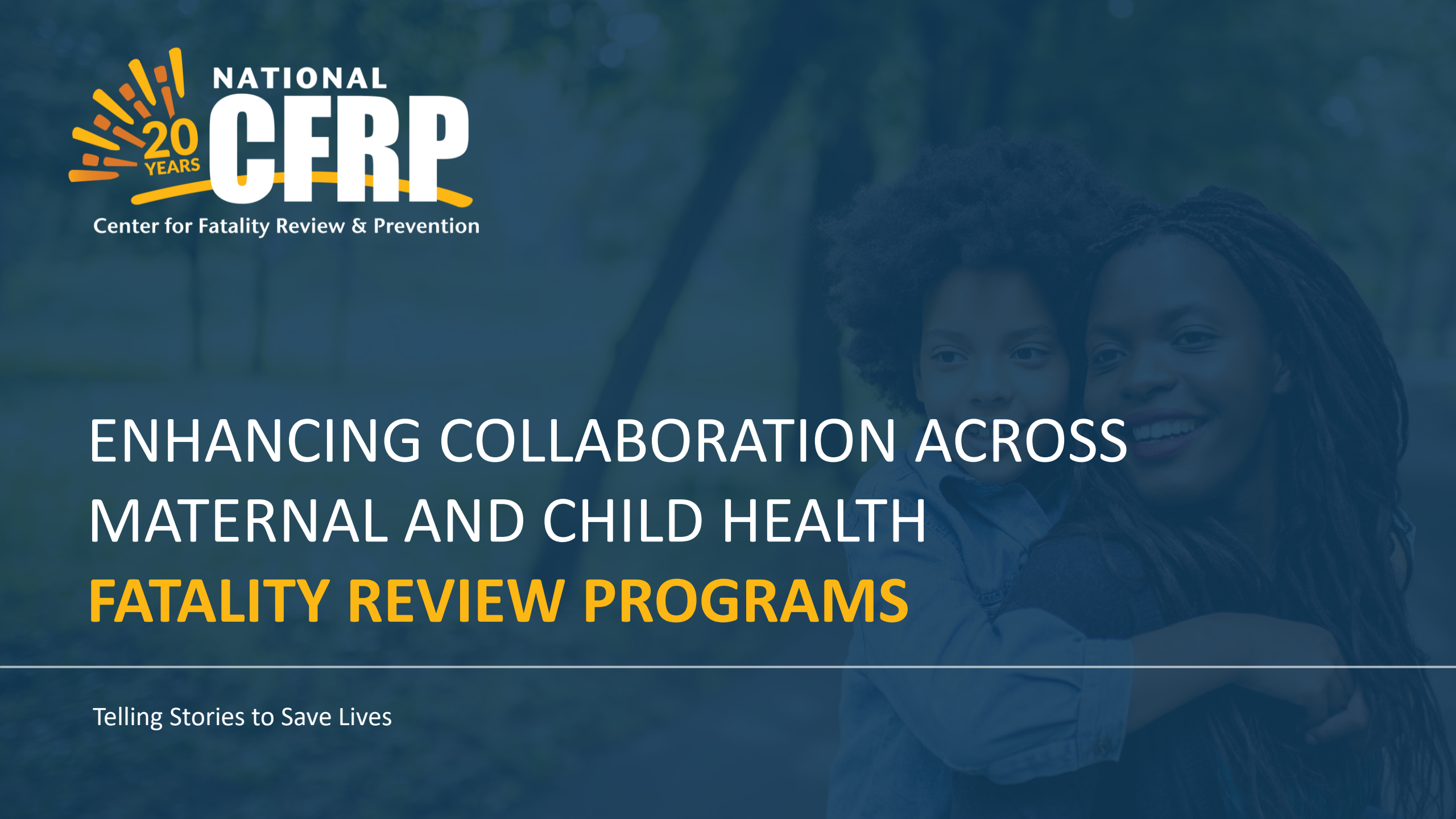
NATIONAL 20 YEARS CFRP

Center for Fatality Review & Prevention



ENHANCING COLLABORATION ACROSS MATERNAL AND CHILD HEALTH FATALITY REVIEW PROGRAMS

Telling Stories to Save Lives

KEY FUNDING PARTNER

FEDERAL ACKNOWLEDGEMENT

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PRESENTATION OBJECTIVES

Describe Fatality Review Programs in Maternal Child Health

Highlight Maternal Mortality Review, Fetal and Infant Mortality Review, Child Death Review, and the Sudden Unexpected Infant Death and Sudden Death in the Young Case Registry activities.

