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MCHB/DCAFH
February, 2009 Webcast

Let's Make It Easy While Getting the Most from
Your Hard Work on Child Death Review
Reporting

February 4, 2009

Moderator:

Stephanie Bryn

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While Getting the Most from Your
Hard Work on Child Death Review
Reporting**

February 4, 2009

MCHB Webcast
3:00 - 4:30 p.m., Eastern time
CAPT Stephanie Bryn, Moderator
Director of Injury Prevention, Division of Child, Family and Adolescent Health
HRSA MCHB

Teri Covington, Executive Director
Heather Dykstra, Senior Data Analyst
Esther Shaw, Senior Data Analyst
National Center for Child Death Review



Welcome

Thank you to Arizona, Hawaii, Michigan and online survey respondents.

Thank you to Mary Overpeck for your input in developing this web cast.



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Overview of Webcast

Why the Report Tool is Important to CDR Users

Why Data Quality is Important

Review of Selected Problem Questions, particularly focusing on:

Section I, Acts of Omission and Commission

Section J, Services

Section K, Prevention

Report Tool's Standardized Reports

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Using the CDR Case Reporting System

(As of January 2009)



■ Considering ■ In Process
■ Participating

n = over 45,000 records in System

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Why is the Report Tool Important to CDR Users?

Ensure results lead to CDR Goals of improved Services and Prevention

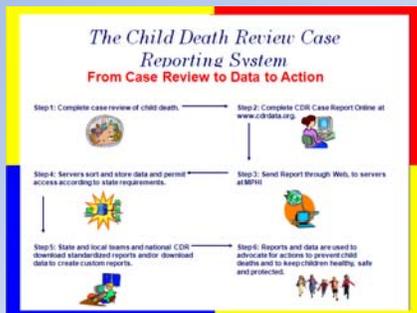
Report Tool elements were selected for what teams need to share with service and prevention programs in states and counties

Data is Part of the Process



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Why is the Report Tool Important to CDR Users?



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CDR Results: Ohio Annual Report*

51 of 88 counties reported local prevention initiatives resulting from CDR

Participating agency boards report increase in cooperation and understanding to:

- Identify gaps in services
- Improve service barrier access
- Maximize use of existing services

Increase collaboration

* Ohio Eighth Annual CDR Report, 2008

Why is Data Quality Important?

Information on circumstances of deaths and involvement of service agencies is needed to:

Accurately guide prevention initiatives

Provide consistent evidence for service agencies and their governing boards



Survey on CDR Case Reporting System

Online survey was conducted in winter 2008
138 participants responded from 18 states

This webcast is based partially on questions and issues raised from this survey.

General Points (ctd)

Confusion about use of “unknown” vs. leaving a question blank

Check “unknown” if you tried to find the information to answer the question, but no clear or satisfactory response was obtained.

Leave question blank (unanswered) if no attempt was made to find the answer or question is not applicable.

Limit the use of the “other, specify”

Be sure to run any definitions or “rules” by your State Coordinator

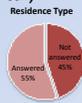
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Section A – Child Information

A9 & A10, Residence

Residence information is often left blank. Please try to complete this important question.

For newborns who never left the hospital, residence is primary caregiver’s.



A22, History of Substance Abuse

For tobacco abuse of child, please select “Other, specify” and state “tobacco” in text box.

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Sections A, B and C – Child, Caregiver and Supervisor

A23, B11, B12, C10, History of Maltreatment

For unsubstantiated referrals, please select ‘Yes’ regarding history, unless the referral was found to be completely falsified.

A23-26, C10, History of Maltreatment & CPS

This data is also not getting reported consistently. Your DHS representative should be bringing this information to meetings.

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Sections B and C – Caregiver and Supervisor Information

From Survey, respondents noted that answers to Section B and C questions were:

“often hard to obtain”

“details are very often not known or not known to nearly the degree the questions ask”

During CDR Review, you should be able to answer these questions. Use these sections as a quality assurance for review.

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Section B (ctd)

B5, Caregiver(s) Income Level

Often difficult to obtain but it is a marker for socioeconomic status (SES).

Income level categorized as “high” or “low” is a subjective response based on the local team’s decision.

