Welcome to the Poster Session on Older Adult Falls, Motor Vehicle Crashes, and Trauma-Informed Care

https://injurycenter.umich.edu/research-symposium-2020/
The Effect of Health Literacy on Fall Prevention for the Elderlies Dae Hyun Kim, PhD, Department of Health Care Administration, College of Business, Idaho State University

Hospitalization and Fall Injuries Among Older Adults: An Examination of Fall Risk in the Pre and Post-Hospital Periods Geoffrey Hoffman, PhD, UM School of Nursing

Reconstruction of Real World Losses Trips and Recovery Responses in Older Adults at Risk for Falls Lauro Ojeda, MS, Department of Mechanical Engineering, University of Michigan

Walkability and Social Ties in Fall Prevention: Lessons Learned in the Recruitment and Retention of Older Adults in Flint Sabah Ganai, MPH, Dept. of Public Health and Health Sciences, University of Michigan Flint

Free-Text Surveys as a Tool to Understand Patient Recovery from Trauma Lauren Shawver, BS, Wayne State University

Understanding Student Experiences with Inappropriate, Disrespectful, and Coercive Healthcare and Physical Exams Michelle L Munro-Kramer, PhD, CNM, FNP-BC, School of Nursing, University of Michigan

Motor Vehicle Collisions Among Patients with Seizure Disorders – A Call to Improve Awareness Among At-Risk Patients Hala Khalil, PhD, King Faisal Specialist Hospital & Research Centre, Department of Biostatistics- Epidemiology and Scientific Computing, Riyadh, Saudi Arabia
The Effect of Health Literacy on Fall Prevention for the Elderly
Dae Hyun (Daniel) Kim
1 Idaho State University (ISU) College of Business Department of Health Care Administration
Pocatello, ID

Introduction

According to the Centers for Disease Control and Prevention (CDC), since 2016, three million elders have been treated in emergency departments and over 800,000 patients a year have been hospitalized due to fall injuries. This has resulted in the medical costs for falls to be totaled in more than $50 billion just in 2016. Despite healthcare organizations bringing out various intervention programs to remedy this phenomenon, fall death rates in the United States have increased by 30% from 2007 to 2016 for older adults and this rate is continuing to increase. One area and a possible solution to this problem, which is yet to be explored more thoroughly is improving American adults' health literacy levels.

The purpose of this study is to examine the effect of health literacy on preventing possible fall injuries for older adults in the United States.

What Is Health Literacy?
“Individual’s capacity to obtain, communicate, process, and understand basic health information and services to make appropriate health decisions.”

Methods

Literature review with three databases, which were PubMed, AItInform, and Google Scholar, was conducted. All peer-reviewed, empirical studies relating to the effect of health literacy on fall prevention for older adults were reviewed. 239 articles met the initial criteria. Once additional key words were inserted and abstract reviews were conducted, only three studies directly examined the effect of health literacy on fall prevention for older adults.

Results

Out of 239 articles that met the initial criteria, only three articles explicitly observed the effect of health literacy on fall prevention for older adults.

The first article (Morris et al., 2017) evaluated the measurement properties of the Health Literacy Questionnaire (HLQ) in a cohort of older adults who presented to a hospital emergency department (ED) after a fall. After conducting Rasch analysis, the result indicated that the HLQ demonstrated good measurement properties in a cohort of older adults who presented to an ED after a fall and that these adults, on average, had lower health literacy levels than patients who visited ED for other medical symptoms.

The second article (Heerman et al., 2014) examined the role of caregivers’ health literacy levels in both caregivers’ and infants’ injury prevention behaviors. Results did show that caregivers with low health literacy levels did not adhere to injury prevention guidelines and it was significantly associated with some injury prevention behaviors.

The last article (Andrade, Silva, & Martins, 2017) developed an improved manual for prevention of falls for older adults with low health literacy entitled “Preventing Falls-I Can Do It,” with the aid of Health Literacy INDEX tool. Results have shown that the manual for prevention of falls developed according to health literacy demands is more likely to be comprehended by low health literacy populations and by offering effective health information materials, older adults can play a more active role in their healthcare.

Conclusion

Despite the fact that health literacy is gaining more from healthcare organizations and researchers for its effect on quality improvement, it is clear that health literacy is not being extensively examined in the context of fall and injury preventions for the elderly.

