



**Indiana**  
**Department**  
**of**  
**Health**

# INDIANA TRAUMA CARE COMMISSION

February 6, 2026

Email questions to: [indianatrauma@health.in.gov](mailto:indianatrauma@health.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

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- Please take breaks as needed.
- There will be opportunity for Q & A during the meeting.

This meeting has been public noticed.

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# Welcome and Introduction

Eric Yazel, M.D., FACEP  
*State EMS Medical Director*

# Statewide Initiatives

1. Growing Care Coordination: Medical Operations Coordination Center
2. Growing Community Connections through Indiana 211
3. Growing Improved Patient Outcomes - Interoperability and Technology
4. Growing Pediatric & Obstetric Readiness in Rural Emergency Departments
5. Growing Cardiometabolic Health Standards of Care in Rural Indiana
6. Growing Access to Hospital Post-Discharge Medications
7. Growing Specialty Provider Access through Expanded Teleconsult
8. Growing Telehealth Access and Infrastructure
9. Growing our Rural Health Paraprofessional Workforce
10. Growing Clinical Training and Readiness
11. Growing our Rural Behavioral Health Workforce

# Growing Care Coordination: Medical Operations Coordination Center (MOCC)

**Description:** A 24/7 statewide hub to coordinate patient transfers, EMS resources, and hospital capacity

- Ensure rural communities get timely access to trauma, stroke, psychiatric, and maternal care.
- Streamline referrals, reduce inappropriate ER use, support rural hospital sustainability, and strengthen preparedness for mass casualty events.

**Budget:** \$56.2 million

- Establish a Statewide Medical Operations Coordination Center (MOCC) as a centralized 24/7 hub for day-to-day hospital operational reporting, patient transfer coordination, and EMS resource alignment. Acts as a single point of contact for referral requests and life-saving resources.

#### 5 year phased approach

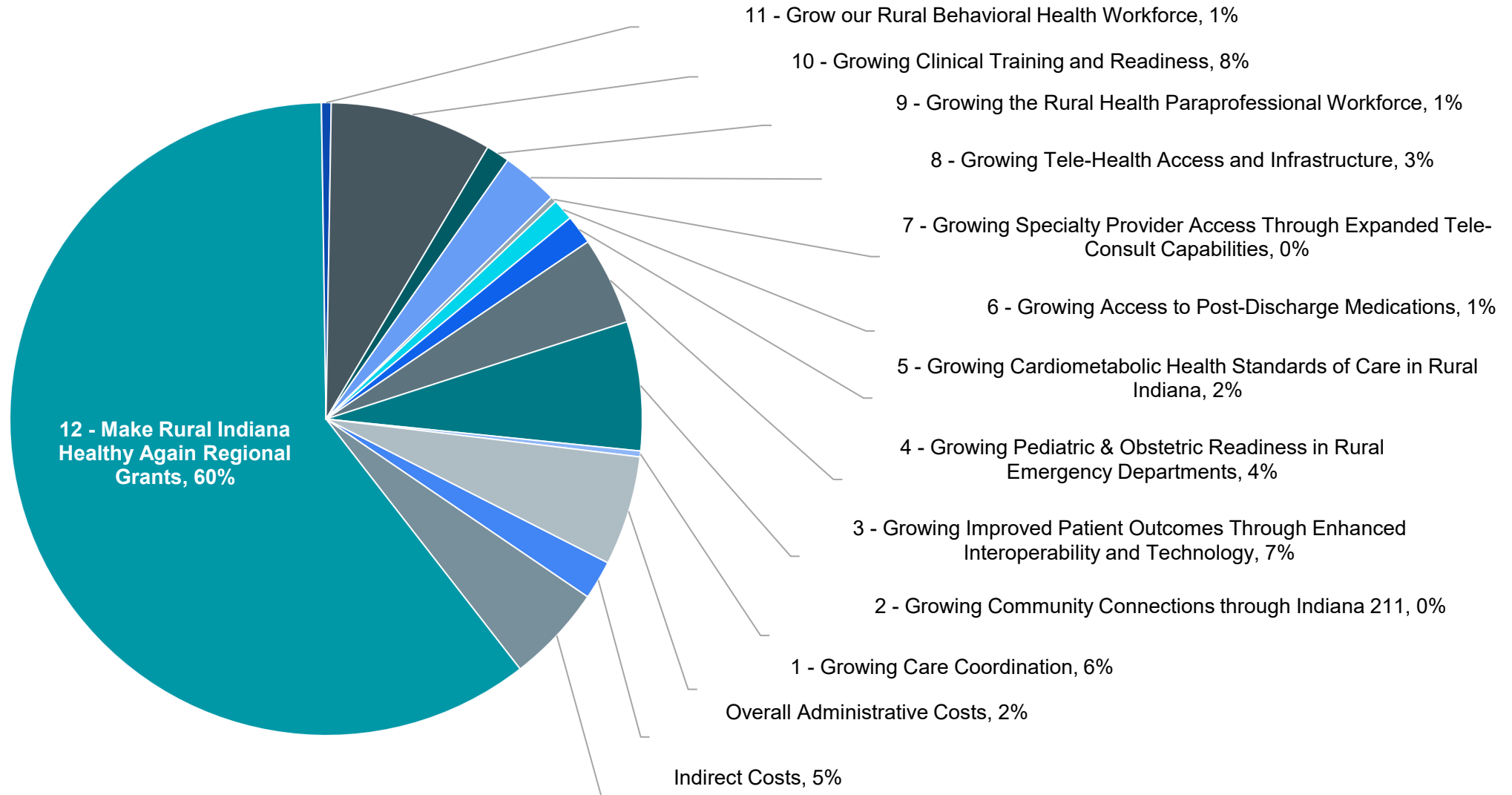
- Stakeholder Engagement and Communications – development of Executive Steering Committee (Year 1)
- IDOH Healthcare Emergency Visibility System - interoperable (Year 1-2)
- MOCC Vendor – operations, collaborative engagement with clinical, advisory committee (Year 1-2)
- Data and Metric surveillance – transparency and performance improvement (Year 1-2)
- Continuity of Care planning and expansion – transfers, behavioral health, specialty care, recovery (Year 2-4)
- Sustainability – shared model, policy – reimbursement, success and benefit experienced (Year 3-5)

# Initiative 12: Make Rural Indiana Healthy Again

## Regional Grants

- Engages local stakeholders across eight regions to identify opportunities for collaboration to improve health outcomes
- Recognizes that while needs may be similar, solutions must reflect each region's unique challenges and partners
- Creates a more comprehensive and effective approach to problem-solving
- Tailors strategies to the specific context of each community
- Strengthens collaboration, maximizes resources, and supports long-term, sustainable outcomes