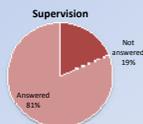
20

Section C (ctd)

C1, Did Child have Supervision

Answer this question carefully. Consider all response options.

For example, infant sleeping in room next to parents. Even though child was asleep at time of incident and parents were in the next room, the child was still “supervised.”



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Section C (ctd)

C4, Primary Person Responsible for Supervision

You can only select one response.

If newborn infant dies in a hospital shortly after birth, in most circumstances, hospital staff should be listed as supervisor.



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Section D – Incident Information

Please answer Section D questions, even if case is a natural death.

For natural deaths, consider the 'incident' as the acute event leading to the death. For a child with a chronic illness, the incident date may be the same as the date of death with no acute event occurring.

D1, Date of Incident

For newborns that do not leave the hospital, select 'same as date of death.'

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Section D (ctd)

D2, Time of day that Incident Occurred

Reminder that this is the time incident occurred, not the time of death (but the incident could be same as death).

D4, Place of Incident

Please note that this is a "check that all apply" question. Reminder that question asks for place of incident and not place where child was pronounced dead. For children that die of natural causes, with no acute event leading to the death, the incident place is usually the same as the place of death.

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Section E – Investigation Information

E1, Death Referred To

There is a difference between a medical examiner and a coroner. Please be sure you are selecting the correct one.

E4, Scene Investigation

Mark the agencies that conducted an investigation at the death scene, not the agencies present or from whom there are records.

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Section E (ctd)

E8, Investigation Find Evidence of Prior Abuse

If no investigation was conducted, leave question blank.

E10, Death in Licensed Setting, Action Taken

If infant dies in hospital, leave question blank.



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Section F - Manner and Cause of Death

F1, Manner of Death

- Choose the **manner** of death from the death certificate.

F2, Cause of Death

- Use the **cause** of death from the death certificate that will take you to the section in G with the richest picture of the case. This should be a cause that is listed on the death certificate but may not necessarily be the first or last cause listed.

If the team does not agree with the designations on the death certificate, this can be captured in Section L.

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Section F (ctd)

F2, Cause of Death

For infant deaths in which the ME declared both manner and cause to be undetermined, please check 'Undetermined if injury or medical cause.'

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Section G1 - Motor Vehicle

G1a, Vehicle

'Bicycle' is an option for vehicles involved in incident. Treat a bicycle as a vehicle for the remainder of this section (d,g,h).

If child is a pedestrian, child's vehicle should be marked 'None.'

G1b, Position of Child

Children boarding or blading are considered 'pedestrians.'

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Section G1 – Motor Vehicle (ctd)

G1c-d, Cause of Incident & Collision Type

For single vehicle rollovers, check 'Rollover' in G1c. If vehicle rolled and hit a ditch, mark 'Other event' in G1d.

G1g, Drivers Involved

Please try to answer driver license status for all involved drivers.

If age of driver is unknown, you may enter '999' to indicate unknown age.

If age of driver is roughly known, you may enter your approximate age estimate.

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Section G4 – Asphyxia & Section G6 - Weapon

Suicide by Hanging

Choose either cause of death = Asphyxia and Strangulation (Section G4) or cause of death = Weapon and Rope (Section G6), but be consistent within your state.

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Section G6 – Weapon Including Person’s Body Part

Physical Abuse is recorded in Section G6 if it is the cause of death.

If Physical Abuse is not the cause of death, use Section I to record the abuse in Question I3.

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Section G9 – Poisoning, Overdose or Acute Intoxication

G9f, What is the difference between Accidental Overdose or Acute Intoxication?

Accidental overdose: Unintentionally administering medication above recommended safe dosage levels. Also includes children ingesting/exposed to agents (including nonpharmaceutical agents) without knowledge of adverse consequences.

Acute Intoxication: Refers to agents taken as a result of recreational use or addiction. It excludes suicide.

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Section G12 – Other, Undetermined or Unknown Cause

Section G12 is only completed if Cause of Death (F2) is one of the following:

- External injury is Undetermined, Other or Unknown cause
- Undetermined if injury or medical cause
- Unknown cause of death

Section G12 is not intended to be used for the Narrative (Section M).

