

—National Center Quick-Look—

Asthma Deaths



Collect

The National Center for Fatality Review and Prevention collects information about children who died due to asthma in the National Fatality Review-Case Reporting System (NFR-CRS)



Data

Deaths of children due to asthma in the U.S. are rare with approximately 155 deaths/year.¹ But because so many of these deaths are preventable, fatality review data provide a unique perspective to better understand these deaths' circumstances. From 2005-2017, fatality teams reviewed deaths of 744 children ages 0-17 who died due to asthma.²

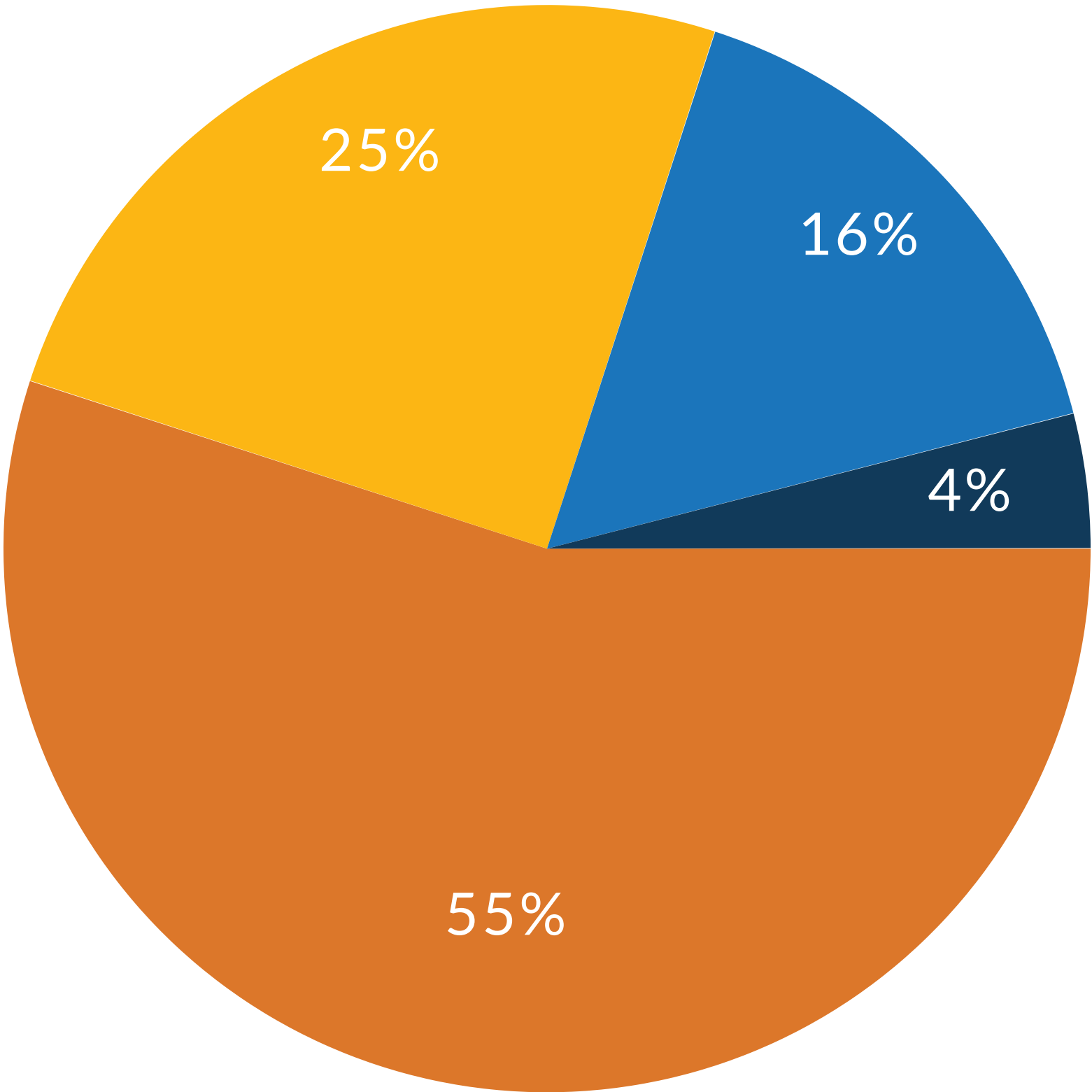


Learn

To see other Quick-Looks using NFR-CRS data and learn more, visit the National Center's website at ncfrp.org.

