12-15-20 RDSTF-5 Trauma Advisory Board Clinical Leadership Committee

Participating: Dr. Traci Bilski, Lynne Drawdy, Dr. Alex Evans, Dr. Joseph Ibrahim, Dr. John McPherson, Matt Meyers, Dr. Peter Pappas

Welcome & Call to Order: Dr. Pappas welcomed the group.

Review and Approval of Minutes: Those present approved the minutes from the October meeting.

Old Business

The five draft trauma protocols presented are meant as a resource, providing guidance but are not a requirement. These include:

- Pediatric Trauma
- TXA in the Field
- C-Spine Immobilization
- Geriatric Trauma
- EMS Management of COVID patients

Dr. McPherson will present these at the December 17 meeting for Executive Committee approval.

New Business

Regional Mass Casualty Planning: The group discussed how to address this issue, which was identified as a need in the September trauma tabletop. Lynne advised that the Trauma Preparedness Committee has agreed to take this on, and that committee is comprised of individuals who have the time and expertise to do this planning. She suggested that others join that group if interested. Dr. Ibrahim agreed and stated that he chairs the Preparedness Committee, and Dr. Bilski is also a member. He said that we will reach out to engage others, including EMS, law enforcement, and the National Guard, in the committee. Lynne will share the individuals who currently serve on the annual regional mass casualty planning committee and we can target missing disciplines using that list. Dr. Ibrahim stated that the Preparedness Committee met yesterday and are looking at he new national MOCC (multi-operations coordination center) concept as a resource for the plan. Dr. McPherson stated that he has noted that EMS doesn't always participate, and Lynne stated that this is a challenge. Dr. McPherson will query the EMS Medical Directors to seek representatives, at least to represent the North (Brevard, Volusia, Lake), Central (Orange, Osceola, Seminole), and South (Indian River, St. Lucie and Martin) portions of the region. Dr. Bilski stated that it would be helpful if the EMS Medical Directors had a generic email so that when people transition in and out we are able to reach them. The group discussed the need to reach out to air medical. Dr. McPherson will reach out to Halifax and the southern portion of the region, and Dr. Ibrahim will reach out to Air Care. Dr. Bilski stated that she would reach out to Dr. Ibrahim and Eric Alberts to start working on a roadmap. Dr. McPherson asked Lynne to copy him on the Preparedness minutes. Lynne reported that the Coalition is working with Florida Hospital Association to pilot a new communications platform called Corvena; this product includes bed availability in real time and patient tracking, and it interfaces with WebEOC which emergency managers use, and EMResource which is used in the Metro Orlando area. The Preparedness Committee has created a list of equipment and supplies that acute care hospitals will need to handle trauma patients in an MCI, and this will be sent out to the hospitals for input. We are also reaching out to hospitals across the country to seek trauma coordination plans. Lynne advised that the annual regional MCI for 2020 was cancelled due to COVID but we are

planning to hold the exercise in 2021. In past exercises, we focused on 20% surge capacity. In this exercise, we can focus on flow and managing higher-acuity patients. Lynne stated that we will need to engage clinicians to evaluate the exercise. She suggested that the committee prepare the plan, that we complete a functional exercise over the summer, and then do a full test in the full scale exercise in the fall.

Next Meeting: Lynne asked the Clinical Leadership Committee if they want to keep the same schedule (Tuesdays at 8 am every other month) for 2021, and the group agreed. Lynne will send out a 2021 schedule and calendar invitations.

10-13-20 R5TAB Clinical Leadership Committee Meeting

Participating: Dr. Traci Bilski, Lynne Drawdy, Dr. Edgar Figueroa, Dr. John McPherson, Matt Meyers, Dr. Andrew Skattum, Melissa Smith, Gaylen Tipps, Dr. Ayanna Walker

Welcome & Call to Order: Dr. McPherson welcomed participants and called the meeting to order at 8:08 am.

Review and Approval of Minutes: Dr. Bilski moved to approve the minutes as submitted. There was no discussion and the motion carried.

Trauma Protocols: Lynne reported that no feedback has been received on any of the protocols. Dr. McPherson advised that the Clinical Leadership Committee now ask the Executive Committee for approval. These were distributed to the Executive Committee following the August meeting.

Mass Casualty Planning: The Central Florida Thunder trauma tabletop was held on September 24, with 72 participants, including trauma clinicians and EMS. The Preparedness Committee will present lessons learned at the Executive Committee, including:

- **Importance of communication platform and how we make this available across the region. Lynne reported that there is a communication workgroup working on this. FHA is looking to pilot CORVENA and we have volunteered for that pilot.**
- **Ensuring hospitals have the equipment/supplies needed for initial response. We previously distributed an MCI cart list by color to acute care hospitals. Do we need additional information or training on this? Dr. Ibrahim stated that the focus will be on acute care hospitals stabilizing patients until they can be shifted to a trauma center, even if outside of region.**
- **Development of a trauma coordination plan for large scale event, both within the region and outside the region. Will look at the new federal MOCC guidance. Will need the CLC to participate in this.**

Dr. Walker stated that it was a good exercise, particularly as it was virtual.
Dr. Bilski agreed and stated that she is looking forward to the after action report. She stated that she is encouraged by the possibility of a plan for the coordination of care. She stated that the situation manual was very helpful.

Dr. McPherson advised that he is looking forward to a time when we can all get together face to face again. He asked if we could use technology so we can see each other at the next meeting. Lynne will set up Microsoft Teams for the next call.

New Business:

The group discussed next steps and agreed to address addressing bariatric patients a next step. Lynne advised that we have posted 350 pound plus scanners within the region to the website.

The group also agreed to be engaged with the Preparedness Committee on the trauma coordination plan.

Dr. McPherson asked about the potential for the committee to engage in distribution of COVID vaccine. He stated that his agency will vaccine themselves and law enforcement. Lynne reported that Clint Sperber is on the statewide task force to develop the vaccine plan and will give an update during the Executive Committee.

Lynne advised that the Coalition has entered into an agreement with Florida Hospital Association and will receive a large grant aimed at improving response to a pandemic. The Coalition's Emerging Infectious Disease (EID) Collaborative will guide development of a plan for these funds.

Dr. Walker suggested that we run simulation exercises for the non-trauma centers. Lynne advised that there is typically an annual mass casualty drill in the region. This year's exercise had to be cancelled due to COVID, but in the next exercise we could focus on trauma capabilities. The group discussed and agreed that we would need clinicians to evaluate this.

Dr. Figueroa stated that a mass casualty during COVID is frightening and asked if we have plans to deal with that. We have focused over the past few months on hurricane preparedness during a pandemic, but no one has heard of any planning for MCIs during the pandemic. Dr. McPherson suggested that the next meeting, the group focus on the regional trauma coordination plan. We will hold a call with the clinical leadership committee and preparedness committee leaders to discuss.

Next Conference Call: December 15, 2020 via Microsoft Teams

Adjourn: Dr. Figueroa moved to adjourn the call; the call adjourned at 8:42 am.

8-11-20 RDSTF-5 Trauma Advisory Board Clinical Leadership Committee Minutes

Attending: Dr. Tracy Bilski, Dr. Ernest Block, Lynne Drawdy, Ed Fowler, Dr. John McPherson, Dr. Peter Pappas, Gaylen Tips, Dr. Chris Zuver

Welcome: Dr. Pappas welcomed and thanked all for joining today.

Call to Order: Dr. McPherson called the meeting to order at 8:06 am.

Review and Approval of June and July Minutes: Dr. Bilski moved to approve; Dr. McPherson seconded. There were no discussion or objections.

CFDMC Update: Lynne reported that the Coalition is still responding to COVID by providing situational awareness through daily situation reports and resource coordination.

Old Business:

July Protocol Town Hall - Trauma Guidelines: Dr. McPherson stated that the five guidelines have been sent out in final draft (pediatric trauma, TXA in field, C-Spine immobilizations, geriatric trauma, management of COVID19 patients) Lynne will set up a survey to put on each asking for feedback. He asked Lynne to send out additional information on geriatric head trauma to the committee. He asked if there were any questions or input prior to presenting these to the Executive Committee. He asked the group for any concerns or discussion.

Dr. Bilski stated that in reviewing data related to geriatric bleeds, she is concerned that not all were symptomatic. She suggested that al patients over 65 on anticoagulants be transported to a trauma center. She said this is a small number but with devastating results. Dr. McPherson stated that his agencies are doing a retrospective study over the past six months to see how many were missed and they should have that data in a month. He has heard concerns from local hospitals about transporting people outside their catchment area. Dr. McPherson will share this summary.

New Business: Dr. McPherson stated that the Clinical Leadership Committee is a clearinghouse for issues. An issue raised is the capability to scan bariatric patients. Holmes has the capability and it was suggested that ORMC does. Dr. Zuver said he does not think Orange County has this. Dr. Block stated that they do not, but he is interested in this. Lynne will send out a request to hospitals to obtain a list.

COVID19 Testing: Dr. McPherson stated that there is an FDA EAU for a rapid antigen test with results in 30 minutes. The product is available for EMS and hospitals and reporting a sensitivity around 95% with specificity at 100%. Vendors are Cardinal and Fisher Scientific. The price is $20 per kit. The local distributor is Henry Shine and the cost from Shine is $37 per kit. through vendors include Henry shrine, Cardinal and Fisher Scientific. The testing machine is $350. The swabs are submitted into the tester and it reports positive or negative. It is being used in urgent care and primary care offices and can be used for influenza as well as COVID19. He stated that Brevard is trying to purchase 1500 kits. There are issues with the vendors selling to local agencies.

