



Indiana State Trauma Care Committee

May 22, 2015



Indiana State
Department of Health



Email questions to: indianatrauma@isdh.in.gov



National EMS Week

Thank you EMS Providers!



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Legislative Wrap-Up

Art Logsdon, JD, *Assistant Health Commissioner*
Health & Human Services Commission



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Newborn safety incubators

- HEA 1016—”baby boxes”
 - Device designed to permit someone to anonymously place a newborn in the device intending to leave the newborn and another to remove the newborn and take custody of it.
 - Requires Children’s Commission to submit report by 1/1/16 on policies regarding abandoned children.
 - Requires ISDH to submit report by 1/1/16 with recommendations re: design, installation, registration, signage, enforcement and other policies re: creation and use of newborn safety incubators.



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Civil immunity—Volunteer health care providers

- **HEA1145—“health shield bill”**
 - Will be legal to voluntarily provide “health care services” and be immune from liability if:
 - You are licensed as a physician/PA/dentist/nurse/advanced practice nurse/optometrist/podiatrist.
 - You provide the service voluntarily, without compensation, within the scope of your license and at a location determined to be appropriate and listed on the health care volunteer registry.
 - Provider notifies the patient that the provider is immune from civil liability.
 - Patient signs a waiver acknowledging provider is immune from civil liability.
 - The provider is listed on the health care volunteer registry.
 - Must register with Professional Licensing Agency, which is implementing this law.
 - “Health care services”= Routine dental services, injections, suturing of minor lacerations, incisions of boils or superficial abscesses.
 - Not included are abortions or the prescribing of a controlled substance or scheduled drug.

Overdose intervention drugs

- **SEA406—“Naloxone bill”**
 - Allows for broader distribution of Naloxone (which reverses the effects of opioid overdoses).
 - Can be prescribed directly to someone at-risk of opioid overdose or to their family/friends or by standing order and be immune from civil liability.
 - Dispensing of Naloxone must be registered with the state trauma registry.
 - ISDH is developing a protocol for registration.

Spinal Cord and Brain Injury Fund

- **SEA166**
 - Purposes of the Fund—administered by ISDH—have been:
 - Fund research re: treatment/care of spinal cord/brain injuries
 - Develop a statewide trauma system
 - New purposes of the Fund—fund post acute extended treatment and services for an individual with spinal cord/brain injuries and facilities that offer such services.
 - Fund breakdown:
 - 10-15% (money in fund) for spinal cord treatment/facilities
 - 10-15% (money in fund) for brain injury treatment/facilities
 - Up to 50% for state trauma system development
 - What remains is for research grant purposes

ISDH agency bill

- **SEA461**
 - Child Fatality Review Teams—responsibility for conducting a review lies with the county team in the county where the incident occurred
 - Emergency Medical Technicians can now check blood glucose with a finger stick.
 - Needle exchange bill also a part of the ISDH agency bill (in response to HIV outbreak in Scott County).

American College of Surgeons (ACS) Needs Assessment Tool

Katie Hokanson, *Director*

Camry Hess, MPH, *Database Analyst*

Division of Trauma and Injury Prevention

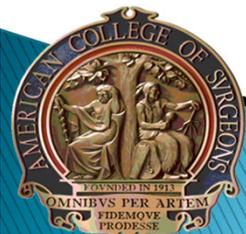


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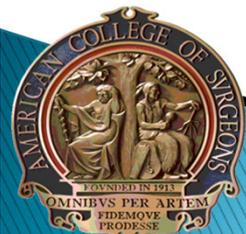
Background

- ▶ Assessment of trauma systems difficult
 - No standards for structure and process
 - No agreement on critical metrics
 - No benchmarks against which to measure
- ▶ Systems are heterogeneous
 - Geographical challenges
 - Structural challenges
 - Availability of data
 - Availability of resources



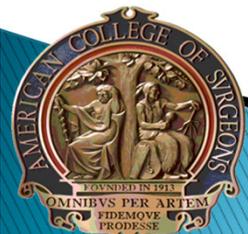
The Goals

- ▶ Select an initial set of system metrics
- ▶ Begin data collection
 - Identify best data sources and uniform methods
 - Establish a range of values to set benchmarks
- ▶ Utilize results to refine assessment tools



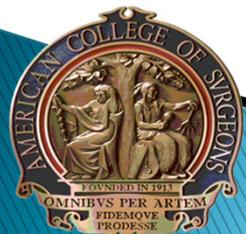
Tool Categories

- ▶ Access
- ▶ Training Mission
- ▶ Efficiency
- ▶ Discovery/Dispatch
- ▶ EMS Response
- ▶ Air Medical Response
- ▶ Triage/Trauma Activation
- ▶ Capacity



What We Are Hoping to Do

- ▶ Advance cooperative NASEMSO/COT project
- ▶ Get as many states as possible to collect data
 - Select practical metrics from “top ten”
 - Share data (confidentially)
- ▶ Utilize this pilot project to establish a way to incrementally develop a comprehensive set of system metrics



How You Can Help

Provide Feedback on the Tool:

1. Will the tool be useful to state/regional system administrators?
2. Does the data exist in your state to populate the form?
3. What group would be convened to complete the form(s) in your state?
4. Would your state office have the authority and political will to act upon findings?

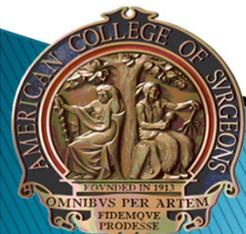


Table 4

American College of Surgeons – Trauma Center Needs Assessment Tool	
Table 4	
Desired State	xx% of injured patients with ISS > 15 treated without transfer at facilities other than designated Level I, II, and III trauma centers
Parameters	xx - no data, suggest < 5%
Current State	<p>Determine:</p> <ul style="list-style-type: none"> • % of patients with ISS > 15 treated in designated trauma centers compared with total number of injured patients with ISS > 15 in the state



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Table 4 (continued)

- Are the resources available to do this measurement?
 - Yes
- What information is available at this time?
 - Level of trauma centers
 - ISS score
 - Transfer status
 - Calendar year (CY) 2014 data



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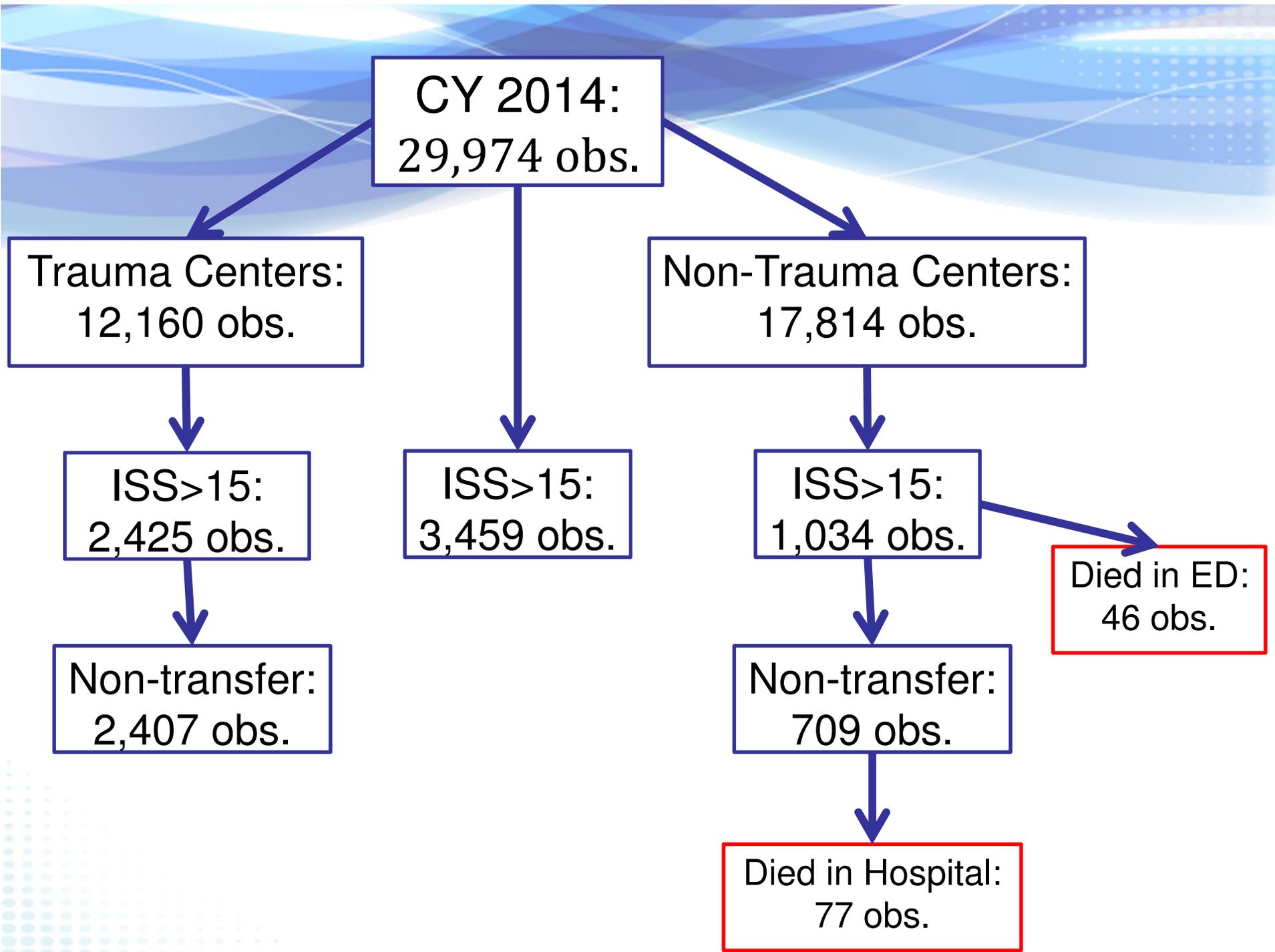


Table 4 (continued)

- Number of patients with ISS>15 treated without transfer at non-trauma center facilities: 709 (68.57%)
- The ACS recommends calculating the percent of patients with ISS>15 treated in trauma centers compared with total number of injured patients with ISS>15 in the state: 70.11%



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Table 4 (continued)

- *What are the conclusions for this table?*
 - 68.57% of patients with ISS>15 are treated at non-trauma centers and are **not** transferred.
 - The recommended suggestion is <5%.



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Table 6

American College of Surgeons – Trauma Center Needs Assessment Tool		
Table 6		
3 Mission	Desired State	Each level I center will see a sufficient volume of injured patients to support continued competence of trauma staff and the training mission of the center
	Parameters	<ul style="list-style-type: none"> • Limit by admissions: COT 1200 • Limit by severe injuries: COT 250 with ISS > 15
	Current State	Determine: <ul style="list-style-type: none"> • Required volume for competency mission • Required volume for training mission



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Table 6 (continued)

- Are the resources available to do this measurement?
 - Yes
- What information is available at this time?
 - Level of trauma centers
 - Patient volume by trauma center
 - Number of patients with ISS > 15
 - Calendar year (CY) 2013 data
 - Calendar year (CY) 2014 data



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Table 6

Parameter 1: Admissions \geq 1200

Hospital Name	Admissions (CY2013)	Admission (CY2014)
IU Health – Methodist Hospital	3365	3133
Eskenazi Health	1234	1560

Parameter 2: Admissions \geq 250 and ISS $>$ 15

Hospital Name	Admissions (CY2013)	Admission (CY2014)
IU Health – Methodist Hospital	627	988

Table 6 (continued)

- *What are the conclusions for this table?*
 - Two Level I trauma centers meet either parameter 1 and/or parameter 2.



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Table 10

American College of Surgeons – Trauma Center Needs Assessment Tool

Table 10

ical Response	Desired State	Use of air medical resources reduces initial transport time by xx minutes for patients meeting step one or step two field triage criteria beyond a yy time-based transport radius.
	Parameters	xx - no data available, suggest 15-30 minutes yy - no data available, suggest >30 minutes (assumes full ALS ground capabilities of ground unit)
	Current State	Determine: <ul style="list-style-type: none"> • Number, location and type of air medical resources in the region or state • Average length of time from dispatch to airborne • Average length of time for patient preparation for flight (scene and inter-hospital) • Average time savings by distance from the nearest appropriate trauma center (may not be the air medical assets home base). <ul style="list-style-type: none"> ○ Requires assessment and comparison of ground transport times

Table 10 (continued)

- Are the resources available to do this measurement?
 - Yes
- What information is available at this time?
 - Service type (air versus ground).
 - E05_02 Date/Time PSAP Call (EMS registry).
 - E05_10 Date/Time Patient Arrived (EMS registry).
 - The components for step one of the field triage criteria are known:
 - Glasgow Coma Score
 - Systolic blood pressure
 - Respiratory rate
 - Patient age
 - Patient age units
 - Time frame: Quarters 2 and 3 2014.
- Note: A 30 minute or greater time-based transport radius was used.

Table 10 (continued)

- *What are the conclusions for this table?*
 - Average initial transport time for ground runs: 52.77 minutes
 - Based on 684 runs
 - Average initial transport time for air runs: 97.01 minutes.
 - Based on 85 runs.
 - Average run time for the air runs was higher than the ground runs.
 - Is this due to long runs being done by air transport?
 - The ACS suggests using a time-based transport radius - geographical radius may be more appropriate.

Does the data exist in our state to populate the form?

- Common themes throughout analysis:
 - Triage & Transport rule does not specify highest level of care.
 - EMS registry needs to be on NEMSIS V3.
 - How are we defining that term?
 - Ex: Catchment area, Geographical boundaries vs. Time boundaries, E911, etc.



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Indiana Injury Prevention Resource Guide

Jessica Skiba, MPH, *Injury Prevention Epidemiologist*
Division of Trauma and Injury Prevention



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Email questions to: indianatrauma@isdh.in.gov

Why Create a Resource Guide?

- Injuries are devastating, deadly, costly and preventable!
- New Division- created in late 2011
- Bring awareness to problem of injury
- Focus on data-driven decision making
- Highlight evidence-based solutions
- Identify unmet needs and priorities

Primary Goals of Project

1. Create a document that can provide easily accessible and understandable data and information on the size and scope of specific injury problems in Indiana.
2. Highlight evidence-based solutions to the problem of injury



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Secondary Goals of Project

1. Enhance the skills, knowledge, and resources of the injury prevention workforce
2. Bring attention to the burden of injury in Indiana
3. Generate energy around the available resources
4. Add a personal story to make problem seem more realistic
5. Promote injury as a priority for the Division of Trauma and Injury Prevention

Injury Prevention Topics

1. Trauma & Trauma System
2. Alcohol & Injury
3. Prescription Drug Overdose
4. Infant Safe Sleep
5. Older Adult Falls



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Injury Prevention Topics

6. Traumatic Brain Injury / Concussion
7. Traffic Safety
8. Child Maltreatment
9. Sexual Violence
10. Distracted Driving



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Add't Injury Prevention Topics

11. Bullying (child injury)
12. Interpersonal Violence/ Homicide
13. Suicide Prevention
14. Intimate Partner Violence (IPV)
15. Child Passenger Safety
16. Teen Driving Safety
17. ATV Safety
18. Rural Health & Injury
19. Carbon Monoxide (CO) & home fires
20. Occupational Safety
21. Poisoning



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Outline per Injury Prevention Topic

1. Short Description of problem
2. How does it affect the U.S.?
3. How does it affect Indiana?
4. How do we address this problem?
5. Additional Resources



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2012 Edition

Preventing Injuries

IN MARYLAND

A Resource
for State
Policy Makers

25 YEARS
1987-2012
JOHNS HOPKINS
CENTER FOR
INJURY RESEARCH
AND POLICY

Maryland's Guide

Johns Hopkins Center for Injury
Research and Policy

1. Alcohol & Injury
2. ATV Safety
3. Distracted Driving
4. Falls among older adults
5. Home fires
6. Intimate Partner Violence
7. Motorcycle safety
8. Poisoning
9. Teen Drivers
10. Trauma & Trauma Systems

ALCOHOL AND INJURY

HOW DOES IT AFFECT THE U.S.?

- On average, 80,374 persons died each year from 2001-2005 as a result of excessive alcohol use, with more than half of these deaths from injuries.¹
- On average, 4,700 children and teens under the age of 21 died each year from 2001-2005 as a result of excessive alcohol use. The vast majority are from injury.¹
- In 2008, 11,773 people died in alcohol-related motor vehicle crashes; of these 1,510 were children and teens younger than 21 years old.²
- The cost of alcohol consumption to society is estimated to be \$223.5 billion in 2006, or approximately \$746 per person in the U.S.³ This includes direct costs such as medical care and the costs of the judicial and penal systems, as well as indirect costs such as lost wages and pain and suffering.⁴

HOW DOES IT AFFECT MARYLAND?

- Between 2001 and 2005, an average of 1,290 Marylanders died each year as a result of excessive alcohol use; more than half were from injuries.¹
- In 2008, 152 Marylanders died in alcohol-related motor vehicle crashes.²
- Alcohol consumption costs Maryland an estimated \$4.3 billion annually; over half of this amount is in productivity losses.⁵

HOW DO WE ADDRESS THIS PROBLEM?

- Increasing the price of alcohol is associated with reduced drinking among adults and adolescents,⁶ as well as fewer suicides,⁷ youth traffic fatalities,^{8,9} and homicides.^{7,10,11} Effective July 1, 2011 Maryland Bill 994 increased the sales tax on alcohol to 9 percent.
- In addition to raising alcohol taxes, the CDC recommends limiting the hours and days when alcohol can be purchased, decreasing the density of alcohol outlets, strengthening commercial host liability laws, and increasing enforcement of minimum legal drinking age laws to curb underage drinking.¹²
- The Institute of Medicine recommends reducing adolescent exposure to alcohol advertising.¹³ At the local or state level, this can be done by restricting outdoor advertising, retail signage and alcohol sponsorships or promotions on public property and in places frequented by youth.¹⁴
- Ignition interlock devices prevent drivers who have measurable alcohol (set to a predetermined level) in their system from driving an interlock-equipped car. They reduce repeat drunk driving offenses by an average of 64 percent as long as the device remains on the vehicle.¹⁵ Other alcohol-sensing technologies show promise for the future.¹⁶

ADDITIONAL RESOURCES

Johns Hopkins Center for Injury Research and Policy: www.jhsph.edu/InjuryCenter
National Center for Injury Prevention and Control, CDC: www.cdc.gov/injury
Center for Substance Abuse Research: www.cesar.umd.edu
Center on Alcohol Marketing and Youth: www.camy.org

REFERENCES

1. Centers for Disease Control and Prevention. Alcohol-Related Disease Impact Software (ARDI). Available at: <http://www.cdc.gov/alcohol/ardi.htm>. Accessed November 15, 2011.
2. Traffic Safety Facts 2008. A Compilation of Motor Vehicle Crash Data from the Fatality Analysis Reporting System and the General Estimates System. National Highway Traffic Safety Administration: DOT HS 811 170. www.nrd.nhtsa.dot.gov/Pubs/811170.PDF.
3. Bouchery EE, Harwood HJ, Sacks JJ, Simon CJ, Brewer RD. Economic costs of excessive alcohol consumption in the U.S., 2006. *American Journal of Preventive Medicine*. 2011;41(5):516-524.
4. Harwood H, Henrick D, Fountain D, Livermore G. The Economic Costs of Alcohol and Drug Abuse in the United States 1992. www.niaaa.nih.gov/Resources/DatabaseResources/QuickFacts/EconomicData/cost5.htm. Note: 2009 estimate calculated based on the assumption that the cost increase remained stable at 3.8 percent per year since 1998.
5. U.S. Census Bureau. State & County QuickFacts: Maryland. <http://quickfacts.census.gov/qfd/states/24000.html>. Note: estimate is based on applying national estimate of costs of alcohol to society of \$746 per capita to MD population.
6. Wagenaar AC, Salois MJ, Komro KA. Effects of beverage alcohol price and tax levels on drinking: A meta-analysis of 1003 estimates from 112 studies. *Addiction*. 2009;104(2):179-190.
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16. Pollard JK, Nadler ED, Stearns MD. Review of Technology to Prevent Alcohol-Impaired Crashes. U.S. Department of Transportation, National Highway Traffic Safety Administration. September 2007. DOT HS 810 827. <http://www.nhtsa.gov/DOT/NHTSA/NRD/Multimedia/PDFs/Crash%20Avoidance/2007/TOPICrev.pdf>.

