Indiana State Trauma Care Committee

April 15, 2016

Indiana State Department of Health

Email questions to: **indianatrauma@isdh.in.gov**

Prescription Drug Overdose Grant Funding

Katie Hokanson, *Director*

Trauma and Injury Prevention Division

Indiana State Department of Health

Email questions to: **indianatrauma@isdh.in.gov**

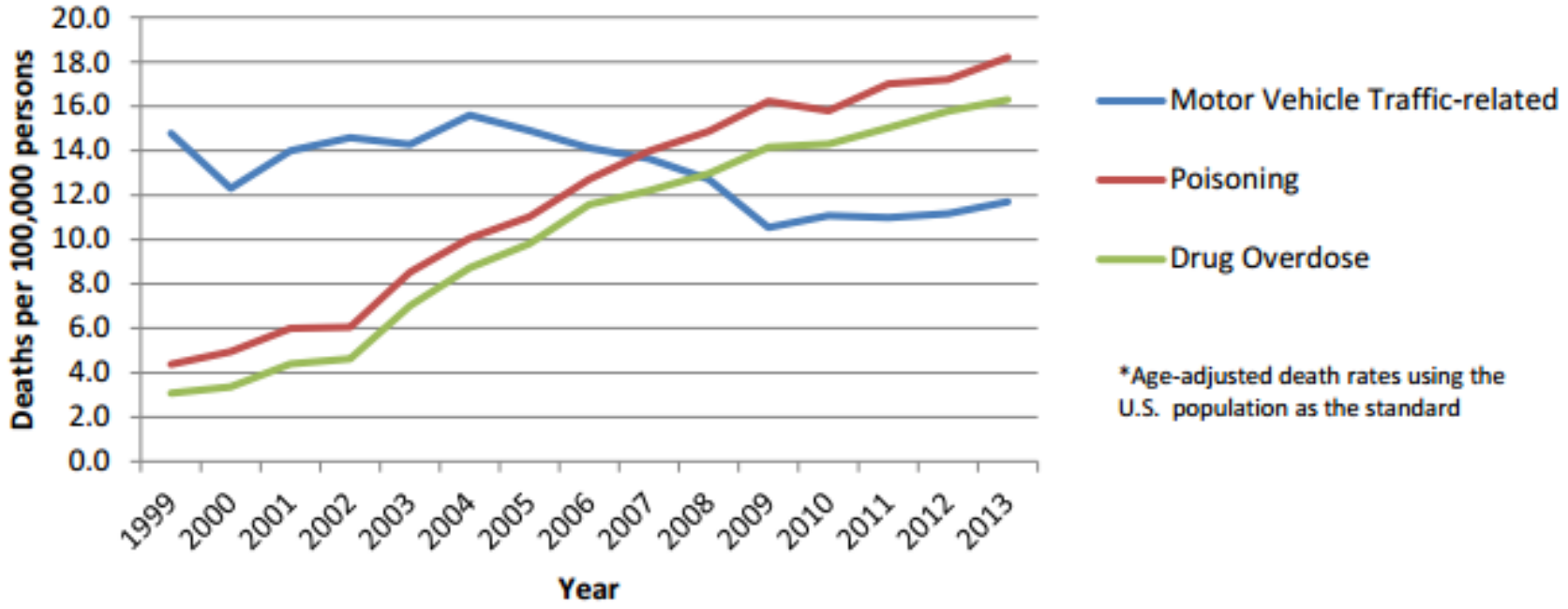
Cause of Injury Categories

- Cut/Pierce
- Drowning/Submersion*
- Fall
- Fire/Burn
  - Fire/Flame
  - Hot object/substance
- Firearm
- Machinery
- Motor Vehicle Traffic
- Pedal Cyclist, Other
- Pedestrian, Other
- Transport, Other
- Natural/Environmental
  - Bites and Stings
- Overexertion
- Poisoning*
- Struck By, against
- Suffocation*

* Not considered Traumatic Injury

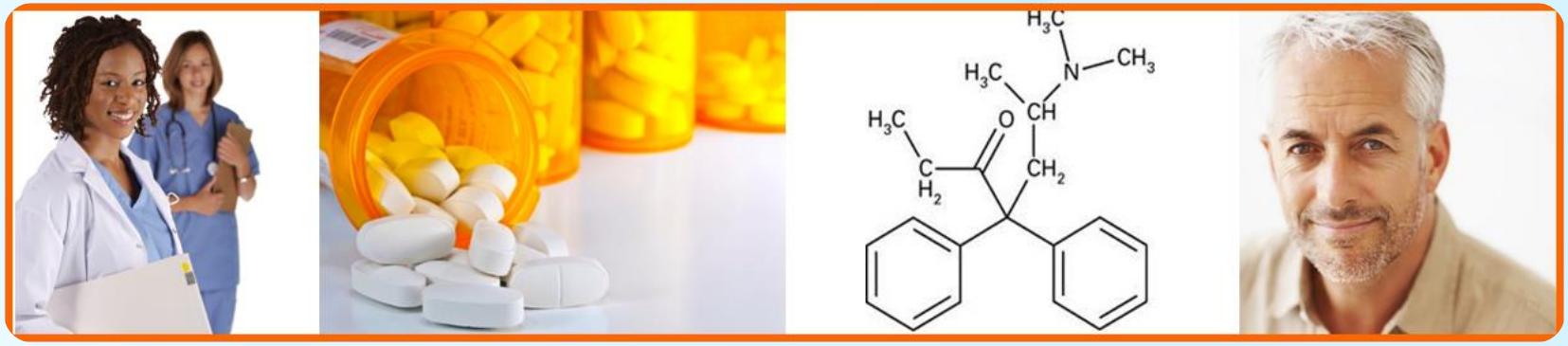
Drug Overdose Death Rates vs Motor Vehicle Traffic-Related Death Rates

Figure 1. Drug overdose death rates* compared to motor vehicle-related death rates, Indiana residents, 1999-2013



CDC Goal

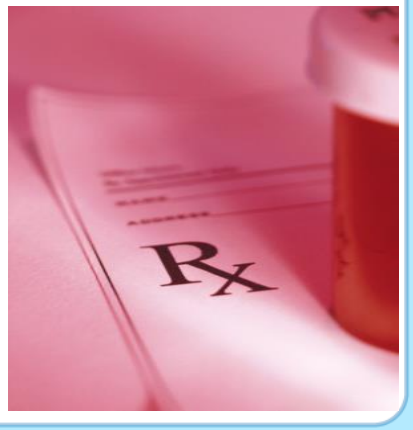
Reduce abuse and overdose of opioids and other controlled prescription drugs while ensuring patients with pain are safely and effectively treated.



Three Pillars of CDC's Prescription Drug Overdose (PDO) Prevention Work

- Improve data quality and track trends
- Strengthen state efforts by scaling up effective public health interventions
- Supply healthcare providers with resources to improve patient safety





CDC Funds "Boost" for State Prevention: 5 states in FY 2014

Advance and evaluate comprehensive state-level interventions for preventing prescription drug overdose in 3 areas:

- Enhancing and maximizing PDMPs
- Improving and evaluating public insurer mechanisms
- Evaluating state-level laws, policies, and regulations
- Scope of program
  - Target high burden states: KY, OK, TN, UT, and WV
  - Hope to expand program and substantial increase in President's and Senate's FY 2015 budget

Prescription Drug Overdose: Prevention for States

- CDC Grant Funding Opportunity
- Application submitted May 8th
- Awarded, but not Funded – Fall 2015
- Notice of Award ~March 15th, 2016
- 3 main grant activities
  - Overarching goal: targeting main driver of epidemic
    - problematic prescribing

Prescription Drug Overdose Prevention for States

Grant Activities:

1. Enhance and maximize prescription drug monitoring program (INSPECT)

2. Implement community interventions in high-need areas

3. Evaluate impact of policy changes in Indiana

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Enhance and Maximize Prescription Drug Monitoring Programs (PDMP)

- **PDMPs**
  - 49 out of 50 states
  - Funding and location vary across states
- **Intervention**
  - Outlier analysis (e.g., identify patients “doctor shopping” or identify inappropriate or illegal prescriber)
  - Clinician review of PDMP before writing a controlled substance prescription
- **Surveillance**
  - Track changes in prescriptions to assess progress and new trends
  - Link with morbidity and mortality data to enhance targeting
- **Guidelines and resources for effective PDMP**
  - Brandeis Center for Excellence: http://www.pdmpassist.org/content/guidelines

Enhance & maximize prescription drug monitoring program (INSPECT)

- PDMP integration with electronic health records.
  - Reduces data reporting interval to PDMPs.
  - Supports effective clinical decision-making.
  - Prevents drug diversion.

