Injury

Injury and Violence

Injury and violence are among the leading causes of death and hospitalization in Kansas. Each year, about 1,600 Kansans die as a result of injury. Motor vehicle crashes, unintentional falls, firearms and unintentional poisonings are the leading causes of injury mortality in Kansas. Injury is responsible for more years of potential life lost in Kansas than cancer, heart disease or stroke. In fact, for people 1 to 44 years old, injury is the leading cause of death in Kansas. In the U.S., violence and injuries cost more than $406 billion in medical care and lost productivity each year.

It is common to consider injuries or accidents as random events. However, this implies that injuries are unpredictable and unpreventable. Injuries are preventable and, at the community level, are also predictable. Although injuries can be categorized in multiple ways—for example, where or how they occur—it is typical to categorize injuries in terms of mechanism and intent. Mechanism (or cause) typifies how the injury occurred—for instance, by motor vehicle, firearm, struck by an object or by falling. Intent is classified as unintentional or intentional (or, unknown or undetermined intent). While unintentional injuries often result as a form of rapid transfer of energy from object to person (e.g. being struck by a motor vehicle), intentional injuries are the result of intentional harm imposed upon one person by another (e.g. homicide), or upon oneself (e.g. suicide).

The public health approach to injury prevention is a process that involves identifying and defining the problem, identifying risk and protective factors, developing and testing prevention strategies, and assuring widespread adoption of effective
strategies. Rather than address single types of injury that occur to individuals on a one to one basis, broad causes and prevention solutions are the focus of injury prevention in public health. Instead of focusing on individuals and the treatment of individual injuries as they arise, it is the whole community, the community’s whole health, and community-level prevention that defines the public health approach. Sometimes, prevention at the community level involves changing the environment in which injuries occur—for example, installing traffic signals at intersections or requiring certain products to be fire safe. At other times, prevention at the community level involves education—such as informing school programs about preventing brain injuries, or providing information to guide changes in health policies or laws. Although the public health workforce may not always directly provide prevention services, public health agencies identify the important conditions and patterns that contribute to injury at the community level, and identify and leverage solutions through community partnerships to promote prevention.

References

Motor Vehicle Crashes

HP 2020 Objective

| Reduce motor vehicle crash-related deaths per 100,000 population | Target: 12.4 deaths per 100,000 population |

Introduction

Motor vehicle crash injuries and deaths and their associated costs are preventable. The Centers for Disease Control and Prevention (CDC) Injury Center supports proven, effective strategies for prevention such as graduated driver licensing (GDL) policies; child passenger safety laws, safety seat distribution and education programs; primary seat belt laws; enhanced seat belt enforcement programs; motorcycle and bicycle helmet laws; sobriety checkpoints; interlock ignition laws; and texting while driving laws.

During the 2000s, Kansas lawmakers and safety advocates focused on passing safety legislation targeting child passengers and young drivers. The major laws passed were the Child Passenger Safety Act, which went into effect in July 2006; Graduated Driver’s Licensing, which went into effect in January 2010; and the Primary Seat Belt Law, which went into effect June 2010. These legislative efforts, improvements to vehicle safety by manufacturers, and improvements to roadway safety by Kansas Department of Transportation (KDOT) may have contributed to noticeable changes in health measures during the this period.
**Motor Vehicle Crash-Related Deaths**

**Trends**

Between 2002 and 2011, the unintentional MVC age-adjusted death rate in Kansas decreased significantly from 19.5 deaths per 100,000 people (95% CI: 17.9-21.1) in 2002 to 13.4 deaths per 100,000 people (95% CI: 12.1-14.8) in 2011.\(^1\)

### Unintentional Motor Vehicle Crash Death Rates by Year, Kansas 2002-2011

![Graph showing the age-adjusted death rate per 100,000 from 2002 to 2011](image)

Source: 2002-2011 Kansas Vital Statistics, Bureau of Epidemiology and Public Health Informatics, KDHE.
Note: Rates are age-adjusted to the 2000 U.S. Standard population using the direct method.

