Washington State Department of Health
Office of Community Health Systems
EMS & Trauma Care Steering Committee

MEETING MINUTES

September 15, 2021

Meeting held virtually via GoToWebinar

PARTICIPATING on GoToMtg:

Committee Members:

Carly Bean
Cameron Buck, MD
Cindy Button
Tom Chavez
Chris Clem
Christine Clutter
Eric Cooper, MD
Scott Dorsey
Bryan Fuhs, MD
Madeleine Geraghty, MD
Beki Hammons
Mike Hilley
Joe Hoffman, MD
Rhonda Holden
Tim Hoover
David Likosky, MD
Denise McCurdy
Patricia McMahon
Brenda Nelson
Lila O'Mahony, MD
Scott Phillips, MD
Bryce Robinson, MD
Eric Roedel, MD
Peter Rutherford, MD
Susan Stern, MD
Mark Taylor
Ken Woffenden

DOH Staff:

Alan Abe
Tony Bledsoe
Christy Cammarata
Eric Dean
Dolly Fernandes
Nicole Fernandus
Dawn Felt
Catie Holstein
Jim Jansen
Jennifer Landacre
Ihsan Mahdi
Matt Nelson
Time Orcutt
Jeff Sinanian
Melissa Stoddard
Sarah Studebaker
Hailey Thacker
Jia Wu

Guests:

Katherine Bendickson
Steve Bowman
Eileen Bulger, MD
Cheryl Burrows
Rinita Cook
Peggy Currie
Marites Descargar
Kandi DeVenere
Lisa Edwards
Megan Grinnell
David Lynde
Christopher Montera
Carolynn Morris
Jacki Mossakowski
Jim Nania, MD
Martina Nicolas
Greg Perry
Tammy Pettis
Rene Ralston
Randy Riesenberg
Karly Schriever
Max Sevareid
John Sinclair
Eduardo Smith Singares, MD
Becky Stermer
Cheryl Stromberg
Timothy Wade
Marvin Wayne, MD
Zita Wiltgen

Call to Order and Introductions: Eric Cooper, MD, Chair
Dr. Cooper and Dolly welcomed new members:

David Likosky, MD/Stroke	Bryce Robinson, MD/ACS
Lila O'Mahony, MD/Pediatrics	Peter Rutherford, MD/WSHA
Patricia McMahon/Prehospital	Ken Woffenden/WSFFA
Commissioner Carly Bean/WSFCA	Christine Clutter/Rehabilitation
Scott Phillips, MD/WA Poison Center	Courtney Stewart/WSP

New EMS & Trauma Regional Council Executive Directors:

Greg Perry/West Region	Randi Riesenberg/Central Region

Minutes from May 19, 2021: Eric Cooper, MD
Handout
Motion #1: Approve minutes from May 19, 2021 meeting.
Approved unanimously.

DOH Updates: Dolly Fernandes

Min Max Project Update: The Min/Max workgroup had been meeting earlier this year and the final meeting was on June 8th. The workgroup came up with their recommendations for assessing need for Level I and II trauma hospitals in our state. These recommendations are forwarded to rulemaking for Min/Max -- to assess the need and criteria to be used in that process.

Tony gave an update on Min/Max rulemaking. DOH is in the early planning stages and has filed the CR101 to open rulemaking. Tony is working on meeting schedules, frequency and making sure all stakeholders are notified about meetings. He anticipates the first stakeholder meeting in late fall or early winter. Dr. Cooper encouraged all steering committee members to attend and participate in the rulemaking meetings.

EMS and WEMSIS Rules: Catie Holstein and Jim Jansen, DOH

EMS Rules: Catie Holstein
The DOH EMS team is working on the CR102 rules package for the EMS rules. This work has been slow because the EMS team is pulled in to assist with COVID work.

