2024

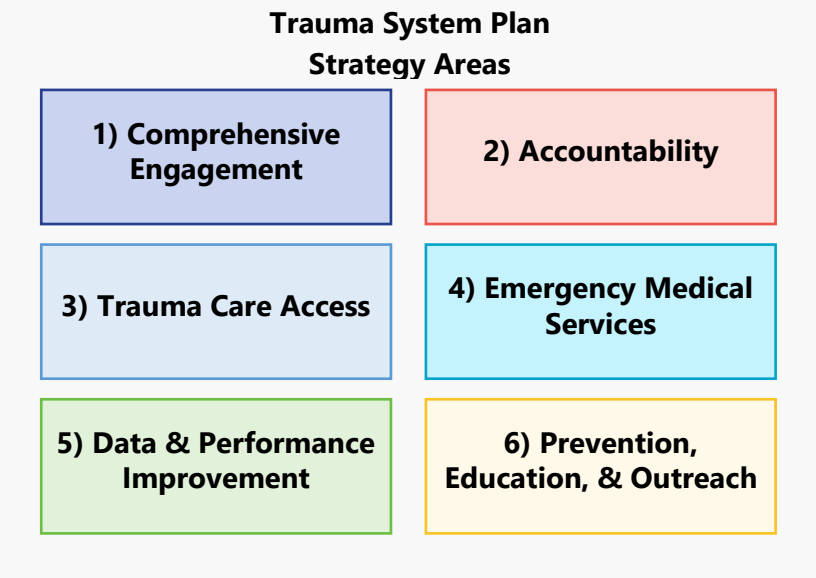
State Trauma System Plan

Indiana Department of Health

Executive Summary

Injury is a prevalent and lethal disease. It affects all populations, whether urban or rural, young, or old. Unfortunately, the disease "injury" tends to be treated as an isolated and often unpredictable event. Using a public health model, such as establishing and coordinating a trauma system, provides a framework to integrate the full spectrum of the disease into one cohesive model. Each individual component of the trauma system should be fully developed and supported. Still, equally important, key leaders and stakeholders should ensure that the components work together and that the public is aware of the burden of injury in the community. Indiana is privileged to have an engaged stakeholder group of insightful and passionate providers across the spectrum of injury care that have been driving statewide trauma system development. **This Trauma System Plan, the first for the State of Indiana, aims to provide a framework for the continued coordination and sustainment of the system to reduce the burden of injury.**

In 2022, the American College of Surgeons (ACS) assessed the State of Indiana's trauma system and provided a report that identified system gaps. Indiana acted in response to that report by establishing the Indiana Trauma Care Commission (TCC) (IC 16-31-2.5-2), a 13-member commission, to support the continued development of a statewide trauma system and the Plan. The Indiana Department of Health (IDOH) engaged Crowe LLP (Crowe) to support the TCC and facilitate the process of developing the Plan. More than 250 individuals from across the state participated in the process.



The Plan on the forthcoming pages is comprised of six strategy areas listed at right. Under each are priorities and objectives that define actions to be taken. IDOH, the TCC and subcommittees, and statewide trauma system stakeholders can leverage this document as a roadmap to support future trauma system development. See Appendix II for TCC Subcommittee information.

The Trauma System Plan is a living document that will be continuously evaluated and updated by the Trauma Care Commission as public health and trauma evolves in Indiana and new federal and state resources are updated.

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Introduction

Indiana Trauma System Background

A trauma system is defined as an organized, coordinated effort in a geographic area that delivers the full range of care to all injured patients. Until March 2006, Indiana was among a handful of states with no laws or regulations granting oversight authority for trauma care. Public Law 155-2006, enacted in 2006 with support from resolutions by the Indiana State Medical Association and the Indiana Emergency Nurses Association changed that. The legislation, adopted as IC 16-19-3-28, designated the Indiana Department of Health (IDOH) as the lead agency for a state trauma care system with the goals of preventing injuries and coordinating care for injured patients to reduce death and disability. The history of Indiana's trauma system is outlined on IDOH's website.

In November 2022, IDOH requested a consultative review of the Indiana State Trauma System, which was conducted with the support of the Trauma Systems Consultation (TSC) Program of the American College of Surgeons (ACS) Committee on Trauma (COT). The Consultation Report provided strengths, weaknesses, and gaps found in Indiana's trauma system. To remediate the issues, IDOH, in collaboration with the TCC, began taking action. One step was to work collaboratively with a comprehensive group of stakeholders to develop a Trauma System Plan.

The Trauma System Plan is intended to improve the health of Hoosiers through the implementation of statewide prevention and outreach programs, formalized triage and transport rules between counties, strong partnership with EMS, and support for hospital registrars to ensure accurate data for the most successful trauma care. The plan will create the optimal level of health for all Hoosiers by engaging with each district and establishing structure for the Trauma Regional Advisory Councils (TRACs).

IDOH Mission, Vision and Core Values

The Trauma System Plan ties to IDOH's overall mission, vision and values outlined below. Indiana is privileged to have mission-driven stakeholder groups across the spectrum of injury care that drive statewide trauma system development. IDOH, the TCC and others strive to improve and support the health and safety of all Hoosiers.

Mission

To promote, protect, and improve the health and safety of all Hoosiers.

Vision

Every Hoosier reaches their optimal health regardless of where they live, learn, work, or play.

Core Values

Health Equity

We place equity at the center of our work to ensure every Hoosier, regardless of individual characteristics historically linked to discrimination or exclusion, has access to social and physical supports needed to promote health from birth to end of life.

Communication

We provide stakeholders and the public accurate and up-to-date scientific data and provide education and resources regarding utilization of evidence informed practices in a timely manner.

Innovation

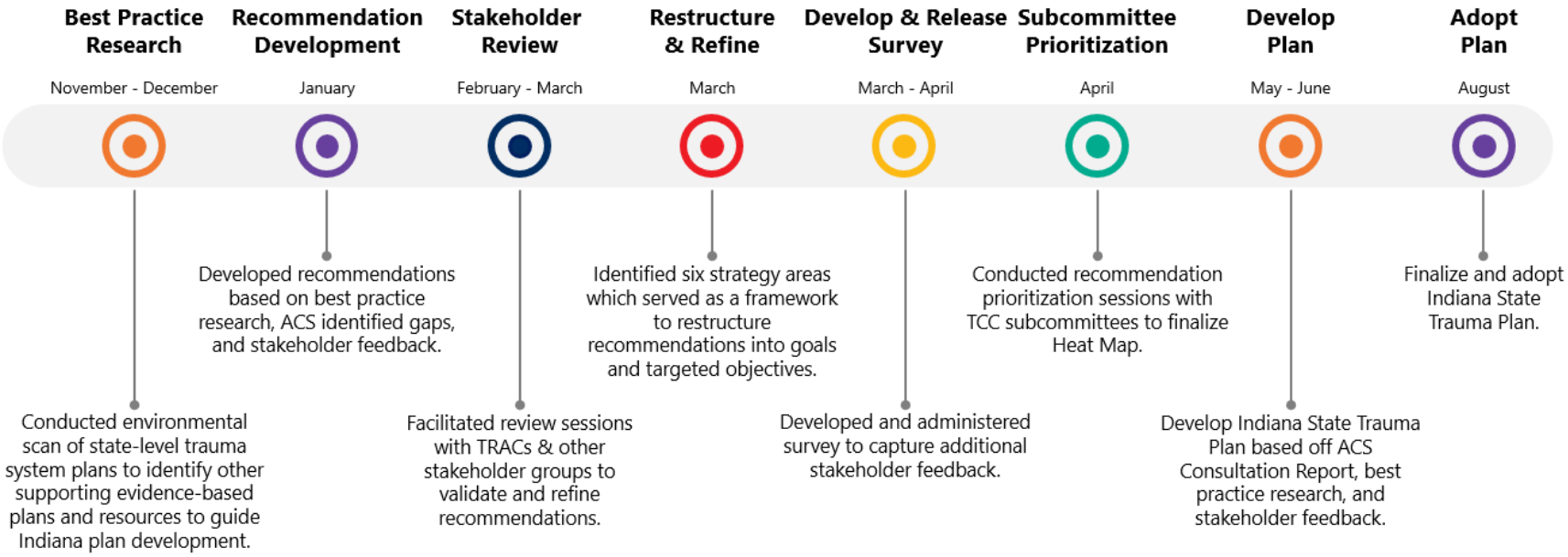
We continue to learn, research evidence-informed practices, advance our services, and be open to new methods, ideas, and products that help build and expand upon the services we provide.

Integrity

We are honest, trustworthy, and transparent. We uphold our standards and do the right things to achieve the best public health and safety outcomes.

Plan Development Process

The statute granting IDOH authority over the state's trauma system included a directive that IDOH was responsible for developing the statewide system and supporting the Plan. To address the provision of a comprehensive state Trauma System Plan, IDOH's Division of Trauma and Injury Prevention (DTIP) engaged Crowe to facilitate the process and to provide expertise to develop the Trauma System Plan. The initial recommendations were developed based on the gaps identified in the 2022 ACS Consultation Report, which included all 12 Essential Trauma System Elements (ETSE) defined in Appendix III. IDOH, TCC and Subcommittees, IDHS and other key stakeholders contributed to the validation and refinement through the stages of development below.



Plan Structure

The Trauma System Plan that follows is organized by strategy, priority, and detailed objectives that include all components of trauma care.

