COLORADO
Department of Public Health & Environment

Child Fatality Prevention System (CFPS) Midpoint Evaluation Report 2016

Executive Summary

In 2005, the Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) established the Child Fatality Prevention System (CFPS), a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Child fatality reviews create understanding of specific child deaths in order to prevent the injury, violence and deaths of other children in the future. During the 2013 Colorado legislative session, Senate Bill 13-255 passed, mandating all reviews of child fatalities in Colorado transition from the state-level to the local-level. All local public health agencies were required to establish, or arrange for the establishment of, local child fatality review (CFR) teams in their jurisdictions by January 1, 2015. Under the new legislation, the CFPS State Support Team at the Colorado Department of Public Health and Environment (CDPHE) oversees the CFPS, coordinates a CFPS State Review Team, develops guidelines and provides training and technical assistance for the local child fatality review process, and evaluates the system as a whole. The purpose of the CFPS evaluation is to assess the outcomes of the changes to Colorado Revised Statute (C.R.S.) 25-20.5-401-409 mandated by Senate Bill 13-255 and to evaluate the process by which the changes are implemented. Starting in July 2013, a five-year evaluation plan was developed and implemented, including a midpoint evaluation report and a final evaluation report.

This document, the *CFPS Midpoint Evaluation Report*, contains the evaluation background, methodology, results, discussion, and recommendations for improvements to the system. The CFPS has three domains in which evaluation activities occur on an ongoing basis throughout the five-year evaluation timeline: (a) the local CFR teams, (b) the CFPS State Review Team, and (c) the CFPS State Support Team housed at CDPHE. Evaluation activities are outlined for each of these domains and the final sections of this document includes the timelines for implementing these activities as well as a discussion of recommendations for improvements to each domain of the system.

Introduction

Child Fatality Prevention System Background

The Child Fatality Prevention Act (Article 20.5 of Title 25, Colorado Revised Statutes) establishes the Child Fatality Prevention System (CFPS), a statewide, multidisciplinary, multi-agency effort to prevent child deaths. Using a public health approach, the CFPS aggregates data from individual deaths, describes trends and patterns of child deaths and recommends prevention strategies. The identified strategies are implemented and evaluated at the state and local levels with the goal of preventing similar deaths from occurring in the future.

The Colorado CFPS is housed at the Colorado Department of Public Health and Environment (CDPHE) in the Prevention Services Division's Violence and Injury Prevention - Mental Health Promotion (VIP-MHP) Branch. CFPS collectively refers to the structure of child fatality prevention in Colorado, comprised of three arms: the CFPS State Review Team, local child fatality review (CFR) teams, and the CFPS State Support Team at CDPHE and associated infrastructure. One of the key aspects of the CFPS is that it operates as a non-hierarchical system. That is, no one arm of the system has complete authority over another. When operating ideally, all arms of the CFPS are working together as equal partners.

Although not codified in Colorado Revised Statutes (C.R.S.) until 2005, the CFPS State Review Team has been conducting retrospective reviews of child deaths in Colorado since 1989. As of January 1, 2015, the child fatality review process transitioned from the state-level to the local-level and local CFR teams became responsible for conducting individual, case-specific reviews of fatalities of children from 0-17 years of age occurring in the coroner jurisdiction of the local team. County or district public health agencies established, or arranged for the establishment of, 48 multidisciplinary, local CFR teams representing every county in Colorado. The variety of disciplines involved and the depth of expertise provided by the local CFR teams result in a comprehensive review process, allowing for a broad analysis of both contributory and preventive factors of child deaths. The CFPS State Review Team is responsible for reviewing the aggregated data and recommendations submitted by the local CFR teams to identify state-level programmatic and policy recommendations to prevent child deaths in Colorado. Under the updated legislation, the CFPS State Support Team at CDPHE oversees the CFPS, coordinates the CFPS State Review Team, develops guidelines and provides training and technical assistance for the local child fatality review process, and evaluates the system as a whole.

According to the National Center for Fatality Review and Prevention, the local child fatality review team model is considered a best practice for the review of child fatalities.[1] Local child fatality reviews operate on the principle that the death of a child is a community responsibility. A local death review requires multidisciplinary participation from the community in order to improve communication and linkages among local agencies and enhance coordination of efforts. State-level child fatality reviews are not as effective as local reviews, because state-level members are not familiar with all local communities. Although local-level child reviews are considered a national best practice, there has been little formal evaluation to assess the effectiveness of the local-level review process. Starting in July 2013, the CFPS began a five-year evaluation, inclusive of a midpoint evaluation report and a final evaluation report. The five-year evaluation plan can be found online at the following link: http://www.cochildfatalityprevention.com/p/evaluation.html. See Appendix A for the Colorado Child Fatality Prevention System Five-Year Evaluation Timeline.

