**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, March 15, 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


- Injury Prevention at your fingertips
- 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

**Katie Hokanson,** *Division Director*

Indiana State Department of Health

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

# Division staffing updates

- Keifer Taylor
  - NVDRS Abstractor

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# Upcoming Events

- 2019 Trauma Symposium
  - March 16
  - Elkhart General Hospital
- EMS Medical Director's Conference
  - April 16
- Child Passenger Safety Conference
  - June 4

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# ISTCC/ITN Meeting Dates

- Indiana State Trauma Care Committee, Indiana Government Center, 10 am EST
  - April 26th
  - June 21st
  - August 16th
  - October 11th
  - December 13th
- Indiana Trauma Network, Indiana Government Center, 12:30 pm EST
  - April 26th
  - June 21st
  - August 16th
  - October 11th
  - December 13th

# 2019 IPAC/INVDRS Meeting Dates

- May 17th
- July 19th
- September 20th
- November 15th

Indiana State Department of Health



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

# Opioid-related webcasts

Schedule for 2019:

- Bimonthly; second Tuesday
- Check back on our website for more info: https://www.in.gov/isdh/27756.htm

Indiana State Department of Health

# Division grant activities

- Administration for Community Living (ACL) – Evidence-based Falls Prevention Program
  - Applied for grant
- Centers for Disease Control (CDC) - Overdose Data to Action
  - In the process of applying

# Coroner Grant Opportunity Announcement

**Completed Grant Application Due: Proposals are to be submitted via e-mail to indianatrauma@isdh.in.gov before March 15, 2019. After March 15, remaining funding will be available to all counties and awarded on a first come, first served basis through September 30, 2019.**

Notice of Award: Respondents will be notified of results no later than 10 business days after receipt of their application.

## Eligibility:

- Respondents must be the county coroner or a designated representative from the coroner's office.

---

- If you have a data sharing agreement with ISDH to supply Indiana Violent Death Reporting System (INVDRS) cases and overdose cases and have not provided the requested reports to ISDH, you are not eligible for this grant. Once records have been received and you have been given a confirmation email, funding will be released for your county.

## Respondent Participation Guidelines:

- If the awardees point of contact changes anytime during the grant program, the awardee must notify the ISDH within 5 business days after the change and provide the contact information for the new contact.
- Must submit data through the Coroner Case Management System.

## Service Delivery Dates:

The services requested will be implemented during the proposed period of January 1, 2019 through September 30, 2019. Failure to comply with all terms of this grant by an awardee will also halt any future unshipped supplies.

Failure to comply includes:

- Not submitting required reports through the Indiana Coroner Case Management System within the required time period.
- Reports having an average of 75% or less validation in the Indiana Coroner Case Management System.
- Selling the supplies instead of using them as outlined in the application.

## Written Proposal Requirements:

1) Cover sheet with:
   a. Name, title, email address and phone number of primary contact.
   b. Name, title, email address and phone number of secondary contact.
   c. Information about eligible county, including:
      i. County Name.
      ii. Mailing address.
      iii. Work phone.
      iv. Cell phone.
      v. Email address.
2) Cover letter expressing interest in receiving supplies.
3) Narrative to include:
   a. List of supplies requested.

## Instructions:

The proposal in its entirety, including all supplemental information, **cannot exceed three (3) pages with one-inch margins, double spaced, and Times New Roman 12-point font.** Applications that do not fully comply with these requirements will be considered non-responsive and will not be considered in the review process.

## Selection Process:

1) Following the application deadline, each proposal will be examined to determine compliance with the format and information requirements specified in the GRANT OPPORTUNITY ANNOUNCEMENT. Incomplete proposals or those that do not fully comply with the requirements stated above will not be considered.
2) Proposals will be evaluated on the basis of the criteria outlined and the best overall compatibility with the intent of the GRANT OPPORTUNITY ANNOUNCEMENT. Additional evaluative weight will be assigned based on:
    a. Any other criteria set out in the GRANT OPPORTUNITY ANNOUNCEMENT or otherwise reasonable and considered relevant.

## Delivery of the Supplies:

Once the coroner's application has been approved, supplies will be ordered through the state's procurement process and sent to the coroner's office. The supplies will be broken into two shipments.

- 1/2 shipped February 15, 2019 – May 30, 2019.
- 1/2 shipped June 1, 2019 – September 30, 2019.

## Reporting Requirements:

Award recipients will be required to submit overdose and violent death cases through the Indiana Coroner Case Management System. Failure to submit the required reports will be deemed a breach of the grant agreement and will be terminated. ISDH shall suspend or cancel the remaining supplies.

The cases will be required to be entered into the Coroner Case Management System within two months of the date of death.

# Intentional Injury Data Presentation: Homicide in Indiana

**Morgan Sprecher,** *INVDRS Epidemiologist*

Indiana State Department of Health

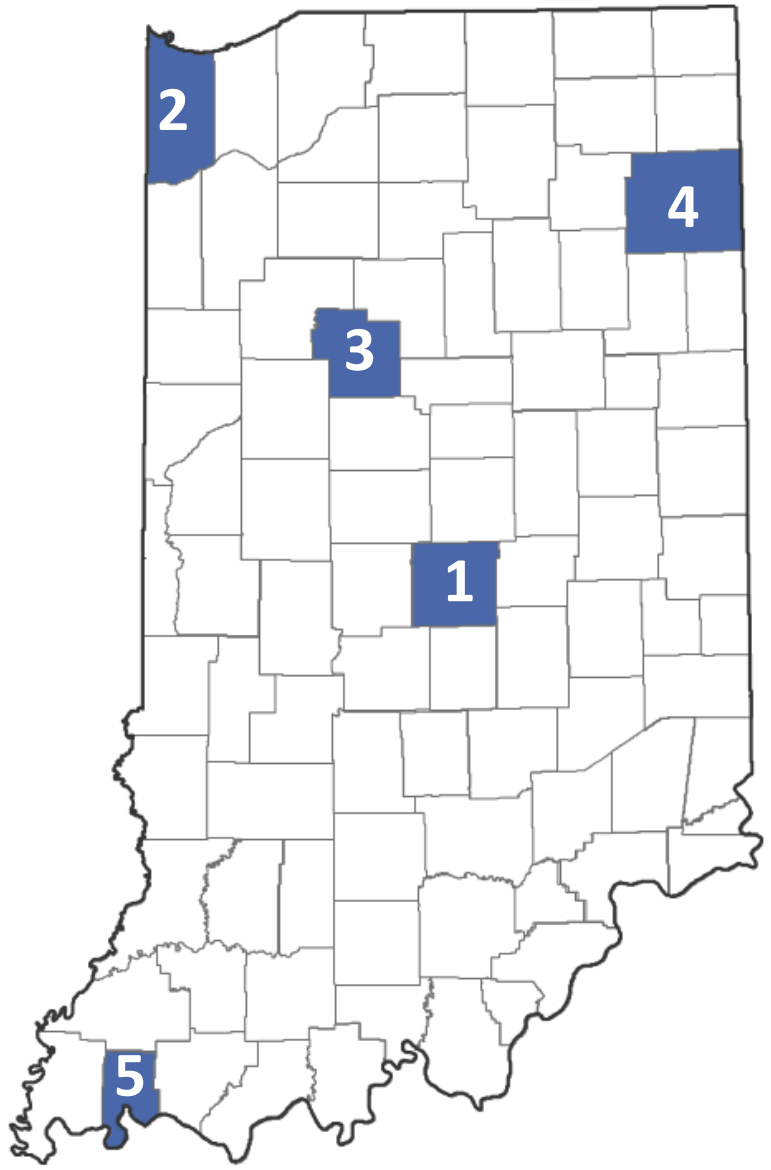
Email questions to: **indianatrauma@isdh.in.gov**

# The homicide rate in Indiana is DECREASING

| Year | Rate per 100,000 |
|---|---|
| 2016 | 8.3 |
| 2017 | 7.5 |
| 2018 | 6.8 |

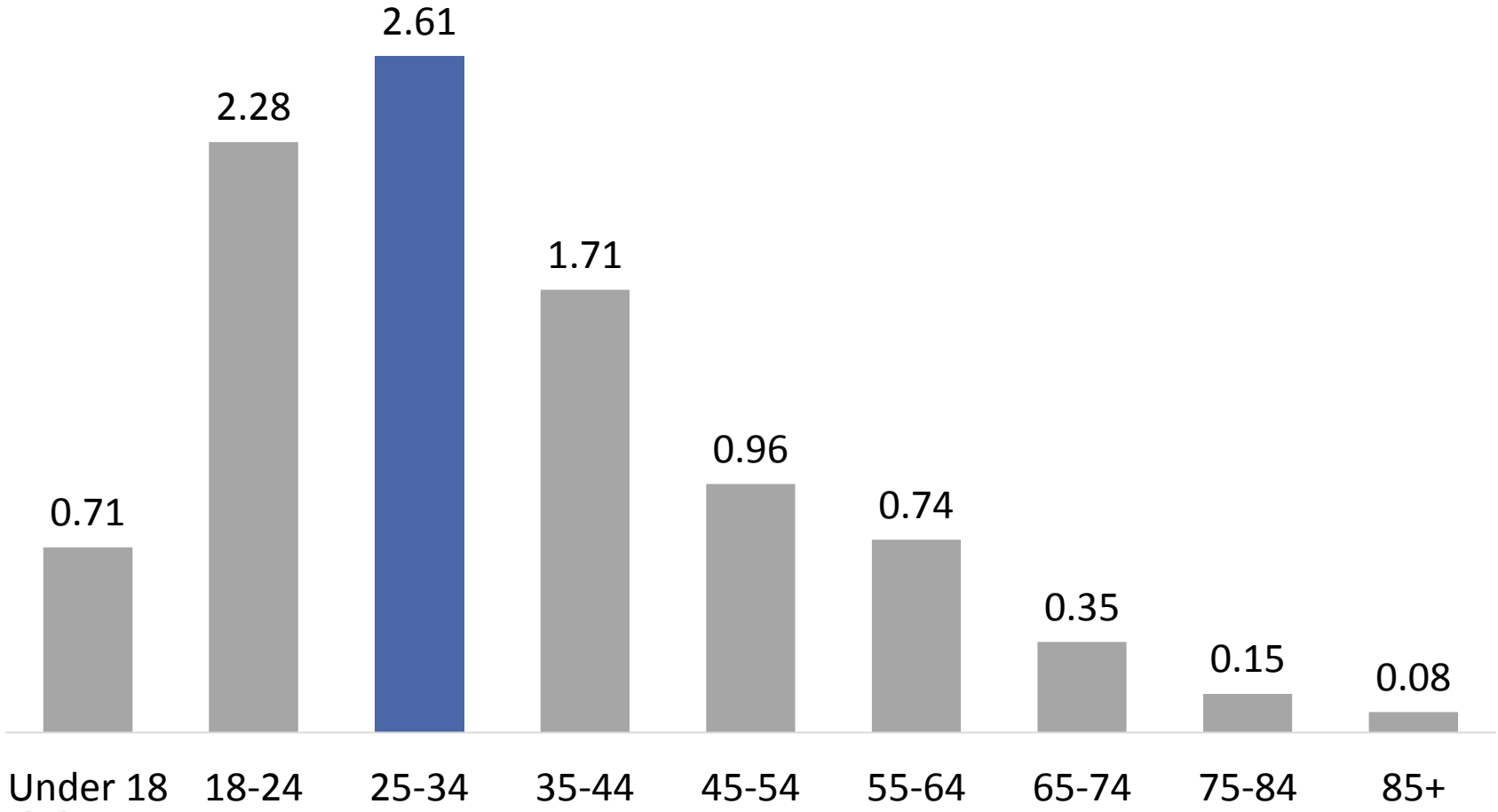
# Highest Homicide Rates (per 100,000) in Indiana, 2016-2018

