Indiana State Department of Health

Trauma and Injury Prevention

Indiana Trauma and Injury Prevention State Plan

January 1, 2019 – December 31, 2020 Strategic Plan

Mission statement

To develop, implement and provide oversight of a statewide comprehensive trauma care system that:

- Prevents injuries.
- Saves lives.
- Improves the care and outcomes of trauma patients.

Vision

Prevent injuries in Indiana.

Core values

- **Integrity**—We are honest, trustworthy, and transparent. We will do the right things to achieve the best public health outcomes.
- **Innovation**— We encourage innovation to continuously enhance our programs and services, engage our workforce, advance our mission, and keep pace with community needs, and to communicate and utilize scientific data and evidence-based practices to achieve optimal health.
- **Collaboration**—We will achieve optimal health for all Hoosiers when we work side by side with partners, communities, and individuals.
- **Excellence**—We will work every day to provide the best public health services to the citizens of Indiana through continuous quality improvement.
- **Dedication**—We are committed to solving public health issues by focusing on what we can do, not what we can't.

Strategic priorities

The Division of Trauma and Injury Prevention considers the following Indiana State Department of Health (ISDH) priorities will have the most impact on the way the division operates and on its ability to deliver on its Mission and Vision:

- Better use of information and data from electronic sources to develop and sponsor outcomes-driven programs.
- Improve relationships and partnerships with key stakeholders, coalitions and networks throughout the State and the nation.
- Decrease disease incidence and burden.
- Improve response and preparedness networks and capabilities.
- Reduce administrative costs through improving operational efficiencies.
- Recruitment, evaluation and retention of top talent in public health.

What is a trauma system?

An ideal trauma system includes all the components identified with optimal trauma care, such as prevention, access, pre-hospital care and transportation, acute hospital care, rehabilitation and research activities. The term "inclusive" trauma system is used for this all-encompassing approach, as opposed to the term "exclusive" system, which focuses only on the major trauma center. It must be noted however that an "inclusive" system does not mean an unplanned or unregulated system. Each facility should have an identifiable role based on resources and needs of the community rather than their self-selected level of designation. Although this document still addresses trauma center verification and consultation, it also emphasizes the need for various levels of trauma centers to cooperate in the care of injured patients to avoid wasting precious medical resources. The intent of this emphasis is to provide optimal care in a cost-effective manner.

Trauma system elements

A trauma system is an organized approach to treating patients with acute injuries. We need to evaluate the entire trauma system to get a better understanding of the continuum of trauma patient care in Indiana. Indiana does not have an integrated statewide trauma system—we are one of only 6 states without one. Indiana has components of a system:

- Emergency medical services (EMS) providers.
- Trauma centers.
- Trauma registry.
- Rehabilitation facilities.

Indiana trauma system history

2004

- Trauma System Advisory Task Force formed.

2006

- IC 16-19-3-28 (Public Law 155) named the State Health Department (ISDH) the lead agency for statewide trauma system:

  State department designated as lead agency of a statewide trauma care system; rule making authority

  Sec. 28

  (a) The state department is the lead agency for the development, implementation, and oversight of a statewide comprehensive trauma care system to prevent injuries, save lives, and improve the care and outcome of individuals injured in Indiana.

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

  (1) A state trauma registry.

  (2) Standards and procedures for trauma care level designation of hospitals.
- ISDH hired a trauma system manager.

2007

- Federal funding from the National Highway Transportation Safety Administration (NHTSA 408) for the state trauma registry was received from the Indiana Criminal Justice Institute (ICJI). A contract with a trauma registry software vendor (ImageTrend) was completed.
  - ICJI funding continues today.

2008

- Senate Bill 249 gave the Department of Homeland Security (IDHS) the authority to adopt Emergency Medical Services (EMS) triage and transportation protocols.
- ISDH hired its first state trauma registry manager.
- The American College of Surgeons (ACS) conducted an evaluation of Indiana's trauma system.

2009

- ACS provided a set of recommendations for further development of Indiana's trauma system.
- Governor Daniels created by executive order the Indiana State Trauma Care Committee (ISTCC).

2010

- The first meeting of the ISTCC (previously the Trauma Care Task Force) was held. The ISTCC serves as an advisory body to the ISDH on all issues involving trauma.

2011

- The ISDH hired a trauma and injury prevention division director, prioritizing trauma as a division within the agency.
- ISDH created the Trauma and Injury Prevention Division.

2012

- The EMS Commission adopted the Triage and Transport Rule.

2013

- Governor Pence re-issued Governor Daniels' original Executive Order creating the Indiana Trauma Care Committee.

- The ISDH and IDHS EMS Commission worked together to approve "in the process of ACS verification" trauma centers for purposes of the Triage and Transport Rule, which will greatly increase the number of trauma centers in Indiana and will better prepare Indiana hospitals to become ACS verified trauma centers.
- Governor Pence signs the Trauma Registry Rule. The trauma registry rule requires all EMS providers, hospitals with emergency departments, and rehabilitation hospitals to submit their trauma data to the state trauma registry.

2014

- The ISDH hosted the first statewide EMS Medical Director's Conference.
- IU Health Arnett Hospital and IU Health Ball Memorial Hospital became the state's first ACS verified level III trauma centers.
- The ISDH received $1.4 million from the Centers for Disease Control and Prevention (CDC) to gather critical data on violent deaths using the National Violent Death Reporting System (NVDRS).

2015

- The ISDH hosted the first statewide Injury Prevention Conference.
- The ISDH hired an INVDRS Epidemiologist, INVDRS Law Enforcement Records Coordinator, INVDRS Records Consultant and Injury Prevention Program Coordinator.
- The ISDH hosted the second annual EMS Medical Directors' Conference.
- As of July 1, the EMS registry responsibilities shifted from the ISDH to the Indiana Department of Homeland Security (IDHS).
- The ISDH published and released "Preventing Injuries in Indiana: A Resource Guide" and application on iOS and Android platforms.

2016

- The ISDH hired an Events Project Coordinator.
- The ISDH received $5.6 million from the CDC through the prescription drug overdose: prevention for states grant to support enhancements to INSPECT, the Indiana prescription drug monitoring program at the Indiana Professional Licensing agency, improve opioid prescribing practices, support prevention efforts at the state and community levels to address new and emerging problems related to prescription drug overdoses and a partnership with the IU Fairbanks School of Public Health to evaluate opioid prescribing practices in Indiana. This is a three and a half year grant.
- The ISDH received $800,000 in the state budget bill for naloxone kit distribution to local health departments. This is over the course of the next three years.
- The ISDH hired a PDO Community Outreach Coordinator, Records Consultant and PDO Epidemiologist.
- The ISDH received a Public Health Associate through the CDC's Public Health Associate Program (PHAP). This associate is with us for two years.

2017

- The ISDH received $800,000 from Indiana Family and Social Services Administration (FSSA) for the 21st Century Cures Act grant to distribute naloxone kits to local health departments for the next two years.
- The ISDH received $957,000 from the CDC through the enhanced state surveillance of opioid-related morbidity and mortality grant to: 1) increase the timeliness of aggregate nonfatal any-drug, any-opioid, and heroin overdoses reporting, 2) increase the timeliness of aggregate fatal

opioid overdose and associated risk factor reporting using the National Violent Death Reporting System (NVDRS) web-based data entry system and 3) create, implement and customize a Dissemination Plan to share fatal and nonfatal surveillance findings to key stakeholders, including the public, working to prevent or respond to opioid overdoses. This is a two year grant.

- The ISDH received $3.2 million from Substance Abuse and Mental Health Services Administration (SAMHSA) through the first responder comprehensive addiction and recovery act (FR CARA) grant to 1) provide resources through the Indiana Naloxone Kit Distribution Program for First Responders for emergency treatment of known or suspected opioid overdoses in rural communities; 2) train first responders on carrying and administering naloxone; and 3) expand the Indiana Recovery and Peer Support Initiative for referral to appropriate treatment and recovery communities.
- The ISDH hired three additional Records Consultants, two additional PDO Community Outreach Coordinators and a naloxone program manager.
- The ISDH received an additional PHAP from the CDC.

