

OREGON STATE TRAUMA ADVISORY BOARD

MEETING MINUTES

January 18, 2008

Portland State Office Building

Members Present:

Will Bean, RN; Susan Benedict, RN; Kevin Van Syoc, EMT-P; Christoph Kaufmann, MD; Robert Read, MD (Chair); Richard Urbanski, MD (Vice-Chair); Brian Graunke, EMT-P; Jon Jui, MD, Paul LeSage, EMT-P; Mary Barnum, RN; Christine Heyen

Members Absent Excused:

Excused: Carla Smith, MD; Martin Schreiber, MD; Nathan Kemalyan, MD; Susan Leathers, RN; David Spiro, MD;

OHD Staff Present:

Susan Werner, RN; Michelle Haun-Hood, RN; Philip Engle

In attendance:

Bobbie O'Connell, RN; Ameen Ramzy, MD; Holly Love, RN; Ted Raschkes, RN; Mark Anderson, RN; Susan Rowell, MD; Justin Dillingham, EMT-P; John McCreary, MD; Rita Wiley; Kelly Kapri; Cathy Murphey RN

Dr. Read, Chair, called the STAB meeting to order at 10:37 am

Review of Minutes – Dr. Read

There was a motion, and a second and unanimous vote to approve the STAB meeting minutes of October 20th.

EMS and Trauma Systems Section Report – Susan Werner RN

- 1) The trauma administrative rules revision process is underway. The next meeting will focus on Exhibit 4, Trauma Hospital Resource Standards and will be scheduled in late February or early March. The working document with the comments/suggestions generated from the first two meetings is available and will be sent out with the meeting notice. Comments will continue to be tracked as the meetings continue and a final draft document is produced.
- 2) A trauma system assessment will be initiated to assist in identifying barriers to the provider's ability to provide trauma care/ pediatric trauma care. The assessment is being conducted with funding from ORHP to assure rural input. A consultant will be selected to conduct focus surveys throughout the state and gather information

- on trauma care and pediatric emergency services. This information will be analyzed as one portion of the state trauma assessment. There was also discussion regarding the possibility of conducting an American College of Surgeons (ACS) consultation for Trauma Systems.
- 3) Concurrently EMSC is conducting surveys of its Oregon hospitals and EMS providers in order to measure the effectiveness of the EMS for Children program. This is part of a national effort to reach federal performance measures. The performance measures evaluate the capacity of a state to provide pediatric emergency care at the scene of an emergency, including the ability to provide on-line and off-line pediatric medical direction and the availability of pediatric equipment, and the capacity of hospitals to identify and transfer pediatric patients who exceed their capacity.
 - 4) Working in collaboration with OHSU, DHS Mobile Training Unit and the Emergency Medical Services for Children program, a pediatric needs-based simulation curriculum will be developed to train pre-hospital providers in the optimal care of the pediatric patient. Using the latest technology in pediatric simulation manikins, in-field scenarios will be developed utilizing wireless high-fidelity simulators. The simulators will also be used to practice multi-step transports in which scenarios begin in the field or office and end in a local or regional hospital emergency department.
 - 5) The designation cycle for trauma accreditation continues for 2008. DHS is developing a (RFPA) Oregon's Request for Provider Applications (RFPA) which will be sent out by e-mail from John Gardner, the DHS Contracts Officer. The contract will require renewal once every 5 years rather than every year. The mandate for professional liability insurance has been removed from the contract.
 - 6) The trauma registry implementation process continues for the new Trauma Registry-TraumaOne. Edit checks have been completed, which is the first of two processes that must be accomplished within the first few months this year. The second process involves bringing the trauma registry into compliance with the administrative rule that states the requirement to submit registry data within 90 days of patient discharge from the hospital. The hospitals have been asked to achieve the 90 day compliance mark by April 15, 2008. The links that allow retrieval of a patient report from either the transferring or receiving hospital is functional, and examples of the records were distributed to the committee. A record is not available for retrieval by a transferring or receiving hospital until such time that the record is completed (has passed the edit check and is marked as completed). These reports and the patient summary were developed with input from several of the various trauma centers. This function of our new trauma registry should assist all of us in conducting quality improvement processes. Next steps include developing reports that will be of use to all the providers. Please e-mail or fax Quality improvement reports that you currently use to advise/inform your administration/ATAB/physicians and/or multidisciplinary trauma

committees that you would like us to consider as a starting point. Please fax or e-mail a copy to Susan Harding. There is also interest in developing an Injury Prevention report and a comprehensive ATAB/STAB report.

