Regional Roadmap

Katie Hokanson, Director
Ramzi Nimry, Trauma System Performance Improvement Manager
Division of Trauma and Injury Prevention

Email questions to: indianatrauma@isdh.in.gov
Indiana’s Public Health Preparedness Districts (PHPDs)
Goal of the regional roadmap

- Provide Public Health Preparedness Districts (PHPDs) with tools/resources for regional system development.
- Highlight the critical role of regional trauma systems.
- Everyone (EMS, hospitals, rehabilitation) is part of the system.
Year 1 goals of regional development

• Meet & Greet
  – Meet with each hospital/EMS provider/rehabilitation facility in the district.
    • System approach.
    • Resource coordination.
    • Improved trauma patient care.
    • Reducing injuries in Indiana through injury prevention.

• Establish Advisory Council.
• Determine meeting structure & topics

Email questions to: indianatrauma@isdh.in.gov
Goal of the Regional System - State Perspective

- Increase communication between state, regional, local entities.
- Address regional PI issues based on hospital/district/statewide data.
- Utilize regional councils to collaborate on statewide injury prevention initiatives.

Email questions to: indianatrauma@isdh.in.gov
Regional Updates

Email questions to: indianatrauma@isdh.in.gov
Regional updates

- District 1
- District 3
- District 6
- District 7
- District 8
- District 10
Trauma Center Advertising

Art Logsdon, Assistant Commissioner
Health & Human Services Commission

Email questions to: indianatrauma@isdh.in.gov
Trauma Center Advertising

• “In the process of ACS verification” trauma centers are considered trauma centers for the purposes of the EMS Commission’s Triage & Transport Rule.
  – Are these hospitals allowed to advertise themselves as trauma centers to the general public?

Email questions to: indianatrauma@isdh.in.gov
Trauma Center Advertising (continued)

- Nothing in the rule prohibits hospitals that are in the process of ACS verification from advertising themselves as trauma centers.
- The rule defines a trauma center in three ways, including hospitals that are in the ACS verification process.
- ISDH does not have the authority to change the Triage & Transport Rule.
Trauma Center Advertising
(continued)

• If the EMS Commission does not intend for these hospitals to advertise:
  – They must change the definition of “trauma center” in the rule, OR
  – They must specifically promulgate a rule to prohibit this type of advertising.

Email questions to: indianatrauma@isdh.in.gov
Risk-Adjusted Benchmarking

Art Logsdon, Assistant Commissioner
Health & Human Services Commission
Katie Hokanson, Director
Division of Trauma & Injury Prevention

Email questions to: indianatrauma@isdh.in.gov
Risk-Adjusted Benchmarking

- The American College of Surgeons Committee on Trauma (ACS COT) currently requires that ACS verified trauma centers participate in a risk-adjusted benchmark program (CD 15-5) as part of the standards set forth in the 2014 Resources for Optimal Care of the Injured Patient.

Email questions to: indianatrauma@isdh.in.gov
Risk-Adjusted Benchmarking (continued)

- The ACS COT is changing CD 15-5 to the following: All trauma centers must use a risk-adjusted benchmarking system to measure performance and outcomes (CD 15-5).
  - This program should be the ACS-COT Trauma Quality Improvement Program (TQIP).
- As of **January 1, 2017** all centers must be enrolled in TQIP.

Email questions to: indianatrauma@isdh.in.gov
Risk-Adjusted Benchmarking (continued)

• Thoughts from the committee?
  – Is this is a good/bad thing?
  – Should the state look at participating in TQIP as a state with this new requirement?
  – How will this impact our system development (hospitals looking at becoming “in the process”)?

Email questions to: indianatrauma@isdh.in.gov
Subcommittee Updates
PI Subcommittee

Dr. Larry Reed, Trauma Medical Director
IU Health – Methodist Hospital

Email questions to: indianatrauma@isdh.in.gov
PI Subcommittee Members

- Merry Addison
- Lynne Bunch
- Annette Chard
- Christy Claborn
- Kristi Croddy
- Dawn Daniels
- Amy Deel
- Emily Dever
- Bekah Dillon
- Amanda Elikofer
- Brittanie Fell
- Spencer Grover
- Jodi Hackworth
- Kris Hess
- Missy Hockaday
- Lisa Hollister
- Dr. Peter Jenkins
- Michele Jolly
- Sean Kennedy
- Lesley Lopossa
- Jeremy Malloch
- Carrie Malone
- Kasey May
- Kelly Mills
- Jennifer Mullen
- Regina Nuseibeh
- Tracy Spitzer
- Wendy St. John
- Amanda Rardon
- Dr. Larry Reed
- Dustin Roe
- Mary Schober
- Tracy Spitzer
- Chuck Stein
- Latasha Taylor
- Cindy Twitty
- Chris Wagoner
- Adam Weddel
- Lindsey Williams
IDSH Staff
PI Subcommittee

- Katie Hokanson
- Ramzi Nimry
- Jessica Skiba
- Camry Hess
Met on 11/10/2015 to cover the following issues:
- Increase the number of hospitals reporting to the Indiana Trauma Registry
- Decrease the average Emergency Department length of stay at non-trauma centers
- Increase EMS run sheet collection
- Reviewed metrics, eliminating some that provided no value
- Discussion of potential new metrics
  - Triage & Transport Rule issues
  - Double transfers
  - Data Quality Dashboard for linking cases
  - Additional registry values for “Reason for Transfer Delay”
  - TQIP & risk-adjusted benchmarking requirement
  - Regional PI

Met on 12/9/2015 and discussed the following issues:
- ED LOS for patients transferred from non-trauma centers
- Regional Trauma System Development
- Review of other States’ PI measures
### Increase # of hospitals reporting to the Indiana Trauma Registry

<table>
<thead>
<tr>
<th>ISDH Actions to Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Action</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Letter from Dr. VanNessto non-reporting hospitals</td>
</tr>
<tr>
<td>2nd Letter from Dr. VanNessto non-reporting hospitals about trauma registry rule</td>
</tr>
<tr>
<td>Trauma registry training events around the state</td>
</tr>
<tr>
<td>Trauma registry refresher training events around the state</td>
</tr>
</tbody>
</table>

