Eastern Association for the Surgery of Trauma
Advancing Science, Fostering Relationships, and Building Careers

Virtual Case Conference Series

Brought to you by the EAST Educational Resources Committee

Thank you to our Virtual Case Conference Series Supporter - CLR Medical

Injury Control and Violence Prevention (ICVP)

May 19, 2026

Case Series: Expert Q&A Review

Presented by the Injury Control and Violence Prevention Committee

Case Presenters

Case 1	**Arnav Mahajan, MD** Matriculating General Surgery Resident University of Wisconsin - Madison Madison, WI
Case 2	**Beverly Tomita, MD** PGY-1, General Surgery Resident Carle Foundation Hospital Champaign Urbana, IL

Expert Panelists

Expert Panelist	**Rashna Ginwalla, MD, MPH** Trauma Surgeon and Director, Violence Prevention Program San Joaquin General Hospital French Camp, California
Expert Panelist	**Missy Anderson, MSN, RN** Trauma Program Director Swedish Medical Center Englewood, CO

This document summarizes the clinical Q&A discussion from two violence-related trauma cases. Patient identifiers have been removed. Intended for educational use only.

Case 1 — Firearm Injury with Complex Psychosocial Recovery

A 19-year-old male with pre-existing psychiatric diagnoses (ADHD, major depression, generalized anxiety, oppositional defiant disorder; multiple prior suicide attempts) presented with three gunshot wounds following interpersonal violence in an urban, high-poverty setting. He required 15 operations over 60+ days, including iliac vessel ligation, fasciotomy, and girdlestone resection arthroplasty, ultimately resulting in permanent wheelchair dependence. His recovery was shaped by compounding psychosocial vulnerabilities including food insecurity, household income disruption, insurance denial of durable medical equipment, and barriers to post-discharge engagement.

Q: How do social determinants of health (SDoH) shape trauma outcomes and what is the role of the trauma team beyond operative care?

- Trauma care does not end at surgical closure. Social factors (housing instability, food insecurity, economic vulnerability, and structural racism) influence both pre-injury health status and post-injury recovery trajectory.
- Returning patients to unchanged social environments without addressing underlying SDoH perpetuates cycles of injury and re-presentation.
- Trauma providers are uniquely positioned at the front line to identify unmet psychosocial needs in real time
- A siloed approach where each provider assumes another has addressed non-surgical needs, systematically fails patients. Coordinated whole-person assessment is required.
- Simple interventions (ensuring discharge clothing, directly asking about food availability, facilitating housing connections) can meaningfully reduce post-discharge vulnerability.
- Screening for SDoH such as food security, housing, transportation, and financial stability should be incorporated into routine trauma assessments.

Q: What is the relationship between psychiatric illness and traumatic injury recidivism, and how should this inform violence intervention programs?

- Psychiatric illness is a major independent risk factor for traumatic injury recidivism. Unaddressed mental illness is associated with 4.5× greater odds of recurrent injury and longer hospital lengths of stay.
- Among violently injured patients, major depression rates reach 50%, PTSD 46%, and up to 61% in violence-specific injury cohorts.
- As of the most recent published data, only three violence injury prevention programs have published on their use of in-hospital psychiatric resources, likely reflecting funding gaps rather than lack of clinical will.
- The Injured Trauma Survivor Scheme (ITSS) is the most validated tool for assessing PTSD and major depressive episode risk in trauma patients; developed across Level I centers with strong predictive accuracy.
- Screening alone is insufficient. Downstream intervention determines whether recidivism risk is reduced. Programs without linked intervention infrastructure provide limited benefit.
- Suicidal ideation rates were ~7% among patients receiving Victims of Crime Act (VOCA) funding versus ~24% among those who did not — a clinically meaningful threefold difference.
- Barriers to activities of daily living (e.g., lack of wheelchair access) were associated with a 270% increase in odds of developing PTSD

Q: What is the evidence for hospital-based direct food assistance versus traditional food banking in the trauma population?

- There is a bidirectional relationship between food insecurity and violent victimization: children in food-insecure households have nearly 6× higher exposure to violence; a 1% increase in county-level food insecurity correlates with a 12% increase in violent crime, independent of other predictors.
- Food banking (requiring transport to brick-and-mortar sites with limited fresh produce) can be unrealistic for patients with mobility limitations, which is common in the post-injury trauma population.
- Direct food assistance (meal vouchers, home grocery delivery, Meals on Wheels) is the clinically appropriate model for patients who cannot physically access food banks, particularly those with new or pre-existing mobility impairment.
- For insulin-dependent patients, food quality and consistency are not discretionary — food insecurity directly destabilizes glycemic management.
- Studies demonstrate that direct food assistance improves coping, increases mental health service utilization, enhances patient-perceived likelihood of recovery, and improves clinician ability to address psychosocial concerns.
- Only 3% of Victim Service Providers (VSPs) are hospital- or ED-based; hospital integration of VSPs dramatically improves identification and timely delivery of eligible services.
- When trauma recovery support is time-limited and withdrawn, food insecurity tends to re-emerge in outpatient documentation, highlighting the need for longitudinal support structures.

