Time Critical Diagnosis-Trauma System Task Force
Conference Call Highlights
1/28/09

Note: Two different calls were held by the Department of Health and Senior Services (DHSS) to accommodate participants from each of the six regions. The East-Central, Southeast and Central Regions participated from 10:30-12:30 p.m. and the Southwest, Kansas City, Northwest participated from 1:00-3:00 pm. The highlights are combined for these calls.

Those participating: Dr. Samar Muzaffar, Department of Health and Senior Services (DHSS); Paula Adkison, DHSS; Dr. Lynthia Andrews, State Advisory Council; Ben Chlapek, Central Jackson Fire Protection District; Karen Connell, DHSS; Dr. Jeff Coughenour, University Hospital and Clinics; Lori Davis, North Kansas City Hospital; Dr. Robert Dodson, St. John's Regional Medical Center; David Durbin, SSM Health Care; Joan Eberhardt, Missouri Emergency Nurses Association; Jay Faulkner, Osage Beach Ambulance; Kelly Ferrara, The Vandiver Group; Dr. Brian Foelke, Washington University EMS; Robert Grayhek, St. Francis Medical Center; Vicki Groce, Andrew County Ambulance District; Paul Guptill, Missouri Hospital Association; Susan Hall, St. John's Regional Medical Center; Mike Hicks, Mid-America Regional Council; Dr. Elliott Hix; Scotland County Memorial Hospital; Daniel Holte, Northeast Regional Medical Center; Sara Howard, The Vandiver Group; Dr. Kelly James, Centerpoint Medical Center; Dr. Robert Johnson, St. John's Regional Health Center; Dr. James Kessel, University Hospital and Clinics; Amy Knoernschild, Lake Regional Hospital; Ken Koch, St. Charles County Ambulance District; Diana Kraus, St. Louis Children's Hospital; Dr. Charles Ludy, Capital Regional Medical Center; Candy McClain, St. Luke's Hospital; Rande McCrary, Atchison-Holt Ambulance District; Bryant McNally, Missouri Hospital Association; Deborah Markenson, DHSS; Ruby Mehrer, Life Flight Eagle; Cathy Menninga, Golden Valley Memorial Hospital; Taz Meyer, St. Charles County Ambulance District; Sally Nance, Excelsior Springs Medical Center; Kaisey Martin, DHSS; Julie Nash, Barnes-Jewish Hospital; Greg Natsch, DHSS; Carol Nierling, University Hospital and Clinics; Patty Parrish, CoxHealth; Wally Patrick, Heartland Regional Medical Center; Dr. Robert Poirier, Washington University; Eric Roberts, Research Medical Center; Dr. Steve Rothert, St. Francis Medical Center; Dr. Joseph Salomone, Kansas City EMS/SAC; D.J. Satterfield, St. John's Life Line Air Medical Service; David Seastrom, St. Luke's Hospital; Dr. Douglas Schuerer, Washington University; Ted Shockley, St. John's Regional Hospital; Andrew Spain, University Hospital and Clinic; Dr. Harry Wilkins, St. Luke's Hospital; Sandy Woods, St. John's Regional Medical Center; Dr. Timothy Woods, CoxHealth; and Monroe Yancie, St. Louis Fire Department EMS

<u>Review of Level IV Center Proposed Regulations</u>

The Trauma Task Force, at their last meeting in October 2008, recommended that Level IV Trauma Centers be added. DHSS staff compiled and shared draft regulations for this designation level prior to the call. The proposed sections listed below were discussed.

19 CSR 30-40.410 Definitions and Abbreviations Relating to Trauma Centers
19 CSR 30-40.440 Trauma Center Designation Requirements
19 CSR 30-40.450 Standards for Level IV Trauma Center Designation

Discussion

Based on the discussion, DHSS staff will make modifications in the draft proposed regulations and distribute the revision to the Trauma Task Force members for another round of review prior to filing. The following comments were shared on the call.

Definitions (40.410)
- Concern that some of the needed definitions have not been included, these will be added.
- Add definition for Certified Registered Nurse Anesthetist (CRNA's), anesthesia, etc.

Standards (40.450)

- Change language for Helipad—cordon off when in use.

Distance Between Trauma Centers

- There were differing opinions on distance requirements or time to transfer requirements between centers as described below:
  - Establish regulations to increase requirement from 15 to 30 miles distance between Level IV centers and any other designated trauma center. Some stated that the time to transfer should be factored into the determination, i.e., if it takes longer to transfer, then mileage may be adjusted to lower requirement (15 miles) but if transfer can be done in less time the mileage requirement could be 30 miles.
  - From a historical perspective this requirement was included so that there would not be Level III centers within 15 miles of Level II centers. This does not guarantee better care. It forces paramedics to make decision they should not have to make.
  - It was also suggested that there be an exemption or variance process for the 30 mile distance requirement. Regulations would have to assure that current statutes would allow this or would need to change statute.
  - On the other side of the discussion were those that proposed the elimination of language that requires mileage distance between Levels I and II Centers and Level III and IV Centers. It was stated that it would be better to be inclusive and allow facilities to become designated at the trauma center level for which they meet requirements.
  - Need to explore the alternatives. Could establish protocols and not stipulate distances between centers in regulations to accommodate differences between the regions.
  - Concerns regarding the times when Level II centers are on diversion.
  - When the reporting stage is in place, this issue could be better evaluated to determine best distance framework.
  - It was also suggested that DHSS could map State by catchment areas and look at highway patterns that can influence practical transportation issues.
- Recommended that regulations should acknowledge differences between rural and urban areas and differentiate requirements that will allow for variances or exemptions that are warranted.

