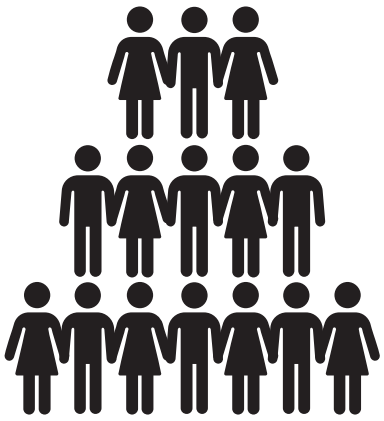
Collaborative approach

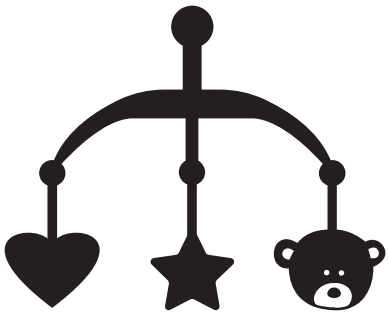
Be clear about risks with parents. If a parent or caregiver is using a substance that can impair them, then support them in developing a plan to ensure that a safe, unimpaired individual is caring for the infant.

Consider including other community partners in these conversations with the family, such as experts on substance use disorders, safe sleep or infant health, or culturally specific providers or supports. Collaborating with a Self Sufficiency Program family coach, a nurse or a Tribal member will allow for a different voice and another perspective. Also, consider connecting the family with providers they trust and who would have credibility on the topic, such as their pediatrician. Studies have repeatedly shown that hearing messages from multiple sources, multiple times increases likely acceptance and implementation of safe sleep behaviors.[15]



Part 3: Safe sleep conversations with families

Conversations with families



When talking with families about safe sleep, they may express concerns or share misconceptions about safe sleep practices. They may also share ideas or opinions on topic that you haven't thought of before. Parents or caregivers may resist engaging in some safe sleep practices because they are committed to a sleep practice that is not recommended.

It is the role of professionals who serve families to not only educate families, but also to engage in authentic conversations with families about safe sleep. These conversations must respect and engage with their lived experiences and opinions. They must also acknowledge and elevate them as experts in and advocates for their children's health.

Think about safe sleep improvements in terms of building parents' and caregivers' sense of competency and control in a purposeful, positive way. That means partnering with families to build their capacity. This can be done by avoiding situations that make parents feel judged, talked down to or overwhelmed. Instead, focus on opportunities to help them feel like they are in control of their infant's health. Take time to celebrate the ways families are already creating comfortable and safe sleep environments for their infants as you also share information about reducing the risks of sleep-related infant death. Engage parents and caregivers as partners in the conversation. Ask if there are ways they think they could enhance their infant's safety based on the information you share.

When the parent or caregiver resists making the recommended change, try to reduce risks as much as possible. The following information, as well as the information covered in Parts 1 and 2, will prepare you to engage families in conversations about safe sleep.

Reducing risk

"If I talk with families about doing anything except what is recommended, then I am condoning unsafe or unhealthy behaviors. They need a firm message about what to do and what not to do or else they may not follow the recommendations."

This concern is common and understandable. Since families will decide what they want to do, it is most productive to focus on giving information about how they can carry out their decisions. If they decide not to use all the recommendations, provide information about what factors create risk so they can address those factors. Help them reduce as much risk as possible. This approach is now included in the new American Academy of Pediatrics (AAP) safe sleep guidelines, which urges open and honest conversations with families.

Not talking about accommodating families' decisions may put infants at risk.[14]

If you suspect power dynamics are creating resistance to changing sleep practices, and if it is safe and within your role to do so, engage both the abusive partner and survivor in the conversation and focus on the safety risks to the infant. Focusing on the effects on children has been shown to be a successful way to engage abusive partners in behavior change. Whenever possible, the best and safest practice is to connect with the survivor first to better understand the abusive partner's pattern of coercive control and any personal safety risks that engaging in these conversations may create for the survivor, the infant and the family.

How the conversation starts

Consider starting the safe sleep conversation with an open-ended question such as one of the following. Several may sound familiar; you were asked some of these questions at the beginning of the training. You may wish to refer to your responses and the related guidance.

- "What do you know about how you were put to sleep as an infant?"
- "What do you already know about safe sleep practices?"
- "What does sleeping comfortably look like for you as an adult?"
- "Would you show me where you put your infant to sleep?" or "Can you describe your infant's sleep environment?"
- "What are all the ways you help make sure your infant has a good sleep?"
- "Tell me how you and your spouse or partner made the decisions about the sleep practices you use?"

Approach to resistance

How do you approach resistance from a parent or caregiver?

- Use a strength-based approach and build on their protective factors (Protective factors are conditions or attributes of individuals, families, communities, or the larger society that reduce risk and promote healthy development and well-being of children and families).
- Praise families for what they are already doing to set up a healthy and supportive sleep environment.
- Explain the risks associated with sleep-related infant death, but don't use shame or fear.
- Explain the worst-case scenario with empathy and in a constructive, personal and caring manner.
- Explain risk reduction measures and encourage their use.
- Encourage follow-up with their medical provider about safe sleep.
- Collaborate with other community professionals and Tribes to share the message in a way that honors family and cultural traditions and values.

It is important to **listen** and understand why families may not utilize the AAP recommendations.

Reasons for resistance may include:

- Comfort of the infant or themselves
- Exhaustion
- Prior experience with other children or their own childhood
- Advice from family members or friends
- Lack of space for a crib
- Lack of a crib (money or access)
- Disbelief in the science because it changes all the time
- Receiving mixed messages from health care providers
- Receiving information that is outside of their cultural framework
- Belief that SIDS is "fate" or "God's will"
- An incorrect perception of what a "good sleeper" is (Contrary to what many believe, a "good sleeper" is not an infant who sleeps 10 hours a night without waking up. A good sleeper is an infant who wakes up periodically and can go back to sleep on his or her own.)
- Feeling that the conversation about safe sleep implies that they are not a "good parent."

Ask the parents and caregivers why they feel the way they do. Their words will guide how you respond and with what information. Approach the conversation with questions and **affirm you are hearing and understanding the family's feelings and reasoning**.

To provide information in a constructive way to the parent or caregiver consider the following:

- Avoid using "should," which may seem like a directive.
- Use interactive educational materials.
- The Jackson County Nurse-Family Partnership Program created safe sleep educational tools that use photos showing various infant sleeping arrangements to spark discussion with prenatal and new mothers about safer sleep practices. They asked parents and caregivers to explain what they see in the pictures and give feedback about the educational tool and how to improve it. This helped the home visitors understand what parents and caregivers learned and how to improve the tool itself. Making the clients the "experts" on how they felt about the tool elevated their participation and engagement as well as knowledge.
- Repeat, reinforce and layer additional information to encourage changing behavior.
- Parents or caregivers are not always ready to receive information or may not have the energy to learn a lot of new information at once. Provide aspects of safe sleep information that are relevant for them when they need it and build on that information over time.
- Combine safe sleep education with providing or referring to community resources for infant sleep sacks or sleep spaces. This increases knowledge and helps reduce economic barriers at the same time.
- Engage in conversations about values and beliefs with a non-judgmental attitude. This may increase trust and honesty about safe sleep practices.

Engagement, trust and ongoing efforts, often from multiple people, are necessary to effect change and reduce risk.

Scenarios

Below are six scenarios showing some statements and questions you may encounter when having conversations about infant safe sleep. Each statement or question is followed by an example response you may find helpful. Consider how you might adapt these potential responses to fit your voice and help in your work.

Scenario 1

When I was an infant, I was put on my stomach to sleep. Was that wrong?

No. Parents and caregivers were following advice based on the evidence they had at that time. Since then, research has shown that sleeping on the stomach increases the risk for SIDS. This research also shows that sleeping on the back carries the lowest risk of SIDS. That's why the recommendation is "back is best."

Scenario 2

"I put my infant to sleep on their stomach because they can roll over if needed."

When infants can easily turn over from back to stomach and from stomach to back, they should still be placed to sleep on their back. After they are asleep, if they roll over, you do not need to put them on their backs again. However, make sure there are no blankets, pillows, bumper pads or other items in the crib that the infant can roll against and suffocate.

Scenario 3

"My infant sleeps on their side because they are most comfortable that way."

If an infant is a stomach or side sleeper, the risk for SIDS is much higher. The side position is just as dangerous as placing the infant on the stomach because they can accidentally roll to the stomach. If an infant is used to sleeping on their stomach or side, changing to sleeping on their back **does not** increase the risk of SIDS. However, infants who are used to sleeping on their backs and are then placed to sleep on their stomachs are more likely to die from SIDS. That's why it's important to tell this to anyone caring for your infant, such as a grandparent who may not have the most current information.

Scenario 4

"When my infant is put to sleep on their back, they wake up scared, so I put them to sleep on their stomach."

The startle response is a sudden movement that is sometimes seen as scary for the infant. Sometimes the infant gasps. This protects the infant, letting them get a breath of air or wake up slightly from too deep a sleep. Try using soothing techniques such as singing, patting or using a pacifier.

Scenario #5

"My parent said I had a bald spot from sleeping on my back and I don't want that to happen to my infant."

Infants who sleep on their backs can develop temporary bald spots on the back of the head. As the infant grows, moves and begins to sit up more often, the hair on the back of the infant's head will grow back. A bald spot on the back of an infant's head can be a sign of a healthy infant, one whose risk for sleep-related SUID or SIDS is lower because they are a back sleeper.

While the infant is awake, aware and supervised, tummy time is recommended and will help decrease the friction on the back of the head that leads to temporary bald spots.

Scenario #6

"I refuse to let my infant sleep on their back because I have heard that they will get a flat head."

Back sleeping can contribute to flattening of the back of the head, but head flattening is usually temporary. As infants grow and become more active, their skulls will round out. You can reduce head flattening by doing the following:

- Providing tummy time during waking hours
- Switching which end of the crib you place the infant's feet and, when changing infant's diaper, alternating where the infant's head is on the changing table
- Changing positions often when the infant is awake, and
- Limiting time spent in freestanding swings, bouncy chairs, car seats and other surfaces that, with a lot of use, can lead to head flattening or temporary bald spots.

Scenario #7

"My infant sleeps in our bed because my partner gets very upset if I get in and out of bed during the night. He has to get a good night sleep to be able to work the next day."

I hear your concern. Are you open to considering other options, such as sleeping in another room or a different bed? If bedsharing is a practice you will continue, let's talk about other ways you can reduce risk for your infant. Are there safe ways to talk about infant sleep with you and your partner at the same time? Also, would you like to talk to someone about when your partner gets upset?

Activity: Practice communicating about safe sleep practices

This is your opportunity to practice responding to a parent's statements or questions. In the space below each of the four statements, fill in how you would respond to the parent or caregiver. Remember, as with all communication with families, building and keeping trust is key!

1. **I know putting my infant to sleep in a crib is safest, but they cry when they are laid down.**

2. **I put this blanket on my infant when they go to sleep so they won't get cold.**

3. **I smoke marijuana in the evening, outside of the home and after the children are asleep to help my anxiety, but I do not smoke around my infant and even shower and change my clothes after coming back into the house.**

4. **I don't drink around the children. Instead, I go out on weekends to drink while a babysitter watches the children (however, the parent comes home intoxicated and relieves the babysitter of duties).**

When an infant's medical needs change sleep recommendations

Some infants may have special prescribed medical equipment, such as a G-tube. In these situations, a medical professional may alter sleeping arrangements. What might you do in these situations?

