

# STRENGTHENING IMPLEMENTATION OF THE 2006 FIELD TRIAGE GUIDELINES



NATIONAL ORGANIZATION MEETING  
WASHINGTON, D.C.  
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*The National Organization Meeting to Strengthen Implementation of the 2006 Field Triage Guidelines was made possible through a cooperative agreement with the Centers for Disease Control and Prevention.*

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## BACKGROUND

On November 2, 2009, the State and Territorial Injury Prevention Directors Association (STIPDA) and the Centers for Disease Control and Prevention's (CDC) National Center for Injury Prevention and Control (NCIPC) convened a meeting of thirteen stakeholders and leaders of national organizations to discuss existing opportunities to strengthen the implementation of the *Guidelines for Field Triage of Injured Patients: Recommendations of the National Expert Panel on Field Triage*.

As part of a national effort to implement the 2006 Field Triage Decision Scheme, participating organizations were asked to brainstorm strategies from an organizational perspective that would address both barriers impeding implementation and strategies that would support the successful implementation of the *Guidelines* at state and local levels.

The objective of this one-day National Organization Meeting in Washington D.C. was to provide a venue for national organizations to:

1. Strengthen their understanding of the *Guidelines* and their role as a foundation for the development, implementation, and evaluation of local and regional field triage protocols;
2. Share an overview of current tools and resources available to promote and ease adoption of the *Guidelines*; and
3. Identify key strategies and develop action plans specific to existing resources.

During the meeting, participants:

- Provided detailed descriptions of their organizations, including (but not limited to): their membership's representation of the trauma field, organizational activities specific to the *Guidelines*, and the main challenges facing their membership today;
- Shared personal and organizational experiences involving barriers and strategies associated with the dissemination and/or implementation of the *Guidelines*;
- Learned about the activities of other participating organizations;
- Identified and prioritized barriers impeding the successful implementation of the *Guidelines*;
- Developed short-term and long-term strategies to overcome barriers discussed; and,
- Committed to identifying key actions to support implementation over the next year.

The National Organization Meeting to Strengthen Implementation of the 2006 Field Triage Guidelines was made possible through a cooperative agreement with the Centers for Disease Control and Prevention. The following report summarizes the *Guidelines for Field Triage of Injured Patients: Recommendations of the National Expert Panel on Field Triage*, describes current implementation activities of participating organizations, identifies barriers and strategies to strengthen implementation of the *Guidelines*, and discusses next steps.

## GUIDELINES FOR FIELD TRIAGE OF INJURED PATIENTS

Scott Sasser, MD, of the CDC's Division of Injury Response and Emory University's Department of Emergency Medicine, provided an overview about the *Guidelines*' history, impetus, and primary goals.

Dr. Sasser began by delineating the impetus behind the *Guidelines*—revealing that patients' risk of death was 25 percent lower when care was provided at a Level I trauma center when compared to care received at a non-trauma center. Dr. Sasser referenced data from the *Resources for Optimal Care of the Injured Patient* (1999) from American College of Surgeon's Committee on Trauma. Content experts and stakeholders convened to discuss this stark difference in mortality, which led to the revision of the 1999 ACS document, and resulted in an updated ACS publication. Supported by new information and evidence, more changes were made to the 2006 ACS document, which led to the publication of the *Guidelines* in the January 2006 edition of CDC's *Morbidity and Mortality Weekly Report* (MMWR).

To date, the *Guidelines* have been downloaded approximately 48,000 times from the CDC website. In addition, the *Guidelines* have been published in the *Journal of Emergency Medical Services* (circulation: 47,000) and has been emailed to more than 200,000 recipients.

Dr. Sasser highlighted content interpretation and lack of scientific data as some of the challenges to implementation. Using an example cited referred to an instance when the *Guidelines* incited debate among local health professionals at Level I and Level II trauma centers. When determining how the *Guidelines* should be interpreted, Dr. Sasser raised the question: Should pre-hospital provider health professionals assume that all trauma patients should be taken to a Level I trauma center? Given the initial study comparing outcomes between a Level I trauma center and a non-trauma center, communities must take into account all resources available to make the best decisions for patient transport and care.

