



# Improving Racial Equity in Fatality Review

*National Center Guidance Report*

## **ACKNOWLEDGEMENTS:**

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# Improving Racial Equity in Fatality Review

## Purpose

Fatality review methodologies offer unique strategies for analyses of individual and community factors that significantly affect health disparities. Many of these community factors are not discoverable through analyses of vital statistics and other population-based data. One such example is fatality review's capacity to examine racism: how it impacts health and creates health disparities. Racism is a pervasive problem throughout our culture and one that is difficult to identify when looking only at medical data. Fatality review processes hinge on in-depth exploration and identification of factors that contribute to poor maternal and child health outcomes, putting them in a unique position to provide great insight into the problems families face in seeking and obtaining healthcare, as well as significant information about health equity and disparities. During fatality review processes, teams use a variety of tools to identify and examine factors that contribute to fetal, infant, and child death.

### CHANGING THE FRAME

In the current frame, teams often ask, "What biological and behavioral risk factors place mothers and families at risk for infant and child death?" This guidance will challenge teams to use a different frame, asking instead, "How do we eliminate the social injustices that produce inequities in health outcomes?"

## Expected outcomes

This guidance is intended to be an evolving document, one that continues to grow and inform communities as more is learned and added to the body of knowledge on health inequities.





It is meant to inform fatality review teams in three distinct areas:

1

*Create guidance for fatality review teams on team composition and education to new and existing teams to help members to understand implicit bias and other equity issues.*

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2

*Create guidance for fatality review teams on gathering the right records to help teams understand mothers'/families' experiences of racism, the impacts of other social determinants of health, and how those experiences may have impacted maternal and child outcomes.*

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3

*Create guidance for fatality review teams on ensuring that—once teams have their findings—they are making and implementing meaningful recommendations that effectively address disparities and the social determinants of health.*

## Introduction

Fatality review programs have been established in all states and in hundreds of communities. These programs support multi-disciplinary team case reviews during which individual infant and child deaths are closely studied. Both Fetal and Infant Mortality Review (FIMR) and Child Death Review (CDR) teams welcome participation from law enforcement, child protective services, and public health professionals; they differ in that FIMR engages professionals who serve pregnant women and infants, and CDR engages professionals who serve childhood and adolescent populations. There are approximately 175 FIMR teams in 28 states, D.C., Puerto Rico, and the Commonwealth of the Northern Mariana Islands, and hundreds of CDRs in cities and counties across the country, in all 50 states, Guam, and the Navajo Nation. State public health departments often provide training and coordination for these entities, but it varies by location. There is national guidance on fatality review methodology, but it does not name racial equity, explicitly.

**Like many community systems, the systems responding to infant and child death were built without the complexities of social and environmental influences in mind.**

### COMMISSIONING THIS DOCUMENT

This guidance document was commissioned by the National Center for Fatality Review and Prevention (National Center) as the first attempt at providing guidance on how to incorporate racial equity into the fatality review process.

Recommendations to address the causes of deaths for infants and children of color have great potential to change social determinants of health. Those recommendations must thoughtfully take racial equity and social determinants into account. Maintaining current operations without pushing towards racial equity prevents teams from receiving and successfully implementing recommendations that will reduce identified preventable infant and child deaths in communities of color. Focusing on social determinants of health and health equity will equip teams to focus on the root causes of mortality and to impact outcomes in measurable ways. This shift is imperative to the sustainability of the program itself, which is an important part of both the maternal child health (MCH) and injury prevention programs.

This guidance is designed to help position fatality review teams as community-facing forces that can simultaneously drum up grassroots commitments and influence medical and social service providers to reframe causation as social responsibility and reduce the deaths of infants and children of color.



## Background

The death of a child is viewed as a sentinel event that is a measure of a community's overall social and economic wellbeing as well as its health. Over the past 25 years, many methods of reviewing deaths have emerged. This toolkit is directed at two of those methods: Child Death Review (CDR) and Fetal and Infant Mortality Review (FIMR); however, the information included in this guidance may be applicable to all fatality reviews.

CDR provides a retrospective review of child deaths and is a comprehensive, multidisciplinary investigation into the death. The CDR process originally served as a mechanism to better identify child maltreatment fatalities. Today, many CDR teams across the country have broadened their scope of review to include all infant and child fatalities.

FIMR brings a multidisciplinary community team together to examine confidential, de-identified cases of fetal and infant deaths to identify gaps in care and improve the care and services for pregnant moms, babies, and families.



All fatality review teams operate under the same guiding principle: Multidisciplinary review aids in better understanding how to prevent future deaths and improve the lives of babies, children, and families. Common to both processes is the building of diverse coalitions/ community partnerships that lead to better understanding of the determinants of infant and child deaths.

Both fatality review models focus on making findings in fatality cases, and then focusing their efforts on prevention recommendations to fill any identified gaps in community services and systems with the goal of preventing future deaths of infants and children. The FIMR model encourages a two-tiered process: a case review team and a community action team. The community action team receives the findings and recommendations of the case reviews and develops the plan for systems improvements and large-scale prevention.

There is an underlying risk in “medicalizing” the death cases brought to fatality review. Focusing exclusively on medical and biological contributors to death understates the social context in which biological or medical issues have developed; it subsequently produces findings that can lead to blaming an individual instead of addressing systems-level issues. Instead, fatality review teams are encouraged to humanize the death, understanding the context of the decedents and their families’ lived experiences. Social and environmental factors account for much of disease risk. Personalizing analysis and response to infant death enables teams to find solutions within the intersections of the social determinants of health. This guidance will suggest ways that teams can humanize case reviews in the pursuit of equitable outcomes.

## Building Effective Teams

Fatality Review teams use a process, that if followed, helps complete thorough reviews that address the service and systems issues around infant and child deaths.

