

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



**Time:** Tuesday, March 24, 2015 1:00-3:00 EDT

**Location:** Rice Auditorium (Basement), 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

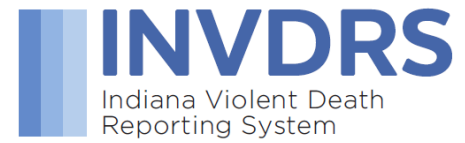
### 1. Welcome & Introductions - Attendees (31):

- 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.

Bennett, Sharon	Burton, Caryn	Conroy, Karen	Craycraft, Annette
Dillon, Bekah	Doolittle, Genesa	Hackworth, Jodi	Harrold, Wendy
Hokanson, Katie	Jenkins, Peter	Kenny, Rachel	Lawry, Murray
Luce, Stephen	Martin, Gretchen	Miles, Amy	Moore, Kelly (for Jane Bisbee)
O'Malley, Susan	Paxton, Michael (for Mike White)	Reichard, Ruth	Reynolds, Anne
Saywell, Robert	Sefton, Scott	Sell, Brian	Skiba, Jessica
Spotts, Travis	St. John, Wendy	Steele, Greg	Stuttle, Rebecca
Van Til, Patricia	Williams, Teresa	Zollinger, Terrell	

- b. New INVDRS Staff were introduced
  - i. Rachel Kenny-INVDRS Epidemiologist
  - ii. Murray Lawry- INVDRS Coroner Records Coordinator
- c. Meeting content was emailed out but the file size was too large. All meeting content can be found on the website: <http://www.in.gov/isdh/26539.htm> .
- d. The Domestic Violence and Firearm Conference is coming up-Ruth Reichard will update the Board at the June 23<sup>rd</sup> meeting.
- e. 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

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



needs to address before the next Board meeting.

## ii. Questions

1. ISDH will follow up on questions asked at the June 23rd meeting.

iii. Please complete the worksheet and send to [khokanson@isdh.in.gov](mailto:khokanson@isdh.in.gov).

## 2. Follow-Up from questions at previous AB Meeting

### a. Date Confidentiality

i. If someone requests a victim's public record (from the INVDRS), does the ISDH have to release the records from coroners and law enforcement and the data collected from those records, or is it protected?

1. Answer from ISDH Office of Legal Affairs using Indiana Legislative Code

a. IC 5-14-3-4(a) exempts confidential records from disclosure

b. IC 5-14-3-6.5 requires a public agency that receives confidential record from another agency to maintain confidentiality.

2. If the coroner's office or law enforcement agency considers a record confidential, then ISDH must also treat it as such

3. Indiana Code Website: <https://iga.in.gov/legislative/laws/2014/ic/>

### b. Data Element 5.6.9-Jealousy "Lovers' Triangle"

i. Concern over use of out dated term: "Lovers' triangle"

1. CDC understands that this term is outdated and could be perceived to have connotations that the victim was involved in or somehow culpable for the circumstances that led to their death.

2. Variable has been around since the data system was created in the early 2000's

3. CDC has a revision process and this term will be up for discussion during the next revision cycle

ii. Cases using this variable must also be coded as intimate partner violence-related as well.

This is to recognize that jealousy that results in homicide is most definitely a form of intimate partner violence and that this circumstance in no way justifies homicide of an intimate partner or other person who might be involved.

### c. Circumstance: Death during commission of a crime?

i. Is there a data element that captures if the people are killed during the commission of a

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



crime?

1. Answer: Yes, Section 5.5 Crime and Criminal Activity
2. Specifically 5.5.5-First Crime in Progress – the precipitating crime was in progress at the time of the incident
  - a. Serious or felony-related crimes

d. Intimate Partner Violence (IPV) data elements?

