

Children's Health Alliance of Wisconsin



WISCONSIN
ASTHMA
COALITION

★ Children's Health Alliance of Wisconsin



EMSC
Emergency Medical Services for Children
WISCONSIN

★ Children's Health Alliance of Wisconsin



Infant Death Center

★ Children's Health Alliance of Wisconsin



Keeping Kids Alive
IN WISCONSIN

★ Children's Health Alliance of Wisconsin



WISCONSIN
Medical Home

★ Children's Health Alliance of Wisconsin



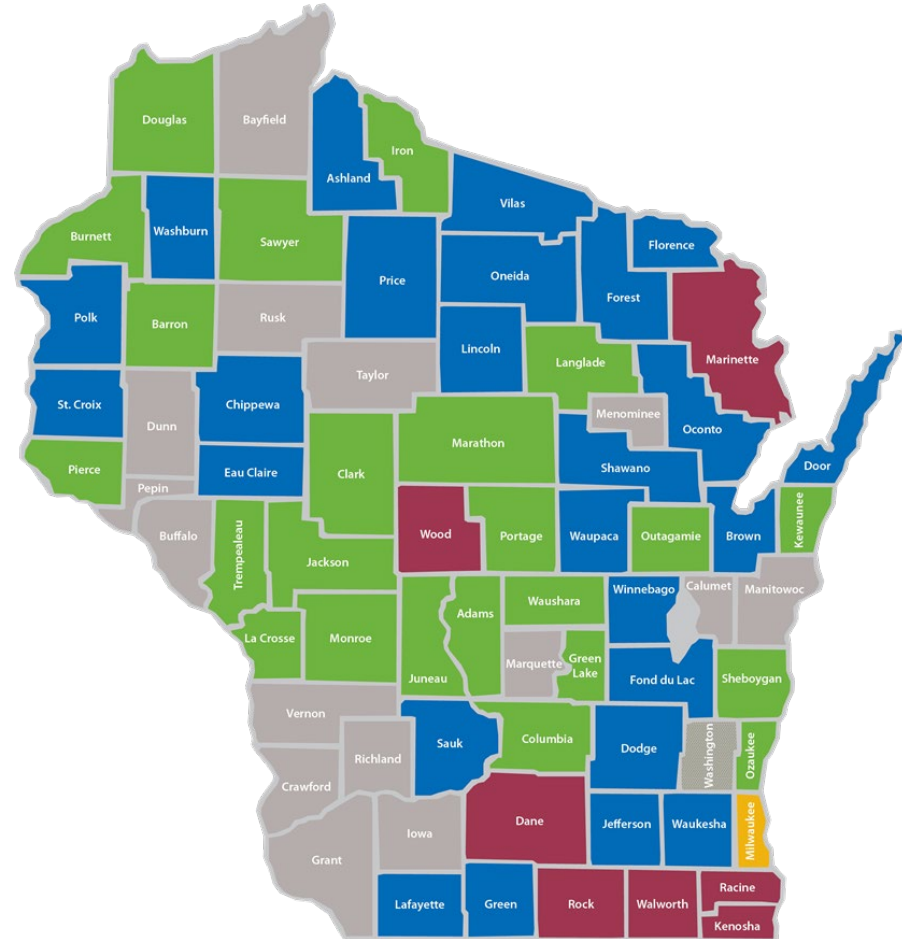
Oral Health

★ Children's Health Alliance of Wisconsin



Keeping Kids Alive IN WISCONSIN

★ Children's Health
Alliance of Wisconsin



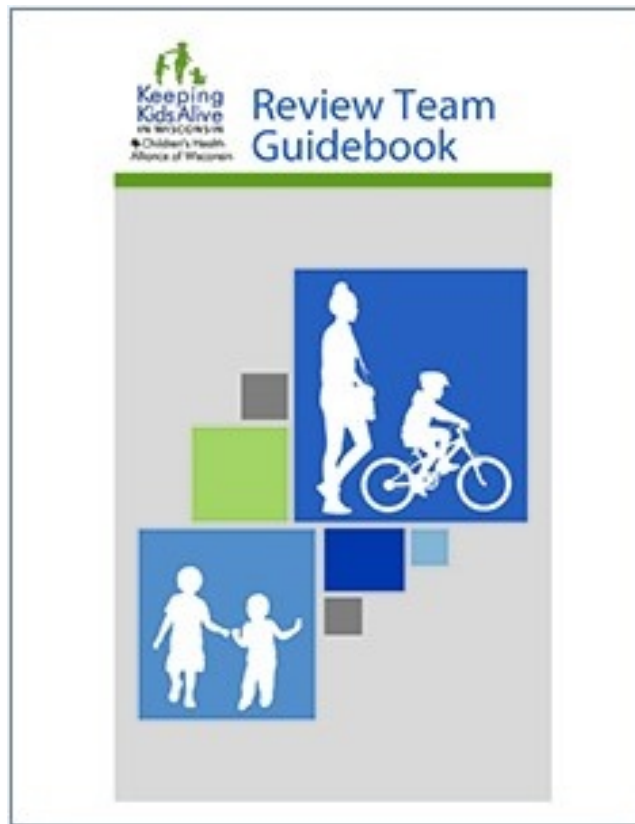
What Is CDR?

