Indiana State Department of Health
Indiana Violent Death Reporting System
Advisory Board

Time: Tuesday, December 9th, 2014 1:00-3:00 EDT
Location: 5th Floor Training Room, ISDH, 2 North Meridian Street
Called by: Katie Hokanson, Director, ISDH Division of Trauma & Injury Prevention
Conference Call line: 1-877-422-1931, Participant Code: 2792437448#

I. Agenda Topics

1. Welcome & Introductions - Attendees (40):
    a. Katie and Jessica welcomed the group and covered the outline for the meeting. Everyone in the room introduce themselves, followed by those on the phone.

Arkins, Tom	Ballew, Alfie	Bannister, Allison	Bell, Teresa
Bingaman, Greg	Brattain, Lisa	Breeker, Ginger	Castor, Jill
Chavez, Laura	Coomer, Joey	Dearth, Snady	Dillon, Bekah
Doolittle, Genesa	Dowden, Richard	Elbert, Gail	Ferguson, Susan
Gray, Lisa	Hackworth, Jodi	Hokanson, Katie	Holsinger, Judi
Hudson, Katharine	Huffman, Gretchen	Kern, Tom	Korobov, Kristina
Kuzma, Abigail	Lawry, Murray	Lockyear, Steven	Moore, Michelle
Nimry, Ramzi	Quaglio, Sarah	Reichard, Ruth	Reynolds, Anne
Saywell, Robert	Sefton, Scott	Skiba, Jessica	Spear, Kenneth
Spitzer, Tracy	Steele, Greg	Walthall, Jennifer	Zollinger, Terrell

    b. ISDH passed out a worksheet for everyone to complete that includes:
        i. Concerns/roadblocks
            1. As the meeting progresses, please note any concerns/roadblocks that the ISDH staff needs to address before the next Advisory Board meeting.
        ii. Potential Electronic Data Sources
            1. We know that some data providers have legal restrictions on what data elements they can share for the INVDRS project. What other electronic data sources could be utilized for this project?
        iii. Counties surrounding the pilot counties that would be interested in participating in INVDRS during the pilot year
            1. ISDH has heard that some counties surrounding the pilot counties are interested in

participating in INVDRS. Everyone is welcome to participate in the pilot phase and ISDH would like to start scheduling meetings with these counties.

iv. Please complete the worksheet and send to kgatz@isdh.in.gov by January 30th, 2015.

2. Highlights of the Indiana Violent Death Reporting System (INVDRS)

a. Violent deaths are a nationwide problem. In 2012, there were 56,000 violent deaths. This equates to 153 deaths per day. 40,600 died by suicide (of the 56,000). This equates to $106 billion in years of direct/indirect costs, including productive life lost.

b. In order for the National Violent Death Reporting System (NVDRS) to collect state based information, each participating state has its own state-level Violent Death Reporting System. This project builds upon previous and current work to conduct surveillance of violent deaths.

c. A violent death is defined by the CDC as a death that results from the intentional use of physical force or power, threatened or actual, against: Oneself, another person, a group or community. Use ICD-10 External Causes of Death Codes located on death certificates processed by State Vital Records Department to identify the cases.

Manner of Death	ICD 10 Codes	
	Death < 1 year after the injury	Death > 1 year after the injury
Intentional self harm (suicide)	X60-84	Y87.0
Assault (homicide)	X85-X99, Y00-Y09	Y87.1
Event of undetermined intent	Y10-Y34	Y87.2, Y89.9
Unintentional exposure to inanimate mechanical forces (firearms)	W32-W34	Y86 determined to be due to firearms
Legal intervention excluding executions, Y35.5	Y35.0-Y35.4 Y35.6-Y35.7	Y89.0
Terrorism	*U01, *U03	*U02

Location of the injury on the death certificates helps to identify the law enforcement jurisdiction.

d. Manners of Violent Death: Case Definitions

i. Suicide: A death resulting from the intentional use of force against oneself. A majority of evidence should indicate that the use of force was intentional.

ii. Homicide: A death resulting from the intentional use of force or power, threatened or actual, against another person, group, or community. A majority of evidence must indicate that the use of force was intentional.