Evaluation Goals

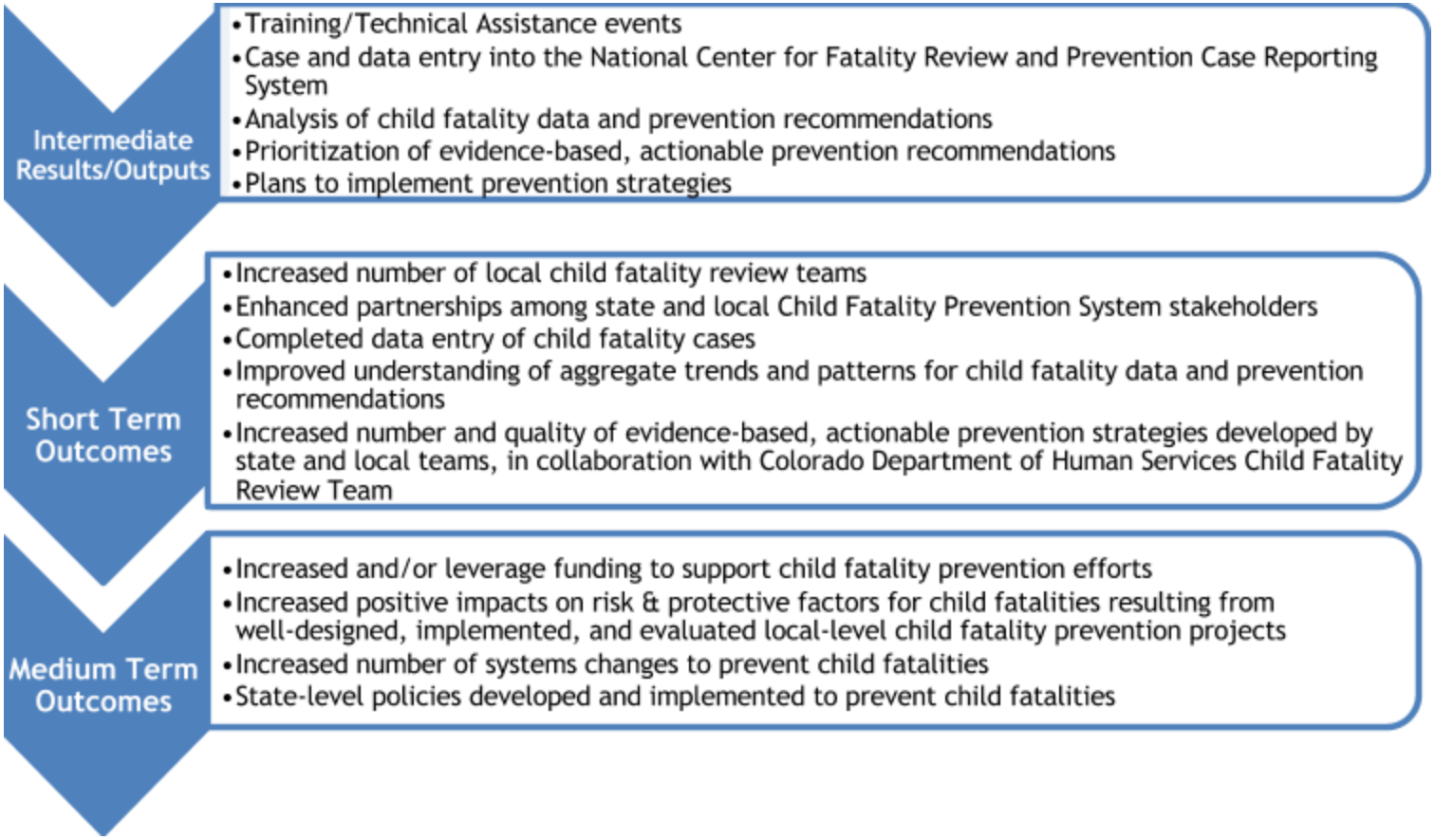
The overarching goal of the CFPS is to prevent deaths of children aged 0-17 years and improve the health and safety of children in Colorado. In order to evaluate if the system has achieved this goal, a five-year evaluation plan was developed to track the progress of the system towards its long-term health impacts. There are two goals of the evaluation:

- A process evaluation of how the CFPS is implemented in order to provide data for continuous quality improvement during implementation and maintenance of the system and evidence-based best-practice recommendations for implementing and running a statewide Child Fatality Prevention System.
- An outcome evaluation of the CFPS with a particular focus on how successful CFPS is at producing actionable prevention recommendations and the actions taken as a result of these recommendations.

[1] National Center for Child Death Review. (2005). A program manual for child death review: Strategies to better understand why children die & taking action to prevent child deaths. Retrieved from: http://www.childdeathreview.org/toolsforteams.htm

The system is also assessed by the meeting of certain outcomes, including immediate results or output and short and medium-term outcomes. These are outlined in Figure 1 (below) and the Colorado Child Fatality Prevention System Logic Model (Appendix B).

Figure 1. Child Fatality Prevention System evaluation immediate results/outputs, short term and medium term outcomes



Evaluation Methodology and Data Sources

The CFPS comprehensive evaluation process includes an analysis and review of data from a variety of sources. This report draws upon the following data sources:

1. **Local CFR team annual surveys**: This report includes highlights from the surveys completed in 2014 (Evaluation Year 1) and 2015 (Evaluation Year 2) by local CFR team coordinators.
2. **CFPS State Review Team annual surveys**: This report includes highlights from the surveys completed in 2014 (Evaluation Year 1) and 2015 (Evaluation Year 2) by CFPS State Review Team members.
3. **National Center for Fatality Review and Prevention Case Reporting System (National Center Data Collection Website)**: This report includes quantitative data from the National Center Data Collection Website.
4. **Key informant interviews and Prevention Strategies Tracking Form**: This report includes information about the development and implementation of injury and violence prevention strategies as reported by local CFR team coordinators during key informant interviews and as tracked in the Prevention Strategies Tracking Form.
5. **Qualitative reviews of the following CFPS documents**:
    a. Annual CFPS Legislative reports (2014, 2015)
    b. State Review Team meeting notes and volunteer hours (2006 - 2015)
    c. Training evaluations from technical assistance provided to local CFR teams
    d. Historical State Team data sources

