Indiana Department of Health

Welcome to the Governor's Public Health Commission

March 17, 2022

Next Steps: Recommendations

- Discuss recommendations and vote on general direction of report at next two meetings
  - **April meeting**: Governance/Infrastructure; Data and Information Integration; and, Workforce
  - **May meeting**: Childhood and Adolescent Health; Funding; and, Emergency Preparedness
- Will seek to achieve consensus, but may opt for majority vote on close items
- Extending the meetings by an hour (1 - 4PM)

Final Meeting

- **June 23** meeting, will review report and finalize changes for adoption
- Staff will finalize and submit report to the Governor's Office
- In conjunction with Governor's Office, legislation will be drafted for 2023 session
- If necessary, will schedule a July meeting for wrap up work but goal is to complete in June

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Emergency Preparedness & Response

Stephen Cox

IDHS Executive Director

March 17, 2022

Threats Change and Public Health Adapts

- Public health preparedness was formally developed in response to terrorism – it has expanded to be applicable to a wide variety of public health events and emergencies
- Public health preparedness has evolved based on the challenges that we have faced nationally
- As we continue to face ever-changing threats and challenges, public health preparedness will continue to adapt and grow

SOURCE: CDC Center for Preparedness and Response, March 2019

Federal Context

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Emergency response is primarily federally funded through FEMA, ASPR and the CDC

- Indiana Department of Health (IDOH) grants:
  - CDC – Public Health Emergency Preparedness (PHEP)
  - ASPR – Hospital Preparedness Program (HPP)
- Indiana Department of Homeland Security (IDHS) FEMA grants:
  - Emergency Management Performance Grant (EMPG)
  - State Homeland Security Program (SHSP)
  - Hazard Mitigation Grant Program (HMGP)
  - Hazardous Materials Emergency Preparedness (HMEP)
- Public Assistance: FEMA has reimbursed $72 million so far to Indiana for eligible COVID-19 expenses
- Individual Assistance

National Standards for PH Emergency Preparedness and Response:
15 Capability Standards Across 6 Domains

Capabilities support the full preparedness cycle

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SOURCE: CDC, Public Health Emergency Preparedness and Response Capabilities, October 2018.

State Context

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Indiana Department of Homeland Security (IDHS):
Operational Divisions and Affiliated Boards

IDHS Preparedness Priorities

- **Prepare, train and exercise** an all-hazards approach, including CBRNE and mass casualty and healthcare surge
- Promote and support community **resiliency** and **mitigation** programs and projects in local communities
- Collaborate, communicate and **support first responders** through training and data collection and analysis
- **Leverage synergies** and resources from all agencies

Emergency Management and Preparedness

- Support first responders/ communities
- EM plans and exercises
- FEMA liaison
- Responds to support requests from County Emergency Management Agencies (EMAs)
- Emergency Operations Center (EOC)

Fire and Building Safety

- State Fire Marshal (enforcement and investigations)
- Hazmat Division
- Code enforcement/Plan Review
- **Emergency Medical Services (EMS)**

Affiliated Boards

- Board of Firefighting Personnel Standards and Education
- EMS Commission
- Fire Prevention and Building Safety Commission
- Indiana Emergency Response Commission
- Secured School Safety Board
- Senior Advisory Committee

County and Regional IDHS Partners

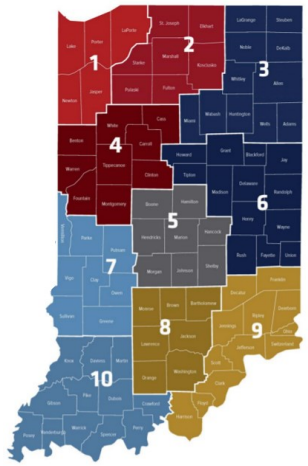
County Emergency Management Agencies (EMAs)	10 District Planning Councils (DPCs)	10 District Planning Oversight Committees (DPOCs)
• First line of response • Work with local public safety partners and organizations to prepare for, mitigate, respond to and recover from emergencies • Liaise with other counties and the state • 91 of 92 Indiana counties have a designated EMA	• Comprised of local emergency responders, emergency managers and representatives from other key agencies • Responsible for developing emergency response strategies, plans and procedures for their district	• Comprised of EMA Directors, President of each component county's County Commissioners, Mayor of the largest city in each component county • Responsible to formally appoint the members of the DPC and provide executive oversight, support and guidance for their activities

Emergency Medical Services (EMS):
Frontline of the Healthcare System Safety Net

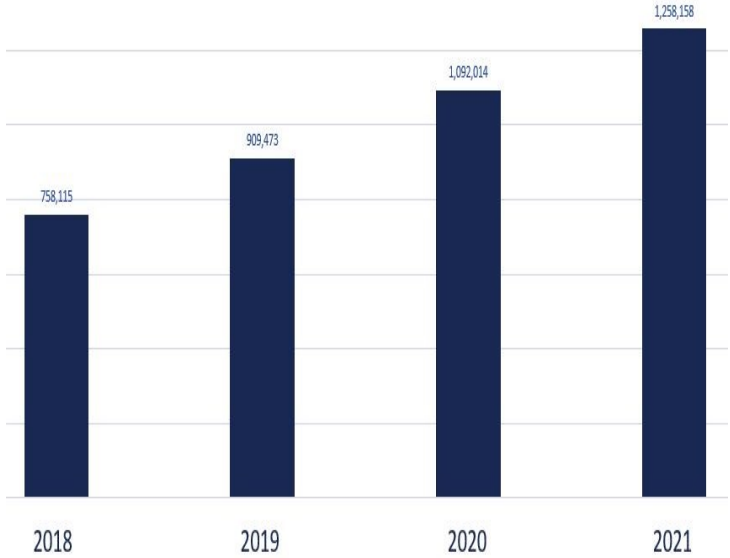
EMS stands at the intersection of public safety, public health, and healthcare

