Trauma System Advisory Committee
3760 South Highland Drive Salt Lake City, UT 84106
5th Floor Board Room
Meeting Minutes
Monday, December 12, 2016

Committee Members:	Craig Cook MD, Mark Dalley, Mark Thompson, Holly Burke RN, Janet Cortez RN, Jason Larson MD, Rod McKinlay MD, Don VanBoerum MD, Grant Barraclough, Annie Relph RN, Chris Drucker
Excused:	Hilary Hewes MD, Matt Birch
Guests:	Clay Mann, Brittany Huff, Kelsie Olsen, Mike Rady, Jean Lundquist
Staff:	Jolene Whitney, Iona Tharen, Peter Taillac MD, Robert Jex, and Suzanne Barton
Presiding:	Craig Cook, MD

Agenda Topic	Discussion	Action
	Welcome	
Welcome and Introductions	Dr. Craig Cook welcomed our newest TSAC Committee member Annie Relph. Introductions made around the room	
	Action Items:	
Approval of Minutes	The September 12, 2016 Trauma System Advisory Committee meeting minutes were reviewed. It was brought to Suzanne's attention to add "or" before trauma patients on the first column on page 4 and on page 10 to change "V to 5" and change "incubated to intubated" and change "as to asked" also on page 10. All of these changes are in the first section on page 10. Also on page 10 it was noted to change "Jordan Valley to Jordan Valley West" in the 2nd section first paragraph. Suzanne will make the appropriate changes to the minutes. The minutes were reviewed further and voted on and approved by the committee.	**Janet Cortez motioned to approve the September 12, 2016 meeting minutes with the noted changes to be made by Suzanne Barton. Dr. Rod McKinlay seconded the motion. All present members voted in favor of the motion. No one opposed; none abstained. Motion carried.**
	Informational Items:	
Open Meetings Act Training – Brittany Huff	Brittany Huff went over the 2016 Legislative changes to the Open & Public Meetings Act. The only change made this year are the following: • "Specified body" does not mean: several things, now additionally it does not mean: (9)(c) (i) a conference committee, rules committee, or sifting committee of the Legislature. The Purpose: • To make sure these special legislative committees are not subject to the Open & Public Meetings requirements. Brittany refreshed the committee on the Open & Public Meetings Act (see attachment).	
R 4269-600 Trauma Center Designation – Bob Jex	At the last meeting we reviewed and discussed R4269-600 Trauma Designation rule change. We have taken it through all the hoops. It was held up in legal awhile for some English changes. The rule will be published for comment on December 15th. Bob will send out notification to all the trauma program managers, trauma medical directors and the hospital administrators because we would appreciate comments (positive or negative) on the rule. It is very helpful to have positive comments on the rule change. We have done all the ground work and have everything in line and Bob met with	

	the Hospital Association last week and got their buy-off as well. It will be posted for 30 days on the Bureau website. Email your comments to Bob. The change that was made is we adopted the ACS Needs Assessment for designation of future Level I and Level II new trauma centers where they had to meet certain criteria in order to be considered for designation. This has taken two years to do this. Craig presented it to the EMS Committee and it was rejected by one member of the committee. Craig would like to thank and congratulate everyone that was involved in this effort. Bob commented that it was collaborative and because of the push-back we were able to craft a better rule and we were able to meet and communicate with the people involved. It's a "win-win" all the way around. Peter commented that from a national level we are ahead of the curve for other states putting something in place to help better design the system in the future and best serve the customer's needs. Jolene said we there are 10 states that already have some legislation in place that helps them to limit the number of Level I and II trauma centers and we are the first state to utilize the American College of Surgeons criteria and integrate those in to the regulations.	
Trauma Center Applications – Bob Jex	There are 27 designated hospitals in the state. He is working actively with 4 additional hospitals; Riverton, Alta View, Jordan West Valley and Mountain Point who we anticipate will have designation visits in 2017. Riverton, Alta View and Mountain Point will be Level 4's and Jordan West Valley will be Level 3. If all goes well they will all be designated in 2017. We will have 12 designation visits in 2017. Dixie Regional is hosting an ACS visit in January on the 9th and 10th for them to be verified as a Level II. It will be great to have a Level II in St. George to take care of the Northern half of the state. Bob represents the Bureau for the Level I and Level II visits and we do require ACS verification for Level I and Level II facilities so we don't have to put together a site visit team but for the other visits we do. Designation is a 3 year process and it takes that long to get the PI up and running. Performance improvement is the stumbling block in designation. Within the performance improvement traditionally hospitals have not done a good job in solving problems and trauma forces them into it.	
Trauma Protocol Revisions – Peter Taillac	We have the State EMS Protocols Guidelines completed and they will be presented to the EMS Committee in January to be reviewed and approved and then they will go in to effect. There guidelines are not mandatory and agencies can decide if they want to adopt them or modify them. It provides a foundation for them to revise their protocols year after year. There are four sections: 1. Cardiac 2. Trauma 3. General 4. Medical The trauma section was done first and the TSAC committee got to review it at our last meeting in September and we need to vote on them. Peter commented that since the committee saw the guidelines, he has gone through them and did some formatting to make them look the same. There is one section that has not been approved yet and that is the burn management section. Peter is waiting for Dr. Morris and Annette Manderly to give me some feedback. The only	**The TSAC Committee members voted to support the State EMS Protocol Guidelines as presented. All present members voted in favor of the motion. No one opposed; none abstained.** **The State EMS Protocol Guidelines will be presented to the State EMS Advisory Committee on January 11, 2017 for their approval.**

