Welcome to the North Carolina Child Fatality Prevention System Summit!

We're so glad you're here!

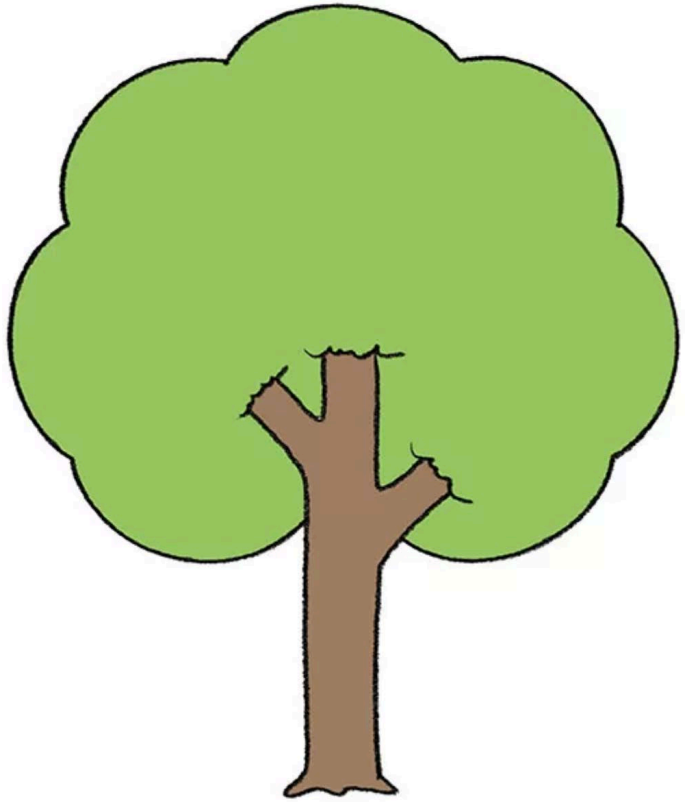
NCDHHS

UNC SCHOOL OF SOCIAL WORK Jordan Institute for Families

“Those we have held in our arms for a little while we hold in our hearts forever”

My Why

Sarah Verbiest, DrPH, MSW, MPH, Director Jordan Institute for Families



Housekeeping!

Welcome from the Jordan Institute for Families and the UNC School of Social Work

Dean Ramona Denby-Brinson, PhD, ACSW, LMSW, Dean of the UNC School of Social Work

Our NC Child Fatality Prevention System – Why We Matter, Where We Are, Where We Want to Go

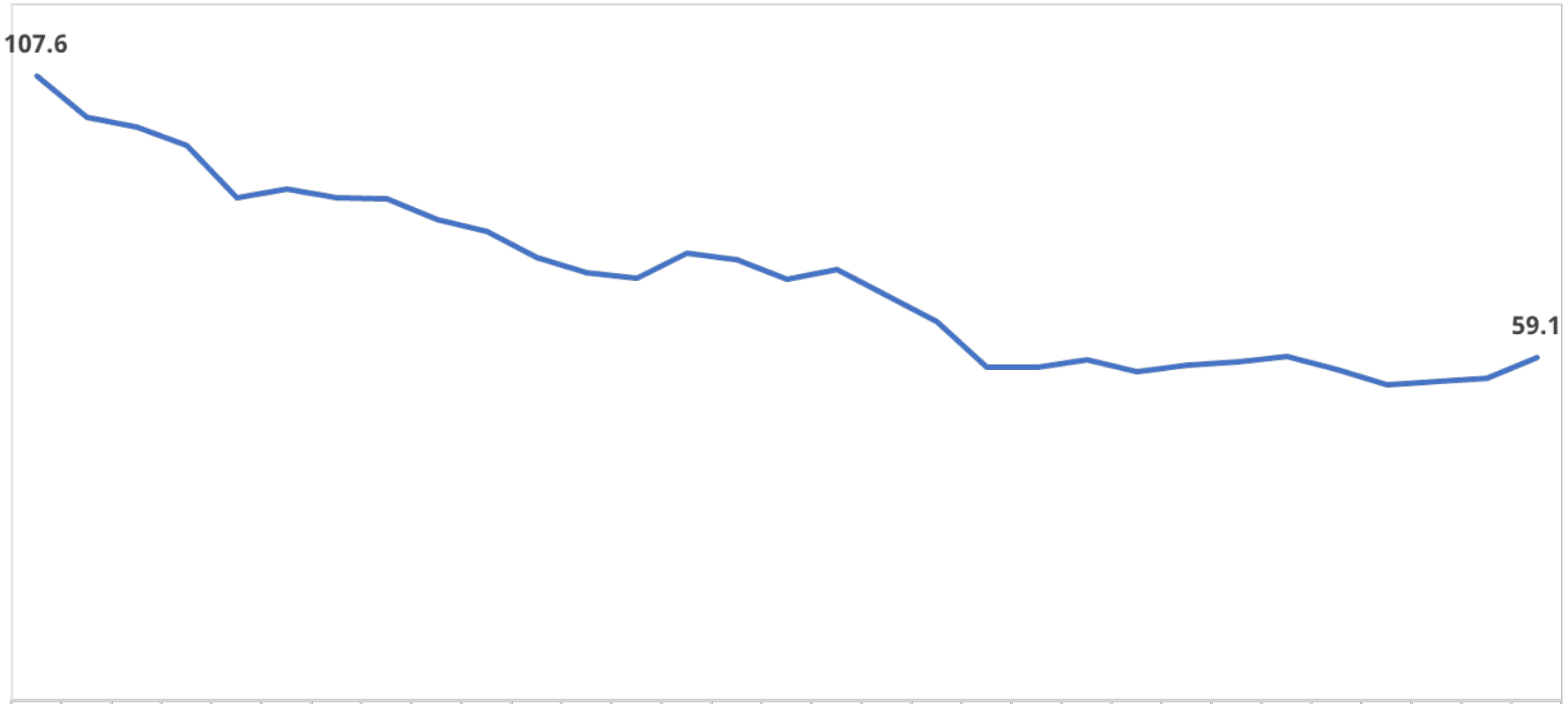
Kella Hatcher, JD
Executive Director
NC Child Fatality Task Force

Karen McLeod, MSW
Co-Chair
NC Child Fatality Task Force

Child Deaths in NC: Rates are going in the wrong direction, making the work of the Child Fatality Prevention System more important than ever!

- The 2021 child death rate was the second highest rate in 12 years and highest rate since 2016
- A total of 1360 NC children & infants died in 2021
- 820 NC infants never saw a first birthday

Child Deaths per 100,000 Children Ages 0 to 17, North Carolina Residents 1991-2021



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Rate	107.6	100.6	98.8	95.6	86.7	88.2	86.7	86.4	83.0	80.8	76.3	73.8	72.9	77.1	76.0	72.6	74.3	69.8	65.4	57.5	57.5	58.7	56.7	57.9	58.4	59.3	57.1	54.5	55.0	55.5	59.1

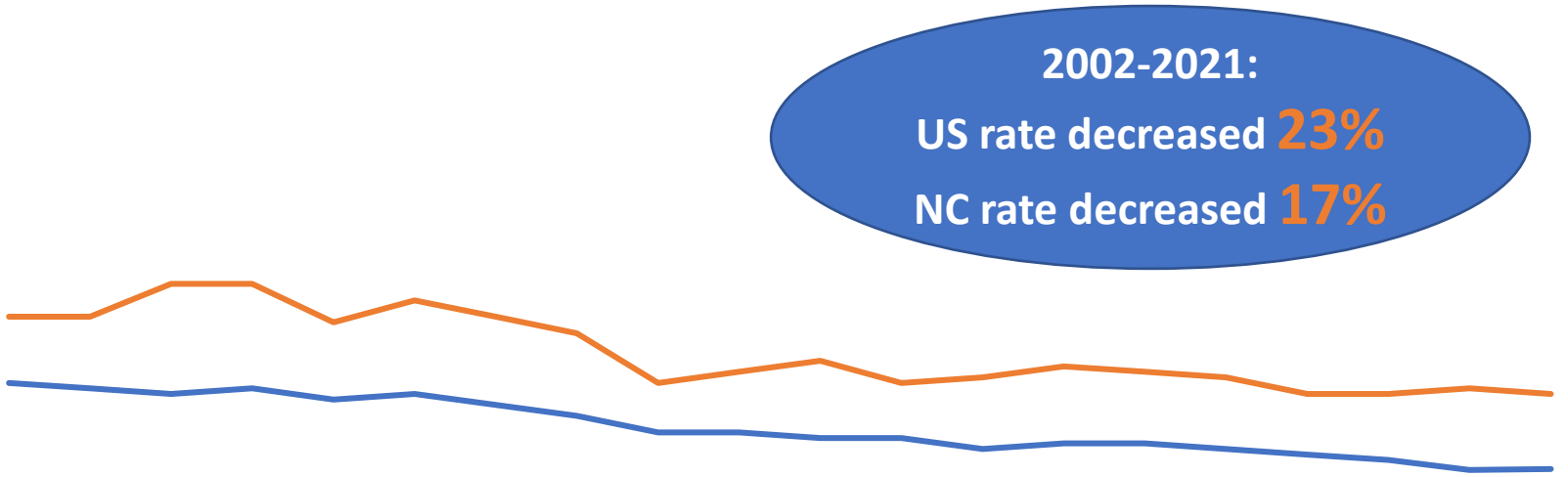
Source: NC State Center for Health Statistics

North Carolina infant mortality rates are consistently higher than US rates and have declined at a slower pace

NC is among ten states with the highest infant mortality rates in the U.S.

Areas of NC with higher rates also have higher social determinant risk factors (e.g., poverty, unemployment)

Infant deaths per 1,000 live births: US & NC 2002-2021

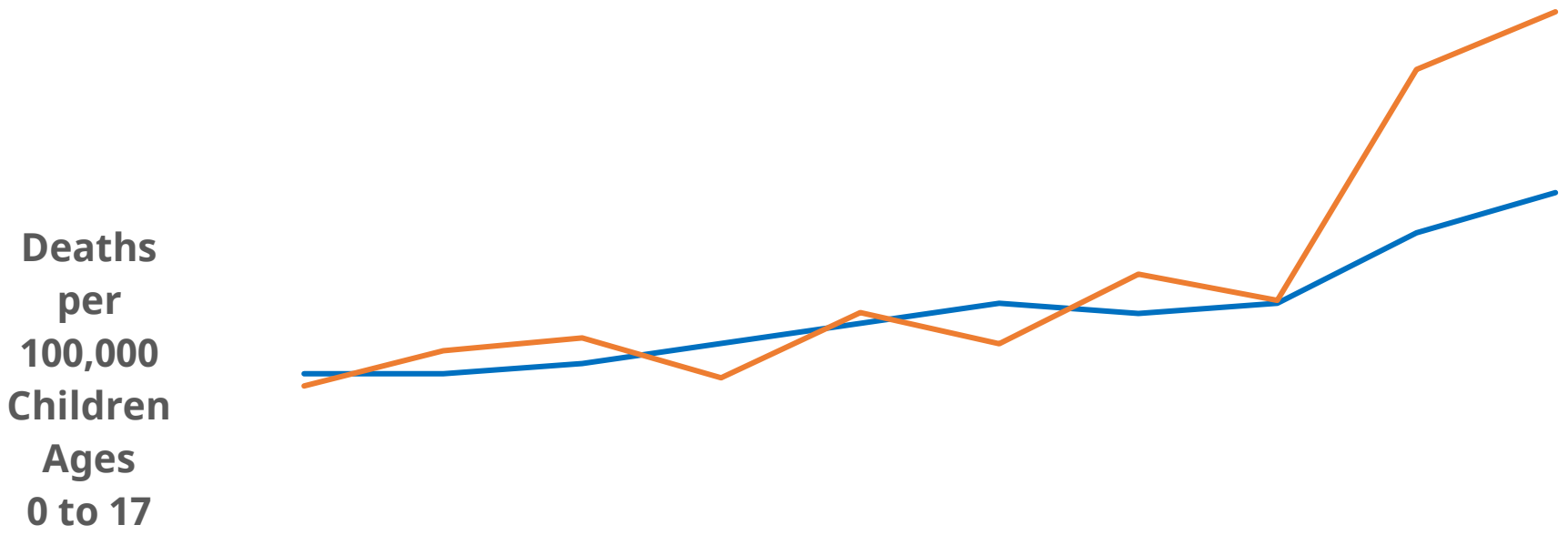


	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
U.S.	7.0	6.9	6.8	6.9	6.7	6.8	6.6	6.4	6.1	6.1	6.0	6.0	5.8	5.9	5.9	5.8	5.7	5.6	5.4	5.4
N.C.	8.2	8.2	8.8	8.8	8.1	8.5	8.2	7.9	7.0	7.2	7.4	7.0	7.1	7.3	7.2	7.1	6.8	6.8	6.9	6.8

Source: NC State Center for Health Statistics & CDC/National Center for Health Statistics

Firearm-related child death rates in NC have increased substantially in North Carolina in the last two years; and have increased 231.3% since 2012

Firearm-related Mortality Rates*, Children Ages 0 to 17: NC & US, 2012-2021



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
US	1.7	1.7	1.8	2.0	2.2	2.4	2.3	2.4	3.1	3.5
NC	1.6	1.9	2.1	1.7	2.3	2.0	2.7	2.4	4.7	5.3

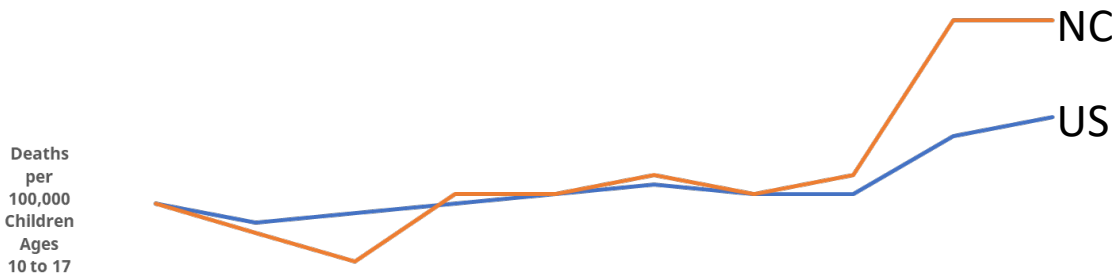
** Firearm deaths include the following ICD mortality codes : W32-W34 (Unintentional), X72-X74 (Suicide), X93-X95 (Homicide), U014 (Terrorism), & Y22-Y24 (Undetermined Intent)*

Source: NC State Center for Health Statistics & National Center for Health Statistics

In 2021,firearms were the lethal means used in 58% of youth suicides and 78% of youth homicides.

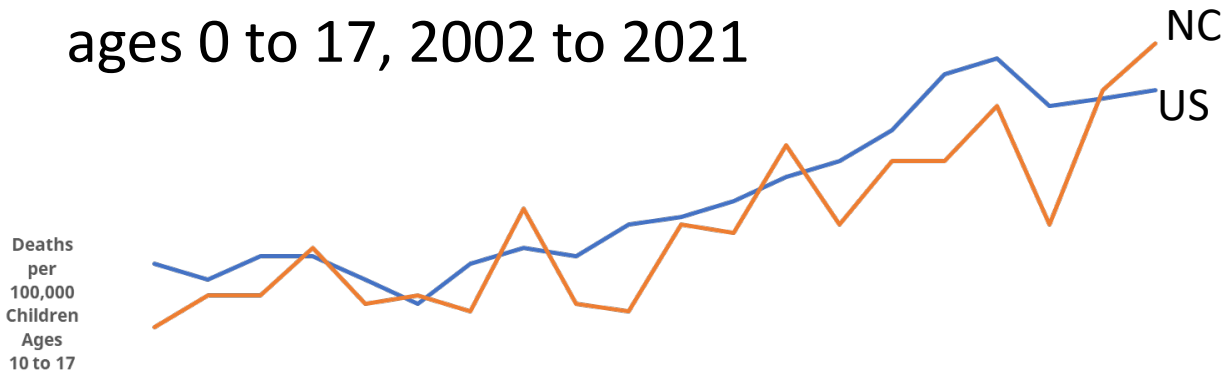
Ages 15 to 17 have experienced the largest increase in firearm deaths; this age group has also experienced the largest increase in mortality rates overall.