Highlight Preliminary Considerations for Collaboration

Describe legal and institutional issues that may impact collaboration.

Identify Opportunities for Collaboration on Essential Program Functions

Describe strategies for coordination, communication through the review process, and data sharing and dissemination for collective impact.

Share a Resource for Fatality Review Teams

Highlight a new resource for programs considering collaboration.

Speakers

Amy St. Pierre, Public Health Advisor
ERASE MM Initiative
Centers for Disease Control and Prevention

Rosemary Fournier, Director
Fetal and Infant Mortality Review
National Center for Fatality Review and Prevention

Abby Collier, Director
National Center for Fatality Review and Prevention

Carri Cottengim, Health Scientist
SUID and SDY Case Registry
Centers for Disease Control and Prevention

Common Among Programs

Fatality Review Programs in MCH

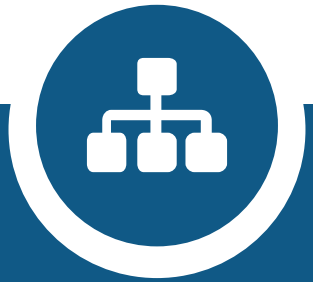
- Multidisciplinary case review
- Not intended to place blame
- Provides more contextual data than vital records alone
- Prevention-focused, resulting in recommendations
- Examines MCH systems
- Strategy for advancing health equity

The Fatality Review Process

Steps to Success

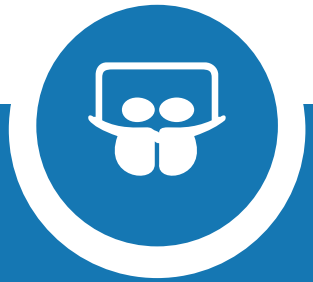
Tell the Story

Tell each story to identify and understand the risk and protective factors



Collect Data

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



Take Action

Fatality Review Teams should be a catalyst for prevention

Fatality Review

Prevention-focused fatality review is different from other processes.

What It IS

- An ongoing, confidential process of data collection, analysis, interpretation, and action
- A systematic process guided by policies, statutes, rules, etc.
- Intended to move from data collection to prevention activities

