Portland State Office Building
800 NE Oregon Street
Portland, OR 97232

State Trauma Advisory Board (STAB)
Friday, January 19, 2018
1:00 p.m. – 4:30 p.m.

Meeting Minutes

Chair	Richard Urbanski, MD
Vice Chair	
Members Present	Richard Urbanski, MD; Marcia Page, RN; Matthew Philbrick, FP-C; Bobbie O'Connell, RN; Justin Sales, MD; Peter Mackwell, EMT; Ameen Ramzy, MD
Members not Present	Michael Lepin, NREMT-P; Marty Schreiber, MD; William Long, MD
Guests Present	Heather Timmons, RN; Jackie DeSilva, RN; Daniel Van Hook, RN; Lynn Eastes, RN; Caroline Stephens; Myles Parilla, RN; Julie Sturman, RN; Carolann Vinzant, RN; Willy Foster, MD; Myles Parilla; RN; Roy Ball, RN; Karen Briggs, RN; Krista Reynolds, RN; Chrystine Hertel, RN; Roy Nelson
PHD Staff Present	Stella Rausch-Scott, EMT; Dana Selover, MD; Justin Hardwick, NREMT-P; David Lehrfeld, MD; Dagan Wright; Candace Toyama, NREMT-P; Nathan Jarrett; Mellony Bernal; Camillie Storm, RN; Renee Schneider
Members on the Phone	Theresa Brock, RN; Daniel Sheerin, MD; Abigail Finetti, RN; Travis Littman, MD; Dawn OpBroek, RN
Guests on the Phone	Davale Meade; Jeremy Buller, RN; Kalissa Mauch; Stacey Holmes, RN; Kelly Kapri; Debbie Smith, RN; Ethan Lodwig, RN
PHD Staff on the Phone	

Agenda Item	*Call to Order/Agenda – Dr. Richard Urbanski*
The meeting was called to order and roll call was taken.	

Agenda Item	*Case Presentation – Deputy Roy Nelson*
Deputy Roy Nelson presented a MCI that took place in Fossil, Oregon on May 27, 2017 that involved multiple critical patients, safety issues on the scene and limited resources with long responses and transport distance from the scene. Deputy Nelson reviewed the patient care provided and issues that arose during the call with lessons learned. These included:	

- A need to review the MCI dispatch protocols for the county and region.
- Providing first responders with equipment to light up a scene.
- Provide more tourniquets to law enforcement.
- Organize MCI training that is not table-top or during ideal conditions.

The committee expressed to Deputy Nelson that his military background and EMS training is what saved more lives that night and that he did an excellent job.

Agenda Item	*– Dr. Richard Urbanski*
October 2017 minutes were reviewed. Bobbie O'Connell motioned for the minutes to be approved and Peter Mackwell seconded the motion. The motion passed.	

Agenda Item	*Vice Chair Nomination – Dr. Richard Urbanski*
The Vice Chair for STAB is vacant; Roy Ball stepped down due to a change in his job. The floor was opened for nominations from the current STAB members for the VC position. Justin Sales nominated Bobbie O'Connell and Matthew Philbrick seconded the motion. Bobby O'Connell accepted the nomination. No other nominations were made. The committee approved Bobby O'Connell as Vice Chair for STAB until January 2020.	

Agenda Item	*Stop the Bleed – Candace Toyama*

The office has been developing a Stop the Bleed (STB) campaign that will help Oregon meet the national ACS goal for training the public. Each ATAB will receive a STB training bag that includes supplies for a trainer to teach the hands-on portion of the class.

The drafted work plan includes:

- Train Oregon Health Authority (OHA) and members of STAB.
- OHA to train and properly equip ATABs.
- ATABs to coordinate the training of EMS & Fire agencies locally.
- OHA staff to provide Stop the Bleed sessions at regional EMS conferences.
- EMS & Fire agencies conduct community Stop the Bleed training sessions.
- ATABs to monitor regional training activities and provide equipment to EMS & Fire agencies as needed.
- ATABs report training activity to STAB quarterly meeting.

The training bags will be housed at a chosen location by each ATAB group. ACS requested that each state track training progress by tracking the number of people trained.

Action Item	**Office:**

	Send out the Call to Action to the ATABs to discuss the next steps for training in their region.