Reducing Injury in Indiana: Promoting Indiana's Injury Prevention Resource Guide

Department of Communication Studies

IUPUI

**INDIANA UNIVERSITY
PURDUE UNIVERSITY
INDIANAPOLIS**

IUPUI INDIANA UNIVERSITY-PURDUE UNIVERSITY INDIANAPOLIS

The Team

- Maria Brann, PhD, MPH
- Graduate-level course
Health Communication Dissemination
- Graduate students
 - Applied Communication, MA
 - Health Communication, PhD



Project Goals

- Develop a strategic communication plan
- Present a strategic communication plan

Strategic communication:

The right message

through the right media

to the right audience

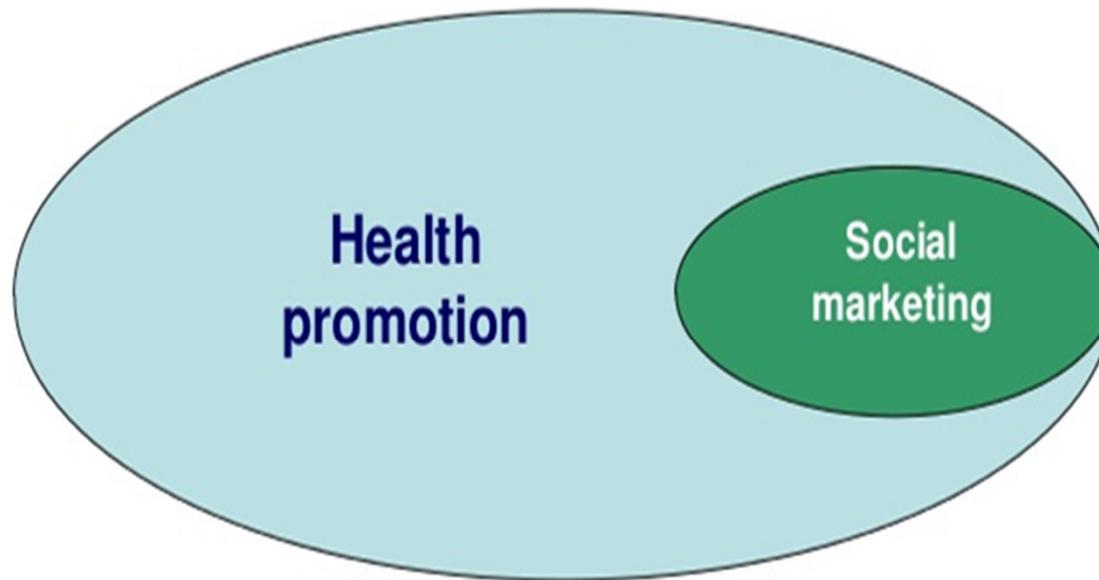
at the right time

and with the right effect.



choice always
in a digital age w
tion and enters

Approach



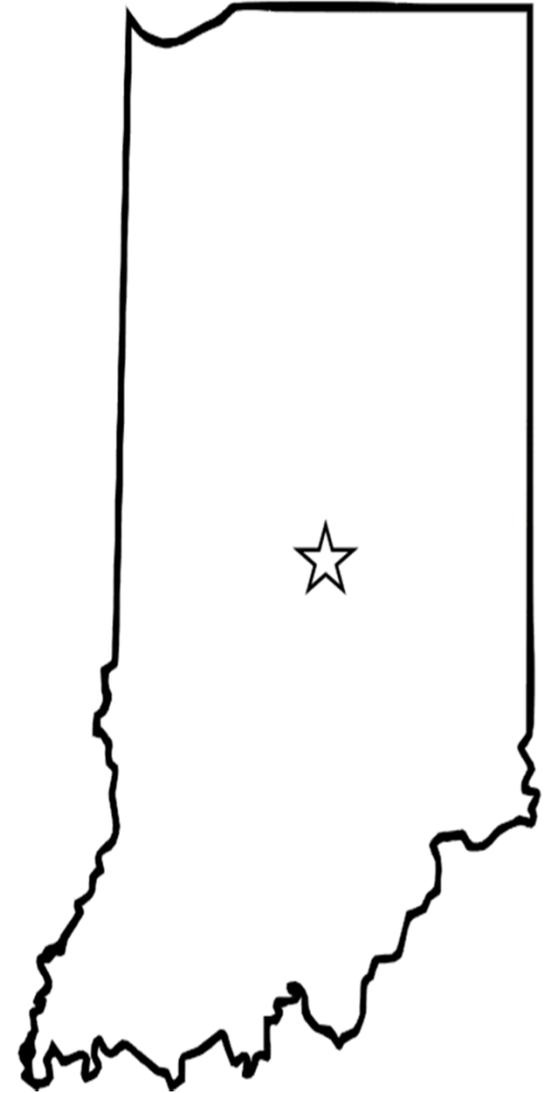
Marketing Mix

Approach



Target Audiences

- Department of Child Services (DCS)
- Emergency Departments (EDs)
- Injury Prevention Advisory Council (IPAC)





Emergency Departments

04/2015
DCS
STRATEGIC COMMUNICATION PLAN

04/2015
STRATEGIC COMMUNICATION PLAN

04/2015
IPAC
STRATEGIC COMMUNICATION PLAN



Prepared for the Indiana State Department of Health: Injury Prevention Resource Guide



Prepared for the Indiana State Department of Health: Injury Prevention Resource Guide



Prepared for the Indiana State Department of Health: Injury Prevention Resource Guide



04/2015
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DCS

STRATEGIC COMMUNICATION PLAN



Prepared for the Indiana State Department of Health: Injury Prevention Resource Guide

Key Benefit

- For regional managers:
 - Make work more efficient
 - Make the Indiana-specific information relevant, accessible, and convenient
- For family case managers:
 - Improve relationship between DCS and foster/adoptive parents
 - Make the Indiana-specific information relevant, accessible, and convenient

Objectives

DCS

The main objectives for the communication dissemination plan for DCS can be evaluated with the following SMART goals:

- More than 30% of DCS employees accessing the digital resource guide within the first two months of dissemination.
- More than 60% of DCS employees accessing the digital resource guide within the first four months of dissemination.

Evaluation Recommendations

DCS

Objectives:

- More than 30% of DCS employees accessing the digital resource guide within the first two months of dissemination.
- More than 60% of DCS employees accessing the digital resource guide within the first four months of dissemination.

Measurement:

- Email open rates can be tracked for pre-launch, launch, and post-launch.
- Access will be measured with number of downloads of the guide from landing page at 2 months and 4 months post-launch.



Emergency Departments

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Objectives

- EDs use the Injury Prevention Resource Guide
- Assist in lowering injury-related ED visits
- Create a phased system in which this information can be used in training and daily routines

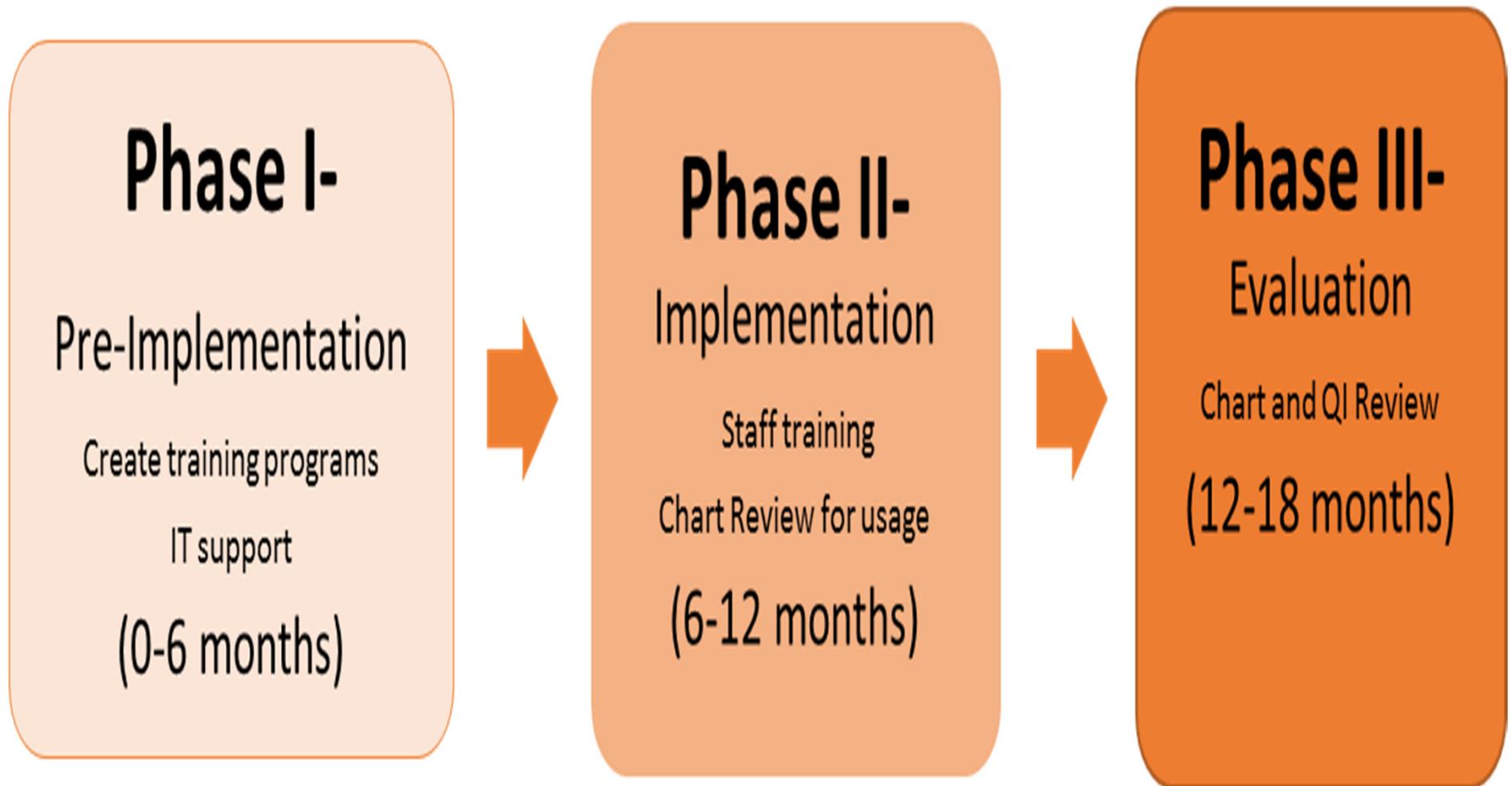
Message Concepts

“Your access to injury prevention”

Information for injury prevention for your trauma center.

“Injury prevention at your fingertips”

A complete guide to all your injury prevention needs.





IPAC

Target Audience

- Members of the Injury Prevention Advisory Council

Purpose

- Provide a communication plan that will support IPAC members in educating themselves and their networks about the resource guide

IPAC

Focus

- Support IPAC chair in supporting IPAC members in outreach efforts
- Provide samples of “talking points” about specific injuries

Objective

- Encourage IPAC members to reach out to members of their professional networks, sharing the resource guide with them and recommending that they pass it along and use it

Message Concepts

- “We are in this together, help each other help make the work better”
- “The whole is more than the sum of its parts”

Message

“As a member of IPAC and a professional committed to reducing preventable injuries, you know that all injuries matter. By using, sharing, and talking about this guide with people in your network, you have the power to increase what people know about injuries and how to prevent them.”

Evaluation Recommendations

- Gauge level of understanding through interactive quizzes in IPAC newsletter
- Reports of activity at IPAC meetings
- Post-plan survey of IPAC members on actions taken to disseminate the guide, who was reached, and how to improve the process

Summary

- Diverse Target Audiences
- Key Recommendations
 - DCS: Focus on Protection
 - EDs: Injury Prevention at your Fingertips
 - IPAC: Your Commitment to Injury Prevention

Questions or Comments?

- For additional information, please contact
Maria Brann
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IUPUI
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Injury Prevention Advisory Council (IPAC) Meetings

- Thursday, June 18, 2015: 1 p.m.-3 p.m. EST
- Thursday, September 17, 2015: 1 p.m.-3 p.m. EST
- Thursday, December 10, 2015: 1 p.m.-3 p.m. EST
 - Rice Auditorium at ISDH



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2015

Injury Prevention 101 conference

Date: Friday, March 13, 2015

Location: Indiana Government Center South- Room 22
402 W. Washington St, Indianapolis, IN 46204

Time: Registration begins at 7:30 a.m.
Event starts at 8:00 a.m.



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Questions?

Jessica Skiba, MPH

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Indiana State Department of Health

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Phone: 317-233-7716



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Emergency Department Education Requirements *Survey Results*

Spencer Grover, FACHE, *Vice President*
Indiana Hospital Association (IHA)



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ISDH Updates

Katie Hokanson, *Director*

Division of Trauma and Injury Prevention



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2015 Trauma Tour

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2015 Trauma Tour Details

- Timeframe: June, July, August
- Audience:
 - Trauma Stakeholders
 - Local hospitals
 - Local EMS/Fire Department
 - County health departments
 - focus on injury prevention and education
 - Elected officials
 - Local police/sheriff
 - Local rehab facilities
 - Local agencies on aging

2015 Trauma Tour Details (Continued)

- Format:
 - *NEW* Trauma Registry Refresher session
 - Displays/information booths
 - Formal presentation
 - Q&A session
- Communication:
 - Emails & snail mail
 - Registration

Email questions to: indianatrauma@isdh.in.gov

2015 Trauma Tour Registration

← → ↻ www.in.gov/isdh/19537.htm

Text Find an Agency Find a Person Account Center Online Services FAQs Help A- A+

IN.gov A State that Works ISDH Search

GOVERNOR
MIKE PENCE

About Indiana Agriculture & Environment Business & Employment Education & Training Family & Health Law & Justice Public Safety Taxes & Finance Tourism & Transportation

 **Indiana State Department of Health**
Trauma System/Injury Prevention Program Home

 **ISDH HOME**

TRAUMA SYSTEM/INJURY PREVENTION

- Site Index
- Injury Prevention**
- Indiana's Trauma System
- Trauma Registry
- Pre-Hospital/EMS
- Trauma Centers
- Trauma and Injury Prevention Division staff
- What we're reading about trauma systems
- Trauma and Injury Prevention Definitions
- Calendar of Events
- 2015 Trauma Tour**
- Trauma Times

TRAUMA SYSTEM/INJURY PREVENTION PROGRAM HOME

 [Click to subscribe](#)

ISDH Mission: Promoting and providing essential public health services to protect Indiana communities

ISDH Vision: A healthier and safer Indiana

Trauma and Injury Prevention Division Mission: To develop, implement and provide oversight of a statewide comprehensive trauma care system that:

- Prevents injuries.
- Saves lives.
- Improves the care and outcomes of trauma patients.

Trauma and Injury Prevention Division Vision: Prevent injuries in Indiana

SEA 180

Senate Enrolled Act (SEA) 180 required the Indiana State Department of Health, in consultation with Indiana Department of Veterans Affairs and Department of Mental Health and Addiction, to study and report findings and recommendations concerning implementation of a program for the treatment of veterans who have traumatic brain injury or posttraumatic stress disorder. [The report can be reviewed here.](#)

Trauma Registry Rule

2015 Trauma Tour Registration

www.in.gov/isdh/26642.htm



Trauma System/Injury Prevention Program Home > 2015 Trauma Tour

ISDH HOME

TRAUMA SYSTEM/INJURY PREVENTION

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2015 TRAUMA TOUR

[Click to subscribe](#)

The Division of Trauma and Injury Prevention is pleased to announce the 2015 Trauma Tour. From June through August, the Indiana State Department of Health will hold a statewide Trauma Tour. Division of Trauma and Injury Prevention staff, along with local stakeholders, will hold "open house" style meetings in all 10 Indiana public health preparedness districts for Hoosiers to learn more about trauma, how state and local agencies currently respond to trauma and how a trauma system could help the state. Click here for a list of the [2015 Trauma Tour dates and locations](#) .

Trauma Tour Dates

Stop 1: District 10 (Knox, Daviess, Martin, Gibson, Pike, Dubois, Crawford, Posey, Vanderburgh, Warrick, Spencer and Perry counties)

Date: Tuesday, June 30 from 2-5 p.m. (Central)

Location: [Southern Indiana Career & Technical Center](#)

1901 Lynch Road
Evansville, IN 47711

[Sign up for the District 10 Event!](#)

Stop 2: District 1 (Lake, Porter, Netwon, Jasper and LaPorte counties)

Date: Tuesday, July 7 from 2-5 p.m. (Central)

Location: [Crown Point Community Library](#)

122 North Main Street
Crown Point, IN 46307

[Sign up for the District 1 Event!](#)

Online Services

- Indiana Death Registration System (IDRS)
- Indiana Immunization Registry
- Food Protection Complaint Form
- MyVaxIndiana
- Nurse Aide Registry
- Radiography License Renewal
- Forms.IN.gov

[MORE ONLINE SERVICES »](#)

[SUBSCRIBER CENTER »](#)

Top FAQs | I Want To...

1. [Apply for a Birth/Death Certificate](#)
2. [Register for the IDRS](#)
3. [Quit smoking](#)
4. [Find information on recent food recalls](#)
5. [Get a Flu Shot](#)



2015 Trauma Tour Registration

→ ↻ 🔒 <https://www.eventbrite.com/e/2015-trauma-tour-district-10-evansville-tickets-15934983966> ★

Eventbrite 🔍 Search for events Browse Events indianatraum... Help [CREATE EVENT](#)

2015 Trauma Tour - District 10 - Evansville

Indiana State Department of Health, Division of Trauma and Injury Prevention
Tuesday, June 30, 2015 from 2:00 PM to 5:00 PM (CDT)
Evansville, IN

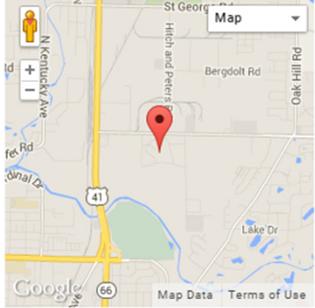
Ticket Information

TYPE	REMAINING	END	Free	QUANTITY
Vendor <small>If your organization is interested in setting up a display at the trauma tour event, please register as a vendor.</small>	20 Tickets	Jun 23, 2015	Free	0 ▾
Attendee <small>If you are interested in attending this event, please register as an attendee.</small>	200 Tickets	Jun 30, 2015	Free	0 ▾

[Register](#)

[Save This Event](#)

When & Where



Southern Indiana Career & Technical Center
1901 Lynch Road
Evansville, IN 47711

Tuesday, June 30, 2015 from 2:00 PM to 5:00 PM (CDT)

[Add to my calendar](#)

Share 2015 Trauma Tour - District 10 - Evansville

[Email](#) [Share](#) [Tweet](#)

Event Details

The Division of Trauma and Injury Prevention is pleased to announce the 2015 Trauma Tour.

Who's Going

Oops! We're having trouble connecting to Facebook. Please [try again](#).

Trauma Tour Stops (Continued)

- 1st Stop: Evansville
 - Tuesday, June 30th
 - Southern Indiana Career & Technical Center



Student Excellence Through Applied Knowledge and Partnerships

- 2nd Stop: Crown Point
 - Tuesday, July 7th
 - Crown Point Community Library



Trauma Tour Stops (Continued)

- 3rd Stop: Terre Haute
 - Tuesday, July 14th
 - Landsbaum Center for Health Education



- 4th Stop: Muncie
 - Thursday, July 16th
 - IU Health – Ball Memorial Hospital



Ball Memorial Hospital

Trauma Tour Stops (Continued)

- 5th Stop: Fort Wayne

- Tuesday, July 21st
- Public Safety Academy



- 6th Stop: Scottsburg

- Tuesday, July 28th
- Mid America Science Park



MID-AMERICA
science park

Email questions to: indianatrauma@isdh.in.gov

Trauma Tour Stops (Continued)

- 7th Stop: Lafayette
 - Thursday, July 30th
 - YWCA

- 8th Stop: South Bend
 - Tuesday, August 4th
 - EMS Education Building



Email questions to: indianatrauma@isdh.in.gov

Trauma Tour Stops (Continued)

- 9th Stop: Columbus
 - Tuesday, August 11th
 - Columbus Learning Center
- 10th Stop:
Indianapolis
 - Thursday, August 13th
 - Eskenazi Health – Outpatient Care Center



Greater Columbus Learning Center
Freedom through literacy
Since 1988

ESKENAZI
HEALTH



Indiana Violent Death Reporting System (INVDRS)



Email questions to: indianatrauma@isdh.in.gov



Indiana State
Department of Health

CDC Grant

Collecting Violent Death Information Using the National Violent Death Reporting System (NVDRS)

