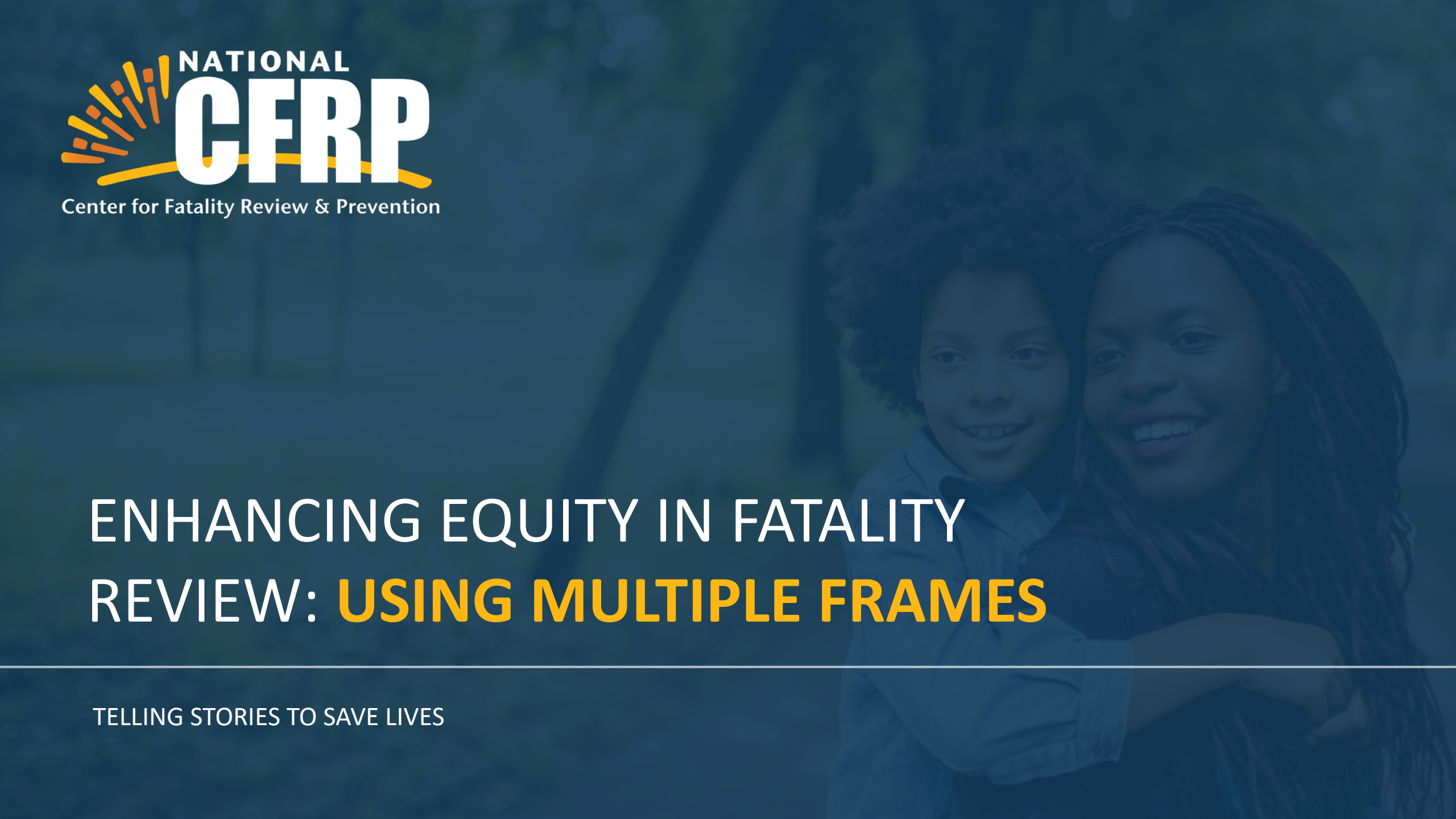
ENHANCING EQUITY IN FATALITY REVIEW: USING MULTIPLE FRAMES

TELLING STORIES TO SAVE LIVES

Abby Collier, DrPH | Director | National Center for Fatality Review and Prevention

NATIONAL CFRP

Center for Fatality Review & Prevention



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TELLING STORIES TO SAVE LIVES

Prioritizing Personal Wellbeing

The content of today's meeting may include information about individual or aggregate fetal, infant, or child deaths. This may evoke strong feelings or other distress. Please prioritize your own wellbeing during this meeting, even if you need to step away from the meeting. Contact the Suicide & Crisis Lifeline at 988 via phone or text for additional support.

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 48 states and provides jurisdictions with real-time access to their fatality review data.

Resources

Training modules, webinars, written products, newsletters, list-serv, website and more.

Communication with Fatality Review Teams

Regular communication via listserv, newsletters and regional coalitions.

