COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

OFFICE OF EMERGENCY MEDICAL SERVICES

IN RE: PREHOSPITAL CARE COMMITTEE MEETING

HEARD BEFORE: MIKE WATKINS

CHAIR, PREHOSPITAL CARE COMMITTEE

MAY 2, 2019

CONFERENCE CENTER

EMBASSY SUITES HOTEL

2925 EMERYWOOD PARKWAY

RICHMOND, VIRGINIA

1:00 P.M.

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APPEARANCES:

Mike Watkins, Presiding
Chair, Prehospital Care Committee

COMMITTEE MEMBERS:

Brad Taylor, Vice-Chair

Allen Yee, MD

Sid Bingley

Ed Brazle

Mike Garnett

Tim McKay

Wayne Perry

Kelley Rumsey

Mark Sikora

Sherry Stanley

Richard Szymczyk

VDH/OEMS STAFF:

Scott Winston
Assistant Director

George Lindbeck, MD

Tim Erskine

Cam Crittenden

ALSO PRESENT:

Mike Aboutanos, MD
TAG, EMS Advisory Board

ALSO PRESENT (con't.):

Greggory Wilhoite

Jason Ferguson

Jeff Michael

Pier Ferguson

Susan Union

Dreama Chandler

Mindy Carter

Valerie Quick

Matt Lawler

R. Jason Ferguson

A G E N D A

(The Prehospital Care Committee meeting commenced at 1:00 p.m. A quorum was present and the Committee's agenda commenced as follows:)

MR. WATKINS: Good afternoon. Just for everybody who attends, I have some instructions from Tim we need to read out loud. And then I would like for everyone -- make sure you sign in.

And we'll go around the room and just make introductions so we know everybody who's in the room. Okay? All the trauma system committee meetings are audio recorded.

These recordings are used for the meeting transcripts. Because of this, all participants must do the following. Number one, please speak clearly.

Two, if not called on by name by the Chair, identify themselves before speaking, and please speak one at a time. The enthusiasm for participation in the trauma system strategic process is both understandable and welcome, but following the above rules will assist in accurate

transcription. So please -- please follow that. So again, my name is Mike Watkins. I'm the Chair. I'm from Hanover County Fire and EMS.

DR. YEE: Allen Yee. Medical director for Chesterfield.

MR. MCKAY: Tim McKay representing Fire Chiefs and Chesterfield Fire and EMS.

MR. SIKORA: Mike Sikora representing ground EMS, County of Orange Fire and EMS.

MR. TAYLOR: Brad Taylor, vice-chair.

MS. RUMSEY: Kelley Rumsey, pediatric trauma program manager at VCU.

MR. WATKINS: Go ahead.

MR. GARNETT: Mike Garnett, Western Virginia EMS Council.

MR. BINGLEY: Sid Bingley, Carilion Clinic life guard representing EMS.

MR. SZYMCZYK: Richard Szymczyk. I run critical care transports, safety officer for Life Care Medical Transports.

MS. STANLEY: Sherry Stanley, trauma program manager at New River Valley Medical Center.

MR. BRAZLE: Ed Brazle, Virginia G-EMS.

DR. ABOUTANOS: Mike Aboutanos, TAG Committee.

MR. ERSKINE: Tim Erskine, faceless bureaucrat.

MR. WATKINS: Could I have the guests introduce themselves?

MS. CARTER: Mindy Carter, Virginia Hospital Center, trauma program manager.

MS. QUICK: Valerie Quick, GAB.

MR. LAWLER: Matt Lawler, Advisory Board representing Central Shenandoah EMS Council.

MR. J. FERGUSON: Jason Ferguson, Advisory Board.

MR. MICHAEL: Jeff Michael, Roanoke County.

MR. R. J. FERGUSON: Jason Ferguson, Advisory Board.

MR. WILHOITE: Greg Wilhoite, emergency medicine resident.

DR. LINDBECK: George Lindbeck from the Office of EMS.

MS. UNION: I'm Captain Susan Union. I'm trauma program manager at Naval Medical Center, Portsmouth.

MS. FERGUSON: Pier Ferguson, Advisory Board and Acute Care Committee.

MR. WINSTON: Scott Winston, Office of EMS.

MS. CRITTENDEN: Cam Crittenden, Office of EMS.

MS. CHANDLER: Dreama Chandler, Advisory Board.

MR. WATKINS: All right. Well, very good. Welcome to everybody. Approval of previous meeting minutes. We have a transcript. We don't have like abbreviated minutes?

MR. ERSKINE: We -- we have -- we have not had the opportunity. The administrative opportunity to put it in minutes form. So it's just a -- it's a transcript as the Board does it. Did I miss a step? Did that get sent to everybody?

MR. WATKINS: Yeah. It was about 100 --

MR. TAYLOR: With the agenda.

MR. WATKINS: Yes. 100 pages with the agenda. All right. Any questions on today's agenda? Any other items that we need to add it? I know we have a couple things that -- that I do need to add.

It's new business. From the Chair report, I actually am kind of glad to see Dr. Aboutanos here. He's from the Trauma Administrative Governance group. Attended that meeting last quarter.

One of the key things that was presented in that was the Stop the Bleed campaign. Kate Challis did a fantastic job of presenting the -- the program and successes that they've had with Stop the Bleed.

And that is something that is crossed over from both the Prehospital realm as well as the community and prevention side. And they've had a lot of -- lot of

process and -- and our EMS approving where we got 250 new instructors. And they're working to solidify the statewide Stop the Bleed Coalition.

So agencies and facilities that want to use that as an initiative, well, they've got a great template. Let's see. Have a whole lot else -- from the TAG -- from the TAG Committee.

Dr. Aboutanos, do you have anything you want to bring forward from that committee? I did also work through the Workforce Development.

One of our charges was recruitment under -- under the Prehospital Care Committee was recruitment and retention of EMS providers. Valerie Quick is now the chair of the Workforce Development Committee.

We had that meeting earlier this morning. And basically, we want to re-identify -- that's an ongoing and continuing issue for agencies of all sizes to both recruit and retain qualified EMS personnel, both the initial process for

training as well as the -- the ongoing. And obvious -- if we don't have the training for the Prehospital providers, the trauma care that they deliver is going to be potentially impaired.

So -- that's kind of all I -- all I have from a Chair report. We've got a couple things to talk about under new business.

Committee crossover report for the -- from those who attended their other committees. Anybody got anything from the crossover? Let me look at my list at whoever -- anybody? Do we have any crossovers?

COMMITTEE MEMBER: Acute care, but nothing to report.

MR. WATKINS: Okay.

COMMITTEE MEMBER: I wasn't to attend last month at all.

MR. WATKINS: Okay.

COMMITTEE MEMBER: I'll catch it tomorrow.

MR. WATKINS: All right. The System Improvement -- Sherry.

MS. STANLEY: Sherry Stanley, I went to that. Right now, it's kind of looking at what databases we have currently in Virginia, that what -- all of the data then how can we use that --

MR. WATKINS: Okay.

MS. STANLEY: As far as the trauma system improvement as a whole.

MR. WATKINS: Injury and Violence Prevention. That was Tim and Mike.

MR. MCKAY: We attended that, both of us were at the same time immediately following this meeting.

MR. WATKINS: Right.

MR. MCKAY: And the discussion in there centered on filling out the roster, largely. Kind of brainstorming for ideas in terms of getting -- who would make a good committee member. So --

MR. WATKINS: I think that covers most of the crossover committee reports. Hopefully as we get this process established, we'll have -- have more information to pass on.

I guess, to -- to add into the -- the Workforce Development. They are looking to try to send out some additional surveys and try to figure out other information.

So as we're looking at both System Improvement and other things, realize that we got -- some surveys that will be circulating out, trying to get more information about how those -- how we're facing some of the challenges. I know from a department standpoint, you know, my department's struggling to fill hiring rosters. I know other departments -- within

the same boat. And we got folks leaving. We had a guy who's leaving with 24 years. Not really eligible to try it quite yet.

He's going to go sell RV's, so lot of challenges retaining folks -- particularly your experienced folks. Next thing I got on the agenda is review of vacant committee positions.

Michael Laird was our law enforcement representative. He contacted me and stated that he was not able to fulfill his commitment to this committee.

So he asked us to select a law enforcement representative as well. So that kind of leaves us with three positions on this committee that need to be filled.

The law enforcement officer, the trauma survivor and citizen and then the non-trauma center. Has anybody had -- I know, Brad, you were reaching out to some trauma survivors from y'all's group.

