



Indiana State
Department of Health

ISDH Trauma System Advisory Task Force
Trauma Systems Consultation



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December 14th – 17th, 2008

Document compiled by Susan Perkins with contributions from Jodi Hackworth, the Trauma Task Force and other stakeholders.

**Pre-Review Questionnaire
Indiana Trauma Systems Consultation
December 14th – 17th, 2008**

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Introduction to the Indiana Trauma System

Indiana became the 19th State of the United States on December 11, 1816, and is nicknamed the Hoosier State, with the capital located in Indianapolis. The 2007 estimated population was 6,345,289. On the 2000 census form, 98.8% of the population reported only one race, with 8.4% reporting being African-American; 3.5% are Hispanic (of any race). The average household size is 2.53 persons compared to an average family size of 3.05 persons. According to the U.S. Census Bureau, Indiana ranks number one in the nation in percentage of workers (19.8%) who work in manufacturing, followed by Wisconsin (19.4%). Jobs in management, business or financial occupations are not as prevalent and Indiana ranks 42nd in the nation. Service jobs make up 15.7% of the workers in Indiana and Indiana ranks 35th in the nation. The average woman makes \$31,158 per year and the average man makes \$43,410. Both figures are below the national average of \$34,278 and \$44,255 respectively. In 55.8% of Indiana households, both parents work outside the home; nationwide it is 53.4%. Indiana ranks 24th in the nation for the percentage of households earning below the poverty level (12.3%). The median household income in Indiana is \$47,448 (31st in the nation).

Indiana has 129 acute care hospitals with emergency departments, as of August, 2007; this includes two Veterans' Administration Hospitals operated by the federal government, one in Indianapolis and one in Fort Wayne. The count excludes 20 long-term care and/or rehabilitation hospitals, as well as psychiatric hospitals. Sixteen of the 92 counties in Indiana do not have a hospital: Newton, Benton, Carroll, Fountain, Parke, Owen, Brown, Union, Franklin, Ohio, Switzerland, Martin, Pike, Crawford, Spencer, and Posey. Currently, 46 of the 129 acute care hospitals in the state are considered rural (located in Non-Metropolitan Counties). Thirty-five Indiana Hospitals are designated as Critical Access Hospitals.

Trauma significantly impacts the lives of Hoosiers. Consider that injury — not cancer or any disease — is the leading cause of death for state citizens 1 to 34 years of age. More than 95,000 Hoosiers are hospitalized and more than 5,000 die from injuries each year. The monetary cost to Hoosiers each year is astronomical. Just the subset of alcohol-related motor vehicle crashes (only 24% of Indiana's crash costs) cost the public an estimated \$2.4 billion in 1998, including \$1.1 billion in monetary costs and almost \$1.3 billion in quality of life losses. Add the remainder of the motor vehicle crashes along with all of the other causes of injuries, and the cost to Hoosiers is estimated to be in the \$10's of billions. The costs of these traumatic injuries can be significantly reduced through timely and effective treatment of the injuries as well as through effective injury prevention programs (\$1 spent on a child safety seat saves \$32 in direct medical costs; \$1 spent on bicycle helmets saves \$30 in direct medical costs; \$1 spent on a smoke alarm saves \$69 in fire related costs & \$21 in direct medical costs).

Trauma refers to people who have sustained moderate to severe injuries, requiring rapid evaluation and transport to hospitals with trauma centers that are best equipped to provide the comprehensive care needed. All hospital emergency departments are not trauma centers. A trauma system is an organized, coordinated effort in a geographic area that

delivers the full range of care to all injured patients. Until March 2006, Indiana was among a handful of states with no laws or regulations granting oversight authority for trauma care. Proper oversight is a necessary element of any trauma system. Public Law 155, enacted in 2006 with support from resolutions by the Indiana State Medical Association and the Indiana Emergency Nurses Association, changed that situation. This legislation designated the Indiana State Department of Health (ISDH) as the lead agency for a state trauma care system with goals of preventing injuries and coordinating care for injured patients in order to reduce death and disability.

However, even prior to enactment of Public Law 155, there were efforts in Indiana to develop a trauma system. In the 1990's, there was an Indiana trauma planning effort called the Indiana Trauma Assessment Group (ITAG) that ran into obstacles because of the inability to obtain a universal patient identifier to be able to track patients through the entire system of care for the examination of patient outcomes. In 2001, a group of stakeholders completed a trauma/disaster preparedness assessment that was published by HRSA in 2002 as part of a national state by state assessment of trauma system and disaster preparedness. There was a stakeholders meeting in 2002 and a SWOT analysis was performed. 2004 was the year that the current effort began with the ISDH working together with a multidisciplinary, multi-hospital, multi-organization group of 50 members interested developing a state trauma system.

The Indiana State Department of Health Trauma System Advisory Task Force, organized in May, 2004 as a stakeholder group, critically needed to work on all aspects of trauma system development and maintenance. The Task Force has broad representation from numerous organizations and individuals interested in developing a statewide trauma care system, with more than 100 people currently involved. Issues being considered by the Task Force include: leadership and authority for a statewide trauma system, policies, legislation and financing needed for such a system, system design (based on data and needs assessments), education of policy-makers, health professionals and the public, information management and quality of care indicators, collaboration, and resources to support a statewide system.

Task Force conclusions so far:

- The goal of a statewide trauma system is preventing injuries and coordinating care of injured patients to accomplish decreased death and disabilities due to trauma.
- It is desirable for all Indiana hospitals to eventually be part of a statewide trauma system, based on the level of care each hospital is able to provide.
- System participation by hospitals would be voluntary.
- Collaboration between emergency medical services, hospitals, rehabilitation facilities and public health is needed.
- A statewide trauma registry is necessary because it provides a proven mechanism to examine trauma patient care data on a confidential basis.

- All hospitals participating in the system must provide data to the state trauma registry.
- There should be a legislatively identifiable and sustainable source of financing.

Widespread education is needed to inform numerous constituencies (legislators, hospitals, and the public) about a statewide trauma system and that trauma is an important public health and health care delivery issue because of its major impact on the lives and health of Hoosiers.

The trauma registry (www.indianatrauma.org) is the foundation component of the trauma system, providing the ability to monitor the system for efficiency and effectiveness, inclusive of local level use for improved patient care and outcomes. The Indiana Trauma Registry was implemented in 2007, with initial participation by the seven hospitals in Indiana that are verified as Level I or Level II trauma centers by the American College of Surgeons Committee on Trauma (ACS-COT): Deaconess and St. Mary's hospitals in Evansville, both Level II; Parkview Hospital in Fort Wayne, Level II; Clarian Methodist Hospital, Riley Hospital for Children, and Wishard Memorial Hospital in Indianapolis, all Level I; and Memorial Hospital in South Bend, Level II.

Several other Indiana hospitals have volunteered to participate in the initial phase of the registry. In 2008, fifteen critical access hospitals participated in a pilot project with the state trauma registry. They entered data on their injured patients that were transferred to a higher level of care for the two-month period of June and July, 2008. They are continuing to provide feedback regarding the use of the registry. So far, the feedback has been positive and good suggestions have been made for improvements to the transfer record form that they use. The vendor that was chosen for the registry is ImageTrend from Minneapolis. ImageTrend has conducted tests to ensure the compatibility of the program with the data from the Firehouse reporting software that is being used by EMS and paramedics; linkage with the Firehouse system will occur when Indiana's Firehouse upgrades are completed in 2009.

Some states with trauma systems have a review process to designate hospitals according to the level of care that can be provided to injured patients – ranging from emergency department evaluation and stabilization in smaller hospitals to the most comprehensive levels of care provided in hospitals verified by the American College of Surgeons Committee on Trauma (ACS-COT). Indiana has the seven hospitals listed above with Level I or Level II trauma centers as verified through a strenuous review process by the ACS-COT.

After two years of study, the task force recommends pursuing a consultation agreement with the Committee on Trauma of the American College of Surgeons, a non-biased, nationally-recognized organization. They would be charged to evaluate the resources, legislation, trauma care delivery, trauma registries/data analysis, performance improvement, interagency cooperation/communication, professional/community education, and injury prevention and control currently in Indiana. The trauma system

consultation team will provide knowledge and experience from other states which will help Indiana as trauma system development proceeds. This consultation requires intensive advance preparation, a four-day visit from the College and the consultation team includes professionals from surgery, emergency medicine, trauma nursing and emergency medical services.

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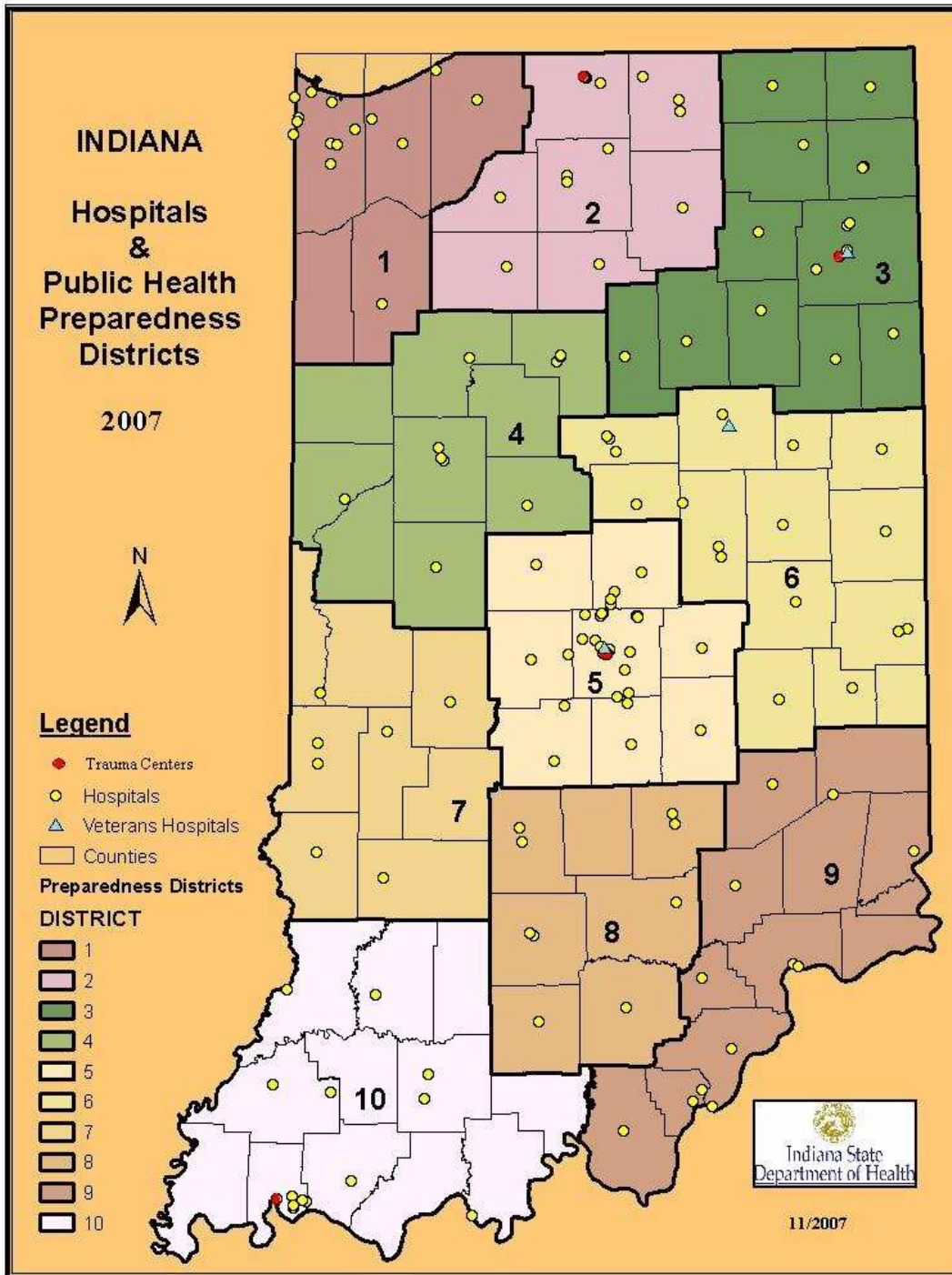
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Section 1: Assessment

Injury Epidemiology

Between 2002 and 2005, 14,316 people in Indiana died because of injuries. Of these, 9,219 were unintentional, 4,400 were intentional, and 696 were undetermined (Figure 3). The majority of unintentional injuries were due to motor vehicle crashes followed by poisoning (Figure 4). Thirty-five percent of the motor vehicle traffic incidents were occupant fatalities, 9.4 percent involved motorcyclists, 7.6 percent were pedestrian fatalities, and 0.3 percent involved pedal cyclists. Of the intentional deaths, 1,432 were from homicide, 40 (1%) were from legal intervention, and 2,928 were from suicide (Figure 5). Over half (56.9%) of the suicide deaths occurred by firearms and 67.7% of homicides occurred by firearms.

When comparing genders, male injury rates were higher than female rates. Figure 6 shows injury rates for males and compares the United States, the Midwest, and Indiana. Indiana's suicide death rate for males was higher than both the United States and the Midwest rates. Figure 7 shows injury rates for females and the comparison between the United States, Midwest, and Indiana. Indiana females had the highest rate for all injuries and homicide as compared to both the US and Midwest rates.

Based on national data, males are at increased risk for motor vehicle crashes, falls, drowning, and homicides. Men over the age of 65 years have the highest suicide rate. They may be less likely to ask for help putting them at an increased risk for depression, a risk factor in suicide. Women are often physically or sexually assaulted by an intimate partner and are also often hospitalized for suicide attempts. Among older women (aged 65 years and older), there is an increased risk of falling and sustaining a hip fracture, with osteoporosis being a major contributor to this type of injury.

The census population of Indiana is almost equally distributed by gender, with females accounting for 50.7 percent (based on Indiana 2006 census population at www.census.gov). Males though have higher injury death rates than females for all age groups (Figure 8). During 2002-2005, males accounted for 68 percent of all injury deaths and were 2.4 times as likely as females to be fatally injured.

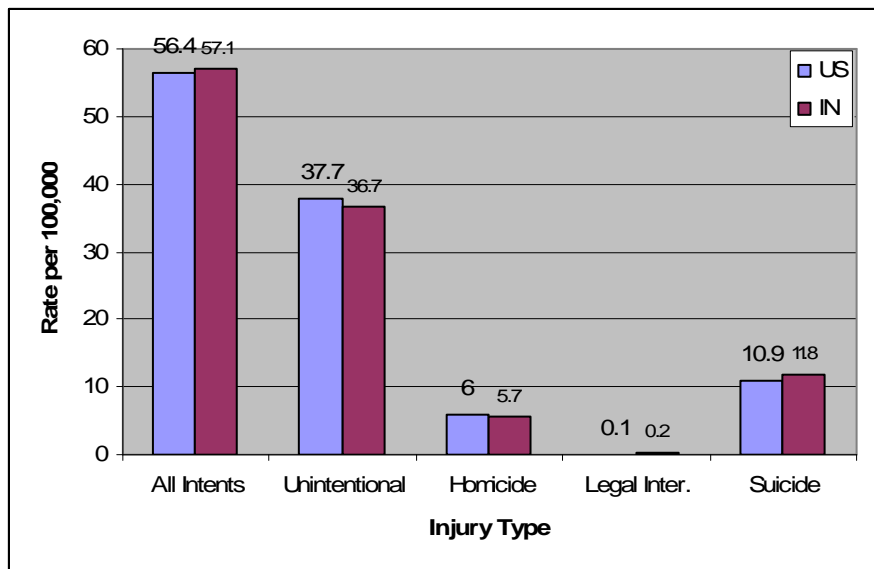
The leading cause of unintentional injury death for both genders during 2002-2005 was motor vehicle traffic crashes. The motor vehicle traffic crashes accounted for 44.7 % of the deaths in males and 35.1% of the deaths in females. Other leading causes of unintentional injury deaths in males included poisoning (13.3%) and falls (10%). As for females, who accounted for 32% of all injury deaths, other leading causes of unintentional injury deaths include falls (14.9%), poisoning (12.2%) and suffocation (8.7%).

Suicide was the 7th leading cause of death for males during 2002-2005. Firearms accounted for 61.6% of all suicides followed by suffocation (22.2%) and poisoning

(11.8%). Homicide was the 13th leading cause of death for males and firearms were used in 74.2% of the intentional injury deaths. Suicide was the 19th leading cause of death for females during 2002-2005. Poisoning accounted for 41.2% of all intentional injury deaths followed by firearms (25.8%) and suffocation (16.8%).

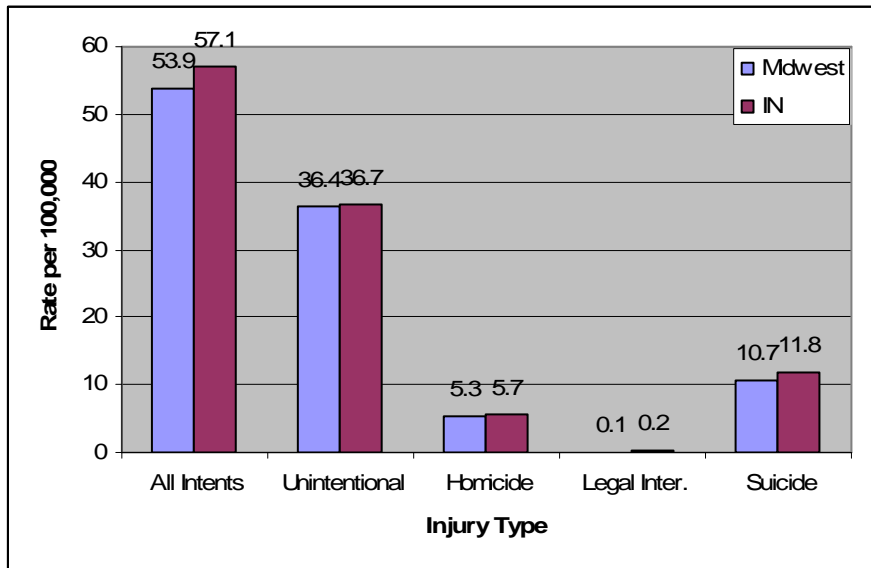
The distribution of the leading causes of injury-related deaths varied by age groups. Injury rates of death were highest among the 75-year and older age groups (125.8 per 100,000 among persons 75 to 84 years and 330.42 per 100,000 among persons 85 years and older. See Figure 8. Following these age groups, rates were high among persons aged 20 to 24 years (75.1 per 100,000). The lowest rates of injury death were among persons aged 5 to 9 (7.0 per 100,000). Males, aged 85+, had the highest rate of injury death (451.4 per 100,000) and females, aged 85+, had the second highest rate of injury (281.1 per 100,000).

Figure 1: Injury Death Rates, United States compared to Indiana, 2002-2005



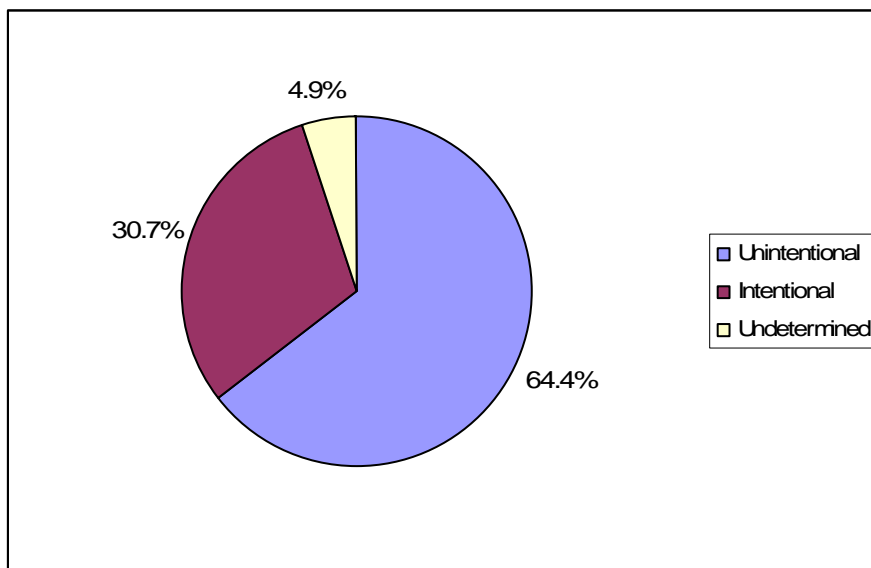
Source: CDC, WISQARS

Figure 2: Injury Death Rates, Midwest compared to Indiana, 2002-2005



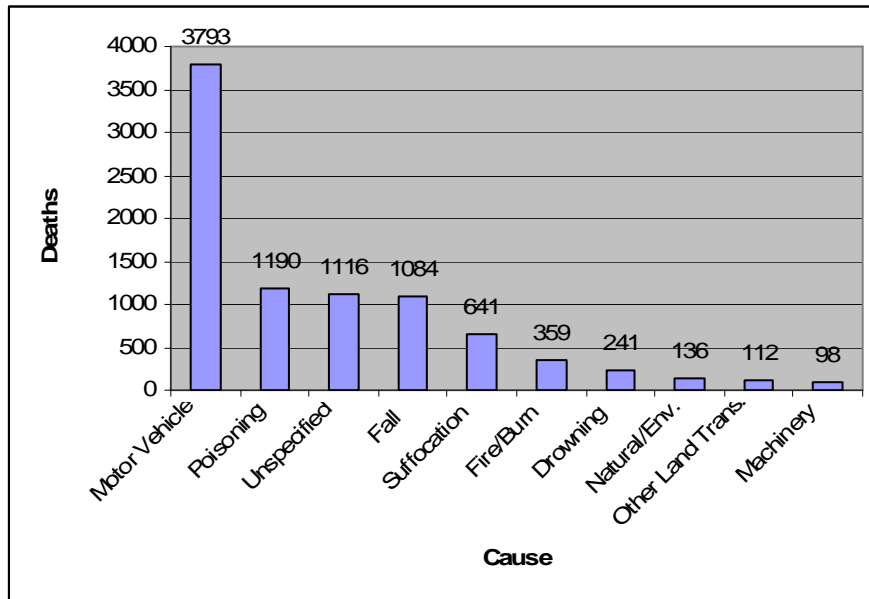
Source: CDC, WISQARS

Figure 3: Injuries by Intent, Indiana, 2002-2005



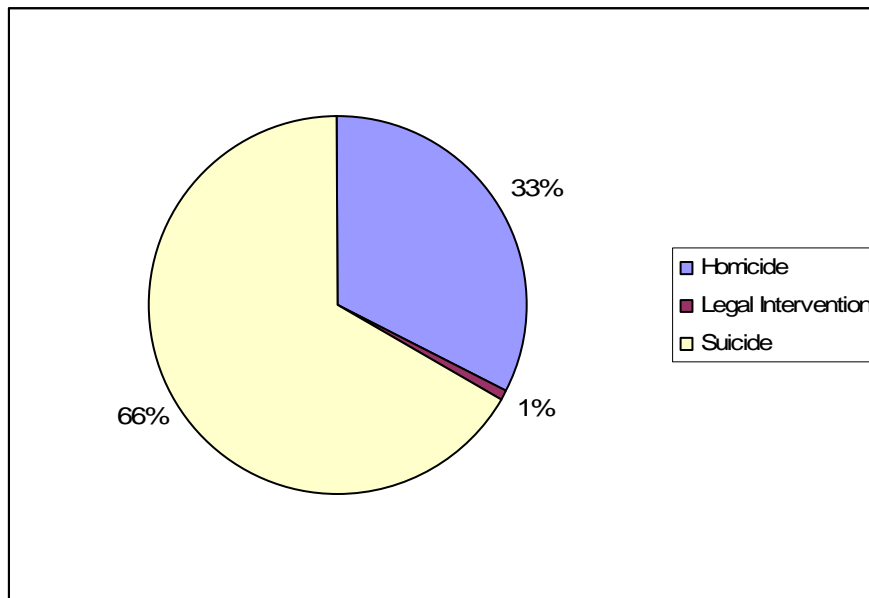
Source: CDC, WISQARS

Figure 4: Top Causes of Unintentional Injury, Indiana, 2002-2005



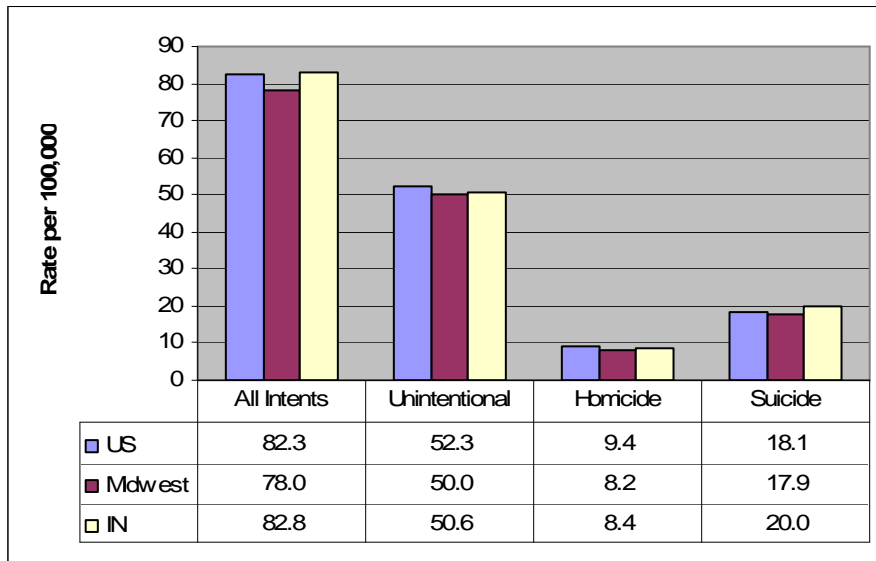
Source: CDC, WISQARS

Figure 5: Intentional Injury by Type, Indiana, 2002-2005



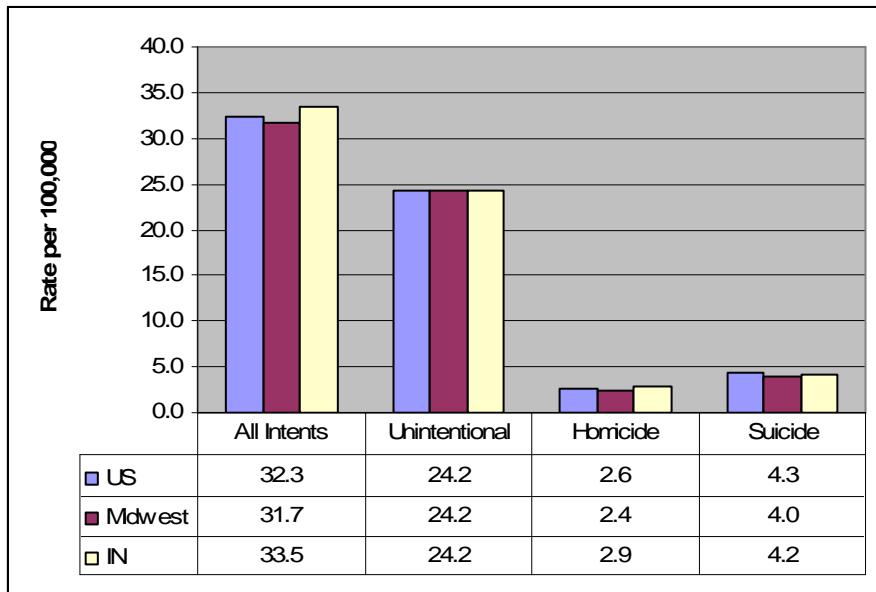
Source: CDC, WISQARS

Figure 6: Injury Death Rates, United States, Midwest and Indiana Comparison, Males, 2002-2005



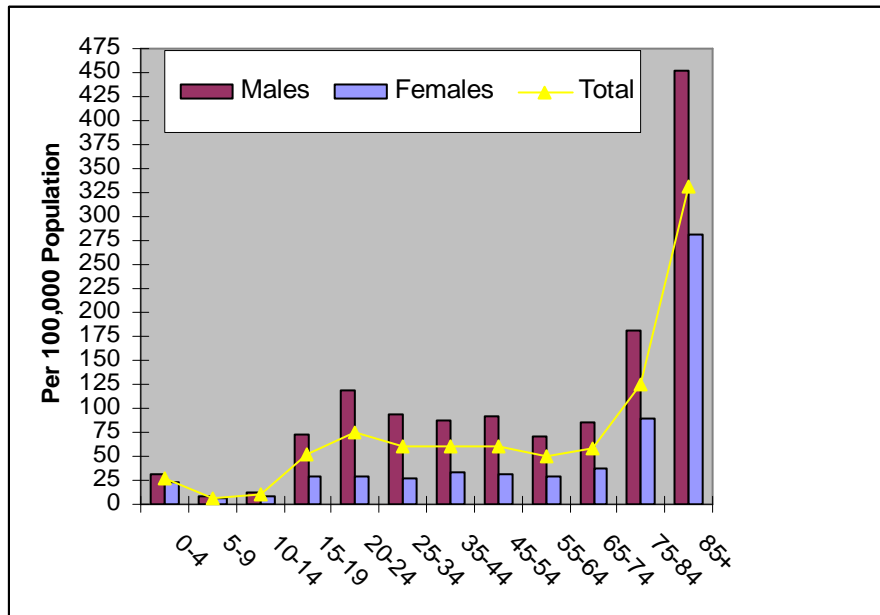
Source: CDC, WISQARS

Figure 7: Injury Death Rates, United States, Midwest and Indiana Comparison, Females, 2002-2005



Source: CDC, WISQARS

Figure 8: Injury Death Rates in Indiana by Gender and Age, 2002-2005



Source: CDC, WISQARS

1. Describe the epidemiology of injury in your region and unique features of:
 - a. Children - **Elementary school age children (aged 5 to 9 years):** From 2002 to 2005, the leading cause of death for elementary school age children was unintentional injuries with 102 deaths. Elementary school age children received more fatal injuries from motor vehicle traffic-related incidents (48%) than from any other cause. Fall-related injuries within this age group accounted for approximately a third (29%) of hospitalizations but this injury mechanism is not among the top five leading causes of death. Drowning and fire-related injuries accounted for 27 percent of all unintentional injury deaths in this age group. Homicide was the fourth leading cause of death with 14 deaths during this time frame. Firearms accounted for approximately 25% of the homicides.
 - b. Adolescents - **(aged 10 to 19 years):** The “pre-teen “and adolescent age groups demonstrate an expanded list of injury prevention concerns to consider. From 2002 to 2005, the leading cause of death for adolescents was unintentional injuries with 739 deaths. In Indiana, motor vehicle traffic incidents were by far the leading cause of injury and death among children and teens (aged 10 to 19 years). Among them, 76 percent of unintentional injury deaths and 42 percent of all hospital admissions resulted from traffic crashes. While driving a car becomes a common “rite of passage” for 16-year-olds in Indiana, their driving skills only improve with experience in operating a motor vehicle. Impulsive, risk-taking behavior continues with this age group which may include experimentation with or involvement in alcohol and substance abuse. While falls are the second leading cause for unintentional injury hospital admission in this age group, poisoning (5.5%) and drowning (3.5%) are the next leading causes of unintentional injury deaths. Suicide and suicide attempts are also important causes of injuries. The

second leading cause of death for adolescents was suicide with 159 deaths, and the third leading cause of death was homicide with 151 deaths.

The youth risk behavior survey is also a tool to determine information about injuries relating to violence and suicide for students in grades 9-12. According to the youth risk behavior survey from 2007, the percentage of students in grades 9-12 who carried a gun during the past thirty days was 9.1% compared to 5.8% during 2005 (statistically significant). Over 9.5% of students indicated they had been threatened or injured with a weapon such as a gun, knife, or club on school property one or more times during the past 12 months which is higher and statistically significant than 8.8% in 2005. Suicide attempts and planning attempts went down during 2007 compared to 2005 and were statistically significant. Over eleven percent (11.7%) of students (compared to 14.8% in 2005) made a plan about how they would attempt suicide. Over 7% of students actually attempted suicide one or more times compared to 9.6% of students in 2005. There were 2.9% of the students who indicated that they had made a suicide attempt that resulted in an injury, poisoning or overdose and had to be treated by a doctor or nurse (compared to 3.5% during 2005).

- c. **Elderly people - (aged 65 years and older):** Both physical and cognitive changes play a role in older Americans' susceptibility to motor vehicle-related injuries, falls, and suicide. As Americans age, their bones become more fragile, they experience problems with vision, their reflexes become slower and some are cognitively impaired by mental illness and/or depression. Although Americans are living healthier and longer lives, facing the reality of poor vision, limited mobility, the loss of loved ones, and/or the development of chronic illnesses can be devastating. Feelings of isolation and adjusting to a less active lifestyle increase the risk of suicide. The rates of death due to injury for the elderly population are between two and four times higher than all other age groups. The elderly aged 75-84 has almost a two-fold higher rate of death compared to the next highest aged group of 20 to 24 year olds (75.1 per 100,000 versus 125.8 per 100,000) and the 85+ year olds have over a four fold higher death rate (330.42 per 100,000) compared to the 20-24 year olds. In Indiana, falls, motor vehicle traffic incidents, and poisoning continue to be the leading causes of unintentional injury hospitalizations for elderly citizens. Among this age group, falls accounted for an overwhelmingly 85 percent of all unintentional injury hospitalizations. From 2002 to 2005, unintentional injuries were the 9th leading cause of death in the elderly with 3,124 deaths. Almost 30% of the deaths were due to falls, and 20.3% were due to motor vehicle crashes. Suicide was the 19th leading cause of injury death in elderly people and approximately 80% of the deaths occurred with a firearm.
- d. **Other special populations:**
Infants (less than one year of age) – From 2002 to 2005, 161 infants died due to unintentional injuries, the sixth leading cause of death for this age group. The majority (84.5%) were due to suffocation. Of the suffocation deaths, 48.5% of

the deaths were due to accidental suffocation and strangulation in bed. The rate of injury death for black infants during 2002-2005 was 165.7 per 100,000 which is over three times higher compared to white infants (53.17 per 100,000). The primary cause of hospital admissions for infants was falls and accounted for 36 % of all hospitalizations.

Adults (20-64 years of age) – Unintentional injuries were the third leading cause of death among adults from 2002 to 2005. Of the 4,923 deaths, over half (51%) were due to motor vehicle crashes and nearly one-fourth (22%) were the result of poisoning. Falls are also of concern, emerging as the sixth leading cause of unintentional death beginning at aged 35 years, then becoming the 3rd leading cause at aged 45 years. Unintentional falls are also the 2nd leading cause of hospital admissions for persons aged 20 to 44 years. Beginning at age 45, falls are the primary reason for hospitalization, ranging from 41% of unintentional injury related hospitalizations for persons aged 45 to 54 years to 85% for persons aged 55 to 64 years. Suicide was the fourth leading cause of death with 2,367 deaths, and homicide was the ninth leading cause of death with 1,096 for the four-year time period. Suicide by firearm and homicide by firearm, among the leading contributors for intentional injuries for persons aged 20 to 64 years, accounted for 54 percent of all intentional injury suicide deaths and 74% of all intentional injury homicide deaths in this age group. Homicide as a cause of death predominated in the 20 to 34 year-old age groups. Suicide by suffocation and poisoning are also of concern in the 20 to 64 year age groupings, comprising 42 percent of intentional injury deaths among them, and suicide by poisoning is the primary reason for hospital admission (93%). Although most adults are experienced motor vehicle drivers, the role of unsafe driving practices, failure to wear a seat belt, or driving while intoxicated continue to be contributing factors to the toll of death and injuries related to motor vehicle crashes.

Since falls are the primary cause of hospital admission for unintentional injuries for 45 to 64 year olds, the behavioral risk factor surveillance survey (BRFSS, 2006 survey) asks questions about recent falls and if the fall caused an injury. Among 45-54 year olds, 14.9% indicated that they had fallen 1-4 times within the past three months and of those who had fallen, 38.8% said the fall caused an injury. Among 55-64 year olds, 15.6% answered they had fallen 1-4 times within the past three months and of those who had fallen, 31.1% indicated that the fall caused an injury.

Note: At the trauma center level, there are differences in the way that the age groups are defined and data is collected. For example, Deaconess Hospital in Evansville (ACS Level II) defines children <15 years of age as pediatric patients. Those \geq 15 years of age are considered adults. They currently do not break down ages for Adolescents or Elders. Because they are an Illinois verified trauma center they do include falls from a standing position requiring hospitalization. They do, however, have the capability to filter data for any age group needed.

2. Describe the databases that are used to formulate the injury epidemiology profile (for example, population-based and clinical). Three primary data sources were utilized to compile fatal and nonfatal injury data for Indiana: Web-based Injury Statistics Query and Reporting System (WISQARS), Fatality Analysis Reporting System (FARS), and Indiana Hospital Discharge Data. Other resources such as the Youth Risk Behavior Surveillance System (YRBSS), the Behavior Risk Factor Surveillance System (BRFSS), and the Indiana Criminal Justice Institute have also been used to collect data.

At the hospital level, there are three different registry software types in use by the seven trauma centers in Indiana: Riley Hospital, Wishard Hospital and Clarian Methodist Hospital (all ACS Level I) use Digital Innovation's Collector database. Deaconess Hospital and Memorial Hospital in South Bend (both ACS Level II) use Digital Innovation's NTRACS database. St. Mary's Medical Center in Evansville and Parkview Hospital (both ACS Level II) in Fort Wayne use Clinical Data Management's Trauma Base.

3. Have system epidemiology profile results (for example, mortality rates, distribution of mechanism, or intent) been compared with benchmark values? If so, please provide comparisons and origins of the benchmarks. Yes. Indiana's death rate for all injuries was 57.1 per 100,000 from 2002 to 2005 which was higher than the United States' rate of 56.34 per 100,000 (Figure 1). Indiana's suicide and legal intervention rates were also higher than the United States rates. Indiana's injury death rate in comparison to other states ranks 28th for all intents, 33rd for unintentional injuries, and 26th for intentional injuries. Indiana's death rate for all injuries was also higher than the Midwest rate (53.9 per 100,000) (Figure 2) and had the 4th highest age-adjusted rate for all injuries. Indiana's unintentional, homicide, legal intervention, and suicide death rates were also higher than the Midwest rates. When comparing between other Midwest states, Indiana had the 7th highest unintentional death rate and 2nd highest rate for violence-related injury deaths.

At the hospital level, the trauma centers submit data annually to the National Trauma Data Bank, which allows for benchmarking against comparable hospitals (size and trauma level) nationally. The NTDB makes these reports available on a yearly basis, and the trauma centers can review these results to ensure that they address areas for improvement and recognize areas of excellence. An example of 2007 NTDB data for one trauma center (Memorial Hospital, South Bend) is below:

Patient Characteristics:

- Age distribution of patients injured in MVCs and by firearm/piercing instruments peaks from 36-55 years (73.3% male) and a second peak from 17-25 years (72.7% male).
- Age distribution for fall-related incidents peaks in the ≥ 65 year age group (68.6% female). A second peak occurs from 36-55 years (63.5% male).
- In comparison, the age distribution of patients in NTDB peaks from 16-24 years, representing patients injured in motor vehicle traffic related incidents and by firearm. There is a second peak between ages 35-44, including motor vehicle traffic related injuries. A third smaller peak occurs between ages 72-85, consisting

of motor vehicle traffic related injuries and falls. Up to age 70, males predominate, but after age 70, most patients are female.

Mechanism:

- Falls account for 47.3% of cases entered into the trauma registry and 39.7% of the deaths; falls were associated with the second largest number of both hospital days and ICU days; average hospital LOS is 5 days and ICU LOS 3.4 days. In the comparative NTDB data, falls account for 27.2% of cases, 22% mortality and are associated with the second largest number of hospital and ICU days.
- MVC related injuries account for 32% of trauma registry entries; these injuries account for 34.5% of mortality; MVCs were responsible for the largest number of hospital days (average 7) and ICU days (average 6.4). In comparison, MVCs account for 41.3% of cases in the 2006 NTDB, 44.5% mortality and are associated with the largest number of hospital and ICU days.
- Penetrating injuries (firearm or piercing instruments) account for 8.2% registry cases and 12% mortality. Average hospital days of 3.0 and ICU days 3.4. In the NTDB data, firearm injuries represent 5.6%, peak around 19 years and account for 22% mortality.

Other mechanisms such as struck, machinery, bike, assault or abuse represent the final 12.5% of registry cases and 13.8% mortality. In the NTDB data, injuries resulting from being struck by/against represent 6.4% of injuries.

4. Describe how emerging injury control patterns (for example, from trend or surveillance data) were identified and acted on. Suicide is one of the main injuries that have been identified and acted on in Indiana. In 2001, in response to the national call to action and the magnitude of the problem in Indiana, the Indiana Suicide Prevention Coalition (ISPC) was formed. ISPC is actively working to have all regions of the state as well as a variety of stakeholders including health, mental health, education, policy makers, coroner's office, the faith community, survivors of suicide, youth, elderly, people of diverse racial, ethnic, and gender backgrounds, and others represented on the Coalition.

The mission of ISPC is to coordinate, facilitate, advise, and provide resources to Indiana communities for activities that reduce deaths due to suicide, the occurrence of suicidal behaviors, and the effects of suicide on Indiana citizens. ISPC's on-going activities include coordinating information sharing via bi-monthly Coalition meetings, a listserv, and a statewide email list; facilitating the growth of local suicide prevention councils in counties and regions across Indiana; raising awareness of the prevalence of suicide, the devastating impact it has on families, and its preventability; helping communities and organizations find and implement suicide prevention and intervention training; providing resources to organizations and community members regarding suicide facts, trends, events, and evidence-based programs. The Coalition also aids schools in responding to suicidal students by both distributing a Youth Suicide Prevention School-Based Guide to help schools plan prevention, intervention, and post intervention efforts, and updating and distributing the Indiana Department of Education's Student Suicide manual used by Guidance Counselors and Social Workers. Past activities include conducting telephone surveys to determine Hoosiers' knowledge and awareness of suicide and suicide prevention to help refine Indiana's suicide prevention programs and surveying Indiana

schools and youth-serving organizations' efforts regarding suicide prevention, intervention, and post intervention programs and services.

In addition to the statewide coalition, Indiana has eleven local suicide prevention councils working in communities across the state to prevent suicide. The local/regional councils and coalitions around Indiana have developed in response to local needs (Allen County St. Joseph County, Dubois County, and Elkhart County) or via efforts by ISPC to bring together interested stakeholders to discuss suicide prevention efforts in their community (Vigo County, Southwestern Indiana, and Northwestern Indiana). The local/regional councils are engaged in different activities such as working with funeral directors to distributing awareness materials (Vigo County), building survivor resources (St. Joseph County), researching barriers to screening with physicians (Allen County), and training school staff in QPR (Question, Persuade, and Refer), a suicide prevention program, (Dubois County).

ISPC has a state suicide prevention plan that local/regional councils can use as a blueprint to shape their community plan. ISPC is available in an advisory capacity for the regional and county-level suicide prevention councils to offer resources and technical assistance in developing, implementing and evaluating their own suicide prevention strategies and plans. The Coalition also helps coordinate statewide efforts and resources, establish suicide prevention and intervention strategies, and document and monitor the implementation of the statewide plan for suicide prevention.

Efforts by the Indiana Criminal Justice Institute in cooperation with the Indiana State Police, the state CODES Board of Directors, the Traffic Records Coordinating Committee and others have led to changes in Indiana's child restraint and adult seatbelt laws. Prior to these efforts, occupants of passenger trucks were not required by law to wear a seatbelt. IC 9-19-10-2 (effective July 1, 2007) states that each front seat occupant of a passenger motor vehicle equipped with safety belts must be properly fastened when the vehicle is in forward motion. Indiana state law (2005) now also requires children less than 8 years old to ride in a federally approved car seat or booster seat that is appropriate for the child's height and weight; it also requires that the car seat or booster seat be installed and used according to the manufacturer's instructions. Children ages 8 to 16 must ride in a seat belt. Below is a press release describing the results of the change in the seatbelt law:

FOR IMMEDIATE RELEASE

July 28, 2008

Indiana Seat Belt Usage Rate Climbs to Over 90 Percent
Surveys show that Hoosiers are buckling up in record numbers

Indianapolis, IN. –Indiana Criminal Justice Institute (ICJI) Executive Director, Neil Moore today announced that Indiana's overall observed seat belt usage rate has reached a record high of 91.2 percent. This surpasses the 2007 record of 88.4 percent by more than two points, according to surveys conducted during the 2008 "Click It or Ticket" statewide enforcement mobilization.

“These numbers are extremely impressive and speak to the level of importance Hoosiers are putting on their safety,” said Executive Director, Moore. “This data is a strong indicator of the remarkable strides that we are all making to save lives on Indiana’s roadways,” Moore continued.

The highest rate of observed seat belt usage, more than 95 percent, was among female drivers and passengers. In slightly fewer numbers, male drivers and passengers were buckled up at a rate of about 88 percent. There was also an increase in seat belt usage rates among pickup trucks with numbers jumping 14 points since 2007 to more than 79 percent in 2008.

“The single most effective way a person can prevent death or injury in a vehicle collision is the use of a seat belt,” said Ryan Klitzsch, ICJI Traffic Safety division director. “Our goal is to sustain awareness of this message while supporting state and local law enforcement agencies in their year-round efforts to enforce Indiana’s seat belt law.”

Indiana traffic fatalities are also down approximately 25 percent (121) in comparison to this time last year. Data derived from the 2007 Indiana Occupant Protection Fact sheet, published by ICJI indicates that 54 percent of the individuals killed in car crashes in 2006 (where restraint usage was known) were unrestrained.

Nearly 80 percent of individuals killed in pickup trucks, also in 2006 (where restraint usage was known) were unrestrained. The Traffic Safety division of ICJI estimates that 269 lives could have potentially been saved if those killed would have worn seat belts. The National Highway Traffic Safety Administration (NHTSA) has determined that seat belts are more than 50 percent effective in preventing a fatality when a crash occurs.

“Motorists should remember that wearing a seat belt is not only their best defense against death or injury in a crash – it’s the law,” said Indiana State Police Superintendent, Paul Whitesell. “We are striving for 100 percent compliance, and until that goal is met, there is still work to be done,” Whitesell added.

In 2007, Governor Mitch Daniels closed the loophole in Indiana’s previous seat belt law by enacting legislation that requires all occupants of every passenger motor vehicle, including pickup trucks, and those vehicles plated as such, to buckle up regardless of where they are seated in the vehicle. During the 2008 “Click It or Ticket” mobilization, law enforcement officers cited more than 23,000 motorists for failure to comply with Indiana’s current seat belt law.

The Indiana Criminal Justice Institute (ICJI) serves as the state's planning agency for criminal justice, juvenile justice, traffic safety, and victim services. ICJI develops long-range strategies for the effective administration of Indiana's criminal and juvenile justice systems and administers federal and state funds to carry out these strategies.

At the trauma center level at Riley Hospital in Indianapolis (Central Indiana), based on injury data from the Riley hospital system (that includes all patients less than 18 years of age treated in ED or as an in-patient), zip codes with the highest injury rates per mechanism were benchmarked against national estimates (FARS, WISQARS, NEISS). Two zip codes which have much higher age-adjusted injury rates than the national average for children less than 18 were targeted for intense interventions at the community level. The data was taken to the neighborhoods and strategic plan was initiated that focused on environmental, behavioral, and policy changes. Community partnerships were formed with the City agencies, School system, United Way, and other agencies that worked in the area. The focus is on home-based injuries and pedestrian/bicycle injuries, as well as improving the daycares/preschools in the neighborhood . In the fall of 2006, an analysis of the fatal injury data at the state and national level (WISQARS to Healthy Families; Indiana Child Fatality Review Team; the Indiana Injury Prevention Advisory Council) was completed. Each year, Indiana is one of the top five states for fatal injury deaths due to unintentional suffocation for infants. A workgroup has been convened to examine this issue. A proposal to examine death certificate data (with IRB approval) is currently waiting approval from ISDH.

Also at the trauma center level, Deaconess Hospital in Evansville (Southwestern Indiana) measures trends as well, and when trends show an increase in injuries as a result of certain MOIs (e.g., bicycle, ATV, MVC, etc.), the Trauma Registrar notifies the Injury Prevention Coordinator and injury prevention courses or seminars are initiated. Their Outreach and Injury Prevention Coordinator has taught community courses in ATV and bicycle safety. Two of their community awareness/education programs include Alive and Think First. These are nationally recognized programs. The Alive program is for teens discussing the dangers of driving under the influence of drugs and alcohol. Think First is a head and spinal cord injury prevention program encouraging youth to “think first” about safety.

Memorial Hospital in South Bend (Northern Indiana) also uses trends in registry data and shares them with internal groups such as the Trauma Committee. Memorial also participates in the Indiana Partnership to Prevent Violent Injury and Death (IPPVID), a statewide firearm injury and death surveillance system, by submitting abstracted data on firearm injuries from their center.

Wishard Hospital in Indianapolis initiated a seat belt safety campaign based on statistics that showed that 60% of people in Indiana who died in 2005 following a motor vehicle crash were not restrained (DOT). Wishard Trauma Services provided a target audience with seat belt safety education through a variety of sources to ensure broad-spectrum awareness. These methods included e-mail bulletins, posters and presentations at staff meetings. The researchers also passed out key chains to serve as a long-term reminder of the need to wear safety belts. Finally, they created a display to illustrate, using life-size silhouettes, the number of unrestrained people who die in car crashes.

Parkview Hospital in Fort Wayne used their trauma registry data to identify key injury patterns with teen drivers and have presented this data to the child death review team and

the local coroner to assist with implementation of a teen “Drive Alive” program to reduce teen driving automobile crashes.

5. Describe how ongoing and routine injury surveillance is completed and how results are shared with constituent groups. An actual injury prevention program does not currently exist at the Indiana State Department of Health. As a result, there is only a partial injury surveillance system that utilizes data from a variety of databases (see page 21, #2). One part-time epidemiologist helps to collect, identify and disperse data when requested by media, constituents in Indiana, etc. Examples of reports that have been written include: annual reports on firework injuries, periodic reports on suicide in Indiana, a report on the medical impact of motor vehicle crashes for the Indiana Department of Transportation, and a major report on injuries in Indiana. The fireworks injury surveillance system is mandated by law and physicians are required to complete a fireworks injury report and send it to the department of health. An annual report is completed and disseminated to the public through the ISDH website and press releases. Other data reports are placed on the ISDH website so that they can be shared with constituent groups. At the institutional level, each trauma center prepares annual reports from their trauma registry data that are disseminated to the public.

Indicators As a Tool for System Assessment

1. Has a multidisciplinary stakeholder group participated in the scoring and consensus process associated with the BIS tool? Yes, this was completed in 2006 by a workgroup of Task Force members representing the ISDH, the Indiana Hospital Association, Wishard and Riley Hospitals in Indianapolis, Deaconess Hospital in Evansville and Memorial Hospital in South Bend. (Results in table below).

Indicator #	ISDH - JB	IHA - SG	Wishard	Riley	Deaconess	SB Mem.	Avg	Median
101.1	0	1	2	3	1	1	1.33	1
101.2	1	1	0	1	1	1	0.83	1
101.3	3	3	1	1	1	1	1.67	1
101.4	1	1	2	3	3	1	1.83	1.5
101.5	1	1	0	5	0	1	1.33	1
101.6	1	1	0	1	1	1	0.83	1
101.7	2	2	0	1	1	1	1.17	1
102.1	1	1	1	2	2	1	1.33	1
102.2	1	1	2	1	1	2	1.33	1
102.3	1	1	3	1	1	1	1.33	1
102.4	1	1	1	1	1	1	1.00	1
102.5	1	1	2	2	1	1	1.33	1
103.1	1	1	0	2	1	1	1.00	1
103.2	1	1	1	1	2	1	1.17	1
103.3	1	1	1	1	1	1	1.00	1
103.4	2	2	3	1	1	1	1.67	1.5
104.1	1	1	2	2	4	4	2.33	2
104.2	1	1	0	1	5	1	1.50	1

104.3	1	1	0	0	0	1	0.50	0.5
105.1	1	1	0	1	1	1	0.83	1
105.2	1	1	2	1	1	1	1.17	1
105.3	1	1	0	1	1	1	0.83	1
105.4	1	1	4	2	1	1	1.67	1
105.5	1	1	0	2	4	1	1.50	1
105.6	1	1	0	1	0	1	0.67	1
105.7	1	1	0	2	2	1	1.17	1
201.1	3	3	5	3	3	4	3.50	3
201.2	4	4	4	4	3	5	4.00	4
201.3	2	2	4	2	1	2	2.17	2
201.4	2	2	2	2	1	2	1.83	2
202.1	3	3	5	3	3	3	3.33	3
202.2	5	5	4	4	4	4	4.33	4
202.3	2	2	3	1	1	1	1.67	1.5
202.4	3	3	2	3	1	2	2.33	2.5
203.1	2	2	0	2	2	3	1.83	2
203.2	2	2	0	2	2	3	1.83	2
203.3	1	1	0	2	1	1	1.00	1
203.4	1	1	0	3	1	0	1.00	1
203.5	2	2	0	1	1	0	1.00	1
203.6	1	1	0	1	1	1	0.83	1
203.7	1	1	0	1	1	1	0.83	1
204.1	1	1	0	0	1	1	0.67	1
204.2	1	1	0	1	1	1	0.83	1
204.3	1	1	0	1	2	3	1.33	1
204.4	1	1	0	1	2	2	1.17	1
204.5	1	1	0	3	0	1	1.00	1
205.1	1	1	0	1	0	1	0.67	1
205.2	1	1	0	1	1	1	0.83	1
205.3	1	1	1	1	1	1	1.00	1
205.4	2	2	5	1	2	1	2.17	2
205.5	1	1	4	1	1	1	1.50	1
206.1	1	1	5	1	2	1	1.83	1
206.2	2	2	2	2	2	1	1.83	2
207.1	1	1	4	2	3	2	2.17	2
207.2	1	1	2	2	2	1	1.50	1.5
207.3	3	3	3	2	1	2	2.33	2.5
207.4	1	1	0	1	1	1	0.83	1
208.1	2	2	0	2	1	1	1.33	1.5
208.2	2	2	0	1	1	1	1.17	1
301.1	1	1	1	1	1	1	1.00	1
301.2	3	3	0	2	1	2	1.83	2
301.3	1	1	2	1	1	0	1.00	1
301.4	1	1	1	1	1	1	1.00	1
302.1	1	1	2	2	1	1	1.33	1
302.2	2	2	3	3	2	2	2.33	2

302.3	1	1	4	4	1	0	1.83	1
302.4	1	1	4	0	1	1	1.33	1
302.5	1	1	3	2	1	1	1.50	1
302.6	2	2	2	1	1	1	1.50	1.5
302.7	2	2	4	3	1	4	2.67	2.5
302.8	2	2	3	0	1	2	1.67	2
302.9	2	2	1	0	1	2	1.33	1.5
302.1	2	2	0	3	1	1	1.50	1.5
303.1	1	1	0	1	1	1	0.83	1
303.2	1	1	1	1	1	1	1.00	1
303.3	3	3	3	3	1	1	2.33	3
303.4	1	1	1	2	1	1	1.17	1
303.5	2	2	0	1	1	1	1.17	1
304.1	3	3	2	1	1	1	1.83	1.5
304.2	1	1	2	1	1	1	1.17	1
305.1	1	1	2	2	1	1	1.33	1
305.2	4	4	3	2	1	2	2.67	2.5
305.3	1	1	0	0	1	1	0.67	1
306.1	1	1	0	2	1	2	1.17	1
306.2	1	1	0	1	1	2	1.00	1
306.3	1	1	0	1	1	3	1.17	1
307.1	3	3	0	1	1	4	2.00	2
307.2	1	1	2	1	1	1	1.17	1
308.1	1	1	0	1	1	1	0.83	1
308.2	1	1	0	1	1	1	0.83	1
309.1	1	1	0	1	1	1	0.83	1
309.2	1	1	2	1	1	1	1.17	1
309.3	2	0	0	1	1	1	0.83	1
309.4	0	1	0	1	1	1	0.67	1
310.1	0	0	4	4	1	2	1.83	1.5
310.2	0	0	1	1	1	5	1.33	1
310.3	1	1	5	1	1	2	1.83	1
310.4	1	1	0	1	1	1	0.83	1
310.5	1	1	5	1	1	1	1.67	1
310.6	1	1	5	1	1	1	1.67	1
310.7	1	1	4	2	1	1	1.67	1
310.8	1	1	0	0	1	1	0.67	1
310.9	2	2	5	1	1	1	2.00	1.5
310.1	1	1	5	5	1	1	2.33	1
310.11	1	1	1	0	1	1	0.83	1
310.12	1	1	0	5	1	1	1.50	1
310.13	1	1	5	1	1	1	1.67	1
311.1	2	2	0	1	1	1	1.17	1
311.2	1	1	0	1	1	1	0.83	1
311.3	1	1	0	2	1	1	1.00	1
311.4	1	1	0	1	1	1	0.83	1
311.5	1	1	0	0	1	1	0.67	1

311.6	1	1	0	2	1	0	0.83	1
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2. If the process has been completed, how were the findings used? They were used to guide the first draft of administrative rules for the designation of hospitals as trauma centers (See Appendix 3). It is also our intent to use the BIS tool to help develop a system plan after recommendations are received from the ACS System Consultation.

3. Is there a date (year/month) set for a reassessment using the BIS tool to mark progress toward agreed-on goals or benchmarks? No specific date has been specified for reassessment with the BIS tool.

Section 2: Policy Development

Statutory Authority and Administrative Rules

1. Describe how the current statutes and regulations allow the state or region to:
 - a. develop, plan, and implement the trauma system, - Public Law 155, 2006 (Wyss, Broden) provides for the “development, implementation, and oversight for a statewide comprehensive trauma care system to prevent injuries, save lives, and improve the care and outcome of individuals injures in Indiana.”
 - b. monitor and enforce rules, - “The state department may adopt rules under IC 4-22-2 concerning the development and implementation” of a state trauma registry and “standards and procedures for trauma care level designation of hospitals.” (No rules are in place at this time.)
 - c. designate the lead agency, - The Indiana State Department of Health is designated as the lead agency by Public Law 155, 2006.
 - d. collect and protect confidential data, and - The legislation below provides for the creation of the state trauma registry and the adoption of rules, but no rules are in place yet.
 - e. protect confidentiality of the quality improvement process. There is no legislation regarding the quality improvement process.

P.L.155-2006

[S.284. Approved March 24, 2006.]

AN ACT to amend the Indiana Code concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 16-18-2-354.5 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS

[EFFECTIVE JULY 1, 2006]: **Sec. 354.5. "Trauma care", for purposes of IC 16-19-3-28, means the assessment, diagnosis, transportation, treatment, or rehabilitation by a health care provider of an acute bodily injury that requires immediate intervention to prevent the loss of life or a serious impairment of a body function or part.**

SECTION 2. IC 16-19-3-28 IS ADDED TO THE INDIANA CODE AS A NEW SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2006]: **Sec. 28. (a) The state department is the lead agency for the development, implementation, and oversight of a statewide comprehensive trauma care system to prevent injuries, save lives, and improve the care and outcome of individuals injured in Indiana.**

(b) The state department may adopt rules under IC 4-22-2 concerning the development and implementation of the following:

- (1) A state trauma registry.**
- (2) Standards and procedures for trauma care level designation of hospitals.**

2. Describe the process by which trauma system policies and procedures are developed or updated to manage the system including: There are not yet any trauma system policies and procedures in place. The Trauma Task Force System Development Subcommittee has been charged with the development of the items below.

- a. the adoption of standards of care,
- b. designation or verification of trauma centers,
- c. direct patient flow on the basis of designation,
- d. data collection, and
- e. system evaluation.

3. Within the context of statutes and regulation, describe how injury prevention, EMS, public health, the needs of special populations, and emergency management are integrated or coordinated within the trauma system. There is no statute or regulation that integrates injury prevention, EMS, public health, the needs of special populations, or emergency management into the trauma system. However, the ISDH Trauma System Advisory Task Force includes representation from all of these groups and continually makes the effort to see that all groups are considered in trauma system planning. Also, the contractual trauma system manager and trauma registry manager are housed within the Office of Primary Care/State Office of Rural Health at ISDH and are very involved with rural trauma system issues.

System Leadership

1. How does the lead agency bring constituency groups together to review and monitor the trauma system throughout each phase of care? At present the Indiana code has not been developed to address the reviewing and monitoring of the trauma system through each phase of care, but there are the ISDH Trauma System Advisory Task Force subcommittees that will be able to address these issues in the future when appropriate legislation/code are in place.

2. Describe the composition, responsibilities, and activities of the multidisciplinary trauma system advisory committee(s) and the working relationship(s) with the trauma lead agency and the EMS lead agency, if they are different. The ISDH Trauma System Advisory Task Force is made up of a wide spectrum of trauma stakeholders from around Indiana (see Task Force membership list, pages 6 through 11 of this document). The Trauma Task Force also has several subcommittees to address specific issues: Legislation and Funding, Systems Development and Maintenance, Information Management, Education, Injury Prevention (added 10/08), Protocol Development for Care. The Trauma Program and EMS Division are housed in different state agencies, with trauma at the Department of Health and EMS within the Department of Homeland Security. The EMS Division historically did not have an interest in being the lead agency for trauma system development but was very supportive of the legislation designating the ISDH as the lead agency. They have continued that support through membership on the Trauma Task Force and by including Task Force members in the EMS trauma protocol development workgroup, which will be described in a later section of this document.

- a. Identify pediatric representatives on the multidisciplinary trauma system advisory committee and any pediatric advisory groups that provide input into trauma system development.

Aaland, Mary, MD, FACS Trauma Medical Director	Parkview Hospital Level II Adult and Pediatric Trauma Center
Bensard, Denis, MD - Chief of Surgery	Peyton Manning Children's Hospital at St. Vincent, Indianapolis, IN
Braun, Cheri, RN, Trauma Program Nurse	Parkview Hospital Level II Adult and Pediatric Trauma Center
Daniels, Dawn, DNS, RN, PHCNS-BC, Clinical Nurse Specialist	Riley Trauma Services Injury Free Coalition for Kids of Indianapolis
Graves, Charlene, MD (retired)	Founding member, pediatrician Indianapolis, IN
Gray, Lisa, RN Pediatric Trauma Coordinator	St. Mary's Medical Center Level II Trauma Center, Evansville, IN
Gutwein, Tom, MD FACEM, Emergency Medical Director	Parkview Hospital Level II Adult and Pediatric Trauma Center
Hollister, Lisa, RN, Trauma Program Manager	Parkview Hospital Level II Adult and Pediatric Trauma Center
Howard, Matthew S., RN, MSN Emergency Dept. Mgr	Riley Hospital for Children, Level I Trauma Center, Indianapolis, IN
McNichols, Autumn, M.A. Safe Kids Indiana State Coordinator	IUSOM, Automotive Safety Program Indianapolis, IN 46202
Reiss, Gene Trauma Registrar	Riley Hospital for Children, Level I Trauma Center, Indianapolis, IN
Scherer, L.R. "Tres", MD Trauma Medical Director	Riley Hospital for Children, Level I Trauma Center, Chair – IN ACS-COT & EMS-C
Shufflebarger, Charles, MD Emergency Medicine Director	Clarian Methodist Level I Trauma Center, Indianapolis, IN

- b. Describe the process of involving experts in, and advocates for, special populations and how they help drive regional trauma system policy. There is no regional (or state) trauma system policy to date and no processes have been developed at this time. Membership of the Trauma Task Force includes pediatric, rural (hospital and EMS level) and pre-hospital representation. When we reach the point of policy development, we will rely on the knowledge and expertise of the representatives from each special population to guide with system changes and improvements. The Indiana Child Fatality Review Panel has the ability to review deaths of all children (under 18 years of age) which occur in the state, but has only been able to concentrate on child abuse and neglect deaths due to a lack of resources. By sharing information and reviewing data, panel members

review the circumstances surrounding the deaths and look for patterns or trends to identify possible prevention strategies.

- c. Describe how the multidisciplinary advisory committee is involved in trauma system performance evaluation (for example, review of system performance reports). The state trauma registry was launched in May of 2007, and is currently in the implementation phase. As registry development progresses, trauma system performance measures will be developed. This process is being developed by the Trauma Task Force, the Indiana Trauma Network, the state trauma manager, and the newly-hired state trauma registry manager. In preparation for a trauma system development retreat that was conducted in 2007 with representation from 17 Task Force members, the state trauma system manager reviewed other state's performance improvement measures and prepared some preliminary working documents that will be used to further refine performance improvement measures (see Appendix 4).

3. Provide examples of how the lead agency and trauma system leadership (for example, trauma centers, trauma medical director, nurse coordinator, trauma administrator, and other stakeholders) inform and educate policy makers, elected officials, community groups, and others about the trauma system, its strengths, and its improvement opportunities. There is active state legislative representation on the Task Force, and Task Force members have been invited to participate in hearings and health care professional days during legislative sessions. One example of this is the summer study commission of Rep. Charlie Brown (2008) which had 6 trauma hospitals and IHA testify on the importance of trauma hospitals and systems. Also in 2008, the Education subcommittee of the Task Force launched the Trauma Times newsletter (see Appendix 7) to inform health professionals and legislators around the state about trauma system development, injury prevention and EMS efforts. This newsletter is sent out electronically to many listserves statewide. St. Mary's Medical Center in Evansville produced a video on CD entitled "When Minutes Matter: Region 10 Level II Trauma" that has been distributed around the state. Each of the trauma centers have regional outreach programs that build relationships with local policy makers, elected officials, and community groups. Deaconess Hospital in Evansville, through their outreach efforts to local policy makers was able to play an integral role in the repeal of the Uniform Accident and Sickness Policy Provision Law (UPPL) law in Indiana. The Alcohol Exclusion Law was embedded in the model (UPPL) in 1947. This law allows insurers to deny coverage to individuals injured as a result of being under the influence of alcohol or narcotics and was adopted by most states in the 1950's. Since approximately 40 percent of trauma center patients have positive blood alcohol levels, this can result in huge debt for patients and huge losses for hospitals for uncompensated care. Deaconess Hospital trauma staff also conduct the Rural Trauma Team Development Course throughout Southern Indiana. The state trauma manager and the retired trauma medical director have given presentations of the trauma system and trauma registry to multiple groups throughout the state. Trauma leaders from Indiana trauma centers have reached out to their communities, giving presentations throughout their districts on the Trauma System and how it benefits the entire state. Members of the Trauma Task Force take trauma information to the groups they represent, and trauma system information is also distributed throughout the state in electronic

newsletter form. The state medical association has distributed information about the trauma system via their electronic newsletter and supported the initial trauma system legislation along with the state ENA. State ENA members also promote trauma system efforts around the state by conducting TNCC and ENPC courses throughout the state, devoting time to trauma system development efforts at each of their state council meetings, lobbying for trauma system/injury prevention legislation (graduated driver's license, others), ENCARE injury prevention efforts around the state, etc.

4. Describe the process to build or expand effective trauma leadership within the trauma system (for example, succession planning, leadership courses, and workshops), including the lead agency and trauma centers. Although there is no formal process of trauma leadership at the state level, the Trauma Task Force and the efforts at the state level are maintained largely by the leadership and input of each of the trauma centers in the state and coordinated by the state trauma manager. Through the communication facilitated by the Trauma Task Force, trauma centers are now coordinating their trauma conferences so that there are no conflicting dates. Each of the trauma centers have active regional system development efforts in place. The Indiana Trauma Network, comprised of trauma coordinators and registrars from around the state, meets regularly to discuss their local/regional issues, consider solutions that would apply to both their regions and throughout the state, and also devote time at each meeting to discuss trauma system development issues to assist the state trauma manager in her efforts.

5. Describe the process by which lead agency staff would identify changes in system performance. No process in place yet.

6. Describe how the multidisciplinary advisory committee is involved in trauma system performance evaluation. No process in place yet.

Coalition Building and Community Support

1. What is the status of the trauma system's coalition (for example, What is the status of recruiting members and building a coalition? Is the coalition a strong and active coalition? Does the coalition need new energy? Who is not currently involved but should be a part of your coalition?)? The Trauma Task Force has been growing over the past two years, and meeting attendance has grown from an average of 30 – 35 members per meeting to an average of 45 in attendance this year. The email distribution list continues to grow as well, with more people around the state expressing an interest in trauma system development. The energy level of the group is high. Although the group has rural membership, there are pockets of the state that are not well represented on the Task Force, and there needs to be representation from the agricultural community. Representation from a minority group or coalition, state Medicaid and the mental health community would be beneficial as the state moves forward with trauma system development. Active participation from more insurers (health and auto) would be beneficial as well. The membership of the Task Force includes ED nurses from both rural and urban hospitals, trauma and other surgeons, ED physicians, pre-hospital providers (ground and air medical), non trauma center hospital representatives (physician, nurse, paramedic/EMT, administrators, etc.) from both urban and rural hospitals, state

legislators, the state hospital association, the state medical association, the EMS commission, the IU School of Nursing, IN Farm Bureau Insurance, Hoosier AAA Motor Club, the state ENA, the state ACEP, the state COT, the state Rural Health Association, the Indiana Trauma Network, trauma medical directors and trauma program managers from each of the seven trauma centers – this list of participants is continuing to grow. The efforts of the seven trauma centers individually and collaboratively cannot be overstated. Through outreach to their communities and districts, they have helped to encourage other hospitals to become interested in this process and have provided their knowledge and experience to the Task Force. In addition, the Indiana Trauma Network has made trauma system development efforts a priority and have collaborated with the state trauma manager on many projects, including the development of the trauma registry data dictionary, providing information for reports as requested and in contributing input into this document. The state ENA has made trauma training for all ED nurses and rural nurses in particular one of their top priorities. They assist the state trauma manager on many levels, particularly by spreading the word to their colleagues about the development of the trauma system in Indiana. The contributions of each member of the Trauma Task Force have kept this initiative alive despite extremely limited resources available at the state lead agency level.

- a. What is the role of the coalition members (constituents and stakeholders) in promoting trauma system development? Each member of the Task Force is taking a leadership role in promoting trauma system development efforts in their respective communities and around the state; without this tremendous volunteer grassroots effort in Indiana, there would be no Trauma Task Force or lead agency legislation. Examples of a just few of these efforts include the following:
 - St. Mary’s developed a DVD entitled “When Minutes Matter: Region 10 Trauma”, utilizing the story of a pediatric patient and her unidirectional flow through St. Mary’s Trauma Center, exemplifying the need for state trauma systems. This DVD was sent to all hospitals in Indiana as well as hospitals throughout the Evansville tri-state area. It has also been shown to various organizations and communities such as the Indiana Rural Health Association Conference, PALS courses, and the Principles of Trauma classes. It is also available to view on St. Mary’s website.
 - Merry Addison, an ED nurse and ENA member from Hillisdale, IN, has reached out to contact more people and organizations than could be recounted here and has been a true champion to the process. She initiated the rural TNCC training effort by the Indiana ENA with a grant from the Christopher Reeve Paralysis Foundation in 2005 (now continuing through a partnership with the State Office of Rural Health and an additional grant from the Foundation). Merry’s efforts were featured in a 2005 episode of “Communities Helping Communities” on PBS, hosted by Judy O’Bannon. She continually champions trauma education and outreach and has contacted many individuals and organizations that have ultimately become involved in trauma system development efforts

- Non trauma center hospitals, such as Terre Haute Regional Hospital and The Methodist Hospitals in Gary/Merrillville have begun conducting annual trauma and emergency conferences
- In 2008, The Methodist Hospitals created a trauma video designed to educate policy makers and others around the state about the violence occurring in their area and the need for a trauma center there
- Each of the trauma centers (surgeons, trauma coordinators, registrars and others) have conducted many outreach efforts in their communities and around the state and have also reached out to organizations and hospitals not involved in the trauma system efforts to inform them and recruit their support. As a result of their efforts, the Trauma Task Force has grown progressively over the past two years with active interest and support from the membership
- State Senator Tom Wyss has been the central legislative champion for the Trauma Task Force (co-author of Public Law 155-2006, SEA 249-2008) and co-chairs the legislative subcommittee of the Task Force.
- Deaconess Hospital staff have been conducting Rural Trauma Team Development Courses throughout Southern Indiana since 2007.

- b. What is the method and frequency for communicating with coalition members?
There are regular email communications to Task Force members, and the group meets quarterly.

2. Describe how the trauma system leadership mobilizes community partners to improve the trauma system through effective communication and collaboration. Through the efforts of the Task Force, trauma system and Task Force leaders continually emphasize the importance of outreach and collaborating with partners and stakeholders, through the quarterly meetings, providing information to the membership and to their respective regions, professional organizations, etc. It is accepted by Task Force members that development of a trauma system is a collaborative effort. Trauma verified hospitals provide education on injury prevention throughout their communities. They make use of local newspapers, churches, schools, health fairs, and other opportunities within their community to be a resource and to provide education.

- a. How has the community been approached to identify injury control concerns?
At the state level, this hasn't been addressed, but at the institutional level, each trauma center uses their registry data to identify needs and present this data to relevant community leaders or groups. As an example, Parkview Hospital (Level II) in Fort Wayne uses the trauma registry to identify key injury patterns with teen drivers and presents this data to the child death review team and the local coroner to assist with implementation of a teen "Drive Alive" program to reduce teen driving automobile crashes. They have also have approached local news channels to create awareness of several injury patterns that have been identified. Another example from Wishard Hospital (Level I) in Indianapolis: After review of their trauma registry data, which revealed a 38% penetrating trauma rate in 2007, they implemented the Educating Kids about Gun Violence and Gun Safety/Trigger

Lock distribution programs in Indianapolis area schools, health fairs, and gun auctions.

- b. What key problems has the community identified?
At the state level, this hasn't been addressed. Each of the trauma centers identifies key problems as described in the examples above in question "a".
- c. How do stakeholders bring system challenges or deficiencies to the attention of the lead agency? Through the Indiana Trauma Task Force and local legislators.

Lead Agency and Human Resources Within the Lead Agency

1. Describe the number, position titles, and percentage of full-time equivalency of all personnel within the lead agency or contract personnel who have roles or responsibilities to the trauma program. There is one full-time contractual trauma system manager, and as of September, 2008, one full-time contractual trauma registry manager. A full-time state position for a trauma registry manager was created but was not able to be filled due to current state hiring freezes.
2. Identify other personnel resources that support the trauma program activities of the lead agency (for example, epidemiology support from other units within the health department, public health interns). There is one part-time contractual injury-prevention epidemiologist (total of 0.3 FTE) who also assists with trauma data requests, and one public health intern from August, 2008 through January, 2009.
3. Describe the adequacy of personnel resources available to the lead agency to sustain trauma program assessment, policy development, and assurance activities.
 - a. Identify impediments or barriers that hinder system development. Lack of funding, state freeze on hiring, lack of state trauma program positions, no trauma or EMS medical director, lack of e-coding in hospital discharge data, incomplete outpatient data in the hospital discharge database all are impediments to the process.

Trauma System Plan

1. Describe the process for the development or revision of the trauma system plan. There is no trauma system plan in place yet.
 - a. Include the role of advisory and stakeholder groups in the process.
2. Is there ongoing assessment of trauma resources and asset allocation within the system? There is no formal assessment process, but we are beginning to identify the trauma resources through Task Force member feedback and injury prevention resources through an injury prevention survey (October, 2008) that has been sent by electronic link to all emergency departments in the state; it has also been sent to the Injury Prevention

Advisory Council members, Trauma Task Force members, state ENA, and Indiana Trauma Network members, all of whom are distributing to their contact lists.

3. Describe the process used to determine trauma system standards and trauma system policies. There are no trauma system standards and policies in place at this time, but we are reviewing other state systems for comparison with Indiana needs for future standard and policy development efforts.

- a. How are they reviewed and evaluated?
- b. What standards and policies exist for special populations, including rural and frontier regions?
- c. How are specialized needs addressed, including burns, spinal cord injury, traumatic brain injury, and reimplantation?

System Integration

1. What is the trauma system’s collaboration and integration with EMS, public health, and emergency management and programs such as:

- a. prevention programs – There is an ISDH Injury Prevention Advisory Council that has been sporadically meeting over the last few years. This group is going to be linked with the Trauma Task Force, through the addition of an Injury Prevention Subcommittee to the Task Force. The hope is that the injury prevention group will benefit from the energy and momentum that the Task Force is experiencing.

ISDH Injury Prevention Advisory Council:

Addison, Meredith, RN, MSN	Terre Haute Regional Hospital State and Local ENA
Benjamin, Suilon, RN	Indiana ENA, ENCARE St. Vincent Frankfort Hospital
Berry, Stephanie, Manager, Community Health Promotions & Community Relations	Clarian Health Indianapolis, IN
Blakesley, Alice, RN IP Coordinator/Safe Kids Co-Chair	Memorial Hospital South Bend
Chadd, Tammy	ISDH State Office of Rural Health
Cole, Barbara	Indiana Poison Center
Daniels, Dawn, DNS, RN, PHCNS- BC, Clinical Nurse Specialist	Riley Trauma Services, Injury Free Coalition for Kids of Indianapolis
Duwve, Joan, MD	ISDH
Field, William, Ed.D. Professor	Purdue University, Breaking New Ground Resource Center
Fox, Julia Emergency Management Trainer	Indiana Dept. of Homeland Security Indianapolis, IN

Ganser, Judith, MD	ISDH
Grover, Spencer, FACHE Vice President	Indiana Hospital Association Indianapolis, IN 46282
Hackworth, Jodi, MPH	ISDH Injury Prevention Program Epidemiologist
Hendrickson, Kevin, RN Outreach Trauma Coordinator	Deaconess Hospital Level II Trauma Center, Evansville, IN
Hollister, Lisa Trauma Program Manager	Parkview Hospital Level II Adult and Pediatric Trauma Center, Fort Wayne
Howard, Matthew S., RN, MSN Emergency Dept. Mgr	Riley Hospital for Children, Level I Trauma Center, Indianapolis, IN
Hudson, Kira Injury Prevention Program Coordinator	Clarian Health Promotions and Community Relations
Lefler, Stephanie, RN Director of Trauma Services	St. Mary's Medical Center Level II Trauma Center, Evansville, IN
Martin, Joanne	IU School of Nursing
McNichols, Autumn, M.A. Safe Kids Indiana State Coordinator	IUSOM, Automotive Safety Program Indianapolis, IN 46202
Montelauro, Nick, EMT-P	Trans-Care EMS Education Terre Haute, IN 47802
Mowry, Jim	Indiana Poison Center
Myers, Donna Maternal Child Health	Indiana State Dept. of Health Indianapolis, IN 46204
O'Neil, Joe, MD	Indiana AAP
Perkins, Susan, RN	ISDH Trauma System/Injury Prevention Manager
Plank, Angela Executive Director	Indiana Partnership to Prevent Violent Injury and Death, Indianapolis
Raley, Mary IP/Outreach Coordinator	St. Mary's Medical Center Evansville
Ray, Nena Think First Program Coordinator	Clarian Health
Scherer, L.R. "Tres", MD Trauma Medical Director	Riley Hospital for Children, Level I Trauma Center, Chair – IN ACS-COT & EMS-C
St. John, Wendy, RN Assistant Trauma Nurse Coord.	Wishard Hospital Level I Trauma Center Indianapolis, IN
Stroup, Karen, PhD. Director	Community Education and Child Advocacy, Riley Hospital for Children
Sullivan-Wright, Dawn, RN Clinical Educator, Emergency Dept.	Community Hospital South Indianapolis, IN
Walton, Serifatu, Injury Prevention Coordinator, Coalition Coordinator	Marion County Health Department, Safe Kids Indianapolis

- b. mental health – None to date.
- c. social services – There is some collaboration with social services through the ISDH's collaboration with the Indiana TBI Grant Advisory Council/Workgroup.
- d. law enforcement – The ISDH is a part of the Indiana Traffic Records Coordinating Committee and the CODES Board of Directors and receives funding for the trauma registry and registry manager through the NHTSA 408 grant submitted by the TRCC. The TRCC is headed by the Indiana Criminal Justice Institute and has representation from the Indiana State Police, EMS, Coroners' Association, and many other agencies, institutions and organizations.
- e. child protective services – The Indiana Child Fatality Review Team(CFRT) has a broad organizational base, including several members from the state child protective services agency. The former medical director for injury prevention/trauma system at the ISDH (Dr. Charlene Graves) served as the ISDH representative on the Indiana CFRT since its inception in 2004. Dr. Joan Duwve is the current ISDH representative on CFRT.
- f. public safety (such as, fire, lifeguard, mountain rescue, and ski patrol)? EMS and Fire are both within the same division at the Indiana Department of Homeland Security, so there is collaboration there that will be expanded as the process moves forward. There is no mountain rescue or ski patrol in Indiana.
- g. The Indiana Spinal Cord and Brain Injury Research Fund was created by the 2007 Indiana General Assembly. At this time a Board for the Fund was created and appointed by the Governor, Indiana University, Purdue University, Brain Injury Association, National Spinal Cord Injury Association and Rehabilitation Hospital of Indiana. The Fund is to be used for the following purposes:
 - (1) Establish and maintain a state medical surveillance registry for traumatic spinal cord and brain injuries,
 - (2) Fulfilling the duties of the board,
 - (3) Funding research related to treatment and cure of spinal cord and brain injuries, including acute management, medical complications, rehabilitative techniques, and neuronal recovery. Research must be conducted in compliance with all state and federal laws.

Financing

1. How does the lead agency track and analyze internal trauma system finances? The ISDH utilizes external financing to support the trauma program as no dedicated/line item financing is provided for the trauma and trauma registry programs. External funding is received from the Rural Hospital Flexibility Program grant through HRSA and the Indiana Traffic Records Strategic Plan, which is sponsored by the National Highway and Traffic Safety Administration 408 grant program.

- a. How does the advisory committee participate in the financial review process?
N/A
- b. How frequently are trauma system financial reports published? N/A
- c. Which financial data are reported (lead agency data, health facility data, or both)?
N/A

2. What is the lead agency's budget for the trauma system? N/A

3. What is the source of funding available to support the development, operations, and management of the trauma system (for example, general funds, dedicated funds)? There are no general or dedicated funds to support the trauma system. The trauma system manager is paid through Rural Health Flex funds (previously paid through hospital preparedness funds), and the trauma registry manager is paid through the NHTSA 408 grant (as part of the Indiana Traffic Records Strategic Plan). The Rural Health Flex grant is also the funding source for the contractual portion of this ACS consultation. The remainder of the expenses for the consultation are being funded by the generous donations from each of the seven trauma centers, as well as a donation from Indiana Farm Bureau Insurance.

4. What financial incentives and disincentives exist to encourage trauma center participation in the trauma system? None.

- a. Specifically include arrangements for uncompensated and under-compensated care. There are no arrangements for uncompensated and under-compensated trauma care in Indiana currently. Based on amounts derived from other states and not knowing the actual numbers for Indiana, it is estimated that somewhere in the range of \$20-\$30 million per year would be needed to help cover uncompensated trauma care in Indiana.

Section 3: Assurance

Prevention and Outreach

1. List organizations dedicated to injury prevention within the region and the issues they address (for example, MADD, SADD, SafeKids Worldwide, Injury Free Coalition for Kids, American Trauma Society, university-based injury control programs). There are numerous organizations active in Indiana, many of whom work together through collaboration with the state's seven trauma centers and also through collaboration with organizations/programs such as Safe Kids, local health departments, local fire departments, local law enforcement, schools, local non-trauma center hospitals, etc. There are also legislative initiatives targeted at injury prevention that are currently being pursued: The AAA Hoosier Motor Club and the Indiana Graduated Drivers' License Coalition are pursuing GDL legislation with the ultimate goal of reducing teen driver motor vehicle crashes. The Indiana Coalition to Reduce Underage drinking is also pursuing legislation that they hope would help to reduce underage drinking.

There has not been state-level networking/coordination of these groups in the past, but the Injury Prevention Advisory Council is beginning work on creation of a statewide injury prevention network. An online survey of statewide injury prevention efforts was conducted in October, 2008, and will be combined with other known activities and organizations to serve as the baseline for creation of this statewide network. A summary of the survey results is in Appendix 13. The injury prevention efforts that are known to be occurring in Indiana include the following:

- **Indiana Poison Control Center** – Multiple poisoning prevention activities
- **Think First** – The ThinkFirst For Kids program represents a collaborative effort of educators, the ThinkFirst National Injury Prevention Foundation, the National Highway Traffic Safety Administration (NHTSA), the American Academy of Pediatrics, the Peace Education Foundation and professionals from the fields of psychology and psychiatry. The goal of the program is to increase knowledge and awareness among children in grades 1-3 of the causes and risk factors of brain and spinal cord injury, injury prevention measures, and the use of safety habits.
- **Project Outreach Prevent (POP) Program** (The Methodist Hospitals - Gary, Merrillville) – Three pilot programs on teenage health awareness and violence prevention were presented to junior high and high school students over the course of 3 months. Presentations included pertinent teenage health issues with an emphasis upon school violence, gang violence, sexual assault, and violence prevention, with an emphasis on conflict resolution. These interactive presentations included discussion by a local homicide detective and linking of students interested in medicine, nursing, and law enforcement with mentors. In the future, there are plans to create questionnaires in order to obtain objective feedback about the project. Discussions are underway with Gary High School ROTC about doing a joint venture and creating a Violence Prevention Day at a host school for each Gary High School.

- **Emergency Nurses Association – ENCARE (Emergency Nurses Cancel Alcohol Related Events- Choices for Living Program)** – The Choices for Living program is a dynamic presentation designed to empower teenagers with skills to make informed decisions and engage in healthy behaviors related to safer driving. The program discusses such topics as underage drinking, binge drinking, drinking and driving, and safety belt use through presentation of national facts and other teenagers’ personal stories. This program is presented to local middle school and high school students.
- **Educating Kids about Gun Violence (EKG)** – EKG is a youth gun-violence education and prevention program. EKG works to prevent youth gun violence by educating students about the legal, medical, and emotional consequences of youth gun possession and related gun violence, as well as encouraging young people to consider options and choices available to them in situations involving guns.
- **ASK Day** - ASK is a national public health initiative that provides something real parents can do to keep their children safe. Based on the astonishing fact that over 40% of homes with children have a gun, many of which are kept unlocked or loaded, the ASK campaign encourages parents to ASK if there are guns in the homes where their children play.
- **Safe Kids - Car Seat Clinics** - Safe Kids Worldwide is the first and only international nonprofit organization dedicated solely to preventing unintentional childhood injury. Multiple hospitals around the state participate in this program.
- **Nurses in the Classroom** is a project that targets 3rd grade classrooms in high injury areas. Nurses adopt classrooms for 6 weeks and provide injury prevention education and skills training on the injuries most prevalent in their neighborhoods. Each nurse receives a two hour training session that includes training on the curriculum as well as teaching techniques.
- **Indiana Partnership to Prevent Violent Injury and Death** – The mission of the Partnership is to prevent and reduce the frequency of violent injuries and deaths throughout the state of Indiana. The Partnership is a statewide multi-disciplinary effort to address violent injury and death in all populations and from a public health perspective. The aim of the Partnership is to facilitate development of a coordinated, unified strategy, and to decrease violent injuries and deaths through the use of data collection, research, education and law reform. The Partnership facilitates collaboration and information sharing among various groups including health care, law enforcement, legal, human services, policymaking, and secular and faith based community organizations.
- **Injury Free Coalition for Kids** - The Injury Free Coalition for Kids of Indianapolis is a partnership of institutions, government agencies, organizations, and community members who are dedicated to preventing childhood injury in Indiana communities.
- **Center of Hope** - The Center of Hope provides crisis intervention, medical treatment, and forensic evidence collection to acute victims of sexual assault and domestic violence to patients at several Indianapolis area hospitals (Wishard was the founding hospital). The Center of Hope also reaches out to members of the community and professionals within the health care, law enforcement, academic, and legal community to present information and resources about sexual assault

and domestic violence through health fairs and lectures. Sexual Assault Nurse Examiner programs for ED nurses around the state have also been launched as a result of this Center's activities.

- **Indiana Farm Bureau Insurance** – distribution of motor vehicle safety materials such as the Insurance Institute for Highway Safety's DVD entitled "Understanding Car Crashes – It's Basic Physics" designed for classroom instruction
- **AAA Hoosier Motor Club** – Many motor vehicle safety efforts, including current graduated driver's license legislative efforts
- **Indiana 4-H and Indiana FFA** – Animal and Household Safety
- **Local Government** (Mayors and City Engineers) – Pedestrian Safety
- **Fire Departments/Ambulance Services** – Fire Prevention, Underage Drinking, Motor Vehicle Safety
- **MADD** – Drinking and Driving
- **SADD** – Impaired Driving and Underage Drinking and Drug Usage
- **Schools** (Private, Public, and Secondary) - Underage Drinking, Seatbelt Usage, Bullying, Suicide Prevention
- **Youth First:** Mission is to reduce substance abuse by providing research proven prevention and early intervention our outreach activities;
- **Southwestern Indiana Regional Perinatal Advisory Board:** Provides education to decrease infant death due to suffocation and asphyxiation.
- **Indiana Rural Safety and Health Council** – It was to promote safer and healthier living for Indiana's farm and rural families that the Council was established over 55 years ago as a volunteer, nonprofit organization. (www.farmsafety.org).
- **Breaking New Ground Outreach Program** – Since its inception in 1979, the Breaking New Ground Resource Center in Purdue's Department of Agricultural & Biological Engineering has become internationally recognized as the primary source for information and resources on rehabilitation technology for persons working in agriculture. (www.breakingnewground.info)
- **The Rural Caregivers Website** (www.ruralcare.info) - Ruralcare.info is designed to help bridge the information gap and assist in creating a web support community for rural caregivers.
- **Indiana Suicide Prevention Coalition** – see pages 21-22.
- **www.preventinjury.org** – An effort organized by the Indiana University School of Medicine Automotive Safety Program that is a partnership with the Indiana Safe Kids Coalition, NHTSA, Kohl's, the Governor's Council on Impaired and Dangerous Driving (Indiana Criminal Justice Institute)
- **Vermillion County Community Foundation Injury Prevention Acorn Fund**
- **Prevent Child Abuse Indiana** provides families and others information, referrals and support for dealing. Call 800-244-5373. To report child abuse, call 800-800-5556.
- **Family Violence Institute** provides education about all aspects of family violence to health professionals, legal professionals, social workers, teachers and lay people. Log on to www.medicine.iu.edu/fvi

- **Law Enforcement** (State Police, Sheriff's Departments, Local Police Departments) – “Click It or Ticket” campaign, underage drinking prevention and control efforts, etc.
- **Riley Safety Store** - Operated by the Community Education and Child Advocacy Department in partnership with The Cheer Guild, the Safety Store, originating at Riley Hospital, is the first in the nation to offer low cost safety products and injury prevention education for families of all children, including children with disabilities. The store has expanded to several locations throughout the state.
- **Parkview Safety Store** since 2004, has been providing bicycle safety supplies at a discounted rate and a car seat fitting station.
- **Indiana's Trauma Centers** – Many Injury Prevention Projects, including:
 - **ETOH Screening, Brief Intervention and Referral to Treatment** – The injury prevention coordinator/trauma coordinators at the seven trauma centers screen admitted trauma and orthopedic patients. If a patient screens positive an intervention is done and referral to treatment is made, if necessary.
 - **Community Education and Child Advocacy** provides information through Riley Children's Hospital about injury prevention, safety products and other resources that can help you keep your family and your children safe. Call 888-365-2022
 - **St. Mary's Drive Rite:** A teenage driving program sponsored by Purdue University
 - **Memorial Trauma Services and HealthWorks! Kids' Museum** have worked together to bring multiple injury prevention programs to area youth. The programs include American Trauma Society's “Trauma Roo”, “Trauma Nurses Talk Tough”, “Think First” and “Crazy Cranium Camp”. In 2007, more than 38,000 youth and adults participated in the programs
 - **Deaconess – The ALIVE program** has been specifically designed to address some of the serious issues that are currently facing the teenage population. Alcohol, drugs, speeding and bad judgment are concerns the ALIVE program targets in a multimedia, interactive format.
 - **Wishard Burn Prevention Efforts** – Displays with Smokey's Safety House- Identifies hazards in the home, Media/Public Service Announcement Prevention Efforts (radio, newspaper, television spots on fireworks safety, etc.)
 - **Gun Safety/ Trigger lock distribution** – Wishard Trauma Services has distributed over 2,500 trigger locks through various health fairs and gun auctions. A gun safety poster was developed and distributed as well.
 - **Parkview Trauma Center and the Car Control Clinic® program** - Teens together with their parents are required to attend both the classroom lectures of 2 1/2 hours about vehicle dynamics and human dynamics, and one 4-hour session of hands-on, in-car instruction in accident avoidance and defensive driving maneuvers. Lectures are supplemented by video and illustrations. A few of the other programs offered by Parkview: “**Helmets All the Pros Wear Them**” poster distribution, **Don't Drink and Drive, Don't Text and Drive.**

- **Clarian Methodist Think First Program** – Nena Ray is the Indiana Think First coordinator and inventor of Mikey, the shaken baby simulator. The **Think First – Never Shake a Baby course** Identifies injuries that occur from shaking, featuring “Mikey,” the doll with a clear skull to show brain damage. The course also presents solutions to control behavior. Presentation available through distance learning. Program video is also offered in Spanish.
- **Programs/Activities from October, 2008 Injury Prevention Survey:**
 - 8 responses did not indicate activities but may have responded for networking purposes.
 - **AAA Hoosier Motor Club** – multiple IP programs in the Central Indiana area
 - **Child Protection Team at Peyton Manning Children’s Hospital** – child abuse, rape/sexual assault education & training (Central Indiana)
 - **Central Indiana Think First Program** – multiple IP activities
 - **Hendricks Regional Hospital** – hospital based task force focusing on falls, fire/burns, TBI in Hendricks County
 - **Safe Patient Handling** – training on use of lift equipment (Indiana & Kentucky)
 - **Ball Memorial Hospital** – car seats and impaired driving programs for high school students
 - **Hendricks Regional Immediate Care** – multiple IP activities for Hendricks County
 - **Clarian Health/Methodist Hospital** – multiple IP activities in Central Indiana
 - **Major Hospital (Shelbyville)** – focus on motor vehicle and rape/sexual assault (Shelby County)
 - **Whiteland Volunteer Fire Dept.** – multiple IP activities in Whiteland (Johnson County)
 - **St. Vincent Hospital** –multiple IP activities in Central Indiana
 - **Lutheran Hospital Trauma Services** – multiple IP activities in Northeast Indiana
 - **Community Health Network South Campus** – multiple IP activities in Southern Marion County, Northern Johnson County and Northern Morgan County
 - **State Council of ENA “Choices” Program** – anti drinking and driving program (statewide)
 - **State Council of ENA ENCARE** – multiple IP programs around the state and IP instructor training for ED nurses statewide
 - **Community Hospital East** – motor vehicle programs for Lawrence & Perry Townships in Marion County
 - **LaPorte Regional Health System** – falls and rape/sexual assault programs in Northwestern Indiana and Southwestern Michigan
 - **Decatur County Memorial Hospital-** multiple IP activities in Decatur County and site of a Riley Safety Store

- **Union Hospital** – no organized IP program but participate in Safe Kids and programs through local police and fire departments (Vigo County)
- **Kosciusko Community Hospital** – Safe Child, fire safety CASA, DARE
- **Sullivan County Community Hospital** – drinking and driving and safe sitter programs
- **Monroe Hospital** – multiple IP activities in Bloomington, Monroe County and South Central Indiana
- **West Central Community Hospital** – back safety for employees, falls (West Central Indiana)
- **Memorial Hospital Trauma Services** – multiple IP activities in St. Joseph, Elkhart and LaPorte Counties
- **Parkview LaGrange Hospital Emergency Dept.** – Amish health fair incorporating farm/tool-related IP activities (LaGrange County)
- **DeKalb Memorial Hospital** – multiple IP activities in DeKalb County
- **Blackford Community Hospital** – employee ergonomics training and Safety Town
- **Injury Free Coalition for Kids of Indianapolis/Riley Trauma Services Injury Prevention Program** – multiple IP activities serving Central Indiana and consulting statewide
- **The Methodist Hospitals Southlake Campus Emergency Dept.** – multiple IP activities in Merrillville, IN
- **Kasey the Fire & Life Safety Dog** – fire/burns, motor vehicle, environmental/weather programs throughout Indiana and the Eastern half of the U.S.
- **IDHS EMS Data Registry Program** – assisting multiple EMS IP programs throughout the State of Indiana
- **Allen County Safe Kids (Lutheran Children’s Hospital)** – multiple IP activities in Allen County
- **Porter Hospital** – multiple IP activities in Porter County
- **St. Mary’s Medical Center Trauma Services** – multiple IP activities serving the tri-state area of Indiana, Illinois, Kentucky
- **Maternal Child Special Health Care Services (ISDH)** – IP activities focusing on suicide prevention and motor vehicles throughout the state
- **Deaconess Regional Trauma Center** – multiple IP activities in Evansville and District 10
- **Marion County Safe Kids/Marion County Health Dept Injury Prevention Program** – multiple IP activities in Marion County
- **The People’s Burn Foundation** – Fire/burn prevention awareness, education, training throughout the state and nationwide
- **St. Francis Hospital Indianapolis** – motor vehicle/automotive safety, rape/sexual assault and other education in Indianapolis & Greenwood
- **IU/Wishard Level I Trauma Center** – multiple IP activities in Marion County
- **Pike Township Fire Dept.** – multiple IP activities in Pike Township (Indianapolis)

- **Ruth Lilly Health Education Center** – multiple IP activities in Central Indiana
- **TransCare Ambulance** – no formal IP program but conduct sporadic IP activities sponsored by local fire depts. in Vigo & Clay counties
- **ENA St. Vincent Frankfort Chapter ENCARE program** – multiple IP activities in Frankfort and Clinton County
- **Automotive Safety Program at Riley** – bike/pedestrian and motor vehicle safety state-wide and nationally
- **Safe Kids Indiana** – multiple IP activities state-wide

2. Describe how the trauma lead agency has funded and coordinated system-wide injury prevention or outreach activities. From 2002-2005, ISDH had grant funding to develop injury prevention infrastructure through the CDC Core Injury Surveillance program; unfortunately the application submitted for continued funding was approved but not funded. Although there is no dedicated funding at this time, in 2007 some short-term internal funding became available and was used to fund 20 injury prevention and trauma education projects around the state. Each of the seven trauma centers received a grant award, as well as the Indiana ENA, five non trauma center hospitals (including two CAHs), and an EMS education organization. Participants who benefited from these programs included nurses, pre-hospital personnel, children, teenagers and the elderly.

- a. Which injuries (including pediatric injuries) have been identified and prioritized for intervention strategies? The draft of the Injury Prevention state plan required for the CDC grant application in 2005 focused on five types of injuries: motor vehicle crashes, falls, poisoning, residential fires and suicide (see Appendix 15). At the institutional level, each of the trauma centers analyze their trauma registry data to target areas of need for injury prevention activities and each have customized their injury prevention programs to meet the needs of their communities.
- b. Identify any dedicated lead agency or other agency staff member (full- or part-time) responsible for injury prevention outreach and coordination for the trauma system. There is no dedicated lead agency person responsible for injury prevention outreach and coordination for the trauma system. Most of this responsibility falls on the state trauma manager, with assistance from the part-time injury prevention epidemiologist.
- c. What is the source of funding? There is no state funding for injury prevention.

3. Explain the evaluation process for injury prevention projects that are conducted by the lead agency, trauma facilities, or other community- based organizations. There are not any injury prevention projects conducted by the lead agency, since there is no funding for an injury prevention program. Methods used by the trauma centers include pre and post tests, program evaluations, community surveys, follow-up phone calls, observation of participant behavior, review of registry for changes in trends, interactive programming, to name a few. The lack of statewide injury morbidity data and the lack of e-code use by

many hospitals within the state hampers efforts to determine long-term outcomes of injury prevention efforts within the state.

- a. Identify any gaps in injury prevention efforts for population groups in the state. Because there is no statewide surveillance system and no state health department injury prevention system, it is difficult to quantify gaps. Anecdotally, there appear to be significant gaps within the rural and Hispanic communities. The elderly population has been identified by more than one of the trauma centers as a group that needs more focus on prevention efforts (falls, etc.).

Emergency Medical Services

EMS Summary

The provision of emergency medical services is a matter of vital concern affecting the public health, safety, and welfare of the people of Indiana. The EMS Branch of the Indiana Department of Homeland Security regulates, inspects and certifies services and facilities engaged in providing emergency medical services in Indiana. The standards and requirements for furnishing emergency medical services to the citizens of Indiana are set by the Indiana Emergency Medical Services Commission under 836 IAC with authority from IC 16-31. This eleven-member commission is appointed by the Governor, which includes two physicians, a registered nurse, and representation from hospitals, EMTs, paramedics, and provider agencies, as well as the public.

Indiana EMS Commission:

Member	From	City
Chair - Gary Miller	Private Ambulance Services	Indianapolis
Open	Public Representative	
Melanie "Jane" Cragin	Hospital Ambulance Service	Williamsport
Charles Valentine	Municipal Fire Services	Indianapolis
G. Lee Turpen	Paramedics	Evansville
Myron Mackey	Emergency Medical Technicians	Bicknell
Dr. Michael Olinger	Trauma Physicians	Indianapolis
Ed Gordon	Volunteer Fire Departments	Lawrenceburg
Sue Dunham	Emergency Nurses	Indianapolis
Terri Hamilton	Volunteer EMS	Knightstown
Dr. William Rutherford	Emergency Physicians	Carmel

The EMS Operations Director supervises five EMS District Managers who are assigned a specific geographic service area for providing EMS coordination within the ten Department of Homeland Security Districts. The EMS District Manager's review applications for initial and renewal certification, conduct inspections, perform audits and

offer technical assistance for Basic Life Support, Advanced Life Support and Air Ambulance Providers, EMS Training Institutions and Supervising Hospitals, local and state officials and the general public. The EMS Branch is involved in emergency preparedness at the District level and responds to emergency events statewide to assist the local EMS providers. As part of emergency response, the EMS Operations staff will coordinate and assist the Medical Response Trailers/Teams, located in each of the ten Districts on mass casualty events. Indiana has a Disaster Portable Mortuary Unit that is now under the responsibility of the EMS Branch.

The EMS Operations Director also investigates any EMS related complaints and assists in the preparation of any sanctions issued against EMS certified persons. Unfortunately, the requirements for EMS provider training varies greatly from state to state. The requirements for state of Indiana are mandated by the Indiana Department of Homeland Security.

Table 1.0 : Certification Requirements of EMS Providers in Indiana

Certification	Skills Included	Hours of Training	Certification Requirements	Recertification
EMT-Basic	National Standard Curriculum DOT EMT-Based program, 1994 edition, plus state-approved IV maintenance, aspirin, geriatric, SIDS, WMD, and Hazmat modules	144.5 minimum - includes 8 hours of ED observation & 8 hours ambulance	Successful completion of Commission-approved Basic EMT training course, plus state practical skills and written examinations for initial certification	Semi-annual participation in and reporting of 40 hours of continuing education (34 hours lecture didactic and 6 skills evaluation) plus 6 hours audit.
EMT Basic-Advanced	Basic EMT skills plus state-developed modules: IV initiation and automatic or manual defibrillation	85 hours	EMT certification plus successful completion of state-approved training curriculum and state practical skills and written examinations.	Semi-annual accumulation of 10 hours of continuing education in ALS and 12 hours of medical director approved audit and review, plus basic requirements
EMT-Intermediate	Those in the DOT's EMT-Intermediate 1999 National Standard Curriculum.	350-400 hours	Pass 1999 EMT-Intermediate National Registry exam	Recertify every 24 months; 72 hours continuing education credits, including skills and audit and review
EMT-Paramedic	Basic EMT skills plus DOT EMT-Paramedic training program.	980-1500 hours	Current EMT certification plus successful completion of commission-approved paramedic training program and National Registry Paramedic examination for initial certification.	Recertify every 24 months; 72 hours continuing education credits, including skills and audit and review

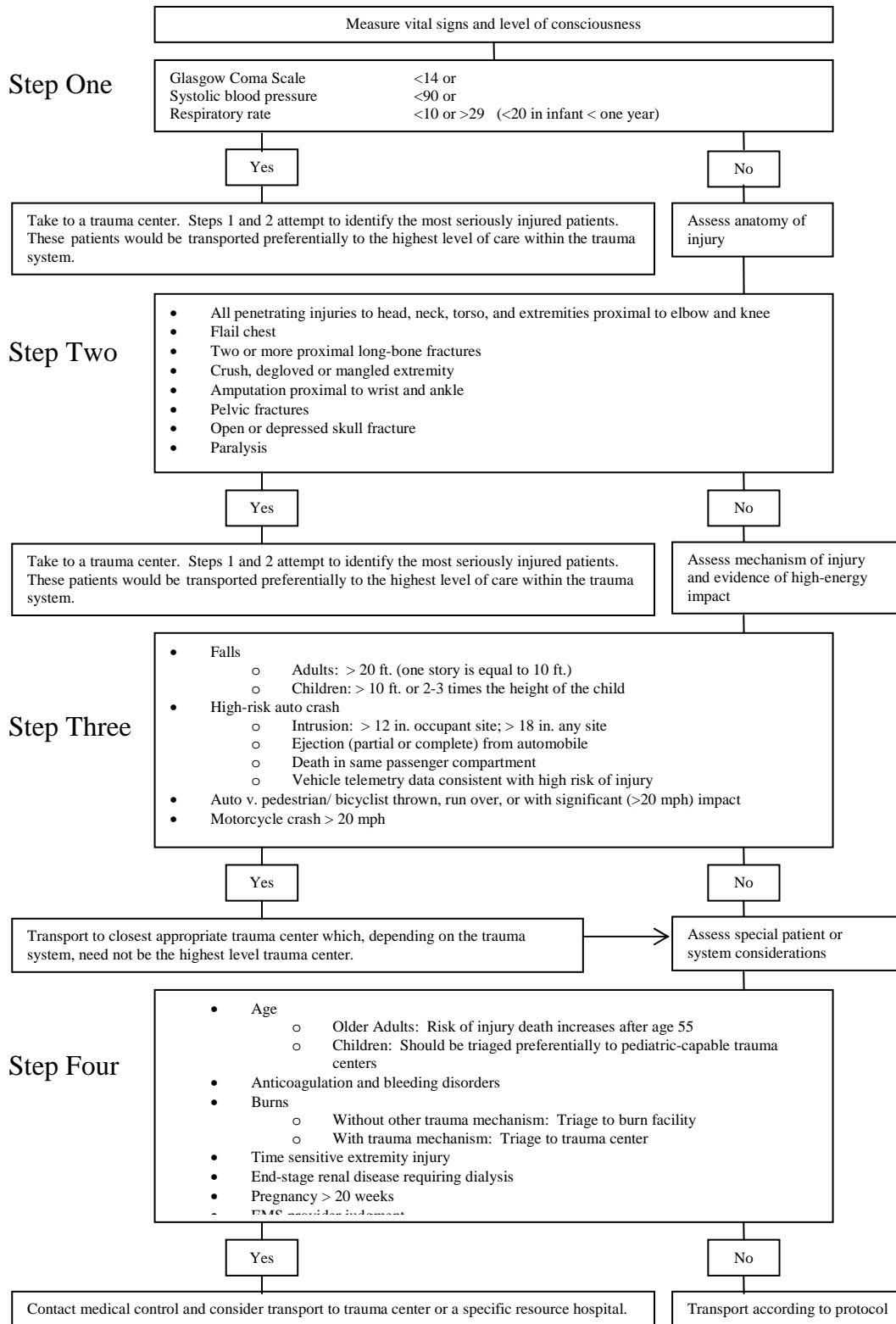
Areas that are rural, such as much of Indiana, have special considerations in terms of EMS care. A wide disparity in the delivery of EMS care between rural and urban areas does exist. One major contributing factor is the high number of volunteers that are

used to operate and maintain these systems of care. In fact, in many rural communities, the emergency care role is a second job for the majority of EMS providers. Due to the large volume of volunteers that provide EMS care in the state of Indiana, it is vital that researchers examine the difference, if any, in the level of care provided between volunteers and paid EMS personnel.

SEA 249 was passed in 2008 (effective July, 2008), giving the EMS commission the authority and mandate to adopt rules concerning triage and transportation protocols for the transportation of trauma patients consistent with the field triage decision scheme of the American College of Surgeons Committee on Trauma (Table 2).

Table 2:

FIELD TRIAGE DECISION SCHEME



This field triage decision scheme, originally developed by the American College of Surgeons Committee on Trauma, was revised by an expert panel representing emergency medical services, emergency medicine, trauma surgery, and public health. The panel was convened by the Centers for Disease Control and Prevention (CDC) with support from National Highway Traffic Safety Administration (NHTSA). Its contents are those of the expert panel and do not necessarily represent the official views of CDC and NHTSA.

A workgroup was created by the EMS commission and the Indiana Department of Homeland Security to review the issues surrounding EMS trauma protocol development, particularly the issues relevant to Indiana, and to develop the protocols and rules for their use that would then go through the State's rule promulgation process before becoming effective. The workgroup's first meeting was held on July 22nd at St. Vincent's in Indianapolis. Immediately from the beginning, it became clear that the consensus of the group was that we needed to create a system for the good of the state...a system that is best for the patient and works for 92 counties. Mike Garvey, DHS, spoke of a very optimistic timeline for the process, noting that it would take at least 18 months (and probably longer) for the workgroup to come up with their recommendations for the commission, for the commission to decide upon their rules, and for the rules to go through the promulgation process. There will also need to be a fiscal impact study done as part of this process that shows how it can or will affect hospitals, providers, and the rest of the state financially.

Discussion was made about the American College of Surgeons Field Decision Scheme and how the statute has been worded to include it. It was the general consensus of the group that using the ACS scheme might create a slight degree of over triage, but that it would be a good starting point and point of reference as the group develops and creates what's effective for Indiana.

Several pieces of information (maps, etc.) were displayed for the attendees of the meeting. It was decided that more data needed to be gathered prior to the next meeting, such as the injuries and runs per county, etc. It was also decided that some (EMS) providers may have, either through protocol or policy/procedure, rules that dictate an inability to transport out of their county or out of their area, and the district managers are polling their providers to determine what, if any of those exist.

In an update to the workgroup discussions, the EMS Commission asked for a definition from State legal counsel, as to whether a paramedic or EMT can legally define a transport destination against the wishes of the patient. The answer from state legal counsel was that an EMS caregiver does not have that authority under statute or regulation. This could potentially be an obstacle to the development of the protocols and insight from other states that have dealt with this issue would be beneficial to the workgroup as it moves forward.