12/22/2015
## Completed Mentorship Programs between Trauma Centers & non-reporting hospitals

<table>
<thead>
<tr>
<th>Non-trauma center hospital</th>
<th>Trauma Center</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUH North</td>
<td>IUH Methodist</td>
<td>Completed 12/2013</td>
</tr>
<tr>
<td>Community Health - North</td>
<td>St. Vincent’s - Indy</td>
<td>Completed 2013</td>
</tr>
<tr>
<td>Community Health - East</td>
<td></td>
<td></td>
</tr>
<tr>
<td>St. Elizabeth - East</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Perry County</td>
<td>St. Mary's - Evansville</td>
<td>Completed 2013</td>
</tr>
<tr>
<td>St. Mary’s – Warrick</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Terre Haute Regional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Deaconess Gateway</td>
<td>Deaconess - Evansville</td>
<td>Completed 2015</td>
</tr>
<tr>
<td>IUH Bedford</td>
<td>IUH Bloomington</td>
<td>Completed 2015</td>
</tr>
<tr>
<td>St. Vincent Randolph</td>
<td>IUH Ball Memorial</td>
<td>Completed 2015</td>
</tr>
<tr>
<td>Elkhart General</td>
<td>Memorial South Bend</td>
<td>Completed 2015</td>
</tr>
<tr>
<td>IUH LaPorte</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IUH Starke</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Franciscan St. Francis - Indianapolis</td>
<td>IUH Methodist</td>
<td>Completed 2015</td>
</tr>
</tbody>
</table>

12/22/2015
Hospitals Not Reporting Any Data

- District 1
  - Jasper County Hospital
  - St. Mary Medical Center (Hobart)
- District 2
  - IU Health – Goshen Hospital
- District 3
  - Adams Memorial Hospital
  - Dupont Hospital
  - St. Joseph Hospital (Fort Wayne)
  - VA Northern Indiana Healthcare System
  - Wabash County Hospital
- District 5
  - Community Westview
  - Richard L Roudebush VA Medical Center
  - St. Vincent – Carmel Hospital
  - St. Vincent – Fishers Hospital
  - St. Vincent – Peyton Manning Children’s Hospital
  - St. Vincent – Indianapolis is working with these facilities.
- District 8
  - St. Vincent – Dunn Hospital
- District 9
  - Harrison County Hospital
  - St. Vincent – Jennings Hospital
  - Kentuckiana Medical Center
- District 10
  - Gibson General Hospital
<table>
<thead>
<tr>
<th>Non-trauma center hospital</th>
<th>Trauma Center</th>
<th>In progress as of:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Terre Haute Regional</td>
<td>St. Mary's Evansville</td>
<td>02/2015</td>
</tr>
<tr>
<td>Good Samaritan Hospital</td>
<td>St. Vincent’s - Indy</td>
<td>05/2015</td>
</tr>
<tr>
<td>Memorial Hospital (Jasper)</td>
<td>IU Health - Ball Memorial</td>
<td>05/2015</td>
</tr>
<tr>
<td>St. Vincent Anderson</td>
<td>IUH Riley</td>
<td>05/2015</td>
</tr>
<tr>
<td>St. Joseph Kokomo</td>
<td>IUH Methodist</td>
<td>08/2015</td>
</tr>
<tr>
<td>IUH White Memorial Hospital</td>
<td>IUH Arnett</td>
<td>08/2015</td>
</tr>
<tr>
<td>Community Health West</td>
<td>Community Health North</td>
<td>08/2015</td>
</tr>
<tr>
<td>Community Health Network</td>
<td>Eskenazi Health</td>
<td>08/2015</td>
</tr>
<tr>
<td>Terre Haute Regional</td>
<td>St. Elizabeth East</td>
<td>08/2015</td>
</tr>
<tr>
<td>St. Elizabeth Crawfordsville Memorial Hospital (Jasper)</td>
<td>St. Elizabeth East</td>
<td>08/2015</td>
</tr>
<tr>
<td>Memorial Hospital (Jasper)</td>
<td>Deaconess</td>
<td>08/2015</td>
</tr>
<tr>
<td>St. Vincent Dunn</td>
<td>IUH Bloomington</td>
<td>11/2015</td>
</tr>
<tr>
<td>Wabash data collection</td>
<td>Parkview RMC</td>
<td>11/2015</td>
</tr>
<tr>
<td>Dupont Hospital</td>
<td>Lutheran</td>
<td>11/2015</td>
</tr>
<tr>
<td>St. Joseph (Fort Wayne)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Increase # of hospitals reporting to the Indiana Trauma Registry

For Quarter 2, 2015

95 hospitals reported data!!
Decrease the average ED LOS at non-trauma centers

Average Non-Trauma Center ED LOS for Patients Transferred to Another Facility

Average Emergency Department Length of Stay (minutes)

Mon-Yr

Decrease the average ED LOS at non-trauma centers

Average Non-Trauma Center ED LOS for Patients Transferred to Another Facility

Goal (less than 2 hours)
Decrease the average ED LOS at non-trauma centers

- Will develop initiative-specific scorecards for each facility
  - Develop and deliver individual facility reports for ED LOS > 2 hours
  - Provide data as percentage of transferred patients with ED LOS > 2 hours (instead of average LOS)

- Current data available cannot identify reasons for prolonged lengths of stay prior to transfers
  - Developing specific data elements to identify potential reasons for prolonged ED LOS
Current Values for “Reason for Transfer Delay”

- EMS Issue
- Other
- Receiving Hospital Issue
- Referring Physician Decision-Making
- Referring Hospital Issue-Radiology
- Weather or Natural Factors
Potential Additional Data Items for “Reason for Transfer Delay”