MR. TAYLOR: We -- well, I was not. We were waiting -- there was -- there was supposed to be something from the State.

They were reaching out --

MR. ERSKINE: Yes. And so far, that has produced nothing.

MR. TAYLOR: Excellent.

MR. WATKINS: So I mean, all the other committees have that same citizen position. And we're just -- we're struggling to fill that. So I know we've got a couple -- couple potential leads out there.

Please let me know if you find somebody. And now we've got, you know, challenges to find a trauma survivor and a citizen, somebody who's truly outside of the system and operates outside of the system.

For a lot of us, I know is a -- is a significant challenge. So anything else on the trauma survivor citizen? All right. But also -- go ahead.

DR. YEE: So to maximize the utility of this committee --

MR. WATKINS: Mm-hmm.

DR. YEE: -- throughout the rest of the GAB, maybe we should just get a citizen, right? Just -- just so -- this way, it doesn't have to be a trauma survivor. This way, we can use it that -- their expertise could be used from stroke, STEMI or whatever.

MR. WATKINS: Right. And that's one of the things, I think, we talked about in the TAG was that we'll try to find a pool of -- of citizens, not necessarily call the survivors, who would be willing to crossover into several --

COMMITTEE MEMBER: She's on one of the other ones.

MR. WATKINS: I think that was -- that was brought up. I'm not sure the level.

DR. ABOUTANOS: And if I could add,

so Susan Watkins was going to be in charge of a group of trauma survivor -- or trauma citizens, basically, meaning more than trauma survivors.

And -- and having -- I think three or four people already talked to her. I'm not sure -- she was supposed to be talking to the Office. I'm not sure if she did --

MR. ERSKINE: I have never --

DR. ABOUTANOS: -- or not. And try to form a group that, you know, put different -- different citizen on different committees.

But they also, themselves, become a strong kind of group that works even with -- or voice for their station, etcetera, from all these aspects.

So -- and she was supposed to go off a web site and all that stuff. That was kind of couple discussions we've had. Cam, is anything that --

MS. CRITTENDEN: She's not reached out to me, no.

DR. ABOUTANOS: Okay. I'll reach out to her.

MR. WATKINS: Okay. So like I said, every -- every committee has that same challenge. So hopefully, you know, we'll benefit from what you said.

Finding somebody who has an interest in it, but is not necessarily an active participant that can -- that can fill in. Or a group of two or three of them that would be willing to cover some of these committees.

Next thing was the non-trauma center. Reaching out to some of the either designated non -- you know, designated hospitals that were not within a -- non-designated hospitals that are not trauma centers, nor affiliated with trauma centers. I think we kind of identified --

MR. ERSKINE: Yeah. I -- I've been

working on that. And for this group, I was given the name of somebody from a non-trauma center. But he was in charge of like security, non-clinical. And so that's not really what we're looking for.

We want somebody who is in the emergency department or is in the ED's hierarchy to understand the interactions between non-trauma centers and the trauma system. And EMS and the non-trauma center, so we're -- we're still working on that.

MR. WATKINS: Which hospital was that? Had sent -- gave you some feedback.

MR. ERSKINE: Oh, actually that came from VHHA.

MR. WATKINS: Okay. I know we talked about Bath County, Wythe County, Dickenson --

MR. ERSKINE: Yeah. I never got anything back from Bath County. I've not -- and that's when VHHA stepped in. So I

haven't reached out to the other two.

MR. WATKINS: Okay.

COMMITTEE MEMBER: What about the Augusta Medical Center? They're not a trauma center. They're independent, right?

COMMITTEE MEMBER: Yeah. But we had this conversation. Augusta's pretty high functioning --

COMMITTEE MEMBER: Okay.

COMMITTEE MEMBER: Like when you -- they -- they know how to run a trauma. They're just not a trauma center. I think the one we talked about -- the ones that were kind of in the weeds with trauma like that than with -- where they're kind of scrambling. But when you go into Augusta with a trauma, they're on it. They have a system.

MR. WATKINS: And I think we were

looking for some of the ones that were truly -- truly remote that had the -- you know, I think the federal designation is outside of it now. When we -- we looked specifically at southwest Virginia.

But I know like some of the -- I don't think there's really any hospitals on the east side that really fit that description. So...

DR. ABOUTANOS: Are we asking for a provider or anybody from there?

MR. WATKINS: A representative of the non-trauma center. So I would say either an administrator or nurse manager.

COMMITTEE MEMBER: So I have a suggestion of a person from Culpeper Hospital.

MR. WATKINS: Okay.

DR. YEE: Would you like me to reach out to them? Her name is Ann Boyer.

She's the ED director.

MR. WATKINS: Okay. Are they affiliated with --

DR. YEE: I worked with her years before.

MR. WATKINS: Are they affiliated with any of the other hospital systems or are they completely non-affiliated?

DR. YEE: They're affiliated -- UVa has something to do with Culpeper. But I don't -- I don't really know what that involvement is.

DR. ABOUTANOS: There's also -- Tappahannock is also another one. The non-designated from the --

MR. WATKINS: I mean, that was the challenge we found was is that you also found a connection between a lot of the larger hospital centers which had trauma

centers with the smaller facilities like -- Tappahannock -- Rappahannock General --

DR. YEE: I mean, UVa's relationship to Culpeper is nothing like a Chippenham/Johnston Willis relationship.

MR. WATKINS: Right.

DR. YEE: Right? I mean, they're -- they're a community hospital. They are -- they are not --

MR. ERSKINE: That sounds -- that's what we're looking for really.

MR. WATKINS: I think that -- I mean, at this point in order to get somebody from non-trauma, I think that'd be appropriate.

DR. YEE: Her name is Ann Boyer.

MR. WATKINS: Do you have contact, Tim?

MR. ERSKINE: If --

DR. YEE: I can give you --

MR. ERSKINE: Point her in my direction or point me in her direction.

DR. YEE: Okay. After the meeting, I'll be happy to do that.

MR. WATKINS: Okay. All right, so making headway on that. So law enforcement. Michael Laird with the Arlington Police Department had a[n] assignment change. So he's -- he said he's no longer available to -- to participate.

So we need to kind of figure out or call down some law enforcement representatives who are involved in EMS, or have some connection to it. So any ideas on a starting point? Is --

COMMITTEE MEMBER: Why don't we just go back to Arlington and say, hey, who got your -- who's got your position? And

that position belongs to Arlington. I mean, it'd be easier to swap because he's swapping the same information.

MR. WATKINS: I can reach back out to him. The impression I got from him was that it'd probably be difficult. But I'll reach back to him and contact. Is -- is -- have your Sheriff's Office still providing EMS and ALS?

COMMITTEE MEMBER: No.

MR. WATKINS: They're no longer doing that? Okay.

COMMITTEE MEMBER: Would private security count as law enforcement?

MR. WATKINS: I probably would stick to -- I would stick to a -- a governmental law enforcement agency.

COMMITTEE MEMBER: Okay.

MS. CRITTENDEN: Do you want us to look in addition and see what law enforcement agencies have their EMS license? I mean, if that's what we're looking for that actually might have a --

MR. WATKINS: I mean, that would probably be a good useful starting point. I think the State Police has a lot of those.

MS. CRITTENDEN: They do. There's a ton -- there's a ton of agencies that are doing some of that. Not a ton -- there's a -- there's more than a handful doing that. I can't -- top of my head.

MR. WATKINS: Okay.

MS. CRITTENDEN: But I come across them a lot. So maybe we can do that since --

MR. WATKINS: Yeah.

MS. CRITTENDEN: -- we're already.

MR. WATKINS: You can reach back out to them. And I guess Tim can -- well, one of us will reach out -- reach out and see if we can find somebody who'd be interested in it.

COMMITTEE MEMBER: I -- I can reach to Blacksburg and Montgomery County. We do -- locally, our squads do a lot of combined training with them.

MR. WATKINS: And I think that's kind of the -- the folks we want are some of the -- the law enforcement agencies that are active involved -- actively involved in EMS.

Not necessarily providing the care, but integrating with that training. I think that --

COMMITTEE MEMBER: Does a law enforcement agency have a large enough stake to travel from Blacksburg all the way to -- to Richmond to come to a meeting? I'm just wondering if -- if we -- like I wonder if Arlington just said this really isn't worth

our time. Right?

MR. WATKINS: It could be. Yeah, I --

COMMITTEE MEMBER: Should we think maybe something a little more local would be --

MR. WATKINS: Who do we have local?