1. Marion: 24.2
2. Lake: 18.9
3. Carroll: 18.4*
4. Allen: 14.3
5. Vanderburgh: 11.4



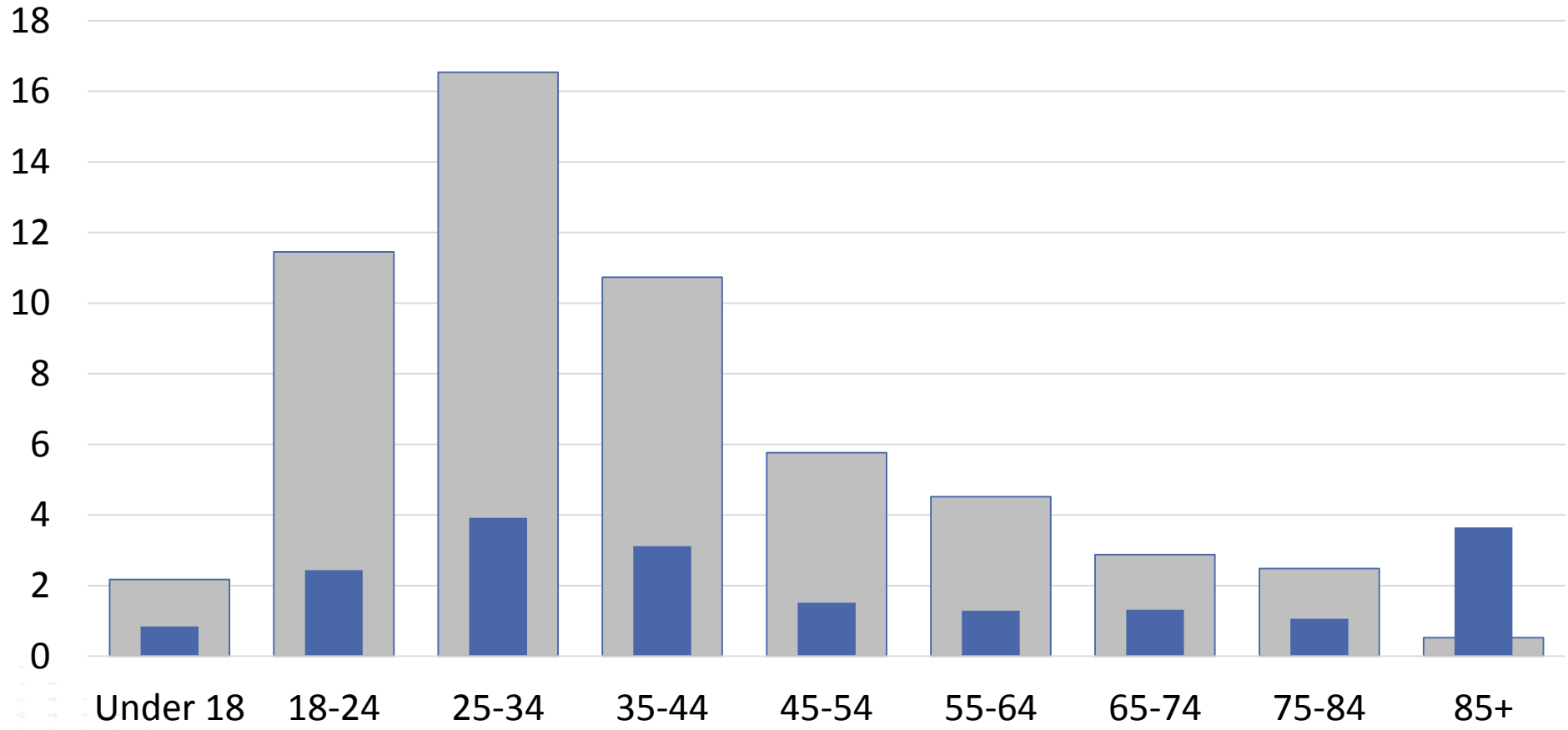

* rate considered unstable because there are less than 20 counts

# The homicide rate is highest for those aged 25-34 years old.



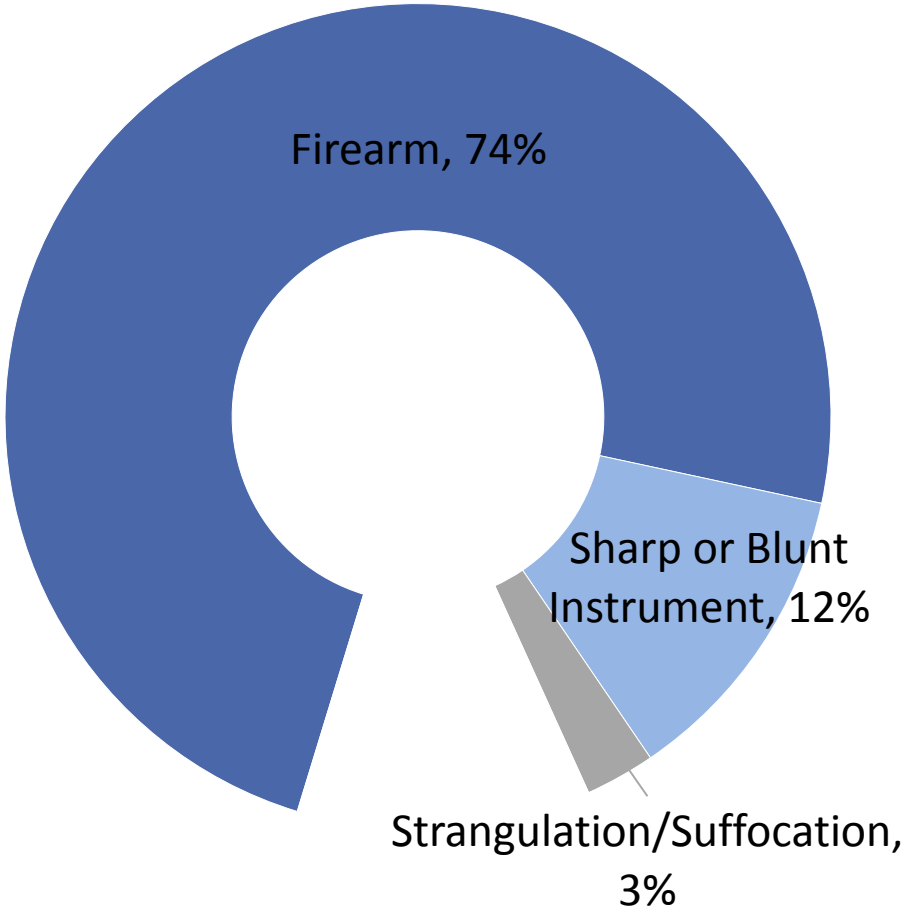

*per 100,000

# The homicide rate is higher for males than females in every age category except for those 85 years and older.

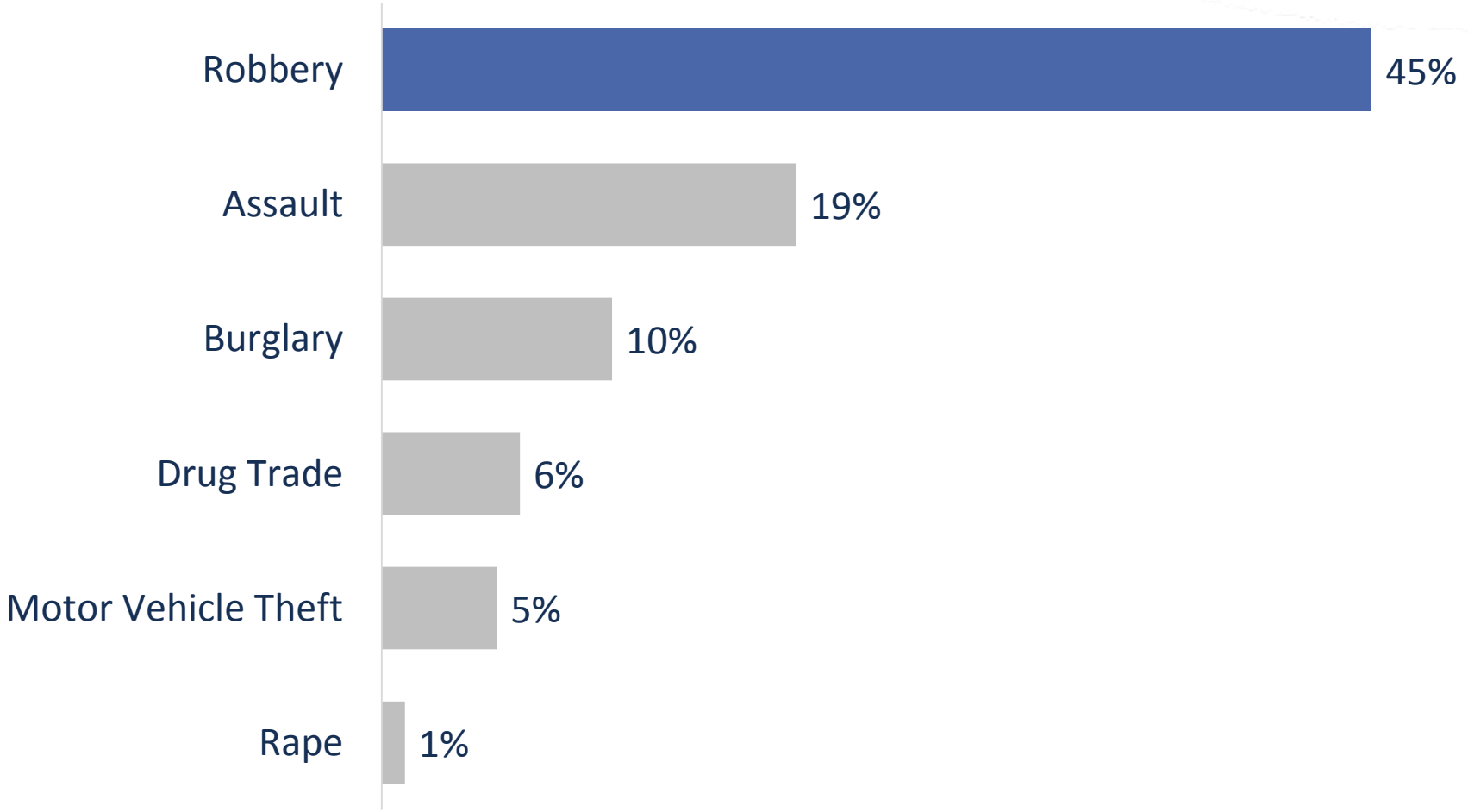



*per 100,000

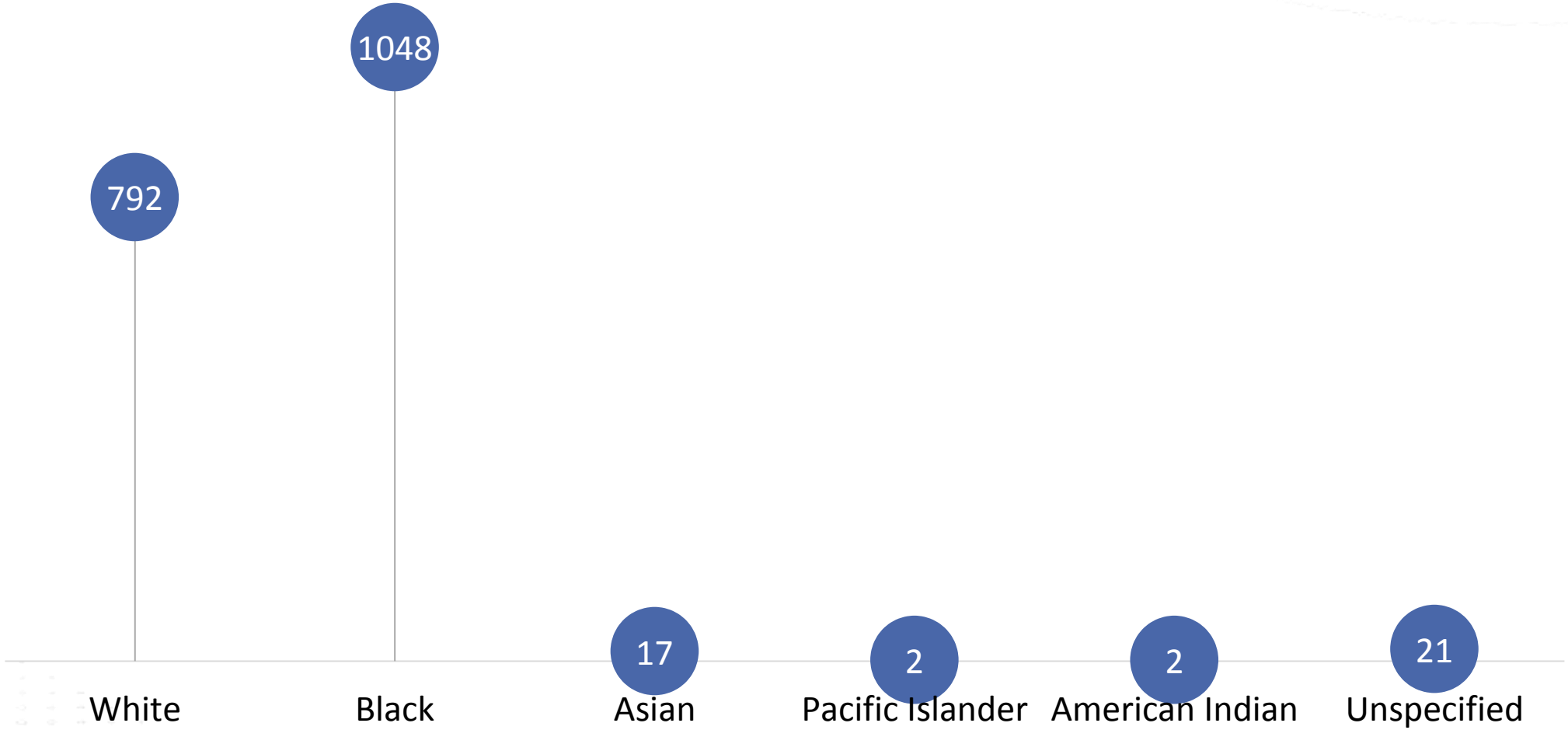
# Nearly three-quarters of homicide deaths are contributed to a firearm.



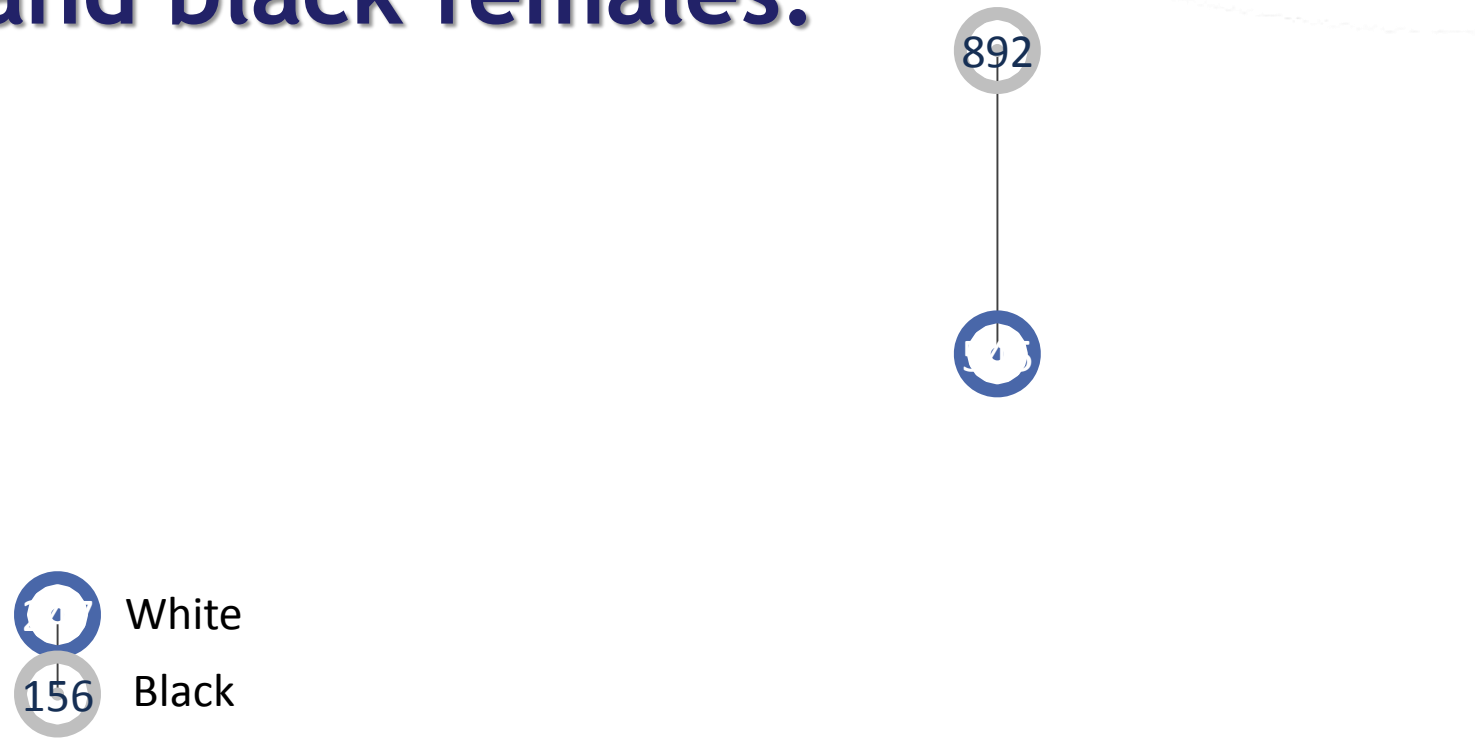
# Nearly half of firearm deaths are the result of a robbery.



# Black Hoosiers account for the most homicide deaths seen from 2016-2018.



# There is a larger disparity of homicide deaths between the white and black males compared to the white and black females.



## Intentional Injury Prevention Program Spotlight:

# Indiana State Homicide Reduction Plan

**Morgan Sprecher,** *INVDRS Epidemiologist*

Indiana State Department of Health

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

# Lethality Assessment Project

1. What It Is
   - Started in 2009 via Indiana Coalition Against Domestic Violence
   - Collaborative partnership between law enforcement and victims of domestic violence
   - Connect individuals determined to be at high risk into domestic violence shelters/programs when the first call is made

# Lethality Assessment Project

2. Goals
   - Prevent domestic violence homicides, serious injury, or re-assault
   - Encourage victims to use shelters, counseling, advocacy, and support services