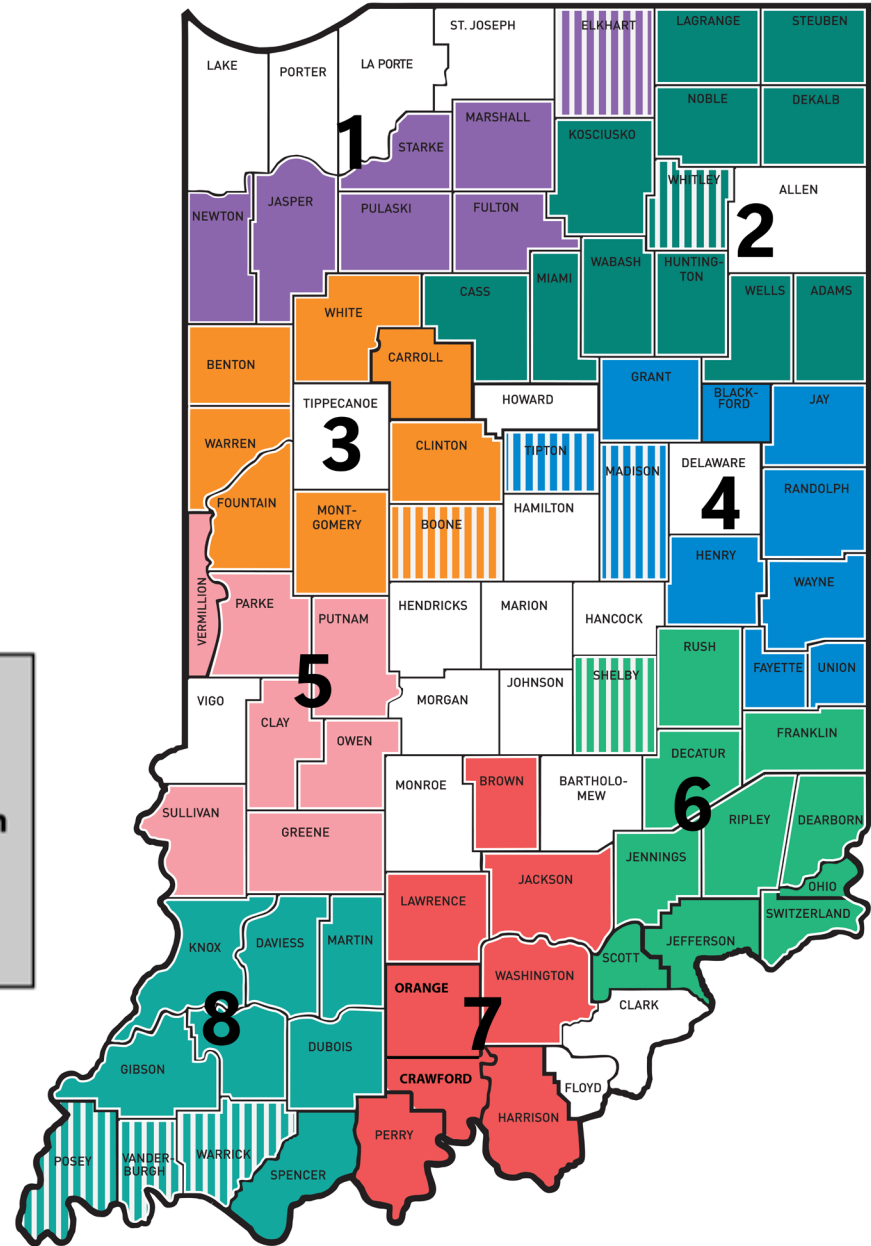
# RHTP Initiative Funding Distribution



# Make Rural Indiana Healthy Again

## Regional Grants

	Ineligible for direct funding
	Partial Rural HRSA Designation
	Fully Rural HRSA Designation



# Make Rural Indiana Healthy Again Regional Grants

## The Regional Committees

Each Regional Committee will include members, approved by the State Executive Oversight Committee, representing key rural health stakeholders

Their role is to use subject matter expertise to evaluate grant beneficiaries, ensuring fair fund distribution and accountability

Committees will provide oversight, encourage collaboration, maintain accountability, and review budgets

Each Committee must include:

- Indiana General Assembly (1)
- Provider (1)
- Non-Provider Medical Worker (1)
- Patient (1)
- Pharmacy (1)
- Regional Business Community (2)
- Community-based Organizations (2)
- Local Health Department (1)
- Medicaid Managed Care (1)
- Rural Hospital (1)

# Application and Award Process

## Five-Year Regional Grant Program

Regional awards: Estimated average award of \$15 million per year per region

Funding adjusted annually based on compliance, outcomes, and cross-regional collaboration

Award amounts determined through state review, proportion of rural population served, application quality with favorable consideration for strong partnerships, innovation and sustainability

- Funding available Oct. 1, 2026: \$120 million annually across eight Regional Coalitions
- All eight regions expected to receive funding
- **Note:** local governments, hospitals, universities, LHDs, CMHCs and other similar health care provider organizations and nonprofits may be eligible to receive subawards as part of the regional application

## Regional Coalitions

Coalitions and applications require collaboration from key local stakeholders including:  
Healthcare organizations (CAHs, FQHCs, rural health clinics, rural hospitals, behavioral health organizations, EMS)

Local health departments (LHDs) and community organizations (CBOs)

Education and workforce development entities (clinical training programs and preceptorship sites)

State agencies and support organizations (IDOH, FSSA, State Office of Rural Health, Indiana Hospital Association, Indiana Rural Health Association)

Patients and community members (patient advisory councils, community advisory boards, chambers of commerce)

Medicaid MCOs, commercial payers

Members of the Indiana General Assembly (IGA)

# Regional Grant Data Snapshots

The State will provide regional data snapshots to include data such as:

Epidemiological profile

- Chronic Disease, Primary Care, & Rural Health

  - Obesity, Diabetes, Hypertension, Heart Disease, Smoking, Stroke

- Maternal & Child Health

  - Infant mortality, Low birthweight, preterm birth, early prenatal care

Trauma & Injury Prevention

- Life Expectancy, Older Adult Falls, Motor vehicle traffic injuries, TBIs, Overdose, Self-Harm

Medicaid patient profile

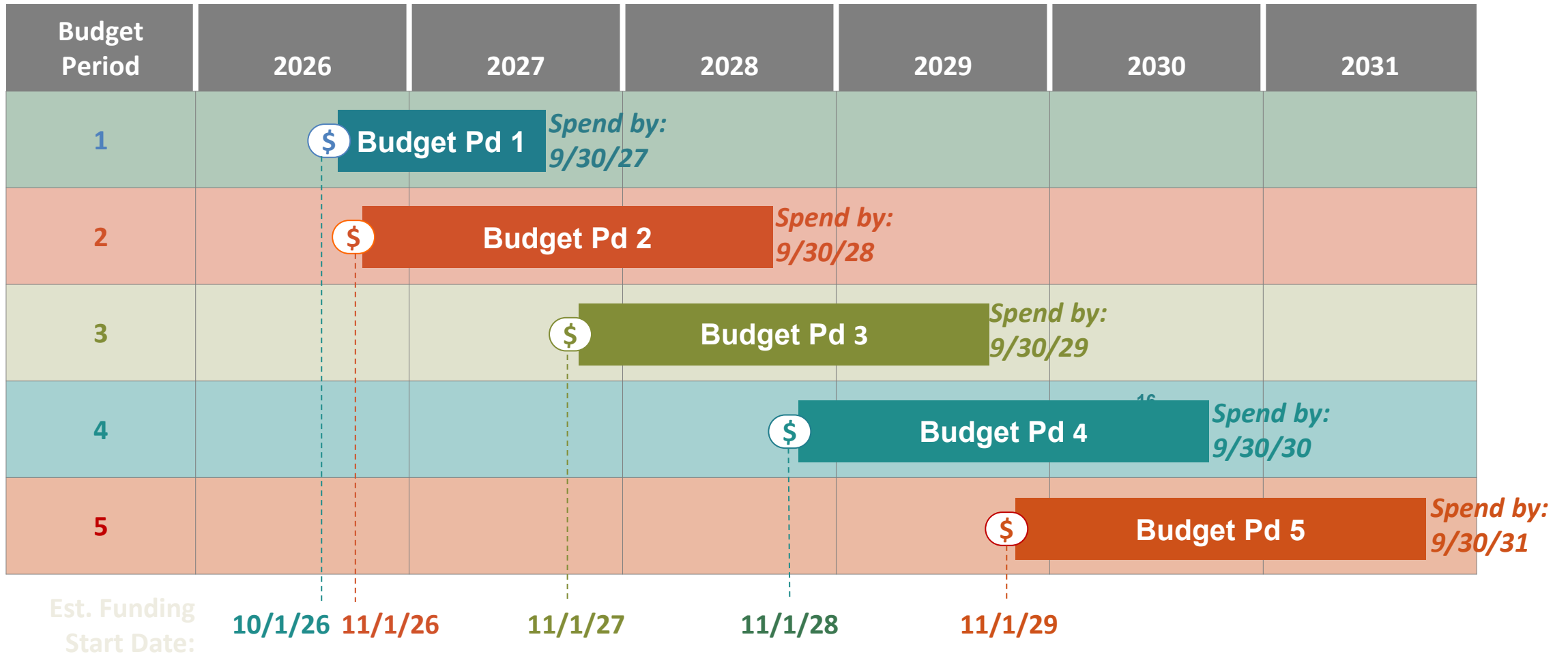
Geospatial analysis - drive time to care

Medical workforce

# Make Rural Indiana Healthy Again Regional Grants Application Timeline

Date	Milestone
March 2026	Request for Applications released to public Letter of Collaboration due to State for each region
February – July 2026	Technical assistance available for coalition formation and application development
July 1, 2026	Applications due to state
July – September 2026	Application review, scoring and award determinations
Oct. 1, 2026	Grant agreement period begins, and funding distributed to individual entities

# RHTP Regional Grants Budget Periods



# Make Rural Indiana Healthy Again Regional Grants

- Identify duplication and gap in services
- Improve maternal and infant health outcomes
- Increase number of women receiving first trimester care and completing all pre and postnatal visits
- Increase access to preventive services and connection to appropriate primary or specialty care through innovative care delivery models
- Improve blood pressure and diabetes control
- Increase workforce recruitment and retention
- Leverage the collective of healthcare providers in rural Indiana, rather than bolstering singular entities there will improve system integration and sustainability

# Regional Grant Capital Funding Limitations from CMS

**Capital expenditures and infrastructure are allowed when** investing in existing rural health care facility buildings and infrastructure, including minor building alterations or renovations and equipment upgrades to ensure long-term overhead and upkeep costs are commensurate with patient volume with following restrictions that are not allowable

Must be clearly linked to program goals.