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Expansion of the Indiana Violent Death Reporting System (INVDRS)

- Collect Poisoning Overdose Module data in National Violent Death Reporting System

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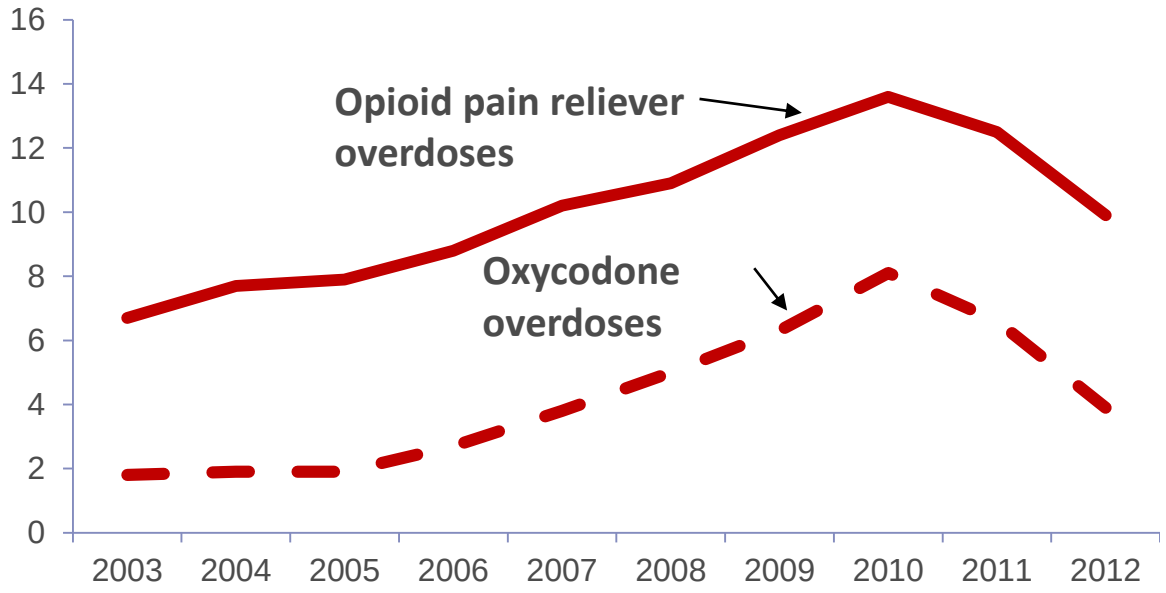
Optional Collection of Unintentional Drug Poisoning Death Data with the NVDRS Web System

Key CDC Surveillance Needs

- Use surveillance data to inform prevention response and identify promising practices in a timely manner

Florida opioid overdoses fell sharply between 2010 and 2012 after policy changes



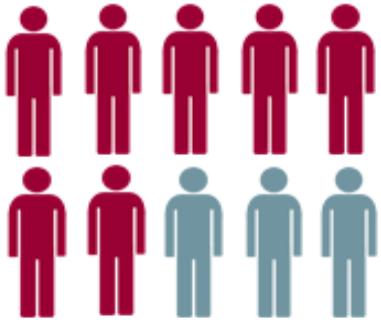
Johnson H; Paulozzi L; Porucznik C. Mack K. Herter B. Decline in Drug Overdose Deaths After State Policy Changes —Florida, 2010–2012. MMWR. 63(26). 569-74. July 2014.

Key Surveillance Needs

- Respond to emerging issues

The heroin increase is an offshoot of the opioid epidemic

3 out of 4 people who used heroin in the past year misused opioids first



7 out of 10 people who used heroin in the past year also misused opioids in the past year

Jones, C.M., Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers – United States, 2002–2004 and 2008–2010. Drug Alcohol Depend. (2013).

Key Challenges with Death Certificate Data

- Identify specific drug(s) causing the death
  - Information missing on ~25% of death certificates
  - Percent missing varies by state
- Improve counting of heroin-related deaths
  - Toxicology findings of morphine only
- Timely information
- Variance in assignment of manner of death across states
  - DUIP reports deaths across manners
- Key context information tied to interventions
  - History of overdoses
  - Scene indications of drug abuse
  - Route of exposure
  - Prescription information (Doctor shopping)

Proposed Solution

- Link death certificate (DC) with coroner and medical examiner (CME) information
  - Links toxicology with descriptive information
  - Collection of key circumstance information
  - More rapid identification (NCHS word search)
- NVDRS platform
  - Collects vast majority of needed information
  - Established infrastructure to collect vital statistics and CME
  - Collaboration with DVP to get “full picture”
  - Maximize limited resources to collect data on unintentional overdoses
- Respond to a need expressed by some NVDRS states
- Use separate tab to collect drug overdose specific information

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.***
  - Includes prescription drugs, over the counter drugs, and illicit drugs such as heroin and cocaine
  - Excludes alcohol, tobacco, and inhaled substances that have non-medical primary purpose such as glue.
- Focus on acute poisonings (e.g., overdoses)
  - Consistent with CDC Injury indicators and ISW7 report

ISW7 report, *Consensus recommendations for national and state poisoning surveillance:* **http://c.ymcdn.com/sites/www.cste.org/resource/resmgr/Injury/ISW7.pdf**

Identify Unintentional Drug Poisoning Deaths

- Add unintentional drug poisoning to *Incident Type* and *Manner of Death per Abstractor*

- Classify the poisoning
  - *Substance abuse related:* Taken to get high
  - *Adverse reaction:* Taken as prescribed
  - *Overmedication:* Patient taking more than prescribed for pain
  - *Unintentional ingestion:* Child or adult took unknowningly or incorrectly

- **Highest priority!**

Substance Abuse

Questions	Priority	Importance
History of overdose	**High**	**Target interventions when OD occurs**
In substance abuse treatment	**Moderate**	**Targeting to get into treatment vs. improved treatment support**
Scene indications of drug abuse	**Moderate**	**-Better identify heroin and prescription opioid overdoses -Informs response**
History of opioid or heroin abuse	**Moderate**	**-Understand risk factors -Better identify heroin and prescription opioid overdoses**
Description of treatment (e.g., MAT or specific drug)	*Later version*	*Needs to be assessed*

Prescription History / Medical

Questions	Priority	Importance
# of controlled substance prescriptions in the 30 days preceding injury	Moderate	Proxy for high dosage and inappropriate use
# of pharmacies dispensing controlled substance prescriptions to decedent in 30 days preceding injury	Moderate	Proxy for illegal behavior by decedent
# of doctors writing controlled substance prescription to the decedent in the 30 days preceding injury	Moderate	Proxy for illegal behavior by decedent
Use of prescription morphine	Moderate	Better identify heroin and prescription opioid overdoses
Treatment for acute or chronic pain	Moderate	Better understand risk factors and context

Prescription History / Medical: Later Version

Questions	Priority	Importance
Track morphine milligram equivalents of decedent	*Later version*	*-Resource intensive* *-Need a tool*
Track PDMP prescriptions including information such as specialty	*Later version*	*-Need to consider how best to integrate with toxicology* *-Need to access feasibility with PDMP data* *-Can indicate prescription causing death in current system*
Information on medical conditions of patient (e.g., cancer, HIV, headaches, etc.)	*Later version*	*-Concerned about feasibility across states* *-Code "Contributing physical health problem"*

Naloxone and Route of Drug Exposure

Questions	Priority	Importance
Naloxone/narcan administered and by whom	Moderate	Important information to inform naloxone administration policies
Bystanders present at overdose	Moderate	Inform “Good Samaritan” laws and response policies
Route of exposure	Moderate	-Priority for previous drug overdose surveillance -Inform interventions such as abuse deterrent formulations

Implement community interventions in high-need areas

- Coordinate intensive prevention efforts:
  - Focus on addressing problematic prescribing
    - Technical assistance
    - Coordinated efforts
  - Data reports to counties to inform local efforts
  - Naloxone education for first responders & lay providers
  - Increased awareness of opioid prescribing, dispensing and OD death at county level.

Evaluate impact of policy changes in Indiana

- Pain clinic ownership.
- Opioid Prescribing.
- First responder and lay provider use of naloxone.
  - IU Fairbanks School of Public Health.

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Questions?

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Regional Updates

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Regional updates

- District 1
- District 3

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Subcommittee Updates
Designation Subcommittee

Dr. Gerardo Gomez, *Trauma Medical Director*
Eskenazi Health

Indiana State Department of Health

Trauma Center Designation Subcommittee Meeting

April 15, 2016
Gerardo Gomez, MD, FACS
Committee Chair

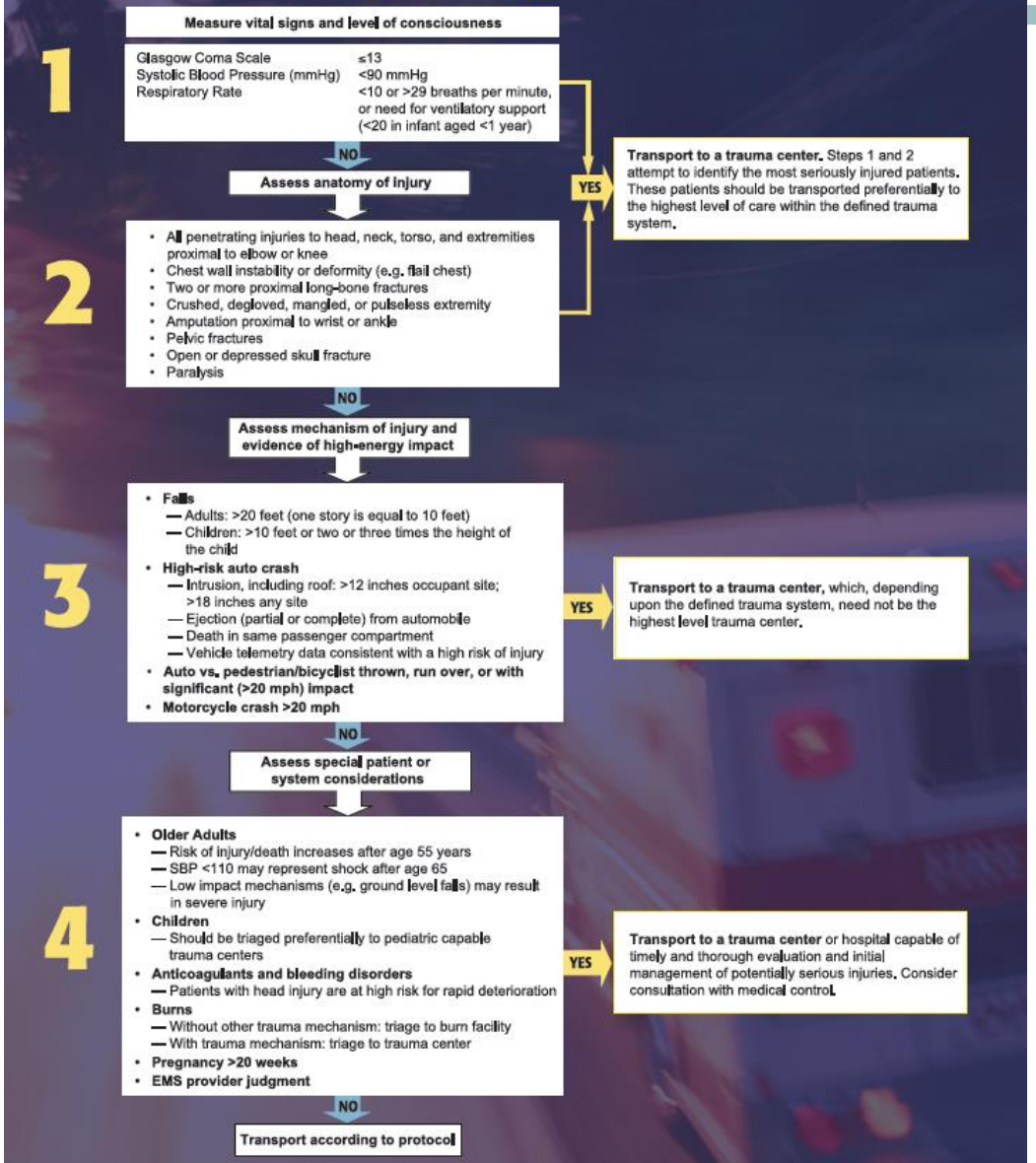
Dr. Lewis Jacobson, Dr. R. Lawrence Reed, Spencer Grover, Wendy St. John, Jennifer Mullen, Lisa Hollister, Amanda Elikofer, Katie Hokanson, Ramzi Nimry, Missy Hockaday, Teri Joy, Art Logsdon, Judy Holsinger, Jennifer Konger, Dr. Emily Fitz, Dr. Matthew Sutter, and Judi Holsinger