### AT THE REVIEW:

- ☐ *Cases are reviewed, including information from team members records (CDR) and abstraction of the medical records and the maternal interview (FIMR).*
- ☐ *Teams identify sentinel events, trends over time, and incidental findings.*
- ☐ *Teams discuss factors that were present and could have contributed to the death.*
- ☐ *Teams discuss service delivery, any barriers or gaps in care.*
- ☐ *Recommendations are conveyed to the community and appropriate stakeholders.*

### CLINICAL RISK FACTORS

This process identifies major clinical risk factors and issues that are relevant to the event. However, the stagnation of infant/child death rates and the widening disparity in deaths of infants and children of color signifies that there is more to be done within the team review process and the team itself.

## Fatality Review Team Membership

In working toward health equity, it is important to consider the participants in the fatality review process. The guiding principles for fatality review team membership include:

### DIVERSITY

Team membership represents a wide array of personal and professional knowledge, expertise and experience, the ethnic and cultural diversity in the community, and a creative range of organizations, including some who may not have been included in traditional maternal and child consortia.

### INFLUENCE

Members with influence include policymakers, institutional and professional leaders, and/or organizational spokespersons who have the power to make decisions and mobilize fiscal and programmatic resources on behalf of their agency or organization.

### COMMITMENT

Choose team members with a proven track record of putting what is good for women, infants, children, and families before what is expected or convenient for his or her own organization or professional interest. Champions make the best team members.



An easy way to have a more varied point of view and more robust recommendations is to include additional members to local review teams. Ad hoc membership is often sought out depending on the circumstances of the death; this can include family members, witnesses, or people with specialized knowledge in a subject relevant to the death. Additional ad hoc members from other agencies, community members, providers, and professions involved in protecting children's safety and health should be included on a case appropriate basis.

## Inviting Additional/Ad Hoc Members

One way to consider ad hoc or additional membership is through Power Mapping. A Power Mapping exercise identifies knowledgeable or potentially helpful community members whose voices can give perspective, knowledge, or further understanding of the event. Power Mapping is a brainstorming tactic that encourages all voices to be represented in a step-up/step-back collaboration model. There are no incorrect answers, only valuable input.



1

*Identify the target based on the death event. For example, if the death has something to do with substance abuse, increasing outreach to mothers who are abusing drugs in the prenatal period may be the target.*

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2

*Brainstorm the people and institutions that know and interact with your target.*

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3

*Determine the nature of the relationship between your target and the people who influence them. Are they agitators, service workers, care providers, leaders, advocates, beneficiaries, etc.?*

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4

*Determine who in the team has access to the influencers and decide who will contact each person/entity on the power map.*

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5

*Invite those people/entities into the team, making sure to stress the opportunity for future death prevention with their valuable perspective.*



### Example:

CASE STUDY	
Fatality review finding/modifiable risk factor:	Prematurity (complications from drug abuse)
Specialist/Ad Hoc Member:	Substance Abuse Counselor
Provides the team with information on/expertise by:	Providing information on the development and implementation of public health prevention activities and programs
Support the team by:	Accessing information from other health professionals who provided services to the child and family
Helps build bridges by:	Presenting information at local Narcotics Anonymous meetings

## Developing Equitable Review Panels

In an equity framework, leadership is not considered a hierarchical power structure or bureaucracy. Each team member has equal value and presence, regardless of professional position. Like most traditional organizations, fatality review teams have structure and roles assigned to positions. Fatality review team coordinators and directors recruit members, facilitate meetings and oversee the operations of the panels among other responsibilities. These are important roles which cannot be replaced. Yet, these positions come with a modicum of power that has the potential to be subconsciously misused. The strong opinion of a leader who does not use an equitable meeting style can cause their own professional knowledge and internal bias to create patterns of assumption. When those assumptions do not consider social determinants of health or racial equity, there is a major opportunity for gaps in recommendations being passed along to the community action team.

- ☐ *It is critical that guests and ad hoc members of each team bring a wide diversity of experience and belief.*
- ☐ *The racial demographics of the community should be represented in the membership of review and prevention teams.*

While team coordinators usually coordinate and facilitate reviews, if there are smaller sub-committees created from the review or community action teams, the committee chairperson can be self-selected as a subject matter expert.



However, this chair needs to be voted upon by the entire panel to vet their expertise among the group. Leadership within fatality review teams should operate as a spokesperson to the team, with full transparency of their own position and bias while meaningfully addressing the social determinants of health through their leadership.

**This acknowledgment of your own internal bias improves a spirit of collaboration, interdependence, and trust that allows for free communication between team members.**

Improved communication between team members prevents the leader's voice from being the filter through which all recommendations flow, which can weaken the recommendations. It also encourages internal accountability that builds a leadership pipeline.

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## RESOURCES:

- [\*Creating Equitable Leaders to Maximize Human Capital\*](#)  
An article outlining the characteristics of an equitable leader.
- [\*Great Leaders Who Make the Mix Work\*](#)  
A Harvard Business Review article which interviewed 24 CEOs from around the world on diversity and inclusion.

## Training and Onboarding with Social Determinants of Health Inequities and Racial Equity

Every new member inducted into a fatality review team should receive some type of training or onboarding within their first six months of participation. Health Equity should be part of new team member orientation. Reading materials on social determinants of health and internal bias will give new members language with which to enter into discussion with team members. They need not be experts on racial equity yet, but acknowledging their own bias and understanding basic tenets of social determinants of health are sufficient for the first few months of participation in lieu of in-depth training.

## Equity Assessment for Established Fatality Review Team Panels

Every staff or volunteer entity working within disparities of health and health care must be aware of social determinants and health equity. Researchers have increasingly been looking at environmental and social factors that influence health behaviors<sup>1,2</sup>. Your position within fatality review teams puts you on the front lines of the movement against preventable death for the most vulnerable in our society: infants and children. Because we are on the front lines, we are ever moving towards equity. To move forward, each fatality review team has to take account of where it is as a team as it relates to addressing the social determinants of health. Social determinants of health include racism; therefore, a team assessment must include examinations of internal bias, power, and racism.

