NATIONAL CENTER FOR FATALITY REVIEW & PREVENTION

March 2016

CONTENTS

Greetings from the Director

by Teri Covington

Dear friends,

I hope you are emerging from winter with renewed energy and enthusiasm for your work in fatality review. We start spring with a new name and image for the Center. As the National Center for Fatality Review & Prevention we want to be a Center that supports child death review and FIMR and reaches out to other review programs so that we can collectively use the power of reviews to improve the lives of not only infants and children but their families and communities. Our new logo is an abstract rendition of a sun interspersed with people, meant to symbolize coming together. We thank our design team at ABC Consultants and CACI Communications for spending the time to understand our work and for their creative genius.

On March 15th we hosted the first meeting of the Center's National Advisory Committee. The committee is an esteemed group, representing a wide swath of agencies engaged in health and safety. It also includes leaders in fatality review from Alabama, Arkansas, California, Colorado, Michigan, Baltimore and Washington, DC. The committee met to hear about the status of FIMR and CDR in the US and about Center initiatives. Most importantly, the members worked to generate ideas to help us better translate data into national action, maximize partnerships at the national level to support reviews, and improve our services and resources. We will report on the meeting in the next newsletter.

We will be exhibiting and presenting on the Center at AMCHP this April. We will use that time to reach out to your state's MCH leaders to acknowledge existing support and encourage greater support for your review programs. If there are certain individuals you want us to meet, please let us know.

Thank you to all of you who participate on the Center's three work groups in data quality, CDR-FIMR collaboration, and the development of the FIMR Case Reporting System Module. Below you will see a notice about our just beginning work group which will focus on addressing disparities through reviews. I hope you will consider lending your knowledge and experiences to the group.

Please use spring as a time to take care of yourselves. Your work can be hard on the soul but is so important. As always, thank you.

Teri

Notes from our Federal Project Officer at MCHB/HRSA

by Diane Pilkey, RN, MPH

I am thrilled to be the federal Project Officer for this integrated Fatality Review Center, having come to the Maternal and Child Health Bureau (MCHB) with experience in Child Death Review (CDR) and an appreciation of the important role that Fatality Reviews can play in preventing deaths of infants, children and adolescents. This work directly advances the mission of the MCHB to provide leadership, in partnership with key stakeholders, to improve the physical and mental health, safety and well-being of the MCH population.

The Bureau has long supported fatality review efforts for the MCH population. The Healthy Start Program has supported the National Fetal and Infant Mortality Review Program (NFIMR) system at the American College of Obstetricians and Gynecologists (ACOG) since 1990 by providing funds to deliver training and technical support for FIMR programs nationwide. The MCHB's Division of Child, Adolescent and Family Health has funded the National Center for the Review and Prevention of Child Deaths at the Michigan Public Health Institute (MPHI) since 2002 to provide training, technical support and to create and host a web-based reporting system for use by state and local CDR teams.

to work together to improve outcomes and to explore components of each unique review process that can be adapted to enhance other reviews.

Diane Pilkey

In addition, the meeting aimed to identify elements, mechanisms or opportunities for collaboration that may improve outcomes across the life course. The full report including recommendations is available at: https://www.childdeathreview.org/wp-content/uploads/NCRPCD-Docs/CoordinatedReviews.pdf

Improving collaboration among fatality reviews is important for several reasons. Deaths across the age span often have intertwined risk factors. Different types of deaths are associated with similar issues either within the same service agencies or across different agencies, and identifying these challenges encourages new collaborations to create improvements. Coordination can also minimize duplication of efforts and create economies of scale. And, finally, the power of recommendations can be strengthened through collaborative fatality review systems.

The MCHB Vision for the integrated Center is:

In 2015, MCHB integrated these two fatality review support centers into one unified Center. Some of the driving factors for one combined Fatality Review Center were: (1) MCHB's emphasis on ensuring access to quality data to drive prevention and quantify outcomes; (2) HRSA's movement to consolidate and increase efficiencies of traditional resource centers, while enhancing the capacity of data centers that demonstrate measurable impact; (3) the 2011 Report on Coordination and Integration of Fatality Reviews and voices from the field seeking improved collaboration, coordination and data capabilities for fatality reviews; and (4) the successful model of the multi-state CDR web-based Case Reporting System.