EMS By the Numbers

- Touches 1.25 million+ Hoosiers annually.
- 831 EMS provider agencies; 331 operate ambulances
- 1,789 emergency ambulances in the state, down from 2000+ only 2 years prior
- 23,000+ Emergency medical personnel
- 10 training/certification districts



Annual Indiana EMS Run Volumes



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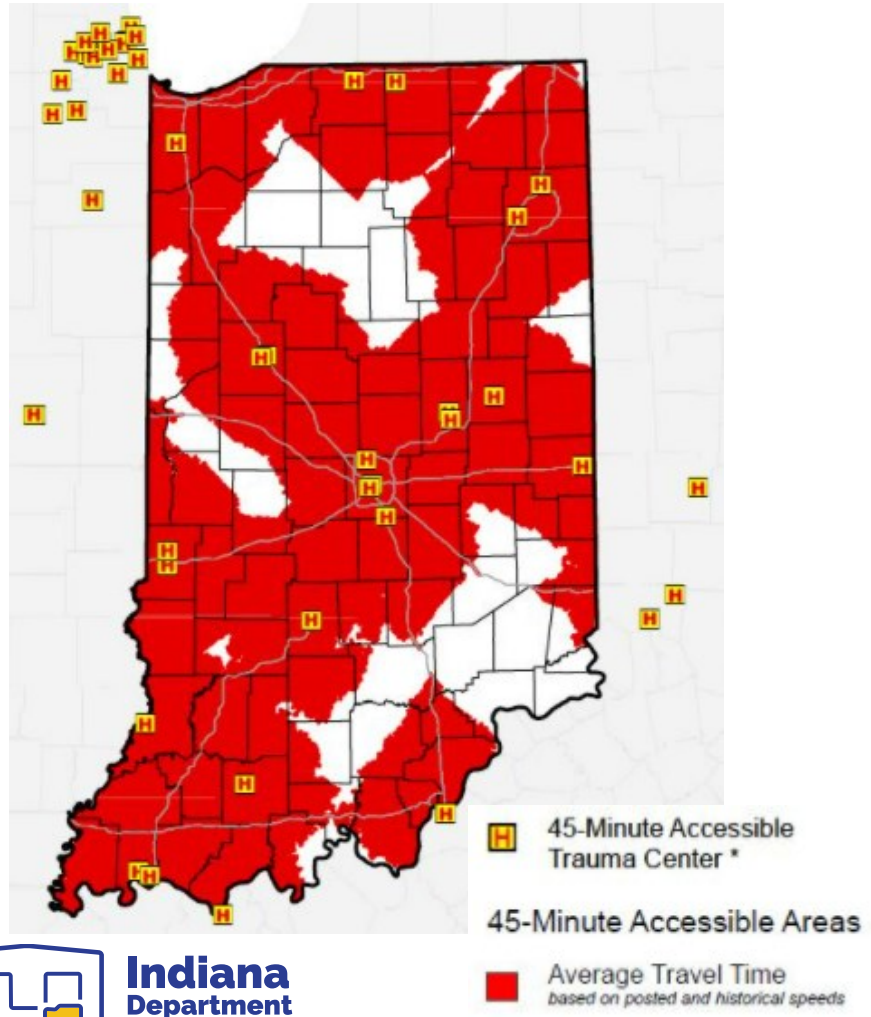
Indiana Trauma Care System:

Significant improvements over the last decade but gaps remain



- **Injury: leading cause of death for Hoosiers <age 45**
- 92% of Hoosiers have access to a trauma center within a 45-minute drive
- Not enough EMS providers, especially in rural areas and not enough trauma centers
- Responsibility shared by two agencies: IDHS/EMS and IDOH Division of Trauma & Injury Prevention

See Appendix for more details.

Number of IN Trauma Centers by Level and Location

Level	Number	Location
I	4 + 1 Prov.	Marion County
II	5	Evansville, Fort Wayne, South Bend
III	13 + 1 Prov	Anderson, Bloomington, Crown Point, Elkhart, Indianapolis, Jasper, Lafayette. Muncie, Richmond, Terre Haute, Vincennes

IDOH Division of Emergency Preparedness (DEP)

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IDOH Division of Emergency Preparedness (DEP):

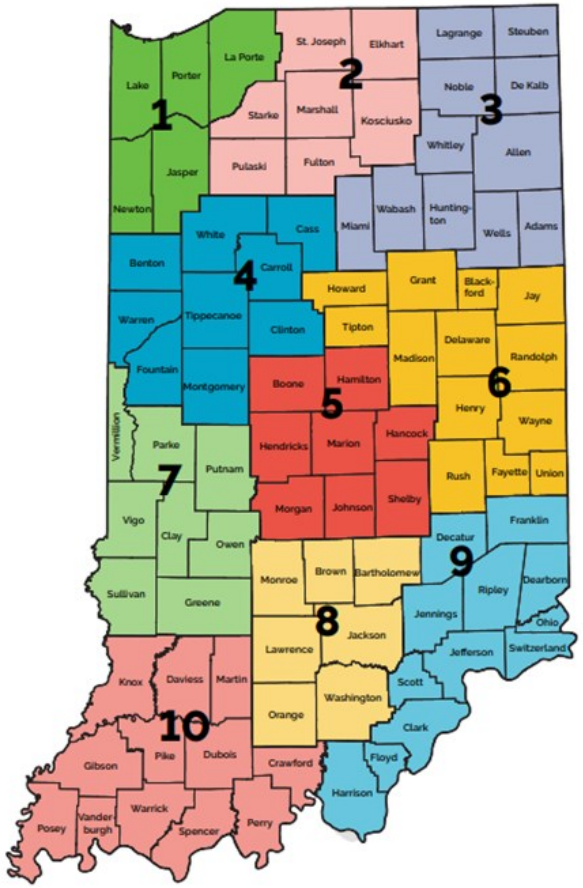
Supports PH and healthcare preparedness & response throughout IN

DEP prepares for and responds to public health emergencies and events throughout Indiana through **four sections:**