- If the parent needs clarification about the prescribed sleeping arrangement, consider offering to have a joint conversation with the medical provider and the parent. This may help the parent better understand the infant's current medical needs.
- Make sure the parent understands the recommendations and how they may differ for another infant in the home without the same medical needs.

Part 4: Wrap up

You have almost made it — great work! This is the final part to the safe sleep self-study. In this section you will:

- Complete the professional action plan
- Complete the knowledge check
- Complete the survey, and
- Review the resources.

Professional action plan

Fill out your action plan here.

As a result of this self-study training, what are three things you will do to make sure you share the information with families who have infants?	

Knowledge check

Answer key provided

Question	Answer options	Write the letter(s) that match your answer
1. What is the age range for an infant?	A. Under 2 years B. 0-12 months C. 0-6 months D. 2-12 months	
2. Side sleeping is an acceptable and safe sleep position for an infant.	A. True B. False	

Question	Answer options	Write the letter(s) that match your answer
3. Sleep-related SUID only occurs in the infant's crib.	A. True B. False	
4. What is a good time in an infant's development to stop swaddling?	A. Two weeks B. One month C. 2 months D. 6 months	
5. What should you do if an infant falls asleep in a baby swing?	A. Be very quiet B. Move the infant to a flat, firm sleep space. C. Stop the swinging.	
6. It is unsafe for a parent or caregiver to bring an infant into their bed if they are under the influence of any substances that interfere with normal sleep patterns.	A. True B. False	
7. Community partners play an important role in engaging parents in safe sleep conversations.	A. True B. False	
8. Examples of outside stressors include the following:	A. Placed to sleep on stomach B. Cigarette smoke C. Too much clothing D. All of the above	
9. Placing an infant on their back is the most effective action caregivers can take to reduce SIDS.	A. True B. False	
10. It is recommended that infants sleep in the same room as their caregiver or parent but on a separate sleep surface.	A. True B. False	

1.B **2.**B **3.**B **4.**C **5.**B **6.**A **7.**A **8.**D **9.**A **10.**A

Online survey

Please complete the online survey and opportunity to provide feedback on this self-study by clicking on this link or pasting the link into your web browser: https://forms.office.com/g/KV94eBzAis

You can also access the survey with the camera on your mobile device using the QR code. Point your camera at the QR code so it appears on your screen. Click the banner and it takes you directly to the survey!

Questions and support

Family serving professionals in Oregon may email questions and requests for support related to this safe sleep self-study to CW.Prevention@dhsoha.state.or.us

Resources

The Safe to Sleep® campaign offers a variety of materials to help share safe infant sleep messages with diverse family audiences (African American, American Indian/Alaska Native and Spanish-speaking) https://www1.nichd.nih.gov/sts/materials/Pages/default.aspx

Videos for parents or guardians
https://www1.nichd.nih.gov/sts/news/videos/Pages/default.aspx

Oregon Public Health safe sleep webpage
https://www.oregon.gov/oha/ph/HealthyPeopleFamilies/Babies/Pages/sids.aspx

Safe Sleep for Babies brochure
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le8213.pdf

Spanish Safe Sleep for Babies brochure (Sueño seguro para bebés)
https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/ls8213.pdf

NICHQ webinar: "Improving Infant Safe Sleep Conversations"
https://www.nichq.org/improving-infant-safe-sleep-conversations

Oregon Prenatal and Newborn Resource Guide (English and Spanish)
http://www.oregon.gov/oha/PH/HEALTHYPEOPLEFAMILIES/WOMEN/PREGNANCY/PRENATALNEWBORNRESOURCEGUIDE/Pages/index.aspx

Cribs for Kids
https://www.cribsforkids.org

AAP 2016 SIDS Task Force Recommendations
https://pediatrics.aappublications.org/content/138/5/e20162938

How to Keep Your Sleeping Baby Safe: AAP Policy Explained
https://healthychildren.org/English/ages-stages/baby/sleep/Pages/A-Parents-Guide-to-Safe-Sleep.aspx

Consumer Product Safety Commission (CPSC)
For information on crib safety, contact the CPSC at 1-800-638-2772 or https://www.cpsc.gov/

Promising Futures: Best Practices for Serving Children, Youth and Parent's Experiencing Domestic Violence
https://promising.futureswithoutviolence.org/

Thank you for doing your part in keeping Oregon's infants safe

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Safe Systems Analysis FAQ

The Child Fatality Prevention & Review Program (CFPRP) joined the National Partnership for Child Safety (NPCS) in early 2020. The NPCS is a collaborative focused on applying safety science and sharing data to develop strategies in child welfare to improve safety and prevent child maltreatment fatalities[1]. In Oregon Child Welfare, this work happens through safe systems analysis.

What is safe systems analysis?

Safe systems analysis is a critical extension of Oregon's child fatality review process and is conducted by the CFPRP Safe Systems Coordinator(s). Through case file review, participation in the Critical Incident Review Team (CIRT), and follow-up supportive inquiry, the coordinator is able to gather important information about what influences common casework problems, also known as improvement opportunities. The information is then synthesized and rated using the Safe Systems Improvement Tool (SSIT).

What is the SSIT?

The Safe Systems Improvement Tool (SSIT) [2] is a multi-purpose information integration tool designed to be the output of an analysis process. The purpose of the SSIT is to support a culture of safety, improvement, and resilience. The SSIT is an effective assessment tool for use in critical incident reviews and provides structure to the output of a review process. It organizes the reviewers' learnings, shares the "system's story" of a critical incident, and advocates for targeted system reform efforts to lessen the likelihood of the problem occurring again in casework (Cull, Lindsey, & Epstein, 2019).

The SSIT is organized into four domains. The family domain is rated similar to the CANS and captures family and child characteristics around the time of the critical incident. The other three domains are nested to measure influencing factors at the professional, team, and environment levels.

When is safe systems analysis conducted?

Safe systems analysis is conducted in all cases reviewed by the CIRT and in some discretionary reviews. Safe systems analysis explores improvement opportunities (IOs) identified through the review processes. In cases where no improvement opportunities are identified, the safe systems

[1] National Partnership for Child Safety Charter: NPCS Charter

[2] SSIT Reference Guide: 2022 SSIT Reference Guide

analysis is brief and only involves documenting family characteristics in the family domain of the SSIT. When improvement opportunities are identified, all four domains of the SSIT are completed.

What are improvement opportunities?

Improvement opportunities (IOs) represent the gap between what the child or family needed and what they received. More technically, IOs are case-specific actions or inactions relevant to the outcome or industry standards and are often representative of relatively common casework problems. While emphasis is given to those IOs within ODHS-CW, IOs also consider the actions/inactions of other entities within the macro child-serving system (e.g., courts, human service providers, law enforcement, schools). In the safe systems analysis process, IOs are first identified through the CIRT or discretionary review. Those IOs are then explored in safe systems analysis. At times, additional IOs are identified through the process and added to the exploration.

In each safe systems analysis, IOs are evaluated for their proximity (i.e., closeness) to the outcome. Proximity is not intended to imply causality or severity of an action or inaction but rather describes how close the IO was in time or distance *and* with relationship to the incident. Since quality improvement resources are finite, considering the frequency and proximity of an IO is important to balancing if, when, and to what degree an agency advances a system improvement effort.

Who is involved in safe systems analysis?

The Safe Systems Coordinator reviews the file, participates in CIRT follow-up meeting, and consults with the CIRT coordinator in order to gather relevant information and determine whether or not to offer safe systems debriefings before completing the SSIT. If debriefings are to be offered, the caseworker(s) and supervisor(s) with recent or substantial contact with the family may be involved. Program managers, MAPS and other child welfare professionals may also be invited to participate. Occasionally external partners may be invited to participate as well.

What are safe systems debriefings?

Safe systems debriefings are the mechanism for gathering more individualized information from those who experienced the outcome in the local office/community.

Debriefings are completely voluntary, one-on-one meetings, lasting about 90 minutes. The coordinator uses supportive inquiry to engage with the child welfare professional. It is the goal of debriefings to promote healing and learning at both the individual and system level.

Are safe systems debriefings completed in every case?

Debriefings are not completed in every case. When improvement opportunities are identified through the CIRT or discretionary review process, the safe systems coordinator evaluates the circumstances of the case and may offer debriefings if there was an open CPS assessment or case with the family in the year prior. Because resources are somewhat limited, whether or not to

offer debriefings depends on availability of the coordinator as well as nature of the IO and its relevance to system challenges currently under exploration.

What happens to the information gathered during debriefings?

The information gathered during debriefings is evaluated along with all other information gathered through the CIRT or discretionary review process and then synthesized through the SSIT. The results of SSITs are aggregated, utilizing frequency and proximity of improvement opportunities as well as frequency of influencing factors in the professional, team, and environment domains to shape strategies for both system improvement and prevention efforts. Recommendations resulting from safe systems analysis may be presented to ODHS executive leadership for review and approval.

For more information, contact the Child Fatality Prevention and Review Program at cw.prevention@dhsoha.state.or.us.

Oregon's State Child Death Review and Prevention Team

CHARTER

2022

CONTENTS

INTRODUCTION

This Charter was developed by and for the State Child Death Review and Prevention Team. Within this document, the State Child Death Review and Prevention Team will be referred to as the state team and the County Child Death Review Teams will be referred to as county teams.

MISSION

The mission of the state team is to serve Oregon by reducing preventable child deaths.

STATUTORY AUTHORITY

ORS 418.748 states:

"The Oregon Health Authority, in collaboration with the Department of Human Services, shall form a statewide interdisciplinary team to meet twice a year to review child fatality cases where child abuse or suicide is suspected, identify trends, make recommendations, and take actions involving statewide issues.

The statewide interdisciplinary team may recommend specific cases to a (county) child fatality review team for its review under ORS 418.785.

The statewide interdisciplinary team shall provide recommendations to (county) child fatality review teams in the development of protocols. The recommendations shall address investigation, training, case selection and fatality review of child deaths, including but not limited to child abuse and youth suicide cases."

PURPOSE

The purpose of the state team is to better understand the circumstances surrounding child deaths occurring in Oregon to prevent future child deaths and serious injuries. The team accomplishes this through:

- Reviewing data gathered from collaborative, multidisciplinary, comprehensive case reviews.
- Supporting county teams where the reviews primarily occur.
- Tracking data-driven trends, improvement opportunities, and recommendations.
- Advocating for equitable prevention strategies at the community, local, state, and national levels.
- Informing continuous quality improvement within Oregon's larger child death review system.

OBJECTIVES

1. Support accurate identification and uniform reporting of the cause and manner of child deaths.

2. Promote cooperation, collaboration, and communication across the child and family serving system and enhance coordination of efforts within the family serving system.
3. Achieve quality, equitable investigation of child deaths consistent with national standards.
4. Design and implement cooperative, standardized protocols for the review of child deaths.
5. Ensure accurate, complete, and timely data entry in the National Fatality Review - Case Reporting System.
6. Review county team prevention recommendations and support prevention efforts.
7. Identify needed changes in legislation, policy, and practices, and recommend expanded efforts in child health and safety to prevent child deaths and serious injuries.

BACKGROUND

Oregon's State Child Death Review and Prevention Team (state team) is an interdisciplinary team. The state team exists within a larger child death response system comprised of professionals working to understand and prevent unexpected child death in Oregon and across the nation. The state team is charged with supporting county child death review teams (county teams) and collecting and analyzing child death information to support local and statewide prevention efforts.

Oregon Revised Statute (ORS) established the state team in 1989, county teams in 1991 and the state technical assistance team in 1995. The technical assistance team supports both the state and county teams and is housed in the Injury and Violence Prevention Program in Oregon Health Authority's Public Health Division.