COMMITTEE MEMBER: We have plenty of locals.

COMMITTEE MEMBER: But I mean -- there probably is -- going local is a few of us already from the Central Virginia region. And you know, Metro Richmond region. It'd be nice to go -- reach out to another region. Maybe, you know, where Ed is.

COMMITTEE MEMBER: You know, try to think of --

MR. WATKINS: I mean, I can reach

back to Arlington as where -- as well and see if somebody's taken over that project. But some of -- some of that is driven by an individual who has a project. And they may -- may or may not maintain it.

COMMITTEE MEMBER: The advantage of the State Police is that you may get someone who's currently assigned to Metro Richmond. So it's easier for them to attend. Yet their perspective is one that's a little more global in terms of --

DR. ABOUTANOS: It's a good point.

COMMITTEE MEMBER: And they could very easily have been volunteering. A rescue squad in Giles County before they got hired by the Stan Lees'.

COMMITTEE MEMBER: You may -- may reach out to Aaron Barrett. It's Aaron Lyle now from the State Police. He's a sergeant.

COMMITTEE MEMBER: I think he

volunteered at Ashland at one point.

COMMITTEE MEMBER: Yes.

COMMITTEE MEMBER: Long time ago.

COMMITTEE MEMBER: Yes.

MR. WATKINS: Okay.

DR. ABOUTANOS: And the higher the function, the better. The higher the position, the better. If you think about what we try to do with the trauma system.

And somebody who can truly be a liaison, can bridge. Not only can give the perspective, but can also act on behalf of the committee.

This -- I think that's the thought -- that's really the thought process when it comes to picking these -- these positions. That's why I adopt the State that's kind of -- about the same line of thinking.

MR. WATKINS: Okay.

COMMITTEE MEMBER: Yeah.

MR. WATKINS: You got a contact for him?

COMMITTEE MEMBER: Yeah.

MR. WATKINS: All right. So making some progress there.

COMMITTEE MEMBER: And on the trauma survivor/citizen, are we just holding on for you and Tim to -- to do that? Or do you want me to turn to my trauma department and trauma survivors and see --

MR. WATKINS: Yeah, I --

COMMITTEE MEMBER: -- if we can come up with some names?

MR. WATKINS: I would say we could try some names.

COMMITTEE MEMBER: I'll do just that.

DR. ABOUTANOS: The other part is that couple of -- couple of the hospitals -- the trauma centers have trauma survivor network.

COMMITTEE MEMBER: We do.

DR. ABOUTANOS: So just reaching out and getting all of this stuff done.

MR. WATKINS: We want somebody who -- who's going to be willing to attend the meetings, I think. And the --

COMMITTEE MEMBER: The tired loved one [unintelligible].

DR. ABOUTANOS: You may want to also reach out to the Injury and Violence Prevention chair because a trauma survivor network is part of their -- what they're working with. So they will have a list as

well. It would be nice to fit with both committees. Who's their liaison for Injury and Violence?

MR. ERSKINE: Actually, no liaisons come here.

DR. ABOUTANOS: I see. Okay.

MR. WATKINS: Tim, Mike could attend that meeting.

DR. ABOUTANOS: Yeah.

MR. WATKINS: Which is at -- right after this one.

DR. YEE: Yeah, what's that? Violence and --

MR. WATKINS: Injury and Violence Prevention.

COMMITTEE MEMBER: Yeah.

DR. ABOUTANOS: This -- that's what I would mention.

MR. WATKINS: See if we can get a trauma survivor from -- through that group.

COMMITTEE MEMBER: Yeah.

DR. ABOUTANOS: Even -- like Karen is the chair of the committee. She's also the head of the VCU trauma survivor network. So she'll have contact and there's also the -- Inova also have the trauma survivor network.

DR. YEE: So we limit ourselves to trauma focus, then we lose the -- you know, multi-purpose of this committee. I mean, other parts of the GAB can use this committee.

Right? So I mean, I was going to suggest -- and I know -- I'm not sure who Chief Watkins feels about it. The lady with -- who's a [unintelligible] of glucagon in the area. You're talking about a highly

engaged citizen.

DR. ABOUTANOS: I think that the difference is this. So the difference, especially with this committee -- which is a very important committee, is the fact that the -- the EMS Advisory Board has significant amount of prehospital. Right?

So there is so -- it's all -- mostly prehospital, right, in EMS. So what makes this committee unique is that this is under the trauma system.

So it's a little bit different from what -- from what you said, Allen, because this is really the -- okay, how much does trauma represent in a system --

COMMITTEE MEMBER: Okay.

DR. ABOUTANOS: -- in a system aspect.

COMMITTEE MEMBER: I -- I get it. I can see that.

DR. ABOUTANOS: That's the only point of it.

MR. WATKINS: And I think we -- we can get a citizen who, if -- if not a trauma survivor, somebody who's had some -- at least exposure to the trauma system.

Either through family or through other connect -- other connectivity that kind of was like -- had -- would -- would be engaged in. All right.

So you guys talk -- I guess, when y'all go to that meeting, talk to them about that. I put on here EMS for Children update. Anybody have any updates from that?

COMMITTEE MEMBER: I attended the last meeting. I don't remember any major updates -- Dave's not here, is he? Oh, the biggest thing that we were trying to encourage was for each regional nomination for the EMS for Children award. Some of those deadlines have already passed, but to encourage nominations for the upcoming regional awards so that they can be

escalated to the State.

MR. WATKINS: Okay.

MS. CRITTENDEN: EMS for Children has asked -- this is Cam. EMS for Children has asked to move their meeting to be more in align with the Advisory Board meetings. Because they feel like kind of --

COMMITTEE MEMBER: Oh, good. One more meeting.

MS. CRITTENDEN: -- about some stuff.

COMMITTEE MEMBER: Yeah. We'll leave that to Tim to get it rescheduled.

MS. CRITTENDEN: Yeah. We worked it out.

COMMITTEE MEMBER: Yes.

MS. CRITTENDEN: It's good.

MR. WATKINS: And Kelley, you're okay with meeting at 11:00 o'clock tonight, right?

COMMITTEE MEMBER: So yeah, that will -- so that having them closer to the meeting of those -- those stakeholders there, too.

MR. WATKINS: All right. That covers most of the report items that -- we have a public comment period. So I invite any of the folks from the -- the guests to please come forward with a comment. No comments. All right.

COMMITTEE MEMBER: We're swift.

MR. WATKINS: Yes, we are moving swift. Any unfinished business? Anybody was aware of.

COMMITTEE MEMBER: You're supposed to [inaudible].

COMMITTEE MEMBER: Can I ask a question?

MR. WATKINS: Sure.

COMMITTEE MEMBER: So where are we with our progress toward the goals? Is that something that should be recurring item on the agenda?

MR. WATKINS: Some of that --

COMMITTEE MEMBER: Isn't that a part of our agenda?

MR. WATKINS: -- was what Allen was going to talk about with -- on scope of practice.

COMMITTEE MEMBER: Okay.

MR. WATKINS: I was going to bring that up under new business.

COMMITTEE MEMBER: Oh, it's new

business. Okay.

MR. WATKINS: Unless there's one that's more appropriate than that. Some of the stuff that was in our goals and objectives got turfed to other committees as well. So -- all right. So no unfinished business. New business.

Kind of going through the goals and objectives that we have. The statewide treatment protocols for adult, pediatric and geriatric patients -- trauma patients.

That's really something that's in our purview, but at the same time, some of that goes back to Medical Direction. Do you have any items on that?

DR. YEE: I think the way -- the previous version of this committee, wanted to see it as what are the elements within the protocol that are needed? We don't -- you know, the -- you know, obviously, regional medical directors don't feel the need for a statewide protocol. And then we

have regional protocols. You know, just tell us what -- what should be in the regional protocols that we will insure, through Medical Direction, that they are in -- they're in each of our protocols.

Pain -- you know, it's going to be pain management. You know, hemorrhage control. It's really key stuff. It's already there, but it's the nuances that we may be missing. Just give us the key elements and we'll make sure that -- we'll just shoot it to all 11 councils.

And then we'll embed it -- we'll embed those elements within those protocols. Because each of us have different formats.

MR. WATKINS: Right. So that pretty much removes that from -- from future consideration. I mean, unless anybody else --

DR. YEE: Sort of. But if there are elements that, through the trauma side of the of EJB, it says we want to include --

for example, let's say we want to include TXA. I'm not saying that's what trauma wants, but we use that as an example. Then we can take it to Medical Direction.