Results from the literature review show that there is a significant relationship between patients’ health literacy levels and their abilities to potentially prevent fall injuries. By targeting patients’ health literacy as a solution for the phenomenon of fall injuries among elders, the rate of fall injuries can be decreased and can ultimately result in better healthcare quality outcomes.

References

Pre- and Post-Hospital Fall Injuries in Older Americans

Geoffrey J. Hoffman, PhD1, 2, Mary Tinetti, MD2, Jinkyung Ha, PhD3,4, Neil B. Alexander, MD 3,4, Lillian Min, MD MS HS3,4
1University of Michigan School of Nursing, 2Yale University School of Medicine, 3Department of Internal Medicine, Geriatrics, University of Michigan, 4Geriatrics Research Education and Clinical Center, VA Ann Arbor Healthcare System 5University of Michigan School of Medicine

Background
- Episode-based reimbursement models are increasingly used to incentivize high-value care across care settings.
- They have not been applied to fall injuries which are typically addressed separately within discrete care settings – hospitals, nursing facilities, and the community.

Aim of Study
Estimate the risk of older adult fall injury during year-long care episodes anchored by an acute hospitalization.

Methods
Data and Study Population
- 10,106 observations for 4,101 Medicare fee-for-service beneficiaries ages ≥ 65 with an anchor hospitalization and 12 months of surrounding Medicare eligibility, using 2006-2014 Health and Retirement Study and linked Medicare claims data

Outcome Variable
- Fall-related injury
  - Using Min-Hoffman algorithm
  - E-codes, diagnosis and procedure codes from IP, OP, physician, and SNF

Covariates
- Patient demographics (age, sex, race/ethnicity, education)
- Chronic conditions (diabetes, cancer, lung disease, stroke, psychological problems, arthritis), cognitive impairment, frailty

Time Periods Examined
- Four periods relative to the anchor hospitalization were examined:
  1) Baseline (-6 to -1 months before hospitalization)
  2) Just before hospitalization (<-1 month before hospitalization)
  3) Just after hospitalization (<1 month after hospitalization)
  4) At follow-up (1 to 6 months after hospitalization)

Analysis
- Piecewise logistic regression that fit multiple models to data, for 4 periods
- Breakpoints separating time periods are where slopes change
- For interpretability, marginal effects computed – change in probability of fall injury for additional week in period (e.g., weekly percentage-point change in risk)
- Sensitivity analysis only examining 327 observations with in-hospital fall injury

Results
- 77.1 years, 59% female, 81% ≤ HS, 25% minority, 33% diabetes, 23% cancer, 48% heart problems, 16% stroke, 78% arthritis;
- Overall fall injury risk of 0.77%
- Risk increased slightly (0.02 percentage point [pp], p=0.001) at baseline

Discussion
- Risk transitions between periods include sizeable increases (+30% each week, or +120% in total) just before hospitalization that do not fully subside after discharge (-9% each week, or -36% in total)
- Risk changes most notable for patients who experienced an inpatient fall injury (pre-hospital increases of 310% each week)
- Interventions to include pre-hospital transitional care handoffs could benefit patients, particularly vulnerable ones, and improve on siloed efforts occurring in discrete care setting
- Shift from point-in-time to episodic fall injury prevention, to identify and address risks before, during, and after hospital stay
- Consider including fall injuries as a bundled payment condition, to incentivize care coordination across care continuum

Limitations
- Cannot infer fall will lead to hospitalization
- Did not capture falls not requiring care
- Some fall injuries could have resulted in hospitalization, but these were excluded

Strengths
- First study to examine variability in period-specific risks over extended time period
Reconstruction of Real World Losses of Balance and Recovery Responses in Older Adults at Risk for Falls

Lauro Ojeda¹, Shirley Handelzalts², Linda Nyquist¹, Debra Strasburg¹, Neil Alexander¹,³
¹University of Michigan, USA, ²Ben-Gurion University of the Negev, Israel, ³VA Ann Arbor Health Care System, USA

Introduction

Trips, slips, and other losses of balance (LOBs) are major risk factors for falls in older adults and can lead to injuries. Falls are associated with walking (54%) such as slips and trips, but a sizeable percentage (over 43%) are associated with non-walking activities such as changing position or reaching. Data. There is few data on the objective detection of and kinematics associated with near falls in older adults during daily life activities.