2018

- The ISDH compiled a list of certified stroke centers per IC 16-31-2-9.5 requirements.
- The ISDH no longer requires firework injury reporting per IC 35-4-7-7.
- The ISDH received $1 million over three years from the Administration for Community Living (ACL) through the Traumatic Brain Injury (TBI) grant to maximize health outcomes and reduce disability following TBI. The division is partnering with the Rehabilitation Hospital of Indiana to carry out the work of this grant.
- The ISDH received $1 million over three years from the Bureau of Justice Administration (BJA) through the STOP School Violence Prevention and Mental Health Training Program grant to expand in-school services and prevention education of school personnel, mental health professionals, students and families; increase the collection and data timeliness of aggregate school violence, bullying and adolescent mental health reporting; and operate a crisis intervention team that will coordinator law enforcement agencies and school personnel.
- The ISDH received $1 million over three years from the BJA through the Comprehensive Opioid Abuse Site-based Program grant to fund the current toxicology program for coroners, expand current efforts to test all suspected overdoses in emergency departments (fatal and non-fatal) and link data between INSPECT (state's prescription drug monitoring program), Coroner Case Management System and toxicology program.
- The ISDH rolled out the coroner toxicology program which requires all coroners to submit toxicology screens for suspected drug overdose deaths and report the findings to the ISDH. As of November 26, 91 counties are participating in the program.

Burden of injuries in Indiana

Injuries are caused by acute exposure to physical agents, such as mechanical force or energy, heat, electricity, chemicals and ionizing radiation, in amounts or at rates that cause bodily harm. Injury may either be unintentional or intentional (violence-related, including assault, homicide and suicide) and can lead to death, disability and lifelong health consequences. Unintentional injury accounts for the vast majority of injury-related deaths and can be defined as involving injury or poisoning by unpremeditated measures. Unintentional injury is also the leading cause of years of potential life lost in Indiana, which is a measure of premature mortality and early death. Regardless of intention, injury has emerged as a public health issue leading to significant morbidity and mortality.

Injury is the leading cause of death for Indiana residents[r1] ages 1 through 44 years, and the fifth leading cause of death overall. In 2016, there were 5,164 injury deaths at an age-adjusted rate of 77.85 per 100,000, compared to a national rate of 68.78 per 100,000. Of the 5,164 injury deaths, 1,034 Hoosiers died by suicide and 480 died from homicide. The leading causes of unintentional injury death in Indiana in 2016 were poisoning (1,526 deaths), motor vehicle collisions (809 deaths) and falls (491 deaths). In the same year, more than 50,000 Hoosiers suffered a traumatic brain injury (TBI), which resulted in 1,239 deaths. The highest number of TBI-related deaths were among 14-24 year olds.

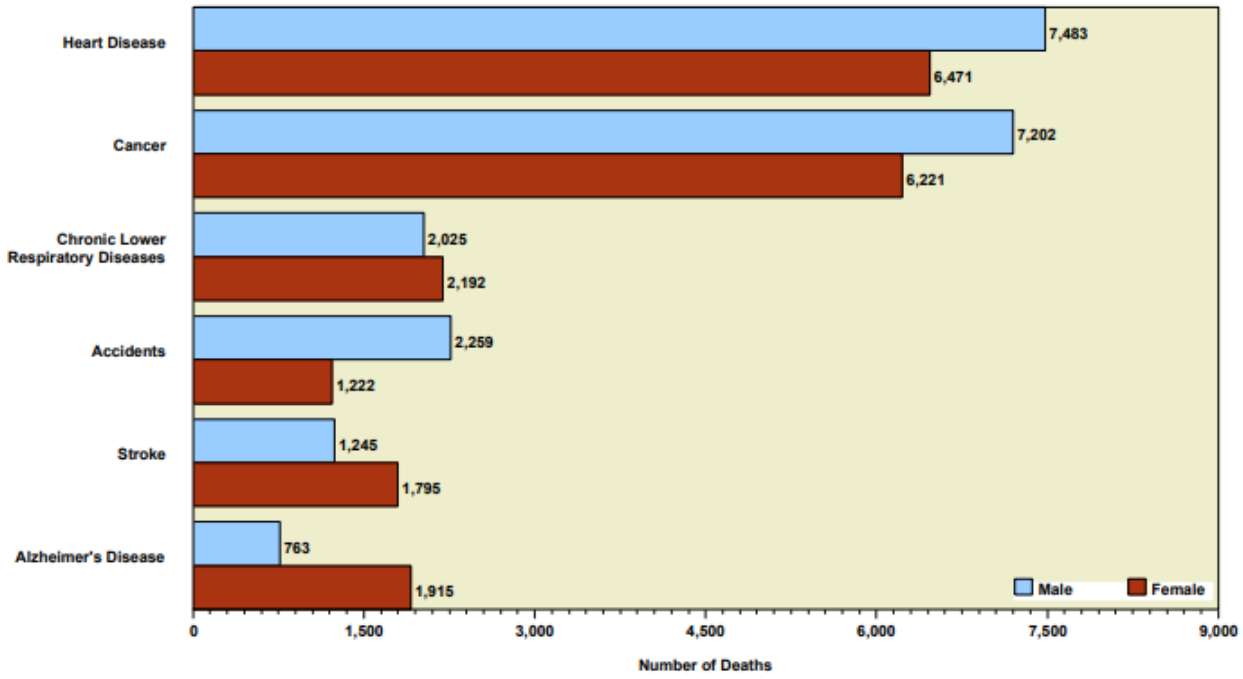
The injury pyramid provides a visualization of injury spectrum, illustrating the reality that injury-related deaths represent a small percentage overall injury-related outcomes. While deaths are the most devastating outcome related to injuries, the analysis of hospitalization and emergency department visits related to injury provides additional useful information. Although injury deaths are significant, non-fatal injuries occur more frequently. More than 36,000 Hoosiers are hospitalized and more than 620,000 visit emergency departments for injuries each year.

Adapted from Safe States Alliance (formerly State and Territorial Injury Prevention Directors Association): Safe States, 2003 Edition

The financial consequences from injuries are extensive. The CDC estimates that the lifetime medical costs were more than $47.9 million and work loss costs totaled more than $4.1 billion for injury deaths occurring in Indiana in 2010. From motor vehicle crash deaths in Indiana in one year, the CDC estimates $10 million in medical costs and $1.06 billion in work lost costs. These totals do not include other costs such as impacts on the quality of life.

