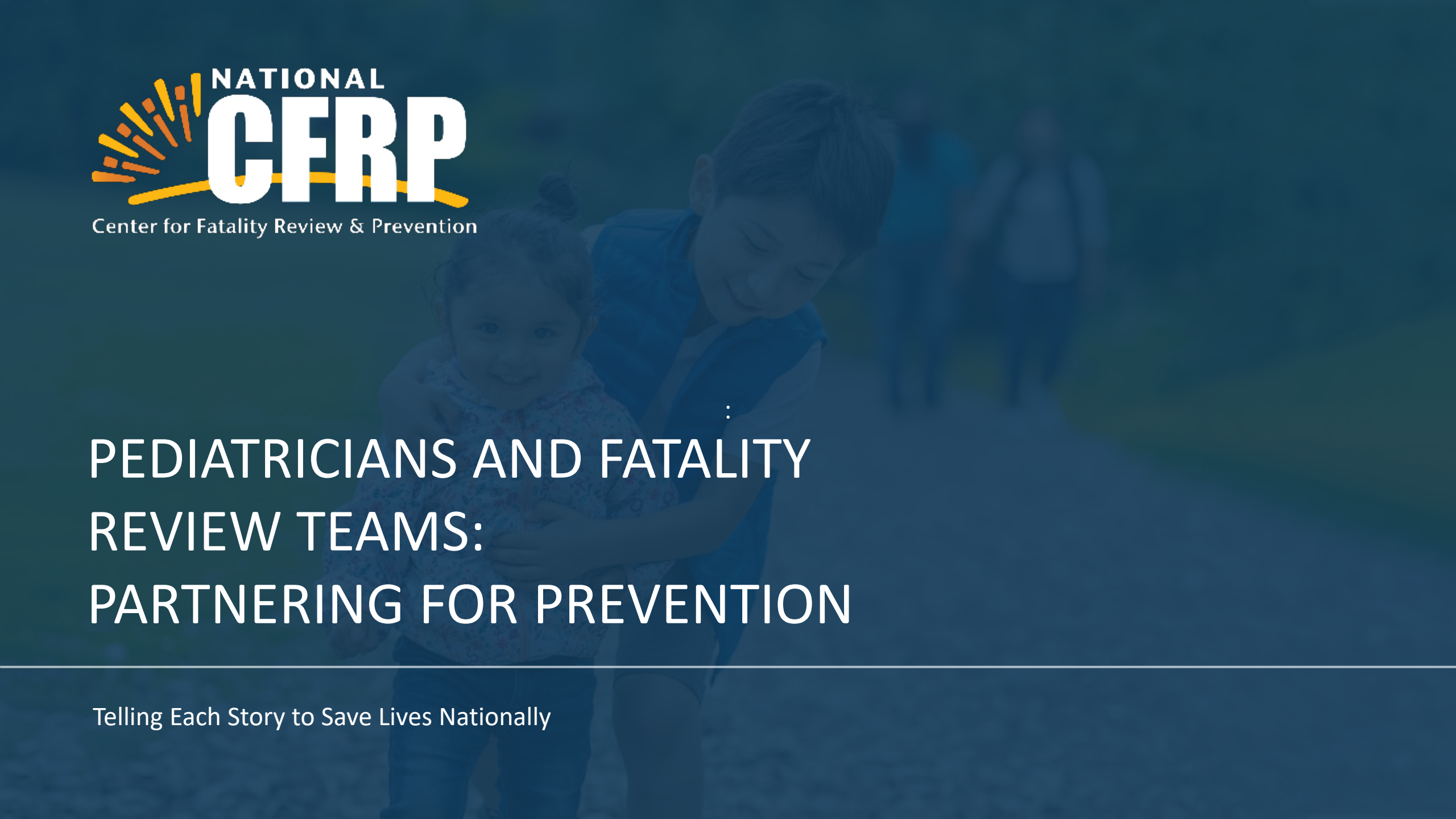


NATIONAL CFRP
Center for Fatality Review & Prevention

PEDIATRICIANS AND FATALITY REVIEW TEAMS: PARTNERING FOR PREVENTION

Telling Each Story to Save Lives Nationally

KEY FUNDING PARTNER

FEDERAL ACKNOWLEDGEMENT

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

The American Academy of Pediatrics is funded in part by Cooperative Agreement number Uf745730, 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 $500,000 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.

HOUSEKEEPING

Before we get started

- This webinar is being recorded and will be available on the National Center's webpage (URL: www.ncfrp.org).
- Participants are **NOT** muted. Please mute yourself unless you are speaking
- Contact the National (email: info@ncfrp.org) for any tech problems.

