

Indigenous Measures for Protecting and Addressing Critical Trauma (IMPACT) – Project protocol

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Abstract:

Objective: The Indigenous Measures for Protecting and Addressing Critical Trauma (IMPACT) project aims to transform trauma care for Aboriginal and Torres Strait Islander peoples by embedding Indigenous knowledges and culturally responsive practices into trauma systems.

Methods: Using Knowledge-Interface Methodology, the IMPACT will be implemented across two South Australian trauma sites through four phases: establishing trauma profiles and lived experiences; co-designing relational clinical quality indicators and patient-reported outcome measures; piloting and evaluating the program using RE-AIM QuEST framework; and translating findings into national trauma systems. Guided by an Aboriginal Governance Council, the project ensures Indigenous Data Sovereignty and community-led decision-making.

Results: IMPACT will lead to the co-design of relational clinical quality indicators and patient-reported outcomes that enhance cultural safety in trauma care for Aboriginal and Torres Strait Islander communities.

Conclusion: IMPACT will demonstrate improved cultural safety in trauma care, increased use of Indigenous-led quality indicators, and enhanced patient-reported outcomes. IMPACT will build capacity among Aboriginal researchers, foster clinical champions, and provide a replicable model for national reform.

Implications for Public Health: IMPACT lays the groundwork for developing culturally responsive quality of life tools tailored to priority populations, improving outcome measurement and advancing health equity.

Key words: indigenous, co-design, trauma systems, equity, Australia

Introduction

Serious traumatic injury (hereafter referred to as injury) is largely an invisible public health concern, killing more than 14,000 Australians every year.¹ For every trauma-related death, a

further 130 injured Australians present to emergency departments, of whom 40 are hospitalised, often leaving these individuals with lifelong disabilities.¹ In Australia an injury inequity gradient exists, impacting on priority populations (i.e. rural and remote). Aboriginal

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and Torres Strait Islander peoples are significantly over-represented in this inequity gradient. For Aboriginal and Torres Strait Islander communities, injuries are the third leading cause of death (15%), the second leading cause of disease burden (12%), and account for 20% of total emergency department presentations.² Major causes of injury hospitalisations for Aboriginal and Torres Strait Islander communities includes falls and assault, and the major contributors to injury mortality are suicide and road traffic crashes.² Life-course differences also exist, hospitalisation rates are greatest for Aboriginal and Torres Strait Islander males and females aged 25-44 years, but for non-Indigenous Australians, this is 20-24 years for males and 85-89 years for females.² Of particular concern, injury is not on the decline, with a 12% age-standardised increase in injury rates for Aboriginal and Torres Strait Islander communities from 2012/13 to 2021/22.²

Australian trauma care systems are predominantly built upon Western biomedical concepts of health, wellbeing and clinical systems of care. These world-class systems have effectively demonstrated reductions in injury mortality and improved survivorship from major injury events in the dominant Australian population.³ However, inequities are apparent, and a “one model fits all” concept does not apply to priority population groups. Different trauma care requirements for paediatric and the elderly have been recognised and effectively addressed,^{4,5} but we are yet to action Aboriginal and Torres Strait Islander trauma care requirements. Current systems lack integration of Indigenous knowledges (knowing, being and doing) into all trauma system facets, particularly in models of care and clinical quality reporting. This includes integrated models of care which are well-established nationally in the Aboriginal community-controlled sector; the relationality of clinical quality indicators to encompass central cultural and social wellbeing concepts, and patient-reported outcome measures (PROMs), which have been designed with and for injured Aboriginal and Torres Strait Islander patients. Moreover, critical knowledge is lacking surrounding immediate and lifelong physical and psychological disabilities (induced from injury events), impacting on Aboriginal and Torres Strait Islander individuals, their family and community. These should be considered foundational elements in all Australian health systems to drive better outcomes and close the gap for Aboriginal and Torres Strait Islander communities, yet they are not. While largely invisible and unintentional, the implicit bias and invisible whiteness ingrained in health systems more broadly establish powers structures which act to disregard Indigenous sovereign health rights and reinforce health inequities.^{6,7} This, in turn, perpetuates a lack of policy, funding and support, contributing to a widening health gap between injured Aboriginal and Torres Strait Islander and non-Indigenous Australians.⁸ At a national and jurisdictional level, governments, policy-makers and healthcare providers face significant challenges in designing and maintaining health systems to meet these ongoing and growing trauma challenges, especially for Aboriginal and Torres Strait Islander patients, families and communities.