- i. Homicide-Suicide happens frequently in Intimate Partner Violence cases. Is there a way to capture this in the Registry?
  1. Identify Incident Type 1.4
    - a. Overall description of whether the incident involved a single or multiple victims and the manner of all the victims deaths
    - b. Response Option: Homicide(s) followed by suicide
  2. IPV data elements
    - a. 5.4 for victim-related
    - b. 7.3-8 for suspect related- 7.7 Suspect attempted suicide after incident (indicate fatal or non-fatal)
  3. Case linking by the INVDRS epidemiologist
    - a. Following 24-hour rule for timing of the injuries (not death) AND strong correlating source data
    - b. Using potential suspects and narratives explaining the linkage
- ii. Is there a data element that indicates whether there was an order for protection/protection or restraining order in effect at the time of the incident?
  1. Restraining Order Variables-Section 10.7
    - a. Restraining order ever-Yes/No
    - b. Restraining Order at time of incident
    - c. Restraining order Type-Emergency/Temporary/Permanent
    - d. Restraining order Persons protected-IPV Victim/IPV Perpetrator/Both
- iii. Is there a data element that indicates that the victim had contact (any contact) with the court system within the 2 weeks leading up to the incident?
  1. Answer: Not Quiet

2. Closest thing-5.7.8-Civil Legal Problems
    - a. At the time of the incident the victim was facing civil legal problems, such as divorce, custody dispute or civil lawsuit, or legal problems that were unspecified as either criminal or civil, and these problems appeared to have contributed to the death.
  3. Action: INVDRS staff will suggest “Contact with the court system” to CDC’s NVDRS team
- iv. Is there a data element for cyber bullying?
1. Answer: Not at this time. Option to utilize the narrative, natural language processing
  2. Action: Suggest to CDC’s NVDRS team, include specific definitions for cyber bullying (revenge porn vs. other bullying on social media)
- v. Is there a data element for sex trafficking?
1. Answer: Not quite, closest thing 5.5.8 Prostitution
    - a. Includes: prostitutes, pimps, clients, other person involved in such activity (prostitution ring, sex trafficking)
    - b. Crisis Element
  2. Action: Suggest to CDC’s NVDRS team
- e. Funeral Director Involvement
- i. Could we increase funeral director involvement in data collection?
    1. Create a form that families could fill out while at the funeral home?
    2. Create a web-based system that funeral directors could fill out information?
    3. Create a brochure/packet of resources for families that they receive at the funeral home that has a voluntary survey that families can mail in or submit via a website?
  - ii. Thoughts from group?
    1. Concern was voiced on the validity and reliability of the family self-reporting data.
    2. The funeral director would be potentially duplicating information that is already found on the CME report.

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



- f. Utilizing EMS/Fire Department run sheets for data collection?
  - i. Murray presented data elements that could potentially be used in the INVDRS.
  - ii. Gold Elements are not required and might not be reported
  - iii. NEMSIS V3 will change elements collected. The system will switch to NEMSIS V3  
1/1/2016

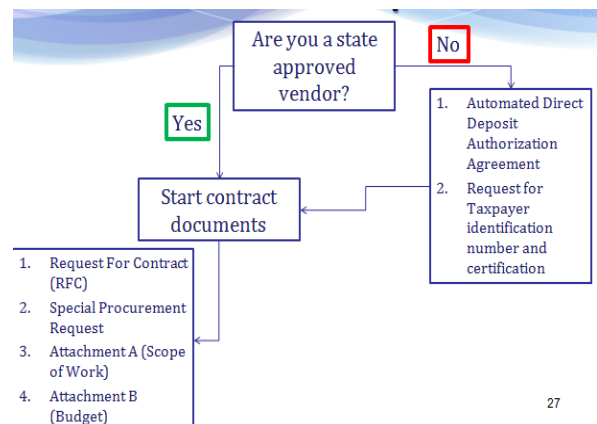
### 3. Progress on data reporting 2015

#### a. Death Certificate Data Update

- i. Working with Vital Records to successfully upload test file to the web-based NVDRS system. The CDC has been helping us modify our test file
- ii. Once test file is successful, will start submitting completed death certificate data on a monthly basis.
  - 1. Example: January deaths by end of February/beginning of March
- iii. Through an electronic text file we can upload 100 records at a time
- iv. “Initiates” case in the NVDRS
- v. Does NOT contain Patient Identifiable Information (PII)

#### b. Coroner Data Update-Contracts

- i. Must be a state approved vendor, if not, must go through the process to become one
  - 1. Automated Direct Deposit Authorization Agreement
  - 2. Request for Taxpayer identification number and certification
- ii. Once a State-Approved Vendor –Start contract documents
  - 1. Request for Contract
  - 2. Special Procurement Request
  - 3. Scope of Work (Attachment A)
  - 4. Budget (Attachment B)
- iii. Murray, Coroner Records Coordinator is the go-to-guy on this!
  - 1. [mlawry@isdh.in.gov](mailto:mlawry@isdh.in.gov)



