The presentation will begin shortly.

You may not have sound at the moment, but will have sound once the presentation begins.

Thank you for your patience.

Indiana State Department of Health

Questions?

Email questions to:
indianatrauma@isdh.in.gov

OR

Utilize chatbox underneath the video.

Indiana State Department of Health

Injury Prevention Advisory Council (IPAC) and Indiana Violent Death Reporting System (INVDRS) Meeting

Friday, September 20, 2019

Indiana State Department of Health

Round Robin and Introductions

- Name
- Position
- Organization/ Association
- Updates
- Current Projects and Programs
- Upcoming events

@INDTrauma #SafetyIN

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

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Invite New Members

Please forward my contact information to colleagues interested in violence & injury prevention!

Indiana State Department of Health

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

Resource Guide App

- UPDATED!
- Free download for iOS & Android
  - phone & tablet capabilities
- Available in Apple & Google Play stores

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

ISDH Updates

Indiana State Department of Health

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

Division staffing updates

- Lauren Harding
  - PDO Epidemiologist
- Jacqui Langer
  - PDO Intern
- Crystal Cating
  - INVDRS Intern
- Maria Cariaso
  - Injury Prevention Intern
- Maddie Wright
  - Naloxone Intern

Indiana State Department of Health

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

Upcoming Events

- Celebration of Lives Lost
  - September 28
- Mental Illness Awareness Week
  - October 6-12
- Rehabilitation Hospital of Indiana (RHI) Research, Training & Outcomes Center (RTOC) Meeting
  - October 9-10
- CDC Site Visit to ISDH
  - October 15-17
- Labor of Love Summit
  - December 11

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

ISTCC/ITN Meeting Dates

- Indiana State Trauma Care Committee, Indiana Government Center, 10 am EST
  - October 11th
  - December 13th
- Indiana Trauma Network, Indiana Government Center, 12:30 pm EST
  - October 11th
  - December 13th

2019 IPAC/INVDRS Meeting Dates

- November 15th

Indiana State Department of Health

Division grant activities

- Centers for Disease Control (CDC) - Overdose Data to Action
  - Granted!

- Centers for Disease Control (CDC) – National Violent Death Reporting System
  - Granted!

Overdose Data to Action (OD2A) Grant

Indiana State Department of Health

Agenda

- Grant Overview
- Project Echo- Grant Framework
- RFP Process and Application
- Questions

- This grant opportunity was supported by Grant No. NU17CE2019001953 awarded by the Centers for Disease Control and Prevention (CDC). Its contents are solely the responsibility of the ISDH and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

Overview of OD2A

- Three year CDC grant award to ISDH
- Start date: 09/01/2019
- Two components: Surveillance and Prevention

Main goal: Leverage high quality, comprehensive, and timely data surveillance to drive state and local drug overdose prevention efforts.

Purpose

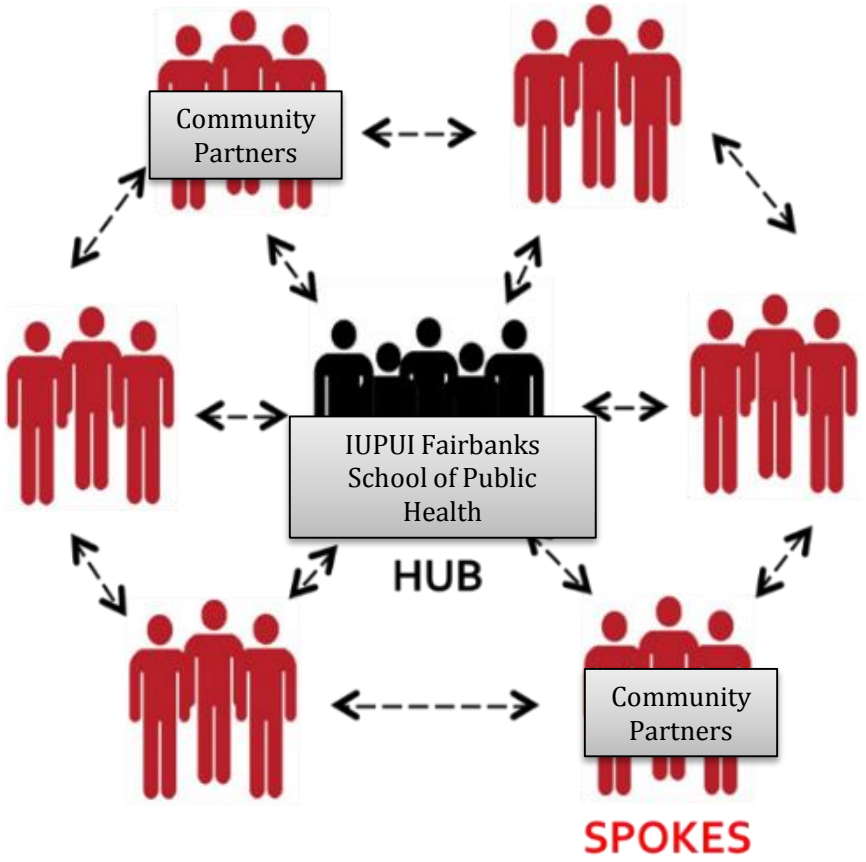
- Increase local community capacity
- Decrease opioid-related morbidity and mortality
- Increase timeliness, comprehensiveness, and access to data
- Reduce barriers to treatment
- Increase treatment admissions
- Increase law enforcement (LE) awareness of Harm Reduction strategies
- Continue building bridges between LE and those in recovery
- Decrease Stigma

Strategies and Activities under OD2A

- ISDH has named 11 key strategies, including, but not limited to:
  - Collect, analyze, and disseminate timely syndromic emergency department (ED) data on all suspected drug overdoses
  - Enhance and maximize Indiana's PDMP
  - Establish linkages to care for those with opioid use disorder
  - Serve as a peer-to-peer learning mentor for states implementing a overdose fatality review team

Framework- Project Echo

What is an ECHO?



Eligible Awardees

- Due to the importance of interdisciplinary work in this field, applicants must have a minimum of **five** different sectors represented on their team.
  - Potential applicants include
  - Local Health Departments (LHDs)
  - Hospitals
  - Local government agencies
  - Local Coordinating Councils (LCCs)
  - Recovery-Oriented Systems of Care
  - Drug Free Coalitions
  - Other community coalitions and non-profit organizations.

- It is highly recommended that that applicants include **someone in active recovery** on their team

Request for Proposal (RFP)

- Communities can implement **up to four** action strategies:

Strategy 1: Primary Prevention for Opioid Misuse and Opioid Use Disorder

Strategy 2: Linkage to Care for Recovery Services and Evidence-Based Treatment for OUD

Strategy 3: Harm Reduction and Anti-Stigma Promotion

Strategy 4: Additional Activities

Timeline

- October 31, 2019, 5:00pm- Grant application due
- November 30, 2019- Grantees notified
- January 2020- IN CARE ECHO Welcome call
  - Grantees must participate in monthly ECHO sessions and submit quarterly reports
- November 2020- Successful grantees can apply for continuation of funding

Grantee Responsibilities

- Activity 1: Grantees will convene a local multidisciplinary stakeholder team.
  - Each chosen grantee will be referred to as a "Community Convener" and will serve as an organizer to assemble a multi-disciplinary Spoke team, including, but not limited to, the following sectors: public health, health care, behavioral health, ED, EMS, recovery community, law enforcement, and faith leaders.

- Activity 2: Grantees will participate in monthly ECHO sessions.
  - Grantees are required to convene their Spoke teams and to tune in to monthly ECHO sessions. Grantees may be asked to present during an ECHO session.

Grantee Requirements (cont)

- Activity 3: Grantees will organize monthly post-ECHO action planning meetings with their Spoke teams.
  - The purpose of this is for grantees to implement positive community changes related to substance use disorder based on the knowledge gleaned from the Project ECHO sessions.

- Activity 4: Evaluation and reporting requirements.
  - Grantees must:
    - 1) provide quarterly reports (template provided by ISDH)
    - 2) participate in the evaluation of this program
    - 3) provide periodic oral updates, as requested by ISDH.

Funding Available

- Each grantee can apply for funding ranging from $25k, up to $225k, based on the project(s) they intend to complete.
- Maximum funding rates have been set for several possible activities, for examples:

Example Activities	Maximum Funding
Implementation of post-overdose protocol in partnership with a hospital.	$75,000
Implementation of the CDC Rx Awareness campaign or other substance use prevention and awareness campaign	$25,000
Placement of peer recovery specialists in targeted locations (EDs, fire stations, police stations, etc.)	$25,000

Ineligible Activities

- Program funds cannot be used for:
  - purchasing naloxone
  - implementing or expanding drug “take-back” programs or other drug disposal programs
  - purchasing fentanyl test strips
  - directly funding or expanding direct provision of substance abuse treatment programs
  - human subjects research
  - building/expanding a building

Application Scoring

- Each application will be scored by at least two reviewers within the ISDH using the rubric provided in the RFP, summarized here:

Scoring Criteria	**% of Score**
Organizational Information	10%
Narrative	40%
Organizational Capacity	20%
Budget Template (Attachment B & Budget Narrative)	20%
Submission	10%

Contact Information

Contacts:

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khokanson@isdh.in.gov
317-234-2865

Klaudia Wojciechowska

kwojciechowska@isdh.in.gov
317-232-1392

Questions?