GUIDING PRINCIPLES

EQUITY

The state team acknowledges generations-long social, economic, and environmental inequities result in adverse health outcomes. Systematic oppressions affect communities differently and may have a greater influence on health outcomes than either individual choices or one's ability to access health care. Some of the reviewed child deaths are not the result of the actions or behaviors of those who died, or their parents or caregivers. Social factors such as where they live, how much money or education they have and how they are treated because of one or more of their identities can also contribute to a child's death. When reviewing individual cases and interpreting the data, it is critical not to lose sight of these systemic, avoidable, and unjust factors. These factors perpetuate the inequities we observe in child deaths across populations in Oregon. It is critical that state team members and the system's, members represent, including state data systems, identify and understand the life-long inequities that persist across groups to eradicate them. Reducing health disparities through policies, practices, and organizational systems can help improve opportunities for all Oregonians.

The interdisciplinary state team commits to:

- Review and support the review of all death cases from a health equity lens and engage in difficult discussions that arise. Structural racism, interpersonal racism, and discrimination will be noted as findings.
- Regularly review data to identify populations with disproportionate outcomes.
- Make ongoing efforts to have state team membership reflect the diversity in Oregon communities.
- Evaluate our own biases and prejudices and engage in ongoing equity trainings.
- Support and promote equitable child death investigation.

HEALTH

The state team recognizes social determinants of health, including but not limited to poverty, food insecurity, housing instability, a lack of access to medical care (physical and mental health care), parental educational status, and systemic racism play a role in child deaths in Oregon. The state team commits to bringing social determinants of health to the forefront of team discussions and recommendations.

RIGHTS OF CHILDREN

The state team embraces a child rights-based approach to death investigation, review, and prevention. This includes (1) the basic rights to life, survival, and development of one's full potential; (2) protection from harm; and (3) having an active voice. Consistent with the United Nations Convention on the Rights of the Child, the state team, "respects and promotes the human dignity and the physical and psychological integrity of children as rights-bearing individuals, rather than perceiving them primarily as victims" (https://www.unicef.org/child-rights-convention/convention-text).

TRAUMA-INFORMED

The death of any child is a tragedy. The state team seeks to honor the trauma that results from the death of a child for the family and the community through all the activity and output of the team. As part of the work of the state team, the team will mindfully consider and seek to improve (1) how systems are, or are not, addressing the trauma of child death; and (2) the supports available to caregivers, community members, and county teams in managing trauma related to child death.

The state team recognizes the impact participation in child death reviews has on the emotional wellbeing of team members. To remain trauma-informed and responsive, the team will continue to take steps to support wellness of team members, which may include:

- Training opportunities regarding trauma and responding to secondary trauma.

- Taking intentional breaks during team meetings to engage in activities which support managing the impact of exposure to traumatic material.
- Actively working to create a safe culture focused on learning that encourages open communication and emotional support among team members without judgment.

SAFETY CULTURE

The state team values open communication, curiosity, continuous learning and improvement, and each team member's perspective, professional knowledge, lived experience, and expertise. The state team seeks to create an environment and culture that is free of blame and shame, where mistakes are opportunities for improvement, and individual accountability is balanced with systems accountability.

While disagreements between members are sometimes unavoidable, if navigated with care, they may help the team to function effectively and support quality work. It is the responsibility of the state team co-chairs to support and foster productive exchanges and dialogue between team members.

ORGANIZATIONAL STRUCTURE

The state team acts as the center of the child death review system in Oregon. This includes serving as support and oversight for Oregon's county teams.

While the state team's effectiveness depends on its membership forming a statewide interdisciplinary team, ORS 418.748 provides responsibility for the state team to the Oregon Heath Authority (OHA) and Oregon Department of Human Services (ODHS). As a result, co-chair positions are assigned to representatives of OHA and ODHS.

The state technical assistance team as outlined in ORS 418.706, provides staff support for the state team and technical assistance to the county teams. The state technical assistance team operates out of Oregon Health Authority, Public Health Division, Injury Violence and Prevention Program.

MEMBERSHIP

RECRUITMENT

The state team commits to ongoing recruitment of team members with a focus on team diversity and representation and seeks the support of active members in identifying and recruiting individuals who may bring value to the work of the team through their professional associations, personal experience, and expertise.

ONBOARDING

When a new team member is identified, the co-chairs will initiate the onboarding process with the assistance of the state technical assistance team. State team onboarding activities include but are not limited to:

- Dissemination of orientation materials to include team charter, recent annual reports, meeting minutes for two prior meetings, the National Center for Child Death Review Program Manual for Child Death Review, and a link to the Oregon Child Death Review and Prevention website.
- An initial onboarding virtual meeting with one or both co-chairs to discuss team member roles and responsibilities including active participation requirements, associated time commitment, and the onboarding timeline. If the onboarding member is replacing an existing member, the existing member will also participate.
- Co-chairs will create and send an email to the state team introducing the new team member.
- Observing a state team and county team meeting prior to team membership, whenever possible.
- Completion of a voluntary diversity questionnaire.
- A post-meeting check in between the co-chairs and the new team member after the new team member attends their first state team meeting.

ROLES AND RESPONSIBILITIES

The state team is comprised of individuals who hold one of three roles: co-chair, core team member or designee, and state technical assistance team member. Roles and responsibilities may shift over time and with agreement of the team member and co-chairs. However, all members regardless of role share the following responsibilities:

- Review and abide by the state team charter.
- Actively uphold the guiding principles, mission, and purpose of the state team.
- Actively and consistently engage with the team during state team meetings.
- Adequately prepare for state team meetings by completing necessary activities, such as document review, research, communication with county teams, completion of action items from prior meeting, or any other work required to support state team efforts.
- Participate in recommended trainings independently and during team meeting. Team members are encouraged to participate in and share learnings from training offered through their parent agency. When training relevant to child death review and prevention is available, the training information will be shared with the team.
- Share information openly and honestly within the state team.
- Share information with and from others in represented role.

- Protect the confidentiality of information by not sharing identifying information of the family and any law enforcement, health care, child protective services, or other protected information with anyone outside the child death review process.
- Use respectful, strengths-based, person-centered language when discussing children and families whose experience is shared through the child death review process, as well as when conversing with other team members. This includes the ongoing critical self-reflection necessary for the recognition of team members' individual biases and privileges.
- Understand that team membership is a long-term commitment with an associated workload and time commitment.
- Continuously work to strengthen relationships and improve communication with county teams.

DESIGNEES

Effective child death review requires a variety of perspectives. As such, state team members are asked to identify a designee should they be unable to attend a team meeting. When a designee cannot be identified, it is the member's responsibility to ensure alternative means for contributing to the agenda items. When possible, communication from the member to co-chairs informing of the need for a designee should occur at least one week prior to the team meeting. Team members may also choose to provide the co-chairs a letter authorizing an individual to serve as a permanent designee.

REPRESENTATION IN MEMBERSHIP

To support the commitment to policy and system improvement, state team members should have an ability to impact statewide change through role, connections, or access to and support from their represented group. When a permanent designee is assigned, the designee may represent a local connection to the work but will maintain a statewide connection through the member. Members will be selected for their subject matter expertise gained through education, work experience, and/or lived experience.

The state team is committed to diversity among team members and utilizes a voluntary diversity questionnaire as an assessment tool to inform recruitment efforts. The state team will continue to utilize this tool annually or as needed to fulfill the goal of ongoing reflection and growth toward creating a diverse team that represents perspectives and lived experiences of the Oregonians served by the broader child and family serving system.

The state team recognizes the sovereignty of Oregon Tribal Nations and continues to seek out opportunities to engage tribes in child death review and prevention efforts in a manner determined by the Oregon Tribal Nations.

The state team will at a minimum seek to include members representing the following perspectives and roles:

- Oregon Health Authority, Public Health Division, Injury and Violence Prevention Program, co-chair
- Oregon Department of Human Services, Child Welfare, Child Fatality Prevention and Review Program, co-chair
- Sheriff's Association
- Chiefs of Police
- Oregon State Police
- Department of Public Safety Standards and Training
- Office of the State Fire Marshall
- Oregon District Attorneys Association
- State Medical Examiner
- Oregon Child Abuse Solutions
- Oregon Pediatric Society
- Early Learning Division, Office of Childcare (Department of Early Learning and Care)
- Oregon Department of Education
- County Team Lead
- County Team Coordinator
- Oregon Department of Justice, Child Abuse Multidisciplinary Intervention (CAMI) Fund Coordinator
- Oregon Department of Justice, Child Advocacy Division
- Oregon Youth Authority
- Oregon Health Authority, Public Health Division, Maternal and Child Health
- Oregon Health Authority, Health Systems Division, Behavioral Health
- Oregon Health Authority, Public Health Division, Emergency Medical Services
- Oregon Department of Human Services, Office of Developmental Disabilities Services
- County Health Department medical provider
- Oregon Tribal Nations
- Oregon Council Against Domestic and Sexual Violence
- Safe Kids
- Oregon Child Development Coalition
- Oregon Association of Hospitals and Health Systems
- Faith Leader
- Oregon Health & Science University, Office of Rural Health
- Oregon Infant Mental Health Association

- Toxicologist
- Oregon Health & Science University, Doernbecher's Children's Hospital, Tom Sargent Safety Center
- Legacy Health Systems, Injury Prevention
- Family Support and Connections
- Oregon Council for Behavioral Health
- Pediatrician
- Coordinated Care Organizations
- Child and Adolescent Psychiatry
- Oregon Medical Board
- Oregon State Board of Nursing
- Oregon Board of Naturopathic Medicine
- Mental Health and Addiction Certification Board of Oregon
- Oregon Vital Records
- Oregon Department of Transportation

The state technical assistance team members, although not state team members, support the work of the state and county teams, and participate in the state team meetings.

EXITING THE TEAM

A state team member may end their membership for a variety of reasons, including change in role, and inability to meet the roles and responsibilities of a team member.

It is expected that any team member exiting the team will participate in an offboarding process as follows:

- When possible, if a team members become aware of their need to exit the team, they will communicate this to the co-chairs prior to their final meeting.
- The co-chairs provide an opportunity to receive feedback from the exiting team member.
- The exiting team member will work with the co-chairs to identify a possible replacement.
- When a replacement has been approved, the exiting team member will work with the co-chairs to develop a transition plan to support onboarding of a replacement. The transition plan will include:
  - Conversation regarding team responsibilities and time commitments will occur between the co-chairs and the exiting and onboarding team members.
  - Determination of when the transition between exiting and onboarding team members will occur.
  - Communication with any counties assigned to the exiting team member to inform them of the change.

- Exiting team member to participate in an exit interview with a co-chair to gather information to support overall program improvement.
- Removal of exiting member from future communications and confirmation the exiting member has disposed of all state team review materials or information not relevant to their job duties at their parent agency.

LOGISTICS

MEETING SCHEDULE

The state team will have half day meetings that occur at least quarterly.

MEETING LOCATION

To ensure inclusivity and access to statewide experts, the state team will be held virtually for the foreseeable future. The co-chairs will communicate any change in meeting format.

GUESTS/INTERNS

Periodically, the state may consider inviting guests to participate in or present at a state team meeting. Guests may include individuals with a particular expertise, case specific knowledge, or those for whom the experience would provide educational or professional development. Guests at state team meetings will be oriented to the team's purpose and guiding principles and must complete a statement of confidentiality prior to participation.