Lynne stated that the Preparedness Committee met yesterday and asked if the Clinical Leadership Committee would take on developing MCI trauma guidelines or training for acute care hospitals (like the pediatric guidelines). Dr. Pappas suggested the Clinical Leadership Committee create a regional mass casualty plan. Dr. Bilski suggested that we ask all hospitals to provide their mass casualty plans. Lynne stated that the Preparedness Committee plans to work with the Coalition to host a virtual tabletop as a beginning step. Orlando Health provided all hospitals with a red, yellow, and green MCI trauma cart list. Dr. McPherson stated that DOH has a mass casualty EMS plan. Dr. Pappas suggested that the two committees work together on a plan. Dr. Bilski will follow-up with Lynne and Susan Ono and report at the next Executive Committee meeting.

Actions:

- **Lynne will develop a survey to obtain feedback on the protocols**
- **Lynne will ask the region's hospitals for open scanner/bariatric scanners and produce a list within the region**
- **Lynne will ask the hospitals for their MCI plans**

Next Meeting: The next Executive Committee meeting is August 18. The next Clinical Leadership Committee meeting is October 13, 2020.

Adjournment: The meeting adjourned at 8:48 a.m.

7-7-20 RDSTF5 Trauma Advisory Board Clinical Leadership Committee Virtual Town Hall

Attendees: Dr. Traci Bilski, Dr. Ernest Block, Commissioner Elise Dennison, Lynne Drawdy, Dr. Edgar Figueroa, Dave Freeman, Dr. John McPherson, Dr. Peter Pappas, Dr. Andrew Skattum, Dr. Hezedean Smith, Melissa Smith, Gaylen Tips, Tina Wallace, Kimberly Wright

Welcome: Dr. Pappas welcomed all and thanked all for participating. Purpose is to hear about the exciting work of CLC. Provided some guidelines as a resource for all on hot topics. RTAB is a completely voluntary and grass-roots efforts. Come together and share wisdom to benefit trauma systems

Call to Order: Dr. McPherson called the meeting to order and recapped what the Clinical Leadership Committee has accomplished to date. He stated their task was to develop protocols that would benefit the region if generalized.

Draft Protocols: Dr. McPherson stated that the committee tackled first those that were controversial or where there were issues that there was interest in standardizing. These included pediatric trauma guidelines, TXA used by EMS, spinal immobilization, and geriatric head trauma on anticoagulants. The committee researched and provided drafts for review and input.

Dr. Traci Bilski stated that these protocols are not mandates and no one must adopt these. The purpose was to create a clearinghouse with resources, and these guidelines can be used or modified. These are researched, evidence-based and vetted, and can be used by EMS or hospitals.

Dr. McPherson stated that he will send out updated documents with the references included for discussion at the next Executive Committee meeting on August 18. Dr. Bilski encouraged questions or feedback. Dr. Block asked if these gain consensus and are used as a resource and guidelines, do we have a process for capturing experience or feedback? Dr. McPherson stated that is the purpose of the Clinical Leadership Committee, which is supported by the Coalition. Lynne stated that we can set up a survey link for feedback and include it on the documents. Dr. Dean suggested that we capture ease of implementation and if the protocol is measurable. Dr. Bilski stated that it might be difficult to evaluate as these will be locally implemented.

New Business:

Regional Imaging Resources for Patients of Larger Dimensions: Dr. Skattum brought up the issue of problems imaging large patients, and CTs limited by girth or weight. He asked if others have this problem or any solutions? He asked if we need to identify a facility and develop transport protocols. Dr. Skattum asked if any of the hospitals in Central Florida can scan a patient over 350 pounds? Dr. Figueroa stated that he has not seen this as a problem, and they do bariatrics in Viera with open scanners; and Holmes can scan up to 450 pounds. Dr. Dean stated that he does not believe there are any barriers at ORMC. Dr. McPherson will ask each of the counties and report back at next meeting. Dr. Skattum stated that would be helpful as right now the assumption is that it can't be done. Lynne will send out a request to the hospitals and EMS requesting this information.

Testing: Dr. McPherson expressed concern re testing with flu season coming up and a spike in COVID. Right now, PCR studies are the standard? There is an FDA emergency use authorization for mini rapid point of care tests; the devices cost about $300-$400 and tests are $20 and with a result in 30 minutes. He asked if an update on availability of testing/turnout time on results be helpful? Dr. Figueroa stated that are also questions regarding the validity of the tests. With many false negatives, they are treating everyone as if COVID positive and minimizing contact. Dr. McPherson said he is looking at potential for rapid test with high specificity. Dr. Pappas agreed and stated that COVID is not going away and this could be a discussion at the next Clinical Leadership Committee call.

Closing:

Dr. McPherson raised the issue of permissive hypotension in hemorrhagic patients receiving fluids by EMS. These need guidance from the trauma centers. Dr. Bilski stated that these patients shouldn't be getting a lot of fluid. She asked if

there was any new literature challenging this. Dr. McPherson stated that this may require re-education. Dr. Dean stated their protocol states a maximum of two liters. Dr. Pappas stated that we can ask the EMS directors to share their protocols.

Dr. Bilski thanked all for participating. She asked if anyone has questions or needs clarification on the protocols to please reach out. Dr. McPherson stated that the Clinical Leadership Committee wants to be a clearinghouse for information/resources, such as the bariatric issue. Dr. Pappas reminded all that anyone can call for a meeting to discuss an issue. He thanked Dr. McPherson and Dr. Bilski for their leadership.
The meeting adjourned at 10:46 am.

6-9-20 Trauma Clinical Leadership Committee Minutes

Participating: Dr. Traci Bilski, Dr. Block, Lynne Drawdy, Dr. Joseph Ibrahim, Dr. John McPherson, Dr. Peter Pappas, Melissa Smith, Dr. Andrew Skattum, Dr. Chris Zuver

Welcome & Call to Order: The meeting was called to order at 8:04 am. Dr. McPherson welcomed all to the call. Dr. Pappas welcomed Dr. Block to the committee and stated that the purpose of the committee is to create standardized protocols for managing trauma patients throughout Region 5.

Old Business:

Draft Trauma Protocols: Dr. McPherson provided updates on the first four draft protocols: Dr. Plumley drafted pediatric trauma guidelines. The committee also researched and drafted best practice guidelines around use of TXA, use of C Spine immobilizations, and geriatric head trauma with anticoagulants. The committee also agreed to address COVID transport and turnover of COVID patients. Dr. McPherson just sent the table of contents and those four protocols, along with standard principles and guidelines, and asked if we should include the COVID specific protocol. He asked the group to please review and let him and Dr. Bilski know of any recommendations or changes. This will complete the first assignment. Dr. McPherson standardized the format to be user-friendly to paramedics; Dr. Bilski will revise hers to match. Dr. Bilski stated that in the geriatric population, the goal is to avoid these patients going to a non-trauma center. If the group does not feel this is necessary information for EMS, we can remove that. The group discussed the criteria for these patients to be a trauma alert. Dr. Block asked if it is age-specific and anti-coagulant or both. Dr. Bilski replied both and stated that the age came from literature research. Some other counties have included OB patients, and eating disorders of any age but this protocol is specific to this subset of patients. Dr. McPherson suggested that we send out these out to the Executive Committee for review. He will introduce this at today's Executive Committee meeting. Dr. Zuver asked if we know how many EMS agencies have a geriatric or anticoagulant protocol. He rolled out his protocol last year. For smaller agencies, this can present challenges as it would take one of their vehicles out of service to go to a trauma center. He said that he had to sell this by providing evidence. As well, many of these patients want to refuse transport if they are going away from their local hospitals, so we will need a strong messaging point when rolling this out. We may need to add calling in when patients refuse to go to a trauma center. Dr. Bilski agreed these are difficult issues. Dr. Zuver said these become a teaching opportunity. All agreed that the focus has to be what is best for the patient. Dr. Ibrahim stated that we also need public education on why these patients need to go to a trauma center. Do we have a way to do outreach or has anyone had any success with this? Dr. McPherson stated that if it is significant enough for a protocol change there

should be education and outreach. Do we reach out to physicians who prescribe anticoagulants, so they educate patients if they have a fall you need to go to trauma center vs. just an emergency room. Dr. McPherson stated that he doesn't feel these protocols represent departure from practices, but we are trying to drive consistency. The Clinical Leadership Committee may need to help develop training packages, and he asked for volunteers or if anyone has training already prepared that they can share. Dr. Bilski volunteered to work on this. Dr. Ibrahim also volunteered to help. Dr. Zuver stated that he has training, but it includes other age groups; he will look at this and exclude all but geriatrics and send those. Dr. McPherson will reach out to Dr. Husty.

New Business: Dr. McPherson asked what are other projects/protocols that the group wants to tackle next? Dr. Bilski suggested geriatric trauma alert criteria and OB triage/trauma alert criteria or guidelines as a special population, similar to pediatrics.

The next call is scheduled for August 11.

The call adjourned at 8:44 am.

4-29-29 Trauma Clinical Leadership Committee Minutes

Welcome: Dr. Pappas welcomed and thanked all for participating.

Attending: Dr. Peter Pappas, Dr. John McPherson, Dr. Traci Bilski, Chief Smith, Dr. Andrew Skattum, Dr. Edgar Figueroa, Tina Wallace, Melissa Smith, Lynne Drawdy

Call to Order: Dr. McPherson called to the meeting to order at 2:34 pm.

