Intentional Death Prevention Committee
March 12, 2012
Approved Minutes (Approved September 10, 2012)

In attendance: Dr. Elaine Cabinum-Foeller, Michelle Hughes, Sen. Austin Allran, Patrick Betancourt, Sarah Currier, Alan Dellapenna, Gloria Hale, Rep. Craig Horn, Trishana Jones, Catherine Joyner, Leslie Karkanawi, Kevin Kelley, Earl Marett, Kristin O'Connor, Amy O'Neal, Scott Proescholdbell, Krista Ragan,

By phone: Deanna Fleming, Laura Louison

Dr. Cabinum-Foeller welcomed participants.

The minutes were moved by Kevin Kelley, seconded by Earl Marett and unanimously affirmed.

Messages to New Parents

Elizabeth Hudgins presented on a recommendation from the Perinatal Health Committee to appropriate $50,000 in nonrecurring funds relating to Prenatal and Postpartum Patient Education. This work began through PHC as an attempt to coordinate messages to new parents in hospitals. Currently, breastfeeding, smoking cessation, Period of Purple Crying, Safe Sleep and others work with hospitals to assure that important messages are provided. However, research shows messages should be bundled and delivered more than one time immediately after birth to have a strong affect. The time for such message dissemination is particularly ripe given the roll out of Pregnancy Medical Homes. A full description, handed out at the meeting, is appended at the end of the minutes.

Child Maltreatment Surveillance Update

Full presentation is available on-line under Intentional Death Prevention.

Alan Dellapenna presented on work from the Injury and Violence Prevention (IVP) Branch. The CFTF has been supportive of enhanced surveillance work for many years, at one point recommending funding for these efforts.

Public health surveillance is the on-going, systematic collection of health data to understand and address health problems. Part of surveillance is managing and analyzing data from various sources to determine variations in expected patterns to identify and address problems. It allows us to quantify the size of the problem and to determine stronger prevention strategies.

While surveillance has been an issue for many years, only recently has IVP received money to devote dedicated resources to improving surveillance. IVP recently received a five-year grant of statewide surveillance is one piece and a 3 year grant from the John Rex Endowment to focus on surveillance as it relates to child abuse and neglect (child maltreatment) in Wake County. The Wake Child Maltreatment Surveillance project can serve as an incubator to identify data sources and key partners for expanding surveillance into other counties at a later time.

Rep. Horn was concerned why the effort was focused in Wake County. The John Rex Endowment funding is limited to Wake. Rep. Horn clarified that we knew as a fact that no other county is doing this well. Catherine Joyner confirmed that and noted that once we figure out the key components for Wake we can apply it to other counties across the state.

Sen. Allran asked if such a system would have helped track the data for Zahra Baker, a child whose step-mother was convicted of her murder. One factor in the case was that many of the reports of abuse and neglect of the family were in Caldwell County and the family then moved to Catawba. The NC FAST case management system that is still being developed would have captured these types of transitions from county to county. Surveillance data is designed to track overall trends to better understand some of the cases that get missed by any one system alone.

Earl Marett noted that case automation was needed. There was some discussion on NC FAST.

Finalize Recommendations for Full CFTF
The following recommendations were approved for forwarding to the full CFTF. The motion was made by Catherine Joyner and seconded by Sen. Allran.

2012 Short Session

- Maintain existing support for surveillance efforts and monitor policies/funding cuts that would reduce data robustness or information about child death and injury, including
    - Key data collection systems including instruments, IT, and staffing for NC Child Fatality Prevention Team, Behavioral Risk Factor Surveillance System, Violent Death Reporting System, PRAMS and CHAMP, etc.
    - Staff positions such as those relating to the State Child Fatality Prevention Team, DSS Child Death Reviewers, etc.
    - NC FAST
- Maintain existing support for evidence-based prevention, screening and treatment programs for FY12-13, including
    - Child Medical Evaluation Program
    - Child Advocacy Centers
    - Child Treatment Program
    - Suicide gatekeeper programs, such as ASIST and QPR
    - Child physical and behavioral health services
    - Other primary prevention programs and services
- Monitor policies that would change access to lethal means by depressed or suicidal teens
- Support $50,000 NR for to further prenatal, postpartum patient education best practice, especially through Pregnancy Medical Home roll-out
- Continue to endorse from last year's agenda recommendations from the NC Coalition Against Domestic Violence and the Domestic Violence Commission that affect children:
    - Improved tracking of DV cases (H176 – passed House 116-0)

Administrative Recommendations and Monitoring for 2012

- Monitor administrative activities promoting evidence based programs, promising practices and evidence-informed strategies

- Promote strategies that integrate service delivery and data systems for children and families receiving support from multiple public agencies
- Support administrative efforts to improve e-codes
- Track use of elements from the High Priority Infant Program screening tool
- Support enhanced surveillance efforts