Injured Aboriginal and Torres Strait Islander patients need culturally responsive trauma systems, representative clinical quality and safety indicators and outcome measures that capture their unique healthcare needs and outcomes. They require system level processes and approaches to care that are integrated, relational and include health professionals who understand their health and wellbeing requirements (i.e. Aboriginal Health Workers). Our IMPACT

(Indigenous Measures for Protecting and Addressing Critical Trauma) project will change these system-level concerns, transform the narrative for trauma systems, and in turn enable improved outcomes for Aboriginal and Torres Strait Islander individuals. In partnership with local health networks, clinical teams, Aboriginal community organisations, community and researchers, IMPACT will co-design and evaluate an Indigenous-led, strength-based program to facilitate positive change for trauma systems. Capacity building will be a priority of the IMPACT program to not only build Aboriginal researcher capacity, but to develop non-Indigenous clinical champions for change.

Aims

The IMPACT study objective is to improve trauma system processes, and clinical and quality indicators, thereby providing health and wellbeing gains for Aboriginal and Torres Strait Islander patients impacted by significant injury through the integration of Indigenous knowledges. This will be achieved through the following aims:

- Aim 1: Determine the Aboriginal and Torres Strait Islander major trauma profile in Australia and how clinical and quality indicators for trauma are measured.
- Aim 2: Co-design system processes and relational clinical and quality indicators (i.e. PROMs) over the trauma journey for Aboriginal and Torres Strait Islander patients.
- Aim 3: Pilot and evaluate IMPACT indicators, governance processes and measures across Trauma South Australia (SA).
- Aim 4: Translate IMPACT program into trauma systems

Methods

Methodology

IMPACT will employ Knowledge Interface Methodology, an Indigenous research methodology that interfaces knowledge systems, research methodologies, and methods across trauma, public health and Aboriginal and Torres Strait Islander health. This approach brings these elements together through mutual respect, shared benefits, human dignity and discovery, allowing power differentials to be redressed for new knowledge formation.⁷ In this methodology, Indigenous knowledges are central to the research questions, which are addressed through employing Indigenous research methods. This includes IMPACT conceptualisation, data collection, analyses and translation, which provides space for relational and authentic understandings for Aboriginal communities that focus on the cultural and social determinants of health. This includes a strength-based approach that captures the cultural and social determinants of health for community in trauma systems. Strength-based approaches are essential in shifting white possessive logic, deficit-based (negative) discourses and the framing of trauma outcomes for Aboriginal and Torres Strait Islander patients. This will occur through valuing and centring Aboriginal knowledge and understandings of trauma in the IMPACT program, and actively redressing ongoing colonisation.

Aboriginal governance

The IMPACT project will be governed by an Aboriginal Governance Council (AGC), consisting of Aboriginal researchers on the IMPACT project and two Aboriginal community representatives with lived experience of injury. The strong Aboriginal leadership provided

Figure 1: Impact project overview.



through the AGC brings personal wisdom, skills, credibility and connection to community for the project. IMPACT also emerges out of long trusting relationships that have been built with Aboriginal organisations in South Australia (i.e. Far West Community Partnerships, Aboriginal Community Controlled Health Service and Aboriginal departments in Local Health Networks).

The AGC will have a leading role in providing Indigenous Governance of Data for the IMPACT project (Figure 1). Indigenous Governance of Data encompasses formal ethical structures for managing and governance of any data including the data structures, procedures and policies that relate to Aboriginal and Torres Strait Islander peoples. IMPACT will focus on and ensure Aboriginal and Torres Strait Islander control in decision-making processes across all aspects of the IMPACT project; this includes data management and analysis plans, ensuring they are culturally safe and community-centric.

