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

MEETING MINUTES

January 16, 2019
Creekside Conference Room
20809-72nd Avenue South, Kent, WA

ATTENDEES:

Committee Members:

Sam Arbabi, MD	Mark Freitas	Erica Liebelt, MD
Cameron Buck, MD	Madeleine Geraghty, MD	Sam Mandell, MD
Eric Cooper, MD	Denise Haun-Taylor	Mark Taylor
Peggy Currie	Joseph Hoffman, MD	David Tirschwell, MD
Kim Droppert	Rhonda Holden	
Tony Escobar Jr., MD	Tim Hoover	

DOH Staff

Tony Bledsoe	Dolly Fernandes	Matt Nelson
Ben Booth	Hailey Green	Jason Norris
Christy Cammarata	Catie Holstein	Tim Orcutt
Aimee D'Avignon	Elizabeth Molina	Sarah Studebaker

Guests:

Anne Benoist	Tyler Dalton	Cyndi Rivers
Bob Berschauer	David Lynde	Leah Salmon-Conroy
Brian Burns	Denise McCurdy	Max Sevareid
Brian Cain	Jim Nania	Nicole Siegel
Chris Clutter	Tammy Pettis	Traci Stockwell
Dave Collins	Adam Richards	Zita Wiltgen
Rinita Cook	Brian Purse	Libby Witter
Rachel Cory		

Call to Order: Sam Arbabi, MD

Dr. Nania introduced Dr. Joe Hoffman, Medical Program Director representing MPDs on the committee

Review of previous meeting minutes: Sam Arbabi MD, Chair
Handout: *Minutes from the November 21, 2018 EMS and Trauma Care Steering Committee meeting*.

Motion #1: Approve November 14, 2018 meeting minutes.
Approved unanimously.

DOH Updates: Dolly Fernandes, DOH

Handout: Assessment Announcement with dates and times for sessions

The legislative session began on Monday, January 14; it is the long, 105 day session. There have not been any bills for EMS and trauma yet, though 15 bills on behavioral health and facilities have been introduced.

In the Office of Community Health Systems, the Research, Analysis and Data section (RAD) has been reinstated; and Jim Jansen selected to manage RAD. The section is made up of Ben Booth, Elizabeth Molina, Asnake Hailu, Donna Bybee, Melissa Belgau and Jim Jansen.

Trauma Assessment: The American College of Surgeons will be conducting an assessment of the EMS and Trauma Care System. The on-site assessment will be held at the Department of Health, in Tumwater, the week of April 22 – 26. Dr. Arbabi and Dolly invited all steering committee members, TACs, Regional Councils and stakeholders to attend the site review. Dolly provided a handout on the schedule for on-site assessment which included dates and times for the sessions. The review team will provide a preliminary report on the assessment findings on Friday, April 26, 1:00 – 2:00, at Department of Health.

Dolly was asked which positions are open on the steering committee. There is a vacancy for a neurosurgeon; a neurosurgeon from King County has submitted an application. There is also a vacancy for a cardiologist. Peggy Currie indicated there may be a cardiologist from Spokane interested in applying.

Rules Update: There are three sets of rules that the EMS and Trauma program is working on: EMS, Trauma Registry and the Trauma Designation.

The Trauma Designation rules are done and went into effect on January 3, 2019. Thank you to Tony Bledsoe for leading that rule-making process and to the Hospital TAC for their input.

The next set of rules are for Trauma Registry which Tim Orcutt has been leading. He has completed the CR 103 package, and it is in the final stages of the department review. The department's Assistant Attorney General has reviewed and made minor changes to the format and some wording. We anticipate the registry rules will go into effect around the end of April.

The last set of rules are for EMS, and several chapters of the rules have been opened. Catie Holstein is leading that work and meeting with stakeholder groups. Catie anticipates being done with the stakeholder meetings by summer of 2019. The rule-making meetings schedule is posted on the department's website.