In 2007, the Purdue University Department of Health and Kinesiology and (George Avery, Ph.D., MPA Assistant Professor of Public Health Department of Health and Kinesiology) conducted an Indiana Emergency Medical Services Needs Assessment Conducted in cooperation with the Indiana State Office of Rural Health by mail survey of 2360 EMS personnel and 716 EMS organizations in Indiana. Responses were received from 1054 individuals and 324 organizations, reflecting 44.7% and 45.3% response rates, respectively. Major findings of the survey were:

- Evidence exists of a shortage of EMS personnel in Indiana due to high vacancy rates. This is particularly acute in volunteer organizations, which report the greatest difficulty in recruiting EMS personnel.

- Paid EMS personnel work on average significantly more than a standard 40 hour week, and high percentages of EMS personnel add a second job. Because excessive working hours have been linked to low quality healthcare, this may indicate potential problems with the quality of EMS care.
- Differences in training needs and training received in areas related to cardiac care indicate potential disparities in the quality of care for heart attacks between rural and urban areas.
- Contrary to the Indiana requirements for recertification, it appears that a significant proportion of Indiana EMS personnel and organizations are not using audits as a tool for ensuring quality and developing skills.
- A wide variety of training needs have been identified. While some clinical skill areas (basic and advanced life support) are needed, many of these areas are in important non-clinical areas, such as automobile extrication, foreign languages, safety, and incident management.
- The training environment, both in terms of initial and continuing training, is so varied that it cannot realistically be considered a “system.”
- In the abstract, EMS personnel prefer “hands-on” type training, but when presented with specific scenarios they indicate a greater affinity for locally-delivered mechanisms such as classroom courses at a local school or computer-based training. This probably reflects the tradeoff between time and utility, and is consistent with findings that time is the largest barrier to continuing education and the high percentage EMS personnel who hold second jobs.
- Self-assessment of preparedness levels by EMS personnel reveals that the EMS system in rural areas is likely to be less prepared and capable than in urban areas. Volunteer organizations rate themselves as less capable than paid organizations, although this is largely not reflected in self-assessments by volunteer EMS personnel.

Results of the Purdue 2007 needs assessment, the EMS trauma protocol workgroup, this trauma system consultation, along with much additional information are being used to develop a Rural Trauma-EMS Plan for the State of Indiana.

1. Provide information on the last assessment of EMS, including assessor and date.
Unknown.

- a. Describe the EMS system, including the number and competencies (that is, ALS or BLS) of ground transporting agencies, non-transporting agencies, and air medical resources.

EMS PROVIDER CERTIFICATION REPORT

Provider Level

Rescue Squad Organization (non-EMS certification)	7
Basic Life Support Non-Transport Organization	477
Ambulance Service Provider	129
EMT Basic Advanced Organization	39
EMT Basic Advanced Organization Non-Transport	12
EMT Intermediate Organization (ALS)	10
EMT Intermediate Organization Non-Transport (ALS)	1
Paramedic Organization (ALS)	182
Paramedic Organization Non-Transport (ALS)	12
Rotorcraft Air Ambulance (ALS)	21
Fixed Wing Air Ambulance	1
Total	891

- b. How are these resources allocated throughout the region to serve the population? The provision or authorization of emergency medical services is a requirement of the governing body of a city, town, township, or county according to Indiana statute (IC 16-31). Each political subdivision decides what level of care they choose to fund and to provide.
 - c. Describe the availability of enhanced 911 and wireless E-911 access in your region. Enhanced 911 is available throughout the state. Wireless E-911, including Phase II, is available throughout a majority of the state, largely dependent upon the wireless carrier and areas of coverage (See map Appendix 6).
 - d. Identify any specialty pediatric transporting agencies and aeromedical resources. Several specialty transport units exist (Riley & St. Francis in Indianapolis); however they are born from the need of a specific program/facility, and the respective program bears that cost.
 - e. Describe the availability of pediatric equipment on all ground transporting units. Indiana Administrative Code 836 IAC 1-3-5 denotes the required emergency care basic life support equipment for ground ambulances in the State of Indiana, including pediatric equipment. 836 IAC 2-2-3 denotes additional required emergency care equipment for advanced life support. (See Appendix 12 for EMS code and legislation.)
2. Describe the procedures for online and off –line medical direction, including procedures for the pediatric population. Currently no statewide protocols exist. Protocols may function on a “regional” basis if several providers in the same region have the same medical director and utilize the same protocols. Pre-hospital emergency care (EMS) is highly protocol driven and specific protocols may be online or off-line, dependent upon the decision of the organization’s medical director.
- a. Describe how EMS and trauma medical direction and oversight are coordinated and integrated. There is no statewide or regional medical direction or oversight.
3. Describe the pre-hospital workforce competencies in trauma:

- a. Initial training and certification/licensure requirements
Indiana utilizes National Standard Curriculums for First Responder, EMT-Basic, EMT-Intermediate, and EMT-Paramedic. All National Standard Curricula are available for download at the NHTSA EMS National Standard Curricula website: <http://tinyurl.com/US-DOT-NSC>.

- b. Continuing education and recertification/re-licensure requirements

First Responder

(c) To renew a certification, a first responder shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirement to take and report twenty (20) hours of continuing education according to the following:

- (1) Participate in a minimum of sixteen (16) hours of any combination of lectures, critiques, skills proficiency examination, or audit and review that reviews subject matter presented in the Indiana first responder curriculum.
- (2) Participate in a minimum of four (4) hours in defibrillation and airway management as presented in the Indiana first responder curriculum.

EMT-Basic

(d) To renew a certification, a certified emergency medical technician shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirement to take and report forty (40) hours of continuing education according to the following:

- (1) Participate in a minimum of thirty-four (34) hours of any combination of lectures, critiques, skills proficiency examinations, continuing education courses, or teaching sessions that review subject matter presented in the Indiana basic emergency medical technician curriculum.
- (2) Participate in a minimum of six (6) hours of audit and review.
- (3) Participate in any update course as required by the commission.
- (4) Successfully complete proficiency evaluation that tests the skills presented in the Indiana basic emergency medical technician curriculum.

EMT-Basic Advanced

Sec. 3.5. To renew a certification, a certified emergency medical technician-basic advanced shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirements to take and report fifty-six (56) hours of continuing education according to the following:

- (1) Participate in a minimum of thirty-four (34) hours of any combination of lecture, critiques, skills proficiency examination, continuing education course, or teaching sessions that review subject matter presented in the Indiana basic emergency medical technician curriculum.
- (2) Participate in a minimum of ten (10) hours of any combination of lecture, critiques, skills proficiency examination, or teaching sessions that review subject matter presented in the Indiana emergency medical technician-basic advanced curriculum.
- (3) Participate in a minimum of twelve (12) hours of audit and review.
- (4) Participate in any update course as prescribed by the commission.

(5) Successfully complete a proficiency evaluation that tests the skills presented in the Indiana basic emergency medical technician curriculum and the Indiana emergency medical technician-basic advanced curriculum.

EMT-Intermediate

(b) An applicant shall report a minimum of seventy-two (72) hours of continuing education consisting of the following:

(1) Section Ia, completion of an emergency medical technician-intermediate refresher course based on federal DOT-approved curriculum consisting of a minimum of thirty-six (36) hours, which refresher course may be completed through a supervising hospital-approved continuing education course consisting of the following:

(A) Twelve (12) hours in airway, breathing, and cardiology.

(B) Six (6) hours in medical emergencies.

(C) Five (5) hours in trauma.

(D) Twelve (12) hours in obstetrics and pediatrics.

(E) One (1) hour in operations.

(2) Section Ib, attach a current copy of advanced cardiac life support certification. The certification expiration date shall be concurrent with the emergency medical technician-intermediate certification expiration date.

(3) Section Ic, attach a current copy of cardiopulmonary resuscitation for the professional rescuer certification. The certification expiration date shall be concurrent with the emergency medical technician-intermediate certification expiration date.

(4) Section II, participate in a minimum of twelve (12) hours audit and review.

(5) Section III, participate in twenty-four (24) hours of additional emergency medical services-related continuing education. Additional hours may include participation in any update course as required by the commission.

(6) Section IV, skill maintenance (with no specified hour requirement). All skills shall be directly observed by the emergency medical service medical director or emergency medical service educational staff of the supervising hospital, either at an inservice or in an actual clinical setting. The observed skills include, but are not limited to, the following:

(A) Patient assessment and management; medical and trauma.

(B) Ventilatory management skills/knowledge.

(C) Cardiac arrest management.

(D) Bandaging and splinting.

(E) Medication administration, intravenous therapy, intravenous bolus, and intraosseous therapy.

(F) Spinal immobilization; seated and lying patients.

(G) Obstetrics and gynecological scenarios.

(H) Communications documentation.

EMT-Paramedic

(b) An applicant shall report a minimum of seventy-two (72) hours of continuing education consisting of the following:

- (1) Section IA, forty-eight (48) hours of continuing education through a formal paramedic refresher course as approved by the commission or forty eight (48) hours of supervising hospital-approved continuing education that includes the following:
- (A) Sixteen (16) hours in airway, breathing, and cardiology.
 - (B) Eight (8) hours in medical emergencies.
 - (C) Six (6) hours in trauma.
 - (D) Sixteen (16) hours in obstetrics and pediatrics.
 - (E) Two (2) hours in operations.
- (2) Section IB, attach a current copy of cardiopulmonary resuscitation certification for the professional rescuer. The certification expiration date shall be concurrent with the paramedic certification expiration date.
- (3) Section IC, attach a current copy of advanced cardiac life support certification. The certification expiration date shall be concurrent with the paramedic certification expiration date.
- (4) Section II, twenty-four (24) additional hours of emergency medical services related continuing education; twelve (12) of these hours shall be obtained from audit and review. The participation in any course as approved by the commission may be included in this section.
- (5) Section III, skill maintenance (with no specified hour requirement). All skills shall be directly observed by the emergency medical service medical director or emergency medical service educational staff of the supervising hospital either at an inservice or in an actual clinical setting. The observed skills include, but are not limited to, the following:
- (A) Patient medical assessment and management.
 - (B) Trauma assessment and management.
 - (C) Ventilatory management.
 - (D) Cardiac arrest management.
 - (E) Bandaging and splinting.
 - (F) Medication administration, intravenous therapy, intravenous bolus, and intraosseous therapy.
 - (G) Spinal immobilization.
 - (H) Obstetrics and gynecological scenarios.
 - (I) Communication and documentation.
- c. Pediatric trauma training requirements for recertification
There are no pediatric specific requirements.

Definitive Care Facilities

1. Describe the extent to which all acute care facilities participate in the trauma system. The participation of the trauma centers in the Trauma Task Force and other groups is one of the driving forces of Indiana's trauma system development. The seven trauma centers have been active in the process of trauma system development from the beginning. Currently, there are 28 different hospitals represented on the Trauma Task Force, with an additional 13 hospitals that are participating by submitting data to the trauma registry.

This represents 32 percent of the acute care hospitals (with emergency departments) in the state participating in some way (41/129).

- a. Describe the availability and roles of specialty centers within the system (pediatric, burn, TBI, SCI) – There are two pediatric hospitals in the state of Indiana, Riley Hospital for Children and Peyton Manning Children’s Hospital at St. Vincent, both in Indianapolis. Riley Hospital is also an ACS verified, Level I pediatric trauma center and pediatric burn center (American Burn Association). There are two other burn centers in the state, Wishard Hospital (also a Level I trauma center) in Indianapolis, and St. Joseph Hospital in Fort Wayne. The Rehabilitation Hospital of Indiana in Indianapolis is the largest rehabilitation facility in the state for TBI and SCI patients. Riley Hospital at Methodist (Level I), St. Vincent Pediatric Rehabilitation hospital and St. Mary’s Medical Center (verified Level II trauma center) all have pediatric rehabilitation beds. Other hospitals with rehabilitation beds for TBI and/or SCI are Ball Memorial Hospital in Muncie, Columbus Regional Hospital in Columbus, Daviess Community Hospital in Washington, Deaconess Hospital in Evansville (also a Level II trauma center), Fayette Memorial Hospital in Connorsville, Gibson General Hospital in Princeton (CAH), HealthSouth Deaconess Rehabilitation Hospital in Evansville, Hook Rehabilitation Center in Indianapolis, Howard Regional Health System in Kokomo, Indiana University Acute Rehabilitation Center at Wishard in Indianapolis, Jasper County Hospital in Rensselaer, Memorial Hospital in South Bend (also a Level II trauma center), Methodist Hospitals Rehabilitation Center in Merrillville, Parkview Hospital in Fort Wayne (also a Level II adult and pediatric trauma center), Rehabilitation Center at St. Catherine Hospital in East Chicago, Rehabilitation Hospital of Fort Wayne, Reid Hospital and Health Care Services in Richmond, Roudebush VA Medical Center in Indianapolis, Southern Indiana Rehabilitation Hospital in New Albany, St. Joseph Regional Medical Center – IRF in South Bend, St. Mary Medical Center in Hobart, Union Hospital Medical Rehabilitation in Terre Haute, Wabash Valley Hospital in West Lafayette and Whitewater Valley Rehabilitation in Connorsville.

2. Describe the roles of the non-designated acute care facilities in the trauma system. There are several non-designated hospitals which are a part of the Trauma Task Force, and they are assisting with trauma system development efforts. In addition, there are several other hospitals that have voluntarily begun to use the state trauma registry. It is the intent of the Task Force to include all hospitals in the trauma system, and the Task Force will encourage non-designated hospitals to consider participation as a designated center when the designation process is in place.

- a. Address their representation on the regional trauma committee. We have representation from several non-trauma hospitals (both large and small facilities) on the Trauma Task Force.
- b. Do they submit registry and/or financial data? Some are starting to submit registry data: 15 CAHs participated in a trauma registry pilot project entering severely injured patients transferred to a higher level of care into the registry, and

most are continuing to use the registry. One additional non trauma center hospital (Elkhart General) is currently entering data into the registry. The hospitals that participated are listed below:

- West Central Community Hospital in Clinton (Vermillion County)
- St. Mary's Warrick Hospital in Boonville (Warrick County)
- Blackford Community Hospital in Hartford City (Blackford County)
- Dunn Memorial Hospital in Bedford (Lawrence County)
- St. Vincent Mercy Hospital in Elwood (Madison County)
- White County Memorial Hospital in Monticello
- Tipton Hospital in Tipton (Tipton County)
- Woodlawn Hospital in Rochester (Fulton County)
- Gibson General Hospital in Princeton (Gibson County)
- Washington County Memorial Hospital in Salem (Washington County)
- Community Hospital of Bremen (Marshall County)
- Bedford Regional Medical Center (Lawrence County)
- Rush Memorial Hospital in Rushville (Rush County)
- Bloomington Hospital of Orange County in Paoli
- Jay County Hospital in Portland

- c. What is their degree of engagement in the system-wide performance improvement process? There is no system-wide PI process yet.

3. Describe the process for verification and designation. Briefly outline the extent of authority granted to the lead agency to receive applications and to verify, designate, and de-designate regional trauma centers. This process is not in place yet. Current Trauma Task Force plans are that Level I and Level II trauma centers would be verified by the American College of Surgeons' (ACS) Committee on Trauma (COT) with subsequent designation from the State of Indiana. Level III and Level IV trauma centers would be designated by the State of Indiana (see Appendix 3).

4. Describe your standards for trauma center verification (including pediatric standards) and the extent to which they are aligned with national standards. This process is not in place yet. Current Trauma Task Force plans are that Level I and Level II trauma centers would be verified by the American College of Surgeons' (ACS) Committee on Trauma (COT) with subsequent designation from the State of Indiana. Level III and Level IV trauma centers would be designated by the State of Indiana (see Appendix 1). In June of 2007, 17 members of the Trauma Task Force came together for a full-day retreat to discuss the designation process for Level III and IV hospitals, which resulted in the draft rules seen in Appendix 3, which have not yet gone through the promulgation process. Notes from that meeting follow:

Notes From June 23, 2007 Trauma System Planning Retreat

I. Trauma Task Force Members in Attendance:

Charlene Graves, MD – ISDH (Trauma Medical Director); Susan Perkins, RN – ISDH (Trauma System Manager); Joan Marciniak – ISDH (Injury Prevention Epi); John

Braeckel – ISDH (Hospital Preparedness); Spencer Grover – IHHA; Tom Madden, MD – Indiana ACEP, Bloomington Hospital; Chris Hartman, MD Indiana ACEP, St. Francis Hospital; Tres Scherer, MD – Indiana ACS-COT and EMS-C, Riley Hospital; Matt Howard, RN – Riley Hospital; Sharon Hubrich – VPPCS Daviess Community Hospital; Tim Hayward, MD – Wishard Hospital; Brian Mullis, MD – Wishard Hospital; Gerardo Gomez, MD – Wishard Hospital; Rick Lowry, RN – Methodist Hospital; Merry Addison, MSN – Terre Haute Regional Hospital, IN ENA; Larry Addison, RN – West Central Community Hospital (CAH), IN ENA; Andrew Bowman, MSN, EMT-P – Witham Hospital

II. Tom Madden reviewed the goals of a trauma system related to designation of hospital levels of care. In previous discussions, the Trauma System Advisory Task Force agreed that the system should be voluntary - once the criteria have been developed, hospitals can select what level of care fits best and apply accordingly for that status. The goals of a trauma system facility designation process include:

- A) to facilitate the rapid identification, evaluation and treatment of the trauma victim,
- B) to promote cooperation among treating facilities and efficient transportation of the trauma victim to the appropriate treating facility,
- C) to collect data concerning trauma victims and analyze it to improve performance,
- D) to use this data to save lives and improve the health of the population of Indiana.

Hospital designation should be inclusive and all designated hospitals will be required to submit data to the state trauma registry. The hospital designation process should be kept as simple and flexible as possible and needs to be elucidated in Administrative Rules which are now beginning to be developed in draft form (a brief discussion was held later in the retreat).

Because it has already been agreed to utilize the ACS-COT verification process for Level I and II hospitals, the retreat was designed to focus on what is needed for Level III and IV hospitals to be designated, as in other states, through a state government agency, in this case ISDH.

Comments included the need to create incentives for hospitals to become Level III care facilities, because extra costs to the hospital will be involved.

Tom Madden and Tres Scherer then led the group through a comprehensive review and discussion of the Level III and Level IV hospital designation criteria, with the final consensus being the criteria listed in Table 1 below.

Table 1: TRAUMA CENTER DESIGNATION CRITERIA COMPARISON: ACS & Indiana Criteria. (X = Required; D = Desirable). Comments are highlighted in yellow; items highlighted in red are from after the retreat.

INSTITUTIONAL ORGANIZATION	ACS		Indiana: Proposed Criteria	
	LEVEL III	LEVEL IV	LEVEL III	LEVEL IV
Trauma Program – Definition needed. Core is surgeon, EM doc, ED nurse. EM doc and surgeon can be co-directors – facility	X		X	

decides. Level IV does not require a surgeon.				
Trauma Service – Have to have the correct type of physicians to care for the pt in the hospital (i.e. ortho trauma admission must have ortho surgeon available, etc.). Create policies if needed.	X		X	
Trauma Team (ED physician, nurse, RT, surgeon on call for level III)	X		X	X
Trauma Coordinator/trauma program manager – usually an ED nurse.	X		X	X
Trauma Program Medical Director (Can be ED physician, but surgeon must be involved on committee)	X		X	X
Trauma Multidisciplinary Committee/PIPS Program – must meet at least twice per year	X		X	
Trauma Registrar (Can be trauma coordinator)	X		X	
HOSPITAL SECTIONS (Determined by hospital by-laws & federal regulations, so does not need to be included in the criteria)				
Anesthesia				
Emergency Medicine	X	X	X	X
a. Emergency Medicine liaison				
General Surgery	X		X	
Orthopedic Surgery	X		X	
a. Orthopedic trauma liaison				
Radiology			X	
CLINICAL CAPABILITIES – must have emergent care capabilities (on call & available 24-7)				
Anesthesia – includes CRNAs under physician (anesthesia or surgeon) supervision	X		X	
Delete Hospitalist				
Emergency Medicine - 24-7 staffing of ED on-site IF receive ambulances	X	X	X	X
General Surgery	X		X	
Orthopedic Surgery	X		X	
Radiology	X		X	
CLINICAL QUALIFICATIONS				
Board Certification/Eligible (VOTED to use ACS-COT wording)				
Anesthesia – not required, so DELETED				
Hospitalist – DELETED				
Emergency Department Medical Director			X	
Emergency Medicine	X		D	
a. ATLS completion at least once			X	X
General Surgery	X		X	
a. ATLS completion at least once	X		X	
b. Multidisciplinary Committee Attendance >50%				
Orthopedic Surgery – should require a time limit for certification (exclude fellowship from time limit)	X		X	
Radiology			X	
Non-board certified/Eligible				
Emergency Physicians				
a. ATLS Certification (must maintain current)	X	X	X	X
b. Multidisciplinary Committee Attendance >50%				
Emergency Department Nurses – TNCC required for at least one			X	X
FACILITY RESOURCES				
Clinical Laboratory Service	X	X	X	X
PACU	X		X	
Critical Care Unit	X		X	
Emergency Department 24 hr. physician staffing	X		X	X

Pharmacy 24 hr. pharmacist staffing			D	
Physical Therapy & Occupational Therapy	X		X	
Radiology Services				
Sonography			D	
Radiology technician 24 hr.	X		X	
Computed Tomography	X		X	
CT technician 24 hr.	X		X	
Respiratory Care Services	X		X	
Social Services	X		X	
Surgery Suite on call 24 hr.	X		X	

Note: Requirement for ED medical director at a Level III center would “grandfather in” those ED medical directors not currently board certified. The rules will need to be written to reflect this and have a deadline date (i.e. “Emergency department medical directors must be board certified for hospitals applying for Level III designation after [date].”).

1. Regional organization of the trauma system – RACs (Regional Advisory Councils) should be considered at some point.
2. Redesignation process for hospitals will need a site survey team for Level III, but Level IV initial designation and redesignation may be possible to accomplish through processes already in place for ISDH hospital surveys for licensure.
3. Ideally, Level I and II hospitals would sponsor/reach out to proposed Level III or IV hospitals to assist them with accomplishing state designation.
4. Transport, transfer and care protocols are needed within the trauma system but are not included in the current Indiana legislation (SEA 284 of 2006).
5. Discussion was held as to the site survey process and who should be involved, but no final consensus was achieved.
6. The recent development of free-standing emergency departments (geographically separate from hospitals) creates issues that will need to be identified and discussed.
7. ? : Does there need to be a requirement for Level III centers for minimum number of ED visits per year?

III. Administrative Rules Discussion:

1. A first rough draft of administrative rules for trauma center designation was compiled by Charlene Graves from information gathered from other states. This document was reviewed and briefly discussed. Spencer Grover and John Braeckel will work on revisions to the language/content of this
2. Under Levels of Care, the need for transfer language for I’s & II’s for receiving patients from III’s & IV’s was discussed. Resources need to be in place to facilitate communication from physician to physician for ease of transfer to higher level of care. It was noted that Level I & II facilities should always agree to receive trauma patients from Level III & IV facilities. Reference was made to the language in Chapter 4, p. 27 of the ACS green book.
3. There should be a transfer plan in place to facilitate the process – tells when a patient needs to be transferred.
4. There was discussion regarding the terminology in the Levels of Care, III & IV sections: transfer agreements should be changed to transfer plans, and treatment protocols should be changed to treatment guidelines.

5. Throughout the day, the term “system hospital” was mentioned several times. This was in reference to hospitals that do not choose any of the other designations or that do not qualify for any of the other designations. Susan Perkins is going to research the terminology that other states use for these hospitals.

IV. Trauma Registry Update

Susan Perkins provided an update on the status of the Indiana Trauma Registry. She also handed out a copy of Ohio’s Trauma Registry Rules as an example that Indiana can use to start developing rules for the trauma registry.

V. Performance Improvement (PI) Indicators

Susan Perkins handed out copies of:

- PI information from the ACS-COT Trauma Performance Improvement Reference Manual,
- Chapter 16 of the ACS green book (Performance Improvement and Patient Safety),
- Quality improvement filters from Washington State, and
- Performance Indicators and Outcome Measures from Australia.

Tres Scherer handed out Indiana EMSC Performance Improvement Measures for 2006. The group was asked to review these documents after the retreat and provide feedback to Susan either by email or by participating in the PI discussion at the upcoming August 3rd Task Force meeting. Susan will compile a brief document on proposed PI indicators for Indiana to present at the next Task Force meeting.

VI. Strategic Planning

Many strategic planning issues were covered in earlier discussion during the retreat. Issues and comments from the discussion of 12 issues are provided below.

Strategic Planning for Indiana Trauma System Development – From June 23, 2007 Retreat (Comments from discussion at the Retreat are bulleted and in italics)

The following is a list of some issues that seem pertinent to our strategic planning efforts:

1. Should there be a State Trauma Care Commission created and appointed by the Governor? Currently the ISDH Trauma System Advisory Task Force is a voluntary group of interested parties that has been meeting since 2004. With more than 50 members and broad representation, it provides a strong forum for dialogue. About 35 members attend each quarterly meeting. The group has worked well to provide the input needed to ISDH and continues to examine a number of important issues. There are pros and cons to consider when comparing the current advisory group to a state commission, which would be a more official entity.

- *Commission is needed eventually, although the Task Force currently accomplishes*

the functions needed for the initial development of the trauma system.

- *A summer Study Commission (in 2008) might be useful in creating further legislation that may be needed. A status report and data related to the trauma system would need to be provided.*
- *Should this commission be a governmental entity or a not-for-profit type of non-governmental entity?*

2. Should there be more efforts at regionalization in the development of the state trauma system? Some states utilize a regional basis for their trauma system (Texas, Michigan, others). Are there good reasons to consider regionalization for Indiana, assuming the regions would be aligned with the ten EMS/Public Health Preparedness Districts already in existence? Are there drawbacks to regionalization?

- *Further efforts at regionalization are desirable to enhance communication between all stakeholders and to deal with local issues. RACs (Regional Advisory Councils) provide this function in some states.*

3. How can the critically needed financing for trauma system infrastructure and for compensation to hospitals for non-reimbursed care to trauma patients be accomplished? Spencer Grover of IHHA surveyed a number of states to determine the sources for funding their trauma systems. While there are a number of possibilities to be considered, it is likely that something similar to a fee on motor vehicle registrations, automobile purchases, or alcoholic beverages should be considered since motor vehicle crashes and violence related to alcohol are large contributors to the burden of trauma. How can advocacy for such funding be accomplished?

- *At a previous Task Force meeting, Dr. Hanni suggested we should begin working on this issue, and indicated his willingness to begin addressing it with local legislators.*

4. Selecting performance improvement indicators and processes is important in the early stages of the state trauma registry and the trauma system hospital designation process. What are the optimal methods to incorporate performance and outcome measures into the system? What should be the role of sentinel events?

- *Susan Perkins is researching and collecting performance improvement indicators, which will be disseminated and presented for discussion at future Task Force meetings. A Committee or Workgroup may be needed to provide initial feedback.*

5. What are the special issues affecting trauma care providers, including orthopedic surgery, neurosurgery, anesthesiology and rehabilitation medicine?

- *On-call coverage is a growing issue for the surgical subspecialties.*

6. How do we incorporate trauma care considerations for special populations, e.g., pediatrics, patients with burns, geriatrics, etc. into the trauma system?

- *These issues will need further exploration as the trauma system is developed.*

7. Delivery of trauma care in the rural areas of the state is problematic for a number of reasons. How can we improve that situation?

- *Improved EMS capabilities and funding need to be examined. The use of telemedicine as well as thinking in regional terms rather than counties are also important factors. Expanded education related to trauma issues has begun and needs to continue.*

8. How can coordination best be maintained between the governing agencies and organizations for pre-hospital care, hospitals with varying levels of ability to provide trauma care, rehabilitation services, and injury prevention?

- *The Task Force provides a valuable forum for information sharing and coordination. ENA representation on the Indiana EMS Commission would be helpful. More work needs to be done on standards and guidelines for triage, transfer and care of trauma patients.*

9. How can coordination and collaboration be maintained between governing agencies and organizations involved in preparedness and disaster planning? What is the role of the trauma system and trauma centers in this collaboration?

- *Much coordination and collaboration is already being achieved through federal funding to support preparedness/bioterrorism. More attention to the function and role of state trauma systems and trauma centers is becoming evident in the federal hospital preparedness objectives.*

10. What is the role of new technologies, such as telemedicine, in the trauma care system?

- *Improving care through telemedicine is of particular importance for small rural hospitals, many of which are critical access hospitals that receive federal funding through FLEX grants administered by the Indiana Office of Rural Health at ISDH.*

11. Should trauma registry data for smaller hospitals (Level IV) be somewhat different than that for larger hospitals?

- *Issue not discussed due to lack of time.*

12. Statewide protocols for transport and care of trauma patients are a necessary element of a state trauma system, but were not included as a responsibility in PL 155 of 2006. How can protocol development and adoption be achieved?

- *It appears that the initial legislation may need to be amended at some point in the future, but much preparatory work on disseminating information and educating EMS*

and hospital providers can be done in the interim.

- a. Describe any waivers or program flexibility granted for centers not meeting verification requirements. *N/A at the state level.*
- b. Describe the process and frequency of use for de-designation of trauma centers. *N/A at the state level.*

5. Outline how the geographic distribution and number of designated acute care facilities is aligned with patient care needs. *There are no designated facilities in Indiana yet. With the locations of the seven ACS-verified level I and II trauma centers in Northeastern, Central and Southwestern Indiana, there are two areas of the state that could potentially benefit from the addition of trauma centers: Northwestern and Southeastern Indiana.*

- a. Describe the process by which additional trauma centers are brought into the system. *Additional trauma facilities can be brought into the system through verification and designation when Indiana has rules in place to do that. Generation of interest in the trauma system is being accomplished by the efforts of the Trauma Task Force membership. Examples of how the trauma centers are promoting trauma system involvement follow:*
 - *St. Mary's trauma staff have visited seven of the District 10 hospitals to encourage their involvement in the state trauma system and have offered support in the verification process if the hospitals in their district wish to pursue verification. They provided each hospital with a copy of Resources for Optimal Care of the Injured Patient, Indiana Trauma Network minutes, Trauma Task Force minutes, and the Indiana State Trauma System DVD. Three facilities have expressed interest in becoming a Level III or IV center. St. Mary's staff maintain contact with them via e-mails and letters offering support and opportunities for them to send nursing representatives to St. Mary's to observe their processes. The Injury Prevention/Outreach Coordinator travels to speak to various groups, such as pre-hospital providers and critical access hospital staff, about the trauma system through invitation and various conferences. They have several trauma lectures for anyone to view through the St. Mary's website. They have a 1-800 trauma transfer line in their Emergency Department.*
 - *Parkview Trauma Center's trauma outreach coordinator has taken on a leadership role serving the regional twenty county referral area in Northeastern Indiana and Northwestern Ohio to provide education on trauma system and trauma system development. Dr. Aaland has done many outreach presentations as well. Parkview also has a Trauma Prevention Coordinator and Trauma Strategist. They have a "one call does it all" 1-800-727-6911 flight response number.*
 - *The other trauma centers reach out to the hospitals and providers in their districts as well and have had staff from surrounding hospitals attend a*

variety of courses such as Principles of Trauma, PALS, ACLS, TNCC, ENPC, ATLS, and PHTLS. Deaconess Hospital continues to conduct RTTD courses throughout District 10.

- b. Describe the system response to the voluntary withdrawal of designation by acute care facilities. *N/A at the state level.*
 - c. Describe the mechanism for tracking and monitoring patient volume and flow between centers and how this influences the overall configuration of designated facilities. *N/A at the state level.*
6. Describe your system for assessing the adequacy of the workforce resources available within participating centers. *N/A at the state level.*
- a. Address nursing and subspecialty needs (trauma or general surgery, intensivists, neurosurgeons, orthopedic surgeons, anesthesiologists, pediatric surgeons, and others, as required). *N/A at the state level.*
 - b. What human resource deficiencies have been identified, and what corrective actions have been taken? *N/A at the state level.*
7. Describe the educational standards and credentialing for emergency physicians and nursing staff, general surgeons, specialty surgeons, and critical care nurses caring for trauma patients in designated facilities. *N/A at the state level.*
- a. What regional educational multidisciplinary conferences are provided to care providers? Who is responsible for organizing these events? *N/A at the state level.*

Hospitals hosting annual trauma conferences:

- *Clarian Health (Methodist and Riley –Level I)*
- *Wishard – Level I*
- *Parkview – Level II*
- *Memorial (South Bend) – Level II*
- *Deaconess – Level II*
- *St. Mary’s (Level II) is planning a Pediatric Trauma Symposium in 2009.*
- *The Methodist Hospitals (Gary)*
- *Terre Haute Regional Hospital*

System Coordination and Patient Flow

1. Describe the source of pre-hospital trauma triage protocols, and specify whether they are consistent with national guidelines. *N/A at the state level yet – there is now legislation for the creation of these (based on the ACS triage scheme – see EMS section), and a workgroup has been established.*

An example of local pre-hospital trauma triage protocols follows:

For response in the city of Fort Wayne, the provisions are established by the city ordinance. Allen County has been divided between two hospitals, one a verified trauma center (Parkview) and one that is currently pursuing Level II verification (Lutheran). For ambulance transports, the protocol is for the patient to be taken to the closest hospital between Parkview and Lutheran hospitals. For flight response, all flights are to be transported to the verified trauma center per the protocol agreed upon by the medical directors of the providers.

The authority for the Fort Wayne EMS program is through a city ordinance that establishes an EMS public utility model with an EMS board and a medical control process that is tied to all five of the Fort Wayne hospitals. Through an agreement with Allen County, the city EMS program also has jurisdiction in the county to provide Advanced Life Support to residents living in the county outside the city limits of Fort Wayne. All Allen County providers are a mixture of volunteer and paid staff and provide BLS to the townships they serve. Each EMS service has a Medical Director and EMS Chief that provide leadership, audit and review, QA, and medical control of the service. The local unit of government, township trustee, county government and hospital administration, depending on the specific organization, governs counties adjacent to Allen County.

- a. Describe how children and patients with severe TBI and SCI are triaged from the field to appropriate facilities. There are no pediatric triage protocols.
2. Within the system, what criteria are used to guide the decision to transfer patients to an appropriate resource facility and are these criteria uniform across all centers?
There are no uniform criteria in place at the state level.
3. Specify whether there are inter-facility transfer agreements to address the needs of each of the following: Each of the trauma centers have transfer agreements in place with the other hospitals that they service, as well as with hospitals in other states as applicable and with other trauma centers in the state.
 - a. Transfer to an appropriate resource facility - Each of the trauma centers have transfer agreements in place with the other hospitals that they service, as well as with hospitals in other states as applicable and with other trauma centers in the state.
 - b. TBI - Each of the trauma centers have transfer agreements in place with the other hospitals that they service, as well as with hospitals in other states as applicable and with other trauma centers in the state.
 - c. SCI - Each of the trauma centers have transfer agreements in place with the other hospitals that they service, as well as with hospitals in other states as applicable and with other trauma centers in the state.

- d. Re-implantation - unknown
- e. Burns – Each of the trauma centers have transfer agreements in place with the other hospitals that they service, as well as with hospitals in other states as applicable and with other trauma centers in the state. Additionally, Richard M. Fairbanks Burn Center at Wishard Memorial Hospital has local agreements with Clarian Health Partners and Deaconess Hospital and Burn Center transfer agreements with University of Cincinnati, Loyola University, Riley, St Joseph's, Ohio State University.
- f. Children – Each of the trauma centers have transfer agreements in place with the other hospitals that they service, as well as with other trauma centers.
- g. Repatriation - Each of the trauma centers have transfer agreements in place with the other hospitals that they service, as well as with other trauma centers.

4. Describe the system-wide policies addressing the mode of transport and the type and qualifications of transport personnel used for inter-facility transfers. This does not exist at the system level.

5. Specify whether there is a central communications system to coordinate inter-facility transfers. Describe how this system has access to information regarding resource availability within the region. This does not exist at the system level.

Rehabilitation

1. Provide data about the number of rehabilitation beds and specialty rehabilitation services (SCI, TBI, and pediatric) available within the trauma system's geographic region. On average, how long do patients need to wait for these rehabilitation beds? Does the average wait vary by type of rehabilitation needed? There are 21 CARF accredited rehab providers in Indiana, five with specialty accreditation for BI and one (Rehabilitation Hospital of Indiana) with SCI specialty accreditation. The total number of inpatient acute care hospital rehabilitation beds is 904 (see table below). Onset days for SCI from eRehabData for last 180 days (as of September, 2008) lists regional (including Indiana) at 25.14 and Nation as 23.91 and BI at 22.93 Regional and 23.19 for the Nation.

Indiana Hospitals with Rehabilitation Beds:

FACILITY NAME	CITY	PROV NUM	COUNTY	REHAB BEDs
Ball Memorial Hospital	Muncie	150089	Delaware	23
Bloomington Hospital	Bloomington	150051	Monroe	21
Clark Memorial Hospital	Jeffersonville	150009	Clark	20
Columbus Regional Hospital	Columbus	150501	Bartholomew	18

Community Hospital Community Hospital East (Hook Rehab Inpatient)	Munster Indianapolis	150125 150074	Lake Marion	37 44
Daviess Community Hospital	Washington	150061	Daviess	12
Doctor's Hospital	Bremen	153040	Marshall	20
Elkhart General Hospital	Elkhart	150018	Elkhart	20
Fayette Regional Health System	Connersville	150064	Fayette	16
Good Samaritan Hospital	Vincennes	150042	Knox	18
Hancock Regional Hospital	Greenfield	150037	Hancock	9
Healthsouth Deaconess Rehabilitation Hospital	Evansville	153025	Vanderburgh	64
Howard Regional Specialty Care LLC	Kokomo	153039	Howard	30
Johnson Memorial Hospital	Franklin	150001	Johnson	15
La Porte Hospital and Health Services	La Porte	15006	La Porte	10
Lafayette Home Hospital	Lafayette	150109	Tippecanoe	18
Marion General Hospital	Marion	150011	Grant	18
Memorial Hospital of South Bend Inc	South Bend	150058	St Joseph	20
Morgan Hospital and Medical Center	Martinsville	150038	Morgan	7
Parkview Hospital	Fort Wayne	150021	Allen	31
Rehabilitation Hospital of Fort Wayne	Fort Wayne	153030	Allen	36
Rehabilitation Hospital of Indiana	Indianapolis	153028	Marion	90
Reid Hospital and Health Care Services Saint Anthony Medical Center of Crown Point	Richmond Crown Point	150048 150126	Wayne LaPorte	17 16
Saint Anthony Memorial Health Center	Michigan City	150015	LaPorte	16
Saint John's Health System	Anderson	150008	Madison	13
Southern Indiana Rehab	New Albany	153037	Floyd	38
St Catherine Hospital	East Chicago	150008	Lake	25
St Joseph Hospital & Health Center	Kokomo	150010	Howard	18
St Mary Medical Center	Hobart	150034	Lake	20
St Mary's Medical Center	Evansville	150100	Vanderburgh	50

Starke Memorial Hospital	Knox	150102	Starke	1
Terre Haute Regional Hospital	Terre Haute	150046	Vigo	12
The Methodist Hospitals, Inc.	Gary	15002	Lake	39
Union Hospital, Inc.	Terre Haute	150023	Vigo	28
Westview Hospital	Indianapolis	150129	Marion	14

Pediatric: St. Mary's hospital in Evansville has 6 pediatric rehabilitation beds. Typically a bed is available in rehab within 48 hours of the request. Riley Hospital for Children at Methodist Hospital has a 14 bed pediatric rehabilitation unit as well as a day treatment program and outpatient services. St. Vincent Pediatric Rehabilitation Hospital also provides pediatric rehabilitation services.

2. Describe how existing trauma system policies and procedures appropriately address treatment guidelines for rehabilitation in acute and rehabilitation facilities. Indiana has no existing trauma system policies and procedures.

3. Identify the minimum requirements and qualifications that rehabilitation centers have established for the physician leaders (for example, medical director of SCI program, medical director of TBI program, and medical director of rehabilitation program). Inpatient Rehabilitation Facility basic requirements for the Medical Director are set by Medicare, requiring a licensed MD/DO with at least a one year internship and two years of experience treating patients in need of rehabilitation. At the institutional level, Rehabilitation Hospital of Indiana requires that program medical directors (BI and SCI) maintain specialty certification as provided by American Academy of Physical Medicine & Rehabilitation.

4. Describe how rehabilitation specialists are integrated into trauma system planning and advisory groups. At the trauma system level, Marc Duerden, a physiatrist at Hook Rehab is a member and active participant of the Trauma Task Force; the Rehabilitation Hospital of Indiana is showing an interest in participating now as well. The ISDH also maintains relationships with the rehabilitation community through its assistance with the Indiana Spinal Cord and Brain Injury Research Board and the state trauma system manager's participation in the TBI Grant Advisory Council/Work Group. Rehabilitation representatives in addition to Dr. Duerden have also been invited to participate in this trauma system consultation.

Disaster Preparedness

1. When was the last assessment of trauma system preparedness resources conducted, and what were the significant findings of the assessment as they relate to emergency preparedness? Trauma system preparedness is not currently specifically assessed. ED readiness is assessed and the Incident Command System is instituted where applicable.

A group of stakeholders met in 2001 and completed a trauma/disaster preparedness assessment that was published by HRSA in 2002 as a national state by state assessment of trauma system and disaster preparedness. This same group of stakeholders had a meeting in 2002 and performed a SWOT analysis of the assessment, and a summary of that assessment is below (full documentation can be found in Appendix 5):

INDIANA TRAUMA ASSESSMENT CONFERENCE SWOT ANALYSIS (2002)

NOTE: At the Indiana trauma assessment conference, discussion topics reflected various components of a trauma system (injury prevention, emergency medical services, hospital care, special needs [burns, pediatrics, and geriatrics], rehabilitation, trauma registry, etc.). Participants completed a SWOT analysis sheet (attached) after each topic. Responses are listed and summarized below. Fewer than five responses are omitted due to illegibility or duplication of another response in the same section from the same participant. Editorial interpolation is indicated by brackets ([.....]).

Participants were not asked to prioritize responses from most to least important. In addition, the number, diversity, and brevity of responses makes it impractical to weight a particular response based on whether a participant listed it first or last. Therefore, “Top Choices” indicates the frequency of each response in a particular section. Substantially equivalent responses in a section are grouped together for purposes of this summary.

Injury Prevention

Strengths

Top Choices:

1. Strong existing programs/agencies/committees/framework (12)
2. Availability of data (7)
3. Many committed/passionate experts with much technical knowledge (6)
4. Noble purpose with wide appeal/“feel good” (3)
5. Educational programs (2)

Weaknesses

Top Choices:

1. Data insufficient, incomplete, or uncoordinated (14) – see also # 4
2. Agencies/programs uncoordinated and/or duplicative (11) – see also # 5
3. Inadequate funding (3)
4. Lack of usable E-code data (3)
5. Lack of statewide “system” [injury prevention or trauma?] (3)
6. Lack of access to EMS in rural areas (2)
7. Misuse of care seats (2)

Opportunities

Top Choices:

1. Improve data use – update data, make it more accessible, use for teaching, etc. (11)

2. Improve education – in or through schools, hospitals/trauma centers, Internet, etc. (9)
3. Better collaboration among injury prevention agencies/programs (6)
4. Funding opportunities – MCHB, EMS-C, private foundations, etc. (6)
5. Injury prevention as part of a state trauma system (3)
6. Strengthen seat belt laws and enforcement, including pick-up trucks (3)
7. Strengthen booster seat laws and enforcement (3)

Threats/Obstacles

Top Choices:

1. Funding needs and priorities (17)
2. Lack of legislative understanding and support (6)
3. Turf battles/competition/fear of competition (5)
4. Lack of effective leadership/central control (4)
5. Rural diversity/lack of infrastructure (2)
6. Lack of primary seat belt law for pick-up trucks (2)

Emergency Medical Services

Strengths

Top Choices:

1. Adequate/well organized EMS resources – manpower and ambulances (10)
2. EMT training – national standards, continuing education, etc. (7)
3. Scope of aeromedical coverage (6)
4. Effective and cooperative SEMA/EMS commission (5)
5. Data collection system (5)
6. Dedication of EMS professionals (4)

Weaknesses

Top Choices:

1. Uneven access to and quality of EMS throughout state, esp. in rural areas (23)
 - 15 counties have no hospital (9)
 - Some counties lack paramedics (6)
 - 2 counties lack 911 (3)
2. EMT and medical director training/continuing education is inadequate, inconsistent, inaccessible, or redundant (10)
3. Inadequate funding (7)
4. Inadequate communications systems (6)
5. Lack of field protocols, esp. for calling aeromedical service (5)
6. Low pay/benefits (4)

Opportunities

Top Choices:

1. Standard statewide protocols for dispatch (including aeromedical) and field (9)
2. Strengthen EMT/EMD training (5)
3. Public education (3)

4. Use post-Sept. 11 atmosphere to recruit volunteers (2)

Threats/Obstacles

Top Choices:

1. Funding needs (14)
2. Turf battles/competition>cooperation (8)
3. Insufficient recruitment and retention of paramedics and volunteers in rural areas (4)

Trauma Care in Hospitals

Strengths

Top Choices:

1. Indiana already has several good trauma centers – some say they're well distributed (5)
2. Informal statewide trauma system already exists (4)
3. Indiana has single medical school (3)

Weaknesses

Top Choices:

1. Cost/lack of funding (9)
2. Turf battles/competition/politics (6)
3. Trauma centers currently concentrated in a few areas, esp. for pediatrics (6)
4. Staffing shortages – RN's, ED/trauma physicians, radiology, etc. (5)
5. No legislative mandate (3)
6. Lack of commitment – hospitals and/or physicians (3)
7. Challenges of rural areas (2)
8. Lack of data/trauma registry (2)

Opportunities

Top Choices:

1. Data/trauma registry – improve collection and use of data to document need for trauma system (6)
2. Solve funding/reimbursement issue (5)
3. Improve injury prevention (4)
4. Use lessons/data from other states (3)
5. Legislation to establish/fund trauma system (2)

Threats/Obstacles

Top Choices:

1. Cost/lack of funding (18)
2. Competition/politics (9)
3. Staffing shortages (6)

Special Needs: Pediatrics and Geriatrics

Strengths

Top Choices:

No clear choice, but some think Indiana is doing a good job of addressing special needs

Weaknesses

Top Choices:

1. Lack of education (public and pre-hospital) re pediatric and geriatric needs (5)
2. Not enough pediatric surgeons and PICU's (3)

Opportunities

Improve patient outcomes

Public education

Fast-growing geriatric population

Develop specific protocols for treating patients at age extremes – share with community hospitals

Create geriatric continuing education course [not specified for whom]

Perform pediatric surgery regionally outside Indianapolis

Potential of telemedicine (technology exists)

Pediatric center use may reduce cost and LOS

Top Choices:

No clear choice

Threats/Obstacles

Top Choices:

1. Cost/lack of funding

Post-Hospital Trauma Care: Rehabilitation and Support

Strengths

Top Choices:

No clear choice, but some suggest adequate facilities/resources are already available

Weaknesses

Top Choices:

No clear choice, but general agreement that this area is overlooked and suffers a shortage of resources.

Opportunities

Many rehab centers exist

Public education

Interface between acute care and community

Identify resources

Bridge data gap between surgeon and rehab

"Return trauma patient to function"

support groups, e.g., Brain Injury Assn.

"Avoid extenuating circumstances"

"Community resources for optimal functionality"

Top Choices:

No clear choice

Threats/Obstacles

Top Choices:

1. Cost/lack of funding (8)
2. Lack of knowledge of how access/use system -- burden on families (2)

Trauma Registries

Strengths

Top Choices:

1. Substantial pre-hospital and hospital discharge data already exist and are being collected (16)
2. Technology exists to improve data collection and analysis (4)
3. Expertise exists in Indiana to design/run trauma registry (3)

Weaknesses

Top Choices:

1. Existing databases not linked (4)
2. Lack of clear mission/authority/leadership by state agencies (3)
3. Cost/lack of funding (3)
4. No consensus on what data to collect or how to use it (2)
5. Some hospitals will resist a trauma registry (2)

Opportunities

Top Choices:

1. Better linkage of existing/future databases (4)
2. QA/AI – improve quality of care and patient outcomes (3)
3. Help locate and secure funding for trauma care (2)
4. Help tailor community-specific injury prevention programs (2)

Threats/Obstacles

Top Choices:

1. Cost/lack of funding (10)
2. Lack of legal immunity for providers of data (6)
3. Competition among providers (5)
4. Potential loss of confidentiality (2)
5. Concern about which state agency would administer trauma registry (2)

Another trauma system/injury prevention SWOT analysis (Appendix 14) was written in January of 2008 by the trauma system manager, who was unaware at the time that a previous SWOT analysis had been completed. This document is not as comprehensive as the 2002 assessment, but can provide some useful information for system assessment.

2. What actions were taken to remediate or mitigate the gaps identified through tabletop or simulated responses in disaster drills among the acute care facilities participating in the system? Since the SWOT analysis in 2002, there have been several changes in Indiana to help resolve some of the issues identified. Indiana now has a primary seatbelt law that includes passenger trucks, as well as new booster seat laws (both described in the injury epidemiology section of this document). All counties in Indiana now have 911 access.

Public Law 155, 2006 gives legislative authority to the ISDH for development of a trauma system in Indiana, and through the diverse group of individuals represented on the Trauma Task Force, there is now a commitment to ensuring that a comprehensive trauma system is developed. We now have a statewide trauma registry that will assist with the development of the system and with performance improvement activities, and the creation of the Spinal Cord and Brain Injury Research Board and Fund, as well as the Indiana TBI Grant Advisory Board are generating much needed interest in the rehabilitation needs around the state.

The trauma system has not been addressed in tabletop, simulated responses, or disaster drills. Monthly communications checks were inaugurated and interoperable communication systems are being established. The state is looking at the IPICS system for communication utilization.

A statewide Triage tag system is being established and utilized by EMS and hospitals for continuity of care. Regular evaluation of preparedness is done on a district level with drills and exercises involving ED functions and hospital capacity.

3. What is the trauma system plan to accommodate a need for a surge in personnel, equipment, and supplies? At present, each of the 10 Preparedness Districts is developing district plans for surge in beds, supplies and personnel. The state has established a Bed Tracking system to comply with the HAvBED national system. Most of the 147 hospitals will be on line with this system reporting utilization of beds on at least a daily basis indicating the vacant beds, the surge beds, and the ED capacity. Each of the districts is developing a cache of needed supplies and equipment. A state wide hospital materials management tracking system will be inaugurated in 2009/2010. All of the hospitals in the state will have access to the information on both systems.

The state's Emergency System for Advance Registration of Volunteer Health Personnel (ESAR-VHP) has approximately 3500 names listed, and the registry became operational at the end of September, 2008. This has allowed additional volunteers to be added, and the information is kept current. Of note, through the efforts of Senators Wyss and Miller (members of the Trauma Task Force) volunteer health care workers in Indiana who are deployed in a disaster now have liability protection (P.L.138-2006, SEC.13).

4. How is the trauma system integrated into the state's incident command system and the communications center? During all of the preparedness drills and actual incidents, the hospitals activate their Incident Command Systems when applicable. Regular communication checks and drills are held in each of the districts.

5. What strategies and mechanisms are in place to ensure adequate inter-hospital communication during an MCI? It is suggested that each hospital have redundant interoperable communication capabilities internally and externally, as well as with other hospitals, EMA's, and community entities that are utilized during a Mass Casualty Incident. The state is instituting a communications program called IPICS, which is an interoperable system that coordinates all forms of communication, (i.e. radio, land lines phones, cell phones, computers, and more). The state is also setting up District talk

groups for each of the 10 preparedness districts that will allow hospital communications free of other confusing communications traffic.

System-wide Evaluation and Quality Assurance

1. What is the membership of the committee charged with ongoing monitoring and evaluating of the trauma system? There is no mandate in place for any ongoing monitoring and evaluation of the trauma system. The Trauma Task Force is comprised of members from each of the state's seven trauma centers, the ISDH, the IDHS, Indiana ENA, Indiana ACEP, Indiana ACS-COT, EMS-C, ISMA, Indiana legislature, rural and urban EMS, rural and urban non trauma center hospitals, insurance, medicine, nursing, pediatrics and others.

- a. To whom does it report its findings? The Indiana State Department Health.
- b. How does it decide what parameters to monitor? We are in the process of looking at what other states are doing to help determine what parameters we should be monitoring in Indiana.
- c. What action is it empowered to take to improve trauma care? So far, legislation only covers the establishment of ISDH as the lead agency, creation of a state trauma registry, creation of rules for the designation of hospitals as trauma centers, and for the EMS Commission to establish EMS trauma transport protocols.

2. Describe the trauma system performance improvement efforts as they pertain to the system for the following groups of providers in the context of system integration:

- a. Dispatch centers – There is no formal PI process in place.
- b. Pre-hospital provider agencies – More and more pre-hospital providers and agencies are becoming interested in trauma system development through the EMS trauma protocol workgroup and/or the Trauma Task Force. Their input is critical as Indiana moves forward in this process.
- c. Trauma centers – All of the state's seven trauma centers have representation on the Trauma Task Force and are some of it's most active members; several are participating in the EMS workgroup as well.
- d. Other acute care and specialty facilities – There are now many non-trauma center hospitals represented on the Trauma Task Force, including several critical access hospitals, and the interest and participation continues to grow(see Trauma Task Force Membership list in the introductory section of this document).
- e. Rehabilitation centers – To date, only one rehabilitation facility has provided representation to the Trauma Task Force, but more interest is being generated, in part because of the recently created Indiana Spinal Cord and Brain Injury

Research Fund and Board (2007). More involvement of rehabilitation centers does need to occur in the future and is being encouraged.

3. List the process and patient outcome measures that are tracked at the trauma system level, including measures for special populations. There are none to date. The state trauma registry is still in the implementation phase, and there is not enough data to analyze yet.
4. As part of your system-wide performance improvement, specify whether each of the following is assessed on a regular basis:
 - a. Time from arrival to a center and ultimate discharge to a facility capable of providing definitive care. If yes, specify the mean time to transfer. Not at the system level yet.
 - b. Proportion of patients with injury more severe than a predefined injury severity threshold (for example, ISS >15, or other criteria) who receive definitive care at a facility other than a Level I or II trauma center (under-triage). Not at the system level yet.
 - c. Proportion of patients with injury less severe than a predefined injury severity threshold (for example, ISS <9) who are transferred from any facility to a Level I or II trauma center (over-triage). Not at the system level yet.
5. Describe how your system addresses problems related to significant over-triage or under-triage, both primary and secondary. This is an issue that has not been assessed.

Trauma Management Information Systems

1. Which agency has oversight of the trauma MIS? The ISDH.
 - a. Describe the role and responsibilities of the lead agency in collecting and maintaining the data. The ISDH is responsible for collecting trauma data for the State of Indiana. Indiana selected ImageTrend's Trauma Bridge as the software for the state registry. The seven trauma centers have existing trauma registries at their facilities, and they are in the process of importing their data to the state registry electronically. The registry is still in the implementation phase, but 16 critical access hospitals have participated in a pilot project with the registry, and one other non trauma center hospital is currently entering trauma data into the registry as well. The newly-hired trauma registry manager will be responsible for encouraging additional hospitals to participate in the registry and for monitoring the quality of data in the registry.
 - b. How are the completeness, timeliness, and quality of the data monitored? The state trauma registry is still in the implementation phase, and this has not been monitored yet, other than the validity checks that are done when data is uploaded, etc.

2. Specify which of the following data sources are linked to the information system. Describe the method of linkage (for example, probabilistic or deterministic).

- a. Motor-vehicle crash or incident data – Not yet. That is planned for the future, after the implementation issues are resolved. (CODES Network Program Grant via P.U. CRS)
- b. Law enforcement records - Not yet. That is planned for the future, after the implementation issues are resolved.
- c. EMS or other transporting agency records – Scheduled for early 2009, when the EMS reporting system is upgraded to compliance with NEMSIS standards.
- d. ED records – See “ f ” below.
- e. Hospital records (hospital trauma registries) – Trauma centers export data from their registries and import into the state system. Their registry vendors are currently completing their state export process and/or working out the issues detected, along with the state vendor. Four trauma centers have successfully imported data and two more are expected soon. One Level I trauma center has experienced a data corruption problem with their trauma registry, so their import will be delayed for an as yet undetermined amount of time.
- f. Hospital administrative discharge data – This includes inpatient and outpatient (ED) data. Linkage to hospital discharge data is not currently feasible due to the incompleteness of records that limits the usefulness of data (lack of mandatory e-coding resulting in only about 44 to 55 percent of records e-coded, lack of outpatient reporting by one Level I trauma center).
- g. Rehabilitation data – This is planned for the future.
- h. Coroner and medical examiner records – This is also planned for the future. (CODES Network Program Grant via P.U. CRS)
- i. Financial or payer data – This is included in hospital discharge data.
- j. Dispatch – Much of this will be included in the EMS data.

3. What are the regional trauma registry inclusion criteria?

Indiana Inclusion/Exclusion Criteria:

Definition:

To ensure consistent data collection across the State and with the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria:

At least one of the following injury diagnostic codes defined in the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM): 800–959.9, 994.8 (electrocution & nonfatal effects of electric current)*

And including **one or more** of the following:

- hospital admission (24 hours or greater) **and/or:**
- pt transfers via EMS/law enforcement (including Air Ambulance) from one hospital to another (even if later discharged from the ED) **and/or:**
- death resulting from the traumatic injury (independent of hospital admission or transfer status)

Excluding: ICD-9-CM 905-909.9 (late effects of injury)

ICD-9-CM 910-924.9 (superficial injuries: blisters, contusions, abrasions, insect bites)

ICD-9-CM 930-939.9 (foreign bodies – ingested, “on” eye, etc.)

Injuries greater than **14 days** old

4. Which stakeholders had a role in selecting the data elements for inclusion into the regional registry? *The ISDH, the Indiana Trauma Network and a workgroup of several of the hospital trauma registrars and the trauma system manager.*

- a. From what source(s) were the data field definitions derived? *It is based on the National Trauma Data Standard, with a few extra data points added from other states data dictionaries, as well as the NEMSIS dataset.*
- b. What pediatric data elements are captured? *Patient weight, Pediatric Trauma Score, Child Specific Restraint.*

5. What local or system-wide reports are routinely generated and at what frequency? *There has not been enough data in the registry yet to determine routine reports.*

6. Are data contributed to the National Trauma Data Bank (NTDB) or other outside agencies? If so, please specify which agencies. *The state trauma registry is too new and doesn't yet have sufficient data to report to the NTDB or other agencies. Reporting is planned in the future. EMS is working on contract between INDHS EMS and Univ of Utah / NEMSIS.*

Research

1. Describe the current procedures and processes investigators must follow to request access to the trauma system registry. *N/A at this time at the state level. At the hospital level, each trauma center has established policies and procedures for requesting data from their registries.*

2. What are the mechanisms used to ensure patient confidentiality when regional trauma registry data are used by investigators? *N/A at this time at the state level.*

3. Provide examples of where research was conducted for the purpose of providing evidence that the processes of care and outcome of injured patients in the system's region are within acceptable standards. [N/A at this time at the state level.](#)

4. How has research been used to modify policy or practice within the system? [N/A at this time at the state level.](#)

5. What resources (for example, personnel and fiscal) are available to the lead agency to assist in conducting system research? [N/A at this time at the state level.](#) [However, data from the individual trauma center trauma registries will be transmitted to the State to enable them to conduct research.](#)

Section 4: Postconsultation Measures

Indicators of Trauma System Development Status:

ASSESSMENT

101.2 There is a description of injuries within the trauma system jurisdiction including the distribution by geographic area, high-risk populations (pediatric, elder, distinct cultural/ethnic, rural, and others), incidence, prevalence, mechanism, manner, intent, mortality, contributing factors, determinants, morbidity, injury severity (including death), and patient distribution using any or all the following: vital statistics, emergency department (ED) data, EMS data, hospital discharge data, State police data (those from law enforcement agencies), medical examiner data, trauma registry, and other data sources. The description is updated at regular intervals.

**Note: Injury severity should be determined through the consistent and system-wide application of one of the existing injury scoring methods, for example, Injury Severity Score (ISS).*

0 Not known

1 There is no written description of injuries within the trauma system jurisdiction.

2 One or more population-based data sources (e.g., vital statistics and medical examiner data) describe injury within the jurisdiction, but clinical data sources are not used.

3 One or more population-based data sources and one or more clinical data sources are used to describe injury within the jurisdiction.

4 Multiple population-based and clinical data sources are used to describe injury within the jurisdiction, and the description is systematically updated at regular intervals.

5 Multiple population-based and clinical data sources (e.g., trauma registry, ED data, and others) are electronically linked and used to describe injury within the jurisdiction.

102.2 Injury surveillance is coordinated with statewide and local community health surveillance.

0 Not known

1 Injury surveillance, as described in 102.1, does not occur within the system.

2 Injury surveillance occurs in isolation from other health risk surveillance and is reported separately.

3 Injury surveillance occurs in isolation but is combined and reported with other health risk surveillance processes.

4 Injury surveillance occurs as part of broader health risk assessments.

5 Processes of sharing and linkage of data exist between EMS systems, public health systems, and trauma systems, and the data are used to monitor, investigate, and diagnose community health risks.

102.3 Trauma data are electronically linked from a variety of sources.

**Note: Deterministically means with such patient identifiers as name and date of birth. Probabilistically means computer software is used to match likely records through such less certain identifiers as date of incident, patient age, gender, and others.*

0 Not known

1 Trauma registry data exist but are not deterministically or probabilistically linked to other databases.

2 Trauma registry data exist and can be deterministically linked through hand-sorting processes.

3 Trauma registry data exist and can be deterministically linked through computer-matching processes.

4 Trauma registry data exist and can be deterministically and probabilistically linked to at least one other injury database including: EMS data systems (i.e., patient care records, dispatch data, and others), ED data systems, hospital discharge data, and others.

5 All data stakeholders (insurance carriers, FARS, and rehabilitation, in addition to typical trauma system resources) have been identified, data access agreements executed, hardware and software resources secured, and the “manpower” designated to deterministically and probabilistically link, analyze, and report a variety of data sources in a timely manner.

POLICY DEVELOPMENT

201.4 The lead agency has adopted clearly defined trauma system standards (e.g., facility standards, triage and transfer guidelines, and data collection standards) and has sufficient legal authority to ensure and enforce compliance.

0 Not known

1 The lead agency does not have sufficient legal authority and has not adopted or defined trauma system performance and operating standards, nor is there sufficient legal authority to do so.

2 Sufficient authority exists to define and adopt standards for trauma system performance and operations, but the lead agency has not yet completed this process.

3 There is sufficient legal authority to adopt and implement operation and performance standards including enforcement. Draft process procedures have been developed.

4 The authority exists to fully develop all operational guidelines and standards; the stakeholders are reviewing draft policies and procedures; and adoption by the lead agency, including implementation and enforcement, is pending.

5 The authority exists; operational policies and procedures and trauma system performance standards are in place; and compliance is being actively monitored.

203.1 The lead agency, in concert with a trauma-specific multidisciplinary, multi-agency advisory committee, has adopted a trauma system plan.

0 Not known

1 There is no trauma system plan, and one is not in progress.

2 There is no trauma system plan, although some groups have begun meeting to discuss the development of a trauma system plan.

3 A trauma system plan was developed and adopted by the lead agency. The plan, however, has not been endorsed by trauma stakeholders.

4 A trauma system plan has been adopted, developed with multi-agency groups, and endorsed by those agencies.

5 A comprehensive trauma system plan has been developed, adopted in conjunction with trauma stakeholders, and includes the integration of other systems (e.g., EMS, public health, and emergency preparedness).

203.4 The trauma system plan clearly describes the system design (including the components necessary to have an integrated and inclusive trauma system) and is used to guide system implementation and management. For example, the plan includes references to regulatory standards and documents, and includes methods of data collection and analysis.

0 Not known

1 There is no trauma system plan.

2 The trauma system plan does not address or incorporate the trauma system components (prehospital, communication, transportation, acute care, rehabilitation, and others), nor is it inclusive of all-hazards preparedness, EMS, or public health integration.

3 The trauma system plan provides general information about all the components including all-hazards preparedness, EMS, and public health integration; however, it is difficult to determine who is responsible and accountable for system performance and implementation.

4 The trauma system plan addresses every component of a well-organized and functioning trauma system including all-hazards preparedness and public health integration. Specific information on each component is provided, and trauma system design is inclusive of providing for specific goals and objectives for system performance.

5 The trauma system plan is used to guide system implementation and management. Stakeholders and policy leaders are familiar with the plan and its components and use the plan to monitor system progress and to measure results.

204.2 Financial resources exist that support the planning, implementation, and ongoing management of the administrative and clinical care components of the trauma system.

0 Not known

1 There is no funding to support the trauma system planning, implementation, or ongoing management and operations for either trauma system administration or trauma clinical care.

2 Some funding for trauma care within the third-party reimbursement structure

has been identified, but ongoing support for administration and clinical care outside the third-party reimbursement structure is not available.

- 3 There is current funding for the development of the trauma system within the lead agency organization consistent with the trauma system plan, but costs to support clinical care support services have not been identified (transportation, communication, uncompensated care, standby fees, and others). No ongoing commitment of funding has been secured.
- 4 There is funding available for both administrative and clinical components of the trauma system plan. A mechanism to assess needs among various providers has begun. Implementation costs and ongoing support costs of the lead agency have been addressed within the plan.
- 5 A stable (consistent) source of reliable funding for the development, operations, and management of the trauma program (clinical care and lead agency administration) has been identified and is being used to support trauma planning, implementation, maintenance, and ongoing program enhancements.

204.3 Designated funding for trauma system infrastructure support (lead agency) is legislatively appropriated. **Note: Although nomenclature concerning designated, appropriated, and general funds varies between jurisdictions, the intent of this indicator is to demonstrate long-term, stable funding for trauma system development, management, evaluation, and improvement.*

0 Not known

1 There is no designated funding to support the trauma system infrastructure.

- 2 One-time funding has been designated for trauma system infrastructure support, and appropriations have been made to the lead agency budget.
- 3 Limited funds for trauma system development have been identified, but the funds have not been appropriated for trauma system infrastructure support.
- 4 Consistent, though limited, infrastructure funding has been designated and appropriated to the lead agency budget.
- 5 The legislature has identified, designated, and appropriated sufficient infrastructure funding for the lead agency consistent with the trauma system plan and priorities for funding administration and operations.

208.1 The trauma system and the public health system have established linkages including programs with an emphasis on population-based public health surveillance, and evaluation, for acute and chronic traumatic injury and injury prevention.

0 Not known

1 There is no evidence that demonstrates program linkages, a working relationship, or the sharing of data between public health and the trauma system. Population-based public health surveillance, and evaluation, for acute or chronic traumatic injury and injury prevention has not been integrated with the trauma system.

2 There is little population-based public health surveillance shared with the

trauma system, and program linkages are rare. Routine public health status reports are available for review by the trauma system lead agency and constituents.

- 3 The trauma system and the public health system have begun sharing public health surveillance data for acute and chronic traumatic injury. Program linkages are in the discussion stage.
- 4 The trauma system has begun to link with the public health system, and the process of sharing public health surveillance data is evolving. Routine dialogue is occurring between programs.
- 5 The trauma system and the public health system are integrated. Routine reporting, program participation, and system plans are fully vested. Operational integration is routine, and measurable progress can be demonstrated. (Demonstrated integration and linkage could include such activities as rapid response to and notification of incidents, integrated data systems, communication cross-operability, and regular epidemiology report generation.)

ASSURANCE

301.1 The lead trauma authority ensures that each member hospital of the trauma system collects and uses patient data as well as provider data to assess system performance and to improve quality of care. Assessment data are routinely submitted to the lead trauma authority.

0 Not known

1 **There is no system-wide management information data collection system that the trauma centers and other community hospitals regularly contribute to or use to evaluate the system.** *The Indiana Trauma Registry is still in it's implementation phase. When fully functional, the registry will be used to assess system performance.*

- 2 There is a trauma registry system in place in the trauma centers, but it is used by neither all facilities within the system nor the lead trauma authority to assess system performance.
- 3 The trauma management information system contains information from all facilities within a geographic area.
- 4 The trauma management information system is used by the trauma centers to assess provider and system performance issues.
- 5 Hospital trauma registry data are routinely submitted to the lead trauma authority, are aggregated, and are used to evaluate overall system performance.

302.1 There is well-defined trauma system medical oversight integrating the specialty needs of the trauma system with the medical oversight for the overall EMS system.

**Note: The EMS System medical director and the trauma medical director may, in fact, be the same person.*

0 Not known

1 There is no medical oversight for EMS providers within trauma system.

2 EMS medical oversight for all levels of prehospital providers caring for the trauma patient is provided, but such oversight is provided outside of the purview of the trauma system. *There is no state-wide oversight (oversight is at the local level only). Also, there is no trauma or state EMS medical director in Indiana at this time.*

3 The EMS and trauma medical directors have integrated pre-hospital medical oversight for pre-hospital personnel caring for trauma patients.

4 Medical oversight is routinely given to EMS providers caring for trauma patients. The trauma system has integrated medical oversight for pre-hospital providers and routinely evaluates the effectiveness of both on-line and off-line medical oversight.

5 The EMS and trauma system fully integrate the most up-to-date medical oversight and regularly evaluate program effectiveness. System providers are included in the development of medical oversight policies.

302.6 There are mandatory system-wide pre-hospital triage criteria to ensure that trauma patients are transported to an appropriate facility based on their injuries. These triage criteria are regularly evaluated and updated to ensure acceptable and system-defined rates of sensitivity and specificity for appropriately identifying the major trauma patient.

0 Not known

1 There are no mandatory universal triage criteria to ensure trauma patients are transported to the most appropriate hospital. *Legislation was passed in 2008 directing the EMS Commission to develop pre-hospital trauma triage protocols for Indiana. A workgroup has been established and is working to develop these protocols.*

2 There are differing triage criteria guidelines used by different providers. Appropriateness of triage criteria and subsequent transportation are not evaluated for sensitivity or specificity.

3 Universal triage criteria are in the process of being linked to the management information system for future evaluation.

4 The triage criteria are used by all pre-hospital providers. There is system-wide evaluation of the effectiveness of the triage tools in identifying trauma patients and in ensuring that they are transported to the appropriate facility.

5 System participants routinely evaluate the triage criteria for effectiveness. There is linkage with the trauma system, and sensitivity and specificity (over- and under-triage rates) of the tools used are regularly reported through the trauma lead authority. Updates to the triage criteria are made as necessary to improve system performance.

303.1 The trauma system plan has clearly defined the roles and responsibilities of all acute care facilities treating trauma and of facilities that provide care to specialty populations (e.g., burn, pediatric, spinal cord injury, and others).

0 Not known

1 There is no trauma system plan that outlines roles and responsibilities of all

acute care facilities treating trauma and of facilities that provide care to special populations.

- 2 There is a trauma system plan, but it does not address the roles and responsibilities of licensed acute care and specialty care facilities.
- 3 The trauma system plan addresses the roles and responsibilities of licensed acute care facilities or specialty care facilities, but not both.
- 4 The trauma system plan addresses the roles and responsibilities of licensed acute care facilities and specialty care facilities.
- 5 The trauma system plan clearly defines the roles and responsibilities of all acute care facilities treating trauma within the system jurisdiction. Specialty care services are addressed within the plan, and appropriate policies and procedures are implemented and tracked.

307.1 The trauma system engages in regular evaluation of all licensed acute care facilities that provide trauma care to trauma patients and designated trauma hospitals. Such evaluation involves independent external reviews.

0 Not known

1 There is no ongoing mechanism for the trauma system to assess or evaluate the quality of trauma care delivered by all licensed acute care facilities that provide trauma care to trauma patients and designated trauma hospitals.

- 2 There is a mechanism for the trauma system to evaluate trauma care services in designated trauma hospitals through internal performance improvement processes.
- 3 There is a mechanism to evaluate trauma care services across the entire trauma care system through performance improvement processes.
- 4 Review of trauma care quality is both internal (through routine monitoring and evaluation) and external (through independent review during re-designation or re-verification of trauma centers).
- 5 Quality of trauma care is ensured through both internal and external methods. Internal review is regular, and participation is routine for trauma stakeholders. External independent review teams provide further assurance of quality trauma care within all licensed acute care and trauma facilities treating trauma patients.

308.1 The lead agency has incorporated, within the trauma system plan and the trauma center standards, requirements for rehabilitation services including interfacility transfer of trauma patients to rehabilitation centers.

0 Not known

1 There are no written standards or plans for the integration of rehabilitation services with the trauma system or with trauma centers.

- 2 The trauma system plan has incorporated the use of rehabilitation services, but the use of those facilities for trauma patients has not been fully realized.
- 3 The trauma system plan has incorporated requirements for rehabilitation services. The trauma centers routinely use the rehabilitation expertise although written agreements do not exist.

- 4 The trauma system plan incorporates rehabilitation services throughout the continuum of care. Trauma centers have actively included rehabilitation services and their programs in trauma patient care plans.
- 5 There is evidence to show a well-integrated program of rehabilitation is available for all trauma patients. Rehabilitation programs are included in the trauma system plan, and the trauma centers work closely with rehabilitation centers and services to ensure quality outcomes for trauma patients.

311.4 Laws, rules, and regulations are routinely reviewed and revised to continually strengthen and improve the trauma system.

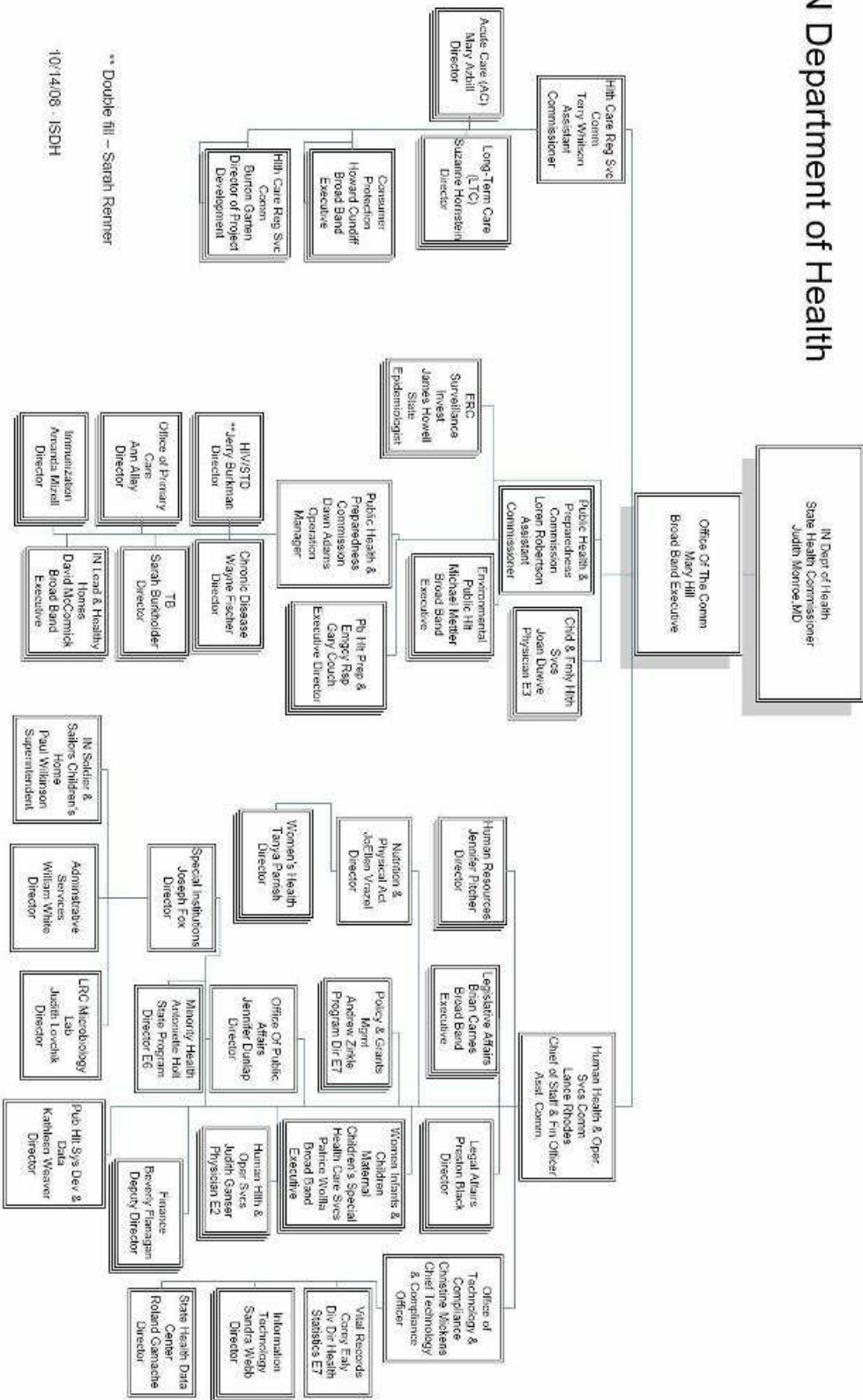
0 Not known

1 There is no process for examining laws, rules, or regulations.

- 2 Laws, rules, and regulations are reviewed and revised only in response to a “crisis” (e.g., malpractice insurance costs).
- 3 Laws, rules, and regulations are reviewed and revised on a periodic schedule (e.g., every 5 years).
- 4 Laws, rules, and regulations are reviewed by agency personnel on a continuous basis and are revised as needed.
- 5 Laws, rules, and regulations are reviewed as part of the performance improvement process involving representatives of all system components and are revised as they negatively impact system performance.

Appendix 1: State Agency Organizational Charts

IN Department of Health



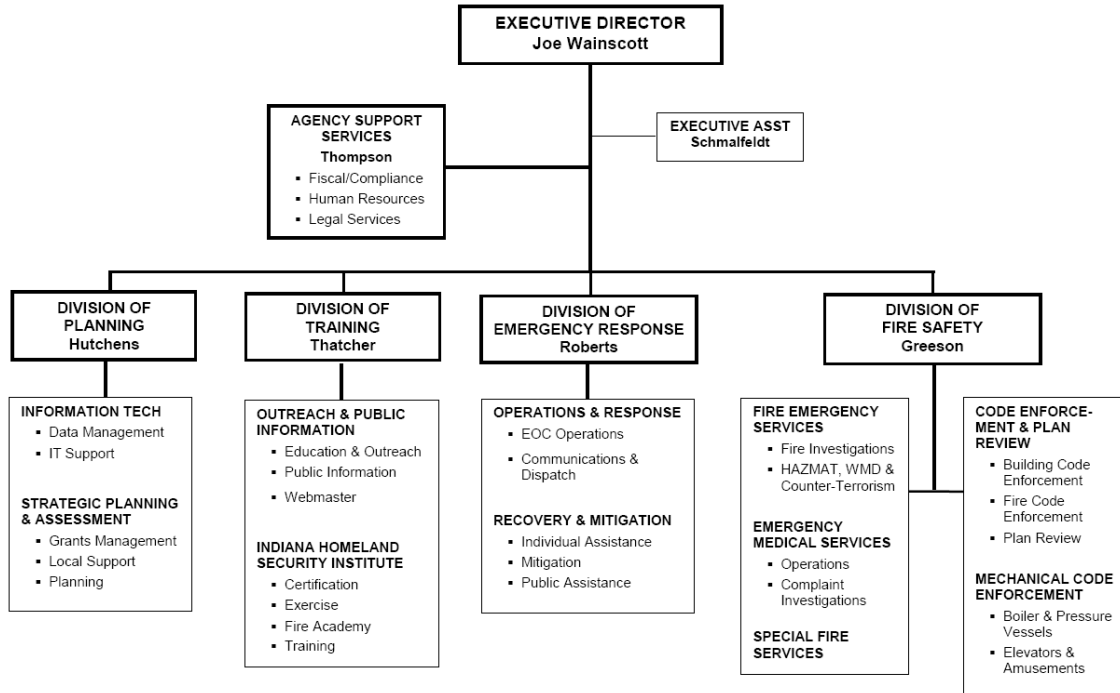
** Double fill - Sarah Renner

10/14/08 - ISDH

INDIANA DEPARTMENT OF HOMELAND SECURITY

Updated 4/6/05

Office of the Executive Director

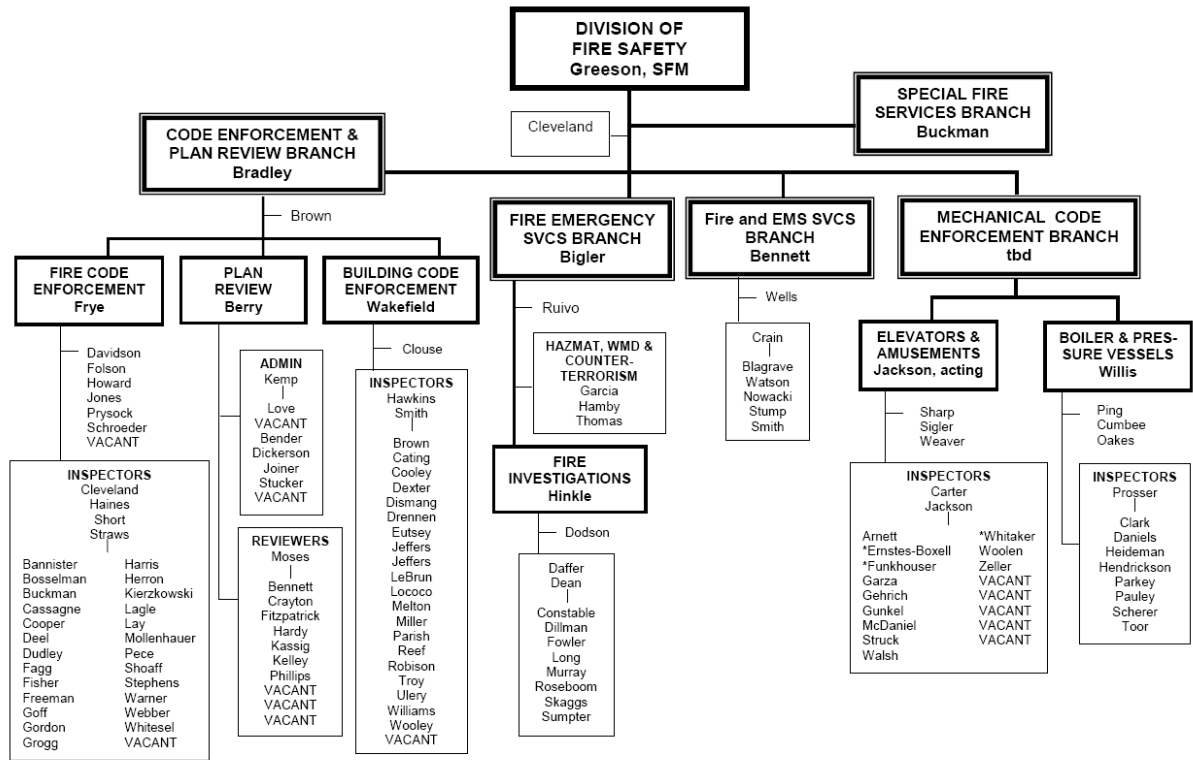


Executive Staff (as of 10/08)

- [Executive Director - Joe Wainscott](#)
- [Chief of Staff - Mike Garvey](#)
- [Director of Emergency Response & Recovery - Arvin Copeland](#)
- [Director of Fire & Building Safety - Jim Greson - State Fire Marshal](#)
- [Director of the Indiana Intelligence Fusion Center - Monte McKee](#)
- [Director of Planning & Assessment - Jason Hutchens](#)
- [Director of Preparedness & Training - Brad Thatcher](#)
- [Director of Support and Services - George Thompson](#)

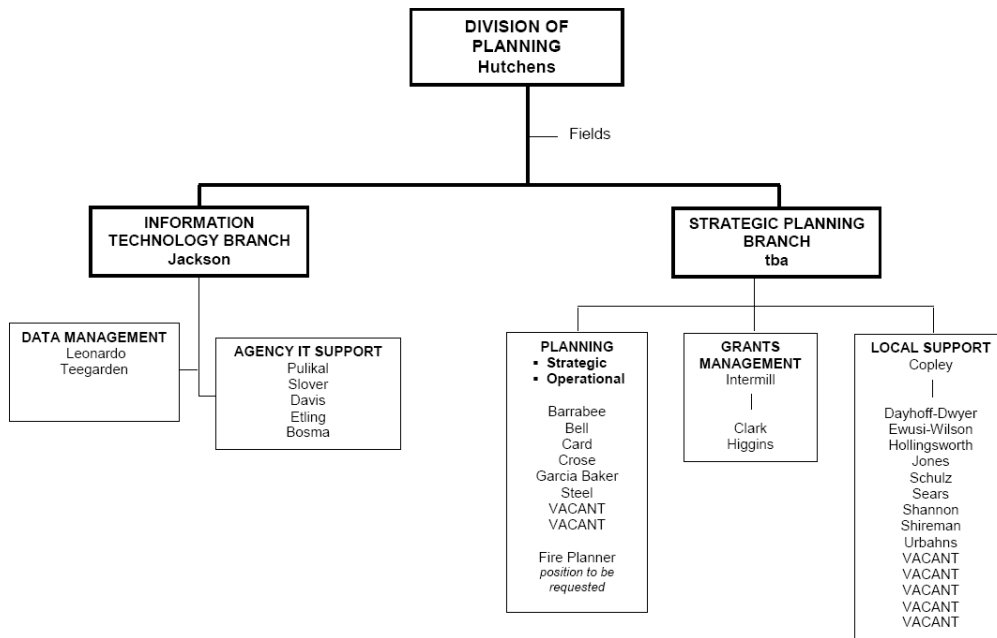
INDIANA DEPARTMENT OF HOMELAND SECURITY

DIVISION OF FIRE SAFETY

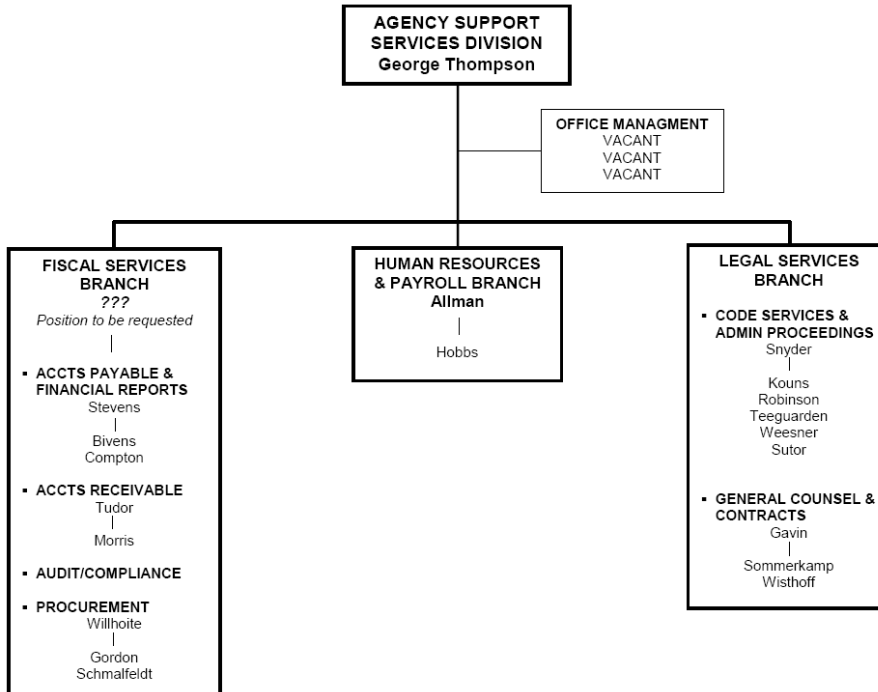


INDIANA DEPARTMENT OF HOMELAND SECURITY

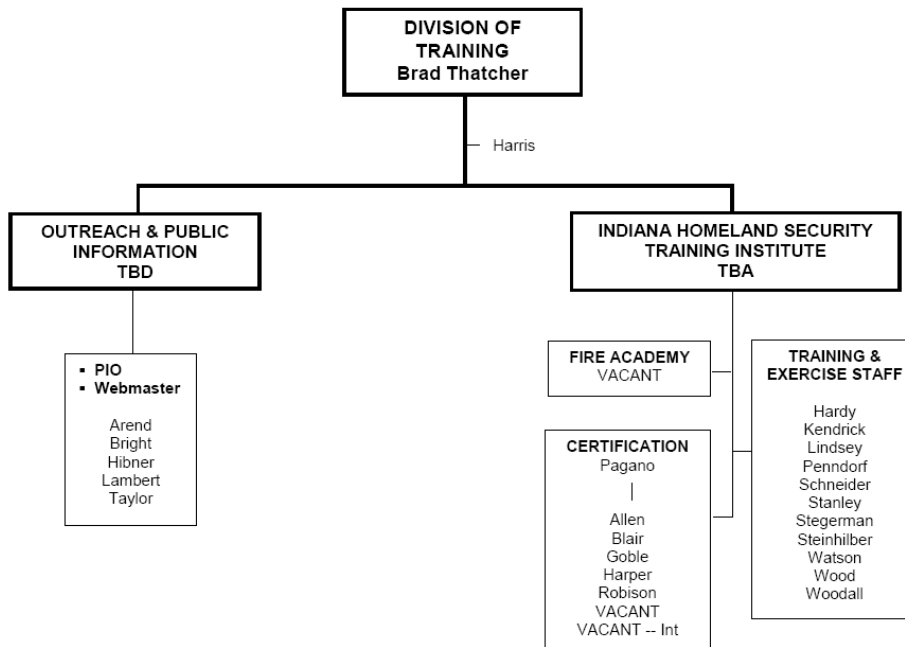
DIVISION OF PLANNING & ASSESSMENT



INDIANA DEPARTMENT OF HOMELAND SECURITY AGENCY SUPPORT SERVICES DIVISION



INDIANA DEPARTMENT OF HOMELAND SECURITY DIVISION OF TRAINING



Appendix 2: Indiana Draft Trauma Registry Rules

INDIANA STATE DEPARTMENT OF HEALTH

Emergency Rule LSA Document #07- (E)

DIGEST

Temporarily adds rules to establish a state trauma registry for the collection of information regarding the delivery of emergency medical services in the state and the frequency at which the services are provided for purposes of IC 16-19-3-28. Authority: IC 4-22-2-37.1; IC 16-19-3-28. Effective October 10, 2007.

SECTION 1. The definitions in this document apply throughout this document.

SECTION 2. “Glasgow coma scale” or “GCS” means a numeric rating used to assess the severity of neurologic injury.

SECTION 3. “Health care facility” has the meaning set forth in IC 16-18-2-161.

SECTION 4. “Injury severity score” or “ISS” means a mathematical measure assessing the cumulative effect of injury severity.

SECTION 5. “Major Trauma Outcome Study” or “MTOS” is a nationally based research project conducted between 1982 and 1987, that created and validated the TRISS methodology.

SECTION 6. “Patient medical record” means written, electronic, or printed information possessed or maintained by a provider concerning any diagnosis, treatment, or prognosis of the patient, including such information possessed or maintained on microfiche, microfilm, or in a digital format. The term includes mental health records and alcohol and drug abuse records and information that describes services provided to a patient and a provider's charges for services provided to a patient.

SECTION 7. “Provider” has the meaning set forth in IC 16-18-2-295.

SECTION 8. “Risk adjustment” means methodologies applied to a data set in order to identify and control patient variables that are present which may influence patient outcome.

SECTION 9. “State department” refers to the state department of health.

SECTION 10. “State health commissioner” means the state health commissioner of the state department of health.

SECTION 11. “Trauma registry” means an injury incidence reporting system for the collection of information regarding the delivery of hospital trauma services and the frequency at which the services are provided.

SECTION 12. “TRISS” means a methodology which combines the following variables in order to determine a probability of survival:

- 1. Physiologic (systolic blood pressure, respiratory rate, GCS score).**
- 2. Anatomic (injury severity score).**
- 3. Age (55 years or older, or younger than 55 years).**
- 4. Trauma type (blunt or penetrating injury).**

SECTION 13. The state department shall establish and use the trauma registry to collect and analyze data that is necessary to evaluate the delivery of adult and pediatric trauma care within the state.

SECTION 14. Data collected by the state department for the trauma registry shall include but not be limited to data of such a nature as to allow the state department to identify and evaluate the following:

- 1. Incidence, type, severity, and outcome of trauma injuries.**
- 2. Criteria used to establish and/or refine triage guidelines.**
- 3. Geographic patterns of injury, including but not limited to areas or regions of the state where improvements are needed in the delivery of trauma care.**
- 4. Other factors to consider in recommending, designing, or implementing an integrated statewide trauma care delivery system, including but not limited to public education on trauma and injury prevention, access to trauma care, prehospital care availability, and cost of trauma care.**

SECTION 15. Data and information submitted to and maintained by the trauma registry shall be in such a format that:

- 1. Protects the identity of specific patients to whom medical care has been rendered.**
- 2. Identifies specific health care facilities by a code or similar designation other than name.**
- 3. Avoids or minimizes duplication of entry.**

SECTION 16. The following entities shall submit data and information to the trauma registry:

- 1. Health care facilities.**
- 2. State and other public agencies designated by the state department that possess information regarding trauma care.**

SECTION 17. Trauma injuries for purposes of this document include the following injuries as identified in the International Classification of Diseases, Ninth Revision, Clinical Modification, 2007 (ICD-9-CM):

ICD-9-CM Codes	Name
800-829	Fractures
830-839	Dislocation
840-848	Sprains and strains of joints and adjacent muscles
850-854	Intracranial injury, excluding those with skull fracture
860-869	Internal injury of thorax, abdomen, and pelvis
870-897	Open wounds
900-904	Injury to blood vessels
925-929	Crushing injury
940-949	Burns
950-957	Injury to nerves and spinal cord
958-959	Certain traumatic complications and unspecified injuries
994.8	Electrocution and nonfatal effects of electric current

SECTION 18. The entities required to submit data and information to the trauma registry under section 16 of this document shall provide information regarding injured patients in the following categories that are applicable to its operations:

- 1. trauma patients that have at least one trauma injury as set out in section 17 of this document; and**
- 2. have injuries that are less than fourteen (14) days old; and**
- 3. include one (1) or more of the following:**
 - a. Hospital admission of twenty-four (24) hours or more.**
 - b. Patient transferred via emergency medical services or law enforcement (including air ambulance) from one hospital to another (even if later discharged from the emergency department).**
 - c. Death resulting from the traumatic injury (independent of hospital admission or transfer status).**

SECTION 19. Data to be submitted to the trauma registry includes the following:

- 1. Demographic and patient information, including, but not limited to patient's:**
 - a. First and last name.**
 - b. Home zip code.**
 - c. Home country.**
 - d. Home state.**
 - e. Home county.**
 - f. Home city.**
 - g. Alternate home residence.**
 - h. Social security number.**

- i. Date of birth.
 - j. Age and age units.
 - k. Race and ethnicity.
 - l. Gender.
2. Injury information, including, but not limited to:
- a. Trauma registry ID.
 - b. Injury incident date.
 - c. Injury incident time.
 - d. Work-related.
 - e. Patient's occupational industry.
 - f. Patient's occupation.
 - g. Primary e-code.
 - h. Location e-code.
 - i. Incident location zip code.
 - j. Incident state.
 - k. Incident county.
 - l. Incident city.
 - m. Protective devices.
 - n. Child specific restraint.
 - o. Airbag deployment.
3. Pre-hospital information, including, but not limited to:
- a. EMS dispatch date and time.
 - b. EMS unit arrival on scene date and time.
 - c. EMS unit scene departure date and time.
 - d. Transport mode.
 - e. Other transport mode.
 - f. initial field recorded data, including, but not limited to:
 - i. systolic blood pressure;
 - ii. pulse rate;
 - iii. respiratory rate;
 - iv. oxygen saturation;
 - v. GCS-eye;
 - vi. GCS-verbal;
 - vii. GCS-motor;
 - viii. GCS-total; and
 - ix. assessment qualifiers.
 - g. Inter-facility transfer.
4. Emergency department information, including, but not limited to:
- a. Emergency department/hospital arrival date and time.
 - b. Initial emergency department / hospital data, including, but not limited to:
 - i. systolic blood pressure;
 - ii. pulse rate;
 - iii. temperature;
 - iv. respiratory rate;
 - v. respiratory assistance;

- vi. oxygen saturation;
- vii. supplemental oxygen;
- viii. GCS-eye;
- ix. GCS-verbal;
- x. GCS-motor;
- xi. GCS-total; and
- xii. GCS assessment qualifiers.
- c. Alcohol use indicator.
- d. Alcohol intervention.
- e. Drug use indicator.
- f. Emergency department discharge disposition.
- g. Emergency department death.
- h. Emergency department discharge date and time.
- 5. Hospital procedure information, including, but not limited to:
 - a. Procedures.
 - b. Procedure start date.
 - c. Procedure start time.
- 6. Diagnoses information, including, but not limited to:
 - a. Co-morbid conditions.
 - b. Injury diagnoses.
- 7. Outcome information, including, but not limited to:
 - a. Total ICU length of stay.
 - b. Total ventilator days.
 - c. Hospital discharge date, time, and disposition.
 - d. Autopsy.
 - e. Organ donation.
 - f. Self-feeding score.
 - g. Locomotion score.
 - h. Expression score.
 - i. Calculated independence score.
- 8. Financial information, including, but not limited to
 - a. Primary method of payment.
 - b. Billed hospital charges.
- 9. Quality assurance information, including, but not limited to hospital complications.
- 10. State EMS registry data, including, but not limited to:
 - a. Mass casualty incident.
 - b. Pregnancy.
 - c. Estimated body weight.
 - d. Law enforcement / crash report number.
 - e. Incident location type.
 - f. Vehicular injury indicators.
 - g. Area of the vehicle impacted by the collision.
 - h. Seat row location of patient in vehicle.
 - i. Position of patient in the seat of the vehicle.
 - j. Height of fall.

- k. Barriers to patient care.
- l. Pre-hospital revised trauma score.
- m. Pediatric trauma score.
- n. Pre-hospital procedure(s).
- o. Procedure successful.
- p. Procedure complication.
- q. Intent of the injury.
- r. EMS procedures.

SECTION 20. In accordance with IC 5-14-3-4(a)(9), all patient medical records and charts created by a provider and submitted to the state department for inclusion in the trauma registry are excepted from public disclosure requirements unless written consent is provided pursuant to IC 16-39.

SECTION 21. The information required to be provided to the trauma registry under this document shall be reported on at least a quarterly basis and shall be submitted to the trauma registry not later than thirty (30) calendar days after March thirty-first, June thirtieth, September thirtieth, and December thirty-first of each year. The state department may develop policies for granting extensions to the submission deadlines.

SECTION 22. The information required to be provided to the trauma registry under this document shall be submitted by direct data entry or by electronic data transfer using an xml format and data scheme that is based on the National Trauma Data Standard Data Dictionary Version 1.1.1 (May 2007).

SECTION 23. In identifying the information to be provided to the trauma registry under this document, the state department shall take into consideration the financial and other burdens that these requirements will place on the entities that are required to report.

SECTION 24. Any entity that fails to submit data and information to the state trauma registry will be ineligible for designation by the state department as a trauma center and may be ineligible for other programs, including but not limited to, grants and other state-sponsored sources of funding related to trauma care.

SECTION 25. Risk adjustment of the trauma registry data shall be by the primary methodology of TRISS. Other methodologies may be evaluated and used by the state department as the need arises.

SECTION 26. The coefficients used to calculate TRISS shall be those derived from MTOS. The state department may evaluate the possibility of creating Indiana specific coefficients, based upon the trauma registry data

set, to utilize with the TRISS methodology, and when appropriate, these equations may be utilized. The state department may evaluate other appropriate data sets for use in developing specific coefficients.

SECTION 27. The state department shall utilize a variety of acceptable techniques for providing statistical analysis of risk-adjusted data.

SECTION 28. The state department shall utilize a variety of methodologies to risk adjust by sex, age, or other factors, in order to analyze state trauma registry data for specific age groupings, including pediatric and geriatric age groupings.

SECTION 29. Mortality shall be an outcome that is risk adjusted. The state department may evaluate the feasibility of risk adjusting other outcomes and select and evaluate such outcomes.

SECTION 30. The state department may contract with individuals or organizations with specific expertise in risk adjustment and statistical analysis of medical data in order to perform risk adjustment of trauma registry data.

SECTION 31. Sections 1 – 31 of this document take effect October 10, 2007.

**Appendix 3: Indiana Draft Trauma Center Designation
Administrative Rules**

Table of Contents

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410 IAC _____ STATEWIDE TRAUMA SYSTEM RULES

AUTHORITY. Public Law _____ enacted by the Indiana legislature in _____ provides authority to the Indiana State Department of Health to develop and maintain a statewide trauma system, including the authority to adopt Administrative Rules.

DEFINITIONS. The following definitions apply in this Article, unless otherwise specified:

- (1) "Categorization" means a process for determining the level of a hospital's trauma care capability and commitment which allows any hospital which meets criteria to receive trauma patients.
- (2) "Communications Coverage Area" means a geographic region representing a primary radio service area for emergency medical communications. When primary service areas substantially overlap they will be considered as one coverage area.
- (3) "Department" means the Indiana State Department of Health. "
- (4) "Designation" means a competitive process for identifying the level of a hospital's trauma care capability and commitment which selects a limited number of hospitals which meet criteria to receive trauma patients.
- (5) "District Trauma Advisory Board" (DTAB) means an advisory group appointed by the Department for each established trauma district to represent providers of trauma care and members of the public.
- (6) "Emergency Medical Condition" means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus, in the case of a pregnant woman, in serious jeopardy.
- (7) "Emergency Medical Services Agency" (EMS Agency) means an ambulance service or other agency which provides pre-hospital emergency medical care.

(8) "Emergency Medical Technician" (EMT) has the meaning set forth in 410 IAC _____

(9) "First Responder" has the meaning set forth in 410 IAV _____

(10) "Glasgow Coma Scale" (GCS) means an internationally recognized scoring system for the assessment of head injury severity and degree of coma.

(11) "Hospital" has the meaning set forth in 410 IAC 16-18-2-179 (a).

(12) "Hospital Catchment Area" means a geographic region representing a primary service area for hospitals. When primary service areas substantially overlap they shall be considered as one catchment area.

(13) "Injury Severity Score" (ISS) means a method for quantifying the degree of anatomic injury. As described in Baker, S.P., O'Neill B., Hadden W. Jr., et al: The Injury Severity Score, Journal of Trauma, 1974, 14: 187-196.

(14) "Level I Trauma Hospital" means a hospital which is categorized by the American College of Surgeons Committee on Trauma and designated by the Department as having met the hospital resource standards for a Level I hospital. Level I hospitals manage severely injured patients, provide trauma related medical education and conduct research in trauma care.

(15) "Level II Trauma Hospital" means a hospital categorized by the American College of Surgeons Committee on Trauma and designated by the Department as having met the hospital resource standards for a Level II hospital. Level II hospitals manage the severely injured patient.

(16) "Level III Trauma Hospital" means a hospital categorized and designated by the Department as having met the hospital resource standards for a Level III hospital.. Level III hospitals provide resuscitation, stabilization, and assessment of the severely injured patient and provide either treatment or transfer the patient to a higher level trauma system hospital..

(17) "Level IV Trauma Hospital" means a hospital categorized and designated by the Department as having met the hospital resource standards for a Level IV hospital, as described in Exhibit 4. Level IV hospitals provide resuscitation and stabilization of the severely injured patient prior to transferring the patient to a higher level trauma system hospital.

(18) "Managed Health Care System" means a business enterprise, e.g., health maintenance organization, which contracts with organizations, individuals, or government programs to provide for the delivery of a agreed upon set of medical or referral services for a enrolled group of individuals and families in a defined geographic district at a fixed periodic rate paid per enrolled individual or family.

(19) "Medical Control" means physician responsibility for the operation and evaluation of pre-hospital emergency medical care performed by emergency care providers.

(20) "Off-Line Medical Control" means the direction provided by a physician to pre-hospital emergency medical care providers through communications such as written protocols, standing orders, education and quality improvement reviews.

(21) "On-Line Medical Control" means the direction provided by a physician to pre-hospital emergency medical care providers through radio, telephone, or other real time communication.

(22) "Indiana Trauma Registry" means the data collection and analysis system operated by the Department.

(23) "Response Time" means the length of time between the notification of a provider and the arrival of that provider's emergency medical service unit(s) at the incident scene.

(24) "Stabilization" means that, within reasonable medical probability, no material deterioration of a emergency medical condition is likely to occur.

(25) "State Trauma Advisory Board" (STAB) means a advisory group appointed by the Department to represent providers of trauma care.

(26) "Trauma Patient" means a person who at any time meets criteria for inclusion in the Oregon Trauma System, as described in Exhibit 2 of these rules.

(27) "Trauma System Hospital" means a hospital categorized or designated by the Department to receive and provide services to trauma patients.

(28) "Trauma System Plan" means a document which describes the policies, procedures and protocols for a comprehensive system of prevention and management of traumatic injuries.

(29) "Triage Criteria" means the parameters established to identify trauma patients for treatment in accordance with the trauma system plan. These criteria are set forth in _____.

410 IAC _____ TRAUMA HOSPITAL LEVELS OF CARE & REQUIREMENTS.

Sec. 1. (a) The levels of care adopted by the department are the American College of Surgeons Trauma Center Levels I, II, III, and IV.

(1) Level I Trauma Center: The Level I facility is a resource trauma center that is a tertiary care facility central to the trauma care system. Ultimately, all patients who require the resources of the Level I center should have access to it. This facility must have the capability of providing leadership and total care for every aspect of injury, from prevention through rehabilitation. In its central role, the Level I center must have adequate depth of resources and personnel. In addition to acute care responsibilities, Level I trauma center have the major responsibility of providing leadership in education, research, and system planning. This responsibility extends to all hospitals caring for injured patients in their districts. Research and prevention programs are essential for Level I trauma centers.

(2) Level II Trauma Center: The Level II trauma center is a hospital that also is expected to provide initial definitive trauma care, regardless of the severity of injury. Depending on geographic location, patient volume, personnel, and

resources, however, the Level II trauma center may not be able to provide the same comprehensive care as a Level I trauma center. Therefore, patients with more complex injuries may have to be transferred to a Level I center. Level II trauma centers may be the most prevalent facility in a community, managing the majority of trauma patients. In some areas where a Level I center does not exist, the Level II center should take on the responsibility for education and system leadership.

(3) **Level III Trauma Center:** The Level III trauma center serves communities that do not have immediate access to a Level I or II institution. Level III trauma centers can provide prompt assessment, resuscitation, emergency operations, and stabilization and also arrange for possible transfer to a facility that can provide definitive trauma care. General surgeons are required in a Level III facility. Planning for care of injured patients in these hospitals requires transfer agreements and standardized treatment guidelines.

(4) **Level IV Trauma Facility:** Level IV trauma facilities provide advance trauma life support before patient transfer in remote areas where no higher level of care is available. Because of geographic isolation, however, the Level IV trauma facility is the de facto primary care provider. As at Level III trauma centers, treatment guidelines for resuscitation, transfer guidelines, data reporting, and participation in system performance improvement are essential.

(b) Each trauma center shall:

(1), submit trauma care patient data electronically to the state trauma registry on all (closed?) patient files at least quarterly for the purpose of allowing ISDH to analyze causes and medical consequences of serious trauma while promoting the continuum of care that provides timely and appropriate delivery of emergency medical treatment for people with acute traumatic injury.

(2) submit trauma care patient data that includes the payor source for patient care on discharge with financial data classified as :

- (A) self pay,
- (B) commercial insurance,
- (C) Medicare,
- (D) Medicaid, or
- (E) workers compensation.

(3) submit trauma care patient data no later than 30 days after each quarter.

(4) maintain documentation to show that timely transmission of data has been submitted to the state trauma registry on a quarterly basis.

(c) Failure to timely submit trauma care patient data to the state trauma registry for three consecutive quarters shall result in disciplinary action deemed appropriate, including, but

not limited to, citation of civil monetary penalties and/or loss of trauma designation status.

10 IAC _____ TRAUMA HOSPITAL DESIGNATION

Sec.2. (a) To be eligible to obtain designation, the hospital shall,

(1) For Level I and Level II trauma centers

(A). Comply with one of the following:

(i). Hold a current license to operate as a hospital, issued by the Department under I.C. 16-21-2.or

(ii).Be an administrative unit of the U.S. government under federal law, and

(B) Have current documentation issued by the American College of Surgeons (ACS) stating that the hospital meets the ACS standards for a Level I or Level II trauma center.

(2) For Level III and Level IV trauma centers

(A). Comply with one of the following:

(i). Hold a current license to operate as a hospital, issued by the Department under I.C. 16-21-2 or

(ii).Be an administrative unit of the U.S. government under federal law, and

(B). Have current documentation issued by the Department stating that the hospital meets Indiana standards for a Level III or Level IV trauma center.

(b) To be eligible to retain designation, the hospital must:

(1). Maintain a current license; and

(2). Comply with the trauma center responsibilities as listed below:

(A).The trauma center meets the state standards or, if designation is based on ACS verification, meets the ACS standards;

(B).The trauma center must submit data related to the trauma services provided at the trauma center to the Indiana Trauma Register as required by the Department; and

(C).The hospital and the trauma center staff comply with all applicable federal and state laws relating to confidentiality of information.

(c) To be eligible to apply for provisional designation a hospital shall comply with one of the following:

(1). Hold a current license issued by the Department under I.C. 16-21-2; or

(2).Be an administrative unit of the U.S. government under federal law,

(d).The hospital may apply for one 18-month provisional designation as a Level III or Level IV trauma center if:

(1). When the hospital applies for provisional designation, the hospital has not produced at least 12 consecutive months of data related to trauma services provided at the hospital; and

(2).The hospital cannot comply with _____

(e). The hospital applying for provisional designation shall submit to the Department an application including:

(1). An application form that contains the information and items listed in STATE FORM # _____, and

(2). An attestation that:

(A). The hospital has the resources and capabilities necessary to meet the state standards for the Level of designation sought and will meet the state standards for the Level of designation sought during the term of the provisional designation; and

(B).During the term of the provisional designation, the hospital will:

(i). Ensure that the trauma center meets the state standards;

(ii). Apply for state designation for the trauma center.

410 IAC _____ SURVEY REQUIREMENTS FOR DESIGNATION AS A LEVEL III OR LEVEL IV TRAUMA CENTER

Sec. 3.(a) Upon receipt of a request from the Hospital indicating they have met ht criteria for designation as a Level III or Level IV trauma center, the Department shall arrange for completion of an announced on-site survey of the health care institution trauma center that includes:

- (1). Reviewing equipment and the physical plant;
- (2). Interviewing personnel; and
- (3). Reviewing: medical records, patient discharge summaries, patient care logs, personnel rosters and schedules; and performance improvement-related documents other than peer review documents privileged under XXXX, and other documents relevant to the provision of trauma services as at Level III or Level IV trauma center that are not privileged under federal or state law.
- (4). The surveyor/team shall conduct an exit conference to report the findings to the hospital upon completion of an on-site survey.

