NATIONAL 20 YEARS CFRP
Center for Fatality Review & Prevention

Enhancing Collaboration Between
CDR AND OVERDOSE FATALITY REVIEW TEAMS

Telling Stories to Save Lives

KEY FUNDING PARTNER

FEDERAL ACKNOWLEDGEMENT

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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 muted. Use the question-and-answer box ask questions.
- Contact the National (email: info@ncfrp.org) for any tech problems.

EVALUATION

https://www.surveymonkey.com/r/32BRMMX

Diane Pilkey, RN, MPH

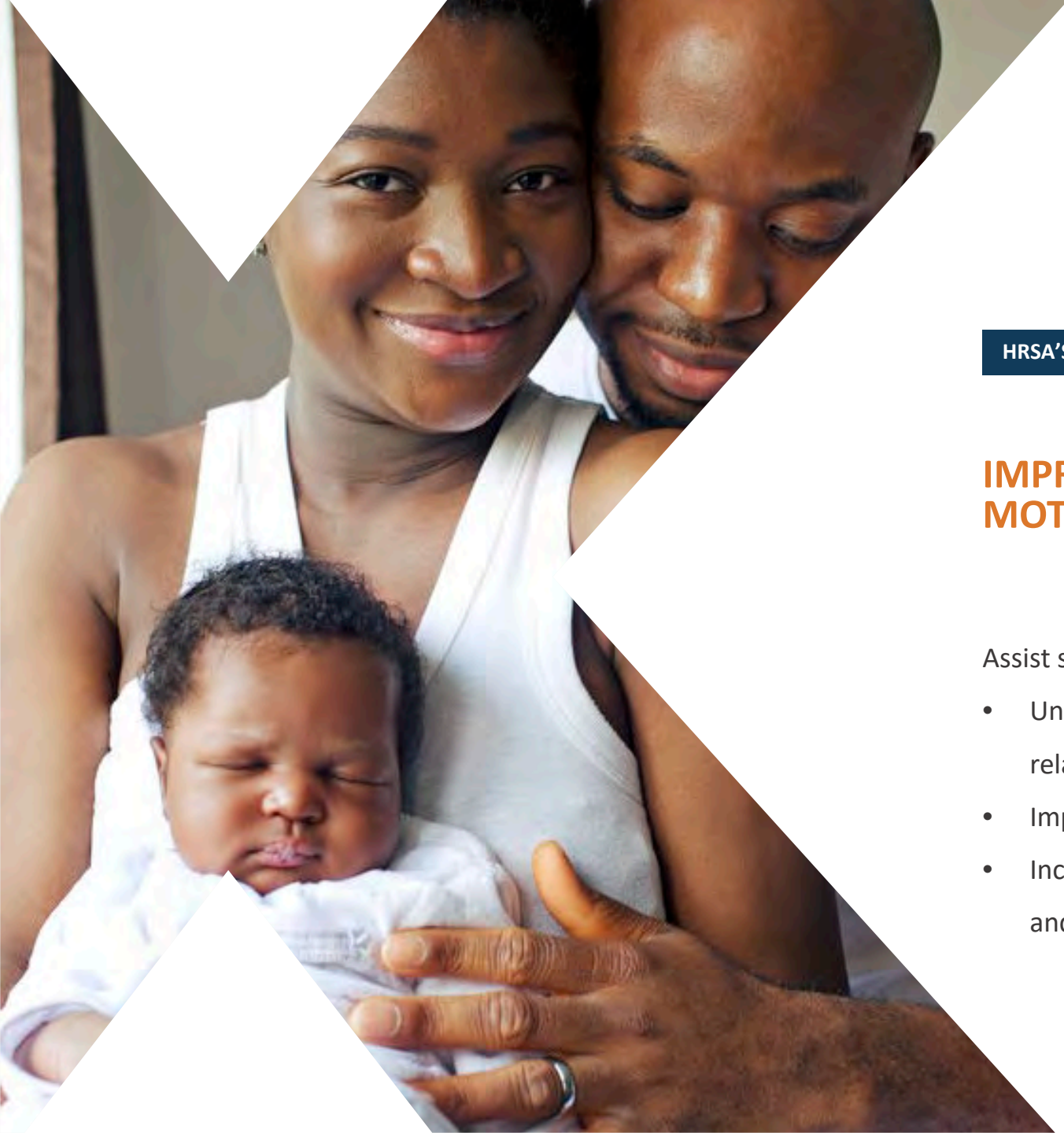
Welcome and Introductions

Senior Nurse Consultant

Division of Child, Adolescent and Family Health

Maternal and Child Health Bureau

Health Resources and Service Administration



HRSA'S VISION FOR THE NATIONAL CENTER

IMPROVING SYSTEMS OF CARE AND OUTCOMES FOR MOTHERS, INFANTS, CHILDREN, AND FAMILIES

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

PRESENTATION GOALS

Overview of Child Death Review (CDR)

Discuss the CDR process and how data are collected.