## **PARTICIPATING ORGANIZATIONS: MEMBERSHIP & DISSEMINATION ACTIVITIES**

Participating organizations were asked to prepare a brief introduction of their organizations, which included:

- A description of their membership and its representation of the broader field
- The main activities of their organization (i.e., continuing education, advocacy, etc)
- The main communication methods that are most effective for reaching out to their members
- The main challenge(s) facing their members today
- Their organization's priorities over the next 6 – 12 months
- Activities their organization has undertaken to disseminate *the Guidelines* with their members

Summaries of the introductions provided by each participating organization are below:

### ***American Association for the Surgery of Trauma (AAST) and American College of Surgeons (ACS)***

Jeffrey Salamone, MD, of AAST's Military Liaison Committee and Chair of ACS' Prehospital Emergency Services Subcommittee, provided an overview of the activities of both organizations.

AAST is the premier academic trauma surgery organization in the United States with approximately 1,000 members from 30 countries. The organization was established to further the study and practice of traumatic surgery in its various departments, in the United States and Canada. The Association publishes the *Journal of Trauma* and holds annual scientific meetings designed to exchange knowledge pertaining to current research practice and training in the surgery of trauma. The association also designs research studies to investigate new methods of preventing, correcting, and treating traumatic injuries. AAST was involved in the development of the *Guidelines*.

ACS is a scientific and educational association of surgeons that was founded in 1913 to improve the quality of care for the surgical patient by setting high standards for surgical education and practice. The ACS has a Committee on Trauma that is dedicated to improving all phases of care for the injured patient. Each state has a state committee on trauma, as well as a chair for the Pre-Hospital Subcommittee. ACS published the first Field Triage Decision Scheme in 1986 and has actively participated in the development and dissemination of the updated Decision Scheme.

### ***American College of Emergency Physicians (ACEP)***

Rick Murray, Director of ACEP's Emergency Medical Services (EMS) and Disaster Preparedness Department, and Sabina Braithwaite of ACEP'S EMS Committee gave an overview of ACEP's membership and current activities related to the dissemination of the *Guidelines*.

With a mission to seek solutions to the problems confronting the emergency care system—ensuring patients' safety and access to care, ACEP's 27,000-member organization supports 119 million annual

emergency department visits in 4,500 hospitals, nationwide. ACEP has 53 chapters – one in each state, Washington D.C., Puerto Rico, as well as a Government Services Chapter.

The values of the organization focus on advocating for injury prevention and traffic safety, ensuring the growth and future of health and emergency care, as well as providing high quality emergency care for all Americans. ACEP has prioritizes ensuring access to emergency care, improving quality of care and patient safety, reducing crowding, enacting liability reform, achieving fair reimbursement, and promoting emergency medical preparedness for disasters.

ACEP described three resources available through their organization: the National Report Card on the State of Emergency Medicine, *VitalCare* Magazine, and *Emergency Care For You*.

The National Report Card is a unique and innovative project developed to measure America's commitment to emergency care resources and to focus public attention on the challenges facing emergency care services, nationwide. Using an expert taskforce to analyze existing data of 100 measures, ACEP gave each state a grade on a scale of A to F. ACEP assessed each state's support of five crucial elements of emergency care: Access to Emergency Care, Quality & Patient Safety, Public Health & Injury Prevention, Medical Liability Environment, and Disaster Preparedness.

*VitalCare* Magazine is a consumer magazine that can be found in more than 1,100 emergency department waiting rooms in all 50 states. It is a tool to educate and entertain captive audiences. The magazine has a readership nearly one million people and focuses its content on emergency-medicine themes, health, safety, and aftercare. *Emergency Care For You* is the web-based compliment to *VitalCare* Magazine. This resource is promoted through traditional media outlets and cross-promoted in *VitalCare* and on the ACEP Foundation website.

In order to communicate with their members, ACEP uses email, the ACEP website, and a monthly Newsmagazine. The ACEP website allows members to access information and resources that can help them practice emergency medicine. E-mails are used to relay specific messages to individual members about self-identified interests (i.e., EMS, disaster response, etc.) and to drive members back to the website. The monthly Newsmagazine informs members and also drives them to the ACEP website as well.

