WHY SHOULD I CARE ABOUT PREVENTION?
I'M BUSY SAVING LIVES.
Trauma Grand Rounds
Piedmont Walton Hospital
November 18, 2021

Shelli Stephens-Stidham
Senior Program Consultant

The Safe States Alliance is a national non-profit organization and professional association whose mission is to strengthen the practice of injury and violence prevention.

Financial Disclosure & Accreditation

The planners, developers, and presenters for this activity report no relevant financial disclosures.

All relevant financial relationships have been mitigated by Piedmont Healthcare.

Piedmont Healthcare is accredited by the Medical Association of Georgia to provide continuing medical education for physicians. Piedmont Healthcare designates this enduring activity for a maximum of 1.0 *AMA PRA Category 1 Credit*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Piedmont Healthcare is an approved provider of nursing continuing professional development by the South Carolina Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

Safe States staff work remotely across the country to support the mission of Safe States and the strategic direction set by the Executive Committee.

You are
you're meant to be.
@kendrascott | #kendrascott
Shelli Stephens Stidham

National Injury
Prevention Day

Established in 2020 by the Injury Free Coalition for Kids to highlight safety practices, products, and the implementation of strong legislative policies.

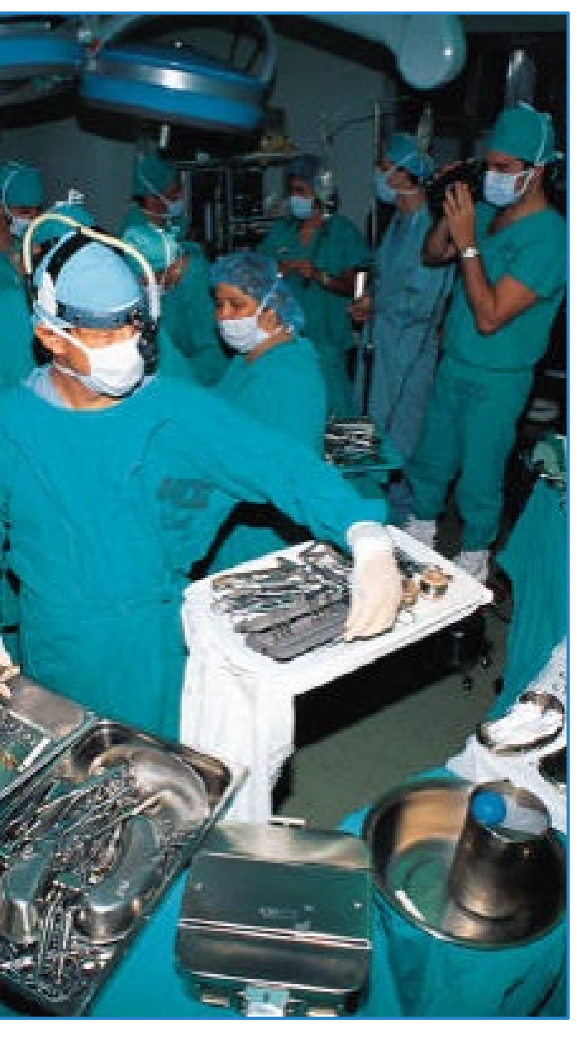
Conflicting Priorities

TRAUMA CENTERS

- Focus on the individual
- Acute care delivery
- Patient outcomes
- Tertiary prevention
- Revenue reimbursement
- Clinical research

INJURY PREVENTION PROGRAMS

- Focus on populations
- Upstream prevention interventions
- Population outcomes
- Primary prevention
- Reduce costs
- Community research



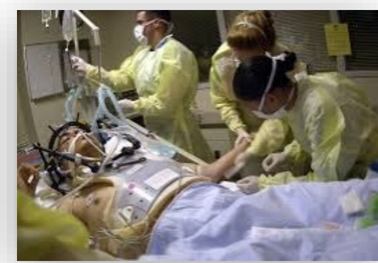
Medical Care Alone Cannot Reduce Injuries

- Not the primary determinant of health
- Treats one person at a time
- Often comes late; can't always restore health

Prevention Institute

National Consensus on Trauma
1966

"The long-term solution to the injury problem is prevention. The major responsibility for accident prevention rests not with the medical profession, but with educators, industrialists, engineers, public health officials, regulatory officials, and private citizens."



Seeley, S. (1966). Accidental death and disability: the neglected disease of modern society. *Committee on Trauma and Committee on Shock, Division of Medical Sciences. National Academy of Sciences, National Research Council*, *2101*.

ACS Addresses Prevention
1979, 1983

Resources For Optimal Care of the Injured Patient

"… injury prevention in the home and industry, and on the highways and athletic fields: standard first-aid: problems confronting public, medical profession and hospitals regarding optimal care for the injured"

American College of Surgeons. Committee on Trauma. (1979). *Hospital resources for optimal care of the injured patient*. American College of Surgeons

ACS Increases Focus on Prevention
1990

"Unfortunately, prevention is one of the most difficult to achieve…"

"Prevention, nevertheless, is an essential component and an integral part of a trauma system"

"More emphasis must be placed on innovative prevention programs…"

American College of Surgeons. Committee on Trauma. (1990). *Resources for optimal care of the injured patient*.

ACS Requires Injury Prevention
1993

- Chapter on Prevention added
- Required designated Prevention Coordinator for Level I and II
- Required injury control research (Level 1)
- Required special ED and filed data collection (Level 1)

American College of Surgeons. Committee on Trauma. (1993). *Resources for optimal care of the injured patient*.

