Washington State Department of Health
EMS & Trauma Care Steering Committee
MEETING MINUTES
September 20, 2023
Meeting held virtually by ZOOM.

ATTENDEES:

Committee Members:

Tim Bax
Carly Bean
Cameron Buck, MD
Tom Chavez
Christine Clutter
Brian Fuhs, MD
Madeleine Geraghty
Mike Hilley
Joe Hoffman, MD
Tim Hoover
David Likosky, MD
Shawn Maxwell
Denise McCurdy
Pat McMahon
Lila O'Mahony, MD
Brenda Nelson
Scott Phillips
Bryce Robinson, MD
Joey Rodrigues
Peter Rutherford
Mark Taylor
Rick Utarnachitt, MD

DOH Staff:

Eric Dean
Marla Emde
Dawn Felt
Dolly Fernandes
Nicole Fernandus
Catie Holstein
Jim Jansen
Jennifer Landacre
Ihsan Mahdi
Matt Nelson
John Nokes
Jason Norris
Tim Orcutt
Anthony Partridge
Jeff Sinanian
Sarah Studebaker
Hailey Thacker
Nate Weed

Guests:

Trixie Anderson
Nadja Baker
Katherine Bendickson
April Borbon
Steve Bowman
Shelley Briggs
Cheryl Burrows
Cindy Button
Christy Caldwell
Abigail Cole
Rinita Cook
Sarah Downen
Janna Finley
Allen Friend
Jenna Hannity
Crystal Hedrick
Danielle Huddleston
Barb Jensen
Claire Johnson
Scott Latimer
David Lynde
Betony Martin
Carolynn Morris
Jim Nania, MD
Mary Ohare
Norma Pancake
Kelly Pearson
Greg Perry
Scott Phillips
Randi Riesenberg
Wendy Rife
Paul Ross
Paul Shah
Jason Spencer
Beck Stermer
Traci Stockwell
Cheryl Stromberg
Timothy Wade
Deborah Walker
Jessica Wall

Call to Order: Cameron Buck, MD, Chair

Minutes from May 17, 2023
Handout

Motion #1
Approve the May, EMS and Trauma Care Steering Committee meeting minutes.

Approved unanimously.

DOH Updates: Ian Corbridge, DOH

Bill implementation and Legislative Session - Over the past several months, the Office of Community Health Systems (OCHS) has been focused on legislation implementation. There is a major focus hospital staffing legislation.

- **Rural Workforce Supports** – Preliminary budget proposal to support rural health care workforce ($2 million, 2024 session). This would further expand and emphasize some existing rural workforce support programs we have in place. This budget ask is intended to provide additional financial support to communities with the goal of growing talent with an emphasis on keeping them at their facilities.
- **Uniform Facilities Enforcement Framework** – A uniform approach to enforcement and expanding DOH enforcement tools (2024 session)

Cardiac & Stroke Report: Due to OFM soon.

Charity Care - Clarifying hospitals can't restrict charity care based on geographic restrictions.

CN Modernization – Exploring opportunities around CN modernization.

Enforcement - Leveraging data to move upstream and asked inspectors to assess ED staffing and impact on EMS.

Trauma Designation Rules, Ian

DOH submitted the CR102 for trauma designation after a great deal of stakeholder conversation. OCHS proposed a draft rule we felt best spoke to conversations we heard and set a path forward to best support a trauma system here in Washington State.

We received a lot of great input from the community in terms of their thoughts on the proposed rule. Also, many concerns surfaced across the community.

Some of the concerns were contradictory, one group of stakeholders indicated that they felt the rules were too broad and would allow more trauma designation than is needed in our state and another group felt the rules were too restrictive and would not allow for the broader expansion of trauma designation.

DOH continues to reflect on all the comments we have received, and we are thinking critically about our next steps. The agency has until December to make a formal decision on our proposed rule.

Dr. Buck asked Ian if there could be other scenarios other than the department and the secretary approving the draft rules.

Ian explained a few options might be:

- Agency leadership could choose to move forward with the proposed rule as written.
- Agency leadership could make modifications to the proposed rule. If the modifications are substantial in nature and change the intent or structure – the department would have to revise the CR101 and -102 and re-engage stakeholders to socialize the modifications.
- To withdrawal the CR-102 which would suspend the rulemaking process entirely and would mean we would revert to the current rules that stakeholders are functioning under.