Objective

To determine key body kinematics using inertial measurement units (IMU) underlying real life losses of balance and falls.

Methods

Eleven (5M, 6F, age 76) community dwelling older adults at fall-risk.
A voice recorder and 4 body worn inertial measurement units were used to provide accurate record of the context of LOBs events as well as body kinematics.
IMUs data were processed to estimate foot trajectories and trunk and arm orientations.¹
Information was combined to generate a 3D animation showing kinematic representation of the LOB.²,³
LOBs were identified from 10 minute window prior to participant’s report. Then, the animation was used to corroborate the occurrence of a LOB.

Results

Over a two-week period, these sensor data recorded over 200 potential LOB events during waking hours.
Events reported as a trip by the participant and identified as a trip by a researcher, blinded to voice recordings description.
A total of 18 trips obtained from 5 participants were analyzed, 2 trips occurred at home, 3 outside and for 3 the location was not reported.
One trip lead to a fall.

Examples showing foot speed for the right (yellow) and left (blue) foot.

Conclusions

This sensor-based approach combined with voice recordings of near falls demonstrates the feasibility of identifying trip-related near falls during real world activities.
These preliminary results constitute the basis for development of an algorithm for automated detection of near falls among older adults.

References: ¹ Ojeda and Borenstein, J of Nav. 2007; 60(3): 391-407;
² Ojeda, L., et al. ME&P. 2018; 64: 86-92.;
³ Handelzalts S, et. al Frontiers in Medicine, 2020
Background and Purpose

Recruiting older adults living in lower-income communities into research studies has become an increasingly difficult task. Previous research has shown that the utilization of multiple modes of recruitment increases potential participants’ likelihood to engage in research studies. The purpose of our research is to describe our experiences in recruiting older adults in Flint. The current study followed up with participants from a previous study and invited them to come to the University of Michigan-Flint campus to complete questionnaires and study activities on two separate days.

Methodology

- Recruitment started in June 2019.
- In 12 weeks, we approached previous study participants up to 6 times.
- Multiple strategies were used for study recruitment. First, potential participants received a flyer, and two follow-up postcards. Then attempts were made to contact participants by phone up to 3 times. Additionally, a reminder confirmation phone call was made one day before the scheduled testing session. Participants received up to $60 total for completing both sessions.
- One flyer and two postcards were sent to 140 past study participants.
- There were 10 participants that were recruited into the study with an overall response rate of 9.6% out of 104 with known addresses.
- There were 2 participants that were recruited into the study with an overall response rate of 2.06% out of 97 with known phone calls made.

Results

- Participants from past research: N=140
- Participants with available address and phone number: N=320
- Interested participants: N=23 (1 from mail, 20 from postcards, and 2 from phone calls)
- Eligible participants: N=18
- Participated: N=12

- No address and phone number available currently (N=30)
- No response (N=97)
- Not meet the eligibility criteria (2 not eligible due to physical condition)
- Could not meet at the interview site (1 due to task of transportation)
- No show (N=4)

Conclusion

The use of flyers/postcards as the initial approach was adequate. However, it did not result in increased participation. Further, the phone call alone sometimes could not obtain participants’ trust, and flyers/postcards were more effective at getting participants’ attention. The recruitment and retention of the repeated measures study are challenging in Flint, MI.

References


Acknowledgments

This study was supported by the Mcubed at University of Michigan. Special recognition to our community partners and survey participants at the Hamilton Community Health Network in Flint.
Free-text Surveys as a Tool to Understand Patient Recovery from Trauma

Lauren Shawver BS1, Brittany Punches PhD2, Viviane Kazan MD3, Christopher Lewandowski MD4, Michael Lyons MD MPH2, Francesca Beaudoin MD, PhD5, Phyllis Hendry MD6, Sophia Sheikh MD3, Paul Musey MD3, Alan Storrow MD3, Christopher Jones MD10, Robert Swor DO11, Michael Kurz MD, MS-HES12, Meghan McGrath MD13, Jennifer Stevens MD, MS16, Lauren Hudak MD, MPH17, Samuel McLean MD, MPH18, Claire Pearson MD, MPH1