Developing the National Standards & Indicators

Purpose: *Strengthen Trauma Center IVP programs and increase the alignment of these efforts with public health practice.*

1. Build consensus on core components of Trauma IVP programs
2. Develop standards and indicators for model Level I and II Trauma IVP programs
3. Identify opportunities to strengthen collaboration between local public health and hospital trauma centers

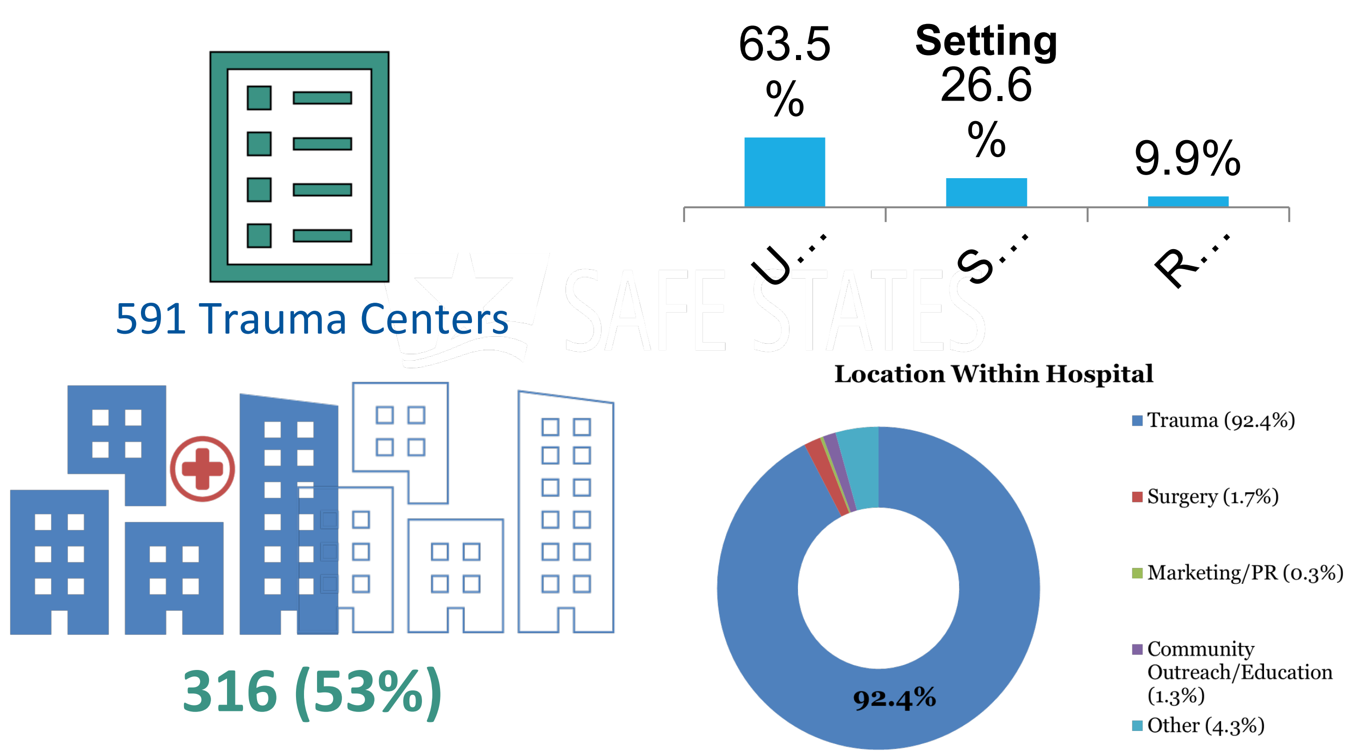
Process

- Developed with funding from the CDC, and facilitated by NACCHO and Safe States Alliance
- Reviewed documents
- *American college of surgeons committee on trauma, resource for optimal care of the injured patient: 2014 (ORANGE BOOK)*
- *NACCHO AND SAFE STATES ALLIANCE GUIDELINES, STANDARDs & INDICATORS FOR LOCAL HEALTH DEPARTMENT INJURY AND VIOLENCE prevention programs (2011)*
- *National training initiative for injury and violence prevention (NTI), core competencies for injury and violence prevention (2005)*
- *Texas governor's ems and trauma advisory council (GETAC) injury prevention & public education committee, hospital-based injury prevention components (2014)*
- Conducted a national survey of trauma hospitals
  - 53% response (316/591)
  - Convened stakeholders
- Document produced and published in November 2017
- Assessment tools produced in 2018

