Statewide Trauma Advisory Council (STAC)

Wednesday, October 7th, 2009

Sheraton Madison Hotel, 706 John Nolen Drive, Madison, WI

13:00pm - 14:30pm

AGENDA

1)	Welcome/Introductions, Agenda Review	Cecile D'Huyvetter (chair)
2)	Review/Approval of June 2009 Meeting Minutes (STAC)	Jeff Grimm (secretary)
3)	Sub-committee reports:	
	a) Trauma Coordinators	Cheryl Paar (chair)
	b) Regional Trauma Advisory Council (RTAC) Coordinators	Dan Diamon (chair)
	c) Designation Review Committee (DRC)	Nirav Patel (chair)
	d) Data Systems	Annette Bertelson (chair)
	e) Trauma Systems Management	Cecile D'Huyvetter (chair)
4)	State Trauma Coordinator Update	Connie Rigdon
5)	New Business to be added for action at next meeting	
6)	Next Meeting – Wednesday, December 2, 2009	

2009 OCTOBER STATEWIDE TRAUMA SYSTEM MEETING SCHEDULE

The next Trauma System Meetings are scheduled for Wednesday, October 7th 2009 at the Sheraton Hotel in Madison, Wisconsin. Questions related to the times or agenda items for the meetings should be directed to the State Trauma Coordinator, Connie Rigdon at (608) 266-0601 or connie.rigdon@dhs.wisconsin.gov.

Time	**Room #1 (Ballroom upstairs)**		**Time**	**Room #2 (Reflections D)**
08-09			08-09	Data Systems – (Trauma Registry) Chair - Annette Bertelsen *Meeting is open to the public*
09:00 10:00	Trauma Coordinators/Registrars (TC/R) Chair – Cheryl Paar *Meeting is open to the public*		09-10	
10-11	TC/R follow up – training, mentoring and networking session, Chair – Cheryl Paar *Meeting is open to the public*		10- 1130	Designation Review Committee (DRC) Chair – Nirav Patel *This is a closed session and is not open to the public* ▪ 3 site reviews (Sept) ▪ 2 potential – 6 month follow-ups ▪ Admin issues: MOA, SOG, etc
11:00 1130	Hot Topic – Discussion: H1N1 We will have a quick update related to H1N1 efforts and have an open discussion with representatives from the state.			
1130- 1300	Trauma Systems Management Chair: Cecile D'Huyvetter *Meeting is open to the public*		1130- 1230	
1300- 1430	Statewide Trauma Advisory Council (STAC) Chair: Cecile D'Huyvetter *Meeting is open to the public*		1230- 1330	Open – no meetings scheduled

STAC Data Management Subcommittee
Agenda
October 7, 2009

- Update on Registry contract- Connie Rigdon
- Review of current regional PI reporting ability
- Review of current regional PI results
- Start reviewing indicator definitions
- New Business

Trauma Systems Sub -- Committee

October 7th, 2009

Sheraton Madison Hotel, 706 John Nolen Drive, Madison, WI

11:30 – 12:30

Agenda Items

1. Approval of June minutes
2. Budget update – Connie Rigdon
   a. Trauma budget not cut by 5%
      i. Status Quo except for 1% cut in RTAC budget
      ii. RTAC budgets cut to 49,500, final funds have not yet been allocated
3. State of WI Trauma System evolvement – Eric Wendorf
   a. Legal impact of opening DHFS 118
   b. Impact of STAC recommendations
4. State of WI Triage and Transfer Guidelines
   a. Review, amend as needed, approve
   b. Forward to STAC meeting for final approval
5. Standard Operating Guidelines Draft (See attached)
   a. Review, amend as needed, approve
6. Leadership discussion
7. Next meeting – December 2nd, 2009

TRAUMA SYSTEMS MANAGEMENT SUB COMMITTEE

Standard Operating Guidelines

A **Mission Statement**:

The mission of the State Trauma Systems Management Subcommittee is to develop components and make recommendations regarding strategies and the objectives of the state trauma system goals as directed by the State Trauma Advisory Council (STAC).