- EMS issue
  - No response for transfer
  - Out of county
  - Unavailable
  - Ground critical care not available
  - Shortage of ground transport availability
  - Air transport not available due to weather
  - Air Transport ETA > Ground Transport TAT
  - Condition of patient warranted securing higher level of transport than what was immediately available (i.e. pediatric transport specialists)
- ED volume/capacity at time of event
- Patient not identified as trauma patient at time of event
- Imaging
- New staff in ED
- Communication issue
  - Nursing delay in calling for/arranging transport
  - Nursing delay in contacting EMS
- Referring Facility issue
  - Surgeon availability
  - Radiology workup delay
  - Priority of transfer
  - Referring physician decision-making
- Receiving Hospital Issue
  - Bed availability
  - Surgeon decision making
  - Difficulty obtaining accepting MD
  - Difficulty obtaining accepting hospital
- Time required to ensure stability of patient prior to transfer
- Change in patient condition
- Transport/Triage Decision – low triage for transfer
Triage & Transfer Rule issues
  - 45 minute rule
    - Use trauma registry data for accurate determination of EMS providers meeting requirement.
    - Previous discussion was around identifying ZIP codes that are within 45 minutes of a trauma center no matter where they are in the ZIP code.
    - Katie provided a data analysis of this issue to the Designation Subcommittee.
      - Requires further discussion
    - Analyzing patients that met Step 1 Criteria in the field from January 1, 2014 to December 31, 2014
      - Will be presented to further PI Subcommittee meeting

Double transfers
  - Patients sequentially transferred to more than one facility

Data Quality Dashboard – Camry Hess is developing
For Level III centers to satisfy the risk-adjusted benchmarking requirement, the center must participate in the TQIP pilot program.

[https://www.facs.org/quality-programs/trauma/vrc/site-packet](https://www.facs.org/quality-programs/trauma/vrc/site-packet)
Regional Performance Improvement: Illinois Model

- Cases Reviewed:
  - Deaths caused by traumatic injury
    - Excluding DOA
    - Excluding head AIS > 3
  - And TRISS > .75

- Each trauma center (trauma medical director and/or coordinator) presents to the region 6 months' worth of completed data 2x/year on:
  - Unexpected deaths.
  - Other interesting cases (ex: unexpected survivors).

- Data is presented during the regular district meeting and all members can be involved in the discussion.

- Data are confidential and bound by the Medical Studies Act

- Conclusions (minus the identifiers) are included in the regular meeting minutes
Sought to find commonly employed trauma system PI measures that we could adopt

Ramzy Nimry compiled a listing of PI Measures obtained from other states

248 different measures
  - Very little consistency
  - Most commonly employed (3 states): “Trauma patients with more than 1 inter-hospital transfer prior to definitive care”
  - 36 measures used by as many as 2 states
  - All of the remaining 231 measures used by only 1 state

While some of these may be useful to us at some point, for now we need to focus on issues that are pertinent to our evolving system
  - Data capture
  - Data accuracy
  - Improving the processes of care (i.e., referring ED LOS, EMS data integration)
Increase EMS run sheet collection

- Please continue to send Katie a list of EMS providers not leaving run sheets
- We are seeking to provide list to EMS Commission at their next meeting
- Instead of creating guidelines or a form that EMS providers can leave at hospitals when dropping off patients (given the problem with consistent EMS data capture), the Subcommittee recommends the implementation of a “60 second timeout” when EMS arrives at the hospital with the patient
  - Allows the recording nurse to document pre-hospital care
Other Assistance Needed

- Provide us with possible reasons for prolonged ED LOS at referring hospitals
  - We will be reviewing them at our next PI Subcommittee Meeting on January 12, 2016
  - Will add them as potential Registry data elements to check

- Any other ideas for potential additional PI Measures are appreciated

12/22/2015
Thank you!!
Subcommittee Updates
Designation Subcommittee

Dr. Lewis Jacobson,  
_Trauma Medical Director_
St. Vincent Indianapolis Hospital

Email questions to: indianatrauma@isdh.in.gov
“In the Process” Updates

- Methodist Hospital – Northlake Campus:
  - Trauma surgeon response times.
- Good Samaritan Hospital:
  - Meeting attendance.
- Community Hospital of Anderson:
  - Meeting attendance.
Trauma Registry Report

Camry Hess, Database Analyst
Ramzi Nimry, Trauma System Performance Improvement Manager
Division of Trauma and Injury Prevention

Email questions to: indianatrauma@isdh.in.gov
Hospitals reporting to the Indiana Trauma Registry - Quarter 2 2015

**District 1**

Community Hospital - Munster
Franciscan St. Anthony – Crown Point
Franciscan St. Anthony – Michigan City
Franciscan St. Margaret – Dyer
Franciscan St. Margaret - Hammond
IU Health – La Porte

**Jasper County**

Methodist Hospital Northlake
Methodist Hospital Southlake
Portage Hospital

Porter Regional Hospital (Valparaiso)

Email questions to: indianatrauma@isdh.in.gov
District 2
Community Hospital of Bremen
Elkhart General Hospital
IU Health – Goshen
IU Health – Starke Hospital
Kosciusko Community Hospital
Memorial Hospital South Bend
Pulaski Memorial Hospital
St. Catherine Regional – East Chicago
St. Joseph Regional Medical Center (Mishawaka)

St. Joseph Regional Medical Center (Plymouth)
Woodlawn Hospital

Email questions to: indianatrauma@isdh.in.gov
Hospitals reporting to the Indiana Trauma Registry - Quarter 2 2015

**District 3**
- Bluffton Regional Medical Center
- Cameron Memorial Community Hospital
- DeKalb Health
- Dukes Memorial Hospital
- **Dupont Hospital**
- Lutheran Hospital of Indiana
- Parkview Huntington Hospital
- Parkview LaGrange Hospital
- Parkview Noble Hospital
- Parkview Randallia
- Parkview Regional Medical Center
- Parkview Whitley Hospital

**District 4**
- Franciscan St. Elizabeth - Crawfordsville
- Franciscan St. Elizabeth – Lafayette East
- IU Health – Arnett Hospital
- IU Health – White Memorial
- Memorial Hospital (Logansport)
- St. Vincent Frankfort
- St. Vincent Williamsport Hospital

Email questions to: indianatrauma@isdh.in.gov
Hospitals reporting to the Indiana Trauma Registry - Quarter 2 2015