ISDH Trauma Designation Subcommittee Meeting Agenda from April 12, 2016

1. Pre-hospital Triage and Transportation Rule review

2. In-process trauma center updates

2011 Guidelines for Field Triage of Injured Patients



When in doubt, transport to a trauma center.

Find the plan to save lives, at www.cdc.gov/Fieldtriage

ational Center for Injury Prevention and Control
ivision of Injury Response

Trauma Center Definition Change

Trauma Center means a hospital that is verified by the ACS as meeting its requirements to be a trauma center, or is designated a trauma center under a state designation system that is substantially equivalent to the ACS verification process, or has been approved by the EMS Commission as an Indiana in process Trauma Center.

Summary of Suggested Changes (Sec. 4.b.)

- Patients determined to need trauma center care by virtue of their satisfying either step one or step two of the field triage decision scheme shall be transported to a **Level I or Level II** trauma center, unless transport time exceeds 45 minutes or, in the judgment of the emergency medical services certified responder, a patient's life will be endangered if care is delayed by going directly to a **Level I or Level II** trauma center, in which care the patient shall be transported to a **Level III trauma center**.

Summary of Suggested Changes Cont.

- If transport time to a Level III trauma center exceeds 45 minutes or, in the judgment of the emergency medical services certified responder a patient's life will be endangered if care is delayed by going directly to a Level III trauma center, the patient shall be transported to the nearest appropriate hospital as determined by the provider's protocols.

Summary of Suggested Changes Cont. (Sec. 4.c.)

- Patients determined to need trauma center care by virtue of their satisfying either step three of the field triage decision scheme shall be transported to a trauma center, unless transport time exceeds 45 minutes or, in the judgment of the emergency medical services certified responder, a patient's life will be endangered if care is delayed by going directly to a trauma center, in which case the patient shall be transported to the nearest appropriate hospital as determined by the provider's protocols.

Summary of Suggested Changes Cont. (Sec. 4.d.)

- Patients determined to need trauma center care by virtue of their satisfying step four of the field triage decision scheme shall be transported to a trauma center or the nearest appropriate hospital, as determined by the provider's protocols.

Trauma Centers

in Indiana

Level I

Indianapolis

Eskenazi Health

IU Health Methodist Hospital

Riley Hospital for Children at IU Health

St. Vincent Indianapolis Hospital

Level II

Evansville

Deaconess Hospital

St. Mary's Medical Center of Evansville

Ft. Wayne

Lutheran Hosptial of Indiana

Parkview Regional Medical Center

South Bend

Memorial Hospital of South Bend

Level III

Lafayette

IU Health - Arnett Hospital

Muncie

IU Health - Ball Memorial Hospital

Anderson

St. Vincent Regional Hospital

In the process of ACS Verification

Level II

Terre Haute

Terre Haute Regional

Level III

Anderson

Community Hospital - Anderson

Gary

Methodist Hospital - Northlake Campus

Lafayette

Franciscan St. Elizabeth - East

Vincennes

Good Samaritan Hospital

Richmond

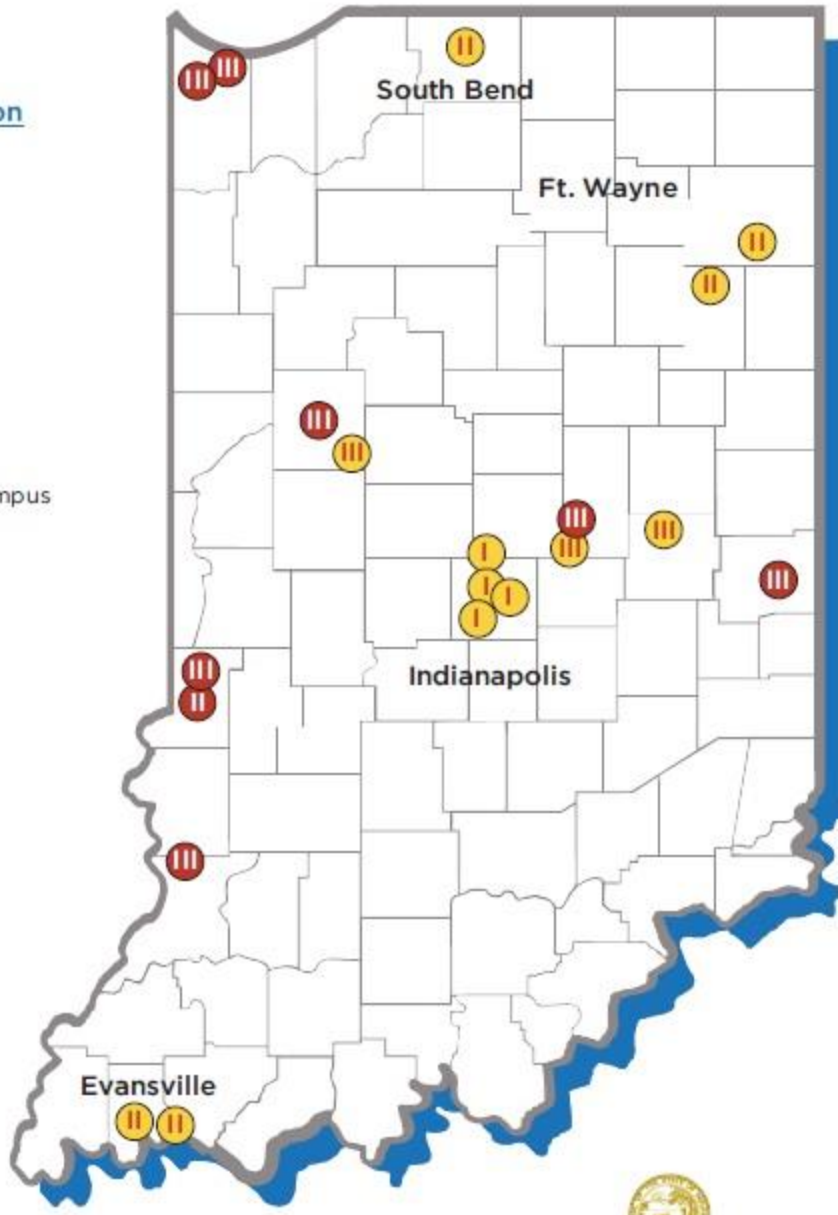
Reid Health

Crown Point

Franciscan St. Anthony Health

Terre Haute

Union Hospital - Terre Haute



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Trauma and Injury Prevention

Indiana Trauma Center Access: Areas Within a 45-Minute Drive

H 45-Minute Accessible Trauma Center *

45-Minute Accessible Areas

Average Travel Time
based on posted and historical speeds

	45-Minute Coverage (at average speed)		State Total
	n	% of state	n
Land Area	20,270 sq mi	57%	35,826 sq mi
Population	5,254,205 people	81%	6,483,802 people
Interstates	1,090 miles	88%	1,239 miles

* Considered a trauma center for purposes of the triage and transport rule.

Travel times are calculated with 2016 Indiana street network reference data published by Esri. Travel times do not take into account current traffic volume or restrictions. Population and land area are calculated from the 2010 U.S. Census block summary geography. Interstate mileage is calculated using a single direction of a divided highway (source: INDOT). All statistics should be considered an estimate.