iii. Undetermined Intent: A death resulting from the use of force or power against oneself or another person for which the evidence indicating one manner of death is no more compelling than the evidence indicating another manner of death.

iv. Unintentional Firearm Death: A death resulting from a penetrating injury or gunshot wound from a weapon that uses a powder charge to fire a projectile when there was a preponderance of evidence that the shooting was not intentionally directed at victim.

v. Legal Intervention: A death when the decedent was killed by a Police officer or other peace officer (persons with specified legal authority to use deadly force), including military police, acting in the line of duty.

vi. Terrorism: Homicides or suicides that result from events that are labeled by the FBI as acts of terrorism.

e. The most important output of the Indiana Violent Death Reporting System (INVDRS) project is establishing a surveillance system to collects violent death information that is: High quality, comprehensive, timely, and complies with CDC guidelines and definitions.

f. At the last meeting, the INVDRS AB established the following goals, mission and vision:

i. Goals

1. Increase scientific understanding of violent injury through research
2. Translate research findings into prevention strategies
3. Disseminate knowledge of violence prevention to professionals and the public
4. Drop Indiana's violent death rate below the National Average
5. Target specific groups at-risk of suicide, such as 14 year-olds and incarcerated

ii. **Mission**: The INVDRS is dedicated to the reduction of violent injuries and deaths by providing comprehensive, objective, and accurate information regarding violence-related morbidity and mortality

iii. **Vision**: Prevent violent deaths in Indiana

iv. The INVDRS now has a logo:

INVDRS
Indiana Violent Death Reporting System

3. Outcomes of county-specific INVDRS meetings

a. Year 1 Pilot Project:

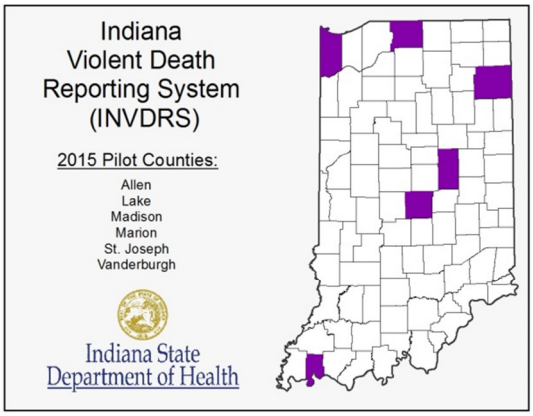
i. Collect data on deaths that occurred in 6 counties: Marion, Allen, Lake, Vanderburgh, St.

Joseph, and Madison. Selected based on rank of number of violent deaths in 2010

ii. Collect data on all child deaths (<18 years)

iii. Link related violent deaths that occurred within 24 hours: multiple homicides, suicide pacts, suicide-homicide, etc.

b. The division staff traveled to each of the 6 pilot counties (Allen, Lake, Madison, Marion, St. Joseph, and Vanderburgh) and met with local law enforcement, coroners, hospitals, child fatality review teams, and other interested local stakeholders.



c. Madison County Meeting:

i. Held October 16th.

ii. Attended by: Child Fatality Review Team members and Domestic Violence Fatality Review Team

iii. Discussed:

1. Utilization of child fatality review data in INVDRS
2. Potential to capture Intimate Partner Violence (IPV) data in the INVDRS system

d. Lake County Meeting

i. Held October 29th.

ii. Attended by: Lake Co Prosecutor, Methodist Hospital, Lake Co Coroner, Lake Co Sheriff's Department

iii. Discussed:

1. Coroner's Office press releases to help identify INVDRS staff of cases
2. Domestic Fatality Review team in Lake County
3. Potential for county level Advisory Board
4. Potential for Sheriff's Dept. to be point of contact because of 17 local law enforcement jurisdictions

e. St. Joseph County Meeting

i. Held October 29th.

ii. Attended by: St. Joseph Co. Police Dept., St. Joseph Co. Health Dept., St. Joseph Co.

