Novel Use of a National Case Reporting System for Data Delivery and Case Notification

Julie Lenoch, D.V.M., M.P.H.
Wisconsin Department of Health Services
Office of Health Informatics
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Outline

- Background
 - Definitions
 - Wisconsin statistics
- Methods
 - Local health department interviews
 - Identify data needs
 - Identify common data barriers

- Results
 - Goals
 - Technical solutions
 - Use of case reporting system
- Limitations





Definitions

- In Wisconsin, a fetal death is defined as one of the following:
 - 350 grams or more
 - 20 completed weeks gestation or more, calculated from the date the last normal menstrual period began to the date of delivery





Definitions

- Infant death: death occurring before a child's first birthday if the child was born alive, without regard to gestational age or weight
- Infant mortality rate (IMR): number of infant deaths per 1,000 live births during the given time period





Definitions

- Child: "A child means every human being below the age of 18 years." (WHO, United Nations' Convention on the Rights of the Child, 2015).
- Child death: death of a child from birth until 18 years.





Fetal and Infant Mortality Review (FIMR) and Child Death Review (CDR)

FIMR

- Community led teams
- Stillborn and Infant (up to one year) deaths
- De-identified data presentation
- Includes maternal health factors
- Local action

CDR

- Community led teams
- Review deaths of all children 0-18 years (may extended up to 20 or 25)
- May include Infant Death Review
- Identified cases
- Leads to local action





FIMR and CDR

	Child death review (CDR)	Fetal infant mortality review (FIMR)	
Cases reviewed	At a minimum, CDR teams review all deaths to children younger than age 18. However, many Wisconsin teams review deaths to children and adults younger than age 25.	FIMR teams review all stillbirths weighing more than 350 grams or 20 weeks gestation and all infant deaths occurring in the first year of life.	
Purpose	CDR teams are comprised of professionals from a variety of agencies who identify risk factors and circumstances surrounding the death in order to prevent future deaths.	FIMR teams are comprised of professionals and community members from a variety of backgrounds who seek to improve maternal and fetal (stillbirth) health.	





Wisconsin Statistics

- Population: 5,730,937 (2013)
- 72 counties
- 99 local health departments
- Approximately 350 fetal deaths and 425 infant deaths annually

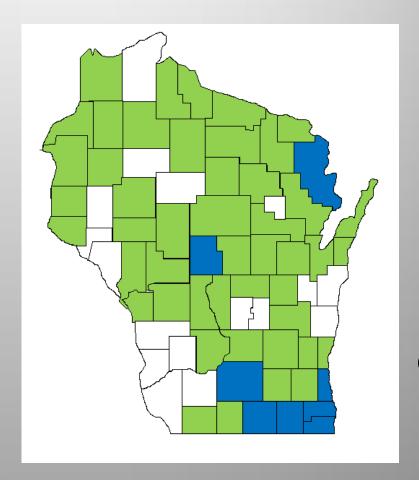




Wisconsin FIMR and CDR

Wisconsin has:

- 8 active FIMR teams
- Covering 2.2 million people (38% of the population)
- Represents 48% of infant deaths
- Wisconsin has:
 - 48 CDR teams
 - Covering 51 counties and 90% of the population



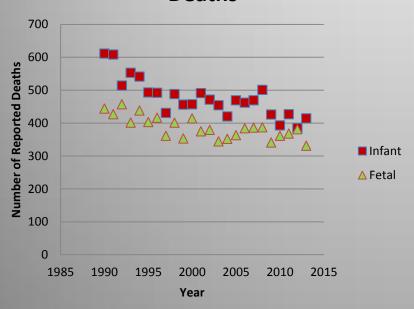




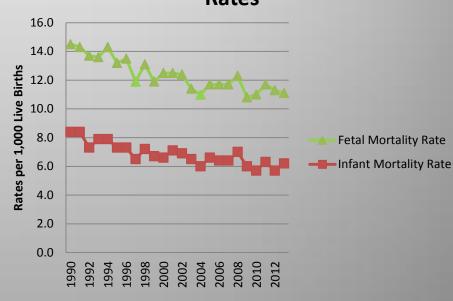


Infant and Fetal Death Trends

Wisconsin Fetal and Infant Deaths



Wisconsin Fetal and Infant Mortality Rates





Source: Wisconsin Department of Health Services, Division of Public Health, Office of Health Informatics. P45364-13.