Deaths That Occurred Due to Opioid Ingestion

Review data from CDR teams on deaths that occurred due to opioid ingestion.

Reasons CDR and OFR Teams Might Seek Alignment

Learn similarities between CDR and OFR teams, unique process goals and features, and why these programs might seek enhanced collaboration.

Opportunities for Collaboration

Understand opportunities for CDR and OFR teams to coordinate efforts and support progress across the life course.

Success Stories

Learn how CDR and OFR programs collaborate in Utah and Wisconsin.

Speakers

Experts Joining in the Discussion

Gretchen Martin, MSW
Senior Project Coordinator
National Center

Sasha Mintz, MPH
Senior Epidemiologist
National Center

Gabby Fraley, MPH
Senior Data Analyst
National Center

Kacy Robinson, MS
Fatality Review Specialist
Utah Department of Health

Megan Broekemeier, MPH
Forensic Epidemiologist
Utah Office of the Medical Examiner

Karen Nash, MBA
Program Leader
Children's Health Alliance of Wisconsin

Technical Assistance and Training

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

National Fatality Review-Case Reporting System

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

Resources

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

Communication with Fatality Review Teams

Regular communication via listserv, newsletters and regional coalitions.

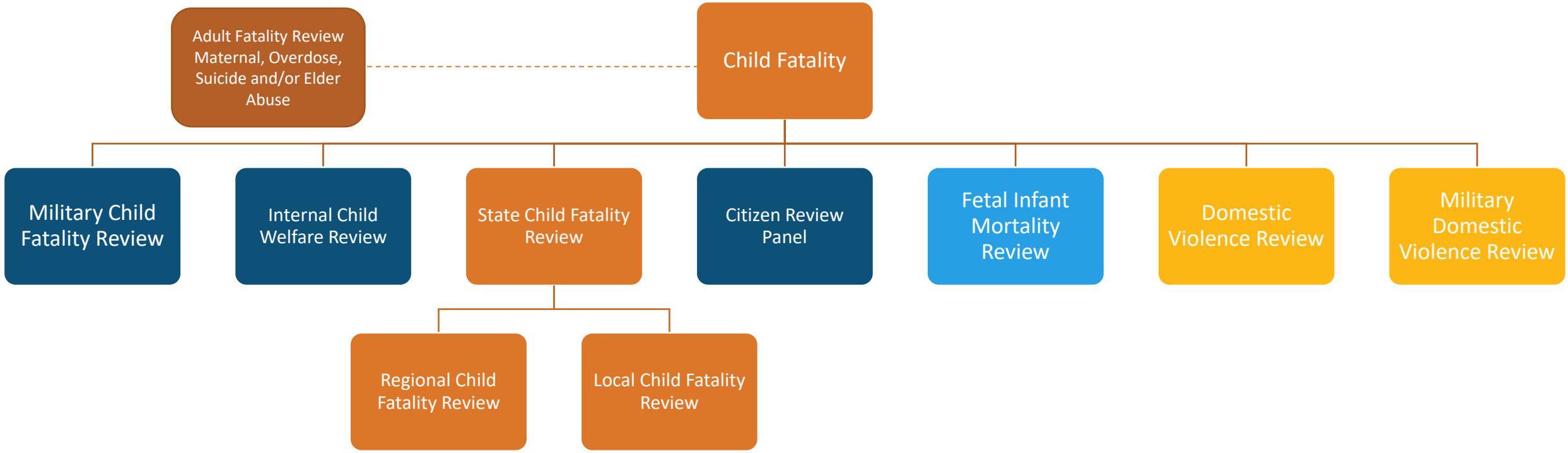
Connection with National Partners

Develop or enhance connections with national organizations, including federal and non-federal partners.

ABOUT THE NATIONAL CENTER

The Web of Reviews

Intentional Connections to Improve Health and Safety



WHAT IS CDR?

Understanding Fatalities to Improve Safety

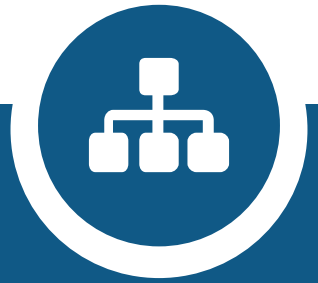
- Multidisciplinary, community-oriented process that brings together professionals to understand how and why children die.
- Illuminates where systems are successful in working together as well as opportunities for improvement.
- Uncovers disparities in how families are offered resources, access services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