#### c. Drug Overdose & Poisoning data collection

- i. Information on Drug Overdoses, supplied by the CDC

# Indiana State Department of Health

## Indiana Violent Death Reporting System

### Advisory Board



1. Nationally, Drug Overdoses have surpassed motor vehicle crashes as the leading cause of injury death. There has been a dramatic increase in overdose deaths related to opioid pain relievers.
  - a. Indiana has one of the higher rates of opioid prescriptions per 100 persons.
2. Who is at Risk?
  - a. Risk factors
    - i. Patients receiving opioids from multiple prescribers and/or pharmacies
    - ii. Patients taking high daily doses of opioids
  - b. Demographics
    - i. Men; 35-54 years old
    - ii. Whites; American Indians/Alaskan Natives
  - c. Socioeconomics and Geography
    - i. Medicaid and Rural
3. CDC Goal-Reduce abuse and overdose of opioids and other controlled prescription drugs while ensuring patients with pain are safely and effectively treated.
4. Three Pillars of Prescription Drug Overdose (PDO) Prevention Work
  - a. Improve data quality and track trends
  - b. Strengthen state efforts by scaling up effective public health interventions
  - c. Supply healthcare providers with resources to improve patient safety
- ii. Currently CDC Funds “Boost” for State Prevention: 5 states FY 2014
  1. Advance and evaluate comprehensive state-level interventions for preventing prescription drug overdose in 3 years
  2. Enhancing and maximizing Prescription Drug Monitoring Programs (PDMPs)
    - a. Intervention-outlier analysis, clinician review of PDMP before prescribing
    - b. Surveillance-track changes in prescriptions to assess progress and new trends, link with morbidity and mortality data to enhance targeting
  3. Improving and evaluating public insurer mechanisms
    - a. Reimbursement incentives/disincentives; quantity limits; claim analysis

and review programs

4. Evaluating state-level laws, policies, and regulations
  - a. Pain Clinic laws, PDMP laws, Naloxone laws
5. Scope of Program
  - a. Target High burden States
- iii. Collection of Unintentional Drug Poisoning Death Data with the NVDRS Web System
  1. Definition of Drug Poisoning: A drug is any chemical compound that is chiefly used by or administered to humans or animals as an aid in the diagnosis, treatment, or prevention of disease or injury, for the relief of pain or suffering, to control or improve any physiologic or pathologic condition, or for the feeling it causes.
  2. CDC Presented this module at the December 2014 Reverse Site Visit
  3. Link Death Certificate with coroner and medical examiner information to link toxicology with descriptive information, collect key circumstance information, and more rapid identification
  4. Project Plan
    - a. Pre-Pilot-modify NVDRS so it is able to collect existing variables, collect general feedback from states, secure approvals from OMB and IRB
    - b. Pilot- Fund <5 states, NO funding currently available
    - c. Assess feasibility and utility of scaling up
  5. This is a new and optional module in NVDRS that will be available at the end of March 2015
  6. All drug-related deaths: prescription and non-prescription
    - a. Unintentional Drug Poisoning Category Tab
      - i. This tab is to keep separate violent/suicidal drug overdoses and unintentional overdoses, yet still maintain them in the same system
      - ii. Add Unintentional Poisoning to Incident Type and Manner of Death per Abstractor
  7. Questions coded: History of Overdose, In substance abuse treatment, scene indication of drug abuse, history of opioid or heroin abuse, Use of prescription

morphine, etc

8. Limited Technical Assistance from CDC Prescription Drug Overdose Team

iv. Meeting Discussion

1. Question: How often is the intentionality of a death undetermined?
  - a. Scott Sefton from Lake County Deputy Coroner says they have a suicide form of 16 questions that is asked to the family and helps determine intentionality of death. A lot of times a drug overdose is deemed “Undetermined”
2. Question: How can we help reduce the number of times the coroner has to mark a death as “undetermined”?
  - a. A high toxicology screen indicated an intentional drug overdose. We need to note the rates over time to see if we are truly improving the rates or is there a process shift that allows us to better determine intentionality