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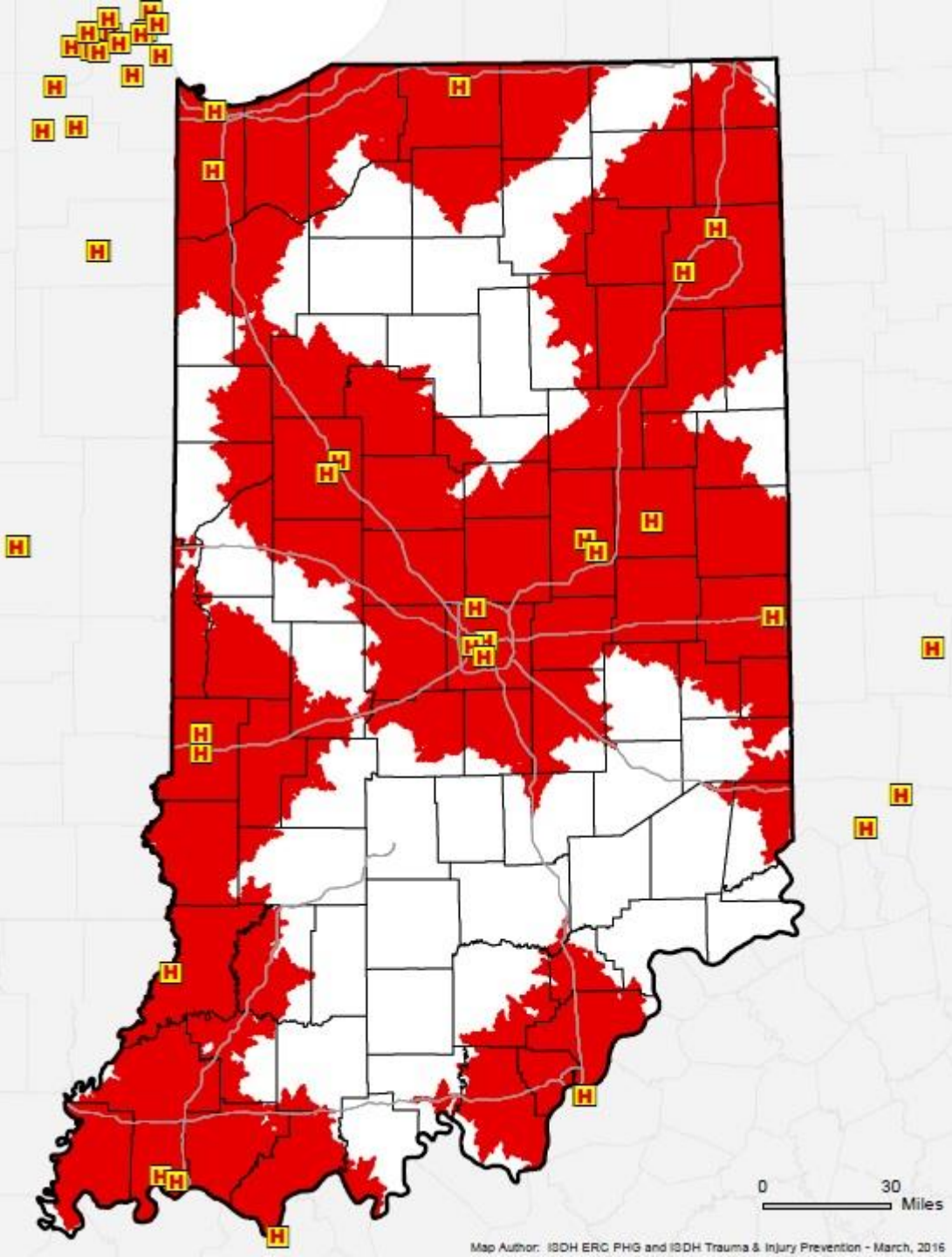
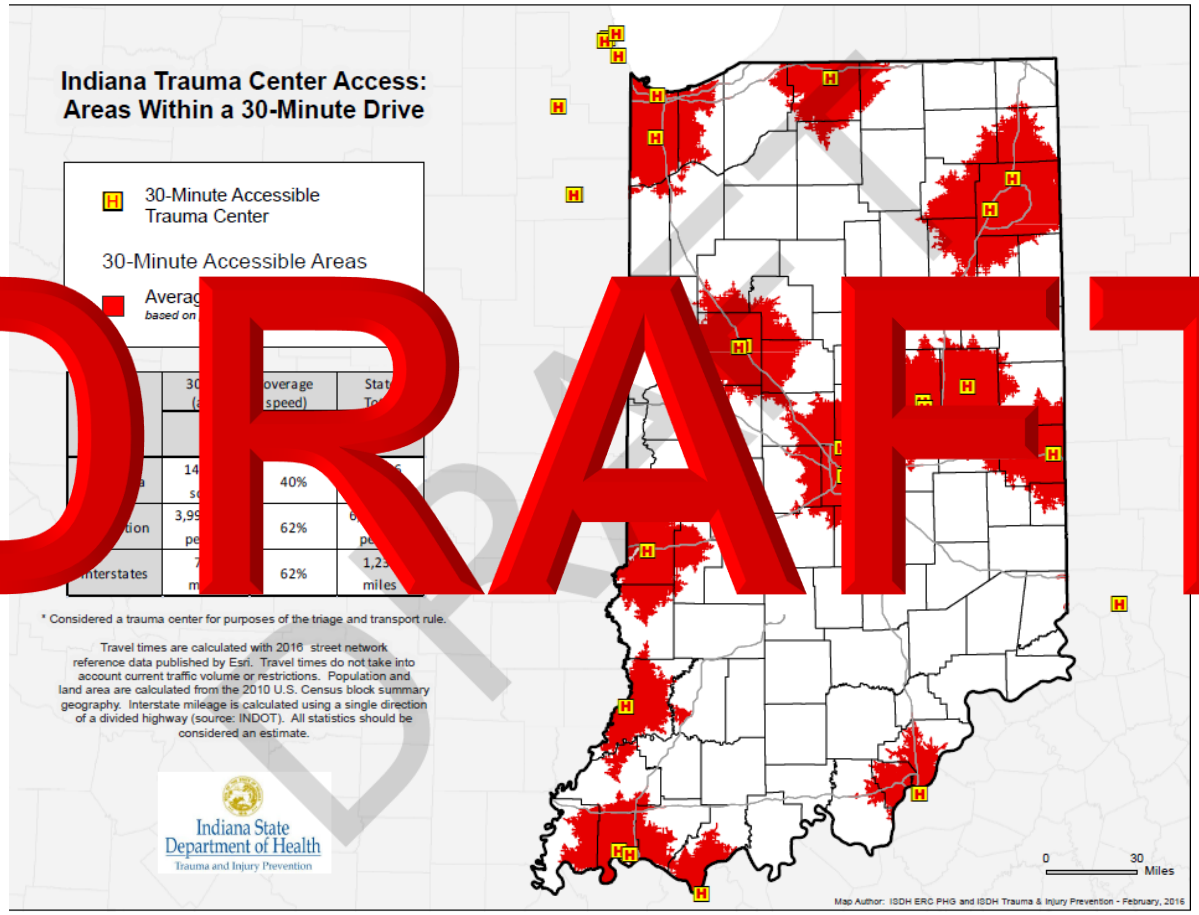
Trauma and Injury Prevention



Map Author: ISDH ERC PHG and ISDH Trauma & Injury Prevention - March, 2016

30-Minute Map



“In the Process” of ACS Verification Trauma Centers

Facility Name	City	Level	Adult / Pediatric	“In the Process” Date*	1 Year Review Date**	ACS Consultation Visit Date	ACS Verification Visit Date
Franciscan St. Elizabeth East	Lafayette	III	Adult	12/20/2013	02/20/2015	02/12-02/13, 2015	December 2015
St. Vincent Anderson	Anderson	III	Adult	12/20/2013	02/20/2015	11/12-11/13, 2014	11/18-11/19, 2015
Community Hospital Anderson	Anderson	III	Adult	06/20/2014	08/21/2015	May 2016	TBD
Good Samaritan	Vincennes	III	Adult	06/20/2014	08/21/2015	05/19-05/20, 2015	05/23-05/24, 2016
Methodist Northlake	Gary	III	Adult	08/20/2014	10/30/2015	10/7-10/8, 2015	February 2017
Franciscan Health St. Anthony Crown Point	Crown Point	III	Adult	12/18/2015	January/February 2017	TBD	TBD
Reid Health	Richmond	III	Adult	12/18/2015	January/February 2017	TBD	TBD
Terre Haute Regional	Terre Haute	II	Adult	12/18/2015	January/February 2017	TBD	TBD
Union Hospital	Terre Haute	III	Adult	02/26/2016	March/April 2017	TBD	TBD

*Date the EMS Commission granted the facility “In the process” status

**Date the Indiana State Trauma Care Committee (ISTCC) reviewed/reviews the 1 year review documents. This date is based on the first ISTCC meeting after the 1 year da

Facility is no longer “In the Process” and is an officially ACS Verified trauma center

ACS Verification Visit

- Documentation provided must include recognition by the hospital that if it does not pursue verification within one year of this application and/or does not achieve ACS verification within two years of the granting of “in the ACS verification process” status that the hospital’s “in the ACS verification process” status will immediately be revoked, become null and void and have no effect whatsoever.
- The hospital will need to become verified through the ACS COT verification process to become a trauma center.

ACS Type I and Type II Criteria Deficiencies (Ch. 22, pg. 159)

- One of the most significant evolutions has been the identification of the essential requirements for verification of Type I and Type II criteria (or deficiencies). Type I criteria must be in place at the time of the verification site visit to achieve verification. Type II criteria are also required but are less critical. If three or fewer Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of verification is issued. During the ensuing 12 months, if the trauma center successfully corrects the deficiencies, the period of verification will be extended to 3 years from the date of the initial verification visit or, for a reverification visit, from the expiration date of the original certificate.

ACS Type I and Type II Criteria Deficiencies (Ch. 22, pg. 159)

- If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital is not verified. A successful focused review is required to achieve verification. The focused review must occur 6–12 months from the date of the initial site visit.

ACS Type I and Type II Criteria Deficiencies (Ch. 22, pg. 159)

- During an on-site focused review, a two-surgeon team returns to the facility to determine if the deficiencies have been corrected. In general, efforts are made to ensure that one member of the original team is involved in the focused review process.