Leading Causes of Death

Total Population, by Sex: Indiana Residents, 2016



Indiana State Department of Health, Epidemiology Resource Center, Data Analysis Team.
Indiana Mortality Report, State and County Data 2016. 2018

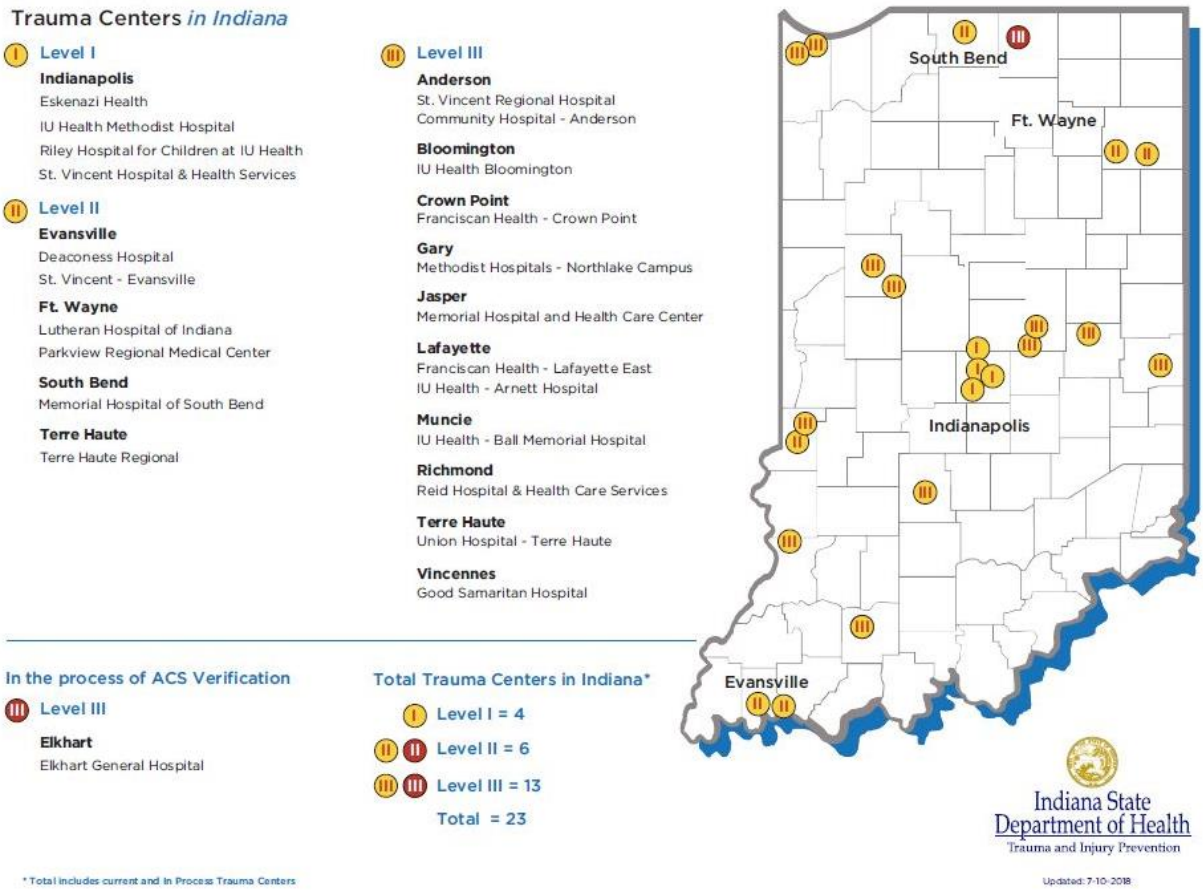
10 Leading Causes of Injury Deaths, Indiana

2016, All Races, Both Sexes

	Age Groups												
Rank	<1	1-4	5-9	10-14	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+	All Ages
1	Congenital Anomalies 151	**Unintentional Injury 26**	Malignant Neoplasms 11	**Unintentional Injury 17**	**Unintentional Injury 340**	**Unintentional Injury 620**	**Unintentional Injury 497**	Malignant Neoplasms 973	Malignant Neoplasms 2,766	Malignant Neoplasms 3,736	Malignant Neoplasms 3,460	Heart Disease 5,071	Heart Disease 13,952
2	Short Gestation 132	Congenital Anomalies 10	**Homicide ---**	Malignant Neoplasms 10	**Suicide 147**	**Suicide 162**	Heart Disease 260	Heart Disease 860	Heart Disease 1,815	Heart Disease 2,512	Heart Disease 3,316	Malignant Neoplasms 2,107	Malignant Neoplasms 13,424
3	**Unintentional Injury 55**	Malignant Neoplasms ---	**Unintentional Injury ---**	**Suicide 10**	**Homicide 141**	**Homicide 129**	Malignant Neoplasms 248	**Unintentional Injury 510**	Chronic Low. Respiratory Disease 566	Chronic Low. Respiratory Disease 1,052	Chronic Low. Respiratory Disease 1,341	Alzheimer's Disease 1,748	Chronic Low. Respiratory Disease 4,214
4	SIDS 40	**Homicide ---**	Influenza & Pneumonia ---	**Homicide ---**	Malignant Neoplasms 32	Heart Disease 87	**Suicide 171**	**Suicide 209**	**Unintentional Injury 451**	Cerebro-vascular 476	Cerebro-vascular 788	Cerebro-vascular 1,314	**Unintentional Injury ---**
5	Maternal Pregnancy Comp. 22	Cerebro-vascular ---	Congenital Anomalies ---	Septicemia ---	Heart Disease 22	Malignant Neoplasms 71	**Homicide 83**	Liver Disease 167	Diabetes Mellitus 343	Diabetes Mellitus 449	Alzheimer's Disease 746	Chronic Low. Respiratory Disease 1,077	Cerebro-vascular 3,040
6	Bacterial Sepsis 21	Heart Disease ---	Chronic Low. Respiratory Disease ---	Cerebro-vascular ---	Influenza & Pneumonia 10	Diabetes Mellitus 19	Liver Disease 59	Diabetes Mellitus 161	Liver Disease 328	Septicemia 269	Diabetes Mellitus 492	Nephritis 541	Alzheimer's Disease 2,678
7	Neonatal Hemorrhage 15	Five Tied ---	Septicemia ---	Congenital Anomalies ---	Complicated Pregnancy ---	Cerebro-vascular 17	Diabetes Mellitus 58	Chronic Low. Respiratory Disease 140	Cerebro-vascular 272	Nephritis 261	Nephritis 369	Diabetes Mellitus 461	Diabetes Mellitus 1,992
8	Placenta Cord Membranes 11	Five Tied ---	Seven Tied ---	HIV ---	Diabetes Mellitus ---	Liver Disease 17	Cerebro-vascular 43	Cerebro-vascular 122	Septicemia 183	**Unintentional Injury 258**	Septicemia 308	**Unintentional Injury 416**	Nephritis 1,411
9	Respiratory Distress 11	Five Tied ---	Seven Tied ---	Influenza & Pneumonia ---	Chronic Low. Respiratory Disease ---	Complicated Pregnancy 15	Nephritis 22	Septicemia 77	**Suicide 167**	Liver Disease 179	**Unintentional Injury 300**	Influenza & Pneumonia 387	Septicemia 1,211
10	Three Tied ---	Five Tied ---	Seven Tied ---		Septicemia ---	Influenza & Pneumonia 13	Septicemia 22	Nephritis 68	Nephritis 137	Alzheimer's Disease 161	Parkinson's Disease 296	Septicemia 328	**Suicide 1,034**

WISARS Note: Counts of less than 10 deaths have been surpressed (---).
Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control, CDC
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System

Trauma Centers in Indiana



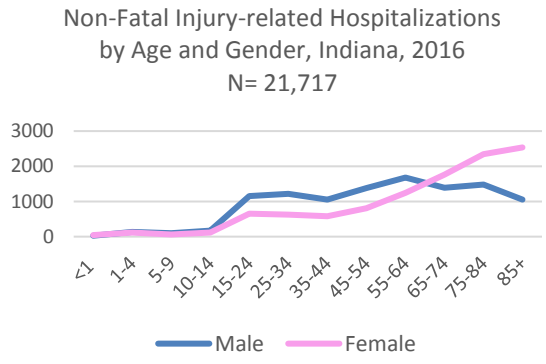
As of 7/10/2018

SNAPSHOT OF THE INDIANA TRAUMA SYSTEM

VERIFICATION	**23 Trauma Centers**
	4 Level I
	6 Level II
	13 Level III
DESIGNATION	**1 "In the Process" Trauma Center**
	1 Level III

Indiana EMS/Trauma Registry Reporting

Hospitals Reporting Trauma Records



5

The top five causes of injury leading to hospitalization were:

1. Falls
2. Motor vehicle/Traffic
3. Firearm
4. Struck by/Against
5. Cut/Pierce

Indiana efforts to reduce injuries and violence

There are a variety of strategies that can be effective for preventing injuries and mitigating their effects. These strategies generally fall within three categories: legal or policy changes, product and environmental safety developments, and education. While the burden remains high, Indiana has implemented policies, programs and prevention efforts to reduce injury and trauma morbidity and mortality.