# What Causes Homicides?

## Family Level Risk Factors

- Child Maltreatment
- Toxic environmental chemicals

## Community/Social Level Risk Factors

- Feeling of disrespect
- Gangs
- Low-income or unemployed neighborhoods

# Early Prevention Strategies - Family Level

Home Visitation Programs

- Counseling and referrals
- Identification of parental competence
- Parent education about child development and parenting skills
- Track development of positive social skills, self-control, problem solving skills, and reduction of defiance/aggression
- Aimed for children 3 – 8 years old

# Early Prevention Strategies - Community/Social Level

CeaseFire

- Increase decision alternatives to violence
- Change the norms around violence
- Increase the perceived risks/costs to committing violence
- Strategies:
  - Street intervention
  - Client outreach by community members who monitored risky individuals
  - Public education campaigns
  - Increased police presence and prosecution for violent crimes

# Mixed Methods

1) Identify individuals who are high risk of perpetrating gun violence using police/criminal justice records
2) Deliver clear message to these individuals that they are being watched and will be targeted for federal prosecution if illegally possess or use guns
3) Encourage community to stay away from violence
4) Offer services to reduce risks (job trainings)

# 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

# Unintentional Injury Data Presentation:

# Unintentional Injury Deaths in Indiana

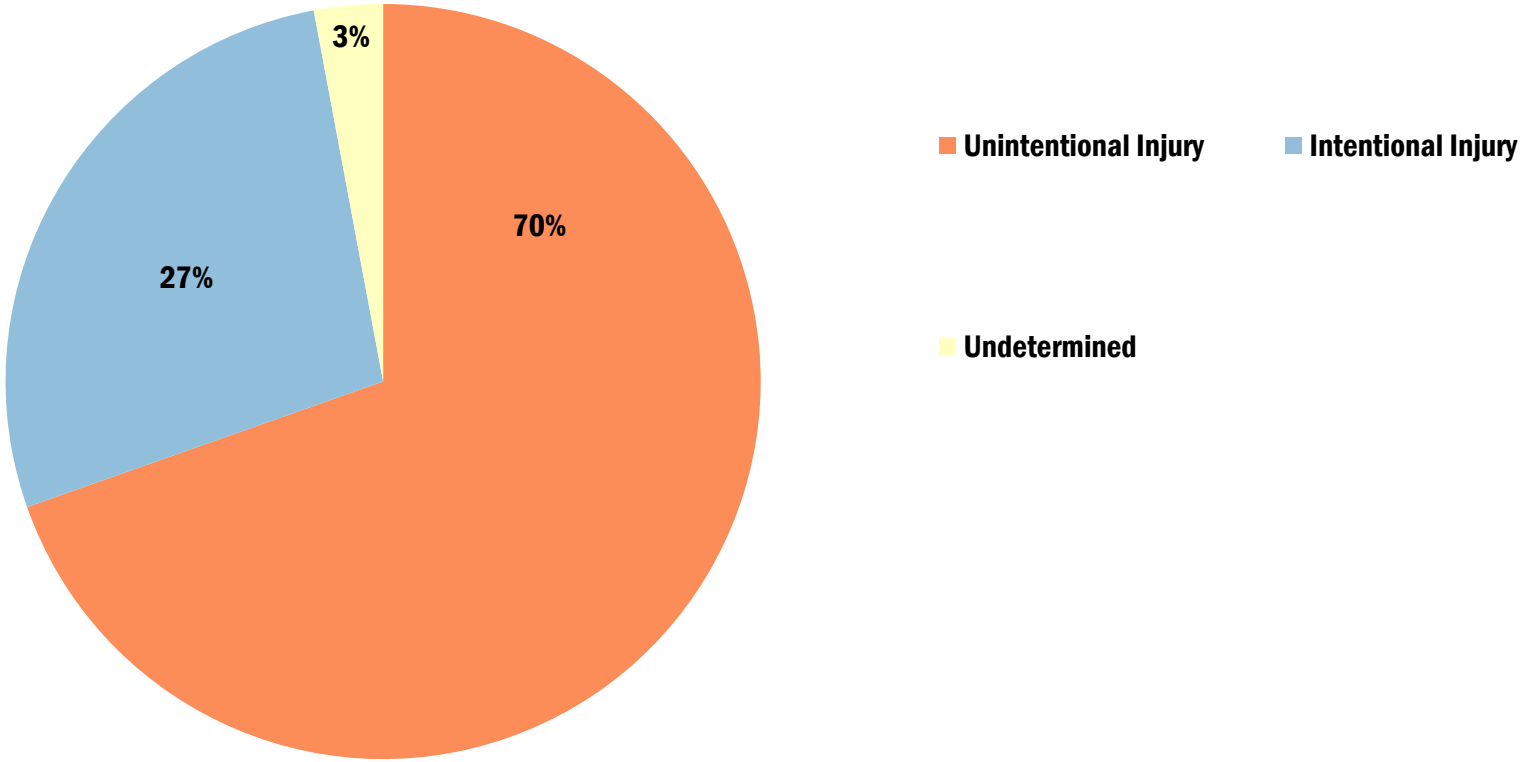
**Andzelika Rzucidlo,** *Injury Prevention Epidemiologist*