WEMSIS Rules: Jim Jansen
Jim and the WEMSIS team are working on the CR102 WEMSIS rules package which includes the significant analysis and small business impact if appropriate. He anticipates the rules will be finalized by mid-2022.

Proposed Legislation for 2022 for EMS to administer vaccinations: Catie Holstein, DOH
Handout

The Department of Health is considering a legislative proposal to expand the abilities of certified EMS providers to administer vaccine and testing for COVID-19 without the need for a local or state declared emergency. The Secretary has not yet decided if this proposal will move forward to the governor's office for consideration for the 2022 legislative session. We are in the fact-finding stage.

Current law limits the practice of an EMT to respond to the emergency environment: a 911 call, transporting a patient to an appropriate medical facility, participating in an emergency services supervisory organization as defined in RCW 18.73.030 or a Community Assistance Referral and Education Services (CARES) program under RCW 31.25.930. This limits public health agencies to use EMTs during a public health response to reduce or prevent the spread of communicable diseases such as COVID or influenza. While EMTs do these things based on skill and scope of practice, there must be a declared emergency for them to assist outside the boundaries of the law. The proposed change to the definition will allow EMTs to provide medical care in settings beyond 911 response at the request of a public health agency in coordination with the Medical Program Director.

In 2020, the department issued a policy under the declared state of emergency in order to allow EMTs to assist in the COVID-19 response by assisting public health agencies with activities such as nasal swab testing, administration of vaccine, conducting medical assessment of farmworkers, monitoring people with suspected or confirmed COVID-19 in isolation and quarantine facilities and other related activities. Now we need to consider how EMS can continue to help conduct these activities in continued response to the pandemic and in a more prevention centered approach for future epidemic or disaster related situations without the requirement for a state or local declared emergency.

The proposed bill would include two amendments: 1) Amend the definition of EMT in RCW 18.73.030 to allow them to provide "collaborative medical care" 2) Define "collaborative medical care" as medical treatment and care provided in collaboration and partnership with local, regional, or state public health agencies to control and prevent the spread of communicable diseases which is rendered separately from emergency medical service.

This proposal supports public health response to communicable diseases by allowing the use of EMS to prevent or address the spread of disease. This will increase public access to testing and vaccine, especially for vulnerable populations who may be less mobile, rural populations, the elderly, homeless and people experiencing behavioral health disorders. Increased access to testing and vaccine could ultimately reduce the resources needed to support a surge of hospitalizations during an outbreak.

Dr. Cooper asked if there is a way for EMS personnel to get reimbursed for their services in administering vaccines and testing outside of a declared disaster. Catie indicated that this proposal does not address reimbursement, however she will add it to a list of things to consider and explore. Dr. Joe Hoffman agreed with the need to adequately reimburse EMS for their services and pointed out that small public health departments are especially hit hard by the shortage of providers. Catie Holstein asked the committee to send her any suggestions or concerns for this proposed legislation.

Committee Business

Update Bylaws with revised convention for terms on the committee Dr. Cooper and Dolly
At the May Steering Committee meeting the committee voted to base terms of Steering Committee members on their date of appointment and not when the position was appointed. The committee decided they needed at least a month to review the proposed amendment for the By Laws and vote on it in September. Having had more than a month to review the amendment, the committee voted on the following:

Motion #2: Approve language in the Bylaws referring to Membership and Appointment, that "a term is three years and an appointed member may serve no more than three terms or up to nine consecutive years on the committee".
Approved unanimously.

New TAC Chairs
Dr. Cooper announced that he is appointing Chris Clutter as the new Rehab TAC Chair, and Denise McCurdy as the Pediatric TAC Chair. Both have been long time and active members of these TACs. The Outcomes TAC needs a Chair, and we are in need of a Steering Committee member to take on the leadership of this TAC. Jim Jansen is the DOH Outcomes TAC lead and has taken on the TAC leadership responsibilities until a new chair is appointed. Dr. Cooper asked the committee members to consider whether they are interested in chairing the Outcomes TAC and send him and Dolly an email if you are interested.