Participants

Christy Adams, RN, MPH, PhD(c) | UC Davis Health System
Julie Alonso, BA | Safe States Alliance
Cynthia Blank-Reid, RN, MSN, CEN | Society of Trauma Nurses
Margaret Carr, BS | The National Association of County and City Health Officials
Tara Reed Carlson, MSN, RN | R. Adams Shock Trauma Center
Renan Castillo, PhD | Johns Hopkins Bloomberg School of Public Health
Carnell Cooper, MD, FACS | Dimensions Healthcare System / Prince George's Hospital Center
Dyann Daley, MD | The Center for Prevention of Child Maltreatment
Joan Duwve, MD | Indiana Department of Health; Safe States Alliance
Elizabeth Edgerton, MD | Health Resources and Services Administration
Courtney Edwards, MSN, MPH, RN, CCRN, CEN, TCRN | Parkland Health & Hospital System
Kimberly Everett, MA | St. Mary Medical Center
Joanne Fairchild, RN (Retired) | Legacy Emanual Hospital
Debby Gerhardstein, RN, BSN, MA | ThinkFirst National Injury Prevention Foundation
Sharon Gilmartin, MPH | Safe States Alliance
A. Chevelle Glymph, MPH, CPM | The National Association of County and City Health Officials
Anne Goodman, MPH | Grant Medical Center
Susan Hardman | Safe States Alliance
Mike Hirsh, MD | Worcester Division of Public Health
Sheree Keitt, MPH | The National Association of County and City Health Officials
Deborah Kuhls, MD, FACS, FCCM | American College of Surgeons Committee on Trauma
Cindy Magnole, MSN, RN | Jackson Memorial Hospital, Ryder Trauma Center
Angela Marr, MPH | Centers for Disease Control and Prevention
Maria F. McMahon, MSN, RN, PNP | Society of Trauma Nurses
Angela Mickalide, PhD, MCHES | Society for Public Health Education
Beverly Miller, MEd | Injury Prevention Center, Arkansas Children's Hospital and the University of Arkansas for Medical Sciences
Anna Bradford Newcomb, PhD, LCSW | Inova Fairfax Hospital
Donovan Newton, MPA | Centers for Disease Control and Prevention
Jennifer Northway, CHES, CPSTI | University Health System
Tim Orcutt, MSN, RN, CEN | Washington State Department of Health
Helaina Roisman, LGSW | George Washington University Hospital
Dwayne Smith, MEd, MCHES | Children's Hospital Colorado
Cora Speck , MS | Queen's Medical Center
Shelli Stephens-Stidham, MPA | Injury Prevention Center of Greater Dallas
Christa Thelen, MA, CHES, CPST-I | Children's Hospital & Medical Center
Sallie Thoreson, MS | Colorado Department of Public Health and Environment
Calondra Tibbs, MPH | The National Association of County and City Health Officials
Glen Tinkoff, MD | Trauma Prevention Coalition
Pina Violano, PhD, RN | Trauma Center Association of America
Jennifer Ward, MBA, BSN, RN | Trauma Center Association of America
Janet Werst, BS | UC Health
Ian Weston, MPP | American Trauma Society
Amber Williams, MPH | Safe States Alliance
Janice Williams, MSED | Carolinas Medical Center
Stewart Williams, BS, CPSTI | Dell Children's Medical Center

National Survey of Level I & II Trauma Centers



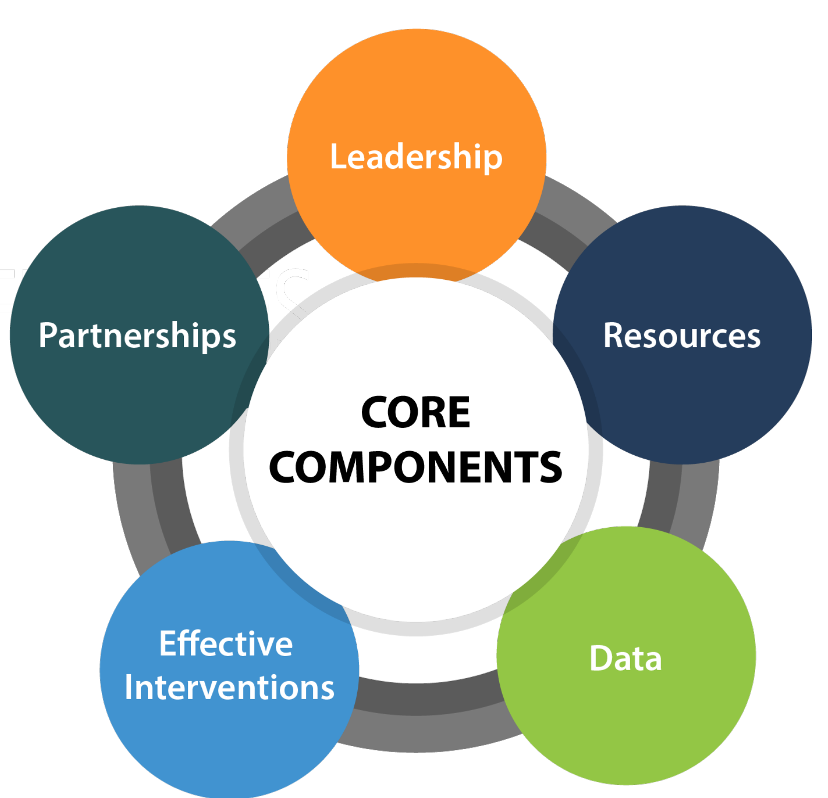
Key Findings

- Strong involvement and commitment from hospital leadership team
- 3 out of 4 trauma center IVP programs operate with a total annual budget of $100,000 or less (inclusive of salaries).
- Highly experienced staff, but nearly 1/3 reported no IVP training during the past five years
- Data gaps between sources available and sources used
- <50% programs collaborate on data activities with SHD/LHD