Coroner, Memorial Hospital South Bend

iii. Discussed:

1. Some entities utilize UCR and does not include suicide deaths
2. More than one local law enforcement agency in St. Joe Co.
3. Concern for confidentiality and data sharing in terms of compromising investigations and prosecutions
4. INVDRS designing template for requested data

f. Marion County Meeting

i. Held October 31st.

ii. Attended by: Indianapolis Metro Police, Indianapolis EMS, Eskenazi, IU Health Riley, IU Methodist, Marion Co Health Department

iii. Discussed:

1. Potential use of EMS/ Trauma Registry data
2. Newly announced drug poisoning module
3. IMPD covers ~85% of Marion Co. and there are several other LEA needed to collect all data

g. Vanderburgh County Meeting

i. Held November 19th.

ii. Attended by: Vanderburgh Co HD, Evansville Police, Vanderburgh Sheriff, Coroner, Southwestern Healthcare St. Mary's Medical Center, Deaconess Hospital

iii. Discussed:

1. Case Ascertainment (death certificate vs. Law enforcement)
2. Burden of collecting data by data providers
3. Creating list of questions to ask families after suicide death

h. Allen County Meeting

i. Held November 26th

ii. Attended by: Allen Co PD, Allen Co Prosecutor, Allen Co Coroner, Allen Co DOH, Lutheran Hospital, Parkview Hospital

iii. Discussed:

1. Issues of confidentiality and data sharing in terms of compromising investigations

and prosecutions

2. How specific data elements will impact prevention
3. Differences in County of residence vs. County of injury vs. County of death

4. CDC NVDRS Reverse Site Visit
    a. Overview: The CDC NVDRS Reverse Site Visit was December 2-4 in Atlanta, Georgia. 32 states are participating in the NVDRS.
        i. Conference agenda:
            1. December 2nd: Working With Partners. Topics Covered:
                a. Planning & Implementing a Violent Death Reporting System (VDRS)
                b. Data Quality, Completeness, Timeliness
                c. National Implementation of a State-based Network of Enhanced Electronic Death Registration
                d. State & Territorial Exchange of Vital Events (STEVE)
                e. Data from Vital Records
                f. Working with Medical Examiners
                g. Working with Coroners
                h. Working with Law Enforcement
        ii. December 3rd: Data Abstractor Training. Topics Covered:
            1. National Violent Death Reporting System (NVDRS) Overview
            2. Documents & Data Providers
            3. Case Linking, Privacy, & Personally Identifiable Information (PII)
            4. Incident Narratives
            5. Data Security
        iii. December 4th: Expansion and Utility. Topics Covered:
            1. Overview of Web Software
                a. Incident Record
                b. Document Record
                c. Victim Record
                d. Circumstances
                e. Toxicology

f. Weapons
g. Suspects
h. Child Fatality Review & Intimate Partner Violence modules

2. NVDRS Administration
3. State-specific Data Elements
4. Prescription Drug Overdose (PDO) – Data Collection
5. State Use of VDRS Data: Alaska, Colorado, and Wisconsin
6. CDC Data Usage & Publications
7. Cross State Data Sharing

b. NVDRS Data Elements

i. There are several reasons why we collect data:
   1. Uniformity: Same case definitions and data sources across states
   2. Timeliness: Early detection of trends
   3. Completeness: Complete, comprehensive data

ii. The data for the INVDRS project comes from:
   1. Death Certificate
   2. Coroner Report
   3. Law Enforcement Record
   4. Local Law enforcement
   5. Child Death Review
   6. Collected by Child Fatality Review

iii. Data has to be reported in a timely manner:
   1. Goal to have incidents **initiated** within 6 months of violent death
   2. Goal to have incidents **finalized** within 18 months of violent death

iv. Incident variable discussion (see .PDF titled "National Violent Death Reporting system – Data Elements")

v. Discussion of other potential electronic data sources
   1. ISDH sources could include: Indiana Trauma Registry, ED/ hospital discharge data

