Rappahannock EMS Council
TRAUMA COMMITTEE MEETING MINUTES
September 9, 2010

Present: Chair: Lawrence Roberts-Mary Washington Trauma Center; Amy Cantwell-Aircare, Greg Fleck-Spotsy FREM, Kelly Keener- Aircare, Tina Skinner-REMS Council, Dale Simmons-Spotsylvania Regional Medical Center, Todd Van deBussche-Life Evac, Debbie McIntyre -Aircare, Melissa Hall-MWH Trauma, Shin Sato-Mary Washington Emergency Department/FEMA

Meeting Called to Order at 1510 at the Rappahannock EMS Council Regional Training Center

TOPIC	DISCUSSION	ACTION ITEMS
Introductions	Introductions were made to all members of the meeting	
State Trauma Triage Plan	Tina discussed the mandate for a regional trauma committee, referring to the "state trauma triage plan" handout. She also discussed the new updates to the state plan, including the new trauma PI program components. ▪ The Trauma PI committee will report to the Regional PI committee. ▪ The Trauma PI committee must meet quarterly, per State Trauma Triage Plan	December Agenda Item: review & discuss current Regional Trauma PI Plan
Inclusive Trauma System	Reviewed the purpose of the Trauma Committee. Dr. Roberts discussed the nationwide movement of "inclusive trauma systems" and the importance of involving everyone along the continuum of care. He discussed the goal of "regionalizing trauma care".	
Letter from REMS/MWH Trauma	The letter has been completed to send out to all EMS agencies. The letter includes information on the updated Regional Trauma Triage Plan. The group reviewed the letter during the meeting. The letter along with MWH trauma reference cards will be sent out via REMS. The Regional Trauma Triage Plan and Regional Trauma PI Plan are available on the REMS website. It was noted that the "closest appropriate trauma center" wording is deemed most appropriate by national (CDC), state, and regional recommendations.	

OMD Letter	Dr. Roberts completed & sent a letter to all regional OMD's. See attached letter.	Group to encourage their jurisdiction's OMD to participate.
Regional Trauma Triage Plan	The state trauma guidelines requires the regional trauma triage plans to be reviewed the 2nd quarter of each fiscal year.	December Agenda Item: Review Regional Trauma Triage Plan
Regional Trauma Patient Care Protocols	It was noted that the current regional patient care protocols do not incorporate the updated trauma triage plan. Amy & Greg made a recommendation to revise the current trauma patient care protocols to include the trauma triage plan. What are the patient care protocol changes we need to make to comply with the trauma triage plan? ▪ Currently, 5-6 trauma patient care protocols exist ▪ A calculated GCS is not included in the protocols, may be a cause of some patients not having a pre-hospital calculated RTS ▪ Field providers most often refer to their patient care protocols and most have them memorized ▪ OMD's are the owners of the patient care protocols ▪ The protocols are reviewed yearly by the regional protocol committee ▪ Dr. Garth is chair of the protocol committee	December Agenda Item: discuss protocol changes & recommendations before REMS Board meets on December 15th Greg to work on protocol updates to reflect the trauma triage plan and any other recommendations from group. Dr. Roberts to discuss with Dr. Garth.
EMD Subcommittee	Group discussed the purpose of the EMD Subcommittee. The goal is appropriate level of response & timeliness once a call is received and the appropriate activation of aeromedical. The level of EMD response varies between counties. Who doesn't have EMD and how do we help them get it or use it better? ▪ Must standardize approach ▪ 9 out of 10 jurisdictions have EMD—Westmoreland??	Nael Hasan, Mark Crnarich, Greg Fleck, and Amy Cantwell to work on EMD standardization. Recruit an EMD member to take part in subcommittee. Tina will have additional information, regarding Westmoreland at December meeting.

Process for Trauma QI	Is there a confidential process for case review for trauma care in REMS region? Many questions were brought up about: ▪ How is this information shared ▪ Reports ▪ Peer review reporting etc. ▪ Incorporation of non-trauma hospitals ▪ Institutional concerns regarding data sharing Representation from all aspects of trauma care-should an EMD representative be included? Group discussed ways to present PI issues in an educational manner. There are several ways to sanitize information. Group discussed the methods of reporting PI issues. What are the trauma PI indicators? It was noted that an OMD needs to have representation on Trauma PI Committee. Dr. Roberts suggested the Trauma PI Committee report to the Trauma Committee.	Tina will send a copy of the PI plan to each committee member. Amy and Todd will help with establishing trauma PI indicators. Dr. Roberts will speak with the OMD group.
LZ Safety	Discussed the need for a standardized presentation.	Brian Solada to send slides.
Misc.	Kevin Dillard was elected President of the REMS Council. He is currently working on committee appointments & letters will be mailed out soon. Communication of "need to know" information: ▪ Group can utilize the REMS list serve ▪ Flyers in EMS rooms at hospitals Dr. Roberts discussed MWHC's utilization of "cloud technology" in radiography.	
Meeting was adjourned at 1635		
Next Meeting **TBD**		