PRESENTATION GOALS

Provide an Overview of AAP SUID Prevention

Learn about AAP work for the SUID Prevention Cooperative Agreement and the AAP Section on Child Death Review and Prevention

Overview of CDR and FIMR

Learn about child death review (CDR) and fetal and infant mortality review (FIMR) processes and data collection in the National Fatality Review-Case Reporting System

Overview of Funding Opportunity

Learn about the unique funding opportunity provided through a partnership between the National Center and the AAP

Stories from the Field

Hear from physicians engaged in fatality review about successes, opportunities and challenges

Resources

Learn about resources from the AAP and National Center

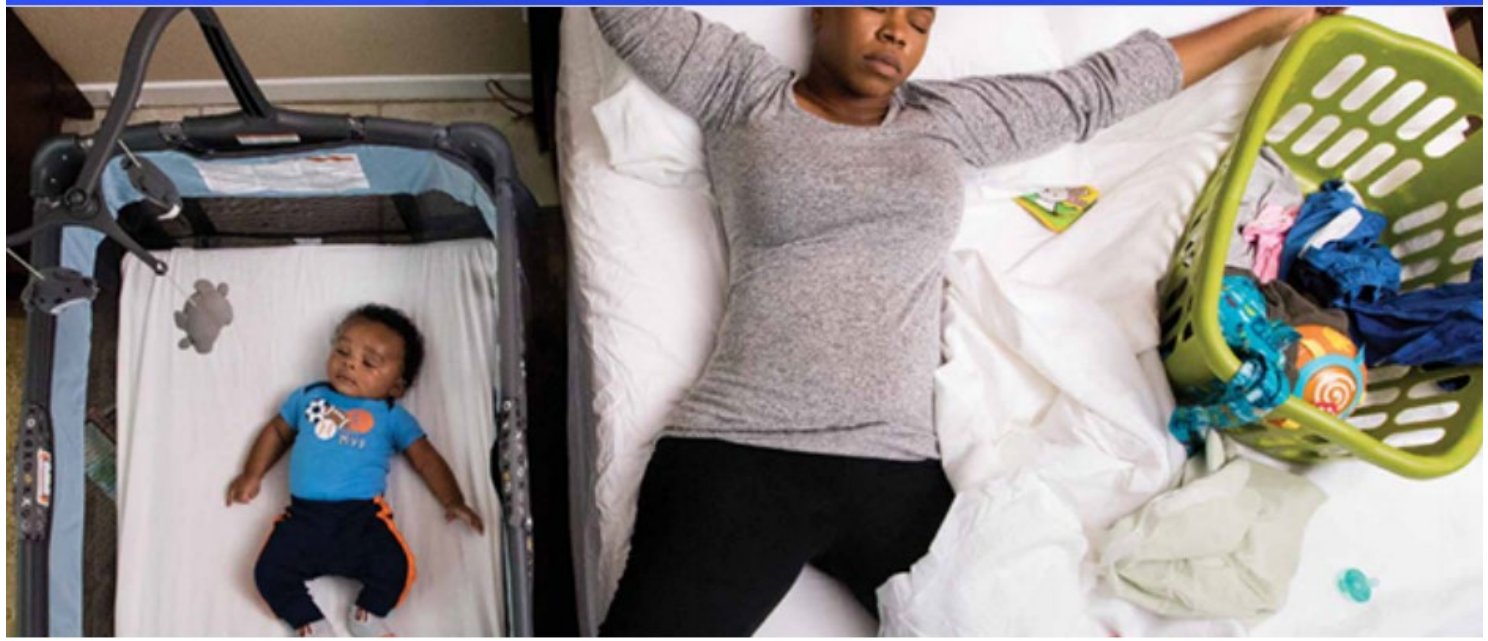
American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®

Patient Care

Safe Sleep

Home / Patient Care / Safe Sleep



- Task Force on SIDS
- Section on Child Death Review and Prevention
- SSNUGLE QI Collaborative
- Resource Library

Program Background

The AAP was awarded the 3-year cooperative agreement for the Sudden Unexpected Infant Death (SUID) Prevention Program through