(b). Within 30 days after completing an on-site survey, the Department shall send to the hospital a written report of the Department's findings, including a list of any deficiencies identified during the on-site survey and a request for a written corrective action plan.

(c). Within 10 days after receiving a request for a written corrective action plan, the hospital shall submit to the Department a written corrective action plan for each identified deficiency, which provides a description of how the deficiency will be corrected, and a date of correction for the deficiency.

(d). The Department shall accept a written corrective action plan if it describes how each identified deficiency will be corrected, and includes a date for correcting each deficiency as soon as practicable based on the actions necessary.

410 IAC _____ DENIAL OR REVOCATION OF DESIGNATION

Sec 4.(a)The Department may deny or revoke designation if the hospital:

- (1). Has provided false or misleading information to the Department
- (2). Is not eligible for designation under Section 2 (a) or, if applicable, Section 2 (b)
- (3). Fails to submit to the Department all of the information requested in a written request for additional information.
- (4). Fails to submit a written corrective action plan as requested and required under Section 3 (c)
- (5). Fails to comply with a written corrective action plan accepted by the Department under Section 3 (d).

(6). Fails to allow the Department or its designees to enter the premises of the owner's health care institution, to interview personnel, or to review documents that are not documents privileged under federal or state law; or

(7). Fails to comply with any applicable provision in Section 1 or Section 3

(b).????????????????

Appendix 4: Preliminary Performance Improvement Guidelines

Regional and state trauma quality improvement filters for Indiana (taken from Washington State)

EMS

1. Mean and median response times by level of service (ALS vs. BLS), geographic area type (rural, urban, suburban, etc.), and region
2. Mean and median scene times by level of service (ALS vs. BLS), geographic area type (rural, urban, suburban, etc.), and region
3. Mean and median transport times by level of service (ALS vs. BLS), geographic area type (rural, urban, suburban, etc.), and region
4. Mean and median time from dispatch to hospital by level of service (ALS vs. BLS), geographic area type (rural, urban, suburban, etc.), and region
5. Field intubations requiring reintubation in ED
6. Patients transported by ALS without field intubation, but requiring intubation on arrival in ED

Transfers

1. Delayed transfers (transfer after initial admission)
2. Transfer to same or lower level of designation
3. Minor injury transfers
4. Transfers by payer status
5. Transfers by transport mode (air vs. ground)

Emergency department Length of Stay

1. Length of stay by injury severity
2. Length of stay for hypotensive patients
3. Length of stay for patients transferred out to another acute care facility
4. Length of stay for patients sent from ED to operating room

Trauma team activation

1. Overall (all patients)
2. Major trauma patients
3. Pediatric trauma patients
4. Geriatric trauma patients
5. Patients sent from ED to OR
6. Hypotensive trauma patients

Pediatric trauma

1. % of pediatric trauma patients receiving definitive care at a designated pediatric trauma service
2. % of pediatric ICU trauma patients receiving definitive care at a designated pediatric trauma service (% of pediatric ICU stays occurring at pediatric centers)
3. Pediatric trauma deaths by location of death
4. Pediatric trauma deaths by mechanism/external cause
5. Pediatric deaths occurring at non-pediatric trauma services

6. Protective device use for pediatric trauma – trends over time, variation by region and hospital
7. Pediatric spleen management – splenectomies vs. conservative management
8. Pediatric splenectomies at non-pediatric trauma services
9. Pediatric traumatic brain injuries - % receiving care at a level 1 or 2 trauma service

Outcomes

1. Case fatality for trauma patients
2. Case fatality for major trauma patients
3. TRISS analysis for deaths (unexpected survivors, unexpected deaths)
4. Case fatality by mechanism and protective devices
5. % of trauma deaths occurring out of hospital (death certificate data)
6. Deaths by intent
7. Hospital variation in mortality rates
8. Length of stay comparison by hospital and ISS
9. % of major trauma discharged to rehabilitation vs. skilled nursing facility
10. Differences in outcomes based on functional independence measure at discharge
11. % of trauma deaths receiving autopsy
12. Charges and reimbursement by ISS and mechanism – comparison across levels and regions

We also plan to use the American College of Surgeons' filters and the JCAHO filters as appropriate and plan to look at ad hoc clinical issues that arise as a result of our designation surveys or systems analyses.

Indiana Trauma System Performance Improvement (from Utah)

The goals of Indiana's Trauma System are to:

- promote optimal care of trauma patients by matching the injured patient's needs to existing resources so that appropriate, cost effective trauma care is achieved;
- alleviate unnecessary death and disability from trauma and emergency illness;
- inform health care providers about trauma system capabilities;
- encourage the efficient and effective continuum of patient care, including prevention, pre-hospital care, hospital care, and rehabilitative care;
- and minimize the overall cost of trauma care.

The goals of the Department of Health, the Trauma System Advisory Task Force and the Trauma Performance Improvement Team (not developed yet) are to develop, implement, and conduct trauma care system evaluation, quality assessment, and performance improvement. The trauma committees will assist the ISDH in establishing standards for the collection of data, evaluation of the results and to recommend refinements in the established standards.

As trauma care systems have developed over the years, it has become evident that ongoing assessment, evaluation, and re-evaluation of the care of trauma patients and of a trauma system is essential to the nurturing and building of improvement initiatives focused on optimal patient care. The on-going assessment, evaluation, and reevaluation of trauma care and of the trauma system must be done within a well-defined performance improvement process.

A trauma system performance improvement (PI) process consists of two major components: The **internal** component within each hospital or EMS provider agency, and the **external** (system) component. Trauma centers, resource hospitals and EMS providers are responsible to conduct internal PI. With the assistance of this guide and the TPIT, ISDH will conduct statewide external PI.

Quality of care can be evaluated on the basis of structure, process, and outcomes. Resources are characteristic of structure; components of the encounter between practitioner and patient are characteristics of process; and the patient's health status is characteristic of outcome. Hospital and agency (**internal**) PI evaluates *structure* by monitoring availability of resources, equipment, communication, policies, procedures, and organization. Hospital and agency PI evaluates *process* by monitoring personnel availability, timeliness of treatment, procedures, adherence to protocols, appropriateness of care, and practitioner performance compared to an established norm. Hospital PI evaluates *outcome* by monitoring patient response to treatment, complications, morbidity, mortality, disability and effects of rehabilitation. Trauma care facility PI programs are of paramount importance and cannot be under recognized. As Indiana's trauma system continues to evolve, trauma care facilities across the state are developing and/or evaluating their respective internal PI programs for trauma care.

The focus of **internal** PI is on individual practitioners and individual patients. The focus of **external** PI is on system components and overall system effectiveness. Both programs look at structure (resources), process (care delivered), and results (outcome), but differ in how this is accomplished. The key to success in any PI program is to base improvement initiatives on information that comes from valid and reliable data. Indiana's trauma system has set the stage for trauma care facilities, ambulance service programs, and the Department of Health to do just that. It is essential that system performance improvement be pursued to facilitate evolution of Indiana's trauma system and to evaluate the overall effectiveness of the system. System (**external**) PI evaluates *structure* by monitoring hospital availability, ambulance service program availability, and overall resource availability. System PI evaluates *process* by monitoring patient triage and transfer, trauma system standards (local protocols or state guidelines), transport times, appropriateness of the receiving facility, appropriateness of inter-facility transfer, over-triage and under-triage, and how the components of the trauma system interact with each other. System PI evaluates *outcome* by monitoring morbidity, mortality, disability, and by monitoring the overall effectiveness of the system.

The purpose of the Trauma Performance Improvement Team is to assist the Department of Health in developing, implementing, and conducting trauma care system evaluation, performance assessment, and performance improvement.

Components of the trauma system:

Prevention

- a. Public Information & Education/Prevention - to heighten public awareness of injury as a preventable public health problem, of how to access the EMS system, and emphasize prevention as the key to reduce traumatic injuries.

Acute Care

- b. Access/Communication Centers - the process by which the public places a call for help and how emergency medical services are mobilized. This also includes communication between facilities (e.g., consultation between physicians by means of phone, ICN, telemedicine.)
- c. Pre-hospital Care - the evaluation, treatment, and appropriate field management of the injured patient at the scene by pre-hospital care providers.
- d. Triage, Transport, and Transfer - the process by which patients are assessed for time critical injuries; the determination of the most appropriate transportation resources; and the determination of the most appropriate facility capable of meeting the needs of the injured patient.
- e. Definitive Care - a network of trauma care facilities that provide a full spectrum of care for injured patients.

Rehabilitation

- f. Rehabilitative Care – a network of facilities that provide care and reconditioning necessary to bring the patient back to maximal functional capacity in society.

Hospitals will report information (data) to the Trauma Registry at the Indiana State Department of Health. The trauma registry data represents information regarding the most critically injured patients. Pre-hospital, hospital discharge and eventually rehabilitation data will be linked to the trauma registry. ISDH will develop a state report generated from the Trauma Registry. Specialized reports will be created based on the audit filters and performance indicators created by the TPIT. The Team will analyze the reports to identify strengths or areas needing improvement regarding the treatment, triage, transport and transfer of the most critically injured patients. Areas needing improvement will undergo further analysis, which may require additional information from the Trauma Registry or other available sources of data. Problem solving methods will be initiated and recommendations for improvement may be provided to ISDH by the TPIT. A process to follow-up (re-evaluate) will be established for the recommendations made to ISDH by the TPIT.

Recommended Hospital System Indicators

1. Presence of trauma surgeon in ED upon arrival of designated trauma patient (<5 minutes of patient arrival) and/or

- 1a. The Trauma Surgeon response time is not documented.
2. “Recognized trauma patient” arrived at ED within 6 hours after injury occurrence.
 - 2a. And/or the injury times are not documented.
3. “Recognized Trauma Patient” with GCS < 8 had definitive airway control prior to leaving ED and/or
 - 3a. The definitive airway status for patient with GCS < 8 is not documented.
4. “Recognized Trauma Patient” with ISS > = 9 had vascular access established prior to leaving ED and/or
 - 4a. The vascular status established for patient with ISS > 9 is not documented.
5. Probability of survival (Ps) was calculated on a recognized trauma patient – STR by hospital and/or
 - 5a. The Ps is not calculated on designated trauma patient.
6. Trauma patients that were autopsied – State Trauma Registry or by hospital.
7. Safety equipment was documented for recognized trauma patients involved in motor vehicle, motorcycle, and bicycle collisions.
 - 7a. The safety equipment was not used or was not documented.
8. Blood alcohol content was measured in recognized trauma patients age 16+ involved in motor vehicle, motorcycle, and bicycle collisions or in penetrating trauma.
 - 8a. Blood alcohol content positive.
9. Drug screen was performed in recognized trauma patients age 16+ involved in motor vehicle, motorcycle, and bicycle collisions or in penetrating trauma.
 - 9a. Drug screen positive.

Descriptive Report Content

Survival Rates

1. Total number and rate of deaths caused by injury per year by state and county.
 - A. By Age & Gender
 - 1) 0 - 17 years
 - 2) 18 - 44
 - 3) 45 - 64
 - 4) 65 & over
 - B. Total number of injuries, urban and rural by state and by county for:
 - 1) Work
 - 2) Home
 - 3) Farm
 - 4) Roadway

Types of Injury

1. Total Number of Deaths per year by state and by county.
 - A. Motor Vehicle Collision
 - B. Motor Cycle Collision
 - C. Pedestrian
 - D. Penetrating Injury
 1. Intentional
 2. Unintentional
 - E. Other

Charges

1. Total charges by Level I and II trauma centers per year for care of the trauma patient.
2. Total charges by Level I and II trauma centers per year by cause.
3. Total charges by Level I and II trauma centers per year by region.
4. Total charges by Level I and II trauma centers per year by severity.
5. Total charges by Level I and II trauma centers per year by 3rd party payer.
6. Total charges by Level I and II trauma centers per year for patients transferred in.
7. Total charges by Level I and II trauma centers per year for patients transferred from the scene to the trauma center.

Prevention

1. If death with MVC, was safety belt worn/airbags by state and by county.
2. If death with MCC, was safety helmet worn by state and by county.
3. If death on a farm – were farm safety precautions taken by state and by county.
4. Total number of injury deaths that were substance abuse related per year by state and by county.
5. If MVC caused death, was a car safety seat utilized (age group specific).

Transportation

1. Mode of transportation to initial to initial hospital per year by state and by county.
 - A. Private Vehicle
 - B. Ground Ambulance
 - C. Air Ambulance
2. Utilization of transport for the dead per year by state and by county.
 - A. Ground Ambulance
 - B. Funeral Home

Autopsies

1. Total number of deaths caused by injury, autopsied per year by state, by and county.

Indiana Trauma System Audit Filters

Trauma patients who die in-hospital between 4 and 24 hours after the time of injury, stratified by hospital level. (Time from injury to hospital discharge used since time of death is not collected.)

List hospital, elapsed time, ED admission time, age, cause code, transport mode, and ISS for each patient meeting criterion.

Trauma patients with more than one inter-hospital transfer prior to definitive care. (Definitive care is defined as the final discharge hospital.)

List hospitals sending and accepting the transfer for each patient meeting criterion.

Ground transport trauma patients with an ED RTS less than or equal to 5.5 and scene transport times (scene departure to ED arrival) greater than 20 minutes.

List (and sort by) hospital, transport mode, EMS agency, scene to hospital transport time, injury county, cause code, ISS, and outcome for each patient meeting these criteria.

Revised Trauma Score

The Revised Trauma Score is a physiological scoring system, with high inter-rater reliability and demonstrated accuracy in predicting death. It is scored from the first set of data obtained on the patient, and consists of Glasgow Coma Scale, Systolic Blood Pressure and Respiratory Rate.

Glasgow Coma Scale (GCS)	Systolic Blood Pressure (SBP)	Respiratory Rate (RR)	Coded Value
13-15	>89	10-29	4
9-12	76-89	>29	3
6-8	50-75	6-9	2
4-5	1-49	1-5	1
3	0	0	0

$RTS = 0.9368 GCS + 0.7326 SBP + 0.2908 RR$

Values for the RTS are in the range 0 to 7.8408. The RTS is heavily weighted towards the Glasgow Coma Scale to compensate for major head injury without multi-system injury or major physiological changes. A threshold of $RTS < 4$ has been proposed to identify those patients who should be treated in a trauma center, although this value may be somewhat low.

Trauma patients with EMS scene times (EMS scene arrival to EMS scene departure) greater than 20 minutes.

List EMS agency, transport mode, scene time, scene procedures (air, CPR, fluids), trauma type, injury zip code (injury county), ISS, and outcome for patients meeting criterion.

Transferred trauma patients with an ISS greater than 15 and transfer time (ED admit to definitive hospital admit) greater than 6 hours for rural place of injury or 4 hours for urban place of injury.

List ED hospital, definitive hospital, urban or rural place of injury, transfer time, cause code, ISS, and outcome for patients meeting criteria.

Trauma patients with an ISS greater than 15 and ED time (ED admit to ED discharge) greater than 2 hours.

List hospital, patient transfer? (yes or no), cause code, and ED time for patients meeting criteria.

Trauma patients who die with a probability of survival (TRISS) > 50%. (TRISS score for trauma patients using physiologic measures collected at the first presenting hospital.)

List hospital, age, cause code, transport mode, ISS, outcome, LOS, and TRISS for patients meeting criteria.

Trauma patients who live with a probability of survival (TRISS) < 50%. (TRISS score for trauma patients using physiologic measures collected at the first presenting hospital.)

List hospital, age, cause code, transport mode, ISS, outcome, LOS, and TRISS for patients meeting criteria.

TRISS determines the probability of survival (Ps) of a patient from the ISS and RTS using the following formula: $Ps = 1 / (1 + e^{-b})$

Where 'b' is calculated from:

$$b = b_0 + b_1(RTS) + b_2(ISS) + b_3(AgeIndex)$$

The coefficients b0 - b3 are derived from multiple regression analysis of the Major Trauma Outcome Study (MTOS) database. Age Index is 0 if the patient is below 54 years of age or 1 if 55 years and over. b0 to b3 are coefficients which are different for blunt and penetrating trauma. If the patient is less than 15, the blunt coefficients are used regardless of mechanism.

	Blunt	Penetrating
b0	-0.4499	-2.5355
b1	0.8085	0.9934
b2	-0.0835	-0.0651
b3	-1.7430	-1.1360

The TRISS calculator determines the probability of survival from the ISS, RTS and patient's age. ISS and RTS scores can be inputted independently or calculated from their base parameters.

Trauma patients with an ISS greater than 15 who are discharged from non-trauma centers.

List hospital, age, cause code, transport mode, ISS, outcome, discharge disposition, and time to discharge for each patient meeting criteria.

Trauma patients transported by EMS without an associated ambulance report in the medical record.

List percentage of missing run reports by transport mode and EMS agency.

Trauma patients less than 13 years old (children) who either had an ED GCS less than or equal to 8, intubation, or ISS greater than 15 and not transferred to a regional pediatric trauma center.

List hospital, age, ED GCS, ISS, cause code, LOS, and transport mode for each patient meeting criteria.

Appendix 5: 2002 SWOT Analysis and Survey

INDIANA TRAUMA ASSESSMENT CONFERENCE SWOT ANALYSIS (2002)

NOTE: At the Indiana trauma assessment conference, discussion topics reflected various components of a trauma system (injury prevention, emergency medical services, hospital care, special needs [burns, pediatrics, and geriatrics], rehabilitation, trauma registry, etc.). Participants completed a SWOT analysis sheet (attached) after each topic. Responses are listed and summarized below. Fewer than five responses are omitted due to illegibility or duplication of another response in the same section from the same participant. Editorial interpolation is indicated by brackets ([.....]).

Participants were not asked to prioritize responses from most to least important. In addition, the number, diversity, and brevity of responses makes it impractical to weight a particular response based on whether a participant listed it first or last. Therefore, “Top Choices” indicates the frequency of each response in a particular section. Substantially equivalent responses in a section are grouped together for purposes of this summary.

Injury Prevention

Strengths

Reduced ETOH level enforced	Increased use of infant/child car seats
Community willingness to evaluate trauma system concept	Strong EMS in urban areas
High OSHA compliance rate	Good “push” for seat belt use (except pick-up trucks)
Strong base of agencies & personnel	
Excellent, nationally recognized resources in Indiana	Small state – easy access to resources
Good existing “framework” on which to build	Availability of data
Existing statewide safety council on which to build	Recognition of issues and challenges
Coalition of injury prevention agencies	People are more focused
“Feel good” nature facilitates public and legislative support	Desire to save lives
Available funding	Availability of data
Indiana comparable to other states	Methods of injury prevention
Knowledgeable experts can reproduce, locals can implement	Knowledgeable professionals
Causes of “incidences”	Education
Availability of data	Desire to improve injury prevention
Caring participants	Strong farm injury prevention program
Availability of data	Availability of data
Goods programs available	Availability of data
Lots of interested organizations	Passionate advocates
Existing injury prevention programs	Existing injury prevention programs
Availability of data	Committees in place
Working relationship between hospitals and EMS	Improved education cooperation
Improved cooperation with BMV	Some excellent programs in place
Committed advocates	Available resources
Many diverse organizations working on injury prevention	Many interested parties
Lots of technical expertise	

Grants available

Committed professionals

Top Choices:

1. Strong existing programs/agencies/committees/framework (12)
2. Availability of data (7)
3. Many committed/passionate experts with much technical knowledge (6)
4. Noble purpose with wide appeal/"feel good" (3)
5. Educational programs (2)

Weaknesses

Misuse of infant/child car seats	Lack of statewide trauma registry
Many older cars not engineered to prevent injuries	Limited data
Injury prevention education for new parents	EMS availability in rural areas
Lack of clear data on injury/death causes	Lack of funding
Lack of fire safety education for 0-4 year olds and handgun safety for 14-19 year olds	
Little dialogue among hospitals due to politics	
Lack of state support (lip service>tangible commitment)	
Competition>cooperation among agencies	
Programs often driven by funding rather than needs or data	
Too little data (fatalities vs. injuries)	
Lack of standardized definitions, age ranges, etc.	Lack of mandates
Must rely on comparability to other states	OSHA
Lack of morbidity data	Knowledge of grants and other funding
Public education	Lack of political will
Data collection insufficient and incomplete	No central data repository
Placing too many burdens on schools	Perception that "it's not my problem"
Lack of integrated approach	Data collection
Lack of established system [registry? trauma?]	Lack of funding
Uncoordinated, duplicative services	Lack of E-code data
Lack data system with global accessibility	
Lack of interaction between trauma centers and Purdue Farm injury programs	
Resources and funding not marketed across state	
Some agencies/programs not aware of each other's efforts	
Lack of "organized" approach by agencies	Lack of coordination (no "hub")
Lack of coordination among agencies/programs	Lack of E-code data
Lack of "bridge funding" to ensure projects continue	Lack of data
Lack of data on adults and geriatric populations	Legislative bottlenecks
Lack of fire/EMS involvement in community	Lack of coordinated data analysis
"How to collect data"	Access to EMS in rural areas
Small numbers, but huge costs/long-term impacts	Seat belts not required in all vehicles
Lack of coordination among agencies/programs	Lack of collaboration
Misuse/non-use of infant/child car seats	Misuse of infant/child car seats
Lack of "centralization"	Duplication of services
Data collection and reporting	Lack of specific injury data
Lack of "Indiana plan" [injury prevention or trauma?]	
Lack of medical system support for E-coding	

Top Choices:

1. Data insufficient, incomplete, or uncoordinated (14) – see also # 4
2. Agencies/programs uncoordinated and/or duplicative (11) – see also # 5
3. Inadequate funding (3)

4. Lack of usable E-code data (3)
5. Lack of statewide “system” [injury prevention or trauma?] (3)
6. Lack of access to EMS in rural areas (2)
7. Misuse of care seats (2)

Opportunities

Develop E-links among prevention agencies	Update data
Strengthen booster seat laws and enforcement	Build on strong volunteer base and ethic
Implement state trauma system	Mandate E-code use in hospital data
Strengthen open container law and enforcement	Money available
New safety initiatives based on available data	Educate, educate, educate
Broaden and strengthen Safe Kids Coalition	Group progress by coming together
Educate new parents at/through hospitals	Regional networking
Educational outreach by trauma centers	Better education [no specifics]
Better use of existing data from other states	Money, money, money
More population-based comparisons with other states	A school of medicine
Strengthen laws (seatbelts, helmets, pick-up trucks)	Public acceptance and support
Broaden collaboration among prevention agencies	Education
(encourage “win-win” relationships)	Engineering
Build on Hoosier Safety Council	Enforcement
Annual statewide Safety Conference to provide professional education for local educators	
Multiple schools of education	Use E-codes in hospitals
Develop childhood injury prevention collaborative	Solicit MCHB funding
Internet	Solicit private foundation funding
EMS-C grants	Federal grants
Better integrate prevention and medical care	
Discussion of importance of injury prevention to state trauma system	
Build on existing injury prevention network as subcommittee of state trauma system	
Use data for teaching opportunities	
Make resources (equipment, slides, helmets, etc.) available to all parts of state	
Trauma center outreach (educational role)	Education
Many good ideas/concepts	Injury prevention program in schools
Make info and data more accessible	Increase education
Strengthen booster seat laws and enforcement	Seat belt law for pick-up trucks
Improve/expand data collection	Stronger seat belt laws and enforcement
Better use strengths of concerned citizens/groups	
Strengthen booster seat laws and enforcement	

Top Choices:

1. Improve data use – update data, make it more accessible, use for teaching, etc. (11)
2. Improve education – in or through schools, hospitals/trauma centers, Internet, etc. (9)
3. Better collaboration among injury prevention agencies/programs (6)
4. Funding opportunities – MCHB, EMS-C, private foundations, etc. (6)
5. Injury prevention as part of a state trauma system (3)
6. Strengthen seat belt laws and enforcement, including pick-up trucks (3)
7. Strengthen booster seat laws and enforcement (3)

Threats/Obstacles

Lack of funding	Funding needs
Resistance to pick-up truck seat belt law	Turf battles (self-interest>big picture)
Lack of legislative understanding/support	Legislative “buy-in”

Hospital politics
 Lack of commitment to giving complete and accurate trauma data [no persons/parties specified]
 Need for funding
 Lack of support from hospital administrators
 Lack of legislative mandate for injury prevention study
 Shortage of hospital resources (FTE's, etc.)
 Lack of legal immunity for providers who give data
 Providers fear giving data will harm them in competitive environment
 Attempt by state to control injury prevention activities (too complex & volunteer driven for central control)
 Competition among special interests/agencies to be most visible/lead player
 Many rural counties lack infrastructure for effective injury prevention programs
 Changing culture, e.g., language barrier due to growing Hispanic population
 Bureaucracy
 Data collection costly for state-specific data that has marginal value
 Lack of funding
 Injury prevention leaders can't articulate a strategy
 No coherent policy from gov't. [level not specified]
 Lack of strong leadership
 Personnel shortage
 Lack of funding
 Lack of legislative understanding/support
 Need funding for one agency/organization to assume leadership of childhood injury prevention activities
 Barriers to E-code use, including funding needs
 Administering state funds for injury prevention
 No primary seat belt law for pick-up trucks
 Turf battles
 Funding needs
 Need to broaden data and emphasize "cost of survival"
 Cost of educational programs
 Funding – amounts & sources

Lack of consensus re data collection
 Lack of funding
 Funding priorities
 Speed limits too high
 Lack of injury prevention education
 No way to apply stats to a strategy
 No single statewide voice
 Many rural communities
 Lack of funding
 Funding needs
 Funding needs
 Funding needs
 Funding needs
 Legislative "self interest"
 Duplication of effort
 Attitude

Top Choices:

1. Funding needs and priorities (17)
2. Lack of legislative understanding and support (6)
3. Turf battles/competition/fear of competition (5)
4. Lack of effective leadership/central control (4)
5. Rural diversity/lack of infrastructure (2)
6. Lack of primary seat belt law for pick-up trucks (2)

Emergency Medical Services

Strengths

Good base/foundation
 Dedicated personnel
 Strong SEMA/EMS commission
 Moving to nationally-recognized EMT-I with standard (DOT) curriculum
 Many committed people

Aeromedical coverage
 Cooperative state agency (SEMA)
 Statewide collection of data
 Some willing resources

Good relationship between EMS and hospitals	Strong EMS training programs
Mandatory continuing education for EMT's	Talented and interested providers
Strong EMS organizations and personnel	Numerous providers
Cooperation among EMS professionals	Multi-level care
Some excellent programs to model best practices	"Open law"
EMS community well-structured	Many training facilities
Adequate resources	Aeromedical coverage
Medical direction	Aeromedical coverage
Manpower	Aeromedical coverage
E-911 covers 90% of population	Numerous providers
Indianapolis system well organized – can serve as model for others	
Statewide data collection	
Electronic data filing – NHTSA elements	Aeromedical coverage
Aggressive pre-hospital guideline	EMS professionals very committed
Maps/data supporting need to improve care	Mandatory continuing education
IHERN	Adequate number of ambulances
Aeromedical coverage	SEMA strong & effective
Multiple levels of EMT care available in most counties	Strong state EMS commission
Good development of ALS	Strong volunteer base
Excellent EMS access in most areas of state	EMT/paramedic/ambulance training
Clear evidence of continuing improvement through SEMA actions	
Strong EMS network	Data collection (but it needs analysis)
Use of national standards in EMT training	

Top Choices:

1. Adequate/well organized EMS resources – manpower and ambulances (10)
2. EMT training – national standards, continuing education, etc. (7)
3. Scope of aeromedical coverage (6)
4. Effective and cooperative SEMA/EMS commission (5)
5. Data collection system (5)
6. Dedication of EMS professionals (4)

Weaknesses

Unequal quality of EMS throughout state	Too many levels of EMS
Many counties lack hospital and paramedics	EMS professionals underpaid
Lack of uniform standards for 911, EMS training, protocols, etc.	
Variety of aeromedical organizations/structures	EMS not under Dept. of Health
Unclear how EMS would be involved in trauma system	
Many counties lack hospital and paramedics	Not enough paramedics
Need more hospital supervision (medical direction)	2 counties lack 911
No standard protocols or training for decision to call aeromedical service	
Not enough BTLs/PHTLS courses available	EMT levels redundant
Too many levels of providers and inconsistency in care	Access to service
No regulation of aeromedical protocols and activities	Lack of volunteers
Legislature not educated on lack of 911	Lack of funding
Lack of consistency in educator [?] certification	Advanced and intermediate
Low pay	Lack of data to document worth
Poor "inter-communication" abilities	Training too thinly spread
Rigid mind set in educators	Rigid mind set in operations
Lack of funding	15 counties with no hospital
Not enough educators in professional positions	Some counties lack hospital

Too many “BLS non-hospital” counties	Some counties lack paramedic care
Low pay reduces professionalism (creates “McDonalds mentality”)	
Statewide common communications system [lack of?]	
Medical directors not required to have EMS background	
Lack of uniform in-service education for EMS providers	
Some counties lack hospital and paramedics	Lack of trauma centers
Lack of facilities (kind not specified), staff, other resources	
Variation in providers (public/private) and funding in some areas (esp. southern tip of Indiana)	
No state protocol for aeromedical service	No standardized EMS protocols
Variability of funding sources	EMS continuing education
No Level III trauma center in some areas	Certification vs. license
Lack of paramedic services	Lack of public education
No data on funding	Volunteer retention
MD’s, RN’s, other hospital staff not educated about care different levels of EMT’s provide	
Decreased response time of volunteer EMS crews vs. survivability of sudden cardiac arrest	
Not paid according to duties performed	Home rule
Public education from EMS commission on injury prevention and EMS personnel	
911 (holes, slow response, etc. not specified)	Statewide communications
No evaluation and follow-up of aeromedical service	15 counties with no hospital
Lack of statewide radio system for ambulances	2 counties without 911
Lack of specific criteria for ambulance medical directors	
Maintaining skills for rare medical conditions	Lack of funding
Lack of first responder coordination	Inaccessibility of training
Lack of insurance and benefits for EMS personnel	Too many levels of training
Lack of funding for data collection and analysis	Skill levels vary throughout state
Communications system (“not ambulance”)	Inadequate communications systems
Ambulance funding varies by service	Lack of EMS in some rural areas
No state protocol for fixed wing certification	

Top Choices:

1. Uneven access to and quality of EMS throughout state, esp. in rural areas (23)
 - 15 counties have no hospital (9)
 - Some counties lack paramedics (6)
 - 2 counties lack 911 (3)
2. EMT and medical director training/continuing education is inadequate, inconsistent, inaccessible, or redundant (10)
3. Inadequate funding (7)
4. Inadequate communications systems (6)
5. Lack of field protocols, esp. for calling aeromedical service (5)
6. Low pay/benefits (4)

Opportunities

Public education on EMS availability	Lobby to improve EMS funding
Improve cooperation of EMS and fire depts.	Can Indiana support NAEMT?
Use people already in place to build system	911 access in all counties
Training on when to call aeromedical service	Create vision for future of EMS
Increased education/training through trauma system	Change levels of EMT’s
Develop more paramedic resources in south Indiana	Put EMS under Dept. of Health
Trauma guidelines to standardize care across state	Legislature mandate 911

Increase trauma-related education for EMS personnel	Aeromedical protocols
Legislation to support EMS initiatives, including medical directors manage aeromedical programs	
Paramedic service in all counties	Improve trauma outcomes as a whole
State assistance [funding?] with communications	Be flexible to change
Faculty [facility?] for BTLs/PHTLS education	New technology
Collect and use data to show need for trauma system	Develop statewide protocols
Establish another intermediate level of care (EMS?)	Diverse funding
Many people interested [public support, interest in EMS after Sept. 11?]	
Independent state agency [EMS, trauma?]	Develop statewide protocols
Recruitment and retention of EMS providers	Project future needs of EMS providers
Improve trauma care training	More degree programs increases pay
Public education	Mandated EMD training and certification
Public education	Enhance EMS personnel training
Enhanced 911	Correlate EMS dispatch guidelines
Uniform aeromedical protocols	Bring all together, including fire depts.
Develop field triage protocols for rural areas	High interest in EMS since Sept. 11
Develop protocols for calling aeromedical service	Dispatch/medical control
Use Bush's call for voluntarism to recruit EMS volunteers	
Build on excellent base (26,000 EMS personnel)	Electronic reporting of ambulance run data
Expand/unify communications system (EMS, police, fire)	
Revise 16-18 months required for paramedic training	
Standardize care protocols across state, esp. pediatric (provide more flexibility)	
No medical direction over ambulance dispatch	

Top Choices:

1. Standard statewide protocols for dispatch (including aeromedical) and field (9)
2. Strengthen EMT/EMD training (5)
3. Public education (3)
4. Use post-Sept. 11 atmosphere to recruit volunteers (2)

Threats/Obstacles

Inadequate required continuing education for RN's	Big vs. small hospitals
Unequal urban/rural resource distribution	Lack of funding
Lack of legislative authority to create statewide system	Too many levels of EMS
Unclear who would regulate trauma system	Lack of funding
Turf battle between BTLs and PHTLS	Lack of funding
Need for local input/sharing of information	Integrated health care systems
Physicians' unwillingness to follow standard protocols	Lack of funding
Physicians' unwillingness to promote trauma education	Regionalism
Politics (appointments to trauma commission, categorization of trauma centers, etc.)	
Turf battles, including aeromedical	Rural areas
Can medical directors be non-biased in trauma patient triage?	Federal payer mix
More education needed [about trauma systems?]	Too much "local" mentality
No force of personality to hold people accountable	Cost/funding needs
Employment (hospitals, fire depts.)	No hospital in some counties
Inconsistency in provision of EMS	Lack of funding
Low EMT clinical experience if establish statewide protocols	Volunteer retention
Low EMT clinical experience for some medical conditions	Funding needs
"Most RN treatment of EMS staff"	Rural paramedic retention
Territoriality of local/state agencies	Lack of funding
Rural counties without hospital or paramedics	Lack of funding

Refusal of Martinsville or Morgan Co. to fund EMS
Getting agencies to work together
Too many levels of EMT training
Funding for EMS, esp. ambulance services

Cost control
Home rule may not reflect needs
Us vs. them mentality
Rural paramedic retention

Top Choices:

1. Funding needs (14)
2. Turf battles/competition>cooperation (8)
3. Insufficient recruitment and retention of paramedics and volunteers in rural areas (4)

Trauma Care in Hospitals

Strengths

One medical school
ACS verified Level I trauma centers
EMS/hospitals desire to deliver optimal trauma care
Hospitals can be verified by ACS without gov't.
Skilled personnel desire to improve trauma care
“Legislative” [?]
One medical school
Surgeon availability
Trauma centers are “community resource”
One medical school
Trauma centers are “centers of excellence”
Standardization of care across Indiana
Trauma centers in most major Indiana cities
Leading trauma centers – IU and Methodist
Grants [trauma centers better able to get them or Indiana better able to get grants if have trauma system?]
Trauma centers have teaching role [medical or injury prevention/community outreach?]
“Talented, highly skilled individuals” [applies to hospitals generally or specifically to trauma centers?]
Trauma centers are centers for education, local info, community resource
Trauma center designation/verification develops teamwork and cooperation at all levels
Some hospitals already have in place many components
Trauma center status confers community prestige of trauma center
Level I and II trauma centers already fairly well distributed in Indiana
Some (not all) hospitals can meet ACS verification standards
Need for trauma center already realized in north and south Indiana [does this mean need is apparent but unmet, or need is already met?]

Informal system [already exists?]
Trauma is reimbursable
ED physicians available in urban areas
Research
Good intentions
Public education
Aeromedical transport
Trauma centers have better outcomes
Indiana works pretty well
Informal system already exists
“Comprehensive trauma care”
Informal trauma system already exists
Indiana has good Level I trauma centers
ACS Committee on Trauma is available

Top Choices:

1. Indiana already has several good trauma centers – some say they're well distributed (5)
2. Informal statewide trauma system already exists (4)
3. Indiana has single medical school (3)

Weaknesses

Lack of physicians, esp. trauma

Weak trauma care in rural areas

Stable resources	No legislative mandate
Not enough level II and III trauma centers	No state trauma standards
Pediatric trauma resources only in Indianapolis	Nurse shortage
Trauma surgeon availability [times or locations?]	Few transfer agreements
M.D. structure	Poor data
Staffing shortage	Lack of funding
"Legislative" [lack of legislative support or mandate?]	Hospital shortage
Lack of funding	"Difficulty of rural health involvement"
Small volume of "true" (severe) trauma patients	No legislative mandate
Local control of hospitals	Cost
"Questionable commitment to a system"	Medical politics
Academic vs. community medical staff (politics)	Lack of funding
"Heavy regulations" [currently or with trauma system?]	Outside QA costly
Lack of commitment	Expensive care for the few
No "buy in" from community-based surgeons	Duplication of services
Only 2 level I trauma centers – both in Indianapolis	Poor feedback to EMS providers
Not effectively communicating role of trauma centers	Only 2 level II pediatric trauma centers
Staffing shortages – nurses, radiology, other	Economic concerns > patient concerns
Turf battle – hospitals and physicians	2200 RN vacancies
Heavy demands on verified trauma center (time/\$)	Lack of funding
Trauma centers expensive and resource intensive	No statewide trauma registry
Competition	Large part of state is rural
"Surgeon commitment" [lack of? hard to get?]	
Resources insufficient and unequally allocated	
Need better networking with trauma centers, esp. pediatrics	
EMT's misunderstand what degree of injury requires trauma center care	

Top Choices:

1. Cost/lack of funding (9)
2. Turf battles/competition/politics (6)
3. Trauma centers currently concentrated in a few areas, esp. for pediatrics (6)
4. Staffing shortages – RN's, ED/trauma physicians, radiology, etc. (5)
5. No legislative mandate (3)
6. Lack of commitment – hospitals and/or physicians (3)
7. Challenges of rural areas (2)
8. Lack of data/trauma registry (2)

Opportunities

Work on education and injury prevention	Lessons learned from other states
Let market work on providers	Implementation of state trauma system
Statewide analysis of TRACS data	"Raising" ER nurses
Standardize EMS protocols for hospital bypass	Grant money
Grants for trauma education of MD's/RN's/EMT's	Keep dialogue going
Improve trauma patient outcomes	Research grants
Public education	Public education
Learn from other states	Share rural vs. urban outcomes data
Many potential level II and III trauma centers	Improve injury prevention
Funding from tobacco trust fund	"Do what is best with what we have"
Develop community education and resources	"Crossroads – collecting data"
Improve care through QA/QI	Simplify data collection process
Develop coordinated injury prevention program	Legislation for trauma care

How to get physicians committed to participate Injury prevention education
 Use ACS for assistance Develop state trauma registry
 Collectively address reimbursement solutions (e.g., coding)
 “Stats of statewide trauma vs. locations of trauma centers”
 Strengthen relations between EMT’s and hospital personnel
 Educate pre-hospital personnel about trauma centers/system
 Use data from other states that show trauma system benefits
 Identify hospitals and resources for various levels of designation/verification to build trauma system
 Legislation to develop/fund trauma system (referrals, bypass, triage, transfer agreements)
 Develop rural pilot programs
 Is collecting data in Indiana necessary in light of data from other states?
 Use current focus on disaster planning to advance trauma system

Top Choices:

1. Data/trauma registry – improve collection and use of data to document need for trauma system (6)
2. Solve funding/reimbursement issue (5)
3. Improve injury prevention (4)
4. Use lessons/data from other states (3)
5. Legislation to establish/fund trauma system (2)

Threats/Obstacles

Competing hospitals threatened by trauma centers	Money!
Time needed to apply for designation/verification	Lack of surgeon involvement
Resistance of administration [of hospital or state gov’t.?)	Funding
Inclusive system	Lack of interest
Funding	Funding
MD shortage	Funding
Variable public funding	Patient acuity
Competition between hospitals	Competition
Turf battle between pre-hospital/hospital staff	“Economic peers”
Lack of patient transfer agreements	High per patient cost
Punitive	Nurse shortage
Shortage of radiologists	Shortage of anesthesiologists
Funding	Expensive – no reimbursement
Turf fights (not wanting to transfer patients)	Funding
Threat of regulation	Cost for some hospitals
Fiscal crisis [hospitals, state, or Medicaid/Medicare?]	Lack of care in rural areas
Decrease in Medicaid/Medicare reimbursement	Cost of “preparedness”
Commitment of people, administration, resources	Cost analysis
Funding	State/local politics
Competition between hospitals	Funding
Budget cuts [hospitals, state, or Medicaid/Medicare?]	Staffing [cost or shortage?]
Hospitals compete – unwilling to share data	
Lack of incentives for state trauma system	
Will increase competition, resulting in closures[of hospitals or trauma center service?]	
Staff shortage (RN’s, lab techs, etc.) – need state support for recruitment and retention	

Top Choices:

1. Cost/lack of funding (18)

2. Competition/politics (9)
3. Staffing shortages (6)

Special Needs: Pediatrics and Geriatrics

Strengths

Recent push for better pediatric care in EMS	EMS-C is excellent educational resource
Recognizing special need of pediatric/geriatric patients	Established pediatric trauma center
Established burn centers work well with other hospitals	
Riley provides excellent guidance to others	Good pediatric transport system in place
Improve education re age-specific patient considerations	EMS-C
Established pediatric-focused courses (PALS, ENPC, etc.)	
Tiered response help identify the trauma patient	Shorter ED stay for injured patient
Improved functional outcome	Long-term benefits

Top Choices:

No clear choice, but some think Indiana is doing a good job of addressing special needs

Weaknesses

Special needs unknown to public	Education
Not enough public education	Not enough pre-hospital education
Lack of practitioners with expertise	Few pediatric surgeons
Lack of special geriatric training course like PALS	Quality of life
"All PICU's not able to care for all pediatric	"Rural setting in Indiana"
Public education re geriatrics patients, e.g., pelvic fractures"	
Fewer in number, but requires different sub-specialties	

Top Choices:

1. Lack of education (public and pre-hospital) re pediatric and geriatric needs (5)
2. Not enough pediatric surgeons and PICU's (3)

Opportunities

Improve patient outcomes	Fast-growing geriatric population
Pediatric center use may reduce cost and LOS	Public education
Develop specific protocols for treating patients at age extremes – share	with community hospitals
Create geriatric continuing education course [not specified for whom]	
Perform pediatric surgery regionally outside Indianapolis	
Potential of telemedicine (technology exists)	

Top Choices:

No clear choice

Threats/Obstacles

Family's desire to have patient close to home	Lack of funding
Cost of specialized people and equipment	"Different considerations for peds/geriatric"
Lack of funding (smaller volume of pediatric cases, but still need facilities, equipment, etc.)	

Top Choices:

1. Cost/lack of funding

Post-Hospital Trauma Care: Rehabilitation and Support

Strengths

Rehab recognized as important part of trauma care	Facilities are available
Variety of rehab services available	Many advances in care
Rehab personnel	Nursing home
Day care	Traditional living setting
Possible to improve functional outcomes	Focus on "quality of life"
Start planning for discharge at admission	
"Identify need to standardize data collection and continue data through rehab"	

Top Choices:

No clear choice, but some suggest adequate facilities/resources are already available

Weaknesses

Patient outcomes often not measured past ER	Unknown to public
Lack of outpatient services, esp. in rural areas	Lack of knowledge about resources

Lack of data re traumatic brain injury [Indiana-specific data or medical understanding of TBI?]

Lack of information	Lack of long-term facilities
Cognitive changes due to TBI falls thru cracks	Lack of public education
Poor networking among agencies (region-to-region)	Not enough rehab in hospital
Lack of Medicaid/Medicare reimbursement in Indiana	Public education
"Have NH and HHA with little awareness"	Often overlooked
Little data	Lack of resources
Funding available in other states, but not Indiana	Coordination of benefits
Difficult maze to get thru	Lack of long-term facilities

Top Choices:

No clear choice, but general agreement that this area is overlooked and suffers a shortage of resources

Opportunities

Many rehab centers exist	Public education
"Return trauma patient to function"	"Avoid extenuating circumstances"
"Community resources for optimal functionality"	Identify resources
Bridge data gap between surgeon and rehab	
Interface between acute care and community support groups, e.g., Brain Injury Assn.	

Top Choices:

No clear choice

Threats/Obstacles

Cost of long-term care	Cost/time to families
Reimbursement varies among payer sources	Very time/resource/money consuming
Medicaid crisis	Very costly
Paperwork nightmare	Medicaid not pay for rehab in Indiana
Resources	Lack of data
Who to contact?	"What facilities require vary"

"Family doesn't know what to do or get help" Patient sent out of state
Non-acceptance of families [family doesn't circumstances or facilities don't accept families?]
Funding for long/short-term care

Top Choices:

1. Cost/lack of funding (8)
2. Lack of knowledge of how access/use system -- burden on families (2)

Trauma Registries

Strengths

Hospital assn. prior experience with data collection
Availability of ambulance run and hospital discharge data
Some level I and II trauma centers have trauma registry
Databases available Electronic capacity exists
Have input from hospitals and pre-hospital providers Expertise exists to design a system
Existing, tested data collection hardware/software
Some data already being collected EMS data is available
Already many databases in Indiana Existing data collection
Widespread interest to access data Databases available
Technology available Funding available
"Lots of players" "Many sites"
"Lots of trauma" Already collect data
Existing pre-hospital data base Existing hospital discharge data
Multiple agencies are collecting data Dedicated personnel
Improved care results from data use Research
Plenty of other systems to pattern after Data collection underway
Customize injury prevention Ability to increase knowledge
Can make data available to all on website "Index" [already done or need to do?]
"Data based systems available" [data is available or hardware/software is available?]
Level I and II trauma centers already collecting data Hospital discharge data is available

Top Choices:

1. Substantial pre-hospital and hospital discharge data already exist and are being collected (16)
2. Technology exists to improve data collection and analysis (4)
3. Expertise exists in Indiana to design/run trauma registry (3)

Weaknesses

Provider hesitancy to share data due to cost and liability
"Multi-faceted" data collection No linkage
Past negative experience with record keeping "Buy in" from threatened parties
Lack clear understanding of what data needed No linkage
Need legislation, including confidentiality protection Cost of implementation
No IT person at state level to coordinate system State databases not yet linked
Many small hospitals don't want to collect/remit data "Cleanliness" of data
Patient personal info Lack of links
Variability in collection Available software not universal
"The pipeline of data widens over many agencies" "Data goes in and never comes out"
No clear mission by state agencies "How interpret data"

Weak state gov't. system (home rule)	Collect data, but little feedback
Sharing of data by DOT	Lack of consensus on data development
Expertise available at hospitals to manage data well	"Help desk functions"
EMS unable to get post-discharge data outcomes data	Cost
Implementation of statewide data base	Cost/lack of funding
"Need to have all vendors view all trauma software opportunities"	
No legislation protecting registry data confidentiality	
Variability in collection by different individuals and institutions	"Sharing of data – optional E-coding?"
Hospital assn. and Health Dept. resist data collection required for effective trauma registry	
No state agency willing to "own" and manage trauma data (should be Health Dept. or SEMA/EMS-C)	

Top Choices:

1. Existing databases not linked (4)
2. Lack of clear mission/authority/leadership by state agencies (3)
3. Cost/lack of funding (3)
4. No consensus on what data to collect or how to use it (2)
5. Some hospitals will resist a trauma registry (2)

Opportunities

Help tailor area-specific injury prevention programs	Technology
Develop ED database (the "missing link")	Software
Develop database to be used <u>annually</u> for injury prevention	Existing data bases
Develop statewide trauma data tracking system	Existing data bases
Link hospital and pre-hospital data	Identify lost charges?
Use data for community-specific injury prevention	Locate funding sources
"CODGS/CDC/GTC" programs and grants are available	Identify trends, needs, training
Linkage of EMS and hospital data	Research
"What can we do to lower cost?"	
"Collection offers valid data for policy development"	
Analyze potential linkage of databases	
Selection of standard statewide data base	
Opportunity to follow patient from pre-hospital thru discharge or death	
"Establish registry between EMS-hospital as per prognosis and outcome of patient"	
Trend and improve patient care, transport times, LOS, outcomes, etc.	
"Process associated with trauma registry"	
Use university depts. or students to devise IT analysis	
Begin trauma registry by linking current databases(ambulances run reports and hospital discharges)	

Top Choices:

1. Better linkage of existing/future databases (4)
2. QA/AI – improve quality of care and patient outcomes (3)
3. Help locate and secure funding for trauma care (2)
4. Help tailor community-specific injury prevention programs (2)

Threats/Obstacles

Lack of legal immunity for providers giving data	Lack of funding
Lack of funding	"HIPPA on patient info"
"Fear from exposure to weakness"	Lack of funding

Lack of leadership to collect, analyze, report data	Time commitment
Cost	HIPPA
Cost of data collection	Technology
Delay in collection/analysis/use of data reduces value	Loss of confidentiality
Cost/source of funding (who will pay?)	Time commitment
Lack of legal immunity if give data	Lack of funding
Serious hole in EMS peer review process	Staffing needed
Turf battles	Who is lead agency?
Legal immunity issues	Ownership of data
“Legal” [legal immunity issue?]	Cost of collection/analysis
Decreased revenue for hospitals that aren’t trauma center	Confidentiality problems
Standardization of data elements and collection methods	Variability in patient names
Competitive complications [among providers?]	Lack of funding
Who will be responsible for administering data?	How to link data
Cost/lack of funding	Legal issues [legal immunity?]
Linkage of data in light of consistency and impurity	Potential legal liability
Hospitals concerned that data will be used as “report card”	
Not enough hospitals [currently?] collecting data to get accurate statewide picture	

Top Choices:

1. Cost/lack of funding (10)
2. Lack of legal immunity for providers of data (6)
3. Competition among providers (5)
4. Potential loss of confidentiality (2)
5. Concern about which state agency would administer trauma registry (2)

Participants

Name	Affiliation
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Bob Zahnke, Director Trans Center	Purdue University – West Lafayette

Adapted from Bazzoli et al, 1992

Survey of State/Local Efforts To Coordinate Trauma Care Delivery

Instructions

The purpose of this survey is to identify the variety of programs and activities that have been developed to coordinate the delivery of trauma care. Our discussions with state/local emergency medical service directors and our review of available information suggest that substantial variability exists across the country. A comprehensive data collection effort is needed, however, to precisely delineate these differences.

This survey is intended to be completed by the lead agency in states with a statewide system of trauma care. In states with regional systems of trauma care, one survey should be completed each regional lead agency. In states with no organized system of trauma care, the survey should be filled out by the State EMS Office.

Throughout the survey, we use certain abbreviations and terminology commonly associated with emergency medical services and trauma care delivery. These terms are defined below for your information:

- ACS: American College of Surgeons
- ALS: Advanced Life Support
- BLS: Basic Life Support
- DOT: Department of Transportation
- EMS: Emergency Medical Services
- EMT: Emergency Medical Technician
- Hospital Categorization: A mechanism for grouping hospitals based on their perceived or actual capability to provide trauma services.
- Hospital Designation/Accreditation: A formal process for identifying hospitals that meet trauma center standards and for authorizing these hospitals to provide trauma care.
- Verification: A process for substantiating the qualifications and credentials of hospital or pre-hospital providers of trauma care.
- Promptly Available: Physician or staff are on-call outside the hospital, but can be assembled within a short time (5 – 20 minutes) after a trauma patient arrives at the hospital.
- Immediately Available: Physician and/or staff are either on call or in-house, and can be assembled prior to arrival of trauma patient at the hospital (allows for 5 minute prenotification).

If you have any questions about items in this survey that require clarification, please call Dr. Clay Mann, (801) 585.9161. Completed surveys should be December 31, 2001.

**SURVEY OF STATE/LOCAL EFFORTS
TO COORDINATE TRAUMA CARE DELIVERY**

I. Organizational Background Information:

a) Name and contact information of statewide or regional survey respondent:

Name of statewide or regional trauma system: None
 Contact: Michael Garvey
 Title: Deputy Director, State Emergency Management Agency
 Phone number: 317-232-3983
 Fax number: 317-233-0497
 Email address: mgarvey@sema.state.in.us

b) Name and contact information of medical director for your organization (if your organization has no medical director, check here:)

Name:
 Phone number:
 Fax number:
 Email address:

c) Please list the counties (or county metropolitan areas for states in New England) in which your organization is actively involved in the coordination of trauma care delivery. If your organization serves the entire state, simply report this on the first line below.

PLEASE NOTE: In the sections of the survey that follow, we will refer to the area described below as your "service area".

State of Indiana

2. Legal Authorities for Trauma Coordination Activities

In this section, you will report the specific legal authorities that your organization and others have to develop activities that coordinate the delivery of trauma care for your service area. Such legal authority is typically established through statutes, law, municipal ordinances, executive orders, administrative code, regulations, or related legal actions that specify the responsibilities of public and private organizations.

For this section, please identify whether your organization has the legal authority to conduct each of the specific activities below. If an organization other than yours has legal authority for an activity, please provide the name of this organization in the space provided. **PLEASE NOTE:** We are interested in authorities that currently exist through legal mandate: not if the specific activities below are currently implemented and/or operational.

Does your organization have legal authority?	If your organization does not have legal authority but another organization does, please identify the name of this organization.
----------------------------------------------	----------------------------------------------------------------------------------------------------------------------------------

Activity	Yes	No	Uncertain
a) Design and implement EMS plan for service area		X	
b) Design and implement trauma care plan for service area		X	
c) Develop trauma center standards or criteria		X	
d) Verify that hospitals meet trauma center criteria		X	
e) Formally designate/accredit hospital trauma centers		X	
f) De-designate/revoke trauma center designation		X	
g) Restrict hospitals <u>not</u> verified or designated from holding themselves out to public as trauma centers		X	
h) Establish EMT training requirements	X		
i) Establish EMT certification requirements	X		
j) Establish ambulance vehicle staffing requirements	X		
k) Establish ambulance vehicle equipment requirements	X		
l) License ambulance services	X		

Activity	Yes	No	Uncertain
m) Establish trauma patient triage procedures		X	
n) Establish patient transport protocols that allow the by-pass of hospitals without trauma centers		X	
o) Require formal inter-hospital transfer agreements		X	
p) Establish medical control procedures and protocols		X	
q) Establish a trauma registry		X	
r) Require hospital assurance programs		X	
s) Establish continuing education/outreach programs		X	
t) Establish trauma prevention programs	X		
u) Evaluate trauma system operations and effectiveness		X	

3. Identification of Hospital Trauma Centers

a) Does your organization or some other organization designate, verify, accredit, and/or categorize hospital trauma centers within your service area?

Yes, activity in place Yes, activity under development
 No Uncertain

If **YES** complete the rest of this section; **OTHERWISE**, skip to SECTION 4.

b) Please report the year in which trauma centers were (or will be) first identified in this way.

Year: _____ (Check here if uncertain;)

c) Did an assessment of community trauma care needs and available health resources take place prior to the initial identification of trauma centers?

Yes, activity took place Yes, activity under development
 No Uncertain

IF YES:

- 1) Was (or will) the need assessment (be) used to determine the number and perhaps types of trauma centers needed within your service area?
- Yes, assessment was used this way
 - Yes, assessment will be used this way
 - No, (if assessment was/will be used in some other way, please specify):

Uncertain

- 2) Were (or will) the number of trauma centers identified for your service area (be) limited based on the results of the need assessment?

Yes No Uncertain

- d) Which of the following sources were used as a basis for the trauma center standards in your service area?

- ACS hospital resource guidelines without modification
- ACS hospital resource guidelines with modification
- Other sources (please specify):

Basis for guidelines not yet selected

Uncertain

- e) As a pre-requisite to identification as a trauma center, must a hospital obtain ACS verification based on ACS trauma center standards?

Yes, activity in place Yes, activity under development

No Uncertain

- f) Was a request for proposal or request for application used to identify hospitals interested in being identified as trauma centers?

Yes, activity in place Yes, activity under development

No Uncertain

IF NO: What process was used to identify hospital trauma centers?

g) Is an on-site hospital visit required to determine a hospital's initial compliance with trauma center standards?

Yes, activity in place Yes, activity under development
 No Uncertain

IF NO: What process, if any, is used to substantiate a hospital's compliance with trauma center standards?

h) Do hospital trauma centers within your service area have formal contracts that specify their obligations and responsibilities as trauma centers?

Yes, activity in place Yes, activity under development
 No Uncertain

IF NO: What types of arrangements, if any, are made with hospital trauma centers?

i) What is the duration of a hospital's designation, verification, accreditation, or categorization as a trauma center?

Initial designation: ___ years (Please check if no limit on duration: ___)
Re-designation: ___ years (Please check if no limit on duration: ___)

j) Does the periodic re-verification of a hospital's continued compliance with trauma center standards take place?

Yes, activity in place Yes, activity under development
 No Uncertain

IF YES: (1) How often do (or will) these periodic re-verifications occur?
(e.g., every 6 months; annually) _____

(2) Is (or will) an on-site hospital visit (be) required for re-certification?

Yes No Uncertain

k) Can a hospital identified as a trauma center have its designation, verification, accreditation, or categorization revoked or suspended?

- Yes, activity in place Yes, activity under development
 No Uncertain

IF YES: Can the loss of trauma center identification occur:

- Only at end of specified designation, verification or accreditation period
 Only after periodic re-verification of qualifications
 At any point when serious concern is raised about center
 Other (please specify:) _____
 Uncertain

l) Please answer the following questions on specialty referral centers that may be present in your service area:

Are the following types of specialty referral Centers present within your service area (check all that apply): If checked: were hospital standards specific to these specialty referral centers developed?

Check	Type of Center	Yes	No	Under Development	Uncertain
	Pediatric trauma centers				
	Burn centers				
	Neurotrauma centers				
	Trauma rehabilitation centers				
	Other (please specify below)				

m) Please report major changes in trauma center designation, verification, accreditation, and/or categorization that are planned for your service area over the next five years:

4. Pre-Hospital Care Personnel

a) Which of the following categories of pre-hospital personnel are present within your service area (check all that apply):

- First Responders
 EMT Basic
 EMT Intermediate

- ~~EMT/AA/AA/AA/AA~~ (Paramedic)
- Aeromedical Personnel
- EMT-D - All EMT's have defib training
- EMD - Voluntary
- MICN
- Other

b) Please provide the following information by specific category of pre-hospital personnel:

Does your organization or some other organization provide standardized training to the following categories or pre-hospital personnel (check all that apply):

If checked: please identify the type of training program that is used:

Check	Category	DOT National Standard Curriculum Unmodified	DOT National Standard Curriculum Modified	Other	Uncertain
	First Responders		<input checked="" type="checkbox"/>		
	EMT Basic		<input checked="" type="checkbox"/>		
	EMT Intermediate		<input checked="" type="checkbox"/>		
	EMT/AA/AA/AA/AA (Paramedic)	<input checked="" type="checkbox"/>			
	Aeromedical Personnel				
	EMT-D				
	EMD				
	MICN				
	Other				

c) Approximately what percent of the population in your service area is currently covered by pre-hospital personnel that have received standardized training:

Category	% of population in your service area that is currently covered by personnel with standardized training (List by percentage)
First Responders	95%
EMT Basic	100%
EMT Intermediate	30%
EMT/AA/AA/AA/AA (Paramedic)	80%
Aeromedical Personnel	
EMT-D	N/A
EMD	50%
MICN	N/A
Other	

d) Please provide the following information on licensure/certification of pre-hospital personnel in your service area:

Check	Which of the following categories of pre-hospital personnel are currently licensed/certified within your service area (check all that apply):	If checked, in what year were licensure/certification programs first implemented (record "?" if uncertain)
X	First Responders	1978
X	EMT Basic	1974
X	EMT Intermediate Advanced	1976
X	EMT Advanced (Paramedic)	1977
	Aeromedical Personnel	N/A
	EMT-D	N/A
	EMD	Unknown
	MICN	N/A
	Other	

e) Please report major changes in pre-hospital that are planned for your service area over the next five years:

Indiana will implement intermediate level training/certification for EMT's in 2002 (in Indiana, advanced level training/certification is comparable to national intermediate level)

5. Emergency Transportation

a) Do standards for ground ambulance vehicles operating in your service area exist that specify:

	Yes	No	Uncertain
The number of ambulance personnel in different vehicles	X		
The qualifications of ambulance personnel in different vehicles	X		
The medical equipment available on different vehicles	X		

b) Do standards for air ambulance vehicles operating within your service area exist that specify:

	Yes	No	Uncertain
The number of ambulance personnel in different vehicles	X		
The qualifications of ambulance personnel in different vehicles	X		
The medical equipment available on different vehicles	X		

c) Are ambulance service agencies licensed certified and/or franchised within your service area?

X Yes, activity in place ___ Yes, activity under development
 ___ No ___ Uncertain

d) Are ambulance service agencies required to have designated dispatch centers?

Yes, activity in place Yes, activity under development
 No Uncertain

e) Can licensure, certification, and/or franchise agreements with ambulance service agencies be revoked or suspended?

Yes, activity in place Yes, activity under development
 No Uncertain

f) Please identify the approximate percent of the resident population in your service area that is currently covered by different classes of ambulance services:

Ground Ambulance Classes	Percent of population in service area that is currently covered by ambulance class (List by percentage)
Basic Life Support	100%
Advanced Life Support	85%
Critical Care Support	25%
Other (please specify)	

Air Ambulance Classes	Percent of population in service area that is currently covered by ambulance class (List by percentage)
Helicopter	100% in 100 mile radius
Fixed Wing	0%
Other (please specify)	

g) Please report major changes in emergency transportation standards or agreements that are planned for your service area over the next five years:

None

6. Medical Control and Direction

a) Were physicians active participants in the initial development of:

	Yes	No	Uncertain
EMS and trauma system design		X	
Pre-hospital care protocols	X		
System and patient evaluation	X		

- b) Is on-line medical control available in your service area?
 Yes, activity in place ___ Yes, activity under development
 ___ No ___ Uncertain

If YES: Approximately, what percentage of the pre-hospital personnel in your service area currently have access to on-line medical direction: 100 %

- c) Do pre-established standing medical orders for the management and treatment of trauma patients in the field exist for pre-hospital personnel?
 Yes, activity in place ___ Yes, activity under development
 ___ No ___ Uncertain

- d) Please report major changes in on-line and off-line medical control activities that are planned for your service area over the next five years:

None

7. Communications

- a) Community access to 9-1-1 service:

- 1) Is 9-1-1 available in your service area?

Yes, activity in place ___ Yes, activity under development
 ___ No ___ Uncertain

- 2) Is enhanced 9-1-1 (which identifies phone number of caller) available in your service area?

Yes, activity in place ___ Yes, activity under development
 ___ No ___ Uncertain

- 3) If yes to either of the above two questions, approximately what percent of the population in your service area currently has access to these services:

Basic 9-1-1 95 %
 Enhanced 9-1-1 85 %

- b) Is emergency call screening and priority dispatch for ambulance services available in your service area?

Yes, activity in place ___ Yes, activity under development
 ___ No ___ Uncertain

If YES, approximately what percent of the population in your service area currently is covered by this service: 60 %

c) Please answer the following questions about ambulance and hospital communication capability:

Check	Is direct two-way communication capability currently available: (check all that apply)	If checked, approximately what percentage of the population in your service area is currently covered by this service:
<input checked="" type="checkbox"/>	Between dispatcher and ambulances	100%
<input checked="" type="checkbox"/>	Between different ambulances	75%
<input checked="" type="checkbox"/>	Between ambulances and hospitals	100%
<input checked="" type="checkbox"/>	Between different hospitals	85%

d) Please report major changes in emergency communication activities that are planned for your service area over the next five years?

State developing a statewide, interoperable (police, fire, EMS, etc.) 800 mhz radio system. Pilot sites on-line, but no statewide implementation deadline.

8. Patient Categorization and Triage Procedures

a) Are trauma patient categorization or triage procedures for assessment of trauma patient condition in the field used within your service area?

Yes, activity in place Yes, activity under development
 No Uncertain

If YES, complete the rest of this section; OTHERWISE skip to SECTION 9.

b) Please report the year in which these trauma patient categorization or triage protocols were (or will be) implemented:

Year: _____ Check here if uncertain: _____

c) Which of the following were used as a basis for trauma patient categorization or triage procedures in your service area (check all that apply):

ACS Guidelines without modification
 ACS Guidelines with modification
 Other Sources (Please specify): _____

 Specific procedures are under development
 Uncertain

d) Please answer the following questions about patient categorization or triage procedures:

Does trauma patient categorization or triage conducted in the field by pre-hospital personnel include assessment of (check all that apply):

If checked: Does specific written policy exist on patient triage decision for this item?

Check	Assessment	Yes	No	Under Development	Uncertain
	Physiological signs (if checked, identify which of the following measures are used):				
	___ Glasgow coma scale				
	___ Trauma score or revised trauma score				
	___ CRMS score				
	___ Other (specify):				
	___ Anatomic injury				
	___ Mechanism of injury				
	___ Presence of co-morbid condition				
	___ Patient age (i.e., PTS)				
	___ Other (please specify below)				

e) Does a standardized program for teaching the application of trauma patient categorization and triage procedures exist?

___ Yes, activity in place ___ Yes, activity under development
 ___ No ___ Uncertain

If YES, Does (or will) all pre-hospital personnel in your service area receive standardized training?

___ Yes ___ No ___ Uncertain

f) Approximately how often does on-line medical control participate with pre-hospital personnel in making the decision about hospital destination for trauma patients (please check the category that you believe is most appropriate; approximate percentage ranges are provided for definition purposes):

- ___ Always (100%)
- ___ Frequently (50 - 99%)
- ___ Occasionally (25 - 49%)
- ___ Rarely (1 - 24%)
- ___ Never (0%)

g) Which of the following statements best describe the transportation practice that occurs in your service area when field assessment identifies a trauma patient with severe injuries that threaten loss of life or limb (check only one):

Pre-hospital providers transport patient directly to trauma center, bypassing any nearer hospital that does not have a trauma center unless extenuating circumstances are present (e.g., inability to maintain an airway or excessive transport time to trauma center)

Pre-hospital providers are not required to take patient to trauma center; they typically take patient to nearest available hospital

Other transport practice (please specify):

Transport policy under development

Uncertain

h) Do assessments of the compliance of pre-hospital providers with trauma patient categorization or triage procedures take place?

Yes, activity in place

Yes, activity under development

No

Uncertain

IF YES: Please specify how these assessments are (will be) conducted (e.g. what agencies/committees are involved, what data is collected and evaluated)?

i) Please report major changes in trauma patient categorization and triage procedures that are planned for your service area over the next five years:

9. Inter-hospital Transfer Arrangements

a) Do written protocols exist for inter-hospital transfer of trauma patients within your service area?

Yes, activity in place

Yes, activity under development

No

Uncertain

IF YES: Complete the rest of this section; OTHERWISE skip to SECTION 10.

- b) Please report the year that these protocols or guidelines were (or will be) implemented:

Year: _____ Check here if uncertain: _____

- c) Within your service area, do written transfer agreements exist between hospitals with or without trauma centers?

___ Yes, activity in place ___ Yes, activity under development
___ No ___ Uncertain

- d) Which of the following resources were used as a basis for the development of inter-hospital transfer guidelines for trauma patients (check all that apply):

___ ACS Guidelines without modification
___ ACS Guideline with modification
___ Other Sources (Please specify)

___ Guidelines under development
___ Uncertain

- e) Does written policy exist that identifies the specific types of trauma patients that should be transferred from hospitals without a trauma center to those with such centers?

___ Yes, activity in place ___ Yes, activity under development
___ No ___ Uncertain

If YES:

- 1) Do (or will) emergency room personnel in non-trauma center hospitals receive standardized training on the application of trauma patient transfer criteria?

___ Yes ___ No ___ Uncertain

- 2) Do (or will) assessments of emergency room compliance with trauma patient transfer criteria take place?

___ Yes ___ No ___ Uncertain

- f) Please report major changes in trauma patient inter-hospital transfer procedures that are planned for your service area over the next five years:

10. Procedures for Ongoing Evaluation

a. Is a trauma registry present for your service area?

- Yes, activity in place Yes, activity under development
 No Uncertain

If YES:

- 1) Please identify whether submission of trauma registry data is (or will be) mandatory for the following groups of hospitals
 Hospitals with trauma centers
 Hospitals without trauma centers
- 2) Is (or will) a pre-established standard format (be) required for trauma registry data? Yes No Uncertain
- 3) Are (or will) trauma registry data (be) computerized?
 Yes No Uncertain
- 4) Can (or will) system-wide trauma registry data be linked with the following types of data (check all that apply):
 Fatal accident reports Ambulance run reports
 Police reports
 Uniform state or local patient discharge databases
 Other (Please specify):

b) Do you have a designated trauma advisory committee that evaluates the performance of trauma care delivery within your service area?

- Yes, activity in place Yes, activity under development
 No Uncertain

If YES:

Does (or will) the committee assess system performance based on (check all that apply):

- Review of pre-hospital care
 Hospital medical reports, including autopsy data or trauma patients
 Reports on all trauma deaths within the service area, including review of the preventability of these deaths
 Uncertain
 Other (please specify)

c) Please report major changes in evaluation activities that are planned for your service area over the next five years:

Appendix 6: Maps

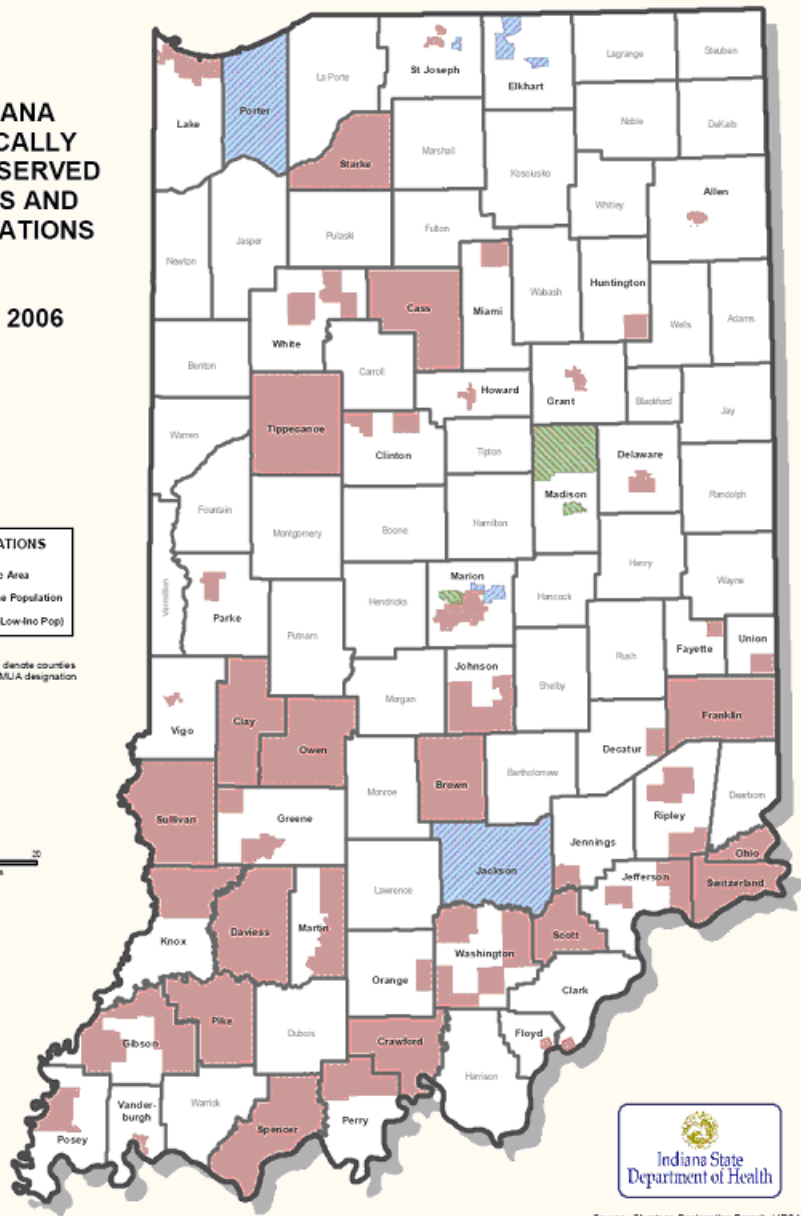
INDIANA MEDICALLY UNDERSERVED AREAS AND POPULATIONS

May, 2006

DESIGNATIONS

- Geographic Area
- Low-Income Population
- Governor (Low-Inc Pop)

Bold county names denote counties having any type of MUA designation



Source: Shortage Designation Branch, HRSA,
U.S. Department of Health and Human Services

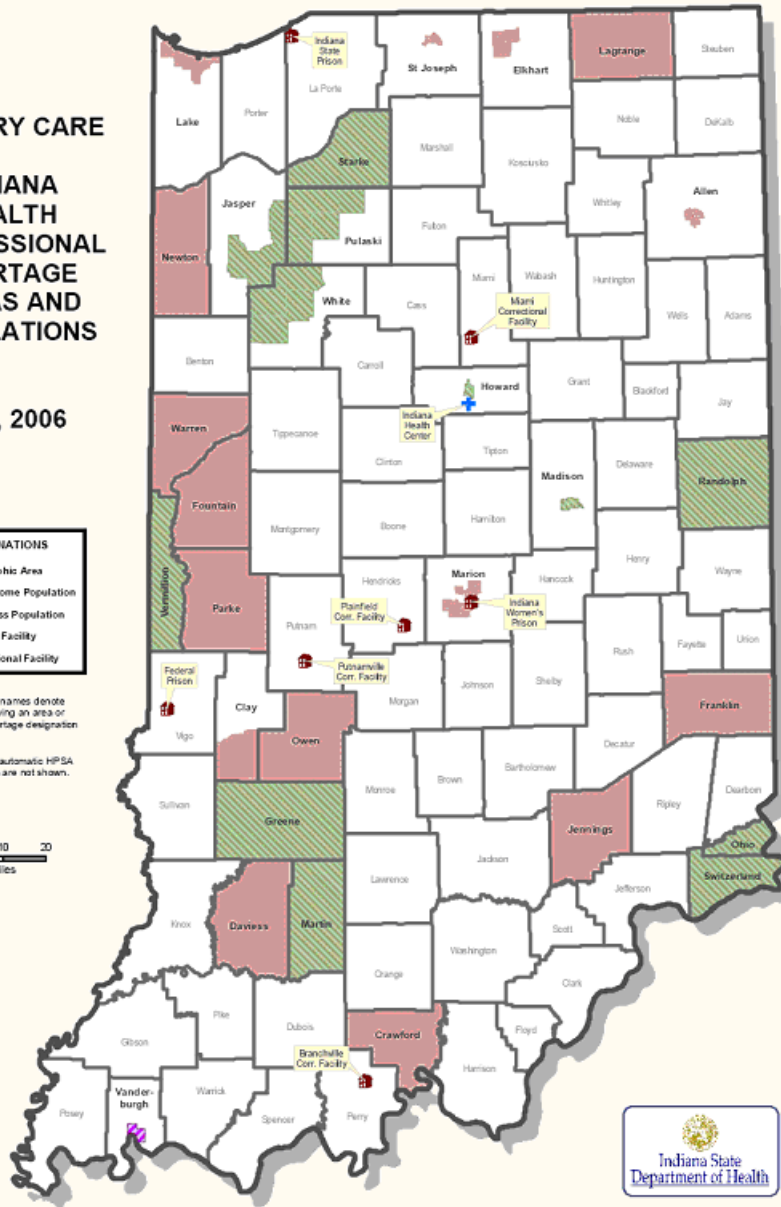
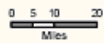
**PRIMARY CARE
INDIANA
HEALTH
SHORTAGE
AREAS AND
POPULATIONS**

May, 2006

DESIGNATIONS	
	Geographic Area
	Low-Income Population
	Homeless Population
	Medical Facility
	Correctional Facility

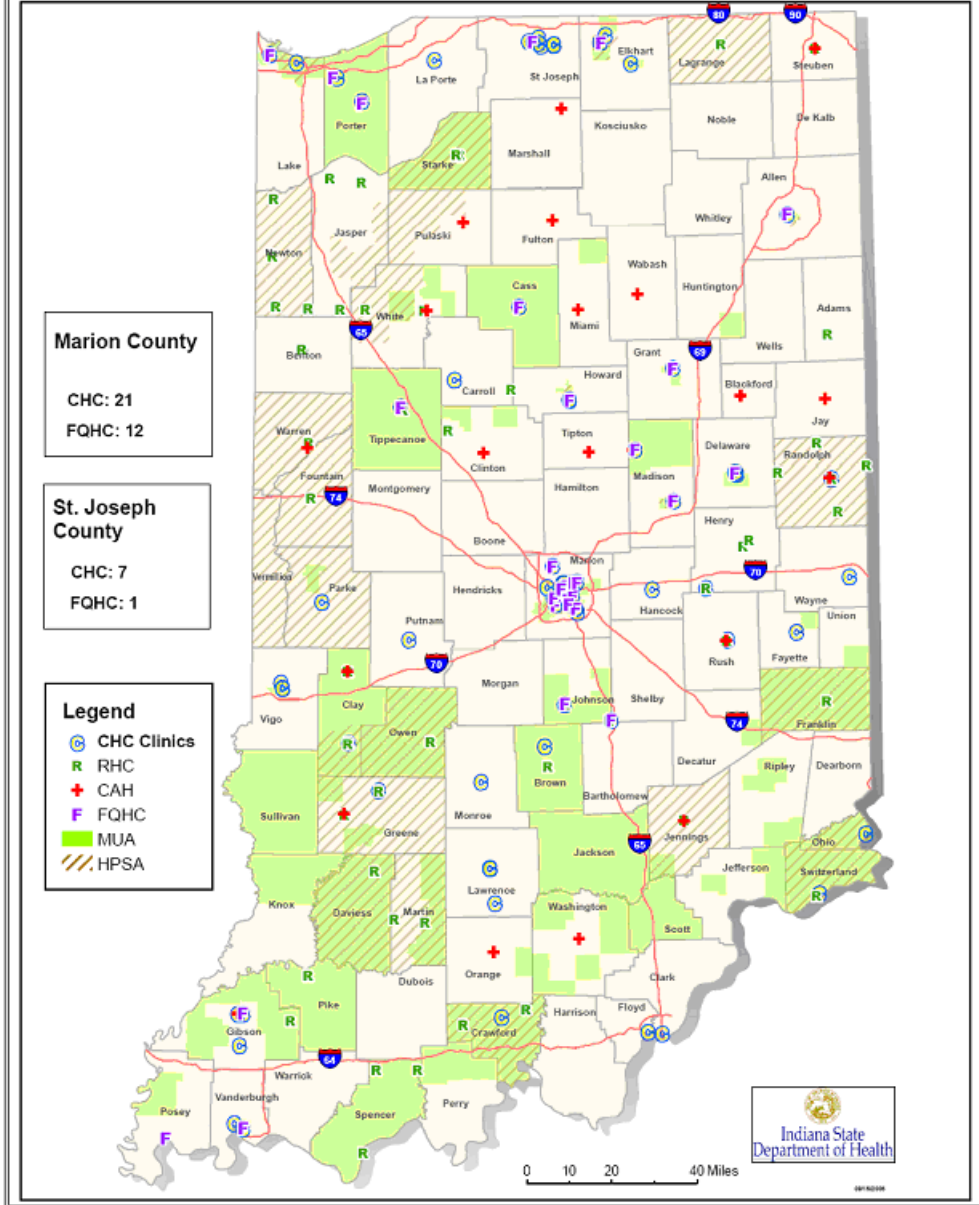
Bold county names denote counties having an area of population shortage designation

Facilities with automatic HP/SA designations are not shown.

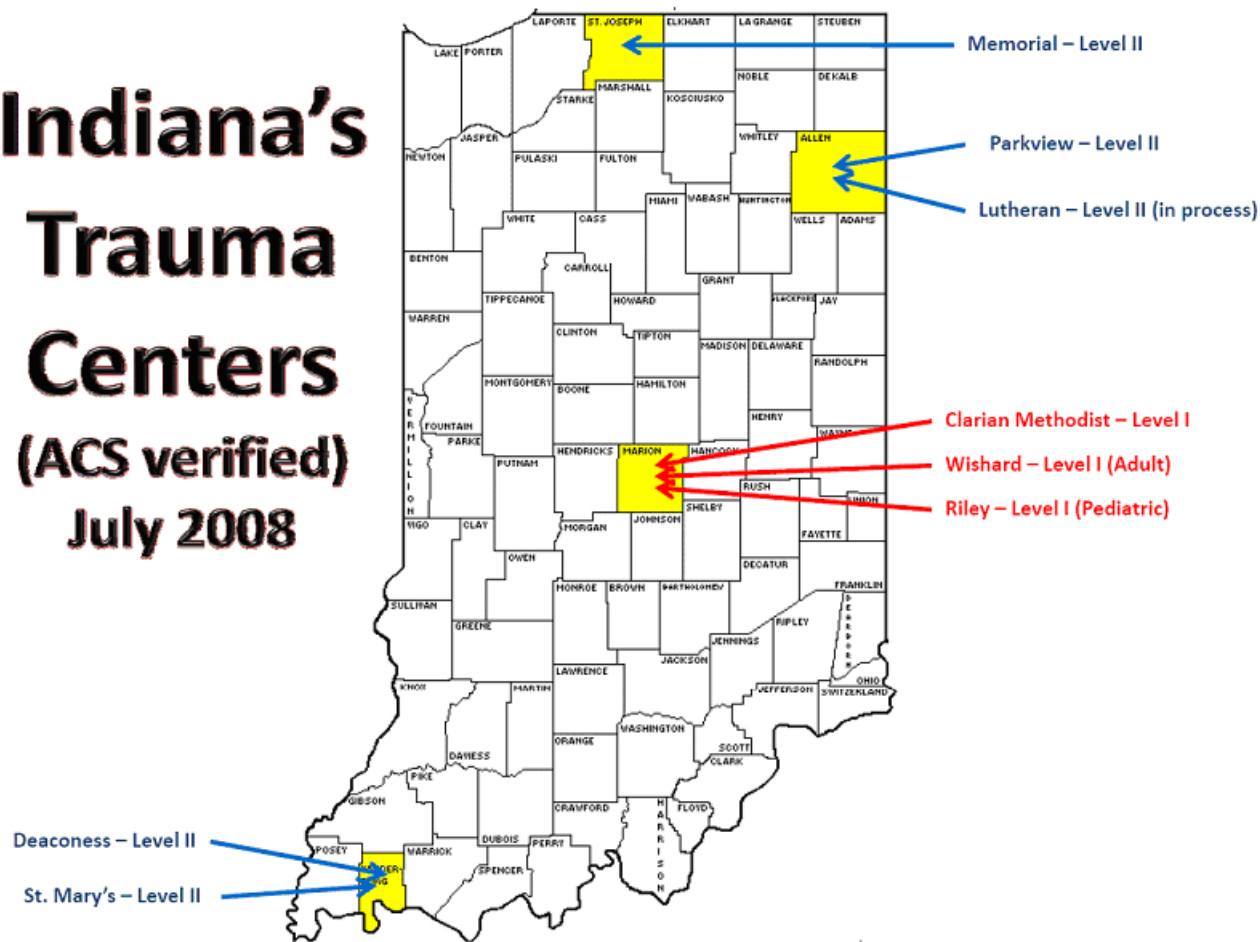


Source: Shortage Designation Branch, HRSA, U.S. Department of Health and Human Services

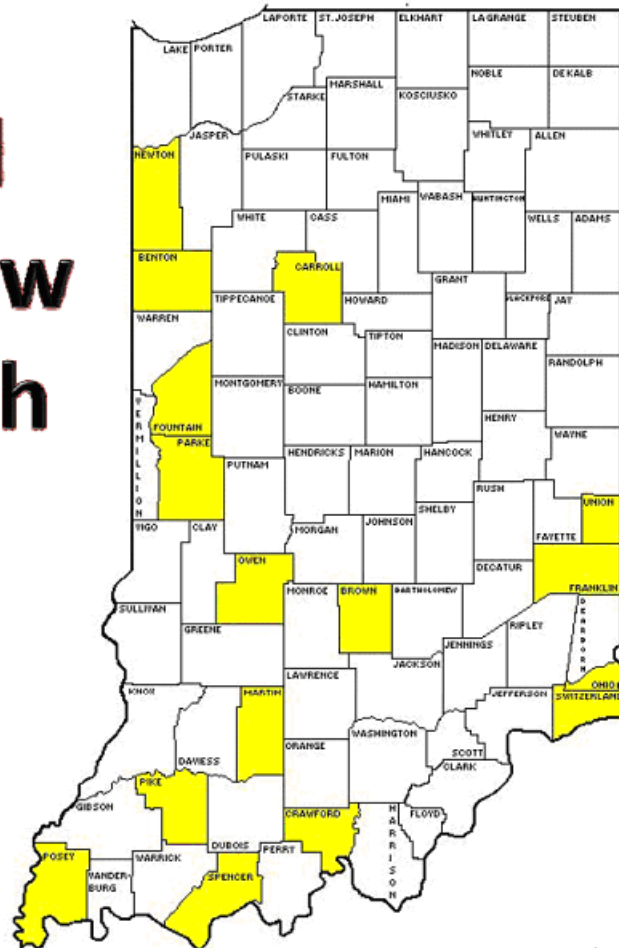
Clinics Facilities



Indiana's Trauma Centers (ACS verified) July 2008



**Highlighted
Counties show
counties with
no hospital
July 2008**

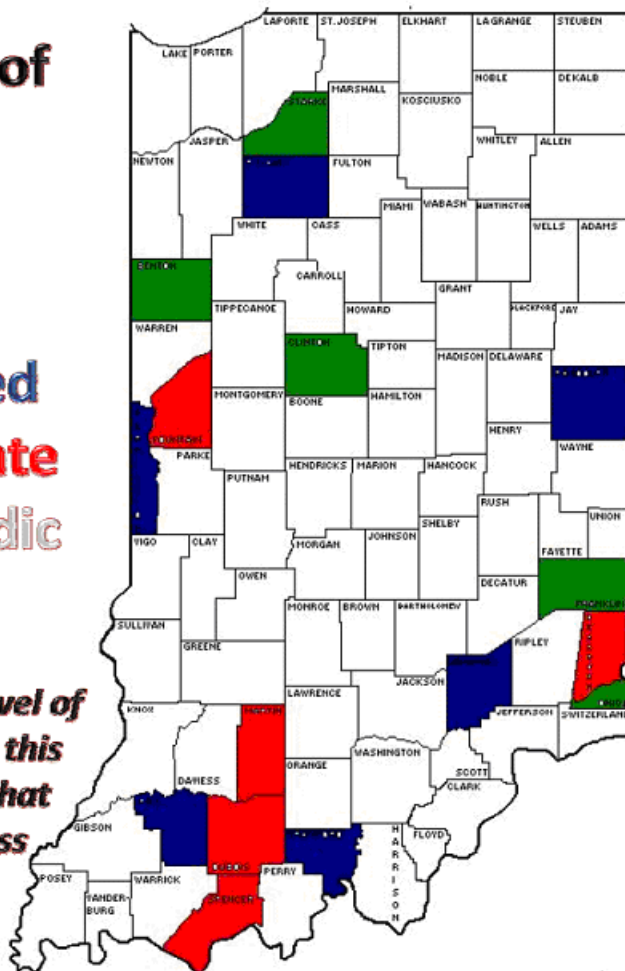


Depicts Highest Level of EMS Care Available (by county)

- GREEN = EMT-Basic**
- BLUE = Basic-Advanced**
- RED = EMT-Intermediate**
- WHITE = EMT-Paramedic**

as of July 2008

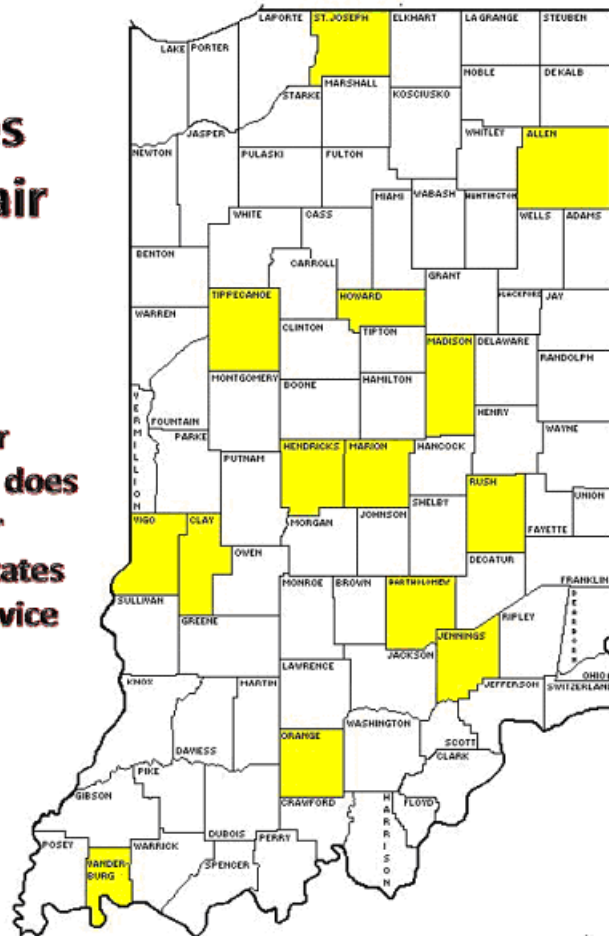
Note: This slide depicts the highest level of EMS care available in each county – this does NOT mean all citizens within that county have full-time “24/7” access to that particular level of care.

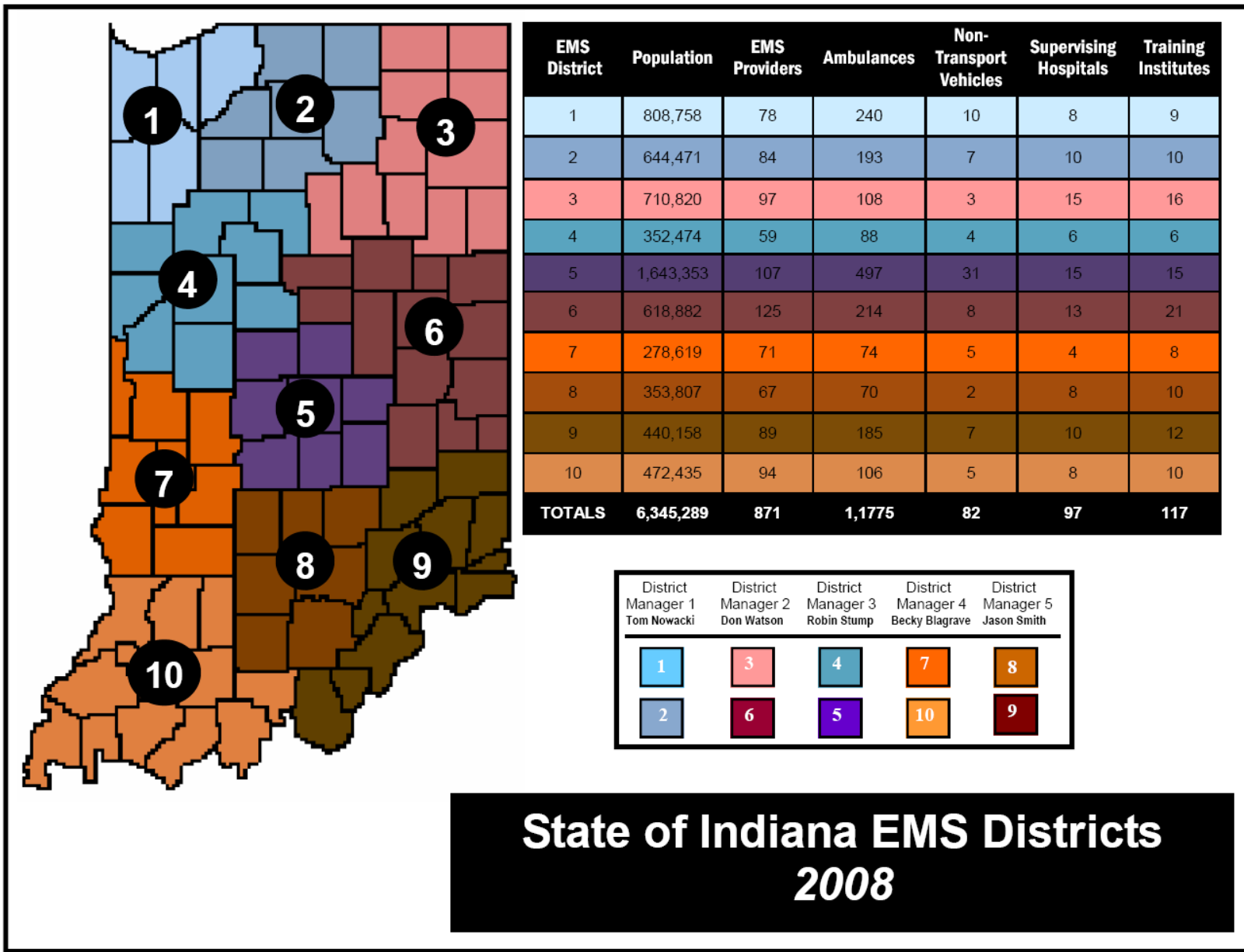


Highlighted Counties show counties with air ambulance bases

as of July 2008

**Note: This slide only depicts air
ambulance bases within Indiana, it does
NOT show Indiana certified air
ambulance services in adjoining states
that may or may not routinely service
portions of Indiana.**





**State of Indiana EMS Districts
2008**

COUNTIES INCLUDED IN EACH DISTRICT

District Manager 1
Tom Nowacki

IN DHS DISTRICT 1

Jasper
Lake
LaPorte
Newton
Porter

District Manager 2
Don Watson

IN DHS DISTRICT 3

Allen
Adams
DeKalb
Huntington
LaGrange
Miami
Noble
Steuben
Wabash
Wells
Whitley

District Manager 3
Robin Stump

IN DHS DISTRICT 4

Benton
Carroll
Cass
Clinton
Fountain
Montgomery
Tippecanoe
Warren
White

District Manager 4
Becky Blagrave

IN DHS DISTRICT 7

Clay
Greene
Owen
Parke
Putnam
Sullivan
Vermillion
Vigo

District Manager 5
Jason Smith

IN DHS DISTRICT 8

Bartholomew
Brown
Jackson
Lawrence
Monroe
Orange
Washington

IN DHS DISTRICT 2

Elkhart
Fulton
Kosciusko
Marshall
Pulaski
Starke
St. Joseph

IN DHS DISTRICT 6

Blackford
Delaware
Fayette
Grant
Henry
Howard
Jay
Madison
Randolph
Rush
Tipton
Union
Wayne

IN DHS DISTRICT 5

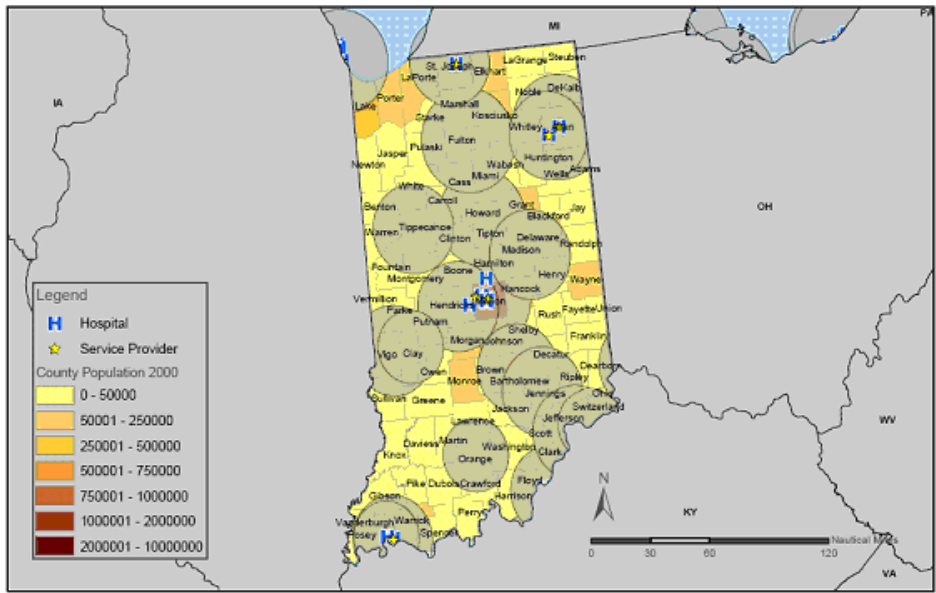
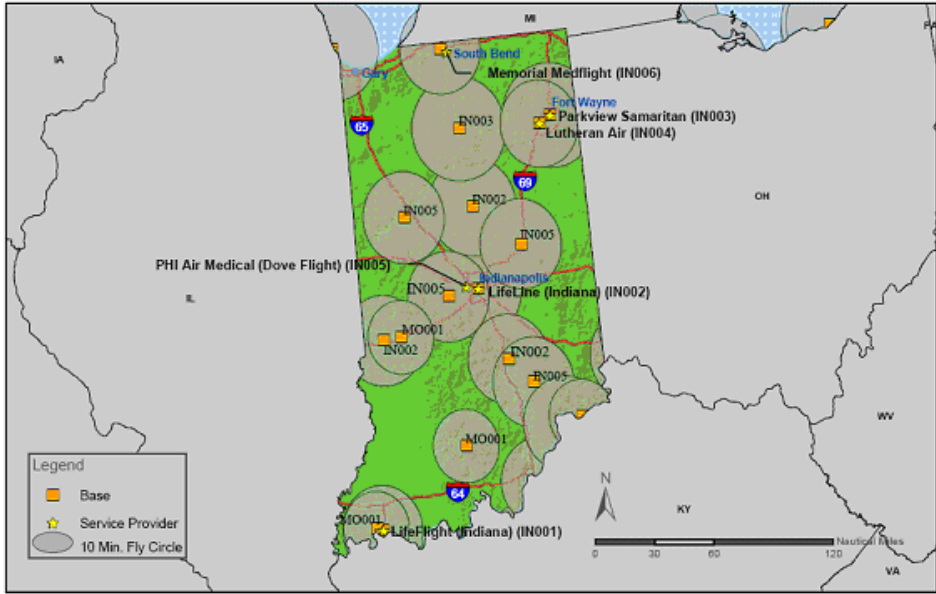
Boone
Hamilton
Hancock
Hendricks
Johnson
Marion
Morgan
Shelby

IN DHS DISTRICT 10

Crawford
Daviess
Dubois
Gibson
Knox
Martin
Perry
Pike
Posey
Spencer
Vanderburgh
Warrick

IN DHS DISTRICT 9

Clark
Dearborn
Decatur
Floyd
Franklin
Harrison
Jefferson
Jennings
Ohio
Ripley
Scott
Switzerland



INDIANA
2007

Air Medical	RW only Services	RW/FW Services	FW only Services	Total Services (Row Sum)
Services Headquartered in State	6	0	0	6
Out-of-State Services with RW or FW Bases in State	1	0	0	1
State Size				
Population (Y2000)			6,080,485	
Geographic Area (Square Miles)			36,420	

Number of Bases & Aircraft Operating in State		
Type	Bases in State	Aircraft in State
Rotor Wing (RW)	16	17
Fixed Wing (FW)	0	0
Total** RW & FW	16	17

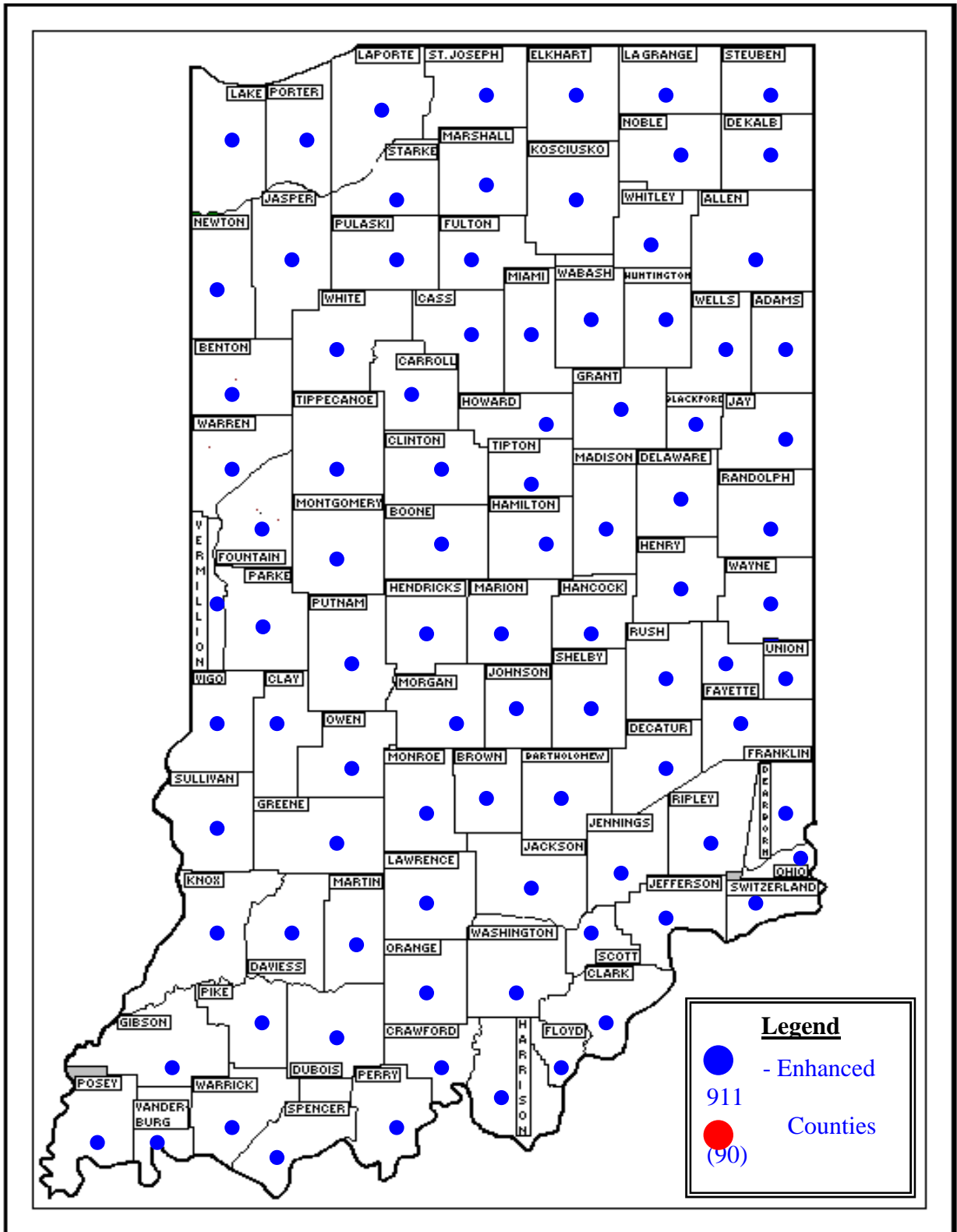
**If a single air medical service has a base with both RW and FW aircraft types, the base is included in RW base inventory AND in FW base inventory, but included only once in Total RW & FW base inventory

Rotor Wing Services (May also have Fixed Wing)							
Provider ID#	Service Name	Base Name / Site	City (IN)	Zip	Type Location	# Aircraft	
						RW	FW
IN001	LifeFlight (Indiana)	St. Mary's Medical Center	Evansville	47750	Hospital	1	
IN002	LifeLine (Indiana)	Howard Regional Health System	Kokomo	46902	Hospital	1	
IN002		Terre Haute International Airport-Hulman Field	Terre Haute	47803	Airport	2**	
IN002		Columbus Regional Hospital	Columbus	47201	Hospital	1	
IN002		Methodist Hospital	Indianapolis	46206	Hospital	1	
IN003	Parkview Samaritan	Rochester Airport / Fulton County Airport	Rochester	46975	Airport	1	
IN003		Parkview Hospital	Fort Wayne	46805	Hospital	1	
IN004	Lutheran Air	Lutheran Hospital	Fort Wayne	46804	Hospital	1	
IN005	PHI Air Medical (Dove Flight)	Dove 1 (Lafayette)	Lafayette	47906	Airport	1	
IN005		Dove 3 (Anderson)	Anderson	46017	Airport	1	
IN005		Dove 4 (Danville)	Danville	46122	Hospital	1	
IN005		Dove 2 (North Vernon)	North Vernon	47265	Hospital	1	
IN006	Memorial Medflight	South Bend Regional Airport	South Bend	46628	Airport	1	
MO001	Air-Evac EMS (Lifeteam)	Brazil (AE39)	Brazil	47834	Helipad	1	
MO001		Paoli (AE17)	Paoli	47454	Hospital	1	
MO001		Evansville (AE46)	Evansville	47710	Hospital	1	

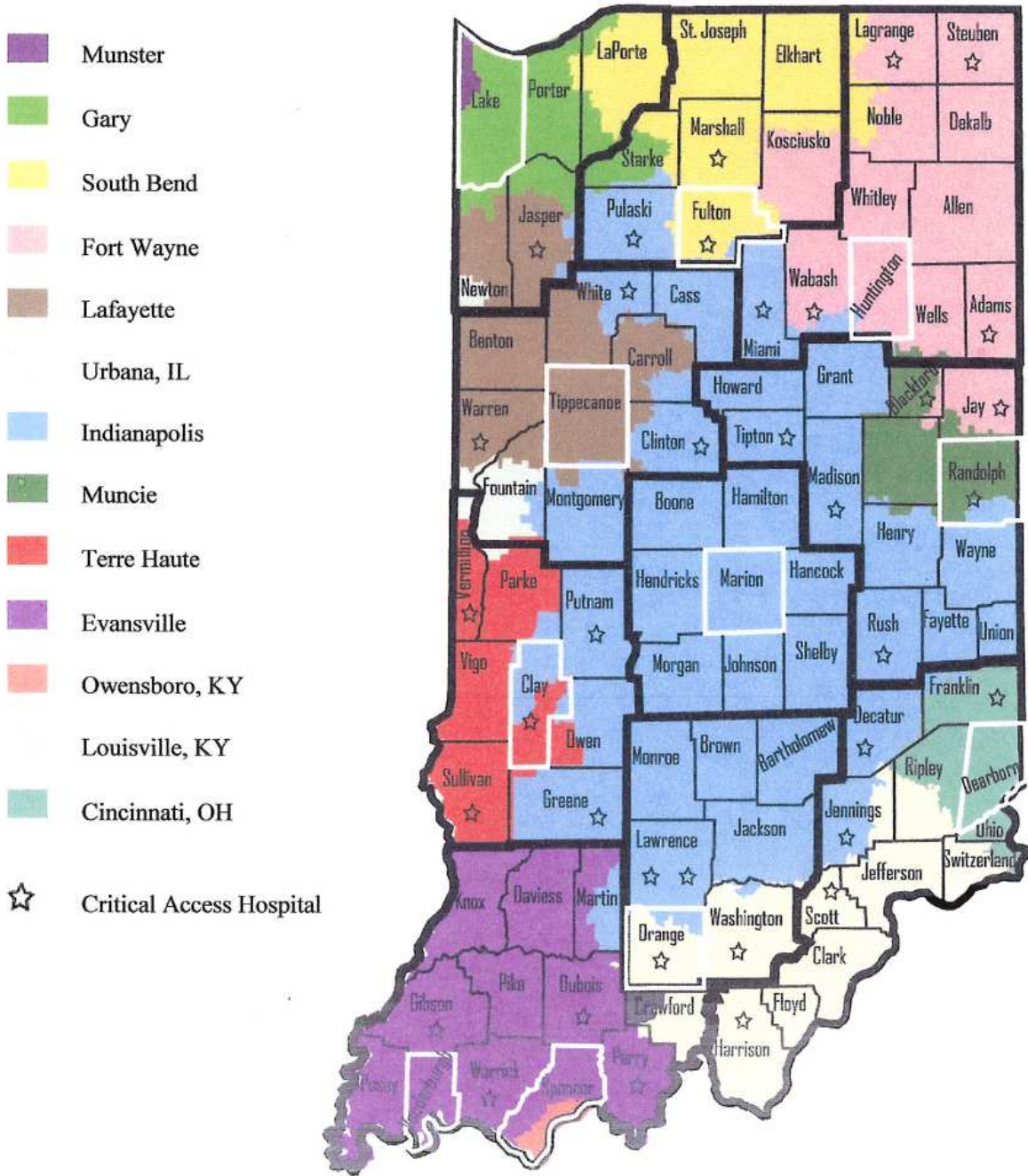
**One is a SPARE.