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Local Health Department Outreach

- Children's Health Alliance of Wisconsin
- Met with each of the eight local health departments to discuss data access for purpose of FIMR
- Aggregated common data sources and data barriers





Data Needs

How do FIMR teams get their information?



Data Sources for FIMR

- Vital records: death certificate and birth certificate data
- Autopsy report
- Family or maternal interview
- Maternal and pediatric medical records
- Law enforcement
- Child Protective Services





Data Barriers

- Absence of mandated collection and reporting of specific data
- Varied interpretation at hospital level
- Varied access to electronic medical records
- Timely access to data
- Multiple LHD jurisdiction example





Vital Records Data Needs

Fetal Death	Fetal Death Record
Infant Death	Death Certificate Birth Certificate
Child Death	Death Certificate





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Goals of Project

- Timely notification
- Matched birth-death information
- Maternal data access
- Standardized format
- Reduce errors in data entry

- Secure format
- Initiate process for FIMR or CDR
- Reduce data requests
- Reduce access to unnecessary data fields





Technical Solutions

- Provide data file from Vital Records to LHD.
- Use Child Death Review Case Reporting System to securely deliver data.
- Inform LHD via case notification to initiate download and review.





Process of Case Entry

Death of infant

Death certificate filed to DHS Vital Records (VR)

Infant death identified by VR staff; triggers data abstraction and matching to birth certificate

Matched infant birth-death certificate entered into CDR-CRS by DHS-MCH

Secure notification to LHD to inform of case





Process of Case Entry (Continued)

LHD searches CDR-CRS using PII and "pulls" case into jurisdiction.

Local FIMR decides whether to review or report without review.

Local FIMR team may continue with investigation.

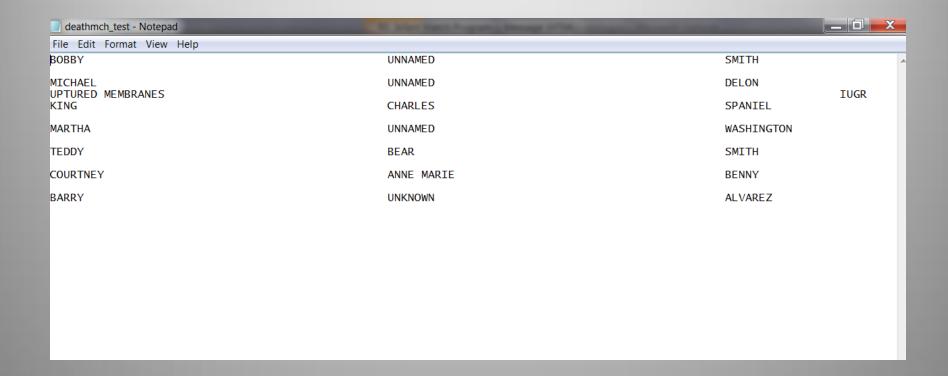
Local FIMR team can amend CDR-CRS.

FIMR team meeting: de-identified presentation.





Vital Records Infant Death File







Vital Records Infant Birth File

birthmch_test - Notepad	C 81 100	Match Programs, Stronge (1754)	Street Street Laboratory	
File Edit Format View Help				
201306170612062013ALVAREZ 201400047201062014SMITH 201400144101042014DELON 201400338101152014SPANIEL 201400668602102014BENNY 201306635808132013WASHINGTON	BARRY BOBBY MICHAEL KING COURTNEY MARTHA	03042014008552 01062014000533 01042014001885 01152014003156 02102014010901 02082014201400542	WI383856018802Y11081975MARRY WI210422018801Y01011988BETH WI180142020201Y04271991BRITTANY WI210380018804Y01251982RITA WI230615018800Y05171992MEGHAN 28WI402750018800Y01011990KATHERINE	UNN, BETI LIE: UNN, UNN, UNN,





