Convene one or more meta-groups, state-level or community-level multidisciplinary groups to discuss findings, recommendations, and actions, e.g. do a state-of-the-state review.





Q3: What elements, mechanisms, or opportunities have not yet been addressed but could have an impact?

One theme that emerged from the third break-out session was the importance of understanding the perspectives, language, and concerns of all the stakeholders (agencies, government, providers, etc.) in order to engage them in the process and outcomes.

A major topic of discussion was the development of recommendations from reviews. As one group put it: “frame cross-review findings and recommendations to a specific audience; forward one to three recommendations to the stakeholder who can act on it; prioritize—don’t overload the process with too many recommendations.” It was recommended that similar recommendations coming from different fatality reviews be coordinated and delivered in a coordinated fashion to key stakeholders. Other suggestions were to create a template for recommendations to make them “smart” and actionable; to increase the use of consultants; to share those resources and results; and to utilize existing frameworks or tools that help to develop specific recommendations.

The issue of training emerged from several groups. One suggested a self-assessment tool should be developed to identify all of the review teams’ strengths and weaknesses and respond with cross-training. Another suggested the national resource centers help with cross-training around issues and efforts that overlap, for example, developing training for all of the review types on promoting policy change and interacting effectively with policymakers.



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The small group work concluded with each team tasked with designing a conceptual model, using a collection of craft supplies, that captured the team’s understanding of how the coordination and integration of reviews could improve outcomes across the Life Course. The thoughtful and colorful results each group presented demonstrated the creativity, experience and growth of knowledge by all of the participants during the course of the meeting.





The importance of and potential benefits of collaboration were reiterated. It was universally acknowledged that for coordination to work, all processes must be flexible and willing to compromise on aspects of their own processes. Many felt that the goal should be to respect the individual processes and to collaborate and compromise for the greater good when it will yield “outcomes with more power.”

Participant Closing Comments and Key Take-Away Messages

To close the meeting, the participants offered key take-away ideas and shared plans to implement their learning from the meeting.

State and local participants expressed their plans to contact and convene the different fatality review teams in their states in order to explore opportunities for collaboration. The representatives of the national resource centers identified their plans to take the meeting conversations to their constituencies, through conferences, webinars, and other activities. Highlights of the participant follow-up plans include:

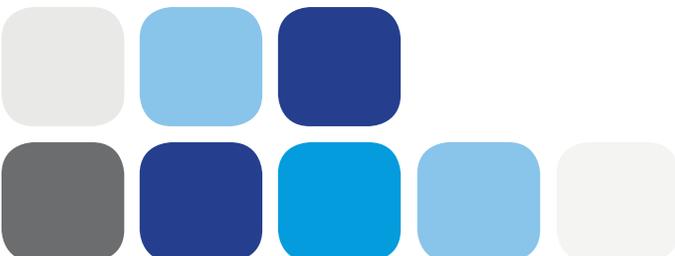
Participants from states:

- As a first step, find out what type of review programs we have in my state.
- Purchase and utilize the Life Course game for all of my state’s review teams at both the local and state levels.

- Convene all the state’s fatality review coordinators to pursue collaboration using the life course model.
- Work in my state to build DV and elder abuse reviews and reconvene the state MMR committee.
- Re-charge our teams to develop evidence-based recommendations.
- Bring FIMR and MMR teams together for purposes of making and implementing recommendations.
- Develop communication with many of the participants convened at the meeting.
- Bring state agency leaders together to discuss improved coordination.

Participants from National Organizations:

- Incorporate these discussions into our national conference this year.
- Work to build a national resource center on elder abuse.
- Conduct a national webinar on CRP and CDR coordination.
- Utilize the Life Course game with my university students.
- Focus our resource center on improving coordination.





Participants from Federal agencies:

- Explore opportunities for building suicide/homicide review teams that can link with other review programs.
- Explore possibilities for creating an interagency task force on fatality reviews.