- Established in 2002



Indiana State
Department of Health

NVDRS

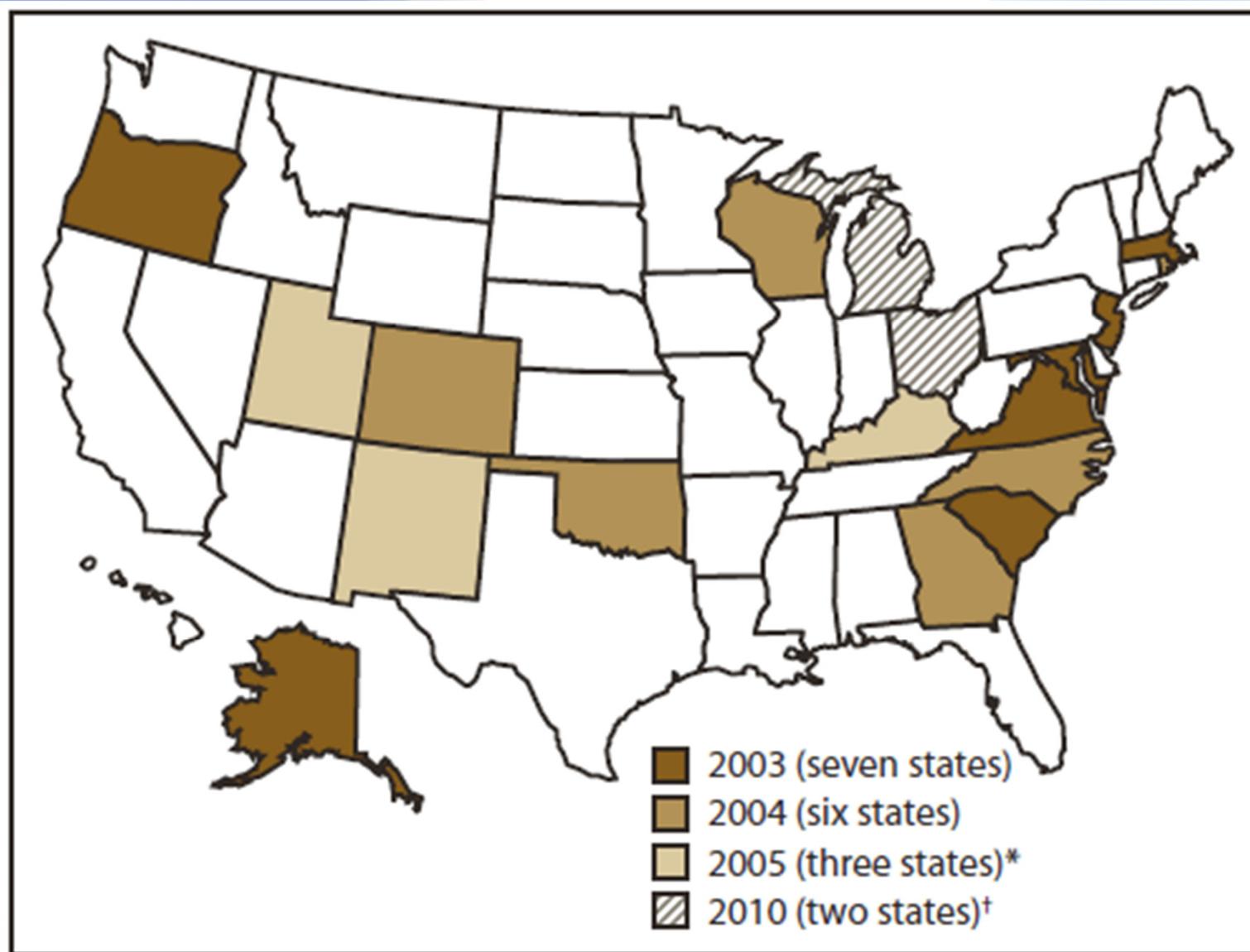
- National, ongoing, state-based surveillance system
- Data collected by states through partnerships
- Data for informing prevention efforts
- Comprehensive information on violent deaths in participating states
 - Incident-based system



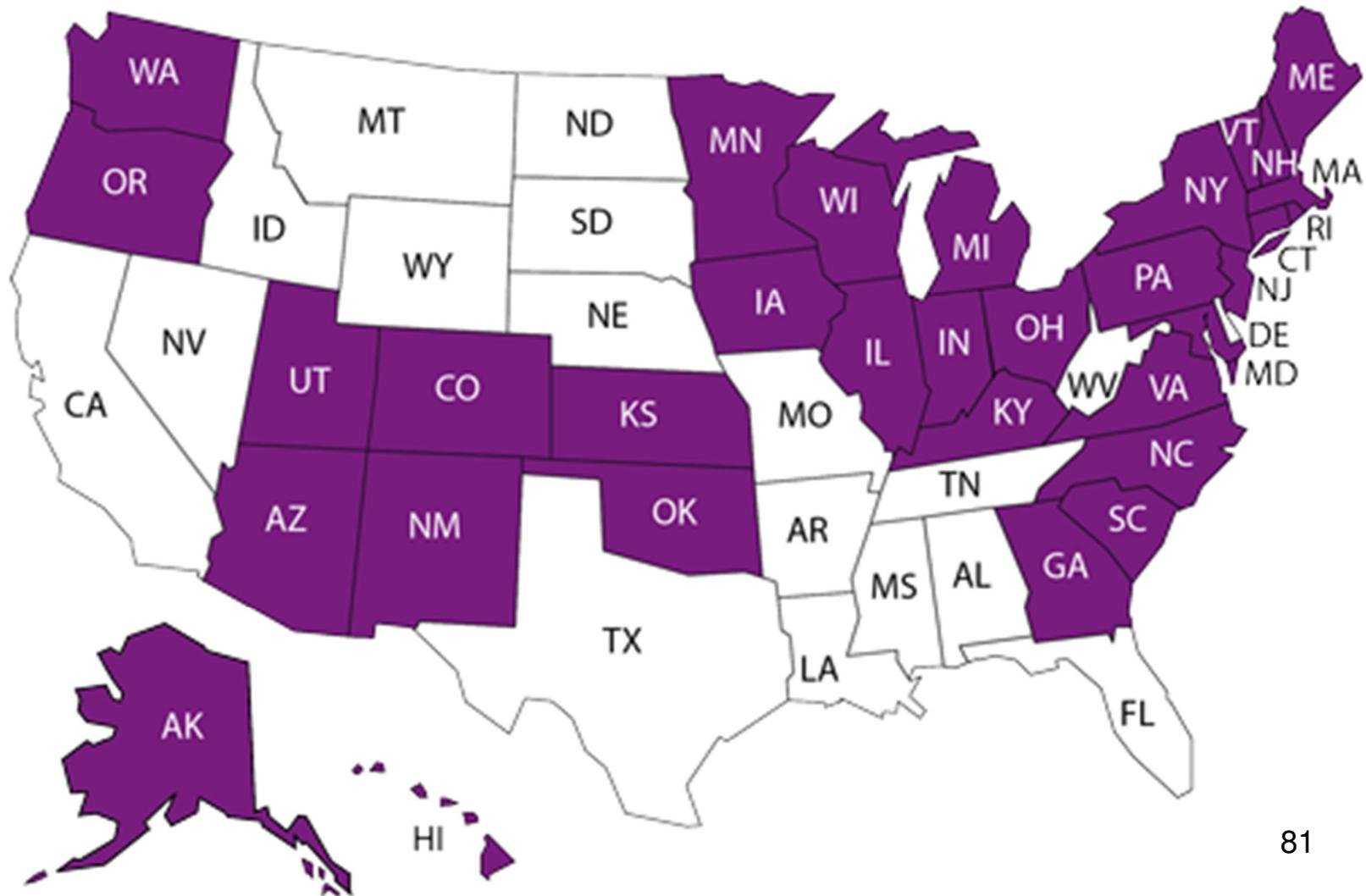
Indiana State
Department of Health

Email questions to: indianatrauma@isdh.in.gov

Previously Funded States



32 States Funded in 2014



INVDRS

- Indiana Violent Death Reporting System
- Database to monitor and track trends of violent deaths in Indiana
- Data for informing local prevention efforts



Indiana State
Department of Health

Critical Output

Establishing a surveillance system to collect violent death information that is:

- High quality
- Comprehensive
- Timely
- Complies with CDC guidelines
 - Compare “apples to apples”

What is a Violent Death?

- A death that results from the intentional use of physical force or power, threatened or actual, against:
 - Oneself
 - Another person
 - A group or community



Manners of Violent Death

- Suicide
- Homicide
- Undetermined Intent
- Unintentional Firearm Death
- Legal Intervention
- Terrorism



Four Primary Objectives

1. Create and update a plan to implement INVDRS in Indiana
2. Collect and abstract comprehensive data on violent deaths from:
 - Death Certificates
 - Coroner reports
 - Law enforcement records
 - Optional Modules:
 - *Child Fatality Review*
 - Intimate Partner Violence
 - Drug Overdose/Poisonings



Indiana State
Department of Health

Email questions to: indianatrauma@isdh.in.gov

Four Primary Objectives, Cont'd

3. Disseminate aggregate INVDRS data to stakeholders, the public, and CDC's multi-state database
4. Explore innovative methods of collecting, reporting, and sharing data
 - Improve timeliness and greater utilization of data for prevention efforts

Year 1 Pilot

- Collect data on deaths that occurred in 6 counties:
 - **Marion**
 - **Allen**
 - **Lake**
 - **Vanderburgh**
 - **St. Joseph**
 - **Madison**
- Selected based on rank of number of violent deaths in 2010
- Collect data on all child deaths (<18 years)

After Pilot

- Expand to all counties in Indiana to collect all violent deaths
- Deaths as of January 1, 2016
 - **More** complete database to monitor and track trends of violent deaths in Indiana
 - **More** data for informing local prevention efforts

2015 Advisory Board Meeting Dates

- June 23rd
- September 29th
- December 15th
 - 1-3pm EDT
 - ISDH, Rice Auditorium



INVDRS Staff

Name	Position	Phone	Email Address
Murray Lawry	Coroner Records Coordinator	317-233-7695	mlawry@isdh.in.gov
Rachel Kenny	Epidemiologist	317-233-8197	rkenny@isdh.in.gov
John O'Boyle	Law Enforcement Records Coordinator	317-233-7987	joboyle@isdh.in.gov
TBD	Records Consultant		



New

Rehabilitation Data Report

Email questions to: indianatrauma@isdh.in.gov



Indiana State
Department of Health

Let's go back in time...August 2012

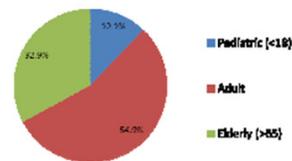
January 1, 2012 to March 31, 2012

8 Trauma Centers
16 (Non-Trauma) Hospitals

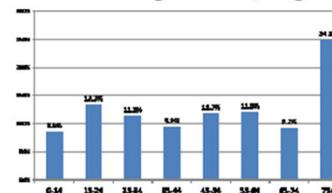
3,041 Incidents

24 Total Hospitals Reporting

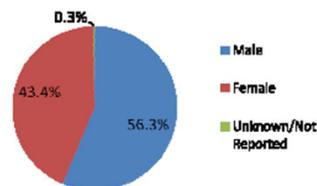
Patient Age



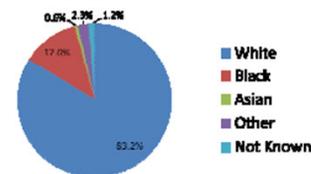
Patient Age Groupings



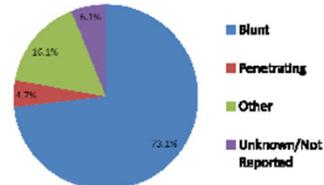
Patient Gender



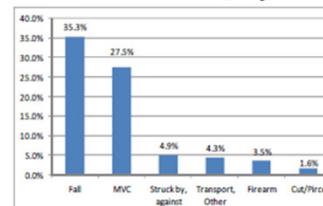
Patient Race



Trauma Type



Cause of Injury



* <1% COI: Bites/Stings, Pedal Cyclist (Other), Machinery, Fire/Burn, Pedestrian (Other)

Statewide Report

- 921 incidents
- December 2013 to November 2014
- 5 rehabilitation facilities reporting.



Indiana State
Department of Health

Email questions to: indianatrauma@isdh.in.gov

Rehabilitation Hospitals reporting to the Indiana Trauma Registry

- Community Health Network – Rehabilitation Facility
- Community Howard – West Campus Specialty Hospital
- Franciscan St. Elizabeth Health Acute Inpatient Rehabilitation – Central Campus
- Rehabilitation Hospital of Fort Wayne
- Rehabilitation Hospital of Indiana

Email questions to: indianatrauma@isdh.in.gov

Why is Rehabilitation Data Important?



Email questions to: indianatrauma@isdh.in.gov

Why is Rehabilitation Data Important?





Indiana's Trauma System



Why is Rehabilitation Data Important?



Email questions to: indianatrauma@isdh.in.gov

Why is Rehabilitation Data Important?



Email questions to: indianatrauma@isdh.in.gov

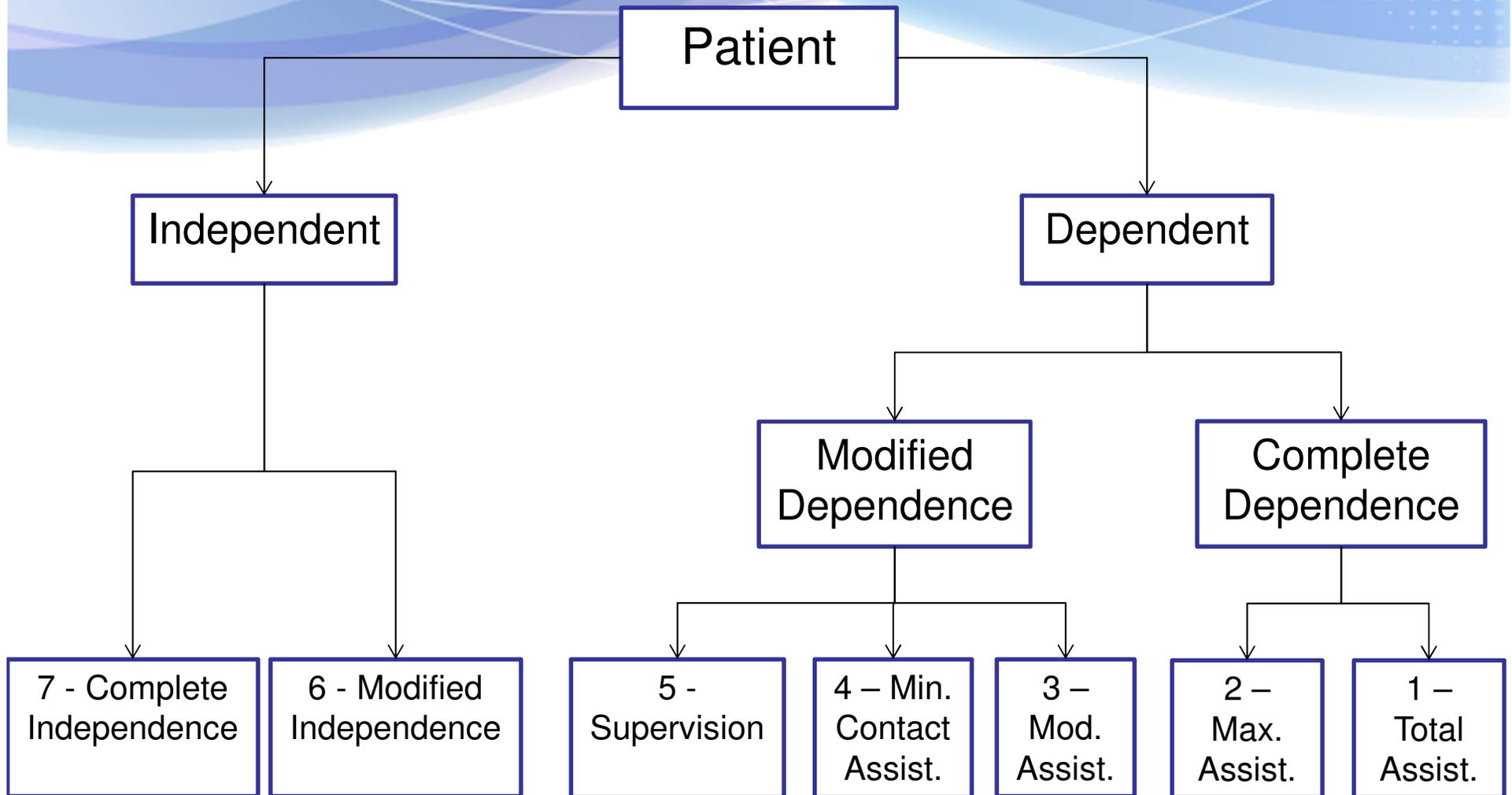
Functional Independence Measure (FIM™) Instrument

- Basic indicator of severity of disability.
- As the severity of the disability changes during rehabilitation, the data generated by the FIM instrument can be used to:
 - Track changes.
 - Analyze the outcomes of rehabilitation.
- The FIM instrument includes a seven-level scale that designates major gradations in behavior from dependence to independence.
- This scale rates patients on their performance of activity.
 - Takes into account their need for assistance from another person or a device.
 - If help is needed, the scale quantifies that need.
- The FIM instrument is a measure of disability, not impairment.

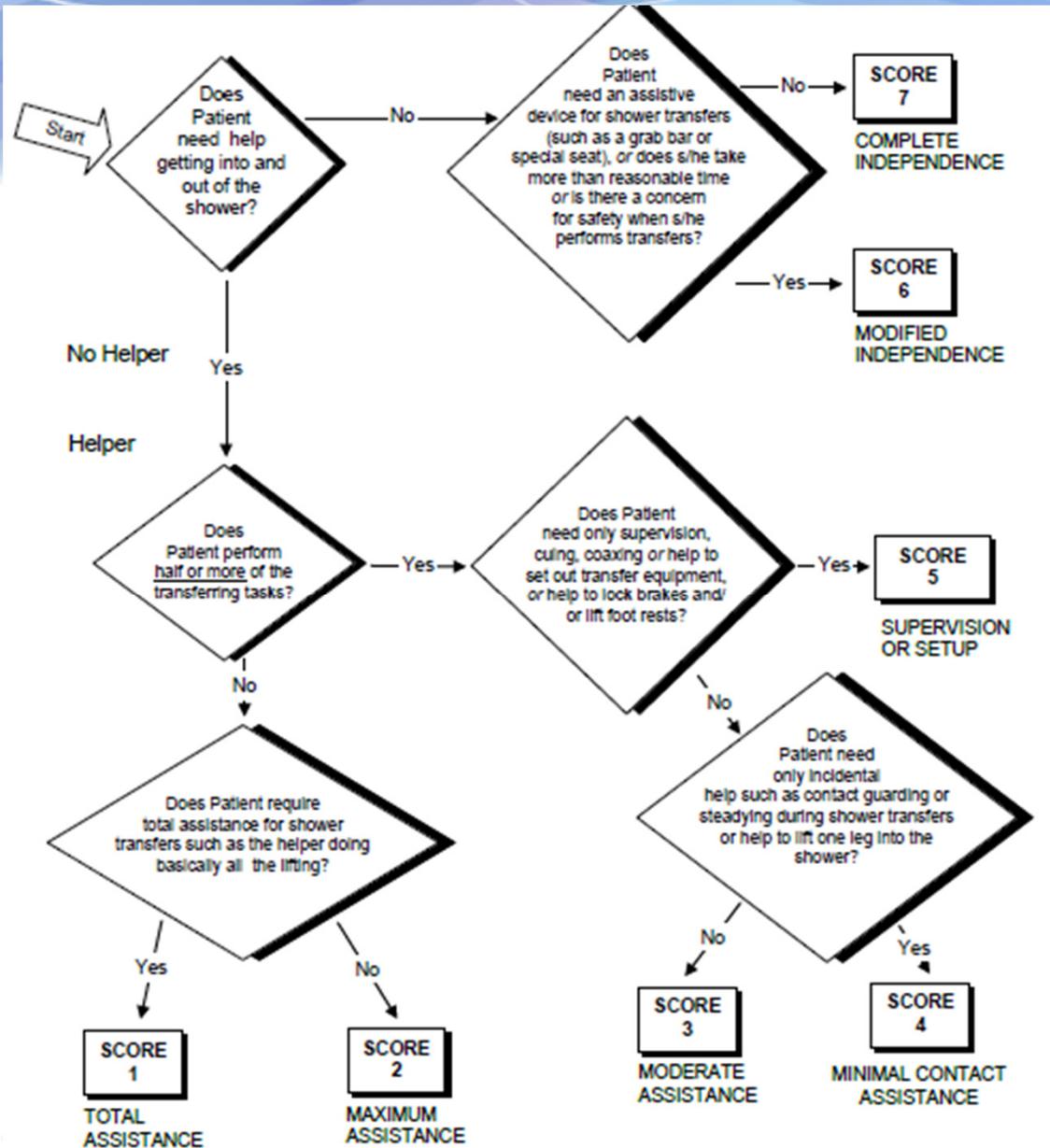
Function Modifiers

- Assist in the scoring of related FIM instrument items.
- Provide explicit information as to how a particular FIM item score has been determined.
- Examples of Function Modifiers:
 - Bladder Level of Assistance
 - Tub Transfer
 - Distance Traveled in Wheelchair

Function Modifiers (continued)



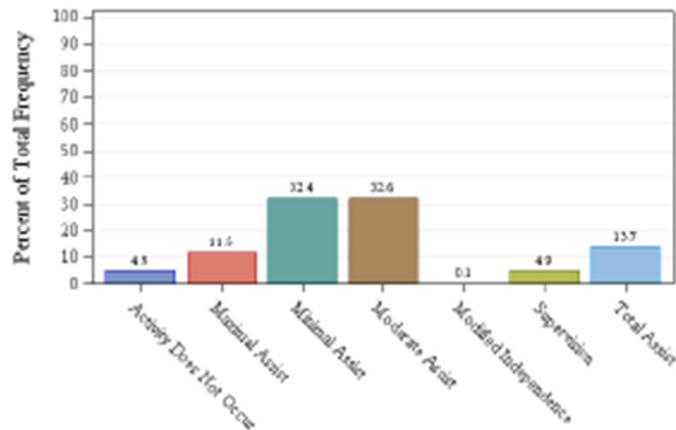
Function Modifiers (continued)



