Data Quality Initiative Webinar

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June 23, 2016

NATIONAL CFRP

Saving Lives Together

The National Center for Fatality Review and Prevention

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The National Center for Fatality Review and Prevention is a resource and data center that supports child death review (CDR) and fetal and infant mortality review (FIMR) programs around the country.

It is funded in part by Cooperative Agreement Number UG7MC28482 from the U.S. Department of Health and Human Services (HHS), Health Resources Services Administration (HRSA), Maternal and Child Health Bureau (MCHB).

Webinar Agenda

- Housekeeping issues
- Introduction to GoToWebinar polling
- Introduction to data quality initiative
  - Priority variables
  - Written guidance
  - Data quality summary
- Scenarios
- Guidance details on supervision, omission/commission, preventability

GoToWebinar and Other Housekeeping Details

- Listen-only mode = you are muted.
- Questions can be typed into the chat window. They will be answered at the end of the presentation.
- We will use polling during this webinar.
- Webinar will be recorded and archived.
- We will launch an evaluation survey at the end of the webinar. Please complete this survey, your feedback is very important to us!

Let's Have Some Fun!

Icebreaker Poll

Icebreaker Poll

What is your experience in using the CDR-CRS?

A. Newbie (what am I doing?)
B. Rookie (still in training)
C. Ranger (I can hold my own)
D. Seasoned (get the salt and pepper)

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Introduction to the Data Quality Initiative

Goal:

Improve the quality and consistency of the data entered into the CRS in an effort to improve usefulness of the data at the state and national level for identifying prevention strategies and monitoring the effectiveness of prevention measures that have been implemented.

Components of the Data Quality Initiative

- Convene workgroup
- Identify priority variables for monitoring data quality
  - How important is variable (for prevention/systems)?
  - How easy/possible is it to obtain?
- Develop written guidance
- Develop a data quality summary
  - Baseline analysis, deaths occurring in 2014
- Data Quality Webinar to all CRS users, June 2016
- Technical Assistance to select states
- CRS user survey

Overview of Priority Variables

- In most cases, ONLY the “gatekeeper” questions monitored.
  - That is, if there is a follow-up question we will only monitor completeness of the initial question.
  - For example, in A23: *Child had history of child maltreatment? If yes, specify.* We will only monitor “Did child have a history of child maltreatment?”
- CORE variables

Written Guidance

Goal:

Increase consistency within and across states in completing the priority variables in the CRS.

- Lists the priority variables along with definitions and guidance for completing each variable.
- Includes ONLY the priority variables identified by the Data Quality Workgroup.
- Intended as a streamlined reference for specific guidance on completing the priority variables.
- Does NOT replace the CRS data dictionary.

Data Quality Summary

DRAFT CDR_CRS Data Quality Summary Template

CDR-CRS Data Quality Priority Variables Variables highlighted in PINK are designated CORE variables		How data from all states looks right now				How your state's data looks right now				How your state's data looked at the same time last year			
		All States 2014				Your State 2014				Your State			
		Missing		Unknown		Missing		Unknown		Missing		Unknown	
CDR-CRS DQ Priority Variables		N	%	N	%	N	%	N	%	N	%	N	%
A4	Child's age												
A5	Child's race												
A6	Hispanic origin?												
A7	Child's sex												
A19	Child's health insurance?												
A20	Child had disability or chronic illness?												
A21	Child's mental health: Had received services												
	Child's mental health: Was receiving services												
	Child's mental health: On meds for MH issue												
	Child's mental health: Issues prevented from receiving services												
A23	Child had history of maltreatment as victim?												

Missing/Unknown Distinction

- CRS developed so all fields set to missing
- Response of ‘unknown’ indicates team discussed and information not known or available
- Missing indicates question was skipped or not discussed/mentioned during review
- Data quality summary takes CRS skip patterns into consideration

Scenarios

Scenario 1

2-year old in care of grandmother while mom at work

Toddler in front of TV, grandmother in basement doing laundry.

Toddler wanders out of the house and drowns in sewage lagoon on property.

Scenario 1: 2 yo drowns in sewage lagoon

C1. Did child have supervision at time of incident leading to death?

A. Yes
B. No, not needed given age/development
C. No, but needed
D. Unable to determine

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Guidance on Supervision

Section C. Supervisor Information

Supervision defined

- The action or process of watching and directing what someone does.
- With respect to supervision of a child, supervision can be measured by:
  - the proximity of the supervisor to the child, and
  - the attention (visual and auditory) to the child.

