



# SHARING YOUR DATA: WRITING ABSTRACTS AND PROPOSALS

Telling Stories to Save Lives



# Key Funding Partner

## Federal Acknowledgement

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# What to Expect Today

OFFICE HOURS




## **SHARING YOUR DATA: WRITING ABSTRACTS AND PROPOSALS**

Provide guidance on writing effective abstracts and proposals.



## **OPEN DISCUSSION**

How can we help you today?



**What challenges do you  
experience writing  
abstracts or sharing data  
in general?**



### Follow Instructions Closely

Do not exceed word limits, abstract might be structured or unstructured, may include learning objectives.



### Be Concise

Brevity and clarity are key. Avoid jargon. Background and methods should be brief.



### Highlight the Key Results

For a research or data abstract, the abstract should devote the most emphasis on the results.



### State Conclusions/Implications for Prevention

End with a succinctly stated conclusion and/or implications for prevention.



### Consider the Audience

It's okay to be more academic when speaking to a research-oriented audience but use plain language for other audiences.



**KEY CONSIDERATIONS  
FOR ABSTRACTS**

# Additional Considerations For Conference Abstracts

Abstract Criteria May Vary



## TYPE OF PRESENTATION



Different requirements based on presentation option: Oral, poster, technical workshop, peer learning.



## DIFFERENT FOCUS



Research/data abstract versus program or policy description.



## CONFERENCE THEME



Abstracts may receive priority if they address a theme or stated topic of interest.

# PUBLISHED JOURNAL ABSTRACTS

Recent Examples

## Contextual Factors Influencing Firearm Deaths Occurring Among Children

Heather A. Hartman, MD,<sup>a,b</sup> Laura A. Seewald, MD,<sup>a,c,d</sup> Eugenio Weigend Vargas, PhD,<sup>a</sup> Jorge Portugal, MS,<sup>a</sup> Peter F. Ehrlich, MD,<sup>a,b</sup> Sasha Mintz, MPH,<sup>a</sup> Cynthia Ewell Foster, PhD,<sup>a,f</sup> Rebecca Sokol, PhD,<sup>a,g</sup> Douglas Wiebe, PhD,<sup>a,c,e</sup> Patrick M. Carter, MD<sup>a,c,h,i,j</sup>

**OBJECTIVES:** Contextual factors that contribute to firearm injuries among children aged 0 to 10 are not well understood.

**METHODS:** A retrospective review of the National Fatality Review-Case Reporting System was conducted for firearm deaths of children aged 0 to 10 from 2004 to 2020. Descriptive analyses characterized child and parent demographics, incident details, firearm characteristics, and firearm use. Cluster analysis identified key clustering of contextual variables to inform prevention efforts.

**RESULTS:** Within the study timeframe, 1167 child firearm deaths were reported ( $M_{age} = 4.9$ ; 63.2% male; 39.4% urban). At the time of the incident, 52.4% of firearms were reported unlocked and 38.5% loaded. Firearm deaths occurred primarily at the child's home (69.0%) or a friend or relative's home (15.9%), with most involving a handgun (80.6%). Children were supervised in 74.6% of incidents, and 38.4% of child supervisors were impaired during the incident. Cluster analysis identified incident contextual factors clustering in distinct groups, including unsupervised firearm play, long gun discharge while cleaning, hunting, or target shooting, supervised discharge within the child's home, murder-suicide events, deaths occurring in the context of intimate partner violence, and community violence firearm deaths.

**CONCLUSIONS:** Data highlight the importance of primary prevention through secure firearm storage to prevent child firearm deaths. Efforts focused on identifying and reducing intimate partner violence, addressing community violence (eg, community greening), and implementing policy that limit firearm access (eg, domestic violence restraining orders, background checks), may reduce child firearm deaths.

[abstract](#)

# PUBLISHED JOURNAL ABSTRACTS

Recent Examples

## Fetal, Infant, and Child Death Review: A Public Health Approach to Reducing Mortality and Morbidity

Michael D. Warren, MD, MPH, FAAP,<sup>a</sup> Diane Pilkey, RN, MPH,<sup>a</sup> Deepa S. Joshi, MD, MPH,<sup>a</sup> Abigael Collier, MS, DrPH<sup>b</sup>

Fetal, infant, and child death reviews are a longstanding public health effort to understand the circumstances of individual deaths and use individual and aggregate findings to prevent future fatalities and improve overall child health. Child death review (CDR) began in the United States in the late 1970s to better identify children who died of abuse or neglect; fetal and infant mortality review (FIMR) began in the mid-1980s as a response to the stagnant rates of infant mortality. Today, there are >1350 CDR teams and >150 FIMR teams across the United States, including in tribal communities, territories, and freely associated states. Since the 1990s, the Health Resources and Services Administration's Maternal and Child Health Bureau has supported fetal, infant, and child death review work through funding and thought leadership. The Health Resources and Services Administration-funded National Center for Fatality Review and Prevention provides support to CDR and FIMR teams, including a standardized data collection system for use by state and local CDR and FIMR teams. Although distinct processes, CDR and FIMR both use a public health approach to identify system gaps contributing to early death and make recommendations that impact programmatic and policy changes at the local, state, and national levels. Although progress has been made in standardizing data collection and deepening our understanding of fetal, infant, and child deaths, opportunities persist for preventing future deaths.