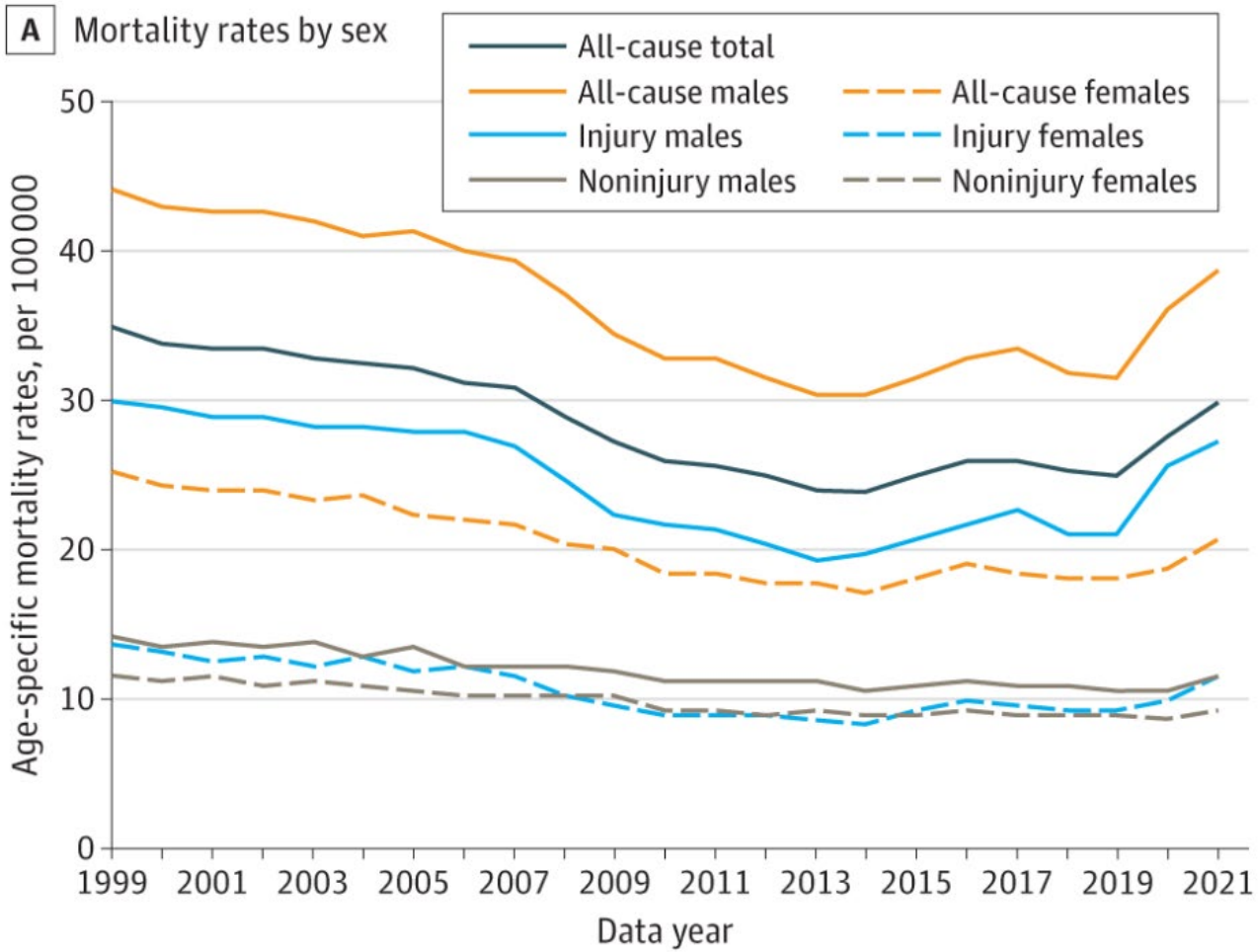
Connection with National Partners

Develop or enhance connections with national organizations, including federal and non-federal partners

ABOUT THE NATIONAL CENTER

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

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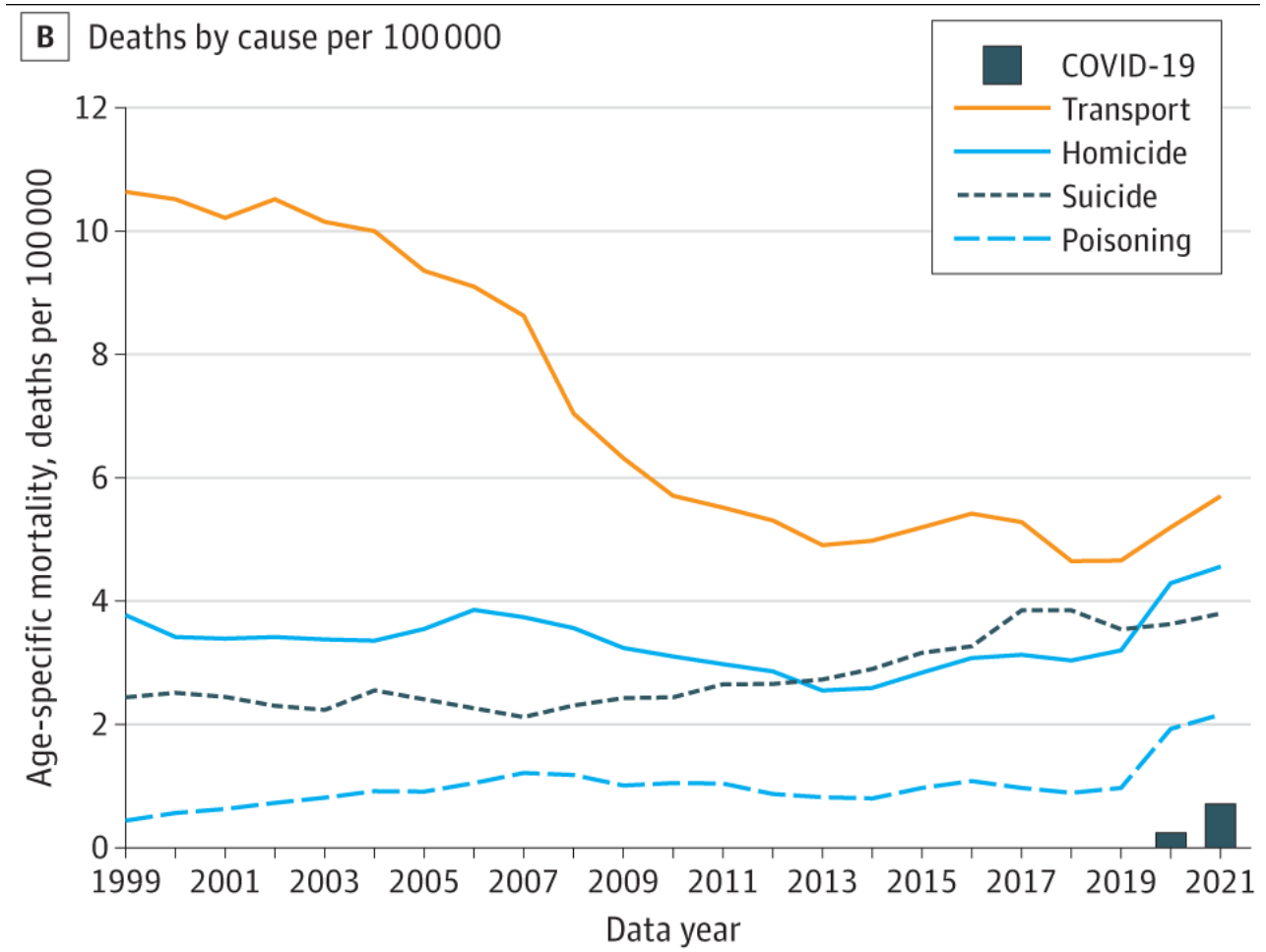