v. Current Project Status

1. Funding Not currently available
  - a. Widespread and consistent data collection requires funding
  - b. No guarantees funding for pilot will become available
2. No requirement for states to collect data
3. States are free to use pre-pilot items
4. Cannot use current NVDRS funding for data collection or data entry

vi. New Funding Opportunity: Prescription Drug Overdose Prevention for States

1. Competition Limited to State Health Department-must for 51% of the work
  - a. State Health Departments have unique epidemiologic and surveillance capacity to identify crucial trends and patterns driving the epidemic
2. Required Strategies
  - a. Enhance and maximize a state PDMP- Indiana has INSPECT
  - b. Implement community or insurer/health system interventions aimed at preventing prescription drug overdose and abuse
3. Optional Strategies
  - a. Conduct policy evaluations



# Indiana State Department of Health

## Indiana Violent Death Reporting System

### Advisory Board



b. Develop and implement Rapid Response Projects

4. Funded states will track heroin morbidity and mortality as an outcome of their work and have opportunities to evaluate policies with implications for preventing both prescription drug and heroin overdoses

#### 4. Grant Deliverables

- a. Evaluation and Performance Measurement Plan-Due 3/31
- b. Continuation Applicant- Due 4/2
- c. The INVDRS staff is working hard on these documents and awaiting their approval by OGM. The content will be shared at the next Advisory Board Meeting

#### 5. Data & Reports

a. National

i. 2012 NVDRS Data Now Available

- 1. Web-based Injury Statistics Query and Reporting System (WISQARS) NVDRS module has 2012 violent death data from 16 states (not nationally representative)
  - a. <http://www.cdc.gov/injury/wisqars/nvdrs.html>
  - b. Indiana's data is not in this system (Indiana's data to be collected beginning in 2015)
- 2. WISQARS also updated with 2013 injury fatality data. WISQARS is an interactive, online database that provides fatal and nonfatal injury data from a variety of sources. Researchers, practitioners, the media, and the general public can use WISQARS data to learn more about the public health and economic burden of injury in the United States. Users can search, sort, and view the injury data and create reports, charts, maps, and slides.

ii. Virginia Violent Death Reporting System: *Women and Suicide in Virginia*

- 1. Released by the Office of the Chief Medical Examiner in the Virginia Department of Health at the request of their Advisory Board
- 2. Characteristics of women's suicide in Virginia from 2003-2012
- 3. Because most suicide decedents are men (77%), insights specific to women's suicide are often camouflaged by their male counterparts. Unique circumstances for women's suicide are discussed to suggest prevention or intervention strategies that might be

- distinctive in reducing suicide among women
4. Greatest at-risk suicide: white, middle-aged women; population with substance abuse and mental health problems who are likely to be receiving mental health treatment at the time of their suicide
  5. Women suicide decedents use poisons to end their lives in high proportions. Often with drugs that were prescribed to address their mental health and medical concerns
  6. Women often have non-fatal suicide attempts prior to completing a suicide, and frequently disclose their intent to end their lives to others
  7. Report available at:  
<http://www.vdh.virginia.gov/medExam/documents/pdf/Women%20and%20Suicide.pdf>
- iii. Quick Stats: Age-Adjusted Homicide Rates by Urbanization of County of Residence
1. From 2004 to 2013 in the United States, the age-adjusted homicide rate in large central metropolitan counties decreased 23% (from 9.1 to 7.0 deaths per 100,000 population), and the rate in large fringe metropolitan counties (suburbs of large cities) decreased by 10% (from 4.1 to 3.6).
  2. For four other county urbanization types (medium and small metropolitan and town/city [micropolitan] and rural nonmetropolitan), rates in 2004 and 2013 were similar.
  3. For both years, the homicide rates in large central metropolitan counties were higher than the rates for all other county types, and the rates for medium metropolitan counties were higher than the rates for large fringe and small metropolitan counties, and town/city (micropolitan) nonmetropolitan counties.
  4. Overall, in the United States, the 2004 age-adjusted homicide rate was 5.9 deaths per 100,000 populations, and the 2013 rate was 5.2.
  5. Report available at: <http://wonder.cdc.gov>.
- iv. Suicide Mortality Data Reliability- Editorial by Diego De Leo, Australian Institute for Suicide Research and Prevention
1. Profiling the size of the suicide phenomenon and the related costs is extremely important for addressing the needs of those bereaved and fighting the stigma attached

# Indiana State Department of Health

## Indiana Violent Death Reporting System

### Advisory Board



to suicidal behavior. Despite the clear need for reliable mortality data related to it, suicide possibly remains one of the most under-reported causes of death worldwide (it is rarely over-enumerated).