One committee member asked what the most common concerns were raised about the rule. Ian said some of the comments:

- Were that the rules were too expansive, that it would allow for trauma facilities to be too close to one another, and that would create an underutilization of trauma facilities which would have a negative impact on our system.
- Were that the proposed rules were too restrictive and don't allow for further expansion of trauma services in our state to meet the needs of their community.
- Indicated this has been a difficult process and they feel like the proposed rules may help to move us forward as a state, but there was still too much concern within the communities.

EMS Rules: Catie Holstein, DOH

EMS rules were completed, and we submitted our CR102 package to our policy team in May. The DOH is working to complete the internal review. Afterwords, our policy team is submitting our CR102 package to the code revisor office and stakeholders will have access to the final draft of proposed rules.

Catie will email it out to them and place it on our website. Everyone will be able to comment on rules by mail, then a public hearing will be scheduled.

WEMSIS Rules: Jim Jansen, DOH
WEMSIS Rules are trailing along just slightly behind Catie's rules. We are working on our DOH review of our CR 102 documentation and we are hoping to complete it by the end of the month. Then we will move on to sending it to the code advisor and get the draft rules posted.

Trauma Registry: Jim Jansen, DOH

Good news for trauma registry. About 150,000 records have come into the system since we got the trauma registry back online under a waiver to allow us to continue despite being non-compliant with certain security standards at the state level.

Those 150,000 records are coming from 90% of trauma designated facilities. We are working with the remaining 10% to work through some technical issues with their being able to submit data to the system.

At the same time, we are working on validating the data as it's coming in. We typically do one quarter at a time of validation. Once we validate and finalize the data we can begin using the data; right now we have a three-year backlog, 2020-2021, 2021-2022, 2022-2023.

The validation process is somewhat lengthy. It involves going back to the hospital registrars to make corrections and identifying more systematic issues. We are dealing with a new system, and there are some systemic issues that may arise from how the system communicates.

RAD is working through the validation process and they are hoping to have the first quarter of 2020 available for analysis by the end of the year, and then work their way forward from there. In the meantime, they are also working on a long-term solution to the security compliance issues.

No matter what the solution is, it will cost money. We plan to seek funding to support a new registry system in the 2025 legislative session. Following that session, successful or not, we will go directly into the RFP process that spring. We are working on requirements right now for what it would look like. We've already received a response to a request for information from four different potential vendors.

We have a good idea of what capabilities exist externally and a good idea of what our requirements and needs are. We anticipate a fully functioning new system by 2027.

Cardiac and Stroke Study: Cameron Buck, MD

DOH is reviewing the report that was submitted by the University of Washington Team. It will involve some edits, revisions, re-formatting to conform to DOH publication standards. Then the report is due to the legislature by October 1st.

Matt Nelson, DOH, plans on sending the report out to the ECS TAC members and the steering committee members.

The summary of this report will identify some of the gaps in our current cardiac and stroke system of care and provide some recommendations for addressing these gaps. A lot of it will center around data infrastructure, QI standards, and hospital and EMS capacity challenges.

Dr. Buck encouraged members to review the report, and then take it to your organization and look at it as a potential steppingstone to seeking legislative support in 2025 to address these gaps.

Ian noted that the summary has gone to agency leadership. The process is moving forward. DOH has a huge amount of appreciation for the UW team who we worked with as a contractor.

Prehospital Trauma Triage Destination Procedure 2023 Update: Tim Orcutt, DOH

For three decades, the ACS has published a national guideline for the field triage of trauma patients which has been widely adopted by trauma systems in the United States to support decision making by EMS providers for the triage, transport, and destination determinations for injured patients. The goal has been to ensure that seriously injured patients are transported to the

most clinically appropriate trauma centers. The guideline helps to minimize variation in destination decisions to achieve optimal patient outcomes through transport to the most appropriate destination with the trauma system. Right patient, right place, right time.

Recent revisions have been made to the guideline because of new and updated research on field triage guidelines.

The process for ACS to revise the national guideline took 2 to 3 years, with a heavy focus on gathering EMS field provider input. The expert panel included EMS clinicians, emergency physicians, trauma surgeons, nurses, EMS medical directors, EMS educators, EMS & trauma system administrators, systems experts, & representatives from stakeholder organizations. The work included a literature review & criteria for adding/deleting/modifying the trauma triage criteria. A statistical process for adding or removing criteria was developed by experts in predictive analytics and guideline development. The addition and removal of criterion was guided by rigorous, consistent criteria including likelihood ratios and AUROC (Area Under the Receiver Characteristic Curve).