The Trust for America's Health, with funding from the Robert Wood Johnson Foundation, published the 2017 *The Facts Hurt: A State-By-State Injury Prevention Policy Report***.** The Report focused on a series of 10 indicators that provides a snapshot of efforts states are taking to prevent and reduce injuries and violence. Indiana met seven of the ten indicators and, while not a comprehensive evaluation of injury and violence prevention, they do provide information about the strengths and weaknesses of each state's injury prevention program.

Indicator	Indiana Status	Number of States Meeting Indicator
1. Does the state have a primary seat belt law?	Yes	34 states and D.C. have primary seat belt laws

2. Does the state require mandatory ignition interlocks for all convicted drunk drivers, even first-time offenders?	Yes	51 states require mandatory ignition interlocks for all convicted drunk drivers, even first-time offenders
3. Does the state require car seats or booster seats for children up to at least the age of 8?	Yes	35 states and D.C. require that children ride in car seats or booster seats up to at least the age 8
4. Does the state restrict teens from nighttime driving after 10 p.m. (Most states have a Graduated Drivers License (GDL) with some time and passenger restrictions, but this indicator requires a 10 p.m. restriction)?	Yes	49 states restrict nighttime driving for teens starting at 10 p.m. in their Graduated Driver Licensing laws.
5. Does the state require bicycle helmets for all children?	No	38 states and Washington, D.C. require bicycle helmets for all children.
6. Does the state have fewer homicides than the national goal established by the U.S. Department of Health and Human Services (HHS)?	Yes	31 states have homicide rates at or below the national goal of 5.5 per 100,000 people.
7. Does the state have a child abuse and neglect rate at or below the national rate?	No	25 states have child abuse and neglect rates at or below the national rate of 9.1 per 1,000 children.
8. Does the state have fewer deaths from falls than the national goal established by HHS?	No	13 states have fewer fall-related deaths than the national goal of 7.2 per 100,000 people
9. Does the state require mandatory use of data from the prescription drug monitoring program (PDMP) by at least some healthcare providers?	Yes	25 states require mandatory use of PDMPs for healthcare providers in at least some circumstances.
10. Does the state have laws in place to expand access to, and use of, naloxone, an overdose rescue drug?	Yes	34 states and D.C. have a law making it easier for medical professionals to prescribe and dispense naloxone and/or for lay administrators to use it without the potential for legal ramifications

Robert Wood Johnson Foundation (June 2015). *The facts hurt: A state-by-state injury prevention policy report 2015.* Retrieved from http://healthyamericans.org/assets/files/TFAH-2015-InjuryRpt-final6.18.pdf

System development

The statute granting ISDH authority over the state's trauma system includes a directive that ISDH develop that system. System development is a process in which different stakeholders cooperate to enhance and improve performance. As trauma center and non-trauma centers programs develop and

emerge, it is important to integrate individual facility and regional trauma systems into a larger public health framework. The division will collaborate with statewide partners to integrate systems and improve the standard of trauma care across the state of Indiana.

Objectives	Strategies
1. Build relationships with internal and external organizations involved with trauma-related activities (e.g., disaster preparedness, mental health, burns, rehabilitation, and specific patient populations).	1.1 Identify partners and stakeholders to be involved with the Indiana State Trauma Care Committee.
	1.2 Obtain data sharing agreements and Memorandums of Understanding (MOUs) with entities.
	1.3 Provide data reports relevant to their area of focus.
	1.4 Attend meetings and events to engage with new partners and provide information about Indiana's trauma system and how it pertains to their work.
2. Develop regional trauma systems.	2.1 Continually update roadmap to help districts develop their regional trauma committee.
	2.2 Encourage regular collaboration within the region.
	2.3 Provide region-specific data to assist regions in identifying areas of opportunity.
	2.4 Provide state-level updates to regions to align regional and state goals and initiatives.
	2.5 Establish patient care review processes.
	2.6 Explore methods to monitor regional trauma system development.
	2.7 Facilitate cross-regional communication and collaboration, especially in areas without verified trauma centers.
	2.8 Implement regional PI processes that feed into statewide PI processes.
	2.9 Evaluate region-specific resources to maximize the continuum of trauma care while minimizing expenses.
	2.10 Identify experts from other states to present successes and lessons learned in regional trauma system development.
	2.1 Connect ACS-verified trauma centers and non-trauma centers through mentorship program.
3. Develop a budget to fund a statewide trauma system.	3.1 Identify top priority areas and funding needed to support these activities. Research other states' trauma funding streams and budgets to identify trauma system activities that improve patient care. Tie to cautification of statewide trauma care committee.
	3.2 Present the budget to the ISTCC.
	3.3 Present the budget to the ISDH Chief Financial Officer.
	3.4 Explore the capabilities of establishing a trauma care fund as referenced in Executive Order for ISTCC.

	3.5 Work with Indiana Hospital Association to budget funds left over from 2008 ACS consultation visit.
4. Establish a funding stream to sustain the statewide trauma system.	4.1 Provide a budget and justification as part of the budget legislative proposal for FY19 and FY21.
	4.2 Work with ISDH Finance to identify and apply for funding opportunities (federal, state and local) based on division's priority areas.
	4.3 Work with the Healthy Hoosiers Foundation (HHF) to promote donations earmarked for trauma programs.
	4.4 Work with other ISDH divisions to identify collaborative funding opportunities.
	4.5 Share funding opportunities with stakeholders and partners to enhance local trauma and injury prevention efforts.
5. Establish next steps in statewide trauma system development with the American College of Surgeons (ACS).	5.1 Invite ACS to return to Indiana for a statewide trauma system reassessment.
	5.2 Work with the ACS Advocacy group to identify what has worked in other states regarding trauma system development and funding.
6. Establish an annual awards banquet for those providing excellent trauma care in the state.	6.1 Create an awards subcommittee to establish awards and criteria to qualify for awards.
	6.2 Utilize end of the year meetings or events to include an awards ceremony.
7. Create state Designation Rule.	7.1 Work with Designation subcommittee of ISTCC to establish criteria for state designation of trauma centers.
	7.2 Ensure that designation rule subsumes "in the process" designation and adds the ability to review "in the process" hospitals during the two-year process.
8. Update Executive Order for the Indiana State Trauma Care Committee (ISTCC).	8.1 Update Executive Order to reflect current state of trauma system (~~rehabilitation facility~~post-acute care representative and~~, "in the process" facility representative,~~ air medical representative).
	8.2 Discuss creating ISTCC in state law versus Executive Order.[HK1]
	8.3 Establish terms of committee members.
9. Create tools that can be utilized by new trauma stakeholders regarding the history of statewide trauma system development.	9.1 Update Orientation Packet on a monthly basis and share with new ISTCC members, as well as new trauma stakeholders.
	9.2 Establish an orientation folder that contains: • Orientation document. • *Trauma Times* newsletter. • Opportunities to get involved with the development of the statewide trauma system. • Contact information for division staff. Orientation folder will be given to hospitals submitting "in the process" applications and new ISTCC members.
	10.1 Evaluate skills of current staff and identify areas of opportunity for advancement within the Division.