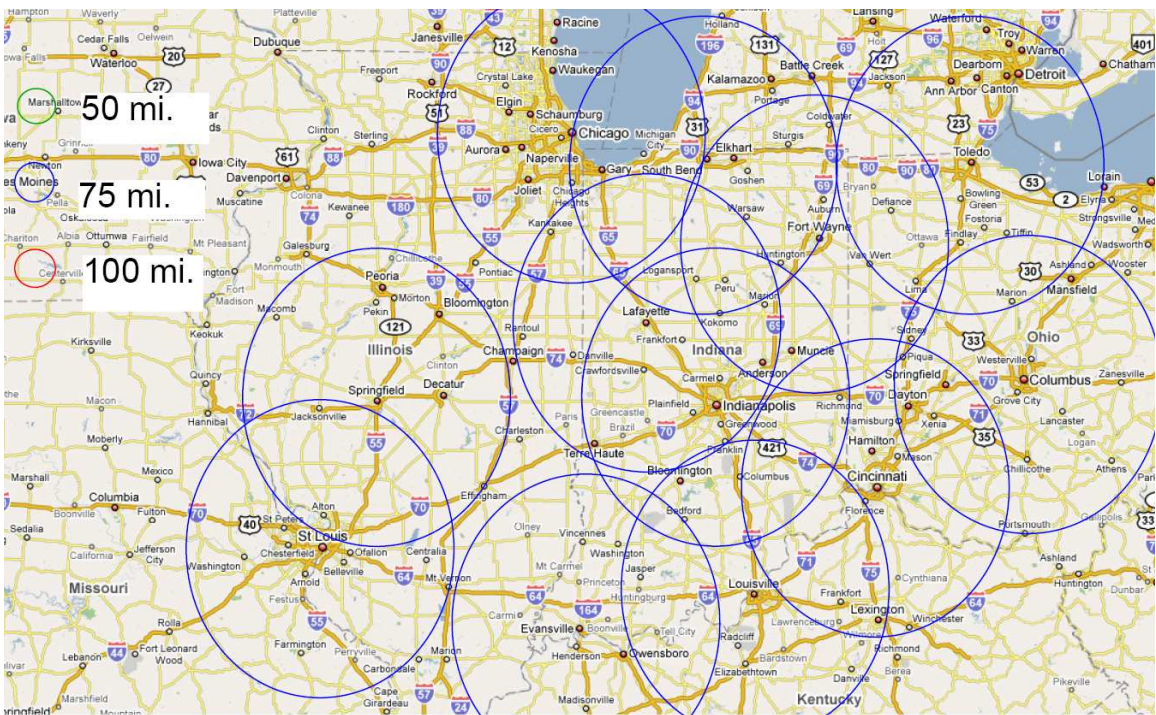
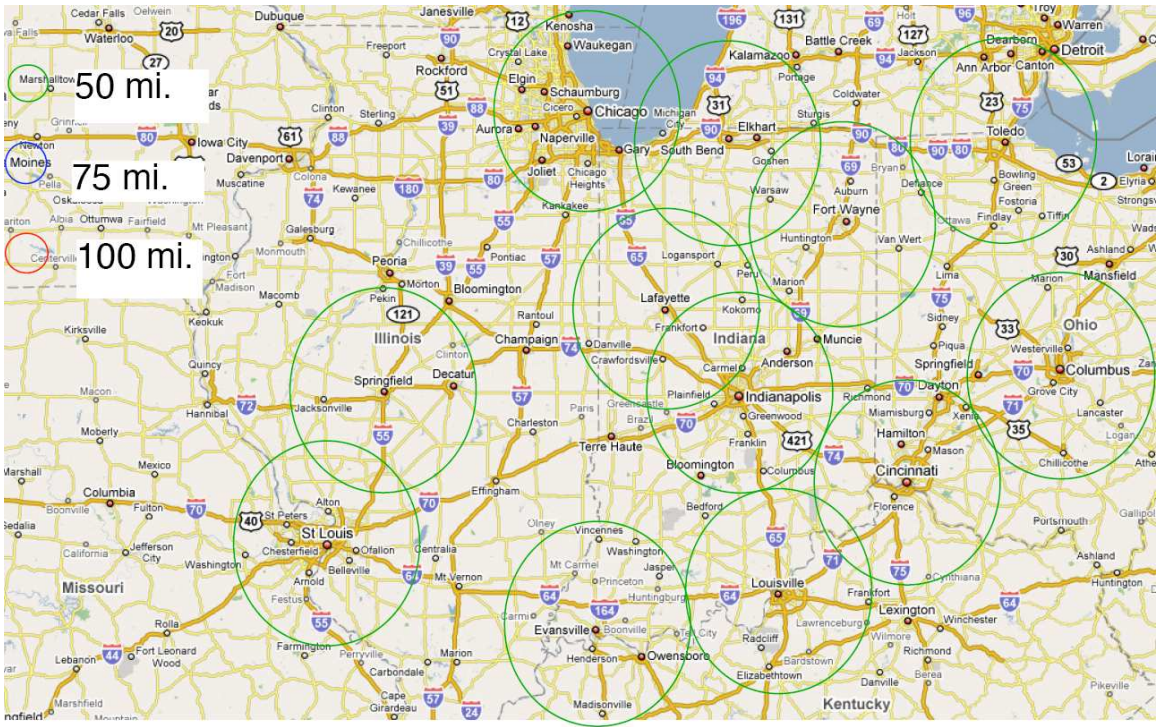
Fixed Wing Only Services					
Provider ID#	FW Service Name	Airport Name	City (IN)	Zip	# FW
NONE					

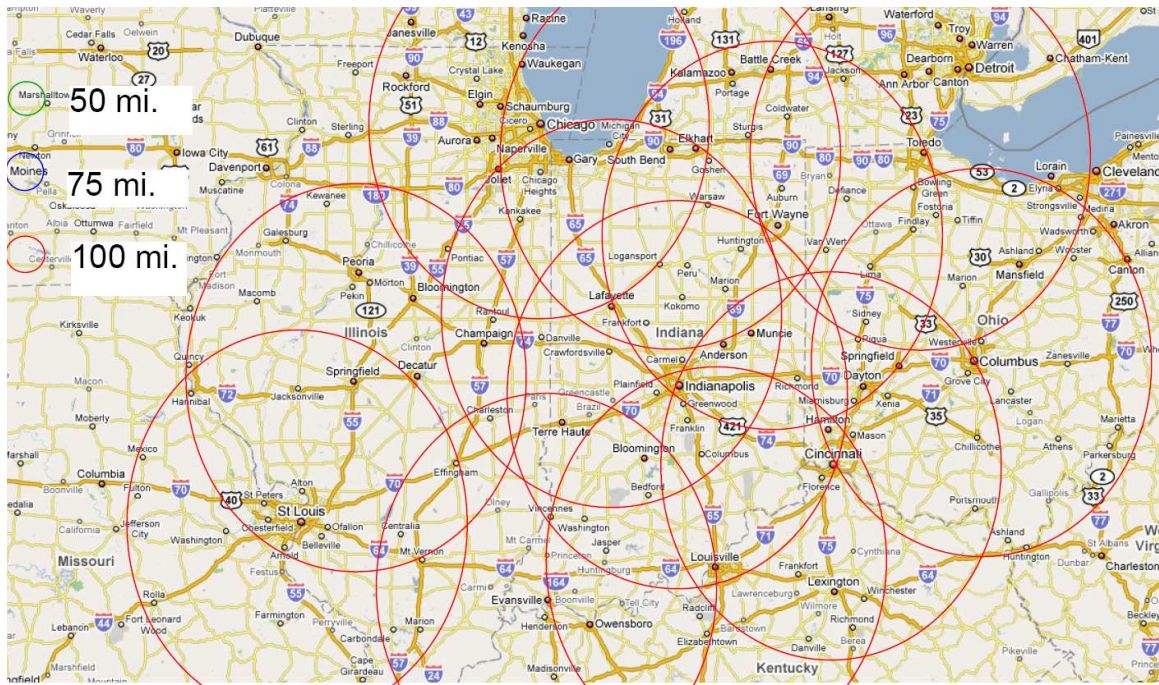
Indiana 911 County System



Hospital Referral Regions







Appendix 7: Trauma Times Newsletter

TRAUMA TIMES

"The heartbeat of Indiana"

Volume 1: Issue 1



INDIANA TRAUMA SYSTEM FACTS

Injury is the leading cause of death from 1 year to 34 years of age. More than 95,000 Hoosiers are hospitalized and more than 5,000 die from injuries each year.

Trauma refers to people who have sustained moderate to severe injuries, requiring rapid evaluation and transport to hospitals with trauma centers that are best equipped to provide the comprehensive care needed. All hospital emergency departments are not trauma centers, as many believe. A trauma system is an organized, coordinated effort in a geographic area that delivers the full range of care to all injured patients. Indiana is one of only two states with no laws or regulations providing legal authority for state oversight of trauma care, a necessary element of a trauma system.

States with trauma systems have a review process to designate hospitals according to the level of care that can be provided to injured patients – ranging from emergency department evaluation and stabilization in smaller hospitals to the most comprehensive levels of care provided in hospitals verified by the American College of Surgeons Committee on Trauma (ACS-COT). Indiana has seven hospitals with Level I or Level II trauma centers (comprehensive care), as verified through a strenuous review process by the American College of Surgeons Committee on Trauma: Evansville – Deaconess and St. Mary’s hospitals; Fort Wayne – Parkview Hospital; Indianapolis – Methodist Hospital, Riley Hospital for Children and Wishard Memorial Hospital; and South Bend – Memorial Hospital.

Indiana trauma system development is being accomplished by the Indiana State Department of Health Trauma System Advisory Task Force, organized in May 2004, by Charlene Graves, MD. The Task Force has broad representation from numerous organizations and individuals interested in developing a statewide trauma care system. Issues being considered by the Task Force include: leadership and authority for a statewide trauma system, policies, legislation and financing needed for such a system, system design, based on data and needs assessments, education of policy-makers, health professionals and the public, information management and quality of care indicators, collaboration, and resources to support a statewide system.

Task Force conclusions thus far:

- The goal of a statewide trauma system is preventing injuries and coordinating care of injured patients to accomplish decreased death and disabilities due to trauma.
- It is desirable for all Indiana hospitals to eventually be part of a statewide trauma system, based on the level of care each hospital is able to provide.
- System participation by hospitals would be voluntary.
- Collaboration between emergency medical services, hospitals, rehabilitation facilities and public health is needed.
- A statewide trauma registry is necessary because it provides a proven mechanism to examine trauma patient care data on a confidential basis.
- Widespread education is needed to inform numerous constituencies (legislators, hospitals, and the public) about a statewide trauma system.

Trauma is an important public health and health care delivery issue because of its major impact on the lives and health of Hoosiers.

TRAUMA SYSTEM DEVELOPMENT

Indiana is in the process of establishing a voluntary, statewide system of trauma care. A trauma system is a pre-planned, comprehensive, and coordinated statewide and local injury response network that includes all medical facilities with the capability to care for the injured.

There are four primary components of the trauma system: trauma hospital designation criteria; trauma registry; EMS/pre-hospital triage and transport guidelines; and inter-facility (hospital to hospital) transfer guidelines.

Trauma-specific statewide multidisciplinary, multi-agency advisory committee meetings are important for planning, implementing, and evaluating the state trauma care system. To that end, the 50-member ISDH Trauma System Advisory Task Force, with representation from numerous stakeholders interested in trauma system development, has been meeting on a quarterly basis since May of 2004.



With support from resolutions by both the ISMA and the Emergency Nurses Association in 2005, legislation was enacted in 2006 (Public Law 155) designating the Indiana State Department of Health as the lead state agency for trauma system development. The Task Force is currently working on criteria for designation of Indiana hospitals for various levels of trauma care, which will eventually become administrative rules that define Indiana's trauma care system.

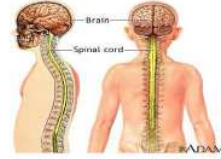
TRAUMA REGISTRY

The trauma registry (www.indianatrauma.org) is the foundation component that supports the others, providing the ability to monitor the system for efficiency and effectiveness, including local level use for improved patient care and outcomes. The Indiana Trauma Registry was implemented in 2007, with initial participation by the seven hospitals in Indiana that are verified as Level I or Level II trauma centers by the American College of Surgeons Committee on Trauma (ACS-COT). The hospitals involved are: Deaconess and St. Mary's hospitals in Evansville; Parkview Hospital in Fort Wayne; Methodist Hospital, Riley Hospital for Children, and Wishard Memorial Hospital in Indianapolis; and Memorial Hospital in South Bend.

Several other Indiana hospitals have volunteered to participate in the initial phase of the registry. In 2008, there will be 20 rural hospitals voluntarily participating in a pilot project on utilization of the registry. The vendor that was chosen for the registry is Image Trend from Minneapolis. Image Trend has conducted tests to ensure the compatibility of the program with the data from the Firehouse reporting software that is being used by EMS and paramedics; linkage with the Firehouse system will occur when firehouse upgrades are completed in 2008.



Indiana Spinal Cord and Brain Injury Research Board ISCBIRB



The law (PL 234-2007 Sections 43-48) establishing the Indiana Spinal Cord and Brain Injury Research Fund was enacted, effective July 1, 2007. This dedicated fund is created to support spinal cord and brain injury research activities within the state of Indiana, as well as the establishment and maintenance of a medical surveillance registry for Indiana for traumatic spinal cord and brain injuries.

This law created a nine (9) member board to oversee the distribution of these funds

- Brain Injury Association of Indiana: Dr. Lance Trexler
- Indiana University: Dr. Paul Nelson
- National Spinal Cord Injury Association: Mrs. Janeen Earwood
- Purdue University: Dr. Alan Rebar
- Rehabilitation Hospital of Indiana: Mrs. Annette Seabrook

Governor appointments were made in November, 2007.

- Dr. Chuck Dietzen (physiatrist holding board certification from the American Board of Physical Medicine and Rehabilitation)
- Dr. Henry Feuer (physician who has specialty training in neuroscience and surgery)
- Mr. Ronald Henriksen (representative of the technical life sciences industry)
- Mr. Bob Setree (individual with a spinal cord or head injury or who has a family member with a spinal cord or head injury)



The initial board meeting was held on December 12, 2007 at the Indiana State Department of Health. Items on the agenda included: introduction of board members, review of financial details (current funding level: \$622,960), overview of legislation, overview of the current state of the Indiana Trauma Registry, discussions regarding priorities and first steps, and a discussion concerning funding security.

Next steps are to formulate an agenda and present proposed plan to the Governor, the Indiana General Assembly, and possibly the media to show funding is being spent according to findings of the symposium and the current state of research in Indiana. Once these opportunities are identified, funding will be disbursed, and research will commence. Reports and detailed receivables will ensure compliance and return on investment.



**Indiana Spinal Cord and Brain Injury Research Fund
2008 Preliminary Plan**

First Quarter	<ul style="list-style-type: none"> • Approve By-laws • Elect Officers • Finalize contractual agreements for Administrative Support and Scientific Reviewers • Develop Indiana Spinal Cord and Brain Injury Research Symposium. Symposium to be held in central location and bring together representatives from throughout the state to discuss current research activities, as well as future opportunities and priorities. Governmental, academic, advocacy and health care organizations to be represented, as well as representation for individuals with these disabilities. • Create draft of initial grant offerings and grant review process
Second Quarter	<ul style="list-style-type: none"> • Host the Indiana Spinal Cord and Brain Injury Research Symposium • Finalize grant review process including types of grants, grant cycles, applications and processes for distribution • Work with ISDH on contractual agreements for next period • Assess opportunity for development of web page within ISDH
Third Quarter	<ul style="list-style-type: none"> • Develop scientific review panel • Announce call for first grants and accept applications for first grant cycle • Identify needs surrounding collaborative state medical surveillance registry for traumatic spinal cord and brain injuries.
Fourth Quarter	<ul style="list-style-type: none"> • Announce first recipients of grants from the Indiana Spinal Cord and Brain Injury Research Fund • Analyze process of first grant cycle for improvements in 2009 • Dependant upon identified grant cycles, begin process for next grant cycle

- ***In-state trauma conferences:***
 - Memorial Hospital, South Bend: March 15, 2008
 - Clarian Methodist Hospital, Indianapolis: April 18, 2008
 - Parkview Hospital, Fort Wayne: May 9, 2008
 - Wishard Hospital, Indianapolis: November 7 & 8, 2008
 - Deaconess Hospital, Evansville: November 14[&] 15, 2008

2008 Trauma Task Force Meetings:

- ISDH Trauma System Advisory Task Force Meetings:
 - February 15, 2008
 - May 2, 2008
 - August 1, 2008
 - November 21, 2008

If you are interested in attending or have questions regarding trauma care in Indiana, please contact:

Susan Perkins, RN, BSN, CCRC
 Trauma System Manager/Rural Health Liaison
 2 North Meridian St, 6B
 Indianapolis, IN. 46204
sperkins@isdh.IN.gov



TRAUMA TIMES



TRAUMA REGISTRY UPDATE

Inside this issue:

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Injury Prevention	2
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Wishard and Riley Hospitals have successfully exported trauma data from their trauma registries into the state registry. They are currently comparing selected records from the state registry to the data in their hospital registries to verify that data transferred without errors. Deaconess and Memorial South Bend have also just imported their first data and are awaiting data validation. CDM, the vendor for the St. Mary's and Parkview trauma registries is expected to have their export ready later this month. Clarian Methodist has experienced a data corruption issue and is working with their vendor to resolve this before attempting a state import.

State server issues have been resolved, and the state is now proceeding with the Critical Access Hospital pilot project. A letter was sent out to all Critical Access Hospitals to explain the project in detail, and 15 hospitals chose to participate. The project is running from June 1, 2008 through July 31, 2008. The participating hospitals are reporting on the critically injured patients that require transfer to a higher level of care. Data gathered during this project will assist with trauma system planning efforts.

Laura Gano, an MPH student at IU, will be starting an internship with the trauma registry on August 5th. She will analyze data from the CAH project and assist with other registry projects.

INTERESTING INDIANA TRAUMA SYSTEM FACTS:

- ◆ Injury is the leading cause of death from 1 year to 34 years of age.
- ◆ More than 95,000 Hoosiers are hospitalized and over 5,000 die from injuries each year.
- ◆ Indiana is 1 of only 2 states with no laws or regulations providing legal authority for state oversight of trauma care.

The trauma registry is available to all hospitals in the state. If your hospital is interested in more information about the trauma registry, contact the state trauma system manager, Susan Perkins, at sperkins@isdh.in.gov.

EMS LEGISLATIVE UPDATE

Second Regular Session 115th General Assembly (2008)

SENATE ENROLLED ACT No. 249: This bill requires the Emergency Medical Services Commission to adopt rules concerning triage and transportation protocols for the transportation of trauma patients consistent with the field triage decision scheme of the American College of Surgeons Committee on Trauma. The EMS division of the Department of Homeland Security has implemented a workgroup to work on these protocols. For more information on the workgroup's activities contact Jason Smith at jsmith@idhs.in.gov.



INJURY PREVENTION



ATVs are a popular but dangerous form of entertainment, with 7 million currently in use in the United States. Currently marketed as 4-wheelers, the original 3-wheeled ones that came out as alternatives to off-road motorcycles caused so many injuries that the manufacturers were required to take them off the market.

The U.S. Consumer Product Safety Commission reported 916 ATV-related fatalities nationwide from 2002 to 2006. Indiana Emergency Medical Services reported 311 ambulance runs due to ATV injuries during 2007. Researchers from Oklahoma reported on 193 patients they treated over a 2-year period. While only 3 were fatalities, 50% of patients suffered head injuries, and while children represent only 14% of all ATV users, they accounted for 47% of injuries (of those, 30% involved brain or spinal cord injuries).

Donald Reed, MD
Trauma Medical Director
Lutheran Hospital



INDIANA TRAUMA SYSTEM CONSULTATION VISIT

Indiana is actively in the process of developing a trauma system. In 2006, the Indiana General Assembly passed and the governor signed legislation empowering the Indiana State Department of Health (ISDH) to develop a trauma system in the state (P.L. 155-2006). The ISDH created a Trauma Systems Advisory Task Force to help in the development of this system.

After 2 years of study, the task force recommends pursuing a consultation agreement with the Committee on Trauma of the American College of Surgeons, a non-biased, nationally-recognized organization. They would be charged to evaluate the resources, legislation, trauma care delivery, trauma registries/data analysis, performance improvement, interagency cooperation/communication, professional/community education, and injury prevention and control currently in Indiana. They would make available their knowledge and experience of other states to develop the trauma system in Indiana that works for everyone. This consultation requires intensive advance preparation, a 3-day visit from the College and includes professionals from surgery, emergency medicine, trauma nursing and emergency medical services.

The 7 trauma hospitals in Indiana verified by the American College of Surgeons Committee on Trauma have contributed \$10,000 each to fund this consultation, which is expected to cost \$60-70,000. If funds received exceed the total amount needed for the consultation, the remaining funds will be added to funds being requested from the ISDH Office of Rural Health and commercial health insurers in Indiana to begin implementation of the ACS recommendations and to support educational needs for all trauma system components.

The Indiana Hospital Association has agreed to collect and distribute the financial support.

AUTHORS:

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Chair, Indiana Committee on Trauma



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DEFINITIVE CARE FACILITIES “What sets them apart?”

The **Level I** facility is a regional resource trauma center that is a tertiary care facility central to the trauma care system. Ultimately, all patients who require the resources of the Level I center should have access to it. This facility must have the capability of providing leadership and total care for every aspect of injury, from prevention through rehabilitation. In its central role, the Level I center must have adequate depth of resources and personnel. Because of the large personnel and facility resources required for patient care, education, and research, most Level I trauma centers are university-based teaching hospitals. Other hospitals willing to commit these resources, however, may meet the criteria for Level I recognition. In addition to acute care responsibilities, Level I trauma centers have the major responsibility of providing leadership in education, research, and system planning. This responsibility extends to all hospitals caring for injured patients in their regions. Medical education programs include residency program support and postgraduate training in trauma for physicians, nurses, and prehospital providers. Education can be accomplished through a variety of mechanisms, including classic continuing medical education (CME), trauma and critical care fellowships, preceptorships, personnel exchanges, and other approaches appropriate to the local situation. Research and prevention programs, as defined in this document, are essential for a Level I trauma center.

The **Level II** trauma center is a hospital that also is expected to provide initial definitive trauma care, regardless of the severity of injury. Depending on geographic location, patient volume, personnel, and resources, however, the Level II trauma center may not be able to provide the same comprehensive care as a Level I trauma center. Therefore, patients with more complex injuries may have to be transferred to a Level I center (for example, patients requiring advanced and extended surgical critical care). Level II trauma centers may be the most prevalent facility in a community, managing the majority of trauma patients. The Level II trauma center can be an academic institution or a public or private community facility located in an urban, suburban, or rural area. In some areas where a Level I center does not exist, the Level II center should take on the responsibility for education and system leadership.

The **Level III** trauma center serves communities that do not have immediate access to a Level I or II institution. Level III trauma centers can provide prompt assessment, resuscitation, emergency operations, and stabilization and also arrange for possible transfer to a facility that can provide definitive trauma care. General surgeons are required in a Level III facility. Planning for care of injured patients in these hospitals requires transfer agreements and standardized treatment protocols. Level III trauma centers are generally not appropriate in an urban or suburban area with adequate Level I and/or Level II resources.

The **Level IV** trauma facilities provide advanced trauma life support before patient transfer in remote areas where no higher level of care is available. Such a facility may be a clinic rather than a hospital and may or may not have a physician available. Because of geographic isolation, the Level IV trauma facility is the de facto primary care provider. If willing to make the commitment to provide optimal care, given its resources, the Level IV trauma facility should be an integral part of the inclusive trauma care system. As at Level III trauma centers, treatment protocols for resuscitation and transfer, data reporting, and participation in system performance improvement are essential. A Level IV trauma facility must have a good working relationship with the nearest Level I, II, or III trauma center. This relationship is vital to the development of a rural trauma system in which realistic standards must be based on available resources. Optimal care in rural areas can be provided by use of existing professional and institutional resources supplemented by guidelines that result in enhanced education, resource allocation, and appropriate designation for all levels of providers. Also, it is essential for the Level IV facility to have the involvement of a committed health care provider who can provide leadership and sustain the affiliation with other centers. An inclusive system should leave no facility without direct linkage to a Level I or Level II trauma center. This association should facilitate transfer of seriously injured patients who require a higher level of care. Exchange of medical personnel between Level I/II and Level III/IV facilities may be an excellent way to develop this relationship. The Level I and II trauma centers have an obligation to extend their education to rural areas in the form of Introduction professional education, consultation or community outreach. A mechanism should provide feedback about individual patient care and outcome analysis to the referring hospital.

Committee on Trauma American College of Surgeons, Resources For Optimal Care of the injured Patient 2006, p. 18, 19,20, 2006.



INDIANA ENA OUTREACH GRANT

On June 24, 2008, the Christopher Reeve Paralysis Foundation granted the Indiana State Council of the Emergency Nurses Association \$15,000 to do additional outreach and teaching of the Emergency Nurses Pediatric Course (ENPC) and the Trauma Nursing Core Course (TNCC). This grant especially entices and encourages rural Indiana nurses to gain verification of these basic core trauma skills. These grant funds are not restricted to only critical access facilities, but are for any rural facility. In particular, these funds are to be targeted to facilities which receive trauma patients and frequently have to stabilize, package, and transfer to a higher level of care. It is encouraged that all who teach any TNCC or ENPC course actively reach out to any and all nurses who face trauma patients in rural or outlying facilities. These facilities potentially qualify to have each of their attendees receive \$100 off of the course fee with no limitation to the total number of attendees qualified to receive the decreased rate.

The funds are available through the Indiana State Council of the Emergency Nurses Association. Contact person is Merry Addison, RN, MSN, CEN-grant writer, at larrymerry@mail.ccsdana.net or 765-665-3667.

RESEARCH SYMPOSIUM

On April 17, 2008 the Indiana Spinal Cord and Brain Injury Research Board held its first research symposium at the Indiana History Center in downtown Indianapolis. The program was well-received by the approximately 90 people who attended.

Attendees were representative of several areas with an interest in spinal cord and brain injury, including neurosurgery, neuropsychology, vocational rehabilitation, trauma, injury prevention, traumatic brain injury survivors, universities and public health.

Gerry Oxford, PhD, of the Stark Neurosciences Research Institute at the IU School of Medicine welcomed everyone and was followed by Annette Seabrook, PT, of the Rehabilitation Hospital of Indiana and Chairperson of the Research Board, who spoke on the history of the Indiana Spinal Cord and Brain Injury Research Fund. Chuck Dietzen, MD, of Crossroads Rehabilitation Center, the Timmy Foundation, and the Research Board, discussed the epidemiology and health care costs for SCI and TBI. Research projects were presented in both the morning and afternoon sessions, and attendees were introduced to the Indiana TBI grant and related programs. A panel discussion wrapped up the days events. The Board used information from presenters and attendees to guide its first research grant application process, which is currently underway. The first grant awards will be distributed by the end of 2008.

2008 Trauma Task Force Meetings:
ISDH Trauma System Advisory Task
Force Meeting:
♦ November 21st, 2008

In-State Trauma Conferences:
♦ Wishard Hospital, Indianapolis:
November 7th & 8th, 2008

♦ Deaconess Hospital, Evansville:
November 14th & 15th, 2008

If you have any suggestions, comments, ideas, etc., please contact the publisher of this newsletter:
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Appendix 8: Hospital Preparedness

Model of an Emergency Prepared Hospital

Indiana State Department of Health (ISDH) has adopted and modified a model emergency prepared hospital from the Center for Disease Control and Prevention (Bioterrorism Readiness Plan: Template for Healthcare Facilities) to assist individual hospitals in achieving the minimum levels of readiness established by the Hospital Preparedness Program (HPP) within the Assistant Secretary for Preparedness and Response (ASPR).

ISDH provides ASPR funds to all willing hospitals for emergency preparedness efforts. To better assist individual hospitals in becoming better prepared and more coordinated, a guide was developed to assist in achieving this goal. This is to act as a guide in developing hospital emergency preparedness efforts. Individual hospitals will need to evaluate and modify this model based on resources and capabilities. However, all participating hospitals must have written procedures for each highlighted component. Highlighted components are ASPR Grant Level-One, Two and Overarching Sub-Capabilities. All other components are encouraged, but not required.

The ISDH Area Hospital Coordinators can provide assistance in emergency preparedness efforts. A model emergency prepared hospital, when fully developed, will have the following components, but not limited to:

Basic Hospital Emergency Preparedness Components

1. Safety/Emergency Preparedness Committee
 - The hospital has a committee to oversee the development and implementation of a hospital emergency operations plan (EOP).
 - The committee will be composed of numerous hospital employees of various management levels and from various departments, but should have at least the chief medical officer, an executive administrator, infection control and a safety officer.
 - The committee should be chaired by an executive administrator to ensure upper management has knowledge and supports emergency preparedness efforts.
 - The committee will ensure emergency preparedness policies are addressed and implemented in the hospital's EOP.
 - The committee will also ensure the hospital meets all 17 National Incident Management System (NIMS) elements.
 - The hospital's Chief Executive Officer will identify one official Bioterrorism (BT) Coordinator, preferably a safety officer or risk manager, to organize and manage the emergency preparedness efforts as well as represent the facility at the district level.
2. Emergency Operations Plan (EOP)
 - The hospital will designate the BT Coordinator to be responsible for developing, maintaining and implementing the hospital's EOP.
 - The hospital has an EOP, which addresses "all hazards" and coordinates efforts with the local community and district EOP.

- The hospital has a multi-disciplinary Emergency/Safety Committee, which meets regularly to ensure the EOP is being maintained.
 - a. **Surge Bed** the hospital will develop evaluation, discharge and transfer procedures in the event of an emergency.
 - The hospital has a procedure to rapidly discharge, transfer and create additional surge beds in the event of an emergency, natural or unnatural.
 - All hospitals will determine surge beds based on the following calculation:
 - 1) Number of current staffed beds + other beds you could staff in a disaster – average daily census + beds made available from discharged/transfer = potentially available staffed surge bed capacity.
 - The hospital will meet the minimum surge bed level for the community by using the following calculation:
 - 1) County population ÷ 2,000 = minimum surge bed level
 - 2) 3) If a county has multiple hospitals, the following calculation is to be used:
 - 3) County population ÷ 2,000 = ?? ÷ Number of hospitals = surge bed level per hospital.
 - The hospital will participate in the State provided bed and inventory tracking system (EWA Phoenix).
 - b. **Hospital Incident Command System (HICS)**: the hospital will maintain a list of hospital incident commanders and copies of IS – 100, 200, 700 and 800 certificates.
 - The hospital has a process to implement the Hospital Incident Command System (see HICS Guidebook) and to coordinate their HICS with that of other emergency response organizations (local and district – wide).
 - The hospital has provided appropriate staff (i.e. Chief Executive Officer, Chief Fiscal Officer, and Chief Operations Officer) with training (IS-100, IS-200, IS-700, IS-800) regarding the individual’s role and the hospitals role in the county and district EOP.
 - The hospital has adopted the top 8 positions of the HICS and has Job Action Sheets for these 8 positions.
 - The hospital has identified a Hospital Incident Commander (HIC) and a Hospital Command Center (HCC).
 - The hospital incident command team will be educated and trained in all NIMS classes and in the district and state hospital EOP. Developing and maintaining ICS within all Indiana hospitals will maintain NIMS compliance and ensure a more effective and efficient hospital response to an emergency.

- The hospital will provide an overview of its emergency operations plan in new employee orientation.
- c. Alert Message System
 - The hospital has identified a communication mode that will receive “Alert” messages from the Indiana State Department of Health (i.e. IHAN).
 - The hospital has identified the person, who will be responsible for distributing this “Alert” message to the appropriate staff through a hospital emergency call tree.
- d. Surveillance
 - The staff of the hospital has been trained to identify “unusual occurrences.” Staff knows how and to whom to report “unusual occurrences.
- e. Infection Control
 - The hospital has implemented a plan for day-to-day infection control measures. An infection control plan for isolation of patients with communicable diseases and an infection control plan, ready for implementation, for outbreak situations.
 - The hospital has a procedure for the isolation of a surge in the number of patients with communicable diseases.
 - The hospital has at least one negative isolation room.
- f. Communications: the hospital has a policy for conducting monthly internal and external communication tests.
 - The hospital has a communication plan with redundant internal and external interoperable communication systems. If landlines and cell phones are inoperable, hospitals will have back-up communication capabilities.
 - The hospital has a communications plan with redundant communication capabilities with all the hospitals in the district.
 - The hospitals (100%) will have interoperable communication capabilities by August 8, 2008. All hospitals (100%) will also have individual and district-wide 800 MHz radio communication capabilities and will conduct monthly internal and external tests.
- g. Security
 - The hospital has a security management plan, based on a current hazards vulnerability analysis, which includes a designated security officer (or a person designated to assume this role).
 - Staff assigned to security responsibilities have Job Action Sheets and have received the appropriate training to carry out these responsibilities.
 - The hospital has a plan to “lockdown” the facility and to allow only authorized persons to enter.

- A hospital security plan must address how to secure pharmaceuticals and other medical supplies.
- h. **Supplies and Equipment**
- The hospital has sufficient supplies to function on its own for no less than 96 hours.
 - The hospital has signed a Mutual Aid Agreement with the Indiana Hospital Association to allow for the sharing of supplies and personnel.
 - The hospital has agreements with its vendors to obtain supplies in a disaster scenario or has identified alternative resources of supplies if the current vendor cannot deliver supplies as requested in a disaster scenario.
- i. **Personal Protective Equipment:** the hospital will develop a written policy on increasing, maintaining and dispensing PPE to staff.
- The hospital will have no less than a 96 hour supply of PPE for staff (one changer per hour per HCW, based on surge bed calculations and treating communicable diseases).
 - The hospital will use surge bed numbers to determine staffing needs by using the following formula:
Surge beds ÷ 4 = total healthcare providers needed x 96 hrs
 - The hospital has a sufficient supply of “surgical masks” for patients, when necessary and a plan to access additional PPE (local or district) as hospital supplies are depleted.
- j. **Mental Health**
- The hospital has a plan to treat and refer patients and their family members, who may display behavioral health symptoms, resulting from a disaster.
 - The hospital has a plan to treat and refer staff, who may display behavioral health symptoms, resulting from a disaster.
- k. **Business Continuity**
- The hospital has a business continuity of operations plan (COOP) that takes into consideration, but not limited to: Staffing; Finances; Back-up of essential business; Back-up of essential Medical; Records; Emergency Power
- l. **Training**
- The hospital provides immediate training in disaster preparedness to all essential staff and then to all remaining hospital staff over time.
 - Training must include NIMS, the hospital EOP and the district EOP. Training essential staff should be conducted, at minimum, once per year.
- m. **Exercises**
- The hospital exercises its EOP at least twice per year and participates in a district exercise at least once per year.

- The hospital has a protocol in place to modify its EOP in light of recommendations made in an After-Action Reports (AAR) from exercises or actual occurrences.
 - The hospital exercise (functional or tabletop) will test the ICS structure of the hospital.
- n. Collaboration
- The hospital's EOP will coordinate with that of its local health department, emergency management agency, other local hospitals and the district EOP.
 - The hospital BT Coordinator will oversee community and district coordination efforts and report to the hospital's Safety/Emergency Committee.
 - The hospital's Safety/Emergency Committee will update the hospital's EOP on an annual basis and incorporate guidance from the BT Coordinator. Local collaboration is extremely important for maintaining a working hospital emergency operations plan, but also in building community relations.
- o. **Decontamination:** the hospital will develop a written policy on decontamination.
- Hospitals with an emergency department (ED) must have decontamination capability, a Level C (minimum) personal protection capability and a hospital decontamination policy.
 - The hospital with an ED must have the capacity to decontaminate 1 person per 2,000 of population within three hours for both ambulatory and non-ambulatory patients. The formula to calculate minimum level of readiness is:
 - 1) County population ÷ 2,000 =?? Total number of decons within three hours.
- p. District Coordination
- The hospital BT Coordinator will attend and participate in district level hospital preparedness planning.
 - The hospital will comply with the district hospital EOP and participate in a hospital incident command structure for the district. District coordination will be conducted through the hospital's BT Coordinator.
- q. **Disaster Surge Evacuation Plan:** the hospital will develop a written policy on evacuating the hospital during a disaster.
- The hospital will develop, implement and maintain a hospital surge disaster evacuation plan.
 - The hospitals will develop a standard operations plan for the partial or full evacuation of the hospital.
- r. **Needs of Special Population**
- The hospital, through the current hospital vulnerability analysis and community outreach, will assess the special

needs population within the hospital's community and develop an emergency procedure to treat during an emergency, natural or man made.

- s. **Fatality Management Plan:** the hospital will develop a written policy on storing and transferring fatalities.
 - The hospital will work with the local coroner to develop a fatality management plan in the event of a mass casualty or pandemic influenza.
 - The hospital will share plans with neighboring hospitals and local leaders.
- t. **Pandemic Influenza Plan:** the hospital will update a plan that addresses alternate care site(s).
 - The hospital will develop a pandemic influenza plan with local alternate care sites.
 - The hospital will utilize the triage tags and state bed tracking system.
 - The hospital plan will be coordinated with local emergency management agencies and will not supersede any policy released by the state.
 - The hospital plan will incorporate the State triage checklist; alternate site location(s); patient level of care; and medical supplies needed.
- u. **Pharmaceutical Caches:** the hospital will develop a written staff prophylaxis plan.
 - The hospital should maintain or have access to pharmaceutical caches sufficient to cover hospital personnel, hospital based emergency first responders and family members associated with the hospital for a 72-hour time period.
 - The hospital will also develop an anti-nerve agent antidote cache based on hospital size to support the strategically located district CHEMPACKs caches.
 - Hospital Pharmacy Director will develop and maintain a hospital CHEMPACK policy that is coordinated with the district and State CHEMPACK policy.
- v. **Re-Ordering SNS**
 - The Indiana State Department of Health (ISDH), Public Health Preparedness and Emergency Response Division requires Local Health Departments (LHDs) and Hospitals to follow the steps outlined in this document to request re-order SNS material. This procedure along with the attached documents will clarify the SNS re-order process and diminish response time.
 - The hospitals re-order process moves from the hospital to the LHD and from the LHD to ISDH. **Steps for hospitals to request a SNS re-order:**

Step 1: The hospital needs to re-order. The hospital completes the hospital re-order form.

Step 2: The hospital writes a statement on their letterhead. This statement should be signed by an authorized hospital representative and should say that their hospital requires additional resources in order to maintain their ability to treat symptomatic patients directly affected by the event.

Step 3: The hospital then faxes the re-order form and the signed statement to the contact/fax number for their appropriate LHD.

Step 4: When the LHD receives these documents, the LHD staff adds a LHD fax cover sheet and faxes the re-order form and the statement on letterhead from the hospital with the LHD cover sheet to one of the following numbers at ISDH: 317-234-2814, 317-234-3723 or 317-234-3724.

w. **NIMS Compliant**

- The hospital Safety/Emergency Committee will review and comply with all current and future NIMS elements.
- The hospital will develop documentation to show compliance has been met by the hospital for all 17 elements.

Appendix 9: 2005 Child Injury Fatalities

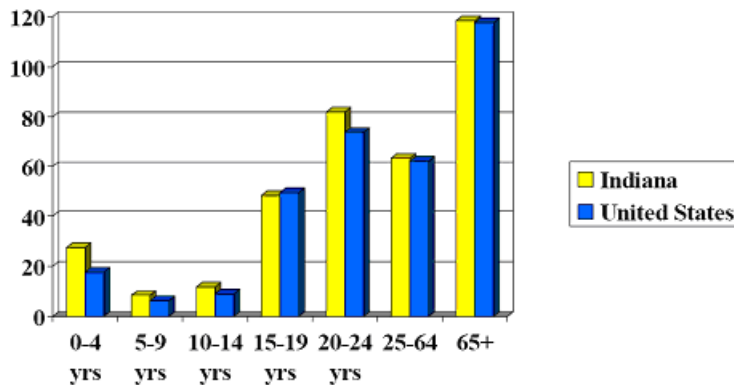
2005 Child Injury Fatalities

Dawn Daniels, DNS, RN, PHCNS-BC
Clinical Nurse Specialist
Riley Trauma Services
Riley Hospital for Children

All raw data is from the CDC WISQARS data base.

1

2005 Fatal Injury Rates*: All Causes

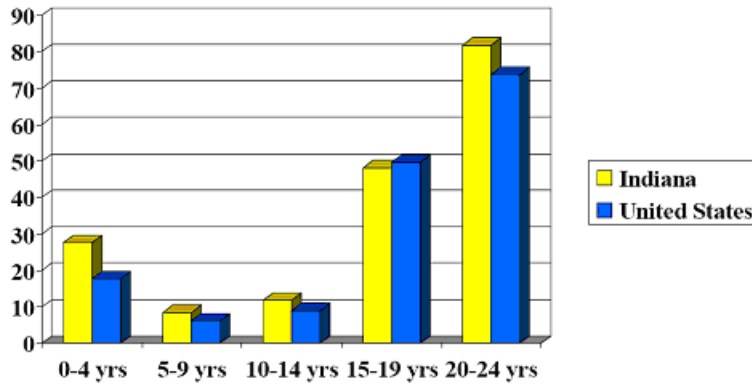


*Rates per 100.00

Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control.
Web-based Injury Statistics Query and Reporting System (WISQARS)

2

2005 Fatal Injury Rates: All Causes

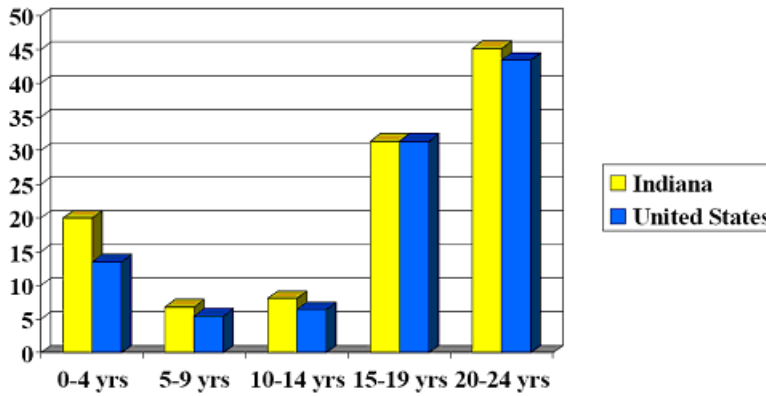


*Rates per 100.00

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Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control.
Web-based Injury Statistics Query and Reporting System (WISQARS)

2005 Unintentional Injury Fatality Rates

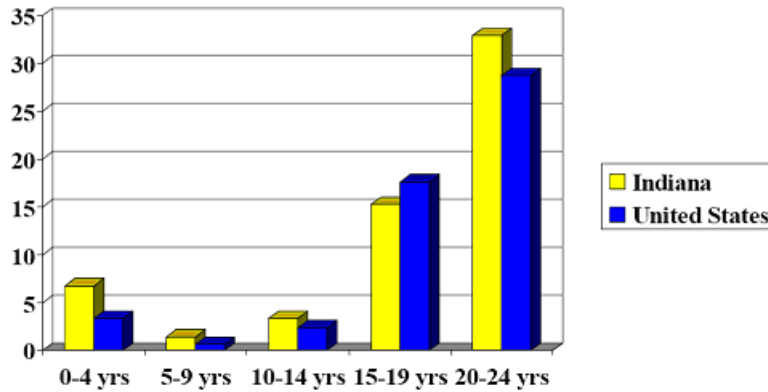


*Rates per 100.00

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Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control.
Web-based Injury Statistics Query and Reporting System (WISQARS)

2005 Intentional Injury Fatality Rates

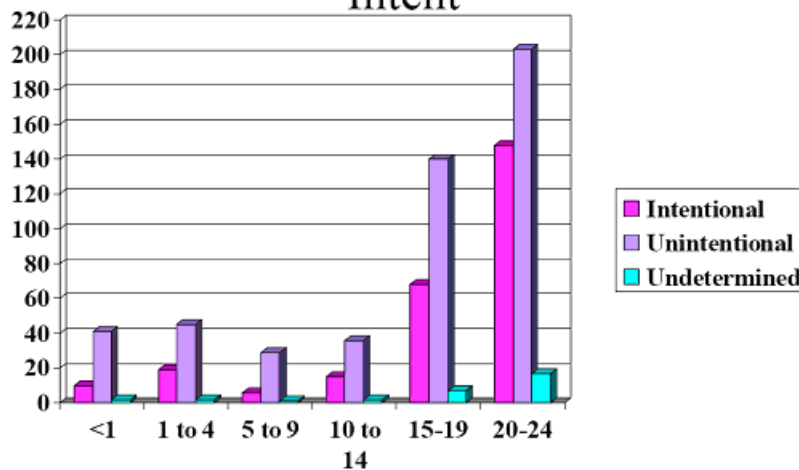


Please note: Indiana rates for 5-9 & 10-14 yr old are unstable
Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control
Web-based Injury Statistics Query and Reporting System (WISQARS)

*Rates per 100,00

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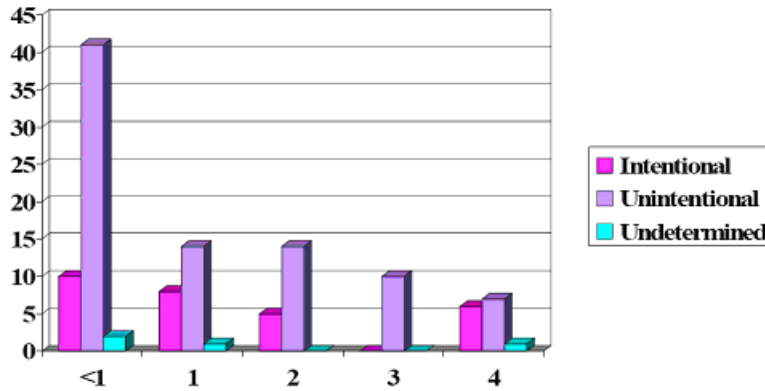
2005 Indiana Fatal Injury Deaths by Intent



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control
Web-based Injury Statistics Query and Reporting System (WISQARS)

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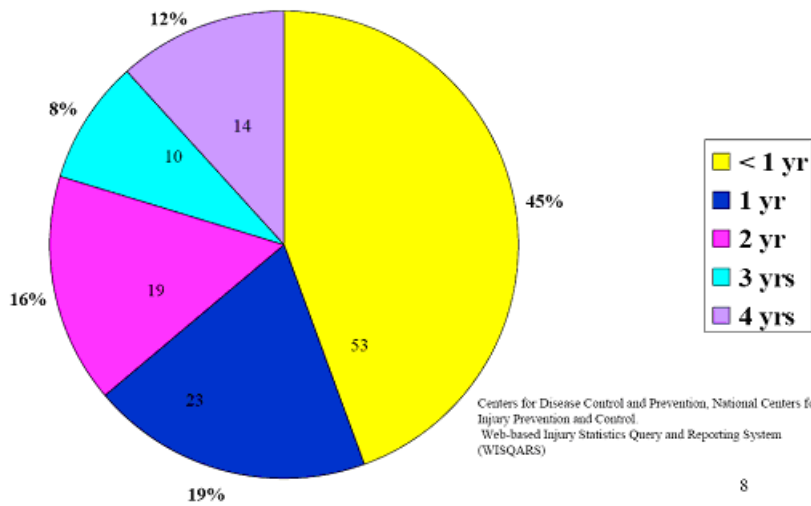
2005 Indiana Fatal Injury Deaths by Intent: Newborn-4 years of Age



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control.
Web-based Injury Statistics Query and Reporting System (WISQARS)

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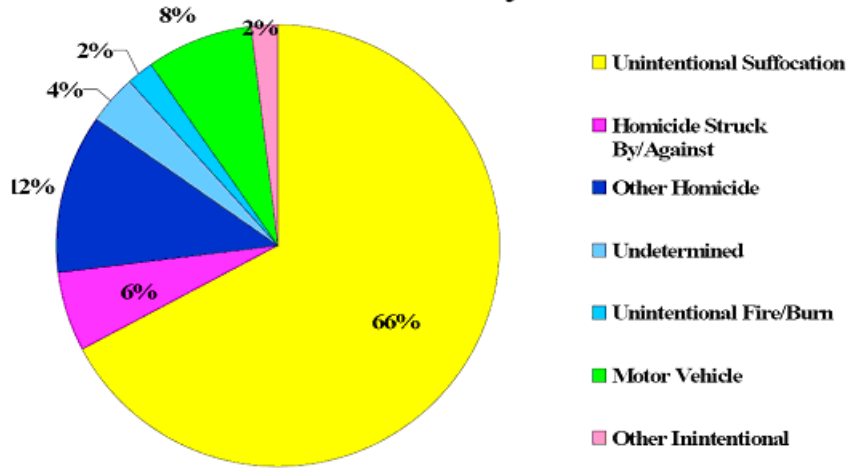
2005 Indiana Injury Fatalities (All Causes) by Age for Children 0-4 yrs



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control.
Web-based Injury Statistics Query and Reporting System (WISQARS)

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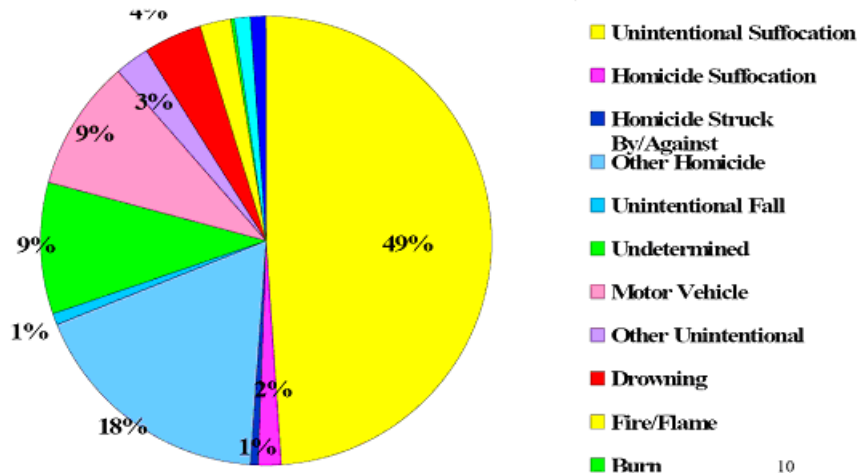
2005 Indiana Fatal Injuries for Children Less than 1 year



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS)

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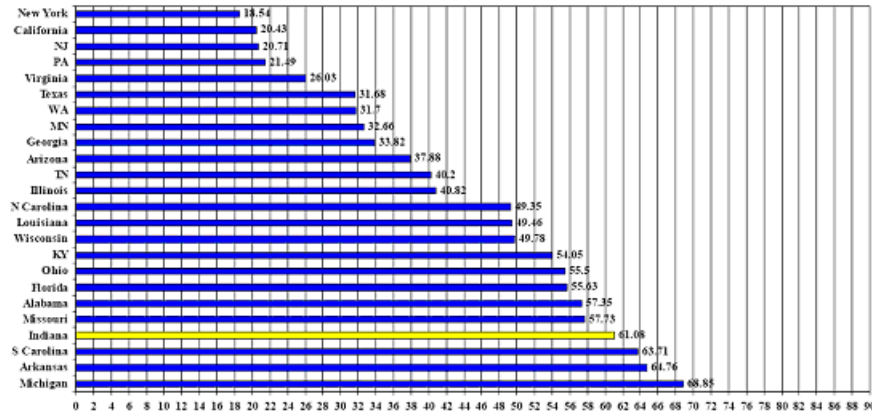
2005 United States Fatal Injuries for Children Less than 1 year



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS)

10

2005 Infant Injury Fatality Rates

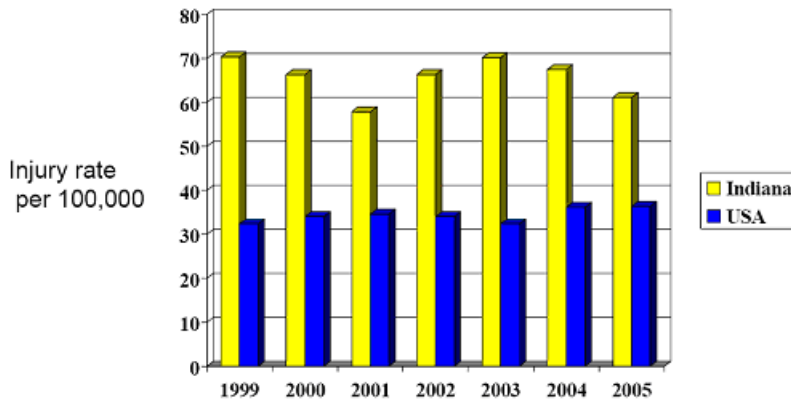


States not represented have unstable rates

Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS)

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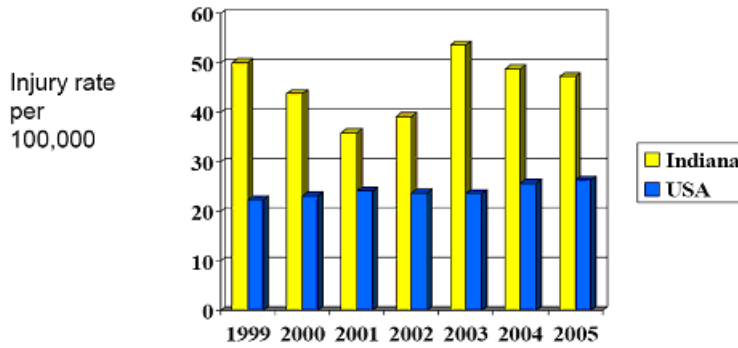
Injury-related deaths—Indiana Infants, 1999-2005



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS)

12

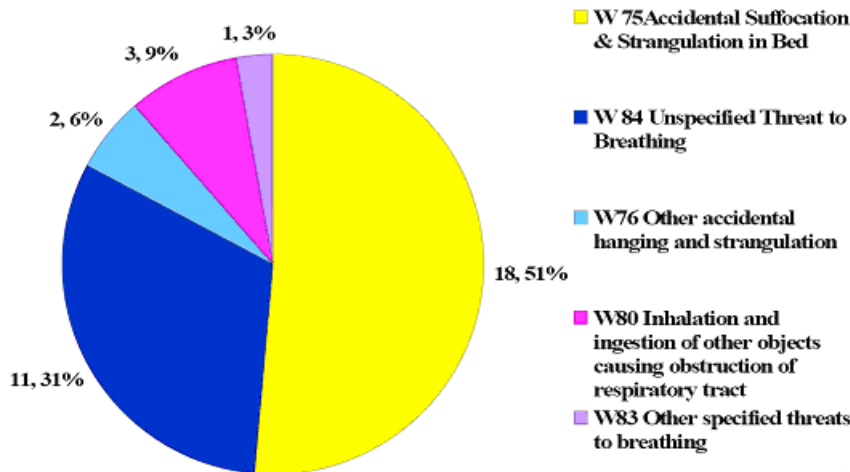
Unintentional injury-related fatalities Infants, 1990-2005



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control
Web-based Injury Statistics Query and Reporting System (WISQARS)

13

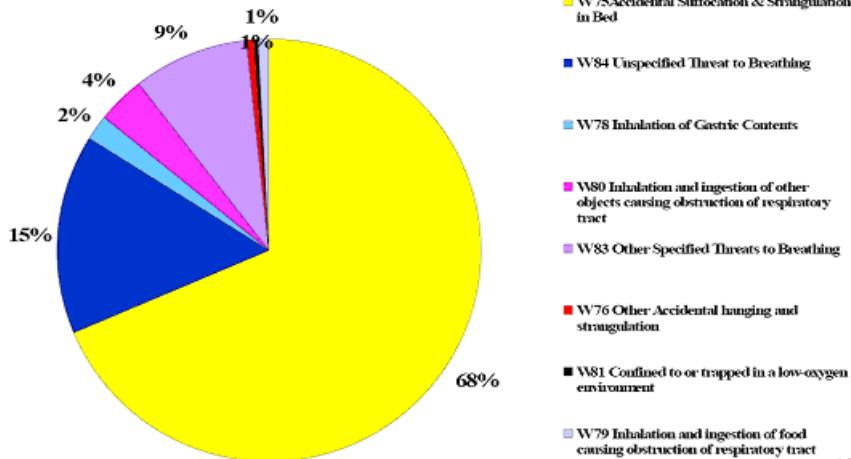
2005 Indiana Unintentional Suffocations for Children Less Than One Year of Age



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control
Web-based Injury Statistics Query and Reporting System (WISQARS)

14

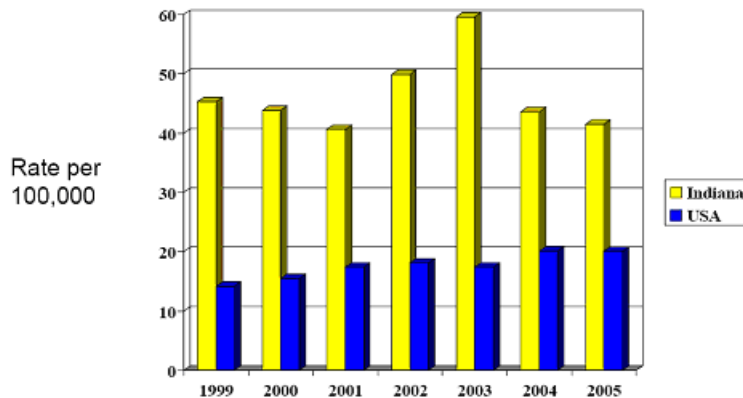
2005 United States Unintentional Suffocations for Children Less Than One Year of Age



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control
Web-based Injury Statistics Query and Reporting System (WISQARS)

15

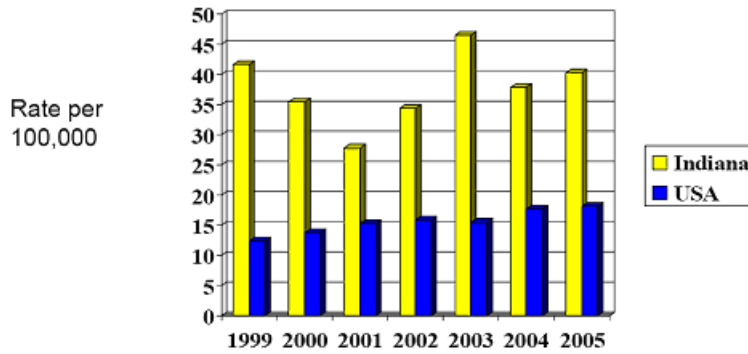
Suffocation deaths, Infants 1999-2005



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control
Web-based Injury Statistics Query and Reporting System (WISQARS)

16

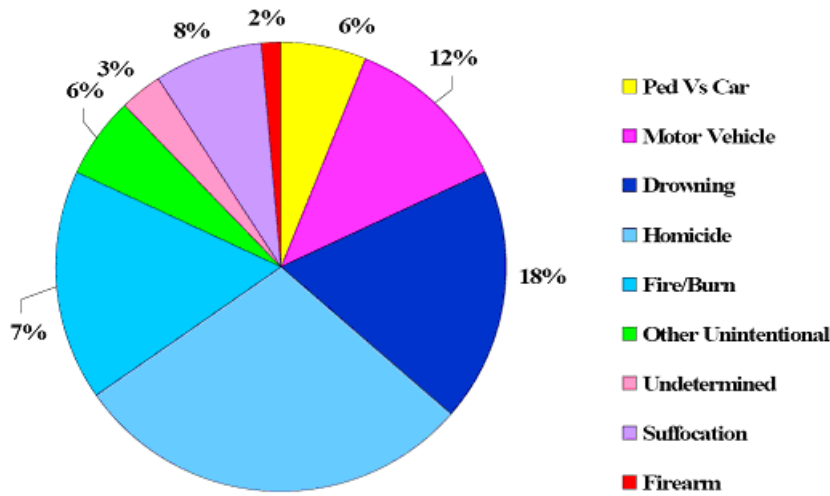
Unintentional suffocation deaths Infants, 1999-2005



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS)

17

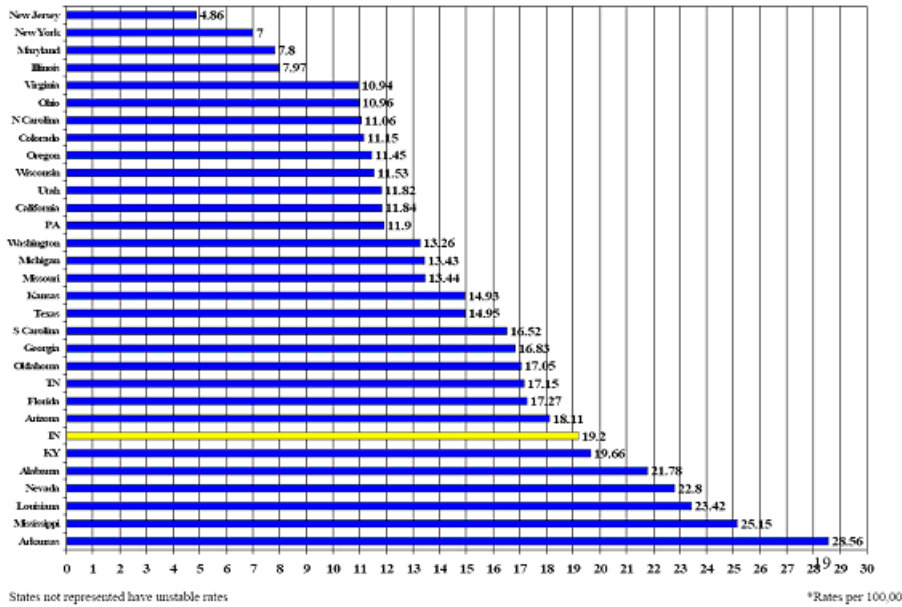
2005 Indiana Fatal Injuries for Children 1-4 Years



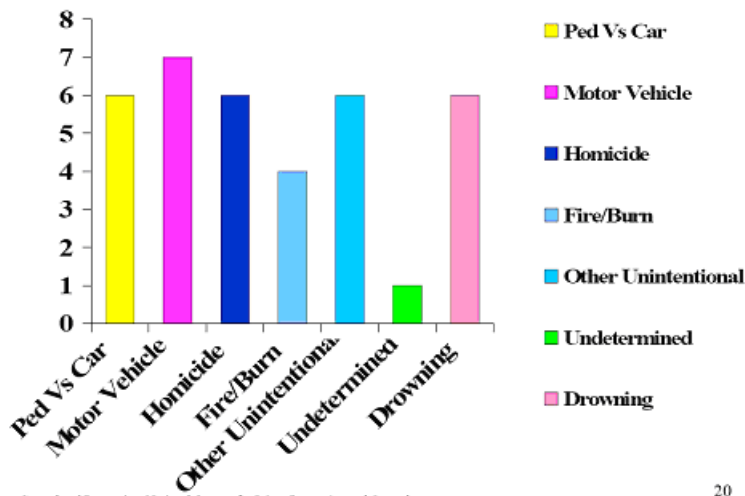
Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS)

18

2005 Fatality Rates by State: Ages 1-4

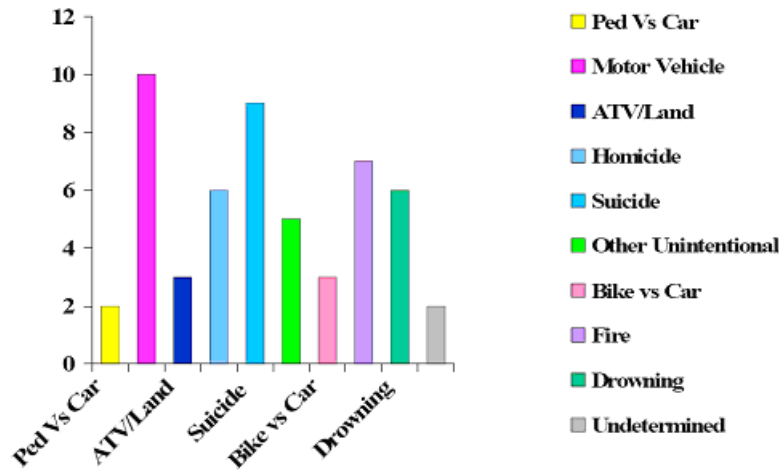


2005 Indiana Fatal Injuries for Children 5-9 Years



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control
Web-based Injury Statistics Query and Reporting System (WISQARS)

2005 Indiana Fatal Injuries for Children 10-14 Years



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS)

21

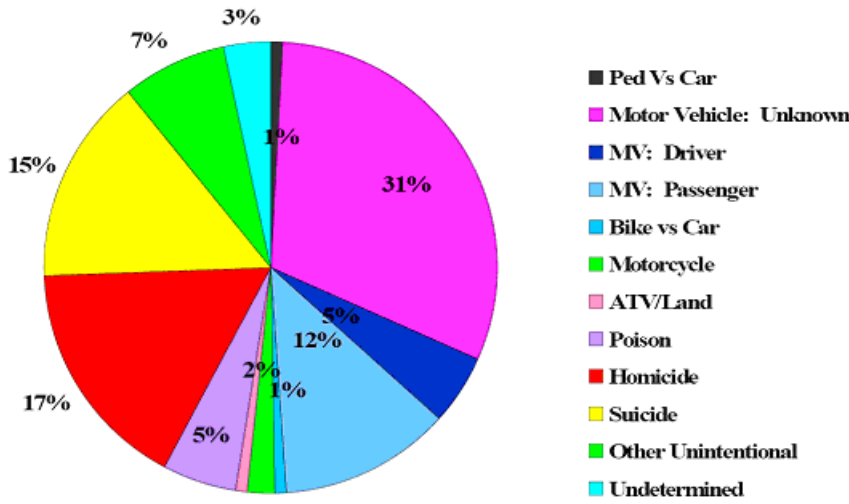
2005 Leading Causes of Injury Death in Indiana

- 5-9 Years of Age
 - Motor Vehicle (7)
 - Ped vs Car (6)
 - Homicide (6)
 - Burns (4)
 - Drowning (6)
 - Other Unintentional (6)
 - Undetermined (1)
- 10-14 Years of Age
 - Motor Vehicle (10)
 - Ped vs Car (2)
 - Bike vs Car (3)
 - Homicide (6)
 - Suicide (9)
 - ATV/Land (3)
 - Other Unintentional (5)
 - Fire (7)
 - Drowning (6)
 - Undetermined (2)

Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS)

22

2005 Indiana Fatal Injuries for Children 15-19 Years



Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS)

23

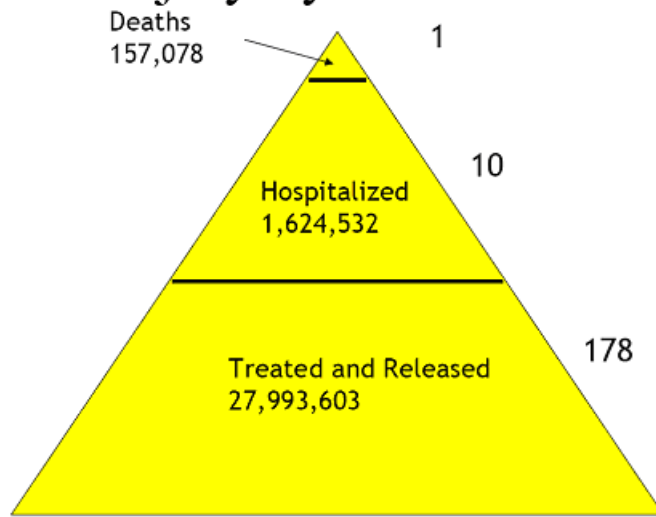
2005 Leading Causes of Injury Death in Indiana

- 15-19 Years of Age
 - Motor Vehicle Unknown (66)
 - Bike vs Car (2)
 - MV Driver (11)
 - MV Passenger (26)
 - Motorcycle (4)
 - Ped vs Car (2)
 - ATV/Land (2)
 - Homicide (36)
 - Suicide (32)
 - Undetermined (7)
 - Other Unintentional (16)
- 20-24 Years of Age
 - Motor Vehicle (101)
 - Motorcycle (15)
 - Ped vs Car (5)
 - ATV (9)
 - Poison (44)
 - Drowning (5)
 - Fire (5)
 - Other Unintentional (19)
 - Homicide (74)
 - Suicide (73)
 - Legal Intervention (1)
 - Undetermined (17)

Centers for Disease Control and Prevention, National Centers for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS)

24

Injury Pyramid for 2001

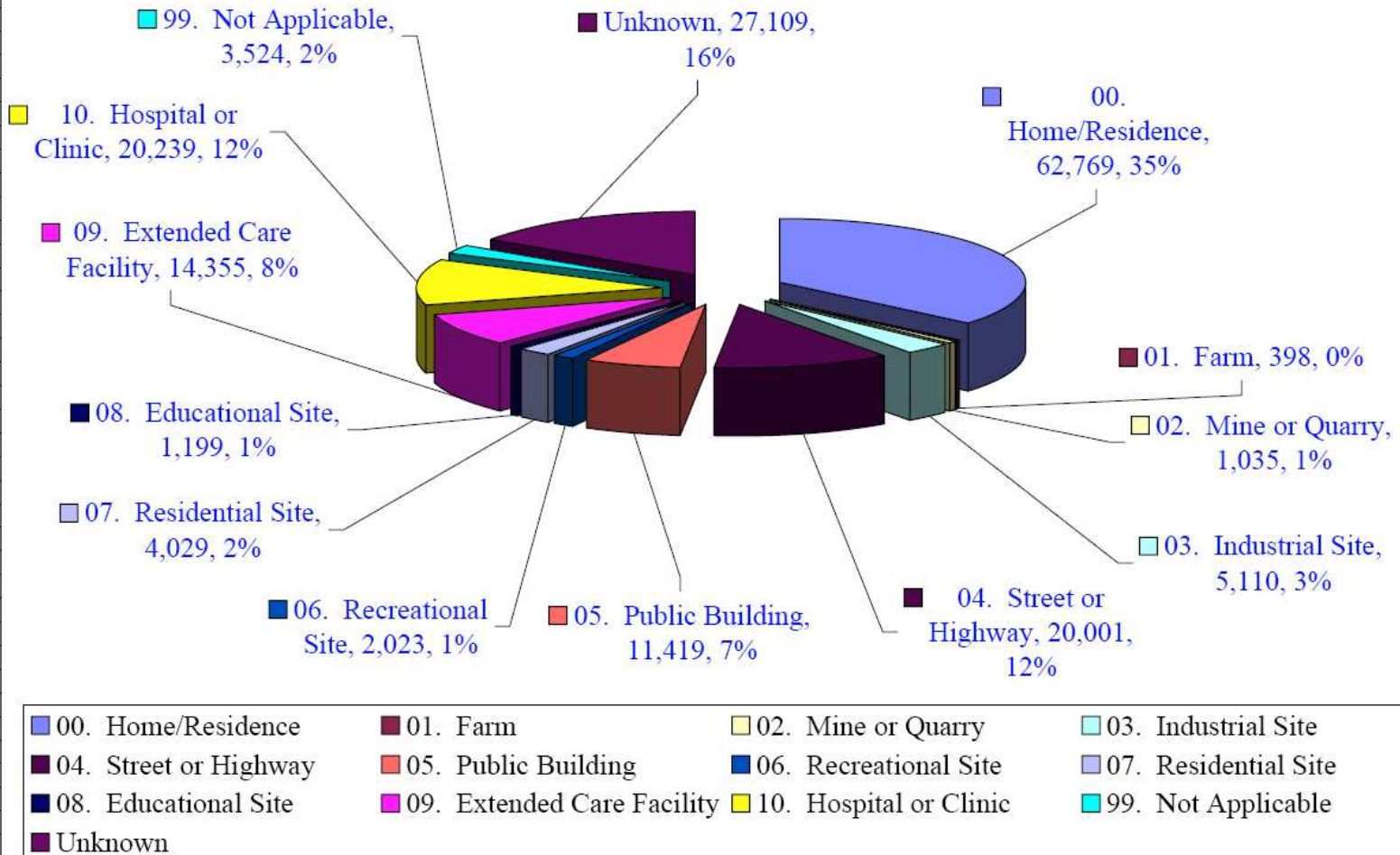


CDC, 2004

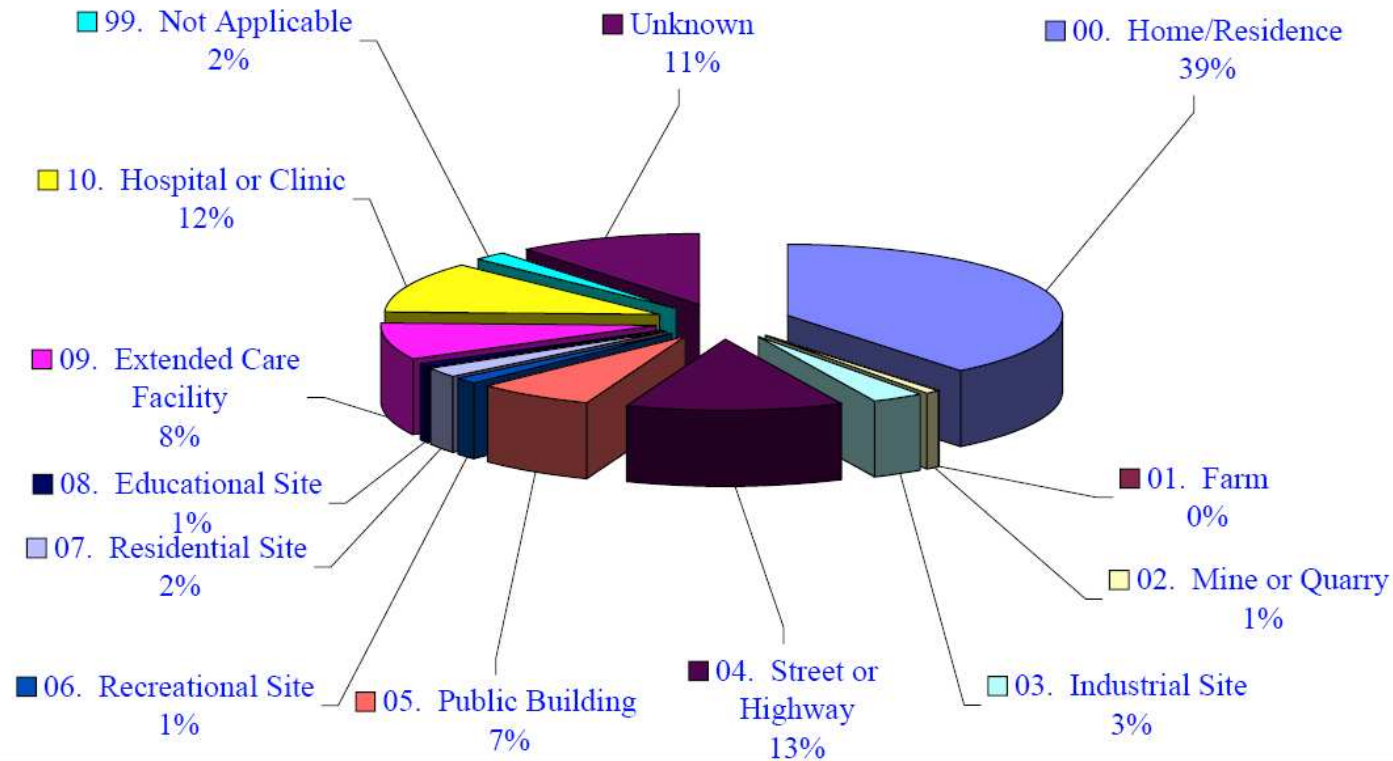
25

Appendix 10: EMS Data

Indiana Location Type Summary Report (Ten Years: 1998 - 2007)



Indiana Location Type Summary Report (Ten Years: 1998 - 2007)



00. Home/Residence	01. Farm	02. Mine or Quarry	03. Industrial Site
04. Street or Highway	05. Public Building	06. Recreational Site	07. Residential Site
08. Educational Site	09. Extended Care Facility	10. Hospital or Clinic	99. Not Applicable
Unknown			



Indiana EMS Registry
 Indiana EMS Statistics Report
 February 29, 2008

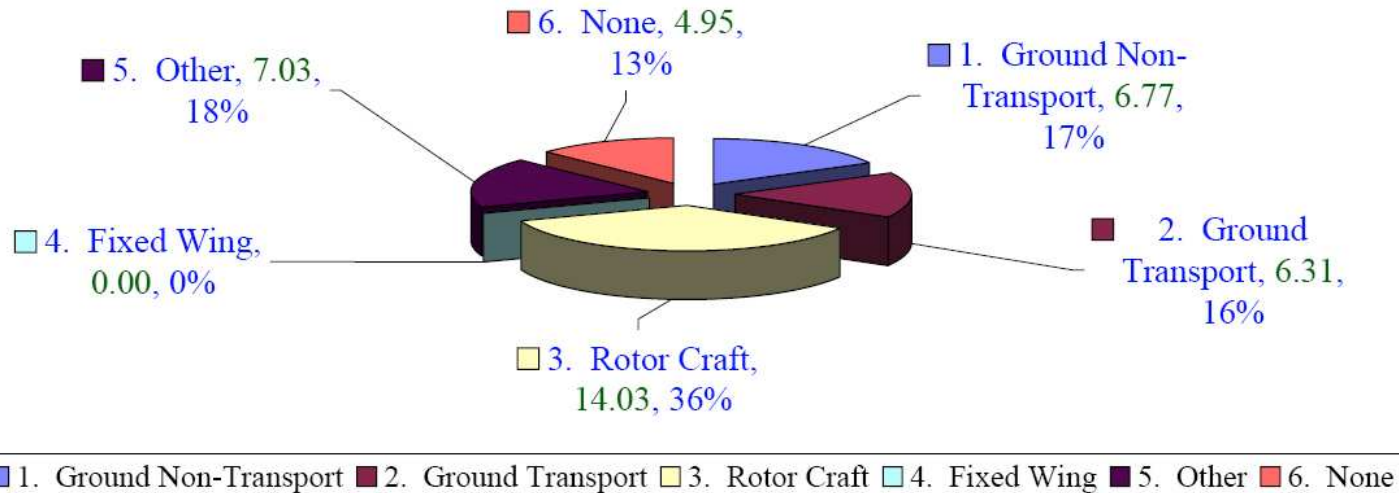


Indiana Average Response Times by Mode of Transport Summary Report
 (Minutes per Run)

Transport Type	2005-2007		Count 2007	Times 2007	Avg. Time 2007	Count 2006	Times 2006	Avg. Time 2006	Count 2005	Times 2005	Avg. Time 2005
	3 Year Count Avg.	3 Year Time Avg.									
1. Ground Non-Transport	24,939	6.77	11,658	74,661	6.40	6,477	46,928	7.25	6,804	45,399	6.67
2. Ground Transport	281,276	6.31	47,049	385,669	8.20	123,031	650,655	5.29	111,196	606,063	5.45
3. Rotor Craft	2,280	14.03	807	11,113	13.77	754	11,440	15.17	719	9,463	13.16
4. Fixed Wing	2	0.00	2	0	0.00	0	0	0.00	0	0	0.00
5. Other	2,082	7.03	851	5,905	6.94	707	5,120	7.24	524	3,620	6.91
6. None	18,286	4.95	6,629	33,728	5.09	5,381	24,986	4.64	6,276	32,161	5.12
Total	328,865	6.20	66,996	511,076	7.63	136,350	739,129	5.42	125,519	696,706	5.55

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**Indiana Average Response Times
 by Mode of Transportation Summary Report
 (Minutes Per Run for Three Years: 2005 - 2007)**





Indiana EMS Registry
 Indiana EMS Statistics Report
 February 29, 2008

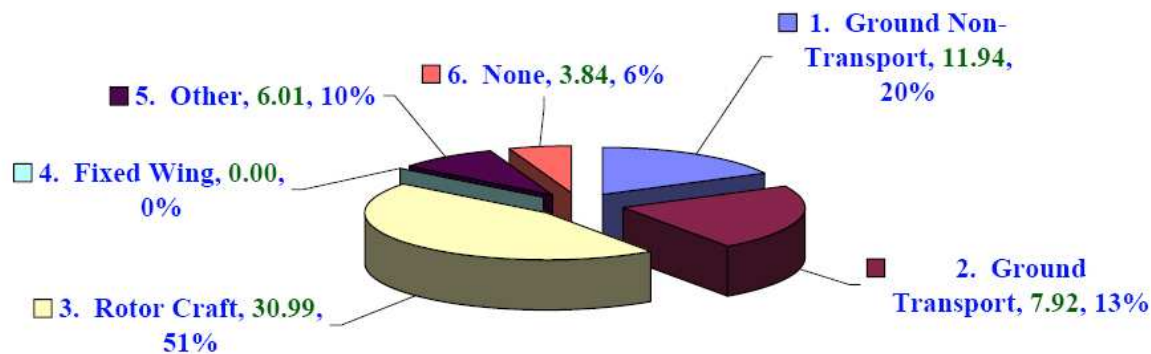


Indiana Average Destination Times by Mode of Transport Summary Report
 (Minutes per Run)

Transport Type	2005-2007		Count 2007	Times 2007	Avg. Time 2007	Count 2006	Times 2006	Avg. Time 2006	Count 2005	Times 2005	Avg. Time 2005
	3 Year Count Avg.	3 Year Time Avg.									
1. Ground Non-Transport	20,210	11.94	5,502	74,391	13.52	7,920	72,140	9.11	6,788	89,506	13.19
2. Ground Transport	96,686	15.49	39,629	516,114	13.02	28,168	558,001	19.81	28,889	393,536	13.62
3. Rotor Craft	1,877	30.99	722	23,914	33.12	579	12,578	21.72	576	21,952	38.11
4. Fixed Wing	2	0.00	2	0	0.00	0	0	0.00	0	0	0.00
5. Other	930	6.01	305	1,385	4.54	284	1,881	6.62	341	2,345	6.88
6. None	2,185	3.84	1,676	3,660	2.18	254	1,101	4.33	255	1,274	5.00
Total	121,890	14.70	47,836	619,464	12.95	37,205	645,701	17.36	36,849	508,613	13.80

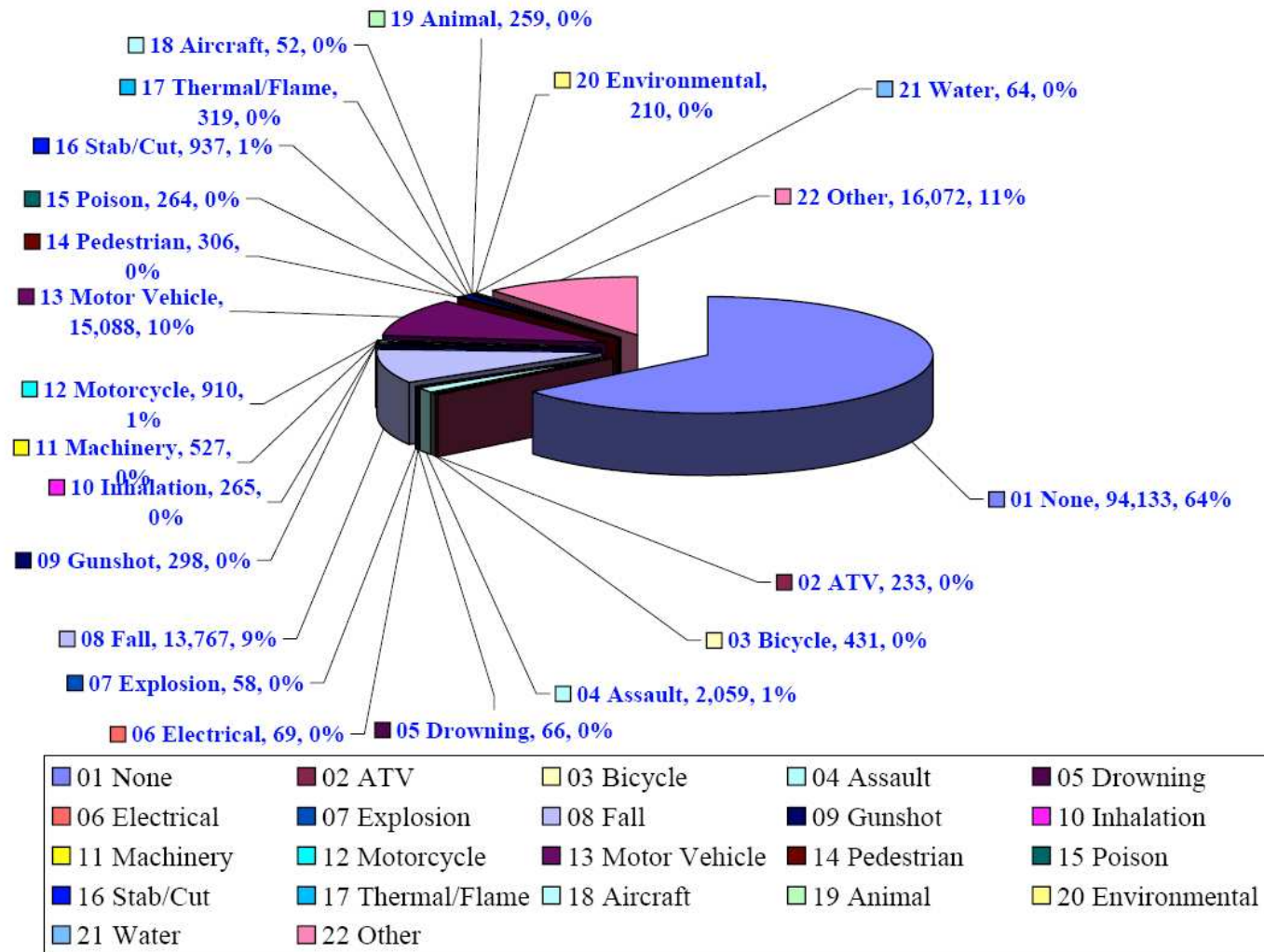
Print in Letter Landscape

Indiana Average Times to Destination
 by Mode of Transport Summary Report
 (Minutes per Run for Three Years: 2005-2007)

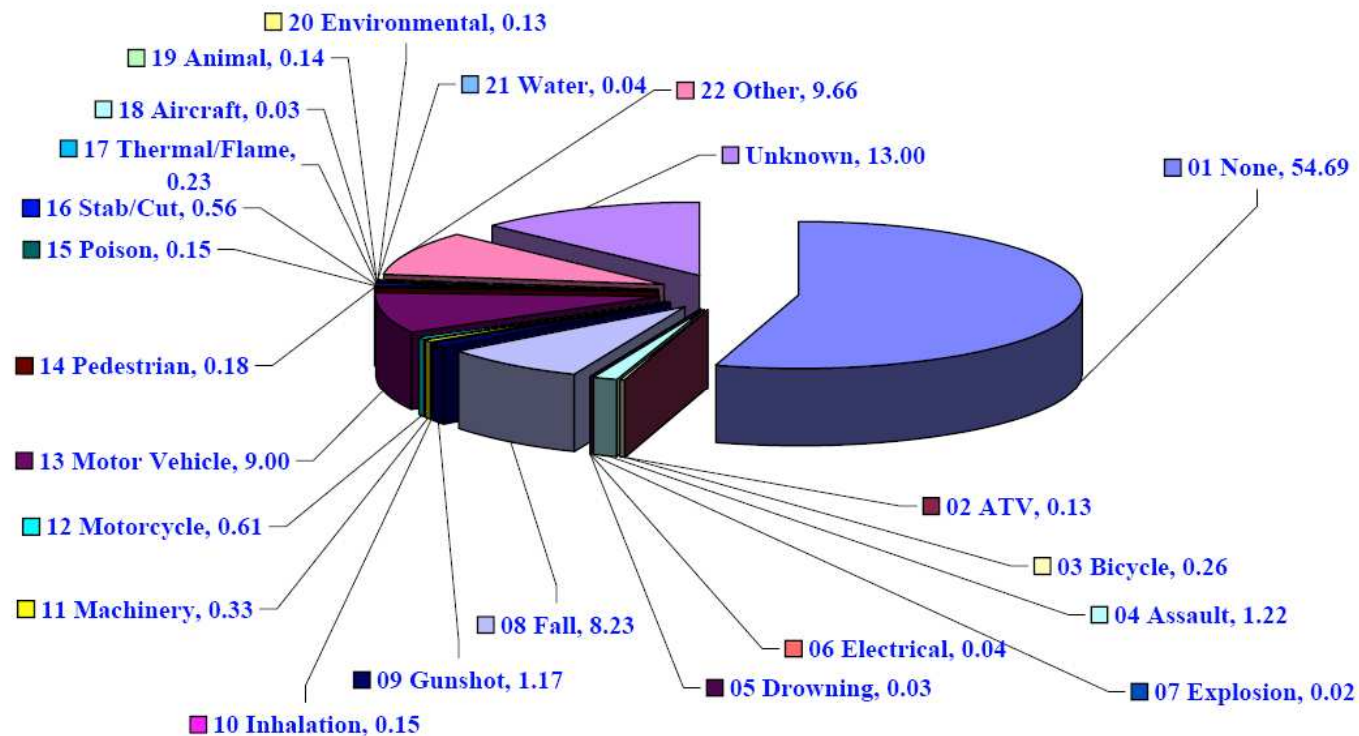


Legend: 1. Ground Non-Transport 2. Ground Transport 3. Rotor Craft 4. Fixed Wing 5. Other 6. None

Cause of Injury Average Numbers (10 Years: 1998 - 2007)



Cause of Injury Percent Averages (10 Years: 1998 - 2007)



01 None	02 ATV	03 Bicycle	04 Assault	05 Drowning	06 Electrical
07 Explosion	08 Fall	09 Gunshot	10 Inhalation	11 Machinery	12 Motorcycle
13 Motor Vehicle	14 Pedestrian	15 Poison	16 Stab/Cut	17 Thermal/Flame	18 Aircraft
19 Animal	20 Environmental	21 Water	22 Other	Unknown	



Indiana Emergency Medical Services Data Registry

Indiana EMS Statistics Report

29-Jan-08

Injury Intent Summary Report

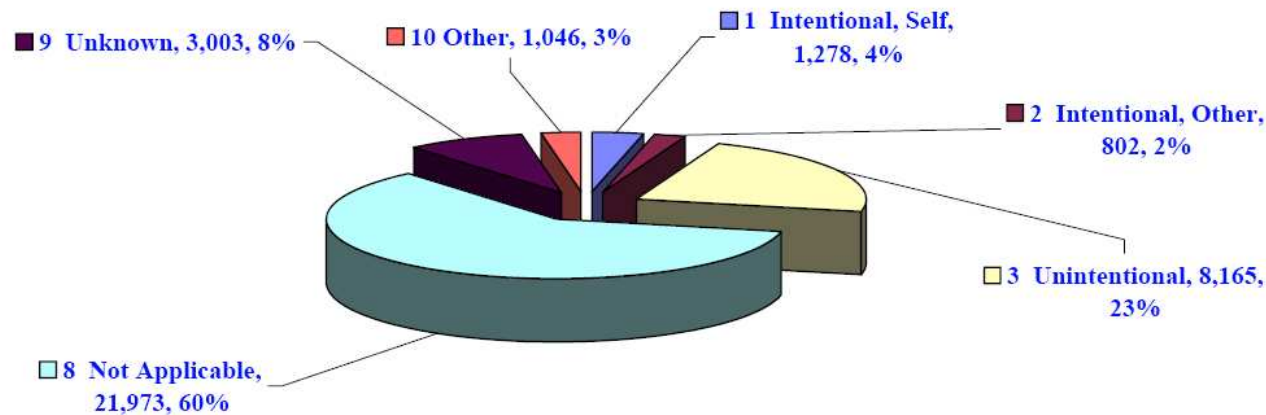
Number of Runs by Year



	1998-2007										
	10 Yr Count	Count	Count	Count	Count	Count	Count	Count	Count	Count	Count
<u>Injury Intent</u>	<u>AVG</u>	<u>2007</u>	<u>2006</u>	<u>2005</u>	<u>2004</u>	<u>2003</u>	<u>2002</u>	<u>2001</u>	<u>2000</u>	<u>1999</u>	<u>1998</u>
1 Intentional, Self	1,278	1,078	1,853	2,400	1,280	1,306	846	1,310	149	na	na
2 Intentional, Other	802	878	1,054	1,191	1,024	1,104	603	532	28	na	na
3 Unintentional	8,165	14,905	9,975	9,862	9,466	7,389	4,779	8,610	332	na	na
8 Not Applicable	21,973	33,212	28,913	25,001	20,132	20,937	21,100	26,154	332	na	na
9 Unknown	3,003	6,874	5,211	5,360	3,126	1,572	819	991	71	na	na
10 Other	1,046	185	1,181	933	438	2,668	2,156	769	35	na	na
Total Patient Count	36,266	57,132	48,187	44,747	35,466	34,976	30,303	38,366	947	na	na

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Indiana Injury Intent Average Number Summary Report
(10 Years: 1998 - 2007)



1 Intentional, Self 2 Intentional, Other 3 Unintentional 8 Not Applicable 9 Unknown 10 Other



Indiana Emergency Medical Services Data Registry

Indiana EMS Statistics Report

29-Jan-08

Injury Intent Summary Report

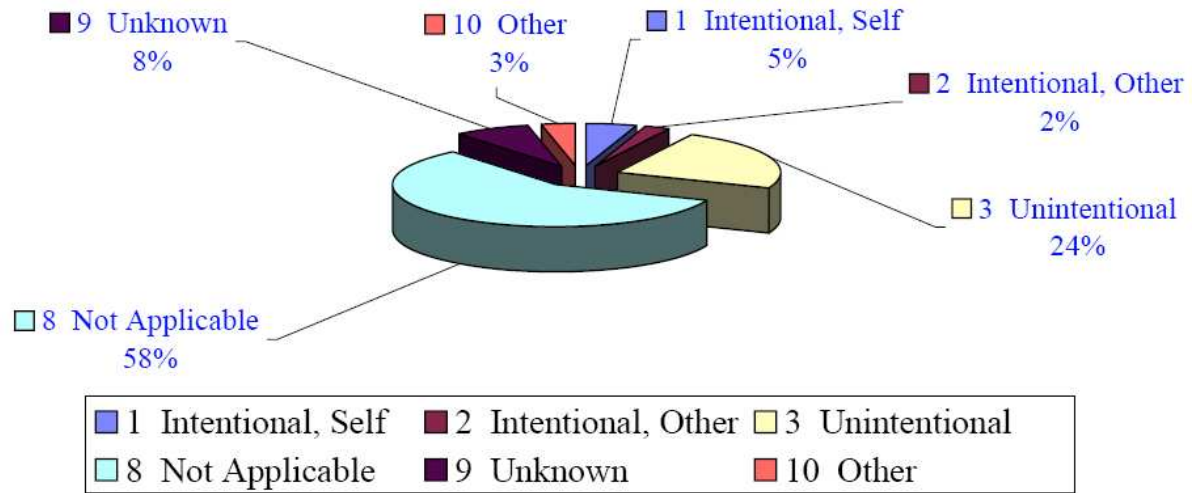
Percentages by Year



	1998-2007											
	10 Yr %	%	%	%	%	%	%	%	%	%	%	%
<u>Injury Intent</u>	<u>AVG</u>	<u>2007</u>	<u>2006</u>	<u>2005</u>	<u>2004</u>	<u>2003</u>	<u>2002</u>	<u>2001</u>	<u>2000</u>	<u>1999</u>	<u>1998</u>	
1 Intentional, Self	5.05	1.89	3.85	5.36	3.61	3.73	2.79	3.41	15.73	na	na	
2 Intentional, Other	2.35	1.54	2.19	2.66	2.89	3.16	1.99	1.39	2.96	na	na	
3 Unintentional	23.74	26.09	20.70	22.04	26.69	21.13	15.77	22.44	35.06	na	na	
8 Not Applicable	57.94	58.13	60.00	55.87	56.76	59.86	69.63	68.17	35.06	na	na	
9 Unknown	7.61	12.03	10.81	11.98	8.81	4.49	2.70	2.58	7.50	na	na	
10 Other	3.32	0.32	2.45	2.09	1.23	7.63	7.11	2.00	3.70	na	na	
Total Percent:	80.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	100.00	0.00	0.00	

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**Indiana Injury Intent Percentage Average Summary Report
(Ten Years: 1998 - 2007)**



**Appendix 11: Sample Data Request Policy and Form from
Memorial Hospital**

Policy for data use and request form:

<i>Memorial Hospital & Health System</i>	<i>POLICY / PROCEDURE DOCUMENT</i>	<i>Effective Date AUGUST 2007</i>
TITLE:	TRAUMA GUIDELINE: Trauma Registry	
<i>Document of (Entity)</i>	<i>Hospital</i>	
POLICY:	<p><i>Memorial Hospital, Trauma Services, maintains a registry of trauma patients using Digital Innovations, Inc. (NTRACS) software. Trauma Registry data is password protected and access is limited to the Trauma Medical Director, Trauma Program Director, Trauma Clinical Nurse Specialist, Trauma Registrar and Trauma Resource Nurse. The Trauma Registry data may be used for the following:</i></p> <ul style="list-style-type: none"> <i>• To facilitate the recording and analysis of injury-related data.</i> <i>• To facilitate the process of performance improvement.</i> <i>• For trending and optimizing care and resources through comparative analysis and benchmarking.</i> <i>• To support public health and legislative initiatives related to the implementation and participation in a local, regional, state or national registry (National Trauma Data Bank).</i> <p><i>The Trauma Registry data is maintained in a confidential manner and only aggregate data will be reported to outside agencies.</i></p>	
PURPOSE:	<i>To identify the purpose, responsibility and process for using trauma registry data.</i>	
PROCEDURE:		
<ol style="list-style-type: none"> <i>1. Reports will be requested using the Request for Trauma Registry Data Form (Appendix) and reported in a timely manner. <ol style="list-style-type: none"> <i>A. Requests for a report will require 72 hours notification</i> <i>B. Requests will be generated within one week of approval</i> <i>C. All requests will be logged to include. <ol style="list-style-type: none"> <i>1. Date of request</i> <i>2. Requestor name</i> <i>3. Requestor affiliation</i> <i>4. Description of data requested</i> <i>5. Intended use</i> <i>6. Intended audience</i> </i> </i> <i>2. The following information will be filed in the Trauma Services Department: <ol style="list-style-type: none"> <i>A. Trauma Registry Log of Data Requests</i> <i>B. Completed and approved request, including signature of requestor and a copy of data sent to requestor.</i> <i>C. Completed unapproved requests</i> </i> 		

Memorial
Trauma Services
REQUEST FOR TRAUMA REGISTRY DATA

NAME (Please Print): _____ DATE _____

TITLE: _____ PH: _____ BEEPER#: _____

DEPT: _____ ALTERNATE PHONE: _____

PURPOSE FOR
DATA: _____

COLLABORATION WITH OTHER (In-Hospital) DEPT.: YES NO

INFORMATION REQUESTED: (Please be as specific as possible)

SIGNATURE OF REQUESTOR: _____

REQUEST APPROVED: _____
TRAUMA MEDICAL DIRECTOR

REQUEST NOT APPROVED: _____
TRAUMA MEDICAL DIRECTOR

Date _____

VARIABLES
SELECTED: _____

Appendix 12: Indiana EMS Legislation, Rules and Code

TITLE 836 INDIANA EMERGENCY MEDICAL SERVICES COMMISSION

ARTICLE 1. EMERGENCY MEDICAL SERVICES

Rule 1. Definitions and General Requirements

836 IAC 1-1-1 Definitions

Authority: IC 16-31-2-7

Affected: IC 10-14-3-12; IC 16-18; IC 16-21-2; IC 16-31-2-9; IC 16-31-3; IC 25-22.5-1-1.1; IC 25-23-1-1.1; IC 35-41-1-26.5

Sec. 1. The following definitions apply throughout this title unless the context clearly denotes otherwise:

(1) "14 CFR 135 and 14 CFR 119" means air carriers with reference to F.A.R. 135 and 119, and holding a current F.A.A. air carrier certificate, with approved air ambulance operations-helicopter or air ambulance operation-airplane operations specifications.

(2) "Advanced life support", for purposes of IC 16-31, means the following:

(A) Care given:

(i) at the scene of an:

(AA) accident;

(BB) act of terrorism (as defined in IC 35-41-1-26.5), if the governor has declared a disaster emergency under IC 10-14-3-12 in response to the act of terrorism; or

(CC) illness;

(ii) during transport; or

(iii) at a hospital; by a paramedic, emergency medical technician-intermediate, and that is more advanced than the care usually provided by an emergency medical technician or an emergency medical technician-basic advanced.

(B) The term may include any of the following:

(i) Defibrillation.

(ii) Endotracheal intubation.

(iii) Parenteral injection of appropriate medications.

(iv) Electrocardiogram interpretation.

(v) Emergency management of trauma and illness.

(3) "Advanced life support fixed-wing ambulance service provider organization" means a service provider that utilizes fixedwing aircraft to provide airport to airport transports where the patients involved require a stretcher or cot and are being transported to or from a definite care medical setting.

(4) "Advanced life support nontransport vehicle" means a motor vehicle other than an ambulance, owned or leased by a certified emergency medical service provider organization, that provides advanced life support but does not supply patient transport from the scene of the emergency. The term does not include an employer-owned or employer-operated vehicle used for first aid purposes within or upon the employer's premises.

(5) "Advanced life support rotorcraft ambulance service provider organization" means a service provider that utilizes rotorcraft aircraft to respond directly to the scene of a medical emergency either as an initial first responder or as a secondary responder and are utilized to airlift critically ill or injured patients directly to or between definitive care facilities or to a point of transfer with another more appropriate form of transportation.

(6) "Agency" means the state emergency management agency emergency medical services division.

(7) "Air-medical director" means a physician with an unlimited license to practice medicine in Indiana and who has an active role in the delivery of emergency care. The licensed physician shall be ultimately responsible for patient care during each transport. The air-medical director is responsible for directly overseeing and assuring that appropriate aircraft, air-medical personnel, and equipment are provided for each patient transported by the air ambulances within the air-medical services as well as the performance of air-medical personnel.

(8) "Air-medical personnel" means a person who is certified by the commission as a paramedic or is a registered nurse or physician.

(9) "Ambulance" means any conveyance on land, sea, or air that is used, or is intended to be used, for the purpose of responding to emergency life-threatening situations and providing transportation of an emergency patient.

(10) "Ambulance service provider organization" means any person certified by the commission who engages in or seeks to furnish, operate, conduct, maintain, advertise, or otherwise engage in services for the transportation and care of emergency patients as a part of a regular course of doing business, either paid or voluntary.

(11) "Auto-injector" means a spring-loaded needle and syringe that:

(A) contains a single dose of medication; and

- (B) automatically releases and injects the medication.
- (12) "Basic life support" means the following:
- (A) Assessment of emergency patients.
 - (B) Administration of oxygen.
 - (C) Use of mechanical breathing devices.
 - (D) Application of antishock trousers.
 - (E) Performance of cardiopulmonary resuscitation.
 - (F) Application of dressings and bandage materials.
 - (G) Application of splinting and immobilization devices.
 - (H) Use of lifting and moving devices to ensure safe transport.
 - (I) Use of an automatic or a semiautomatic defibrillator if the defibrillator is used in accordance with training procedures established by the commission.
 - (J) Administration by an emergency medical technician or emergency medical technician-basic advanced of epinephrine through an auto-injector.
 - (K) For an emergency medical technician-basic advanced, the following:
 - (i) Electrocardiogram interpretation.
 - (ii) Manual external defibrillation.
 - (iii) Intravenous fluid therapy.
 - (L) Other procedures authorized by the commission, including procedures contained in the revised national emergency medical technician-basic training curriculum guide.
 - (M) Except as provided by:
 - (i) clause (J) and the training and certifications standards established under IC 16-31-2-9(4);
 - (ii) clause (K)(iii); and
 - (iii) the training standards established under IC 16-31-2-9(5); the term does not include invasive medical care techniques or advanced life support.
- (13) "Basic life support nontransport provider organization" means an organization, certified by the commission, that provides first response patient care at an emergency that includes defibrillation but does not supply patient transport from the scene of the emergency.
- (14) "Certificate" or "certification" means authorization in written form issued by the commission to a person to furnish, operate, conduct, maintain, advertise, or otherwise engage in providing emergency medical services as a part of a regular course of doing business, either paid or voluntary.
- (15) "Commission" means the Indiana emergency medical services commission.
- (16) "Director" means the director of the state emergency management agency.
- (17) "Emergency ambulance services" means the transportation of emergency patients by ambulance and the administration of basic life support to emergency patients before or during such transportation.
- (18) "Emergency management of trauma and illness" means the following:
- (A) For a paramedic, those procedures for which the paramedic has been specifically trained and:
 - (i) that are a part of the curriculum prescribed by the commission; or
 - (ii) are a part of the continuing education program and approved by the supervising hospital and the paramedic provider organization's medical director.
 - (B) For an emergency medical technician-intermediate, those procedures for which the emergency medical technician intermediate has been specifically trained:
 - (i) in the Indiana basic emergency medical technician and Indiana emergency medical technician-intermediate curriculums; and
 - (ii) that have been approved by the administrative and medical staff of the supervising hospital, the emergency medical technician-intermediate provider organization medical director, and the commission as being within the scope and responsibility of the emergency medical technician-intermediate.
- (19) "Emergency medical services" means the provision of emergency ambulance services or other services, including extrication and rescue services, utilized in serving an individual's need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury.
- (20) "Emergency medical services driver" means an individual who has a certificate of completion of a commission-approved driver training course.
- (21) "Emergency medical services provider organization" means any person certified by the commission who engages in or seeks to furnish, operate, conduct, maintain, advertise, or otherwise engage in services for the care of emergency patients as part of a regular course of doing business, either paid or voluntary.
- (22) "Emergency medical services vehicle" means the following:

- (A) An ambulance.
- (B) An emergency medical service nontransport vehicle.
- (23) "Emergency medical technician" means an individual who is certified under this article to provide basic life support at the scene of an accident or an illness or during transport.
- (24) "Emergency medical technician-basic advanced" means an individual who is certified under IC 16-31 to provide basic life support at the scene of an accident or an illness or during transport and has been certified to perform manual or automated defibrillation, rhythm interpretation, and intravenous line placement.
- (25) "Emergency medical technician-basic advanced provider organization" means an ambulance service provider or other provider organization certified by the commission to provide basic life support services administered by emergency medical technicians-basic advanced and has been certified to perform manual or automated defibrillation, rhythm interpretation, and intravenous line placement in conjunction with a supervising hospital.
- (26) "Emergency medical technician-intermediate" means an individual who can perform at least one (1) but not all of the procedures of a paramedic and who:
 - (A) has completed a prescribed course in advanced life support;
 - (B) has been certified by the commission;
 - (C) is associated with a single supervising hospital; and
 - (D) is affiliated with a provider organization.
- (27) "Emergency medical technician-intermediate provider organization" means an ambulance service provider organization or other provider organization certified by the commission to provide advanced life support services administered by emergency medical technician-intermediates in conjunction with a supervising hospital.
- (28) "Emergency patient" means an individual who is acutely ill, injured, or otherwise incapacitated or helpless and who requires emergency care. The term includes an individual who requires transportation on a litter or cot or is transported in a vehicle certified as an ambulance under IC 16-31-3.
- (29) "Extrication service" means any actions that disentangle and frees [*sic., free*] from entrapment.
- (30) "F.A.A." means the Federal Aviation Administration.
- (31) "F.A.R." means the federal aviation regulations, including, but not limited to, 14 CFR.
- (32) "First responder" means an individual who is:
 - (A) certified under IC 16-31 and who meets the commission's standards for first responder certification; and
 - (B) the first individual to respond to an incident requiring emergency medical services.
- (33) "Fixed-wing ambulance" means a propeller or jet airplane.
- (34) "Flight physiology" means the physiological stress of flight encountered during air medical operations to include, but not be limited to:
 - (A) temperature;
 - (B) pressure;
 - (C) stresses of barometric pressure changes;
 - (D) hypoxia;
 - (E) thermal and humidity changes;
 - (F) gravitational forces;
 - (G) noise;
 - (H) vibration;
 - (I) fatigue; and
 - (J) volume and mass of gases.
- (35) "Medical director" means a physician with an unlimited license to practice medicine in Indiana and who has an active role in the delivery of emergency care.
- (36) "Nontransporting emergency medical services vehicle" or "emergency medical service nontransport vehicle" means a motor vehicle, other than an ambulance, used for emergency medical services. The term does not include an employer-owned or employer-operated vehicle used for first aid purposes within or upon the employer's premises.
- (37) "Paramedic" means an individual who:
 - (A) is:
 - (i) affiliated with a certified paramedic provider organization;
 - (ii) employed by a sponsoring hospital approved by the commission; or
 - (iii) employed by a supervising hospital with a contract for inservice education with a sponsoring hospital approved by the commission;
 - (B) has completed a prescribed course in advanced life support; and
 - (C) has been certified by the commission.

- (38) "Paramedic provider organization" means an ambulance service provider organization or other provider organization certified by the commission to provide advanced life support services administered by paramedics or physicians with an unlimited license to practice medicine in Indiana in conjunction with supervising hospitals.
- (39) "Person" means any:
- (A) natural person or persons;
 - (B) partnership;
 - (C) corporation;
 - (D) association;
 - (E) joint stock association; or
 - (F) governmental entity other than an agency or instrumentality of the United States. "Agency or instrumentality of the United States" does not include a person operating under a contract with the government of the United States.
- (40) "Physician" means an individual who currently holds a valid unlimited license to practice medicine in Indiana under IC 25-22.5-1-1.1.
- (41) "Program director" means a person employed by a certified training institution to coordinate the emergency medical services training programs.
- (42) "Provider organization" means an ambulance service or other emergency care organization certified by the commission to provide emergency medical services.
- (43) "Provider organization operating area" means the geographic area in which an emergency medical technician-basic advanced, affiliated with a specific emergency medical technician-basic advanced provider organization, is able to maintain two-way voice communication with the provider organization's supervising hospitals.
- (44) "Registered nurse" means a person licensed under IC 25-23-1-1.1.
- (45) "Rescue services" means the provision of basic life support except it does not include the following:
- (A) Administration of oxygen.
 - (B) Use of mechanical breathing devices.
 - (C) Application of antishock trousers.
 - (D) Application of splinting devices.
 - (E) Use of an automatic or a semiautomatic defibrillator.
 - (F) Electrocardiogram interpretation.
 - (G) Manual external defibrillation.
 - (H) Intravenous fluid therapy.
 - (I) Invasive medical care techniques.
- (46) "Rescue squad organization" means an organization that holds a voluntary certification to provide extrication, rescue, or emergency medical services.
- (47) "Supervising hospital" means a hospital licensed under IC 16-21-2 or under the licensing laws of another state that has been certified by the commission to supervise paramedics, emergency medical technicians-intermediate, emergency medical technician-basic advanced, and provider organizations in providing emergency medical care.
- (48) "Training institution" means an institution certified by the commission to administer emergency medical services training programs. (*Indiana Emergency Medical Services Commission; Emergency Medical Services Preliminary; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 84; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2191; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1035; filed Aug 18, 1986, 1:00p.m.: 10 IR 23; filed May 15, 1998, 10:25 a.m.: 21 IR 3865; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2718; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2333; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3507*)

836 IAC 1-1-2 Enforcement

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-16; IC 16-31-3-17

Affected: IC 16-31

Sec. 2. Enforcement actions will be taken in accordance with IC 16-31. (*Indiana Emergency Medical Services Commission; 836 IAC 1-1-2; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2335; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3510*)

836 IAC 1-1-3 Request for waiver

Authority: IC 16-31-2-7

Affected: IC 16-31-2-11; IC 16-31-3-5

Sec. 3. (a) The commission shall waive any rule for a person who provides emergency ambulance service, an emergency medical technician, an emergency medical technician-basic advanced, an emergency medical technician-intermediate, a paramedic, or an ambulance when operating from a location in an adjoining state by contract with an

Indiana unit of government to provide emergency ambulance or medical services to patients who are picked up or treated in Indiana. To receive such a waiver, an applicant shall submit the following:

- (1) An application that shall include the following information:
 - (A) Organizational structure, including name, address, and phone number for the owner, chief executive officer, chief operations officer, training officer, and medical director.
 - (B) A description of the service area.
 - (C) Hours of operation.
 - (D) Proof of insurance coverage in amounts as specified in 836 IAC 1-3-6.
 - (E) Other information as required by the commission.
- (2) A copy of the contract with the Indiana unit of government. This contract shall describe the emergency medical services that are to be provided.
- (3) A list of the rule or rules for which the applicant is requesting a waiver.
 - (b) The commission may waive any rule, including a rule establishing a fee, for a person who submits facts demonstrating that:
 - (1) compliance with the rule will impose an undue hardship on the person; and
 - (2) either:
 - (A) noncompliance with the rule; or
 - (B) compliance with an alternative requirement approved by the commission; will not jeopardize the quality of patient care. However, the commission may not waive a rule that sets forth educational requirements for a person regulated under this article.
 - (c) A waiver granted under subsection (b)(2)(B) is conditioned upon compliance with the alternative requirement approved under subsection (b).
 - (d) A waiver granted under subsection (a) or subsection (b) expires on the earlier of the following:
 - (1) The date established by the commission when the waiver is granted.
 - (2) Two (2) years after the date the commission grants the waiver.
 - (e) The commission may renew a waiver if the person makes the same demonstration required for the original waiver.
 - (f) The commission may grant an applicant a waiver from all or part of the continuing education requirement for a renewal period if the applicant was not able to fulfill the requirement due to a hardship that resulted from any of the following:
 - (1) Service in the armed forces of the United States during a substantial part of the renewal period.
 - (2) An incapacitating illness or injury.
 - (3) Other circumstances determined by the commission. (*Indiana Emergency Medical Services Commission; 836 IAC 1-1-3; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2336; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3511*)

836 IAC 1-1-4 Exemptions

Authority: IC 16-31-2-7

Affected: IC 4-21.5; IC 16-31-3-3

Sec. 4. (a) Under IC 16-31-3-3, a certificate is not required for a person who provides emergency ambulance service, advanced life support, an emergency medical technician, an ambulance, or a nontransporting emergency medical services vehicle when doing any of the following:

- (1) Providing assistance to persons certified to provide emergency ambulance service or to emergency medical technicians.
 - (2) Operating from a location or headquarters outside Indiana to provide emergency ambulance services to patients who are picked up outside Indiana for transportation to locations within Indiana. This includes the return of that patient to the patient's original state of origin if the return trip occurs within twenty-four (24) hours of the transport to Indiana.
 - (3) Providing emergency medical services during a major catastrophe or disaster with which persons or ambulance services are insufficient or unable to cope.
- (b) An agency or instrumentality of the United States and any paramedic, emergency medical technician, emergency medical technician-basic advanced, or ambulances of the agency or instrumentality are not required to be certified or to conform to the standards prescribed under IC 16-31-3. An agency or instrumentality of the United States does not include a person operating under a contract with the government of the United States. (*Indiana Emergency Medical Services Commission; 836 IAC 1-1-4; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3512*)

836 IAC 1-1-5 Reports and records

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 4-21.5; IC 16-31-3

Sec. 5. (a) All emergency medical service provider organizations shall comply with this section.

