Indiana Department of Health

INDIANA STATE TRAUMA CARE COMMITTEE

May 20, 2022

Email questions to: indianatrauma@isdh.in.gov

OUR MISSION:

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

OUR VISION:

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

Housekeeping

- There will be breaks in the agenda.
- There will be opportunity for Q & A during the meeting.

This meeting has been public noticed.

Introduction and approval of meeting minutes

Lindsay Weaver, M.D., FACEP

Chief Medical Officer

Indiana Department of Health

PI Subcommittee Updates

Peter Hammer, MD, FACS

Trauma Medical Director, IU Methodist

2022 PI Goals

- Decrease ED LOS for critical patients at non-trauma centers
- Increase trauma registry quiz participation
- Collect hospital level variables
- Continued EMS run sheet collection
- Work with District leadership for PI process development

Q4 2021

- 109 Hospitals reported
- 9686 cases
  - LV I & II = 4566
  - LV III = 1669
  - NTC = 3451

- 112 review cases
  - No ED admit/discharge date/time
  - We will send these cases to hospitals for additional review

- Q1 2022 will be due on **June 30th**

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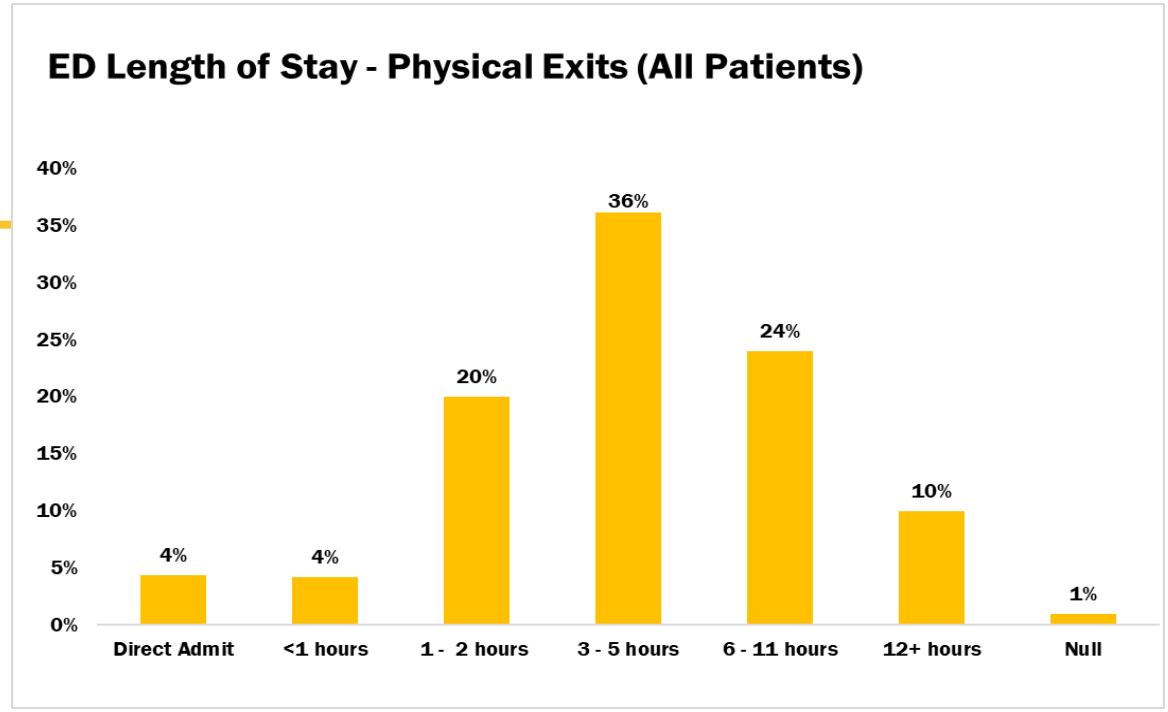
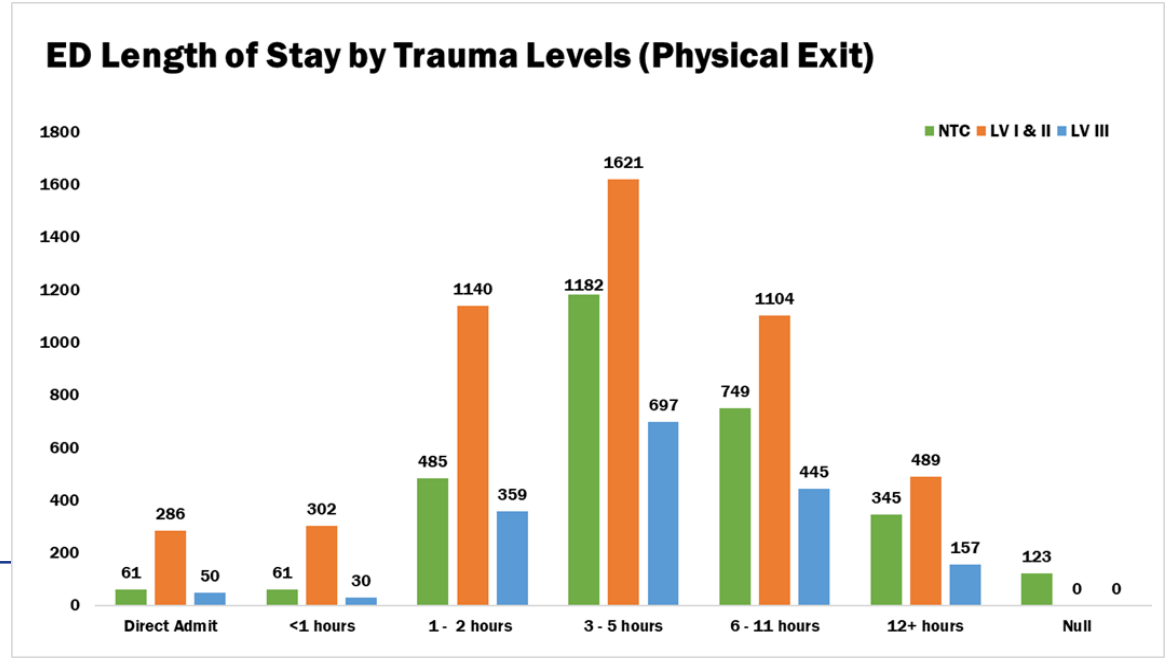
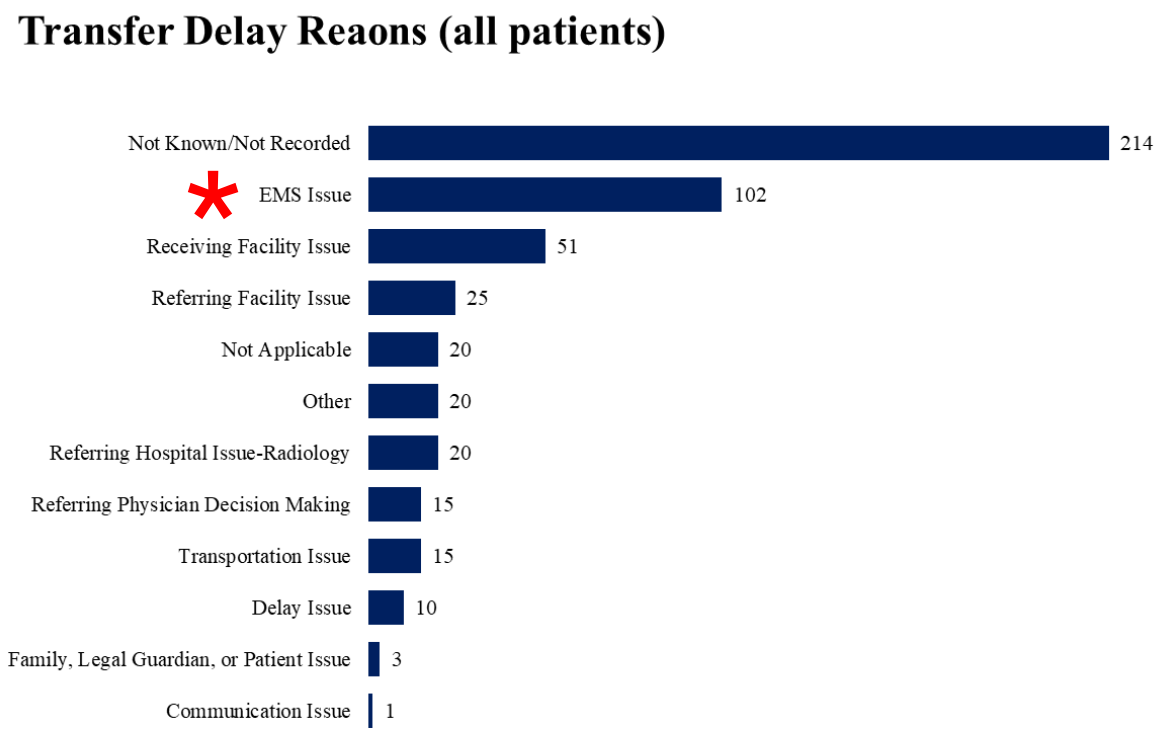
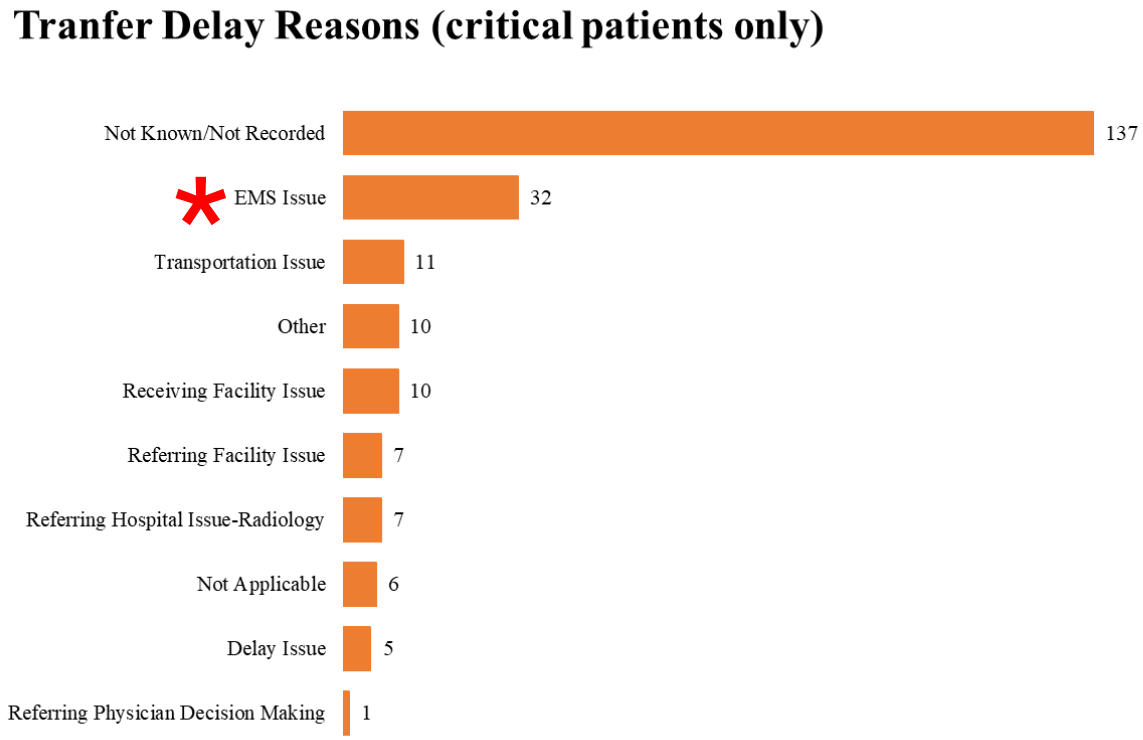




Transfer Delay (NTC only)





- **NTC = 3110**
  - Transfer Delay
    - Yes = 496
    - Critical = 226

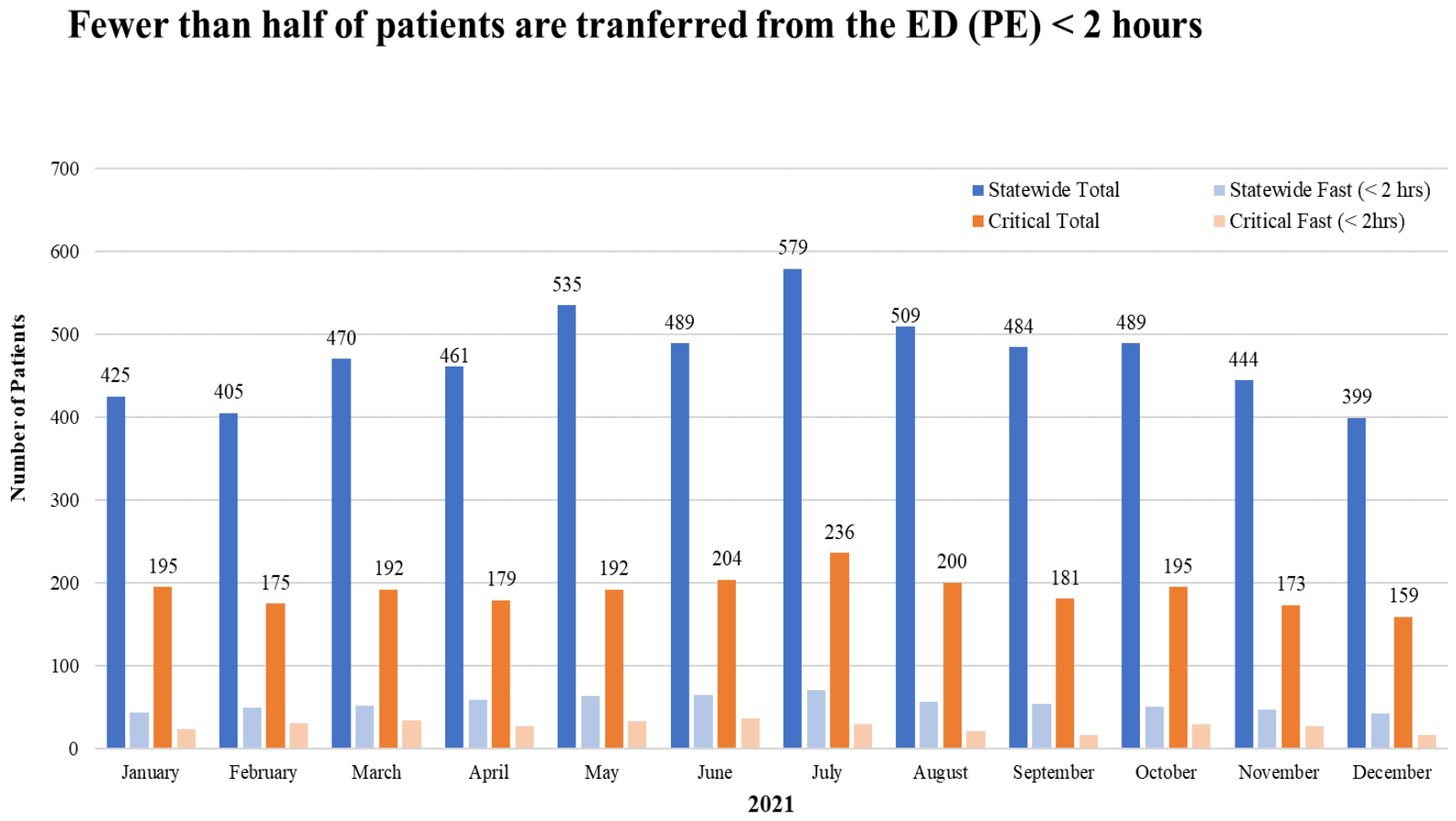
- **EMS Issue**
  - **EMR note from sending facility with more detail**