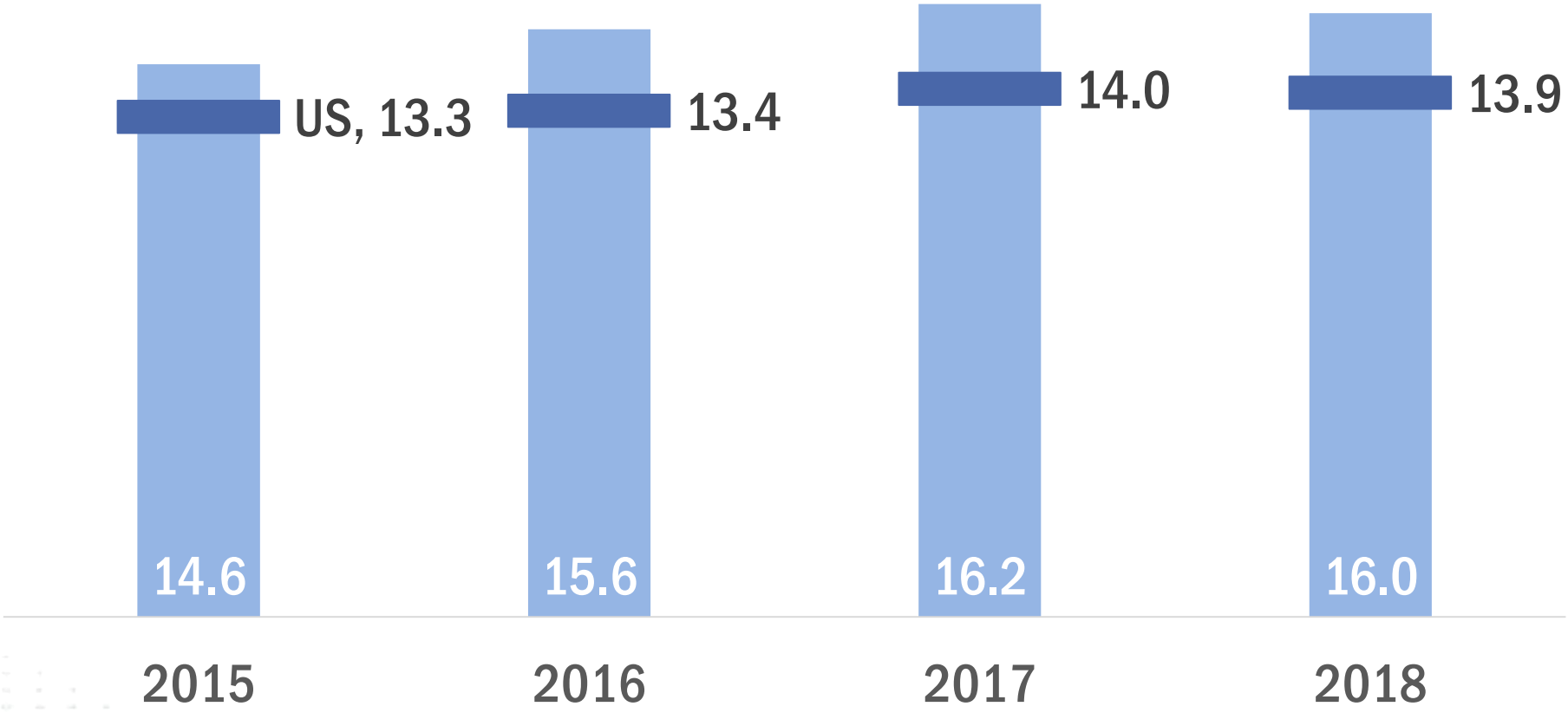
Intentional Injury Data Presentation: Suicide Risks

Morgan Sprecher, *INVDRS Epidemiologist*

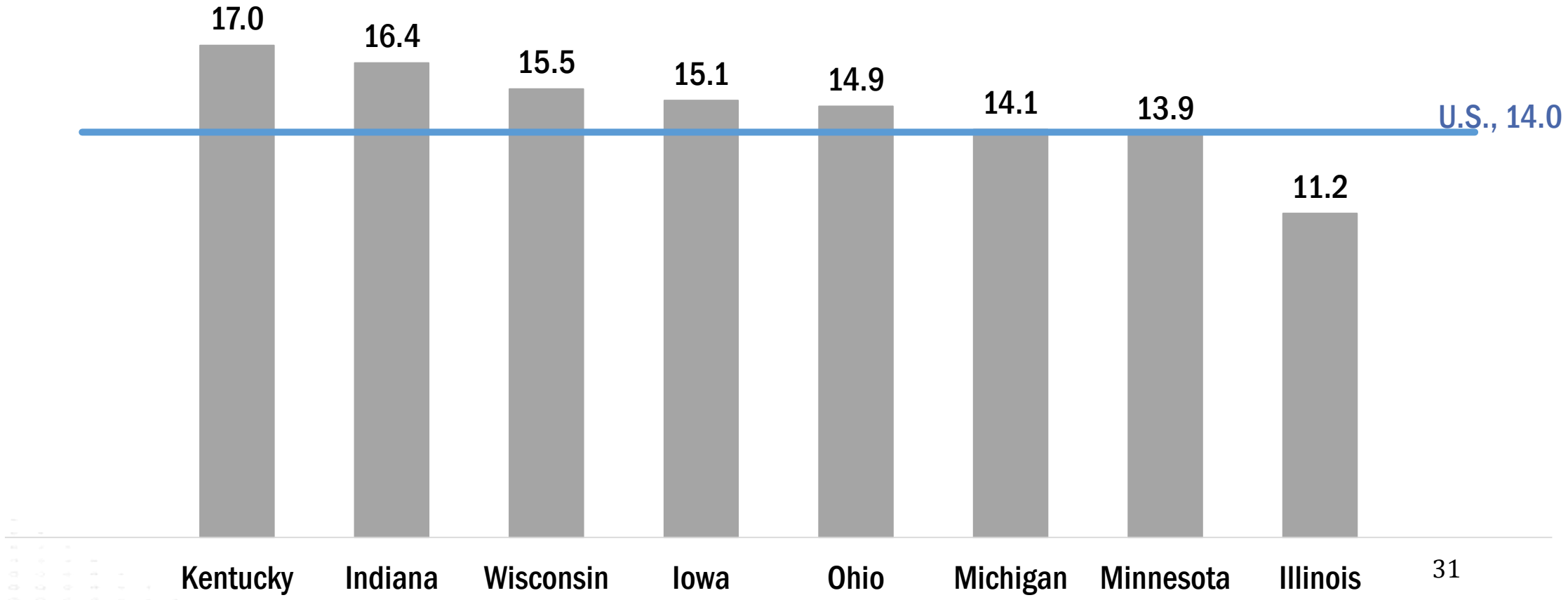
Indiana State Department of Health

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

Indiana has seen higher suicide rates than the United States average over the years.



Indiana is 1 of 6 Midwest States that had a higher suicide rate than the United States average in 2017.



How many times more likely is someone to die by suicide?

Circumstance	Risk Ratio
Financial Problem	10x
Job Problem	4.2x
IPV	0.98x
School Problem	0.98x
Physical Health Problem	0.71x

Scenario 1

Officers spoke with the V's wife who advised that she and the V had gone to bed that night and nothing appeared out of the ordinary. She reported that when the V came home both of them drank some vodka and argued about their financial hardship, due to her not having a job. She advised that the argument was minor and that the V showed no signs of distress. She advised that sometime during the night one of their children started crying, and she spent the rest of the night in the child's bedroom... She also reported that the V had never spoken of suicide and in her knowledge had never attempted it.

Scenario 2

Per the roommates, the V was overall a depressed and unhappy person. The V had run in with LE and minimal employment. The decedent was upset over the recent diagnosis of testicular cancer as well as being recently arrested with a brief incrassation in local jail due to missing a court appearance.

Scenario 3

Per the fiance and niece, they had left the residence earlier to buy cigarettes and had watched the V go to the garage as they were leaving. They advised that he seemed fine and that he had not mentioned wanting to harm himself. The niece also advised that she could tell that the V had been drinking. Per reports, the V was diagnosed with diabetes mellitus and had been having trouble with his health insurance and having enough insulin.

Scenario 4

The V was found lying unresponsive suffering from an apparent self-inflicted GSW to the head, in a cluttered aisle of a store (the V was the owner of the store)... The V had a meeting that afternoon with representatives from several departments about the V's business not being up to code standard. Reports indicate that the V had been told that if the code violations were not corrected by the end of the month the business would be closed down. Per the V's son, the V had been having financial difficulties and was going through a rough time in his life.

Demographics for Financial-Related Suicides (2015-2018)

		Female	Male
Age			
	15-25	2	7
	25-34	2	10
	35-44	1	14
	45-54	3	21
	55-64	2	22
	65-74	0	8
	75+	0	2
Race			
	White	8	74
	Black	2	7
	Asian	0	2
	American Indian	0	1

ACTIVITY

How can we use this data to support those in financial stress?

Contact Information

Morgan Sprecher, *INVDRS Epidemiologist*
Trauma and Injury Prevention Division
317.233.9825 (office)
msprecher@isdh.in.gov

Email questions to: **Indianatrauma@isd.in.gov**

Indiana State Department of Health

Intentional Injury Prevention Program Spotlight:
Zero Suicides

Laurie Gerdt, *Community Health Network*

Indiana State Department of Health

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

Zero Suicide in Health and Behavioral Health Care

Community Health Network

FAST FACTS

- Deaths by suicide in Indiana have increased by 31.9% from 1999 – 2016 *(CDC)*.
- Strengthening access and delivery of suicide care is one strategy of suicide prevention *(CDC)*.
- In 2014, Community Health Network (CHNw) committed to implementing Zero Suicide initiatives.
- Community Health Network was awarded a five year, 3.7 million dollar federal grant to assist with the implementation of Zero Suicide initiatives in October of 2014.

WHAT IS ZERO SUICIDE?

Zero Suicide is a commitment to suicide prevention in health and behavioral health care systems, and also a specific set of tools and strategies. It is both a concept and a practice.

The challenge of Zero Suicide is not one to be borne solely by those providing behavioral health care. Zero Suicide relies on a system-wide approach to improve outcomes and close gaps rather than on the heroic efforts of individual practitioners.

LEAD

TRAIN

IDENTIFY

ENGAGE

TREAT

TRANSITION

IMPROVE

1 **LEAD** Create a leadership-driven, safety-oriented culture committed to dramatically reducing suicide among people under care. Include suicide attempt and loss survivors in leadership and planning roles.

2 **TRAIN** Develop a competent, confident and caring workforce.

3 **IDENTIFY** Systematically identify and assess suicide risk among people receiving care.

4 **ENGAGE** Ensure every person has a suicide care management plan, or pathway to care, that is both timely and adequate to meet his or her needs. Include collaborative safety planning and restriction of lethal means.

5 **TREAT** Use effective, evidence-based treatments that directly target suicidality.

6 **TRANSITION** Provide continuous contact and support, especially after acute care.

7 **IMPROVE** Apply a data-driven quality improvement approach to inform system changes that will lead to improved patient outcomes and better care for those at risk.