	part that might change is the fluid recommendations for EMS. We want to simplify it for the average EMS burn transport. Annette likes the Parkland formula and Peter thinks it is way too complicated for EMS so they are trying to find a middle ground with it. Some of the highlights for the trauma section are backboards are de-emphasized not eliminated as far as the use. Ketamine is in the medical section and we will introduce Ketamine as an approved pre-hospital drug in the State of Utah. The State Protocol guidelines will limit use to agitated delirium for which it is extraordinarily good. When it is in the system if any single medical director wants to use it also for pain management that will be purview to do as the medical director or their agency. In smaller doses it is quite effective for pain. Ketamine is the best tool with these dangerous patients to keep our providers safe and also protect the patient medically. The TSAC committee voted to support the revisions made to the EMS State Protocol Guidelines so they can be presented to the EMS Advisory Committee in January.	
PI Update – Bob Jex	A handout draft of the PI Guidelines was handed out. The changes that were suggested in the last TSAC meeting have been done. There was a discussion on the audit filters. Your assignment was to take those and see if there were any additions that you needed approval for. The Trauma Program Managers did review all of those at their last meeting and they will be the ones that have the biggest stake in it. Janet commented on the following changes from the Trauma Program Managers: • On number 3, (page 15), they discussed 60 to 90 minutes and 90 minutes was the consensus. • On number 1 definitive care was defined as the final tertiary center to eliminate the patients that go to the VA or UNI and on number 6 take the word "less" out. Bob commented that on the draft the word less has a line through it so it will be removed. Peter commented that for the record, number 6 should be "less" not "greater", so that change will not be made. Kris Hansen from Primary's is going to make sure there is a report written on the registry to be standardized for hospitals so we can look at our own hospital's filters and utilize the filters which will be really helpful to us and they will be more real-time. As we move towards more real-time submission of the registry data it will be easier with the audit filters. Right now trauma centers are allowed a considerable period of time before they are required to have their registry data in. ACS requires that 80% of the registry records be submitted within 60 days and that is inconsistent with our rule. We are going to have to address that for a couple of reasons: 1. To bring it in to compliance with ACS 2. So the trauma centers can start using the data more real-time. Janet commented that the great thing with the data reporting is that the IICRC is using TABLEAU. Hopefully hospitals will have access to more real-time data which will be helpful.	**The TSAC Committee members voted to adopt the Performance Improvement guidelines and audit filters as outlined with the changes discussed. All present members voted in favor of the proposal. No one opposed; none abstained.** **The PI Guide will be published on the Bureau's website.**