The Plan encompasses six strategy areas that organize the priorities of the Indiana Trauma System Plan. They are as follows:

Under each strategy are the related priorities, which define the Plan's key activities. Detailed objectives are listed under most priorities, serving as more actionable items for implementation by the identified stakeholder(s) to move the priorities forward (Stakeholder list and descriptions are defined in Appendix II). The priorities and objectives are sequenced by prioritization based on TCC Subcommittee feedback through a heat map exercise to align priorities to prioritization criteria (See Appendix III for Prioritized Heat Map).

The Trauma System Plan is a living document that will be continuously evaluated and updated by the Trauma Care Commission as public health and trauma evolves in Indiana and new federal and state resources are updated.

Strategies, Priorities and Objectives

STRATEGY 1: Comprehensive Engagement

Comprehensive Engagement refers to diverse membership and participation in the trauma system with respect to geography, population (rural/ urban/ adult/ pediatric/ burn), and hospital facility type through all phases of care. These facility types include designated trauma centers (levels I-III), non-designated acute care facilities, and rehabilitative facilities (See Appendix II for the roles and responsibilities of each facility type). All activities associated with trauma system development and implementation should engage a broad set of representatives to capture the entire landscape of Indiana. The Trauma Care Commission (TCC), Subcommittees, Healthcare Coalitions, and Trauma Regional Advisory Councils (TRACs) should consist of these key stakeholders, so trauma system activities are comprehensive.

Strategy 1 priorities and objectives aim to engage additional stakeholders and formalize membership to create an inclusive, statewide trauma system.

Number	Priorities & Objectives	Owner
Priority 1: Restructure, expand, and formalize TRACs.		
1.1	Engage additional TRAC members so trauma centers and non-trauma centers are represented in each region.	System Planning Subcommittee
1.2	Consult TRACs on methods to increase communication and collaboration between hospitals and staff statewide.	System Planning Subcommittee
1.3	Establish policies and procedures, up to administrative code, that formalize structure, function, and accountability of TRACs.	IDOH
Priority 2: Formalize and expand TCC subcommittees and their membership.		
2.1	Review subcommittee membership to confirm there is diverse representation respective to hospitals, specialties, demographics, and the full continuum of care.	IDOH

Number	Priorities & Objectives	Owner
2.2	Target additional stakeholders to expand TCC subcommittees based on gaps identified in the review process.	IDOH
2.2.1	Engage additional stakeholders from the Family and Social Services Administration (FSSA) Division of Aging.	TCC
2.2.2	Engage stakeholders from the Indiana Department of Child Services (DCS).	TCC
2.3	Validate all EMS provider types are represented across the TCC subcommittees.	TCC
Priority 3: Formally engage the state, regional trauma leadership, and physiatrists to promote engagement from the rehabilitation workforce.		
3.1	Collaborate with the IHA Indiana Rehab Task Force for trauma system development activities.	IDOH
Priority 4: Conduct routine reviews to verify TCC appointments are representative of the full continuum of care including hospitals, specialties, populations, and geography, of Indiana.		
Priority 5: Conduct periodic workforce assessments across the full continuum of trauma care.		
5.1	Collect data through surveys, interviews, and workforce and performance reviews.	System Planning Subcommittee
5.2	Engage community leaders and vulnerable populations to understand their workforce and education needs.	Education & Outreach Subcommittee
Priority 6: Develop a strategy to engage and maintain stakeholder participation within TCC subcommittees and TRACs.		
6.1	Continually update and improve the distribution and stakeholder list to develop a comprehensive trauma care network.	IDOH

STRATEGY 2: Accountability

Accountability refers to establishing guidelines and procedures to hold stakeholders accountable for the implementation and maintenance of Indiana's trauma system activities. These activities include taking meaningful, actionable steps in data collection, continued prevention efforts, education, decision-making, etc. This strategy outlines by-laws and legislation that were identified as gaps to provide guidance to stakeholders.

Strategy 2 priorities and objectives aim to implement operational guidelines, agreements, and legislation, where appropriate, that holds stakeholders accountable for the creation and maintenance of a successful statewide trauma system.

Number	Priorities & Objectives	Owner
Priority 1: Develop and codify operational guidelines, roles, and responsibilities for TRACs.		
1.1	Consider the development and implementation of contractual agreements with TRACS that establish structure and include all trauma system elements.	System Planning Subcommittee
1.2	Monitor TRACs operational guidelines to validate compliance.	System Planning Subcommittee
1.3	Develop a position within IDOH that focuses exclusively on organizing, supporting, and expanding TRACs.	IDOH
1.4	Hold an annual TRAC meeting to review the work of TRAC members and the regional trauma system.	System Planning Subcommittee
1.5	Establish participation requirements for TRAC members.	IDOH and System Planning Subcommittee
Priority 2: Develop and implement comprehensive policies and procedures for the TCC.		
2.1	Establish governance rules for the TCC.	IDOH
2.2	Evaluate the TCC's performance, structure, governance, and reporting on an established basis.	IDOH

Number	Priorities & Objectives	Owner
2.3	Maintain and consider updating the TCC's operational guidelines outlined in legislation on an established basis.	IDOH
Priority 3: Determine where formal agreements defining the roles and responsibilities of each agency for trauma system coordination exist.		
3.1	Identify all agencies involved in trauma system coordination.	IDOH
3.2	Identify where additional formal agreements are needed to streamline trauma patient care.	IDOH
Priority 4: Explore developing and implementing regional trauma system plans to improve quality and coordination of statewide care. Implement if feasible.		
4.1	Engage TRACs with implemented regional trauma system plans to understand the plan's impact on the quality and coordination of care.	System Planning Subcommittee
Priority 5: Explore administrative rules through IDOH that outline the trauma center designation process for each designation level that aligns with the American College of Surgeons (ACS) verification process.		
5.1	Validate clear, specific designation criteria that align with the American College of Surgeons Verification Standards for level I-III trauma centers. Explore designation criteria for level IV trauma centers and non-designated acute care facilities.	System Planning Subcommittee
5.2	Define additional designation criteria that align with the goals and landscape of Indiana's trauma system plan.	System Planning Subcommittee
5.3	Consider designating rehabilitation facilities. Define designation criteria as applicable.	System Planning Subcommittee

Number	Priorities & Objectives	Owner
5.4	Define a formal application process that facilities must follow for designation. Regularly review and update the process to confirm it remains effective and reflects current best practices in trauma care.	IDOH
5.5	Develop a review and evaluation process to assess each application for trauma center designation.	System Planning Subcommittee
5.6	Develop a clear process for removing a facility's designation if it fails to meet the required standards or breach the terms of their contract.	IDOH
5.7	Optimize readiness to provide trauma care in non-designated acute care facilities.	IDOH
Priority 6: Explore rules and legislation that outline trauma service standards by designation levels I-III.		
6.1	Require facilities to enter into contractual agreements that outline its responsibilities and obligations as a designated trauma center.	IDOH
6.2	Require level I/II facilities to develop partnerships with level III facilities.	IDOH
6.3	Conduct random audits on facilities' performance improvement data to certify compliance with continuous improvement.	IDOH
6.4	Implement and enforce data submission policies for designated facilities to improve the quality of data.	IDOH
6.5	Develop criteria and coordinate continued trauma education courses for hospital and EMS personnel.	IDOH
6.6	Require designated facilities to develop trauma care outreach and public injury prevention education programs.	IDOH
6.7	Require mentorship and support from designated urban facilities to rural trauma program managers in process improvement training.	IDOH

Number	Priorities & Objectives	Owner
6.8	Update rules and legislation as standards of care change.	IDOH

STRATEGY 3: Trauma Care Access

Many Hoosiers do not have adequate access to trauma care, including care at acute medical care facilities and rehabilitation centers.

- **Acute medical care facilities** are hospitals that provide care for short periods of time. Trauma patients are admitted to an acute medical care facility to allow them to recover from their injuries, as well as recover from procedures and surgeries performed to address their injuries. Patients with the most serious injuries recover in the intensive care unit, while less seriously injured patients may recover in the critical care unit, step-down care unit, or medical-surgical care unit.
- **Rehabilitation centers** care for trauma patients' post-acute care and seek to enable patients to realize their fullest post-injury potential. These patients have often sustained severe or catastrophic injuries resulting in long-standing or permanent impairments.

The rural nature of the state makes it difficult for all residents to receive the same access to care (see Appendix III for trauma care access map). Additionally, rehabilitative care is not currently integrated into the trauma system.

Strategy 3 priorities and objectives aim to expand regional trauma care access, integrate rehabilitative care, and develop disaster plans focused on public health needs.