DECISION-MAKING PROCESS

The state team uses a consensus-based decision-making model where the co-chairs identify decision-making junctures, encourage open dialogue, and facilitate the decision-making process. Should the team fail to reach consensus, all members are provided an opportunity to provide feedback to the co-chairs, who weigh information and come to a final decision on behalf of the team.

CONFIDENTIALITY

State team members will sign and return a statement of confidentiality. Members will periodically be asked to provide a new signed statement.

The state technical assistance team will obtain and maintain the confidentiality agreements, ensuring no individual attends the state team meeting without a signed and returned confidentiality agreement. State team guests are required to complete a statement of confidentiality prior to participation in meetings.

ACCESSIBILITY

For the benefit of the state team and each member and guest, it is imperative all members and guests can fully participate in the state team process. The state team is committed to ensuring the accessibility needs of team members and guests are met during team meetings and with team communication. Prior to meetings members and guests will be asked what can be done to make participation easier. Actions taken may include but are not limited to:

- Including an accommodation statement in meeting invitations.
- Holding meetings via a virtual platform that provide a variety of means of participation including audio, visual, and dial-in via conference phone number.
- Co-chairs will ensure the chat box is monitored, read aloud the author and questions/comments to be addressed, and offer use of the chat box as an alternative method of communication during meetings.
- Providing captioning or live sign language or translation services as needed.
- Distributing communication in a minimum of 14-point font.

CASE REVIEW

SCOPE OF REVIEW

Child deaths which come under the purview of the state team include unexpected deaths of individuals under the age of 18 years including deaths as the result of maltreatment, suicide, or unexpected injury. Any questions or disagreements regarding the appropriateness of a child death review will be addressed by state team co-chairs.

CASE SELECTION

While review of individual child deaths occur at the county level, the state team may conduct a formal child death review in the following circumstances:

- A county is requesting assistance in reviewing a death due to insufficient resources to conduct a review.

- When the co-chairs determine an additional review is necessary to understand system improvement opportunities.
- When the co-chairs determine the review will serve as a learning opportunity for state team members.

To ensure access to a review, the state team will prioritize requests for review from counties with insufficient resources to conduct their own.

REVIEW PROCESS

Any state team member bringing forward a death for team review will do the following to ensure a quality death review occurs:

- Utilize the child death case summary abstract and disseminate to team members at least two weeks prior to the review.
- Identify individuals whose participation would provide value to the review and inform co-chairs and technical assistance team members at least 10 business days prior to the review.
- Review and utilize quality practice guidelines for conducting child death reviews available through the National Center for Child Fatality Review and Prevention.
- Present case information with a strengths-based, person-centered framework that seeks to identify opportunities for improvement while considering the totality of the family's experience with the broader child and family serving system rather than focusing on individuals or specific actions.

COUNTY TEAMS

COMMUNICATION WITH COUNTY TEAMS

Communication between county teams and state team primarily occur through regular contact resulting from the technical assistance team duties, administration of the Child Abuse Multidisciplinary Intervention funds, and co-chair contact.

COUNTY SUPPORT

State team members are strongly encouraged to participate in the critical work of supporting county teams.

County Support Goals:

- Enhance communication between the county and state death review teams.
- Support and encourage the county in the completion of death reviews.

- Increase the understanding of the purpose and value of the death reviews.
- Remove barriers to completing death reviews.
- Ensure Oregon has data on child deaths to inform prevention and intervention.

DATA

DATA COLLECTION

Data collection will occur through regularly scheduled data imports from the National Fatality Review-Case Reporting System (NFR-CRS), the data system supporting Child Death Review and Fetal and Infant Mortality Review teams across the country. Collection of data through the NFR-CRS is facilitated by the state technical assistance team. The County Support Program will serve as an additional means to ensure the timely and accurate entry of information into NFR-CRS by county teams.

DATA SHARING

The state team members will engage in data sharing with other Oregon child death review professionals and national partners as needed to fulfill the objectives of the state team and pursuant to ORS 418.747(13).

IDENTIFICATION OF TRENDS

Using their unique expertise and connection with county teams, state team members are responsible for identifying trends in Oregon child deaths using available data and through discussion with county teams.

PREVENTION

PREVENTION RECOMMENDATIONS & SUPPORT OF PREVENTION EFFORTS

A foundational purpose of the state team is the creation of child death prevention strategies based on data obtained during child death reviews occurring throughout Oregon. The state team addresses the status of current statewide prevention efforts, identifies gaps in child death prevention, and develops additional plans and strategies as needed as part of the team's core work pursuant to ORS 418.748.

ENGAGEMENT OF COUNTY TEAMS IN PREVENTION

County teams are vital partners in the work of child death prevention in Oregon. Using available data, the state team will make efforts to partner with county teams to identify, develop, and implement prevention efforts occurring both at a local level and statewide level.

LEGISLATION AND PUBLIC POLICY

The state team recognizes the limitations placed on some team members, such as their ability to participate in lobbying activities, because of their employment. The state team co-chairs, along with impacted team members, will ensure that state team actions are not in violation of such restrictions.

Despite restrictions, there are opportunities for many members to impact legislation and public policy through legislative concepts, policy option packages, and other means. Members are encouraged to reach out to the state team for potential partnership and support for such opportunities.

COORDINATION WITH OTHER REVIEWS

The state team will continue to explore opportunities to coordinate child death reviews with county teams and death reviews occurring as part of the ODHS Child Welfare's Child Fatality Prevention and Review program.

Additionally, the state team will make efforts to engage and learn from other death reviews in Oregon, including but not limited to domestic violence, sex trafficking, overdose, suicide, firearm, and maternal mortality and morbidity.

OUTPUTS

ANNUAL REPORT

The state team publishes an annual report regarding child death reviews conducted in Oregon. This report focuses on child death reviews known to the state team that occurred during the prior calendar year and is issued no later than 6 months after the end of the year. The annual report is provided to the Governor's Office and ODHS and OHA leadership. The report is published on the Oregon Child Death Review and Prevention web pages.

The report contains but is not limited to the following:

- The number of known child deaths for the applicable year.
- The manner and/or cause of death in such deaths.
- The age, gender, race, ethnicity, and geographic areas of child deaths for the applicable year.
- Identified local and statewide trends.
- The status of local and statewide prevention efforts stemming from current and previous annual reports.

ANNUAL CONFERENCE

The state team will host an annual (virtual or in-person) conference to enhance the work of the county teams and to offer an opportunity for networking and sharing of expertise between individuals conducting child death reviews within Oregon.

WEBSITE

The state team will maintain a webpage on the OHA website with child death review and prevention information and resources.

Safe Systems Mapping in Oregon: Learning across critical incident reviews to drive collaborative system improvement

Aimee Dickson, BA[1]
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Tiffany O. Lindsey, Ed.D.[2]

INTRODUCTION

In July of 2019, Oregon Department of Human Services Child Welfare Division began using safety science to transform its critical incident reviews. This shift included moving away from assigning individual blame for tragedies to adopting a systems-focused approach rooted in learning and improvement. Oregon Child Welfare uses the Safe Systems Improvement Tool to capture this learning.

METHODS

Over time, Oregon Child Welfare's Child Fatality Prevention and Review Program began to see common challenges emerging in cases involving parent or caregiver substance use. These challenges, known as improvement opportunities, represent a gap between what the child and/or family needed from Child Welfare and the broader child and family serving system and what they received.

Improvement opportunities related to caregiver substance use were prevalent across 9 of 48 cases reviewed through safe systems analysis during the period under review. In addition, of the 48 total cases reviewed in the time period, 20 cases had actionable scores under Caregiver Substance Use in the Family Domain of the Safe Systems Improvement Tool. Program coordinators gathered the identified improvement opportunities and SSIT data from across these cases for further evaluation through safe systems mapping.

Oregon Department of Human Services
CHILD WELFARE

[1]Oregon Department of Human Services
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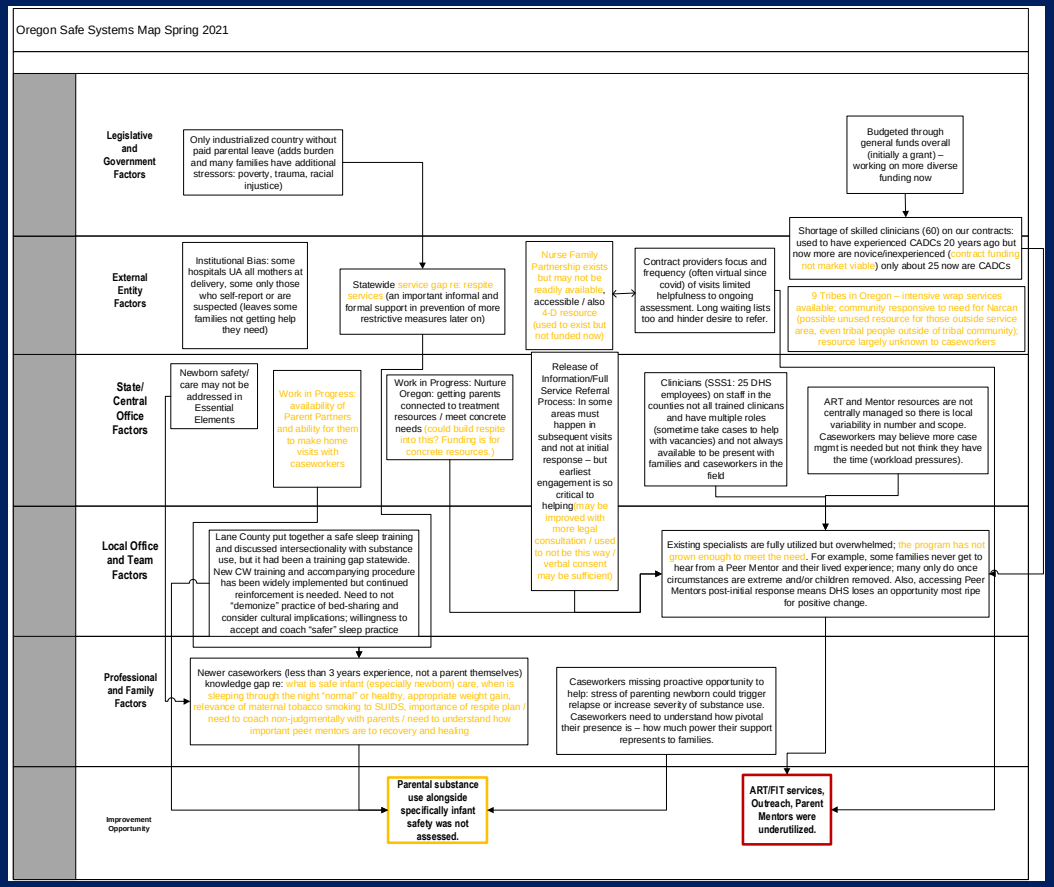

The purpose of safe systems mapping is to discuss in a group of experienced professionals their perceptions of what factors influence identified improvement opportunities at all levels of the system – from the local team level to the legislative/government level.

The safe systems mapping team met a total of five times April and May 2021 to explore the challenges and brainstorm strategies for improvement. Throughout the mapping process and during development of recommendations, it became clear caseworkers need support and perspective from individuals with lived experience as well as professional experience in the field of substance use disorder assessment, treatment, and recovery.

TCOM
Transformational Collaborative Outcomes Management

RESULT

This exercise resulted in eight system improvement recommendations, which were presented to executive leadership in September 2021.