Cannot exceed 20% of the total regional funding from States in a given budget period.

## **Explicitly Unallowable**

New Construction

Supplanting funding for in-process or planned construction projects or directing funding towards new construction builds

# Regional Grant EMR Funding Limitations from CMS

## EMR Replacement

No more than 5% of total funding CMS awards in a given budget period can support funding the replacement of an EMR system if a previous Health Information Technology for Economic and Clinical Health (HITECH) certified EMR system is already in place as of September 1, 2025.

Replacement refers to the purchase of a completely new EMR system to take the place of an existing one.

Upgrades, enhancements, and added modules, interfaces, or functionality to existing EMR/EHR systems are allowable uses of funds and are not subject to the 5% limitation.

May substitute G10 certified modules to meet needs and this substitution is not subject to the 5% limitation. These upgrades, enhancements, and added modules, interfaces, or functionality to existing EMR systems should be aligned with CMS's Health Technology Ecosystem criteria (including the CMS Interoperability Framework) and ASTP/ONC criteria

Use of funds related to EMR/EHR systems should be associated with an initiative that adheres to the scope and furthers the strategic goals of the RHT Program

# Application for participating in your coalition

If you are interested in participating in your regional coalition, please scan the QR Code or complete the form found [here](#).

Due by **Jan. 22**

<https://forms.office.com/g/fSxhfsvCMC?origin=lprLink>

Make Rural Indiana Healthy Again  
Regional Grants Leadership and  
Committee Nomination Form



# Website: [GrowRuralHealth.in.gov](https://GrowRuralHealth.in.gov)

**GROW: Cultivating Hoosier Health** website should be consulted for updates including:

- Frequently Asked Questions
- Initiative Descriptions
- Regional grant application
- Results of stakeholder survey

Email questions to [GrowRuralHealth@health.i](mailto:GrowRuralHealth@health.i)





**GROW**  
CULTIVATING HOOSIER HEALTH



# Questions & Answers



# Prehospital Spinal Immobilization

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**ANDREW BOWMAN, NP**

# North Trauma Regional Advisory Council Update

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**DR. SCOTT THOMAS**

TRAUMA MEDICAL DIRECTOR, MEMORIAL SOUTH BEND

# NTRAC Strategic Plan Progress

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- Regional calendar of trauma events is continuously updated on SharePoint page
- Two trauma manikins purchased in the North to support skill development
- Incentivized trauma data input with support to trauma & non-trauma hospitals
  - Survey to go out in April to see how funds were utilized
- Save the date going out soon for Great Lakes Regional Trauma Symposium year two
- Beacon Trauma Symposium being held in March
- Virtual AIS15 and ICD-10 courses completed with 11 students completing a course from the North
- North TRAC PI subcommittee being formed to start evaluating regional data and addressing gaps
- Exploring partnerships between LHDs and hospitals in five pilot counties for Injury Prevention initiatives
- Inaugural RMOCC Consortium meeting held between TRAC leadership and HCC leadership with the three Northern districts
  - Plans to continue these in the future

# NTRAC Quarterly Report

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## January N-TRAC meeting participation

25 of 45 affiliated system representation

4 of 5 trauma hospitals

HCC representation (2 of 3)

EMS district manager representation

## Budget spenddown

Initial budget: \$489,642

Amount spent: \$394,530

Amount remaining: \$95,112.22

# Questions?

**Dr. Scott Thomas**

NTRAC Chair

[sthomas@beaconhealthsystem.org](mailto:sthomas@beaconhealthsystem.org)



# Central Trauma Regional Advisory Council Update

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**KAITLYN SHERIDAN**

TRAUMA PROGRAM MANAGER, IU METHODIST

# CTRAC Strategic Plan Progress

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- Reallocation of Funds between strategic objectives based on identified needs
- Incentivized Data Input for non-trauma hospitals, including guidance on allowable uses of funds to support data validity and timely submission
- Quarterly Newsletter launched in 2026, highlighting TRAC impact, financial updates with real-use examples, and upcoming educational opportunities
- Funding Impact Highlights integrated into quarterly TRAC meetings, allowing recipients to report how funds were used and the measurable outcomes generated
- Recent Funded Initiatives include the Trauma Symposium, HCC Surge Exercise, TCRN Review Course, disaster supplies, Stop the Bleed kits, and EMS cadaver labs
- Regional Public Calendar in development to consolidate events, training opportunities, and educational offerings
- Performance Improvement Subcommittee being formed based on themes identified through quarterly report reviews
- Next CTRAC Meeting will include review of an AAR from the recent Mass Casualty Incident

# CTRAC Quarterly Report

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## October STRAC meeting participation

17 of 43 (40%) non-trauma hospitals

12 of 13 (92%) trauma hospitals

Various EMS/FDs throughout region represented

HCC representatives

## Budget spenddown

Initial budget: \$765,224

Amount allocated: \$712,009

Amount remaining: \$53,215

# Questions?

**Kaitlyn Sheridan**

CTRAC Chair

[ksheridan@IUHealth.org](mailto:ksheridan@IUHealth.org)



# South Trauma Regional Advisory Council Update

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**DR. DAVID WELSH**

SURGEON, MARGARET MARY HEALTH

# STRAC Strategic Plan Progress

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- Advisory Committee meets monthly to vote on items presented
- Quarterly SharePoint News Continues
- Virtual AIS15 & ICD-10 courses completed
- Various trauma educational reimbursements
  - TCRN course roster finalized-149 participants
- Shared Regional High-Fidelity Simulator approved for purchase
- STRAC SharePoint calendar utilized to organize regional events & educational courses
- STRAC Injury Prevention Coalition Formed
  - Planning Safety Days in each district for Trauma Awareness Month
  - Created IP Toolkits with various mechanism of injury topics
- Review Statewide Performance Improvement Indicators on a Southern TRAC level.
- MCI Inflatables delivered to share regionally to increase MCI drills/ exercises
- Regional Needs Assessment Survey to be sent in March

# STRAC Quarterly Report

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## October STRAC meeting participation

11 of 20 non-trauma hospitals joined

5 of 5 trauma hospitals joined

EMS managers for all districts

9 EMS/FDs throughout region

All 3 HCCs represented

## Budget spenddown

Initial budget: \$395,134

Amount Allocated: \$242,969.58

Amount Remaining: \$152,030.42

# Questions?

**David Welsh**

STRAC Co-Chair

[djwelsh\\_1980@yahoo.com](mailto:djwelsh_1980@yahoo.com)



# Legislative Update

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Ethan Wright

*IDOH Legislative and External Affairs Director*

# IDOH Legislative Update

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- **HB 1358: Indiana department of health**

- Moves reports to dashboards
- Removes sunset for universal lead screening requirement
- Expands standing orders for nicotine cessation and epinephrine
- Moves administrative rules to statutory code

- **HB 1335: Nonprofit hospitals**

- Requires a nonprofit hospital to spend more on community benefit than a hospital's estimated tax exemption value.

- **SB 91: Syringe exchange program**

- Extends sunset on SSPs across the state



# INDIANA EMS State Update

Kraig Kinney, State EMS Director / Dr. Eric Yazel, State EMS Medical Director

November 2025



# EMS and GROW



About

Regional Grants



GROW Initiatives

Contact



## Initiative #1 -- Medical Operations Coordination Center (MOCC)

## Initiative #3 -- Growing Improved Patient Outcomes Through Enhanced Interoperability

- Could include EMS care report integration into EHR
- Includes MIH incorporation into data including a data platform for MIH and MIH liaisons.