Issues to Explore for 2013 Long-Session

- Institutionalize funding and support for the Child Treatment Program so that we can assure evidence-based mental health treatment for children and youth is available in NC and is done with fidelity
- Support increased screening and stronger linkages to appropriate medical/mental health treatment for children and youth with mental illness and trauma symptoms, including teens at-risk for suicide
- Promote greater use of Evidence Based Programs (EBP) implemented with fidelity (including rostering, coaching, data collection/program evaluation, preparation time) to build resiliency and prevent death, violence and other negative outcomes
- Maximize use of existing infrastructure to support EBP with fidelity
- Improve support of surveillance
- Monitor children with psychotropic prescriptions

Much of the discussion was around the use of e-codes and follow-up work on psychotropic meds for the 2013 session.

Health care uses a set of code numbers to describe the diagnosis and causes of disease and injury, the code definitions are reached by international consensus under the World Health Organization and know as the International Classification of Diseases (ICD). The diagnosis codes are N-codes, an injury example would be a broken arm. In the US, N-Codes are the basis for billing and reimbursement, hospitals are highly motivated to provide complete and accurate N-codes. The external cause (E-code) of the broken arm could be a fall, car crash, fight, sports-related, etc. E-codes are primary public health tools to describe the cause of injury across a community and state. E-codes are not linked to billing and far less consistently coded. Hospital staff may not see the benefits of their use. Thus motivation to fill them in properly may be low. Improving the quality and consistency of e-coding is key in improving NC's ability to describe, understand, and prevent injury. Dr. Cabinum-Foeller noted that as a doctor, she does not fill in the e-code; it is filled in by someone else in the hospital relying on her notes. Scott Proescholdbell added that NC was one of a handful of states working with CDC on e-code quality. Gloria Hale asked who set the standard for the e-code. Alan Dellapenna replied it was set internationally.

Sen. Allran was concerned that young people who have trauma are prescribed psychotropic medications and then not monitored by a specialist in follow-up. Michelle Hughes echoed that was an issue of national concern as well and that a lack of child psychiatrists was also a factor. Kevin Kelley added that federal legislation will likely require more tracking of the issue so that input from IDPC could be particularly helpful. Dr. Cabinum-Foeller noted that with good counseling, the meds can often be ramped down. Trishana Jones noted that kids often want to be off their medications – that the drugs have undesirable side effects or the youth just don't like taking them – but need help sometimes to stop taking them safely. Sen. Allran noted that new

efforts requiring identification for prescription medications were a good step in the right direction.

Language will be slightly modified and provided to IDPC participants prior to April 16th full CFTF meeting for their review.

Training to Recognize and Refer Child Maltreatment

Sarah Currier from Prevent Child Abuse reported that PCA recently posted an on-line training to help professionals and other recognize signs of possible maltreatment and refer families to DSS for assistance. This work builds on years of training and is possible because of DSS support. It is free to anyone in the state and was designed with professionals in mind. Helping people overcome barriers to responding is a key component. Their goal was that 100 people use it in the first year. In less than 6 months, more than 523 people have gone through the training and 99% have passed the post-test. Users include county CPS staff, law enforcement, social work, and teachers. The majority of people using the training are child care workers. Here is the link: http://www.preventchildabusenc.org/index.cfm?fuseaction=cms.page&id=1047

Andrea Lewis from the Division of Child Development reported the resource has been very well received by child care providers. Providers must get training within the first two weeks of teaching. The PCA web-based resource meets the training requirement and does not require travel. It also meets the annual continuing education requirement. Traditionally, child care teachers are among the least likely to refer families to DSS for services and this training may help improve that statistic.

Gloria Hale asked how often professionals should undergo training. Sarah Currier suggested annually to keep current and noted that the training would be updated as needed.

DSS Update

Kevin Kelly reported on a variety of DSS Efforts.

NC FAST (Families Accessing Services Through Technology) is a technical tool that better manages case data and allows information to be shared across county lines. Various information systems for services provided through the Department of Health and Human Services will be coordinated. SNAP (formerly known as Food Stamps) will be the first system to go live. Roll-out for the DSS section is anticipated in about 18 months. Much upfront work is needed to determine the data that is needed without requiring too many screens for workers to fill out. Data is the means to better case management, not the end goal. The State DSS is working with counties to assist in development to assure that county needs are met.

Sen. Allran asked if data could be linked with school records. NC Wise handles school records and the systems are not planned to be linked at this time. Sen. Allran followed up asking how a county will know that a school needs to be involved when a child moves. Mr. Kelley noted that DSS records often have some school information in their files that will be shared across lines; however, DSS will not be involved in a closed case. (For example, if a family with a report of abuse that has been unsubstantiated moves across county lines; or a family who received services

and then had their case closed moved across county lines.) Dr. Cabinum-Foeller added that it can be hard for a school in any county to know that a child's family has been involved with DSS.

