

## Merged Child Fatality and Maternal Mortality Review Teams

**About Technical Assistance Briefs.** The MCH Evidence Center provides ongoing technical assistance (TA) to Title V agencies related to the emerging evidence base, strategies, and measures related to many topics interconnected with National Performance Measures and other critical topics in MCH. *Technical Assistance Briefs* are an outcome of these TA sessions that are designed to act as *conversation starters* in thinking about programs that can be developed to address issues that affect women, infants, children, adolescents, youth, families, and communities. These briefs are not meant to be comprehensive; full analyses of the NPM topic areas are provided in [Evidence Analysis Reports](#).

The Center makes these customized briefs available during TA and on the program website to identify evidence-based/informed strategies, promising practices, examples of ESMs from the field and peer-reviewed resources. Please [contact us](#) if you would like us to develop a similar report for topics that you are working on.

**Initial Query for this Brief.** Research on which states use merged child fatality and maternal mortality review teams and the pros and cons of merging these programs.

### Start Here

The [National Center for Fatality Review and Prevention \(NCFRP\)](#), funded in part by HRSA's Maternal and Child Health Bureau, is the technical support and data center serving Child Death Review (CDR) and Fetal and Infant Mortality Review (FIMR) programs throughout the United States. CRRP's website includes resources that address this issue, including:

[Enhancing Collaboration Across Maternal and Child Health Fatality Review Programs.](#)

Webinar. Presented by the Center for Fatality Review & Prevention. Fatality review is a proven process in maternal and child health (MCH), equipping communities and states with unique data and prevention recommendations. As it becomes more common for jurisdictions to have multiple fatality review processes, partners from the National Center for Fatality Review and Prevention and the Centers for Disease Control and Prevention highlights a new resource to support effective collaboration between MCH fatality review processes while maintaining program integrity.

The [National Fatality Review-Case Reporting System \(NFR-CRS\)](#) is a web-based standardized case report tool available to states that was first created in 2005. The system allows local and state Child Death Review (CDR) and Fetal and Infant Mortality Review (FIMR) users to enter case data, summarize findings, review team recommendations, access and download data, and create standardized reports.

## National Summaries

The following summary is of seven states that have merged or highly-connected child and maternal fatality teams; it is drawn from NCFRP's [CDR Map](#):

**AK.** Alaska has two review programs: The [Maternal and Child Death Review](#) (MCDR) and the Child Fatality Review Team (CFRT). MCDR has been in place since 1989. Initially, the program only reviewed maternal, infant and occasionally fetal deaths. In 2005, the age criterion was expanded to include children. The age range of children has varied over time; currently MCDR reviews infants and children 0 – 17 years of age statewide. Alaska's MCDR staff consist of a Program Manager, Epidemiologist, Health Program Associate and a consulting Senior Epidemiologist. Federal funding like the Title V MCH Block Grant and the CDC SUID grant are blended to fund these positions which are housed in Alaska's Title V Agency, within the Section of Women's, Children's, and Family Health of the Alaska Division of Public Health. The MCDR program reviews maternal cases and infant and child deaths ages 0 – 17. All deaths occurring in the state of Alaska or among Alaskan residents that meet these criteria are reviewed. All reviews are conducted retrospectively, with the committee meeting once a month.

**Collaboration innovations:** Alaska has streamlined the work process by creating an administrative database to track all fatality cases across its fatality review programs. This customized access database is an automated platform to track all data requests to partner agencies and automate pre-populated records request letters to relevant agencies. The programs have also partnered to publish resources focused on cross-cutting issues, including youth suicide risk and Adverse Childhood experiences.

**AZ.** [Arizona Child Fatality Review](#) does not specifically state that they have merged programs, but the same staff member serves as the "Child Fatality and Maternal Mortality Review Program Manager." It appears that the two programs act independently, but report to the same program lead.

**DE.** Delaware's child death review process was statutorily established on July 19, 1995, after a pilot project showed the effectiveness of such a review process for preventing future child deaths. The legislation established the [Child Death Review Commission](#), which has been charged to create up to three regional Review Panels, establish confidentiality for the reviews, and provide the Commission with the ability to secure pertinent records. During FY08, the Commission's statute was amended to include Maternal Death Review. The Commission reviews the work of three child death panels, two FIMR case review teams and one Maternal Death review team. Delaware reviews the deaths of mothers within 364 days of giving birth, children under the age of 18, and stillbirths occurring after at least 20 weeks of gestation.