Trauma and Injury Prevention Division

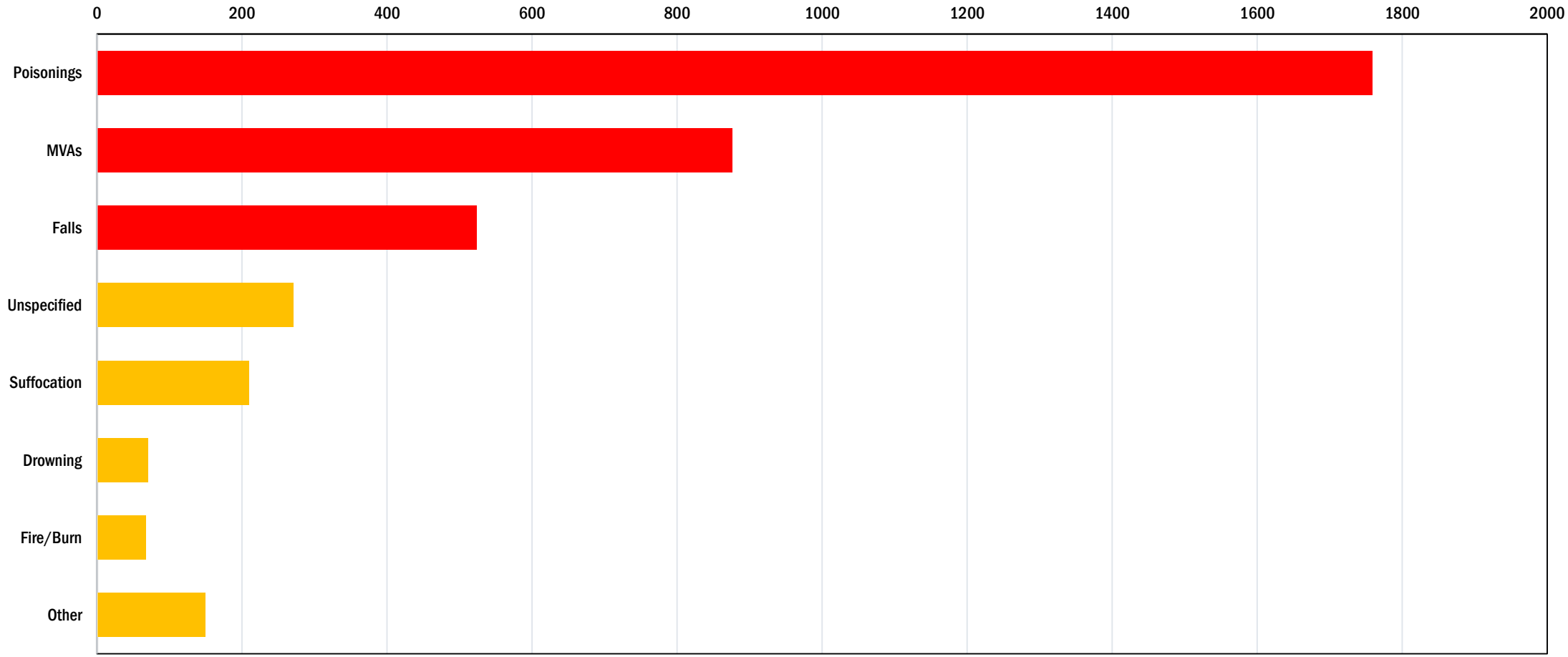
Indiana State Department of Health

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

# 70% of all injury-related mortality were unintentional in Indiana during 2017

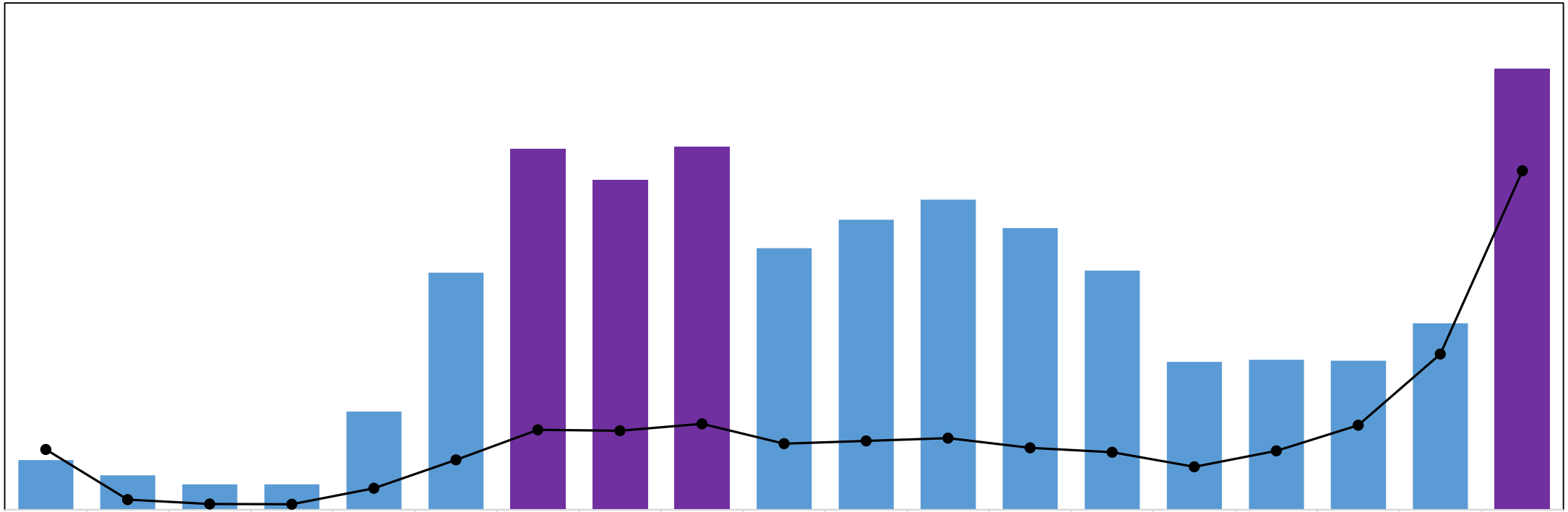


# Poisonings, traffic motor vehicle injuries, and falls were the top 3 causes of unintentional death in 2017



# Higher incidence rates and counts of unintentional injury occurred among Indiana residents ages 25-39 and 85+ in 2017

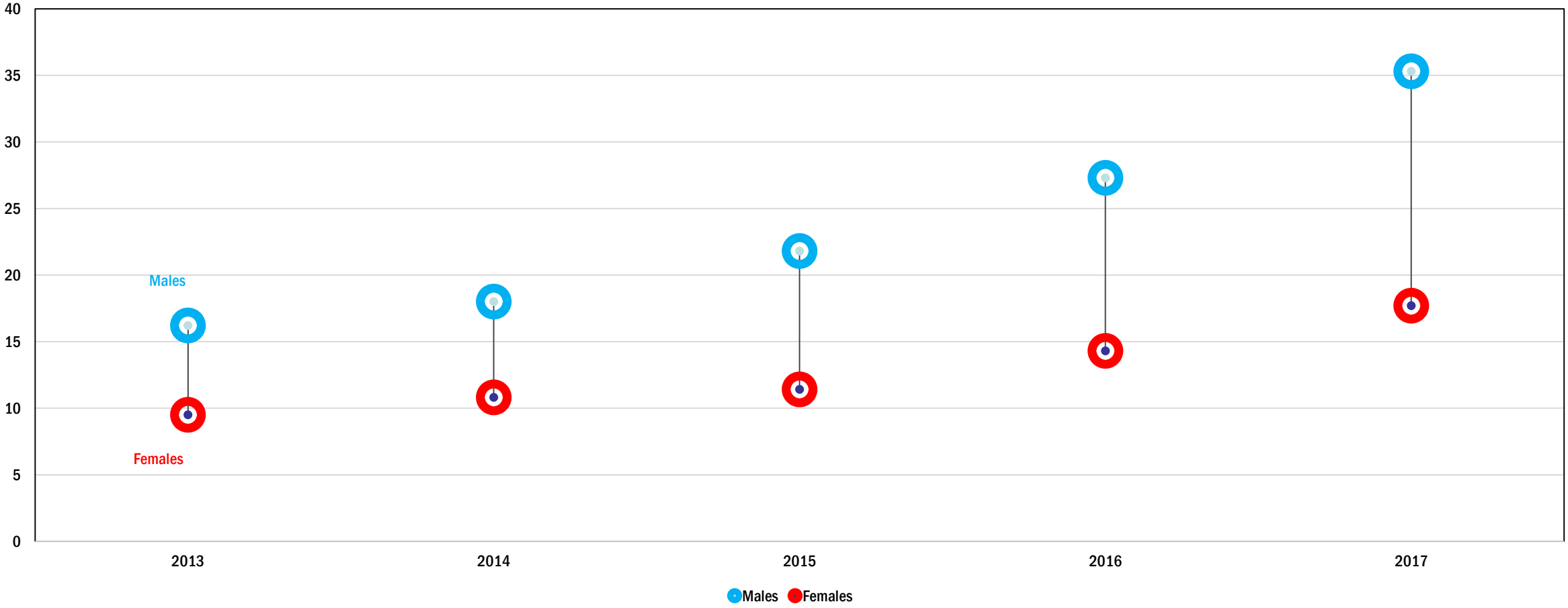
**Rate per 100,000 people**



| | 00-01 | 01-04 | 05-09 | 10-14 | 15-19 | 20-24 | 25-29 | 30-34 | 35-39 | 40-44 | 45-49 | 50-54 | 55-59 | 60-64 | 65-69 | 70-74 | 75-79 | 80-84 | 85+ |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Count | 49 | 34 | 25 | 25 | 97 | 234 | 356 | 325 | 358 | 258 | 286 | 306 | 278 | 236 | 146 | 148 | 147 | 184 | 435 |
| Rate | 59.42 | 10.04 | 5.79 | 5.60 | 21.22 | 49.30 | 78.83 | 77.90 | 84.91 | 65.29 | 67.92 | 70.61 | 61.08 | 56.81 | 42.43 | 58.07 | 83.46 | 153.64 | 334.46 |