Evaluation Results

Results from Local Child Fatality Review Team Annual Surveys, 2014 and 2015

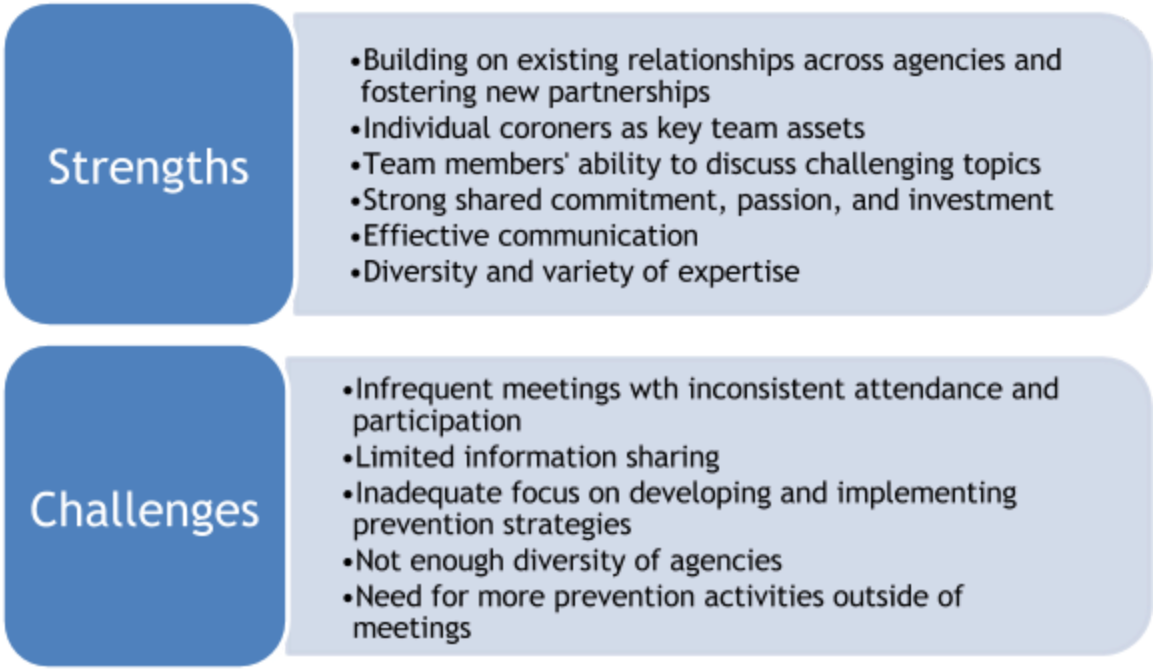
The annual local CFR team survey was disseminated and completed by local CFR team coordinators in the fall of 2014 (Evaluation Year 1) and fall of 2015 (Evaluation Year 2). In 2014, 29 local CFR coordinators responded to the annual survey, and 26 coordinators completed the entire survey. In 2015, 24 local CFR coordinators representing 33 countries across the state participated in the annual survey; 22 respondents completed the entire survey.

The results of the 2014 Local CFR Team Annual Survey confirmed that 2014 was a formative year for local child fatality review teams. Therefore, the results from the 2014 survey will be used as a baseline measure for the evaluation. Beginning in 2014, local-level single-county and regional, multi-county teams began to form and organize across Colorado's 64 counties. By June 30, 2014, every county in Colorado confirmed its local review team structure. Forty-eight local CFR teams developed, including seven regional teams comprised of multiple counties. In 2014, the majority of teams, except for those from counties that had already been reviewing child fatality cases at the county level before the legislation was updated, had yet to review a child fatality case. There were two reasons why these teams had not started child fatality case reviews: 1) they were still establishing their team structure and recruiting members to join the teams; or 2) there were no child fatality cases assigned to their local team for review because the CFPS State Review Team continued to review cases that occurred in 2014.

The results of the 2015 Local CFR Team Annual Survey indicated progress towards enhanced ability of local coordinators to facilitate local CFR team meetings and conduct individual, case-specific reviews of the deaths. In addition, results in 2015 suggested enhanced partnerships among multidisciplinary team members at the local level.

In both 2014 and 2015, the majority of agency representatives mandated by statute participated on local CFR teams. In both years, teams also included additional participants not mandated by the legislation, which implies that existing relationships and partnerships among agencies may have been leveraged for both case review and prevention activities at the local level. While the majority of teams across the state operated as single-county teams in 2014 and 2015, according to the survey results, there was no clear evidence to support that single teams are more or less optimal than regional, multi-county teams. Survey respondents reported many of the same or similar challenges and strengths for both single-county and regional or multi-county teams, as listed in Figure 2 (below).

Figure 2. Reported strengths and challenges of local child fatality review teams



Local CFR team funding allocation, as reported by survey respondents, varied little between 2014 and 2015. Local CFR teams across Colorado received a total of $323,700 in fiscal year 2015 (July 1, 2014-June 30, 2015) and $310,000 in fiscal year 2016 (July 1, 2015-June 30, 2016). According to survey results in both years, teams predominately used funding from CDPHE to support the team coordinator's position as well as review meeting activities and supplies. In both 2014 and 2015, the majority of local teams indicated that funding from CDPHE was adequate to support local child fatality review team activities. However, responses to both the 2014 and 2015 surveys emphasized a need for funding for prevention efforts and not just funding to support the team coordinator position and review team meetings.

Since few of the teams reviewed cases or developed prevention recommendations in 2014, the majority of respondents to the 2014 survey indicated that many of the team activities were unknown at the time of surveying. In 2015, more coordinators responded that they knew how the team functioned or about team activities suggesting that as teams became more established there was a greater sense of team functioning. From the perspective of the local coordinators, teams increased in their understanding of the purpose of the local CFR teams, which suggests that local teams have progressed beyond team formation and initial meetings to focus on case review and prevention recommendations.