Strategic Plan Progress Report 2021 - 2025: DOH TAC Leads
PowerPoint Presentation

The EMS and Trauma strategic plan was started in 2006. The Steering Committee and TACs are responsible for updating and implementing it. Each of the TACs lead a component of the system – prevention, prehospital, hospital, rehabilitation, QI/Outcomes. Dolly presented the strategic plan's mission, vision and goals for 2021 - 2025. It is a dynamic plan and objectives and strategies added when needed and taken off when completed. Each of the DOH TAC leads presented what their TAC is working on.

There are five Emergency Care System strategic plan goals:
1. Increase access to quality, affordable, and integrated emergency care for everyone in Washington
2. Prepare for, respond to, and recover from public health threats
3. Promote programs and policies to reduce the incidence and impact of injuries, violence and illness
4. Promote and enhance continuous quality improvement of emergency care systems for Washington
5. Work toward sustainable emergency care funding, enhance workforce development, and demonstrate impact on patient outcomes

In 2019 the American College of Surgeons assessed the system. Their recommendations for improving the system have been incorporated into the strategic plan as appropriate. Once a year, in September, the entire strategic plan is shared with the Steering Committee. Dolly started the review of the strategic plan by going over the objectives assigned to the Steering Committee and the Department of Health for implementation. These included access to care, system sustainability, partnership and stakeholder collaboration and improving system operations.

Next Eric Dean presented the objectives assigned to the Cost TAC, which is to identify, recommend and implement strategies to support the emergency care system sustainability.

Tony Bledsoe discussed the current three objectives of the Hospital TAC: Ensure that the WAC pertaining to trauma care are current and appropriate, use Washington State Trauma Registry data to improve and evaluate system effectiveness, and review, evaluate and make updates as needed to decision tools for triage and transport.

Alan Abe presented the objectives for the Injury and Violence TAC. The TAC facilitates networking opportunities for the Regional IVP programs. They will be working on regional and statewide IVP public awareness campaigns to reduce injuries and 911 calls. The TAC will also facilitate relevant trainings for professionals, stakeholders, and partners.

Jim Jansen discussed the Outcomes TAC's five objectives. The TAC will develop a master plan for system performance improvement to implement data-driven performance improvement initiatives. They also want to ensure trauma, EMS, stroke and cardiac quality improvement efforts are occurring both regionally and statewide.

Matt Nelson spoke about the work assigned to the Pediatric TAC. They will be evaluating regional and facility QI plans for pediatrics, evaluate EMSC clinical guidelines, monitor and provide subject matter expertise with work related to the EMS for Children Grant and review and make recommendations to improve prehospital pediatric care is new evidence arises.

Hailey Thacker spoke of the work of the RAC TAC will be doing including identifying and collaborating with DOH to develop wise practices for managing Regional Council affairs and collaborate with the department on recommendations for improvement and to standardize Patient Care Procedures (PCP), education tools and improving administrative processes.

Tim Orcutt presented the work being done by the Rehab TAC. The TAC plans to continue working on increasing awareness of the benefits of inpatient rehabilitative care following injury. They will use rehabilitation trauma registry data to develop best practices, inform decision making, and aid in system analysis and are planning on developing a way to track rehabilitation specialty services.

Performance Measures by TAC: Jim Jansen, DOH Outcomes TAC Lead
PowerPoint Slide

Background: Early this year the Steering Committee expressed interest in having a standardized way to monitor progress of the Emergency Care System and asked the Outcomes TAC for their advice. Dr. Mandell suggested that each TAC identify 3-5 outcome measures for their component of the Emergency Care System and those can be tracked over time. Each of the TACs have been working on the measures they would like to see tracked. Since Dr. Mandell has left, Jim Jansen provided the steering committee the plan for how this work will be carried out with support from Research, Analysis and Data (RAD).

