Washington State Department of Health
EMS & Trauma Care Steering Committee
MEETING MINUTES
January 17, 2024
Meeting held virtually by ZOOM.

ATTENDEES:

Committee Members:

Carly Bean
Cameron Buck, MD
Tom Chavez
Christine Clutter
Bryan Fuhs
Madeleine Geraghty
Beki Hammonds
Mike Hilley
Joe Hoffman
Tim Hoover
Lance Jobe
David Likosky, MD
Shawn Maxwell
Denise McCurdy
Pat McMahon
Lila O'Mahony, MD
Brenda Nelson
Bryce Robinson, MD
Joey Rodrigues
Erik Roedel
Mark Taylor
Rick Utarnachitt, MD

DOH Staff:

Ian Corbridge
Eric Dean
Xinyao Degrauw
Herbie Duber
Nicole Fernandus
Dawn Felt
Jim Jansen
Jennifer Landacre
Ihsan Mahdi
Matt Nelson
Jason Norris
Tim Orcutt
Jeffry Sinanian
Adam Rovang
Sarah Studebaker
Erika Stufflebeem
Scott Williams

Guests:

Trixie Anderson
Patrick Bi
April Borbon
Melanie Brandt
Shelley Briggs
Sarah Brouwer
Cindy Button
Diana Clinch
Rinita Cook
Michelle Corral
Sarah Downen
Janna Finley
Dawn Fritts
Rashi Gupta
Daielle Huddleston
Paul Inouye
Tristan Jafari
Claire Johnson
Ryan Keay
Sandra Kellso
Karen Kettner
David Lynde
Betony Martin
Jae McGinley
Chris Montera
Carolynn Morris
Brook Moser
Jim Nania, MD
Jamison Nielson
Kayla Nored
Mary Ohare
Norma Pancake
Kelly Pearson
Greg Perry
K Will Pierce
Wendy Rife
Randi Riesenberg
Wendy Rife. Sanders
Paulesh Shah
Pat Songer
Becky Stermer
Courtney Stewart
Traci Stockwell
Cheryl Stromberg
Jason Taylor
Mike Tribble
Timothy Wade
Deborah Walker
Jet Washington
Marvin Wayne
Scott Williams
Deborah Woolard

Call to Order: Cameron Buck, MD, Chair

Minutes from November 15, 2023
Handout

Motion #1
Approve the November 15, 2023, EMS and Trauma Care Steering Committee meeting minutes. Approved unanimously.

Committee Vacancies: Dr. Buck

Dr. Timothy Bax from Spokane has announced his resignation from his position on the steering committee. Dr. Bax represented the American College of Surgeons. He was recently voted in as vice-chair of the committee. He has other priorities consuming his time, so the committee appreciates his work and effort not just recently but through the years.

The committee will discuss filling that position. There are two other positions that are vacant, one Washington State Fire Chief Association position and the public member position.

Dr. Shah, Secretary of Health at the department, has asked that the committee connect with the Community Collaborative to see if there might be someone from the collaborative who would be interested in filling the public position vacancy and participating in the committee. Community collaborative has members who are involved in many different sectors that uplift and support communities related to a variety of things but particularly healthcare. One of its priorities is to collaborate and advocate for people that are most impacted by health inequities.

The annual elections for the chair, the vice chair and the public member will take place in March. Mark Taylor is the chair of the nominating committee. Please email all nominations to Mark Taylor.

DOH Updates: Ian Corbridge, DOH

PowerPoint Presentation

The Office of Community Health Systems has been busy with legislative session. It is a short session, 60 days. It started on January 8 and ends on March 7.

A major focus for DOH is behavioral health and opioids. There were over 450 profiled bills, and DOH had reviewed over 160 different pieces of legislation. It is quite an active session for a short session.

The bills need to move forward out of origin, either the House or Senate. If they don't move by the cutoff date, February 13, they will likely not be moving on in this session.