Every individual on the panel gives their perspective through their own set of unique experiences and beliefs. The beliefs that we hold—our internal bias—informs our choices. Internal bias is not negative, but normal to humans. Similarly, everyone on the panel has a professional position within their own industry. Clinicians are heavily relied on in the community and have authority because they are gatekeepers to knowledge. A community health worker is also heavily relied upon by their clients, but they have less authority within their professional positions. The variable amount of authority a position gives someone can translate to an imbalance of power over resources and over others. Fatality review team members have power due to their position on a panel that makes recommendations intended to better a community for the purpose of saving lives.

Power is neutral on its own. When internal bias is exercised through the power that someone yields, it can converge as racism. If the entire FIMR panel was made of obstetric doctors and hospital administrators who had an underlying distrust of the Latino

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1 Hood, C.M., K.P. Gennuso, G.R. Swain, and B.B. Catlin. 2016. County health rankings: Relationships between determinant factors and health outcomes. *American Journal of Preventative Medicine* 50(2): 129-135.

2 Lu, M. C., and N. Halfon. 2003. Racial and ethnic disparities in birth outcomes: A life-course perspective. *Journal of Maternal Child Health* 7(1), 13-30.

population in their city, they may not take their responsibility to identify **root causes** of Latino infant mortality seriously. They would not be likely to leverage their power on behalf of people they did not trust. Understanding both their own internal bias and the power they hold allows them to build accountability into their own participation in the fatality review and recommendations processes.



In addition to an assessment, trainings are necessary to fill in the gaps in understanding to establish a health equity frame within the team. It is best if all team members can participate in this type of training, because it establishes a common vocabulary for equity-focused discussions, and the understanding that equity and equality are not the same thing.

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## RESOURCES:

- <https://guides.co/g/creativity/60955>  
Power Mapping/Mind Mapping.
- <https://implicit.harvard.edu/implicit/takeatest.html>  
Internal bias assessment and group activity – Project Implicit.
- [\*Advancing Holistic Maternal Care for Black Women through Policy\*](#)  
Black Mamas Matter.
- [\*Advancing the Human Right to Safe and Respectful Maternal Health Care\*](#)  
Black Mamas Matter.

For additional information on building and maintaining effective fatality review teams, please visit the National Center website: <https://www.ncfrp.org>.



## Troubleshooting - FAQs and Solutions

*What if our team does not have another intensive racial equity training scheduled within the six-month period of onboarding for new members?*

Technical assistance from the National Birth Equity Collaborative or the National Center can provide that member with additional resources or access to other trainings if the fatality review team does not have one scheduled. These include the following National Center webinars and training modules:

- ☐ [Using Health Equity in Fatality Review](#)  
*Leading for Equity within the Fatality Review Process.*
- ☐ [Using Social Determinants of Health to Inform Fatality Review](#)  
*June 7, 2017.*
- ☐ [Black/White Equity in the Opportunity to Survive the 1st Year of Life...a dream deferred](#)  
*June 5, 2019.*
- ☐ [Exploring how FIMR and CDR teams identify and address disparities](#)  
*June 26, 2019.*

## Understanding Historical Context

Teams must broaden their historical perspective on local and American society. Through settlement and colonization, slavery, the Oregon Trail, the Trail of Tears, the Great Migration, war, politics, reconstruction, Jim Crow, the war on drugs, wage inequality, and modern-day redlining, each U.S. city has a history of oppression that can be discovered and analyzed. There are many resources analyzing the effect of white supremacy, racism, classism, and environmental violence on the physical and psychological well-being of populations. Learning these stories and discussing them together helps us correctly label oppression, inequality, and its effects. Without consensus on language and definitions around the social determinants of health and racial equity, there will not be recommendations that clearly define solutions to the resulting inequality.

In group settings, individuals can have a very different understanding of history based on their beliefs and knowledge. Just as their definitions of and language about history can vary, their understanding of and language about themselves will also vary. In accordance with trainings, onboarding, and equity assessments, fatality review team participants will need to create a shared set of language and definitions about their own internal biases. Members will learn that institutional racism fuels many of the social determinants of health inequalities and disparate infant and child death rates. Members will learn that institutional racism is perpetuated by internal bias and oppression, and they will be challenged to determine how white supremacy has supported inferiority and superiority complexes in the systems and communities they represent.



## Common Language and Definitions

Imagine a scientist explaining the formation of a rainbow to a toddler using college-level vocabulary. Imagine two pastry chefs preparing dessert for a dinner party, one speaks German and the other, English. There are ways to effectively communicate within these two examples, but both require a set of concepts, language, and definitions that all parties agree upon. The scientist will have to discuss with the toddler that light acts differently when passing through different substances and decide together that light can “bend.” The chefs will have to compromise on their definitions for “biskuit” in their separate languages, which are two culturally different dishes. Common language and definitions set a playing field where everyone can discuss complex ideas on one plane. This is very important for fatality review teams as they grapple with social determinants and racial equity in locations across the country.

Members will be asked to question how their own biases can affect their professional positions and their positions within fatality review teams, how bias contributes to individual patient or client care, and how it can produce generations of racial oppression and poor health outcomes. It is optimal that fatality review teams consult for an intensive, multiday training on these concepts. Assistance in determining shared language will be extremely helpful for teams who have not meaningfully engaged with or received training on social determinants of health or racial equity before.

## Social Determinants of Health Inequities

According to the World Health Organization, the social determinants of health are the conditions in which people are born, grow, live, work and age<sup>3</sup>. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen between populations. The key concepts include employment conditions, social exclusion, public health programs and increased access to health care for socially and economically disadvantaged groups, women and gender equality, early childhood development, globalization, health systems, and urbanization.

## Race and Experience of Racism

To ensure that stakeholders have a shared vocabulary in the following contexts, the following definitions will be helpful.

### **RACE:**

Defined as physical differences that groups and cultures consider socially significant<sup>4</sup>.

### **ETHNICITY:**

Defined as a shared culture, such as language, ancestry, practices, and beliefs<sup>5</sup>.

### **RACISM:**

Defined as racial prejudice or bias used along with social or institutional power to advance or oppress people<sup>6</sup>.