SAFE STATES

Core Components identified

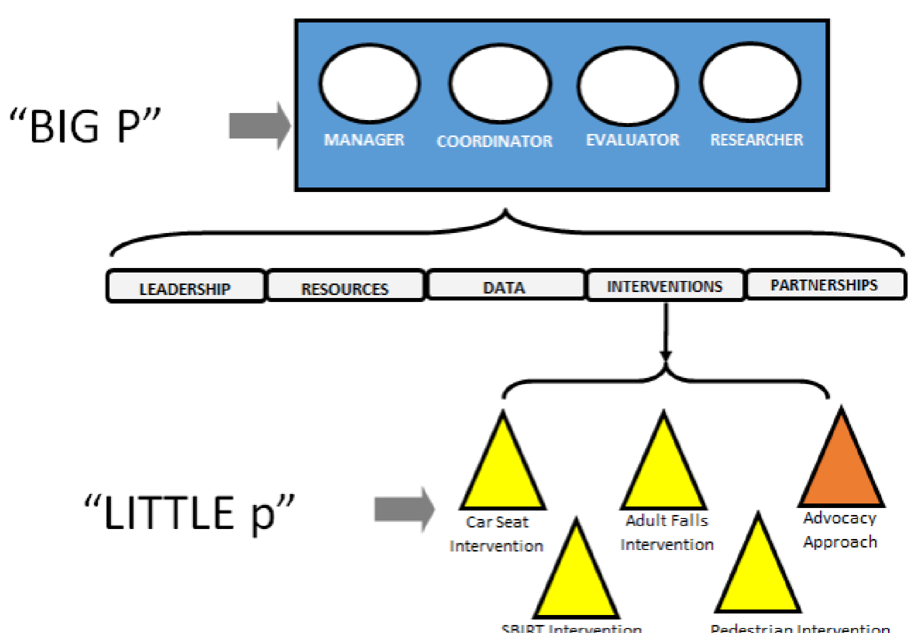
- Leadership
- Resources
- Data
- Effective interventions
- Partnerships

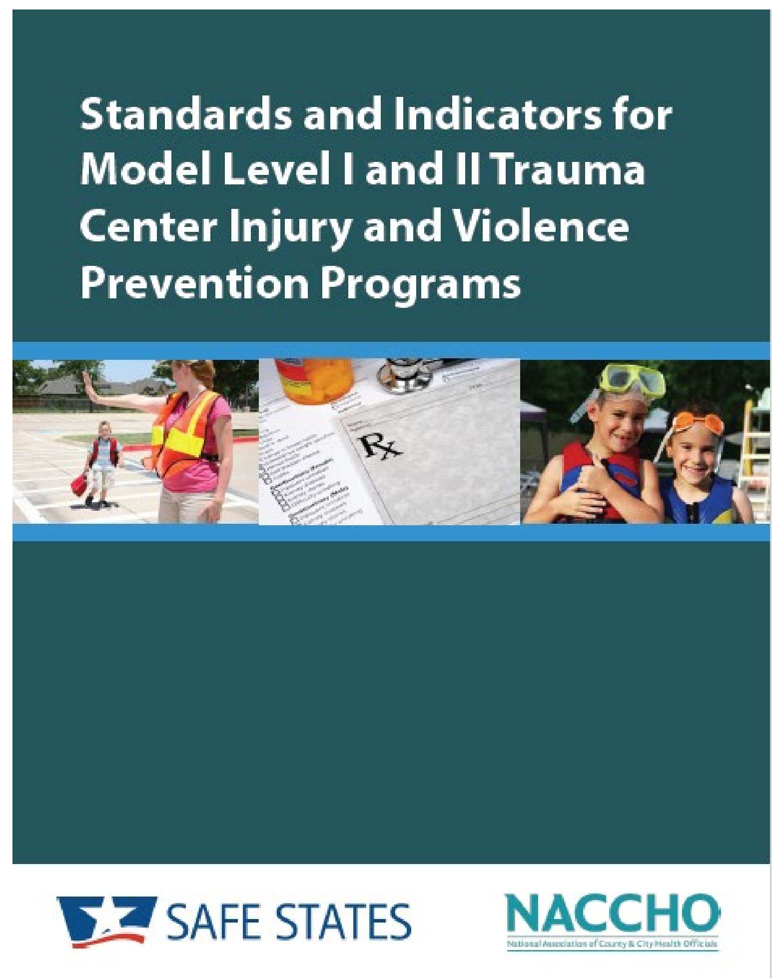


Let’s Define “Program”

PROGRAM: The organizational structure/department within the hospital (differs by institution)

PROGRAMMATIC INTERVENTION: The specific IVP-related work that the program’s staff implement




Standards and Indicators for Model Level I and II Trauma Center Injury and Violence Prevention Programs
SAFE STATES
NACCHO
National Association of County & City Health Officials

Considerations for Standards and Indicators

- Acknowledge realities of basic (1 FTE) program vs. model/aspirational
- Broader systems view
- Philosophical differences between hospitals and public health
  - Different language and metrics

SAFE STATES

- **Rationale** – explains the importance of each core component
- **Standard** – sets the model to achieve
- **Indicators** – provide specific functions that are suggested to achieve the standard

STANDARDS AND INDICATORS FOR ENSURING SUPPORTIVE LEADERSHIP

RATIONALE

Trauma centers have a leadership role in educating and influencing others about the potential of injury and violence prevention to reduce the burden of injury and its costs to health systems and society, and its potential to drive positive changes in community health outcomes. This occurs both *internally*, helping to articulate the need for and value of the program's activities and impact within hospital chains of command, and *externally* in the community.

