TRAUMA SYSTEM ADVISORY COMMITTEE MEETING
BUREAU OF EMS AND PREPAREDNESS
March 24, 2014
1:28 p.m.

Location: Viridian Event Center
8030 South 1825 West
West Jordan, Utah 84088

Reporter: Katie Harmon

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APPEARANCES

A P P E A R A N C E S

Don Van Boerum, M.D.
Craig Cook, M.D.
Mark Dalley
Marc Sanderson
Mark Thompson
Whitney Levano
Karen Glauser, R.N.
Deanna Wolfe, R.N.
Holly Burke, R.N.
Jolene Whitney, M.P.A.
Suzanne Barton
Clay Mann
Sue Day
Robert Jex
Whitney Levano
Kris Hansen
Matthew Christensen, Ph.D.
Peter Taillac, M.D.
Jason Larson, M.D.

MARCH 24, 2014

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DR. COOK: Let's go ahead and get started with our Trauma System Advisory Committee meeting. Thank you for being here. Remind you that for those of you who are involved in our prior meeting that that was not part of this discussion and this will be our formal TSAC meeting now.

And Jolene, I think you wanted to mention something.

MS. WHITNEY: Yeah. I just wanted to mention that because of this room, we're going to need to project when you're speaking. And also, remember if you do not have a name plate and want to speak, ask the chair for the opportunity to speak so that the recorder can keep better track of who is speaking and get their name.

If you do not have a name plate, please state your name before speaking after you've been recognized by the chair. So just wanted to remind that.

DR. COOK: Thank you. Do we have minutes from the last meeting? We had minutes that were sent out electronically. And I have a personally reviewed them but do we have --

MS. BARTON: Here is a copy.

DR. COOK: Okay. Thank you.

MS. BARTON: I didn't make copies for everyone since they were all sent out.

DR. COOK: So I have the copy of the minutes from our last meeting and the minutes were also sent out electronically. Anyone who would like to review the hard copy, and if not, if you've reviewed the electronic copy. Do we have any motion to approve the minutes?

MR. THOMPSON: I make a motion to approve.

MR. DALLEY: Second.

DR. COOK: Thank you. Second. Okay. Our minutes from our prior meeting are approved without any objections.

Let's move on to -- we have a lot to discuss today. We will try to get through it as expeditiously as possible, let's move on to Item No. 3 which is the report on audit filters which is follow up from our last meeting.

MR. CHRISTENSON: Okay. I'm Matthew Christenson. I'm the Epidemiologist from the Bureau of Emergency Medial Services and Preparedness. And I want to start with this slide, which isn't what I originally planned but in our previous meetings we -- we were talking about this issue. So I just want to show this to you briefly to wrap up that idea that we were talking

1 about.
2 So this is our Northern Region in Utah when
3 our state is split into seven regions. And we're
4 looking at the CDC triage criteria. That are four
5 steps. This is the Step No. 1 criteria to take patients
6 to the highest level triage center in the region.
7 And so what we've got here are -- the green
8 circles are the hospitals in the Northern Region. And
9 next to each circle is -- are two numbers. The first
10 number is the designation, the trauma designation for
11 that hospital. The second number is the percentage of
12 patients meeting that criteria that went to that
13 facility.
14 So starting at the top you'll see that we've
15 got three hospitals. We have a level four. We have two
16 level fours and a level three. And 7 percent,
17 0 percent, and 11 percent of those step one triage
18 patients went to those three hospitals.
19 Is everyone following?
20 So what we're doing is we're just mapping this
21 first criteria for triage. And the CDC guidelines say
22 take these patients to the highest trauma level in the
23 region. So those for those first three hospitals, two
24 level fours and a level three, 11 percent and 7 percent.
25 In 2011, there were 149 patients in the

1 Northern Region that met this criteria for the first
2 step of CDC criteria. You will see moving down the map
3 another hospital, level four, got 6 percent of patients.
4 And then we have two level twos; one of them got
5 40 percent, another got about 21 percent.
6 And then continuing down, we have another
7 hospital that was not designated, they got 3 percent.
8 And then down at the bottom of the map another hospital
9 that is not a designated trauma center and they got
10 11 percent of patients. So this just feeds -- kind of
11 wraps up the idea that we were talking about previously
12 in that we can put this kind of information on a map.
13 And this is only looking at the first step and we would
14 want to look at the other CDC criteria. But it starts
15 to help us understand where these patients are being
16 triaged and taken to from the field.
17 Yeah.
18 MR. MANN: Thanks, Matthew. I was just going
19 to ask you two questions. And so that the step one
20 guideline is a level one or level two, right? Not the
21 nearest.
22 DR. TAILLAC: Yeah.
23 MR. MANN: And then I just wanted to ask: Are
24 these initial admissions, discharges, or just arrivals
25 at the ED --

1 MR. CHRISTENSON: So these are from the field.
2 These are first-time admissions from the field.
3 DR. TAILLAC: So the destinations from the
4 field.
5 MR. CHRISTENSON: Yep. Destinations from the
6 field. For those patients have met that first step
7 criteria.
8 MR. MANN: And were they hospitalized? They
9 were admitted into the hospital.
10 DR. TAILLAC: No. No.
11 MR. MANN: Okay.
12 DR. TAILLAC: Just --
13 MR. CHRISTENSON: This is where they were
14 delivered by EMS.
15 MR. MANN: Great. Thank you.
16 DR. TAILLAC: So whoever knows this, Bob may,
17 is there a timeframe and I think -- I thought it was 30
18 minutes. That if the patient is within 30 minutes of
19 level one or level two, that's where they should
20 preferentially go? Isn't that the ACS' general
21 guideline.
22 And if they are 45 minutes from a level one or
23 two, they should preferentially go to the closest
24 appropriate facility, is that -- is that right, Dr.
25 Cook?

1 DR. COOK: Peter, I don't know that I've seen
2 in writing an actual minute or hour number. The ACS --
3 and perhaps there will be a different rendition -- but
4 they always say the closest -- the closest appropriate
5 facility. So if you're, you know, 300 miles away from a
6 level one or level two center, then it very well could
7 be appropriate for you to go to a level three center
8 with the next step being the level one or level two
9 center if needs be.
10 But I don't think the ACS and -- and Don,
11 maybe you could chime in. I don't know think they've
12 ever set a time limit.
13 DR. VAN BOERUM: I don't think so. The time
14 limit they do have is -- and metric that they use is if
15 you show up at the level two or level three center or
16 the level four center and it's not -- that patient is
17 not appropriate for your availability there that the
18 decision to be out of there is 30 minutes and they're
19 trying to actually push it to 15.
20 DR. TAILLAC: For the decision?
21 DR. VAN BOERUM: Yeah.
22 DR. TAILLAC: And there was a big discussions
23 in the rural trauma team development meeting this last
24 week about is it 15 or 30 minutes from the time the
25 patient arrives or from the time the physician arrives.

Because if they're not requiring the physician to be there for, you know, 15 or 30 minutes then how can we say we need to have the patient ready to be out of there before the clinician has arrived? They may be at home or --

But there is definitely a push to try to contract that time as soon as you know you can't take care of the patient to get them out of there and not do any diagnostic studies, etcetera, etcetera.

DR. COOK: I think -- I think the time that's in the RTTDC right now is 15 minutes. But again, I don't think they ever define whether that's from when the doc arrives or when the patient arrives.

DR. VAN BOERUM: Yeah.

DR. COOK: That's a good point.

DR. TAILLAC: The reason I ask is as -- whatever, the hospitals and what's the word? Their districts or what's the --

DR. COOK: Regions.

DR. TAILLAC: Regions. Thank you.

Are trying to put together how should this map look. You know, if we, arbitrarily or not, gave them some guidance about if you can get a chopper to the scene and the patient to level one or level two within whatever, 30 minutes, an hour, skip the other hospitals

and go to a level one or level two, even if by air. In other words, give them something that they can actually draw circles on map time wise and come up with a plan.

Because, you know, looking up at the upper Cache County areas, I have feeling that's pretty far from the level twos to drive. So I'm not surprised they're getting a fair amount of patients up there.

And so if we could redo this with just an arbitrary 30-minute drive time and see if patients within 30 minutes are making it to the level twos that should -- I don't know that would almost be more information to me, I guess. I just don't know if 30 minutes is the right number.

DR. COOK: Peter, that's a great point. When we were trying to wade through this in Utah County, we actually did come up with a -- you know, how many minutes is it to the level two center. And we went back and forth between 20 and 30 minutes but, you know, 30 minutes I think is a very reasonable --

DR. TAILLAC: That's where I got then, from those discussions.

DR. COOK: Yeah.

DR. TAILLAC: I had that in my head.

DR. COOK: Yeah, it was 30 minutes. Yeah.

No, you go around Utah Lake or whatnot, how

far really are you from the level two center?

Deanna.

MS. WOLFE: And I know that there is national and ACS abides by this, is that you call a helicopter if you're greater than 30 minutes by ground but that's the only time I've seen it.

DR. TAILLAC: Coming up with something like that would help us and them figure out what makes sense.

DR. COOK: So Matthew, how -- how easy could you come up with this data for level one patients for the state?

MR. CHRISTENSON: For all seven regions?

DR. COOK: For all seven regions.

MR. CHRISTENSON: I think I've already got most of it together. I just really wasn't planning on presenting and it I just put this one slide in. So I've got the other seven regions mapped just like this.

DR. COOK: Could you present that at our next meeting and could we see with and without the 30-minute radius or --

DR. TAILLAC: Because really what you have here is all of the patients in that large graphic area. So again, the fact that 11 -- I'm almost surprised aren't more than 11 although that's less populated up north. You know, because essentially everything up

north is going to go a small level four. I bet there is drive time issue there.

DR. COOK: Sure.

DR. TAILLAC: And the 40 and 21 percent that come down to the center, there is some more densely populated area --

DR. COOK: Yeah.

DR. TAILLAC: -- so they are by definition closer. So this doesn't quite get to what we want, I guess.

DR. COOK: Yeah.

DR. TAILLAC: Without some sort of time constraint.

DR. COOK: Correct.

DR. TAILLAC: That's good information.

DR. COOK: One thing -- one thing that I could be concerned about and I -- I mean, my first glance at this is that nonlevel center getting 11 percent of those patients, I guarantee you that there is a patient or two in there that probably could have been cared for better had they gone to a --

DR. TAILLAC: Because is --

DR. COOK: -- close level --

DR. TAILLAC: -- not very across that board to the level one.

DR. COOK: Yeah.
DR. TAILLAC: Probably.
DR. COOK: Yeah.
MS. WOLFE: It's actually -- I can speak to this because the two levels two, the first hospital that you see the level four up north with 6 percent, that's 35 minutes from our door going the speed limit.
DR. TAILLAC: Really?
MS. WOLFE: And the 11 percent; zero is 29 minutes to our door going the speed limit. It's 29 minutes to St. Marks. It's 29 minutes to the U and 31 -- or 31 minutes to the U and 29 to Intermountain.
So I already know this data for the north.
DR. COOK: Very interesting.
DR. TAILLAC: Really.
DR. COOK: Very interesting.
MR. JEX: They're saying getting them from Brigham City to you is 35 minutes?
MS. WOLFE: Yeah.
MR. JEX: And 29 minutes from?
MS. WOLFE: Lake View to Ogden.
MS. GLAUSIER: By air are you saying?
MS. WOLFE: No, I'm saying by ground.
MR. JEX: Oh, from Lake View. I was looking at Bear River up there.

MS. WOLFE: No, Bear River I --
MR. JEX: It's 45 minutes.
MS. WOLFE: Yeah, I can't tell you Bear River. I can tell you Brigham and Lake View. And is Logan is an hour.
DR. COOK: So do we -- do we have -- are there other points that we'd like to have Matthew look at at our meeting on this or is that good start?
DR. TAILLAC: I think what he has here is outstanding. And we can talk some more Matthew, but is there a way to do a 30-minute drive time ring around each facilities?
MR. CHRISTENSEN: We can -- we can look at it. The thing about 30 minutes is each these one of these is at a different point because it's in the field. And so that pick up starting point isn't going to be at a facility.
DR. COOK: Good point.
MR. CHRISTENSON: So the idea of the 30 minutes to that designation, you know, for each patient it's going to be a little different depending on where they're picked up. And so we can look at it and see what we can do.
DR. TAILLAC: Let's talk after. But we can put a 30-minute circle around a trauma center

essentially.
MR. CHRISTENSON: Yeah. Yeah. We can --
DR. TAILLAC: So anything picked up within that circle --
MR. CHRISTENSON: Sure.
DR. TAILLAC: -- might should have gone to the trauma center.
DR. COOK: Yeah.
DR. VAN BOERUM: But there is also the -- where -- I mean, where does the patient come from because, you know, the 11 percent way up north, that could have actually been a hundred percent of patients that met the level one guidelines in that area, you know.
DR. TAILLAC: Probably was.
DR. VAN BOERUM: So you say, well, it's only 11 percent but it may actually be a hundred percent of the number that was in that area.
DR. COOK: In that area.
DR. TAILLAC: Yeah.
MS. LEVANO: And Peter?
DR. TAILLAC: Yeah.
MS. LEVANO: Another issue we've come across, is that it will be the address that the person lives at and not that the address where they were injured or

picked up. So they were, you know, snow-mobling or off-roading and 30 minutes away is different than where their home is 30 minutes away.
MS. HUNSAKER: Well, but actually in POLARIS, we do track the incident location which is where EMS picks them up and then we generally have the time that they reached their designation facility and so we can extrapolate from that how long the transport time was.
DR. COOK: So again, I'd remind you -- and I know both of you, but state your name.
MS. HUNSAKER: I'm sorry, I'm Shari Hunsaker. S-H-A-R-I.
DR. COOK: She's got it. Just a reminder. And I got you, too, Whitney. Thanks.
MS. LEVANO: Thank you.
DR. COOK: Okay. Let's --
MR. CHRISTENSON: Move on.
DR. COOK: Move on.
MR. CHRISTENSON: Yes.
DR. TAILLAC: Do more of this at the next meeting.
DR. COOK: Yes.
DR. TAILLAC: Each region.
DR. COOK: Yes. And if we could have this as an early point so we don't run out of time that would be

great.
MS. WOLFE: And I would just say one thing, Brigham and Ogden Regional have worked out a plan so that if there is a stemi patient past a certain address where it's equal distance to go, they'll come to the chest pain -- to the stemi receiving and -- or the -- anyway, to the stemi center instead of going backwards and then having to do another transport. We actually saved a life by having EMS understand those rules and do that last month. And he would have -- had pressure of 60 and he would have died had he gone back and then come forward. So we've got some models out there.
DR. COOK: That's a great point. I think that if we can take this several steps down the line within our regions and come up with some geographic guidelines, it will make it a -- for our trauma patients it will make a big difference. That's good.
MR. CHRISTENSON: Okay. Trauma audit filters. You will remember at our last meeting in December we reviewed the audit filters. We, at that time, deleted two of the 10 and then we split another one of the audit filters into two separate ones. And that led to a lot of questions and needing more information to be able to finalize those two audit filters.
And so with these -- with this revised list