5. Follow-up from questions at previous AB meeting

a. Data Providers

1. What mechanism do you use to get the funds directly to the data provider? Do you accomplish this through a county ordinance? Do you have a line item that specifies funding mechanism in your MOU?
    i. Maryland specifies how payments are made in their MOU with law enforcement
    ii. Kentucky does not pay for data
2. If there are more than one Law Enforcement Agency (LEA) in the county, do you have an MOU with each agency that reports data?
    i. North Carolina: has ~300 LEA MOUs (out of 500); took ~2 years to establish. Some jurisdictions do not experience violent deaths. If one cases occurs within a jurisdiction without an MOU, the jurisdiction and state agency create an MOU to share data.
    ii. Kentucky: agreement with Kentucky State Police (KSP) which has forensics lab; do NOT have an MOU with each county

b. Case Ascertainment
    i. How do you deal with suicides that may not be captured on the death certificate because we believe that the true burden of suicide is much higher than currently reported on death certificate (although may be due to older data, etc.)?
        1. Look at cause of injury vs. cause of death
        2. This is also why the NVDRS captures other types of deaths, such as undetermined and unintentional firearm injury deaths (in hope of capturing this situation no matter what)
    ii. Is initiating a case through the death certificate really efficient (May be difficult to ascertain some death certificate data in short period of time)?
        1. CDC does not mandate that case initiation start with the death certificate, but the death certificate is the most common starting point due to the VDRS typically being housed at state health department. We could utilize the coroner reports.
        2. Law enforcement report is typically the last document to receive, so not advised to wait until this information is received
        3. Ohio initiates through death certificate and it takes ~84 days to get that data
    iii. Uniform Crime Report (UCR) does not typically include suicide deaths, how do you obtain this information?

1. In general for suicides, we will not receive a lot of data from LEAs. However, the use of multiple, complementary data sources will allow for more comprehensive and accurate data to be collected on each incident as more information becomes available. The information collected in the system is documented by source.

iv. Are vehicular homicide/vehicular suicide cases included in NVDRS?

1. Specific scenarios that should not be classified as homicide: "vehicular homicide" without a preponderance of evidence of intent to use force against another (would be classified as unintentional injury)
2. Vehicular suicide cases *must* result from the intentional use of force against oneself

c. Data Collection

i. How long do we have to complete an incident/case (For example, if not able to receive information due to pending investigation or more information comes to light, what is the time limit to enter data)?

1. The CDC has deadlines in place that specify how long we have to initiate a case and complete a case, but we can always add more information when we get it later, it just may not be included in the data reports

ii. What if the coroner does not do an autopsy or toxicology screen for suicide or another manner of death?

1. Option to mark if a toxicology screen is done or not. Toxicology may not be applicable in every situation.

iii. How do you handle cases in which law enforcement do not investigate the case?

1. The system can be indicated that there was not an investigation.

iv. Some data elements collected do not appear to be directly related to prevention efforts. Why are these data elements collected?

1. Some elements are analyzed more frequently than others, but all data elements allow for a better understanding of the circumstances surrounding the violent death. For instance, the location of the wounds indicate how the person was positioned during the death (standing, laying down, etc.), which may indicate the overall manner of death (such as through recreating the incident.)

v. How do you ensure accurate information is reporting regarding the firearm at the scene? How do you address situations in which a vague description may be given about firearm?
    1. The crime lab data may be used to better describe the firearm if the incident involved a firearm. Additionally, other sources of law enforcement information may be able to best describe the firearm used in the situation.

vi. Do states provide a general template to data providers about what elements are needed for the NVDRS?
    1. Yes, and Kentucky created a template for their coroners

d. Confidentiality

i. Issue with not turning over homicide reports - County Prosecutor concern with jeopardizing cases/prosecutions:
    1. Cases still under investigation are typically not available and follow-up on cases is needed for such cases.
    2. Wisconsin: If a fatality does not clear after two years, it is considered lost-to follow up and only vital records, coroner/medical examiner, supplemental homicide report, and crime lab data (if applicable) are entered into the database.
    3. Only get the detective report in some states
    4. Alaska: Only fully adjudicated records are entered into the database thereby ensuring no legal cases pending before the courts are compromised.
    5. Oregon: phone call to LEA to gather information; focus on priority data elements
    6. Kentucky: Agreement in place that LEAs will send not prosecuted homicide cases
    7. Utah: Request Victim and Suspect demographics and all associated reports for each “closed” incident

ii. Have other states been able to get statutory language that specifically addresses this issue and keeps state-level, identifiable data from being open to subpoena? Post-Conviction Relief: Concern for Prosecutors.
    1. Utah: The police records, requested through the Government Records Access Management Act (GRAMA) 63-G-2-206 UCA Sec 26-1-30, will be used for legitimate surveillance and for the prevention of childhood and violent deaths.