In consultation with several technical advisory committees and interested parties, the department has updated the state Prehospital Trauma Triage and Destination Procedure to reflect the changes in the updated national guideline.

Tim explained what is new in the procedure, what has been modified and what has been retained and is seeking steering committee input and recommendation for approval of the revised state procedure.

The department will begin working with stakeholders to orient them to the new tool, provide support to EMS, MPDs, Regional EMSTC councils by providing education and guidance. The revised procedure will be implemented by January 1, 2024.

Emergency Care System Strategic Plan Annual Report: DOH TAC Leaders

Catie started the discussion with a brief reminder of the mission and vision of the emergency care system. The goals of the strategic plan are written broadly so each technical advisory committee that works on each component of the plan can develop strategies and do work related to the goals. The strategic goals are related to:

- Access to care
- Public Health
- Prevention
- Quality Improvement
- Sustainable Funding

The emergency care system recognizes that there are challenges and priorities to our rapidly evolving health care systems, and we work to address them. We evaluate these goals every couple of years and update them accordingly. Following this introduction each technical

advisory committee will provide a summary of their work for this annual report up to the steering committee.

Cost TAC: Eric Dean, DOH

Strategies and outcomes for Cost TAC include:

- Explore use of data to focus on health equity issues. Our trauma epidemiologist is currently looking at the available data related to this strategy.
- In terms of strategies around emergency care system sustainability, our office and division leadership are aware of the decline in trauma care fund revenue. Our office is preparing an agency request legislative decision package that will be routed through the internal process at DOH – We hope it will go forward for the 2025 session.

Hospital TAC and Medical Director's TAC: Anthony Partridge

The Hospital TAC and the TMD TAC have accomplished 3 major strategic objectives this year, as well as making significant progress on continuous objectives.

- Ensure that the Washington Administrative Code pertaining to trauma care is current and appropriate – DOH is currently engaging stakeholders in rulemaking activities.

- Use Washington State Trauma Registry Data to improve and evaluate system effectiveness. The hospital TAC developed outcome and performance measures to evaluate the effectiveness of this component of the system.

- Review, evaluate, and make updates as needed to the decision tools for triage and transport. The Hospital TAC participated in the review and updating of the Prehospital Trauma Triage & Destination Procedure.

Injury and Violence Prevention TAC: Marla Emde

- Facilitate quarterly or semi-annual networking opportunities for the Regional IVP programs to allow for community engagement and coalition building. IVP TAC continues to facilitate these activities. Participation in the TAC has increased and the awareness of IVP programs across the state has improved through this work.

- Support regional and/or statewide IVP programs/public awareness campaigns which are data and outcome driven to reduce injuries or reduce 911 calls. This work includes successful implementation of falls prevention programs, hospital discharge packet programs, patient navigator programs, Naloxone distribution program and more.

- By the end of each state fiscal year, use relevant data to inform and adjust program planning and implementation. The program conducts yearly inventory of new and existing programs which leads to development and focuses on new partnership opportunities.

- Annually identify and develop key stakeholders and partnerships for the delivery of data driven community injury prevention programs with organizations such as MADD, Injury Prevention/violence Network, AARP, church groups and SafeKids to promote community awareness for injury prevention.

- Support trainings for stakeholders and partners. These include IVP TAC-sponsored trainings, webinars, Regional QI forums, falls coalition meetings, Trauma Nurse Trauma Registrar Network (TNTRN) meetings, Drowning Prevention Network, and other prevention-focused gatherings.

Outcomes TAC: Jim Jansen

The TAC has 5 objectives identified. The first three are longstanding objectives and are met by monitoring data reports provided to the steering committee on established cadences, conducting targeted studies with EMSTC partners and monitoring TQUIP performance.

- Ensure the EMS and trauma system move patients effectively through the system.
- Identify national benchmarks for trauma system and trauma (hospital) service performance.
- Identify national benchmarks for trauma system and trauma (hospital) service performance.

The next two were added within the last couple of years. The objectives are met through establishing and monitoring a set of statewide performance measures consisting of a few from each component of our emergency care system, and monitoring TQUIP performance. Also, our team is conducting a review and analysis of compliance with EMS triage and destination procedures for trauma, cardiac, and stroke.