Setting

The IMPACT project will be conducted in South Australia, across two sites:

Site 1: Royal Adelaide Hospital (RAH) is a Level 1 Major Trauma Service and has the fifth-highest major trauma load in Australia, treating over 3000 patients per year. Twenty-four percent are major trauma cases (Injury Severity Score >12) and 6.2% of cases are Aboriginal and Torres Strait Islander patients. The RAH covers all of SA and is the main referral centre for the Northern Territory and New South Wales (Broken Hill). The RAH will be the central hub for the IMPACT pilot. The RAH is located on Kurna country, however displacement from colonisation means a variety of Aboriginal and Torres Strait Islander groups are represented. Site 2: Ceduna District Health Service (CDHS) is a regional hospital providing acute emergency medical care to trauma patients presenting to this site. Major trauma patients presenting here require secondary transfer/retrieval to the RAH for definitive trauma care. CDHS is in the Far West of South Australia (Kokatha, Mirning and Wirangu country), providing outreach to remote communities of Koonibba, Yalata, Scotdesco and Oak Valley.

Eligible participants

Patients and family recruited to IMPACT will identify as an Aboriginal and/or Torres Strait Islander person on their medical record, be aged ≥ 18 years, present for trauma treatment at IMPACT site, and meet one of the following: Injury Severity Score ≥ 9 ; hospital admission ≥ 48 hours or Level 1 or 2 SA Trauma Activation Criteria. Trauma staff (clinicians, administration) will be registered health professions treating Aboriginal and Torres Strait Islander patients and/or administration staff working with trauma patient data.

Phase 1: Aboriginal and Torres Strait Islander trauma profile

The major trauma profile for Aboriginal and Torres Strait Islander communities will be determined through examining the epidemiological profile of trauma and investing in understanding the narrative and lived experience behind this epidemiological profile. This will be conducted over a two-part process, centred around determining; 1. injury data narrative and; 2. injury lived experience narrative.

Injury data narrative

The Australian and New Zealand Trauma Registry (ANZTR) report on major trauma events in Australia. Data are provided annually by state and territory trauma registries that collect patient data meeting the following criteria (9, p.10):

- Presentation to a participating centre with a severe injury (irrespective of age)
- Death after injury
- Injury Severity Score > 12 done

Recently (August 2024) the ANZTR requested state and territory trauma registries expand item collections to include ethnicity, to capture Indigenous status across Australia and New Zealand.⁹ Given the early state of this data collection process, we will not draw on the ANZTR registry to determine the overall epidemiological profile for major trauma in Aboriginal and Torres Strait Islander communities. Rather, we will access state and territory trauma registries that have

been collecting ethnicity prior to the ANZTR mandate. These include the following state and territory registries: Australian Capital Territory, South Australia, Queensland, Western Australia and the Northern Territory.

Trauma registry data will be accessed for adult cases (≥ 18 years) and stratified by ethnicity. Descriptive statistics (proportions, averages and confidence interval around proportions and averages), univariate and multivariate Poisson regression (rate ratios) will be used to estimate the incidence rates across injury types (i.e. burns, falls, and road traffic). Trauma-specific risk factors for prolonged length of stay will be examined through regression modelling. Variable selection in analytics will be presented, discussed and confirmed by the AGC prior to execution. Outcomes will be used to inform the yarning guide for lived-experience participants. If data are available (e.g. data on diagnostic-related groups), the cost of hospital services will be analysed and stratified by demographic characteristics and injury types. A Nonparametric bootstrapping approach will be used to represent uncertainty around the mean estimates.

Injury lived experience narrative

Yarning, a conversational Indigenous research method for rich data collection will be conducted with 8-12 Aboriginal and/or Torres Strait Islander patients and/or families to explore their trauma journeys. Prospective participants will be recruited through the RAH and/or Local Health Network (LHN), with IMPACT staff embedded at these sites (Aboriginal health worker and/or research assistant). Yarns will be conducted in a setting that is comfortable for the participant (online, by phone or on-Country) by an Aboriginal member of the IMPACT team and supported by primary investigator Ryder. All yarns will be recorded, transcribed and de-identified. NVivo 12 will be used to assist with classification of themes through thematic coding processes, focussing on strength-based themes and the cultural determinants of health. Outcomes will be presented for approval by the AGC and used to inform co-design in Phase 2 and in design of relational clinical quality and safety indicators for Aboriginal and Torres Strait Islander patients.