ACS Type I and Type II Criteria Deficiencies (Ch. 22, pg. 159)

- When correction of deficiencies can be demonstrated by submission of data to the ACS, the focused review can be completed without an on-site review. The trauma medical director and the hospital chief executive officer must attest to the accuracy and completeness of the submission. If the deficiencies are deemed to have been corrected as attested to in the submission, a certificate will be issued. If all deficiencies are not corrected at the time of the focused review, further extensions will not be considered. The verification visit will need to be repeated.

Subcommittee Updates

Performance Improvement Subcommittee – Follow-Up

Katie Hokanson, *Trauma and Injury Prevention Director*

Camry Hess, MPH, *Data Analyst*

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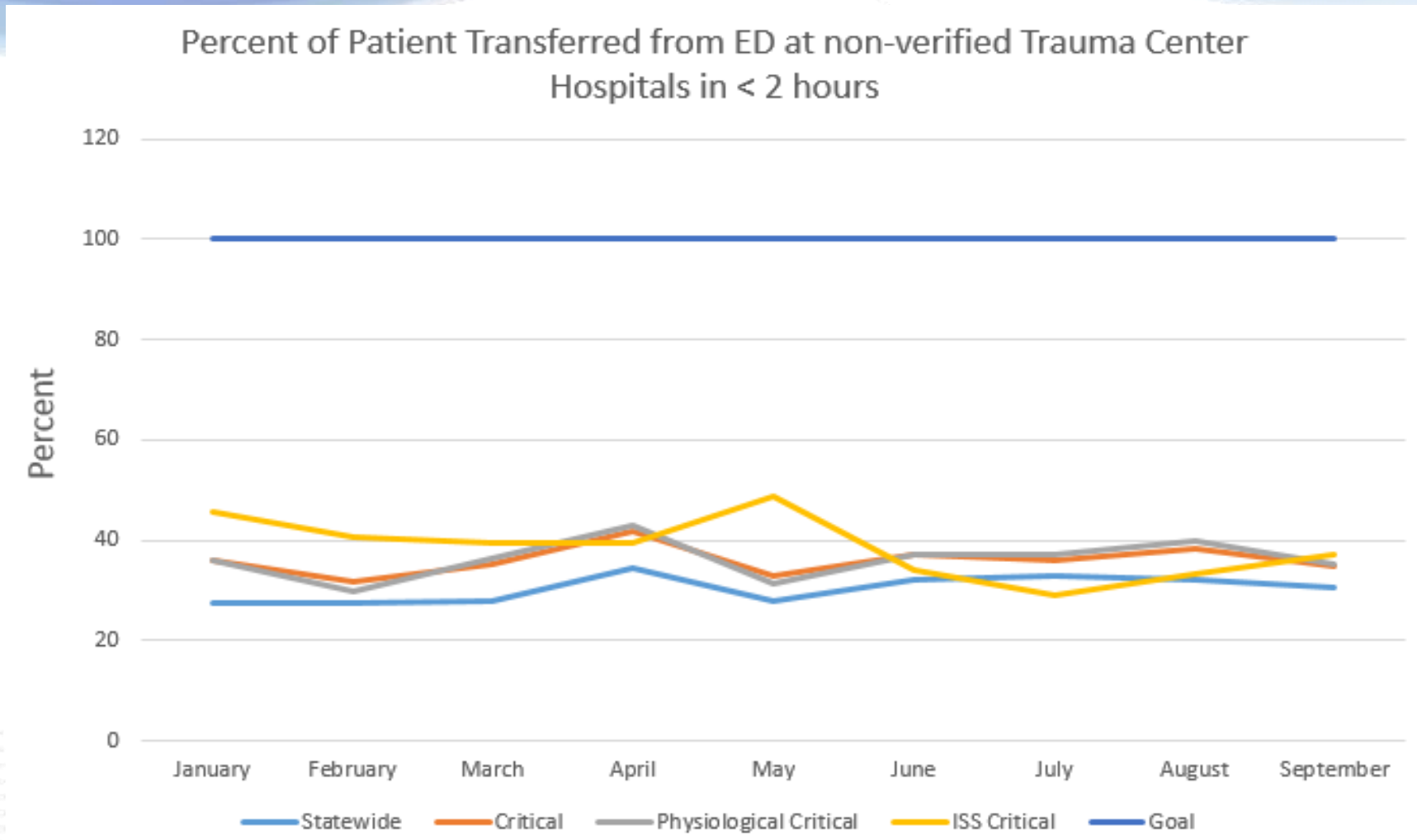
ED LOS by Severity



Under- and Overtriage

- The orange/starburst book *Resources for Optimal Care of the Injured Patient* uses multiple definitions for over- and undertriage (page 28)
- Trauma activations are not a required element

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Undertriage

- Numerator: patients at a non-trauma center with an ISS ≥ 16
- Denominator: patients at a non-trauma center
- 'An acceptable undertriage rate could be as high as 5 percent.' (page 28)

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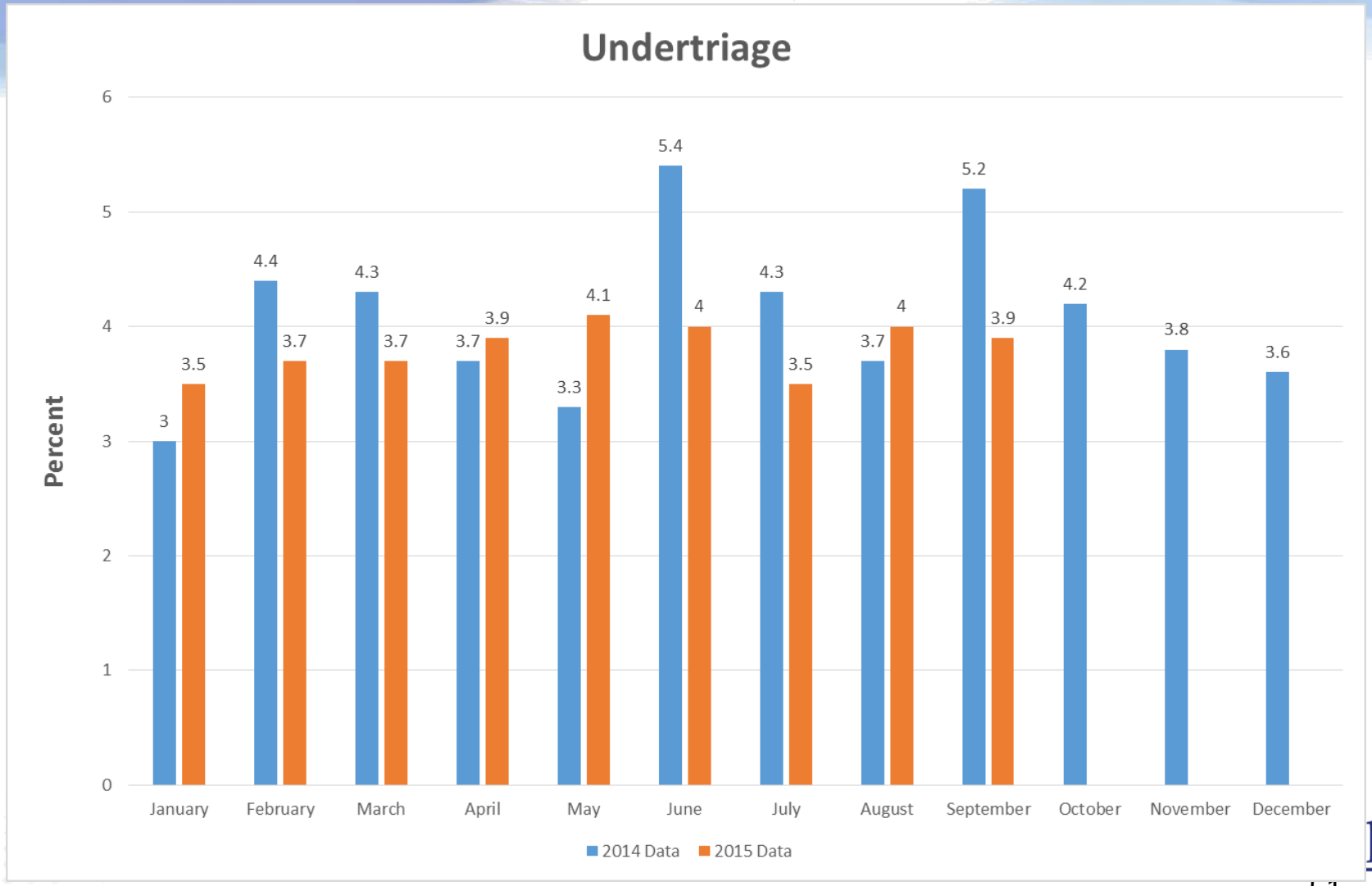
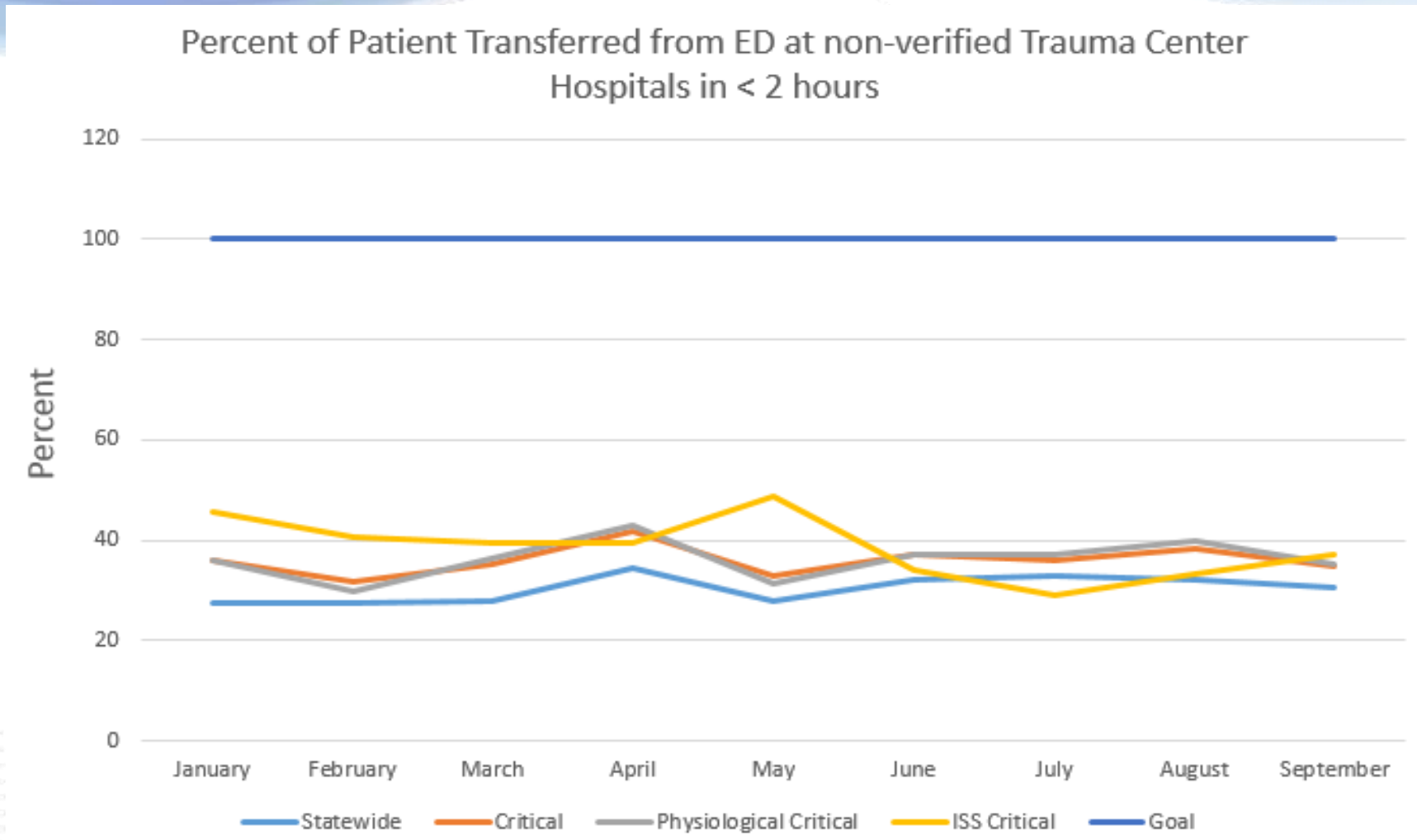
Undertriage