[abstract](#)

# ABSTRACTS FROM CONFERENCE PRESENTATIONS

Recent Examples

City MatCH 2024

## Examining Stillbirth through the Fetal and Infant Mortality Review Process

**Background:** Stillbirth is the death of a baby during pregnancy at or after 20 weeks of pregnancy. Every year in the United States about 24,000 babies are stillborn, or 1 out of every 100 pregnancies that reach 20 weeks gestation. Disparities are observed in stillbirth, as Black mothers are more than twice as likely to experience stillbirth than White mothers, and stillbirth rates are higher in the southern U.S. than the rest of the country.<sup>1</sup> It can be challenging to study stillbirth due to lack of adequate investigation and autopsy and lack of standardized categorization of stillbirth. Fetal and Infant Mortality Review (FIMR) is a multidisciplinary fatality review process that uses de-identified information from records and parental interviews to understand and address fetal-infant mortality. As of February 2024, there are 151 FIMR teams in 26 states. Standardized FIMR data are collected in the National Fatality Review-Case Reporting System (NFR-CRS), including rich contextual data.

**Study question:** This research describes characteristics of stillbirths reviewed by FIMR teams, including information on modifiable and non-modifiable risk factors unavailable from other sources.

**Methods:** FIMR teams reviewed and entered data on 1,805 stillbirths occurring between 2017 and 2020 into the NFR-CRS. Descriptive statistics were generated for specific indicators using SPSS 29.

**Results:** Among stillbirths reviewed and [entered into](#) NFR-CRS, 19% of childbearing parents smoked during pregnancy, and 43% had a BMI of 30 or greater (affected by obesity). While 91% of the parents received prenatal care, 31% experienced access or barrier issues related to prenatal care. One-third (33%) of parents reported receiving health education related to fetal movement monitoring. One-fifth (21%) reported a lack of home visiting services even though the household was eligible. In 17% of the deaths, parents reported experiencing three or more family, economic, or other stressors, collected as FIMR teams deliberated Life Stressors in the NFR-CRS, and 13% reported depression during pregnancy.

**Conclusions:** Some stillbirth information is uniquely available from FIMRs. Even though FIMR data are not population-level, this study highlights the important work of local FIMR teams to help understand contextual factors present in stillbirths.

**Public Health Implications:** These findings provide insights into social and contextual information for families who experience stillbirth. This information can inform local, state, and national maternal child health programming, service delivery, and policy.

# ABSTRACTS FROM CONFERENCE PRESENTATIONS

Recent Examples

**Safe States 2024**

## **Unique Findings from a Fatal Drowning Pilot**

**Statement:** The National Center for Fatality Review & Prevention (National Center) partnered with the Centers for Disease Control and Prevention (CDC), the National Network of Public Health Institutes (NNPHI), and child death review (CDR) pilot sites to conduct a feasibility study of enhanced collection of death scene investigation (DSI) information to inform youth drowning prevention.

**Approach:** Since 2022, details from 94 deaths have been entered from pilot jurisdictions, with data collection ongoing. Information is collected in the National Fatality Review-Case Reporting System (NFR-CRS) and the Water-Related DSI Protocol REDCap database. Through the pilot, technical assistance to sites and key informant interviews with law enforcement, death scene investigators, boating law administrators, and others were conducted to refine and finalize the protocol.

**Results:** In addition to demographic data, rich contextual data were collected. Six deaths (6.4%) mentioned the child had diagnosed or suspected autism. Other vulnerable populations identified include those living in densely populated areas with few recreational public water options available, and children and young adults with a history of wandering or elopement. Pilot site barriers from the first year of data collection include state and local CDR workforce turnover and the length and usability of the DSI protocol, which was addressed in the final version.

**Significance to the field:** The data gleaned from this enhanced DSI protocol is far richer than death certificate data on its own. Better understanding of pediatric drowning can be used to advance health equity and inform local and state prevention planning.

# ABSTRACTS FROM CONFERENCE PRESENTATIONS


Recent Examples

**SAVIR 2025**

## **New Insights From Child Fatality Review to Advance Equity**

Child death review (CDR) is a long-standing public health effort to understand the circumstances of individual deaths and utilize findings to prevent future fatalities and improve overall child health. CDR is a multidisciplinary process that provides detailed information about the circumstances of a fatality, beyond the limited data available from death certificates. Today, there are over 1,350 CDR teams across the United States, including in tribal communities, territories, and freely-associated states.