- County or regional multidisciplinary team
- Identify and understand risk factors and circumstances of child deaths
- A process used to improve system responses to child deaths
- An opportunity to improve the health and safety of children

CDR Team Members

- Child Protective Services
- District Attorney's Office
- Emergency Medical Services
- Family Court
- Law Enforcement
- Medical Examiner or Coroner
- Medical Professionals
- Mental Health Clinicians
- Public Health

Review Process



- Case selection
- Team members share information
- Information is translated into data
- Data is analyzed
- Prevention



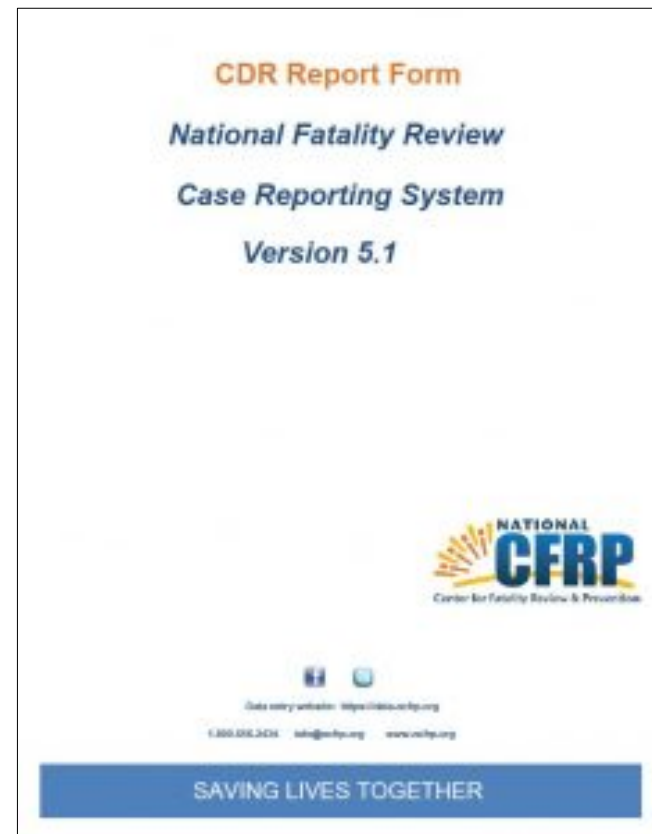
CHILD DEATH REVIEW DATA

Why Collect Data?

- Provides ability to track trends at county, regional, state & national level
- Captures the risk factors and circumstances contributing to the death
- Allows prevention to be targeted to specific groups or risk factors
- Needed to drive policy change

Data Collection


- National Case Reporting System:
 - Internet based
 - Training provided
 - Enter case information into system
- Access to data is limited
 - Local, state, and national users
 - All data de-identified at the National level



SUID Report



- Sudden Unexpected Infant Death
- Demographics, socioeconomic factors, and AAP safe sleep factors.
- While the majority of SUIDs do not occur as a result of alcohol or illicit drug use by the parents, it can play a part.



“Even as we grieve our loss, we must seek whatever good can come from such a catastrophic event. We must find how the death could have been prevented, so that other children might be spared the same fate.”