B **Membership:**

1 Representation to preferentially include:

a) Minimum of 1 voting member of the STAC shall serve on each committee with 60% attendance requirement

b) RTAC Coordinators subcommittee

c) Trauma Coordinators/Registrar subcommittee

d) Data Systems subcommittee

e) Hospital Designation Review subcommittee

f) Administrative member of the Department of Health Services

g) Stakeholders actively involved in Wisconsin Trauma System who which to participate

2 Terms of Membership**:** No defined terms for general membership

C **Leadership:**

1 The Chair, vice-chair, and secretary shall be elected by the Trauma Systems Management subcommittee membership and approved by STAC.

2 **Terms:**

a) Elected every three years

b) Vice chair assumes chair role at end of term

3 **Responsibilities:**

a) STAC Trauma Systems Management committee discusses and makes recommendations to STAC on issues related to the Wisconsin's Statewide Trauma Care System.

b) The chair or vice-chair shall preside over each meeting

c) Set agenda based on directives from STAC and forward to State trauma System coordinator for posting on website at least 2 weeks prior to scheduled meeting

d) A short verbal report shall be given at each STAC meeting and meeting minutes shall be forwarded to the STAC secretary within 7 days after committee meeting

D **Voting privileges**:

1. Each attending member shall be entitled to one vote.

E **Conflict of Interest:**

1. All sub-committee and ad hoc members of STAC are held to this same standard

    a) Members shall exercise good faith in all transactions touching upon their duties to STAC. In their dealings with and on behalf of STAC, members are each held to rule of honest and fair dealings between themselves and STAC. They shall not use their positions as members or knowledge gained, to advance their personal benefit and to the detriment of STAC. Any member having a conflict of interest on a matter shall disclose such interest and abstain from voting as appropriate.

F **Conduct of Meetings**

1. Agendas will include the opportunity for General Public comments and participation.
2. Any committee member or the Department of Health Services may request additional virtual/in person meetings as needed.
3. Robert's Rule of Order will determine the code of conduct of the subcommittee meetings.

G **Meeting Times, Frequency, and Location to be determined by DHS**

1. Trauma Systems Management committee will meet at a minimum of 4 times a year.
2. Meetings shall be held at a site secured by the Department of Health Services.
3. Necessity may include holding a minimum of two meetings in various locations throughout the state in order to increase participation from those who travel a great distance.

H **Notification**

1. Written notice of Trauma Systems Management committee meetings and agendas shall be given to the members at least 2 weeks prior to the date of the meeting. The date, time and place shall be specified. Written notice of STAC meetings shall also be available per the State EMS Web page. The Bureau will make all attempts to have Trauma Systems Management committee meetings set up one year in advance for scheduling purposes.

I **Council Members interaction with the legislature**

1. STAC members can answer questions as trauma experts and private citizens, but not as representatives of STAC. If legislators desire STAC input, they should request it through DHS, since the Council is advisory to the Department.
2. All sub-committee and ad hoc members of STAC are held to the same standard

J **Maintain close interrelationships with STAC and trauma care stakeholders**

Trauma Systems Management Committee 2009 – 2010

Responsibilities delineated by STAC through Strategic Plan

GOAL 1: Secure Sustained Funding, To Support All Functions Of The State Trauma System.

Objectives	Strategies	Responsibility	Timeline
Develop a committee to investigate and make recommendations for consistent / stable funding	Assign to existing sub committee	Trauma systems management	Ongoing
Identify and recruit legislative support	Develop talking points to present to legislative champions and trauma stakeholder lobbyists	Trauma systems management	June 2009

GOAL 2: Build the Wisconsin Trauma Care infrastructure.