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Cause for Concern

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*.

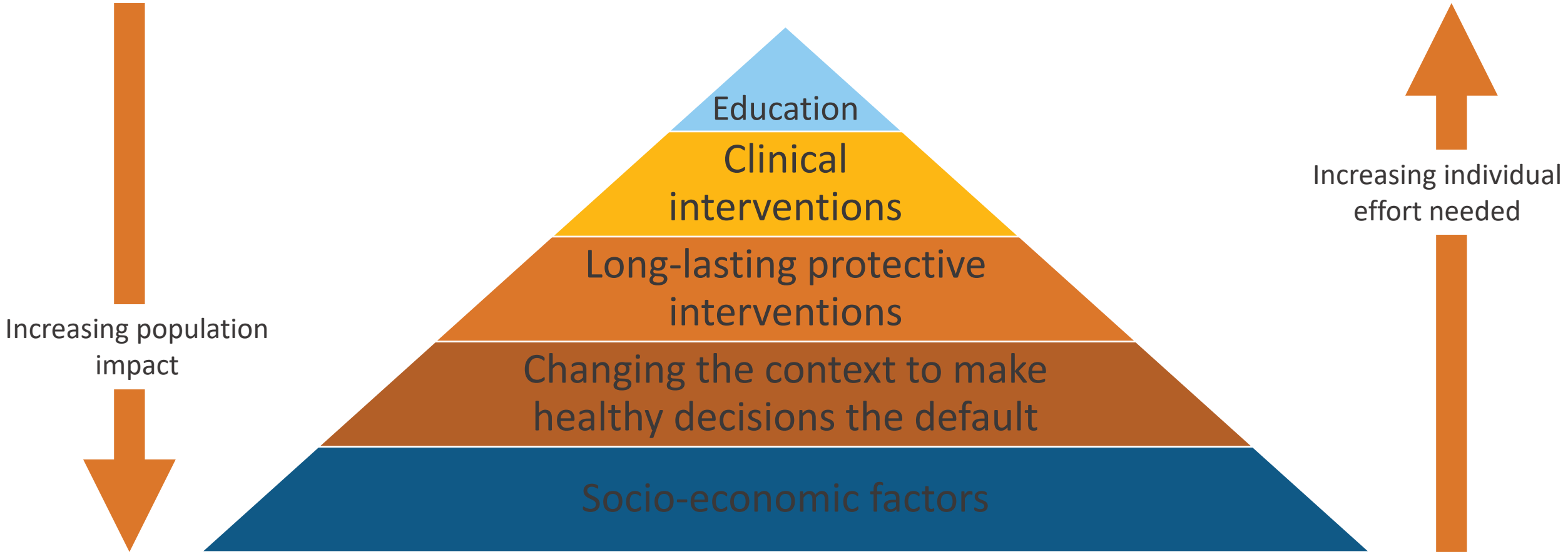
Meet Jane

A Mock Case

Jane is a three-month-old, Black female who was found unresponsive in an adult bed that she was sharing with her brother (age 4) and mother (age 21). Jane lives with her family in a one-bedroom apartment. Mom works the night shift (12am-8am). Mom's sister supervises Jane and her brother overnight while mom is at work. Due to her income, mom has difficulty paying rent and the family moves frequently.

