Prescription Drug Overdose Grant Funding

Katie Hokanson, Director
Trauma and Injury Prevention Division

Email questions to: indianatrauma@isdh.in.gov
Cause of Injury Categories

- Cut/Pierce
- Drowning/Submersion*
- Fall
- Fire/Burn
  - Fire/Flame
  - Hot object/substance
- Firearm
- Machinery
- Motor Vehicle Traffic

- Pedal Cyclist, Other
- Pedestrian, Other
- Transport, Other
- Natural/Environmental
  - Bites and Stings
- Overexertion
- Poisoning*
- Struck By, against
- Suffocation*

* Not considered Traumatic Injury
Drug Overdose Death Rates vs Motor Vehicle Traffic-Related Death Rates

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

*Age-adjusted death rates using the U.S. population as the standard

Email questions to: indianatrauma@isdh.in.gov
CDC Goal

Reduce abuse and overdose of opioids and other controlled prescription drugs while ensuring patients with pain are safely and effectively treated.
Three Pillars of CDC’s Prescription Drug Overdose (PDO) Prevention Work

- Improve data quality and track trends
- Strengthen state efforts by scaling up effective public health interventions
- Supply healthcare providers with resources to improve patient safety
CDC Funds “Boost” for State Prevention: 5 states in FY 2014

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

- Enhancing and maximizing PDMPs
- Improving and evaluating public insurer mechanisms
- Evaluating state-level laws, policies, and regulations

Scope of program
- Target high burden states: KY, OK, TN, UT, and WV
- Hope to expand program and substantial increase in President’s and Senate’s FY 2015 budget
Prescription Drug Overdose: Prevention for States

- CDC Grant Funding Opportunity
- Application submitted May 8th
- Awarded, but not Funded – Fall 2015
- Notice of Award ~March 15th, 2016

- 3 main grant activities
  - Overarching goal: targeting main driver of epidemic
    - problematic prescribing
Prescription Drug Overdose Prevention for States

Grant Activities:

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

2. Implement community interventions in high-need areas

3. Evaluate impact of policy changes in Indiana

Email questions to: indianatrauma@isdh.in.gov
Enhance and Maximize Prescription Drug Monitoring Programs (PDMP)

- **PDMPs**
  - 49 out of 50 states
  - Funding and location vary across states

- **Intervention**
  - Outlier analysis (e.g., identify patients “doctor shopping” or identify inappropriate or illegal prescriber)
  - Clinician review of PDMP before writing a controlled substance prescription

- **Surveillance**
  - Track changes in prescriptions to assess progress and new trends
  - Link with morbidity and mortality data to enhance targeting

- **Guidelines and resources for effective PDMP**
  - Brandeis Center for Excellence: http://www.pdmpassist.org/content/guidelines
Enhance & maximize prescription drug monitoring program (INSPECT)

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

Email questions to: indianatrauma@isdh.in.gov
Expansion of the Indiana Violent Death Reporting System (INVDRS)

• Collect Poisoning Overdose Module data in National Violent Death Reporting System
Optional Collection of Unintentional Drug Poisoning Death Data with the NVDRS Web System
Key CDC Surveillance Needs

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

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

Key Surveillance Needs

- Respond to emerging issues

The heroin increase is an offshoot of the opioid epidemic

- 3 out of 4 people who used heroin in the past year misused opioids first
- 7 out of 10 people who used heroin in the past year also misused opioids in the past year

Key Challenges with Death Certificate Data

- Identify specific drug(s) causing the death
  - Information missing on ~25% of death certificates
  - Percent missing varies by state

- Improve counting of heroin-related deaths
  - Toxicology findings of morphine only

- Timely information

- Variance in assignment of manner of death across states
  - DUIP reports deaths across manners

- Key context information tied to interventions
  - History of overdoses
  - Scene indications of drug abuse
  - Route of exposure
  - Prescription information (Doctor shopping)
Proposed Solution

- Link death certificate (DC) with coroner and medical examiner (CME) information
  - Links toxicology with descriptive information
  - Collection of key circumstance information
  - More rapid identification (NCHS word search)