- District and Local Readiness
- Logistics
- Planning and Preparedness
- Mobile Response

Recent DEP coordinated response efforts:

- Scott County HIV outbreak
- East Chicago lead response
- Hepatitis A outbreak
- COVID-19 pandemic



IDOH 10 Public Health Preparedness Districts align with IDHS Districts

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DEP District and Local Readiness Section:

Supports local health departments (LHDs) and regional Health Care Coalitions (HCCs)

LHD Coordination:

- Coordinate with field staff members throughout Indiana to address LHD needs
- Provide technical assistance and guidance to LHD partners
- Support LHD preparedness and response activities

HCC Coordination:

- Coordinate with field staff members throughout Indiana to address HCC and hospital needs
- Provide technical assistance and guidance from IDOH to HCCs and hospital partners
- Support HCC preparedness and response activities

10 Health Care Coalitions

Must include representatives of at least two acute care hospitals, one LHD, one EMA and one EMS provider, but some also include LTC facilities, MH providers, ASCs, rural health clinics and others

DEP Logistics Section: Roles and responsibilities

- **Identify and procure preparedness and response assets** needed to address actual or potential public health events and emergencies
- **Maintain and deploy assets** as needed to address public health emergencies or events
- **Coordinate resources** with vendors, partners, and state agencies during public health emergencies or events
- **Administer emergency systems** such as EMResource, IHAN, SERV-IN, etc.

DEP Planning and Preparedness and Mobile Response Sections:

Roles and responsibilities

Planning and Preparedness Division

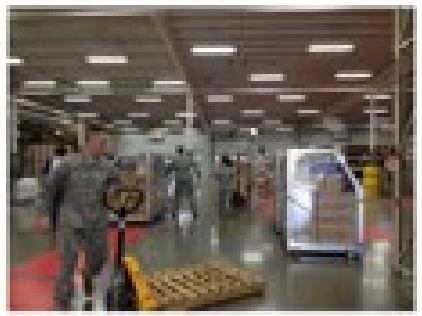
- **Planning:** Create preparedness and response emergency plans based on grant requirements and demonstrated need and provide planning assistance to others in the section/agency as needed
- **Training and Exercise:** Identify training needs, create/implement training to address those needs, conduct exercises as needed based on grant requirements
- External state agency coordination **(ESF-8)**

Mobile Response Division

- **Mobile vaccination and testing sites:** Hold targeted vaccination and testing sites throughout Indiana
- **Future Uses:** Provide a variety of public health mobile services beyond COVID-19 throughout the state of Indiana to increase health accessibility and equity

IDOH/DEP Resources

Strategic National Stockpile




Mobile Hospital, Rapid Inflatable Shelters

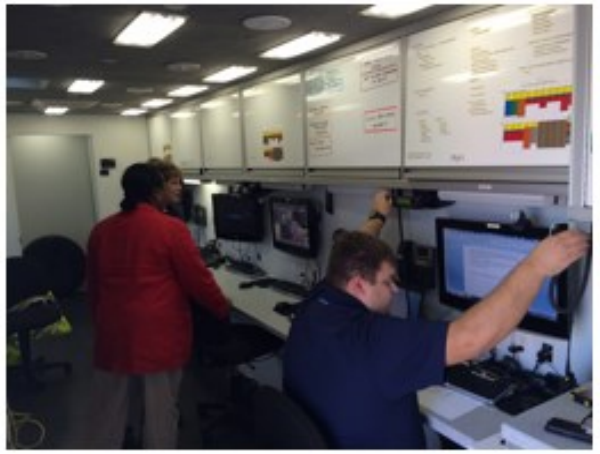






Advance Medical Supply Unit, Mobile Command Unit





Lessons Learned from Two Recent Emergencies

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Scott County HIV Outbreak (2014-2015)

One Community/One County

Timeline

Nov 2014: 1st case diagnosed

Jan 2015: IDOH investigation begins – link to intravenous drug use established

Mar 2015: Governor declares PH Emergency

Apr 2015: Governor signs Exec. Order authorizing temporary Syringe Services Program

Mar 2017: Total of 215 HIV cases attributed to the outbreak

Lessons Learned

- Community buy-in essential
- Need for law enforcement engagement with public health
- Must build trust with users
- Engagement of mental health and addiction services key to implementing a successful harm reduction program (syringe services)

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COVID-19 Pandemic Response (2020 - current)

Statewide, Nationwide, Worldwide

Indiana's Response

Helped **3.6M+** Hoosiers get **vaccinations**

Supported **testing** for 5M+ Hoosiers

Distributed over **40M+** pieces of PPE and **770k** testing supplies

Held **mass testing and vaccination sites** at the Indianapolis Motor Speedway, Gary, University of Notre Dame, Ivy Tech and several other locations throughout Indiana

