Dynamic Collaboration Across Fatality Review Processes

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Introduction

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Maternal and Child Health Bureau
Health Resources and Services Administration
About The National Center for Fatality Review and Prevention

• The National Center is funded in part by Cooperative Agreement Numbers UG7MC28482 and UG7MC31831 from the US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) as part of an award totaling $1,099,997 annually with 0 percent financed with non-governmental sources. Its contents are solely the responsibility of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
HRSA’s Overall Vision for National Center

Through delivery of data, training, and technical support, National Center will assist state and community programs in:

- Understanding how CDR and FIMR reviews can be used to address issues related to adverse maternal, infant, child, and adolescent outcomes
- Improving the quality and effectiveness of CDR/FIMR processes
- Increasing the availability and use of data to inform prevention efforts and for national dissemination

Ultimate Goal:
- Improving systems of care and outcomes for mothers, infants, children, and families
Housekeeping Notes

• Webinar is being recorded and will be available within 2 weeks on our website: www.ncfrp.org

• All attendees will be muted and in listen only mode

• Questions can be typed into the “Questions” pane
  – Due to the large number of attendees, we may not be able to get to all questions in the time allotted
  – All unanswered questions will be posted with answers on the NCFRP website
Speakers

Julie Zaharatos, MPH
Building U.S. Capacity to Review and Prevent Maternal Deaths
Division of Reproductive Health
Centers for Disease Control and Prevention

Melvina Thornton, LICSW
Senior Program Analyst
Military Community & Family Policy
Military Community & Family Readiness, Family Advocacy Program (FAP)
Office of the Deputy Assistant Secretary of Defense
Webinar Goals

• Learn about maternal mortality reviews (MMR) and how to effectively collaborate with MMR programs.
• Learn about military child death review and how to effectively collaborate to examine military child fatalities.
• Highlight new collaboration guidances from the National Center
  – Enhancing Collaboration between CDR and FIMR
  – Improving Coordination between civilian and military CDR
2012

18 States + Philadelphia

Dissimilar

- Processes
- Terms

Divides

- Clinical
- Public health

Data

- Paper records
- Excel, Access databases
“Every state needs a standard review process so that we can understand the drivers of maternal mortality”
MMRCs: Where we are today

Existing Review

Planning a review

New York City
Washington D.C.
Philadelphia
• Pregnancy-associated death
The death of a woman while pregnant or within one year of the termination of pregnancy, regardless of the cause.

• Pregnancy-related death
The death of a woman during pregnancy or within one year of the end of pregnancy, from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy.
Establish a Committee

- Authorities and Protections
- Mission and Scope
- Policies and Procedures
- Multidisciplinary Membership
- Time and Cost Estimator for Staff and Committee Meetings
- Data Strategy
Abstract Cases

- Hire an abstractor
- Request records
  - Autopsy
  - Prenatal Care
  - ER Visits and Hospitalizations
  - Other Medical Office Visits
  - Medical Transport
  - Social and Environmental
  - Mental Health
- Prepare case narrative
- Enter committee decisions and summarize notes
Experience a Maternal Mortality Review Committee in Action
Using MMRIA Committee Decisions Form

- Speak a Common Language

- Using MMRIA Committee Decisions Form
Expert input: Review Committees, CDC, ACOG

One stop shop for abstraction, developing case narratives, and documenting committee decisions

Data can be exported and read into standard statistical analysis software (e.g., SAS)

Enables states to share data with each other, and CDC

Support and training provided free of charge

http://mmria.org/
Report from Nine Maternal Mortality Review Committees
Distribution of Pregnancy-Related Deaths by Timing of Death in Relation to Pregnancy

- 38% While pregnant
- 45% Within 42 days
- 18% 43 days to 1 year
Leading Underlying Causes of Pregnancy-Related Deaths

- Hemorrhage: 14.0%
- Cardiovascular and Coronary Conditions: 14.0%
- Infection: 10.7%
- Cardiomyopathy: 10.7%
- Embolism: 8.4%
- Preeclampsia and Eclampsia: 7.4%
- Mental Health Conditions: 7.0%
Distribution of Preventability Among Pregnancy-Related Deaths

**OVERALL**

- **33.5%** Not Preventable
- **63.2%** Preventable
- **3.2%** Unable to Determine
Recommendation Themes

Improve training
Enforce policies and procedures
Adopt maternal levels of care/ensure appropriate level of care determination
Improve access to care
Improve patient/provider communication
Improve patient management for mental health conditions
Improve procedures related to communication and coordination between providers
Improve standards regarding assessment, diagnosis and treatment decisions
Improve policies related to patient management, communication and coordination between providers, and language translation
Improve policies regarding prevention initiatives, including screening procedures and substance use prevention or treatment programs
Data Analyst Trainings
- Developing an analytic approach
- SAS code to answer key questions

Webinars
- Qualitative analysis
- Data visualization
Technical Assistance

MMRIA TA visit

Attended Regional MMRIA Training and/or MMRIA User Meeting
How do we better understand the deceased woman’s perspective?