The lack of registry support and resources in conjunction with the role of the hospital trauma coordinator was discussed by the committee. Trauma coordinators have experienced limitations on their time and resources necessary to maintain the trauma registry standards for accreditation. Limitations include time necessary for data input and analysis of the trauma registry data as well as appropriating time for other essential duties including outreach to other hospitals and prehospital agencies and injury prevention activities. Many trauma coordinators have experienced a decrease in their dedicated trauma coordinator hours or resources. There has been discussion during the Trauma Administrative Rule Revision to address specific FTE components for the trauma coordinator position, similar to the ACS registry criteria. The recent revision of the ACS Resources for Optimal Care of the Injured Patient 2006 decreased the number of hours/patient volume criteria for dedicated registry support, although members of the committee stated that computerized documentation has not made it easier for the trauma registry inputting issues.

ACTION: Mary Barnum made a motion that the STAB initiate a letter to Susan Werner in support of the dedicated hours for the trauma coordinator role. This letter would be distributed to hospital administration and assist in educating them on the necessary resources and support for this role. Dr. Kaufmann seconded this motion and it was animously passed.

ATAB Reports – as presented:

1. ATAB 1 – The meeting was held January 14, 2008. SAG and TAG provided reports on their activities. Discussion regarding the new KING airway and the issues of education when a new technique or protocol in the prehospital arena is started and the education at the trauma hospitals. The learning points included the needs for hospital and prehospital providers to be updated when changes occur.
2. ATAB 2 – The meeting was held January 17, 2008 in Salem. QI cases were presented and discussed. Stabilization prior to transport was discussed. Statistics were distributed to the committee. Work to update the ATAB Trauma Plan continues.
3. ATAB 3 – The meeting held was held November 14, 2008 in Eugene. There was discussion regarding massive transfusion guidelines, activation guidelines for the geriatric patient, transfer issues with orthopedic patients and patients who are delayed in transfer. Change in the ATAB plan included the utilization of air ambulance guidelines. QI cases were presented and discussed.

4. ATAB 5 – The meeting was held January 9, 2008 in Ashland. There was discussion regarding interhospital transfers. Dr. Brawner who served for many years as the trauma director at Rogue Valley Medical Center is retiring and Dr. O’Neil, the new Trauma Director at Rogue Valley Medical Center was introduced. The QI meeting included case reviews.
5. ATAB 6 – The next meeting will be held January 22, 2008.
6. ATAB 7 – The meeting was held November in Bend. Air autolaunch and the potential issues of landing at the hospital helipad were discussed. A subcommittee on this issue will be proposing guidelines for inclusion of air transport in the ATAB plan. The QI meeting included case reviews and presentations
7. ATAB 9 – No meetings scheduled at this time.

Action: For information.

State EMS Committee Report – Jon Jui, MD

1. Dr. Jui reported on the development of the State of Oregon EMS Mass Casualty Incident Plan. Oregon has not had a single document outlining roles and responsibilities of the various components of our EMS system during a natural disaster or manmade large-scale medical event. Development of the plan is a cooperative effort between DHS EMS and Trauma Systems Program, the DHS Emergency Preparedness Program and the Office of Rural Health at Oregon Health & Science University. Technical consultants Shawn Baird, Justin Dillingham and Denise Girard have been retained to assist in developing and writing the plan. The completed plan will provide a blueprint for use during large-scale disasters that require more EMS resources than are locally available. In order to create a useful, workable plan, input and expertise of all our colleagues in EMS, as well as other emergency service providers will be necessary. Focus groups will be held in regions across the state starting in spring 2008.
2. Intermediate level providers will be adding Fentanyl to their scope of practice as approved by the Board of Medical Directors.
3. The transition from the HOSCAP system to the HAN system is occurring at this time.
4. There was discussion regarding several of the current and potential prehospital changes and updates including EZ I-O, the King airway, fluid resuscitation choices, ETCOs and RSI. Concerns were voiced that a method of sharing evidence based practices for prehospital providers has not been developed and decisions and changes in prehospital care are not shared in a timely manner. It was proposed that a STAB subcommittee be formed to address these issues.

Action: There was a motion and second to institute an adhoc committee, chaired by Dr. Jui with members to include Dr. Read, Dr. Ramzy, Paul Lesage, EMT-P, Dr. Sahni, and members of the State EMS Committee/ Board of Medical Examiners EMS Subcommittee, including Dr. Paul Rostykus to address the identification and distribution of evidence-based trauma practices to prehospital supervising physicians and EMTs.

Association of Air Medical Responders of Oregon (AAMRO) – Ameen Ramzy, MD

AAMRO has met quarterly and is focusing on education and safety issues. Dan Brattain from Cal-Oregon Life Flight is the new chair.

Action: For information.

OLD BUSINESS

TOPOFF 4 Update from Emergency Preparedness- Jere High

Jere High ND, Emergency Preparedness Program Health Care System Integration Manager, discussed TOPOFF 4 as well as an overview of the emergency preparedness response during the Vernonia floods. Lessons learned:

- Engaging in the TOPOFF 4 exercise for longer than a few hours drove home the reality of the long-term commitment during a disaster response. It also made clear the realization of really how understaffed the effort is on all fronts.
- During TOPOFF 4 there was plenty of help reading plume models, but this resulted in numerous opinions, often conflicting, which lead to indecision.
- There are two systems used to request resources. This resulted in delays in receiving services and supplies and made tracking resources difficult from the DHS point of view.
- Hospitals:
 - Recruit your own actor victims – there are never enough
 - The exercise didn't stretch internal resources enough, didn't stretch medical resources
 - There were too few victims transported into hospitals to test surge capacity
- Learned about requesting resources, forms, the flavor of what our federal partners need in order to fill the request etc.