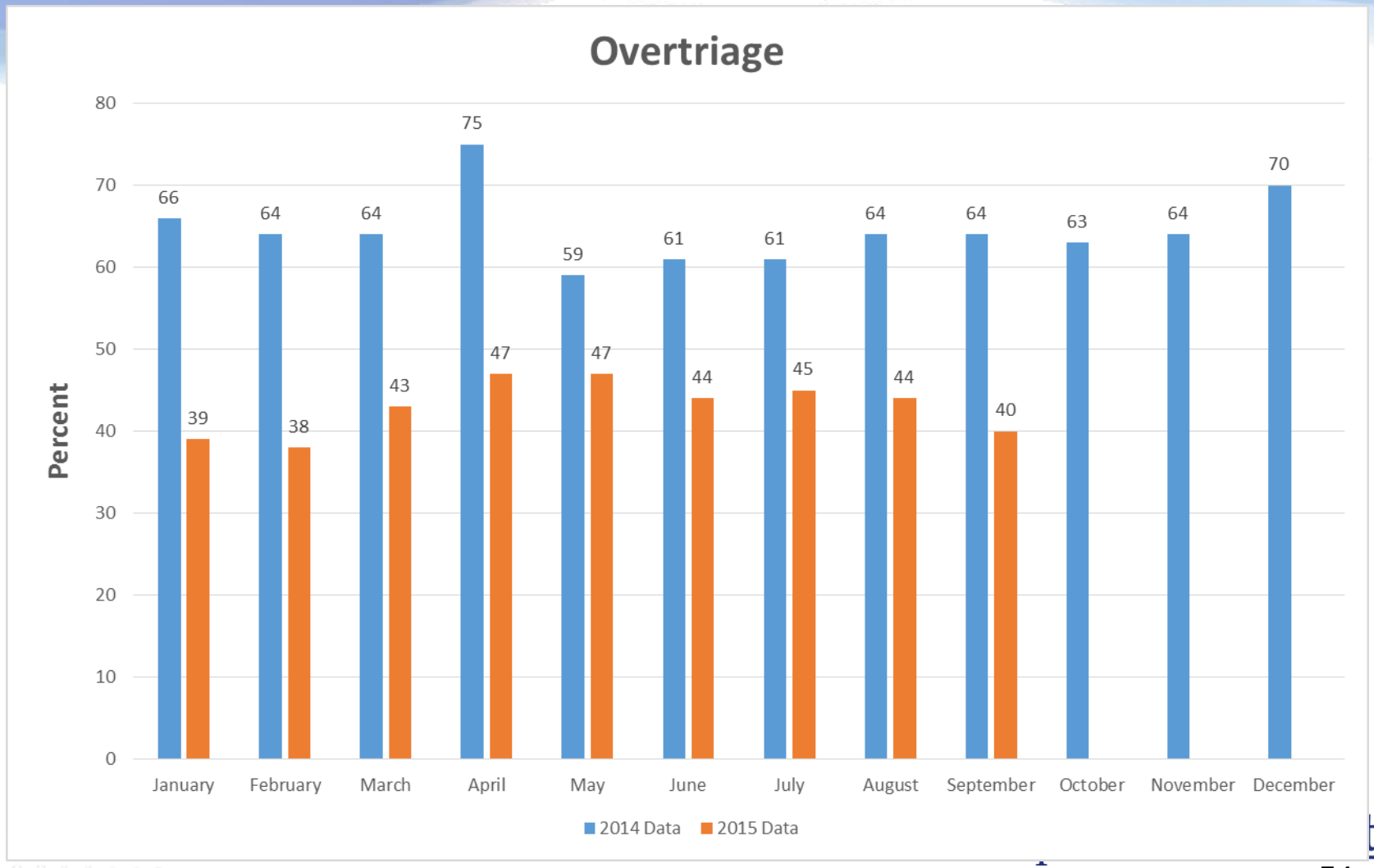
ED LOS by Severity



Overtriage

- Numerator: (NOT one of the following at a trauma center)
  - ED disposition = died, ICU, OR
  - ED disposition = floor bed or step/stepdown and hospital LOS > 48 hours
- Denominator: patients at a trauma center
- 'An acceptable percentage of over triage is in the range of 25 to 35 percent.' (page 28)

Overtriage


Overtriage
Percent
80
70
60
50
40
30
20
10
0
66
39
64
38
64
43
75
47
59
47
61
44
61
45
64
44
64
40
63
64
70
January
February
March
April
May
June
July
August
September
October
November
December
2014 Data
2015 Data

Updates

Katie Hokanson, *Trauma and Injury Prevention Director*

Indiana State Department of Health

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2016 IPAC Conference

- May 19th, 2016
- Rapp Family Conference Center at Eskenazi Health

- Registration open: 2016ipac.eventbrite.com

- Still in need of conference supporters: Email Tanya if interested TaBarrett@isdh.in.gov

Indiana State Department of Health

2016 Conference Draft Agenda

Time	Session
8:00 – 9:00 a.m.	Registration and Networking Breakfast
9:00 – 9:15 a.m.	Welcome & Opening Remarks Jennifer Walthall, MD, MPH Deputy State Health Commissioner
9:15 – 10:15 a.m.	**Keynote Speaker** Angela Marr, MPH, Branch Chief for the Practice Integration and Evaluation Branch, Division of Analysis, Research and Practice Integration, National Center for Injury Prevention and Control Moderator: Jessica Schultz, MPH
10:15 – 10:30 a.m.	Networking Break
10:30 – 11:15 a.m.	Session 1 – **The illusion of opioid pain medications. Why do we love these pills?** Donald Teater, MD, Medical Advisor, National Safety Council
11:15 a.m. – 12:00 p.m.	Session 2 – **Social Inclusion as Sexual Violence Prevention: A Public Health Project in Collaboration with Adults with Developmental Disabilities** Kate Gasiorowski, MPH, Rape Prevention and Education Program Coordinator, Indiana Coalition Against Domestic Violence (ICADV), an ISDH Sexual Violence Primary Prevention Program Rape Prevention & Education grantee Cierra Olivia Thomas-Williams, MA, Prevention Specialist, ICADV
12:00 – 1:00 p.m.	Lunch
1:00-1:15 p.m.	Networking Break & Shift in Conference Space

2016 Conference Draft Agenda

Breakout Sessions		
1:15 – 2:00 p.m.	Session 3a –**Bicycle Safety** Dona Sapp, Senior Policy Analyst, IU Public Policy Institute	Session 3b – **E-cigarettes and Electronic Nicotine Delivery Systems: An emerging public health challenge** Katelin Ryan, MA, Director of Program Evaluation, ISDH Tobacco Prevention and Cessation
2:00 – 2:45 p.m.	Session 4a – **Zero Suicide Initiatives: Prevention and Data** Laurie Gerdt, MA, LMHC, Project Manager for the Zero Suicides for Indiana Youth GLS Grant Community Health Network Julia Clement, BSN, RN Quality Resources/Risk Management Coordinator, Behavioral Health Services Community Health Network	Session 4b – **Off Road Vehicle Laws, Accidents and Safety Practices** Officer Scott McDaniel, Indiana Department of Natural Resources Moderator:
2:45 – 3:00 p.m.	Networking Break	
3:00 – 4:00 p.m.	Session 5a – **Older Adult Falls** Catana Philipps, BSN, RN, CEN, IU Health Methodist Injury Prevention Coordinator Moderator: Jessica Schultz, MPH	Session 5b – **Safe Transportation of Children with Behavioral Issues** Jason Skinner, MOTR, CPST, Occupational Therapist at the National Center for Safe Transportation of Children with Special Healthcare Needs Moderator: Lauren Savitskas, MPH
4:00 – 4:10 p.m.	Evaluation	
4:10 – 4:30 p.m.	Closing Remarks	

Booster Bash Collaboration

Lauren Savitskas, MPH , Injury Prevention Program Coordinator

Division of Trauma and Injury Prevention

EMAIL QUESTIONS:
LSAVITSKAS@ISDH.IN.GOV

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The Magnitude of the Problem

http://www.nhtsa.gov/nhtsa/ImageLibrary/displayIMG.cfm?ID=951&Category=Child%20Passenger%20Safety

- In 2013 in the United States 638 children ages 12 and under died as occupants in MVCs and more than 127,250 were injured
- In Indiana (2011-2014) unintended motor vehicle traffic deaths claimed 128 lives ages 14 and under
- In Indiana (2011-2014) 640 children ages 14 and under were injured from MVCs

What Can Be Done?