- Develop a master plan for system performance improvement on the state and regional levels to implement and complete data-driven performance improvement initiatives.
- Ensure trauma, EMS, stroke, and cardiac quality improvement efforts are occurring both regionally and statewide.

Pediatric TAC: Matt Nelson

- Evaluate current statewide, regional, and facility level quality improvement programs, plans, and processes and make recommendations for improvement. The first strategic objective for the Pediatric TAC is quality improvement programs and involves not just the hospitals, but EMS as well. They are going to be launching not just in Washington state, but a nationwide EMS survey.

- Evaluate the feasibility of development and implementation of EMSC clinical guidelines. Pediatric interfacility transfer guidelines were updated.

- Monitor and provide subject matter expertise as needed to assist with work related to EMSC. Washington state was fortunate to receive a four-year grant which just started on April 1st. The Peds TAC will be reaching out and ensuring that the larger EMS agencies are working in collaboration with smaller hospitals and EMS agencies to ensure that work is being done at both levels and that kids have the same level of care as adults.

- Review and make recommendations to improve prehospital pediatric care as new evidence arises.

RAC TAC: Hailey Thacker

- The RAC TAC has several accomplishments on the objectives. They were able to sustain regional council membership post pandemic.

- They continue to improve the regional planning process to be more efficient and transparent. The TAC also continues to onboard and train new executive directors and chairs to educate them about our emergency care system and enhance communication between the DOH and the regions.

- The bulk of their work this year is continuing to support the executive directors in succession planning. They will create an executive director resource hub to promote collaboration on policies and procedures. The TAC will continue to standardize PCPs with the anticipated updates to the trauma triage tool.

Rehab TAC: Tim Orcutt

The TAC has three primary objectives that they have been working on.

- The first one is to increase awareness of the benefits of inpatient rehabilitative care following injury. This has been a long-standing objective for us. But Washington still lags compared to the nation when it comes to consulting rehab.

- The second objective is to use rehabilitation registry data to develop best practices, inform decision making, and aid in system analysis.

- Lastly, they continue to use rehabilitation registry data to develop best practices, inform decision making, and aid in system analysis.

Dr. Buck thanked the TACs for their work and reports and opened the floor for comments from committee members.

Joey Rodrigues suggested the Pediatric TAC consider adopting a strategy to develop guidance to help educate and standardize the use of car seats in ambulances during transport.

Prehospital TAC Annual Report: Catie Holstein, DOH EMS Director
PowerPoint Presentation

PHTAC is comprised of 23 members representing state EMS and fire associations, EMS physician medical program directors (MPDs), EMS & Trauma regional councils, Fire/EMS Chiefs of ground and air EMS services, training programs, instructors and EMS providers.

Shaughn Maxwell, who represents Washington State Fire Chief's Association on the Steering Committee is appointed by you as the PHTAC chairperson. We are grateful to Shaughn and the PHTAC members for their attendance, participation and input to the EMS component of our system.

Three areas we could improve our membership is to recruit E-911, a state level emergency preparedness representative, and Tribal EMS representative(s).

PHTAC meets four times per year. We will continue to meet virtually for the foreseeable future. In person meetings may resume at some point, but a virtual option will always be available.

There are six workgroups under PHTAC, each representing a specific aspect of EMS. Our strategic plan objectives are bundled in these workgroup areas. Last year we reported 16% completion. This year we report we have completed 30% of our strategic plan work. You can find our strategies and progress in the strategic plan report in your handouts.

EMS Data / WEMSIS

Accomplishments

- The WEMSIS team has developed additional data quality feedback tools for EMS services, including agency-level reports showing data submission quality and areas for improvement.
- As of January 2023, Key Performance Indicator reports are distributed quarterly to MPDs and Regional QI Directors. These reports provide information on how EMS services are performing in accordance with our statewide metrics. This report availability follows a year-long effort to revise KPIs in collaboration with stakeholders.
- The WEMSIS team expanded the use of WEMSIS data to monitor opioid and substance use, injury surveillance and various other purposes.
- linkages between WEMSIS and both hospitalization and Emergency Department data has been successful and continues to be refined. WEMSIS will begin working on a linkage to death records soon.
- A transition from NEMSIS Version 3.4 to Version 3.5 is well underway with most EMS services already reporting in Version 3.5. All reports should be in 3.5 by 2024.