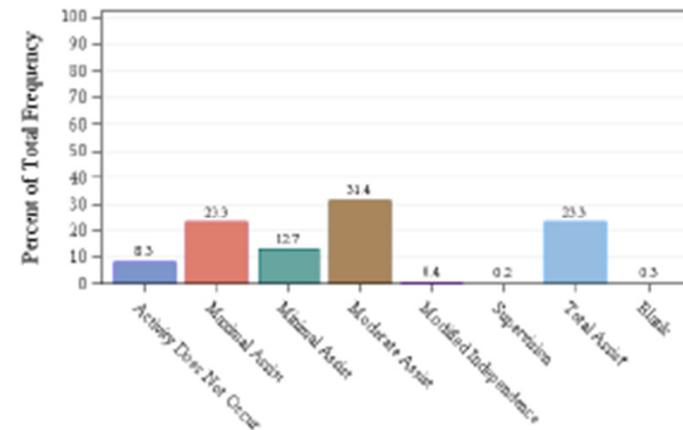
Admission Function Modifiers

Indiana State Department of Health-Indiana Rehabilitation Registry
 921 Incidents Statewide
 Data from September 2013 - September 2014

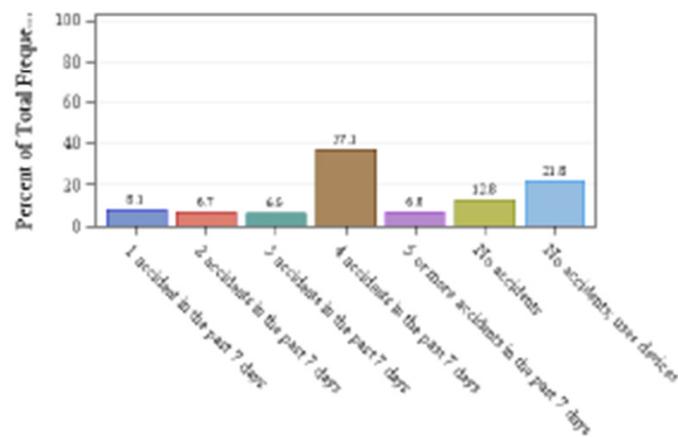
Admission - Bathing



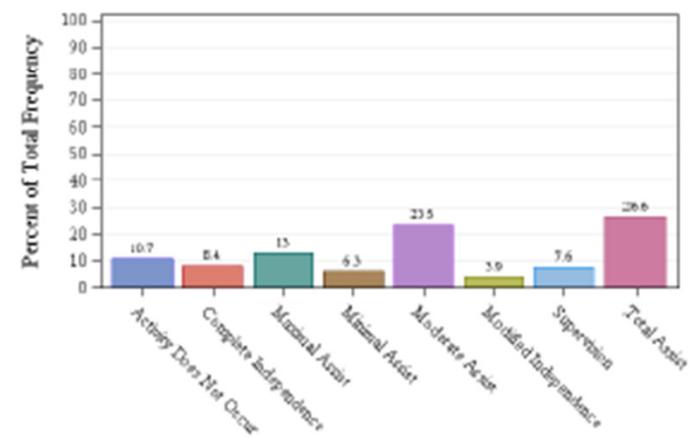
Admission - Bed to Chair



Admission - Bladder Frequency of Accidents



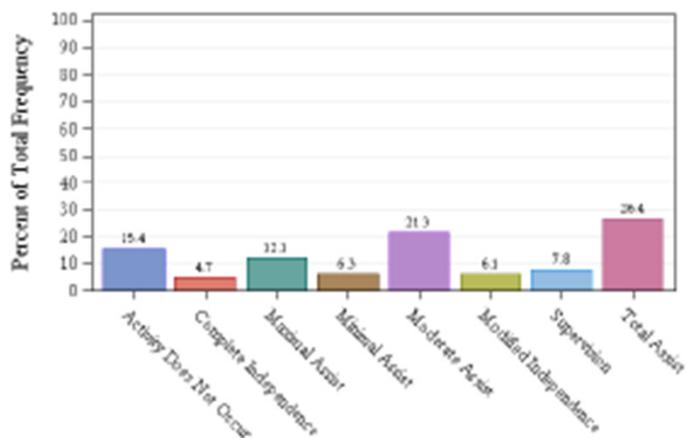
Admission - Bladder Level of Assistance



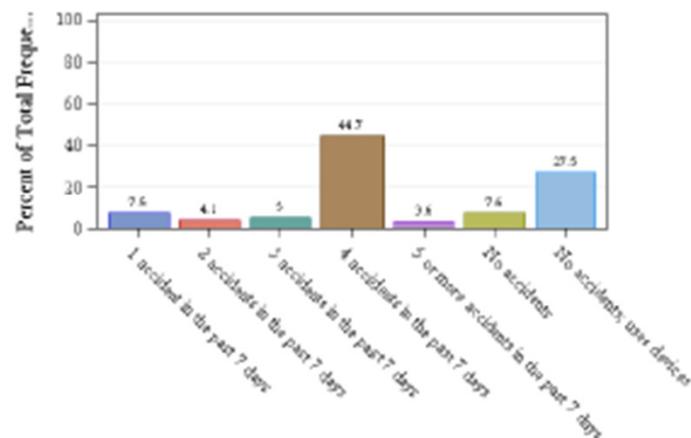
Admission Function Modifiers (continued)

Indiana State Department of Health-Indiana Rehabilitation Registry
 921 Incidents Statewide
 Data from September 2013 - September 2014

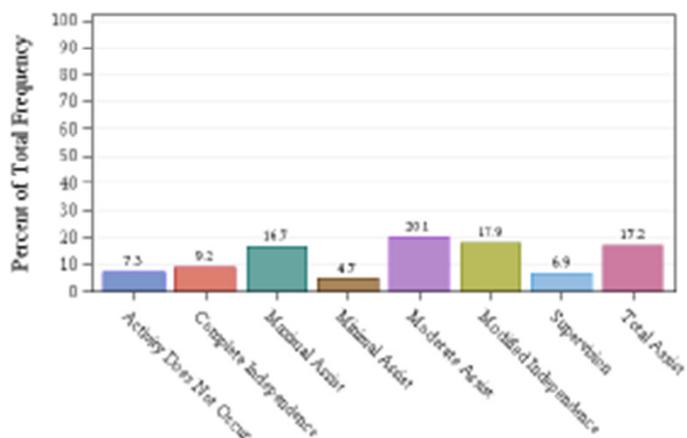
Admission - Bladder Management



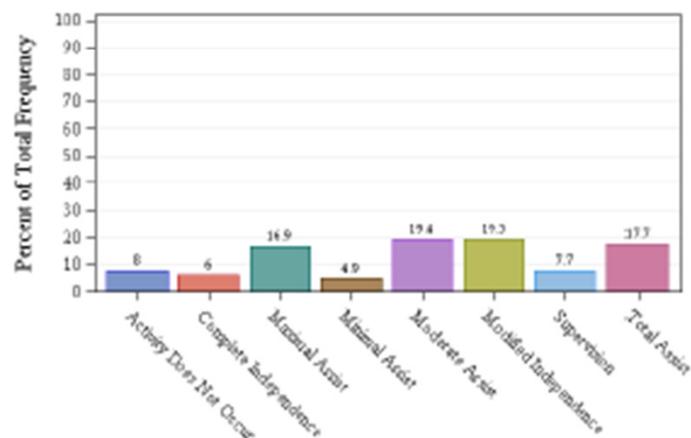
Admission - Bowel Frequency of Accidents



Admission - Bowel Level of Assistance

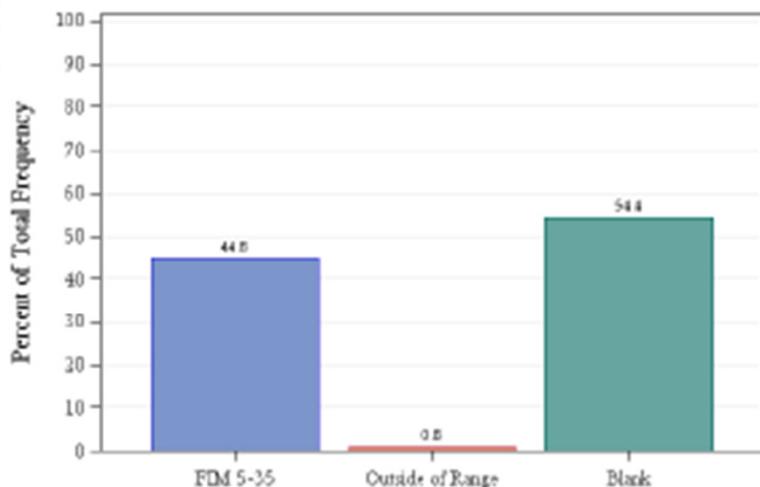


Admission - Bowel Management

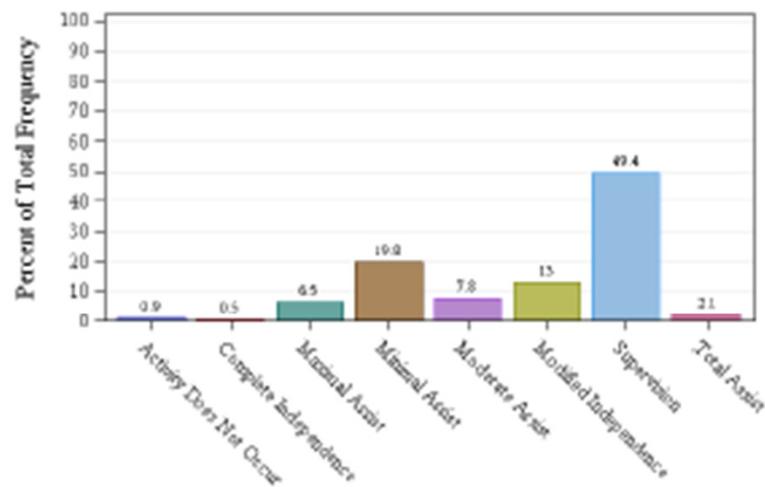


Admission Function Modifiers (continued)

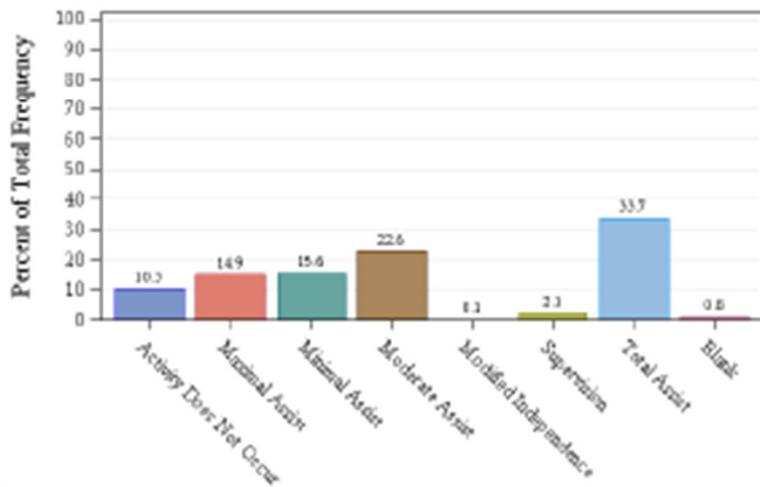
Admission - Cognitive FIM Score



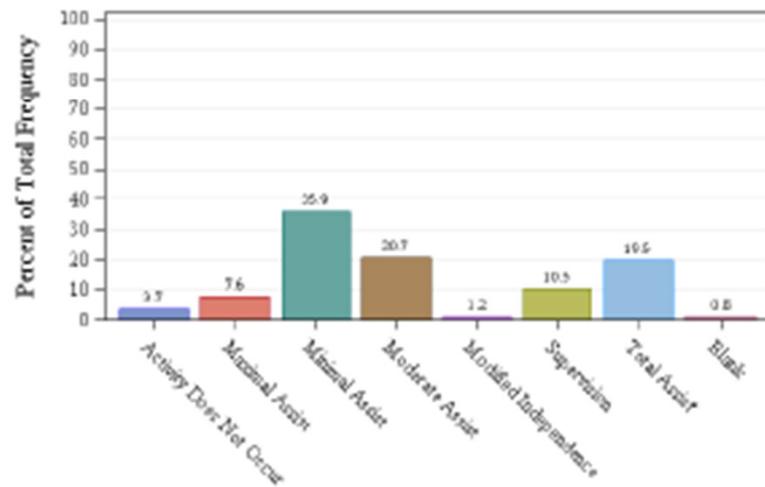
Admission - Comprehension



Admission - Dressing Lower Body

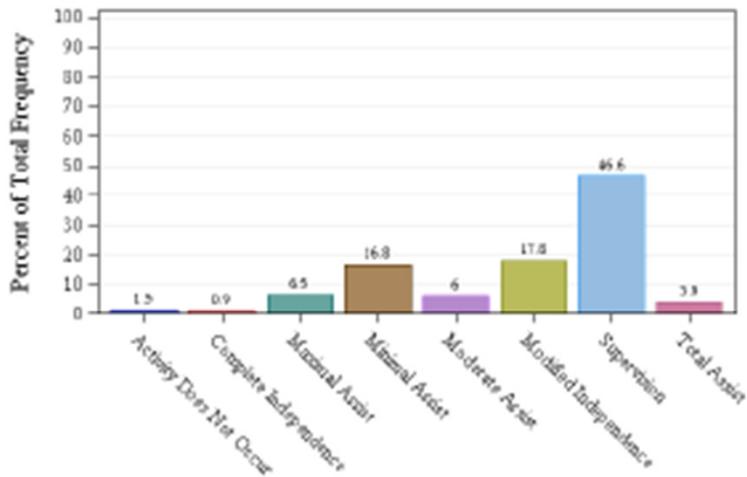


Admission - Dressing Upper Body

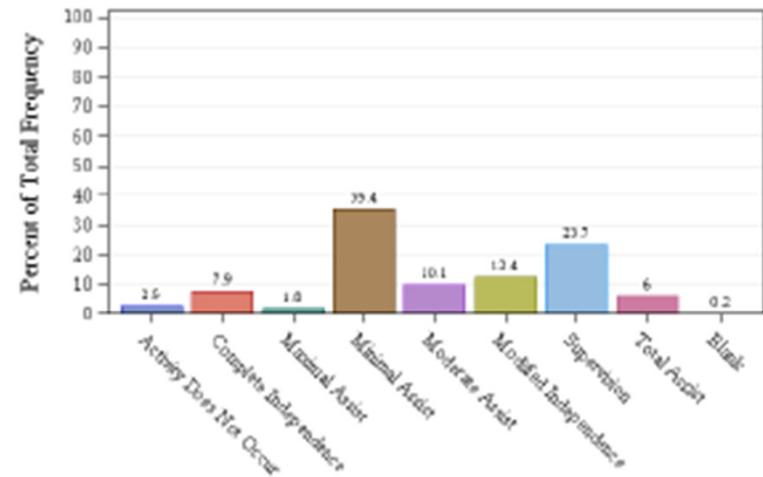


Admission Function Modifiers (continued)

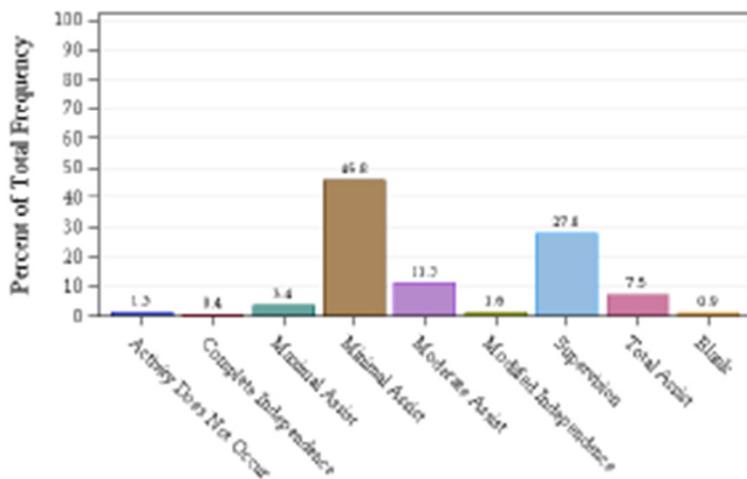
Admission - Expression



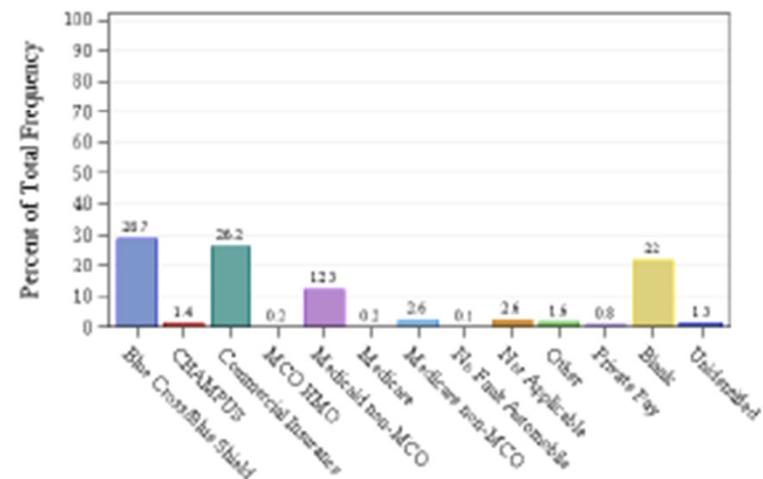
Admission - Feeding



Admission - Grooming

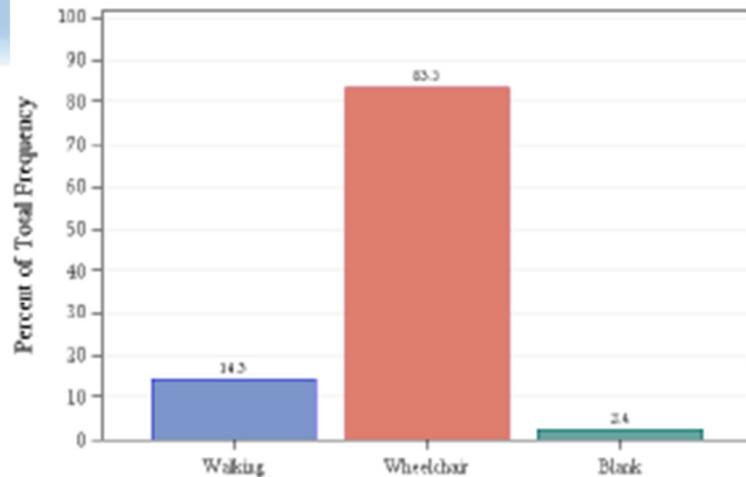


Secondary Billing Info

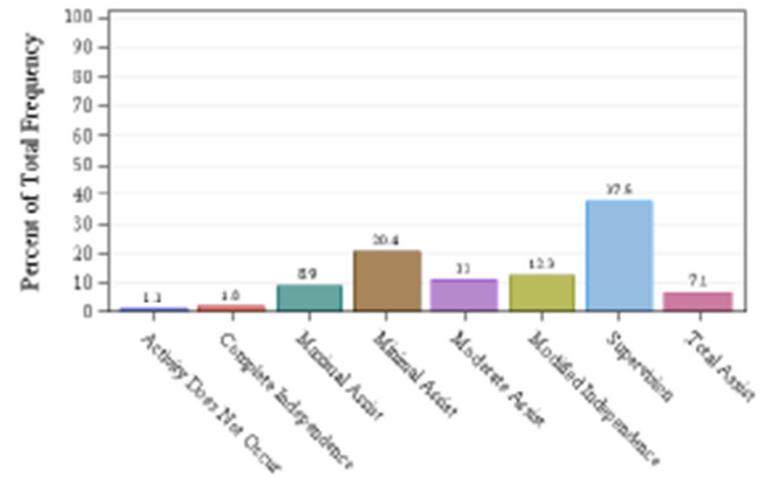


Admission Function Modifiers (continued)