Three Steps to Child Death Review

Steps to Success

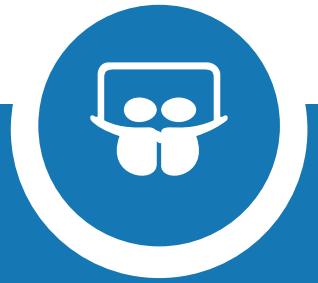
Tell the Story

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

NFR-CRS Utilization

There are currently 47 states using NFR-CRS

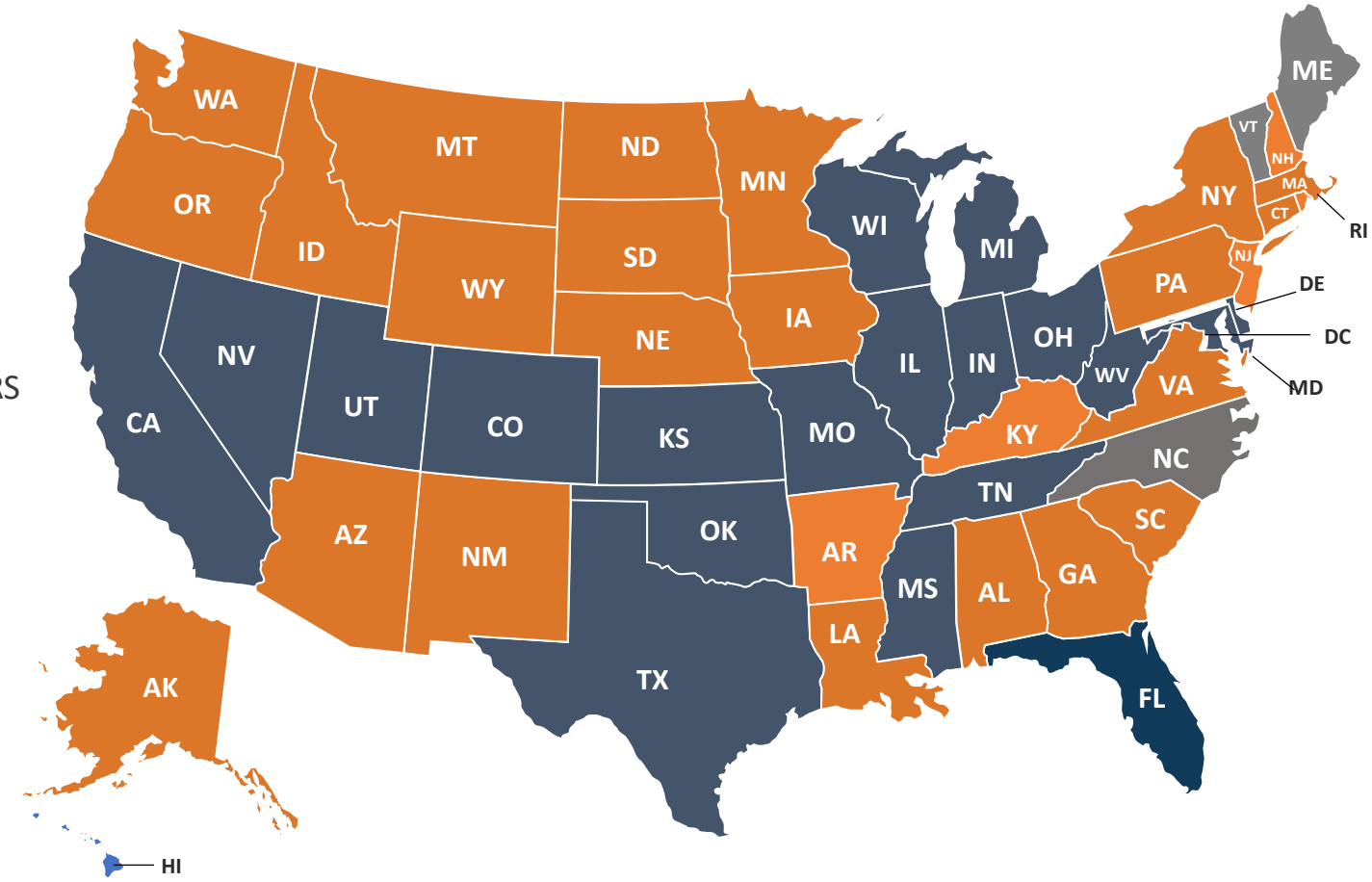
- 47 use NFR-CRS for CDR
- 19 use NFR-CRS for FIMR

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 opportunity.