Objectives	Strategies	Responsibility	Timeline
Review, maintain, and implement applicable national trauma system regulations	Incorporate new guidelines into Triage & Transport guideline review	Trauma systems management Final approval STAC Implementation DHS	
	Review and alter current administrative rules to be representative of current and future system development	Data systems sub committee	2009 -- 2010
2011 – 2015 Trauma System Strategic Plan	Identify goals	STAC	September 2009
	Identify objectives & strategies	Trauma systems management	March 2010

GOAL 6: Coordinated System Development Through Effective Direction To And Involvement From STAC Sub-Committees & DHS

Objectives	Strategies	Timeline
Coordinated system development	Report of ongoing development at each STAC meeting	Starting in April 2009
Regional Performance Improvement	Consider/develop potential RTAC objectives	February annually

State of Wisconsin Trauma Coordinators

Meeting Date and Time: October 7, 2009

Sheraton, John Nolen Drive Madison WI

10:00-11:00 a.m. Trauma Coordinators/Registrars Meeting
11:30-12:30 a.m. Educational Hour – Trauma Coordinator Orientation DVD – Stephanie (Sutton) Carter

AGENDA:

TOPIC	DISCUSSION (Main Purpose)	ACTION/DECISIONS
Introductions- 2 minutes		
Educational Opportunities-2 minutes	Sharing of Educational opportunities in the state and across the nation Update for 2009 and 2010 Please send additions to paar.cheryl@mayo.edu	
Update Trauma Coordinator Contact List- 1 minute	Review listing and add new members	
List serve update- 5 minutes		
Updates from the State- 15 minutes • Registry – Registrar training on updates • State Website • Security Access for Registry • Charging for Trauma Activations by Hospitals		

State of Wisconsin Trauma Coordinators

• Other Items		
Goals 2009-10 minutes	Review and update	
Establish goals for Registrars – 10 min		
State Trauma Coordintaor Survey Update - 5 minutes		
State Trauma Coordinator Subcommittee Vice Chair Election – 10 min		
RTAC Update – 5 min minutes		
Site visit sharing- 5 min minutes		
Open forum-		
Next meeting: **December 2, 2009**		
Adjourn		

STATE OF WISCONSIN
TRAUMA CARE SYSTEM
FACILITY CLASSIFICATION[1] PROCESS

Constituents:

1. Designation Review Committee (DRC)
2. Site Visit Team members (appointed by the State)
3. State of Wisconsin (identified in DHS 118 as the Lead Agency)
4. Hospitals requesting designation by the State as a level III or IV Trauma Care Facility
5. Statewide Trauma Advisory Council (STAC)

Purpose:

1. Support and maintain the classification process for level III and IV trauma care facilities within the State of Wisconsin as defined in HFS 118.
2. Identification of trauma systems issues and concerns within the State of Wisconsin and in particular, issues related to the classification process to STAC.
3. To advise and recommend resolutions and/or solutions to identified issues and concerns to STAC.

Key Outcomes:

- Designated level III and IV trauma care facilities throughout the State of Wisconsin meet essential criteria related to care of the trauma patient in accordance with DHS 118.

[1] HFS 118.03 (6) defines classification as the process whereby a hospital identifies its service level as a trauma care facility and the department reviews and approves the hospital as a provider of a level of trauma care services to meet the needs of the severely injured patient. This process is also referred to as the designation review or site review process.

DRC Committee Responsibilities in the Classification Process:

1. Committee members will adhere to the approved Standard Operating Procedures/Guidelines.
2. Provide appropriate documentation to the lead agency related to all meeting activities (minutes, final documents, etc).
3. Forward recommendations for changes/improvements/issues to STAC.
4. Maintain close communication with the representative of the Lead Agency (Trauma Coordinator).
5. Mentoring and/or communication to trauma care facility post visit regarding resolution of any identified criteria deficiencies as needed.