(b) All emergency medical service provider organizations shall participate in the emergency medical service system review by collecting and reporting data elements. The elements shall be submitted to the agency by the fifteenth of the following month by electronic format or submitted on disk in the format and manner specified by the commission. The data elements prescribed by the commission are as follows:

- (1) Provider organization number.
- (2) Date of incident.
- (3) Time call received.
- (4) Incident number.
- (5) Service type.
- (6) Time of dispatch.
- (7) Location type.
- (8) Patient name.
- (9) Response number.
- (10) Patient care record number.
- (11) Patient zip code.
- (12) Gender.
- (13) Race.
- (14) Time unit responding.
- (15) Time of arrival at scene.
- (16) Time unit left scene.
- (17) Time available for service.
- (18) Lights and siren to scene.
- (19) Lights and siren used from scene.
- (20) Level of care provided.
- (21) Provider impression.
- (22) Mode of injury.
- (23) Incident/patient disposition.
- (24) Vehicle type.
- (25) Destination/transferred to.
- (26) Destination determination.
- (27) Time of arrival at destination.
- (28) Incident location.
- (29) Date of birth.
- (30) Medical history.
- (31) Signs and symptoms.
- (32) Injury description.
- (33) Safety equipment.
- (34) Suspected drug/alcohol use.
- (35) Pulse rate.
- (36) Respiratory rate.
- (37) Respiratory effort.
- (38) Systolic blood pressure.
- (39) Skin perfusion.
- (40) Glasgow eye opening.
- (41) Glasgow verbal component.
- (42) Glasgow motor component.
- (43) Airway treatment.
- (44) Stabilization treatment.
- (45) Miscellaneous treatment.
- (46) Medication name.
- (47) Research code.
- (48) Crew member one number.
- (49) Crew member two number.

Basic life support nontransport provider organizations that are paid or volunteer fire departments that render fire prevention or fire protection services to a political subdivision are not required to submit data under this rule.

(c) Each emergency medical services provider organization shall retain all records required by this rule *[sic]* title for a minimum of three (3) years, except for the following records that shall be retained for a minimum of seven (7) years:

(1) Audit and review records.

(2) Run reports.

(3) Training records.

(4) Maintenance records.

(d) An emergency medical service provider organization that has any certified vehicles involved in any traffic accident investigated by a law enforcement agency shall report that accident to the agency within ten (10) working days on a form provided by the agency.

(e) Each provider organization, except basic life support nontransport provider organization, shall maintain accurate records concerning the assessment, treatment, or transportation of each emergency patient, including a run report form in an electronic or written format as prescribed by the commission as follows:

(1) A run report form shall include, at a minimum, the following:

(A) Name.

(B) Identification number.

(C) Age.

(D) Sex.

(E) Date of birth.

(F) Race.

(G) Address, including zip code.

(H) Location of incident.

(I) Chief complaint.

(J) History, including the following:

(i) Current medical condition and medications.

(ii) Past pertinent medical conditions and allergies.

(K) Physical examination section.

(L) Treatment given section.

(M) Vital signs, including the following:

(i) Blood pressure.

(ii) Pulse.

(iii) Respirations.

(iv) Level of consciousness.

(v) Skin temperature and color.

(vi) Pupillary reactions.

(vii) Ability to move.

(viii) Presence or absence of breath sounds.

(ix) The time of observation and a notation of the quality for each vital sign.

(N) Responsible guardian.

(O) Hospital destination.

(P) Radio contact via UHF or VHF.

(Q) Name of patient attendants, including emergency medical service certification numbers and signatures.

(R) Vehicle certification number.

(S) Safety equipment used by patient.

(T) Date of service.

(U) Service delivery times, including the following:

(i) Time of receipt of call.

(ii) Time dispatched.

(iii) Time arrived on scene.

(iv) Time of departure from scene.

(v) Time arrived at hospital.

(vi) Time departed from hospital.

(vii) Time vehicle available for next response.

(viii) Time vehicle returned to station.

- (2) The run report form shall be designed in a manner to provide space for narrative notation of additional medical information.
- (3) A copy of the completed run report form shall be provided to the receiving facility when the patient is delivered unless it is not feasible; however, the form shall be provided to the receiving facility no [sic] not later than twenty-four (24) hours after the patient is delivered.
- (4) When a patient has signed a statement for refusal of treatment or transportation services, or both, that signed statement shall be maintained as part of the run documentation.
- (f) Each basic life support nontransport provider organization shall maintain, in a manner prescribed by the commission, accurate records, including a run report form, concerning the assessment and treatment of each emergency patient as follows:
- (1) A run report form shall be required by all basic life support nontransport provider organizations, including, at a minimum, the following:
- (A) Name.
 - (B) Identification number.
 - (C) Age.
 - (D) Sex.
 - (E) Race.
 - (F) Physician of the patient.
 - (G) Date of birth.
 - (H) Address, including zip code.
 - (I) Location of incident.
 - (J) Chief complaint.
 - (K) History, including the following:
 - (i) Current medical condition and medications.
 - (ii) Past pertinent medical conditions and allergies.
 - (L) Physical examination section.
 - (M) Treatment given section.
 - (N) Vital signs, including the following:
 - (i) Pulse.
 - (ii) Blood pressure.
 - (iii) Respirations.
 - (iv) Level of consciousness.
 - (v) Skin temperature and color.
 - (vi) Pupillary reactions.
 - (vii) Ability to move.
 - (viii) Presence or absence of breath sounds.
 - (ix) The time of observation and a notation of the quality for each vital sign.
 - (O) Responsible guardian.
 - (P) Name of patient attendants, including emergency medical services certification numbers and signatures.
 - (Q) Vehicle emergency medical services certification number.
 - (R) Responding service delivery times, including the following:
 - (i) Time of receipt of call.
 - (ii) Time dispatched.
 - (iii) Time arrived on scene.
 - (iv) Time of patient released to transporting emergency medical services.
 - (v) Time vehicle available for next response.
 - (S) Date of service.
 - (T) Safety equipment used by patient.
- (2) The report form shall provide space for narrative description of the situation and the care rendered by the nontransport unit.
- (3) A signed statement for refusal of treatment or transportation services, or both, shall be maintained as part of the run documentation. (*Indiana Emergency Medical Services Commission; 836 IAC 1-1-5; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3512; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 1-1-6 Audit and review

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 4-21.5; IC 16-31-3

Sec. 6. Each emergency medical service provider organization shall conduct audit and review at least quarterly to assess, monitor, and evaluate the quality of patient care as follows:

- (1) The audit shall evaluate patient care and personnel performance.
- (2) The results of the audit shall be reviewed with the emergency medical service personnel.
- (3) Documentation for the audit and review shall include the following:
 - (A) The criteria used to select audited runs.
 - (B) Problem identification and resolution.
 - (C) Date of review.
 - (D) Attendance at the review.
 - (E) A summary of the discussion at the review.
- (4) The audit and review shall be conducted under the direction of one (1) of the following:
 - (A) The emergency medical services provider organization medical director.
 - (B) An emergency department committee that is supervised by a medical director. An emergency medical service provider organization representative shall serve as a member on the committee.
 - (C) A committee established by the emergency medical service provider organization and under the direction of the medical director or medical director designee. The medical director designee must:
 - (i) be a physician with an unlimited license to practice medicine in Indiana;
 - (ii) have an active role in the delivery of emergency care; and
 - (iii) have been designated in writing by the medical director as the medical director designee.
- (5) A method of identifying needs to staff development programs, basic training, in-service, and orientation.
- (6) The audit shall include all levels of care by emergency medical service personnel. (*Indiana Emergency Medical Services Commission; 836 IAC 1-1-6; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3514; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 1-1-7 Training

Authority: IC 16-31-2-7

Affected: IC 4-21.5; IC 16-31-3

Sec. 7. (a) Each emergency medical service provider organization shall designate one (1) person as the organization's training officer to assume responsibility for inservice training. This person shall be certified as one (1) of the following:

- (1) First responder (only for the basic life support nontransport provider organization).
 - (2) An emergency medical technician.
 - (3) An emergency medical technician-basic advanced.
 - (4) An emergency medical technician-intermediate.
 - (5) A paramedic.
 - (6) A registered nurse.
 - (7) A certified physician assistant.
 - (8) A licensed physician who is actively involved in the delivery of emergency medical services with that organization.
- (b) The provider organization and training officer shall be responsible for the following:
- (1) Providing and maintaining records of inservice training offered by the provider organization.
 - (2) Maintaining the following inservice training session information:
 - (A) Summary of the program content.
 - (B) The name of the instructor.
 - (C) The names of those attending.
 - (D) The date, time, and location of the inservice training sessions.
 - (3) Signing individual training records or reports to verify actual time in attendance at training sessions.
- (*Indiana Emergency Medical Services Commission; 836 IAC 1-1-7; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3514*)

836 IAC 1-1-8 Operating procedures

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 4-21.5; IC 16-31-3

Sec. 8. (a) All emergency medical service provider organizations shall comply with this section.

- (b) Emergency medical service provider organization's premises shall be maintained, suitable to the conduct of the provider organizations service, with provision for adequate storage of emergency medical service vehicles and equipment.
- (c) Each emergency medical service provider organization shall provide a written periodic maintenance program to assure that:
- (1) all emergency medical service vehicles, including equipment, are maintained in good working condition at all times; and
 - (2) equipment, medication, and supplies have not exceeded the manufacturer's specified expiration date.
- (d) All emergency medical service provider organization's:
- (1) premises;
 - (2) records;
 - (3) garaging facilities; and
 - (4) emergency medical service vehicles; shall be made available for inspection by the agency at any time during operating hours.
- (e) An emergency medical service provider organization shall not act in a reckless or negligent manner so as to endanger the health or safety of emergency patients or members of the general public while in the course of business as an emergency medical service provider organization.
- (f) Each emergency medical service provider organizations shall notify the agency within thirty (30) days of the present and past specific location of any emergency medical service vehicles if the location of the emergency medical service vehicles is changed from that specified in the provider organization's application for emergency medical service provider organizations certification or certification renewal.
- (g) An emergency medical service provider organization shall not engage in the provision of advanced life support unless the:
- (1) emergency medical service provider organization is certified under 836 IAC 2; and
 - (2) vehicle meets the requirements of 836 IAC 2.
- (h) Each emergency medical services provider organization shall conduct audit and review under section 6 of this rule.
- (i) An emergency medical service provider organization may operate a nontransport emergency medical services vehicle in accordance with 836 IAC 1-11-4.
- (j) The following reporting requirements are applicable to all emergency medical service provider organizations:
- (1) For an individual certified by the commission and employed (either paid or volunteer) by an emergency medical service provider organization, the provider organization shall notify the agency within thirty (30) days of any of the following:
 - (A) An action taken by the provider organization or the provider organization's medical director to:
 - (i) restrict, suspend, or revoke the individual's authorization to perform emergency medical services for the provider organization; or
 - (ii) suspend or terminate the individual's employment or affiliation with the provider organization.
 - (B) The individual is no longer:
 - (i) employed;
 - (ii) affiliated; with the provider organization either voluntarily or involuntarily.
 - (2) The notification required under this subsection shall include the following:
 - (A) Name of individual.
 - (B) Certification number.
 - (C) Date action was taken.
 - (D) Description of the action taken, including:
 - (i) the length of the action if the action was temporary; and
 - (ii) any conditions and terms associated with the action.
 - (E) Reason action was taken.
- (k) Each emergency medical service provider organization shall ensure that sanitation procedures are in effect at all times. The following sanitation standards apply to all emergency medical services vehicles:
 - (1) The interior of ambulances and the equipment within the vehicle shall be clean and maintained in good working order at all times. Smoking shall be prohibited anywhere in the interior of the vehicle.
 - (2) Freshly laundered linen or disposable linens shall be used on litters and pillows, and linen shall be changed after each patient is transported.
 - (3) Clean linen storage shall be provided.
 - (4) Closed compartments shall be provided within the vehicle for medical supplies.

- (5) Closed containers shall be provided for soiled supplies.
- (6) Blankets shall be kept clean and stored in closed compartments.
- (7) Implements inserted into the patient's nose or mouth shall be single-service, wrapped, and properly stored and handled. Multiuse items shall be kept clean and sterile when indicated and properly stored.
- (8) When a vehicle has been utilized to transport a patient known to have a communicable disease or suffered exposure to hazardous material or biohazard material, the vehicle and equipment shall be properly cleansed and all contact surfaces washed properly. All hazardous and biohazard materials shall be disposed of properly. (*Indiana Emergency Medical Services Commission; 836 IAC 1-1-8; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3515; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

Rule 2. Certification of Ambulance Service Providers

836 IAC 1-2-1 General certification provisions

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 4-21.5; IC 16-31-3; IC 16-41-10

Sec. 1. (a) A person shall not:

- (1) furnish;
 - (2) operate;
 - (3) maintain;
 - (4) advertise; or
 - (5) otherwise engage in providing; emergency ambulance services unless the person is certified by the commission as an ambulance service provider organization.
- (b) Each ambulance, while transporting a patient, shall be staffed by not fewer than two (2) persons, one (1) of whom shall be:
- (1) a certified emergency medical technician; and
 - (2) in the patient compartment.
- (c) An emergency patient shall only be transported in a certified ambulance.
- (d) Each ambulance service provider organization shall notify the agency in writing as follows:
- (1) Within thirty (30) days of any changes in any items in the application required in section 2(a) of this rule.
 - (2) Immediately of change in medical director, including medical director approval form and protocols.
- (e) Each ambulance service provider organization shall have a medical director or medical director designee as described in 836 IAC 1-1-6(4)(C). The duties and responsibilities of the medical director are as follows:
- (1) Provide liaison between the:
 - (A) local medical community; and
 - (B) emergency medical service provider organization.
 - (2) Assure compliance with defibrillation training standards and curriculum established by the commission.
 - (3) Monitor and evaluate the day-to-day medical operations of the ambulance service provider organization.
 - (4) Assist in the continuing education programs of the ambulance service provider organization.
 - (5) Provide technical assistance concerning the delivery of automated defibrillation and other medical issues.
 - (6) Provide individual consultation to the emergency medical personnel affiliated with the ambulance service provider organization.
 - (7) Participate in the audit and review of cases treated by the emergency medical personnel of the ambulance service provider organization.
 - (8) Assure compliance with approved medical standards established by the commission performed by the ambulance service provider organization.
 - (9) Establish protocols for:
 - (A) automatic defibrillation;
 - (B) airway management;
 - (C) patient-assisted medications; and
 - (D) emergency medical technician-administered medications;
 as approved by the commission.
 - (10) Provide liaison between the:
 - (A) emergency medical service provider organization;
 - (B) emergency medical service personnel; and
 - (C) hospital; in regards to communicable disease testing under IC 16-41-10.

(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule I, A; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 84; filed Dec 15, 1977: Rules and Regs. 1978, p. 244; filed Dec 15, 1977: Rules and Regs. 1978, p. 245; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2192; errata, 4 IR 531; filed Oct 13, 1981, 10:05 a.m.: 4 IR 2419; filed Dec 2, 1983, 2:43 p.m.: 7 IR 352; errata, 7 IR 1254; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1036; filed Aug 18, 1986, 1:00 p.m.: 10 IR 24; filed May 15, 1998, 10:25 a.m.: 21 IR 3866; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2719; filed Apr 4, 2002, 9:15 a.m.: 25 IR 2506; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2337; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3516; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 1-2-2 Application for certification; renewal

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-8

Sec. 2. (a) Application for ambulance service provider organization certification shall be made on forms as provided by the agency, and the applicant shall comply with the following requirements:

(1) Applicants shall complete the required forms and submit the forms to the agency not less than sixty (60) days prior to the requested effective date of the certificate.

(2) Each ambulance and its equipment shall be made available for inspection by the agency.

(3) The premises on which:

(A) ambulances are parked or garaged; and

(B) ambulance supplies are stored; shall be open during business hours to the agency for inspection.

(4) Each application shall include the following information:

(A) A description of the service area.

(B) Hours of operation.

(C) Number and location of ambulances.

(D) Organizational structure, including name, address, and phone number for the:

(i) owner;

(ii) chief executive officer;

(iii) chief operations officer;

(iv) training officer; and

(v) medical director.

(E) Current Federal Communications Commission license or letter of authorization.

(F) Location of ambulance service provider organization's records.

(G) Proof of insurance coverage for ambulances and nontransport vehicles as required by 836 IAC 1-3-6.

(H) Staffing pattern of personnel.

(I) Base of operations.

(J) Roster of all affiliated personnel, signed by the medical director and chief executive officer, including certification numbers.

(K) Copy of protocols and standing orders established and signed by the medical director.

(L) Other information as required by the commission.

(b) Upon approval, a certificate shall be issued by the commission.

(c) The certificate:

(1) expires on the date appearing in the expiration date section of the certificate; and

(2) shall be prominently displayed at the place of business.

(d) Application for ambulance service provider organization certification renewal shall be made not less than sixty (60) days prior to the expiration date of the current certificate to assure continuity of certification. Application for renewal shall be made on forms as provided by the agency. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule I,B; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 86; filed May 10, 1977, 10:52 a.m.: Rules and Regs. 1978, p. 218; filed Dec 15, 1977: Rules and Regs. 1978, p. 245; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2193; filed Oct 13, 1981, 10:05 a.m.: 4 IR 2420; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1037; filed Aug 18, 1986, 1:00 p.m.: 10 IR 25; filed May 15, 1998, 10:25 a.m.: 21 IR 3867; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2720; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2338; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3517; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)*

836 IAC 1-2-3 Ambulance service provider organization operating procedures

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-2; IC 34-6-2-49

Sec. 3. (a) Each ambulance service provider organization shall maintain accurate records under 836 IAC 1-1-5.

(b) An ambulance service provider organization shall not operate a land ambulance on any public way in Indiana unless the ambulance is in full compliance with the ambulance certification requirements established and set forth in this article, except an ambulance service provider organization may operate, for a period not to exceed sixty (60) consecutive days, a noncertified ambulance if the noncertified ambulance is used to replace a certified ambulance that has been taken out of service providing the following:

- (1) The replacement ambulance shall meet all certification requirements.
- (2) The ambulance service provider organization shall notify the agency in writing within seventy-two (72) hours of the time the replacement ambulance is placed in service. The written notice shall identify the following:
 - (A) The replacement date.
 - (B) The certification number of the replaced ambulance.
 - (C) The:
 - (i) vehicle identification number; and
 - (ii) make and type; of the replacement ambulance.

Upon receipt of the notification, a temporary certificate shall be issued effective the date the certified ambulance was replaced. Temporary certification shall not exceed sixty (60) days from the date that the replacement ambulance is placed in service, and, upon return to service of the certified ambulance, the use of the replacement vehicle shall cease.

(c) Each ambulance service provider organization shall do the following:

- (1) Provide and maintain a communication system that meets or exceeds the requirements set forth in 836 IAC 1-4.
- (2) Within seven (7) calendar days of the date a certified ambulance is permanently withdrawn from service, return to the agency the certificate and window sticker issued for the ambulance.

(d) No ambulance service provider organization may operate any noncertified vehicle that displays to the public any word, phrase, or marking that implies in any manner that the vehicle is an ambulance.

(e) Each ambulance service provider organization shall ensure that *[sic]* do the following:

- (1) Follow sanitation procedures listed in 836 IAC 1-1-8.
- (2) Conduct audit and review under 836 IAC 1-1-6.

(f) An ambulance service provider organization with approval from the provider organization's medical director may transport

a patient with the following:

- (1) PCA pump with any medication or fluid infusing through a peripheral IV.
- (2) Medication infusing through a peripheral IV or continuous subcutaneous catheter via a closed, locked system.
- (3) A central catheter that is clamped off.

(4) A patient with a:

- (A) feeding tube that is clamped off;
- (B) Holter monitor; or
- (C) peripheral IV infusing vitamins.

(5) IV fluids infusing through a peripheral IV via gravity or an infusing system that allows the technician to change the rate of infusion are limited to D5W, Lactated Ringers, sodium chloride (nine-tenths percent (0.9%) or less), potassium chloride (twenty (20) milliequivalent per liter or less for emergency medical technicians, forty (40) milliequivalent per liter or less for emergency medical technicians-basic advanced). At no time will piggy-back or secondary intravenous line or blood products be transported. (*Indiana Emergency Medical Services Commission; Emergency Medical Services Rule I, C; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 86; filed May 10, 1977, 10:52 a.m.: Rules and Regs. 1978, p. 218; filed Dec 15, 1977: Rules and Regs. 1978, p. 245; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2194; errata, 4 IR 531; filed Dec 2, 1983, 2:43 p.m.: 7 IR 353; errata, 7 IR 1254; errata, 7 IR 1551; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1038; filed Aug 18, 1986, 1:00 p.m.: 10 IR 26; filed Oct 11, 1988, 11:05 a.m.: 12 IR 354; filed May 15, 1998, 10:25 a.m.: 21 IR 3868; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2721; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2339; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3517; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 1-2-4 Penalties (Repealed)

Sec. 4. (*Repealed by Indiana Emergency Medical Services Commission; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372*)

836 IAC 1-2-5 Interfacility transfers and response

Authority: IC 16-31-2-7

Affected: IC 16-18-2-7; IC 16-28-2-161; IC 16-31

Sec. 5. (a) A basic life support ambulance service provider organization may transport an emergency patient who would normally require transport by an advanced life support ambulance service provider organization if the following conditions are met:

(1) The emergency patient is being transported from one (1) health care facility to another health care facility. Health care facility has the meaning set forth in IC 16-28-2-161.

(2) The transferring physician has issued written approval of the interfacility transfer by the basic life support ambulance service provider organization.

(3) The ambulance is equipped with the medical supplies and equipment determined by the transferring physician to be necessary to maintain the patient's medical condition and to manage patient complications that may be reasonably anticipated to occur en route to the patient's destination.

(4) The patient compartment of the ambulance is staffed by at least one (1) employee of the transferring health care facility who the transferring physician has determined has the training and skills necessary to maintain the patient's medical condition and to manage patient complications that may be reasonably anticipated to occur en route to the patient's destination.

(b) A basic life support ambulance service provider organization may transport an emergency patient who would normally require transport by an advanced life support ambulance service provider organization if the following conditions are met:

(1) The emergency patient is being transported from the scene of a medical emergency to a health care facility.

(2) An advanced life support provider organizations also responded to the scene, and advanced life support treatment has been initiated by a paramedic or emergency medical technician-intermediate and a paramedic or emergency medical technician intermediate is present in the patient compartment of the transporting ambulance.

(3) The medical director of the basic life support ambulance service provider organization has established a protocol.

(c) The vehicle staffing required in subsection (a) is in addition to the staffing required as determined by the level of certification by the commission for the ambulance service provider organization that transports the patients. (*Indiana Emergency Medical Services Commission; 836 IAC 1-2-5; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3520*)

Rule 3. Standards and Certification Requirements for Ambulances

836 IAC 1-3-1 General certification provisions

Authority: IC 16-31-2-7

Affected: IC 16-31-3

Sec. 1. (a) This rule is applicable to all emergency medical service vehicles eligible for certification.

(b) All emergency medical service vehicles shall be in full compliance and meet minimum specifications and certification requirements set forth in this rule to be certified. (*Indiana Emergency Medical Services Commission; Emergency Medical Services Rule II, A; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 87; filed Dec 15, 1977: Rules and Regs. 1978, p. 245; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2196; errata, 4 IR 531; filed Oct 13, 1981, 10:05 a.m.: 4 IR 2421; filed Dec 2, 1983, 2:43 p.m.: 7 IR 354; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1041; filed May 15, 1998, 10:25 a.m.: 21 IR 3872; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2724; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3520*)

836 IAC 1-3-2 Application for certification

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-2; IC 16-31-3-8

Sec. 2. (a) Application for emergency medical service vehicle certification shall be made by the emergency medical service provider organization on such forms as provided by the agency and shall comply with the following requirements:

(1) Applicants shall complete the required forms and submit the forms to the agency with the following information:

(A) Name and address of the emergency medical service provider organization.

(B) Vehicle information, including make, model, year, and vehicle identification number.

(C) Color scheme of emergency medical service vehicle.

(2) Each emergency medical service vehicle for which certification is requested shall be made available for inspection by the agency with its equipment as required by this article or 836 IAC 2 prior to approval for certification.

(b) If the emergency medical service vehicle is found to comply with all applicable requirements in this article, a certificate shall be issued to the emergency medical service provider organization for the vehicle. The certificate:

(1) expires on the date appearing in the expiration date section of the certificate; and

(2) shall be prominently displayed within the patient compartment of the ambulance or driver compartment of the emergency medical service nontransport vehicle. (*Indiana Emergency Medical Services Commission; Emergency Medical Services Rule II, B; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 88; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2196; filed Dec 2, 1983, 2:43 p.m.: 7 IR 354; errata, 7 IR 1254; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1042; filed May 15, 1998, 10:25 a.m.: 21 IR 3872; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2725; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3520; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 1-3-3 Land ambulance specifications

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 3. (a) All land ambulances shall meet or exceed the following minimum performance characteristics:

- (1) Vehicle brakes shall be of the heavy-duty power assist type.
- (2) Parking brake shall hold vehicle when engaged.
- (3) The vehicle engine shall be a six (6) or eight (8) cylinder internal combustion, liquid cooled engine that meets ambulance chassis manufacturer's standard horsepower/displacement requirements.
- (4) The fully loaded vehicle shall be capable of a sustained speed of at least sixty-five (65) miles per hour over dry, level, or hard-surfaced roads.
- (5) The vehicle transmission shall have a minimum of three (3) forward gears and one (1) reverse gear. Automatic transmission is required.
- (6) The steering system shall be:
 - (A) the manufacturer's recommended design; and be *[sic]*
 - (B) power assisted.
- (7) Shock absorbers shall be of the heavy-duty, double action type.
- (8) Tires shall meet the manufacturer's standards for the gross vehicle weight of the vehicle. Retread tires shall not be used on ambulances. No tire shall:
 - (A) display exposed tire cord; or
 - (B) have tread depth less than two thirty-seconds ($2/32$) on back tires and four thirty-seconds ($4/32$) on front tires spaced equally around the tire, with no visible defects.

(b) All land ambulances shall meet or exceed the following minimum physical characteristics:

- (1) The overall width of the vehicle shall be a minimum of seventy-five (75) inches and shall not exceed ninety-six (96) inches, excluding mirrors, lights, and trim.
- (2) The overall vehicle exterior height shall be a maximum of one hundred ten (110) inches, measured at curb height from the ground to a point that is level with the top of the vehicle, including emergency warning devices, but excluding two-way radio antenna.
- (3) The vehicle shall have a wheelbase of one hundred twenty-three (123) inches, minimum. See subsection (e)(1) for minimum inside length of patient compartment.

(c) All land ambulances shall meet or exceed the following minimum specifications for electrical systems:

- (1) Wiring shall be made up into harnesses, properly sized, and coded. These shall be reasonably accessible for checking and maintenance. In any area where wiring would be exposed to the elements, it shall be protected by a weatherproof harness or loom. This loom shall be installed so as to eliminate the possible entrance of water that could cause damage through freezebursting. Wiring, in loom or otherwise, shall not be accepted if in the area of wheel wash abrasion. Wiring shall be protected by a rubber grommet or plastic bezel at any point where it may pass through, or over, the edge of any metal panel unless the hole or edge of the metal is hemmed or flanged. Wiring connectors and terminals shall be the manufacturer's recommended standard. Horizontal wiring shall be supported by insulated clips located and spaced to minimize sag. Complete wiring diagrams for standard and for optional equipment shall be supplied for each vehicle. Ambulance body and accessory electrical equipment shall be served by circuits separate and distinct from vehicle chassis circuits.
- (2) The electrical generating system shall consist of a one hundred five (105) ampere alternator minimum.
- (3) Two (2) batteries shall be provided, each with a seventy (70) amp hour rating.
- (4) Lighting shall be designed and located so that no glare is reflected from surrounding areas to the driver's eyes or line of vision, from instrument panel, switch panel, or other areas that may require illumination while the vehicle is in motion.
- (5) Illumination shall:
 - (A) be adequate throughout the compartment; and
 - (B) provide an intensity of light at the level of the patient for:
 - (i) adequate observation of vital signs, such as skin color and pupillary reflex; and for *[sic]*

(ii) care in transit; and

(C) be automatically activated when opening the patient compartment doors in addition to being controlled by a switch panel in the patient compartment located at the head of the patient.

Reduced light level may be provided by rheostat control of the compartment lighting or by a second system of low intensity lights.

(6) The ignition system shall be suppressed to prevent interference with radio transmission and receiving.

(7) The vehicle shall have floodlights that illuminate a half-circle as wide as the vehicle to a point six (6) feet behind the vehicle on its center line. The floodlight shall be body-mounted and activated when rear doors are opened.

(8) All circuits shall be protected by automatic circuit breakers of proper capacity.

(9) Each ambulance for which certification is requested shall have an audible backup warning device that is activated when the ambulance is shifted into reverse.

(d) All land ambulances shall meet the following requirements for external identification:

(1) Warning lights of red or red and white, at the discretion of the owner, and shall conform with *[sic]* to Indiana state law. Rear facing amber lights may be used. All lights on the vehicle shall be in working condition.

(2) The word "AMBULANCE" shall be displayed on the exterior of the vehicle, on front, back, or at least one (1) side of the vehicle in letters not less than three (3) inches in height and a color contrasting material.

(3) Each fully certified ambulance shall display the four (4) numbers of the commission-assigned ambulance certification number. The four (4) numbers, in sequence, shall be placed on each side of the ambulance on the right and left front fenders and on the rear portion of the vehicle. Each number shall be in block letters not less than three (3) inches in height. This number shall be displayed in color contrasting, reflective material. The numbers shall be placed on the vehicle within seven (7) days of the receipt of the ambulance certificate. The numbers shall be removed or permanently covered by the ambulance service provider organization when the ambulance is permanently removed from service by the ambulance service provider organization.

(4) A commission certified vehicle sticker shall be displayed on all certified vehicles.

(e) All land ambulance bodies shall meet or exceed the following minimum specifications:

(1) The length of the patient compartment shall be a minimum of one hundred eleven (111) inches and provide a minimum of twenty-five (25) inches clear space at the head of the litter, and a minimum of ten (10) inches shall be provided from the end of the litter's mattress to the rear loading doors.

(2) An aisle free of obstruction the full length of the stretcher shall be provided.

(3) The inside height of the patient compartment shall be a minimum of sixty (60) inches measured floor to ceiling in the center of the patient compartment.

(4) One (1) seat shall be provided within the patient compartment for the technician, the dimensions of which shall be at the discretion of the owner.

(5) If a bulkhead or partition is provided between the driver and patient compartments, a means of voice or signal communication between the driver compartment and the patient compartment shall be provided.

(f) All land ambulances shall meet or exceed the following minimum standards of construction:

(1) The body structure shall be of prime commercial quality metal or other material with strength at least equivalent to all-steel. Wood shall not be used for structural framing. The exterior of the body shall be finished smooth with symmetrically rounded corners and edges, except for rub rails, and embody provisions for door and windows specified in this subsection. The ambulance body as a unit shall be of sufficient strength to support the entire weight of the fully loaded vehicle on its top or side if overturned, without:

(A) crushing;

(B) separation of joints; or

(C) permanently deforming:

(i) roof bow or reinforcements;

(ii) body posts;

(iii) doors;

(iv) strainers;

(v) stringers;

(vi) floor;

(vii) inner linings;

(viii) outer panels;

(ix) rub rails; and

(x) other reinforcements.

(2) The vehicle shall have a loading door or doors on the right side and at the rear of the vehicle. Rear patient compartment doors shall incorporate a tension, spring, or plunger type holding device to prevent the door from closing unintentionally from wind or vibration.

(3) The floor:

(A) shall be:

- (i) at the lowest level permitted by clearances; and
- (ii) flat and unencumbered in the access and work area; and

(B) may be:

- (i) metal properly reinforced to eliminate oil canning and insulated against outside heat and cold; and
- (ii) marine plywood provided the plywood is sufficient in thickness to rigidly take the loads imposed upon it. A combination of plywood over metal shall be acceptable provided the surfaces between are coated with waterproof adhesive. There shall be no voids or pockets in the floor to side wall areas where water or moisture can become trapped to cause rusting or unsanitary conditions.

(4) The floor covering shall be:

(A) seamless;

(B) one (1) piece;

(C) skid-resistant; and

(D) extend the full length and width of the compartment.

Linoleum vinyl or urethane quartz poured not less than one-sixteenth (1/16) of an inch in thickness permanently applied is required. Covering joints at the side walls, where side panels and covering meet, shall be sealed.

(g) All windows shall be intact. The vehicle shall have windshield wipers that are in working condition.

(h) Dual, firmly secured, vibrationless, rear-view mirrors, one (1) mounted on the left side of the vehicle and one (1) mounted on the right side, shall be included.

(i) In addition to any other requirements specified in this section, the patient compartment shall meet the following minimum requirements:

(1) Crash-stable fasteners shall be provided to secure litters to the floor or side walls. Where a single patient may be centered in the area on the wheeled litter, additional attachments shall be provided.

(2) If the litter is floor supported on its own support wheels, a means shall be provided to secure it in position under all conditions. These restraints shall permit quick attachment and detachment for quick transfer of patient.

(3) Appropriate passenger restraints shall be installed in all seating facilities for drivers, passengers, and attendant.

(j) All land ambulances shall meet or exceed the following minimum communication standards:

(1) Two-way radio communication equipment shall conform to the requirements set forth in this article.

(2) Type and number of sirens shall:

(A) be at the discretion of the ambulance service provider organization; and

(B) conform to Indiana law.

(k) All ambulances shall meet or exceed the following minimum requirements for environmental equipment:

(1) Separate heating units shall be provided for the driver and patient compartments. The driver compartment shall provide for window defrosting.

(2) An adequate air-conditioning system shall be provided for cooling both driver and patient compartment.

(3) An adequate heating system shall be provided for heating both driver and patient compartment. The patient compartment shall be heavily insulated to minimize conduction of heat, cold, or external noise entering the vehicle interior. (*Indiana Emergency Medical Services Commission; Emergency Medical Services Rule II,C; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 88; filed May 10, 1977, 10:52 a.m.: Rules and Regs. 1978, p. 218; filed May 10, 1977, 10:52 a.m.: Rules and Regs. 1978, p. 219; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2197; errata, 4 IR 531; filed Oct 13, 1981, 10:05 a.m.: 4 IR 2421; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1042; filed Aug 18, 1986, 1:00 p.m.: 10 IR 29; filed May 15, 1998, 10:25 a.m.: 21 IR 3872; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2725; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3521; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 1-3-4 Land ambulance rescue equipment

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 4. Land ambulances shall carry the following assembled and readily accessible minimum rescue equipment:

(1) Equipment for safeguarding personnel includes:

(A) one (1) fire extinguisher with an Underwriters Laboratory rating of not less than 4A; 4-B; C; or

(B) two (2) fire extinguishers with individual Underwriters Laboratory ratings of not less than 2A:4-B; C;

that shall have a current inspection date within the last twelve (12) months and be mounted so that they are readily accessible.

(2) Equipment for release from entrapment or confinement, including the following:

(A) One (1) hammer, four (4) pound minimum.

(B) One (1) wrecking bar, twenty-four (24) inch combination tool minimum.

(C) One (1) self-contained portable light source. (*Indiana Emergency Medical Services Commission; Emergency Medical Services Rule II, D; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 93; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2200; filed Dec 2, 1983, 2:43 p.m.: 7 IR 355; errata, 7 IR 1254; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1045; filed May 15, 1998, 10:25 a.m.: 21 IR 3875; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2727; readopted filed Nov 30, 2006, 9:17 a.m.: 20061213-IR-836060486RFA; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 1-3-5 Emergency care equipment

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 5. Each and every land ambulance will have the following minimum emergency care equipment, and this equipment shall be assembled and readily accessible:

(1) Respiratory and resuscitation equipment as follows:

(A) Portable suction apparatus, capable of a minimum vacuum of three hundred (300) millimeters mercury, equipped with two (2) each of the following:

(i) wide-bore tubings;

(ii) rigid catheters;

(iii) soft pharyngeal suction tips in child size; and

(iv) soft pharyngeal suction tips in adult size.

(B) Onboard suction, capable of a minimum vacuum of three hundred (300) millimeters mercury, equipped with widebore tubing and both rigid and soft pharyngeal suction tips.

(C) Bag-mask ventilation units, hand operated, one (1) unit in each of the following sizes, each equipped with clear face masks and oxygen reservoirs with oxygen tubing:

(i) Adult.

(ii) Child.

(iii) Infant.

(iv) Neonatal (mask only).

(D) Oropharyngeal airways, two (2) each of adult, child, and infant.

(E) One (1) pocket mask with one-way valve.

(F) Portable oxygen equipment of at least three hundred (300) liters capacity (D size cylinder) with:

(i) yoke;

(ii) medical regulator;

(iii) pressure gauge; and

(iv) nondependent flowmeter.

(G) Onboard oxygen equipment of at least three thousand (3,000) liters capacity (M size cylinder) with:

(i) yoke;

(ii) medical regulator;

(iii) pressure gauge; and

(iv) nondependent flowmeter.

(H) Oxygen delivery devices shall include the following:

(i) High concentration devices, two (2) each, adult, child, and infant.

(ii) Low concentration devices, two (2) each, adult.

(I) Nasopharyngeal airways, two (2) each of the following with water soluble lubricant:

(i) Small (20-24 french).

(ii) Medium (26-30 french).

(iii) Large (31 french or greater).

(J) Bulb syringe individually packaged in addition to obstetrics kit.

(K) Nonvisualized airway minimum of two (2) with water soluble lubricant.

(L) Semiautomatic or automated external defibrillator and a minimum of two (2) sets of pads.

(2) Wound care supplies as follows:

(A) Multiple trauma dressings, two (2) approximately ten (10) inches by thirty-six (36) inches.

(B) Fifty (50) sterile gauze pads, three (3) inches by three (3) inches or larger.

- (C) Bandages, four (4) soft roller self-adhering type, two (2) inches by four (4) yards minimum.
- (D) Airtight dressings, four (4), for open chest wounds.
- (E) Adhesive tape, two (2) rolls.
- (F) Burn sheets, two (2), sterile.
- (G) Triangular bandages, four (4).
- (H) Bandage shears, one (1) pair.
- (3) Patient stabilization equipment as follows:
 - (A) Traction splint, lower extremity, limb-supports, padded ankle hitch, and traction strap, or equivalent, one (1) assembly in adult size.
 - (B) Upper and lower extremity splinting devices, two (2) each.
 - (C) One (1) splint device intended for the unit-immobilization of head-neck and torso. These items shall include the splint itself and all required accessories to provide secure immobilization.
 - (D) One (1) long backboard with accessories to provide secure spinal immobilization.
 - (E) Rigid extrication collar, two (2) each capable of the following sizes:
 - (i) Pediatric.
 - (ii) Small.
 - (iii) Medium.
 - (iv) Large.
 - (F) One (1) ambulance litter with side rails, head-end elevating capacity, mattress pad, and a minimum of three (3) adjustable restraints to secure the chest, hip, and knee areas.
- (4) Medications if approved by medical director, and solely for use by individuals with a certification as an emergency medical technician or higher, are as follows:
 - (A) Baby aspirin, eighty-one (81) milligrams each.
 - (B) Activated charcoal.
 - (C) Instant glucose.
 - (D) Epinephrine auto-injector or auto-injectors.
- (5) Personal protection/universal precautions equipment, minimum of two (2) each, including the following:
 - (A) Gowns.
 - (B) Face masks and shields.
 - (C) Gloves.
 - (D) Biohazard bags.
 - (E) Antimicrobial hand cleaner.
- (6) Miscellaneous items as follows:
 - (A) Obstetrical kit, sterile, one (1).
 - (B) Clean linens consisting of the following:
 - (i) Pillow.
 - (ii) Pillow case.
 - (iii) Sheets and blankets.
 - (C) Blood pressure manometer, one (1) each in the following cuff sizes:
 - (i) Large adult.
 - (ii) Adult.
 - (iii) Pediatric.
 - (D) Stethoscopes, one (1) each in the following sizes:
 - (i) Adult.
 - (ii) Pediatric.
 - (E) Sharps collector, one (1) being a minimum of seven (7) inches in height.
 - (F) A current copy of the basic life support protocols.

(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule II, E; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 93; filed May 10, 1977, 10:52 a.m.: Rules and Regs. 1978, p. 219; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2200; filed Dec 2, 1983, 2:43 p.m.: 7 IR 355; errata, 7 IR 1254; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1045; filed Aug 18, 1986, 1:00 p.m.: 10 IR 31; filed May 15, 1998, 10:25 a.m.: 21 IR 3875; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2727; filed Apr 4, 2002, 9:15 a.m.: 25 IR 2507; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2342; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3523; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 1-3-6 Insurance

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3; IC 16-31-3-17; IC 34-13-3

Sec. 6. (a) This section is applicable to the following emergency medical service vehicles:

(1) Ambulance.

(2) Emergency medical technician-basic advanced nontransport vehicles.

(3) Advanced life support nontransport vehicles.

(b) All emergency medical service vehicles to which this section is applicable must be:

(1) insured in accordance with the requirements contained in this section; or

(2) owned by a governmental entity covered under IC 34-13-3.

(c) If insurance is required for an emergency medical services vehicle under subsection (b), a certification for a vehicle will not be issued until the applicant has submitted a certificate of insurance demonstrating that the applicant has liability insurance:

(1) in effect with an insurer that is authorized to write insurance in Indiana; and

(2) that provides a combined single limit of at least one million dollars (\$1,000,000) for the injury or death of any number of persons in any one (1) occurrence.

(d) If an insurance policy required under this section:

(1) is canceled during the policy's term;

(2) lapses for any reason; or

(3) has the policy's coverage fall below the required amount; the person to whom the certification for the emergency medical services vehicle was issued shall immediately notify the agency and must also immediately replace the policy with another policy that complies with this section so that the vehicle is never operated without the insurance required under this section.

(e) If the insurance policy for an emergency medical services vehicle that is required to be insured under this section is canceled, lapses for any reason, or has the policy coverage fall below the required amount, the use of the emergency medical services vehicle:

(1) must immediately cease; and

(2) shall not resume until approval to resume its use has been obtained in writing from the agency.

(Indiana Emergency Medical Services Commission; 836 IAC 1-3-6; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2343; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3524; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

Rule 4. Communications System Requirements

836 IAC 1-4-1 Provider dispatch requirements

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-2

Sec. 1. All emergency medical service provider organizations dispatch centers shall be:

(1) capable of two-way communications with associated provider vehicles;

(2) used exclusively for dispatch and tactical communications; and

(3) apart from any involved in the Indiana Hospital Emergency Radio Network. *(Indiana Emergency Medical Services Commission; Emergency Medical Services Rule III, A; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 94; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2201; filed Oct 13, 1981, 10:05 a.m.: 4 IR 2424; filed Dec 2, 1983, 2:43 p.m.: 7 IR 356; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1046; filed May 15, 1998, 10:25 a.m.: 21 IR 3877; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3525; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)*

836 IAC 1-4-2 Emergency medical services vehicle radio equipment

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-2

Sec. 2. (a) All communication used in emergency medical service vehicles for the purpose of dispatch or tactical communications shall demonstrate and maintain the ability to provide a voice communications linkage with the emergency medical service provider organization's dispatch center within the area that the emergency medical service provider organization normally serves or proposes to serve.

(b) Communication equipment used in emergency medical services vehicles shall be appropriately licensed through the Federal Communications Commission, when applicable. The maximum power of the transmitter shall be not more than the minimum required for technical operation, commensurate with the:

(1) size of the area to be served; and

(2) local conditions that affect radio transmission and reception.

(c) All emergency medical services vehicles shall be equipped with two (2) channels or talk-groups as follows:

- (1) One (1) channel or talk-group shall be used primarily for dispatch and tactical communications.
- (2) One (1) channel or talk-group shall be 155.340 MHz and have the proper tone equipment to operate on the Indiana Hospital Emergency Radio Network (IHERN) unless the provider organization vehicles and all the destination hospitals within the operational area of the provider organization have a system that is interoperable with the Indiana statewide wireless public safety voice and data communications system. (*Indiana Emergency Medical Services Commission; Emergency Medical Services Rule III, B; filed Jun 5, 1975, 11:57 a.m.: Rules and Regs. 1976, p. 94; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2201; filed Dec 2, 1983, 2:43 p.m.: 7 IR 356; errata, 7 IR 1254; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1046; filed May 15, 1998, 10:25 a.m.: 21 IR 3877; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3525; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

Rule 5. Certification of Emergency Medical Technicians (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759)

Rule 6. Requirements and Standards for Emergency Medical Technician Training

836 IAC 1-6-1 General requirements for training institutions; staff (Repealed)

Sec. 1. *(Repealed by Indiana Emergency Medical Services Commission; filed May 15, 1998, 10:25 a.m.: 21 IR 3930)*

836 IAC 1-6-2 Primary instructor; medical director (Repealed)

Sec. 2. *(Repealed by Indiana Emergency Medical Services Commission; filed May 15, 1998, 10:25 a.m.: 21 IR 3930)*

836 IAC 1-6-3 Training institution report requirements (Repealed)

Sec. 3. *(Repealed by Indiana Emergency Medical Services Commission; filed Nov 3, 1980, 3:55 pm: 3 IR 2250)*

836 IAC 1-6-4 Student qualifications for basic training (Repealed)

Sec. 4. *(Repealed by Indiana Emergency Medical Services Commission; filed Nov 3, 1980, 3:55 pm: 3 IR 2250)*

836 IAC 1-6-5 Requirements for basic emergency medical technician training (Repealed)

Sec. 5. *(Repealed by Indiana Emergency Medical Services Commission; filed Nov 3, 1980, 3:55 pm: 3 IR 2250)*

836 IAC 1-6-6 Basic training standards; in-service training standards (Repealed)

Sec. 6. *(Repealed by Indiana Emergency Medical Services Commission; filed Jul 29, 1987, 2:25 pm: 10 IR 2722, eff Jul 1, 1987 [IC 4-22-2-36 suspends the effectiveness of a rule document for 30 days after filing with the secretary of state. LSA Document #87-172(F) was filed Jul 29, 1987.]*

Rule 6.1. Emergency Medical Services Training Institution (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759)

Rule 7. Standards and Certification Requirements for Air Ambulance Service Providers and Air Ambulances (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed Oct 11, 1988, 11:05 a.m.: 12 IR 381)

Rule 8. Waivers; Exceptions

836 IAC 1-8-1 Request for waiver (Repealed)

Sec. 1. *(Repealed by Indiana Emergency Medical Services Commission; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372)*

Rule 9. Emergency Medical Services Primary Instructor Certification (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759)

Rule 10. First Responders (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759)

Rule 11. Emergency Medical Services Nontransport Providers

836 IAC 1-11-1 General certification provisions

Authority: IC 16-31-2-7

Affected: IC 4-33; IC 10-11-8-2; IC 16-21; IC 16-31; IC 22-12-1-12

Sec. 1. (a) The following organizations are required to obtain certification as a basic life support nontransport provider organization prior to providing first response emergency patient care that includes defibrillation:

(1) Fire department as defined in IC 22-12-1-12.

(2) Any provider organization required to be certified under IC 16-31.

(b) The following organizations not included under subsection (a) are not required to obtain certification as a basic life support nontransport provider organization prior to providing first response emergency patient care that includes defibrillation; however, the organizations may apply to obtain certification in accordance with the provisions of this rule:

(1) A law enforcement agency as defined in IC 10-11-8-2.

(2) A riverboat on which lawful gambling is authorized under IC 4-33.

(3) A hospital licensed under IC 16-21.

(4) Other organizations approved by the commission. (*Indiana Emergency Medical Services Commission; 836 IAC 1-11-1; filed May 15, 1998, 10:25 a.m.: 21 IR 3887; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2728; filed Apr 4, 2002, 9:15 a.m.: 25 IR 2508; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2343; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3526*)

836 IAC 1-11-2 Application for certification; renewal

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-2; IC 16-31-3-8

Sec. 2. (a) Application for basic life support nontransport provider organization certification shall be made on forms as provided by the agency, and the applicant shall comply with the following requirements:

(1) Applicants shall complete the required forms and submit the forms to the agency not less than sixty (60) days prior to the requested effective date of the certificate.

(2) Each vehicle with emergency medical services equipment required by section 4 of this rule shall be made available for inspection by the agency.

(3) The premises on which emergency medical service nontransport vehicles are stored shall be open during operating hours to the agency for inspection.

(4) Each application shall include the following information:

(A) A description of the service area.

(B) Hours of operation.

(C) Number and location of emergency medical services vehicles.

(D) Organizational structure, including names, addresses, and telephone numbers of the:

(i) owner;

(ii) chief executive officer;

(iii) chief operations officer;

(iv) training officer; and

(v) medical director.

(E) Current Federal Communications Commission license or letter of authorization.

(F) Location of emergency medical services nontransport provider organization's records.

(G) Proof of insurance coverage for vehicles if required by 836 IAC 1-3-6.

(H) Medical director approval form provided by the agency.

(I) Personnel roster form provided by the agency.

(J) A copy of the agreement with an ambulance service provider organization as required by subsection (e).

(K) Other information as required by the commission.

(b) Upon approval, a certificate shall be issued by the commission.

(c) The certificate:

(1) expires on the date appearing in the expiration date section of the certificate unless earlier revoked or suspended by the commission; and

(2) shall be prominently displayed at the place of business.

(d) Application for emergency medical services nontransport provider organization certification renewal shall be made not less than sixty (60) days prior to the expiration date of the current certificate to assure continuity of certification. Application for renewal shall:

(1) be made on forms as provided by the agency; and

(2) indicate compliance with the requirements set forth for original certification.

(e) Basic life support nontransport provider organizations shall have and maintain in place an agreement between the nontransport provider organization and an ambulance service provider organization certified under IC 16-31. The agreement shall:

(1) ensure that the nontransporting provider organization can be assured that patients treated shall be transported in a timely and safe manner; and

(2) not preclude another ambulance service provider organization, if available, from transporting the patients.

(f) Each basic life support nontransport provider organization shall notify the agency within thirty (30) days of any change in the operation as outlined in the application. (*Indiana Emergency Medical Services Commission; 836 IAC 1-11-2; filed May 15, 1998, 10:25 a.m.: 21 IR 3887; filed Apr 4, 2002, 9:15 a.m.: 25 IR 2509; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2344; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3526; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 1-11-3 Emergency medical services nontransport provider organization operating procedures

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-41-10

Sec. 3. Each basic life support nontransport provider organization shall do the following:

(1) Provide and maintain a communication system that meets or exceeds the requirements set forth in 836 IAC 1-4.

The basic life support nontransporting vehicles are not required to be equipped with the Indiana Hospital Emergency Radio Network frequency (155.340 MHZ) as specified in 836 IAC 1-4-2(c)(2).

(2) Follow the rigid sanitation procedures listed in 836 IAC 1-1-8.

(3) Conduct quarterly audit and review under 836 IAC 1-1-6.

(4) Secure a medical director. The duties and responsibilities of the medical director are as follows:

(A) Provide liaison between the local medical community and the emergency medical services provider organization.

(B) Assure compliance with defibrillation training standards and curriculum established by the commission.

(C) Monitor and evaluate the day-to-day medical operations of the emergency medical service provider organization.

(D) Assist in the continuing education programs of the emergency medical service provider organization.

(E) Provide technical assistance concerning the delivery of automated defibrillation and other medical issues.

(F) Provide individual consultation to the emergency medical personnel affiliated with the emergency medical services provider organization.

(G) Participate in the audit and review of cases treated by the emergency medical defibrillation personnel of the emergency medical service provider organization.

(H) Assure compliance with approved medical standards established by the commission performed by the provider organization.

(I) Establish protocols for automatic defibrillation, airway management, and medication administration as approved by the commission.

(J) Provide liaison between the:

(i) emergency medical service provider organization;

(ii) emergency medical service personnel; and

(iii) hospital;

in regards to communicable disease testing under IC 16-41-10.

(5) Maintain accurate records under 836 IAC 1-1-5.

(6) Employ at least one (1) certified individual trained in the use of the automated defibrillator. Only trained personnel shall use an automated defibrillator.

(7) Comply with rule 1 of this chapter [*sic*].

(*Indiana Emergency Medical Services Commission; 836 IAC 1-11-3; filed May 15, 1998, 10:25 a.m.: 21 IR 3888; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2729; filed Apr 4, 2002, 9:15 a.m.: 25 IR 2510; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3527; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 1-11-4 Basic life support nontransport provider organization emergency care equipment

Authority: IC 16-31-2-7

Affected: IC 16-31-3-2

Sec. 4. Every basic life support nontransport provider organization shall have one (1) set of the following assembled and readily accessible emergency care equipment for every vehicle utilized as an emergency medical service nontransport vehicle:

(1) Respiratory and resuscitation equipment as follows:

(A) Portable suction apparatus, capable of a minimum vacuum of three hundred (300) millimeters mercury, equipped with wide-bore tubing and both rigid and soft pharyngeal suction tips.

(B) Bag-mask ventilation units, hand operated, one (1) unit in each of the following sizes, each equipped with clear face masks and oxygen reservoirs with oxygen tubing:

(i) Adult.

(ii) Child.

(iii) Infant.

(iv) Neonatal (mask only).

(C) Portable oxygen equipment of at least three hundred (300) liters capacity (D size cylinder) with yoke, medical regulator, pressure gauge, and nondependent flowmeter. Oxygen delivery devices shall include high concentration devices, one (1) each of the following:

(i) Adult.

(ii) Child.

(iii) Infant.

(D) Oropharyngeal airways, two (2) each of adult, child, and infant.

(E) One (1) pocket mask with one-way valve.

(F) Nasopharyngeal airways, two (2) each of the following:

(i) Small (20-24 french).

(ii) Medium (26-30 french).

(iii) Large (31 french or greater).

(G) Semiautomatic or automated external defibrillator and a minimum of two (2) sets of pads.

(2) Wound care supplies as follows:

(A) Ten (10) sterile gauze pads, three (3) inches by three (3) inches or larger.

(B) Bandages, two (2) soft roller self-adhering type, two (2) inches by four (4) yards minimum.

(C) Adhesive tape, two (2) rolls.

(D) Bandage shears, one (1) pair.

(3) Miscellaneous items as follows:

(A) Water soluble lubricant for airway insertion.

(B) Stethoscope, one (1).

(C) Blood pressure manometer, one (1) adult size.

(D) Diagnostic penlight or portable flashlight, one (1).

(E) Disposable gloves, two (2) pairs.

(F) A current copy of the basic life support protocols.

(4) Medications, if approved by medical director, and solely for use by individuals with a certification as an emergency medical technician or higher, are as follows:

(A) Baby aspirin, eighty-one (81) milligrams each.

(B) Activated charcoal.

(C) Instant glucose.

(D) Epinephrine auto-injector or auto-injectors. (*Indiana Emergency Medical Services Commission; 836 IAC 1-11-4; filed May 15, 1998, 10:25 a.m.: 21 IR 3890; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2731; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2345; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3529*)

836 IAC 1-11-5 Penalties (Repealed)

Sec. 5. (*Repealed by Indiana Emergency Medical Services Commission; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372*)

Rule 12. Emergency Medical Technician-Basic Advanced Provider Organizations; Requirements; Standards

836 IAC 1-12-1 Emergency medical technician-basic advanced provider organizations; general requirements

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3; IC 16-41-10

Sec. 1. (a) A person shall not:

- (1) furnish;
- (2) operate;
- (3) maintain;
- (4) advertise; or

(5) otherwise engage in providing;

emergency medical services as an emergency medical technician-basic advanced provider organization unless the person is certified by the commission as an emergency medical technician-basic advanced provider organization.

(b) An emergency medical technician-basic advanced provider organization certification provides authority to perform skills set forth and approved by the commission for which certification is granted. The medical director may limit the skills according to local protocols.

(c) If an emergency medical technician-basic advanced provider organization also provides transportation of emergency patients, the emergency medical technician-basic advanced provider organization shall be certified as an ambulance service provider organization under 836 IAC 1-2.

(d) The chief executive officer of an emergency medical technician-basic advanced provider organization shall certify that the provider organization has an agreement, or interdepartmental memo if hospital based, with one (1) or more supervising hospitals for the following services:

(1) Continuing education.

(2) Audit and review.

(3) Medical control and direction.

(4) Provision to allow the emergency medical technician-basic advanced affiliated with the supervised emergency medical technician-basic advanced provider organization to function within the appropriate hospital department in order to obtain continuing practice in their clinical skills. The agreement or interdepartmental memo shall include a detailed description of how such services shall be provided to the emergency medical technician-basic advanced provider organization. In those cases where more than one (1) hospital enters into an agreement, or seeks to enter into an agreement, with an emergency medical technician-basic advanced provider organization as a supervising hospital, the interhospital agreement shall clearly define the specific duties and responsibilities of each hospital to ensure medical and administrative accountability of system operation.

(e) All ambulances used by the emergency medical technician-basic advanced provider organization shall be certified under 836 IAC 1-3.

(f) All nontransport vehicles used for the provision of emergency medical technician-basic advanced services shall meet all of the following requirements:

(1) Each nontransport vehicle shall carry the following assembled and readily accessible minimum rescue equipment:

(A) Equipment for safeguarding personnel, including one (1) fire extinguisher with an Underwriters Laboratory rating of not less than a five (5) pound rating for 2A:4-B; C, that shall have a current inspection date and be mounted so that it is readily accessible.

(B) Equipment for release from entrapment or confinement, including the following:

(i) One (1) hammer, four (4) pound, fifteen (15) inch handle (hammer weight and length are minimums).

(ii) One (1) wrecking bar, twenty-four (24) inch combination tool minimum.

(iii) One (1) self-contained portable light source.

(2) Each nontransport vehicle shall wrap, properly store, and handle all the single-service implements inserted into the patient's nose or mouth. Multiuse items are to be kept clean and sterile when indicated and properly stored. The vehicle shall carry the following assembled and readily accessible minimum equipment:

(A) Respiratory and resuscitation equipment as follows:

(i) Portable suction apparatus, capable of a minimum vacuum of three hundred (300) millimeters mercury, equipped with two (2) each of the following:

(AA) wide-bore tubings;

(BB) rigid catheters;

(CC) soft pharyngeal suction tips in child size; and

(DD) soft pharyngeal suction tips in adult size.

(ii) Bag-mask ventilation units, hand operated, one (1) unit in each of the following sizes, each equipped with clear face masks and oxygen reservoirs with oxygen tubing:

(AA) Adult.

(BB) Child.

(CC) Infant.

(DD) Neonatal (mask only).

- (iii) Oropharyngeal airways, two (2) each of adult, child, and infant.
- (iv) One (1) pocket mask with one-way valve.
- (v) Portable oxygen equipment of at least three hundred (300) liters capacity (D size cylinder) with:
 - (AA) yoke;
 - (BB) medical regulator;
 - (CC) pressure gauge; and
 - (DD) nondependent flowmeter.
- (vi) Oxygen delivery devices shall include the following:
 - (AA) High concentration devices, two (2) each, adult, child, and infant.
 - (BB) Low concentration devices, two (2) each, adult.
- (vii) Nasopharyngeal airways, two (2) each of the following with water soluble lubricant:
 - (AA) Small (20-24 french).
 - (BB) Medium (26-30 french).
 - (CC) Large (31 french or greater).
- (viii) Bulb syringe individually packaged in addition to obstetrics kit.
- (ix) Nonvisualized airway minimum of two (2) with water soluble lubricant.
- (x) Portable defibrillator equipped with defibrillation pads or paddles appropriate for defibrillation.
- (B) Wound care supplies as follows:
 - (i) Airtight dressings, four (4), for open chest wounds.
 - (ii) Assorted bandaging supplies for the care of soft tissue injuries.
- (C) Patient stabilization equipment as follows:
 - (i) Upper and lower extremity splinting devices, two (2) each.
 - (ii) Rigid extrication collar, two (2) each capable of the following sizes:
 - (AA) Pediatric.
 - (BB) Small.
 - (CC) Medium.
 - (DD) Large.
- (D) Personal protection/universal precautions equipment, minimum of one (1) each, including the following:
 - (i) Gowns.
 - (ii) Face masks and shields.
 - (iii) Gloves.
 - (iv) Biohazard bags.
 - (v) Antimicrobial hand cleaner.
- (E) Miscellaneous items as follows:
 - (i) Obstetrical kit, sterile, one (1).
 - (ii) Blood pressure manometer, one (1) each in the following cuff sizes:
 - (AA) Large adult.
 - (BB) Adult.
 - (CC) Pediatric.
 - (iii) Stethoscopes, one (1) each in the following sizes:
 - (AA) Adult.
 - (BB) Pediatric.
 - (iv) Sharps collector, one (1) being a minimum of seven (7) inches in height.
 - (v) Intravenous fluids and administration supplies approved by the medical director.
 - (vi) Medication as approved by the medical director limited to the following:
 - (AA) Baby aspirin, eighty-one (81) milligrams each.
 - (BB) Activated charcoal.
 - (CC) Instant glucose.
 - (DD) Epinephrine auto-injector or auto-injectors.
- (3) A current copy of protocols shall be maintained on board the nontransport vehicle at all times.
- (4) A copy of the medication list, including quantities and concentrations approved by the medical director.
- (g) An emergency medical technician-basic advanced provider organization shall have a medical director. The duties and responsibilities of the medical director are as follows:
 - (1) Provide liaison between the local medical community and the emergency medical service provider organization.
 - (2) Assure that appropriate intravenous solution, supplies, and equipment are available to the emergency medical technician basic advanced provider organization.

- (3) Monitor and evaluate the day-to-day medical operations of the provider organization.
- (4) Assist the supervising hospital in the coordination of in-service training programs.
- (5) Assure continued competence of emergency medical technician-basic advanced affiliated with, or employed by, the emergency medical technician-basic advanced provider organization.
- (6) Participate in the quarterly audit and review of cases treated by emergency medical technician-basic advanced of the provider organization.
- (7) Establish protocols for emergency medical technician-basic advanced.
- (8) Establish and publish a list of intravenous fluids and administration supplies, including minimum quantities to be carried on the vehicle.
- (9) Provide liaison between the:
 - (A) emergency medical service provider organization;
 - (B) emergency medical service personnel; and
 - (C) hospital; in regards to communicable disease testing under IC 16-41-10.
- (10) Provide individual consultation to the emergency medical personnel affiliated with the ambulance service provider organization.
- (h) Each emergency medical technician-basic advanced provider organization shall notify the agency in writing within thirty (30) days of any changes in the operation as outlined in the application for which certification was granted.
- (i) When services administered by an emergency medical technician-basic advanced at the scene of an accident or illness are continued en route to an emergency facility, as a minimum, the patient compartment of the ambulance shall be staffed by not fewer than one (1) person certified as:
 - (1) an emergency medical technician-basic advanced;
 - (2) an emergency medical technician-intermediate; or
 - (3) a paramedic.
- (j) Provide for a periodic maintenance program to assure that:
 - (1) all emergency medical service vehicles, including equipment, are maintained in good working condition at all times; and
 - (2) equipment, medication, and supplies have not exceeded the manufacturer's specified expiration date.
- (k) Each emergency medical technician-basic advanced provider organization shall show proof of insurance coverage as required by 836 IAC 1-3-6.
- (l) The emergency medical technician-basic advanced provider organization shall maintain a communications system established under 836 IAC 1-4.
- (m) Each nontransport vehicle used for the purpose of providing emergency medical technician-basic advanced services when dispatched for the purpose of an emergency medical run shall be staffed, as a minimum, by a certified emergency medical technician basic advanced. (*Indiana Emergency Medical Services Commission; 836 IAC 1-12-1; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3530; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 1-12-2 Application for provisional certification

Authority: IC 16-31-2-7

Affected: IC 4-21.5; IC 16-31-3-8; IC 16-31-3-20

- Sec. 2. (a) An applicant may apply for and obtain provisional certification as an emergency medical technician-basic advanced provider organization for the purpose of prehospital training of emergency medical technician-basic advanced students when in the presence of a preceptor approved by the commission in accordance with this section.
- (b) A provisional certification may only be issued to a certified ambulance service provider organization.
 - (c) The applicant shall submit a fully completed application for provisional certification on forms provided by the agency.
 - (d) The provisional certification may only be issued after the applicant has demonstrated to the satisfaction of the director that the ambulance to be used for such training is certified and meets the requirements of this article.
 - (e) The provisional certification expires no later than the earlier of the following dates:
 - (1) Sixty (60) days after the completion date of the emergency medical technician-basic advanced course completion as identified on the approved course application.
 - (2) Six (6) months from the starting date of the course contained on the approved course application.
 - (f) The issuance of an emergency medical technician-basic advanced provider organization certification invalidates any provisional certification. (*Indiana Emergency Medical Services Commission; 836 IAC 1-12-2; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3532*)

836 IAC 1-12-3 Application for certification

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-8; IC 16-31-3-20

Sec. 3. (a) Application for certification as an emergency medical technician-basic advanced provider organization shall be made on forms provided by the agency and shall include the following:

(1) Each application shall include the following information:

(A) A description of the service area.

(B) Hours of operation.

(C) Number and location of ambulances and nontransport vehicles.

(D) Organizational structure, including name, address, and phone number for the:

(i) owner;

(ii) chief executive officer;

(iii) chief operations officer;

(iv) training officer; and

(v) medical director.

(E) Current Federal Communications Commission license or letter of authorization.

(F) Location of provider organization's records.

(G) Proof of insurance coverage for ambulances and nontransport vehicles as required by 836 IAC 1-3-6.

(H) Staffing pattern of personnel.

(I) Base of operations.

(J) Roster of all affiliated personnel, signed by the medical director and the chief executive officer, including certification numbers.

(K) Other information as required by the commission.

(2) Plans and methodologies to ensure that the trained personnel are provided with supervised continuing education to maintain proficiency. Continuing education is under the direct supervision of the emergency medical technician-basic advanced provider organization medical director or medical director designee as described in 836 IAC 1-1-6(4)(C).

(3) A listing of intravenous fluids and administration sets, including quantities to be carried on board each vehicle as approved by the medical director.

(b) Emergency medical technician-basic advanced provider organizations that do not also provide transportation of emergency patients shall submit a copy of a current agreement between the nontransporting emergency medical technician-basic advanced provider organization and a certified ambulance service provider organization. The agreement shall:

(1) provide that the nontransporting emergency medical technician-basic advanced provider organization assures that patients treated shall be transported in a timely and safe manner; The agreement shall *[sic]*

(2) not preclude another ambulance service provider organization, if available, from transporting the patients.

(c) Upon approval, an emergency medical technician-basic advanced provider organization shall be issued a certification.

(d) The certificate:

(1) expires on the date appearing in the expiration date section of the certificate; and

(2) shall be prominently displayed at the place of business.

(e) Application for emergency medical technician-basic advanced provider organization certification renewal shall be made not less than sixty (60) days prior to the expiration date of the current certification. Application for renewal will:

(1) be made on forms provided by the agency; and

(2) show evidence of compliance with the requirements as set forth for original certification.

(Indiana Emergency Medical Services Commission; 836 IAC 1-12-3; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3532; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 1-12-4 Emergency medical technician-basic advanced provider organization; operating procedures

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 4. (a) Each emergency medical technician-basic advanced provider organization shall do the following:

(1) Comply with the emergency medical service provider organization operating procedures of 836 IAC 1-1-8.

(2) Establish daily equipment checklist procedures to ensure the following:

(A) Mechanical and electronic equipment is in proper operating condition.

- (B) Emergency response vehicles are maintained in a safe operating condition at all times.
 - (C) Intravenous fluids and administration sets are available and functional.
 - (D) Equipment, medication, fluid, and supplies do not exceed the manufacturer's specified expiration date.
 - (b) A copy of the protocols and list of intravenous fluids and administration supplies shall be maintained by the emergency medical technician-basic advanced provider organization. Any changes to the protocols and *[sic]* or list of intravenous fluids or administration supplies shall be provided in writing to the agency within thirty (30) days.
 - (c) The following requirements apply to the use of equipment and supplies by emergency medical technician-basic advanced:
 - (1) Emergency medical technician-basic advanced are prohibited from having in their possession, or maintained on board emergency response vehicles, any equipment or supplies that have not been approved by the emergency medical technician basic advanced provider organization medical director.
 - (2) Accountability for:
 - (A) distribution;
 - (B) storage;
 - (C) ownership; and
 - (D) security;
 of equipment and supplies shall be in accordance with the requirements established by the issuing pharmacy and medical director.
 - (d) Each emergency medical technician-basic advanced provider organization shall do the following:
 - (1) Follow sanitation procedures established in 836 IAC 1-1-8.
 - (2) Ensure that all ambulances used for the provision of emergency medical technician-basic advanced contain the rescue equipment required in 836 IAC 1-3-4, the emergency care equipment required in 836 IAC 1-3-5, and the communication equipment required in 836 IAC 1-4-2. In addition, the emergency medical services vehicles used for the provision of emergency medical technician-basic advanced shall also carry the following items:
 - (A) One (1) portable ECG monitor/defibrillator with defibrillation pads or paddles, which may be the defibrillator listed in 836 IAC 1-3-5(1)(L).
 - (B) Intravenous fluids and administration supplies as approved by the medical director.
 - (C) A current copy of emergency medical technician-basic advanced protocols shall be maintained on board the emergency medical services vehicle at all times.
 - (D) A copy of the list of intravenous fluids and administration sets, including quantities as approved by the medical director.
 - (e) An emergency medical technician-basic advanced provider organization and any affiliated emergency medical technician basic advanced possessing approval for intravenous line placement from the medical director may transport and treat a patient or patients from a health care facility as follows if:
 - (1) The only procedure that has been previously initiated for the patient is an intravenous line or lines administering prepackaged solutions of dextrose or electrolytes that contain one (1) or more of the following additives and no others:
 - (A) Vitamins.
 - (B) Sodium chloride, excluding saline solutions in excess of nine-tenths percent (0.9%) concentration.
 - (C) Potassium chloride (forty (40) milliequivalent per liter maximum).
 - (D) Cortisone.
 - (E) Antibiotics.
 - (2) The ambulance contains sufficient quantities of the intravenous supplies and solutions received by the patient in order to:
 - (A) maintain the patient's established medical intervention; and to *[sic]*
 - (B) manage patient complications that may be reasonably anticipated to occur en route to the patient's destination.
 - (f) An emergency medical technician-basic advanced provider organization shall not do the following:
 - (1) Operate an ambulance or other emergency medical service vehicle unless it is in full compliance with this article.
 - (2) Transport any emergency patient in any vehicle except a certified ambulance.
- (Indiana Emergency Medical Services Commission; 836 IAC 1-12-4; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3533; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)*

ARTICLE 2. ADVANCED LIFE SUPPORT

Rule 1. Definitions

836 IAC 2-1-1 Definitions

Authority: IC 16-31-2-7

Affected: IC 16-31-3

Sec. 1. The definitions in 836 IAC 1-1-1 apply throughout this article. (*Indiana Emergency Medical Services Commission; Advanced Life Support Preliminary; filed Dec 15, 1977; Rules and Regs. 1978, p. 248; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2214; filed Oct 13, 1981, 10:05 a.m.: 4 IR 2433; errata, 5 IR 400; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1061; filed May 15, 1998, 10:25 a.m.: 21 IR 3891; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2732; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2345; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3534*)

Rule 2. Requirements and Standards for Paramedic Organizations

836 IAC 2-2-1 General requirements for paramedic provider organizations

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3; IC 16-41-10

Sec. 1. (a) A person shall not:

- (1) furnish;
- (2) operate;
- (3) maintain;
- (4) advertise; or
- (5) otherwise engage in providing;

emergency medical services as a paramedic provider organization unless the person is certified by the commission as a paramedic provider organization.

(b) If the paramedic provider organization also provides transportation of emergency patients, the paramedic provider organization shall be certified as an ambulance service provider organization in accordance with the requirements specified in 836 IAC 1. The paramedic nontransport provider organizations shall meet the requirements specified in 836 IAC 1-1-5 through 836 IAC 1-1-8.

(c) The paramedic provider organization shall ensure the following:

- (1) Ambulances used are certified and meet the requirements specified in 836 IAC 1-3.
- (2) All nontransport emergency medical services vehicles used for the provision of advanced life support meet all of the requirements in 836 IAC 2-14.

(d) The chief executive officer of each paramedic provider organization shall certify that the provider organization has an agreement, or interdepartmental memo if hospital based, with one (1) or more supervising hospitals that agree [*sic*] agrees to provide the following services:

- (1) Continuing education.
- (2) Audit and review.
- (3) Medical control and direction.
- (4) Provision to allow the paramedics affiliated with the supervised paramedic provider organization to function within the appropriate hospital department in order to obtain continuing practice, remediation, and continuing education in their clinical skills.

The agreement or interdepartmental memo shall include a detailed description of how such services shall be provided to the paramedic provider organization. In those cases where more than one (1) hospital enters into an agreement, or seeks to enter into an agreement, with a paramedic provider organization as a supervising hospital, the interhospital agreement shall clearly define the specific duties and responsibilities of each hospital to ensure medical and administrative accountability of system operation.

(e) The paramedic provider organization shall have a medical director provided by the paramedic provider organization or jointly with the supervising hospital. The medical director is responsible for providing competent medical direction as established by the medical control committee. Upon establishment of a medical control policy, the paramedic provider organization medical director and the chief executive officer have the duty to enact the policy within the paramedic provider organization and accordingly enforce the policy. The duties and responsibilities of the medical director include, but are not limited to, the following:

- (1) Provide liaison with physicians and the medical community.
- (2) Assure that the:
 - (A) drugs;
 - (B) medications;
 - (C) supplies; and

- (D) equipment;
are available to the paramedic provider organization.
- (3) Monitor and evaluate day-to-day medical operations of paramedic provider organizations.
- (4) Assist the supervising hospital in the provision and coordination of continuing education.
- (5) Provide individual consultation to paramedics.
- (6) Participate in at least quarterly audit and review of cases treated by paramedics of the provider organization.
- (7) Attest to the competency of paramedics affiliated with the paramedic provider organization to perform skills required of a paramedic under 836 IAC 4-9-5.
- (8) Establish protocols for basic and advanced life support in cooperation with the medical control committee of the supervising hospital.
- (9) Establish and publish a list of medications, including minimum quantities and dosages to be carried on the emergency medical services vehicle.
- (10) Provide liaison between the:
- (A) emergency medical service provider organization; the [sic]
- (B) emergency medical service personnel; and the [sic]
- (C) hospital;
- in regards to communicable disease testing under IC 16-41-10.
- (f) The paramedic provider organization shall maintain a communications system that shall be available twenty-four (24) hours a day between the paramedic provider organization and the emergency department, or equivalent, of the supervising hospital using UHF (ultrahigh frequency) or cellular voice communications. The communications system shall be licensed by the Federal Communications Commission.
- (g) Each paramedic provider organization shall do the following:
- (1) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services.
- (2) Notify the commission in writing within thirty (30) days of assigning any individual to perform the duties and responsibilities required of a paramedic. This notification shall be signed by the provider organization and medical director of the provider organization.
- (h) A paramedic ambulance service provider organization must be able to provide a paramedic level response. For the purpose of this subsection, "paramedic response" consists of the following:
- (1) A paramedic.
- (2) An emergency medical technician or higher.
- (3) An ambulance in compliance with the requirements of section 3(e) of this rule.
- (4) During transport of the patient, the following are the minimum staffing requirements:
- (A) If paramedic level advanced life support treatment techniques have been initiated or are needed:
- (i) the ambulance must be staffed by at least a paramedic and an emergency medical technician; and
- (ii) a paramedic shall be in the patient compartment.
- (B) If an emergency medical technician-intermediate level advanced life support treatment techniques have been initiated or are needed:
- (i) the ambulance must be staffed by at least an emergency medical technician-intermediate and an emergency medical technician; and
- (ii) an emergency medical technician-intermediate shall be in the patient compartment.
- (C) If advanced life support treatment techniques have not been initiated and are not needed:
- (i) the ambulance must be staffed by at least an emergency medical technician; and
- (ii) an emergency medical technician shall be in the patient compartment.
- (i) For a paramedic provider organization, when an advanced life support nontransport vehicle is dispatched for a paramedic response, it shall, at a minimum, be staffed by a paramedic.
- (j) The paramedic provider organization shall do the following:
- (1) Notify the agency in writing within thirty (30) days of any changes in the operation as stated in the application.
- (2) With medical director and chief executive officer approval, allow a student or graduate of an Indiana approved paramedic course to perform advanced life support under the direction of a preceptor. This person shall be actively pursuing certification as an Indiana certified paramedic. This provision shall be limited from one (1) year from date of course completion as indicated on course report.
- (3) Show proof of insurance coverage as required by 836 IAC 1-3-6. (*Indiana Emergency Medical Services Commission; Advanced Life Support Rule I, A; filed Jan 21, 1977, 11:30 a.m.: Rules and Regs. 1978, p. 200; filed Dec 15, 1977: Rules and Regs. 1978, p. 250; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2216; filed Oct 13, 1981, 10:05 a.m.: 4 IR 2434; errata, 5 IR 400; filed Dec 2, 1983, 2:43 p.m.: 7 IR 364; errata, 7 IR 1254; filed Dec 13, 1985,*

9:13 a.m.: 9 IR 1062; filed Aug 18, 1986, 1:00 p.m.: 10 IR 41; filed Oct 11, 1988, 11:05 a.m.: 12 IR 358; filed May 15, 1998, 10:25 a.m.: 21 IR 3892; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2733; filed Apr 4, 2002, 9:15 a.m.: 25 IR 2512; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2348; errata, 26 IR 2624; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3535; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 2-2-2 Application for certification; renewal

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 2. (a) Application for certification as a paramedic provider organization shall be made on forms provided by the agency and shall comply with the following:

(1) Applicants shall complete the required forms and submit the forms to the agency not less than sixty (60) days prior to the requested effective date of the certificate.

(2) Each application shall include a narrative summary of plans for providing advanced life support services, including the following:

(A) Defined primary area of response, including location of advanced life support response vehicles.

(B) A roster of all affiliated personnel, signed by the medical director and the chief executive officer, including certification numbers.

(C) The staffing pattern of personnel.

(D) Base of operations.

(E) Organizational structure, including name, address, and phone numbers for the:

(i) owner;

(ii) chief executive officer;

(iii) chief operations officer;

(iv) training officer; and

(v) medical director.

(F) Location of paramedic provider organizations records.

(G) Proof of insurance coverage for emergency medical service vehicles if required by 836 IAC 1-3-6.

(H) Plans and methodologies to ensure that the trained personnel are provided with supervised continuing education to maintain proficiency. Continuing education is under the direct supervision of the paramedic provider organization medical director with the cooperation of the supervising hospital.

(I) A listing of medications and special onboard life support equipment to be carried on board each vehicle as approved by the medical director.

(J) All scheduled medications shall be stored in a locked container within a locked compartment. Medications storage shall be approved in writing by medical director or issuing pharmacy.

(K) Letter of approval from the supervising hospital stating:

(i) acceptance of the paramedics;

(ii) compatibility of the UHF communications with the paramedic provider organization's vehicles; and

(iii) agreement to fulfill the responsibilities of the supervising hospital.

(L) Copy of agreement or interdepartmental [*sic, interdepartmental*] memo as required in section 1(d) of this rule.

(M) Other information as required by the agency.

(b) Paramedic provider organizations that do not also provide transportation of emergency patients shall submit and maintain a copy of a current agreement between the nontransporting paramedic provider organization and an ambulance service provider organization certified under IC 16-31. The agreement shall:

(1) ensure that the nontransporting paramedic provider organization can be assured that patients treated shall be transported in a timely and safe manner; and

(2) not preclude another ambulance service provider organization, if available, from transporting the patients.

(c) Upon approval, a paramedic provider organization shall be issued certification for the provision of advanced life support.

(d) The certificate:

(1) expires on the date appearing in the expiration date section of the certificate; and

(2) shall be prominently displayed at the place of business.

(e) Application for paramedic provider organization certification renewal should be made not less than sixty (60) days prior to the expiration date of the current certification. Application for renewal shall:

(1) be made on forms provided by the agency; and shall [*sic*]

(2) show evidence of compliance with the requirements as set forth for original certification. (*Indiana Emergency Medical Services Commission; Advanced Life Support Rule I, B; filed Jan 21, 1977, 11:30 a.m.: Rules and Regs.*)

1978, p. 202; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2218; errata, 4 IR 531; filed Oct 13, 1981, 10:05 a.m.: 4 IR 2436; filed Dec 2, 1983, 2:43 p.m.: 7 IR 366; errata, 7 IR 1254; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1064; filed May 15, 1998, 10:25 a.m.: 21 IR 3895; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2735; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3537; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 2-2-3 Paramedic provider organization operating procedures

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 3. (a) Each paramedic ambulance service provider organization shall comply with the ambulance service provider organization operating procedures of 836 IAC 1-2-3. The paramedic nontransport provider organization shall comply with the operating procedures listed in 836 IAC 1-1-8.

(b) Each paramedic provider organization shall establish daily equipment checklist procedures to ensure the following:

- (1) Electronic and mechanical equipment are in proper operating condition.
- (2) Emergency response vehicles are maintained in a safe operating condition at all times.
- (3) All required medications and intravenous fluids approved by the medical director of the paramedic provider organization and the supervising hospital are on board all nontransport emergency medical services vehicles and ambulances when used for the provision of advanced life support and available to the paramedic.
- (4) Equipment, medication, fluid, and supplies have not exceeded the manufacturer's specified expiration date.
- (c) A copy of the medication list and protocols signed by the medical director shall be maintained by the paramedic provider organization and the supervising hospital emergency department. Any changes to the medications list shall be forwarded to the agency within thirty (30) days.
- (d) All medications and advanced life support supplies are to be supplied by order of the medical director.

Accountability for:

- (1) distribution;
- (2) storage;
- (3) ownership; and
- (4) security;

of medications is subject to applicable requirements as determined by the medical director, pharmacist, and the United States Department of Justice Drug Enforcement Administration.

(e) The paramedic provider organization shall ensure that all ambulances used for the provision of advanced life support contain the emergency care equipment required in 836 IAC 1-3-5, the rescue equipment required in 836 IAC 1-3-4, and communication equipment required in 836 IAC 1-4-2. The advanced life support emergency medical services vehicles shall also carry the following equipment:

- (1) Portable defibrillator with self-contained cardiac monitor and ECG strip writer and equipped with defibrillation pads or paddles appropriate for both adult and pediatric defibrillation. This may be the defibrillator listed in 836 IAC 1-3-5(1)(L).
- (2) Endotracheal intubation devices, including the following:
 - (A) Laryngoscope with extra batteries and bulbs.
 - (B) Laryngoscope blades (adult and pediatric, curved and straight).
 - (C) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter.
- (3) Intravenous fluids, medication, and administration supplies approved by the medical director.
- (4) A current copy of advanced life support protocols shall be maintained on board the emergency medical services vehicle at all times.
- (5) A copy of the medication list, including quantities and concentrations approved by the medical director.

(f) The paramedic provider organization shall do the following:

- (1) Ensure that all nontransport emergency medical services vehicles used for the provision of advanced life support meet all of the requirements in 836 IAC 2-14.
- (2) Follow the rigid sanitation procedures listed in 836 IAC 1-1-8.
- (g) All scheduled medications shall be stored in a locked container within a locked compartment. Medications storage shall be approved in writing by medical director or issuing pharmacy.

(h) A paramedic provider organization shall not do the operating [*sic, following*]:

- (1) Operate an ambulance or other emergency medical service vehicle unless it is in full compliance with this article.
- (2) Transport any emergency patient or patient receiving advanced life support in any vehicle except an ambulance certified under IC 16-31.

- (i) Provisions for temporary vehicle certification are addressed in 836 IAC 1-2-3 and 836 IAC 2-14-2(e).
- (j) Paramedics are prohibited from having in their possession, or maintained on board emergency response vehicles, any advanced life support equipment or supplies that have not been approved by the paramedic provider organization medical director.
- (k) A paramedic provider organization is considered to be providing specialty care transport when the level of service or procedures required:
 - (1) exceed the procedures identified in the Indiana paramedic curriculum;
 - (2) are those in which the paramedic has received additional medical director approved training; and
 - (3) have been approved by the organization medical director. (*Indiana Emergency Medical Services Commission; Advanced Life Support Rule I, C; filed Jan 21, 1977, 11:30 a.m.: Rules and Regs. 1978, p. 204; filed Nov 3, 1980, 3:55 p.m.: 3 IR 2219; filed Oct 13, 1981, 10:05 a.m.: 4 IR 2437; errata, 5 IR 400; filed Dec 2, 1983, 2:43 p.m.: 7 IR 367; errata, 7 IR 1254; filed Dec 13, 1985, 9:13 a.m.: 9 IR 1065; filed Aug 18, 1986, 1:00 p.m.: 10 IR 43; filed Oct 11, 1988, 11:05 a.m.: 12 IR 360; filed May 15, 1998, 10:25 a.m.: 21 IR 3896; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2736; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3538; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 2-2-4 Application for provisional certification

Authority: IC 16-31-2-7

Affected: IC 4-21.5; IC 16-31-3-8; IC 16-31-3-20

Sec. 4. (a) An applicant may apply for and obtain provisional certification as a paramedic provider organization for the purpose of prehospital training of paramedic students when in the presence of a preceptor approved by the commission in accordance with this section.

(b) A provisional certification may only be issued to a certified ambulance service provider organization.

(c) The applicant shall submit a fully completed application for provisional certification on forms provided by the agency.

(d) The provisional certification may only be issued after the applicant has demonstrated to the satisfaction of the director that the ambulance to be used for such training is certified and meets the requirements of this article.

(e) The provisional certification may only be issued if the ambulance service provider organization has and shall maintain an adequate number of paramedic students, preceptors, and ambulances to provide continuous twenty-four (24) hour advanced life support service.

(f) The provisional certification expires no later than the earlier of the following dates:

(1) Sixty (60) days after the completion date of the paramedic course completion as identified on the approved course application.

(2) Twenty-four (24) months from the starting date of the course contained on the approved course application.

(g) The issuance of a paramedic provider organization certification invalidates any provisional certification.

(*Indiana Emergency Medical Services Commission; 836 IAC 2-2-4; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3540*)

Rule 3. Requirements and Standards for Emergency Paramedic Training (Repealed)

(*Repealed by Indiana Emergency Medical Services Commission; filed May 15, 1998, 10:25 a.m.: 21 IR 3930*)

Rule 3.1. Paramedic Training (Repealed)

(*Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759*)

Rule 4. Requirements and Standards for Supervising Hospitals (Repealed)

(*Repealed by Indiana Emergency Medical Services Commission; filed May 15, 1998, 10:25 a.m.: 21 IR 3930*)

Rule 4.1. Supervising Hospitals

836 IAC 2-4.1-1 Certification as a supervising hospital; renewal

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-14

Sec. 1. (a) All hospitals supervising, or seeking to supervise, an emergency medical services provider organization at the following levels shall be certified by the commission:

(1) Paramedic.

(2) Emergency medical technician-intermediate.

(3) Emergency medical technician-basic advanced.

(b) Application for certification shall be submitted to the commission not less than sixty (60) days prior to the date for which approval is requested and made on forms provided by the agency. The application shall include the following:

- (1) A description of the communication system, licensed per FCC rules and regulation, that is available twenty-four (24) hours a day, and any other means of communications with emergency medical service provider organizations certified emergency medical technician-basic advanced, emergency medical technician-intermediate, or paramedic vehicles with a copy of the current FCC license attached.
 - (2) A description of procedures to supervise via voice communication the procedures performed by:
 - (A) emergency medical technician-basic advanced;
 - (B) emergency medical technician-intermediate; or
 - (C) paramedic; personnel.
 - (3) A list of hospital staff positions approved to give orders for on-line medical control.
 - (4) A description of the procedures for audit and review of cases transported by:
 - (A) emergency medical technician-basic advanced;
 - (B) emergency medical technician-intermediate; or
 - (C) paramedic; provider organizations, including the membership of the medical control committee.
 - (5) A written approval from the administrative and medical staff to supervise the procedures performed by the:
 - (A) emergency medical technician-basic advanced;
 - (B) emergency medical technician-intermediate; or
 - (C) paramedic; personnel.
 - (6) Certification by the chief executive officer that the hospital has contractual agreements, or interdepartmental memos if hospital based, with emergency medical technician-basic advanced, emergency medical technician-intermediate, or paramedic provider organizations whereby the administrative and medical staff have agreed to provide the following:
 - (A) Continuing education.
 - (B) Audit and review.
 - (C) Medical control and direction.
 - (D) Liaison and direction for supply of:
 - (i) medications;
 - (ii) fluids; and
 - (iii) other medical items.
 - (E) Procedures to allow emergency medical technician-basic advanced, emergency medical technician-intermediate, or paramedic personnel to function within the appropriate hospital department to maintain continuing education for the:
 - (i) emergency medical technician-basic advanced;
 - (ii) emergency medical technician-intermediate; or
 - (iii) paramedic;personnel skills as defined in 836 IAC 4, including a list of hospital departments involved and supervisory personnel.
- (c) Commission certification as a supervising hospital [*sic*] the date appearing in the expiration date section of the certificate.
- (d) Application for the renewal shall be made on forms provided by the agency. The application shall document compliance with this rule. (*Indiana Emergency Medical Services Commission; 836 IAC 2-4.1-1; filed May 15, 1998, 10:25 a.m.: 21 IR 3898; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3540; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 2-4.1-2 General requirements

Authority: IC 16-31-2-7

Affected: IC 16-31-3

Sec. 2. Hospitals seeking commission certification shall meet the following minimum requirements:

- (1) Have an emergency department open and staffed by a physician twenty-four (24) hours a day.
- (2) The hospital's administration shall have approved a written agreement, or interdepartmental memo if provider organization is hospital-based, with one (1) or more emergency medical services provider organizations that furnish advanced life support or emergency medical technician-basic advanced services. The agreement or interdepartmental memo shall include a detailed description whereby the hospital agrees to provide the following services to the certified emergency medical service provider organization:

- (A) Continuing education to include the following:
 - (i) Frequency of training.
 - (ii) Length of training.
 - (iii) Attendance policies.
 - (iv) Policy on acceptance of training obtained outside of supervising hospital.
 - (B) Audit and review to include items listed in subdivision (5).
 - (C) Medical control and direction to include the following:
 - (i) Procedure to assure medical control available at all times.
 - (ii) How hospital personnel are trained on provider organization protocols.
 - (D) Provision and supervision of arrangements that allow the emergency medical services clinical personnel affiliated with the supervised emergency medical service provider organization to function within appropriate hospital departments in order to obtain continuing education and remediation in their clinical skills.
 - (3) Provide and maintain a voice communication system between the emergency medical service provider organization response personnel and the hospital's emergency department. The communication system shall include the following:
 - (A) A system capable to provide UHF (ultrahigh frequency) communications.
 - (B) A system capable to communicate on the frequency of 155.340 MHz to operate on the Indiana Hospital Emergency Radio Network.

The communications system shall be licensed by the Federal Communications Commission. If the method of UHF communication is wireless, the hospital shall maintain a dedicated telephone number with answering points in the emergency department directly accessible to emergency department personnel.
 - (4) The hospital shall provide a physician or physician designate who is at all times immediately available to supervise the medical procedures performed by the emergency medical service provider organization's clinical personnel via the voice communication system.
 - (5) The hospital shall establish a process for the audit and review of medical procedure performed by the clinical personnel of the emergency medical service provider organization. Audit and review shall be conducted at least quarterly. Requirements for audit and review are as follows:
 - (A) The audit shall ensure an appropriate level of compliance with medical protocols and appropriate level of skill in the performance of medical techniques by those personnel.
 - (B) The results of the audit shall be reviewed with the emergency medical service personnel.
 - (C) Documentation for the audit shall include the following:
 - (i) The criteria used to select audited runs.
 - (ii) Problem identification and resolution.
 - (iii) Date of review.
 - (iv) Attendance at the review.
 - (v) A summary of the discussion at the review.
 - (D) The audit and review shall be conducted by the medical control committee as defined in subdivision (9).
 - (6) The supervising hospital shall review and approve the inservice of the certified paramedics affiliated with the emergency medical services provider organization.
 - (7) Send annually during the last quarter of each calendar year a roster of clinical personnel whose sole advanced life support affiliation is with the supervising hospital and personnel affiliated with the emergency medical service provider organizations supervised by the hospital.
 - (8) The supervising hospital shall report in writing any changes, including affiliated clinical personnel, within thirty (30) days.
 - (9) The supervising hospital shall establish a medical control committee for audit and review of medical procedures perform by the advanced life support personnel and establish policies for medical direction and control. The membership of the medical control committee shall include the following:
 - (A) Medical director of provider organization.
 - (B) One (1) or more emergency department supervisory personnel.
 - (C) One (1) or more provider organization supervisory personnel.
 - (D) EMS educator.
 - (E) One (1) or more advanced life support personnel of appropriate level from provider organization.
- (Indiana Emergency Medical Services Commission; 836 IAC 2-4.1-2; filed May 15, 1998, 10:25 a.m.: 21 IR 3899; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2737; filed Apr 4, 2002, 9:15 a.m.: 25 IR 2514; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3541)*

Rule 5. Requirements and Standards for Sponsoring Hospitals (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed May 15, 1998, 10:25 a.m.: 21 IR 3930)

Rule 6. Certification of Emergency Paramedics

836 IAC 2-6-1 General certification (Repealed)

Sec. 1. (Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759)

836 IAC 2-6-2 Application for certification; renewal (Repealed)

Sec. 2. (Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759)

836 IAC 2-6-3 Continuing education requirements (Repealed)

Sec. 3. (Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759)

836 IAC 2-6-4 Continuing education reporting requirements (Repealed)

Sec. 4. (Repealed by Indiana Emergency Medical Services Commission; filed May 15, 1998, 10:25 a.m.: 21 IR 3930)

836 IAC 2-6-5 Paramedic certification based upon reciprocity (Repealed)

Sec. 5. (Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759)

Rule 7. Requirements and Standards for Provider Organizations (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed May 15, 1998, 10:25 a.m.: 21 IR 3930)

Rule 7.1. Advanced EMT Provider Organizations; Requirements; Standards (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3579)

Rule 7.2. Requirements and Standards for Emergency Medical Technician-Intermediate Provider Organizations

836 IAC 2-7.2-1 General requirements for emergency medical technician-intermediate provider organizations

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 4-21.5; IC 16-31-3; IC 16-41-10

Sec. 1. (a) A person shall not:

- (1) furnish;
- (2) operate;
- (3) maintain;
- (4) advertise; or
- (5) otherwise engage in providing;

emergency medical services as an emergency medical technician-intermediate provider organization unless the person is certified as an emergency medical technician-intermediate provider organization.

(b) If the emergency medical technician-intermediate provider organization also provides transportation of emergency patients, the emergency medical technician-intermediate provider organization shall be certified as an ambulance service provider organization in accordance with the requirements specified in 836 IAC 1 under IC 16-31. The emergency medical technician-intermediate nontransport provider organizations shall meet the requirements specified in 836 IAC 1-1-4 through 836 IAC 1-1-8.

(c) The emergency medical technician-intermediate provider organization shall ensure the following:

- (1) Ambulances used are certified and meet the requirements specified in 836 IAC 1-3.
- (2) All nontransport emergency medical services vehicles used for the provision of advanced life support meet all of the requirements in 836 IAC 2-14.

(d) The chief executive officer of each emergency medical technician-intermediate provider organization shall certify that the provider organization has an agreement, or interdepartmental memo if hospital based, with one (1) or more supervising hospitals for the following services:

- (1) Continuing education.
- (2) Audit and review.
- (3) Medical control and direction.

(4) Provisions to allow the emergency medical technician-intermediates affiliated with the supervised emergency medical technician-intermediate provider organization to function within the appropriate hospital department in order to obtain continuing practice in their clinical skills.

The agreement or interdepartmental memo shall include a detailed description of how such services shall be provided to the emergency medical technician-intermediate provider organization. In those cases where more than one (1) hospital enters into an agreement, or seeks to enter into an agreement, with an emergency medical technician-intermediate provider organization as a supervising hospital, the interhospital agreement shall clearly define the specific duties and responsibilities of each hospital to ensure medical and administrative accountability of system operation.

(e) The emergency medical technician-intermediate provider organization shall have a medical director provided by the emergency medical technician-intermediate provider organization or jointly with the supervising hospital. The medical director is responsible for providing competent medical direction as established by the medical control committee. Upon establishment of a medical control policy, the medical director and chief executive officer of the emergency medical technician-intermediate provider organization have the duty to enact the policy within the emergency medical technician-intermediate provider organization and accordingly enforce the policy. The duties and responsibilities of the medical director include, but are not limited to, the following:

(1) Provide liaison with physicians and the medical community.

(2) Assure that the:

(A) drugs;

(B) medications;

(C) supplies; and

(D) equipment;

are available to the emergency medical technician-intermediate provider organization.

(3) Monitor and evaluate day-to-day medical operations of emergency medical technician-intermediate provider organizations.

(4) Assist in the provision and coordination of continuing education.

(5) Provide individual consultation to emergency medical technician-intermediates.

(6) Participate in at least quarterly audit and review of cases treated by emergency medical technician-intermediates of the supervising hospital.

(7) Attest to the competency of emergency medical technician-intermediates affiliated with the emergency medical technician intermediate provider organization to perform skills required of an emergency medical technician-intermediate under 836 IAC 4-7.1.

(8) Establish protocols for basic life support and advanced life support.

(9) Establish and publish a list of medications, including minimum quantities and dosages to be carried on the vehicle.

(10) Provide liaison between the:

(A) emergency medical service provider organization;

(B) emergency medical service personnel; and

(C) hospital;

in regards to communicable disease testing under IC 16-41-10.

(f) The emergency medical technician-intermediate provider organization shall do the following:

(1) Maintain a communications system that shall be available twenty-four (24) hours a day between the emergency medical technician-intermediate provider organization and the emergency department, or equivalent, of the supervising hospital using UHF (ultrahigh frequency) and cellular voice communications. The communications system shall be licensed by the Federal Communications Commission.

(2) Maintain an adequate number of trained personnel and emergency response vehicles to provide continuous, twenty-four (24) hour advanced life support services.

(3) Notify the commission in writing within thirty (30) days of assigning any individual to perform the duties and responsibilities required of an advanced emergency medical technician-intermediate. This notification shall be signed by the provider organization and medical director of the provider organization.

(g) An emergency medical technician-intermediate ambulance service provider organization must be able to provide an emergency medical technician-intermediate level response. For the purpose of this subsection, "emergency medical technician intermediate response" consists of the following:

(1) An emergency medical technician-intermediate.

(2) An emergency medical technician or higher.

(3) An ambulance in compliance with the requirements of section 3(d)(2) of this rule.

- (4) During transport of the patient, the following are the minimum staffing requirements:
- (A) If emergency medical technician-intermediate level advanced life support treatment techniques have been initiated or are needed:
- (i) the ambulance must be staffed by at least an emergency medical technician-intermediate and an emergency medical technician; and
 - (ii) an emergency medical technician-intermediate shall be in the patient compartment.
- (B) If advanced life support treatment techniques have not been initiated and are not needed:
- (i) the ambulance must be staffed by at least an emergency medical technician; and
 - (ii) an emergency medical technician shall be in the patient compartment.
- (h) For an emergency medical technician-intermediate provider organization, when an advanced life support nontransport vehicle is dispatched emergency medical technician-intermediate response, it shall, at a minimum, be staffed by an emergency medical technician-intermediate.
- (i) The emergency medical technician-intermediate provider organization shall do the following:
- (1) Notify the agency in writing within thirty (30) days of any change in the operation as stated in the application.
 - (2) With medical director and chief executive officer approval, allow a graduate or student of an Indiana approved emergency medical technician-intermediate course to perform advanced life support under the direction of a preceptor. This person shall be actively pursuing certification as an Indiana certified emergency medical technician-intermediate. This provision shall be limited from one (1) year from date of course completion as indicated on course report.
- (j) All ambulances and nontransport vehicles used by the emergency medical technician-intermediate provider organization shall meet the insurance requirements under 836 IAC 1-3-6. (*Indiana Emergency Medical Services Commission; 836 IAC 2-7.2-1; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2353; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3542; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 2-7.2-2 Application for certification; renewal

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3 Sec. 2. (a) Application for certification as an emergency medical technician-intermediate provider organization shall be made on forms provided by the agency and shall include, but not be limited to, the following:

- (1) An applicant shall complete and submit the required forms to the agency at least sixty (60) days before the requested effective date of the certificate.
- (2) Each application shall include a narrative summary of plans for providing advanced life support services, including the following:
 - (A) Defined primary area of response, including location of advanced life support response vehicles.
 - (B) A listing of all emergency medical technician-intermediates, including certification numbers, to be affiliated by the emergency medical technician-intermediate provider organization.
 - (C) The staffing pattern of personnel.
 - (D) Base of operations.
 - (E) Organizational structure, including name, address, and phone numbers for the:
 - (i) owner;
 - (ii) chief executive officer;
 - (iii) chief operations officer;
 - (iv) training officer; and
 - (v) medical director.
 - (F) Location of emergency medical technician-intermediate provider organizations records.
 - (G) Proof of insurance coverage for emergency medical service vehicles as required by 836 IAC 1-3-6.
 - (H) Plans and methodologies to ensure that the trained personnel are provided with supervised continuing education to maintain proficiency. Continuing education is under the direct supervision of the emergency medical technician-intermediate provider organization medical director with the cooperation of the supervising hospital.
 - (I) A listing of medications and special onboard life support equipment to be carried on board each vehicle as approved by the medical director.
 - (J) All scheduled medications shall be stored in a locked container within a locked compartment. Medications storage shall be approved in writing by medical director or issuing pharmacy.
 - (K) Letter of approval from the supervising hospital stating acceptance of the:
 - (i) emergency medical technician-intermediates;

(ii) compatibility of the UHF communications with the emergency medical technician-intermediate provider organization's vehicles; and
(iii) agreement to fulfill the responsibilities of the supervising hospital.

(L) Certification required in section 1(d) of this rule.

(M) Other information as required by the agency.

(b) Emergency medical technician-intermediate provider organizations that do not also provide transportation of emergency patients shall submit and maintain a copy of a current written agreement between the nontransporting emergency medical technician intermediate provider organization and an ambulance service provider organization certified under IC 16-31. The agreement shall:

(1) ensure that the nontransporting emergency medical technician-intermediate provider organization can be assured that patients treated shall be transported in a timely and safe manner; and

(2) not preclude another ambulance service provider organization, if available, from transporting the patients.

(c) Upon approval, an emergency medical technician-intermediate provider organization shall be issued certification for the provisions of advanced life support certification.

(d) The certificate:

(1) expires on the date appearing in the expiration date section of the certificate; and

(2) shall be prominently displayed at the place of business.

(e) An application for an emergency medical technician-intermediate provider organization certification renewal shall be made at least sixty (60) days before the expiration date of the current certification. Application for renewal shall:

(1) be made on forms provided by the agency; and

(2) show evidence of compliance with the requirements as set forth for original certification.

(Indiana Emergency Medical Services Commission; 836 IAC 2-7.2-2; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2355; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3544; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 2-7.2-3 Emergency medical technician-intermediate provider organization operating procedures

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 3. (a) Each emergency medical technician-intermediate provider organization shall do the following:

(1) Comply with the ambulance service provider operating procedures of 836 IAC 1-2-3. The emergency medical technician intermediate provider organization nontransport provider organization shall comply with the operating procedures listed in 836 IAC 1-1-8.

(2) Establish daily equipment checklist procedures to ensure the following:

(A) Electronic and mechanical equipment are in proper operating condition.

(B) Emergency response vehicles are maintained in a safe operating condition at all times.

(C) All required medications and intravenous fluids approved by the medical director of the emergency medical technician-intermediate provider organization and the supervising hospital are on board all nontransport emergency medical services vehicles and ambulances when used for the provision of advanced life support and available to the emergency medical technician-intermediate.

(D) Equipment, medication, fluid, and supplies have not exceeded the manufacturer's specified expiration date.

(b) A copy of the medication list and protocols shall be maintained by the emergency medical technician-intermediate provider organization and the supervising hospital emergency department. Any changes to the medications list shall be forwarded to the agency within thirty (30) days.

(c) All medications and advanced life support supplies are to be supplied by order of the medical director.

Accountability for:

(1) distribution;

(2) storage;

(3) ownership; and

(4) security;

of medications is subject to applicable requirements as determined by the medical director, pharmacist, and the United States Department of Justice Drug Enforcement Administration.

(d) The emergency medical technician-intermediate provider organization shall ensure the following:

(1) That stocking and administration of supplies and medications are limited to the Indiana emergency medical technician intermediate curriculum. Procedures performed by the emergency medical technician-intermediate are also limited to the Indiana emergency medical technician-intermediate curriculum.

(2) That all ambulances used for the provision of advanced life support contain the emergency care equipment required in 836 IAC 1-3-5, the rescue equipment required in 836 IAC 1-3-4, and communication equipment required in 836 IAC 1-4-2. The advanced life support emergency medical services vehicles shall also carry the following equipment:

(A) Portable defibrillator with self-contained cardiac monitor and ECG strip writer and equipped with defibrillation pads or paddles appropriate for both adult and pediatric defibrillation. This may be the defibrillator listed in 836 IAC 1-3-5(1)(L).

(B) Endotracheal intubation devices, including the following:

(i) Laryngoscope with extra batteries and bulbs.

(ii) Laryngoscope blades (adult and pediatric, curved and straight).

(iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter.

(C) Crystallite intravenous fluids and administration supplies approved by the medical director.

(D) Medications limited to, if approved by the medical director, the following:

(i) Acetylsalicylic acid (aspirin).

(ii) Adenosine.

(iii) Atropine sulfate.

(iv) Bronchodilator (beta 2 agonists):

(AA) suggested commonly administered medications:

(aa) albuterol;

(bb) ipratropium;

(cc) isoetharine;

(dd) metaproterenol;

(ee) salmeterol;

(ff) terbutaline; and

(gg) triamcinolone; and

(BB) commonly administered adjunctive medications to bronchodilator therapy:

(aa) dexamethasone; and

(bb) methylprednisolone.

(v) Dextrose.

(vi) Diazepam.

(vii) Epinephrine (1:1,000).

(viii) Epinephrine (1:10,000).

(ix) Vasopressin.

(x) Furosemide.

(xi) Lidocaine hydrochloride, two percent (2%).

(xii) Amiodarone hydrochloride.

(xiii) Morphine sulfate.

(xiv) Naloxone.

(xv) Nitroglycerin.

(E) A current copy of advanced life support protocols shall be maintained on board the emergency medical services vehicle at all times.

(F) A copy of the medication list, including quantities and concentrations approved by the medical director.

(e) The emergency medical technician-intermediate provider organization shall do the following:

(1) Ensure that all nontransport emergency medical services vehicles used for the provision of advanced life support meet all of the requirements in 836 IAC 2-14.

(2) Follow the rigid sanitation procedures listed in 836 IAC 1-1-8.

(f) All scheduled medications shall be stored in a locked container within a locked compartment. Medications storage shall be approved in writing by medical director or issuing pharmacy.

(g) An emergency medical technician-intermediate provider organization shall not do the following:

(1) Operate an ambulance or other emergency medical service vehicle unless it is in full compliance with this article.

(2) Transport any emergency patient or patient receiving advanced life support in any vehicle except an ambulance certified under IC 16-31.

(h) Emergency medical technician-intermediates are prohibited from having in their possession, or maintained on board emergency response vehicles, any advanced life support equipment or supplies that have not been approved by the emergency medical technician-intermediate provider organization medical director. (*Indiana Emergency*

Medical Services Commission; 836 IAC 2-7.2-3; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2356; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3545; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 2-7.2-4 Application for provisional certification

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 4-21.5; IC 16-31-3-8; IC 16-31-3-20

Sec. 4. (a) An applicant may apply for and obtain provisional certification as an emergency medical technician-intermediate provider organization for the purpose of prehospital training of emergency medical technician-intermediate students when in the presence of a preceptor approved by the commission in accordance with this section.

(b) A provisional certification may only be issued to a certified ambulance service provider organization.

(c) The applicant shall submit a fully completed application for provisional certification on forms provided by the agency.

(d) The provisional certification may only be issued:

(1) after the applicant has demonstrated to the satisfaction of the director that the ambulance to be used for such training is certified and meets the requirements of this article; and

(2) if the ambulance service provider organization has and shall maintain an adequate number of emergency medical technician-intermediate students, preceptors, and ambulances to provide continuous twenty-four (24) hour advanced life support service.

(e) The provisional certification expires not later than the earlier of the following dates:

(1) Sixty (60) days after the completion date of the emergency medical technician-intermediate course completion as identified on the approved course application.

(2) Twenty-four (24) months from the starting date of the course contained on the approved course application.