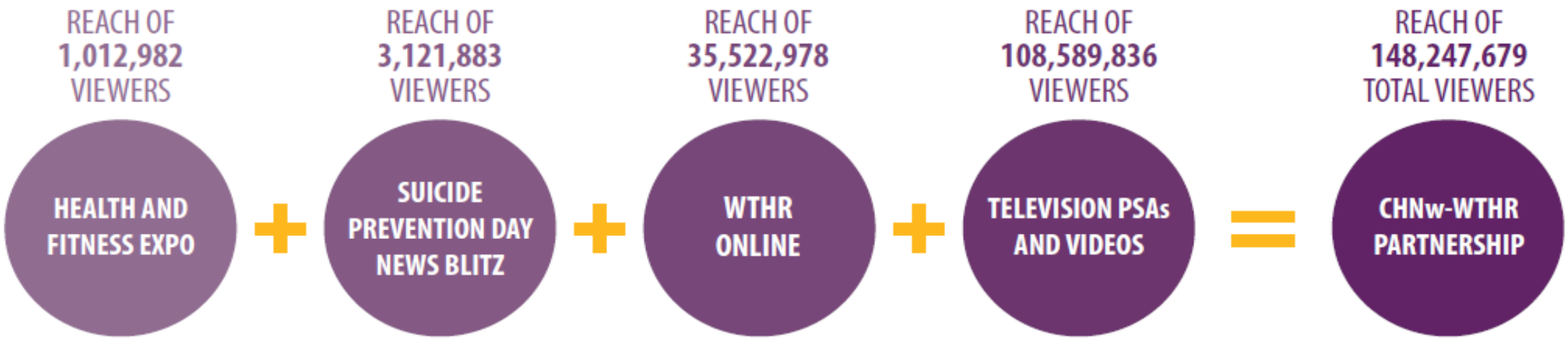
1 LEAD

COMMUNITY HEALTH NETWORK LEADERSHIP ACTIVITIES PROMOTING THE ZERO SUICIDE INITIATIVE

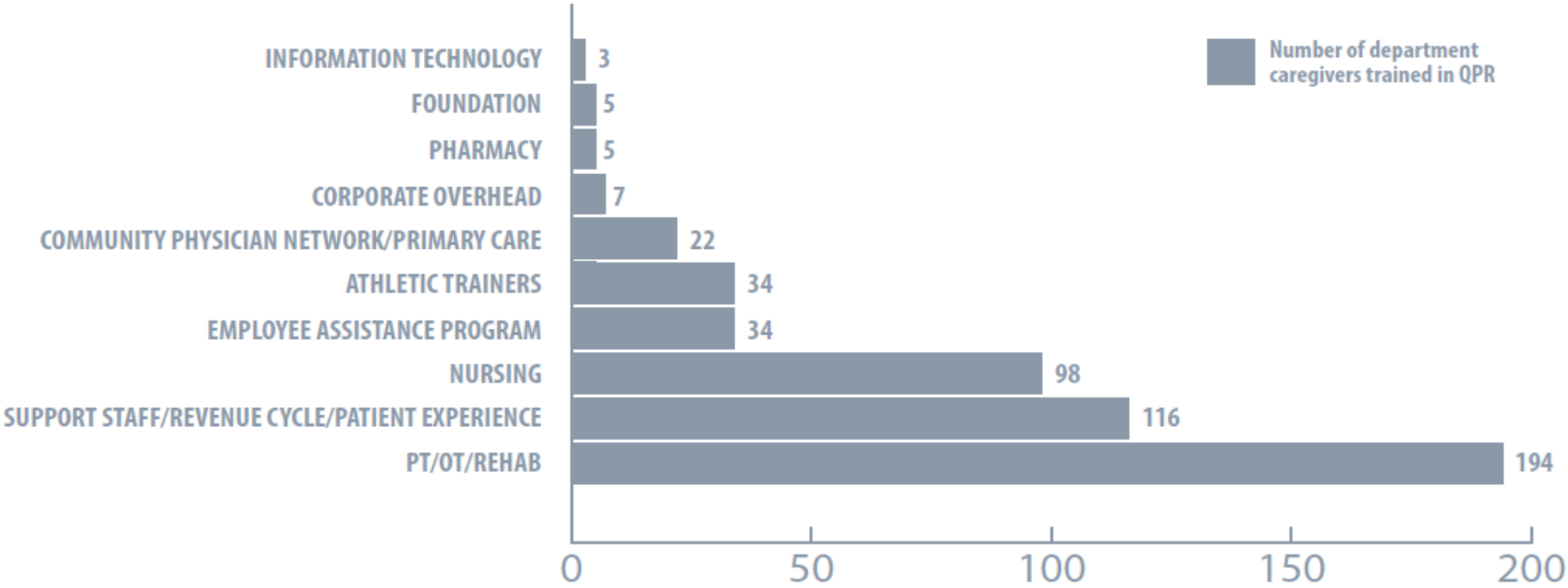
From 2015 – 2018, Community Health Network leaders promoted the Zero Suicide Initiative through the following activities:

- Speakers and presentations at three of CHNw's Leadership Development Institutes/All Team Experience gatherings
- Developing a partnership with WTHR for a three year Have Hope campaign
- Features and highlights in ten network leadership newsletters
- Participation in a social media campaign **#BeThere**

CHNw-WTHR PARTNERSHIP | The partnership activity highlighted below occurred between 2017 – 2018



2 TRAIN



From 2015 – 2019, 518 non-behavioral health CHNw caregivers were trained in Question, Persuade, Refer (QPR): a two-hour suicide prevention evidence-based training. Like CPR, QPR can be a life-saving intervention.

3 IDENTIFY

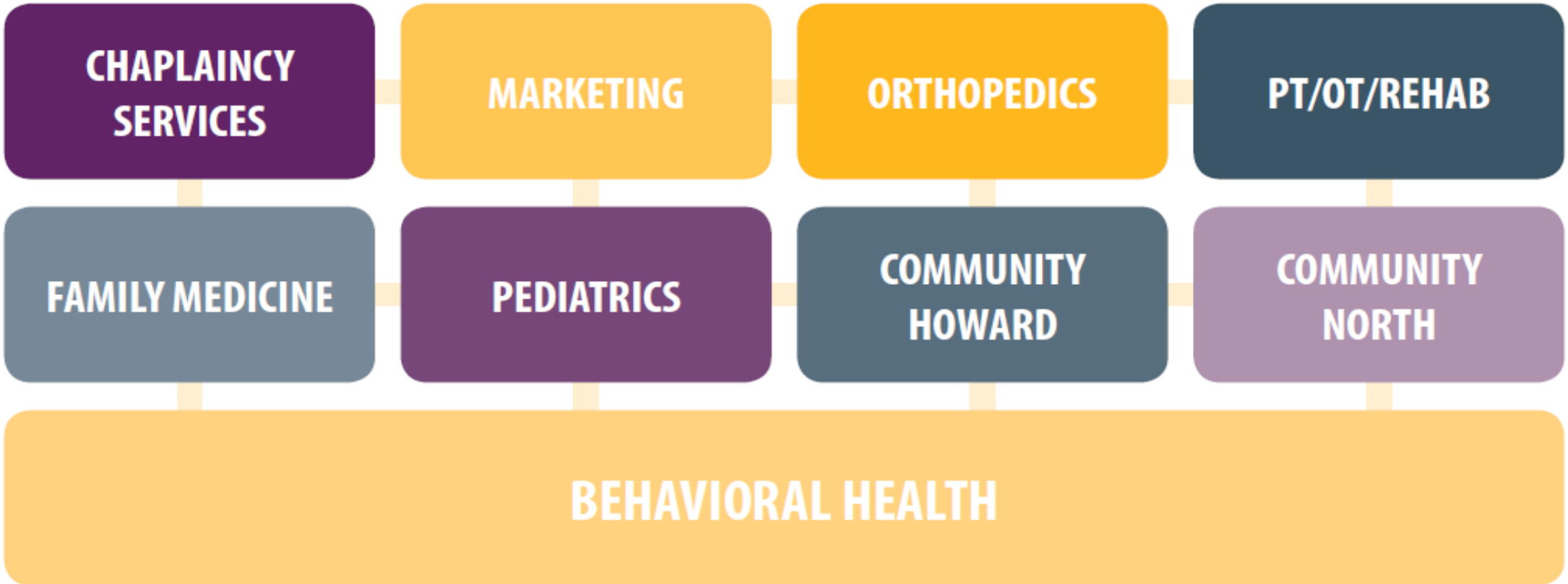
9,144 established CHNw patients were referred for behavioral health services from over 200 CHNw provider locations from July 1, 2018 - June 30, 2019.

These patients were screened for suicide risk by our Community Behavioral Health Access Caregivers using a newly implemented evidenced based tool, the Columbia Suicide Severity Rating Scale. During that same timeframe:

161 patients out of all patients screened by Access Caregivers were found at high risk for suicide and were provided support via text messages and calls while awaiting their initial Behavioral Health appointment.

4 ENGAGE

From 2015 – 2019, the below CHNw departments ordered crisis text-line cards to distribute to their patients as an additional resource. The crisis text line cards are available to all CHNw departments via InComm (form #19679).



5 TREAT

Improving the Community Behavioral Health workforce competence

After completion of Assessing and Managing Suicide Risk (AMSR) training between August 2016 and October 2018, 196 (85%) clinical providers stated they had an increase in knowledge in the following areas:

- Managing your own emotional reactions to patients at risk of suicide
- Collaboratively developing a crisis response plan
- Planning a response to a patient at risk of suicide based on a solid risk formulation
- Gaining the right information to inform a clinical judgment of suicide risk
- Developing a written treatment and services plan that addresses the patient's immediate, acute and continuing suicide ideation and risk for suicide behaviors
- Developing policies and procedures for following patients closely, including taking reasonable steps to be proactive
- Using skilled questions to discover each patient's subjective experience of their suicidal thoughts and behaviors

6 TRANSITION

In July 2015, the HaveHope Pathway, an enhanced suicide care pathway, was implemented. The HaveHope Pathway can include supportive calls and text messages for Community Behavioral Health clients identified as high risk for suicide.

From July 2015 – June 2019

3,157 clients were referred to this care pathway

7 IMPROVE

Improvements in recording and tracking of suicide attempts within the Community Behavioral Health patient population resulted in recognizing poisoning as the most common suicide attempt method. As a result, locking medication bags were purchased and are available for distribution by Behavioral Health providers to enhance safety planning.

