



National Center Steering Committee

New Member Orientation

Telling Stories to Save Lives



KEY FUNDING PARTNER

FEDERAL ACKNOWLEDGEMENT

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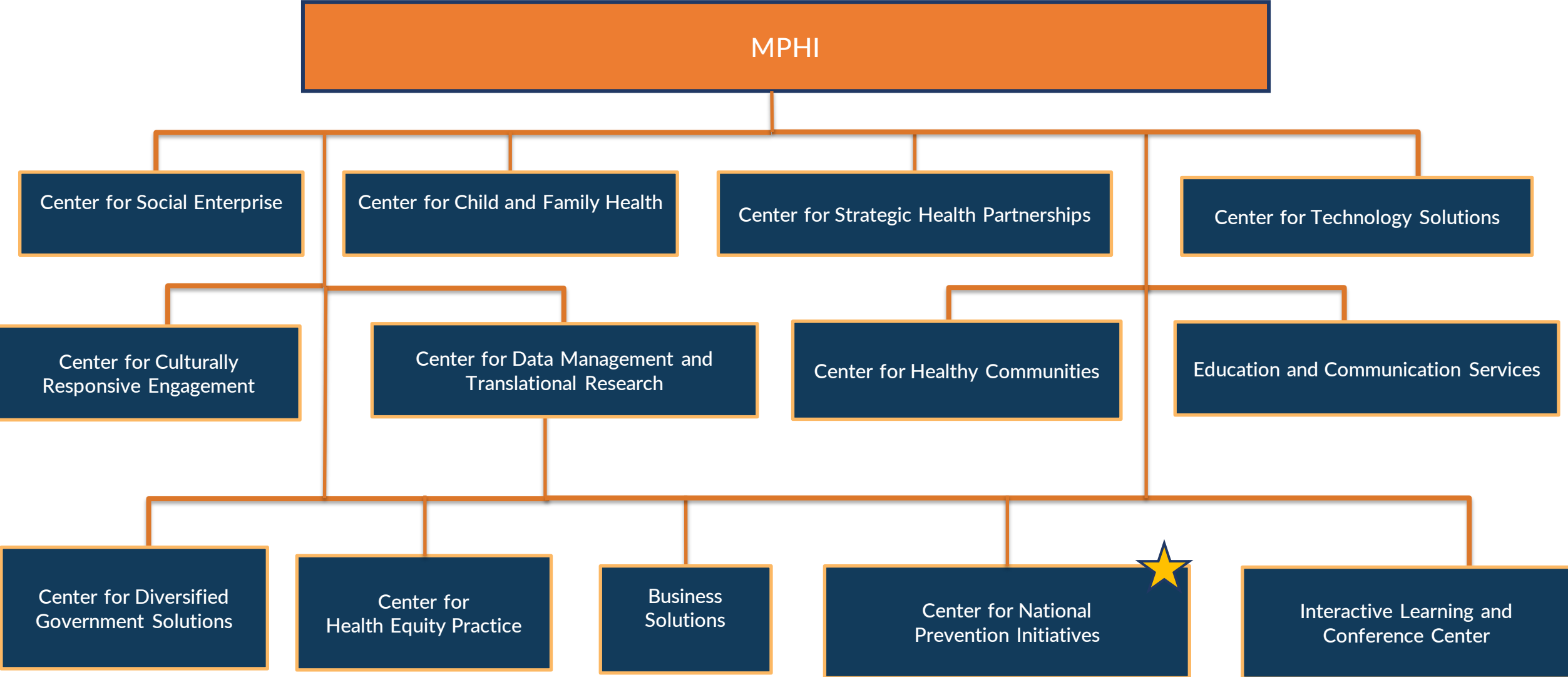
HRSA'S VISION FOR THE NATIONAL CENTER