As an endorsing organization, ACEP has supported the dissemination of the *Guidelines* through the physical dissemination of posters and pocket cards distributed at Emergency Medical Service Conferences and to the ACEP EMS Section of over 550 members. In addition, ACEP developed an EMS Week Kit 2009 that included a full-page print ad with information on downloading National Trauma Triage Protocol. This resource was distributed to 30,000 people. In the upcoming year, ACEP plans to:

- Continue distribution of the Field Triage Decision Scheme information at EMS Conferences;
- Extend distribution of the *Guidelines* to other organization sections (i.e., Air Medical Transport, Tactical, etc.);
- Print the Field Triage Decision Scheme in the EMS Section Newsletter;
- Continue to print a full-page version of the Decision Scheme in the EMS Week Kit 2010; and
- Add Field Triage Decision Scheme information to the EMS Week website.

## *National Association of Emergency Medical Services Officials (NASEMSO)*

Jolene Whitney, a representative from the Trauma Managers Council, and Kathy Robinson, a program advisor, gave an overview of NASEMSO focusing on changes within their organization, as well as the tools and resources the organization has to offer.

NASEMSO is committed to supporting its members in developing EMS policy and oversight, as well as in providing vision, leadership and resources in the development and improvement of state, regional and local EMS and emergency care systems. The organization consists of a nationwide network of coordinated state, regional and local EMS and emergency care systems. The systems use public health principles, data, and evidence as a basis for safe and effective care in day-to-day operations and during catastrophic events.

NASEMSO has nine operational and mission-specific committees including (but not limited to): executive, financial, program, domestic preparedness, government affairs, and rural EMS committees. There are also several State Councils under the NASEMSO umbrella: the EMS Training Coordinators Council, the EMS Medical Directors Council, the EMS Data Managers Council, the EMS Trauma Managers Council, and the EMSC Coordinators Council.

Overall, NASEMSO councils create a national forum for communication and networking where members can share best practices, develop and encourage mentoring programs, come to joint resolution of challenges, and nationally promote evidence-based decision making for EMS system development.

NASEMSO's goals for the 2009 – 2010 year are as follows:

- Improved EMS presence in government affairs
- Produce monographs and data
- EMS presence in domestic preparedness
- EMS presence in communications / technology
- Scope of practice and education standards
- Outreach – liaison organizations such as federal agencies and other trade associations
- Collaboration and fusion leading to enhanced EMS care nationwide

Currently, NASEMSO is involved in several projects that span several important topics, including data collection, homeland security, air medical, EMS education standards implementation, and pandemic flu.

NASEMSO's NEMESIS project included a survey sent to members that looked at current adoption of the *Guidelines* among member states. With 45 states responding, the survey found that 32 states (71% of the total survey group) indicated that a written protocol for trauma patient triage is in effect at the state level and that the CDC/ACS field triage guidelines (or a modified version) are used by 24 states (53% of the total survey group). This member survey revealed an important tool that could be used to support the national implementation of the *Guidelines*.

To support the dissemination of the *Guidelines*, NASEMSO highlighted the *Guidelines* in their Washington Update, posted announcements and links on the NASEMSO website, and discussed the *Guidelines* within their various organizational councils and committees.

### ***National Association of Emergency Medical Services Physicians (NAEMSP)***

Michael Millin, MD, NAEMSP's Standards & Clinical Practice Committee Chair, gave an overview of the organization's membership and highlighted other challenges hindering successful dissemination of the *Guidelines*.

NAEMSP represents more than 1,200 members, including physicians, EMS professionals, residents, and medical students. NAEMSP strives to provide leadership and foster excellence in and outside of hospital emergency medical services.

NAEMSP has supported dissemination of the *Guidelines* by informing their membership at annual conferences, through journals and newsletters, and by linking to the CDC website from the NAEMSP website.

NAEMSP is interested in supporting the national implementation of the *Guidelines* by:

- Conducting a member survey to learn more about who is implementing the *Guidelines*, and what challenges they are facing; and,
- Developing a joint position statement with other national organizations to assert the importance of the implementing the *Guidelines*.