Medical Direction will say, you know, TXA to everybody. But as new modalities come up through the trauma side, do they need to go into regional protocols.

Do we use this mechanism to go there. So this probably needs to be a standing agenda item --

MR. WATKINS: Okay.

DR. YEE: -- so we can have good crossover.

DR. ABOUTANOS: Yeah. I think this is a very critical item. TXA is a perfect example.

MR. WATKINS: Okay.

DR. ABOUTANOS: So where you have -- so you have a -- the prehospital

community, we think, with which -- at least for trauma. So this committee would -- is representing now, is saying okay, TXA. Let's look at it, see how we could use it.

Everybody try to get -- and you and I have been talk about this forever. And -- but then the Acute Care Committee is dealing with that, where they have a different perspective.

As a system, you got to come up with one solution. What you don't want is bunch of TXA protocols moving forward. Then get to the hospitals and the hospitals just take them off and throw them away.

Then use of that system is not communicating, you know. And so I think that's -- those are the issues that will be thought up here and brought up to the TAG.

Because that's when both committees will talk, also, and just say, hey. What happened to Prehospital protocol that influence -- that depend on hospital protocols. How do we cross that?

DR. YEE: So for today we're want

-- is there any particular issues that we need to bring forward that you're aware of. You know, we're still determining TXA is a big controversial --

DR. ABOUTANOS: Yeah.

DR. YEE: -- item.

COMMITTEE MEMBER: Use that as an example.

MR. WATKINS: I mean, it could be something as simple as -- as needle decompression, feel by skill.

DR. LINDBECK: Oh, no. That's been answered no.

COMMITTEE MEMBER: Speak clear and name yourself. George Lindbeck.

DR. LINDBECK: Man, I was wondering when that was going to happen. I think Medical Direction did address that a few

meetings ago, if I recall. And we deemed that to be an ALS skill -- if I recall correctly.

DR. ABOUTANOS: What is that again? The which one --

DR. LINDBECK: Needle decompression at the BLS level.

DR. ABOUTANOS: Okay.

MR. WATKINS: And again, there is a little bit of discrepancy with what's going to be done like from our law enforcement counterparts or military counterparts with what somebody does.

COMMITTEE MEMBER: Yeah.

MR. WATKINS: Okay. All right. So that's goal number one. Goal number two, establish a minimum statewide destination guideline standards for each step of the trauma triage criteria for both adult and

pediatric population. I heard NHTSA was taking that on. Trying to focus with communication and early access. Where are our disparities in the application of field triage based on geography.

We already kind of identified that last time. The rural areas clearly have a greater challenge. You know, and in the next piece of that -- not only in rural, but also what about traffic areas.

High traffic, summer time trying to get to Virginia Beach or out of Virginia Beach. Across two bridge tunnels is a real challenge as far as trauma center access.

And then you just have plain being landlocked in Northern Virginia or other places. So any other thoughts on that?

COMMITTEE MEMBER: So are we waiting for something to come out from NHTSA before we make or take any further --

MR. WATKINS: That was your comment

from last time.

COMMITTEE MEMBER: Anything that goes to NHTSA may take considerable amount of time to come out of. I know that they did take this up as they wanted to take it over from the CDC. You know, I have not talked to Dr. Cramer [sp] in a couple months.

But in the meantime, we could take a look at what we already have existing and making sure -- looking at the disparities just based on what we currently have. Which I would -- let's not -- we have some disparities.

MR. WATKINS: And some of it is in here. You got geographic and you have financial disparities, you know, people being able to -- not only get access to the care, but also get the rehab and other parts of the trauma system that are necessary.

DR. YEE: And I think we need a true understanding of what the CDC

guidelines they wrote were. It sets the highest level of trauma in your system. That it -- so how do you define your system? Is it the regional council, is it the EMS agency, or is it the state? Right?

I mean, my understanding of this when they created this -- when they talk about the EMS system, they're really looking at the -- the lower common -- lower denominators. It was agency level.

COMMITTEE MEMBER: Right.

DR. YEE: So you know, if my system -- Chesterfield County -- is -- is part of the system I'm close to. There are a couple Level II trauma centers, a Level II trauma center, a Level I trauma center.

I'm going to choose all of those. But if I was out in the North Carolina/Virginia border, I may not have the opportunity to go to a Level I center. I would have -- my system may say, it'd be a Level III. So this is -- we need some -- we have to look at that, what the expectations

are. The big Virginia system versus the local system.

MR. WATKINS: And what about developing that -- enhancing that training at the community hospital and rural agency level?

DR. YEE: Or -- I would suggest enhance the mechanisms to quickly transport a patient to the highest level of care. So maybe encouraging EMS to say, it's okay to leave your area.

Maybe change the dynamics within the system, as well as work with the hospital so you can move it. But --

COMMITTEE MEMBER: So one thing to consider with that is agencies that are on the border of other states. The Southwest Virginia EMS Council is having a lot of issue right now because their agencies are licensed in Virginia, but they're transporting to Tennessee. So they're having to try to figure out how to navigate

two different trauma systems and trauma triage criteria. So something else to consider when we're talking about the agencies that are close to borders.

MR. WATKINS: Any time when we're getting out of state trauma patients coming into Virginia system. So...

COMMITTEE MEMBER: Is REPLICA active in -- in Tennessee?

COMMITTEE MEMBER: Yes.

COMMITTEE MEMBER: Good.

MR. WATKINS: So there's no licensure issues. It's just when we go to North Carolina.

MS. CRITTENDEN: With the Tennessee issue and the Ballad system, they are getting set up right now in the trauma registry. And they will be submitting trauma data to our registry for any Virginia

patients that they receive. So we're getting access and starting training. Some of their hospitals, obviously, on the Virginia side are already accessing and doing the data right for the trauma center as well.

And Anita Perry has taken a very active role and Ballad's corporate trauma system, and will be attending our meetings, too. And will be working with us to also kind of dislodge some of that.

MR. WATKINS: Okay. Any additional discussion on the state trauma triage criteria for populations? All right. Going on to goal three, resources for critical care and ground transport.

A lot of this was put over to Medical Direction Committee. Have we gotten anything back from them as far as expectations?

DR. YEE: So Medical Direction Committee has a work group looking at what is critical care. After the last Medical

Direction Committee, that work group did meet. They -- and they've not reported out their findings back to Medical Direction just because of timing.

However, I do believe that the current plan is to create a framework for licensure of a critical care agency. Right now in Virginia, your -- your EMS agency is -- you know, ALS, BLS and that's it.

So now it will be ALS, BLS, critical care as well as more integrated health care. You'll be licensed -- the thing for me is you'll be licensed to do this.

So it'll be taken -- sort of taken the air medical guidelines and -- and editing that to meet what is critical care. You need this many years of -- of experience, this level of education and this amount of equipment. Licensed critical care.

MR. WATKINS: So would it be both people as well as equipment?

DR. YEE: Yes. It'd be -- it'd be strictly regulatory based. What it would allow agencies then to do is bill critical care. Because right now, you're not getting reimbursed for critical care or -- or SCT because you're not licensed to do so in Virginia.

So in that case, now you create a potential financial margin for agencies to create, you know, the resource. Right now, there's no marginal mission.

So if you create an opportunity to bill, you'll -- you'll create the opportunities to create the resource. Then they'll be considerably more available to hospitals.

But at the end of the day, you'll still need cooperation from the facilities to donate people -- to give people at -- at times to supplement the transport. They fall under the supplemental transport rules. That's my humble opinion.

MR. WATKINS: Meaning for a critical -- a significant patient that the

hospital will provide personnel --

DR. YEE: Yeah.

MR. WATKINS: -- as appropriate to the level of care.

DR. YEE: Yes.

MR. WATKINS: Okay.

DR. YEE: Because there may not be a critical care transport per -- agency per se. It may be the critical access hospital. They may have to have a resource to put on an ambulance to make it a -- a BLS ambulance to make it -- to provide advanced life support care, or in that case, nursing care.

MR. WATKINS: Okay. I think the thing that we -- we still have is each jurisdiction is tasked to insure that ground transport for the critically ill and injured patient is available. I think that's something that's -- I mean, as an agency

that gets called upon to do 911 calls out of a hospital on occasion, that's something that you have to question what is and isn't, you know, your mission. I know you guys do it as well. I mean, where does that fit into this?

I mean, is that an incentive to get prehospital units, 911 services to license as critical care? Or is that giving them a reason to say, you can't do this call?