Ian displayed the list of bills that have an EMS/Trauma focus, and the other bills that HSQA is tracking. The bills are on the internet at: Leg.wa.gov.

HB 1907/SB5940 - MA-EMT Certification is a piece of legislation that is being brought forward by the Washington State Hospital Association with an intended goal of creating a medical assistant EMS certification. It would allow currently licensed EMTs here in Washington to work in a hospital, under a defined scope of practice.

WSHAs intent around this bill is to address hospital staffing issues that healthcare has faced over the past couple of years. DOH provided input into the draft bill in advance of the session, to make sure that we were clear on the regulatory structure that we would need should the legislature look to enact the bill. Dawn Felt added that the bill also includes AE and paramedics, not just EMTs.

Dawn spoke about HB2166 – POLST/DNR Registry. The bill requires the department to establish an electronic POLST registry and alternatives to the forms, such as a bracelet and to develop standards for these requirements.

DOH Staffing Changes: Dawn Felt

Scott Williams has been hired as the regional EMS and Trauma Care liaison. DOH will be recruiting for the part time regional liaison position that Scott vacated when he moved into the new position.

Anthony Partridge's position, which was the trauma designation program administrator, was vacated when he moved to another position within DOH. Mariah Conduff has been hired into that position.

Catie is still in the acting role as the executive director for the emergency care system and Dawn is still in the acting role for the EMS program manager position.

EMS is recruiting to temporarily backfill Dawn's position as the EMS education and training consultant.

WEMSIS Rules: Jim Jansen, DOH

The rules are currently at the CR102 step. Jim and his team have gone through one round of review with a broader DOH review team, and based on feedback are providing some additional information.

The WEMSIS rules are a couple of weeks behind the EMS rules. We will know the public hearing date for WEMSIS rules in a couple of weeks and will inform stakeholders about the hearing.

Hospital TAC Report – Annual Report: Tim Orcutt DOH/ Mark Taylor, TAC Chair

The membership of Hospital TAC is all the participating designated trauma hospitals in the state. The TAC works on things related to the trauma designation program, trauma clinical care in general and the trauma registries.

There are 82 hospitals in the state that are trauma designated. Pediatric trauma hospitals are also designated, but only levels I – III.

Tim described the trauma designation process.

When hospitals need to redesignate, they apply for redesignation. Since COVID, DOH started a virtual designation process.

The level I through III hospitals receive a site visit, which includes DOH staff and contracted external surveyors.

During the site review DOH conducts a review of hospital policies, reviews documents, and meets with trauma leaders within the facility. The trauma staff discuss the strengths and weaknesses and some of the challenges they are having. Then the survey team makes their decision, and we begin drafting the final report.

The designation process is cyclical and starts annually on December 20, and it goes through mid-April when the team conducts the last facility site visit.

The virtual site review process was developed during the pandemic and is working exceptionally well. DOH is not currently planning to revert to in person site visits.

The question was asked if there was a cost or financial savings with the new designation process. Tim said that they are paying the surveyors a bit more, just because it was hard to get surveyors on board. But the agency is saving money because it's not paying for travel, hotels, etc.

Tim went on to share some strategic plan items that the TAC has been working on. The Hospital TAC serves as a resource to advise the steering committee and other healthcare partners on clinical and technical matters, taking time to answer clinical related questions. This is a standing agenda item. It's in the strategic plan because assuring consistent, updated, and contemporary clinical guidance is an important component of supporting the quality of care.

Some of the TAC accomplishments and key activities for 2023 were:

- Consulting on Trauma Registry
- WAC requirements and clarifications
- Trauma Clinical Guidelines
- Trauma Designation Review Process
- Trauma Triage Tool Updated

Another goal is to promote and enhance continuous quality improvement of trauma services for Washington. Our goal during the next plan cycle is to identify gaps to further inform the strategic plan and areas of focus.

Some successes have been in the TAC participation. Program managers and medical directors have found a way to participate in the TAC meetings. Another success has been the Prehospital Trauma Triage Tool update, and the establishment of the Trauma Registry Workgroup, as well as the trauma designation virtual review process.