Covid-19 Protocol Discussion: Dr. Pappas stated that he hopes we are beginning to see light at the end of the tunnel with COVID, although we do expect future waves and need to be prepared. Dr. McPherson has updated the protocols as discussed last week (see attached).

Trauma Protocols in Development:

Pediatric Trauma: Tina Wallace reported that Dr. Plumley is working on this.

TXA in the Field: Dr. McPherson said he will send a final draft document out for consensus.

C-Spine Immobilization: Dr. McPherson stated that he would send his recommendation and asked Dr. Husty and Dr. Bilski to review and finalize draft.

Geriatric Trauma: Dr. Bilski is working on this and will send a draft. There was discussion on whether to broaden this and the group agreed to creating geriatric trauma guidelines. Dr. McPherson will send a TBI study to Dr. Figueroa to send to hospitals.

Next Meeting: The group agreed to return to the regular schedule. The next call is June 9, 2020.

Adjourn: 2:45 p.m.

4-15-20 Trauma Clinical Leadership Committee Summary

Welcome: Dr. McPherson welcomed the group and called the meeting to order. Dr. Pappas thanked all for participating.

Roll Call:

Seminole EMS: Dr. Todd Husty
Brevard EMS: Dr. John McPherson
Orlando Health: Dr. Joseph Ibrahim, Tina Wallace, Melissa Smith
Health First: Dr. Edgar Figueroa
Osceola Regional: Kim Wright, Andrew Skattum
Orange EMS: Dr. Christian Zuver
Martin EMS: Dr. Michael Ferraro
Dr. Peter Pappas
Lynne Drawdy

Review and Approval of Minutes: The minutes are posted on the website. A draft summary of protocols Dr. McPherson compiled was shared; the goal is to standardize these.

Draft Protocols: The group reviewed and discussed the draft protocol statements. It was agreed that it is too late to change the terminology each county is currently using as an alert for potential or COVID positive patients. Next time, the group will immediately discuss and standardize. Regarding patients with altered mental status being considered COVID19 positive until proven otherwise. Dr. Husty stated that if there are respiratory problems, they consider the case positive. The group discussed the issue of handoffs. Each hospital has a process in place and the unique features of hospitals, and the volume of patients make standardizing this difficult. All agreed that the goal is to minimize the number of paramedics coming into the hospital.

Finally, the group agreed that each county needs a standard process for dispatch to notify EMS units that the case is potentially COVID, and any patients with altered mental status are to be considered COVID positive until proven otherwise. Each hospital will have a process to either meet paramedics outside or escort patient to room and minimize the number of paramedics entering the hospital. Dr. McPherson will send out a revised draft.

Trauma Center Updates or Issues: Tina advised Dr. Plumley is working on the pediatric trauma guidelines for acute care hospitals and plans to have a draft by the next meeting. Dr. Husty is working on the TXA protocol and Dr. McPherson is working on the spinal immobilizations protocol. Dr. Bilski is working on the protocol for the elderly with head injury using anticoagulants. All will try to have a draft by the next meeting. Dr. Husty will send out a study on use of TXA in head injury with anticoagulants.

General and Executive Committee Virtual Meeting: Dr. Pappas reminded all of the next meeting, scheduled April 16th, 2020 from 9:30 am – 12 pm.

The group agreed to cancel the April 22 Clinical Leadership Committee call; the next call will be on April 29.

4-8-20 Special Clinical Leadership Committee Minutes

Welcome: Dr. McPherson welcomed all and called the meeting to order at 2:32 pm.

Roll Call:
Dr. Peter Pappas
Dr. Bilski & Andrew Chatham
Dr. Ayanna Baker (Walker) – Osceola EMS
Melissa Smith – EMS/ORMC
Tina Wallace – Orlando Health
Dr. John McPherson
Erin Wright with Osceola Regional
Dr. Figueroa
Dr. Rodriguez
Dr. Ibrahim
Lynne Drawdy

Protocol Discussion

Dr. McPherson advised we are looking for best practice protocols to adopt for use in COVID response. These will be posted to the Trauma page on coalition website.

There was discussion regarding six potential protocols. The group discussed screening protocols and how dispatch is alerted to potential COVID cases. Each agency has a protocol but all call these something different. The group agreed these need to be plain and direct. Osceola calls it a viral alert. Orange calls it severe respiratory precaution and Seminole calls it respiratory precaution. Lake calls it isolation alert. Brevard calls it infectious surveillance alert. All agreed it would be helpful to call it the same thing across the region, particularly for data collection. CDC has not given this a name but recommends an early warning form dispatch to EMS. The group discussed that there would need to be two alerts if it were a suspected COVID case and a trauma alert. The group agreed to consider standardizing around viral alert.

The group discussed patients who are unconscious or are with altered mental status, and no next of kin; these will be considered COVID until ruled out. All agreed this was the safest approach.

The group discussed handoff between EMS and the hospital, with the purpose to minimize EMS coming into the hospital. This also minimizes use of PPE. Processes included being met outside by trauma and the one medic in, and a one medic out scenario where one medic goes in with patients, provides a report, and immediately leaves. Orlando Health said they tried this approach but cannot always keep up with the volume coming in. They have worked through a direct in and out process with Dr. Zuver. If COVID19 or suspect case, the medics transport them straight to the room, and hospital escorts them outside and helps them clean up, both for trauma and medical patients. Dr. Figueroa stated that for COVID or suspect cases, the trauma physician or PA meets medics outside of in the vestibule. Inside the trauma bay is just the physician or PA, the trauma nurse, and a scribe outside. The group discussed whether the patient should be transported into the hospital on an EMS stretcher or transferred to a hospital bed outside.

Dr. McPherson suggested the following be standardized:

- Dispatch alert that a COVID 19 patient is being transported to hospital – called a viral alert
- Trauma patients with altered mental status are considered positive until ruled out– called viral alert
- Trauma patients with altered mental status - considered positive
- COVID or suspect trauma cases are met outside by trauma team - for secondary screening, medic must don PPE before entering
- Suspect medical cases are met outside by medical personnel if available
- One EMS goes in with patient, and leaves expeditiously (both trauma and medical)

Dr. Rodriguez advised that they have trained all EMS and hospital personnel in Orange County on the following procedure: They do not meet EMS outside; they do a transfer of care inside the patient room in the ED. If COVID19 or suspect patient, the full crew comes in donned in PPE; after handoff they go out the most expeditious route with PPE still on. Dr. Ibrahim stated that with their volume they can run out of people and they have EMS waiting until a room is available. He stated that volumes are down now, and if volumes go up, they can look to streamline the in and out.

Dr. McPherson said that one size may not fit all. He will draft the standardized protocol language and send out for review. Dr. Pappas said this is a dynamic situation and what makes sense one week may not the next week.

The call adjourned at 3:36 pm

4-2-20 Trauma Advisory Board Special Clinical Leadership Committee Minutes

Welcome: Dr. Pappas welcomed the group and thanked all for participating.

Attending:
Dr. Pappas
Dr. Traci Bilski
Dr. Gary Curcio
Melissa Smith
Dr. John McPherson
Dr. Figueroa
Dr. Christian Zuver
Dr. Alex Evans
Lynne Drawdy

Call to Order: Dr. McPherson called to order at 2:34 pm

Review and Approval of Minutes: The minutes from last week's call were previously distributed. No issues were expressed but approval will be held until the formal meeting.

CFDMC Update: Lynne reported that the state has requested PPE and upon receipt the Division of Emergency Management will distribute, we hear based on a population-based methodology. The Coalition has ordered Dover hood systems, negative air pressure capacity, and chemical PPE consumables, based on hospital requests and what is currently available. Lynne advised that the regional medical assistance team has deployed command staff to lead a medical team at a nursing home with COVID patients and will be sending command staff to operate a 250-bed field hospital in South Florida. The Coalition is sending out daily situation reports with all available information and is creating a COVID page on the website.

Trauma Center Updates:

- Dr, Bilski stated that they have made modifications to their protocols and she is willing to share these. They have also created an altered staffing model, have altered patient contacts, have limited contacts with other staff and visitation. General surgery residents have been taken off service and during morning rounds they decide who will see which patient (for example a spinal cord injury patient awaiting placement is seen by a PA). They have altered the trauma alert response with only four responding to trauma alerts. They are finishing a tracheotomy protocol for use during the pandemic, as part of the surge plan for ICU staffing.
- Dr. Curcio stated they are working with ICC for surge capacity and trauma is integrated into this. Two staff are doing intubations in the OR to limit exposure and all staff not involved are out of the room for 15 minutes, with the OR door closed at all times. He stated this is based on fact as the air turns completely over in 15 minutes. Dr. Bilski stated they also created an intubation team.

- Dr. Figueroa stated they are still seeing an occasional EMS coming straight into trauma room without stopping at the door. They changed their policy to meet them at the door. They have also changed the policy re stocking their supplies and have put these in a vestibule near the flite deck. Due to a shortage of PPE, the community has responded and is willing to make masks. The University created homemade masks using OR materials which provides 99% filtering. Dr. Pappas asked if he could share the template/instructions with the group. Dr. Figueroa stated they are thinning out the amount of trauma surgeons on duty at any point, including ICU rounds. They are looking at ways to do rounds using telemedicine. They are very open to credentialing other people but would prefer not. They are trying to create a model with telemedicine for the ICU with one surgeon rounding in-house and others using telemedicine.

