Indiana Department of Health

INDIANA STATE TRAUMA CARE COMMITTEE

September 16, 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

Legislative Update

Alyssa Schroeder

IDHS Legislative Director

House Enrolled Act 1314 & Senate Enrolled Act 247

Require IDOH, IDHS, the Statewide 911 Board, and the Integrated Public Safety Commission to make recommends to the Statehouse regarding:

(1) ways that the 911 system can increase interoperability to better facilitate an EMS 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

House Enrolled Act 1314 & Senate Enrolled Act 247

Increasing 911 Interoperability

- 119 Public Safety Answering Points (PSAPs) in Indiana
- 13 different Computer-aided Dispatch (CAD) vendors being used by Indiana PSAPs
- PSAPs that use different CAD vendors cannot communicate with each other
- Goal – PSAPs achieve situational awareness and dispatch capabilities between different PSAP CAD vendors

House Enrolled Act 1314 & Senate Enrolled Act 247

Regionalized Trauma Systems

- Lack of standardization and structure by district/region

- Wide variation in:
  - Trauma outcomes
  - Coordination in geographically remote areas
  - Participation and allocation of resources
  - EMS capacity by location

House Enrolled Act 1314 & Senate Enrolled Act 247

Goal: Organized approach to facilitating and coordinating a multidisciplinary system response to severely injured patients (time-sensitive emergencies) regardless of location

- Ensure appropriate infrastructure and time-sensitive care coordination throughout the state
- Improve technology, including trauma and EMS data quality and sharing
- Enhance trauma center access for optimal patient care
- Provide ongoing injury prevention technical assistance and education

Discussion

Feedback on 911 Interoperability and Trauma Regionalization Recommendations

- Geography and Access
- Standardization and Coordination
- Technology
- Education and Training

PI Subcommittee Updates

Peter Hammer, MD, FACS

Trauma Medical Director, IU Methodist

2022 PI Goals

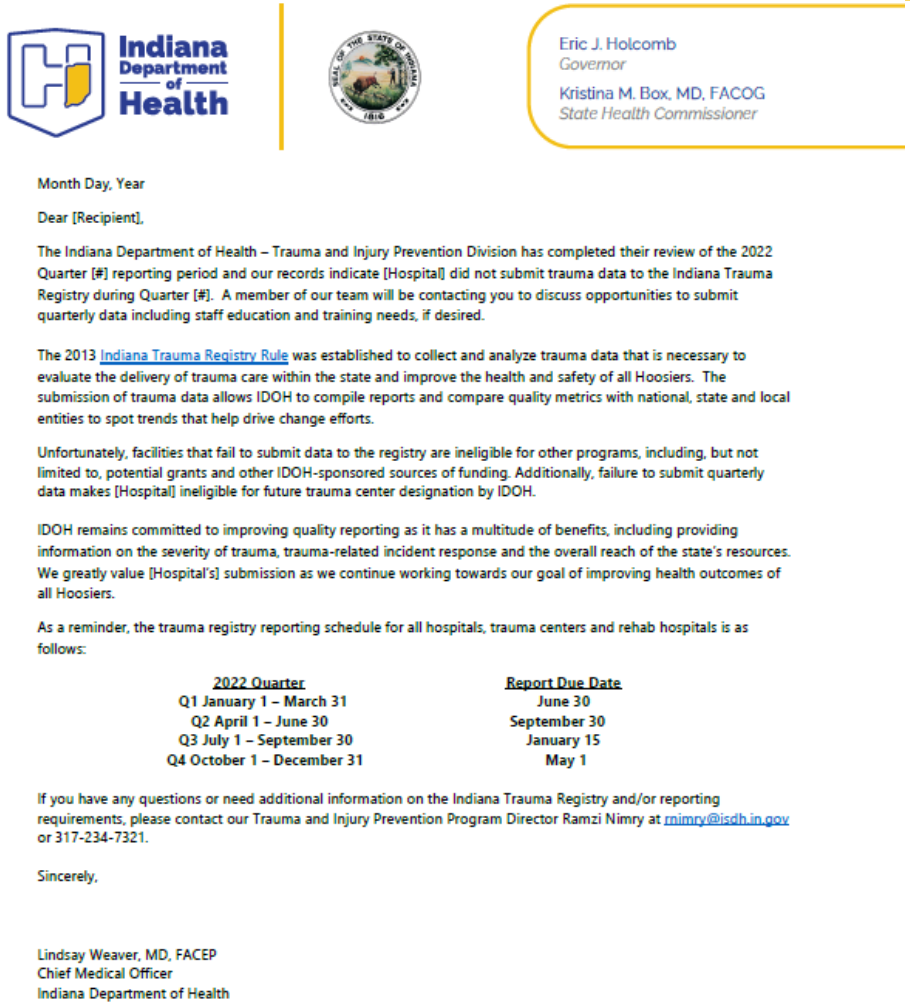
- Decrease ED LOS for critical patients at non-trauma centers
- Increase trauma registry quiz participation
- Collect hospital level variables
- Continued EMS run sheet collection
- Work with District leadership for PI process development