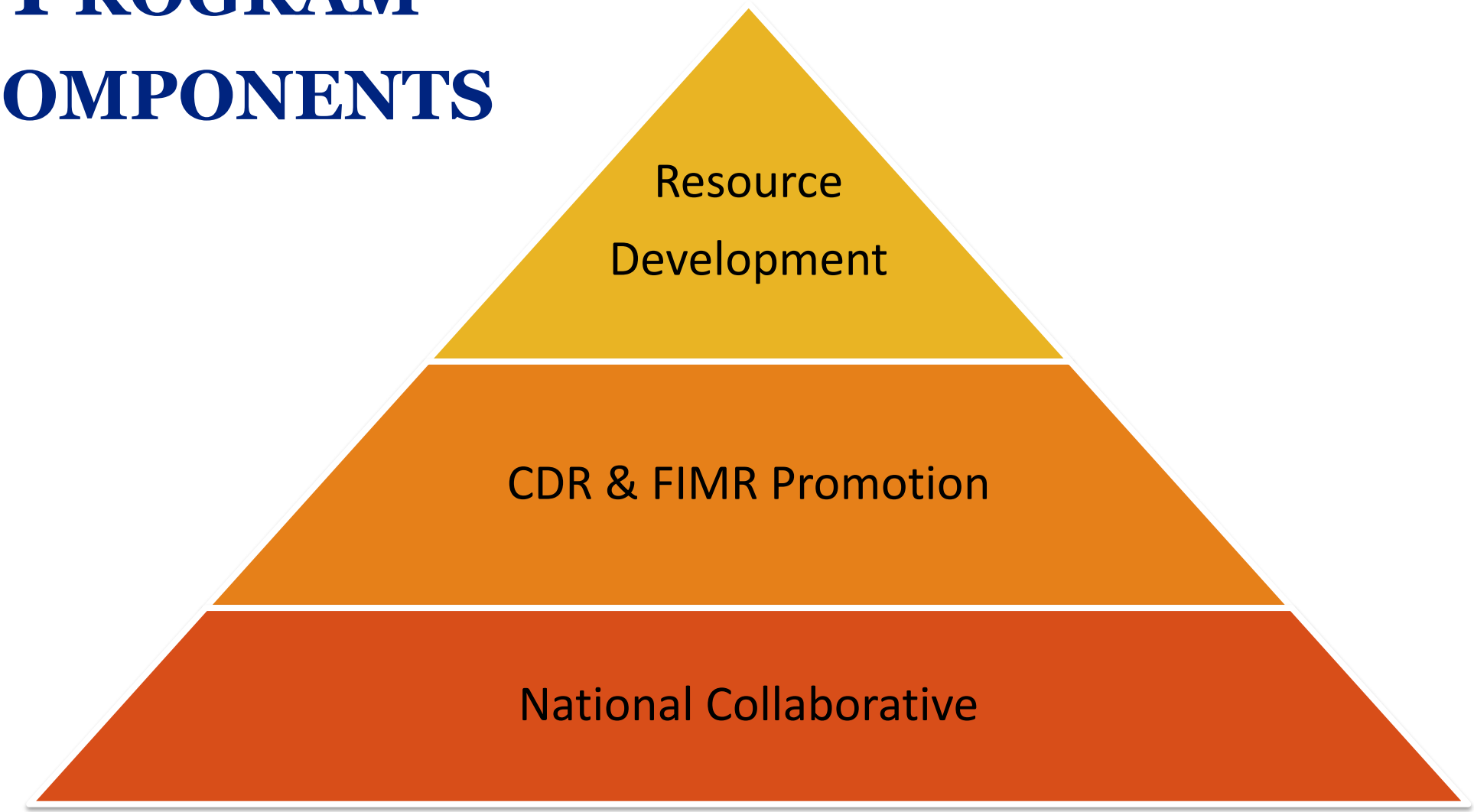
the Health Resources and Services Administration (HRSA) Maternal and Child Health Bureau (MCHB)

Program Aim & Goals

The Sudden Unexpected Infant Death (SUID) Prevention Program aims to reduce overall rates of SUID and reduce racial and ethnic disparities in SUID

- Evidence-based counseling and education
- System improvements
- Policy changes

Program Components



Technical Assistance and Training

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

National Fatality Review-Case Reporting System

Support the NFR-CRS which is used in 47 states and provides jurisdictions with real-time access to their fatality review data.

Resources

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

Communication with Fatality Review Teams

Regular communication via listserv, newsletters and regional coalitions.

Follow Us on Social Media

@NationalCFRP on Twitter and Facebook.