- NVDRS platform
  - Collects vast majority of needed information
  - Established infrastructure to collect vital statistics and CME
  - Collaboration with DVP to get “full picture”
  - Maximize limited resources to collect data on unintentional overdoses

- Respond to a need expressed by some NVDRS states

- Use separate tab to collect drug overdose specific information
Definition of Drug Poisoning

- A drug is any chemical compound that is chiefly used by or administered to humans or animals as an aid in the diagnosis, treatment, or prevention of disease or injury, for the relief of pain or suffering, to control or improve any physiologic or pathologic condition, or for the feeling it causes.
  - Includes prescription drugs, over the counter drugs, and illicit drugs such as heroin and cocaine
  - Excludes alcohol, tobacco, and inhaled substances that have non-medical primary purpose such as glue.

- Focus on acute poisonings (e.g., overdoses)
  - Consistent with CDC Injury indicators and ISW7 report

Identify Unintentional Drug Poisoning Deaths

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

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

- Highest priority!
### Substance Abuse

<table>
<thead>
<tr>
<th>Questions</th>
<th>Priority</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of overdose</td>
<td>High</td>
<td>Target interventions when OD occurs</td>
</tr>
<tr>
<td>In substance abuse treatment</td>
<td>Moderate</td>
<td>Targeting to get into treatment vs. improved treatment support</td>
</tr>
<tr>
<td>Scene indications of drug abuse</td>
<td>Moderate</td>
<td>- Better identify heroin and prescription opioid overdoses</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Informs response</td>
</tr>
<tr>
<td>History of opioid or heroin abuse</td>
<td>Moderate</td>
<td>- Understand risk factors</td>
</tr>
<tr>
<td></td>
<td></td>
<td>- Better identify heroin and prescription opioid overdoses</td>
</tr>
<tr>
<td>Description of treatment (e.g., MAT or specific drug)</td>
<td>Later version</td>
<td>Needs to be assessed</td>
</tr>
<tr>
<td>Questions</td>
<td>Priority</td>
<td>Importance</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>-----------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td># of controlled substance prescriptions in the 30 days preceding injury</td>
<td>Moderate</td>
<td>Proxy for high dosage and inappropriate use</td>
</tr>
<tr>
<td># of pharmacies dispensing controlled substance prescriptions to decedent in 30 days preceding injury</td>
<td>Moderate</td>
<td>Proxy for illegal behavior by decedent</td>
</tr>
<tr>
<td># of doctors writing controlled substance prescription to the decedent in the 30 days preceding injury</td>
<td>Moderate</td>
<td>Proxy for illegal behavior by decedent</td>
</tr>
<tr>
<td>Use of prescription morphine</td>
<td>Moderate</td>
<td>Better identify heroin and prescription opioid overdoses</td>
</tr>
<tr>
<td>Treatment for acute or chronic pain</td>
<td>Moderate</td>
<td>Better understand risk factors and context</td>
</tr>
</tbody>
</table>
### Prescription History / Medical: Later Version

<table>
<thead>
<tr>
<th>Questions</th>
<th>Priority</th>
<th>Importance</th>
</tr>
</thead>
</table>
| Track morphine milligram equivalents of decedent                          | Later version       | - Resource intensive  
- Need a tool                                                                  |
| Track PDMP prescriptions including information such as specialty           | Later version       | - Need to consider how best to integrate with toxicology  
- Need to access feasibility with PDMP data  
- Can indicate prescription causing death in current system |
| Information on medical conditions of patient (e.g., cancer, HIV, headaches, etc.) | Later version       | - Concerned about feasibility across states  
- Code “Contributing physical health problem”                                |
## Naloxone and Route of Drug Exposure

<table>
<thead>
<tr>
<th>Questions</th>
<th>Priority</th>
<th>Importance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Naloxone/narcan administered and by whom</td>
<td>Moderate</td>
<td>Important information to inform naloxone administration policies</td>
</tr>
<tr>
<td>Bystanders present at overdose</td>
<td>Moderate</td>
<td>Inform “Good Samaritan” laws and response policies</td>
</tr>
</tbody>
</table>
| Route of exposure                       | Moderate | -Priority for previous drug overdose surveillance  
                                          |                       -Inform interventions such as abuse deterrent formulations |
Implement community interventions in high-need areas

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

Email questions to: indianatrauma@isdh.in.gov
Evaluate impact of policy changes in Indiana

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

Email questions to: indianatrauma@isdh.in.gov
Questions?

