Medical Committee
Meeting Minutes
September 15, 2008

Present	Representing
Chief Barry Cousino	Chairman – Springfield Twp. FD
Todd Brookens, D.O.	Toledo Hospital
David Miramontes, M.D.	Mercy Health Partners – TFD
Cheryl Herr, R.N.	Nurse Manager's Association

Staff

David Lindstrom, M.D.	Medical Director
Gary Orlow	EMS Manager
Brent Parquette	EMS QA/QI
Pat Moomey	Communications Manager

Other

EMS Chief Martin Fuller	Whitehouse Fire Dept.
Chief Daryl McNutt	Whitehouse Fire Dept.
Rob Martin	St. Vincent's Life Flight

Absent

Mary Beth Crawford, M.D.	St. Luke's Hospital
Kenneth Chelucci, M.D.	St. Anne Mercy Hospital
Pat Mattevi, M.D.	Bay Park Hospital
Lucas Delatore, M.D.	Flower Hospital
Kris Brickman, M.D.	UTMC Hospital
Rod Standiford (primary)	Paramedic Committee
Matt Homik (alternate)	Paramedic Committee

Call to Order

Chief Cousino called the meeting to order at 8:30 am.

Minute Approval

The minutes from the August 11, 2008 meeting were made available for review. With no corrections, the minutes were approved as printed.

Dr. Miramontes inquired into the status of the neurologist from UTMC making a presentation. Chief Cousino reported he has been contacted, but has been busy.

CE

Brent reported September's CE topic is Trauma. The paramedics are going over the Trauma Triage Protocol. (attached). Brent reported he has heard comments/confusion back from the hospitals through the paramedics. Brent went through the protocol with those in attendance. Dr. Lindstrom explained the changes made to comply with the State's changes in geriatrics.

Brent highlighted areas of the age breaks and physiological and anatomic conditions of each. He also talked about special considerations as well as appropriate destinations.

Brent reported hospitals will ask what level Trauma Alert the patient meets. Brent stated that it is not the paramedics call to make, they are given the TAGEM assessment and the hospital translates it into their own Trauma Alert classifications. There are 5 Trauma Verified Centers and their classifications are all unique. Brent reported geriatric patients who present with altered mental status due to an injury is hard to define and will be sent to a trauma center.

A discussion ensued regarding parameters of the hospital trauma levels and Level 3 Trauma centers.

ICE Protocol – Brent reported they are working towards criteria for outcome. Cheryl Herr asked if the paramedics are to take the last tympanic temperature at the hospital's Emergency Departments. Brent reported yes. Cheryl reported the patients are cooling fast with the fluids.

Protocols – Brent reported he is still in the process of revising the protocols.

Phillips – Brent reported he is still awaiting a representative from Phillips because there is a hard time establishing a blue tooth connection, it's still not functioning yet. The question was raised if a Phillips representative could attend the Nurse Manager's meeting being held October 10th. Brent reported he will contact the rep.

Internet component for EPCR – Brent reported it is his intent to present to the paramedics at December's CE how to transfer the EPCR from the tablet to a desktop computer. Brent reported it is not as user friendly and it is a matter of getting used to filling in the data different. Brent said he has identified areas the paramedics wont like, i.e., intervention areas and they will have to frequently put in the date because it doesn't populate automatically. The paramedics will be shown at CE and they will have to practice at their departments.

The question was raised if the report could be completely done on the desktop. Brent reported yes, but the EKG data still needs to be imported to the EPCR. Also the EKG data won't be able to be seen in the desktop, but can be seen as an attachment.

Brent reported the workflow piece would be available to make comments or notes in QA charts to send back to the paramedic. Dr. Lindstrom reported one of the QA flaws is when the chart is finished and downloaded at that point the chart is complete and subsequent changes are recorded as addendums. The question was raised regarding the hospital piece. Dr. Lindstrom reported when he does QA later on the charts, it could be weeks or months after transports and patients may have been discharged from the hospital. The workflow piece of closing out the chart and letting the respective people know has not been worked out. It would be the intent to let all parties know of changes to the document after the fact.

Dr. Miramontes reported at the hospital a disclaimer is placed on charts he dictates in that it's not a completed record and suggested something like this be placed on the patient report when the paramedics leave the patient and report at the hospital.

Old Business

ResQGARD – Dr. Lindstrom reported there is movement in reporting our experience with the ResQGARD. The data will be presented at the NAEMSP Scientific Conference.

