

**Washington State Department of Health
Office of Community Health Systems
EMS & Trauma Care Steering Committee
Meeting Minutes**

March 18, 2015
Creekside Conference Room
20809 72nd Ave. S., Kent, WA

Attendance:

Committee members:

Stephen Anderson, MD	Mark J. Correira	Chris Martin
Sam Arbabi, MD	Mark Freitas	Russ McCallion
Suzanne Beck	Denise Haun-Taylor	Norma Pancake
Eileen Bulger, MD	Claudia Lengenfelder	Susan Stern, MD
Robert Conroy, MD	Valerie Lyttle	Lynn Wittwer, MD

Department of Health staff:

Scott Hogan	Matt Nelson	Sarah Studebaker
Dolly Fernandes	Zeyno Nixon	Kathy Williams
Catie Holstein	Eva Rooks	Samantha Yake

Guests:

Shahram Aarabi	Madeleine Geraghty, MD	Adam Richards
Bob Berschauer	Beki Hammons	Casey Stewart
Melanie Billingsley	Paul Inouye, MD	Beth Stuebing, MD
Rinita Cook	Karen Kettner	Mark Taylor
Rachel Cory	Denise McCurdy	Joanna Wied
Terri Christy	Ed Nickel	Deborah Woolard, MD
Janna Finley	Tammy Pettis	
	Karrie O'Brien	

Call to order and review of previous meeting minutes: Eileen Bulger MD, Chair

Handout: Minutes of January 21, 2015 EMS and Trauma Care Steering Committee meeting.

Motion #1: Approve minutes with changes to the attendance.

Approved Unanimously

Department of Health updates: Dolly Fernandes

Personnel changes at the Office of Community Health Systems: Karen Brownson hired to work on the State Suicide Prevention Plan that is due to the legislature in November.

Budget: We're waiting for the March revenue forecast to be released. House and Senate budgets will follow. That will be followed by the reconciling of all budgets and if all goes well, sine die is April 26.

Legislative update: We're coming up on some cut off dates:

- **April 1:** Last day to read in committee reports from opposite house, except House fiscal committees and Senate Ways.
- **April 7:** Last day to read in opposite house committee reports from House fiscal committees and Senate Ways & Means.
- **April 15:** Last day to consider opposite house bills (5 p.m.)
- **April 26:** Last day allowed for regular session under state constitution (Sine die).

This year there are several bills that may have some impact on EMS. **The ones that failed to pass cut off deadline include:**

HB 1340: develops a process to allow pilot programs for healthcare professionals to learn new skills, new roles or use existing skills in new circumstances.

The following are moving along:

HB 1135: Health professions remediation plans (concept presented to medical program directors last June).

HB 1009: Allowing rural counties providing EMS to locations with rural amphitheater additional admission surcharge.

SB 5175: Telemedicine as a reimbursable service.

HB 1339: Allows the secretary of health to intercede and stay any decision of a disciplinary authority that expands scope of practice.

HB1878: Glucagon administration by EMTs. The bill failed to move forward. The glucagon portion was merged into another bill, HB1625.

HB 1498: Make hydrocortisone sodium succinate or similar medication for the treatment of acute adrenal insufficiency available to their emergency medical technicians in their emergency care materials. Emergency medical technicians may administer epinephrine and hydrocortisone sodium succinate or similar medications for the treatment of acute adrenal insufficiency. The bill failed, but parts of it got merged into 1625.

HB 1721: Alternative destination requires consultation from Department of Health and Department of Social and Health Services to convene a work group to establish guidelines for emergency medical transport of patients to chemical dependency treatment programs or mental health facilities by ambulance.

HB 1625: Hospital pharmacies needed to provide minimal amounts of drugs to ambulances for some specific conditions. It requires the Pharmacy Quality Assurance Commission to work with the EMS and Trauma Care steering committee to develop guidelines for hospitals, ambulance and aid services, and medical program directors for the provision of medications in accordance with state and federal laws. Administration of Glucagon (HB 1878) and Hydrocortisone (HB 1498) by EMS was added to this bill.