Phase 2: IMPACT design

The co-design of the IMPACT program and associated outcome measures will occur over two parts: 1. Outcome measure assessment and 2. Co-design of the IMPACT program.

Outcome measure assessment

A systematic review will be conducted of national literature (grey and peer reviewed) for patient-reported outcome measures (PROMs) (i.e. health related quality of life, functional outcomes) that have been used to measure trauma and injury outcomes. Studies will be critiqued against the Aboriginal and Torres Strait Islander Quality Appraisal Tool, psychometric processes and reported through a narrative based synthesis. Outcomes will provide a comprehensive critique of trauma and injury PROMs and their design for Aboriginal and Torres Strait Islander communities. This will be presented to the AGC, who will determine which PROM should undergo psychometrically assessment with Aboriginal and Torres Strait Islander peoples. Psychometric assessment will focus on PROM validity and reliability. We have estimated a sample size of $n=100$,

based on a 10:1 participant to PROM item ratio, sample size adjustment may be required to ensure sampling adequacy.

Participants will be recruitment through an Aboriginal external consulting organisation for social media research iMob through Qualtrics. Exploratory factor analysis will test construct validity and reproducibility. Item internal consistency will be determined through test-retest methods (over two-weeks) using Stata by the IMPACT project manager an overseen by investigators Ryder, Shannon and Mittinty.

IMPACT program

Co-design will occur through participatory action research, where empowering actions will be guided by Indigenous principles of consultation and reciprocity, investigator reflexivity and Indigenous research methods of yarning and deep listening.¹⁰ This will occur over two workshops where the following themes will be explored: 1. The journey for Aboriginal and Torres Strait Islander patients with major injuries, what are the enablers and barriers to improving outcomes? 2. What trauma system changes are required for IMPACT – training, clinical quality indicators, outcome measures, patient safety, governance? Each workshop will build on the previous one, with attendance including members from the AGC, Aboriginal community-controlled organisations, Local Health Network, clinicians and researchers. Workshops will be recorded, transcribed and thematically analysed focusing on protective factors within the Cultural Determinants of Health.

Phase 3: Embedding IMPACT processes

Pilot and evaluation targeting the utility of IMPACT across Trauma SA trauma services requires multifactor input from trial sites, clinical teams, patients and/or their families.

IMPACT usability and acceptability

Testing will occur in trauma divisions in RAH, LMH and CDHS over a 9-month period. These trauma divisions will be provided with training and support for staff involved in the pilot and evaluation of IMPACT. The RE-AIM QuEST (Qualitative Evaluation for Systematic Translation) framework will be used to evaluate key dimensions of the IMPACT program in clinical trauma settings: reach, effectiveness, adoption, implementation and maintenance/sustainability (RE-AIM).²² The RE-AIM QuEST framework provides a mixed-methods approach to identify and address site challenges throughout the evaluation process. To ensure inclusion of relational Aboriginal and Torres Strait Islander factors to the cultural and social determinants of health, the IMPACT investigation team and AGC will adapt the RE-AIM QuEST guided by Williams's (2017) Ngaa-bi-nya Evaluation Framework²³ and Kelaher's (2018) Lowitja Institute Evaluation Framework.²⁴ Evaluation will occur across 4 time points: pre-IMPACT implementation (0 months), during IMPACT implementation (3 and 6 months) and post-IMPACT implementation (9 months). At each evaluation points, key site trauma staff (clinical and administration) will participate in data collection through "Yarning Aloud" sessions targeting RE-AIM QuEST themes with the IMPACT research staff. Yarning Aloud combines yarning for rich data collection and thinking-aloud techniques, which explores an individual inner dialogue in relation to specific task completion.²⁵ Aboriginal and Torres Strait Islander patients will be recruited through trauma service by the IMPACT Aboriginal health worker and research

assistant. Recruitment will occur when patients are deemed clinically stable as assessed and approved by the site trauma team. Quantitative information over RE-AIM themes will be drawn from patient demographics, Close the Gap Program, medical records, Medicare and Pharmaceutical Benefit Scheme of consenting patients. These consenting patients and families will participate in a trauma patient journey yarn exploring RE-AIM QuEST themes.

