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.
Questions?

Email questions to: indianatrauma@isdh.in.gov

OR

Utilize chatbox underneath the video.
Injury Prevention Advisory Council (IPAC) and Indiana Violent Death Reporting System (INVDRS) Meeting

Friday, September 20, 2019
Round Robin and Introductions

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

@INDTrauma #SafetyIN

Email questions to: indianatrauma@isdh.in.gov
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

Email questions to: indianatrauma@isdh.in.gov
ISDH Updates

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

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

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

Email questions to: indianatrauma@isdh.in.gov
2019 IPAC/INVDRS Meeting Dates

- November 15th
Division grant activities

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

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

Email questions to: indianatrauma@isdh.in.gov
Overdose Data to Action (OD2A) Grant
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 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 multidisciplinary 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:

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

<table>
<thead>
<tr>
<th>Scoring Criteria</th>
<th>% of Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Information</td>
<td>10%</td>
</tr>
<tr>
<td>Narrative</td>
<td>40%</td>
</tr>
<tr>
<td>Organizational Capacity</td>
<td>20%</td>
</tr>
<tr>
<td>Budget Template (Attachment B &amp; Budget Narrative)</td>
<td>20%</td>
</tr>
<tr>
<td>Submission</td>
<td>10%</td>
</tr>
</tbody>
</table>
Contact Information

Contacts:

Katie Hokanson
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

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?

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Risk Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Problem</td>
<td>10x</td>
</tr>
<tr>
<td>Job Problem</td>
<td>4.2x</td>
</tr>
<tr>
<td>IPV</td>
<td>0.98x</td>
</tr>
<tr>
<td>School Problem</td>
<td>0.98x</td>
</tr>
<tr>
<td>Physical Health Problem</td>
<td>0.71x</td>
</tr>
</tbody>
</table>
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.
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 incarccation 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.
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)

<table>
<thead>
<tr>
<th>Age</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-25</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>25-34</td>
<td>2</td>
<td>10</td>
</tr>
<tr>
<td>35-44</td>
<td>1</td>
<td>14</td>
</tr>
<tr>
<td>45-54</td>
<td>3</td>
<td>21</td>
</tr>
<tr>
<td>55-64</td>
<td>2</td>
<td>22</td>
</tr>
<tr>
<td>65-74</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>75+</td>
<td>0</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Race</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>8</td>
<td>74</td>
</tr>
<tr>
<td>Black</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Asian</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>American Indian</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>
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
Intentional Injury Prevention Program Spotlight:
Zero Suicides

Laurie Gerdt, Community Health Network

Email questions to: indianatrauma@isdh.in.gov
Zero Suicide in Health and Behavioral Health Care
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.
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

- REACH OF 1,012,982 VIEWERS
- REACH OF 3,121,883 VIEWERS
- REACH OF 35,522,978 VIEWERS
- REACH OF 108,589,836 VIEWERS
- REACH OF 148,247,679 TOTAL VIEWERS

HEALTH AND FITNESS EXPO

SUICIDE PREVENTION DAY NEWS BLITZ

WTHR ONLINE

TELEVISION PSAs AND VIDEOS

= CHNw-WTHR PARTNERSHIP
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.
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.
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).
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
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
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**

<table>
<thead>
<tr>
<th>Method</th>
<th>All Ages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poisoning</td>
<td>54%</td>
</tr>
<tr>
<td>Asphyxiation</td>
<td>33%</td>
</tr>
<tr>
<td>Cut/Pierce</td>
<td>7%</td>
</tr>
<tr>
<td>Motor vehicle/transportation</td>
<td>3%</td>
</tr>
<tr>
<td>Drowning</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>1%</td>
</tr>
</tbody>
</table>
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.

QPR Instructors by Profession
277 Total
- 114 | Mental Health
- 83 | Higher Education
- 39 | K-12 Education
- 10 | Healthcare
- 12 | Emergency Responders
- 9 | Child Welfare
- 9 | Juvenile Justice
- 2 | Other

QPR Trainees by Profession
9,616 Total
- 1,585 | Mental Health
- 302 | Higher Education
- 5,385 | K-12 Education
- 720 | Healthcare
- 357 | Emergency Responders
- 268 | Child Welfare
- 201 | Juvenile Justice
- 770 | Other