**District 5**
- Community East Health Network Community Hospital
- Community North Health Network Community Hospital
- Community South Health Network Community Hospital
- Eskenazi Health
- Franciscan St. Francis Health – Indianapolis
- Franciscan St. Francis Health – Mooresville
- Hancock Regional Hospital
- Hendricks Regional Health
- IU Health – Methodist Hospital
- IU Health – Morgan Hospital
- IU Health – North Hospital
- IU Health – Riley for Children
- IU Health - Saxony Hospital
- Johnson Memorial Hospital
- Major Hospital
- Riverview Hospital
- St. Vincent - Indianapolis
- Witham Health Services
- Witham Health Services at Anson

Email questions to: indianatrauma@isdh.in.gov
Hospitals reporting to the Indiana Trauma Registry - Quarter 2 2015

**District 6**
- Community Hospital of Anderson & Madison Co.
- Community Howard Regional Health
- Fayette Regional Health System
- Henry County Memorial Hospital
- IU Health – Ball Memorial Hospital
- IU Health – Blackford Hospital
- IU Health – Tipton Hospital
- Jay County Hospital
- Marion General Hospital
- Reid Hospital and Health Care Services
- Rush Memorial Hospital
- St. Vincent Anderson Regional Hospital
- St. Vincent Kokomo
- St. Vincent Mercy Hospital
- St. Vincent Randolph Hospital

Email questions to: indianatrauma@isdh.in.gov
District 7
Greene County General Hospital
Putnam County Hospital
St. Vincent Clay Hospital
Sullivan County Community Hospital
Terre Haute Regional Hospital
Union Hospital (Terre Haute)
Union Hospital Clinton

Email questions to: indianatrauma@isdh.in.gov
Hospitals reporting to the Indiana Trauma Registry - Quarter 2 2015

District 8
Columbus Regional Hospital
IU Health – Bedford Hospital
IU Health – Bloomington Hospital
IU Health – Paoli Hospital
Monroe Hospital
Schneck Medical Center
St. Vincent Salem Hospital

District 9
Clark Memorial Hospital
Dearborn County Hospital
Decatur County Memorial Hospital
Floyd Memorial Hospital and Health Services
Harrison County
King’s Daughters’ Health
Margaret Mary Community Hospital
Scott County Memorial Hospital

Email questions to: indianatrauma@isdh.in.gov
Hospitals reporting to the Indiana Trauma Registry - Quarter 2 2015

District 10
Daviess Community Hospital
Deaconess Hospital
Deaconess Gateway Hospital

Gibson General
Good Samaritan Hospital
Memorial Hospital & Health Care Center
Perry County Memorial Hospital
St. Mary’s Medical Center of Evansville
St. Mary’s Warrick Hospital

Email questions to: indianatrauma@isdh.in.gov
Summary of Hospitals Reporting Status - Q2 2015

New to Reporting / Started Reporting Again

- Bluffton Regional Medical Center
- Community Howard Regional Health
- Dearborn County Hospital
- Hancock Regional Hospital
- St. Vincent Mercy Hospital
- St. Vincent Randolph Hospital

Dropped off

- Columbus Regional Hospital
- Dupont Hospital
- IU Health – Starke Hospital
- Margaret Mary Community Hospital
- Portage Hospital
- Sullivan County Community Hospital

Email questions to: indianatrauma@isdh.in.gov
Quarter 2 2015 Statewide Report

- 8,605 incidents
- April 1, 2015 – June 30, 2015
- 95 total hospitals reporting
  - 9 Level I and II Trauma Centers
  - 10 Level III Trauma Centers
  - 76 Non-Trauma Hospitals

Email questions to: indianatrauma@isdh.in.gov

Indiana State Department of Health
ED Disposition by Percentage

- Floor Bed: 44%
- ICU: 12%
- Transferred: 19%
- OR: 6%
- Home w/o Services: 3%
- Observation: 5%
- Step Down: 5%
- Expired: 1%
- N/A/N/A: 4%

ED Length of Stay (Hours)

- Direct Admit: 5%
- <1: 5%
- 1-2: 33%
- 3-5: 41%
- 6-11: 10%
- 12+: 2%
- Null: 4%

Email questions to: indianatrauma@isdh.in.gov
ED Disposition for ED LOS >12 Hours

N=168  *No cases expired

Email questions to: indianatrauma@isdh.in.gov
### ED LOS > 12 Hours, N=121

<table>
<thead>
<tr>
<th>Facilities</th>
<th>ISS</th>
<th>RTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Distance from Scene to Facility</td>
<td>6.2 Miles</td>
<td>RTS—Systolic</td>
</tr>
<tr>
<td>Transport Type</td>
<td>90 Ambulance; 5 Helicopter; 26 Private Vehicle/Walk-In</td>
<td>RTS—GCS Scale</td>
</tr>
<tr>
<td>Trauma Type</td>
<td>111 Blunt; 10 Penetrating</td>
<td>RTS—Resp. Scale</td>
</tr>
<tr>
<td>Cause of Injury</td>
<td>63 Fall; 31 MVC; 9 Struck by, Against; 4 Firearm; 6 Transport; 6 Cut/Pierce; 2 Bicyclist</td>
<td>RTS</td>
</tr>
<tr>
<td>Signs of Life</td>
<td>110 Yes; 11 No</td>
<td>B Value</td>
</tr>
<tr>
<td>Age</td>
<td>57.5 Years (6-95 Years)</td>
<td>Ps</td>
</tr>
<tr>
<td>Gender</td>
<td>62 Female; 59 Male</td>
<td>Resp. Assistance</td>
</tr>
<tr>
<td>Interfacility Transfer</td>
<td>26 Yes; 95 No</td>
<td>ED LOS</td>
</tr>
<tr>
<td>Region</td>
<td>23 North; 73 Central; 6 South; 19 Missing</td>
<td>ED Disposition</td>
</tr>
</tbody>
</table>

- Region was created from injury zip code. Missing = no injury zip or injury zip from out of state.
- Numbers represent counts per category or mean with minimum and maximum in parentheses.
A table with all the values for ED LOS is found on page 47.