Number	Priorities & Objectives	Owner
Priority 1: Engage regional TRAC members and hospitals to expand trauma system access in each region.		
Priority 2: Expand the coordination of triage and transfer of injured patients through the development of comprehensive, well-defined agreements between IDOH, TCC, IDHS, designated trauma facilities, and non-designated acute care facilities.		
Priority 3: Identify opportunities to expand rehabilitative care in Indiana.		
3.1	Meet with relevant rehabilitation representatives to assess the current state of rehabilitation services in Indiana.	IDOH
3.2	Collaborate with the IHA Indiana Rehab Taskforce to conduct a need and capabilities assessment for rehab services at the state and regional level.	IDOH
3.3	Identify and develop an action plan to implement resources to expand the rehab capacity to ineligible individuals.	System Planning Subcommittee
3.4	Consider utilizing swing beds in rural facilities to improve patient outcomes.	IDOH

Number	Priorities & Objectives	Owner
3.5	Create a database of rehabilitation facilities according to the capabilities for treating patients with various conditions and acuity.	IDOH
3.6	Engage the Family and Social Services Administration (FSSA) Division of Aging and Division of Disability and Rehabilitative Services.	IDOH
3.7	Collaborate with the IDOH, TCC, and IHA Indiana Rehab Task Force to brainstorm incentives to encourage rehabilitation facility participation in the trauma system.	IDOH
3.8	Explore establishing designation process, service standards, and funding to rehabilitation facilities.	IDOH
Priority 4: Review and maintain a statewide Disaster Preparedness Plan, focused on public health needs, in coordination with existing plans.		
4.1	Collaborate with the Emergency Management Agency (EMA) to maintain a comprehensive, focused public health disaster plan that considers all disaster types, including cyberattacks.	IDOH & IDHS
4.2	Engage a wider range of stakeholders across the state for the awareness and education of the state disaster plan including, but not limited to the following: • Healthcare Sector • Private Sector • Elected Officials • Local Health Departments	IDOH & IDHS
4.3	Engage additional state agencies, including the Indiana Department of Homeland Security (IDHS), Emergency Management Agency (EMA), and Family and Social Services Administration (FSSA), to garner new perspectives related to disaster planning.	Disaster Preparedness & Military Integration Subcommittee

Number	Priorities & Objectives	Owner
4.4	Conduct a hazard vulnerability analysis to identify the potential threats and risks to the state trauma system and prioritize the most likely and impactful scenarios.	IDOH & IDHS
4.5	Conduct regular training and simulation exercises to test the disaster plan, identify gaps and weaknesses, and enhance the readiness and competency of the state trauma system partners. Create a streamlined process for TRACs and facilities to obtain disaster preparedness training and simulation exercise information.	IDHS
4.6	Develop a statewide and regional disaster plan that coordinates with healthcare coalition (HCC) representatives, hospitals, and call centers to: • Address the immediate social and mental health needs of the population • Consider post-disaster resource allocation and service delivery • Utilize the recommended RMOCC structure for patient transport, transfers, and load balancing	Disaster Preparedness & Military Integration Subcommittee
4.7	Consider conducting a gap and needs analysis to determine whether the resource capacity tool meets the state's needs. Implement a statewide resource management dashboard for hospitals, EMS, and local health departments.	IDHS & IDOH
4.8	Engage the Indiana Statewide 911 Board to enhance dispatch efficiency and effectiveness.	IDHS
4.9	Modify and update the statewide and regional disaster plans to include lessons learned as Indiana experiences disasters or multi-patient incidents.	IDOH & IDHS

STRATEGY 4: Emergency Medical Services (Prehospital)

Emergency Medical Services (EMS) is the first phase of Indiana's trauma system, which activates immediately following an injury. EMS crews are often the critical link between the location of injury and definitive care at a trauma center or local hospital. When a call is made to the 911 operator, the response can be coordinated among various first responders, including emergency medical services (EMS) ambulances, law enforcement, and fire. If the trauma is initially directed to EMS, the first assessments and diagnoses of the patient are completed. The patient is stabilized and quickly, but safely, transported to a local hospital or trauma center. See Appendix III for EMS District Map.

The Indiana Department of Homeland Security (IDHS) is responsible for EMS oversight in Indiana (IC 16-31-2), but the system requires a coordinated response with IDOH. The roles and responsibilities of the Division of EMS within IDHS are outlined in Title 836 of the Indiana EMS Commission. Indiana's rural geography and unique EMS systems across cities and counties can make patient triage and transport, interfacility transfer, and patient destination decision-making difficult.

Strategy 4 priorities and objectives aim to streamline patient care, improve EMS registry data, and conduct assessments to create an inclusive, efficient EMS system.

Number	Priorities & Objectives	Owner
Priority 1: Partner with the Indiana EMS to develop actionable recommendations that establish an RMOCC (Regional Medical Operations Coordination Center) structure statewide for resource monitoring, patient transport, transfers, load balancing, and data oversight.		
1.1	Accentuate the American Society for Testing and Materials (ASTM) standard for the use of emergency medical dispatchers (EMD).	IDHS
Priority 2: Explore methods to streamline patient triage and trauma care within Indiana and across state lines.		
2.1	Assess the current landscape of EMS transport and identify agency overlap to increase collaboration and efficiency.	IDHS
2.2	Develop memorandums of understanding for neighboring states to guide the triage and transfer of injured patients.	IDHS
2.3	Evaluate the effectiveness of the triage and transport rule statewide.	IDOH

Number	Priorities & Objectives	Owner
2.4	Host an IDOH & IDHS summit to address inter-facility transfer issues.	IDOH
2.5	Encourage neighboring states to become part of the EMS Compact so the *Privilege to Practice* can be granted across states.	IDHS
2.6	Oversee TRACs to validate each region has established interstate agreements to reduce the triage and transfer time of injured patients to appropriate trauma centers.	IDOH
2.7	Collaborate with the Indiana Statewide 911 Board to extend the IN911 network to Illinois.	IDHS
Priority 3: Elevate EMS as an essential service to decrease triage and transport times and improve the quality of care statewide.		
3.1	Engage Indiana EMS to explore recommendations for elevating EMS as an essential service.	IDHS
3.2	Consider policy, compensation, and workforce assessments to evaluate EMS as an essential service including the Indiana Home Rule Code.	IDHS
Priority 4: Assess EMS registry vendor and service provision needs to adequately support trauma data system needs and improve the data quality.		
4.1	Evaluate the EMS registry to validate that it is compliant with national NEMSIS standards and includes comprehensive prehospital data repository.	IDHS
4.2	Assess data integration between the EMS registry and trauma registry.	IDHS & IDOH
4.3	Expand the existing infrastructure with IDHS and regional managers to establish regional administrators who serve as experts and confirm their region complies with updating the software to promote patient flow.	IDHS
4.4	Implement electronic patient care record (ePCR) that allows the automatic submission of injury data from electronic health records (EHR) at clinical sites to state	IDOH & IDHS

Number	Priorities & Objectives	Owner
	and local health departments. ePCR should begin with the EMS response and include inter-facility transfers.	
Priority 5: Implement a system for monitoring and evaluating EMS compliance with the triage and transport protocols.		
Priority 6: Complete the on-going EMS workforce assessment and evaluate the findings to determine an action plan for Indiana.		
Priority 7: Formalize continued coordination and efficiency of the division of EMS within IDHS regarding stakeholder interaction and healthcare partnerships.		
Priority 8: Assess the need, role, and function to establish a State Trauma Medical Director at IDOH. Consider the capabilities of this role regarding the EMS State Medical Director.		

STRATEGY 5: Data & Performance Improvement

IDOH operates the Indiana Trauma Registry and is responsible for instituting processes to evaluate the performance of all aspects of the system. The Trauma Registry Rule, adopted in 2013, was established to collect and analyze trauma-related data to improve outcomes for injured patients. The trauma registry is used to measure and analyze all aspects of the system to ensure the highest quality care is provided to all. Data collection should include the full continuum of trauma care so opportunities for improvement can be identified.

The way data is used to support state-wide performance improvement, quality improvement initiatives, or research can be improved. Additionally, the trauma registry is not linked to other datasets, like the EMS Registry, and data quality is an issue for some hospitals.

Strategy 5 priorities and objectives aim to improve data quality and enhance data interoperability to identify opportunities for performance improvement (PI) within the trauma system.

Number	Priorities & Objectives	Owner
Priority 1: Develop a comprehensive approach to data quality to improve the trauma registry.		
1.1	Develop a formalized feedback process for all stakeholders submitting data to determine challenges and barriers for data collection, submission, and validation.	IDOH
1.2	Develop a process to resolve issues shared by hospitals and EMS to mitigate identified challenges.	Registry Subcommittee
1.3	Evaluate trauma registry education training programs across designated trauma centers and non-designated acute care facilities.	Registry Subcommittee
1.4	Offer trainings, software guides, and resources to non-designated acute care facilities to promote quality data collection and submission.	Registry Subcommittee
1.5	Consider implementing a grant program that provides registrar funding to hospitals to improve the statewide trauma system registry.	IDOH
1.6	Develop and implement rehabilitative data collection, submission, and reporting policies for all facility types.	IDOH
1.7	Conduct audits on trauma registry data across regions and hospitals.	IDOH

Number	Priorities & Objectives	Owner
1.8	Develop a surveillance process that includes: • Regular audits • Real-time monitoring feedback mechanism • Data analysis	Registry Subcommittee
Priority 2: Assess current state of data interoperability to develop a mechanism to facilitate data sharing among agencies.		
2.1	Implement Health Data Exchange Interoperability to facilitate streamlined care coordination between healthcare agencies.	IDOH
2.2	Review and prioritize findings in the IDHS 9-1-1 Interoperability & Regionalized Trauma System Recommendations report. Formulate an action plan based on prioritized findings that encourage bi-directional data sharing between EMS and hospitals through data sharing agreements.	IDHS
2.3	Continue to encourage data reporting among all hospitals and implement data reporting standards.	IDOH
Priority 3: Evaluate trauma registry data to establish outcomes and identify gaps.		
3.1	Educate IDOH staff conducting the data quality and validation process.	IDOH
3.2	Implement audit filters and identify indicators to monitor and benchmark long-term and short-term post-acute care.	IDOH
3.3	Evaluate data concerning long-term functional and financial outcomes to identify gaps.	Performance Improvement Subcommittee
3.4	Develop performance indicators that include: • Triage accuracy • Response time • Patient outcome	Performance Improvement and Registry Subcommittee