10. Focus on staff development for the Division of Trauma and Injury Prevention.	10.2 Identify continuing education opportunities for staff.
11. Maintain Indiana Spinal Cord and Brain Injury Research Fund Board.	11.1 Coordinate meetings for Indiana Spinal Cord and Brain Injury Research Fund Board.
	11.2 Coordinate bi-annual conference for recipients of Indiana Spinal Cord and Brain Injury Research Fund.
12. Encourage opportunities for policymakers and health department leadership regarding public health approaches to trauma and injury prevention.	12.1 Coordinate state policymaker visits to trauma centers.
	12.2 Facilitate opportunities (i.e., trauma tour events) with policymakers to increase recognition of the role of public health in injury prevention and trauma care system development.
13. Focus on pediatric population injury prevention and trauma care needs.	13.1 Identify and implement pediatric injury prevention programs, including child passenger safety, Neonatal Abstinence Syndrome (NAS) and Sudden Unexpected Infant Death (SUID).
	13.2 Support pediatric readiness initiatives including pediatric care coordinators at facilities through the Pediatric Emergency Care Coordinator (PECC) Advisory Board.
	13.3 Conduct surveillance and disseminate pediatric trauma and injury findings to support prevention programs.

Pre-hospital

The first phase of Indiana's trauma system activates immediately following an injury or an overdose.

When a call is made to the 911 operator. The response can be coordinated among various first responders including Emergency Medical Services (EMS) ambulances, law enforcement and Fire.

If the Trauma or Overdose call is initially directed to Emergency Medical Services (EMS) initial assessments and diagnoses of the patient are made, and the patient is stabilized and quickly but safely transported to a local hospital or trauma center. EMS crews are often the critical link between the injury-producing event and definitive care at a trauma center or local hospital. The first hour post-injury is known as "the Golden Hour," when critical skilled care must be provided. The Indiana Department of Homeland Security (IDHS) is responsible for oversight of EMS in Indiana.

If the initial call is directed to law enforcement or Fire for an Overdose, naloxone is given if available.

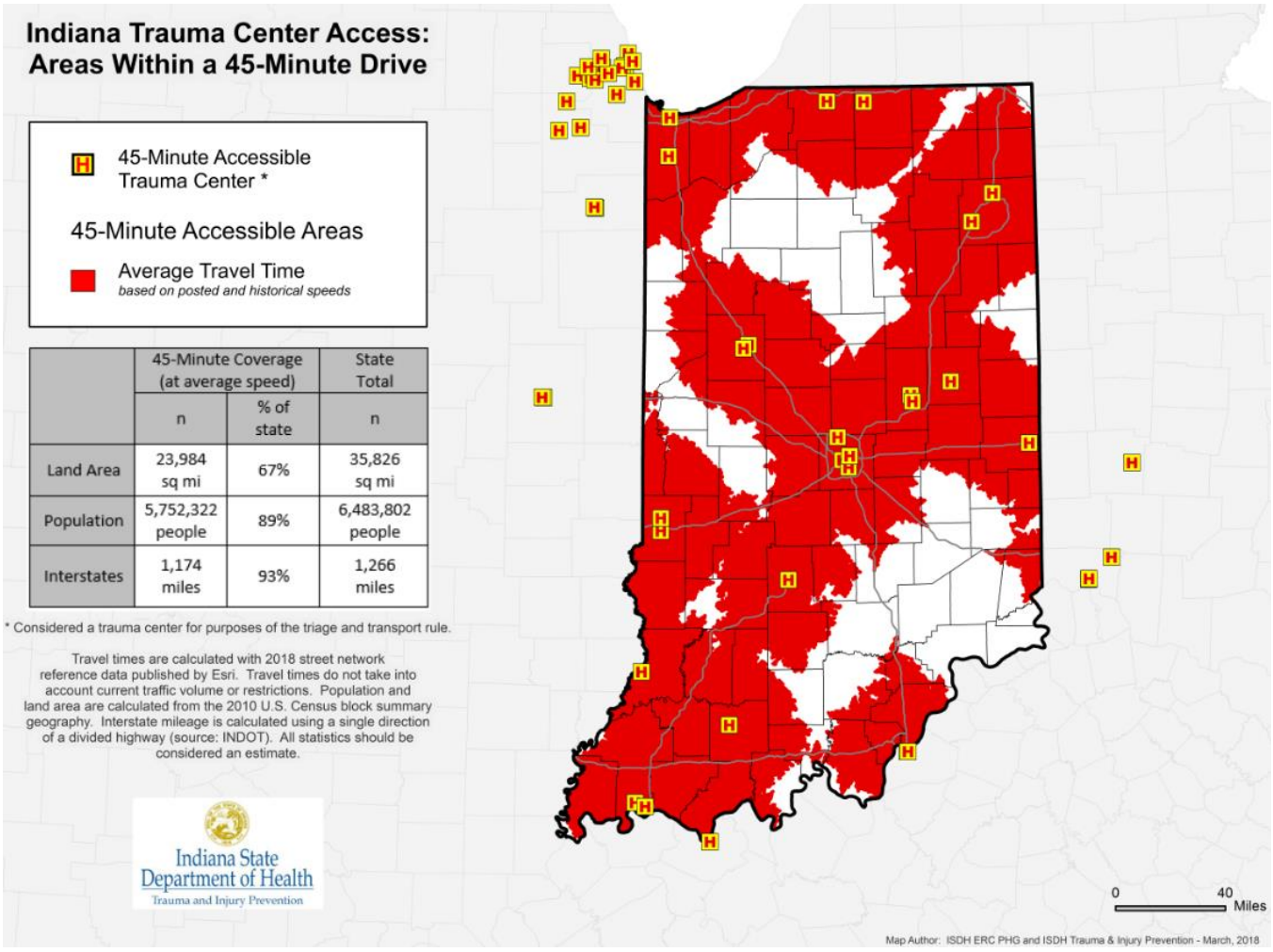
Objective	Strategy
1. Update the Triage & Transport Rule in collaboration with the EMS Commission	1.1 Convene the extended Designation subcommittee (consists of hospitals and EMS providers) to review the rule in detail and make suggestions on what can be done to update the rule.
	1.2 Analyze prehospital data to assist with recommendations.

	1.3 Present the recommendations established by the Designation subcommittee to the Indiana State Trauma Care Committee (ISTCC).
	1.4 Make recommendations to the EMS Commission based on the ISTCC discussion and ISDH review.
	1.5 Support learning opportunities to educate EMS providers about Rule changes.
2. Evaluate compliance of EMS providers with Triage and Transport Rule.	2.1 Work with IDHS to establish educational opportunities for EMS providers to gain better understanding of rule.
	2.2 Work with IDHS to analyze EMS and trauma registry data to determine compliance with rule.
	2.3 Work with IDHS to provide regular data reports to EMS Commission and ISTCC to determine rule compliance.
3. Assist EMS Commission with tracking EMS delivery of run sheets to hospitals.	3.1 Encourage compliance with EMS run sheet law by communicating with hospitals to identify EMS providers not leaving run sheets.
	3.2 Report bi-monthly to EMS Commission EMS providers not leaving run sheets at hospitals and trauma centers.
4. Develop database to track Narcan/Naloxone administration by pre-hospital providers.	4.1 Track Narcan/Naloxone administration by pre-hospital providers in registry.
	4.2 Report statewide Narcan/Naloxone administration by pre-hospital providers to governor's office.
5. Enhance knowledge of EMS workforce.	5.1 Coordinate conference events related to EMS education, including annual EMS Medical Directors' Conference, to increase the knowledge and expertise of Indiana's EMS workforce.
	5.2 Provide and support trauma education opportunities for prehospital workforce.
6. Assist with developing emerging policies, practices and standards.	6.1 Work with IDHS and ISDH Division of Chronic Disease, Primary Care and Rural Health to work on establishing Community Paramedicine practices in Indiana.
	6.2 Support IDHS with legislative initiatives, such as liability coverage for EMS medical directors.
7. Evaluate pre-hospital resources.	7.1 Identify types of services provided by each EMS provider.
	7.2 Identify gaps in pre-hospital care.
8. Coordinate annual EMS Medical Directors' Conference.	8.1 Work with EMS Medical Directors' (MD) conference planning committee to identify areas of focus and speakers.
	8.2 Work with Indiana Chapter of American College of Emergency Physicians (INACEP) to coordinate EMS MD conference with the annual INACEP conference.
	8.3 Obtain Continuing Medical Education (CME) hours for event.
9. Insure that naloxone rescue kits are available.	9.1 Supply naloxone rescue kits to first responders (includes EMS Services, law enforcement and fire.) Currently working to recruit first responders that are not carrying naloxone through a SAMHSA grant for rural counties.
	9.2 Supply naloxone rescue kits to local health departments for distribution to community members and partners. Currently

	working to recruit local health departments that have not received naloxone kits in the past through 21st Century CURES funds.