Note for EDLOS by ISS, there were 8 cases with ISS of 73; none were at non-trauma centers.

A table with values for ED LOS by ISS may be found on page 48.
*There are new categories for the Hospital Disposition for the 2014 Data Dictionary
<1%: inpatient, psych., long term care hospital, AMA, hospice and intermediate care.

Email questions to: indianatrauma@isdh.in.gov
## ED Disposition of Expired for Ps ≥ 50%, N=10

| Facilities          | 2 Non-Trauma Centers  
|                    | 8 Trauma Centers      | ISS                      | 3 (1-8 cat.); 4 (16-24 cat.); 1 (25-44); 2 No ISS |
| Average Distance from Scene to Facility* | 7.5 Miles              | RTS—Systolic             | 3.0 (0-4)                               |
| Transport Type      | 7 Ground ambulance; 2 Helicopter; 1 Walk-in | RTS—GCS Scale           | 1.8 (0-4)                               |
| Trauma Type         | 10 Blunt               | RTS—Resp. Scale          | 3.2 (2-4)                               |
| Cause of Injury     | 2 Falls; 7 MVC; 1 Transport | RTS                     | 4.8 (0.9-7.5)                           |
| Signs of Life       | 8 Yes; 2 No            | B Value                  | 1.6 (0.04-2.97)                        |
| Age                 | 51.9 Years (17-92 Years) | Ps                      | 0.8 (0.5-0.95)                         |
| Gender              | 5 Female; 5 Male       | Resp. Assistance         | 3 Yes; 7 No                             |
| Interfacility Transfer | 1 Yes; 9 No          | ED LOS                   | 1.4 hours (0.13-3.55 hours)            |
| Region              | 7 North; 3 Central     |                          |                                        |

- Region was created from injury zip code. Missing = no injury zip or injury zip from out of state.
- Numbers represent counts per category or mean with minimum and maximum in parentheses.
### ED Dispo ≠ Expired, Hospital Dispo = Expired for Ps ≥ 50%, N=108, Trauma Centers

<table>
<thead>
<tr>
<th>Interfacility Transfer</th>
<th>Interfacility Transfer</th>
</tr>
</thead>
<tbody>
<tr>
<td>43 Yes</td>
<td>65 No</td>
</tr>
</tbody>
</table>

| Average Distance from Scene to Facility | 18.9 Miles | 7.3 Miles |

| Transport Type | 23 Ambulance; 20 Helicopter | Transport Type | 45 Ambulance; 11 Helicopter; 8 Private Vehicle; 1 Unknown |
|                | 23 Blunt; 2 Penetrating; 4 Burn; 4 Other | Trauma Type | 57 Blunt; 1 Burn; 3 Penetrating; 4 Other |

| Cause of Injury | 20 Fall; 10 MVC; 1 Struck by, Against; 2 Firearm; 2 Transport; 1 Machinary; 4 Fire/Burn; 3 Unknown |
|                | 34 Fall; 19 MVC; 1 Struck; 2 Firearm; 2 Transport; 1 Cut/Pierce; 1 Fire/Burn; 3 Not Categorized; 1 Natural; 1 Bicyclist |

| Signs of Life | 32 Yes; 1 No; 10 Unknown | Signs of Life | 51 Yes; 1 No; 13 Unknown |
|              | Age 58.8 Years (0.2-97 Years) | Gender | 16 Female; 27 Male | 20 Female; 45 Male |
|              | Region 6 North; 21 Central; 3 South | Region | 9 North; 30 Central; 12 South; 14 Other |

| ISS | 8 (1-8); 11 (9-15); 5 (16-24); 17 (25-44); 2 (45-74) | ISS | 4 (1-8); 19 (9-15); 9 (16-24); 32 (25-44); 1 (45-74) |

| RTS — Systolic | 3.8 (2-4) | RTS — Systolic | 3.8 (1-4) |
|               | RTS — GCS Scale | 1.9 (0-4) | RTS — GCS Scale | 2.7 (0-4) |
|               | RTS — Resp. Scale | 3 (0-4) | RTS — Resp. Scale | 3 (0-4) |

| RTS | 6.1 (3.8-7.8) | RTS | 6.4 (2.9-7.8) |
| B Value | 1.9 (0.2—3.6) | B Value | 1.8 (0.1-5.3) |
| Ps | 0.8 (0.5-1) | Ps | 0.8 (0.5-1) |

| Resp. Assistance | 20 Yes; 23 No | Resp. Assistance | 16 Yes; 49 No |

| ED LOS | 2.7 Hours (0.5-9.7 Hours) | ED LOS | 3.6 Hours (0.3-22 Hours) |

- Region was created from injury zip code. Missing = no injury zip or injury zip from out of state.
- Numbers represent counts per category or mean with minimum and maximum in parentheses.

Email questions to: indianatrauma@isdh.in.gov
<table>
<thead>
<tr>
<th></th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interfacility Transfer</td>
<td>28 No</td>
</tr>
<tr>
<td>Average Distance from</td>
<td>8.7 Miles</td>
</tr>
<tr>
<td>Scene to Facility</td>
<td></td>
</tr>
<tr>
<td>Transport Type</td>
<td>25 Ambulance; 3 Private Vehicle</td>
</tr>
<tr>
<td>Trauma Type</td>
<td>23 Blunt; 1 Burn; 1 Penetrating; 3 Other</td>
</tr>
<tr>
<td>Cause of Injury</td>
<td>22 Falls; 1 MVC; 1 Firearm; 1 Fire/Burn; 3</td>
</tr>
<tr>
<td></td>
<td>Not Categorized</td>
</tr>
<tr>
<td>Signs of Life</td>
<td>28 Yes</td>
</tr>
<tr>
<td>Age</td>
<td>80 (28-98)</td>
</tr>
<tr>
<td>Gender</td>
<td>12 Females; 16 Males</td>
</tr>
<tr>
<td>Region</td>
<td>8 North; 12 Central; 6 South</td>
</tr>
<tr>
<td>ISS</td>
<td>10 (1-8); 15 (9-15); 0 (16-24); 2 (25-44);</td>
</tr>
<tr>
<td></td>
<td>1 Unknown</td>
</tr>
<tr>
<td>RTS—Systolic</td>
<td>3.9 (3-4)</td>
</tr>
<tr>
<td>RTS—GCS Scale</td>
<td>3.5 (0-4)</td>
</tr>
<tr>
<td>RTS—Resp. Scale</td>
<td>3.0 (2-4)</td>
</tr>
<tr>
<td>RTS</td>
<td>7.2 (5.4-7.6)</td>
</tr>
<tr>
<td>B Value</td>
<td>2.9 (1.2-3.8)</td>
</tr>
<tr>
<td>Ps</td>
<td>0.9 (0.8-9.8)</td>
</tr>
<tr>
<td>Resp. Assistance</td>
<td>7 Yes; 13 No; 8 Unknown</td>
</tr>
<tr>
<td>ED LOS</td>
<td>4.8 Hours (1.6-20.4)</td>
</tr>
</tbody>
</table>