EMS Updates:

- Dr. McPherson stated there is a lot going on and they are developing treat and release protocols, with established criteria for who we can leave at home with pamphlets to call the CHD. They also have developed a protocol for reuse and cleaning of N-95 masks. Most agencies are working with nursing homes; they call in advance and meet someone outside. They have a point person and system in place for ALFs and retirement homes to avoid entering these as much as we can. They have expanded the screening process for trauma patients who are not responsive. They have developed a protocol for COVID patients with chest pains and MI as cardiologists don't want to take these patients to the cath lab. He said they are hearing from the state and national EMS that some patients present with GI symptoms, and other symptoms such as the inability to smell or taste. He said the State EMS medical director and the executive medical director committee are developing protocols for continuity in nursing homes and hospitals.

  Dr. McPherson mentioned at study on hydroxychloroquine for field EMS as a treatment. For medics testing positive they are initiating a course of hydroxychloroquine and Zithromax. A pool of EMS agencies across country are pooling information. Dr. Bilski stated that she has seen a shortage of this drug and asked how they are getting it. Dr. McPherson stated they are trying to secure medication to try this. It is suggested that it could be a quick prophylactic treatment like Tamiflu, but this is in the early stages. Dr. Bilski stated she saw literature with information on why this might work. Air flites are using HEPA filters and shields for aerosolized treatments.

Protocols Discussions:

- Dr. Pappas stated that Dr. Ibrahim had asked if each trauma center has direct in and out protocols. Dr. Zuver stated that in Orange, Osceola, Seminole and Lake, EMS stays with the rescue until met, and then go right into the trauma bay and right out. They piloted a change in stretchers and discontinued this because of staffing concerns, so all go in and out with the EMS stretcher. They discontinue all aerosolized procedures before going in, and these are performed with filters.

Dr. Pappas asked how these are going, and Dr. Zuver stated that before rolling out these procedures he was receiving multiple calls daily and these calls have almost stopped. He had calls with the hospitals and EMS agencies to gain buy-in before these were implemented. Dr. Pappas asked if we can standardize this across all counties, and Dr. Zuver agreed to send the protocols. Dr. McPherson will secure protocols from each county and send these to Dr. Pappas and Lynne for distribution. He stated that he can hold a meeting with just the EMS directors if needed.

Lynne will set up a resource bank on the trauma page on the coalition website and share the link. Dr. Pappas stated that at some point we may have to share staff and the more standardized we are, the better.

Note: the link is: https://www.centralfladisaster.org/trauma (Click on Resources)

Dr. Evans asked if there were any mechanisms to report or to share concerns re flow. We need can develop a structure for individual hospitals to issues and get feedback. For example, if there is pushback on how EMS transports into a facility, we can have the trauma and EMS medical directors discuss, or approach as a group through this committee. The Clinical Leadership Committee can also be a source for sharing and standardizing protocols.

Dr. Pappas also asked the group to share protocols related to arrive at the ER and trauma bay, and inter-facility transports.

New Business

The group agreed to weekly calls through April.

Dr. Pappas reminded the group that the next Trauma Advisory Board Executive Committee and General Meeting will be held virtually on April 16 from 9:30 to noon.

Adjourn: The call adjourned at 3:20 pm/

3-25-20 RDSTF5 Trauma Advisory Board Clinical Leadership Committee Call

- Dr. Vincent Hsu, AdventHealth, presented on COVID19 (see attached presentation), including case numbers, forecasts and how to manage personnel, space and equipment. He stated that the most successful strategy for containing the outbreak is testing and isolation. Dr. Figueroa asked about clinicians vs. administration leading the effort. Dr. Hsu advised that clinicians are managing operational issues while administration is working with government leaders.

- Lynne Drawdy advised that the Coalition's response roles are situational awareness and resource coordination. The Coaliton puts out a daily sitrep to all members and monitors all local EOC requests to the state and offers what we have to fill these. She stated that the state has purchased and is managing distribution of PPE and ventilators. All requests must go through the local emergency management office and local emergency management distributes these to hospitals and other healthcare providers. She advised that AHCA's ESS bed reporting system has been opened and they are tracking the number of acute care and ICU beds available. ESS has also been expanded to collect information on burn rates for PPEs and the need for ventilators.

- The group discussed interfacility transfers and will continue this discussion at the next meeting.

- Additional new protocols were tabled until after the COVID-19 event is concluded

2-11-20 Trauma Clinical Leadership Committee Meeting Minutes

Participants: Dr. Traci Bilski, Dr. Alex Evans, Gaius Hall, Dr. John McPherson, Matt Meyers, Dr. Peter Pappas, Christine Wallace for Dr. Donald Plumley, Dr. Todd Husty, Dr. Gary Curcio, Dr. Alexander Evans

Welcome: Dr. McPherson the group and thanked all attending. The meeting was called to order at 8:02 a.m.

Review and Approval of Minutes: Dr. McPherson asked if there were any corrections or comments. Motion to approve. There were no further corrections and no opposition, and the motion carried.

Focus Initiatives: Dr. McPherson advised the committee has four projects underway. All the literature and protocols received were shared with the committee members. Some emails were unable to be received or delivered.

- **Pediatric Trauma Guidelines: Dr. Plumley was unable to be on the call but discussion was held on the subject including age of TXA use as early as 2 years of age.**
- **Field use of TXA/Adults and Pediatric: Dr. McPherson advised he has a rough draft and Gaius agreed to help with this. Dr. McPherson stated they will have a final draft to send out with today's input prior to the April meeting. The issue of requiring large bolus of normal saline was deemed unnecessary and the recommendation of 1gm in 100cc IV solution over 10 minutes was accepted. Follow up drips was not required for field EMS units. Choice of IV solutions of NS,LR, was not specified. Dr Husty brought the use of TXA for medical related bleeds such as GI bleeds or Aortic aneurisms and the need to add this to trauma transport protocols. There is currently underway a Haltit trial for TXA use on GI bleeds.**
- **Cervical Collar Regional Guidelines: McPherson will develop a draft with references and send to Dr. Husty for review. Dr Bilski will resend Osceola's protocols.**
- **Head Injury in the Elderly: Dr. McPherson stated that he has distributed literature and protocols regarding the addition of a trauma alert criteria for TBI in the elderly on anticoagulants. There was concern mention by Dr Husty about over triage. Criteria to be included; blunt trauma, over 65years of age, on anticoagulants, altered consciousness. Dr McPherson stated that the CDC has a grey protocol.**

  Dr. Bilski stated that the roll out of such protocols will require training and a coordinated release. Dr. McPherson stated that he hopes to disseminate protocols and supporting literature for adoption of changes to the group by the April meeting. All will need to be presented to the Executive Committee for approval. Once approved, we can distribute across the region and share with FCOT, EMSAC, etc.

Adjourn: Dr. McPherson adjourned the call at 9:04 am.

12-10-19 Trauma Clinical Leadership Committee Meeting Minutes

Participants: Dr. Traci Bilski, Lynne Drawdy, Dr. Alex Evans, Gaius Hall, Dr. John McPherson, Matt Meyers, Dr. Peter Pappas, Dr. Donald Plumley

Welcome: Dr. McPherson the group and thanked all attending. The meeting was called to order at 8:04 a.m.

Review and Approval of Minutes: Dr. McPherson asked if there were any corrections or comments. Dr. Plumley moved to approve the minutes as submitted and Dr. Bilski seconded the motion. Dr. McPherson stated that he had one correction. The minutes stated that he met with Dr. Ferraro and this was by phone vs. a meeting. There were no further corrections and no opposition and the motion carried.

Focus Initiatives: Dr. McPherson advised the committee has four projects underway. All the literature and protocols received were shared with the committee members. He asked for updates on each:

- **Pediatric Trauma Guidelines: Dr. Plumley drafted pediatric trauma guidelines for acute care hospitals; these were previously shared with committee. He has also shared these with Arnold Palmer Hospital and AdventHealth for Children. He stated that he plans to continue to expand on these guidelines. Yesterday, there was a bad pediatric case that didn't get to the trauma center until late in the day. Dr. Plumley will finalize the draft and send it out over the holidays. Dr. Bilski stated that she had comments and she agreed t to reach out to Dr. Plumley. He stated that after these are finalized, he will move on to the acute care phase, and possibly air care.**

- **Field use of TXA/Adults and Pediatric: Dr. McPherson advised he has a rough draft and Gaius agreed to help with this. Dr. McPherson stated they will have a final draft to send out by the end of the year.**

- **Cervical Collar Regional Guidelines: McPherson will develop a draft with references and send to Dr. Husty for review. He stated there are some best practices in the materials. He hopes to complete this by the end of the year and we will need to gain buy-in from the trauma center surgeons. Dr. Bilski suggested creating the protocol and then scheduling a call or webinar with the trauma medical directors and EMS medical directors to discuss; it is their responsibility to get this out in their departments. Lynne advised that we can record and share the webinar. Dr. Evans stated that most departments are already considering this and he agreed that buy-in is vital. He stated that he would take this to his monthly trauma meeting and then to his ER meeting.**

- **Head Injury in the Elderly: Dr. McPherson stated that he has distributed literature and protocols regarding the addition of a trauma alert criteria for TBI in the elderly on anticoagulants. Dr. Bilski agreed to finalize the draft created by Dr. McPherson.**

Dr. McPherson stated that he hopes to have all of these in final draft by the end of the year to show the committee's accomplishment in establishing best practice guidelines for the region. All will need to be presented to the Executive Committee for approval. He stated that if we can demonstrate that we have shared and received buy-in, this will expedite

approval. Once approved, we can distribute across the region and share with FCOT, EMSAC, etc.

The group discussed selecting the new initiative. Dr. Bilski stated that in the last call she recommended looking at geriatric injury care protocols, including trauma alerts, transports, etc. She stated that Florida should be leading the way in geriatric care. The group agreed.