Number	Priorities & Objectives	Owner
	• Interfacility Transfer	
Priority 4: Propose an amendment to 410 IAC 34-9-1 that secures the confidentiality of peer review activities and protects activities from discoverability.		
Priority 5: Engage stakeholders in the data quality process and development of performance improvement initiatives.		
5.1	Schedule quarterly meetings between TRACs and the PI subcommittee to maintain and promote interactive dialogue on priority areas related to quality improvement.	Performance Improvement Subcommittee
5.2	Collaborate with the Performance Improvement (PI) subcommittee to include the rehabilitative phase of care.	IDOH
5.3	Provide feedback to regions based on data analysis so regions can identify areas of improvement and track their progress.	IDOH
5.4	Collaborate with the IDOH Division of Trauma and Injury Prevention (DTIP), registry subcommittee, and the PI subcommittee to evaluate and strategically address issues to align with a PI plan.	IDOH
5.5	Facilitate quality initiative discussions between the registry, planning, and PI subcommittees and stakeholders.	IDOH
5.6	Consult subject matter experts and research institutions to identify gaps within the data quality process.	IDOH
5.7	Leverage data and engage local providers, agencies, and health departments to develop a statewide and regional quality improvement plan.	Performance Improvement Subcommittee
5.8	Develop a formalized process with levels of review to identify PI opportunities through data analysis and develop an action plan.	Performance Improvement Subcommittee

Number	Priorities & Objectives	Owner
Priority 6: Offer trauma registry education training programs for healthcare personnel to improve data quality.		
6.1	Host yearly, mandatory training sessions for designated hospital registrars.	IDOH
6.2	Provide training and troubleshooting resources to hospital registrars. Examples include: • Software training manual • Online references • Helpline or Helpdesk	IDOH
6.3	Utilize training and resources offered by TQIP for National Trauma Data Standards (NTDS) data elements.	IDOH
6.4	Assist non-designated acute care facilities and rural hospitals in submitting trauma system registry data and provide increased training resources.	IDOH
Priority 7: Maximize participation in the American College of Surgeons (ACS) Trauma Quality Improvement Program (TQIP) and/or other benchmarking programs events, collaborative, and best practice guidelines.		
7.1	Engage the TQIP Collaborative regularly to identify PI opportunities through surveillance, data collection, and data analysis.	Performance Improvement Subcommittee
7.2	Attend TQIP Annual Conference.	Registry and Performance Improvement Subcommittee
7.3	Leverage ACS TQIP training and education resources to improve PI process and activities.	Performance Improvement Subcommittee

Number	Priorities & Objectives	Owner
7.4	Leverage the Collaborative Toolkit and Trauma Quality Programs (TQP) Best Practice Guidelines.	Performance Improvement Subcommittee
Priority 8: Create a Public Health Information Portal (PHIP) for data request submissions. Hire a dedicated analyst or utilize analysts within IDOH for the approval, payment, assignment, and fulfillment of these requests.		

STRATEGY 6: Prevention, Education & Outreach

Trauma systems must develop prevention, education, and outreach strategies to control traumatic injury and educate stakeholders. Injury prevention and outreach begins with the collection and analysis of population and patient data from a variety of sources to describe the status of injury morbidity, mortality, and burden distribution throughout the state.

The Division of Trauma and Injury Prevention (DTIP) within IDOH collects and analyzes data to drive program implementation. While there is some coordination of state-led injury prevention programs, there are inconsistent hospital-based efforts. Additionally, engaging and integrating with additional stakeholders, such as local health departments, is essential to the implementation of programs. The Indiana Trauma System must develop strategies that help prevent traumatic injury as part of an integrated, coordinated, and inclusive system. See Appendix III for further information regarding the burden of injury in Indiana.

Strategy 6 priorities and objectives aim to increase education for trauma system personnel, engage additional stakeholders, and report and implement targeted injury prevention programs.

Number	Priorities & Objectives	Owner
Priority 1: Conduct a statewide assessment for tracking and reporting of injury prevention efforts across Indiana.		
1.1	Develop reporting process that engages local agencies and health departments.	IDOH
1.2	Create and analyze an injury prevention dashboard to develop a statewide community engagement and public outreach plan.	Education & Outreach Subcommittee
Priority 2: Increase education and training for personnel across the full continuum of trauma care.		
2.1	Offer professional education courses and validate appropriate training and certifications for all workforce members that have regular contact with injured patients.	IDOH
2.1.1	Develop partnerships with agencies and facilities to promote trauma care training and certifications. See Appendix III for course examples.	IDOH
2.1.2	Create a course calendar and repository to oversee trauma training program schedules.	IDOH
2.1.3	Require facilities seeking designation to provide data on the number of Trauma Certified Registered Nurses (TCRN) and physicians with trauma training certifications.	IDOH

Number	Priorities & Objectives	Owner
2.1.4	Continue to partner with Indiana Certified EMS Training Institutions to address the educational needs for EMS.	IDHS
2.2	Standardize rural trauma educational programs to provide the capability to manage traumatically injured patients across the continuum of care.	Education & Outreach Subcommittee
Priority 3: Leverage injury epidemiology data and conduct surveys among hospital-based clinical staff and key constituents to implement targeted injury prevention efforts.		
Priority 4: Engage a variety of stakeholders to develop and evaluate targeted injury prevention programs.		
4.1	Partner with local health departments to understand the current state of injury prevention and implement targeted injury prevention efforts statewide.	Education & Outreach Subcommittee
4.2	Engage the Family and Social Services Administration (FSSA) Division of Mental Health and Addiction (DMHA) to implement targeted prevention efforts.	Education & Outreach Subcommittee
4.3	Develop a process for regularly evaluating the effectiveness of injury prevention efforts and initiatives that have been implemented by hospitals, public health agencies, and health departments.	Education & Outreach Subcommittee
4.4	Consider implementing a reporting mechanism for local injury prevention initiatives.	IDOH
4.5	Engage and partner with mobile integrated healthcare (MIH) programs and all aspects of EMS to guide injury prevention and education activities.	Education & Outreach Subcommittee
4.6	Explore data and resources related to trauma and injury within the IDOH Division of Family Health Data and Fatality Review.	IDOH
Priority 5: Create and implement a plan to routinely educate and inform the public of the status of injury prevention activities.		
5.1	Utilize contemporary media messaging processes and protocols for public outreach related to the status of injury prevention activities.	Education & Outreach Subcommittee

Number	Priorities & Objectives	Owner
5.2	Create and share public information through visualizations and dashboards.	IDOH
5.3	Integrate injury prevention and outreach activities into the annual trauma system report.	IDOH
Priority 6: Identify and consult key stakeholders to explore the development of an injury surveillance and injury control data consortium.		

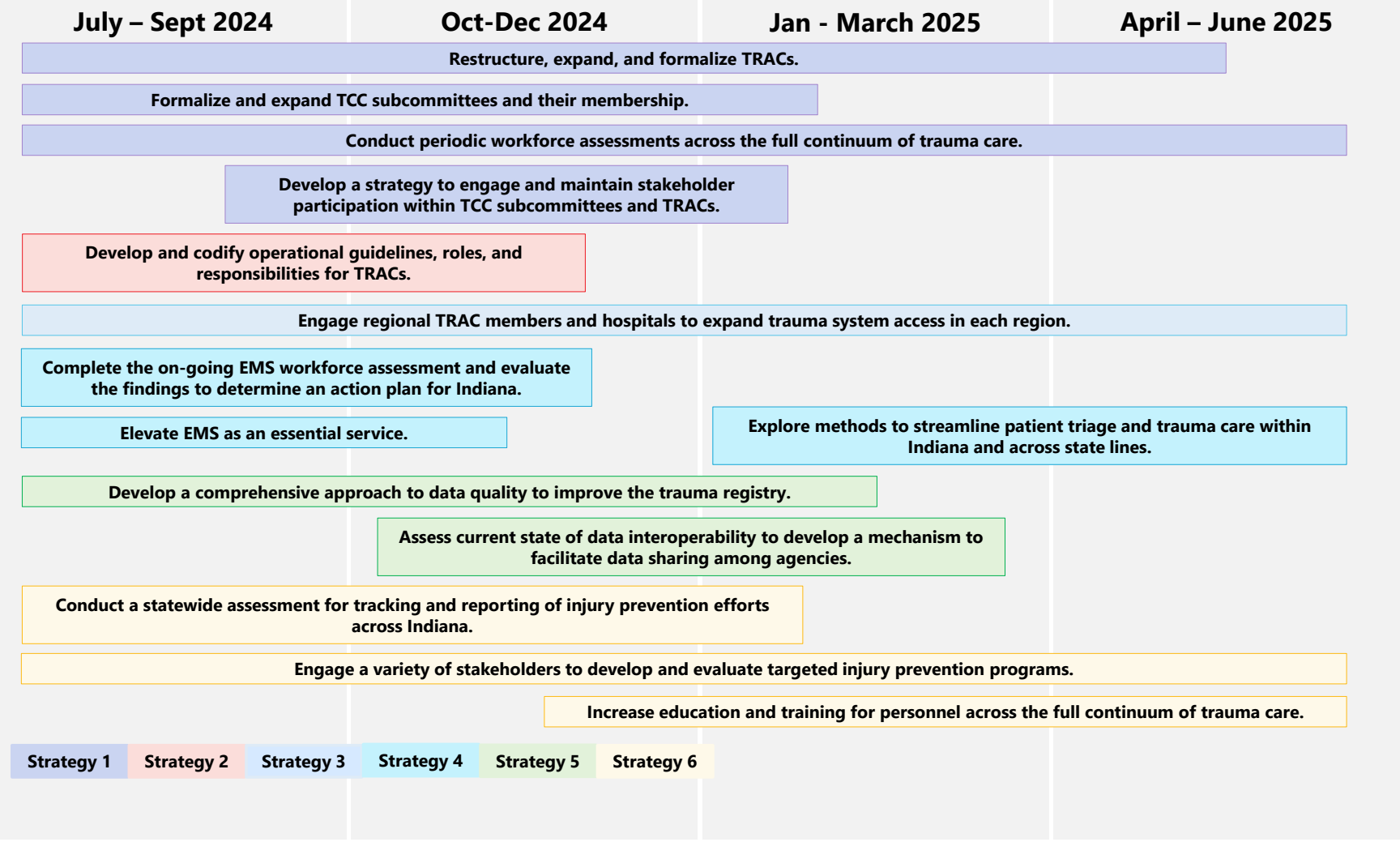
Implementation Plan

The TCC subcommittees and stakeholders have identified key priorities and objectives to implement in the statewide trauma system. The implementation of the priorities is separated into three phases.