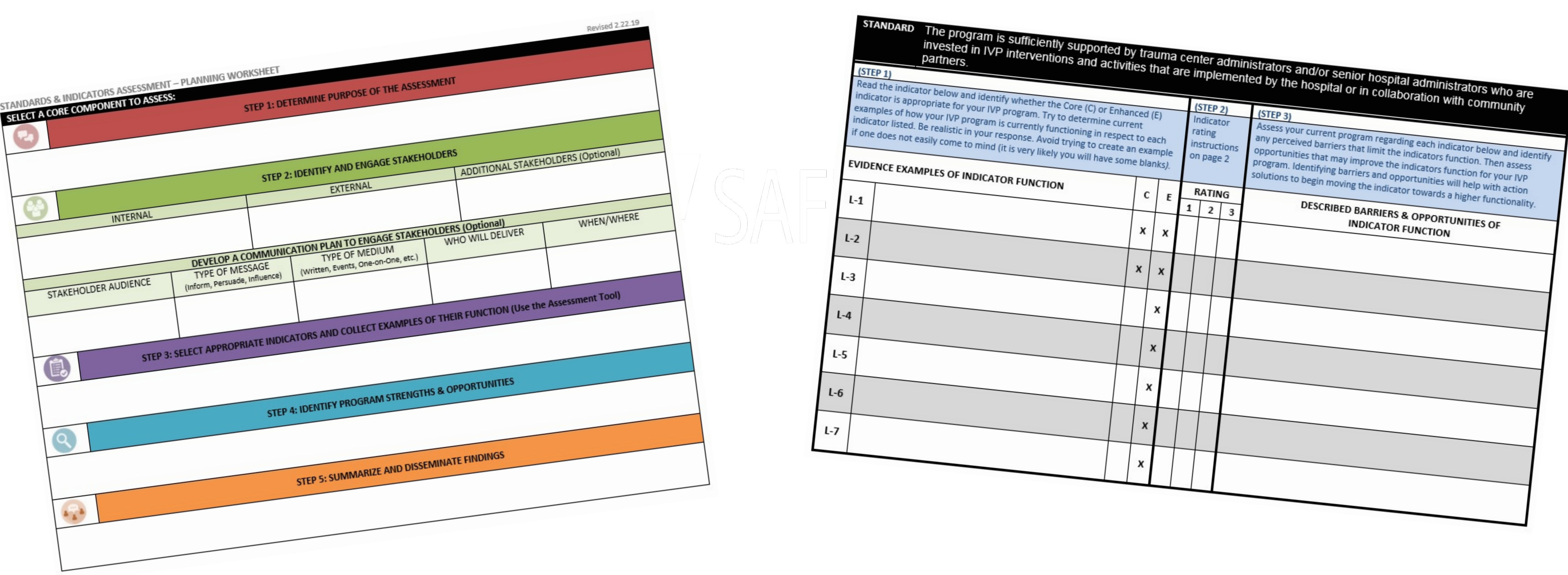
STANDARD

The program is sufficiently supported by trauma center administrators and/or senior hospital administrators who are invested in IVP interventions and activities that are implemented by the hospital or in collaboration with community partners.

INDICATORS

	Indicators of Leadership Standard	Core Model Program Indicators	Enhanced Model Program Indicators
L-1	Internal hospital chains of command (within the hospital/ system infrastructure) are aware of and support IVP activities in collaboration with the IVP professional.	x	x
L-2	The IVP program demonstrates how its activities and priorities align with those of the hospital's strategic plan.	x	x
L-3	The program promotes its visibility and value by tracking IVP countermeasures in a variety of ways that are meaningful to the hospital (e.g., outcome data from evaluations, billing data, reimbursement coding, revenue generation).		x
L-4	The IVP program's activities/priorities are reflected in high-level hospital and system planning documents.		x

Tools and resources



Revised 2.22.19

STANDARDS & INDICATORS ASSESSMENT – PLANNING WORKSHEET

SELECT A CORE COMPONENT TO ASSESS:

STEP 1: DETERMINE PURPOSE OF THE ASSESSMENT

STEP 2: IDENTIFY AND ENGAGE STAKEHOLDERS

INTERNAL	EXTERNAL	ADDITIONAL STAKEHOLDERS (Optional)

DEVELOP A COMMUNICATION PLAN TO ENGAGE STAKEHOLDERS (Optional)

STAKEHOLDER AUDIENCE	TYPE OF MESSAGE (Inform, Persuade, Influence)	TYPE OF MEDIUM (Written, Events, One-on-One, etc.)	WHO WILL DELIVER	WHEN/WHERE

STEP 3: SELECT APPROPRIATE INDICATORS AND COLLECT EXAMPLES OF THEIR FUNCTION (Use the Assessment Tool)

STEP 4: IDENTIFY PROGRAM STRENGTHS & OPPORTUNITIES

STEP 5: SUMMARIZE AND DISSEMINATE FINDINGS

STANDARD The program is sufficiently supported by trauma center administrators and/or senior hospital administrators who are invested in IVP interventions and activities that are implemented by the hospital or in collaboration with community partners.

(STEP 1) Read the indicator below and identify whether the Core (C) or Enhanced (E) indicator is appropriate for your IVP program. Try to determine current examples of how your IVP program is currently functioning in respect to each indicator listed. Be realistic in your response. Avoid trying to create an example if one does not easily come to mind (it is very likely you will have some blanks).

(STEP 2) Indicator rating instructions on page 2

(STEP 3) Assess your current program regarding each indicator below and identify any perceived barriers that limit the indicators function. Then assess opportunities that may improve the indicators function for your IVP program. Identifying barriers and opportunities will help with action solutions to begin moving the indicator towards a higher functionality.

EVIDENCE EXAMPLES OF INDICATOR FUNCTION		C	E	RATING 1	RATING 2	RATING 3	DESCRIBED BARRIERS & OPPORTUNITIES OF INDICATOR FUNCTION
L-1							
L-2		X	X				
L-3		X	X				
L-4			X				
L-5			X				
L-6			X				
L-7			X				
			X				

Steps for conducting the assessment

1. Describe the purpose for the assessment
2. Identify and engage stakeholders
3. Collect examples of indicator function
4. Identify program (Big P) strengths and opportunities
5. Summarize and disseminate findings

Access the Report

http://www.safestates.org/TraumaIVP

Other Resources

Texas Hospital-Based Injury Prevention Program Core Components for Level III & IV Trauma Centers

Updated August 22, 2018

LEADERSHIP

Rationale

Trauma centers should take a leadership role in educating and influencing others about the potential of injury and violence prevention to reduce the burden of injury and its costs to health systems and society, and it's potential to drive positive changes in community health outcomes. This can occur both *internally*, helping to articulate the need for and value of the program's activities and impact within hospital chains of command, and *externally* in the community.