## Initiative #4 – Pediatric and Obstetric Readiness in Rural Emergency Departments

- IDHS to conduct a needs assessment of EMS Prehospital Pediatric Readiness Project
- IDHS to conduct a needs assessment for training and equipment for EMS agencies related to OB care.

## Initiative #12 -- Make Rural Indiana Healthy Again Regional Grants (eight regions)

- Mirrored after the Federal RHTP concept with sending money to regions for one single, unified regional application.
- The grants will require collaboration across hospitals, federally qualified health centers (FQHCs), mental health providers, community-based GROW: Cultivating Hoosier Health | Page 43 Section 3: Proposed Initiatives and Use of Funds organizations, local health departments, schools, the business community, and other key players in the delivery of local healthcare.



# EMS Commission Update

- The Commission has directed the EMS Education Oversight Committee and IDHS to do a full cost-benefit analysis of allowing Advanced EMTs (AEMT) to perform cardiac monitoring.
- This will be a Scope of Practice change that could impact interfacility transfers
- The Committee had indicated that it recommends ALL AEMT to upgrade and to do the full cardiology module from paramedic curriculum. AEMT providers would need to have cardiac monitors.



## Next Steps:

- AEMT clinician surveys
- AEMT provider organizations surveys
- Cost analysis (time, financial costs, potential AEMT gains versus potential AEMT losses).



**HEALTH FIRST**  
**EMS READINESS**

# IDHS AED Grant

- The EMS division offered grants from EMS Readiness to BLS non-transport organizations to purchase AEDs and AED supplies via a state vendor.
- 164 approved applications
  - Total awarded amount \$410,000





Indiana General Assembly  
2026 Session



# Legislative Update

Kraig Kinney



# HB1003 BOARDS AND COMMISSIONS

- Makes changes to requirements for the readoption of administrative rules. Repeals, merges, consolidates, or otherwise modifies various boards, commissions, committees, councils, authorities, and funds. Removes certain appointed members from various boards, commissions, and districts.
- Current Status: Eligible for passage in the House.
- Includes merging the Firefighters Board of Professional Standards with the EMS Commission.
- Was passed in the House and referred to the Senate

COMMENTARY EDUCATION ECONOMY GOVERNMENT & POLITICS HEALTH & ENVIRONMENT

GOVERNMENT & POLITICS

## Some legislators want to slash from Indiana's 250-plus boards and commissions

BY: TOM DAVIES - NOVEMBER 10, 2025 2:00 PM



Sen. Chris Garten, R-Charlestown, speaks during a legislative committee meeting. (Photo by Whitney Downard/Indiana Capital Chronicle)



# HB1202 VARIOUS PUBLIC SAFETY MATTERS

- **Require EMS Background Checks**
- Indiana is a member of the U.S. Emergency Medical Services (EMS) Compact, which standardizes EMS licensing among member states. Standardized EMS licensing allows EMS professionals to practice across state lines without needing state-specific licensure. All U.S. EMS Compact member states are required to conduct FBI-compliant background checks on individuals seeking EMS licensure. In 2024, the Indiana EMS Commission adopted a rule requiring background checks. However, IDHS has had trouble with the FBI releasing the results of the background checks to IDHS. The FBI claims they cannot release the results to IDHS unless it is mandated in state law.
- IDHS is proposing to amend state law to require EMS personnel to undergo background checks and allow the results to be released to IDHS.



# HB1202 VARIOUS PUBLIC SAFETY MATTERS

- **Require EMS Background Checks**
- Amends Ind. Code 16-31-3-2 for requirements for all EMS certified persons to:
- (F) Submit to a national criminal history background check. The state police department shall release the results of the national criminal history background check conducted under this clause to the: (i) commission; or (ii) department of homeland security.
- Was passed in the House and referred to the Senate where it is assigned to Homeland Security and Transportation. .



# HB1251 EMERGENCY AMBULANCE SERVICES

- Specifies that emergency medical services, including emergency ambulance services, are essential services in Indiana. Specifies that the provision of emergency medical services is an essential purpose of political subdivisions. Requires the county commissioners of each county to: (1) identify areas that are unserved by emergency ambulance services; and (2) provide emergency ambulance services to those areas by establishing a county emergency ambulance service, contracting with a public, private, or nonprofit provider of emergency ambulance services, or by any other available means.
- Was passed in the House and referred to the Senate

# EMS Division



- 2025 Annual Report with data from the last year.

- 2025 EMS Readiness Evaluation Report

**COMING  
SOON**



# HAVE FEEDBACK?

We want to hear from you!

Kraig Kinney [kkinney@dhs.in.gov](mailto:kkinney@dhs.in.gov)

Dr. Eric Yazel [eyazel@dhs.in.gov](mailto:eyazel@dhs.in.gov)

**Indiana Extended Trauma Quality  
Improvement Program:  
*Design & Results at 1-Year***

**Peter C. Jenkins, MD, MSc**



Methodist Hospital

# Personal Background



- Trauma Surgeon



- Health Services Researcher – Focused on trauma quality improvement (MTQIP)



- Associate Professor of Surgery



- Indiana Department of Health (2015 – )

# Background

ORIGINAL ARTICLES

## Extending Trauma Quality Improvement Beyond Trauma Centers

### Hospital Variation in Outcomes Among Nontrauma Hospitals

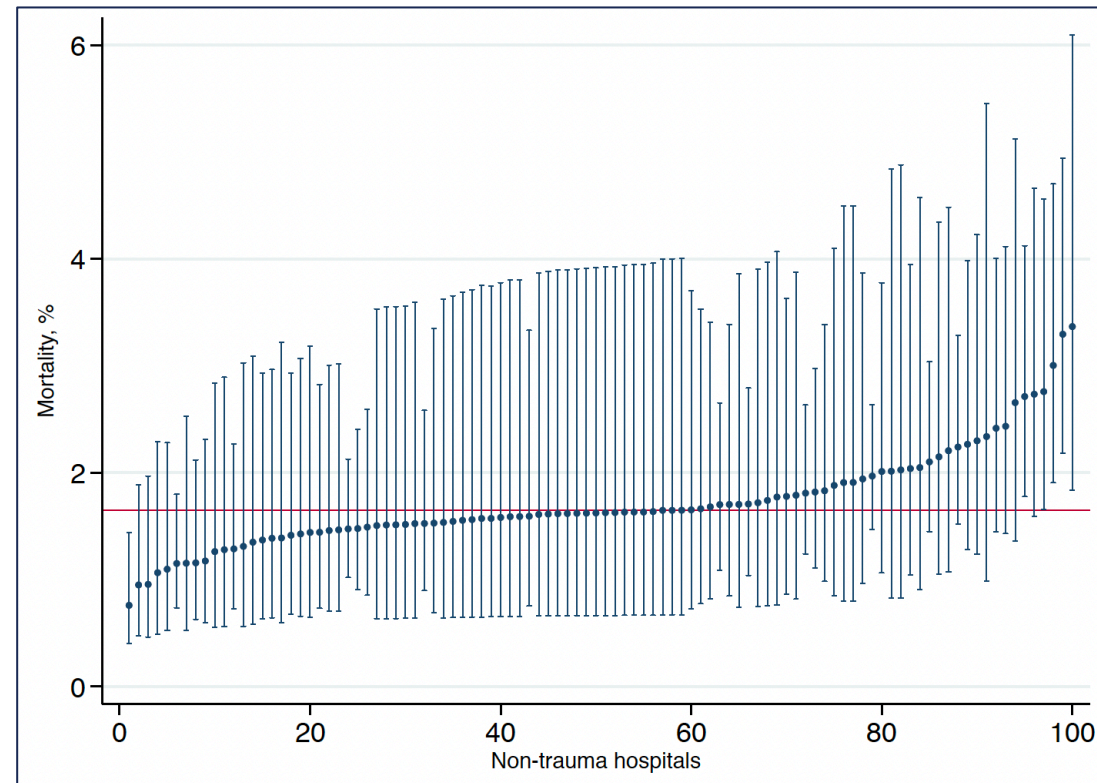
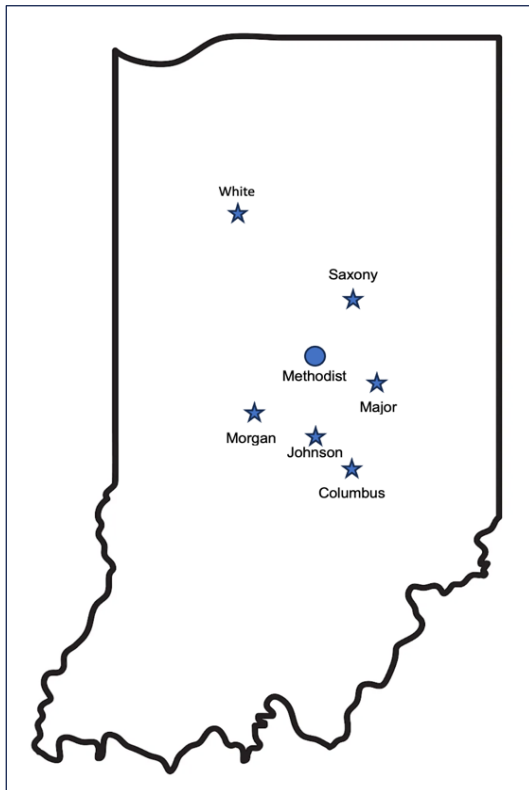