Percentages of suicide attempt methods for Behavioral Health clients from 7/1/18 – 6/30/19

Method	All Ages
Poisoning	54%
Asphyxiation	33%
Cut/Pierce	7%
Motor vehicle/transportation	3%
Drowning	1%
Other	1%

Community Health Network

Zero Suicide for Indiana Youth GLS Grant

Year 1 (October 2014) – **Year 4** (September 2018)

Zero Suicide Academy

In the past two years, 25 health and behavioral healthcare organizations participated in a Community Health Network-sponsored Zero Suicide Academy. A Zero Suicide Academy is a 2-day training in how to provide safer suicide care using a 7 essential elements evidence-based framework. The following information documents the outcomes reported by 16 of the 25 participating organizations.

LEAD
87.5%
14 of 16 Implemented an Advisory Team

TRAIN
62.5%
10 of 16 Provided Evidence-Based Training to Staff

IDENTIFY
62.5%
10 of 16 Implemented a Universal Assessment Tool

ENGAGE
56.25%
9 of 16 Created Protocols for Suicide-Safe Care

TREAT
68.75%
11 of 16 are Mental Health Service Organizations

TRANSITION
68.75%
11 of 16 Created Guidelines for Follow-up Care for Clients at Risk of Suicide

IMPROVE
37.5%
6 of 16 Implemented Models for Tracking Suicide Attempts and Deaths

Fast Facts

Indiana Department of Education

School model policy guide for suicide prevention created in response to legislation HEA 1430: www.doe.in.gov/sites/default/files/student-services/suicide-resource-guide-indiana-schools-4.pdf

haveHOPE.com

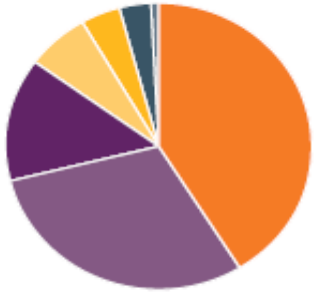
www.havehope.com website and campaign created in collaboration with central Indiana's NBC affiliate, WTHR

Emergency Medical Service suicide prevention education developed and placed in web based education system, ACADIS

Indiana Suicide Prevention Network

The Indiana Suicide Prevention Network created in July 2018 as a subsidiary of Mental Health America of Indiana

QPR Instructors by Profession



277 Total

- 114 | Mental Health
- 83 | Higher Education
- 39 | K-12 Education
- 18 | Healthcare
- 12 | Emergency Responders
- 9 | Child Welfare
- 0 | Juvenile Justice
- 2 | Other

QPR Trainees by Profession

9,616 Total

- 1,585 | Mental Health
- 302 | Higher Education
- 5,305 | K-12 Education
- 728 | Healthcare
- 357 | Emergency Responders
- 368 | Child Welfare
- 201 | Juvenile Justice
- 770 | Other

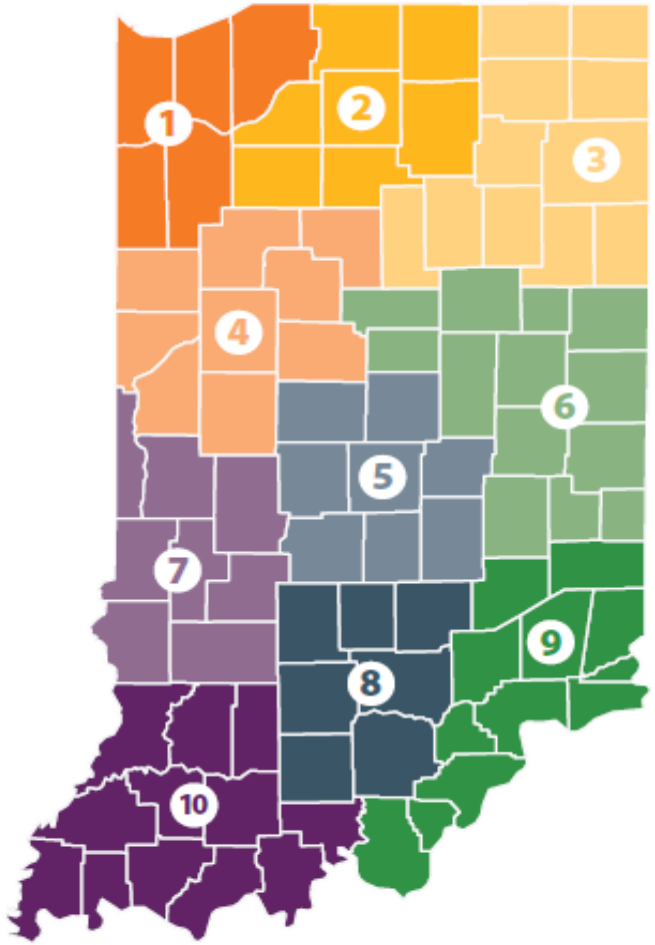
Number of Organizations that Updated Policies

140 School Districts

13 Healthcare Organizations

Instructors and Trainees Certified by Zero Suicide for Indiana Youth Grant

(per Indiana Suicide Prevention Coalition (ISPC) Regions)



1 — **10** QPR Instructors, **402** Trainees

2 — **16** QPR Instructors, **163** Trainees

3 — **35** QPR Instructors, **1,348** Trainees

4 — **78** QPR Instructors, **754** Trainees

5 — **81** QPR Instructors, **4,704** Trainees

6 — **8** QPR Instructors, **763** Trainees

7 — **12** QPR Instructors, **244** Trainees

8 — **7** QPR Instructors, **54** Trainees

9 — **23** QPR Instructors, **595** Trainees

10 — **7** QPR Instructors, **501** Trainees

Total QPR Instructors: **277**
Total Trainees: **9,616**

Unintentional Injury Data:
Older Adult Falls Special Emphasis Report

Andzelika Rzucidlo, *Injury Prevention Epidemiologist*
Trauma and Injury Prevention Division

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

Indiana

Special Emphasis Report: Fall Injuries among Older Adults 2017

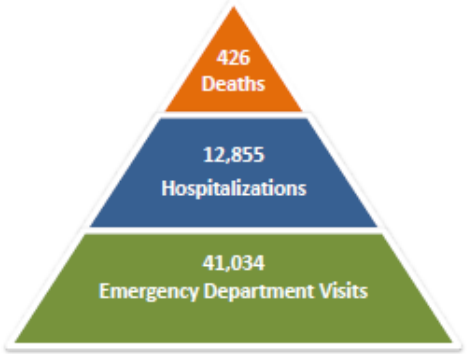
A GROWING CONCERN

Unintentional falls are the leading cause of fatal and nonfatal injury in the U.S. and Indiana among older adults. Hospital costs associated with injuries sustained by falls account for a substantial share of health care dollars for injury-related care.

In 2017, 426 Indiana residents aged 65 and older died due to an unintentional fall and over 55,000 fall injuries were treated at hospitals and emergency departments (Figure 1).

This report provides recent data on unintentional fall injuries and deaths among Indiana residents ages 65 and older. It includes information about groups with the highest rates, associated costs, and current prevention strategies and activities in Indiana.

FIGURE 1. Burden of Fall Injuries among Residents Ages 65 and Older—Indiana, 2017



QUICK FACTS

Unintentional falls are the leading cause of death for older adults in Indiana. Indiana residents 65 and older account for **81.3%** ***of all fall deaths*** and 73.3% of nonfatal fall hospitalizations in Indiana.

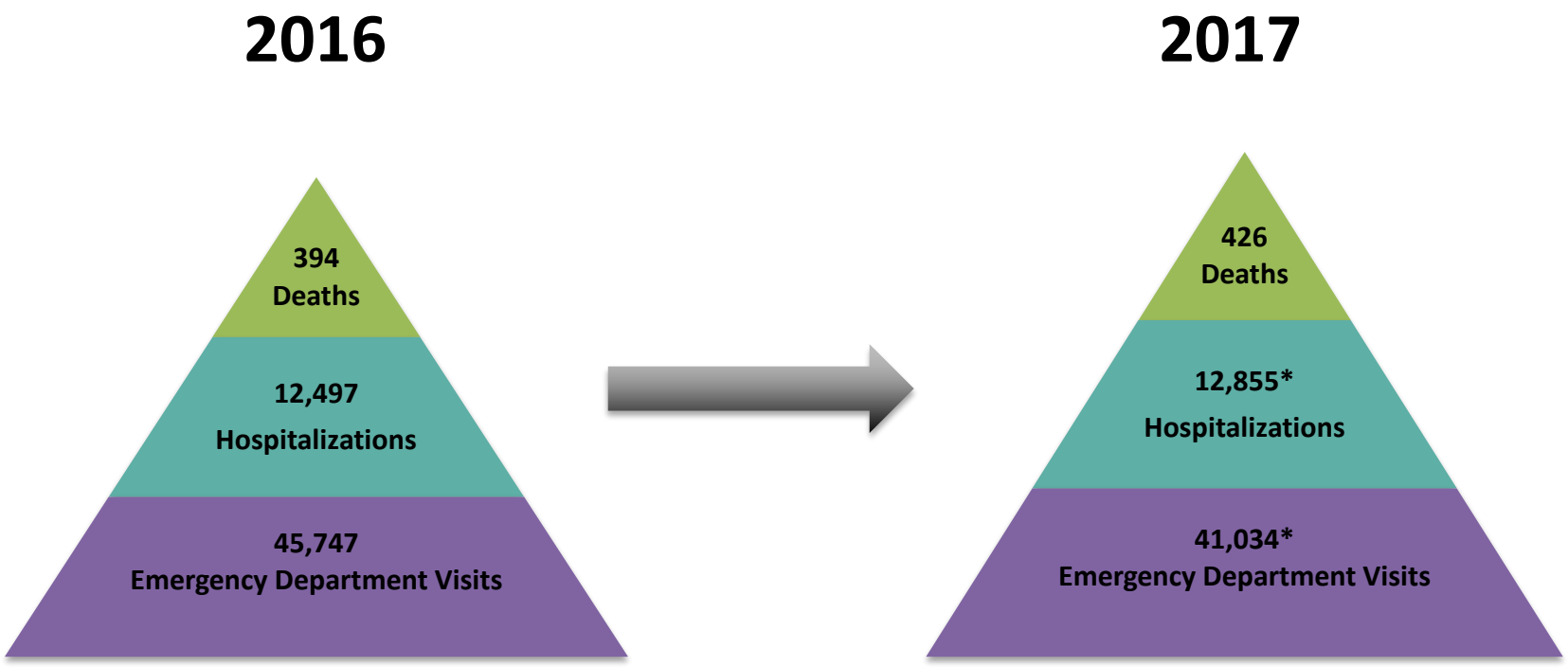
Falls are the ***leading cause of traumatic brain injury (TBI)*** in Indiana residents aged 65 and older, accounting for 57.3% of TBI deaths and 41.2% of TBI hospitalizations.

