CSN Children's Safety Network
at Education Development Center

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Using Quality Improvement to Prevent Childhood Injuries:

Strategies from the Child Safety Collaborative Innovation and Improvement Network

May 11, 2017, 3:00 – 4:00 p.m. ET

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This session is being recorded

Agenda & Objectives

- Project Purpose
- The Approach
- Team Stories
- Q&A

Objectives

- Explain the purpose and goals of the CS CoIIN
- Explain the CS CoIIN methodology, including the fundamentals of Continuous Quality Improvement
- Describe innovative strategies and results from Cohort 1

Presenters

Jenny Stern-Carusone, M.S.W.
Technology Director

Jen Leonardo, Ph.D.
Improvement Advisor

Bekah Thomas, M.P.A.
CS CoIIN Director

Laurin Kasehagen, Ph.D.
CDC Assignee/Lead Epidemiologist
Vermont Departments of Health and Mental Health

Jessica Schultz, M.P.H
Injury Prevention Epidemiologist Consultant
Division of Trauma and Injury Prevention
Indiana State Department of Health

Kaci Wray, M.B.A.
Child Passenger Safety Program Manager
Indiana Criminal Justice Institute (ICJI).

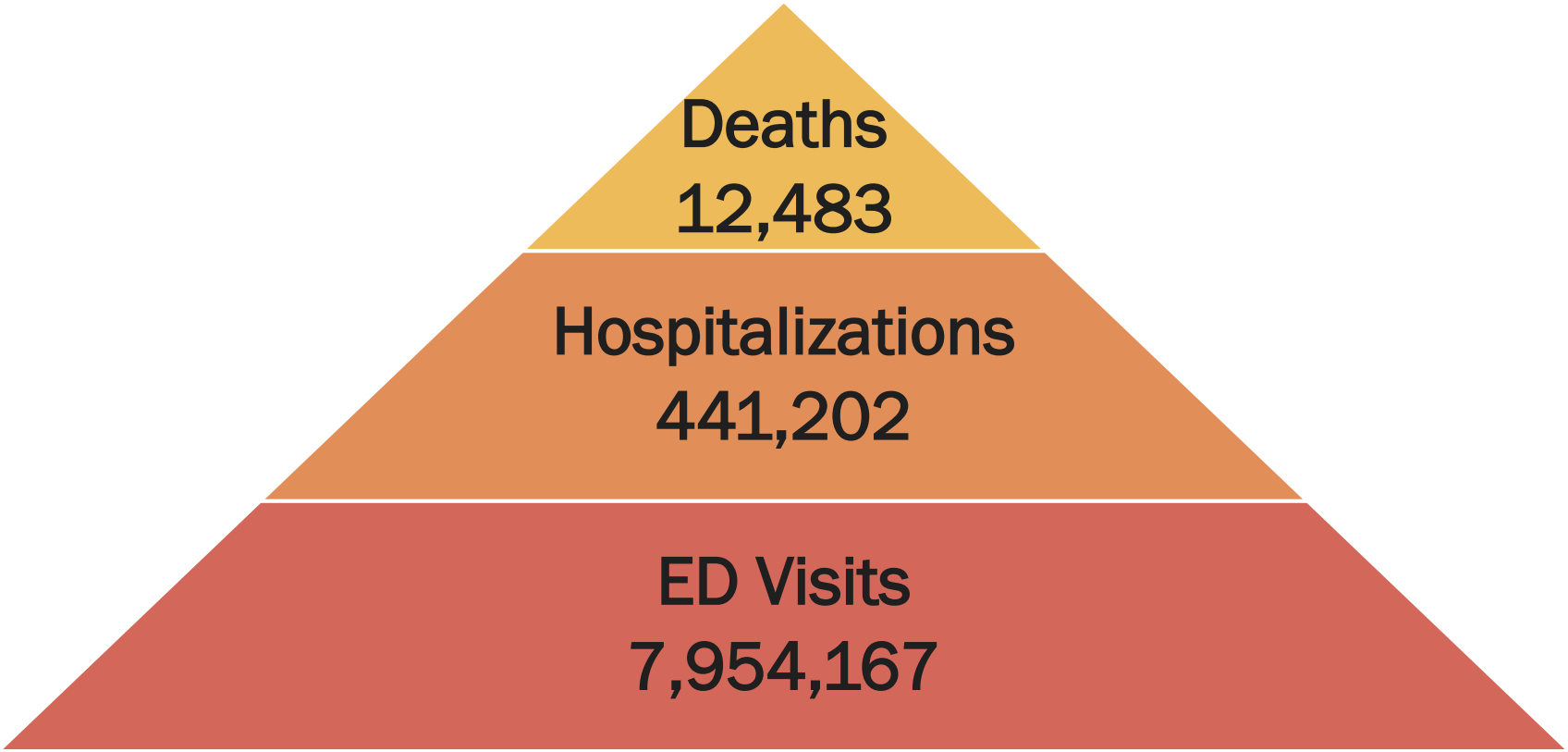
Project Purpose

Bekah Thomas, M.P.A.
CS CoIIN Director

The Problem

More children and adolescents ages 1-19 die from injuries and violence than from all diseases combined.

(National Center for Health Statistics, Multiple Cause of Death Data, 2010.)



2014 (Source: CDC WISQARS query April 2017)

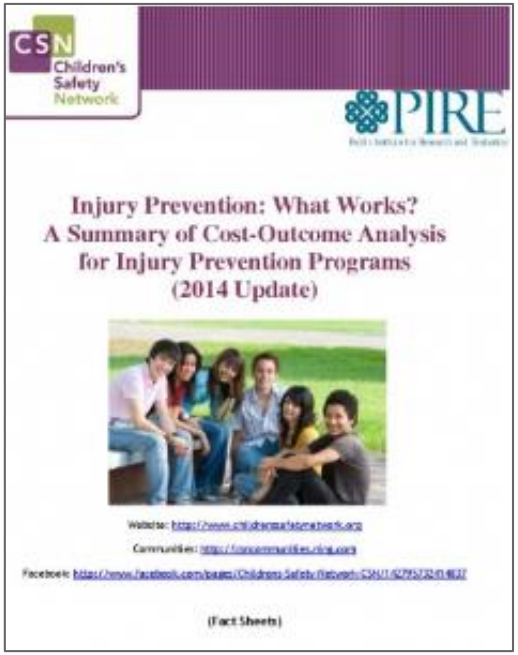
Leading Causes

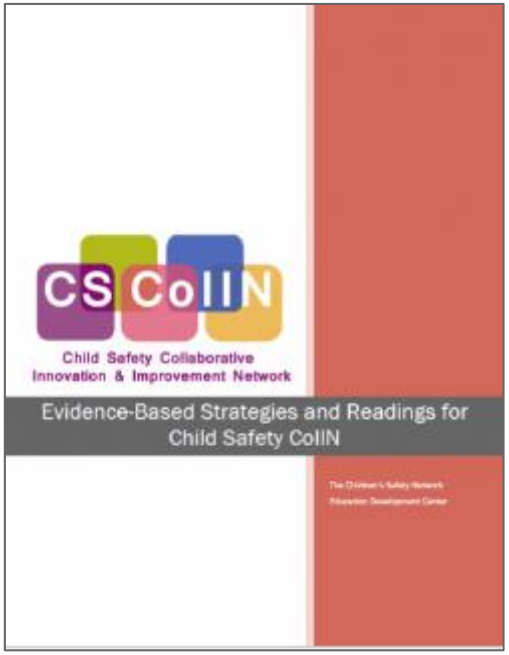
Rank	Deaths
1	Motor Vehicle Overall (3,817)
2	Homicide (2,289)
3	Suicide (2.262)
4	Suffocation / Inhalation (1,220)
5	Drowning (892)

Rank	Hospitalizations
1	Falls (42,364)
2	Motor Vehicle Overall (39,376)
3	Self-Harm (31,839)
4	Struck By/ Against (15,102)
5	Assault (13,984)

Rank	ED Visits
1	Falls (2,437,301)
2	Struck By/ Against (1725409)
3	Motor Vehicle Overall (783,402)
4	Cut/Pierce (447,214)
5	Assault (275,988)