- **2023 PI Goals?**
  - What should we retain and/or change or do we leave everything as is?

Transfer Delay Reasons Refresh – EMS Issue

i. EMS issue
   a) Delayed due to waiting on interfacility transport from receiving hospital
   b) EMS transfer unit with the appropriate level of care (example, patient needs ALS) not available.
   c) Local EMS unit unavailable to transfer as required to stay available in area for 911 services
   d) Local EMS unit unavailable due to length of transport.
   e) EMS declines interfacility transfer.
      a. Give reason if known
   f) Multiple EMS declines interfacility transfer.
      a. Give reason if known
   g) Inclement weather

Trauma Registry Non-Reporting Letter



Indiana Department of Health

Eric J. Holcomb
Governor
Kristina M. Box, MD, FACOG
State Health Commissioner

Month Day, Year

Dear [Recipient],

The Indiana Department of Health – Trauma and Injury Prevention Division has completed their review of the 2022 Quarter [#] reporting period and our records indicate [Hospital] did not submit trauma data to the Indiana Trauma Registry during Quarter [#]. A member of our team will be contacting you to discuss opportunities to submit quarterly data including staff education and training needs, if desired.

The 2013 Indiana Trauma Registry Rule was established to collect and analyze trauma data that is necessary to evaluate the delivery of trauma care within the state and improve the health and safety of all Hoosiers. The submission of trauma data allows IDOH to compile reports and compare quality metrics with national, state and local entities to spot trends that help drive change efforts.

Unfortunately, facilities that fail to submit data to the registry are ineligible for other programs, including, but not limited to, potential grants and other IDOH-sponsored sources of funding. Additionally, failure to submit quarterly data makes [Hospital] ineligible for future trauma center designation by IDOH.

IDOH remains committed to improving quality reporting as it has a multitude of benefits, including providing information on the severity of trauma, trauma-related incident response and the overall reach of the state's resources. We greatly value [Hospital's] submission as we continue working towards our goal of improving health outcomes of all Hoosiers.

As a reminder, the trauma registry reporting schedule for all hospitals, trauma centers and rehab hospitals is as follows:

2022 Quarter	Report Due Date
Q1 January 1 – March 31	June 30
Q2 April 1 – June 30	September 30
Q3 July 1 – September 30	January 15
Q4 October 1 – December 31	May 1

If you have any questions or need additional information on the Indiana Trauma Registry and/or reporting requirements, please contact our Trauma and Injury Prevention Program Director Ramzi Nimry at rnimry@isdh.in.gov or 317-234-7321.

Sincerely,

Lindsay Weaver, MD, FACEP
Chief Medical Officer
Indiana Department of Health

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Other Discussions

- EMS Run Sheet Collection
  - Please send Robin Stump with Dept. of Homeland Security at rstump@dhs.IN.gov with a list of EMS providers not leaving run sheets.