In November 2024, Pediatrics published “Insights from Fatality Reviews: Informing Pediatric Practice, Policy, and Research,” a first of its kind special supplement highlighting data from CDR. The supplement describes the unique utility of the CDR process and data, highlights findings that articulate unique risk factors for specific populations and identifies examples of how communities and states have translated findings into action for population health improvement. This symposium will feature four articles from the supplement that, together, emphasize how CDR prioritizes achieving equity for all children, families, and communities. This symposium will tell a complete story about the history of CDR data, the inequities that continue to drive disparities in child mortality, and how we are striving to make process improvements informed by science that move the needle toward equity.



**Have you presented about  
your fatality review program  
or data at a conference or  
meeting? Was an abstract  
required?**

# NATIONAL CONFERENCES

## Potential Venues for Presentation of Fatality Review Data

- Safe States Annual Injury and Violence Prevention.
- CityMatCH Leadership and MCH Epidemiology Conference.
- PrevCon – SafeKids WorldWide Conference (Biannual).
- American Public Health Association Annual Meeting and Expo.





## State or Local Meetings

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- State Coroner/Medical Examiner meetings.
- State Law Enforcement meetings.
- Local coalition meetings:
  - Safe Sleep
  - Suicide prevention
- State Child Death Review Committee meetings.
- State or Regional Public Health Conferences.

# Writing a Proposal

## Tips for Success



### FOLLOW INSTRUCTIONS



Read and follow the instructions very closely. Seek help from agency issuing call for proposals.



### SEEK EXAMPLES



Request access to successful past proposals.



### GET HELP



Request help with writing or review of draft proposal from experienced person.



# NEWS AND UPCOMING OPPORTUNITIES

Pediatrics Supplement, SAVIR Seminar, and Office Hours 2025

# PEDIATRICS SUPPLEMENT

November 2024

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- National call for papers March 2023.
- 34 papers submitted.
- Papers reviewed by NCFRP staff and invited experts.
- 17 papers submitted, peer-reviewed by Pediatrics, all accepted for publication.
- Supplement is open access and available here:  
<https://publications.aap.org/pediatrics/issue/154/Supplement%203>

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# PEDIATRICS®

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[www.pediatrics.org](http://www.pediatrics.org)

## A SUPPLEMENT TO PEDIATRICS

**Insights From Fatality Reviews: Informing Pediatric Practice, Policy, and Research**

Sponsored by the National Center for Fatality Review and Prevention, a Program of the Michigan Public Health Institute.

American Academy  
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN®

## To Register:

<https://us02web.zoom.us/meeting/register/tZMrdeCrrTMpG92ph47Gvp5or3TdYXeYE8ZX#/registration>

Title: Unlocking Insights with Fatality Review Data

Date: January 23, 2025, 1-2:30pm ET

This session will highlight the broad range of research that has been done using National Fatality Review-Case Reporting System data and share the data dissemination process currently available to researchers.

Moderator: Sasha Mintz, MPH, Senior Epidemiologist,  
National Center for Fatality Review and Prevention

## Presenters:

Christopher Gaw, MD, MPH, MBE

Bridget Duffy

Laura Seewald, MD

Heather Hartman, MD



**SAVIR and NCFRP**

**Winter Methods Session**

Visit [ncfrp.org/center-resources/office-hours/](https://ncfrp.org/center-resources/office-hours/) to register and view past sessions!

Date	Topic
1/21/2025	Partnering with Medical Examiners/Coroners for Death Scene Investigation Training
2/18/2025	Pulling Data Highlights From the NFR-CRS
3/18/2025	Working with Plain Communities
4/15/2025	The National Center's Favorite NFR-CRS Tools and Tips
5/20/2025	Supportive Systems for Team Mental Health
6/17/2025	Quality Assurance Practices
7/15/2025	Connecting Teams to Tribal Resources
8/19/2025	Meaningful Data Visualizations
9/16/2025	Reviewing Suicide Deaths
10/21/2025	Handling Conflicting Data
11/18/2025	Facilitating Difficult Conversations
12/16/2025	Interactive Meetings: Designing Live Icebreaker Dashboards

Upcoming topics may be subject to change.



# National Center Office Hours

## 2025



**WE'RE HERE TO HELP!**



## CONTACT INFORMATION



2395 Jolly Rd., Suite 120  
Okemos, MI 48864



Phone: 800-656-  
2434



[info@ncfrp.org](mailto:info@ncfrp.org)



[www.ncfrp.org](http://www.ncfrp.org)