C1. Did child have supervision at time of incident leading to death?

Indicate whether a person was responsible for supervising the child at the time of incident.

- Children less than 6 years of age require constant or close supervision most of the time. If the supervisor of a child less than age 6 was out of visual or auditory proximity, that is, they could not see or hear the child at the time of the incident, code supervision as “No, but needed.”
- For children of any age, if the supervising adult is not within close enough proximity to see or hear the child, consider the child not supervised. There are 2 possible responses for not supervised: “No, but needed” and “No, not needed given developmental age or circumstances.” Infants should always be supervised.
- If the adult is within proximity that would permit them to see or hear the child, but was attending to other tasks (e.g., talking on the phone, making dinner,) consider the child supervised, but document that the supervisor was impaired in C15 (check C15 = yes; and check “distracted”)

Scenario 1: 2 yo drowns in sewage lagoon

C1. Did child have supervision at time of incident leading to death?

A. Yes
B. No, not needed given age/development
C. No, but needed
D. Unable to determine

Scenario 2

2am. 3 month old infant asleep in crib in nursery. Biological parents asleep in their room. No drugs or alcohol used in house. Mom goes to check on baby and finds its face wedged in the crib bumper pad. Crib rails surrounded by bumper pads. Crib also contains blankets and several stuffed animals.

Scenario 2: Sleep-related infant death

C1. Did child have supervision at time of incident leading to death?

A. Yes
B. No, not needed given age/development
C. No, but needed
D. Unable to determine

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Scenario 2: Sleep-related infant death

C15. At the time of incident was supervisor impaired?

A. Yes

B. No

C. U/K

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Scenario 2: Sleep-related infant death

C15. At the time of incident was supervisor impaired?

If yes, check one:

A. Drug/alcohol impaired
B. Asleep
C. Distracted
D. Absent
E. Impaired by illness/disability

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C1. Did child have supervision at time of incident leading to death?

Indicate whether a person was responsible for supervising the child at the time of incident.

- If the child was asleep at time of incident and the supervisor was also asleep, and the incident occurred during the night (when you would expect families to be sleeping), the child would be considered “supervised.”
- However, if the supervisor is sleeping during the day or evening hours when they should be supervising the child, and the child is awake, document this in C15 by indicating that the supervisor was impaired (check C15 = yes; and check “asleep”)

C15. At time of incident was the supervisor impaired? If yes, check all that apply

- *Drug impaired*: Drug impaired refers to being under the influence of any intoxicating compound or combination of intoxicating compounds to a degree that impairs a person's ability to supervise a child.
- *Alcohol impaired*: Alcohol impaired refers to being under the influence of alcohol to a degree that impairs a person's ability to supervise a child.
- *Asleep*: Supervisor was sleeping at time of incident. This is only considered an impairment if the incident occurred at a time of day that is not typical for the supervisor to be sleeping. For example, the supervisor of a young child is sleeping at 2pm, no alternative supervisor is assigned, and the child wonders off and is fatally injured.
- *Distracted*: Distracted refers to the supervisor's attention being diverted off the child and onto something else; talking on the telephone, watching TV, cooking, doing laundry, for example.

C15. At time of incident was the supervisor impaired? If yes, check all that apply

- *Absent*: Supervisor was not present at time of incident.
- *Impaired by illness, specify*: Impaired by illness refers to a physical illness that renders a person incapable of effectively supervising a child. This includes any acute or chronic medical condition that may limit the person's ability to care for a child. Impaired by mental illness may include conditions such as depression, PTSD, bi-polar disorder or other diagnosed mental health condition.
- *Impaired by disability, specify*: Impaired by disability refers to a condition that renders a person incapable of effectively supervising a child. Impaired by disability may include developmental delays. Blindness is an example of a disability that may limit a person's ability to care for a child.
- *Other*: Specify all other factors that contributed to poor quality of supervision.

Scenario 2: Sleep-related infant death

C1. Did child have supervision at time of incident leading to death?

A. Yes
B. No, not needed given age/development
C. No, but needed
D. Unable to determine

Scenario 2: Sleep-related infant death

C15. At the time of incident was supervisor impaired?

A. Yes

B. No

C. U/K

Scenario 3

5-year old child lives with biological mom, who is separated from biological dad. Dad comes to house, argument with mom ensues, dad pulls a gun and in the struggle, shoots the gun. Bullet hits and kills the child.