Response Challenges

Unique Scope impacting the entire state/country simultaneously

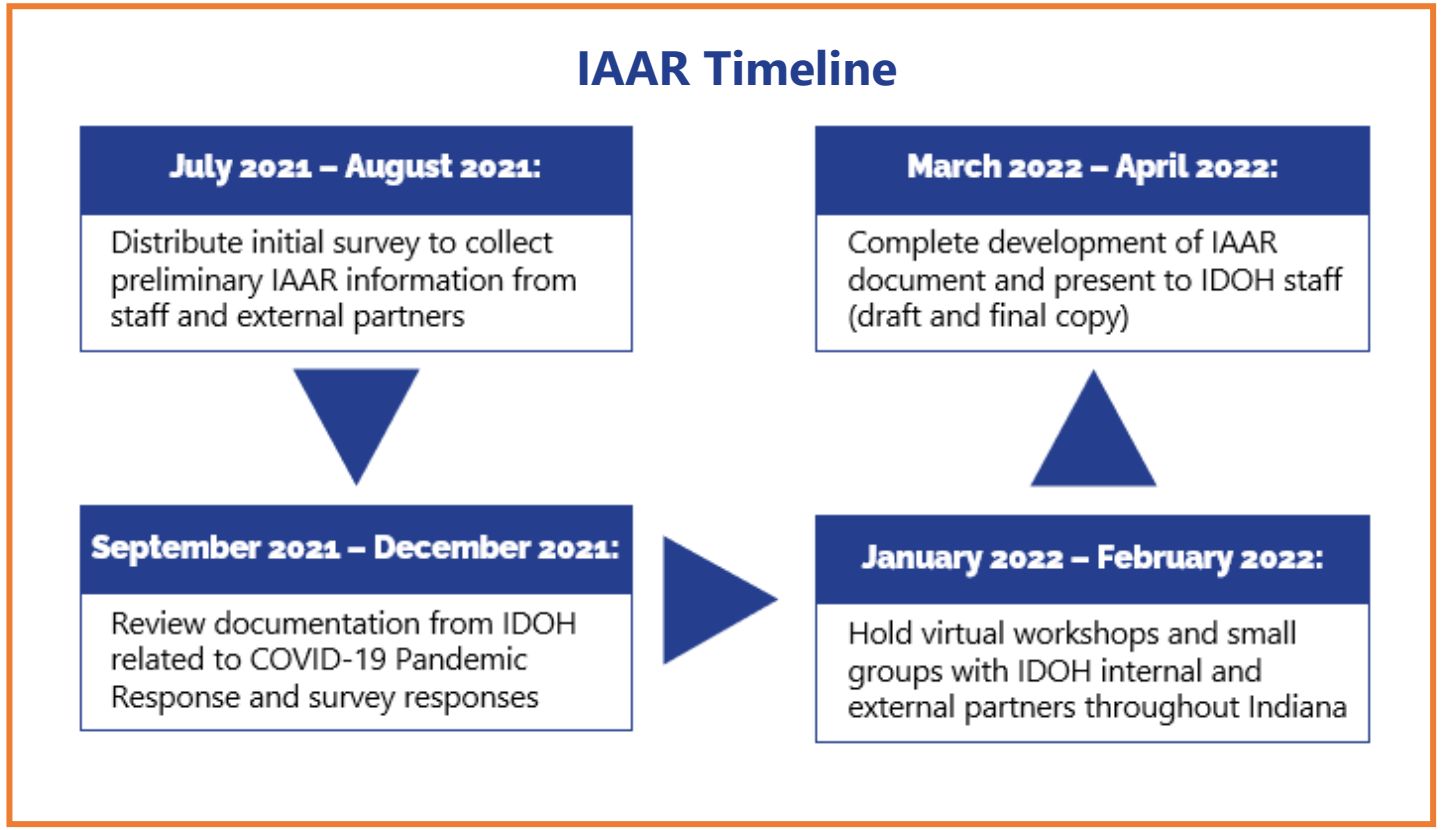
Supply scarcity impacting the ability to test locally and nationally

Evolving guidance that changed rapidly as new information became available

Need for testing with contact tracing and follow up with each close contact to control spread of infection

IDOH COVID pandemic Interim After Action (IAAR) Report development currently underway

- Purpose:
  - Assess strengths
  - Identify areas for improvement
  - Create an Improvement Plan (IP) to build on strengths and address areas for improvement
- IDOH partnered with DCMC Partners to gather feedback from internal and external partners and to develop the IAAR document



COVID Pandemic IAAR Survey Results

- In July 2021 IDOH surveyed internal staff and external partners involved in IDOH's response to the pandemic.
- 250+ individuals responded from local health departments, FQHCs, hospitals/health systems and healthcare providers
- Survey identified strengths and areas of improvement of various response activities

Most Cited Strengths:	Most Cited Areas for Improvement:
▪ **Worked relentlessly** to meet pandemic demands, including quick problem solving, rapidly learning and implementing new technology, taking on multiple roles, and maintaining open lines of communication at all hours ▪ Provided **outstanding guidance** and updated information throughout the pandemic ▪ Demonstrated **ability to learn and adapt** over the course of the pandemic	▪ Need **better communication** processes; ability to receive information prior to public announcement, e.g., at a Governor's press conference ▪ Increased IDOH **call center capacity** ▪ **Better training** of IDOH response staff on best practices for emergency operations coordination and the Incident Command System (ICS)

Considerations for Improvement

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Enhance Connectivity

Everybody wants to be the first to have information, especially during an emergency. While this is not always possible, Indiana can make improvements moving forward.

- Explore additional **technologies** to communicate
- Better **target demographic groups** utilizing better data
- Better **manage/anticipate** how information is **received and interpreted**
- Utilize **partnerships** to share consistent information

Enhanced Communications During COVID-19 Pandemic

Communication approaches in addition to direct messaging with hospitals, local health officials, first responders and others:

- Regular press conferences
- Real-time updated dashboard
- 2-1-1 service enacted
- Regular planning calls
- Bus wraps/advertising
- Geo-fenced text messages
- Highest level EOC activation
- IPAWS alert system for vaccines