New Business

Trial Research Program – Dr. Lindstrom reported Advanced Circulatory Systems, the company who created the ResQGARD, ResQPOD and ResQPUMP (CPR chest Plunger Device which delivers chest compressions) has asked LCEMS to participate in an NIH (National Institute of Health) study which compares survivability of regular CPR vs. active compression decompression (ACD) CPR + ResQPOD. The NIH has money to fund participation by LCEMS. Dr. Lindstrom reported currently there are six sites, which are Minneapolis, St. Paul, Osh Kosh, Troy/Royal Oaks, Ann Arbor and surroundings and Whatcom, WA. Dr. Lindstrom explained LCEMS has been invited to this study to provide more data. Dr. Lindstrom reported that they are pursuing this opportunity. Dr. Lindstrom explained there will be two groups in the CPR study. One week will compose of treatment therapy of standard CPR. Week two will be ACD, CPR, POD, PUMP. There is a difference in the POD pressure going from -10 to -16. There will also be a change in protocol. ACS report 80% cardiac output using new CPR, POD and PUMP.

The question was raised about the legal ramifications from this study. Dr. Lindstrom reported it's a controlled study and the IRB would verify that.

Dr. Lindstrom reported there will be a "train-the-trainer" session which would be a four hour session, but he is talking to the rep to see if it could be done in two hours. Dr. Lindstrom reported the representative wants us to start enrolling patients before March 1st, if pre-approved, enroll and bugs worked out, we could semi enroll patients in the study and could back us up to January. We are looking at doing this training as soon as possible by starting the training of the first responders in November and December. The company wants us to cover the whole county. Dr. Lindstrom reported Brent will be visiting their research site in Minnesota and to "pick" their brains on the process.

A very lengthy discussion ensued regarding the whys and wherefores.

800 Radios – Dr. Miramontes reported since going to the 800 system he thought the privates were going to be kept off. Pat Moomey explained the County does not have the funding to have extra dispatchers assigned to individual radio channels. Pat reported there is a permanent patch in the system all the time. You will hear all transmissions because currently there is a current patch between UHF Med 10 and 800 LC Med 1.

Dr. Miramontes questioned about the helicopters using the system for their LZ and staying off the main channels. Pat reported there are actually two channels specifically for the helicopters for the LZ in the system which is being worked on. The channels will be Air Med 1 and Air Med 2

Discussion ensued regarding it being a fire function and not a life squad's to coordinate the LZ and it will be forwarded to the chiefs for discussion the chief's meeting.

Next Meeting and Adjournment

The next Medical Committee meeting will be Monday, October 6th at 8:30 am. With no further business, the meeting was adjourned at 10:17 am.

TRAUMA TRIAGE PROTOCOL

Definitions (Ohio's legal definition of trauma):

A. "Trauma" or "traumatic injury" means severe damage to or destruction of tissue that satisfies both of the following conditions:

1. It creates a significant risk of any of the following:

a) Loss of life;
b) Loss of a limb;
c) Significant, permanent disfigurement;
d) Significant, permanent disability; and

2. It is caused by any of the following:

a) Blunt or penetrating injury;
b) Exposure to electromagnetic, chemical, or radioactive energy;
c) Drowning, suffocation, or strangulation;
d) A deficit or excess of heat.

B. "Evidence of poor perfusion" means physiologic indicators of hemorrhage or decreased cardiovascular function, which may include any of the following symptoms:

1. Weak, distal pulse;
2. Pallor;
3. Cyanosis;
4. Delayed capillary refill;
5. Tachycardia.

C. "Evidence of respiratory distress or failure" means physiologic indicators of decreased ventilatory function, which may include any of the following symptoms:

1. Stridor;
2. Grunting;
3. Retractions;
4. Cyanosis;
5. Hoarseness;
6. Difficulty speaking.

D. "Evidence of hemorrhagic shock" means physiologic indicators of blood loss that may include any of the following symptoms:

1. Delayed capillary refill;
2. Cool, pale, diaphoretic skin;
3. Decreased systolic blood pressure with narrowing pulse pressure;
4. Altered level of consciousness.

E. "Seatbelt sign" means abdominal or thoracic contusions and abrasions resulting from the use of a seatbelt during a motor vehicle collision.

F. "Signs or symptoms of spinal cord injury" means physiologic indicators that the spinal cord is damaged, including, but not limited to, paralysis, weakness, numbness, or tingling of one or more extremities.

G. "Evidence of neurovascular compromise" means physiologic indicators of injury to blood vessels or nerves including, but not limited to, pallor, loss of palpable pulses, paralysis, paraesthesia, or severe pain.