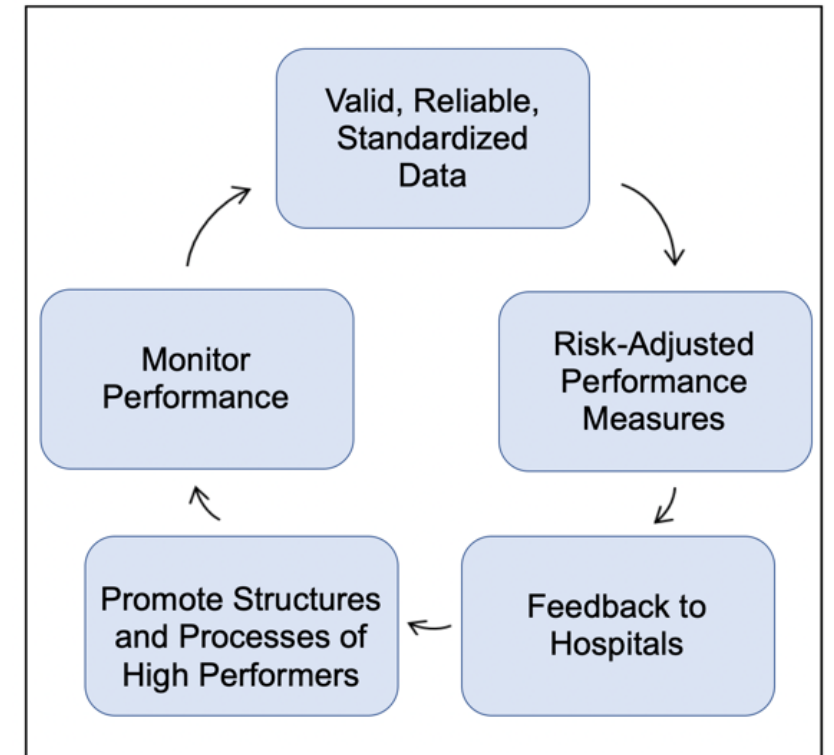
Figure 1. Ranked variation in risk-adjusted and reliability-adjusted mortality of injured patients treated at non-trauma hospitals with 95% CIs and cohort mean (N=100). *Annals of Surgery*, 2022.

# INX-TQIP

Apply TQIP model of collaborative quality improvement (CQI) to non-trauma hospitals



- Columbus Regional Hospital
- Johnson Memorial Hospital
- Major Hospital
- IUH Morgan Hospital
- IUH Saxony Hospital
- IUH White Hospital



- Increased engagement
- Improved data quality
- Improved outcomes
  - Mortality
  - Transfer rates
  - ED-LOS



## Activities

- Developed HPI
- Data Validation
- Site visits (x2)
  - In-person and virtual
- Collaborative-wide meetings
  - 1 Registrar conference
  - 2 Conferences
- Support for On-going Projects

## Team

- Program Director, 0.3 FTE
- Trauma Educator(s), 0.3 FTE
- Data Quality Specialist(s), 0.3 FTE



## Data Validation



# Example: Data Validation Form

Patient #1										
Variable	Incident Number	Incident ID	DOB	Incident Date	ISS	GCS	HR	SBP	ICD 10 Injury Code	ICD 10 Injury Description
IDOH Data	mh20221202048	2210292	[REDACTED]	[REDACTED]	33	.	.	.	V01.0	Pedestrian injured in collision w pedal cycle nontraf
Hospital Data			✓	✓		0	67	145		
Reason for Case Selection High ISS						1710 1710		pedestrian on bike unknown Lee fall		
Notes Name: [REDACTED]										
multiple rib fx, pneumo, traumatic cerebral intraparenchymal hemorrhage										
pelvic fx										
GCS 15 provider note										

# Hospital Performance Index, 2024-2025

<b>Measure Description</b>	
<b>Meeting Participation</b> <ul style="list-style-type: none"><li>• Trauma registry meeting for registrars (3 pt)</li><li>• Virtual collaborative meeting for physician and nursing leadership (3 pt)</li><li>• In-person collaborative meeting for physician and nursing leadership (4 pt)</li></ul>	0-10
<b>Site Visits</b> <ul style="list-style-type: none"><li>• Completion of in-person and remote site visits (5 pts each)</li></ul>	0-10
<b>Data Quality – Presence of Protocol to Identify Trauma Patients &amp; Abstract Clinical Data</b> <ul style="list-style-type: none"><li>• Presentation of protocol at a collaborative meeting (5 pt)</li></ul>	5
<b>Data Validation Error Rate</b> <ul style="list-style-type: none"><li>• 0-10% (5 pt)</li><li>• 11-20% (3 pt)</li><li>• 21-30% (1 pt)</li><li>• &gt; 30% (0 pt)</li></ul>	0-5



<p><b>Remote Data Access</b></p> <ul style="list-style-type: none"> <li>• Provides access to electronic medical records for data validation (2 pt)</li> </ul>	2
<p><b>Quality Improvement Initiative (Not reflected elsewhere on this document).</b></p> <ul style="list-style-type: none"> <li>• Presentation of a QI initiative at a collaborative meeting (10 pt)</li> <li>• Examples may include: <ul style="list-style-type: none"> <li>○ Rural Trauma Team Development Course</li> <li>○ Trauma Nursing Core Course</li> <li>○ Advanced Trauma Life Support</li> <li>○ Massive transfusion protocol</li> <li>○ Create trauma supply carts</li> <li>○ Increase identification of Advanced Directives</li> </ul> </li> </ul>	10
<p><b>Case reviews</b></p> <ul style="list-style-type: none"> <li>• Presentation of a case at a collaborative meeting (3 pt)</li> <li>• Examples may include: <ul style="list-style-type: none"> <li>○ Over-triage</li> <li>○ Success story</li> <li>○ Collaboration between facilities</li> <li>○ Opportunity for improvement suspected</li> </ul> </li> </ul>	3