Site Visit Team Members Responsibilities in the Classification Process:

1. Execute (sign) a Memorandum of Agreement (MOA) with the State of Wisconsin.
2. Maintain clinical and behavioral skills/competencies/expectations as identified/outlined in the MOA and the Standard Operating Guidelines (SOG).
3. Avoid activities or behaviors that would/could be considered a conflict of interest or would reflect negatively on the state.
   a. Members shall not use their positions as members or knowledge gained, to advance their personal benefit and to the detriment of the state or the DRC.
   b. Maintain strict confidentiality of facility information and reviews.
   c. Any member having a conflict of interest on a matter shall disclose such interest and abstain from voting as appropriate.
4. Complete and forward all documentation/paperwork within the established time frame.
5. Site visit team members shall exercise good faith in all transactions touching upon their duties to the classification process. In their dealings with and on behalf of the state and the DRC, members are each held to rule of honest and fair dealings between themselves and DRC.
6. Support the agreed upon standard for site review teams:
   a. Level III Trauma Care Facility: board certified/eligible surgeon and an RN.
   b. Level IV Trauma Care Facility: board certified/eligible physician and RN and/or 2 RNs.
   c. Composition may be altered at the discretion of Designation Review Committee, in conjunction with the Lead Agency to accommodate process and facility needs/requests.
   d. Lead Agency reserves the right to use external/extra reviewers.
   e. Lead Agency reserves the right to discontinue the services of any individual site visit team member in accordance with the process outlined in the MOA.

Lead Agency/Department Responsibilities in the Classification Process:

1. Provide/maintain budgetary support for the classification process, including but not limited to:
   a) Processes and systems that support the timeliness of payment for site reviewers.
   b) Financial support for any needed education/training for site reviewers.
   c) Financial support for DRC conference calls/meetings.
2. Provide/maintain administrative support for the classification process and the DRC including, but not limited to:
   a) Creation of documents that support the process (forms, MOAs, etc).
   b) Appointment of site reviewers.
   c) Tracking and monitoring of site reviewer feedback including peer review and feedback from hospital staff.
   d) Administrative support to DRC officers.
3. Establish and maintain a plan to support the cyclical review of trauma facilities.
   a) Cyclical reviews will occur on a 3 year (calendar year) facility review order and schedule, finalized by the first quarter of the preceding fiscal year.
   b) Maintain communication/notification with/to the facilities undergoing review:

i. Whenever possible, communication will occur electronically with a record maintained by the Lead Agency. Communications will be timely with an appropriate amount of lead time for the facility to prepare.
ii. Once the cyclical calendar is established and site review dates are finalized, there will be a communication to each affected facility regarding their planned site review date, the process and directions for accessing any required forms.
iii. Three months prior to the scheduled site notification: CEO, Trauma Program Manager and/or Trauma Coordinator.

c) Maintain communication/notification with/to the individual site reviewers:
d) Forward preview packet from hospital to site reviewers two weeks prior to visit (electronically as possible).
e) Forward copy of designation review report to DRC members within 10 days of receipt (electronically whenever possible).

4. Review and approve reports and recommendations from the DRC regarding the designation level for specific facilities and submit final report to respective facility within 7 calendar days of receipt of final documents from the DRC Secretary/designee.
5. Maintain accuracy and concurrency of any/all websites related to the classification process.
6. Maintain a permanent copy of all documents related to the site review process.

Hospital/Facility Responsibilities:

1. Preparation for site review process:
   a. Review the required materials for completion required for their site review several months prior to scheduled visit (electronically downloaded from web site whenever possible).
   b. Submission of fully completed, pre-review documents one month prior to facility visit through the identified electronic process (electronically whenever possible).
   c. Have all requested resources and information readily available for the site review team at the time of classification visit.
2. Financial support for the classification process:
   a. Costs associated with preparations, submission of application and actual day of the visit are the sole responsibility of the applicant hospital.
3. Submit post-review visit evaluation to the representative of the Lead Agency (electronically when available).
4. Any issues/concerns with site team members or the DRC findings, should be communicated in writing to the representative of the Lead Agency (State Trauma Coordinator).

STAC Responsibilities in the Classification Process:

1. Oversight committee for the DRC.
2. Review of recommendations from the DRC for potential approval and advisement to the state including the development of policies, procedures and processes associated with the designation review process.
3. Review of recommendations from the DRC for potential approval by the state for the approval of site review team reviewers.