Trauma Registry Report: Jim Jansen, DOH

The data that Jim is presenting is from 2019. It is the most recent data available. DOH has been struggling with this data challenge for a few years.

Jim explained what they are doing to support the trauma registry and bring data into the system. The state has been backlogged since 2020. The hospitals are currently entering data into the system under a security waiver from OCIO.

Jim said that DOH is looking to obtain funding from the legislature to replace the current registry system with one that is compliant with state security standards.

Right now, Jim and his team are resolving technical problems that hospitals have encountered while they try to submit data into the system, providing training for the hospitals on a new environment for the submission process.

Once the data reaches Jim and his team, they need to validate it, make sure records make sense, time fields go in order, and that there are no systematic errors that might be due to the problem with the data system itself or from the vendor platform. Also, Jim's team looks for and corrects entry errors, and resolves technical issues. They request those record corrections as they identify them. Then the goal is to finalize quarterly data sets.

The hospitals are submitting some backlog of records from 2020 and they are working a little faster to update more current, 2023 records. Better for everyone, better for the hospitals. Then the hospitals can use the registry information more readily for their own purposes and slowly build up that trend and back data from a few years ago.

Finally, Jim and his team will incorporate all the newly finalized data into their QI analysis and present it all to the committee.

The Research, Analysis and Data team (RAD) gets about 45,000 to 50,000 records a year into the trauma registry. They look at levels I and II and compare 2018 and 2019 which is the two most recent complete sets of data. They then look to see if they have equivalent or higher numbers of records in the system for the later years, 2020 through 2023. Levels I and II trauma centers are getting their data in at a good pace, but a few hospitals have more work to do. RAD is working one on one with them.

When they look at data at levels III – V, There a little more variability for 2020 through 2023. The numbers aren't quite matching up yet, to the previous years, 2018 and 2019. RAD will look at the data hospital by hospital.

Jim discussed how this situation arose. Issues were expected by the end of 2020, with the V5 collectors, the system that transfers records from the trauma registry platforms at the hospital to the trial register platform at the Department of Health servers. That system was based on Adobe Flash software. The technology was no longer supported by DOH. It lacked sufficient security standards and functionality. They needed to replace it with what ESO had, called the Gen 6 system. The hospitals were able to submit and enter their records into their localized data systems. What they couldn't do anymore was submit it to DOH, so the Gen 6 system is the answer to moving data from point A to point B.

RAD expected the transition to take about two weeks. On December 31, 2020, at midnight, they shut the system down. Delays in the transition extended to about March. IT staff at DOH discovered a gap in ESO security compliance. The system doesn't allow users to log in to the trauma registry through the Secure Access Washington System (SAW). That stopped RAD from continuing with the Gen 6 system from March 2021 to March 2022.

The option that RAD is still operating on is a waiver through the Office of Chief Information Officer (OCIO). Data collection resumed in November 2022. They put out a request for information (RFI) to various vendors and received four responses. That provided RAD with some cost and design information for what's available, beyond our current system.

Our office is working to draft a decision package for the 2025 legislative session to seek funding to replace the existing trauma registry system with a modernized solution. In April, assuming they are awarded funding from the legislature, RAD will begin a project initiation and planning phase. In July, funding would be released from the legislature. RAD will have their RFP developed by that time. They will release that RFP and start collecting responses. The timeframe to collect responses will be between July and October.

RAD has been in communication with the Chief Information Officer and they are supportive of this process. RAD would begin developing in July of 2026. By January 2027 RAD would have a modernized trauma registry solution in place.

When RAD is asked to provide data to partners and stakeholders, they put together a PowerPoint presentation, and schedule a time to walk through it. It's not an efficient or modern way to provide data on a regular basis to partners. What is really needed is a dashboard system, an automated reporting system, so that steering committee members and TAC members can look at the data that they are authorized to view. RAD could dig deeper, and better leverage the epidemiologist's time to look more in-depth at the data.