2. Virginia: § 32.1-283.4. Confidentiality of certain information and records collected and maintained by the Office of the Chief Medical Examiner.
    a. "The confidential records and information set forth in subsections A and B shall not be subject to subpoena, subpoena duces tecum, or discovery when in the possession of the Office of the Chief Medical Examiner, or be admissible in any criminal or civil proceeding through any discovery relating to the Office. If available from other sources, however, such records and information shall not be immune from subpoena duces tecum, or discovery when obtained through such other sources solely because the records and information were presented to the Office during a death investigation."

e. Data Elements
    i. Do you prepare a list of data elements for coroners to talk with the families of people who have died by suicide (Typically have one shot to ask questions with family)?
        1. Pocket cards, list of questions available

f. Data Abstraction
    i. Can entity providing data enter the information directly into the system instead of the ISDH INVDRS staff?
        1. CDC only allows up to 10 users onto the NVDRS web-based system
    ii. How long does it take to document an entire case?
        1. A lot depends on the availability of the data
        2. Colorado: 10-20 coroners reports/day; 10 LEA reports/day
        3. Electronic death certificates can be uploaded electronically in batches up to 100

g. Data Abstractors
    i. Records Abstractors: More information/ examples of utilizing students to abstract
        1. Kentucky: Does not allow interns to abstract data, but does allow students who make a one year commitment to the project

h. Data Linking
    i. What information is used to link an event? (multiple-victim incidents)

1. Linking victims who die in a multiple-victim incident may be a challenge due to victim-based data sources. The Supplementary Homicide Report of the Uniform Crime Reporting Program has a field called Situation, which indicates whether a victim died in a single or multiple victim incident. The police report offers another opportunity to link deaths, as it may refer to other related deaths. The Coroner report may list other fatalities in multiple-death incidents. Querying data for cases that occur in the same county on the same day may also identify missing linkages.

ii. What elements are used in the matching process?

1. Truncated "linking fields" in the National System are not fully Personally Identifiable Information. The fields do not under our present understanding, constitute PII. Every data element is state optional and are not required to be populated in the system. They are most useful for linking incoming data to existing records. The system uses probabilistic matching to search on linking fields.
    a. First Initial of last name
    b. City, County, ZIP of residence
    c. City, County, ZIP of Injury
    d. Day and Month of Birth
    e. Last 4 digits of death certificate record number (or any 4 numbers of the record)
    f. Last 4 digits of coroner record number (or any 4 numbers of the record)
    g. Race, Sex, Ethnicity
    h. Date of Injury
    i. Date of Death

i. Advisory Board

i. Do other states have county-specific advisory boards (like fatality review)?

1. Kentucky: Does not have county-specific advisory boards. KY suggested having these county specific advisory boards be separate from project in order to promote violence prevention activities locally.
2. Colorado: Does not have county-specific advisory boards
3. County-based advisory board would be independent of INVDRS AB

j. NVDRS Success Stories
    i. Have other states seen overall death counts decrease?
        1. Strictly collecting the data does not translate into a decrease in deaths; utilizing the data leads to decreases in death
        2. Important to look at counts vs. rates [rates can go down even if counts go up based on increase in population size]
        3. Utilization of data for prevention activity is how lives are saved

k. NVDRS Innovations
    i. More information/ examples of integration with other data sets (prescription drug monitoring program [PDMP], Trauma Registry/ EMS Registry, DV, APS, CPS, etc.)?
        1. Oklahoma: utilizing PDMP dataset
        2. North Carolina: APS dataset

l. Prevention
    i. Will Prevention Funding be available in the future?
        1. As of right now, there will not be additional funding through existing FOA for the purposes of prevention, but the data collected will be used for

m. Interstate Data Collection
    i. Are deaths of Indiana residents that occur out of state collected in this system? Are deaths of non-Indiana residents that occur in state collected in this system?
        1. States are expected to collect violent deaths among their residents, wherever they occur, and fatal violent injuries occurring within their borders irrespective of residence. If the states of residence and injury occurrence are both NVDRS states, the state of injury occurrence is responsible for collecting the death.

n. Unintentional (Prescription) Drug Overdose Data Collection
    i. Collection of unintentional prescription drug overdose deaths:
        1. Create new module to collect information on unintentional drug overdoses
        2. When NVDRS started years ago, it was a lot about weapons as the U.S. underwent a surge of firearm violence, but then morphed into a focus on suicides as the numbers dictated. Drug overdoses have proceeded to affect communities greatly.