No. 5 is new. No. 6 is new and No. 9 is also new. Starting with No. 5, this is looking at the referring facility. So both Audit Filter 5 and 6 are for transfer patients.
And Audit Filter 5 is looking at the time in that referral facility from admission to discharge. And what we want to do here is make a decision for the state what that time should be ideally for the referring facility.
For Audit Filter No. 6, this is looking at transport time from the discharge facility to admission at the definitive care and what this time should be.
If you have any questions please just interrupt and raise your hand.
MS. HANSEN: Can I go back? Kris Hansen --
DR. COOK: State --
SPEAKER 2: -- from Primary Children's. I have a question about No. 10. I'm wondering how you came to 13 years old as the definition of a child and submit that to be congruent with the ACS recommendations that that should be 14 or less. Just to be -- just so we all have the same definition what is a pediatric patient.
MS. WOLFE: And that also matches our triage and transport guidelines.

MS. HANSEN: It's through the age 14 so it's less than 15, it's 14 or less.
MR. THOMPSON: Anyone less than 14.
MS. HANSEN: I don't have any passion about that except that if everybody calls a kid a kid by the same --
DR. COOK: We should be consistent and that's a good point and we should change it.
MR. CHRISTENSEN: Less than 15?
DR. TAILLAC: So less than 15.
DR. COOK: It's 14 or less, less than 15.
MS. HANSEN: Yeah, greater -- less than or equal to 14 or less than 15. Which I think the State of Utah redefined a child.
MS. WOLFE: And do we have any centers that have a pediatric intensive care unit other than Primary Children's?
DR. COOK: No, we don't.
MS. WOLFE: U doesn't? Intermountain doesn't?
MR. CHRISTENSON: Should we just change the language to Primary Children's?
MS. WOLFE: No, leave it.
DR. COOK: Does Dixie Regional have a PTU?
MS. HANSEN: No, just leave it there as either a regional pediatric trauma center or a level one PTU --

level one or two trauma center because as we grow there may be other pediatric trauma centers and I think level one or two to be appropriate.
DR. COOK: Thank you.
MS. HUNSAKER: Deanna, didn't you have some questions regarding this audit filters earlier? Did she leave?
MS. WOLFE: Yes, but it's not one we're talking about right now.
MS. HUNSAKER: Okay.
MR. CHRISTENSON: We can make that change for No. 10. This slide simply compares Audit Filter 5 and Audit Filter 6. And when I was putting this together it made the point to me -- and the reason I put this together, it wasn't in the handout that was sent out or the PDF that was sent out, what it shows, essentially, is we're losing a lot more time for our -- these time sensitive patients with an ISS greater than 15 in the referring to facility as compared to in transportation between facilities.
So these -- both of these pie charts have the same time breakouts: One to 30 minutes, 31 to 60 minutes, 61 to 90, and 91 to 20. So for the No. 5, our two-hour window is catching a third of our patients. So in other words in 2011, a third of the patients were

1 discharged out of that referral facility in two hours or
2 less.
3 DR. VAN BOERUM: Which is pretty long to start
4 with.
5 DR. COOK: A long time.
6 MR. CHRISTENSON: Yeah, it struck me as long
7 as well.
8 Compared to our transport time, 30 minutes, 60
9 minutes is capturing 62 percent of getting all of our
10 patients to that referral facility. And then if we
11 bounce it up to two hours, we're catching 85 percent of
12 all patients in the state are getting transported in two
13 hours or less. So comparatively, the two-hour window,
14 we're looking at only getting a third of the patients
15 out of that referral facility but yet we're transporting
16 85 percent in that two-hour window. Just for
17 comparison.
18 So this graph just break out -- now looking
19 specifically at Audit Filter No. 5 so that we can make a
20 decision as to what the time point -- the cut point
21 should be. This is the raw number. The previous slide
22 showed the percentage of total and this gives you an
23 idea of where the raw numbers stack out. It's the same
24 time break out, it's one to 30 minutes. So there were
25 only two patients in 2011 that got out of that referral

1 facility in under 30 minutes. Eighteen got out in 31 to
2 60. The high majority is there at two to three hour
3 window, 82 of the patients in 2011.
4 This is that same pie chart. And so we have a
5 third of the patients getting out of the referral
6 facility in 2 hours. If you add another hour, we're up
7 to about two thirds getting out of the referral
8 facility. And then the orange slice of the pie is four
9 hours. And beyond that is more than four hours.
10 So this is what the time look like. This is
11 the last slide for Audit Filter No. 5 and then we can
12 talk about what the cut point should be. This is broken
13 out by hospital number. So the hospital in the state in
14 2011 with the fastest turnaround time, in terms of
15 referring all their patients, was No. 140 and they were
16 1.4 hours. That was their average time.
17 If you look over at Hospital No. 535, that's
18 three and a half hours. So you can see about two-thirds
19 of our patients -- or excuse me, our hospitals that are
20 referring patients are somewhere between an hour and a
21 half and three hours in terms of getting those patients
22 out the door.
23 And then we've got four hospital that are from
24 about five to nine hours on average and then three
25 hospitals that are over 20 hours.

1 DR. VAN BOERUM: Matt.
2 MR. CHRISTENSON: Yeah.
3 DR. VAN BOERUM: In your audit is there anyway
4 of knowing what the time was for the decision to
5 transport and then how much time actually ran after that
6 decision was made? You know, because there are
7 facilities in the state that are -- you know, if it's
8 someone needs to fly, there is not a helicopter in their
9 location then it takes time to get a facility -- you
10 know, helicopter from, you know, Provo to Vernal or
11 something to get that patient out of there and --
12 MR. CHRISTENSON: There isn't -- there
13 isn't -- as far as I know, there isn't one for decision,
14 when the decision was made if that's what you're asking.
15 DR. VAN BOERUM: Because really, the -- I mean
16 what -- what we're hoping to gain by this metric is to
17 shorten the time -- the decision time to get the patient
18 out of there.
19 MR. CHRISTENSON: Yeah.
20 DR. VAN BOERUM: Because some patients are
21 going to be sitting in ERs longer just because of their
22 location because you have to get, you know, the
23 helicopter down to them to get them out of there. If we
24 can't --
25 MR. CHRISTENSON: Is this just for helicopter

1 patients though? Would that -- does that also apply to
2 ground ambulance?
3 DR. VAN BOERUM: Well, if it's -- if it's
4 ground ambulance then, you know, once the decision is
5 made they ought to be out of there in 15 minutes.
6 MR. CHRISTENSON: So in terms of helicopter
7 transports, I believe statewide it's around -- and I've
8 got a slide that speak to it -- around 18 percent
9 statewide. So that would apply to 18 percent.
10 DR. VAN BOERUM: You know, because you can't
11 compare, you know, the hospital in Filmore, you know,
12 their time to transfer to, you know, one that's -- you
13 know, like Pioneer Valley here where it's -- you know,
14 they're going to -- they should be out of there quickly.
15 MR. JEX: Doctor, I will just a general
16 observation of that. As I go around to talk to
17 hospitals about designation, the vast majority of them
18 are making their decision in less than one hour. They
19 understand the difference between the door to the
20 decision time and door to transfer time. And where the
21 door to transfer time and door to decision time are
22 significantly different, that's where they focus their
23 efforts. Is to -- what's causing that delay in
24 transport. Do we have to delay for the transportation
25 or is there some other reason.

1 We do, indeed, focus on the door to transfer
2 and door to decision time. But I think if door to
3 decision time is reasonable then we ask them to focus on
4 what's the problem in getting out the door.
5 MR. CHRISTENSON: That's two tissues.
6 DR. TAILLAC: But how do you -- how do you
7 document the door to decision time? Do they have to
8 make a point of doing that.
9 MR. JEX: If they use a trauma -- trauma flow
10 sheet it's on the trauma flow sheet.
11 DR. TAILLAC: Okay.
12 MR. LARSON: So Peter, I work with one of
13 these facilities. I work in Uintah Basin Medical in
14 Roosevelt. We don't have a helicopter out there. We've
15 recently had helicopter service in Vernal. But our
16 point is well made that we focus as a trauma center our
17 PI program is we do track door to decision time. We
18 have to write it down, as Bob said, on the trauma flow
19 sheet. We track that very carefully.
20 We were hundred percent under an hour last
21 time we did that. But our door to transfer time is
22 significantly greater, as you can imagine, we have
23 weather problems, call the doctor problems, even getting
24 your voluntary ambulance services isn't that quick. So
25 it's a lot -- a lot that goes into it. So I agree with

1 you it's more one issue here.
2 DR. TAILLAC: But you can document those.
3 MR. LARSON: But we do document those.
4 DR. TAILLAC: Only because you're a designated
5 trauma center.
6 MR. LARSON: Well, yeah. And that's part of
7 the process I guess.
8 DR. TAILLAC: I didn't mean it --
9 MR. LARSON: Yeah.
10 MR. JEX: Stop and consider there are 25
11 hospitals in the state that are either designated or
12 working towards designation. So the outliers are the
13 difference between 43 and 25.
14 DR. TAILLAC: Right.
15 MS. WOLFE: And this slide isn't going to show
16 those that document that they can't get out because of
17 weather or whatever.
18 MR. JEX: But we do ask them to PI.
19 MS. WOLFE: Right.
20 DR. COOK: We're being --
21 MR. CHRISTENSON: Yep. So asked to --
22 DR. COOK: Oh, go ahead.
23 MR. CHRISTENSON: Our decision now is then --
24 this is maybe the best single slide to look at in terms
25 of what out cut point should be for this referral

1 facility or how you want to move forward in trying to
2 make a decision for Audit Filter No. 5 what that
3 timeframe should be.
4 DR. COOK: And the real purpose of this filter
5 is for us to be able to track and follow up and follow
6 through on this issue. So it's not -- I don't think
7 that this is a punitive thing, per se, it's for us to be
8 able to gather data and to be able to go to the
9 different facilities and say, hey, you know, we can do
10 better in this area.
11 So the question I have is: Do we keep the
12 filter as is and determine a specific number that we
13 think will get us the data that we want or do we need to
14 tweek the filter some? Do we need to add a door to
15 decision to transfer time as part of our filters?
16 DR. TAILLAC: How about for the designated
17 facilities who are expected to keep the door to decision
18 time we have a separate audit filter for them, 5A, if
19 you want, for the designated facilities look at your
20 decision time, because that's what we care about. And
21 for the others, this is best we can get, probably, door
22 to transport.
23 DR. COOK: That's reasonable and as they
24 become leveled, if they do, then they move over to that
25 5A, if you would, that door to decision.

1 DR. VAN BOERUM: Just an interesting point, if
2 you take this data, you know, from these two pie charts
3 that you showed, you know take average of those, add
4 them together for the transport time and, you know, that
5 time you hit the door at the level four center or
6 whatever, until you're getting to the definitive center,
7 then look at the very first slide you showed.
8 So the decision out in the field to take the
9 patient to the level four center, as opposed to, well,
10 we might have to wait here for 30 minutes to get a
11 helicopter in effect delays the patient getting to the
12 definitive center on average by four hours.
13 So even though you think, well, I'm doing the
14 patient a better service by taking him here, you may not
15 be just 'cause it -- just as an interesting point.
16 DR. TAILLAC: That was helpful, Matthew,
17 putting those two charts together. Thank you.
18 DR. COOK: Very helpful.
19 MR. CHRISTENSON: Good.
20 DR. COOK: Do we have -- I think Peter, I
21 think your proposal is a good one. Does anyone have any
22 angst with that? Having two -- two separate parts to
23 the filter.
24 MR. CHRISTENSON: I have a question. So does
25 that imply that after decision there is nothing we can

do with those other factors, those are just factors out of our control or they can't be addressed?

MR. LARSON: No. No. I don't think so.

MR. CHRISTENSON: Because the implication is if we're looking at that decision being a timeframe, then we want to speed up the decision and after that because this is -- this is broader than just the decision. This is the -- to me -- to me this is the issue, it's admission discharge. And there are many factors: Decision time, helicopter -- you know helicopter transport or other factors.

DR. TAILLAC: I think Bill can address this. Feel free. But I look at it two ways. In a designated trauma facility with a good system in place, we expect a decision to object made in a timely fashion. Then ultimately we would like the discharge or transfer to happen in a timely fashion. But bottom line is the hospitals have less control over that portion of it. So if consistently a trauma center has a decision time that's short and long transport time, I think that should be worked on.