Challenges:

- The WEMSIS team worked with EMS stakeholders to evaluate the feasibility of EMS integration with HIE and made the determination that there are too many limitations for its execution at this time. DOH continues to monitor the project for funding availability and feasibility.
- With increased usability and data quality an increase in demand for data is also occurring. The team is always working to improve efficiency to meet this demand.
- Last, data quality and standardization continue to be a limiting factor for analysis and use of WEMSIS data, though drastic improvements in the past few years have dramatically increased our ability to use WEMSIS data.

EMS Preparedness

Accomplishments

- Our EMS staff here at DOH have been working with EMS stakeholders, regional healthcare coalitions, and the DOH Office of Health Resiliency and Security on a final draft of a statewide patient movement plan. The plan describes the main components of the public health and medical system that would be involved in a large-scale patient movement, and the states strategic approach to how the system components would respond and coordinate activities.

Challenges

- Challenges with providing EMS situational awareness to state level partners during surge events and disasters.
- Challenges in finding resources to conduct long distance inter-facility transports and stage ambulances at hospitals.
- We expect to hear an increase in concerns regarding EMS to ED off loading delays, hospital divert of ambulances as flu season gets under way
- As a healthcare partner EMS is also experiencing staffing shortages

EMS Medical oversight, protocols, and clinical standards

Accomplishments

- Published guidance for EMS & Naloxone and establishing Naloxone leave behind programs.
- And guidance for provision of Pharmacy drugs to EMS which allows pharmacies to provide drugs to rural ambulance services, who often lack the buying power and resources to get drugs directly from suppliers.
- The group continues to work on updates to the Washington State BLS and ILS EMS protocols which they are hoping to conclude by end of year.
- MPDs continue to experience challenges related to:

Challenges

Providing oversight to EMS in new roles and environments

- EMS continues to expanded its role to:
- Partner with public health
- Implement community paramedic programs
- Partner with other healthcare providers to establish co-responder models to help better serve some patient populations.

More Risk and Increased workload

- Because of the expanded environments and scope of practice for EMS in the past several years 0 MPDs have more risk, responsibility and workload for managing oversight of EMS than ever before.

Last, Funding remains a primary concern amongst MPDs

- MPDs receive $5000.00 a year / $500 per month from the Trauma Fund to provide medical oversight to EMS. This amount supports only 3-4 hours per month of physician time.
- Some MPDs have community funding models that augment the state stipend, but many do not.

- MPDs are expressing the need for more support such as a dedicated FTE to perform administrative work related to training, QA, and protocols.
- The lack of state funding and FTE support is a primary barrier to recruitment and retention for MPDs in rural areas that lack community funding models to support MPDs locally.
- In rural communities where MPD's do not have the community resources to garner additional financial support for their role as MPD –It is becoming more and more difficult to recruit and retain MPDs in rural communities.
- In 2014 – we had two MPDs that provided oversight of more than one county. (Dr. Jobe and Dr. Larry Smith). Today, we have nine MPDs providing oversight of EMS in more than one county (Counties represented in blue) because recruitment of MPDs in rural communities is so difficult. We have 39 counties and 30 MPDs.

EMS education and certification

Accomplishments

- Our state has continued success in pass rates for certification exams in Washington. Washington paramedic programs have an overall pass rate of 98% and EMT, EMR, and AEMT courses continue to perform above national average. What this means is that our EMS training programs continue to do a good job training our EMS workforce.
- Dawn Felt and John Nokes with DOH partnered with Stevens County Sheriffs Ambulance Service to conduct a couple of virtual EMS instructor workshops this reporting period. The target audience was rural services, but the workshops were open to all. Workshops were well attended (about 75 students). The goal of the workshops is to help EMS instructors in rural communities improve instructor knowledge and skills and to meet the instructor renewal requirements. Two more workshops have been scheduled for January and July 2024.
- We secured more grant funding for this reporting period – about $5000.00 from the Rural Health Medicare Flexibility grant program to pay for initial certification testing fees for rural responders. Since DOH started this program several years ago – we have issued 482 vouchers to rural EMS responders needing to take the certification examination.

