Child Safety Learning Collaborative: Supporting States Across the Phases of Improvement: Webinar Transcript

Jenny Stern-Carusone, CSN: Welcome everyone to the Child Safety Learning Collaborative, supporting states across the phases of improvement. This is a Children's Safety Network webinar.

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I'll now hand it over to Caitlin for some technical tips.

Children's Safety Network: Hi everyone, welcome. A few technical notes before we begin. Your audio quality depends on your internet connection—if it's choppy, try a more stable connection or dial in using the phone number in your Zoom invite. All participants are muted, but you can submit questions in the chat anytime. We'll address them during the discussion.

For captions, click the CC button at the bottom of your screen. It may be under the "More" icon (three dots). This webinar will be recorded, and we'll share the slides and resources on our website within two weeks.

Jenny, back to you.

Jenny Stern-Carusone, CSN: Thank you, Caitlin.

I'm Jenny Stern-Carusone, Associate Director of the Children's Safety Network and lead of the CSLC Motor Vehicle Traffic Safety topic team. I'll be co-moderating with Maria Katradis, who leads our Suicide and Self-Harm Prevention topic team and serves as the CSLC Data Manager.

Today we'll give an overview of the CSLC design, followed by presentations from representatives of each of our topic teams.

The Children's Safety Network was established in 1990 through HRSA's Maternal and Child Health Bureau. We provide technical assistance to Title V agencies on injury and violence prevention.

One key initiative is the Child Safety Learning Collaborative, or CSLC.

The CSLC's vision is to provide targeted technical assistance to Title V agencies, helping to advance injury prevention strategies and reduce child and adolescent injuries, hospitalizations, and fatalities.

Learning collaboratives are structured methods for process improvement. They involve sharing experiences to accelerate learning and implementing best practices—what we refer to as “All Teach, All Learn.”

In our model, states form strategy teams around selected injury topics. These teams are organized into topic teams, and we apply quality improvement methods to build shared aims and adopt evidence-based approaches.

Our goal is to help states apply a public health approach to close the gap between research and practice. Over five years, they aim to reduce injury and violence through sustainable, evidence-based strategies.

To achieve this, we use the CSN Framework for Quality Improvement and Innovation in Child Safety. This framework incorporates elements from the CDC’s social-ecological model, the Collective Impact approach, IHI’s Breakthrough Series, and the Model for Improvement.

The framework is designed to help states improve their child safety systems and strengthen the workforce. It enables data-driven decision-making and supports capacity building in key areas.

Our technical assistance targets three core areas: identifying evidence-based strategies, enhancing management and leadership effectiveness, and improving systems through shared learning and implementation science.

We tailor our support to state strategy teams, topic teams, and the collaborative as a whole. This includes webinars, tools, resources, and emerging research to support innovative strategies.

We also help states build sustainable partnerships and align their improvement work with broader state objectives.

A key component of our work is the Model for Improvement. This begins with clarifying an aim: What are we trying to accomplish? Then, teams determine what changes might lead to improvement and what data to collect to evaluate those changes.

We use Plan-Do-Study-Act (PDSA) cycles to test changes in real-world settings. This allows for adaptation before broader implementation.

The collaborative supports identifying areas ready for improvement, building knowledge management systems, using real-time data, and spreading evidence-based strategies.

Strategies must close a gap between current practice and scientific knowledge, show potential to reduce injuries and deaths, and demonstrate feasibility and potential for breakthrough improvement.

These strategies are collected into a change package, a key tool used in the collaborative.

Our quality improvement process begins with teams identifying a need and building partnerships. They form SMART aims and select change ideas, collecting and using data to measure progress.

They set short-term goals, conduct small tests of change, and assess results to inform broader implementation.

I'll now hand it over to Maria to talk more about our current CSLC work.

Maria Katradis, CSN: Thanks so much, Jenny. The Learning Collaborative consists of three cohorts over a five-year period. Each cohort lasts approximately 18 months. We're currently concluding our first cohort.

Between cohorts, the application period reopens. States and jurisdictions can choose to continue or join for the first time. They may also switch or add new topics based on their evolving needs.

In Cohort One, our four priority topics were: bullying prevention, motor vehicle traffic safety (including child passenger safety and teen driver safety), suicide and self-harm prevention, and sudden unexpected infant death (SUID) prevention.