Vital Records Linked Data File

	F16 ▼				
	A A	В	С	D	
1	birth record		<u> </u>		
2	Birth state file number	1-10			
3	date of birth	11-18			
4	last name	19-40			
5	first name	41-61			
6	date of death	62-69			
7	death state file number	70-79	This field is 10 characters and some records have the six digit number preceded by the year and others don't		
8	death state	80-81			
9	gestation weeks	82-83			
10	weight in grams	84-87			
11	plurality	88-89			
12	births born alive this delivery if plural	90-91			
13	live births now living	92-93			
14	prenatal care	94-94			
15	mother's date of birth	95-102			
16	mother's first name	103-122			
17	mother's middle name	123-142			
18	mother's current last name	143-162			
19	mother's birth last name	163-182			
20	birth id	182-191			
21					
22					
23					
24					
25					





Case Reporting System



Logged in as Wisconsin Training1. (Wisconsin - Vernon) Logout

Main

Your Account
Enter New Case
Manage Cases
Standardized Reports
My CDR Outcomes
Data Download
Help
Logout

Understanding How And Why Children Die



& Taking Action to
Prevent Child Deaths

Welcome, Wisconsin

Nothing compares to the death of a child, in the sadness, the sense of loss, the unfulfilled promise. It reverses the natural order, and challenges our belief in a universal good.

- Dr. William Perloff, Chair, Wisconsin Child Fatality Review Team

Thank you for your efforts to prevent future injuries and deaths of children in your community. Entering your data into this system allows you to monitor the deaths that occur in your community and identify key prevention efforts that will protect your community's children.

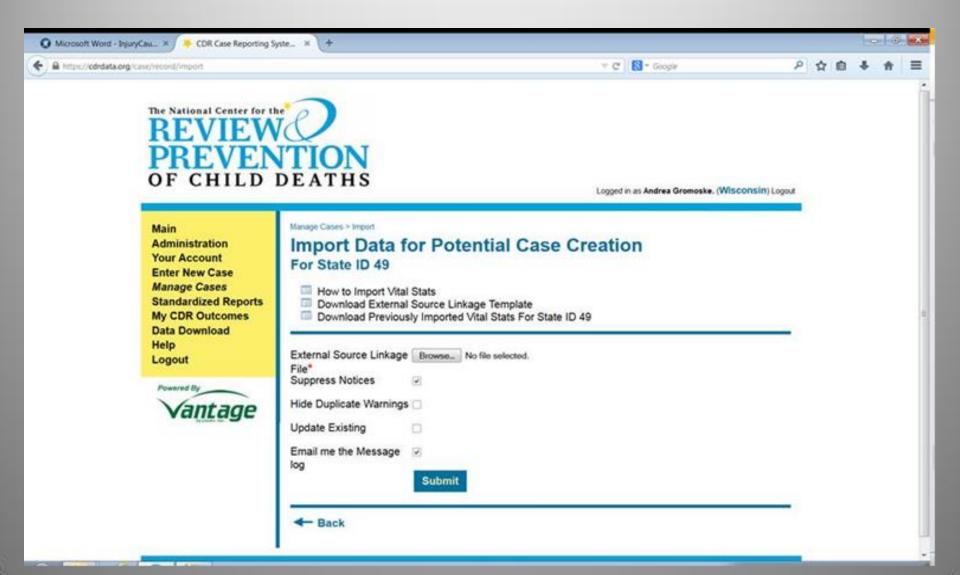
For more information, please contact: Abby Collier Project Manager, Children's Health Alliance of Wisconsin ajcollier@chw.org 414-292-4016

If you need assistance using the data system, please contact Abby Collier or the National MCH Center for Child Death Review at 800-656-2434.