Challenges

- We are hearing from training programs and educators that students want more flexibility in training programs for work/life balance. More hybrid online/in person options. More ability to take didactic information at their own pace. The educators will have to work on ways to address the needs of generations of workers entering our profession.

Rural EMS

Accomplishments

- During this reporting period we applied for and received another 2-year grant focused on improving data collection, reporting, and quality improvement within another cohort of rural EMS services across the state. This project is scheduled to conclude in summer of 2024, and we'll provide a report of the outcomes next year.
- The Greater Columbia Accountable Community of Health was awarded a 1.5-million-dollar appropriation from the Legislature in 2023 to develop community paramedic programs within their catchment area. Legislature directed DOH to contract with the ACH to provide the funding. Nine EMS services were enrolled in what the ACH called

the "**EMS Innovation program"** and each received $150,000 from the ACH to develop / enhance community paramedic programs in partnership with the ACH. The overall goals of the program were to help high utilizers of the EMS system to find and use preventative and primary care services, strengthen the primary healthcare delivery system, increase access to care, improve patient outcomes and reduce healthcare costs. The ACH did provide some training to the participating services.

- They reported an overall decrease in emergent transports by 35% and implemented a collective medical database shared across EMS services and healthcare partners for high utilizers.
- They also reported some lessons learned in implementing community paramedic programs including:
- The need for access and sharing of electronic medical records, the importance of building sustainable payment models for the program, recommendations for universal screening tools and referral algorithms, and noting that medication misuse and misunderstanding was a primary driver for the overuse of EMS.
- This is a good example of how regional organizations such as ACH's can partner with and support EMS with education, collaboration, needs assessments, and other services in developing and improving the effectiveness of community paramedic programs.

Challenges

- Continued decrease in the number of volunteers
- Rural EMS service sustainability
- Sustainable funding to support DOH Rural EMS Sustainability Model

EMS resource update

There are:

- 478 Licensed aid and ambulance services (includes ground and air).
- 64% of which can transport patients. The rest of the services are aid services and only provide first response to the scene and do not transport.
- There are 17,531 certified EMS providers; 23% are reported to be volunteers.

EMS service trends between 2015 – 2022.

- There is a slight decline in the number of AID services and a slight increase in the number of ambulance services in this period.
- Some AID services upgraded to ambulance services when GEMT reimbursement became available.
- A few fire services merged which when reconciled semantically reduced the number of licensed ambulances services
- The number of air ambulance services have remained consistent since 2018. Currently, we have three air ambulance services – Island Air, Airlift NW, and Life Flight Network

EMS provider trends between 2015 and 2022

- The number of paid EMTs and Paramedics increased. The number of paid AEMTs remained relatively the same and the number of paid EMRs decreased. (AEMTs and EMRs are primarily used in rural communities).

- We can see a decline in volunteer Emergency Medical Responders and Advanced EMTs. A slight increase in the number of volunteer paramedics in the last year – but overall decline from 2015
- And last – we see a decline of volunteer EMT level providers. EMS workforce decline, predominantly in volunteer populations is an issue in every state and is not exclusive to Washington.

With challenges come opportunities. Looking forward into the next reporting period we see the need to identify work that can help us better understand workforce trends and identify and target specific solutions to improve recruitment and retention into our workforce, monitoring and provide input into the work in establishing a behavioral health / SUD response system integrating more with EMS responders and finding ways to promote resiliency and wellness in our profession.

EMS Acute Coronary Care: an evaluation of EMS adherence with the cardiac triage tool:

Ihsan Mahdi, EMS Epidemiologist
PowerPoint Presentation

The Summary:

- Certain elements in triage are not documented in the data.
- ACS related EMS responses in 2022 accounted for 1% of all responses statewide, the highest in Pacific County (3.4%), and lowest in Thurston County (0.4%).
- ACS patients were more men than women, with ages most affected ranging between 50-89 years in both sexes.
- Over 60% of ACS patients were transported, the majority by ground ambulance and with ALS level of care.
- Most ACS patients were transported in accordance with triage protocol.
- Adherence to triage was more noted when Unit level of care is ALS.

Emergency Cardiac and Stroke Annual Report: Matt Nelson, DOH and Cameron Buck, MD
PowerPoint Presentation

Participating Stroke and Cardiac hospitals: Currently there are 8 Level I, 32 Level II, and 45 Level III stroke hospitals; and 34 Level I and 52 Level II cardiac hospitals in WA.