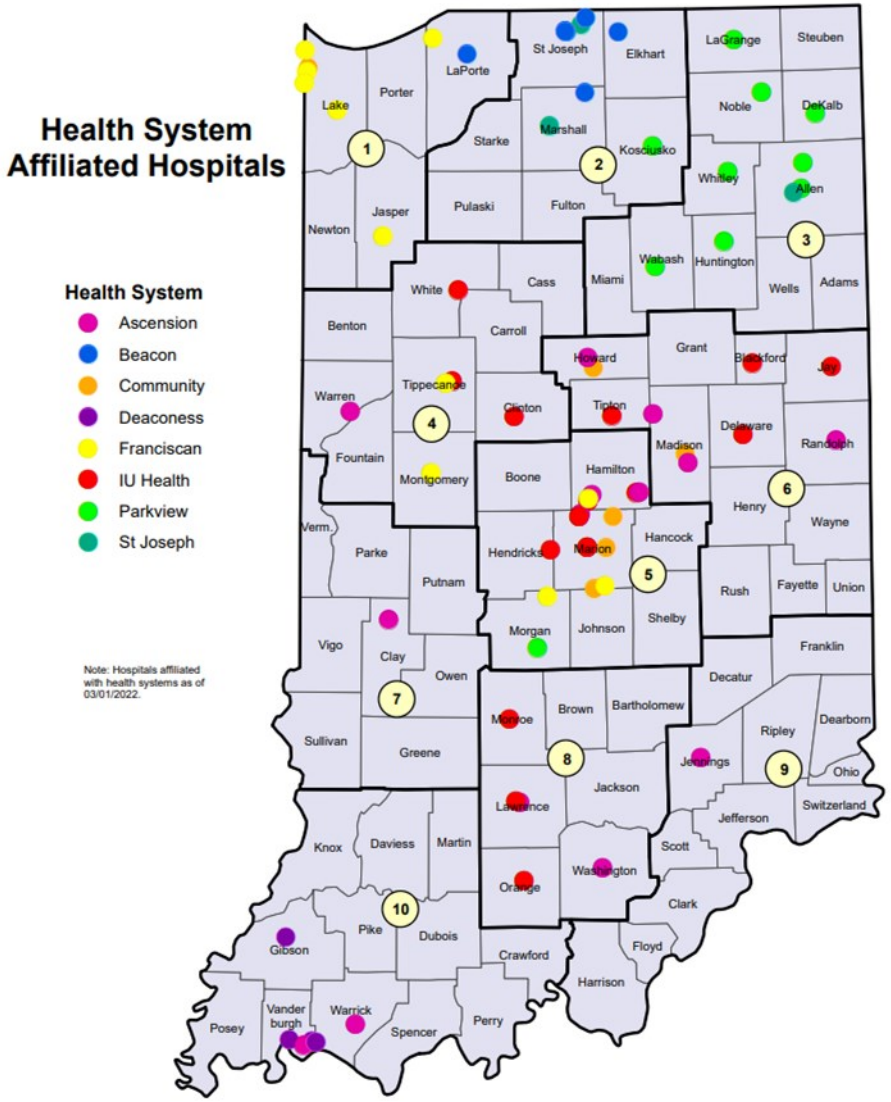
Enhance Integration and Coordination

- Create/expand **public/private partnerships**
- Encourage/promote participation, leadership, and **buy-in** from partners, facilities, providers and local elected officials
- Encourage/promote greater buy-in and participation at the **executive level**

Reconsider current IDOH DEP district boundaries, roles and responsibilities

Current boundaries are not always consistent with organic healthcare and emergency response referral patterns and may not work consistently regarding emergency response vs. emergency medicine/trauma care.

- **Different needs** in different districts
- Districts **vary in distance** from Level 1 facilities
- **Kokomo**: example of a city on the edge of two districts; training does not align with response model
- Need to consider how to address emergencies that **cross state lines**
- Need to **level set expectations** for those at the State and District levels. Currently no standardized approach
- **Training and messaging** need to go beyond district boundaries



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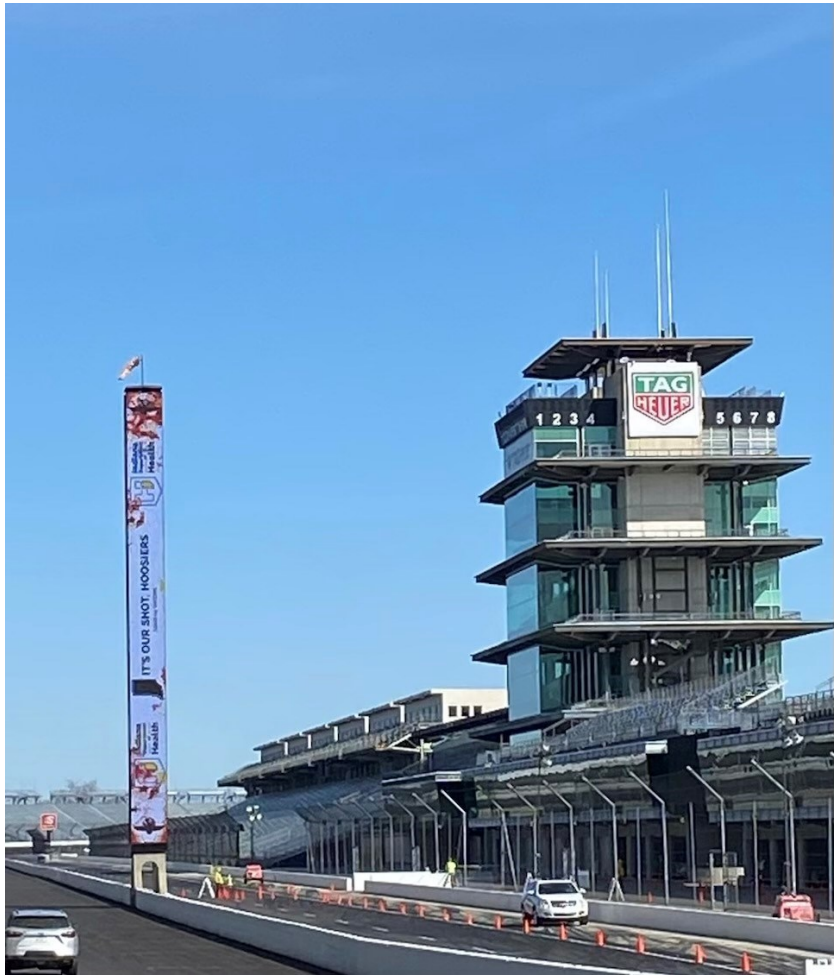
Improve and Sustain Readiness

Address lack of local ownership and resources in some areas of the state

- Some counties lack a full-time public health preparedness manager and/or an EMA director

Promote buy-in/utilization of EMResource

- The COVID-19 pandemic allowed for the acquisition and use of new technologies, including EMResource (EMR)
- EMR has been a vital part of the response by providing real-time situational awareness to hospitals, LHDs, EMS and others deemed appropriate and necessary
- Information captured includes bed capacity, bed availability, diversion status