# Unintentional drug poisonings have increased for both males and females, but males have increased at an exponentially greater rate

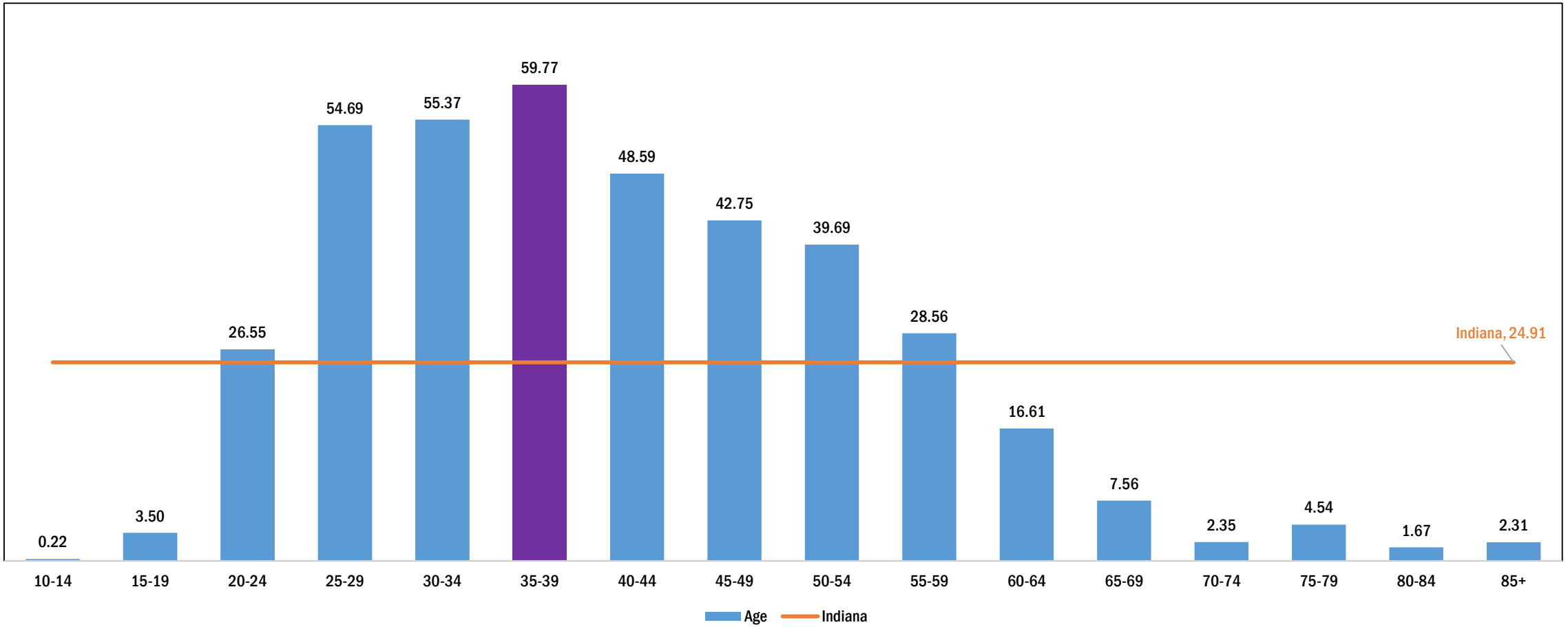
Age-Adjusted Rate per 100,000 people




*Please note: The drug rates presented here consist of rates for unintentional drug poisonings and should not be compared to overall drug overdoses rates.

# Unintentional drug poisoning is higher among those ages 20-59 with the highest rate among 35-39 year olds

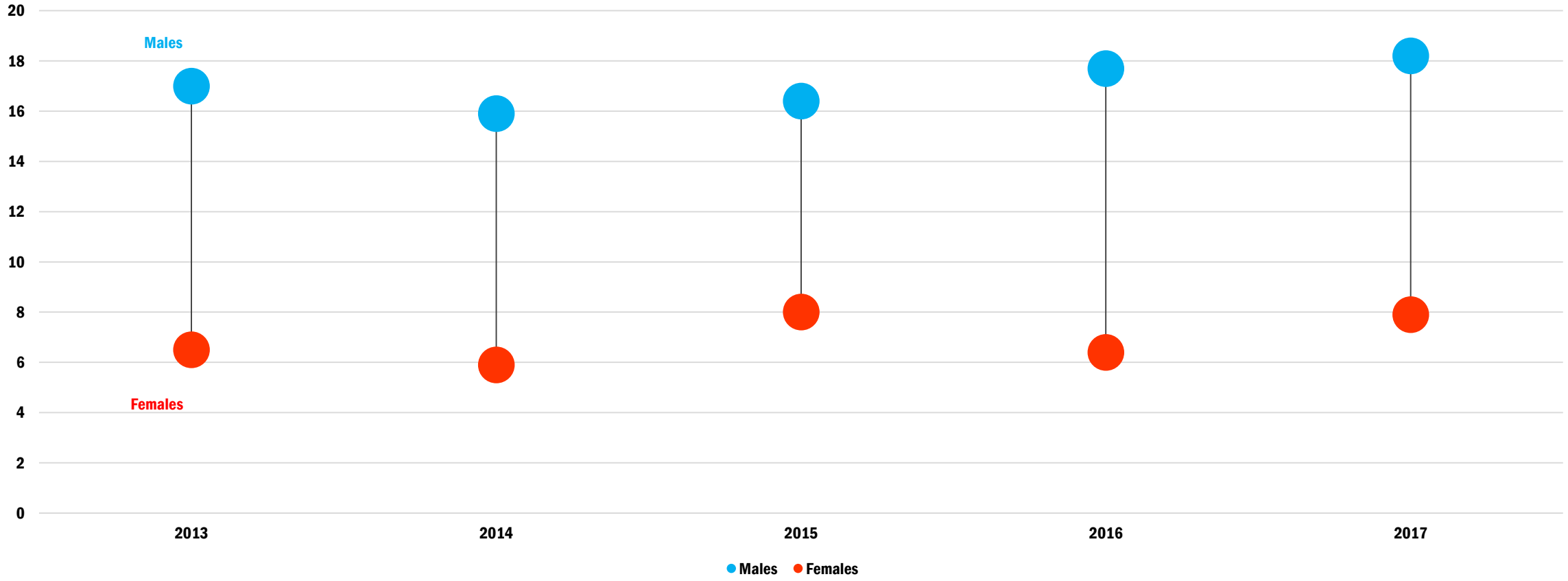
Age-Specific Rate per 100,000 people




*Please note: The drug rates presented here consist of rates for unintentional drug poisonings and should not be compared to overall drug overdoses rates.

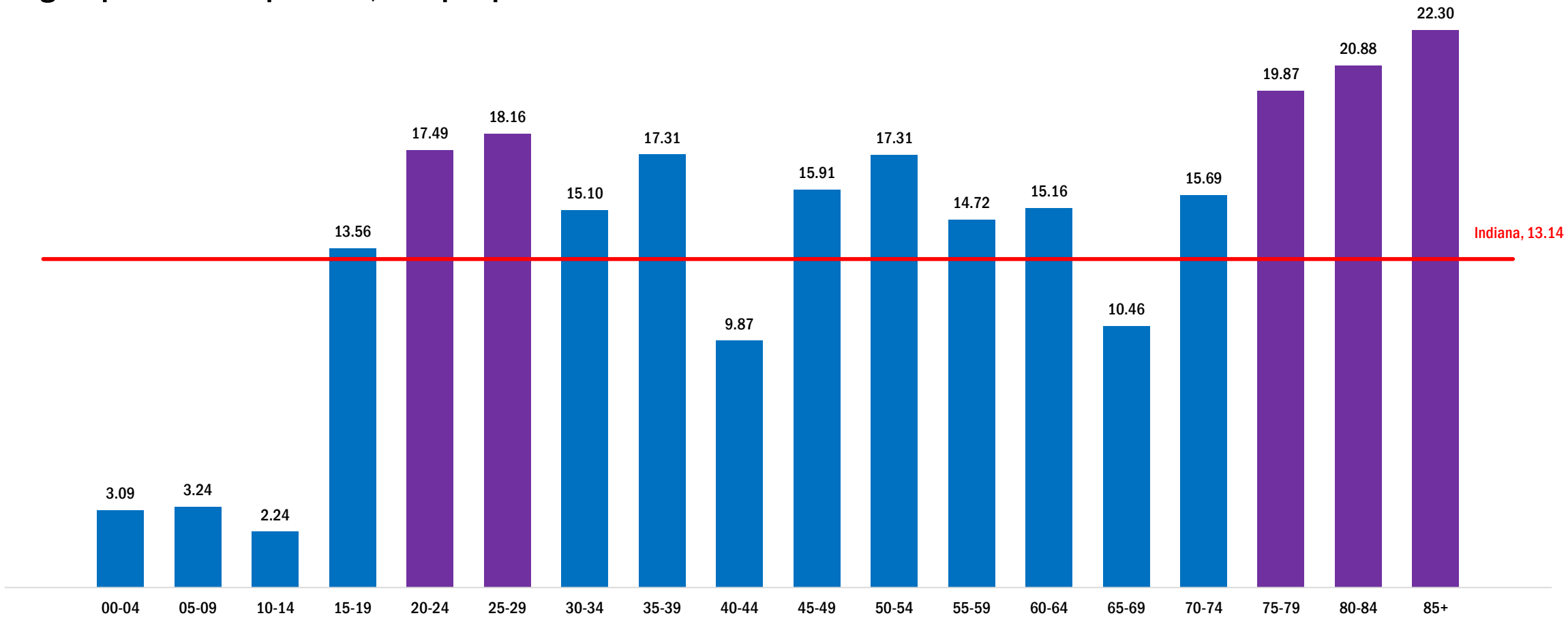
# More males are dying from traffic motor vehicle injuries than females in Indiana