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3 World Health Organization (2019). Social determinants of health. Retrieved June 2, 2019, from [https://www.who.int/social\\_determinants/sdh\\_definition/en/](https://www.who.int/social_determinants/sdh_definition/en/).

4 American Sociological Association. *Race and Ethnicity*. (n.d.) Retrieved June 2, 2019, from <https://www.asanet.org/topics/race-and-ethnicity>.

5 American Sociological Association. *Race and Ethnicity*. (n.d.) Retrieved June 2, 2019, from <https://www.asanet.org/topics/race-and-ethnicity>.

6 From the People's Institute for Survival and Beyond, adapted by the National Birth Equity Collaborative.

## Camara Phyllis Jones MD, MPH, PhD

Dr. Jones is a family physician and epidemiologist whose work focuses on the impacts of racism on the health and well-being of the nation. She seeks to broaden the national health debate to include not only universal access to high quality health care, but also attention to the social determinants of health (including poverty) and the social determinants of equity (including racism). Dr. Jones presents a theoretical framework for understanding racism on three different levels: institutions, personally-mediated, and internalized.

## Levels of Racism<sup>7</sup>

### INSTITUTIONAL RACISM:

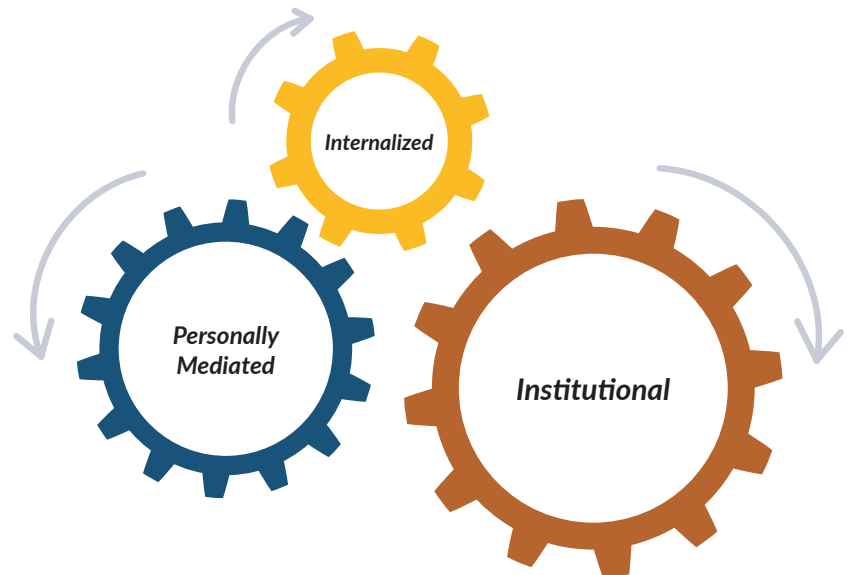
Differential access to the goods, services, and opportunities of society by race (within institutions).

### PERSONALLY-MEDIATED RACISM:

Differential assumptions about the abilities, motives, and intent of others by race, and differential action based on those assumptions (between individuals).

### INTERNALIZED RACISM:

Acceptance by members of stigmatized races of negative messages about their own abilities and intrinsic worth (within individuals).



Racism functions on several different levels, making it a complex target for systems to acknowledge and quantify. Institutions are steeped in the same structural racism that individuals feel in their lived experience. The cumulative effective of institutionalized, personally-mediated, and internalized racism is a cultural level of oppression that shapes collective ideas about what is normal, true, right, and beautiful<sup>8</sup>.

<sup>7</sup> Jones, C.P. Levels of racism: A theoretic framework and a gardener's tale. (2000). *American Journal of Public Health*, 90(8), 1212-1215. doi:10.2105/ajph.90.9.1212

<sup>8</sup> Batts, V. (2017). Is reconciliation possible? The question remains bridging troubled waters: Lessons from combating "modern racism" in the US and South Africa. 1-29.



Experiences of racism are traditionally not quantified because of their subjectivity. Self-reporting on experiences of racism is also undervalued because the potential for reporting bias; however, part of the individual damage of racism is the severity at which the person perceives the harm. There are very few tools with which to quantify the experience of racism, and none of which are adopted as the standard or common scale. Agreeing upon, adopting, and applying data of experiences of racism can be challenging for health departments to operationalize. Yet, there is significant evidence that the different levels of racism play a role in adverse outcomes and fatality. Given this, the fundamental dismantling of racism would affect health institutions and how they operate within their external and internal policies. Both FIMR and CDR teams need to be equipped with tools for difficult conversations and conflict resolution, grounding in relevant language and complex concepts, and strategies for weaving these concepts into the fabric of the fatality review process.

## Criminalization of People of Color

Families of color bear the burden of infant death at inequitable rates to white families<sup>9</sup>. They also bear the burden of criminalization and policing that can bring harm in other ways. Low-income families, oppressed and marginalized groups, and people of color face a greater risk of being targeted, fined, profiled, harassed, arrested, and incarcerated for minor offenses than other Americans. High-income families and white Americans have a lower risk of being targeted, arrested, or incarcerated for minor offenses, and they are more likely to be given pardon for offenses for which other groups of people may be seriously questioned.

In some instances, the cause of death and recommendations from an infant or child death review can be accusatory to the guardian. It is our duty to refrain from blaming individuals and recommend systems-level changes to intentionally dismantle any unintentional harm done to families who may be criminalized by the FIMR/CDR process.

For example, the decades long “war on drugs” has had a devastating impact on communities of color in the U.S. Though rates of drug use across age and race categories are equitable, the systemic response has targeted African Americans, Latino, and Native Americans at a rate that has created sweeping rates of incarceration for those populations. Various methods like traffic stops, SWAT-style raids on homes, and random searches of people’s property were carried out in low-income communities of color more frequently than in less policed, high-income areas. The assumption that low-income people use and should be penalized for use of drugs is also carried out in our health systems.