Projected lifetime costs associated with fall injuries in 2017 among Indiana residents aged 65 and older are estimated to be ***over $1 billion.***

Each week, there are **794.3** emergency department visits among residents aged 65 and older, **247.2** hospitalizations ***and 8.2 deaths due to fall injuries*** in Indiana.

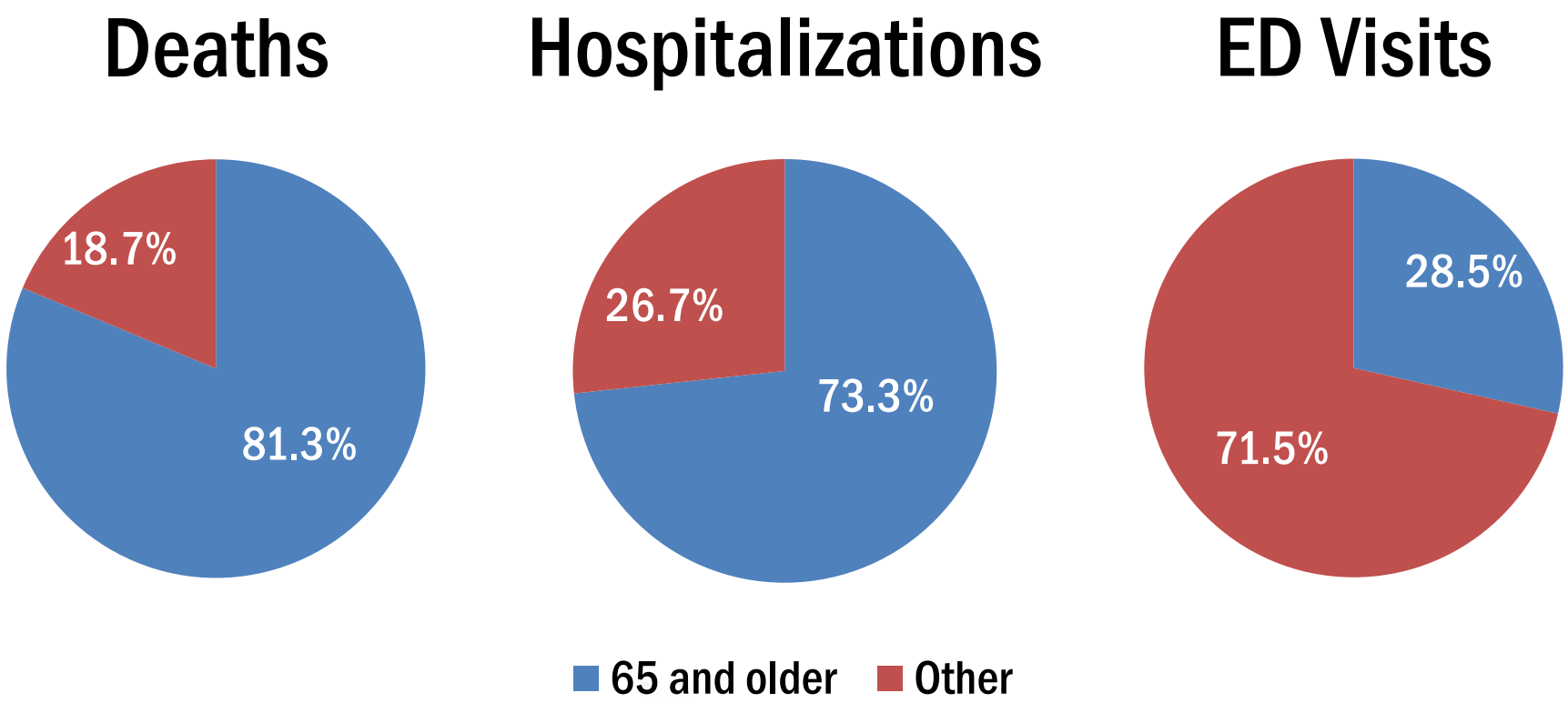
In 2017, 29.1% of fall deaths among this age group ***occurred due to bumping against an object*** while 6.6% occurred due to falling off stairs or steps. This information was unspecified or not known for 50% of fall deaths.

Older Adult Falls Special Emphasis Report



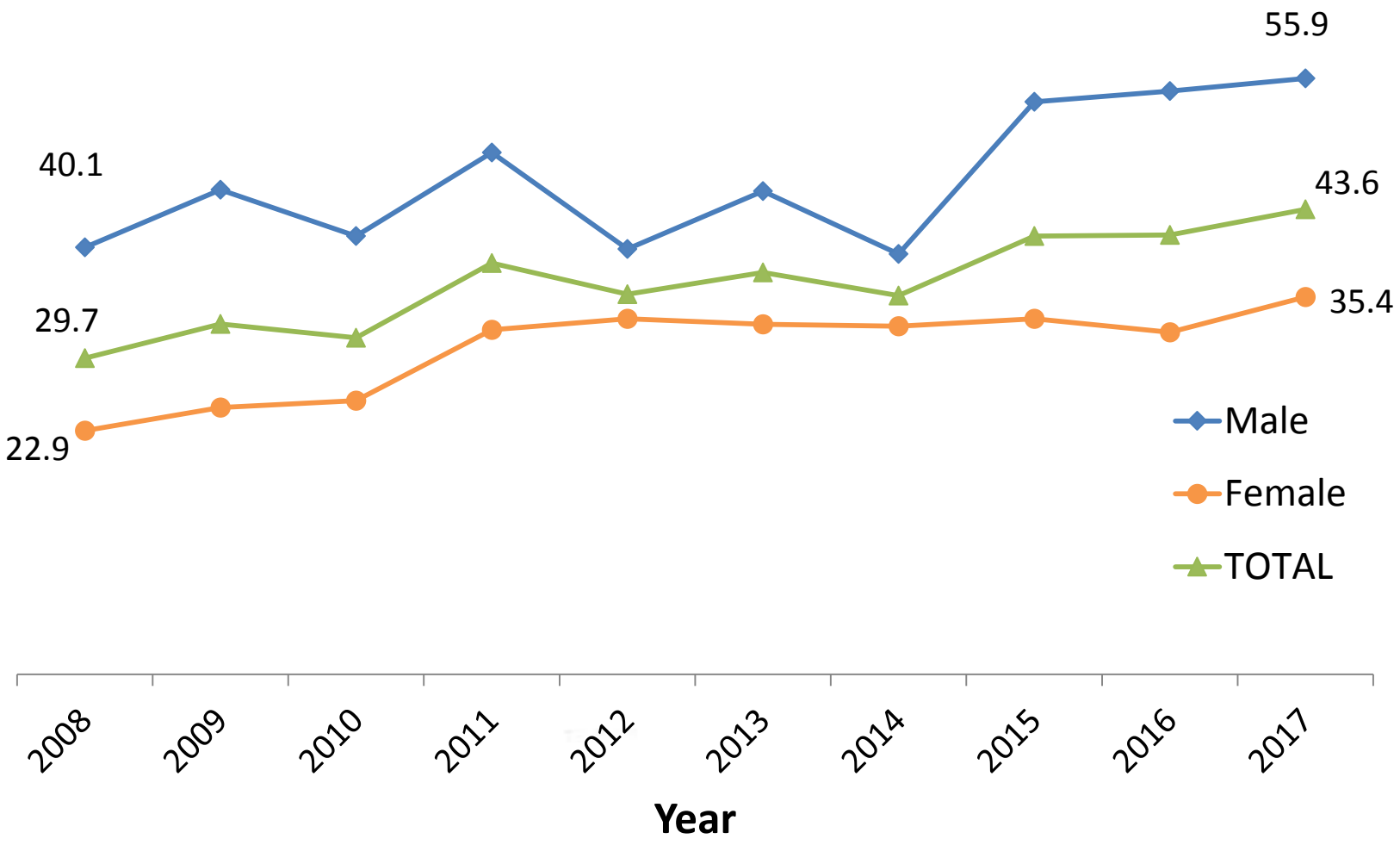
*Changes in reporting – transfers and deaths were removed