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

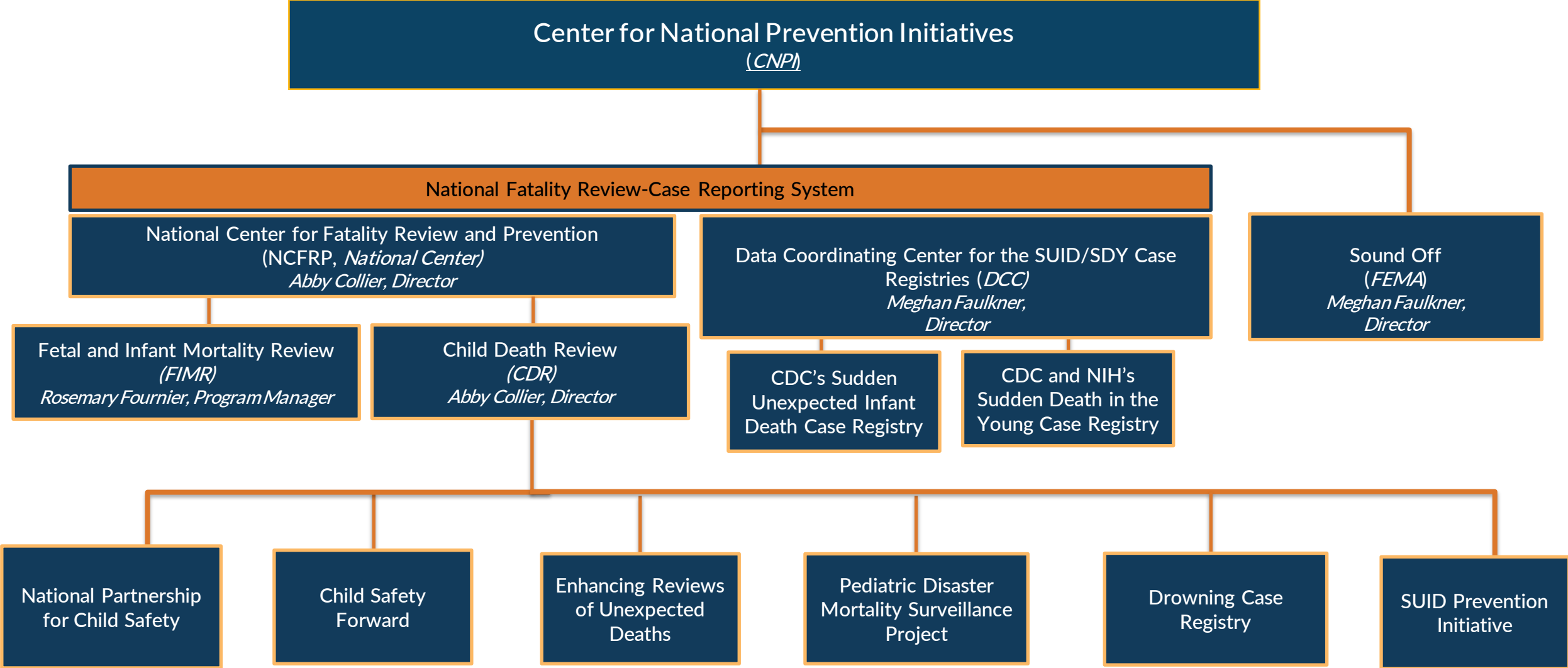
Assist state and community programs in:

- Understanding how CDR and FIMR reviews can be used to address issues related to adverse maternal, infant, child, and adolescent outcomes
- Improving the quality and effectiveness of CDR/FIMR processes
- Increasing the availability and use of data to inform prevention efforts and for national dissemination

Centers of the Michigan Public Health Institute



CNPI Project Organizational Chart



CNPI Staff

Celebrating 20 Years of More Birthdays





Leadership/Training

Provide guidance, training, and technical assistance to state, community, and tribal CDR and FIMR teams, including those that are Healthy Start grant recipients.



National Fatality Review Case Reporting System (NFR-CRS)

Support the CDR and FIMR National Case Reporting System including standardized data collection and quality improvement efforts.



Disseminate Data

Assist teams to use data and key findings from fatality review to inform prevention efforts, including innovative, user-friendly data visualization tools and data summaries.



Action for Prevention!

Facilitate the translation of CDR and FIMR data and recommendations into practice, system, and policy change at the community, state, and national levels.



Expansion Activity

Increase data collection, support data dissemination, and inform activities for prevention of SUID and SUDC.



GOALS OF THE FETAL, INFANT CHILD DEATH REVIEW PROGRAM

WHAT IS FIMR?

Fetal and Infant Mortality Review

- Community-focused, action-oriented fatality review process to examine fetal and infant deaths
- Multidisciplinary, de-identified, and confidential
- Continuous Quality Improvement (CQI) for systems that serve birthing families and infants