(f) The issuance of an emergency medical technician-intermediate provider organization certification invalidates any provisional certification. (*Indiana Emergency Medical Services Commission; 836 IAC 2-7.2-4; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3547; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

Rule 8. Requirements and Standards for Supervising Hospitals (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed May 15, 1998, 10:25 a.m.: 21 IR 3930)

Rule 8.1. Supervising Hospitals; Requirements, Standards (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed May 15, 1998, 10:25 a.m.: 21 IR 3930)

Rule 8.2. Advanced Emergency Medical Technician Training (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759)

Rule 9. Certification of Advanced Emergency Medical Technicians (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed May 15, 1998, 10:25 a.m.: 21 IR 3930)

Rule 9.1. Advanced Emergency Medical Technicians; Certification (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759)

Rule 10. Standards and Certification Requirements for Advanced Life Support Air Ambulance Service Providers and Advanced Life Support Air Ambulances (Repealed)

(Repealed by Indiana Emergency Medical Services Commission; filed Oct 11, 1988, 11:05 a.m.: 12 IR 381)

Rule 11. Inter-Facility Transfers and Response; Exemptions

836 IAC 2-11-1 Exemptions from the certification requirements of IC 16-31 when transporting an advanced life support patient (Repealed)

Sec. 1. (*Repealed by Indiana Emergency Medical Services Commission; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3579*)

Rule 12. Waiver of Certification

836 IAC 2-12-1 Request for waiver (Repealed)

Sec. 1. (*Repealed by Indiana Emergency Medical Services Commission; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372*)

Rule 13. Penalties and Fines

836 IAC 2-13-1 Penalties (Repealed)

Sec. 1. (Repealed by Indiana Emergency Medical Services Commission; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372)

Rule 14. Advanced Life Support Nontransport Vehicles; Standards and Certification

836 IAC 2-14-1 General certification provisions

Authority: IC 16-31-2-7

Affected: IC 16-31-3

Sec. 1. (a) This rule is applicable to all advanced life support nontransport vehicles eligible for certification.

(b) All advanced life support nontransport vehicles shall be in full compliance with the minimum specifications and certification requirements established in this rule. (*Indiana Emergency Medical Services Commission; 836 IAC 2-14-1; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2742; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3547*)

836 IAC 2-14-2 Application for certification

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-2; IC 16-31-3-8

Sec. 2. (a) Application for advanced life support nontransport vehicle certification shall be made by the provider organization on such forms as provided by the agency and shall comply with the following requirements:

(1) An applicant shall complete and submit the required forms to the agency with the following information:

(A) Name and address of provider organization.

(B) Vehicle information including:

(i) make;

(ii) model;

(iii) year; and

(iv) vehicle identification number.

(2) Each advanced life support nontransport vehicle for which certification is requested shall be made available for inspection by the agency with its equipment as required by this article or 836 IAC 1 prior to approval for certification.

(b) Upon approval, a certificate shall be issued to the advanced life support nontransport vehicle provider organization for each advanced life support nontransport vehicle.

(c) The certificate:

(1) expires on the date appearing in the expiration date section of the certificate; and

(2) shall be prominently displayed within the advanced life support nontransport vehicle driver compartment.

(d) Except as provided in subsection (e), a provider organization shall not operate an advanced life support nontransport vehicle on any public way in Indiana if the advanced life support nontransport vehicle:

(1) is not in full compliance with the advanced life support nontransport vehicle certification requirements established in this article; and

(2) does not have a certificate issued under IC 16-31.

(e) A provider organization may operate, for a period not to exceed sixty (60) consecutive days, a noncertified advanced life support nontransport vehicle if the noncertified advanced life support nontransport vehicle is used to replace a certified advanced life support nontransport vehicle that has been taken out of service providing the following:

(1) The replacement advanced life support nontransport vehicle shall meet all certification requirements.

(2) The provider organization shall notify the agency in writing within seventy-two (72) hours of the time the replacement advanced life support nontransport vehicle is placed in service. The written notice shall identify the following:

(A) The replacement date.

(B) The certification number of the replaced advanced life support nontransport vehicle.

(C) The:

(i) vehicle identification number; and

(ii) make and type;

of the replacement advanced life support nontransport vehicle.

Upon receipt of the notification, a temporary certificate shall be issued effective the date the certified advanced life support nontransport vehicle was replaced. Temporary certification shall not exceed sixty (60) days from the date that the replacement ambulance is placed in service and, upon return to service of the certified ambulance, the use of the replacement vehicle shall cease. (*Indiana Emergency Medical Services Commission; 836 IAC 2-14-2; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2742; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3547; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 2-14-3 Advanced life support nontransport vehicle specifications

Authority: IC 16-31-2-7

Affected: IC 16-31-3

Sec. 3. (a) All advanced life support nontransport vehicles shall meet or exceed the following minimum performance characteristics:

- (1) The vehicle engine shall be an internal combustion, liquid-cooled engine that meets advanced life support nontransport vehicle chassis manufacturer's standard horsepower/displacement requirements.
- (2) The fully loaded vehicle shall be capable of a sustained speed of at least sixty-five (65) miles per hour over dry, level, or hard-surfaced roads.
- (3) The steering system shall be the manufacturer's recommended design and be power assisted.
- (4) Tires shall meet the manufacturer's standards for the gross vehicle weight of the vehicle. No tire shall display exposed tire cord or have tread depth less than two thirty-seconds ($\frac{2}{32}$) on back tires and four thirty-seconds ($\frac{4}{32}$) on front tires spaced equally around the tire and with no visible defects. Retread tires shall not be used on advanced life support nontransport vehicles.

(b) All advanced life support nontransport vehicles shall meet or exceed the following minimum specifications for electrical systems:

- (1) The electrical generating system shall consist of a one hundred five (105) ampere alternator minimum.
- (2) Lighting shall be designed and located so that no glare is reflected from surrounding areas to the driver's eyes or line of vision, from instrument panel, switch panel, or other areas that may require illumination while the vehicle is in motion.
- (3) Each advanced life support nontransport vehicle shall have an audible backup warning device that is activated when the advanced life support nontransport vehicle is shifted into reverse.

(c) All advanced life support nontransport vehicles shall meet the following requirements for external identification:

- (1) Warning lights of red or red and white, at the discretion of the owner, and shall conform with Indiana law. All lights on vehicle shall be in working condition.
- (2) Each advanced life support nontransport vehicle shall display the four (4) numbers of the commission-assigned advanced life support nontransport vehicle certification number. The four (4) numbers, in sequence, shall be placed on each side of the advanced life support nontransport vehicle on the right and left front fenders and on the rear portion of the vehicle. Each number shall be in block letters not less than three (3) inches in height. These numbers shall be displayed in color contrasting, reflective material. The numbers shall be placed on the vehicle within seven (7) days of the receipt of the advanced life support nontransport vehicle certificate. The numbers shall be removed or permanently covered by the provider organization when the advanced life support nontransport vehicle is permanently removed from service by the provider organization.
- (3) A commission-certified vehicle sticker shall be displayed on all certified advanced life support nontransport vehicles.

(d) All windows shall be intact. The vehicle shall have windshield wipers in working condition.

(e) Dual, firmly secured, vibrationless rear-view mirrors, one (1) mounted on the left side of the vehicle and one (1) mounted on the right side, shall be included.

(f) The driver compartment, at a minimum, shall be equipped with appropriate passenger restraints that are installed in all seating facilities for the driver and the passenger.

(g) All advanced life support nontransport vehicles shall meet or exceed the following minimum communication standards:

(1) All radios used in emergency medical services vehicles for the purpose of dispatch or tactical communications shall demonstrate and maintain the ability to provide a voice communications linkage, during transmission, with the emergency medical service provider organization's associated base station within the area the emergency medical service provider organization normally serves or proposes to serve.

(2) Radio equipment used in emergency medical services vehicles shall be appropriately licensed through the Federal Communications Commission. The maximum power of the transmitter shall be no more than the minimum

required for technical operation commensurate with the size of the area to be served and local conditions that affect radio transmission and reception.

(3) All emergency medical services vehicles shall be equipped with two-way radios that shall have one (1) channel or talkgroup used primarily for dispatch and tactical communications.

(4) All nontransport vehicles shall maintain a communication system that shall be available twenty-four (24) hours a day between the paramedic provider organization and the emergency department, or equivalent, of the supervising hospital using UHF (ultrahigh frequency) voice communications. The communications system shall be licensed by the Federal Communications Commission.

(5) Type and number of sirens shall be at the discretion of the advanced life support nontransport vehicle provider organization and shall conform to Indiana law.

(h) All advanced life support nontransport vehicles shall provide an adequate system for heating and window defrosting of the driver compartment.

(i) Each provider organization shall ensure that rigid sanitation procedures are in effect at all times. The following sanitation standards apply to all vehicles used for the purpose of providing advanced life support services:

(1) The equipment within the vehicle shall be clean and maintained in good working order at all times.

(2) Compartments shall be provided within the vehicle for medical supplies and equipment storage.

(3) All scheduled medications shall be stored in a locked container within a locked compartment. Medications storage shall be approved in writing by medical director or issuing pharmacy. (*Indiana Emergency Medical Services Commission; 836 IAC 2-14-3; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2743; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3548*)

836 IAC 2-14-4 Advanced life support nontransport vehicle rescue equipment

Authority: IC 16-31-2-7

Affected: IC 16-31-3

Sec. 4. Advanced life support nontransport vehicles shall carry the following assembled and readily accessible minimum rescue equipment:

(1) Equipment for safeguarding personnel, including one (1) fire extinguisher with an Underwriters Laboratory rating of not less than a five (5) pound rating for 2A:4-B; C; that shall have a current inspection date and be mounted so that they are readily accessible.

(2) Equipment for release from entrapment or confinement, including the following:

(A) One (1) hammer, four (4) pound, fifteen (15) inch handle (hammer weight and length are minimums).

(B) One (1) wrecking bar, twenty-four (24) inch combination tool minimum.

(C) One (1) self-contained portable light source.

(*Indiana Emergency Medical Services Commission; 836 IAC 2-14-4; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2744; readopted filed Nov 30, 2006, 9:17 a.m.: 20061213-IR-836060486RFA*)

836 IAC 2-14-5 Advanced life support nontransport vehicle emergency care equipment

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 5. Each advanced life support nontransport vehicle shall wrap, properly store, and handle all the single-service implements to be inserted into the patient's nose or mouth. Multiuse items are to be kept clean and sterile when indicated and properly stored.

The vehicle shall carry the following assembled and readily accessible minimum equipment:

(1) Respiratory and resuscitation equipment as follows:

(A) Portable suction apparatus, capable of a minimum vacuum of three hundred (300) millimeters mercury, equipped with two (2) each of the following:

(i) wide-bore tubings;

(ii) rigid catheters;

(iii) soft pharyngeal suction tips in child size; and

(iv) soft pharyngeal suction tips in adult size.

(B) Endotracheal intubation devices, including the following:

(i) Laryngoscope with extra batteries and bulbs.

(ii) Laryngoscope blades (adult and pediatric, curved and straight).

(iii) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter.

(C) Bag-mask ventilation units, hand operated, one (1) unit in each of the following sizes, each equipped with clear face masks and oxygen reservoirs with oxygen tubing:

- (i) Adult.
- (ii) Child.
- (iii) Infant.
- (iv) Neonatal (mask only).
- (D) Oropharyngeal airways, two (2) each of adult, child, and infant.
- (E) One (1) pocket mask with one-way valve.
- (F) Portable oxygen equipment of at least three hundred (300) liters capacity (D size cylinder) with:
 - (i) yoke;
 - (ii) medical regulator;
 - (iii) pressure gauge; and
 - (iv) nondependent flowmeter.
- (G) Oxygen delivery devices shall include the following:
 - (i) High concentration devices, two (2) each, adult, child, and infant.
 - (ii) Low concentration devices, two (2) each, adult.
- (H) Nasopharyngeal airways, two (2) each of the following with water soluble lubricant:
 - (i) Small (20-24 french).
 - (ii) Medium (26-30 french).
 - (iii) Large (31 french or greater).
- (I) Bulb syringe individually packaged in addition to obstetrics kit.
- (J) Nonvisualized airway minimum of two (2) with water soluble lubricant.
- (K) Portable defibrillator with self-contained cardiac monitor and ECG strip writer and equipped with defibrillation pads or paddles appropriate for adult and pediatric defibrillation.
- (2) Wound care supplies as follows:
 - (A) Airtight dressings, four (4), for open chest wounds.
 - (B) Assorted bandaging supplies for the care of soft tissue injuries.
- (3) Patient stabilization equipment as follows:
 - (A) Upper and lower extremity splinting devices, two (2) each.
 - (B) Rigid extrication collar, two (2) each capable of the following sizes:
 - (i) Pediatric.
 - (ii) Small.
 - (iii) Medium.
 - (iv) Large.
- (4) Personal protection/universal precautions equipment, minimum of one (1) each, including the following:
 - (A) Gowns.
 - (B) Face masks and shields.
 - (C) Gloves.
 - (D) Biohazard bags.
 - (E) Antimicrobial hand cleaner.
- (5) Miscellaneous items as follows:
 - (A) Obstetrical kit, sterile, one (1).
 - (B) Blood pressure manometer, one (1) each in the following cuff sizes:

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- (i) Large adult.
- (ii) Adult.
- (iii) Pediatric.
- (C) Stethoscopes, one (1) each in the following sizes:
 - (i) Adult.
 - (ii) Pediatric.
- (D) Sharps collector, one (1) being a minimum of seven (7) inches in height.
- (E) Intravenous fluids and administration supplies approved by the medical director.
- (6) A current copy of advanced life support protocols shall be maintained on board the advanced life support nontransport vehicle at all times.
- (7) A copy of the medication list, including quantities and concentrations approved by the medical director.
- (8) Medications if approved by medical director, and solely for use by individuals with a certification as an emergency medical technician or higher, are as follows:

- (A) Baby aspirin, eighty-one (81) milligrams each.
 - (B) Activated charcoal.
 - (C) Instant glucose.
 - (D) Epinephrine auto-injector or auto-injectors.
- (9) Intermediate services shall also carry medications as approved by the medical director not to exceed the items listed in 836 IAC 2-7.2-3(d)(2)(D). (*Indiana Emergency Medical Services Commission; 836 IAC 2-14-5; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2744; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2357; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3549; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

ARTICLE 3. AIR AMBULANCES

Rule 1. Definitions

836 IAC 3-1-1 Definitions

Authority: IC 16-31-2-7

Affected: IC 16-31-3-20

Sec. 1. The definitions in 836 IAC 1-1-1 apply throughout this article. (*Indiana Emergency Medical Services Commission; 836 IAC 3-1-1; filed Oct 11, 1988, 11:05 a.m.: 12 IR 366; filed May 15, 1998, 10:25 a.m.: 21 IR 3917; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2490; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3550*)

Rule 2. Advanced Life Support Rotorcraft Ambulance Service Provider

836 IAC 3-2-1 Air ambulances; general requirements

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 16-31

Sec. 1. (a) Any organization providing, or seeking to provide, rotorcraft ambulance services utilizing rotorcraft aircraft is required to be certified as an advanced life support rotorcraft ambulance service provider organization by the commission. The advanced life support rotorcraft ambulance service provider organization shall be certified in accordance with this article under IC 16-31 as appropriate.

(b) The provider organization of rotorcraft ambulance services shall ensure that the aircraft used in conjunction with the provision of advanced life support services meets the guidelines as specified in this article under IC 16-31 and is certified by the commission. Each rotorcraft ambulance service provider organization shall meet all applicable parts of F.A.A. regulation and shall hold a valid 14 CFR 135 air carrier certificate or shall have a contract with the holder of a 14 CFR 135 air carrier certificate to provide aviation services under their certificate. Either must also have current F.A.A. approved air ambulance operations specifications.

(c) Advanced life support rotorcraft ambulance service provider organizations will have an agreement with one (1) or more supervising hospitals for the following services:

- (1) Continuing education.
- (2) Audit and review.
- (3) Medical control and direction.
- (4) Provide liaison and direction for supply of medications, fluids, and other items utilized by the provider organization.
- (5) Safety and survival programs and education.

The agreement shall include a detailed description of how such services will be provided to the advanced life support rotorcraft ambulance service provider organization. In those cases where more than one (1) hospital enters into an agreement, or seeks to enter into an agreement, with an advanced life support rotorcraft ambulance service provider organization as a supervising hospital, an interhospital agreement will be provided to the commission that clearly defines the specific duties and responsibilities of each hospital to ensure medical, safety, and administrative accountability of system operation. An agreement is not required when the hospital and the provider are the same organization.

(d) The advanced life support rotorcraft ambulance service provider organization will have an air-medical director provided by the advanced life support rotorcraft ambulance service provider organization, or jointly with the supervising hospital, who has knowledge of air transport problems and flight physiology. The air-medical director is responsible for providing competent medical direction and overall supervision of the medical aspects of the advanced life support rotorcraft ambulance service provider organization. The duties and responsibilities of the air-medical director include, but are not limited to, the following:

- (1) Assuming all medical control and authority over any and all patients treated and transported by the rotorcraft ambulance service.
- (2) Providing liaison with physicians.
- (3) Assuring that the drugs, medications, supplies, and equipment are available to the advanced life support rotorcraft ambulance service provider organization.
- (4) Monitoring and evaluating overall medical operations.
- (5) Assisting in the coordination and provision of continuing education.
- (6) Providing information concerning the operation of the advanced life support rotorcraft ambulance service provider organization to the commission.
- (7) Providing individual consultation to the air-medical personnel.
- (8) Participating on the medical control committee of the supervising hospital in at least quarterly audit and review of cases treated by air-medical personnel.
- (9) Attesting to the competency of air-medical personnel affiliated with the advanced life support rotorcraft ambulance service provider organization.
- (10) Designating an individual or individuals to assist in the performance of these duties.
- (e) Each rotorcraft ambulance service provider organization will designate one (1) person to assume responsibility for inservice training. This person shall be certified as a paramedic, a registered nurse, or a licensed physician and actively provide patient care during air ambulance transport.
- (f) A rotorcraft ambulance service provider organization shall not engage in conduct or practices detrimental to the health and safety of emergency patients or to members of the general public while in the course of business or service as a rotorcraft ambulance service provider organization.
- (g) The advanced life support rotorcraft ambulance service provider organization shall have an areawide plan to provide safety education and coordinate rotorcraft ambulance service with emergency medical services rescue, law enforcement, mutual aid backup systems, and central dispatch when available.
- (h) Each advanced life support rotorcraft ambulance service provider organization shall do the following:
 - (1) Maintain an adequate number of trained personnel and aircraft to provide continuous twenty-four (24) hour advanced life support services.
 - (2) Notify the agency in writing within thirty (30) days of a paramedic's affiliation or termination of employment, or for any reason that has prohibited a certified individual from performing the procedures required of a paramedic under 836 IAC 2.
- (i) Each rotorcraft ambulance service provider organization shall designate one (1) person to assume the responsibilities for establishment of a safety committee consisting of the following:
 - (1) Pilot or pilots.
 - (2) Air-medical personnel.
 - (3) Aircraft maintenance technician or technicians.
 - (4) Communications personnel.

The safety committee shall meet at least quarterly and may be concurrent and in conjunction with the audit/review committee. (*Indiana Emergency Medical Services Commission; 836 IAC 3-2-1; filed Oct 11, 1988, 11:05 a.m.: 12 IR 367; filed May 15, 1998, 10:25 a.m.: 21 IR 3918; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2491; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3551*)

836 IAC 3-2-2 Certification; application

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31

Sec. 2. (a) Application for certification as an advanced life support rotorcraft ambulance service provider organization will be made on forms provided by the agency and include, but not be limited to, the following:

- (1) A narrative summary of plans for providing rotorcraft ambulance services, including the following:
 - (A) The staffing pattern of air-medical personnel and pilots.
 - (B) Defined area of primary and secondary response and an areawide coordination plan.
 - (C) Base of operations, a description of the visual flight rules weather minimums for both cross-county and local flight, and the definition of the "local flying area" quoted from the approved F.A.A. Part 135 operations specifications.
 - (D) Aircraft types and identification numbers.
 - (E) A listing of all personnel and their qualifications by category who will regularly serve as pilots and air-medical personnel on the aircraft.
 - (F) A copy of the patient care transport record to be utilized on each transport.

(2) Plans and methodologies to ensure that the trained personnel are provided with continuing education relative to their level of training. Continuing education on air transportation problems and flight physiology shall be provided on an annual basis.

Continuing education will be approved by the advanced life support rotorcraft ambulance service provider organization airmedical director with the cooperation of the supervising hospital.

(3) A listing of all onboard life support and medical communications equipment available, including a list of drugs and medications to be carried on each aircraft.

(4) When appropriate, a copy of the contract between the advanced life support rotorcraft ambulance service provider organization and the supervising hospital or hospitals.

(5) A copy of all treatment protocols and standing orders (if applicable) under which all nonphysician personnel operate.

(6) Each rotorcraft ambulance service provider organization shall show proof of insurance coverage as required by 836 IAC 1-3-6.

(7) The insurance coverage specified in subdivision (6) shall be for each and every aircraft owned or operated, or both, by or for the rotorcraft ambulance service provider organization.

(b) Upon approval, an advanced life support rotorcraft ambulance service provider organization will be issued certification for the provision of advanced life support services as required in 836 IAC 2 and this article.

(c) The certificate issued under this article:

(1) expires on the date appearing in the expiration date section of the certificate; and

(2) shall be prominently displayed at the place of business.

(d) Application for certification renewal shall:

(1) be made at least sixty (60) days before the expiration date of the current certificate;

(2) be made on such forms provided by the agency; and

(3) show evidence of compliance with this article as set forth for original certification. (*Indiana Emergency Medical Services Commission; 836 IAC 3-2-2; filed Oct 11, 1988, 11:05 a.m.: 12 IR 368; filed May 15, 1998, 10:25 a.m.: 21 IR 3919; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2492; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3552; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 3-2-3 Minimum specifications

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 16-31

Sec. 3. (a) The rotorcraft ambulance performance characteristics are inherent in the type of aircraft selected by the rotorcraft ambulance service provider organization. The aircraft and its equipment and operations shall be in compliance with prevailing F.A.R. for the type of aircraft in question and flying conditions under which the aircraft will be operated as specified in the 14 CFR 135 air carrier certificate of the air ambulance service provider organization.

(b) The aircraft shall be capable of carrying a minimum of one (1) patient on a litter in a horizontal position located so as not to obstruct the pilot's vision or interfere with the performance of any member of the flight crew or required air-medical personnel.

(c) There shall exist a means of securing each litter and attached patient securely to either the floor (deck), walls (bulkhead), seats, or specific litter rack, or any combination thereof, that shall comply with an acceptable method using either approved data from the aircraft manufacturer or data approved by the F.A.A. If data approved by the F.A.A. is required, a field approval or supplemental type certificate (STC) shall be obtained.

(d) There shall be demonstrable unobstructed vertical space at the head and thorax areas of the upper surface of a litter or litters to allow for performance of advanced life support cardiac care.

(e) Both the head and thorax of a secured patient shall be accessible by a minimum of two (2) air-medical personnel at one (1) time.

(f) The patient compartment shall have lighting available for patient observation (a minimum of forty (40) foot-candles at the level of the patient is recommended). Lighting shall be such as to not interfere with the pilots vision and will be focused, shielded, diffused, or colored illumination.

(g) The patient compartment shall have fresh air ventilation for the comfort of all persons on board.

(h) The patient compartment shall have temperature regulation to assure the comfort of all persons on board.

(i) The aircraft shall have one (1) door demonstrably large enough for ease of patient litter loading and unloading in the supine position.

(j) The electrical system of the aircraft shall be capable of supporting all of the ancillary equipment without the threat of overload or systems failure.

(k) Other specialized equipment may be required to conduct certain operations. The installation of this equipment shall comply with an acceptable method using either approved data from the aircraft manufacturer or data approved by the F.A.A. If data approved by the F.A.A. is required, a field approval or supplemental type certificate (STC) shall be obtained.

(l) The aircraft shall have a searchlight rated as a minimum of four hundred thousand (400,000) candlepower or greater, manipulated by the pilot with a minimum movement of ninety (90) degrees vertical and one hundred eighty (180) degrees horizontal with the capability of illuminating the proposed landing site.

(m) The aircraft shall have air to ground communication capability to allow the pilot to communicate with all of the following ground personnel:

(1) Law enforcement.

(2) Fire/rescue.

(3) Ambulances.

(4) Hospital or hospitals.

(n) The aircraft shall be equipped with adequate patient restraint or restraints to preclude interference with the crew or aircraft flight controls.

(o) The aircraft shall have an intercommunications system. (*Indiana Emergency Medical Services Commission; 836 IAC 3-2-3; filed Oct 11, 1988, 11:05 a.m.: 12 IR 369; filed May 15, 1998, 10:25 a.m.: 21 IR 3920; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2493; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3553*)

836 IAC 3-2-4 Operating procedures; flight and medical

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 4-21.5-1

Sec. 4. (a) Each provider organization shall maintain accurate records concerning the emergency care provided to each patient within the state as well as the following:

(1) All advanced life support rotorcraft ambulance service provider organizations shall utilize a patient care transport record.

(2) All advanced life support rotorcraft ambulance service provider organizations shall maintain accurate records under 836 IAC 1-1-5.

(b) Premises will be maintained, suitable to the conduct of a rotorcraft ambulance service, with provision for adequate storage or maintenance, or both, of rotorcraft ambulances and the on-board equipment.

(c) Each rotorcraft ambulance service provider organization shall have a periodic maintenance program as outlined for each specific aircraft certified by the commission in compliance with F.A.A. guidelines and manufacturer's service recommendations (MSR) as a minimum to assure that each rotorcraft ambulance, including equipment, is maintained in good, safe working condition and that rigid sanitation conditions and procedures are in effect at all times.

(d) All rotorcraft ambulance service provider organization premises, records, hangars, padding, tie-down facilities, and rotorcraft ambulances will be made available for inspection by the agency at any time during regularly scheduled business hours.

(e) A determination of noncompliance with F.A.R. may result in immediate suspension of commission certification as a rotorcraft ambulance service provider organization.

(f) Each rotorcraft ambulance service provider organization shall make available to the commission for inspection at place of operation during regular business hours any manual of operations required under F.A.R.

(g) Commission certification as a rotorcraft ambulance service provider organization may be terminated upon the date specified in the notice.

(h) Each rotorcraft ambulance service provider organization shall establish equipment checklist procedures to ensure the following:

(1) Electronic and mechanical equipment are in proper operating condition.

(2) Rotorcraft ambulances shall be maintained in safe operating conditions at all times.

(3) Emergency patient care equipment required for rotorcraft ambulance certification is maintained in minimum quantities either directly on board the rotorcraft ambulance or available at the time of patient transport.

(i) Each rotorcraft ambulance service provider organization shall ensure that rigid sanitation conditions and procedures are in effect at all times. The following sanitation standards apply to all rotorcraft ambulances:

(1) The interior and the equipment within the aircraft are clean and maintained in good working order at all times.

(2) Freshly laundered linens are used on all litters, and pillows and linens shall be changed after each patient is transported.

(3) When the aircraft has been utilized to transport a patient known to have a communicable disease, the aircraft shall be cleansed and all contact surfaces be disinfected.

(j) A rotorcraft ambulance service provider organization shall not operate a rotorcraft ambulance in Indiana if the aircraft does not meet the certification requirements of this article and does not have a certificate issued under this article; however, a rotorcraft ambulance service provider organization may operate, for a period not to exceed one hundred eighty (180) consecutive days, a noncertified rotorcraft ambulance if the noncertified rotorcraft ambulance is used to replace a certified rotorcraft ambulance that has been temporarily taken out of service providing the following:

(1) The replacement rotorcraft ambulance meets all certification requirements of this article.

(2) The rotorcraft ambulance service provider organization shall notify the agency, in writing, within seventy-two (72) hours of the time the replacement rotorcraft is placed in service. The written notice shall identify the following:

(A) The replacement date.

(B) The certification number of the replaced rotorcraft ambulance.

(C) The aircraft identification number of the replacement rotorcraft.

(D) The make and type of the replacement rotorcraft ambulance.

Upon receipt of the notification, a temporary certificate shall be issued effective the date the certified rotorcraft ambulance was replaced. Temporary certification will not exceed one hundred eighty (180) days from the date that the replacement rotorcraft ambulance is placed in service, and, upon return to service of the certified rotorcraft ambulance, the use of the replacement rotorcraft ambulance shall cease. If the replaced rotorcraft ambulance is not returned to service within the one hundred eighty (180) day period,

use of the replacement rotorcraft ambulance shall cease unless certification is approved in accordance with this article. (*Indiana Emergency Medical Services Commission; 836 IAC 3-2-4; filed Oct 11, 1988, 11:05 a.m.: 12 IR 370; filed May 15, 1998, 10:25 a.m.: 21 IR 3920; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2494; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2358; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3554*)

836 IAC 3-2-5 Staffing

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 4-21.5-1

Sec. 5. (a) Each certified rotorcraft ambulance, while transporting an emergency patient, will be staffed by no fewer than three (3) people that have completed air-medical oriented training as prescribed by the air-medical director.

Staffing will include the following requirements:

(1) The first person shall be a properly certified pilot who shall complete an orientation program covering flight and airmedical operations as prescribed by the air-medical director.

(2) The second person shall be currently certified, registered, or licensed in Indiana as:

(A) a paramedic;

(B) a registered nurse; or

(C) a physician;

within the state the air-ambulance is stationed and operating.

(3) The third person shall be any appropriate personnel required to properly care for the medical needs of the patient at the discretion of the air-medical director. The air-medical personnel on board the aircraft shall be trained in air transport problems and flight physiology.

(b) The advanced life support rotorcraft ambulance service provider organization shall notify the agency in writing within thirty (30) days of any change in the advanced life support services provided.

(c) Upon suspension, revocation, or termination of a certificate, the provision of advanced life support services shall cease. (*Indiana Emergency Medical Services Commission; 836 IAC 3-2-5; filed Oct 11, 1988, 11:05 a.m.: 12 IR 372; filed May 15, 1998, 10:25 a.m.: 21 IR 3922; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2496; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2360; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3555*)

836 IAC 3-2-6 Equipment list

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 16-31-3-20

Sec. 6. (a) The advanced life support rotorcraft ambulance service provider organization shall ensure that the following basic life support and advanced life support equipment is carried on board each rotorcraft ambulance at the time of dispatch:

(1) Portable suction apparatus, capable of a minimum vacuum of three hundred (300) millimeters of mercury, equipped with wide-bore tubing and other rigid and soft pharyngeal suction tips.

- (2) Oropharyngeal airways (adult, child, and infant sizes).
- (3) Nasopharyngeal airways (small, 20-24 french; medium, 26-30 french; large, 30 french or greater).
- (4) Bag mask ventilation units, hand operated, one (1) unit in each of the following sizes, each equipped with clear face masks and oxygen reservoirs with oxygen tubing:
 - (A) Adult.
 - (B) Child.
 - (C) Infant (mask only).
 - (D) Neonatal (mask only).
- (5) Portable oxygen equipment of at least three hundred (300) liters capacity (D size cylinder) with yoke, medical regulator, pressure gauge, and nondependent flowmeter.
- (6) Oxygen delivery devices shall include the following:
 - (A) High concentration devices, two (2) each, in adult, child, and infant sizes.
 - (B) Low concentration devices, two (2) in adult size.
- (7) Blood pressure manometer, one (1) each in the following cuff sizes:
 - (A) Large adult.
 - (B) Adult.
 - (C) Child.
- (8) Stethoscope in adult size.
- (9) Wound care supplies to include the following:
 - (A) Sterile gauze pads four (4) inches by four (4) inches.
 - (B) Airtight dressing.
 - (C) Adhesive tape, two (2) rolls.
 - (D) Bandage shears.
- (10) Rigid extrication collars, two (2) each capable of the following sizes:
 - (A) Pediatric.
 - (B) Small.
 - (C) Medium.
 - (D) Large.
- (11) Portable defibrillator with self-contained cardiac monitor and ECG strip writer and equipped with defibrillation pads or paddles, appropriate for both adult and pediatric defibrillation, that will not interfere with the aircraft's electrical and radio system.
- (12) Endotracheal intubation devices, including the following equipment:
 - (A) Laryngoscopes with spare batteries and bulbs.
 - (B) Laryngoscope blades (adult and pediatric, curved and straight).
 - (C) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter.
- (13) Medications, intravenous fluids, administration sets, syringes, and needles will be specified by the air-medical director identifying types and quantities.
 - (b) Additional equipment and supplies approved by the supervising hospital shall be identified by the rotorcraft ambulance service provider organization's air-medical director and reported in writing to the agency for initial certification and recertification.
 - (c) All drugs shall be supplied by the supervising hospital, or by written arrangement with a supervising hospital, on an even exchange basis. Lost, stolen, or misused drugs shall only be replaced on order of the advanced life support rotorcraft ambulance service provider organization air-medical director. All medications and advanced life support equipment are to be supplied by order of the medical director. Accountability for distribution, storage, ownership, and security of medications is subject to applicable requirements as determined by the medical director, pharmacist, and the United States Department of Justice Drug Enforcement Administration. (*Indiana Emergency Medical Services Commission; 836 IAC 3-2-6; filed Oct 11, 1988, 11:05 a.m.: 12 IR 373; filed May 15, 1998, 10:25 a.m.: 21 IR 3923; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2497; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3555*)

836 IAC 3-2-7 Communications systems requirements

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 16-31-3-20

Sec. 7. (a) Each rotorcraft ambulance shall have all communications equipment required under 14 CFR 135 for the type of aircraft and service provided. In addition, the rotorcraft ambulance shall have radio communications

equipment that allows it to communicate directly with Indiana hospitals utilizing either the Indiana Hospital Emergency Radio Network (IHERN) system or the ultrahigh frequency medical communications channels used for advanced life support.

(b) Transmitters are to operate with an output power not to exceed ten (10) watts as applicable to FCC rules and regulations.

(c) The rotorcraft ambulance service provider organization shall maintain a dispatch and tactical communications system with the capability to provide a coordinated voice communications linkage within the flying area of the rotorcraft ambulance service provider organization. This channel or these channels will be used exclusively for dispatch and tactical communications and shall be apart from any involved in the IHERN.

(d) Authorization or authorizations for the use of any frequencies necessary for the required communications linkages with ground personnel identified in section 3(m) of this rule shall be part of the areawide coordinated plan identified in section 2(a)(1)(B) of this rule. (*Indiana Emergency Medical Services Commission; 836 IAC 3-2-7; filed Oct 11, 1988, 11:05 a.m.: 12 IR 373; filed May 15, 1998, 10:25 a.m.: 21 IR 3923; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2498; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3556*)

836 IAC 3-2-8 Penalties (Repealed)

Sec. 8. (*Repealed by Indiana Emergency Medical Services Commission; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372*)

Rule 3. Fixed-Wing Air Ambulance Service Provider Organization

836 IAC 3-3-1 Air ambulances; general requirements

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 16-31-3-20

Sec. 1. (a) Any organization based in Indiana providing, or seeking to provide, fixed-wing air ambulance services utilizing fixed-wing aircraft is required to be certified as an advanced life support fixed-wing air ambulance service provider organization by the commission. The advanced life support fixed-wing air ambulance service provider organization shall be certified in accordance with this article under IC 16-31 as appropriate.

(b) The provider organization of fixed-wing air ambulance services shall ensure that the aircraft used in conjunction with the provision of advanced life support services meets the guidelines as specified in this article under IC 16-31 and is certified by the commission. Each fixed-wing air ambulance service provider organization shall meet all applicable parts of F.A.A. regulation and shall hold a valid 14 CFR 135 air carrier certificate or shall have a contract with the holder of a 14 CFR 135 air carrier certificate to provide aviation services under their certificate. Either must also have current F.A.A. approved air ambulance operations specifications.

(c) Advanced life support fixed-wing air ambulance service provider organizations will have an agreement with one (1) or more supervising hospitals for the following services:

- (1) Continuing education.
- (2) Audit and review.
- (3) Medical control and direction.
- (4) Provide liaison and direction for supply of medications, fluids, and other items utilized by the provider organization.
- (5) Safety and survival programs and education.

The agreement will include a detailed description of how such services will be provided to the advanced life support fixed-wing air ambulance service provider organization. In those cases where more than one (1) hospital enters into an agreement, or seeks to enter into an agreement, with an advanced life support fixed-wing air ambulance service provider organization as a supervising hospital, an interhospital agreement will be provided to the agency that clearly defines the specific duties and responsibilities of each hospital to ensure medical, safety, and administrative accountability of system operation. An agreement is not required when the hospital and the provider are the same organization.

(d) The advanced life support fixed-wing air ambulance service provider organization will have an air-medical director provided by the advanced life support fixed-wing air ambulance service provider organization, or jointly with the supervising hospital, who has knowledge of air transport problems and flight physiology. The air-medical director is responsible for providing competent medical direction and overall supervision of the medical aspects of the advanced life support fixed-wing air ambulance service provider organization. The duties and responsibilities of the air-medical director include, but are not limited to, the following:

- (1) Assume all medical control and authority over any and all patients treated and transported by the fixed-wing air ambulance service.

- (2) Providing liaison with physicians.
- (3) Assuring that the drugs, medications, supplies, and equipment are available to the advanced life support fixed-wing air ambulance service provider organization.
- (4) Monitoring and evaluating overall operations.
- (5) Assisting in the coordination and provision of continuing education.
- (6) Providing information concerning the operation of the advanced life support fixed-wing air ambulance service provider organization to the agency.
- (7) Providing individual consultation to the air-medical personnel.
- (8) Participating on the assessment committee of the supervising hospital in at least quarterly audit and review of cases treated by air-medical personnel.
- (9) Attesting to the competency of air crewmembers affiliated with the advanced life support fixed-wing air ambulance service provider organization.
- (10) Designating an individual or individuals to assist in the performance of these duties.
- (e) Each fixed-wing air ambulance service provider organization shall designate one (1) person to assume responsibility for inservice training. This person shall be certified as a paramedic, a registered nurse, or a licensed physician and actively provide patient care during air transport.
- (f) A fixed-wing air ambulance service provider organization shall not engage in conduct or practices detrimental to the health and safety of emergency patients or to members of the general public while in the course of business or service as a fixed-wing air ambulance service provider organization.
- (g) Each advanced life support fixed-wing air ambulance service provider organization shall maintain an adequate number of trained personnel and aircraft to provide advanced life support services as advertised and specified in the fixed-wing air ambulance service provider organization's application for certification or certification renewal.
- (h) Each fixed-wing air ambulance service provider organization shall designate one (1) person to assume the responsibilities for establishment of a safety committee consisting of the following:
 - (1) Pilot or pilots.
 - (2) Air-medical personnel.
 - (3) Aircraft maintenance technician or technicians.
 - (4) Communications personnel.

The safety committee shall meet at least quarterly and may be concurrent and in conjunction with the audit/review committee. (*Indiana Emergency Medical Services Commission; 836 IAC 3-3-1; filed Oct 11, 1988, 11:05 a.m.: 12 IR 374; filed May 15, 1998, 10:25 a.m.: 21 IR 3924; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2498; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3556*)

836 IAC 3-3-2 Certification; application

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31

Sec. 2. (a) Application for certification as an advanced life support fixed-wing air ambulance service provider organization will be made on forms provided by the agency and include, but not be limited to, the following:

- (1) A narrative summary of plans for providing fixed-wing air ambulance services, including the following:
 - (A) The staffing pattern of air-medical personnel and pilots.
 - (B) Base of operations.
 - (C) Aircraft types and identification numbers.
 - (D) A listing of all personnel and their qualifications by category who will regularly serve as pilots and air-medical personnel on the aircraft.
 - (E) A description of the weather minimums for both cross-country and local flights.
 - (F) A copy of the patient care transport record to be utilized on each transport.
- (2) Plans and methodologies to ensure that the trained personnel are provided with continuing education relative to their level of training. Continuing education on air transportation problems and flight physiology shall be provided on an annual basis. Continuing education will be approved by the advanced life support fixed-wing air ambulance service provider organization air-medical director with the cooperation of the supervising hospital.
- (3) A listing of all onboard life support and medical communications equipment available, including a list of drugs and medications to be carried on each aircraft.
- (4) When appropriate, a copy of the contract between the advanced life support fixed-wing air ambulance service provider organization and the supervising hospital or hospitals.
- (5) A copy of all treatment protocols and standing orders (if applicable) under which all nonphysician personnel will operate.

(6) Each fixed-wing ambulance service provider organization shall show proof of insurance coverage as required by 836 IAC 1-3-6.

(7) The insurance coverage specified in subdivision (6) shall be for each and every aircraft owned or operated, or both, by or for the fixed-wing air ambulance service provider organization.

(b) Upon approval, an advanced life support fixed-wing air ambulance service provider organization will be issued certification for the provision of advanced life support services as required in 836 IAC 2 and this article.

(c) The certificate issued under this article:

(1) expires on the date appearing in the expiration date section of the certificate; and

(2) shall be prominently displayed at the place of business.

(d) Application for certification renewal shall:

(1) be made not less than sixty (60) days prior to the expiration date of the current certificate;

(2) be made on such forms provided by the agency; and

(3) show evidence of compliance with this article as set forth for original certification. (*Indiana Emergency Medical Services Commission; 836 IAC 3-3-2; filed Oct 11, 1988, 11:05 a.m.: 12 IR 375; filed May 15, 1998, 10:25 a.m.: 21 IR 3925; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2499; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3558; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 3-3-3 Minimum specifications

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 16-31-3-20

Sec. 3. (a) The fixed-wing ambulance performance characteristics are inherent in the type of aircraft selected by the fixed-wing air ambulance service provider organization. The aircraft and its equipment and operations shall be in compliance with prevailing F.A.R. for the type of aircraft in question and flying conditions under which the aircraft will be operated as specified in the 14 CFR 135 air carrier certificate of the fixed-wing air ambulance service provider organization.

(b) The aircraft shall be capable of carrying a minimum of one (1) patient on a litter in a horizontal position located so as not to obstruct the pilot's vision or interfere with the performance of any member of the flight crew or required air-medical personnel.

(c) There shall exist a means of securing each litter and attached patient securely to either the floor (deck), walls (bulkhead), seats, or specific litter rack, or any combination thereof, that shall comply with an acceptable method using either approved data from the aircraft manufacturer or data approved by the F.A.A. If data approved by the F.A.A. is required, a field approval or supplemental type certificate (STC) shall be obtained.

(d) There shall be demonstrable unobstructed vertical space at the head and thorax areas of the upper surface of a litter or litters to allow for performance of advanced life support cardiac care.

(e) Both the head and thorax of the secured patient shall be accessible by a minimum of two (2) air-medical personnel at one (1) time.

(f) The patient compartment shall have lighting available for patient observation (a minimum of forty (40) foot-candles at the level of the patient is recommended). Lighting shall be such as to not interfere with the pilot's vision and will be focused, shielded, diffused, or colored illumination.

(g) The patient compartment shall have fresh air ventilation for the comfort of all persons on board.

(h) The patient compartment shall have temperature regulation to assure the comfort of all persons on board.

(i) The aircraft shall have one (1) door demonstrably large enough for ease of litter patient loading and unloading in the supine position.

(j) The electrical system of the aircraft shall be capable of supporting all of the ancillary equipment without the threat of overload or systems failure.

(k) Other specialized equipment may be required to conduct certain operations. The installation of this equipment shall comply with an acceptable method using either approved data from the aircraft manufacturer or data approved by the F.A.A. If data approved by the F.A.A. is required, a field approval or supplemental type certificate (STC) shall be obtained.

(l) The aircraft shall be equipped with adequate patient restraints to preclude interference with the crew or aircraft flight controls.

(m) The aircraft shall have an intercommunications system. (*Indiana Emergency Medical Services Commission; 836 IAC 3-3-3; filed Oct 11, 1988, 11:05 a.m.: 12 IR 376; filed May 15, 1998, 10:25 a.m.: 21 IR 3926; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2500; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3558*)

836 IAC 3-3-4 Operating procedures; flight and medical

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 4-21.5-1

Sec. 4. (a) Each provider organization shall maintain accurate records concerning the emergency care provided to each patient within the state as well as the following:

(1) All advanced life support fixed-wing ambulance service provider organizations shall utilize a patient care transport record.

(2) All advanced life support fixed-wing ambulance provider organizations shall maintain accurate records under 836 IAC 1-1-5.

(b) Premises shall be maintained, suitable to the conduct of a fixed-wing air ambulance service, with provision for adequate storage or maintenance, or both, of fixed-wing ambulances and the on-board equipment.

(c) Each fixed-wing air ambulance service provider organization shall have a periodic maintenance program as outlined for each specific aircraft certified by the commission in compliance with F.A.A. and manufacturer's service recommendations (MSR) guidelines as a minimum to assure that each fixed-wing ambulance, including equipment, is maintained in good, safe working condition.

(d) All fixed-wing air ambulance service provider organization premises, records, and fixed-wing ambulances shall be made available for inspection by the agency at any time during regularly scheduled business hours.

(e) A determination of noncompliance with F.A.R. may result in immediate suspension of commission certification as a fixedwing air ambulance service provider organization.

(f) Each fixed-wing air ambulance service provider organization shall make available to the commission for inspection at place of operation during regular business hours any manual of operations required under F.A.R.

(g) Commission certification as a fixed-wing air ambulance service provider organization may be terminated upon the date specified in the notice.

(h) Each fixed-wing air ambulance service provider organization shall establish equipment checklist procedures to ensure the following:

(1) Electronic and mechanical equipment are in proper operating condition.

(2) Fixed-wing ambulances shall be maintained in safe operating conditions at all times.

(3) Emergency patient care equipment required for fixed-wing ambulance certification is maintained in minimum quantities either directly on board the fixed-wing ambulance or available at the time of patient transport.

(i) Each fixed-wing air ambulance service provider organization shall ensure that rigid sanitation conditions and procedures are in effect at all times. The following sanitation standards apply to all fixed-wing ambulances:

(1) The interior and the equipment within the aircraft are clean and maintained in good working order at all times.

(2) Freshly laundered linens are used on all litters, and pillows and linens shall be changed after each patient is transported.

(3) When an aircraft has been utilized to transport a patient known to have a communicable disease, the aircraft shall be cleansed and all contact surfaces be washed with soap and water and disinfected.

(j) A fixed-wing air ambulance service provider organization shall not operate a fixed-wing ambulance in Indiana if the fixedwing ambulance does not meet the certification requirements of this article and does not have a certificate issued under this article; however, a fixed-wing air ambulance service provider organization may operate, for a period not to exceed one hundred eighty (180) consecutive days, a temporary replacement fixed-wing ambulance if the temporary replacement fixed-wing ambulance is used to replace a certified fixed-wing ambulance that has been temporarily taken out of service providing the following:

(1) The replacement fixed-wing ambulance shall meet all certification requirements of this article.

(2) The fixed-wing air ambulance service provider organization shall notify the agency, in writing, within seventy-two (72) hours of the time the replacement fixed-wing ambulance is placed in service. The written notice shall identify the following:

(A) The replacement date.

(B) The certification number of the replaced fixed-wing ambulance.

(C) The aircraft identification number of the replacement fixed-wing ambulance.

(D) The make and type of the replacement fixed-wing ambulance.

Upon receipt of the notification, a temporary certificate shall be issued effective the date the certified rotorcraft ambulance was replaced. Temporary certification will not exceed one hundred eighty (180) days from the date that the replacement fixed-wing ambulance is placed in service, and, upon return to service of the certified fixed-wing ambulance, the use of the replacement fixedwing ambulance shall cease. If the replaced fixed-wing ambulance is not returned to service within the one hundred eighty (180) day period, use of the replacement fixed-wing ambulance shall cease unless certification is approved in accordance with this article. (*Indiana Emergency Medical Services Commission; 836 IAC 3-3-4; filed Oct 11, 1988, 11:05 a.m.: 12 IR 376; filed May 15, 1998, 10:25 a.m.: 21 IR 3926;*

filed Apr 4, 2002, 9:08 a.m.: 25 IR 2501; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2360; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3559)

836 IAC 3-3-5 Staffing

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 4-21.5-1; IC 16-31-3-14

Sec. 5. (a) Each certified fixed-wing ambulance while transporting an emergency patient shall be staffed by no less than three (3) people and include the following requirements:

(1) The first person shall be a properly certified pilot who shall complete an orientation program covering flight and airmedical operations as prescribed by the air-medical director.

(2) The second person shall be an Indiana certified paramedic or registered nurse or a physician.

(3) The third person shall be any appropriate personnel to properly care for the medical needs of the patient as required on board the fixed-wing aircraft in the patient compartment.

(4) All medical personnel on board the aircraft must be trained in air transport problems and principles of flight physiology.

(b) The advanced life support fixed-wing air ambulance service provider organization shall notify the agency in writing within thirty (30) days of any change in the advanced life support services provided.

(c) Upon suspension, revocation, or termination of a certificate, the provision of advanced life support services shall cease. (*Indiana Emergency Medical Services Commission; 836 IAC 3-3-5; filed Oct 11, 1988, 11:05 a.m.: 12 IR 378; filed May 15, 1998, 10:25 a.m.: 21 IR 3928; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2503; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2362; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3560*)

836 IAC 3-3-6 Equipment list

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 16-31-3-20

Sec. 6. (a) The advanced life support fixed-wing air ambulance service provider organization shall ensure that the following basic life support and advanced life support equipment is available on board each aircraft and is appropriate for the age and medical condition of the patient to be transported at the time of transport:

(1) Portable or fixed suction apparatus, capable of a minimum vacuum of three hundred (300) millimeters of mercury, equipped with wide-bore tubing and other rigid and soft pharyngeal suction tips.

(2) Oropharyngeal airways (adult, child, and infant sizes).

(3) Nasopharyngeal airways (small, 20-24 french; medium, 26-30 french; large, 30 french or greater).

(4) Bag mask ventilation units, hand operated, one (1) unit in each of the following sizes, each equipped with clear face masks and oxygen reservoirs with oxygen tubing:

(A) Adult.

(B) Child.

(C) Infant (mask only).

(D) Neonatal (mask only).

(5) Portable oxygen equipment of at least three hundred (300) liters capacity (D size cylinder) with yoke, medical regulator, pressure gauge, and nondependent flowmeter.

(6) Oxygen delivery device shall include the following:

(A) High concentration devices, two (2) each, in adult, child, and infant sizes.

(B) Low concentration devices, two (2) in adult size.

(7) Blood pressure manometer, one (1) each in the following cuff sizes:

(A) Large adult.

(B) Adult.

(C) Child.

(8) Stethoscope in adult size.

(9) Wound care supplies to include the following:

(A) Sterile gauze pads four (4) inches by four (4) inches.

(B) Airtight dressing.

(C) Bandage shears.

(D) Adhesive tape, two (2) rolls.

(10) Rigid extrication collars, two (2) each capable of the following sizes:

(A) Pediatric.

(B) Small.

(C) Medium.

(D) Large.

(11) Portable defibrillator with self-contained cardiac monitor and ECG strip writer and equipped with defibrillation pads or paddles, appropriate for both adult and pediatric defibrillation, that will not interfere with the aircraft's electrical and radio system.

(12) Endotracheal intubation devices, including the following equipment:

(A) Laryngoscopes with spare batteries and bulbs.

(B) Laryngoscope blades (adult and pediatric, curved and straight).

(C) Disposable endotracheal tubes, a minimum of two (2) each, sterile packaged, in sizes 3, 4, 5, 6, 7, 8, and 9 millimeters inside diameter.

(13) Medications, intravenous fluids, administration sets, syringes, and needles will be specified by the air-medical director identifying types and quantities.

(b) Additional equipment and supplies approved by the supervising hospital shall be identified by the fixed-wing air ambulance service provider organization air-medical director and reported in writing to the agency for initial certification and recertification.

(c) All drugs shall be supplied by the supervising hospital, or by written arrangement with a supervising hospital, on an even exchange basis. Lost, stolen, or misused drugs shall only be replaced on order of the advanced life support fixed-wing air ambulance service provider organization medical director. All medications and advanced life support equipment are to be supplied by order of the medical director. Accountability for distribution, storage, ownership, and security of medications is subject to applicable requirements as determined by the medical director, pharmacist, and the United States Department of Justice Drug Enforcement Administration. (*Indiana Emergency Medical Services Commission; 836 IAC 3-3-6; filed Oct 11, 1988, 11:05 a.m.: 12 IR 379; filed May 15, 1998, 10:25 a.m.: 21 IR 3929; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2503; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3561*)

836 IAC 3-3-7 Communications systems requirements

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 16-31-3-20

Sec. 7. (a) Each fixed-wing ambulance shall have all communications equipment required under 14 CFR 135 for the type of aircraft and service provided. In addition, the fixed-wing ambulance shall have radio communications equipment that allows it to communicate directly with Indiana hospitals utilizing either the Indiana Hospital Emergency Radio Network (IHERN) system, the ultrahigh frequency medical communications channels used for advanced life support, or air-to-ground radio telephone.

(b) Transmitters are to operate with an output power not to exceed ten (10) watts as applicable to FCC rules and regulations.

(c) The fixed-wing air ambulance service provider organization shall maintain a dispatch and tactical communications system with the capability to provide a voice communications linkage with the fixed-wing air ambulance service provider organization's base station. This channel will be used exclusively for dispatch and tactical communications and shall be apart from any involved in the IHERN.

(d) In addition to subsection (a), each multiengine fixed-wing air ambulance shall be equipped with a minimum of two (2) VHF aircraft band transceivers and two (2) independently functioning audio panels allowing each required pilot to communicate with ground resources separately. (*Indiana Emergency Medical Services Commission; 836 IAC 3-3-7; filed Oct 11, 1988, 11:05 a.m.: 12 IR 380; filed May 15, 1998, 10:25 a.m.: 21 IR 3929; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2504; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3561*)

836 IAC 3-3-8 Penalties (Repealed)

Sec. 8. (*Repealed by Indiana Emergency Medical Services Commission; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372*)

Rule 4. Waivers

836 IAC 3-4-1 Exception (Repealed)

Sec. 1. (*Repealed by Indiana Emergency Medical Services Commission; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372*)

Rule 5. Registry for Out-of-State Advanced Life Support Fixed-Wing Ambulance Service Provider Organization

836 IAC 3-5-1 Certificate of registry

Authority: IC 16-31-2-7; IC 16-31-3-20

Affected: IC 16-31-3-20

Sec. 1. (a) Application for certificate of registry as a fixed-wing ambulance service provider organization shall be made on forms provided by the agency and include, but are not limited to, a narrative summary of plans for providing fixed-wing ambulance services, including the following:

- (1) The staffing pattern of personnel.
- (2) Base of operations and a level of care to be provided.
- (3) The training and experience of the applicant in the transportation and care of patients.
- (4) A description and general location of each aircraft to be used as an air ambulance, including the make, model, year of manufacture, insignia, name or monogram, or other distinguishing characteristics.
- (5) Types and quantity of medical equipment on board.
- (6) Proof of current valid certification or license issued by another state.
- (7) Other information as requested by the commission.

(b) Upon approval by the commission, the fixed-wing ambulance service provider organization shall be registered by the commission.

(c) Each fixed-wing ambulance shall comply with all applicable F.A.A. and F.A.R. requirements pertaining to operating as a commercial air transport service.

(d) Certificate of registry is required for all advanced life support fixed-wing ambulance service provider organizations based outside of Indiana and transporting patients originating in Indiana to a location outside of Indiana. (*Indiana Emergency Medical Services Commission; 836 IAC 3-5-1; filed Oct 11, 1988, 11:05 a.m.: 12 IR 380; filed May 15, 1998, 10:25 a.m.: 21 IR 3930; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2505; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3562*)

Rule 6. Medicolegal Responsibilities

836 IAC 3-6-1 Medicolegal responsibilities between medical facilities (Repealed)

Sec. 1. (*Repealed by Indiana Emergency Medical Services Commission; filed Apr 4, 2002, 9:08 a.m.: 25 IR 2505*)

ARTICLE 4. TRAINING AND CERTIFICATION

Rule 1. Definitions

836 IAC 4-1-1 Definitions

Authority: IC 16-31-2-7

Affected: IC 16-31

Sec. 1. The definitions in 836 IAC 1-1-1 apply throughout this article. (*Indiana Emergency Medical Services Commission; 836 IAC 4-1-1; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2745; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2362; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3562*)

Rule 2. Emergency Medical Services Training Institution

836 IAC 4-2-1 General requirements for training institutions; staff

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 4-21.5; IC 16-21; IC 16-31-3-2; IC 20-12-62-3; IC 20-12-71-8; IC 20-18-2-7

Sec. 1. (a) All institutions administering or seeking to administer emergency medical services training programs shall:

- (1) be certified by the commission prior to providing such training; and
- (2) comply with this section.

Any multiple campus institution administering or seeking to administer such programs shall have its training institution certified by the commission on a campus-by-campus basis.

(b) Each Indiana emergency medical services training institution of emergency medical technician programs shall be:

- (1) a postsecondary institution as defined in IC 20-12-71-8 [*IC 20-12 was repealed by P.L.2-2007, SECTION 390, effective July 1, 2007.*];

(2) a private technical, vocational, or trade school as defined in IC 20-12-62-3 [IC 20-12 was repealed by P.L.2-2007, SECTION 390, effective July 1, 2007. See IC 21-17-1-15.];

(3) a high school as defined in IC 20-18-2-7;

(4) a provider organization as defined in IC 16-31; or

(5) an appropriately accredited hospital licensed under IC 16-21; that has adequate resources and dedication to educational endeavors. Educational institutions shall be appropriately accredited by a regional accrediting association for higher education or have state licensure that assures comparable educational standards.

(c) Such an institution shall submit an application to the agency at least ninety (90) days prior to the date for which certification is requested in a manner prescribed by the agency. The application shall include the following:

(1) The name and address of the training institution.

(2) The name of the institution official.

(3) Agreement or agreements of affiliation with clinical and internship facilities.

(4) Type of emergency medical service courses conducted.

(5) Medical director approval form listing affiliated instructor or instructors.

(6) In-course standards and criteria by which the instructor is to determine successful completion of the didactic and clinical portions of the course to include the following:

(A) Attendance requirements and absentee policies.

(B) Testing procedures.

(C) Number and scope of in-course tests.

(D) Didactic pass/fail grade average and criteria.

(E) Provision for makeup test and classes.

(F) Minimal age for enrollment.

(G) Policies for provider organization reasonable accommodations under the Americans with Disabilities Act.

(H) Description of the screening and evaluation process for acceptance into any certified training program.

(7) Other information as required by the agency.

(d) Certification as an emergency medical services training institution is valid for a period of two (2) years from the date of certification.

(e) Certified emergency medical services training institutions shall be certified according to the institution's intent and ability to teach various levels of emergency medical services curricula as follows:

(1) A basic life support training institution is defined as an institution that presents one (1) or more of the following training courses:

(A) Basic emergency medical technician.

(B) Emergency medical technician-basic advanced.

(C) Emergency medical first responder training courses.

(2) An advanced life support training institution is defined as an institution that presents one (1) or more of the following training courses and may include one (1) or more of the basic life support training courses listed under subdivision (1):

(A) Emergency medical technician-intermediate.

(B) Paramedic.

(f) A certified training institution shall submit an application for recertification to the agency at least sixty (60) days prior to the date of certification expiration. The application for recertification shall indicate compliance with the requirements currently in effect at the time of the application for renewal.

(g) Certified advanced life support training institutions conducting paramedic training programs on or after July 1, 2008, shall show written proof of national accreditation of the program. (*Indiana Emergency Medical Services Commission; 836 IAC 4-2-1; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2747; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2364; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3564; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 4-2-2 Institutional responsibilities

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 2. A certified training institution seeking commission approval for administering emergency medical services training courses shall meet the following minimum requirements:

(1) Designate one (1) person as a training institution official responsible for:

(A) administering all of the activities of the emergency medical services training institution; and

(B) communicating with the agency.

(2) Submit to an inspection of training facilities and equipment.

- (3) Provide a list of educational staff to meet staffing-student ratio requirements established in approved curricula.
- (4) Have the necessary clinical facilities, or affiliations with clinical facilities, to conduct the required clinical phases of emergency medical service training programs.
- (5) Under conditions where didactic and clinical training are to be conducted by separate institutions, program responsibility will rest with the institution that is certified by the commission. In cases where two (2) or more certified training institutions are cooperating in the presentation of an emergency medical services training program, both institutions will be held jointly responsible for the training programs.
- (6) Provide classroom space to effectively present the various requirements in the curricula.
- (7) The curriculum requirements for all certified training programs shall be approved by the commission. Course applications will be made in a manner prescribed by the agency. The agency or commission may disapprove a course application when it has been determined that the training institution or primary instructor has been found in noncompliance with rules and regulations.
- (8) Have the training equipment and training aids (including the emergency care equipment) required by the curriculum of the courses that the training institution offers. The training institution shall have an adequate amount of the training equipment to be utilized by students to meet any equipment-to-student ratios prescribed by the curriculum being presented.
- (9) Make available a minimum of twelve (12) hours, over a two (2) year period, of continuing education in educational principles and techniques for each of its affiliated primary instructors. A training institution may offer this continuing education or advise its faculty members of such continuing education at other sites. The training institution official may accept educational programs conducted at other facilities.
- (10) Evaluate each course and retain a record of the evaluation.
- (11) Evaluate each affiliated instructor at least one (1) time a calendar year and retain a record of the evaluation.
- (12) Provide educational personnel for each approved training course, consisting of the following:
 - (A) A medical director.
 - (B) A program director for the following levels:
 - (i) For an emergency medical technician-basic advanced course, the program director shall be:
 - (AA) a physician;
 - (BB) a registered nurse;
 - (CC) an emergency medical technician-basic advanced;
 - (DD) an emergency medical technician-intermediate; or
 - (EE) a paramedic.
 - (ii) For an emergency medical technician-intermediate course, the program director shall be:
 - (AA) an emergency medical technician-intermediate;
 - (BB) a paramedic;
 - (CC) a physician; or
 - (DD) a registered nurse.
 - (iii) For a paramedic course, the program director shall be:
 - (AA) a paramedic;
 - (BB) a physician; or
 - (CC) a registered nurse.
 - (C) A primary instructor.
 - (D) Instructional staff.
- (13) Be responsible for in-course standards and criteria by which it determines a student's successful completion of the didactic and clinical portions of the course. The criteria include, but are not limited to, the following:
 - (A) Attendance requirements and absentee policies.
 - (B) In-course testing procedures.
 - (C) Number and scope of in-course tests.
 - (D) Didactic pass/fail grade average and criteria.
 - (E) Provision for makeup classes and tests.
 - (F) Minimum age for enrollment.
 - (G) Policies for providing reasonable accommodation under the Americans with Disabilities Act.
- (14) Be responsible for the screening and evaluation criteria for admission into any certified training program.
- (15) Assure a certified primary instructor, affiliated with the training institution, is present in each emergency medical technician class session unless a specialty topic instructor in:
 - (A) hazardous materials;
 - (B) terrorism;

(C) emergency vehicle operation; or

(D) extrication; is presenting the specific session in their specialty.

(16) Have a retention schedule of seven (7) years for all training and course records. (*Indiana Emergency Medical Services Commission; 836 IAC 4-2-2; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2748; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2365; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3565; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 4-2-3 Educational staff qualifications and responsibilities

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 3. (a) Minimum personnel qualifications for the training institution's education staff shall be as follows:

(1) A medical director.

(2) A program director who shall:

(A) have appropriate education and experience necessary to teach in the assigned areas at the discretion of the medical director;

(B) be thoroughly and appropriately knowledgeable about all subject matter;

(C) be able to demonstrate all skills assigned to teach or evaluate;

(D) be a certified primary instructor; and

(E) hold a clinical certification or license at least equal to that of the curriculum of the course in which the individual acts as the program director.

(3) The primary instructor shall be certified by the commission.

(4) Instructional staff members will be selected from various specialties and have appropriate education and experience necessary to teach in the assigned areas at the discretion of the training institution official. The individual must be:

(A) thoroughly and appropriately knowledgeable about all subject matter; and

(B) able to demonstrate all skills that the individual is assigned to teach or evaluate.

Instructional staff members involved in the skills testing of students shall be persons who hold a clinical certification or license at least equal to that of the curriculum of the course in which the individual acts as instructional staff.

(b) Education staff responsibilities are as follows:

(1) The medical director is responsible for the following:

(A) Providing competent medical direction in the conduct of the training program by providing necessary liaison with physicians to obtain adequate instructor services.

(B) Assuring accurate and thorough presentation of the medical content of the course curriculum.

(C) Attesting on forms provided by the agency to the competency of the course graduates to perform the medical skills required by the certification for which the student has been trained.

(2) The program director for any advanced life support course is responsible for the following:

(A) Developing teaching plans.

(B) Assuring that the course of instruction meets established standards of the commission and training institution.

(C) Providing liaisons with physicians and other specialists to obtain adequate instructor services for the course.

(D) Monitoring and evaluating classroom activities, including clinical and practice sessions.

(E) Assuring that the required equipment and materials necessary for teaching the course being offered are available at each class session.

(F) Coordinating and evaluating all:

(i) didactic;

(ii) clinical;

(iii) practical; and

(iv) field/internship; activities associated with the course.

(G) Acting as the liaison between the students and the program staff.

(H) Maintaining student class records concerning:

(i) attendance;

(ii) performance; and

(iii) grades.

(I) Fulfilling other course requirements as designated by the medical director and the training institution official.

(3) Instructional staff and primary instructors are responsible to teach and to test students during selected lessons or class sessions as assigned by the program director or medical director. The instructional staff is evaluated and held accountable prescribed by the medical director and the training institution official.

(Indiana Emergency Medical Services Commission; 836 IAC 4-2-3; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2749; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3566; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 4-2-4 Institution reporting requirements

Authority: IC 16-31-2-7

Affected: IC 16-31-3

Sec. 4. (a) Each training institution shall submit any changes within thirty (30) days to the agency that includes the following information:

(1) Name, address, and telephone number of the training institution official.

(2) List of affiliated educational staff, including name, certification level, and certification number.

(3) Changes in the training institutions standards and criteria.

(b) Each training institution will provide a final report on each course to the agency within fifteen (15) days following the completion of the course. These reports will be submitted in a manner prescribed by the agency.

(c) Each training institution official will complete other forms as required by the agency for purposes of course, student, or training institution evaluation. The institution will cooperate with and assist the agency in collecting statistics and evaluating performance and costs related to emergency medical services training. *(Indiana Emergency Medical Services Commission; 836 IAC 4-2-4; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2750; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3567)*

836 IAC 4-2-5 Penalties (Repealed)

Sec. 5. *(Repealed by Indiana Emergency Medical Services Commission; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372)*

Rule 3. First Responders

836 IAC 4-3-1 Training standards

Authority: IC 16-31-2-7

Affected: IC 16-18-2-131; IC 16-31-2-8

Sec. 1. The minimum requirements for first responder training shall be the following:

(1) The curriculum of the first responder training course shall be the Indiana emergency medical first responder training curriculum, which is based on the current national standard curriculum for first responders, as amended and approved by the commission.

(2) Each first responder training course shall be coordinated by a primary instructor, and each class shall be conducted by approved faculty members who shall be certified at a minimum as emergency medical technicians, or appropriate nurses and physicians.

(3) To successfully complete the Indiana emergency medical first responder training course for original certification or for certification renewal, a student shall pass the commission-authorized practical and written examinations. *(Indiana Emergency Medical Services Commission; 836 IAC 4-3-1; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2750; readopted filed Nov 30, 2006, 9:17 a.m.: 20061213-IR-836060486RFA)*

836 IAC 4-3-2 Certification standards

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-2-8; IC 16-31-3

Sec. 2. (a) Applicants for original certification as a first responder shall meet the following requirements:

(1) Be a minimum of fourteen (14) years of age.

(2) Have successfully completed the following:

(A) A commission-approved first responder course.

(B) State written and practical skills examinations as approved by the commission.

(b) Certification as a first responder shall be valid for a period of two (2) years.

(c) To renew a certification, a first responder shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirement to take and report twenty (20) hours of continuing education according to the following:

(1) Participate in a minimum of sixteen (16) hours of any combination of lectures, critiques, skills proficiency examination, or audit and review that reviews subject matter presented in the Indiana first responder curriculum.

(2) Participate in a minimum of four (4) hours in defibrillation and airway management as presented in the Indiana first responder curriculum.

(d) An individual who fails to comply with the continuing education requirements described in this article:

- (1) forfeits all rights and privileges of a certified first responder; and
 - (2) shall cease from providing the services authorized by a first responder certification as of the date of expiration of the current certificate.
 - (e) An individual wanting to reacquire a certification shall:
 - (1) complete a first responder recertification training course as approved by the commission; and
 - (2) successfully complete the state written and practical skills examinations as set forth and approved by the commission. If the individual fails either certification examination, the person must retake an Indiana first responder training course.
 - (f) First responders shall:
 - (1) not perform procedures for which the first responder has not been specifically trained:
 - (A) in the Indiana first responder curriculum; and
 - (B) that have not been approved by the commission as being within the scope and responsibility of the first responder;
 - (2) not act negligently, recklessly, or in such a manner that endangers the health or safety of emergency patients or the members of the general public;
 - (3) comply with the state and federal laws governing the confidentiality of patient medical information;
 - (4) not delegate to a less qualified individual any skill that requires a first responder; and
 - (5) comply with the protocols established by the:
 - (A) commission;
 - (B) provider organization; and
 - (C) provider organization's medical director.
- (Indiana Emergency Medical Services Commission; 836 IAC 4-3-2; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2751; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2366; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3567; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)*

836 IAC 4-3-3 Certification based upon reciprocity

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-8; IC 16-31-3-10

Sec. 3. (a) To obtain certification based upon reciprocity, an individual shall be a minimum of fourteen (14) years of age and meet one (1) of the following requirements:

- (1) Be a person who:
 - (A) possesses a valid certificate or license as a first responder from another state;
 - (B) while serving in the military of the United States, successfully completed a course of training and study equivalent to the material contained in the Indiana first responder training course;
 - (C) holds a valid unlimited license to practice medicine in Indiana; or
 - (D) successfully completed a course of training and study equivalent to the material contained in the Indiana first responder training course and successfully completes the written and practical skills certification examinations prescribed by the commission.
 - (2) Be a person who:
 - (A) holds a current first responder registration issued by the National Registry; and
 - (B) has completed a course equivalent to Indiana approved curriculum.
- (b) Any nonresident of Indiana who possesses a certificate or license as a first responder that is valid in another state, upon affiliation with an Indiana certified provider organization, may apply to the agency for temporary certification as a first responder.

Upon receipt of a valid application and verification of valid status by the agency, the agency may issue temporary certification, which shall be valid for:

- (1) the duration of the applicant's current certificate or license; or
- (2) a period not to exceed six (6) months from the date that the reciprocity request is approved by the agency; whichever period of time is shorter. A person receiving temporary certification may apply for full certification using the procedure required in subsection (a). *(Indiana Emergency Medical Services Commission; 836 IAC 4-3-3; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2751; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3568; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)*

Rule 4. Certification of Emergency Medical Technicians

836 IAC 4-4-1 General certification provisions

Authority: IC 16-31-2-7

Affected: IC 16-31-3

Sec. 1. (a) Applicants for original certification as an emergency medical technician shall meet the following requirements:

- (1) Be a minimum of eighteen (18) years of age.
 - (2) Successfully complete the Indiana basic emergency medical technician training course as approved by the commission and administered by a certified training institution.
 - (3) Pass the emergency medical technician written and practical skills examinations as set forth and approved by the commission.
- (b) The applicant shall apply for certification on forms provided by the agency postmarked within one (1) year of the date that the course was concluded as shown on the course report.
- (c) The minimum requirement for basic emergency medical technicians training shall be as follows:
- (1) The current version of the Indiana basic emergency medical technician training course as amended and approved by the commission.
 - (2) Each Indiana basic emergency medical technician course shall be supervised by a program director who is affiliated with the course sponsoring training institution as described in this article.
- (d) No course shall be approved as equivalent to subsection (c) unless the course meets the training standards in effect on the date an equivalency determination is requested.
- (e) Emergency medical technicians shall comply with the following:
- (1) An emergency medical technician shall not perform procedures for which the emergency medical technician has not been specifically trained:
 - (A) in the Indiana basic emergency medical technician curriculum; and
 - (B) that have not been approved by the commission as being within the scope and responsibility of the emergency medical technician.
 - (2) An emergency medical technician shall not act negligently, recklessly, or in such a manner that endangers the health or safety of emergency patients or the members of the general public.
 - (3) An emergency medical technician shall comply with the state and federal laws governing the confidentiality of patient medical information.
 - (4) An emergency medical technician shall not delegate to a less qualified individual any skill that requires an emergency medical technician.
 - (5) An emergency medical technician shall comply with the protocols established by the commission, the provider organization, and the provider organization's medical director. (*Indiana Emergency Medical Services Commission; 836 IAC 4-4-1; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2752; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2366; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3568*)

836 IAC 4-4-2 Application for original certification or certification renewal

Authority: IC 16-31-2-7

Affected: IC 16-31

Sec. 2. (a) Application for emergency medical technician certification shall be made on forms provided by the agency. Applicants shall complete the required forms and submit the forms to the agency. The application shall include the following:

- (1) Name and address of applicant.
 - (2) Criminal history declarations of applicant.
 - (3) Name of training institution where training was completed.
 - (4) Other information required by agency.
- (b) All applicants for original certification shall provide evidence of compliance with the requirements for certification.
- (c) Certification as an emergency medical technician shall be valid for a period of two (2) years.
- (d) To renew a certification, a certified emergency medical technician shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirement to take and report forty (40) hours of continuing education according to the following:
- (1) Participate in a minimum of thirty-four (34) hours of any combination of lectures, critiques, skills proficiency examinations, continuing education courses, or teaching sessions that review subject matter presented in the Indiana basic emergency medical technician curriculum.
 - (2) Participate in a minimum of six (6) hours of audit and review.

- (3) Participate in any update course as required by the commission.
- (4) Successfully complete proficiency evaluation that tests the skills presented in the Indiana basic emergency medical technician curriculum.
- (e) Notwithstanding any other provisions of this article, a person also certified as an emergency medical technician-basic advanced, emergency medical technician-intermediate, or paramedic under IC 16-31 may substitute the required continuing education credits for those of subsection (d).
- (f) An individual who fails to comply with the continuing education requirements described in this article shall not exercise any of the rights and privileges of an emergency medical technician and shall cease from providing the services authorized by an emergency medical technician certification as of the date of expiration of the current certificate.
- (g) An individual wanting to reacquire a certification shall:
 - (1) complete an emergency medical technician recertification training course as approved by the commission; and
 - (2) successfully complete the state written and practical skills examinations as set forth and approved by the commission. If the individual fails either certification examination, the person must retake an Indiana basic emergency medical technician training course. (*Indiana Emergency Medical Services Commission; 836 IAC 4-4-2; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2752; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3569*)

836 IAC 4-4-3 Certification based upon reciprocity

Authority: IC 16-31-2-7

Affected: IC 16-31-3-8; IC 16-31-3-10

Sec. 3. (a) To obtain certification based upon reciprocity, an individual shall be a minimum of eighteen (18) years of age and meet one (1) of the following requirements:

- (1) Be a person who:
 - (A) possesses a valid certificate or license as an emergency medical technician from another state; and
 - (B) successfully completes the written and practical skills certification examinations as prescribed by the commission.
- (2) Be a person who:
 - (A) while serving in the military of the United States, successfully completed a course of training and study equivalent to the material contained in the Indiana basic emergency medical technician training course; and
 - (B) successfully completes the written and practical skills certification examinations prescribed by the commission.
- (3) Be a person who:
 - (A) holds a valid unlimited license to practice medicine in Indiana; and
 - (B) successfully completes the written and practical skills certification examinations prescribed by the commission.
- (4) Be a person who:
 - (A) successfully completed a course of training and study equivalent to the material contained in the Indiana basic emergency medical technician training course; and
 - (B) successfully completes the written and practical skills certification examinations prescribed by the commission.
- (5) Be a person who:
 - (A) holds a current emergency medical technician registration from the National Registry; and
 - (B) has completed a course equivalent to the Indiana approved curriculum.
- (b) Any nonresident of Indiana who possesses a certificate or license as an emergency medical technician that is valid in another state, or a valid registration issued by the National Registry, upon affiliation with an Indiana certified provider organization may apply to the agency for temporary certification as an emergency medical technician. Upon receipt of a valid application and verification of valid status by the agency, the agency may issue temporary certification, which shall be valid for the duration of the applicant's current certificate or license or for a period not to exceed six (6) months from the date that the reciprocity request is approved by the agency, whichever period of time is shorter. A person receiving temporary certification may apply for full certification using the procedure required in section 1 of this rule. (*Indiana Emergency Medical Services Commission; 836 IAC 4-4-3; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2753; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3570*)

Rule 5. Emergency Medical Services Primary Instructor Certification

836 IAC 4-5-1 Student qualifications to enter training

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-14

Sec. 1. An applicant for Indiana primary instructor training shall meet the following requirements:

- (1) Have been certified, registered, or licensed as an emergency medical technician for a period of not less than one (1) year.
- (2) Have at least one (1) year of experience in the delivery of emergency medical care in the prehospital setting.
- (3) Submit a letter of intent to affiliate from at least one (1) Indiana certified training institution.
(Indiana Emergency Medical Services Commission; 836 IAC 4-5-1; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2754; readopted filed Nov 30, 2006, 9:17 a.m.: 20061213-IR-836060486RFA; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 4-5-2 Certification and recertification; general

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-14

Sec. 2. (a) Application for certification will be made on forms and according to procedures prescribed by the agency. In order to be certified as an emergency medical services primary instructor, the applicant shall meet one (1) of the following requirements:

- (1) Successfully complete a commission-approved Indiana emergency medical services primary instructor training course and complete all of the following:
 - (A) Successfully complete the primary instructor written examination.
 - (B) Successfully complete the primary instructor training program.
 - (C) Be currently certified as an Indiana emergency medical technician.
 - (D) Successfully pass the Indiana basic emergency medical services written and practical skills examinations within one (1) year prior to applying for certification as a primary instructor.
- (2) Successfully complete a training course equivalent to the material contained in the Indiana emergency medical service primary instructor course and complete all of the following:
 - (A) Successfully complete the primary instructor written examination.
 - (B) Successfully complete the primary instructor training program.
 - (C) Be currently certified as an Indiana emergency medical technician.
 - (D) Successfully pass the Indiana basic emergency medical services written and practical skills examinations within one (1) year prior to applying for certification as a primary instructor.
- (b) Certification as an emergency medical services primary instructor is valid for two (2) years.
- (c) In order to retain certification as a primary instructor, a person shall meet the following requirements:
 - (1) Retain affiliation with at least one (1) Indiana certified training institution.
 - (2) Conduct a minimum of eighty (80) hours of educational sessions based upon the emergency medical service curricula, which in content are either less than or equal to the primary instructor's level of clinical certification.
 - (3) Complete a minimum of twelve (12) hours of continuing education that specifically addresses the topic of educational philosophy and techniques, offered or approved by the affiliating training institution.
 - (4) Be evaluated by the training institution in regard to instructional skills and compliance with existing standards of the training institution and the commission at least once per course.
 - (5) Every two (2) years present, to the agency, evidence of compliance with this subsection during the period of certification as prescribed by the commission.
 - (6) Maintain the prerequisite certification described in subsection (a)(1)(C).
- (d) The minimum requirements for emergency medical services primary instructor training is the current version of the Indiana primary instructor course, based upon the current national standard curriculum as amended and approved by the commission.
- (e) A primary instructor shall comply with the following:
 - (1) All state and federal laws governing the confidentiality of student information.
 - (2) The material taught by the primary instructor shall not conflict with the curriculum approved by the commission.
 - (3) Not negligently, recklessly, or willfully endanger the health or safety of emergency patients or students.
 - (4) All course standards as established by the training institution course policies and procedures.
- (f) Individuals who have failed to comply with the continuing education requirements shall not exercise any of the rights and privileges of a primary instructor.
- (g) An individual wanting to reacquire a primary instructor certification shall do the following:
 - (1) Meet all prerequisites of an Indiana emergency medical services primary instructor training course.
 - (2) Successfully complete the primary instructor written examination.
 - (3) Successfully complete the primary instructor recertification evaluation.

(4) Successfully pass the Indiana basic emergency medical services written and practical skills examinations within one (1) year prior to applying for certification as a primary instructor. (*Indiana Emergency Medical Services Commission; 836 IAC 4-5-2; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2754; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2367; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3570; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

Rule 6. Advanced Emergency Medical Technician Training

836 IAC 4-6-1 Advanced emergency medical technician training (Repealed) Sec. 1. (*Repealed by Indiana Emergency Medical Services Commission; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3579*)

Rule 6.1. Advanced Emergency Medical Technician Intermediate Training

836 IAC 4-6.1-1 Advanced emergency medical technician intermediate training

Authority: IC 16-31-2-7

Affected: IC 16-31-3-20

Sec. 1. (a) All institutions administering or seeking to administer training programs for advanced emergency medical technician intermediates who engage in the provision of advanced life support services are required to be certified by the commission.

(b) An institution certified by the commission to conduct training programs for advanced emergency medical technician intermediates must:

(1) be a training institution certified under 836 IAC 4-2; and

(2) operate according to the procedures described in 836 IAC 4-2.

(c) The minimum curriculum requirements for advanced emergency medical technician intermediate training shall be the Indiana advanced emergency medical technician intermediate training curriculum based upon the current national standard curriculum as amended and approved by the commission.

(d) The program director shall be a physician, a registered nurse, a paramedic, or an advanced emergency medical technician intermediate responsible for the duties of 836 IAC 4-2. (*Indiana Emergency Medical Services Commission; 836 IAC 4-6.1-1; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2368*)

Rule 7. Emergency Medical Technicians-Basic Advanced; Certification

836 IAC 4-7-1 Student qualification to enter training

Authority: IC 16-31-2-7

Affected: IC 16-31-3-14

Sec. 1. (a) An applicant for Indiana emergency medical technician-basic advanced training shall hold a valid certificate as an emergency medical technician.

(b) Individuals who have successfully completed an Indiana basic emergency medical technician course or are accepted for basic reciprocity and have taken the Indiana basic written and practical certification examinations may hold a provisional spot in the emergency medical technician-basic advanced course. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7-1; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2755; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3571*)

836 IAC 4-7-2 Certification provisions; general

Authority: IC 16-31-2-7

Affected: IC 4-21.5; IC 16-31-3-14

Sec. 2. (a) An applicant for certification as an emergency medical technician-basic advanced shall meet the following requirements:

(1) Be an Indiana certified emergency medical technician.

(2) Be affiliated with a certified emergency medical technician-basic advanced provider organization or a supervising hospital.

(3) Successfully complete the Indiana emergency medical technician-basic advanced training course as approved by the commission and administered by a certified training institution.

(4) Pass the emergency medical technician-basic advanced written and practical skills examinations as approved by the commission.

(b) The applicant shall apply for certification on forms provided by the agency postmarked within one (1) year of the date that the course was concluded as shown on the course report.

- (c) The applicant shall submit verification of all affiliated provider organizations and supervising hospitals.
- (d) Certification exemptions identified under 836 IAC 1-1-4 shall apply to the certification of emergency medical technician basic advanced.
- (e) Emergency medical technicians-basic advanced are prohibited from having in their possession, or maintained on board emergency response vehicles, any equipment or supplies that have not been approved by the emergency medical technician-basic advanced provider organization medical director.
- (f) Emergency medical technicians-basic advanced shall comply with the following:
 - (1) An emergency medical technician-basic advanced shall not perform a procedure for which the emergency medical technician-basic advanced has not been specifically trained:
 - (A) in the Indiana emergency medical technician basic and the Indiana emergency medical technician-basic advanced curriculums; or
 - (B) that have not been approved by the commission as being within the scope and responsibility of the emergency medical technician-basic advanced.
 - (2) An emergency medical technician-basic advanced shall not act negligently, recklessly, or in such a manner that endangers the health or safety of emergency patients or the members of the general public.
 - (3) An emergency medical technician-basic advanced shall comply with the state and federal laws governing the confidentiality of patient medical information.
 - (4) An emergency medical technician-basic advanced shall not delegate to a less qualified individual any skill that requires an emergency medical technician-basic advanced.
 - (5) An emergency medical technician-basic advanced shall comply with the protocols established by the commission, the provider organization, and the provider organization's medical director. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7-2; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2755; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2368; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3571*)

836 IAC 4-7-3 Application for certification

Authority: IC 16-31-2-7

Affected: IC 16-31-3-8; IC 16-31-3-20

Sec. 3. (a) Application for certification as an emergency medical technician-basic advanced shall be made on forms provided by the agency and shall submit the forms to the agency.

(b) All applicants for original certification shall provide evidence of compliance with the requirements for certification.

(c) Certification as an emergency medical technician-basic advanced shall be valid for two (2) years.

(d) Emergency medical technicians-basic advanced are authorized to perform manual or automated defibrillation, rhythm interpretation, and intravenous line placement. These procedures may only be performed when affiliated with a certified emergency medical technician-basic advanced provider organization and while operating under written protocols or the direct supervision of a physician of the supervising hospital or an individual authorized in writing by the medical staff to act in the behalf of a physician of the approved supervising hospital. Emergency medical technicians-basic advanced are prohibited from performing any advanced life support procedure other than manual or automated defibrillation, rhythm interpretation, and intravenous line placement as prescribed in the Indiana emergency medical technician-basic advanced course, with or without physician direction, for which certification by the commission has not been granted.

(e) Individuals who have failed to comply with the continuing education requirements shall not exercise any of the rights and privileges of an emergency medical technician-basic advanced or administer advanced life support to any emergency patient.

(f) An individual wanting to reacquire a certification shall complete an emergency medical technician-basic advanced recertification training course and successfully complete the state written and practical skills examinations as set forth and approved by the commission. If the individual fails the certification examinations, the person shall retake an entire emergency medical technician-basic advanced training course.

(g) Emergency medical technicians-basic advanced failing to satisfy the requirements of subsection (f) shall satisfy the requirements for certification renewal by fulfilling the requirements for original certification as outlined in this article. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7-3; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2756; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3572*)

836 IAC 4-7-3.5 Continuing education requirements

Authority: IC 16-31-2-7

Affected: IC 16-31-3

Sec. 3.5. To renew a certification, a certified emergency medical technician-basic advanced shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirements to take and report fifty-six (56) hours of continuing education according to the following:

- (1) Participate in a minimum of thirty-four (34) hours of any combination of lecture, critiques, skills proficiency examination, continuing education course, or teaching sessions that review subject matter presented in the Indiana basic emergency medical technician curriculum.
- (2) Participate in a minimum of ten (10) hours of any combination of lecture, critiques, skills proficiency examination, or teaching sessions that review subject matter presented in the Indiana emergency medical technician-basic advanced curriculum.
- (3) Participate in a minimum of twelve (12) hours of audit and review.
- (4) Participate in any update course as prescribed by the commission.
- (5) Successfully complete a proficiency evaluation that tests the skills presented in the Indiana basic emergency medical technician curriculum and the Indiana emergency medical technician-basic advanced curriculum. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7-3.5; filed Apr 4, 2002, 9:15 a.m.: 25 IR 2517; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3573*)

836 IAC 4-7-4 Emergency medical technician-basic advanced certification based upon reciprocity

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-2; IC 16-31-3-20

Sec. 4. (a) To obtain emergency medical technician-basic advanced certification based upon reciprocity, an individual shall meet the following requirements:

- (1) Be affiliated with an Indiana certified emergency medical technician-basic advanced provider organization or supervising hospital.
- (2) Possess a valid certificate or license as an emergency medical technician-basic advanced from another state or successfully complete a course of training and study equivalent to the material contained in the Indiana emergency medical technician-basic advanced training course.
- (3) Successfully pass the Indiana emergency medical technician-basic advanced written and practical skills examinations as set forth and approved by the commission.

(b) Application for certification shall be postmarked or delivered to the agency office within six (6) months after the request for reciprocity.

(c) Any nonresident of Indiana who possesses a certificate or license as an emergency medical technician-basic advanced, or intermediate that is valid in another state, or a valid registration with National Registry, upon affiliation with an Indiana certified emergency medical technician-basic advanced provider organization may apply to the agency for temporary certification as an emergency medical technician-basic advanced. Upon receipt of a valid application and verification of valid status by the agency, the agency may issue temporary certification that shall be valid for:

- (1) the duration of the applicant's current certificate or license; or
- (2) a period not to exceed six (6) months from the date that the reciprocity request is approved by the director; whichever period of time is shorter. A person receiving temporary certification may apply for full certification using section 1 of this rule. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7-4; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2756; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3573; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

Rule 7.1. Emergency Medical Technician-Intermediate; Certification

836 IAC 4-7.1-1 Student qualifications to enter training

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-2

Sec. 1. (a) An applicant for Indiana emergency medical technician-intermediate training shall meet the following requirements:

- (1) Hold a valid certificate as an emergency medical technician.
- (2) Be at a minimum of eighteen (18) years of age.
- (3) Have a high school diploma or general education diploma.

(b) Individuals who have successfully completed an Indiana basic emergency medical technician course or are accepted for basic reciprocity and have taken the Indiana basic written and practical certification examinations may hold a provisional spot in the emergency medical technician-intermediate course. (*Indiana Emergency Medical*

Services Commission; 836 IAC 4-7.1-1; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2369; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3573; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 4-7.1-2 Registered nurses; qualification to enter training

Authority: IC 16-31-2-7

Affected: IC 16-31-3-2

Sec. 2. (a) A registered nurse may challenge the emergency medical technician-intermediate course if he or she meets the following requirements:

- (1) Be a registered nurse in Indiana.
- (2) Be an Indiana certified emergency medical technician.
- (3) Be able to document one (1) year of experience in an emergency department or as a flight nurse with an air ambulance service.
- (4) Hold an advanced cardiac life support certification.
- (5) Hold either an American Heart Association or American Red Cross health care provider card or equivalent.
- (6) Be able to meet prerequisites required by the commission, the emergency medical technician-intermediate curriculum, and the local training institution course.

(b) For successful completion of the emergency medical technician-intermediate training course, a registered nurse must meet all of the requirements set forth by the training institution for all students or meet the prerequisites as described in subsection (a) and the following:

- (1) May earn credit by written examination for individual modules of the emergency medical technician-intermediate course.
- (2) Test out of a module to be completed prior to the beginning of that module by completing:
 - (A) the written examination with a passing score; and
 - (B) the practical skills examination with a passing score.

Failure of any module exam will require the students to participate in the entire module.

- (3) Successfully complete the emergency medical technician-intermediate program comprehensive final examination.
- (4) Demonstrate skill proficiency by completing the emergency medical technician-intermediate level skills with course proficiency.
- (5) May earn credit of clinical hours by review of the student's past experience in the clinical areas.
- (6) Complete all field internship and required hospital clinical hours.
- (7) Pass the emergency medical technician-intermediate written and practical skills examinations as approved by the commission.
- (8) Meet general certification requirements in section 3 of this rule. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7.1-2; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2369; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3574*)

836 IAC 4-7.1-2.5 Inactive status for an Indiana certified emergency medical technician-intermediate

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-2

Sec. 2.5. (a) An emergency medical technician-intermediate requesting inactive emergency medical technician-intermediate status shall be:

- (1) currently certified in Indiana as an emergency medical technician-intermediate; and
- (2) an individual who has previously recertified as an emergency medical technician-intermediate in Indiana at least one (1) time.

The individual's certification must be in good standing with the commission at the time inactive status is applied for and granted. Applicants for inactive status do not have to be affiliated with an emergency medical technician-intermediate provider organization at the time the inactive status is applied for or granted. Applicants requesting inactive status shall submit a request in writing to the commission.

(b) If an emergency medical technician-intermediate wants to keep an active emergency medical technician certification, the emergency medical technician-intermediate shall meet the requirements set forth in 836 IAC 4-4.

(c) An emergency medical technician-intermediate on inactive status shall collect and report continuing education requirements listed in section 5(b)(1) through 5(b)(3) of this rule, during the inactive period, and the continuing education hours shall be reported to the commission prior to the expiration date of the certificate.

(d) An emergency medical technician-intermediate with an inactive status wishing to return to active status must meet the following requirements:

- (1) Comply with subsection (b) during inactive status.
- (2) Submit a fully completed application for advanced life support.
- (e) Upon completion of the requirements listed in subsection (d), the emergency medical technician certification shall become active. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7.1-2.5; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 4-7.1-3 General certification

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 4-21.5; IC 16-31-3-14

Sec. 3. (a) An applicant for certification as an emergency medical technician-intermediate shall meet the following requirements:

- (1) Be a certified emergency medical technician.
- (2) Be affiliated with a certified emergency medical technician-intermediate provider organization or a supervising hospital.
- (3) Successfully complete the Indiana emergency medical technician-intermediate training course as approved by the commission and administered by an Indiana certified training institution.
- (4) Pass the emergency medical technician-intermediate written and practical skills examinations as approved by the commission.
- (b) The applicant shall do the following:
 - (1) Apply for certification on forms provided by the agency postmarked within one (1) year of the date of successful completion of the required certification examinations.
 - (2) Submit verification of all affiliated provider organizations and supervising hospitals.
- (c) Certification exemptions identified under 836 IAC 1-1-4 apply to the certification of emergency medical technician intermediates.
- (d) Emergency medical technician-intermediates are prohibited from having in their possession, or maintained on board emergency response vehicles, any advanced life support equipment or supplies that have not been approved in writing by the emergency medical technician-intermediate provider organization medical director.
- (e) Emergency medical technician-intermediates shall:
 - (1) not perform a procedure for which the emergency medical technician-intermediate has not been specifically trained:
 - (A) in the Indiana emergency medical technician basic and the Indiana emergency medical technician-intermediate curriculums; or
 - (B) that have not been approved by the commission as being within the scope and responsibility of the emergency medical technician-intermediate;
 - (2) not act negligently, recklessly, or in such a manner that endangers the health or safety of emergency patients or the members of the general public;
 - (3) comply with the state and federal laws governing the confidentiality of patient medical information;
 - (4) not delegate to a less qualified individual any skill that requires an emergency medical technician-intermediate; and
 - (5) comply with the protocols established by the:
 - (A) commission;
 - (B) provider organization; and
 - (C) provider organization's medical director. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7.1-3; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2370; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3574; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 4-7.1-4 Application for certification; renewal

Authority: IC 16-31-2-7

Affected: IC 16-31-3

- Sec. 4. (a) Application for certification as an emergency medical technician-intermediate shall be made on forms provided by the agency. An applicant shall complete the required forms and shall submit the forms to the agency.
- (b) All applicants for original certification shall provide evidence of compliance with the requirements for certification.
 - (c) Certification as an emergency medical technician-intermediate shall be valid for two (2) years.
 - (d) Individuals who have failed to comply with the continuing education requirements shall not exercise any of the rights and privileges nor administer advanced life support services to emergency patients.

(e) An individual wanting to reacquire a certification shall complete an emergency medical technician-intermediate recertification training course and successful completion of state written and practical skills examinations as set forth and approved by the commission. If the individual fails the certification examinations, the person shall retake an entire emergency medical technician-intermediate training course. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7.1-4; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2370; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3575*)

836 IAC 4-7.1-5 Continuing education requirements

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-8; IC 16-31-3-20

Sec. 5. (a) To renew a certification, a certified emergency medical technician-intermediate shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirements in subsection (b).

(b) An applicant shall report a minimum of seventy-two (72) hours of continuing education consisting of the following:

(1) Section Ia, completion of an emergency medical technician-intermediate refresher course based on federal DOT-approved curriculum consisting of a minimum of thirty-six (36) hours, which refresher course may be completed through a supervising hospital-approved continuing education course consisting of the following:

(A) Twelve (12) hours in airway, breathing, and cardiology.

(B) Six (6) hours in medical emergencies.

(C) Five (5) hours in trauma.

(D) Twelve (12) hours in obstetrics and pediatrics.

(E) One (1) hour in operations.

(2) Section Ib, attach a current copy of advanced cardiac life support certification. The certification expiration date shall be concurrent with the emergency medical technician-intermediate certification expiration date.

(3) Section Ic, attach a current copy of cardiopulmonary resuscitation for the professional rescuer certification. The certification expiration date shall be concurrent with the emergency medical technician-intermediate certification expiration date.

(4) Section II, participate in a minimum of twelve (12) hours audit and review.

(5) Section III, participate in twenty-four (24) hours of additional emergency medical services-related continuing education. Additional hours may include participation in any update course as required by the commission.

(6) Section IV, skill maintenance (with no specified hour requirement). All skills shall be directly observed by the emergency medical service medical director or emergency medical service educational staff of the supervising hospital, either at an inservice or in an actual clinical setting. The observed skills include, but are not limited to, the following:

(A) Patient assessment and management; medical and trauma.

(B) Ventilatory management skills/knowledge.

(C) Cardiac arrest management.

(D) Bandaging and splinting.

(E) Medication administration, intravenous therapy, intravenous bolus, and intraosseous therapy.

(F) Spinal immobilization; seated and lying patients.

(G) Obstetrics and gynecological scenarios.

(H) Communications documentation. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7.1-5; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2371; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3575; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 4-7.1-6 Emergency medical technician-intermediate certification based upon reciprocity

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 6. (a) To obtain emergency medical technician-intermediate certification based upon reciprocity, an applicant shall be affiliated with a certified emergency medical technician-intermediate provider organization and be a person who, at the time of applying for reciprocity, meets one (1) of the following requirements:

(1) Possesses a valid certificate or license as an emergency medical technician-intermediate from another state and who successfully passes the emergency medical technician-intermediate practical and written certification examinations as set forth and approved by the commission. Application for certification shall be postmarked or delivered to the agency office within six (6) months after the request for reciprocity.

(2) Has successfully completed a course of training and study equivalent to the material contained in the Indiana emergency medical technician-intermediate training course and successfully completes the written and practical skills certification examinations prescribed by the commission.

(3) Possesses a valid National Registry intermediate certification based on the emergency medical technician-intermediate curriculum approved by the commission.

(b) Notwithstanding subsection (a), any nonresident of Indiana who possesses a certificate or license as an emergency medical technician-intermediate that is valid in another state may apply to the director for temporary certification as an emergency medical technician-intermediate. Upon receipt of a valid application and verification of valid status by the agency, the agency may issue temporary certification that shall be valid for:

(1) the duration of the applicant's current certificate or license; or

(2) a period not to exceed six (6) months from the date that the reciprocity request is approved by the agency; whichever period of time is shorter. A person receiving temporary certification may apply for full certification using the procedure required in section 1 of this rule. (*Indiana Emergency Medical Services Commission; 836 IAC 4-7.1-6; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2371; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3576; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

Rule 8. Paramedic Training

836 IAC 4-8-1 Paramedic training (Repealed)

Sec. 1. (*Repealed by Indiana Emergency Medical Services Commission; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3579*)

Rule 9. Emergency Paramedics; Certification

836 IAC 4-9-1 Student qualifications to enter training

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-2

Sec. 1. (a) An applicant for Indiana paramedic training shall meet the following requirements:

(1) Hold a valid certificate as an emergency medical technician.

(2) Be at a minimum of eighteen (18) years of age.

(3) Have a high school diploma or general education diploma.

(b) Individuals who have successfully completed an Indiana basic emergency medical technician course or are accepted for basic reciprocity and have taken the Indiana basic written and practical skills certification examinations may hold a provisional spot in a paramedic course. (*Indiana Emergency Medical Services Commission; 836 IAC 4-9-1; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2757; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3576; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 4-9-2 Registered nurses; qualification to enter training

Authority: IC 16-31-2-7

Affected: IC 16-31-3-2

Sec. 2. (a) A registered nurse can challenge the paramedic course if they meet the following:

(1) Be a registered nurse in Indiana.

(2) Be an Indiana certified emergency medical technician.

(3) Be able to document one (1) year of experience in an emergency department or as a flight nurse with an air ambulance service.

(4) Hold an advanced cardiac life support certification.

(5) Hold either an American Heart Association or American Red Cross Health care provider card or equivalent.

(6) Be able to meet prerequisites required by the commission, the emergency medical technician paramedic curriculum, and the local training institution course.

(b) For successful completion of the paramedic training course, a registered nurse must meet all of the requirements set forth by the training institution for all students or meet the prerequisites as described in subsection (a) and the following:

(1) May earn credit by written examination for individual modules of the paramedic course.

(2) Test out of a module to be completed prior to the beginning of that module by completing:

(A) the written examination with a passing score; and

(B) the practical skills examination with a passing score.

Failure of any module exam will require the students to participate in the entire module.

- (3) Successfully complete the paramedic program comprehensive final examination.
- (4) Demonstrate skill proficiency by completing the paramedic level skills with course proficiency.
- (5) May earn credit of clinical hours by review of the student's past experience in the clinical areas.
- (6) Complete all field internship and required hospital clinical hours.
- (7) Pass the paramedic written and practical skills examinations as approved by the commission.
- (8) Meet general certification requirements in section 3 of this rule. (*Indiana Emergency Medical Services Commission; 836 IAC 4-9-2; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2757; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3576*)

836 IAC 4-9-2.5 Inactive status for an Indiana certified paramedic

Authority: IC 16-31-2-7

Affected: IC 16-31-3

Sec. 2.5. (a) A paramedic requesting inactive paramedic status shall be currently certified in Indiana as a paramedic and be an individual who has previously recertified as a paramedic in Indiana at least one (1) time. The individual's certification must be in good standing with the commission at the time inactive status is granted. Applicants for inactive status do not have to be affiliated with a paramedic provider organization. Applicants wanting inactive status shall submit a request in writing to the commission.

(b) If a paramedic wants to keep an active emergency medical technician certification, the paramedic shall meet the requirements set forth in 836 IAC 4.4 [*sic.*, 836 IAC 4-4].

(c) Paramedics on inactive status must collect the following continuing education hours during the inactive period, and the continuing education hours must be reported to the commission prior to the expiration date of the certificate:

- (1) Collect and report continuing education requirements listed in section 5(b)(1) through (5)(b)(3) of this rule.
- (2) Collect and report twelve (12) additional continuing education hours.

(d) Paramedics with an inactive status wishing to return to active status must meet the following requirements:

- (1) Comply with subsection (b) during inactive status.
- (2) Be affiliated with an Indiana certified paramedic provider organization or an Indiana certified paramedic supervising hospital by submitting a signed application for advanced life support.
- (3) Submit in writing a verified statement attesting to the applicant's competency in skills listed in section 5(b)(5) of this rule signed by the paramedic provider medical director.

Upon completion of these requirements, the emergency medical technician certification will become active. (*Indiana Emergency Medical Services Commission; 836 IAC 4-9-2.5; filed Apr 4, 2002, 9:15 a.m.: 25 IR 2517; readopted filed Jul 29, 2008, 8:50 a.m.: 20080820-IR-836080410RFA*)

836 IAC 4-9-3 General certification

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 4-21.5; IC 16-31-3-14

Sec. 3. (a) An applicant for certification as a paramedic shall meet the following requirements:

- (1) Be a certified emergency medical technician.
- (2) Be affiliated with a certified paramedic provider organization or a supervising hospital.
- (3) Successfully complete the Indiana paramedic training course as approved by the commission and administered by an Indiana certified training institution.
- (4) Pass the paramedic written and practical skills examinations as approved by the commission.

(b) The applicant shall do the following:

- (1) Apply for certification on forms provided by the agency postmarked within one (1) year of the date of successful completion of the required certification examinations.
- (2) Submit verification of all affiliated provider organizations and supervising hospitals.

(c) Certification exemptions identified under 836 IAC 1-1-4 apply to the certification of paramedics.

(d) Paramedics are prohibited from having in their possession, or maintained on board emergency response vehicles, any advanced life support equipment or supplies that have not been approved in writing by the paramedic provider organization medical director.

(e) Paramedics shall:

(1) not perform a procedure for which the emergency medical technician paramedic has not been specifically trained:

(A) in the Indiana emergency medical technician basic and the Indiana emergency medical technician paramedic curriculums; or

(B) that have not been approved by the commission as being within the scope and responsibility of the emergency medical technician paramedic;

- (2) not act negligently, recklessly, or in such a manner that endangers the health or safety of emergency patients or the members of the general public;
- (3) comply with the state and federal laws governing the confidentiality of patient medical information;
- (4) not delegate to a less qualified individual any skill that requires a paramedic; and
- (5) comply with the protocols established by the:

- (A) commission;
- (B) provider organization; and
- (C) provider organization's medical director.

(Indiana Emergency Medical Services Commission; 836 IAC 4-9-3; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2757; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3577; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 4-9-4 Application for certification; renewal

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 4. (a) Application for certification as a paramedic shall be made on forms provided by the agency. An applicant shall:

- (1) complete the required forms; and
 - (2) submit the forms to the agency.
- (b) All applicants for original certification shall provide evidence of compliance with the requirements for certification.
- (c) Certification as a paramedic shall be valid for two (2) years.
- (d) Individuals who have failed to comply with the continuing education requirements shall not exercise any of the rights and privileges nor administer advanced life support services to emergency patients.
- (e) An individual wanting to reacquire a certification shall complete a paramedic recertification training course and successful completion of state written and practical skills examinations as set forth and approved by the commission. If the individual fails the certification examinations, the person shall retake an entire paramedic training course.

(Indiana Emergency Medical Services Commission; 836 IAC 4-9-4; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2758; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3577; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA)

836 IAC 4-9-5 Continuing education requirements

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3-8; IC 16-31-3-20

Sec. 5. (a) To renew a certification, a certified paramedic shall submit a report of continuing education every two (2) years that meets or exceeds the minimum requirements in subsection (b).

(b) An applicant shall report a minimum of seventy-two (72) hours of continuing education consisting of the following:

- (1) Section IA, forty-eight (48) hours of continuing education through a formal paramedic refresher course as approved by the commission or forty-eight (48) hours of supervising hospital-approved continuing education that includes the following:
 - (A) Sixteen (16) hours in airway, breathing, and cardiology.
 - (B) Eight (8) hours in medical emergencies.
 - (C) Six (6) hours in trauma.
 - (D) Sixteen (16) hours in obstetrics and pediatrics.
 - (E) Two (2) hours in operations.
- (2) Section IB, attach a current copy of cardiopulmonary resuscitation certification for the professional rescuer. The certification expiration date shall be concurrent with the paramedic certification expiration date.
- (3) Section IC, attach a current copy of advanced cardiac life support certification. The certification expiration date shall be concurrent with the paramedic certification expiration date.
- (4) Section II, twenty-four (24) additional hours of emergency medical services related continuing education; twelve (12) of these hours shall be obtained from audit and review. The participation in any course as approved by the commission may be included in this section.
- (5) Section III, skill maintenance (with no specified hour requirement). All skills shall be directly observed by the emergency medical service medical director or emergency medical service educational staff of the supervising

hospital either at an inservice or in an actual clinical setting. The observed skills include, but are not limited to, the following:

- (A) Patient medical assessment and management.
- (B) Trauma assessment and management.
- (C) Ventilatory management.
- (D) Cardiac arrest management.
- (E) Bandaging and splinting.
- (F) Medication administration, intravenous therapy, intravenous bolus, and intraosseous therapy.
- (G) Spinal immobilization.
- (H) Obstetrics and gynecological scenarios.
- (I) Communication and documentation. (*Indiana Emergency Medical Services Commission; 836 IAC 4-9-5; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2758; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3578; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

836 IAC 4-9-6 Paramedic certification based upon reciprocity

Authority: IC 16-31-2-7; IC 16-31-3-14; IC 16-31-3-14.5; IC 16-31-3-20

Affected: IC 16-31-3

Sec. 6. (a) To obtain paramedic certification based upon reciprocity, an applicant shall be affiliated with a certified paramedic provider organization and be a person who, at the time of applying for reciprocity, meets one (1) of the following requirements:

(1) Possesses a valid certificate or license as a paramedic from another state and who successfully passes the paramedic practical and written certification examinations as set forth and approved by the commission. Application for certification shall be postmarked or delivered to the agency office within six (6) months after the request for reciprocity.

(2) Has successfully completed a course of training and study equivalent to the material contained in the Indiana paramedic training course and successfully completes the written and practical skills certification examinations prescribed by the commission.

(3) Possesses a valid National Registry paramedic certification.

(b) Notwithstanding subsection (a), any nonresident of Indiana who possesses a certificate of license as a paramedic that is valid in another state, upon residing at an Indiana address, may apply to the agency for temporary certification as a paramedic. Upon receipt of a valid application and verification of valid status by the agency, the agency may issue temporary certification that shall be valid for:

(1) the duration of the applicant's current certificate or license; or

(2) a period not to exceed six (6) months from the date that the reciprocity request is approved by the director; whichever period of time is shorter. A person receiving temporary certification may apply for full certification using the procedure required in section 1 of this rule. (*Indiana Emergency Medical Services Commission; 836 IAC 4-9-6; filed Jun 30, 2000, 4:18 p.m.: 23 IR 2759; filed Jun 11, 2004, 1:30 p.m.: 27 IR 3578; filed Jul 31, 2007, 10:01 a.m.: 20070829-IR-836060011FRA*)

Rule 10. Penalties

836 IAC 4-10-1 Penalties (Repealed) Sec. 1. (*Repealed by Indiana Emergency Medical Services Commission; filed Feb 20, 2003, 8:00 a.m.: 26 IR 2372*)

ARTICLE 18. GENERAL PROVISIONS AND DEFINITIONS

IC 16-18-1 Chapter 1. General Provisions

IC 16-18-1-1 Application of definitions

Sec. 1. Except as otherwise provided, the definitions in this article apply throughout this title.
As added by P.L.2-1993, SEC.1.

IC 16-18-1-2 References to federal statutes or regulations

Sec. 2. Except as otherwise provided in this title, a reference to a federal statute or regulation in this title is a reference to the statute or regulation as in effect on January 1, 1993.
As added by P.L.2-1993, SEC.1.

IC 16-18-1-3

References to federal statutes or regulations relating to the National Voter Registration Act

Sec. 3. Except as otherwise provided in this title, a reference in this title to a federal statute or regulation relating to the federal National Voter Registration Act of 1993 (42 U.S.C. 1973gg) is a reference to the statute or regulation as in effect January 1, 2005. *As added by P.L.122-2000, SEC.16. Amended by P.L.81-2005, SEC.33 and P.L.230-2005, SEC.70.*

IC 16-18-2 Chapter 2. Definitions

IC 16-18-2-5 Adult

Sec. 5. "Adult" means an individual who is at least eighteen (18) years of age. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-7 Advanced life support

Sec. 7. (a) "Advanced life support", for purposes of IC 16-31, means care that is given:

(1) at the scene of:

(A) an accident;

(B) an act of terrorism (as defined in IC 35-41-1-26.5), if the governor has declared a disaster emergency under IC 10-14-3-12 in response to the act of terrorism; or

(C) an illness;

(2) during transport; or

(3) at a hospital; by a paramedic or an emergency medical technician-intermediate and that is more advanced than the care usually provided by an emergency medical technician or an emergency medical technician-basic advanced.

(b) The term may include any of the following:

(1) Defibrillation.

(2) Endotracheal intubation.

(3) Parenteral injections of appropriate medications.

(4) Electrocardiogram interpretation.