Update on Legislative efforts for Cardiac and Stroke Funding:
Cameron Buck, MD, ACEP and David Tirschwell, MD, ESC TAC Chair

Dr. Tirschwell presented background on the emergency cardiac and stroke system, based on legislation passed in 2010. It was an unfunded mandate. Heart disease and stroke are by far the most common cause of death in Washington State with more than 15,000 deaths every year. Hospital and long term care charges are more than four billion dollars a year. The most common risk is to people over 65 years of age. Cardiac arrests and stroke are rapidly increasing; supposed to double by 2030. Less than 15 percent of acute stroke patients actually receive emergency evidenced-based treatment.

What is broken? Simply put, there are too many deaths and not enough patients receiving these evidenced based interventions. There are always opportunities for improvement, which is exactly what a funded system of care would continuously address.

In 2010, the intent of the bill that was passed was to improve emergency cardiac and stroke care in Washington through evidenced based coordinated system of care, which included hospital to voluntarily self-identify their cardiac and stroke capabilities. If you have external certification you can be given that status. It also allowed for DOH endorsed patient care protocols and triage protocols. Hospitals that are participating can self-identify and are supposed to participate in internal, regional and state-wide quality improvement activities, participate in data collection system and to advertise their participation in the system. But there was no funding attached to that legislation, and there is no required verification that any of these activities are really taking place. Traction and progress have been severely hampered by the lack of funding. On the stoke side, the Coverdell Grant funding from the CDC has allowed for some of this work to go forward. It has been successful, though funding is not permanent and there is no guarantee that the funding will continue.

The system goals are to save lives and reduce disabilities for all people in Washington, regardless of where they live, work or play, and regardless of who pays for their care. Building and sustaining a robust coordinated emergency cardiac and stroke system that reduces time to treatment, improves patient safety, and supports evidence-based care by EMS and hospitals everywhere in the state, will save and avoid costs. Also, the system addresses rural, racial, ethnic, gender and income variability and disparities in care and outcomes.

Components of the system needed: more funding, on-site verification of levels of care for both cardiac and stroke, support for data collection with funding, especially for smaller rural hospitals that don't have the resources to be able to do it on their own. Also, support for local and regional QI, and professional education for both rural and urban and also to educate the public.

Dr. Buck acknowledged that Dr. Tirschwell explained where they were with the history of the system and why they need action. Dr. Buck notified the committee and the people present what the next steps are in terms of legislation. Specificity is needed on why we need action. It is very difficult to go from this idea to funding legislation. There are certain requirements and restrictions about what Department of Health can do, and what they can't do in terms of lobbying and educating. This also applies to what the steering committee can do as an extension to the executive branch of government.

Dr. Buck gave the committee an update on what the American College of Emergency Physicians (ACEP) is doing on legislation. First, ACEP has identified this as a strategic initiative that they are willing to take on. As an organization, they want to build a coalition of other leaders and organizations with the sole purpose of creating a bill they could get in front of the legislature. This requires sponsors and a long list of other things. They plan to start the list and initiate the process. They have a lobbyist, they have talked about strategy, and identified individuals and organizations. They are also creating a one page handout to present to the legislature. What it will take is other individuals and organizations to step up and join this coalition. Dr. Buck wanted to bridge that opportunity with the steering committee. He knows that they need to be very careful as to rules and laws that prohibit lobbying by DOH and DOH advisory committees.

Peggy Currie asked if this proposal supported on-site verification of cardiac and stroke centers and was informed that it did. She cautioned that the Washington State Hospital Association (WSHA) had concerns about some hospitals, especially rural hospitals, being able to afford on-site verification.

Dr. Tirshwell asked for the committee's vote to support this proposal to fund a cardiac and stroke system for Washington.

Dr. Arbabi expressed concern that if a funding source is not named, the legislature might take the trauma fund and give half of it to cardiac and stroke. Committee members indicated that a separate and dedicated funding source for cardiac and stroke was necessary. The committee offered wording suggestions for the motion.