The 2011 Report referenced above came out of an MCHB sponsored national invitational meeting held in 2011. Twenty-one state and local experts and six federal representatives attended, representing CDR, FIMR, Domestic Violence fatality reviews, maternal mortality reviews, etc. The focus of the meeting was to explore possibilities

- One coordinated data and technical support center that builds upon data collection and coordinated strategies to prevent fetal, infant, and child deaths while preserving unique components of these two diverse processes.
- Improvement in the quality and effectiveness of the CDR and FIMR processes and of the data collected.
- State and community CDR and FIMR programs use their data to design and propose changes to policy and practice that can reduce adverse maternal, infant, child, and adolescent outcomes.
- Dissemination of results nationally, and increased availability and use of data to inform prevention efforts.

MCHB is so appreciative of the hard work of FIMR and CDR teams and programs across the country and of the work of MPHI, ACOG, and other partners involved in the new Center. We look forward to this collaboration unfolding over the next three years.

NEW FATALITY REVIEW COORDINATORS

Welcome to new Child Death Review coordinators:
Louan Cottrell in Kentucky
Charlene Collier in Mississippi.
Let us know of new FIMR and CDR leaders in your state.

FIMR IN ACTION
by Jodi Shaefer

NFIMR Database Work Group

A stand-alone FIMR data system with 300 variables was launched in 2015 and is used by FIMR programs in Michigan, Delaware, Mississippi, and Elkhart County Indiana. All FIMR programs can use it NOW at no charge. The FIMR Database Work Group is hard at work developing a new FIMR module that will be integrated into the current National CDR Case Reporting System. Once that integration happens, the FIMR Data System and the CDR Case Reporting System will become the new National Fatality Review Case Reporting System sometime in 2017. The work group is creating a master list of variables for the new module, which will also have the capacity to generate case and aggregate data reports and to track actions taken as a result of FIMR reviews. Contact Jodi Shaefer (jshaefer@acog.org) or Esther Shaw (eshaw@mphi.org) if you want to use the current FIMR data system or are interested in participating in the 2017 National Case Reporting System in your jurisdiction.

Florida FIMR training


Jodi Shaefer_ Sharon Owens of Florida_ Hanan Abdulahi

In February, National Center NFIMR personnel conducted FIMR 101 training at Gulf StateCollege in Panama City, FL. NFIMR staff discussed process, resources and updates, and FIMR coordinators from three states presented innovative community actions plans from their programs and focused on energizing and engaging community action teams. Presenters were Jodi Shaefer, NFIMR; Tracy Claveau, Northeast Florida Healthy Start Coalition, Inc.; Mary Craig, Mississippi FIMR; Carol Isaac, FIMR for Douglas County Health Department, Omaha NE; and Kelly Byrns-Davis, Healthy Start of Bay, Franklin, & Gulf Counties, FL. Slides and other resources from the program are available at the NFIMR website, www.nfimr.org.

WHAT'S NEW IN CDR
by Teri Covington

CDR regional meetings

The five CDR regions have been holding many conference calls in preparation for their annual regional meetings. State CDR coordinators will be meeting in late spring in Seattle, Charleston, Hartford or Washington DC. Each region designs its own meeting agenda. This year there will be a continued focus on sharing between states on challenges and successes of managing review programs, and presentations on topics of high interest to the region. These meetings are terrific opportunities for new CDR state coordinators to meet their more experienced colleagues.

CDR at SAFE STATES annual meeting

This April the SAFE STATES annual meeting in Albuquerque (April 12th-14th) will includepresentations from Colorado on its CDR program evaluation and from Minnesota on its mega-review effort to review all its SUID deaths at one time. Kudos to Colleen Kapsimalis and Naomi Thyden for submitting successful abstracts. You can still register for the conference at safestates.org.