Trauma Center/Emergency Department (ED)

Trauma centers are hospitals that have applied for, and been granted, verification as a trauma center by the American College of Surgeons (ACS). Hospitals in Indiana that are working on becoming a verified trauma center can apply to become "in the process of ACS verification" trauma center status for purposes of the triage and transport rule. Currently there is one "in the process" trauma center in Indiana including: Elkhart General Hospital. ACS-verified centers for Levels I, II and III, with Level I trauma centers providing the highest level of trauma care. Trauma centers are unique in their capabilities and are not the typical community hospital ED. Indiana now has twenty-two ACS-verified trauma centers around the state: Eskenazi Health, IU Health Methodist Hospital, Riley Hospital for Children at IU Health, St. Vincent Indianapolis, Deaconess Hospital, St. Vincent Evansville, Lutheran Hospital of Indiana, Parkview Regional Medical Center, Memorial Hospital of South Bend, Terre Haute Regional, St. Vincent Regional Anderson, Community Hospital in Anderson, IU Health Bloomington, Franciscan Health Crown Point, Methodist Hospital Northlake, Memorial Hospital and Health Care Center, Franciscan Health Lafayette East, IU Health Arnett, IU Health Ball Memorial, Reid Hospital and Health Care Services, Union Hospital Terre Haute and Good Samaritan Hospital. In addition to the in-state trauma centers there are also over twenty trauma centers located across state lines in Ohio, Michigan, Kentucky and Illinois that receive patients from Indiana. But for all the trauma centers Indiana has, there are not enough of them to adequately meet the needs of injured Hoosiers and visitors to the state. Hospital EDs are part of the statewide trauma system, as not all injured patients are taken to trauma centers; the vast majority of injured patients can be, and are, treated at local, non-trauma center hospitals. Non-trauma center hospitals stabilize and provide definitive life-saving care for patients who do not require trauma center care. Many times, especially in rural areas where timely access to trauma centers is not possible, non-trauma center hospital EDs provide definitive care to trauma patients out of necessity.



Objectives	Strategies: Enhance the "in the process" process
1. Increase trauma system coverage in Indiana.	1.1 Develop more ACS-verified trauma centers.
	1.2 Monitor trauma system coverage through 45 minute travel map with continuous update and inclusion of new trauma centers on the map.
2. Enhance knowledge of trauma workforce.	2.1 Coordinate conference events related to trauma education.
	2.2 Provide and support trauma education opportunities for non-trauma centers.
	2.3 Identify and address gaps in trauma knowledge and training qualification requirements.
	2.4 Survey hospital workforce to track educational progress.
	2.5 Encourage hospitals to establish minimum educational requirements for emergency department staff.
	2.6 Produce report of each hospital's staff qualification requirements (e.g. TNCC, TCAR, ATLS, PHTLS, ITLS, TNATC, ATCN, CCRN, CEN, PALS, etc.).

	2.7 Encourage Indiana Trauma Network meetings as an opportunity for all trauma centers to network and work together on knowledge gaps.
3. Assist Preparedness Division in ~~E~~evaluating~~e~~ and maintaining database of trauma center resources.	3.1 Identify types of surgeons.
	3.2 Identify burn care services.
	3.3 Identify classifications of physicians providing burn care services.
	3.4 Investigate role of burn centers in trauma system.
	3.5 Categorize trauma activation criteria per facility.
	3.6 Collect admissions volumes: adult trauma center treating injured children, burn centers, level I trauma centers and pediatric trauma centers.
	3.7 Collect trauma certifications per facility.
	3.8 Assemble information on the types of injury prevention programs the trauma centers are implementing.
	3.9 Gather performance improvement audit filters.
	3.10 Identify types of psychological and psychiatric services available per facility for trauma patients.
	3.11 Categorize types of in-patient rehabilitation services per facility.
	3.12 Compile inter-facility transfer agreements per facility.
4. Encourage level I and II trauma centers to serve as the regional resource center.	4.1 Encourage trauma centers to teach Rural Trauma Team Development Course (RTTDC).
	4.2 Maintain inter-facility transfer criteria (ACS)
5. Track performance improvement of trauma centers.	5.1 Standardize subset of trauma system performance improvement activities per each facility.

Acute Medical Care

Acute medical care facilities are hospitals that provide care for short periods of time. Trauma patients are admitted to an acute medical care facility in order to allow them to recover from their injuries as well as recover from procedures and surgeries utilized to fix their injuries. Patients with the most serious injuries recover in the intensive care unit, while less seriously injured patients may recover in a critical care unit, a step-down care unit or a medical-surgical care unit. There are more than 120 hospitals in Indiana, all of which are regulated by the ISDH.

Objectives	Strategies:
1. Assist Preparedness Division in compiling~~Compile~~ a list of acute care resources.	1.1 Compile a database of services provided by each hospital with an emergency department to identify areas of need in trauma care.
2. Connect acute care facilities to the trauma centers to which they transfer patients.	2.1 Encourage non-trauma centers to receive Rural Trauma Team Development Course (RTTDC) training from trauma centers.

	2.2 Assist acute care facilities with identifying their role in Indiana's trauma system.

Rehabilitation

Rehabilitation centers care for trauma patients' post-acute care and seek to enable these patients to realize their fullest post-injury potential. Oftentimes, these patients have sustained severe or catastrophic injuries, resulting in long-standing or permanent impairments. Rehabilitative interventions strive to allow the patient to return to the highest level of function, reducing disability and avoiding handicap whenever possible. When rehabilitation results in independent patient function, there is a 90 percent cost savings compared with costs for custodial care and repeated hospitalizations. Unfortunately, the rehabilitation phase of care often is not sufficiently integrated into the trauma system, even in the most mature, well-developed statewide trauma systems.

Objectives	Strategies
1. Assist Preparedness Division with compiling~~Compile~~ a list of rehabilitation resources.	1.1 Compile services provided by each rehabilitation facility to identify areas of need in rehabilitation trauma care.
2. Integrate rehabilitation phase of care into the statewide trauma system.	2.1 Build relationships with divisions, agencies and organizations that are involved with trauma-related activities, specifically rehabilitation.
	2.2 Identify partners and stakeholders to be involved with the Indiana State Trauma Care Committee.
	2.3 Provide data reports relevant to their area of focus.
	2.4 Attend events and meetings to engage with new partners and provide information about Indiana's trauma system and how it pertains to their line of work.

Injury Prevention and Outreach

Injury prevention and outreach begins with the collection and analysis of population and patient data from a wide variety of sources to describe the status of injury morbidity, mortality and burden distribution throughout the state. Injury epidemiology is concerned with the evaluation of the frequency, rates and pattern of injury events in a population and is obtained by analyzing data from sources such as death records, hospital discharge databases and data from EMS, emergency departments and trauma registries. Trauma systems must develop strategies that help prevent injury as part of an integrated, coordinated and inclusive trauma system. For years, the ISDH has conducted an array of injury prevention programs. With the creation of the ISDH Trauma and Injury Prevention Division in 2011, ISDH has focused on the collection and analysis of injury data and injury prevention programming implementing best available evidence-based practices in the field. The overall mission is to prevent injuries in Indiana through collaborative efforts in leadership, education and policy.