### Age and Gender

Between 2007 and 2011, the unintentional MVC death rate per 100,000 people in Kansas was highest among young adults between 15 and 24 years old (23.2; 95% CI 21.2-25.4) and adults 75 years old and older (75-84 years: 22.2; 95% CI: 18.7-26.2; 85+ years: 28.9; 95% CI: 23.2-35.6). During this period, the unintentional MVC age-adjusted death rate per 100,000 people was significantly higher among males (20.3; 95% CI: 17.9-21.1) compared with females (8.7; 95% CI: 8.0-9.4).\(^2\)

### Race and Ethnicity

Between 2007 and 2011, the unintentional MVC age-adjusted death rate per 100,000 people was significantly lower among non-Hispanic Asians/Pacific Islanders (4.5; 95% CI: 2.3-9.3) in Kansas compared with other racial and ethnic groups.\(^2\)
### Other measures

#### Non-fatal Motor Vehicle Crash Injuries

Between 2006 and 2010, there were 10,022 unintentional MVC hospital discharges (HD) in Kansas (age-adjusted rate: 71.1 MVC hospital discharges per 100,000 people). The age-adjusted MVC HD rate among males was significantly higher than females (87.6 vs. 54.5 MVC HD per 100,000 people, respectively). The MVC HD rate was highest among those between 15 and 24 years old (125.2 MVC HD per 100,000 people) compared with all other age groups.³

Between 2007 and 2009, there were 44,725 unintentional MVC emergency department visits (EDV) in Kansas (age-adjusted rate: 534.1 MVC EDV per 100,000 people). The age-adjusted MVC EDV rate among females was significantly higher than males (590.7 vs. 480.4 MVC EDV per 100,000 people, respectively). The MVC EDV rate was highest among those between 15 and 24 years old (1,156.3 per 100,000 people) compared with all other age groups.⁴

#### Seat Belt Use

Seat belt use is an effective and simple way to save lives while driving or riding in a car. The prevalence of Kansas adults 18 years old and older who always wear a seatbelt increased from 62.5 percent (95% CI: 60.7%-64.4%) in 1999 to 76.1 percent (95% CI: 74.7%-77.4%) in 2010.⁵ In 2010, the prevalence of people always using a seatbelt when driving or riding in a car was higher among Kansas females compared with males; lower among those between 18 and 24 years old compared with those between 35 and 44 years old; higher among college graduates compared with those with lower levels of educational attainment; and much lower among adults living in frontier counties compared with those living in urban counties.⁶

During the 2010/2011 school year, 8.1 percent of Kansas high school students in grades 9 through 12 never or rarely wore a seat belt when riding in a car driven by someone else.⁷

#### Drinking and Driving

Alcohol-impaired driving accounts for nearly one-third (31%) of all traffic-related deaths in the U.S..⁸ In 2010, 2.2% of all Kansans 18 years old and older reported that they had driven drunk during the past 30 days. The prevalence of drinking and driving during the past 30 days was four times higher among Kansas men compared with women; more than four times higher among those between 18 and 24 years old compared with those between 55 and 64 years old; and more than two times higher among those living in urban counties compared with semi-urban counties.⁶

During the 2010/2011 school year, nearly 1 in 4 (23.8%) Kansas high school students in grades 9 through 12 rode one or more times during the past 30 days in a car or other vehicle driven by someone who had been drinking alcohol and nearly 1 in 10 (8.7%) drove a car or other vehicle one or more times during the past 30 days when they had been drinking alcohol.⁷
Prevalence of Drunk Driving in the Past 30 Days and Always Using Seat Belt when Driving or Riding
Among Kansans 18 years and older, Kansas 1999-2010


References
Older Adult Falls

<table>
<thead>
<tr>
<th>HP 2020 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prevent an increase in fall-related deaths among adults aged 65 years old and older</td>
</tr>
<tr>
<td>Target: 45.3 deaths per 100,000 population</td>
</tr>
</tbody>
</table>

Introduction

Falls happen throughout an individual’s life. For example, falling is a part of the process that toddlers experience while learning to stand. However, some fall-related injuries can impact individuals’ lives for the worse. A child who falls and suffers a traumatic brain injury (TBI) may unfortunately live with a resulting physical and/or mental impairment for the rest of his or her life. A senior citizen who falls may break a hip, a medical event from which he or she may never be able to fully recover. In 2010, fall-related deaths among Kansans 65 years old and older cost more than $34 million in medical and work loss expenses. Fortunately, fall injuries and deaths and their associated costs are preventable. The Centers for Disease Control and Prevention (CDC) Injury Center supports proven, effective strategies for fall-related injury prevention such as comprehensive, community-based fall prevention programs; motorcycle and bicycle helmet laws; playground safety; and use of window guards.

