National Center Update:
HEALTH EQUITY IN FATALITY REVIEW

Telling Each Story to Save Lives Nationally
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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.
Cause for Concern

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

Cause for Concern

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

Cause for Concern

Widening Disparities

1. CDC WONDER: 2018-2021, ages 0-17 years old.

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
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

Education

Clinical interventions

Long-lasting protective interventions

Changing the context to make healthy decisions the default

Socio-economic factors

Preventability

Are All Deaths Preventable?

Primary
Prevents the death from ever occurring.
May occur at any point in the child’s life.
Often focused on systems.

Secondary
Identifies communities at risk and implements prevention.
Often focuses on a mix of systems focus and individual education.

Tertiary
Reduces the severity of injury.
Occurs near the death causing event.
Focuses on how agencies respond.
### 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*
- **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)

#### Secondary:
*At the time of the incident*
- **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.)

#### Tertiary:
*In response to the incident*
- **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

Jones CP et al. *Journal Health Care Poor Underserved* 2009
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
The Cliff of Good Health

Jones CP et al. Journal Health Care Poor Underserved 2009

Differences in Quality of Care
The Cliff of Good Health

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

Differences in Access to Care
The Cliff of Good Health

Jones CP et al. Journal Health Care Poor Underserved 2009
Structural and Cultural “-isms”

- Racism
- Classism
- Homophobia
- Xenophobia
- Ableism
- Sexism
- Transphobia
Redlining in Nashville, Tennessee

Source: Mapping Inequality, 1939
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

- Acknowledge your biases
- Challenge your negative biases
- Be empathetic
- See differences
- Be an ally
- Recognize that this is stressful and painful
- Engage in dialogue
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

- 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

- 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
Disrupt Bias and Incorporate Equity Into Fatality Reviews

- 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
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

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

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