But, you know, weather, ambulance availability, the volunteer guys are on vacation that week, you know, there is all these individual things make one case long -- that, you know, are out of their

control. That's the bottom line. But the decision time is within their control.

DR. VAN BOERUM: I guess I would just say, I mean, the purpose of a filter is to pick them up so you can then look at them.

DR. COOK: Yeah.

DR. VAN BOERUM: So if you could see, well, yeah, there was a snowstorm, couldn't get them out, fine, that's done. You did the best you could.

DR. TAILLAC: Exactly. Exactly.

DR. VAN BOERUM: But if you find, well, it's a long transfer time because they decided they wanted to get a CT scan of everything in the body, which doesn't help the patient at all, that's what you don't --

MR. CHRISTENSON: That is exactly what we're doing with the audit filters. We're casting the best net that we can and a lot are going to fall out once we look closer but that net is hopefully catching a lot that are going to make sense to look at.

DR. COOK: So we should continue to track that data for the trauma centers, as well and then we can use that to look at, you know, reasons additionally.

Clay.

MR. MANN: I was going to mention that I agree. I think the door to decision to is a great

measure to include but you're going to collect the decision -- we don't have data point.

MS. HUNSAKER: That was going to be my suggestion. Shari Hunsaker. Is that -- do you want to consider adding a data element to the trauma registry for transfer decision time?

DR. COOK: I would say absolutely.

MR. MANN: Yeah.

MS. HUNSAKER: And in our EMS System, we also have a field for reason for transportation delay where the EMS agency can document, you know, there were traffic -- there was a traffic jam, there was bad weather. This is why we were delayed in reaching the scene or in reaching the destination.

So do you also want to consider adding that data element as a Utah specific data element in the trauma registry?

MS. DAY: Sue Day, Intermountain -- all of the --

THE REPORTER: Excuse me? I'm sorry.

DR. COOK: Sue Day.

MS. DAY: Sue Day.

THE REPORTER: Sorry.

MS. DAY: All of the Intermountain facilities have already added over the past two or three years the

decision time to transfer. That was a protocol for us because that was an important goal. So it would just be the other centers, we already have it.

MR. JEX: Yeah, you're not -- you're not putting that into the State data base, are you?

MS. DAY: What's that?

MS. HUNSAKER: No.

MR. JEX: That's the term, isn't it?

MS. HUNSAKER: So we would have to create the element and I could submit the change request to CDM. And it generally takes 90 days from the date had they receive the request until it's implemented in our system. It would probably be best to wait until our 2015 update to include those two new data elements. I will let this body make that decision.

Because if you add them right now, you're going to ask facilities to go back and retrofit data that they may not have.

MR. LARSON: Is that -- is that -- what reason for just transfer, just a text box of some sort? Because is that going to be helpful for them just to generically general type some --

MS. HUNSAKER: Decision time to transfer will be --

MR. LARSON: A number, right.

1 MS. HUNSAKER: A number.
2 MR. LARSON: But I mean, the reason, I'm just
3 wondering how helpful that's going to be.
4 MS. HUNSAKER: It would -- I would suggest
5 that it be a pick list.
6 MR. LARSON: Okay. Yeah.
7 MS. HUNSAKER: And only to help you throw out
8 those outliers like bad weather, you know, to try and
9 get a handle on why there was a delay. And it
10 doesn't -- it's certainly not required, but if you want
11 to look at why we are having extended delays between the
12 transfer decision time and the transfer, that would be a
13 way to quantify a lot of those.
14 MR. LARSON: Yeah, I was just trying to --
15 eliminate unnecessary fields if they weren't going to be
16 helpful down the road.
17 DR. COOK: Sure.
18 MS. HUNSAKER: I don't blame you one bit.
19 Because as a former data entry person, I don't want any
20 unnecessary fields either.
21 DR. COOK: So let's make a decision on this
22 and move forward. As I hear it, we want to have for the
23 trauma centers a door to decision time and we want to
24 track that in our trauma registry. And we want to start
25 that in 2015 or we do want to start that now and try to

1 retroactively go back? I think that's going to be a
2 problem.
3 DR. VAN BOERUM: I'd say get it put in and
4 then we have, you know -- by the time that gets in then
5 you got six months to everyone to kind of learn it.
6 DR. COOK: Ramp up and get used to it.
7 DR. VAN BOERUM: Data starting 2015 will --
8 should be accurate. If you wait until 2015 then --
9 DR. COOK: It will be 2016 --
10 DR. VAN BOERUM: -- your 2015 data is going to
11 all be muddied by some of them were doing it, some of
12 them weren't.
13 MS. HUNSAKER: So why don't we make it -- I
14 can set it up as a warranting edit right now, if they
15 put the data -- if they submit a record that doesn't
16 have it in there, it just gives them a warning but it's
17 not a fatal edit. And then starting in 2015, in January
18 of 2015 it become a fatal edit.
19 DR. COOK: That's reasonable. That's
20 reasonable. Let's do that. And then with regards to
21 the time that we want to put in for our audit filter for
22 door to transfer time, what time do we want to put in
23 there? I will tell you that the ACS and the State as we
24 out and we talk to trauma centers, I mean, we're pushing
25 hard for an hour turnaround time.

1 Now, that's not even close to what we're
2 talking about here and I know that it's totally
3 unreasonable in many centers. But I think that we've
4 got to -- we've got to, you know, be reasonable in what
5 we're asking but something that will also not -- we
6 don't want to have so many numbers that we can't
7 actually make a difference, you know, falling out but we
8 want a reasonable goal so that, you know, the centers
9 are really being pushed a little bit to get these
10 patients out faster.
11 So what's -- what's the -- is it two hours is
12 it an hour and a half? What is it?
13 MR. LARSON: Craig, are you talking -- are you
14 talking again from --
15 DR. VAN BOERUM: Out the door.
16 DR. COOK: Out the door. Out the door.
17 MR. LARSON: Because it's going to vary for
18 me.
19 DR. COOK: I know. So do you regionalize it
20 somehow?
21 MR. LARSON: Yeah.
22 DR. COOK: It makes it a quandary for the
23 state.
24 MR. CHRISTENSON: No, we can regionalize it.
25 That's -- certainly.

1 DR. COOK: Can you make an urban and a rural
2 category? And you give the rural two hours and the
3 urban an hour or something like that?
4 Sue.
5 MS. DAY: Well, and again, this is Sue Day
6 from Intermountain -- Intermountain Healthcare. Because
7 it was our goal, we actually set it at 90 minutes and
8 that -- I think it was three years ago. We've done
9 steadily better with this year being our best. If you
10 look at our website.
11 So actually once the goal is set it takes a
12 little while to get there. So, you know, we shoot for
13 less than 60 at our place but the overall goal is 90.
14 Pay attention to it.
15 DR. COOK: What do you think, Don?
16 DR. VAN BOERUM: I mean, I wonder if it would
17 reasonable to actually look at each facility and give
18 them a time? Is that --
19 MR. CHRISTENSON: Say that again.
20 DR. VAN BOERUM: Wonder if you can set it per
21 specific for each facility, you know.
22 DR. COOK: A percentage decrease where from
23 they are currently or something like that?
24 DR. VAN BOERUM: Well, even a time. I mean,
25 if you know it's going to take, you know -- you know,

it's going 30 -- if you know it's going to take 45 minutes to get --
DR. COOK: A helicopter --
DR. VAN BOERUM: -- airport out there then --
DR. COOK: Do you give them say an hour plus whatever their helicopter arrival time is? I mean I don't know I'm trying to --
DR. VAN BOERUM: I don't know. I mean, I guess -- I would ask the --
MR. LARSON: That's the hard one. Because, you know, we can do everything we can to get that decision time made. We scramble to them gone and then we're at the mercy of the transport services.
DR. COOK: Sure. Sure.
MR. LARSON: And what can we -- I mean, and there are things we do. I mean, frankly, we've looked at this and gone, all right, so what can we do. We go to Life Flight and say what can you do. We go to our EMS providers and say you call them on scene so they're on their way by the time -- you know, those kinds of things. And we've done that.
So it's helpful to have this filter say, you know, pick this up so you're thinking about it but at the same time you don't want to unrealistic.
DR. COOK: Okay.

MS. GLAUSIER: Coming from rural, what we find is that we call the helicopter, they'll come, the patient is there still at our facility but then they're doing all these other interventions. So then, you know, they're there taking care of them but they're still there. And we can't say they're out of our door until, you know, their flying out the door.
MR. JEX: Well, how long does it take the patient to get packaged and before?
MS. GLAUSIER: Well --
MR. JEX: -- take them?
MR. LARSON: Sometimes they are --
MS. GLAUSIER: Sometimes --
MR. THOMPSON: -- they still redo everything.
DR. COOK: Peter.
DR. TAILLAC: That brings up kind of a separate question. But first of all, if we want to pick something to start with, if Intermountain, who owns half of the hospitals in the state said 90 minutes, why don't we just pick 90 minutes to start with and then we can sort of -- my vote No. 1. And then see how it goes and there is no penalties involved here, it's just a goal.
Two, is it fair for them to count out the door the time the flight team takes control of the patient.

Because a lot times they do take control -- and I know, I've worked in small hospitals, I will go see another patient and do something else while they're in there doing whatever it is they do prior to transport. But I'm done essentially at that point. I think to me that seems fair the hospital standpoint.
DR. COOK: That's very reasonable.
Do we have any --
MS. WOLFE: How are you going to track it?
DR. COOK: What's that?
DR. TAILLAC: How do you even call it --
MS. GLAUSIER: So is that door to --
DR. TAILLAC: That's the discharge time.
DR. COOK: That's the official disposition time of the providers that -- at that facility.
MR. LARSON: But then you're going to have to -- you are going to have train the facilities because right now our staff is not putting that at the discharge time.
DR. COOK: True.
MR. LARSON: -- they are putting that --
MS. BURKE: Right.
MS. WOLFE: The doctor may go see another patient but the staff is still in there helping the flight crew and so we're still documenting on that

patient.
MS. BURKE: And has the ERS person really signed off on that patient?
MR. LARSON: No.
MS. WOLFE: Not until --
MS. BURKE: Because they are still responsible until they leave the hospital.
MR. LARSON: I mean, it's gotten to the point where we have gone to these services and said you need to be careful with your times here because you're doing -- your spending far too much time on scene.
DR. COOK: And that's the purpose of the filter, really. I mean, perhaps the filter helps us, you know, let's move along everybody. Let's move along, not just, you know, one part of the team, the whole time has to move along.
DR. TAILLAC: Well said.
MS. GLAUSIER: So I'm --
DR. TAILLAC: Go ahead.
MS. GLAUSIER: I'm good to go 90 and try to reach that goal. If that's going to help our patients then let's push for it.
Okay. One last comment, Sue.
MS. DAY: Sue Day again. We actually used a time on the patient transport form, there is a box on

there it that says time of decision made to transfer. So that's where we're going to get that time. So not even starting -- we're able to make a decision and filling that patient transport transfer form out.

MS. WOLFE: So on that transform form, too.

MS. GLAUSIER: So that's the decision but then to discharge, if like their -- like if Life Flight comes in --

MS. DAY: You want to collect all those times but, you know, I think we need to -- I don't have it right here in front of me, you will have to pull up the website to see whether our time was better.

But it was time to decision and transfer and then I think a time of arrival but I will check.

DR. COOK: Okay. Oh, please, Mark.

MR. SANDERSON: It all depends on the goal, right. If we're looking at out the door then that's the time we ought to track. If we're looking at time of disposition to transport -- because there is two -- they are two separate issues. So what's the most important or are both of they key that we want to track?

DR. TAILLAC: I think both of them are very important.

DR. VAN BOERUM: So I think -- I guess I would make the motion that we track both and then set a time

to decision that, you know -- the ACS is 30 minutes.

DR. COOK: In the Rural Trauma Team Development Course that we go out and teach, it's 15 minutes. Decide in 15 minutes, that's what it is. And maybe we say 15 minutes from the time the provider shows up.

MR. LARSON: Yeah, we don't -- we don't often have a physician in the ER in 15 minutes.

DR. VAN BOERUM: That was about a 20 minute discussion about that.

DR. COOK: So let's say 15 minutes from the time the provider arrives and then 90 minutes to out the door time.

MS. GLAUSIER: So I've got another question. On No. 5 it says ISS greater than 15. Well, we transfer a lot of our patients that are like from nine to 15. So does this only go if they're over 15 or we -- is it just if they need to be transferred to a higher level trauma center?

DR. COOK: I think we leave it as the ISS greater than 15 just so that we're consistent. I think what we're trying to do is make sure that the patient -- the sickest patients are not sitting in the ED for a long time.

DR. VAN BOERUM: And you make -- you know, you

won't always know what ISS is --

MS. GLAUSIER: Right, exactly.

DR. VAN BOERUM: -- until they get to a definitive center and get all the diagnostic studies.

DR. COOK: The patients clearly very ill who have sustained major trauma, hopefully you're going to recognize that sooner than later and send those patients to --

MS. WOLFE: But it's only the --

DR. COOK: -- the ones that are quasi or not so sure.

MS. WOLFE: Only in ISS and don't wait on those.

DR. COOK: So Don, made a motion that we added to a little bit time ways 15 minutes from the time the provider arrives, 90 to -- out the door or --

DR. VAN BOERUM: Yes.

DR. COOK: We good with that start?

DR. VAN BOERUM: As a starting point. We can adjust that.

DR. COOK: Any opposed to that?

MS. GLAUSIER: Okay. So 15 minutes to decision and then 90 minutes to out the door?