What It is NOT

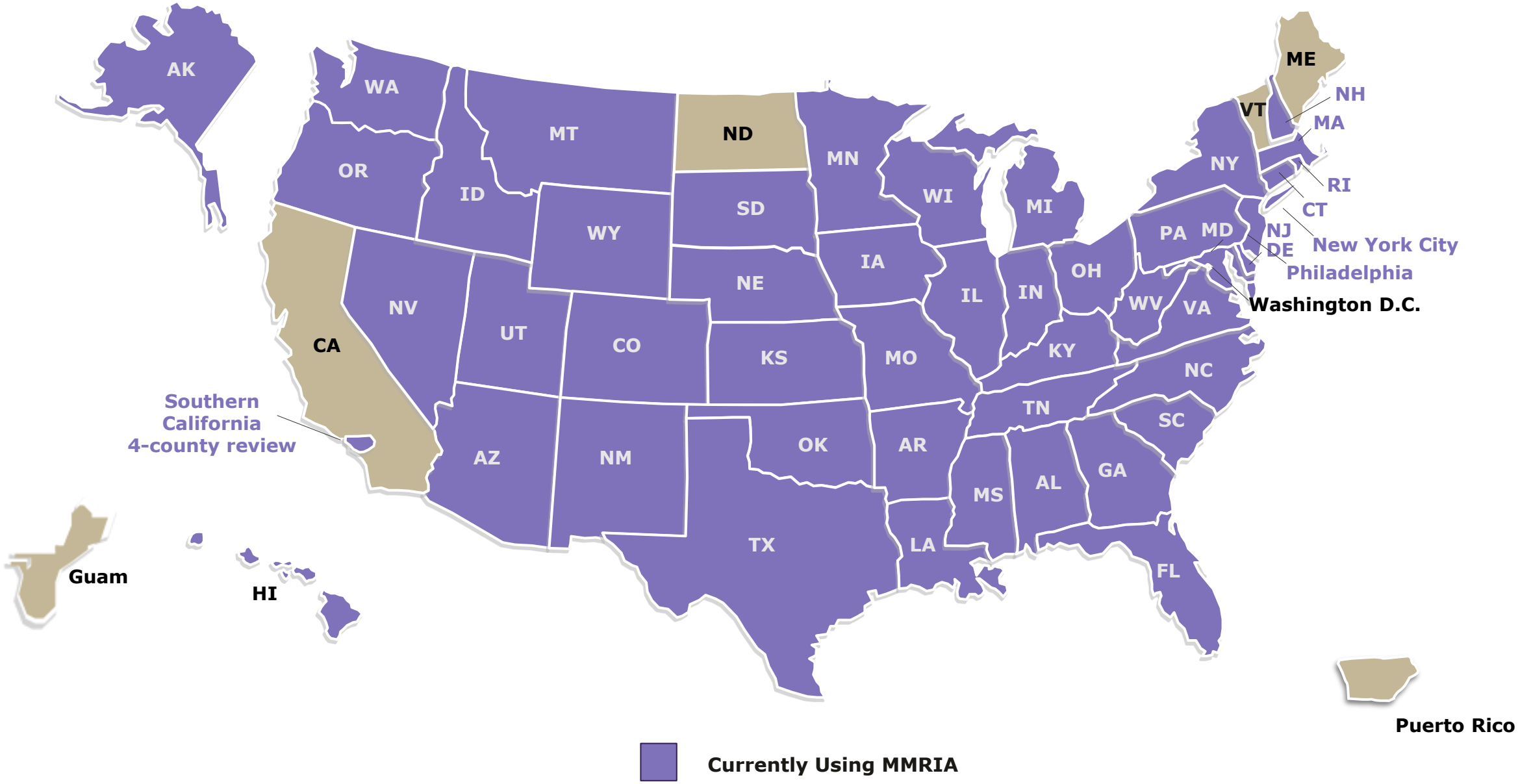
- A mechanism for assigning blame or responsibility for any death
- A research study
- Peer review, institutional review, or substitute for existing mortality and morbidity inquiries

What is Maternal Mortality Review?