Scenario 3: Child shot during domestic violence

I1. Did any act of omission or commission cause or contribute to the death?

A. Yes

B. No

C. Probable

D. U/K

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Scenario 3: Child shot during domestic violence

I2. What acts CAUSED or contributed?

A. Poor/absent supervision
B. Child abuse
C. Child neglect
D. Other negligence
E. Assault not child abuse

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Guidance on Acts of Omission/Commission

Section I. Acts of Omission or Commission

Section I should be considered for all deaths

- Most natural deaths will not be related to acts of omission or commission
  - potential for failure to seek or provide medical care, or religious practices to contribute to a death should be considered and documented when appropriate.

- Injury deaths are most likely to be related to acts of omission or commission;
  - circumstances of all injury deaths should be reviewed and any identified acts of omission or commission should be documented when appropriate.

- Undetermined or unknown cause deaths -- acts of omission or commission that directly cause or indirectly contribute to the death might be identified and when they are, should be documented.

I1. Did any acts of omission or commission cause or contribute to the death?

Acts of omission or commission defined:

- Any act or failure to act which directly causes or indirectly contributes to the death of the child.
- Please consider act(s) of commission and omission broadly.
- The purpose of this question is to identify whether there were specific human behaviors that caused or contributed to the child's death.
- It is NOT intended to determine blame or legal culpability.

I1. Did any acts of omission or commission cause or contribute to the death?

- Check "Yes" if the team determines that any act(s) of omission or commission directly caused or indirectly contributed to the child's death.
- Check "No" if the team determines that no act(s) of omission or commission directly caused or indirectly contributed to the child's death.
- Check "Probable" if there is not sufficient evidence for the team to be certain that any act(s) of omission or commission directly caused or indirectly contributed to the child's death, but there is evidence indicating such a link.
  - Use of this "Probable" category is particularly relevant to deaths due to unknown or undetermined causes such as sudden unexpected infant deaths in the sleep environment, particularly if hazards in the sleep environment are noted (e.g., bed-sharing, soft bedding, sleeping on surface not intended for infant sleep).

I2. What act(s) caused or contributed to the death?

- Indicate which acts of omission or commission directly caused or indirectly contributed to the child's death.
- This field should be used to identify deaths in which child maltreatment directly caused or indirectly contributed to the death.
- The purpose of this section (and CDR more broadly) is to document circumstances and identify risk factors for use in developing prevention strategies, NOT to determine legal culpability or substantiate child maltreatment.
- Consequently, although legal definitions for some categories (e.g., child abuse, neglect, negligence) may be available, they should not be used as criteria for completing this section.

I2. What act(s) caused or contributed to the death? Acts defined

- *Poor/absent supervision:* Caregiver's failure to supervise, provide alternative appropriate supervision, or engage in other behavior that causes or contributes to the child's death. This category is typically used when lack of supervision causes or contributes to injury death in a young child and the team does not feel that the lapse of supervision meets criteria to be classified as child neglect.
- *Child abuse:* An act (usually commission) on the part of a parent or caregiver that results in, or presents imminent risk of harm to a child.
- *Child neglect:* A failure to act (omission) on the part of a parent or caregiver that results in or presents imminent risk of harm to a child. This might be a failure to provide for a child's basic physical, medical, or emotional needs.

I2. What act(s) caused or contributed to the death? Acts defined

- *Other negligence*: Refers to acts or failures to act on the part of a parent or caregiver that are neglectful but do not raise to a standard of child neglect. This category should be used for sudden unexpected infant deaths when hazards are documented in the sleep environment but the team does not feel that the circumstances meet the criteria to be classified as child neglect.
- *Assault, not child abuse*: Refers to acts of commission where the alleged perpetrator is not a parent or in an explicit or implicit caregiver role.
- *Religious or cultural practices*: Religious or cultural practices that result in a child's death should usually be classified as child abuse or neglect. Use this category if the CDRT considers the particular circumstances of the death as an exception. Primary consideration should be given to the best interests of the child and the level of risk of harm to the child.