How can we come to understand her community context?
“Invite women or their families to contribute a natural history, to understand the context of their care and the health care decisions they made.”

5 domains with examples of indicators

**General Health Services**
- Primary care provider availability
- Medicaid eligible
- Uninsured

**Reproductive Health Services**
- Obstetrician availability
- Certified Nurse Midwife availability
- Family planning needs

**Behavioral Health**
- Mental health provider availability
- Frequent mental distress
- Unmet substance use needs

**Transportation**
- Rural/Urban composition
- Car ownership
- Public transit availability

**Social and Economic**
- Persistent poverty
- Violent crime
- Income inequality

Tools for
- Securing authorities and protections
- Establishing a committee
- Identifying cases for review
- Case abstraction
- Committee facilitation
- Storing and managing data
- Analyzing and using data for action
- Connecting with peers
## Comparison of FIMR and MMR

Adapted from Florida Department of Health, July 2000

<table>
<thead>
<tr>
<th>Comparison Points</th>
<th>Fetal and Infant Mortality Review (FIMR)</th>
<th>Maternal Mortality Review (MMR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Ages for review – 20 weeks gestation to 1 year, and in some projects to age 3. Some incl. LBW.</td>
<td>The death of any woman pregnant within 1 year of death is included in surveillance data.</td>
</tr>
<tr>
<td>Type of Cases Reviewed</td>
<td>De-identified case reviews.</td>
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</tr>
<tr>
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<td>Team Member Protection</td>
<td>Laws that govern immunity, confidentiality, and discovery protect members of the project In some areas this means formulation under the auspices of a specially designated sponsor (such as a medical board or health department).</td>
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<td>Composition of Review Team (CRT)</td>
<td>CRTs are multidisciplinary to represent the system of care for prenatal women, infants, and the preconception period-further, the teams are ongoing, representative of the diversity of the community, and voluntary.</td>
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✓ abstraction staff obtain information on deaths from multiple sources
✓ broad, multidisciplinary case-study approach
  ▪ law enforcement is not typically part of an MMR team
✓ confidential, de-identified process
  ▪ open discovery of information is not part of the MMR process
✓ goes beyond surveillance to make recommendations for action
✓ identify the risk factors and circumstances surrounding a death in order to prevent future deaths
 ✓ Link common findings to strengthen recommendations for change
 ✓ Share effective methods and tools for disseminating results
 ✓ Promote self-care resources for abstractors
 ✓ Share best practices for informant interviews
Questions?
DoD’s Fatality Review of Child Abuse & Neglect & Domestic Violence-Related Fatalities

Melvina Thornton, LICSW
OSD Family Advocacy Program
Program Analyst
May 7, 2019
DISCLAIMER

The views presented are those of the speaker and do not necessarily represent the views of the DoD or its components.
The Family Advocacy Program (FAP) is a congressionally mandated DoD program designed to be the policy proponent for and a key element of the Department of Defense’s Coordinated Community Response system to prevent and respond to reports of child abuse/neglect (CAN) and domestic abuse (DA) in military families - in cooperation with civilian social service agencies and civilian law enforcement.

- FAP is located at every CONUS and OCONUS installation with command sponsored families

- FAP support, treatment and case management services are provided to individuals who are eligible for treatment in military medical treatment facilities.
Coordinated Community Response

- Command
- Health Care
- Community
- Family Advocacy Program
- Mil Police/MCIO
- Chaplain
- Legal/SJA
- DoDEA
- Child and Youth
- Family Programs
- Civilian Medical
- Civilian Police
- Family Courts
- Child Protective Services
- Shelters
- Child Advocacy Centers
FAP Goals

• Promote prevention, early identification, reporting, and treatment of CAN and DA

• Preserve families in which abuse has occurred, if possible, without compromising the health, welfare, and safety of victims

• Provide effective treatment for all family members, as appropriate

• Identify risk factors that contribute to family violence (and related suicides) and implement programs to reduce risk

• Effectively collaborate with civilian and federal agencies to stay abreast of current research and best practices for preventing family violence
Guidance & Background


- **Department of Defense (DoD) Instruction 6400.06**, “Domestic Abuse Involving DoD Military and Certain Affiliated Personnel,” August 21, 2007, as amended, (1) directs the secretariats of the Military Departments to establish fatality review teams; and (2) that reports of their reviews be forwarded to ODASD(P&R/MC&FP) 24 months following the end of the fiscal year in which fatalities that are the subject of the report occur.

- Per DoD requirement, Services are required to notify DoD FAP within 72 hours of being notified of a DoD-related fatality known or suspected to be (1) an act of domestic violence (2) an act of child abuse or (3) an act of suicide related to an act of domestic abuse or child abuse.

