12-9-19 Trauma Preparedness Committee Minutes

Participants: Eric Alberts, Dr. Traci Bilski, Lynne Drawdy, Dr. Joseph Ibrahim, Matt Meyers, Meghan Thomas

MCI Carts: The MCI carts (by color) were approved by the Executive Committee, shared with all hospitals within the region, and were posted to the website.

Communications: Lynne stated that communications is always a major issue in exercises and events. The coalition will be scheduling a communications forum in the near year with hospitals, emergency management, and EMS to identify the essential elements of information, review communications platforms, and identify and prioritize gaps. She stated that the Preparedness committee will be invited and we need to encourage all stakeholders to participate. Dr. Ibrahim stated that it is crucial to get EMS buy-in. Lynne stated that EMS engagement has been a challenge and the Trauma Clinical Leadership group is working on this. Dr. Ibrahim asked if we could identify meetings they attend and meet them there. Lynne advised that the EMS Advisory Council holds quarterly meetings and we could ask to be on the disaster committee agenda. Lynne will find out when the next meeting is scheduled and Eric stated that he will attend if possible (see attached EMSAC committee schedule).

Trauma Training: – Dr. Bilski stated that she has had difficulty in freeing up staff for this training. She stated that her idea was to do the training to see how easy it would be to export this and provide it to all critical access hospitals. The problem is there are few course directors. There is no instructor course and she will need to have a dedicated course director to serve as a train-the-trainer. She advised this is a one-day course and takes a bed in the emergency department. She will be piloting this at Poinciana and St. Cloud. Dr. Bilski advised that she will follow-up with Michelle Rud and provide an update at the next meeting.

Next Meeting: The group agreed to move to bimonthly calls.

Other announcements:

All are working on Stop the Bleed training.

Eric advised that the regional full-scale mass casualty exercise is scheduled for April 9. There will be two components – Central Florida and the south end of the region.

Lynne reminded all that the Trauma Advisory Board Executive Committee and General Meeting is scheduled for December 17 at Halifax Hospital in Daytona Beach.

11/11/19 Trauma Preparedness Committee Minutes

Participating: Eric Alberts, Lynne Drawdy, Michele Rud

Agreed to reschedule to next month; Lynne will update calendar invitation.

9-9-19 Trauma Preparedness Committee Call

Participating: Eric Alberts, Lynne Drawdy, Michelle Rud, Margot Ververis, Collins Walker, Andy Watts

August Meeting Recap: At the last meeting, the group reviewed the draft letter and MCI cache by color list, discussed status of trauma trainings, and communications.

MCI Surge Cart: The drafter letter and lists have been distributed. Eric asked for any input. Michelle reviewed this and asked if this is what Orlando Health currently uses; Eric stated that it is. The next step is to present this at the September 10 Trauma Executive Committee and ask for approval to send out as a best practice to acute care hospitals. Eric agreed to present.

Communications: At the last meeting, the group brainstormed essential elements of information (EEIs) for communications during a mass casualty event. The next step is for the coalition to schedule a meeting with hospitals regarding the use of EMResource as a communication mechanism.

Trauma Trainings: Michelle reported that Osceola Regional is piloting the trauma course for rural hospitals in Osceola. The individual in charge of this has been out but will pilot and bring information back to the group.

Other Issues: No other issues were raised. Lynne suggested asking members if we need to move to bi-monthly calls. Margot agreed and stated that everyone is busy. The group agreed to move to bimonthly calls. Lynne will update calendar invitations.

8-12-19 Trauma Preparedness Call

Participating: Eric Alberts, Dr. Traci Bilski, Lynne Drawdy, Matt Meyers, Susan Ono, Collins Walker

Trauma Cart List: Susan reminded the group that Dr. Ibrahim sent out the trauma cart lists. Please let Lynne know if you did not receive this or you have any suggestions/additions. Eric will draft a letter to acute care hospitals to send out the list – this will be brought to the Executive Committee for approval.

Trainings: Dr. Bilski found a rural trauma course coordinator in Ocala. Michelle Rud is working with him to put together a course for one of their smaller hospitals. Once this is off the ground, they will include others.