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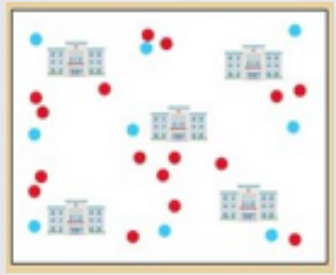
Close the Urban/Rural EMS Gap

- Emergencies happen every day in Indiana, and how EMS responds can be the difference between life and death
- Preparedness begins by being ready for those emergencies 24/7/365
- All Hoosiers should be guaranteed an ALS ambulance regardless of where they live
- Unfortunately, people are dying because access to EMS service is unequally distributed across rural and urban areas
- Having reliable and sustainable sources of funding for EMS readiness and emergency preparedness will help EMS provider agencies who deliver EMT and paramedic services to become and stay operational

*see appendix Trauma Transfer Delays slide 33

Urban/Suburban County, IN
Pop. 338,000



Time to definitive care = minutes

16 ambulances available 24/7

45 ALS capable apparatus

Ave Response Time = 3 minutes

Ave Transport Time = 5 minutes

Destinations facilities in county: 2 Level 1 Trauma, 2 Pediatric Trauma, 1 Burn Center

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Rural County, IN
Pop. 15,498

Time to definitive care = hours

2 ambulances available 24/7

8 BLS non-transport apparatus

Ave Response Time = 17 minutes

Ave Transport Time = 30 minutes

No destination facilities in county

Air transport available outside county

Transport time to trauma center = 5 hours roundtrip

Ambulance **Other ALS First Responder** **Destination Facility**

Scope and Scalability

- All emergencies begin and end on the local level
- An emergency that starts in one county or one community may expand to impact the district, state, or entire country
- As Indiana moves forward, we must ensure that our preparedness is scalable, reproducible, and sustainable

Appendix

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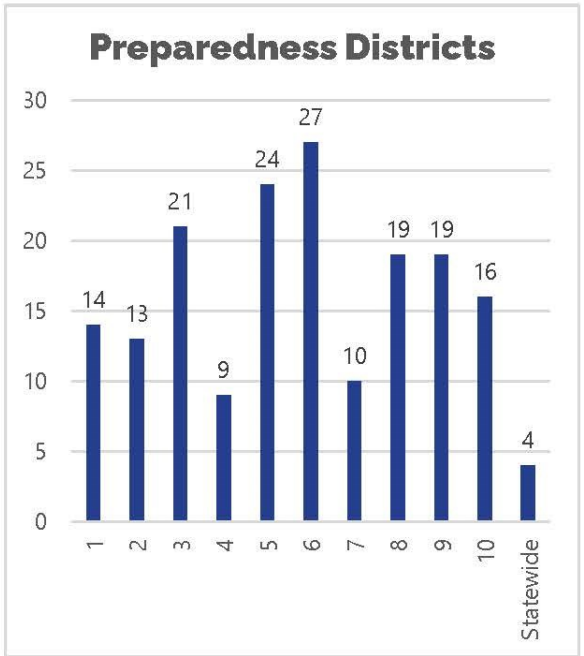
Indiana Trauma Transfer Delays

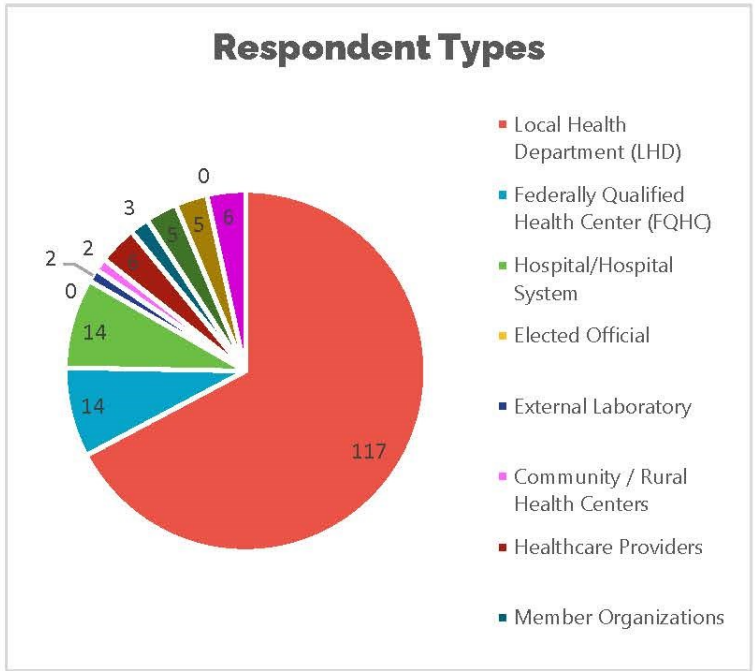
- Many traumatically injured patients require care at designated Trauma Centers due to the expertise and services available at those hospitals
- Hospitals are expected to transfer a patient needing a higher level of care within 2 hours
- A delay in transfer can lead to increased morbidity and mortality. Unfortunately, 31% of patients experienced a delay in their transfer
- **The shortage of available ground transportation was reported to be the number one cause of delay**