Unintentional Older Adult Fall Deaths

Time Trends

Between 2002 and 2011, the unintentional older adult fall death rate in Kansas increased significantly from 40.3 deaths (95% CI: 33.9-47.4 per 100,000 people) in 2002 to 70.3 deaths (95% CI: 62.1-79.2 per 100,000 people) in 2011.

Unintentional Older Adult Fall Death Rates by Year, Kansas 2002-2011

Gender, Race and Ethnicity

Between 2007 and 2011, the unintentional older adult fall death rate per 100,000 people in Kansas did not differ significantly by gender or across racial and ethnic groups.2

Other Measures

Non-fatal Unintentional Older Adult Falls

Between 2006 and 2010, there were 29,515 unintentional fall hospital discharges (HD) among Kansans 65 years old and older (rate: 1,614.3 fall HD per 100,000 people). The unintentional older adult fall HD rate was significantly higher among Kansas females than males (2,015.8 vs. 1,064.5 fall HD per 100,000 people).2

Between 2007 and 2009, there were 38,645 unintentional fall emergency department visits (EDV) among adults 65 years old and older in Kansas (rate: 3,530.9 fall EDV per 100,000 people). The unintentional older adult fall EDV rate was significantly higher among females than males (4,169.9 vs. 2,648.6 fall EDV per 100,000 people).3

Prevalence of Adult Falls

In 2010, 17.2 percent of those 45 years old and older reported experiencing at least one fall in the past three months. Among those who reported experiencing at least one fall during the past three months, 29 percent reported an injury that limited regular activities for a day or necessitated a visit to a doctor. Among Kansans 45 years old and older, the prevalence of having at least one fall-related injury within the past three months was significantly higher among males (78.8%) compared with females (65.4%); Hispanics (86.8%) compared with non-Hispanics (70.6%); whites (71.7%) compared with African-Americans (47.8%); those with an annual household income of $50,000 or more (73.7%) compared with those with an annual household income less than $15,000 (49.8%); those who were unable to work (50.4%) compared with those who were employed for wages (74.5%); and those living with a disability (65.1%) compared with those living without a disability (77.3%).

References

2. 2006-2010 Kansas Hospital Discharge Database. Kansas Hospital Association.
Poisonings

HP 2020 Objective

| Prevent an increase in poisoning deaths | Target: 13.1 deaths per 100,000 population |

Introduction

A poisoning is defined as an exposure to any extrinsic substance (solids, liquids or gases and natural or synthetic chemicals) by ingestion, inhalation, injection or absorption through the skin or mucous membranes that results in at least one related adverse clinical effect (sign, symptom or laboratory abnormality). Today, in Kansas and the broader U.S., the majority of fatal and non-fatal poisonings are drug-related. A drug is defined as 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. Drugs include prescription drugs and illicit drugs such as nonopioid analgesics (e.g., ibuprofen, acetaminophen and aspirin) and narcotics (e.g., morphine, heroin and hydrocodone).