Oklahoma and Montana CDR training

Lisa Rhoades, OK CDR coordinator

Lisa Oklahoma and Montana are each conducting intensive, day-long regional trainings in all corners of their states to improve the quality of data entered into the CDR Case Reporting System and to improve reviews at the local level. The Center is attending the trainings with Lisa Rhoades in Oklahoma and Kari Tutwiler in Montana. We are each becoming our own version of a road warrior.

SELF-CARE FOR FATALITY REVIEW PROFESSIONALS

by Abby Collier, CDR/FIMR Wisconsin

On the surface, mortality review seems hopeless and depressing. People often ask me how I am able to manage the content of this work. There is no doubt our work is challenging and heart wrenching. Self-care is an important component of mortality review that all professionals should practice.

Self-care is a personal, individual process that involves looking holistically into several levels of wellbeing - including physical, psychological, emotional, spiritual and professional. The goal with self-care is to build up a repertoire of activities that keep you healthy and thriving.

I try to practice self-care daily. Sometimes that is not enough to keep me in a positive frame of mind; when I find myself in a negative mindset, I know to pause and take extra time for myself. Although taking time practiced in 2 minutes, 30 minutes, a few hours or even a few days. Below are a few of my self-care strategies. Some of these take two minutes, where others take a few hours.

- Google funny jokes; knock-knock jokes are my personal favorite
- Exercise
- Host "walking meetings"
- Take a few deep breaths
- Send a kind email to a coworker or friend
- Make a list of recent successes
- Listen to music or an audiobook

You can figure out what strategies work for you. The National Center for Fatality Review and Prevention will be releasing a toolkit in late spring on self-care for mortality review teams, and a webinar on self-care will be held shortly after. For more information on

out for me feels selfish, I know that if I am not healthy, I cannot help others.

People often think of self-care as a long or involved process. However, self-care can be

self-care, contact Abby Collier at ajcollier@chw.org or (414) 337-4566.

Version 4.0 of Child Death Review Case Reporting System fully launched!!

We are pleased to announce that all features of Version 4.0 of the CDR-CRS have been rolled out to all users. All 32 Standardized Reports are now available in the System. Additionally, state CDR Coordinators can now contact the National Center to request the addition of state customized questions to the report tool. Finally, My CDR Outcomes is now accessible from the main menu as a means to track prevention initiatives undertaken by your teams. Please contact the National Center at info@childdeathreview.org to learn more about any of these features.

CDR-CRS tip

Did you know that users have the ability to upload scene re-creation photos into the CDR-CRS? This can be found at Section H2s in the report tool. The section was added so that a doll re-enactment photo depicting where the infant was found (ideally noting the position of the child's airway in relation to the sleeping environment and other objects found in the sleep place) could be added to the database. One photo less than 6MB in size can be attached per case. For confidentiality reasons, be sure to blur or crop all facial images depicted.

Program Highlight: Idaho CFRT

The Idaho Child Fatality Review team was re-established by a Governor's Executive Order in 2012 under the auspices of the Task Force on Children at Risk. Operating at the state level, the team reviews all deaths that are preventable including all child abuse; external causes; and deaths with unexplained factors. The team holds full reviews of deaths coded natural, "When questions were raised about the cause as coded on the death certificate and/or if a direct link to an existing medical condition was not apparent." In 2012, the team reviewed 77 of the 182 Idaho child deaths. Teresa Abbott of the Idaho Department of Health and Welfare is the coordinator of the team, which she describes as active and effective. Teresa receives notice of all Idaho deaths and is funded to complete case abstracts for her team. She tells us the process is working well but she would like to see better access to educational records for suicide reviews. She reports that obtaining schools records is is difficult and there is no representation on the team from education. Teresa reports that the team is working towards a solution and welcomes ideas from other states.