**William H. Perloff, M.D.
Past Chair, Wisconsin Child Death Review Council**

Questions and thank you

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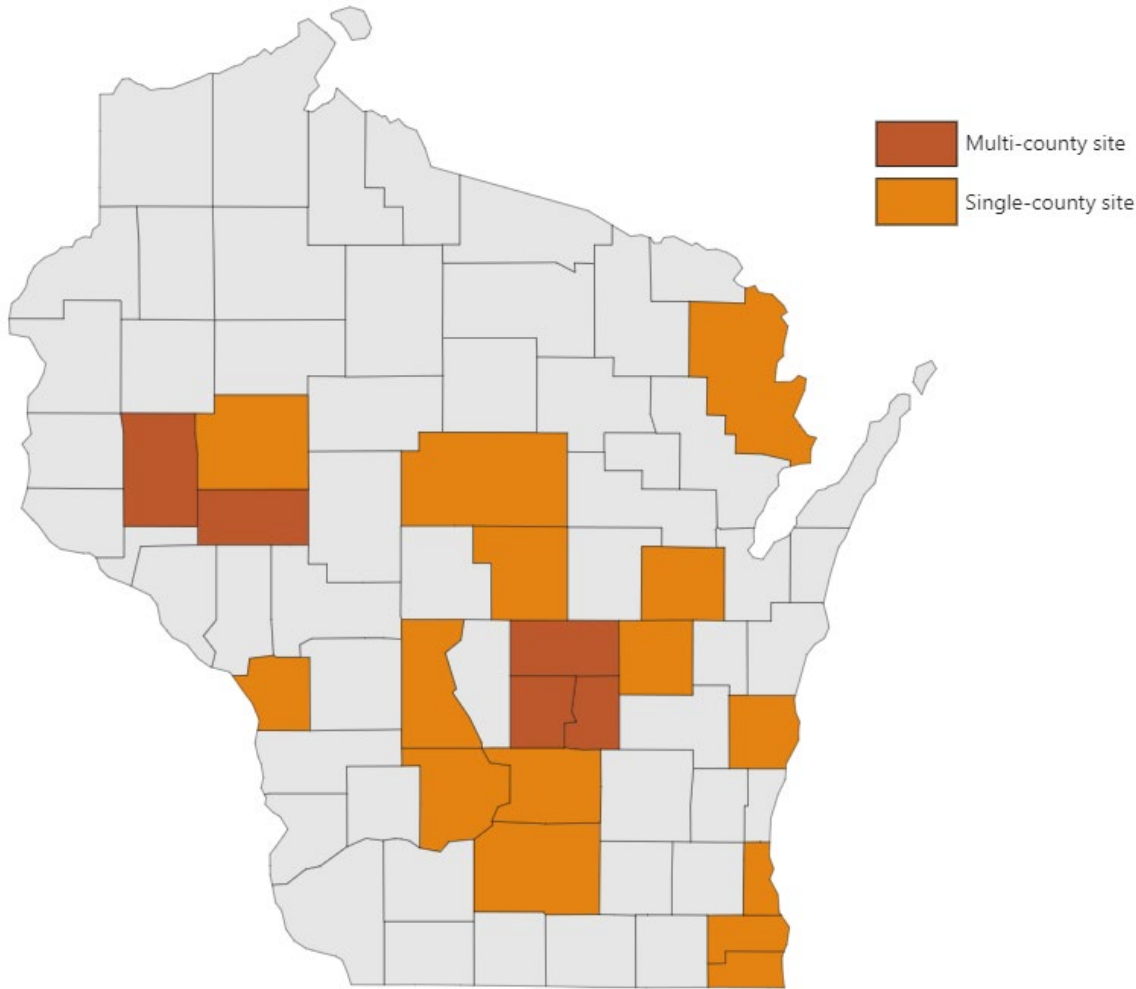
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Overdose Fatality Review



Collaboration of
Wisconsin Department of Health Services
Division of Public Health (DHS) ,
Wisconsin Department of Justice (DOJ), &
Medical College of Wisconsin

Funding: Bureau Justice Assistance Comprehensive Opioid Abuse
Program and Centers for Disease Control and Prevention Overdose
Data to Action



OFR Teams

Ashland (Fall 2021)

Chippewa

Columbia

Dane

Eau Claire/Dunn

Juneau

Kenosha

La Crosse

Marinette

Marathon

Milwaukee

Outagamie

Portage

Racine

Sauk

Sheboygan

Tri-county (Waushara,
Marquette & Green Lake)

Winnebago

OFR purpose

OFRs utilize a systematic, multi-disciplinary review process to prevent future overdose fatalities through improvement in organizational policy or practice or refinement of public policies or systems' operations to enhance community health and safety.

Goals of OFR

To better understand the nature of overdose fatalities through **comprehensive information sharing**

To develop innovative, **proactive** responses

To **strategically** focus limited enforcement and intervention activities on identifiable risks

OFR team members

- Public health: local health departments and tribal health centers
- Law enforcement (municipal police and/or sheriff)
- Emergency Medical Services
- Corrections
- County district attorney's office
- Healthcare
- Behavioral health
- Drug treatment

OFR review process

- Teams focus primarily on overdose fatalities which were ruled an accident or undetermined in manner.
- Reviews are identified, partially or fully in most counties.
- Team members research their interactions with the decedent and share with the team.
- The team discusses risk factors and circumstances leading to the death to identify gaps in service or barriers to treatment and harm reduction.
- Prevention recommendations are generated and implemented by the team, work groups, or community coalitions.

OFR Data System

National tool used by OFR teams across the county

Version 1.0 released Fall 2020; Version 2.0 expected Fall 2021

In Wisconsin, hosted by Department of Health Services

- REDCap server - secure web platform for building and managing online databases and surveys
- Data use agreement between OFR grantee and DHS
 - Safeguarding of case data from your reviews
 - Provision of hospital discharge and Prescription Drug Monitoring Program data by DHS for cases you review

Data reporters are assigned to a data access group

Data can be easily exported for aggregate analysis

OFR State Advisory Group

Department of
Children And
Families

Department of
Corrections

Department of
Health Services

Department of
Justice

Department of
Safety and
Professional
Services

Wisconsin State
Lab of Hygiene

Purpose: The Overdose Fatality Review (OFR) State Advisory Group is a multi-disciplinary group which seeks to:

- Promote OFR as a tool for local communities to address the overdose epidemic
- Receive, evaluate, and implement state-level recommendations from local OFR teams
- Address data sharing barriers in understanding the circumstances leading to fatal overdoses

Mission: To reduce overdose fatalities in Wisconsin through support of the overdose fatality review process and recommendations of local multi-disciplinary review teams.

Questions and Thank you

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OFR website

www.mcw.edu/departments/epidemiology/research/overdose-fatality-review