Brainstorming EEIs: The group identified essential elements of information needed during a mass casualty incident, including:

- OR availability
- Bed status
- Staff beds available (by type)
- Surge capacity
- # received/ acuity of those received
- Supplies (e.g. blood products, etc.). The state monitors and directs where supplies go
- Ability to receive alerts / decon hazmat status
- Significant event notifications (to other regions)

Lynne reported that following Matt Meyers' presentation on communications at the June Regional Trauma Advisory Board meeting, she was asked to schedule a presentation on EMResource for the Clinical Leadership Committee. This was provided at the July committee meeting and the committee recommended that this presentation be given to the region's acute care hospitals, and include a discussion by a hospital user on the benefits to the hospital. All agreed this was a good idea. Lynne will schedule this and Eric or John will speak from the hospital perspective.

7-8-19 Trauma Preparedness Call

Attending: Eric Alberts, Dr. Traci Bilski, Catherine Billen, Lynne Drawdy, Dr. Joseph Ibrahim, Matt Meyers, Michelle Rud

- Red/yellow/green cart list (standardize MCI carts for non-trauma centers). Dr. Ibrahim will send their list to the group. He stated that these have been in place for a long-time and may need review.

- ATLS & TNCC courses: Dr. Ibrahim said Orlando Health routinely opens ATLS to others; they have a course this week but it is full; another class will be held in December. He stated that faculty is the biggest limitation; they have had individuals from other hospitals come in to help teach and so a regional approach makes sense. Dr. Bilski said they offer TNCC. She doesn't feel there is an issue regarding opening it up but there may be issues regarding availability. She stated that at Osceola Regional, TNCC is put on by third party and they can open it to other facilities, not just HCA. The only issue is the advertising piece. Dr. Ibrahim felt that the Advisory Board, the Coalition and the RDSTF can help advertise. He stated that if we find the courses are filling up, we can think about how we can make them more available. He asked if anyone else offers ATLS and Dr. Bilski stated that Holmes does. Dr. Ibrahim can find out when they are offering courses. Lynne can post to the website, send out notices, and announce on the monthly hospital call. Dr. Ibrahim asked if Dr. Bilski and Michelle can follow-up on TNCC. Michelle agreed to follow-up with Susan and also thinks Central Florida Regional offers this course. Dr. Bilski stated that when onboarding new staff, it is sometimes difficult to find these courses and we may need to think about how we can increase the availability of the courses, including reaching outside of the region (to Ocala and Lakeland). Dr. Ibrahim will talk with his coordinator about availability, and will talk with Dr. Bilski offline re increasing availability.

- Rural trauma course for acute care hospitals: Dr. Ibrahim stated that he has not taught this course and asked Dr. Bilski if she has. Dr. Bilski stated this course is taught at our facility and we are trying to get approved to be a teaching site.

- Communications: Dr. Ibrahim asked about follow-ups from the discussion at the June meeting. Lynne reported that Todd Stalbaum from Orange County is speaking on EMResource on Tuesday's clinical leadership call, and the Preparedness Committee members are invited to participate. Lynne stated that in addition to the communication mechanisms, we need to identify the essential elements of information needed (what do you need to share, what do you need to know)? Dr. Ibrahim stated that for a start, hospitals need to know how many beds are available by type (e.g. ICU, gen surge, ED), and how many ORs are running. Dr. Bilski stated that we may need a brainstorming session on this.

Actions:

1. Lynne will send email with summary.
2. Dr. Ibrahim will send cart lists to the group.

3. Dr. Ibrahim will follow up on ATLS course and Dr. Bilski will follow-up on TNCC course and rural trauma course.
4. Preparedness Committee members are invited to July 9 clinical leadership call at 8 am to hear the presentation on Orange County's use of EMResource
5. The group will brainstorm on information needs in a mass casualty event at the next meeting.

6-10-19 Region 5 Trauma Preparedness Committee Call Minutes

Participating: Eric Alberts, Catherine Billen, Lynne Drawdy, Matt Meyers, Susan Ono, Michelle Rudd

Welcome: Susan Ono welcomed the group.

April Mass Casualty Exercise After Action Report: The AAR was sent to the committee for review. Eric agreed to present this the June Trauma Advisory Board meeting. The group discussed the regional opportunities for improvement, and areas in which the Trauma Preparedness Committee can assist:

- Communication: We need to know the Essential Elements of Information (EEIs) the trauma community needs in a disaster.
- Decontamination: Trauma can champion support by hospital leadership for decontamination team recruitment and sustainment.
- Mass Fatality: This also needs support from hospital leadership.
- Patient tracking (across entities and the region): This is being addressed by the Coalition and they will let Trauma know if input or assistance is needed.
- Foreign Nationals: This will be addressed by the Coalition.