2017 Statistics

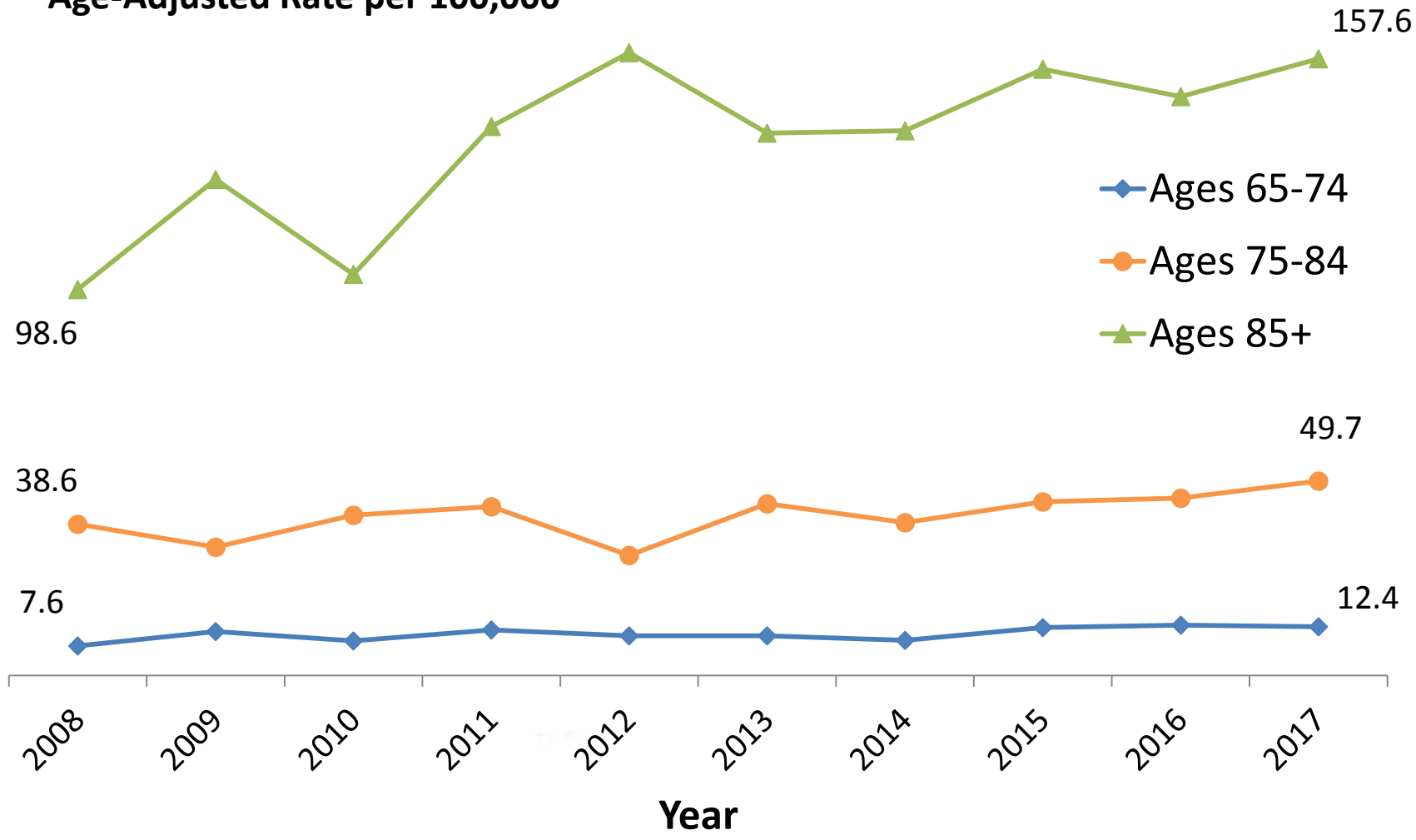


Fall Deaths, Ages 65 and older, 2008-2017

Age-Adjusted Rate per 100,000



Fall Deaths, Ages 65 and older, 2008-2017



Projected Lifetime Costs

	Number of Injuries	Medical Cost	Work Loss Cost	Combined Cost
Deaths	426	$10,296,000	$49,902,000	$60,198,000
Hospitalizations	12,855	$493,786,000	$357,780,000	$851,566,000
ED Visits	41,304	$125,481,000	$53,860,000	$179,341,000
TOTAL	55,422	$632,106,000	$462,634,000	$1,091,105,000

Hospitalizations account for 78% of projected lifetime costs of older adult falls

Source: http://www.cdc.gov/injury/wisqars/

Special Emphasis Reports

INDIANA

Special Emphasis Report: Infant and Early Childhood Injury, 2016

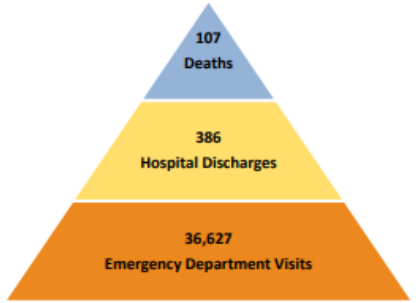
Injury is a Leading Cause of Death in Children

By the Numbers

Injuries are a major public health problem across the United States and in Indiana. Injuries are not random events. They follow a predictable sequence of events and can be prevented using specific injury prevention strategies. In 2016, there were 107 injury-related deaths of children ages 0-5. 67 children were less than one year of age and 40 children were ages 1-5.

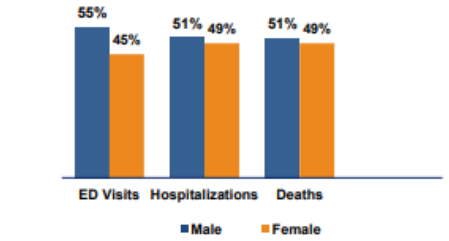
In addition to injury-related mortality, there were 386 hospitalizations and 36,627 emergency department (ED) Visits. Children who received treatment in physician offices or at home were not included in this frequency report.

Figure 1: Annual Injuries among Children Ages 0-5 Years, Indiana, 2016



For every child who died, more than three children were hospitalized and 342 were treated in emergency departments.

Figure 2: Percent of Injury Deaths, Hospitalizations and Emergency Department Visits among Children Ages 0-5 Years, by Sex, Indiana, 2016



*ED visits, hospitalizations, and mortality data are all based on ICD-10-CM diagnosis codes or ICD-10 underlying cause codes of unintentional and intentional injury for the calendar year 2016.This document was produced in conjunction with CDC's Core Violence and Injury Prevention Program under Cooperative Agreement 11-1101.

Childhood Injuries by Sex

Males consistently had higher percentages of injury-related ED visits, hospitalizations, and deaths than females of ages 0-5 in Indiana and accounting for a larger number of injuries overall. When observing more specific age categories among Indiana children ages 0-5, female deaths were higher than males among children ages 1-5 and hospitalizations were higher in females than males among children younger than 1.

Indiana State Department of Health

Indiana

Special Emphasis Report: Traumatic Brain Injury 2017

Understanding TBI

Traumatic brain injury (TBI) is a serious public health problem in the United States. A TBI is caused by a bump, blow, jolt or penetration to the head that disrupts the normal function of the brain. Each year, traumatic brain injuries contribute to a substantial number of deaths and cases of permanent disability.

Impact and Magnitude of TBI

During 2017, a TBI was sustained by more than 33,000 people in Indiana. Among those injured, 1,316 (18.9 per 100,000) died where TBI was reported as a cause of death on the death certificate alone or in combination with other injuries or conditions; another 6,681 (93.4 per 100,000) were hospitalized with a TBI alone or in combination with other injuries or conditions; and an additional 25,198 (384.0 per 100,000) were treated and released from emergency departments with a TBI alone or in combination with other injuries or conditions. An unknown number of individuals sustained injuries that were treated in other settings or went untreated.

Causes of TBI

Cause of injury varies across the three levels of severity. Suicide was the leading cause of injury among those who died where TBI was reported as a cause of death on the death certificate alone or in combination with other injuries or conditions. Unintentional falls was the leading cause of injury among those who were hospitalized with a TBI alone or in combination with other injuries or conditions. And, unintentional falls was the leading cause of injury among those who were treated and released from emergency departments with a TBI alone or in combination with other injuries or conditions.

Notes: Firearm-related injuries were reported but excluded from the etiology graphic due to overlap with multiple categories (e.g., homicide/assault, suicide). Firearms were related with 619 deaths, 89 hospitalizations and 33 emergency department visits. Completeness of external-cause coding for TBI-related cases can impact the accuracy of the cause classifications for hospitalizations and emergency department visits.

Figure 1: Percentage of Annual TBI-Related Deaths, Hospitalizations and Emergency Department Visits (by External Cause) in Indiana, 2017

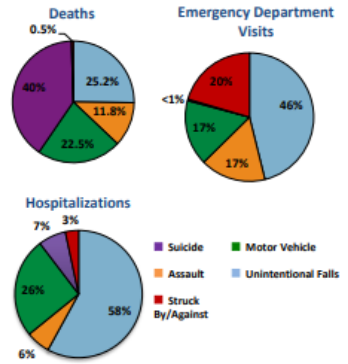
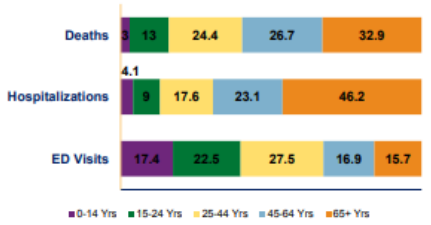


Figure 2: Percentage of Annual TBI-Related Deaths,* Hospitalizations** and Emergency Department Visits,**by Age, in Indiana, 2017



TBI by Age

The highest number of TBI-related deaths* were among persons ages 55-64. Among those with TBI-related hospitalizations,** persons ages 75-84 were most affected. Persons ages 15-24 made the most TBI-related emergency department visits.**

*TBI was reported as a cause of death on the death certificate alone or in combination with other injuries or conditions.
** TBI alone or in combination with other injuries or conditions.

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https://www.in.gov/isdh/25396.htm

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Indiana State Department of Health

Injury Prevention Program Development

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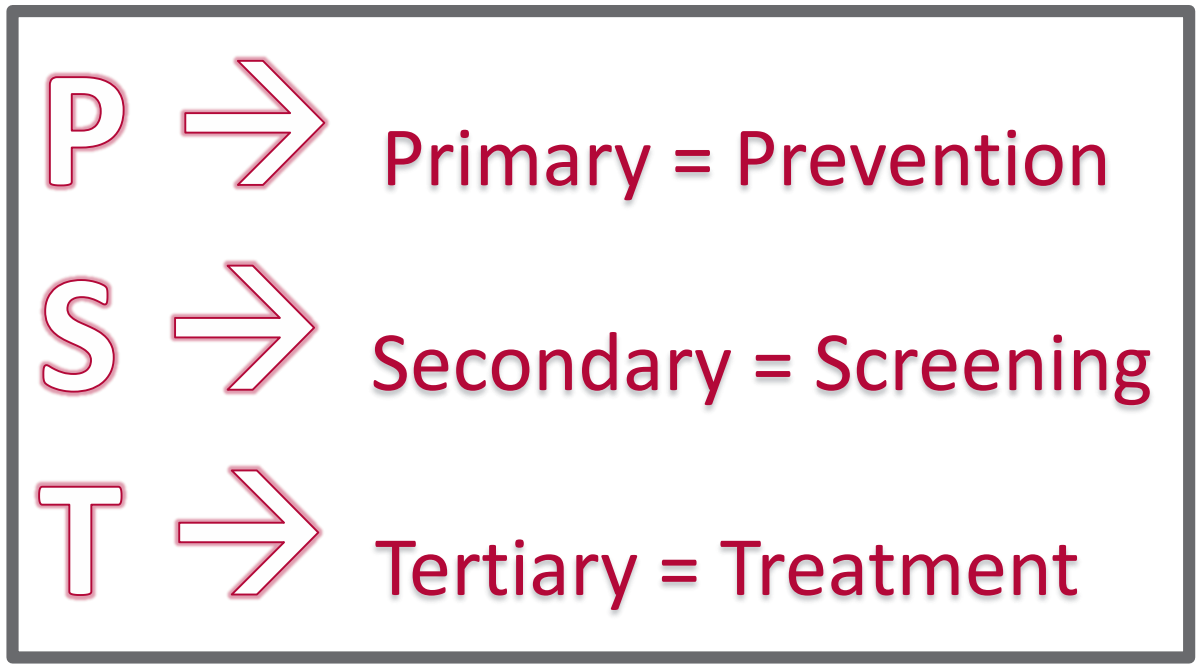
Methodist Hospital