Poisoning Deaths

Time Trends

Between 2002 and 2011, the age-adjusted poisoning death rate in Kansas increased significantly from 7.7 deaths (95% CI: 6.7-8.8 per 100,000 people) in 2002 to 11.7 deaths (95% CI: 10.4-13.1 per 100,000 people) in 2011.¹

Poisoning Death Rates by Year, Kansas 2002-2011

Source: 2002-2011 Kansas Vital Statistics, Bureau of Epidemiology and Public Health Informatics, KDHE.
Note: Rates are age-adjusted to the 2000 U.S. Standard population using the direct method.
Age and Gender

Between 2007 and 2011, the poisoning death rate per 100,000 people in Kansas was highest among those between 45 and 54 years old (27.3; 95% CI 25.1-29.7). During this period, the age-adjusted poisoning death rate per 100,000 people was significantly higher among males (13.5; 95% CI: 12.7-14.4) compared with females (9.7; 95% CI: 9.0-10.5).²

Poisoning Death Rate by Gender, Kansas 2007-2011

Race and Ethnicity

Between 2007 and 2011, the age-adjusted poisoning death rate per 100,000 people was significantly lower among Hispanics in Kansas (5.7; 95% CI: 4.2-7.7) compared with other racial and ethnic groups.²

Poisoning Death Rates by Racial/Ethnic Groups, Kansas 2007-2011

Note: Rates are age-adjusted to the 2000 U.S. Standard population using the direct method.
Non-Fatal Poisonings

Between 2006 and 2010, there were 12,967 poisoning hospital discharges (HD) in Kansas (age-adjusted rate: 93.6 poisoning HD per 100,000 people). The age-adjusted poisoning HD rate was significantly higher among Kansas females than males (108.4 vs. 79.1 poisoning HD per 100,000 people, respectively). The poisoning HD rate was highest among those between 35 and 44 years old (137.2 per 100,000 people) compared with all other age groups.\(^3\)

Between 2007 and 2009, there were 13,668 poisoning emergency department visits (EDV) in Kansas (age-adjusted rate: 163.0 poisoning EDV per 100,000 people). The age-adjusted poisoning EDV rate was significantly higher among females than males (177.7 vs. 148.9 poisoning EDV per 100,000 people, respectively). The poisoning EDV rate was highest among those between 1 and 4 years old (568.7 poisoning EDV per 100,000 people) compared with all other age groups.\(^4\)

Intent

Between 2007 and 2011, almost three-quarters (70%) of all poisonings deaths in Kansas were unintentional; 1 in 5 (20%) were suicides.\(^2\)

Poisoning Deaths by Intent, Kansas 2007-2011


References

Suicide

HP 2020 Objective

<table>
<thead>
<tr>
<th>Objective</th>
<th>Target: 10.2 deaths per 100,000 population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the suicide rate</td>
<td></td>
</tr>
</tbody>
</table>

Summary

This section reviews suicide mortality data from the past decade. Time trends, demographic characteristics and causes are presented to articulate the burden of suicide in Kansas. The burden of non-fatal self-harm injury is also presented.

Introduction

In 2010, suicide was the 10th leading cause of death among Kansans of all ages. Aside from the emotional burden on families and communities, the cost of suicide in Kansas was nearly $500 million.\(^1\) Many believe that suicides are due to singular events or circumstances in a person’s life, but it is a complex issue and multiple approaches are needed to prevent suicide, including reducing risk factors and increasing protective factors that promote resilience. Risk factors for suicide include family history of suicide or child maltreatment, previous suicide attempts, history of mental disorders including clinical depression, history of alcohol and substance abuse and feelings of hopelessness.\(^2\) Protective factors include effective clinical care for mental, physical and substance abuse disorders; easy access to a variety of clinical intervention and support for help seeking; family and community support; and skills in problem solving, conflict resolution and nonviolent ways of handling disputes.\(^2\)

Suicide Deaths

Time Trends

Between 2002 and 2011, the age-adjusted suicide rate in Kansas remained relatively stable at around 13 deaths per 100,000 population.\(^3\)

Suicide Rates by Year, Kansas 2002-2011

Source: 2002-2011 Kansas Vital Statistics, Bureau of Epidemiology and Public Health Informatics, KDHE.
Note: Rates are age-adjusted to the 2000 U.S. Standard population using the direct method.
**Age and Gender**
Between 2007 and 2011, the suicide rate per 100,000 population in Kansas was highest among middle-aged adults 45 to 54 years old (20.9; 95% CI 19.0-23.0). During this time period, the age-adjusted suicide rate per 100,000 population was significantly higher among males (22.3; 95% CI: 21.2-23.5) as compared to females (5.1; 95% CI: 4.5-5.6).\(^4\)

![Suicide Rate by Gender, Kansas 2007-2011](image)

Note: Rates are age-adjusted to the 2000 U.S. Standard population using the direct method.