Spectrum of Prevention

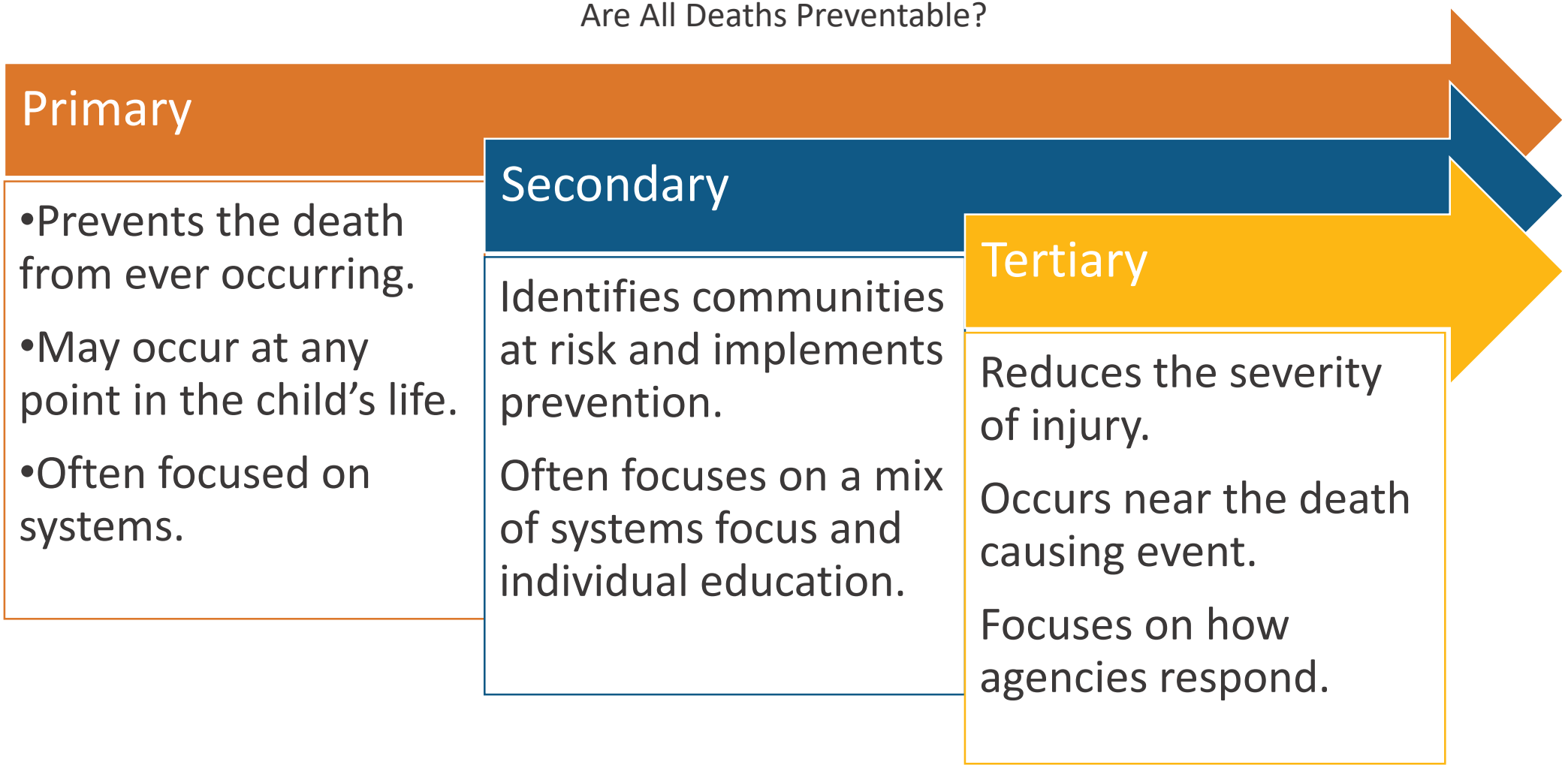
Individual effort balanced with population impact



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

Preventability

Are All Deaths Preventable?



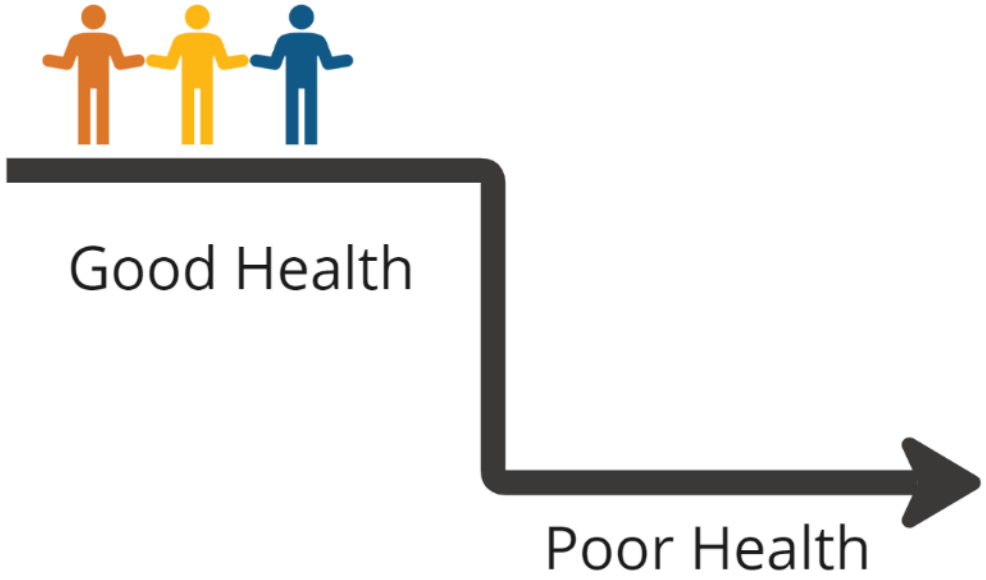
Timelines for Preventability

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



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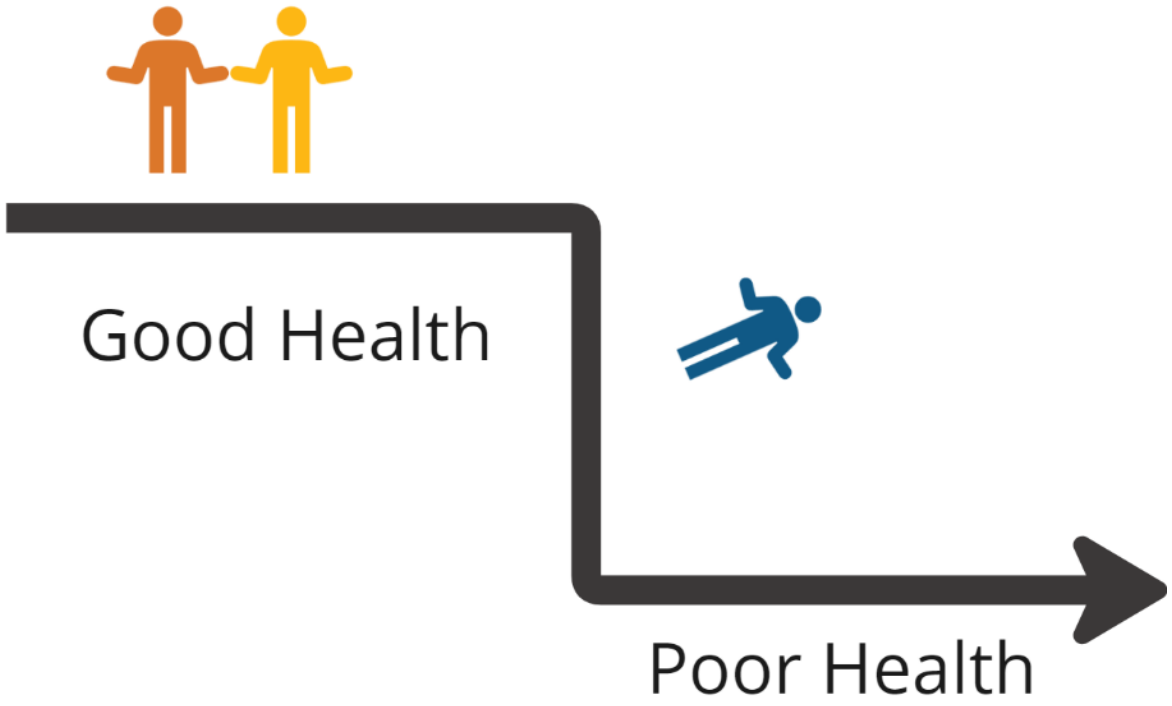