## Age-Adjusted Rate per 100,000 people



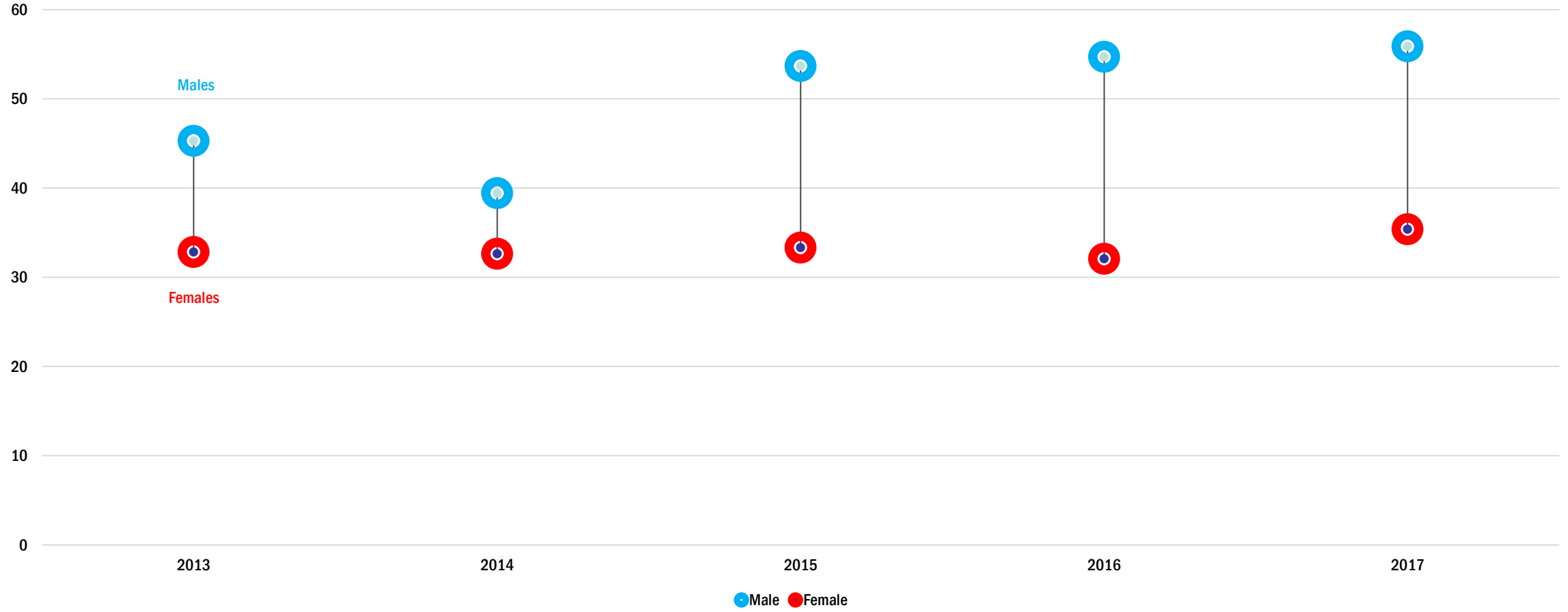
# Traffic Motor Vehicle Injuries are statistically higher for young adults ages 20-29 and older adults 75+ than the Indiana average (2017)

Age-Specific Rate per 100,000 people



# Males have statistically higher rates of unintentional falls deaths than females

Age-Adjusted Rate per 100,000 people



# Older adults aged 85 and older have exponentially higher rates of unintentional falls than other older adults

Age-Specific Rate per 100,000 people

# Contact information

**Andzelika Rzucidlo,** *Injury Prevention Epidemiologist*
Trauma and Injury Prevention Division
317.234.7463 (office)
arzucidlo@isdh.in.gov

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

Indiana State Department of Health

# Unintentional Injury Prevention Program Spotlight: Stepping On Falls Prevention Initiative

**Katie Hokanson,** *Division Director*

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

Indiana State Department of Health

# What to expect…

- This Leader Training will provide the attendee with all the information and build the skill set to lead the 7 week Stepping On Fall Prevention Workshop.
- Most of all, this is a training to become a leader for Stepping On and to build and enhance skills to become a leader.
- 3-day in-person training – 8am to 5:00pm each day
- After completing the 3-day, in-person leader training, attendees are expected to facilitate a minimum of two (2) workshops per year to stay active
- All the materials they need for the 3 days will be supplied.
- The dress is casual and attendees will be doing the exercises from Stepping On each day.

# Stepping on Leader Trainer Initiative

- For Who? *Anyone interested in falls prevention!*
- March 5-7 Leader Trainer Class (*completed*)
  - Southern Indiana Focus
  - Ellettsville IN
  - 12 Participants Trained
- May 15-17 Leader Trainer Class
  - Northern Indiana, Ft. Wayne, Parkview Trauma Hosting
- September 17-19 Leader Trainer Class
  - Central Indiana, Indianapolis, St. Vincent Indy Hosting
- Cost : $300
- All stepping on courses must be ran by two trainers

- Contact Pravy Nijjar, pnijjar@isdh.in.gov for more information.
- Eventbrite weblink to go live soon!!

# Pediatric Injuries Guest Speaker: Child Fatality Review Board

**Gretchen Martin,** *Director of Child Fatality Review*

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

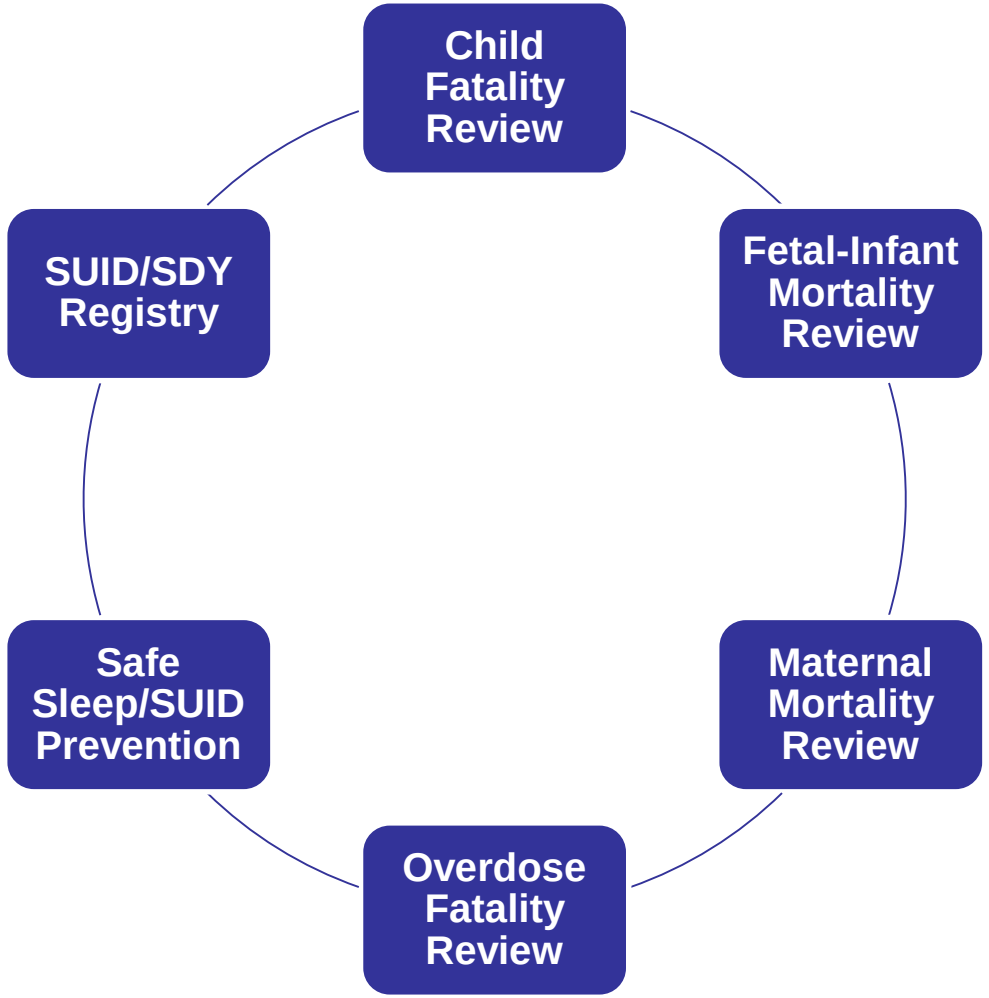
Indiana State Department of Health

# Fatality Review & Prevention

Fatality Review & Prevention is a public health injury prevention process that examines the preventability of the circumstances and risk factors involved in a death. The overall goal is to improve the health and safety of children and families by identifying and understanding the factors that place them at risk for illness or injury. This includes:

- Reviewing and learning from the reported deaths
- Monitoring data
- Identifying trends
- In collaboration with key partners, developing recommendations and community interventions that may help prevent injury and death

# Fatality Review and Prevention Programs






Indiana State Department of Health

# What is child fatality review?

- A multidisciplinary team seeking to understand the risk factors surrounding the death of a child
- A professional process aimed at improving system responses to child deaths
- An opportunity to improve the health and safety of our children

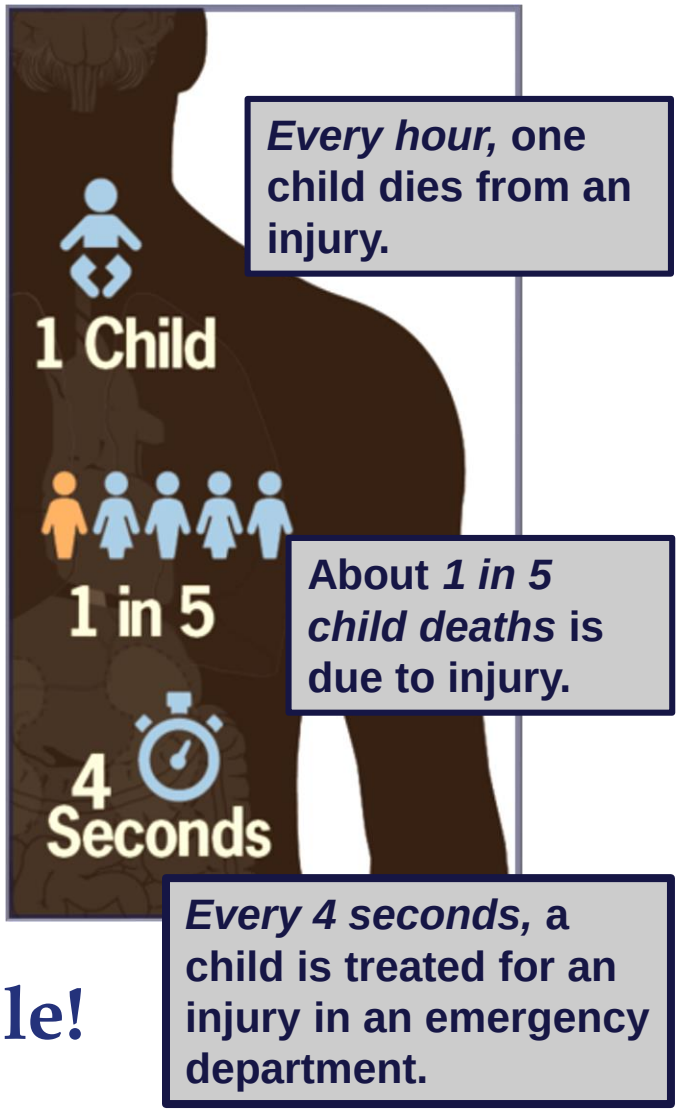
Children's Health Alliance of Wisconsin, www.chawisconsin.org

# Deaths Reviewed

- IC 16-49 requires review of any death that is
  - Sudden, unexpected, or unexplained
  - Assessed by DCS
  - Determined to be the result of
    - Homicide
    - Suicide
    - Accident
    - Undetermined
- Essentially, any death that is not medically expected!
- Near fatalities

# Why child fatality reviews?

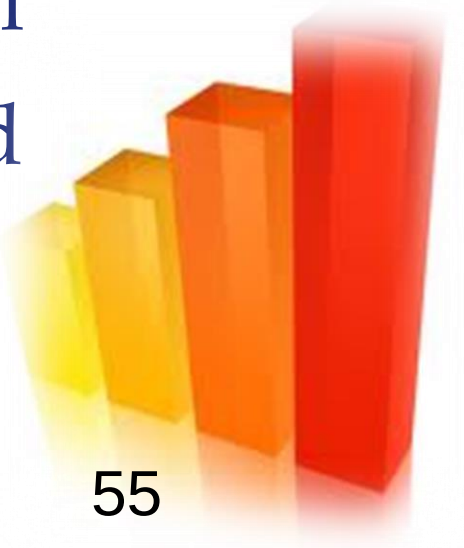
- Injury is the No. 1 cause of death among children
- From 2007 – 2017 in Indiana, there were 2755 children who died from injuries (ages 0 – 17 years)
  - This is an average of 250 *preventable* deaths per year
- In 2016, there were more than 4,800 hospitalizations and more than 210,000 ED visits.
- Every two minutes a child is treated for an injury in an ER.