If a mother’s use, or suspected use, of drugs is called into question during a FIMR/CDR process, there is a concern that race and class bias may weigh into the deliberations of committee members. Being mindful of the historical, political, and social context of the case will require that reviewers discern where there is an increased risk of bias and criminalization that can cause more harm than benefit to a grieving family.

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9 Centers for Disease Control and Prevention. (n.d.) *Morbidity and Mortality Weekly Report: CDC Health Disparities and Inequalities Report—United States, 2011* (Vol. 60, pp.1-116).

Below is an exploration of how racism may play out at the different levels introduced by Dr. Jones:



### **RACISM AT THE INDIVIDUAL LEVEL**

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*Poor white citizens in locations where they will benefit from state and local decisions to resource low-income populations of other races (Latino, Asian, African American, immigrant populations, etc.) may decide to vote against them. Racism directly impacts the potential for positive legislation and resources from reaching the community at large.*



### **RACISM AT THE INTERPERSONAL LEVEL**

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*Individuals working in health departments, hospitals, academic institutions, etc., may have racist values that become apparent in their decision-making in different parts of life. Racial bias and discrimination can easily play out in hiring decisions, even subconsciously, when a hiring official determines that the applicant of color may not be a “good fit.”*



### **RACISM AT THE INSTITUTIONAL LEVEL**

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*Rules in an institution can impact how resources are disseminated and who is hired to complete work. If there is a rule in your institution that only allows the department to contract with sole proprietors with business insurance, it excludes individuals and community members without the means and capacity for those requirements. No matter how important you believe it is to incorporate community members into your review committees, if the institution has some policy that disproportionately affects one population over another, it may be due to an antiquated value that began as a discriminatory policy and has turned into the norm.*



### **RACISM AT THE STRUCTURAL LEVEL**

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*Structural racism is the compound disadvantage someone can live in, piling on the complexities of everyday life. To consider the above examples, structural racism is experienced when elected officials refuse to fund needed social services, when it is disproportionately difficult to find employment, and when contracting policies exclude certain individuals from equal opportunities to bid for work. The cumulative effect on the exclusion and lack of access codify a structurally racist system.*

## ADOPTING A NEW STRATEGY

A strategy that some fatality review teams are beginning to adopt is to leave off the client demographics, or re-order the demographics to the end of the case summary. Rather than leading the summary with information on race, socioeconomic status, education, and marital status, details that could bias team members' deliberations, demographics are either omitted or left to the end of the case summary.









## Personal Responsibility vs. Social Responsibility

Anytime there is a death, responsibility can lie on the individual's choices and behavior or on the circumstances that were shaped by society and the environment. This diagram shows competing worldviews on typical causes of death. Though the cause of death itself is written in broad social terms, the lens through which review teams examine fatality cases—either as a personal or social responsibility—can dictate the type of discussion and guides the substance of the subsequent recommendations.

Factor that may have contributed to a death/ modifiable risk factor	Personal Responsibility	Social Responsibility
<b>Opioid Abuse</b>	Mother's friend group encouraged her relapse after treatment.	State refusal to expand Medicaid leaves working families without health insurance. Women with chronic pain self-prescribe and are vulnerable to addiction in their childbearing years.
<b>Domestic Violence</b>	The mother should have left the father in earlier instances of abuse.	Wage inequality makes women/ children fully dependent on a spouse, creating vulnerability in abusive relationships. Isolation and residential segregation limits social networks.
<b>Unsafe Housing</b>	Parents could not support the needs of the children.	Lack of affordable housing causes low-income families to frequently migrate/couch-surf. Husband was on parole and could not contribute to family finances due to exorbitant legal fees in that county.

### DISCUSSION GUIDE:

- ☐ *What type of recommendations can result from the "Personal Responsibility" column compared to the "Social Responsibility" column?*
- ☐ *How are they different?*
- ☐ *What systems-level change can occur with recommendations for individual behavior change?*
- ☐ *What systems-level change can occur with recommendations for social responsibility?*

## RESOURCES:

- [\*\*Introduction to Cultural Responsiveness - A Training Tool\*\*](#)

This document is a guide for facilitators using the Community-Based Child Abuse Prevention PowerPoint presentation **Introduction to Cultural Responsiveness: A Training Tool** as a guide for instruction and discussion about (a) what cultural competence is and why it is important, (b) how to evaluate individual and organizational cultural competence, and (c) how to begin to develop cultural competence and create means to ensure ongoing success. (2014)

- [\*\*Knowing Who You Are \(KWYA\)\*\*](#)

This training is designed to raise awareness about the importance of developing a healthy sense of racial and ethnic identity (REI). It helps child welfare professionals explore race and ethnicity, preparing them to support the healthy development of racial and ethnic identity of youth in care. (2010)

- [\*\*Diversity QuickBit Module 1: Cultural Identity and Situational Factors\*\*](#)

Knowing ourselves helps us to recognize our personal biases and stereotypes and to see the world from the perspective of others. This short 7-minute module also explores two situational factors that affect our ever-changing sense of cultural identities: saliency and intersectionality. (2016)

- [\*\*Diversity QuickBit Module 2: Cultural Openness\*\*](#)

An important dimension of cultural humility is to maintain an openness to cultural differences. This short, 3-minute module provides an overview of the ways we can learn from the people with whom we interact, reserving judgment, and bridging the cultural divide between our perspectives. (2016)

- [\*\*Assessing Organizational Racism\*\*](#)

This organizational assessment offers a sampling of questions designed to help predominately white organizations and multi-racial organizations of white people and people of color examine and change the ways your organization replicates larger racist patterns. (2001)

- [\*\*The Wakanheza Project™ Creating Welcoming Environments\*\*](#)

This document provides principles and strategies that prevent or de-escalate stressful situations in public to create more welcoming environments for children, young people, families, and adults. (2015)