Differences in the Cliff of Good Health

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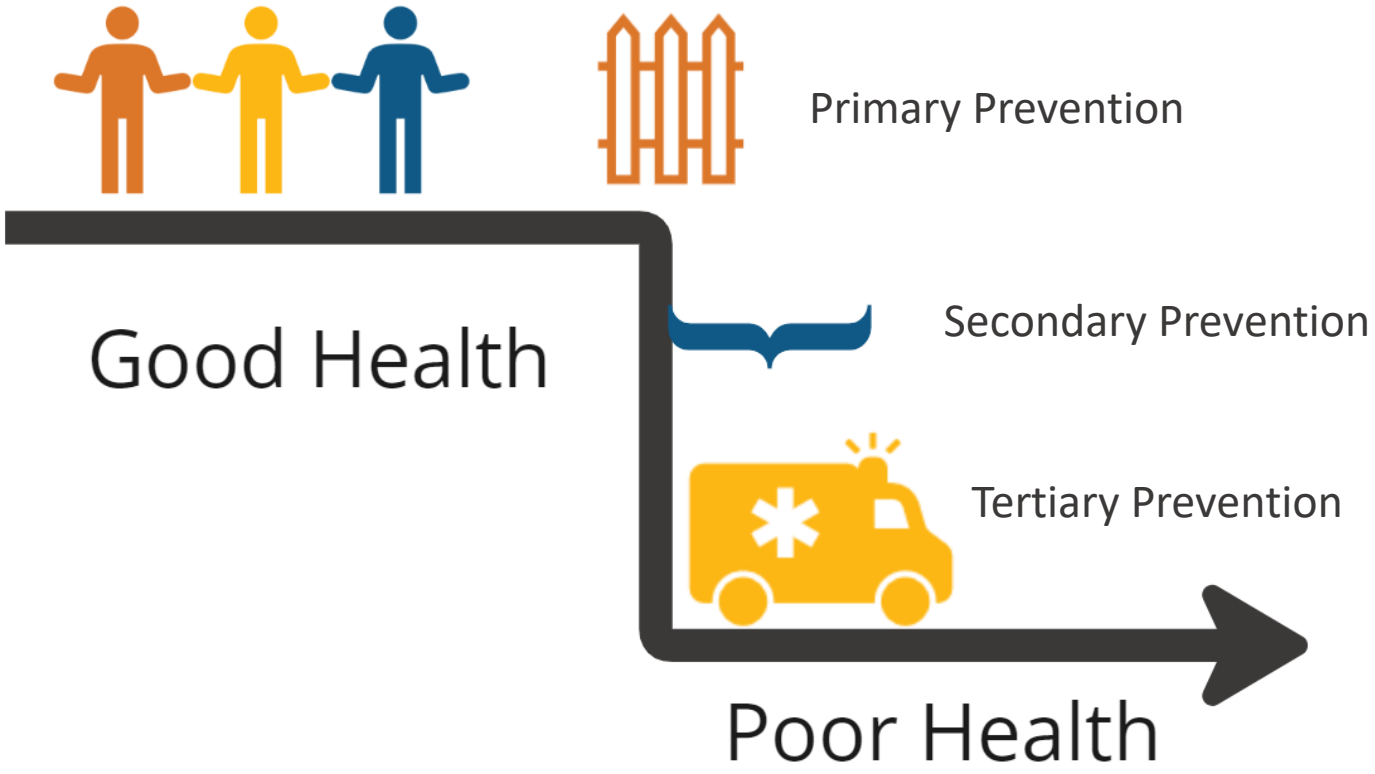