Agenda Item	*EMS Director and Medical Director update – Dr. Dana Selover, Dr. David Lehrfeld and Candace Toyama*
Legislation started a short session; there are no bills submitted that effects EMS and the Trauma System now. The office 2017 year-end report is available. Projects for 2018 include, the preparation for EMR license renewal and annual Ambulance relicensing period. The Office of Rural Health (ORH) is working on a $15,000 grant that will be used to pay the CARES fee for 2018. CARES has been notified that the funds would be received in mid/late April 2018 The Stroke Care Committee is reviewing prehospital patient care and Oregon's ability to get the right patient, to the right hospital in the appropriate amount of time. The Mobile Integrate Health (MIH) coalition met and is continuing to support MIH programs in the state and measure the success of care through the collection of data. The office is reviewing the EMS exam process for opportunities to improve in-state testing. It was discussed at the October 2017 meeting that many Paramedic students travel out of state to take their test for NREMTP. A new Professional Standards presentation has been created that discusses the expectations of a EMS provider's behavior, how actions can impact a provider's license, and how criminal history can impact a EMS career. The presentation is approximately an hour with questions. The presentation will be packaged in video format and used for schools to present to their EMS classes. The EMS Licensing and Discipline Subcommittee has three open EMS provider positions and is seeking field providers to fill those seats. This will help ensure a fair disciplinary process for EMS providers. The Mobile Training Unit (MTU) created a 2018 training calendar based on needs identified by the program through surveys and data collection.	
Action Item	None

Agenda Item	*Trauma System Review – Camillie Storm*

The Trauma Hospital Survey reports were reviewed to identify results from two different survey cycles.

- Cycle 1: Survey 2010, 2013 and 2016.
  Unfortunately, most charts containing 2010 trauma reports are not yet available electronically; 2013 & 2016 surveys were used only.
- Cycle 2: Survey 2011, 2014 and 2017 are complete.

Common Exhibit 4 standard deficiencies and OARs 333-200-0265 & 0080 deficiencies from the year 2014 to 2017 included:

- Trauma Center Description and their roles in a trauma program.
- Hospital organization and the trauma program.
- Clinical functions – Emergency Medicine
- Clinical functions – General Surgery

- Performance Improvement and Patient Safety (PIPS)
  The number of deficiencies for PIPS has been the most common deficiency with 2011 – 13; 2014 – 26 and 2017 – 18.

Breakdown of criteria that was commonly missed:

- Performance Improvement and Patient Safety (PIPS):
  Rule example:
  - CD 16-1-1 Trauma centers must have a PIPS program that includes a comprehensive written plan.
  - CD 16-1-3 The processes of event identification and levels of review must result in the development of corrective action plans, and methods of monitoring, reevaluation and benchmarking must be present.
  - CD 16-2-1 Problem resolution, outcome improvements, and assurance of safety (loop closure) must be readily identifiable through methods of monitoring, reevaluation, benchmarking and documentation.
- Trauma Registry:
  Rule example:
  - CD 15-3 The trauma registry is essential to PIPS program and must be used to support the PIPS process.
  - CD 15-6 Trauma registries should be concurrent and entered within 60 days of discharge.
  - CD 15-7 The Trauma Registrar must attend or have previously attended 2 courses within 12 months of hire.
  - CD 15-9-1 Proportionate FTE dedicated to the registry.
- Clinical Functions – Emergency Medicine:
  Rule example:
  - CD 7-13-1 (Level I, II and III) and CD 7-13-2 (Level IV) Emergency physicians must have 16 hours of trauma-related CME/yr for Level I, II and III and 8 hours/yr for Level IV.
- Clinical Functions – General Surgery:
  - CD 6-10-1 (Level I, II & III) and CD 6-10-2 (Level IV) General surgeons must have 16 hours of trauma-related CME/year for level I, II and III and 8 hours/year for Level IV.
- Hospital Organization and the Trauma Program:
  - CD 5-13 Criteria for a graded activation must be clearly defined.
  - CD 5-23-2 A proportionate FTE Trauma Coordinator must be employed for trauma centers with < 250 patients per year.
- OAR 333-200-0265 Trauma System Hospital Responsibilities:
  - (5) Provide the resources, personnel, equipment and response required by these rules.
  - (9) Record resuscitation data using official trauma flow sheet. If using a form other than the official form, that form must contain at least the same information.

Get the team together and plan:

- Performance Improvement should not be tasked alone to the Trauma Coordinator, but instead should be a collaboration with the TMD and the rest of the multidisciplinary team.
- There is a direct correlation between consistent involvement of the TMD and TNC with the success of the trauma program.
- Strong need for the trauma program to have administrative support.
- Process and outcome measures (audit filters) must have defined criteria and metrics.
- Refer to pp 119-121 of the Orange Book for list of required PIPS Core Measures (e.g. mortality, TS response times, TTA criteria, etc.)
- Improving the value of care to the injured patient Value of care = Quality of process + Quality of outcome divided by Cost.
- *(American College of Surgeon (2014) Resources For Optimal Care Of The Injured Patient, 16, 117-118)*

Electronic patient care records (ePCR) are now the new normal charting preference for hospitals but creates issues for surveyors reviewing the flow of trauma patient care. It was discussed that the national requirements of patient care review need to adjust for trauma programs. The trauma programs use their hospital provided vendor for patient record. The state should consider the hospital trauma program administration's position when stating a deficiency because of the ePCR flow.