States Using NFR-CRS for CDR

States Using NFR-CRS for CDR and FIMR

States Not Using NFR-CRS



Deaths that Occurred Due to Opioid Ingestion

NFR-CRS data from 1,339 deaths, that occurred to children ages 1-17 between 2004-2020

AGE

15% 1-4 years old

3% 5-9 years old

11% 10-14 years old

71% 15-17 years old

RACE AND ETHNICITY

3% AI/AN, 2% Asian, 17% Black, 2% Multiracial, 76% white, and 18% Hispanic

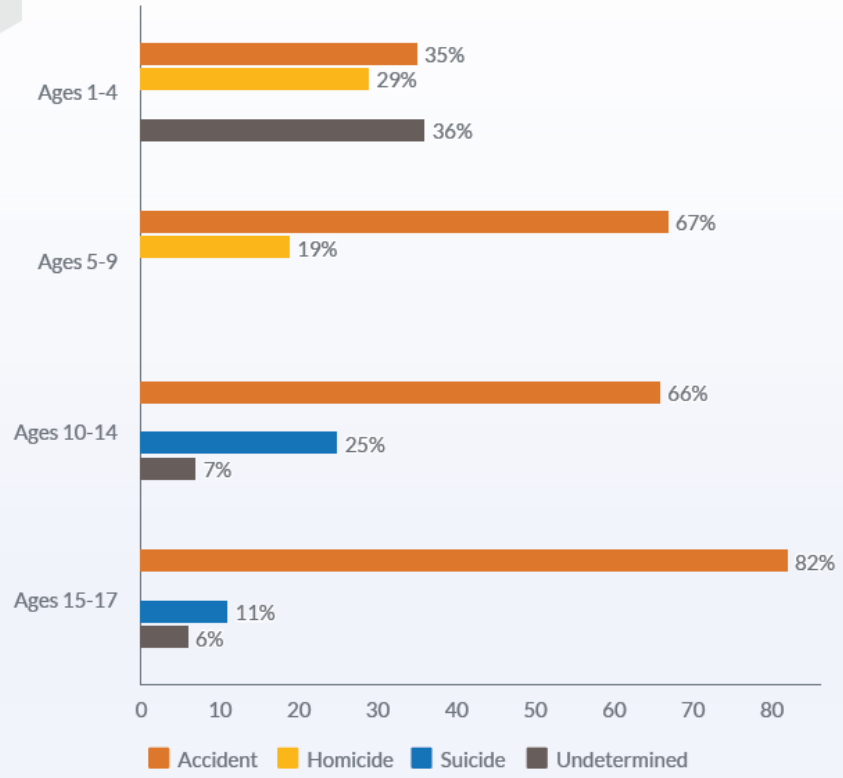
SEX

64% were male and 36% were female according to their death certificate

Manner of Death and Child History

NFR-CRS data from 1,339 deaths, that occurred to children ages 1-17 between 2004-2020

Manner of Death by Age Group



Child History

- **45%** had a history of child maltreatment as a victim
- **36%** had a prior disability or chronic illness

Among Youth 10-17 Years Old

- **88%** had a history of substance use
- **69%** had problems in school
- **65%** had received prior mental health services
- **39%** were receiving mental health services at time of death

Incident and Investigation Information

NFR-CRS data from 1,339 deaths, that occurred to children ages 1-17 between 2004-2020

Investigation

99% of deaths had had toxicology testing; **96%** had a death investigation completed; **95%** had an autopsy conducted.

Type of Incident

84% were an accidental overdose/acute intoxication; **10%** were a deliberate poisoning.

Place of Incident

65% occurred at the child's home; **14%** occurred at a friend's house.

Geographic Area

43% of the deaths occurred in urban areas; **39%** in suburban areas; **17%** in rural areas.

Type of Opioid Substance

NFR-CRS data from 1,339 deaths, that occurred to children ages 1-17 between 2004-2020

Type of Opioid Substance*

- **90%** prescription opioid pain medication (including fentanyl)
- **9%** illicitly manufactured fentanyl/fentanyl analog
- **6%** heroin

* Substance categories total beyond 100%. More than one substance could have been identified at the time of investigation as contributing to the death.

Polysubstance Deaths

NFR-CRS data from 686 deaths, that occurred to children ages 1-17 between 2004-2020

51% (n=686) of opioid-related deaths were attributed to two or more substances (i.e., polysubstance).

This includes deaths where more than one type of opioid contributed (e.g., fentanyl and heroin).

Number of Substances

- 59% two substances
- 27% three substances
- 14% four or more substances

Other Contributing Substances Include*:

- 57% prescription medication (non-opioid)
- 36% illicit substance (non-opioid)
- 18% over-the-counter medication
- 17% other substance (e.g., alcohol)

Polysubstance by Manner

- 65% of suicide deaths were polysubstance
- 53% of accidental deaths were polysubstance

Polysubstance by Age Group

83% of polysubstance deaths were in youth 15-17 years old

* Substance categories total beyond 100%. More than one substance could have been identified at the time of investigation as contributing to the death.