As the majority of teams in 2014 were engaged in team formation and preparation for case review and prevention recommendations, prevention activities were limited in 2014. By comparison, in 2015, all teams that had cases assigned to them for review in 2015 reviewed them: a total of 202 cases from deaths that occurred in 2014. An additional seven teams reported they had developed and implemented prevention strategies at the local level. Among 2015 survey respondents, teams participated in a wider range of prevention activities than in 2014. These activities included safe sleep education (creation of a traveling display demonstrating safe sleep principles, presentations to local community agencies, and distribution of kits with sleep sacks and information on safe sleep to expecting and new parents); new driver education; ATV safety education materials; training on marijuana use across the lifespan (prenatal to adolescence); distribution of car seats; and collection of local substance use data, particularly on accidental overdose.

Despite increased certainty and understanding of local CFR team activities overall, coordinators reported high ratings of neutrality for the following activities in 2015: 1) teams develop recommendations that are actionable; and 2) team members champion prevention recommendations in their communities. This was a shift from not knowing about these team activities in 2014 to neutrality in 2015. It may be too early in the implementation process for teams to assess their prevention activities; however, this shift may signal that while teams are functioning and completing case reviews, the prevention work is an area for improvement in the coming years.

In both 2014 and 2015, survey respondents reported high levels of satisfaction with CFPS State Support Team technical assistance (TA). While satisfied with the support, 2014 respondents desired continued support in facilitation of meetings, reviews, and

prevention activities. Similarly, 2015 respondents stated a need for continued support in prevention, including assistance with developing and implementing prevention recommendations and trainings on violence and injury prevention for team members.

Overall, survey results from 2014 and 2015 suggest that teams have progressed from a planning and formative year in 2014 to an implementation year in 2015, which included conducting case reviews and developing and enacting prevention recommendations. Despite commonalities across the respondents, individual team responses demonstrate variability and flexibility. This suggests that teams are not only adopting the local child fatality review model, but are also adapting the model to best meet the needs of the local communities the teams serve.

Detailed reports about the results of the 2014 and 2015 Local Child Fatality Review Team Annual Surveys are available on the Colorado Child Fatality Prevention System Collaboration Website Evaluation Page: http://www.cochildfatalityprevention.com/p/evaluation.html.

Results from the CFPS State Review Team Annual Surveys, 2014 and 2015

From 1989 to 2015, the CFPS State Review Team conducted comprehensive reviews of child fatalities that occurred in the state of Colorado. However, with the updates to the Child Fatality Prevention Act during the 2013 legislative session, review of child fatalities became the responsibility of local-level teams rather than the centralized state team beginning in January 2015. The primary responsibility of the CFPS State Review Team is to review aggregate child fatality data to prioritize programmatic and policy-level recommendations to prevent child fatalities. These recommendations are included in an annual legislative report that is submitted to the Governor and the Colorado legislature and disseminated to internal and external partners. In order to evaluate the CFPS State Review Team, an annual CFPS State Review Team survey was disseminated and completed by CFPS State Review Team members and subject matter experts in the fall of 2014 (Evaluation Year 1) and fall of 2015 (Evaluation Year 2). In 2014, 20 CFPS State Review Team members responded to the annual survey, and 14 respondents completed the entire survey. In 2015, 38 CFPS State Review Team members responded to the survey; and 31 respondents completed the entire survey.

Based on the results of the annual surveys of the team, the CFPS State Review Team's composition did not vary widely from 2014 to 2015. In 2014 and 2015, the majority of responding team members had served on the team for less than three years. In 2015, a question was added to the annual survey to better understand which disciplines the respondents represent on the CFPS State

Review Team. The majority of respondents in 2015 represented the fields of public health, medical/health, and injury and violence prevention. Finally, respondent rating of team function, structure, and member participation did not change markedly between 2014 and 2015.

The CFPS State Review Team appears to have been more active in implementing prevention recommendations in 2015 compared to 2014. In 2015, three-quarters of respondents indicated that their agencies took action to implement the prevention recommendations outlined in the 2014 annual legislative report. Further, in 2015, more respondents agreed that their agencies contributed to implementation or promotion of prevention recommendations than in 2014.

In both 2014 and 2015, the majority of respondents were satisfied or very satisfied with the technical assistance provided by the CFPS State Support Team at CDPHE and offered a variety of suggestions for improvement. Below are a list of examples for areas of improvement:

- Include more detailed and relevant information in the case abstraction summaries for review by the CFPS State Review Team
- Distribute agendas and meeting materials in advance to members who cannot attend the meetings in person and need to call into the meetings
- Encourage meaningful participation of all members of the CFPS State Review Team, specifically for members who call into the meetings and for members from agencies who have not engaged in prevention efforts
- Improve meeting facilitation through better time management
- Change the location of the meetings
- Provide more direction and information for new team members regarding roles and governing rules and bodies
- Delegate more responsibilities to the CFPS State Review Team

Regarding collaboration with the Colorado Department of Human Services (CDHS) Child Fatality Review Team (CFRT), annual survey respondents rated the collaboration in 2015 more favorably than in 2014. The 2015 results indicate that respondents found the joint recommendations to be both more actionable and meaningful and the collaboration to be more useful and effective than in 2014.

Team members who responded to the survey in 2014 and 2015 highlighted the same or similar areas for future work: implementation of prevention strategies, use of data to inform prevention activities, additional funding sources for prevention efforts, and support for prevention across the state. The consistency in recommendations for future work across both years suggests that the CFPS State Review Team is still in the process of achieving its goals. Going forward into the next year, the CFPS State Support Team can be useful in assisting the CFPS State Review Team to fulfill the more long-term goals of implementing and supporting prevention strategies. As the structure of the CFPS State Review Team continues to evolve, the prevention efforts of the team will be assessed to determine the success of the CFPS State Review Team.

Detailed reports about the results of the 2014 and 2015 CFPS State Review Team Annual Surveys are available on the Colorado Child Fatality Prevention System Collaboration Website Evaluation Page: http://www.cochildfatalityprevention.com/p/evaluation.html.