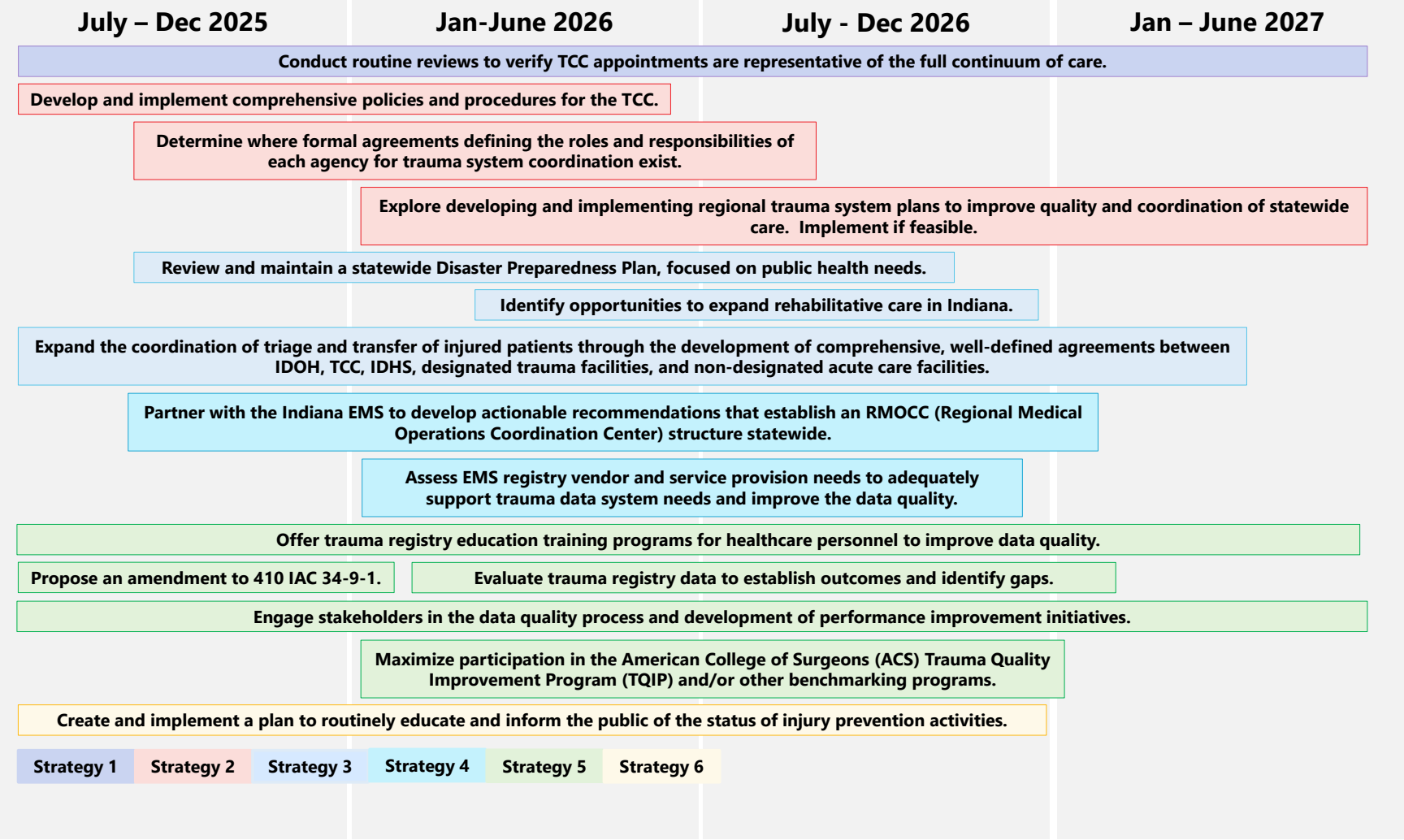
- **Phase 1** includes priorities that are in progress or planned to begin in the next year (July 2024-June 2025).
- **Phase 2** includes priorities that are projected to be implemented, or to begin implementation, between July 2025 and June 2027.
- **Phase 3** includes anticipated priorities for future implementation.

The Implementation Plan is provided by phase on the following pages. It is recommended that the TCC review this plan annually to assess the overall progress of priorities and objectives, and to establish the priorities of focus for the next year.

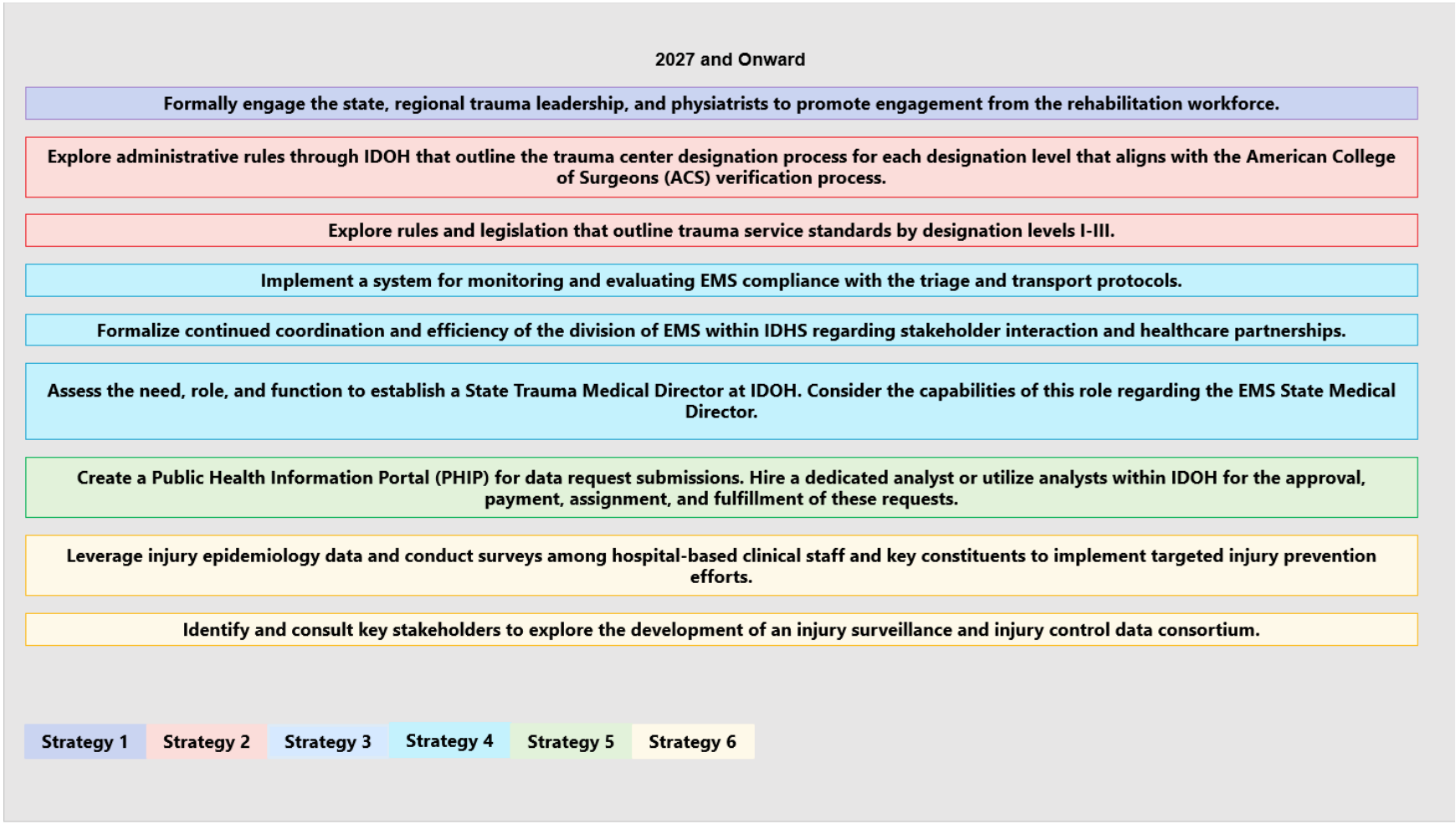
Implementation Plan - Phase 1



Implementation Plan - Phase 2



Implementation Plan - Phase 3



Appendix I - Contributions and Acknowledgements

Indiana Department of Health Project Team

Name	Role
Brian Busching, MPH	Division Director, Trauma and Injury Prevention
Ramzi Nimry	Program Director, Trauma and Injury Prevention
Lauren Milroy	Director, Surveillance and Evaluation
Vincente Benchino	Clinical Director, Trauma and Injury Prevention
Michael Lopez	Director, Strategic Planning

Trauma Care Commission (TCC)