DR. COOK: Yes.

MS. GLAUSIER: Is that right?

DR. COOK: Correct.

Clay.

MR. MANN: So we need to another data element, as well by the time the physician arrives.

DR. VAN BOERUM: Yeah, that's right. We don't have -- what we have is admission to the hospital. We don't have --

DR. TAILLAC: Is it simpler to do the ACS 30 minutes since that's sort of their standard. And a hospital who has a doc that takes 20 minutes to arrive needs to push him to arrive in 10 minutes instead of 20. I just -- just --

DR. VAN BOERUM: That's probably -- that's probably simpler and easier.

MR. JEX: The probably appropriate because it is 15 minutes for a level one, but it's 30 minutes for a level two.

MS. HUNSAKER: Don't we still -- we still are not tracking the MD arrival time in the registry. So what Clay is saying --

MR. JEX: That's not at all.

MS. HUNSAKER: -- we'd still need to add that to the registry.

DR. COOK: So again, in the Rural Trauma Team Development Course which is the ACS course, they preach

15 minutes. They preach call the helicopter before the patient ever shows up. EMS calls and says, we've got this guy with bilateral femur fractures, call the helicopter. You could have a negative decision time.

DR. TAILLAC: Got you.

MS. WOLFE: We are tracking time the physician is called and the time they arrive, that is in trauma base.

MS. GLAUSIER: I don't think it's a stared field but we --

MS. WOLFE: But we have them in that way.

DR. VAN BOERUM: Every facility ought to be tracking that.

DR. COOK: Any trauma -- level trauma center has to track that. So we should have that.

MS. WOLFE: Every hospital in the state has it because it's in trauma base.

DR. COOK: Okay.

MR. MANN: I don't know if it's in trauma basic though. It's not going to be trauma basic because that has the state level elements that's going to be 20-some small hospitals.

MS. HUNSAKER: Yeah, it's not a state element. So it's not in the dictionary.

DR. VAN BOERUM: Can we make it a state

element?

DR. COOK: Are we good? Are you clear as mud?

MS. WHITNEY: Well, we need a second to the motion and --

DR. COOK: Oh, yes, we do.

MS. WHITNEY: And then a vote.

DR. COOK: 15 and 90.

DR. TAILLAC: Restate the motion.

DR. VAN BOERUM: 30 or 90 -- 30 and 90.

MS. GLAUSIER: Let's do 30 and 90.

DR. COOK: I have angst again 30 because it's not what the ACS has in their Rural Trauma Team Development Course. So it's a separate --

DR. VAN BOERUM: Well, they need to change that actually.

DR. COOK: Well, if they do, that's great. Don -- Don has just been to the meeting.

DR. VAN BOERUM: Because of the -- that conflict.

DR. COOK: 30 minutes, that would be great.

DR. TAILLAC: 30 minutes is easier with the existing data could our start point is the admission time. We have that no question.

DR. COOK: Okay.

DR. TAILLAC: For all the hospitals.

DR. COOK: Just say 30 minutes?

DR. VAN BOERUM: Yeah.

MR. CHRISTENSON: And it does cast a net -- maybe it's, you know, we're catching a lot of patients there that would fall out but right now it's doable.

DR. VAN BOERUM: Yeah.

MR. CHRISTENSON: If they do --

DR. COOK: So the motion is 30 and 90.

DR. VAN BOERUM: You know, that -- if you I think about it, that 30 minutes --

DR. COOK: It's reasonable.

DR. VAN BOERUM: -- that might be establishing, you know, some decent IV access.

DR. COOK: Sure.

DR. VAN BOERUM: They may be putting in a chest tube, they may be intubating a patient. I mean, there is a lot of stuff that you can -- that's -- that's 30 minutes would be really quick.

DR. COOK: What I would say though, and I don't want to digress, but as soon as you think you need intubation the patient, that's your decision right there.

DR. VAN BOERUM: That's true.

DR. COOK: They're not staying at your hospital.

MR. LARSON: That's exactly --

DR. COOK: Send for the helicopter.

MR. LARSON: We're sending this patient and that's all we say, is track -- is track that number.

DR. VAN BOERUM: Good point.

MS. WOLFE: The reality in practice is most of them don't make a decision to transfer until they got their scans and they --

MS. GLAUSIER: That's just if it's in the lower --

MR. MANN: And what's we're trying to change.

MR. LARSON: That's what trying to change.

MS. WOLFE: I know. That's what we're finding.

DR. COOK: But I will say, you know, from a perspective working with a lot of these Intermountain facilities in rural areas, there has been a lot of change based on that one goal. So I think we can make a lot of difference here.

MS. WOLFE: Well, we need do.

DR. COOK: Yeah, we have to.

Do we have a second for Don't amended motion?

I think we're going to 30 and 90.

MR. LARSON: I second that.

DR. COOK: Okay. Second. Okay. Let's move

1 forward.
2 MR. CHRISTENSON: So we will have a 5A and 5B
3 and we will recalculate --
4 MS. WHITNEY: Craig, just hold on.
5 Sorry. We have a motion that I think you need
6 to vote on.
7 DR. COOK: Do we -- all in favor? Opposed?
8 It's unanimous. Let's move on.
9 MR. CHRISTENSON: Okay. We will have a 5A and
10 5B and we will present those at our next meeting or
11 include that with your existing.
12 I will go through quickly because there is a
13 lot to filter on Audit 5 and I want to just call this to
14 your attention because it's a issue in the trauma
15 registry. There were 330 patients in 2011 that met this
16 criteria for Audit Filter No. 5. They had an ISS score
17 of greater than 15 and they were transferred. That was
18 330 patients. Only 235 patients qualified. So that's
19 what we've been looking at in these graphs, 235.
20 Because 95 didn't have complete time data so we can't
21 look at their time.
22 The graph on the right shows all hospitals
23 that report into the registry. The blue slice of the
24 pie shows 18 hospitals reported times and dates on all
25 of their trauma base patients. The red slice of the pie

1 shows 16 hospitals reported missing times and dates on
2 all of their trauma patients.
3 The green slide shows five reported on
4 complete time on some of their patients and then the
5 purple slice is five hospitals that didn't meet any
6 of -- didn't meet this criteria.
7 In addition, more than 95 percent of the data
8 were at discharge. So you could look down the column
9 and see that admission for these 16 hospitals was there
10 but discharge was missing. So the pattern is so clear.
11 I think this something we can affect.
12 And so my thought in bringing this to you was,
13 is this also something we want to look at with Audit
14 Filter 5 and even Audit Filter No. 6 that the time data
15 should just be reported. There is really no reason why
16 it shouldn't be.
17 MS. HUNSAKER: I don't think it needs to be
18 audit filter, I think we just need to make it a fatal
19 edit on trauma base so that the record can't be uploaded
20 to the trauma registry unless the discharge time is
21 there.
22 DR. COOK: Sue.
23 MS. DAY: I think this points out, and it's
24 probably recognized over the years, and it's education.
25 All this missing stuff, you go back to that facility to

1 be fixed and then resubmitted. Never should it be
2 allowed to be accepted with all of this stuff that's
3 missing.
4 DR. COOK: It would be an easy fix it's a
5 required field and it's not done until it's --
6 MS. HUNSAKER: Easy fix.
7 DR. COOK: -- done.
8 MS. WOLFE: It's a failing filter and I
9 don't -- I mean, I said this Karen in the other meeting
10 how can this data get to the hospital without a
11 discharge date and time because it is a failed edit. It
12 won't download to the state. So how are you getting
13 those records?
14 MR. CHRISTENSON: The data from the
15 registry -- this is what's in the registry, that's all
16 I'm presenting to you. I don't -- I can't explain how
17 it got here. I'm telling you what's in the registry.
18 And I looked at it very carefully. This is -- it was
19 shocking to me that there was no admission date on 18
20 hospitals -- on 16 there was a very clear pattern.
21 MS. HANSEN: This is Kris Hansen from Primary
22 Children's. We found in your own institution trying to
23 download -- or downloading patients to the state that we
24 were passing the criteria when we should not because in
25 this specific field sometimes we'll put unknown or not

1 rather than a number. We were using it, erroneously, as
2 a place holder to remind the staff to go back and fill
3 that in, which we should never have done. It was an
4 error in logic. But they were doing it that way and in
5 an effort to get to the next patient, work on that
6 patient, and then they'd forget to go back and fill it
7 in.
8 But my guess is if we're doing it at our
9 place, probably other people are doing something
10 similar.
11 MS. DAY: So that's all --
12 MS. HANSEN: If you put something in the field
13 it will go --
14 MS. HUNSAKER: Well, I can make it -- I can
15 make it not nullable.
16 MS. HANSEN: Right.
17 MS. HUNSAKER: So it will not accept unknown
18 or not.
19 MS. HANSEN: And that's what we're doing on
20 our site but --
21 DR. COOK: It should be number. It has to be
22 a number.
23 MS. WOLFE: It make a motion that we make it a
24 failed edit through Shari and then this problem goes
25 away.

DR. COOK: I second it. All in favor?
MS. HUNSAKER: One comment: Do you want it to be not nullable?
DR. COOK: What do you mean?
MS. HUNSAKER: So it won't accept an empty or an unknown value.
DR. COOK: Correct. Yeah, that's the --
MS. HUNSAKER: Okay.
DR. COOK: That's the motion. That's the -- has to be a number.
MS. WOLFE: Has to be passible. It has to, you know, --
DR. TAILLAC: A number greater than zero.
MS. GLAUSIER: Has to be right on format date. It has to be date date, slash, blah, blah.
MS. HUNSAKER: It will. Yeah. It will.
DR. COOK: Any opposed to that? Okay.
MS. WHITNEY: Clay, did you have a comment?
MR. MANN: No. I think I was just going to say, we need to make sure that audit filters that are in trauma base are in trauma basic.
MS. HUNSAKER: They will be.
MR. MANN: I don't they currently or in the past have been.
DR. COOK: Okay. Let's move on.

MR. CHRISTENSON: I will brush right through this. We have the same issue with Audit Filter No. 6, almost the same percentage of missing data. So we want to look at the list the way -- I mean, probably do the same thing in our --
DR. COOK: Applied --
MR. CHRISTENSON: So that we get time data for this. So all of the stuff that we're going to look at now is based on these 1,484 complete reports with time data or 69 percent. Now, we're looking at transport time statewide. We have our same time cut points, one to 30 minutes, 31 to 60 minutes. So within that first hour, 62 percent of patients in 2011 were transported from that discharge time to admission time from the referral facility to definitive care.
If we bump out to two hours then we have our 85 percent window. And this is that graph which we have already looked at, this, however, is strongly effected by where you're at in the state. So once we look regionally transport times, which is what we're talking about a little bit earlier, things get complicated really quick.
So statewide, the one hour cut point is 62 percent in terms of transport. Within the SST region, Salt Lake and Summit and Tooele though, in 2011 81,

percent of all transfer patients make it to their designation facility in an hour or less.
Utah County was right there, to, at 80 percent making it within an hour. The Northern Region 64 percent. But then you see the other four regions of the state, Tricounty, Central, Southeast, and Southwest, quite a bit lower, not really getting the majority of their patients there within a hour and especially the southwest.
And so when I first saw the Southwest it kind of spurred me to try and understand what's going on here a little bit. This is the two-hour window now so bumping up the time -- Peter?
DR. TAILLAC: I'm sorry, but real quick. That 81 and the one was that 81 or more or is it really 81?
MS. HUNSAKER: Eighty-one percent.
MR. CHRISTENSON: So of all transfer --
DR. TAILLAC: Yeah.
MR. CHRISTENSON: -- trauma patients transferred from hospitals inside the SST region, they made it to their designation facility within an hour, 81 percent of all transfer patients.
DR. TAILLAC: So it's exactly 81 percent.
MR. CHRISTENSON: It's exactly 81 percent.
DR. COOK: I'm just surprised it that's low

frankly.
MR. CHRISTENSON: Well, yeah, it's SST. But we do have Tooele and Summit.
DR. VAN BOERUM: It's a window.
DR. TAILLAC: There is a window, that's true.
MR. CHRISTENSON: Bumping it up to two hours are the northern SST Utah Region almost a hundred percent, making it within that 2-hour window.
DR. TAILLAC: Okay.
MR. CHRISTENSON: 97, 98. And then the reset of the state also increases, Central 74 percent. Southwest was still quite a bit lower, which led me to create this graph trying to understand where each of the regions are sending their patients. And I will go through quickly.
This is 2011 data still. And at the bottom, XX, is we have our seven regions along with the number of patients that were transferred.
So for the Northern Region there were 368 transfer patients in 2011, 25 percent of them went to the U. About 40, 50 percent went to Primary's. Ten percent IMC. Fifteen percent to McKay Dee Hospital and about 10 percent to Ogden Regional. So that's the pattern there.
Do we have time to go through this? This is

1 an interesting slide but I don't know what our timeframe
2 is.
3 DR. COOK: I think we should.
4 MR. CHRISTENSON: It's a good slide. I go
5 through it quickly. SST, there were 829 transfer
6 patients, 30 percent of them went to the U, 20 percent
7 went to Primary and about 45 percent went to IMC. So
8 all of SST transfer patient stayed inside the SST
9 regions, which makes sense.
10 Utah Wasatch, there were 294 discharged from
11 those hospitals in that region. Ten percent went to the
12 30 to U. Thirty to Primary's. Ten to Primary
13 Children's and about 45 percent Utah Valley Regional
14 Medical Center.
15 Tricounty, there were only 83 that came out of
16 Tricounty, those two hospitals. Seventy of them --
17 65 percent went to the University. And then you can see
18 Primary Children's at 10 and IMC at 10.
19 Looking at the Central District there were 305
20 patients transferred from those hospitals in the Central
21 District. About 70 percent went to Utah Valley Regional
22 Medical Center which explained part of this. So here is
23 the two-hour window, we have 74 percent of those
24 patients in Central making it in that 2-hour window
25 because the far majority are going up to Utah Valley

1 Regional.
2 Southeast, we have 103 patients. Thirty
3 percent went to the U and about 45 percent went to Utah
4 Valley Regional.
5 And then the Southwest Region, which was what
6 got me started on this, trying to understand what was
7 happening down in the Southwest Corner because they are
8 lower than everyone else by quite a bit. About
9 15 percent are going to the U out of the Southwest. Ten
10 percent to Primary. And about 40, almost 50 percent
11 going to Intermountain Medical.
12 So looking at the map, we've got our Southwest
13 Region down here, patients are going up to Salt Lake at
14 IMC, about half of those patients. Central District is
15 going to Utah Valley Regional. So that explains at
16 least part of what's going on here, the designation of
17 why that Southwest Region is a little bit slower in
18 terms of getting to --
19 DR. COOK: I think another big part of that is
20 Dixie regional, really, is on course hopefully to become
21 a level two center at some point and they probably for
22 better or for worse right now they hold on to patients
23 longer than a lot these other lower level trauma centers
24 based on the fact that they're not sure whether or not
25 they're going to keep that patient or not.