Reasons for Collaboration

Why Fatality Review Programs May Seek Enhanced Collaboration or Alignment

Maximizing Resources

Separate groups seen as parts of whole population and similar system or community-level recommendations

Reduce Redundancy

Shared processes, shared partners, and may even share review of the same deaths

Learn from Successes of Parallel Program

Learn how recommendations focus on systems-level risks that affect populations across the life course

SHARED PROCESSES

FATALITY REVIEW TEAMS:

- Identify deaths
- Request records to inform death review
- Convene multidisciplinary teams
- Review individual deaths
- Identity risk and protective factors
- Identify systems gaps
- Compile aggregate data
- Make prevention recommendations
- Improve communication and linkages among local and state agencies to enhance coordination and collaboration
- Share data with community collaborators to move data forward and catalyze action

Overdose Fatality Review

Identifying System Gaps and Innovative Community-specific Overdose Prevention and Intervention Strategies

Tell the Story

Tell each story, de-identified, to understand the missed opportunities for prevention and intervention

Collect Data

Multidisciplinary review examines decedent's life cycle in terms of drug use, systems encounters, local conditions, etc.

Take Action

Present recommendations to a governing committee to provide resources for implementation and framework for accountability

Case Review Criteria

CDR recommends the review of deaths of children from birth to 17-years-old and prioritize sudden, unexpected deaths and child maltreatment. OFR teams primarily focus on the review of adult deaths and recommend a themed review process.

Key Team Members and Partners

Both fatality review programs share many MDT members (child welfare, law enforcement, coroners/ME's, public health, etc.). OFR teams encourage including persons with lived experience in the review process.

Unique Process Goals

Prevention, improved death scene investigation, and systems improvements are the goal for both programs. CDR teams strive to ensure the accurate identification and uniform reporting of the cause and manner of death for every incident reviewed.

Unique Process Features

CDR teams share identifiable information and records with the review team. OFR records are de-identified for the review process.

UNIQUE PROCESSES

Opportunities for Collaboration

Coordinated Efforts to Support Progress Across the Life Course

- Improve Communication Throughout the Review Preparation Process.
- Shared Partners.
- Formalize Coordination of Different Programs.
- Share Data Collected to Support Planning Objectives.
- Amplify Shared Messages.

SUCCESS STORIES

Utah and Wisconsin

QUESTIONS

WHAT ADDITIONAL INFORMATION WOULD BE HELPFUL?

USE THE QUESTION-AND-ANSWER BOX

The box is located at the bottom of the screen.

UNANSWERED QUESTIONS

All unanswered questions will be answered and posted on the National Center's website (URL: www.ncfrp.org).

Utah overdose fatality review: CDR/OFR Collaboration

Kacy Robinson, M.S.
Fatality Review Specialist
Department of Health and Human Services
Office of Health Promotion
Violence and Injury Prevention

Utah Department of Health & Human Services

Purpose of the Utah fatality reviews

The primary purpose of all fatality reviews is develop effective strategies to improve agency and community response to prevent and respond to fatalities as well as to cultivate discussion and action to establish a unified multi-agency approach to addressing public health issues.

Utah code and subpoenas

- The police records, requested through the **Government Records Access Management Act (GRAMA) 63-G-2-206 UCA Sec 26-1-30,** will be used for legitimate surveillance and for the prevention of violent deaths.
- **Utah Admin Code Rule R386-703 (injury reporting rule)**
  Reportable injuries:
  (j) Intentional Injuries
  (k) Injuries Related to Substance Abuse

Utah legislation

House Bill 295, Fatality Review Amendments:
https://le.utah.gov/~2020/bills/static/HB0295.html

- Passed in 2020.
- Creates the Opioid Overdose Fatality Review Committee (OFRC).
- Outlines the use and inspection of vital records.
- Mandates the use and confidential distribution of the medical examiner final report.
- Acknowledges the purpose and rules of closed meetings to discuss the medical examiner's final report and committees

Fatality reviews in Utah overview

Statewide fatality reviews:

- Fatality review specialist at the Utah Department of Health and Human Services.
  - Conducts and facilitates 5 different fatality reviews.
  - Serves as a consultant for additional fatality reviews.
  - Assists as a training and technical assistance (TTA) provider for other national overdose fatality reviews.

Fatality reviews in Utah

Statewide fatality reviews:

- Advanced Clinical Child Fatality Review (SUID/SDY)
- Child Fatality Review
- Child Suicide Fatality Review
- Domestic Violence Fatality Review
- Overdose Fatality Review

Overview of the CFRC

- Representatives from multiple agencies, jurisdictions, and fields.
- A small portion of the committee are data providers. These members are the only ones members who receive the case list.
- Case information is de-identified prior to presenting to the committee and any observers for confidentiality.
- All attendees are required to sign a confidentiality agreement prior to attending a committee meeting.
- Meetings are held the third Wednesday of each month.