- Hospital Level Variables
  - 31 responses collected so far for 2022

- Injury Prevention
  - Stepping On at the University of Indianapolis
    - September 16 from 9:30a-11:30a
    - September 23 from 9:30a-11:30a
    - September 30 from 9:30a-11:30a
  - Booster Bash
    - September 17 from 10a-12p at Parkview Wabash Hospital
    - September 18-24 from 9a – 12p at LaPorte County Health Department
  - Car Seat Safety Clinic
    - September 24 from 9a to 1p at Legacy Hospital in Michigan City

2022 Microsoft Teams Meeting Dates

- ❑ November 15

2023 Microsoft Teams Meeting Dates:

- ❑ January 17
- ❑ March 14
- ❑ May 16
- ❑ July 11
- ❑ September 12
- ❑ November 14

Indiana Department of Health

Designation Subcommittee Updates

Lewis Jacobson, MD, FACS

Trauma Medical Director, Ascension St. Vincent Hospital

One Year Review - Update

In the Process – LIII

- Franciscan Health Indianapolis

IDOH Update

Lindsay Weaver, M.D., FACEP

Chief Medical Officer

American College of Surgeons Trauma System Consultation

Key Reminders

ACS Consultation Introductory Presentation: November 2, 2022 – Virtual Only; 11 am to 12 pm

- Introduction from ACS Review team and State team

ACS Consultation In-Person Stakeholder Meeting: November 7, 2022 – IGC-S Auditorium; 8 am to 5 pm

- Full day discussing all trauma system elements

ACS Consultation Exit Presentation: November 10, 2022 – Virtual Only (IDOH Staff & ACS in Yoho); 10 am to 11 am

- ACS presentation of preliminary consultation report recommendations/findings

American College of Surgeons Pre-Review Questionnaire

Elements

- Statutory Authority
- Funding
- Multidisciplinary Advisory Group
- Trauma System Plan
- Continuum of Care
- Needs Based Designation
- Trauma System Registry
- Injury Epidemiology
- System-wide Performance Improvement
- Confidentiality and Discoverability
- Disaster Preparedness
- Military Integration

American College of Surgeons Pre-Review Questionnaire

Common Themes

- Lack of dedicated funding to support trauma system development
- Considerable variation of resources within and between districts
- Interfacility transfer agreements are trauma center/district dependent
- Trauma registry data submission is minimal from non-trauma centers

American College of Surgeons Pre-Review Questionnaire

Common Themes

- Opportunity for standardization within ISTCC for design, development, and evaluation of trauma system
- Trauma center verification and “In the Process” state designation are defined
- Trauma center designation is voluntary and not based on population needs
- Opportunity for statewide trauma system plan clarity
  - System planning occurs largely at the district/hospital level

American College of Surgeons Pre-Review Questionnaire

Common Themes

- EMS resources are limited within districts
- Trauma registry data accuracy/validity has been a concern

Discussion - Pre-Review Questionnaire

Continuum of Care

Definitive Care Facilities

-Describe your system for assessing the adequacy of the workforce resources within participating centers.

a. How are nursing and subspecialty needs (trauma or general surgery, intensivists, neurosurgeons, orthopedic surgeons, anesthetists, pediatric surgeons, and others, as required) addressed?

b. What human resource deficiencies have been identified, and what corrective actions have been taken?

- 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.

a. What regional educational multidisciplinary conferences are provided to care providers?

b.Who is responsible for organizing these events?

Discussion - Pre-Review Questionnaire

Continuum of Care

Rehabilitation

- What are the barriers to access to rehab services (ie patient insurance status)?
- How long do patients wait for rehabilitation beds?
- Does the average wait vary by type of rehabilitation needed?
- Describe how rehabilitation specialists are integrated into trauma system planning and advisory groups.

Discussion - Pre-Review Questionnaire

Continuum of Care

System Integration

- Describe how the trauma system plan drives the various components to work together to achieve the intended goal.

- Describe how the lead agency and each aspect of the trauma system participate in trauma system design, evaluation, and operation, as well as policy development, legislative advocacy, public education, and strategic planning.

- Describe the trauma system's collaboration and integration with community services (ie: public health, emerg. mgmt., prevention programs, etc.)?

Discussion - Pre-Review Questionnaire

Disaster Preparedness

- How does your system or center assess disaster preparedness?
- How does your system or center include disaster preparedness planning as a part of trauma care?
-What stakeholders do you engage for disaster preparedness planning and implementation?