Injury and Violence Prevention (IVP) Programs need to regularly support continuing education and training for staff members. Because IVP programs address a diverse range of social, behavioral, policy and industrial conditions, IVP professionals need a multi-skilled set of education and knowledge.

Standard

The program is sufficiently supported by trauma center administrators, hospital staff and/or senior hospital administrators who are invested in IVP interventions and activities that are implemented by the hospital or in collaboration with community partners.

	Indicator	Essential or Desired Indicator
L-1	Internal hospital chains of command (within the hospital infrastructure) are aware of and support IVP activities in collaboration with the IVP professional.	Essential
L-2	The IVP program demonstrates how its activities and priorities align with those of the hospital's strategic plan.	Desired
L-3	The IVP professional attends and/or reports to hospital leadership meetings.	Desired
L-4	The IVP professional seeks ongoing leadership development training and mentorship.	Desired
L-5	The program provides a report to the community annually that includes the scope and status of its partnerships, data findings and evaluation of programs and activities designed to reduce injury and violence in the communities served, in an accessible, user-friendly format.	Desired

Suggested Leadership Resources

- Texas Injury Prevention Leadership Collaborative
- UCLA Mindful Awareness Research Center
- Simon Sinek

Publications

- Finding the Space to Lead by Janice Marturano
- What Got You Here Won't Get You There by Marshall Goldsmith

https://www.dshs.texas.gov/emstraumasystems/GETAC/PDF/IPPE-TXHospitalBasedIP-CoreComponents2018Update.pdf

BMJ
Trauma Surgery & Acute Care

Current opinion

Consensus-based Standards and Indicators to strengthen trauma center injury and violence prevention programs

Christy Adams [1], Deborah A Kuhls [2], Shelli Stephens-Stidham [3], Julie Alonso [3], Stewart Williams [4], Glen H Tinkoff [5]