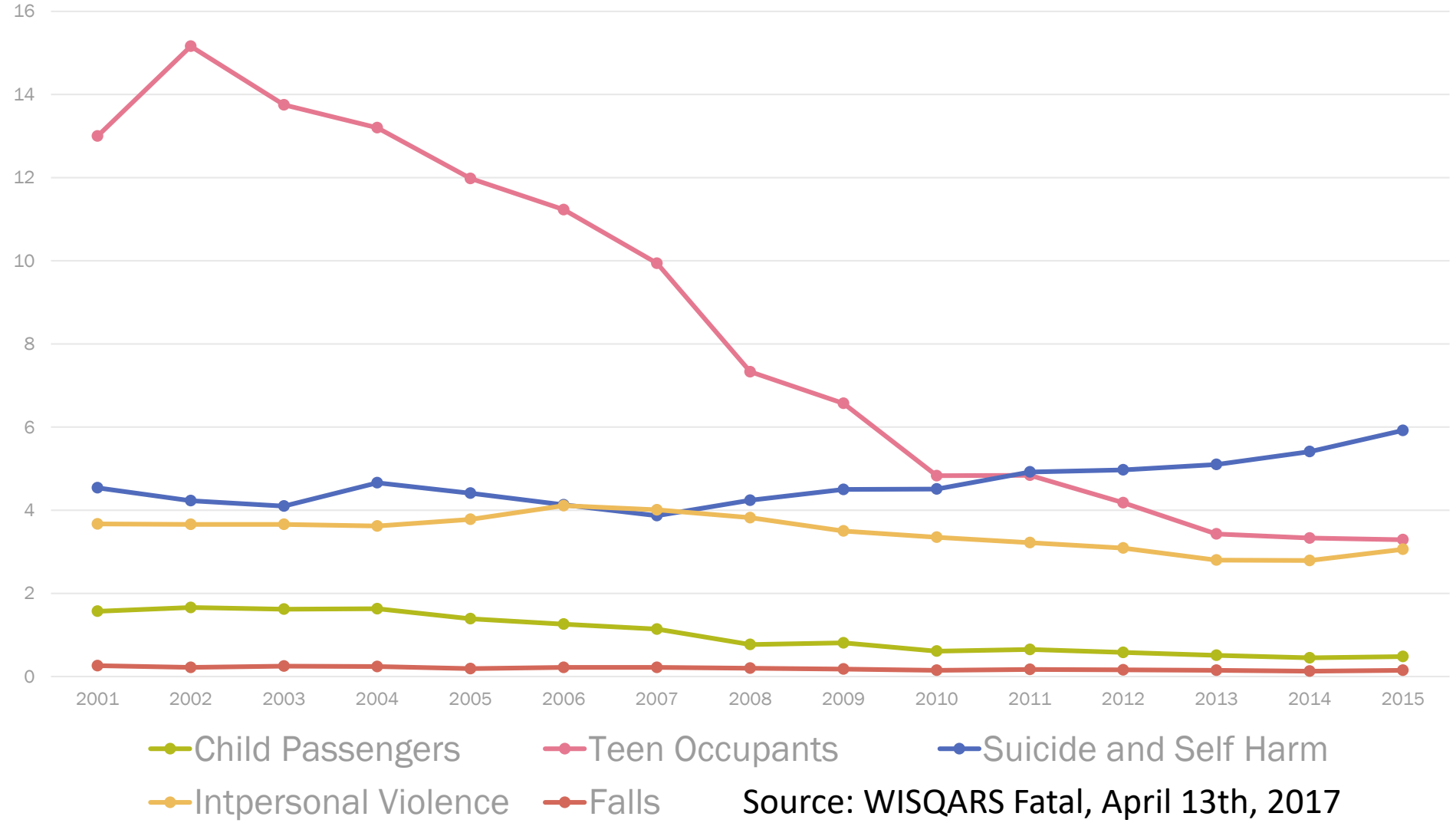
Evidence Exists





Death Trend Data

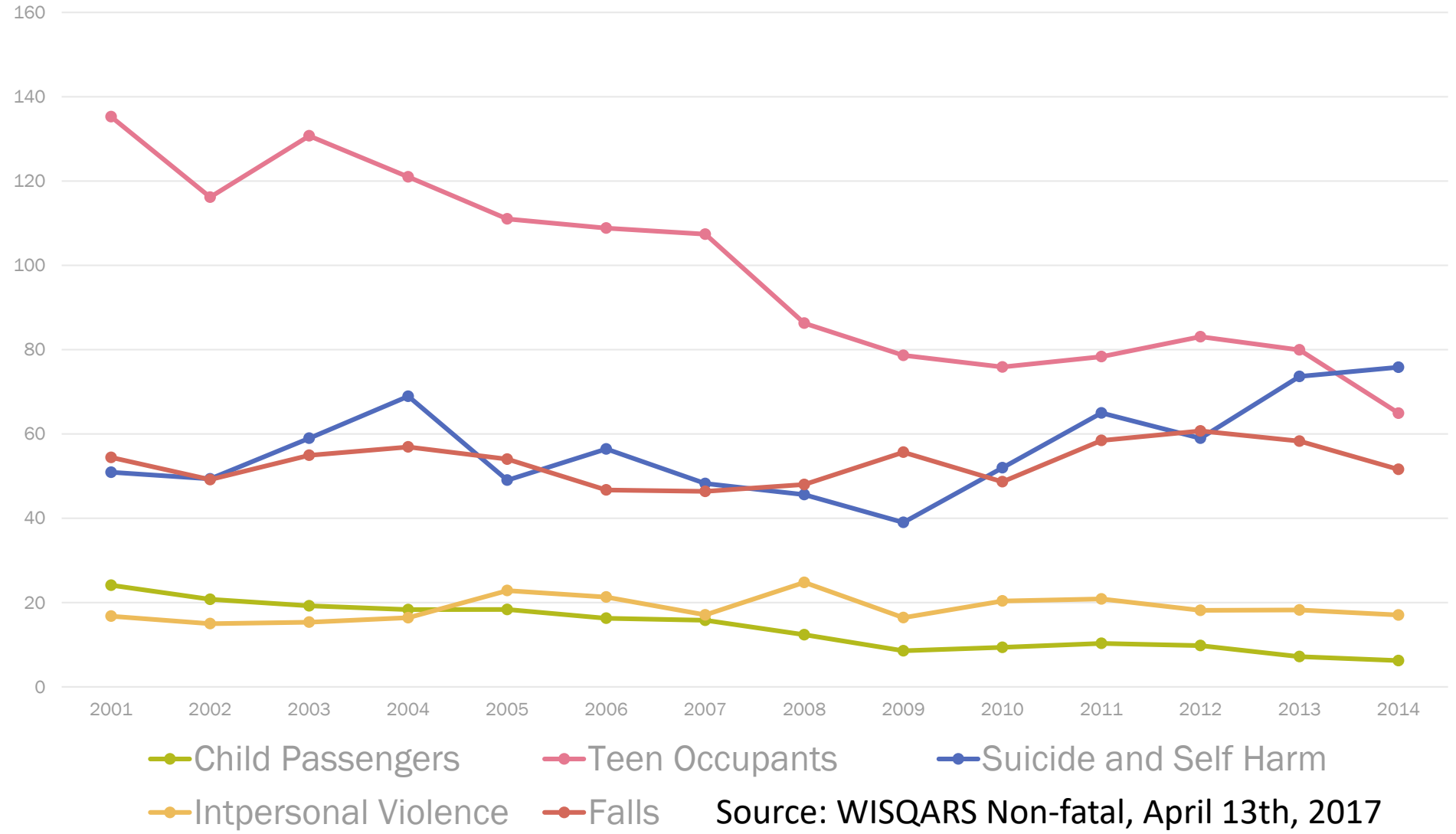
Crude rate per 100,000



Source: WISQARS Fatal, April 13th, 2017

Hospitalization Trend Data

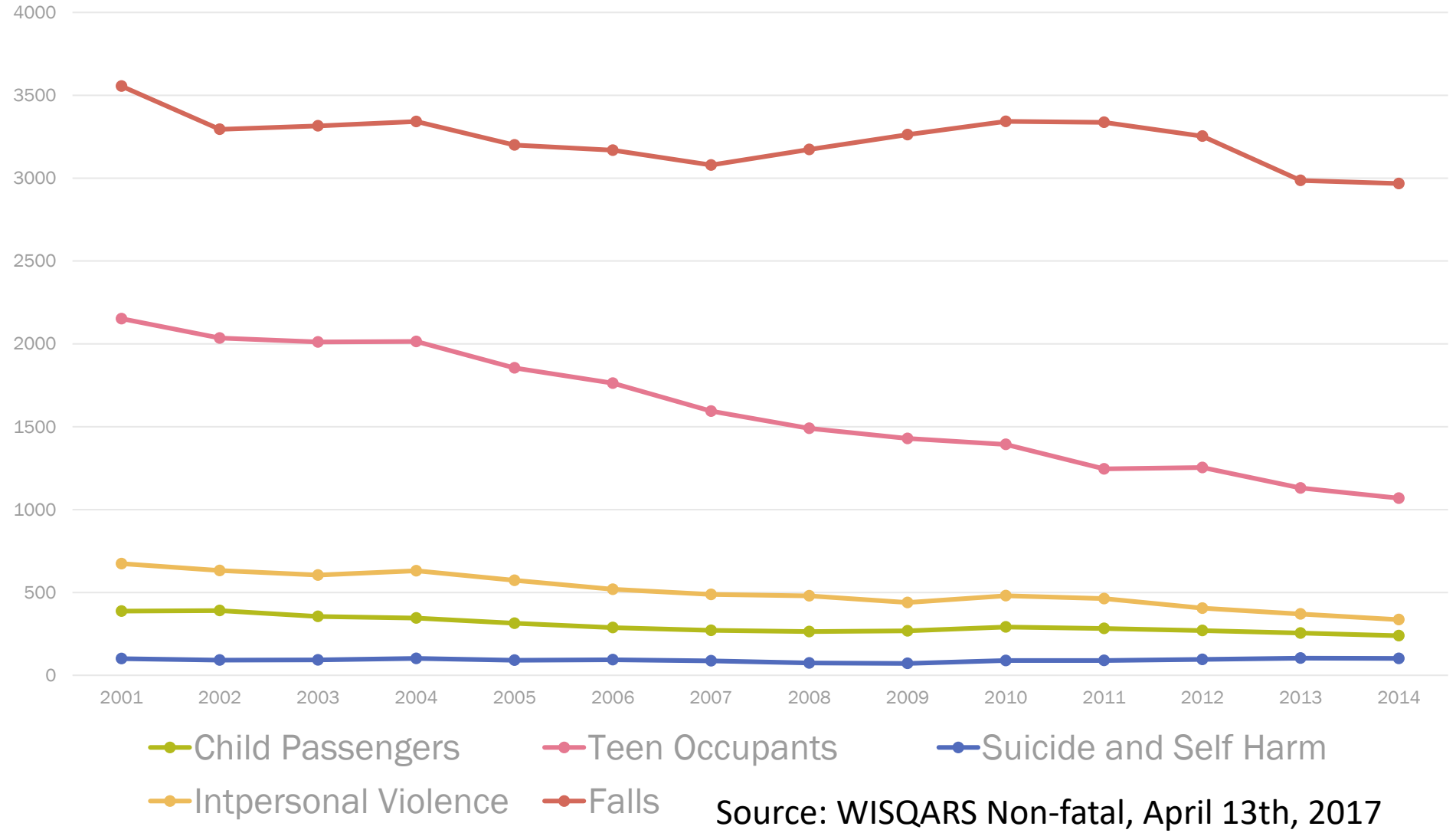
Crude rate per 100,000



Source: WISQARS Non-fatal, April 13th, 2017

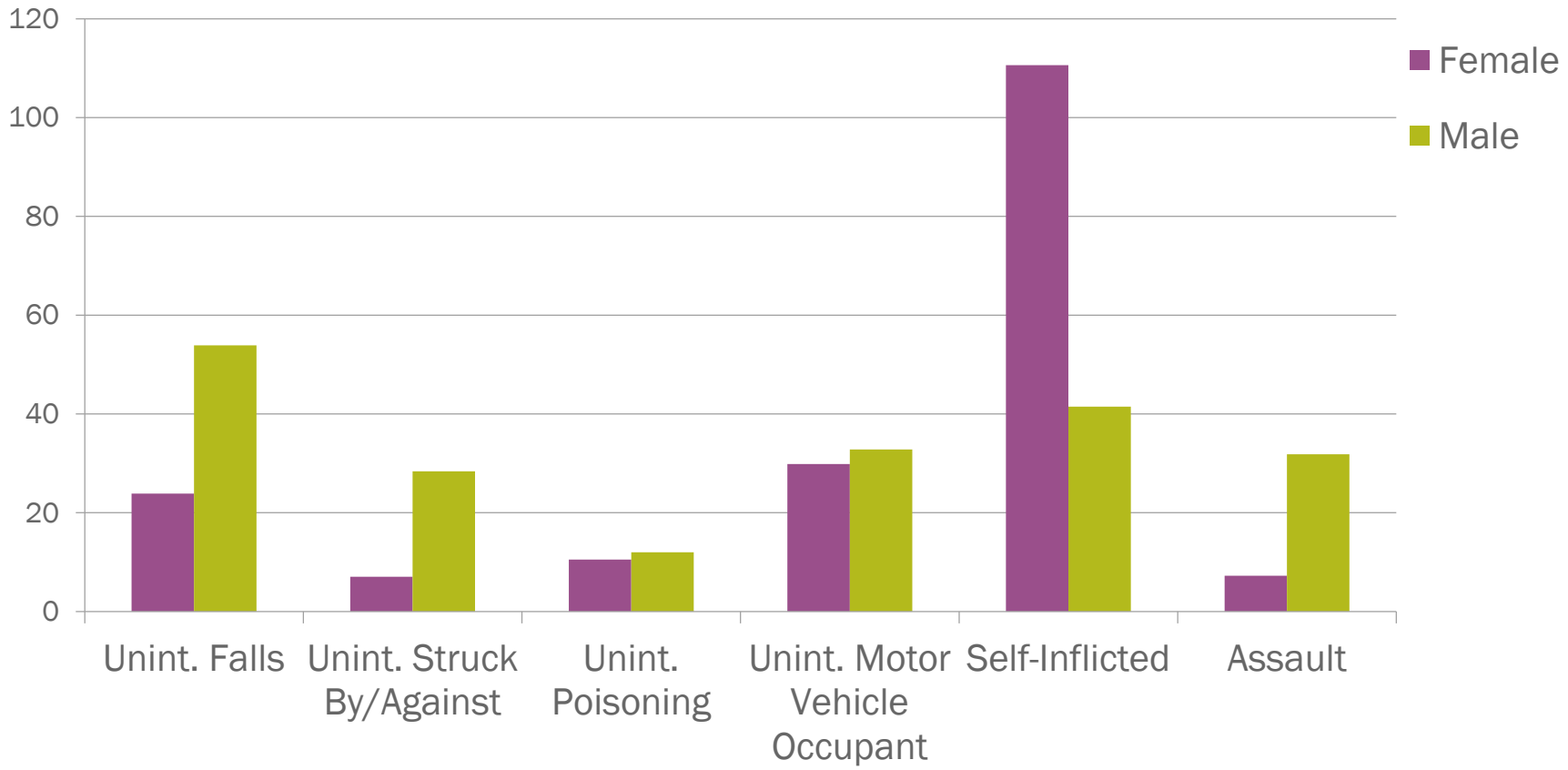
ED Visit Trend Data

Crude rate per 100,000



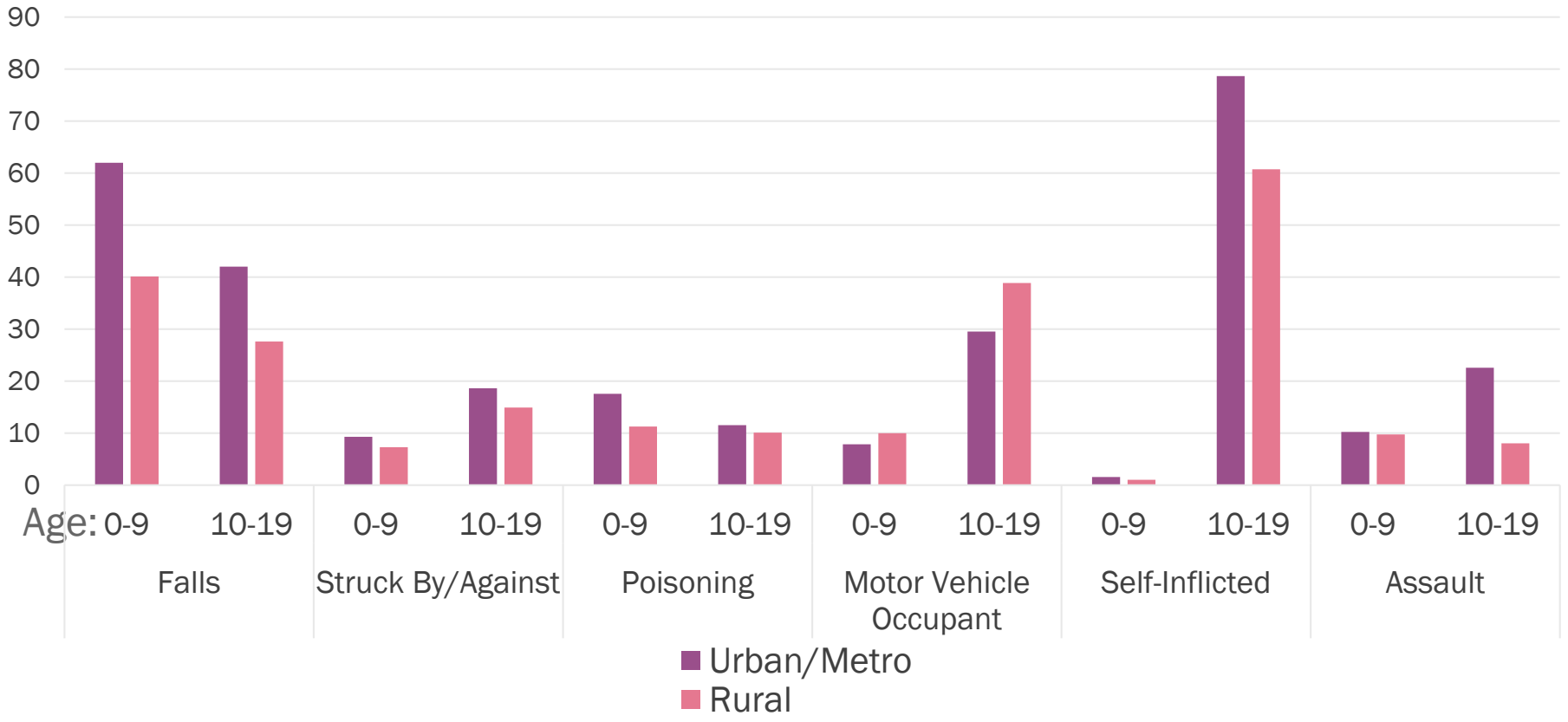
Source: WISQARS Non-fatal, April 13th, 2017