Military Integration

- How does your system or center integrate/collaborate with military organizations and personnel as a part of trauma care?
- How does your system activate military response?

IDHS/EMS Updates

Kraig Kinney

State Director and Counsel of EMS

RECENT CHANGES FROM THE EMS COMMISSION

TRAUMA RULE

- On July 15, 2022, the EMS Commission adopted a non-rule policy that permits EMS providers to use updated 2021 national Field Trauma Triage Guidelines while meeting the requirement to use the prior 2011 guidelines which are the requirement of the existing rule.
- The NRP was published and effective on July 27, 2022

- Simply put, if your organization choose to follow the current ACS Field Trauma Triage Guidelines (2021 version) instead of the 2011 version referenced in the Indiana Trauma Rule, then the organization is considered compliant with the rule.

TRAUMA RULE

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

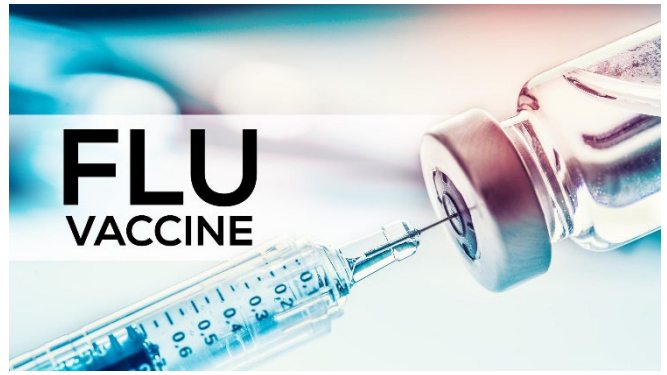
Patients meeting any one of the above RED criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

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**

EMS SCOPE OF PRACTICE AMENDED

- On July 15, 2022, the EMS Commission expanded the EMT scope of practice to permit EMTs to administer COVID and influenza vaccinations. This was a result of a statutory change effective July 1, 2022, which removed the prohibition against invasive procedures for basic life support or EMTs. Previously EMTs had been able to administer COVID vaccinations due to the Governor's executive order suspension of the prohibition.