2. To be registered as caused by suicide, a death first needs to be reported. There may be circumstances that occasionally hinder this process, such as communication difficulties (the death cannot be timely referred to relevant authorities) or the remoteness of the location where the death occurred. However, there are also issues in recording suicide deaths that are common to most (if not all) countries. Some are represented by cases in which the intention to die is equivocal or in which there are reasons to disguise the suicide in the form of accident or other cause of death
3. Need to identify gaps, priorities and practical solutions within and across different domains; adoption of standardized definition; link death databanks with databanks related to other environments of public health interest. NVDRS provides a platform for this comparison.

#### b. Ohio: New VDRS Report

- i. There were 609 homicides among Ohio residents in 2012. Men were more likely than women to be victims of homicides
- ii. The overall homicide rate in 2012 was 5.5 per 100,000 persons. Homicide rates for black, non-Hispanic males were six times higher than homicide rates for black, non- Hispanic females and 13 times higher than rates for white, non- Hispanic males.
- iii. Thirty-one percent of homicides were associated with another crime: robbery and assault were the most common crimes reported.
- iv. Brawls, hate crimes and gang activity were rarely reported among homicides in 2012
- v. Report available at:

<http://www.healthy.ohio.gov/~media/HealthyOhio/ASSETS/Files/injury%20prevention/Homicides%20in%20Ohio.ashx>

#### c. Indiana:

- i. Trauma Registry Data and INVDRS
  1. Element Connections
    - a. Injury Intentionality = Assault, Self-inflicted, undermined or other

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



- b. ED Disposition = Died/Expired
- c. Hospital Disposition = Expired
- 2. Many hospitals report
  - a. 2013= 191 cases
  - b. 2014-160 cases (YTD)
    - i. Quarter 4 2014 data is due into trauma registry by May 1<sup>st</sup>
  - c. 2015-2 cases (YTD)
    - i. Quarter 1 2015 data is due into trauma registry by June 30<sup>th</sup>
- ii. Child Fatality Review Data (Handout)
  - 1. New handout to show the value in INVDRS and child fatality review program.
- iii. 2013 Violent Death Counts (Handout)
  - 1. 994 were suicides
  - 2. County data may be different from the state’s mortality data, because the state works diligently to get all residents death information

County of Residence:	Violent Death Counts:	Rank in State:
Marion County*	313	1
Lake County*	146	2
Allen County*	90	3
St. Joseph County*	50	4
Johnson County	41	5
Vigo County	40	6
Vanderburgh County*	39	7
Madison County*	35	8
<b>Indiana Total:</b>	<b>1,526</b>	

\* Indicates Pilot County for INVDRS in 2015



## 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

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



vi. Be Spokesperson for NVDRS/INVDRS

b. Point of contact for each organization

i. If interested in being the POC please contact Rachel ([rkenny@isdh.in.gov](mailto:rkenny@isdh.in.gov))

c. Call to Action

i. Send interested parties to ISDH Division of Trauma and Injury Prevention

1. [Indianatrauma@isdh.in.gov](mailto:Indianatrauma@isdh.in.gov)

2. INVDRS Epidemiologist

Rachel Kenny  
317-233-8197  
[rkenny@isdh.in.gov](mailto:rkenny@isdh.in.gov)

## 7. Additional discussion

a. 2015 Meeting Dates, 1-3 EDT, ISDH, Rice Auditorium

i. June 23<sup>rd</sup>

ii. December 15<sup>th</sup>

b. Key Activities for 2015

i. Continue to establish collaboration for INVDRS project

ii. Obtain Vital Records (death certificate) data electronically & monitor data import timelines

iii. Begin manual abstraction of Coroner and Law Enforcement data by end of 1<sup>st</sup> quarter

## IV. Next Advisory Board Meeting: June 23<sup>rd</sup>, 2015

### ISDH Division of Trauma and Injury Prevention Contact Information:

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