Rate of Injury Hospitalizations, Ages 10-19 by Sex, 2013



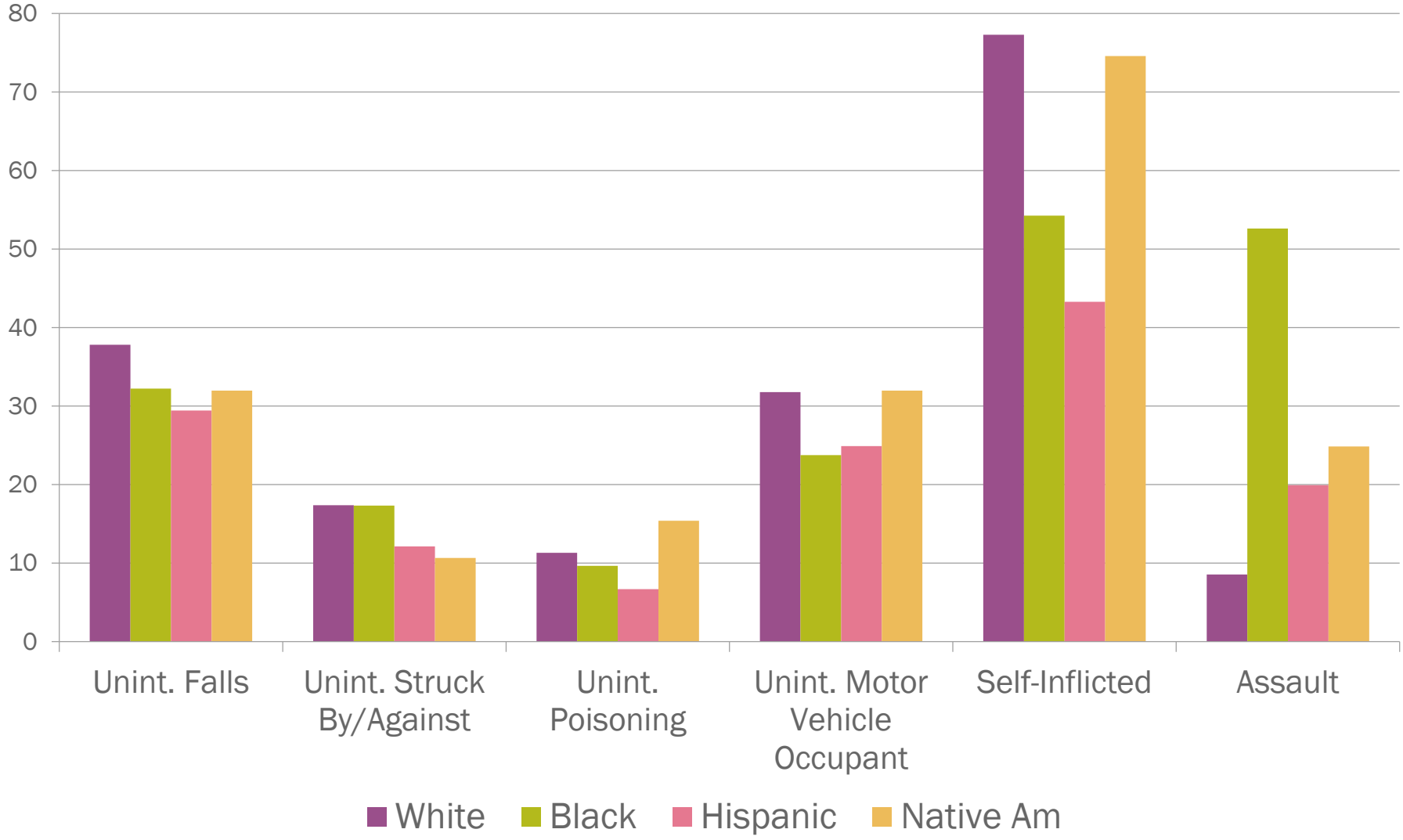
Source: 2013 Healthcare Utilization Project, Nationwide Inpatient Sample

Rate of Injury Hospitalizations, Urban vs Rural
for select causes by age group, 2013



Source: 2013 Healthcare Utilization Project, Nationwide Inpatient Sample

Rate of Injury Hospitalizations, Age 10-19, by Race/Ethnicity for select causes, 2013



Source2013 Healthcare Utilization Project, Nationwide Inpatient Sample

Percent Change in Fatal Injury Rates between 2007-2009 and 2013-2015

To Move the Needle, the Field Needs to. .

Integrate evidence-based child safety practices into relevant care settings

Forge collaborative partnerships across silos and state lines

Streamline child safety messages and activities

Increase the adoption of effective child safety interventions at state and local levels

Child Safety Collaborative Innovation & Improvement Network

Boldly Focusing on Leading Causes of Injury

- Teen Driver Safety
- Child Passenger Safety
- Falls Prevention
- Interpersonal Violence Prevention
- Suicide and Self-Harm Prevention

Approach

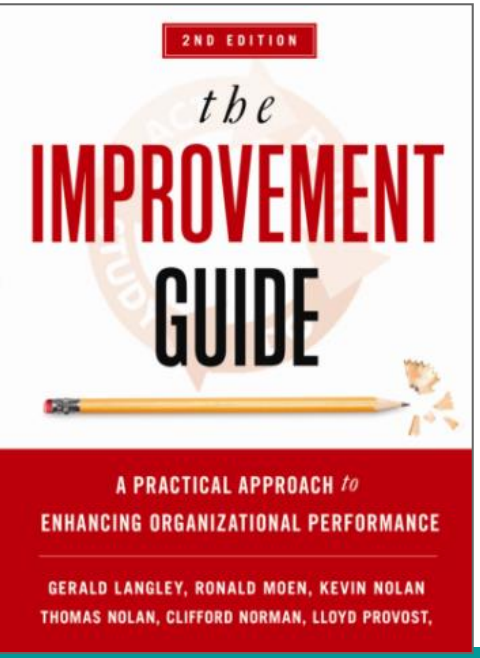
Jen Leonardo, Ph.D.
Improvement Advisor

Model for Improvement

Aim — What are we trying to accomplish?

Measures — How will we know that a change is an improvement?

Changes — What change can we make that will result in improvement?



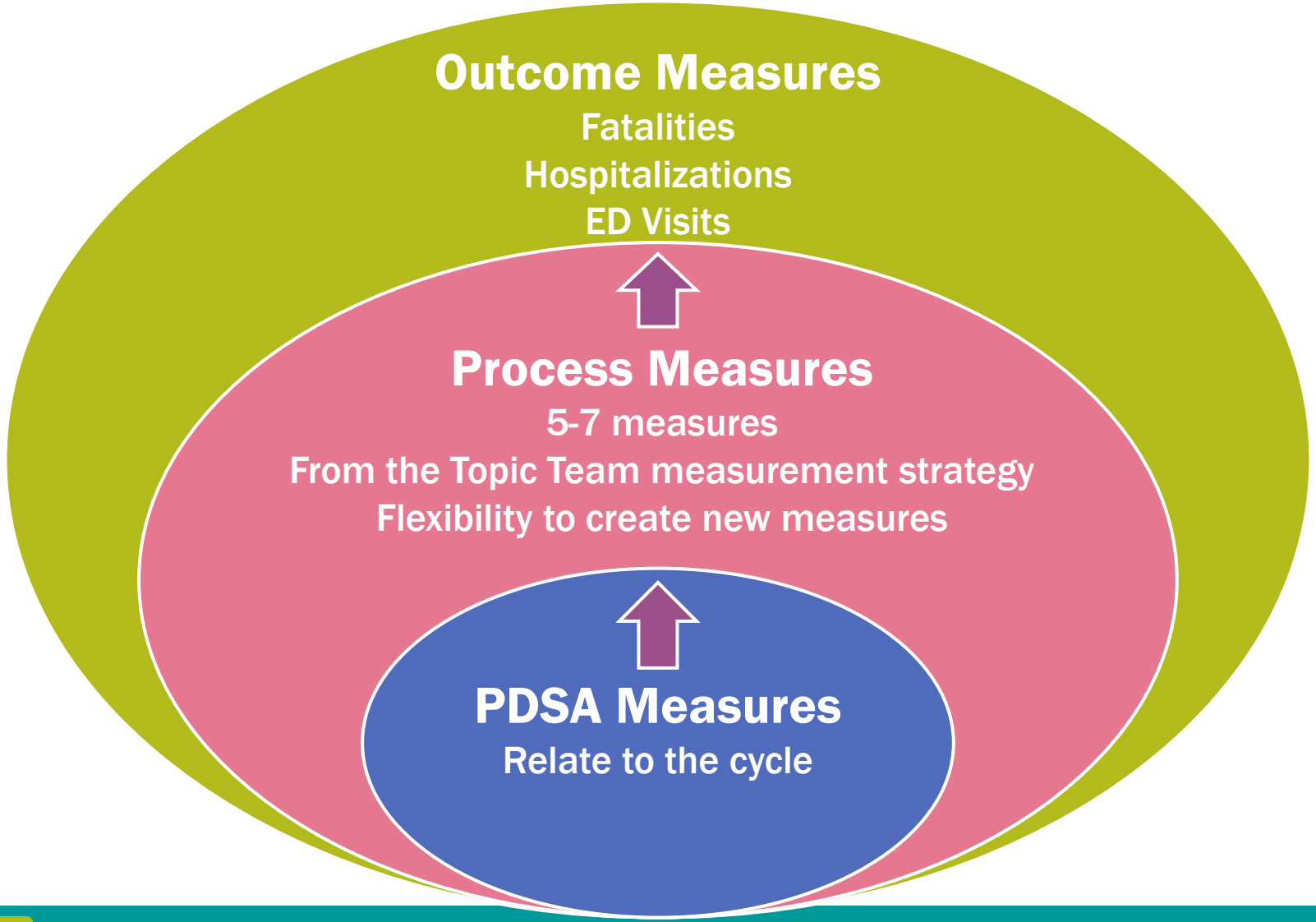
What are we Trying to Accomplish?

Aim

By May 2018, we will reduce deaths, hospitalizations, and emergency department (ED) visits resulting from child passenger safety, falls, interpersonal violence, suicide and self harm and teen driving, in children ages 0 through 9 and in adolescents ages 10 through 19. Our goals are to:

Deaths	Decrease the rate of injury-related mortality among 0-19 year olds by **5.83%** relative to the participating state/jurisdiction baseline rate for the CS CoIIN topic areas.
Hospitalizations	Decrease the rate of injury-related hospitalizations among 0-19 year olds by **3.81%** relative to the participating state/jurisdiction baseline rate for the CS CoIIN topic areas.
ED Visits	Decrease the rate of injury-related ED visits among 0-19 year olds by **3.74%** relative to the participating state/jurisdiction baseline rate for the CS CoIIN topic areas.

How Will We Know that a Change Is an Improvement?



What Change Can We Make that Will Result in Improvement?

Develop a theory of change using the Change Packages & your current Strategic Plan(s).

Outcome Primary Driver Changes

If I want to _____I need to focus on _____, one way(s) to do that is_____

Source: National Board for the Certification of Teachers, Lisa Clark

Sample Theory of Change

If I want to reduce teen fatalities from motor vehicle crashes,

I need to focus on enforcing graduated drivers licensing policies.