All expressed appreciation for the opportunity to come together to forge ties across the spectrum of fatality reviews.

Closing Remarks

Liz Oppenheim, Senior Research Manager at Walter R. McDonald & Associates (WRMA), described the firm’s project, funded by ACF, that is going to continue the work of examining collaboration across fatality reviews. WRMA, which has undertaken the project jointly with the National Center for the Review and Prevention of Child Deaths, will build upon the

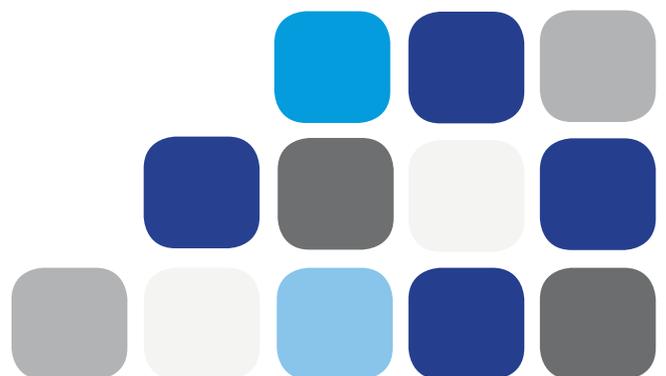
“If we can make progress, no matter how slowly and painfully, it’s worth doing.”

Dr. David Heppel

deliberations from this meeting through a literature review of promising practices for fatality reviews and site visits to locations where collaboration is underway. It will conclude the project with another national meeting about fatality review collaboration in Summer 2012.

David Heppel, Director of the Division of Child and Family Health, HRSA, MCHB offered closing remarks. He noted the importance of acting locally. He

stated that his vision and the goal of the HRSA, MCHB is to support state programs so that they can better support local programs that support families. He also noted the difficulty of planning in today’s economic climate and effectively utilizing limited funds. In closing, he remarked: “If we can make progress in saving lives, no matter how slowly and painfully, it’s worth doing.”



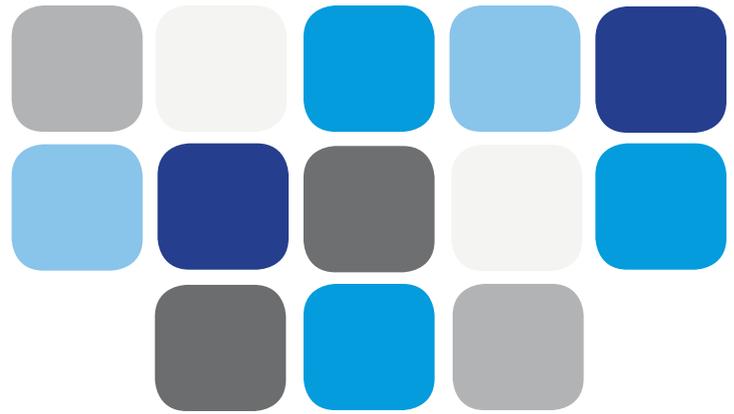
Part Three:

Next Steps

Collaboration among fatality reviews will take place at the local, state and national levels both spontaneously and as a result of the initiatives described above. It is notable that HRSA and ACF are both dedicating resources to fatality review collaboration, and their efforts should show results beginning in 2012. Dr. David Heppel suggested that the federal partners could model collaboration through a federal interagency workgroup on fatality reviews.

Walter R. McDonald and Associates will continue the work of their ACF-funded project, Examining Child Fatality Review Teams and Cross-System Fatality Reviews to Promote the Safety of Children and Youth at Risk. This effort will evaluate and identify promising practices for child death review, FIMR, Citizens Review Panels, and Domestic Violence Review Teams, and promising practices for collaboration among the four. The products of the project will be a literature review of literature about fatality reviews, a report on the recommendations for change made by the four types of fatality review, site visits to five states which exhibit collaborative cross-review initiatives, and a national meeting on cross-review collaboration in Summer 2012.