Sen. Allran wanted to know if we fully implemented NC FAST if that would prevent another Zahra Baker case. Mr. Kelley noted that there were no guarantees, but the reports from County A will now show up for County B if a family moves to help better predict a pattern.

Trishana Jones asked if caseworkers will have the technology to actually use NC FAST. Mr. Kelley noted that hardware is a county responsibility and that the state will provide the system that will be accessed with that hardware. Earl Marett added that Johnson County was assuring that their caseworkers had the tools to use NC FAST appropriately.

Child Welfare Services Innovations and Improvement Act. This federal legislation includes requirements for states to develop protocols for the appropriate use and monitoring of psychotropic medications for children in the foster care program.

Child and Family Services Review: National analysis shows that states are doing fairly well at safety and particularly at permanency for children but more needs to be done on broader well-being. Mental health data on children who have been maltreated but never involved with the system function as adults similarly to maltreated children who have been DSS involved. Thus, simply addressing safety is not helping the life trajectory as much as it should. Trauma informed care is an important strategy for minimizing the negative impact and treating the problem.

NC is one of five states to get federal money from a discretionary grant to address trauma in the child welfare system. Pilots will operate in 9 counties to educate the child welfare system on trauma treatment techniques. Evidence-based programs implemented with fidelity, such as Child Treatment Program, will be used. Pilots will focus on children most likely to enter foster care (very young children and older teens).

Sen. Allran wanted clarification on the study that DSS involvement did not appear to help children long-term. Mr. Kelley said he was reporting the findings of Bryan Samuels, Commissioner of the federal Administration for Children and Families who conducted a retrospective analysis of children with traumatic backgrounds, regardless of DSS involvement. Indicators reviewed included job, homeless, substance abuse and serious relationships.

Sen. Allran asked if children who were adopted fared better. Mr. Kelley was not aware of studies specifically on that. He noted that adoption itself does not overcome trauma, which is why DSS provides supports to adoptive families.

Sen. Allran summarized that it was trauma that led to poor outcomes, not involvement in the foster care system.

Rep. Horn was very concerned that it appeared that all efforts were for naught if outcomes did not improve. He asked for guidance on how to respond to constituents who complain that the State spends too much money on feel good programs that don't work. Would it be better to do a few things really well instead of going off in a myriad of directions?

Kevin Kelley noted that we are getting the very important outcomes of safety and permanency. Alan Dellapenna noted that successes have focused on shorter-term measures, such as safety and permanency and that longer-term approach to healing are relatively new. Mr. Kelley added that the federal trauma grant helps us know where to focus moving forward.

Sen. Allran asked if Mr. Kelley could help the CFTF prioritize funding and what should be emphasized since the goal of the CFTF is to make targeted recommendations.

Mr. Kelley noted that it was important to be as scientific as possible moving forward. Data from NC FAST will help to target efforts. Other states experience similar difficulties.

Rep. Horn recognized that sometimes the effort was as important as the result, but also noted that we can't be all things to all people.

Dr. Cabinum-Foeller agreed, adding that was why it's it so important to be as evidence based as possible to get the desired results. She said harder questions could come later if we are asked to prioritize IDPC recommendations.

Earl Marett offered his Johnston County experience. They have an adolescent pregnancy program aimed at reducing second births. Nationally, 40% of teen mothers have a second baby. In Johnston County, that is 5%. He has data for that program as evidence of its success. Another program (LINKS) links teens in foster care with internships. Feedback is very positive but he does not have data on the impact of that program once teens become adults.

Community Response Program: Kristin O'Connor reported on the Children's Trust Fund. In 2002, the CFTF supported legislation to create Kids First license tags with the funds going to prevent child abuse. The funds had been at the Dept. of Public Instruction but were moved over to DSS in 2009. DSS is using $1.2 million over three years to pilot a Community Response Program (CRP). To focus on the highest need families and address situations where there are multiple reports but no substantiated cases of abuse and neglect, the program will focus on serving families where there are reports of maltreatment, but the calls were either screened-out upon in-take, or after initial assessment have case decisions of case closed services not needed, services recommended. Services will focus on children ages 0-5 since that is such a critical period of development and those children tend to stay in care longer once screen into the system. Intended applicants thus far are about half county DSS agencies and about half non-profit organizations. Applications are due by March 30, 2012.

Agencies are required to implement evidence based programs with fidelity and to help promote protective factors provide to reduce the risk of child abuse and neglect. Additionally, families need to be linked with concrete supports including financial planning.