National Center Data Collection Website Data Entry Results

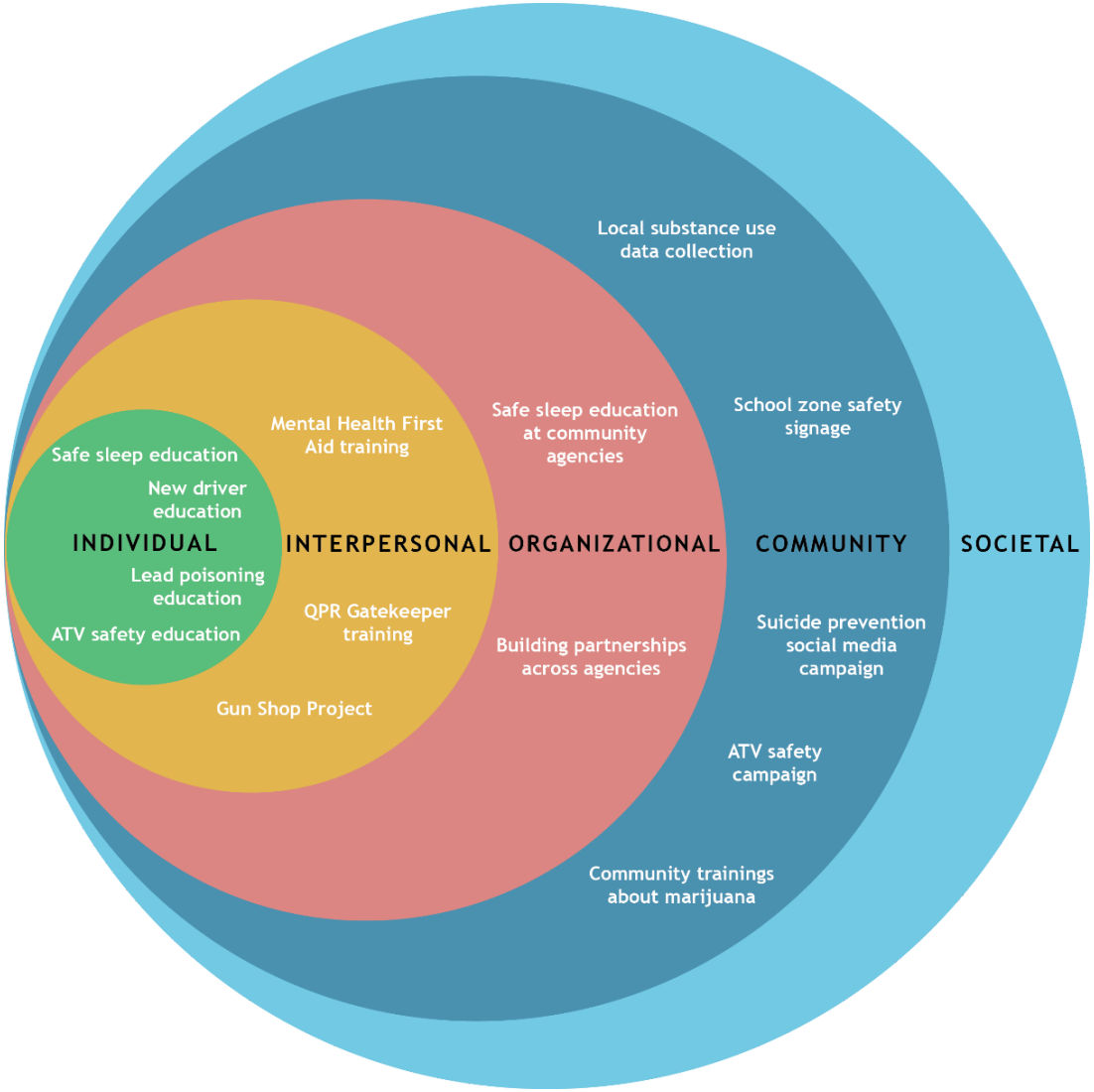
In the first year that local CFR teams were assigned cases to review, all of the assigned cases were reviewed and entered into the National Center for Fatality Review and Prevention Case Reporting System (National Center Data Collection Website). Starting January 1, 2015, local CFR teams began reviewing child fatality cases from 2014. By January 2016, review and data entry were complete on the all 202 cases that occurred in 2014 and were assigned to local CFR teams. While there are 48 teams serving the entire state, not all teams reviewed cases, as some communities did not experience any child fatalities and therefore no cases were assigned to those teams for review.

Child Fatality Prevention System Prevention Activities

Based on the results from the local CFR teams and CFPS State Review Team annual surveys as well as data entered by local teams into the Prevention Strategies Tracking Form and key informant interviews conducted with local CFR team coordinators, CFPS has generated and implemented various prevention interventions at various levels of the socio-ecological model. Local CFR team coordinators can fill out the web-based Prevention Strategies Tracking Form at any time to notify the CFPS State Support Team of prevention activities initiated at the local level. The topics of the prevention efforts vary widely, including suicide prevention,

motor vehicle safety, safe sleep education to reduce sudden unexpected infant death, and substance abuse education and prevention. The bulk of the local CFR team activities target individuals and communities through education and public awareness campaigns, as demonstrated in Figure 3.

Figure 3. Prevention activities of local child fatality review teams across the socio-ecological model



The CFPS State Review Team also engaged in prevention efforts across the socio-ecological model. For example, at the individual level, members distributed CFPS prevention recommendations to stakeholders and the public; promoted CFPS prevention recommendations and advocated for action on the recommendations and educated others on the recommendations. At the organizational level, CFPS State Review Team members trained county social service agencies about safe sleep regulations. Finally, at the societal level, members secured increased state funding for the prescription drug take back program.