In addition, NCRPCD plans to continue its connection with Elder Abuse Fatality Review to



It is critical that the review processes continue to seek ways to work together to prevent the premature deaths of America's infants, children, domestic violence victims, and vulnerable older adults.

help grow this new review process. The center will work with the National Adult Protective Services Association and will share materials, tools and methods for building a national system of Elder Abuse Fatality Review. NCRPCD will also learn valuable lessons for itself and the field of CDR from its sharing with the Elder Review program.

As conveners of the December 2011 national meeting, NCRPCD is confident that through its cooperative agreement with HRSA, MCHB the enthusiasm for collaboration that grew in the meeting will lead to effective joint work among fatality reviews and that the WRMA national meeting in Summer 2012 will provide

additional opportunities for state fatality reviews to report on the growth of collaborative efforts in their states. By the end of next year, the NCRPCD plans to work together with HRSA, MCHB to promote specific recommendations to ensure that all fifty state CDR programs work towards coordinating their child death reviews with other reviews to ensure that lives are improved and deaths are prevented across the life course.

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Appendices

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Appendix C: Meeting Agenda



Grand Hyatt Washington Hotel, 1000 H Street, NW

Washington DC

December 7- 8, 2011

Wednesday, December 7th

1. Welcome and Introductions
2. Brief Review of History, Context and Objectives of Meeting
3. The Life Course Perspective
4. Overview of Key Elements of Fatality Reviews -- *Presentations by National Resource Center Representatives*
5. Examples from the Field: *Improved outcomes through fatality review coordination*
6. Thinking Together: What are the possibilities for working together to improve outcomes?
 - What are the unique components of individual review processes that could be adapted to enhance other review processes?
 - What are suggested approaches to integrate review processes?

Thursday, December 8th

6. Continuing to Think Together – What are the possibilities for working together to improve outcomes? (Continued from Day 1)
 - What are the elements, mechanisms or opportunities for collaboration that may improve outcomes across the life course?
7. Creating Life Course Model Frameworks to Improve Collaboration and Outcomes Across Fatality Reviews
8. Key “Take-Aways”
 - State and local representatives
 - National resource centers
 - Federal representatives
9. Next Steps

Appendix C: A Summary of the Components of Fatality Review Processes

Review elements	Maternal Mortality Review	Fetal Infant Mortality Review	Child Death Review	Citizens Review Panels	Domestic Violence Fatality Review	Elder Death Review
Purpose	To improve services for women with the overall goal of preventing maternal mortality.	To improve services and resources for women, infants and families with the long-term goal of reducing fetal and infant deaths. FIMR is a type of continuous quality improvement (CQI) identifying women's and infants' health problems, analyzing those problems, re-designing systems to address them and subsequently determining if these changes in the system have been successful.	Reviewing all circumstances in child deaths, ages 0-18, to improve investigation, service delivery and agency systems and to catalyze prevention initiatives across a broad spectrum of child health, safety, and protection.	To provide an evaluation of state child protection systems. CRPs use citizen volunteers to review and evaluate the state's compliance with the CAPTA plan, and to review policy, practice and procedure in their state. Approximately twelve states use Child Death Review Teams as CRPs.	To identify deaths caused by domestic violence, examine the effects of interventions prior to the death, consider changes in prevention and intervention systems to prevent such deaths, and develop recommendations for coordinated community prevention and intervention initiatives.	Most of the teams have systems change as their purpose, but some also have prosecution of perpetrators as a purpose. All focus on prevention.
Scope of Programs in U.S.	In 2010, 29 states and 3 major cities reported some type of MMR. In 2011, 5 additional states are involved in developing a MMR process.	200 programs in 40 states, DC, Puerto Rico and the Virgin Islands.	All states have a CDR program manager and support state and/or local review teams. There are approximately 1300 review teams in place throughout the U.S.	All states now have CRPs, as well as the District of Columbia and Puerto Rico. Each state is required to have at least three panels (some need only one). States were given considerable flexibility in implementing CRPs, thus a number of states use Child Death Review Teams as CRPs.	Forty-three states now have Domestic Violence Fatality Review teams. There are a total of 144 state and local teams.	Limited in scope throughout the U.S. According a survey conducted in 2011, 12 states reported that they have elder abuse review teams including a total of 47 local teams.
Authority to Conduct Reviews	Varies: Over half rely solely on state public health law. States increasingly are required to enact legislation to engage public health resources for MMR committee work.	Varies: usually general public health law, may be FIMR specific.	44 states have legislation that mandates or enables state and/or local review teams. Most state programs are based in either public health or social services.	CRPs are federally mandated by a 1996 federal amendment to CAPTA. A handful of states have enacted state legislation to support their CRPs (or had state legislation already in place).	Some but not all states have statutes mandating or enabling DV fatality reviews, and requiring confidentiality of proceedings.	Only a couple of states have legislation. California's is probably the most extensive and permitting.