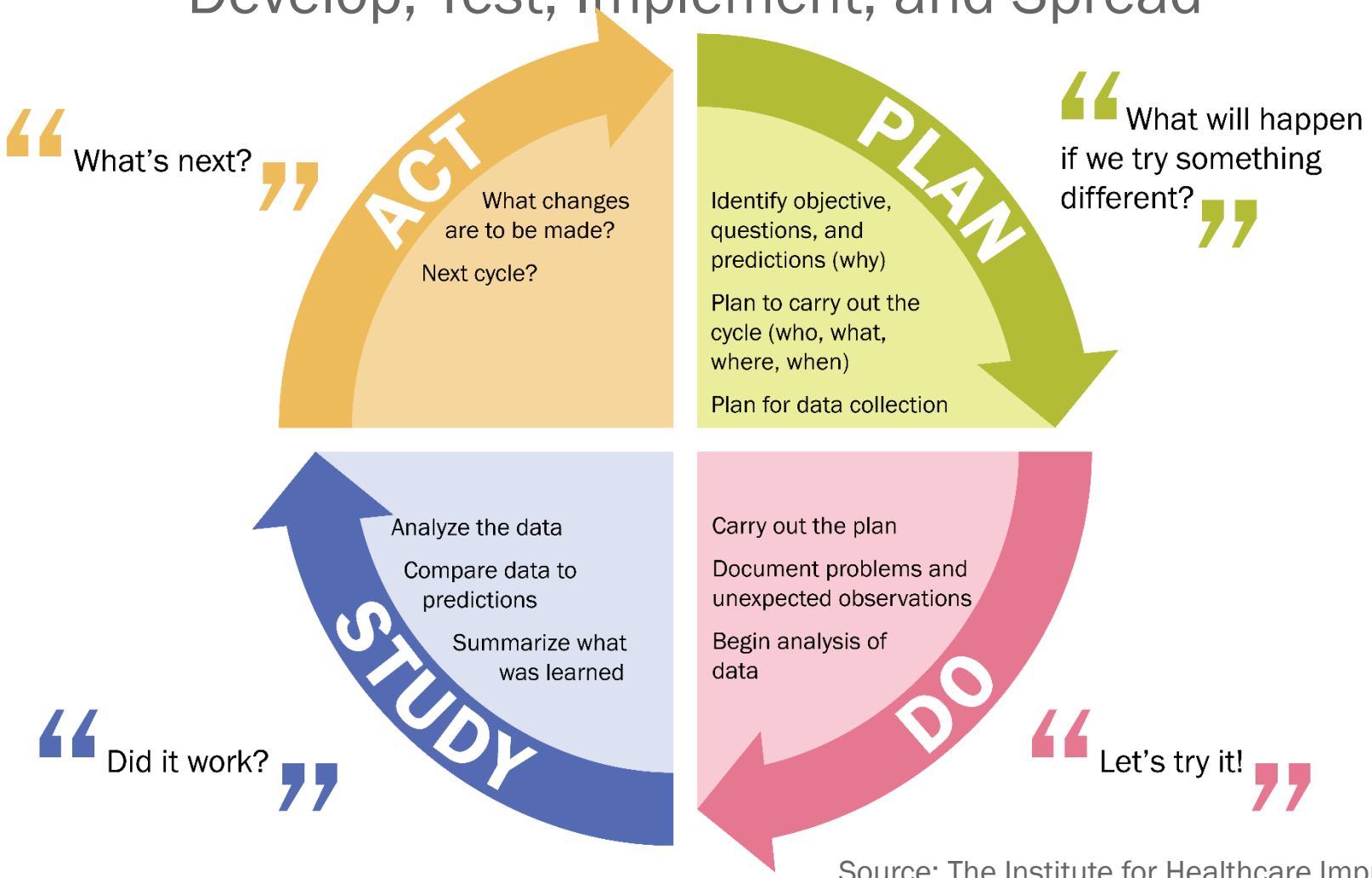
One way to do that is to leverage incentives for completion of teen driver safety programs/interventions.

Teen Driver Safety Driver Diagram

Primary Drivers	Secondary Drivers	Change Ideas
PD2: Organizational level **Organizational policies and procedures support the culture and practice of teen driver safety**	SD1: Enforced GDL policies, programs, and best practices	1. Partner with law enforcement on standard procedures to ensure teens are in compliance with state GDL law 2. Provide incentives for participation in teen driver safety programs/interventions 3. Partner with health care organizations to implement standard procedures for health care professionals to provide anticipatory guidance on teen driver safety to teens and parents/caregivers at adolescent wellness visits 4. Create/improve your data collection, assessment, tracking, and reporting systems 5. Partner with teen driver safety programs to develop evaluation plans

Put Your Theory Into Action

Develop, Test, Implement, and Spread

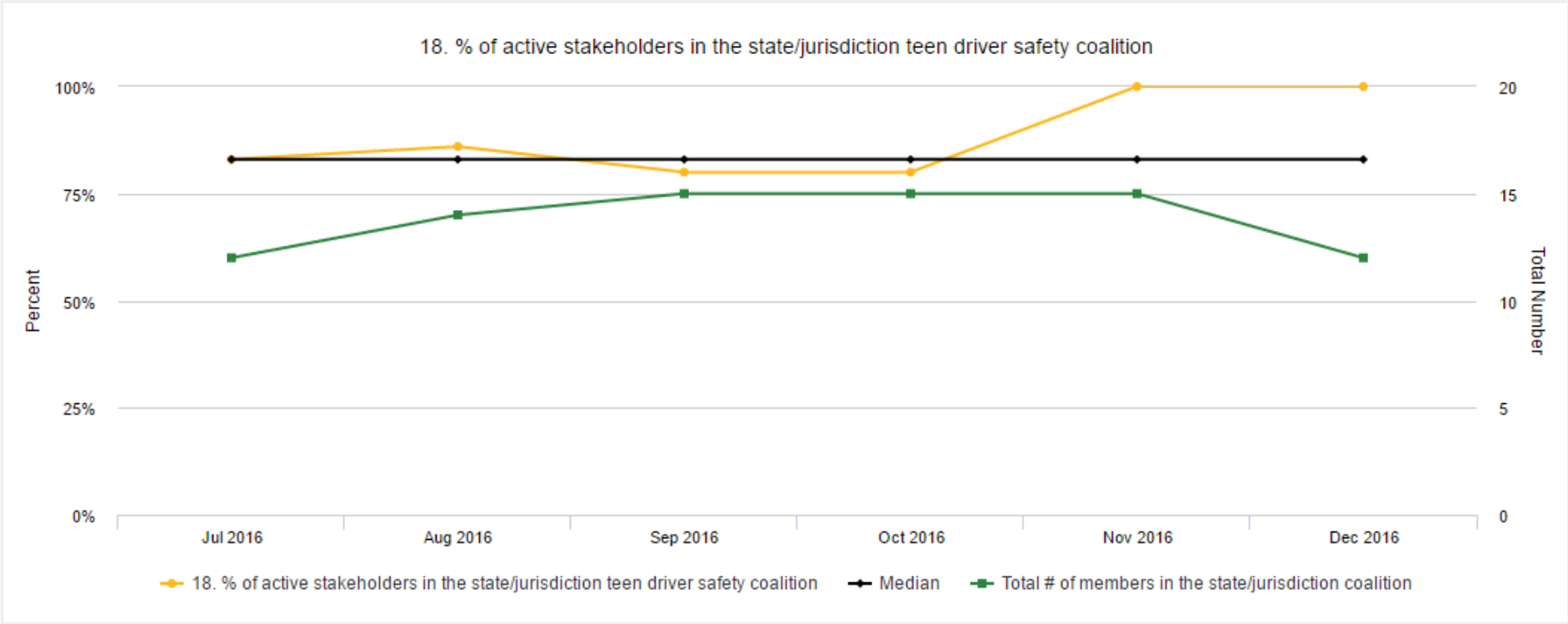


Source: The Institute for Healthcare Improvement

Change Packages

Aim Statement	• A written, measurable, and time sensitive statement of the expected results of an improvement process. For the CS CoIIN, these relate to injury-related ED visits, hospitalizations, and deaths (outcome measures). They exist for the overarching CS CoIIN, for each Topic Team, and for each Strategy Team.
Drivers	• The underlying strategies that have a significant and direct impact on the improvement aim you are trying to achieve. Primary drivers are typically major processes, operating rules, or structures. Secondary drivers are often system components necessary to impact primary drivers.
Change Ideas	• A specific, identifiable change, based on evidence that can lead to improvement. A change idea can be tested and measured so a decision can be made to adapt, adopt, or abandon the idea.
Measurement Strategy	• Outcome Measures and Process Measures aligned with the drivers and change ideas selected

Run Charts


18. % of active stakeholders in the state/jurisdiction teen driver safety coalition
100%
75%
50%
25%
0%
Percent
20
15
10
5
0
Total Number
Jul 2016
Aug 2016
Sep 2016
Oct 2016
Nov 2016
Dec 2016
18. % of active stakeholders in the state/jurisdiction teen driver safety coalition
Median
Total # of members in the state/jurisdiction coalition

Challenge: Collecting Real-Time Data

A two or more year delay before data becomes available to practitioners is typical

States Reporting Real-Time Outcome Data

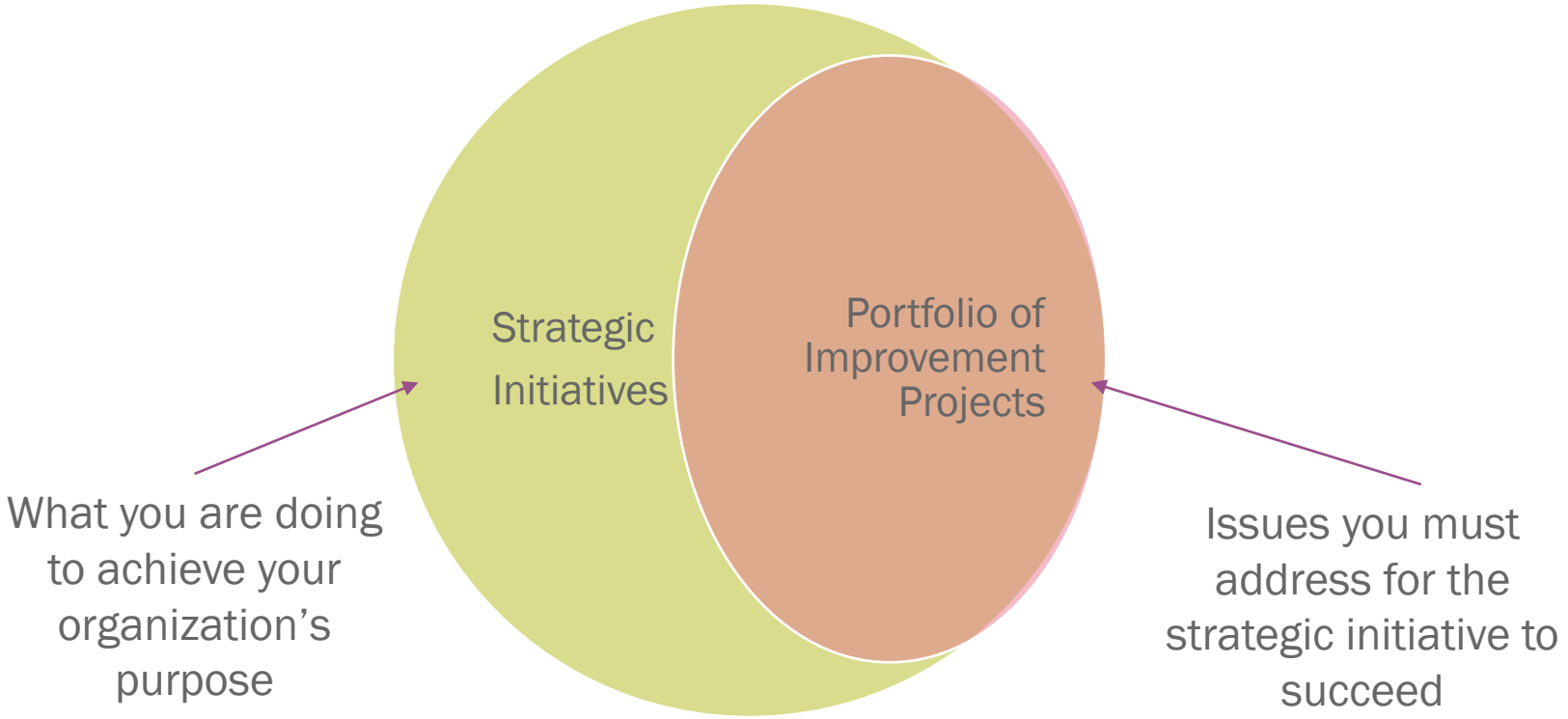
State or Jurisdiction	Cause of Injury	Death	Hosp.	ED Visits
Florida	Interpersonal Violence Prevention	√	√	√
Indiana	Child Passenger	√	√	
Indiana	Interpersonal Violence	√	√	
Kentucky	Interpersonal Violence	√		
Kentucky	Child Passenger	√		
Massachusetts	Suicide and Self Harm	√		√
Tennessee	Falls Prevention	√	√	

Innovative Data Sources

- Ambulance Usage Records
- Traumatic Brain Injury Registries
- Medicaid
- Trauma Registries

Identify a Portfolio of Improvement Projects

a group of complementary projects with a common goal

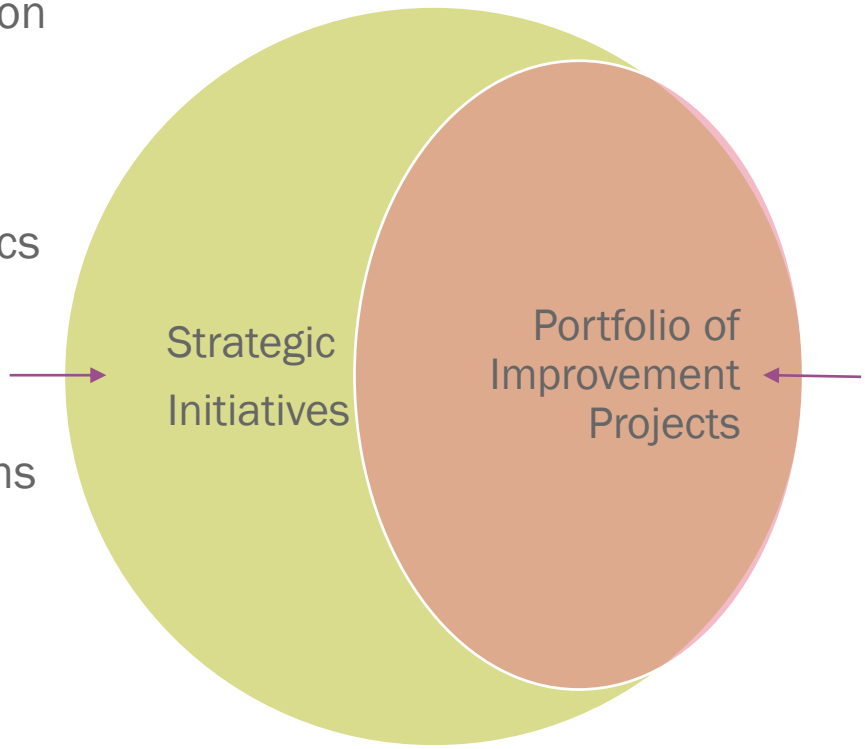


Source: The Improvement Guide, Pg. 321

Example of a Portfolio of Improvement Projects

Teen Driver Safety

- Managing a Coalition
- Collecting Data
- Analyzing Data
- Creating County-Specific Infographics on Teen Driving Statistics
- Writing Grants
- Evaluating Programs
- Testifying to Congress
- Proving Trainings
- Implementing CheckPoints