Costing study

To assess the cost of implementing IMPACT within SA Trauma services, a micro-costing analysis will be conducted. Taking a health-system perspective, all direct healthcare costs including staff assignment/hiring, training and overheads will be prospectively recorded. A costing model will be developed (using data from the study and experts) to predict the cost of IMPACT for national translation.

Phase 4: IMPACT translation

A national roundtable with key Aboriginal stake holder organisations, community, clinicians and researchers will be undertaken to review and refine IMPACT. This roundtable will be informed by Phase 3 outcomes and will develop a blue print for reform to translate and embed IMPACT into 1. Trauma Systems and Networks nationally and 2. Other health care systems nationally.

Reporting of research findings

Project outcomes will be published in peer-reviewed journals, presented at congress papers and seminars. Equity and Indigenous knowledges will remain central to the process, ensuring capacity building among Aboriginal and Torres Strait Islander researchers, Aboriginal Health Workers and students within the research team. Research findings will also be translated into infographics for communities and disseminated through Aboriginal community organisations, newsletters and social media networks.

Key research outcomes and impact

The IMPACT project will bring meaningful benefits to Aboriginal and Torres Strait Islander peoples by addressing systemic inequities in Australia's trauma care systems. IMPACT will be co-designed to incorporate Indigenous ways of knowing, being and doing, resulting in culturally responsive care, PROMs and clinical quality indicators for Aboriginal patients. This will ensure trauma care reflects the health and wellbeing priorities of Aboriginal patients, families and communities.

By collaborating with Aboriginal community organisations (i.e. Far West Community Partnerships), local health networks (i.e. Central Adelaide), and clinical teams (i.e. Trauma SA), the project will create a system that not only addresses culturally specific needs, but also prioritises community empowerment through training and mentoring Aboriginal researchers, producing strength-based resources, and embedding Indigenous Data-Sovereignty principles into trauma data governance. These efforts will improve the quality and safety of care while fostering trust and engagement between Aboriginal communities and healthcare providers. Beyond trauma, the methods developed through IMPACT can be adapted to other

areas of healthcare, creating lasting systemic change and reducing health inequities for Aboriginal and Torres Strait Islander peoples.

Conclusion

Aboriginal and Torres Strait Islander trauma patients require culturally responsive approaches to care, meaningful clinical quality and safety indicators and PROM measures that reflect their unique healthcare needs. IMPACT will co-design, pilot and evaluate an Indigenous-led, strength-based program in collaboration with local health networks, clinical teams, Aboriginal community organisations, community members and researchers to positively transform trauma care, targeting inequities impacting on Aboriginal and Torres Strait Islander communities. IMPACT will drive the implementation of integrated care, relational clinical quality and safety indicators, and tailored PROMs, through a scalable approach designed to address health inequalities nationally for Aboriginal and Torres Strait Islander communities.

Ethics

Ethics approval has been granted by the Aboriginal Health Research Ethics Committee (#04-25-1177) and the Flinders University Human Ethics Committee (#9099). Further ethics approval will be sought through the Local Health Networks (LHN) Ethics Committees (Central Adelaide and Ayre and Far North LHNs). For the use of interstate trauma registry data, approvals will be sought from ethics committee bodies in the Northern Territory, Victoria and New South Wales.

Conflicts of interest

The authors have no competing interests to declare.

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Author contributions

CR conceptualised and edited all versions (on Kurna Yerta); CR and GS contributed to the initial version (on Kurna Yerta country); [CR, GS, PS, DE, NK, MF, BG, MFitz, JC, LW, BS, GO, MM, KH, HA, MT] assisted in all revisions (on Kurna Yerta, Kokatha, Mirning and Wirangu, Gadigal, Awabakal and Wurundjeri country). HA and MT provided academic mentorship and support of revisions (on Kurna Yerta and Gadigal country). (Aboriginal lands on which the contributions occurred, in parentheses).

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