1 And a lot those patients ultimately they
2 probably will keep as they become a level two center and
3 have more neurosurgical capabilities as part of that.
4 DR. TAILLAC: I can see that.
5 DR. VAN BOERUM: Also that's 2011 data, I bet
6 if you did it now they're sending a lot more of their
7 patients to Utah Valley.
8 DR. COOK: It's interesting --
9 MR. CHRISTENSON: Oh, really. You think their
10 destination has changed recently?
11 DR. VAN BOERUM: Uh-huh.
12 DR. COOK: There is definitely some change.
13 Definitely some change. But I think a lot of it really
14 does come down to those patients are at a quasi level
15 two trauma center right now and they are getting all of
16 their scans and they are trying to figure out, can we
17 take care of this patient or not. When they finally
18 decide that we can't and then they send them. And I
19 think that it's growing pain issue.
20 MS. HUNSAKER: But isn't this on transport
21 time? This isn't on how long their staying at the
22 hospital, isn't --
23 DR. COOK: No, that is true.
24 MS. HUNSAKER: -- this audit filter on
25 transport time, Matthew?

1 DR. COOK: No, that's is true. It's a good
2 point. It's a good point.
3 MR. CHRISTENSON: Which one? This is not --
4 MS. HUNSAKER: No. 6.
5 DR. COOK: This is simply transport times.
6 MR. CHRISTENSON: These are destinations,
7 these are times.
8 DR. COOK: Yeah. But it's time of transport.
9 MS. HUNSAKER: Transport times. Okay.
10 MR. CHRISTENSON: These are transport times.
11 This is Audit Filter No. 6.
12 MS. HUNSAKER: Okay. Okay.
13 DR. TAILLAC: So asking you on this one, in
14 the Southeast -- can you click back?
15 MR. CHRISTENSON: Yeah. Yeah.
16 DR. TAILLAC: The Southeast, did you take into
17 account -- take into account a lot of those go to the
18 same areas -- out of state, would you -- would those be
19 on your radar?
20 MR. CHRISTENSON: Yeah. No, we don't get
21 those. So if they go out of state they're falling off
22 the registry. Their destination is not --
23 DR. TAILLAC: So that's going to skew your
24 data because a lot of short transport times will be to
25 Saint Mary's I think. Right?

MR. CHRISTENSON: Yeah. And I wondered that about St. George, too, if that might be part of -- if some of those patients --
DR. TAILLAC: Dixie goes to Vegas.
MR. CHRISTENSON: Right.
MS. HUNSAKER: They're sending them down to Vegas.
MR. CHRISTENSON: Right. Right.
DR. TAILLAC: So that's going to skew those numbers then. So you're only going to see the one that didn't have a short transport time.
MR. CHRISTENSON: Yeah.
DR. TAILLAC: For some reason they came north instead of south.
MR. CHRISTENSON: Yeah.
DR. TAILLAC: That's great numbers though.
MR. CHRISTENSON: The last part is just out of state where those patients go to and just either about 75 or 65 percent are going to the University. So there is really four destinations where transfer patients go primarily. The University is getting in 2011 a little over 30 percent of all transfer patients.
Primary Children about 22. IMC about 20 and Utah Valley about 16 percent. You add those up, that's over 90 percent. And so those are really the

destination hospitals for trauma care. That's where they're being taken to by enlarge, it's those four.
This is our transport mode. So earlier we were talking been helicopter transports by region. The highest is Tricounty, so 45 percent of all those transports were by helicopter coming out of Tricounty in 2011. The second lowest, interestingly enough, which helped us explain the slower times, I guess, is southwest, only percent 12 transports were for helicopter.
Only -- only SST Region had fewer helicopter transports.
Craig?
DR. COOK: I guess, I just don't understand that. Is that fixed wing --
DR. VAN BOERUM: They can't. That's too far for the helicopter so it's fixed rate.
MR. CHRISTENSON: That's what I was wondering. Is it?
DR. COOK: Well, for 2011 data that's correct. Things have changed now. They have a helicopter there.
MR. CHRISTENSON: Where?
DR. COOK: In St. George.
MR. CHRISTENSON: Okay.
DR. COOK: So this data is could be going very

different now.
MR. CHRISTENSON: Within the last couple of years.
DR. COOK: Within the last year.
DR. VAN BOERUM: Even with the helicopter, they won't fly from St. George to IMC. They may fly to you guys.
DR. COOK: I think they will now.
DR. VAN BOERUM: It's a fixed wing to get to Salt Lake. It's fixed wing to Salt Lake.
DR. TAILLAC: So would you have -- do you know if it's fixed wing or only helicopter in this graph or is this just --
MR. CHRISTENSON: I would have to go in -- I don't know if it distinguishes between fixed wing and helicopter.
DR. VAN BOERUM: It does.
DR. TAILLAC: It does.
MR. CHRISTENSON: So it does it out by --
DR. TAILLAC: Okay.
MS. HUNSAKER: And now that you have 2012 data set, could you rerun the numbers for 2012?
DR. COOK: I don't think it will change a whole lot until 2013 because I think St. George had their helicopter base start around --

DR. TAILLAC: 2012.
DR. COOK: End of 2012; start of 2013.
DR. TAILLAC: But I think you should include helicopter and fixed wing in this graph. Would you agree? Just --
DR. COOK: Yes.
DR. TAILLAC: -- air transport.
DR. COOK: Absolutely.
MR. CHRISTENSON: Because fixed wing is going to be so much faster?
DR. TAILLAC: No, it's the same. Just it's either ground or air. That's all we care about.
MR. CHRISTENSON: Well, I know but that's what this is. This is just air. So but -- is there a difference between -- do we expect one to be faster or slower?
DR. VAN BOERUM: Fixed wing is slow.
DR. TAILLAC: Is just air --
DR. COOK: It's a lot slower.
DR. TAILLAC: This is air --
(Multiple speakers at once.)
MR. CHRISTENSON: This is -- is it --
MS. HUNSAKER: So even though --
THE REPORTER: Excuse me. I'm sorry, it's when --

1 DR. COOK: Okay. One person at a time.
2 DR. VAN BOERUM: Aren't you getting that down?
3 This says helicopter, Matt, does it mean air?
4 MR. CHRISTENSON: Oh, I'm sorry. It's all
5 air. It's non-ground transport. Sorry. Yep, it is.
6 It includes --
7 DR. COOK: Includes the --
8 MR. CHRISTENSON: Fixed wing and helicopter.
9 My error, yeah. So it's just title change on that.
10 DR. COOK: Okay. More slides on Filter 6 or
11 is that --
12 MR. CHRISTENSON: There is a couple more and
13 then we're done.
14 DR. COOK: Okay.
15 MR. CHRISTENSON: You also want to look at
16 ISS, how the transport times differ by ISS and injury
17 severity. And so looking at the 25 to 75 scores for
18 ISS. It is if we expect more patients are getting
19 transport -- transported in that 30-minute window as
20 evidenced by the blue part of the graph.
21 So looking at the far right bar, which is
22 patients 25 to 75, 30 percent of them are making it
23 within 30 minutes. If you bump up to an hour you're up
24 at about 75 percent of those most seriously injured
25 patients. So this confirms what we would want to see in

1 terms of the higher ISS scores of getting there quicker,
2 at least from the transport perspective.
3 This is just at the raw numbers. I think we
4 can move on and go to trying to make a decision as to
5 what this should be for Audit Filter No. 6.
6 DR. COOK: So we're trying to decide on an
7 actual time that we expect for transport --
8 DR. TAILLAC: Yeah.
9 DR. COOK: -- from hospital to hospital.
10 Thoughts? It's so variable based on where
11 your hospital is. It's a hard --
12 DR. TAILLAC: Yeah. And again, the south part
13 is skewed because you don't have the out of state
14 destinations, unfortunately. I love the data, I really
15 do. I just -- I don't feel like -- I don't want say I
16 don't care how long it takes, but it's so much out of
17 the control of the facilities that -- do we really want
18 to study it, I guess --
19 DR. COOK: It seems --
20 DR. TAILLAC: -- except to know.
21 DR. COOK: Yeah, I mean, it seems like if you
22 take the two southernmost regions out that clearly if
23 it's over two hours then you ought to look at it. I
24 mean --
25 DR. TAILLAC: Yeah.

1 DR. COOK: But if you're looking at that for
2 the southernmost regions, it's -- it's just -- there is
3 just too many variables, it's impossible.
4 MR. LARSON: Yeah, but isn't there something
5 that we can do? I mean, I feel like we can't just
6 totally put it -- push it aside. Even if it is sort of
7 out of the site of the hospital facility, we still can
8 push to have something done with it, transport
9 mechanism, whatever. I just feel like there is more to
10 be done.
11 DR. TAILLAC: This could help to determine
12 future helicopter, you know --
13 DR. COOK: Locations.
14 DR. TAILLAC: -- zones or bases.
15 MR. LARSON: Exactly. Something along those
16 lines.
17 DR. TAILLAC: Scary thought but it could.
18 Only because that's very controversial.
19 But no, it's good data, it's I don't feel like
20 we don't much control over the data. I don't know. Any
21 other thoughts?
22 MR. CHRISTENSON: What is your suggestion,
23 doctor?
24 MR. LARSON: I'm saying, well, I mean if -- as
25 we all know in trauma time is of essence. Do we need to

1 start putting someone from the helicopter services on
2 this committee? I mean, something like that. I
3 don't -- I don't know. It's this just -- something to
4 throw out to help so we have some control. I don't
5 know, maybe they'd say the same thing. We have no
6 control, it's just geography.
7 DR. TAILLAC: It's a great idea actually.
8 MR. LARSON: But, you know, we're throwing
9 rehabilitation, and, you know, those kind of things
10 as -- stuff on those lines, but it seems like we have
11 some way to influence these transport times. I don't
12 know. I'm just throwing it out.
13 DR. TAILLAC: I like your suggestion about a
14 helicopter representative. I never thought of that.
15 DR. COOK: It's a super good suggestion.
16 MS. WHITNEY: I don't know --
17 MR. LARSON: I guess the only problem with
18 that is --
19 DR. TAILLAC: Which one?
20 MR. LARSON: Which one. Because they --
21 DR. TAILLAC: That's exactly right. It's
22 tough. We could alternate. Yeah.
23 MS. WHITNEY: Well, that actually depends on
24 the make up the Trauma System Advisory Committee because
25 I can only have -- we have only three representatives

from one particular healthcare organization. See what I'm saying?

DR. TAILLAC: Yeah.

MS. WOLFE: Bob -- Bob has brought the awareness to all of these centers that have become leveled in our state. He's brought the awareness and I think that's why our numbers are improving. They're not where they need to be but I think the awareness that you bring to getting them out and getting to next hospital quickly is being done. I don't think we can abandon it because we'll just slide back to where we were and I think we still keep pushing for the decision to transfer and then getting them out of there.

And if we want to say 90 minutes sobeit, and let's -- when we reach 90 minutes then let's lower it. But I think we have to -- I think we have a responsibility to track this and make a difference in the patients' outcomes.

DR. COOK: So Deanna, though on this filter though, this is just transport time. I think Filter 5 is the -- what we talked about --

MS. WOLFE: Right.

DR. COOK: -- with 30 and 90 minutes.

MS. WOLFE: From the time you get out of one door to the next door. Well, do you think the ambulance

is stopping at McDonald's?

DR. COOK: I hope not.

MR. LARSON: Well, but then that's what you got to look at. You know, when you see these long times. I mean, they're not but --

MR. SANDERSON: Hey, they are hungry guys.

MR. LARSON: What's that?

MR. SANDERSON: They are hungry guys.

DR. TAILLAC: They buy something for the patient, too.

MR. SANDERSON: Right.

MR. LARSON: But I wonder if there is something -- I don't know. I'm just thinking in our facility, we do things like we have to -- this is air so I shouldn't say that. But we have to -- we try to influence how fast we can get the ground team together and those kind of things.

DR. COOK: Can we break this up like we did 5 and do 6A and 6B and have 6A is all regions of the state other than the two southernmost regions and 6B is the southernmost regions and give them two different times? Two hours for everyone other than the two southernmost regions and give them three hours or something like that? I mean, I --

MR. CHRISTENSON: That was -- in putting this

together that was my thought. The numbers are so disparate by regions those top three regions are a lot tighter and then the east and the southern regions, almost like there should be two, at least two for those top three regions. Maybe I would suggest in an hour and trying to get 90 percent of the patients in within an hour.