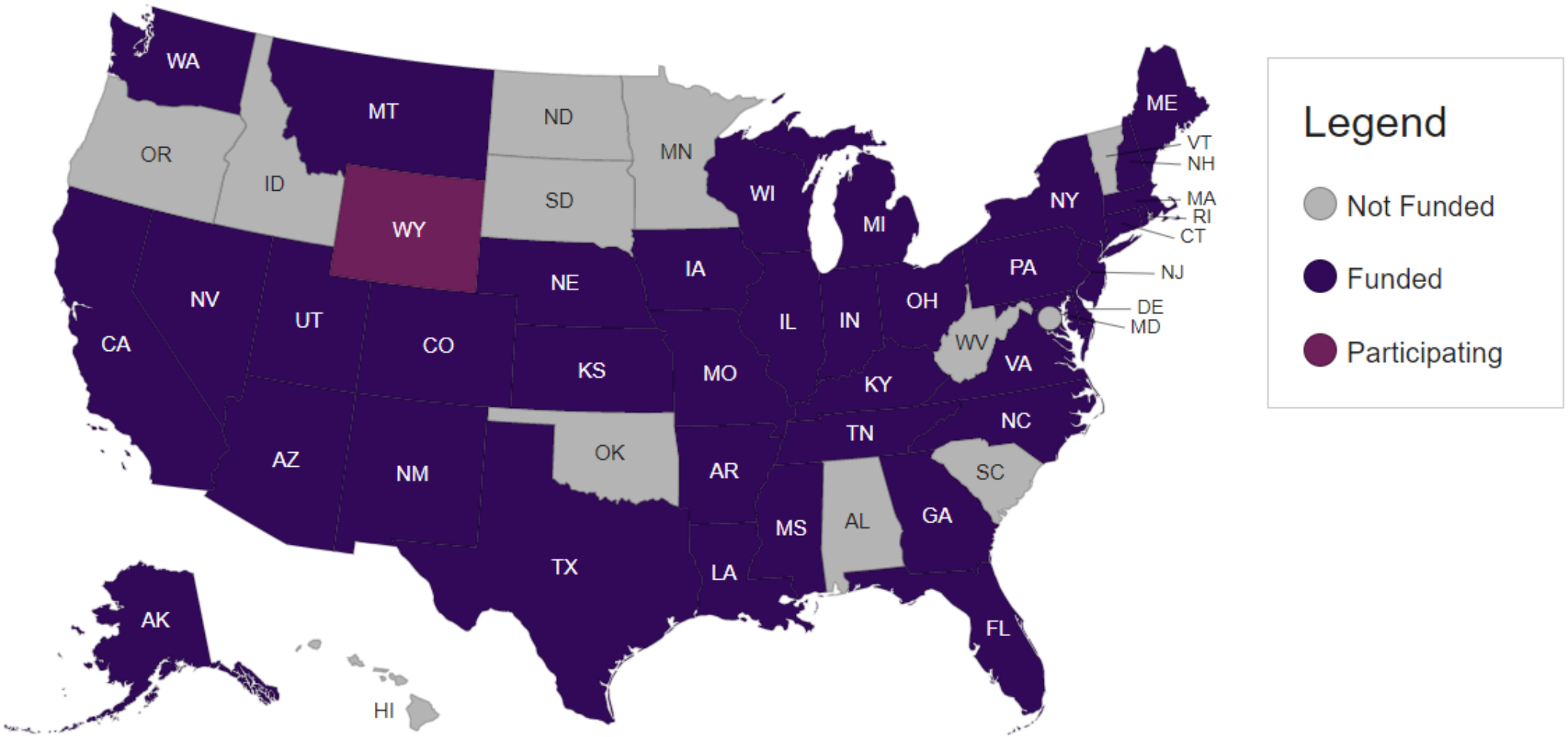
	State and Local Maternal Mortality Review Committees (MMRCs)
Data Source	Death certificates and death certificates linked to birth or fetal death certificates, medical records, social service records, autopsy, informant interviews, etc.
Time Frame	During pregnancy – 1 year
Source of Classification	Multidisciplinary committees
Terms	Pregnancy associated, (Associated and) Pregnancy related, (Associated but) Not pregnancy related
Measure	Pregnancy Related Mortality Ratio - # of Pregnancy Related Deaths per 100,000 live births
Purpose	Understand medical and non-medical contributors to deaths, inform prioritization of interventions to effectively reduce pregnancy-related deaths

Adapted from: St. Pierre A, Zaharatos J, Goodman D, Callaghan WM. Challenges and opportunities in identifying, reviewing, and preventing maternal deaths. *Obstet Gynecol*. 2018;131(1):138–142.

MMRIA: A Common Language for MMRCs



States and US Territories Funded Through ERASE MM



Territories AS GU PR VI MP

www.cdc.gov/erasemm

WHAT IS FIMR?