Homicide rates for NC & U.S. children ages 0 to 17, 2012 to 2021



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
US	2.1	1.9	2.0	2.1	2.2	2.3	2.2	2.2	2.8	3.0
NC	2.1	1.8	1.5	2.2	2.2	2.4	2.2	2.4	4.0	4.0

Suicide rates for NC & U.S. children ages 0 to 17, 2002 to 2021



	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
US	2.9	2.7	3.0	3.0	2.7	2.4	2.9	3.1	3.0	3.4	3.5	3.7	4.0	4.2	4.6	5.3	5.5	4.9	5.0	5.1
NC	2.1	2.5	2.5	3.1	2.4	2.5	2.3	3.6	2.4	2.3	3.4	3.3	4.4	3.4	4.2	4.2	4.9	3.4	5.1	5.7

** Suicides include the following ICD mortality codes : X60-X84 (Intentional self-harm; Y87.0 (Sequelae of intentional self-harm), U03 (Suicide Terrorism)*

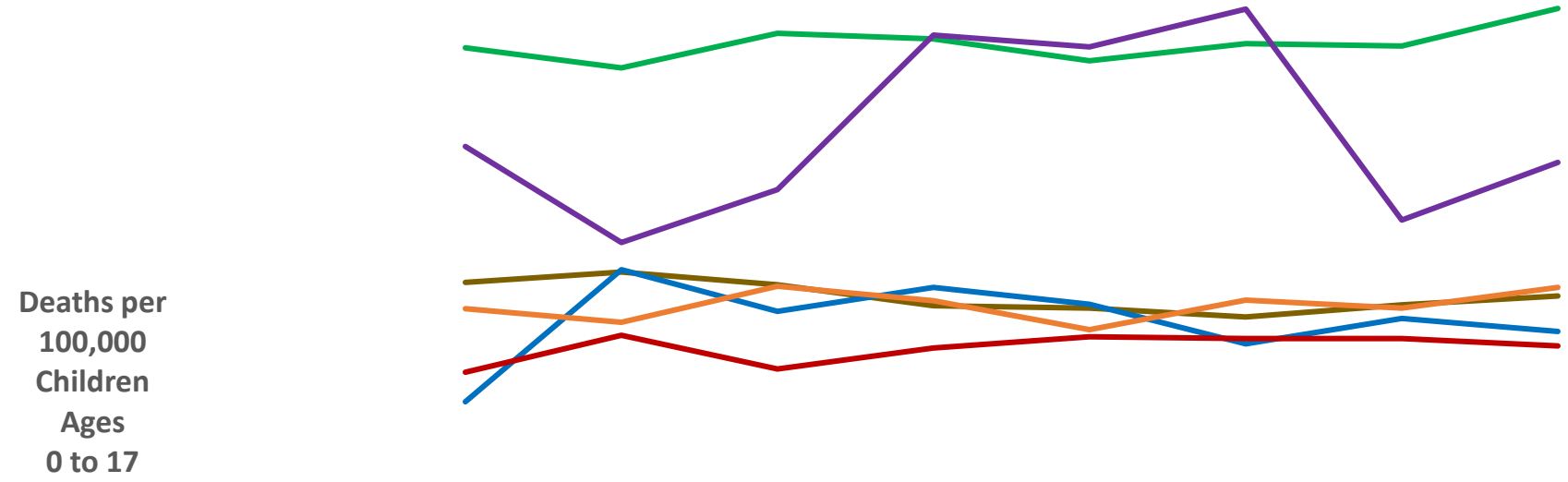
Source: NC State Center for Health Statistics & National Center for Health Statistics

Source: NC State Center for Health Statistics & National Center for Health Statistics

Non-Hispanic Black & American Indian children consistently have higher mortality rates compared to other groups

Disparities Continue to be a Major Concern: the rate of deaths for Black children is more than twice the rate for White children

Child Death Rates by Race/Ethnicity: NC 2014-2021



	2014	2015	2016	2017	2018	2019	2020	2021
NH White	48.0	50.2	47.5	43.0	42.5	40.6	43.2	45.1
NH Black	98.1	93.8	101.2	100.0	95.3	99.0	98.5	106.5
NH Am. Ind.	77.0	56.5	67.8	100.8	98.3	106.4	61.3	73.6
NH Asian/P.I.	22.5	50.7	41.8	46.9	43.3	34.9	40.3	37.5
NH Multiracial	28.8	36.7	29.5	34.0	36.4	36.0	36.0	34.4
Hispanic	42.4	39.5	47.2	44.1	37.9	44.2	42.5	46.9

Note: NH=Non-Hispanic. P.I.=Pacific Islander. Am.Ind. includes American Indian & Alaskan Native.
Caution: Racial categories have changed from prior years and now reflect single race categories & multi-race. Comparisons with prior reports are not advised.

Source: NC State Center for Health Statistics

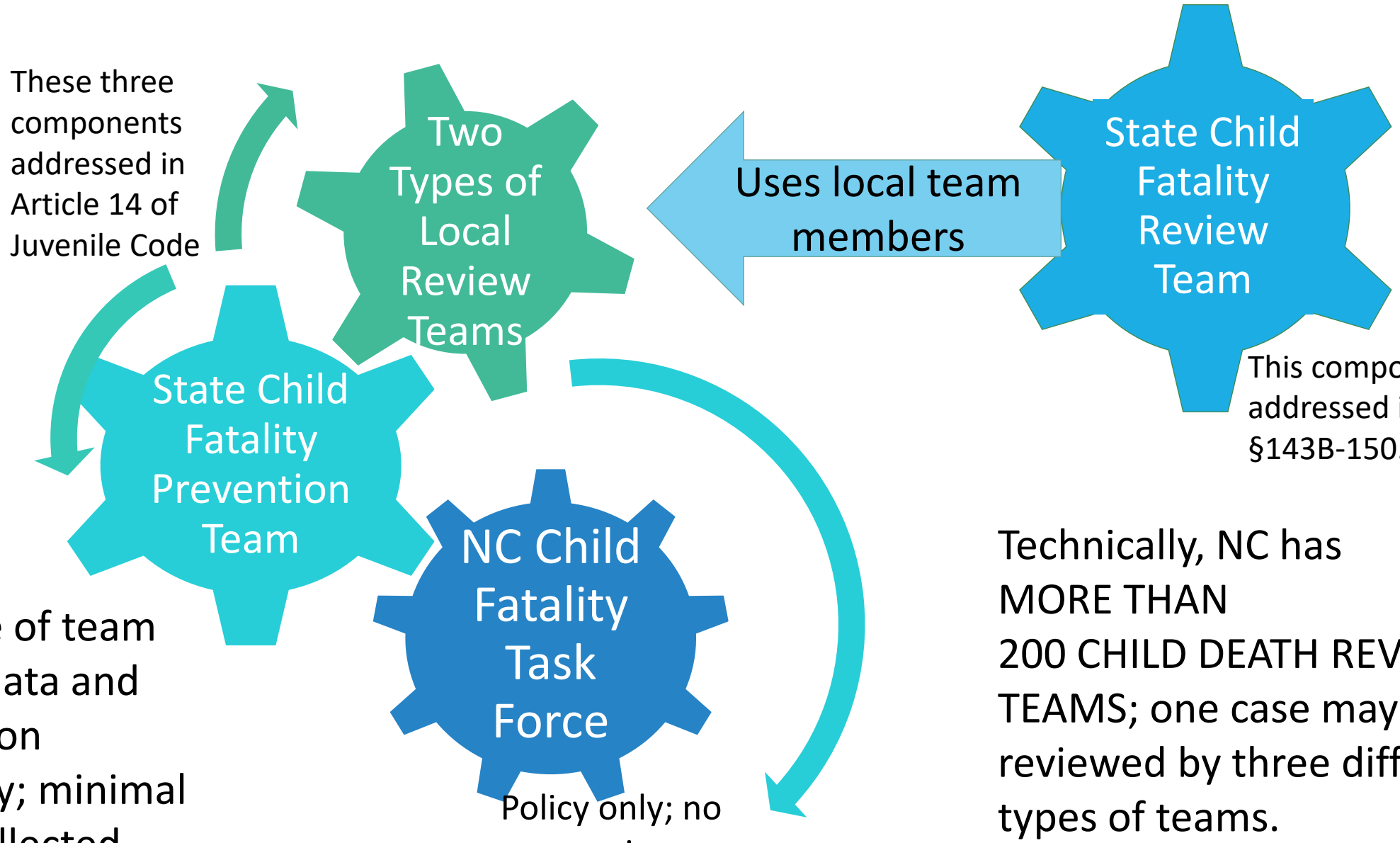
Child Death Review is Critical for Prevention!

- CDR in the U.S. started around the 1980's
- North Carolina's Child Fatality Prevention System was created in 1991
- By 2001, all states had some type of CDR program
- CDR programs vary widely among states
- The National Center for Fatality Review and Prevention supports review teams across the nation; 3 of its experts are here today!

Charge of State Child Fatality Prevention System [via Article 14 of NC Juvenile Code]

- **Develop a communitywide approach** to child abuse and neglect;
- **Study and understand causes** of childhood death;
- **Identify gaps in service delivery** in systems designed to prevent abuse, neglect, and death; and
- **Make and implement recommendations for laws, rules, and policies that will support the safe and healthy development of our children and prevent future child abuse, neglect, and death.**

NC's Child Fatality Prevention System: large, complex, unique



Each type of team handles data and information differently; minimal data is collected.

Technically, NC has MORE THAN 200 CHILD DEATH REVIEW TEAMS; one case may be reviewed by three different types of teams.

This Summit continues efforts to strengthen & support our CFP system that have been ongoing **for over five years**

- Initial 2017 discussions led to two-day **Child Fatality Prevention System Summit** April 2018: gathering of over 200 people & local team input
- Post-Summit work involved **research on other states' CFP systems, consultation with national experts, stakeholder discussions**
- **Each year since 2019, the CFTF has made a set of recommendations to strengthen the CFP system**
- The recommendations were **adopted in the Child Welfare Reform Plan Final Report from the Center for the Support of Families** and submitted to legislature in 2019
- In 2019 & 2020, **DHHS undertook further study, planning, and stakeholder engagement related to implementing these recommendations** (e.g., interviews with other states, partnering with NCIOM to convene a stakeholder group, additional research and consultation with national experts).
- CFTF recommendations were addressed in bills in 2019 and 2021 that did not become law (CFTF knows of no opposition)

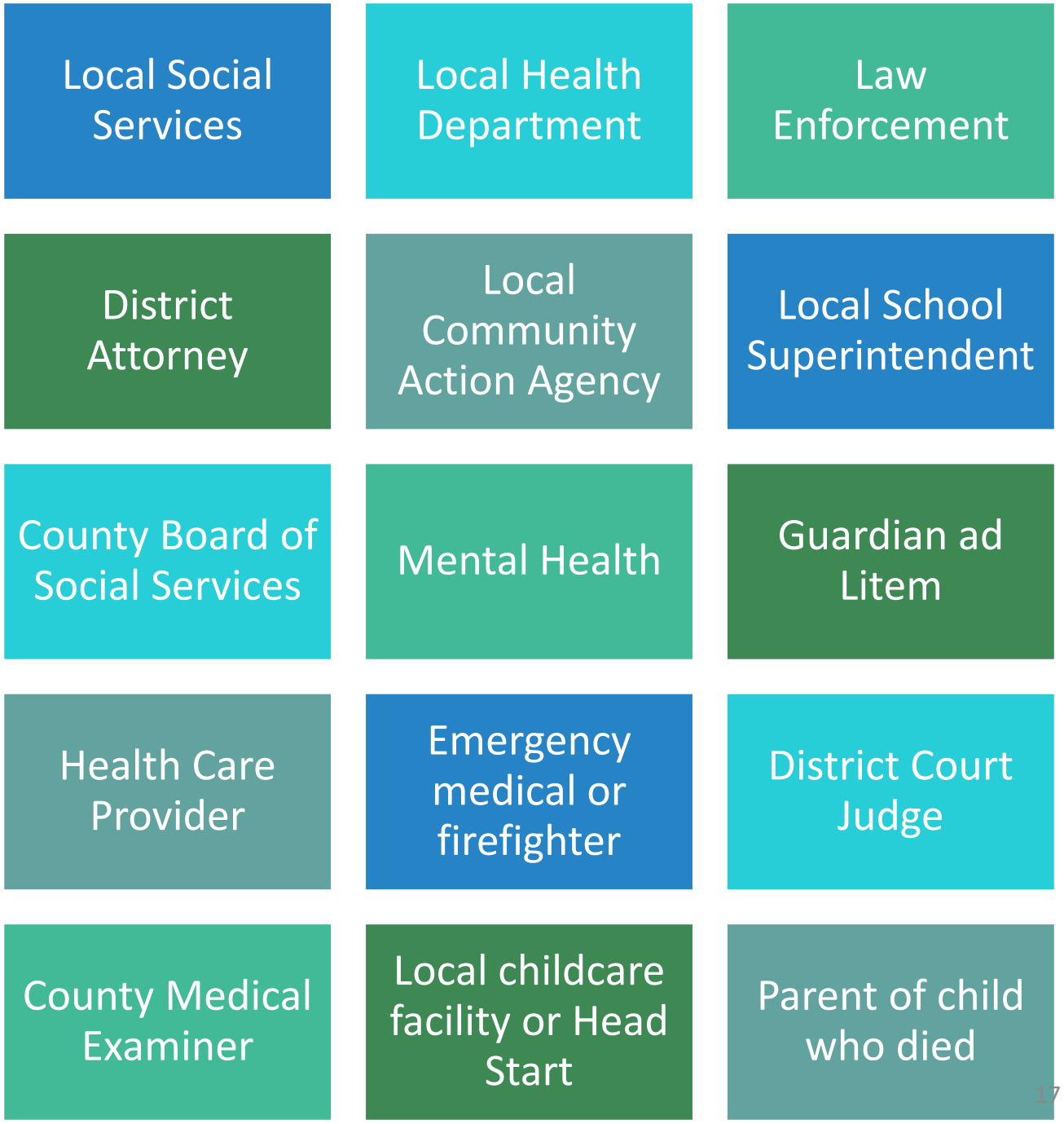
NC's CFP System Strengths

- Having multidisciplinary local review teams covering all 100 NC counties
- Ability of community leaders on local teams to collaborate and implement prevention initiatives
- Having a state medical examiner system with dedicated child fatality staff at OCME
- Child Fatality Task Force: experts in child health and safety, state agency leaders, 10 legislators; three committees with additional expertise; history of success in advancing policy

Local Teams are the BACKBONE of this system!!

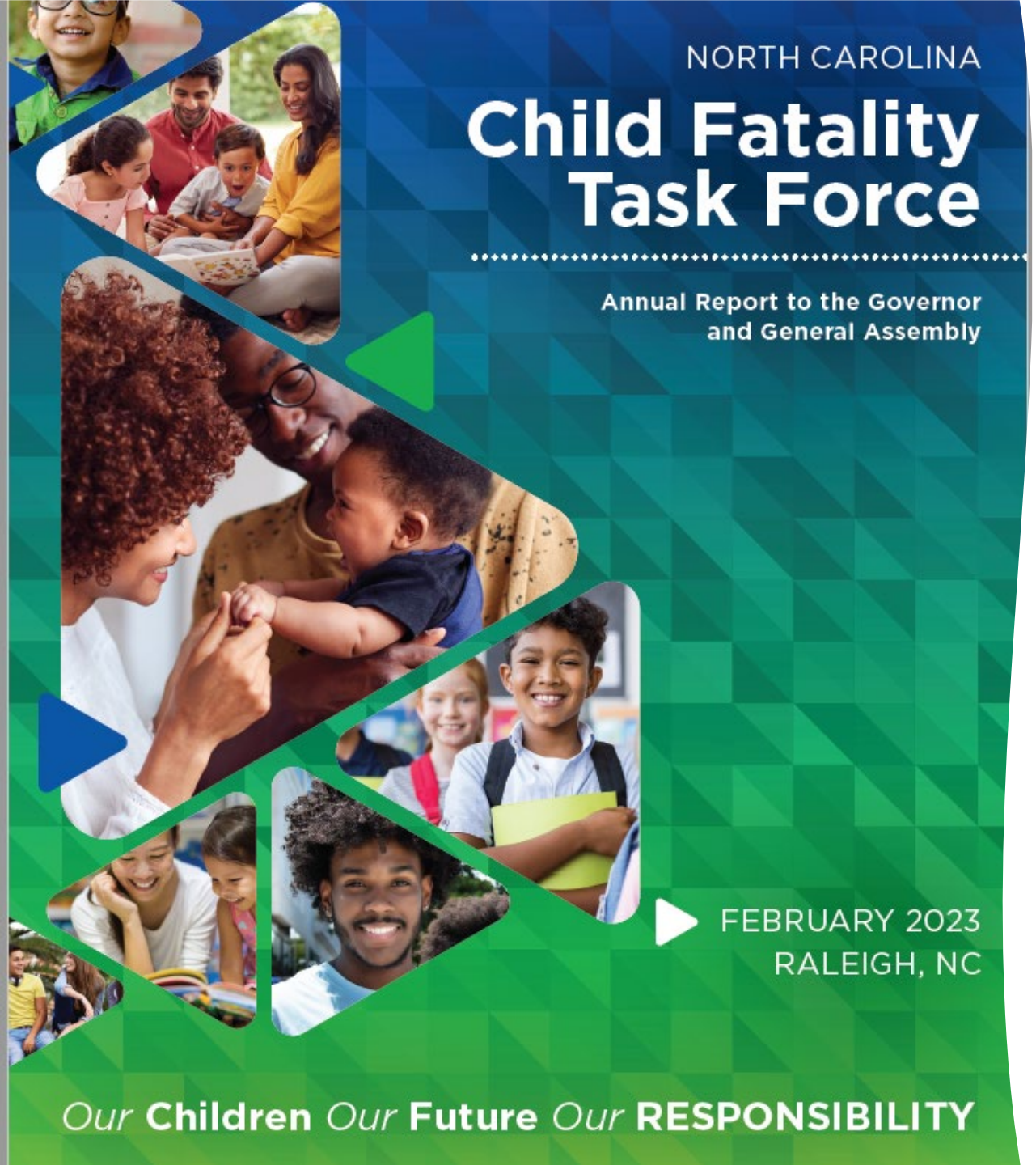
THE PREVENTION CAPABILITY & POTENTIAL IS HUGE when community leaders and experts come together on a local team to understand the circumstances surrounding a death and take steps to prevent it from happening again.