Review elements	Maternal Mortality Review	Fetal Infant Mortality Review	Child Death Review	Citizens Review Panels	Domestic Violence Fatality Review	Elder Death Review
<p>Typical Funding Source</p>	<p>State Title V, state medical society, other department of health funds.</p>	<p>60% of FIMR programs are funded by local health departments, many times with state Title V funds. The other 40% of FIMR programs are funded through regional perinatal networks, universities, community advocacy groups, federal Healthy Start.</p>	<p>Most state programs use Title V (MCH), Children's Justice Act, CAPTA or state general funds. Mean funding level is about \$100,000 per state. Local teams are almost never funded.</p>	<p>This varies greatly from \$0 funding (Delaware) to \$187,000 (Wyoming). Most states use a combination of CAPTA dollars, CJA grant money, Governor's Task Force money, etc.</p>	<p>Everything from no dedicated funding source to federal DOJ [primarily OVWJ] grants.</p>	<p>State agency on aging or state attorney general's office support some work, but local reviews tend to be voluntary with no funding.</p>
<p>State and/or Local Reviews</p>	<p>Recommend state level reviews to assure confidentiality and enough cases.</p>	<p>FIMR reviews are local: a city, a county, a perinatal region or a part of any of the above.</p>	<p>37 states have state level advisory boards with local review teams operating at county or regional level; 12 states only have state level reviews.</p>	<p>According to CAPTA, Citizens Review Panels are supposed to review both state and local CPS issues. 16 states have local CRPs only, 24 states have one panel which has a statewide focus and 8 have a dual focus.</p>	<p>More than 40 states have developed fatality review initiatives. In more sparsely populated states such as Montana, New Mexico, Iowa, and Oklahoma, teams operate over the entire state, sometimes working with local communities where deaths occur. More populated states have larger numbers of teams. Florida now has 20 teams, New York at least 10, and California at least 20. In the space of 20 years, anywhere from 150-175 permanent teams have sprung up in communities all over the country.</p>	<p>Most review teams are local but there are a number of state teams as well.</p>