Preparedness Committee Role: Susan suggested that to avoid replication she'd like the Trauma Preparedness Committee members to participate in Coalition activities and the Coalition can identify areas in which the Trauma Preparedness Committee can assist or lead. Lynne stated that Eric is the Board Vice Chair and very engaged in the Coalition projects. She suggested that the group also review the ASPR Hospital Preparedness Program capability statement regarding trauma:

> *The HCC and its members should coordinate a response to large-scale trauma emergencies with all trauma system partners. All hospitals should be prepared to receive, stabilize, and manage trauma patients. However, given the limited number of trauma centers, an emergency resulting in large numbers of trauma patients may require HCC and ESF-8 lead agency involvement to ensure those patients who can most benefit from trauma services receive priority for transfer. Health care facilities should ensure enough availability of operating rooms, surgeons, anesthesiologists, operating rooms, nurses, surgical equipment, and supplies to provide immediate surgical interventions to patients with life threatening injuries.*

Lynne reminded the group that they previously discussed providing guidance to acute care facilities receiving trauma patients in a mass casualty; that would support the capability statement. Michelle stated that their hospitals are interested in the rural trauma course. Susan advised that courses such as TNCC (Trauma Nurse Core Course) and ATLS (Advanced Trauma Life Support) are already provided by the trauma centers. She suggested as a first step that we ask the trauma centers if they are willing to open these up to others. Eric recommended that we also develop a list with critical equipment and supplies (such as tourniquets and chest tubes). Susan offered to provide her red, yellow and green cart list for comparison and will ask others for recommendations in developing this. Susan reported that the regional advisory council puts on a regional course twice a year for acute care hospitals. She asked if the coalition could sponsor this, including providing CEUs. Lynne stated the Coalition can support this.

Susan asked that Coalition provide a report at the beginning of each Preparedness Committee meeting and identify areas where the committee can provide support.

Actions:

- Eric Alberts will present on the exercise at the June 25 Trauma Advisory Board meeting (this needs to be early on the agenda).
- Susan will provide red/yellow/green cart list.
- Susan will give report on Preparedness at June meeting.
- Susan and Michelle will ask about advertising the trauma courses externally.
- The committee will explore working with the coalition on a regional trauma course for acute care hospitals.

Region 5 Trauma Preparedness Committee Call
Tuesday, May 14, 2019

Participating: Dr. Ibrahim, Dr. John McPherson, Dr. Tracy Bilski, Michelle Rudd from Osceola Regional, Matt Myers, Andrew Watts from FDLE, Lynne Drawdy, Catherine Billen (introduced)

Lynne welcomed group and reported there were two issues from the last meeting:

- Review AAR
- Update Matt Myers on communications.

Matt stated he would like to set up a GoToMeeting next month for a formal presentation on communications. He discussed the current communication avenues. First, each county establishes a county warning point. This is the collection point for what's going on and is transferred up to state as appropriate. Information is usually received through dispatch centers. Secondly, several counties have been using EMResource which connects dispatch, EMS and hospitals. Third method is ESS established by state AHCA, which reports bed availability at hospitals. This method is new as it took over for FLHealthSTAT which has been discontinued. The coalitions have been working with AHCA to improve the view at local and regional level with ESS. Still remaining gaps. Information from state does not flow down for awareness level.

Lynne discussed the draft coalition operations plan, which outlines a framework we can use to build better communication processes.

Dr. Ibrahim discussed having looked at this across the country, and mentioned nobody has it right, but this gave him a better understanding of what we are trying to build. He's been struggling to understand what all the groups do (RDSTF, trauma advisory board, coalition). He then questioned, "What is EMREsource used for, and what are its pros and cons? Matt explained that this is used in Orange County for hazmat alerts, trauma alerts, alerts for mass casualty incidents, allows the dispatch center to alert the hospitals and identify what type of incidents are coming their way. This system is not as useful in rural counties with one or two hospitals. The big issue is its cost. In times past, grant funds have paid for and all had access. Once grant funding dried up, Orange County paid for it to continue. This system shows bed availability across hospitals by bed type. ESS system – shows bed availability, but no alerts. Could EMResource provide all those needs or is there something that could provide all those needs? Don't know whether EMResource can share data with AHCA to meet their requirements.

A question was raised as to what southern counties use for their trauma alerts? Phone calls and radios still being utilized which is not so reliable, but they don't have the volume. In order to get across the region, funding would have to be identified and education provided. EMS and hospitals agree.

Dr. Ibrahim looked at trauma centers on the south end, in Lawnwood and Osceola Regional, for example. Downstream EMResource is a good way to look at PI. How can we make things better? This issue will be brought to Trauma Advisory Council for input. Orange, Seminole, Osceola

and Lake Counties already utilizing. These hospitals have access, but not all EMS utilize. Lake County, for example.