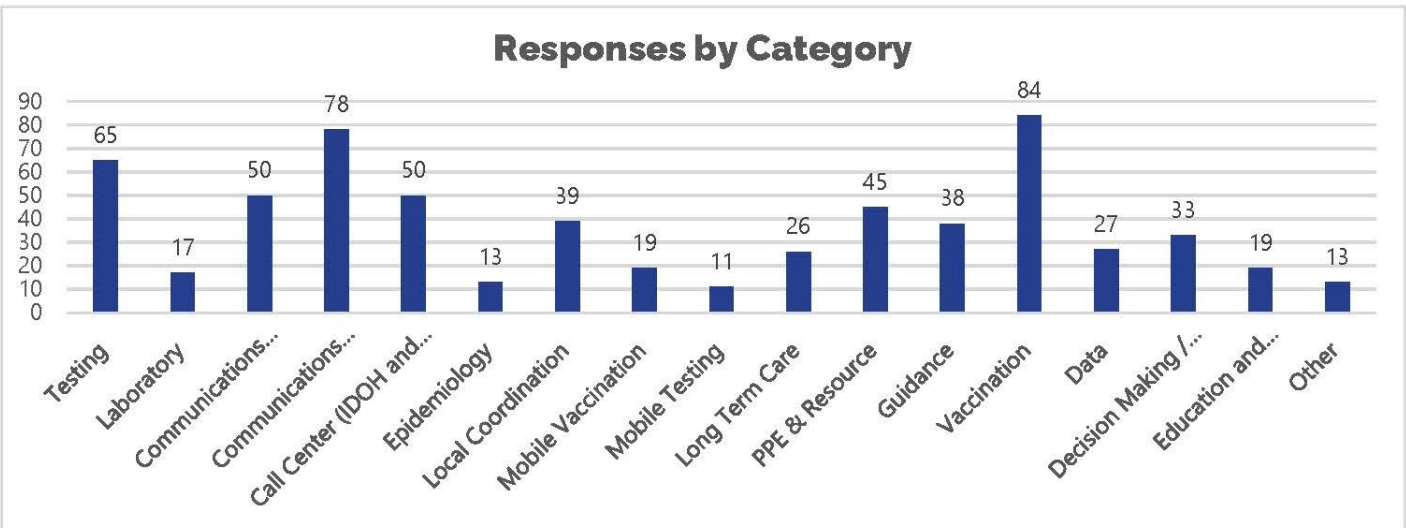
- Indiana Trauma Registry, from 2019-2021:
- 91% of delays occurred at Non-Trauma Hospitals, which are frequently rural and critical access hospitals
- "EMS Issues" made up the largest category of known reasons for transfer delay at 30% (902 people)
- The shortage of ground transportation made up 50% (429 people) of the reported "EMS issues" that caused the delay

IDOH COVID-19 AAR External Survey Results Summary

Responses by Category	
Testing	65
Laboratory	17
Communications (Public)	50
Communications (from IDOH to partner)	78
Call Center (IDOH and 211)	50
Epidemiology	13
Local Coordination	39
Mobile Vaccination	19
Mobile Testing	11
Long Term Care	26
PPE & Resource	45
Guidance	38
Vaccination	84
Data	27
Decision Making / Strategy	33
Education and Communication for Healthcare	19
Other	13







Respondent Types	
Local Health Department (LHD)	117
Federally Qualified Health Center (FQHC)	14
Hospital/Hospital System	14
Elected Official	0
External Laboratory	2
Community / Rural Health Centers	2
Healthcare Providers	6
Member Organizations	3
College / University	5
Business / Industry	5
Vendor	0
Other	6
Total	174

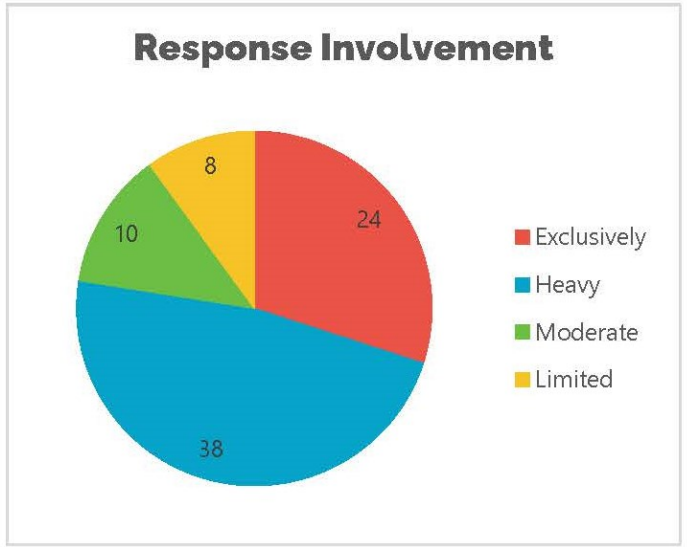
IDOH COVID-19 AAR Internal Survey Results Summary

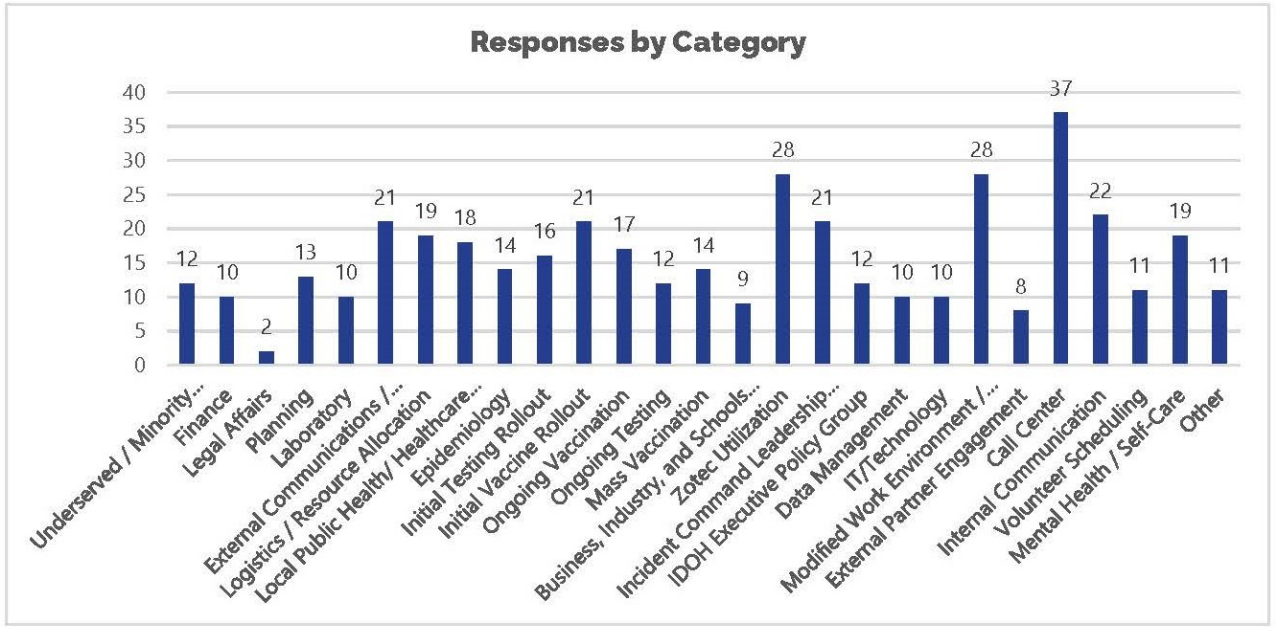
Category	Responses
Underserved / Minority Population Engagement	12
Finance	10
Legal Affairs	2
Planning	13
Laboratory	10
External Communications / Public Information	21
Logistics / Resource Allocation	19
Local Public Health/ Healthcare Outreach	18
Epidemiology	14
Initial Testing Rollout	16
Initial Vaccine Rollout	21
Ongoing Vaccination	17
Ongoing Testing	12
Mass Vaccination	14
Business, Industry, and Schools Outreach	9
Zotec Utilization	28
Incident Command Leadership and Structure	21
IDOH Executive Policy Group	12
Data Management	10
IT/Technology	10
Modified Work Environment / Remote Work	28
External Partner Engagement	8
Call Center	37
Internal Communication	22
Volunteer Scheduling	11
Mental Health / Self-Care	19
Other	11