Administrator Case Entry



LHD Case Retrieval



Logged in as Wisconsin Training1. (Wisconsin - Vernon) Logout

Main
Your Account
Enter New Case
Manage Cases
Standardized Reports
My CDR Outcomes
Data Download
Help
Logout



Create New Case From Import

Last Name	First Name	Death Cert #	Birth Cert #	Death Date	Manner of Death	Actions	Status
No results.							
Search Imports: Date of Death	11/0)2/2014	*				
First Name	Sch	wartz					
Last Name	Virg	inia					
	Sea	rch Imports					
					<u> </u>		

Back

Data Elements



Logged in as Wisconsin Training1. (Wisconsin - Vernon) Logout

Main
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Data Download

- View Codebook
- View Pared Down Flat File Codebook
- Macro to Import Data into Microsoft Access

Download All Sections

All	Every Section	All Data	zip
Flatfile	Most Sections	Selected Data	txt

Download By Section

tCase	Section Case	Case Information	txt
tINF	Section A	Child Information	txt
tINF2	Section A	Child Information, Part II	txt
tGIV	Section B	Primary Caregiver(s)	txt
tSUP	Section C	Supervisor Information	txt
tINC	Section D	Incident Information	txt
tINV	Section E	Investigation Information	txt
tCAU	Section F	Official Manner and Primary Cause of Death	20
	Section G12	Other cause, undetermined cause or unknown cause	txt

Case Modification

OF CHILD DEATHS

Logged in as Wisconsin Training1. (Wisconsin - Vernon) Logout

Case Sections

- # Case Definition
- A Child Information
- **B** Primary Caregivers
- C Supervisor
- D Incident
- **E** Investigation
- F Cause of Death
- H Circumstances
- I Acts
- J Services
- K Prevention
- L Review
- M Narrative
- N Form Completion

Save and Exit



Manage Cases > Section F

Enter Case Information [49-63-2015-00003]

Print this section

Section F: Official Manner and Primary Cause of Death

- 1. Official manner of death from the death certificate
- Natural
- Accident
- Suicide
- Homicide
- Undetermined
- Pending
- Unknown
- 2. Primary cause of death.

Choose only 1 of the 4 major categories, then a specific cause. For pending, choose most likely cause.

- From an external cause of injury
- From a medical condition
- Undetermined if injury or medical cause
- Unknown

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Benefit of the CDR-CRS

- Rapid notification of cases
- Reduced work and data entry from LHD
- Consistent format of birth and death data
- Compliance with reporting
- Reporting reviewed and non-reviewed cases
- Improved data access from Vital Records





Future Use of the CDR-CRS

- Phase I: infant death case notification
 - Most difficult; matched death-birth record
- Phase II: child death case notification
- Phase III: fetal death case notification





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Limitations of the CDR

- LHD needs to register for access to CDR-CRS.
- Unclaimed cases need jurisdictional assignment.
- Duplicate case reviews.
- Out-of-state birth or death restrictions.





The Big Picture







Acknowledgements

Wisconsin Department of Health Services

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Strengthening Health Systems through Interprofessional Education

A collaboration between the Association of State and Territorial Health Officials, Centers for Disease Control and Prevention, the Council of State and Territorial Epidemiologists, the National Association of County and City Health Officials, and the Public Health Informatics Institute

Vision statement: Illuminate pathways for professionals, organizations, and communities to achieve a collective, transformative, and sustainable impact on population health.





Questions?

Julie Lenoch, D.V.M., M.P.H.

Health System Integration Program

CDC/CSTE Fellowship

Julianna.lenoch@wisconsin.gov

To learn more about Project SHINE, check out our website: http://shinefellows.org.

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Additional Slides





FIMR and CDR team members

- Local public health
- Coroner
- Law enforcement
- Child Protective
 Services
- District attorney
- Pediatrician/OB-Gyn/ health care
- SHEDNE

 Strengthening Health Systems through Interprofessional Education

- Ems
- Hospital
- Tribal council
- Domestic violence
- Mental health
- School district
- Child care facility
- Neonatology
- SIDS SME



Criteria for FIMR Review

Reviewed

- SIDS
- Low birth weight
- Premature
- Homicide
- Suicide
- Unintentional injury
- Undetermined causes



Not reviewed

- Cancer
- Congenital



Partners

- Wisconsin Department of Health Services
 - Office of Health Informatics
 - Maternal and Child Health (MCH)
- Children's Health Alliance of Wisconsin (CHAW)





Partners

- Local health departments
- National Center for the Review and Prevention of Child Deaths
 - Child Death Review Case Reporting System