DR. YEE: That's up to the individual jurisdiction. We do not address that.

MR. WATKINS: Okay.

DR. YEE: We just address it how -- structurally, how do we create critical care across the state.

MR. WATKINS: Okay.

COMMITTEE MEMBER: Which takes us

back to defining what is critical care. Right?

COMMITTEE MEMBER: Right.

COMMITTEE MEMBER: So that the --

DR. YEE: Well now you have CMS rules that now apply. So -- so then you -- from a billing perspective, it sort of defines what is critical care. And a transferring and receiving facility is -- you can ask for whatever resources you want.

You know, you're thinking I want a critical care, you know, service, you call. You know, Sid's organization says, you know, Sid's ambulance go like, I need a critical care agent -- unit.

By golly, I have a -- I'm a critical care agency. I'll send you a certified -- or a licensed unit. When the patient needed critical care, not -- who knows. But they have that capability.

COMMITTEE MEMBER: Just as a point

of information, CMS allows the states to define their requirements for critical care. So there's BLS, ALS I, II and then critical care billing under CMS. The air medical programs haven't had a problem with that.

It has probably been the ground commercial interfacility agencies that have had difficulties with that. Because the State has not defined what critical care means in that context.

MR. WATKINS: All right. Good discussion there. I think the one thing that I'm curious about is this change to Virginia Code, each jurisdiction is tasked to insure that -- that seems like that's some past -- that's kind of an unfunded mandate for a locality.

The more rural, obviously, the bigger challenge. But then, you know, depending on your county administrator, they'd say, well, we're going to bill this every single time. Or hey, this takes valuable resources out of play. So...

COMMITTEE MEMBER: I would suggest that it should be changed to each facility to insure the availability of critical care transport. It should be up to the localities. It should be up to the transferring hospital.

COMMITTEE MEMBER: Yeah.

COMMITTEE MEMBER: Right. That was going to be my question. Does that statement refer to scene calls and the critically injured patient on the scene, versus an interfacility transport?

DR. YEE: That employs -- yeah. Seek to insure the provision of EMS. It's actually the Code language now, if I recall correctly.

COMMITTEE MEMBER: So this -- this really is more about interfacility.

MR. WATKINS: The authority -- the jurisdiction having authority, you know, the

Code is pretty clear of what we have to provide and ultimately be responsible for whether you're a large crew agency or small rural agency. The -- the jurisdiction still has to figure out how to provide it.

But to have the jurisdiction also figure out how to get somebody from the hospital -- from one hospital to another doesn't seem like that. So it's not really their area.

COMMITTEE MEMBER: That's the sending hospital.

MR. WATKINS: Right. Any other discussion on goal three? All right. Goal four is support programs for recruitment and retention of EMS providers. Again, this is something that Workforce Development is -- is working through.

I know that several paramedic programs are changing, you know, formats trying to figure out how to entice people to come into their programs. I know Valerie mentioned something about a -- a --

MS. QUICK: Department training.

MR. WATKINS: Yeah, the department training. We had the community -- the community college work force alliance is working on trying to develop pathways into the EMS system, starting with EMT.

And again, those are -- that's a long list of discussions. I mean, those are in the -- in the education realm know there are challenges with working within the community college system and there are challenges working without the community college system. I kind of -- anybody have any discussion on that? Go ahead, sir.

COMMITTEE MEMBER: We have a committee working on this.

MR. WATKINS: Can we take it off of ours?

COMMITTEE MEMBER: Take it off of our -- I mean, we're all part of the -- the GAB system.

MR. WATKINS: Okay.

COMMITTEE MEMBER: Whether we do it or the Workforce Development group does it, it still gets the -- the goal. So to reduce duplication.

DR. ABOUTANOS: Actually, the whole -- the whole system is set up -- actually, even the way as we -- all of us structure this, was to actually identify the resource already exist.

So your call would be as a -- as the Chair is to actually say, okay, how am I going to make that link in order to be able to work.

You know, we know eventually that within -- initially -- it's in the documents in the plan that this needs to happen. And then the -- the whole idea is that now it just by nature will happen.

So there's no reason to duplicate efforts if something already is established. But now it becomes more of a -- an opportunity for you kind of to reach

out and just say, okay. You guys going to handle this. I need the report back for my committee. How is it going to work. This is -- this is where the interaction begins.

MR. WATKINS: One of the things that I kind of thought about would be, you know, having the trauma centers actually develop -- I mean, or have some interaction with the programs and make sure that these programs that are out in the community have access to a trauma center for an educate -- for educational purposes.

A lot of the students want the ability to go to a trauma center to be exposed to that clinical environment to figure out whether they're going to do this or not.

I mean, they may see that major trauma and say, no, thank you. Or they may say, yeah. This is what I want to do. I want to take care of folks. And making sure that the trauma centers have some investment in -- and most trauma centers are affiliated in some fashion with

programs. But we also -- trauma centers that don't let students into trauma alerts. So it's like, where does that -- where -- where -- what is the best approach to making sure that -- because that -- that may be part of the care is getting, you know, people exposed to -- I hate to say this -- the bad things.

They need -- they need to know what they're getting in to if they're going to get into this work force.

So -- all right. So we'll -- I'll continue to report back from Workforce Development with -- with that as -- but we won't really focus on it.

DR. ABOUTANOS: I think this is a -- I mean, this is a -- well, you just pointed out is something really great. Because education is part of the trauma system plan.

And if we're saying we're going to be connecting with each other from now on, this is -- this will be something that -- okay, so now this is a -- an ask for

what does it mean? What's the proposal for it? And how does the Acute Care Committee --

MR. WATKINS: Okay.

DR. ABOUTANOS: -- going to respond to the Prehospital Committee of saying, hey, we need this at the educational level. And so -- and so that's how you -- we bring that up.

And then, like Allen said, you also link it with -- here's the Workforce Development. This is part of it. So it's an ask for the trauma centers to take over, who has program, who doesn't.

And -- and if we -- if we make it, this is a part of the State plan for this to happen. Then you got to go to the next level eventually.

Is that something that's required, is that something that is volunteer? So -- but you got to start initially with the idea that you just said. This -- this is what is needed. Okay, let's

define the need and see who's going to answer it.

MR. WATKINS: And I'll kind of look at those who do trauma -- who do education, how challenging is it to get students exposed to both trauma center experience, but trauma patients in general.

I know as a -- as a paramedic program coordinator, getting somebody intubations in an OR was always a challenge. You know, getting people exposed to those critical -- critical needs.

And it's not just necessarily intubating patients, but managing the airway. Dealing with these things that, hey, this is what a pneumothorax is and why.

So I think there's still some gaps there in making sure that -- that the facilities, particularly trauma centers, take the onus with the students to get them exposed when they're -- when they're in that environment. So do we -- do we need to formulate an ask? Go ahead.

COMMITTEE MEMBER: And to kind of piggyback on that thought. I think one of the things that has become a real benefit for EMS over the last, probably, 10 years is the accrediting bodies for -- let's say like the Chesapeake center accreditation, now has a very specific line in there about how they are to interact with EMS.

And it has forced the hospitals to have that relationship in there. I can certainly say from a trauma perspective, I have -- having worked with like trauma, stroke and STEMI for many years, there is a whole lot more that's written into the accreditation for both stroke and STEMI than there actually is for trauma.

So having that as part of their accreditation makes them kind of have to drag along --

MR. WATKINS: Mm-hmm.

COMMITTEE MEMBER: -- and participate. Having them show and

demonstrate that there's some way that they tie in with the community resources from an educational standpoint I think would be also beneficial.

COMMITTEE MEMBER: All right. They mapped out education to EMS, but not necessarily education to EMS students.

COMMITTEE MEMBER: Right. And they're -- and they're education from EMS --

DR. YEE: So that's -- that's where the huge gap is, right? You've got these schools that turn to these hospitals and say, hey, we want you to take these students.

And then they just stop right there, right? And there's no -- there's -- hinders -- the hospitals aren't willing to say, you know what?

I'll hire a bunch of people to walk around with your students all day. And the schools aren't willing to say, you know what? I'll put a planning coordinator in to

assure that this experience takes place. Right? No one does that, right?

COMMITTEE MEMBER: Right.

DR. YEE: And it changes the game.

MR. WATKINS: Mm-hmm.

DR. YEE: Down here, that does not happen. I -- I don't know about around the -- the rest of the state. I think it's fabulous that the hospitals do what they do already, right?

