



Child Death Review Overview

Telling Each Story to Save Lives Nationally



Disclosure

- Neither I nor any member of my immediate family has a financial relationship or interest (currently or within the past 12 months) with any proprietary entity producing health care goods or services consumed by, or used on, patients related to the content of this CME activity.
- I do not intend to discuss an unapproved/investigative use of a commercial product/device.



KEY FUNDING PARTNER

FEDERAL ACKNOWLEDGEMENT

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Technical Assistance and Training

On-site, virtual and/or recorded assistance, customized for each jurisdiction, is provided to CDR and FIMR teams.



National Fatality Review-Case Reporting System

Support the NFR-CRS which is used in 45 states and provides jurisdictions with real-time access to their fatality review data.



Resources

Training modules, webinars, written products, newsletters, listserv, website and more.



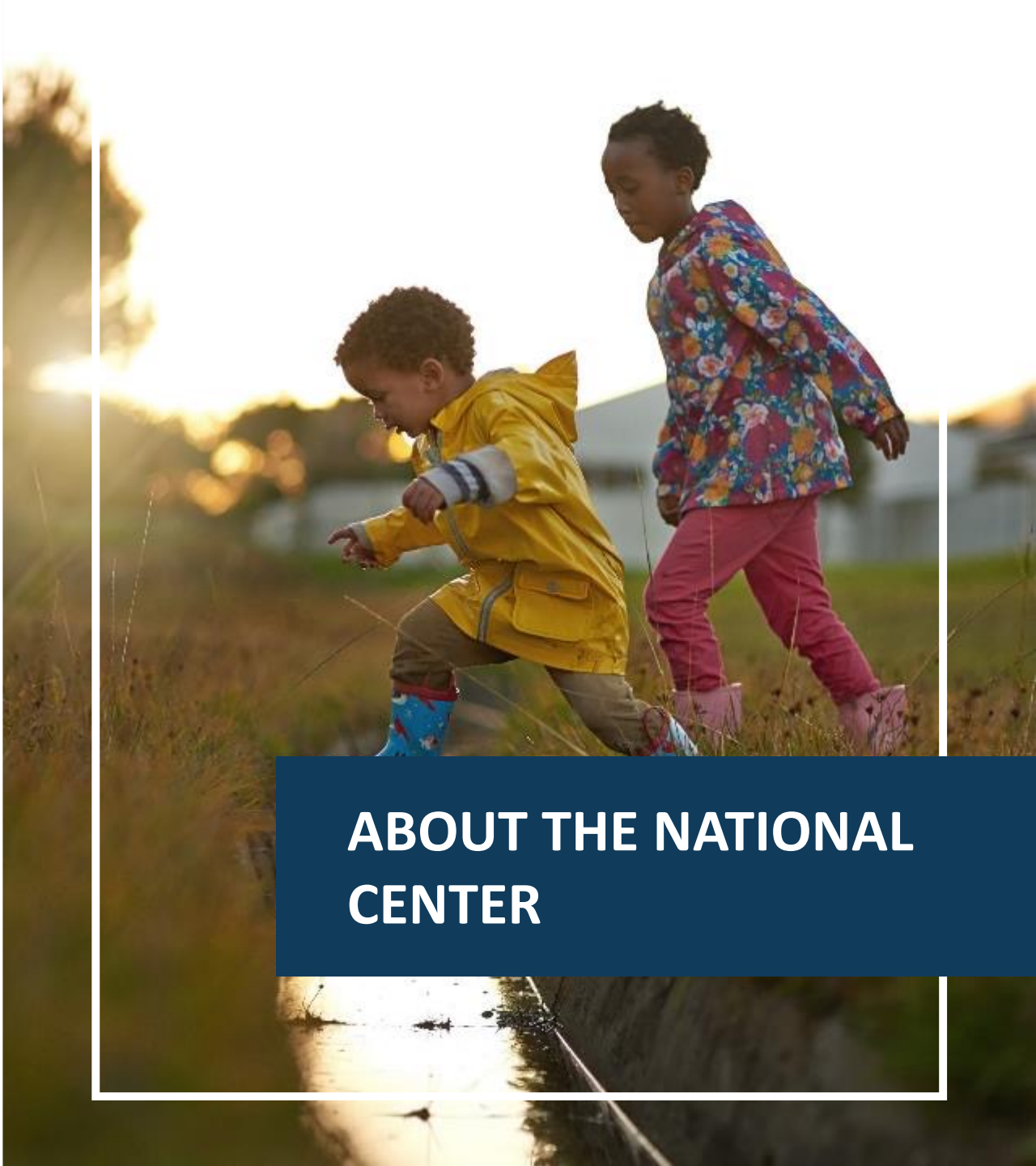
Communication with Fatality Review Teams

Regular communication via listserv, newsletters and regional coalitions.