Fetal and Infant Mortality Review

- Extensive case abstraction facilitates de-identified case review of stillbirths and deaths of infants through the 1st birthday
- 151 FIMR programs in 25 states, the District of Columbia, and U.S. Territories
- FIMR teams request interviews to include the family perspective in case reviews
- Typically in communities with a high infant mortality rate or disparities in infant mortality

FIMR: A Two-Tiered Process

AN ANALYTIC TEAM AND AN ACTION-FOCUSED TEAM

Case Review Team (CRT)

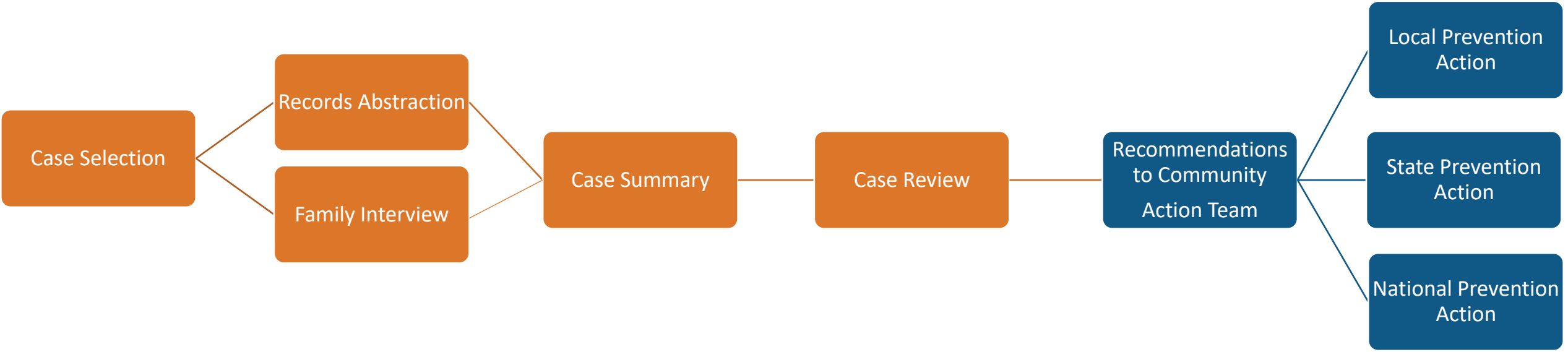
- **Reviews the story**: What happened to this family from the time conception until the time of death?
- **Identifies the issues:** Were there clinical, community, or health system factors that contributed to the death?
- **Makes recommendations**

Community Action Team (CAT)

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

FIMR Process

Best Practices in Reviews



WHAT IS CDR?

Understanding Fatalities to Improve Safety

- Identified, multidisciplinary case reviews of infants, children and youth from birth through <19 years
- Different states have different case selection criteria
- Operating in all 50 states, the District of Columbia, and some Native American tribes and U.S. Territories
- Over 1250 teams operating at the state or local level