Overview of OFRC

- Representatives from multiple agencies, jurisdictions, and fields.
- A small portion of the committee are data providers. These members are the only members who receive the case lists.
- Case information is de-identified prior to presenting to the committee and any observers for confidentiality.
- All attendees are required to sign a confidentiality agreement prior to attending a committee meeting.
- Cases are reviewed in “themes” due to the large amount of cases.

Coordination between reviews

- Statewide reviews
- Centralized agencies
- Members of committees sit on multiple fatality reviews
- Data sharing between agencies
- Specialist has access to cross-review information
- Cases can are reviewed by multiple fatality review committees
- Reports are disseminated through one agency

Chief Medical Examiner

- Education about determining cause and manner of death
- Expertise and technical support for interpreting autopsy and toxicology results
- Access to other data sources

Opioid Fatality Examiner

- Conducts and prepares NOK interviews
- Shares information from other data sources, as appropriate
- Assists with case selection
- Subject matter expert

CDR members: Utah Office of the Medical Examiner

Assistant Medical Examiner

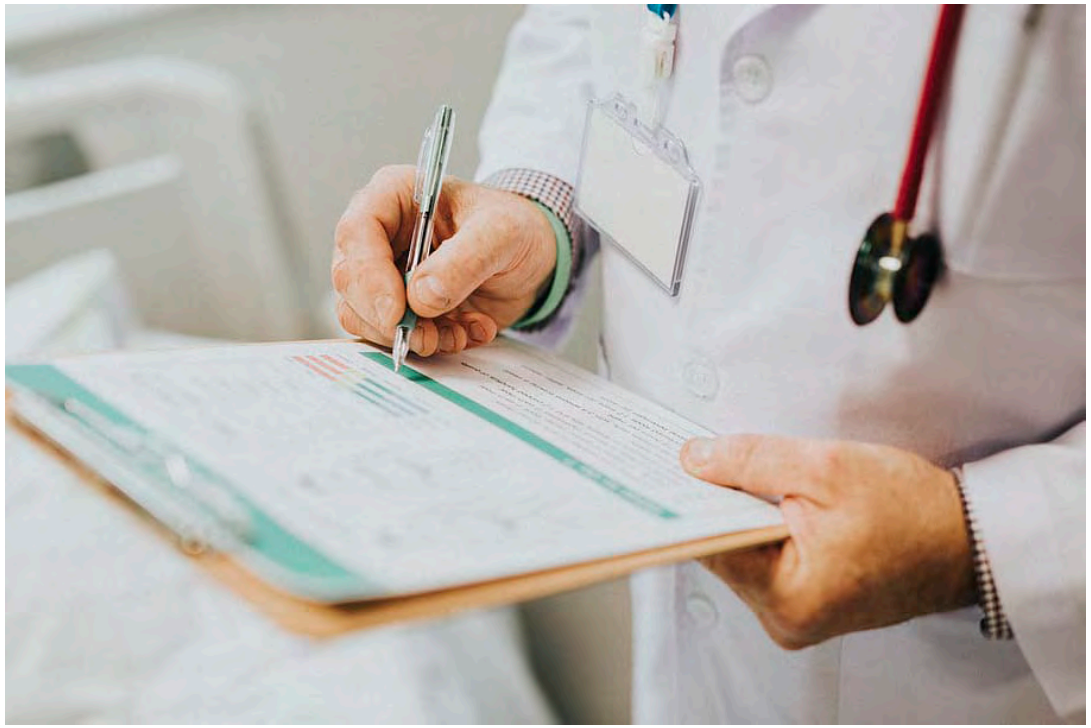
- Education about determining cause and manner of death
- Expertise and technical support for interpreting autopsy and toxicology results
- Access to other data sources

Suicide Fatality Examiner

- Conducts and prepares NOK interviews
- Shares information from other data sources, as appropriate
- Subject matter expert

Next of kin interviews

Medical records



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Utah Department of
Health & Human
Services

Voice for children's health

Children's Health Alliance of Wisconsin

Injury prevention and death review

Keeping Kids Alive IN WISCONSIN

Children's Health Alliance of Wisconsin

History of CDR in Wisconsin

- Funds were awarded to expand CDR statewide
- CDR teams increased from 10 to more than 50
- Impacts of COVID

Goals

- Assemble multidisciplinary teams to meet, share, and discuss unexpected child fatalities
- Improve understanding of how and why children die by collecting information to create a complete picture of the incident
- Translate information to data that will lead to actionable prevention
- Influence policies and programs that promote child safety
- Increase collaboration with local and state partners

Ultimate goal is to take action to improve child safety, prevent other deaths and make communities safer

Activities

- Facilitate the development of local child death review and fetal infant mortality review teams
- Assist teams with managing the review process, data collection, and analysis processes to identify trends
- Utilize prevention-focused data analysis to inform prevention recommendations
- Collaborate with and be a resource for injury prevention professionals

Overdose Fatality Review (OFR)

COLLABORATION OF WISCONSIN DEPT OF HEALTH SERVICES, WISCONSIN DEPT OF JUSTICE, AND MEDICAL COLLEGE OF WISCONSIN

What is an overdose fatality review?