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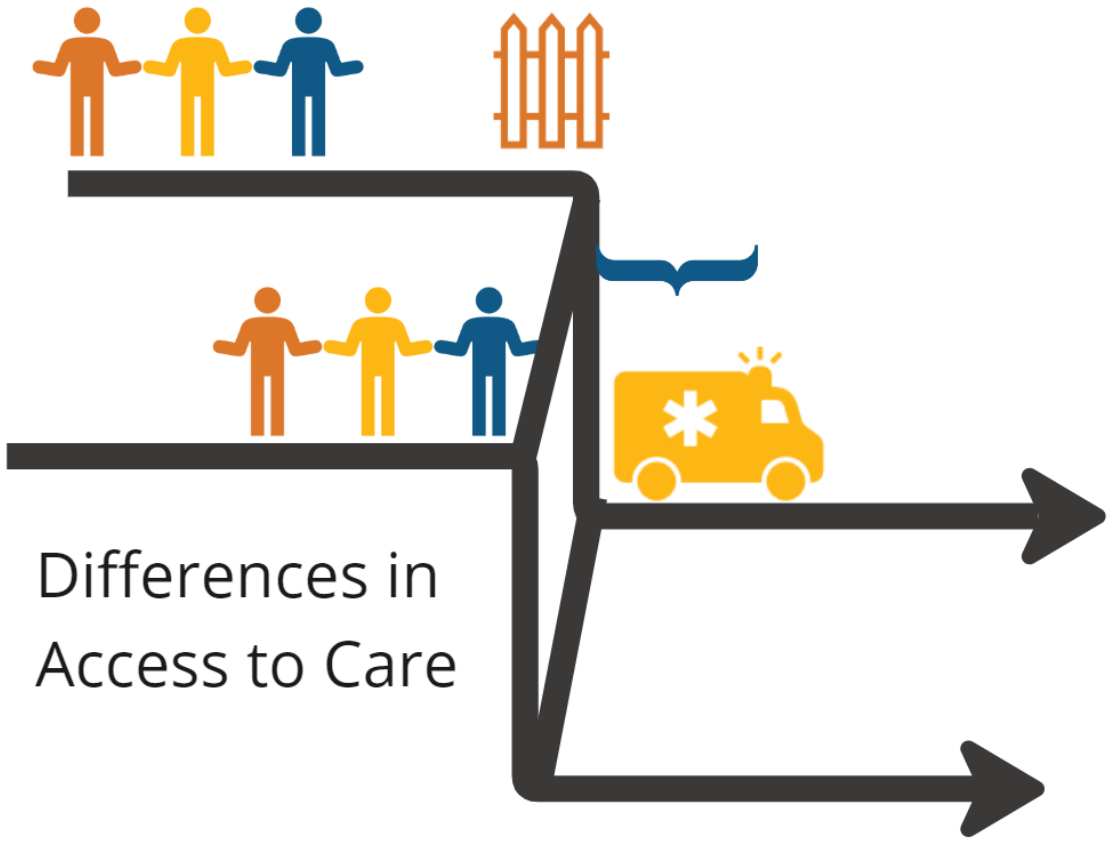