There are countless examples of the ways in which local teams have made a difference!



Medical Examiner Attention to Child Fatality

- Chief Medical Examiner dedicated to child fatality work
- Expertise and training in child death scene investigation
- Staff to review all child deaths under ME jurisdiction
- Data analysis and reporting on child deaths



36 members: experts in child health and safety, state agency leaders, ten state legislators

Since 1991, the CFTF has advanced numerous laws and state funding to prevent child deaths and support child well-being. A summary can be found here on the CFTF website: https://webservices.ncleg.gov/ViewDocSiteFile/74396

Educational efforts about data, evidence, and recommendations via public meetings (over 50 presentations a year), annual report, fact sheets, email blasts, in-person meetings, presentations to groups, press releases, press interviews, guest blogs, journal article, etc.

CFTF 2023 Annual Report with 11 legislative recommendations directed to governor and General Assembly: https://webservices.ncleg.gov/ViewDocSiteFile/75628

So much good work . . . and we can do better by addressing our challenges!

North Carolina Child Fatality Review System Challenges Compared to Some Other States

NC may have the most complex system in the U.S.

Very large number and types of local and state-level groups (2 local in each county; 3 state-level; 200+ review teams!)

Very large number and types of cases (all) required for review with minimal resources

Does not use National Fatality Review Case Reporting System as 48 other states have

Weak connection between local teams/data and state-level groups

Does not have centralized, state-level staff to coordinate and support system

Uses 100 CCPTs as Citizen Review Panels

Common themes repeated from stakeholders, including local teams, that made it clear that we need to make changes that will . . .

Capitalize on strengths	Capitalize on current system strengths
Restructure	Restructure the system to address inefficiencies, disconnects, and duplication of efforts
Provide more support	Provide effective training, tools, support, and collaboration opportunities for local review teams
Improve data	Improve data to ensure that information learned from team reviews is appropriately gathered, analyzed, and reported in meaningful ways to inform local and state-level prevention efforts
Create stronger connections & follow-through	Create stronger connections between local and state-level CFP work; ensure accountability and follow-through so that review efforts lead to meaningful change to save lives and promote wellbeing

Currently, state-level support for CFP System is in **FIVE *different* places in DHHS,** and there is overlapping work among all of these groups. GOAL: create a *team* of sufficient (more) state-level support that is not disjointed.

	Local Community Child Protection Teams (CCPT) in every county	Local Child Fatality Prevention Teams (CFPT) in every county	State Child Fatality Prevention Team (State CFPT or "State Team")	State Child Fatality Review Team (State CFRT or "DSS Intensive Review")	NC Child Fatality Task Force
DHHS Division and/or local agency providing support	NC Division of Social Services & Local DSS	NC Division of Family and Child Well Being & Local health departments	NC Division of Public Health (Office of the Chief Medical Examiner)	NC Division of Social Services (these reviews use members of local teams)	One staff member in DHHS Office of the Secretary

Optimizing reviews to elevate their ability to impact child health outcomes while providing sufficient support for teams

Currently:

- 1360 deaths in 2021, all requiring a team review
- 200 local teams (most blended but some functions are separate regardless)
- Two state-level teams, one using local team members
- One case may be reviewed by 3 teams

Challenge:

- Volume can compromise quality when resources are insufficient
- Duplication of efforts is inefficient
- No system for collecting, analyzing, or reporting information from all reviews

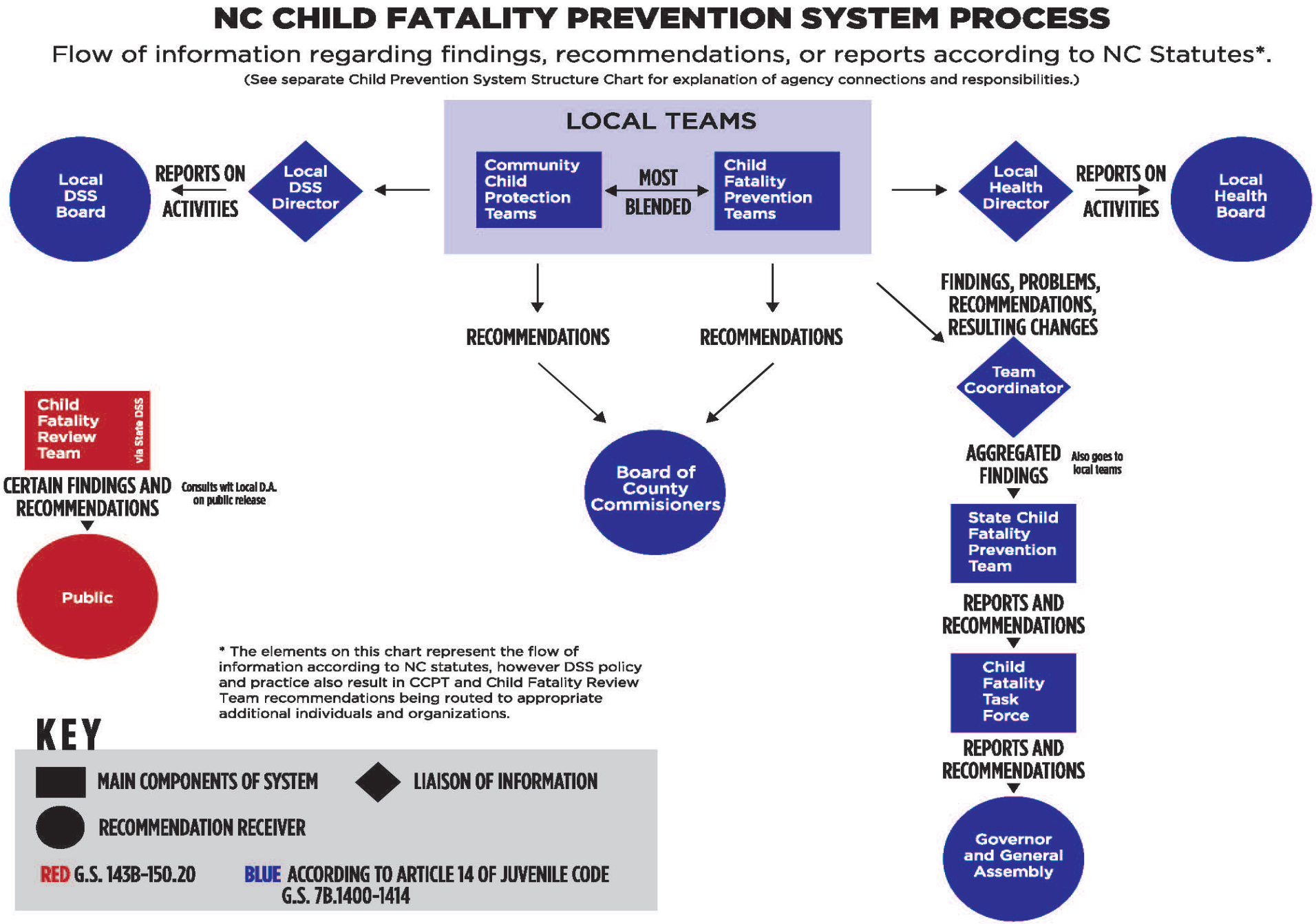
GOAL: Ensure quality reviews at the local level by:

- Focusing on reviews and reporting for categories most likely to yield prevention opportunities
- Consolidating functions of 4 types of teams into local review with more support from state-level staff (including similar support for intensive-type reviews) and more resources for local teams

Currently: insufficient & disjointed data collection, analysis, and reporting.

GOAL: ensure that information learned from reviews is collected, analyzed, and **reaches those who can and should react!**

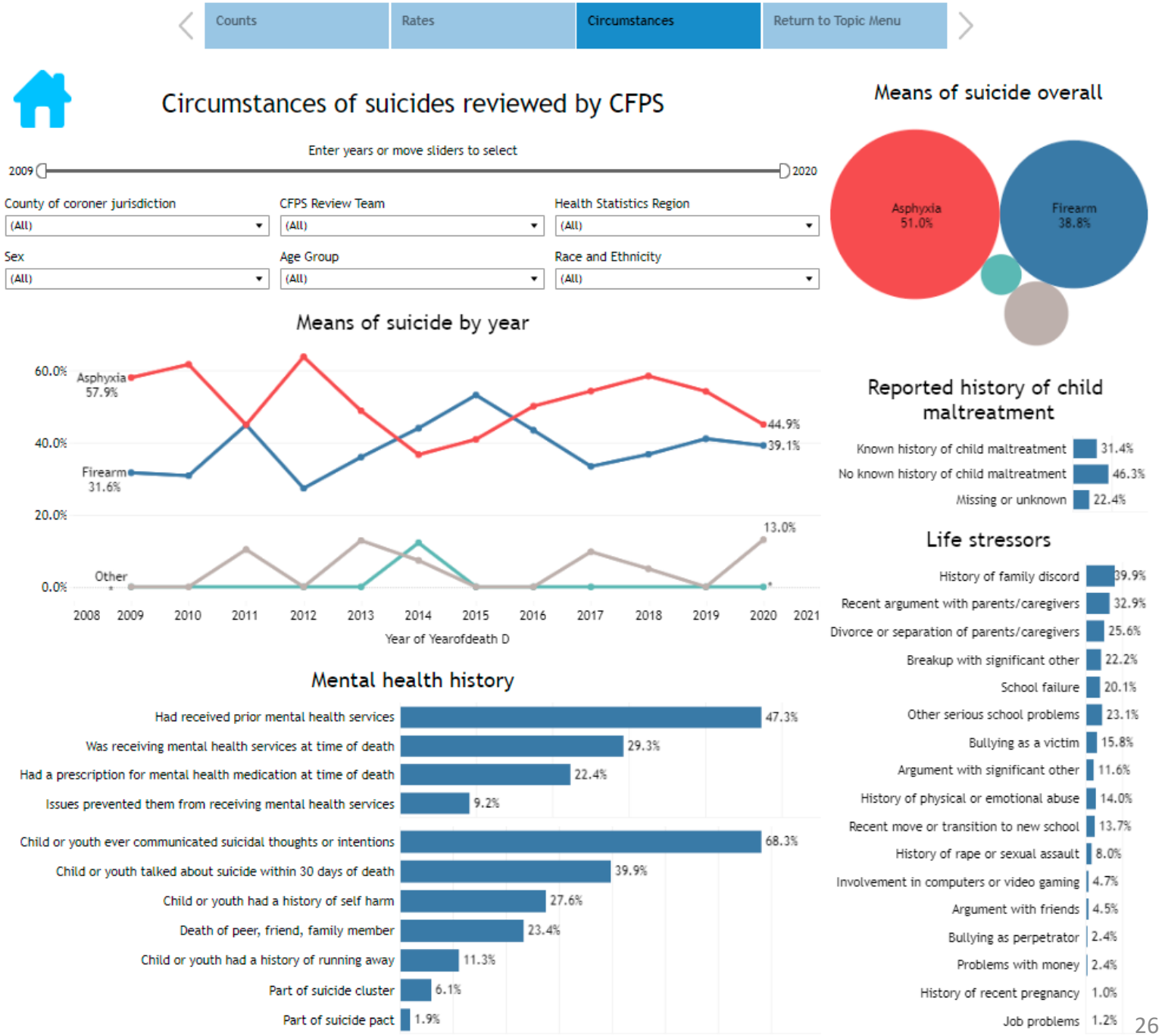
Use national data system that's been used in 48 other states but not NC



Here's what's possible in NC with DATA!

This screenshot of *one tab* of a suicide dashboard from Colorado's Child Fatality Prevention System provides an example of the type of data report that could be produced in North Carolina through participation in the National Fatality Review Case Reporting System used by 48 states but not NC.

BUT – NC needs sufficient state-level staff/infrastructure and support for local teams to successfully use the system



Michigan SUID Report:

- Via CDC's SUID Case Registry which uses the National Fatality Review Case Reporting System
- 66 pages
- 56 data tables – a few examples here

As important as this work is, if your CFP work feels overwhelming at times, maybe that's because it's A LOT!

We get it!!

- Teams are composed of leaders **with already REALLY big and demanding jobs!**
- Teams have to (collectively) **review well over 1000 cases per year** (1360 in 2021!)
- There are **expectations/requirements for teams related to advocacy, recommendations, reports, prevention work**
- Teams have **limited resources** for their work

AND . . . team members sit in review meetings where you must process and discuss information surrounding children who have died, sometimes in especially horrific and disturbing ways, and then go back to work and life

Our hope for today and for the future

- **Continue to acknowledge and celebrate** the important role of the statewide child fatality prevention system in saving children's lives and supporting child well-being, and strive to improve it!
- **Provide effective support and training** for local teams to optimize their work
- **Provide opportunities** for those working in the CFP system to learn from one another
- **Strengthen data** collection, analysis, and reporting
- Acknowledge and **support those who may experience secondary trauma and/or burnout** with this work
- Ensure that the very difficult work of reviewing a child's death results in information learned that can inform policy and prevention efforts at the state and local level TO SAVE CHILDREN'S LIVES AND SUPPORT THEIR WELL-BEING!