	Holly asked if they could update the map with Jordan West Valley. Bob said they will get the map updated. TSAC committee members voted on the proposal to adopt the audit filters as outlined with the changes discussed. All members voted in favor of the proposal. Bob said they will publish the PI Guidelines on the Bureau website.	
Satellite ED Rule – Peter Taillac	We've been having a few conversations on the freestanding ED's and their impact on the trauma system as well as the larger EMS and ED emergency care system in the state. Two to three months ago the Licensing Bureau headed by Joel Hoffman published a rule that went through public comment phase with no comments were made and it is now in rule regarding freestanding ED's or other satellite operations with hospitals. No one noticed it at first, but recently in the last 2 to 3 weeks he has received several phone calls in regards to it and so has Joel Hoffman. The part that got the most attention was the very last line on the second page, #7 which says a licensed hospital is limited to one emergency department satellite location. Where that came from is our San Antonio, Texas experience where the freestanding ED's are unregulated and are popping up on many corners in affluent neighborhoods only where people have insurance and/or the ability to pay. They make a lot of money because after they have the infrastructure in place which is usually leased, they only need to see 10 patients a day to turn a profit. If they see more patients it is very lucrative. One of those Texas companies called Joel Hoffman about getting a license here in Utah. They also called one of the large ED groups to ask them if they wanted to partner on this and that large ED group was concerned and declined and said that wouldn't be good for our community even though they would make a lot of money doing it. He connected with Joel and Peter was used as a consultant the Licensing Department came up with a solution to limiting the amount of freestanding ED's in our state. Each hospital that is licensed in the state, not hospital system, is allowed to have 1 licensed freestanding ED distant from it to help with their capacity and provide service to their customers. But a company could not come in with a proposal to set up a "boutique hospital" that would have 5 inpatient beds that meet the letter of every law for being a hospital and then have an uncontrolled number of free standing ED's that they metastasize which would take the paying customer business from the hospitals who are taking "every comer" and providing a community service for a long time. This puts a control lever on the ability for an outside company to come and start taking the market away and raping the consumer in his opinion. The other part we discussed is the trauma criteria. We did a presentation at the last meeting about freestanding issues in general and the TSAC committee asked him to come up with some proposed guidelines for when EMS could bring a trauma patient to a free standing ED. The way this was worded is there is a national free standing ED organization now and they have their own criteria. He took their criteria that was related to trauma and reviewed them and made them ours. What is says is these patients that shouldn't be taken to a freestanding ED which is easier to find than the ones that should. These are just draft guidelines and he would like the	**The TSAC Committee members voted to adopt the Performance Improvement guidelines and approve the addition of number 6 and 7 as discussed. All present members voted in favor of the proposal. No one opposed; none abstained.**

committee's blessing on them. Jolene asked if we were going to develop them as part of our guidelines. Peter commented that would be a good idea and we could add them to our state guidelines in the trauma section next to the trauma field triage guidelines and make it a part of rule.

If you look at the field triage guidelines, there is box 1, box 2 and box 3. In box 1 these are patients that should be transported to trauma center:

Box 1

- Patients who have a Glasgow coma scale of less or equal to 13
- Systolic blood pressure of less or equal to 90 or the appropriate pediatric hypertension criteria
- Respiratory rate of less than 10 or greater than 29 breathes per minute or any need for ventilator support

Box 2

- Any patient with penetrating injuries to the head, neck, torso and extremities proximal to elbow or knee
- Chest wall instability or deformity
- Two or more proximal long-bone fractures
- Crushed, degloved, mangled or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fractures
- Paralysis

Steps 1 and 2 attempt to identify the most seriously injured patient. These patients should be transported preferentially to the highest level of care within the defined trauma system. We define that in Utah generally speaking as regionally what is the highest level of care within your area in your region. EMS knows this pretty well.

Step 3 is falls. Adults who fall greater than 20 feet, children who fall greater than 10 feet or high risk auto crashes which are defined as intrusion greater than 12 inches of the occupant site or 18 inches of any site, ejection from the automobile, death in the same passenger compartment or vehicle telemetry data consistent with a high risk of injury. This is the OnStar information that can identify based on the dynamics of the wreck if it's likely to have injuries. This information is really accurate and as more and more cars get OnStar we are going to use that potentially as some of the triage criteria.

Box 3

- Falls (adults and children)
- Ejection
- Death
- Vehicle Telemetry Data
- Auto versus pedestrian, bicyclist thrown, run over or with significant impact of 20 mph
- Motorcycle crash over 20 mph

Step 3 is falls. Adults who fall greater than 20 feet, children who fall greater than 10 feet or high risk auto crashes which are defined as

	intrusion greater than 12 inches of the occupant site or 18 inches of any site, ejection from the automobile, death in the same passenger compartment or vehicle telemetry data consistent with a high risk of injury. This is the OnStar information that can identify based on the dynamics of the wreck if it's likely to have injuries. This information is really accurate and as more and more cars get OnStar we are going to use that potentially as some of the triage criteria. In this system it is not the highest level trauma center and if the patient doesn't meet box 1, don't meet box 2 but do meet box 3 then they can go to any trauma center according to the CDC. In Utah we have adopted it as our criteria as well. Box 4 • Older adults • Children • Anticoagulation • Burns • Pregnancy over 20 weeks Box 4 is general guidelines ideally to go to a trauma center. It includes burns but it doesn't say how much of a burn. So a scald injury on a 2 year old with a blister on their arm can safely go to a freestanding ED. Peter cut it off at box 3. Bob commented that any of these in box 4 that exhibit physiologic conditions and meet 1, 2 and 3 then they wouldn't go to a trauma center. Don was concerned about the elderly fall with a GCS of 14 that may or may not be on Plavix and those patients can deteriorate rather quickly. Peter commented if an older person falls and has a laceration on their forehead and gets a CAT scan from the freestanding would not be able to go there and they would have to be transferred to a trauma center. An older person on Plavix that sprains their ankle that might be broken or not would not go to a freestanding. Peter commented that when you get to box 4 and they don't meet any of the criteria there are a lot of patients in that group, in his opinion, that can be safely screened and if they do have a bleed they could be transferred. Discussion about head bleed injury with a GCS of 15 or higher could be added to the criteria. Time is of the essence with head bleeds. Don commented that according to brain trauma guidelines, if you have a head bleed injury you go to the closest facility that can treat them. Peter commented that would be patients with a GCS of 14 or greater. Level I criteria is The goal of these criteria is to get the sickest patients that will require surgery to the trauma center and to avoid duplication of transfer. Craig commented that with the actual trauma center visits we have to have a specific line item that we have to look at the data of the information if that hospital is the mother ship for a free standing ED and see the data to make sure there isn't a large percentage of the trauma patients seen at that freestanding ED to see if 25% of them are being transferred. Bob commented that he thinks it would need to be part of their performance improvement. Bob will look at the ACS	