Developed in collaboration with the Indiana Injury Prevention Advisory Council (IPAC), this injury prevention strategic plan outlines objectives and strategies, featuring specific, data-informed injury mechanisms and targets. The plan provides a blueprint for individuals, organizations and agencies to use in facing challenges to the health and lives of Indiana residents. While there are certainly many injury issues that require consideration, the injury issues selected for the plan were based on the analysis of relevant data, of which some is extracted in this plan report. Injury data was used to establish these priorities and to select best available evidence strategies. The Division's *Preventing Injuries in Indiana: A Resource Guide* provides detailed information on a variety of injuries affecting Hoosiers.

Objectives	Strategies
1. Identify and support the use of evidence-based injury prevention interventions.	1.1 Identify and support data-informed priorities and opportunities to prevent injuries and reduce the burden of injury and violence.
	1.2 Facilitate opportunities for collaborative injury prevention efforts in: • Traffic safety, • Poisoning and • Traumatic brain injury (TBI).
	1.3 Provide statewide direction and focus for older adult (age 65+) falls prevention.
	1.4 Provide statewide direction and focus for child injury prevention efforts in: • Safe sleep, • Child abuse and maltreatment, • Child passenger safety and • Bullying.
	1.4 Provide statewide direction and focus for violence prevention focus on reducing homicides, suicides, intimate partner violence and sexual assault and other types of violence.
	1.5 Conduct public health surveillance of injury and violence to identify priorities and opportunities.
2. Establish a sustainable and relevant infrastructure that provides leadership, funding, data, policy and evaluation for injury and violence prevention.	2.1 Provide access and technical assistance for best practices and evidence-based injury prevention strategies, especially related to: • Child passenger safety for all children in Indiana, and • CDC Stopping Elderly Accidents, Deaths & Injuries (STEADI) toolkit implementation and Stepping On for older adult falls prevention.
	2.2 Apply for injury-related funding opportunities to support continuation of efforts.
	2.3 Collect, analyze, and disseminate injury and violence data through fact sheets, maps and other data reports.
	2.4 Select, implement and evaluate effective policy and program strategies.

	2.5 Evaluate and assess outcomes, successes and opportunities for injury prevention.
	2.6 Build injury prevention program evaluation capacity.
	2.7 Maintain list of trauma center-based injury prevention programs on Division's website.
	2.8 Support other ISDH divisions conducting injury prevention efforts, such as Office of Women's Health Rape Prevention & Education Program and the Maternal and Child Health Division.
3. Increase the quality and availability of injury data for planning, surveillance, and evaluation.	3.1 Maintain, update and enhance the *Preventing Injury in Indiana: A Resource Guide* and associated mobile application.
	3.2 Promote the usability and flexibility of the *Preventing Injury in Indiana: A Resource Guide* and associated mobile application.
	3.3 Increase public awareness activities through resource guide and mobile app.
4. Enhance the skills, knowledge and resources of injury prevention workforce.	4.1 Establish, maintain and increase Indiana Injury Prevention Advisory Council (IPAC) membership.
	4.2 Plan and host an annual IPAC Injury Prevention Conference as an educational and awareness effort.
	4.3 Provide technical assistance to support injury prevention workforce.
	4.4 Establish and maintain regular communication through email, conference calls, newsletter, ListServs and social media to collaborate and keep injury workforce engaged and up-to-date on emerging injury data trends.
	4.5 Engage partners from various sectors for collaboration, especially related to priority strategies.
5. Facilitate violent death data collection, analysis and dissemination through the Indiana Violent Death Reporting System (INVDRS).	5.1 Utilize stakeholder networks to increase partner participation of providing and using data.
	5.2 Build relationships with other organizations and agencies that are working on violence prevention to identify best practices and emerging trends.
	5.3 Encourage partners to promote INVDRS mission and vision.
6. Stay current with trauma and injury prevention trends and emerging issues.	6.1 Collaborate with partners to inform Division of local, state and national emerging issues within the field.
	6.2 Utilize committees and subject matter experts to provide direction and guidance to the division.

The Indiana State Department of Health, in partnership with the Indiana Injury Prevention Advisory Council (IPAC) and associated partners and stakeholders, will use these objectives and priorities as a framework to strengthen statewide injury prevention coordination and expansion in Indiana. To impact the morbidity and mortality associated with the aforementioned injuries will require collaboration by many agencies and organizations; continued education of the public, health care providers, partner agencies and organizations; and consideration of environmental safety measures that can be implemented.

Injury Prevention and Trauma Public Education

Objectives	*Strategies*
1. Create trauma training opportunities.	1.1 Utilize IN-TRAIN system to provide distance learning opportunities.
	1.2 Utilize webcast system to provide distance learning opportunities.
2. Utilize multiple communication outlets to provide trauma stakeholders with consistent messaging.	2.1 Maintain website content.
	2.2 Maintain handouts and fact sheets.
	2.3 Create relevant and timely social media content for Twitter account @INDTrauma.
	2.4 Release monthly newsletter, *Trauma Times,* highlighting the work of the ISDH and trauma partners throughout the state.
	2.5 Travel the state (trauma tour) providing trauma stakeholders with opportunities to share what is going on in their community.
	2.6 Utilize Indiana Trauma Network to promote ongoing local trainings.

Prescription Drug Overdose Prevention

In response to the ever-growing opioid problem in the state of Indiana, beginning in 2015 the Division of Trauma and Injury Prevention pursued federal funding to address the crisis. The division was awarded funding through the Prevention for States (PfS) grant in 2015 and funding through the Enhanced State Opioid Overdose Surveillance (ESOOS) grant in 2017. Since then, the division has implemented and piloted several prescription drug overdose-related projects. This issue has become a priority for not only the division, but the Indiana State Department of Health and Governor Eric Holcomb through his 2018 and 2019 Next Level Agenda.

Objectives	*Strategies*
1. Expand naloxone access and education	1.1 Provide naloxone to more local health departments across Indiana.
	1.2 Provide naloxone to more rural first responders.
	1.3 Increase public awareness of OptIN through avenues such as PDO weekly newsletter, PDO booth events, PDO website, community outreach coordinators.
	1.4 Continue to carry out biannual audits to ensure that OptIN is up to date.
	1.5 Continue to provide naloxone trainings to organizations such as LHDs, correctional facilities, educational institutions, community groups, faith-based communities.
	1.6 Develop a standardized online naloxone training that would eliminate the need for the naloxone program manager to travel across the state.
	2.1 Create and distribute educational materials.

2. Provide public education regarding prescription opioids	2.2 Utilize the drug overdose booth to engage with the public and pertinent professionals.
	2.3 Work to continuously update website with relevant and emerging content.
	2.4 Continue to plan monthly/bimonthly educational webcasts.
3. Gather and analyze improved data regarding drug overdoses	3.1 Continue to partner with the IU Fairbanks School of Public Health on the naloxone postcard survey project.
	3.2 Collect and analyze data gleaned from OptIN, such as doses of naloxone sold.
	3.3 Fund toxicology testing for Indiana Coroners. Create monthly/quarterly reports with toxicology results (Brad Ray).
	3.4 Collect and analyze ESSENCE data.
	3.5 Educate coroners to improve drug overdose investigations and death certificate data.
4. Disseminate drug overdose data	4.1 Send various reports to the governor's office (toxicology results, drug overdose deaths, naloxone administrations).
	4.2 Create and disseminate county-specific mortality and INSPECT reports.
	4.3 Use existing tools such as our website, PDO booth, PDO weekly email to disseminate data to stakeholders.
	4.4 Update stats explorer with emerging data as appropriate.
	4.5 Disseminate ESSENCE alerts to appropriate stakeholders (LHDs, hospitals, etc.).
	4.6 Disseminate comprehensive data reports related to opioid overdoses collected in INVDRS/SUDORS.
5. Abstract PDO-related cases in NVDRS	5.1 Utilize NVRDS abstractors to abstract cases.
	5.2 Create a new toxicology abstraction system to optimize abstraction of toxicology reports.
6. Provide technical assistance (TA) to priority counties	6.1 Have community outreach coordinators attend community meetings (LCC, systems of care, interfaith coalitions meetings).
	6.2 Coordinate the overdose response project in the awarded counties.
	6.3 Implement regional faith-based meetings in conjunction with FSSA and Overdose Lifeline.
	6.4 Provide training: naloxone, SBIRT.
	6.5 Utilize webcasts as a medium to provide TA.
	6.6 Partner with pertinent organizations on local community initiatives and projects to build local capacity for responding to local overdose events, including creation of an Overdose Response Plan.
	6.7 Help counties implement and record initiatives and projects developed in county Overdose Response Plans.