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Section H – Other Circumstances of Incident

H1a,d – Incident & Usual Sleep Place

- Port-a-crib or Pack ‘n Play should be marked as “Crib”. (Current Data Dictionary needs to be amended.)

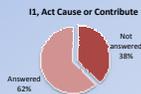
- If child was sleeping in a twin bed, select “Adult bed” and then specify “Twin” in the follow up question.



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Section I – Acts of Omission and Commission

This section should be considered for the majority of deaths, excluding natural deaths.



I1, Act Cause or Contribute to Death

An act of homicide or suicide would be a **cause** of death.

An act such as failing to supervise a child may **contribute** to the death.

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Section I – Acts of Omission and Commission

I3, What Act Caused or Contributed to Death

This question is the one place on the form where you can provide more information for suicides, homicides, child abuse and neglect.

Check poor absent supervision if you believe it was a factor, but did not rise to the level of abuse or neglect.

“Suicide” leads you to I28 and I29 (detailed suicide risk factor questions).

“Other negligence” captures acts such as vehicular homicide from drunk driving, negligent manslaughter, etc.

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Caused or Contributed?

Examples:

Caused: Abuse-Mother's boyfriend beat an infant to death.

Contributed: Neglect-Mother knew boyfriend was abusive to child.

Caused: Suicide- Teen shot himself with a firearm

Contributed: Other negligence or supervision-Father knew son was suicidal but kept loaded and unlocked weapons in house.

Caused: Neglect-Mother would not seek medical attention for infant.

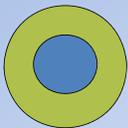
Contributed: Religious practices-Mother's religious beliefs opposed traditional medicine.

Section I 11



Chronic with Child

Versus



Pattern in Family

Section J – Services to Family and Community

53% of our survey respondents “Always” try to complete this section.

Respondents indicated they frequently don’t have this information; however, these questions should generate a conversation among the team.

Only 23% said they had more than 60% of the information needed to complete this section.

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Section K – Prevention Initiatives Resulting from the Review

52% of survey respondents say they ‘Always’ try to complete this section. Only 32% said they had more than 60% of the information they needed to complete this section.

K1 “Could the death have been prevented” is frequently used in analysis

During team review, this question can drive a useful conversation.

Please do not include recommendations or actions already in place.

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Section L – The Review Meeting Process

Please try to complete L5 (Factors that Prevented Effective Review) and L6 (Review Meeting Outcomes) in order to evaluate changes needed to your review process.

L6 is the place to record the team’s disagreement with the official manner or cause of death.



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Section M – Narrative

The responses don't always tell the complete story. Often, even a short narrative here goes a long way to communicate what happened in the case.

Do not record identifying information in the narrative (names, addresses).

Exclude information already provided elsewhere in the form.

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This Is Your Data!

The Standardized Reports give many of the summary statistics that allow you to give feedback to your collaborating agencies and prevention workers.



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This Is Your Data!

Standardized Reports

- Select reports with multiple filters
- 33 reports are readily available

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General Definitions

Opiates (A22,B10,C9,9a,I18)

Morphine, methadone, heroin, codeine and oxycodone among a host of others. You may have to look them up online to see if it was an opiate pain killer. Methadone is now being widely prescribed for pain so you may check 'pain killer – opiate' and methadone for the same overdose.

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General Definitions

“Chronic with child” versus “pattern in family or with perpetrator” (I11)

– *Chronic with child* refers to a pattern of ongoing acts of abuse or negligence inflicted specifically on this child. A *pattern in family or with perpetrator* refers to a pattern of ongoing acts of abuse or negligence inflicted on one or more members of a family or household. An isolated incident refers to a single event with no documentation of similar prior incidents.

Funeral Arrangements (J1)

- This captures if the funeral arrangements were provided as a service to the family, not if the child had a funeral.

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Thank You

The Child Death Review Case Reporting System is supported in part by Grant No. 1 U93 MC 00225-01 from the Maternal and Child Health Bureau (Title V, Social Security Act), Health Resources and Services Administration, Department of Health and Human Services



www.childdeathreview.org

info@childdeathreview.org

1-800-656-2434

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Questions and Answers

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