Dr. Pappas asked Dr. McPherson to present the group's work at the December 17 Executive Committee meeting. Dr. Evans stated that the work to standardize protocols will raise the bar in patient care.

New Business: Lynne reported that the Hillsborough Trauma Agency organized a call with the three trauma agencies in Florida and we were invited to participate. She shared information on the RDSTF5 Trauma Advisory Board and its committees, and they were particularly interested in the work of the Clinical Leadership committee. They asked if we would share protocols as they are finished.

Adjourn: Dr. McPherson adjourned the call at 8:40 am.

Next Clinical Leadership Committee Conference Call: February 11 at 8 am.

Next General Meeting December 17th Halifax Health

10-8-19 RDSTF-5 Trauma Clinical Leadership Committee Minutes

Participants: Dr. Traci Bilski, Lynne Drawdy, Dr. Ed Figueroa, Dr. Steve Fitzgerald, Chief Gaius Hall, Dr. Todd Husty, Matt Meyers, Dr. John McPherson, Dr. Donald Plumley

Welcome: Dr. Bilski welcomed the group.

Review and Approval of Minutes: Dr. Plumley moved to approve the September minutes; Dr. Husty seconded the motion. There was no further discussion or opposition and the motion carried.

<u>Focus Initiative - Pediatric Trauma Guidelines</u>: Dr. Plumley sent out a rough draft of basic pediatric guidelines for EMS; he stated that he will work next on guidelines for acute care hospitals. He stated that he looked at local trauma protocols from Orange, Orange, Seminole, Lake, Polk, Osceola and some national protocols including basic information on use of TXA and antibiotics. He stated that most have good algorithms for spinal restraints. Dr. Fitzgerald stated that the guidelines look very comprehensive. Dr. Plumley advised that he can add references. He stated this gives local EMS agencies a place to begin a conversation on what they do and why they do it. He stated that he feels that the group should continue to standardize protocols for the good of the patients, for example head trauma. Dr. McPherson asked if he was able to establish standards for physicians at his hospital and he stated that they have policies for TBI, mass transfusions. He would like to share these with Level II trauma centers and acute care hospitals.

Dr. McPherson asked re the approach to managing a pediatric head injury, utilizing a specific cocktail for managing the airway. Dr. Plumley stated that they use the recommendation listed in the guidelines from neurosurgeons but he will follow-up on that. Dr. Husty stated that they tend to mix and match, depending on shortages. Dr. Plumley stated that for closed head injury, he does not think there is one that is far superior but he will look this up.

Dr. Bilski suggested we take this draft and make it a working document. She stated that it is a great way to categorize these and feels it should be adopted and shared with all. Dr. Plumley stated that he will keep working on this and will get the draft for acute care hospitals done within the next two months. Dr. Husty advised that he will share it with his council, including acute care hospitals. He stated that it is much less scary when we all have something we agree on. Dr. McPherson stated that this is a great document.

Dr. McPherson stated that he is still trying to engage all EMS directors. He met with Dr. Ferraro and is still trying to reach the Lake County medical director. He asked if there were any success in disseminating information and getting an acknowledgement. Lynne reported that we have added additional EMS medical directors from the south end of the region but have not received an acknowledgement. Dr. Plumley suggested that we meet have a formal EMS medical director meeting by phone or in person. Dr. Fitzpatrick stated that the EMS medical directors meet quarterly. Dr. McPherson asked if we have the agenda for the next meeting. Lynne will share. Dr. McPherson agreed to schedule a meeting following their meeting.

Active Initiatives:

Field use of TXA/Adult and Pediatric: Dr. Plumley stated that for children, 20 per kilo is well within range. Dr. Husty stated that this is similar to multiple albuterol treatments which became practice before it was accepted. He stated that when a subject matter expert like Dr. Plumley says it is safe and he uses it all the time, we don't need a study, we should just do it. Dr. Plumley stated that we need to put out recommendations on when to use and the dosage. He stated that there are no good studies but there is no real downside. He stated that he will add this when he does the acute care protocol. He stated that he has two pharmacists who can review this, and Dr. Husty suggested asking Nemours to review. Dr. Plumley agreed and stated that he will also reach out to AdventHealth for Children.
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Cervical Collar Regional Guidelines: Dr. McPherson asked that all send their protocols to Lynne to distribute. He asked if any of the protocols are on-line. Dr. Husty stated that the EMS chief maintains an online repository of protocols and he will send that link. Dr. McPherson says that the ACEP has an online list of protocols and he will send that link. Dr. Husty stated that he has heard many are loosening, and the definition of a distracting injury is under discussion to raise awareness. He stated that if someone is really injured, they may not know their neck is hurt, and just because they are injured doesn't mean they need to be immobilized. Dr. Bilski stated that this is a source of criticism for EMS from the ER physicians. She did some research and found recently literature moving away from distracting injury and more evidence-based. She will send those, and state that she is happy to help work on this.

Head Injury in the Elderly: Dr. McPherson will send an article to Lynne to send out re guidance on when to send these to a trauma center. Dr. Husty stated that this is a training issue as it is mostly a judgement call. Dr. McPherson said that studies show that a lot of elderly are being triaged to trauma centers and that we need guidelines. Dr. Husty stated that it helps to promote collaboration; it used to take an hour to get a patient transferred to a trauma center, and now it is just a phone call. He stated that if someone is under triaged it just takes a phone call to get to a neurosurgeon. He stated that in fixing the transfer of patients this has alleviated a lot of these issues. Dr. McPherson will send a study he just found on elderly with head injuries which shows large numbers with intercranial hemorrhages. He asked if there is an adverse outcome in not transferring all immediately to a trauma center? Dr. Bilski stated that we should be able to collect data from the trauma centers on transfers that need immediate surgical are. Dr. McPherson cited statistics and stated that we need to look at the incidence. He stated that he will share the Brevard stroke patient data; he was amazed at this. Dr. McPherson stated that we need to heighten sensitivity; many EMS don't write down meds, so many anticoagulant medications are missed, and are seen as stroke symptoms vs. bleeds.

Dr. Bilski raised a new issue. She stated that she firmly believes that a geriatric population is a special population, like OB and peds, and suggested that we look at specific guidance on geriatrics. We have a lot of these patients in Florida. Dr. Figueroa agreed and stated that there tends to be higher morbidity and mortality and we need to look at these differently. Dr. Bilski volunteered to work on a different set of criteria for this population, similar to what Dr. Plumley did for pediatrics – one for EMS and one for acute care hospitals. Dr. Husty stated that this is also a training issue. He saw this in three cases and brought this up and has had

no problem since. He stated that we need to propose guidelines and train ERs on responding to risks.

Dr. McPherson stated that we need to get all of these on paper. Dr. Husty agreed to take on spinal immobilizations. Dr. McPherson and Dr. Bilski will work on the elderly taking anticoagulants with head injuries. Dr. Plumley will continue his work on pediatric guidelines. Dr. McPherson stated that he would look at TXA.

Next Meeting: The committee is moving to bi-monthly calls so the next call will be December 10. The next Executive Committee meeting will be December 17 at Halifax.

9-10-19 Trauma Clinical Leadership Committee

Participating: Dr. Traci Bilski, Lynne Drawdy, Matt Meyers, Dr. Peter Pappas, Dr. Christian Zuver

August Meeting Recap: Dr. McPherson is ill and cannot join today's call. The group has been working on four issues:

- TXA: We are gathering protocols. Dr. Plumley was to give input on use in children
- Spinal immobilizations: Literature was shared and Dr. Husty had the lead.
- Elderly with head injuries taking anticoagulants: The group has discussed making this part of the trauma grey criteria. Dr. McPherson had the lead
- Pediatric trauma guidance for acute care hospitals: Dr. Plumley has provided a white paper. Lynne stated that the coalition and two hospitals were working on a grant for a pediatric response network but we were not successful. The coalition will be required to develop a pediatric response plan this year. This will be discussed at the next meeting.

Engagement: The group discussed how to engage all the trauma and EMS medical directors. Lynne asked if we need to send calendar invitations to all stakeholders and not just committee members. Dr. Bilski stated that she likes calendar invitations, but the downside is that getting too many can be overwhelming and if you miss one you might feel you should miss all. Dr. Pappas stated that the clinical leadership committee has a specific membership. He will draft a letter to the group, outlining its purpose and the issues the group is working on. Dr. McPherson had also planned to meet with each member. The group agreed to formalize the committee structure, including appointing a co-chair and producing agendas. Dr. Pappas stated that it would be helpful to have a list of what the committee is working on and who has the lead. Dr. Bilski agreed to co-chair with Dr. McPherson. Dr. Zuver suggested reminding members that it is in their best interested to play a role. He volunteered to reach out to medical directors to discuss this. The group also agreed that we could publicize this at state meetings. Dr. Zuver will ask Dr. Hunter to bring this up at the state association meeting. The group discussed the time of the call and agreed that 8 am works. Dr. Pappas stated that at today's Executive Committee call there will be a discussion on moving to bimonthly meetings. The bylaws allow this. The committee can consider moving to bimonthly if they choose.