Email questions to: indianatrauma@isdh.in.gov
Regional Updates
Regional updates

• District 1
• District 3
Subcommittee Updates
Designation Subcommittee

Dr. Gerardo Gomez, Trauma Medical Director
Eskenazi Health

Email questions to: indianatrauma@isdh.in.gov
Trauma Center Designation
Subcommittee Meeting

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

Dr. Lewis Jacobson, Dr. R. Lawrence Reed, Spencer Grover, Wendy St. John, Jennifer Mullen, Lisa Hollister, Amanda Elikofer, Katie Hokanson, Ramzi Nimry, Missy Hockaday, Teri Joy, Art Logsdon, Judy Holsinger, Jennifer Konger, Dr. Emily Fitz, Dr. Matthew Sutter, and Judi Holsinger
ISDH Trauma Designation Subcommittee Meeting Agenda from April 12, 2016

1. Pre-hospital Triage and Transportation Rule review

2. In-process trauma center updates
2011 Guidelines for Field Triage of Injured Patients

1. Measure vital signs and level of consciousness
   - Glasgow Coma Scale \geq 13
   - Systolic Blood Pressure (mmHg) < 90
   - Respiratory Rate < 10 or \geq 29 breaths per minute, or need for ventilatory support
   - NO

2. Assess anatomy of injury
   - All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
   - Chest wall instability or deformity (e.g., flail chest)
   - Two or more proximal long bone fractures
   - Crushed, deformed, lacerated, or pulseless extremity
   - Amputation proximal to wrist or ankle
   - Pelvic fractures
   - Open or depressed skull fracture
   - Paralysis
   - NO

3. Assess mechanism of injury and evidence of high-energy impact
   - Falls
     - Adults: \geq 20 feet (one story is equal to 10 feet)
     - Children: \geq 10 feet or two or three times the height of the child
   - High-risk auto crash
     - Impact, including rollover: \geq 12 inches occupant seated; \geq 19 inches any seat
     - Ejection (partial or complete) from automobile
     - Death in same passenger compartment
     - Vehicle telemetry data consistent with a high risk of injury
   - Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact
   - Motorcycle crash \geq 20 mph
   - YES

4. Assess special patient or system considerations
   - Older Adults
     - Risk of injury death increases after age 55 years
     - SBP \leq 110 may represent shock after age 65
     - Low impact mechanism, e.g., ground level fall, may result in severe injury
   - Children
     - Should be triaged preferentially to pediatric capable trauma centers
   - Anticoagulants and bleeding disorders
     - Patients with head injury are at high risk for rapid deterioration
   - Burns
     - Without other trauma mechanism: triage to burn facility
     - With trauma mechanism triage to trauma center
   - Pregnancy > 20 weeks
   - EMS provider judgment
   - NO

Transport to a trauma center, Step 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the defined trauma system.

When in doubt, transport to a trauma center.
Find the plan to save lives, at www.cdc.gov/fieldtriage
Trauma Center Definition Change

Trauma Center means a hospital that is verified by the ACS as meeting its requirements to be a trauma center, or is designated a trauma center under a state designation system that is substantially equivalent to the ACS verification process, or has been approved by the EMS Commission as an Indiana in process Trauma Center.
Summary of Suggested Changes (Sec. 4.b.)

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

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

**Level I**
- Indianapolis
  - Eskenazi Health
  - IU Health Methodist Hospital
  - Riley Hospital for Children at IU Health
  - St. Vincent Indianapolis Hospital

**Level II**
- Evansville
  - Deaconess Hospital
  - St. Mary’s Medical Center of Evansville
- Ft. Wayne
  - Lutheran Hospital of Indiana
  - Parkview Regional Medical Center
- South Bend
  - Memorial Hospital of South Bend

**Level III**
- Lafayette
  - IU Health - Arnett Hospital
  - Muncie
  - IU Health - Ball Memorial Hospital
  - Anderson
  - St. Vincent Regional Hospital
- Terre Haute
  - Terre Haute Regional