ABOUT THE NATIONAL CENTER

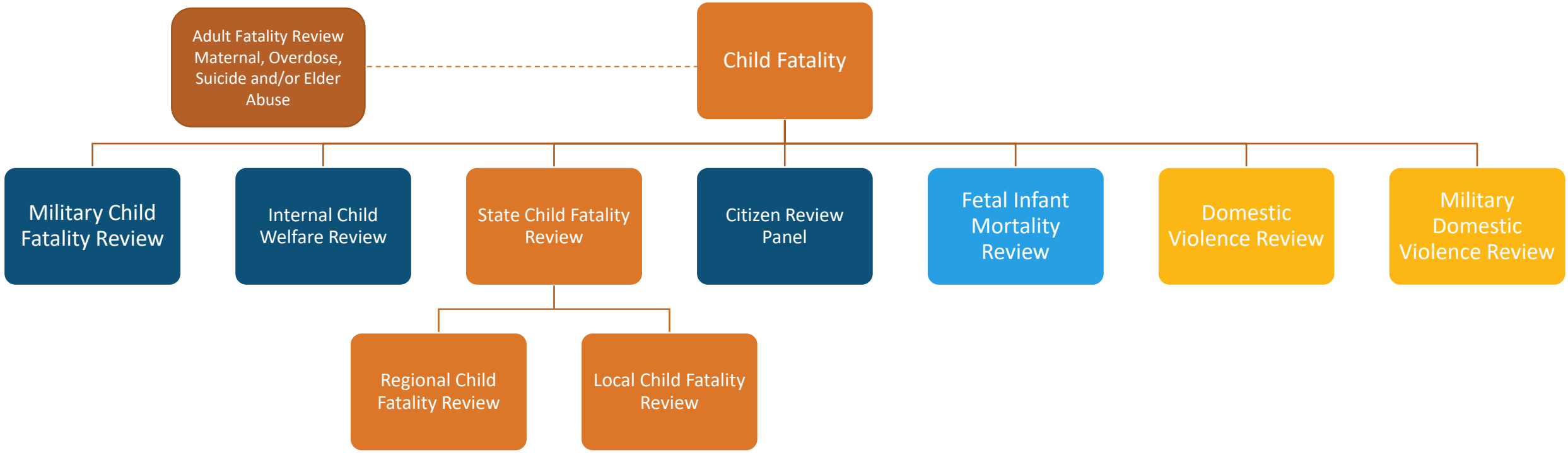
THE ROLE OF PEDIATRICIANS

Collaborating for Prevention

Pediatricians provide critical insight into typical anticipatory guidance provided to families, normal growth and development across childhood and an understanding of how families access medical care

The Web of Reviews

Intentional Connections to Improve Health and Safety



WHAT IS CDR?

Understanding Fatalities to Improve Safety

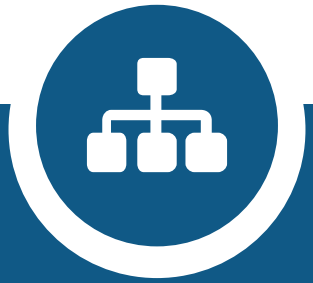
- Multidisciplinary, community-oriented process that brings together professionals to understand how and why children die.
- Illuminates where systems are successful in working together as well as opportunities for improvement.
- Uncovers disparities in how families are offered resources, access services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

Three Steps to Child Death Review

Steps to Success

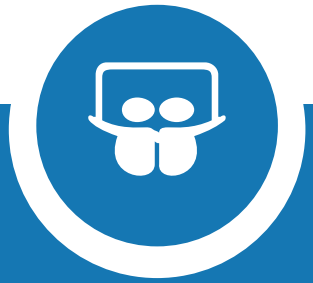
Tell the Story

Tell each story, identified, to understand the risk and protective factors



Collect Data

Multidisciplinary data on the context in which the child lived should be documented



Take Action

Fatality Review Teams should be a catalyst for prevention

CDR Process

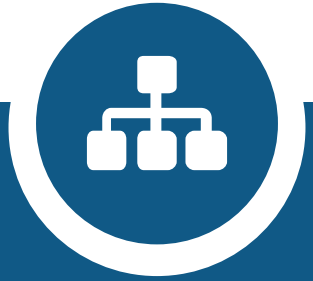
Best Practices in Reviews

Brief History of FIMR

Maternal Child Health Bureau conceptualized IMR, the forerunner of FIMR

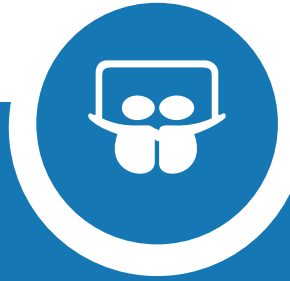
1988: 10 pilot programs funded

MA, SC, CT, NY, AL, UT, AR, IN, KS were among the original pilot sites



1990: ACOG funded as the TA and resource Center

Transitions to **FIMR** in 1991 when stillbirth review was added



1997–2004: MCHB funded 12 state FIMR Support Programs

2004: National Evaluation of FIMR by Johns Hopkins University Women's and Children's Health

What is FIMR?

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

Changes in Community Systems

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

Data Gathering

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

Community Action

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

Case Review

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

A Two-Tiered Process

Case Review Team (CRT)

- **Reviews the story**: What happened to this baby and family from the time his/her mother got pregnant until the time of death?
- Identifies the issues: Were there clinical, community or health system factors that contributed to the death?
- Makes recommendations

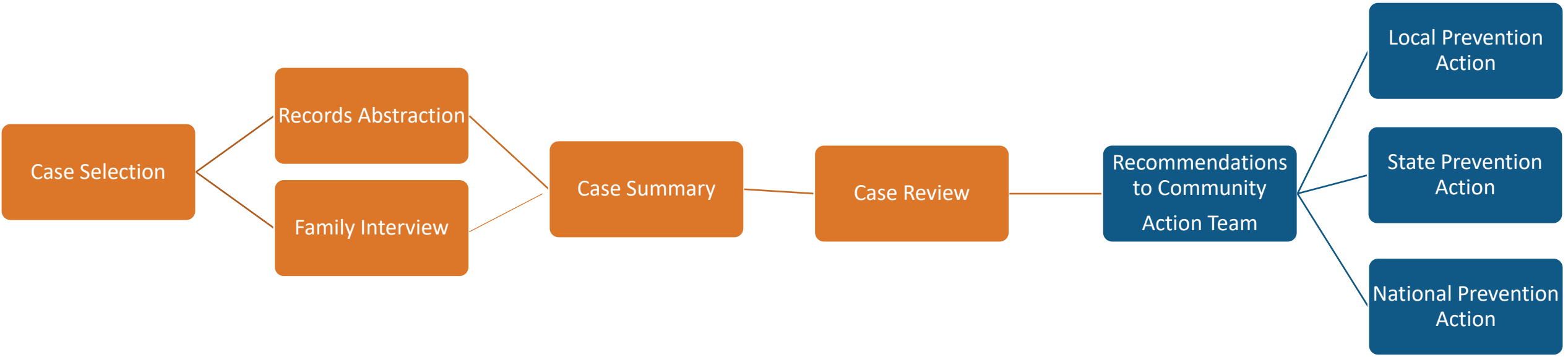
Community Action Team (CAT)