1. Restructure and expand Addiction Recovery Teams and corresponding contracted services
2. Develop comprehensive case practice guidelines for cases involving substance use
3. Develop a process for referring to community-based supports or services on reports that are closed at screening
4. Develop statewide staffing guidance for infant cases
5. Enhance knowledge and skill through creative education for caseworkers and supervisors
6. Actively promote partnership with local prevention organizations
7. Identify and support culturally appropriate paid respite, child-care programs, and safety service providers
8. Develop an application to provide information and guidance to child welfare professionals

IMPLEMENTATION

Since the presentation of the recommendations to executive leadership, the Child Fatality Prevention and Review Program has monitored the progress of each recommendation, noting both successes and continued challenges in moving large scale system improvement once the review and recommendation process has been completed.

While staffing support for taking on the work of the recommendations remains a challenge, this inaugural safe systems mapping exercise was successful in engaging Child Welfare and other professionals who may not otherwise participate in system improvement work.

For more information on Oregon's fatality prevention work and Vision for Transformation, scan the QR code

TeamFirst

A Field Guide for Safe, Reliable, and Effective Child Welfare Teams

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Cull & Lindsey, 2019

ACKNOWLEDGEMENTS

A large number of individuals have collaborated in the development of the TeamFirst Field Guide. Special acknowledgement belongs to Tennessee Department of Children's Services, who, with the support of Casey Family Programs, first tested some of these strategies with their workforce. This TCOM reference guide represents the curation, adaptation and development of a set of strategies, tools and tactics the support more safe, effective and reliable team-driven casework. The history of this approach traces to aviation's Crew Resource Management and The Agency for Healthcare Research and Quality's TeamSTEPPS and CUSP. The copyright for TeamFirst is held by the Praed Foundation to allow for its continued development and ensure that it remains free to use.

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INTRODUCTION

A field guide is a reference book that helps users learn by providing them with real examples from "the field." In his seminal work, *The Field Guide to Understanding Human Error*, Sydney Dekker (2014) introduced us to a new way of thinking about professional behavior in complex systems and gave readers a practical guide for engineering safer systems. Building on the work of Dekker and many others, *The TeamFirst Field Guide* is designed as a reference for safe, reliable and more effective teamwork. Readers will find descriptions of specific team-based strategies and tactics that work and are illustrated with some real-life examples of implementations in the field.

Culture is an implicit pattern of shared basic assumptions among a group of people (Schein, 2010). It can be defined, measured and changed. Culture lives in habit—the implicit routines people enact to problem solve—it is how members "get work done around here." In a Safety Culture, safe and engaged teams practice six enduring habits. These teams…

1) Spend time identifying what could go wrong.
2) Talk about mistakes and ways to learn from them.
3) Test change in everyday work activities.
4) Develop an understanding of "who knows what" and communicate clearly.
5) Appreciate colleagues and their unique skills.
6) Make candor and respect a precondition to teamwork.

In summary, teams in a Safety Culture plan forward, reflect back, test change, communicate clearly, appreciate their colleagues, and manage professionalism. This field guide is a collection of strategies organized by each of the six habits.

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PLAN FORWARD

Spend Time Identifying What Could Go Wrong

By nature, human service work experiences a level of volatility, ambiguity, and complexity rivaling other high-risk industries, like healthcare. Consistently safe decision-making is the result of open-minded, adaptive, shared accountability among a team. The inextricably connected sociotechnical nature of human service work—often highly pressured and under resourced—requires multiple professionals to collaborate as seamlessly as possible. Getting into the cadence of "planning ahead" is central to projecting and resolving risk factors before they lead to harm. The following are strategies designed to cultivate this habit among intact and ad hoc teams of professionals.

Huddles

For example, in child welfare, all professionals assigned to work with a family gather before heading into court to summarize the family's status, verbalize concerns, and project plans for what likely happens next.

Huddles also occur before important meetings where the child and family will be present.

Planning forward is an essential aspect of building and supporting a safety culture. It means that rather than being reactive to situations and events, the team can be proactive. Further, it increases the likelihood that decisions will be thoughtful, intentional, and systematic, rather than last minute and made under pressure.

Huddles are used successfully in many high-risk industries. For example, in healthcare, the use of preoperative huddles reduced the number of surgical errors (Criscitelli, 2015).

GROUND RULES

- Standing is better than sitting
- Keep it short (no more than 15 minutes)
- Start and end on time

PREP = **P**REPARE, **R**EVIEW AND ANTICIPATE, **E**NACT, **P**ROMOTE RESILIENCE

Prepare

- Ensure team members have what they need to prioritize case activities (e.g., referrals assigned, case logs, overdue reports).
- Organize the materials the team needs (e.g., case assignments, family contact logs, overdues, information on any incident reports/new referrals on open cases, etc.)

Review and anticipate

- State the purpose: to update and anticipate
- Provide team-level update (e.g., case closures, caseload data, overdue #s)

- Facilitate case-level updates
- Anticipate care needs/challenges with questioning. Always ask "What are you concerned about?"

Enact

- Mobilize resources to remove barriers.
- Expect team members will experience challenges throughout the day. Build individual resilience and team shared meaning with an eliciting/evoking style and closed loop communications.

Promote resilience

- Close each huddle with a statement that reinforces Safety Culture and promotes resilience.

Checklists

For example, when transporting a child with type 1 diabetes to a new foster home, the case manager consults a checklist to ensure she provides the correct supplies, education, and medical contacts to the caregivers.

Checklists for safety-critical tasks are crucial, especially in building strong casework practices and remembering relevant details during infrequently conducted, safety-centered tasks. For example, a checklist about things to do when removing a child from a caregiver's home can be extremely helpful to a new professional and even to an experienced professional who is affected by fatigue or stress and/or has not completed a similar task in some time.

As an abiding principle, checklists need to be:

- Readily-Accessible
- Clear
- Concise
- Relevant
- Easy to Use

Though checklists can be meaningfully used to list steps on a variety of issues, teams may find checklists are most useful during crucial safety moments, when pressures are high and errors, if made, could have a dire impact on employee, child, or family safety, such as the following: meeting initial response to a home, removing a child(ren) from a home, addressing a safety concern about a family member's mental health, and/or reunifying a family after some time apart.

Be mindful of not creating unnecessary checklists or getting in the habit of marking off checklists without truly reflecting upon each item.

Pre-Mortem Strategy

For example, during group supervision, clinicians use pre-mortem strategy to consider discharge planning for a client with a complex history of psychiatric hospitalizations.

A reflective, mental strategy where you imagine a future state, when a plan has been put into place but failed. The strategy is useful because, in some cases, we know how a plan is likely to fail. Taking the time to think through likely failures gives an opportunity to proactively create safeguards.

Follow these guidelines:

- You've engaged the family in response to an event…
- The plan you wanted to put into place has happened, but…
- The plan has failed…
- What went wrong?

For example, you might use pre-mortem strategy about a child beginning a trial home placement with his father. You imagine the home placement started with desired services (e.g., counseling, case management) in place, yet the trial home placement failed, and the child re-entered foster care. By imagining what could likely go wrong, you consider the father's limited social and mental health supports to raise a child with autism. As a result, he becomes overwhelmed and depressed.

With the outcome of the pre-mortem strategy in mind, a new plan is developed, where the father begins attending a monthly support group for parents raising children with autism, connects with local grant-funded respite services for occasional caregiving assistance, and the father attends individual mental health counseling.

REFLECT BACK

Talk About Mistakes and Ways to Learn from Them

Making a mistake does not guarantee learning, but processing a mistake is foundational to learning and improvement. In psychologically safe cultures, disclosing an error is respected and supported—not because team members engage in pat responses—but because mistakes are viewed as opportunities to learn and receive support to press onward with more wisdom at hand for the next time. Without question, no human service professional engages in perfect, error-free work. Expressing vulnerability through transparent discussion of mistakes is a display of great professionalism and courage. As such, "reflecting back" is a value of safe, engaged teaming (Edmondson, 2019; Perlo et al., 2017). The following are strategies to promote the habit of reflecting back:

Structured Debriefs

For example, a supervisor debriefs with his team anytime a child/youth is disrupted from a foster home.

Structured debriefs should follow important trigger events. For example, in foster care, placement disruptions or maltreatment recurrence could trigger a team debriefing. Being inconsistent and/or not communicating in advance what events will trigger debriefing can make the process feel less psychologically safe, because team members could be worried debriefings only occur when the supervisor believes a team member made a mistake. For example, debriefs could be done as a team or between a case manager and supervisor at the end of certain Child and Family Team meetings or after unanticipated court ordered removals of children to state custody.

Note: During debriefings, if someone responds unprofessionally or disrespectfully towards the person who made the mistake, it is crucial this person receive an honest and prompt correction (see Section Six: Managing Professionalism for related strategies, like OSSCR).

Ask three simple questions:

- What went well?
- What could have been better?
- What will we do differently next time?

Debriefs are a leader facilitated discussion that accomplish two important goals:

- Team unity and psychological safety
- Learning and improvement

Facilitator Checklist:

- Communication clear?
- Roles and responsibilities understood?
- Situation awareness maintained?
- Workload distribution equitable?
- Task assistance requested or offered?
- Were errors made or avoided?
- Availability of resources?

PMI: Plus – Minus – Interesting

For example, a teammate uses PMI while mentoring a new employee to discuss what the new employee is learning from her fieldwork.

An activity where you look at an event or case retrospectively and think through the following questions:

- **Plus**: What went well? What went according to plan? What did I/we do that worked so well, and is there anything learned to apply again the next time?
- **Minus**: What did not go well? Was there anything that should not be replicated in a future situation? What were the "lessons learned"?
- **Interesting**: What things were learned that were previously unknown? Anything unique or curious and worthy of sharing with others?

Restorative Accountability

For example, a case manager working with adults recovering from drug-dependency experiences a suicide on his caseload. He is grieved and worried his last visit with the client was shortened by an emergency on another case. Affected by the emergency on the other case, he had quickly concluded the client was safe, acknowledging the client was experiencing a "bad day" but believing sufficient supports existed to assure safety. Rather than exact discipline on the traumatized case manager, the supervisor offers support and gives the case manager an opportunity to process, learn, and heal.

A **retributive approach** to accountability is concerned with rules, rule-breaking, and sanctions. It assumes blame and the threat of sanctions motivate safe behavior and error avoidance. A retributive approach asks the following:

- Who broke which rule?
- How serious is the violation?
- What is the proportional punishment?

A **restorative approach** to accountability is concerned with learning and assumes the complexity through which mistakes or errors occur. Such an approach achieves accountability through repair, prevention, and learning. A restorative approach asks:

- Who was harmed?
- What do they need now?
- Whose responsibility is it to provide help?

In a retributive culture an account becomes something to be paid back – something that is owed. In a restorative culture an account is a story to be told – something to help us learn and get better (Dekker, 2007).

The Substitution Test

For example, a mental health counselor inadvertently allows a safety plan to expire on a child with ongoing emotional disturbances. In determining appropriate accountability and next steps, the supervisor mentally questions if other similarly experienced counselors in the same situation would be likely to make the same mistake.

A reflective, mental activity to consider a professional's culpability in context.

Would three (3) other individuals with similar experience and in a similar situation and environment act in the same manner as the person being evaluated?

- If the answer is **yes**: The problem is not the individual but more likely an environment which would lead most professionals to the same action.
- If the answer is **no**: If similarly experienced individuals would not have acted in a similar manner, it is possible the individual is more culpable and individual accountability is appropriate—whether through services (e.g., mental health treatment), coaching, disciplinary action, or otherwise.