- Some agencies (not Public Health) tried to do warm starts and pre-plan some actions, what we found out is a cold start worked best and letting things play out provided the best training and lessons learned.
- Unified command worked great at the IC level, but never really got into the ‘command staff’ and integrating some Logistics and Operations.
- Had problems getting the tasking for our DMAT during TOPOFF, but worked like clockwork last week during an actual event (first time we have ever deployed within the state (our own team)
- There were communication issues outward-inward (not within), knowing what numbers to call, knowing whom to call – points out the need for strong relationships at the local level and the need to practice together more.
- Difficulties getting information out in general, due in some part to the artificiality of an exercise. Some was lack of depth of staff numbers required to coordinate this, although at times it appeared driven by systems issues.
- Resource ordering pointed to needing realistic expectations from the local level and state perspective; this was also seen in our winter storm event.

The STAB thanked Jere for an excellent presentation, and the lessons that could be utilized by the trauma system. Jere will send his PowerPoint to the committee for the minutes.

OAR Revision Schedule –Michelle Haun-Hood RN

As reviewed in the EMS and Trauma Systems Report.

Action: The schedule of meetings of the OAR adhoc subcommittee will be distributed.

QI Filter/Data Committee –Michelle Haun-Hood RN

The current STAB quality indicators were distributed electronically for comment. These have been sent out for trauma coordinators to review. Additionally the quality indicators can be reviewed at each ATAB; comments should be referred to the Trauma Program/STAB. These indicators can be utilized within the new registry. Bobbi O’Connell and Michelle Haun-Hood will continue to work on the process. Identification of a core group of indicators could result in benchmarks that could be used at the hospital, regional and state levels to identify optimal care and to identify opportunities for improvement.

Action: Continue to review.

Legislative Update – Christine Heyen/Susan Werner

1. Christine Heyen and Susan Werner discussed the options for the legislative initiative to change/improve the EMS and Trauma Systems that could be reconsidered during the February 2008 session and readied for the 2009 session. A one page legislative concept paper can be presented February 22nd to create a placeholder for the following session. It was suggested that five priorities for trauma system development be ranked to develop the concept paper, focusing on two primary key concepts. Susan suggested that a survey monkey tool be sent to the stakeholders throughout the state and the results utilized for this concept paper.
2. It was also determined that it is appropriate to gather data in other forums, including the EMSC focus groups, that could be used in conjunction with survey data and which can be presented in July to the legislature to gain support and utilize in the fall to be ready in the 2009 session.

ACTION: Christine will send out the format for the concept paper. Susan will create a survey on the Survey Monkey Website; it will be available to the stakeholders till February 7th. The results will be forwarded to Dr. Read and will be used to develop a legislative concept paper for presentation in February.

Open STAB Positions

There are a number of STAB positions that are unfilled.

Hospital Administrator
Anesthesiologist
Emergency Physician- Level 1
Trauma Surgeon- Level 3-4
Neurosurgeon- Level 1

Handouts for each position are available and are posted on the WEB site
<http://egov.oregon.gov/DHS/ph/ems/trauma/index.shtml#stab>

Ms. Werner has received applications for some positions but preference will be given to representatives that are from an area not already heavily represented on STAB.

Simultaneous ACS survey and Oregon Health Division Trauma Site Surveys

A handout was included on the process utilized in other states for simultaneous surveys. Susan pointed out that the ACS standards may be difficult for Oregon to include in their regulations.

ACTION: Dr. Kaufmann made a motion that the state allows simultaneous visits. Discussion included the criteria and concerns for Level 3s and the standards. Ms. Murphey asked what requirement for the survey documents would be, in various states it differs but in Oregon hospitals would be required to do the PRQ for ACS

and the site survey proposal for the state. Dr. Kaufmann amended his motion that the state supports the use of simultaneous surveys but not mandate. Dr. Jui seconded the motion and it was animously passed. DHS will continue to research the process.

Imaging/Radiation Exposure- Dr. Ameen Ramzy

Dr. Ramzy presented on the issues of imaging/radiation exposure and the potential concerns with the increase in imaging in trauma patients. Comments included various issues with the data, but agreement that increased imaging is certainly utilized in the care given to trauma patients although not clear if the risk/benefit is certain.

MEETING SCHEDULE for 2008

January 18, 2008- Portland State Office Building
April 18, 2008
July 18, 2008
October 17, 2008

As there was no further business, the meeting was adjourned at 1:43 pm.

Recorder: Michelle Haun-Hood RN MA CCRN, DHS Trauma Coordinator