- Composed of those who have the political will and fiscal resources to create large scale systems change
- Responsible for taking recommendations to **ACTION**
  - -Creative solutions to improve services and resources
  - -Prioritize and implement interventions

FIMR includes a Family Perspective: A home interview with the parents who have suffered a loss and the families' story is conveyed to the FIMR team members

FIMR Process

Best Practices in Reviews



NFR-CRS Utilization

There are currently 47 states using NFR-CRS

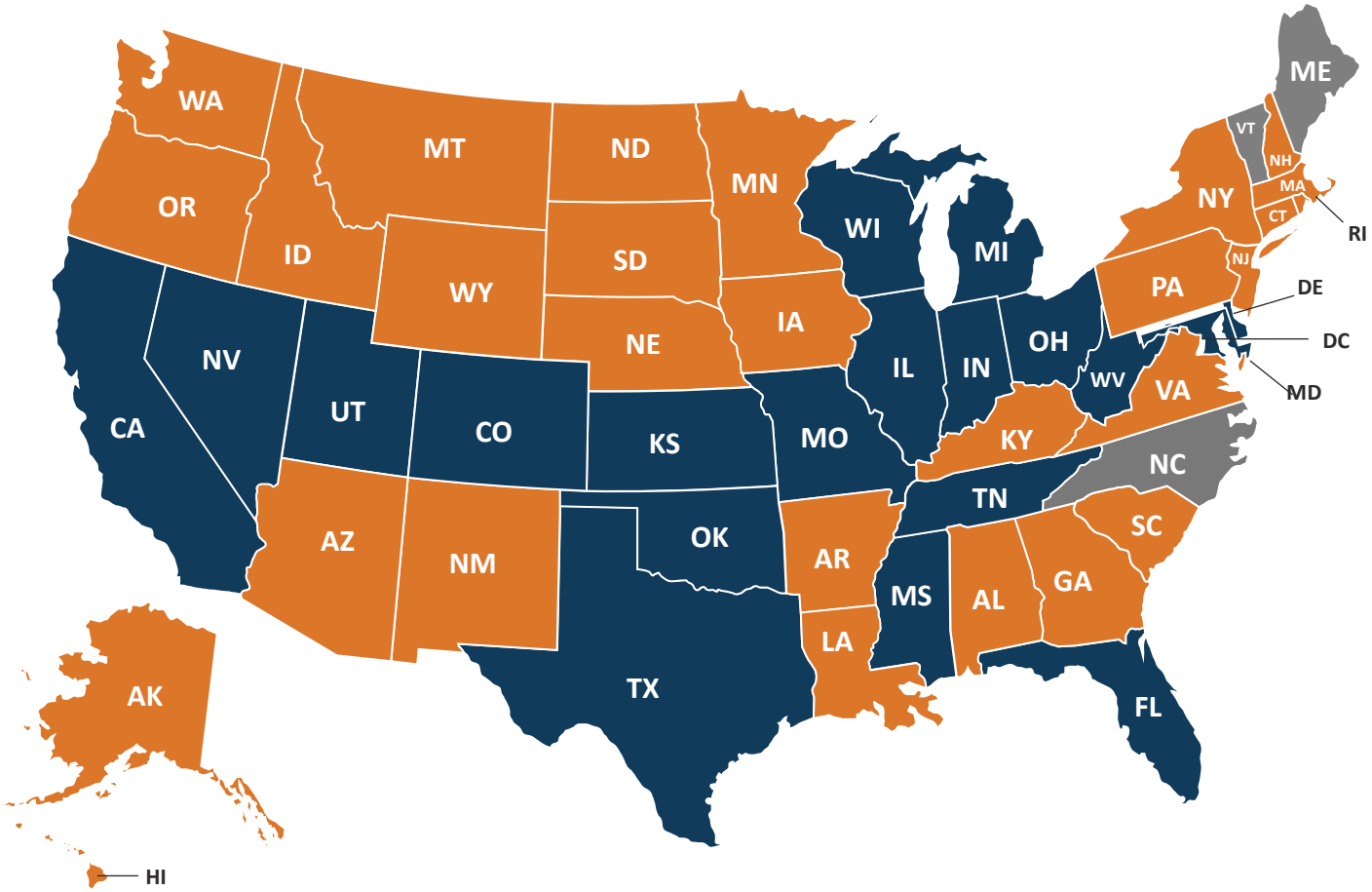
- 47 use NFR-CRS for CDR
- 19 use NFR-CRS for FIMR