- Increasing sign up and completion of CheckPoints
- Improving data collection on adherence to GDL collected by Law Enforcement

Phases of Improvement

Develop

- Preparation for changing how work or activity gets accomplished

Test

- A small-scale trial of a new approach or a new process (change)

Implement

- Making a change a permanent part of your system
- Only changes tested under a wide variety of conditions, that demonstrate improvement, should be implemented

Spread

- Intentional and systematic expansion of the number and type of people, units, or organizations implementing the change

Vermont SSH Team: Testing the Feasibility of Screening for Suicide Risk in a Community Hospital Emergency Department & Improving Injury Claims Coding

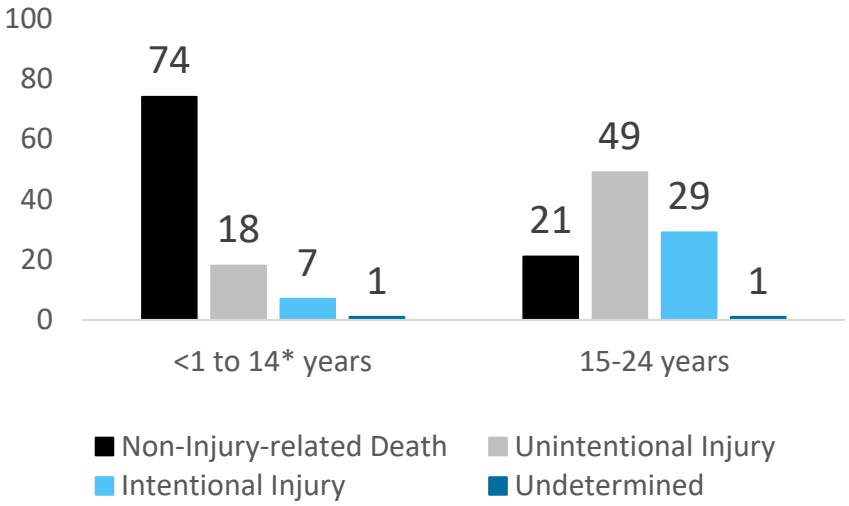
LAURIN KASEHAGEN, MA, PHD

CDC ASSIGNEE TO VERMONT DEPARTMENTS OF HEALTH & MENTAL HEALTH

MAY 8, 2017

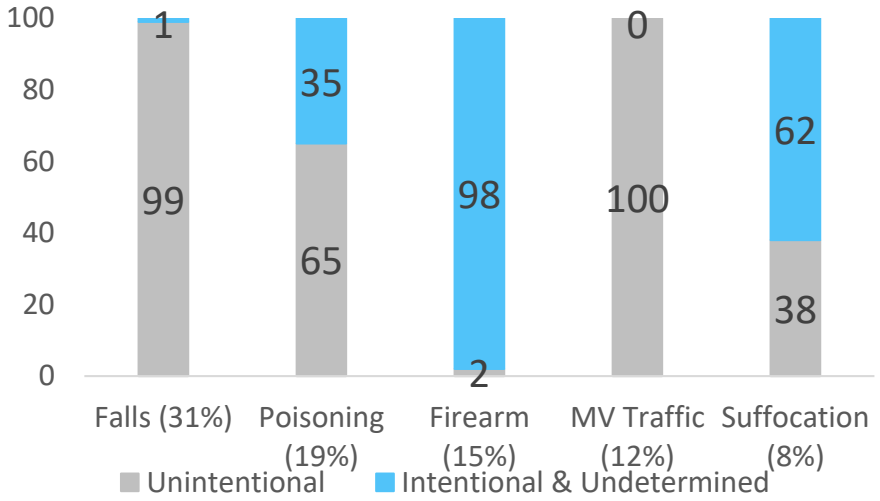
Background 1: Injury morbidity among Vermonters, Vermont Vital Statistics System, 2010-2014

DISTRIBUTION OF INJURY TYPE (%), BY AGE GROUP



*Please note these include residents who die of congenital anomalies and other conditions occurring in infants/newborns

LEADING CAUSES OF DEATH AS A PERCENTAGE OF ALL INJURY DEATHS, BY INTENT



Data from VDH Injury Morbidity & Mortality Data Briefs, 2017

Background 2: Suicidal ideation, suicidal and undetermined self-directed violence, and medicinal poisonings, among Vermont Youth 10-24 Years Vermont Uniform Hospital Discharge Data, 2010-2014, n=6,008

OVERLAPPING EMERGENCY DEPARTMENT VISITS, BY TYPE OF EPISODE

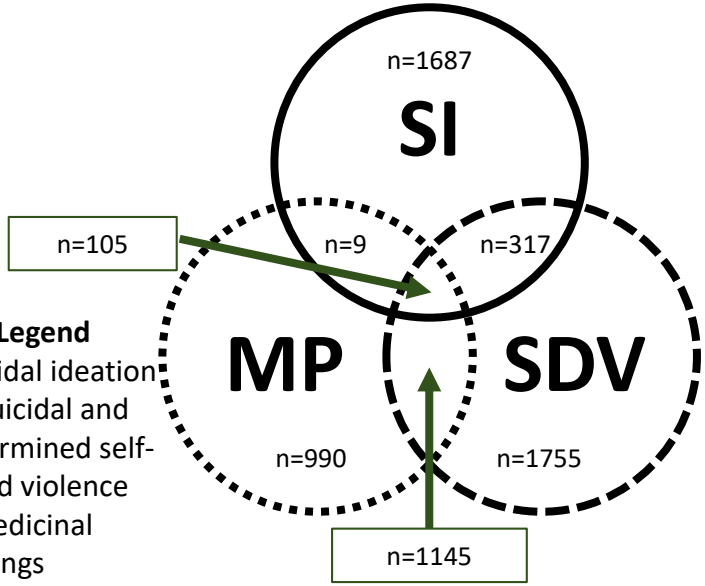
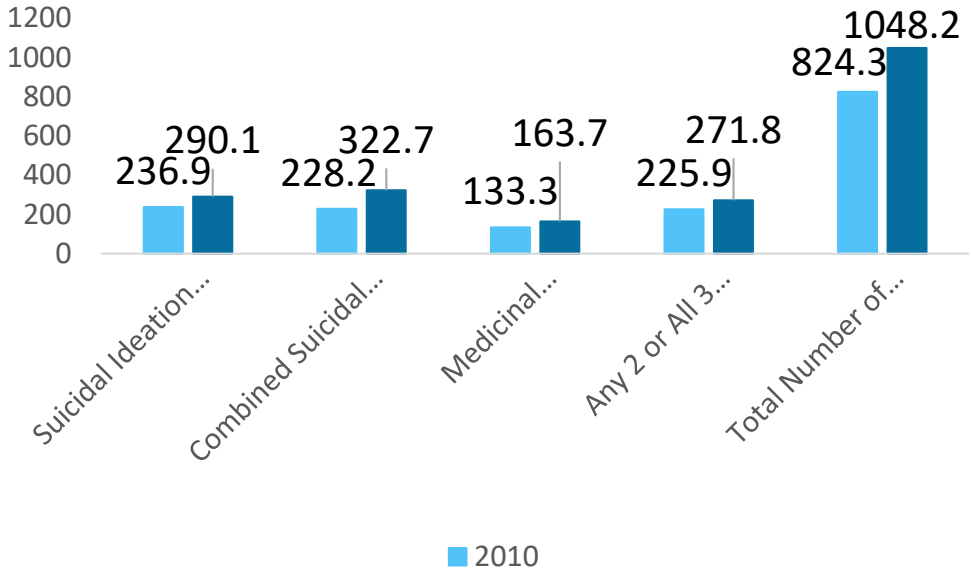


Figure Legend
SI=suicidal ideation
SDV=suicidal and undetermined self-directed violence
MP=medicinal poisonings

CRUDE RATES OF SUICIDAL IDEATION, SELF-DIRECTED VIOLENCE (SDV), AND MEDICINAL POISONINGS PER 100,000 POPULATION AMONG VERMONT YOUTH 10-24 YEARS



Why screen for suicide risk?

If we want to prevent suicide, we need to move 'upstream' from mortality to look at morbidity and the systems issues and social determinants that play a role in suicide

Suicide prevention is a priority for the community served by Northwestern Medical Center (NMC) and Northwestern Counseling & Support Services (NCSS)

- Community Health Assessment listed suicide as 1 of 6 priority health issues

Suicide prevention is a priority for Vermont

- Measure in HV2010, HV2020, HV2030
- State is piloting Zero Suicide in 3 counties (Franklin, Grand Isle, and Chittenden)
- Agency of Human Services (AHS) Suicide STAT process to start in 2017
- CMS measure around reducing the suicide rate
- Joint Commission accreditation measure

Take advantage of momentum nationally, statewide, and locally on suicide prevention

Why Northwestern Medical Center (NMC)?

Located in one of Vermont's Zero Suicide pilot counties

Small and progressive community hospital with hospital champions

ED has an established relationship with Northwestern Counseling & Support Services (NCSS) for crisis services

- 1 FTE from NCSS works in the emergency department (ED)

SBIRT Team conducting work in ED around alcohol and drug use

NMC data feed into 4 key data systems

- Hospital discharge / All Payor claims / Medicaid claims
- Syndromic surveillance

Why Northwestern Medical Center (NMC)?, cont.

NMC provides an unique opportunity to

- Make sure we know what we are collecting, analyzing, interpreting
- Improve the systems that detect and report the conditions
- Improve hospital and emergency department (ED) practices and services
- Serve as a model for other community hospitals in Vermont
- Showcase quality improvement work in an ED with other ED directors across the state in their monthly meetings
- Provide local level information for the State's Suicide STAT

Pilot Project Goals: Screening for Suicide Risk

NMC Health Information Systems Staff

1. Increase accurate, consistent coding for suicidal ideation, suicidal self-directed violence, and medicinal poisonings

NMC Emergency Department Clinicians & Staff

1. Increase accurate, consistent coding for suicidal ideation, suicidal self-directed violence, and medicinal poisonings in emergency department settings
2. Increase the use of evidence-based screening and assessment instruments and protocols
3. Increase the use of referral protocols

NCSS

1. Increase the use of evidence-based screening and assessment instruments and protocols
2. Improve the ability of clinicians and healthcare systems to provide clinical evaluation and treatment to individuals who are identified through screening and assessment as being at-risk for suicide

Who is Responsible for What?

VDH

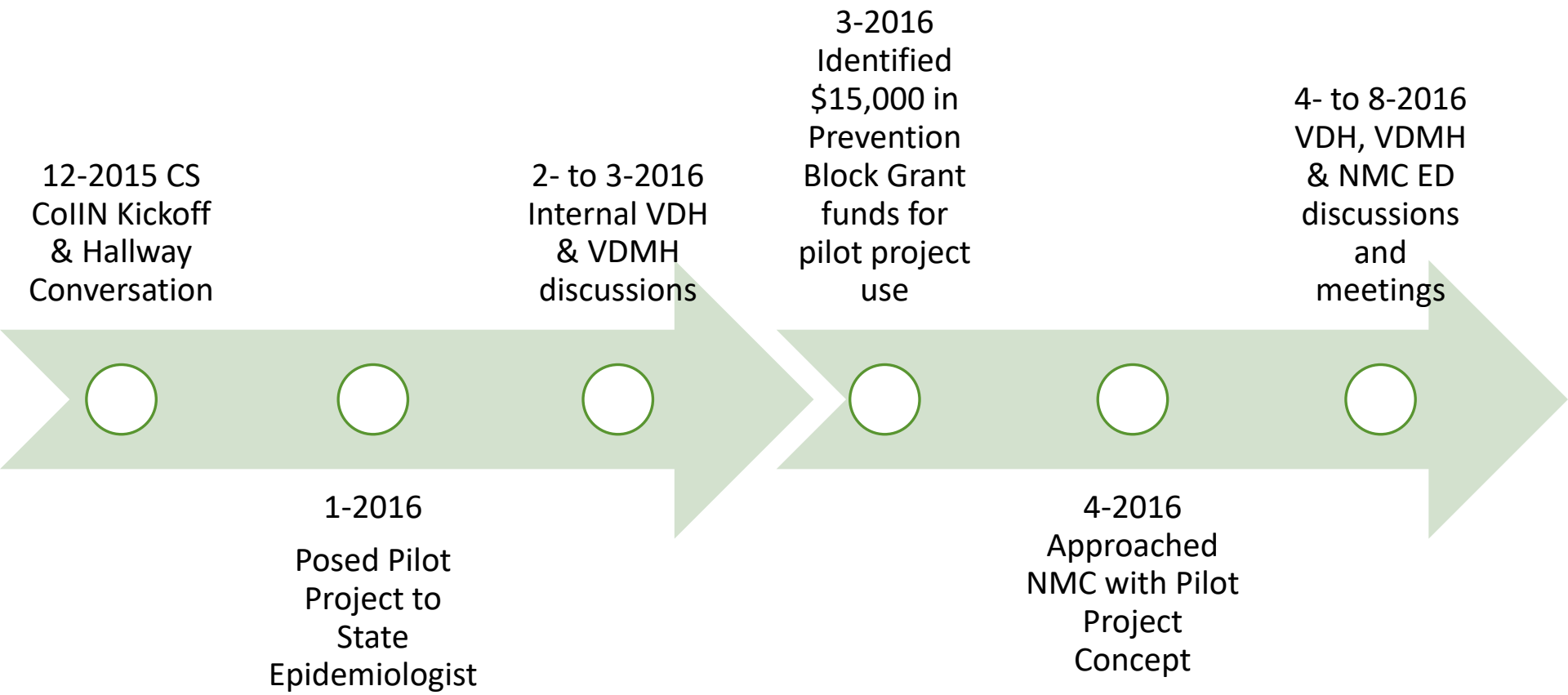
- Providing a $30,000 grant to NMC / NCSS, a project assistant to help with the work at the NMC, and obtaining an IRB determination
- Observing current practices and validation
- Reviewing protocols / algorithms and data analysis
- Providing oversight of / technical assistance with PDSAs
- Providing assistance with collecting / reporting PDSA results
- Providing training or assisting in locating specific training