- [\*\*Continuum on Becoming an Anti-Racist Multicultural Organization\*\*](#)  
This is a chart that describes the six phases of becoming an anti-racist multicultural organization. (2013)
- [\*\*Tools for Thought: Using Racial Equity Impact Assessments for Effective Policymaking\*\*](#)  
This study explores assessment tools that measure the impact of proposed legislation on populations of color and are effective in shaping policy. (2016)
- [\*\*A Progressive's Style Guide\*\*](#)  
There is power in word choice, and this guide helps those helping to drive community change to use language that is inclusive, just, and reflects the individuals and communities we serve. (2016)
- [\*\*Racial Equity Glossary of Terms\*\*](#)  
A glossary of terms for conversations around race.
- [\*\*Bias-Free Language Guide\*\*](#)  
A guide around inclusive language—language that does not stereotype or demean people based on personal characteristics.
- [\*\*Building an Effective Tribal-State Child Welfare Partnership\*\*](#)  
A glossary of terms for tribal-state child welfare partnerships.
- [\*\*GLAAD Media Reference Guide\*\*](#)  
Glossary of terms around LGBTQ people and their lives.
- [\*\*Communication Key to Success\*\*](#)  
Create A Common Language Within Your Organization: Information on how to create common language within institutions.
- [\*\*Internalized Oppression and its Impact on Social Change\*\*](#)  
Outlines what internalized oppression is and how it can impact those working to make community change.
- [\*\*Healing from the Effects of Internalized Oppression\*\*](#)  
Steps on how to help people overcome the effects of discrimination and internalized oppression.

## Conducting Effective Review Meetings

Fatality review teams attract competent and thoughtful members because of the importance and complexity of their work. Team members are not paid. All volunteer endeavors are at the mercy of participant schedules. While fatality review teams are tasked with having efficiently operating review and community action processes that impact the community, boldly confronting the role of systems in social determinants of health and the role of institutionalized and individual racism on racial equity can be time intensive. Fatality review teams will need to be supported as more complex concepts are introduced into the limited professional time participants reserve for this process.

### EFFICIENT MEETINGS

An efficient meeting will hinge on individual competency of social determinants and the ability to challenge one another without feeling threatened or deeply emotional. The purpose of challenging fatality review colleagues and deeply engaging in discussion is to upend the root causes of preventable infant and child death.

Along with following National Center guidance on effective meetings, teams are encouraged to use the following guidance on using design thinking in the case review context.

## Design Thinking

[Design Thinking](#) is a process that seeks to understand the user, challenge assumptions, and reframe problems to identify alternative solutions and strategies that may usually supersede our initial level of understanding. As fatality review teams dive into social determinants and racial equity, members will be met with problems that they've not thought deeply about using an equity lens. Design thinking can be useful in tackling ill-defined causes of death and those that need more systems-oriented solutions.

## Challenging Assumptions in Fatality Review

Challenging assumptions requires questioning everyday thoughts and reasoning pathways. Commonly-held beliefs are sometimes incorrect, but widely accepted, because no one has challenged the assumption. Any time people approach problem solving, they bring their cumulative life experience, beliefs, and knowledge with them. Their experience may also justify their conscious and unconscious biases, which may incorporate some racist beliefs. This is especially true when climbing professional ladders, because assumptions increase with the mental baggage of experience. If left unchecked, these assumptions can prevent the acceptance of innovative ideas. Accepting innovative ideas requires creative thinking, imagining oneself in different roles, and frequently asking, "Why?"





## How to Resolve Team Conflicts

The answers that participants come to, individually, are based on their own unique perspective, life experience, and internal bias. The diverse perspectives brought to fatality review teams are invaluable; there would be no interdisciplinary, systems-level efforts to prevent infant and child death without it. However, teams must courageously challenge themselves and their colleagues to be the most impactful influencers working to prevent child death in their communities. As they challenge each other, they may find they have emotional responses to feeling that their beliefs and experiences are being challenged.

### STEPS TO CONFLICT RESOLUTION:

Conflict resolution should be led by team leadership at the first sign of conflict. Leadership may be not aware of the conflict until it has progressed. In these instances, steps toward conflict resolution may include:

- 1 *Set initial ground rules and review them at each meeting. Fatality review teams should be a safe space for candid discussion. Ask all parties to treat each other with respect and to make an effort to listen and understand others' views.*
- 2 *Ask each participant to describe the conflict, including desired changes. Direct participants to use "I" statements, not "you" statements. They should focus on specific behaviors and problems rather than people.*
- 3 *Ask participants to restate what others have said.*
- 4 *Summarize the conflict based on what you have heard and obtain agreement from participants.*
- 5 *Brainstorm and record solutions. Discuss all the options in a positive manner, assuming there will be a resolution.*
- 6 *Rule out any options that participants agree are unworkable.*
- 7 *Summarize the remaining possible options for a solution.*
- 8 *Assign individual participants to further analyze the potential options if additional information is necessary.*
- 9 *Make sure all parties agree on the next steps.*
- 10 *Close the meeting by asking participants to reflect on putting the needs of families first and working to resolve conflict.*





## WARNING SIGNS OF UNRESOLVED CONFLICT

- *Team members speak and interact less frequently*
- *Team members threaten to disassociate from fatality review*
- *Team members seek to reduce their responsibilities*
- *Disagreements and discussions are more personal in nature, referencing individual perspectives and stories told in confidence to the group*
- *Conflicts noticeably affect the morale of the team*

## RESOURCES:

- [\*The Discomfort Zone: How Leaders Turn Difficult Conversations into Breakthroughs\*](#)  
A book on how difficult conversations can be a catalyst for growth.
- [\*Crucial Conversations: Tools for Talking When Stakes Are High\*](#)  
A book on how to communicate in high stakes situations.
- [\*Introduction to the Essential Ideation Techniques \(Design Thinking\)\*](#)  
An explanation about the basics of Ideation—the mode of design process in which you concentrate on idea generation.
- [\*Learn How to Use the Best Ideation Methods: Challenge Assumptions\*](#)  
An explanation on when and how to challenge assumptions.
- [\*How Challenging Assumptions Every Day Improves Problem Solving\*](#)  
A collection of articles outlining how challenging assumptions can help you change the way you think, and the solutions you generate. Includes examples.
- [\*Challenge and Manage Assumptions\*](#)  
Information on how challenging assumptions can lead to creative problem solving and a culture of innovation.
- [\*Running Effective Meetings: A Guide for Humans\*](#)  
Tips on how to conduct meetings that function better and produce better results.
- [\*Running Effective Meetings\*](#)  
Information on how to prepare for and host effective meetings.
- [\*Reverse Brainstorming\*](#)  
Information on how reverse brainstorming can lead to creative solutions.
- [\*How to Resolve Workplace Conflicts\*](#)  
Article on how to manage conflicts, rather than avoiding them.