Trauma Service Statewide Analysis: Ian Corbridge & Jim Jansen

Ian started the conversation by noting that the department is pivoting and has developed an approach and next steps related to determining a method to identify the need and distribution of trauma services across the state.

Ian spent a few minutes reflecting on the work that has been done so far, acknowledging the challenges, setbacks, and uncertainties that we face. Our recent past work is a steppingstone and the work already accomplished will be leveraged as the foundation for the new approach we will talk with you about today. Ian's vision is for us to continue working to build an emergency care system that is resilient, allows for evolution and growth, and is predicated on our continued collaboration.

Since 2018 – the department has been engaged in evaluating our methods for determining the minimum and maximum number of levels I and II trauma designated centers in the state.
In 2019 we contracted with the American College of Surgeons to conduct a statewide assessment of the EMS & Trauma Care System with an emphasis on providing a methodology for how our state should determine the needs and distribution of trauma services across the state. The assessment provided some criteria for the state to consider but was inconclusive as to a defined methodology.

Between 2020 and 2021, the department implemented a moratorium on trauma designation while we worked to establish a method to determine the minimum/maximum numbers of trauma facilities across the state. The department convened a workgroup where criteria was proposed and discussed but unfortunately, we could not achieve consensus and it was determined that perhaps we could move towards solutions in a rulemaking setting.

The department conducted rulemaking with stakeholders towards the same goal and unfortunately were unable to achieve consensus during rulemaking. Following the public hearing on the proposed rules, the department rescinded the proposed rules and has reverted to the current rules in our regulations.

The department has determined that the next steps are to leverage existing authority and process in our laws, develop a statewide trauma service analysis that can be used to inform regional planning activities for recommending the need and distribution of trauma services around the state.

Jim Jansen and his team are leading the work in conducting the analysis and will advise you on what this work entails, our timeline, and how you can participate.

The department has determined that the next steps are to leverage existing authority and process in our laws, develop a statewide trauma service analysis that can be used to inform regional planning activities for recommending the need and distribution of trauma services around the state.

Jim stated that the analysis will be conducted and updated every two years. This will be done in alignment with the EMS & Trauma Care Regional planning cycle.

Leveraging an existing process, the analysis will be distributed to EMS & Trauma Care regions for them to use in their planning work. The councils will work together to make recommendations to the steering committee and the department for the minimum and maximum number of trauma services needed in their region. The region memorializes their planned work in the EMS & Trauma Care Plans.

Plans are reviewed by the steering committee for input and the department evaluates the recommendations and input and makes a final determination on approval for the plan. The analysis will better position DOH to support regional conversations around the need for trauma services in their communities. The assessment will include consensus driven criteria from the proposed rules.

The program plans to conduct 3 stakeholder engagement sessions throughout the development of the assessment including a kickoff, mid-project check-in and final product review.

This needs assessment will primarily be based on data analysis conducted by DOH staff using the Washington Trauma Registry and Washington EMS Information System. Other DOH and external data sources may be cited as applicable.

During the stakeholder kickoff meeting, DOH staff will present an initial set of key measures and datapoints for review and input from stakeholders to determine applicability of various measures for regional decision-making support and system assessment.

The assessment will include a geospatial analysis and reference map, identifying existing trauma facilities and access to care. Some of the factors to consider include time for initial and definitive patient care, injury severity, and outcomes (e.g. mortality, length of stay). A key goal of this assessment will be to identify areas of the state where gaps in trauma services may exist due to a lack of resources or other factors.

Once the analysis is completed, the department will provide it to the regions for their planning cycle.

Councils will develop their plans and work with their stakeholders to make recommendations for the min/max numbers.

Draft plans are submitted to the DOH for review and input then returned to councils for initial revisions. This cycle will continue until the plans reflect the data, information, collaboration, consensus, etc.