- Advanced Trauma Life Support (ATLS) certification is required for physicians. Advanced Trauma Care for Nurses (ATCN) is required for nurses.
  - Several recommended that the ATLS course be audited by nurses that are in positions where they oversee the Emergency Department.
  - It was suggested that the regulation language be modified to read that physicians "successfully complete and maintain current ATLS certification."

- Licensed trauma providers response time was discussed. Regulations need to define what timely means in (3)(A)(5)(F) in relation to timely interpretations. Regulations need to be in line with ATLS standards that stipulate that individual will interpret the results. General

agreement on afternoon call that regulatory emphasis should focus on preventing any delays in transfers for definitive treatment.

- Define "qualified" for trauma program manager. Discussion points:
  - Debate on whether program manager needs to be a nurse. During morning call identified three options: RN, Qualified RN; or RN, paramedic, CMT, or PA; Different requirements for the Level IV compared to Level III. (verify that statute doesn't define or stipulate).
  - Agreement that use RN or qualified personnel as defined by American College of Surgeons (ACS)

- Emergency Department must be covered 24/7. When Nurse Practitioner or Physicians Assistant is working they must be backed by the physician that is within 20 minutes.

- Regarding performance improvement patient safety measures, it was recommended that should review evidence-base for the current recommendation: *(4) (B) 7. Trauma patients remaining greater than six (6) hours prior to transfer will be reviewed as a part of the performance improvement and patient safety program.*
  At this time there is no documentation to support this time frame. It was stated that the current time serves as a flag for the state reviewers and the sending facility to conduct a review, identify causes for delays, and improve process and procedures, if indicated.

- Provide guidelines for centers that do CT's.

- Delay in transfer should not occur waiting for additional radiologic studies not indicated by patient's condition

<u>Trauma Classification and Triage</u>

The recently published article in the Morbidity and Mortality Weekly Report (MMWR) 2009; 58(NoRR-1) was reviewed and discussed. This article presents national standards for classification scheme and field triage algorithm of injured patients that can provide base for Missouri's protocol to establish consistency across the state. Classification consistency provides the following advantages: follow national standards and consistency across state helps with disaster management that involves multiple regions.

<u>Classification Schemes</u>

- Need to have some wiggle room for Glasgow Coma Scale (GCS) so EMS does not over triage. It was suggested that use <13.

- Proposed
  - GCS <14
  - SBP<90, or
  - RR <10 or >29

  } Put in one algorithm with addition of age specific history
- Need different level for children than adults. There is a State Advisory Council (SAC) pediatric subcommittee that is working on the triage and classifications for children. Some

expressed concern that it would be difficult for EMS staff to have two different guidance documents for adults and children. The morning callers voted to merge guidance for both age groups into one document.

- Dr. Muzaffar will revise protocol based on Center for Disease Control and Prevention (CDC) recommendations and the input from these calls for all to review at the next trauma meeting.

ACS-Committee on Trauma (COT)—will conduct a trauma system review for the State. The ACS-COT national team will conduct this review June 22-25, 2009. DHSS is compiling the information required for the review that includes statutes, regulations, protocols and other documents related to the system.

On and Offline Medical Control, Emergency Medical Dispatch (EMD) and Pre-Arrival Instructions (PAI)

- Medical control, both on-line and off-line, was reviewed for each of the regions, as well as EMD and PAI. DHSS would like a more coordinated system. Much education will have to be done to rollout standardization across the state. It was suggested that the National Academy of Emergency Medical Dispatch (NAEMD) tool would be beneficial to use. We want to get the Medical Directors from the six regions involved with this task.

SAC Communication Sub-Committee is doing a survey to find out the number of dispatch areas, how many EMDs and the number of directors. They expect to complete those surveys within 45 days. Concern was expressed regarding the '911' system and the need to do additional work for statewide coverage.

Representatives from each of the regions on the call provided the following information on medical control:

Central

- More off-line than on-line medical control is used, EMD Columbia-Boone
- Use uniform PAI but some counties with no EMD/PAI
- Online specifications related to controlled substances

East Central

- EMD-using medical priority dispatch
- Much more off-line control

Southeast

- EMD is protocol driven
- PAI to ambulances is not formalized in rural areas
- Some with no EMD at all

Northwest

- Two new 911 centers
- Need clarification on roles of off and on-line medical control
- Currently there are consistent protocols that are shared among EMD

Kansas City

- Similar to St. Louis, EMD-using medical priority dispatch and more off-line control
- Using EMD and both on-and off-line medical control in the more populated areas of the region
- No representation on the call to report on the rural areas of the region

Southwest

- Overall good EMD coverage with just a few areas with limited EMS coverage
- Good medical control coverage