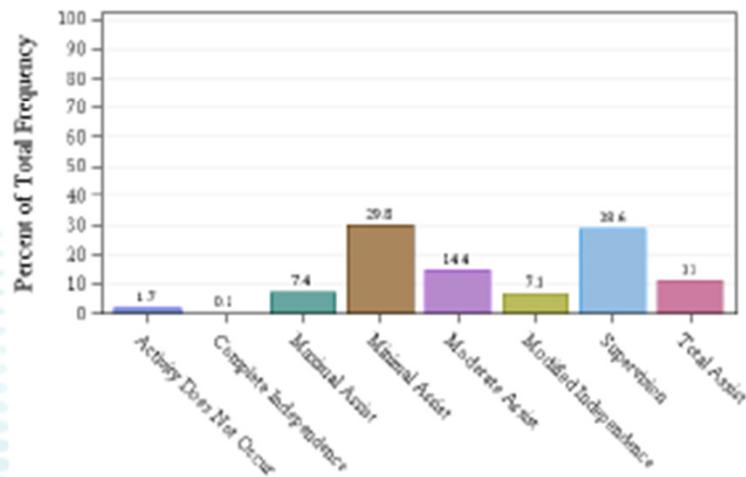
Admission - Locomotion Mode



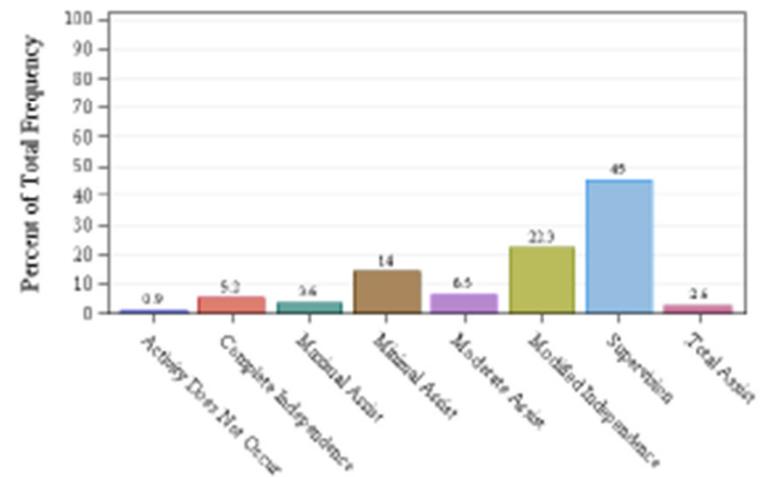
Admission - Memory



Admission - Problem Solving

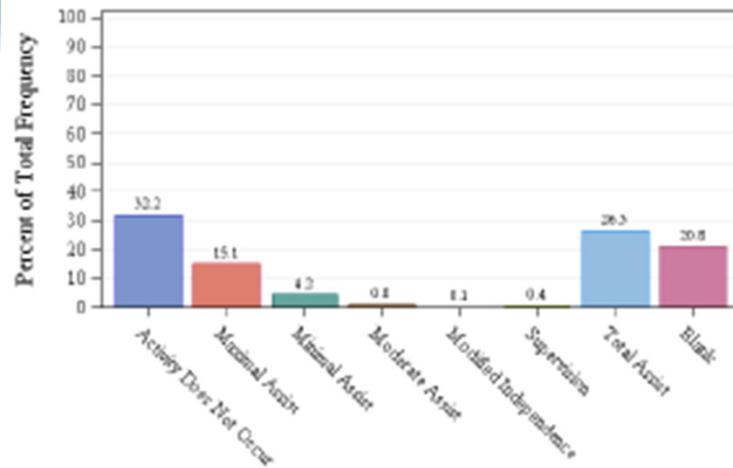


Admission - Social Interaction

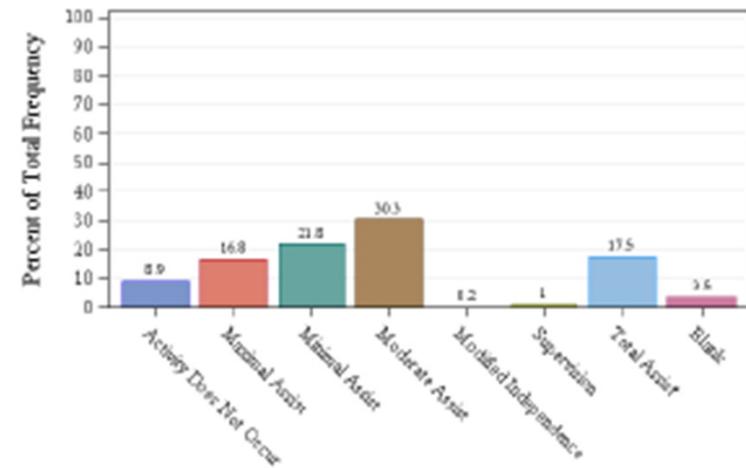


Admission Function Modifiers (continued)

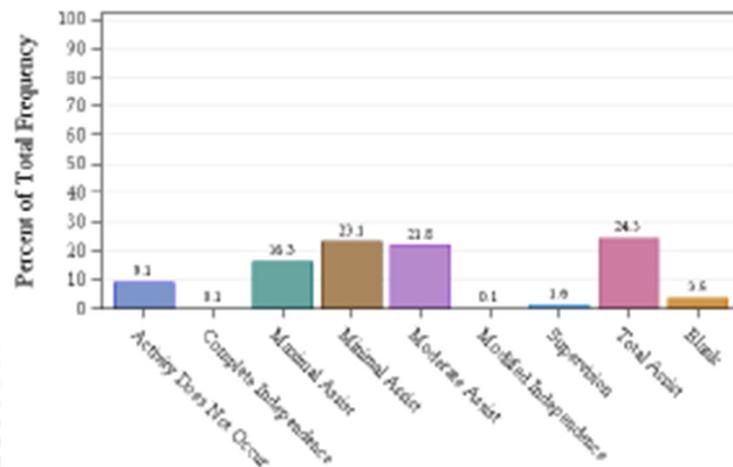
Admission - Stairs



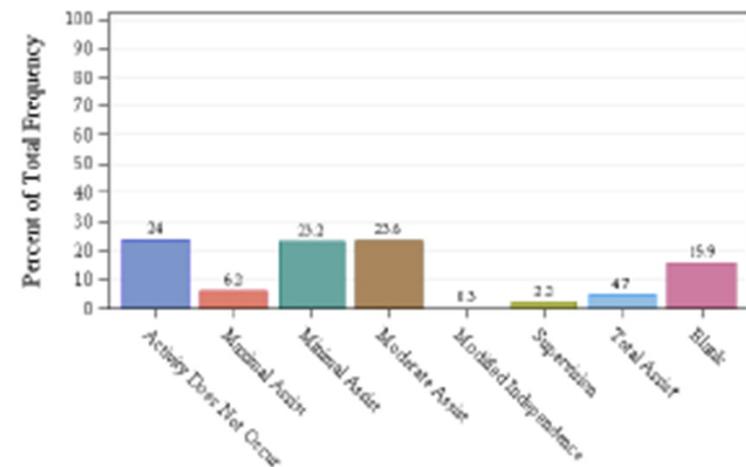
Admission - Toilet Transfers



Admission - Toileting

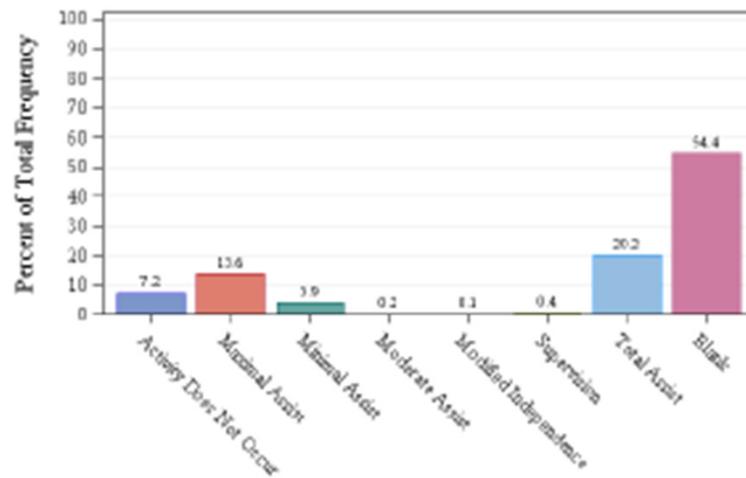


Admission - Tub or Shower

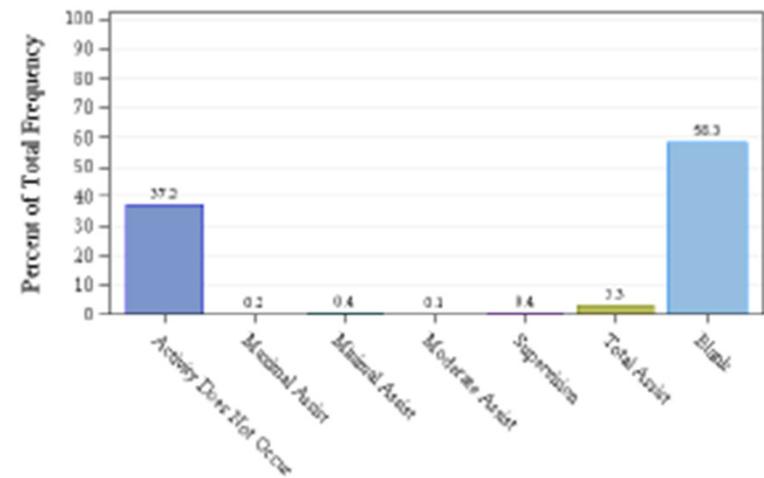


Admission Function Modifiers (continued)

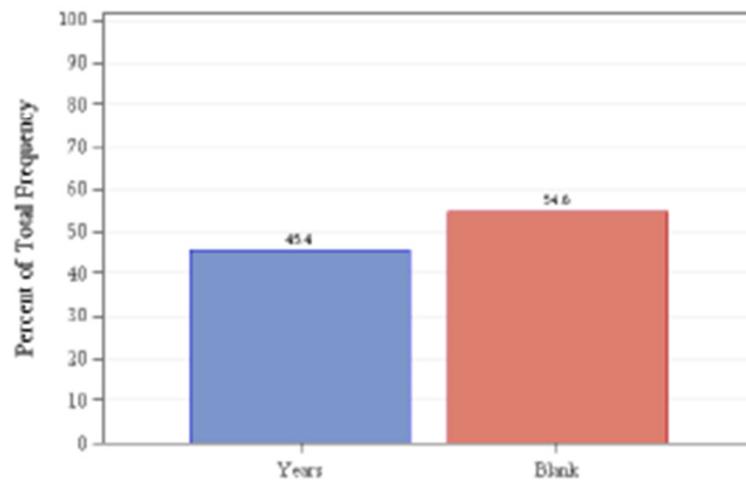
Admission - Walking



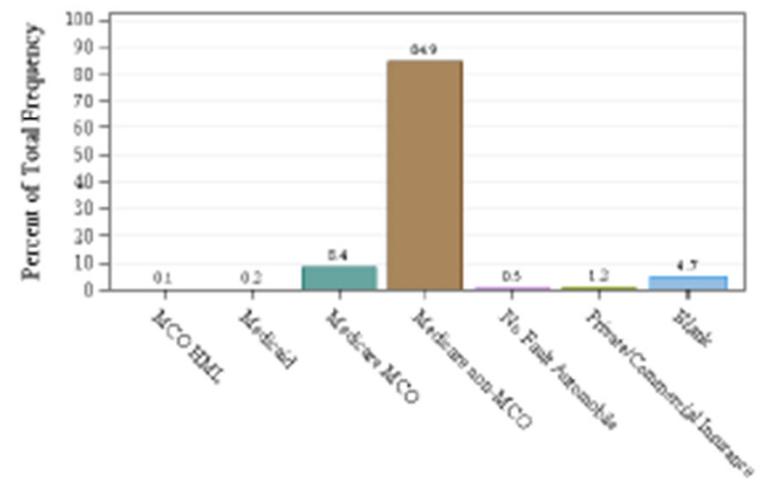
Admission - Wheelchair



Admission - Age Units

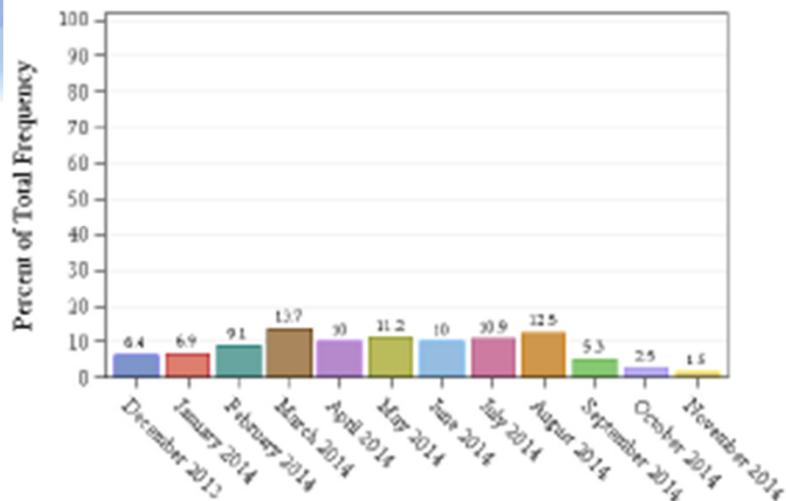


Billing Info

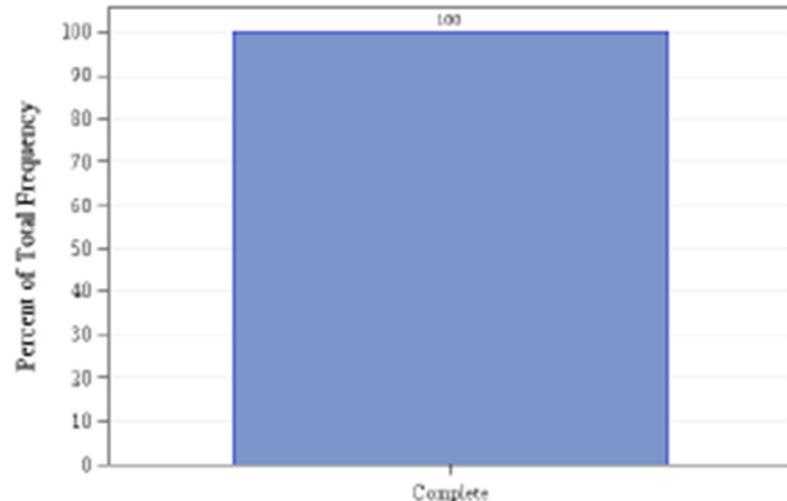


Discharge Function Modifiers (continued)

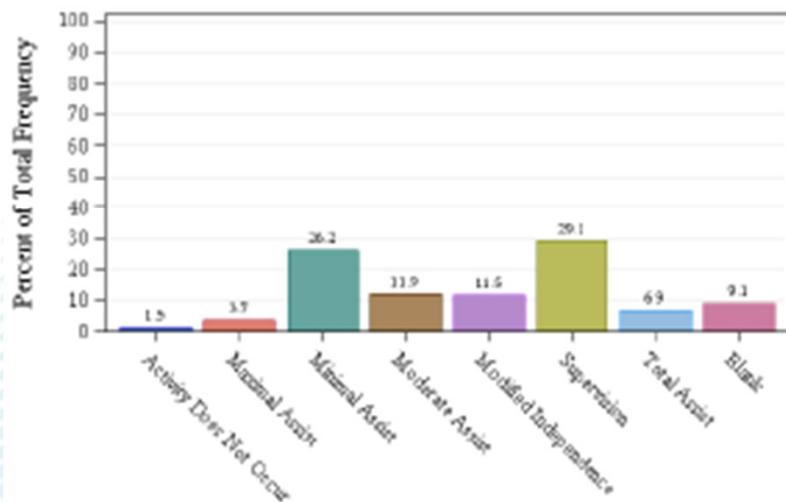
Date Arrived



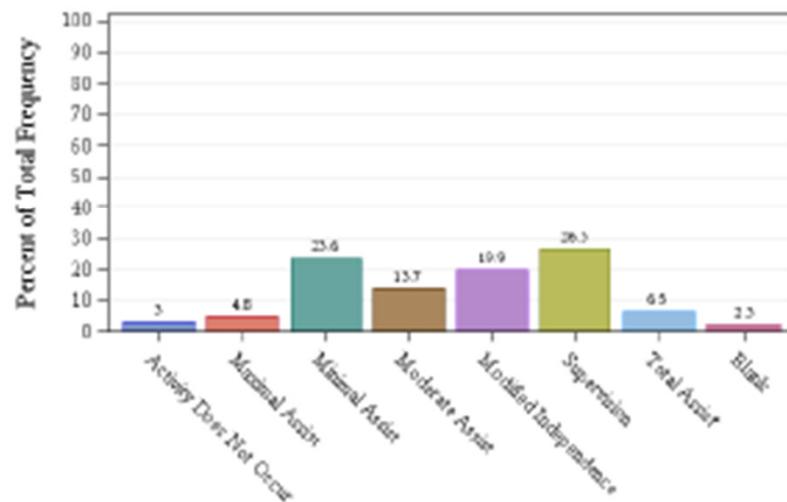
Date Of Birth



Discharge - Bathing

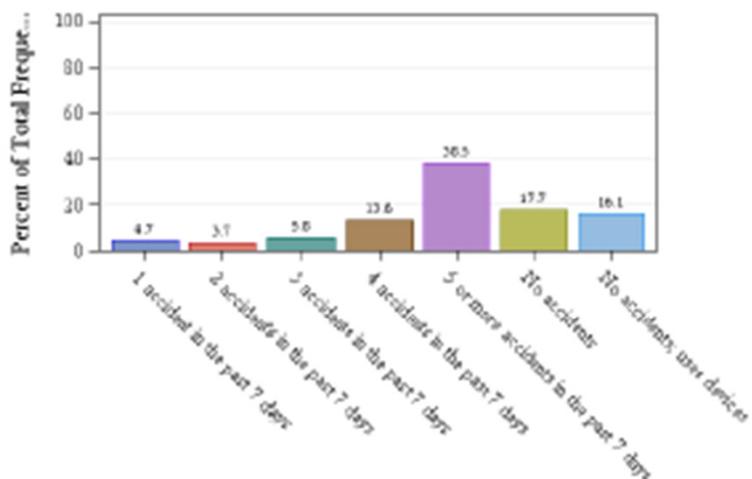


Discharge - Bed to Chair

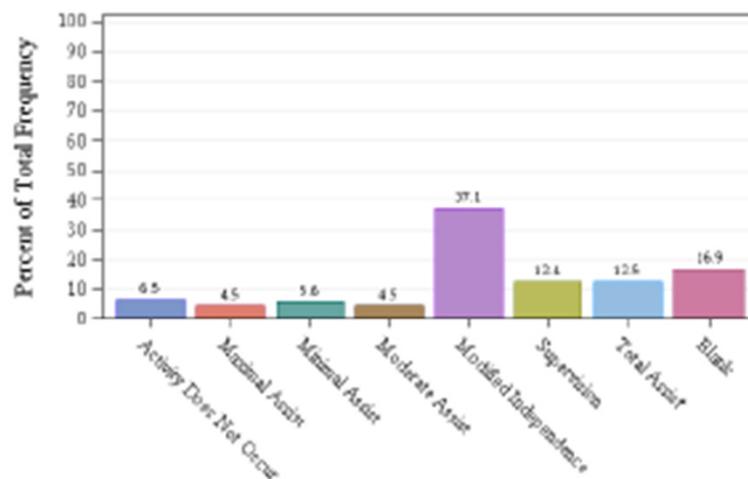


Discharge Function Modifiers (continued)

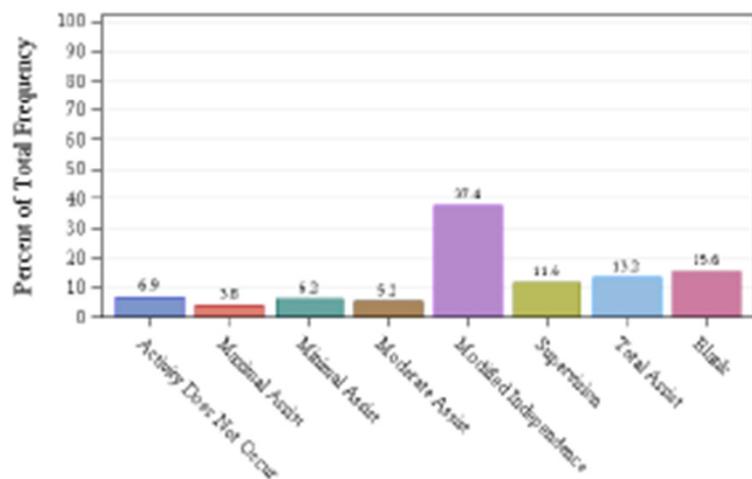
Discharge - Bladder Frequency of Accidents



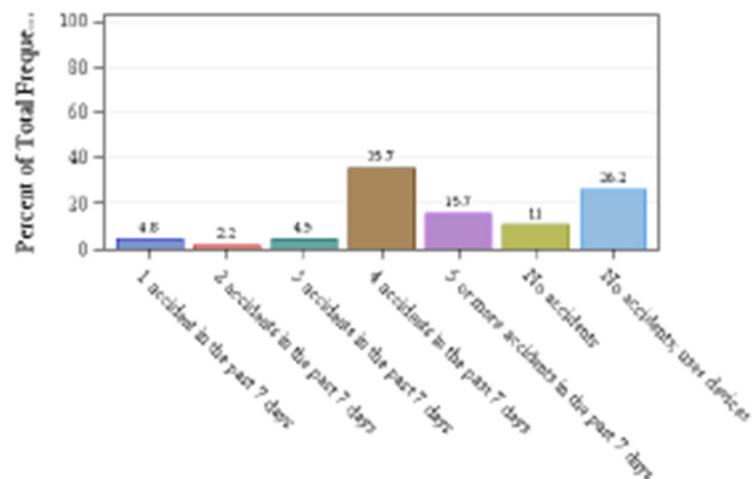
Discharge - Bladder Level of Assistance



Discharge - Bladder Management

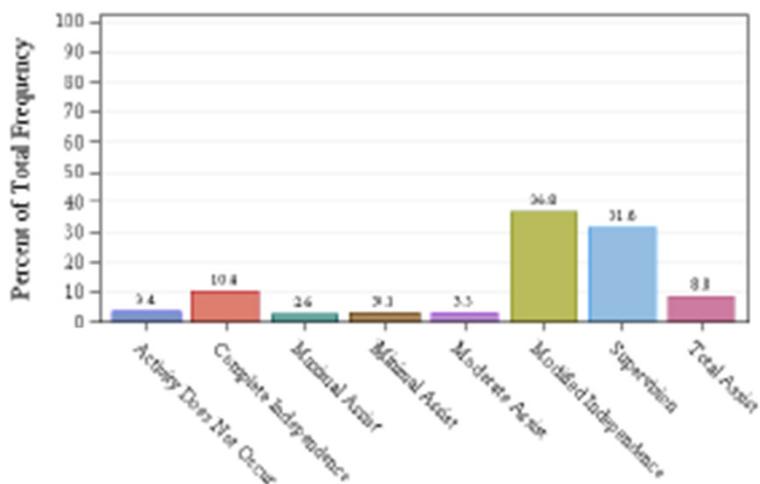


Discharge - Bowel Frequency of Accidents

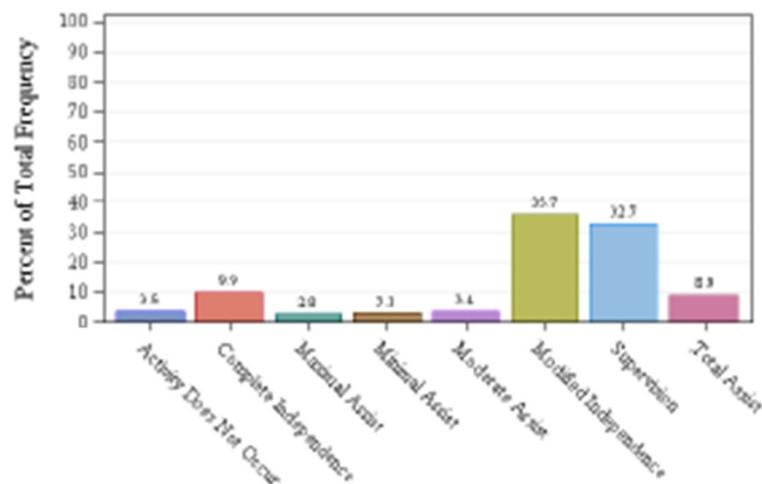


Discharge Function Modifiers (continued)