(5) Emergency management of trauma and illness. *As added by P.L.2-1993, SEC.1. Amended by P.L.156-2001, SEC.1; P.L.17-2002, SEC.1; P.L.2-2003, SEC.43; P.L.205-2003, SEC.8.*

IC 16-18-2-9 Advisory commission

Sec. 9. "Advisory commission", for purposes of IC 16-41-35, has the meaning set forth in IC 16-41-35-2.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-9.3 Advisory council

Sec. 9.3. "Advisory council", for purposes of IC 16-41-39.4, refers to the lead-safe housing advisory council established by IC 16-41-39.4-6. *As added by P.L.102-2008, SEC.1.*

IC 16-18-2-10 Agency

Sec. 10. (a) "Agency", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-2.

(b) "Agency", for purposes of IC 16-40-5, has the meaning set forth in IC 16-40-5-1.

(c) "Agency", for purposes of IC 16-41-37, has the meaning set forth in IC 16-41-37-1.

As added by P.L.2-1993, SEC.1. Amended by P.L.205-2003, SEC.9; P.L.101-2006, SEC.23; P.L.2-2007, SEC.178; P.L.101-2007, SEC.1.

IC 16-18-2-13 Ambulance

Sec. 13. "Ambulance", for purposes of IC 16-31, means a conveyance on:

(1) land;

(2) sea; or

(3) air;

that is used or is intended to be used for the purpose of responding to emergency life-threatening situations and providing emergency transportation service. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-20 Appropriate facility

Sec. 20. "Appropriate facility", for purposes of IC 16-36-3, has the meaning set forth in IC 16-36-3-1. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-22 Approved postsecondary educational institution

Sec. 22. "Approved postsecondary educational institution" has the meaning set forth in IC 21-7-13-6(a). *As added by P.L.2-1993, SEC.1. Amended by P.L.2-2007, SEC.179.*

IC 16-18-2-23 Approved laboratory

Sec. 23. "Approved laboratory", for purposes of IC 16-41-6 and IC 16-41-15, has the meaning set forth in IC 16-41-15-1. *As added by P.L.2-1993, SEC.1. Amended by P.L.237-2003, SEC.3.*

IC 16-18-2-26 Assembly

Sec. 26. "Assembly", for purposes of IC 16-41-22, has the meaning set forth in IC 16-41-22-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-26.5 Association

Sec. 26.5. "Association", for purposes of IC 16-39-5-3, has the meaning set forth in IC 16-39-5-3(a). *As added by P.L.231-1999, SEC.10.*

IC 16-18-2-27 ASTM

Sec. 27. "ASTM" refers to the American Society for Testing and Materials. *As added by P.L.2-1993, SEC.1. Amended by P.L.177-1993, SEC.1.*

IC 16-18-2-28.5 Attendant care services

Sec. 28.5. (a) "Attendant care services", for purposes of IC 16-27-1 and IC 16-27-4, means services:

- (1) that could be performed by an impaired individual for whom the services are provided if the individual were not impaired; and
- (2) that enable the impaired individual:
 - (A) to live in the individual's home and community rather than in an institution; and
 - (B) to carry out functions of daily living, self-care, and mobility.
- (b) The term includes the following:
 - (1) Assistance in getting in and out of beds, wheelchairs, and motor vehicles.
 - (2) Assistance with routine bodily functions, including:
 - (A) bathing and personal hygiene;
 - (B) using the toilet;
 - (C) dressing and grooming; and
 - (D) feeding, including preparation and cleanup.
 - (3) The provision of assistance:
 - (A) through providing reminders or cues to take medication, the opening of preset medication containers, and providing assistance in the handling or ingesting of noncontrolled substance medications, including eye drops, herbs, supplements, and over-the-counter medications; and
 - (B) to an individual who is unable to accomplish the task due to an impairment and who is:
 - (i) competent and has directed the services; or
 - (ii) incompetent and has the services directed by a competent individual who may consent to health care for the impaired individual. *As added by P.L.255-2001, SEC.12. Amended by P.L.212-2005, SEC.3.*

IC 16-18-2-29 Attending physician

Sec. 29. "Attending physician" means the licensed physician who has the primary responsibility for the treatment and care of the patient. For purposes of IC 16-36-5, the term includes a physician licensed in another state. *As added by P.L.2-1993, SEC.1. Amended by P.L.148-1999, SEC.1.*

IC 16-18-2-30 Authority

Sec. 30. "Authority" refers to the following:

- (1) For purposes of IC 16-22-6, the authority created under IC 16-22-6-2.
- (2) For purposes of IC 16-22-7, the authority created under IC 16-22-7-5.
- (3) For purposes of IC 16-22:

- (A) the authority created under IC 16-22-6-2; or
(B) the county building authority provided for in IC 36-9-13. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-30.5 Auto-injector

Sec. 30.5. "Auto-injector" means a spring loaded needle and syringe:

- (1) containing a single dose of medication; and
(2) that automatically releases and injects the medication. *As added by P.L.17-2002, SEC.2.*

IC 16-18-2-32 Autopsy

Sec. 32. "Autopsy", for purposes of IC 16-36-2, has the meaning set forth in IC 16-36-2-1.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-33.5 Basic life support

Sec. 33.5. (a) "Basic life support", for purposes of IC 16-31, means the following:

- (1) Assessment of emergency patients.
(2) Administration of oxygen.
(3) Use of mechanical breathing devices.
(4) Application of anti-shock trousers.
(5) Performance of cardiopulmonary resuscitation.
(6) Application of dressings and bandage materials.
(7) Application of splinting and immobilization devices.
(8) Use of lifting and moving devices to ensure safe transport.
(9) Administration by an emergency medical technician or emergency medical technician-basic advanced of epinephrine through an auto-injector.
(10) For an emergency medical technician-basic advanced, the following:
(A) Electrocardiogram interpretation.
(B) Manual external defibrillation.
(C) Intravenous fluid therapy.
(11) Other procedures authorized by the Indiana emergency medical services commission, including procedures contained in the revised national emergency medical technician basic training curriculum guide.
(b) Except as provided by:
(1) subsection (a)(9) and the training and certification standards established under IC 16-31-2-9(3); (2) subsection (a)(10)(C); and (3) the training standards established under IC 16-31-2-9(4); the term does not include invasive medical care techniques or advanced life support. *As added by P.L.186-1995, SEC.1. Amended by P.L.17-2002, SEC.3; P.L.93-2002, SEC.1; P.L.205-2003, SEC.10; P.L.74-2006, SEC.1.*

IC 16-18-2-36 Biologicals

Sec. 36. "Biologicals", for purposes of IC 16-41-19, has the meaning set forth in IC 16-41-19-1.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-37.5 Board

Sec. 37.5. (a) "Board", for purposes of IC 16-22-8, has the meaning set forth in IC 16-22-8-2.1.

(b) "Board", for purposes of IC 16-41-42.2, has the meaning set forth in IC 16-41-42.2-1.

As added by P.L.184-2005, SEC.4. Amended by P.L.234-2007, SEC.44; P.L.3-2008, SEC.103.

IC 16-18-2-37.7 Board of commissioners

Sec. 37.7. "Board of commissioners", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-3. *As added by P.L.2-2007, SEC.180.*

IC 16-18-2-37.8 Board of trustees

Sec. 37.8. "Board of trustees", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-4. *As added by P.L.2-2007, SEC.181.*

IC 16-18-2-41 Building

Sec. 41. (a) "Building", for purposes of IC 16-22 and except as provided in subsection (b), means a building, or an addition, for hospital purposes, and includes the site if a site is acquired, the equipment, heating facilities, sewage

disposal facilities, landscaping, walks, drives, parking facilities and other structures, facilities, appurtenances, materials, and supplies that may be necessary to render that building suitable for use and occupancy for hospital purposes.

(b) "Building", for purposes of IC 16-22-2, has the meaning set forth in subsection (a) and includes, in the discretion of the governing board, clinics and offices for physicians. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-48.5 Cardiopulmonary resuscitation or CPR

Sec. 48.5. "Cardiopulmonary resuscitation" or "CPR", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-1. *As added by P.L.148-1999, SEC.2.*

IC 16-18-2-49 Carrier

Sec. 49. "Carrier", for purposes of IC 16-41, means a person who has:

- (1) tuberculosis in a communicable stage; or
- (2) another dangerous communicable disease. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-50 Case

Sec. 50. "Case", for purposes of IC 16-42-11-10, has the meaning set forth in IC 16-42-11-10(a). *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-51 Center

Sec. 51. (a) "Center", for purposes of IC 16-19-10, has the meaning set forth in IC 16-19-10-1.

(b) "Center", for purposes of IC 16-33-3, has the meaning set forth in IC 16-33-3-1. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-52 Certificate or certification

Sec. 52. "Certificate" or "certification", for purposes of IC 16-31, means authorization in written form issued by the Indiana emergency medical services commission to a person to furnish, operate, conduct, maintain, advertise, or otherwise engage in providing emergency medical services as a part of a regular course of doing business, either paid or voluntary.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-52.5 Charity care; financially indigent; medically indigent

Sec. 52.5. (a) "Charity care", for purposes of IC 16-21-6 and IC 16-21-9, means the unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting health care services:

- (1) to a person classified by the hospital as financially indigent or medically indigent on an inpatient or outpatient basis; and
- (2) to financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.

(b) As used in this section, "financially indigent" means an uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's financial criteria and procedure used to determine if a patient is eligible for charity care. The criteria and procedure must include income levels and means testing indexed to the federal poverty guidelines. A hospital may determine that a person is financially or medically indigent under the hospital's eligibility system after health care services are provided.

(c) As used in this section, "medically indigent" means a person whose medical or hospital bills after payment by third party payors exceed a specified percentage of the patient's annual gross income as determined in accordance with the hospital's eligibility system, and who is financially unable to pay the remaining bill. *As added by P.L.94-1994, SEC.1.*

IC 16-18-2-53 Checklist

Sec. 53. "Checklist", for purposes of IC 16-20-8, has the meaning set forth in IC 16-20-8-1.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-54.5 Childhood hazards

Sec. 54.5. "Childhood hazards", for purposes of IC 16-41-40, has the meaning set forth in IC 16-41-40-1.5. *As added by P.L.101-1999, SEC.1.*

IC 16-18-2-55 Children

Sec. 55. "Children", for purposes of IC 16-35-2, has the meaning set forth in IC 16-35-2-1.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-55.5 Chronic disease

Sec. 55.5. "Chronic disease", for purposes of IC 16-38-6, has the meaning set forth in IC 16-38-6-1. *As added by*

P.L.212-2003, SEC.2.

IC 16-18-2-56 City health department

Sec. 56. "City health department", for purposes of IC 16-20-4, has the meaning set forth in IC 16-20-4-2. *As added*

by P.L.2-1993, SEC.1.

IC 16-18-2-56.2 Clearance examination

Sec. 56.2. "Clearance examination", for purposes of IC 16-41-39.4, means an activity conducted by a clearance examiner who is licensed under IC 13-17-14 to establish proper completion of interim controls (as defined in 24 CFR 35.110).

As added by P.L.102-2008, SEC.2.

IC 16-18-2-56.3 Client

Sec. 56.3. "Client", for purposes of IC 16-27-4, has the meaning set forth in IC 16-27-4-1.

As added by P.L.212-2005, SEC.4.

IC 16-18-2-62 Commission

Sec. 62. (a) "Commission", for purposes of IC 16-19-6, refers to the commission for special institutions.

(b) "Commission", for purposes of IC 16-31, refers to the Indiana emergency medical services commission.

(c) "Commission", for purposes of IC 16-46-11.1, has the meaning set forth in IC 16-46-11.1-1.

As added by P.L.2-1993, SEC.1. Amended by P.L.61-2004, SEC.1.

IC 16-18-2-64 Communicable disease

Sec. 64. "Communicable disease", for purposes of IC 16-41, has the meaning prescribed by the state department

under IC 16-41-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-64.4 Community

Sec. 64.4. "Community", for purposes of IC 16-21-6 and IC 16-21-9, means the primary geographic area encompassing at least the entire county in which the hospital is located and patient categories for which the hospital provides health care services. *As added by P.L.94-1994, SEC.2.*

IC 16-18-2-65 Community health services

Sec. 65. "Community health services", for purposes of IC 16-46-1, has the meaning set forth in IC 16-46-1-3. *As*

added by P.L.2-1993, SEC.1.

IC 16-18-2-66

Community or migrant health center Sec. 66. "Community or migrant health center", for purposes of IC 16-46-5,

has the meaning set forth in IC 16-46-5-1. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-66.5 Competent witness

Sec. 66.5. "Competent witness", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-2. *As added by*

P.L.148-1999, SEC.3.

IC 16-18-2-67 Comprehensive care bed

Sec. 67. "Comprehensive care bed", for purposes of IC 16-29-2, has the meaning set forth in IC 16-29-2-1. *As added*

by P.L.2-1993, SEC.1. Amended by P.L.97-2004, SEC.63.

IC 16-18-2-67.5 Comprehensive plan

Sec. 67.5. "Comprehensive plan", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-5. *As added*

by P.L.2-2007, SEC.182.

IC 16-18-2-68 Confirmatory test

Sec. 68. "Confirmatory test", for purposes of IC 16-41-12 and IC 16-41-14, has the meaning set forth in IC 16-41-12-4. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-69 Consent

Sec. 69. "Consent", for purposes of IC 16-34, means a written agreement to submit to an abortion:
(1) after the consenting party has had a full explanation of the abortion procedure to be performed, including disclosures and information required by IC 16-34-2-1.1; and
(2) as evidenced by the signature of the consenting party on a consent form prescribed by the state department of health. *As added by P.L.2-1993, SEC.1. Amended by P.L.187-1995, SEC.1.*

IC 16-18-2-69.2 Consumer product

Sec. 69.2. "Consumer product", for purposes of IC 16-41-39.4, means an item or a component of an item that is produced or distributed for:
(1) sale to a consumer for use; or
(2) the personal use, consumption, or enjoyment of a consumer. *As added by P.L.102-2008, SEC.3.*

IC 16-18-2-69.4 Contractual allowances

Sec. 69.4. "Contractual allowances", for purposes of IC 16-21-6, has the meaning set forth in IC 16-21-6-0.1. *As added by P.L.94-1994, SEC.4.*

IC 16-18-2-69.5 Contributions

Sec. 69.5. "Contributions", for purposes of IC 16-21-6 and IC 16-21-9, means the dollar value of cash donations and the fair market value at the time of donation of in kind donations to the hospital from individuals, organizations, or other entities. The term does not include the value of a donation designated or otherwise restricted by the donor for purposes other than charity care. *As added by P.L.94-1994, SEC.5.*

IC 16-18-2-74 Contaminated sharp

Sec. 74. "Contaminated sharp", for purposes of IC 16-41-16, has the meaning set forth in IC 16-41-16-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-75 Contaminated with filth

Sec. 75. "Contaminated with filth", for purposes of IC 16-42-1 through IC 16-42-4, applies to a food, drug, device, or cosmetic not securely protected from dust, dirt, and as far as necessary by all reasonable means, from all foreign or injurious contaminations. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-76 Contracting county

Sec. 76. "Contracting county", for purposes of IC 16-24-2, has the meaning set forth in IC 16-24-2-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-77 Contributing county

Sec. 77. "Contributing county", for purposes of IC 16-22-6, has the meaning set forth in IC 16-22-6-27. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-78 Controlled premises

Sec. 78. "Controlled premises", for purposes of IC 16-42-20-2, has the meaning set forth in IC 16-42-20-2(a). *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-79 Controlled substance

Sec. 79. "Controlled substance", for purposes of IC 16-42-21, has the meaning set forth in IC 16-42-21-1. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-80 Corporation

Sec. 80. "Corporation", for purposes of IC 16-22-8, IC 16-42-5, and IC 16-42-5.2, means the health and hospital corporation created under IC 16-22-8. *As added by P.L.2-1993, SEC.1. Amended by P.L.266-2001, SEC.2.*

IC 16-18-2-84 Council

Sec. 84. "Council" refers to the following:

- (1) For purposes of IC 16-21, the hospital council.
- (2) For purposes of IC 16-25 and IC 16-27, the home health care services and hospice services council.
- (3) For purposes of IC 16-28 and IC 16-29, the Indiana health facilities council.
- (4) For purposes of IC 16-46-6, the interagency state council on black and minority health.

As added by P.L.2-1993, SEC.1. Amended by P.L.12-2004, SEC.1.

IC 16-18-2-85 Counterfeit drug

Sec. 85. "Counterfeit drug", for purposes of IC 16-42-1 through IC 16-42-4, means a drug:

(1) that, without authorization:

(A) bears;

(B) is labeled with; or

(C) is in a container that bears;

the trademark, trade name, or other identifying mark, imprint, or device, or any likeness of a drug manufacturer, processor, packer, or distributor other than the person or persons who in fact manufactured, processed, packed, or distributed the drug; and

(2) that falsely purports or is represented:

(A) to be the product of; or

(B) to have been packed or distributed by; the other drug manufacturer, processor, packer, or distributor. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-86 County

Sec. 86. "County", for the purposes of IC 16-22, means a county that owns and operates a county hospital. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-86.5 County council

Sec. 86.5. "County council", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-6. *As added by P.L.2-2007, SEC.183.*

IC 16-18-2-87 County health fund

Sec. 87. "County health fund", for purposes of IC 16-46-1, has the meaning set forth in IC 16-46-1-4. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-88 County of residence of the child

Sec. 88. "County of residence of the child", for purposes of IC 16-33-4, has the meaning set forth in IC 16-33-4-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-89 Customer

Sec. 89. "Customer", for purposes of IC 16-42-22, has the meaning set forth in IC 16-42-22-3.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-91 Dangerous communicable disease

Sec. 91. "Dangerous communicable disease", for purposes of IC 16-41, means a communicable disease that is classified by the state department as dangerous under IC 16-41-2-1.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-91.3 Data aggregation

Sec. 91.3. "Data aggregation" has the meaning set forth in IC 16-39-5-3(b). *As added by P.L.44-2002, SEC.1.*

IC 16-18-2-92 Dead body

Sec. 92. "Dead body", for purposes of IC 16-37-3, has the meaning set forth in IC 16-37-3-1.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-92.4 Declarant

Sec. 92.4. "Declarant", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-3.
As added by P.L.148-1999, SEC.4.

IC 16-18-2-92.6 Department

Sec. 92.6. (a) "Department", for purposes of IC 16-31-8.5, has the meaning set forth in IC 16-31-8.5-1.
(b) "Department", for purposes of IC 16-47-1, has the meaning set forth in IC 16-47-1-1.
As added by P.L.50-2004, SEC.2. Amended by P.L.101-2006, SEC.24.

IC 16-18-2-93 Designated health official

Sec. 93. "Designated health official", for purposes of IC 16-41, means:
(1) the state health commissioner;
(2) an assistant state health commissioner; or
(3) a person designated by the state health commissioner or assistant state health commissioner to implement IC 16-41 in a specific situation. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-94 Device

Sec. 94. "Device", for purposes of IC 16-42-1 through IC 16-42-4 except for IC 16-42-1-7, IC 16-42-1-16(7), IC 16-42-2-3(7), IC 16-42-3-4(3), and IC 16-42-4-3(3), means instruments, apparatus, and contrivances, including their components, parts, and accessories, intended:
(1) for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; or
(2) to affect the structure or any function of the body of man or other animals. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-95 Directed donation

Sec. 95. "Directed donation", for purposes of IC 16-41-12, has the meaning set forth in IC 16-41-12-5. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-96 Director

Sec. 96. (a) "Director", for purposes of IC 16-19-13, refers to the director of the office of women's health established by IC 16-19-13.
(b) "Director", for purposes of IC 16-27, means the individual acting under the authority of and assigned the responsibility by the state health commissioner to implement IC 16-27.
(c) "Director", for purposes of IC 16-28, IC 16-29, and IC 16-30, means the individual acting under the authority of and assigned the responsibility by the state health commissioner to implement IC 16-28, IC 16-29, and IC 16-30.
(d) "Director", for purposes of IC 16-31, refers to the executive director of the department of homeland security established by IC 10-19-2-1.
(e) "Director", for purposes of IC 16-35-2, refers to the director of the program for children with special health care needs. *As added by P.L.2-1993, SEC.1. Amended by P.L.52-1999, SEC.1; P.L.2-2003, SEC.44; P.L.12-2004, SEC.2; P.L.22-2005, SEC.18.*

IC 16-18-2-97 Division

Sec. 97. "Division" means the following:
(1) For purposes of IC 16-21-8, the meaning set forth in IC 16-21-8-0.1.
(2) For purposes of IC 16-22-8, the meaning set forth in IC 16-22-8-3.
(3) For purposes of IC 16-27, a group of individuals under the supervision of the director within the state department assigned the responsibility of implementing IC 16-27.
(4) For purposes of IC 16-28, a group of individuals under the supervision of the director within the state department assigned the responsibility of implementing IC 16-28.
(5) For purposes of IC 16-41-40, the division of family resources established by IC 12-13-1-1.
As added by P.L.2-1993, SEC.1. Amended by P.L.51-1998, SEC.1; P.L.12-2004, SEC.3; P.L.90-2005, SEC.1; P.L.41-2007, SEC.3; P.L.3-2008, SEC.104.

IC 16-18-2-98

Division director and director of a division Sec. 98. "Division director" and "director of a division", for purposes of IC 16-22-8, has the meaning set forth in IC 16-22-8-4. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-99 DNA test

Sec. 99. "DNA test", for purposes of IC 16-37-2-10, has the meaning set forth in IC 16-37-2-10(a). *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-99.3 DNR

Sec. 99.3. "DNR", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-4. *As added by P.L.148-1999, SEC.5.*

IC 16-18-2-99.5 Donations

Sec. 99.5. "Donations", for purposes of IC 16-21-6 and IC 16-21-9, means the unreimbursed costs of providing cash and in kind services and gifts, including facilities, equipment, personnel, and programs, to other nonprofit or public outpatient clinics, hospitals, or health care organizations. *As added by P.L.94-1994, SEC.6.*

IC 16-18-2-101 Drug

Sec. 101. (a) "Drug", for purposes of IC 16-42-1 through IC 16-42-4, means the following:

- (1) Articles recognized in the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, or official National Formulary, or any supplement to any of them.
- (2) Articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals.
- (3) Articles other than food intended to affect the structure or any function of the body of man or other animals.
- (4) Articles intended for use as a component of any article specified in subdivision (1), (2), or (3).

The term does not include devices or their components, parts, or accessories.

(b) "Drug", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-2.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-102 Drug order

Sec. 102. "Drug order", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-3.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-103 Drug sample

Sec. 103. "Drug sample", for purposes of IC 16-42-21, has the meaning set forth in IC 16-42-21-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-104 Dwelling

Sec. 104. "Dwelling" includes any part of any building or the building's premises used as a place of residence or habitation or for sleeping by a person.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-104.5 Education related costs

Sec. 104.5. "Education related costs", for purposes of IC 16-21-6, has the meaning set forth in IC 16-21-6-0.2. *As added by P.L.94-1994, SEC.7.*

IC 16-18-2-105 Effective treatment

Sec. 105. "Effective treatment", for purposes of IC 16-41-16, has the meaning set forth in IC 16-41-16-3. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-106 Electronic products

Sec. 106. "Electronic products", for purposes of IC 16-41-35, has the meaning set forth in IC 16-41-35-5. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-106.3 Electronic signature

Sec. 106.3. For purposes of IC 16-42-3 and IC 16-42-22, "electronic signature" means an electronic sound, symbol, or process:

- (1) attached to or logically associated with an electronically transmitted prescription or order; and
- (2) executed or adopted by a person; with the intent to sign the electronically transmitted prescription or order.

As added by P.L.204-2005, SEC.1.

IC 16-18-2-106.4 Electronically transmitted and electronic transmission

Sec. 106.4. For purposes of IC 16-42-3, IC 16-42-19, and IC 16-42-22, "electronically transmitted" or "electronic transmission" means the transmission of a prescription in electronic form. The term does not include transmission of a prescription by facsimile. *As added by P.L.204-2005, SEC.2.*

IC 16-18-2-106.5 Eligible medical condition

Sec. 106.5. "Eligible medical condition" means a condition for which an individual is eligible for assistance under IC 16-35-2. *As added by P.L.79-1999, SEC.1.*

IC 16-18-2-107 Emergency ambulance services

Sec. 107. "Emergency ambulance services", for purposes of IC 16-31, means the transportation of emergency patients by ambulance and the administration of basic life support to emergency patients before or during the transportation. *As added by P.L.2-1993, SEC.1. Amended by P.L.186-1995, SEC.2.*

IC 16-18-2-109.1 Emergency medical dispatch agency

Sec. 109.1. "Emergency medical dispatch agency", for purposes of IC 16-31-3.5, has the meaning set forth in IC 16-35-3.5-1. *As added by P.L.205-2003, SEC.11.*

IC 16-18-2-109.3 Emergency medical dispatcher

Sec. 109.3. "Emergency medical dispatcher", for purposes of IC 16-31-3.5, has the meaning set forth in IC 16-35-3.5-1. *As added by P.L.205-2003, SEC.12.*

IC 16-18-2-109.5 Emergency medical dispatching

Sec. 109.5. "Emergency medical dispatching", for purposes of IC 16-31-3.5, has the meaning set forth in IC 16-35-3.5-1. *As added by P.L.205-2003, SEC.13.*

IC 16-18-2-110 Emergency medical services

Sec. 110. "Emergency medical services", for purposes of IC 16-31, means the provision of emergency ambulance services or other services, including extrication and rescue services, utilized in serving an individual's need for immediate medical care in order to prevent loss of life or aggravation of physiological or psychological illness or injury. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-111 Emergency medical service facility

Sec. 111. "Emergency medical service facility", for purposes of IC 16-31 and IC 16-41, means those facilities that are licensed and operated under IC 16-21-2 and that are equipped, prepared, and staffed to provide medical care for emergency patients. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-112 Emergency medical technician

Sec. 112. "Emergency medical technician", for purposes of IC 16-31, means an individual who is certified under this article to provide basic life support at the scene of an accident, illness, or during transport. *As added by P.L.2-1993, SEC.1. Amended by P.L.186-1995, SEC.3.*

IC 16-18-2-112.5 Emergency medical technician-basic advanced

Sec. 112.5. "Emergency medical technician-basic advanced", for purposes of IC 16-31, means an individual who is certified under IC 16-31 to provide basic life support at the scene of an accident or illness or during transport. *As added by P.L.205-2003, SEC.14.*

IC 16-18-2-112.7 Emergency medical technician-intermediate

Sec. 112.7. "Emergency medical technician-intermediate", for purposes of IC 16-31, means an individual who can perform at least one (1) of but not all the procedures of a paramedic and who:

- (1) has completed a prescribed course in advanced life support;
- (2) has been certified by the Indiana emergency medical services commission;
- (3) is associated with a single supervising hospital; and
- (4) is affiliated with a provider organization. *As added by P.L.205-2003, SEC.15.*

IC 16-18-2-113 Emergency patient

Sec. 113. (a) "Emergency patient", for purposes of IC 16-31, means an individual who:

- (1) is acutely ill, injured, incapacitated, or helpless; and
- (2) requires emergency medical services.

(b) The term includes an individual who:

- (1) requires transportation on a litter or cot; or
- (2) is transported in a vehicle certified as an ambulance under IC 16-31-3. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-114 Employer

Sec. 114. "Employer", for purposes of IC 16-41-11, has the meaning set forth in IC 16-41-11-1.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-117 Established name

Sec. 117. "Established name", for purposes of IC 16-42-3, has the meaning set forth in IC 16-42-3-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-119 Executive

Sec. 119. "Executive" has the meaning set forth in IC 36-1-2-5. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-120 Executive board

Sec. 120. (a) "Executive board", except as provided in subsection (b), refers to the executive board of the state department of health.

(b) "Executive board", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-7.

As added by P.L.2-1993, SEC.1. Amended by P.L.2-2007, SEC.184.

IC 16-18-2-121 Executive director

Sec. 121. "Executive director", for purposes of IC 16-22, means the chief administrative officer, president, or other individual appointed under IC 16-22-3-8.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-121.5 Extended length of stay

Sec. 121.5. "Extended length of stay" means a length of stay in an acute care hospital inpatient unit that exceeds one

(1) standard deviation of the hospital wide average length of stay.

As added by P.L.162-1999, SEC.1.

IC 16-18-2-122 Facility

Sec. 122. "Facility", for purposes of IC 16-41-11, has the meaning set forth in IC 16-41-11-2.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-124 Federal act

Sec. 124. "Federal act", for purposes of IC 16-42-1 through IC 16-42-4, refers to the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.; 52 Stat. 1040 et seq.) and amendments to that statute. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-131**First responder**

Sec. 131. "First responder", for purposes of IC 16-31, means an individual who is:

- (1) certified under IC 16-31 and who meets the Indiana emergency medical services commission's standards for first responder certification; and
- (2) the first individual to respond to an incident requiring emergency medical services.

As added by P.L.2-1993, SEC.1. Amended by P.L.186-1995, SEC.4.

IC 16-18-2-132**Fiscal body**

Sec. 132. "Fiscal body", except as provided in subsection (b), has the meaning set forth in IC 36-1-2-6.

As added by P.L.2-1993, SEC.1. Amended by P.L.72-2001, SEC.1.

IC 16-18-2-139.5

Forensic medical exam

Sec. 139.5. "Forensic medical exam", for purposes of IC 16-21-8, means the following:

- (1) Appropriate procedures for acquiring evidence that may be used in a criminal proceeding against a person charged with a sex crime.
- (2) Suturing and care of wounds that stem directly from the sex crime, including anesthesia and prescribed medication. *As added by P.L.121-2006, SEC.21.*

IC 16-18-2-145 General hospital

Sec. 145. "General hospital", for the purposes of IC 16-22-9, has the meaning set forth in IC 16-22-9-2.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-146 General hospital services

Sec. 146. "General hospital services", for purposes of IC 16-22-9 has the meaning set forth in IC 16-22-9-3.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-147 General license

Sec. 147. "General license", for purposes of IC 16-41-35, has the meaning set forth in IC 16-41-35-6.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-148 Generically equivalent drug product

Sec. 148. "Generically equivalent drug product", for purposes of IC 16-42-22, has the meaning set forth in IC 16-42-22-4. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-148.5 Gift

Sec. 148.5. "Gift", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-8.

As added by P.L.2-2007, SEC.185.

IC 16-18-2-149 Governing board

Sec. 149. "Governing board" means the board of trustees, governing board, board of directors, or other body responsible for governing a hospital. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-150 Governing body

Sec. 150. (a) "Governing body", for purposes of IC 16-22-7, has the meaning set forth in IC 16-22-7-2.

(b) "Governing body", for purposes of IC 16-27-0.5, has the meaning set forth in IC 16-27-0.5-0.5.

(c) "Governing body", for purposes of IC 16-41-22, has the meaning set forth in IC 16-41-22-3.

As added by P.L.2-1993, SEC.1. Amended by P.L.152-2005, SEC.1.

IC 16-18-2-150.4 Government sponsored indigent health care

Sec. 150.4. "Government sponsored indigent health care", for purposes of IC 16-21-9, has the meaning set forth in IC 16-21-9-2. *As added by P.L.94-1994, SEC.8.*

IC 16-18-2-151 Governmental unit

Sec. 151. "Governmental unit", for purposes of IC 16-28 and IC 16-29, means an agency, a bureau, or a commission. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-153.5 Nurse aide

Sec. 153.5. "Nurse aide", for purposes of IC 16-28-13, has the meaning set forth in IC 16-28-13-1.

As added by P.L.152-1995, SEC.15.

IC 16-18-2-154 Gross patient revenue

Sec. 154. "Gross patient revenue", for purposes of IC 16-21-6, has the meaning set forth in IC 16-21-6-1.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-155 Guest

Sec. 155. "Guest", for purposes of IC 16-41-31, has the meaning set forth in IC 16-41-31-2.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-156 Guest room

Sec. 156. "Guest room", for purposes of IC 16-41-31, has the meaning set forth in IC 16-41-31-3.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-159.1 Health benefit plan

Sec. 159.1. "Health benefit plan", for purposes of IC 16-47-1, has the meaning set forth in IC 16-47-1-2.
As added by P.L.50-2004, SEC.3.

IC 16-18-2-160 Health care

Sec. 160. "Health care", for purposes of IC 16-36-1, has the meaning set forth in IC 16-36-1-1.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-160.5 Health care entity

Sec. 160.5. "Health care entity", for purposes of IC 16-41-42.1, has the meaning set forth in IC 16-41-42.1-1. *As added by P.L.193-2007, SEC.1. Amended by P.L.3-2008, SEC.107.*

IC 16-18-2-161 Health care facility

Sec. 161. (a) "Health care facility" includes:

- (1) hospitals licensed under IC 16-21-2, private mental health institutions licensed under IC 12-25, and tuberculosis hospitals established under IC 16-11-1 (before its repeal);
 - (2) health facilities licensed under IC 16-28; and (3) rehabilitation facilities and kidney disease treatment centers.
- (b) "Health care facility", for purposes of IC 16-28-13, has the meaning set forth in IC 16-28-13-0.5.
(c) "Health care facility", for purposes of IC 16-40-5, has the meaning set forth in IC 16-40-5-2.

As added by P.L.2-1993, SEC.1. Amended by P.L.108-1999, SEC.1; P.L.101-2007, SEC.2.

IC 16-18-2-161.5 Health care interpreter

Sec. 161.5. "Health care interpreter", for purposes of IC 16-46-11.1, has the meaning set forth in IC 16-46-11.1-2.
As added by P.L.61-2004, SEC.2.

IC 16-18-2-162 Health care professional

Sec. 162. (a) "Health care professional", for purposes of IC 16-27-1 and IC 16-27-4, has the meaning set forth in IC 16-27-1-1.
(b) "Health care professional", for purposes of IC 16-27-2, has the meaning set forth in IC 16-27-2-1.
As added by P.L.2-1993, SEC.1. Amended by P.L.212-2005, SEC.5.

IC 16-18-2-163 Health care provider

Sec. 163. (a) "Health care provider", for purposes of IC 16-21 and IC 16-41, means any of the following:

- (1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or legally authorized by this state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), a dentist, a registered or licensed practical nurse, a midwife, an optometrist, a pharmacist, a podiatrist, a chiropractor, a physical therapist, a respiratory care practitioner, an occupational therapist, a psychologist, a paramedic, an emergency medical technician, an emergency medical technician-basic advanced, an emergency medical technician-intermediate, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.
- (2) A college, university, or junior college that provides health care to a student, a faculty member, or an employee, and the governing board or a person who is an officer, employee, or agent of the college, university, or junior college acting in the course and scope of the person's employment.
- (3) A blood bank, community mental health center, community mental retardation center, community health center, or migrant health center.
- (4) A home health agency (as defined in IC 16-27-1-2).

- (5) A health maintenance organization (as defined in IC 27-13-1-19).
- (6) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).
- (7) A corporation, partnership, or professional corporation not otherwise qualified under this subsection that:
 - (A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;
 - (B) is organized or registered under state law; and
 - (C) is determined to be eligible for coverage as a health care provider under IC 34-18 for the corporation's, partnership's, or professional corporation's health care function. Coverage for a health care provider qualified under this subdivision is limited to the health care provider's health care functions and does not extend to other causes of action.
- (b) "Health care provider", for purposes of IC 16-35, has the meaning set forth in subsection (a). However, for purposes of IC 16-35, the term also includes a health facility (as defined in section 167 of this chapter).
- (c) "Health care provider", for purposes of IC 16-36-5, means an individual licensed or authorized by this state to provide health care or professional services as:
 - (1) a licensed physician;
 - (2) a registered nurse;
 - (3) a licensed practical nurse;
 - (4) an advanced practice nurse;
 - (5) a licensed nurse midwife;
 - (6) a paramedic;
 - (7) an emergency medical technician;
 - (8) an emergency medical technician-basic advanced;
 - (9) an emergency medical technician-intermediate; or
 - (10) a first responder, as defined under IC 16-18-2-131.

The term includes an individual who is an employee or agent of a health care provider acting in the course and scope of the individual's employment.

- (d) "Health care provider", for purposes of IC 16-40-4, means any of the following:
 - (1) An individual, a partnership, a corporation, a professional corporation, a facility, or an institution licensed or authorized by the state to provide health care or professional services as a licensed physician, a psychiatric hospital, a hospital, a health facility, an emergency ambulance service (IC 16-31-3), an ambulatory outpatient surgical center, a dentist, an optometrist, a pharmacist, a podiatrist, a chiropractor, a psychologist, or a person who is an officer, employee, or agent of the individual, partnership, corporation, professional corporation, facility, or institution acting in the course and scope of the person's employment.
 - (2) A blood bank, laboratory, community mental health center, community mental retardation center, community health center, or migrant health center.
 - (3) A home health agency (as defined in IC 16-27-1-2).
 - (4) A health maintenance organization (as defined in IC 27-13-1-19).
 - (5) A health care organization whose members, shareholders, or partners are health care providers under subdivision (1).
 - (6) A corporation, partnership, or professional corporation not otherwise specified in this subsection that:
 - (A) provides health care as one (1) of the corporation's, partnership's, or professional corporation's functions;
 - (B) is organized or registered under state law; and
 - (C) is determined to be eligible for coverage as a health care provider under IC 34-18 for the corporation's, partnership's, or professional corporation's health care function.
 - (7) A person that is designated to maintain the records of a person described in subdivisions (1) through (6).
 - (e) "Health care provider", for purposes of IC 16-45-4, has the meaning set forth in 47 CFR 54.601(a).
- As added by P.L.2-1993, SEC.1. Amended by P.L.26-1994, SEC.7; P.L.188-1995, SEC.1; P.L.1-1998, SEC.116; P.L.148-1999, SEC.6; P.L.205-2003, SEC.17; P.L.95-2005, SEC.1; P.L.108-2007, SEC.2.*

IC 16-18-2-163.3 Health care quality indicator data

Sec. 163.3. "Health care quality indicator data", for purposes of IC 16-40-4, has the meaning set forth in IC 16-40-4-1. *As added by P.L.95-2005, SEC.2.*

IC 16-18-2-163.5 Health care translator

Sec. 163.5. "Health care translator", for purposes of IC 16-46-11.1, has the meaning set forth in IC 16-46-11.1-3. *As added by P.L.61-2004, SEC.3.*

IC 16-18-2-164.6 Health coverage provider

Sec. 164.6. "Health coverage provider", for purposes of IC 16-40-4, has the meaning set forth in IC 16-40-4-2. As added by P.L.95-2005, SEC.3.

IC 16-18-2-165 Health data

Sec. 165. "Health data", for purposes of IC 16-19-10, has the meaning set forth in IC 16-19-10-2. As added by P.L.2-1993, SEC.1.

IC 16-18-2-166 Health directive

Sec. 166. "Health directive", for purposes of IC 16-41, means:

- (1) a written statement; or
- (2) in an emergency, an oral statement followed by a written statement within seventy-two (72) hours; to a carrier issued by a designated health official under IC 16-41. As added by P.L.2-1993, SEC.1.

IC 16-18-2-167 Health facility

Sec. 167. (a) "Health facility" means a building, a structure, an institution, or other place for the reception, accommodation, board, care, or treatment extending beyond a continuous twenty-four (24) hour period in a week of more than four (4) individuals who need or desire such services because of physical or mental illness, infirmity, or impairment.

(b) The term does not include the premises used for the reception, accommodation, board, care, or treatment in a household or family, for compensation, of a person related by blood to the head of the household or family (or to the spouse of the head of the household or family) within the degree of consanguinity of first cousins.

(c) The term does not include any of the following:

- (1) Hotels, motels, or mobile homes when used as such.
- (2) Hospitals or mental hospitals, except for that part of a hospital that provides long term care services and functions as a health facility, in which case that part of the hospital is licensed under IC 16-21-2, but in all other respects is subject to IC 16-28.
- (3) Hospices that furnish inpatient care and are licensed under IC 16-25-3.
- (4) Institutions operated by the federal government.
- (5) Foster family homes or day care centers.
- (6) Schools for individuals who are deaf or blind.
- (7) Day schools for individuals with mental retardation.
- (8) Day care centers.
- (9) Children's homes and child placement agencies.
- (10) Offices of practitioners of the healing arts.
- (11) Any institution in which health care services and private duty nursing services are provided that is listed and certified by the Commission for Accreditation of Christian Science Nursing Organizations/Facilities, Inc.
- (12) Industrial clinics providing only emergency medical services or first aid for employees.
- (13) A residential facility (as defined in IC 12-7-2-165).
- (14) Maternity homes.
- (15) Offices of Christian Science practitioners. As added by P.L.2-1993, SEC.1. Amended by P.L.61-1993, SEC.62; P.L.111-1996, SEC.2; P.L.58-2000, SEC.1; P.L.99-2007, SEC.153.

IC 16-18-2-168 Health records

Sec. 168. (a) "Health records", for purposes of IC 16-39, means written, electronic, or printed information possessed or maintained by a provider concerning any diagnosis, treatment, or prognosis of the patient, including such information possessed or maintained on microfiche, microfilm, or in a digital format. The term includes mental health records and alcohol and drug abuse records.

(b) For purposes of IC 16-39-5-3(e), the term includes information that describes services provided to a patient and a provider's charges for services provided to a patient.

(c) The term does not include information concerning emergency ambulance services described in IC 16-31-2-11(d). As added by P.L.2-1993, SEC.1. Amended by P.L.231-1999, SEC.11; P.L.127-2001, SEC.1; P.L.44-2002, SEC.2; P.L.255-2003, SEC.45.

IC 16-18-2-179 Hospital

Sec. 179. (a) "Hospital", except as provided in subsections (b) through (g), means a hospital that is licensed under IC 16-21-2.

(b) "Hospital", for purposes of IC 16-21, means an institution, a place, a building, or an agency that holds out to the general public that it is operated for hospital purposes and that it provides care, accommodations, facilities, and equipment, in connection with the services of a physician, to individuals who may need medical or surgical services. The term does not include the following:

- (1) Freestanding health facilities.
- (2) Hospitals or institutions specifically intended to diagnose, care, and treat the following:
 - (A) Individuals with a mental illness (as defined in IC 12-7-2-117.6).
 - (B) Individuals with developmental disabilities (as defined in IC 12-7-2-61).
- (3) Offices of physicians where patients are not regularly kept as bed patients.
- (4) Convalescent homes, boarding homes, or homes for the aged.
- (c) "Hospital", for purposes of IC 16-22-8, has the meaning set forth in IC 16-22-8-5.
- (d) "Hospital", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-9.
- (e) "Hospital" or "tuberculosis hospital", for purposes of IC 16-24, means an institution or a facility for the treatment of individuals with tuberculosis.
- (f) "Hospital", for purposes of IC 16-34, means a hospital (as defined in subsection (b)) that:
 - (1) is required to be licensed under IC 16-21-2; or
 - (2) is operated by an agency of the United States.
- (g) "Hospital", for purposes of IC 16-41-12, has the meaning set forth in IC 16-41-12-6. *As added by P.L.2-1993, SEC.1. Amended by P.L.144-1996, SEC.1; P.L.162-1999, SEC.3; P.L.2-2007, SEC.186; P.L.99-2007, SEC.154.*

IC 16-18-2-180 Hospital based health facility

Sec. 180. "Hospital based health facility", for purposes of IC 16-21 and IC 16-28, means that part of a hospital that provides long term care services and functions as a health facility. *As added by P.L.2-1993, SEC.1. Amended by P.L.152-1995, SEC.16.*

IC 16-18-2-181 Hospital fund or hospital funds

Sec. 181. "Hospital fund" or "hospital funds" means money, securities, real or personal property or interests, collected or received by or paid over, transferred, or conveyed to the hospital or the county for hospital purposes or hospital buildings. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-182 Hospital purposes

Sec. 182. "Hospital purposes" means providing inpatient or outpatient diagnostic and treatment facilities and services generally recognized as hospital services to the public, under the direction and supervision of the patient's attending physician, including, at the discretion of the governing board, the following:

- (1) Extended care facilities.
- (2) The provision of services to other health care entities.
- (3) Other health care services and facilities, including the provision of acute care in hospital inpatient units to patients with extended lengths of stay.

As added by P.L.2-1993, SEC.1. Amended by P.L.162-1999, SEC.4.

IC 16-18-2-188.1 Indiana University hospitals

Sec. 188.1. "Indiana University hospitals", for purposes of IC 16-23.5, has the meaning set forth in IC 16-23.5-1-10. *As added by P.L.2-2007, SEC.187.*

IC 16-18-2-189 Infectious waste

Sec. 189. "Infectious waste", for purposes of IC 16-41-16, has the meaning set forth in IC 16-41-16-4. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-190 Informed consent

Sec. 190. "Informed consent", for purposes of IC 16-41-6, has the meaning set forth in IC 16-41-6-2.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-191.5 Interdisciplinary team

Sec. 191.5. "Interdisciplinary team", for purposes of IC 16-25, has the meaning set forth in IC 16-25-1.1-7.
As added by P.L.256-1999, SEC.8.

IC 16-18-2-193 Invasive medical care

Sec. 193. "Invasive medical care", for purposes of IC 16-31, does not include the administration of a nonvisualized airway. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-194 Investigational or new drug

Sec. 194. "Investigational or new drug", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-4.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-194.5 Isolation

Sec. 194.5. "Isolation", for purposes of IC 16-41-9, means the physical separation, including confinement or restriction, of an individual or a group of individuals from the general public if the individual or group is infected with a dangerous communicable disease (as described in IC 16-18-2-91 and 410 IAC 1-2.3-47), in order to prevent or limit the transmission of the disease to an uninfected individual. *As added by P.L.138-2006, SEC.1.*

IC 16-18-2-199 Legend drug

Sec. 199. "Legend drug", for purposes of IC 16-42, means a drug that is:

- (1) subject to 21 U.S.C. 353(b)(1); or
- (2) listed in the Prescription Drug Product List as:
 - (A) published in United States Department of Health and Human Services Approved Drug Products with Therapeutic Equivalence Evaluations, Tenth Edition, (1990); and
 - (B) revised in United State Department of Health and Human Services, Approved Drug Products with Therapeutic Equivalence Evaluations, Cumulative Supplement to the Tenth Edition, Number 10 (1990). *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-200 Legislative body

Sec. 200. "Legislative body" has the meaning set forth in IC 36-1-2-9. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-202 Licensed physician

Sec. 202. "Licensed physician" means an individual who holds an unlimited license to practice medicine in Indiana under IC 25-22.5. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-203 Life prolonging procedure

Sec. 203. "Life prolonging procedure", for purposes of IC 16-36-4, has the meaning set forth in IC 16-36-4-1.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-204 Life prolonging procedures will declarant

Sec. 204. "Life prolonging procedures will declarant", for purposes of IC 16-36-4, has the meaning set forth in IC 16-36-4-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-205 Live birth or birth

Sec. 205. "Live birth" or "birth", for purposes of IC 16-37, means the birth of a child who shows evidence of life after the child is entirely outside of the mother. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-208 Living will declarant

Sec. 208. "Living will declarant", for purposes of IC 16-36-4, has the meaning set forth in IC 16-36-4-3.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-209 Local board

Sec. 209. "Local board", for purposes of IC 16-41-27, has the meaning set forth in IC 16-41-27-3.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-210 Local board of health

Sec. 210. (a) "Local board of health", for purposes of IC 16-22-8, means a local board of health referred to in IC 16-20.

(b) "Local board of health", for purposes of IC 16-46-1, has the meaning set forth in IC 16-46-1-7.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-211 Local health department

Sec. 211. "Local health department" means a department organized by a county or city executive with a board, a health officer, and an operational staff to provide health services to a county, city, or multiple county unit.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-212 Local health officer

Sec. 212. "Local health officer", for purposes of IC 16-22 and IC 16-37, means a local health officer as referred to in IC 16-20. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-223.5 Medical emergency

Sec. 223.5. "Medical emergency", for purposes of IC 16-34, means a condition that, on the basis of the attending physician's good faith clinical judgment, complicates the medical condition of a pregnant woman so that it necessitates the immediate termination of her pregnancy to avert her death or for which a delay would create serious risk of substantial and irreversible impairment of a major bodily function. *As added by P.L.187-1995, SEC.2.*

IC 16-18-2-223.6 Medical director

Sec. 223.6. "Medical director", for purposes of IC 16-31-3.5, has the meaning set forth in IC 16-35-3.5-1.

As added by P.L.205-2003, SEC.18.

IC 16-18-2-223.7 Medically contraindicated

Sec. 223.7. "Medically contraindicated", for purposes of IC 16-28-14, has the meaning set forth in IC 16-28-14-1.

As added by P.L.97-1999, SEC.1.

IC 16-18-2-225 Member of the armed forces

Sec. 225. "Member of the armed forces", for purposes of IC 16-33-4, has the meaning set forth in IC 16-33-4-4.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-225.8 Mental health provider

Sec. 225.8. "Mental health provider", for purposes of IC 16-36-1.5, has the meaning set forth in IC 16-36-1.5-2.

As added by P.L.145-1996, SEC.1. Amended by P.L.34-2001, SEC.6.

IC 16-18-2-226 Mental health records

Sec. 226. "Mental health records", for purposes of IC 16-39, means recorded or unrecorded information concerning the diagnosis, treatment, or prognosis of a patient receiving mental health services or developmental disability training. The term does not include alcohol and drug abuse records. *As added by P.L.2-1993, SEC.1. Amended by P.L.4-1997, SEC.2.*

IC 16-18-2-227 Migratory temporary increase in population

Sec. 227. "Migratory temporary increase in population", for purposes of IC 16-46-1, has the meaning set forth in IC 16-46-1-8. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-235 Minor

Sec. 235. "Minor", for purposes of IC 16-36, means an individual who is less than eighteen (18) years of age.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-236 Minority

Sec. 236. "Minority", for purposes of IC 16-46-6, has the meaning set forth in IC 16-46-6-2.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-245 Net operating revenue

Sec. 245. "Net operating revenue", for purposes of IC 16-22-7, has the meaning set forth in IC 16-22-7-3.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-246 Net patient revenue

Sec. 246. "Net patient revenue", for purposes of IC 16-21-6, has the meaning set forth in IC 16-21-6-2.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-247 Net revenues

Sec. 247. "Net revenues", for purposes of IC 16-22-6, means the revenues of the hospital remaining after provisions for reasonable expenses of operation, repair, replacements, and maintenance of the hospital.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-248 New

Sec. 248. "New", for purposes of IC 16-41-32, has the meaning set forth in IC 16-41-32-8.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-249 New drug

Sec. 249. "New drug", for purposes of IC 16-42-1 through IC 16-42-4, means:

(1) any drug whose composition is such that the drug is not generally recognized among experts, who are qualified by scientific training and experience to evaluate the safety of drugs, as safe for use under the conditions prescribed, recommended, or suggested in the labeling of the drug; or (2) any drug whose composition is such that the drug, as a result of investigations to determine the safety for use under such conditions, has become so recognized, but which has not, otherwise than in investigations, been used to a material extent or for a material time under such conditions.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-250 Noncompliant behavior

Sec. 250. "Noncompliant behavior", for purposes of IC 16-41, means behavior of a carrier that is not in compliance with a health directive. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-251 Nonprofit hospital

Sec. 251. "Nonprofit hospital", for purposes of IC 16-21-9, has the meaning set forth in IC 16-21-9-3.

As added by P.L.2-1993, SEC.1. Amended by P.L.94-1994, SEC.9; P.L.144-1996, SEC.2.

IC 16-18-2-252 Nonprofit hospital corporation

Sec. 252. "Nonprofit hospital corporation" means a corporation that:

- (1) is organized and doing business under IC 23-17;
- (2) is authorized by the corporation's charter to and does own and operate a hospital;
- (3) is licensed under IC 16-21; and
- (4) operates the hospital as a charitable or benevolent institution making the hospital's services available to persons unable to pay to the extent of the hospital's financial ability to do so. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-253.5 Nontransporting emergency medical services vehicle

Sec. 253.5. "Nontransporting emergency medical services vehicle", for purposes of IC 16-31-3, has the meaning set forth in IC 16-31-3-0.5. *As added by P.L.186-1995, SEC.5.*

IC 16-18-2-254 Oath

Sec. 254. "Oath" includes affirmation. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-254.5 Office

Sec. 254.5. "Office", for purposes of IC 16-19-13, refers to the office of women's health established by IC 16-19-13.

As added by P.L.52-1999, SEC.2.

IC 16-18-2-256 Official compendium

Sec. 256. "Official compendium", for purposes of IC 16-42-1 through IC 16-42-4, means the official United States Pharmacopoeia, official Homeopathic Pharmacopoeia of the United States, official National Formulary, or any supplement to any of the publications. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-264 Operator

Sec. 264. "Operator", for purposes of IC 16-41-31, has the meaning set forth in IC 16-41-31-4. *As added by P.L.2-1993, SEC.1. Amended by P.L.144-1996, SEC.4; P.L.104-2003, SEC.2.*

IC 16-18-2-264.5 Other unlicensed employee

Sec. 264.5. "Other unlicensed employee", for purposes of IC 16-28-13, has the meaning set forth in IC 16-28-13-2. *As added by P.L.152-1995, SEC.17.*

IC 16-18-2-264.7 Out of hospital

Sec. 264.7. "Out of hospital", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-5. *As added by P.L.148-1999, SEC.7.*

IC 16-18-2-264.8 Out of hospital DNR declaration and order

Sec. 264.8. "Out of hospital DNR declaration and order", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-6. *As added by P.L.148-1999, SEC.8.*

IC 16-18-2-264.9 Out of hospital DNR identification device

Sec. 264.9. "Out of hospital DNR identification device", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-7. *As added by P.L.148-1999, SEC.9.*

IC 16-18-2-266 Paramedic

Sec. 266. "Paramedic", for purposes of IC 16-31, means an individual who:

(1) is:

(A) affiliated with a certified paramedic organization;

(B) employed by a sponsoring hospital approved by the commission; or

(C) employed by a supervising hospital with a contract for inservice education with a sponsoring hospital approved by the commission;

(2) has completed a prescribed course in advanced life support;

and

(3) has been certified by the Indiana emergency medical services commission. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-266.5 Parent personal services

Sec. 266.5. "Parent personal services agency", for purposes of IC 16-27-4, has the meaning set forth in IC 16-27-4-2. *As added by P.L.212-2005, SEC.6.*

IC 16-18-2-267 Parental consent

Sec. 267. "Parental consent", for purposes of IC 16-34, means the written consent of the parent or legal guardian of an unemancipated pregnant woman less than eighteen (18) years of age to the performance of an abortion on the minor pregnant woman. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-267.5 Partial birth abortion

Sec. 267.5. "Partial birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery. *As added by P.L.145-1997, SEC.1.*

IC 16-18-2-268 Partnership responsibility

Sec. 268. "Partnership responsibility", for purposes of IC 16-46-1, has the meaning set forth in IC 16-46-1-9. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-271 Pathological waste

Sec. 271. "Pathological waste", for purposes of IC 16-41-16, has the meaning set forth in IC 16-41-16-5. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-272 Patient

Sec. 272. (a) "Patient", for purposes of IC 16-27-1, has the meaning set forth in IC 16-27-1-6.

(b) "Patient", for the purposes of IC 16-28 and IC 16-29, means an individual who has been accepted and assured care by a health facility.

(c) "Patient", for purposes of IC 16-36-1.5, has the meaning set forth in IC 16-36-1.5-3.

(d) "Patient", for purposes of IC 16-39, means an individual who has received health care services from a provider for the examination, treatment, diagnosis, or prevention of a physical or mental condition.

As added by P.L.2-1993, SEC.1. Amended by P.L.145-1996, SEC.2.

IC 16-18-2-274 Person

Sec. 274. (a) "Person" means, except as provided in subsections (b), (c), and (d), an individual, a firm, a partnership, an association, a fiduciary, an executor or administrator, a governmental entity, or a corporation.

(b) "Person", for purposes of IC 16-25, has the meaning set forth in IC 16-25-1.1-8.

(c) "Person", for purposes of IC 16-31, means an individual, a partnership, a corporation, an association, a joint stock association, or a governmental entity other than an agency or instrumentality of the United States.

(d) "Person", for purposes of IC 16-42-10, has the meaning set forth in IC 16-42-10-3.

As added by P.L.2-1993, SEC.1. Amended by P.L.256-1999, SEC.9.

IC 16-18-2-275 Person at risk

Sec. 275. (a) "Person at risk", for purposes of IC 16-41-7-4, has the meaning set forth in IC 16-41-7-4(a).

(b) "Person at risk", for purposes of IC 16-41-7-1 and IC 16-41-7-3, has the meaning set forth in IC 16-41-7-1(c).

As added by P.L.2-1993, SEC.1.

IC 16-18-2-276 Person in attendance at birth

Sec. 276. "Person in attendance at birth", for purposes of IC 16-37-2, has the meaning set forth in IC 16-37-2-1.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-277 Person in charge of interment

Sec. 277. "Person in charge of interment", for purposes of IC 16-37-3, has the meaning set forth in IC 16-37-3-2.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-277.5 Person with a disability

Sec. 277.5. "Person with a disability", for purposes of IC 16-32, IC 16-33, and IC 16-40-1, means an individual who, by reason of physical, mental, or emotional defect or infirmity (whether congenital or acquired by accident, injury, or disease) is or may subsequently be totally or partially prevented from achieving the fullest attainable physical, social, economic, mental, and vocational participation in the normal process of living.

As added by P.L.23-1993, SEC.58.

IC 16-18-2-277.6 Personal representative

Sec. 277.6. "Personal representative", for purposes of IC 16-27-4, has the meaning set forth in IC 16-27-4-3.

As added by P.L.212-2005, SEC.7.

IC 16-18-2-277.7 Personal services

Sec. 277.7. "Personal services", for purposes of IC 16-27-2 and IC 16-27-4, has the meaning set forth in IC 16-27-4-4. *As added by P.L.212-2005, SEC.8.*

IC 16-18-2-277.8 Personal services agency

Sec. 277.8. "Personal services agency", for purposes of IC 16-27-4, has the meaning set forth in IC 16-27-4-5.

As added by P.L.212-2005, SEC.9.

IC 16-18-2-281 Pharmacist

Sec. 281. "Pharmacist" means a person licensed by law to practice pharmacy in Indiana.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-282 Physician

Sec. 282. (a) "Physician", except as provided in subsection (b), means a licensed physician (as defined in section 202 of this chapter).

(b) "Physician", for purposes of IC 16-41-12, has the meaning set forth in IC 16-41-12-7. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-287.7 Post-organ transplant program

Sec. 287.7. "Post-organ transplant program", for purposes of IC 16-41-19.5, has the meaning set forth in IC 16-41-19.5-1. *As added by P.L.27-1999, SEC.1.*

IC 16-18-2-288 Practitioner

Sec. 288. (a) "Practitioner", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-5.

(b) "Practitioner", for purposes of IC 16-41-14, has the meaning set forth in IC 16-41-14-4.

(c) "Practitioner", for purposes of IC 16-42-21, has the meaning set forth in IC 16-42-21-3.

(d) "Practitioner", for purposes of IC 16-42-22, has the meaning set forth in IC 16-42-22-4.5.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-289 Precursor

Sec. 289. "Precursor", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-6.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-290 Pregnant woman

Sec. 290. "Pregnant woman", for purposes of IC 16-26, means an individual of any age who:

(1) has been a resident of Indiana continuously for at least sixty (60) days before her pregnancy;

(2) has verified her pregnancy and intends to carry her pregnancy to term or has given birth to a child; and

(3) is in need of assistance and temporary residence. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-292 Prescription

Sec. 292. "Prescription", for purposes of IC 16-42-19, has the meaning set forth in IC 16-42-19-7.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-292.5 Primary caregiver

Sec. 292.5. "Primary caregiver", for purposes of IC 16-39-4-2, has the meaning set forth in IC 16-39-4-2(a).

As added by P.L.189-1995, SEC.1.

IC 16-18-2-292.7 Primary prevention

Sec. 292.7. "Primary prevention", for purposes of IC 16-41-39.4, means the removal or remediation, including the use of interim controls, of lead hazards before lead poisoning of an individual occurs.

As added by P.L.102-2008, SEC.8.

IC 16-18-2-293.5 Probable gestational age of the fetus

Sec. 293.5. "Probable gestational age of the fetus", for purposes of IC 16-34, means what, in the judgment of the attending physician, will with reasonable probability be the gestational age of the fetus at the time an abortion is planned to be performed. *As added by P.L.187-1995, SEC.3.*

IC 16-18-2-295 Provider

Sec. 295. (a) "Provider", for purposes of IC 16-21-8, has the meaning set forth in IC 16-21-8-0.5.

(b) "Provider", for purposes of IC 16-38-5, IC 16-39 (except for IC 16-39-7) and IC 16-41-1 through IC 16-41-9 and IC 16-41-37, means any of the following:

(1) An individual (other than an individual who is an employee or a contractor of a hospital, a facility, or an agency described in subdivision (2) or (3)) who is licensed, registered, or certified as a health care professional, including the following:

(A) A physician.

(B) A psychotherapist.

(C) A dentist.

(D) A registered nurse.

(E) A licensed practical nurse.

- (F) An optometrist.
- (G) A podiatrist.
- (H) A chiropractor.
- (I) A physical therapist.
- (J) A psychologist.
- (K) An audiologist.
- (L) A speech-language pathologist.
- (M) A dietitian.
- (N) An occupational therapist.
- (O) A respiratory therapist.
- (P) A pharmacist.
- (Q) A sexual assault nurse examiner.
- (2) A hospital or facility licensed under IC 16-21-2 or IC 12-25 or described in IC 12-24-1 or IC 12-29.
- (3) A health facility licensed under IC 16-28-2.
- (4) A home health agency licensed under IC 16-27-1.
- (5) An employer of a certified emergency medical technician, a certified emergency medical technician-basic advanced, a certified emergency medical technician-intermediate, or a certified paramedic.
- (6) The state department or a local health department or an employee, agent, designee, or contractor of the state department or local health department.
- (c) "Provider", for purposes of IC 16-39-7-1, has the meaning set forth in IC 16-39-7-1(a). *As added by P.L.2-1993, SEC.1. Amended by P.L.188-1995, SEC.2; P.L.20-1998, SEC.1; P.L.231-1999, SEC.12; P.L.256-1999, SEC.10; P.L.205-2003, SEC.19; P.L.90-2005, SEC.2; P.L.41-2007, SEC.4.*

IC 16-18-2-296 Provider organization

Sec. 296. "Provider organization", for purposes of IC 16-31, means an ambulance service provider or other emergency care organization certified by the Indiana emergency medical services commission to provide emergency medical services. *As added by P.L.2-1993, SEC.1. Amended by P.L.186-1995, SEC.6.*

IC 16-18-2-296.3 Psychiatric advance directive

Sec. 296.3. "Psychiatric advance directive", for purposes of IC 16-36-1.5 and IC 16-36-1.7, has the meaning set forth in IC 16-36-1.7-1. *As added by P.L.16-2004, SEC.1.*

IC 16-18-2-297 Public accommodation

Sec. 297. "Public accommodation", for purposes of IC 16-32-3-2, has the meaning set forth in IC 16-32-3-2(a). *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-298 Public building

Sec. 298. "Public building", for purposes of IC 16-41-37, has the meaning set forth in IC 16-41-37-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-298.5 Public health authority

Sec. 298.5. "Public health authority", for purposes of IC 16-22-8 and IC 16-41-9, means:

- (1) the state health commissioner of the state department;
- (2) a deputy or an assistant state health commissioner appointed by the state health commissioner, or an agent expressly authorized by the state health commissioner;
- (3) the local health officer; or
- (4) a health and hospital corporation established under IC 16-22-8-6. *As added by P.L.138-2006, SEC.2.*

IC 16-18-2-301 Publish, published, or cause to be published

Sec. 301. "Publish" or "published" or "cause to be published", for purposes of IC 16-22, means publication of notice in a newspaper or newspapers in accordance with IC 5-3-1, unless otherwise specified. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-302 Qualified patient

Sec. 302. "Qualified patient", for purposes of IC 16-36-4, has the meaning set forth in IC 16-36-4-4. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-302.3 Qualified person

Sec. 302.3. "Qualified person", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-8.
As added by P.L.148-1999, SEC.10.

IC 16-18-2-302.6 Quarantine

Sec. 302.6. "Quarantine", for purposes of IC 16-41-9, means the physical separation, including confinement or restriction of movement, of an individual or a group of individuals who have been exposed to a dangerous communicable disease (as described in IC 16-18-2-91 and 410 IAC 1-2.3-47), during the disease's period of communicability, in order to prevent or limit the transmission of the disease to an uninfected individual.
As added by P.L.138-2006, SEC.3.

IC 16-18-2-303 Radiation

Sec. 303. "Radiation", for purposes of IC 16-41-35, has the meaning set forth in IC 16-41-35-8.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-304 Radiation machine

Sec. 304. "Radiation machine", for purposes of IC 16-41-35, has the meaning set forth in IC 16-41-35-9.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-306 Radioactive material

Sec. 306. "Radioactive material", for purposes of IC 16-41-35, has the meaning set forth in IC 16-41-35-10.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-306.5 Radon gas

Sec. 306.5. "Radon gas", for purposes of IC 16-41-38, has the meaning set forth in IC 16-41-38-1.
As added by P.L.1-1996, SEC.72.

IC 16-18-2-308 Real property

Sec. 308. "Real property" or "land" means improved or unimproved real estate or land and all of the fixtures, buildings, and improvements upon the real property or land. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-311 Record

Sec. 311. "Record", for purposes of IC 16-21, means a health, medical, or business record, including records generated or stored electronically. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-312 Recording officer

Sec. 312. "Recording officer" has the meaning set forth in IC 16-22-7-4. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-313 Reduction in license

Sec. 313. "Reduction in license", for purposes of IC 16-28 and IC 16-29, means the reduction of the number of licensed beds of a health facility. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-315.8 Remediation

Sec. 315.8. "Remediation" means actions that constitute:

- (1) abatement (as defined in IC 13-11-2-0.5); or
- (2) interim control (as defined in 24 CFR 35.110); of a lead hazard. *As added by P.L.102-2008, SEC.9.*

IC 16-18-2-316 Renovate

Sec. 316. "Renovate", for purposes of IC 16-41-32, has the meaning set forth in IC 16-41-32-9.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-317 Representative

Sec. 317. (a) "Representative", for purposes of IC 16-36-1, has the meaning set forth in IC 16-36-1-2.
(b) "Representative", for purposes of IC 16-36-5, has the meaning set forth in IC 16-36-5-9.
As added by P.L.2-1993, SEC.1. Amended by P.L.148-1999, SEC.11.

IC 16-18-2-318 Responsible head

Sec. 318. "Responsible head", for purposes of IC 16-41-12, has the meaning set forth in IC 16-41-12-20.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-324 Screening test

Sec. 324. "Screening test", for purposes of IC 16-41-12, has the meaning set forth in IC 16-41-12-8.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-325 Secondhand

Sec. 325. "Secondhand", for purposes of IC 16-41-32, has the meaning set forth in IC 16-41-32-10.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-326 Secure area

Sec. 326. "Secure area", for purposes of IC 16-41-16, has the meaning set forth in IC 16-41-16-6.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-328 Serious and present danger to the health of others

Sec. 328. "Serious and present danger to the health of others", for purposes of IC 16-41-7 and IC 16-41-9, has the meaning set forth in IC 16-41-7-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-328.1 Services

Sec. 328.1. "Services", for purposes of IC 16-27-2, has the meaning set forth in IC 16-27-2-2.2.
As added by P.L.178-1993, SEC.1.

IC 16-18-2-328.5 Shaken baby syndrome

Sec. 328.5. "Shaken baby syndrome", for purposes of IC 16-41-40, has the meaning set forth in IC 16-41-40-2.
As added by P.L.51-1998, SEC.2.

IC 16-18-2-331 Shortage area

Sec. 331. "Shortage area", for purposes of IC 16-46-5, has the meaning set forth in IC 16-46-5-6.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-331.8 Small employer

Sec. 331.8. "Small employer", for purposes of IC 16-46-13 has the meaning set forth in IC 16-3.1-31.2-3.
As added by P.L.218-2007, SEC.43.

IC 16-18-2-336 Specific license

Sec. 336. "Specific license", for purposes of IC 16-41-35, has the meaning set forth in IC 16-41-35-13.
As added by P.L.2-1993, SEC.1.

IC 16-18-2-337 Sponsoring or supervising hospital

Sec. 337. "Sponsoring" or "supervising hospital", for purposes of IC 16-31, means a hospital:
(1) that is licensed under IC 16-21-2 or under the licensing law of another state; and
(2) that has been certified by the emergency medical services commission to sponsor or supervise paramedics, emergency medical technicians-intermediate, and provider organizations in providing advanced life support.
As added by P.L.2-1993, SEC.1. Amended by P.L.205-2003, SEC.20.

IC 16-18-2-338.5 State authority

Sec. 338.5. "State authority", for purposes of IC 16-22, means the Indiana finance authority established by IC 4-4-11-4. *As added by P.L.43-1993, SEC.12. Amended by P.L.162-2007, SEC.36.*

IC 16-18-2-339 State department

Sec. 339. (a) "State department" refers to the state department of health.
(b) For purposes of IC 16-42-1 through IC 16-42-4, the term means the Indiana state board of animal health when impounding or disposing of adulterated or misbranded products under IC 15-17-5 and IC 15-18-1.
As added by P.L.2-1993, SEC.1. Amended by P.L.137-1996, SEC.66; P.L.2-2008, SEC.37.

IC 16-18-2-340 State health commissioner or commissioner

Sec. 340. (a) "State health commissioner" or "commissioner", except as otherwise provided, means the state health commissioner of the state department of health.

(b) For purposes of IC 16-21, IC 16-28, and IC 16-29, the term includes a deputy or an assistant state health commissioner appointed by the state health commissioner, or an agent expressly authorized by the state health commissioner.

(c) For purposes of IC 16-42-1 through IC 16-42-4, the term means the state veterinarian when impounding or disposing of adulterated or misbranded products under IC 15-17-5 and IC 15-18-1. *As added by P.L.2-1993, SEC.1. Amended by P.L.179-1993, SEC.1; P.L.137-1996, SEC.67; P.L.144-1996, SEC.5; P.L.2-2008, SEC.38.*

IC 16-18-2-341 Stillbirth

Sec. 341. "Stillbirth", for purposes of IC 16-37, means a birth after twenty (20) weeks of gestation that is not a live birth. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-342 Storage facility

Sec. 342. "Storage facility", for purposes of IC 16-41-12, has the meaning set forth in IC 16-41-12-9. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-342.4 Subsidized health services

Sec. 342.4. (a) "Subsidized health services", for purposes of IC 16-21-6 and IC 16-21-9, means services that:

(1) are provided by a hospital, in response to community needs, for which the reimbursement is less than the hospital's cost for providing the services; and

(2) must be subsidized by other hospital or nonprofit supporting entity revenue sources.

(b) Subsidized health services may include:

(1) emergency and trauma care;

(2) neonatal intensive care;

(3) free standing community clinics; and

(4) collaborative efforts with local government or private agencies in preventive medicine, such as immunization programs.

(c) As used in this section, "nonprofit supporting entity" means a nonprofit entity that is created by the hospital or the hospital's parent entity to further the charitable purposes of the hospital and that is owned or controlled by the hospital or the hospital's parent entity. *As added by P.L.94-1994, SEC.10.*

IC 16-18-2-343 Substitute

Sec. 343. "Substitute", for purposes of IC 16-42-22, has the meaning set forth in IC 16-42-22-5. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-344 Superintendent

Sec. 344. "Superintendent", for purposes of IC 16-36-3, has the meaning set forth in IC 12-7-2-188(3). *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-346 Surgeon

Sec. 346. "Surgeon", for purposes of IC 16-41-12, has the meaning set forth in IC 16-41-12-10. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-346.5 Task force

Sec. 346.5. "Task force", for purposes of IC 16-41-41, has the meaning set forth in IC 16-41-41-1. *As added by P.L.69-2004, SEC.1.*

IC 16-18-2-351 Terminal condition

Sec. 351. "Terminal condition", for purposes of IC 16-36-4, has the meaning set forth in IC 16-36-4-5. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-351.5 Terminal illness

Sec. 351.5. "Terminal illness", for purposes of IC 16-25, has the meaning set forth in IC 16-25-1.1-9.

As added by P.L.256-1999, SEC.11.

IC 16-18-2-353.5 Training or educational purposes

Sec. 353.5. "Training or educational purposes", for purposes of IC 16-39-7.1, has the meaning set forth in IC 16-39-7.1-1.5. *As added by P.L.179-2003, SEC.1.*

IC 16-18-2-354.5 Trauma care

Sec. 354.5. "Trauma care", for purposes of IC 16-19-3-28, means the assessment, diagnosis, transportation, treatment, or rehabilitation by a health care provider of an acute bodily injury that requires immediate intervention to prevent the loss of life or a serious impairment of a body function or part. *As added by P.L.155-2006, SEC.1.*

IC 16-18-2-355 Trimester

Sec. 355. "Trimester", for purposes of IC 16-34, means any one (1) of three (3) equal periods of time of normal gestation period of a pregnant woman derived by dividing the period of gestation into three (3) equal parts of three (3) months each and to be designated as the first trimester, second trimester, and the third trimester, respectively. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-356 Truck

Sec. 356. "Truck", for purposes of IC 16-42-18, has the meaning set forth in IC 16-42-18-2. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-357 Tuberculosis

Sec. 357. "Tuberculosis", for purposes of IC 16-24, includes other chronic diseases unless the context clearly requires otherwise. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-358 Unfit for human habitation

Sec. 358. "Unfit for human habitation", for purposes of IC 16-41-20, has the meaning set forth in IC 16-41-20-1. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-359 Unit

Sec. 359. "Unit", for purposes of IC 16-41-22, has the meaning set forth in IC 16-41-22-4. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-360 Universal precautions

Sec. 360. "Universal precautions", for purposes of IC 16-41-11, has the meaning set forth in IC 16-41-11-3. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-361 Unnecessary radiation

Sec. 361. "Unnecessary radiation", for purposes of IC 16-41-35, has the meaning set forth in IC 16-41-35-14. *As added by P.L.2-1993, SEC.1.*

IC 16-18-2-361.5 Unreimbursed costs; government sponsored indigent health care; nonprofit supporting entity

Sec. 361.5. (a) "Unreimbursed costs", for purposes of IC 16-21-6 and IC 16-21-9, means the costs a hospital incurs for providing services after subtracting payments received from any source for such services, including the following:

- (1) Third party insurance payments.
- (2) Medicare payments.
- (3) Medicaid payments.
- (4) Medicare education reimbursements.
- (5) State reimbursements for education.
- (6) Payments from drug companies to pursue research.
- (7) Grant funds for research.
- (8) Disproportionate share payments.

(b) For purposes of this definition, costs must be calculated by applying the aggregate cost to charge ratios for all hospital services derived from the hospital's Medicare cost report to billed charges. Before January 1, 1997, for

purposes of this definition, charitable contributions and grants to a hospital, including transfers from endowment or other funds controlled by the hospital or the hospital's nonprofit supporting entities, shall not be subtracted from the costs of providing services for purposes of determining unreimbursed costs. Beginning January 1, 1997, for purposes of this definition, charitable contributions and grants to a hospital, including transfers from endowment or other funds controlled by the hospital or the hospital's nonprofit supporting entities, shall not be subtracted from the costs of providing services for purposes of determining the unreimbursed costs of charity care and government sponsored indigent health care.

(c) As used in this section, "government sponsored indigent health care" has the meaning set forth in IC 16-21-9-2.

(d) As used in this section, "nonprofit supporting entity" means a nonprofit entity that is created by the hospital or the hospital's parent entity to further the charitable purposes of the hospital and that is owned or controlled by the hospital or the hospital's parent entity. *As added by P.L.94-1994, SEC.11.*

IC 16-18-2-362 Utilization facility

Sec. 362. "Utilization facility", for purposes of IC 16-41-35, has the meaning set forth in IC 16-41-35-15.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-363 Vector

Sec. 363. "Vector", for purposes of IC 16-41-33, has the meaning set forth in IC 16-41-33-2.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-365 Viability

Sec. 365. "Viability", for purposes of IC 16-34, means the ability of a fetus to live outside the mother's womb.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-365.5 Victim

Sec. 365.5. "Victim", for purposes of IC 16-21-8, has the meaning set forth in IC 16-21-8-0.9.

As added by P.L.90-2005, SEC.3. Amended by P.L.41-2007, SEC.5.

IC 16-18-2-366 Vital statistics

Sec. 366. "Vital statistics" includes the following:

- (1) Factual data concerning births, deaths, and stillbirths and relevant personal, medical, and social data.
- (2) The registration, preparation, transcription, collection, compilation, and preservation of that data.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-367 Volunteer fire department

Sec. 367. "Volunteer fire department", for purposes of IC 16-31-3, has the meaning set forth in IC 16-31-3-6(a).

As added by P.L.2-1993, SEC.1. Amended by P.L.1-1999, SEC.43.

IC 16-18-2-368 Volunteer firefighter

Sec. 368. "Volunteer firefighter", for purposes of IC 16-31-3, has the meaning set forth in IC 16-31-3-6(b).

As added by P.L.2-1993, SEC.1.

IC 16-18-2-370 Waste blood specimen

Sec. 370. "Waste blood specimen", for purposes of IC 16-41-17, has the meaning set forth in IC 16-41-17-1.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-371 Wastes

Sec. 371. "Wastes", for purposes of IC 16-41-16-3, has the meaning set forth in rules adopted under 16-41-16-8.

As added by P.L.2-1993, SEC.1.

IC 16-18-2-379 X-ray film

Sec. 379. "X-ray film", for purposes of IC 16-39, has the meaning set forth in IC 16-39-7-2.

As added by P.L.2-1993, SEC.1.

IC 16-18-3 Chapter 3. Effect of Recodification by Senate Enrolled Act 24 of the 1993 Regular Session of the General Assembly

IC 16-18-3-1 "Prior health and hospital law" defined

Sec. 1. As used in this chapter, "prior health and hospital law" refers to the statutes that are repealed or amended in senate enrolled act 24 of the 1993 regular session of the general assembly as the statutes existed before the effective date of the applicable or corresponding provision of senate enrolled act 24 of the 1993 regular session of the general assembly. *As added by P.L.2-1993, SEC.1.*

IC 16-18-3-2 Purpose of act; operation and effect of prior health and hospital law

Sec. 2. The purpose of senate enrolled act 24 of the 1993 regular session of the general assembly is to recodify prior health and hospital law in a style that is clear, concise, and easy to interpret and apply. Except to the extent that: (1) senate enrolled act 24 of the 1993 regular session of the general assembly is amended to reflect the changes made in a provision of another bill that adds to, amends, or repeals a provision in senate enrolled act 24 of the 1993 regular session of the general assembly; or (2) the minutes of meetings of the code revision commission during 1992 expressly indicate a different purpose; the substantive operation and effect of the prior health and hospital law continue uninterrupted as if senate enrolled act 24 of the 1993 regular session of the general assembly had not been enacted. *As added by P.L.2-1993, SEC.1.*

IC 16-18-3-3 Application

Sec. 3. Subject to section 2 of this chapter, sections 4 through 7 of this chapter shall be applied to the statutory construction of senate enrolled act 24 of the 1993 regular session of the general assembly. *As added by P.L.2-1993, SEC.1.*

IC 16-18-3-4 Preservation of rights, liabilities, penalties, violations, proceedings, indebtedness, and tax levies

Sec. 4. Senate enrolled act 24 of the 1993 regular session of the general assembly does not affect any:

- (1) rights or liabilities accrued;
- (2) penalties incurred;
- (3) violations committed;
- (4) proceedings begun;
- (5) bonds, notes, loans, or other forms of indebtedness issued, incurred, or made; or
- (6) tax levies made;

before the effective date of senate enrolled act 24 of the 1993 regular session of the general assembly (July 1, 1993). Those rights, liabilities, penalties, offenses, proceedings, bonds, notes, loans, other forms of indebtedness, and tax levies continue and shall be imposed and enforced under prior health and hospital law as if senate enrolled act 24 of the 1993 regular session of the general assembly had not been enacted. *As added by P.L.2-1993, SEC.1.*

IC 16-18-3-5 Construction of act

Sec. 5. Senate enrolled act 24 of the 1993 regular session of the general assembly shall be construed as a recodification of prior health and hospital law. If the literal meaning of senate enrolled act 24 of the 1993 regular session of the general assembly would result in a substantive change in the prior health and hospital law, the difference shall be construed as a typographical, spelling, or other clerical error that must be corrected by: (1) inserting, deleting, or substituting words, punctuation, or other matters of style in senate enrolled act 24 of the 1993 regular session of the general assembly; and (2) using any other rule of statutory construction; as necessary or appropriate to apply senate enrolled act 24 of the 1993 regular session of the general assembly in a manner that does not result in a substantive change in the law. The principle of statutory construction that a court must apply the literal meaning of an act if the literal meaning of the act is unambiguous does not apply to senate enrolled act 24 of the 1993 regular session of the general assembly to the extent that senate enrolled act 24 of the 1993 regular session of the general assembly is not substantively identical to the prior health and hospital law. *As added by P.L.2-1993, SEC.1.*

IC 16-18-3-6 References to repealed statutes

Sec. 6. Subject to section 7 of this chapter, a reference in a statute or rule to a statute that is repealed and replaced in the same or a different form in senate enrolled act 24 of the 1993 regular session of the general assembly shall be treated after the effective date of the new provision as a reference to the new provision. *As added by P.L.2-1993, SEC.1.*

IC 16-18-3-7 Construction of citation references to include references to prior law

Sec. 7. A citation reference in senate enrolled act 24 of the 1993 regular session of the general assembly to another provision of senate enrolled act 24 of the 1993 regular session of the general assembly shall be treated as including a reference to the provision of prior health and hospital law that is substantively equivalent to the provision of senate enrolled act 24 of the 1993 regular session of the general assembly that is referred to by the citation reference.

As added by P.L.2-1993, SEC.1.

IC 16-31 ARTICLE 31. EMERGENCY MEDICAL SERVICES

IC 16-31-1 Chapter 1. General Provisions

IC 16-31-1-1 Intent

Sec. 1. (a) The general assembly declares that the provision of emergency medical services is a matter of vital concern affecting the public health, safety, and welfare of the people of Indiana.

(b) It is the purpose of this article:

- (1) to promote the establishment and maintenance of an effective system of emergency medical service, including the necessary equipment, personnel, and facilities to ensure that all emergency patients receive prompt and adequate medical care throughout the range of emergency conditions encountered;
- (2) that the emergency medical services commission established under IC 16-31-2 shall cooperate with other agencies empowered to license persons engaged in the delivery of health care so as to coordinate the efforts of the commission and other agencies; and
- (3) to establish standards and requirements for the furnishing of emergency medical services by persons not licensed or regulated by other appropriate agencies. *As added by P.L.2-1993, SEC.14.*

IC 16-31-1-2 Essential purpose of political subdivisions

Sec. 2. The provision of emergency medical service is an essential purpose of the political subdivisions of the state.

As added by P.L.2-1993, SEC.14.

IC 16-31-1-3 Religious objections to medical treatment

Sec. 3. This article or a rule adopted under this article does not authorize transporting to a hospital or medical treatment of a person who objects to medical treatment on religious grounds. *As added by P.L.2-1993, SEC.14.*

IC 16-31-2 Chapter 2. Indiana Emergency Medical Services Commission

IC 16-31-2-1 Creation

Sec. 1. The Indiana emergency medical services commission is created. *As added by P.L.2-1993, SEC.14.*

IC 16-31-2-2 Membership

Sec. 2. (a) The commission is composed of eleven (11) members. The governor shall appoint the members for four (4) year terms as follows:

- (1) One (1) must be appointed from a volunteer fire department that provides emergency medical service.
- (2) One (1) must be appointed from a full-time municipal fire or police department that provides emergency medical service.
- (3) One (1) must be a nonprofit provider of emergency ambulance services organized on a volunteer basis other than a volunteer fire department.
- (4) One (1) must be a provider of private ambulance services.
- (5) One (1) must be a state certified paramedic.
- (6) One (1) must be a licensed physician who:
 - (A) has a primary interest, training, and experience in emergency medical services; and
 - (B) is currently practicing in an emergency medical services facility.
- (7) One (1) must be a chief executive officer of a hospital that provides emergency ambulance services.
- (8) One (1) must be a registered nurse who has supervisory or administrative responsibility in a hospital emergency department.
- (9) One (1) must be a licensed physician who:

(A) has a primary interest, training, and experience in trauma care; and

(B) is practicing in a trauma facility.

(10) One (1) must be a state certified emergency medical service technician.

(11) One (1) must be an individual who:

(A) represents the public at large; and

(B) is not in any way related to providing emergency medical services.

(b) The chief executive officer of a hospital appointed under subsection (a)(7) may designate another administrator of the hospital to serve for the chief executive officer on the commission.

(c) Not more than six (6) members may be from the same political party.

As added by P.L.2-1993, SEC.14. Amended by P.L.110-2000, SEC.1.

IC 16-31-2-3 Vacancies

Sec. 3. An appointment to fill a vacancy occurring on the commission is for the unexpired term.

As added by P.L.2-1993, SEC.14.

IC 16-31-2-4 Compensation and expenses

Sec. 4. (a) Each member of the commission who is not a state employee is entitled to the minimum salary per diem provided by IC 4-10-11-2.1(b). The member is also entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(b) Each member of the commission who is a state employee is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency. *As added by P.L.2-1993, SEC.14.*

IC 16-31-2-5 Meetings

Sec. 5. The commission may meet as often as is necessary upon call of the chairman but meetings shall be held at least four (4) times each year. *As added by P.L.2-1993, SEC.14.*

IC 16-31-2-6 Seal

Sec. 6. The commission may adopt and use a seal, the description of which shall be filed at the office of the secretary of state, which may be used for the authentication of the acts of the commission.

As added by P.L.2-1993, SEC.14.

IC 16-31-2-7 Emergency medical program; emergency medical services; financial assistance

Sec. 7. The commission shall do the following:

(1) Develop and promote, in cooperation with state, regional, and local public and private organizations, agencies, and persons, a statewide program for the provision of emergency medical services that must include the following:

(A) Preparation of state, regional, and local emergency ambulance service plans.

(B) Provision of consultative services to state, regional, and local organizations and agencies in developing and implementing emergency ambulance service programs.

(C) Promotion of a statewide system of emergency medical service facilities by developing minimum standards, procedures, and guidelines in regard to personnel, equipment, supplies, communications, facilities, and location of such centers.

(D) Promotion of programs for the training of personnel providing emergency medical services and programs for the education of the general public in first aid techniques and procedures. The training shall be held in various local communities of the state and shall be conducted by agreement with publicly and privately supported educational institutions or hospitals licensed under IC 16-21, wherever appropriate.

(E) Promotion of coordination of emergency communications, resources, and procedures throughout Indiana and, in cooperation with interested state, regional, and local public and private agencies, organizations, and persons, the development of an effective state, regional, and local emergency communications system.

(F) Organizing and sponsoring a statewide emergency medical services conference to provide continuing education for persons providing emergency medical services.

(2) Regulate, inspect, and certify services, facilities, and personnel engaged in providing emergency medical

services as provided in this article.

(3) Adopt rules required to implement an approved system of emergency medical services.

(4) Adopt rules concerning triage and transportation protocols for the transportation of trauma patients consistent with the field triage decision scheme of the American College of Surgeons Committee on Trauma.

(5) Apply for, receive, and accept gifts, bequests, grants-in-aid, state, federal, and local aid, and other forms of financial assistance for the support of emergency medical services.

(6) Employ necessary administrative staff. *As added by P.L.2-1993, SEC.14. Amended by P.L.20-2008, SEC.1.*

IC 16-31-2-8 First responder training and certification; reciprocal certification for military personnel

Sec. 8. The commission may do the following:

(1) Develop training and certification standards for first responders under this article.

(2) Require first responders to be certified under the standards developed under subdivision (1).

(3) Develop reciprocal certification training standards for individuals who have received medical training by a branch of the United States armed forces. *As added by P.L.2-1993, SEC.14.*

IC 16-31-2-9 Emergency medical personnel; standards

Sec. 9. The commission shall establish the following:

(1) Standards for persons who provide emergency medical services and who are not licensed or regulated under IC 16-31-3.

(2) Training standards for the administration of antidotes, vaccines, and antibiotics to prepare for or respond to a terrorist or military attack.

(3) Training and certification standards for the administration of epinephrine through an auto-injector by:

(A) an emergency medical technician; or

(B) an emergency medical technician-basic advanced.

(4) Training standards to permit the use of antidote kits containing atropine and pralidoxime chloride for the treatment of exposure to nerve agents by an emergency medical technician-basic advanced, an emergency medical technician, or a first responder. *As added by P.L.2-1993, SEC.14. Amended by P.L.156-2001, SEC.2; P.L.17-2002, SEC.4; P.L.93-2002, SEC.2; P.L.205-2003, SEC.21; P.L.74-2006, SEC.2.*

IC 16-31-2-10 Technical advisory committee

Sec. 10. (a) In adopting rules concerning the duties of the commission, the commission shall appoint a technical advisory committee.

(b) Members of the technical advisory committee shall be selected by the commission subject to the approval of the governor on the basis of technical expertise and competency in the specific area of emergency medical service concerned.

(c) Each member of a technical advisory committee who is not a state employee is entitled to the minimum salary per diem provided by IC 4-10-11-2.1(b). The member is also entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

(d) Each member of a technical advisory committee who is a state employee but who is not a member of the general assembly is entitled to reimbursement for traveling expenses as provided under IC 4-13-1-4 and other expenses actually incurred in connection with the member's duties as provided in the state policies and procedures established by the Indiana department of administration and approved by the budget agency.

As added by P.L.2-1993, SEC.14.

IC 16-31-2-11 Pre-hospital ambulance rescue and report records

Sec. 11. (a) The commission shall develop procedures for ongoing review of all emergency ambulance services.

(b) The commission may review any pre-hospital ambulance rescue or report record regarding an emergency patient that is utilized or compiled by an emergency ambulance service employing paramedics, emergency medical technicians-intermediate, emergency medical technicians, or emergency medical technicians-basic advanced. However, except as provided in subsection (d), those records shall remain confidential and may be used solely for the purpose of compiling data and statistics. The use of such data or statistics is subject to IC 4-1-6.

(c) The commission may develop and oversee experimental study projects conducted by ambulance service providers in limited geographic areas of Indiana. These study projects must be developed and conducted in accordance with rules adopted by the commission under IC 4-22-2. These study projects must be designed to test the

efficacy of new patient care techniques and new ambulance service systems.

(d) This subsection applies to emergency ambulance services that are provided by or under a contract with an entity that is a public agency for purposes of IC 5-14-3. The following information, if contained in a pre-hospital ambulance rescue or report record regarding an emergency patient, is public information and must be made available for inspection and copying under IC 5-14-3:

- (1) The date and time of the request for ambulance services.
- (2) The reason for the request for assistance.
- (3) The time and nature of the response to the request for ambulance services.
- (4) The time of arrival at the scene where the patient was located.
- (5) The time of departure from the scene where the patient was located.

(6) The name of the facility, if any, to which the patient was delivered for further treatment and the time of arrival at that facility. *As added by P.L.2-1993, SEC.14. Amended by P.L.127-2001, SEC.2; P.L.205-2003, SEC.22.*

IC 16-31-2-12 Fee

Sec. 12. The commission may impose a reasonable fee for the issuance of a certification under this chapter. The commission shall deposit the fee in the emergency medical services fund established by IC 16-31-8.5-3. *As added by P.L.101-2006, SEC.25.*

IC 16-31-3 Chapter 3. Certification Requirements for the Provision of Emergency Medical Services

IC 16-31-3-0.5 "Nontransporting emergency medical services vehicle" defined

Sec. 0.5. (a) As used in this chapter, "nontransporting emergency medical services vehicle" means a motor vehicle, other than an ambulance, used for emergency medical services.

(b) The term does not include an employer owned or employer operated vehicle used for first aid purposes within or upon the employer's premises. *As added by P.L.186-1995, SEC.7.*

IC 16-31-3-1 Certification required

Sec. 1. (a) Except as provided in subsection (b), a person other than:

- (1) a licensed physician;
- (2) a registered nurse or an individual acting under the supervision of a licensed physician; or
- (3) a person providing health care in a hospital or an ambulatory outpatient surgical center licensed under

IC 16-21;

may not furnish, operate, conduct, maintain, advertise, or otherwise be engaged in providing emergency medical services, except for the use of an automated external defibrillator, as a part of the regular course of doing business, either paid or voluntary, unless that person holds a valid certificate issued by the commission.

(b) A:

- (1) licensed physician;
- (2) registered nurse or an individual acting under the supervision of a licensed physician; or
- (3) person providing health care in a hospital or an ambulatory outpatient surgical center licensed under IC 16-21; who operates a business of transporting emergency patients by ambulance or using a nontransporting emergency medical services vehicle must hold a valid certificate issued by the commission under this article.

As added by P.L.2-1993, SEC.14. Amended by P.L.186-1995, SEC.8; P.L.74-2006, SEC.3.

IC 16-31-3-2 Standards for certifications

Sec. 2. The commission shall establish standards for persons required to be certified by the commission to provide emergency medical services. To be certified, a person must meet the following minimum requirements:

- (1) The personnel certified under this chapter must do the following:

(A) Meet the standards for education and training established by the commission by rule.

(B) Successfully complete a basic or an inservice course of education and training on sudden infant death syndrome that is certified by the commission in conjunction with the state health commissioner.

(C) Beginning January 1, 2009, successfully complete a basic or an inservice course of education and training on autism that is certified by the commission.

- (2) Ambulances to be used must conform with the requirements of the commission and must either be:

(A) covered by insurance issued by a company licensed to do business in Indiana in the amounts and under the terms required in rules adopted by the commission; or

(B) owned by a governmental entity covered under IC 34-13-3.

(3) Emergency ambulance service shall be provided in accordance with rules adopted by the commission. However, the rules adopted under this chapter may not prohibit the dispatch of an ambulance to aid an emergency patient because an emergency medical technician is not immediately available to staff the ambulance.

(4) Ambulances must be equipped with a system of emergency medical communications approved by the commission. The emergency medical communication system must properly integrate and coordinate appropriate local and state emergency communications systems and reasonably available area emergency medical facilities with the general public's need for emergency medical services.

(5) Emergency medical communications shall be provided in accordance with rules adopted by the commission.

(6) A nontransporting emergency medical services vehicle must conform with the commission's requirements. *As added by P.L.2-1993, SEC.14. Amended by P.L.22-1994, SEC.4; P.L.186-1995, SEC.9; P.L.1-1998, SEC.117; P.L.22-2005, SEC.19; P.L.71-2008, SEC.1.*

IC 16-31-3-3 Exceptions to certification requirement

Sec. 3. (a) A certificate is not required for a person who provides emergency ambulance service, an emergency medical technician, an emergency medical technician-basic advanced, an ambulance, a nontransporting emergency medical services vehicle, or advanced life support when doing any of the following:

(1) Providing assistance to persons certified to provide emergency ambulance service or to emergency medical technicians.

(2) Operating from a location or headquarters outside Indiana to provide emergency ambulance services to patients who are picked up outside Indiana for transportation to locations within Indiana.

(3) Providing emergency medical services during a major catastrophe or disaster with which persons or ambulances certified to provide emergency ambulance services are insufficient or unable to cope.

(b) An agency or instrumentality of the United States and any paramedic, emergency medical technician-intermediate, emergency medical technician-basic advanced, emergency medical technician, or first responder of the agency or instrumentality is not required to:

(1) be certified; or

(2) conform to the standards prescribed under this chapter.

As added by P.L.2-1993, SEC.14. Amended by P.L.186-1995, SEC.10; P.L.22-2005, SEC.20.

IC 16-31-3-4 Agencies and instrumentalities of the United States; exception to certification requirement

Sec. 4. An agency or instrumentality of the United States and emergency medical technicians or ambulances of the agency or instrumentality are not required to be certified or to conform to the standards prescribed under this article. *As added by P.L.2-1993, SEC.14.*

IC 16-31-3-5 Waiver of rules; requirements; expiration date; renewal

Sec. 5. (a) The commission shall waive any rule for a person who provides emergency ambulance service, an emergency medical technician, an emergency medical technician-basic advanced, an emergency medical technician-intermediate, a paramedic, or an ambulance when operating from a location in an adjoining state by contract with an Indiana unit of government to provide emergency ambulance or medical services to patients who are picked up or treated in Indiana.

(b) The commission may waive any rule, including a rule establishing a fee, for a person who submits facts demonstrating that:

(1) compliance with the rule will impose an undue hardship on the person; and

(2) either:

(A) noncompliance with the rule; or

(B) compliance with an alternative requirement approved by the commission;

will not jeopardize the quality of patient care. However, the commission may not waive a rule that sets forth educational requirements for a person regulated under this article.

(c) A waiver granted under subsection (b)(2)(B) is conditioned upon compliance with the alternative requirement approved under subsection (b).

(d) The commission shall establish an expiration date for any waiver that is granted.

(e) The commission may renew a waiver if the person makes the same demonstration required for the original waiver. *As added by P.L.2-1993, SEC.14. Amended by P.L.205-2003, SEC.23.*

IC 16-31-3-6 Volunteer fire departments and firefighters; exception to certification requirement

Sec. 6. (a) As used in this section, "volunteer fire department" has the meaning set forth in IC 36-8-12-2.

(b) As used in this section, "volunteer firefighter" has the meaning set forth in IC 36-8-12-2.

(c) A certificate is not required for a volunteer fire department or volunteer firefighter to engage in extrication or rescue services. *As added by P.L.2-1993, SEC.14. Amended by P.L.1-1999, SEC.44.*

IC 16-31-3-7 Withholding of certificates

Sec. 7. The commission may not withhold certification from a person providing emergency medical services that include extrication and rescue services because the person is not affiliated with a hospital, law enforcement agency, or fire department. *As added by P.L.2-1993, SEC.14.*

IC 16-31-3-8 Applications for certificates

Sec. 8. An application for a certificate must be made upon the forms, provide the information, and be in accordance with the procedures prescribed by the commission. *As added by P.L.2-1993, SEC.14.*

IC 16-31-3-9 Duration of certificates

Sec. 9. Except as otherwise provided in this chapter, all certificates are valid for a period specified by the commission unless earlier suspended, revoked, or terminated. *As added by P.L.2-1993, SEC.14.*

IC 16-31-3-10 Renewal of certificates; conditions

Sec. 10. (a) Except as provided in subsection (b), to renew a certificate issued under this chapter upon expiration of the certificate for any reason, a person must comply with any continuing education requirements that have been established by the commission. To renew a certificate issued under this chapter after a revocation of the certificate, a person must comply with all the requirements of this chapter that apply to the original certification.

(b) A renewal of an emergency medical technician, an emergency medical technician-basic advanced, an emergency medical technician-intermediate, or a paramedic certificate shall be issued to an individual who meets the following conditions:

(1) While holding a valid certificate, enters the armed forces of the United States, including:

- (A) the army;
- (B) the navy;
- (C) the air force;
- (D) the marines; or
- (E) the coast guard;

but excluding the guard and reserve components of those forces.

(2) Is discharged from the armed forces of the United States within forty-eight (48) months after the individual entered the armed forces.

(3) Successfully completes, not more than nine (9) months after the individual's discharge from the armed forces of the United States, a refresher course approved by the commission.

(4) Applies for the certificate renewal not more than one (1) year after the individual's discharge from the armed forces of the United States.

(5) Passes the written and practical skills examinations.

(c) A renewal of an emergency medical technician, an emergency medical technician-basic advanced, an emergency medical technician-intermediate, or a paramedic certificate must be issued to an individual who meets the following conditions:

(1) While holding a valid certificate, the individual is called to active military duty as a member of the Indiana national guard or a reserve component of the armed forces of the United States, including:

- (A) the army;
- (B) the navy;
- (C) the air force;
- (D) the marines; or
- (E) the coast guard.

(2) The individual provides the emergency medical services commission with a copy of the document from the armed forces that called the individual to active duty.

(3) The individual applies for the certificate renewal not more than one hundred twenty (120) days after the individual leaves active duty. *As added by P.L.2-1993, SEC.14. Amended by P.L.205-2003, SEC.24.*

IC 16-31-3-11 Certificates nonassignable and nontransferable

Sec. 11. A certificate issued under this chapter is not assignable or transferable.

As added by P.L.2-1993, SEC.14.

IC 16-31-3-12 Defacing, removal, and obliteration of official entries upon certificates prohibited

Sec. 12. An official entry made upon a certificate may not be defaced, removed, or obliterated.

As added by P.L.2-1993, SEC.14.

IC 16-31-3-13 Repealed

(Repealed by P.L.101-2006, SEC.39.)

IC 16-31-3-13.5 Fee

Sec. 13.5. The commission may impose a reasonable fee for the issuance of a certification under this chapter. The commission shall deposit the fee in the emergency medical services fund established by IC 16-31-8.5-3.

As added by P.L.101-2006, SEC.26.

IC 16-31-3-14 Disciplinary sanctions; rescind certificate; deny certification; physical or mental examination; convictions; appeals; investigation; consistency of sanctions; approval to surrender certificate

Sec. 14. (a) A person holding a certificate issued under this article must comply with the applicable standards and rules established under this article. A certificate holder is subject to disciplinary sanctions under subsection (b) if the department of homeland security determines that the certificate holder:

(1) engaged in or knowingly cooperated in fraud or material deception in order to obtain a certificate, including cheating on a certification examination;

(2) engaged in fraud or material deception in the course of professional services or activities;

(3) advertised services or goods in a false or misleading manner;

(4) falsified or knowingly allowed another person to falsify attendance records or certificates of completion of continuing education courses required under this article or rules adopted under this article;

(5) is convicted of a crime, if the act that resulted in the conviction has a direct bearing on determining if the certificate holder should be entrusted to provide emergency medical services;

(6) is convicted of violating IC 9-19-14.5;

(7) fails to comply and maintain compliance with or violates any applicable provision, standard, or other requirement of this article or rules adopted under this article;

(8) continues to practice if the certificate holder becomes unfit to practice due to:

(A) professional incompetence that includes the undertaking of professional activities that the certificate holder is not qualified by training or experience to undertake;

(B) failure to keep abreast of current professional theory or practice;

(C) physical or mental disability; or

(D) addiction to, abuse of, or dependency on alcohol or other drugs that endanger the public by impairing the certificate holder's ability to practice safely;

(9) engages in a course of lewd or immoral conduct in connection with the delivery of services to the public;

(10) allows the certificate holder's name or a certificate issued under this article to be used in connection with a person who renders services beyond the scope of that person's training, experience, or competence;

(11) is subjected to disciplinary action in another state or jurisdiction on grounds similar to those contained in this chapter. For purposes of this subdivision, a certified copy of a record of disciplinary action constitutes prima facie evidence of a disciplinary action in another jurisdiction;

(12) assists another person in committing an act that would constitute a ground for disciplinary sanction under this chapter; or

(13) allows a certificate issued by the commission to be:

(A) used by another person; or

(B) displayed to the public when the certificate is expired, inactive, invalid, revoked, or suspended.

(b) The department of homeland security may issue an order under IC 4-21.5-3-6 to impose one (1) or more of the following sanctions if the department of homeland security determines that a certificate holder is subject to disciplinary sanctions under subsection (a):

(1) Revocation of a certificate holder's certificate for a period not to exceed seven (7) years.

(2) Suspension of a certificate holder's certificate for a period not to exceed seven (7) years.

- (3) Censure of a certificate holder.
- (4) Issuance of a letter of reprimand.
- (5) Assessment of a civil penalty against the certificate holder in accordance with the following:
 - (A) The civil penalty may not exceed five hundred dollars (\$500) per day per violation.
 - (B) If the certificate holder fails to pay the civil penalty within the time specified by the department of homeland security, the department of homeland security may suspend the certificate holder's certificate without additional proceedings.
- (6) Placement of a certificate holder on probation status and requirement of the certificate holder to:
 - (A) report regularly to the department of homeland security upon the matters that are the basis of probation;
 - (B) limit practice to those areas prescribed by the department of homeland security;
 - (C) continue or renew professional education approved by the department of homeland security until a satisfactory degree of skill has been attained in those areas that are the basis of the probation; or
 - (D) perform or refrain from performing any acts, including community restitution or service without compensation, that the department of homeland security considers appropriate to the public interest or to the rehabilitation or treatment of the certificate holder.

The department of homeland security may withdraw or modify this probation if the department of homeland security finds after a hearing that the deficiency that required disciplinary action is remedied or that changed circumstances warrant a modification of the order.

(c) If an applicant or a certificate holder has engaged in or knowingly cooperated in fraud or material deception to obtain a certificate, including cheating on the certification examination, the department of homeland security may rescind the certificate if it has been granted, void the examination or other fraudulent or deceptive material, and prohibit the applicant from reapplying for the certificate for a length of time established by the department of homeland security.

(d) The department of homeland security may deny certification to an applicant who would be subject to disciplinary sanctions under subsection (b) if that person were a certificate holder, has had disciplinary action taken against the applicant or the applicant's certificate to practice in another state or jurisdiction, or has practiced without a certificate in violation of the law. A certified copy of the record of disciplinary action is conclusive evidence of the other jurisdiction's disciplinary action.

(e) The department of homeland security may order a certificate holder to submit to a reasonable physical or mental examination if the certificate holder's physical or mental capacity to practice safely and competently is at issue in a disciplinary proceeding. Failure to comply with a department of homeland security order to submit to a physical or mental examination makes a certificate holder liable to temporary suspension under subsection (i).

(f) Except as provided under subsection (a), subsection (g), and section 14.5 of this chapter, a certificate may not be denied, revoked, or suspended because the applicant or certificate holder has been convicted of an offense. The acts from which the applicant's or certificate holder's conviction resulted may be considered as to whether the applicant or certificate holder should be entrusted to serve the public in a specific capacity.

(g) The department of homeland security may deny, suspend, or revoke a certificate issued under this article if the individual who holds or is applying for the certificate is convicted of any of the following:

- (1) Possession of cocaine or a narcotic drug under IC 35-48-4-6.
- (2) Possession of methamphetamine under IC 35-48-4-6.1.
- (3) Possession of a controlled substance under IC 35-48-4-7(a).
- (4) Fraudulently obtaining a controlled substance under IC 35-48-4-7(b).
- (5) Manufacture of paraphernalia as a Class D felony under IC 35-48-4-8.1(b).
- (6) Dealing in paraphernalia as a Class D felony under IC 35-48-4-8.5(b).
- (7) Possession of paraphernalia as a Class D felony under IC 35-48-4-8.3(b).
- (8) Possession of marijuana, hash oil, or hashish as a Class D felony under IC 35-48-4-11.
- (9) Maintaining a common nuisance under IC 35-48-4-13.
- (10) An offense relating to registration, labeling, and prescription forms under IC 35-48-4-14.
- (11) Conspiracy under IC 35-41-5-2 to commit an offense listed in subdivisions (1) through (10).
- (12) Attempt under IC 35-41-5-1 to commit an offense listed in subdivisions (1) through (10).
- (13) An offense in any other jurisdiction in which the elements of the offense for which the conviction was entered are substantially similar to the elements of an offense described by subdivisions (1) through (12).

(h) A decision of the department of homeland security under subsections (b) through (g) may be appealed to the commission under IC 4-21.5-3-7.

(i) The department of homeland security may temporarily suspend a certificate holder's certificate under IC 4-21.5-4 before a final adjudication or during the appeals process if the department of homeland security finds that a certificate holder would represent a clear and immediate danger to the public's health, safety, or property if the certificate holder were allowed to continue to practice.

(j) On receipt of a complaint or information alleging that a person certified under this chapter or IC 16-31-3.5 has engaged in or is engaging in a practice that is subject to disciplinary sanctions under this chapter, the department of homeland security must initiate an investigation against the person.

(k) The department of homeland security shall conduct a factfinding investigation as the department of homeland security considers proper in relation to the complaint.

(l) The department of homeland security may reinstate a certificate that has been suspended under this section if the department of homeland security is satisfied that the applicant is able to practice with reasonable skill, competency, and safety to the public. As a condition of reinstatement, the department of homeland security may impose disciplinary or corrective measures authorized under this chapter.

(m) The department of homeland security may not reinstate a certificate that has been revoked under this chapter.

(n) The department of homeland security must be consistent in the application of sanctions authorized in this chapter. Significant departures from prior decisions involving similar conduct must be explained in the department of homeland security's findings or orders.

(o) A certificate holder may not surrender the certificate holder's certificate without the written approval of the department of homeland security, and the department of homeland security may impose any conditions appropriate to the surrender or reinstatement of a surrendered certificate.

(p) For purposes of this section, "certificate holder" means a person who holds:

- (1) an unlimited certificate;
- (2) a limited or probationary certificate; or
- (3) an inactive certificate.

As added by P.L.2-1993, SEC.14. Amended by P.L.65-1998, SEC.1; P.L.205-2003, SEC.25; P.L.22-2005, SEC.21; P.L.1-2006, SEC.300; P.L.151-2006, SEC.6.

IC 16-31-3-14.5 Denial or permanent revocation of certificate for conviction of drug offenses or crimes of violence

Sec. 14.5. The department of homeland security may issue an order under IC 4-21.5-3-6 to deny an applicant's request for certification or permanently revoke a certificate under procedures provided by section 14 of this chapter if the individual who holds the certificate issued under this title is convicted of any of the following:

- (1) Dealing in or manufacturing cocaine or a narcotic drug under IC 35-48-4-1.
- (2) Dealing in methamphetamine under IC 35-48-4-1.1.
- (3) Dealing in a schedule I, II, or III controlled substance under IC 35-48-4-2.
- (4) Dealing in a schedule IV controlled substance under IC 35-48-4-3.
- (5) Dealing in a schedule V controlled substance under IC 35-48-4-4.
- (6) Dealing in a substance represented to be a controlled substance under IC 35-48-4-4.5.
- (7) Knowingly or intentionally manufacturing, advertising, distributing, or possessing with intent to manufacture, advertise, or distribute a substance represented to be a controlled substance under IC 35-48-4-4.6.
- (8) Dealing in a counterfeit substance under IC 35-48-4-5.
- (9) Dealing in marijuana, hash oil, or hashish under IC 35-48-4-10(b).
- (10) Conspiracy under IC 35-41-5-2 to commit an offense listed in subdivisions (1) through (9).
- (11) Attempt under IC 35-41-5-1 to commit an offense listed in subdivisions (1) through (9).
- (12) A crime of violence (as defined in IC 35-50-1-2(a)).
- (13) An offense in any other jurisdiction in which the elements of the offense for which the conviction was entered are substantially similar to the elements of an offense described under subdivisions (1) through (12).

As added by P.L.65-1998, SEC.2. Amended by P.L.17-2001, SEC.2; P.L.1-2002, SEC.74; P.L.205-2003, SEC.26; P.L.1-2006, SEC.301; P.L.151-2006, SEC.7.

IC 16-31-3-15 Repealed (*Repealed by P.L.205-2003, SEC.44.*)

IC 16-31-3-16 Misrepresentation of certification; penalty

Sec. 16. A person who is not certified under this chapter and identifies or holds out to other persons that the person is:

(1) certified under this chapter; or
(2) authorized to do any act allowed under this chapter;
commits a Class C misdemeanor. *As added by P.L.2-1993, SEC.14.*

IC 16-31-3-17 Violation; penalty

Sec. 17. (a) The state emergency management agency may issue an order to a person who has practiced without a certificate in violation of this article imposing a civil penalty of not more than five hundred dollars (\$500) per occurrence.