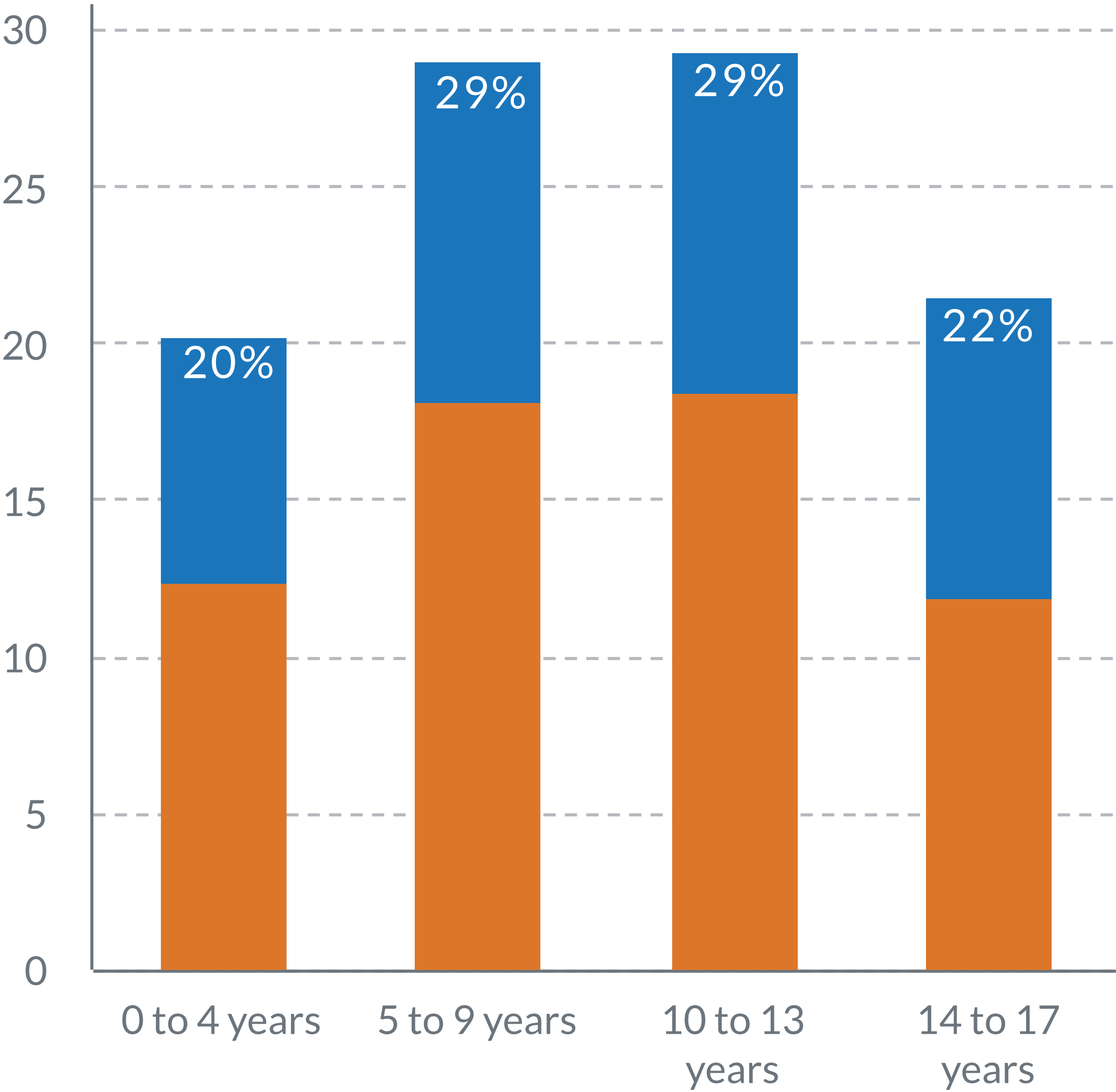
Demographics

Race/Ethnicity



- Non-Hispanic Black (55%)
- Non-Hispanic White (25%)
- Hispanic (16%)
- Other (4%)