Strategies and outcomes

- The ECS TAC will support the cardiac and stroke study to identify gaps in the system and make recommendations for improvement. A consultant was hired to conduct the study. The ECS TAC and all stakeholders were key informants to the consultant.
- The ECS TAC plans to explore reforming the interfacility transport workgroup and continuing with that work.
- Much work is underway on KPIs for ECS.

- And the TAC continues to seek sustainable funding for our ECS system. We are pleased that the WA Legislature provided us funding for a study, and we hope the study will inform the legislature on gaps in the system and what is needed to improve cardiac and stroke care in WA.

Matt provided a report on the performance measures ECS submitted to Outcomes TAC to be included in the statewide performance measures. They included:

- Cardiac (STEMI and OHCA)
- Stroke treatment times (symptom onset to intervention)
- Compliance with the Prehospital Stroke Triage Destination Procedure

ECS TAC 2022 Accomplishments:

- Supported Cardiac and Stroke workgroup efforts to implement the legislation and study
- Supported efforts regarding EMS data reporting requirements
- Reformed interfacility transfer guideline workgroup to finalize IFT for stroke.
- Regular data presentations at TAC meetings -- opportunity to examine trends and identify areas of improvement for ECS
- Evaluating prehospital stroke triage tool and possible inclusion of BEFAST.

Future Goals:

- Analyze EMS data reports and KPI's to identify areas of opportunity
- Support ECS system study and advocate for what is needed.
- Analyze stroke triage tool data and adjust if necessary (to improve, or with new time frame, BEFAST)
- Finalize and distribute Interfacility transport guidelines for stroke
- Review and revise cardiac triage tool

Technical Advisory Committee Reports: TAC Chairs, TAC Leads

Hospital TAC:
The TAC met in the morning before the committee meeting. They discussed the trauma triage destination tool. Comments were generally very favorable across the TAC.

They also talked about the trauma registry updates, and everyone was very excited to get data back online as soon as possible. It will still be a fair amount of time not only to finish the submissions, but to go through the data, clean it up and make it usable.

The only other thing they covered was a discussion regarding our steering committee presentation which will be just after the first of the year.

Outcomes TAC: Eric Dean, DOH

No Cost TAC updates.

Trauma fund update: Eric Dean, DOH

We are waiting for accounting to complete the settlement process for the last biennium. There was an increased federal matching percentage for longer than was expected, so we had to spend fewer state dollars to pay out to the ceiling of trauma supplemental Medicaid per our state plan with CMS. This may result in a positive balance carried forward from the prior biennium. Consequently, the negative impact to direct pass-through payments to providers from DOH, may not be as bad as our budget anticipates. One of the assumptions of the spending plan is that any increase in revenue will be restored proportionally to DOH direct pass-through disbursements.

Rehab TAC:

The Rehab TAC meets tomorrow, and they will review and continue to work on their strategic plan. They will also discuss the TAC's update for the steering committee, which will be in November. Ihsan will do a data presentation.

Pediatric TAC: Matt Nelson

The TAC will meet this afternoon. They will review the trauma triage tool that Tim presented earlier. The TAC will provide their feedback. The next meeting will involve a discussion about the pediatric pandemic network. This is a collaborative effort for hospitals nationwide. It includes Seattle Children's Hospital, and 8 or 10 other hospitals to serve as a kind of regional hub for caring for children and pandemics and disasters as well.

RAC TAC: Hailey Thacker

The RAC TAC met yesterday to finalize some of their new strategies in their plan. They also had best practice activity on ADA website compliance. The TAC will meet again in November.

MPDs: Joe Hoffman
MPDs had their quarterly meeting in August. There was a similar presentation about the new trauma triage tool. The TAC is anxious to have some educational materials to help roll that out. They also had a version of Ihsan's ACS presentation. There was discussion, guidance, and input on pharmacy-to-EMS medication distribution.

They will meet again on November 7. The TAC will take another round at the EMS skills procedure against Washington specific objective and national standards, some of the challenges incentive and support for MPD oversight for EMS.

Lastly, Catie Holstein, DOH, recognized Hailey Thacker, who is leaving at the end of the month. Hailey was their EMS and Trauma regional consultant. She is responsible for modernizing and

improving all the various processes between DOH and the EMS care regions. She thanked Hailey for her support and talent.

Meeting Adjourned 1:00 pm.