Review elements	Maternal Mortality Review	Fetal Infant Mortality Review	Child Death Review	Citizens Review Panels	Domestic Violence Fatality Review	Elder Death Review
<p>Team Membership</p> <p>Public health, obstetric providers, pediatricians and neonatologists, anesthesiologists, forensic pathologists, internists, pathologists, OB nurses, state medical examiners, Title V and Title X reps, epidemiologists, hospital administrators, state medical society representatives, social service programs, nutritionists, domestic violence and substance abuse prevention programs, risk management expert.</p>	<p>Two-tiered team. Membership varies. (25-60 team members) Public health, OB/L&D/prenatal/preconceptional health care providers, forensic pathologists, pediatric providers, including NICU, public health nurse home visitors/case managers, WIC, bereavement professionals, federal Healthy Start, advocacy groups such as HM/HB and MOD, community leaders, substance abuse and domestic violence representatives, social service, Medicaid, policy makers, businessmen, educators.</p>	<p>By definition multidisciplinary and teams average 25 members including at a minimum public health, social services, coroners/medical examiners, law enforcement, prosecutors, EMS, pediatricians, other health care providers, mental health, education, injury prevention, and child advocates.</p>	<p>Team membership varies widely. In states which use CJA panels as their CRPs, team membership is prescribed by federal law. This is also true in other states which have members who are appointed. Most states, however, allow volunteer citizens to serve on the panels. States which use Child Death Review teams have a large number of physicians, nurses and other health professionals.</p>	<p>Membership includes prosecutors, defense attorneys, shelter staff, victim advocates, survivors, surviving family members, school personnel, medical examiners and public health workers, housing authority staff, members of faith communities, batterer intervention program staff, child protection workers, probation and parole, mental health professionals, researchers, police, and court personnel.</p>	<p>Membership includes adult protective services, aging services, attorney general, coroner, county counsel, disability services, domestic violence program, emergency services, facility regulators, financial planners, forensic psychologist or psychiatrist, geriatrician, gerontologist, hospital discharge planner, law enforcement, legislators, long term care ombudsman, Medicaid fraud control unit, medical examiner, mental health services, nursing, other health care providers, prosecution, public guardian and/or conservator, public health agency.</p>	
<p>Team Structure and Administration</p>	<p>Varies, generally a single multidisciplinary state-wide team convened periodically or yearly. Administration generally from state health departments or state medical society.</p>	<p>Two-tiered team (see above).</p>	<p>Most teams consist of one review board that conducts case reviews, with leadership coming from any number of agencies, including public health, social services, medical examiners, judiciary, non-profit organizations.</p>	<p>This varies as well. Some states provide program coordination at the state level (i.e., Illinois) while other CRPs are locally coordinated (i.e., California). Most states have a statewide contact person who is responsible for pulling together the annual reports, for example.</p>	<p>This varies as well. Some states provide program coordination at the state level while other DV reviews are coordinated only locally.</p>	