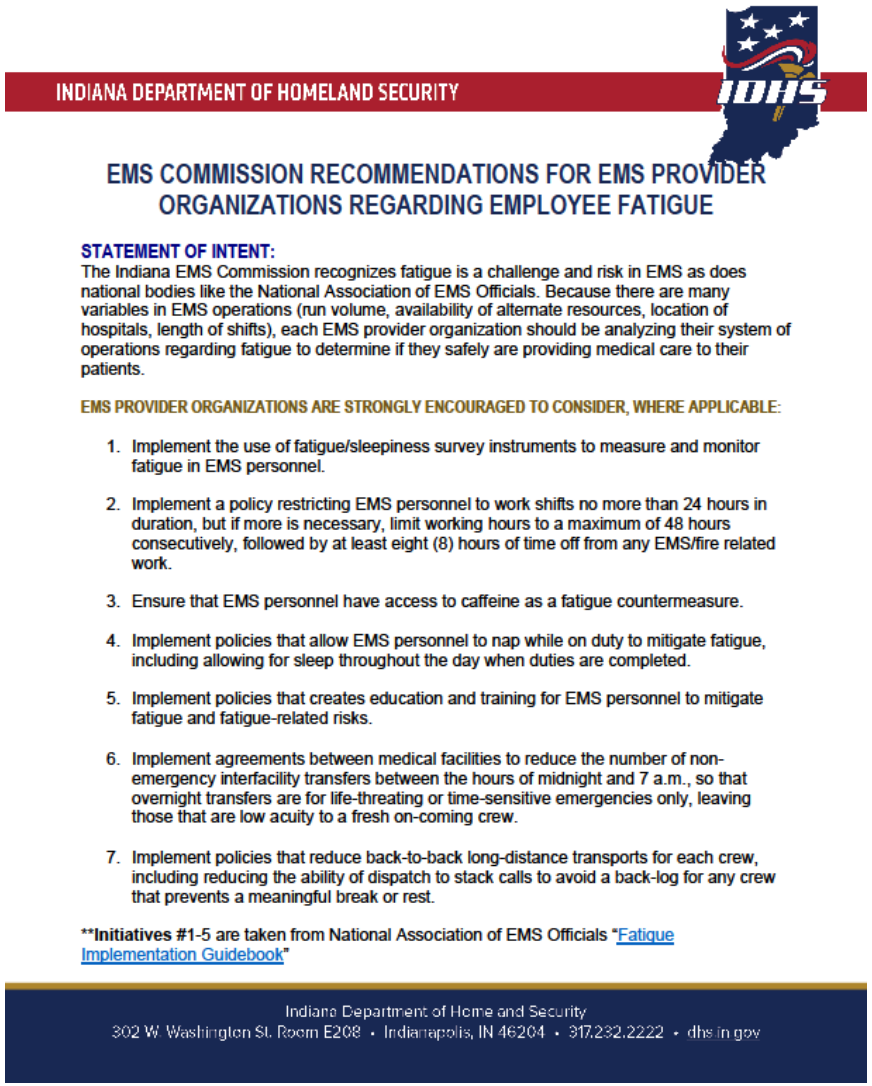


FATIGUE COMMITTEE UPDATE

FATIGUE COMMITTEE FOR EMS COMMISSION

- The Fatigue Committee was formed by the EMS Commission with EMS district manager Stan Frank as the chairperson in September of 2021.
- The Committee is made up of individuals that wish to address fatigue and safety concerns in EMS.

FATIGUE COMMITTEE RECOMMENDATIONS



INDIANA DEPARTMENT OF HOMELAND SECURITY

EMS COMMISSION RECOMMENDATIONS FOR EMS PROVIDER ORGANIZATIONS REGARDING EMPLOYEE FATIGUE

STATEMENT OF INTENT:
The Indiana EMS Commission recognizes fatigue is a challenge and risk in EMS as does national bodies like the National Association of EMS Officials. Because there are many variables in EMS operations (run volume, availability of alternate resources, location of hospitals, length of shifts), each EMS provider organization should be analyzing their system of operations regarding fatigue to determine if they safely are providing medical care to their patients.

EMS PROVIDER ORGANIZATIONS ARE STRONGLY ENCOURAGED TO CONSIDER, WHERE APPLICABLE:

1. Implement the use of fatigue/sleepiness survey instruments to measure and monitor fatigue in EMS personnel.
2. Implement a policy restricting EMS personnel to work shifts no more than 24 hours in duration, but if more is necessary, limit working hours to a maximum of 48 hours consecutively, followed by at least eight (8) hours of time off from any EMS/fire related work.
3. Ensure that EMS personnel have access to caffeine as a fatigue countermeasure.
4. Implement policies that allow EMS personnel to nap while on duty to mitigate fatigue, including allowing for sleep throughout the day when duties are completed.
5. Implement policies that creates education and training for EMS personnel to mitigate fatigue and fatigue-related risks.
6. Implement agreements between medical facilities to reduce the number of non-emergency interfacility transfers between the hours of midnight and 7 a.m., so that overnight transfers are for life-threating or time-sensitive emergencies only, leaving those that are low acuity to a fresh on-coming crew.
7. Implement policies that reduce back-to-back long-distance transports for each crew, including reducing the ability of dispatch to stack calls to avoid a back-log for any crew that prevents a meaningful break or rest.

****Initiatives #1-5 are taken from National Association of EMS Officials "Fatigue Implementation Guidebook"**

Indiana Department of Home and Security
302 W. Washington St. Room E208 • Indianapolis, IN 46204 • 317.232.2222 • dhs.in.gov

- On May 13, 2022, the Indiana EMS Commission approved fatigue recommendations for EMS providers, individuals and organizations.

FATIGUE RECOMMENDATIONS

- Statement of Intent
  - The Indiana EMS Commission recognizes that fatigue is a challenge and risk in EMS as does national bodies like the National Association of EMS Officials. Because there are many variables in EMS operations (run volume, availability of alternate resources, location of hospitals, length of shifts), each EMS provider organization should be analyzing their system of operations regarding fatigue to determine if they are safely providing safe medical care to their patients.