List of hospital not reporting for Q4 2021

Adams Memorial Hospital
Ascension St Vincent Mercy Hospital
Ascension St. Vincent - Kokomo
Ascension St. Vincent- Noblesville (Neighborhood Hospital)*
Ascension St. Vincent Randolph
Ascension St. Vincent Salem Hospital
Decatur County Memorial Hospital
Franciscan Health Crawfordsville
Goshen Health
Greene County General Hospital
Harrison County Hospital
Kings Daughters Health
Pulaski Memorial Hospital
Scott County Memorial Hospital
St Mary Medical Center (Hobart)
Union Hospital Terre Haute
Woodlawn Hospital

* *no qualifying cases to report*

ED Length of Stay – NTC only



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

*** Critical patient criteria for GCS will be update to ≤ 14 starting Q1 2022*

GCS Update

Indiana Trauma System - Registry Definition Update

What

Updating the definition of critical transfer patients to a Glasgow Coma Score (GCS) < 14

Old Definition – Glasgow Coma Score (GCS) < 13

New Definition - Glasgow Coma Score (GCS) < 14

Why

- The change from a GCS < 13 to a GCS < 14 was made to include patients with a GCS = 13 as "critical" due to the high-risk of mortality and to align with the CDC and Indiana Field Triage and Transfer Guidelines.
- The goal with this change is to ensure that patients are transferred to designated trauma centers within 120 minutes.

When

Effective 1st Quarter 2022 reporting period

How/Where

The definition change will impact the following reports:

- **Statewide report** - the transfer patient section (linking initial to final hospital) will be updated to reflect the definition change.

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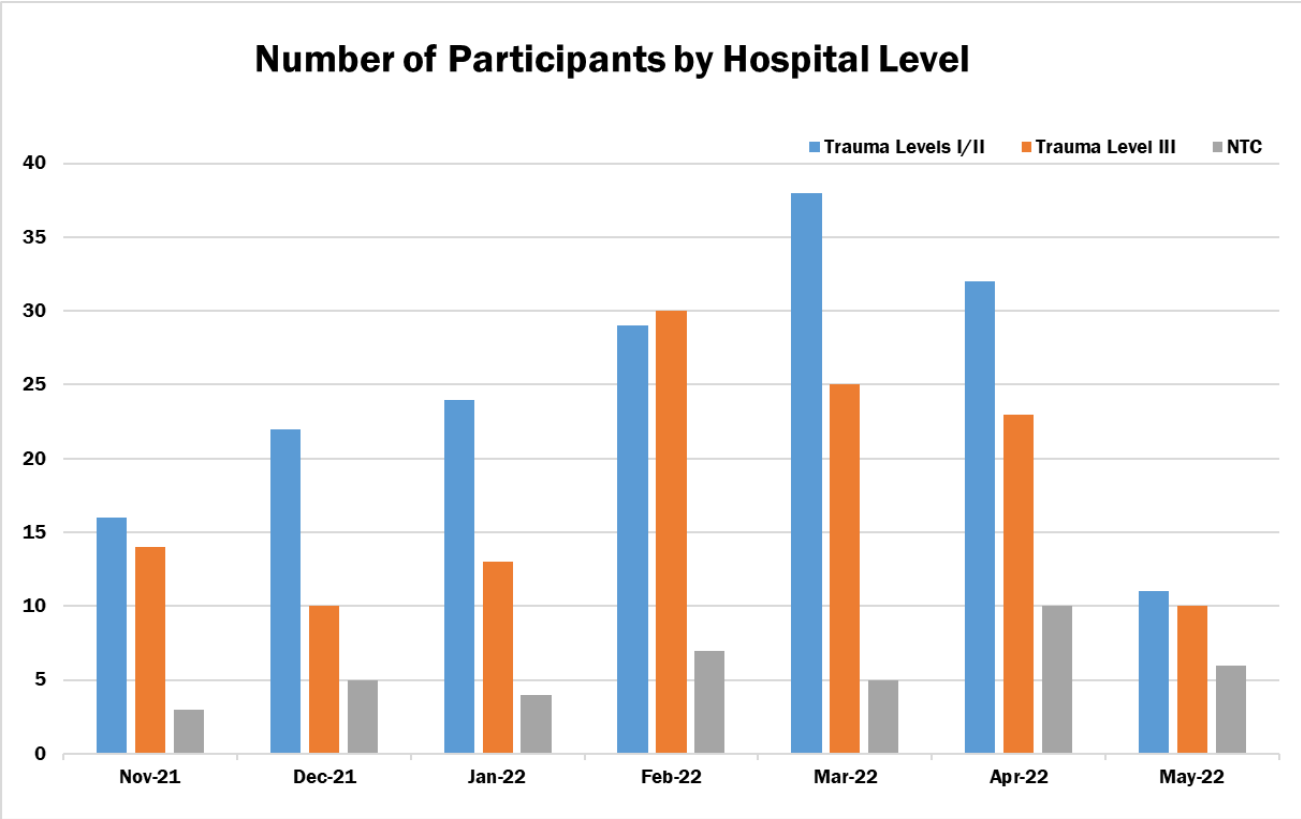
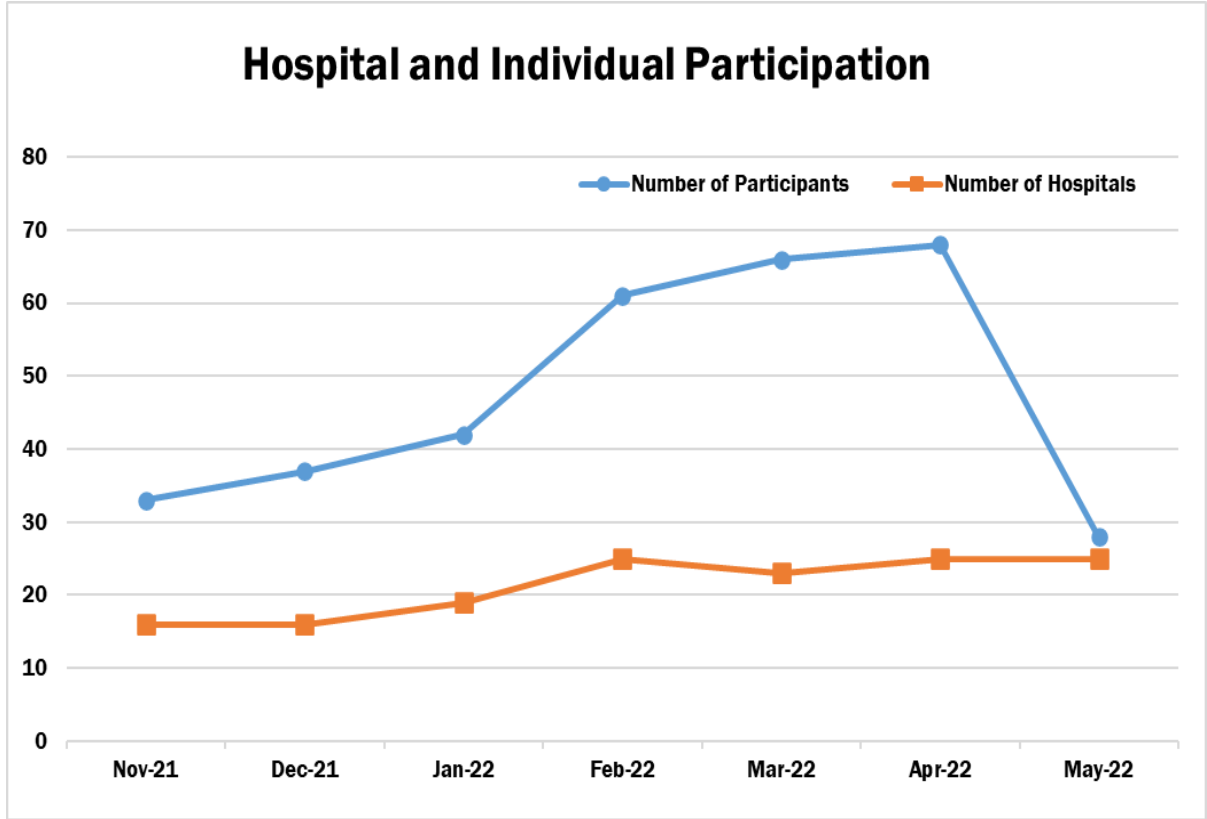
ACS Field Triage

- New Red Criteria – “Unable to follow commands (GCS Motor < 6)
  - vs GCS < 14

Trauma Registry Quiz Participation





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2022 Microsoft Teams Meeting Dates

- ❑ July 12
- ❑ September 13
- ❑ November 15

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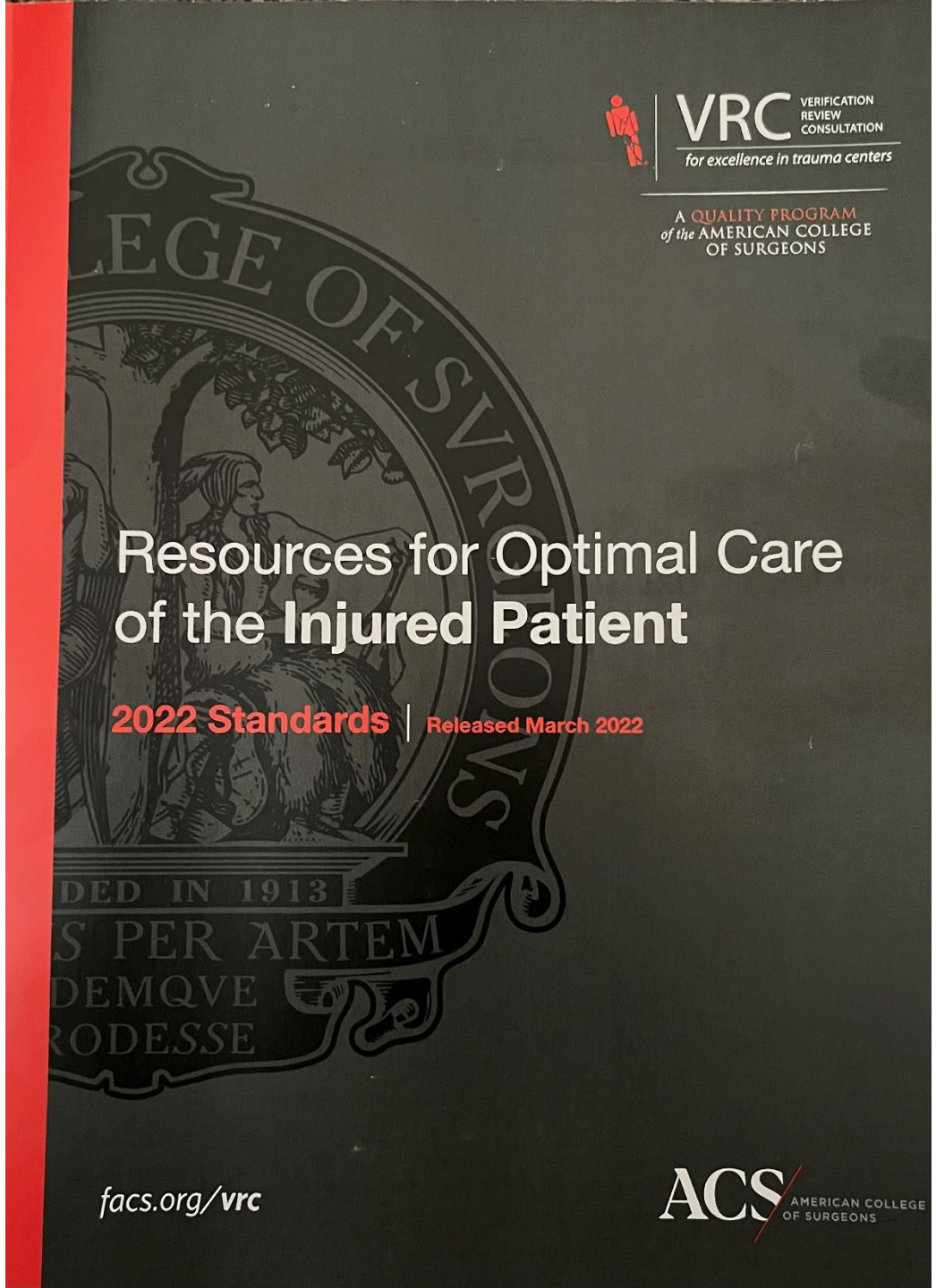
ACS Updates

Scott Thomas, MD, FACS

Trauma Medical Director, Beacon Health



- Implementation – September 2023

National Guideline for the Field Triage of Injured Patients

RED CRITERIA
High Risk for Serious Injury

Injury Patterns	Mental Status & Vital Signs
• Penetrating injuries to head, neck, torso, and proximal extremities • Skull deformity, suspected skull fracture • Suspected spinal injury with new motor or sensory loss • Chest wall instability, deformity, or suspected flail chest • Suspected pelvic fracture • Suspected fracture of two or more proximal long bones • Crushed, degloved, mangled, or pulseless extremity • Amputation proximal to wrist or ankle • Active bleeding requiring a tourniquet or wound packing with continuous pressure	**All Patients** • Unable to follow commands (motor GCS < 6) • RR < 10 or > 29 breaths/min • Respiratory distress or need for respiratory support • Room-air pulse oximetry < 90% **Age 0–9 years** • SBP < 70mm Hg + (2 x age years) **Age 10–64 years** • SBP < 90 mmHg or • HR > SBP **Age ≥ 65 years** • SBP < 110 mmHg or • HR > SBP