H. "Body region" means a portion of the trauma victim's body divided into the following areas:

1. Brain
2. Head, face and neck
3. Chest
4. Abdomen and pelvis
5. Extremities
6. Spine

I. "Evidence of traumatic brain injury (TBI)" means signs of external trauma and physiologic indicators that the brain has suffered an injury caused by external force including, but not limited to:

1. Decrease in level of consciousness from the victim's baseline
2. Unequal pupils
3. Blurred vision
4. Severe or persistent headache
5. Nausea or vomiting
6. Change in neurological status

Emergency medical service personnel shall use the criteria in this policy, consistent with their certification, to evaluate whether an injured person qualifies as an adult trauma victim, geriatric trauma victim, or pediatric trauma victim, in conjunction with the definition of trauma in section 4765.01 of the Revised Code.

A. An ***adult trauma victim*** is a person ***between the ages of 16 and 69 years of age*** inclusive exhibiting one or more of the following physiologic or anatomic conditions:

1. **Physiologic Conditions:**
    a. Glasgow coma scale ≤ 13;
    b. Loss of consciousness greater than 5 minutes;
    c. Deterioration in level of consciousness at the scene or during transport;
    d. Failure to localize to pain (GCS motor component ≤ 4);
    e. Respiratory rate < 10 or > 29;
    f. Requires endotracheal intubation;
    g. Requires relief of tension pneumothorax;
    h. Pulse > 120 in combination with evidence of hemorrhagic shock;
    i. Systolic BP < 90, or absent radial pulse with carotid pulse present;

2. **Anatomic Conditions:**
    a. Penetrating trauma to the head, neck, or torso;
    b. Significant penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;
    c. Injuries to the head, neck, or torso where the following physical findings are present:
        i. Visible crush injury;
        ii. Abdominal tenderness, distention, or seatbelt sign;
        iii. Pelvic fracture;
        iv. Flail chest;
    d. Injuries to the extremities where the following physical findings are present:
        i. Amputations proximal to the wrist or ankle;
        ii. Visible crush injury;
        iii. Fractures of two or more proximal long bones;
        iv. Evidence of neurovascular compromise;
    e. Signs or symptoms of spinal cord injury;
    f. Second or third degree burns > 10% total body surface area or other significant burns involving face, feet, hands, genitalia or airway.

B. A ***pediatric trauma victim*** is a person ***< 16 years of age*** exhibiting ***one or more*** of the following physiologic or anatomic conditions:

1. **Physiologic Conditions:**
    a. Glasgow coma scale ≤ 13;
    b. Loss of consciousness greater than 5 minutes;
    c. Deterioration in level of consciousness at the scene or during transport;
    d. Failure to localize pain (GCS motor component ≤ 4);
    e. Evidence of poor perfusion or evidence of respiratory distress or failure.

2. **Anatomic Conditions:**
    a. Penetrating trauma to the head, neck, or torso;
    b. Significant penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise;
    c. Injuries to the head, neck, or torso where the following physical findings are present:
        i. Visible crush injury;
        ii. Abdominal tenderness, distention, or seatbelt sign;
        iii. Pelvic fracture;
        iv. Flail chest;
    d. Injuries to the extremities where the following physical findings are present:
        i. Amputations proximal to the wrist or ankle;
        ii. Visible crush injury;
        iii. Fractures of two or more proximal long bones;
        iv. Evidence of neurovascular compromise.
    e. Signs or symptoms of spinal cord injury;
    f. Second or third degree burns > 10% total body surface area or significant burns involving face, feet, hands, genitalia or airway.

C. A ***geriatric trauma victim*** is a person ***≥ 70 years of age*** exhibiting ***one or more*** of the following causes of injury or physiologic or anatomic conditions:

1. **Physiologic Conditions:**
    a. Glasgow coma scale less ≤ 14 in a trauma patient with a known or suspected traumatic brain injury (TBI).
    b. Glasgow coma score ≤ 13;
    c. Loss of consciousness greater than 5 minutes;
    d. Deterioration in level of consciousness at the scene or during transport;
    e. Failure to localize pain (GCS motor component ≤ 4);
    f. Respiratory rate less < 10 or > 29;
    g. Requires endotracheal intubation;
    h. Requires relief of tension pneumothorax;
    i. Pulse > 120 in combination with evidence of hemorrhagic shock;
    j. Systolic blood pressure < 100, or absent radial pulse with carotid pulse present;

2. **Anatomic Conditions:**
    a. Penetrating trauma to the head, neck, or torso;
    b. Significant penetrating trauma to extremities proximal to the knee or elbow with evidence of neurovascular compromise:
    c. Injuries to the head, neck, or torso where the following physical findings are present:
        i. Visible crush injury;
        ii. Abdominal tenderness, distention, or seatbelt sign;
        iii. Pelvic fracture;
        iv. Flail chest;
    d. Injuries to the extremities where the following physical findings are present:
        i. Amputations proximal to the wrist or ankle;
        ii. Visible crush injury;
        iii. Fracture of one proximal long bone sustained as a result of a motor vehicle crash;
        iv. Fractures of two or more proximal long bones;
        v. Evidence of neurovascular compromise;
    e. Signs or symptoms of spinal cord injury;

f. Second degree or third degree burns > 10% total body surface area, or other significant burns involving the face, feet, hands, genitalia, or airway;
g. Injury sustained in two or more body regions.