Each state uses NFR-CRS differently. Some have comprehensive reviews whereas others may only use NFR-CRS in one jurisdiction. States do not have to participate in NFR-CRS to be eligible for this funding

States Using NFR-CRS for CDR

States Using NFR-CRS for CDR and FIMR

States Not Using NFR-CRS



Partners For Child Fatality Prevention: Education & Advocacy

Phyllis Agran, MD, MPH • Van Nguyen Greco, MD • Diane Winn, RN, MPH • Jaya Bhalla • Mary Jo Quintero, RN, PNL • Ameer Mody, MD, MPH • Katherine Gitz, MD • Sandra Murray, MD • Sara Brown, PhD, EdD, RN • Alfonso Valdez, PhD • Jamie McDonald, MPH • Emma Course

Background

Child Death Review Teams (CDRT) review circumstances surrounding child deaths to prevent future fatalities

American Academy of Pediatrics (AAP) provided local Chapter awards to promote engagement with CDRTs

Partners for Child Fatality Prevention (AAP-OC) was designed to develop a sustainable partnership that shares, translates, and disseminates data with recommendations to inform interventions and advocacy

Methods

Pediatrician-led Multidisciplinary Team with CA Statewide Members

- Reviewed and analyzed available de-identified data from 2018-2020

Data Sources

- CDRT
- California Department of Public Health (CDPH) EpiCenter
- National Center for Health Statistics (NCHS)

Educational Advocacy

Webinar Topics

- Leading causes of death
- Role of CDRT
- Pediatric drowning
- Youth suicide

Policy Advocacy

Results

Data Review Leading Causes of Fatality (CA)

Ages <1 (N=239)	Ages 1-4 (N=329)	Ages 5-9 (N=196)	Ages 10-14 (N=391)	Ages 15-17 (N=930)
Suffocation (128)	Drowning (139)	MVT, Unspec. (41)	Suicide (102)	Suicide (257)
Homicide (46)	Homicide (66)	Drowning (32)	MVT, Unspec. (64)	Homicide (202)
MVT, Unspec. (18)	Pedestrian (44)	Homicide (25)	Homicide (48)	Poisoning (131)
Drowning (10)	MVT, Unspec. (34)	MV Occupant (25)	Pedestrian (43)	MVT, Unspec. (123)
All Other (37)	Suffocation (26)	Pedestrian (20)	MV Occupant (22)	MV Occupant (69)

5 Leading Causes of Injury Deaths by Age Groups, California Residents 0-17 Years: (2018-2020), N= 2,085

Educational Advocacy

Webinars *(41% Physicians; 59% Other Learners)*

1. Child Death Review (127 participants)
2. Drowning (172 participants)
3. Youth Suicide (154 participants)

Policy Advocacy California in Collaboration with AAP-CA

CA SB 855 (Newman)

- Establish fatal and non-fatal statewide drowning data collection system
- Inform on strategies & policies for drowning prevention
- CA Water Safety Plan
- Implement recommendations

Assembly Bill 2660 (Maienschein) Child Death Investigations: Review Teams (2021-2022). 8/2022 sent to Governor's Office for signature. CA-CDR Council defunded in 2008 due to great recession.
Senate Bill 855 (Newman) Childhood Drowning Data Collection Pilot Project (2022). 8/2022 sent to the Governor' Office for signature. **Sponsor: AAP-CA & the CA Alliance for YMCA's**

Childhood Drowning Data Collection Pilot Program

Water Safety Resource for Families

Conclusions

Sustainable collaboration with the Orange County Child Death Review Team

New AAP-OC Project: Foundations for Childhood Drowning Surveillance and Prevention

Future educational webinars (CME and community)

Policy advocacy to reduce preventable fatalities and injuries

Authors have no financial relationships to disclose.

AAP/National Center for Fatality Review and Prevention 2020-2021 Chapter Grant

(Presented at American Academy of Pediatrics NCE. H0320: Joint Program: Section on Child Death review and Prevention and Council on Injury, Violence and Poison Prevention, October 10, 2022, Anaheim, CA)

References

- Cindy W. Christian, Robert D. Sege, The Committee on Child Abuse and Neglect, The Committee on Injury, Violence, and Poison Prevention, The Council on Community Pediatrics; Child Fatality Review. Pediatrics September 2010; 126 (3): 592–596. 10.1542/peds.2010-2006
- California Department of Public Health. EpiCenter California Injury Data Online. https://epicenter.cdph.ca.gov
- California Department of Public Health. EpiCenter California Injury Data (personal communication)
- Centers for Disease Control. WISQARS™ — Web-based Injury Statistics Query and Reporting System https://www.cdc.gov/injury/wisqars/index.html.
- Sarah A. Denny, Linda Quan, Julie Gilchrist, Tracy McCallin, Rohit Shenoi, Shabana Yusuf, Benjamin Hoffman, Jeffrey Weiss, Council on Injury, Violence and Poison Prevention, Phyllis F. Agran, Michael Hirsh, Brian Johnston, Lois K. Lee, Kathy Monroe, Judy Schaechter, Milton Tenenbein, Mark R. Zonfrillo, Kyran Quinlan; Prevention of Drowning. Pediatrics May 2019; 143 (5): e20190850.10.1542/peds.2019-0850