I2. What act(s) caused or contributed to the death? Acts defined

- *Suicide*: Select “Caused” and “Suicide” in I2 for any cases where manner of death has been marked “Suicide” in Section F1. This permits availability of the more detailed suicide risk factor questions in I27 and I28
- *Medical misadventure*: Encompasses unintentional events or errors made by medical institutions or by medical practitioners. This does not refer to individual’s intentional or unintentional misuse of medicines or medical procedures carried out without medical supervision.
- *Other*: Use this category when an act of omission or commission directly caused or indirectly contributed to the death (I1 checked “Yes” or “Probable”), but the circumstances of the death do not meet the criteria for any of the above categories. This category is most appropriate for deaths of adolescents where high risk behaviors (e.g. ingesting drugs or alcohol, reckless driving) cause or contribute to the death.

Scenario 3: Child shot during domestic violence

I1. Did any act of omission or commission cause or contribute to the death?

A. Yes

B. No

C. Probable

D. U/K

Scenario 3: Child shot during domestic violence

I2. What acts CAUSED or contributed?

A. Poor/absent supervision
B. Child abuse
C. Child neglect
D. Other negligence
E. Assault not child abuse

Scenario 4

Family outing in rural campground to learn to shoot. 2 biological parents, 4 children ages 11, 6, 3, and 6 months. Dad sets up target and is teaching 6-year old how to shoot a rifle, using sights. 11-year old is instructed to watch his 3-year old brother. Mom is changing the baby. 3-year old goes to car to get something and runs in front of the 6-year old who is shooting, using sights so doesn't see her brother run in her path. Shoots and kills 3-year old.

Scenario 4: Child shot by sibling

I1. Did any act of omission or commission cause or contribute to the death?

A. Yes

B. No

C. Probable

D. U/K

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Scenario 4: Child shot by sibling

I2. What acts CAUSED or contributed?

A. Poor/absent supervision
B. Child abuse
C. Child neglect
D. Other negligence
E. Assault not child abuse

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Scenario 4: Child shot by sibling

K1. Could the death have been prevented?

A. Yes, probably

B. No, probably not

C. Team could not determine

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Guidance on Preventability

K1. Could the death have been prevented?

- Team's conclusions regarding the preventability of the death.
- A child's death is considered to be preventable if an individual or the community could reasonably have done something that would have changed the circumstances that led to the child's death.
- Consider preventability broadly and that most injury deaths are preventable.

K1. Could the death have been prevented? Examples of preventable deaths*

- **Unintentional injury deaths** of young children that occur under absent or poor adult supervision
- **Motor vehicle and other transport deaths** when fatal injuries are sustained due to failure to use appropriate restraints (child seat, seatbelt) in a motor vehicle, or failure to wear a helmet while riding a bicycle, motorcycle or ATV.
- **Deaths due to fire or burns** when fire caused by heating residence with a stove or children playing with matches.
- **Drowning deaths** when infant or toddler left unattended in a bathtub, lack of barriers around swimming pools or other bodies of water, failure to use mandated floatation devices.
- **Sleep-related deaths** when asphyxia results from bed-sharing or other unsafe infant sleep environment (e.g., place on couch, on pillow)

*Adapted from list provided by Tennessee

K1. Could the death have been prevented? Examples of preventable deaths*

- **Weapon-related deaths** when firearm left loaded and/or unsecured.
- **Fall deaths** from balconies/windows.
- **Poisoning, Overdose, Acute Intoxication** unsecured prescription drugs or poisons.
- **Suicide** If parent or caregiver did not seek care for child when child had history of previous suicide attempts, mental illness, or indicated intent to commit suicide.
- **Medical Condition** if caregiver does not seek care or delays seeking care for a known medical condition, or fails to follow prescribed care/treatment plan.

*Adapted from list provided by Tennessee

K1. Could the death have been prevented? Examples of deaths not typically preventable*

- Cardiovascular disease
- Congenital anomalies (birth defects)
- Prematurity and other perinatal conditions
- Other chronic medical conditions

*Adapted from list provided by Tennessee

Scenario 4: Child shot by sibling

I1. Did any act of omission or commission cause or contribute to the death?

A. Yes

B. No

C. Probable

D. U/K

Scenario 4: Child shot by sibling

I2. What acts CAUSED or contributed?

A. Poor/absent supervision
B. Child abuse
C. Child neglect
D. Other negligence
E. Assault not child abuse

Scenario 4: Child shot by sibling

K1. Could the death have been prevented?

A. Yes, probably

B. No, probably not

C. Team could not determine

QUESTIONS?

Thank you!

- Because of limited time for this webinar, we have focused on the CRS sections for which we receive the most questions – supervision, omission/commission, preventability.
- The evaluation survey will be launched next.
- Contact us if you have questions or comments:

  info@childdeathreview.org