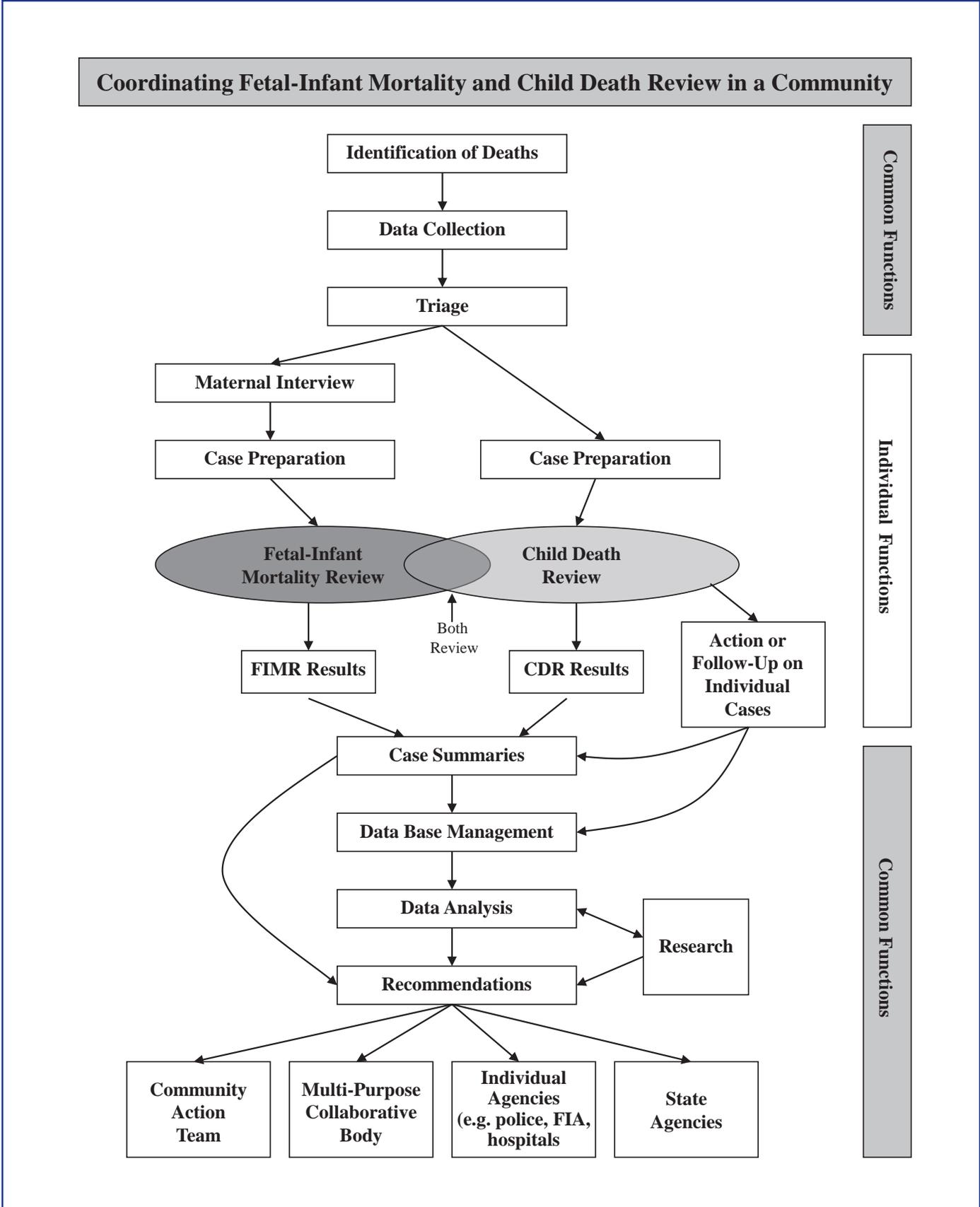
Review elements	Maternal Mortality Review	Fetal Infant Mortality Review	Child Death Review	Citizens Review Panels	Domestic Violence Fatality Review	Elder Death Review
Case Preparation	Generally a full case presentation with patient hospital record abstraction or team may request hospital record sent to the health department where de-identified record is reviewed by committee. Reviews are confidential.	Yes. FIMR reviews are confidential and anonymous. The names of providers, institutions and families are excluded. A case summary is prepared.	Few teams have staff to abstract cases prior to the meetings. More often, team members bring their records to review and share information from them.	For CRP teams doing fatality review this varies greatly. Some states fund a full time abstractor to obtain case information, complete a full abstract and present a case to a team. Others do not have the capacity to develop full case abstracts. Some CRPs do not do individual case reviews.	Some teams disseminate information prior to the review [snail mail or electronically], other teams receive the information [frequently verbally rather than written] once they have gathered for the review.	
Types of Deaths Reviewed/Case Selection	Review may be for pregnancy-related deaths only or both pregnancy-associated and pregnancy-related deaths. Time period included is either 42 days after death or one year after death.	Reviews may include fetal deaths from 20 weeks gestation to infant deaths up to one year of age. A few may also review VLBW infants who survived. The local program decides the number and types of cases to be reviewed.	All states review to at least age 18 except one (age 14); half of the states review deaths to all causes; more than 80% review all external causes and SUID; all review child maltreatment. Most teams obtain death notices from registrars/ or medical examiners/ coroner offices. Healthy People 2020 objectives aim for reviews of at least 90% of all external and SUID deaths in a state.	Most CRP fatality teams conduct case reviews of children that have died from suspected abuse or neglect, while under the care and custody of the state's social service agency. This includes deaths of children in foster care. States are required through CAPTA to also report on the deaths of children receiving family preservation services.	Most teams review intimate partner homicides involving the killing of wives and female partners. However, a few teams also examine other deaths such as female perpetrated killings; suicides; sexual competitor killings; homeless women; sex workers or prostitutes; drug-addicted women and those with HIV-AIDS; familicides; near deaths; bystander killings; contract deaths; and other suspicious deaths, accidents and disappearances.	Some teams review only elder abuse deaths; others review adult abuse deaths.
Timing of Review (from death)	Varies. Because of definitions of MM some reviews will not occur until 1-2 years after the death; if a large retrospective review is done it may be 3-5 years.	Varies. Cases should reflect the current system of health care in the community, and are usually reviewed 6-8 months after the death.	Varies greatly. Averages 6 months but some review within days and a few are reviewing deaths that occurred 2-3 years ago. Note: majority of deaths in national database are infants due to natural causes.	The CDRs which function as CRPs tend to review cases which are at least 6 months old. Some take as much as a year to obtain and review cases. Many teams will wait until a case has been fully adjudicated before review.	The majority of teams will only review closed cases. Cases reviewed range from several months old to several years.	