In the process of ACS Verification

**Level II**
- Terre Haute
  - Terre Haute Regional

**Level III**
- Anderson
  - Community Hospital - Anderson
- Gary
  - Methodist Hospital - Northlake Campus
- Lafayette
  - Franciscan St. Elizabeth - East
- Vincennes
  - Good Samaritan Hospital
- Richmond
  - Reid Health
- Crown Point
  - Franciscan St. Anthony Health
- Terre Haute
  - Union Hospital - Terre Haute

Indiana State Department of Health
Trauma and Injury Prevention
Indiana Trauma Center Access: Areas Within a 45-Minute Drive

45-Minute Accessible Trauma Center *

45-Minute Accessible Areas

Average Travel Time
*based on posted and historical speeds

<table>
<thead>
<tr>
<th>45-Minute Coverage (at average speed)</th>
<th>State Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>n</td>
</tr>
<tr>
<td>% of state</td>
<td></td>
</tr>
<tr>
<td>Land Area</td>
<td>20,270 sq mi</td>
</tr>
<tr>
<td></td>
<td>35,826 sq mi</td>
</tr>
<tr>
<td>Population</td>
<td>5,254,205 people</td>
</tr>
<tr>
<td></td>
<td>6,483,802 people</td>
</tr>
<tr>
<td>Interstates</td>
<td>1,090 miles</td>
</tr>
<tr>
<td></td>
<td>1,239 miles</td>
</tr>
</tbody>
</table>

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

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

Indiana Trauma Center Access: Areas Within a 30-Minute Drive

30-Minute Accessible Trauma Center
30-Minute Accessible Areas

Average based on:

Interstates

40%

40%

40%

40%

40%

40%

40%

40%

40%

40%

40%
## “In the Process” of ACS Verification Trauma Centers

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

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

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

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

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

- The hospital will need to become verified through the ACS COT verification process to become a trauma center.
ACS Type I and Type II Criteria Deficiencies (Ch. 22, pg. 159)

- One of the most significant evolutions has been the identification of the essential requirements for verification of Type I and Type II criteria (or deficiencies). Type I criteria must be in place at the time of the verification site visit to achieve verification. Type II criteria are also required but are less critical. If three or fewer Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of verification is issued. During the ensuing 12 months, if the trauma center successfully corrects the deficiencies, the period of verification will be extended to 3 years from the date of the initial verification visit or, for a reverification visit, from the expiration date of the original certificate.
ACS Type I and Type II Criteria Deficiencies (Ch. 22, pg. 159)

• If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital is not verified. A successful focused review is required to achieve verification. The focused review must occur 6–12 months from the date of the initial site visit.
ACS Type I and Type II Criteria Deficiencies (Ch. 22, pg. 159)

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

Deficiencies (Ch. 22, pg. 159)

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

Katie Hokanson,  *Trauma and Injury Prevention Director*
Camry Hess, MPH,  *Data Analyst*

Email questions to: indianatrauma@isdh.in.gov
ED LOS by Severity

Percent of Patient Transferred from ED at non-verified Trauma Center Hospitals in < 2 hours

Email questions to: indianatrauma@isdh.in.gov
Under- and Overtriage

• The orange/starburst book *Resources for Optimal Care of the Injured Patient* uses multiple definitions for over- and undertriage (page 28)

• Trauma activations are not a required element
Undertriage

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

![Bar chart showing undertriage percentages for each month, with blue bars representing 2014 data and orange bars representing 2015 data.]

Email questions to: indianatrauma@isdh.in.gov
ED LOS by Severity

Percent of Patient Transferred from ED at non-verified Trauma Center Hospitals in < 2 hours

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

• Numerator: (NOT one of the following at a trauma center)
  – ED disposition = died, ICU, OR
  – ED disposition = floor bed or step/stepdown and hospital LOS > 48 hours

• Denominator: patients at a trauma center

• ‘An acceptable percentage of over triage is in the range of 25 to 35 percent.’ (page 28)
Overtriage