Patients meeting any one of the above RED criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

YELLOW CRITERIA
Moderate Risk for Serious Injury

Mechanism of Injury	EMS Judgment
• High-Risk Auto Crash – Partial or complete ejection – Significant intrusion (including roof) • >12 inches occupant site OR • >18 inches any site OR • Need for extrication for entrapped patient – Death in passenger compartment – Child (Age 0–9) unrestrained or in unsecured child safety seat – Vehicle telemetry data consistent with severe injury • Rider separated from transport vehicle with significant impact (eg, motorcycle, ATV, horse, etc.) • Pedestrian/bicycle rider thrown, run over, or with significant impact • Fall from height > 10 feet (all ages)	**Consider risk factors, including:** • Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact • Anticoagulant use • Suspicion of child abuse • Special, high-resource healthcare needs • Pregnancy > 20 weeks • Burns in conjunction with trauma • Children should be triaged preferentially to pediatric capable centers **If concerned, take to a trauma center**

Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)

- Consolidate criteria into 2 catagories
  - High risk for serious injury
  - Moderate risk for serious injury
- Structure/format re-imagined
  - Align better with information flow to EMS
  - Align better with how FTG's were being used

NHTSA
NATIONAL HIGHWAY TRAFFIC SAFETY ADMINISTRATION

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AMERICAN COLLEGE OF SURGEONS

2021 Revision Process

- Systemic review of current FTG literature
  - Clearly defined thresholds for addition/deletion of criteria
- EMS input integral to revision process
  - Expanded expert panel
- NHTSA funding/support

EMS Feedback

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- FTG are widely used by EMS in the U.S.
  - Prior versions seen to be overly complex
- Stepwise approach felt to be useful
  - But mechanism/injury is evaluated first and drives most decisions

"I see the wreck before I see the patient"

"I see the patient before I know the BP"

Nat'l – Field Triage Guidelines

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National Guideline for the Field Triage of Injured Patients

RED CRITERIA

High Risk for Serious Injury

Injury Patterns	Mental Status & Vital Signs
• Penetrating injuries to head, neck, torso, and proximal extremities	**All Patients**
• Skull deformity, suspected skull fracture	• Unable to follow commands (motor GCS < 6)
• Suspected spinal injury with new motor or sensory loss	• RR < 10 or > 29 breaths/min
• Chest wall instability, deformity, or suspected flail chest	• Respiratory distress or need for respiratory support
• Suspected pelvic fracture	• Room-air pulse oximetry < 90%
• Suspected fracture of two or more proximal long bones	**Age 0-9 years**
• Crushed, degloved, mangled, or pulseless extremity	• SBP < 70mm Hg + (2 x age years)
• Amputation proximal to wrist or ankle	**Age 10-64 years**
• Active bleeding requiring a tourniquet or wound packing with continuous pressure	• SBP < 90 mmHg or • HR > SBP
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Field Triage Guidelines

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YELLOW CRITERIA

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2021 FTG's

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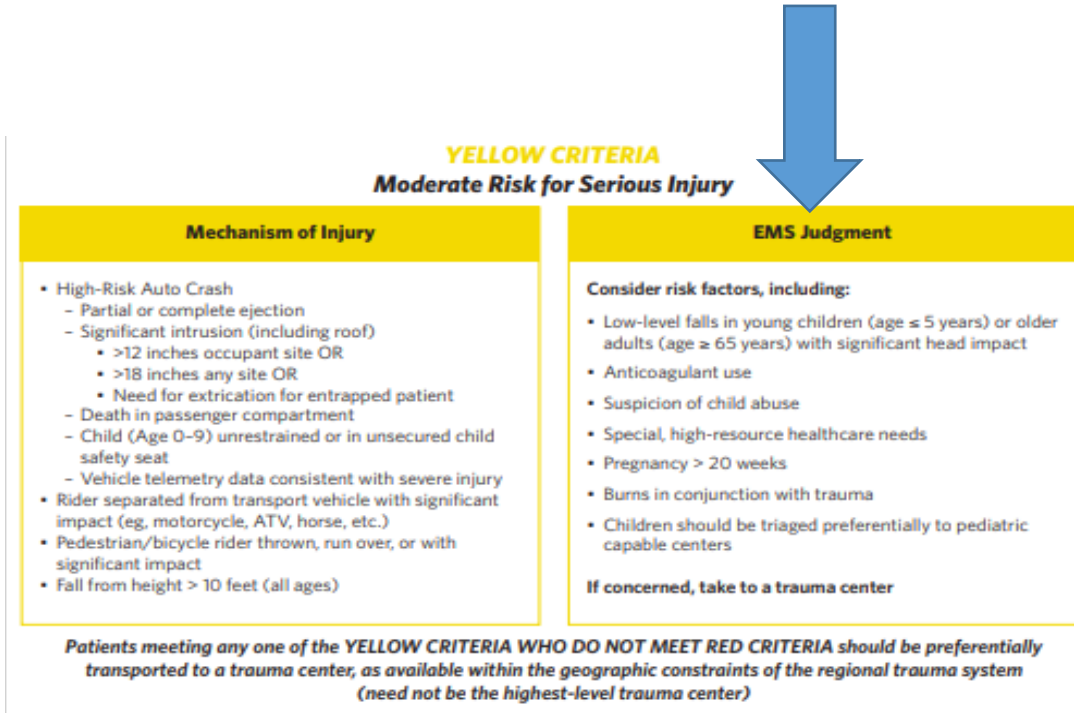

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Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)

- EMS judgement section now includes factors that the expert panel felt were important to consider, but which lacked a robust and consistent evidence base

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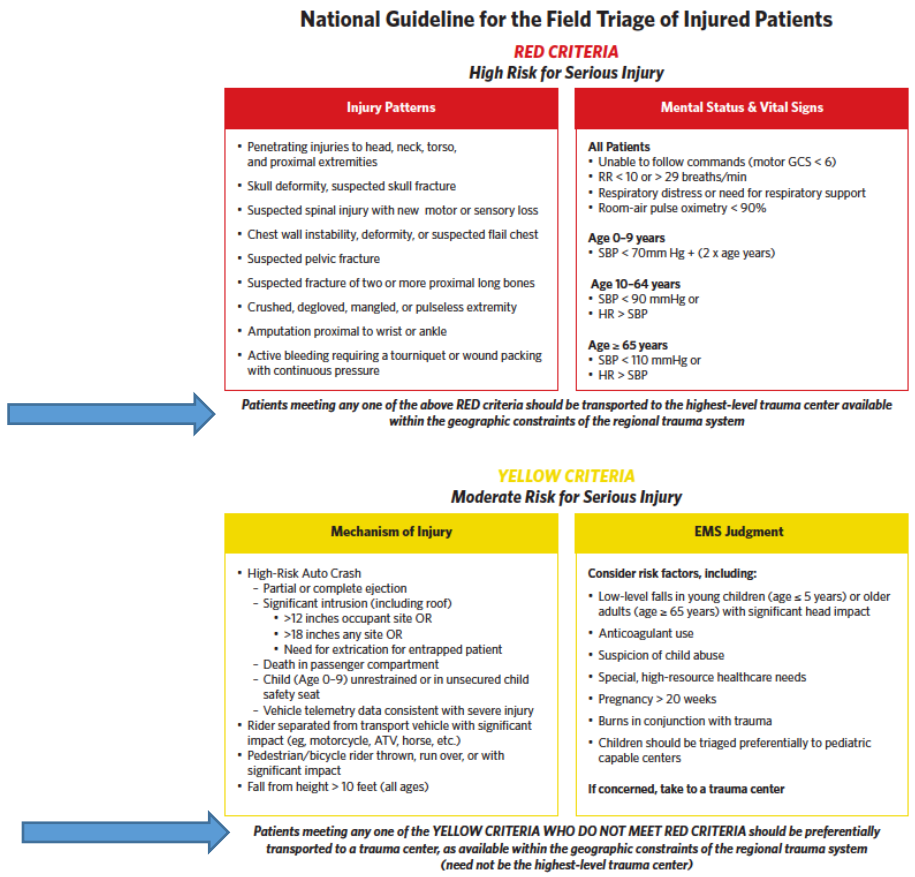

National Guideline for the Field Triage of Injured Patients

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Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)

- Each risk category is aligned with recommendations for selection of a destination hospital
- Organized by risk of serious injury
  - Transport recommendations aligned with level of risk

Transport recommendations

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- Goal
  - “Right Patient, Right Place, Right Time”
  - Patients meeting “ high risk” risk criteria should be triggered to the highest level trauma center within the region – whenever possible
- No “ one size fits all”
  - Account for regional differences
- Guidelines designed to help EMS identify patient who should go to a trauma center
- NOT meant to dictate how trauma teams are activated at the trauma center

Trauma System Consultation

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John Armstrong MD FACS

IDHS/EMS Updates

Kraig Kinney

State Director and Counsel of EMS

Emergency Medical Services

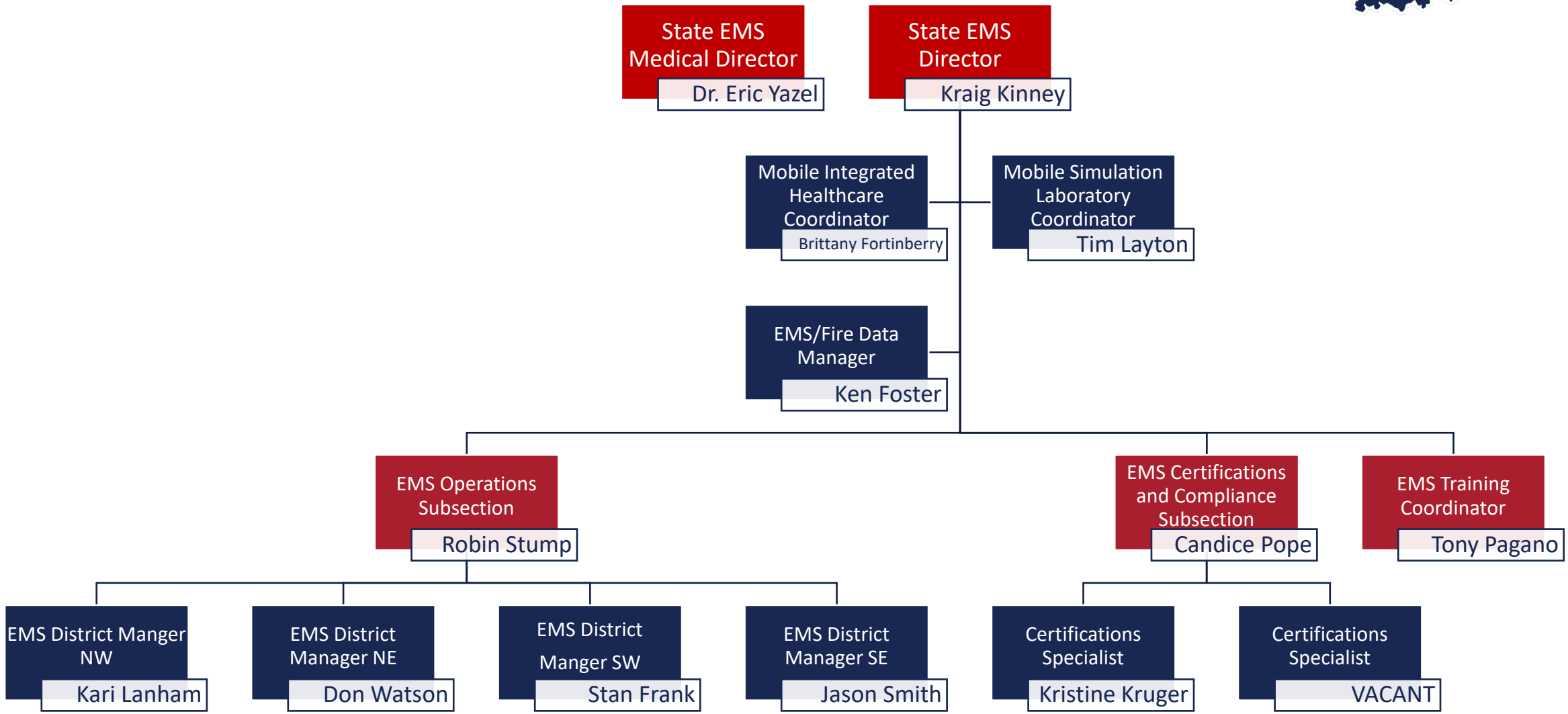
- The Indiana Emergency Medical Services is created in statute in IC 16-31-2-1.
- The EMS Commission is the body that develops EMS policy and authorizes certification of EMS personnel and organizations.
- EMS Commission members are appointed to four (4) year terms (no term limits on renewal appointments) by the Governor in specific categories.

Emergency Medical Services – EMS Section

- While the EMS Commission sets the policy and provides oversight functions, the Indiana Department of Homeland Security is the administrative agency that handles EMS operations and implements EMS Commission directives.