- **2005** - Military Departments began fatality reviews

- **2007** - First DoD Summit held
A DoD-related fatality includes the death of any of the following:

- A member of a Military Department on active duty.
- A current or former dependent of a member of a Military Department on active duty.
- A current or former intimate partner who has a child in common or has shared a common domicile with a member of a Military Department on active duty.
Review Board Objectives

- Review fatalities for the purpose of identifying trends and patterns that may assist in developing policy recommendations that promote more effective prevention efforts and earlier and more effective intervention.

- Ensure the accurate identification and uniform reporting of child CAN and DA related deaths.

- Identify and recommend opportunities to improve communication and collaboration within the coordinated community response for improved multiple level and cross-systems intervention.
Screen in/Screen out

Screen In:
• All deaths *known or suspected* to be related to CAN and DA and involving an active duty member and/or their dependent
  • CAN & DA homicide
  • CAN & DA Related-Suicide
  **Other: natural, accidental, undetermined

Screen Out:
• No DoD affiliation
• Near-death cases
• Public health related deaths
Fatality Review Process

- Reviews completed two years after deaths has occurred to allow for full adjudication of cases

- Conducted at Military Department Headquarters

- Team may include civilians, but generally limited to DoD personnel

- Conduct regularly scheduled and ad hoc meetings to complete review

- Completion of review can be delayed by prolonged adjudication
Strengths

• **Scope and number of cases

• Intrinsic association: Team members are DoD assets and connected through DoDs coordinated community response

• Full access to DoD records: medical, behavioral health, law enforcement

• Military Department Specific

• Allow for consideration of unique military and installation specific events and factors (e.g. deployments, installation population)

• Consistent findings with broader society
Limitations

- Scope and number of cases
- Limited or no contact with state death review boards
- No or limited access to CPS files
- Limited access to information when case investigated by civilian law enforcement (location specific)
- No post-death interviews of family members
- Limited ability for rates comparison to civilian findings
- Privacy concerns by DoD and state review teams limit info sharing
Summit Objectives

Fatality reviews are a deliberative examinations of the systemic interventions into the lives of the deceased to:

• To review and assess findings and recommendations made by the Military Services against the backdrop of current abuse policies and practices

• Conduct a system review to determine what organizations had contact with the deceased and the quality of services

• To foster joint-Service discussion about the factors resulting in child abuse and neglect (CAN) and domestic violence (DA) related fatalities and lessons learned in conducting reviews

• Identify trends and patterns that may help in developing policy recommendations and review progress made in implementing recommendations previously made

• To achieve greater consistency in fatality review reporting to enable more effective data analysis
Current Focus

• Encouraging opportunities for collaborative efforts with federal partners and state team representatives to:
  • Maximize DoD and civilian team findings
  • Share training opportunities, as appropriate
  • Reduce duplicative efforts, as appropriate

• Evaluating implementation of past and current recommendations

• Examining impact on policy and practices and future fatality reports
THANK YOU
New Guidance Publication

- *Improving Coordination Between Civilian and Military Child Death Review Programs: A Primer on Cooperation to Improve Outcomes for Children and Families*
New Guidance Publication

- Enhancing Collaboration Between Child Death Review and Fetal and Infant Mortality Review
Products and Publications

CDR Publications

The following CDR publications can be downloaded in electronic format or ordered in hard-copy format. Click on the "Order Publications" box to send us an email requesting the following materials in hard copy:

- A Program Manual for Child Death Review
- National Center Brochure PDF
- National Center FiMR Brochure PDF
- National Center Services and Initiatives PDF
- A Sampler of Prevention Outcomes from State and Community CDR Teams
- Pediatricians and Child Death Review
- Access to Death Review Data: Research Opportunities to Save Children’s Lives
- Sudden Unexplained Infant Death & Child Death Review Teams Flyer
- The Coordination & Integration of Fatality Reviews: Improving Health and Safety Outcomes Across the Life Course, Findings from the National Invitational Meeting December 7-8 2011
- Farm Fatalities Guide to Effective Reviews – June 2015
- Farm Fatalities – Presentation on Effective Reviews
Questions

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  – Recording of webinar and copy of slides will be posted within 2 weeks on the NCFRP website: [www.ncfrp.org](http://www.ncfrp.org)
Video Modules

• 13 video modules to support the work of CDR and FIMR teams
• **Session 12: Collaborating Across Review Systems**
• All under one-hour in length
• All available on our website [https://mediasite.mihealth.org/Mediasite/Catalog/catalogs/cnpi](https://mediasite.mihealth.org/Mediasite/Catalog/catalogs/cnpi)
What’s Next?

Our next webinar:
Black/White Equity in the Opportunity to Survive the 1st Year of Life . . . a dream deferred

June 5, 2019
1:00 p.m.– 2:30 p.m.

Arthur R. James, MD, FACOG

https://attendee.gotowebinar.com/register/1079194150929730060

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National Center is on Social Media

@NationalCFRP

The National Center for Fatality Review and Prevention
THANK YOU!

Additional questions can be directed to: info@ncfrp.org