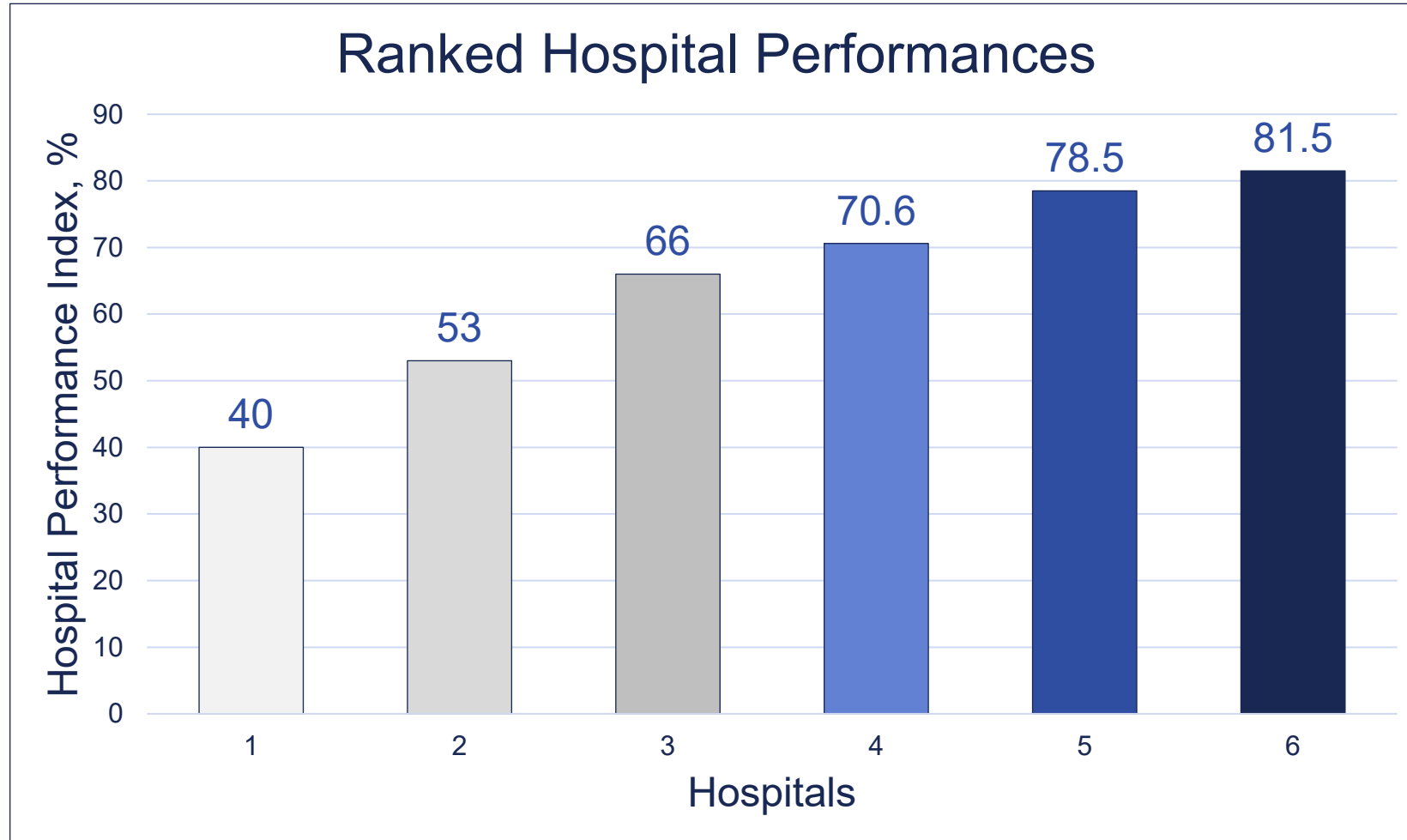
<p><b>Screening for Traumatic Brain Injury</b></p> <ul style="list-style-type: none"> <li>• 80-100% Glasgow Coma Scores (GCS) recorded (10 pt)</li> <li>• 50- 79% GCS recorded (5 pt)</li> <li>• &lt;50% GCS recorded (0 pt)</li> </ul>	0-10
<p><b>Completion of National Pediatric Readiness Assessment</b></p> <ul style="list-style-type: none"> <li>• More information available <a href="#">here</a>.</li> <li>• Assessment completed (5 pt)</li> </ul>	5
<p><b>Presence of an ED Pediatric Readiness Plan</b></p> <ul style="list-style-type: none"> <li>• Presentation at a collaborative meeting (5 pt)</li> </ul>	5
<p><b>Presence of Assessment and/or Treatment Protocol for Injured Patients</b></p> <ul style="list-style-type: none"> <li>• Examples: Trauma Activation Protocol &amp; Radiographic Imaging for Geriatric Falls</li> <li>• Presentation at a collaborative meeting (15 pt)</li> </ul>	15



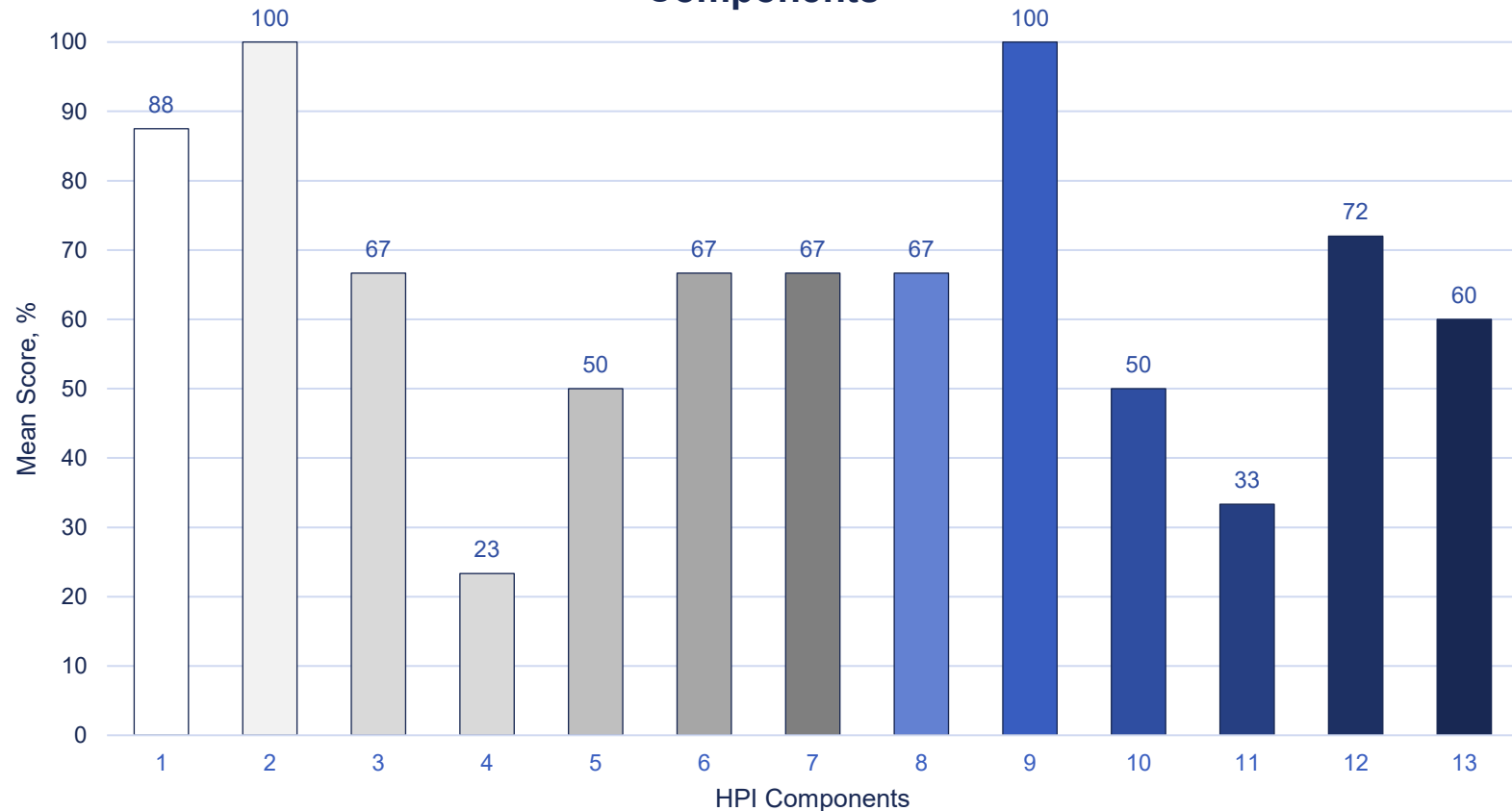
<p><b>Undertriage (under-recognition of injury severity)</b>  High-risk patients defined by <u>Indiana Field Triage and Transfer Guidelines</u></p> <ul style="list-style-type: none"> <li>• GCS &lt; 14</li> <li>• Systolic blood pressure &lt; 90 mmHg</li> <li>• Respiratory rate &lt; 10 or &gt; 29 breaths per minute or need for ventilator support (&lt;20 in infant aged &lt; 1 year)</li> </ul> <p>Rates of transfer to trauma center</p> <ul style="list-style-type: none"> <li>• 90-100% (10 pt)</li> <li>• 70-89% (8 pt)</li> <li>• 50-69% (6 pt)</li> <li>• &lt;50% (0 pt)</li> </ul>	0-10
<p><b>Timeliness of transfer from Emergency Department (goal &lt; 120 min.) for high-risk patients</b></p> <ul style="list-style-type: none"> <li>• 90% (10 pt)</li> <li>• 70-89% (8)</li> <li>• 50-69% (6)</li> </ul>	0-10