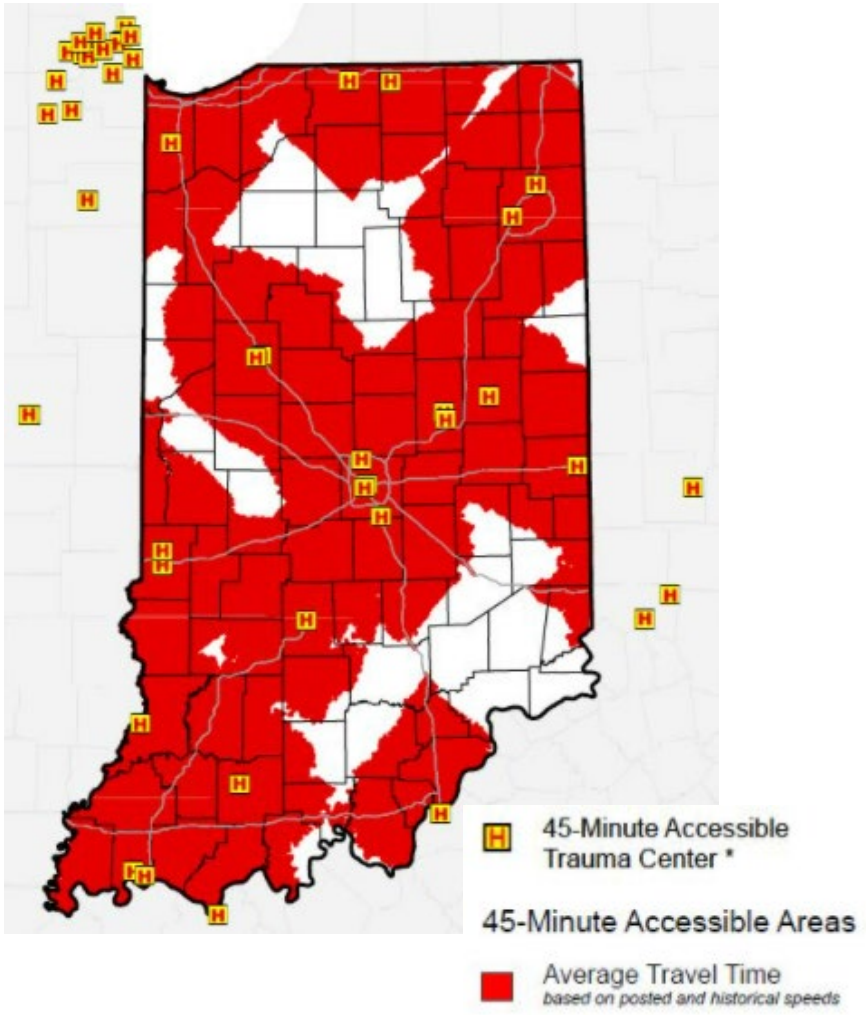
EMS is a section of the Division of Fire and Building Safety that falls under direction of the State Fire Marshal.

EMS Section Organization Chart



New State EMS Medical Director– Dr. Eric Yazel

Significant improvements over the last decade but gaps remain



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

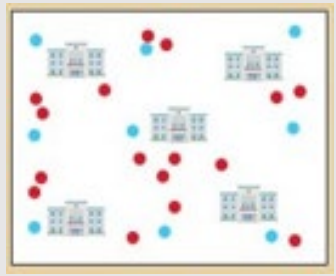
Number of IN Trauma Centers by Level and Location

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

Close the Urban/Rural EMS Gap

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

Urban/Suburban County, IN
Pop. 338,000



Time to definitive care = minutes

16 ambulances available 24/7

45 ALS capable apparatus

Ave Response Time = 3 minutes

Ave Transport Time = 5 minutes

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

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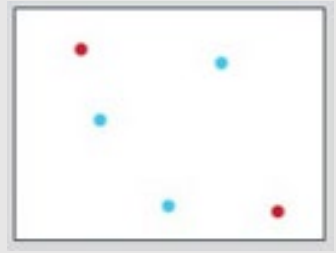
Rural County, IN
Pop. 15,498



Time to definitive care = hours

2 ambulances available 24/7

8 BLS non-transport apparatus

Ave Response Time = 17 minutes

Ave Transport Time = 30 minutes

No destination facilities in county

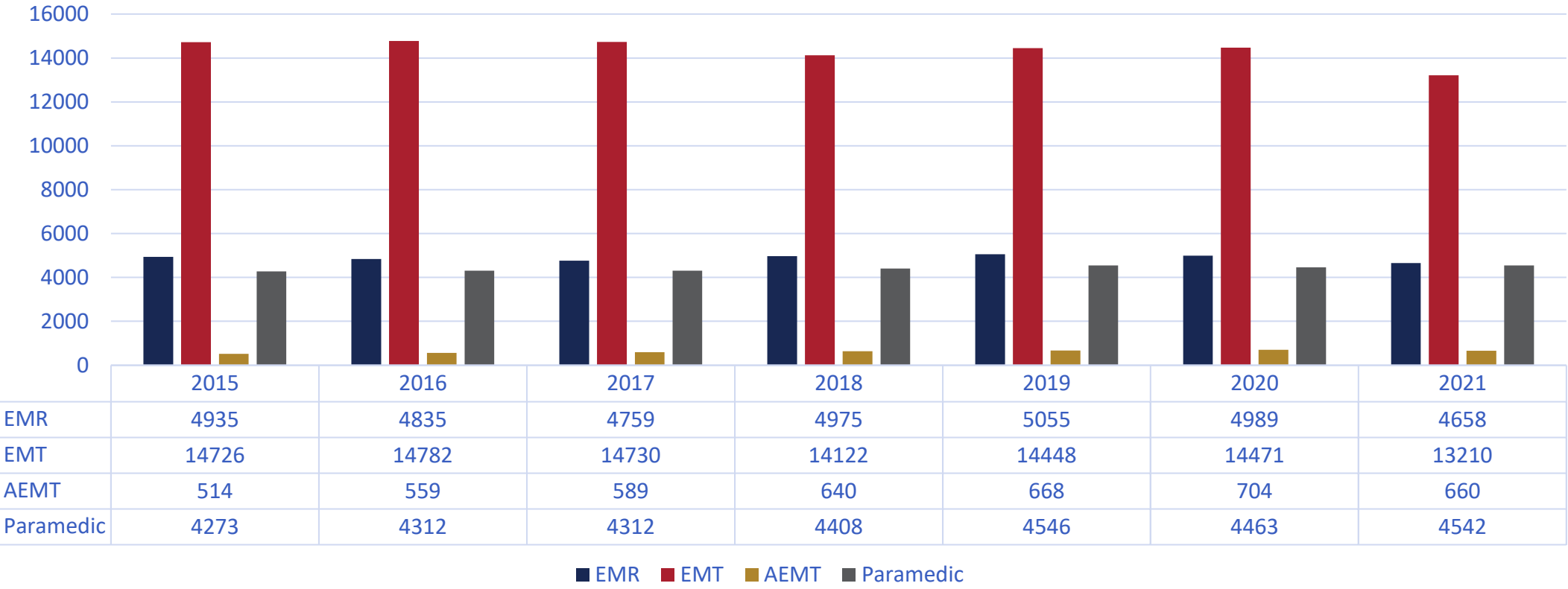
Air transport available outside county

Transport time to trauma center = 5 hours roundtrip

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

State of Indiana EMS Personnel

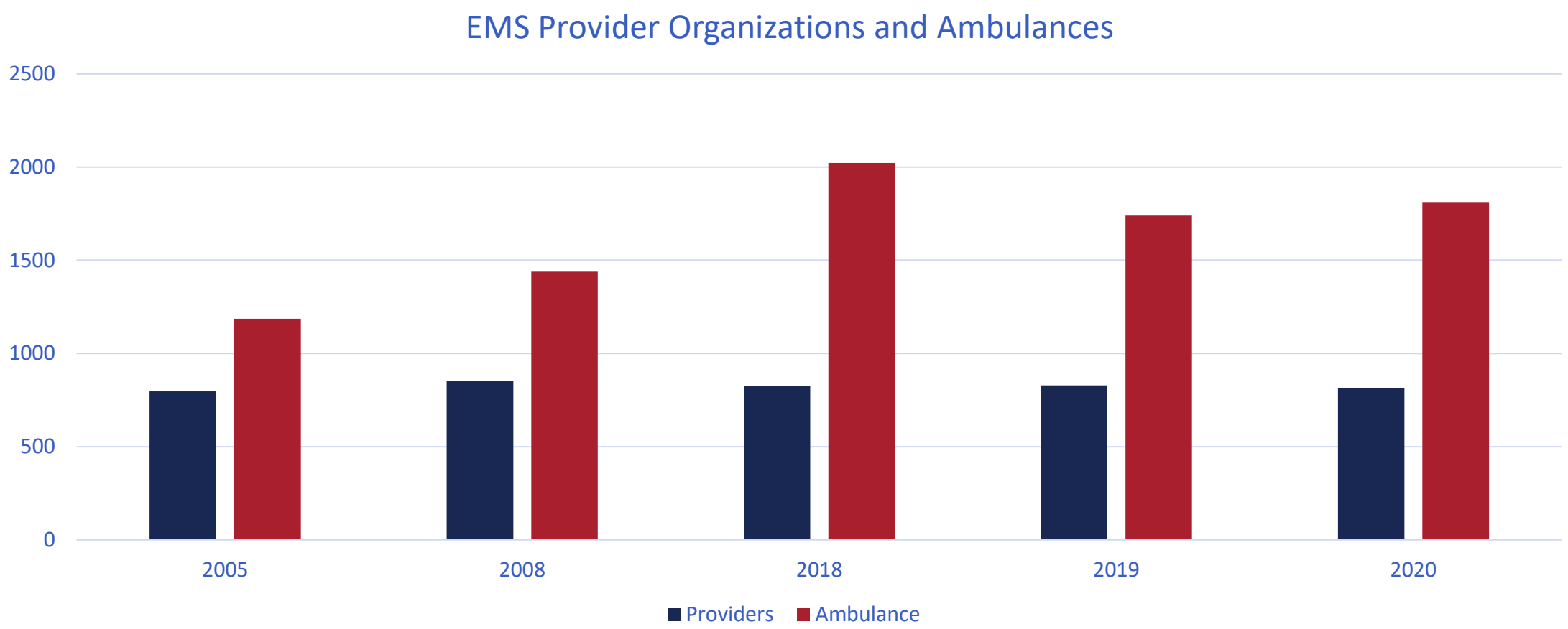
EMS Personnel Certifications by Group 2005-2021



	2015	2016	2017	2018	2019	2020	2021
EMR	4935	4835	4759	4975	5055	4989	4658
EMT	14726	14782	14730	14122	14448	14471	13210
AEMT	514	559	589	640	668	704	660
Paramedic	4273	4312	4312	4408	4546	4463	4542

Source: Indiana Department of Homeland Security ACADIS Certifications Database Records

Status of Indiana Ambulances



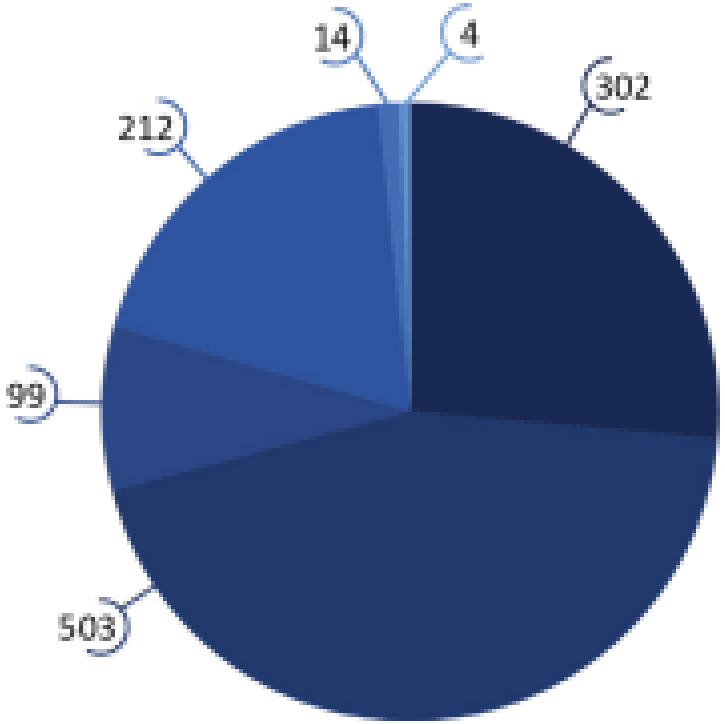
Source: Indiana Department of Homeland Security ACADIS Certifications Database Records

Provider organizations for 2021

Organization Certification Statistics (as of Dec. 31, 2021)

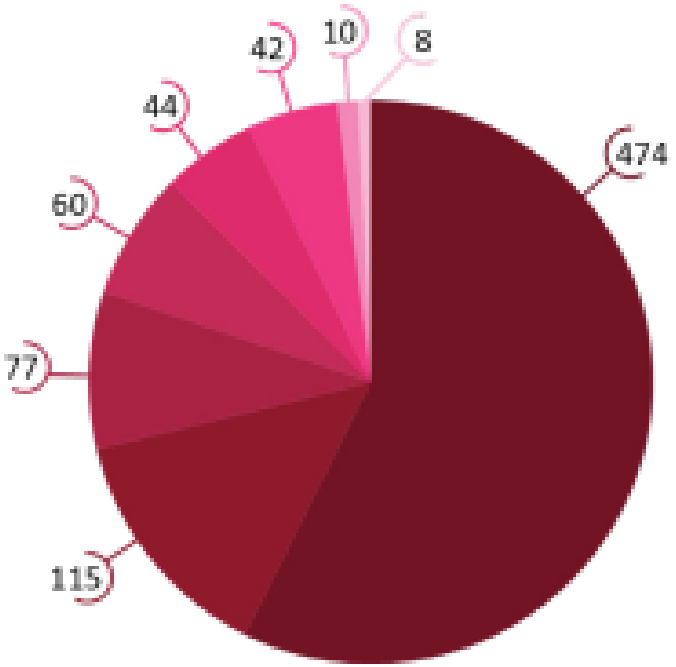
Total provider organizations: 831

- Transporting ambulance service providers
- BLS non-transport providers
- BLS transport providers
- Paramedic provider organizations
- Rotorcraft organizations



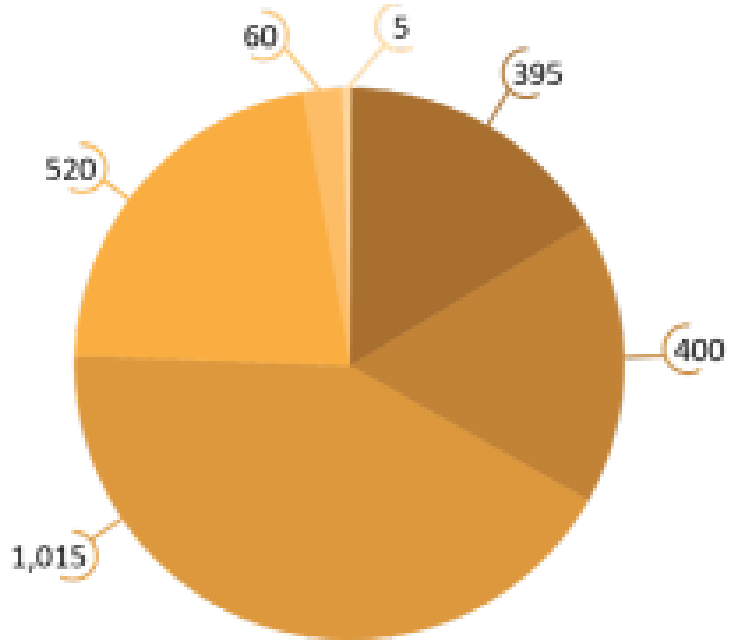
Provider organizations by organization structure for 2021