**All injury deaths are preventable!**

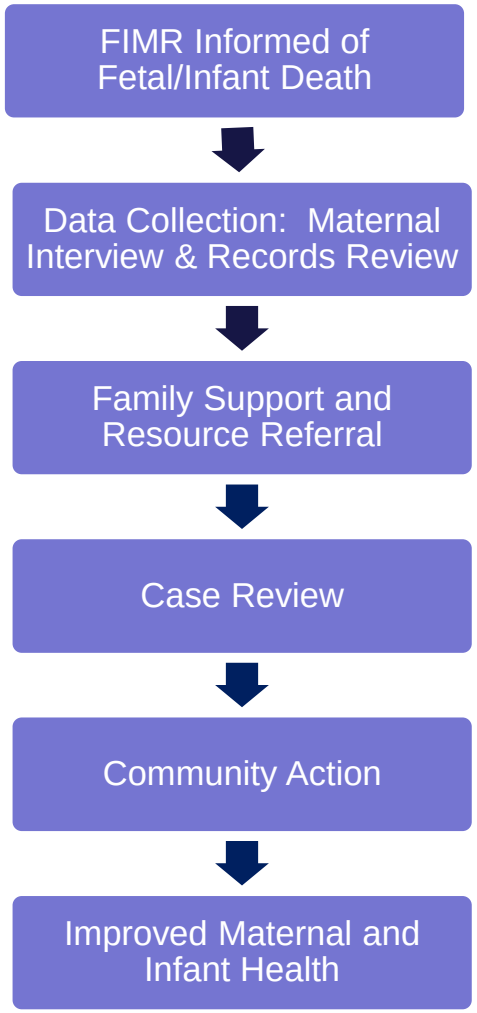
# Why collect data?

- Captures the risk factors and circumstances contributing to the death of a child
- Provides ability to track trends at county, regional, state, and national level
- Allows prevention to be targeted to specific groups or risk factors



# Fetal-Infant Mortality Review (FIMR)

- Improves systems of care and community resources
- Used to better understand all factors leading to an infant death
- Maternal interviews allow valuable input from mothers who have lost an infant
- Facilitates community action to implement interventions to improve maternal and child health services, systems and resources
- Is a continuous quality improvement model



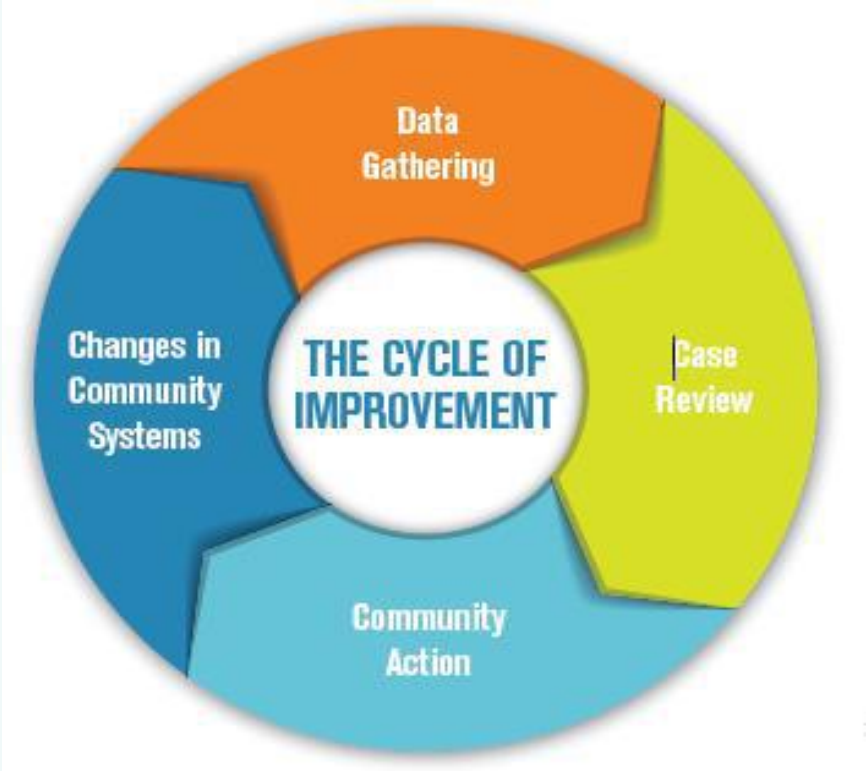
# FIMRs compared to CFRs

| FIMR | CFR |
| --- | --- |
| Medical model | Multidisciplinary team approach |
| De-identified case review | Identified case review |
| Members are maternal and infant health professionals | Diverse members including LE, social services, education, health, etc. |
| Implement interventions to improve maternal and child health service systems and resources | Identify Issues and implement intervention/prevention activities across systems |

| Child Fatality Review | Fetal Infant Mortality Review |
| --- | --- |
| Focus on Injury Prevention | Focus on Improving Health Resources and Access |
| Birth – 17 years | Fetal Loss<br>Infants: Birth – 1 year |

## Commonalities Between Reviews

- Shared cases – child maltreatment, SUID/SIDS/Unsafe Sleep
- Goals of improving systems, supporting families and preventing deaths
- Shared membership
- State and local focus
- Data collection and reporting



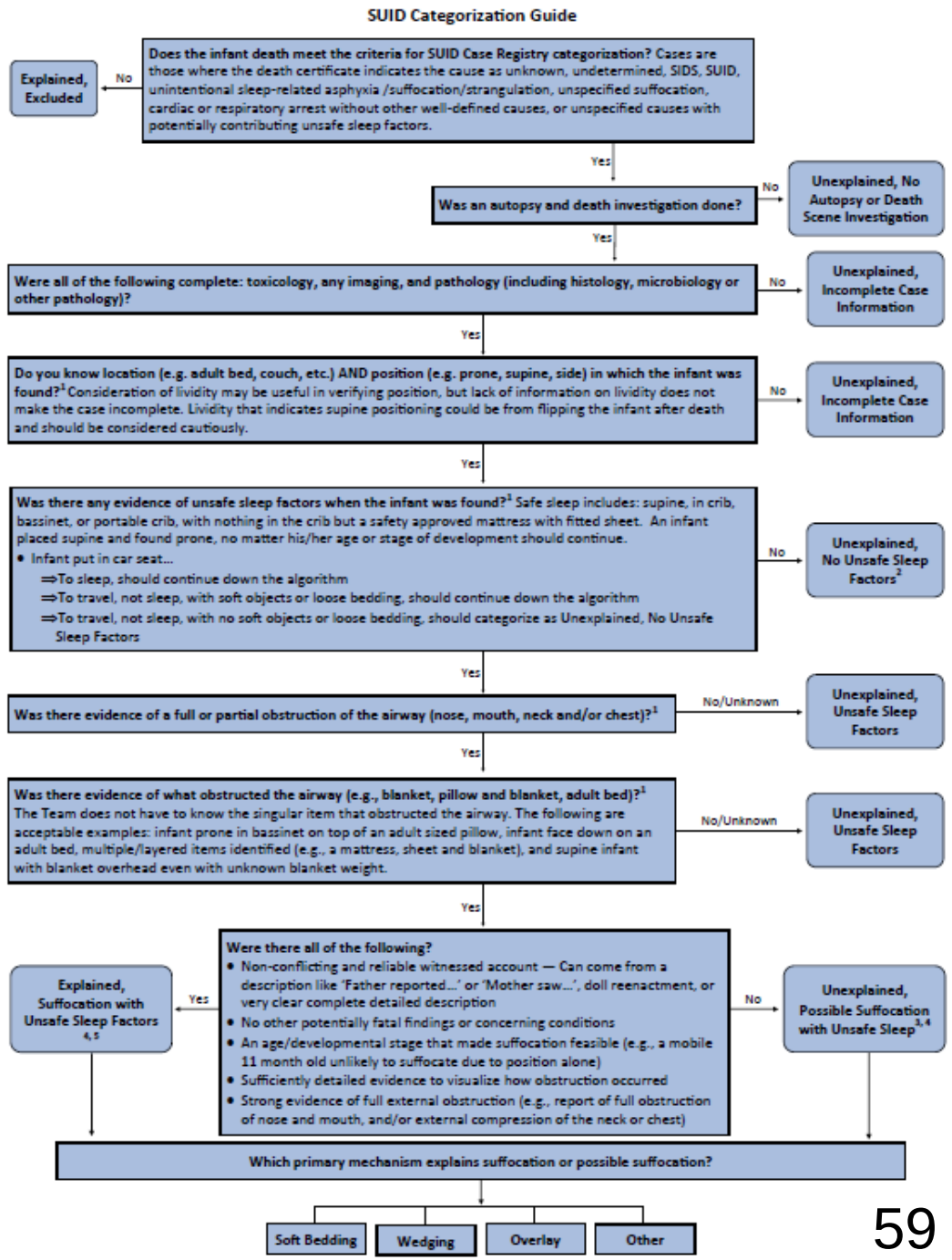
# SUID/SDY Case Registry

## $130,000 granted to ISDH from the CDC for 5 years

- Improve Death Scene Investigation Techniques
- Promote Safe Sleep Education
- Obtain More Accurate and Complete Data

**Who this involves:**

- Coroners
- CFR Teams
- Law Enforcement
- Department of Child Services



# Information needed from the investigation

- Autopsy including toxicology, imaging, and pathology
- Location and Position infant was found
- Unsafe sleep factors
- Full or partial obstruction of airway (nose, mouth, neck, chest)
- What item is obstructing airway (pillow, blanket, adult bed, etc.)
- Witness statements
- Doll reenactment (including visualization of how obstruction occurred, body, face, and neck positions)
- Developmental age and abilities

# SUID/SDY Case Registry

- Will help build on existing Child Fatality Review programs and assist in data completion obtained from reviews
- Conduct Advanced Medical Reviews for cases ruled Undetermined
- Collect and store DNA for future research and genetic testing
- Improve prevention efforts using evidence-based data
- We can provide assistance with:
  - Autopsy Guidance Summaries
  - Data Input
  - Review Technical Assistance
  - Community Specific Data

# Sudden Unexplained/Unexpected Infant Death Investigation (SUIDI)

Created by the CDC in 2006, aims to standardize and improve data collected at infant death scenes and to promote consistent classification and reporting of SUIDs

- Teach death scene investigators how to:
  - Conduct a comprehensive infant death scene investigation
  - Conduct witness Interviews and doll re-enactment
  - Develop a narrative report for the forensic pathologist
  - Complete the Sudden Unexplained Infant Death Investigation Reporting Form (SUIDIRF) during and after the scene investigation
  - Incorporate a Pre-Autopsy Conference in the investigative process

# SUID Prevention

- Interpret Sudden Unexpected Infant Death data, provided by ISDH vital records, fatality review teams and external partners to monitor Indiana's SUID death; rates, locations, trends, and contributing factors
- Use the data to help guide local outreach and prevention efforts
- Inform local partners of SUID data related to their areas
- Provide educational resources to educators and providers
- Connect community partners with state efforts and facilitate local collaboration to increase collective impact

# Indiana's Safe Sleep Program

- Strives to reduce the Infant Mortality Rate by providing early intervention and education to infant caregivers, medical professionals, day care providers, faith-based partners - everyone that may be involved in the life of an infant.
- Collaborates with other agencies to ensure consistent safe sleep education is provided statewide.
- Establishes partnerships with local agencies across the state to provide safe sleep education.
- Provides resources (portable crib, sleep sacks, etc.) to ensure that all infants have a safe place to sleep.