DESIGNATION REVIEW COMMITTEE STANDARD OPERATING GUIDELINES

Purpose:

1. Ensure compliance of trauma care facilities within the state of Wisconsin with minimal/ essential requirements for appropriate designation level via facility site review reports.
2. Recommend action regarding designation to Department of Health Services.
3. Reviewer and process, evaluation/compliance.
4. On-going designation process development, reviewer updates.

Membership:

1. Ten site reviewers with non-voting chair (minimum 40% physician).

Appointment:

1. At the discretion of the Lead Agency (currently titled the Division of Public Health, Bureau of Communicable Diseases and Emergency Response).
2. New member appointment as needed by the Lead Agency at the recommendation of the DRC as needed to maintain a 10 member committee.
3. Lead Agency has right to terminate membership at any time during the active term.

Voting Privileges:

1. Each member shall be entitled to one vote.
2. A committee member may not request a proxy to serve in his or her position on DRC.
3. Committee member may abstain from vote or discussion of trauma facility is in their participating RTAC or potential conflict of interest.
4. Lead Agency representative (State Trauma Coordinator) is a non voting member.

Attendance requirement:

1. A minimum of 60% of virtual and/or face to face meetings.

Quorum:

1. 50% of active/voting membership (5 members with a minimum of 2 physicians).
2. Meetings will be conducted in accordance with Robert's Rules. Meetings will be open to all officially appointed state reviewers, except during the portion when personnel issues are discussed.
3. Meeting agenda will be posted/forwarded electronically one week prior to meeting

Officers:

1. Chair, Vice Chair and Secretary elected by the DRC membership and approved by the Department of Health Services
2. Term: 2 years
3. An officer shall preside over each DRC meeting and communicate with the appropriate personnel at the Lead Agency review schedule and outcomes. An update of committee activities will also be given at each STAC meeting.

Resignation:

1. Member may resign by giving written notice to the DRC Chair and the Lead Agency, to be effective one month after receipt.

Vacancies:

1. Interested individuals shall submit a resume/CV, letter of intent along with a letter of recommendation to the Lead Agency/State Trauma Coordinator who will forward to the DRC Chair or their designee.

Conduct:

1. Members shall exercise good faith in all transactions touching upon their duties to DRC. In their dealings with and on behalf of DRC, members are each held to rule of honest and fair dealings between themselves and DRC.
2. Members shall not use their positions as members or knowledge gained, to advance their personal benefit and to the detriment of DRC and must maintain confidentiality of facility information and reviews.
3. Any member having a conflict of interest on a matter shall disclose such interest and abstain from voting as appropriate

Reporting Structure:

1. The DRC results of site reviews and committee work makes recommendations directly to the Lead Agency representative (State Trauma Coordinator).
2. The DRC is a sub committee of STAC and also generates a report for that Committee that includes general progress, issue identification, and recommendations.

Commitment:

1. Sign up for a minimum of four site reviews per year.
2. Sign up for reviews in a timely manner (within 6 weeks of schedule being available).
3. Reviewers will abstain from participating in reviews that are within their individual Regional Trauma Advisory Council (RTAC) or in arenas where personal, political or financial conflicts of interest arise.
4. Attend open DRC meetings where reviews are discussed when requested to do so.
5. Attend training sessions as requested or required.

Evaluation:

1. Annual review: peer and reviewed facility.
2. Evaluation, however, may also occur ad hoc at the discretion of the Designation Review Committee/Lead Agency for the State of Wisconsin.

Resignation:

1. Any sight reviewer may resign by giving written notice to the DRC Chair and the Lead Agency to be effective one month after receipt.