Purpose: To create a standardized and regularly monitored set of outcome measures to track progress of the entire Emergency Care System – EMS, trauma, cardiac and stroke.

1) Each TAC to develop a 3-5 outcomes measures; these do not have to be newly created measures
2) DOH RAD staff will consult with TACs on measures and help refine them if necessary
3) Each TAC submits their measures to Outcomes TAC for review and approval
4) Final measures are presented to Steering Committee during annual report
5) Measures are submitted to Outcomes TAC annually for standardized tracking/dashboard

A question was asked about whether DOH had enough Epidemiologists to do this work as well as what is the role of the Outcomes TAC. Jim responded that while DOH just lost the Stroke Epidemiologist with the Coverdell Stroke grant ending, the RAD section should have enough support to track three to five measures per TAC. In terms of the Outcomes TAC role, Jim's opinion is that it serves the systems of care that contribute to the emergency care system and having representation from all the time sensitive areas- trauma, EMS, stroke, and cardiac at the Outcomes TAC meetings is critical for system evaluation.

Strategic Plan Annual Report:
Prehospital TAC Annual Report: Catie Holstein, DOH EMS Manager
PowerPoint Presentation

Catie thanked Scott Dorsey, Deputy Chief for Snohomish County Regional Fire and Rescue who represents the Washington State Fire Chiefs Association on the Steering Committee and is the chairperson of the Prehospital Technical Advisory Committee (PHTAC). Scott's vision and leadership have been integral for the success of this work. She also thanked members and attendees of the prehospital TAC for supporting this work by attending meetings, providing meaningful input, and working on projects.

PHTAC oversees workgroups, each representing a specific aspect of EMS:

- Medical Oversight, Protocols and Clinical Standards
- EMS Data / WEMSIS
- EMS Education and Certification
- Ground and Air Licensing and Verification
- EMS Preparedness and Planning
- Rural EMS Learning Action Network

The PHTAC advises the steering committee and the department on rules, implementation of legislative initiatives and other projects that occur throughout a year. As of their last report in September 2020, PHTAC had completed 81% of the work in our plan. Since that time, the TAC has reconciled objectives and strategies from previous plan and has pivoted to the 2021-2025 plan.

Catie reviewed the six new PHTAC objectives and their current status:

1. Prehospital data / WEMSIS
2. Continue identifying EMS role in emergency preparedness and response and continue to improve collaboration with public health and emergency preparedness partners
3. Improve recruitment, retention, and support of MPDs
4. Continue to work to improve sustainability of our rural EMS systems

5. Working to identify how to improve access to and quality of EMS transport resources – especially inter-facility transport
6. Working to continue to adjust education and training standards to be more accessible, affordable, and to reduce barriers to certification and recertification

The TAC's work for the next year includes:

- Continued response to the pandemic
- Conclude EMS rulemaking
- Implement 2021 legislation for EMTs in Diversion Centers and standards for ESSOs
- Address EMS to ED off load ambulance delays and hospital diversion of ambulances
- Establish statewide standards and guidelines for EMS protocols – to improve consistency in standards and data collection, reduce risk and duplication of effort.
- Explore and expand the use of EMS data to focus on health equity issues.

Prehospital Health Disparities – Suicide, Alcohol and Opioids: Ihsan Mahdi, EMS Epidemiologist, DOH
PowerPoint Presentation

Ihsan presented on equity within EMS services pertaining to specific situations: Opioid overdose, Alcohol intoxication, and Suicide in Washington State in 2020.

As outcome data that can be used as measures of EMS services are limited, the analysis also looks at how the prevalence of these issues varies between different patient groups. EMS responses are categorized by patients age, sex, race, and by geographical distribution. Based on available data, no clear disparities were shown as far as the quality of EMS services provided. The prevalence of suicide-related EMS responses is much higher among patients 10-19 years old despite their relatively smaller proportion of the population. The prevalence of alcohol-related EMS responses is much higher among AI/AN than other race groups despite their relatively smaller proportion of the population. Opioid overdoses are equally distributed across age and race groups. Naloxone administration documentation is low overall.