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**

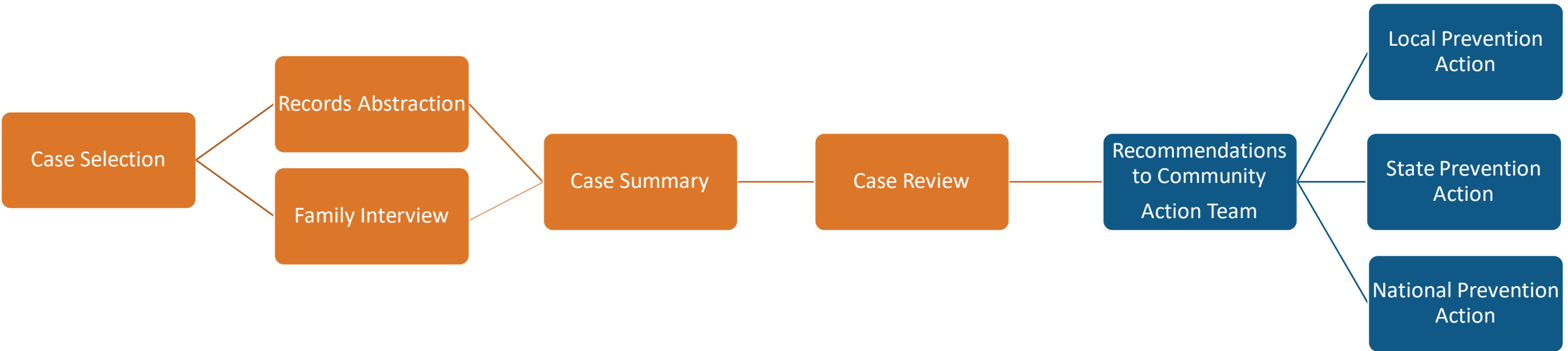


Community Action Team (CAT)

- 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

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



Three Steps to Child Death Review

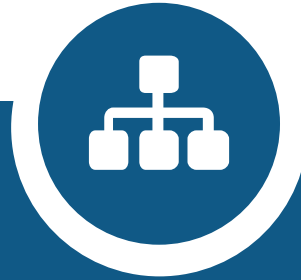
Steps to Success



Tell the Story



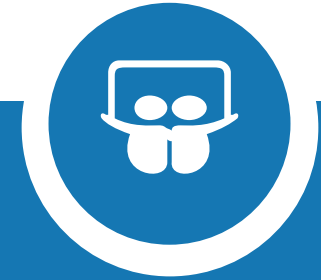
Tell each story, identified, to understand the risk and protective factors



Collect Data



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



Take Action



Fatality Review Teams should be a catalyst for prevention

CDR Process

Best Practices in Reviews



National Fatality Review- Case Reporting System

A National Tool for CDR and FIMR Teams

The purpose of NFR-CRS is to systematically collect, analyze, and report comprehensive fatality review data that includes:

- Information about the fetal, infant or child and their family, supervisor at the time of the incident and person responsible (when applicable)
- Services needed, provided, or referred
- Risk and protective factors
- Findings and recommendations
- Factors affecting the quality of the review meeting