7. Implement and expand drug overdose fatality review (OFR) teams	7.1 Create the Indiana Overdose Fatality Review Program and select participating counties.
	7.2 Conduct reviews and collect observational data on fatality reviews.
	7.3 Identify opportunities to improve prevention in participating counties and create stronger prevention plans based on OFR findings.
	7.4 Develop OFR issue briefs with recommendations for state-wide enactment.

Injury Surveillance & Quality Improvement

A state's trauma registry is not only the repository for data about trauma in its state; it also exists to improve outcomes for injured patients. The trauma registry data is used to measure and analyze all aspects of the system to ensure the highest quality care is provided to all. ISDH operates the Indiana Trauma Registry and is responsible for instituting processes to evaluate the performance of all aspects of the system, from the EMS provider to the trauma center/acute care hospital to the rehabilitation provider. The Indiana Trauma Registry monitors variations in incidence and outcomes and system performance. The ISDH Trauma Registry began receiving trauma data in 2007 from the seven ACS-verified trauma centers at that time.

Objectives	*Strategies*
1. Increase and maintain the participation of emergency medical services (EMS) providers, hospitals with emergency departments (ED) and rehabilitation facilities trauma data reporting.	1.1 Work with hospitals that are already reporting data to serve as mentor facilities for hospitals that are not yet reporting data.
	1.2 Establish and maintain a reporting schedule.
	1.3 Provide consistent communication with entities that are required to report to serve as reminders of the reporting deadlines.
	1.4 Promote free software that is available for entities to use.
	1.5 Provide trauma registry training and support for entities reporting data.
	1.6 Provide data reports for entities that have submitted data.
	1.7 Publish list of providers submitting data to the Indiana Trauma Registry.
	1.8 Utilize stakeholder networks to increase partner participation.
	1.9 Offer funding opportunities to data providers (if funding is available).
2. Increase and maintain the participation of coroners and law enforcement agencies reporting violent death cases.	2.1 Work with associations to serve as supporting entities to encourage entities to participate in the Indiana Violent Death Reporting System (INVDRS).
	2.2 Establish and maintain a reporting schedule.
	2.3 Provide consistent communication with entities that are required to report to serve as reminders of the reporting deadlines.
	2.4 Promote free software that is available for entities to use.

	2.5 Provide registry training and support for entities reporting data.
	2.6 Provide data reports for entities that have submitted data.
	2.7 Publish list of providers submitting data to the INVDRS.
	2.8 Utilize stakeholder networks to increase partner participation.
	2.9 Offer funding opportunities to data providers.
3. Develop processes to exchange data with surrounding states (Illinois, Kentucky, Ohio and Michigan).	3.1 Establish Data Sharing Agreements with equivalent state agencies.
	3.2 Establish and maintain a reporting deadline schedule.
	3.3 Include the information in the division's data reports.
	3.4 Utilize work groups (i.e. Midwest Injury Prevention Alliance [MIPA]) to establish data exchanges.
4. Build relationships with other state agencies that are working on similar projects (i.e., state trauma registry, National Violent Death Reporting System, etc.) so that we can identify best practices and emerging trends.	4.1 Utilize ListServs, conference calls, webinars, regional subcommittees, national conferences, etc. to collaborate with key partners.
	4.2 Adapt and modify already-existing strategies established by other states.
5. Utilize committees (Indiana State Trauma Care Committee, Indiana Trauma Network, Injury Prevention Advisory Council, INVDRS Advisory Board, etc.) and Subject Matter Experts (SMEs) to provide direction and guidance to the division.	5.1 Meet regularly to review the state's current landscape and ask for feedback to guide the future direction.
	5.2 Regular communication (email, phone calls, newsletter, ListServs, social media) to keep committees up-to-date on developments.
6. Create clear and comprehensive databases to establish the division as a leader in statewide data collection.	6.1 Utilize our committees to address data quality concerns and to review data analysis.
	6.2 Send data quality reports to data providers.
	6.3 Encourage data providers to submit feedback regarding data reports.
	6.4 Continue recruiting efforts to increase completeness (number of entities reporting data).
	6.5 Establish and maintain a reporting deadline schedule.
	6.6 Review individual cases to identify data quality issues and report summary findings to committees.
	6.7 Link datasets to provide a complete picture of the burden of violence and injury in Indiana.
	6.8 Develop standard operating procedures to handle data system issues (i.e., data storage, large data files, etc.).

	6.9 Provide ongoing educational opportunities (monthly quizzes, training events, etc.) to help with education of registrars to ensure consistency and accuracy in data reporting.
7. Maximize the utilization of data.	7.1 Identify the burden of injury in Indiana.
	7.2 Process data requests submitted by vested partners.
	7.3 Adapt and modify already-existing data analysis and dissemination strategies established by other states.
	7.4 Disseminate data to injury prevention stakeholders, data providers and other interested parties through reports, fact sheets, and other materials.
	7.5 Complete all legislatively mandated reports.
	7.6 Report data graphically through charts, tables, and maps when appropriate.
	7.7 Investigate best practices for data analysis and reporting, including ACS Resources for Optimal Care of the Injured Patient.
	7.8 Collaborate with clinical researchers to utilize their expertise and provide clinical relevance of metrics.
8. Utilize technology to stay current in injury surveillance database best practices.	8.1 Establish a process to take data directly from hospitals' Electronic Medical Record (EMR) into the Indiana Trauma Registry – "Blue Sky Project".
	8.2 Improve the accessibility while minimizing costs of reporting data through the "Blue Sky Project" by providing technical assistance to facilities that want to utilize new technologies.
	8.3 Promote new technologies through a variety of communication outlets (e.g., HL7).
	8.4 Develop technology to transfer data across data systems and to improve existing data systems.
	8.5 Research new technologies to improve communication in the trauma system (Field Bridge, Hospital Hub, etc.).
	8.7 Explore feasibility of implementing unique patient identifiers to track patients through healthcare system. Work with Traffic Records Coordinating Committee to investigate possibilities for tracking system.
	8.8 Develop and integrate ESSENCE surveillance data into injury prevention efforts. (Toxicology and TBI)
	8.9 Establish toxicology syndromic surveillance for fatal and non-fatal drug-related overdoses.
9. Utilize Performance Improvement (PI) Subcommittee to identify areas of opportunity in the statewide trauma system.	9.1 Track and trend data results in improving the overall system.
	9.2 Encourage compliance with EMS run sheet law by communicating with hospitals to identify EMS providers not leaving run sheets and provide that information to the Indiana Department of Homeland Security (IDHS) and the EMS Commission so that they can follow-up with those EMS providers.
10. Track the performance of the statewide trauma system.	10.1 Create a dashboard of metrics (mortality rate, ACS Needs Assessment Tool, education for trauma care providers [pre-

	hospital & hospital] Risk Factors, etc.) that will be shared with the PI Subcommittee and ISTCC. The division will be mindful of seasonality in trauma.
	10.2 Improve and maintain baseline metrics for grant deliverables (i.e. ICJI NHTSA grant).
	10.3 Implement regional PI processes that feed into statewide PI processes.