DOH Suicide Prevention: Elizabeth Cayden, DOH, *PowerPoint Presentation*

Elizabeth Cayden, Suicide Prevention Specialist at DOH presented the work DOH is doing on suicide prevention. She started with suicide prevention timeline highlights at DOH. The State Youth Suicide Prevention Plan was started in 1995. Since then, there has been suicide prevention training for health professionals and training for school health professionals. In 2015, a higher education task force was formed, and a Washington State Suicide Prevention Plan and fact sheets were developed. The legislature passed legislation in 2021 (ESHB 1477) to implement the 988 system to enhance and expand behavioral health crisis response and suicide prevention services. The Department of Health was assigned lead for implementing this work and Elizabeth will keep stakeholders, including first responders, informed about meetings.

Emergency Cardiac and Stroke TAC Annual Report Cameron Buck, MD, Chair ECS TAC
PowerPoint Presentation

Dr. Buck presented the annual report for the Emergency Cardiac and Stroke TAC. Dr. Tirschwell and Dr. Buck have shared chairing this TAC with Dr. Tirschwell leading the Stroke meetings and Dr. Buck leading the Cardiac meetings. In the future the ECS TAC will be restructured and meetings will be combined with Dr. Buck leading them. The plan is to have fewer meetings and perhaps longer meetings if needed. The presentation covered the who, what and how the ECS TAC operates; hospitals participating in the Emergency Cardiac and Stroke system by region; strategic plan objectives for the TAC; activities of the ECS system including the Cardiac Arrest Registry to Enhance Survival program, Coverdell Stroke Grant program, the American Heart Association work; and the Foundation for Health Care Quality COAP quality indicators, PCI volumes and STEMI volumes; a comparison of stroke scales; key performance indicators for ECS; 2020 accomplishments and future objectives for the ECS TAC. The TAC took opportunities to review stroke and cardiac literature. Dr. Buck showed two examples of an ECS TAC journal club. A lot of their work was identifying KPIs, time measures, and outcome measures for stroke and cardiac. This included first medical contact less than 90 minutes, ED dwell time, arrival to PCI, ECG (time to DX) and hypothermia for OHCA.

The TAC continues to strategize their next steps to establish sustainable funding from a legislative standpoint. They believe they have gaps in cardiac and stroke care. In 2010 there was legislation creating the Emergency Cardiac and Stroke systems of care. In 2019-2020, they proposed HB 2838 relating to improving cardiac and stroke outcomes. While it brought light and understanding to the gaps and opportunities for cardiac and stroke care, it did not pass. The TAC has enormous stakeholder support to do something to strengthen the cardiac systems of care; but they are not sure how to go about it.

Based on Dr. Buck's involvement as a representative of Washington ACEP and meetings with DOH and legislators including Representative Cody, who chairs the House Healthcare Committee, there is acknowledgement of the challenges in healthcare, particularly in the last couple years with the current fiscal situation. Passing a bill will be extremely challenging until everyone, including hospitals, evaluate exactly what is needed from a resource standpoint, and how to go about funding potential interventions and management needs.

Instead of spinning wheels and duplicating the same bill that was proposed in 2019, WA ACEP and their lobbyists are looking into funding for a study to evaluate the system. Or, maybe a better approach would be to have DOH head up a study to evaluate what resources are needed. Then get legislative support and sponsors for it. Get legislative support to draft a bill that would encompass what the study found and then make it a budget note. Outline items that would be studied, strengths, weaknesses, and opportunities. Focusing the study on specific things such as quality, access to care, and data driven decision making. Then identify interventions such as education or specific resources for vulnerable populations might be included.