	criteria in regard to that. Peter said let's wordsmith head injury. Is it anticoagulation, age or both? Grant commented that they can still have a GCS that is higher and can be on Plavix especially with EMS time and if they are there quickly; Jason and Don agreed. GCS does not apply so age over anticoagulation with significant head trauma. Clay read the section that described the criteria. Peter commented that EMS does not have a problem right now with taking the patient to the correct facility. Rod M. made comments that they activate the trauma team if there is a patient on the way that is anticoagulant and has head trauma. He suggested the addition of a section b to box 3. Bob asked if Taylorsville has trauma guidelines in place and Rob said yes but they haven't had a lot of transfers from Taylorsville so they are not receiving those types of patients. Peter commented about incorporating all of box 4 that all old people over 55 years should not go to a freestanding by ambulance if you have hurt yourself. Peter will write in "patients with head injury that are 65 years or older or are on anticoagulation should not be taken to a freestanding ED". Janet asked about how busy ER's now and how often are they over capacity? Peter commented that is the Bureau of Licensing and we don't have anything to do with that. That rule is a done deal and we do not have any input in that. Craig asked if we can put something in the document for the hospitals as they undergo the process of trauma designation visits to ask how many free standing they have and how many transfers they have. Bob commented that it would be pretty easy to add that to the criteria that they have and use in their surveys as a memory jog but to make it a criteria it would require a rule change. They do ask to see their data and freestanding ED's should be part of their data. Peter will add to number 6 to include head injury patients that are 65 years or older or are on anticoagulation should not be taken to a freestanding ED. In box 4 for EMS provider judgement Peter will add 7 that EMS will decide what patients should be taken to a freestanding ED. TSAC Committee members voted to be in favor of adopting the guidelines as outlined and adding 6 and 7 as discussed. All members voted in favor of the guidelines and the additions.	
NASEM National Trauma Care System Report – Clay Mann	There was a project ran by the National Academy of Sciences that began in December 2015 and its purpose was to see if there was a way to merge the trauma system that is now present in the military with the civilian side. The military system is called the JTS (joint trauma system) and the idea was that all 5 arms of the military would come together and have a joint trauma system that was able to track a patient from the theater all the way through arrival back in the states for rehabilitation and including the VA. It was an expert panel that was brought together and they received testimony for about 1 ½ years and this document resulted from it.	

	There were some interesting recommendations that came out of it and most of them were political just trying to get these folks to speak together about these issues and potentially share data. Through the process it is harder for the branches of the military to share data than it is for states to share data. They have made no progress whatsoever with cross-sharing of data. The recommendation that would be most applicable for us would be recommendation 5 that there be a home for trauma care in the Federal Government in the Secretary of HHS. They indicated that there should be joint work done so that the American College of Surgeons and NEMSIS would be able to link their data together and that there would be efforts made to bring in a rehabilitation data in to this joint system. Clay said that the report is a "good read" and very forward thinking and whether anything comes out of it, we'll see. Jolene commented that there was already some legislation passed from the House and the Senate where funding to have the military teams function in some trauma 30 centers across the country. This will help the military surgeons keep up their trauma skills up between deployments. Janet will be attending the annual conference for the Trauma Association of American in May 2017 at Myrtle Beach, South Carolina and they will be discussing this topic. There are some civilian trauma centers in the country that have a trade of finances that they will pay a certain amount to these hospitals to allow these military surgeon to practice at their facility. There is an active military surgeon, Dr. Marty who is out of Portland that will be speaking at this conference about the pros and cons of this. This will be a very interesting topic. Janet will be attending this conference.	
2017 Meeting Schedule	March 13th , June 12th , September 11th , December 11th	
End of Meeting	Next Meeting: March 13, 2017	**Meeting Adjourned**