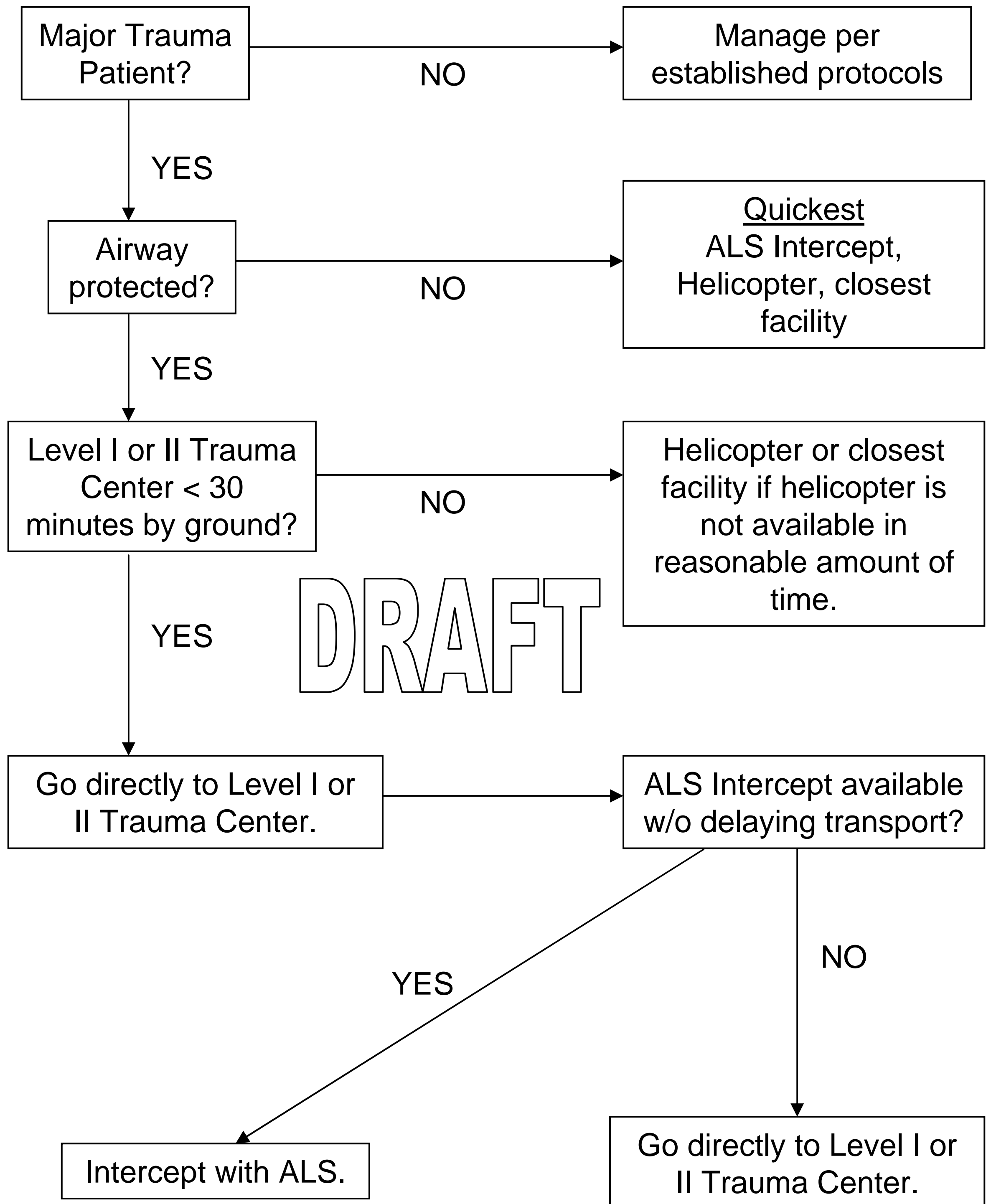
Vacancies:

1. Interested individuals shall submit a resume/CV, letter of intent along with a letter of recommendation to the Lead Agency /State Trauma Coordinator and DRC Chair.

Compensation:

1. Flat fee, equal amongst reviewers as defined in the MOA.
2. Reviewer will be responsible for submitting the supplied compensation form to State Trauma Coordinator/Lead Agency per established protocol.
3. Compensation will be subject to timely completion and in required format.

Trauma Destination/ Transport Guidelines



State of Wisconsin
Emergency Medical Services

Sample Medical Guidelines

Routine Trauma Care (Adult/Peds)

Note: This protocol may be used as a general guide for trauma in both Adults and Pediatrics.