- Region was created from injury zip code. Missing = no injury zip or injury zip from out of state.
- Numbers represent counts per category or mean with minimum and maximum in parentheses.
For Quarter 2, 2015, of the 8,605 incidents reported to the Indiana Trauma Registry, 1,627 cases that had an ED Disposition of “Transferred to another acute care facility” at the initial facility or that had the Inter-Facility Transfer equal to “Yes” at the Trauma Center. Of those transferred, 430 cases were probabilistically matched. The linked cases make up 22% of the Q2 2015 data. All public health preparedness districts are represented. The diagram below illustrates the overlap between the transfers reported from the initial facility and from the final facility that can be matched.

The initial facility in which transfers come from may be considered Critical Access Hospitals (CAHs). All Indiana CAHs are considered Rural, and must meet additional requirements to have a CAH designation, such as having no more than 25 inpatient beds and being located in a rural area. Facilities that are highlighted indicate that these facilities reported data for Quarter 2, 2015.

Within this transfer data section, the purple columns represent the transfer cases and the single percentages represent the percent for the transfer cases. For two demographic variables, patient age groupings and gender, the Indiana average is included to provide more insight to this transfer population.

Email questions to: indianatrauma@isdh.in.gov
For Quarter 3, 2014, of the 8,814 incidents reported to the Indiana Trauma Registry, 1580 cases that had an ED Disposition of “Transferred to another acute care facility” at the initial facility or that had the Inter-Facility Transfer equal to “Yes” at the Trauma Center. Of those transferred, 301 cases were probabilistically matched. The linked cases make up 9.1% of the Q3 2014 data. All public health preparedness districts are represented. The diagram below illustrates the overlap between the transfers reported from the initial facility and from the final facility that can be matched.

For Quarter 4, 2014, of the 8,052 incidents reported to the Indiana Trauma Registry, 1472 cases that had an ED Disposition of “Transferred to another acute care facility” at the initial facility or that had the Inter-Facility Transfer equal to “Yes” at the Trauma Center. Of those transferred, 200 cases were probabilistically matched. The linked cases make up 6.7% of the Q4 2014 data. All public health preparedness districts are represented. The diagram below illustrates the overlap between the transfers reported from the initial facility and from the final facility that can be matched.

For Quarter 1, 2015, of the 7,050 incidents reported to the Indiana Trauma Registry, 1,329 cases that had an ED Disposition of “Transferred to another acute care facility” at the initial facility or that had the Inter-Facility Transfer equal to “Yes” at the Trauma Center. Of those transferred, 430 cases were probabilistically matched. The linked cases make up 17% of the Q1 2015 data. All public health preparedness districts are represented. The diagram below illustrates the overlap between the transfers reported from the initial facility and from the final facility that can be matched.
### Facility to Facility Transfers

<table>
<thead>
<tr>
<th>For Transfer Patients:</th>
<th>Incident Counts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initial Hospital Type</strong></td>
<td><strong>Final Hospital Type</strong></td>
</tr>
<tr>
<td>Trauma Center</td>
<td>Hospital</td>
</tr>
<tr>
<td>Hospital</td>
<td>Hospital</td>
</tr>
<tr>
<td>Critical Access Hospital</td>
<td>Hospital</td>
</tr>
<tr>
<td>Rural</td>
<td>Hospital</td>
</tr>
<tr>
<td><strong>Trauma Center</strong></td>
<td><strong>Trauma Center</strong></td>
</tr>
<tr>
<td>Rural</td>
<td>Trauma Center</td>
</tr>
<tr>
<td>Critical Access Hospital</td>
<td>Trauma Center</td>
</tr>
<tr>
<td>Hospital</td>
<td>Trauma Center</td>
</tr>
</tbody>
</table>

### Facility Transfer Type

<table>
<thead>
<tr>
<th># of Transfers</th>
<th>TC → Hospital</th>
<th>Hospital → Hospital</th>
<th>CAH → Hospital</th>
<th>Rural → Hospital</th>
<th>TC → TC</th>
<th>Rural → TC</th>
<th>CAH → TC</th>
<th>Hospital → TC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural = Rural Hospital; TC = ACS Verified or In Process Trauma Center;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CAH = Critical Access Hospital; Hospital = does not fall into above categories</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Email questions to: indianatrauma@isdh.in.gov
### For Linked Transfer Patients:

<table>
<thead>
<tr>
<th></th>
<th>All Transfer Patients</th>
<th>Critical*</th>
<th>Physiological Critical**</th>
<th>ISS Critical***</th>
<th>$P_s &lt; 0.5^{****}$</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Number of Patients</strong></td>
<td>724</td>
<td>407</td>
<td>384</td>
<td>60</td>
<td>5</td>
</tr>
<tr>
<td><strong>EMS Notified to Scene</strong></td>
<td>8.6 minutes</td>
<td>9.0 minutes</td>
<td>9.1 minutes</td>
<td>8.3 minutes</td>
<td>12.8 minutes</td>
</tr>
<tr>
<td><strong>EMS Scene Arrival to Departure</strong></td>
<td>20.7 minutes</td>
<td>24.0 minutes</td>
<td>24.5 minutes</td>
<td>55.2 minutes</td>
<td>13.4 minutes</td>
</tr>
<tr>
<td><strong>EMS Scene Departure to Initial Hospital ED Arrival</strong></td>
<td>16.7 minutes</td>
<td>15.5 minutes</td>
<td>15.4 minutes</td>
<td>15.9 minutes</td>
<td>17.2 minutes</td>
</tr>
<tr>
<td><strong>Initial Hospital ED Arrival to Departure</strong></td>
<td>2 hours 58.4 minutes</td>
<td>2 hours 51.6 minutes</td>
<td>2 hours 51.3 minutes</td>
<td>2 hours 30.1 minutes</td>
<td>1 hour 6.6 minutes</td>
</tr>
<tr>
<td><strong>Initial Hospital ED Departure to Final Hospital ED Arrival</strong></td>
<td>58.1 minutes</td>
<td>1 hour 1.2 minutes</td>
<td>1 hour 1.2 minutes</td>
<td>56.5 minutes</td>
<td>29.2 minutes</td>
</tr>
<tr>
<td><strong>TOTAL TIME</strong></td>
<td>4 hours 42.5 minutes</td>
<td>4 hours 41.3 minutes</td>
<td>4 hours 41.5 minutes</td>
<td>4 hours 46 minutes</td>
<td>2 hours 19.2 minutes</td>
</tr>
</tbody>
</table>

*Critical patient is defined as having a GCS ≤ 12, OR Shock Index > 0.9 OR ISS >15 at the initial hospital.

**Physiological Critical Transfer patient is defined as having a Shock Index > 0.9 OR GCS ≤ 12 at the initial hospital.

***ISS Critical Transfer patient is defined as having an ISS > 15.

****Patients with a probability of survival ≤ 0.5.

Email questions to: indianatrauma@isdh.in.gov
**For Transfer Patients:**

<table>
<thead>
<tr>
<th>Public Health Preparedness District Initial Hospital</th>
<th>Public Health Preparedness District Final Hospital</th>
<th>Incident Counts</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>7</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>8</td>
</tr>
<tr>
<td>1</td>
<td>5</td>
<td>12</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>12</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>8</td>
</tr>
<tr>
<td>2</td>
<td>5</td>
<td>8</td>
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<tr>
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<td>5</td>
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<td>4</td>
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<td>5</td>
<td>8</td>
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<td>6</td>
<td>3</td>
<td>5</td>
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<td>6</td>
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<td>15</td>
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<td>7</td>
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<td>8</td>
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<td>8</td>
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<tr>
<td>9</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>10</td>
<td>10</td>
<td>84</td>
</tr>
</tbody>
</table>

*The thickness of the line indicates the frequency of transfers out of or within the public health preparedness district. The circles represent transfers from a specific PHPD, not a specific hospital or county.*
### Transfer Patient Data - Page 16

**For Linked Transfer Patients:**

<table>
<thead>
<tr>
<th></th>
<th>All Transfer Patients</th>
<th>Critical*</th>
<th>Physiological Critical**</th>
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<th>Ps &lt;0.5****</th>
</tr>
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<td>4 hours 41.3 minutes</td>
<td>4 hours 41.5 minutes</td>
<td>4 hours 46 minutes</td>
<td>2 hours 19.2 minutes</td>
</tr>
<tr>
<td><strong>Total Mileage</strong></td>
<td>55.0</td>
<td>53.7</td>
<td>53.0</td>
<td>63.1</td>
<td>61.0</td>
</tr>
<tr>
<td><strong>Injury Scene to Initial Hospital Mileage</strong>*</td>
<td>7.5</td>
<td>8.1</td>
<td>8.2</td>
<td>6.8</td>
<td>5.3</td>
</tr>
<tr>
<td><strong>Initial Facility to Final Facility Mileage</strong></td>
<td>47.5</td>
<td>45.6</td>
<td>44.7</td>
<td>56.3</td>
<td>55.7</td>
</tr>
</tbody>
</table>

**Estimated Average Distance (miles) by Region (region of final hospital):**

<table>
<thead>
<tr>
<th>Region</th>
<th>Injury Scene to Initial Facility Mileage*</th>
<th>Initial Facility to Final Facility Mileage</th>
<th>Total Mileage</th>
<th>Drive Count</th>
<th>Air Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indiana Average</td>
<td>7.5</td>
<td>47.5</td>
<td>55.0</td>
<td>604</td>
<td>120</td>
</tr>
<tr>
<td>North Region</td>
<td>6.7</td>
<td>43.4</td>
<td>50.0</td>
<td>263</td>
<td>39</td>
</tr>
<tr>
<td>Central Region</td>
<td>8.5</td>
<td>56.7</td>
<td>65.2</td>
<td>162</td>
<td>52</td>
</tr>
<tr>
<td>South Region</td>
<td>7.9</td>
<td>43.9</td>
<td>51.8</td>
<td>179</td>
<td>29</td>
</tr>
</tbody>
</table>

*Critical patient is defined as having a GCS ≤ 12, OR Shock Index > 0.9 OR ISS >15 at the initial hospital.
**Physiological Critical Transfer patient is defined as having a Shock Index > 0.9 OR GCS ≤ 12 at the initial hospital.
***ISS Critical Transfer patient is defined as ISS > 15 at the initial hospital.
****Probability of Survival < 0.5

*Injury Scene to Initial Facility Mileage location estimated by zip code centroid

Statistics for Estimated Average Distance by Region calculated by Public Health Geographics, Epidemiology Resource Center, ISDH
Higher than Average ED LOS for Transferred Patients

<table>
<thead>
<tr>
<th>Hospital ID</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID 1</td>
</tr>
<tr>
<td>ID 34</td>
</tr>
<tr>
<td>ID 44</td>
</tr>
<tr>
<td>ID 73</td>
</tr>
<tr>
<td>ID 84</td>
</tr>
<tr>
<td>ID 90</td>
</tr>
<tr>
<td>ID 92</td>
</tr>
<tr>
<td>ID 94</td>
</tr>
<tr>
<td>ID 97</td>
</tr>
<tr>
<td>ID 99</td>
</tr>
<tr>
<td>ID 109</td>
</tr>
<tr>
<td>ID 122</td>
</tr>
</tbody>
</table>