**Race and Ethnicity**
Between 2007 and 2011, the age-adjusted suicide rate per 100,000 population was significantly higher among non-Hispanic whites (14.5; 95% CI: 13.8-15.2) in Kansas as compared to other race/ethnic groups.\(^4\)

![Suicide Rates by Race/Ethnic Groups, Kansas 2007-2011](image)

Note: Rates are age-adjusted to the 2000 U.S. Standard population using the direct method. Rates for non-Hispanic (NH) Asians/Pacific Islanders and NH Native Americans not shown due to count<20.
Cause

Between 2007 and 2011, more than half (55%) of suicides in Kansas were caused by firearms; nearly 1 in 4 (22%) were caused by suffocation.

Suicide Attempts

During a five year period from 2006 to 2010, there were 7,952 attempted suicide hospital discharges (HD) in Kansas (age-adjusted rate: 58.3 attempted suicide HD per 100,000 population). The age-adjusted attempted suicide HD rate was significantly higher among females than males (69.7 vs. 47.3 attempted suicide HD per 100,000 population, respectively). The attempted suicide HD rate was highest among those 15 to 44 years old (nearly 100 attempted suicide HD per 100,000 population) as compared to all other age groups.

During a three year period from 2007 to 2009, there were 5,869 attempted suicide emergency department visits (EDV) in Kansas (age-adjusted rate: 70.8 attempted suicide EDV per 100,000 population). The age-adjusted attempted suicide EDV rate among females was significantly higher than males (83.1 vs. 59.2 attempted suicide EDV per 100,000 population, respectively). The attempted suicide EDV rate was highest among those 15 to 24 years old (200.3 per 100,000 population) as compared to all other age groups.

Suicide and Youth

During the 2010/2011 school year, slightly more than 1 in 10 (11.8%; 95% CI: 10.3-13.5%) Kansas high school students seriously considered attempting suicide during the previous year, and approximately 1 in 10 (9.9%; 95% CI: 8.2-11.9%) made a plan about how they would attempt suicide. Approximately 6 percent (5.9%; 95% CI: 4.6-7.6) reported actually attempting suicide one or more times during the past year.

References

5. 2006-2010 Kansas Hospital Discharge Database. Kansas Hospital Association.
Traumatic Brain Injury

<table>
<thead>
<tr>
<th>HP 2020 Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce fatal traumatic brain injuries</td>
</tr>
</tbody>
</table>

Introduction

Traumatic brain injury (TBI) is caused by a bump, blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. Each year, TBIs contribute to a substantial number of deaths and cases of permanent disability in the U.S.\(^1\) On average, approximately 1.7 million people sustain a TBI each year in the U.S.\(^1\) In addition, TBI is a contributing factor to nearly 1 in 3 injury-related deaths. Although the majority of TBIs aren’t fatal, they can cause long-term health complications such as loss of function or permanent disability. Short-term effects of TBI include loss of consciousness, retrograde amnesia and changes in mental state. Long-term effects can include neurological/physical effects, including post-traumatic epilepsy, sensory deficit, impaired strength and coordination and pain; cognitive effects such as memory impairment, slowed processing speed, decreased intelligence and impaired executive functioning; and psychosocial/emotional effects, including rapid shifts in outward emotional expressions, social inappropriateness, mood swings, stress/anxiety and depression.