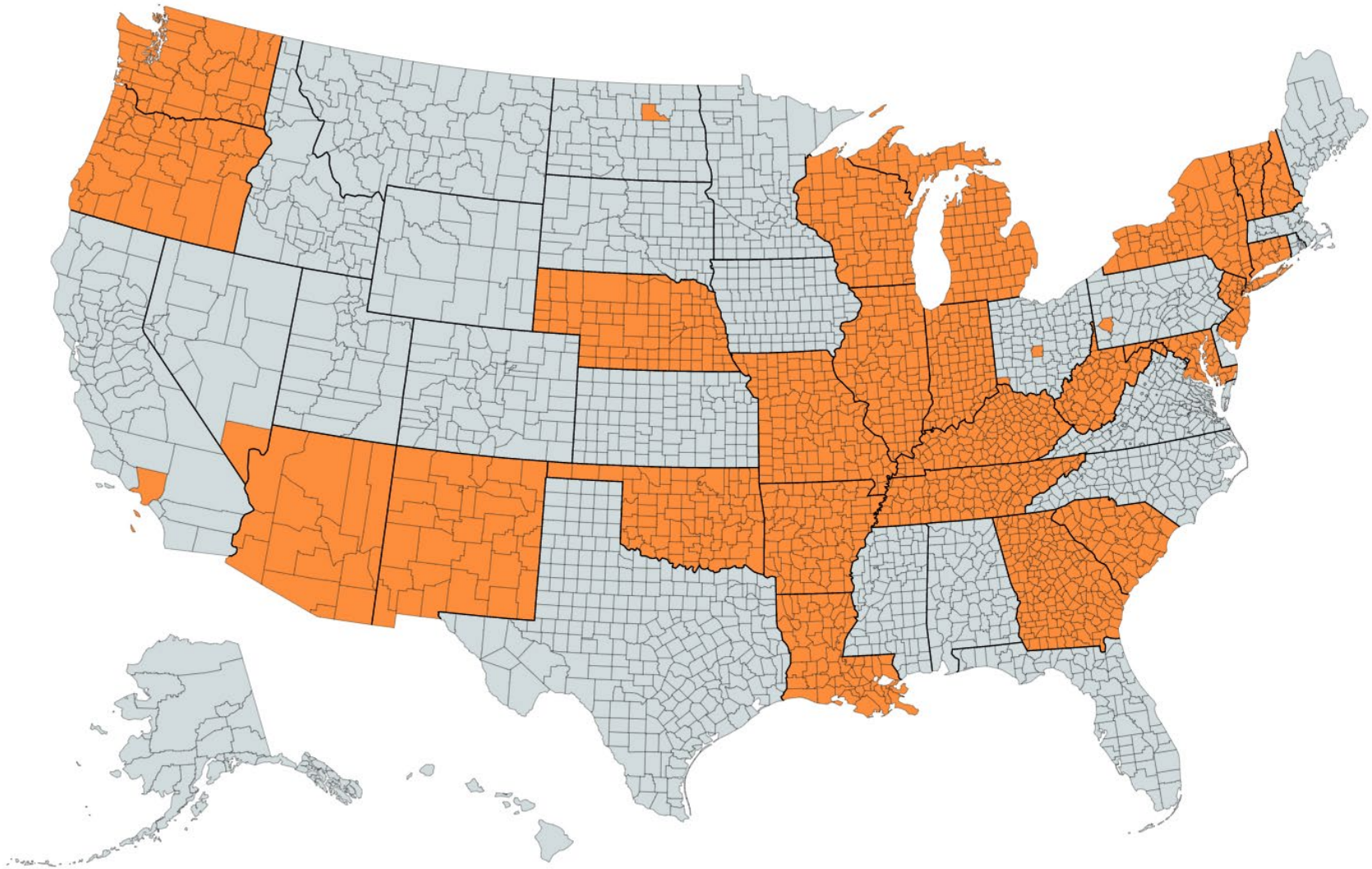
Your job is hard! Dealing with Secondary Trauma and Burnout

Michael Cull, PhD, MSN

Center for Innovation in Population Health

College of Public Health, University of Kentucky

NATIONAL PARTNERSHIP FOR CHILD SAFETY



casey family programs

NATIONAL CFRP
Center for Fatality Review & Prevention

Center for Innovation in Population Health

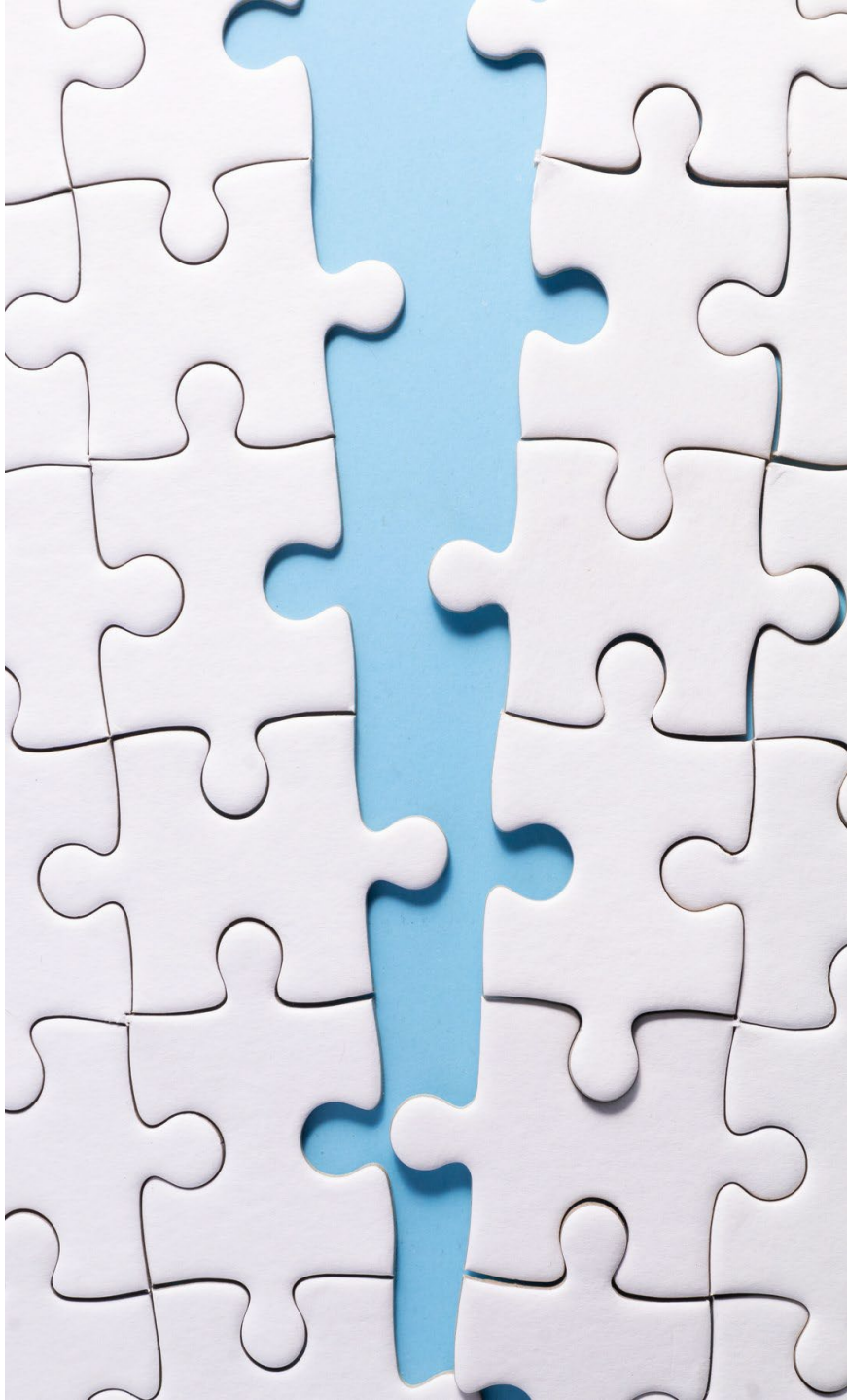
THREE INTERRELATED STRATEGIES

Tools for Teams

Systems-focused improvement

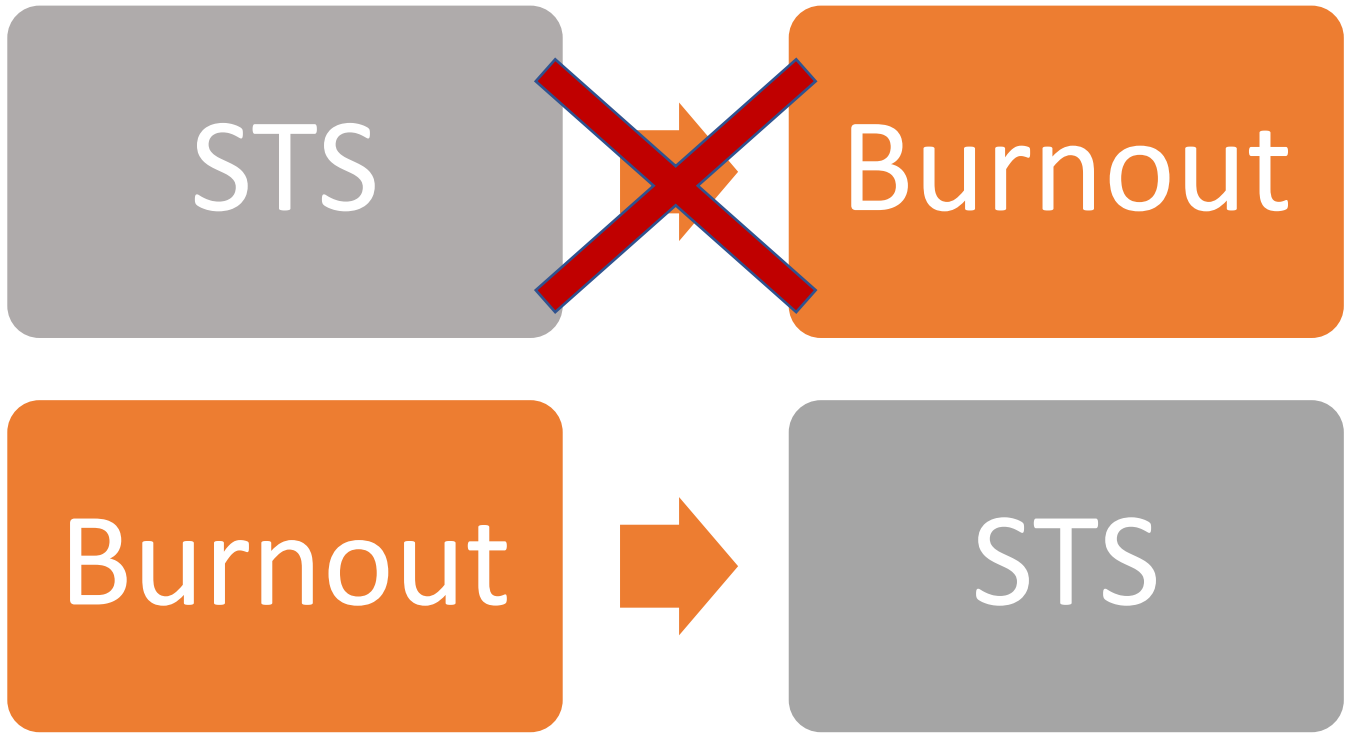
Organizational Assessment

Cull, Rzepnicki, O'Day, & Epstein (2013)

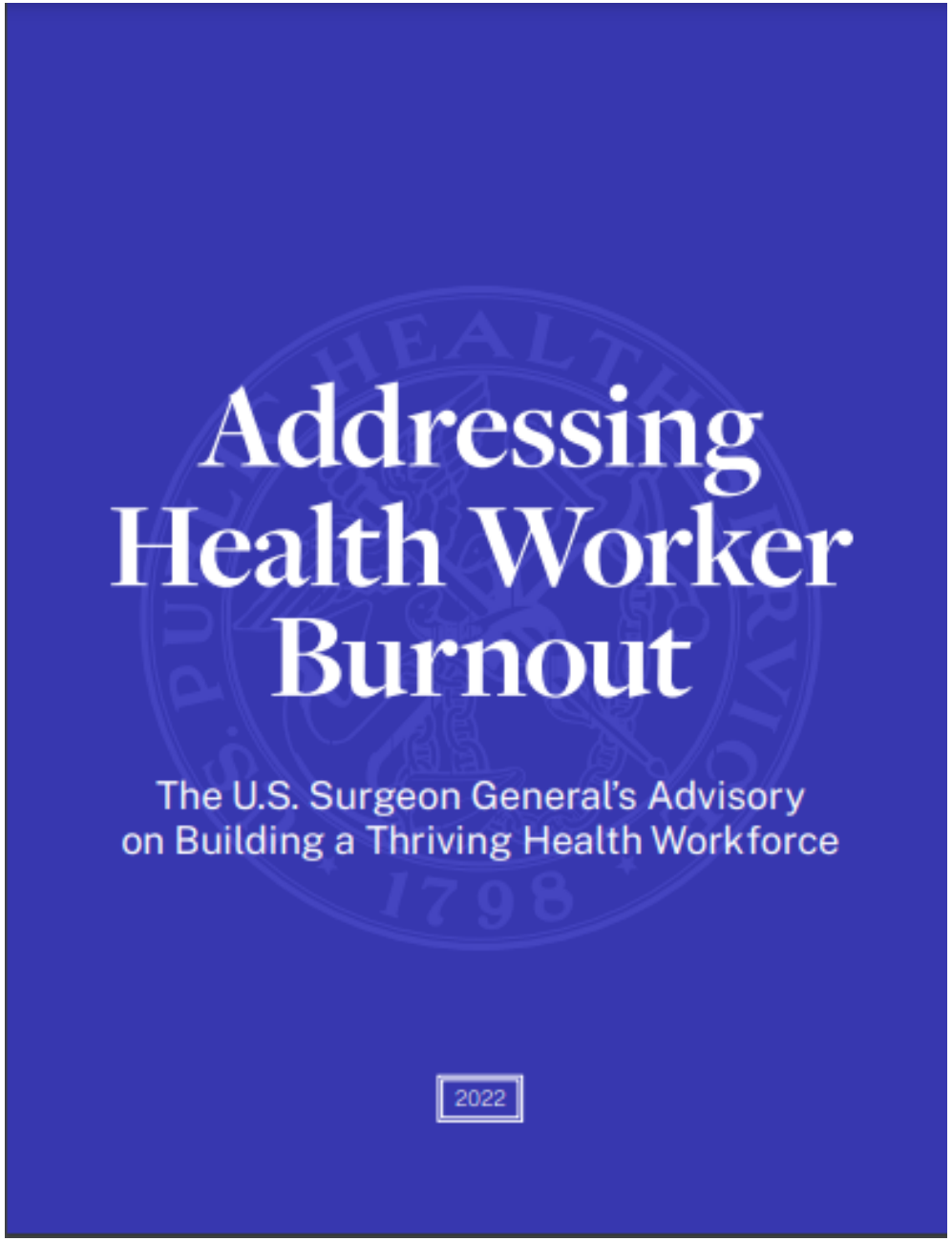


Secondary Trauma and Burnout

- Secondary Traumatic Stress/Vicarious Trauma (STS/VT): STS is a secondary trauma which results from indirect exposure to trauma. Defined by Dr. Charles Figley, Secondary Traumatic Stress Disorder is **"the natural consequent behaviors resulting from knowledge about a traumatizing event experienced by a significant other. It is the stress resulting from helping or wanting to help a traumatized or suffering person"** (Figley, 1995).
- Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is **characterized by feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy**. (WHO, 2019)



Shoji, et. al. (2015) What Comes First, Job Burnout or Secondary Traumatic Stress? Findings from Two Longitudinal Studies from the U.S. and Poland



"pre-COVID burnout statistics that showed up to **54%** of nurses and physicians" Dr. Vivek Murphy, Surgeon General

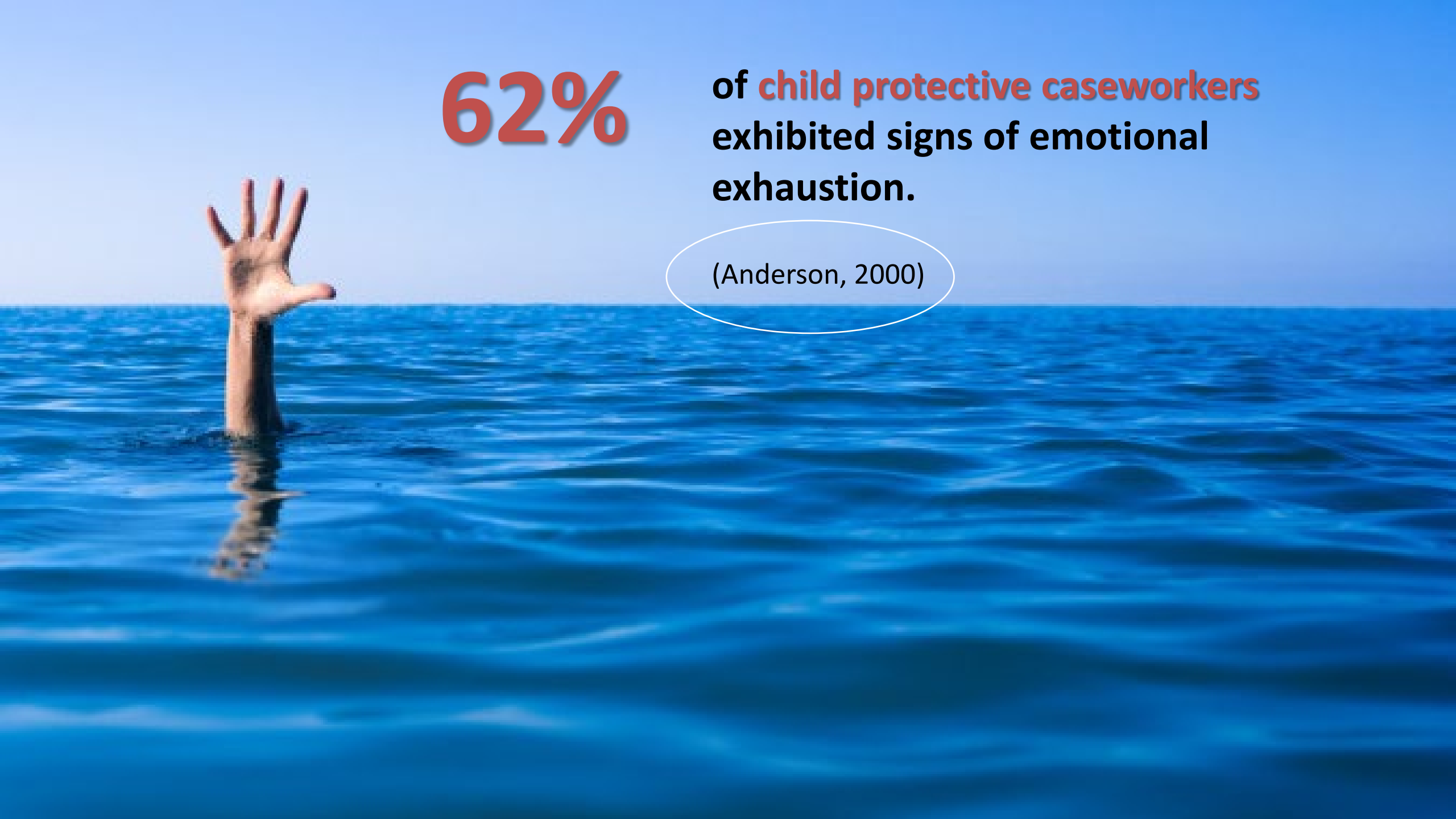
Over 50%

of child welfare professionals reported relatively high levels of **secondary traumatic stress.**

(Rienkes, 2020)

29.6% of child welfare professionals reported **severe levels of secondary traumatic stress**.