8-13-19 Trauma Clinical Leadership Committee Minutes

Participating: Dr. Traci Bilski, Lynne Drawdy, Dr. Edgar Figueroa, Dr. John McPherson, Matt Meyers

Dr. McPherson advised that Dr. Plumbley and Susan Ono can't attend today. There are several patient issues we want to standardize within our region, including use of TXA and spinal immobilizations. Dr. Plumbley was working on standardized trauma care for pediatric patients. We have not yet received any protocols. Dr. McPherson will send his protocols to Lynne and ask others to send so she can distribute to the committee. Dr. Figueroa reviewed his policy for TXA and will send it. The group discussed use of TXA, including for children, based on size, expanded use in field for TXA, e.g. for ectopic pregnancy or for trauma with obvious internal hemorrhage or not responding to liters. Dr. Bilski asked if they will know in the field if it is a massive GI bleed or obvious bleeding. Dr. McPherson said he thinks that is reasonable; he hasn't seen that in protocols. He asked Dr. Figueroa how he feels about receiving patients with TXA. Dr. Figueroa said he hasn't looked at the literature but thinks this might be appropriate if the patient is not responding or really far away; in other situations, he feels it should be administered in the hospital after diagnosis. He stated that he is leaning more toward more hospital based than field. Dr. Bilski stated that they do use TXA but not broadly, it is used more liberally in rural areas where transport times are longer. Dr. Figueroa stated that he agrees with that but most are close enough to the hospital. He stated that he feels this is worth exploring. Dr. McPherson stated they have been using TXA in the field for the last 2-3 years, very infrequently. He has sent out his protocols which outline when TXA can be used; both Dr. Bilski and Dr. Figueroa agreed with the criteria for usage in his protocol. Dr. Bilski suggested that the protocols be simple and limited to the trauma population and Dr. Figueroa agreed. He stated that First Flite carries TXA for usage in trauma when they lose pulse and it is given as a bolus instead of slowly. He agreed with exploring us for GI bleeds. This is commonly used in Israel and middle east. Dr. McPherson will talk to Todd Husty and will send out the literature for review. He stated that early in the discussions some trauma surgeon expressed concerned re hypercoagulation and DVT or stroke. Dr. Bilski stated that the literature doesn't bear that out. Dr. McPherson asked if they felt the other trauma surgeons would have an issue with this and no one did. Some counties, including Seminole and Volusia, already have this in their protocol. Dr. McPherson stated that his goal is to have a common protocol for TXA use for presentation to the Executive Committee in September.

The group continued discussions on spinal immobilizations. Dr. McPherson will ask the region's EMS medical directors to share their protocols and review the literature. Dr. McPherson sent information from a large study in Canada in 2005, and protocols from Maine. He stated that in the Canadian study of 2,200 patients, six of them had C spine injuries and using the nexus criteria all six received a collar. Dr. Bilski stated the criteria is clear and easy to use. She stated she will share a three-page position paper on this issue from last year. Dr. McPherson stated that he has seen this and it reinforces the group's discussions. Dr. Bilski stated that there is confusion between immobilizing the spine and using a backboard. With a c collar, it is important to maintain alignment of the body. For EMS, there are downsides to immobilization, including discomfort, pain, lack of cooperation, and that if a c collar is used when not needed it increases difficulty in intubation when an airway is needed which may worsen pulmonary function. There is no evidence that a hard collar decreases secondary injury, and it makes physical examination of the patient harder. New information shows that in closed head injury patients, c collars can decrease venous return in the jugular and decrease cranial pressure. Dr. Figueroa stated that you cannot legislate common sense. He stated that in the field, they need to make the best call. He stated that whatever the literature supports, we should support. He stated that the literature is unclear on penetrating trauma including the head but the literature is clear on the use of the c spine use unless there is a loss of consciousness. Dr. McPherson suggested that the proposed protocol not try to address every potential issue but be clear and simple. He will review the protocols to try to get the best example out to the group.

Dr. McPherson suggested that these protocols be sent out to the trauma physicians to get their buy-in, and then bring these to the Trauma Executive Committee to approve for disbursal to all agencies within the region. He suggested that we set a go live date and include training, beginning with TXA.

Dr. McPherson advised that he has reviewed the literature on elderly individuals with head injuries who take anti-coagulant medications, and including that as part of the trauma scorecard methodology. He cited a study that looked at more than 2,000 patients and most were not flagged under the current trauma alert criteria. Out of 2100 patients, 131 had a traumatic hemorrhage and 41 had hospital death or neurosurgery. Only 62 (8%) met the standard trauma alert criteria and got flagged. The number that did not get sent to a trauma center was startling (1,948 did not meet trauma alert criteria and 566 (29%) were taking anticoagulant medications. He stated that this was a large, well-done study and while we don't want to overwhelm the trauma centers, we can estimate the number of patients this would add. He suggested this as a topic for the group to consider. Dr. Figueroa would like an in-person discussion with the entire committee, and Dr. McPherson agreed. He asked for other topics of discussion, including changes in EMS care, and permissive hypotension. Lynne reported that Dr. Zuver emailed and tried to call in today but could not get through. All agreed that an in-person meeting would be productive.

Dr. McPherson asked the group to send protocols to Lynne to collect and send out to the group. Dr. McPherson will reach out to the other counties to gain their protocols. He asked Lynne is the coalition can support additional calls and meetings and she said the coalition will provide whatever support is needed. Dr. Figueroa stated that as the group represents Region 5, we need to look at that as a real network where what affects one affects all. That way in an event, mutual aid is more effective as well are using the same protocols, equipment, supplies, etc.

Dr. McPherson will send information to Lynne to send out to the group, checking that the 8 am time is ok, and asking that they share protocols for TXA and spinal immobilizations.

7-9-19 Trauma Clinical Leadership Committee

Participating: Dr. Traci Bilski, Catherine Billen, Lynne Drawdy, Dr. Figueroa, Dr. John McPherson, Dr. Donald Plumbley, Todd Stalbaum, Gallen Tripps

Welcome: The group welcomed Dr. Figueroa from Holmes. Dr. Figueroa introduced the new Holmes trauma program manager, Gallen Tripps. Dr. Figueroa stated that all four Health First hospitals are now under one leadership. Dr. Shinebart is the head of the hospital division and Brett Esrock is the CEO. Trauma falls under the hospital division.

Dr. McPherson advised that the minutes from the last meeting were distributed. To recap, the Clinical Leadership Committee's focus is to assess existing best practices in EMS and trauma and standardize management of trauma patient throughout Region 5.

TXA: Dr. McPherson reminded the group that they began with TXA utilization, assessed the literature, and reviewed use across the region. Some EMS and trauma agencies are using TXA. Dr. Plumbley discussed use in pediatric patients, and Dr. Husty discussed use in adults and children who meet age/weight criteria. He sent out some literature reviews on TXA from Iraq. Dr. McPherson suggested sending out a request for protocols, and use these to come to consensus on best practice in the use of TXA. There is a physician statement on TXA use that Dr. Zuver sent out from National Association of EMS MDs but it has little detail. He has the TXA protocol from Martin County and Dr. Husty agreed to send the Seminole protocol. Dr. Plumbley stated that he did some research on pediatric use and the literature provides information on pre-hospital use by weight. Dr. McPherson asked Dr. Plumbley to send the literature to Lynne to share with group. He stated that we need to include trauma center directors and physicians in this decision. Dr. Figueroa stated they have an established policy on TXA but he is not sure if it extends to use with EMS. He will find and send the policy. Dr. McPherson will send these out to the group. The goal is a standard procedure within the region. Dr. McPherson asked Dr. Husty to review the protocols and draft this to send out to trauma centers and EMS directors to gain their consensus. This can then be submitted to the Executive Committee to adopt. We cannot require compliance but can encourage all to adopt the regional protocol.

Spinal Immobilization: Dr. McPherson stated that the group has also reviewed spinal immobilization; this varies throughout the region. Dr. Husty will provide his protocol. Dr. Zuver presented the national best practice paper. The discussion last meeting was focused on over immobilizations being the problem, not under. The group discussed appropriate use and Dr. Figueroa expressed concern at allowing this to be at the discretion of first responders at the scene. He cited an issue with a trauma center in South Florida that had some issues. He feels that is the patient is a trauma alert, they should be immobilized. Dr. McPherson stated that some are concerned over over-immobilizations. He suggested the group review Dr. Husty's protocol as it seems to be working. He suggested that paramedics have a checklist to follow that would allow for discretion. Dr. Figueroa suggested gathering all protocols across the region and doing a literature review for further discussion on this issue. Dr. Bilski volunteered to work on this. She stated she has protocols from Pennsylvania, New York and Virginia. McPherson stated that in a literature review he found a large study that stated there was a very small number that missed fractures. Dr. Bilski reported that she attended a recent national meeting where a study showed that there was allow incidence of missed injuries. Dr. McPherson will reach out to the medical directors and ask that they send their protocols to Lynne to share with the committee. He stated that he knows this will be a little controversial with the trauma centers. He asked if there is any literature from a trauma surgeon perspective. Dr. Plumbley stated that it will be important to educate the acute care hospitals. Lynne advised that there are monthly calls with the acute care hospitals emergency preparedness staff and if we know what level to target, we can invite them to participate. Dr. Plumbley suggested the ED medical directors.

Dr. McPherson stated that there are other issues that are controversial that the group can tackle at future meetings.