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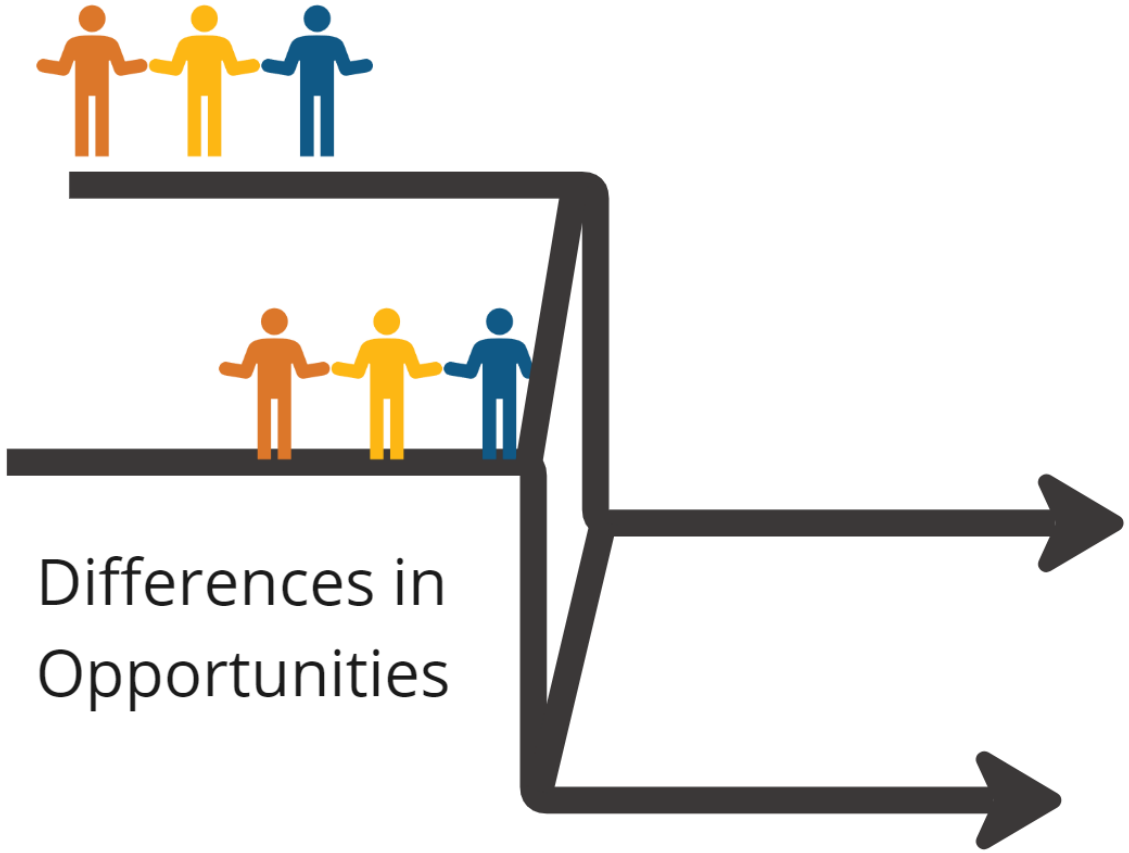
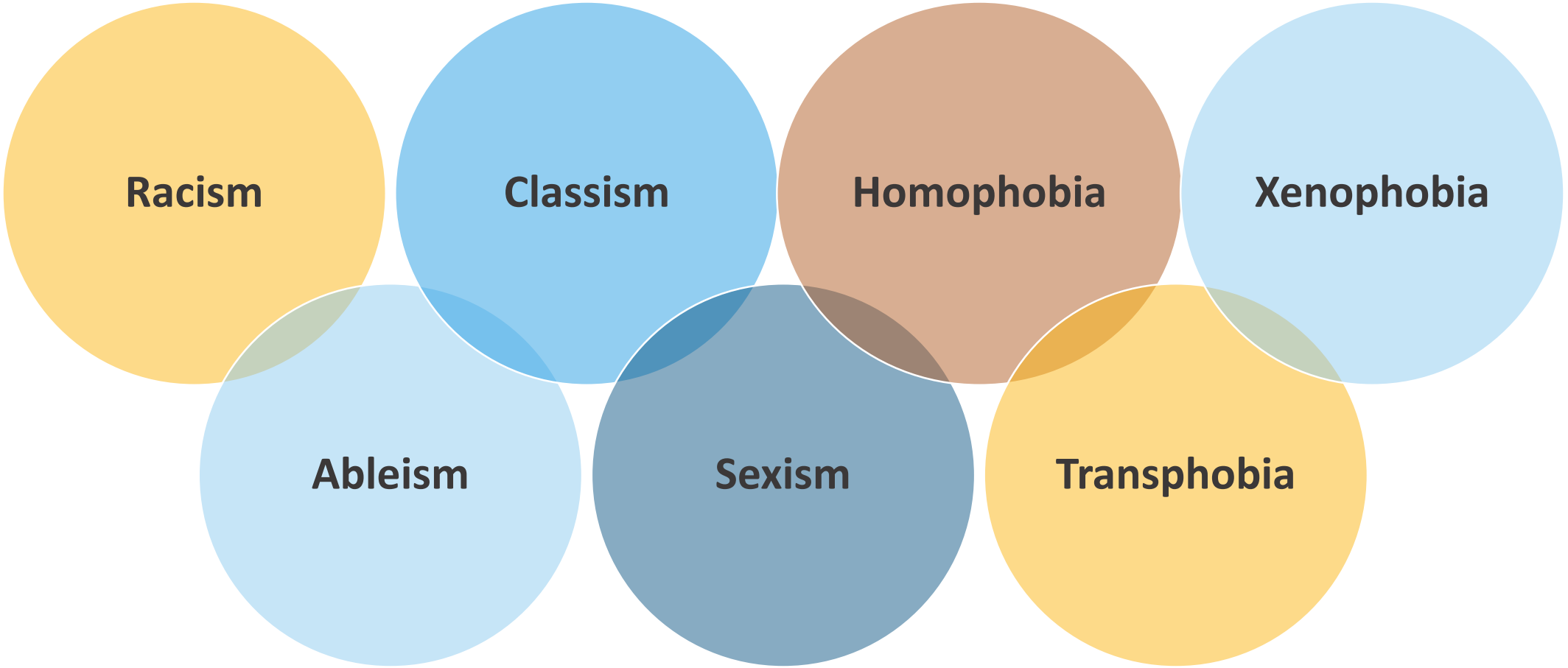
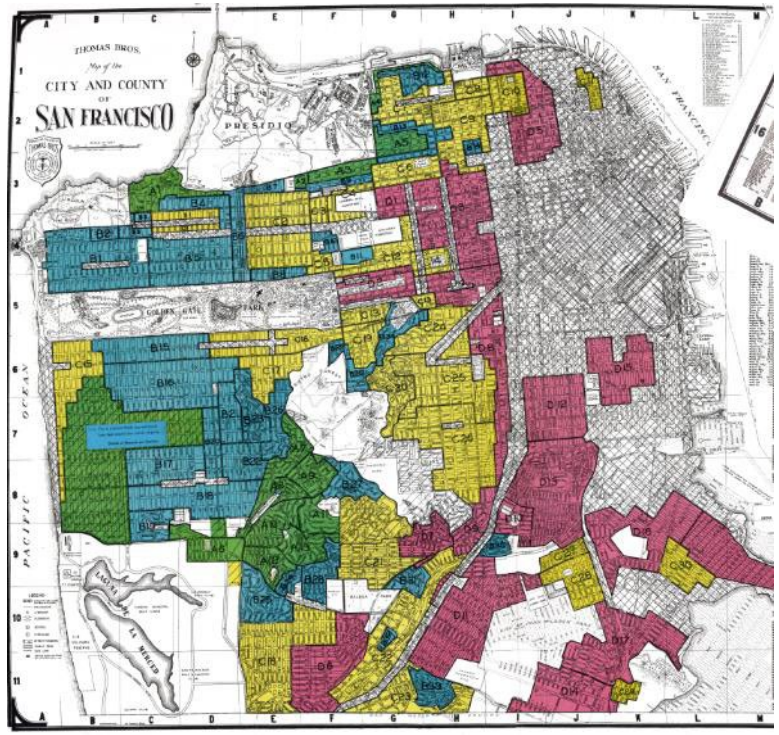


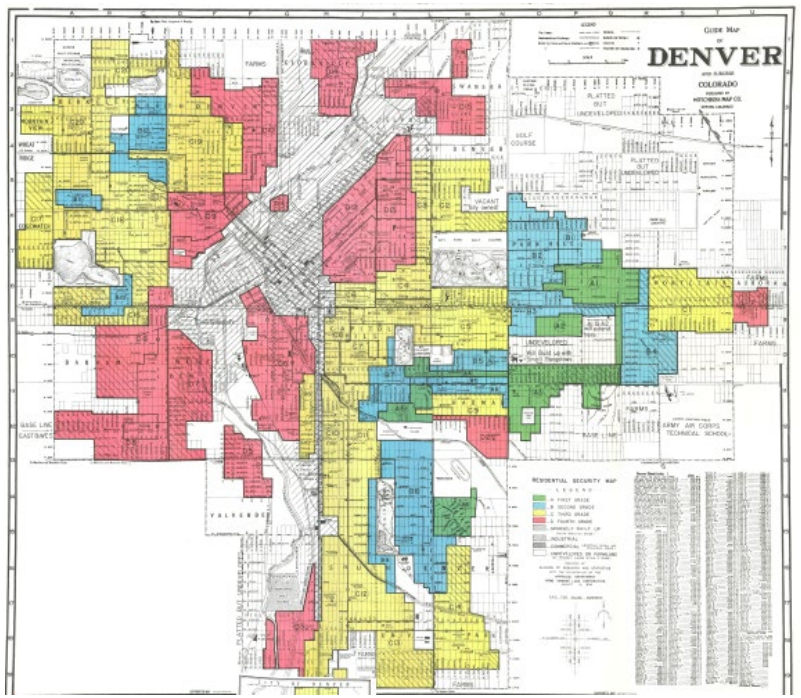
Structural and Cultural “-isms”