(Rienkes, 2020)



62% of child protective caseworkers exhibited signs of emotional exhaustion.

(Anderson, 2000)

Resilience as a property of the system…

Three Levels of Stress Response

Positive

Brief increases in heart rate.

Mild elevations in stress hormone levels

Tolerable

Serious, temporary stress responses,

Buffered by ***supportive relationships.***

Toxic

Prolonged activation of stress response systems

In the absence of ***protective relationships.***

Harvard Center of the Developing Child

Journal of Psychiatric Research 86 (2017) 18–25

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journal homepage: www.elsevier.com/locate/psychires

The impact of social support, unit cohesion, and trait resilience on PTSD in treatment-seeking military personnel with PTSD: The role of posttraumatic cognitions

Yinyin Zang [a, *], Thea Gallagher [a], Carmen P. McLean [a], Hallie S. Tannahill [a], Jeffrey S. Yarvis [b], Edna B. Foa [a], the STRONG STAR Consortium[1]

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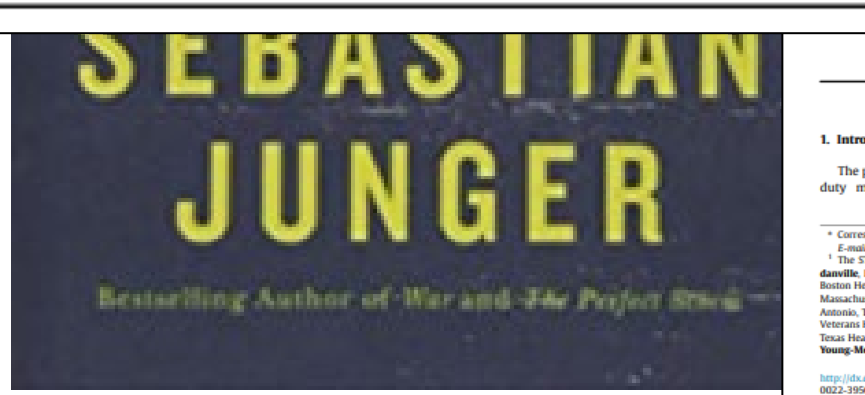

by reducing negative posttraumatic cognitions.

1. Introduction

The prevalence of posttraumatic stress disorder (PTSD) in active duty military personnel who have deployed in support of Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF), is estimated to be between 5% and 17% (Gates et al., 2012; Hoge et al., 2004; Milliken et al., 2007; Richardson et al., 2010). Prior research examining predictors of PTSD have identified several psychosocial

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http://dx.doi.org/10.1016/j.jpsychires.2016.11.005
0022-3956/

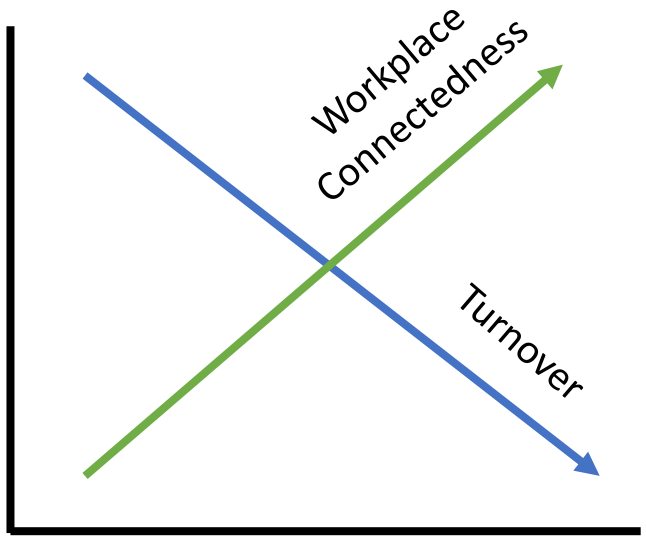
Some Early Data Tells Us…

PSYCHOLOGICAL SAFETY

The shared belief team members are accepted, respected, supported, and able disclose a concern or mistake

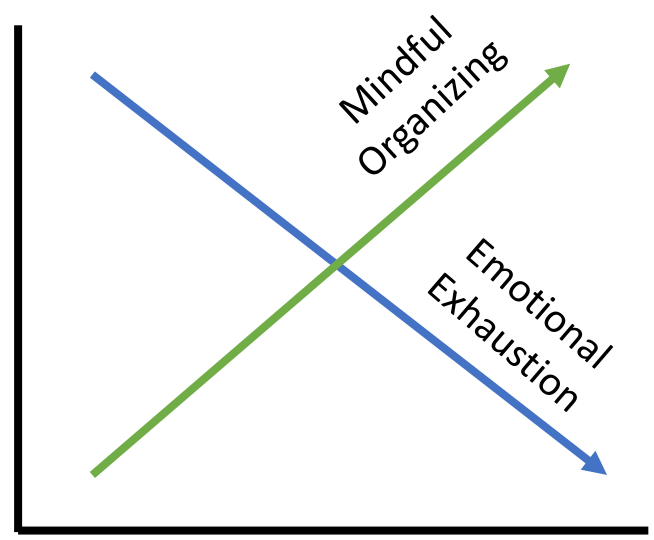
MINDFUL ORGANIZING

Measures teamwork and team resilience – how teams monitor, plan, innovate, learn, and support one another



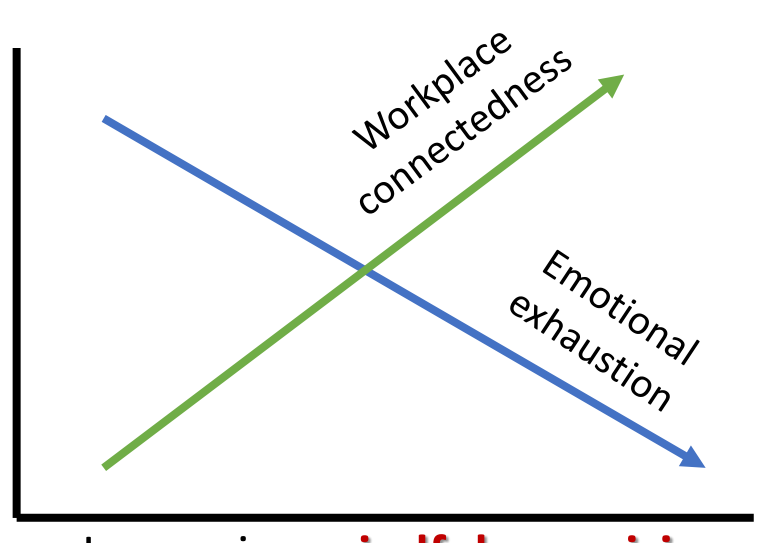
Increasing **psychological safety**

(Leake et al., 2017; NPCS data, 2021; Vogus et al., 2016)



Increasing **psychological safety**

(NPCS data, 2021; Vogus et al., 2016)



Increasing **mindful organizing**

(Epstein et al., 2020; NPCS data, 2021)

ORIGINAL RESEARCH

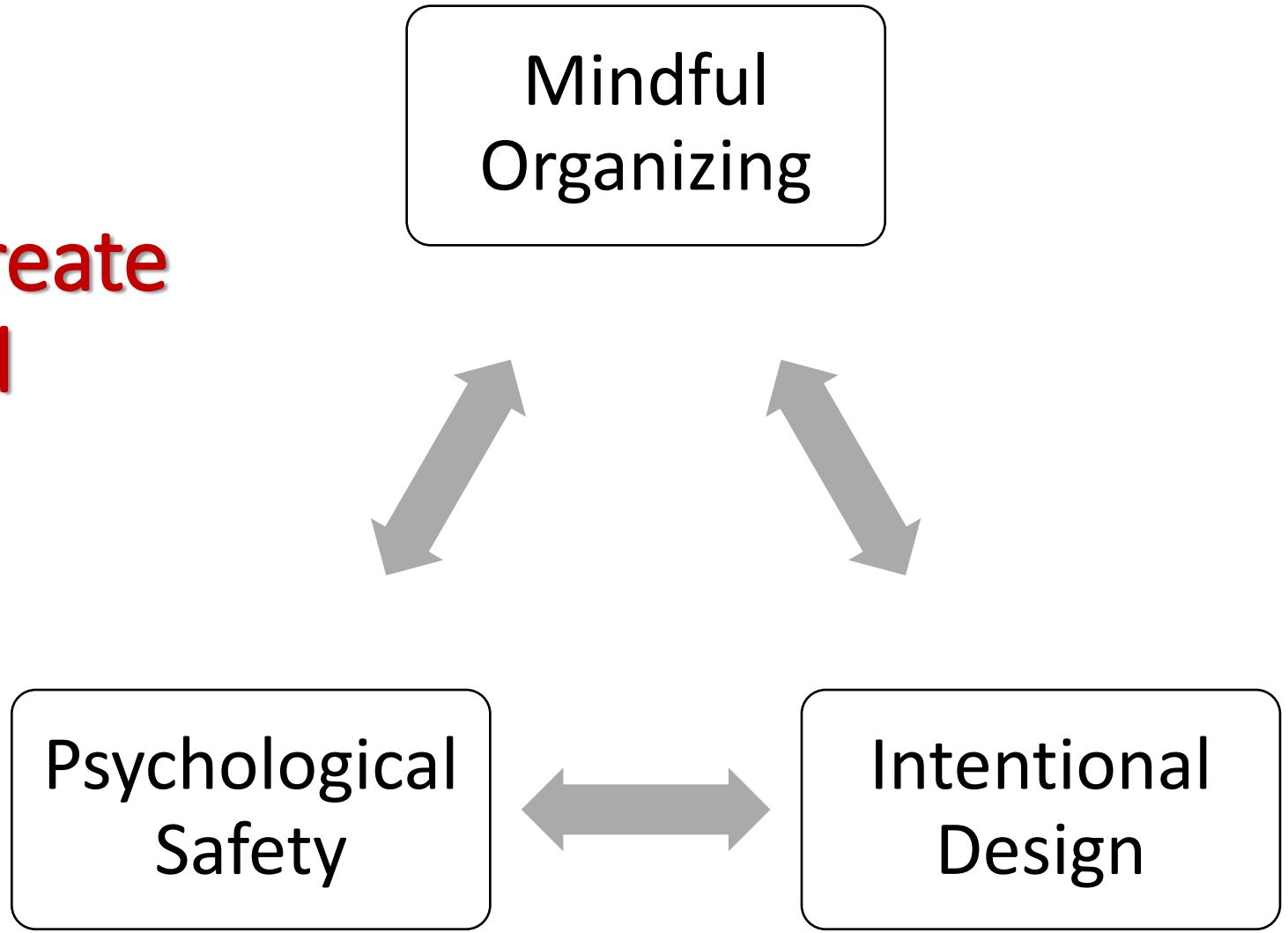
Variation in safety culture dimensions within and between US and Swiss Hospital Units:

Conclusions The authors found differences in SAQ dimensions at the country, hospital and unit level. The general emphasis placed on teamwork and safety climate in quality and safety efforts appear to be highlighting dimensions that vary more at the unit level than the hospital level. They suggest that patient safety improvement interventions target unit level changes, and they support the emphasis being placed on teamwork and safety climate, as these vary significantly at the unit level across countries.

Team Health is Contagious!

Being DISCONNECTED is a significant health risk

How might we create teams-based strategies?



Psychological Safety

What it is:

- A **shared belief** that comes from **shared experiences.**
- A state of feeling accepted, supported, respected, and free to take **interpersonal risks**.
- A place where **mistakes** are treated as **opportunities to learn** – not a time to blame and punish.

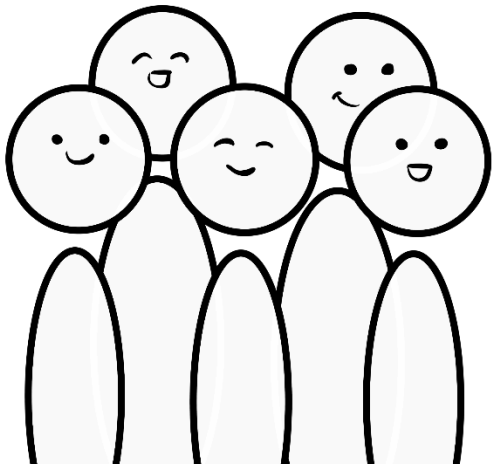
What it is NOT:

- Free from **accountability.**
- A place where people always feel **comfortable.**

Mindful Organizing

A social process and collective capability to detect and respond to unexpected events - it depends on understanding context and capabilities. Teamwork and team resilience – how teams monitor, plan, innovate, learn, and support one another

Team-based Strategies for Building Habit



Plan Forward

- Huddles and Briefings

Reflect Back

- Triggered debriefings

Communicate Effectively

- Structured tools, SBAR, Conscious narratives

Test Change

- Driver Diagrams and PDSA cycles

Promote Professionalism

- Struggling well together, Self-care

Center for Innovation in Population Health

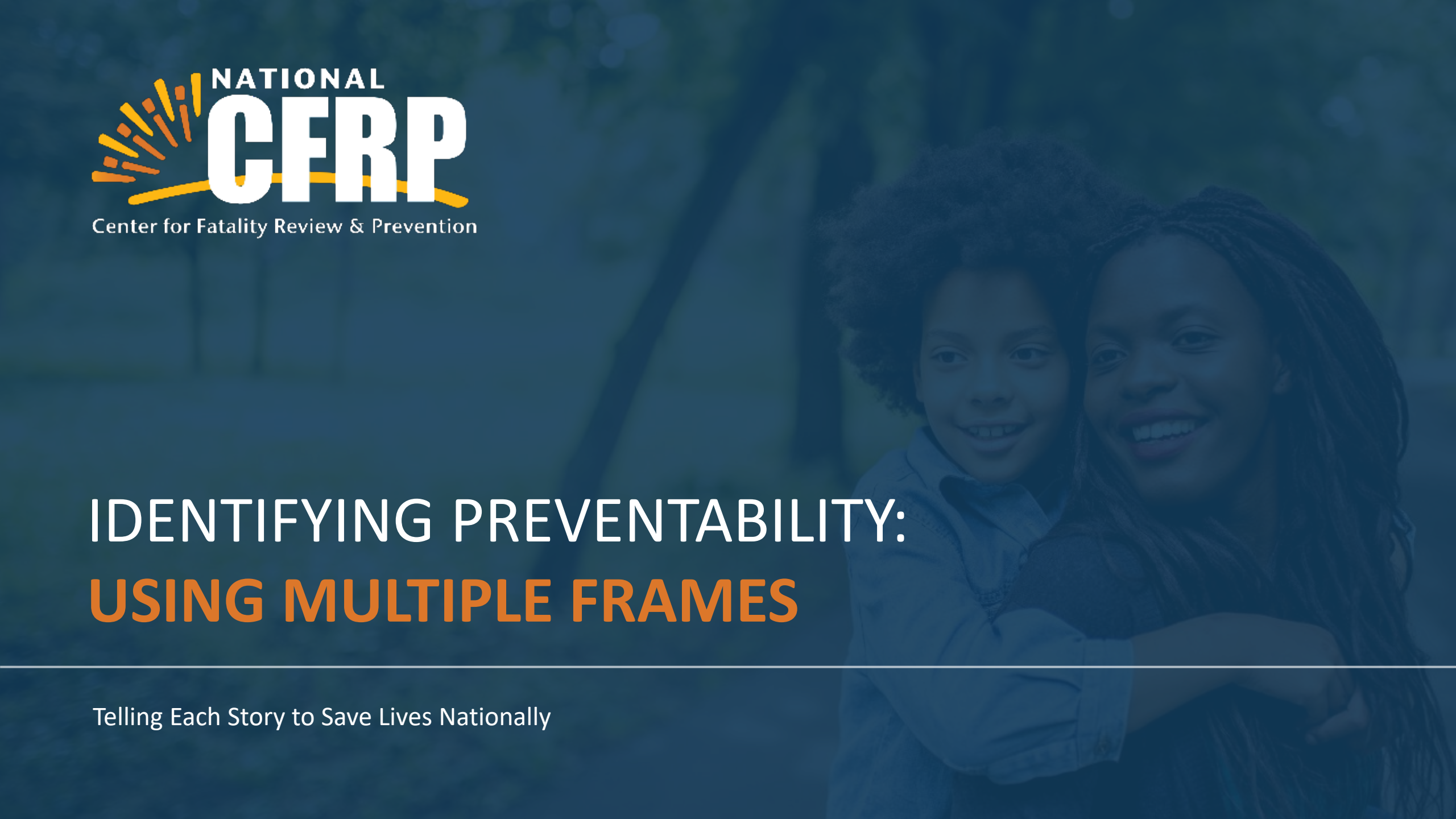
Thank You!