SB 5591: Allowing emergency medical services to develop community assistance referral and education services programs.

HB 2044: Any fire department may develop a community assistance, referral and education services program to provide community outreach and assistance to residents of its jurisdiction in order to improve population health and advance injury and illness prevention within its community.

HB1159: New drivers' safety. The bill requires new drivers to have a sticker on the back of their car.

HB1276: Traffic infraction for any person that has an open container of marijuana in their car while driving on public highways.

SB 5656: Distracted driving by using any sort of personal device while driving. Dr. Bulger indicated that she had heard from committee members with concerns about HB 1625. No concerns on the first section that addresses hospital pharmacies providing limited medications to EMS ambulances. However the concerns are on section 2 that addresses glucagon and hydrocortisone administration by EMTs.

Dr. Bulger asked Dr. Wittwer about the use of these drugs in the prehospital setting. Dr. Wittwer explained that glucagon is used for a very small percent of the patient population with diabetes. An IV with dextrose is the preferred way to treat diabetics in the field.

Glucagon might be a good idea for a child who is having an insulin reaction at school, in a community where only EMTs could arrive in time to administer it. The cost of carrying glucagon on every ambulance across the state, not including the training, would be about \$2 million a year. It's an expensive drug, about \$200 a dose.

The bill does have the option of localized solutions to specific community needs for glucagon and hydrocortisone. Then the EMT could administer the patient's own glucagon if it was at the school or at work, or the EMT could assist in giving the medication.

Dr. Wittwer also explained that hydrocortisone is for acute Addisonian Crisis. People who are experiencing an Addisonian crisis typically get an immediate injection of hydrocortisone. It would be difficult for EMT's to be trained to identify the symptoms unless the person has a history of Addison's Disease, and/or has a medic alert tag on that says they have the problem.

Discussion ensued on these medications, use by EMTs and significantly high cost of carrying the medications when only an extremely small percentage of the population needs it. The committee asked that a letter from the committee be sent to the legislature addressing the concerns. Dolly informed the committee that since it is advisory to the department, the letter would need to be

reviewed and processed through the department. It usually takes a little time to be processed and might get to the legislature after the hearing. Dr. Anderson indicated that he was going to ask the American College of Emergency Physicians to send the legislature a letter or comment on this bill.

Dr. Bulger and Dr. Wittwer agreed to draft a letter from the EMS and Trauma Care Steering Committee. They'll send it out for comment to the committee and then to Dolly Fernandes to be processed through the Department of Health to the Legislature.

Russ McCallion talked about the Community Paramedicine bills: SB5591 and HB 2044. Russ McCallion thinks that the bills will eventually help us move forward, but the hard work will begin after the bills are passed. The paramedics will be dealing with a host of implementation issues. He is leading a stakeholder workgroup that has been meeting since early this year and have been discussing Community Paramedicine or Mobile Integrated Health. They're also discussing how to build bridges with all the different players in healthcare.

Bob Berschauer expressed concerns with the community paramedicine bills and specifically language that permits it only for fire departments and tax-supported EMS agencies. Privates, either non-profit or for-profit are excluded. Washington Ambulance Association does not think this is good public policy.

Dr. Steve Anderson, speaking for the American College of Emergency Physicians, indicated they are very much intrigued with the idea of paramedicine. The bill is good in the fact that it starts out saying it is not trying to expand scope of practice. One of the conversations on the other side of the bill is the concern of private systems restricting access or directing access. For example, a Kaiser Ambulance service that diverts past the closest facility to take a patient to a Kaiser facility. That is where the concern comes into play; there are economic advantages to diverting and going to a different direction. They thought they might be able to move forward quicker if they took the private economic gains out of the equation.

On Alternate Transport Destination, HB 1721, Dr. Anderson acknowledged that the American College of Emergency Physicians has concerns over denying people that are requesting 911 transports for medical screening exams, being diverted. However, they're all for trying to get the right person to the right place at the right time. He praised Russ McCallion for putting together the stakeholder workgroup to try and solve some of those issues. One compromise that has been suggested is if a person specifically requests a hospital evaluation they should be entitled to hospital evaluation for medical screening. What if the person is too drunk to request a hospital evaluation? What if they have a brain injury and get transported and left for 12 hours in someplace to sober up? The issue is trying not to tie up the emergency departments.