Qualitative Document Review Results

As part of a comprehensive evaluation, a qualitative review of past CFPS documents and reports not only highlights the system's successes, challenges and outcomes, but also provides insight into trends and changes in the system over time. When available, documents reviewed included CFPS historical documents from before the system's codification, CFPS State Review Team meeting notes from 2012 to present, annual legislative reports 2006-2015, and the results of training evaluations from technical assistance provided by the CFPS State Support Team. These documents provide insight into how the system has transitioned in the face of major changes.

Results of the review indicate the immense transformation that CFPS has experienced since the beginning of the child fatality review process in Colorado in the late 1980s. The codification of the system through the passage of the Child Fatality Prevention Act in 2005 brought increasing structure to the child fatality review process. However, as noted in many of the documents, piecemeal federal funding and limited staff resources were inadequate to sufficiently collect and analyze the child fatality data and provide the needed administrative structure and support to generate prevention recommendations and advocate on behalf of those recommendations. This is evidenced by the repetition of many of the prevention recommendations year after year and the reliance of the system on significant volunteer hours whether through CFPS State Review Team members and/or a Centers for Disease Control and Prevention (CDC) fellowship position that assisted CFPS from 2012 to 2013.

The update to the Child Fatality Prevention Act during the 2013 legislative session brought significant state funding to the system, and the scaling up of the system can be seen in the hiring of three fulltime staff and the increasing complexity and nuanced presentation of the data in various annual legislative reports. Similarly, CFPS prevention recommendations became increasingly specific and focused with more funding and staff time dedicated to building the infrastructure of the system. At this time, the

role of the CFPS State Review Team began to change as the responsibility for child fatality case reviews shifted to the local teams. CFPS State Review Team meeting notes demonstrate the team's shift from reviewing cases and generating prevention recommendations to assisting local CFR teams to establish and review cases and prioritizing state-level prevention recommendations. The formation of local CFR teams across the state exemplifies the increasing complexity of the system. Starting in 2011, the prevention work of existing local CFR teams was highlighted by CFPS in legislative reports. By 2015, the CFPS State Review Team meeting minutes indicate that the local CFR teams were expected to help craft and prioritize the prevention recommendations presented to policymakers in the annual legislative report.

Despite the distinction between roles of the state and local teams, the system continues to function in a unified manner. Local CFR teams focus on conducting case reviews and developing and implementing prevention strategies, while the CFPS State Review Team's role has transitioned to focus on the prioritization of prevention recommendation at the policy-level and the complimentary advocacy and implementation on behalf of those recommendations. CFPS will continue to track and evaluate the transition of the system as both state and local teams become more established in their distinct roles and collaborate to prevent child fatality across the state.

Discussion

Progress towards Evaluation Goals

The evidence provided in the midpoint results of the CFPS evaluation suggests that significant progress has been made on achieving specific CFPS goals and outcomes. The process evaluation goal of generating data for continuous quality improvement of the system as well as maintenance of the system has been met. In addition, there has been significant progress made towards establishing an evidence base for best practices to implement a statewide child fatality prevention system with both local and state teams. The achievement of outcome evaluation goals continues to be an area for potential growth for the system; however, progress has been made. In addition to disseminating annual surveys to evaluate both the CFPS State Review Team and local CFR teams across the state, the CFPS evaluation is supported by data generated through the Prevention Strategies Tracking Form and key informant interviews, which provide information on how well the system functions and the outcomes it produces, specifically actionable prevention recommendations and the resulting actions taken to reduce the number of child fatalities across the state.

Progress towards Logic Model Outcomes

The system has achieved many of the immediate results, short term, and some of the medium term outcomes outlined in the CFPS logic model (Appendix B). It is clear from this evaluation that reviews of child fatalities and the entry of this data into the National Center Data Collection Website has been accomplished. The number of local CFR teams in Colorado has increased from five teams in 2013 to 48 teams across the state in 2016. These teams report development of new and fostering of existing local partnerships across agencies. The CFPS support team has analyzed the data and prevention recommendations generated by the system in a nuanced and meaningful way, in addition to providing training and technical assistance to local CFR teams and the CFPS State Review Team. Since 2006, these recommendations have been prioritized and publicized through the annual legislative reports submitted to the Governor and the Colorado General Assembly.

As previously mentioned, the implementation of prevention recommendations and strategies is an area in which the CFPS will continue to grow. To date, CFPS has participated in significant prevention activities, both at the state and local levels, as demonstrated in the evaluation results. These efforts have broadened and deepened local relationships among agencies as well as promoted child fatality topics across the state. Some teams have begun to leverage additional sources of funding outside of the CFPS state funding allocation to address issues such as youth suicide in their communities. As the system continues to evolve, more progress on medium term outcomes to meet the long term impact of reducing child mortality across the state will include:

- Additional prevention activities with a stronger evidence base at the local and state levels;
- Focus on both risk and protective factors to prevent child fatality; and
- Development and promotion of policy recommendations to create systems-level changes and state-level policies to reduce child fatalities.

Strengths and Weaknesses of the System

Pursuant to C.R.S. 25-20.5-407 (1)(g), the CFPS State Review Team is required to provide a list of system strengths and weaknesses identified during the child fatality review process. Tracking changes on these outcomes and goals is best seen when contemporary documents are compared to the historical CFPS documents.