1Wayne State University, 2University of Cincinnati, 3Ascension St. John Hospital, 4Henry Ford Medical Center, 5The Alpert Medical School of Brown University, 6University of Florida Jacksonville, 7Washington University School of Medicine in St. Louis, 8Indiana University School of Medicine, 9Vanderbilt University Medical Center, 10Cooper Medical School of Rowan University, 11Beaumont Health, 12University of Alabama at Birmingham School of Medicine, 13University of Massachusetts Medical School, 14Temple University Hospital, 15Boston Medical Center, 16Harvard Medical School, 17Emory University School of Medicine, 18University of North Carolina School of Medicine

STATEMENT OF PURPOSE

• Adverse posttraumatic neuropsychiatric sequelae (APNS), including posttraumatic stress (PTS), depression, post-concussion syndrome (PCS), and regional or widespread pain, causes great suffering in trauma survivors.

• Trauma survivors experience complex patterns of overlapping/co-occurring symptoms, and little is known about recovery processes.

• The analysis categorizes free-text comments to identify themes at 2 weeks, 8 weeks, and 3 months.

METHODS

• This a secondary qualitative analysis of the AURORA (Advancing Understanding of RecOvery afteR traumA) study, a large cohort (n=1616) of trauma survivors recruited from >27 Emergency Departments (EDs).

• AURORA assesses neurocognitive, physiologic, digital phenotype, psychophysiological, neuroimaging, and genomic domains in individuals after trauma exposure discharged from EDs.

• Participants completed standardized assessments and provided free-text responses about their experience at 2 weeks, 8 weeks, and 3 months.

RESULTS

• A subset (n=48) of patients provided at least one free-text comment at each of 3 time points.

• Most were female 67% (32) and non-white 60% (25) with a mean age of 39.1 years.

• Patients were asked what was “most important to understand about their experience.”

• At 2 weeks, 15% reported other previous or concurrent trauma. At 8 weeks, 98% provided a response for what was “most important to understand about their experience.”

CONCLUSIONS

• Trauma is a recurrent event for a significant number of patients and responses suggest themes in recovery persist for months.

INNOVATION & SIGNIFICANCE

• Free-text responses provide a better understanding to recovery after trauma in patients own words.

Table 1: Survey Response Rate

<table>
<thead>
<tr>
<th>Time</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-weeks (Anything Else)</td>
<td>39 (81%)</td>
</tr>
<tr>
<td>8-weeks (Most Important)</td>
<td>47 (96%)</td>
</tr>
<tr>
<td>3-months (Most Important)</td>
<td>46 (96%)</td>
</tr>
</tbody>
</table>

Table 2: Most Important Responses

<table>
<thead>
<tr>
<th>Time</th>
<th>Resources</th>
<th>Financial</th>
<th>Medical</th>
<th>Support</th>
<th>Emotional</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 weeks</td>
<td>6 (13%)</td>
<td>0 (0%)</td>
<td>1 (2%)</td>
<td>5 (10%)</td>
<td>6 (13%)</td>
</tr>
<tr>
<td>3 months</td>
<td>8 (17%)</td>
<td>4 (8%)</td>
<td>2 (4%)</td>
<td>10 (21%)</td>
<td>10 (21%)</td>
</tr>
</tbody>
</table>

Table 2: Most Important Responses

<table>
<thead>
<tr>
<th>Time</th>
<th>Financial</th>
<th>Emotional</th>
</tr>
</thead>
<tbody>
<tr>
<td>8 weeks</td>
<td>0 (0%)</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>3 months</td>
<td>3 (6%)</td>
<td>10 (21%)</td>
</tr>
</tbody>
</table>
Understanding Student Experiences with Inappropriate, Disrespectful, and Coercive Healthcare and Physical Exams

Michelle L. Munro-Kramer, Katherine E. Martin, Emily J. Smith, Diana Parish, Charisse M. Loder, Claire Kalpakjian, & Susan D. Ernst

BACKGROUND

- There have been increasing accusations of misconduct by healthcare providers at universities across the country.
- College-aged students are particularly vulnerable, as they are frequently navigating healthcare independently for the first time.
- A valid survey tool is necessary to investigate the frequency of inappropriate, disrespectful, and coercive (IDC) healthcare exams for this population.