**IN.** [The Indiana Department of Health's Division of Fatality Review and Prevention](#) its [MMR](#), [FIMR](#), [CFR](#), and SUID Case Registry activities, as well as Overdose Fatality Review, and Suicide Fatality Review programs. The programs share funding, case records, staff, leadership,

team members, and case findings. Statutory changes have increased records access and facilitated collaboration. **Collaboration Innovations:** The fatality review programs in Indiana create joint external reporting for relevant agencies and partners. Borrowing from the two-tiered FIMR model, Indiana's fatality review programs share regional Community Action Teams (CATs) to spearhead prevention activities based on local fatality review findings and recommendations for FIMR and CFR. They are currently exploring how their individual, community, provider, facility, and systems-level MMR recommendations could best fit with this regional prevention model to address risk across the life course.

**MT.** Montana's [Fetal, Infant, Child, and Maternal Mortality Review](#) (FICMMMR) program was established in 1997 through legislation and was amended by the 2013 Legislature to include the review of maternal deaths. FICMMMR is housed in the Family and Community Health Bureau (FCHB) at the MT Department of Public Health and Human Services. Montana has 31 county mortality review teams, which are defined in state statute. Due to the state's rural population, 23 other counties utilize a neighboring county's FICMMMR team to help review their county deaths and help generate evidence-based and best practice prevention recommendations. The recipient county is responsible for implementing evidence-based or best practice prevention initiatives in their county. The cooperative agreement serves as an efficient use of review resources for the 54 counties and seven American Indian Reservations. They have developed a [FICMMMR Team Operational Plan](#) that can be modified as necessary.

**NE.** The Nebraska Child and Maternal Death Review Team (NCMDRT) was established in 1993 by legislation, with authority for maternal deaths added in 2013. Funds from the MCH Block Grant support the program with an annual budget of \$70,000. Funding for the program is year-to-year. The program is housed out of the Nebraska Department of Health and Human Services. There are 1.2 FTEs that staff the program and .25 in kind staff. Nebraska is a member of the Midwest Regional CMDR coalition. A [report from 2017](#) is available for review.

**NJ.** New Jersey's Department of Health and Senior Services received funding from MCHB to institute a Mortality/Morbidity Review Project. The goal of this project is to enhance the mortality/morbidity infrastructure in New Jersey by integrating functions of the New Jersey FIMR and Maternal Mortality Review in the Department of Health and Senior Services and the Child Fatality and Near Fatality Review in the Department of Children and Families.

**PA.** The Pennsylvania [MMRC](#), [CDR](#), and SUID Case Registry activities sit in the Pennsylvania Department of Health's Bureau of Family Health. The programs are managed under different divisions within the larger Bureau organizational structure. CDR and the SUID/SDY Case Registry share programmatic staff. The state subcontracts with Philadelphia's medical examiner's office to conduct SDY reviews in the local jurisdiction. **Collaboration Innovations:** The Pennsylvania Department of Health is in the process of cross-walking and comparing MMR findings and recommendations with findings in their CDR data to explore how these data may identify similar issues or solutions. The Department of Health created a "Working with Coroners and Medical Examiners Workgroup." The group includes all offices who make records requests to coroners and medical examiners in the state, including CDR, MMR, SUID/SDY Case Registry,

National Violent Death Reporting System, Overdose Fatality Review, Prescription Drug Monitoring Program, and Injury Prevention. This group holds quarterly calls to discuss how to streamline and make effective data requests.

**WV.** West Virginia's Fatality and Mortality Review Team began as a voluntary CDR process in 1994 and was put into statute in 1996. In 2013 [new legislation](#) was enacted and WV Code §61-12A-2 created the Unintentional Pharmaceutical Drug Overdose Fatality Review and combined Child Death Review, Domestic Violence Fatality Review and the Infant and Maternal Mortality Review Teams as one.

### **Benefits of Merged Child Fatality and Maternal Mortality Review Teams**

The follow has been summarized from NCFRP's guidance report: [Enhancing Collaboration Across Maternal and Child Fatality Review Programs](#) and webinar: [Enhancing Collaboration Across Maternal and Child Health Fatality Review Programs](#).

- There are several benefits in aligning the work of child and maternal death review committees including maximizing resources, reducing redundancy, and learning from the success of a parallel program.
  - Shared functions across all review committees: death identification, records request to inform case review, convening multidisciplinary teams, review individual cases, make determination about individual cases, make prevention recommendations, compile aggregate data, and share data with additional community collaborators to move data forward to catalyze action.
- Recommendations for collaborating on essential functions among review teams:
  - Recommendation 1: Formalize coordination of different review programs within states and/or locales.
  - Recommendation 2: Improve communication throughout the case preparation process.
  - Recommendation 3: Share data from different reviews to support planning objectives.

### **Implementation of Merged Child Fatality and Maternal Mortality Review Teams**

The follow has been summarized from NCFRP's guidance report: [Enhancing Collaboration Across Maternal and Child Fatality Review Programs](#) and webinar: [Enhancing Collaboration Across Maternal and Child Health Fatality Review Programs](#).