Overtriage

<table>
<thead>
<tr>
<th>Month</th>
<th>2014 Data</th>
<th>2015 Data</th>
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<tbody>
<tr>
<td>January</td>
<td>66</td>
<td>39</td>
</tr>
<tr>
<td>February</td>
<td>64</td>
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</tr>
<tr>
<td>March</td>
<td>64</td>
<td>43</td>
</tr>
<tr>
<td>April</td>
<td>75</td>
<td>47</td>
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<tr>
<td>May</td>
<td>59</td>
<td>47</td>
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<tr>
<td>June</td>
<td>61</td>
<td>44</td>
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<td>July</td>
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<td>45</td>
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<tr>
<td>August</td>
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<td></td>
</tr>
<tr>
<td>December</td>
<td>70</td>
<td></td>
</tr>
</tbody>
</table>

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

Katie Hokanson, *Trauma and Injury Prevention Director*

Email questions to: indianatrauma@isdh.in.gov
2016 IPAC Conference

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

- Registration open: 2016ipac.eventbrite.com

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

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

EMAIL QUESTIONS:
LSAVITSKAS@ISDH.IN.GOV
The Magnitude of the Problem

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

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

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

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

Email questions to: indianatrauma@isdh.in.gov
Hospital-Based Child Passenger Safety in Indiana

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

Background

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

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

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

http://www.in.gov/cji
Cost of Crash Related Deaths in Indiana

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

Source: CDC 2013 Data
What We See
What You See
What We Want to See
Injury Prevention

- Trauma Services
- Child Passenger Safety
- Prevention
Decline in Child Occupant Fatality Rates

Source: NHTSA
Hospital Discharge Recommendations for Safe Transportation of Children

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

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

**Level I**
- Indianapolis
  - Eskenazi Health
  - IU Health Methodist Hospital
  - Riley Hospital for Children at IU Health
  - St. Vincent Indianapolis Hospital

**Level II**
- Evansville
  - Deaconess Hospital
  - St. Mary's Medical Center of Evansville
- Ft. Wayne
  - Lutheran Hospital of Indiana
  - Parkview Regional Medical Center
- South Bend
  - Memorial Hospital of South Bend

**Level III**
- Lafayette
  - IU Health - Arnett Hospital
  - Muncie
  - IU Health - Bell Memorial Hospital
  - Anderson
  - St. Vincent Regional Hospital

**In the process of ACS Verification**
- **Level II**
  - Terre Haute
  - Terre Haute Regional

- **Level III**
  - Anderson
    - Community Hospital - Anderson
  - Gary
    - Methodist Hospital - Northlake Campus
  - Lafayette
    - Franciscan St. Elizabeth - East
  - Vincennes
    - Good Samaritan Hospital
  - Richmond
    - Reid Health
  - Crown Point
    - Franciscan St. Anthony Health
  - Terre Haute
    - Union Hospital - Terre Haute
Child Safety Seat Inspection Stations at Hospitals with Trauma Centers

- Riley Hospital for Children
  - Methodist and IU
- St. Mary’s
- Lutheran
- Parkview
- Memorial South Bend
- IU Health Arnett
- IU Health Ball

- Community Hospital Anderson
- Franciscan St. Elizabeth
- Franciscan St. Anthony Crown Point
Child Passenger Safety at Riley Hospital at IU Health

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

- 8-14 year olds
- 182 treated and released
- 150 admitted
- Will look at relationship of:
  - Seating position
  - Restraint use
  - Crash injuries
  - Length of stay for those admitted
Committee of Hospital-Based Child Passenger Safety Programs

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

- What resources do you have?
Pediatric Transport

How are your pediatric patients being transported?

Safe transport in ambulances complex
  - Purpose different
  - Vehicle characteristics different
  - Crash environment and exposure are different from that of a family car

Patient compartment not required to meet federal motor vehicle safety standards

New dynamic crash tests and SAE standards

Training for EMS providers through Automotive Safety Program
Safe Kids Indiana

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

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

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

- Contact: April Brooks, apbrooks@iu.edu, 317-274-8380
Health Care Hero Nominations

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

Email questions to: indianatrauma@isdh.in.gov
Other Business
Committee Meeting
Dates for 2016

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

Email questions to: indianatrauma@isdh.in.gov