CDR Process

Best Practices in Reviews

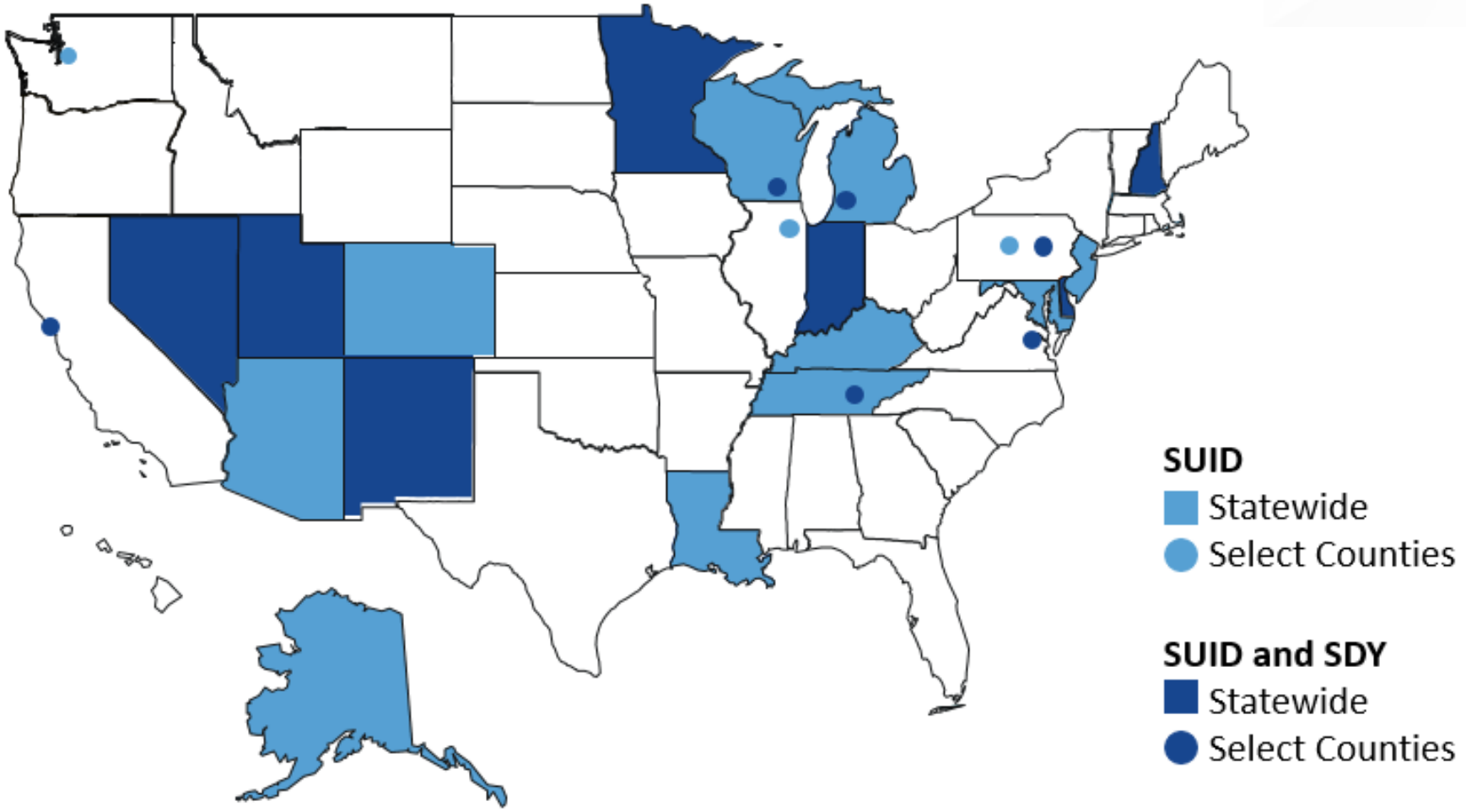
Goals of the SUID & SDY Case Registry

- Conduct population-based surveillance of sudden and unexpected infant and child deaths
- Monitor trends using a case classification algorithm
- Provide information that will improve death investigations
- Inform prevention activities to reduce death rates

The Relation Between SUID & SDY

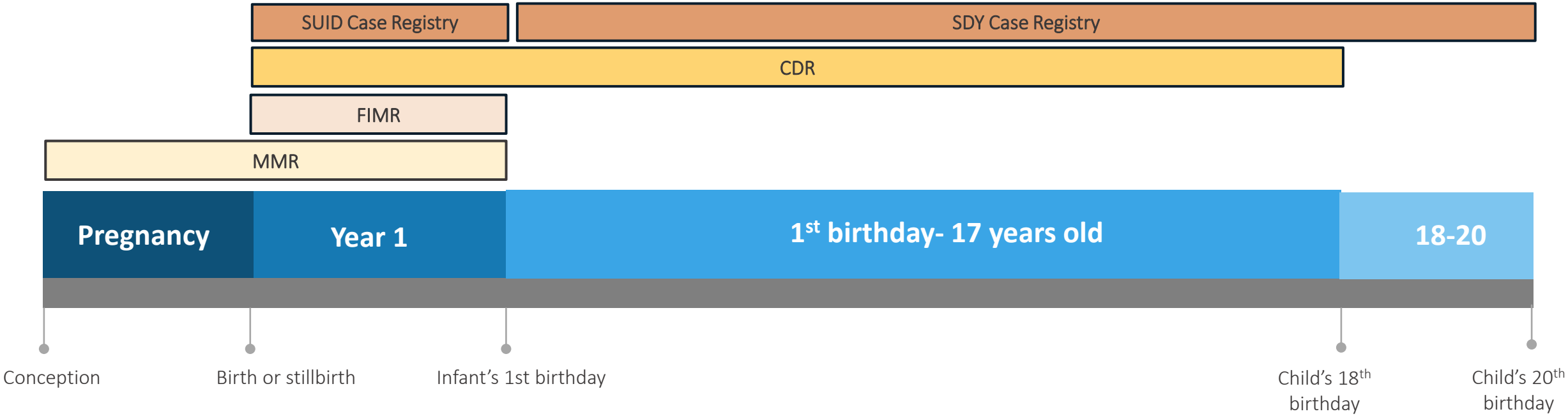
- SDY has an expanded case definition
  - Unexpected/unexplained deaths up to the maximum child death review age limit
- SDY process includes:
  - A second review with clinical experts for all cases
  - Saving of a biospecimen and obtaining consent for later research
  - Applying an additional categorization algorithm