Motion #2: This committee supports an independent, dedicated and new funding source for an organized system of cardiac and stroke care in the State of Washington.
Approved by all but one steering committee member.

Washington Trauma Registry Data Requests for academic research: Sam Arbabi, MD

One of the healthcare issues facing Washington is opioid use. Researchers want to use data from the Washington state Trauma Registry (WTR). They are looking at: Who are the trauma patients that are becoming chronically dependent on opioid prescriptions, and who are the patients that overdose on it later on. They know that past use of opioids is quite important, so they want to know how many people were using pain medication six months before the trauma happened. Then, do they became chronic users and continue to use opioids for six months or a year, and/or overdose on it? In order to do this research, the researchers need to get the trauma registry data, link it to All Claims Payers Database (ACPD). Then they will know if the patients were using opioids at 6 months or a year after their injuries. They also want to link this to CHARS, which will inform on readmission of the patient and other issues. The goal is to identify the group of people that are at risk for overdose and the group that are at risk for becoming chronically dependent on prescription drugs.

Department of Health has told the researchers that they cannot release data with patient identifiers from the trauma registry. Dr. Arbabi asked for some discussion and a statement of support from the steering committee.

Dolly provided some background on this issue. She informed the committee that Department of Health has received a Trauma Registry data request from a graduate student. DOH and the Trauma

Registry has received a dozen such data requests. Most of the data requests have required linking up with CHARS, which was done by DOH when resources are available. This is a new type of request and DOH needs to work out the processes needed and what framework the other parties need to go through in order to share data that includes patient identifiers. Currently Ben Booth, Trauma Epidemiologist and Jim Jansen, RAD Manager are working on data sharing processes for the Trauma Registry data. As part of the processes, DOH will also include guidance as to what our parameters would be for the third party. This is something DOH has not done and currently do not have processes and protocols worked out for that aspect of the trauma registry. Jim indicated that one of the main miscommunications is that DOH is putting a hard "no" on this request. That is not the case. When DOH says yes to this request, it needs to be under the parameters discussed.

Motion #3: This committee supports research using Washington Trauma Registry data for the purposes of improving trauma patient outcomes, after appropriate IRB review process and patient safety parameters are set.
Unanimously approved.

Dolly introduced Max Sevareid. Max worked for the US Dept. of Transportation's National Highway Traffic Safety Administration (NHTSA) in Seattle in management and oversight of traffic safety public health programs. Currently he works for NHTSA's Office of Emergency Medical Services (EMS) on a national level. Max informed the committee that the NHTSA Office of EMS is focusing on evidence based guideline promotion and development in Washington DC. They manage the national contract with NEMSIS and use NEMSIS to measure the health in the National EMS system. They are hoping to deliver more data to the EMS State agencies.

STRATEGIC PLAN REPORT: Hospital TAC Annual Report Tony Bledsoe, DOH

The Hospital TAC serves as a resource to and advises the Steering Committee and DOH on clinical and technical matters related to the structure, standards and best practices of the acute care trauma system.

They have 204 Listserv subscribers, and meetings are attended by between 25 to 40 members. Most of the participants are trauma program managers; but they also have a lot of surgeons and physicians that participate. They meet right before the steering committee meeting from 8:00 am to 9:15 am.

Currently there are 82 trauma designated hospitals in Washington. Two new ones added: Snoqualmie Valley Hospital and Multicare Allenmore Hospital. Designation has stayed relatively stable for the last five to ten years.

Three hospital TAC strategic plan tasks were identified for 2018. The first was to provide guidance and subject matter expertise for formal WAC revision work. This task has been completed. Second the TAC wanted to develop metrics for systems and program evaluation for hospital QI programs. This task is about half completed. The last was to use registry data to determine the impact of clinical practice guidelines. This task is about 30% complete and will be ongoing through 2019 and beyond.

Focus for 2019 will be for the Hospital TAC to continue to use data for system improvement, to work on more formally developing a data report schedule for the TAC, and to align state processes and documents with the new WAC requirements.