Presentation Overview

- What is Prevention?
- How to Pick a Program
- Public Health Approach
- Examples

Prevention Continuum



Primary

- Intervening before disease or injury occurs
- Altering risky behaviors, vaccinations, or banning substances
- Prevention

Secondary

- Screening before signs and symptoms set in
- Mammography or regular testing
- Early Intervention

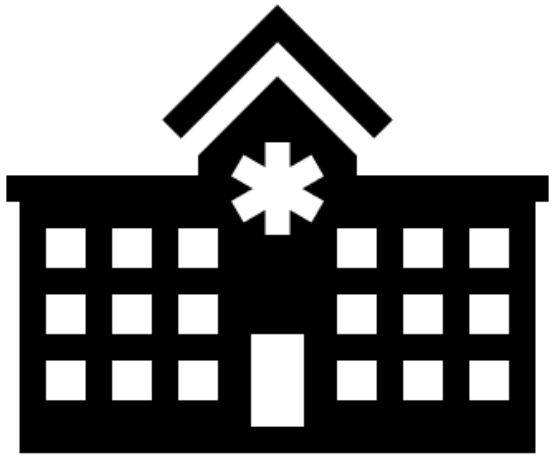
Tertiary

- Managing disease or injury
- Stop the Bleed, treatment, or screening for complications
- Response

Determination of Program

- Epidemiologic Data
  - Your data
  - Government
  - Healthcare
- Passionate Issue
  - Sentinel events
  - Political momentum
  - Pain points
- Funding Opportunities
  - Grants
  - Marketing
- Requirements
  - Verifications

Our Program Drivers



- American College of Surgeons
  - Trauma Center Verification Requirements
    - Top mechanisms of Injury
    - Evidence based risks
- Epidemiological Data
  - From registry
  - Geographic orientation
  - Root cause
- Sentinel Events
  - Engaging topics

Public Health Approach

The Problem

- A health problem
- Issue that is of interest

Risk and Protective Factors

- Eliminate or decrease risk factors
- Increase or promote protective factors
- Not always obvious or directly health related

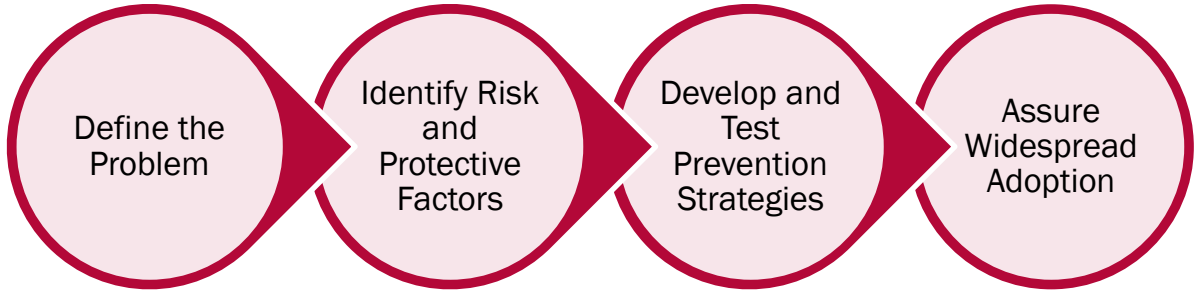
Prevention Strategies

- Don't reinvent the wheel
- Promising or proven
- Data, Data, Data!

Adoption

- Practitioners
- Recipients

Hypothetical



The Issue

- Sentinel event or chronic issue
- College Transition Safety or Senior Falls

Risk or Protective Factors

- College Transitions – Substances, personal safety, mental health, buddy system, laws
- Falls – home hazards, vision, nutrition, acute or chronic health issues

Prevention Strategies

- College Transition – youthful presenters, lived experience, interactive
- Falls – Stepping On, STEADI Toolkit, home checklists, coalition approach

Adoption

- College Transition – changes in behavior, trends or laws
- Falls – Decrease in falls or injuries due to falls

Identify the problem

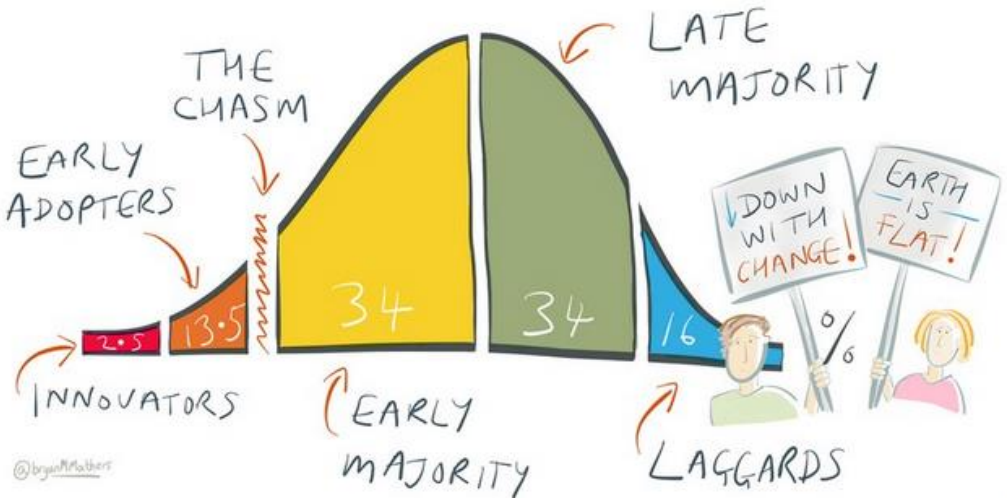
You need to care

- Frontline capacity
- Sources
  - Sentinel case(s)
  - Turn to your run data
  - Community or regional data
- Collect data relevant to you and your stakeholders
  - Define the population
  - Identify data sources
  - Identify stakeholders

Identify Risk and Protective Factors

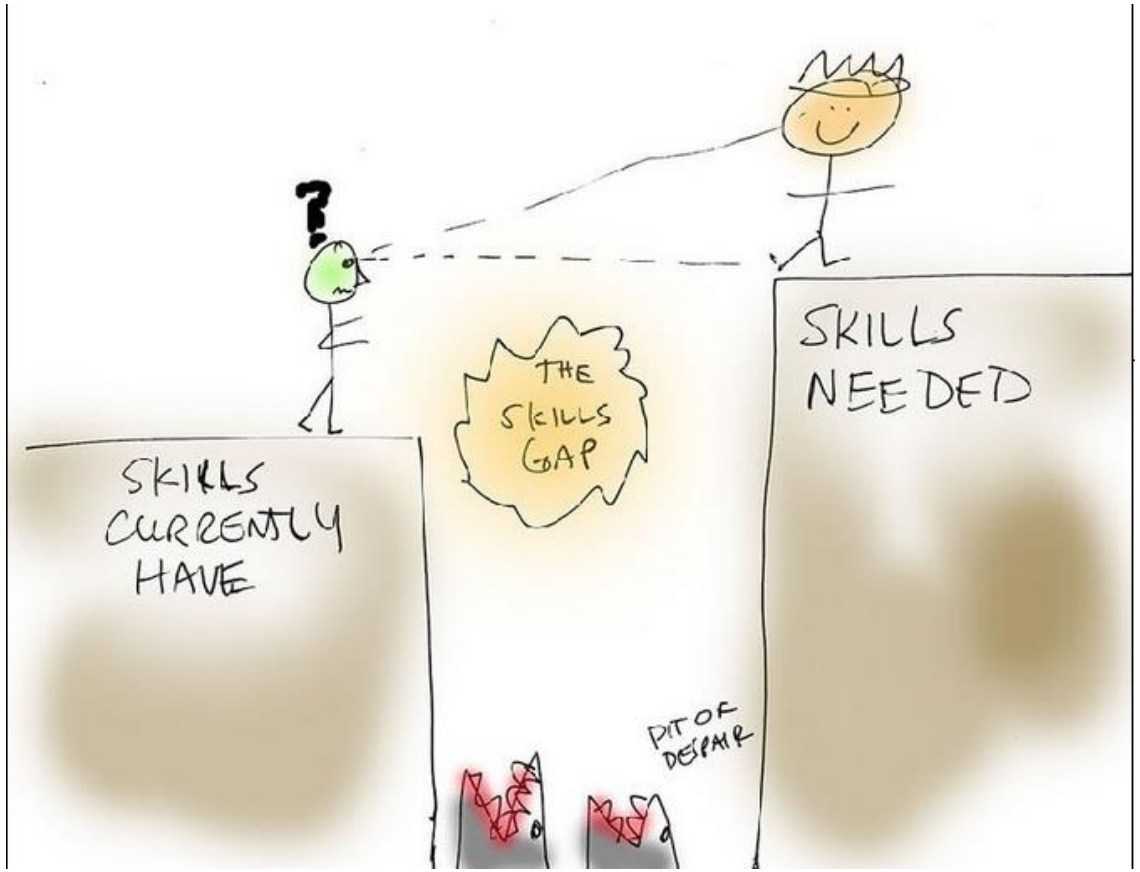
- Read up
- Review data available
  - Trauma Registry
  - Indiana Statistics Library – by topic!
  - SAVI
  - Stakeholders
- Ask
  - Who is in contact with the problem?
  - Take time to gather qualitative data from the source
    - Ask about both risk and protective
  - Student resources