Email questions to: indianatrauma@isdh.in.gov
Indiana State Department of Health
Indiana Trauma Registry

Hospitals Not Reporting Trauma Data
to the Indiana Trauma Registry

Adams Memorial Hospital
Community Westview Hospital
IU Health - West Hospital
Kentuckiana Medical Center
Parkview Wabash Hospital
Richard L Roudebush VA Medical Center
St. Joseph Hospital (Fort Wayne)
St. Mary Medical Center Hobart
St. Vincent - Carmel Hospital
St. Vincent - Dunn Hospital
St. Vincent - Fishers Hospital
St. Vincent - Jennings Hospital
St. Vincent - Peyton Manning Children’s
VA Northern IN Healthcare System

Not reporting as of 10/1/2015
Indiana State Department of Health
Indiana Trauma Registry

Hospitals Reporting Trauma Data
Quarter 2, 2015
April 1, 2015 – June 30, 2015

Level I and II Trauma Centers
Deaconess Hospital
Eskanazi Health
IU Health - Methodist Hospital
Memorial Hospital of South Bend
Parkview Regional Medical Center
Riley Hospital for Children at IU Health
St. Mary's Medical Center of Evansville
St. Vincent Indianapolis Hospital

Level III Trauma Centers
Community Hospital of Anderson
Community Hospital - East
Community Hospital - North
Community Hospital - South
Franciscan St. Elizabeth East Hospital
Good Samaritan Hospital
IU Health - Arnett Hospital
IU Health - Belle Memorial Hospital
Methodist Hospital - Northlake Campus
St. Vincent Anderson Regional Hospital

Non-Trauma Hospitals
76 Non-Trauma Hospitals
Hospital categories include "Verified" Trauma Centers

Map Author: ISDH EMSR and ISDH Trauma and Injury Prevention - July 2015
Updates
Child Safety COIIN

Email questions to: indianatrauma@isdh.in.gov
Resource Guide & App Development

Email questions to: indianatrauma@isdh.in.gov
Resource Guide App

• Injury Prevention at your fingertips
• Free download for iOS & Android
  • phone & tablet capabilities
• Available in Apple & Google Play stores

Email questions to: indianatrauma@isdh.in.gov
Installs per day, N = 336

**ISDH press release on 10/20/2015**

Email questions to: indianatrauma@isdh.in.gov
Launches per day, N = 1,385

**ISDH press release on 10/20/2015**

Email questions to: indianatrauma@isdh.in.gov
Program Evaluation – Measuring Impact and Continuously Improving Implementation for Success

Sally Thigpen, MPA

Division of Analysis, Research, and Practice Integration
Core VIPP Evaluation Team
December 10, 2015
Integrating Processes to Achieve Continuous Quality Improvement

- Continuous Quality Improvement (CQI) cycle.
  - Planning—*What* actions will best reach our goals and objectives.
  - Performance measurement—How are we doing?
  - Evaluation—*Why* are we doing well or poorly?

Credit: Tom Chapel, MA, MBA
<table>
<thead>
<tr>
<th>Key Component</th>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific</td>
<td>What is the specific task?</td>
</tr>
<tr>
<td>Measurable</td>
<td>What are the standards or parameters?</td>
</tr>
<tr>
<td>Attainable</td>
<td>Is the task feasible?</td>
</tr>
<tr>
<td>Reasonable</td>
<td>Are sufficient resources available?</td>
</tr>
<tr>
<td>Time-Bound</td>
<td>What are the start and end dates?</td>
</tr>
</tbody>
</table>

http://www.cdc.gov/phcommunity/resourcekit/evaluate/smart_objectives.html
CDC CORE STATE VIOLENCE AND INJURY PREVENTION (CORE SVIPP) FUNDING OPPORTUNITY ANNOUNCEMENT
Core SVIPP

- Duration: 5 years, beginning 8/1/2016
- Ave. Award: $250,000 ($200,000-$475,000)

- FOA Released 12/7/2015
- Letter of Intent due 3/1/2016
- Application due 4/8/2016

- Will need LOS from partners!
Core SVIPP

• Four Priority Focus Areas:
  – Child abuse and neglect
  – Traumatic brain injury
  – Motor vehicle crash injury and death
  – Intimate partner/sexual violence

• Multicomponent: BASE
  – SQI
  – RNCO
1. Educate health department leaders & policy makers about Public Health approach to IVP

2. Engage, coordinate, and leverage other internal state department of health and external partners and Injury Control Research Centers or other injury research institutes

3. Enhance statewide IVP plan and logic model for 4 priority areas
4. Implement 3 strategies that address 4 priority focus areas
   one selected strategy must address shared risk and protective factors across two priority focus areas

5. Develop evaluation plan reflecting process and outcome measures

6. Disseminate surveillance and evaluation information to stakeholders and use to inform continuous quality improvement

7. Enhance surveillance systems to capture IVP data
INVDRS Data Collection Update

Rachel Kenny, INVDRS Epidemiologist
Death Certificates

- 1242 cases statewide (as of 11/17 DC update)
  - 786 Suicides (63.3%)
  - 308 Homicides (24.8%)
  - 117 Undetermined (9.4%)
  - 31 Accidental (2.5%)

*preliminary numbers
Death Certificates

- Pilot Counties
  - 47.8% of all cases (594)
  - 40.3% of all suicides (317)
  - 75.6% of all homicides (233)

*preliminary numbers*
Data Agreements, Collection and Abstraction

- 20 Coroner Data Sharing Agreements.
- 168 Law Enforcement Data Sharing Agreements.
- Received 183 reports (coroner and law enforcement).
  - Abstracted 90 of those reports.
Coroner

• 228 coroner records requested
• 47 records received
• 41 records abstracted
Law Enforcement

- 168 signed Data Sharing Agreements
  - 28 of the agencies are in pilot counties
Law Enforcement

- 246 police records requested
- 136 records received
- 49 records abstracted
Other Updates?