EMResource: Lynne advised that she invited the Preparedness Committee to this call to hear about EMResource. Todd Stalbaum discussed use of EMResource, which has been used in Orange County since 2001. This is a communication tool among hospital EDs, fire and EMS. Orange County piloted this and the state then adopted this for have a bed reporting. Two years ago, the state moved to FLHealthSTAT; this did not work well. Now AHCA has moved to ESS but that only provides bed reporting, it does not allow for communication. The communication provided via EMResource allows for better transportation decisions and allows EMS to alert hospitals re trauma, hazmat, etc. It also provides an alerting mechanism in a mass casualty event; texting alerts to clinicians at the hospitals. In the April regional mass casualty exercise, lack of communication was cited as the biggest issue. EMResource eliminates that problem. Lynne reported that DOH has a new tool they are looking at and we will soon be given information on that. Dr. McPherson asked which counties use this; Todd explained that Orange County uses and pays for Seminole and Osceola hospitals. Dr. McPherson asked re cost and expressed concern over adding FTEs to manage data. Todd explained that no FTEs are needed; the EDs update every two to four hours, using paramedics sitting with patients or the charge nurse. It is approximately five minutes of entry time per 24 hours for each facility. The licensing cost is per capita (approximately $15,000 annually for a county with a population of 350,000). This might be something that we could do as a region through the coalition. Dr. McPherson suggested a brief overview to hospital administrators. Lynne stated that Chief Stabile from Martin County has also expressed interest. Todd will put together a quick overview and will also ask EMResource for any videos. Todd stated that even BOLOs can be sent via EMResource. Lynne will raise this at the next Preparedness Committee meeting and ask that they champion a presentation for the region's EDs using GotoMeeting. Todd provided a link to the EMResource website: https://www.juvare.com/emresource/

Next meeting:

TXA – Dr. McPherson & Dr. Husty

Spinal mobilization – Dr. Bilski

Pediatric guidelines – Dr. Plumbley

Region 5 Trauma Clinical Leadership Committee Call

Tuesday, June 11, 2019

Participants: Catherine Billen, Dr. Traci Bilski, Lynne Drawdy, Chief Gaius Hall, Dr. Todd Husty, Matt Meyers, Dr. John McPherson, Susan Ono

Background: Dr. McPherson asked group if they had reviewed May minutes and thanked Catherine for preparing these. He reminded the group that the Clinical Leadership Committee was convened to identify and review EMS and trauma care that is controversial or needs to be standardized throughout the region.

Initial issues included:

- Use of TXA and best practices in management of trauma patients (adult and pediatric) before they arrive at a trauma center
- Spinal immobilization

TXA

The group discussed utilization of TXA in a pre-hospital setting. Dr. Husty provided literature and discussed the use of TXA in Seminole County. He stated that the protocols he has seen are simple and consistent and training is key. Dr. Bilski stated that the only patients she has seen with TXA are those brought in by the flight crews in Osceola. Dr. McPherson stated that Brevard County minimized the use for a number of years. Dr. Husty thinks debate about adult TXA is personal preference.

The group discussed use in pediatric populations. Pediatric trauma centers now use TXA for trauma related injuries. Hemorrhagic patients have seen a positive change in vital signs. Other uses include the need to stop bleeding, require blood, or undergo certain surgical procedures. Dr. Plumbley researched and found nothing that indicates it is harmful. Further, literature states that anyone of adult size can be treated as an adult. They have added a TXA protocol without an age range based on size.

Discussion arose regarding the amount of fluids being given. Suggestion was made that protocols should include mixing fluids over 10 minutes as a small amount is believed to be inconsequential. Susan shared their protocol where fluids are administered via IV push over 10 minutes or diluted in saline which is in line with Dr. Husty's protocol. Dr. Husty mentioned that during the EMS Chief meeting this topic was discussed using dial-a-flows to ensure all fluids go into 100 cc of saline. This frees up personnel to properly take care of patients.

Dr. McPherson sent out protocols available online from other states. He checked with the EMS medical directors' website; very few had TXA protocols and the ones that did were very consistent. He would like to hear Dr. Plumbley's thoughts regarding its use in the pediatric population. Dr. McPherson would like to put together a standardized document for use throughout the region. Dr. Husty stated that not all surgeons would agree but that's not unusual. At some point a decision would have to be made as far as when too much caution is too much. The use of TXA in adults is standard yet not all agree. Dr. McPherson suggested getting buy in from each trauma center medical director and their expectations. He further recommends a best practice protocol that includes literature review for Executive Committee

approval, which would then go out to all EMS medical directors. Dr. Husty suggested one for the adult population and another for pediatrics. Chief Hall stated they have a lot of protocols they work off, but his main concern is ensuring all understand the reasons to overcome local practice. Dr. McPherson will work on getting Lake, Martin, and other counties to attend or review minutes. He stated that Dr. Springer is interested in participating.

Spinal Immobilization

Dr. Zuver presented best practice literature on spinal mobilization from the National Association of EMS Physicians. Dr. McPherson was surprised at how little information was included and isn't sure it will be of much help. He asked what is the biggest controversy in spinal mobilization? All agreed that over-immobilizing every trauma patient has become an issue. More than ten years ago, the Florida Association stated that not all trauma patients need to be immobilized; this statement alone allows for deviation. The question then is, who should and who shouldn't be immobilized and how is that determination made? Training in this area is imperative.

The group further discussed the immobilization of cooperative vs. uncooperative patients. At times, immobilization can hurt a patient because it can compromise the airway especially in the elderly population. Most trauma patients need restriction not immobilization. Dr. McPherson asked if those present were using strict protocols to immobilize or following criteria? Most agreed that we are indeed over immobilizing and need to find evidence to support this. Chief Hall shared the trepidation that exists in using it for every trauma patient, even when not indicated, because they are afraid they will be yelled at. All agreed training was important. Dr. Husty stated their hospitals have a zero-tolerance policy regarding yelling at EMS personnel as it impacts care if you are doing things out of fear. He suggested asking when that last happened? If hospitals are allowing this, they should be called out. Dr. McPherson stated hospitals are asking that patients not be immobilized if not necessary, but then he hears from paramedics that they will get chewed out if they don't. Chief Hall agreed that the culture is slowly changing as some hospitals aren't calling them out. Again, the easiest way to get the field staff to change is through training so they feel competent and comfortable in making decisions within the criteria. Dr. McPherson agreed and suggested periodic review of protocols, particularly those with challenges. Dr. McPherson will request protocols from the medical directors and collate these to determine differences and draft consensus.

Other topics for discussion:

Permissive hypertension and the use of ani-coagulants with head trauma. Dr. Husty stated this has become a controversial topic due to the increase in airtime. EMS studies do not make sense in this regard. They have tried to back away at the urging of ORMC, initially over a decade ago. This is a good issue as there are no written protocols and this is being handled through training.

Dr. Husty discussed the matter with Central Florida Regional. He mentioned the topic is indeed very controversial as it lends to a vast amount of opinions. He firmly believes it's a topic worth tackling. Dr. Husty agrees that all free-standing ER's can handle and even transport immediately if needed. Susan motioned to standardize protocols for elderly patients to reduce delay in anti-coagulants. ORMC, Lakeland, and Osceola were all presented with information on the topic. Susan agreed to share additional information.

Dr. McPherson asked Susan to present literature and asked committee members to identify any other controversial issues or topics and send via email.

Actions:

Dr. McPherson and Dr. Husty will gather literature regarding use of TXA in field and will forward to Lynne for distribution.

Susan will email Dr. Plumbley to share his thoughts on the use of TXA in the pediatric population.

Susan will follow-up with Dr. Plumbley on pediatric guidelines.

Dr. McPherson will give update on June 25 at the Executive Committee.

Dr. Husty moved to adjourn. Adjourned at 9:10 am.

Region 5 Trauma Clinical Leadership Committee Call
Tuesday, May 14, 2019

Participants: Dr. John McPherson, Dr. Todd Husty, Lindsay Martin, Lynne Drawdy, Catherine Billen

Background: Dr. McPherson called meeting to order. He asked the group if they wanted to be formal, using Robert's Rule of Order, or if they preferred to be more relaxed and have an open forum? All agreed they preferred to be informal. Dr, McPherson summarized the last meeting, including defining the group's purpose, and setting some priorities regarding developing clinical best practices guidelines for presentation to the Region 5 Trauma Advisory Board Executive Committee.

He stated that there were three topics identified last month as priorities:

1. Dr. Plumley has agreed to develop a draft pediatric guidance document over next couple of months.
2. Dr. Husty to discuss use of TXA.
3. Dr. Zuver sent a white paper from National Association of EMS Medical Directors regarding spinal immobilization.

TXA: Dr. Husty stated Seminole County adopted a TXA protocol and they focused on intensive training for their 800 personnel. He discussed a case where a robbery suspect being chased hit a mother/daughter, both in bad shape, 15 y/o had fractured pelvis and was in and out of consciousness. Patient had a firm abdomen, and an elevated blood pressure. Chose to use TXA. As per Dr. Plumley, patient did very well and it helped save her life. That day he changed protocol to include adult sized pediatric population. They use it all the time at the pediatric trauma center, don't have an age restriction.

Discussion regarding a report read about patient vomiting blood, TXA given over 10 minutes and got to hospital in good shape. Their protocol is not just for trauma patients but includes other obvious hemorrhage and hypertension. They train to the numbers 90 systolic and 110 pulse rate. There is a good amount of paramedic discretion. Used quite a bit over past months, and all were reviewed and were appropriately used. Didn't include neck wounds in protocol because tourniquets don't work well with neck.

Dr. McPherson stated that TXA has been around a while, protocols are easy, and evidence is compelling that it works. The Military has done a lot of studies including large samples from the Middle East which indicate TXA has a higher survival rate than those in control group. It is not intended for head traumas, but it is not a contraindication. Dr. Husty stated that his son was an EMT and later becoming a surgeon and he is a big fan. He feels there is little downside. More information is needed on use with pediatric populations,

Dr. McPherson stated that he had to sell to Trauma, got over that hurdle, and is increasing use and seeing good results. He asked Dr. Husty to send their protocol. Dr. McPherson will send his and give summary to EMS directors, ask for others to stimulate discussion.