TESTING CHANGE

Discuss Alternatives to Everyday Work Activities

Implementation science is the study of what factors promote and accelerate successful, scalable, and sustainable improvements. Studies may inform "what" achieves the best client outcomes in human service professions, but guiding professionals (the "who") and offering the motivation (the "why") to change practices can be hard. This adaptive side of leadership and teamwork is challenging but well-harnessed by implementation science (Hilton & Anderson, 2018). Empowering teams to collaborate and conduct "small tests of change" is central to safe, reliable teamwork.

Using Implementation Science Principles

Implementation science underlies successful quality improvement. Whenever you are considering an improvement activity, ask three simple questions:

- **Overall Aim or Goal:** What are we trying to accomplish?
- **Desired Outcome:** How will we know a change is an improvement?
- **Ideas for Strategies, Tools, or Practices:** What changes can we test that will result in improvement?

Small Tests of Change (PDSA CYCLE)

For example, a regional office tries a new on-call schedule for one month in one county and assesses the impact to employee's workhours before implementing on a larger scale.

Rather than trying to implement something big and different all at once with some office-wide "roll-out," testing strategies and tools on a small scale first can be much more effective. The Plan-Do-Study-Act method is a way to test ideas quickly on a small scale.

The Plan-Do-Study-Act (PDSA) methodology is intended to help people move quickly from identifying solutions, strategies, and opportunities to trying them out – on a small scale – in the real world. It is based on a simple continuous quality improvement model in which you plan what you want to do (Plan); you try it out (Do); you think about and review what happened when you did it (Study); and you adjust it based on what you learned (Act/Adjust).

Why Use a PDSA

- Check to see whether the idea will actually result in improvements
- Allow those closest to the work – and those who know the real-world environment best – to test the changes they identify
- Determine whether the idea will work in the real-world environment

- Increase belief from others that your idea will actually result in improvement (gain proof and buy-in)
- Identify possible costs, side effects, or unintended consequences while the impacts and risks are fairly low
- Evaluate how much improvement can be expected from the change

How to Test a PDSA

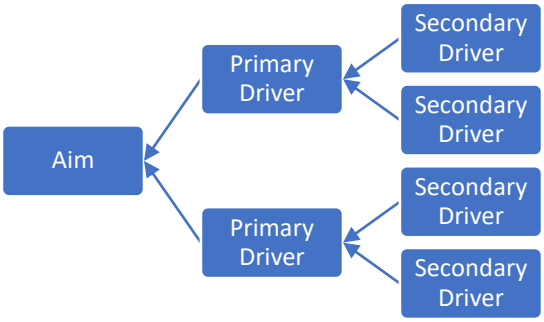
- **Plan:** Identify a strategy or idea you want to test. Think about what it would look like if you just tried it out with one child, one family, one colleague, etc. Remember you are not trying to figure everything out at once, nor do you want to spend time trying to figure out how to make it work for everyone, all the time. You just want to try it once to make sure it is a good idea worth pursuing.
- **Do:** Try it out with that one child, family, colleague, etc. Just do it exactly as you planned.
- **Study:** Reflect on what worked the way you expected and what might have surprised you in the process. Ask the person who you tested this idea on what they thought about it. Did they like it better than whatever happened for them in this situation previously? What worked for them? What did not? What other recommendations do they have for you?
- **Act/Adjust:** Use the results of your 'study' – what you experienced, observed, reflected on, heard from the person you tested it with – to inform how you might make this idea even more effective next time. This 'adjust' phase should feed directly into your next **Plan** so that the next time you do it, you'll have worked out some more of the real-world kinks.

Driver Diagram

For example, a public health director wants to reduce the infant mortality rate. He understands the primary drivers of infant mortality to be inadequate prenatal maternal health, postnatal care, and the presence societal issues like poverty and substance abuse. He decides to hone his improvement opportunity at postnatal care. He studies and identifies drivers of strong postnatal care include caregiver attachment, parenting education, and pediatric care. As a result, he begins a Nurse Family Partnership program in a county with a high infant mortality rate.

A simple, visual diagram of what is theorized to "drive" a goal or achievement. A driver diagram identifies both key and secondary drivers and their relationship to one another.

A driver diagram is used to articulate a theory of what drivers can be changed to result in improvement. It organizes and justifies the changes a team is wanting to make.



COMMUNICATE EFFECTIVELY

Develop an Understanding of Who Knows What

Human service work is high-risk, interdependent and also fast-paced. Though intact teams can struggle to communicate effectively, cross-team communications are even riskier. In those cases, professionals need to work seamlessly to make safe decisions, and vital decision-makers may not even have previously met one another (Edmondson, 2019). Furthermore, safe, engaged teaming requires teammates to know one another's unique skills. A professional regularly receiving the opportunity to use personal strengths is crucial to engagement. In a Gallup poll that asked respondents if they "have the opportunity to do what [they] do best every day," every single respondent who disagreed additionally reported being emotionally disengaged at work (Rath, 2007). An emotionally disengaged workforce cannot reliably make safe decisions. Communicating concisely and to the person with the right expertise helps ensure vital information gets handed off to the right person, the right way, at the right time, and in a manner supporting the recipient's memory retention.

4Cs of Communication

Communication should be:

- **Clear.** Avoid jargon. Be professional.
- **Concise.** Shorter is better. Your colleague will be more likely to retain and use the information you provide if it is kept brief and only focused on relevant information.
- **Comprehensive.** The balance to being Concise. Keep it short, but include all crucial content.
- **Congruent (words match body language and expression).** 55% of communication is done non-verbally. Pay attention to your body language and non-verbal cues.

Briefs

For example, before walking into a family's home, a social worker and Law Enforcement officer quickly brief one another on the current concern, family history, and next steps. They develop quick contingency plans should safety become an issue, and they succinctly remind one another of standard safety procedures (e.g., not to walk in front of the family down a hallway, if sitting stay close to an exit).

A discussion between two or more teammates to succinctly process case-specific information. A brief can be requested by any team member anytime.

A briefing immediately:

- Maps out the current plan for the child or family
- Identifies each teammate's responsibilities
- Assesses if the current plan should be revised and, if so, how
- Articulates safety concerns and plans to ensure safety
- Often uses STEP or SBAR (see below)

Situational Awareness with STEP

For example, a social worker describes a current situation with a client using STEP: " **[Situation]** Neveah appears content and safe in Visitation Room A with her mother, but Neveah was crying and threw a small children's chair in the moments before her mother arrived. **[Team Members]** Amy and I are monitoring the visit together. **[Environment]** Currently, Neveah is playing a card game with her mom, and [**Progress**] their visit has approximately 45 minutes left."

An acronym to quickly communicate a current situation with a child or family (i.e., client)

- **S**tatus of the client
- **T**eam members
- **E**nvironment
- **P**rogress

SBAR

For example, Child Protective Service Investigators use SBAR to present a case to a Department Attorney when considering if a child should be removed from a home. Using SBAR streamlines dialogue and creates an environment where the attorney and frontline investigator communicate well directly, rather than communicating indirectly through a supervisor.

A useful acronym for processing safety-critical information, like a child and family case. For example, SBAR can be used to succinctly describe a case to a supervisor, assisting agency, and other internal professionals who are responsible for making case-specific decisions (e.g., an attorney responsible for evaluating if sufficient evidence exists for exigent removal of a child)

- **Situation.** What is the current status? What's going on?
- **Background.** What is important to know about the service provider, case, child, or family's background? What is the context?
- **Assessment.** What risks do I and/or others see?
- **Recommendation.** What would I do to provide safety? What is the next decision I believe needs to be made?

When listening:

- Avoid mental distractions (i.e., "Tech down; eyes up.")
- Listen intently
- Take notes if possible—and especially if discussing multiple cases or case decisions
- Ask questions
- **Reflect back** always (and use SBAR when you do)

Common pitfalls:

- Assuming you are using SBAR naturally—even when stressed and tired
- Drifting into tangents

Three things you can do right now to increase the structure and efficiency of your communication:

- Write SBAR in your office space or on a notecard to go behind your employee badge.
- Practice…Practice…Practice. Use SBAR when speaking with your supervisor or legal about a case.
- Engage in mindfully staying on task when transferring a case or offering safety-critical information to someone else who is making important decisions.

For example, a social worker uses I PASS to communicate critical information to a colleague who will be temporarily assigned her cases while she is on vacation.

"I PASS"

An acronym to structure the exchange of information during handoffs (e.g., transferring a case from one case manager and/or team to another).

Introduction: introduce yourself and your role/job

Person: provide the child and/or family's name and important identifiers (e.g., age, gender, location)

Assessment: list presenting concerns and current assessment of those concerns

Situation: identify the current situation (e.g., housing, employment, family supports, childcare) and care plan

Safety Concerns: process all current or recent safety concerns

APPRECIATION

Appreciate Colleagues and their Unique Skills

The psychological benefits of experiencing gratitude is well-documented, but a recent healthcare study involving nurses found even physical advantages (i.e., improved sleep quality and adequacy, fewer headaches, healthier eating) to receiving appreciation in the workplace—because appreciation increased job satisfaction (Starkey, Mohr, Cadiz, & Sinclair, 2019). Human service professionals often associate their careers with core pieces of their identity, placing themselves in hazardous conditions and looking out for their clients, at times, even above looking out for themselves (Portland State University, 2019). Expressing gratitude is a crucial and not-to-be-underestimated habit of safe, engaged teamwork.

Intentional Affirmations

A supervisor writes a handwritten note to one of his employees after she testifies in court for the first time. He affirms her efforts to prepare her testimony as well as her sense of professionalism in the courtroom.

Intentional affirmations, particularly ones about character or effort, generate positivity and synergy among teams. Acknowledging specific successes is useful but could become a source of anxiety since successes are closely aligned with performance indicators.

Generally-speaking, intentional affirmations are best when they are:

- Unique to the individual or team
- Administered in a personal way (e.g., a handwritten note)
- Given freely at irregular intervals and not in a regimented or scheduled way

Managing Up

For example, while transferring a case from one social worker to another, the original social worker speaks well of the colleague who will begin work with the family.

Managing up is simple tool for affirming your colleagues and setting the stage for engagement. We "manage up" by speaking positively of our colleagues and genuinely expressing their strengths to others. For example:

> *"Angie is going to begin working with you next week. I know you've only met Angie once, at our last meeting, but I have worked alongside Angie for the past year. She is knowledgeable, compassionate, and great at coordinating services."*

What is the goal?

- Families and youth feel better about their next case manager and experience.
- Families and youth feel more at ease about the coordination of their care.
- Coworkers give/get a head start on engagement.

Manage up at two levels:

- Positively position team members with other team members.
- Positively position team members with families and youth.

Resilience Rounds

For example, an executive leadership team meets with regional staff. While on-site at the regional office, each leader meets with 4-5 frontline regional staff and takes a moment to express appreciation, model values, and asks the group how the leader can better connect and contribute to their work.

Senior leaders can reinforce goals and support resilience through informal conversations with professionals.

Ground Rules

Teams should decide whether to announce the time and place of Resilience Rounds, and the decision should be agreed to by senior leaders and managers. Leadership should reassure professionals information discussed in Resilience Rounds is private.

What are the Goals?

Resilience rounding provides an opportunity for senior leaders to interact directly with frontline professionals to promote resilience. Authentic conversations with leaders can empower field professionals, breakdown communication silos, and inform improvement. Positive affirmation, anticipatory care practices, and supportive professional relationships are among the most effective tools we have for reducing burnout, stress and the effects of secondary trauma exposure. Resilience rounds:

- Promote professionals' resilience through direct affirmation and active listening from leaders
- Model a positive, responsive culture and promote effective team behaviors
- Allow leaders to identify system-level improvement opportunities

What is the format?