Priorities	***Assessment Findings***
Chief Complaint	Various depending on incident.
OPQRST	Identify specific cause of traumatic injury
Associated Symptoms/ Pertinent Negatives	Significant mechanism, loss or altered level of consciousness, evidence of intoxicant use.
SAMPLE	Identify medical conditions that may have lead to the event (e.g. Alzheimer's, CVA, Diabetes, Seizures,)
Initial Exam – Rapid Trauma Assessment	Check ABCs and correct any immediate life threats. Manual C-spine stabilization. Perform rapid trauma assessment as appropriate.
Detailed Focused Exam	**General Appearance:** Unresponsive, pale, diaphoretic? Signs of trauma? **HEENT:** PERRL? Pupils constricted or dilated? Discharge from ears or nose? **Lungs:** Signs of respiratory distress, hypoventilation, diminished or absent lung sounds? **Heart:** Rate and rhythm? Signs of hypoperfusion? **Abdomen:** Distended? Firm? Tender to palpation? **Neuro:** Loss of movement and/or sensation in extremities? Unresponsive? Focal deficits? **Skin:** Bleeding?
Goals of Therapy	Maintain ABCs, restore adequate respiration and circulation, reduce pain
Monitoring	BP, HR, RR, EKG, SpO_2.

EMERGENCY MEDICAL RESPONDER (EMR)

- Ensure "Scene Safety" and Body Substance Isolation (BSI)
- Determine need for additional resources (e.g. helicopters, additional ambulances, heavy rescue). *This may be done prior to arrival on the scene based on dispatch information / local response guidelines.*
- Airway: Relieve airway obstruction, if present
  - Open the airway with a jaw-thrust (No head tilt-chin lift in trauma patients)
  - Remove foreign material, emesis and blood
  - Suction the airway
  - If no gag reflex consider oropharyngeal airway or nasopharyngeal airway (nasopharyngeal airway not recommended in facial or head trauma)
- Breathing:
  - Administer Oxygen
  - Assist ventilations with bag-valve-mask and high-flow oxygen, as needed
  - Cover open / sucking chest wounds with a three-sided flap valve

- Circulation:
  - Control external hemorrhage with direct pressure or pressure points.
  - If the patient arrests,
    - Re-assess the airway and oxygen delivery
    - Consider initiating the *Cardiac Arrest Guidelines*.
    - Prolonged efforts to restore spontaneous circulation in a traumatic arrest should not be made
    - CPR should not be attempted if:
      - Blunt trauma caused the arrest
      - There are other injured survivors with urgent needs for help
- C-Spine: Manual stabilization, spinal immobilization as indicated/authorized.
- Splint obvious extremity fractures
- Refer to *Pain Management Guidelines*
- Begin other interventions as needed according to specific guidelines

EMERGENCY MEDICAL TECHNICIAN (EMT)

- If there is ALOC
  - Check Blood Glucose
  - Follow *Hypoglycemia Guidelines* if < 60
- Spinal Immobilization, as indicated.
- Refer to the CDC "**Field Triage Decision Scheme: The National Trauma Triage Protocol"**

1. **MEASURE VITAL SIGNS AND LEVEL OF CONSCIOUSNESS:**
   - **i. If any of the following are present –**
     1. Glasgow Coma Scale of 14 or
     2. Systolic blood pressure <90 / *unable to palpate a radial/brachial pulse*
        - a. Infant < 2 years < 65 mmHg
        - b. Child 2 – 5 years < 70 mmHg
        - c. Child 6 – 12 years < 80 mmHg
     3. Respiratory rate <10 or >29
        - a. Pediatrics under 12: Less than 10 and greater than 60 breaths/minute
        - b. Infant 0-6mos <20; 6-12 mos <16
        - c. Ineffective breathing, grunting or stridor in a child
   - **ii. Take the patient to the highest level Trauma Center in region**