# Overall scores based on HPI, 2024-2025.



## Mean Cohort Scores by Hospital Performance Index (HPI) Components



### Legend

1. Meeting Participation
2. Site visits
3. Data Quality Protocol Presented
4. Data Validation Error Rate
5. Remote Data Access
6. Quality Improvement Initiative
7. Case Reviews
8. Screening for TBI
9. Peds Readiness Assessment
10. Pediatric Readiness Plan
11. Assessment and Treatment Protocol
12. Transfer Rates
13. Timeliness of Transfer



## Summary of INX-TQIP Accomplishments at One Year, 2024-2025.

<u>Project</u>	<u>Scope</u>	<u>Description</u>
Trauma Registry Data Validation Rules	Statewide	<ul style="list-style-type: none"> <li>• IDOH revised data validation rules based on feedback from participating hospital</li> </ul>
Inter-facility Transfer Protocol	Level 1 Trauma Center	<ul style="list-style-type: none"> <li>• Riley developed and instituted auto-accept policy based on feedback from participating hospital</li> </ul>
Radiographic Imaging Protocol for Geriatric Falls	Non-Trauma Hospitals	<ul style="list-style-type: none"> <li>• Adopted Methodist Trauma protocol to decrease repeated CTs and standardize care at 2 hospitals</li> </ul>
Increasing EMS Transfer Capacity	Non-Trauma Hospital	<ul style="list-style-type: none"> <li>• Hospital &amp; local FD partnered to staff ambulance                             <ul style="list-style-type: none"> <li>- AM – Wellness checks</li> <li>- PM – Transfers</li> </ul> </li> </ul>
Increasing Regional Trauma Leadership	Regional	<ul style="list-style-type: none"> <li>• ED Director joined the Trauma Regional Advisory Committee.</li> </ul>



## Summary of INX-TQIP Accomplishments at One Year, 2024-2025.

<u>Project</u>	<u>Scope</u>	<u>Description</u>
Trauma Registrar Training	Non-Trauma Hospital	<ul style="list-style-type: none"> <li>Funded the training of three trauma registrars for one hospital</li> </ul>
Trauma Registry Protocol & Registrar Mentorship	Non-Trauma Hospital	<ul style="list-style-type: none"> <li>Developed patient identification &amp; data abstraction protocol</li> <li>Included registrar mentorship with a nearby Level 3 trauma center</li> </ul>
Rural Trauma Education	Non-Trauma Hospital	<ul style="list-style-type: none"> <li>Completed rural trauma training course AND achieved 100% TNCC certification</li> </ul>
Trauma Education	Non-Trauma Hospital	<ul style="list-style-type: none"> <li>Established TNCC and ATLS certification goals of 50% among RN and EM providers</li> </ul>
Screening for Traumatic Brain Injuries	Non-Trauma Hospital	<ul style="list-style-type: none"> <li>Changed intake triage form to include GCS to improve screen and data collection at one hospital</li> </ul>
Trauma Champions	Non-Trauma Hospital	<ul style="list-style-type: none"> <li>Adopted trauma champions as a 2026 quality metric</li> </ul>



# Thanks!



***Thanks!***

**IDOH Team**

Vincente Benchino  
Lauren Milroy  
Ramzi Nimry  
Murray Lawry  
Brian Busching  
Dr. Lindsay Weaver

**IUH Methodist Team**

Scott Isenberg  
Lori Kelshiemer  
Maria Thurston  
Catana Phillips  
Michelle Yang  
Whitney Garrison



# Trauma System Planning Subcommittee Update

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Andy VanZee, Co-Chair

*Vice President of Regulatory & Hospital Operations, IHA*

Erik Streib, MD, Co-Chair

*Trauma Medical Director, Eskenazi Health*

# Trauma Planning (Feb 4th)

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## Trauma System Financing

- Non-reverting Fund as Part of 2027 Legislative Cycle
- Develop Plans for Long-Term Sustainability Beyond State Line Item

## Trauma Regional Advisory Committees

- Year 2 TRAC Funding – recommend full \$2.5M allocation for FY2026
- Administration of TRAC Funds & Daily Operations – further discussion needed

## RFA Proposals

- Military Integration – support concept, further discussion of details and budget
- QI System Development – update on previous funding outcomes at TCC

# Trauma Planning (Feb 4th)

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## Trauma System Designation

- Continue discussion on Whitespace and Level 3 expansions
  - Seymour (conversations on-going, strong support from administration)
  - New Albany (site visit completed and grant proposal development)
  - Columbus (initial discussion started)
  - Hancock (initial discussion started)

## State and Regional Coordination (Focus for 2026)

- Regional Medical Operation Centers update as part of RHTP efforts

# Trauma Planning (Sept 17th)

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## Verification Activity since last meeting

- Good Samaritan Hospital – Vincennes, Renewal of level 3 adult – 4/28/2026
- Franciscan Health- Indianapolis, Renewal of level 3 adult – 5/20/2026
- Elkhart General Hospital, Renewal of level 3 adult – 6/4/2026
- Riley Hospital for Children, Renewal of L1 pediatric verification- 8/5/2025, Renewed through 12/14/2028
- Franciscan Health Crown Point, Renewal of L3 adult verification- 9/17/2025, Renewed through 12/5/2027
- Franciscan Health Lafayette, Renewal L3 adult verification- 10/21/2025, Renewed through 12/15/2026
- Ascension St. Vincent Anderson, Renewal L3 adult verification - 10/28/2025, Renewed through 11/19/2028
- Ascension St. Vincent Indianapolis/Peyton Manning Children's, Renewal L1 adult/pediatric – 11/4/2025, Renewed through 12/5/2028

# Trauma Education & Outreach Subcommittee Update

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Matt Landman, MD, Co-Chair  
*Trauma Medical Director, IU Riley*

Jay Woodland, MD, Co-Chair  
*Deaconess Hospital*

# Trauma Education & Outreach Subcommittee

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- Meeting 2.29.26
  - Discussion – Injury Prevention Map
  - Injury Prevention social media update
  - ATLS/ATCN instructor discussion
  - Project ChildSafe firearm proposal
  
- 2026 KPIs
  - Increase IN ATLS instructor cohort by 10% (10-11 instructors)
  - Injury Prevention Social Media Campaign – 6 topics in 2026
  - Injury Prevention Interactive Map creation & population

Next Meeting: Wednesday, March 18<sup>th</sup> 12:30-1:30p EST



**Indiana**  
**Department**  
**of**  
**Health**

# INDIANA HOSPITAL ASSOCIATION TRAUMA & INJURY PREVENTION GRANT UPDATE



Madeline Wilson, MSN, RN, CLSSBB

February 6, 2026

# 2025 Activity Report

2025 Students Trained	North	Central	South
ABLS		14	
AIS Training	5	9	9
AICN	12	1	24
ATLS	4	142	18
ATLS Instructor	2	12	1
ATLS Recert			8
BDLS		41	
Cadaver Lab (multiple students)	1	1	
ENPC	135	171	52
ENPC Instructor	2	8	
ICD-10 Coding			2
Injury Prevention Professional			1
IILS			9
Mental Health First Aid		20	
PHILS			12
RTIDC		13	
STN Optimal			1
STN Topic			4
TCRN Review			149
TNCC	194	390	110
TNCC Instructor	4	9	
Trauma Registry			1
Vent Training			9
<b>Total</b>	<b>359</b>	<b>831</b>	<b>410</b>

Additional Items Reimbursed	North	Central	South
Thermoreflective caps	1300		
Trauma Simulation Mannequin	1		
Q in flow blood warmer		12	
Refrigerator for blood		1	
STB kits		50+	2
Fluid warmer		8	
Blanket warmers			120
Inflatable mannequins			150
Virtual Trauma Library			1
Trauma Registry Data Stipend	39 hospitals		

TCAR/PCAR Course	North	Central	South
# of Seats	118	285	90
# Completed	40	174	70
# Expired (Did not complete the course)	11	14	3
# Unwound*	10	26	18

Completion Rate-  $284/493=58\%$  (does not include expired students)

Cost per seat=\$300

\* Unwound=deleted student and reassigned seat (54)

2026 Total Spent= \$924,936

# Trauma Registry Subcommittee Update

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## *Chair:*

*Lisa Hollister, DNP, MSN, RN, LSSBB*

*Director, Parkview Health Trauma System and Better Future Clinic*

## *Co-Chairs:*

- *Summer Blakemore, CSTR, MA*  
*Trauma Data Quality Coordinator, Elkhart General*
- *Missy Smith, BNS, RN, TCRN*  
*Trauma PI Coordinator, St. Vincent*