FATIGUE RECOMMENDATIONS

- EMS provider organizations are strongly encouraged to consider, where applicable:
    1. implement the use of fatigue/sleepiness survey instruments to measure and monitor fatigue in EMS personnel.
    2. implement a policy that EMS personnel work shifts no more than 24 hours in duration, but if more is necessary, limit working hours to a maximum of 48 hours consecutively, followed by at least 8 hours of time off from any EMS/Fire related work.
    3. ensure that EMS personnel have access to caffeine as a fatigue countermeasure.
    4. implement policies that EMS personnel can nap while on duty to mitigate fatigue including allowing for sleep throughout the day when duties are completed.
    5. Implement policies that EMS personnel receive education and training to mitigate fatigue and fatigue-related risks.

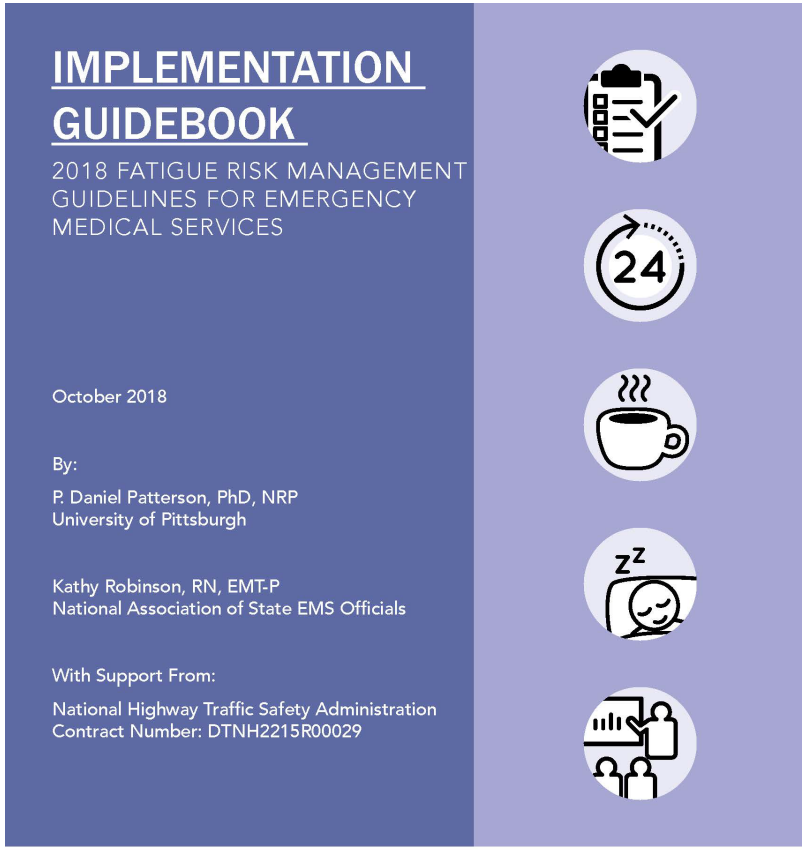
** These are adopted from the National Association of State EMS Officials (NASEMSO) Fatigue Implementation Guidebook:
: https://nasemso.org/wp-content/uploads/Fatigue-Guidebook-FINAL-2018Oct.pdf

FATIGUE RECOMMENDATIONS

- EMS provider organizations are strongly encouraged to consider, where applicable:

6. Implement agreements between medical facilities to reduce the number of non-emergency interfacility transfers between the hours of midnight and 7 a.m., so that overnight transfers are for life threating or time-sensitive emergencies only--leaving those that are low acuity to a fresh on-coming crew.
7. implement policies that would reduce back-to-back long-distance transports for each crew, including reducing the ability of dispatch to stack calls in order to avoid a back-log for any crew that prevents meaningful break or rest.

FATIGUE RECOMMENDATIONS



The National Association of State EMS Officials (NASEMSO) has the guidebook that the first five fatigue guidelines were adopted from as well as a variety of other useful resources on their website.

https://nasemso.org/projects/fatigue-in-ems/

Other Business

Next ISTCC Meeting:

November 18, 2022 – In-Person

9:00am to 12:00pm (Eastern Time)