Providers organization by type:	831
Volunteer Fire	
Paid Fire	
Governmental	
Private	
Hospital based	
Volunteer Ambulance	
Industrial	
Other	

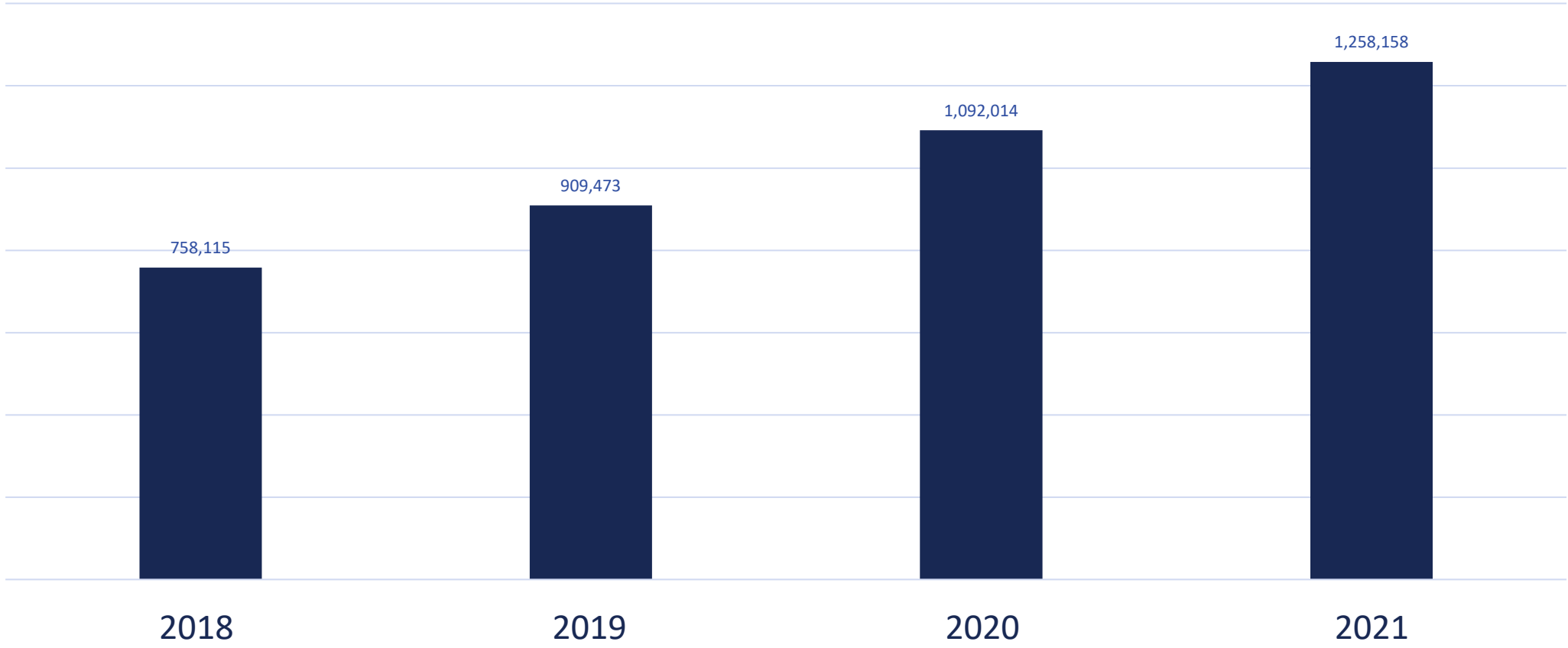


Certified EMS Vehicles by type for 2021

Certified vehicles by type:	2,396
Type I (Ambulance)	
Type II (Ambulance)	
Type III (Ambulance)	
ALS Non-transport	
Rotorcraft	
Fixed Wing	

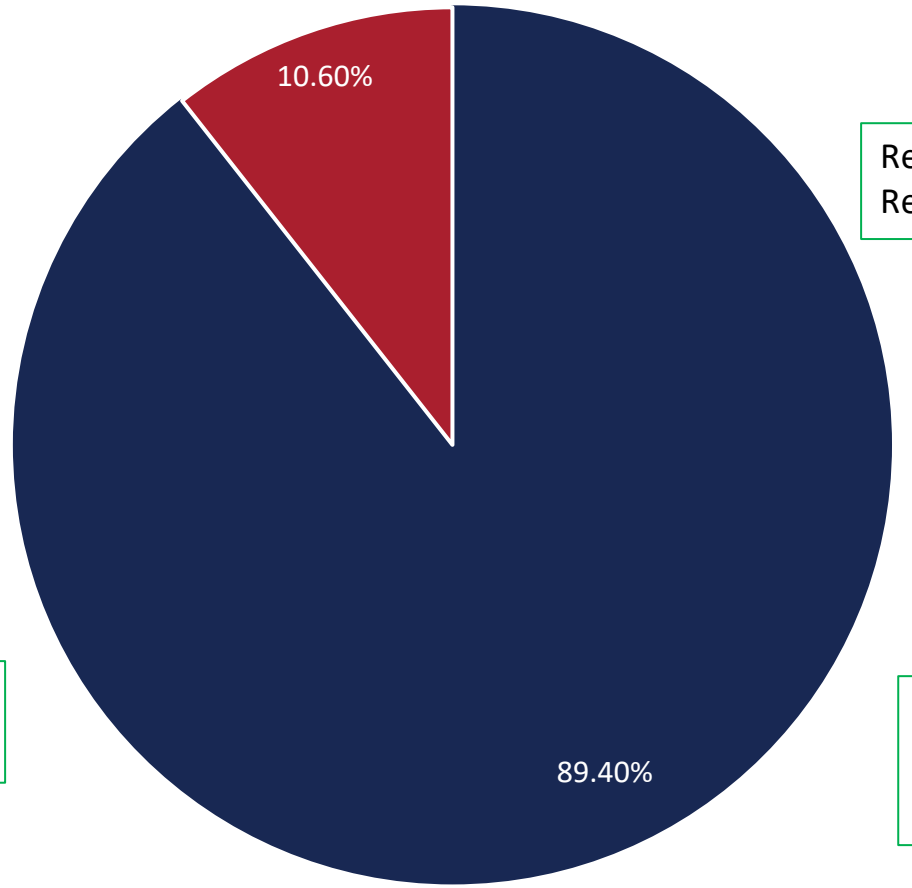


Annual Indiana EMS Run Volume - YOY



EMS Agency Reporting Percentage: Required to Report

5/2/22-5/15/22



Required to Report = 322
Reporting = 288

Average Daily ePCRs
2,464

Year to Date
Patient Care Reports
333,471

MIH Programs addressing trauma prevention

- IDHS EMS is tracking mobile integrated healthcare (MIH) programs.
- A common area is trauma prevention, specifically falls.
- These 14 approved MIH programs have a component that includes injury prevention.

1. Boone County EMS/Witham Health Services
2. City of Bloomington Fire Department
3. Crawfordsville Fire Department
4. Daviess Community Hospital
5. Good Samaritan Hospital
6. Indiana University Health Ball Hospital
7. Monticello Fire Department
8. New Castle-Henry County EMS
9. Noblesville Fire Department
10. Parkview Health
11. Richmond Fire Department
12. Scott Township Fire and EMS
13. Warsaw-Wayne Fire Territory
14. Zionsville Fire Department.

2022 Legislative Recap for EMS

- **<u>SEA 247 (2022) Report on 911 and Regionalized Trauma Care</u>**
- IDHS, IDOH, Statewide 911 Board, & Integrated Public Safety Commission Recommendations
  - Authority: IC 10-19-2.1-3
- Requirement: Not later than October 1, 2022, the agencies shall develop and submit recommendations to LSA regarding:
  1. Ways that the 911 system can increase interoperability to better facilitate an emergency medical services response for the closest and most appropriate source; and
  2. The effectiveness of regionalized trauma systems and the impact of regionalized trauma systems on patient care
- In doing so, the agencies may consult stakeholder groups such as EMS provider organizations, fire departments, hospitals or other emergency medical facilities, or units of local government.

**** This is on the Agenda for discussion later in the meeting**

2022 Legislative Recap for EMS

- **HEA 1314 (2022) is the IDHS agency bill that was amended to become a Public Safety bill.**
- **Section 11** – Requires IDHS, IDOH, the Integrated Public Safety Commission, and the Statewide 911 Board to make recommendations to the General Assembly regarding: 1) ways the 911 system can increase interoperability for EMS responses, and 2) the effectiveness of regionalized trauma systems and the impact on patient care
  - This provision is in response to discussions that arose during the 2021 Interim Study Committee on Public Health, Behavioral Health, and Human Services - Trauma Care hearing
- **Section 19** – Modernizes the definition of "emergency medical services" to account for care rendered without transportation and care provided during interfacility transfers
  - The current definition does not include two significant aspects of EMS – providing care to a patient when the patient does not need to be transferred to a hospital and providing care to a
  - patient while transferring the patient from one hospital to another hospital if a higher level of care is needed for the patient
- **Section 20** – Amends the definition of "emergency patient" to remove reference to transportation
  - The current definition is outdated as EMS often renders care without transporting the patient

2022 Legislative Recap for EMS

- **Section 26** - Allows the EMS Commission or IDHS to share certain EMS data with another entity for the purpose of improving patient care and outcomes.
- Allows the EMS Commission or IDHS to harness the data EMS providers share with IDHS in order to identify and address trends in patient health outcomes
- **Section 27 –** Requires EMS licensed and certified personnel to report a criminal conviction within 90 days of a criminal conviction for a misdemeanor or felony.
- **Section 29** – Update IC 16-31-3-26 to remove old “audit and review” language to more current “quality assurance program”. Removes (a)(1) through (a)(6) but leaves (a) through (d) so rules can be adopted and keeps confidentiality.

  (a) Each provider organization shall participate in a written quality assurance program. Proceedings under this section are confidential, and any communication related to the quality assurance program is considered a privileged communication.

  (b) This section does not prevent participation by a provider

  organization in a peer review committee proceeding under IC 34-30-15.

  (c) The commission may adopt rules under IC 4-22-2 to implement this section.

2022 Legislative Recap for EMS

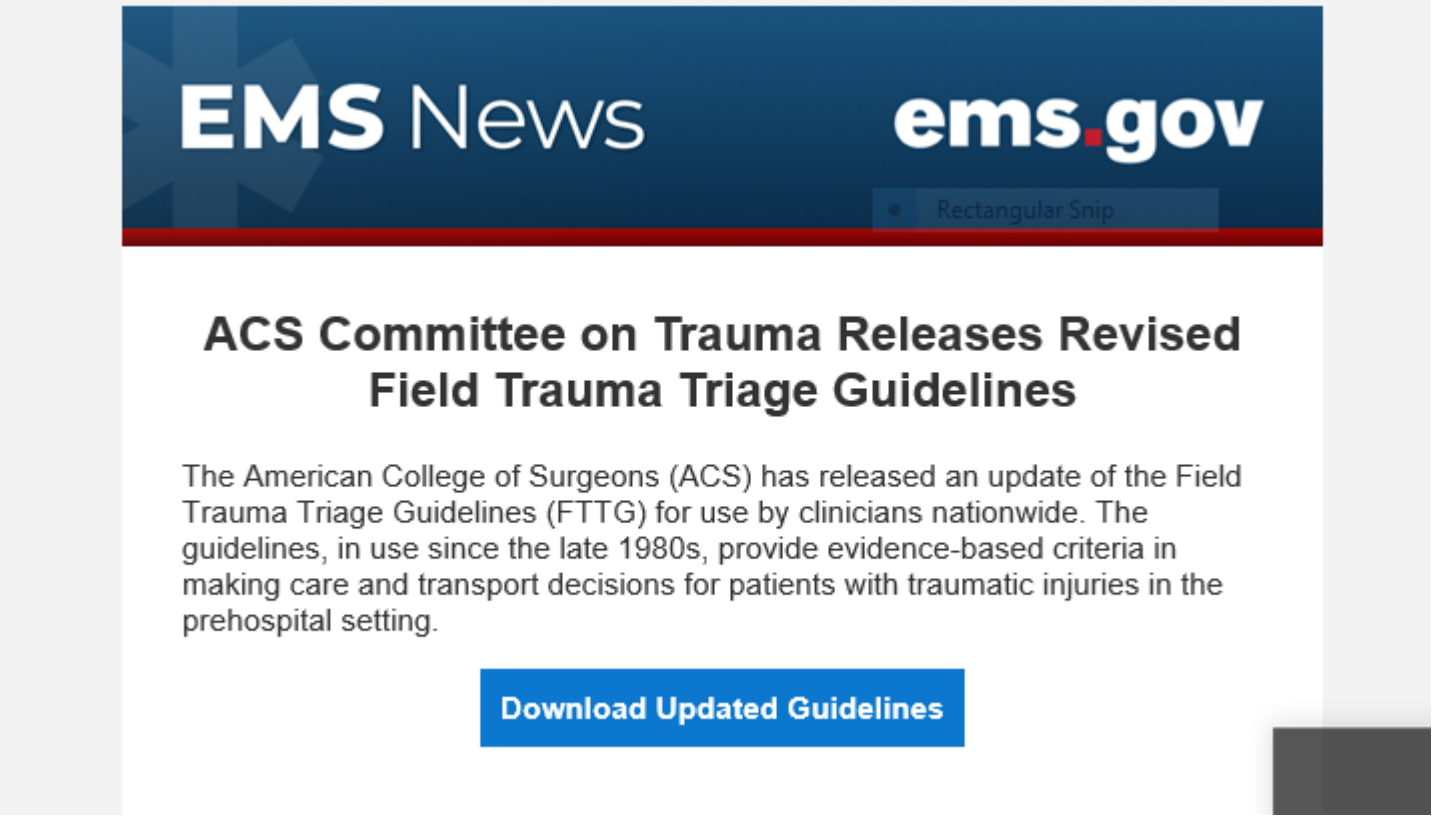
- **Section 36** – Requires a health plan operator to fairly negotiate rates and terms with an ambulance service provider willing to become a “participating provider” and provides that if negotiations do not result in the ambulance service provider becoming a “participating provider” both entities must keep certain records regarding the negotiations for two years
- **Section 37** – Requires certain life, accident, and health insurance plans that provide reimbursement for different types of EMS care must provide reimbursement on an equal basis regardless if the service involves transporting the patient

•**Section 38** - Requires certain accident and sickness insurance policies or HMOs that provide reimbursement for EMS must also provide reimbursement for certain ambulance services or specialty care transport services

•**Section 39** - Requires certain health maintenance organization plans that provide reimbursement for different types of EMS care must provide reimbursement on an equal basis regardless if the service involves transporting the patient.