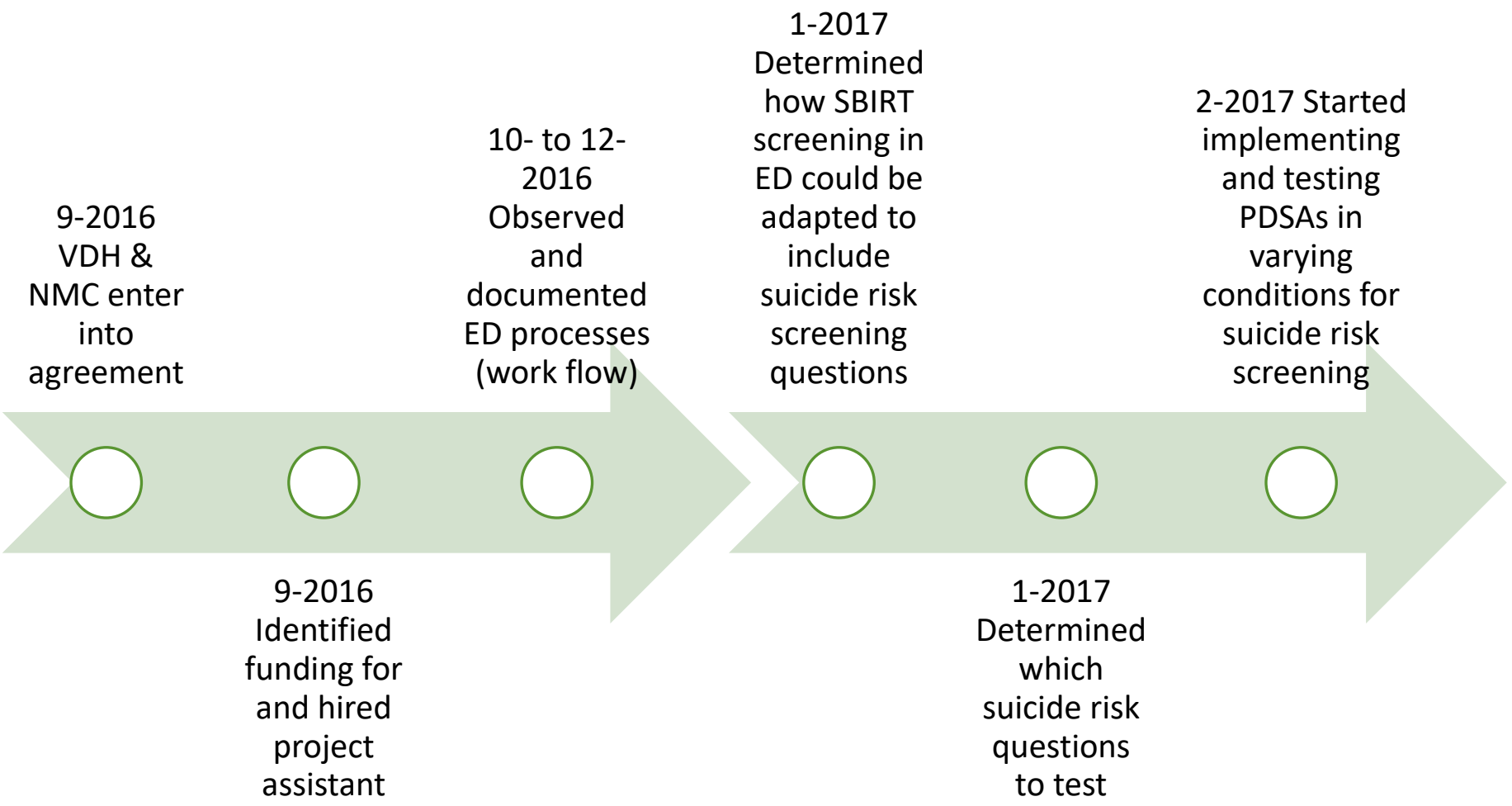
NMC

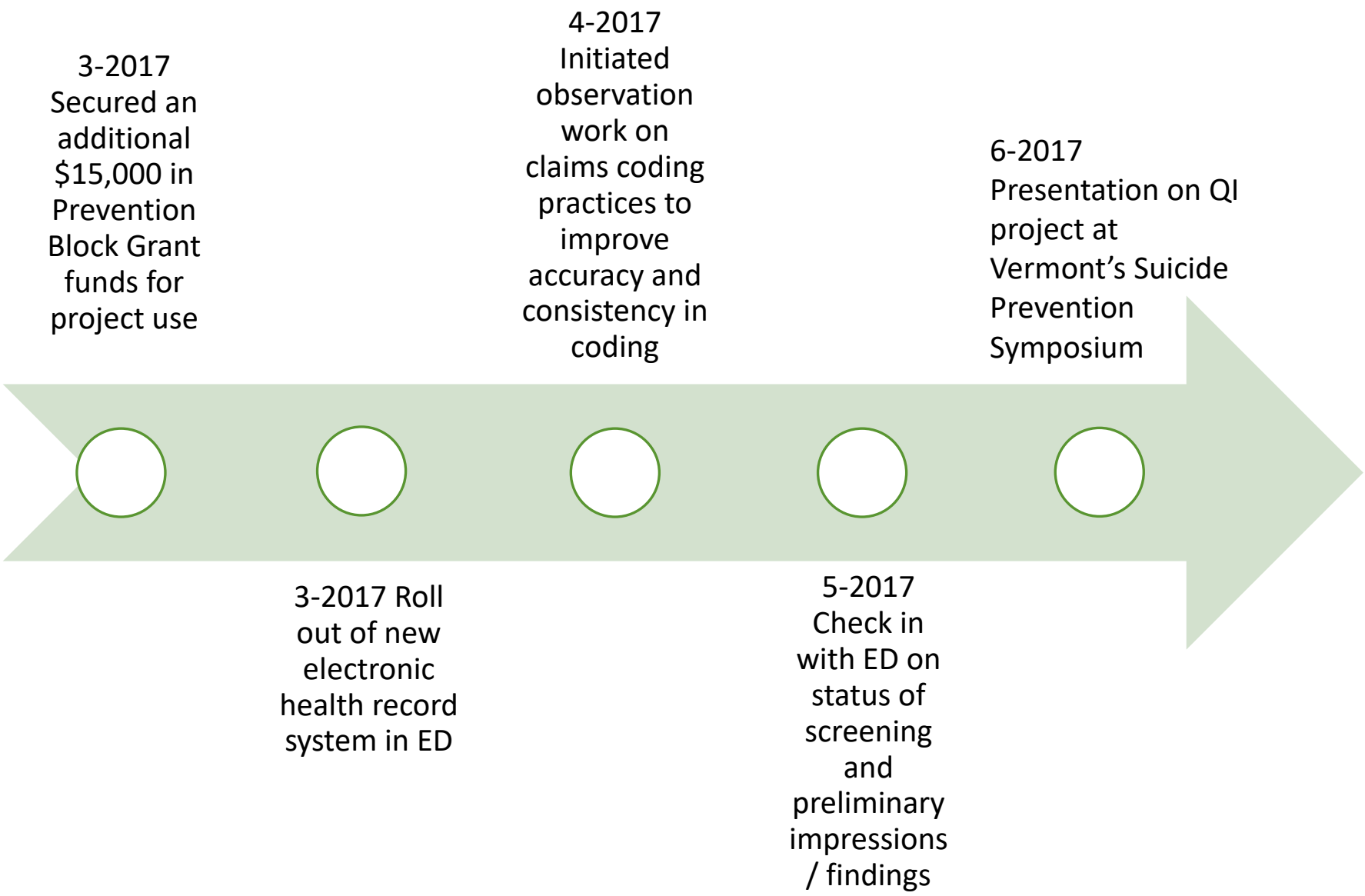
- Participating in meetings, discussions for validation
- Participating in training
- Providing protocols / algorithms
- Reviewing / testing new protocols / algorithms
- Conducting / testing PDSAs
- Helping to collect / report PDSA results
- Instituting change!
- Pulling data from NMC systems

Both

- Selecting screening tools
- Developing or adapting protocols / algorithms
- Determining content of PDSAs
- Writing a manuscript(s)
- Presenting to peers or at conferences
- Disseminating findings / results of work


12-2015 CS CoIIN Kickoff & Hallway Conversation
1-2016
Posed Pilot Project to State Epidemiologist
2- to 3-2016 Internal VDH & VDMH discussions
3-2016 Identified $15,000 in Prevention Block Grant funds for pilot project use
4-2016 Approached NMC with Pilot Project Concept
4- to 8-2016 VDH, VDMH & NMC ED discussions and meetings


9-2016 VDH & NMC enter into agreement
9-2016 Identified funding for and hired project assistant
10- to 12-2016 Observed and documented ED processes (work flow)
1-2017 Determined how SBIRT screening in ED could be adapted to include suicide risk screening questions
1-2017 Determined which suicide risk questions to test
2-2017 Started implementing and testing PDSAs in varying conditions for suicide risk screening


3-2017
Secured an additional $15,000 in Prevention Block Grant funds for project use
3-2017 Roll out of new electronic health record system in ED
4-2017
Initiated observation work on claims coding practices to improve accuracy and consistency in coding
5-2017
Check in with ED on status of screening and preliminary impressions / findings
6-2017
Presentation on QI project at Vermont's Suicide Prevention Symposium

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version

Testing the past 2 weeks

SUICIDE IDEATION DEFINITIONS AND PROMPTS	month YES	NO
Ask questions that are bolded and underlined.		
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up. ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself*" without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		

3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might kill yourself?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** · Over a year ago? · Between three months and a year ago? · Within the last three months?		

PDSA Tests		
Test Cycle	Conditions for Testing	Reasons for Cycle
1-1 to 1-3 conducted 2-14-2017 through 2-27-2017	• Monday through Friday • Between 8 am and 6 pm • QI Team on-site • SBIRT Screener available • ED Crisis Counselor on site • Crisis Counselor not engaged with another ED patient • Old EHR system	• Determine if SBIRT screener can successfully integrate first 2 questions of Columbia Suicide Risk questions into the SBIRT alcohol and drug use screening instrument • Determine where questions should be asked in the SBIRT screener • Determine whether questions need a soft lead in • Work on SBIRT screener comfort level with asking the 2 Columbia Suicide Risk Assessment questions • Determine if asking the 2 screening questions disrupts the SBIRT screening process • Determine if asking the 2 screening questions significantly increases patient wait time in the ED • Determine if asking the 2 screening questions creates an overload of patients in the ED • Determine process for patients who screen positive • Determine how SBIRT screeners hand off / alert ED crisis counselor for patients who screen positive • Determine if there are types of patients who should not be screened • Determine what and how to document suicide risk screening

PDSA Tests		
Test Cycle	Conditions for Testing	Reasons for Cycle
2-1 conducted 3-1-2017 through 4-4-2017	• Monday through Friday • Between 8 am and 6 pm • QI Team on-site • SBIRT Screener available • ED Crisis Counselor on site • Crisis Counselor not engaged with another ED patient • **New EHR system**	• ~~Determine if SBIRT screener can successfully integrate first 2 questions of Columbia Suicide Risk questions into the SBIRT alcohol and drug use screening instrument~~ • Determine where questions should be asked in the SBIRT screener • Determine whether questions need a soft lead in • Work on SBIRT screener comfort level with asking the 2 Columbia Suicide Risk Assessment questions in the new EHR environment • Determine if asking the 2 screening questions disrupts the SBIRT screening process • Determine if asking the 2 screening questions significantly increases patient wait time in the ED • Determine if asking the 2 screening questions creates an overload of patients in the ED • Determine process for patients who screen positive • Determine how SBIRT screeners hand off / alert ED crisis counselor for patients who screen positive • Determine if there are types of patients who should not be screened • Determine what and how to document suicide risk screening

Note: no screening occurred between 3-11 and 4-3-2017 due to scheduling problems, new EHR, unusually high ED surge