Current Awardees 2018-2023



New funding opportunity to join the Registry coming in early 2023

Maternal, Fetal, Infant, and Child Death Reviews



Initial Considerations for Collaboration

Ensuring Programmatic Integrity

LEGAL AUTHORITY

Identify relevant statutes and policies that impact information sharing between programs.

INSTITUTIONAL AGREEMENTS

Review existing agreements with organizations to identify opportunities and limitations. Consider amendments.

INTERVIEWS

Determine if information from interviews can/should be shared, and if so, how.

Collaborating on Essential Functions

Strategies for Fatality Review Teams

Formalize coordination of different review programs within jurisdictions

Examine leadership, membership, and funding strategies to support formalized program collaboration.

Jointly disseminate reports and other information to amplify shared messages

Amplify shared or related team findings, coordinate prevention activities, and disseminate data to achieve collective impact.

Improve communication throughout the case preparation process

Consider collaborative approaches to records access and family/ informant interviews.

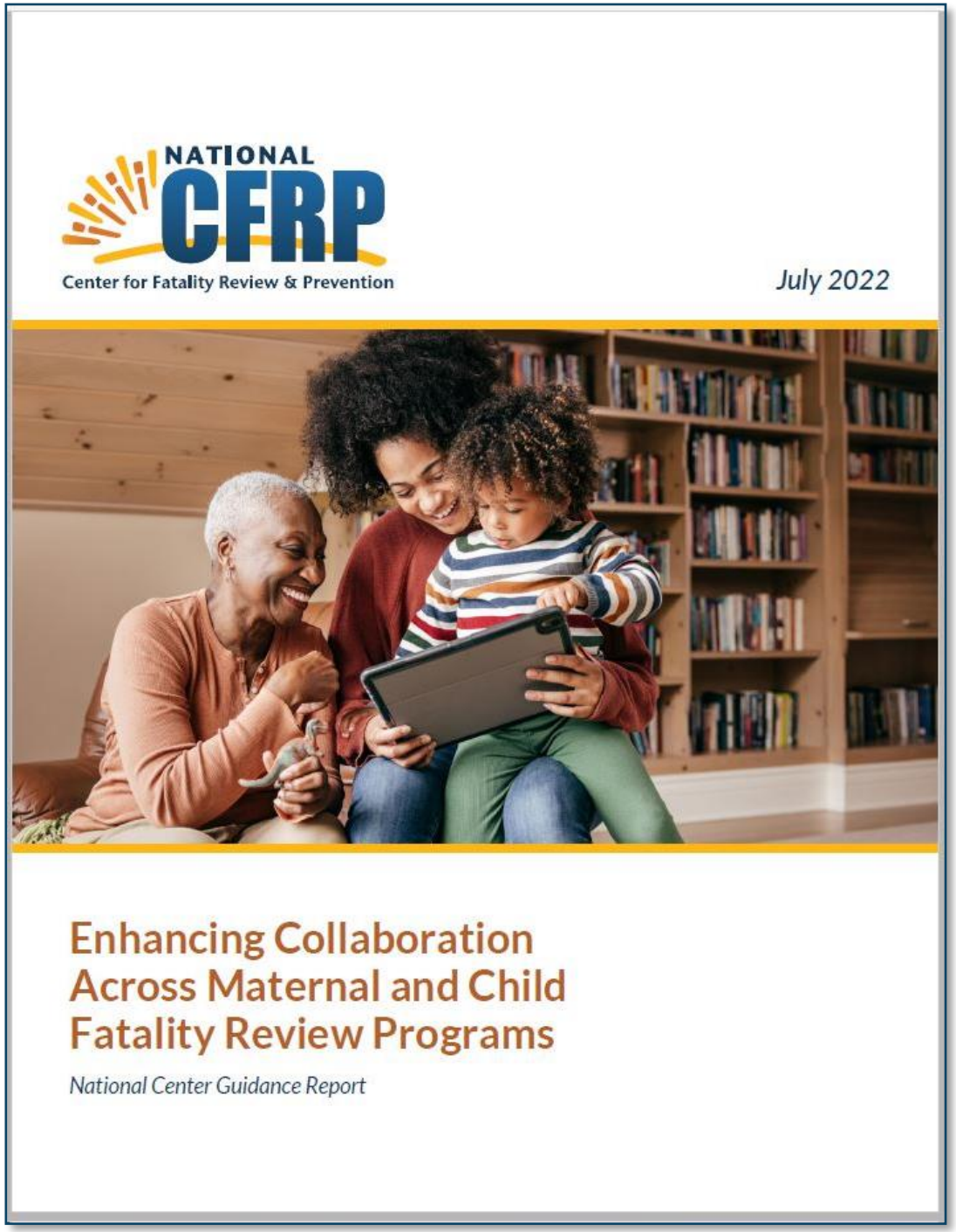
Share data collected from different reviews to support planning objectives

Explore data compilation, data entry, and data sharing strategies to improve program alignment.

Resource to Support Fatality Review Collaboration

Strategizing for Program Alignment

- Descriptions of programs and unique program features
- Support for teams strategizing for collaboration on essential functions
- Examples of effective collaboration and lessons learned



Collaboration Convening

Sharing and Strategizing

MCH Fatality Review Collaboration Convening

Wednesday, November 30, 2022