Survey Dates	
Opened	6/29/2021 (Tuesday)
Closed	7/14/2021 (Thursday)

Respondent Number	
Total	81

Response Involvement			
Exclusively	**Heavy**	**Moderate**	**Limited**
24	38	10	8

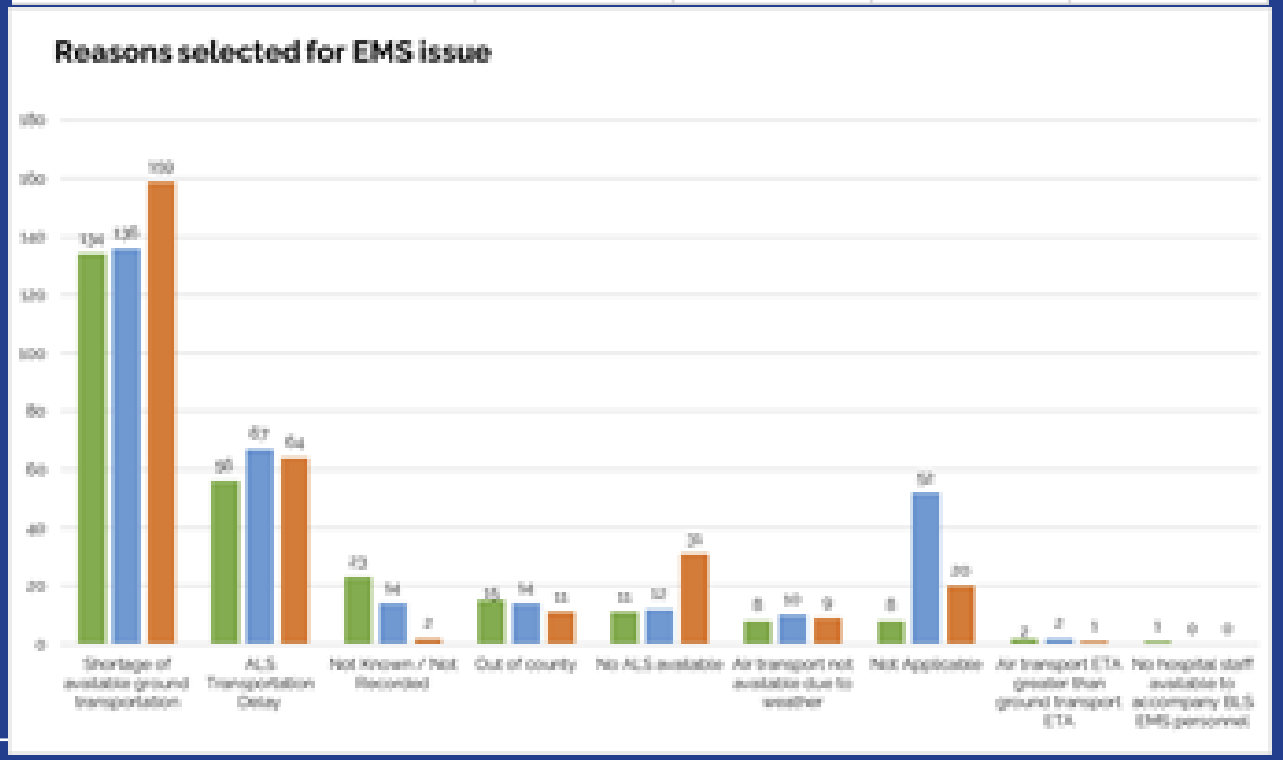




*Trauma Transfer Delays

- Patients from Non-Trauma Centers (NTCs) made up 79% of the trauma transfer patients from 2019-2021
- Of those patients, 31% of the patients transferred were identified as having been delayed for a variety of reasons
- After "unknown", **"EMS Issue" was listed as the number one reason** as the cause for the transfer delay
- Of those where a reason is given, "EMS Issue" made up 30% (902) of the reasons for delay from 2019 through 2021
- Of those listed due to "EMS Issue", 50% (429/862) were due to the shortage of available ground transportation.

TRAUMA (all transfer pts)	ED dispo = Transfer vs YearN			
	2019	2020	2021	Total
NTC	5907	6013	4796	16716
LV I & II	334	144	138	616
LV III	1277	1376	1219	3872
Total	0	7518	7533	21204



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