3. Drug poisonings are now the leading cause of injury death, and the issue cuts across different programs at both the state and national levels. Drug deaths are already well represented in the intentional and undetermined categories of the current NVDRS. Conceptually, therefore, it is not a big leap for NVDRS practitioners and would represent about a 60% expansion of NVDRS case coverage. However, NVDRS funds cannot be used for this project

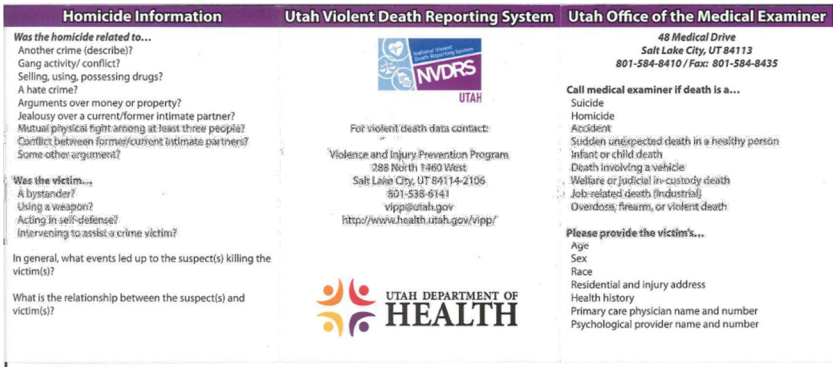
o. Other Information

i. Homicides may go unsolved, so we may not get all the information about the case

ii. Undetermined cases may have less data available to collect

iii. Death Investigation Cards: Stresses the importance of collecting a wide range of data

Front:



Homicide Information

Was the homicide related to...
Another crime (describe)?
Gang activity/ conflict?
Selling, using, possessing drugs?
A hate crime?
Arguments over money or property?
Jealousy over a current/former intimate partner?
Mutual physical fight among at least three people?
Conflict between former/current intimate partners?
Some other argument?

Was the victim...
A bystander?
Using a weapon?
Acting in self-defense?
Intervening to assist a crime victim?

In general, what events led up to the suspect(s) killing the victim(s)?

What is the relationship between the suspect(s) and victim(s)?

Utah Violent Death Reporting System

NVDRS
UTAH

For violent death data contact:

Violence and Injury Prevention Program
288 North 1460 West
Salt Lake City, UT 84114-2106
801-538-6141
vipp@utah.gov
http://www.health.utah.gov/vipp/

UTAH DEPARTMENT OF HEALTH

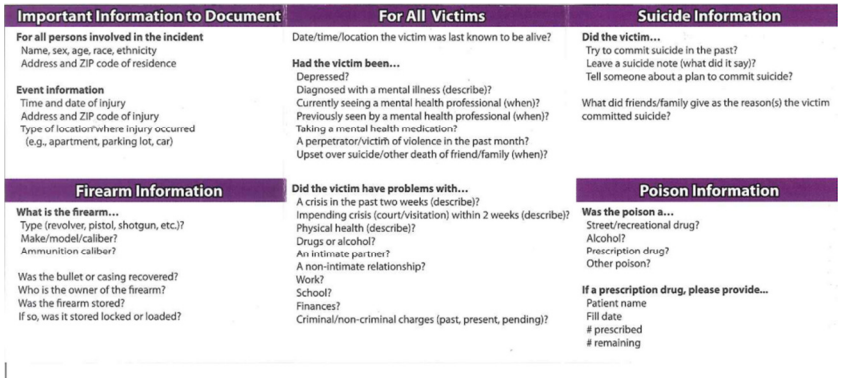
Utah Office of the Medical Examiner

48 Medical Drive
Salt Lake City, UT 84113
801-584-8410 / Fax: 801-584-8435

Call medical examiner if death is a...
Suicide
Homicide
Accident
Sudden unexpected death in a healthy person
Infant or child death
Death involving a vehicle
Welfare or judicial in-custody death
Job-related death (industrial)
Overdose, firearm, or violent death