CDR REPORT FORM

Version 6.0

National Fatality Review Case Reporting System

Data Entry Website: data.ncfrp.org

Phone: 800-656-2434

Email: info@ncfrp.org

ncfrp.org



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NFR-CRS Utilization

There are currently 47 states using NFR-CRS

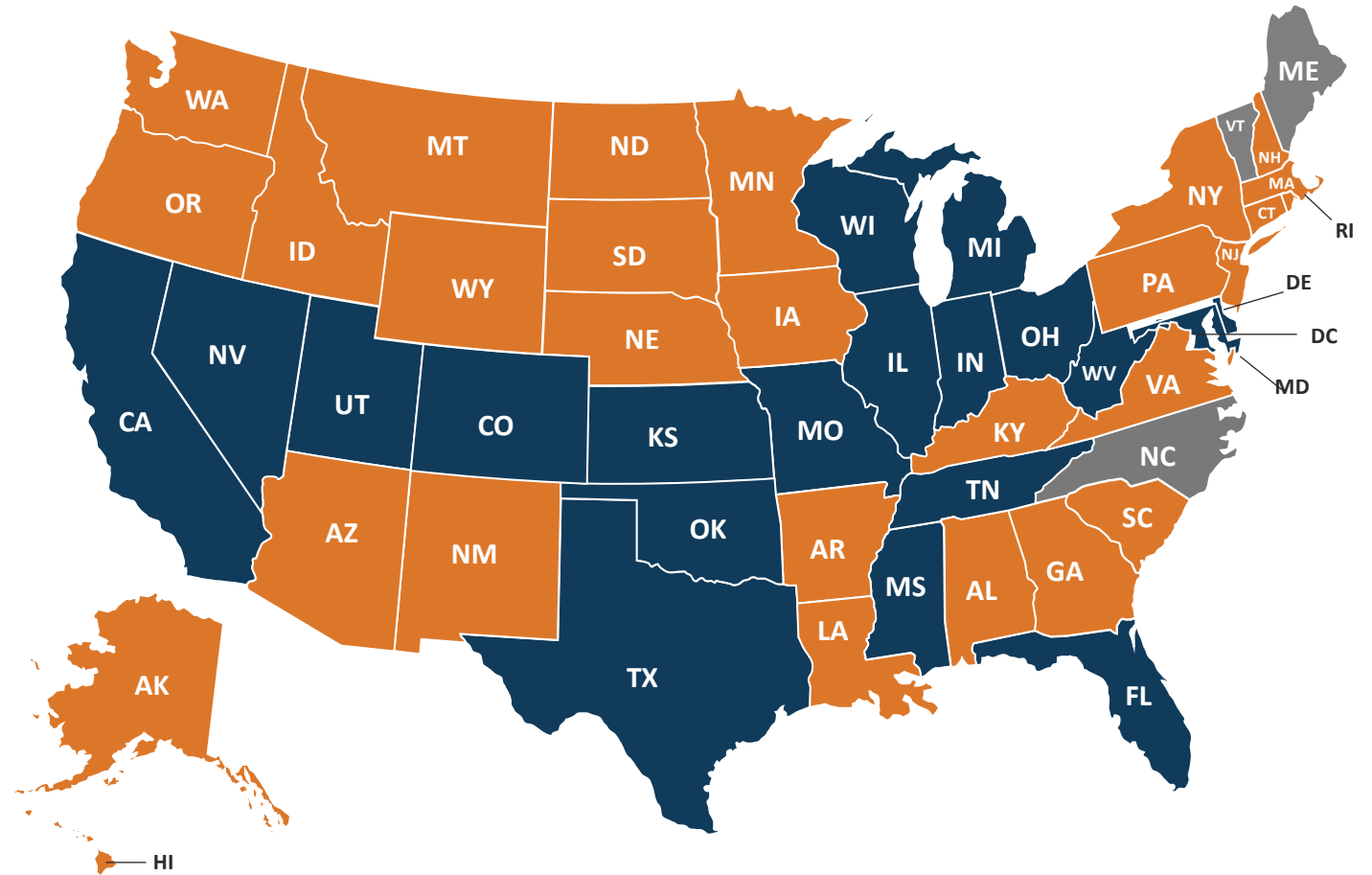
- 47 use NFR-CRS for CDR
- 19 use NFR-CRS for FIMR

Each state uses NFR-CRS differently. Some have comprehensive reviews whereas others may only use NFR-CRS in one jurisdiction.

States Using NFR-CRS
for CDR

States Using NFR-CRS for
CDR and FIMR

States Not Using
NFR-CRS





Oral Presentations

Presentations at conferences such as PrevCon, Cribs for Kids, American Academy of Pediatrics (AAP), CityMatCH, AMCHP, and the Healthy Start virtual grantee meeting.



International Presentations

Presentations at conferences such as Australian and New Zealand CDR Conference and the International Society for the Study and Prevention of Perinatal and Infant Death



Posters and Exhibits

Exhibits at conferences such as PrevCon, AMCHP, Safe States, Cribs for Kids, National Association of Medical Examiner's, and CityMatCH



Peer Reviewed Publications

Staff coauthored/led submissions to peer-reviewed journals such as *Pediatrics*, *American Journal of Preventive Medicine*, and *Journal of Behavioral Medicine*



Data Collaborations

Data collaborations with organizations such as AAP, Safe Kids, school associations, and federal workgroups



DISSEMINATION



Steering Committee Overview

Goals, Previous Success, and Future Plans

Charge of the Steering Committee

<https://ncfrp.org/about-us/steering-committee/>



- Provides expertise in areas of fetal, infant, child and family health, safety and protection
- Maximizing national partnerships that help improve the health and safety of communities
- Creates opportunities to connect member organizations to fatality review programs to help build the capacity
- Expands the capacity of the National Center
- Provides guidance for improving Center resources, products and services
- Advocates for improvements in the capacity of fatality review findings to drive prevention
- Provides guidance for strategies to sustain fatality review at local, state and national levels

Recap of past successes

Focus areas 2018 - 2022

- **Suicide Prevention Action Team**
 - Review of existing CRS Data
 - Revise Suicide CRS section
 - Enhanced Life Stressors section
- **Family Health Equity Action Team**
 - Revised Parental Interview guidance
 - 2020 FIMR Program Manual
 - Design Team for FIMR Storytelling collaborative



Steering Committee direction 2022 - 2027

Leveraging Partnerships to Increase Success



INCORPORATING FAMILY VOICE

- Expand family interviews
- Engage family serving organizations
- Build CDR and FIMR capacity and comfort



TRANSLATING DATA TO ACTION

- Through assessment, gain a better understanding of barriers teams face
- Create tools
- Leverage partnerships



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