### ***National Center for Injury Prevention and Control (NCIPC) at the Centers for Disease Control and Prevention (CDC)***

CDC's National Center for Injury Prevention and Control (NCIPC), in collaboration with the National Expert Panel on Field Triage, developed the *Guidelines for Field Triage of Injured Patients: Recommendations of the National Expert Panel on Field Triage*. These guidelines are based on the 2006, "Field Triage Decision Scheme," which the National Expert Panel considered to be the "basis for trauma destination protocols for Emergency Medical Services (EMS) systems across the United States" (MMWR 2009; Vol. 58; RR-1; page 8).

There are approximately 15,000 different EMS systems in the United States, following a variety of trauma triage protocols. In addition, as noted in the 2009 MMWR, "EMS providers in the United States are regulated by the individual states." It is therefore critical for national implementation efforts to have strong support from state level EMS stakeholders.

Now that development and dissemination of the *Guidelines* has been occurring in large scale through the efforts of leaders at the CDC and endorsing organizations, implementation is the next step. Mr. Guthrie

implementation as having Emergency Medical Services (EMS) and Emergency Medical Technicians (EMTs) actively put the *Guidelines* into practice on a daily basis.

Implementation of the *Guidelines* could be measured through:

- An increase in the number of EMS systems that adopt the *Guidelines*; and,
- An increase in the number of EMTs that use the Field Triage Decision Scheme with patients in the field.

### ***National Highway Traffic Safety Administration (NHTSA)***

Cathy Gotschall, from NHTSA's Office of Planning and Budget, gave insight into the resources NHTSA can provide, and voiced the perspective of the organization.

NHTSA, a global leader in motor vehicle and highway safety, provides leadership to the motor vehicle and highway safety community through the development of innovative approaches to reducing motor vehicle crashes and injuries. Some of NHTSA's leadership activities include spearheading innovative research and data analysis, setting the motor vehicle and highway safety agenda, and serving as a catalyst for addressing critical safety issues that affect the motor vehicle and highway safety communities.

### ***State and Territorial Injury Prevention Directors Association (STIPDA)***

Founded in 1993, STIPDA is a national non-profit membership association of professionals committed to strengthening the ability of state, territorial, and local health departments to reduce death and disability associated with injury and violence by:

- Increasing awareness of injury including violence as a public health problem;
- Providing injury and violence prevention and control education, training, and professional development for those within the injury and violence prevention field;
- Enhancing the capacity of public health agencies to conduct injury and violence prevention programs; and
- Supporting public health policies designed to advance injury and violence prevention.

STIPDA is open to all injury prevention professionals, public health professionals, students, and others interested in injury prevention. Members come from a range of settings including, federal, state, and local public health departments; hospitals; non-profit organizations; and colleges and universities.

Committed to strengthening injury and violence prevention, STIPDA participated in the National Expert Panel on Field Triage to update the *Guidelines* is supporting implementation of the *Guidelines* by working directly with national organizations and three states. Through their work, STIPDA hopes to:

- Help states achieve their action plan deliverables;
- Engage national organizations through quarterly calls; and,
- Assess lessons learned, as well as identify and address barriers associated with implementation of the *Guidelines*.

## BARRIERS & STRATEGIES

Participants had an opportunity to discuss the challenges they felt hindered the national dissemination of the *Guidelines*. Participants then prioritized barriers, recognized useful resources that could be provided by their organizations, and developed strategies that specifically addressed the barriers discussed. Below is a summary of barriers and proposed strategies.

### *Prioritized Barriers*

1. *Local Politics*

In many instances, local politics govern policies at state and local levels, instead of evidence-based care of the trauma patient.

2. *Overtriage and Undertriage, Mechanism of Injury*

The 2006 Field Triage Guidelines highlighted undertriage as the main issue. Overtriage, however, is equally important and from a population perspective can be equally detrimental to patients if ignored. EMS providers must be trained to care for injured patients, not to make assumptions about the condition of a patient based on the condition of the vehicle.

3. *Linked Data*

While the availability of data is also a problem, the absence of linked data also hinders progress in the field of trauma care.