Visit our website

michael.cull@uky.edu

NATIONAL CFRP

Center for Fatality Review & Prevention



IDENTIFYING PREVENTABILITY:
USING MULTIPLE FRAMES

Telling Each Story to Save Lives Nationally

KEY FUNDING PARTNER

FEDERAL ACKNOWLEDGEMENT

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. Its contents 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 U.S. Government.

Cause for Concern

Why is equity important in child fatality review? We will review current data and disparities.

Spectrum of Prevention

Prevention strategies range from strengthening individual knowledge to influencing policy. Initiatives implemented across the spectrum have a compounding impact.

Cliff of Good Health

We will describe the work of Dr. Camara Jones, who depicts a cliff as a representation of good health and the various levels of protection provided to people to reduce poor health outcomes.

Action Steps

We will review systems of oppression that impact children, how they influence implicit biases, and the action steps we can take to disrupt bias and incorporate equity into our work.

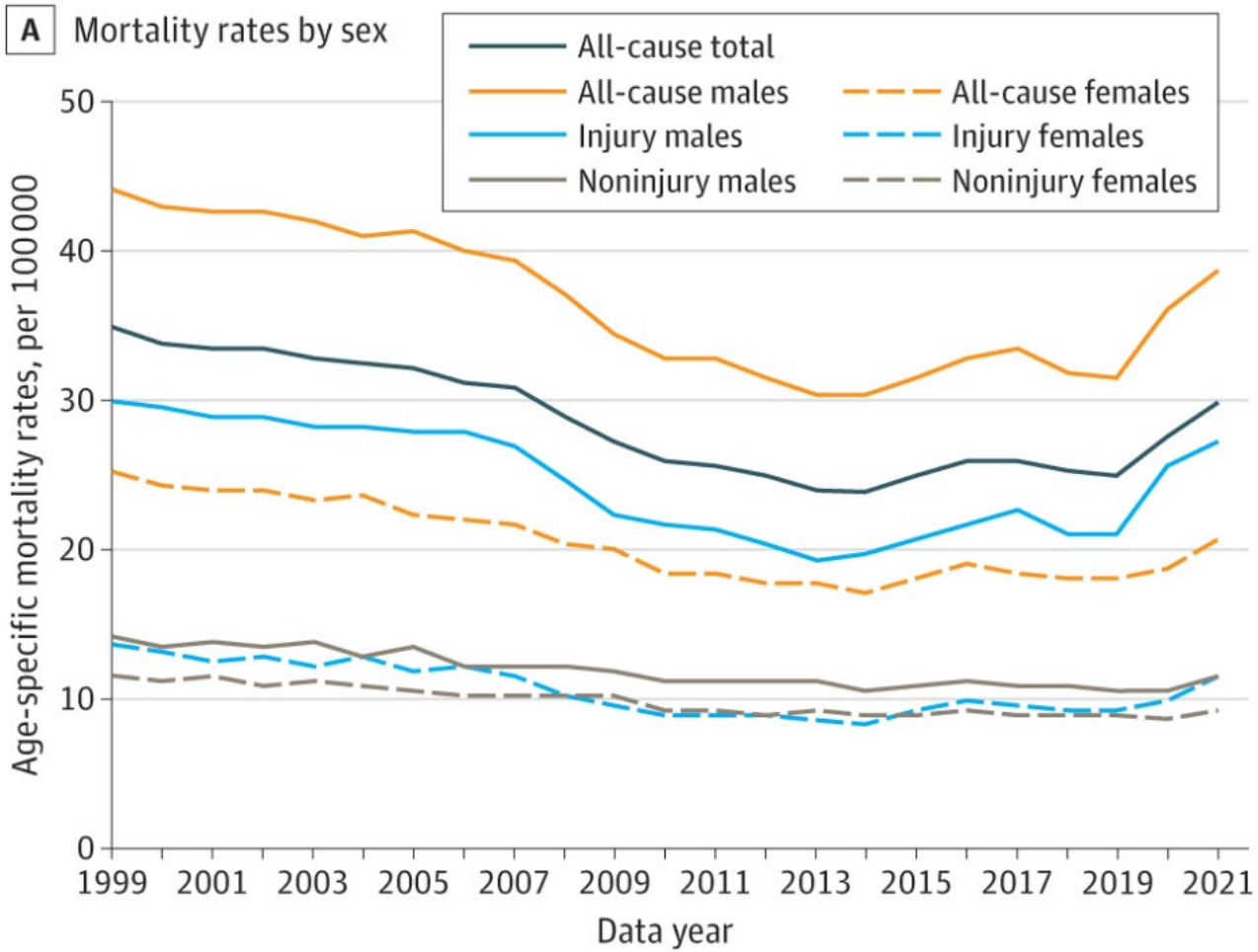
Resources

Helpful resources to continue learning and take action.

PRESENTATION GOALS

Cause for Concern

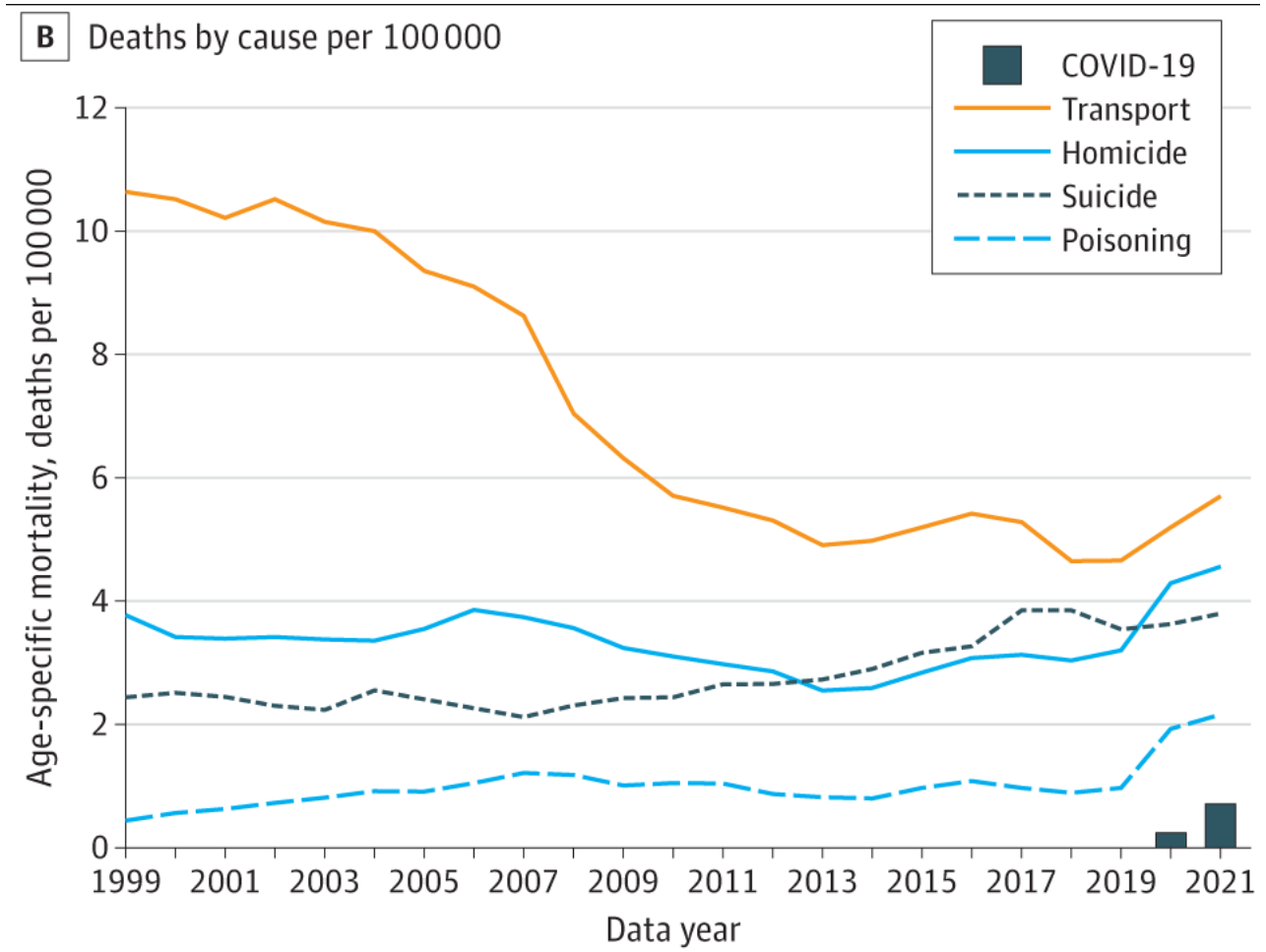
All-Cause, Injury, Noninjury, COVID-19, and Selected Injury Mortality Rates, Ages 1 to 19 Years, 1999-2021 by Sex



Woolf, S. H., et al. (2023). *JAMA*.

Cause for Concern

All-Cause, Injury, Noninjury, COVID-19, and Selected Injury Mortality Rates, Ages 1 to 19 Years, 1999-2021 by Cause



Woolf, S. H., et al. (2023). *JAMA*.

Cause for Concern

Widening Disparities

Black children die from injury at 4x the rate of Asian children and 2x the rate of white children.[1]

American Indian or Alaska Native children die from injury at 3x the rate of Asian children and 1.5x the rate of white children.[1]

Children in rural communities die from injury at 2x the rate of children in urban communities.[2]

1. CDC WONDER: 2018-2021, ages 0-17 years old.
2. Bettenhausen, J. L., et al. (2021). *Academic pediatrics*.

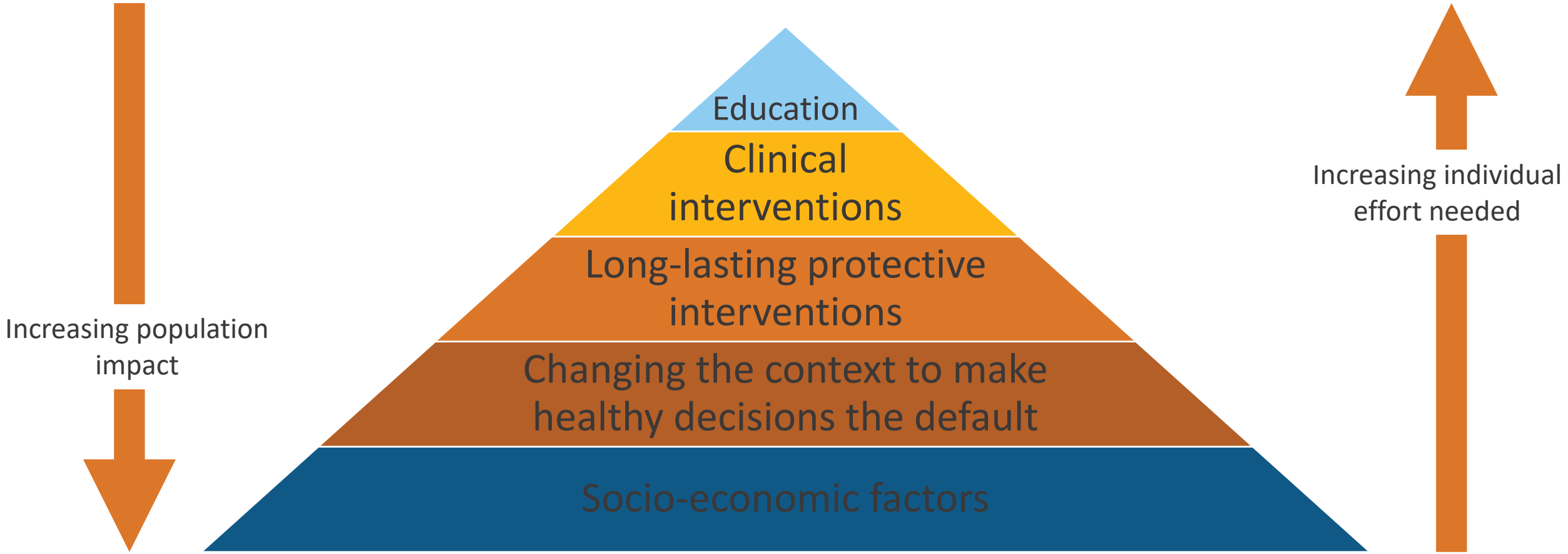
Meet John

A Mock Case

John is an eight-year-old, Black male who died due to drowning. At the time of the incident, John was swimming with his summer camp at a public pool. John had just reached the height minimum to be in the “big kid” area. John was last seen alive five minutes before he was discovered under the water. John was wearing a yellow camp bracelet which signified he could be in the “big kid” area. John had minimal exposure to swimming lessons but was comfortable in the water.

Spectrum of Prevention

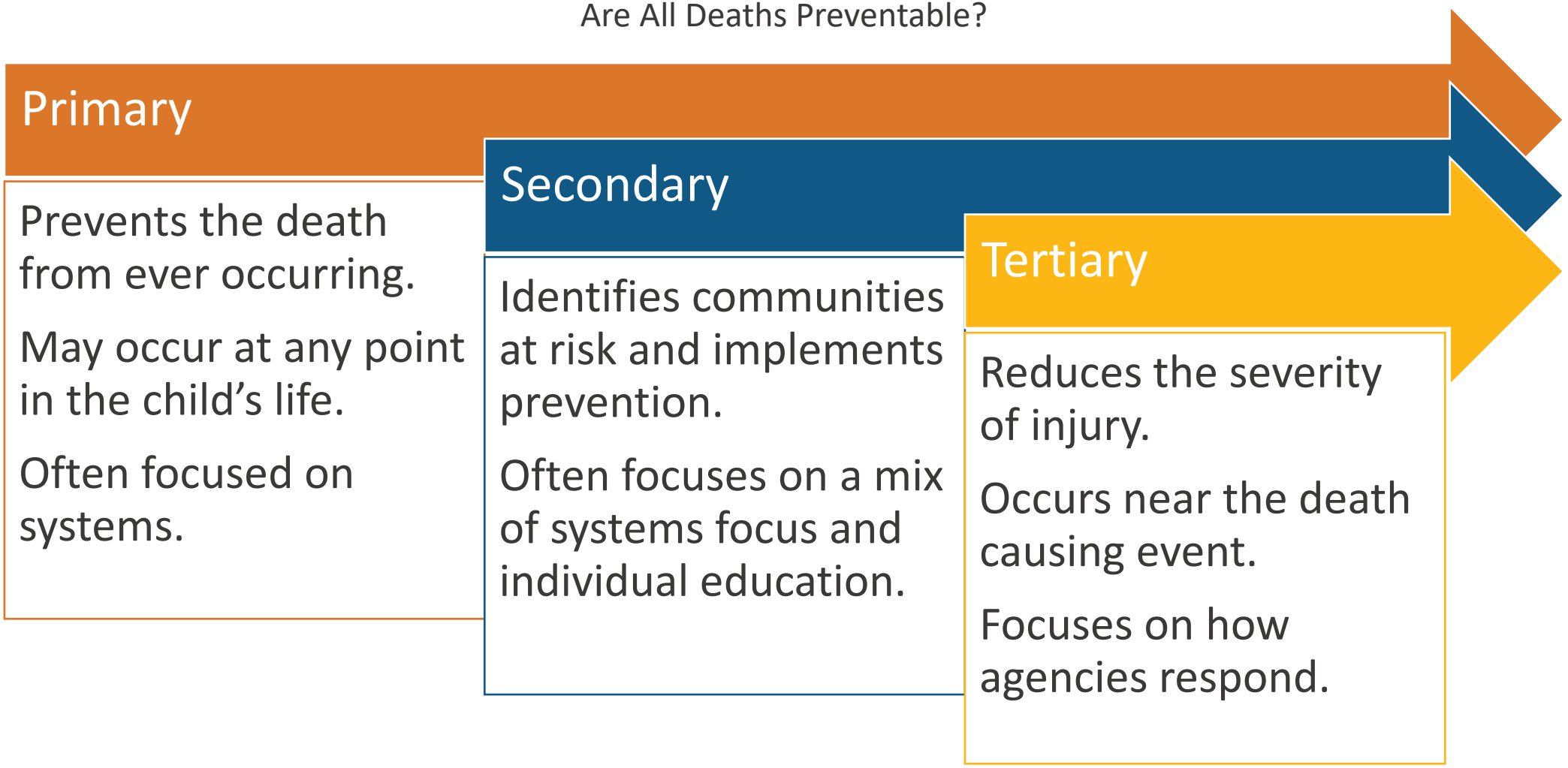
Individual effort balanced with population impact



Frieden, T. R. (2010). *American journal of public health*.