Teresa Abbott
Idaho CFRT Coordinator

The team has been grappling with two 2012 deaths from preventable illnesses where the

Program Highlight: NE Florida FIMR

In Northeast Florida, sleep-related deaths rose from 2012 to 2015, accounting for 16.8% of all infant deaths in the five Florida counties of Baker, Clay, Duval, Nassau, and St. Johns counties. The Northeast Florida Fetal and Infant Mortality Review (FIMR) program has identified bed sharing as a significant issue warranting additional efforts to reduce it. The FIMR Community Action Team developed a pilot survey that was administered by The Magnolia Project, an inner city initiative to improve the health and well-being of women in their childbearing years. The survey was administered in the urban core of Jacksonville, FL, where poverty, crime, and racial disparities are common. It sought to determine the population's understanding of safe sleep and sleep- related risk factors, and the reasons caregivers choose to bed share. Most respondents provided an accurate description of safe sleep, but nearly 25% of those surveyed cited "feeling safer" as a reason for bed-sharing with their babies.

The FIMR program is now focused on learning more about the meaning of "feeling safer" as a rationale to bed share. The Northeast Florida Healthy Start Coalition has been awarded a grant from March of Dimes to expand the survey questions, to reach a larger number of consumers, and to subsequently revise its Safe Sleep materials to align with the needs of the population. For more information about the program, contact Tracy Claveau, RN, BAN, FIMR/ Momcare Manager at tclaveau@nefhsc.org.

parents did not seek care due to religious beliefs. Idaho law shields parents who refuse medical care for their children due to religious beliefs, from civil and criminal penalties for neglect. Dr. Paul McPherson, a pediatrician, reports that the team responded with a recommendation in its Annual Report for a narrow exemption to law in cases where the "child's death or severe disability is imminent and would, within a reasonable degree of medical certainly, be prevented by the administration of appropriate medical care." Dr. McPherson then helped draft a bill based on its recommendation that was introduced and scheduled for a hearing in early March.

(continued in next column)

However, the legislature announced that no hearing will be held this legislative session. The next session begins January 2017, and Dr. McPherson worries there will be similar deaths before then. The team received good news, though, when their findings got the attention of Governor Butch Otter. In February, he requested the legislature convene a work group to "assess the Child Fatality Review Team's report along with other sources of research and testimony regarding this policy issue." He also stated, "I believe we must give this issue a thorough examination."

Disparities Work Group

The Center is starting a new Disparities Work Group to develop specific strategies to improve CDR and FIMR attention to disparities, such as increasing team membership of persons representing communities at highest risk and analysis of data and formulation of team recommendations to address mortality disparities. Both CDR and FIMR representatives are encouraged to participate. Contact Hanan Abdulahi at habdulahi@acog.org if you would like to join the work group.

UPCOMING EVENTS

Western Regional CDR Meeting,
Seattle WA, May 8-10, 2016
Southeastern Regional CDR Meeting,
Charleston SC, May 17-19, 2016
New England Regional CDR Meeting
Hartford CT, June 9-10, 2016
Mid-Atlantic and Midwest Regional Meeting,
Washington DC, June 26-28, 2016

IN THE NEXT ISSUE: A report from the first meeting of the new Center's **National Advisory Committee**, held March 15, 2016, in Washington DC.

PAPER ON PEDIATRIC SUICIDE USES NATIONAL CENTER CDR-CRS DATA

Using the National Child Death Review Case Reporting System (CDR-CRS) database, the authors examined the data from suicide deaths reviewed by CDR teams to identify psychosocial risk factors contributing to pediatric suicide and to examine whether these factors are more common among individuals with a history of mental illness or illicit substance abuse. The paper was shared with SAMHSA, and SAMHSA is working with the Center and Dr. Lichtenstein, one of the paper's authors, to develop a national white paper on suicide using the data. SAMHSA also shared the paper with state and tribal Garrett Lee Smith Suicide Prevention Grantees around the country.

Triglylidas T, Reynolds E, Teshome G, Dykstra H, Lichenstein R. (2016). Pediatric Suicide in the United States: Analysis of the National Child Death Case Reporting System. Injury Prevention 0:1-6. Published first online doi:10.1136/injuryprev-2015-041796.

JOIN OUR MAILING LIST

This newsletter was made possible in part by Cooperative Agreement Number UG7MC28482 from the US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB). 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.

MPHI, 2455 Woodlake Circle, Okemos, MI 48864