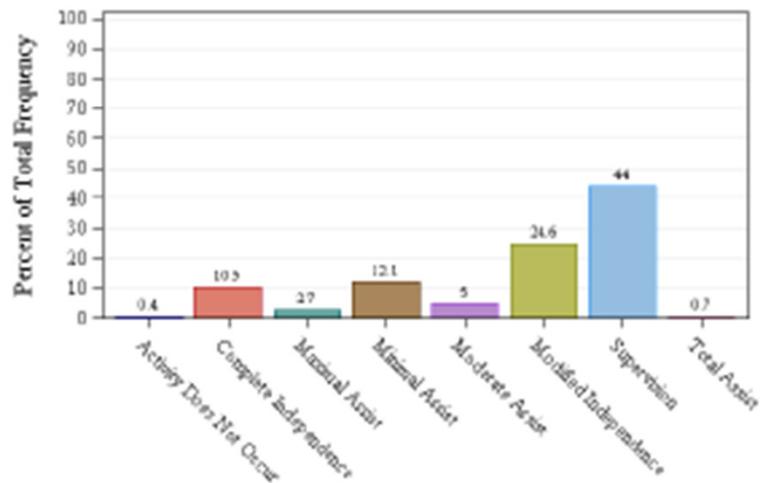
Discharge - Discharge - Bowel Level of Assistance



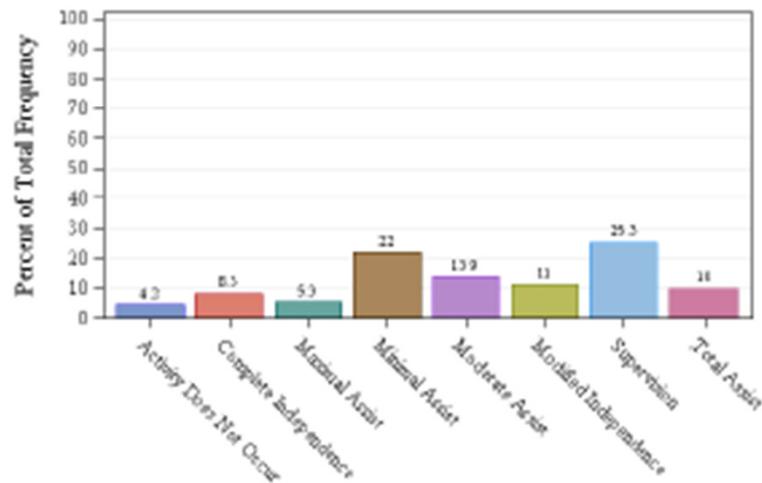
Discharge - Bowel Management



Discharge - Comprehension

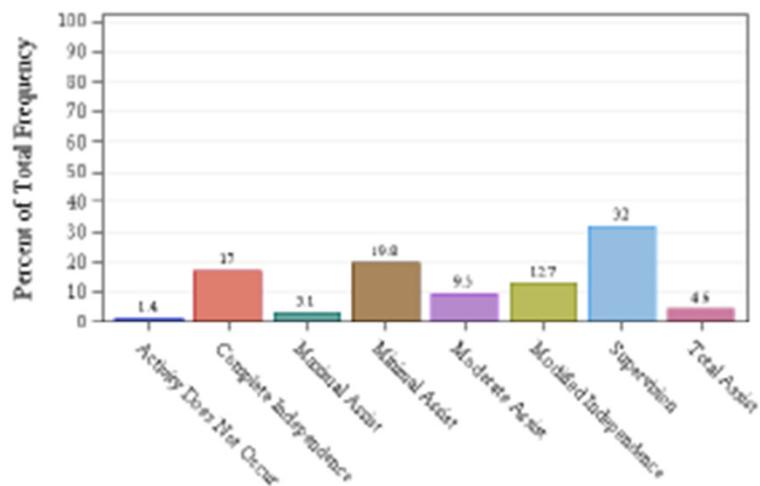


Discharge - Dressing Lower Body

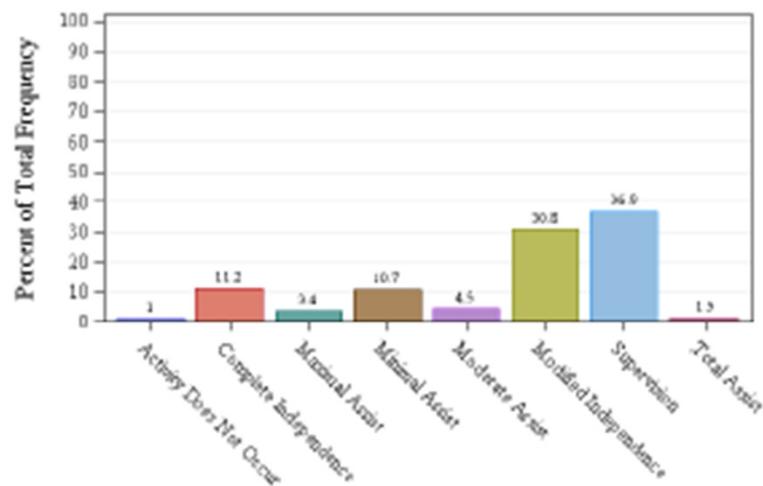


Discharge Function Modifiers (continued)

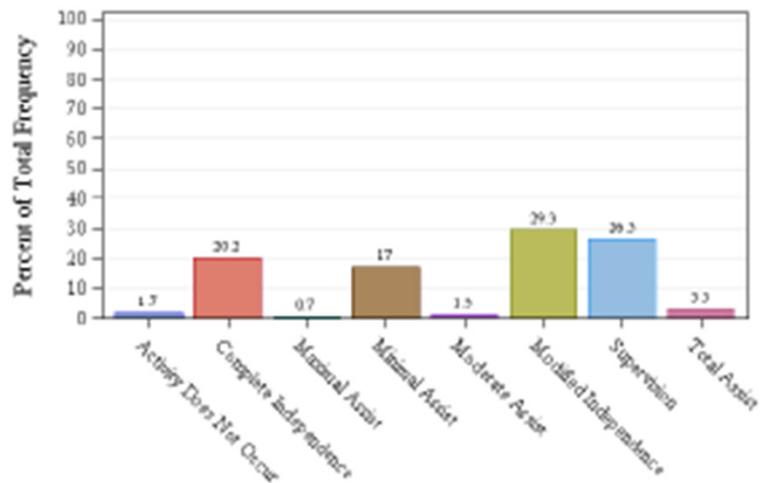
Discharge - Dressing Upper Body



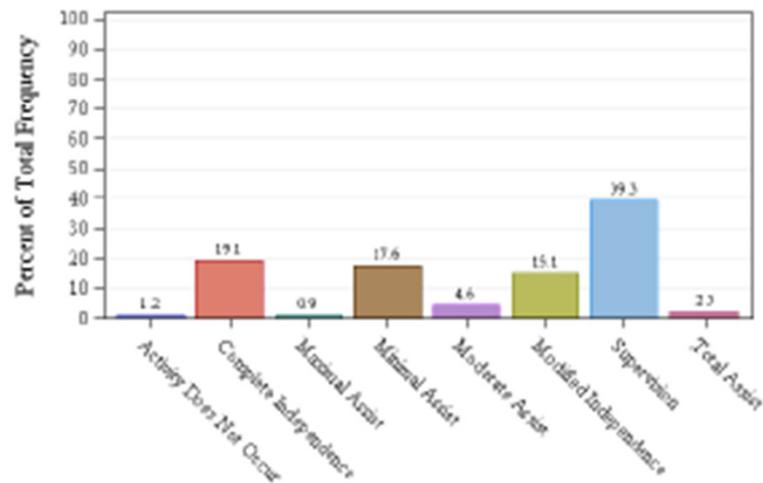
Discharge - Expression



Discharge - Feeding

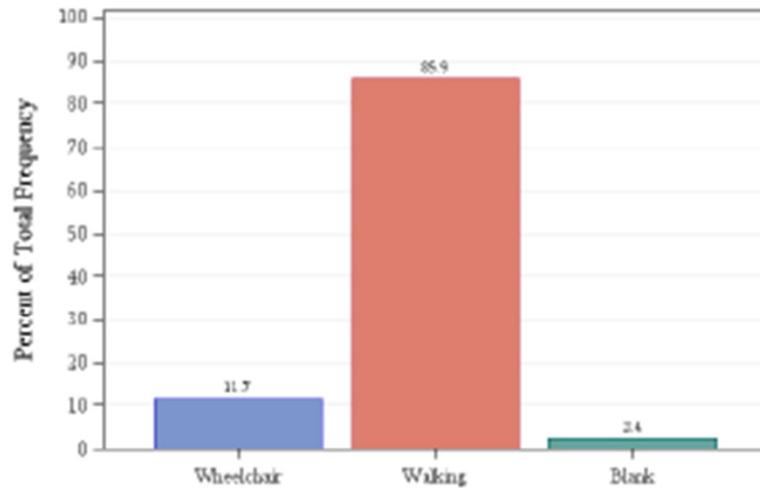


Discharge - Grooming

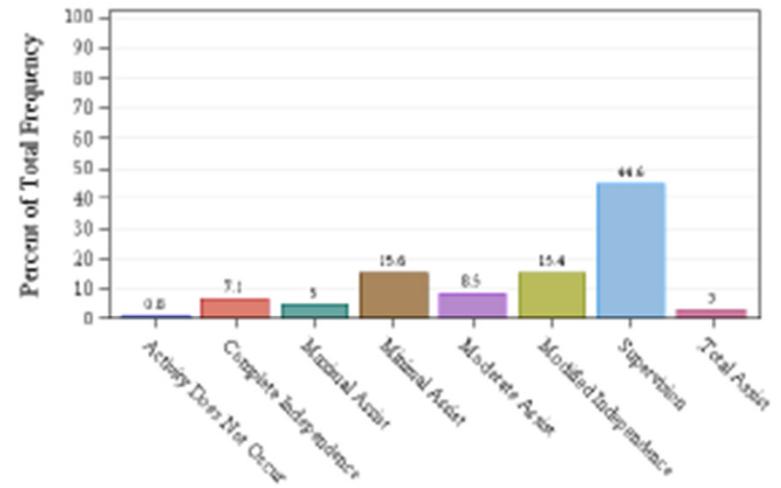


Discharge Function Modifiers (continued)

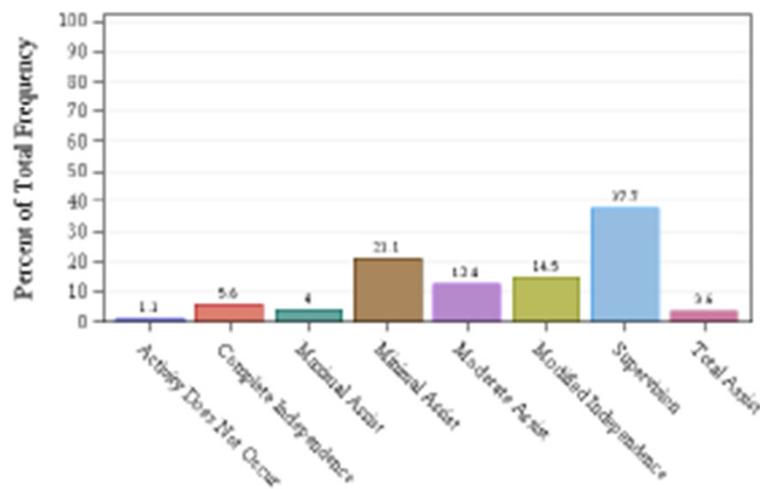
Discharge - Locomotion Mode



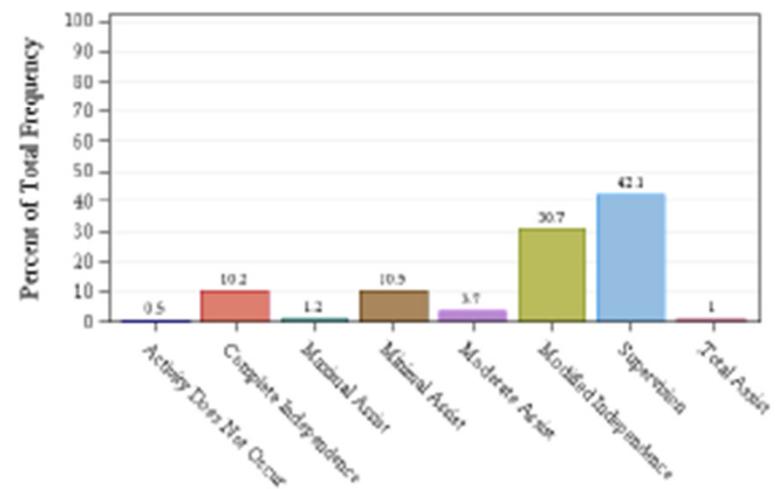
Discharge - Memory



Discharge - Problem Solving

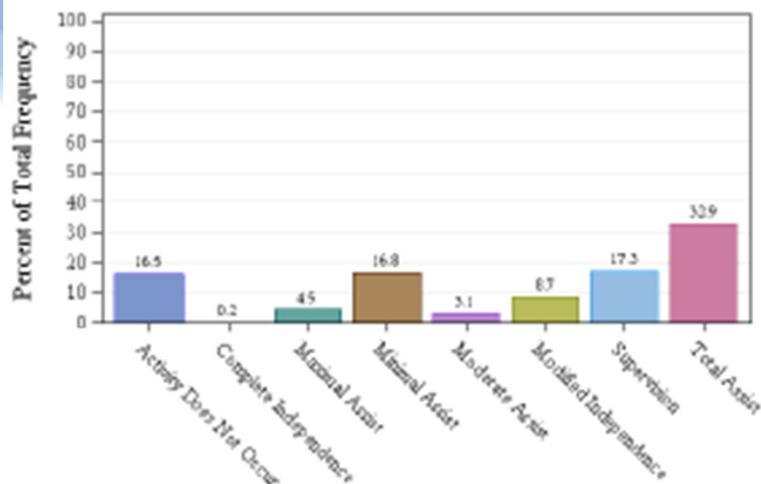


Discharge - Social Interaction

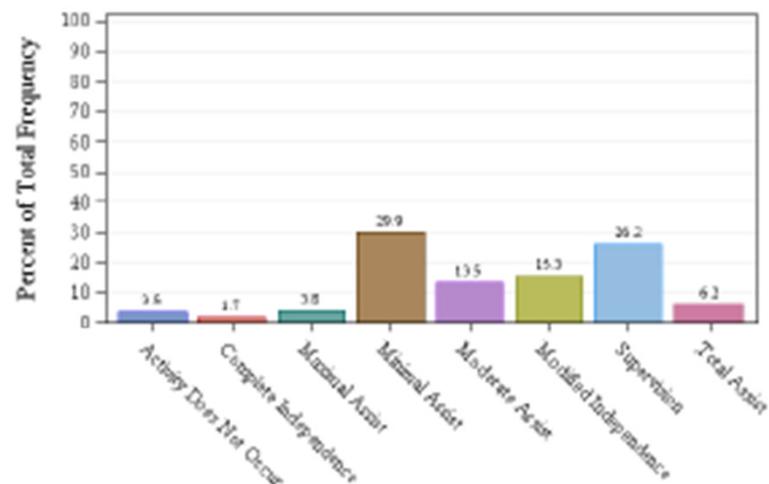


Discharge Function Modifiers (continued)

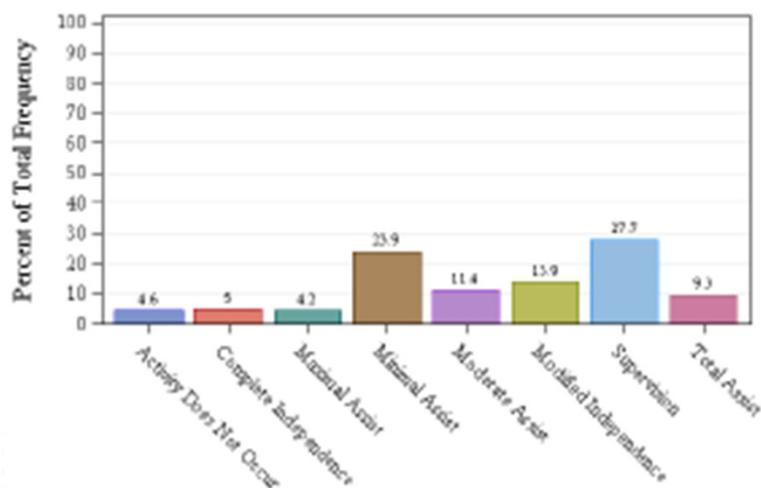
Discharge - Stairs



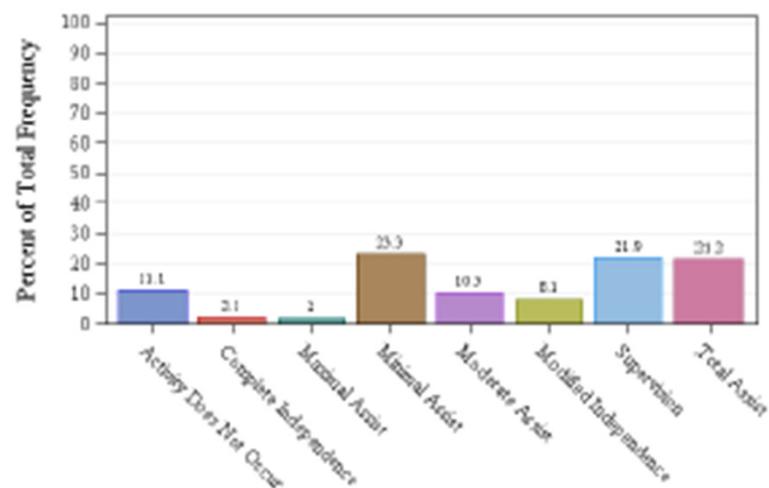
Discharge - Toilet Transfers



Discharge - Toileting

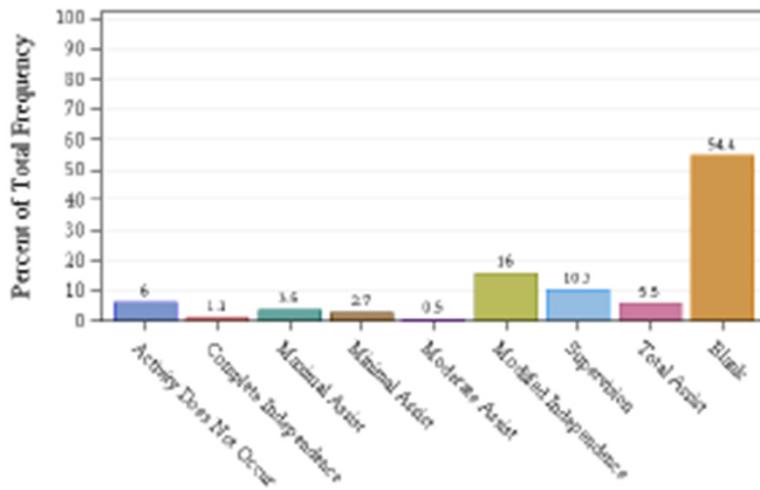


Discharge - Tub or Shower

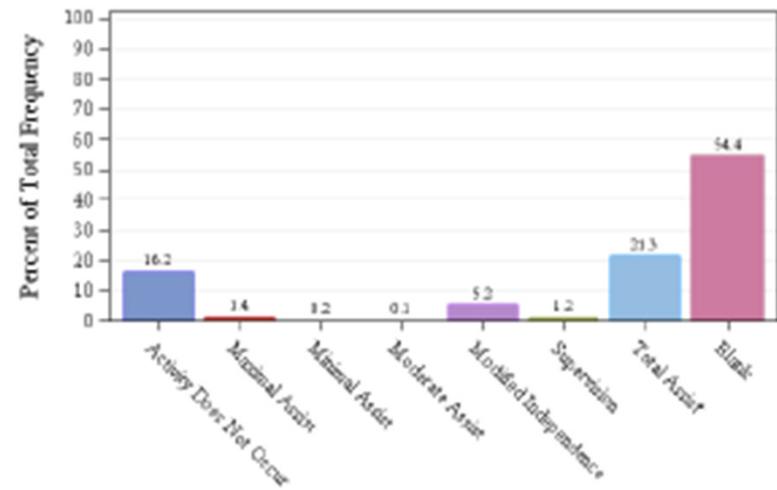


Discharge Function Modifiers (continued)

Discharge - Walking



Discharge - Wheelchair





PI Subcommittee Update

Dr. R. Lawrence Reed, *Trauma Medical Director*
IU Health – Methodist Hospital



Indiana State
Department of Health



Email questions to: indianatrauma@isdh.in.gov



Designation Subcommittee Update

Dr. Gerardo Gomez, MD, *Trauma Medical Director*
Eskenazi Health



Indiana State
Department of Health



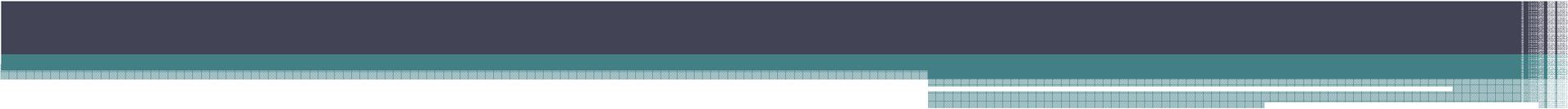
Email questions to: indianatrauma@isdh.in.gov

Trauma Center Designation Subcommittee Update

May 22, 2015

Gerardo Gomez, MD, FACS
Committee Chair

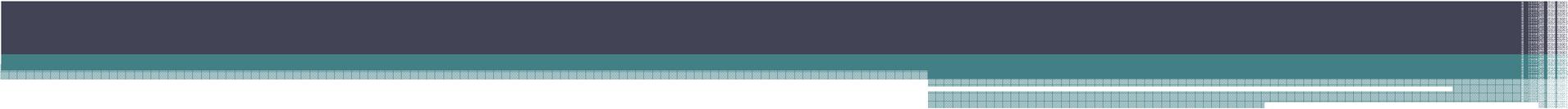
Dr. R. Lawrence Reed, Dr. Lewis Jacobson, Spencer Grover,
Wendy St. John, Jennifer Mullen, Lisa Hollister, Amanda
Elikofer, Katie Hokanson, Ramzi Nimry, Missy Hockaday, Teri
Joy, Art Logsdon, Judy Holsinger, Jennifer Conger.