Please provide the victim's...
Age
Sex
Race
Residential and injury address
Health history
Primary care physician name and number
Psychological provider name and number

Back:



Important Information to Document

For all persons involved in the incident
Name, sex, age, race, ethnicity
Address and ZIP code of residence

Event information
Time and date of injury
Address and ZIP code of injury
Type of location where injury occurred (e.g., apartment, parking lot, car)

For All Victims

Date/time/location the victim was last known to be alive?

Had the victim been...
Depressed?
Diagnosed with a mental illness (describe)?
Currently seeing a mental health professional (when)?
Previously seen by a mental health professional (when)?
Taking a mental health medication?
A perpetrator/victim of violence in the past month?
Upset over suicide/other death of friend/family (when)?

Suicide Information

Did the victim...
Try to commit suicide in the past?
Leave a suicide note (what did it say)?
Tell someone about a plan to commit suicide?

What did friends/family give as the reason(s) the victim committed suicide?

Firearm Information

What is the firearm...
Type (revolver, pistol, shotgun, etc.)?
Make/model/caliber?
Ammunition caliber?

Was the bullet or casing recovered?
Who is the owner of the firearm?
Was the firearm stored?
If so, was it stored locked or loaded?

Did the victim have problems with...
A crisis in the past two weeks (describe)?
Impending crisis (court/visitation) within 2 weeks (describe)?
Physical health (describe)?
Drugs or alcohol?
An intimate partner?
A non-intimate relationship?
Work?
School?
Finances?
Criminal/non-criminal charges (past, present, pending)?

Poison Information

Was the poison a...
Street/recreational drug?
Alcohol?
Prescription drug?
Other poison?

If a prescription drug, please provide...
Patient name
Fill date
prescribed
remaining

6. <u>NVDRS State Success Stories</u>

a. Data Uses

i. Inform Communities: Documents circumstances of all violent deaths, including events preceding and surrounding the incident (who, what, when, where, & insight into why)

ii. Characterizes perpetrators as well as victims

iii. Characterizes incidents involving more than one victim

b. Alaska
   i. Helped improve forensic toxicological capabilities
   ii. Strengthen public health and law enforcement communications and infrastructure
   iii. Only fully adjudicated records are entered into the database thereby ensuring no legal cases pending before the courts are compromised

c. Colorado
   i. Report: Adolescent Suicide in Colorado, 2008-2012
      1. The Health Statistics Branch at CDPHE has released the Health Watch - Adolescent Suicide in Colorado, 2008-2012 report on youth suicide data. This report describes the issue of adolescent suicide in Colorado by using the NVDRS surveillance data. The purpose of this report is to increase suicide awareness, as well as present unique aspects and factors of adolescent suicide. These data can be used at the state and local levels in Colorado to help inform intervention and prevention efforts that will reduce adolescent suicide.
   ii. Man Therapy Campaign (www.mantherapy.org): Gentlemental Health 101
      1. Middle aged males and females have the highest numbers of suicide across age groups, specifically the 45-54 year old age range (Figure 6). Men account for the greatest number of suicides, with 810 of the 1,053 deaths in 2012 alone. Male suicide numbers from 2008-2012 outnumber female suicides more than 3 to 1. These high numbers of suicide among working-aged males was the impetus for creating Man Therapy.

d. Georgia
   i. Georgia Department of Public Health obtained critical information on violent deaths from Georgia-VDRS (GA-VDRS).
      1. For example, more than half of all violent deaths from 2006 to 2009 were due to suicide (51%) followed by homicide (36%).
   ii. Males were 3X more likely than females to die from a violence-related injury
   iii. Rural areas had the highest age-adjusted suicide rate while metropolitan areas had the highest age-adjusted homicide rate. GA-VDRS able to show burden by county, highlight

need for special efforts in geographical areas

e. Kentucky
   i. Indicated that among women who were killed by an intimate partner, only 39% had filed for a restraining order or had previously been in contact with APS, which lead to improved outreach potential to link victims to protective services
   ii. KY-VDRS also created a web-based coroner reporting system to facilitate the collection of violent death data and to ease the burden of reporting for Kentucky Coroners
   iii. Data used in NIH grant, "Suicide Bereavement in Military and their Families."