Review elements	Maternal Mortality Review	Fetal Infant Mortality Review	Child Death Review	Citizens Review Panels	Domestic Violence Fatality Review	Elder Death Review
Protocols, Tools, and Resources	<p>CDC has many reports and guides on MMR including one on accomplishing MMR review. This can be accessed from www.cdc.gov/reproductivehealth/Products/Pubs/PDFs/Strategies_tagged.pdf.</p> <p>ACOG has materials including a legislative tool kit to assist in the development of state legislation to facilitate MMR.</p> <p>The state of Florida has adapted FIMR to maternal mortality review http://www.doh.state.fl.us/Family/mch/pamr/pamr_info.html.</p>	<p>NFIMR has a large selection of materials, including a how-to manual that can aid a local FIMR program to begin and continue its efforts. Materials are available at www.nfimr.org.</p>	<p>National Child Death Review Program Manual, adapted by states for their own use according to their legislation, is used by most states. Many have their own protocols developed in accordance with their legislation. National manual has many tools for teams to use in startup, at meetings and for recommendations.</p>	<p>States were given considerable flexibility when implementing CRPs, so most panels develop the protocols and procedures for their work. The following document was developed early on as a support for CRPs: <i>Citizens review panels for the child protective services system: Guidelines and protocols (Cot, Bruner and Scott, 1998)</i>.</p>	<p>Varies widely depending on statewide vs. local teams and rural vs. urban. See ndvfri.org site for extensive list of suggested protocols.</p>	<p>In 2005 the American Bar Association and Office for Victims of Crime published <i>Elder Abuse Fatality Review Teams: a Replication Manual - 2005</i>. This includes a number of resources from elder abuse teams.</p>
Confidentiality	<p>Yes. Some states require legislation to assure findings are non-discoverable.</p>	<p>Yes.</p>	<p>Child's identity shared at most reviews, all but a few states have legislation that require the sharing of agency case records with teams, close case review meeting to the public, and penalties for members disclosing review discussions outside of meeting except within scope of their professional duties.</p>	<p>CRPs are bound by state and federal confidentiality laws. Congress made it clear in CAPTA that CRPs are to be given access to information that they need in order to function as a Panel, but with the caveat that disclosing confidential information could result in liability for panel members.</p>	<p>All teams require signed confidentiality forms. Confidentiality requirements are mandated by statute for many teams.</p>	<p>Teams have a variety of confidentiality agreements and requirements. A couple of states have legislation protecting the confidentiality of the meetings.</p>