Age and Sex



- male
- female

Incident and Investigation



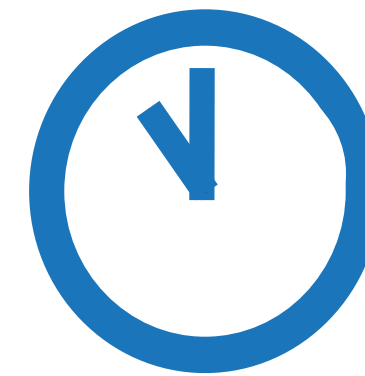
PLACE

73% of asthma deaths occurred in the child's home



AREA

60% occurred in urban areas; 26% in suburban areas; 14% in rural areas



TIME of DAY

42% of deaths occurred during the night (9pm-5am) with the peak time of incident at 11pm



AUTOPSY

70% of asthma deaths had an autopsy performed

Medical Care for Asthma



2% of children who died due to asthma had not been diagnosed prior to their death



91% of children were receiving health care for asthma



96% of children had health care plans in place for asthma



29% of children/families were not able to follow prescribed health care plans for asthma

- Medication adherence (70%) and missed appointments (55%) were the most common treatment components not completed
- The age group with the most difficulty following prescribed treatment plans was children ages 10-13 (39%) followed by children ages 5-9 (25%)

Health Disparities

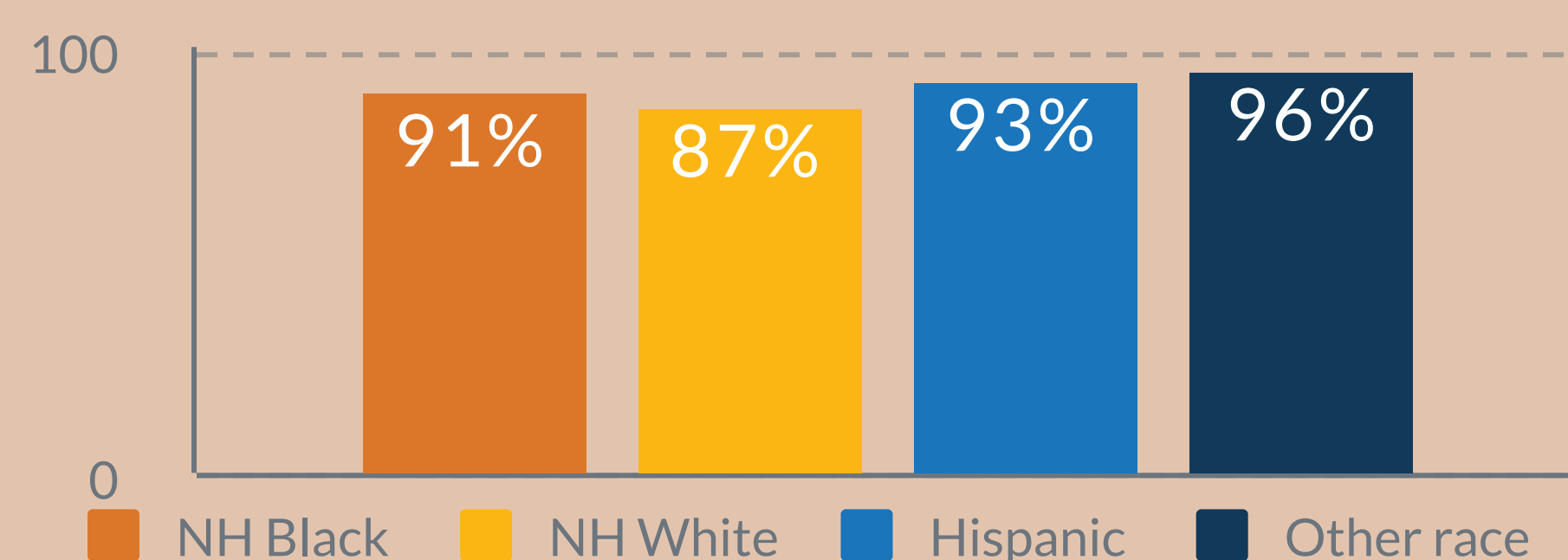
National Center's Structural Inequity Statement