4. *Successful Implementation*

There is a lack of consensus as to whether successful implementation is implementing the *Guidelines* as written, then modifying the application based on local resources, or if successful implementation includes making modifications to the decision-making scheme. Most organizations represented during this meeting felt that the *Guidelines* should be adopted as written, unless there is an evidence-base for desired modifications.

5. *Time, Distance, and Resource Depletion*

In conjunction with other types of data needed in the trauma field, data on the appropriate time, distance, and regionalization of protocols will be necessary to successfully disseminate and implement the 2006 Field Triage Guidelines.

## Summary of Brainstorming: Strategies to Address Prioritized Barriers

Barriers	Strategy
<b>Local Politics</b>	<ul style="list-style-type: none"><li>• Emulate NHTSA course (DOTS) to educate politicians, hospitals, and hospital administration about trauma system development and stakeholders</li><li>• Develop a list of all stakeholders that should be engaged to discuss common issues and guideline implementation</li><li>• Develop a trauma system definition and a curriculum surrounding that definition</li><li>• Engage people and make them part of the process (i.e., rural health self-assessment tool)</li><li>• Utilize local data to educate stakeholders</li></ul>
<b>Overtriage and Undertriage</b>	<ul style="list-style-type: none"><li>• Data needed for local areas to determine acceptable levels of over- and undertriage, definitions of regions, etc.</li><li>• Education:<ul style="list-style-type: none"><li>– Treatment of Overtriage as an equivalent issue to Undertriage</li><li>– Create info packet delineating the consequences of Over- and Undertriage from systems and patient perspectives (case study approach), while also highlighting money that is lost from these practices</li><li>– Engage hospital administration as stakeholders</li></ul></li><li>• Create a tool to help locals calculate appropriate levels of over- and under-triage</li></ul>
<b>Linked Data</b>	<ul style="list-style-type: none"><li>• Develop model statutes/policies to address HIPAA and IRB requirements to allow use of data for public health purposes</li><li>• Develop partnerships with state injury prevention programs with surveillance capacity</li></ul>

**Successful Implementation**

- Develop joint position statement regarding the importance of implementation for endorsing organizations to sign on (to be led by NAEMSP)
- Develop a system to collect local implementation challenges and successes
- Identify what current implementation looks like at a local level
- Conduct a literature search on the national implementation of guidelines (beyond the medical field)
- Encourage more system improvement process development standard measures for trauma systems

**Mechanism of Injury**

- Conduct data analysis/research to compare mortality and morbidity related to care at Level II or III trauma centers compared to non-trauma hospitals
- Train EMS providers to take complete patient assessments and not make assumptions based on the condition of the vehicle
- Develop support among physicians and critical-care/emergency nurses

**Time, Distance, and Resource Depletion**  
(From system and patient points of view)

- Conduct research to identify the “golden hour” or the real amount of time that determines whether a sick patient will live (will vary by injury)
- Encourage mutual aid/backups with nearby communities
- Educate community hospitals about roles in trauma care (i.e., do not have to turn away all cases in a certain category like pediatrics and burns; telemedicine may also be a strategy to consider)
- Consider facility licensure/regulations requiring hospitals to treat trauma patients that don’t meet field triage guidelines for transport to trauma centers
- Expand reach of rural trauma team development course (ACS)

## NEXT STEPS

Participating organizations were asked to commit to at least two activities to directly support implementation of the *Guidelines* over the next 9 – 10 months. Each organization's commitment is summarized below. Please refer to Appendix B for more detailed information.

The National Association of Emergency Medical Services Officials has committed to:

1. Increasing awareness of NASEMSO members regarding availability of field triage guidelines
2. Increasing utilization of field triage guidelines in the states

The American College of Emergency Physicians has committed to:

The National Association of Emergency Medical Services Physicians has committed to:

The National Highway Traffic Safety Administration has committed to:

The American Association for the Surgery of Trauma has committed to:

The American College of Surgeons has committed to:

As participating organizations begin implementation of their action plans, STIPDA and CDC will provide technical support to facilitate successful execution of their plans.

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