Some trauma programs have adapted the ePCR to attempt different types of PIPS but still find it difficult with the tools that are implemented by their hospital. The objective of the surveyor is to review a trauma flow chart and identify any potential needs for patient care. It was asked if it is useful to have the deficiency on the survey results? Will this help the trauma administrative staff have leverage to request improvement from the hospital?

The discussion about PIPS' review through ePCRs will eventually need to be reviewed at a national level as hospitals continue to use ePCRs and electronic health record programs.

Action Item	**Office:** Send presentation to committee and stakeholders.

Agenda Item	*Trauma patient hospital outcome data – Dagan Wright*

OR-EMSIS is providing trauma patient outcome data to approximately 50 agencies that are enrolled. Prehospital data training videos are available for users to learn how to retrieve hospital outcome data which can support QI/QA efforts for patient care.

It has been noted by several trauma programs that the data being input from the ePCR is not accurate. The Data team has been working with individual hospitals to understand where this

error is occurring. It was requested that if this error occurs contact the data team with screen shots.	
Action Item	**None**

Agenda Item	*Pediatric Trauma System – Dr. David Lehrfeld*

The office has been discussing whether there is a need for a state-wide pediatric trauma system. Oregon's Level 1 trauma centers have applied for a ACS Level 1 Pediatric Trauma Center verification. With this ACS verification, there has been interest in pediatric trauma and statewide standards. The OTR captures pediatric trauma care (ACS identifies pediatric patients as 15 years old and under) and the three common traumas for pediatric patients are falls, motor vehicle accidents and pedestrian struck by a motor vehicle.

When reviewing the data injury and transfer patterns the data identifies what types of services are available at the hospital.
Proposed pediatric trauma data to review includes:

- Where did they come from?
- When?
- Where were they transported to?

Tracking the progression of pediatric care through the hospital charting system, by date, will allow the data to show what services are available and the ED disposition will tell what type of resources are available. Tracking proposed is one way of identifying what pediatric systems are already established. Reviewing the data would identify if the state needs to create an established Pediatric Trauma System.
Other possible questions include:

- What changes should occur now vs. later?
- What impact should this have on Oregon's Level II Trauma hospitals for supporting patients?
- What impact will this have for Oregon's transfer patterns?
- Should this topic be a standing agenda item for STAB?

A suggestion was to include the disposition of the patient to understand the current patient outcomes.

It was agreed that a report should be run to understand what type of pediatric trauma care is already taking place in the state. The pediatric volume is low for some trauma hospitals and results in patients being transferred to a pediatric hospital due to a lack of available specialty care. This can add stress to the families. It is easy for hospitals to send patients to the pediatric centers directly instead of a higher level of trauma care that is not a L1 because the hospital is ready for pediatric patients. Non-Pediatric trauma hospitals may or may not be able to accept, which could delay the patient transfer.

It was requested to have this trauma data review be a priority and to keep this topic as a standing agenda item for STAB.	
Action Item	**Office:** Review preliminary data reports for pediatric care in Oregon. **Committee:** Send questions for pediatric data requests.

Agenda Item	*Subcommittee Updates & Standing Reports – Dr. Richard Urbanski*
EMS Committee – Ameen Ramzy The committee reviewed proposed rule revision for ambulance licensing. Deputy Nelson presented a case review that was presented also to STAB. *TNC/TM – Bobbie O'Connell* The group discussed EMS reporting and the trauma registry's prehospital data destination. The office presented to the group expectations from the survey team to the hospital during a trauma hospital survey. EMS for Children – Jackie DeSilva Oregon was chosen as 1 of the 16 states to be a part of Pediatric Readiness Collaborative. There are approximately 116 hospitals that will be reviewing data to create quality metrics and a train-the-trainer program that supports pediatric care in the patient's local community hospital avoiding referal to a higher level of care, if possible.	
Action Item	**None**

Agenda Item	*ATAB Updates – ATAB Representatives*
ATAB 1 – Is continuing the work of the ATAB plan. Discussed at the last meeting the role of the ATAB during a mass casualty incident. ATAB 2 – Case reviews were the main topic of discussion at the last meeting. The board is reviewing the proposed ATAB plan. ATAB 3 – Is creating a process for case reviews at future meetings. Continuing the work of improving communication around the ATAB for and various counties. ATAB 5 – Has a full membership, including both public at large positions. Discussing level 2 and 3 transport and patient disbursement for the region. ATAB 6 – The board continues to work on membership and is working on updating their ATAB plan. ATAB 7 – St. Charles Bend Trauma team has traveled to other hospitals in the region to discuss general patient care issues and conduct case reviews. St. Charles Redmond received a grant to purchase a bio-feedback mannequin for Stop the Bleed training.	

ATAB 9 – No update.	
Action Item	

Agenda Item	*Public Forum and Comment*
No public comment.	

The next State Trauma Advisory Board meeting will be April 13, 2018 1:00 p.m. to 4:30 p.m. at the Portland State Office Building.