KEY TAKEAWAYS

- Pre-injury psychiatric illness compounds, not creates, mental health burden after trauma; this must inform the intensity of post-injury psychiatric support.
- Peer mentorship and purposive engagement (e.g., trauma recovery peer mentor roles) may be more effective for sustained mental health stabilization than traditional talk therapy alone in this population.
- Victims of Crime Act (VOCA) funding can significantly reduce suicidal ideation in violently injured patients; eligibility should be proactively assessed for every victim of violence.
- Wheelchair and mobility aid access is not purely a rehabilitation concern — barriers to ADLs independently increase PTSD risk by 270%.
- Direct food assistance that reaches the household is clinically necessary when the patient or caregiver cannot leave the home; food banking is not an equivalent alternative for this population.
- Federally sponsored structural inequities (redlining, supermarket redlining) are upstream drivers of food insecurity and violent victimization that share common structural roots — trauma surgeons are on the front line of their consequences.

Case 2 — Firearm Injury in a Post-Industrial Rust Belt Community

A 30-year-old male from a post-industrial Rust Belt community with history of polysubstance use and prior incarceration presented via transfer with a gunshot wound to the back resulting in L1 burst fracture, multiple abdominal injuries, and an aortoenteric fistula. He required resuscitative thoracotomy with aortic cross-clamp, massive transfusion (>70 units), seven damage control laparotomies in the first 11 days, and a 62-day hospitalization. He was discharged with an end ileostomy, J-tube, duodenostomy, and skin graft, requiring a wheelchair and walker for six months. Within one year he was involved in an MVC (left AMA), a police pursuit, and subsequent incarceration for cocaine possession.

Q: How do SDoH in post-industrial (Rust Belt) cities specifically impact trauma care access and recovery outcomes?

- Post-industrial Rust Belt cities face compounding structural disadvantages: population decline, concentrated poverty, loss of employer-based insurance, reduced public service tax base, and limited access to surgical or specialty care.
- This patient had limited access to surgical care at the index facility (requiring transfer), was initially denied disability benefits, and was unable to return to physical labor due to a large ventral hernia which eliminated his sole income source for a family of four.
- Prior incarceration, active substance use, and residence in a high-crime community are intersecting SDoH that collectively increase re-injury risk and reduce engagement with follow-up care.
- The patient's community (population <30,000; violent crime rate >1,000/100,000) represents an environment where more than 1% of residents are estimated to be victims of violence annually.
- Medicaid insurance status combined with inability to work creates a sustained financial vulnerability that extends the injury's impact well beyond discharge.

Q: What are differences in injury prevention strategy between urban centers and rural or small post-industrial communities?

- Urban trauma centers may have access to existing community violence intervention (CVI) infrastructure (peacekeepers, VSPs) — the gap is often integration with the hospital, not resource creation from scratch.
- Rural and post-industrial communities have distinct safety culture norms (e.g., firearms normalized for hunting) requiring culturally tailored prevention messaging rather than urban-adapted programming.
- The three-tiered AAST injury prevention framework applies across settings, but feasibility varies: primary prevention (e.g., firearm safety education), secondary (e.g., rapid transfer protocols), and tertiary (rehabilitation, recidivism prevention) each require locally specific implementation.
- Rural outreach by urban trauma centers can fill prevention gaps while simultaneously building referral networks, demonstrating both community value and institutional volume growth.
- Injury prevention professionals in rural settings are often isolated with no peer support or institutional backing; cross-institutional mentorship and network participation (e.g., EAST ICVP Committee) is valuable.

Q: What practical strategies exist for building and sustaining hospital-based violence intervention and injury prevention programs?

- Programs dependent on a single champion are at high risk of collapse when that individual departs; structural embedding across departments and administrative levels is required for sustainability.
- Hospital C-suite engagement requires translating prevention work into financial terms: reduced readmissions, increased referral volume, improved community standing, and long-term census growth are quantifiable returns.
- For-profit institutions require framing prevention work in terms of volume generation, quality metrics, and competitive positioning. E.g. demonstrating that rural outreach drives patient bypass of competitor facilities.
- Falls prevention in elderly patients offers a high-ROI entry point: reduced hospitalization duration and decreased placement burden can be directly quantified to justify resource investment.
- Community-based CVI programs and hospitals often operate in parallel without patient-level connectivity due to HIPAA constraints; the key operational challenge is establishing compliant linkage between existing systems, not building new infrastructure.
- Key resources: EAST ICVP Committee guidelines, Hospital-Based Violence Intervention Program (HVIP) model, Health Alliance for Violence Intervention (HAVI), and VIP Coalition.
- Persistence is the most cited predictor of program success; prevention work is chronically under-resourced and requires sustained federal advocacy to change the structural funding landscape.

Q: What is the role of trauma psychology integration within trauma divisions, and how does it affect readmissions and institutional financial performance?