f. Oregon
   i. In 2012, suicide among older adults was identified as a significant public health problem in Oregon, and the state began utilizing Oregon- VDRS (OR-VDRS) data to create a profile of elderly suicide victims.
   ii. Using data from OR-VDRS, public health officials discovered that almost 50% of men and 60% of women 65 years of age or older who died by suicide were reported to have a depressed mood before death. However, only a small proportion were receiving treatment for their depression when they died, suggesting screening and treatment for depression might have saved lives.
   iii. Information was incorporated in Oregon's Older Adult Suicide Prevention Plan to better integrate primary care and mental health services. The plan is currently implemented.
   i. State health officials to monitor suicides more accurately among specific populations including:

      1. older adults
      2. veterans
      3. foster children
      4. youths in custody

b. Utah
   i. The police records, requested through the Government Records Access Management Act (GRAMA) 63-G-2-206 UCA Sec 26-1-30, will be used for legitimate surveillance and for the prevention of childhood and violent deaths.
   ii. The data collected will be used in aggregate form and any requests for copies of reports will be redirected to the appropriate investigating agency.

iii. Upon request, reimbursement for records is available at $5.00 per record.
iv. Data enabled the state-wide task force to identify trends and risk factors for prescription drug-related suicides
    1. Prevention strategies put in place:
        a. Training on prescribing practices
        b. Improved access to a controlled substances database for medical providers
v. All persons working on UTVDRS & CFRC to sign statement of Confidentiality
vi. Request Victim and Suspect demographics and all associated reports for each "closed" incident to be provided to UTVDRS and CFRC

c. Wisconsin
    i. Report: The Burden of Suicide in Wisconsin
        1. Key findings from the report demonstrate risk factors at each level of the social-ecological model
    ii. What can Wisconsin do to Prevent Suicide?
        1. Target higher-risk populations with appropriate primary and secondary prevention strategies and programs
        2. Promote and use evidence-based interventions and programs that can improve mental health, behavioral health, and interpersonal relationships
        3. Reduce access to lethal means of suicide for populations with imminent risk.
        4. Learn about state-specific prevention activities through Prevent Suicide Wisconsin
d. CDC Use of NVDRS Data at a National level: Aggregate Data Reports
    i. National Data from 16 NVDRS states (Not Nationally Representative)
    ii. 2003-2011 data Available online: http://www.cdc.gov/injury/wisqars/nvdrs.html

5. County Funding Discussion
    a. ISDH originally proposed two funding options:
        i. For Coroners & Law Enforcement: $10 per report submitted to ISDH (January 1, 2015 to December 31, 2015)
        ii. ISDH Records Consultant comes to your office to abstract the data needed for INVDRS
    b. We want to make sure that this project is collaborative and beneficial to all of those involved. What other ideas does the group have regarding local funding ideas?

i. For Indiana, we have between 1,200 and 1,500 violent deaths each year, so the CDC recommends we should be giving data partners $31,000 of grant.

6. Advisory Board Members
   a. Role of an Advisory Board member
      i. Serve on the INVDRS AB
      ii. Provide access to data (if applicable)
      iii. Help develop solutions to any identified barriers
      iv. Utilize the VDRS data: Informative tool
      v. Connect the ISDH to ***your*** partners
      vi. Be Spokesperson for NVDRS/INVDRS
   b. Who is missing?
   c. Point of contact for each organization – Contracts for funding
7. Additional discussion
   a. 2015 Meeting Dates, 1-3 EDT, ISDH, Rice Auditorium
      i. March 24th
      ii. June 23rd
      iii. September 29th
      iv. December 15th
   b. Key Activities for 2015
      i. Continue to establish collaboration for INVDRS project
      ii. Obtain Vital Statistics & Coroner data electronically & monitor data import timelines
      iii. Begin manual abstraction of Coroner & Law Enforcement data by end of 1st quarter

IV. Next Advisory Board Meeting: March 24th, 2015

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