Review elements	Maternal Mortality Review	Fetal Infant Mortality Review	Child Death Review	Citizens Review Panels	Domestic Violence Fatality Review	Elder Death Review
Family Involvement	Not in the U.S.	Yes. A home interview with the family, usually the mother if she agrees, is included in each case review. The interview provides an opportunity for home and family assessment. Referrals are made if the mother consents.	Very few states include families in their review process, by either contacting them before or after the review. Most do address the need for services to families and make referrals for services, as a core component of their case review.	Families are not usually involved with the working of CRPs, though the Panels may choose to interview families as part of a focus group, for example.	Some teams attempt to contact family members and friends of both the victim and perpetrator in order to gain insights that would not be obtained through document analysis alone.	
Data Collection and Surveillance from Reviews	Deaths identified through pregnancy check box on the death certificate, hospital reporting. Data is analyzed at the state level.	Data is collected at the local level for analysis and in some programs forwarded to the state level.	40 states submit case reviews into the National CDR Case Reporting System and are able to access data from it at both the state and local level. Eight other states have their own state reporting system.	Data collection with CRPs is probably the most well-developed in CDRs which serve as CRPs, as well as foster care review boards. These boards are focused on child-level data and are often statutorily mandated within the state, so the task of obtaining data appears to be easier than the typical CRP.	Many teams have expressed a desire to gather data so they can look for patterns and trends and run statistical analyses. As a result, several teams have developed data collection tools. The Miami-Dade team, for example, has developed a comprehensive 267-question data collection instrument to use when it reviews a case. Many of Florida's twenty teams use this form to collect data when they review cases. Other teams have developed their own tools, such as in Ohio.	There is no standardized data collection system in place throughout the U.S. A number of states have developed reporting tools to collect information from the reviews.

Review elements	Maternal Mortality Review	Fetal Infant Mortality Review	Child Death Review	Citizens Review Panels	Domestic Violence Fatality Review	Elder Death Review
<p>Review Reports and Recommendations</p>	<p>Reports vary from comprehensive to brief. Examples of comprehensive reports include Florida, New York and California.</p>	<p>Local recommendations and actions are published annually – these actions may influence state program and policy development, as well.</p>	<p>44 states issue an annual CDR state report, which typically include mortality and CDR data, risk factor analyses by cause of death, and state and/or local recommendations (37 require this through their legislation). A few large communities issue local reports that are much the same as above. Teams typically send recommendations to other entities for action but some teams actually work on implementation of them within their team structure.</p>	<p>All states receiving CAPTA money and implementing CRPs are required to submit an annual report detailing the work of the Panels and providing recommendations for the state child welfare agency. The CDR reports range in length from just a few pages to a voluminous report detailing child mortality data in the state. Non-CDR CRP's reports usually focus on non-fatality issues within the system.</p>	<p>Team reports range in size from 1 page to almost 100. Some are annual and some are multi-year. Writing recommendations that can be implemented and monitoring that implementation is a major focus of NDVFR currently.</p>	<p>A number of states create annual reports.</p>
<p>Outcomes</p>	<p>Data from reviews are analyzed, leading to improvement in medical management, care coordination and service system management for women.</p>	<p>A continuum of community level system and resource issues related to the health of women and infants are identified from preconceptional period through infancy. Problems are addressed, MCH systems improve, and resources expand. As the cycle of improvement is sustained through FIMR, outcomes can be expected to improve over time.</p>	<p>States are more recently tracking the translation of their reviews into recommendations and then outcomes- the national database has over 20,000 recommendations from teams; most states can describe numerous policies, programs, services that have been implemented through their recommendations; no work yet on measuring fatality rates resulting from reviews.</p>	<p>This is difficult to ascertain because a formal national study of outcomes has not been conducted. Emerging literature suggests that CRPs have a better chance of success when the elements of communication and collaboration are present, rather than an adversarial relationship with the child welfare agency. A study is needed to identify their impact on systems.</p>	<p>Focus is on improvements to systems to protect potential victims. Some outcomes have included passage of legislation to track domestic violence offenders who commit crimes; public awareness initiatives; outreach to seniors and youth who may be in violent relationships; outreach to African American women.</p>	

Appendix D: A Model of Coordination between CDR & FIMR*



* Developed by Peter Vasilenko, Michigan State University; Teri Covington, NCRPCD; and Rosemary Fournier, Michigan FIMR.

Notes

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