- Car seat use reduces the risk of infant death (1 year and younger) by 71% and toddlers (1-4 years) by 54%
- Booster seats reduce the risk of serious injury by 45% for children aged 4-9 when compared to seat belt use alone
- 73% of child restraints are used incorrectly
  1 out of 5 booster-age children are completely unrestrained

http://www.nhtsa.gov/nhtsa/ImageLibrary/displayIMG.cfm?ID=1172&Category=Child%20Passenger%20Safety

“Big Kid” BOOSTER BASH

http://www.nhtsa.gov/nhtsa/ImageLibrary/displayIMG.cfm?ID=1569&Category=Child%20Passenger%20Safety

If you would like to participate please contact Lauren Savitskas at lsavitskas@isdh.in.gov or call 317-234-9657

Child Passenger Safety

Judith Talty, *Automotive Safety Program*
April Brooks, *Automotive Safety Program*

Indiana State Department of Health

Email questions to: **indianatrauma@isdh.in.gov**

Hospital-Based Child Passenger Safety in Indiana

Judith Talty and April Brooks
Automotive Safety Program
Indiana University School of Medicine
Department of Pediatrics
800-KID-N-CAR
www.preventinjury.org

Automotive Safety Program Background

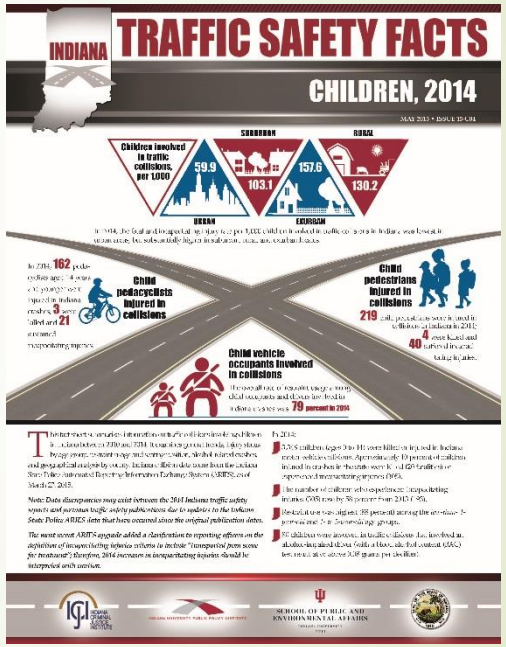
- Established in 1981
- Dr. Marilyn J. Bull and Dr. Joseph O'Neil
- Riley Hospital for Children
- Indiana University School of Medicine
- Federal funding from the Indiana Criminal Justice Institute
- Efforts to increase proper restraint use by children through programming, research, training and education
- National Center for The Safe Transportation of Children with Special Healthcare Needs
- Safe Kids Indiana

Indiana Child Passenger Safety Law

- Under age 8 must ride properly restrained in a child restraint according to manufacturer's instructions
- Age 8 up to age 16 must ride properly restrained in appropriate child restraint according to manufacturers' instructions or vehicle safety belt
- Applies to all seating positions in all vehicles, including pickup trucks and SUV's
- Driver responsible
- $25 fine; points cannot be assessed by BMV

Indiana Traffic Safety Facts

- General trends children 8-14:
  - From 2010 – 2014, fatalities decreased 9% annually
  - Incapacitating injuries increased by 12%
  - Rate of fatalities and injuries higher for 8-14 consistently higher
  - Restraint use declines by age with 8-14 having the lowest rate



http://www.in.gov/cji

Cost of Crash Related Deaths in Indiana

- Total: $1.07 billion
  - $10 million medical costs
  - $1.06 billion work lost costs
- $251 million motor vehicle occupants