Correspondence to Dr Christy Adams; cmadams@ucdavis.edu

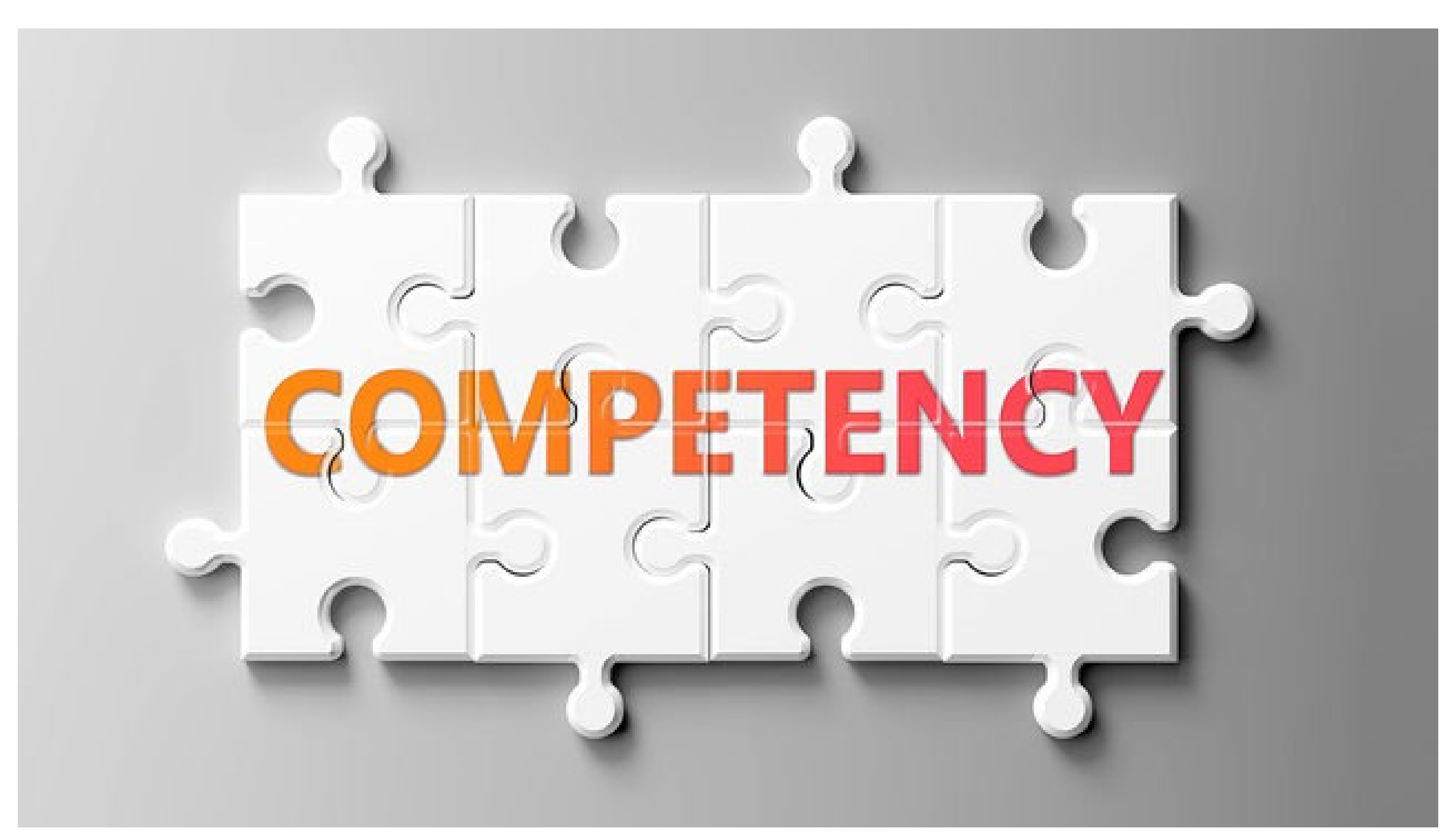
Abstract

For decades, the American College of Surgeons Committee on Trauma (ACSCOT) has published *Resources for Optimal Care of the Injured Patient,* which outlines specific criteria necessary to be verified by the college as a trauma center, including having an organized and effective approach to prevention of trauma. However, the document provides little public health-specific guidance to assist trauma centers with developing these approaches. An advisory panel was convened in 2017 with representatives from national trauma and public health organizations with the purpose of identifying strategies to support trauma centers in the development of a public health approach to injury and violence prevention and to better integrate these efforts with those of local and state public health departments. This panel developed the *Standards and Indicators for Model Level I and II Trauma Center Injury and Violence Prevention Programs*. The document outlines five, consensus-based core components of a model injury and violence prevention program: (1) leadership, (2) resources, (3) data, (4) effective interventions, and (5) partnerships. We think this document provides the missing public health guidance and is an essential resource to trauma centers for effectively addressing injury and violence in our communities. We recommend the Standards and Indicators be referenced in the injury prevention chapter of the upcoming revision of ACSCOT's *Resources for Optimal Care of the Injured Patient* as guidance for the development, implementation and evaluation of injury prevention programs and be used as a framework for program presentation during ACSCOT verification visits.

http://creativecommons.org/licenses/by-nc/4.0/

This is an open access article distributed in accordance with the Creative Commons Attribution Non Commercial (CC BY-NC 4.0) license, which permits others to distribute, remix, adapt, build upon this work non-commercially, and license their derivative works on different terms, provided the original work is properly cited, appropriate credit is given, any changes made indicated, and the