# Safe Sleep Education

- Education includes outreach, meeting caregivers where they are, and offering the educator tools to assist in making outreach effective.
- Educational messages focus on three key risk reduction recommendations from the American Academy of Pediatrics (AAP) and National Institute of Health (NIH) which states that infants sleep safest:
  - Alone
  - On their backs
  - In a separate, safe sleep environment, like a crib

# Create a Safe Sleep Zone

# Direct On-Scene Education(DOSE)™

DOSE is an innovative attempt at eliminating sleep related infant death due to suffocation, strangulation or positional asphyxia by using First Responders to identify and remove hazards while delivering education on-scene during emergency and non-emergency 911 calls.

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# Definitions

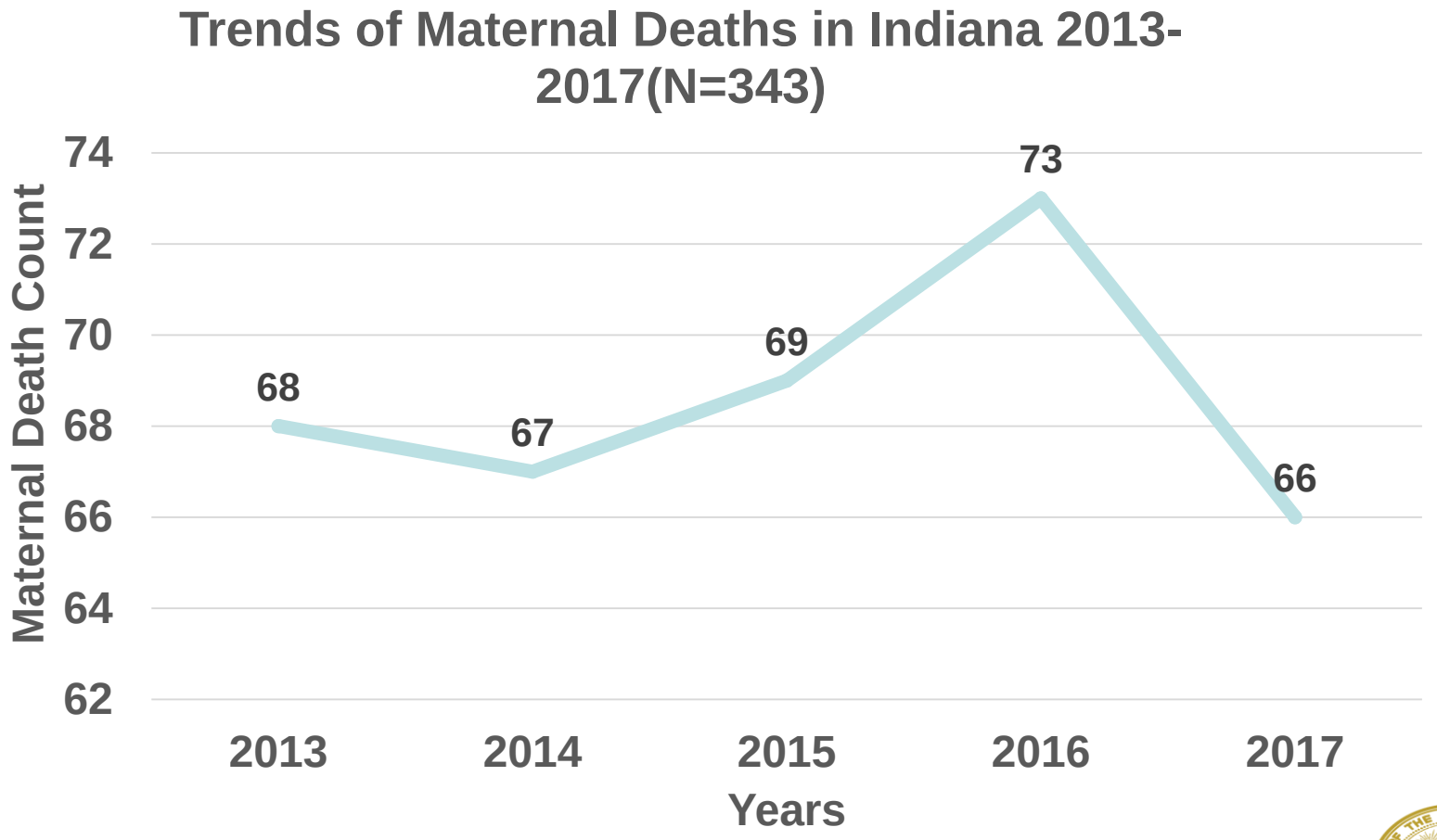
## Maternal Mortality

- Maternal mortality is the death of a woman while pregnant or within one year of the end of pregnancy, regardless of length or site of pregnancy, due to a cause related to or made worse by the pregnancy or its management.

## Maternal Mortality Classified

- **Pregnancy-related deaths**: The death of a woman while pregnant or within one year of the end of pregnancy, regardless of length or site of pregnancy, due to a cause related to or made worse by the pregnancy or its management.
- **Pregnancy associated deaths**: The death of a woman while pregnant or within one year of the end of pregnancy, due to any cause.

# Maternal Mortality in Indiana




Source: https://gis.in.gov/apps/isdh/meta/stats_layers.htm

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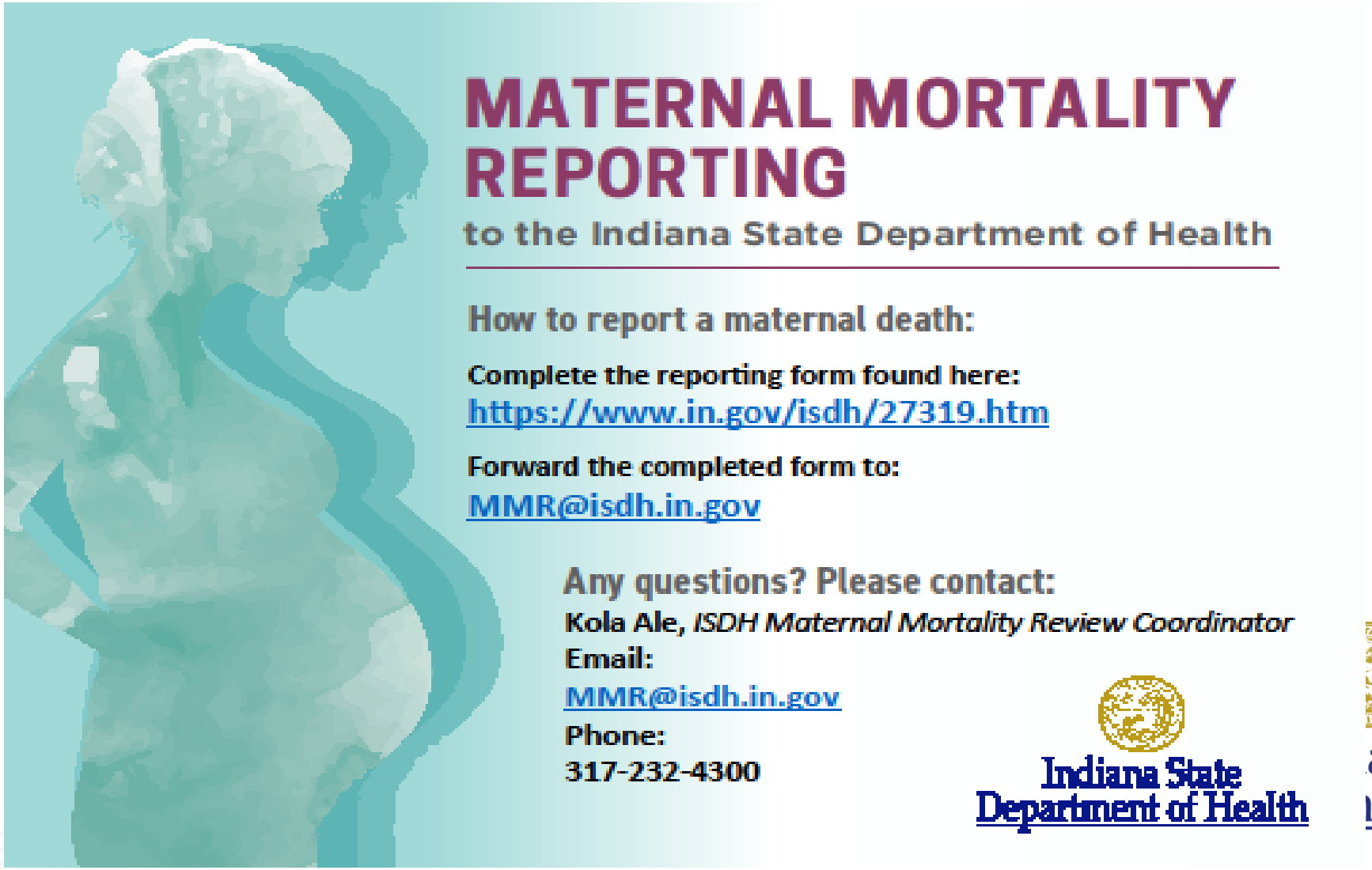
# What are these mothers dying from?

Top causes of maternal death in the United States:

- Cardiovascular diseases, 15.5%
- Infection or sepsis, 12.7%
- Hemorrhage, 11.4%
- Cardiomyopathy, 11.0%
- Thrombotic pulmonary embolism, 9.2%
- Hypertensive disorders of pregnancy, 7.4%


Source: Retrieved from https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pmss.html

# Maternal Mortality Reporting System



# Expected Outcomes

- Identifying the health issue causing maternal deaths
- Reduction in maternal mortality & morbidity
- Improvement in Indiana's population health for women of reproductive age
- Elimination of preventable maternal deaths

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# Overdose Fatality Review

- Modeled after other mortality review teams (CFR, FIMR, etc.)
- Multi-agency/multi-disciplinary team **confidential** case reviews of overdose deaths
- Goal to prevent ***future*** deaths by
  - Identifying missed opportunities for prevention and gaps in system
  - Building working relationships b/t local stakeholders on OD prevention
  - Recommending policies, programs, laws, etc. to prevent OD deaths
  - Informing local overdose prevention strategy
- Team members bring info from respective agencies about decedents to inform review

# Overdose Fatality Review

Pilot Program: January-June 2018

- Teams – Tippecanoe County, Montgomery County, Knox County, Vanderburgh County
- Evaluation will lead to recommendations for policy and program development/expansion

# Adult Injuries Guest Speaker: Community Action of Greater Indianapolis

**Dana Nash,** *Community Action Staff*

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

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# Thanks for joining!

## Feel free to invite new attendees for the next meeting, May 17th!

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