These topics were selected based on data trends in maternal and child health performance measures. They represent areas with high injury rates and strong potential for progress.

Teams were asked to select one or two topic areas to focus on in Cohort One. In subsequent cohorts, they can add new areas.

As Jenny mentioned, our approach involves small tests of change through PDSA cycles. For those unfamiliar, the cycle starts by asking: What happens if we try something different? We identify objectives, collect data, and plan who will do what, when, and where.

Then, we implement the plan, observe any unexpected issues, analyze the results, and determine whether to adapt, adopt, or abandon the strategy.

Our primary tool for documenting changes and evaluating effectiveness is the PDSA cycle.

The phases of improvement include: Develop, Test, Implement, and Spread. We begin by developing a theory and planning, test the strategy under various conditions, implement it as routine practice, and finally spread it across more settings.

For development, teams prepare for changes by forming relationships, planning data collection, and building capacity.

In the testing phase, we conduct small-scale trials to learn what works and refine strategies for specific contexts.

Implementation means embedding the strategy in daily practice with support systems, training, and policies.

Spread involves expanding the use of a strategy across new locations or groups. This is supported by clear communication and evidence of its effectiveness.

We use a Phases of Improvement Decision Tree to help teams identify their current phase and appropriate next steps.

Now, let’s hear from our panelists who will share examples from their work with the CSLC.

Rose Thomas from Ohio will begin. She is a Public Health Consultant with the Ohio Department of Health and worked on SUID prevention. Ohio is in the develop phase.

Rose Thomas - OH: Thank you, Maria. We partnered with our child fatality review coordinator, epidemiologists, researchers, and safe sleep program staff. Using the PDSA framework, we explored existing safe sleep programs in Ohio and the social conditions that shape barriers for parents and caregivers.

We started with a CSLC kickoff and learned a lot from other states. There were some internal shifts, but we moved forward with designing an interagency survey to identify gaps in safe sleep education across the state. We’re considering in-person provider training based on the survey.

We targeted audiences beyond medical providers—like doulas, WIC staff, and community health workers—to understand how they offer culturally relevant safe sleep education. We’re still in the development stage and working on rolling out the survey.

Maria Katradis, CSN: Thank you, Rose. Next is Marissa Rodriguez from Texas, who worked on child passenger safety. Texas is in the test phase.

TX - Marissa Rodriguez: Thanks, Maria. Because Texas is so large and our agency is split in how programs are funded, we wanted to step back and assess how data is collected and reported across different programs.

We launched an interagency survey targeting partner agencies to understand current practices. We found inconsistencies in data reporting and collection, and we’re now moving toward a more unified approach.

Our next step may involve implementing the national digital car seat check form and promoting it across the state. With over 66 partners and 110 sites, consistency is key. The CSLC team helped us frame our questions for the survey, and we're very grateful.

Maria Katradis, CSN: Thank you, Marissa. Now let's hear from Massachusetts—Jane Ayers and Mary Kate Sullivan—on bullying prevention. Massachusetts is in the implement phase.

Massachusetts - Jane Ayers: We work with the Department of Education on a bullying prevention initiative. Through the CSLC, we learned about Pennsylvania's adaptation of the Olweus Bullying Prevention Program for community organizations. We developed an online training for 52 diverse youth organizations.

It took two years to launch. We now have 14 participating sites, including Friends of the Children-Boston. Mary Kate will speak about that.

Mary Kate Sullivan - MA: Thanks, Jane. At Friends of the Children, we partner with Boston Public Schools to support youth from kindergarten through high school. Every child is matched with a paid mentor for 12–16 hours per month.

I became certified in bullying prevention last winter and integrated this into our organization. Now all staff complete training, not just mentors. We also surveyed our youth and found minimal bullying—likely due to adult presence at all times.

We created community agreements, added restorative practices, and promoted peer connection activities to reduce potential bullying.

Maria Katradis, CSN: Thank you both. Finally, Ladonna Merville from Tennessee will share about the suicide and self-harm prevention work. Tennessee is in the spread phase.

TN - LaDonna Merville: Thank you. We implemented the Sources of Strength program in rural schools and community organizations, using CDC funding and a partnership with the Tennessee Suicide Prevention Network.