And for maybe the bottom part of the state trying to get 50 percent of the patients in within an hour or maybe that's not even reasonable. But I think it should be broken down.

DR. COOK: I think if we keep the filter we should break it into two different sections.

DR. TAILLAC: Unless there is some way, Matthew, to get the destinations for the out of state facilities. I mean, if the air agency flies them from Utah to St. Mary's or Vegas, you should have that record from the state agency to say -- from the air agency to say what time they arrived.

MR. DALLEY: Might not be that easy. Sometimes agencies comes from --

DR. TAILLAC: Okay. You're right. It starts out of state.

MR. DALTON: Las Vegas will pick up.

DR. TAILLAC: You're right. And then drive

from St. George.

DR. COOK: Yeah. I mean, if the helicopter in St. George takes that patient almost immediately and flies them to Las Vegas, a lot of those patients are still going to have just over an hour time just from St. George.

Any motions?

Jason, what do you think? You're -- you live this so what -- I mean, should we break it into two sections?

MR. LARSON: I guess I can go both ways on it. I don't know. I think part of -- part of me wants to say just don't and just have -- just track it all.

DR. COOK: Have that standard.

MR. LARSON: And like you said, Dixie now has a helicopter, that may change anyway.

DR. TAILLAC: That's true.

DR. COOK: Yeah. They will change. And as they are a level two center, if they become a level two center, which I'm sure they will soon, this then goes away for them with the patients they're keeping and the ones that they're not keeping they need to try to get transferred as quickly as possible.

DR. TAILLAC: Yeah. And I guess, even if the shorter ones are going south, you still want a good

1 transport time for the ones that do go north, right?
2 DR. COOK: You do.
3 You have a motion?
4 MR. SANDERSON: Well, you got to realize, too,
5 with time, the air agencies are spreading out throughout
6 the state, becoming more remote. So I think that
7 inherently might speed up our transport times because of
8 the location they get placed.
9 DR. TAILLAC: It will be interesting to track
10 this over the next few years because there has been a
11 fair amount changes in the -- in the state --
12 DR. COOK: There have been.
13 DR. TAILLAC: -- over the last two years.
14 DR. COOK: So if we're going to pick one
15 number, if we're to keep it as one number, what's the
16 number? Is it two hours? Is it three hours? What is
17 it? For transport time.
18 MR. LARSON: I would almost say, keep it the
19 same. Do the same thing and just see what -- I mean,
20 had enough change like you said maybe -- maybe that's
21 good change. I mean, for instance, we have a helicopter
22 service Tricounty area, ours isn't changed, you know
23 what I mean. Dixie is changing. What if we just look
24 at this --
25 DR. TAILLAC: Just track it for while --

1 DR. COOK: We look at it next year.
2 DR. TAILLAC: -- and before we make a
3 decision, before we change it. How about that? See
4 what it looks like next year.
5 DR. COOK: Got a motion?
6 MR. LARSON: That's a motion.
7 DR. COOK: Okay. Second?
8 MR. DALLEY: Second.
9 DR. COOK: Second. Okay. All in favor aye.
10 Any opposed?
11 MR. CHRISTENSON: Can you tell me what it was?
12 DR. COOK: Yeah, keep it the same.
13 MR. CHRISTENSON: That was quick.
14 DR. COOK: Keep it the same.
15 MR. CHRISTENSEN: There isn't a time right
16 now -- so -- there isn't a time yet. We're just looking
17 at it.
18 DR. COOK: But this is under an hour.
19 MR. CHRISTENSEN: Yeah, is map is under an
20 hour. We have the other map under two hours.
21 DR. TAILLAC: So let's do that again.
22 MR. DALLEY: Break it up.
23 MR. CHRISTENSON: Just keep doing -- keep
24 monitoring this way?
25 MR. DALLEY: Yeah.

1 MR. CHRISTENSON: Okay. So we're not going to
2 set a definitive time, we're just going to continue to
3 look at times of transport?
4 DR. COOK: Correct. Correct.
5 Anything else?
6 MR. CHRISTENSON: That's it.
7 DR. COOK: Thank you, very much. That was
8 very, very interesting data.
9 It's that sort of data that will really make a
10 difference in our trauma care delivery. Thank you.
11 That was great.
12 Shari, I think you're next up and --
13 MS. HUNSAKER: You know what? This is going
14 to be so short and sweet.
15 DR. COOK: Make it short and make it sweet,
16 that would be good. Thank you.
17 MS. HUNSAKER: Okay. As far as our trauma
18 registry is concerned, the 2012 data is now scrubbed,
19 cleaned and available in the cube for data analysis.
20 And the 2014 updates have been submitted to
21 CDM. There was some delay, totally on me because I was
22 out for knee surgery. I didn't them in to them before I
23 took sometime off. But that might work to our favor
24 because I'm going to try and squeeze in these last two
25 that we came up with today into that.

1 As far as -- I mean, are there any other
2 questions regarding the registry? We had our Tug Spring
3 Seminar the first part of March. It was extremely well
4 attended. We hired Cathy Cookman and her consultants
5 team to come out and train our trauma users on ICD10
6 coding specific to trauma. And I think it was
7 excellent.
8 If you'd like to me jump down to No. 7, I can
9 tell you that for our free-standing emergency department
10 data reporting, it had come to my attention that the
11 standalone EDs were not reporting any trauma data. And
12 I was able to do a query out of POLARIS to determine how
13 many runs were delivered to those standalone EDs but
14 getting the destination from those EDs out the count for
15 the various destinations was impossible because of the
16 various ways that EMS agencies record their
17 destinations. Some of them put the name. Some of them
18 put the street address. So I can't get any meaningful
19 data for their destinations.
20 But I have started the process of letting the
21 standalone ED departments know that they are responsible
22 for submitting trauma data whether it's through their
23 hosting hospital or they do the data entry themselves.
24 DR. TAILLAC: I would argue, for what is it's
25 worth, that they should -- and we've made them do this

for stroke. Not that they're designated --
MR. JEX: That's true.
DR. TAILLAC: -- but they had should be sending data separate because they're a separate -- freaking geography, you know, separate building. So I don't care who does it, their same trauma manager can do it from the mothership but they need to be able to code themself --
MS. HUNSAKER: They are breaking it out by -- yeah.
DR. TAILLAC: So it doesn't all say St. Marks or University of Utah --
MS. HUNSAKER: Right. Right.
DR. TAILLAC: -- whatever.
DR. COOK: It has to be separate.
DR. TAILLAC: Okay.
MS. HUNSAKER: It says Davis Hospital, Weber Campus and South Jordan.
DR. TAILLAC: We can know. Okay. That's good.
MS. HUNSAKER: And I fixed it up in POLARIS so that hospital users at the U can see the PCRs from both South Jordan and the U. And the users at Davis Hospital can see the PCRs for their hospital or the Weber Campus destinations.

DR. COOK: Thank you. Thank you.
Bob, do you want to go designation and then I think we will have some more that comes up with on free-standing emergency departments under designation, as well.
MR. JEX: Well, I will do five and six together just because I can do it in five minutes or less.
Currently, there are 19 designated trauma centers in the state. This year we will have a plan on five additional trauma centers by the -- by December 31: San Pete, Delta, Heber, Ashley Valley and Jordan Valley will -- are on track for designation this year. Two other -- I'm sorry, take Ashley Valley out of that because I'm not sure.
Davis and Lake View are on track for next year. Lake View is having a hard time determining whether they want to be one or not.
The SST, which is Summit, Tooele and Salt Lake Counties, it was reported last time, the COT indicated they're wanting us to work with the department on setting reasonable expectations for members and types of call centers to be designated in that region.
Dr. Marrouche from the University and I've talked to Dr. Von Boram here today, we will be getting

together with the -- with the trauma medical directors both in the designated trauma centers and our seating designation. We had that discussion and we have something to report on that basis at our next meeting.
DR. COOK: That is terrific that's monumental actually.
MR. JEX: That's it.
DR. COOK: Let me ask, Bob, is there someone who is spearheading that specifically, who is making sure that everyone is included that needs to be included what's --
MR. JEX: Ahh...
DR. COOK: I guess I'm just trying to understand if --
MR. JEX: At the meeting Dr. Morris indicated at the -- that Dr. Van Boerum and Dr. Marrouche be cochairs of that on behalf of the COT and make sure that -- short answer, is I'm staffing -- yeah, they'll --
DR. COOK: Okay.
MR. JEX: -- make sure that happens.
DR. TAILLAC: Did you want to discuss this briefly or just take it off line? Because you are -- like I just ask are you inviting all of the hospital representatives from SST to are you meet withing trauma

centers first kind of hash out a plan I guess?
MR. JEX: Hash out a plan and then invite the others.
DR. TAILLAC: Okay.
MR. JEX: So those that we'd inviting would be: University, Primary, IMC, St. Marks, Jordan Valley. Should be five.
MS. HUNSAKER: And Pioneer.
MR. JEX: Pioneer. And then we'll come up with a plan and then invite the others involved to go drill out a plan.
DR. TAILLAC: Okay. That's great.
DR. COOK: Don, you have to any comments on that? Okay.
That's -- that's very -- that's going to very productive. Very helpful.
DR. TAILLAC: Interesting.
DR. COOK: Over time it will be very productive.
DR. TAILLAC: That's right.
DR. COOK: In the short term we will have some fireworks.
DR. TAILLAC: Have you been invited to do opening the ceremonies potentially?
DR. COOK: I have not. I'm more than happy to

be present and involved in any role asked to be.
MR. JEX: And in reality, that was part of the discussion, that we ask that Dr. Cook come -- he was not at the meeting so...
DR. TAILLAC: He got invited.
DR. COOK: When you're not there.
MR. JEX: Dr. Cook would be there to talk about a concept and it's suggested he come.
DR. COOK: I'm happy to participate in whatever way you guys want me to participate.
DR. TAILLAC: I don't think you need to come to every meeting but I think it would be help to.
DR. COOK: Start the ball rolling.
DR. TAILLAC: Share your experience, basically.
DR. COOK: Sure.
DR. VAN BOERUM: Set the stage.
DR. COOK: Sure.
Anything else, Bob, on either of those two points?
MR. JEX: Not unless there are questions.
Okay.
MR. CHRISTENSON: When?
MR. JEX: When?
MR. CHRISTENSON: When?

MR. JEX: We haven't set up a date but we will have it done -- we will have an additional meeting prior to report at the next trauma system meeting.
DR. COOK: Great. Thank you. Yeah, if we can -- let me know on that would be good.
Back to point No. 7, freestanding emergency department data reporting.
DR. TAILLAC: Say that again.
DR. COOK: Are you presenting No. 7 or is --
DR. TAILLAC: Oh, yeah. Yeah. Sure. Yep, I can.
So this is the freestanding. So here is -- Lone Peak Emergency Center, South Jordan Health Center, Davis Emergency Department. Just here is the data that we're able to pull out of POLARIS.
MS. HUNSAKER: That Lone Peak is now a hospital. They're not -- they're no longer a standalone ED.
DR. TAILLAC: Right.
MR. CHRISTENSON: Yep, that's true.
DR. TAILLAC: They weren't in 2011.
You can show that data if you want.
MR. CHRISTENSON: Yep.
Lone Peak opened in May 2010, 10,000 patients that first year. Lone Peak Hosptial opened last year so

they've opened -- been open for quite a year. They have 30 beds. Here is the data for Lone Peak.
The graph is transports to Lone Peak broken out by primary impression. You can see the bottom, they were 49 trauma injuries that EMS delivered to Lone Peak Emergency Center. The -- on far the right-hand side from Lone Peak are the transfers out of the Lone Peak Emergency Center.
So there were clearly a lot more -- a lot more activity in terms of just inter-facility transports during this three and a half/four year period. 2650 transfers and 64 went to -- 64 percent went to St. Marks.
MS. HUNSAKER: Now, it is possible that some of those 1707 did not arrive at the Lone Peak by EMS.
MR. CHRISTENSON: Most of them didn't. Yeah, the only ones that -- only 226 was the total delivered by EMS. The far and away majority was not delivered to EMS --
DR. TAILLAC: Right.
MR. CHRISTENSON: -- or not delivered through EMS.
DR. TAILLAC: So not a lot, that's almost four years.
MR. CHRISTENSON: Yeah, I don't think -- May

of 2010 and that was just queried in March of 2014 so right at four years.
Here is South Jordan. That opened in January 2012. There were 8,000 new patients in that 2012 year. Same graphic. These are the EMS transports to South Jordan broken out by primary impression at the bottom. Twenty-four traumatic injuries, so a total of 226 in about a two-year period. And then on the right-hand side the inter-facility transfers, 894. And 81 percent went to the University.
Davis Emergency Department, Weber Campus has not been open quite a year. There were 51 -- so far there has been 51 EMS transports to the Weber Campus. Eight were traumatic injury and then 327 inter-facility transports with 65 percent going to Davis Hospital.
A quick rundown of the numbers for those freestanding entities.
DR. COOK: Thank you.
So with this data, I'm remembering back to our discussion, I believe, at our last meeting about how these freestanding emergency departments fit into our trauma system what -- what standard do they need to be held to. I think that that is what we need to discuss and potentially decide from, you know, our committee perspective.