## Opportunities for Fatality Review Subcommittees

Subcommittees offer unique opportunities in the work of fatality review, creating more flexibility and opportunities for community engagement. They offer members the opportunity to:

- ☐ *Engage in a less structured aspect of FIMR/CDR where community voices can still be heard.*
- ☐ *Further engage professionals (medical, first responders, etc.) on a schedule that may more easily fit their schedules.*
- ☐ *Build internal leadership pathways.*
- ☐ *Strengthen ties within the community.*
- ☐ *Build trust between the community and service providers through increased interactions.*
- ☐ *To craft and catalyze prevention recommendations and action around specific risk factors and causes of death.*

Subcommittee engagement is creative way to extend the work of a FIMR or CDR, even with limited resources. Subcommittees can meet regularly, either adjacent to or on an alternating schedule from the larger fatality review team. The committee chair can be self-selected and voted upon by the fatality review team, and he or she has the agency to choose the core membership of sub-committee participants.

### *Example - Sub-Committee Leadership:*

Subcommittee Focus	Chair	Potential Members
<b>Perinatal HIV</b>	Immunologist	HIV testing advocate; parents living with HIV; nurse; OB/GYN
<b>Teen Pregnancy Complications</b>	Teen Parent Alliance President	School board members; teachers; clergy; teen parents; WIC representative
<b>Substance Abuse</b>	Psychologist	Infant mental health specialist; rehabilitation counselors; recovering drug addict; local public health

Committee chairs can touch base with each other as needed, or monthly, to share notes between FIMR or CDR meetings. This can be done through video-conference calls or face-to-face meetings.



## Subcommittee Chair Debrief

The chairs can report out in a debrief discussion during the broader fatality review meeting. This process helps the entire group be able to hear detailed information about local social determinants without having to become subject matter experts themselves. Debriefs will increase the pace with which the entire review panel can process complex interactions between social determinants and racial equity within their jurisdiction. A debrief outline may look something like this:

- ☐ *Share issue-specific data.*
- ☐ *Discuss policy changes and issues to advocate for/fight against.*
- ☐ *Discuss local trends and changes within the community.*
- ☐ *Share accomplishments internally and externally.*
- ☐ *Identify accountable parties and/or additional sub-committee members.*

## Guidelines for Writing Effective Recommendations

At the heart of the fatality review process is a careful, thorough study of every case by the review team to determine the adequacy of local systems of care and community resources for women, infants, children, and families in order to make recommendations for their improvement. To ensure that these recommendations are specific and actionable, many teams use the acronym of SMART:

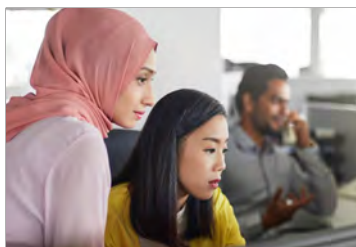
- ☐ *Specific: Targets a specific area for improvement.*
- ☐ *Measurable: Quantify an indicator of progress.*
- ☐ *Achievable: Who will do it.*
- ☐ *Relevant: Can it be realistically achieved given available resources.*
- ☐ *Time-bound: Gives a clear deadline for when results will be achieved.*

### EQUITY AND INCLUSION

By incorporating IE into recommendations, organizations and agencies can make sure that their commitment to diversity, equity, and inclusion is anchored by tangible and actionable steps (<http://www.managementcenter.org/resources/smartie-goals-worksheet/>).



**SMARTIE** | The Management Center recommends adding I and E to SMART recommendations, making them “SMARTIE” goals<sup>10</sup>.



**INCLUSIVE** | Brings traditionally excluded individuals and/or groups into processes, activities, and decision/policy making in a way that shares power.



**EQUITABLE** | Includes an element of fairness or justice that seeks to address systemic injustice, inequity, or oppression.

<sup>10</sup> Open Source Leadership Strategies. Retrieved June 2, 2019 from <http://www.managementcenter.org/article/tips-for-writing-smartie-goals/>.

## Troubleshooting - FAQs and Solutions

### *What happens when there is an internal conflict within the team during a review discussion?*

Because fatality reviews are a volunteer effort, there is no staff or dedicated human resource department that participants can consult for conflict resolution. If there is an irreconcilable difference or unhealthy discussion at a review team meeting, technical assistance should be requested. Technical assistance from state fatality review leadership will engage team members one-on-one and collectively, providing guidance for restoration and team building through conflict resolution. The National Center is always here to help.

### *If there are budget constraints, how are we to start subcommittees with limited time and resources?*

Ask state-level leaders how other teams are most effectively using and leveraging funds, or what types of funders may support this work locally. They can have insights on grant funding, fundraising opportunities, or the opportunities to share staff between local programs. In states without state-level leadership for fatality review, the National Center is available for these discussions.

## Recommendations:

1

*Fatality teams may want to take stock of resources available through their state and local offices and websites. Printed and web materials should align with information within this toolkit. Common language throughout all fatality review guiding materials will ease the transition as teams begin working closely with this information.*

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2

*Intensive, multi-day equity training for fatality review and community action teams (CAT) are recommended on an annual or biannual basis. A deep dive into race, racism, health inequities, and social determinants is important for entire working groups to experience together. It is an opportunity to create further consensus on complex social issues, team build, and operate more efficiently with concepts of equity.*

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3

*In-person technical assistance is preferred. As an add-on to a longstanding institution of death review, this transition to adopting equity frameworks will need additional support to meaningfully take hold and create the desired change. The knowledge and positioning of each fatality review team can differ based on its leadership and location. Subsequently, the journey of each fatality review team will differ as they employ the toolkit. Technical assistance in the form of meetings, video calls, webinars, or regular check-ins will be requested and should be made available from state, regional, and national leadership.*



## Making Systems-Level Recommendations and Taking Action

During case reviews, the team may decide whether a death is preventable. The team should consider these two questions<sup>11</sup>.