TBI-Related Deaths

Trends

Between 2002 and 2011, the age-adjusted TBI-related death rate in Kansas remained relatively stable around 18 deaths per 100,000 people.\(^2\)

Age and Gender

Between 2007 and 2011, the TBI-related death rate per 100,000 people in Kansas was highest among those 85 years old and older (107.1; 95% CI: 95.8-119.4). During this period, the age-adjusted TBI-related death rate per 100,000 people was significantly higher among males (29.2; 95% CI: 27.9-30.6) compared with females (9.5; 95% CI: 8.8-10.2).\(^3\)
Race and Ethnicity
Between 2007 and 2011, there were no significant differences in age-adjusted TBI-related death rates across racial and ethnic groups.³

Cause and Intent
Between 2007 and 2011, more than one-third (36%) of TBI-related deaths in Kansas were caused by firearms. An additional one-quarter were caused by suffocation (27%) and poisoning (26%), respectively.³

Between 2007 and 2011, more than half (61%) of TBI-related deaths in Kansas were unintentional. An additional one-third (31%) were suicides.³
Non-Fatal TBI

Between 2006 and 2010, there were 13,683 TBI-related hospital discharges (HD) in Kansas (age-adjusted rate: 93.6 TBI-related HD per 100,000 people). The age-adjusted TBI-related HD rate among males was significantly higher than females (120.9 vs. 66.8 TBI-related HD per 100,000 people, respectively). The TBI-related HD rate was highest among those 85 years old and older (582.1 TBI-related HD per 100,000 people) compared with all other age groups.4

Between 2007 and 2009, there were 34,406 TBI-related emergency department visits (EDV) in Kansas (age-adjusted rate: 405.5 TBI-related EDV per 100,000 people). The age-adjusted TBI-related EDV rate among males was significantly higher than females (454.1 vs. 352.8 TBI-related EDV per 100,000 people, respectively). The TBI-related EDV rate was highest among those less than 1 year old (1,006.8 per 100,000 people) compared with all other age groups.5

References

**Unintentional Injury**

**HP 2020 Objective**

| Reduce unintentional injury deaths | Target: 36 deaths per 100,000 population |

**Introduction**

Injury is the fifth leading cause of death in Kansas, and is also among the leading causes of hospitalization. About 1,600 Kansans die each year as the result of injury; about 1,100 of which are unintentional injuries. Although injuries can be categorized in multiple ways—for example, where or how they occur—it is typical to categorize injuries in terms of their mechanism and intent. Mechanism (or cause) typifies how the injury occurred—for instance, by motor vehicle, firearm, struck by an object or by falling. Intent is classified as unintentional or intentional (or unknown or undetermined intent). While unintentional injuries often result as a form of rapid transfer of energy from object to person (e.g. being struck by a motor vehicle), intentional injuries are the result of intentional harm imposed by one person upon another (e.g. homicide) or upon oneself (e.g. suicide).

**Unintentional Injury Deaths**

**Trends**

Between 2002 and 2011, the age-adjusted unintentional injury death rate in Kansas remained relatively stable around 40 deaths per 100,000 people.¹

---

**Unintentional Injury Death Rates by Year, Kansas 2002-2011**


Note: Rates are age-adjusted to the 2000 U.S. Standard population using the direct method.
Age and Gender

Between 2001 and 2011, the unintentional injury death rate per 100,000 people in Kansas was highest among those 85 years old and older (362.9; 95% CI: 341.8-384.9). During this period, the age-adjusted unintentional injury death rate per 100,000 people was significantly higher among males (57.1; 95% CI: 55.3-58.9) compared with females (29.1; 95% CI: 27.9-30.3).²

Race and Ethnicity

Between 2007 and 2011, the age-adjusted unintentional injury death rate per 100,000 people was significantly lower among non-Hispanic Asians/Pacific Islanders (13.1; 95% CI: 8.4-20.3) in Kansas compared with other racial/ethnic groups.²
Non-Fatal Unintentional Injuries

Between 2006 and 2010, there were 67,803 unintentional injury hospital discharges (HD) in Kansas (age-adjusted rate: 451.6 unintentional injury HD per 100,000 people). The rate among males was significantly higher than females (453.8 vs. 430.5 injury HD per 100,000 people, respectively). The unintentional injury HD rate was highest among those 85 years old and older (4,798.8 per 100,000 people) compared with all other age groups.3