Preventability

Are All Deaths Preventable?



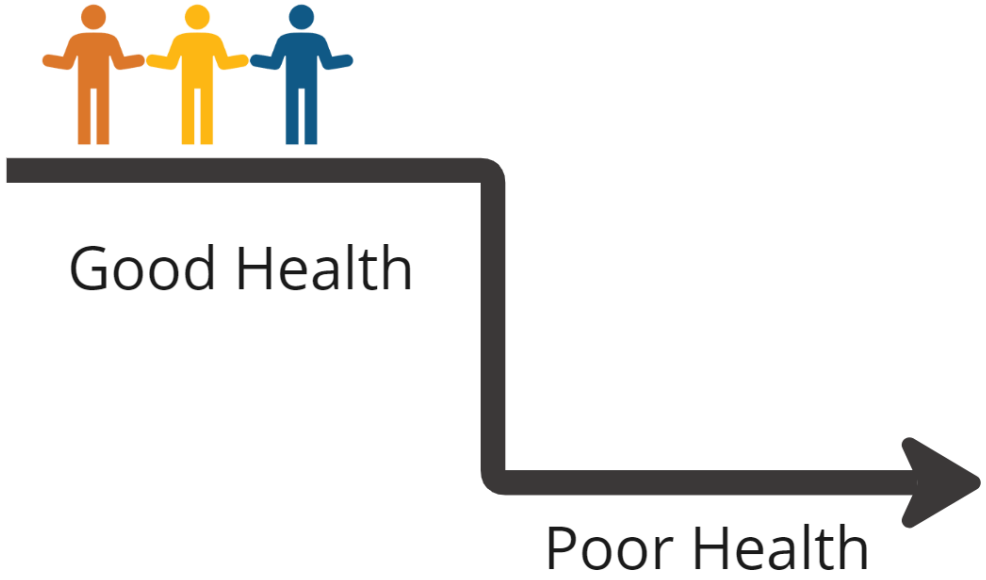
Timelines for Preventability

Could a death have been prevented at any time **prior to, during, or after** the precipitating incident?

Primary: Prior to the incident	Secondary: At the time of the incident	Tertiary: In response to the incident
Reducing risk • Appropriate safety info, guidance, policies • Limiting access as appropriate (childproof lids) • Medical insurance and access to care • Paid parental leave • Safe, stable housing • Structural safety (speed limits, stoplights, crosswalks, pool barriers or alarms)	Increasing safety • Adequate supervision • Safety guidelines understood and followed • Seatbelts worn/ car seats properly installed • Adequate family/community education • Necessary safety equipment available (PFDs; helmets, etc.)	Intervening • Emergency responders available • Necessary transportation available • Bystanders know emergency first aid/ CPR • Access to needed medical care • Access to Narcan

The Cliff of Good Health

Jones CP et al. *Journal Health Care Poor Underserved* 2009



The Cliff of Good Health

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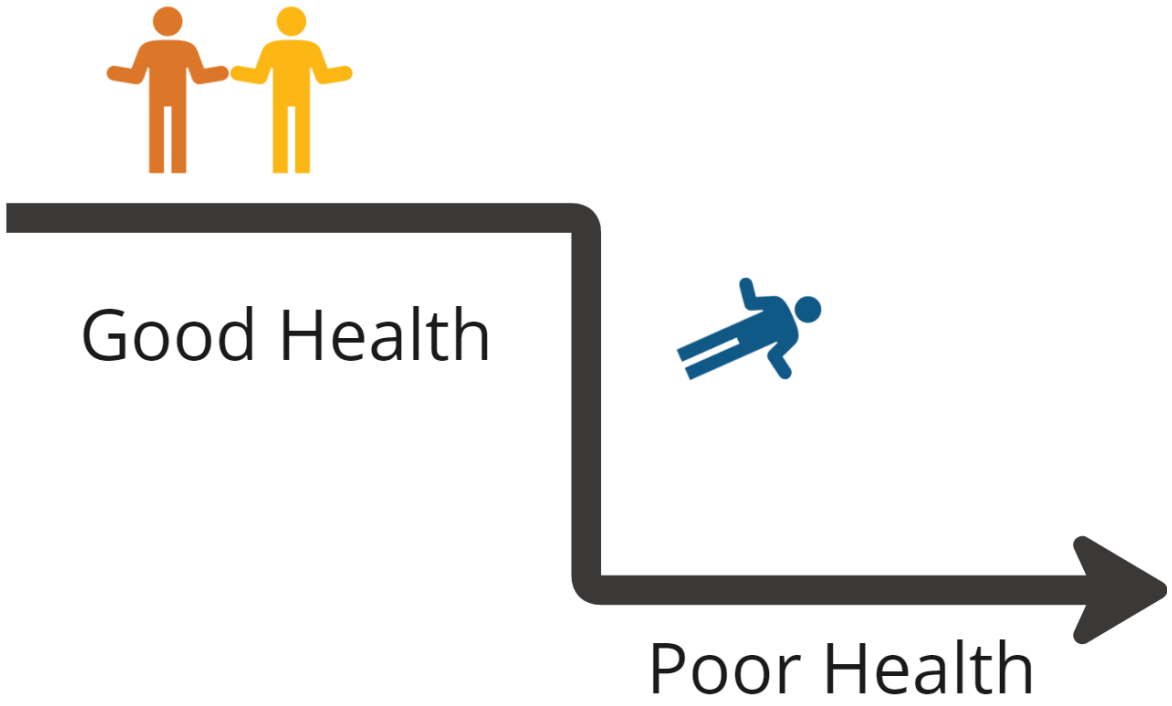
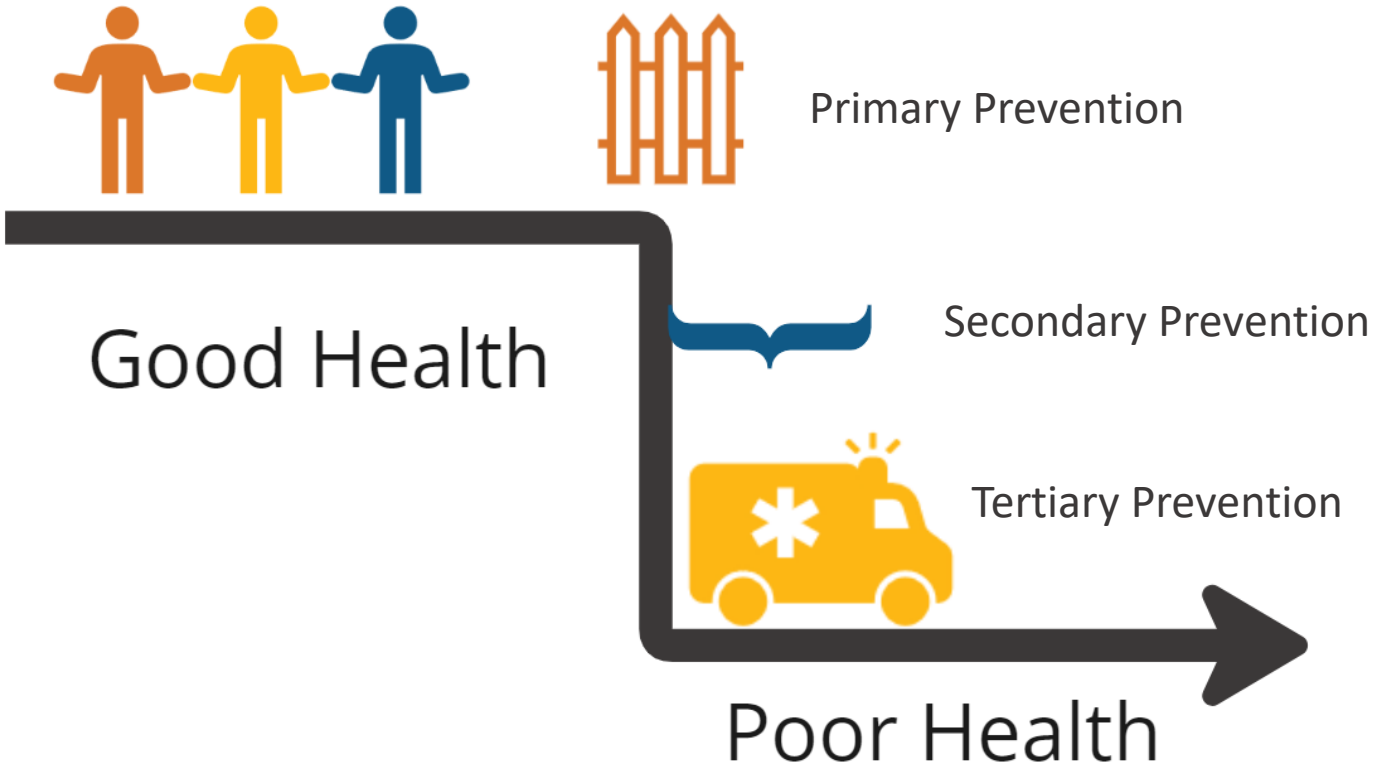


Differences in the Cliff of Good Health

Jones CP et al. *Journal Health Care Poor Underserved* 2009

The Cliff of Good Health

Jones CP et al. *Journal Health Care Poor Underserved* 2009



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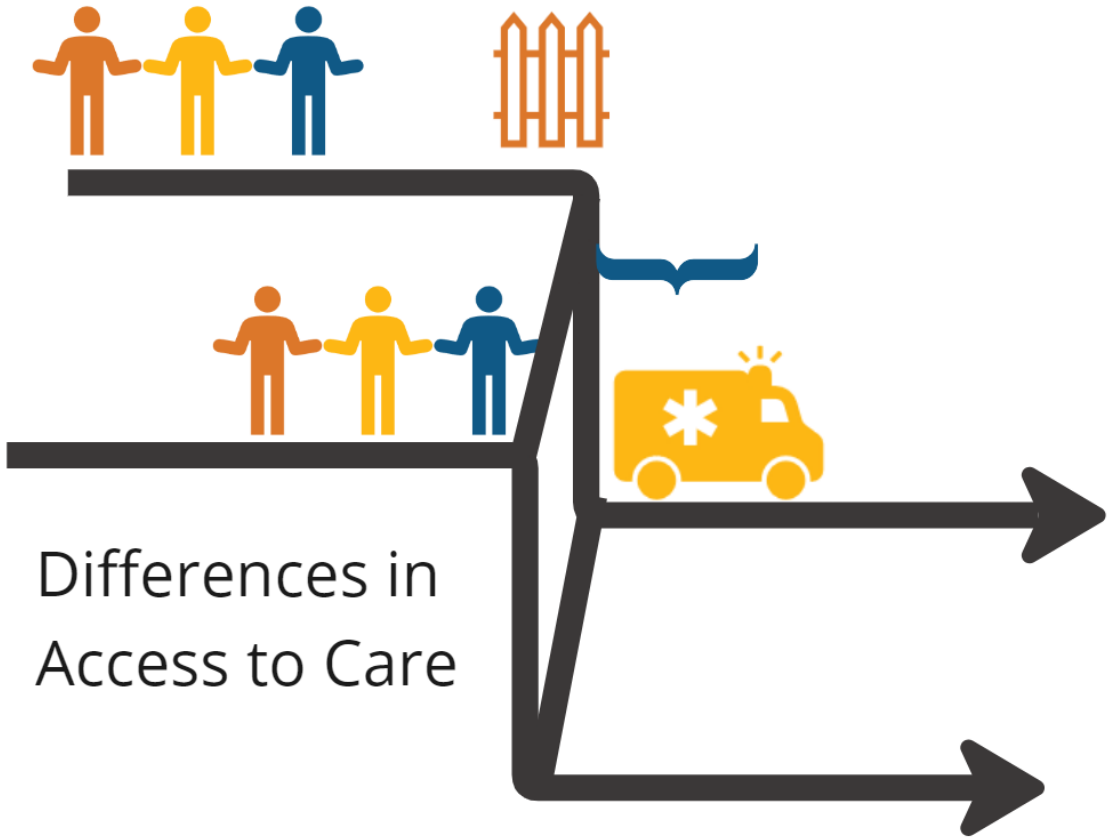