1 Are there thoughts? I have some strong
2 opinions but what does the committee feel?
3 DR. TAILLAC: Why don't you start?
4 DR. COOK: Well, my -- my personal opinion is
5 that these facilities ought to be held to the same
6 standard as any facility receiving trauma patients. And
7 that if they -- if they would like to receive trauma
8 patients they should jump through the same hoops that
9 any other facility should jump through and that would
10 include potentially leveling at whatever level they can
11 level at which very well may be a level-five trauma
12 center.
13 DR. TAILLAC: Does a level five never to have
14 a have surgeon?
15 MR. JEX: That's correct.
16 DR. COOK: Never has to have surgeon.
17 DR. TAILLAC: Does a four does, right?
18 MS. WOLFE: Does a level five have to be able
19 to keep patients in their hospital?
20 MR. JEX: By definition a level five facility
21 is a treat -- or is a reception, a stabilize and
22 transfer, resuscitate. The standards do indicate
23 that -- that there should be an operating room, but in
24 reality these are centers that are not offering any
25 definitive care.

1 DR. TAILLAC: So could they qualify at the
2 level five under current guidelines?
3 MR. JEX: In the current guidelines, no. They
4 would have to make the availability of a 24-hour
5 operating room option.
6 DR. COOK: Is --
7 MS. WOLFE: So a clinic with a CAT scan cannot
8 accept trauma patients. I mean, I think we have to take
9 that stand.
10 DR. VAN BOERUM: I fully agree. I don't think
11 there should be any trauma patients going.
12 DR. TAILLAC: Ever? Any? I mean, because,
13 you know --
14 DR. COOK: Again, the reality is that they are
15 going to -- patients are going to go there with
16 trauma --
17 DR. VAN BOERUM: They still can't care of
18 them.
19 DR. COOK: -- diagnosis.
20 DR. VAN BOERUM: So why don't they just go to
21 the closest facility. You know, you're already going
22 delay their treatment by on average about four hours.
23 DR. TAILLAC: I would like -- we could
24 probably -- I'm not trying to defend it although I work
25 in one so I got to be careful. But, you know, a kid who

1 falls and breaks his leg and you put a splint on it and
2 he sees ortho the next week is the same thing that he
3 could go to an InstaCare, same thing happen.
4 So not all of them will need, you know, a
5 second transport. I see what you're saying. But the
6 hard part is defining which ones won't.
7 MS. WOLFE: Well, if they're injured enough to
8 go by ambulance they maybe shouldn't go to a
9 freestanding clinic.
10 MS. GLAUSIER: And that's what I was
11 wondering. Can we limit what EMS are taking to them?
12 Like if -- they show up, but -- the vehicle, there is
13 nothing we can do about. But can we limit what EMS are
14 taking to them? Because if it has to go by EMS, I don't
15 know if you could have them transferred out to another
16 facility.
17 MS. WOLFE: Look at that 51 transports in and
18 327 transports out. That's whole lot of ambulance usage
19 in less than a year.
20 MR. SANDERSON: But you're going to run into
21 --
22 DR. TAILLAC: Only 51 came in though, that's
23 the point. So even if all 51 were transported out,
24 which they weren't -- the rest were just walk ins that
25 got transported out.

1 MR. SANDERSON: From an EMS perspective, too,
2 if I know Dr. Taillac is in this facility and I've got a
3 ground level fall or I've got a broken ankle isolated,
4 trauma injury, yeah, from an EMS perspective, be more
5 comfortable taking it in to him knowing it's going to be
6 splinted and then just sent out.
7 But, our guidelines in Utah County, we would
8 never take a trauma criteria patient to that type of
9 facility.
10 DR. VAN BOERUM: Yeah.
11 DR. TAILLAC: And EMS generally does not want
12 to put a patient in position to get a secondary
13 transport for a whole bunch of reasons. They just know
14 that's not a good idea so they try and avoid that. So
15 there is self-triage on EMS --
16 MR. SANDERSON: And they -- and the patient
17 may request. The patients --
18 DR. VAN BOERUM: There is some abuse that goes
19 on in that. I've actually had -- an ambulance driver
20 told me, you know, off the record, that he was
21 instructed take the patient to this place, drop him off
22 and go out to the parking lot hang around for a little
23 bit because there was a pretty good chance they were
24 going to be transferred to the next facility that way --
25 MS. GLAUSIER: Sure, it's more revenue. I

1 mean, that's --
2 DR. VAN BOERUM: -- their -- that's --
3 DR. TAILLAC: Dang, I hadn't thought of that.
4 MS. WOLFE: Peter, this is what's happening
5 and I know this for a fact. This came out in our EMS
6 case review. The agencies contracted with this
7 freestanding and they said, we guarantee you at least 11
8 transfers a month. So they brought in a new rig, hired
9 new people to handle those transfers. Those patients
10 are coming into them by ambulance, they wait, they get
11 called to transport them to another hospital.
12 They said it's a great revenue generation for
13 their city and they're doing that for revenue
14 generation. And the patient doesn't get stuck with the
15 bill, the freestanding pays the ambulance to transport
16 them a second time. So it's -- it's an unethical
17 practice.
18 MR. DALLEY: I agree. I don't disagree with
19 anything that's anything that is being said but I don't
20 we, as a committee, have the ability to say you can't do
21 this or you can't do that. I think we can recommend and
22 I certainly wouldn't be opposed to recommending
23 something we've talked about.
24 But I guess that's the question is where those
25 recommend -- where do those recommendations go and who

1 has the ability to control that kind of stuff because
2 we're an advisory committee.
3 DR. COOK: Sure.
4 Jolene, do you have any comments on that based
5 on what --
6 MS. WHITNEY: I'm sorry? I wasn't paying
7 attention.
8 DR. COOK: I didn't mean to catch you
9 offguard.
10 MS. WHITNEY: I know, I slipped away for one
11 second.
12 MS. WOLFE: We can't tell anybody what do to
13 so where do we go.
14 DR. TAILLAC: So this committee can't say that
15 ambulances can't go to freestanding -- so even though
16 they might want to, I don't know if that's the case, but
17 if they wanted so. So they advise the bureau. Who can
18 say that?
19 MR. DALTON: The local medical directors in
20 the protocols.
21 DR. TAILLAC: Right. Is there something above
22 that?
23 MS. HUNSAKER: Could the EMS committee make
24 it?
25 MS. WHITNEY: That you could make it a rule if

1 you wanted to.
2 DR. TAILLAC: You being who? Not out here but
3 the bureau.
4 MS. WHITNEY: Yeah, you could make a
5 recommendation to make a rule change.
6 MR. DALTON: Yeah, we can make a
7 recommendation. I guess that's my point. And I'm not
8 opposed to doing that, I'm just -- when Karen was
9 saying, you know, how do we impose that, we can't. But
10 we can certainly make a recommendation.
11 DR. TAILLAC: I guess, if we could -- I'd
12 interested, Bob, what in other markets around the
13 country where there are freestanding ERs popping up,
14 what are other states doing that have trauma systems?
15 MR. JEX: I don't know the answer to that
16 question.
17 DR. TAILLAC: I know in Texas it's a complete
18 free-for-all. It's an absolute disaster. Yeah.
19 Because in Texas -- here we don't have the problem at
20 least all of ours are connected to a real hospital. In
21 Texas they literally are InstaCares with CT scans.
22 That's it. No connection to a facility. It's -- and
23 the ambulances don't know what to do.
24 MS. WHITNEY: And it's like 7-Eleven. There
25 is --

1 DR. TAILLAC: One at every corner.
2 MR. DALTON: I mean, could it be implemented
3 in the hospital triage guidelines.
4 DR. TAILLAC: You certainly could and they
5 would apply, but, you know, I mean, the question is: Do
6 you want any trauma patients to go there? I mean, is it
7 zero or is it trying to pick the right ones. Which is
8 slippery slope, it's hard to do.
9 MR. SANDERSON: It is.
10 DR. TAILLAC: Especially if there is this, I'm
11 going to wait in the parking lot and take them again
12 attitude. That's horrible.
13 MR. SANDERSON: If it's not what's best for
14 the patient, it's easy for a medical director and any
15 one of our agencies to say, that doesn't meet our
16 protocols, we don't do it.
17 DR. TAILLAC: Sure. The medical director is
18 in power to decide destination and can say you will not
19 go there with trauma.
20 MS. WOLFE: But we have inactive medical
21 directors so it's not being -- there no oversight.
22 DR. TAILLAC: And those medical directors are
23 hired by the very higher agencies who are making
24 money --
25 MS. WOLFE: That's right.

DR. TAILLAC: -- on these transports, by the way. Yeah.
DR. COOK: Correct.
MS. WHITNEY: But it is an issue that could be discussed with the medical directors.
MS. WOLFE: And you have trauma patients going to freestanding EDs when they're -- the hospital they are affiliated with is not even a trauma center and then the patients are getting taken to another trauma center.
DR. COOK: Do we have any -- it's obviously a complicated problem and I think we all have pretty strong feelings about what the right answer is here. But do we feel like we have enough information or consensus to make some sort of a recommendation? Do we want to think over this and reassess it next meeting? I mean, we talked about this to a certain at our last -- last meeting. It's --
MS. WOLFE: I think it's to the point we make a recommendation. We were going to think about it last meeting, haven't thought about it. I don't think we can think about it anymore.
DR. COOK: I like that.
MR. SANDERSON: I was just going to say, what about approaching the freestanding clinics from our perspective and laying it out and saying, look, divert

them or if EMS calls -- maybe they will just accept them because it's revenue, I understand that. But let's put it on their shoulders to turn EMS away.
DR. TAILLAC: I think they won't do that. That their whole reason for being is to get --
MR. SANDERSON: Money.
DR. TAILLAC: -- as many patients as possible. They will we understand we will careful. We only do the right thing. But I don't think that would work.
I wonder is -- and Jolene, help me.
Is there a bigger venue, although this is the State Trauma Committee. But this an important thing to nip in the butt early --
DR. COOK: Absolutely.
DR. TAILLAC: -- in my opinion No. 1.
No. 2, I think we should probably get a lot of voices at the table to discuss it and I don't know if this is the only venue. Because honestly, well, it's bigger than trauma for one thing. We only control trauma in this group.
I don't know. Is there a bigger venue where this could be discussed?
MS. WHITNEY: Well, it does EMS -- State EMS Committee --
DR. TAILLAC: So that --

MS. WHITNEY: -- or even one of the subcommittees like operations.
MS. WOLFE: Because you think stemis and strokes and septic patients and hot belly patients from a perforated bowel and you can tell that they are sick, shouldn't be going there. Not just trauma.
DR. TAILLAC: The ones you can tell are really sick, right. A patient --
DR. COOK: Sue --
DR. TAILLAC: -- with stable vitals signs shouldn't go there.
DR. COOK: Yeah.
DR. TAILLAC: That's a discriminator.
DR. COOK: Sue, do you have a comment?
MR. JEX: We do designate them as stroke facilities with the rational that if a patient, a stroke patient, needs treatment in a three-hour window and transport down the street or across town, will take them out of that window, it's more important that they get the care there then fall out of triage --
MS. WOLFE: If they haven't done anything to really deserve that -- that designation. They're riding on the coattails of their momma and they need do it themselves.
MR. JEX: We do designate them.

DR. TAILLAC: No, they're designate them.
MS. GLAUSIER: Because the freestanding ED's they have to have their own stroke and --
DR. TAILLAC: Yeah.
MS. GLAUSIER: -- stemi catheter or stroke receiving in primary --
MS. WOLFE: Are there any freestanding EDs that are -- that are more than 10 minutes away from a large hospital? There are not.
DR. TAILLAC: How large a hospital?
MS. GLAUSIER: A hospital that is --
MS. WOLFE: A full service hospital.
MS. HUNSAKER: A real hospital.
MS. BURKE: That's true.
MS. WOLFE: I mean, it's true. They're not a hospital.
(Multiple people talking at once.)
MS. WOLFE: Not unless -- you need to call a spade a spade. They're not a hospital.
DR. COOK: So let's have -- let's have person speak at a time.
Sue, can you --
MS. DAY: Well, I guess I would make a recommendation, I would just say, that is some reason we have a level fives that are really not a ACS criteria.