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**ABOUT THE NATIONAL
CENTER**

Three Steps to Child Death Review

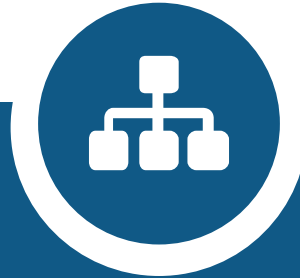
Steps to Success



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



Case Specific Information

Review agency records for information about the child, family and community



Professional Liaison

Explain agency limitations, responsibilities and assist with making linkages to access data and promote prevention



Data Collection

Participate in data collection, including access to records and understanding content



Catalyze Prevention

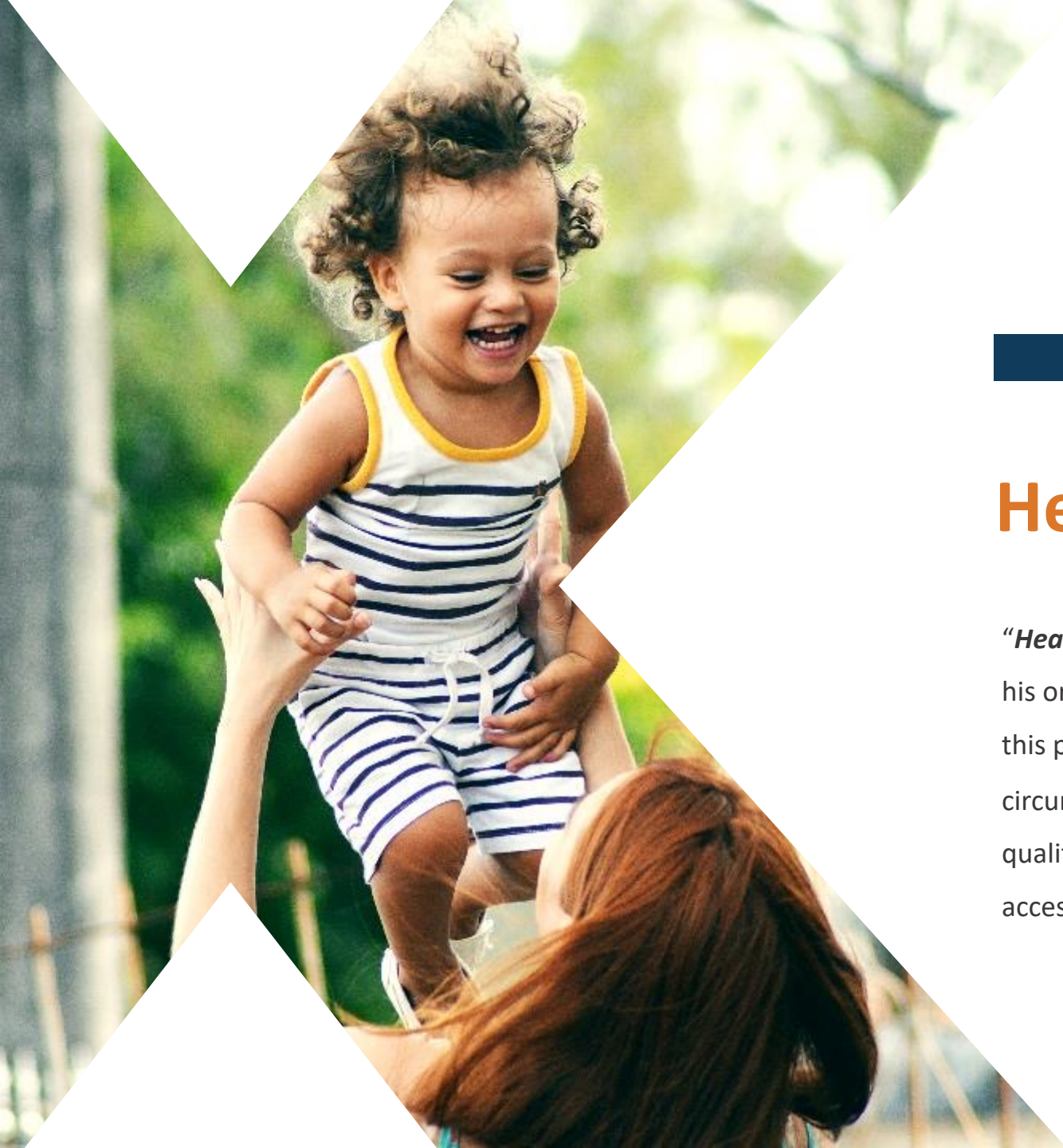
Support prevention work through identifying findings, writing recommendations and advocating for change



Honor Team Agreements

Abide by agreements related to information access and sharing and actively participate in all aspects of teamwork





Health Equity

“**Health equity** is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances. Health inequities are reflected in differences in length of life; quality of life; rates of disease; disability; and death; severity of disease; and access to treatment.”¹

1. Centers for Disease Control and Prevention. *Health Equity*: <https://www.cdc.gov/chronicdisease/healthequity/index.htm>

National Fatality Review-Case Reporting System

COLLECTING HIGH QUALITY DATA SUPPORTS PREVENTION



BEFORE MEETING



Enter as much data as possible before the review meeting. Highlight key missing and unknown variables.



DURING MEETING



Once all team members have shared information, identify any remaining highlighted variables that are missing.



AFTER MEETING



Enter information from review meeting within 30 days of the meeting to ensure data quality and completeness.



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