Acknowledgments

- AAP Council on Injury Violence and Poison Prevention
- National Center for Child Death Review and Prevention
- Partners for Child Fatality Prevention Team
- AAP-National, AAP-California and AAP-Orange County staff and members
- Orange County Sheriff's Department (Tiffany Williams, Senior Deputy Coroner)
- The Raise Foundation (Eldon Baber, Executive Director)

Further Information

AAP-OC Injury and Violence Prevention Initiative • www.aap-oc.org/initiatives/injury-violence-prevention-2

AAP-OC Partners for Child Fatality Prevention • www.aap-oc.org/pcfp

AAP-OC Partners for Childhood Drowning Prevention • www.aap-oc.org/pcdp

Methods

Pediatrician-led Multidisciplinary Team with Statewide Members

- Reviewed and analyzed available de-identified data from 2018 to 2020

Data Sources

- CDRT
- California Department of Public Health (CDPH) EpiCenter
- National Center for Health Statistics (NCHS)

Educational Advocacy & Webinars

- Leading causes of death
- Role of CDRT
- Pediatric drowning
- Youth suicide

Policy Advocacy

Webinars were developed with the intent to expand on the role CDRT plays in the prevention of such fatalities. Participants were presented with fatality data and case studies, in addition to topic-specific content. Webinars were evaluated with standard tools for CME/MOC-2.

Results: Data Review. Leading Causes of Fatality (CA)

5 Leading Causes of Injury Deaths by Age Groups, California Residents 0-17 Years: (2018-2020), N= 2,085

Age <1 (N=239)	Ages 1-4 (N=329)	Ages 5-9 (N=196)	Ages 10-14 (N=391)	Ages 15-17 (N=930)
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All Other (37)	Suffocation (26)	Pedestrian (20)	MV Occupant (22)	MV Occupant (69)

Source: *EpiCenter, California Department of Public Health*

Results: Educational Advocacy

Webinars

1) Child Death Review (127 participants) - July 15, 2021
2) Drowning (172 participants) - August 19, 2021
3) Youth Suicide (154 participants) - September 30, 2021
4) Youth Suicide Update (59 participants) - December 8, 2022
5) Firearm Violence Prevention (105 participants) - February 16, 2023

Intent to Implement Change (from CME evaluation)

1) Increased specific injury prevention anticipatory guidance
2) Increased awareness of CDRT
3) Informing others on CDRT findings/recommendations
4) Advocacy for reactivation of CA CDR-Council

Results: Policy Advocacy (AAP-CA)

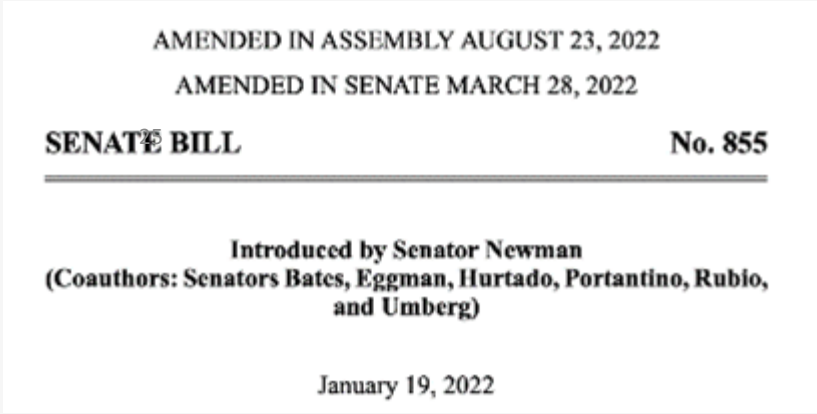
Assembly Bill 2660 Maienschein. Child Death Investigations: Review Teams (2021-2022) sent to the Governor for signature
CA-CDR Council defunded in 2018 due to great recession

> *The Attorney General shall annually, and in time to be included in the Governor's January Budget, submit to the Governor and the Legislature a budget that is sufficient to fund the council, and the requirements of Section 11174.33 and this section.*

Senate Bill 855 Newman. Childhood Drowning Data Collection Pilot Project (2022) Sponsors: AAP-CA & the CA Alliance for YMCA's