A conversation with the leader and three to five employees can be structured in various ways, including:

- Hallway conversations or informal team talks
- Individual conversations in succession
- Group conversations with employees in a specific type function or job

Large formal convenings should be avoided. Look for small, safe, comfortable spaces.

Remember: Two people are likely to do 60% of the talking. The leader's role is to listen and bring everyone into the conversation.

Open with something appreciative:
"Thank you for your work. I appreciate your…"

Discussion Question:
"Does your team spend time identifying activities we do not want to go wrong? For example, placement disruptions."

- Possible follow up from Information Technology staff – How does our electronic case record help you prevent things from going wrong or create barriers?
- Possible follow up from Fiscal Director – How do our fiscal processes help you prevent things from going wrong or create barriers?
- Possible follow up from Regional Leader—How do our monthly reviews help prevent problems or create them?
- *The goal is to encourage open, authentic dialogue in order for the leader to promote safe conversations about issues and to demonstrate genuine interest in understanding how the leader's work is affecting the frontline and vice versa*.

You may also consider the following discussion question if time permits.
"Does your team have opportunities to talk about mistakes and ways to learn from them? Do you feel like mistakes are often held against you?"

"On your team, is it okay to speak up when you disagree with a team member's decision?" In asking these questions, take a brief moment to express values as a leader of the organization.

- "We (leaders) always want people to come forward with concerns."
- "We (leaders) want to foster safe, collaborative conversations about mistakes—not to unfairly judge or blame, but always to learn and improve."

Things to listen for:

- Do teams have the tools and resources they need?
- Who do they go to with tough problems?
- How do they manage the stress of the job?
- Remember tackling and implementing solutions to issues, when possible, and circling back to teams with improvements helps encourage these conversations to continue.

MANAGE PROFESSIONALISM

Candor and Respect are Preconditions to Teamwork

High-stakes conversations are daily practice in human service organizations. Teams need to feel ready—even mandated—to challenge ideas, assertively confront concerns, and learn from successes as well as failures. (Edmondson, 2019). A silent workforce cannot make safe choices, but an overly aggressive and confrontational one cannot either. To that end, candor and respect are preconditions to safe, engaged teamwork. Candor and respect generate the trust teams need to engage in productive, healthy conflict (Lencioni, 2012; Patterson, Grenny, McMillan, & Switzler, 2012). The strategies below are simple yet effective tools in building the habits of candor and respect.

Signal Words: CUS

For example, during a huddle, a new case manager is worried a child is unsafe and needs to be removed from a foster home, but no one else on the team seems to feel that way. Rather than say nothing, the case manager says "Help me **understand**. I don't think this home is safe." When the response does not address her concerns, she says, "Let's **stop** for a minute. I'm worried." As a result, the team gives the case manager an opportunity to more fully articulate her concerns and revises their plan.

Team with a strong safety culture embrace “speaking up” behaviors. With a foundation of trust and positive regard for one another, all teammates are expected to share safety concerns. Even if this leads to conflict, such dialogue is essential in considering all known risks and creating the safest, best outcome for an employee, child, or family. The key is to engage in healthy conflict and use repair when needed.

Assertive statements follow the “two challenge rule”—meaning it is your responsibility to assertively voice a safety concern at least two times. The team member being challenged must acknowledge your concern.

To facilitate “speaking up” behaviors, it is helpful to use signal words, like CUS, that immediately alert team members to the presence of a safety issue.

CUS when necessary

- Can we CHECK-IN
- Help me UNDERSTAND
- Let’s STOP for a minute

I'm SAFE

For example, prior to transporting a child several hours to a residential facility across state lines, a team convenes and uses I'm SAFE to decide which of them are most fit for the long transport.

A mnemonic used to assess fitness to perform safety-critical tasks.

I	**Illness**	Is the professional free from illness?
M	**Medication**	Is the professional affected by any medications that impact physical or cognitive functioning?
S	**Stress**	Is the professional overly worried by life factors? Is the professional managing stress well?
A	**Alcohol**	Is the professional free from alcohol or other impairing substances?
F	**Fatigue**	Is the professional rested and generally sleeping well?
E	**Eating**	Is the professional "fed, watered, and ready to go"?

OSSCR (Oscar)

For example, a supervisor uses OSSCR to express concern when someone repeatedly shows up late for meetings and is not working equitably with teammates.

OSSCR Script is delivered colleague to colleague:

- **OPEN** with specific situation or behaviors; provide concrete information
- **SHARE** how the situation makes you feel and what your concerns are
- **SUGGEST** other alternatives and seek agreement
- **CLOSE** and avoid enabling, don't expect thanks, not a control contest
- **REFLECT** and breathe and move forward

Before having a discussion about a concerning or problematic situation or behavior, mentally ask yourself why a reasonable person would do the problematic or concerning thing. Avoid making unhelpful assumptions about why a problem exists or what it means. While using OSSCR in conversation with your colleague, be both honest and respectful, and ask clarifying questions rather than assume causes or underlying motivations. Being candid and respectful is a key to psychologically safe conversations and to making positive changes.

If a problematic or concerning behavior is recurrent, in spite of OSSCR conversations, be certain you are addressing the right issue, and not just a symptom. For example, a person who is routinely late to meetings, even after communicating concerns and making an agreed upon plan to improve, is breaking commitments, and this (rather than just tardiness) needs to be the topic of an OSSCR conversation.

Healthy feedback is:

- Timely – given soon after the target behavior has occurred
- Respectful – focuses on behaviors, not personal attributes
- Specific – relates to a specific task or behavior that needs correction or improvement
- Framed as an opportunity – provides direction for future improvement
- Considerate – considers a team member's feelings and delivers negative information with fairness and respect. It is both 100% candid and 100% respectful.

Three Good Things

For example, a leadership team commits to journaling Three Good Things every evening for two weeks. Afterwards, over half of the leadership team continues the practice. During meetings, the team is more clear-headed, collaborative, communicative, and solution-focused.

Three Good Things is an evidence-based exercise in positive psychology (Rippstein-Leuenberger et al., 2017). Before bedtime, write or electronically log three good things that happened during the day. To be effective, it needs to be done for a minimum of two weeks, but continuing three good things could be a habit to keep for a lifetime.

Three Good Things works by training your mind to focus on positives. It is normal for our minds to primarily recall negative experiences, because these are the experiences we want to negate in the future. By practicing Three Good Things right before bedtime, you unconsciously train your mind to acknowledge and recall positive experiences as well. It lessens fatigue and the impact of traumatic stress.

Your Three Good Things log might look like this:

- Date:
- Three Good Things that happened today:

  1)

  2)

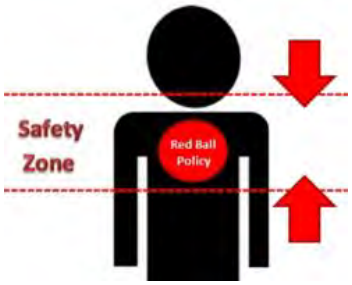
  3)

Red Ball

For example, a frontline child welfare team keeps an actual Red Ball in their shared office space. When a teammate notices a colleague seems disengaged, he rolls the ball (signifying "ball too low") and asks what's going on. Another time, a teammate is feeling anxious about an upcoming court date and grabs the ball, placing it above her head (signifying "ball too high"). Her teammates take a time out to discuss the court case with her.

The Red Ball (Ebert & Kuhn, 2017) is a metaphor for emotions, especially the way we manage stress, anxiety, and fatigue. It refers to individuals or teams. You can use the metaphor to make sure you and your teammates are seeking balance between your "head and heart" in interactions, discussions, and decisions.

- Ball is too high = Stress and anxiety are high
- Ball is too low = Exhausted, resigned, or frustrated
- Throw the ball at others = Aggressive, yelling, blaming
- Hold ball too tight = Guarded, isolating, "putting up walls"



If we think about our emotional state as a red ball, the goal is to keep it centered. Somewhere between "the head and the heart"—where feelings are energized, psychologically safe, thoughtful, and responsive. This is called the "safety zone."

When the ball is too high, we may feel intense worry, respond in angry/agitated ways, sleep poorly, and make decisions too quickly. When the ball is too low, we may be tired, disinterested, and delay in making decisions or being responsive to others. Sometimes people throw their ball at others by raising their voice or speaking negatively of a colleague, and people can also hold their ball too tightly and become guarded– not sharing their feelings with others.

Individuals can contribute to a team's mindful organizing by regulating their Red Ball and helping their teammates do the same. By acknowledging the constant presence of the Red Ball, we identify our emotional responses and can help keep ourselves and one another in the "safety zone."

TIPS IN USING THE RED BALL:

- Know where your own red ball is
- Reach out to others as needed, and let them help you keep your Red Ball in balance
- Visualize where others' Red Ball is and help keep theirs' in balance
- Overall Goal = Maintain all of our Red Balls in balance, so we can function effectively as individuals and as teams

STRATEGIES FOR KEEPING OUR RED BALL IN THE BALANCED ZONE BETWEEN OUR HEAD AND OUR HEART:

- Create distraction-free zones (e.g., quiet spaces)
- Listen to music
- Go for walks outside
- Open windows (if able); have pictures of nature in your space
- Stretch (e.g., yoga)
- Structure for increased teamwork during high-stress moments (i.e., avoid over taxing any one team member)
- Verbally acknowledging the Red Ball and responding mindfully to teammates

CAPTA COORDINATORS

Activity Summary

This document is an attachment to the APSR 2024 and provides a summary of the activities performed by the Child Fatality Prevention and Review Program CAPTA Coordinators during the reporting period.

Contents

1. Child Fatality Prevention & Review Program Implementation and Policy Lead Position

Summary of Activities from July 1, 2022, through June 30, 2023

- Provided technical advice and assistance to ODHS and OCWP managers, and executives in supporting the work of the Child Fatality Prevention and Review Program (CFPRP).
- Continued to deepen understanding of equity through active and passive efforts.
- Educated and prepared CPS consultants on practice changes to successfully support CPS and permanency professionals in local offices.
- Evaluated CW and Oregon child fatality data and identified trends to enhance child abuse prevention and intervention efforts.
- Conducted interviews with CW professionals through a voluntary process to inform continuous critical incident review team and safety culture improvement efforts.
- Supported implementation and continuous improvement of revised protocols and procedures to guide staff in operationalizing child fatality requirements in local offices to ensure statewide consistency.
- Supported revised process for notifying leadership of sensitive issues and initiated and maintained a continuous quality improvement process.
- Prepared reports summarizing research and review findings for OCWP management and ODHS executives and supported others in learning data visualization.
- Drafted amendments to Oregon Administrative Rules (OAR) and Child Welfare procedure to support all Child Welfare program efforts.
- Applied sound, current social work practice to enhance program operations and mitigate operational risk.
- Reviewed, consulted, and provided guidance on sensitive, high profile, and or high-risk child abuse cases.
- Established cooperative inter-agency memorandum of understanding to promote effective communication and collaboration in the interest of child abuse prevention.
- Simplified complex policy material for non-specialists, such as citizens, community partners, non-CPS managers and administrators from other state agencies, to ensure stakeholders and others have enough understanding of the material.
- Engaged family-serving systems to inform change.