American College of Surgeons Resources

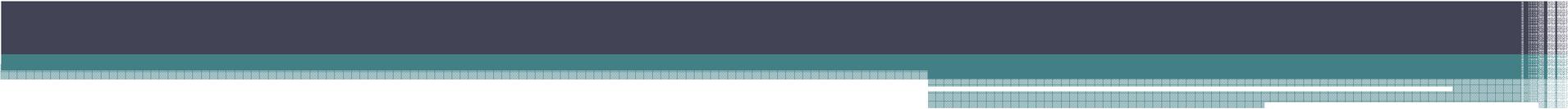
- Resources for Optimal Care of the Injured Patient 2014/Resources Repository
 - <https://www.facs.org/quality-programs/trauma/vrc/resources>
- Interim PRQ 2014 (for visits scheduled after July 1, 2015)
- Clarification Document





2015 Trauma Center Designation Subcommittee Meetings

- January 28, 2015
- April 20, 2015
- Meeting minutes available on-line:
 - <http://www.state.in.us/isdh/25400.htm>



Trauma Center Designation Subcommittee

- Developed One Year Progress Report for in-process trauma centers (Level I, II, III)
- Revised Level III application and One Year Progress Report for in-process level III trauma centers
- Drafted Level II revised application and One Year Progress Report for in-process level II trauma centers

In-process Indiana Level III Trauma Centers

Facility Name	“In the Process” Date*	1 Year Review Date**	ACS Consultation Visit Date	ACS Verification Visit Date
IU Health – Ball Memorial	08/16/2013	N/A	06/2013	05/15-05/16, 2014
Franciscan St. Elizabeth East Lafayette	12/20/2013	02/20/2015	02/12-02/13, 2015	<i>Tentative:</i> September 2015
St. Vincent Anderson	12/20/2013	02/20/2015	11/12-11/13, 2014	<i>Tentative:</i> November 2015
IU Health – Arnett	02/14/2014	N/A	04/30-05/01, 2013	04/29-04/30, 2014
Community Hospital Anderson	06/20/2014	08/21/2015	TBD	TBD
Good Samaritan - Vincennes	06/20/2014	08/21/2015	05/19-05/20, 2015	TBD
Community East	08/20/2014	10/30/2015	TBD	TBD
Community North	08/20/2014	10/30/2015	TBD	TBD
Community South	08/20/2014	10/30/2015	TBD	TBD
Methodist Northlake	08/20/2014	10/30/2015	TBD	TBD

*Date the EMS Commission granted the facility “In the process” status

**Date the Indiana State Trauma Care Committee reviewed the 1 year review documents

Facility is no longer “In the Process” and is an officially ACS Verified trauma center

APPLICATION FOR "IN THE ACS VERIFICATION PROCESS" LEVEL II TRAUMA CENTER STATUS

Part of State Form 55271 (R / 2-15)

Hospitals that wish to apply for status as an "in the ACS verification process" Level II Trauma Center must provide sufficient documentation for the Indiana Emergency Medical Services Commission to conclude that your hospital complies with each of the following requirements:

1. **A Trauma Medical Director** who is Board-Certified, or Board-Eligible, or an American College of Surgeons Fellow. This is usually a general surgeon who participates in trauma call and is current in Advanced Trauma Life Support (ATLS). The Trauma Medical Director must be dedicated to one (1) hospital.
2. **A full-time Trauma Program Manager:** This person is usually a registered nurse and must show evidence of educational preparation, with a minimum of sixteen (16) hours (internal or external) of trauma-related continuing education per year and clinical experience in the care of injured patients.
3. **Submission of trauma data to the State Registry:** The hospital must be submitting data to the Indiana Trauma Registry following the Registry's data dictionary data standard within thirty (30) days of application and at least quarterly thereafter.
4. **A Trauma Registrar:** This is someone who abstracts high-quality data into the hospital's trauma registry and works directly with the hospital's trauma team. This position is managed by the Trauma Program Manager.
5. **Tiered Activation System:** There must be a clearly defined Tiered Activation System that is continuously evaluated by the hospital's Performance Improvement and Patient Safety (PIPS) program.
6. **Trauma Surgeon on call:** The surgeon must be dedicated to the trauma center while on call. Supporting documentation for this requirement must also include a written letter of commitment signed by all surgeons of the hospital that the scheduled Trauma Surgeon will be dedicated to the trauma center. There must also be evidence provided that a Trauma Surgeon is a member of the hospital's disaster committee. A roster of the membership of the disaster committee must be provided.
7. **Trauma Surgeon response times:** Evidence must be submitted that response times for the Trauma Surgeon are as defined by the Optimal Resources document of the American College of Surgeons. A published back-up schedule for trauma surgery must also be available and provided as part of the documentation. Also, there must be a written letter of commitment to the center's Trauma Surgeon response times, signed by the Trauma Medical Director, that is included as part of the hospital's application.
8. **In-house Emergency Department physician coverage:** The Emergency Department must have a designated emergency physician director, supported by an appropriate number of additional physicians to ensure immediate care for injured patients.
9. **Orthopedic Surgery:** There must be a written letter of commitment, signed by orthopedic surgeons and the Trauma Medical Director, that Orthopedic Surgery team members have dedicated call at the hospital. There must also be a back-up Orthopedic Surgery call schedule that is provided as part of this application.
10. **Neurosurgery:** Neurosurgery must be promptly available twenty four (24) hours per day for severe traumatic brain injury and spinal cord injury, as well as for less severe head and spine injuries. A back-up call schedule must also be available with formally arranged contingency plans in case the capability of the neurosurgeon, hospital or system to care for neurotrauma patients is overwhelmed. The documentation must include a letter of commitment signed by neurosurgeons and the Trauma Medical Director that neurosurgeons are available to the trauma center twenty four (24) hours per day.
11. **Trauma Operating room, staff and equipment:** There must be prompt availability of a Trauma Operating Room (OR), an appropriately staffed and readily available OR team, essential equipment (including equipment needed for a craniotomy) and anesthesiologist services twenty four (24) hours per day. The application must also include a list of essential equipment available to the OR and its staff.
12. **Critical Care physician coverage:** Physicians must be capable of a rapid response to deal with urgent problems as they arise in critically ill trauma patients. Level II trauma centers must have prompt availability of Critical Care physician coverage twenty four (24) hours per day. Supporting documentation must include a signed letter of commitment and proof of physician coverage twenty four (24) hours a day.

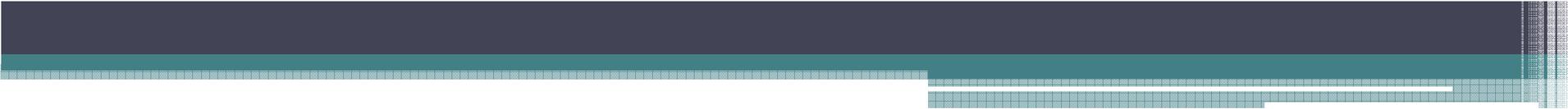
APPLICATION FOR "IN THE ACS VERIFICATION PROCESS" LEVEL II TRAUMA CENTER STATUS

(continued)

13. **CT scan and conventional radiography:** There must be twenty four (24) hour availability of CT scan and conventional radiography capabilities. Level II trauma centers must show documentation of multiple CT scan machine capabilities and a written letter of commitment from the hospital's Chief of Radiology.
14. **Interventional radiology:** There must be twenty four (24) hour availability of interventional radiology (conventional catheter angiography and sonography) and a written letter of commitment signed by the Chief of Radiology.
15. **Intensive care unit:** There must be an intensive care unit with patient/nurse ratio not exceeding 2:1 and appropriate resources that include intracranial pressure monitoring equipment to resuscitate and monitor injured patients, all of which are available twenty four (24) hours per day.
16. **Blood bank:** A blood bank must be available twenty four (24) hours per day with the ability to type and crossmatch blood products, with adequate amounts of packed red blood cells (PRBC), fresh frozen plasma (FFP), platelets, cryoprecipitate and other proper clotting factors to meet the needs of injured patients. The facility must also have the capability for coagulation studies, blood gases, and microbiology twenty four (24) hours per day.
17. **Laboratory services:** There must be laboratory services available twenty four (24) hours per day.
18. **Post-anesthesia care unit:** The post-anesthesia care unit (PACU) must have qualified nurses and necessary equipment twenty four (24) hours per day. Documentation for this requirement must include a list of available equipment in the PACU.
19. **Relationship with an organ procurement organization (OPO):** There must be written evidence that the hospital has an established relationship with a recognized OPO. There must also be written policies for triggering of notification of the OPO.
20. **Diversion policy:** The hospital must provide a copy of its diversion policy and affirm that it will not be on diversion status more than five percent (5%) of the time. The hospital's documentation must include a record for the previous year showing dates and length of time for each time the hospital was on diversion.
21. **Operational process performance improvement committee:** There must be a trauma program operational process performance improvement committee and documentation must include a roster of the committee and meeting times for the previous year.
22. **Nurse credentialing requirements:** Briefly describe credentialing requirements for nurses who care for trauma patients in your Emergency Department, ICU and PACU.
23. **Commitment by the governing body and medical staff:** There must be separate written commitments by the hospital's governing body and medical staff to establish a Level II Trauma Center and to pursue verification by the American College of Surgeons within one (1) year of this application and to achieve ACS verification within two (2) years of the granting of "in the ACS verification process" status. Further, the documentation provided must include recognition by the hospital that if it does not pursue verification within one (1) year of this application and/or does not achieve ACS verification within two (2) years of the granting of "in the ACS verification process" status that the hospital's "in the ACS verification process" status will immediately be revoked, become null and void and have no effect whatsoever.

Level II Trauma Center Application and One Year Progress Report Proposed Revisions

- Draft revisions of the Application for “in the process” Level II Trauma Center status and One year progress report for “in the process” Level II Trauma Center
 - Emailed to Indiana State Trauma Care Committee on May 12, 2015
 - Documents posted online:
<http://www.state.in.us/isdh/25400.htm>

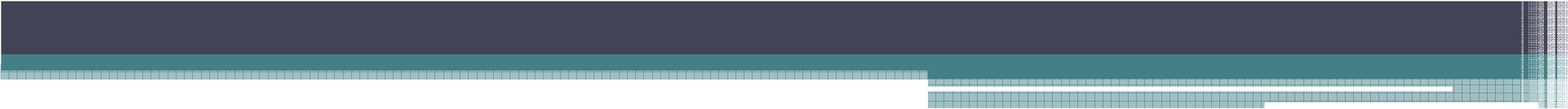


Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Trauma Medical Director
 - Eligible for board certification
 - The Trauma Medical Director must be appointed six months before the “in the process” application can be submitted.

Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Trauma Medical Director documentation required:
 - Current ATLS certificate. Physician must have successfully completed course prior to application.
 - Trauma Medical Director’s full CV.
 - Guideline/policy/contract that states Medical Director is dedicated to only one facility.
 - Copy of past 3 months call rosters documenting Trauma Medical Director’s activity on call panel.
 - Copy of board certification, ACS Fellow status, or eligible for board certification documentation for Trauma Medical Director.
 - Documentation of attendance to at least three trauma operation meetings. Meetings must be at least one month apart.
 - Documentation of attendance to at least three peer review meetings. Meetings must be at least one month apart.
 - 16 hours of external, trauma-related CME’s obtained in the 12 months prior to submission of the application.

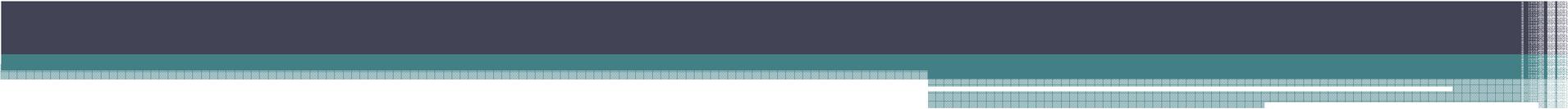


Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Trauma Program Manager
 - Full-time and dedicated to the trauma program

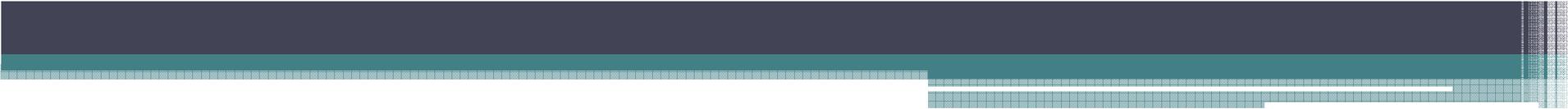
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Trauma Program Manager documentation required:
 - Trauma Program Manager CV.
 - Trauma-related continuing education information from the past 12 months in a spreadsheet format.
 - Provide job description that defines authority and responsibilities of the Trauma Program Manager.
 - Documentation of attendance to at least three trauma operation meetings. Meetings must be at least one month apart.
 - Documentation of attendance to at least three peer review meetings. Meetings must be at least one month apart.



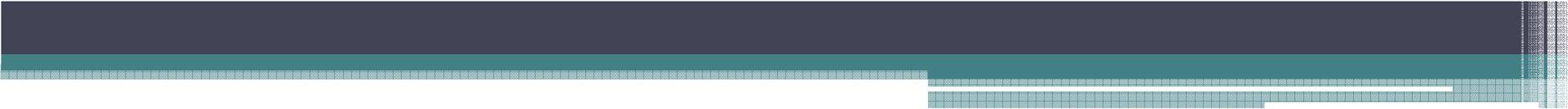
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Submission of trauma data to the State Registry:
 - The hospital must be submitting data to the Indiana Trauma Registry following the Registry’s data dictionary data standard for the last two quarters prior to submitting the application and at least quarterly thereafter.



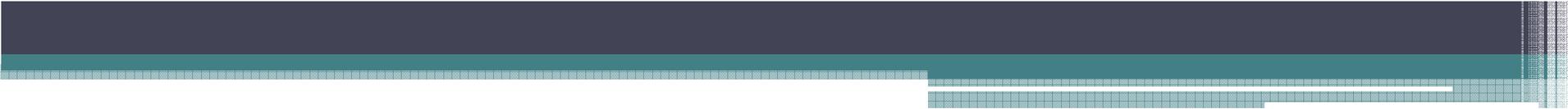
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Submission of trauma data to the State Registry documentation required:
 - The State Trauma Registrar will validate your participation in the Indiana Trauma Registry as required.



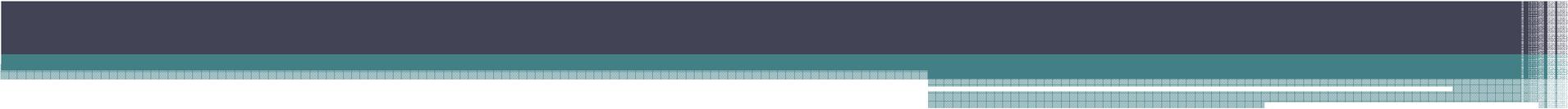
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- A Trauma Registrar documentation required:
 - Trauma Registrar CV.
 - Trauma Registrar job description.
 - Proof of trauma registry training (i.e. may include ISDH training or vendor training).



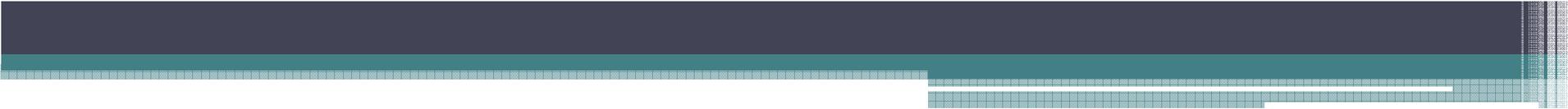
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Tiered Activation System:
 - Should be inclusive of ACS criteria.



Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Tiered Activation System documentation required:
 - Activation guideline/policy.

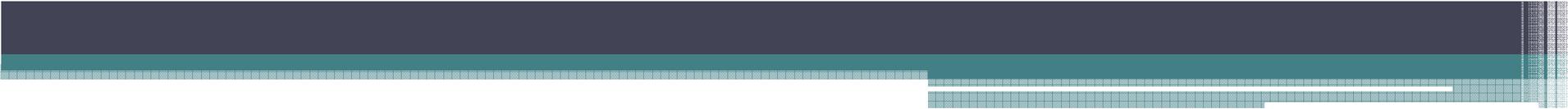


Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Trauma Surgeon response times (Trauma Surgeon on call and Trauma Surgeon response times combined):
 - All trauma surgeons on the call panel must have successfully completed ATLS at least once.

Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Trauma Surgeon response times documentation required:
 - Individual written statements of support of the trauma program from all participating trauma surgeons, orthopedic surgeons, and neurosurgeons on the call panel, including signature by Trauma Medical Director.
 - Complete Surgeon Response Time spreadsheet provided by ISDH Designation Subcommittee.
 - Letter from Disaster Committee Chairperson validating a trauma surgeon’s participation and include record of attendance from past year.
 - Copies of past three months general surgery call coverage to show proof of continuous coverage and back up.
 - Contingency plan policy regarding back up schedules.
 - Copies of ATLS cards for each general surgeon on the call schedule.
 - Copies board certification status for each general surgeon on the call schedule.
 - Provide documentation of acquisition of 16 hours of trauma-related CME per year on average or by demonstrating participation in an internal education process (IEP) conducted by the trauma program based upon the principles of practice-based learning and PIPS program for the trauma surgeons participating on the call panel.

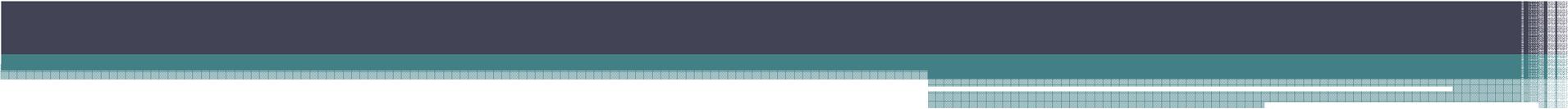


Application for “in the process” Level II Trauma Center Status Proposed Revisions

- In-house Emergency Department physician coverage:
 - All ED physicians must have successfully completed ATLS at least once.
 - Physicians who are not board-certified in emergency medicine who work in the ED must be current in ATLS.

