

EMS Trauma Subcommittee  
Meeting Summary  
June 12<sup>th</sup>, 2012 - 3:00 PM

The EMS Trauma Subcommittee met on June 12th at 1500. There were 24 people in attendance, with 8 people on the conference call.

We heard from representatives from the Air services that the consensus is mobile units are needed, as opposed to handhelds. Fortunately, it appears the cost for these will be substantially less than initially feared. We will continue to hear updates as more information becomes available.

We continue to attempt to complete our voting core. So far, we have 8 of our 13 voting positions filled, as well as several permanent alternates named. We are still waiting to hear from some of the TRACS, as well as the training subcommittee.

The backfill agreements are still lacking. As of this meeting, 64 services had two backfills. 77 had no backfills. 21 have one backfill only, and 7 have backfills with non-adjointing counties. These services are being contacted, and it will be stressed that they will not receive additional trauma funding until these are complete. There have been two changes to the backfill agreements. They now state the backfill must be with adjoining counties, and it is now possible for an ALS service to be backed up by a BLS service.

Greg and Ryan updated us on data submission. Greg notes data submission continues to improve. However, there is still considerable variance between the EMS data and the call center data. They continue to work to improve the accuracy of the data. Ryan discussed a NEMESIS 3.0 workgroup, as we need to decide what data elements we would like to collect when we migrate to the new dataset.

Since our last meeting, we discussed pay for performance initiatives with the finance subcommittee. One plan involved funding services who participated in a cost analysis survey. Another plan involved giving additional funds to services that have 85% of their field personnel certified in PHTLS or equivalent. After the finance committee met, it appears the total funds available for EMS are around \$100 K. There is some concern from the health dept that financing the cost survey would not truly be considered a performance improvement initiative. From our perspective, we would rather abandon this option and pursue the PHTLS initiative. The exact amount each service would get would not be known until the deadline, which has yet to be determined. All services that met the qualifications would divide the total available funds, with the amount depending on how many personnel they had certified. The initiatives were to be discussed further at the next TAC meeting.

At the last TAC, we asked the ATCC and Health Dept to look into the cost and feasibility of implementing Fleeteyes, or some other statewide AVLS system. Jeff provided us with some numbers, noting the cost varied widely depending on the vendor and options we got, but it would likely be around \$260-360 K, not counting the annual cost of using the service. Many people expressed considerable concern that providers would be unwilling to participate in this. There is

concern that this would allow competing services to see where another services trucks are. We were assured the system would not be set up to allow this. There was also concern this would allow the ATCC to dispatch an out of town truck to transfers, further delaying the return of said truck to their service area. It was pointed out this is not the intention of having this system at all. After much discussion, the general consensus of the group was this is a good idea. However, there will likely need to be more discussions with all providers to allay their fears and make it clear what the intention of this system would be.

The Health Dept then presented a proposed draft for urgent trauma transfers. This ignited considerable discussion. The Health Dept notes this was developed in response to EMS complaints that they are inundated with transfer requests that aren't truly urgent, and often inappropriate. They note this will help reduce unnecessary transfers, and will also define what truly constitutes an urgent transfer. There was considerable resistance from many EMS providers, who were generally opposed to the idea that these urgent transfers would have to be treated like any other 911 call. After much discussion, it was agreed on by all parties that the document was a good step, but that the language would need to be reworked. The Health Dept had hoped to present this to the Board of Health at the July meeting, but they agreed to postpone this until the document could be revised.

Our next meeting will be July 10<sup>th</sup> at 1500.