Some families lose infants, children and adolescents to the types of deaths reviewed by fatality review teams not as a 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 their racial or ethnic backgrounds can also contribute to a child's death. Segregation impacts access to high-quality education, employment opportunities, healthy foods and healthcare. Combined, the economic injustices associated with residential, educational, and occupational segregation have lasting health impacts that include adverse birth outcomes, infant mortality, high rates of homicide and gun violence and increased motor vehicle deaths.

The burden of asthma is not shared equally. Non-Hispanic (NH) black children are disproportionately affected. Although NH black comprise **14%** of the U.S. child population, NH black accounted for **55%** of asthma deaths reviewed by fatality review teams

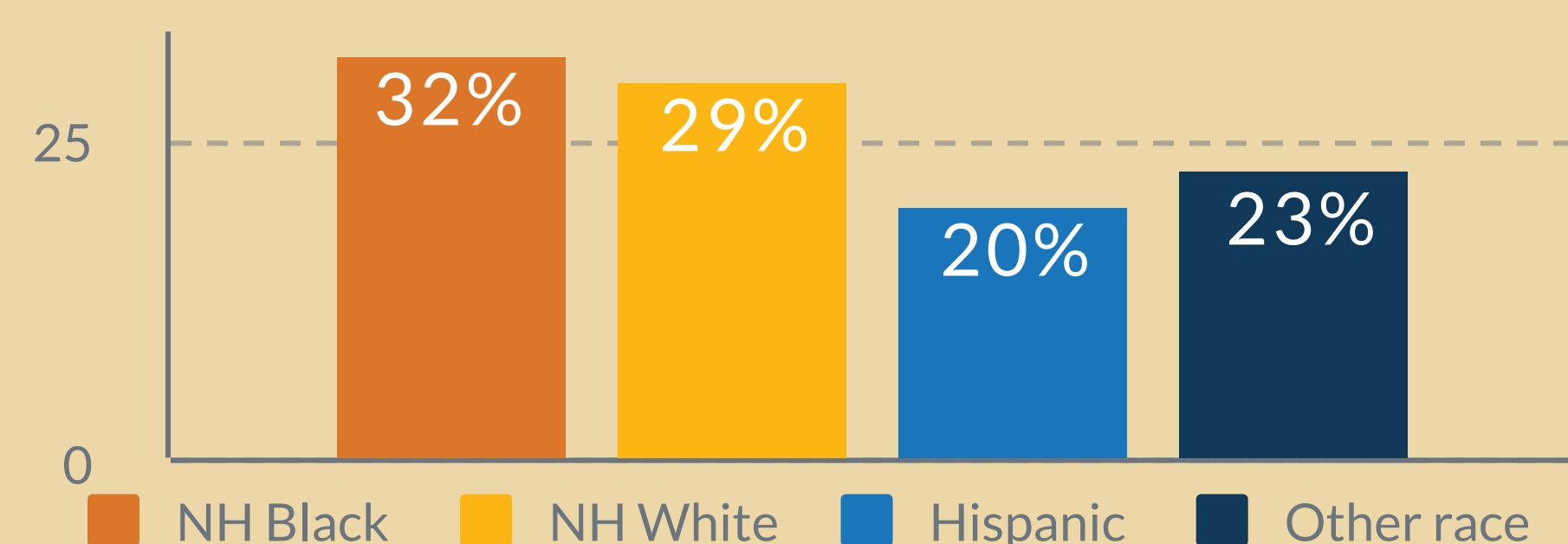
NH black received health care for asthma similarly when compared to other race groups