Name	Representing	Role
Lindsay Weaver, MD	Indiana Department of Health	State Health Commissioner/Chair
Joel Thacker	Indiana Department of Homeland Security	Director or Director's Designee
Daniel Rusyniak, MD	Family Social Services Administration	Family Social Services Administration Secretary
Erik Streib, MD	Chair of Indiana Committee of Trauma/Eskenazi Health	American College Surgeons Committee on Trauma
Andy VanZee	Indiana Hospital Association	Vice President of Regulatory & Hospital Operations
Elizabeth Weinstein, MD	IU Health- Riley Hospital for Children	Emergency Medical Services for Children
Lewis E. Jacobson, MD	Ascension St. Vincent Indianapolis Hospital	Level I Trauma Center Physician

Emily Fitz, MD	IU Health- Tipton	Indiana Chapter of the American College of Emergency Physicians/ Emergency Medicine Physician
Lisa Hollister, DNP, MSN, RN	Parkview Health	Registered Nurse/ Trauma Program Manager
Matthew Landman, MD	IU Health- Riley Hospital for Children	Level I Pediatric Trauma Center Physician
David Welsh, MD	Margaret Mary Health	Rural Area Hospital Physician
Scott Thomas, MD	Memorial Hospital of South Bend	Level II Trauma Center Physician
Jay Woodland, MD	Deaconess Midtown Hospital	Level II Trauma Center Physician

Trauma Care Commission Subcommittees

Trauma System Planning Subcommittee

Name	Representing
Andy VanZee	IHA (Co-Chair)
Erik Streib, MD	Eskenazi (Co-Chair)
Scott Thomas, MD	Beacon
Jen Homan	Franciscan Crown Point
Kraig Kinney	IDHS
Lewis E. Jacobson, MD	St. Vincent 86th
Matthew Landman, MD	IUH Riley
Kelly Blanton	St. Vincent 86th
Raymond Cava, MD	Parkview

Andrew Bowman	EMS Commission
Dharmesh Patel	St. Vincent Evansville
Jarrod Sights	Scott Township EMS

Trauma Education & Outreach

Name	Representing
Jay Woodland, MD	Deaconess (Co-Chair)
Matthew Landman, MD	IUH Riley (Co-Chair)
Andrew Bowman	EMS Commission
Catana Phillips	IU Methodist
Collen Groves	Ascension
Dara Dilger	Deaconess
Elizabeth Weinstein, MD	IU Health
Jen Homan	Franciscan Crown Point
Merry Addison	ENA
Tiffany Davis	IU Methodist

Trauma System Registry

Name	Representing
Lisa Hollister, DNP	Parkview (Chair)
Latasha Taylor	Methodist Hospitals
Madison Halter	Good Samaritan

Betsy Welsh	Community
Clint Rudolph	Schneck
Brandee McKee	Greene County General
Summer Blakemore	Beacon Health
Sydney Hull	Good Samaritan
Whitney Floyd	St. Elizabeth
Dazar Opoku	Parkview
Jennifer List	St. Elizabeth
Jennifer Konger	Parkview
Jennifer Post	IU Health
Amy Ludwig	Ascension

Performance Improvement (PI) Subcommittee

Name	Representing
Eric Yazel, MD	IDHS (Co-Chair)
Scott Thomas, MD	Beacon Health (Co-Chair)
Ashley Estep	Ascension
Dawn Daniels	IUH
Sherri Marley	Eskenazi
Sarah Hoeppner	Parkview
Stephanie Gardner, MD	Ascension
Kailyn Kahre, MD	IUH

Lewis E. Jacobson, MD	Ascension
Peter Hammer, MD	IUH
Raymond Cava, MD	Parkview
Jarrod Sights	Scott Township Fire
Scott Isenberg	IUH

Disaster Preparedness and Military Integration Subcommittee

Name	Representing
Joel Thacker	IDHS (Co-Chair)
David Welsh, MD	Margaret Mary Health (Co-Chair)
Emily Fitz, MD	IU Health
Merry Addison	Public Health Advocate
Justin Koenig, MD	Elkhart General
Nicole Stilianos, LTC	Indiana National Guard, CCO Indiana Primary Health Care Association
Mark Liao, MD	Methodist
Chris Schmidt	Memorial Hospital
Mallory Bray, MD	St. Vincent Evansville
Annika Barce	IDOH
Vince Benchino	IDOH
Mohammed Islam	IDOH
Ramzi Nimry	IDOH
Lauren Milroy	IDOH

Derek Sebold	IDOH
Angelo Soto	IDOH
Brian Busching	IDOH

Appendix II- Stakeholder and Facility Descriptions

Indiana Department of Health (IDOH)

IDOH oversees health promotion and injury/disease prevention with a focus on traditional public health practices such as vital records, immunizations, outbreak investigation, food safety, environmental health and laboratory services; health equity; data collection, analysis, and dissemination; and regulatory services. IDOH collaborates with counties, hospitals, and healthcare providers from across the state, other state agencies, and public and private partnerships interested in promoting a healthier and safer Indiana.

Indiana Department of Homeland Security (IDHS)

IDHS leads Indiana's emergency planning and operations, first responder training, and fire and building safety. The Indiana State Fire Marshal leads the Division of Fire and Building Safety (within IDHS), which oversees the enforcement of building codes and includes a fire investigations unit. The agency certifies and trains thousands of first responders and hosts state-level exercises each year. IDHS also supports the state Emergency Operations Center (EOC), which leads response and coordination efforts for large-magnitude incidents.

Trauma Care Commission (TCC) & Subcommittees

The Indiana Trauma Care Commission (IC 16-31-2.5-2) was established in response to the 2022 ACS consultation report. The 13-member commission works to support the comprehensive development of a statewide trauma system. Duties of the Commission include:

- ***Develop and promote***, in cooperation with state, regional, and local public and private organizations, ***a statewide program for the provision of trauma care and a comprehensive state trauma plan;***
- Use trauma data to promote and support state and regional quality improvement initiatives and evaluations;
- Develop and implement a trauma system performance improvement plan;
- Support state-level multi-disciplined disaster planning;
- Identify opportunities for, and promote the training of, trauma personnel and programs for the education of the general public in injury prevention and trauma care;
- Develop, in coordination with the state department, criteria for the awarding of trauma grant funds in the areas of:
    - trauma system development;
    - quality improvement;

    - trauma and non-trauma center engagement; and
    - injury prevention programming;
- Advise the state department on state trauma center designation.

The Trauma Care Commission (TCC) includes five subcommittees that work to develop, implement and improve the statewide trauma system. Subcommittees are comprised of members across the full continuum of trauma care, representing the entire state of Indiana. Scope of work for subcommittees include:

- **Trauma System Planning**
    - Promote effective coordination of care (right time/ right place), including appropriate hospital triage (with EMS) and timely transfer of critical patients
    - Maintain trauma center designation
    - Ensure commission reporting is completed and funding is allocated.
- **Trauma Education & Outreach**
    - Provide education/outreach to key stakeholders
    - Coordinate with IDOH to utilize data for injury prevention programming
    - Conduct public awareness campaigns
- **Trauma Registry**
    - Review and maintain data element of the Indiana trauma registry
    - Oversee registry outreach and training for data optimization
    - Assure data is valid, accurate, and reliable: Quality data
- **Performance Improvement**
    - Identify quality measures
    - Disseminate best practices
    - Provide hospital and systemwide reports of quality measures
    - Develop a statewide PI plan
- **Disaster Preparedness & Military Integration**

- Assess capabilities to partner and coordinate with military and disaster preparedness stakeholders statewide
- Plan and implement opportunities associated with preparedness and disaster planning including coordination of response with TRACs

Trauma Regional Advisory Councils (TRACs)

The Indiana Department of Health established Trauma Regional Advisory Councils (TRACs) that operate at a district and regional level. The TRACs meet on an *ad hoc* basis to conduct data analysis, quality improvement, and ongoing regional trauma system development activities. The 2022 ACS Consultation Report found that at the regional level, some TRACs are more functional and operationally efficient than others with lower stakeholder interest or participation. They are highly fragmented as there is no clear reporting structure or formal integration of these councils into larger trauma system activities. The Trauma System Plan will address the discrepancies between TRACs, advising for the restructuring, expansion and formalization of TRACs. This will increase representation and engagement within each district to drive a statewide trauma system.

Facility Responsibilities

- Level I designated trauma center: Facilities provide trauma system leadership and care for all injuries. Level I trauma centers have significant resources and personnel that make them equipped for treating severe trauma. These are frequently university-based teaching hospitals with education and research capabilities that take on a larger role in local trauma system development and disaster planning.
- Level II designated trauma center: Facilities provide initial definitive trauma care to a wide range of injuries and severity. Level II centers take on additional responsibilities related to education, trauma system leadership and disaster planning.
- Level III designated trauma center: Facilities provide trauma care to more rural communities that may not have timely access to Level I or II trauma centers. Level III centers provide definitive care to patients with mild to moderate injuries and transfer more severe injuries to Level I or II centers if possible.
- Non-Designated Acute Care Facilities: A facility that is not ACS verified and designated by IDOH as a Level I through III trauma center. The facility would coordinate the triage and transfer of injured patients to a level I-III facility depending on severity of illness or injury.
- Rehabilitative Facilities: A facility that provides care for trauma patients' post-acute care and seek to enable patients to realize their fullest post-injury potential.