- Routine integration of psychological screening and intervention for trauma patients, particularly those injured by violence, should be a standard practice, not an optional service.
- Patients with post-traumatic mental health crises frequently re-enter via the ED rather than through the trauma registry, rendering outcomes invisible to the trauma program without dedicated psychological tracking infrastructure.
- A dedicated trauma psychology provider with capacity for inpatient screening, longitudinal follow-up, and post-discharge contact is necessary to close the current surveillance and intervention gap.
- Psychiatric readmissions driven by inadequately treated post-traumatic mental illness represent a preventable institutional cost; demonstrating this linkage is a viable strategy for securing administrative resources.
- Mental health infrastructure in underserved communities is critically inadequate; in one example cited, a county of 750,000 had only 22 inpatient psychiatric beds serving all diagnoses, not trauma survivors specifically.
- Chronic physiologic stress from structural racism, community violence, and social inequity is increasingly documented in the literature — trauma providers must understand this context to deliver trauma-informed care.

KEY TAKEAWAYS

- SDoH in post-industrial communities compound at multiple levels (access, economics, social context, neighborhood safety) — a single-domain intervention is insufficient; whole-person assessment is required.
- Injury prevention strategies must be locally tailored: rural and Rust Belt communities have distinct cultural, structural, and resource contexts that render urban-adapted programs ineffective.
- Trauma psychology integration should be mandatory within trauma programs; the current gaps in screening, follow-up, and post-discharge contact contribute to preventable readmissions and missed recidivism risk.
- C-suite buy-in for prevention programs requires a financial argument: translate prevention impact into volume metrics, readmission cost reduction, and competitive positioning.
- Sustainable programs require institutional embedding beyond a single champion; community partnerships, formal administrative support, and dedicated personnel are prerequisites for longevity.
- Trauma surgeons are the front line of social justice for these patients — the mandate extends beyond technical operative care to whole-person advocacy, community engagement, and structural change.

Disclaimer Statement

THE EAST VIRTUAL CASE CONFERENCES – WHAT WE LEARNED & KEY TAKEAWAYS (“CASE CONFERENCE SUMMARIES”) ARE INTENDED SOLELY FOR GENERAL INFORMATIONAL PURPOSES. THE CASE CONFERENCE SUMMARIES ARE NOT MEDICAL ADVICE; DO NOT REPLACE PROFESSIONAL MEDICAL EDUCATION, TRAINING, EXPERIENCE, AND JUDGEMENT; ARE NOT DESIGNED FOR SPECIFIC CLINICAL SITUATIONS; ARE NOT STANDARDS; AND DO NOT DEFINE THE STANDARD OF CARE. THE CASE CONFERENCE SUMMARIES ARE PROVIDED "AS IS" WITHOUT ANY REPRESENTATIONS OR WARRANTIES OF ANY KIND, EITHER EXPRESS OR IMPLIED, STATUTORY, OR OTHERWISE. WITHOUT LIMITING THE FOREGOING, EASTERN ASSOCIATION FOR THE SURGERY OF TRAUMA (“EAST”) DOES NOT REPRESENT OR WARRANT THE CASE CONFERENCE SUMMARIES’ ACCURACY, COMPLETENESS, RELIABILITY, QUALITY, OR USEFULNESS; THAT THE CASE CONFERENCE SUMMARIES ARE ERROR FREE OR UP TO DATE; OR THAT THE CASE CONFERENCE SUMMARIES WILL SATISFY A USER’S NEEDS OR EXPECTATIONS. ANY USE OF THE CASE CONFERENCE SUMMARIES IS STRICTLY AT THE USER’S OWN RISK. EAST DISCLAIMS ALL LIABILITY AND RESPONSIBILITY ARISING FROM ANY USE OF THE CASE CONFERENCE SUMMARIES. TO THE EXTENT PERMITTED BY LAW, NEITHER EAST NOR ITS DIRECTORS, OFFICERS, EMPLOYEES, AGENTS, VOLUNTEERS, LICENSORS, OR CONTRACTORS WILL BE LIABLE FOR DAMAGES OF ANY KIND, UNDER ANY LEGAL OR EQUITABLE THEORY, INCLUDING BREACH OF CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHERWISE, EVEN IF FORESEEABLE, RELATED TO THE CASE CONFERENCE SUMMARIES, INCLUDING ANY DIRECT, INDIRECT, SPECIAL, INCIDENTAL, CONSEQUENTIAL, OR PUNITIVE DAMAGES. BY ACCESSING AND USING THE CASE CONFERENCE SUMMARIES, A USER ACKNOWLEDGES THE FOREGOING, WAIVES ANY CLAIMS THE USER MAY HAVE AGAINST EAST RELATED TO THE USER’S USE OF THE CASE CONFERENCE SUMMARIES, AND AGREES TO DEFEND AND INDEMNIFY EAST AGAINST ANY THIRD PARTY CLAIMS AGAINST EAST RELATED TO THE USER’S USE OF THE CASE CONFERENCE SUMMARIES.