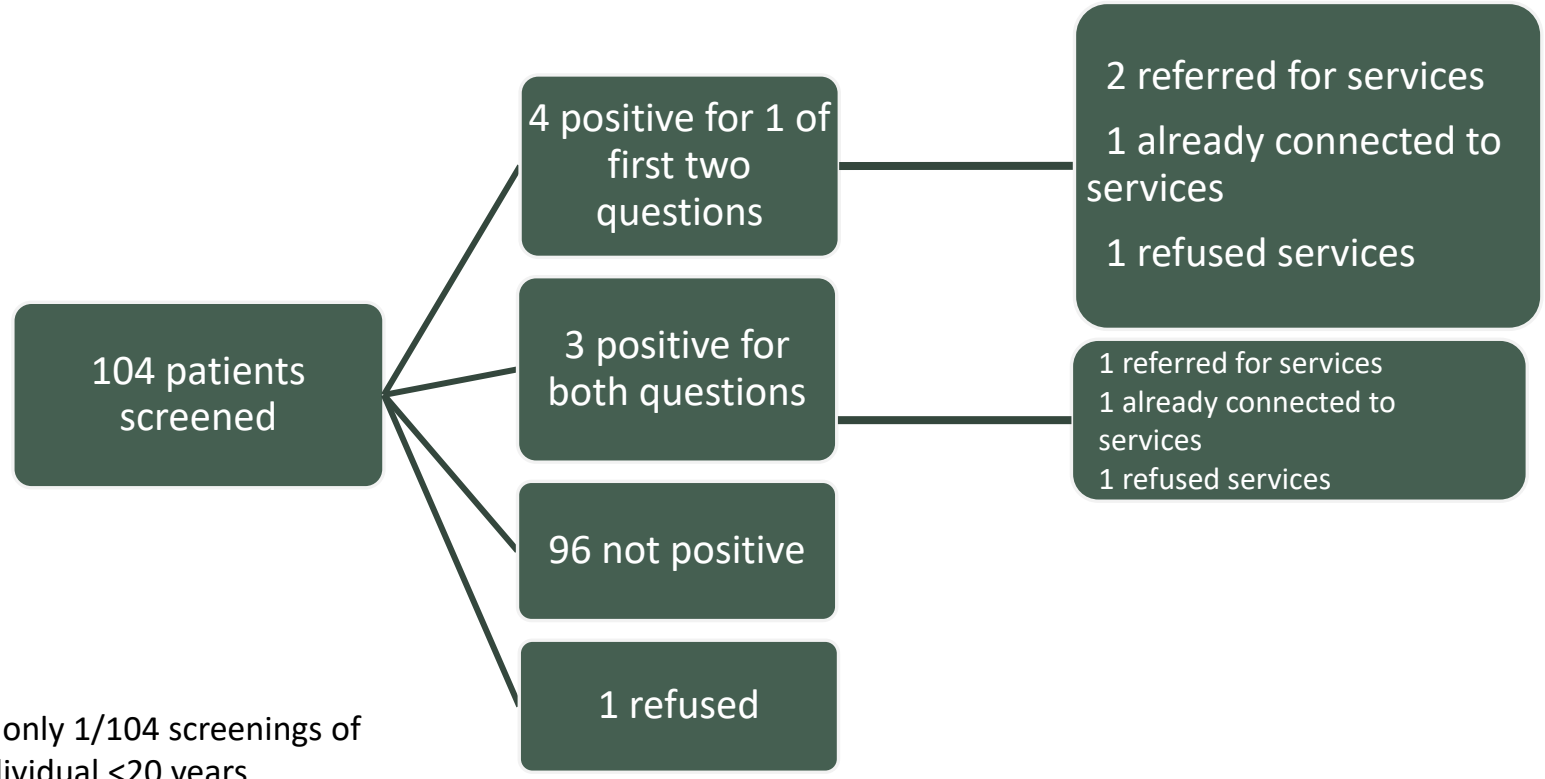
PDSA Tests		
Test Cycle	Conditions for Testing	Reasons for Cycle
3-1 conducted 4-14-2017 to present	• Monday through Friday • Between 8 am and 6 pm • QI Team on-site • SBIRT Screener available • **ED Crisis Counselor on site and has dedicated time to QI project** • **Refined process for positive patients** • **NCSS Crisis Counselors handle ED patients** • **New EHR system**	• ~~Determine if SBIRT screener can successfully integrate first 2 questions of Columbia Suicide Risk questions into the SBIRT alcohol and drug use screening instrument~~ • ~~Determine where questions should be asked in the SBIRT screener~~ • ~~Determine whether questions need a soft lead in~~ • ~~Work on SBIRT screener comfort level with asking the 2 Columbia Suicide Risk Assessment questions in the new EHR environment~~ • ~~Determine if asking the 2 screening questions disrupts the SBIRT screening process~~ • Determine if asking the 2 screening questions significantly increases patient wait time in the ED • Determine if asking the 2 screening questions creates an overload of patients in the ED • Improve process for patients who screen positive • Improve SBIRT screener hand off to ED crisis counselor for patients who screen positive • Continue to determine if there are types of patients who should not be screened • Refine what and how to document suicide risk screening

PDSA Tests

Test Cycle	Conditions for Testing	Reasons for Cycle
4-1 conducted 4-26-2017 to present	• Monday through Friday • Between 8 am and 6 pm • SBIRT Screener available • ED Crisis Counselor available • ED Crisis Counselor not otherwise engaged with a patient in the ED • **No QI Team on-site** • New EHR system	• ~~Determine if SBIRT screener can successfully integrate first 2 questions of Columbia Suicide Risk questions into the SBIRT alcohol and drug use screening instrument~~ • ~~Determine where questions should be asked in the SBIRT screener~~ • ~~Determine whether questions need a soft lead in~~ • ~~Work on SBIRT screener comfort level with asking the 2 Columbia Suicide Risk Assessment questions in the new EHR environment~~ • ~~Determine if asking the 2 screening questions disrupts the SBIRT screening process~~ • **Determine if SBIRT Screener can integrate suicide risk screening into daily work** • Determine if asking the 2 screening questions significantly increases patient wait time in the ED • Determine if asking the 2 screening questions creates an overload of patients in the ED • Improve process for patients who screen positive • Improve SBIRT screener hand off to ED crisis counselor for patients who screen positive

PDSA Tests		
Test Cycle	Conditions for Testing	Reasons for Cycle
5-1 conducted 4-25-2017 to present	• Monday through Friday • Between 8 am and 6 pm • **ED Crisis Counselor available** • **No QI Team on-site** • New EHR system	• **Determine if Crisis Counselor can conduct and document suicide risk screening in daily work** • Determine if suicide risk screening questions significantly increases patient wait time in the ED • Determine if asking the suicide risk screening questions creates an overload of patients in the ED

Screening Results (2/14/2017 - 5/3/2017)



Note: only 1/104 screenings of an individual <20 years

Lessons Learned

We "planned"	We found that	We predict that . . .
To increase the use of accurate coding around suicidal behaviors in Vermont emergency departments	• This project idea had a lot of champions • Even in the best of environments, slow process -- from inception to on the ground took 10 months • Major barrier = getting meetings with decision makers	• Now that we are underway and we are a 'known commodity', things will go a lot more smoothly and testing will be able to move forward • Public Health STAT process may help if we involve NMC key decision makers • May encounter barriers in ED clinician screening • May be tricky to train clinicians to use the "right" phrases / words in documenting for ICD-10 • May encounter barriers in changing screening tools • May have issues--duty to warn
To provide a small amount of funding as an incentive to participate	• This was SUPER easy • Used end of year prevention block grant funds x 2!	• NMC would have done this without funding, but $30,000 was appreciated • Using the funds to offset costs of staff to pull data • NMC & NCSS could use additional infusion of funds
To provide staff support to the hospital willing to take on QI efforts	• This was an after thought • Able to identify funds to hire a project assistant for 1 year	• Providing staff assistance to do QI work -- huge selling point • Without Megan, the ED might not have agreed to the QI work

SSH – Vermont Team Members

- **Vermont Department of Health**
- **Vermont Department of Mental Health**
- **University of Vermont / VCHIP**
- **Northwestern Medical Center**
- **Northwestern Counseling & Support Services**

- **For more information contact:**
  - **Laurin Kasehagen**
  - **Laurin.Kasehagen@partner.Vermont.gov**
  - **802-863-7288**

Indiana

Electronic check-up forms for child passenger safety inspections

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Injury Prevention
Epidemiologist Consultant
Division of Trauma and Injury Prevention
Indiana State Department of Health

Kaci Wray, M.B.A.
Child Passenger Safety Program Manager
Indiana Criminal Justice Institute (ICJI).

Indiana State Department of Health

Partnerships:

- Indiana State Department of Health (ISDH):
  - Katie Hokanson, Jessica Schultz, Preston Harness
  - Booster Bash and Child Passenger Safety Technician Scholarship Program
- Indiana Criminal Justice Institute (ICJI):
  - Kaci Wray
  - State Program Manager for inspection stations
  - Oversee electronic application\website
  - Operation Kids: Next Generation

Partnerships:

- Automotive Safety Program (ASP):
  - Dr. Bull, Dr. O'Neil, and Judith Talty
  - State coordinator of CPST classes
  - Provides opportunities for recertification
  - Provides educational handouts

Electronic check-up forms:

- Currently in implementation stage
- ASP created four page check-up form to gather information
- Work with IN3 to turn this form into an electronic application
- ICJI is now completion of project and maintenance
- ICJI provided tablets to all inspection stations to enable use of electronic application with funds from Title V and NHTSA
- IN3 is also creating a website to host the data as well as provide reports, access to forms, and data entry
- Demo can be found in Apple iTunes store under “Automotive Safety Check-up Application Presentation”

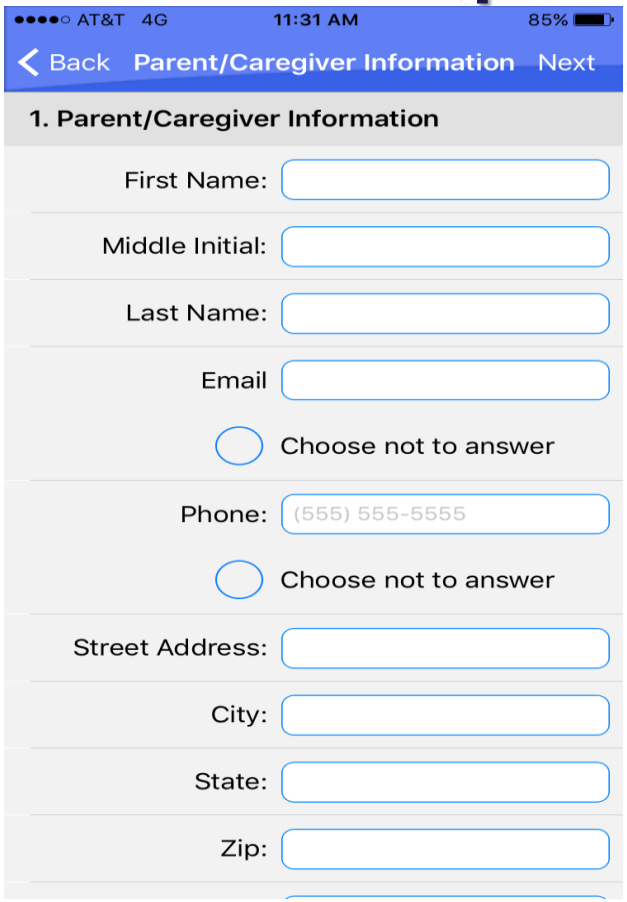
Challenges Encountered and Solutions in Place:

- Some technicians are hesitant to switch to electronic application
- The iPads require each agency to put a credit card on file to begin an iTunes account (which is necessary to download application)
- One tablet makes it difficult in large agencies
- Grant reporting becomes more challenging
- Issues when documenting multiple children
- Length of time for software updates from Apple to go through

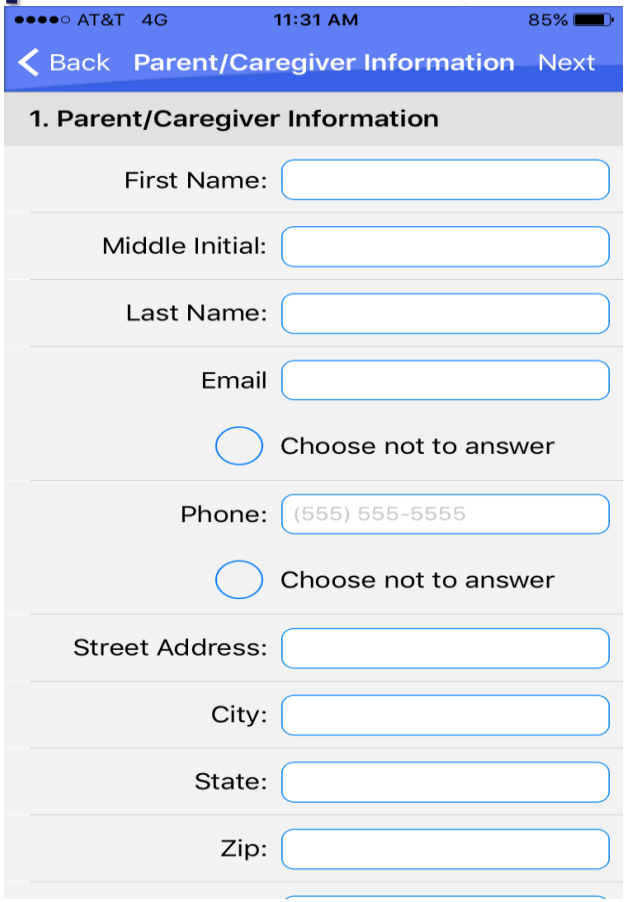
Successes Encountered:

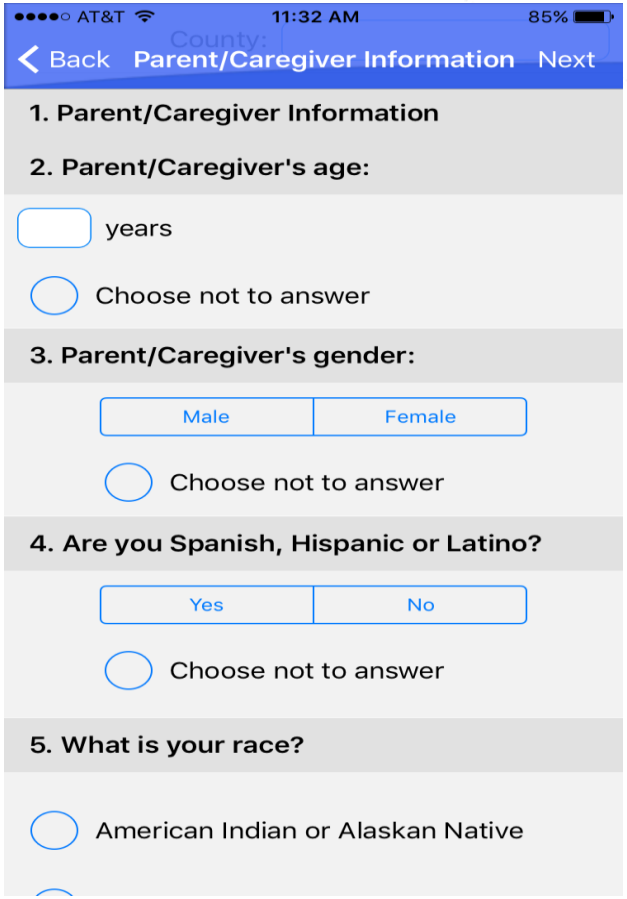
- Amount of data entry for Program Manager will decrease
- Most technicians are loving the tablet and ease of use
  - Would not have been to use the app without the distribution of tablets from ICJI
- Less room for error due to automatic skip patterns
- More accurate and up to date data
- Will allow for better information on targeting certain demographics
  - Forms will track household income, education level, ethnicity, race, etc.