Trauma Clinical Guideline Assessment: Head Injury in Anticoagulated Patients
Ben Booth, Trauma Epidemiologist, DOH

An assessment of the Washington Trauma Clinical Guideline for Head Injury in Anticoagulated Patients was performed to determine whether the goals of the guideline are being met. As identified in the guideline, the main goals are to 1) rapidly identify intracranial hemorrhage in anticoagulated patients and to 2) reduce time from presentation to reversal of anticoagulation. Inclusion in this assessment required patients to be at least 18 years old with an arrival date between 2015 and 2017, a blunt mechanism of injury with a head, neck or facial injury, and an oral anticoagulant received within the last 4 days. From 2015 to 2017, head CT use was steady at around 95%, International Normalized Ratio (INR) testing went down slightly from 90% to 82%, and anticoagulant reversal went down from 21% to 13%. No changes in time to first head CT, first INR, or first reversal were observed during this period.

Dr. Arbabi asked the committee if the anticoagulation guideline indicating the head CT and the INR be done within first 30 minutes and reversal agent be given within the first two hours needed to be modified?

Dr. Cooper indicated that when there is lack of consistency in type of minor head injuries, a large number of patients with some type of injury, and 20 patients in the queue for some type of CT, it would be helpful operationally to have more specific guidelines for triaging and defining head injuries

Dr. Arbabi suggested that patients who need help are those with minor injuries that later get worse. These are the patients who come in, sit in a corner, and are talking and then one hour later you hear a code call for them. If this patient says they had a fall and are on anticoagulants, should you get a rapid head CT and an INR? That is the question here.

Dr. Tirschwell suggested that the dilemma is trying to predict the presence of an intracranial hemorrhage on patients who are anticoagulated. Do models and rules exist? Are there clinical criteria that predict the presence of an intracranial hemorrhage? It seems like there is data that might help with making these decisions. Look at the data on anticoagulated trauma patients where you are trying to predict the presence of an intracranial hemorrhage. Identify factors that are most important and come up with a scoring system that allows you to define a cut off. This would provide an evidence-based approach to find out if the patient needs to get a CT within 30 minutes. Once you have the hemorrhage identified, treatment within 30 minutes is appropriate.

Dr. Madeleine Geraghty suggested that because of the lack of clarity on goal two of the Trauma Clinical Guideline to change it to reduce time from imaging to reversal of anticoagulation.

Dr. Sam Mandell chaired the trauma guideline subcommittee and participated in the development of the Head Injury in Anticoagulated Patients guideline. In his response to Dr. Cooper he explained the

reason for taking anticoagulated head injury patients off the modified Trauma Team Activation guideline criteria was because there were so many patients being put through a rapid triage process that had an exceedingly low percentage of abnormal head CT findings with intracranial hemorrhage. He acknowledged the point of intervening on the person who is asystematic. However, they are not finding a lot of those patients. The criteria for predicting CT abnormality in minor head injuries could not be separated out with the rules in place for anticoagulated patients. There is an operational issue with CT scanning everybody.

Dr. Arbabi thanked the committee for the dynamic discussion and asked Dr. Mandell to continue working on this issue and coordinate with the Outcomes TAC as needed. Dr. Mandell plans to revisit this work in the future to allow more time for possible changes to be observed and to more clearly define the specific types of anticoagulants.

Regional Plan Changes: South Central Region: Zita Wiltgen, SC EMST Region

The South-Central Region EMS and Trauma Care Council recommended an amendment to the Walla Walla County Min/Max numbers for Trauma Verification Prehospital Services reflected in their 2017-2019 Regional Plan. The proposal is to increase the Amb – ALS maximum from two (2) to four (4). The local EMS County Council supported this recommendation based on their EMS call trend, response times, population growth and impact to public health.

Motion #4: Accept the proposed change to the South Central Min/Max numbers.
Unanimously approved.