ACS Committee on Trauma Revised Field Trauma Triage Guidelines

- The guidelines, in use since the late 1980s, provide evidence-based criteria in making care and transport decisions for patients with traumatic injuries in the prehospital setting.



Rule 2.1. Certification of Ambulance Service Providers - Trauma Field Triage and Transport Destination Protocol

- **The ACS Trauma guidelines are adopted into the EMS rules so likely a rule change will be needed to adopt and implement.**

EMS District Forums and Leadership

Northwest	Thursday, August 11, 2022, 0800-1700 EST
	Monticello Fire Department, 120 W Washington St, Monticello, IN 47960
Northeast	Thursday, September 8, 2022, 0800-1700 EST
	Central Christian Church, 500 Macgahan St, Huntington, IN 46750
Central	Thursday, July 14, 2022, 0800-1700 EST
	MADE, 1610 Reeves Rd., Plainfield, IN 46168
Southwest	Thursday, October 6, 2022, 0800-1700 EST
	Greene County Fairgrounds
Southeast	Thursday, November 10, 2022, 0800-1700 EST
	Redeemer Lutheran Church, 504 N Walnut St, Seymour, IN 47274 (back entrance)

Celebrating EMS…

QUESTIONS?
COMMENTS?
FEEDBACK?

iEMSC Updates

Dr. Elizabeth Weinstein, MD, FAAEM, FACEP, FAAP

Director, Indiana Emergency Medical Services for Children

Pediatric Readiness and ACS COT Trauma Designation

Elizabeth Weinstein, MD

Indiana Emergency Medical Services for Children

ACS COT Orange Book 2023

In all trauma centers, the emergency department must evaluate its pediatric readiness and have a plan to address any deficiencies.

Compliance: Gap analysis with plan to address deficiencies in pediatric readiness

ACS-COT Orange Book

What is ”Pediatric Readiness?”

Refers to the infrastructure, administration and coordination of care, personnel, pediatric-specific policies, equipment, and other resources that ensure the center is prepared to provide care to an injured child.

ACS-COT Orange Book

The National Pediatric Readiness Project (NPRP) is a multi-phase quality improvement initiative to ensure that all U.S. emergency departments have the essential guidelines and resources in place to provide effective emergency care to children.

THE PROJECT IS SUPPORTED BY THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, THE EMERGENCY NURSES ASSOCIATION, THE AMERICAN ACADEMY OF PEDIATRICS, AND THE FEDERAL EMERGENCY MEDICAL SERVICES (EMS) FOR CHILDREN PROGRAM

Why is readiness important?

Hospitals with high ED readiness scores demonstrate **a 4-fold lower rate of mortality for children** with critical illness than those with lower readiness scores; thus, improving pediatric readiness improves outcomes for children and their families.

99% OF INDIANA HOSPITALS COMPLETED THE 2021 ASSESSMENT

Assessment Tool

189 Items on the assessment

82 Items Scored for *"Pediatric Readiness"*

Perfect Score = 100

How did my ED participate?

Generally, your ED nurse managers collaborated with your ED leadership to participate in the NPRP assessment.

ED Nurse Managers who completed the NPRP assessment immediately received:

- A pediatric readiness score from 0 – 100
- The avg pediatric readiness score of EDs of similar pediatric volume
- The avg pediatric readiness score of all participating EDs to use as a benchmark
- **An ED Gap Report to target efforts for improvement in pediatric readiness**

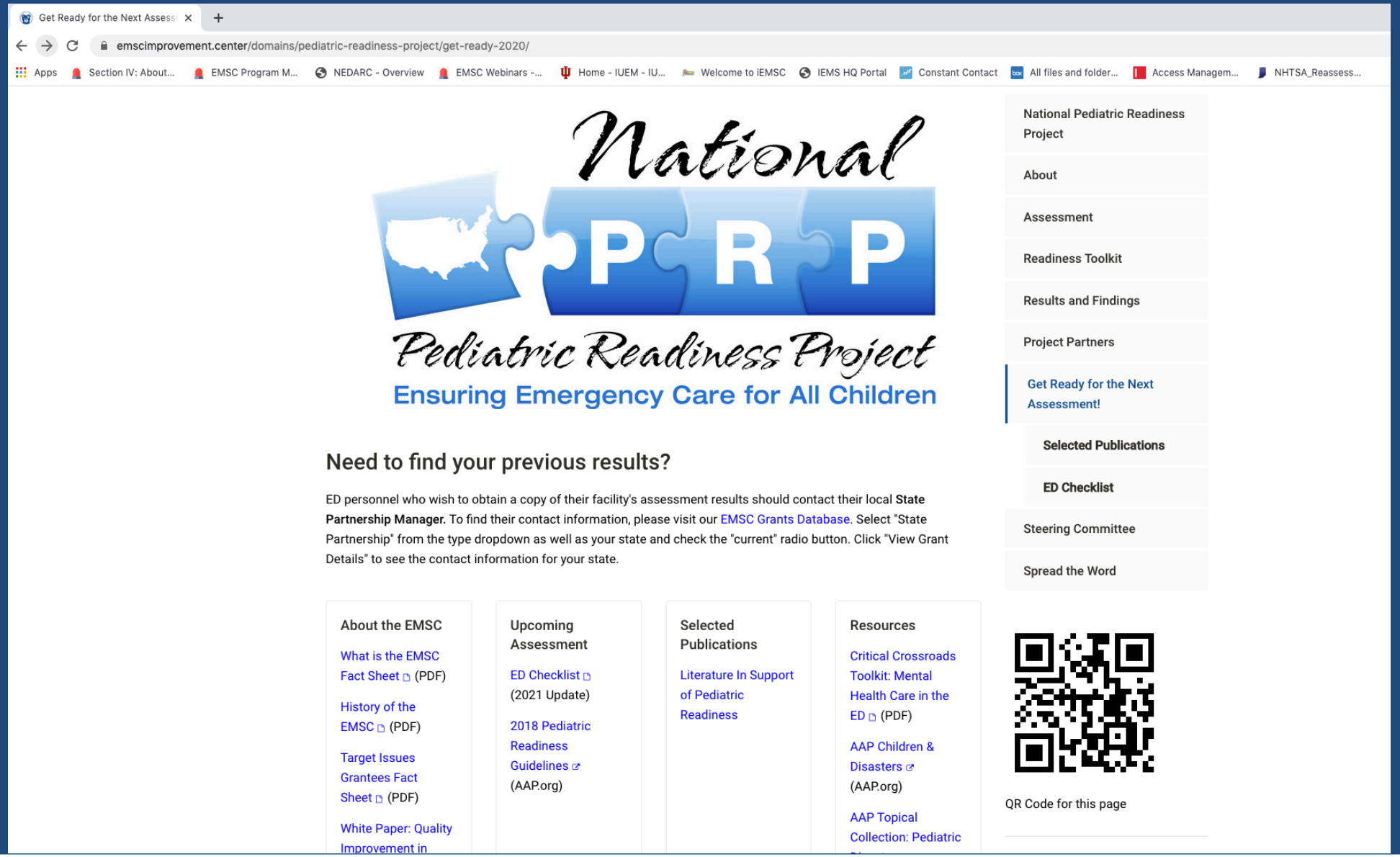
Assessment Tool

6 Major Sections

- Coordination (19 pts)
- Staffing (10 pts)
- QI/PI (7 pts)
- Safety (14 pts)
- Policies (17 pts)
- Equipment (33 points)

What now?

- Finding your data
- Interpreting results
- Addressing gaps
- EMSC is here to help!


Get Ready for the Next Assess
emscimprovement.center/domains/pediatric-readiness-project/get-ready-2020/
Apps
Section IV: About...
EMSC Program M...
NEDARC - Overview
EMSC Webinars -...
Home - IUEM - IU...
Welcome to iEMSC
IEMS HQ Portal
Constant Contact
All files and folder...
Access Managem...
NHTSA_Reassess...
National
PRP
Pediatric Readiness Project
Ensuring Emergency Care for All Children
National Pediatric Readiness Project
About
Assessment
Readiness Toolkit
Results and Findings
Project Partners
Get Ready for the Next Assessment!
Selected Publications
ED Checklist
Steering Committee
Spread the Word
Need to find your previous results?
ED personnel who wish to obtain a copy of their facility's assessment results should contact their local State Partnership Manager. To find their contact information, please visit our EMSC Grants Database. Select "State Partnership" from the type dropdown as well as your state and check the "current" radio button. Click "View Grant Details" to see the contact information for your state.
About the EMSC
What is the EMSC Fact Sheet (PDF)
History of the EMSC (PDF)
Target Issues Grantees Fact Sheet (PDF)
White Paper: Quality Improvement in
Upcoming Assessment
ED Checklist (2021 Update)
2018 Pediatric Readiness Guidelines (AAP.org)
Selected Publications
Literature In Support of Pediatric Readiness
Resources
Critical Crossroads Toolkit: Mental Health Care in the ED (PDF)
AAP Children & Disasters (AAP.org)
AAP Topical Collection: Pediatric
QR Code for this page

Region V For Kids

Great Lakes Pediatric Consortium For Disaster Response

States involved:

Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin

Workgroups:

Supply Chain
Surge/Peds Annex
Telehealth
Legal
Metrics
HVA
Pediatric Coordinating Centers/Exercise
Reunification
IT
Trauma
Behavioral Health
Education
EMS
Facility Recognition

Save the Date

Pediatric Care Coordination Center:
A Demonstration and Table Top Exercise

June 7, 2022, 10:00 am to 2:15 pm EST

The Michigan Bureau of EMS, Trauma and Preparedness in partnership with the Region V for Kids Pediatric Center of Excellence invites you to a pediatric medical operations coordination cell (PMOCC) exercise. The PMOCC is a new model for emergency management of pediatric disaster and surge incidents and is based upon the ASPR TRACIE Medical Operations Coordination Cells Toolkit.

The Pediatric Care Coordination Center (PCCC) is Michigan's conceptual version of a PMOCC. Participants will conduct and validate internal standard operating procedures of a PMOCC. Observers are asked to comment on the activation process and evaluate cell operations.

Suggested participants include:

State Department of Health, Preparedness and Public Health Officials

Healthcare Coalition Preparedness Coordinators

Hospital Emergency Managers and Surge Planners

Emergency Preparedness Personnel

State Hospital Association Representatives

The exercise will feature

1) Pediatric Medical Education Presentations
2) A Functional Demonstration of a PMOCC
3) A Table Top Exercise

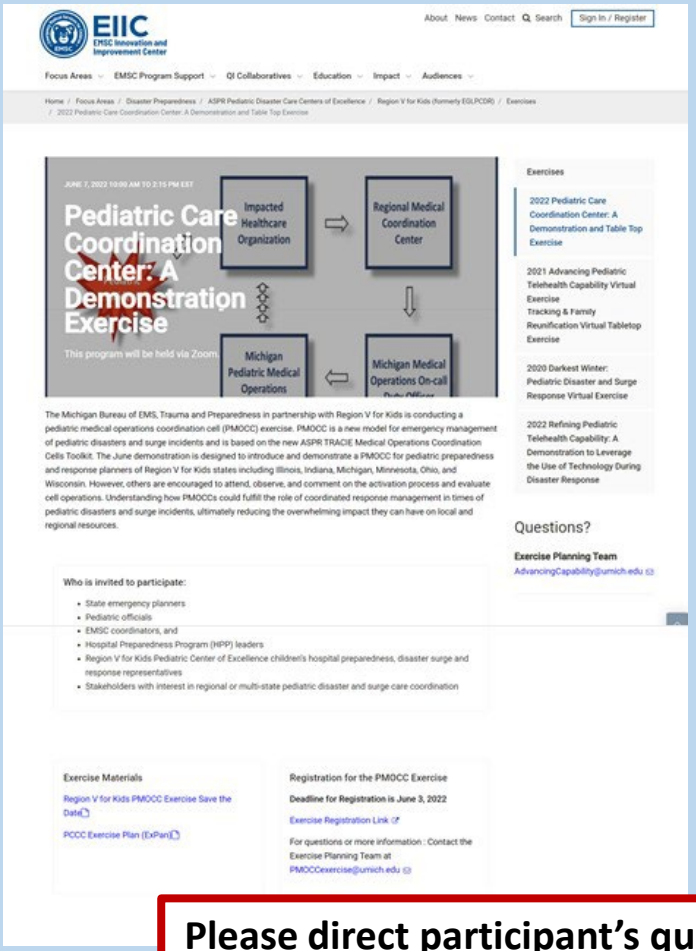
Visit the PCCC webpage (PCCC Homepage) for exercise details

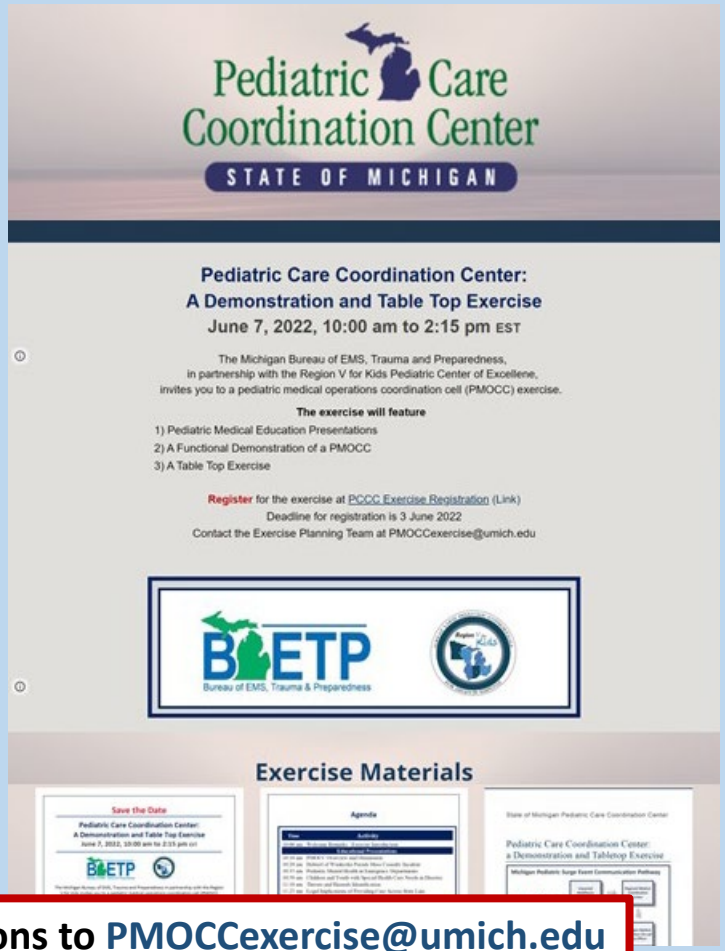
Register for the exercise at PCCC Exercise Registration (Link)