- Before merging review committees, programs should review relevant agreements including:
  - Data use agreements, vital records agreements, interagency agreements, memoranda of understanding, agreements with health systems for medical records, confidentiality agreements, interview consent forms, Institutional Review Board (IRB) approvals.
- There are several considerations when considering merging Child Fatality and Maternal Mortality Review teams. Initial considerations may include:

- Legal Authority - Identify relevant statutes and policies that impact information sharing between programs.
- Institutional Agreements – Review existing agreements with organizations to identify opportunities and limitations; consider amendments.
- Interviews – Determine if information from interviews can/should be shared and if so, how.
- Strategies for Merging Fatality Review Teams:
  - Formalize coordination of different review programs within jurisdictions.
    - Examine leadership, membership, and funding strategies to support formalized program collaboration.
  - Improve communication throughout the case preparation process.
    - Consider collaborative approaches to records access and family/informant interviews.
  - Jointly disseminate reports and other information to amplify shared messages.
    - Amplify shared or related team findings, coordinate prevention activities, and disseminate data to achieve collective impact.
  - Share data collected from different reviews to support planning objectives.
    - Explore data compilation, data entry, and data sharing strategies to improve program alignment.

## Current Literature

Harris S. [Best Practices and Areas of Improvement in Child Death Review: A Qualitative Analysis to Inform Policy Change in Illinois](#) (2021). 21 professionals who serve on child death review teams agreed to participate in this qualitative research study. Interviews were conducted using a semi-structured open-ended format. Interviews were transcribed and then hand coded for recurring themes, similarities, and differences among participants.

Quinton RA. [Child Death Review: Past, Present, and Future](#). *Acad Forensic Pathol.* 2017 Dec;7(4):527-535. This article describes the current state of child death reviews (CDR) in the United States. The CDR process has evolved over almost 40 years from informal local meetings to a coordinated effort involving all 50 states.

Albright, D., Banks, L., Broidy, L., Crandall, C., & Campos, G. (2013). [Ethical Conundrums in Fatality Review Planning, Data Collection, and Reporting: Viewing the Work of Review Teams Through the Lens of Evaluation](#). *Homicide Studies*, 17(4), 436–456. Using the Guiding Principles of Evaluation recommended by the American Evaluation Association (AEA), this paper begins an exploration of potential ethical conundrums faced by domestic violence fatality review teams and identifies suggestions for ensuring that the teams have the necessary tools for ethical practice.

Shanley JR, Risch EC, Bonner BL. [U.S. Child Death Review Programs: Assessing Progress Toward a Standard Review Process](#). *American Journal of Preventive Medicine*, 39(6) 2010,

522-528. The purpose of this study was to conduct a systematic review of the 50 states and District of Columbia CDR programs, with specific focus on the use of standardized procedures and best-practice recommendations. This included assessment of which deaths are reviewed, the model of review, team membership, and standardization of data collection and reporting.

Wirtz SJ, Foster V, Lenart GA. [Assessing and Improving Child Death Review Team Recommendations](#). *Inj Prev*. 2011 Feb;17 Suppl 1:i64-70. A descriptive, non-experimental design was used to analyze publicly available state and local CDRT reports. An assessment instrument, modelled on the public health approach, was developed to score the quality of recommendations. It consists of three components divided into 10 dimensions: problem assessment; written recommendations; and action on recommendations.

Kramer MR, Strahan AE, Preslar J, Zaharatos J, St Pierre A, Grant JE, Davis NL, Goodman DA, Callaghan WM. [Changing the Conversation: Applying a Health Equity Framework to Maternal Mortality Reviews](#). *American Journal of Obstetrics and Gynecology*, 221(6), 2019, 609.e1-609.e9. By considering evidence-informed community and regional resources and policies for addressing causes of health inequity, novel prevention recommendations, including recommendations that extend outside the realm of the formal health care system, may emerge.

## Seminal Historic Literature

This study falls outside of the Evidence Center's approach of highlighting resources from the past 10 years, but is a good introduction to key concepts. However, the reader should understand that the field has changed since the report was published; as such it should be viewed within an understanding of its time.

Hutchins, E., Grason, H. & Handler, A. [FIMR and Other Mortality Reviews as Public Health Tools for Strengthening Maternal and Child Health Systems in Communities: Where Do We Need to Go Next?](#). *Maternal Child Health Journal* 8, 259–268 (2004). This article examines FIMR in relationship to two other maternal and child health mortality reviews—child fatality review (CFR) and maternal mortality review (MMR), and explores how their approaches to reviewing deaths can complement one another. Identifying opportunities for collaboration among these case review methodologies may lead to greater efficiencies at the local and state levels and strengthen the case review approach as a public health tool for improving maternal and child health outcomes.