Appendix III- Supplemental Information

American College of Surgeons (ACS) Essential Trauma System Elements (ETSE)

Essential Trauma System Elements (ETSE) is the conceptual framework of the ACS Trauma Systems Consultation Guide and the foundation of the trauma system and trauma system plan. Since the 1980s, experts in the field of trauma system development have sought to define the necessary and essential components of a working trauma system. The functional elements of highly effective trauma systems were outlined in two documents published by HRSA, the Model Trauma Care System Plan in 1992 and Model Trauma Systems Planning and Evaluation in 2006. Using these sources as well as data gained from over 40 trauma system consultations performed by the Trauma Systems Evaluation and Planning Committee of the ACS COT, a draft set of essential elements was developed in 2018 by a multidisciplinary workgroup led by the ACS COT. These essential trauma system elements were subsequently refined through input from provider organizations from across the spectrum of injury care and have been the foundation for assessment and recommendations to improve trauma systems across the United States.

There are twelve ETSE:

1. Statutory Authority
2. Funding
3. Multidisciplinary Advisory Group
4. Trauma System Plan
5. Continuum of Care
6. Needs Based Designation
7. Trauma System Registry
8. Injury Epidemiology
9. System-Wide Performance Improvement
10. Confidentiality and Discoverability
11. Disaster Preparedness
12. Military Integration

Trauma System Funding

IDOH has successfully acquired and used federal funding to develop and implement a statewide trauma system. Trauma development is funded by:

- Indiana Criminal Justice Institute (ICJI) which administers the NHJTSA 408 traffic records grant
- Federal Centers for Disease Control and Prevention (CDC) Preventive Health and Health Services block grant
- Federal Centers for Disease Control and Prevention (CDC) National Violent Death Reporting System (NVDRS) grant
- Federal Centers for Disease Control and Prevention (CDC) Overdose Data 2 Action (OD2A) grant
- Substance Abuse and Mental Health Services Administration (SAMHSA) First Responder Comprehensive Addiction and Recovery Act (FR CARA) grant
- Bureau of Justice Administration (BJA) Comprehensive Opioid Abuse Program (COAP) grant
- Bureau of Justice Administration (BJA) Student, Teachers, and Officers Preventing (STOP) School Violence and Prevention grant

Burden of Injuries in Indiana

Injury is a highly prevalent and lethal disease. It affects all populations, whether urban or rural, young, or old. Unfortunately, the disease "injury" tends to be treated as an isolated and often unpredictable event. Injuries are caused by acute exposure to physical agents, such as mechanical force or energy, heat, electricity, chemical and ionizing radiation, in amounts or at rates that cause bodily harm. Injury may be either unintentional or intentional (violence-related, including assault, homicide and suicide) and can lead to death, disability, or other lifelong health consequences. Unintentional injury accounts for many injury-related deaths and can be defined as involving injury or poisoning by unpremeditated measures. Unintentional injury is the leading cause of years of potential life lost in Indiana, which is a measure of premature mortality and early death. Regardless of intention, injury has emerged as a public health issue leading to significant morbidity and mortality.

Injury is the leading cause of death for Indiana residents ages 1 through 44 and the fourth-leading cause of death overall. In 2019, there were 5,476 injury deaths at an age-adjusted rate of 79.87 per 100,000, compared to a national rate of 71.09 per 100,000. Of the 5,476 injury deaths, 972 Hoosiers died by suicide and 466 died from homicide. The leading causes of unintentional injury death in Indiana in 2019 were poisoning (1,642 deaths), motor vehicle collisions (839 deaths), and falls (541 deaths). In the same year, more than 40,000 Hoosiers suffered a traumatic brain injury (TBI), which resulted in 1,242 deaths. The highest number of TBI-related deaths were among 25- to 34-year-olds.

While deaths are the most devasting outcome related to injuries, the analysis of hospitalization and emergency department visits related to injury provides additional useful information. Although injury deaths are significant, nonfatal injuries occur more frequently. More than 50,000 Hoosiers are hospitalized and more than 775,000 visit emergency departments for injuries each year.

Trauma Care Training and Certification Courses

- Advanced Trauma Life Support (ATLS) Provider
- Advanced Trauma Life Support (ATLS) instructor
- Trauma Nursing Core Course (TNCC)
- Trauma Care After Resuscitation (TCAR)
- Emergency Nursing Pediatric Course (ENPC)
- Prehospital Trauma Life Support (PHTLS)
- Rural Trauma Team Development Course (RTTDC)
- Disaster Management and Emergency Preparedness (DMEP)
- Advanced Trauma Care for Nurses (ATCN)
- International Trauma Life Support (ITLS)
- Trauma Certified Registered Nurse (TCRN)

TCC Subcommittee Prioritization of Recommendations

A heat map is a graphical prioritization and decision-making tool, where recommendations are ranked against a set of prioritization criteria. The rank or "heat" corresponds with the degree of alignment a given recommendation has with the criteria. The following heat map and used and confirmed through a prioritization process with each TCC Subcommittee.

Indiana Trauma System Plan

Heat Map Rankings - Potential Impact

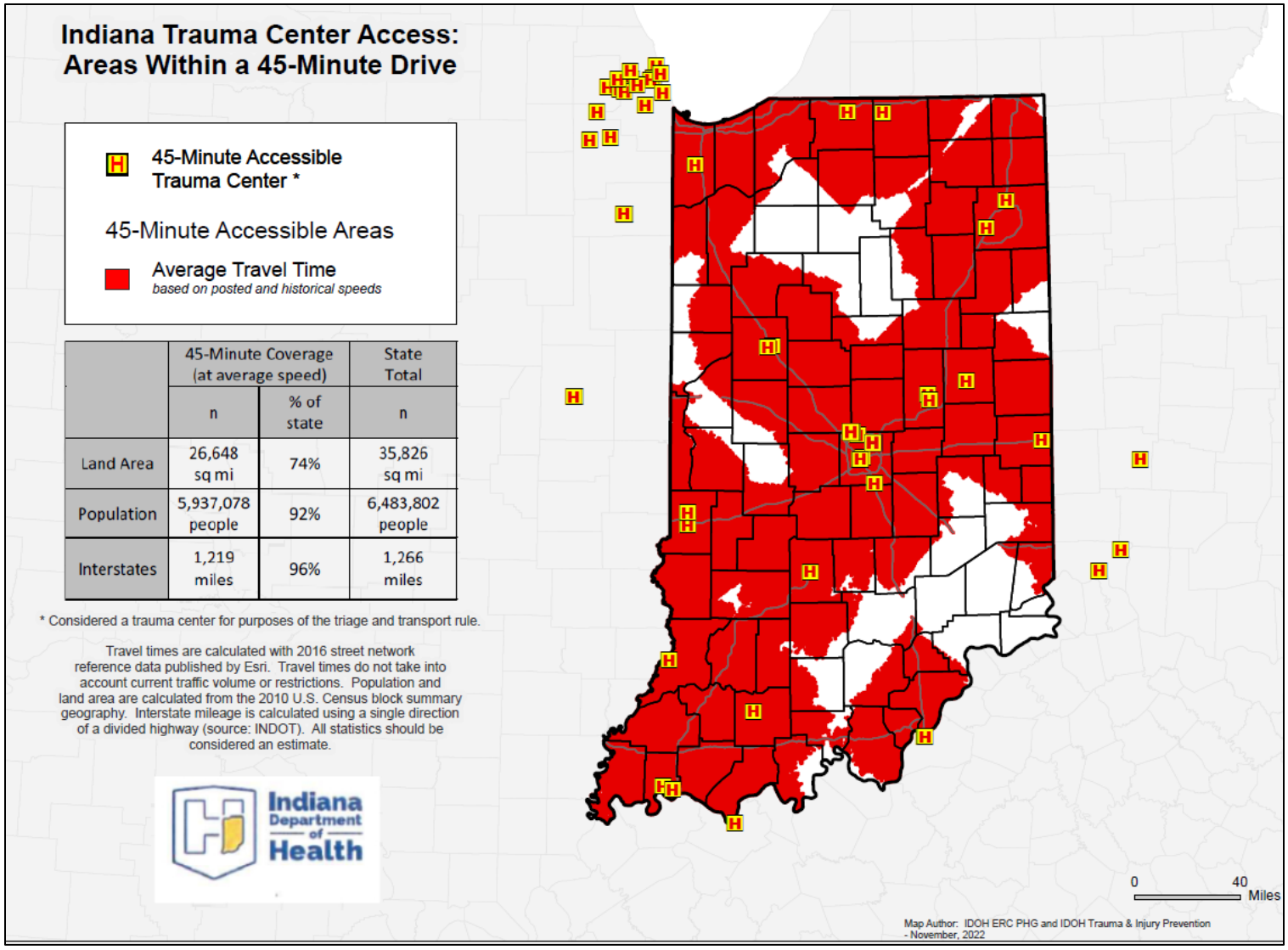
High (3) | Medium (2) | Low (1)