I mean, we had 8000 clinical hours last year at the hospital I work at. Not a -- not a penny for the school, right? These schools are making boo-coo dollars and not -- not putting it into the -- the clinicals for their students, right?

We have people coming all the way from Hampton to do OR rotations at our hospital because none of the hospitals out there will allow it. Because it -- it just becomes so burdensome. You know, it's

difficult. I think hospitals do a fabulous job when they're presented with what they're presented with, right? We kind of open the door and say, we'll take as many as possible and -- and deal with it.

I think it really needs to go back on the schools to figure out how to manage their students inside the clinical setting, right, to assure that that student gets into the trauma alert, right?

That that's not a nurse's job who's not being compensated who has five patients already, who -- who, at the end of the day has to take care of those patients, right? That -- that student is not on the top of that priority list.

COMMITTEE MEMBER: And we actually do that at UVa. We have a preceptor that is dedicated to those two students and goes from -- from room to room to room. It does make a huge difference. But even if we're not --

DR. YEE: For -- for students that

attend UVa. Right?

COMMITTEE MEMBER: Correct.

DR. YEE: Because even your community school comes to my hospital to do rotations.

COMMITTEE MEMBER: They do not come to UVa. You are correct.

COMMITTEE MEMBER: Right.

(At this time, both committee members began talking at the same time.)

COMMITTEE MEMBER: I actually have more [unintelligible] for Piedmont than I did John Tyler and they knew.

COMMITTEE MEMBER: And that -- that's an issue in and saying they're some sort of incentive for the hospitals to have to plan on. And it has made a huge difference in STEMI and stroke. They --

they are now actively inviting people to come to the cath lab. Because they need that relationship there for their accreditation process.

It's -- I think it's been a good thing for the hospitals and I think it's been a good thing for the EMS providers. Because that continuum of care is being recognized all over --

COMMITTEE MEMBER: But see, you've already established EMS provider is -- is welcome to come to all kinds of things. We're -- we're still that -- that student, right?

That person who has no certification level, right, who is -- who is just a student. It's the one that's -- that's kind of getting lost in the mix, right?

And I think the schools need to be responsible for assuring that that student has a certain experience at these hospitals. I don't think it's -- it's the hospitals should --

COMMITTEE MEMBER: That's fine. But if then the hospital doesn't let them in because they --

MR. WATKINS: Hold on. Let's get the --

COMMITTEE MEMBER: And we are not announcing our names, by the way. We -- we have failed the -- the rules.

MR. WATKINS: Jason Ferguson.

MR. R. J. FERGUSON: Jason Ferguson, yes.

MR. ERSKINE: No, not that one. The other one.

MR. R. J. FERGUSON: R. Jason.

MR. WATKINS: R. Jason. The other one.

MR. R. J. FERGUSON: Yeah. I'm

just -- excuse me -- listening to you guys talk. Is that something that's really needs to be talked about in this committee or -- because it's not just trauma. It would be OB. It would be medical.

Is this something that TCC needs to address that if it's a point in one issue versus -- because I -- it goes way beyond trauma. I -- I think it goes to OB, OR, those kind things.

MR. WATKINS: True, but I think --

COMMITTEE MEMBER: This committee keeps on giving away everything that we talk about, we're going to have nothing to talk about.

COMMITTEE MEMBER: Right.

MR. WATKINS: So I think there -- there is an element in there that needs probably to focus on the trauma side of things. You know, there -- there is some specific -- specifically with the trauma

care. And then having the hospital trauma programs being able to push down and support the EMS liaisons. Like I know Brad works his tail off to make sure that the -- people are in the right place at the right time.

And like I said, some hospitals do a fantastic job of bringing the students in. But as a -- as a nurse preceptor, that -- that can be tough to always make sure that that student gets the exposure, the experience that they need.

And -- and you know, that's -- you know, trauma is more rare than your chest pain patients. You know, granted a STEMI doesn't come in all the time and that PPA stroke doesn't come in all the time.

And the traumas come in that are often minor, but that major trauma is the one where these folks really need to know that action on objective. And have -- and need to understand what -- what's important about it.

DR. ABOUTANOS: Right. Sorry. I was going to say that why -- the way I see

it is like if I am Kellogg company. I'm only going to push Kellogg product. I'm only going to push breakfast, even though nutrition is good for everything else. This committee is in charge of trauma prehospital.

MR. WATKINS: Mm-hmm.

DR. ABOUTANOS: So -- and so I agree, by not pushing everything away and you actually use that -- if you push it and everything else comes with it --

MR. WATKINS: Yeah.

DR. ABOUTANOS: -- that's a gain for the other system.

MR. WATKINS: Yes.

DR. ABOUTANOS: That's the whole, you know, prehospital transport system, just one system move to add anybody else, piggyback on -- on each other.

COMMITTEE MEMBER: See, I -- I think that the idea -- ideal way to have this is TCC pushes this and leverages Acute Care and -- and Prehospital trauma committees to assist in the goals of TCC. But this isn't TCC's initiative.

MR. WATKINS: Okay.

COMMITTEE MEMBER: You know, they -- they -- what they need to do is come to this committee and say, I need your help to engage the trauma system, the -- the inpatient trauma system and acute care.

They need to go across the hall at 3:00 o'clock and says, listen. You know what, as part of our ongoing -- well, incoming education and ongoing, we need to introduce you to, you know, critical trauma patients.

MR. WATKINS: And again, we do a good job with the paramedic classes, usually requiring that trauma exposure. But you still have that new person if you got to

figure out something to get them exposed to that. So -- anything else on goal four? All right, goal five. How many notes have we gave this one away? Strengthen the language in the Virginia Code to update the safe transportation of children in the back of ambulances.

I think the -- the key piece and -- and just going through some of the RC -- I know agencies do a pretty good job of obtaining and, you know, requesting pediatric restraint devices.

And the key challenge is enforcement and making sure that a child is appropriately restrained at all times in transport, particular a trauma patient.

The challenge I would say, and don't pivot this as -- as that pediatric nurses. You know, when we look at C-Collars in the pediatric population specifically, what we have in EMS is woefully inadequate I would say.

Most of the time, they're not the two part vista collars. They're that adjustable type that's -- that's usually

disposable. So there's some challenges -- and I think there was some guide -- guidance. I forgot whether it was American College of Surgeons that said, you know, we're -- when you're looking at C-Spine injury in a pediatric patient, you're often not -- not looking at that fracture.

You're looking at ligamentous injury or other stuff that still needs that cervical collar. So I can tell you, my providers are not very good at maintaining that C-Spine stabilization.

And it kind of goes into this -- this -- this goal. What do we do to make sure that the safe transportation of a trauma -- of a pediatric trauma patient in the back of a -- of an ambulance.

You know, obviously, the first part is not letting them become a projectile in the event of an ambulance crash. But also we're transporting from the scene.

We've gone away from C-Collar -- from back boards in a lot of cases. But a C-Collar is still very appropriate.

COMMITTEE MEMBER: I think the original impetus behind that was the car seat or the spinal mobilization device or whatever you're using to attach the pediatric patient --

MR. WATKINS: Right.

COMMITTEE MEMBER: -- was not part of the minimum ambulance requirements. So if -- if that was a concern, then it would need to be changed so that it was part of the requirements.

And then it needs funding and support to make that product available. And Wayne, didn't we -- didn't we turn to EMS-C and -- and inquire about some -- some new standards that were coming out for them?

MR. PERRY: Yeah. And they'd issued a grant for -- recently for -- toward the process.

COMMITTEE MEMBER: I know have a -- flipping the bill, but -- but what --

weren't they trying to push forward a standard across all ambulances and they did not?

MS. CRITTENDEN: What they're -- what they're looking at is there are no national standards because there's been no testing done on children. So at EMS, our -- at the national level, EMS -- the two new steps they're working on getting crash standard -- crash testing done.

Our EMS for Children is committed to contributing $10.00 -- $10.00 -- $10,000.00 a year for four years to help pay for that testing to be done at the crash center out in Ruckersville.

There are some other people contributing at the -- through the CEMSA also, just like kind of spearheading that. Because right now, we are granting out, you know, through their -- the E-Gift system with child restraint. We've set out 68 over the last two months, I guess. We got a whole 'nother purchase coming in. But we're guessing as well as anybody is, is this even

the best one? And so, that's kind of a two-prong thing. We are giving equipment out there if they want it. But we're also trying to support let's get some testing done so we know what the best way to restrain children is.

COMMITTEE MEMBER: NHTSA came out with a position patient -- paper on safe transport of children. It's been out for a while, 2012.