One of the biggest strengths of the CFPS is the structure provided by the 2013 amendment to the Child Fatality Prevention Act (Senate Bill 13-255). In addition to providing a stable source of funding for the CFPS, the updated legislation creates guidance for the system that has not only helped sustain, but also expand the CFPS. For example, while the individual members and appointees on the CFPS State Review Team have changed over time, the legislation ensures that a variety of professionals and disciplines involved in preventing child fatalities are present on the team. In the same way, the legislation mandates membership on the local CFR teams, leading to new partnerships and relationships among individuals and the agencies they represent in communities across the state. Similarly, the legislation's funding allows for dedicated staff and supports provided by CDPHE, including three full-time staff: a program manager, technical assistance and prevention coordinator, and data analyst/epidemiologist. This has led to more nuanced and focused data analysis, enhanced technical assistance and support, dedicated focus on child fatality prevention efforts, and greater visibility of the CFPS.

One of the unintended outcomes of this new child fatality prevention system has been greater integration and understanding of CFPS and child fatality review more broadly within CDPHE and other agencies. In an effort to work across the state, staff at CDPHE have worked more collaboratively on topics across the Violence and Injury Prevention—Mental Health Promotion Branch and Prevention Services Division widely. Likewise, staff at CDPHE and local public health agencies across the state have fostered relationships with previously unfamiliar agencies, such as the local coroner’s offices and hospitals, with the shared goals of preventing child fatalities.

During 2015, the CFPS State Review Team continued to work in subcommittees to conduct multidisciplinary prevention efforts: child abuse/neglect prevention subcommittee, violence prevention subcommittee, motor vehicle safety subcommittee, accident/injury prevention subcommittee, local team liaisons subcommittee, investigative and data quality subcommittee,

advocacy and legislative subcommittee, and infant safe sleep subcommittee. As the structure of the subcommittees continues to evolve, the prevention efforts of each subcommittee will be assessed to determine the success of the CFPS State Review Team.

Funding was an important theme throughout the evaluation. Both the CFPS State Review Team members and local CFR team coordinators highlighted a need for additional funding to move beyond the process of establishing the system and reviewing child fatality cases to affecting real systems change and prevention of future child fatalities. Funding will need to be sustained and diversified at the local-level to ensure that the system continues to develop a robust child fatality prevention system using evidence-based prevention strategies.

Recommendations

Given the significant changes that CFPS has undergone since its inception, this evaluation provides several recommendations to improve the structure of CFPS:

1. **CFPS State Review Team Structure**: As the responsibility of the CFPS State Review Team evolved from reviewing child fatality cases, the overall purpose and role of the team has changed. The subcommittees that at one time reviewed fatality cases and created prevention recommendations for the annual legislative report have been restructured to better accomplish and advocate for prevention. This new structure and the new role of the CFPS State Review Team will continue to be assessed moving forward.
2. **CFPS Communication:** CFPS State Review Team members offered several ways in which they can better communicate the information from CFPS to their own agencies and to others in CFPS. For example, CFPS State Review Team suggested the creation of talking points for CFPS State Review Team members to take back to their agencies and communities to inform them of CFPS activities as well as the creation of one-pagers from each CFPS State Review Team meeting to update others on programs implemented and progress on previous recommendations.
3. **Additional Support and Technical Assistance**: The CFPS State Support Team at CDPHE can ensure that CFPS as a whole progresses towards achieving its outcomes by providing support and technical assistance across the system that is responsive to CFPS State Review Team and local CFR team members. It may be particularly important for local CFR teams to obtain alternative funding sources for prevention efforts at the local level. Responses to both years' annual surveys for

local CFR teams emphasized a need for funding for prevention efforts and not just funding to support the team coordinator position and review team meetings. This information is influencing the CFPS State Support Team's programmatic and funding decisions in 2016 and going forward as staff assist local CFR teams in leveraging existing resources and external funding opportunities and allocate supplemental funding in the CFPS budget for local-level prevention activities.

Limitations

The CFPS evaluation has several strengths and limitations. The evaluation is limited in its scope based on the data available. While the annual surveys, legislative reports, meeting notes, and other documents are reliable sources, they may not capture the whole spectrum of experiences in the CFPS. As the bulk of the data is focused on the CFPS State Review Team and developed or fielded by the CFPS State Support Team, there may be inherent bias in how the information is collected and analyzed. Future planned work including regional trainings, site visits, and individual follow-up on prevention efforts at the local level will provide more detailed information directly from local CFR teams and will better inform the second half of the evaluation process.

Conclusion

In conclusion, over the course of the first two and half years of the updated CFPS, significant transformation in the structure has led to improvements of the child fatality review process in the state of Colorado. In addition, there have been advancements towards prioritizing child fatality prevention strategies as well as implementing them at the state and local levels. Over the next two years, the CFPS evaluation will continue in order to monitor improvements made to the system and upcoming progress towards medium term and long terms outcomes.

Appendices

Appendix A: Colorado Child Fatality Prevention System Five-Year Evaluation Plan

July 2013 to June 2014: Evaluation planning year

- √ Complete evaluation workshops, finalize evaluation plan, design evaluation tools

July 2014 to June 2015: Evaluation implementation Year 1

- √ Finalize evaluation tools
- √ Collection of rolling and annual data sources (Baseline/Year 1 data)
- √ Analysis of baseline data and reporting of Baseline/Year 1 findings
- √ Update evaluation plan and implementation plan

July 2015 to June 2016: Evaluation implementation Year 2

- √ Continued collection of rolling and re-collection of annual data sources (Year 2 data)
- √ Analysis of Year 2 data, and reporting of Year 2 data including comparisons with Year 1 and 2 findings
- √ Midpoint evaluation report
- √ Update evaluation plan & implementation plan

July 2016 to June 2017: Evaluation implementation Year 3

- Same as Year 3, except any changes proposed during implementation planning

July 2017 to June 2018: Evaluation implementation Year 4

- Same as Year 3 & 4, except any changes proposed during implementation planning
- Final evaluation reporting includes new findings (Year 5) and comprehensive analysis of overall evaluation findings