Between 2019 and 2023, Tennessee experienced a 47% increase in youth suicide among ages 10–17. Our initial outreach wasn't effective, so we shifted to a data-informed, targeted approach using CSLC tools.

We set an aim to reach 15 rural sites by August 2025. Through 90-day aim cycles starting in February 2024, we tested and refined recruitment strategies. We now have 15 active sites, reaching 144 youth with peer-led campaigns and staff training.

Maria Katradis, CSN: Thank you, Ladonna. We'll now move into a panel discussion.

Thank you to all our panelists. Let's transition into the discussion. You've all worked on these injury prevention topics even before joining CSLC. Can you share how CSLC changed how you approach your work?

TN - LaDonna Merville: I'll start. The 90-day aim cycles helped us break down what we were doing and see what worked. We realized broad outreach wasn't working, so we refined our strategy. For example, schools and faith-based organizations preferred to begin programs in the fall. Learning this allowed us to adapt our timeline and be more effective.

TX - Marissa Rodriguez: CSLC helped us focus. Sometimes, we take on too much. Aligning what we're doing with CSLC gave us structure and helped define our goals and measures. It created accountability and helped us move forward with purpose.

Massachusetts - Jane Ayers: PDSA cycles helped shift our role from compliance monitoring to partnering with grantees. It built trust. We're more open to feedback, and completing cycles allows us to continuously improve.

Maria Katradis, CSN: Great insights. Have you encountered any challenges when applying the CSLC approach?

Massachusetts - Jane Ayers: It helped break down silos. We're now collaborating across programs and bureaus. Our clinicians and school-based health staff realized they're serving the same youth. The PDSA approach fostered collective impact.

TX - Marissa Rodriguez: Collaboration across different partners and agencies can be hard. Coordination and intention are key.

Maria Katradis, CSN: Can you share any innovative or non-traditional partnerships developed through CSLC?

Rose Thomas - OH: Not necessarily new partnerships, but we re-engaged existing ones. We tapped into our reproductive health section to expand our network and leverage internal relationships.

TN - LaDonna Merville: One team member mentioned Sources of Strength during a meeting for a different program, and the principal was very interested. Even if it's not your project, you can plant the seed and share contact info. That kind of informal promotion helps expand reach.

Massachusetts - Jane Ayers: We're engaging youth more directly. We ask funded agencies to have youth review and provide input. We've learned a lot about how youth respond to bullying and what they want adults to know.

Maria Katradis, CSN: Jenny, would you like to jump in here?

Jenny Stern-Carusone, CSN: Yes. I want to encourage attendees to post questions in the chat. I'm struck by how your stories show the value of recognizing who's already in the room and who still needs to be engaged. We've discussed data a lot today. Can you share how you're using data and whether that's changed since joining CSLC?

TX - Marissa Rodriguez: We plan to use the National Digital Car Seat Check Form to track car seat misuse and other variables across the state. This will give us a much clearer picture of our current landscape.

Massachusetts - Jane Ayers: We work with the Department of Education, which provides school culture data. Attendance is an indicator we track. Mary Kate can share more.

Mary Kate Sullivan - MA: Yes, mentors collect attendance data monthly. If a youth has chronic absences, we engage caregivers and school staff to identify barriers and offer support. It's an early warning system.

Jenny Stern-Carusone, CSN: Thank you all. One question from the chat—have you used PDSA cycles in projects outside of CSLC?

Massachusetts - Jane Ayers: Yes. We launched a training series on using PDSAs to implement culturally and linguistically appropriate services. It's now part of our CLASS initiative.

Jenny Stern-Carusone, CSN: PDSAs can feel daunting at first, but they help break down tasks into manageable pieces. Sometimes you're doing them without realizing it—try, adjust, move forward. That's the heart of quality improvement.

Jenny Stern-Carusone, CSN: As we wrap up, we're still accepting applications for CSLC Cohort 2 in limited topic areas—motor vehicle traffic safety, suicide and self-harm prevention, and drowning prevention. Activities begin in June, and you can find more information on our website.

Jenny Stern-Carusone, CSN: Please take a moment to complete the evaluation form. Your feedback helps us improve. You'll receive the webinar recording, and all past and future events are available on our website. Don't forget to subscribe to our newsletter for updates.

Jenny Stern-Carusone, CSN: Thank you, Maria, and thank you to all our panelists. Goodbye.