Adoption



- Remember to maximize
  - Identify the level of the risk or protective factors in question
  - What level can you impact?
  - Data!
- Evaluate
  - Reevaluate
  - Schedule evaluation
  - Not punishment
  - Don't waste time
- Tie to purpose

Areas of Knowledge



- Need to recognize skills used and skills offered
  - Personal Injury Prevention & Role Modeling
    - "Superusers" of safety
  - Injury Risk Identification
    - Recognize risks and hazards
  - Data and Process Improvement
    - Get to know relevant data/source material
    - Feedback loop if possible
  - Liaising
    - Partners
    - Audience
  - One-on-One Safety Education
    - Interpersonal communication
    - Nonjudgmental & timing skills

Stepping On

- Stopping Elderly Accidents, Deaths, and Injuries
- 2 minute assessment
  - Have you fallen in the past year?
  - Do you feel unsteady when standing or walking?
  - Do you worry about falling?
    - A yes answer to just 1 of the above indicates increased risk of falling
- Toolkit already developed for distribution
  - Brochures
  - Safety Checklist
  - Postural Hypotension Brochure
  - Chair rise Exercise
- Endorsed and Promoted by ISDH

ThinkFirst for Teens

- Second Mechanism
- Young adults engage in at-risk behaviors
  - Brain and Spinal Cord focus
- Evidence based
  - VIP speaker
- Plug-and-chug
  - Whole days of classes
- Partners by topic
  - Neurology

Stop the Bleed

- Tertiary prevention
- Evidence based
- LOTS of partners
  - Legislative backing
- Data driven in audience choice
  - First responders
  - Project LIFE

Rachael's First Week

- Sentinel Event
- Independent program
  - Natural affiliation
- "Enhancing their decision-making skills as they transition into young adult men and women."
- Addresses risk and protective factors
- www.rachaelsfirstweek.org

Intentional Injury

- Violence is our 3rd mechanism
  - On the rise
  - Passionate Issue
- IPV is under-documented and not always physical
  - Sentinel event: Beth's Legacy of Hope
- Come back in November for in depth presentation
  - Project LIFE

Questions/Comments/Concerns

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“ A Day In The Life Of…”

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Lutheran Children’s Hospital/Pediatric Injury Prevention
Michelle Stimpson, RN, Adult Injury Prevention Coordinator

Lutheran Health Network

GOAL

- Increase awareness of job focus as Adult and Pediatric Injury Prevention Coordinators at Lutheran Hospital, Fort Wayne, Indiana (Level II Verified Adult/Pediatric Trauma Center)

Disclaimer:

- We have no financial ties to the items or information we are about to relay

Background

- Who are We
- How did We get here

Pediatric & Neonatal Transport

Lutheran Children's Hospital ER

ER Prize Closet

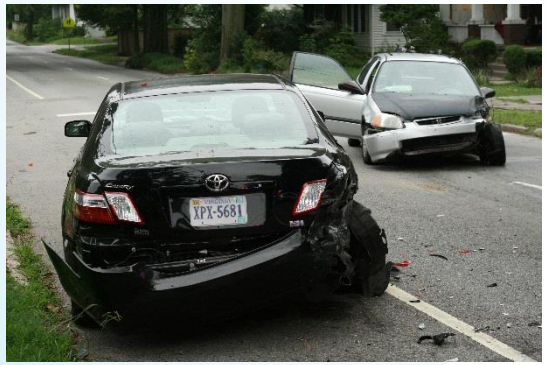
Small, plastic toys & stuffed animals needed

Injury Prevention

- “Oh yeah – we went through that with my Grandma…”
- “That will never happen to me! “
- We never used Car Seats!

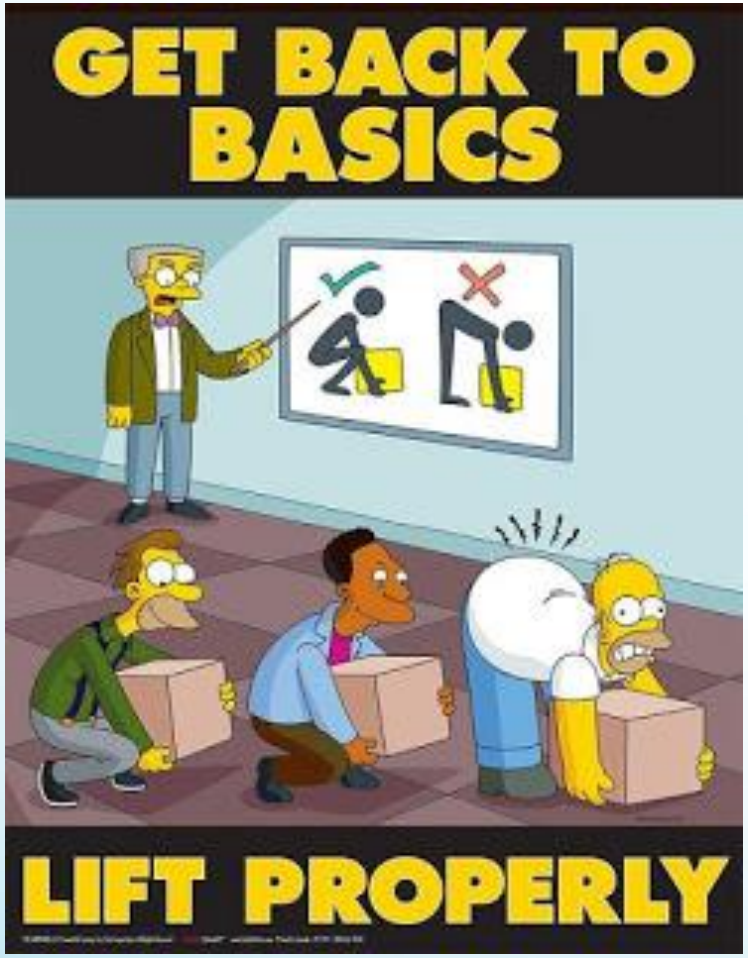
Family/Social Life

On the GO!!!



Things Happen!!

Roles/Responsibilities



- Education
- Outreach

IDENTIFY

- Identify Top Mechanisms of Injury (Based on ACS requirements)
- Looking for “keys” (not as in car !)

Some Fatal Facts

- Falls
- Motor Vehicle Crashes

Annual report compiled from trauma patients placed on registry

Pediatric MOI

1. Falls
2. Motor vehicle Injuries
3. Infant Suffocation related to Sleep Surface
4. Bicycle Injuries
5. Natural/Environmental Factors

Outreach

- Patients/Families
- Community Events
- Schools
- Church Groups
- Health Fairs
- Senior Expos
- Safety Fairs

Pediatric Outreach

- Baby Fair and Family Expo
  - Safety House: Each “room” addresses safety issues often associated with that room or area
- Doctor Day at Science Central
  - Hands on activities related to one of our top MOI
  - Car seat education
  - Teddy Bear Clinic
  - On stage activities

Pediatric Outreach

- Fort 4 Fit
  - Bi-weekly rallies include some aspect of injury prevention
- Safe Sitter
- Jefferson Pointe Safety Day
  - Button Battery Safety
  - Halloween Safety
  - Check Up Car Seat Event
  - Concussion Game

Pediatric Outreach

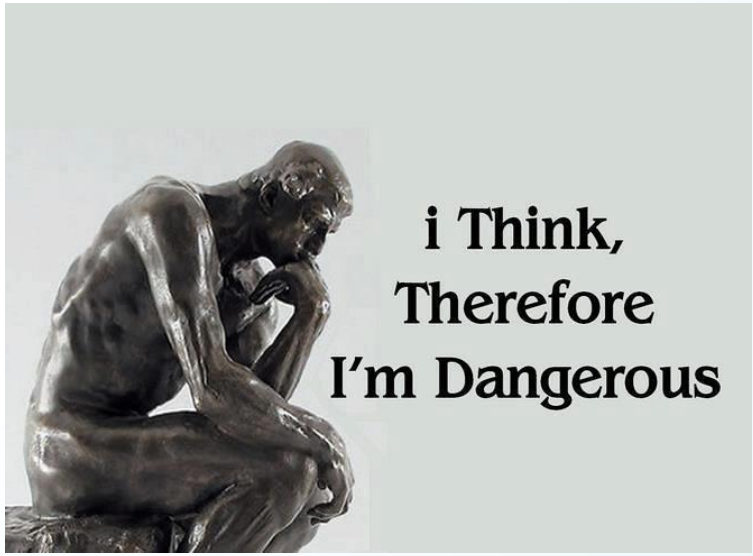
- Car Seat Program
  - Permanent Fitting Station
  - Network-wide education for staff
  - Annual competencies
  - Orientation education
  - Annual ASP Refresher Course
  - Annual CPST course
  - Community Education

Safe Sleep Program

- Part of state Cribs for Kids program- status of program unknown at this time
- Continued education for parents and provision of sleep sacks, board books, pacifiers
- Participate in program for parents working to regain custody of children; sleep program part of requirements
- Community requests for injury prevention education

Education

- Fall Prevention
- SBIRT
- Medication Awareness
- Better Prepared
- Distracted Driving/
  Safe Driver Course
- Stop the Bleed



**Several topics that transpire from the core focus determined by the Mechanism of Injury report

Pediatric Education

- Bi-monthly newsletter
  - Articles related to MOI
  - Information suggested by staff
  - Distributed throughout network
- Pediatric injury prevention included each year for monthly LCH grand rounds
- Safety tips posted in pediatric areas, parent lounges
- PFW Guest lecturer on Child Maltreatment

Additional Involvement

- Marketing/Outreach Groups
- District 3 Hospital Coalition
- Serve as Hospital Alternate to our coalition representative
- ATLS Coordinator

**Enhances opportunity for growth in community, networking, educational opportunities

Pediatric

- Kids Dart Drive Smart Campaign
- Coordinator for Safe Kids Allen County
- Child Passenger Safety Technician Instructor

Putting it all together

- Always trying to add and adjust to current events. What can be added to help further “prevent” injury to all around us. Bringing the thoughts to the for front of our mind.
- Promote HEALTH!

RESOURCES

- American College of Surgeons
- Lutheran Hospital Injury Prevention Program
- Google (for all of the fun pictures!)
- Safe Kids Worldwide
- American Academy of Pediatrics

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Thanks for joining!

Feel free to invite new attendees for the next meeting, November 15th!

Indiana State Department of Health