Air Medical Rules: Catie Holstein, Department of Health

The Air Medical Rules were opened in November of 2014. Stakeholder workshops for these have been taking place and there will be two more workshops. The workgroup has completed review of the air ambulance WAC 246-976-320. The group received some recommendations for minor and major changes from the stakeholders. Some of the minor changes are related to personnel standards, physician direction, equipment standards. A couple of the major changes are the removal of the CAMTS accreditation. They're having to cross-walk some critical components from the CAMTS accreditation to add to the WAC. They need to implement a strategy for an inspection process in place

of the CAMTS accreditation. If all goes well, a review of the Air Medical Rules for the Steering Committee will take place this summer. Please feel free to participate in the webinar workshops.

Strategic Plan Status Reports: Pediatric TAC

Presentation: Pediatric Trauma Data: Zeyno Nixon, Department of Health

While Washington's adult trauma volume increased significantly over the years, since 2001 the statewide pediatric volume stayed stable around 2400-2800 patients. After the implementation of Washington's Trauma System, outcomes of pediatric (age <15) trauma improved significantly. This suggests effectiveness of coordinated trauma care efforts in this age group. Injury prevention resulted in a relative decline in pediatric volumes in recent years. Better trauma care resulted in a decline in pediatric inpatient mortality.

Despite all these improvements, Traumatic Brain Injuries are still the main cause of pediatric deaths and rising pediatric window/balcony falls in ages 1 to 6 is a concern. Department of Health Injury Prevention program has started to work on addressing this problem. The committee asked Zeyno to further analyze the window falls data to determine locations of the injuries if possible, so that prevention efforts could be better targeted.

Pediatric TAC – Status Report: Matt Nelson, Department of Health

Accomplishments for Pediatric TAC:

- Reviewed and updated Pediatric EMS guidelines
- Reviewed and updated Interfacility Transfer guidelines
- Reviewed and approved 2014 document *Equipment for Ground Ambulances*
- Reviewed specific facility protocols on 5 key pediatric injury/illness indicators
- Formed strong partnership with the Northwest Healthcare Response Network to implement statewide pediatric disaster preparedness plan
- Cross walked and streamlined entire Strategic Plan

Current Goals:

- Establish pediatric facility recognition system
- Finalize and distribute statewide pediatric disaster preparedness plan
- Create and distribute statewide pediatric non-accidental trauma (NAT) guidelines

Pediatric Facility Recognition Program

Develop a statewide system that is able to treat pediatric medical emergencies. This could look like:

- Whole hospital pediatric medical designation
- Emergency department pediatric medical designation
- Hybrid of the two

Pediatric Disaster Preparedness Plan

Systems are in place statewide to facilitate children's access to the right services and support before, during, and after disaster events.

- Children are not just little adults and care needs to be appropriate to age/ability in any situation
- This system already exists within King/Pierce counties, created by the Northwest Healthcare Response Network (NWHRN)

Non-accidental Trauma (NAT)

Create and distribute pediatric non-accidental trauma guidelines

- Often unrecognized and under-reported
- With standard guidelines signs of NAT will be more easily identified and children would get appropriate care immediately

Future issues and goals

- Establish strong partnership with IVPP section with focus on prevention
- Window falls
- Traumatic Brain Injury
- Period of PURPLE crying
- E-cigs/marijuana

Pediatric Non-Accidental Trauma: Deb Woolard, MD, filling in for Tony Escobar, MD

Dr. Woolard presented an overview of the problem of Non-Accidental Trauma (NAT).

The categories of abuse are physical, sexual, emotional, and neglect. The greatest percentages of children suffer from neglect. She discussed the injuries that are common in child abuse cases, such as bruises, marks, or scars in patterns that suggest hitting with an object. It is mandated that these suspicious injuries be reported, however that is not always done. Dr. Woolard also discussed how to develop guidelines for reporting.