https://tsaco.bmj.com/content/6/1/e000762.full


COMPETENCY

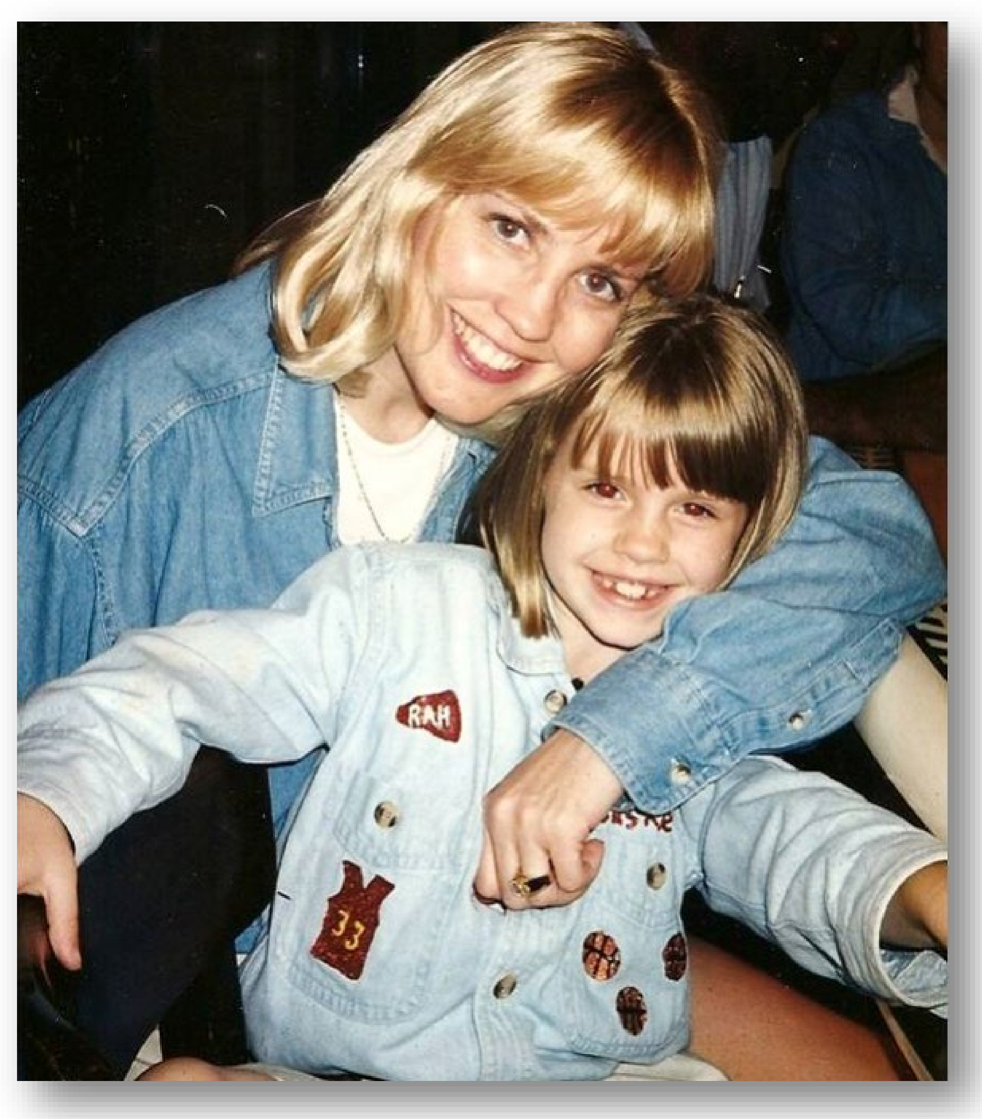
SKILLS
ABILITIES
KNOWLEDGE

Core Competencies for Injury & Violence Prevention Professionals

- Ability to describe and explain injury and/or violence as a major social and health problem.
- Ability to access, interpret, use and present injury and/or violence data.
- Ability to design and implement injury and/or violence prevention activities.
- Ability to evaluate injury and/or violence prevention activities.
- Ability to build and manage an injury and/or violence prevention program.
- Ability to disseminate information related to injury and/or violence prevention to the community, other professionals, key policy makers and leaders through diverse communication networks.
- Ability to stimulate change related to injury and/or violence prevention through policy, enforcement, advocacy, and education.
- Ability to maintain and further develop competency as an injury and/or violence prevention professional.
- Demonstrate the knowledge, skills, and best practices necessary to address at least one specific injury and/or violence topic (e.g. motor vehicle occupant injury, intimate partner violence, fire and burns, suicide, drowning, child injury, etc.) and be able to serve as a resource regarding that area.

Training is available . . .

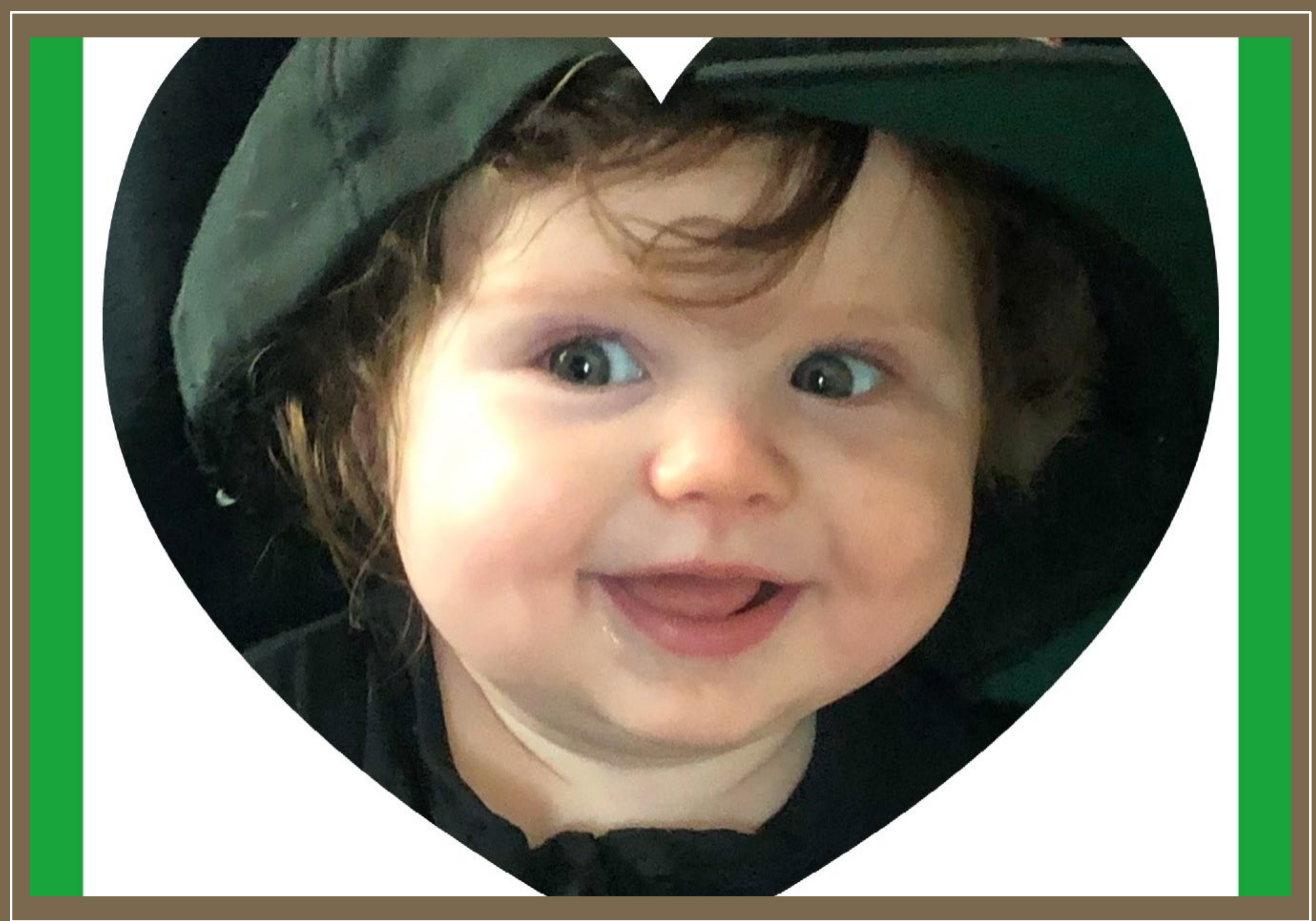
- Safe States Alliance IVP 360 (coming soon)
  - www.safestates.org
- ATS Injury Prevention Coordinator Course
  - https://www.amtrauma.org/general/custom.asp?page=InjuryPrevention
- Johns Hopkins Summer Institute: Principles and Practices of Injury Prevention https://www.jhsph.edu/courses/course/31550/2021/305.670.11/principles-and-practice-of-injury-prevention


RAH
33

January 26, 2007

SAFE STATES

OU



Thank you for saving lives!

shelli.stephens-stidham@safestates.org