Sen. Allran was worried that the funds were being used for lower risk families instead of those with substantiated reports of abuse and neglect.

Ms. O'Connor noted that the statute required the funds are used for prevention efforts prior to substantiation. By focusing on reports, DSS is assuring voluntary services for very high-risk families. This is consistent with the data from LONGSCAN that noted children reported for abuse and neglect had outcomes comparable to children with substantiated cases.

Michelle Hughes added it was a good way to provide services to families where concerns may not reach the level of "abuse or neglect" but are still troubling and lead to poor long-term outcomes for children. It would be better for children and cheaper for the system to treat these concerns before the abuse met official definitions for needing services.

Sarah Currier noted it was often very difficult for people to report neighbors or others for suspected abuse and neglect. If it was serious enough for someone to make the call, then the family likely needs some services.

Michelle Hughes summed up with some closing observations:

- Resources are limited – how do we choose where to invest?
- Traditional outcomes have focused on safety and permanency; now we are looking longer-term. That can be more challenging that "get these kids safe now and that's enough."
- New and emerging research through neuroscience and brain scans show that trauma negatively impacts the developing brain. If we want to help children who have experienced maltreatment, then we must treat their trauma –immediate safety alone is not enough.
- In addition to trauma, we must pay attention to family functioning and parent support.
- Evidence is needed before we take programs across the state. We need to move away from the mentality of "just do *something.*" Indeed, sometimes that "something" can actually be harmful.
- How do we establish criteria to use limited resources in the best possible way?

Alan Dellapenna added that sometimes we were talking about federal funds or grants and needed to assure we were using those as efficiently and well as possible too.

Sarah Currier echoed the theme that it was really important to use data to inform decisions to enhance long-term outcomes.

The meeting adjourned. There is no next meeting of IDPC scheduled. Committees typically do not meet during session and resume after session adjourns.

Prenatal and Postpartum Patient Education

Providing pregnant and new parents with health messages and information is an important strategy in preventing infant mortality and promoting child development. Information about topics such as tobacco use (maternal use and second hand smoke exposure), safe sleep, breastfeeding, managing crying, positive parenting and many others should be provided to families consistently across North Carolina. One effective way to provide this information to new families is through the health care providers – during prenatal care, labor and delivery, postpartum visits and well baby care.

Many different groups in North Carolina have been working to educate parents and providers about these key infant morbidity and mortality preventive topics for many years. The groups have been challenged, however, by limited resources, sometimes competing messages, and the difficulty of reaching hospital nurses and other providers. These groups came together to talk about their work and strategies under the umbrella of the Child Fatality Task Force via the Perinatal Health Committee.

This group of stakeholders decided that they wanted to continue to work together to find possible ways to expand their reach and provide consistent, comprehensive and quality messaging to new parents and their health care providers. They worked with a team of student researchers, coordinated by Dr. Sarah Verbiest, chair of the Perinatal Health Committee, to respond to interviews and then participate in a larger focus group type meeting. The students' analysis indicated that there were opportunities for partnership and also highlighted North Carolina's proactive approach in thinking about developing a comprehensive approach. As the group continued to discuss their work with other perinatal partners, members agreed that it would be interesting to continue to explore the idea of creating and implementing a quality improvement initiative focused on health information/dissemination to pregnant and new parents. They formed the Prenatal and Postpartum Patient Education Workgroup.

Questions to be explored:

- What does the scientific literature describe as potentially best practice messages? How could these be compiled into a comprehensive product that could be disseminated to Pregnancy Medical Home networks to give to patients?
- What are the core messages that health care providers need to provide to their patients? What is the best timing for these messages (e.g. breastfeeding should be discussed prenatally, supported in the hospital and at the postpartum visit, and reinforced at well child visits)?
- What is the best way to make this information available to providers and patients in a way that isn't overwhelming and is useful?

Other opportunities and considerations:

- Build on the Pregnancy Medical Home assessment tool that providers are required to use with all pregnant patients.
- Base planning on research that recommends timing and method of delivery of health messages.
- Highlight the importance of both direct patient education as well as material dissemination.
- Consider all of the key messages that pregnant and new mothers need including: maternal depression, domestic violence, positive parenting, family planning, healthy weight gain, etc.

- Explore models from other states (if any) that have attempted to develop a QI program for prenatal/postpartum patient education
- Demonstrate the cost benefit of this education and initiative.

While members are committed to the work, developing this concept into a program that can be piloted with a group of pregnancy medical home providers will take more resources than can be bootstrapped onto existing job duties. Therefore, the Perinatal Health Committee is recommending to the full CFTF $50,000 non-recurring to the Center for Maternal and Infant Health to devote staff time towards development of a model using coordinated messages to pregnant and new parents to improve infant outcomes.