(b) A decision of the state emergency management agency under subsection (a) may be appealed to the commission under IC 4-21.5-3-7. *As added by P.L.2-1993, SEC.14. Amended by P.L.205-2003, SEC.27.*

IC 16-31-3-18 Advanced life support; scope

Sec. 18. This chapter does not limit the scope of advanced life support. *As added by P.L.2-1993, SEC.14.*

IC 16-31-3-19 Repealed (*Repealed by P.L.22-2005, SEC.55.*)

IC 16-31-3-20 Advanced life support services development; rules

Sec. 20. The commission shall adopt rules under IC 4-22-2 that promote the orderly development of advanced life support services in Indiana. The rules must include the following:

(1) Requirements and procedures for the certification of provider organizations, paramedics, emergency medical technicians-intermediate, and supervising hospitals.

(2) Rules governing the operation of advanced life support services, including the medications and procedures that may be administered and performed by paramedics and emergency medical technicians-intermediate. *As added by P.L.186-1995, SEC.12. Amended by P.L.205-2003, SEC.29.*

IC 16-31-3-21 Persons permitted to perform advanced life support

Sec. 21. (a) Notwithstanding any other law, a certified paramedic or a certified emergency medical technician-intermediate may perform advanced life support in an emergency according to the rules of the commission.

(b) Notwithstanding any other law, a person may, during a course of instruction in advanced life support, perform advanced life support according to the rules of the commission.

As added by P.L.186-1995, SEC.13. Amended by P.L.205-2003, SEC.30.

IC 16-31-3-22 Advanced life support certification; exemptions; offenses

Sec. 22. (a) Except as provided in subsection (c), this section does not apply to the following:

(1) A licensed physician.

(2) A registered nurse or an individual acting under the supervision of a licensed physician.

(3) A person providing health care in a hospital or an ambulatory outpatient surgical center licensed under IC 16-21.

(b) A person may not furnish, operate, conduct, maintain, or advertise advanced life support as a part of the regular course of doing business unless the person holds a valid certificate or provisional certificate issued by the commission to provide advanced life support.

(c) A:

(1) licensed physician;

(2) registered nurse or an individual acting under the supervision of a licensed physician; or

(3) person providing health care in a hospital or an ambulatory outpatient surgical center licensed under IC 16-21;

who operates a business of operating an emergency ambulance service that provides advanced life support must hold a valid certificate issued by the commission under this chapter.

(d) A person who violates this section commits a Class C misdemeanor. Each day of continued violation of this section is a separate offense. *As added by P.L.186-1995, SEC.14.*

IC 16-31-3-23 Use of an auto-injector by a certified emergency medical technician

Sec. 23. An emergency medical technician or emergency medical technician-basic advanced who is certified under this article may administer epinephrine through an auto-injector to an individual who is experiencing symptoms of an allergic reaction or anaphylaxis.

As added by P.L.17-2002, SEC.5. Amended by P.L.205-2003, SEC.31.

IC 16-31-3.5 Chapter 3.5. Emergency Medical Dispatch

IC 16-31-3.5-1 Definitions; applicability

Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Medical director" means a licensed physician who provides emergency medical dispatch medical direction to the emergency medical dispatch agency and works with the local emergency medical services medical director, if not the same person.

(c) "Emergency medical dispatcher" means a person who is trained to provide emergency medical dispatch services and who is certified under this chapter.

(d) "Emergency medical dispatching" means the reception, evaluation, processing, and provision of dispatch life support, management of requests for emergency medical assistance, and participation in ongoing evaluation and improvement of the emergency medical dispatch process. This process includes identifying the nature of the request, prioritizing the severity of the request, dispatching the necessary resources, providing medical aid and safety instructions to the callers, and coordinating the responding resources as needed, but does not include call routing itself.

(e) "Emergency medical dispatch agency" means any person that provides emergency medical dispatching for emergency medical assistance that is certified under this chapter. *As added by P.L.205-2003, SEC.32.*

IC 16-31-3.5-2 Exclusion

Sec. 2. This chapter does not apply to the following:

(1) A person who solely dispatches prescheduled emergency medical transports.

(2) A person who provides emergency medical dispatching during a major catastrophe or disaster with which individuals or dispatch agencies certified to provide emergency medical dispatching are unable to cope.

As added by P.L.205-2003, SEC.32. Amended by P.L.22-2005, SEC.22.

IC 16-31-3.5-3 Certification requirement

Sec. 3. (a) After December 31, 2006, an individual may not furnish, operate, conduct, maintain, or advertise services as an emergency medical dispatcher or otherwise be engaged as an emergency medical dispatcher unless that individual is certified by the commission as an emergency medical dispatcher.

(b) After December 31, 2006, a person may not furnish, operate, conduct, maintain, or advertise services as an emergency medical dispatcher or otherwise be engaged as an emergency medical dispatch agency unless certified by the commission as an emergency medical dispatch agency.

As added by P.L.205-2003, SEC.32. Amended by P.L.22-2005, SEC.23.

IC 16-31-3.5-4 Certification requirement for emergency medical dispatchers; expiration; renewal

Sec. 4. (a) To be certified as an emergency medical dispatcher, an individual must:

(1) meet the standards for education and training established by the commission;

(2) successfully complete a written competency examination approved by the commission; and

(3) pay the fee established by the commission.

(b) An emergency medical dispatcher certificate expires on the expiration date established when it is issued, which must be at least two (2) years after the date of its issuance. To renew a certificate, an emergency medical dispatcher must:

(1) meet the education and training renewal standards established by the commission; and

(2) pay the fee established by the commission.

(c) An emergency medical dispatcher must follow protocols, procedures, standards, and policies established by the commission.

(d) An emergency medical dispatcher shall keep the commission informed of the entity or agency that employs or supervises the dispatcher's activities as an emergency medical dispatcher.

(e) An emergency medical dispatcher shall report to the commission whenever an action has taken place that may justify the revocation or suspension of a certificate issued by the commission.

As added by P.L.205-2003, SEC.32. Amended by P.L.22-2005, SEC.24.

IC 16-31-3.5-4.5 Temporary emergency medical dispatcher certificate

Sec. 4.5. (a) A temporary emergency medical dispatcher certificate may be issued by the state emergency management agency. To obtain a temporary certificate, an individual must do the following:

(1) Meet the standards established by the commission. The commission's standards must include a declaration by a certified emergency medical dispatch agency that the certified emergency medical dispatch agency is temporarily unable to secure a certified emergency medical dispatcher.

(2) Pay the fee established by the commission.

(b) A temporary emergency medical dispatcher certificate is valid:

(1) for sixty (60) days after the date of issuance; and

(2) only for emergency medical dispatching performed for the emergency medical dispatching agency that supported the temporary certification.

(c) A temporary emergency medical dispatcher certificate issued under this section may be renewed for one (1) subsequent sixty (60) day period. To renew the temporary certification, the certificate holder must submit the same information and fee required for the original temporary certification. *As added by P.L.22-2005, SEC.25.*

IC 16-31-3.5-5 Certification requirements for emergency medical dispatch agencies; expiration; operating standards; requirements; report to commission

Sec. 5. (a) To be certified as an emergency medical dispatch agency, a person must:

(1) meet the standards established by the commission; and

(2) pay the fee established by the commission.

(b) An emergency medical dispatch agency certificate expires on the expiration date established when it is issued, which must be at least two (2) years after the date of its issuance. To renew a certificate, an emergency medical dispatch agency must:

(1) meet the renewal requirements established by the commission; and

(2) pay the fee established by the commission.

(c) The emergency medical dispatch agency must be operated in a safe, efficient, and effective manner in accordance with commission approved standards that include the following requirements:

(1) All personnel providing emergency medical dispatch services must be certified as emergency medical dispatchers by the commission before functioning alone in an online capacity.

(2) The protocols, procedures, standards, and policies used by an emergency medical dispatch agency to dispatch emergency medical aid must comply with the requirements established by the commission.

(3) The commission must require the emergency medical dispatch agency to appoint a dispatch medical director to provide supervision and oversight over the medical aspects of the operation of the emergency medical dispatch agency.

(d) The commission may require the submission of periodic reports from an emergency medical dispatch agency. The emergency medical dispatch agency must submit the reports in the manner and with the frequency required by the commission.

(e) An emergency medical dispatch agency shall report to the commission whenever an action occurs that may justify the revocation or suspension of a certificate issued by the commission.

As added by P.L.205-2003, SEC.32. Amended by P.L.22-2005, SEC.26.

IC 16-31-3.5-6 Continuing education requirement; approval

Sec. 6. (a) The commission must require emergency medical dispatchers to participate in continuing emergency medical dispatch education and training.

(b) An emergency medical dispatcher education and training course must:

(1) meet the curriculum and standards approved by the commission; and

(2) be conducted by an instructor or instructors that meet qualifications established by the commission.

(c) A person may not offer or conduct a training course that is represented as a course for emergency medical dispatcher certification unless the course is approved by the department of homeland security and the instructor or instructors meet the qualifications established by the commission.

As added by P.L.205-2003, SEC.32. Amended by P.L.22-2005, SEC.27; P.L.1-2006, SEC.302.

IC 16-31-3.5-7 Rules

Sec. 7. The commission shall adopt rules under IC 4-22-2 to implement this chapter. *As added by P.L.205-2003, SEC.32.*

IC 16-31-4 Repealed (*Repealed by P.L.186-1995, SEC.19.*)

IC 16-31-5 Chapter 5. Provision or Authorization of Emergency Medical Services by Local Governments

IC 16-31-5-1 Provision or authorization of emergency medical services; procedures

Sec. 1. The governing body of a city, town, township, or county by the governing body's action or in any combination may do the following:

- (1) Establish, operate, and maintain emergency medical services.
- (2) Levy taxes under and limited by IC 6-3.5 and expend appropriated funds of the political subdivision to pay the costs and expenses of establishing, operating, maintaining, or contracting for emergency medical services.
- (3) Except as provided in section 2 of this chapter, authorize, franchise, or contract for emergency medical services. However:
 - (A) a county may not provide, authorize, or contract for emergency medical services within the limits of any city without the consent of the city; and
 - (B) a city or town may not provide, authorize, franchise, or contract for emergency medical services outside the limits of the city or town without the approval of the governing body of the area to be served.
- (4) Apply for, receive, and accept gifts, bequests, grants-in-aid, state, federal, and local aid, and other forms of financial assistance for the support of emergency medical services.
- (5) Establish and provide for the collection of reasonable fees for emergency ambulance services the governing body provides under this chapter.
- (6) Pay the fees or dues for individual or group membership in any regularly organized volunteer emergency medical services association on their own behalf or on behalf of the emergency medical services personnel serving that unit of government. *As added by P.L.2-1993, SEC.14.*

IC 16-31-5-2 Restrictions on provision of emergency medical services

Sec. 2. A city, town, or county may not adopt an ordinance that restricts a person from providing emergency ambulance services in the city, town, township, or county if:

- (1) the person is authorized to provide emergency ambulance services in any part of another county; and
- (2) the person has been requested to provide emergency ambulance services:
 - (A) to the county in which the person is authorized to provide emergency ambulance services, and those services will originate in another county; or
 - (B) from the county in which the person is authorized to provide emergency ambulance services, and those services will terminate in another county. *As added by P.L.2-1993, SEC.14.*

IC 16-31-6.5 Chapter 6.5. Automatic External Defibrillators

IC 16-31-6.5-1 Repealed (*Repealed by P.L.205-2003, SEC.44.*)

IC 16-31-6.5-2 Exemptions

Sec. 2. This chapter does not apply to the following:

- (1) A licensed physician.
 - (2) A hospital, an ambulatory outpatient surgical center, an abortion clinic, or a birthing center.
 - (3) A person providing health care in a hospital, an ambulatory outpatient surgical center, an abortion clinic, or a birthing center licensed under IC 16-21.
 - (4) A person or entity certified under IC 16-31-3.
- As added by P.L.24-1998, SEC.1. Amended by P.L.96-2005, SEC.12.*

IC 16-31-6.5-3 "Defibrillator" defined

Sec. 3. As used in this chapter, "defibrillator" means an automatic external defibrillator.
As added by P.L.24-1998, SEC.1.

IC 16-31-6.5-4 Duties of person or entity acquiring defibrillator

Sec. 4. A person or entity acquiring a defibrillator shall ensure that the defibrillator is maintained and tested according to the manufacturer's operational guidelines.
As added by P.L.24-1998, SEC.1. Amended by P.L.74-2006, SEC.4.

IC 16-31-6.5-5 Notice of acquisition and location of defibrillator

Sec. 5. A person or entity in possession of a defibrillator shall notify the:

- (1) ambulance service provider that serves the area where the person or entity is located; or

(2) emergency medical services commission;
of the acquisition and location of the defibrillator. *As added by P.L.24-1998, SEC.1.*

IC 16-31-6.5-6 Contact with ambulance service provider following use of defibrillator

Sec. 6. A person who uses a defibrillator is required to contact:

- (1) the ambulance service provider; or
- (2) a fire department that provides ambulance service;

for the area as soon as practicable following the use of the defibrillator. *As added by P.L.24-1998, SEC.1.*

IC 16-31-6 Chapter 6. Immunity From Liability

IC 16-31-6-1 Emergency medical technician services

Sec. 1. (a) A certified emergency medical technician or a certified emergency medical technician-basic advanced who provides emergency medical services to an emergency patient is not liable for an act or omission in providing those services unless the act or omission constitutes negligence or willful misconduct. If the emergency medical technician or emergency medical technician-basic advanced is not liable for an act or omission, no other person incurs liability by reason of an agency relationship with the emergency medical technician or emergency medical technician-basic advanced.

(b) This section does not affect the liability of a driver of an ambulance for negligent operation of the ambulance. *As added by P.L.2-1993, SEC.14. Amended by P.L.205-2003, SEC.33.*

IC 16-31-6-2 Use of defibrillators

Sec. 2. (a) Except for an act of negligence or willful misconduct, a certified first responder who uses an automatic or semiautomatic defibrillator on an emergency patient according to the training procedures established by the commission under IC 16-31-2-9 is immune from civil liability for acts or omissions when rendering those services.

(b) If the first responder is immune from civil liability for the first responder's act or omission, a person who has only an agency relationship with the first responder is also immune from civil liability for the act or omission. *As added by P.L.2-1993, SEC.14.*

IC 16-31-6-3 Advanced life support

Sec. 3. An act or omission of a paramedic or an emergency medical technician-intermediate done or omitted in good faith while providing advanced life support to a patient or trauma victim does not impose liability upon the paramedic or emergency medical technician-intermediate, the authorizing physician, the hospital, or the officers, members of the staff, nurses, or other employees of the hospital or the local governmental unit if the advanced life support is provided:

- (1) in connection with an emergency;
- (2) in good faith; and
- (3) under the written or oral direction of a licensed physician;

unless the act or omission was a result of negligence or willful misconduct.

As added by P.L.2-1993, SEC.14. Amended by P.L.205-2003, SEC.34.

IC 16-31-6-4 Life support provided in connection with disaster emergency

Sec. 4. (a) This section does not apply to an act or omission that was a result of gross negligence or willful or intentional misconduct.

(b) An act or omission of a paramedic, an emergency medical technician-intermediate, an emergency medical technician-basic advanced, an emergency medical technician, or a person with equivalent certification from another state that is performed or made while providing advanced life support or basic life support to a patient or trauma victim does not impose liability upon the paramedic, the emergency medical technician-intermediate, the emergency medical technician-basic advanced, an emergency medical technician, the person with equivalent certification from another state, a hospital, a provider organization, a governmental entity, or an employee or other staff of a hospital, provider organization, or governmental entity if the advanced life support or basic life support is provided in good faith:

(1) in connection with a disaster emergency declared by the governor under IC 10-14-3-12 in response to an act that the governor in good faith believes to be an act of terrorism (as defined in IC 35-41-1-26.5); and

(2) in accordance with the rules adopted by the Indiana emergency medical services commission or the disaster

emergency declaration of the governor.

As added by P.L.156-2001, SEC.3. Amended by P.L.2-2003, SEC.53; P.L.205-2003, SEC.35; P.L.97-2004, SEC.64.

IC 16-31-7 Chapter 7. Emergency Medical Services Education Fund

IC 16-31-7-1 Establishment of fund

Sec. 1. The emergency medical services education fund is established. *As added by P.L.2-1993, SEC.14.*

IC 16-31-7-2 Administration of fund; use of fund

Sec. 2. The commission shall administer the fund. Money from the fund may be used to fund inservice training programs promoted by the commission. *As added by P.L.2-1993, SEC.14.*

IC 16-31-7-3 Approval of expenditures

Sec. 3. Expenditures from the fund must be approved by the budget agency. *As added by P.L.2-1993, SEC.14.*

IC 16-31-7-4 Sources of fund

Sec. 4. The fund consists of income derived as follows:

(1) Generated by the state emergency medical services conference authorized under

IC 16-31-2-7(a)(1)(F).

(2) Generated by education programs conducted by the commission.

(3) From civil penalties imposed by the commission.

As added by P.L.2-1993, SEC.14.

IC 16-31-7-5 Repealed (*Repealed by P.L.65-1998, SEC.3.*)

IC 16-31-7-6 Investment of unneeded money

Sec. 6. The treasurer of state shall invest the money in the fund not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested. *As added by P.L.2-1993, SEC.14.*

IC 16-31-7-7 Reversion of unused money

Sec. 7. Money in the fund at the end of a state fiscal year does not revert to the state general fund.

As added by P.L.2-1993, SEC.14.

IC 16-31-8 Chapter 8. Emergency Medical Services Restitution Fund

IC 16-31-8-1 Establishment of fund; purpose

Sec. 1. The emergency medical services restitution fund is established for the purpose of reimbursing persons who:

(1) are certified under IC 16-31-3; and

(2) provided emergency medical services to individuals injured as a result of an accident caused by an individual who:

(A) was operating a vehicle while intoxicated at the time the accident occurred; and (B) was subsequently convicted under IC 9-30-5 of that offense. *As added by P.L.2-1993, SEC.14.*

IC 16-31-8-2 Administration of fund

Sec. 2. The department of homeland security shall administer the fund. The expenses of administering the fund shall be paid from money in the fund. *As added by P.L.2-1993, SEC.14. Amended by P.L.1-2006, SEC.303.*

IC 16-31-8-3 Reversion of unused money; transfer of excess money

Sec. 3. Money remaining in the fund at the end of a state fiscal year does not revert to the state general fund. However, if the money in the fund at the close of a particular fiscal year exceeds ten thousand dollars (\$10,000), the treasurer of state shall transfer the excess from the fund into the emergency medical services education fund established under IC 16-31-7. *As added by P.L.2-1993, SEC.14.*

IC 16-31-8-4 Reimbursement from fund; conditions

Sec. 4. A person is entitled to reimbursement from the fund for emergency medical services provided under

section 1(2) of this chapter if the following conditions are met:

(1) The person files with the commission a claim not more than one hundred eighty (180) days after the entry of a conviction under IC 9-30-5 of the individual who caused the accident necessitating the emergency medical services.

(2) The court, as part of the entry of conviction, has ordered the individual to make restitution for emergency medical services under IC 9-30-5-17.

(3) The commission has received a copy of the order for restitution as required under IC 9-30-5-17.

(4) The fund has been paid the restitution ordered by the court under IC 9-30-5-17.

As added by P.L.2-1993, SEC.14.

IC 16-31-8-5 Schedule of costs

Sec. 5. (a) The commission shall prepare a schedule of costs for the following:

(1) Emergency medical services.

(2) Administering a claim made against the fund.

The schedule must be based on the different levels of emergency response required in the types of accidents caused by operators of motor vehicles who are intoxicated.

(b) The commission shall distribute the schedule to all courts in Indiana having jurisdiction over individuals who have been charged with an offense under IC 9-30-5. *As added by P.L.2-1993, SEC.14.*

IC 16-31-8.5 Chapter 8.5. Emergency Medical Services Fund

IC 16-31-8.5-1 "Department"

Sec. 1. As used in this chapter, "department" refers to the department of homeland security established by IC 10-19-2-1. *As added by P.L.205-2003, SEC.36. Amended by P.L.97-2004, SEC.65; P.L.22-2005, SEC.28; P.L.101-2006, SEC.27.*

IC 16-31-8.5-2 "Fund"

Sec. 2. As used in this chapter, "fund" refers to the emergency medical services fund established by section 3 of this chapter. *As added by P.L.205-2003, SEC.36.*

IC 16-31-8.5-3 Emergency medical services fund

Sec. 3. (a) The emergency medical services fund is established to defray the personal services expense, other operating expense, and capital outlay of the:

(1) commission; and

(2) employees of the department.

(b) The fund includes money collected under IC 16-31-2, IC 16-31-3, and IC 16-31-3.5. *As added by P.L.205-2003, SEC.36. Amended by P.L.22-2005, SEC.29; P.L.101-2006, SEC.28.*

IC 16-31-8.5-4 Administration

Sec. 4. (a) The department shall administer the fund.

(b) The department shall deposit money collected under IC 16-31-2, IC 16-31-3, and IC 16-31-3.5 in the fund at least monthly.

(c) Expenses of administering the fund shall be paid from money in the fund.

As added by P.L.205-2003, SEC.36. Amended by P.L.22-2005, SEC.30; P.L.101-2006, SEC.29.

IC 16-31-8.5-5 Investment

Sec. 5. The treasurer of state shall invest the money in the fund that is not currently needed to meet the obligations of the fund in the same manner as other public funds may be invested.

As added by P.L.205-2003, SEC.36.

IC 16-31-8.5-6 Money remains in fund

Sec. 6. Money in the fund at the end of a state fiscal year does not revert to the state general fund.

As added by P.L.205-2003, SEC.36.

IC 16-31-9 Chapter 9. Emergency Choke Saving Methods

IC 16-31-9-1 Food service establishment defined

Sec. 1. (a) As used in this chapter, "food service establishment" means a fixed or mobile establishment that serves food to the public for consumption on the premises.

(b) The term does not include establishments operated on a temporary basis by a charitable or nonprofit corporation, association, or organization. *As added by P.L.2-1993, SEC.14.*

IC 16-31-9-2 Instruction placards

Sec. 2. (a) The state department shall adopt rules under IC 4-22-2 to provide for the approval of placards containing instructions in methods that may be used safely and effectively in an emergency by laymen to remove food lodged in a person's throat. The methods must be limited to first aid procedures and must include techniques that do not require the use of instruments or devices.

(b) The placards must be of a size and design suitable for posting in food service establishments. The instructions must, to the extent practicable, be expressed in words and illustrations that are not offensive to restaurant patrons. *As added by P.L.2-1993, SEC.14.*

IC 16-31-9-3 Training program guidelines

Sec. 3. The state department shall develop and publish guidelines for training programs that may be used on a voluntary basis by food service establishments to train employees in the approved methods.

As added by P.L.2-1993, SEC.14.

IC 16-31-9-4 Civil liability

Sec. 4. (a) A person is not obligated to remove, assist in removing, or attempt to remove food from another person's throat. A person who in good faith gratuitously removes, assists in removing, or attempts to remove food from another person's throat in an emergency occurring at a food service establishment is not liable for any civil damages as a result of any act or omission by the person providing the emergency assistance unless the act or omission amounts to willful or wanton misconduct.

(b) The owner or operator of a food service establishment is not liable for any civil damages that result from an act or omission by a person rendering or attempting the emergency assistance if there is an approved placard posted in the food service establishment.

As added by P.L.2-1993, SEC.14.

IC16-31-10 Chapter 10. Enforcement

IC16-31-10-1 Injunctions

Sec. 1. (a) The:

- (1) attorney general;
- (2) prosecuting attorney; or
- (3) commission;

may, in accordance with the Indiana laws governing injunctions, maintain an action in the name of the state to enjoin a person from violating this article or the rules adopted under this article.

(b) An injunction issued under this section does not relieve a person from criminal prosecution under this article or the rules adopted under this article. An injunctive remedy is in addition to any remedy provided for the criminal prosecution of a violation of this article or the rules adopted under this article. *As added by P.L.2-1993, SEC.14.*

IC 16-31-10-2 Violations

Sec. 2. (a) Except as otherwise provided, a person who recklessly violates or fails to comply with this article commits a Class B misdemeanor.

(b) Each day a violation continues constitutes a separate offense. *As added by P.L.2-1993, SEC.14.*

IC 9-13-2-6

Sec. 6. "Authorized emergency vehicle" means the following: (1) The following vehicles: (A) Fire department vehicles. (B) Police department vehicles. (C) Ambulances. (D) Emergency vehicles operated by or for hospitals or health and hospital corporations under IC 16-22-8.

(2) Vehicles designated as emergency vehicles by the Indiana department of transportation under IC 9-21-20-1.

(3) Motor vehicles that, subject to IC 9-21-20-2, are approved by the Indiana emergency medical services commission that are: (A) ambulances that are owned by persons, firms, limited liability companies, or corporations other than hospitals; or (B) not ambulances and that provide emergency medical services, including extrication and rescue services (as defined in IC 16-18-2-110).

(4) Vehicles of the department of correction that, subject to IC 9-21-20-3, are: (A) designated by the department of correction as emergency vehicles; and (B) responding to an emergency. *As added by P.L.2-1991, SEC.1. Amended by P.L.1-1992, SEC.35; P.L.2-1993, SEC.64; P.L.8-1993, SEC.165.*

IC 9-13-2-100

Sec. 100. "Medical services vehicle" means any of the following:

(1) A vehicle that is used or intended to be used for the purpose of responding to emergency life-threatening situations and providing emergency transportation service.

(2) A vehicle that is routinely used to transport patients who are not acutely ill or injured in a life-threatening manner. *As added by P.L.2-1991, SEC.1.*

IC 9-19-5-3

Sec. 3. (a) Except as provided in subsection (b): (1) a vehicle may not be equipped with; and (2) a person may not use upon a vehicle; a siren, whistle, or bell.

(b) An authorized emergency vehicle may be equipped with a siren, whistle, or bell that is capable of emitting sound audible under normal conditions from a distance of not less than five hundred (500) feet and of a type approved by the department. A siren authorized under this section may not be used except when the vehicle is operated in response to an emergency call or in the immediate pursuit of an actual or suspected violation of the law. The person who drives a vehicle equipped with a siren under this section shall sound the siren when reasonably necessary to warn pedestrians and other persons who are driving vehicles of the approach of the authorized vehicle. *As added by P.L.2-1991, SEC.7. Amended by P.L.1-1991, SEC.85.*

IC 9-19-14-1

Sec. 1. An authorized emergency vehicle must, in addition to any other equipment and distinctive markings required by this article, be equipped with a siren, exhaust whistle, or bell capable of giving an audible signal. *As added by P.L.2-1991, SEC.7.*

IC 9-19-14-2

Sec. 2. Except as provided in section 5 of this chapter, an authorized emergency vehicle must, in addition to other equipment required by this article, be equipped with signal lamps that are capable of displaying flashing, rotating, or oscillating beams of red or red and white light. The lights must be visible to oncoming traffic one hundred eighty (180) degrees around the front of the vehicle. *As added by P.L.2-1991, SEC.7.*

IC 9-19-14-3

Sec. 3. An authorized emergency vehicle may be equipped with a siren, whistle, or bell capable of emitting sound audible under normal conditions from a distance of not less than five hundred (500) feet and of a type approved by the state police department. The siren may not be used except when the vehicle is operated as follows:

(1) In response to an emergency call.

(2) In the immediate pursuit of an actual or suspected violation of the law. In this case, the driver of the vehicle shall sound the vehicle's siren when reasonably necessary to warn pedestrians and other drivers of the vehicle's approach. *As added by P.L.2-1991, SEC.7.*

IC 9-19-14-4

Sec. 4. The use of signal equipment described in this chapter imposes upon a driver of another vehicle the duty to yield right-of-way and stop as prescribed in IC 9-21-8-35. *As added by P.L.2-1991, SEC.7.*

IC 9-19-14-5

Sec. 5. A police vehicle, when used as an authorized emergency vehicle, must be equipped with either of the following:

(1) At least two (2) signal lamps capable of displaying a red beam and a blue beam that meet the following requirements: (A) The signal lamps are mounted as high and as widely spaced laterally as practicable or mounted in a manner that will make the lights visible to oncoming traffic one hundred eighty (180) degrees around the front of

the vehicle. (B) The signal lamps are capable of displaying to the front alternately flashing red and blue lights. (C) The signal lamp capable of displaying the red beam is located on the driver's side of the vehicle and the signal lamp capable of displaying the blue beam is located on the passenger's side of the vehicle.

(2) One (1) signal lamp that is capable of displaying a red beam and a blue beam in a manner that will make the light visible to oncoming traffic one hundred eighty (180) degrees in front of the vehicle. *As added by P.L.2-1991, SEC.7.*

IC 9-19-14.5.5

Sec. 5.5. (a) Except for a vehicle utilized in a funeral procession, a vehicle that is not described by sections 2 or 5 of this chapter may not display a red and white lamp or a red and blue lamp.

(b) A person who: (1) purchases or otherwise acquires a vehicle with equipment described by sections 2 or 5 of this chapter; and (2) is not authorized to display a red and white or red and blue lamp upon the vehicle; shall immediately remove the red and white or red and blue lamp from the vehicle. *As added by P.L.99-1991, SEC.2.*

IC 9-19-14.5-1

Sec. 1. A privately owned vehicle belonging to a certified emergency medical technician, certified emergency medical service driver, or certified emergency medical service first responder while traveling in the line of duty in connection with emergency medical services activities may display green lights, subject to the following restrictions and conditions:

(1) The lights may not have a light source less than fifty (50) candlepower.

(2) All lights shall be placed on the top of the vehicle.

(3) Not more than two (2) green lights may be displayed on a vehicle and each light must be of the flashing or revolving type and visible at three hundred sixty (360) degrees.

(4) The lights must consist of a lamp with a green lens and not of an uncolored lens with a green bulb. However, the revolving lights may contain multiple bulbs.

(5) The green lights may not be a part of the regular head lamps displayed on the vehicle.

(6) For a person authorized under this chapter to display a green light on the person's vehicle, the person must first secure a written permit from the director of the state emergency management agency to use the light. The permit must be carried by the person when the light is displayed. *As added by P.L.2-1993, SEC.66.*

IC 9-19-14.5-2

Sec. 2. Except as provided in section 1 of this chapter, a person who displays on any public or private motor vehicle at any time green lights of any size or shape commits a Class C infraction. *As added by P.L.2-1993, SEC.66.*

IC 9-19-14.5-3

Sec. 3. This chapter does not prohibit the operation of a vehicle lawfully equipped with a green light from being operated as any other vehicle when the green light is not illuminated. *As added by P.L.2-1993, SEC.66.*

IC 9-21-1-8

Sec. 8. (a) This section applies to the person who drives an authorized emergency vehicle when: (1) responding to an emergency call; (2) in the pursuit of an actual or suspected violator of the law; or (3) responding to, but not upon returning from, a fire alarm.

(b) The person who drives an authorized emergency vehicle may do the following: (1) Park or stand, notwithstanding other provisions of this article. (2) Proceed past a red or stop signal or stop sign, but only after slowing down as necessary for safe operation. (3) Exceed the maximum speed limits if the person who drives the vehicle does not endanger life or property. (4) Disregard regulations governing direction of movement or turning in specified directions.

(c) This section applies to an authorized emergency vehicle only when the vehicle is using audible or visual signals as required by law. An authorized emergency vehicle operated as a police vehicle is not required to be equipped with or display red and blue lights visible from in front of the vehicle.

(d) This section does not do the following: (1) Relieve the person who drives an authorized emergency vehicle from the duty to drive with due regard for the safety of all persons. (2) Protect the person who drives an authorized emergency vehicle from the consequences of the person's reckless disregard for the safety of others. *As added by P.L.2-1991, SEC.9.*

IC 9-21-5-1

Sec. 1. A person may not drive a vehicle on a highway at a speed greater than is reasonable and prudent under the conditions, having regard to the actual and potential hazards then existing. Speed shall be restricted as necessary to avoid colliding with a person, vehicle, or other conveyance on, near, or entering a highway in compliance with legal requirements and with the duty of all persons to use due care. *As added by P.L.2-1991, SEC.9.*

IC 9-21-5-4

Sec. 4. The driver of each vehicle shall, consistent with section 1 of this chapter, drive at an appropriate reduced speed as follows:

- (1) When approaching and crossing an intersection or railway grade crossing.
- (2) When approaching and going around a curve.
- (3) When approaching a hill crest.
- (4) When traveling upon a narrow or winding roadway.
- (5) When special hazard exists with respect to pedestrians or other traffic or by reason of weather or highway conditions. *As added by P.L.2-1991, SEC.9.*

IC 9-21-7-10

Sec. 10. This section does not apply to a vehicle required or authorized under this title to display a red, red and white, or red and blue light that is visible from the front of the vehicle. A person may not drive or move a vehicle or equipment upon a highway with a lamp or device on the vehicle or equipment displaying a red, red and white, or red and blue light visible from directly in front of the center of the vehicle or equipment. *As added by P.L.2-1991, SEC.9. Amended by P.L.99-1991, SEC.3.*

IC 9-21-7-11

Sec. 11. (a) Except as provided in subsection (b), a vehicle may not display flashing lights.

(b) Flashing lights may be displayed on a vehicle as follows: (1) On an authorized emergency vehicle. (2) On a school bus. (3) On snow-removal equipment. (4) As a means of indicating a right or left turn. (5) As a means of indicating the presence of a vehicular traffic hazard requiring unusual care in approaching, overtaking, or passing. *As added by P.L.2-1991, SEC.9.*

IC 9-21-8-19

Sec. 19. A person may not drive a vehicle onto or from a freeway or the interstate highway system except at entrances and exits that are established by the public authority in control of the highway. Whenever special crossovers between the main roadways of a freeway or the interstate highway system are provided for emergency vehicles or maintenance equipment only, the freeway or interstate highway system shall be posted prohibiting "U" turns. A person who drives a vehicle, except an emergency vehicle or maintenance equipment, may not use the crossovers or make a "U" turn anywhere on the freeway or interstate highway system. *As added by P.L.2-1991, SEC.9.*

IC 9-21-8-35

Sec. 35. (a) Upon the immediate approach of an authorized emergency vehicle, when the person who drives the authorized emergency vehicle is giving audible signal by siren or displaying alternately flashing red, red and white, or red and blue lights, a person who drives another vehicle shall do the following unless otherwise directed by a law enforcement officer: (1) Yield the right-of-way. (2) Immediately drive to a position parallel to and as close as possible to the right-hand edge or curb of the highway clear of any intersection. (3) Stop and remain in the position until the authorized emergency vehicle has passed.

(b) This section does not operate to relieve the person who drives an authorized emergency vehicle from the duty to drive with due regard for the safety of all persons using the highway. *As added by P.L.2-1991, SEC.9.*

IC 9-21-12-1

Sec. 1. (a) A person who drives a vehicle that: (1) meets or overtakes from any direction a school bus stopped on a roadway and is not stopped before reaching the school bus when the arm signal device specified in IC 20-9.1-5-14 is in the device's extended position; or (2) proceeds before the arm signal device is no longer extended; commits the offense described in section 9 of this chapter.

(b) This section is applicable only if the school bus is in substantial compliance with the markings required by the state school bus committee.

(c) There is a rebuttable presumption that the owner of the vehicle involved in the violation of this section committed the violation. This presumption does not apply to the owner of a vehicle involved in the violation of this section if the owner routinely engages in the business of renting the vehicle for periods of thirty (30) days or less. *As added by P.L.2-1991, SEC.9. Amended by P.L.127-1993, SEC.2.*

IC 9-21-12-3

Sec. 3. On a highway divided into two (2) or more roadways by:

- (1) leaving an intervening space that is unimproved and not intended for vehicular travel;
- (2) a physical barrier; or
- (3) a dividing section constructed to impede vehicular traffic; and if the school bus is on the opposite side of the traffic barrier, the person who drives an approaching vehicle need not stop and may proceed with due caution for the safety of children boarding or leaving the school bus. *As added by P.L.2-1991, SEC.9.*

IC 9-21-12-5

Sec. 5. (a) This section does not apply to the following: (1) A street railway grade crossing within a business or residence district. (2) Abandoned or unused tracks.

(b) A person who drives: (1) a motor vehicle carrying passengers for hire; (2) a school or private bus that is carrying passengers; or (3) a vehicle carrying explosive substances or flammable liquids as a cargo or part of a cargo; shall, before crossing at grade a track of a railroad, stop the vehicle not more than fifty (50) feet and not less than fifteen (15) feet from the nearest rail of the railroad.

(c) While stopped in accordance with subsection (b), the person shall do the following: (1) Listen through an open window or door. (2) Look in both directions along the track for an approaching train and for signals indicating the approach of a train. (3) Not proceed until the person can proceed safely. After stopping the person shall cross only in a gear of the vehicle so there will be no necessity for changing gears while traversing the crossing. The person who drives the vehicle may not shift gears while crossing the track or tracks.

(d) If a police officer or traffic control signal directs traffic to proceed at a railroad crossing, the person who drives a vehicle subject to this section shall proceed in accordance with the instructions of the police officer or traffic control signal. *As added by P.L.2-1991, SEC.9. Amended by P.L.119-1995, SEC.7.*

IC 9-21-12-6

Sec. 6. A street car or vehicle may not be driven over an unprotected hose of a fire department when laid down on a street, private driveway, or street car track to be used at a fire or alarm of fire without the consent of the fire department official in command. *As added by P.L.2-1991, SEC.9.*

IC 9-21-12-7

Sec. 7. A person who drives a vehicle that is not on official business may not do any of the following: (1) Follow any fire apparatus traveling in response to a fire alarm at a distance closer than five hundred (500) feet. (2) Drive into or park a vehicle within the block where fire apparatus has stopped in answer to a fire alarm. *As added by P.L.2-1991, SEC.9.*

IC 9-21-12-8

Sec. 8. A person who is convicted of a violation of section 5 of this chapter shall, in addition to the fine and costs that are assessed against the person, have the person's driving privileges suspended for a period of not less than sixty (60) days. *As added by P.L.2-1991, SEC.9.*

IC 9-21-17-20

Sec. 20. (a) Upon the immediate approach of: (1) an authorized emergency vehicle making use of an audible signal and visual signals; or (2) a police vehicle properly and lawfully making use of an audible signal only; a pedestrian shall yield the right-of-way to the authorized emergency vehicle.

(b) This section does not relieve the person who drives an authorized emergency vehicle from the duty to drive with due regard for the safety of all persons using the highway or from the duty to exercise due care to avoid colliding with a pedestrian. *As added by P.L.2-1991, SEC.9.*

IC 9-21-20-1

Sec. 1. (a) The Indiana department of transportation may designate as an authorized emergency vehicle a vehicle: (1) other than an ambulance that is owned by a person other than a hospital; and (2) that is used in emergency service.

(b) The Indiana department of transportation may designate and authorize other emergency vehicles under the rules the department prescribes. *As added by P.L.2-1991, SEC.9.*

IC 9-21-20-2

Sec. 2. The Indiana emergency medical services commission may not withhold approval of a motor vehicle as an authorized emergency vehicle because the motor vehicle is not affiliated with a hospital, law enforcement agency, or fire department. *As added by P.L.2-1991, SEC.9.*

IC 9-21-20-3

Sec. 3. The department of correction shall establish policies and procedures for the designation of departmental vehicles as authorized emergency vehicles. *As added by P.L.2-1991, SEC.9.*

IC 9-24-1-4

Sec. 4. Except as provided in section 7 of this chapter, an individual must: (1) have a valid Indiana operator's, chauffeur's, or public passenger chauffeur's license; and (2) be at least eighteen (18) years of age; to drive a medical services vehicle upon an Indiana highway. *As added by P.L.2-1991, SEC.12.*

IC 9-26-1-1

Sec. 1. The driver of a vehicle involved in an accident that results in the injury or death of a person shall do the following:

- (1) Immediately stop the vehicle at the scene of the accident or as close to the accident as possible in a manner that does not obstruct traffic more than is necessary.
- (2) Immediately return to and remain at the scene of the accident until the driver does the following: (A) Gives the driver's name and address and the registration number of the vehicle the driver was driving. (B) Upon request, exhibits the driver's license of the driver to the following: (i) The person struck. (ii) The driver or occupant of or person attending each vehicle involved in the accident. (C) Determines the need for and renders reasonable assistance to each person injured in the accident, including the removal or the making of arrangements for the removal of each injured person to a physician or hospital for medical treatment.
- (3) Immediately give notice of the accident by the quickest means of communication to one (1) of the following: (A) The local police department if the accident occurs within a municipality. (B) The office of the county sheriff or the nearest state police post if the accident occurs outside a municipality.
- (4) Within ten (10) days after the accident, forward a written report of the accident to the state police department. *As added by P.L.2-1991, SEC.14.*

IC 9-26-1-2

Sec. 2. The driver of a vehicle involved in an accident that does not result in injury or death of a person but that does result in damage to a vehicle that is driven or attended by a person shall do the following:

- (1) Immediately stop the vehicle at the scene of the accident or as close to the accident as possible in a manner that does not obstruct traffic more than is necessary.
- (2) Immediately return to and remain at the scene of the accident until the driver does the following: (A) Gives the driver's name and address and the registration number of the vehicle the driver was driving. (B) Upon request, exhibits the driver's license of the driver to the driver or occupant of or person attending each vehicle involved in the accident.
- (3) If the accident results in total property damage to an apparent extent of at least seven hundred fifty dollars (\$750), forward a written report of the accident to the state police department within ten (10) days after the accident. *As added by P.L.2-1991, SEC.14.*

IC 9-26-1-2.5

Sec. 2.5. Only the following must be included in the written report prepared under sections 1(4) and 2(3) of this chapter by the driver of a motor vehicle involved in an accident: (1) The name and address of the driver preparing the report. (2) The date of the accident. (3) The names and addresses of the drivers of the other vehicles involved in the accident. (4) If, on the date of the accident, a motor vehicle liability policy was in effect with respect to the motor vehicle driven by the driver preparing the report, the following: (A) The policy number. (B) The name of the insurance company that issued the policy. (C) The name and signature of an agent of the insurance company, who by signing the report verifies that the policy was in effect with respect to the motor vehicle on the date of the accident. *As added by P.L.106-1991, SEC.1.*

IC 9-26-1-3

Sec. 3. The driver of a vehicle that collides with an unattended vehicle shall immediately stop and do one (1) of the following:

- (1) Locate and notify the operator or owner of the vehicle of the name and address of the driver and owner of the vehicle striking the unattended vehicle.
- (2) Leave in a conspicuous place in the vehicle struck a written notice giving the name and address of the driver and the owner of the vehicle doing the striking and a statement of the circumstances of the accident. *As added by P.L.2-1991, SEC.14.*

IC 9-26-1-4

Sec. 4. (a) The driver of a vehicle that causes damage to the property of another person, other than damage to a vehicle, shall do the following: (1) Immediately stop the vehicle at the scene of the accident or as close to the accident as possible in a manner that does not obstruct traffic more than is necessary. (2) Immediately return to and remain at the scene of the accident until the driver does the following: (A) Takes reasonable steps to locate and notify the owner or person in charge of the property of the damage. (B) Gives the person the driver's name and address and the registration number of the vehicle. (C) Upon request, exhibits the driver's license of the driver if the driver is required to have a driving license to operate the vehicle.

(b) If after reasonable inquiry the driver of the vehicle cannot find the owner or person in charge of the damaged property, the driver of the vehicle shall do the following: (1) Notify either the sheriff of the county in which the damaged property is located or a member of the state police department. (2) Give the sheriff or state police department the information required by this section. *As added by P.L.2-1991, SEC.14.*

IC 35-44-3-8

Sec. 8. A person who knowingly or intentionally obstructs or interferes with a fireman performing or attempting to perform his emergency functions or duties as a fireman commits obstructing a fireman, a Class A misdemeanor. *As added by Acts 1976, P.L.148, SEC.4. Amended by Acts 1977, P.L.340, SEC.66.*

IC 35-44-3-8.5

Sec. 8.5. (a) A person who knowingly or intentionally obstructs or interferes with an emergency medical person performing or attempting to perform his emergency functions or duties as an emergency medical person commits obstructing an emergency medical person, a Class B misdemeanor.

(b) "Emergency medical person" means a person who holds a certificate issued by the Indiana emergency medical services commission to provide emergency medical services. *As added by Acts 1977, P.L.341, SEC.2.*

IC 36-8-12-11

Sec. 11. (a) Members of volunteer fire companies may display blue lights on their privately owned vehicles while en route to scenes of fires or other emergencies in the line of duty, subject to the following conditions: (1) A light must have a light source of at least fifty (50) candlepower. (2) All lights must be placed on the top of the vehicle. In addition, lights may be placed on the front of the vehicle upon the bumper or at bumper level. (3) No more than four (4) blue lights may be displayed on one (1) vehicle, and each blue light must be of the flashing or revolving type and visible for three hundred sixty (360) degrees, except for lights that are placed on the front of the vehicle. (4) A blue light must consist of a lamp with a blue lens, not of an uncolored lens with a blue bulb. However, a revolving light may contain multiple bulbs. (5) A blue light may not be a part of the regular head lamps displayed on the vehicles.

(b) In order for a volunteer firefighter to display a blue light on his vehicle, he must secure a written permit from the chief of the volunteer fire company to use the blue light and must carry the permit at all times when the blue light is displayed.

(c) A person who is not a member of a volunteer fire company may not display a blue light of any size or shape on a motor vehicle, except a school bus used to transport children to or from a public or private school.

(d) A permittee of the owner of a vehicle lawfully equipped with a blue light may operate the vehicle only if the blue light is not illuminated.

(e) A person who violates subsection (a), (b), (c), or (d) commits a Class C infraction. If the violator is a member of a volunteer fire company, the chief of the company shall dismiss him from membership in the company.

(f) This section does not grant a vehicle displaying blue lights the right-of-way under IC 9-21-8-35 or exemption from traffic rules under IC 9-21-1-8. A driver of a vehicle displaying a blue light shall obey all traffic rules. *As added by Acts 1981, P.L.309, SEC.64. Amended by P.L.88-1990, SEC.4; P.L.2-1991, SEC.108; P.L.99-1991, SEC.4.*

Second Regular Session 115th General Assembly (2008) PRINTING CODE.

Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in this style type. Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution. Conflict reconciliation: Text in a statute in *this style type* or *this style type* reconciles conflicts between statutes enacted by the 2007 Regular Session of the General Assembly.

SENATE ENROLLED ACT No. 249

AN ACT to amend the Indiana Code concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 16-31-2-7 IS AMENDED TO READ AS

FOLLOWS [EFFECTIVE JULY 1, 2008]: Sec. 7. The commission shall do the following:

(1) Develop and promote, in cooperation with state, regional, and local public and private organizations, agencies, and persons, a statewide program for the provision of emergency medical services that must include the following:

(A) Preparation of state, regional, and local emergency ambulance service plans.

(B) Provision of consultative services to state, regional, and local organizations and agencies in developing and implementing emergency ambulance service programs.

(C) Promotion of a statewide system of emergency medical service facilities by developing minimum standards, procedures, and guidelines in regard to personnel, equipment, supplies, communications, facilities, and location of such centers.

(D) Promotion of programs for the training of personnel providing emergency medical services and programs for the education of the general public in first aid techniques and procedures. The training shall be held in various local communities of the state and shall be conducted by agreement with publicly and privately supported educational institutions or hospitals licensed under IC 16-21, wherever appropriate.

(E) Promotion of coordination of emergency communications, resources, and procedures throughout Indiana and, in cooperation with interested state, regional, and local public and private agencies, organizations, and persons, the development of an effective state, regional, and local emergency communications system.

(F) Organizing and sponsoring a statewide emergency medical services conference to provide continuing education for persons providing emergency medical services.

(2) Regulate, inspect, and certify services, facilities, and personnel engaged in providing emergency medical services as provided in this article.

(3) Adopt rules required to implement an approved system of emergency medical services.

(4) Adopt rules concerning triage and transportation protocols for the transportation of trauma patients consistent with the field triage decision scheme of the American College of Surgeons Committee on Trauma.

(4) (5) Apply for, receive, and accept gifts, bequests, grants-in-aid, state, federal, and local aid, and other forms of financial assistance for the support of emergency medical services.

(5) (6) Employ necessary administrative staff.

Appendix 13: October, 2008 Injury Prevention Survey

Summary of Injury Prevention Survey December 2008

In an effort to move Indiana forward in the area of injury prevention, a short online survey (9 questions) was sent out to try and determine what programs and initiatives exist in the state. The survey link was sent to colleagues on the Indiana Trauma Taskforce listserv, members of the Indiana Trauma Network, the Injury Prevention Advisory Council and a listserv of all emergency departments in the state. The survey directions also indicated to forward the survey to others in the injury prevention field who could provide information and might not have received the survey from the Indiana State Department of Health (ISDH).

The survey was distributed via survey monkey and the ISDH received 55 unduplicated responses. Of the 55 respondents, 70.9% (39/55) indicated that their organization had an injury prevention (IP) program. The majority (71.8%, 28/39) of the injury prevention programs are hospital based. Of the respondents who indicated that they did not have an actual IP program, three indicated that some type of injury prevention was being done at their facility, ie, car seat checks, attendance at health fairs, fire department programs.

After indicating whether or not an injury prevention program existed at the organization, the next question asked about focus area topics for each program. Out of the 55 respondents, 42 groups (39 with specific IP programs and 3 without specific IP programs) checked or wrote in the focus areas that applied to their organizations. The top focus areas were motor vehicle crashes followed by bike/pedestrian safety and falls. Almost three-quarters of the respondents indicated that motor vehicle crashes were a focus area in their organization (30/42, 71.4%) and almost the same number of people indicated that bike/pedestrian safety was a focus area (28/42, 66.7%) (See Table 1).

The next question on the survey asked about the emphasis or goals of each injury prevention program. Again, 42 groups (38 with IP programs and 3 without IP programs) responded to the question. Education was a goal of almost 100% of the respondents (41/42, 97.6%) followed by awareness (39/42, 92.9%) (See Table 2).

A list of different populations was provided in the next question that asked about the types of populations that the IP groups work with. There were 42 respondents to the question (39 with IP programs and 3 without programs). The largest population that the respondents work with around Indiana is children (37/42, 88.1%) followed by adolescents (36/42, 85.7%). Only 54.8% of respondents indicated that they work with the elderly population (23/42). Males and females are represented about equal, but less than half of the respondents indicated that they work with the gay/lesbian/transgender population in their injury prevention efforts (16/42, 38.1%). Different racial groups are represented about equally (See Table 3).

The next question asked: "What geographic location does your program cover?" Respondents answered the question differently and some indicated the counties that they serve, others indicated a region of Indiana, while others indicated specific cities. However, the answers can provide an indication of where injury prevention programs are being conducted. Of the 42 respondents (39 with IP programs and 3 without programs, but whom conduct IP activities), 2 respondents indicated that their IP programs are specific to their hospital employees, 9 respondents indicated large geographic regions such as Northeast Indiana, Northwest Indiana, Central Indiana (6 respondents), and Southwest Indiana. Six respondents indicated that their programs covered the entire state and that they can provide education and programming to any

groups or organizations. Other respondents indicated the specific county that is covered in their IP program and 19.6% (18/92) of Indiana counties were represented in this survey. One respondent said that they cover 50 counties while another said they cover the tri-state area of Indiana, Illinois and Kentucky. One respondent indicated that their program is national and international while another respondent indicated that their group has chapters throughout Indiana.

The survey does have limitations. One limitation is that not all Injury Prevention groups throughout the state submitted data. More follow-up is needed in order to obtain the most complete data. However, the current data provides information on the types of programs that exist and does provide a good baseline of the types of injury prevention being done throughout Indiana. Another limitation is that even if a respondent has an injury prevention program, there is no way to identify if the injury prevention program is being evaluated and if the program is working. A follow-up survey should be sent to expand on the questions already asked. Different age and gender structures, ethnicity and attitudes, resources, social structure and environments lead to different types and severity of injuries and different injury rates. To ensure access to adequate resources required for studying these differences, outcomes and evaluation must be conducted.

Table 1. Injury Prevention Focus Topics

Injury Prevention Focus Topics	Number of Responses	Percent of Total (N=42)
Motor Vehicle	30	71.4
Bike/Pedestrian Safety	28	66.7
Falls	21	50.0
Fire/Burns	16	38.1
Poisoning	14	33.3
Water & Boat Safety	14	33.3
Spinal Cord Injury	12	28.6
Traumatic Brain Injury	11	26.2
Child Abuse	10	23.8
Domestic Violence	10	23.8
Rape/Sexual Assault	10	21.4
ATV/Recreational Vehicle Crashes	9	19.0
Suicide	8	16.7
Fireworks	7	9.5
Agriculture Safety	4	9.5

Car Seat Safety/Child Passenger Safety	4	7.1
Homicide	4	9.5
Alcohol Intoxication and Driving	3	4.8
Environmental/Weather	2	4.8
Home Safety	2	4.8
Playground	2	4.8
Railroad Safety	2	4.8
Safe Patient Handling/Arjo Lift Equipment	2	2.4
All ENCARE Programs	1	2.4
Bullying	1	2.4
Elderly Safety	1	2.4
Gun Safety	1	2.4
Safe Sitter	1	2.4
School Bus Drivers	1	2.4
Senior Drivers	1	2.4
Tool Safety	1	2.4
Toy Recall Awareness	1	2.4
Wilderness Safety	1	2.4

*More than one answer could be selected; therefore, Percent of Total Responses does not add up to 100%.

Table 2.Emphasis or Goals of Injury Prevention Programs

Emphasis/Goals	Number of Responses	Percent of Total Responses (N=42)
Education	41	97.6
Awareness	39	92.9
Training	24	57.1
Giving out Products	19	45.2
Organizing Events	16	38.1
Evaluation	15	35.7
Data Collection	13	31.0
Policy	11	26.2
Research	10	23.8

*More than one answer could be selected; therefore, Percent of Total Responses does not add up to 100%.

Table 3: Populations that Injury Prevention Groups Focus Efforts

Population	Number of Responses	Percent of Total Responses (N=42)
Infants	28	66.7
Children	37	88.1
Adolescents	36	85.7
Young Adults	29	69.0
Adults	31	73.8
Elderly	23	54.8

Males	26	61.9
Females	27	64.3
Gay/Lesbian/Transgender	16	38.1
White	27	64.3
Black	26	61.9
Hispanic	27	64.3
Multi-Racial	26	61.9
Amish	1	2.4
Burmese	1	2.4
Fire Fighters	1	2.4

*More than one answer could be selected; therefore, Percent of Total Responses does not add up to 100%.

Following is the survey that was posted on Survey Monkey:

- Name of your program/organization: _____
- Who is the contact person for your organization's injury prevention activities?
Name: _____ Telephone: _____ email: _____
- Do you (or your organization) have an injury prevention program or initiative?
 Yes No
- What are your injury prevention focus topics?
 Agriculture Safety ATV Crashes Bike/Pedestrian Safety Spinal Cord Injury
 Child Abuse Domestic Violence Falls Suicide
 Fire/Burns Firework Homicide Traumatic Brain Injury
 Motor Vehicle Poisoning Rape/Sexual Assault Water Safety
 Other, please explain: _____
- What is the emphasis or goal of your injury prevention program(s) (check all that apply)?
 Awareness Education Training Research
 Policy
 Data collection Evaluation Organizing events Giving out products
 Other, please explain: _____
- What populations do you work with (check all that apply)?
 Infants Children Adolescents Young Adults Adults
 Elderly
 Males Females Gay/Lesbian/Transgender
 White Black Multi-Racial Hispanic
 Other, please explain: _____
- What geographic location(s) does your program cover (i.e. hospital district number, county, city, township, northwest Indiana, etc.)?

8. What other injury prevention activities exist in your community, if any?

9. May we contact you in the future for additional feedback and to develop a statewide network of injury prevention programs?

Yes

No

Appendix 14: January, 2008 SWOT Analysis

ISDH Trauma System/Injury Prevention Program SWOT ANALYSIS 01/22/08

Background:

The Indiana State Department of Health (ISDH) is involved in injury surveillance through the Trauma System/Injury Prevention Program. Access to data from motor vehicle crash reports and related databases is needed as part of a comprehensive injury surveillance system.

The development of injury surveillance at ISDH began in 2002, with funding from a CDC Core Injury surveillance and program development cooperative agreement. However, that funding, which primarily supported an injury epidemiologist, ended in 2005. Some limited funding is being provided by the ISDH Maternal and Child Health block grant to support an epidemiologist (0.6 FTE) to work on injury data on a part-time basis. Through a change in state law, access to Indiana's hospital discharge database (property of the Indiana Hospital & Health Association) began in 2002. A comprehensive data analysis of Injuries in Indiana was published in September of 2005 and can be accessed through the ISDH website. This report analyzed Indiana injury mortality data from 1999-2001 and hospital discharge data from 2002. Data analysis is limited by the fact that ICD-9-CM E-codes for defining external cause of injury are optional in Indiana, and only 55% of injury-related hospital discharges contain E-codes. An Injury Prevention Advisory Council meets quarterly to assist the program but sufficient resources do not exist at this time to maintain an active injury surveillance system or to expand to implement programs and education campaigns to reduce the toll of the deaths and injuries in the state.

Work on development of an Indiana trauma system began in May of 2004, with the formation of an ISDH Advisory Task Force on Trauma System Development/Emergency Preparedness (now known as the ISDH Trauma System Advisory Task Force). Through broad representation from all seven hospitals with American College of Surgeons Committee on Trauma (ACS-COT)-verified Level I or II trauma centers, all 10 Public Health Preparedness/Emergency Response districts, and numerous other constituencies, much progress has been made in discussing the many issues pertinent to a statewide trauma system.

In 2006, the Indiana legislature passed Senate Enrolled Act 284 (now P.L. 155 2006), which provides ISDH with the authority to develop a state trauma system, including a state trauma registry and a designation process for hospitals as trauma centers. This recent accomplishment is fully supported by the Indiana EMS Program (located within the Indiana Department of Homeland Security) and provides the framework for Indiana to move ahead with trauma system development. While some funding was provided for this effort through the HRSA Trauma-EMS Program during 2004-06, no future HRSA funding is available as that particular HRSA program was eliminated. However HRSA hospital bioterrorism preparedness funding did support the position of the contractual state Trauma System Manager (who began work at ISDH in April 2006) through the end of 2006. The Trauma System Manager is currently being funded through the Office of Rural Health.

Strengths

- A newly developed focus on trauma system development and injury prevention within ISDH
- An initial injury surveillance system developed, with a data report on injuries in Indiana completed in 2005, accessible through the ISDH website
- An injury and violence prevention resource directory published in 2005, available through the ISDH website
- Numerous active partnerships throughout the state:
 - Indiana Rural Health Association
 - Indiana Injury Prevention Advisory Council
 - Indiana Trauma System Advisory Task Force
 - Indiana Farm Bureau Insurance
 - Indiana Emergency Nurses' Association
 - Indiana Chapter of American College of Emergency Physicians
 - Indiana Chapter of American College of Surgeons – Committee on Trauma and Emergency Medical Services for Children (EMS-C)
 - Indiana Hospital and Health Association
 - Indiana Department of Homeland Security, Fire and Emergency Medical Services
 - Indiana Criminal Justice Institute, Traffic Records Division
 - Indiana Trauma Network
 - National Association of State EMS Officials, Trauma Managers Council
 - Indiana Suicide Prevention Coalition
 - Indiana TBI Advisory Council
 - Indiana Adolescent Health Coalition
 - Sexual Violence Primary Prevention Council
 - ISDH Office of Rural Health
 - Indiana Spinal Cord Brain Injury Research Board
 - Brain Injury Association of Indiana
- The Trauma System Task Force is a vigorous and committed group, with broad representation from numerous agencies and organizations
- The seven hospitals with ACS-COT Level I or II trauma centers geographically cover the state fairly well except for northwestern Indiana, which relates to Chicago and Southeastern Indiana, which relates to Cincinnati and Louisville. (Note: three hospitals obtained ACS-COT verification since May 2004)
- A major increase in air medical transport capabilities across the state within the past two years
- An increase in the number of counties with Paramedic-level EMS services in the state
- Trauma centers and Indiana ENA actively involved in injury prevention programs for their communities and throughout the State
- Indiana ENA providing trauma training to ED nurses throughout the state: In 2007, 800+ RNs received TNCC and 350 RNs received ENPC training
- Trauma video, “When Minutes Matter: Region 10 Level II Trauma” produced by St. Mary’s Medical Center in Evansville
- Statewide trauma registry, initial limited implementation in 2007

Weaknesses

- Currently, ISDH has no state and very limited federal (for trauma registry only) funding sources to support injury prevention and trauma system development
- Lack of staff dedicated to trauma and injury prevention: currently have 1.0 FTE contractual Trauma System Manager, 0.6 FTE total contractual injury prevention epidemiologist, 1.0 FTE Trauma Registry Manager (state position, currently vacant)
- Lack of mandatory E-coding for injury-related hospital discharges limits epidemiological analysis of data and planning efforts
- Lack of ED/Outpatient data from one Level I trauma center in the hospital discharge database
- Lack of rehabilitation data limits epidemiological analysis of data and planning efforts and inhibits ability to calculate true costs of trauma and injury prevention in Indiana
- Lack of linkages with databases, including hospital discharge, traffic crash records and EMS data, limits the scope of injury/trauma data analysis
- State trauma registry has limited participation at this time
- Without a more structured Trauma System/Injury Prevention Program at ISDH, it is difficult to coordinate all of the statewide efforts to ensure a general acceptance and use of accepted guidelines for trauma transport and care, implementation of injury prevention programs
- Trauma system development and injury prevention not perceived as important issues in Indiana, and education of legislators and the public is necessary

Opportunities

- (3) Opportunities for collaboration and improvement of data collection and analysis of injury related to motor vehicle crashes have recently become evident (CODES, Traffic Record Steering Committee, state EMS database, state trauma registry development)
- (4) Much interest in state trauma system development and implementation from a wide variety of stakeholders (represented on the Trauma System Task Force)
- (5) The Trauma System Task Force recognizes the critical importance of reliable, timely injury data needed to develop a statewide trauma system. The state trauma registry is the first step in this development
- (6) There is now (2006) a nationally standardized trauma data dictionary and a national model trauma system plan that can be utilized in planning and developing an Indiana trauma system

Threats

- 1) Support by agency leaders is unclear at this time
- 2) Freeze on creation of new state positions
- 3) Inadequate funding/resources to support needed trauma system development and maintain injury prevention surveillance and programming
- 4) No impetus for mandated E-codes of hospital discharge data

2008 Trauma/Injury Prevention Events

- 1) In-state trauma conferences:

- Memorial Hospital, South Bend: March 15th, 2008
 - Clarian Methodist Hospital, Indianapolis: April 18th, 2008
 - Parkview Hospital, Fort Wayne: May 9th, 2008
 - Wishard Hospital, Indianapolis: November 7th & 8th, 2008
 - Deaconess Hospital, Evansville: November 14th & 15th, 2008
- 2) Indiana Emergency Nurses' Association Annual Symposium: June 18, 2008
 - 3) National Child Passenger Safety Week: February (date tbd)
 - 4) May is Elder Abuse Prevention Month, National Bike Safety Month, National Motorcycles Awareness Month, National Trauma Awareness Month, National EMS Week (date tbd), National Safe Boating Campaign (date tbd), Buckle Up America Week (date tbd),
 - 5) June is Fireworks Safety Month
 - 6) September is Baby Safety Month, National Childhood Injury Prevention Week (date tbd), Suicide Prevention Week (date tbd)
 - 7) October is Domestic Violence Awareness Month, National Fire Prevention Week (date tbd), National School Bus Safety Week (date tbd)
 - 8) November: Operation ABC (America Buckles Up Children),
 - 9) December is [National Drunk and Drugged Driving Prevention Month, Safe Toys and Gifts Month,](#)

Appendix 15: Draft 2005 Indiana Injury Prevention Plan

January 31, 2005.

AN INJURY PREVENTION AND CONTROL PLAN FOR INDIANA

DRAFT DRAFT DRAFT

The Indiana State Department of Health

- Injury Prevention Program,**
- Injury Prevention Advisory Council, and the**
- Trauma System Advisory Task Force**

January 2005

Page 2 – Acknowledgements and Contributions

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INTRODUCTION

Injuries pose a public health issue with a major impact on the lives of Indiana citizens. The Indiana State Department of Health (ISDH) proposes this Injury Prevention and Control Plan for Indiana that describes some major injury problems affecting Hoosiers. The Plan provides a “blueprint” for individuals, organizations, and agencies to use in facing this challenge to the health and lives of Indiana residents.

Five goals were selected that address the injury issues of falls, motor vehicle crashes, residential fires, poisonings, and suicide. Related objectives, action steps, and prevention strategies are described in the Plan (pages XX to XX). In Indiana, the unintentional injuries of falls, motor vehicle crashes and poisonings accounted for more than 3 out of 4 injury-related hospitalizations in 2002, and for 60% of unintentional injury deaths from 1999 – 2001. Suicide accounted for 10% of hospitalizations and 20% of injury deaths during the same time periods.

While there are certainly many injury issues that require consideration, the injury issues selected for this Plan were based on an analysis of relevant data, of which some is extracted in this Plan report. The companion report – “Injuries in Indiana” - provides detailed information on a variety of injuries affecting Hoosiers. Copies of both this State Plan and “Injuries in Indiana” can be accessed through the ISDH website: www.statehealth.in.gov/programs/injury or by contacting the ISDH Injury Prevention Program. The work of the ISDH Injury Prevention Program is supported by a cooperative agreement #U17/CCU522371 from the Centers for Disease Control and Prevention (CDC).

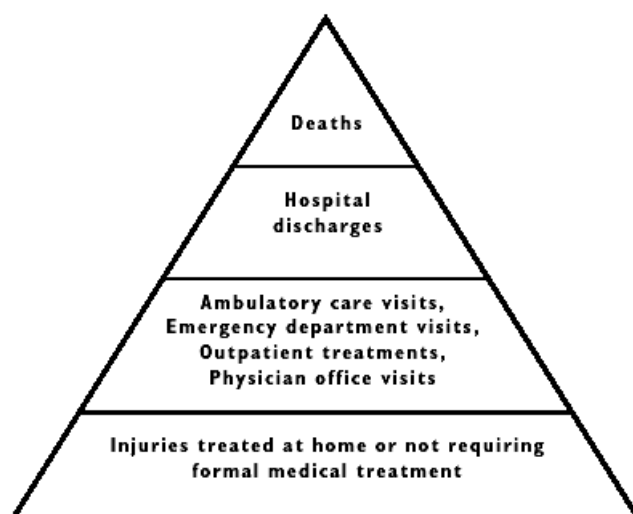
BACKGROUND

Injury refers to damage to the body caused by exchanges with environmental energy that are beyond the body’s resilience. ⁱ Injury may either be unintentional (accidental) or intentional (violence-related including assault, homicide and suicide). For example, a teenager who sustains a head injury while participating in athletics is considered to have an *unintentional* injury, while a teenager who takes an overdose of acetaminophen as a suicide attempt would be categorized as an *intentional* injury. Injuries can lead to lifelong physical and emotional scars. Nationally, injuries (unintentional and intentional) are the 4th leading cause of death for all ages. ^{ii, iii}

Unintentional injury accounts for the vast majority of injury deaths and can be defined as deaths involving injury or poisoning by unpremeditated measures. In Indiana and the United States, unintentional injury is the leading cause of death among persons 1 to 34 years and the 5th leading cause of death overall. ⁴

Although injury deaths are significant, non-fatal injuries happen more frequently and pose a serious public health problem. Hospitalization and other medical care provided to the injured person produce a financial and economic burden on society. In terms of medical treatment, loss of productivity and wages, and rehabilitation for those severely injured, the Centers for Disease Control (CDC) estimates that the financial cost of injuries exceeds \$224 billion annually. Results from a CDC analysis in 2000 showed that injury-attributable medical expenditures accounted for 10 percent of total medical expenditures, a figure similar to percentages of other leading public health concerns, such as obesity and smoking. ²

The injury pyramid below provides a visualization of the reality that injury-related deaths are far outnumbered by nonfatal injuries.



There are a variety of strategies that can be effective for preventing injuries and controlling the effects of injuries. These generally fall within three categories: legal or policy changes, product and environmental safety developments, and education.

The data in this report was compiled by the ISDH Injury Prevention Program staff. It should be noted that the mortality data is based on a 3-year period: 1999 – 2001. The hospital discharge data is from 2002, the first year that this database was made available to the ISDH.

Unintentional Injuries Through the Age Span

Children ages <1 (less than age 1 year) to 14 years accounted for 8 percent (1405) of all unintentional injury hospitalizations in Indiana during 2002. Sixty-five percent of these were males. Infants and young children are at increased risk for sustaining injuries from motor vehicle crashes, falls, drowning, fires, and poisoning. Young children are exploratory in nature and curious about their environment. With limited cognitive ability and physical coordination, children are less capable of identifying and avoiding unsafe environments.

Children and adolescents are more susceptible to motor vehicle crashes, bicycle crashes, pedestrian injuries, dog bites, and suicide. This age group is often unable to judge if an environment is safe and are also more likely to demonstrate risky behaviors stimulated by impulse. ⁽¹⁾

The leading causes of death among teens and young adults are motor vehicle injuries, drowning, suicide and homicide. Consequently, teens are involved in violence more than any other age group. ⁽¹⁾ Safe driving skills only improve with experience in operating a motor vehicle. Experimentation with or involvement in illegal drugs or alcohol are also important risk factors for injuries.

The leading causes of unintentional injury death among adults (ages 20 to 64 years) are overwhelmingly motor vehicle crashes (54.6%), followed by poisonings (12.4%, largely related to suicide attempts). Falls

are also of concern, emerging as one of the five leading causes of death beginning at age 35 years as the 4th leading cause of death, then becoming the 2nd leading cause at age 55 years and the leading cause at age 75 years.

The role of unsafe driving practices, failure to wear a seat belt, or driving while intoxicated continue to be contributing factors to the toll of deaths and injuries related to motor vehicle crashes. Suicide continues to be among the top five leading causes of death (for injury and non-injury causes) for age groups 20 to 54 years. Homicide as a cause of death predominates in the 15 to 34 year-old age groups.

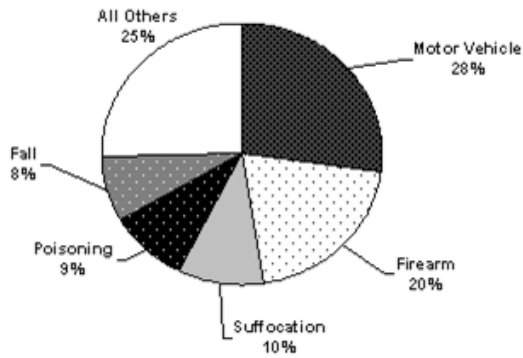
Both physical and cognitive changes play a role in older Americans' (65 years and older) susceptibility to motor vehicle-related injuries, falls, and suicide. As Americans age, their bones become more fragile, they experience problems with vision, their reflexes become slower and some are cognitively impaired by depression or other mental illness. Although Americans are living healthier, longer lives, facing the reality of poor vision, limited mobility, the loss of loved ones, and the development of chronic illness can be devastating. Feelings of isolation and adjusting to a less active lifestyle increase the risk of suicide. ⁽¹⁾

INDIANA INJURY MORTALITY DATA

From 1999-2001, there were 10,143 injury-related deaths in Indiana, an age-adjusted fatality rate of 55.66 per 100,000 people compared to the U.S. rate of 53.7. Among these deaths, 63 percent (6,633) were unintentional, making mortality by an unintentional intent the 5th leading cause of death in Indiana.

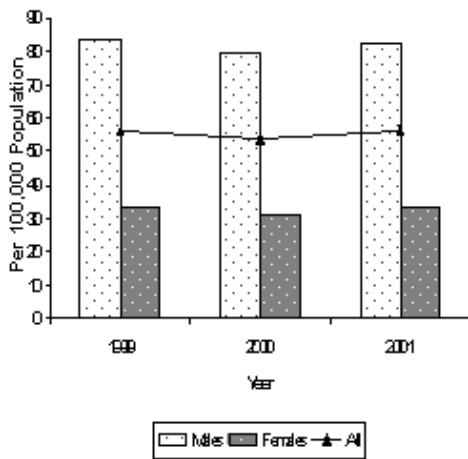
As is typical for all injuries, males die from injuries more often than females (Figure 2). Injury fatality rates vary through the age spectrum, being lowest between 5 and 14 years of age, increasing from age 15 to 24 years, then decreasing somewhat until 65 years of age, when a large increase begins (Figure 3). Injury fatality rates are highest in African-Americans and less in Caucasians and Asians (Figure 4). Table 1 lists Indiana unintentional injury deaths in rank order by mechanism of injury (Page 7).

Figure 1. Leading Causes of Injury Death, Indiana 1999-2001
(Total Fatalities=10,143)



Source: CDC, WISQARS

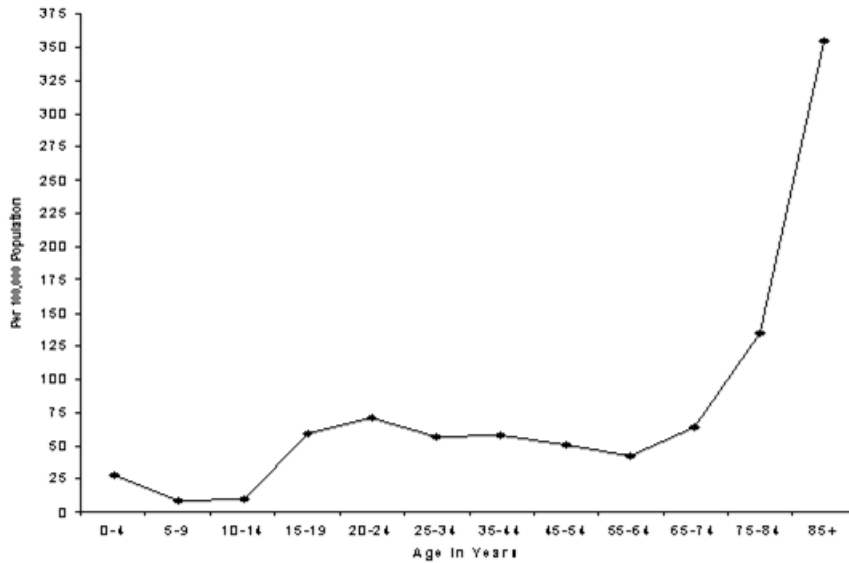
Figure 2. Fatal Injury Rates* by Sex, Indiana 1999-2001
(Total Fatalities=10,143)



Source: CDC, WISQARS

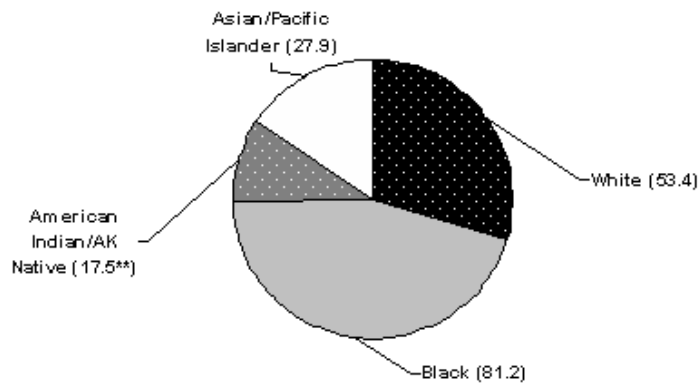
*Rates are age-adjusted.

Figure 3. Fatal Injury Rates* by Age, Indiana 1999-2001
(Total Fatalities=10,143)



Source: CDC, WISQARS, Rates are age-adjusted.

Figure 4. Fatal Injury Rates* by Race, Indiana, 199-2001 (Total Fatalities=10,143)



Source: CDC, WISQARS

*Rates are age-adjusted.

**Rate is based on frequency less than 20 and should be used with caution.

Table 1: Unintentional Injury Deaths, Rank Order by Mechanism, Indiana 1999-2001.

Mechanism	Fatalities	% Injury Deaths	Age-Adjusted Rates per 100,000
MV Traffic	2,750	41.5%	15.01
Unspecified	792	11.9%	4.41
Fall	786	11.8%	4.37

Suffocation	524	7.9%	2.90
Poisoning	442	6.7%	2.44
Fire/Burn	283	4.3%	1.56
Other Land Transport	228	3.4%	1.25
Drowning	214	3.2%	1.16
Natural/Environment	120	1.8%	0.67
Other Specified, Classifiable	99	1.5%	0.55
Pedestrian, Other	76	1.1%	0.42
Firearm	67	1.0%	0.37
Other Transport	65	1.0%	0.36
Machinery	59	0.9%	0.33
Struck by or Against	59	0.9%	0.32
Other Specified, Not Elsewhere Classified	50	0.8%	0.28
Cut/Pierce	10	0.2%	0.05*
Pedal cyclist, Other	7	0.1%	0.03*
Overexertion	2	0.0%	0.01*
Total	6,633	100.0%	36.49

Source: CDC: Web-based Injury Statistics Query and Reporting System (WISQARS)

Note: *Rates that are based on frequencies less than 20 may be unstable and should be used with caution.

HOSPITALIZATIONS RELATED TO INJURY

While deaths are the most devastating outcome related to injuries, the analysis of hospitalizations related to injury provides additional useful information. Although injury deaths are significant, non-fatal injuries occur more frequently. Hospitalization and other medical care provided to the injured places a financial and economic burden on society. In terms of medical treatment, lost productivity and wages, and rehabilitation for those severely injured, injury costs the United States more than \$224 billion annually.

The source agency for the collection of hospital discharge data is the Indiana Hospital & Health Association (IHHA). IHHA supported a recent change in state law allowing the ISDH Epidemiology Resource Center to receive this data for year 2002 and forward.

In 2002, there were a total of 779,332 Indiana inpatient hospitalizations. Among these, 12.5 percent (97,504) had an injury-related diagnosis code (ICD-9-CM 800-999) in any of 15 diagnosis fields. However, only forty-four percent (43,106) had at least one supplemental External Cause of Injury Code (E code). (EXPLAIN E Codes here). This E coded portion of the hospital discharge data was standardized for analysis based on recommendations from the Injury Surveillance Workgroup of the State and Territorial Injury Prevention Directors Association (STIPDA) leaving a total of 20,598 records that were analyzed for this report.

For the purposes of this report, injury-related hospitalizations is defined as records among Indiana residents in which the principal reason for admission to a non-federal, acute care, inpatient facility was an injury, including late effects, but excluding adverse effects of therapeutic drugs and adverse effects of medical/surgical care and the late effects of those adverse effects. Note: this definition includes readmissions, transfers, and deaths occurring in the hospital.

Highlights from an analysis of the Indiana hospital discharge database are listed below:

Unintentional (“accidental”) injuries comprised 84 percent of all injury-related admissions. Ten per cent related to self-inflicted injuries, 4% were assault-related, and 2% were of undetermined intent. Hospitalizations for unintentional injuries were 6 times more frequent than hospitalizations for intentional injuries.

Of the five leading causes of injury resulting in hospitalization, 46 percent (9,516) were due to falls, 17 percent (3,283) were due to motor vehicle traffic-related incidents, 16 percent (3,285) resulted from poisoning, 4 percent (746) were struck by or against injuries, and 3 percent (568) were due to other transport injuries. Burns related to fires accounted for 1% of hospitalizations (221).

Falls were the leading cause of unintentional injury hospitalizations, composing 55% of unintentional injury-related hospitalizations. Seventeen percent of all unintentional injury hospital discharges were due to falls from slipping, tripping or stumbling.

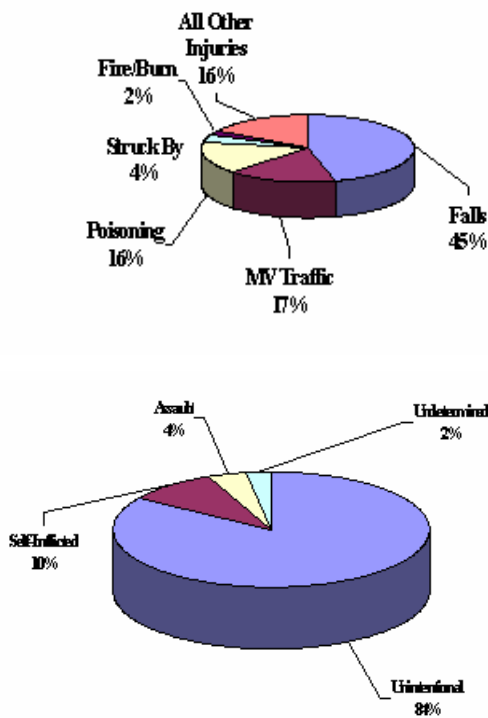
The great majority of motor vehicle traffic-related hospitalizations involved motor vehicle occupants (2,403 of 3,276 =73%). However, the categories of other transport (568), motorcyclists (398), bicyclists (248), and pedestrians (273) are also of concern.

Poisoning was the leading cause of self-inflicted injury hospitalizations, accounting for 93% of this category of hospital admission. Suicide attempts by medication overdoses involved 1,997 persons. Among these, 38 percent resulted from the use of tranquilizers and other psychotropic agents. Another 26 percent were due to the use of analgesics, antipyretics, and anti-rheumatics.

Struck by or against is the leading cause of assault injury hospitalizations, comprising 32 percent of all assault-related hospital discharges. Twenty percent of assault hospitalizations result from unarmed fights or brawls. Another 17 percent resulted from assault involving a cutting and piercing instrument.

For Indiana, the leading mechanisms for unintentional injury hospitalizations were motor vehicle traffic-related incidents (3,276), falls (9,501 and poisoning (965), injury problems that have been selected for incorporation into the State Plan. Residential fire burns are also included in the State Plan because the Indiana death rate is higher than the national rate.

Figure 5: Leading Causes of Injury-Related Hospital Discharges, Indiana 2002
(Total Discharges=21,995)



Source: Indiana State Department of Health, Injury Prevention Program
Indiana Hospital Discharge Data, 2002
Note: Does not include the “Other” category, where N=11.

Table 2: Summary of Injury Hospitalizations by Mechanism / Cause, Indiana 2002

Mechanism and Cause	Uninten- tional	Self Inflicted	Assault	Undeter- mined	Other *	Total	Percent	Crude Rate
Cut/Pierce	156	65	147	4	0	372	1.7%	6.12

Drowning/Submersion	21	0	0	0		21	0.1%	0.35
Fall	10,077	5	6	6		10094	45.9%	166.01
Fire/burn	506	8	11	3		528	2.4%	8.68
Fire/flame	223	6	0	1		230	1.0%	3.78
Hot object/Substance	283	2	11	2		298	1.4%	4.90
Firearm	130	35	212	51	5	433	2.0%	7.12
Machinery	205					205	0.9%	3.37
Motor vehicle Traffic	3,647	6	0	1		3654	16.6%	60.09
Occupant	2,693					2693	12.2%	44.29
Motorcyclist	433					433	2.0%	7.12
Pedal cyclist	78					78	0.4%	1.28
Pedestrian	259					259	1.2%	4.26
Unspecified	156					156	0.7%	2.57
Pedal cyclist, other	189					189	0.9%	3.11
Pedestrian, other	34					34	0.2%	0.56
Transport, other	639	0		0		639	2.9%	10.51
Natural/Environmental	272	0		1		273	1.2%	4.49
Bites and stings***	0					0	0.0%	0.00
Overexertion	296					296	1.3%	4.87
Poisoning	1010	1997	2	433	0	3442	15.6%	56.61
Struck by, against	524		279		4	807	3.7%	13.27
Suffocation	51	9	1	1		62	0.3%	1.02
Other specified, classifiable****	396	3	70	1	0	470	2.1%	7.73
Other specified, not classifiable	73	6	52	7	1	139	0.6%	2.29
Unspecified	248	1	75	12	1	337	1.5%	5.54
All injury	18474	2135	855	520	11	21995	100.0%	361.73

Source: Indiana State Department of Health, Injury Prevention Program (Hospital Discharge Data, 2002)

Note: Only one External Cause of Injury Code (E code) is presented per discharge.

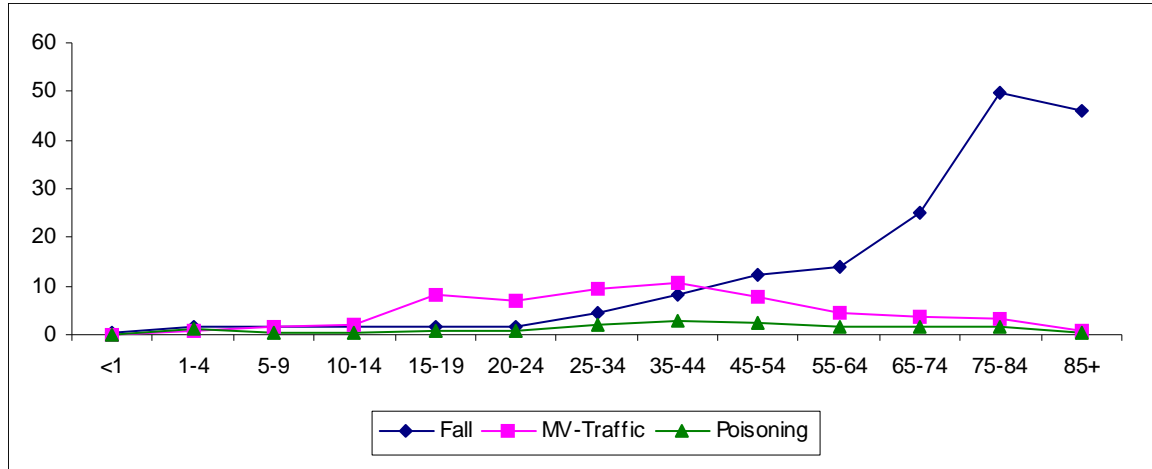
Table 3: Leading Causes of Hospital Discharges by Intent, Indiana 2002
(Total Discharges=21,995)

Unintentional		Self-Inflicted		Assault		Undetermined	
Cause	Number	Cause	Number	Cause	Number	Cause	Number

Falls	10077	Poisoning	1997	Struck by	279	Poisoning	433
MV Traffic	3647	Cut/Pierce	65	Firearm	212	Firearm	51
Poisoning	1010	Firearm	35	Cut/Pierce	147	Fall	6
Other Transport	639	Suffocation	9	Fire/Burn	11	Cut/Pierce	4
Struck by or Against	524	Fire/Burn	8	Fall	6	Fire/Burn	3
All Others	2577	All Others	21	All Others	200	All Others	23
Total	18474	Total	2135	Total	855	Total	520

Source: Indiana State Department of Health, Injury Prevention Program
Indiana Hospital Discharge Data, 2002

Figure 6: Age-Specific Injury Hospitalization Rates by Leading Causes
Indiana 2002
(Total Discharges=21995)



Source: Indiana State Department of Health, Injury Prevention Program
Indiana Hospital Discharge Data, 2002. Rates are per 100,000 population. t

THE STATE PLAN

The Injury Prevention and Control Plan for Indiana focuses on several selected injury problems, as a starting point for the work that needs to be accomplished. These injury problems are:

FALLS
MOTOR VEHICLE CRASHES
RESIDENTIAL FIRES
POISONING
SUICIDE

To impact the morbidity and mortality associated with falls, motor vehicle crashes, residential fire burns, poisonings, and suicide will require collaboration by many agencies and organizations; continued education of the public, health care providers, partner agencies and organizations; and consideration of environmental safety measures that can be implemented.

FALLS

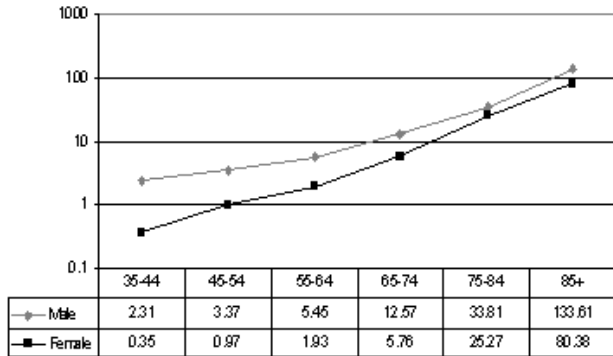
Falls are the third leading cause of unintentional injury deaths in Indiana, resulting in 768 deaths from 1999-2001; 75% of these deaths were among persons 65 years and older. Falls are a problem that largely impact children, being the most common cause of unintentional injury, and the elderly, where they are the leading cause of injury death.

Children are more susceptible to death when they fall from high elevations and when they sustain head injury from contact with hard objects such as concrete surfaces. The majority of falls among children happen in the home, affecting many children age 4 years and under, and children ages 5 to 14 years to a lesser extent. Children fall from windows, down stairs, off furniture, and from bicycles and outdoor play equipment.

Falls in older adults are a result of both personal and environmental factors. Personal factors include gait and balance, muscle weakness, limitations of daily living activities, visual problems, lack of physical activity, and the effects of prescription drugs. Environmental factors include potential hazards in the home such as loose rugs, the absence of railings on stairs or grab bars in the bathroom, and poor lighting.

The most common fall-related injuries in the elderly are fractures involving the hip, spine, or forearms, with hip fractures being the most serious in terms of disability and sometimes death.

Figure 7: Fall Fatalities among Persons Over Age 35 Years by Sex and Age, Indiana 1999-2001.



Source: CDC, WISQARS

Note: Female rates for ages 35-64 years are based on frequencies less than 20 and are not statistically significant.

Goal A. Reduce fall-related injuries and deaths in young children and older adults.

Objective #1. By 2010, decrease hospitalizations of the elderly related to falls by XX%, in collaboration with the Indiana Office on Aging.

Indiana death rate from falls, 2001: 4.4.

U.S. death rate from falls, 2001: 5.3. (From falls in 65-84 year-olds.: 20.3)

Healthy People 2010 goal: 3.0 (all ages)

Action Step 1.A: Support community programs to provide education and in-home safety assessments that reduce the risk of falls.

Action Step 1.B: Work with community programs to determine funding sources that can assist in modification of residences of the elderly.

Action Step 1.C: Promote supervised exercise programs that improve strength, balance, and coordination in the elderly

Action Step 1.D: Promote methods and information that prevent osteoporosis.

Objective #2: By 2009, reduce the number of children below 4 years of age hospitalized related to falls by XX%.

Baseline: _____ in 2002 HP 2010 goal: _____

Action Step 2.A: Promote and monitor fall prevention in young children in collaboration with providers of child health care.

Action Step 2.B: Promote awareness of child safety products for use in the home and safety practices to prevent fall injuries to young children

Action Step 2.C: Disseminate information through media outlets to promote the prevention of falls in young children.

Action Step 2.D: Serve as a clearing house for coordination, development, and distribution of fall prevention educational materials.

Action Step 2.E: Work with communities and city planners to disseminate information on safe playground surfaces and equipment.

Action Step 2.F: Support policy changes for high-rise buildings and apartments that would require the placement of window guards.

Prevention Strategies for Falls

Facilitate distribution of fall injury prevention educational resources and media messages through community networking.

Facilitate coordination of efforts related to fall prevention by various statewide organization, coalitions, and networks.

Serve as a point of contact by organizations and network working to promote adoption and/or enhancement of playground safety and equipment standards and policies.

Promote community adoption of playground safety and equipment standards.

Promote the use of safety equipment in the home as well as awareness of injury hazards.

Safety Messages Focused on Young Children:

Use safety gates (both at the top and bottom of stairways) if young children are in the house.

Do not place chairs and furniture near windows.

Place window guards on all windows beginning at the second story of a residence.

Do not use baby walkers.

Constant supervision of young children is needed, especially when they are climbing on furniture or playing in areas of the house or yard where falls are possible.

Infants should be secure (strapped) when on a changing table.

Playgrounds should have surfaces that can absorb the shock of falls. This includes materials such as wood chips, shredded rubber and sand).

Elderly:

(To be added).

Selected websites for more information

National Center for Injury Prevention and Control www.cdc.gov/ncipc

American Academy of Pediatrics www.aap.org

Safe USA www.cdc.gov/safeusa

National SafeKids Campaign www.safekids.org

American Association of Orthopedic Surgeons

Tool Kit to Prevent Senior Falls www.cdc.gov/ncipc/pub-res/toolkit/toolkit.htm

Consumer Product and Safety Commission www.cpsc.org

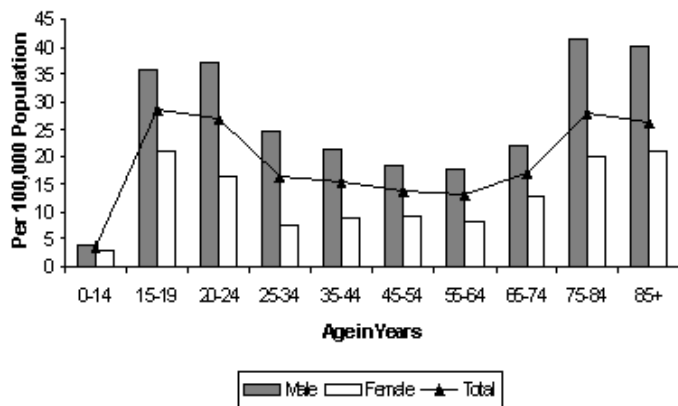
Riley Hospital for Children www.rileyhospital.org/kids1st

MOTOR VEHICLE CRASHES (MVC)

From 1999-2001, there were 2,750 motor vehicle traffic-related fatalities in Indiana, an average of 916 Hoosiers each year. This is the leading cause of injury death for persons 1 to 64 years. Males generally have a higher fatality rate related to motor vehicle traffic incidents than females. Failure to use safety restraints, especially among children, and alcohol-impaired driving contribute significantly to motor vehicle injury and death. Among all Hoosiers fatally injured as a result of a motor vehicle incidents, 58% were unrestrained. Among Hoosiers less than 16 years old and fatally injured, 45% were not properly restrained. According to the Indiana 2003 Youth Risk Behavior Survey, 11% of teens rarely or never wore safety belts and 28% rode with a drinking driver in the past twelve months.

Mandatory seat belt laws apply to all front seat occupants and all rear seat passengers under age 12 years. Indiana practices primary enforcement, which allows police officers to stop a vehicle for the sole purpose of not using a seat belt. Proper use of lap and shoulder belts could prevent approximately 60% of motor vehicle-related deaths.

Figure 11. Motor Vehicle Traffic Deaths by Sex and Age, Indiana 1999-2001
(Total Motor Vehicle Traffic Fatalities for Indiana=2,750)



Source: CDC, WISQARS

Motorcycles as a Special Concern

In 2001, more than 3 thousand deaths occurred nationally among motorcyclists, accounting for 8 percent of all fatalities, 9 percent of motor vehicle occupant fatalities, and 2 percent of all occupants injured. Recent analysis shows that the number of motorcyclists killed on United States highways is on the rise, a trend that began in 1997. Since that time, fatalities have increased more than 50 percent. Although this increase is evident in all age groups, the largest percentage increases are among persons under the age of 40 years. iv

Motorcyclists in Indiana were involved in XX crashes, resulting in XX injuries and 332 fatalities from 1997-2001. Among the fatalities, there was a 56 percent increase, and 59 percent were motorcyclists under age 40 years.

The use of helmets plays a major role in reducing motorcycle-related fatalities and injuries. However, based on the National Occupant Protection Use Survey (NOPUS), there has been a significant increase of nonuse among motorcyclist. NOPUS is an observational survey of motorcycle helmet, safety belt, and child safety seat use implemented by the National Highway Traffic and Safety Administration (NHTSA). Helmet use among operators fell from 71 percent in 2000 to approximately 58 percent in 2002. NHTSA estimates that helmets used in 2001 saved the lives of 674 motorcyclists, are 29 percent effective in preventing fatal injuries, and are 67 percent effective in preventing brain injuries, which is common injury sustained when involved in a motorcycle incident. Among all fatalities in Indiana during the five-year period (1999-2001), only 18 percent were wearing a helmet.

Goal B. Reduce the toll of motor vehicle crashes in teen-age drivers.

Objective # 3: By 2010, reduce the number of deaths in teens secondary to motor vehicle crashes by XX%, in collaboration with agencies and organizations with a similar goal.

Baseline: _____ 2001 HP 2010 goal: _____

Indiana death rate from MVC, 2001: 15.1

U.S. death rate from, MVC, 2001: 14.9. Death rate 15 –24 year-olds, 2001: 26.3

Healthy People 2010 goal: 9.2

Action Step 3.A: Support the initiative for a state law requiring the use of seat belts in trucks.

Action Step 3.B: Support the work being done by multiple organizations to impact teen-age drinking and driving.

Action Step 3.C: Facilitate efforts and research to evaluate the impact of motor vehicle policies on teen driving behaviors and injuries so as to develop or modify policies affecting such injuries.

Action Step 3.D: Work with agencies and organizations to encourage teenagers to use seatbelts every time they drive or ride.

Prevention Strategies for Motor Vehicle Injuries

Promote public awareness of appropriate child restraint use.

Promote use of safety belts for adults and adolescents, as the single most effective occupant protection device in vehicles.

Promote the concept of “Don’t Drink and Drive”.

Selected Websites

American Academy of Pediatrics www.aap.org

Buckle Up America

Centers for Disease Control and Prevention, National Center for Injury Prevention and Control at www.cdc.gov/ncipc

Consumer Products and Safety Commission www.cpsc.gov

US Department of Transportation

National SAFEKIDS Campaign at www.safekids.org

Indiana SafeKids

Indiana Criminal Justice Institute

RESIDENTIAL FIRES

Goal C. Reduce residential fire deaths

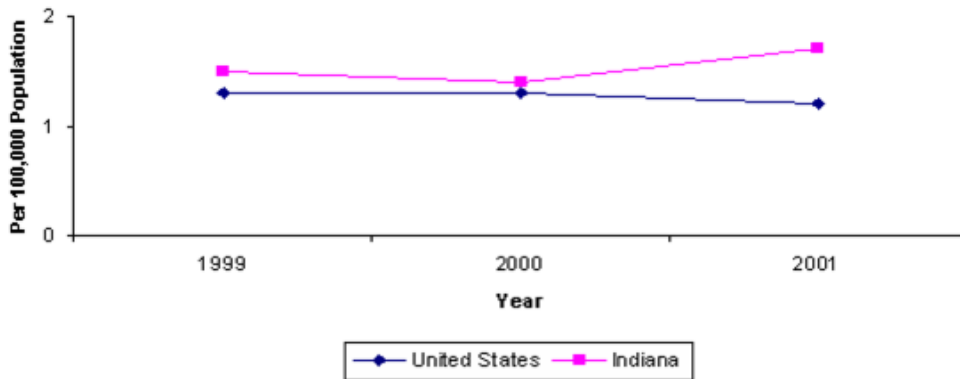
Objective #4: By 2010, reduce the number of residential fire deaths by XX%.

Indiana residential fire death rate, 2001: 1.7
 U.S. residential fire death rate, 2001: 1.2
 Healthy people 2010 goal: 0.2

In Indiana fire-related injuries are among the five leading causes of unintentional injury deaths for each age group. It is the second leading cause of unintentional injury death among Hoosiers ages 1 to 4 and 55 to 64 (based on 2001 data).

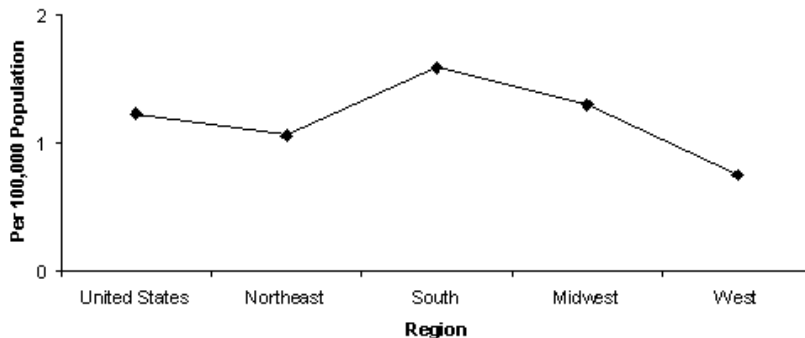
From 1999-2001, 283 persons in Indiana sustained an unintentional fatal fire-related injury at an age-adjusted rate of 1.56 per 100,000 population. This figure is higher than the national fatality rate of 1.23 per 100,000 population. Since 1999, Indiana fatality rates have been consistently higher than those of the United States. (Figure 21.)

Figure 21: Unintentional Fire-Burn Fatality Rates, United States and Indiana, 1999-2001.



Source: CDC, WISQARS

Figure 23: U.S. Fire-Related Fatality Rates by Region



For Indiana, the number of fire-related deaths stratified by age and sex are too small to make meaningful rate comparisons. However, fires remain a leading cause of unintentional injury

death among children 0 to 14 years nationally. The youngest children are at the greatest risk. Children age 5 years and younger are more than twice as likely to die in a fire compared to all other age groups. More than half of those who die in this age group are asleep at the time of the fire, and another one-third are too young to react appropriately. Since 1999, there have been thirty-three unintentional fire fatalities (12 percent of all unintentional fire-related injury deaths) among children 5 years and younger in Indiana.

Rates are consistently higher for males than for females. From 1999-2001, males in Indiana accounted for 63 percent (2.34 males per 100,000 population) of unintentional fire fatalities compared to 37 percent (1.24 females per 100,000 population) of females.

Residential Fires

Residential fires are more common and cause more deaths than any other type, accounting for approximately 85 percent of all fires in the United States. v For 2001, the most recent mortality data available, 3,796 persons died in the United States from residential fire-related injuries, accounting for seventy-four percent (2,813) of fire-related deaths.

In Indiana, considering both unintentional and intentional fire-related deaths from 1999-2001, 65 percent (209 out of 321) were residential, resulting in an age-adjusted fatality rate of 1.15 per 100,000 population. This figure is slightly higher than the national age-adjusted rate of 1.03 per 100,000 population.

In nearly 40 percent of residential fires in the United States, alcohol is involved (source) and victims die primarily of smoke inhalation or toxic gases instead of burns. Residential fires peak during the winter months of December through February, a time when heating equipment such as fireplaces, space heaters and wood stoves are used most frequently in the home.

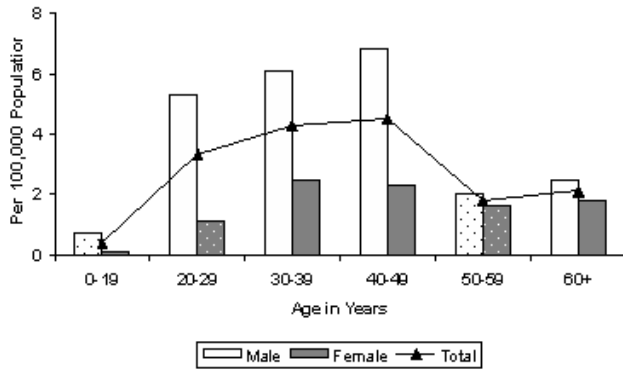
(Prevention Strategies and websites to be added)

POISONING

Poisoning is defined as the ingestion of or contact with a substance that produces toxic effects and results in bodily harm. A substantial number of poisoning deaths result from intentional behaviors, primarily suicide attempts. From 1999-2001, nearly one-fourth of all poison-related deaths in the U.S. were intentional, compared to 36% in Indiana.

Children under 6 years represent more than 50% of poison exposures, and account for 55% of the poisonings managed by the Indiana Poison Center during 2001 and 2002. Two-year-olds make up 20% of these exposures, followed by one-year-olds at 17%. The most common poison exposures for children are the ingestion of household products such as cleaning substances, pain relievers and personal care products.

Figure 9: Poisoning Fatalities by Sex and Age, Indiana 1999-2001.



Source: CDC, WISQARS

Note: Data Points with patterned dots have rates based on frequency of 20 or less and are unstable.

Goal D: Reduce poisonings in young children and teens

Objective #5. By 2009, decrease the number of hospital admissions related to poisoning by XX%.

Baseline: _____ in 2002 HP 2010 goal: _____

Indiana death rate from poisoning, 2001: 6.3

U.S. death rate from poisoning, 2001: 7.8

Healthy People 2010 goal: 1.5

Action Step. 5.A. Collaborate with the Indiana Poison Center in working on strategies to reduce poisonings in young children.

Action Step.5.B. Collaborate with the Indiana Suicide Prevention Coalition and the Indiana Poison Center to reduce the incidence of teenagers attempting suicide by an overdose of medications.

Prevention Strategies for Poisonings

Promote household poison safety by locking up all potentially poisonous household products and medicines and keeping them out of sight and reach of children.

Keep all household products and medicines in their original containers with original labels.

Always read labels before using household products and medicine and follow directions exactly.

Purchase and use household products and medications in child resistant containers whenever possible.

Promote public awareness of services provided by poison centers. Call the national poison toll-free hotline (800-222-1222) if someone has been in contact with a possibly poisonous product.

Educate children and families in their communities about poison safety.

Avoid involvement with illegal drugs such as metamphetamine.

Support the use of carbon monoxide detectors in all homes.

See the next Section on Suicide Prevention Strategies for poisonings related to suicide attempts.

Selected Websites

Indiana Poison Center www.clarian.org/poison control

American Association of Poison Control Centers (AAPCC)

www.1-800-222-1222/info/poisonHelp.asp

Poison Prevention Week Council www.poisonprevention.org

National Inhalant Prevention Coalition www.inhalants.org

Partnership for a Drug Free America www.drugfreeamerica.org/inhalants.html

Office of Pesticide Programs www.epa.gov/pesticides

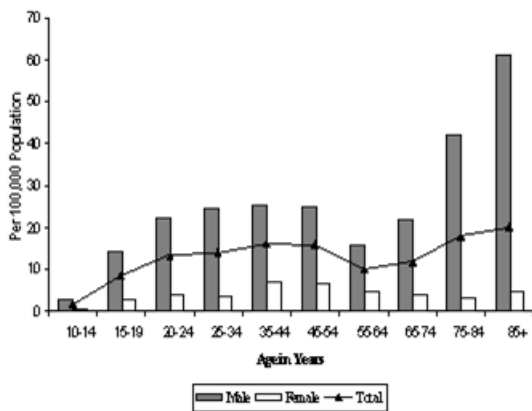
SUICIDE

Mortality due to suicide accounts for approximately 30,000 lives in the United States and more than 700 each year in Indiana. More than 264,000 Americans were treated in U.S. hospital emergency departments after attempting to take their own lives, and many suicides or suicide attempts go unreported. Each day two people in Indiana, and eighty-four people in the United States, commit suicide. Suicide ranks 11th as a cause of death, while homicide ranks 14th; it is not widely known that more people die from suicide than homicide.

Suicide rates are higher with increased age and are highest among Americans 65 years and older, especially affecting men. Suicide also disproportionately affects our youth, ranking as the third leading cause of death in 10 to 24 year-olds. Males are four times more likely to commit suicide, whereas females attempt suicide more often by ingestion of poisons. There is a shift in the methods used to commit suicide in that hanging leading to suffocation has surpassed firearms in 10 to 14 year-olds, although suicide by firearms and suffocation combined accounts for about 90% of suicide deaths in 10 to 19 year-olds.

Risk factors associated with suicide include depression, alcoholism, a recent move, an upsetting end to a relationship, exposure to a non-suicide death or recent loss, and a history of previous suicide attempts. Adolescents may show signs and symptoms of depression, which are often overlooked by family members, school personnel and health care providers.

Figure 10. Suicide Deaths by Sex and Age, Indiana 1999-2001
(Total Suicide Fatalities=2,026)



Source: CDC, WISQARS

In 1999, the Surgeon General’s Call to Action to Prevent Suicide outlined suicide prevention strategies grouped under the “umbrella” term AIM (Awareness, Intervention and Methodology). Awareness seeks to appropriately broaden the public’s awareness of suicide and its risk factors. Intervention refers to the enhancement of necessary services and programs. Methodology refers to advancing the science of suicide prevention. Suicide has been identified as a major public health issue and the Surgeon General has called for a public health approach to address it.

The Indiana Suicide Prevention Coalition has developed a comprehensive Suicide Prevention Plan for Indiana, which is available at: www.indianasuicidepreventioncoalition.org. This website provides links to other websites involved in suicide prevention.

Information on suicide prevention within Indiana schools is available through the publication “Suicide: Students at Risk-A Suicide Prevention Resource Guide for Schools” developed by the Indiana State Dept of Health and the Indiana Department of Education.

There are a number of tools that can be used to assess depression and the potential for suicide. The availability of crisis intervention services, hotlines, and easy access to mental health providers can impact the problem of suicide in Indiana. All communities should become aware of what can be accomplished to prevent suicide in their locale.

Goal E. Through collaboration with the Indiana Suicide Prevention Coalition (ISPC), reduce suicide deaths in Indiana.

Objective # 6: By 2010, reduce the number of teen suicide deaths by XX%.

Baseline: 743 deaths in 2002, rate of 12.1 HP 2010 goal: _____

#Action Step #6.A: Support the ISPC state plan to prevent suicide.

Action Step #6.B: Support community training for recognition of at-risk behavior and intervention for persons with such behavior.

Action Step #6.C: Promote screening for depression and risk of suicide in a variety of health care settings.

Suicide Prevention Strategies

Work with community or regional suicide prevention coalitions to address the issues relating to youth suicide.

Educate all young people, family members and school personnel about suicide risk and how to respond.

Know the warning signs of suicide.

Talk to teens about depression and suicide. Encourage teens to let an adult know when their friends may be depressed or suicidal.

Remove firearms from the household.

Ensure access to clinical services for evaluation and management of teen depression and suicide ideation.

Use a variety of media outlets to promote suicide prevention messages.

Support initiatives that prevent bullying.

Train gatekeepers in screening teens for depression and suicide.

Publicize crisis intervention services and suicide hotline availability.

Selected Websites

Stop a Suicide Today (www.stopasuicide.org)

American Association of Suicidology (www.suicidology.org)

Suicide Prevention Resource Center (www.sprc.org)

The American Foundation for Suicide Prevention (www.afsp.org)

National Organization for People of Color Against Suicide (nopcas.com)

SA/VE - Suicide Awareness/Voices of Education (www.save.org)

Suicide Prevention Action Network (www.spanusa.org)

Reporting on Suicide: Recommendations for the Media

(www.afsp.org/education/recommendations/index.html)

National Strategy For Suicide Prevention (www.mentalhealth.org/suicideprevention/strategy.asp)

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² Centers for Disease Control and Prevention. [Medical Expenditures Attributable to Injuries]. *MMWR* 2004; 53: [1-4].

^{iv} National Highway Traffic Safety Administration)

^v Centers for Disease Control. National Center for Injury Prevention and Control (NCIPC). NCIPC Factsheet: Fire Deaths and Injuries. Available from URL: <https://www.cdc.gov/ncipc/factsheets/fire.htm>

DATA SOURCES