Between 2007 to 2009, there were 498,389 unintentional injury emergency department visits (EDV) in Kansas (age-adjusted rate: 5,941.9 unintentional injury EDV per 100,000 people). The rate among males was significantly higher than females (6,321.0 vs. 5,519.5 unintentional injury EDV per 100,000 people, respectively). The unintentional injury EDV rate was highest among those between 1 and 4 years old (10,235.0 per 100,000 people) compared with all other age groups.4

References

Strengths and Assets

Strengths

Motor Vehicle

Seatbelts Are For Everyone (SAFE) is a cooperative effort to increase teen restraint compliance through positive rewards and enforcement. SAFE works to raise awareness of the importance of wearing a seatbelt to reduce the number of motor vehicle related injuries and fatalities among Kansas teens. Currently, 88 schools (nearly 32,000 students) in 38 counties participate in the SAFE program. In 2012, average seatbelt usage across all participating schools increased by 8.3 percent.

Falls Prevention

To increase fall prevention KDHE works through partnerships to incorporate fall prevention messaging and interventions into existing programs. Thirty-five locations in Kansas are implementing the Arthritis Foundation’s Tai Chi for Health program, which is an evidence-based fall prevention strategy. In addition KDHE coordinates the Stepping On program that offers older adults a way of reducing falls by incorporating and discussing a range of issues that include falls and risks, strength and balance exercises, initiating a medication review, vision exams, home safety, safe footwear and what to do and how to cope after a fall. The Stepping On course consists of seven weekly classes that are each approximately two-hours in length, followed by a home assessment at three months, and a six month follow-up. The Stepping On course is offered regularly throughout Kansas.

Drowning Prevention

Safe Kids Kansas and its local coalitions have collaborated with the U.S. Army Corp of Engineers to construct and maintain personal flotation device (PFD) loaner boards at lakes across the state. The loaner boards display water safety tips and hold multiple sizes of PFDs that can be borrowed by the public. Safe Kids Kansas distributed 229 PFDs to individual children in 2011.

Traumatic Brain Injury

Kansas has several initiatives to reduce traumatic brain injuries including Cycle SMART, the School Sports Head Injury Prevention Act, the Kansas Sports Concussion Partnership and the Youth Sports Safety Campaign.

The Injury Prevention Program at KDHE and Safe Kids Kansas receive funding from the Kansas Department of Transportation (KDOT) and State Farm to support a bike helmet fitting/distribution program called Cycle SMART. This program has distributed more than 127,000 bike helmets since its inception and has been credited with saving 13 lives.

The Kansas Legislature passed the School Sports Head Injury Prevention Act in 2011 requiring an MD or DO to authorize a student athlete’s return to practice and play following a suspected concussion.

The Kansas Medical Society supports the Kansas Sports Concussion Partnership (KSCP) to make sports in Kansas safer. The partnership provides tools and guidelines outlining the signs and symptoms of a concussion and provides answers to specific questions for managing a student athlete’s recovery from a mild traumatic brain injury.

Safe Kids Kansas works with the KSCP to implement the Youth Sports Safety Campaign that educates stakeholders on hydration,
concussion prevention and detection, overuse injury prevention and pre-participation physical examinations. Safe Kids Kansas and two local coalitions held 10 clinics in Kansas in 2011 training nearly 300 participants.

Poison Control

The Poison Control Center hotline is available 24/7 anywhere in the state of Kansas and throughout the Kansas City metropolitan area. Toll free 1-800-222-1222.

Kansas Prescription Drug Monitoring Program (K-TRACS) was started to support the appropriate use of prescription drugs. The information is intended to help people work with their health care providers and pharmacists to determine what medications are best for them.

Assets

- Partners, coalitions and communities - Those working in injury prevention are very passionate and committed to the work
- Child passenger safety: Multi-sector approach has made a difference – excellent laws, good messaging, requiring car seats before going home from hospital, car seat safety checks, etc.
- Improved traffic safety laws, education and enforcement are reducing rates: Includes primary seat belt law, “Click It or Ticket,” improved graduated driver licensing system, and model enforcement by Kansas Highway Patrol and some police/sheriff departments
- Poison Control Center: Covers the entire state and has expertise in multiple areas (agricultural chemicals, drugs, spider bites, bioterrorism, etc.)
- Safe Kids Kansas