A locally based, multi-disciplinary process for understanding risk factors and circumstances leading to fatal overdoses and identifying opportunities to prevent future overdoses.

Typical team membership includes:

- Public health
- Law enforcement (municipal police and/or sheriff)
- Coroner or medical examiner
- Emergency medical services
- Corrections
- District attorney's office
- Behavioral health and substance use disorder treatment providers
- Individuals with lived experience
- Healthcare

Overdose Fatality Review in Wisconsin

Collaboration of Wisconsin Department of Health Services and Wisconsin Department of Justice

Medical College of Wisconsin serves as the training and technical assistance provider

Two federal funding sources:

Centers for Disease Control and Prevention Overdose Data to Action	Bureau of Justice Assistance Comprehensive Opioid Stimulant and Substance Abuse Program

History of OFR

Program began in 2016.

Current structure:

- 22 county-level teams representing 24 counties
- 4 local health department led teams in Milwaukee County that coordinate with the county team

Development of an OFR State Advisory Group in Spring 2021 that receives state-level recommendations from local teams.

Goals of OFR

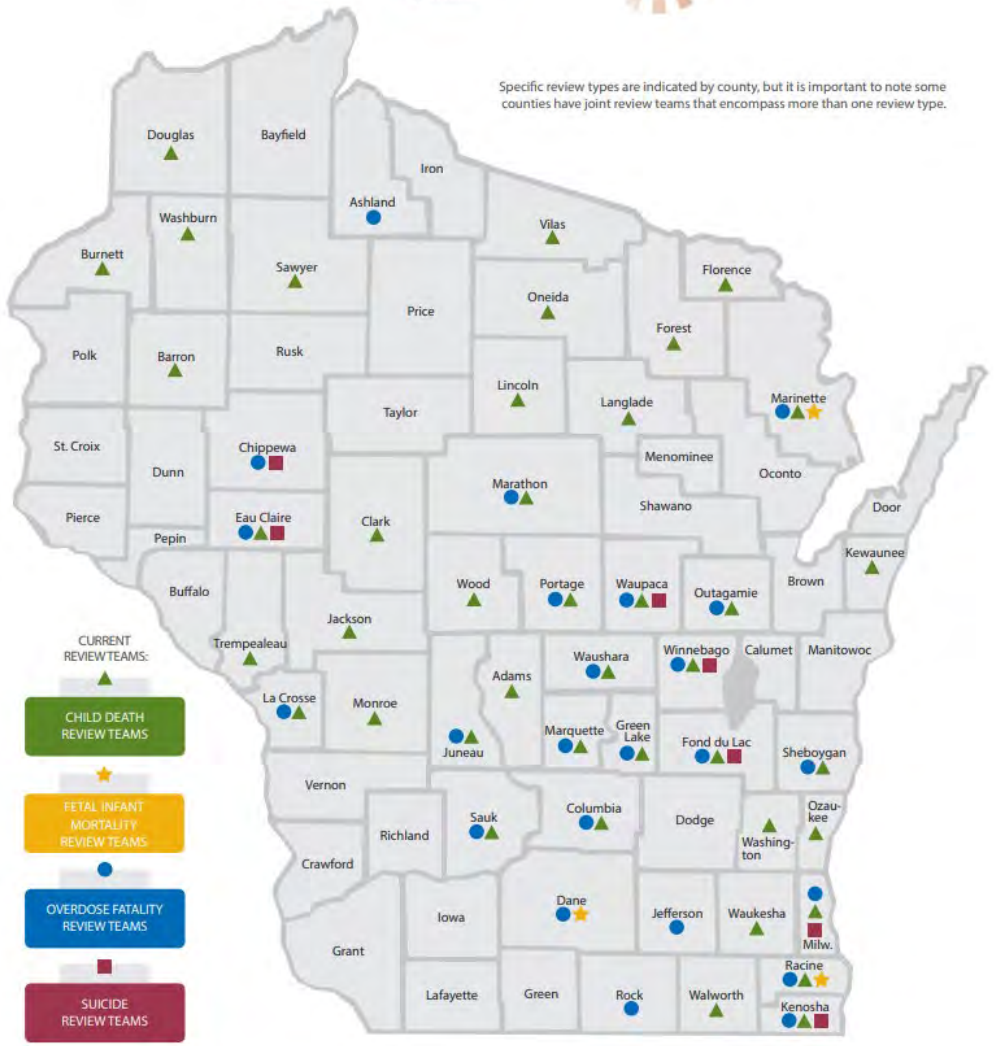
To better understand the nature of overdose fatalities through **comprehensive information sharing**