- Responded to verbal and written concerns and requests for information from Governor's Advocacy Office, the media, and community members.
- Worked collaboratively across program areas, divisions, and agencies to ensure a child safety focus. Significant efforts to partner with CW programs.
- Served as ODHS expert and point of contact on data for child fatalities resulting from abuse. This included:
    - Maintaining a database of Oregon child fatality data.
    - Recommending improvements to the system for collecting and using ODHS child fatality data.
    - Analyzing child fatality data to identify trends and opportunities for reducing child fatalities.
    - Gathering, documenting, and providing annual data for federal and state reports on Oregon's child abuse fatalities.
    - Providing data to assist in the fulfillment of records requests, including from the media.
    - Determining which fatalities meet the OAR definitions of abuse for inclusion in Oregon's child fatality statistics.
- Served as co-chair and ODHS representative on statutorily required interdisciplinary State Child Death Review and Prevention Team. This included:
    - Facilitating changes to ensure equity in fatality review.
    - Researching and interviewing to learn quality practices in other states.
    - Finalizing the team charter.
    - Implementing and maintaining Oregon's Child Death Review and Prevention website in collaboration with OHA, Public Health.
    - Collaboratively developing guidance for county teams and making the guidance accessible.
    - Overseeing the county team support program and providing support to multiple counties.
    - Implementing the resource improvement plan.
- Provided oversight and support for CW safe sleep efforts.
- Provided oversight and support for implementing the Comprehensive Addiction and Recovery Act (CARA).
- Used Critical Incident Stress Management (CISM) certification to provide support to the CW workforce through CISM individual and group support.
- Onboarded new CFPRP team members.

This position works on a variety of workgroups and committees, including:

- Administrative rule advisory committees
- Rule or procedure writing workgroups
- Peer Advisory Review Committee
- State Child Death Review and Prevention Team
- State Child Death Review and Prevention Team co-chair monthly meeting
- State Technical Assistance Team meetings
- Sudden Unexplained Infant Death Investigation / Doll re-enactment training subgroup
- Charter subgroup
- Legislative meetings
- CW and OHA, Public Health Child Maltreatment Prevention Collaboration meetings

- Nurture Oregon Core Team
- CW and OHA, Public Health weekly and then monthly CARA and safe sleep check-ins
- Sensitive Issue Workgroup
- Safe Sleep Coalition
- Child Fatality Prevention and Review Program meetings
- Fatality Review Health Equity Learning Collaborative
- Western Region Child Death Review meetings
- National Partnership for Child Safety affinity group: Connecting internal death review to state and county child fatality review teams
- Fatality data continuous quality improvement monthly meetings

2. Comprehensive Addiction and Recovery Act (CARA) Coordinator #1 Limited Duration Position

Summary of Activities from July 1, 2022, through June 30, 2023

- Served as one of two ODHS CARA experts and points of contact for Child Welfare professionals and supported families with infants exposed to substances.
- Participated in Critical Incident Reviews involving infants with prenatal substance exposure and caregivers using substances to inform system improvement opportunities and workforce support.
- Served as lead on various system improvement opportunities developed during Critical Incident Reviews.
- Identified and connected with other family serving systems in the interest of child fatality and child abuse prevention.
- Implementation of specific maltreatment prevention strategy focused on children ages 0-3 through the development of a county-based resource guide which will be available to child welfare professionals to use during engagement with families.
- Reviewed research and publications to stay up to date on best practices for CARA, prenatal substance exposure, substance use during pregnancy, and Plans of Care.
- Revised procedural guidance for Child Welfare professionals focused on CARA, Plans of Care, and infants with prenatal substance exposure.
- Interpreted rules, statute, and procedures for ODHS staff, community partners, and the public to support statewide consistency in the provision of the ODHS's work on CARA, infant fatality prevention and other related issues.
- Collaborated with Child Safety program to develop procedural guidance for Child Welfare professionals focused on connecting families with infants to quality supports early and often through partnership with Resource Nurses. This partnership will increase Plan of Care completion rates on child welfare involved cases with an infant exposed to substances during the prenatal period.

- Provided Child Welfare professionals with tools to assess for infant safety and promote wellbeing by communicating strategies developed through the logic model process and encouraging implementation of those strategies.
- Developed and delivered training on CARA, Plans of Care, and protective factors to CW leadership and staff statewide, including Nurture Oregon service providers.
- Developed and delivered presentations on CARA at Oregon ICWA Advisory Group and offered technical assistance to Tribal Nations.
- Co-facilitated bi-monthly CARA office hours for CW staff across the state.
- Collaborated with OHA to implement the Comprehensive Addiction and Recovery Act. This included monthly meetings with various OHA partners facilitated by Comagine Health.
- Collaborated with Nurture Oregon sites, OHA and Comagine Health to support implementation of Plans of Care within the demonstration.
- Facilitated Oregon Assessing Patterns and Behaviors of Neglect Training for Child Welfare professionals. This training aims to build knowledge around the societal and system factors influencing families as well as the child welfare response to neglect and support enhanced knowledge of the indicators and impacts of neglect and promote quality practice rooted in the protective factors.
- Support the Office of Research, Reporting, Analytics and Implementation Text Analysis Project sponsored by CFPRP – the initial focus of the project will be a retrospective review of aggregate data from Infant Critical Incident Reviews in comparison to general child welfare cases (search terms will include houselessness, substance use, mental health).
- Developed a Smartsheet containing population and demographic data gathered from community needs assessments and strategic plans developed by other family serving systems for each of Oregon's 36 counties.
- Submitted grants for each of the residential treatment facilities that serve pregnant and parenting people with children.
- Served on interview panels for CPS supervisor and CFPRP CIRT Coordinator

This position participated in learning collaboratives, ongoing education programs, and conferences, including:

- Attended the Transformational Collaborative Outcomes Management (TCOM) Conference in New Orleans, LA to support CFPRP presentation on safe systems mapping exercise
- Completed the Professional Certificate Program in Implementation Practice offered by the Collaborative for Implementation Practice at the University of North Carolina at Chapel Hill School of Social Work.
- Chile Welfare Virtual Expo 2022 (Power in Partnerships: Prioritizing Lived Expertise in CW)
- National Partnership for Child Safety 2022 Virtual Convening
- How We endUP 2022 Convening
- ODHS Child Welfare 2022 Tribal State ICWA Conference - We Are the Drop
- Awarded scholarship to attend the Oregon Conference on Opioids + Other Drugs, Pain, + Addiction Treatment Conference (Sunriver, OR on May 8th-10th, 2023)
- OHSU Substance Use Disorder in Prenatal and Perinatal Care ECHO program
- ODHS Child Welfare Leaders institute

- Safety Culture hours led by CFPRP Safe Systems Coordinator
- ODHS MultiGen Summit

This position participates in workgroups and committees, including:

- Prevention Mindset Institute cohort member
- Oregon Child Abuse Hotline CQI Advisory Committee member
- Child Welfare CQI Advisory Committee member
- Women's Residential Treatment workgroup
- Healthy Brain and Child Development Study Community Advisory Group member
- Sexual Abuse Guidelines Review Workgroup
- Child Fatality Prevention and Review Program meetings
- Nurture Oregon meetings
    - Core Team monthly meetings
    - Monthly site huddles
- Family Preservation Policy and Practice workgroup

3. Comprehensive Addiction and Recovery Act (CARA) Coordinator #2 Limited Duration Position

Summary of Activities from July 1, 2022, through June 30, 2023

- Served as one of two ODHS experts and points of contact for CW related to CARA and supporting families with infants exposed to substances.
    - Developed, established, and implemented systems and practices for CARA within CW and across Oregon's 36 counties.
    - Consulted on cases as requested by local office staff regarding Plans of Care.
    - Implemented and facilitated CARA office hours twice a month to ensure ongoing support for Oregon's CW professionals.
    - Oversaw CARA-specific Microsoft Teams channel to streamline communication statewide with CW professionals and provide ongoing learning opportunities related to CARA.
    - Coordinated with local office leadership across Oregon and provided a refresher training on CARA and Plans of Care at numerous CW offices.
    - Reviewed cases involving infants exposed to substances to inform training needs, prevention efforts, and trends.
    - Participated in Critical Incident Reviews involving infants exposed to substances to inform future prevention and workforce support efforts.
    - Served as CW liaison between local CW offices and Nurture Oregon service providers regarding individuals receiving both services.
    - Reviewed research and publications to stay up to date on best practice regarding prenatal substance exposure, substance use during pregnancy, and Plans of Care to inform workforce support and statewide implementation.

    - Developed and updated informational CARA content for the internal ODHS website to serve as a resource for all ODHS staff.
    - Collaborated with the Office of Research, Reporting, Analytics and Implementation to develop a data dashboard focused on elements related to CARA, infant safety, and wellbeing.
- Served as ODHS expert and point of contact on CW infant safe sleep efforts.
    - Consulted on cases as requested by local office staff regarding infant safe sleep practices.
    - Served as point of contact for all versions of Safe Sleep for Oregon's Infants self-study training materials for Oregon's Resource Families and Family Serving Professionals, Child Abuse Screeners, CPS/Permanency Caseworkers and Adoption/Resource Home Certifiers. Monitored training feedback survey results to evaluate effectiveness and participation.
    - Supplied infant safe sleep tools to CW local offices to support families in reduce sleep-related risk.
    - Promoted SIDS awareness month in coordination with the ODHS communication team, through efforts to educate and engage parents and providers via social media using the toolkit provided by the National Institute of Health (NIH).
    - Participated in Critical Incident Reviews where high-risk infant sleep practices were identified at the time of the critical incident to inform future prevention and workforce support efforts.
    - Reviewed cases where high-risk infant sleep practices were identified to inform training needs, prevention efforts, and trends.
    - Held focus group with CW workforce to explore development of additional infant safe sleep educational supports.
    - Continued collaboration with Child Safety Program, CW's ADA Coordinator, and OHA partners regarding inclusivity of AAP Safe Sleep guidelines to inform training and workforce support efforts.
    - Served as infant safe sleep liaison for Nurture Oregon service providers.
    - Reviewed research and publications to stay up to date on best practice regarding infant safe sleep to inform community and workforce supports.
    - Developed sleep-related infant death prevention content for the internal ODHS website to serve as resource for all ODHS staff.
- Interpreted rules, statute, and procedures for ODHS staff, community partners, and the public to support statewide consistency in the provision of the ODHS's work on CARA, infant fatality prevention and other related issues.
- Identified and connected with other family serving systems in the interest of child fatality and maltreatment prevention.
- Provided ongoing feedback to the Child Fatality Prevention and Review Program manager regarding effectiveness and impact of current and draft procedure/rule on practice and service to eligible families.
- Served as lead on various system improvement opportunities developed during Critical Incident Reviews
- Coordinated distribution and inventory oversight of child safety and injury prevention kits in partnership with OHSU Tom Sargent Safety Center.

- Participated in Child Abuse Prevention Month planning and communications in coordination with Child Safety, Family Preservation, and Self Sufficiency Programs.
- Developed proposal for infant safety and wellbeing summit.
- Facilitated Oregon's Assessing Patterns and Behaviors of Neglect in November 2022 and February 2023.
- Completed UNC's School of Social Worker Certificate Program in Implementation Practice.

This position works on a variety of workgroups and committees:

- Safe Sleep Cross Agency Workgroup
- Substance Use Disorder Casework Practice Guidelines Workgroup
- CPS/Resource Nurse Procedure Workgroup
- Child Protective Services Fidelity Reviews
- Child Fatality Prevention and Review Program meetings
- Early Childhood Technical Assistance Center's Infant and Early Childhood Mental Health Cross-State Cohort Member
- Oregon's Assessing Patterns and Behaviors of Neglect trainers debrief and follow up
- Statewide Infant Plan of Care Implementation Team
- National Partnership for Child Safety Affinity Group: Getting Infants Safely to Their First Birthday
- Nurture Oregon meetings
    - Core Team monthly meetings
    - Site huddles weekly as needed