Instructors and Trainees Certified by Zero Suicide for Indiana Youth Grant (per Indiana Suicide Prevention Coalition (ISPC) Regions)
- 10 QPR Instructors (402 Trainees)
- 16 QPR Instructors (161 Trainees)
- 35 QPR Instructors (1,148 Trainees)
- 78 QPR Instructors (754 Trainees)
- 81 QPR Instructors (4,704 Trainees)
- 6 QPR Instructors (763 Trainees)
- 12 QPR Instructors (244 Trainees)
- 7 QPR Instructors (595 Trainees)
- 7 QPR Instructors (501 Trainees)

Number of Organizations that Updated Policies
- 140 School Districts
- 13 Healthcare Organizations

Fast Facts
www.huehope.com website and campaign created in collaboration with central Indiana's NCB affiliate, W.Fill.
Emergency Medical Service suicide prevention education developed and placed in web-based education system, ACIDES
The Indiana Suicide Prevention Network created in July 2018 as a subsidiary of Mental Health America of Indiana
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
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 16,000 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 aged 65 and older. It includes information about groups with the highest rates, associated costs, and current prevention strategies and activities in Indiana.

QUICK FACTS

Unintentional falls are the leading cause of death for older adults in Indiana. Indiana residents aged 65 and older account for 81.3% of all fall deaths and 73.9% 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 $5 billion.

Each week, there are 746.3 emergency department visits among residents aged 65 and older, 247.2 hospitalizations and 8.2 deaths due to fall injuries in Indiana.

In 2017, 25.1% 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

2016

- 394 Deaths
- 12,497 Hospitalizations
- 45,747 Emergency Department Visits

2017

- 426 Deaths
- 12,855* Hospitalizations
- 41,034* Emergency Department Visits

*Changes in reporting – transfers and deaths were removed
2017 Statistics

Deaths
- 18.7% Other
- 81.3% 65 and older

Hospitalizations
- 26.7% Other
- 73.3% 65 and older

ED Visits
- 28.5% Other
- 71.5% 65 and older

Legend:
- Blue: 65 and older
- Red: Other
Fall Deaths, Ages 65 and older, 2008-2017
Age-Adjusted Rate per 100,000

Year | Fall Deaths | Male | Female | Total
--- | --- | --- | --- | ---
2008 | 22.9 |  |  | 22.9
2009 | 29.7 |  |  | 29.7
2010 | 35.4 |  |  | 35.4
2011 | 43.6 |  |  | 43.6
2012 | 40.1 |  |  | 40.1
2013 | 55.9 |  |  | 55.9

Legend:
- Male
- Female
- Total
Fall Deaths, Ages 65 and older, 2008-2017
Age-Adjusted Rate per 100,000

Ages 65-74
Ages 75-84
Ages 85+

Year


98.6 7.6 38.6 12.4 49.7 157.6
Projected Lifetime Costs

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

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

Special Emphasis Reports

Understanding TBI

Traumatic brain injury (TBI) is a serious public health problem in the United States. A TBI is caused by a bump, blow, 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 hospitalized, 3,289 (99.3%) were hospitalized with a TBI alone or in combination with other injuries or conditions, and an additional 22,609 (69.3%) were treated and released. Of those treated and released for TBI-related injuries between 2015 and 2016, 4% were treated at EDs or in emergency departments of hospitals or emergency departments visits (ED Visits) by TBI alone or in combination with other injuries or conditions.

Causes of TBI

Causes of injury vary across the three levels of severity. Severe was the leading cause of injury among those who died where TBI was reported as a cause of death or the death certificate alone or in combination with other injuries or conditions. Males were treated and released from emergency departments with a TBI alone or in combination with other injuries or conditions.

TBI by Age

The highest number of TBI-related deaths were among persons ages 15-44. 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.

https://www.in.gov/isdh/25396.htm
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
Injury Prevention Program Development

Michaela Graham, MPH, CHES
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

Michaela Graham

IU Health Methodist Hospital
Trauma Services
mgraham4@iuhealth.org
317.962.8150
“A Day In The Life Of...”

By: Carmen DeBruce, BSN, RN, CPN, CPST-I Outreach Coordinator, Lutheran Children’s Hospital/Pediatric Injury Prevention
Michelle Stimpson, RN, Adult Injury Prevention Coordinator
• 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

This Photo by Unknown Author is licensed under CC BY-SA
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 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
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 forefront 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

Thank you!
• Michelle Stimpson
  – mstimpson@lhn.net
  – 260-435-7227

• Carmen DeBruce
  – cdebruce@lhn.net
  – 260-435-7354
Thanks for joining!

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