Automatic Skip Block:



Demographics Collected from App:

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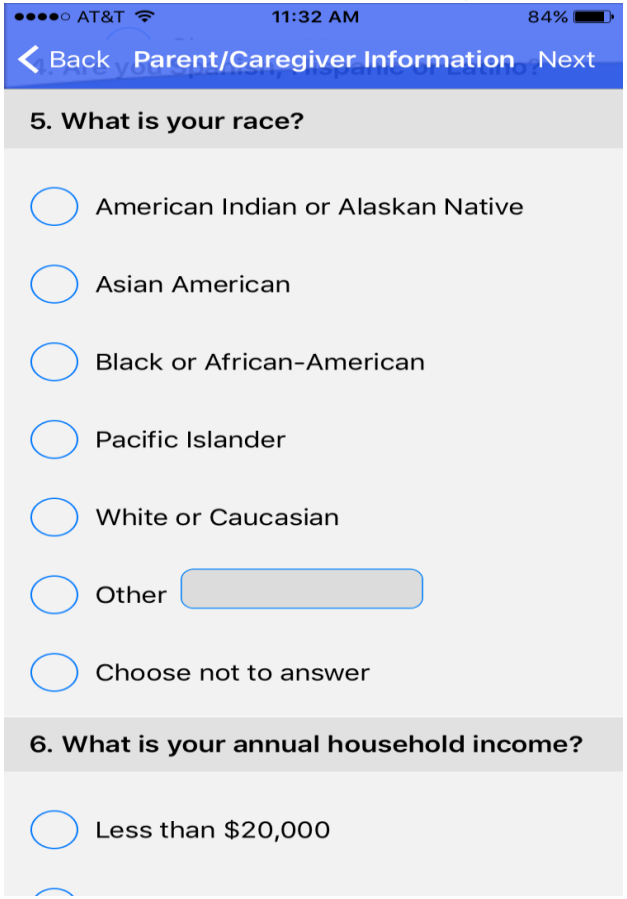
Parent/Caregiver Information
Next
1. Parent/Caregiver Information
2. Parent/Caregiver's age:
years
Choose not to answer
3. Parent/Caregiver's gender:
Male
Female
Choose not to answer
4. Are you Spanish, Hispanic or Latino?
Yes
No
Choose not to answer
5. What is your race?
American Indian or Alaskan Native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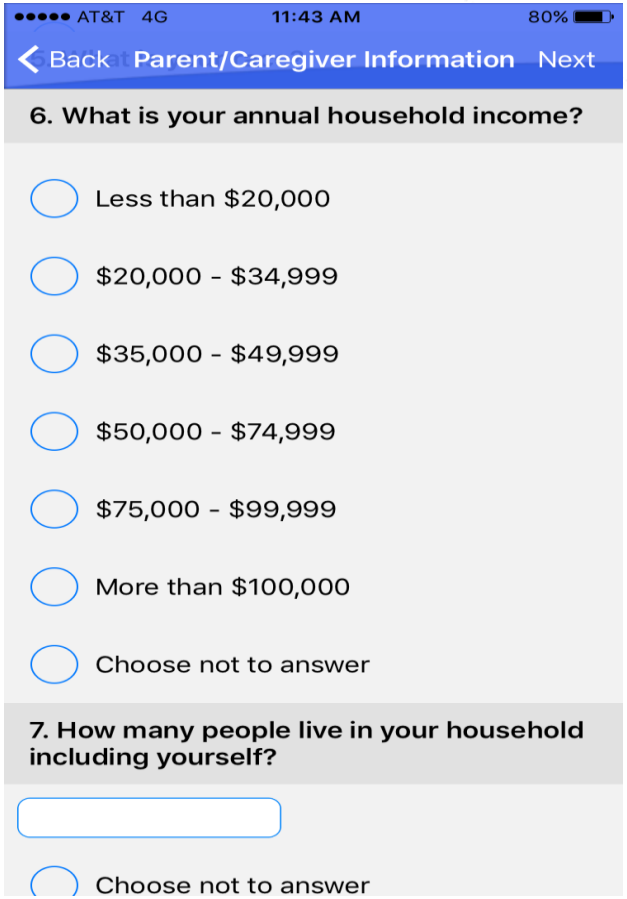
Parent/Caregiver Information
Next
5. What is your race?
American Indian or Alaskan Native
Asian American
Black or African-American
Pacific Islander
White or Caucasian
Other
Choose not to answer
6. What is your annual household income?
Less than $20,000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Parent/Caregiver Information
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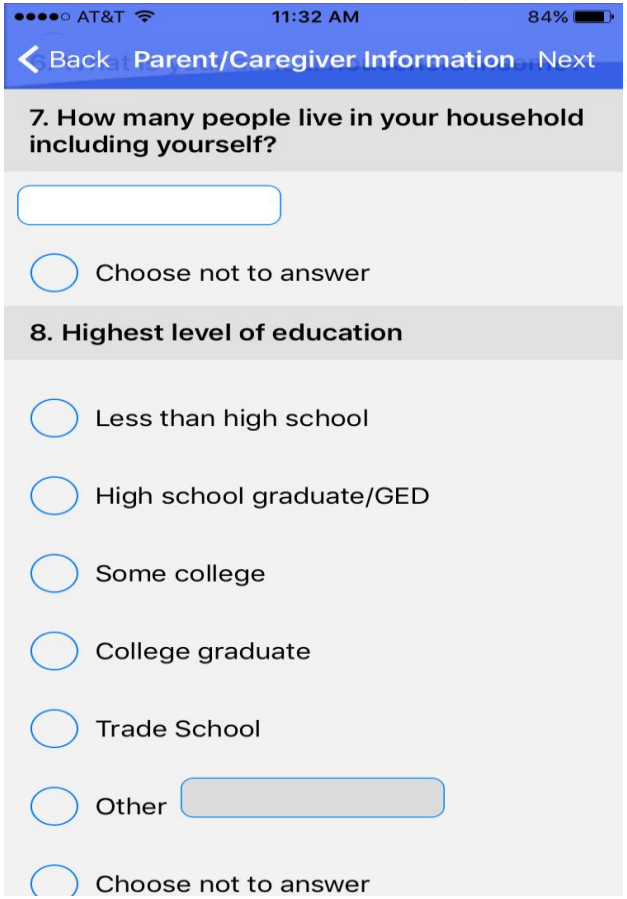
6. What is your annual household income?
Less than $20,000
$20,000 - $34,999
$35,000 - $49,999
$50,000 - $74,999
$75,000 - $99,999
More than $100,000
Choose not to answer
7. How many people live in your household including yourself?
Choose not to answer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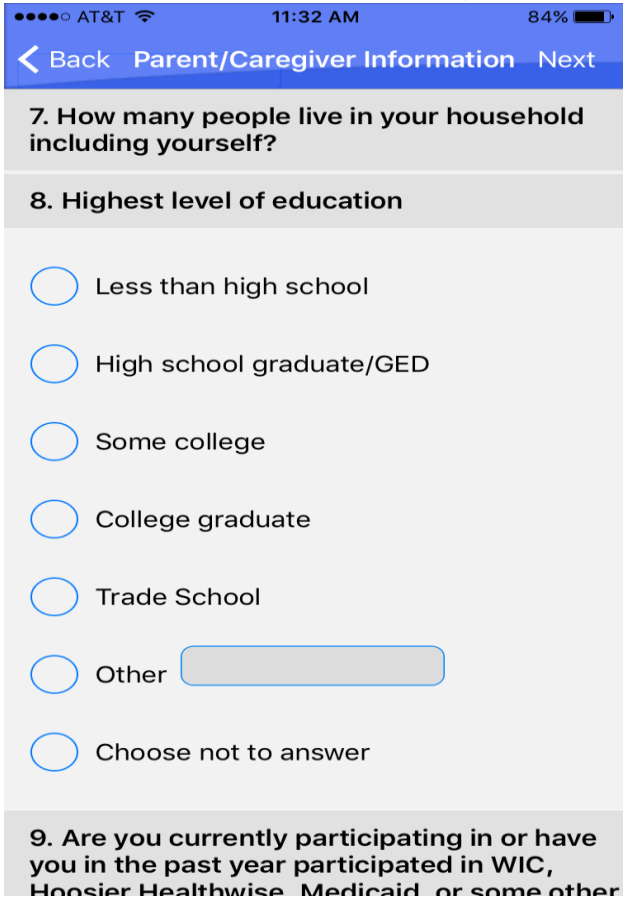
Parent/Caregiver Information
Next
7. How many people live in your household including yourself?
Choose not to answer
8. Highest level of education
Less than high school
High school graduate/GED
Some college
College graduate
Trade School
Other
Choose not to answer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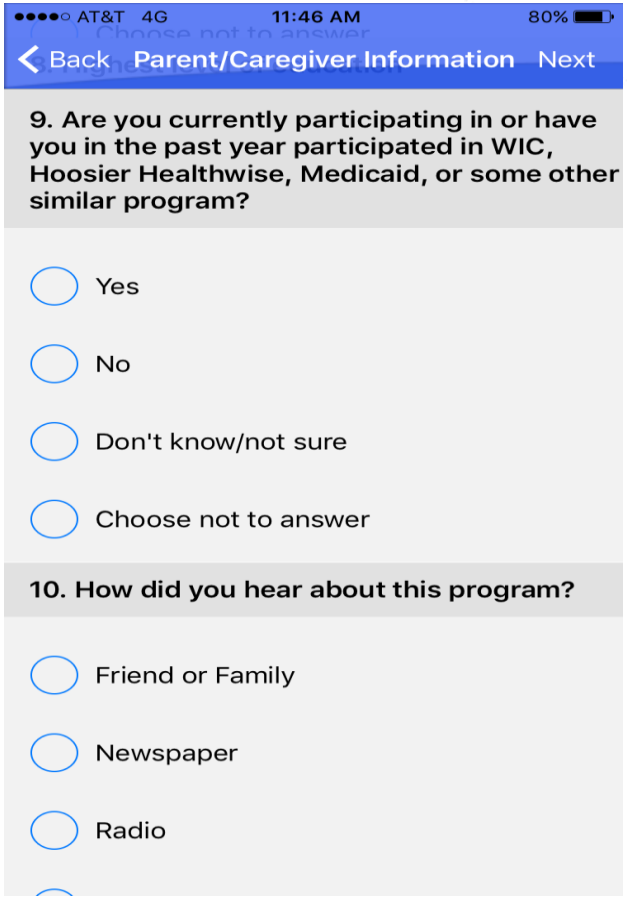
Parent/Caregiver Information
Next
7. How many people live in your household including yourself?
8. Highest level of education
Less than high school
High school graduate/GED
Some college
College graduate
Trade School
Other
Choose not to answer
9. Are you currently participating in or have you in the past year participated in WIC,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Parent/Caregiver Information
Next
9. Are you currently participating in or have you in the past year participated in WIC, Hoosier Healthwise, Medicaid, or some other similar program?
Yes
No
Don't know/not sure
Choose not to answer
10. How did you hear about this program?
Friend or Family
Newspaper
Radio

Contact Information:

Preston Harness, MPH CPST
Injury Prevention Coordinator
Indiana State Department of Health
Division of Injury & Trauma Prevention
PHarness@isdh.IN.gov
(314)-232-3121
http://www.in.gov/isdh/19537.htm
@INDTrauma

Questions

Please enter your questions in the Q & A box

Upcoming Webinar

Wednesday, May 31st, 2017

2:00 – 3:00 p.m. ET

Click here to register

Thank you!

Please fill out our short evaluation:
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