Advancing Education for Bleeding Control: Eileen Bulger, MD

Dr. Bulger presented on bleeding control. Hemorrhage is the leading cause preventable death, and it kills people very quickly. It is the leading cause of preventable death on the battle field. Death from hemorrhage is usually within six hours. There are lots of different types of hemorrhage; extremity hemorrhage, junctional hemorrhage and torso hemorrhage.

The Hartford Consensus group was put together after the Sandy Hook school shooting. It's led by a trauma surgeon named Len Jacobs who is a regent of the American College of Surgeons. He selected a group of people from law enforcement, EMS, acute care hospitals. They discussed how to improve response to these mass casualties, and mass shooting events. There was a lot of emphasis on EMS and law enforcement. The group discussed how to do a better job at bleeding control in the field to prevent some of these deaths. They encouraged bleeding control training include tourniquets for all EMS personnel, law enforcement and bystanders.

THREAT: This is an acronym to give first responders an idea of the order of things that need to happen

- **T**hreat mitigation
- **H**emorrhage control must happen before the injured are moved from the scene; it has to happen very early
- **R**apid extrication to safety
- **A**ssessment by Medical Providers
- **T**ransport to definitive care

The Boston Marathon Bombing: A lot of attention was paid to the use of improvised tourniquets by bystanders. Unfortunately, the improvised tourniquets didn't work very well. If you can't occlude arterial flow, it will actually make the condition worse, because you occlude venous return. But you still have arterial inflow. A recent publication from the Boston surgeons that took care of the patients shows that most of the tourniquets that were placed were mostly ineffective because they were improvised. What probably saved the patients is that they were close to the hospital and got there quickly, in about 20 minutes. The article brought out that there should be access to commercial tourniquets, which do occlude arterial flow, and there needs to be some training for the public on how to use them.

Dr. Bulger was part of a group sponsored by the American College of Surgeons to address bleeding control. The group did a systematic literature review on all the literature around tourniquets and other hemostatic agents and other attempts of bleeding control. They put out a document last year which was published in Prehospital and Emergency Care. The reference is: <http://informahealthcare.com/doi/pdf/10.3109/10903127.2014.896962>.

The National Association of EMTs in collaboration with the American College of Surgeons Committee on Trauma has developed a course on the control of external bleeding and use of tourniquets for lay people who will likely be involved as bystanders in a major event. This is a two hour course and is available for free on line at <http://www.naemt.org/education/B-Con.aspx>. All steering committee members were encouraged to consider how this course could be implemented in their region. The goal is to make this training as widespread as citizen CPR. There are also several groups working at the federal level on how we can deploy bleeding control equipment including tourniquets in public places much as we now deploy defibrillators.

Chair Election: Chris Martin and Eileen Bulger, MD

Dr. Sam Arbabi was the sole nominee for Chair for the EMS and Trauma Care Steering Committee. He provided an overview of his vision for leading the committee. He praised the great Washington EMS and Trauma System and spoke of the importance of publishing what has been done in Washington for EMS and Trauma and now Cardiac and Stroke. His vision is to follow in Dr. Bulger's footsteps. Health Care Systems must be accountable for patient care; and the outcomes. Understand what leads to good outcomes and use that data to improve care. Without change, data is just data. Sam will work with the Steering Committee and Department of Health to publish the data so the public will know what great work is done here.

Voting for the chair was conducted by closed vote with committee members writing their vote on ballot forms. Fourteen votes were made, and fourteen were for Dr. Sam Arbabi.

Appointments to the Committee Update: Dolly Fernandes, Department of Health

There are four vacant positions on the committee. Dolly has emailed information about these vacancies and the application to the Steering Committee, Technical Advisory Committees and several interested parties. The applications are forwarded to the secretary of the Department of Health and he makes the decision on appointments.