Updated draft plans are submitted to the EMSTC-SC members for review and input. Then returned to councils for second revisions. This cycle continues until the plans reflect the data, information, collaboration, consensus, etc. In preparation for further input.

Final draft plans are then reviewed by EMSTC for final input and recommendations and submitted to the department for final determination.

A body of work to support the regional councils will be forming alongside the work to conduct the analysis. Catie is leading the work with the regional councils.

The department has determined that the next steps are to leverage existing authority and process in our laws, develop a statewide trauma service analysis that can be used to inform regional planning activities for recommending the need and distribution of trauma services around the state.

Why OUTCOMES TAC as forum? How will others be notified to attend?
Outcomes TAC has been identified as the most appropriate forum for stakeholder meetings. Outcomes is focused on data analysis, system outcomes and measurement and has a heavy data focus.

The TAC also has a broad membership of stakeholders from across the emergency care system. It is likely that this work will expand in the future to encompass other areas of the emergency care system. The Outcomes TAC is best suited to provide input on system-wide data efforts such as this.

Meetings will be open to all, and communications will go out to all TACs and the EMS and Trauma Steering Committee to announce project updates and meeting information.

Previous Min/Max workgroup members are also invited to attend and encouraged to participate in this effort.

Outcomes TAC meetings will be rescheduled or extended to accommodate these discussions. Announcements of the schedule will be communicated broadly.

EMS Rules – Overview of Proposed Rules & Next Steps – Dawn Felt

Chapter 18.71 RCW requires the department to prescribe minimum standards for initial and ongoing training and certification for advanced emergency medical technician and paramedic level providers. The law defines medical program director and identifies minimum qualifications of an EMS medical program director.

Chapter 18.73 RCW requires the department to prescribe minimum requirements for licensed ambulance and aid services including vehicle standards, communication equipment, and medical equipment. The law also requires the department to prescribe minimum standards for initial and ongoing training and certification for emergency medical responder and EMT level providers. The law requires the department to develop minimum standards and approval processes for EMS training programs and instructors and to certify EMS medical program directors.

Chapter 70.168 RCW requires the department to establish minimum standards for verified prehospital care services including equipment and personnel, prehospital patient care protocols, and regional patient care procedures. The law requires the department to designate emergency medical services and trauma care planning regions and establish the minimum and maximum

number of prehospital providers in the state and within each region that may provide verified trauma care in accordance with regional plans.

Chapter WAC 246-976 establishes rules in topic areas listed:

- Training
- Certification
- Licensure and Verification
- Trauma Registry
- Designation of Trauma Care Facilities
- System Administration
    - Regional QI
    - MPD
    - EMSTC-SC
    - Regional/Local EMS Councils

Dawn explained why they did rulemaking. The primary purpose of this rulemaking was to modernize rules to align our state standards with current national standards, clarify scope of practice for EMS providers, reduce barriers to certification, and address problematic areas that they routinely receive complaints about, and address new legislative requirements. It was also the goal to make the rules clearer, concise, and organized.

Another reason for rulemaking is to keep up with the evolution of EMS practice.
National codified foundation for EMS profession which serves as the floor for all state standards in EMS. The purpose is to support a consistent approach to EMS across the nation, evidence-based practice.

1. Stakeholders complain about how difficult it is to find and understand our standards, and sometimes must review multiple rules to understand one standard or topic.
2. Keep regulations current with national practice.
3. Over last 10 years, significant evolution of practice - expanded scope of environment, skills and procedures EMS can perform
4. Stakeholders complain that it takes a long time to get certified.
    1. Reduce requirements for assessment examination if person holds current NREMT or cert from another state
    2. Reduce requirement for paramedic to have attended an accredited paramedic program
5. Reduced requirements for someone to apply for an EMS instructor certification
6. Update EMS service licensing standards:
    1. Staffing standards to include NMTD, and make staffing standards for both verified and licensed services consistent
    2. Codify ESSO recognition and establish standards
    3. Add equipment / personnel standards for ground critical care ambulances consistent with air medical services who do that same body of work
7. MPD roles and responsibilities scattered across the entire chapter. Moved all into MPD WAC, added and clarified language