Spinal Immobilization Protocols: Dr. Husty stated that Seminole and Winter Park have received a lot of push back regarding why patients weren't being back boarded. As a result, he presented on how only cooperative patients can and should be back boarded. Dr. Husty has been looking at this for 15 years and asked if you can immobilize an uncooperative patient and do you need to immobilize a cooperative patient? Their protocol is that c-collars be used if tolerated without moving their neck. If they don't want to move because it hurts, don't move. Backboards are not anatomically correct. Need a little padding on firm surface – they have those and call them stretchers. No study shows a back board makes it better, and some that shows it can make it worse. Since they began this, all trauma centers agreed.

Dr. McPherson stated patients have been tortured with hard backboards and collars for years. Literature has been clear that the use of rigid devices when not needed is not good medical care. He said Dr. Plumbley previously stated they have a pediatric protocol and he will share. Level I and Level II trauma centers are now on board to discontinue the use of them. If they are neurologically intact on scene they will remain intact. Did not take spine boards off units because they are good for carrying patients in difficult positions and helps to move them carefully. EMS have been told to be selective.

Dr. McPherson feels this is another area where EMS should work with Trauma to agree on protocol. He had a protocol, but Trauma wanted immobilization in any unconscious patients. He stated that the key is collaboration between EMS and trauma, to discuss best practice in the literature and agree on best solutions. There was a Maine study 10 years ago with 30,000 patients, used a simple assessment for each level of consciousness. The miss level in 30,000 patients was about 10 fractures with no bad outcomes. Allow the pre-hospital that they can immobilize the c-spine without the t-spine. When they rolled out protocol, a lot of resistance.

Dr. Husty stated that all Seminole hospitals have agreed that EMS doesn't get chewed out anymore and instead there is a rational discussion on use. He mentioned one case 10 years ago where hospitals realized that rigid protocols can cause harm. Doctors coming in from other parts of the country still push back, but all hospitals agree to not using spine boards and c-collars on everyone. The two missed in the Maine study that were severe injuries – did not have bad outcomes. Not immobilizing them didn't make them worse. Concern that it could but no study that says that they do. He asked Dr. Rick Slevinsky, the state EMS medical director, how they came up with the protocol and he stated that seemed like a good idea at the time but was not evidence-based.

Dr. McPherson stated that the position paper by the national association is not liberating. It drilled down on where EMS was being yelled at. A lot of it was urban legend and boils down to customs. Dr. Husty found a lot of that, and said the Medical Directors meet with every single paramedic/EMT regularly in small groups, so with changes like this, they have an opportunity to discuss and they know they are welcome to speak up. There are a few outliers that are resistant to change. They discussed specific real examples. The Florida Association of EMS Medial Directors created a simple statement: Not all trauma patients need a spinal board. Didn't define which do and don't but this set the stage for training.

Catherine advised she is an EMT at APH and sees the hard time that the hospitals give EMS when patients aren't back boarded. She stated additional education is needed.

Dr. McPherson will summarize and ask others to submit comments, their protocols. The committee will make a recommendation on a regional clinical best care practice on spinal immobilizations as a recommendation to the Trauma Advisory Board Executive Committee and ask that this be adopted by the region.

Dr. Husty will bring a couple of issues up at CFR re controversies in trauma transport protocols. One size doesn't fit all. Head bumps with anticoagulants, not all need trauma center. There are no barriers with community hospital getting patients to trauma centers if needed. 21 y/o intoxicated, fallen and hit their head. Loss of unconsciousness, possible head trauma but may be due to intoxication. Glasgow of 13 – do they all need to go to trauma center? Need paramedic discretion or make the protocols less dogmatic (all must go). Write protocols for the lowest common denominator. They teach to patient needs vs. protocols. Need training to understand why we do what we do. Would like to see these discussed in future with this group.

Dr. McPherson stated about 25% is paramedic judgement. CAT scans in almost every hospital and transport to trauma available. Methodology needs to be re-evaluated

Dr. Husty asked whether we should have a CT alert? Part of the training is to train the opposite direction. UCF student with subdural trauma patient not drunk. Set parameters and educate community. No one wants unnecessary trauma alerts.

Dr. McPherson brought up another issue. Does EMS know their hospitals' capabilities?

Dr. Husty stated that teaching this is complicated because the focus is on that one patient. Can't have perfect parameters. This in turn becomes an education issue. He gets paid to educate all 800 in small groups. You must have a lot of training in order to give discretion to paramedics.

Actions:
Dr. McPherson will send out further studies on TXA protocols.

4-9-19 Trauma Clinical Leadership Committee Call

Participating: Dr. Traci Bilski, Lynne Drawdy, Dr. Todd Husty, Dr. John McPherson, Susan Ono, Dr. Peter Pappas, Dr. Donald Plumbley, Dr. Meredith Tinti, Dr. Christian Zuver

Background: Dr. McPherson stated that the committee originally was charged with putting together a plan for a regional trauma agency, but has changed direction and will now focus on clinical care in pre-hospital and trauma patients. Below is the committee's charge from the Trauma Advisory Board bylaws:

The Clinical Leadership Committee will serve as the best practice committee and the steering committee for Trauma Advisory Board development. It will be comprised of the RDSTF 5 Trauma and EMS medical directors, and will include a pediatric trauma representative.

Dr. McPherson stated that he feels the committee should review controversial care and identify areas for improvement. He asked if there were any specific issues, such as TXA in the pre-hospital setting. He stated that he would like this to be an open forum. Dr. McPherson asked the group for their vision for this committee. Dr. Husty agreed with Dr. McPherson, and stated that he would like to see guidance on TXA. He stated that his county is starting this, and it requires a great deal of training, but feel this is a need due to transport times.

Dr. McPherson asked if there were any issues with which EMS struggles. Dr. Tinto stated that she would like to focus on disaster management preparedness and coordinating clinical care, such as patient distribution, and dealing with scarce resources, such as blood. Lynne advised that the Trauma Advisory Board has a Preparedness Committee and agreed to send Dr. Tinti an invitation to this group.

Dr. Husty raised the issue of anti-coagulants and asked if all goes to trauma centers; some have minor head traumas, and he feels there should be discussion about opening this up with property training.

Dr. Plumbley suggested a focus on pediatrics. He stated that he is the end provider for many pediatrics and would like to see basic pediatric protocols, such as basic toolbox for fluid, scans, what is a good initial resuscitation for a child, when do you clear a c-spine.

Dr. McPherson stated that he would also like a focus on standardizing pre-hospital care, including care from a disaster, longer transports, basic expectations regarding pre-hospital care, and pediatric management. He stated that the group can also address disaster management as not all are large scale events; bad weather can cause a disaster event for some areas.

Dr. Bilski suggested providing clinical leadership and recommendations for day-to-day operations in small and large disasters. She stated that many committees are working on preparedness but are not focused on clinical issues. Lynne reported that Dr. Ibrahim chairs the Preparedness Committee.

Dr. McPherson suggested that the committee tackle one issue and develop a standard process for addressing issues. The group agreed to begin with pediatrics and TXA. The group agreed to begin with having one individual draft guidelines for all to review. Dr. Plumbley agreed to draft pediatric guidelines

including fluid management, mobilization, resuscitation, imaging (over and under), open fracture, appropriate antibiotics, and when to call on trauma. Dr. McPherson suggested calling these clinical recommendations. Dr. Plumbley stated that with appropriate guidelines, local hospitals should be able to identify the problem and treat appropriately. He stated that he feels emergency physicians would welcome guidance. Dr. McPherson agreed, and suggested including trauma scorecard methodology.

The group agreed to begin with this and as they advance will be comfortable taking on more complicated issues. Dr. Plumbley stated that he would send draft this within six or eight weeks and send it out prior to a meeting for discussion. Once the committee has reviewed, he suggested it go to the Executive Committee and then to FCOT.

Dr. Pappas stated that is guidelines come out with approval from the region's EMS and Trauma medical directors, it will carry weight. This will demonstrate an organized approach to issues within out communities and should be presented at FCOT.

Dr. Pappas advised that the committee can assign issues to the other committees to address. He stated that any guidelines developed should be approved by the Regional Trauma Advisory Board Executive Committee and then can be posted to the website and distributed throughout the region.

The group discussed variance in spinal mobilization by EMS. Dr. Husty agrees that EMS over immobilizes. He stated that guidelines and training are needed. Dr. Zuver stated that he will share n NDMS/ACS spinal mobilization paper. Dr. McPherson agreed that we should start with federal guidelines and see how we differ. Dr. Zuver will send to Lynne to share with the committee.

Lynne asked Susan to discuss the Preparedness Committee's plan to provide training on trauma to non-trauma hospitals. Susan stated that the focus of this is for mass casualties and not day-to-day practice. For example, in Vegas, many patients showed up at non-trauma centers. Susan stated that the concept is to give these hospitals the tools they need to triage these patients.

Dr. McPherson asked the group about meeting frequency and times. All agreed to schedule a monthly call on this day/time.

The group discussed how to engage those that are missing. Dr. McPherson asked all to reach out to those they know and share the group's plans, and let them know the group doesn't want to make any decisions without their input. Dr. McPherson will put something together to send out physicians.

Actions:
Dr. Plumbley will provide a draft pediatric guidance document within two months
Dr. Husty will provide TXA research by the next meeting
Dr. Zuver will provide the white paper on immobilization