Child Death Review and Overdose Fatality Review Collaboration

Background

There are many reasons why Child Death Review (CDR) and Overdose Fatality Review (OFR) programs may seek enhanced collaboration or alignment, including maximizing resources, reducing redundancy, or learning from the successes of a parallel program. Fatality review programs often have shared processes, partners, and may even select the same deaths for review. They also have distinct characteristics, are often led by different agencies, have different funders and resources, and may have distinct legal obligations.

While fatality review programs may focus on separate populations, these populations are often seen as parts of a whole population of interest to external prevention partners, and the processes often result in similar system or community-level recommendations. Fatality review programs of all types can identify ways in which the social determinants of health drive outcomes, and recommendations across programs are able to focus on these systems-level risks that affect populations across the life course.

This resource will outline shared program processes, provide an overview of each distinct program, and illustrate ways programs may align or collaborate, acknowledging each is a unique process with specific implementation methodologies.

Distinct Programs with Shared Processes

When different fatality review programs align or collaborate, it is important to do so in ways that allow fidelity to each of the programmatic models as well as each jurisdictional authority. While different fatality review processes have distinct characteristics, there are common processes and functions across programs. For instance, all fatality review teams:

- Identify deaths
- Request records to inform death review
- Convene multidisciplinary teams
- Review individual deaths
- Identify 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

NATIONAL 20 YEARS CFRP
Center for Fatality Review & Prevention

CDR and OFR Programmatic Overview

	Case Review Criteria	Key Team Members and Partners	Unique Process Goals	Unique Process Features
CDR	Deaths reviewed are selected from children from birth to under the age of 18 who died of any cause, commonly prioritizing sudden, unexpected deaths or deaths due to maltreatment.	Injury prevention programs; child welfare agencies; public health; law enforcement; medical examiners/ coroners; pediatricians; schools; EMS/fire responders; emergency room staff; mental health; tribal elder/ traditional leader	Identify risk factors and prevention strategies to address deaths of infants, children, and youth, ensure accurate identification and uniform reporting of the cause and manner of death of every child, and improve agency responses in the investigation of child deaths.	Team members bring identified records to the review meeting to share and discuss the death and document findings. Some teams share findings with Community Action Teams (CAT) to move recommendations to action.
OFR	It may not be feasible for every OFR team to review every death in its jurisdiction. OFR teams may review both pediatric and adult deaths as determined by case selection parameters. Themed review to select deaths for review is recommended. Themes include high risk populations, demographic parameters, jurisdiction inclusion criteria, substance involved, hot spots etc.	Harm reduction; child welfare agencies; public health; law enforcement; medical examiners/ coroners; emergency department physicians; mental health; substance use treatment provider; prosecutor; medication for opioid use disorder (MOUD) provider; social workers; pain management clinician; primary care provider; pharmacist/ toxicologist; EMS; probation; drug court; patient advocate; schools; tribal elder/ traditional leader; housing authority; person with lived experience	Effectively identify system gaps and innovative, community-specific overdose prevention and intervention strategies. Develop program and policy recommendations to improve coordination and collaboration between agencies and community conditions to prevent future substance-related deaths.	During a case review meeting, the OFR reviews aggregate data to understand current overdose trends which informs the deaths reviewed and provides context for case findings and recommendations. The OFR facilitator facilitates a series of confidential individual death reviews by the multidisciplinary team to identify systems and gaps and community specific overdose prevention and intervention strategies. These recommendations are then presented to a governing committee that supports and provides resources to

				ensure implementation and creates a framework of accountability. The governing committee is comprised of community leaders and agency decision makers.

Opportunities for Collaboration

Following are ways in which CDR and OFR fatality review programs may effectively coordinate efforts to support progress across the life course.

Improve communication throughout the case preparation process, as policy permits

- Shared records requests
- Shared abstractors or death-specific documents or summaries
- Shared case-specific data if a death is under review by more than one review program
- Coordination of family and informant interviews

Shared partners

These distinct fatality review programs may be led by different agencies or organizational units within an agency, but often they are coordinated by a state or local health department, and frequently both are housed in a division or bureau focused on injury prevention. Even when program leadership is not adjacent within an organization, similar external partners may be asked to participate in fatality reviews or to advance recommendations. Some of these shared partners may include:

- Medical examiners/coroners
- Public health
- Law enforcement/investigators
- Child welfare
- Mental health providers/professionals

Formalize coordination of different review programs within states and/or locales

- Collaborative or shared leadership
- Shared membership
- Shared funding

Share data collected from different reviews to support planning objectives

- Shared data entry staff or protocols
- Shared aggregate data for internal program planning and prioritization strategies, identifying shared risk or protective factors and priority recommendations for prevention

Amplify shared messages

- Jointly disseminate reports
- Elevate coordinated recommendations or findings
- Collaborate on summarizing shared community resources

- Collaborate around acting on findings or recommendations

This document is not exhaustive. For more information visit:

- *Child Death Review*
  The National Center for Fatality Review and Prevention: www.ncfrp.org
- *Overdose Fatality Review*
  Bureau of Justice Assistance Comprehensive Opioid, Stimulant, and Substance Abuse Program: https://www.cossapresources.org/Tools/OFR

The National Center is funded in part by Cooperative Agreement Number UG728482 from the US Department of Health and Human Services (HHS), Health Resources and Services Administration (HRSA), Maternal and Child Health Bureau (MCHB) as part of an award totaling $2,420,000 annually with 0 percent financed with non-governmental sources. The contents of this presentation are solely the responsibility of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the US Government.