Deadline for registration is 3 June 2022

Contact the Exercise Planning Team at PMOCCexercise@umich.edu

Exercise Websites (x2)





Please direct participant's questions to PMOCCexercise@umich.edu

CONTACT INDIANA EMSC PROGRAM MANAGER, MARGO KNEFELKAMP,
MARGO.KNEFELKAMP@INDIANAPOLISEMS.ORG

INDIANAEMSC.ORG

Legislative Updates

Blaire Viehweg

Deputy Director, Legislative & External Affairs

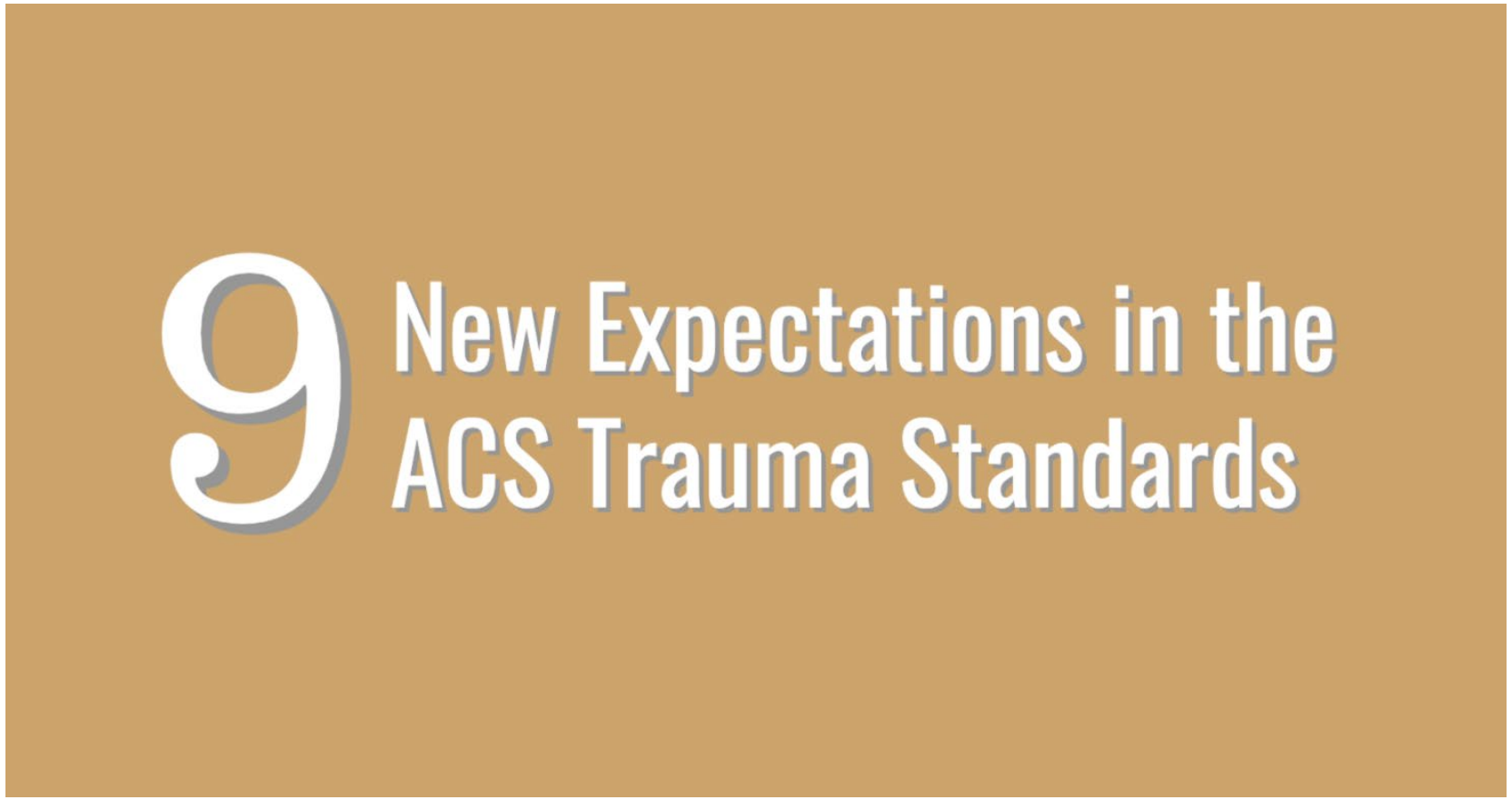
SEA 247 – Report on 911 and Regionalized Trauma Systems

- During the 2021 Interim Study Committee on Public Health, Behavioral Health, and Human Services trauma care hearing, many questions arose surrounding trauma and response
- The IGA is looking to improve regionalized trauma response across Indiana through collaboration between all parties
- SEA 247 requires the Department of Homeland Security, Department of Health, Integrated Public Safety Commission and Statewide 911 board to collaborate and make recommendations before October 31, 2022, to the Indiana General Assembly
- Recommendations must address:
  - Improving emergency medical services response through increased interoperability of the 911 system
  - Effectiveness of regionalized trauma systems and the systems' impact on patient care

IDOH Updates

Lindsay Weaver, M.D., FACEP

Chief Medical Officer


9
New Expectations in the
ACS Trauma Standards

ACS Expectations

1. Meet new staffing and staff education requirements
2. Create a more structured PIPS plan and demonstrate its effectiveness
3. Create a data quality plan
4. Develop several new protocols and guidelines
5. Secure expertise in several new specialty areas
6. Meet new response time and resource availability standards
7. Academic trauma centers: Meet new (relaxed) education and research requirements
8. Level III centers: If neurotrauma provided, demonstrate appropriate resources
9. Assess readiness to treat pediatric patients

Indiana Department of Health

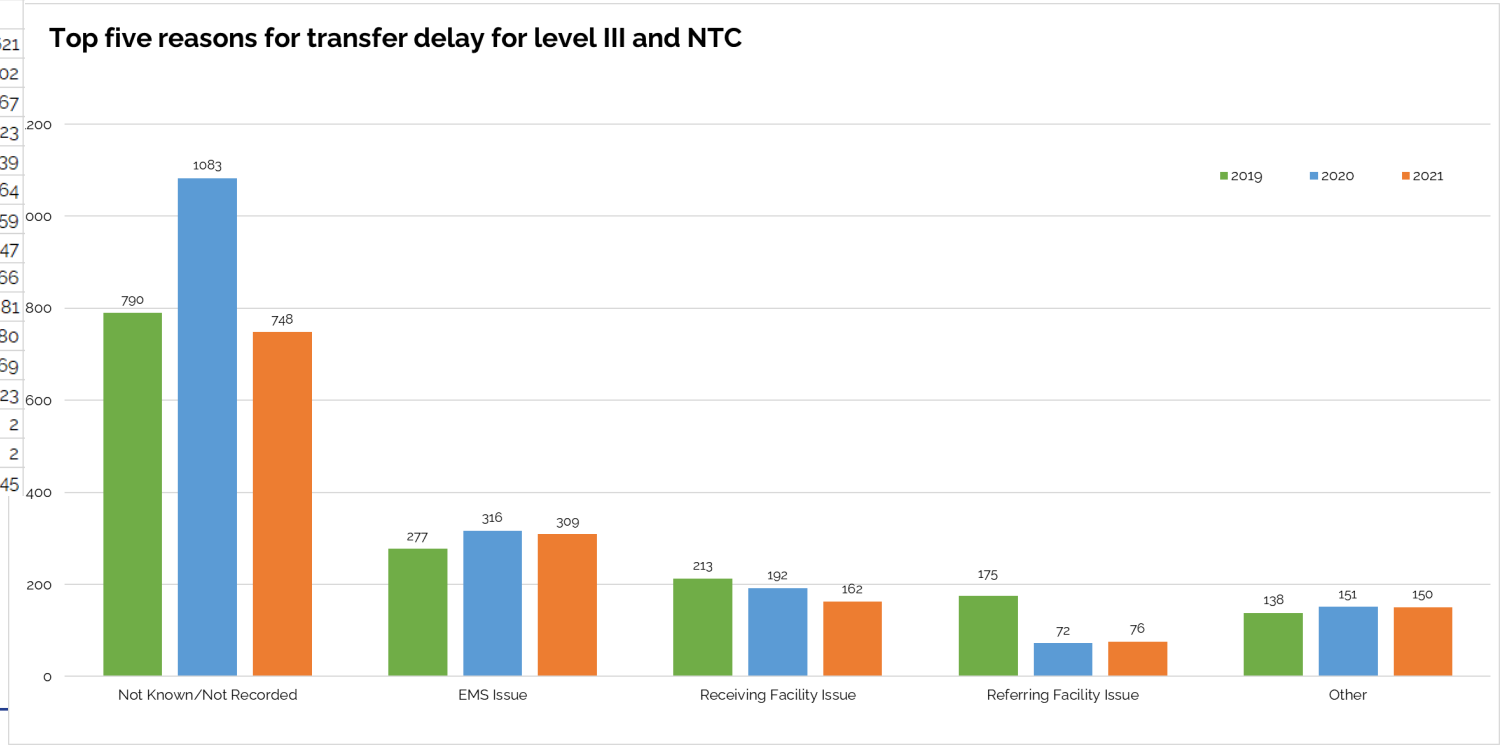
EMS Transport and Transfer

NTC Interviews

- 4 hospitals chosen in coordination with IRHA and IHA to further explore what issues they are having locally with transfer and transport
- ¾ completed
- Review data
- What are they experiencing?
- EMS staffing, training issues?
- 911 vs transport
- Air ambulance use

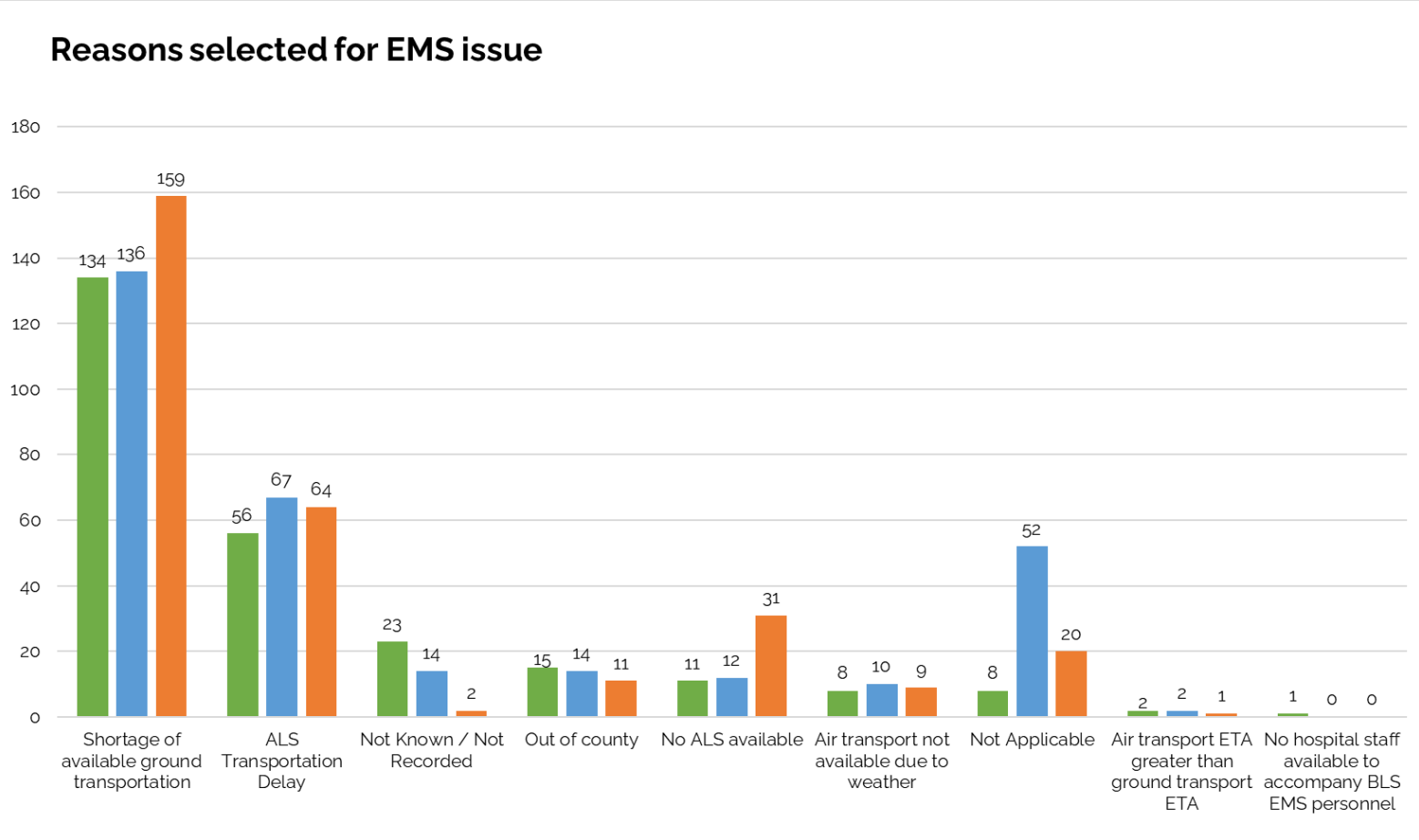
- After “unknown”, **“EMS Issue” is the number one reason** hospitals listed as the cause for the delay.
- Of those where a reason is given, “EMS Issue” made up 30% (902) of the reasons for delay from 2019 through 2021.