2:00-3:00 PM EST

Discussions of Effective Collaboration

- Discuss jurisdictions' programs and collaboration efforts
- What is working?
- What isn't?

Program Distinctives

	Case Review Criteria	Lead Agencies	Data Collection
Maternal Mortality Review	Deaths of women/ birthing people during or within 1 year of pregnancy	State or local public health; ME offices	Maternal Mortality Review Information Application (MMRIA)
Fetal & Infant Mortality Review	Stillbirths and deaths of infants before their 1st birthday	Local public health; hospitals	National Fatality Review-Case Reporting System (NFR-CRS)
Child Death Review	Children from birth to < 18 years	State or local public health; child welfare; ME/coroner	NFR-CRS
SUID and SDY Case Registry	Sudden, unexpected deaths without a well-defined cause; SUID=< 1 year; SDY= <20 years	Public health; ME offices	NFR-CRS

Program Distinctives

	Unique Goals	Unique Processes
Maternal Mortality Review	Categorize deaths as pregnancy related; pregnancy-associated, but not related	Informant interviews; Community Vital Sign Dashboards
Fetal & Infant Mortality Review	Enhance the health and well-being of women, birthing people, infants, and families by improving community resources/delivery	Parental interviews; 2-tiered system to include a Community Action Team
Child Death Review	Identify risk factors and prevention strategies to address deaths of infants, children, and youth	Team members bring identified records to the review meeting to share and make case findings
SUID and SDY Case Registry	Categorize deaths based on the SUID and SDY categorization algorithms	SDY deaths are reviewed by an Advanced Review team of medical experts

CONTACT INFORMATION

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