Stroke Data Presentation: Jim Jansen, DOH RAD Manager/Epidemiologist
PowerPoint Presentation

THE ECS TAC proposed a set of *stroke* performance measures:

- Time from hospital arrival to initiation of IV administration for ischemic stroke patients state-wide is 44 minutes. The US median time is 42 minutes.
- Door to CT scan Time: Time from triage to initial CT imaging work-up for all patients who arrive within 4.5 hours from time last known well in Washington is 14 minutes. The US time is also 14 minutes.
- Door in Door out Time: Patients with confirmed stroke grouped by time spent in the ED prior to transfer to a higher-level stroke center in Washington is 197 minutes. The US door in door out time is 167.
- Last Known Well to arrival time to ED is 4.5 hours. That is consistent with US time, also 4.5 hours.
- tPA for Ischemic Stroke is 16 percent. Washington had an increase of 2 percent to US time.
- Defect Free Care (CDC): Stroke patients in Washington who got all the stroke care that they should have received was 78 percent. Compared to the US, which is consistent at 80 percent.
- Risk-adjusted mortality rate for all ischemic and hemorrhagic stroke cases both with and without a reported NIHSS in Washington is 16 percent. The US rate was 16.3 percent.

Measures that have not been revised by DOH yet are:

- % 30 day readmit, EMS notification to arrival time, FAST/LAMS assessment completed on suspected stroke, FAST/LAMS Score, EMS vs. Hospital Discharge comparison.

Technical Advisory Committee Reports:

Hospital TAC: Mark Taylor, Chair
The TAC met this morning with representatives from the Office of the Insurance Commissioner (OIC) to discuss insurance plans, Balanced Billing Protection Act and the decision making by facilities required to transfer trauma patients who had been seen by the facility and needed escalation of care for specific injuries or specialty services. The trauma system is experiencing challenges with some facilities keeping patients within their networks and not transferring them to higher level trauma hospitals where they can receive the care they need. The OIC indicated that they have heard concerns about similar issues as it relates to the Balanced Billing Protection Act and are working on proposing legislation in 2022 to address these issues. In the meantime, Mark encourages the steering committee members to continue to send the OIC examples of when patients are not appropriately transferred out for the care they need. There is a complaint form on the OIC website to submit these complaints. Mark felt there was good understanding by the OIC representatives of our current situation.

Dr. Cooper is working on a letter from the Steering Committee regarding this issue that will be sent to OIC. He will add in some specifics from the morning meeting to the letter and then he will make it available to the committee before it is sent to the OIC.

Rehabilitation TAC: Tim Orcutt, DOH Lead
Next Rehab TAC meeting is September 29 at 2:00 pm. It will be online.

Pediatric TAC: Matt Nelson, DOH Lead
The TAC was scheduled to meet after this meeting, but they cancelled the meeting because of COVID cases rising in Spokane.

Injury Prevention: Alan Abe, DOH Lead
Fall prevention week is September 20. DOH has developed free Fall Prevention educational materials.

RAC TAC: Hailey Thacker, DOH Lead
The TAC met on September 14 and worked on their strategic plan. Melissa Stoddard gave a presentation on "Patient Movement Planning". They also had a presentation on Rural EMS grant activities by John Nokes from DOH. They meet again in November.

MPD Workgroup: Jim Nania, MD, Chair
The MPDs had a good meeting organized by Catie Holstein and Dawn Felt. They briefly lamented the loss of the Coverdell Stroke grant. They discussed pieces of legislation that may have impaired law enforcement's support of EMS at the scene. That spawned a workgroup that Dawn Felt is leading to develop state policy/protocols for addressing this issue.

Cost TAC: Eric Cooper, MD, Chair
Vehicle sales continue to out-perform the forecasted revenue, although traffic infraction revenue is on a downward trend. Revenue stream is better than expected and going in the right direction.

Dolly encouraged the new members to join one or two of the TACs.

Meeting Adjourned at 1:54 pm.