Transfer_Delay_Reason__TR17_44_(Transfer Delay Reason (TR17#44))	YearN			
	2019	2020	2021	Total
Not Known/Not Recorded	790	1083	748	2621
EMS Issue	277	316	309	902
Receiving Facility Issue	213	192	162	567
Referring Facility Issue	175	72	76	323
Other	138	151	150	439
Referring Physician Decision Making	94	93	77	264
Delay Issue	65	55	39	159
Communication Issue	35	12	0	47
Family, Legal Guardian, or Patient Issue	32	24	10	66
Not Applicable	25	31	25	81
Referring Hospital Issue-Radiology	25	22	33	80
Transportation Issue	25	24	20	69
Weather or Nature Factors Issue	9	6	8	23
Equipment Issue	0	1	1	2
Error Issue	0	0	2	2
Total	1903	2082	1660	5645



Indiana Department of Health

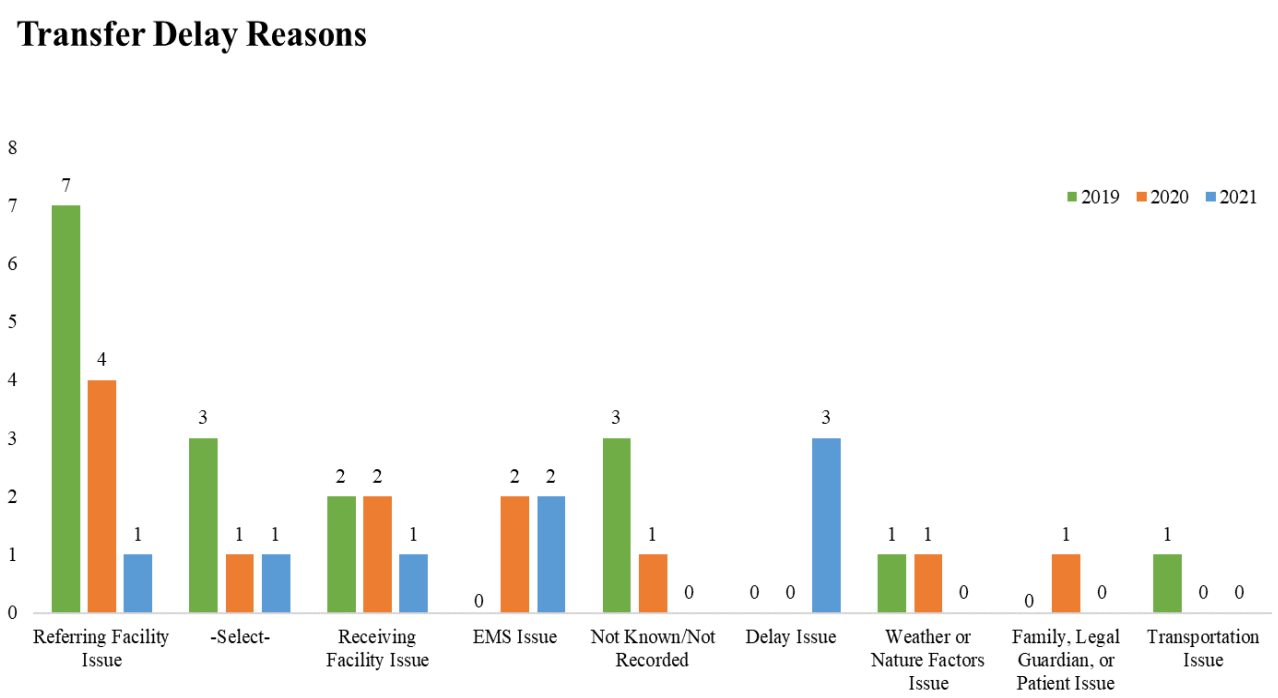
- Of the EMS Issue Transfer delays 50% (429/862) were due to the shortage of available ground transportation. 502 people, whose care was delayed due to lack of available transport.

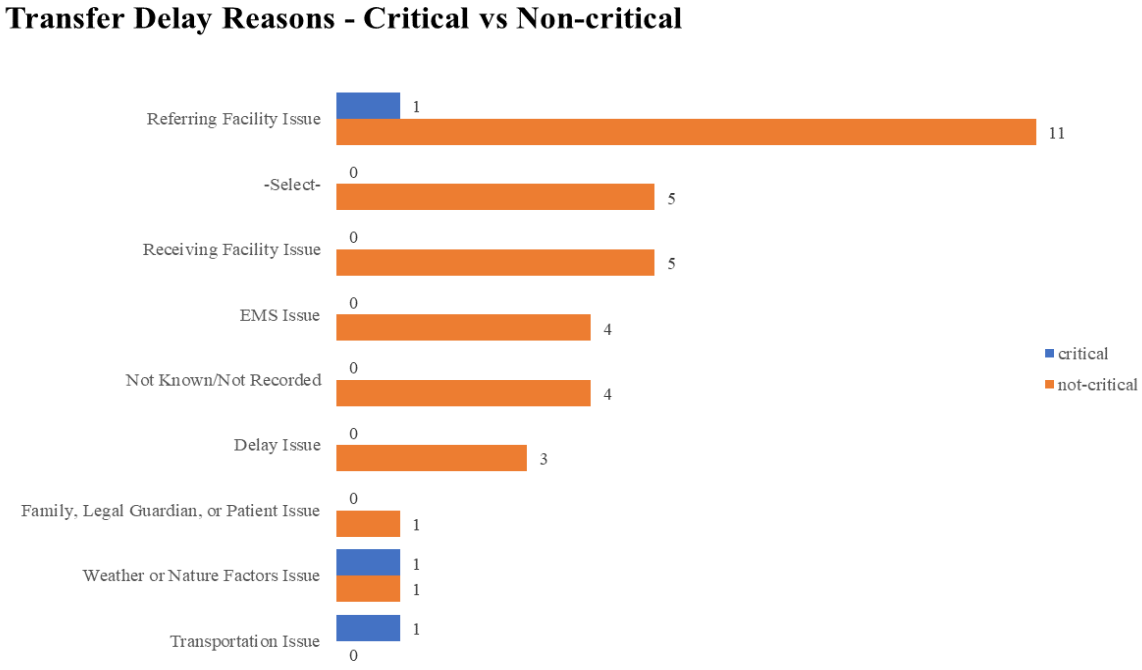


Indiana Department of Health

Transfer Delay – A Medical Center

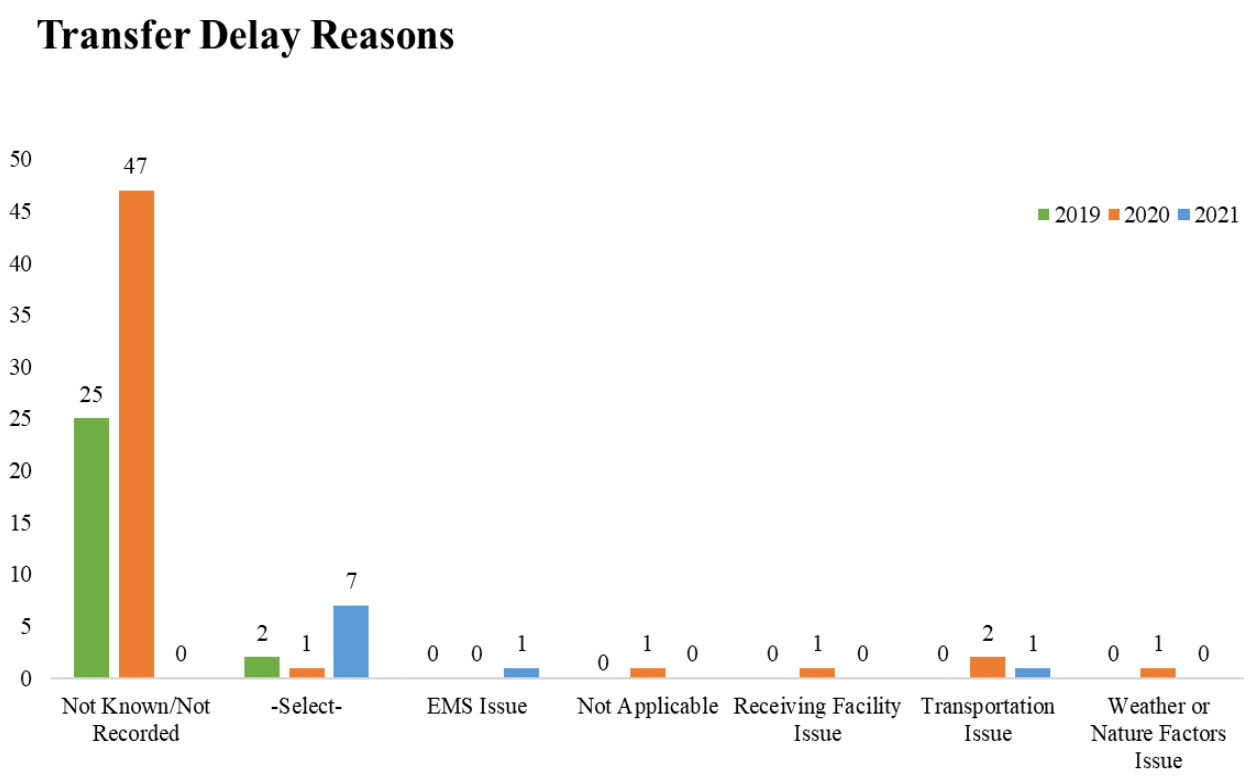
- There are 37 cases recorded as having a transfer delay

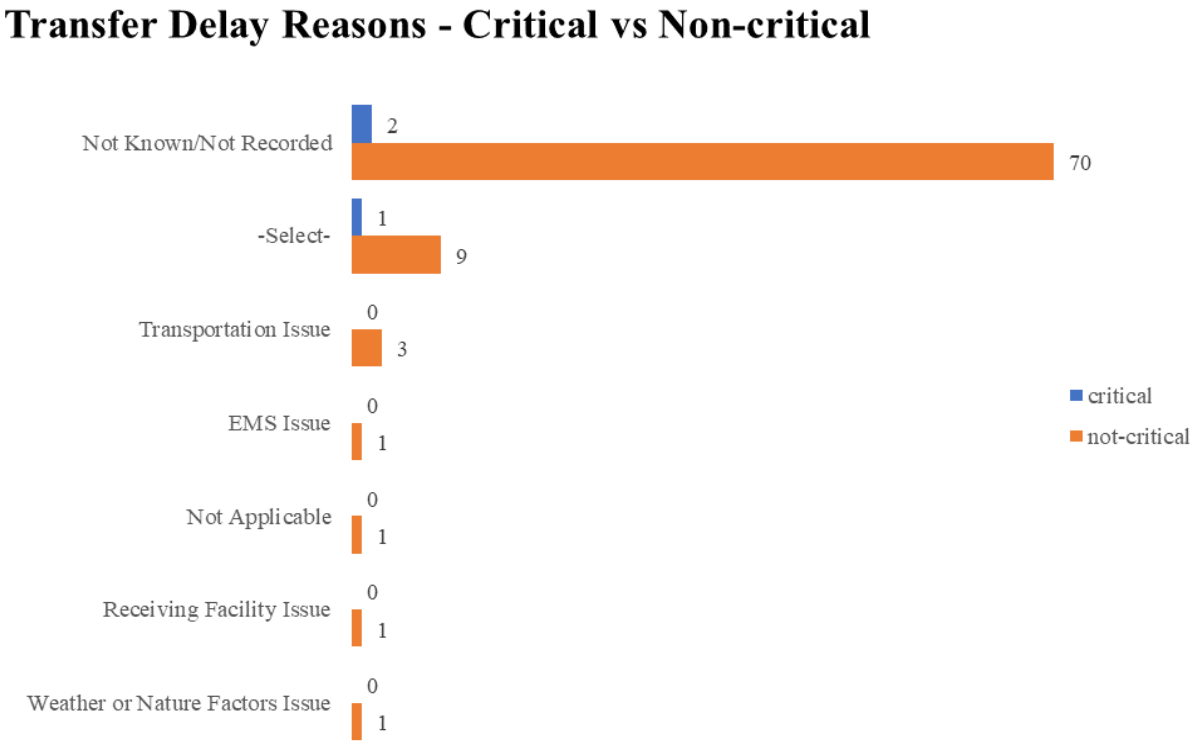




Transfer Delay – B Medical Center

- There are 89 cases recorded as having a transfer delay





Findings

- Decreased number of available ambulances
- Must chose 911 availability over transport (gone for 5-6 hours out of county)
- Air ambulances for critical transport but risk of weather issues
- EMS providers move on to different jobs (nurse etc)- become a pipeline position
- Decreased availability of training opportunities
- Data Entry cumbersome and doesn't allow to get to the true root cause of delay

Findings

- Varying levels of coordination in area
  - Hospital A- great coordination with surrounding areas
  - Hospital B- no coordination with surrounding areas, everybody for themselves. Border town and ambulances right over border will not help
  - Hospital C- have mutual aid agreements with surrounding counties but everyone has to watch out for themselves
- Coordination does not occur at the emergency preparedness district level. Occurs with bordering counties and referral areas

Indiana Department of Health

Opportunities and Next Steps?

Indiana Department of Health

Governor's Public Health Commission Update

Reduce Childhood Injury

Draft Recommendation B

Address childhood injury and violence prevention

Potential action items:

A. Establish an inter-professional coalition of experts focused on keeping youth from unintentional firearm deaths and suicide.

B. Fund and leverage DOH to develop policies to address safety issues and increase equitable access to safety equipment shown to significantly decrease child injuries (such as bike helmets, cabinet locks, and stair gates.)

Enhance EMS readiness

Draft Recommendation 4.

Ensure local level EMS readiness through expansion and sustainability of EMS workforce

Possible action items:

A. Conduct needs assessment of specific EMS gaps in local jurisdictions

B. Ensure funding and prioritized recruitment to address workforce shortages in EMS

C. Establish long-term promotional and retention plans for EMS personnel

D. Explore ongoing training and expansion of community paramedicine programs

Improve the scalability of emergency response efforts beyond the local level

Draft Recommendation 5.

Improve regional coordination efforts to ensure a seamless emergency response

Possible action items:

A. Evaluate stakeholder engagement process to redefine the IDOH emergency preparedness districts

B. Evaluate stakeholder engagement process to redefine roles, responsibilities, and authorities of regional partners

Discussion

- GPHC recommendations– Who, what, when, where, why? What are we missing?
- Quality Improvement – What does this look like? How is the data collected? Opportunity for state or regional efforts?
- Regional Trauma Councils – Review available information
- Regional Trauma Coordination- Why is this necessary? How do we approach reorganization? What will be the expectations of coordination?

Other Business

Next ISTCC Meeting:

July 15, 2022 – Hybrid

10:00am to 11:00am (Eastern Time)