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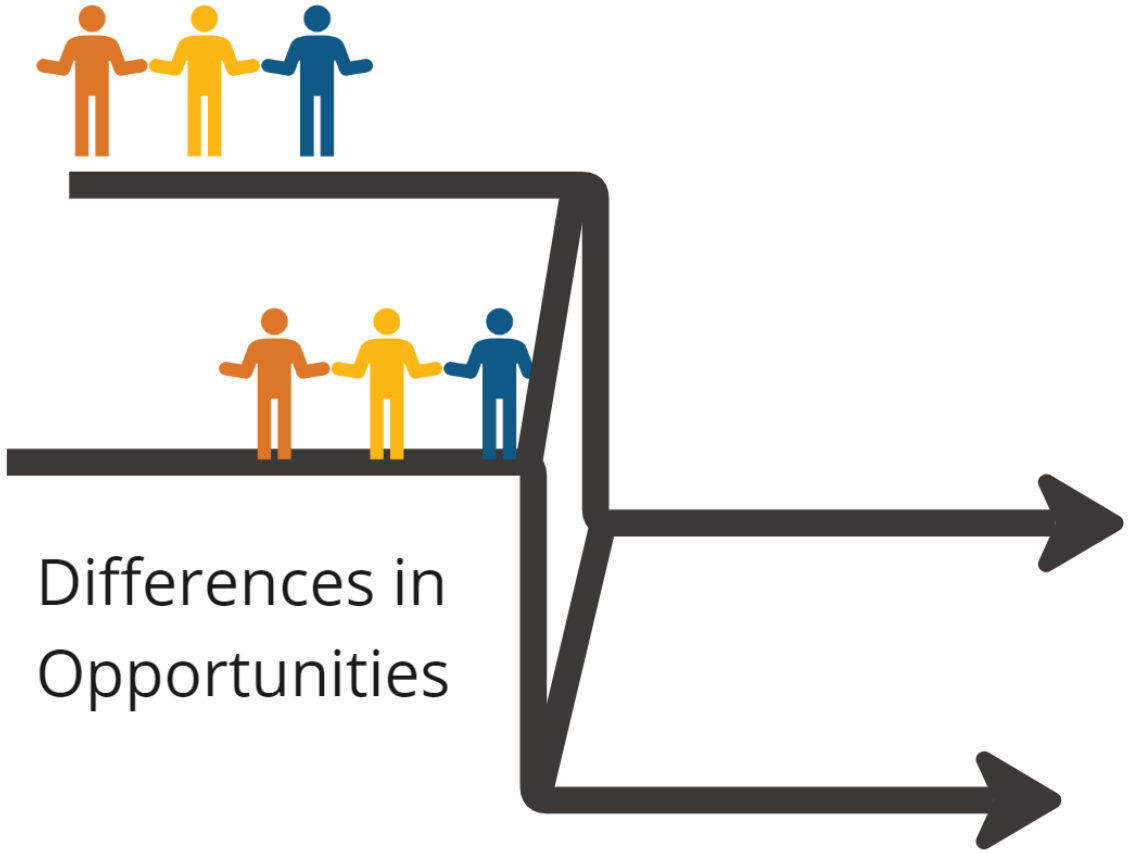
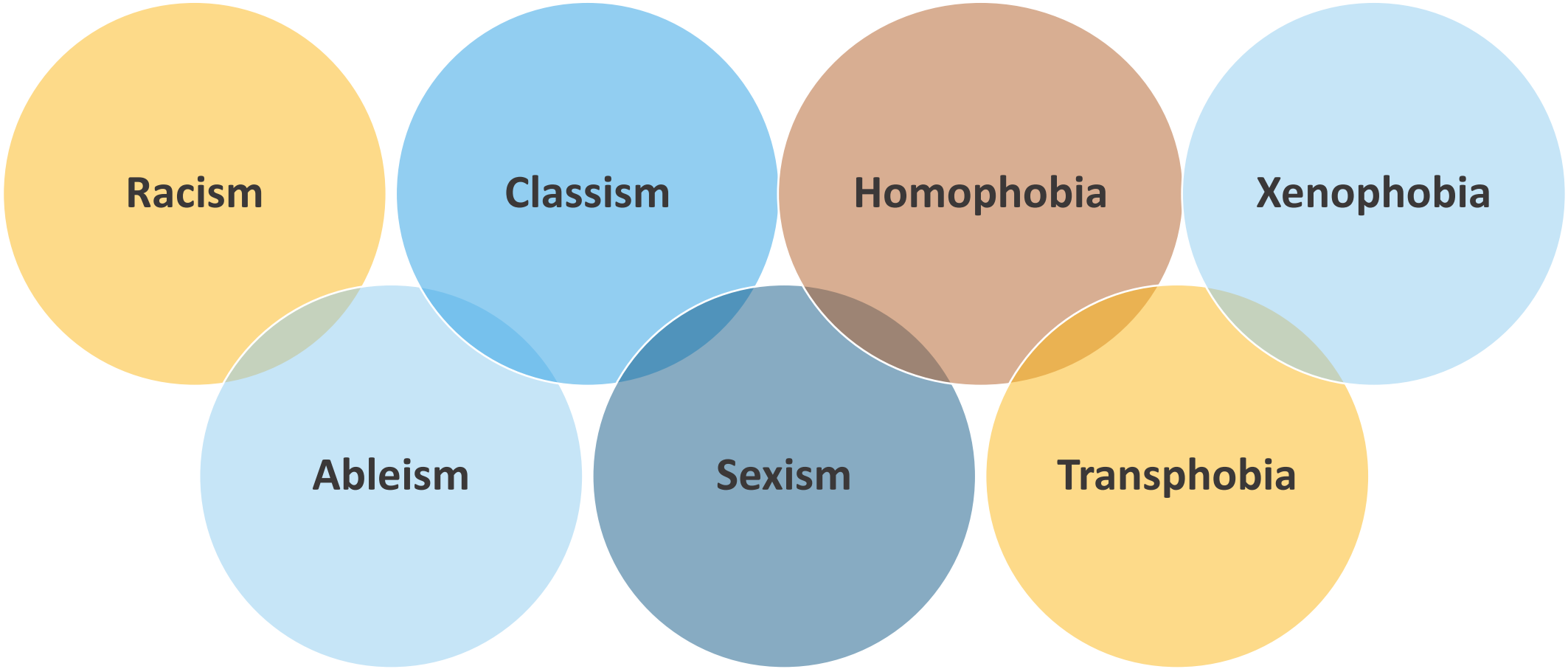
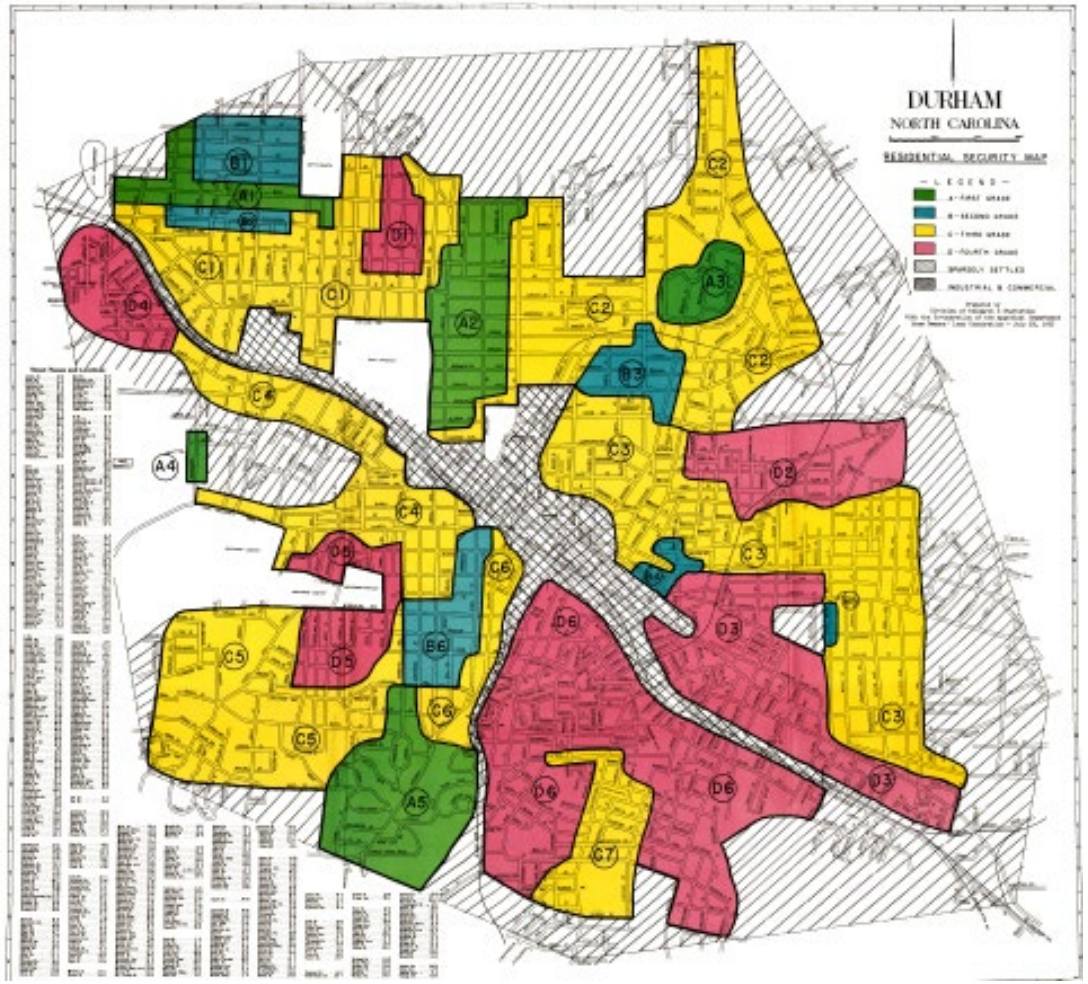


Structural and Cultural “-isms”



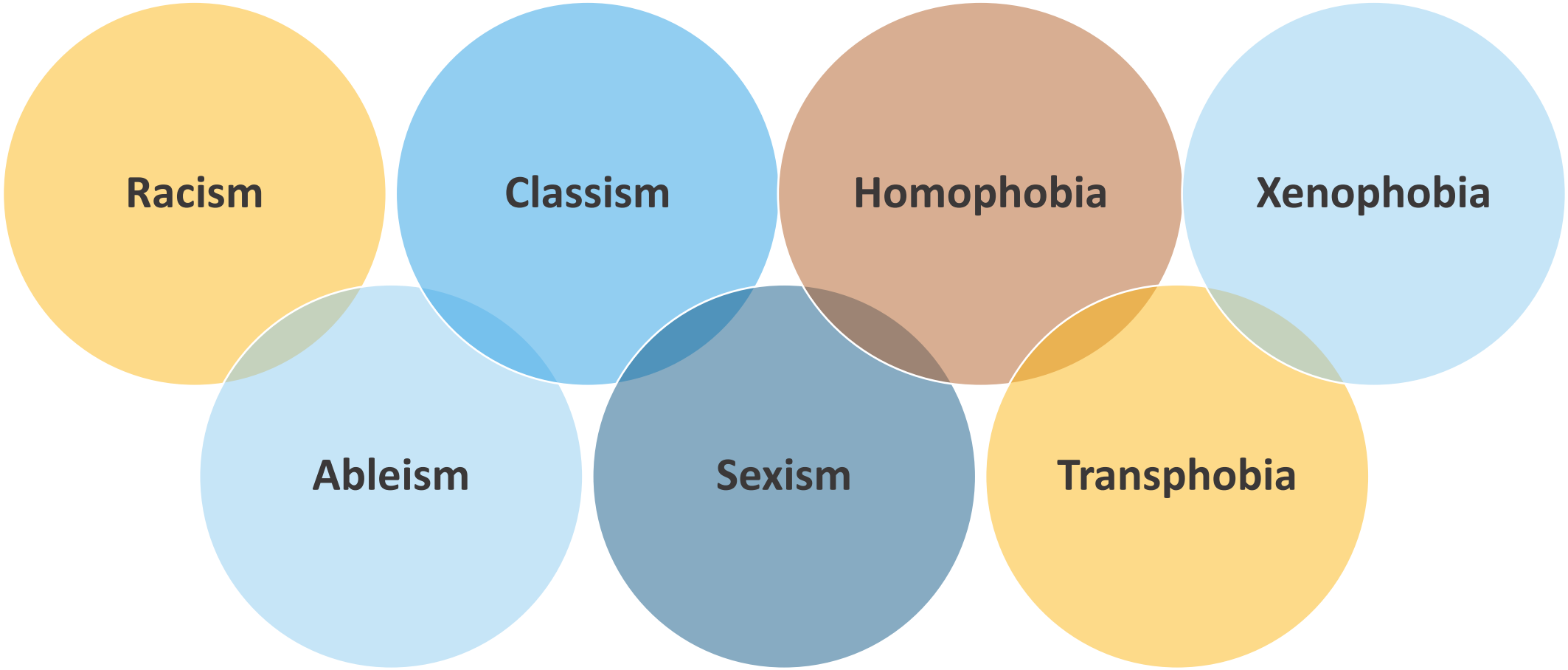
Redlining in Durham, North Carolina

Source: Mapping Inequality, 1939



Structural and Cultural “-isms”

Exposure to systems of oppression enable biases to penetrate deep into our psyches.



What is Implicit Bias?

- Unconscious stereotypes that influence our actions and decisions
- Can be both favorable and unfavorable assessments
- “Implicit bias and perception are often seen as individual problems when, in fact, they are structural barriers to equality.”

-Alexis McGill Johnson, Perception Institute

How Does Bias Show Up In Fatality Review?

A Few Examples

Taking a deficit-based approach

- Focuses on perceived weaknesses, rather than strengths
- Compares a group to the "highest performing group"
- Creates a negative, deficit cycle

Focusing on individual factors

- Highlights individual identity and characteristics (e.g., race, gender, income)
- Places the onus on individuals
- Minimizes the large impact that systemic factors have on people

Victim or family blaming

- Children and families are viewed as "the problem"
- Blames the death on individual characteristics or behaviors without considering systems

Making only individual-level recommendations

- Places the onus solely on individuals to prevent deaths
- Fails to recognize the impact of systems and environmental context
- Not a comprehensive approach

Recognize and Address Your Own Implicit Biases

NICHQ's Seven Steps to Help Minimize Implicit Bias

Action Steps

Disrupt Bias and Incorporate Equity Into Fatality Reviews

Recruit and retain diverse team members

- Each team member has a unique set of identities, personal and professional experiences, and relationships
- Consider which perspectives are represented on your team and which may be missing
- Ask yourself if the diversity of your team reflects the community you are serving (e.g., race, ethnicity, sexual orientation, gender identity, income)

Action Steps

Disrupt Bias and Incorporate Equity Into Fatality Reviews

Have community agreements

- Consensus-based standards outlining how a group will work together; builds understanding and shared expectations
- Common examples: make space for everyone to share, listen to understand and not respond, prioritize impact over intent, “ouch” then educate
- Should be co-created and iterative

Action Steps

Disrupt Bias and Incorporate Equity Into Fatality Reviews

Consider neighborhood and community context

- Use additional tools and resources that may not be specific to the child but inform us about the community more broadly
- Available tools include:
  - March of Dimes PeriStats (https://www.marchofdimes.org/peristats/)
  - City Health Dashboard: Empowering Cities to Create Thriving Communities (https://www.cityhealthdashboard.com/)
  - CDC's PLACES: Local Data for Better Health (https://www.cdc.gov/places/)

Action Steps

Disrupt Bias and Incorporate Equity Into Fatality Reviews

Focus the conversation on systems

- Systems are often the root cause, constraining individual choice
- Strategies include:
  - Doing a root cause analysis, keep asking “why?”
  - Read an equity statement at the start of each review meeting
  - Use equity-centered prompts to promote this discussion (e.g., “How may the parent or child’s environment have impacted their health?”)

Action Steps

Disrupt Bias and Incorporate Equity Into Fatality Reviews

Identify strengths, not just deficits

- Create opportunities to acknowledge the strengths of the family and community
- Have a diversity of perspectives at the review meeting and engage community/family voice
- Conduct a gratitude exercise at the conclusion of the review meeting, highlighting the strengths of the community and what is working well

Action Steps

Disrupt Bias and Incorporate Equity Into Fatality Reviews

Engage with families and communities

- Practice authentic community engagement
- Don’t tokenize: Lived experience and personal stories are a form of expertise and should be treated as such
- Hold space for community members to share information and ideas for prevention

Action Steps

Disrupt Bias and Incorporate Equity Into Fatality Reviews

Make findings and recommendations at multiple levels

- All levels of prevention are complementary and synergistic: when used together, they have a greater effect than would be possible from a single activity or initiative (Prevention Institute)
- Think back to the spectrum of prevention and Cliff of Good Health
    - Use these as visual reminders during the recommendation discussion
- Consider shared risk and protective factors that impact multiple outcomes

Action Steps

Disrupt Bias and Incorporate Equity Into Fatality Reviews

Reflect on implicit biases

- Take 5-10 minutes after each review meeting to acknowledge biases and assumptions that may have shown up in the review
  - Reflect internally
  - Allow space for members to share

Action Steps

Combine multiple action steps for a comprehensive approach

- Recruit and retain diverse team members
- Have community agreements
- Consider neighborhood & community context
- Focus the conversation on systems
- Identify strengths, not just deficits
- Engage with families and community
- Make findings and recommendations at multiple levels
- Reflect on implicit biases

Resources

Levels of Prevention

Prevention Institute

The Spectrum of Prevention

https://www.preventioninstitute.org/tools/spectrum-prevention-0

The Cliff of Good Health

Urban Institute: https://www.urban.org/policy-centers/cross-center-initiatives/social-determinants-health/projects/dr-camara-jones-explains-cliff-good-health and https://www.urban.org/urban-wire/why-are-some-americans-more-likely-fall-cliff-good-health-0

Resources

Implicit Bias: Continue Learning and Take Action

NICHQ's Implicit Bias Resource Guide

A guide for recognizing and addressing our implicit bias, including 7 steps, Q&A with experts, and stories

www.nichq.org/resource/implicit-bias-resource-guide

Harvard Implicit Association Tests

Tools to reveal implicit biases for several categories, including age, sexuality, and race; Try a few and reflect on the results

https://implicit.harvard.edu/implicit/takeatest.html

Resources

Creating Group Agreements

Drawing Change

Co-creating community agreements in meetings

https://drawingchange.com/co-creating-community-agremeents-in-meetings/

National Equity Project

Developing community agreements

www.nationalequityproject.org/tools/developing-community-agreements

Resources

From the National Center for Fatality Review and Prevention

Improving Racial Equity in Fatality Review

National Center guidance report

https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/Health_Equity_Toolkit.pdf

Health Equity: Diversity, Equity, and Inclusion Assessment Guide for Multidisciplinary Teams

Guidance report: https://ncfrp.org/wp-content/uploads/MDT_HealthEquity.pdf

Facilitator's manual: https://ncfrp.org/wp-content/uploads/FacilitatorsManual_HealthEquity.pdf

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Charge for the Day

Susan Kansagra, MD, MBA

Director, NC Division of Public Health / State Health Officer

North Carolina Department of Health and Human Services