5 year project. Budget allocation $1.52M

Major Advocacy Success



AMENDED IN ASSEMBLY AUGUST 23, 2022

AMENDED IN SENATE MARCH 28, 2022

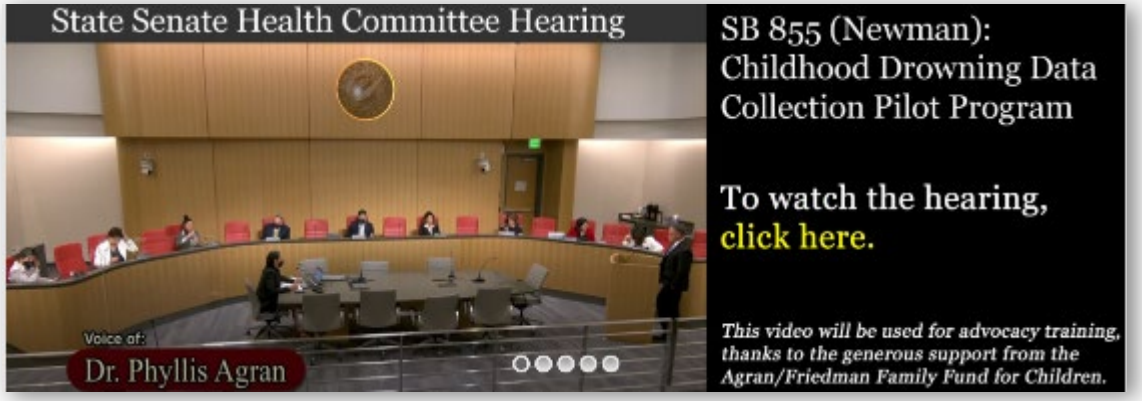
SENATE BILL No. 855

Introduced by Senator Newman
(Coauthors: Senators Bates, Eggman, Hurtado, Portantino, Rubio, and Umberg)

January 19, 2022

Results: Legislative Advocacy
Childhood Drowning Data Collection Pilot Program

- State Senate Health Committee Hearing video posted on our website for educational purposes and shared
- Resident Advocacy Training
- Community Partners
- Pediatricians
- **CA SB 855 (Newman)**
  - Establish fatal and non-fatal statewide drowning data collection system
  - Inform on strategies & policies for drowning prevention
  - CA Water Safety Plan
  - Implement recommendations



Listen Here:
Senate Health Committee Hearing
(Richard Pan, MD, FAAP, Chair)

Project Information

Budget

- Project Coordinator
- Physician Stipends
- Speaker Honoraria
- Administration

CME Provided by Chapter

Engaged Partners

- Committee on Injury, Violence and Poison Prevention and Non-Committee Members
- CDRT Leadership

Consulted with CDPH

Conclusions: Partners for Child Fatality Prevention

- Sustainable collaboration with County Child Death Review Team
- Pilot Site for NCFRP: Drowning Death Scene Investigation and Child Death Review Project
- *2021-2023) Foundations for Childhood Drowning Surveillance and Prevention.
- *Data Collection Project

**Funded in part by the CDPH Kids' Plates Program & Picerne Family Foundation*

- Educational Webinars and Community Events
  - Health care providers (CME & CEU) on drowning prevention
  - Community partners. Leverage with Clinic in the Park, a fiscally sponsored project of AAP-OC, www.clinicinthepark.org
- Policy & Legislative Advocacy

Acknowledgments
Partners for Child Fatality Prevention

CA, AAP and AAP-Orange County thank the national AAP Council on Injury, Violence and Poison Prevention, the Child Death Review and Prevention Section and the National Center for Fatality Review and Prevention for granting us this opportunity.

Team: V. Greco •D. Winn •J. Bhalla •B. Tomuta • J. McDonald •A. Mody, •MJ. Quintero, •S. Brown •A. Valdez, •S. Murray

AAP-OC thanks our team, our CDRT, The Raise Foundation OC's Child Abuse Prevention Council, and our pediatricians who supported this.

A springboard for a lasting collaboration

References

Cindy W. Christian, Robert D. Sege, The Committee on Child Abuse and Neglect, The Committee on Injury, Violence, and Poison Prevention, The Council on Community Pediatrics; Child Fatality Review. Pediatrics September 2010; 126 (3): 592–596. 10.1542/peds.2010-2006

California Department of Public Health. EpiCenter California Injury Data Online. https://epicenter.cdph.ca.gov

California Department of Public Health. EpiCenter California Injury Data (personal communication)

Centers for Disease Control. WISQARS™ — Web-based Injury Statistics Query and Reporting System https://www.cdc.gov/injury/wisqars/index.html.

Sarah A. Denny, Linda Quan, Julie Gilchrist, Tracy McCallin, Rohit Shenoi, Shabana Yusuf, Benjamin Hoffman, Jeffrey Weiss, COUNCIL ON INJURY, VIOLENCE, AND POISON PREVENTION, Phyllis F. Agran, Michael Hirsh, Brian Johnston, Lois K. Lee, Kathy Monroe, Judy Schaechter, Milton Tenenbein, Mark R. Zonfrillo, Kyran Quinlan; Prevention of Drowning. Pediatrics May 2019; 143 (5): e20190850. 10.1542/peds.2019-0850

AAP-OC Injury & Violence Prevention Initiative. https://www.aap-oc.org/initiatives/injury-violence-prevention-2

Funding Opportunity

Goal: Build or enhance collaboration between AAP chapters and fatality review teams

Funding amount: $5,000

Application due: March 20, 2023

URL: https://www.surveymonkey.com/r/2XHVC3S

CONTACT INFORMATION

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THANK YOU FOR YOUR TIME!
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