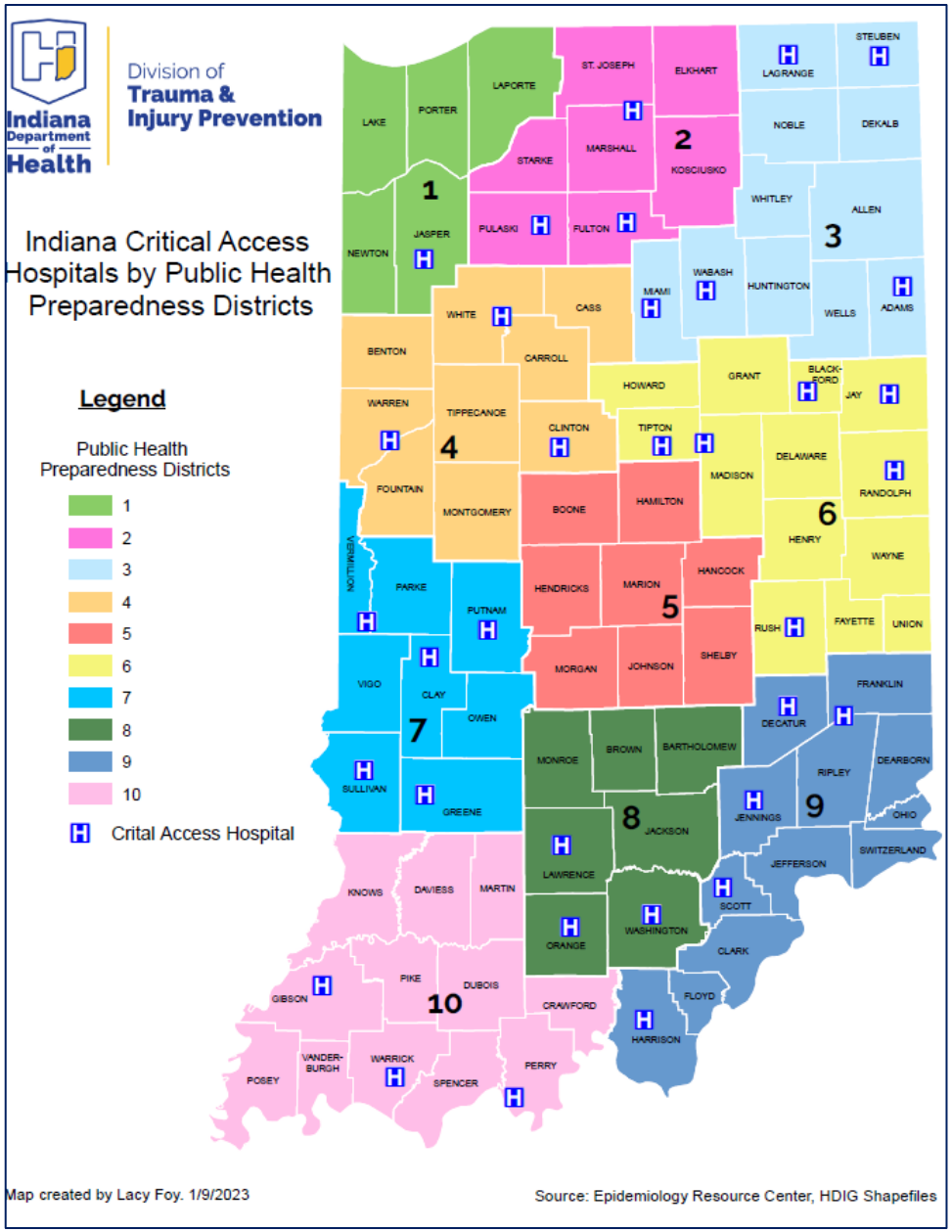
ID	Initiative	Prioritization Criteria: Serves as the prerequisite for advancing other goals	Supports statewide / regional approach	Has high return on investment	Encompasses a sustainable solution	Incentivizes participation in Statewide Trauma System	Score: Prioritization Criteria Heat Score
Comprehensive Engagement							
1	Restructure, expand, and formalize TRACs.						12
2	Formalize and expand TCC subcommittees and their membership.						12
3	Formally engage the state, regional trauma leadership, and physiatrists to promote engagement from the rehabilitation workforce.						10
4	Conduct routine reviews to verify TCC appointments are representative of the full continuum of care including hospitals, specialties, populations, facility types, and geography of Indiana.						10
5	Conduct periodic workforce assessments across the full continuum of trauma care.						10
6	Develop a strategy to engage and maintain stakeholder participation within TCC subcommittees and TRACs.						9
Accountability							
1	Develop and codify operational guidelines, roles, and responsibilities for TRACs.						14
2	Develop and implement comprehensive policies and procedures for the TCC.						11
3	Determine where formal agreements defining the roles and responsibilities of each agency for trauma system coordination exist.						11
4	Explore developing and implementing regional trauma system plans to improve quality and coordination of statewide care. Implement if feasible.						11

5	Explore administrative rules through IDOH that outline the trauma center designation process for each designation level that aligns with the American College of Surgeons (ACS) verification process.							10
6	Explore rules and legislation that outline trauma service standards by designation levels I-III.							9
Trauma Care Access								
1	Engage regional TRAC members and hospitals to expand trauma system access in each region.							14
2	Expand the coordination of triage and transfer of injured patients through the development of comprehensive, well-defined agreements between IDOH, TCC, IDHS, designated trauma facilities, and non-designated acute care facilities.							12
3	Identify opportunities to expand rehabilitative care in Indiana.							9
4	Review and implement a statewide Disaster Preparedness plan, focused on public health needs, that is in coordination with existing plans.							9
Emergency Medical Services								
1	Partner with the Indiana EMS to develop actionable recommendations that establish an RMOCC (Regional Medical Operations Coordination Center) structure statewide for resource monitoring, patient transport, transfers, load balancing, and data oversight.							14
2	Explore methods to streamline patient triage and care within Indiana and across state lines.							13
3	Elevate EMS as an essential service to decrease triage and transport times and improve the quality of care statewide.							12
4	Assess EMS registry vendor and service provision needs to adequately support trauma data system needs and improve the data quality.							12
5	Implement a system for monitoring and evaluating EMS compliance with the triage and transport protocols.							11
6	Complete the on-going EMS workforce assessment and evaluate the findings to determine an action plan for Indiana.							10
7	Formalize continued coordination and efficiency of the division of EMS within IDHS regarding stakeholder interaction and healthcare partnerships.							9
8	Assess the need, role, and function to establish a State Trauma Medical Director at IDOH. Consider the capabilities of this role regarding the EMS State Medical Director.							8
Data & Performance Improvement								
1	Develop a comprehensive approach to data quality to improve the trauma registry.							14

2	Assess current state of data interoperability to develop a mechanism to facilitate data sharing among agencies.							13
3	Evaluate trauma registry data to establish outcomes and identify gaps.							12
4	Propose an amendment to 410 IAC 34-9-1 that secures confidentiality of peer review activities and protects activities from discoverability.							12
5	Engage stakeholders in the data quality process and development of performance improvement initiatives.							12
6	Offer trauma registry education training programs for healthcare personnel to improve data quality.							11
7	Maximize the American College of Surgeons (ACS) Trauma Quality Improvement Program (TQIP) and/or other benchmarking programs events, collaborative, and best practice guidelines.							8
8	Create a Public Health Information Portal (PHIP) for data request submissions. Hire a dedicated analyst or utilize analysts within IDOH for the approval, payment, and assignment of these requests.							7
Prevention, Education, & Outreach								
1	Conduct a statewide assessment for tracking and reporting of injury prevention efforts across Indiana.							13
2	Increase education and training for personnel across the full continuum of trauma care.							13
3	Leverage injury epidemiology data and conduct surveys among hospital based clinical staff and key constituents to implement targeted injury prevention efforts.							12
4	Engage a variety of stakeholders to develop and evaluate targeted injury prevention programs.							12
5	Create and implement a plan to routinely educate and inform the public of the status of injury prevention activities.							9
6	Identify and consult key stakeholders to explore the development of an injury surveillance and injury control data consortium.							8

Trauma Center Access




Indiana Department of Health
Division of Trauma & Injury Prevention
Indiana Critical Access Hospitals by Public Health Preparedness Districts
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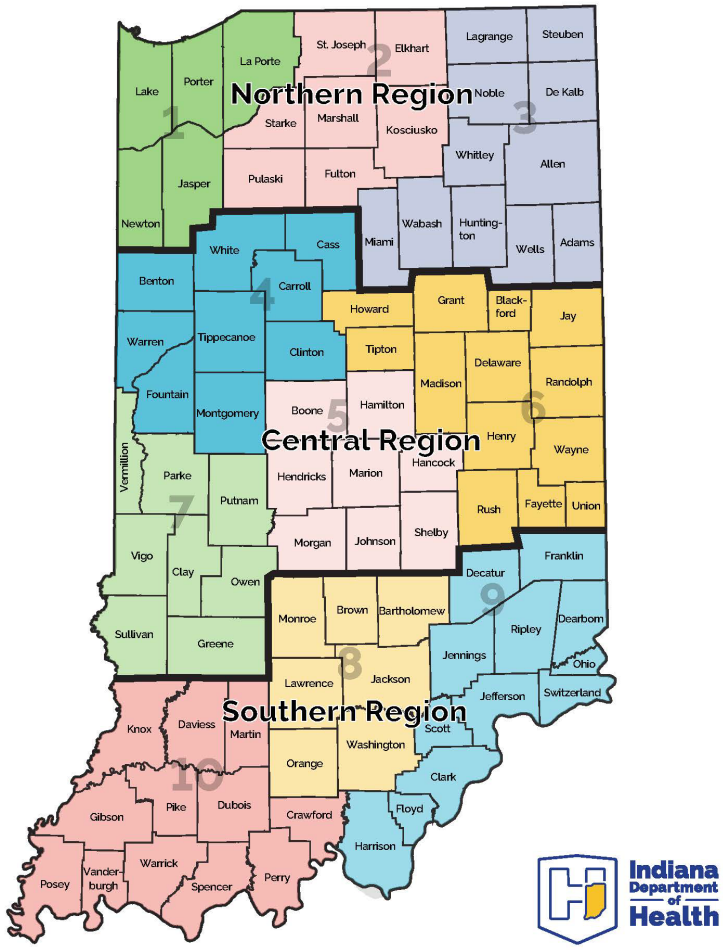
Map created by Lacy Foy. 1/9/2023
Source: Epidemiology Resource Center, HDIG Shapefiles

Trauma Regional Advisory Councils (TRACs)

Indiana Trauma System Regions



Emergency Medical Services (EMS) Districts