# Registry “Themes”

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## Unknown Data in High-Impact Fields Is Increasing

### What we’re seeing (statewide):

- Increased use of “**Unknown**” in:
  - Field triage criteria (**red criteria**)
  - Mechanism and physiology-based elements
- These fields directly inform:
  - **Undertriage** measurement
  - EMS destination analysis
  - PI indicator calculations

### Why this matters:

- “Unknown” is not negative performance
- But **limits precision and confidence** in conclusions

# Why Does This Matter?

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- Our PI indicators **depend on the same data elements** showing increased “Unknown”
- Data quality now has **downstream implications** for:
  - **PI interpretation**
  - **System comparison**
  - **Action** prioritization

*The cost of unknown data increases as reliance on indicators increase*

# What This is Not

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## Important clarifications

This trend does **not** mean:

- Abstractors are underperforming
- EMS documentation is failing
- Registry data are unusable

This **does** mean:

- Certain elements need **shared clarification**
- Definitions and expectations may need reinforcement
- Registry PI has a critical role in interpretation

# Secondary Trauma Registry Consideration

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## Transfer Timestamp Consistency

- Variation **may occur** n:
  - “Decision to transfer”
  - “Orders written”
  - “Physical exit”
- These timestamps directly affect:
  - ED LOS **calculations**
  - <2-hour and <4-hour metric **benchmarks**

*Consistency in definition matters as much as accuracy  
(No deep dive today — flagging for awareness.)*

# Key Take Away

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**We need statewide trauma registry data that's strong enough to guide system discussion and strengthen data completeness that will make future PI efforts precise and effective.**

# Registry Trend **REMAINS:** Undertriage to Non-Trauma Centers

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## What Does the Registry Data Show:

A proportion of patients meeting **high-risk (red) triage criteria**

- Are initially transported to **non-trauma centers**

### Registry note

- This does **not** indicate inappropriate care
- It reflects real-world triage complexity and system factors

*Initial destination matters for downstream system flow...*

# Registry Trend **REMAINS**: Critical Transfers Rarely Meet <2 Hours

## What the Registry Data Show:

- Fewer than **1 in 5 critical secondary transfers** meet the **<2-hour ED exit benchmark**
  - The majority of critical transfers exceed 2 hours
  - <4-hour performance remains relatively stable

## Registry interpretation

*This is not a throughput collapse, it reflects the complexity of critical trauma transfers.*

# How These Patterns Interact (Registry Example)

## Illustrative System Pathway

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### Upstream

- High-risk trauma patients initially taken to a **non-trauma center**
  - Injury severity recognized after evaluation



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## Downstream

Patient requires:

- Stabilization
- Critical care resources
- Acceptance by a trauma center
- Coordinated transport



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ED LOS for transfer often exceeds: **<2 hours**

- **Initial placement may influence downstream transfer timelines**

*(Illustrative — not causal attribution)*

# Why <2 Hours Is Especially Difficult for Critical Patients

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## Registry Context

- Critical transfer patients often require:
  - Airway or hemodynamic stabilization
  - Ongoing critical care during ED stay
  - Imaging, labs, and maybe consultation before transfer
  - Transport capable of managing **high-acuity trauma needs**

*Moving a critically ill trauma patient safely takes time, even when the system works well!*

# Key Registry Takeaway

## Why This Matters

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IF high-risk patients reach trauma centers **initially**:

- Secondary transfers may be avoided
- The <2-hour transfer clock never starts

When correction is required later:

- Time reflects **necessary care**, not delay

*Upstream triage alignment reduces downstream transfer pressure*

# What the Registry Is (and Is Not) Saying

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## The registry is **NOT** saying:

- EMS or hospitals are performing poorly
- <2 hours is an easy or universal expectation
- These metrics should be used punitively

## The registry **IS** saying:

- These patterns coexist and interact
- Interpretation should consider **sequence and acuity**
- Data support **system-level discussion**, not blame

# Recommended Next Step: Trauma Triage Awareness and PI

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We are developing a PI subcommittee in the **North TRAC**.

- These issues cross EMS, hospitals, and system processes
- They are not best addressed by any single stakeholder group
- **Review** regional system patterns, support interpretation of data, and **identify** improvement opportunities
- **Develop** action plan/goals for improvement
- **Follow through** with loop closure

# Role of Registry in PI

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## How Registry PI Supports the System

Registry PI helps by:

- Identifying **where data limitations affect interpretation**
- Validating **trend direction vs artifact**
- **Supporting** appropriate use of PI indicators
- **Preventing** misdirected improvement efforts

*Good PI starts with trusted data*

# Performance Improvement Subcommittee Update

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Eric Yazel, MD, Co-Chair  
*EMS Medical Director, DHS*

Scott Thomas, MD, Co-Chair  
*Trauma Medical Director, Memorial Hospital South Bend*

# Performance Improvement Subcommittee

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- Last meeting 1/22
- Integration with the SMOC for Data Points
- Finalizing overall KPI's

2 KPI's to focus on

- Scene times (minus extrication time)
- Over and under triage of patients

# Performance Improvement Subcommittee

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Nothing to vote on

Next meeting Thursday 4/23 at 1

Any questions, comments, feedback from the commission?

# Disaster Preparedness and Military Integration Subcommittee Update

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David Welsh, MD, Co-Chair  
*Surgeon, Margaret Mary Health*

Mark Liao, MD, Co-Chair  
*Medical Director, Indianapolis EMS*

# Disaster Preparedness and Military Integration

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- Statewide TAA plans are evolving
- Disaster Privileges discussed
- NDMS List
- Burn Injury Tabletop Plans
- Reaching out to the TRACs
- RMOCC discussion
- Military connections
- Urban Search and Rescue
- Ask: Training Opportunities across the state

# Disaster Preparedness and Military Integration

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## IPHCA proposal – TAA / military integration

- Strategy area(s): Trauma system development
- Project objective is to create a statewide collaboration to integrate military medical assets, hospitals, and health centers through training affiliation agreements, joint exercises, and coordinated emergency response to help strengthen Indiana's trauma and disaster readiness
- \$758,119 (FY26 & FY27)

# Final Business

- National Pediatric Readiness Project assessment launches **March 3<sup>rd</sup>**
- Webinar on February 12th.
- The ask:
  - 1 person completes the assessment for the Emergency Department



**NEW JOINT GUIDELINES**

Ensure your ED aligns with the latest evidence on pediatric care.

**National NPRP**  
Pediatric Readiness Project  
Ensuring Emergency Care for All Children

**ASSESSMENT OPENS MARCH 3**

**Learn what's new in the updated 2026 guidelines on pediatric emergency care and the National Pediatric Readiness Project (NPRP) Nationwide Assessment**

The next NPRP Nationwide Assessment of EDs is based on recently updated joint guidelines from the leading organizations in emergency medicine, emergency nursing, pediatrics, and trauma surgery. Participation is vital: high readiness, as measured by the assessment, is associated with as much as 76% reduced mortality risk.<sup>1</sup> Assessment participants receive an instant, individualized score along with benchmarking metrics and a detailed gap analysis.

**2026 updates and areas of emphasis:**

- Availability of physicians 24/7 (in-person vs. on-call)
- Use of validated triage tool
- Suicide screening and assessment
- Acute agitation protocol
- Clinical pediatric protocols for common conditions (seizures, asthma, etc.)
- New equipment recommendations (portable resuscitation cart, specific sizes, cuffed tubes, supraglottic devices)
- Updates to existing questions for improved clarity, including examples

**Nationwide assessments take place every 5 years, so don't miss your chance to show you care about kids!**

 **Learn more and find resources at [pediatricreadiness.org](https://pediatricreadiness.org)**

**Join an informational webinar on February 12. [Click here to register!](#)**

<sup>1</sup> [https://media.emscimprovementcenter.com/documents/Pediatric\\_Readiness\\_Impact\\_Statistics.pdf](https://media.emscimprovementcenter.com/documents/Pediatric_Readiness_Impact_Statistics.pdf)  
This EMSC Innovation and Improvement Center and EMSC Data Center infographic is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of awards totaling \$3.9M and \$5.2M respectively, with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA-gov. 201720 | Updated 1/13/2026

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## 2026 Meetings:

May 1, 2026

August 7, 2026

November 6, 2026

10:00am to 12:00pm (Eastern Time)