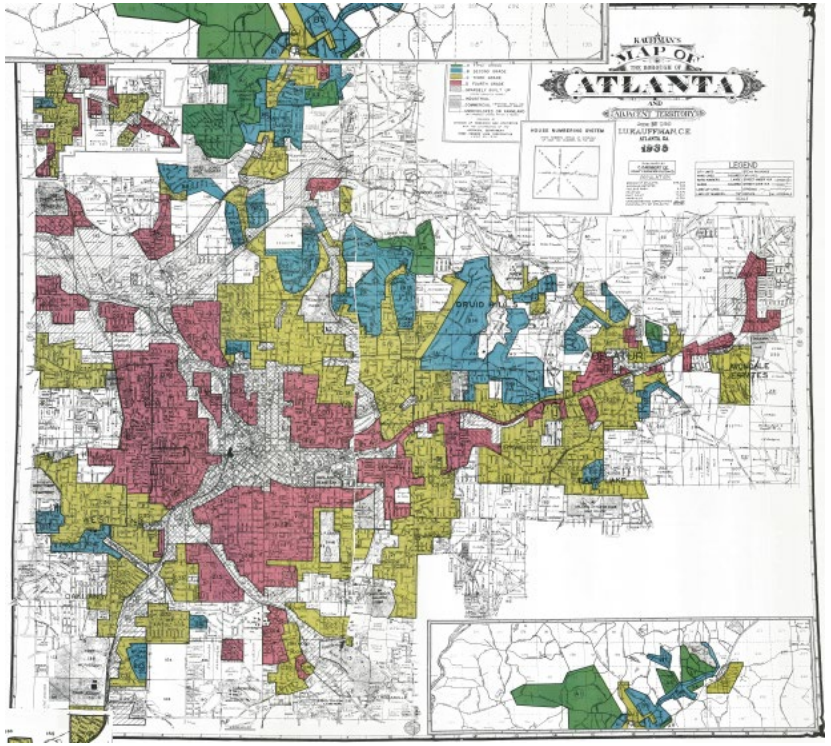


Redlining in the U.S.

Source: Mapping Inequality

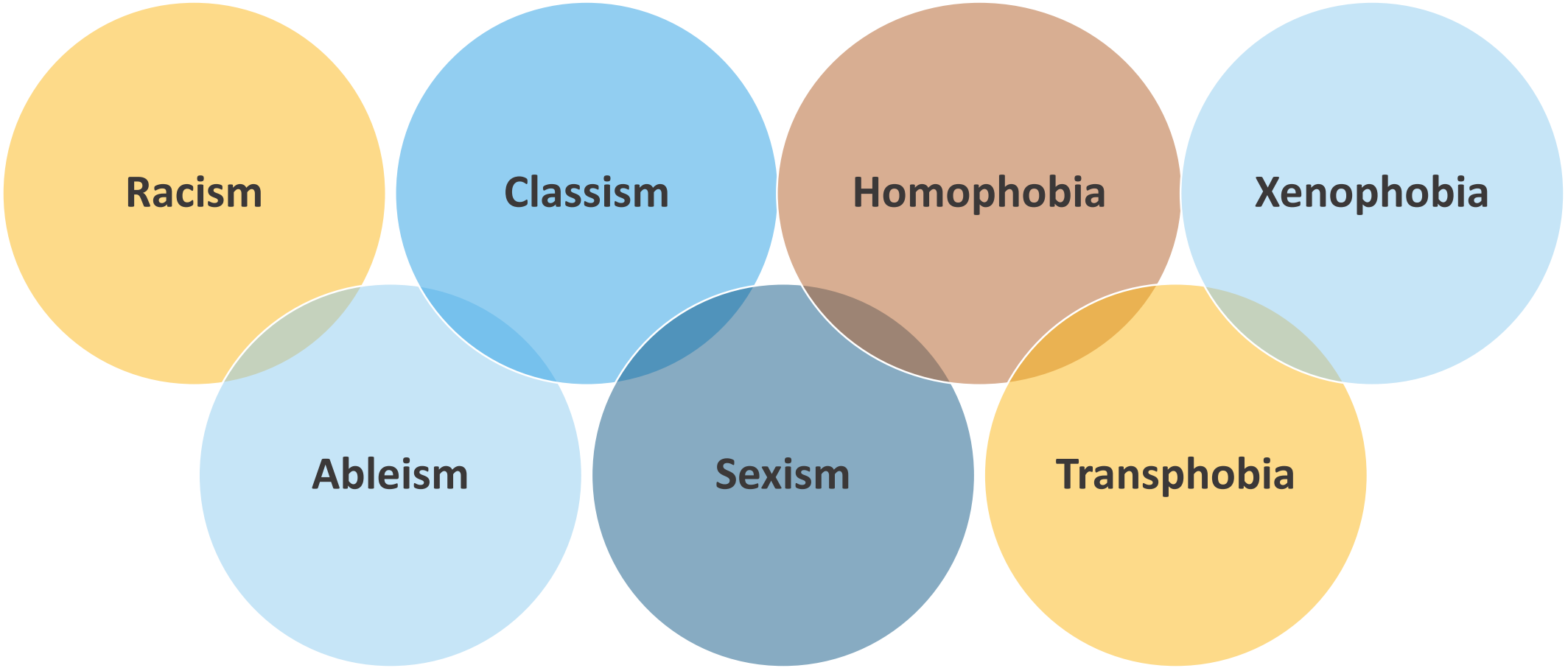






Structural and Cultural “-isms”

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

IMPLICITY 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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