REMS TRAUMA COMMITTEE MEETING MINUTES
March 8, 2011

Present: Marianna Bedway – Mary Washington Hospital Admin, Greg Fleck-Spotsy FREM ,Melissa Hall- Mary Washington Hospital Trauma, Cindy Hearrell- Mary Washington Hospital Trauma, Carolyn Marsh- Rappahannock EMS, Kelly McDonough- Mary Washington Hospital ED, Lawrence Roberts- Mary Washington Hospital Trauma,Tina Skinner- Mary Washington Hospital ED , Brian Solada -Lifeevac

Meeting Called to Order at 1510

TOPIC	DISCUSSION	ACTION ITEMS
Introductions	Introductions where made to all members of the meeting	
Review of Minutes	Minutes were reviewed and approved as written.	
EMD Subcommittee	No report	Mark Cranich to provide updates and was unable to attend today's meeting
2011 EMS Symposium	Call for speakers is open and Tina indicated local speakers would be beneficial to program. If interested in speaking please contact Paul Sharpe at VA OEMS.	
REMS Protocol Subcommittee	No updates- still in process	Greg Fleck to F/U with Linda Harris on this process
REMS PI Report	Carolyn Marsh provided report. 1. Discussed shared concerns forms and process for review at REMS QI meeting. Any trauma concerns would be brought to this committee in the future. 2. Discussed QI Indicators and look at protocol based benchmarks. Dr Hasen and Cindy will work on indicators and provide to Carolyn and QI committee. Current indicators are too broad and a clearer definition of a trauma patient is needed when setting indicators. Look at more evidence based indicators and getting input from OMD and ED doctors. 3. Discussed agency compliance. Some agencies do 100% reviews. Requirement is 10% as some agencies do not have the resources to do 100%. 4. Discussed state trauma bridge. Lifeevac now using	REMS to take info to OMD committee and Dr Hasen to look at improving agency completion compliance.

	this. 5. Discussed need to make more evidenced based process and take education back to agencies as part of Trauma outreach. Process for OEMS requirements of submission of 2012 indicators reviewed per Carolyn. Utilize these as focused reviews and training initiatives. In addition agency does drill down of issues for skills drills. 6. Issue of reporting findings to OMDs and they are responsible for sharing the information with their agency quality and training officers. Process of loop closure is challenging. OMD to work with agencies to develop action plan and loop closure process. QI committee looks at protocols in establishing indicators. Currently very broad references and need to establish more specific streamlined parameters. The person reviewing the data can also acknowledge trends. 7. Discussed issue of State OEMS holding agencies accountable to the trauma triage plan and overall process improvement.	
Trauma Triage Plan	Melissa shared recent EMS outreach and the lack of awareness of new trauma triage plan. As part of the outreach the CDC plan was provided for attendees. Need to provide dissemination of plan to providers. Discussion regarding the fact that goes to administrators and not filtered down. Is on the REMS website. Discussed OMD responsibility in process.	1. REMS to place banner on web page 2. Trauma Services to include in EMS nights and outreach events 3. Include sign off sheet for protocol review that would include trauma triage plan.
Meeting was adjourned at 1620		

Next Meeting June 14th 3-5PM at REMS Office

2011 schedule: 9/13 and 12/13

REMS TRAUMA COMMITTEE MEETING MINUTES
June 14, 2011

Present: Jordan J Crovatin- OMD Culpeper – Committee Chairman, Carolyn Marsh- REMS, Cindy Hearrell- MWH Trauma, Greg Fleck- SF&R, Lawrence Roberts- MWH Trauma Services, Kelly McDonough- MWH ED, Melissa Hall- MWH Trauma Services, Steve Mitchell- PHI AirCare, Tina Skinner- MWH ED, Todd Van de Bussche- LifeEvac, Wayne Perry- REMS

Meeting Called to Order at 1507

TOPIC	DISCUSSION	ACTION ITEMS	RESPONSIBLE PARTY
Welcome/Introductions	Introductions where made to all members of the meeting.		Dr. Roberts, Cindy
Review/Approval of Minutes	March 8, 2011 meeting minutes approved at 1510. Tina motioned to approve the minutes and Greg seconded.		
MWH Trauma Center Update	Cindy discussed the recent updates at MWH to provide better services to our air medical crews. The updates include: ▪ Cabinet with cleaning supplies, gloves, biohazard trash can, etc on the 6th level near the Helipad ▪ Painted lines from helipad to elevators ▪ Access ramp from 1st floor elevators to ED The hospital is also looking to fix the holes on the path from the helipad to the elevators and the ED is looking at the process for providing lifting assistance and suction equipment on the helipad. Steve mentioned the crew utilized the cleaning cabinet on Saturday and felt it was very useful.		Cindy
REMS PI Report	Carolyn discussed the approved FY 2011 indicators. The new trauma indicators handout was also provided to the group. Carolyn also mentioned she was working with Dr. Hasan to establish benchmarks for each indicator. Carolyn discussed the 1st Qtr indicator, "Identify the number of multi-system trauma patients that are being transported to the closest appropriate trauma center". Total # of multi-trauma patients=247. Total # of patients transported to the closest appropriate trauma center=171. Total # of patients not transported to the closest appropriate trauma center=27. Total # of patients transferred to an air medical crew=49. She mentioned that the overall transfers to air medical crews have declined. Dr. Roberts questioned how many of the air medical	**Establish benchmarks for each QI indicator. Will be added to the upcoming QI reporting document.**	Carolyn, QI Committee