3. **Cause of Injury**
   a. Pedestrian struck by a motor vehicle
   b. Fall from any height, including standing falls, with evidence of a traumatic brain injury.

4. Geriatric trauma patients should be given special considerations for evaluation at a trauma center if they have diabetes, cardiac disease, pulmonary disease (COPD), clotting disorder (including anticoagulants), immunosuppressive disorder or require dialysis.

D. Emergency medical service personnel shall also consider mechanism of injury and special considerations, as taught in the EMT-basic, EMT-Intermediate, or EMT-paramedic curriculum, when evaluating whether an injured person qualifies as a trauma victim. ***Mechanism of injury and special considerations are NOT stand alone indicators for determination of trauma protocol, but rather should be factored into the overall assessment.***

Appropriate Destination –

A. Emergency medical service personnel shall transport a trauma victim, as defined in section 4765.01 of the Revised Code and this chapter, directly to an adult or pediatric trauma center ***(Level I or Level II)*** that is qualified to provide appropriate adult or pediatric care, unless one or more of the following exceptions apply:

1. It is medically necessary to transport the victim to another hospital for initial assessment and stabilization before transfer to an adult or pediatric trauma center;

2. It is unsafe or medically inappropriate to transport the victim directly to an adult or pediatric trauma center due to adverse weather or ground conditions or excessive transport time;

3. Transporting the victim to an adult or pediatric trauma center would cause a shortage of local emergency medical service resources;

4. No appropriate adult or pediatric trauma center is able to receive and provide adult or pediatric trauma care to the trauma victim without undue delay;

5. Before transport of a patient begins, the patient requests to be taken to a particular hospital that is not a trauma center or, if the patient is less than eighteen years of age or is not able to communicate, such a request is made by an adult member of the patient's family or a legal representative of the patient.

6. Patients who meet pediatric trauma protocol shall be transported to the closest appropriate pediatric trauma center ***(Toledo and SVMC have been designated as pediatric trauma centers).***

7. Burn patients who meet trauma protocol criteria should be considered for transport to a designated burn center ***(SVMC has been designated as a specialized care facility for burn injuries).***

8. A pregnant trauma patient in the second or third trimester of pregnancy should be transported to a trauma center that also provides obstetrical services.
    a. ***Trauma in the second or third trimester (> 20 weeks) is not to be transported to UTMC because of a lack of neonatal and obstetrical services at that facility.***
    b. ***Third trimester trauma patients in cardiac arrest are to be taken to the closest hospital, including UTMC.***
    c. ***All pregnant trauma patients in the second or third trimester that do not meet adult trauma protocol criteria, but have suspected abdominal injuries, pain or vaginal bleeding/discharge should be taken to the closest acute care facility that can provide fetal monitoring (All Lucas County hospitals can provide fetal monitoring except UTMC).***

NOTE: At no time should interventions be started that would delay transport after the patient has been placed into the life squad for transport. Interventions necessary for airway control may be an exception.

Early ***On-Line Medical Control*** contact will help facilitate emergency department readiness and mobilization of critical assessment/treatment teams (Trauma Services).

Trauma Radio Report

A. Minimal Radio Report
   1. Contact with ***On-Line Medical Control*** is required.
   2. Four elements are required when reporting a "Trauma Protocol" patient. The acronym **TEAM** should be used:

      - **T** – Trauma Protocol (Paramedics must choose and declare one of the following categories to Lucas County EMS Dispatch and ***On-Line Medical Control***:
        - **Adult Trauma Protocol**
        - **Pediatric Trauma Protocol**
        - **Geriatric Trauma Protocol**
      - **E** – ETA
      - **A** – Age of patient (estimated if necessary).
      - **M** – Mechanism of Injury (Briefly describe the mechanism of injury and basis for declaring "Trauma Protocol."

B. Lucas County EMS Dispatch policy for Trauma Center med channel assignments:

   1. Paramedic field assessment that reveals a "Trauma Protocol" patient should be communicated to Lucas County EMS Dispatch with the appropriate patient qualifier (i.e., Adult Trauma Protocol, Pediatric Trauma Protocol, or Geriatric Trauma Protocol). Upon patient designation, Lucas County EMS Dispatch will assign, as medical control and transport, the closest available Trauma Center.