2. **ASSESS THE ANATOMY OF INJURY**:
   - **i. If any of the following injuries are identified --**
     1. All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee.
     2. Flail chest
     3. Two or more proximal long-bone fractures
     4. Crushed, de-gloved, or mangled extremities
     5. Amputation proximal to wrist and ankle
     6. Pelvic fractures
     7. Open or depressed skull fracture
     8. Paralysis
   - ii. **Take the patient to the highest level Trauma Center in region**

3. **ASSESS MECHANISM OF INJURY AND EVIDENCE OF HIGH-ENERGY IMPACT**.
   - **i. If any of the following are present –**
     1. Falls
        - a. Adults >20 ft. (1 story is equal to 10 ft.)
        - b. Children >10 ft. or 2-3 times the height of the child
     2. High risk auto crash
        - a. Intrusion >12 in. occupant site or >18 in. any site
        - b. Ejection (partial or complete) from automobile
        - c. Death in same passenger compartment
        - d. Vehicle telemetry consistent with high risk of injury

3. Auto v. Pedestrian/Bicyclist Thrown, Run Over, or with Significant (>20 MPH) Impact
4. Motorcycle Crash >20 MPH
5. Unrestrained pediatric pt

ii. **Transport to closest appropriate trauma center,** which depending on the trauma system, need not be the highest level trauma center

4. **ASSESS SPECIAL PATIENT OR SYSTEM CONSIDERATIONS.**

   i. **If any of the following are present –**

   1. Age:
      a. Older adults: Risk of injury death increases after age 55
      b. Children: Should be triaged preferentially to pediatric-capable trauma centers
   2. Anticoagulation and Bleeding Disorders
   3. Burns
      a. Without other trauma mechanism: Triage to burn facility
      b. With Trauma mechanism: Triage to trauma center
   4. Time-sensitive extremity injury
   5. End-stage renal disease requiring dialysis
   6. Pregnancy >20 weeks
   7. EMS provider judgment.

   ii. **Contact medical control; consider transport to a trauma center or specific resource hospital.**

   iii. **If none of the above criteria is present, transport according to protocol. When in doubt, transport to a trauma center!**

5. ***IF TRANSPORT TO A TRAUMA CENTER IS INDICATED,*** *consider air medical transport if:*

   i. The time to deliver critical or high-risk patients to definitive care (Trauma Center) can be reduced by air vs. ground transport.

   ii. Advanced treatments deemed necessary that are not available to ground EMS units (e.g. Rapid Sequence Induction (RSI) intubation or blood product administration).

   iii. Transport of the patient(s) by ground ambulance to the trauma center would leave the area without adequate EMS coverage.

ADVANCED EMT (AEMT)

- Initiate IV/IO (18ga or larger) NS, if approved.
- Consider 2nd IV/IO where hypovolemia is suspected (Adult only)
- (Adult) If SBP < 100 mmHg or heart rate > 120, initiate a fluid bolus of Normal Saline: 500 ml
- (Peds) {if approved for peds IV}
  - Infant – 6 months : If SBP < 60 mmHg initiate 20ml/Kg bolus
  - 6 months – 2 years : If SBP < 65 mmHg initiate 20ml/Kg bolus
  - 2 years – 5 years: If SBP <70 mmHg initiate 20ml/Kg bolus
  - 6 years – 12 years : If SBP < 80 mmHg initiate 20ml/Kg bolus

Contact Medical Control for the following:
- Additional fluid orders

INTERMEDIATE

- Respiratory arrest or apnea
  - Consider endotracheal intubation
- If tension pneumothorax is suspected perform needle decompression.
- Consider external jugular (EJ) IV if one cannot be established in the extremities.
- Consider intraosseous (IO) access if an EJ cannot be established.

Contact Medical Control for the following:

- Pain control

PARAMEDIC

- If the airway is obstructed or obstruction is imminent and 3 attempts to intubate the trachea have failed, perform surgical or needle cricothyroidotomy.
- Consider gastric decompression with nasogastric tube, unless contraindicated by facial trauma or skull fracture

Contact Medical Control for the following:

- Additional orders

Figure 1. Field Triage Decision Scheme