METHODS & RESULTS

- Patient Complaint Data (2011-2018):
  - The patient complaint data did not elicit any concerns about egregious sexual or physical abuse.
  - Students frequently reported concerns with communication (n=288); diversity, equity, and inclusion (DEI) (n=79); and system issues (e.g., parking, wait time, facilities, patient portal n=590).
- Phase I: Focus Group Discussion & Individual Interviews (n=38):
  - Themes of IDC experiences that emerged during FGDs included:
    1) Communication
    2) Lack of cultural awareness
    3) Institutional practices
    4) Power imbalances
    5) Lack of patient empowerment
- Patient Satisfaction Data (2011-2018; n=19,015 responses):
  - Press Ganey words not capturing IDC interactions.
  - Developed a list of 156 hot words based on focus group data; found 13 hot words yielded quotes related to IDC.
- Survey Development
  - A 60-item draft survey developed:
    1) Positive Interactions (n=8)
    2) Negative Interactions (n=9)
    3) Structural Items (n=4)
    4) Identity-based Items (n=16 + 4 items for transgender/non-binary participants)
    5) Sensitive Exam Items (n=19)
- Phase II: Cognitive Interviews (n=18):
  - Themes from cognitive interviews for survey validation included:
    1) Clarifying intent
    2) Adding inclusive examples
    3) Reducing redundancy
    4) Clarifying instructions
    5) Modifying answer options

CONCLUSIONS

- Students are having IDC experiences that appear to be related to communication and DEI concerns and rarely include physical or sexual abuse.

INNOVATION & SIGNIFICANCE

- The development of this survey tool will allow for further research to understand the extent of IDC healthcare experiences among college-aged students.
- The next step in this research project is to pilot the survey tool with students at one large public university.

ACKNOWLEDGEMENTS

- This project was funded by a UM IRWG Seed Grant for Research on Gender-Based Violence and Sexual Harassment (PI: Ernst)
Motor Vehicle Collisions among Patients with Seizure Disorders: A Call to Improve Awareness among at-risk Patient Groups

H. Khalil1, R.A. Saleh2, A. Al-Semari3, R. Saleh4, A. AbuJaber1, R. Bin Jaber1, G. Alammar1, M. Aleid1, M. Almarzouqi1
1King Faisal Specialist Hospital & Research Centre, Department of Biostatistics-Epidemiology and Scientific Computing, Riyadh, Saudi Arabia, 2King Abdulaziz Medical City National Guard Health Affairs, Department of Medicine, Riyadh, Saudi Arabia, 3King Faisal Specialist Hospital & Research Centre, Neurosciences Department, Riyadh, Saudi Arabia, 4University College Dublin, School of Medicine, Dublin, Ireland

BACKGROUND Motor vehicle collisions are one of the leading causes of morbidity and mortality in Saudi Arabia having accounted for 11.75% of total mortality in 2010. Previous studies have reported that most patients with epilepsy receive receive counseling from their primary physicians on their risk of driving, however the degree of compliance among patients and their perception of driving risk has not been explored. We aimed to describe the driving patterns of patients with epilepsy, and to audit clinical practice on counseling and offering support services.

METHODS This was a cross-sectional study of patients with epilepsy or seizure disorders who attended the epilepsy outpatient clinics between Jan and Mar 2018. Structured questionnaires were administered by interview to participants. Data for 273 patients who were male (excluding those who were mentally unable to answer the interview and those who reported they were physically unable to drive) were analysed.

RESULTS Fifty-eight-percent of 103 patients who were unfit to drive, while 76% of 173 patients considered fit to drive at time of interview. Reasons to stop driving included physicians’ advice (60%), patients’ own fears (48%), and advice from non-medical persons (30%). All unfit patients who did not drive perceived themselves to be at risk of driving. Seventy-six-percent of patients who were unfit to drive reported that they previously received counseling from their neurologist regarding safety to drive. Among patients who were counselled within the last 6 months of the survey, all unfit patients had been advised not to drive however this did not prevent them from driving.