	transports went to the closest appropriate trauma center. Carolyn responded by stating REMS does not currently collect air medical data and referred to the individual air medical agencies for input. The air medical agencies will look into providing additional data to the committee. Dr. Roberts also questioned "why the 27 patients did not go to the closest appropriate trauma center". He requested that the data continue to be analyzed to find specifically why the patients did not go to an appropriate facility. Carolyn mentioned that the information was not currently available but it is possible to include it in future reports. Steve suggested to include in the data request to the agencies if protocol was not followed then provide REMS with additional details as to why. Carolyn and Wayne reviewed the current REMS data reporting process with the group. Dr. Roberts offered to write a letter to all OMDs to request the additional information in effort to further analyze the data.	**Air medical agencies to look into providing current data on trauma patients in the service region to the committee and report back at the next meeting.** **Further analyze the trauma patients whom did not go to the closest appropriate trauma center.** **Recommendation: In the next quarter, request EMS agencies to include why a protocol was not followed in the QI reports.** **Letter to all OMDs requesting additional data on the 27 patients whom did not go to the closest appropriate trauma center.**	Todd & Steve/Debbie Carolyn Dr. Roberts
New Business: Quality Improvement Initiatives - ETA process - RTS - Out-migration - Transfers In	ETA process: Cindy discussed the current data trends regarding ETA times. The average has been 4-6 minutes. Cindy asked, "How can we improve the 4-6 minute ETA timeline?" Dr. Crovatin suggested looking at "dead zones" regarding radio/cell use. Greg mentioned parts of Spotsylvania County have dead zones. He also mentioned most often crews are busy taking care of the patients and unable to give a report initially. Some may have dispatch call the trauma center to provide an initial notification of a crew arriving. Tina mentioned the "continuum of care" and how EMS reports are important to activating the appropriate resources at the hospital. Steve suggested condensing the amount of questions on the HEAR report. Tina mentioned that there is a team at MWH working to improve the current HEAR report. More to follow at next meeting. Wayne stated this was discussed at the protocol committee meeting and the regional protocols will reflect what the report consists of. Group recommends this to be a protocol directive along with more education. Dr. Roberts mentioned providers should assume the worst in all trauma patients until they can prove otherwise. Wayne suggested the same sense of urgency should be applied at all of	**Recommendation: HEAR report to become a protocol directive.**	Wayne

	the hospitals as well. Cindy discussed the trauma activation work group. There is a work group looking at the current trauma activation plan & collected data in order to make the appropriate changes to the revised activation plan. Dr. Roberts also discussed the over triage and under triage rates with the group. Out-migration: Dr. Roberts discussed out-migration and the importance of having a trauma center in our region to support the community. He mentioned the struggle with collecting data on the trauma patients who are transported to another facility. Dr. Roberts posed, "How do we best analyze the out-migration data?" Air medical agencies do report to the state bridge. Dr. Roberts mentioned the state data is retrospective and not helpful with this data collection request. Todd suggested the only reason they would possibly go elsewhere is due to weather or logistical issues, which would be hard to monitor. Dr. Roberts asked each air medical agency look at the hospital destination of the 49 patients who were transferred to an air medical crew. Transfers In: 3 most common referral hospitals: Stafford, FSED, and SRMC Cindy discussed 7 "transfers in" cases in May. Total transfers in 2011 thus far=12. Group concurred most of the 7 patients were appropriate transports to other facilities. Most of the patients transferred were geriatric and providers need to consider sending this population to a trauma center even if initially the patient was physiologically stable. The group referred to the current Trauma triage guidelines, "step 4 special populations". Providers must consider the possible consequences of sending a trauma patient to a non-trauma facility.	**Air medical agency to further examine the data regarding the 49 patients transferred to an air medical crew.**	Todd & Steve/Debbie
Roundtable Discussion	Wayne discussed the updated REMS surge plan and mentioned it will be available on the REMS website soon.		Group
Plans for future meetings, times, dates, etc.	Group discussed future meetings and felt the current meeting times and dates were appropriate.		No changes indicated.
Meeting was adjourned at 1625			
Next Meeting **September 13, 2011 3-5PM**			