MR. WATKINS: Right.

COMMITTEE MEMBER: So that movement has already started.

MR. WATKINS: It was put out generic.

COMMITTEE MEMBER: Yeah. It -- it was generic, right.

MR. WATKINS: So I guess to -- to drill down from the trauma standpoint, you

know, what's the safe transport of a pediatric trauma patient? What is that supposed to look like? Because you may have some facilities that are okay with no C-Collar.

You have some facilities that absolutely, you need a C-Collar in every kit. And with a kid that was involved in an accident in one county drove four counties away to community hospital and was transferred to a trauma center.

Never had a C-Collar the entire time. But as soon as they got to the trauma center, they had the collar put on. So you know, there's -- there's some discrepancies out there as to what should be done in a prehospital environment. And then, how to do it safely.

COMMITTEE MEMBER: Yeah. I mean, long before C-Collars and -- we were more focused on getting the child out of mom's lap.

MR. WATKINS: Right.

COMMITTEE MEMBER: Yes.

MR. WATKINS: And I think we've made a good -- some good headway there. I'm certain it still happens, but --

COMMITTEE MEMBER: I'm -- I'm pausing. I still haven't said it.

COMMITTEE MEMBER: What happened to the legislation that they put in last year to exempt EMS and public safety from child restraints?

DR. ABOUTANOS: It didn't pass.

COMMITTEE MEMBER: It did not go through.

COMMITTEE MEMBER: Thank goodness.

MR. WATKINS: So -- I mean, that to me is a trauma and a training aspect. What -- what do we do to actually both identify better methods and then train the providers

to be more consistent with things. And that goes -- you know, if somebody's being transferred from one hospital to another, you know, for a vehicle crash.

And obviously, you know, the teenagers are not the real problem. You're talking about the two-year-old, the five-year-old that doesn't like sitting still. That's going to be your big challenge.

COMMITTEE MEMBER: Child restraints are -- they are required under Virginia EMS law.

MR. WATKINS: Pretty -- pretty sure they're -- they're required, but it doesn't necessarily define -- it says an adequate of C-Collars of varying sizes, if I remember correctly.

I know we use the adjustable one that really doesn't fit anybody smaller than about a four-year-old. And what is -- what is -- what does that need -- what does that need to be from the trauma systems perspective in the peds trauma program.

What are -- what are these prehospital units need to be bringing in and how does it need to work?

DR. YEE: It's not just C-Collars. So I mean, the ASC, NMSB, ASAP, whatever -- all these other acronyms -- it's -- it's more than just C-Collars. You can use other immobilization devices.

MR. WATKINS: Right.

DR. YEE: So let's not focus on collars. We want to focus on stabilizing the --

MR. WATKINS: The whole body.

DR. YEE: -- the cervical spine.

MR. WATKINS: The cervical spine.

COMMITTEE MEMBER: You're talking about safe transport, which are child restraints. Let's keep it from being the

projectile --

COMMITTEE MEMBER: To the cars --

COMMITTEE MEMBER: -- or on mom's lap.

COMMITTEE MEMBER: Yeah.

COMMITTEE MEMBER: And then you've got appropriate measure --

COMMITTEE MEMBER: Sure.

DR. ABOUTANOS: Mike, can I interject a little bit?

MR. WATKINS: Yes, sir. Please go ahead, Dr. Aboutanos.

DR. ABOUTANOS: So -- so if you look at -- so -- so this committee's much more advanced, obviously, because 30 years of EMS, you know. So a lot more advanced. And you're jumping very quickly, even our

goals -- even the goals that are identified, it's -- they're all kind of trees. They're not forests. You hit on the forest every once in a while.

But if you think -- if you step back, I mean, education was mentioned. Legislation is mentioned, you know. The process outcome, all this -- all this forward.

So one thing I would encourage that -- what may actually help -- if we -- if we identify -- okay, if the goal of this committee is trauma and prehospital. Those -- those two aspect.

And you get back and just say, okay. Where is our State currently? You know, forget little bit -- how much -- so much stuff is done. Step back and maybe for the next meeting you say, okay.

What is the outcome -- I mean, what are the outcome from prehospital transport? So this -- this kind of goes to the System Improvement Committee. What data you need from that committee? What data already exist? Right? What redefined all

the goals? Then you -- then -- so what is the -- what process already exists? What's the education dedicated only for trauma?

What's the training, what if -- so like -- putting bigger items and start taking from those items. Who are we going to be working with?

Whether it is on the trauma system plan or the EMS Advisory Committees? Doesn't matter. Whoever it is. So that the link can happen.

See, this is not going to happen in one meeting, happen in multiple meeting. But then -- like Allen, you just said that before, hey, it's not just collar.

Now it's other things. So it's really -- if you look at just, you know -- and you also mentioned training, you know.

Training for specifically for trauma. It's going to cross over all the time, obviously, for -- for other aspects, stroke and -- and you name it. But it may kind of define a little bit more overall, what is -- what is this committee function

is. And how -- how are these systems and goals. I mean, we drew these goals initially, right?

MR. WATKINS: Right.

DR. ABOUTANOS: You guys drew them all. You may want to re-take a look again and just say, okay, can you put them in bigger -- bigger category in terms of -- you know, and start each one.

Trauma, training, interaction with centers, legislation. What is the report on legislation when it comes to prehospital transport and trauma? You just ask that question.

So it involves a little bit of -- of stepping back and just saying, okay. How -- how we going to move forward? So we're -- one aspect we're going to do is flip this little bit.

And -- and probably about a -- maybe month or two months, have the -- the TAG Committee come back again and just say, as a trauma system plan, who are we? What

are we trying to do? And then communicate that back to the -- to the -- each committee. So as the Prehospital Committee, just say, these are the things that I think we really need.

And to define this a little bit better. It's easy to get into the -- all the immediate -- I call them trees, but I need a specific -- specific thing inside of kind of the bigger picture. What do you guys think?

MR. WATKINS: Captain.

COMMITTEE MEMBER: So what -- what he's trying to say is kind of like the way we regularly do business is find out what you're requiring.

If you guys are talking about what your big requirements are and what you're currently doing is your requirements. What you're doing when you're looking for your gap, kind of what your gap is. So what is it that you need and how -- is every requirement you're seeking, right? And you

have a lot of stuff that you already have. What are you missing, and that's what you got to figure out. You got an end game and you got minimum.

What are you missing? How can you guys kind of find a minimum, that's what he's kind of describing --

DR. ABOUTANOS: Also the finance committee -- like Allen just said, you know, the TCC needs to come to us. How is that communicated? And like, what is us now for the prehospital trauma as far as -- you know, and so a lot of stuff's been done.

How can you now start carving out little bit so that this committee, you know, a real voice for the trauma, can communicate with the MBC, can communicate with every other committee.

And only when you start going back and saying, in terms of legislation, what happened? In terms of our process, this is what happen. In terms of the outcome for the Prehospital, this is where we're at. And moving that way forward. So

it's kind of little bit of reshaping, you know, and start coming on more and more the trauma part of the Prehospital Committee. The Prehospital system, I should say. And the good thing, a lot of stuff's already been done.

It's just a matter of just, you know, saying okay, who's doing this? Okay. And so what -- and I always suggest start with just the basic data.

What -- where are we with regard to prehospital outcome and process? I mean, if I asked right now, what's the -- what's the prehospital mortality for trauma. This committee should know it the way I see it.

The way we should -- and that's the trauma. It's only one measure, you know. This committee, we should have it. Then we just say, okay, what are people are dying from?

Is there something that involves education? Is that something that involves training? Is that legislation that we need? And then start defining it kind of

that way, you know, from that part. Every other committee is starting that way because they don't have a big background. The Prehospital Committee has a huge background.

So we think you can jump into the trees. It's a way of kind of restraining yourself and stepping back. Do you get what I'm trying to say? I think it's -- that's an important point.

MR. WATKINS: I mean, what we can do -- to wrap up today -- is -- is identify four or five measurables that we can look at.

DR. ABOUTANOS: Right.

MR. WATKINS: All right. I know that it -- at the performance level of the regions, we look at trauma -- trauma performance.

So we need to take a look at it from a State perspective and see, you know, do we have any issues with anything from scene times to how many patients that

-- are they higher level.

DR. YEE: You look at scene times. It's not evidence-based, right?

MR. WATKINS: Okay.

DR. YEE: Scene times are -- are not related to mortality.

MR. WATKINS: Okay.

