STRENGTHENING THE NORTH CAROLINA CHILD FATALITY PREVENTION SYSTEM STAKEHOLDER WORKGROUP

MEETING 2 - FEBRUARY 25, 2020
10:00 AM TO 3:00 PM
630 DAVIS DRIVE, SUITE 100
MORRISVILLE, NC 27560

In attendance: Catherine Joyner, Christina Harrison, Molly Berkoff, Paige Rosemond, Terri Reichert, Teresa Strom, Belinda Pettiford, James Coleman, Phil Redmond, Debbie Jenkins, George Bryan, Scott Proescholdbell, Pam McCall, Abby Collier, Kella Hatcher, Susan Robinson, Tom Vitaglione, Walker Wilson, Michelle Ries, Hattie Gawande, Sarah McCracken, Elaine Cabinum-Foeller, Adam Zolotor, Brenda Edwards, Christina Harrison, Melea Rose-Water, Yvonne Winston, Debra Hawkins, Jenny Cooper, Eric Harbor, Susanna Joy, Terri Reichert, Selena McCarter, Kerry Young, Karen Wade, Kathleen Jones-Vessey, Gerri Mattson, Jennie Kristiansen, Melea Rose-Water, Emily Hooks

Takeaways from Meeting 1 Small Group Discussions – James Coleman, MPH, NCIOM

Mr. Coleman reviewed the takeaways from last meeting's small group discussions. Groups felt when teams are combined, there needs to be standardization around data collection, structure, local support, and reporting of data. They also recognized that currently there is no centralized sharing of data to identify trends, which precipitates the need for state support. When teams are consolidated, the groups voiced a desire to be flexible in team composition; advocated for these teams to focus on child-welfare issues and near fatalities, in addition to fatalities; and wanted to ensure NC is still meeting CAPTA requirements through these groups. Before combining multi-county teams, county commissioners need to be engaged and involved in process.

DSS 7-Day Review of Foster Care/In-home Services Child Fatalities – Teresa Strom, MSW, NCDHHS

Ms. Strom reviewed seven-day reviews to call attention to the fact that these types of reviews occur but were not reviewed at the last meeting. Within seven days of a child's death in an open in-home services or foster care case, an Onsite Services Review Instrument (OSRI) quality assurance consultant goes to the county. This consultant spends two to three days reviewing records and interviewing the social worker or supervisor. An intensive review is conducted if there is abuse or neglect, and the intensive review can review the OSRI. The intensive review team looks at systemic issues, and OSRI examines the child welfare aspects. Several members of the stakeholder group felt the way intensive reviews are shared via email with specific people creates systemic issues. The current dissemination relies on people receiving intensive reviews to make connections and pass on the information to others who could use that information.

National Fatality Review Case Reporting System – Heather Dykstra, The National Center of Child Fatality Review and Prevention

Ms. Dykstra presented on the National Fatality Review Case Reporting System (NFR-CRS), which was established in 2005. The purpose of the system is to systematically collect, analyze, and report comprehensive fatality review data on deaths of each child. It is web-based and easy to use, including the capability to create and download standardized reports. It is a free system, including software updates, training resources, and technical support. Currently, there are 45 states that use the NFR-CRS for child death reviews, and NC is the only state with local teams that does not use this system. Per a data use agreement, data entered in the NFR-CRS is owned by the individual states, and de-identified data available to researchers once they submit and get IRB approval.

No field of the NFR-CRS is mandatory, but there are 100 variables identified as priority variables, which takes 20–30 minutes of data entry per case. Ms. Dykstra demoed the system, including the data entry and download functionalities.

Best Practices in Maltreatment Reviews – Abby Collier, MS, The National Center of Child Fatality Review and Prevention

Ms. Collier shared that the best practice of child death review is a threefold process: to tell the story of the individual child, collect the data, and take action. She reviewed best practices for a two-tiered system, in which one tier doing reviews and data collection occurs at the local level. In these types of system, local teams review data and findings to write recommendations at least once a year which are funneled to new state office which will meets quarterly. The key charge of the newly formed state office would be to train and provide resources to local teams and identify common themes. Ms. Collier stated that when a system works well, all three levels (internal agencies, child welfare systems, and multi-agencies) are communicating and sharing with each other.

Improving Child Fatality Review Capacity to Review Infant Deaths – Susanna Joy, The National Center of Child Fatality Review and Prevention

Ms. Joy reviewed special considerations for reviewing infant deaths. Infant deaths accounted for 56% of North Carolina deaths age 19 and under in 2018, and of those, the vast majority (75%) were due to natural causes. Case selection should reflect community priorities and can focus on shared risk factors approach (i.e., overlap of maternal smoking). These reviews are more clinical, so participation/input should be made as easy as possible. Ms. Joy encouraged NC to focus on considerations for prevention, such as social determinants of health. Addressing the root cause for social determinants of health also addresses the risk for other causes of death.

Small Group Discussions

The Data Group discussed setting specific and realistic expectations for the NFR-CRS and the need to get local input on key variables to include in the system. They agreed that there should be immediate feedback or sharing of insights from aggregate data from the state team. The group also discussed that due to HIPAA, near-death reviews will require specialized procedures, but CCPTs currently review active cases so they've already navigated the HIPAA compliance issue.

The Infant Death Group discussed that bi-directional feedback will help local teams. They reviewed the subject matter experts that would be needed for infant reviews and agreed that the behavioral health representative is particularly important to these types of reviews, as well as medical expertise and someone representing the social determinants of health perspective. Although reviewing these deaths by perinatal region would be possible, the group felt that may cause the local perspective to be lost.

The Child Welfare Group spoke about providing infrastructure and support to underserved counties and the need to ensure local participation. They agreed that support could be based on county need, but the state must be the entity to close the loop. They recognized the need for more clearly defined roles between the state and counties. They cautioned against fear-based accountability and felt the focus of marketing the newly formed office should highlight the benefit of data sharing and support.

The next and final meeting will take place on Thursday, March 19th from 10:00 AM – 3:00 PM.