Regional Plan Review: Dolly Fernandes, DOH

The EMS and Trauma Care Regional Plans are currently being updated and will be ready for review by the Steering Committee very soon. The final approval of the plans will take place at the May 15th Steering Committee meeting. Members of the steering committee are needed to review the plans. At the last meeting six members volunteered to review the plans. They are Scott Dorsey, Kim Droppert, Madeline Geraghty, Becki Hammons, Norma Pancake, and Mark Taylor. Ten more volunteers are needed to review the plans. Each plan needs to be reviewed by at least two steering committee members. Denice Haun-Taylor, Tony Escobar, Rhonda Holden, Eric Cooper, Joe Hoffman, Tim Hoover, and Peggy Currie all volunteered to help. The plans will be sent to the reviewers around the middle of March. The Steering Committee members will have three weeks to review the plans.

TAC Reports:

Injury and Violence Prevention TAC: Mark Freitas reported the TAC had 2 meetings and have done surveys and newsletters. They always have fun; and he encouraged participation.

Cost TAC: The TAC had a meeting on December 10, 2018.. They are in the process of developing a Trauma Care Fund spending plan for 2019-2021. The meeting was to identify additional information from the Cost TAC on modeling of the spending plan. The next meeting will be February 7.

Emergency Cardiac and Stroke TAC: At the last meeting they approved the updated stroke triage tool and getting ready to roll it out. They need a cardiologist on the TAC to help with cardiology issues. The ECS TAC now has co-chairs: Dr. Cameron Buck for the cardiac group and Dr. David Tirschwell for the stroke group of the TAC.

Pediatric TAC: Every TAC meeting includes going over their strategic plan. The TAC is doing an incredible job of keeping up with it. The TAC has noted a disturbing trend of pediatric suicide and are looking at the data with an epidemiologist to identify patterns, regions and so on. The TAC will look at the data at the next meeting. They are going to do a pediatric readiness data survey as was done in 2014. They will survey all the Washington acute care facilities and measure their preparedness and readiness to take care of kids. They are going to do the survey at the end of 2019 or early 2020. The TAC thought they were clever in recognizing that trauma centers are ready to take on any kind of acute patient, but we are hearing that trauma center designation does not equate to pediatric readiness. A recent report by the Associated Press has raised this issue. The TAC is going to start thinking about pediatric readiness and what can be done about it.

Rehab TAC: met the first time this year. They are planning for their live, full day meeting in May at Seattle Children's. They are also working on a marketing and media plan to promote rehab.

Medical Program Directors: will be having an annual meeting in June. The EMS and MPD rules are open, and there is a MPD workgroup that has been working on updating the MPD rules. Some MPDs participated in a recent webinar with National Highway Traffic Safety Administration regarding EMS scope of practice. The final document will be coming out later this spring. The MPDs are trying to figure out how to implement the Travis Alert legislation required education to our providers.

Prehospital TAC: will be meeting in February and on the agenda will be review of EMS rules. They are also reviewing the national body of work by NASEMSO on EMS Fatigue Guidelines.

Committee Business: Denise Haun-Taylor, Nomination Committee Chair**,** Dolly Fernandes, DOH

The steering committee chair election will take place at the April 24, 2019 meeting. Dr. Arbabi has served on the committee for nine years and his final term ends this year. He has chaired the steering committee for four years and will continue as the committee chair until September. Denise Haun-Taylor chairs the nominations committee and will lead the nominations for the next committee chair. Denise Haun-Taylor informed the committee that the Nominations Committee is made up of the TAC chairs. She will soon be in contact with the chairs with instructions. TAC chairs submit nominations for EMS and Trauma Care Steering Committee Chair to Denise. All Steering Committee may also

submit nominees, ideally through a TAC chair. Denise will check with all nominees on their willingness to serve as chair. All names of nominees interested and willing to serve as chair will be brought forward to the April steering committee meeting when the full committee will participate by open vote in the election of the chair. Nominees must be active members of the steering committee.

Meeting adjourned at 1:20 pm.