1 Are there level fives anywhere else in the United
2 States?
3 MR. JEX: There is. And the reason is because
4 we have some rural facilities that benefit by treating a
5 trauma patient in a systematic practice manner that
6 are -- that don't have a general surgeon in their
7 community and are -- their emergency rooms are staffed
8 by mid-levels which falls outside of the ACS criteria.
9 But that's the reason, that's the rational.
10 DR. COOK: Peter.
11 DR. VAN BOERUM: For a rural -- not for --
12 DR. TAILLAC: Yeah, right.
13 One -- we could make this recommendations.
14 One of which is upfront to say that these facilities
15 will not qualify for any trauma designation. Because
16 they don't, right?
17 And then two, again, the discussion about
18 whether any trauma patients should come by EMS to these
19 facilities is another a little more difficult decision
20 but the I think if the committee wanted to make a
21 recommendation I think that's within your purview to do.
22 DR. COOK: We could put the ouns back on them
23 in some sort of a recommendation that simply says
24 until -- until they make a case, until these centers
25 make a case that they should be leveled trauma centers

1 for some reason, that it is not our recommendation to
2 allow them to be, you know, designated.
3 And at some point if one of them feels
4 strongly about it then, you know, they can -- they can
5 come to us and make their case but until that time, we
6 don't --
7 DR. TAILLAC: I think that softens that a
8 little bit more.
9 DR. COOK: We don't recommend and we won't
10 designate any of these freestanding facilities as a
11 trauma center.
12 The more difficult issue as, Peter, brought up
13 would be do would make -- do we carry that
14 recommendation to these facilities accepting ambulance
15 patients with a trauma diagnosis? Do we or do we not?
16 Or do we just leave that as is?
17 DR. TAILLAC: There is the occasional case
18 where, geographically, the patient is completely
19 unstable and crashing or has an airway that needs
20 attention where these places might be better than
21 driving seven more minutes to another place. I mean, so
22 sort of on that extreme end it would sort of be an
23 emergency exception potentially.
24 MS. BURKE: Well, the guidelines, EMS
25 guideline cover that already --

1 DR. TAILLAC: Right.
2 MS. BURKE: -- because it says transport to
3 the most appropriate facility. It doesn't say hospital
4 or facility if they need to stabilize a patient.
5 DR. TAILLAC: Yeah, fair enough. But if this
6 group were to say: We don't recommend ambulances go
7 trauma facilities, that might be an exception.
8 DR. COOK: And that maybe the way to say,
9 Peter, is we do not recommend -- using that language.
10 MR. JEX: That's a pretty soft way of doing it
11 but I think it sends the message.
12 MR. LARSON: I think that comes with what
13 you're saying, Mark.
14 MR. DALTON: We're recommending something. I
15 think that's appropriate.
16 DR. COOK: Yeah, does ultimately matter.
17 Yeah.
18 Do we have a motion?
19 MS. WOLFE: I will make a motion.
20 DR. COOK: What's the motion?
21 MS. WOLFE: The motion is we don't take
22 unstable patients -- do you want to say "unstable or
23 trauma?"
24 MR. LARSON: Yes, something.
25 MS. WOLFE: Kris has something to say. I

1 could see her peripherally.
2 DR. COOK: Kris. Kris, go ahead, and then
3 we'll --
4 MS. HANSEN: What is a trauma patient? So
5 some little kid falls down and breaks his wrist, he
6 can't go to one these emergency centers? That's not
7 a --
8 MS. WOLFE: You know, what? If they're coming
9 by ambulance --
10 MR. LARSON: If there is little kid falling of
11 the monkeys bars they get transported by an ambulance.
12 DR. TAILLAC: Absolutely. Every day.
13 MS. WOLFE: Yeah, they are.
14 DR. TAILLAC: Everyday. That's the day. Is
15 there are the dinky patients that come by ambulance.
16 Everybody comes by ambulance.
17 MS. WOLFE: The schools call an ambulance
18 every time.
19 DR. TAILLAC: That's the problem. They bump
20 their head, school calls the ambulance.
21 MS. WOLFE: It's no big deal, they were --
22 DR. TAILLAC: Yeah, if the -- ideal world
23 there would be a way to cut off very minor trauma.
24 DR. COOK: You could use and your level one
25 level two criteria. I mean, I hate to say it, but --

1 MS. HUNSAKER: Well, when we go live with
2 NEMSIS version 3, there is trauma triage criteria
3 included in those new data elements. And so the EMS
4 agencies will be required to enter values for that. So
5 we may want to table this until we are live with NEMSIS
6 3 and then we can do a quantifiable guideline that says,
7 you know, this value and above it is not appropriate to
8 transport to a standalone ED.
9 DR. COOK: I think that's a good point but I
10 think that we -- like Peter said, I think that need to
11 nip this in the bud before it perpetuates itself beyond
12 what we'd like to see.
13 DR. TAILLAC: I was going to say, the triage
14 and transfer guidelines that we have got now talk
15 about -- the first three which are physiologic, anatomic
16 say closest trauma center, then hospital and then last
17 says facilities.
18 Pull it up here.
19 MR. CHRISTENSON: I'm pulling it up right now.
20 MR. JEX: First two are different policies.
21 DR. COOK: Yeah, I've got it here.
22 MS. WOLFE: Okay. So in our earlier meeting
23 we acknowledged that EMS don't know or follow the rule,
24 the transport and triage guidelines. And that we
25 recognize that as a weakness and we need to get out here

1 and teach it. So how are we going to tell them now that
2 they need to follow that before they consider going to a
3 freestanding and they don't even know what it is.
4 MR. JEX: Yeah. It says, step one, two, three
5 and four transfer to trauma center or hospital capable
6 of taking care.
7 DR. TAILLAC: So they would have not meet any
8 of the steps to be transported, maybe -- that's an
9 interesting --
10 MS. WOLFE: So that takes care of it but they
11 don't know about it.
12 MS. DAY: If they just follow the guideline.
13 DR. TAILLAC: But it's not --
14 MS. WOLFE: But that's an educational point,
15 too, that has to be made. A freestanding ED is clinic
16 with a CAT scan, it's not a hospital.
17 DR. COOK: So according to the guidelines that
18 we were just referring to, we could, one, make the
19 decision that we're not designating freestanding
20 facilities, freestanding emergency facilities as trauma
21 centers at this time and we don't intend to change that
22 but it could be, you know, brought forward in the
23 future.
24 And secondly, we would strongly recommend that
25 we follow our standard triage guidelines for the triage

1 of trauma patients, accordingly.
2 DR. TAILLAC: Which precludes transport to a
3 freestanding emergency --
4 DR. COOK: Accordingly, the patients need to
5 go a trauma center or a hospital capable of taking care
6 of those --
7 MR. LARSON: But a kid that fell and broke the
8 wrist at school would still be able to go there?
9 DR. TAILLAC: It looks like he would. And it
10 says: If you don't go to any of the four steps, it --
11 below that it says: Transport according to protocol
12 which means patients who do not meet any of the triage
13 criteria in steps one through four should be transported
14 to the most appropriate medical facility as outlined in
15 local EMS programs.
16 MR. LARSON: Yeah.
17 DR. COOK: Which is no longer a hospital. So
18 that would cover it.
19 MR. LARSON: We just need to emphasize this.
20 MR. SANDERSON: Well, by putting this out as a
21 minor change, it's going to get each agency at least to
22 review what's been in place forever or for, you know --
23 so at least it's going to get it in front of them.
24 DR. TAILLAC: That's -- I like it because it's
25 kind of real consistent, doesn't really change anything

1 except you got to review this.
2 MR. SANDERSON: Right. Right.
3 MS. WOLFE: So every one of the EMS medical
4 directors needs something from you, Dr. Taillac, that
5 says --
6 DR. TAILLAC: From the committee.
7 MS. WOLFE: -- we need to -- yeah, you can
8 represent the committee. But we need to follow these
9 guidelines. It's been brought to our attention many
10 agencies don't even know they exist. And it's your
11 possibility as the medical director to get this out
12 there and this involves freestanding -- however you have
13 to say it.
14 MS. HANSEN: So back up. We don't know --
15 really don't know that they're not following because on
16 this slide right here, you say eight were traumatic
17 injury patients, but they could have been kids with
18 broken arms. We don't know that.
19 DR. TAILLAC: Sure. Or lacerations.
20 MS. HANSEN: Or a laceration. We don't really
21 know that.
22 MS. WOLFE: We know of four. We know of four
23 that at the facility since June. So we do know some.
24 MS. HANSEN: All we do know, they don't --
25 MS. WOLFE: Right.

DR. COOK: Let's make a motion as to what we're going to do with this. It's going to have to do with designation of these centers and then some sort of emphasis or education that goes out to these centers.
Someone want to make a motion?
I guess I cannot as the chair.
MS. WOLFE: I will make it, what he said.
DR. TAILLAC: Two things. Say your two things. Designation.
MS. WOLFE: Yes, that we're not going to designate freestanding emergency departments as trauma centers.
DR. COOK: Trauma centers.
MS. WOLFE: And that we will have the medical directors be charged with the accountability piece of going out and teaching their agencies what's appropriate and not appropriate based on transport guidelines.
MR. LARSON: Do you want to include what Craig had said about we don't want to -- we're not -- we don't recommend at this time unless they can present a better case for it, just so it softens it a little bit?
MS. WOLFE: Yes.
MR. LARSON: Gives them the ability to come back to us.
DR. TAILLAC: I think the designation is quite

right. They are not a hospital.
MR. JEX: We've got to change the criteria.
MR. LARSON: But I think that could help.
MS. BURKE: And that helps for any 24-hour EDs that are going to pop up, which they will.
DR. TAILLAC: I just think that that's common sense. If someone wants -- I think it's a decision, in my opinion, I'm not on the committee -- but it's a decision. It's a closed issue unless someone brings back to this committee --
MR. LARSON: With good reason.
DR. TAILLAC: -- a real case that says we should change the rules. Because currently the rules say they can't be trauma centers. So if we don't change the rules, then they can't be trauma centers.
MR. JEX: It's a moot point unless you change the rules.
DR. TAILLAC: Right. For a good reason to change the rules --
DR. COOK: Okay.
DR. TAILLAC: -- would be a different argument, I guess.
But would also -- I think, part of -- the second part of the motion I would like to see is that EMS agencies utilize the state-approved field triage

guidelines when deciding transport destinations. And I could send out some teaching that says these would preclude freestanding EDs receiving trauma patients who meet any of the criteria.
DR. COOK: Want to add that to your motion?
MS. WOLFE: That's the motion I just made.
DR. COOK: Okay.
MS. WHITNEY: That's your second amendment.
MR. SANDERSON: I second that.
DR. COOK: I have a second from Dr. Sanderson and a third. All in favor aye. Any opposed?
It is passed unanimously.
It's good. It's very good.
So do we have -- I have one other minor point which has to do with the next meeting by any other issues or concerns that anyone wants to bring up during the meeting?
And secondly, anything that we need to put on the agenda for next meeting that we haven't already made Jolene aware of.
MS. WHITNEY: I have a couple of items that I was given by couple of members already and it was to talk about some PI initiatives for next time. And also, bring the trauma program manager tool kit to the -- to the committee.

DR. COOK: That sounds good.
MS. HUNSAKER: I would also like to discuss modifying our Utah trauma registry data dictionary to only include the Utah specific elements and that we distribute it as an appendix to the NTDS data dictionary.
DR. COOK: Is that something you want to talk about next time?
MS. HUNSAKER: Uh-huh.
DR. COOK: Okay. I have no idea what that means.
MS. HUNSAKER: I've been here way too long today. Just say that Shari Hunsaker wants to talk about the data dictionary.
DR. COOK: Sounds good. Sound goods.
MS. WOLFE: And I have a couple of things right now.
DR. COOK: Okay.
MS. WOLFE: Maybe you're going shoot me and just tell me to walk out, but on our Audit Filter No. 3, should we not say greater than 30 minutes instead of 20 since that's the national standard?
DR. COOK: Where is that?
MS. WOLFE: Ground transport trauma patient scene departure to hospital greater than 20 minutes.

They're saying to -- No. 3.
MR. SANDERSON: Were we just trying to be better than anybody else with 20 minutes?
MS. WOLFE: Oh, I thought it was -- I thought this was -- I thought this was talking about call a helicopter if they were 20 minutes. Okay. So ignore that one.
MS. BURKE: It's scene time.
MS. WOLFE: Yeah. Okay. And then -- so then my only other question as I went through these was on No. 7. Trauma patients who die with a probability of survival rate greater than 50 or who live with the probability of survival less that be 50 and they want the true score for trauma patients using measures collected at the first presenting hospital.
So if we're asking hospitals to transfer quickly, you don't even know all of their injuries and we're going to use the ISS on the two injuries you might know and maybe they've got eight injuries. And I don't think that -- I think you should say definitive hospital.
DR. COOK: Definitive hospital.
MS. WOLFE: Not first presenting hospital.
MR. LARSON: That's a good.
MS. BURKE: I agree.

MR. LARSON: That's a good point.
DR. COOK: Makes perfect sense.
MR. CHRISTENSON: So that's -- the change is just definitive hospital?
MS. WOLFE: Instead of the first presenting hospital.
DR. COOK: It's the ultimate --
DR. TAILLAC: Okay.
DR. COOK: -- definitive ISS.
MS. WOLFE: We where know everything that happens, everything the patient has. Because you're wanting them to make a decision in 15 or 30 minutes and get them out of there, they're not going to have all of the answers --
DR. COOK: True.
MS. WOLFE: -- of what -- they're not going to have the ISS, the full ISS.
DR. COOK: So Deanna, that would be your motion to change that to the definitive ISS?
MS. WOLFE: Yes, sir. And it's my last motion.
DR. COOK: Okay. Second?
MS. BURKE: Second.
DR. COOK: Second from Holly. All in favor aye. Any opposed? Okay. Done.

Anything else? Our next meeting and, Jolene, you can -- just at the bottom here, June 9th. I am out of town. I don't know if anybody else is out of town that day.
MS. WHITNEY: Well, actually I think it was supposed to be the 23rd. So if that's still okay with everybody we'll --
DR. COOK: Better for me.
MS. WHITNEY: Is that better for you, Craig?
DR. COOK: I actually have it on my calendar so, yes.
MS. WHITNEY: There you go. That's probably what it was in the first place.
DR. TAILLAC: It is.
DR. COOK: There we go. At your usual location.
MS. WHITNEY: The 23rd, June 23rd. And then next one after that is September 22nd. One after that is December 15th. And we'll ask Suzanne to send out a calendar appointment so you can accept those -- or deny.
DR. COOK: That sounds great. Thank you. We will adjourn.
(END OF MEETING.)

C E R T I F I C A T E

STATE OF UTAH)
:ss
COUNTY OF SALT LAKE)

I, Katie A. Harmon, a Registered Professional Reporter, Certified Court Reporter, and Notary Public in and for the State of Utah, do hereby certify:
That the foregoing proceedings were taken on March 23, 2014;

That the proceedings were reported by me in stenotype and thereafter transcribed by computer, and that a full, true, and correct transcription, to the best of my ability, of said proceedings so taken is set forth in the foregoing pages;

That the Original transcript of the same was mailed to Suzanne Barton, Bureau of EMS and Preparedness, 3760 South Highland Drive, Salt Lake City, 84114.

I further certify that I am not of kin or otherwise associated with any of the parties to said cause of action, and that I am not interested in the event thereof.

WITNESS MY HAND and official seal at Salt Lake City, Utah, this 14th day of April, 2014.

Katie Harmon, RPR, CSR