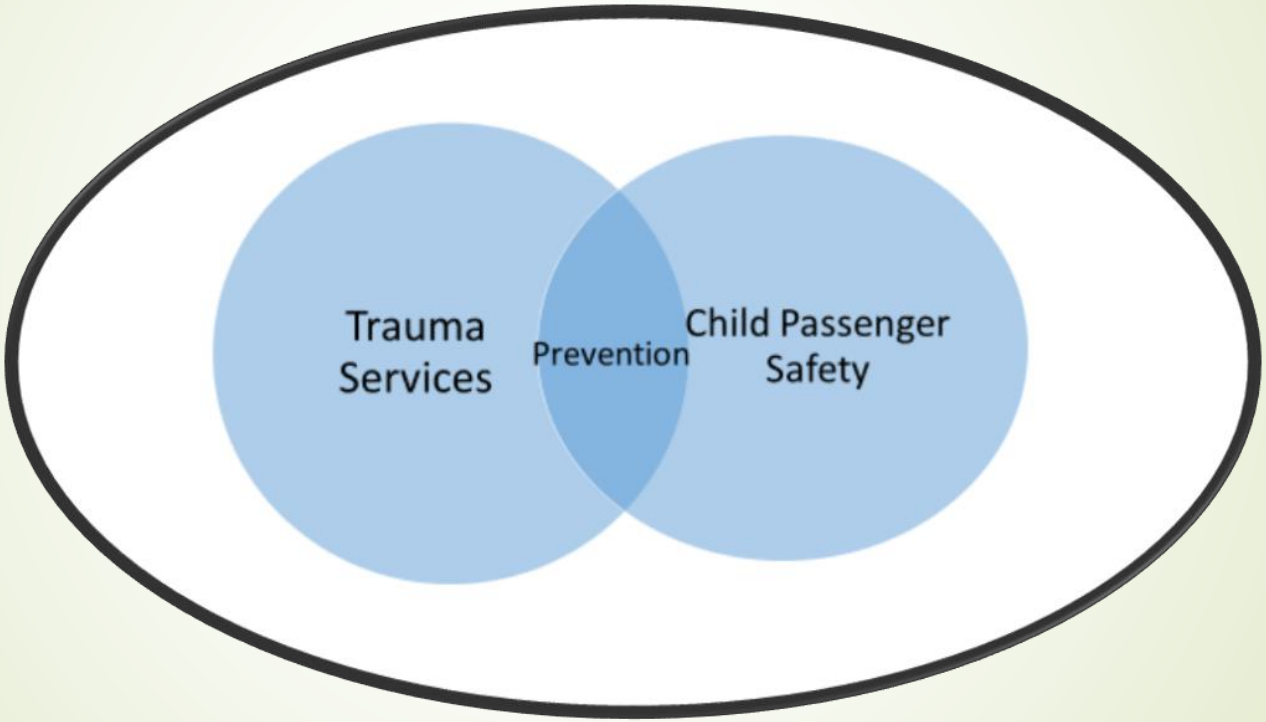
Source: CDC 2013 Data

What We See

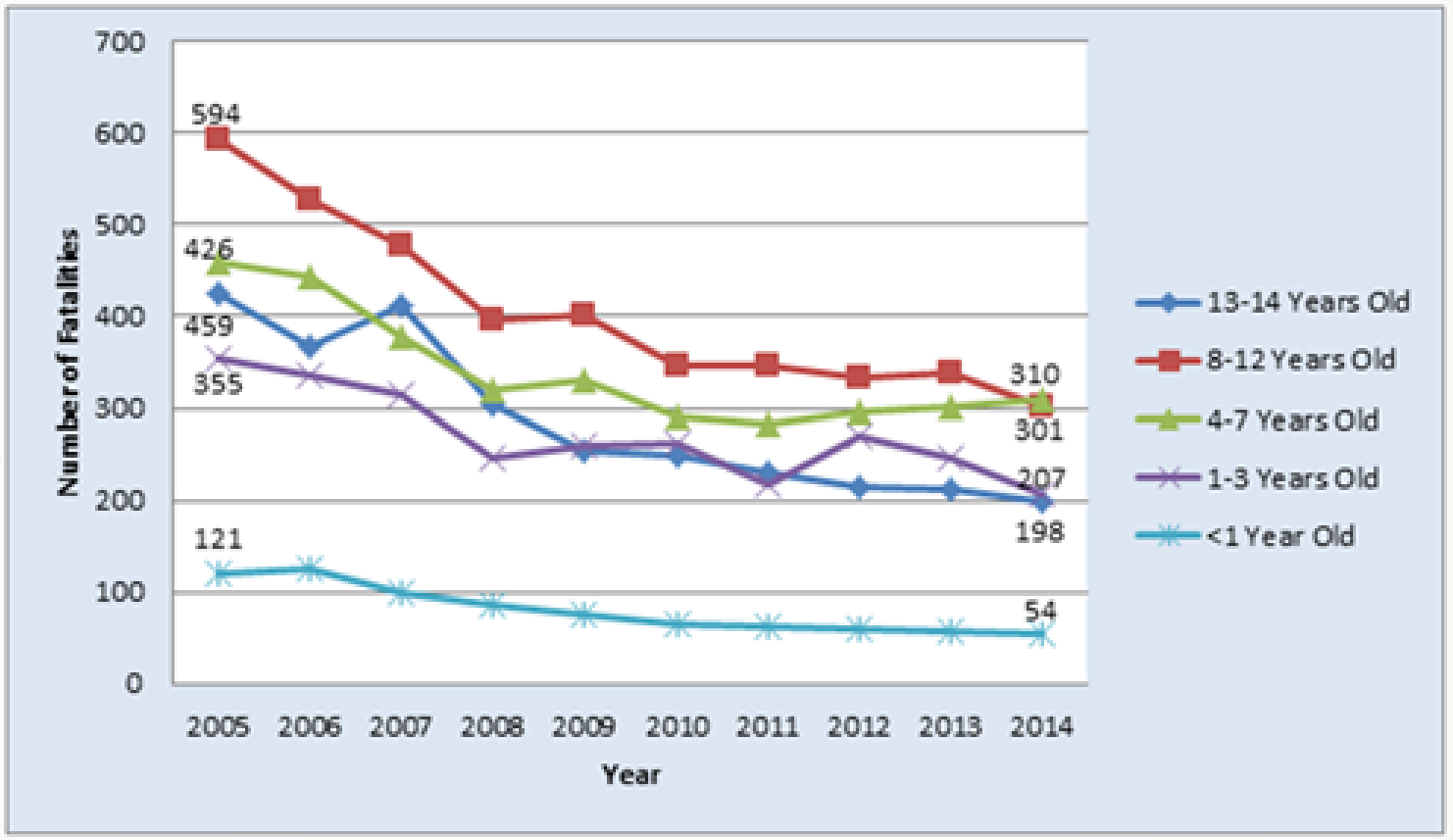
What You See

What We Want to See

Injury Prevention



Decline in Child Occupant Fatality Rates



Source: NHTSA

Hospital Discharge Recommendations for Safe Transportation of Children

- Best Practice Recommendations developed by an Expert Working Group convened by the National Highway Traffic Safety Administration, March 25, 2014
- Participation of the following areas, and other areas as appropriate within the institution, should be considered:
- Trauma services, emergency department, and injury prevention center or program
-

NATIONAL CHILD PASSENGER SAFETY BOARD

CHILDREN'S HOSPITAL ASSOCIATION

NATIONAL SAFETY COUNCIL

NHTSA www.nhtsa.gov

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Hospital-Based Car Seat Programs

- Most through Nursing Services
- Most are part of Indiana's network of ~ 100 child safety seat inspection stations
  - Managed and funded in part by the Indiana Criminal Justice Institute
  - Families make an appointment to have their child safety seat inspected by a certified child passenger safety technician
  - Inpatient and community clients
  - Staffed by child passenger safety technicians
  - www.preventinjury.org or 800-KID-N-CAR
  - Kaci Wray, kwray@cji.in.gov
- Most involved in community events such as car seat clinics
  - Typically one-time events and can be held at a variety of locations and sponsored by a variety of non-profit organizations and/or private businesses.

Trauma Centers

in Indiana

Level I

Indianapolis

Eskenazi Health

IU Health Methodist Hospital

Riley Hospital for Children at IU Health

St. Vincent Indianapolis Hospital

Level II

Evansville

Deaconess Hospital

St. Mary's Medical Center of Evansville

Ft. Wayne

Lutheran Hosptial of Indiana

Parkview Regional Medical Center

South Bend

Memorial Hospital of South Bend

Level III

Lafayette

IU Health - Arnett Hospital

Muncie

IU Health - Ball Memorial Hospital

Anderson

St. Vincent Regional Hospital

In the process of ACS Verification

Level II

Terre Haute

Terre Haute Regional

Level III

Anderson

Community Hospital - Anderson

Gary

Methodist Hospital - Northlake Campus

Lafayette

Franciscan St. Elizabeth - East

Vincennes

Good Samaritan Hospital

Richmond

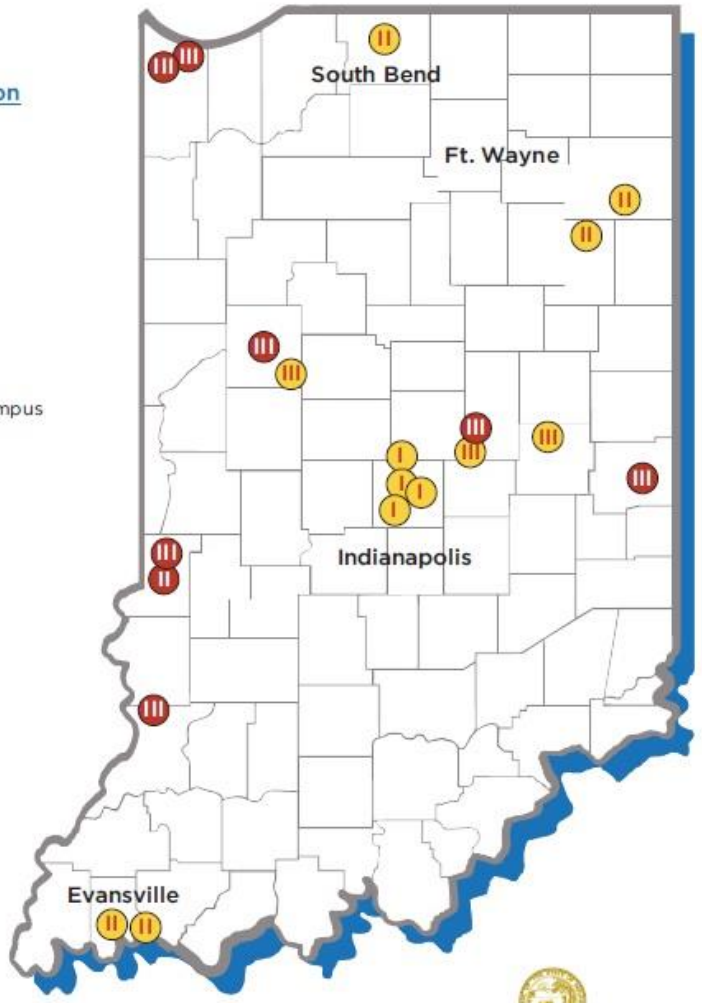
Reid Health

Crown Point

Franciscan St. Anthony Health

Terre Haute

Union Hospital - Terre Haute



Indiana State Department of Health

Trauma and Injury Prevention

Updated: 4-6-2016

Child Safety Seat Inspection Stations at Hospitals with Trauma Centers

- Riley Hospital for Children
  - Methodist and IU
- St. Mary's
- Lutheran
- Parkview
- Memorial South Bend
- IU Health Arnett
- IU Health Ball
- Community Hospital Anderson
- Franciscan St. Elizabeth
- Franciscan St. Anthony Crown Point

Child Passenger Safety at Riley Hospital at IU Health

- Automotive Safety Program
  - Evaluations by occupational therapist
  - Inspection station for Hispanic/Families
- Nursing Services
  - Car seats to inpatients and outpatients
  - Conventional and special needs restraints
  - Trainings: Over 100 nurses in Riley, 8 of whom are in ED
  - Community outreach through car seat clinics and educational booths
- Trauma Services
  - Community outreach to new moms through the Nurse Family Partnership and older children via "Booster Bashes"
  - Research
  - Hannah Mathena, Injury Prevention Coordinator, hmathena@iuhealth.org

Trauma Registry at Riley Hospital

- 8-14 year olds
- 182 treated and released
- 150 admitted
- Will look at relationship of:
  - Seating position
  - Restraint use
  - Crash injuries
  - Length of stay for those admitted

Committee of Hospital-Based Child Passenger Safety Programs

- Coordinated by Michelle Chappelow, RN, Riley Hospital at IU Health
- Quarterly Meetings
- mchappel@iuhealth.org
- 317.944.1235

Trauma and Special Needs

- What resources do you have?

Pediatric Transport

- How are your pediatric patients being transported?
- Safe transport in ambulances complex
  - Purpose different
  - Vehicle characteristics different
  - Crash environment and exposure are different from that of a family car
- Patient compartment not required to meet federal motor vehicle safety standards
- New dynamic crash tests and SAE standards
- Training for EMS providers through Automotive Safety Program

Safe Kids Indiana

- Worldwide organization with local affiliates
- Childhood injuries
- Some local coalitions at hospitals with Trauma Centers:
  - Lutheran Children's Hospital
  - IU Health Ball Memorial
  - Memorial Hospital South Bend
  - Franciscan St. Anthony, Crown Point
  - St. Mary's Medical Center
  - Contact: Judith Talty, jtalty@iu.edu, 317-278-1085

National Child Passenger Safety Certification Training Program

- 3 – 4 day course
- Must attend every day of the course to pass
  - Written quizzes
  - Hands-on skills assessments
  - Car seat check-up event in the community on last day of class
- Cost: $85
- Scholarships available from Automotive Safety Program
- View courses and register online at http://cert.safekids.org

Host A Certification Course

- Any agency can host a course
  - Facility large enough to hold students, instructors, and supplies
  - Accessible parking lot or bay for hands-on activities
  - Instructor payments
    - Automotive Safety Program has funding available to pay instructors
  - Facilitate check-up event on last day of course
    - $500 mini-grant available from Automotive Safety Program to purchase car seats
  - Contact: April Brooks, apbrooks@iu.edu, 317-274-8380

Health Care Hero Nominations

Courtney VanJelgerhuis, *Program Manager*
Indiana EMS for Children (iEMSC)

Indiana State Department of Health

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Other Business

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Committee Meeting Dates for 2016

- June 17
- August 19
- October 21
- December 16

Indiana State Department of Health

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