To develop innovative, **proactive** responses

To **strategically** focus limited enforcement and intervention activities on identifiable risks

FATALITY REVIEW TEAMS BY COUNTY

Last modified - 11/14/2022

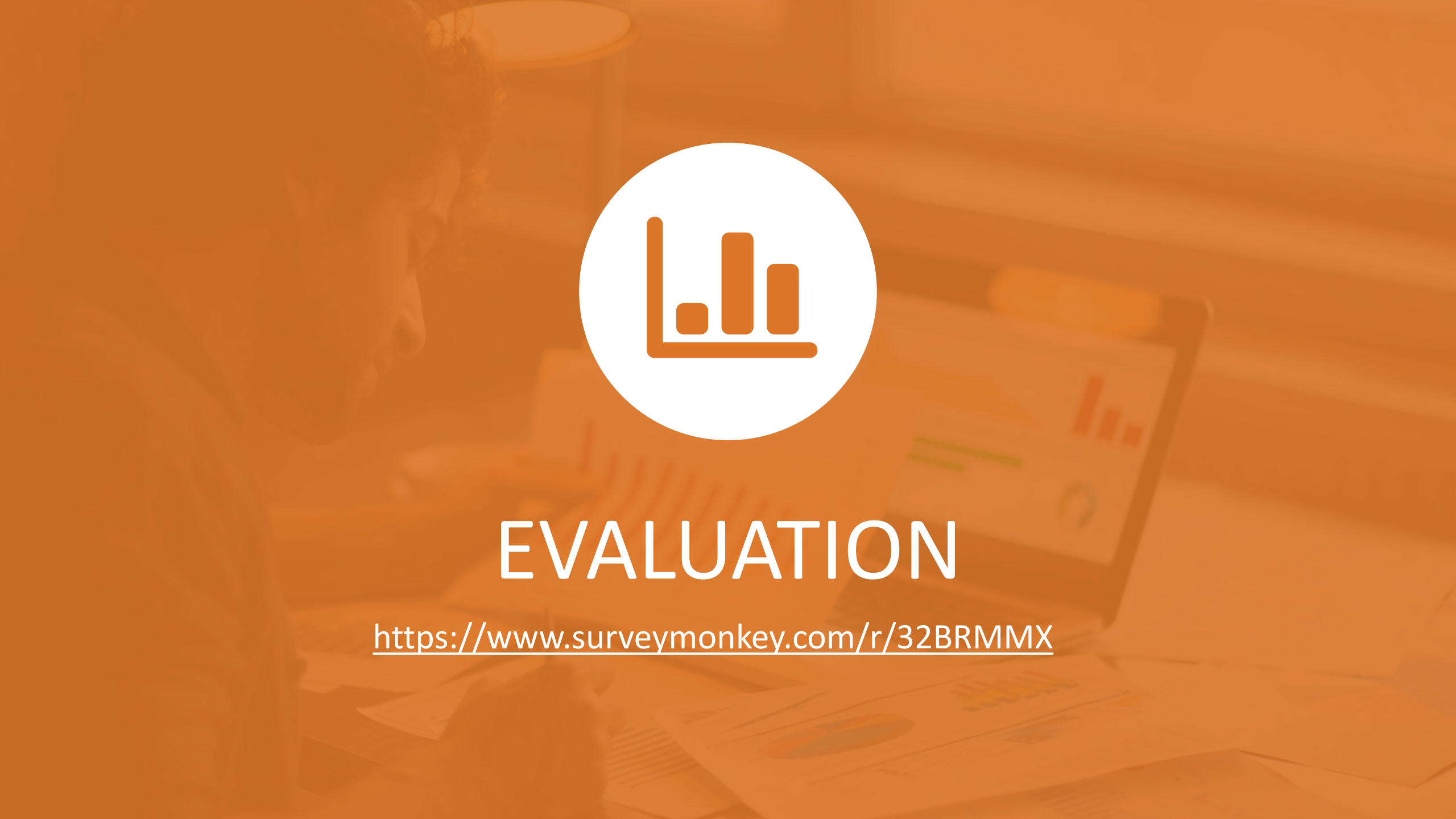


Coordination Between CDR & OFR

- Quarterly state coordinator meetings
- Share and offer feedback on program materials
- Speaking opportunities at meetings, conferences, etc.
- Promoted the joint model for counties, especially where there is overlap
- Shared data collection tools

THANK YOU

Knash@childrenswi.org | chawisconsin.org



EVALUATION

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