- ☐ *If there was at least some chance that the death could have been averted, were there specific and feasible actions which, if implemented, might have changed the course of events?*
- ☐ *The racial demographics of the community should be represented in the membership of review and prevention teams.*



Fatality review teams should also think about the following three categories of prevention when developing recommendations:

### PRIMARY:

Prevents the contributing factor before it ever occurs.

*Examples include infant safe sleep education, folic acid regimens, or seatbelt use mandates.*

### SECONDARY:

Reduces the impact of the contributing factor once it has occurred.

*Examples include treatment of gestational diabetes, screening for birth defects, or reduced access to lethal means in youth at risk of suicide.*

### TERTIARY:

Reduces the progression of an ongoing contributing factor once it has occurred.

*Examples include management of gestational diabetes complications or mental health services for children and families affected by maltreatment.*

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<sup>11</sup> Review to action: Building US capacity to review and prevent maternal deaths. (n.d.). Retrieved June 2, 2019, from <https://reviewtoaction.org/content/review-action>.

Teams should also consider the timing of their recommendations. Varying these options allows fatality review partners to address multiple issues at once and experience some victories while they chip away at larger issues.

### SHORT TERM:

Recommendations that can be implemented in less than a year.

*Examples include updating an internal policy or an agency-level intake form.*

### INTERMEDIATE:

Recommendations that can be implemented in a year or two.

*Examples include providing a plain language, cultural competence, or bereavement training to relevant partners.*

### LONG TERM:

Recommendations that can be implemented in three or more years.

*Examples include establishing a work force that has had undoing racism and implicit bias training.*



Finally, fatality review teams should consider the expected impact level of their proposed recommendations:

- ☐ *Small (one-on-one education, advisement for the community, provider, or health system)*
- ☐ *Medium (clinical intervention, coordination across care)*
- ☐ *Large (lasting protective intervention, improved risk assessment and response)*
- ☐ *Extra-large (healthcare system redesign, improved frameworks or models of care)*
- ☐ *Giant (address social determinants of health)*



## Community Positioning for Systemic Change

Part of creating the equity needed to shift social determinants on behalf of infants and children of color is reconnecting with community organizations and meaningful collaborations with maternal and child health and injury prevention entities. This includes closer relationships with local and state health departments/sub-departments, home visiting programs, early childhood service providers, advocates, etc. Without deep collaboration, the system will be disjointed and inefficient for change. These collaborations are important to educate the community on the social determinants of health and high-risk populations/locations. For example, home visiting programs benefit from fatality review partnerships because fatality review findings inform where their services are most impactful.

Community collaborations ensure accountability to and for the communities being served. Accountability is strengthened by the simple presence of a fatality review team in a community. However, these teams are not typically a visible feature in the community. Creating a fatality review program centering on equity means that awareness of its presence will need to increase within the community.

## Mobilizing within the Community

Fatality review programs have effectively identified disparities and catalyzed action to address them. Some examples are highlighted below.

### *Community education or presentations*

One state's Child Fatality Task Force recommended that the legislature require a study to assess the timely and equitable access to risk-appropriate maternal and neonatal care for state residents. A fact sheet was developed to educate the community and providers about this issue and why the Task Force was making this recommendation.

A local FIMR team identified persistent health disparities between African American and White maternal and infant health outcomes. To increase public awareness of the issue, they convened an annual event to support pregnant African American women. The African American Baby Shower was hosted in partnership with the public health department and other community partners. Educational sessions were held on preterm labor prevention, breastfeeding, and stress reduction.

### *Community service and community organizing*

A fatality review team in one state is working on getting safe sleep brochures translated into Marshallese. This is a community that has a high rate of infant deaths due to co-sleeping and unsafe infant sleep environments. A local high school is conducting the translation and new look for the brochure.

One western FIMR community formed an African American Health Disparities Task Force, a collaborative to improve the African American maternal and infant health outcomes. The focus of the Task Force is to monitor services rendered to African American women and identify priorities. In its first year of operation, the task force increased outreach efforts to engage African American women in perinatal home visiting support services and developed a brochure for African American men on how they could support their partners.

### *Supporting local grief counselors and organizations*

A FIMR team in a Native American community found that few families received referrals and/or follow-up care for grief and bereavement counseling, and that services from a traditional indigenous perspective were absent. The team applied for and received funding to support the first statewide bereavement support network for Native Americans in their state, and members of the team were trained on nursing care and traditional Native protocols for providing bereavement support to grieving families.



## Conclusion

Fatality review teams have the unique opportunity to analyze and address the policies, systems, and environmental factors that are contributing to infant and child deaths, including issues of discrimination and inequity. This toolkit is an introduction into some of the ways fatality review teams can better understand their own implicit biases, the social determinants of health, their impact on infant and child deaths, and how to create and implement recommendations that will address inequities in communities. These are all difficult tasks and will not be completed overnight. The National Center for Fatality Review and Prevention will continue to provide training and support to fatality review programs as they embark on creating more equitable review processes, implement recommendations that address equity and inclusion, and help create communities where all babies, children, and families thrive.

To accompany this guidance, the Center and members of the CDR/FIMR Health Disparities work group have compiled additional resources on the following topics: Implicit Bias, Social Determinants of Health, Adverse Childhood Experiences (ACEs), Undoing Racism and Reproductive Justice

A PowerPoint presentation is also available that communities can use and adapt to their individual needs when educating fatality review team members, partners, and the greater community on racial inequities.

Both additional resources are available on the Center's website at [www.ncfrp.org](http://www.ncfrp.org).





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