1. Allow to request training files from providers
2. Clarify what policies must have / maintain (Controlled substances, MPDD, Integration policy, QI policy)
3. Clarify and allow MPDs to have access to WEMSIS data for services under their purview
4. Clarify qualifications and process for appointing MPDs

8. Clarify roles of regional councils
    1. Reduce signature requirements on certain EMS applications for local / regional councils
    2. Clarify roles and work required

Dawn briefly went through each legislation that has passed from 2018 through this most recent session. There is still some implementation work to do on each of them.

TAC Reports:

Hospital TAC: Mark Taylor
The Hospital TAC met this morning from 8:00 to 9:00 am. Mark thanked and recognized Anthony Partridge who served as the administrator for the Hospital TAC. Most of the meeting was spent on the history of the trauma registry challenges that they have experienced over the last 3+ years, and their plans to move forward including solving the platform challenges moving forward. They especially want to solve the security challenges with the current vendor.

Prehospital TAC:
The last PHTAC meeting was held on October 18. They discussed topics such as EMS and Naloxone. There was a presentation on the EMS innovations project with the Greater Columbia Accountable Community of Health. The next meeting will be held in the first quarter of 2024.

ECS TAC: Matt Nelson
The TAC met last night, discussing the new federal performance measures that were released just this past October. It was nice to finally have a look at those finalized measures that they have been waiting for. Several new measures focused on pediatric readiness and disaster preparedness at both the hospital and the MS agency level.

Outcomes TAC:
Outcomings TAC held their joint meeting with the Hospital TAC on January 4. The TAC heard the draft Hospital TAC report, and they heard the TAC report a detailed trauma summary update as well as plans for the statewide trauma service needs assessment. The next Outcomes TAC meeting is scheduled for February 15 at 10 am.

MPD TAC:
MPDs met for their quarterly meeting on November 7. Dr. Tao Kwan-Gett, Dr. Duber and Chelsea Porter from the DOH Opioid Task Force presented information about Naloxone Leave Behind Programs. The DOH also garnered input from MPDs on incentives for recruitment and retention of MPDs. Their next meeting will be scheduled for the first quarter of 2024.

IVP TAC:
They had a good 2023 with their meetings. The TAC had robust attendance, usually over 50 people. A lot of their focus was on fall prevention. The TAC's last meeting in December, they heard from the Washington Pison Control group. Their next meeting is on March 6.

Rehab TAC: Chris Clutter
The Rehab TAC has not met since the last steering committee meeting but are planning a meeting on January 25. The primary focus will be on data related to UTI's, and also updating the strategic plan.

Cost TAC update: Eric Dean
We spent less state dollars on trauma supplemental Medicaid last biennium due to an increased federal matching rate. Per Cost TAC direction, part of the amount of unspent state funds carried forward into this biennium will be used to restore funding cut from DOH direct pass-through payments to trauma providers. So, providers should see larger pass-through payments this year than what is reflected on the approved spending plan.

RAC TAC: Carly Bean
The RAC TAC met yesterday with an excellent presentation on systems design and the benefits of regionalized EMS and trauma care systems. It was a very educational start to the meeting. It continued with information about the prehospital trauma triage and destination updates and the statewide assessment for needs and distribution of trauma designated facilities.

Pediatric TAC: Matt Nelson
Pediatric TAC meets directly after the steering committee meeting. Agenda items include an update for EMS for Children Project. The TAC had their new performance measures released this past summer, and they haven't had the opportunity to do an in-depth review as their last meeting in September was cancelled. There are several new measures, and the TAC is looking forward to having a discussion today to see what kind of work will result from the measures for the TAC.

Dr. Buck thanked Catie and Ian for supporting the committee and he also thanked the presenters.

The meeting adjourned at 12:15 pm.