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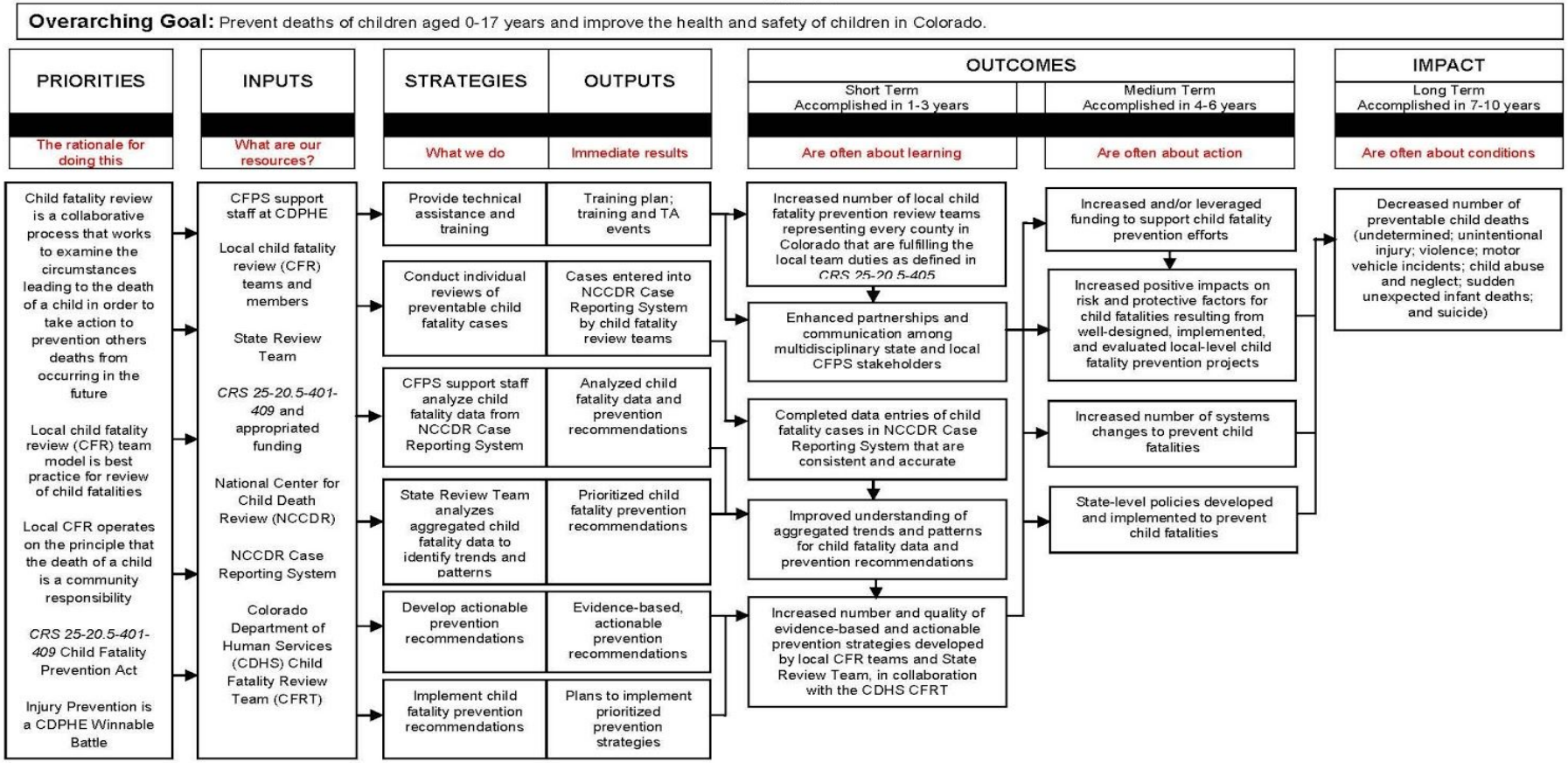
Appendix B: Colorado Child Fatality Prevention System Logic Model



LOGIC ASSUMPTIONS

According to the National Center for Child Death Review, the local CFR team model is considered a best practice for the review of child fatalities. Local child fatality reviews operate on the principle that the death of a child is a community responsibility. A local death review requires multidisciplinary participation from the community in order to improve communication and linkages among local agencies and enhance coordination of efforts. State-level child fatality reviews are not as effective as local reviews because the State Review Team members are not familiar with all local communities.

CFPS refers to the structure of child fatality prevention in Colorado as defined by *CRS 25-20.5-401-409*. CFPS is used to collectively refer to: Local child fatality review (CFR) teams, State Review Team, state support system (CFPS staff at the CDPHE), and associated infrastructure (e.g. data management system). One of the key aspects of CFPS is that it is proposed to operate as a non-hierarchical system. That is, no one arm of the system has complete authority over another. When operating ideally, all arms of CFPS system are working together as equal partners.

EXTERNAL FOCUS

SB-13-255 passed in 2013 and updated the Child Fatality Prevention Act (*CRS 25-20.5-401-409*). This legislation transitions individual child death reviews from the state-level to the local-level. The new legislation also appropriates funding to support local child fatality review teams and CFPS support staff at CDPHE.

EVALUATION FOCUS

Colorado is in a unique position to evaluate a system that conducts reviews at a local level as well as evaluating the process needed to implement such a system. As such, there are two goals of this evaluation: A process evaluation of how the CFPS is implemented and run in order to provide data for continuous quality improvement during implementation and maintenance of the system and to provide some evidence-based best-practice recommendations for implementing and running a state-wide, locally implemented Child Fatality Prevention System. Evaluation of the outcomes of the CFPS with a particular focus on how successful CFPS is at producing actionable prevention recommendations and the actions taken as a result of these recommendations.