Review of EMS & Trauma Regional Plans: Process to for the review of the 8 Regional Plans

Scott Hogan

These Regional plans describe the work that the Regional Councils have been doing to enrich the EMS and Trauma Care System within their region. They have developed a number of goals that are a variation the new State Strategic Plan goals. Scott asked for volunteers from the Steering Committee to review the plans. The reviews must be done by April 15, 2015. The following Steering Committee members volunteered to review the plans: Norma Pancake, Mark Correira, Sam Arbabi, Chris Martin, Mark Freitas, Mark Brogan, Eileen Bulger, and Russ McCallion.

TAC Reports: TAC Chairs

Hospital TAC, Chris Martin: The ACS Green Book is being cross-walked with the new ACS Orange Book. WAC changes will be made as needed. Clinical Practice Guidelines are well under way. The goal is to get them done in the next couple of months. Application revision process was easier this time around. Still a little work to do on it. ED length of stay: looking at why patients stay in emergency departments longer periods of time prior to transfer. Tony and Tim are so valuable to the Hospital TAC. Designation update: working on continuing to streamline the process.

RAC TAC, Scott Hogan: The RAC finalized their respective Strategic Plan objectives, strategies and workplan. They worked on goal #4 - To integrate continuous improvement management of emergency care system. Kathy Williams provided an update on Injury and Violence Prevention TAC and work being done on Prevention of Falls Among Older Adults. The RAC is working on their status update presentation for the May Steering Committee meeting. They also decided to include the Regional and local councils into the Regional meeting calendar.

Pre-hospital TAC, Russ McCallion: The TAC has been working hard on their respective goals, objectives and strategies. Catie has been doing a great job helping them with the crosswalk. They are working on building up the TAC membership and workgroups. So far they have been able to assign most of the work to the workgroups, which are: the indicators, MPDs, clinical standards, air medical, WEMIS data management and pre-hospital disaster planning and management. WEMIS meeting held on February 20, at Ocean Shores. There were a couple dozen people in attendance.

MPDs, Dr. Wittwer: Planning on having an annual MPD meeting on June 8.

Outcomes TAC, Dr. Arbabi: The Outcomes TAC is having regular meetings with different TACs. The last meeting was with the Pediatric TAC. They have met with Rehab and Hospital TACs. As different TACs come up with data questions, they can seek input from the Outcomes TAC. The RAC and IVP will present at the May Steering Committee meeting.

Cardiac and Stroke TAC, Matt Nelson: The TAC is working on revising the stroke protocol triage tool and streamlining the categorization application process by aligning it with the Joint Commission and offering deemed status to certified facilities.

Injury and Violence Prevention TAC, Mark Freitas: They have had two in-person meetings. Kathy Williams is doing a wonderful job spear-heading the group. They are working on their presentation for the May meeting. Mary Borges, the senior falls expert, presented at their last meeting about how the demographic is aging and what to do about that.

Cost TAC, Dr. Bulger: The TAC had a conference call March 3 to discuss the Trauma Fund plan for 2015-2017. Department of Health uses the forecast of revenue to develop the plan. The slight budget cut will be to the department grants. The Cost TAC will recommend the spending plan to the Steering Committee in May. They talked about the need to continue monitoring the Medicaid Managed Care Trauma program. Some of the Trauma Funds are apportioned for Medicaid trauma patients and go out through the Health Exchange. The TAC wants to make sure that is happening appropriately, and Mike Vanderlinde, who is a member of the Cost TAC and the financial expert with UW Medicine is monitoring it. The TAC discussed their strategic plan. The next Cost TAC meeting is scheduled for May 18, right before the Steering Committee meeting.

Rehab TAC: Dr. Arbabi acknowledged the rehab data analysis that was presented in November. Claudia Lengenfelder worked with Harborview Critical Care Fellows on a paper titled “Rehabilitation After Trauma: Does It Really Matter” that was presented at the 2015 annual Trauma Paper Competition of the American College of Surgeons. It won best clinical paper. This is an example of good work initiated by the Rehab and Outcomes TAC that has resulted in national and perhaps international recognition!

Meeting adjourned at 2 p.m.