Table 1 – Demographic and seizure characteristics for 273 male patients with epilepsy or seizure disorder recruited from epilepsy outpatient clinics

<table>
<thead>
<tr>
<th>Fit to drive1 (n=171)</th>
<th>Unfit to drive (n=102)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>Currently driving</td>
<td>131 (76.6)</td>
<td>60 (58.8)</td>
</tr>
<tr>
<td>Self perceived risk of driving</td>
<td>78 (48.1)</td>
<td>61 (66.3)</td>
</tr>
<tr>
<td>Married</td>
<td>60 (50.0)</td>
<td>30 (38.0)</td>
</tr>
<tr>
<td>Currently employed or studying</td>
<td>87 (73.7)</td>
<td>39 (50)</td>
</tr>
<tr>
<td>High school degree or higher</td>
<td>140 (80.9)</td>
<td>67 (65.7)</td>
</tr>
</tbody>
</table>

Table 2 – History of motor vehicle collisions among 273 male patients with epilepsy or seizure disorder who were driving at time of interview

<table>
<thead>
<tr>
<th>Fit to drive1 (n=129)</th>
<th>Unfit to drive (n=60)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>Seizure in the last 6 months while driving</td>
<td>12 (9.3)</td>
<td>11 (18.3)</td>
</tr>
<tr>
<td>Collision due to seizure</td>
<td>0 (0)</td>
<td>7 (11.7)</td>
</tr>
<tr>
<td>Previous seizure while driving (lifetime)</td>
<td>66 (51.2)</td>
<td>37 (61.7)</td>
</tr>
<tr>
<td>Previous fatality due to seizure</td>
<td>2 (16)</td>
<td>1 (1.7)</td>
</tr>
<tr>
<td>Previous injury due to seizure</td>
<td>23 (17.8)</td>
<td>19 (31.7)</td>
</tr>
<tr>
<td>Previous property damage due to seizure</td>
<td>27 (20.9)</td>
<td>21 (35)</td>
</tr>
</tbody>
</table>

Table 3 – Counseling on safety of driving among 273 male patients with epilepsy or seizure disorder recruited from epilepsy outpatient clinics

<table>
<thead>
<tr>
<th>Fit to drive1 (n=171)</th>
<th>Unfit to drive (n=102)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>n (%)</td>
<td>n (%)</td>
<td></td>
</tr>
<tr>
<td>Received counseling from neurologist</td>
<td>110 (67.9)</td>
<td>65 (75.6)</td>
</tr>
<tr>
<td>Received counseling from neurologist in the last 6 months</td>
<td>13 (7.5)</td>
<td>16 (15.5)</td>
</tr>
</tbody>
</table>

Table 4 – Predictors of driving in patients with epilepsy or seizure disorders1

<table>
<thead>
<tr>
<th>OR (CI 95%)</th>
<th>p-value</th>
<th>Adjusted OR3 (CI 95%)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-perceived risk of driving</td>
<td>0.108 (0.04 – 0.30)</td>
<td>&lt;0.001</td>
<td>0.090 (0.02 – 0.44)</td>
</tr>
<tr>
<td>Received counseling from neurologist on driving</td>
<td>1.500 (0.66 – 3.41)</td>
<td>0.332</td>
<td>2.274 (0.83 – 6.27)</td>
</tr>
</tbody>
</table>

Table 5 – Predictors of driving in patients with epilepsy or seizure disorders1

<table>
<thead>
<tr>
<th>OR (CI 95%)</th>
<th>p-value</th>
<th>Adjusted OR3 (CI 95%)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-perceived risk of driving</td>
<td>0.139 (0.04 – 0.45)</td>
<td>0.001</td>
<td>0.104 (0.02 – 0.72)</td>
</tr>
<tr>
<td>Received counseling from neurologist on driving</td>
<td>1.024 (0.36 – 2.92)</td>
<td>0.965</td>
<td>1.719 (0.52 – 5.66)</td>
</tr>
</tbody>
</table>

CONCLUSION Although patients with epilepsy were counselled by their physicians on driving safety, they were found not to comply with advice. Perception of risk may play a greater role in the prevention of driving among at-risk individuals. Counselling methods targeting the risk behaviors need to be re-evaluated to improve road safety.
Q&A

Please type your questions in the Q&A box and the moderator will ask the panelists select questions.
- Evaluation survey to follow by email

- Register now for our upcoming summit - The Science of Suicide Prevention: New Strategies for Understanding and Intervening on March 16, 2021 from 12PM – 5PM. Information on how to register and submit abstracts can be found on the event page on our website injurycenter.umich.edu

- Become a member! Sign up at injurycenter.umich.edu/about-us/membership/becoming-a-member/

- All recordings from today will be available on our website in the coming weeks

Thank You!