Received Health Care for Asthma



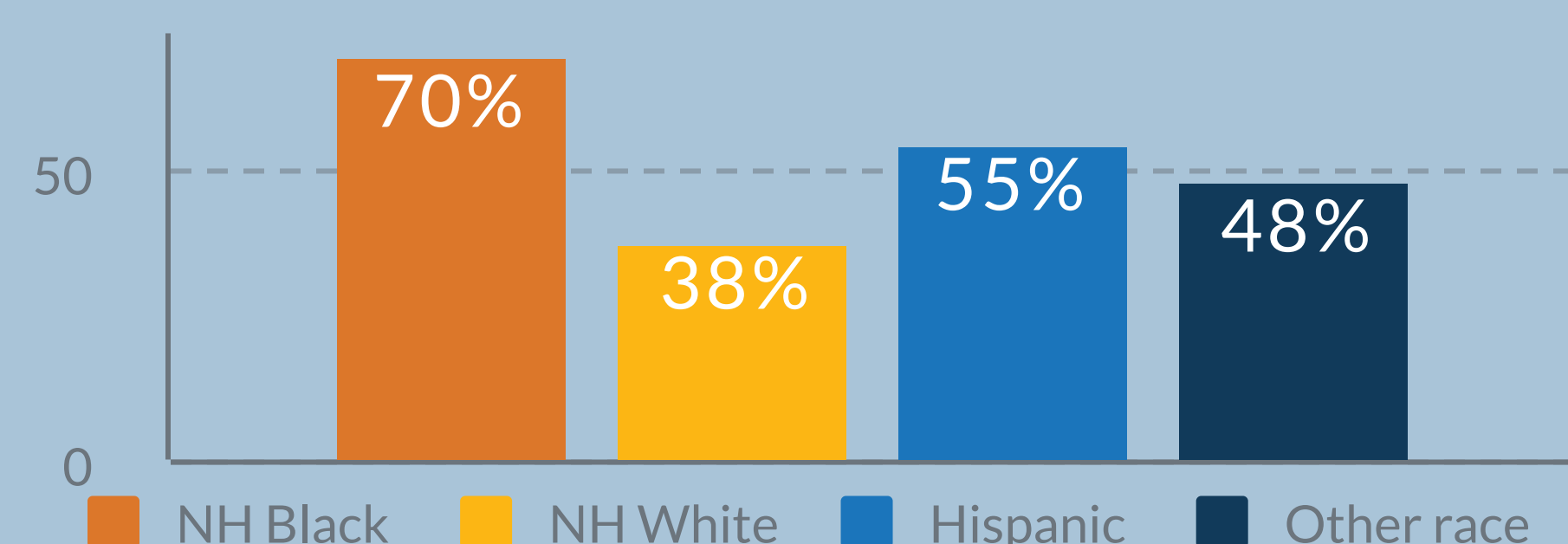
About one-third of NH black children/families were unable to follow prescribed treatment plans for asthma which was a similar proportion to NH white children/families but a higher proportion when compared to Hispanic and other race groups

Not Able to Follow Treatment Plans



Over two-thirds of NH black who died from asthma lived in urban areas which was a higher proportion when compared to other race groups

Reside in Urban Areas



Research is needed to better understand why the proportion of NH black children who die from asthma is higher than other race groups

Prevention Resources



*National Asthma Control
Program,
Centers for Disease
Control and Prevention*

<https://www.cdc.gov/asthma/nacp.htm>



*Resources and
Information,
American Lung
Association*

<https://www.lung.org/lung-health-diseases/lung-disease-lookup/asthma>



*Walkthrough
Programs,
Wisconsin Asthma
Coalition*

<https://www.chawisconsin.org/initiatives/asthma/walkthrough-programs/>

National Center for Fatality Review & Prevention Supporting Fetal and Infant Mortality Review and Child Death Review Teams

There are many ways to stay in touch with the National Center for Fatality Review and Prevention:



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1. Centers for Disease Control and Prevention, National Center for Vital Statistics. Underlying Cause of Death 2010-2019 on CDC WONDER Online Database, released in 2020. Accessed on Jan 11, 2021.
2. These deaths have been reviewed and recorded into the NFR-CRS by participating fatality review teams. Some percentages may not add up to 100% due to rounding.

These data represent a smaller percent of the cases entered into the NFR-CRS. For more information about the data contained in this Quick-Look, please visit https://www.ncfrp.org/wp-content/uploads/NCRPCD-Docs/NCFRP_Quick_Looks_Analysis.pdf