Application for “in the process” Level II Trauma Center Status Proposed Revisions

- In-house Emergency Department physician coverage documentation required:
 - Copies of past three months emergency medicine physician call roster, include names of providers if initials are used on call calendar.
 - Complete ED physician spreadsheet provided by the ISDH Designation Subcommittee.
 - ED liaison CV.
 - Copies of ATLS cards for each ED physician
 - Provide documentation of acquisition of 16 hours of trauma-related CME per year on average or by demonstrating participation in an internal education process (IEP) conducted by the trauma program based upon the principles of practice-based learning and PIPS program for the Emergency Department physicians participating on the call panel.

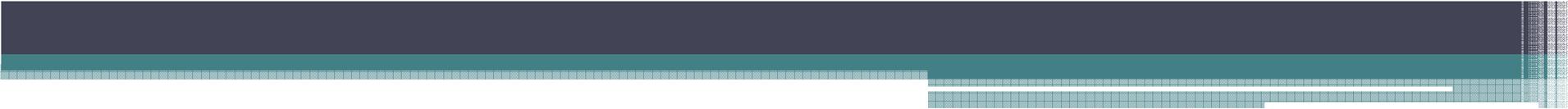


Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Orthopedic Surgery:
 - There must be an orthopedic surgeon on call and promptly available 24 hours per day.
 - There must also be a written letter of commitment, signed by orthopedic surgeons, Orthopedic Trauma Liaison and the Trauma Medical Director, for this requirement.

Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Orthopedic Surgery documentation requirements:
 - Copies of past three months orthopedic physician call roster, include names of providers if initials are used on call calendar.
 - Provide written letter of commitment from orthopedic physicians including signature from all participating orthopedic physicians, Orthopedic Trauma Liaison and Trauma Medical Director.
 - Provide documentation of acquisition of 16 hours of trauma-related CME per year on average or by demonstrating participation in an internal education process (IEP) conducted by the trauma program based upon the principles of practice-based learning and PIPS program for the orthopedic surgeons participating on the call panel.

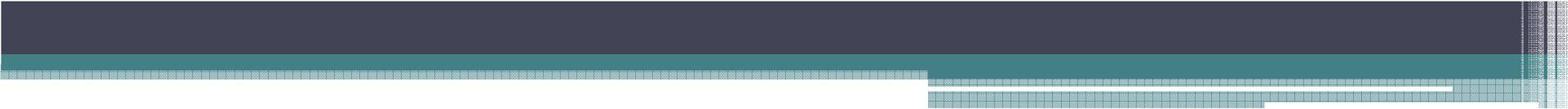


Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Neurosurgery:
 - There must be a neurosurgeon on call and promptly available 24 hours per day.
 - There must also be a written letter of commitment, signed by neurosurgeons, Neurosurgery Trauma Liaison and the Trauma Medical Director, for this requirement.

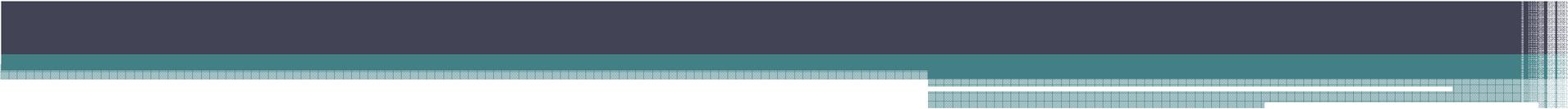
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- **Neurosurgery documentation requirements:**
 - Copies of past three months neurosurgeon physician call rosters (back up included if applicable), include physician names if initials are used on call calendar.
 - Provide written letter of commitment from neurosurgeons, Neuro Trauma Liaison and Trauma Medical Director
 - Provide documentation of acquisition of 16 hours of trauma-related CME per year on average or by demonstrating participation in an internal education process (IEP) conducted by the trauma program based upon the principles of practice-based learning and PIPS program for the neurosurgeons participating on the call panel.
 - Policy/guideline that establishes your scope of care and criteria for transfers as required in Resources for Optimal Care of the Injured Patient 2014 (pg.54).



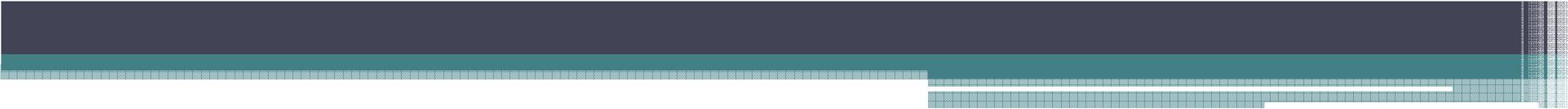
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Transfer agreements and criteria :
 - The hospital must include as part of its application a copy of its transfer criteria and copies of its transfer agreements with other hospitals.



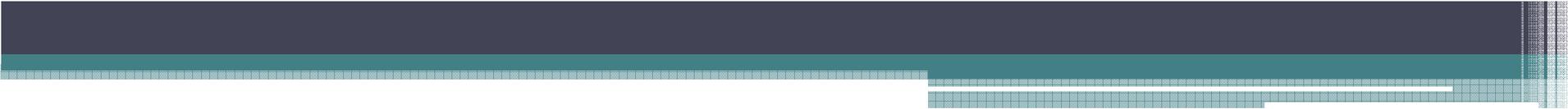
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Transfer agreements and criteria documentation required:
 - Copy of transfer out policy/criteria.
 - Copies of transfer agreements with Level I trauma centers.



Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Trauma Operating room, staff and equipment:
 - Anesthesiologists must be promptly available for emergency operations.
 - The center must have an identified anesthesia liaison for the trauma program.



Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Trauma Operating room, staff and equipment documentation requirements:
 - List of essential equipment as outlined in Resources for Optimal Care of the Injured Patient resource.
 - Policy/guideline outlining staffing procedures for emergent trauma procedures (including OR staff and anesthesia).
 - Anesthesiology liaison CV.

Application for “in the process” Level II Trauma Center Status Proposed Revisions

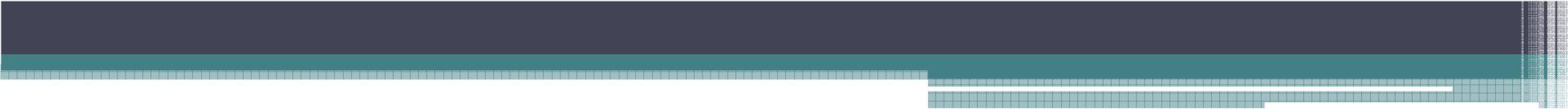
- Critical Care physician coverage:
 - Physician coverage of the ICU must be available in-house within 15 minutes to provide care for ICU patients 24 hours a day with interventions from credentialed provided.
 - Supporting documentation must include a signed letter of commitment from critical care physicians, ICU Liaison, and Trauma Medical Director and proof of physician coverage 24 hours a day.

Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Critical Care physician coverage documentation requirements:
 - Provide board certification documentation for ICU director or co-director.
 - Past three months call schedules for critical care coverage and include physician names if initials are used on the call calendar.
 - Signed letter of commitment from critical care physician group, ICU Liaison and Trauma Medical Director.
 - Policy/guideline for management of emergencies in the ICU.
 - Provide documentation of acquisition of 16 hours of trauma-related CME per year on average or by demonstrating participation in an internal education process (IEP) conducted by the trauma program based upon the principles of practice-based learning and PIPS program for the critical care physicians participating on the call panel.

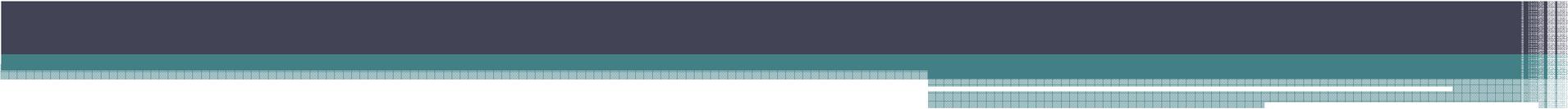
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- CT scan and conventional radiology:
 - Radiologists must be available within 30 minutes for complex imaging or interventional procedures. There must also be a written letter of commitment from the hospital’s Chief of Radiology, Radiology Liaison, and Trauma Medical Director.
 - Deleted Level II trauma centers must show documentation of multiple CT scan machines capabilities.



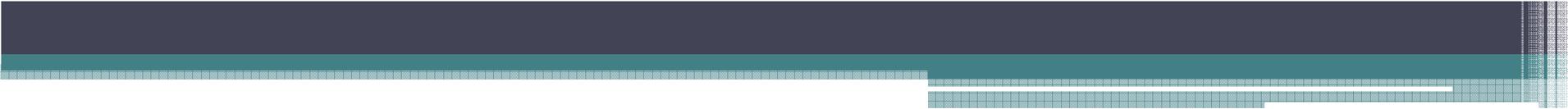
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- CT scan and conventional radiology documentation requirements:
 - Signed letter of commitment from Chief of Radiology, Radiology Liaison and Trauma Medical Director.
 - Policy/guideline outlining services available 24 hours a day and response time requirements for Radiologists.



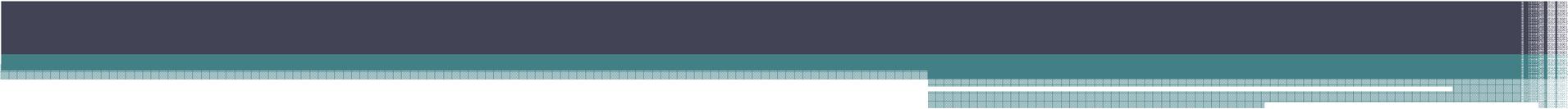
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Intensive care unit documentation required:
 - Scope of care/nursing standards/staffing guidelines for ICU that outlines nurse to patient ratios.
 - Equipment list for the ICU.



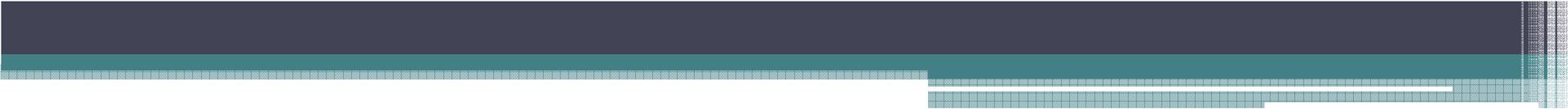
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- **Blood Bank:**
 - Deleted “The facility must also have the capability for coagulation studies, blood gases, and microbiology twenty four hours per day” from Blood Bank and added to Laboratory services.
 - All centers must have massive transfusion protocol developed collaboratively between trauma services and the blood bank.



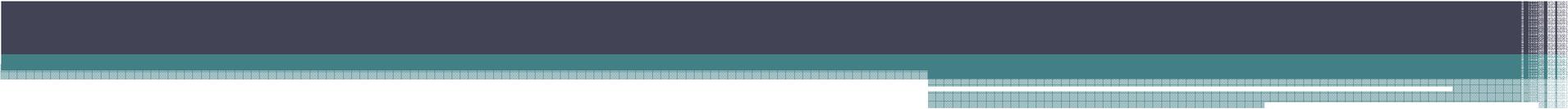
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Blood Bank documentation required:
 - Policy/guideline that includes detail of products available and number of each product on site.
 - Copy of massive blood transfusion protocol.



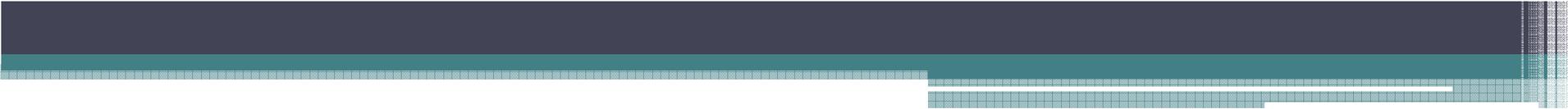
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Laboratory Services Documentation requirements:
 - Guideline/policy that outlines what services are available 24/7.



Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Post-anesthesia care unit:
 - No changes.

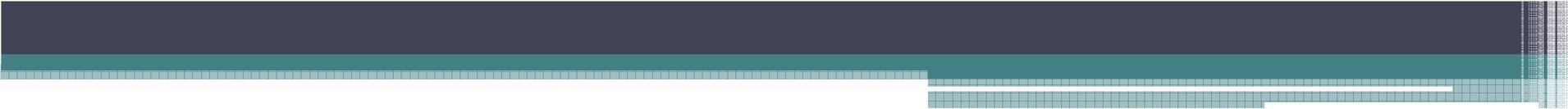


Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Relationship with an organ procurement organization (OPO) documentation required:
 - Written policy regarding OPO participation in the trauma program and triggers for notifying OPO.

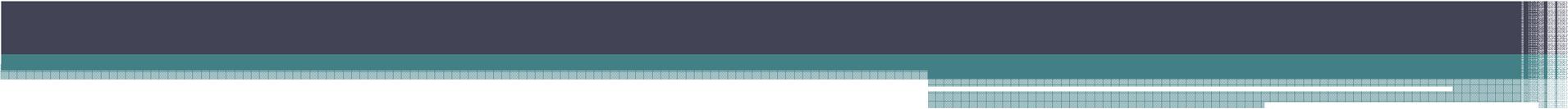
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Diversion policy:
 - The hospital must provide a copy of its diversion policy and affirm that it will not be on diversion status more than 5% of the time in a rolling 12 month period.
 - The hospital’s documentation must include a record of the most recent 12 months showing dates and length of time for each time the hospital was on diversion.



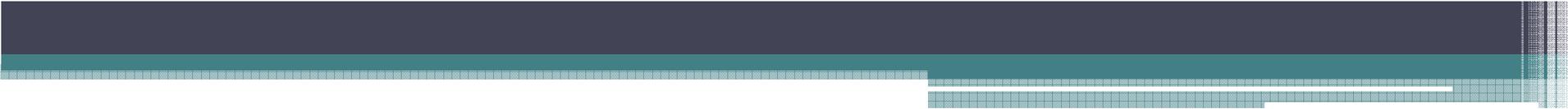
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Diversion policy documentation required:
 - Completed detailed diversion information/why facility activated diversion on required spreadsheet provided by ISDH Designation Subcommittee.



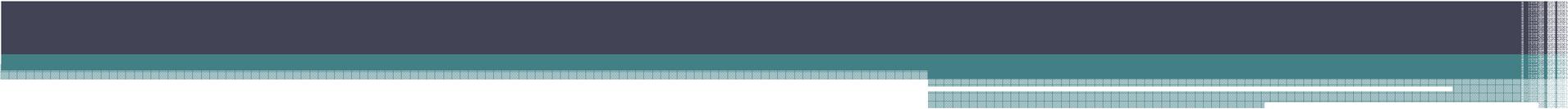
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Operational process performance improvement committee:
 - This meeting must occur at least quarterly.



Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Operational process performance improvement committee documentation required:
 - Signed letter from Trauma Medical Director and Trauma Program Manager outlining committee membership and meeting frequency.
 - Complete Operational Attendance spreadsheet provided by ISDH Designation Subcommittee. Include data from most recent 12 months.
 - All Trauma Surgeons and all the Liaisons must have attended at least two Operational meetings prior to submission of the application, held no more frequently than monthly.

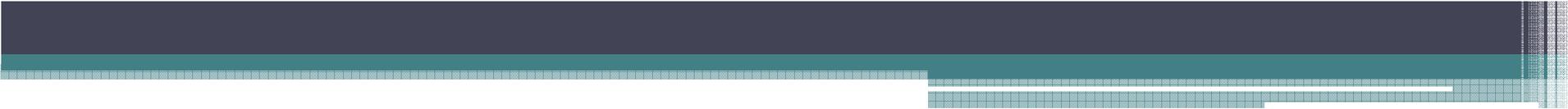


Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Trauma Peer Morbidity and Mortality Committee :
 - The trauma program should have established committee membership and set meeting dates prior to application.
 - This meeting should be held monthly, but the frequency should be determined by the trauma medical director based on the needs of the program.

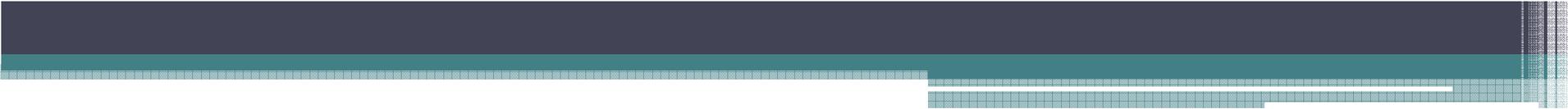
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Trauma Peer Morbidity and Mortality Committee documentation required:
 - Signed letter from Trauma Medical Director and Trauma Program Manager outlining committee membership and meeting frequency.
 - Complete Peer Attendance spreadsheet provided by ISDH Designation Subcommittee. Include data from most recent 12 months.
 - All Trauma Surgeons and all the Liaisons (Orthopedics, Neurosurgery, Critical Care, Radiology, Emergency Medicine, Anesthesia) must have attended at least two Trauma Peer Review meetings prior to submission of the application, held no more frequently than monthly.



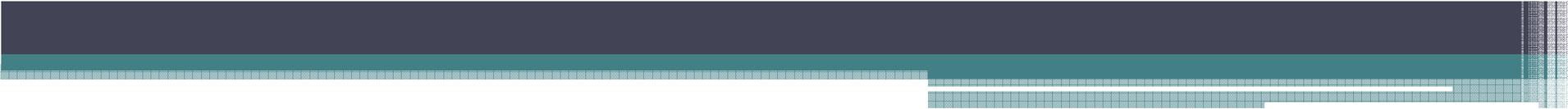
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Nurse credentialing requirements:
 - Deleted PACU.



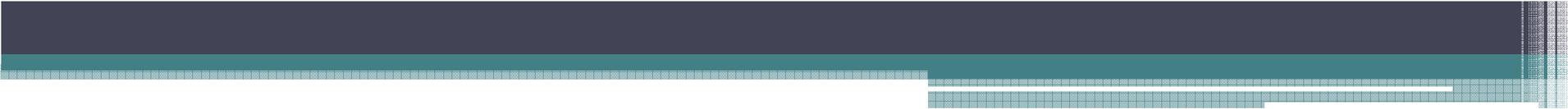
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Nurse credentialing requirements documents required:
 - Policy/guideline that outlines credentialing requirements for nurses in the ED and ICU.
 - Percentage of nurses that have completed credentialing requirements for both ED and ICU.



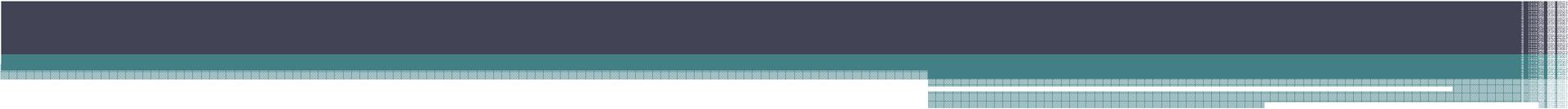
Application for “in the process” Level II Trauma Center Status Proposed Revisions

- Commitment by the governing body and medical staff documentation required:
 - Written statement as outlined under requirements that is signed by governing body and medical staff representative.



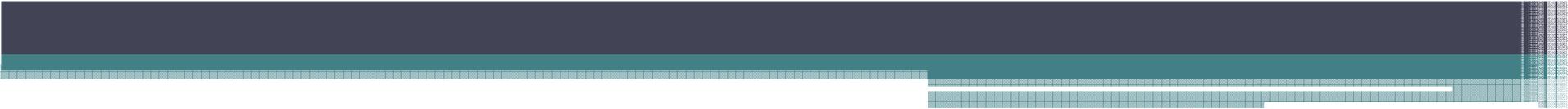
One Year Progress Report for the “in process” Level II Trauma Center

- All "in the process of ACS verification" trauma centers must complete a one year review to ensure the hospital is on track to becoming verified within the two year period.
- Report will be sent to the TPM two months before due date.



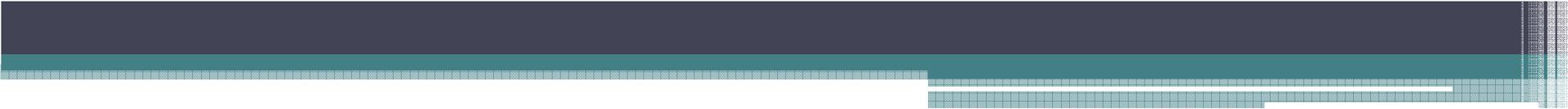
One Year Progress Report for the “in process” Level II Trauma Center

- Hospitals that were granted status as an “in the process” Level II Trauma Center are asked to provide sufficient documentation for the Indiana State Department of Health and the Indiana Department of Homeland Security to demonstrate that your hospital continues to comply with the following requirements:



One Year Progress Report for the “in process” Level II Trauma Center

- Trauma Medical Director
- Submission of Trauma Data to the State Registry
- Trauma Registrar
- Trauma Surgeon Response Times
- Diversion
- In-house MD Coverage
- CT Scan and Conventional Radiology
- Operational process performance improvement committee
- Trauma Peer Review Committee
- Trauma Volumes



Next Steps:

- Review Pediatric Trauma Center Requirements and development of one year progress report



Coming in August!

Trauma Registry implementation research collaborative presentation

District 10 Trauma Regional Advisory Council update

Rural Trauma Team Development Course (RTTDC) Data Presentation





Trauma Registry Data Report

Camry Hess, MPH, *Database Analyst*

Ramzi Nimry, *Trauma System PI Manager*

Division of Trauma and Injury Prevention



Indiana State
Department of Health



Email questions to: indianatrauma@isdh.in.gov