DR. YEE: Right? You got to divide it into time periods. If any one particular time period is more than 50% of the total prehospital time, that's when -- with the exception of intubated patients. That's when mortality is increased.

So if your drive, let's say, is 60% more than your scene time -- of -- of the total time, which is dispatch, scene time and transport time. If you say that transport is 60%, the mortality is going to be high.

MR. WATKINS: Right.

DR. YEE: And they've already shown this. So using stuff like that and retooling what we look at and maybe we look at the whole system as what take -- take the -- for trauma patients, take a look at all those three time intervals and say, all right.

Which one of these is 50%? You've got to go to rural -- rural Virginia. To get someone to the scene may be 50% of your interval.

MR. WATKINS: Mm-hmm.

DR. YEE: We don't know that. Maybe -- maybe we got to focus on that.

MR. WATKINS: So looking at patients that meet certain trauma criteria and what their scene -- what those trauma time intervals are?

DR. YEE: Yeah.

COMMITTEE MEMBER: What's your goal?

MR. WATKINS: Well, we need to figure out what we have first.

COMMITTEE MEMBER: Well, what -- what --

DR. YEE: What's your end game?

COMMITTEE MEMBER: Yeah. What -- what do you -- what are you trying -- what question are you trying to answer?

COMMITTEE MEMBER: Is there a problem.

MR. WATKINS: Is there a problem.

COMMITTEE MEMBER: That's --

COMMITTEE MEMBER: With what?

MR. WATKINS: Response times -- and

again, I'm -- I'm looking to get -- looking to get measurable --

COMMITTEE MEMBER: So you have a response time that you're trying to get to, right? You have a -- you have a what?

MR. WATKINS: Well, we want to try to identify areas -- we already know --

COMMITTEE MEMBER: You have a response time that you need to meet, right?

MR. WATKINS: Yeah.

COMMITTEE MEMBER: With a -- there's a -- a required response time, right?

COMMITTEE MEMBER: No.

MR. WATKINS: Not throughout the state. But it is -- it is -- it'll be useful to identify trauma patients that have an extended access to a trauma center. You

know, we know that they exist. We know rural areas are challenged with both responding to the scene as well as getting to definitive care.

You know, identify what patients we are missing. Where are those -- you know, where are those patients predominantly located?

We assume that that's going to be in -- in certain parts of the -- of the state. But we may find that they're existing in other areas as well. Where -- where are --

COMMITTEE MEMBER: Before you do that, we're going to have to define what a trauma patient is.

MR. WATKINS: Yeah.

COMMITTEE MEMBER: They would -- it's not the standard.

MR. WATKINS: Right. What is the trauma injuries for, say, and what is the --

what is --

COMMITTEE MEMBER: Well, we're not going to have access to a trauma injury base. If you look at steps -- like if you look at steps one and two of the trauma triage criteria, how many of those patients that meet that criteria.

Which, I would venture to say, the average EMS provider on the street could not necessarily tell you what steps one and two are.

But if steps one and two are met, how many of those are going to the highest level trauma center?

MR. WATKINS: You just identified the problem.

COMMITTEE MEMBER: Don't know where you put it. Get that.

MR. WATKINS: You just identified the problem that this committee can address. A lot of EMS providers don't know the

fricking triage criteria. That's a huge problem that this committee can address.

COMMITTEE MEMBER: All right.

MR. WATKINS: There. And they're not going to give that one away.

DR. YEE: Maybe you look at -- so EMS accomplish -- I mean, had to create some national -- some potential national metrics, as well as a process to get -- to develop and execute them.

And that was the EMS Compass Project. EMS Compass is now over now. It's ???, right? So now NEMSQA -- I'm -- I'm pretty confident has created a -- at least working on a trauma metrics.

What -- what should we as a nation be looking at for trauma? So looking at the web site and they -- they haven't posted one yet. But I'm very confident they have one on their books.

MR. WATKINS: Okay.

DR. YEE: And then we can use that as a -- that's our metrics, you know.

MR. WATKINS: Struggling with the national stuff and working --

DR. YEE: Yeah. Work done. Because that's already been developed.

DR. ABOUTANOS: You need to start basic. Just even -- like I said, mentioned before. What's the -- if you look at mortality across Virginia, carve out the prehospital part with regard to trauma.

MR. WATKINS: Yeah.

DR. ABOUTANOS: What is the rate? Is it national or not? What are people dying from? What are the mechanisms? Then you get into the granularity of is it the transport? Did they go to non-transport center? And -- and if -- I mean, non-trauma center. Even if they went to non-trauma center, does that not actually enforce

mortality. The evidence is not always true.

MR. WATKINS: Okay.

DR. ABOUTANOS: So did -- and just stepping in back a little bit, only just say, hey guys, I know we can do this very, very well. Let's be more directed now.

And then -- then pick -- pick the top three and just say, where are we with regard to -- and initially, do we know our data, okay, number one. Is it good enough?

That kind of what was mentioned before with you, right? And we all know, it's not the best data, right? But what -- what are we dealing with, that's number one.

And then -- then you go kind of to step number two, which is, you know, it was just said, if it's identified. Is it because of education? Is it because of training? And if it is, how do we address them? Is it legislation? If it is, who's going to address this? So you have multiple

things and you only focus on the top three deliverables in one sense. And what we really -- what would drive our system really well if the other committees that are also looking at the same thing but from their part. Okay.

So then you'll have a system that thoroughly focused on identifiable aspect. So I think this would be the main thing as a committee.

When you go to the other committees and just say from every part of what you guys are doing, this is what we're going to concentrate on. Is that the same thing or not. And this is where the TAG will end up helping --

MR. WATKINS: Okay.

DR. ABOUTANOS: -- with that part.

MR. WATKINS: Okay. All right. So we've got some [inaudible] issues we want to look at, we want to try to obtain those metrics from EMS. Q --

DR. YEE: NEMSQA. National EMS Quality Alliance.

MR. WATKINS: Okay. NEMSQA. So let's start -- start with that. I'll get with you and maybe we'll see if we can dig up something. And we use that as kind of a core at the next meeting to start with. And we'll get with -- from TAG maybe some guidance that they have.

DR. ABOUTANOS: Yeah. And I mean, it'd be very quick. You also ask the System Improvement -- that's supposed to be the data -- that's supposed to be your data engine.

That's what it's supposed to do. These are all there. So say, hey look, for prehospital, what database -- these are the databases we have.

How does that compare to the Virginia database? And that is something that -- it may end up being a work group from here and System Improvement, in order -- so next time, this committee should

demand to see this data. Say we want to see some kind of a data -- some kind of a quality. I mean, it may not -- it may take more than one meeting to get to that level. But it should be one of the things we should ask for.

MR. WATKINS: Okay. All right.

COMMITTEE MEMBER: Are all of our meetings slated for an hour?

MR. WATKINS: No, two.

MR. ERSKINE: Two.

COMMITTEE MEMBER: Two hours.

DR. ABOUTANOS: Unless you have a place to go.

COMMITTEE MEMBER: No, no. I just say a start time on here. I didn't see an end. So -- so I was just making sure. It's that -- it seems that hour went by very

fast.

MR. WATKINS: We've gone through the agenda. And -- all right. Does anybody have -- I mean, if there's other items we need to look at, let's -- let's bring it up. Again, we don't want to give away any more functions or tasks.

We want to bring more stuff into this committee. I think there -- there is some trauma education stuff we can look at. There's the data points that we can look at moving forward.

DR. ABOUTANOS: And Workforce. You also have -- I think all these are very huge lists that you hit on. If we would -- this possibility of a -- of a trauma center to the prehospital education was something was mentioned.

I thought that was really important as far as who takes that responsibility, you know.

MR. WATKINS: And -- and to go back

to what Brad said, it's theirs on the -- onus on the educators and the schools to connect their students to the trauma system as well.

So -- all right. Anybody else have any business -- new business? Can I have a motion to adjourn?

COMMITTEE MEMBER: So moved.

COMMITTEE MEMBER: Second.

MR. WATKINS: Okay.

(The Prehospital Committee meeting adjourned.)

CERTIFICATE OF THE COURT REPORTER

I, Debroah Carter, do hereby certify that I transcribed the foregoing PREHOSPITAL CARE COMMITTEE MEETING heard on May 2nd, 2019, from digital media, and that the foregoing is a full and complete transcript of the said committee meeting to the best of my ability.

Given under my hand this 6th day of August, 2019.

Debroah Carter, CMRS, CCR
Virginia Certified
Court Reporter

My certification expires June 30, 2020.