Dr. McPherson asked if there was someone he can speak with? Lynne answered that she will forward Todd Stalbaums' contact information.

Dr. Ibrahim mentioned having seen multiple mass casualties here in Florida, and all may now be more willing to see the value.

Matt will give a presentation on communications at the Trauma face to face meeting on June 25, including EMResource pricing and data integration.

Dr. Ibrahim stated this is very helpful and thanked Matt.

Dr. Ibrahim discussed the after-action report on April 11th from 8-12. Reviewed the simulation of suspects attacks on multiple locations, multiple explosions, ricin poisoning, and shooting.

Group discussed the Infrastructure, mainly the traffic congestion where 40 agencies involved, FBI, State, hospitals, municipals, schools.
Exercise went well. Most facilities set up Incident Command quickly. Having traveled around the country, Dr. Ibrahim found that some have not utilized IC as much. They have learned that you need to use this, they just don't utilize it during a disaster except when ER is full. This is being practiced on a regular basis. Decontamination, family assistance, and HICS communications all went well.

Opportunities for improvement:
ED communicating with handsfree device, and or radios. The use of an app called Zello app was suggested. Idea came from one of the college reviewers from UVA. The app turns mobile phones into walkie-talkies. It is can make channels and program groups. Further, the app breaks through, even while on silent. Another benefit is that is saves all messages. Group suggested possibly setting up a channel with all trauma medical directors. Problem arose where PPE ran out due to the number of patients.

Lynne will be sending the regional AAR. Emphasized need for communication across the region.

Dr. Ibrahim asked if others experienced good communications systems?

Tracy mentioned robust systems in other areas. She will research and share with group.

Dr. Ibrahim discussed we may need to look at different meeting times. Due to rounding in the morning this present many challenges. Asked whether we could split meetings up of needed? Later is better – after 3 pm. Going forward, Preparedness Meeting will be moved to the second Monday at 3pm. Group agrees.

Actions:
Lynne will send out AAR to this group.
Tracy: Will look into regional notifications and discuss research with group.

4-9-19 Trauma Preparedness Committee Call

Participating: Lynne Drawdy, Megan for Lindsay Martin, Dr. John McPherson, Matt Meyers, Susan Ono, Michelle Rud, Andy Watts

Communication: Matt stated that he is working on this and will present it at the next meeting. Susan asked that he send it out prior to the meeting.

Physician Engagement: Susan reported that Dr. Ibrahim sent a draft letter out to the planning committee to ask hospitals to engage physicians in participating in Thursday's exercise. Eric has also championed this.

Guidelines to acute care hospitals receiving trauma patients in a mass casualty: The group discussed which should be triaged and send to trauma.

Dr. McPherson stated that this was discussed in the clinical leadership committee this morning, and they are working on this for day-to-day vs. mass casualties. Dr. Plumbley will be drafting pediatric guidelines which will be presented to the Executive Committee. The group will also look at TXA. Susan thanked Dr. McPherson for the update.

Susan suggested that the group focus first on communication, such as starting by welcoming them with local sources and resources. She stated the group can use the clinical leadership recommendations for further discussion about mass casualties. She stated that we will get insight from the exercise after action report. Lynne reminded the group that all hospitals were asked to pilot the adult/pediatric triage forms and give feedback. Any feedback will be brought back to the committee. Susan asked Lynne to send a reminder about using the triage forms.

Next meeting: Presentation on current communication processes and discussion of the after action report.

2-12-19 Trauma Preparedness Committee

Participating: Eric Alberts, Lynne Drawdy, Dr. Joseph Ibrahim, Matt Meyers, Susan Ono, Andy Watts

Best practices in mass casualty communication: Lynne reported that a reminder was sent but none have been received. She distributed the RDSTF 5 Response Plan which includes communications. She stated that this will also be addressed in the Coalition response plan.

Physician engagement: Dr. Ibrahim forwarded a draft letter and thanked Eric Alberts for providing this. Lynne stated that she will share this with all hospitals participating in the exercise. She stated that ASPR feels physician engagement in preparedness is critical.

Guidance to acute care hospitals who may receive trauma patients: The group discussed whether this should be handled by the Preparedness Committee or the new Clinical Leadership Committee. This is for a mass casualty situation and after discussion the group felt it is best handled by the Preparedness Committee. We know that in a mass casualty, like the Vegas shooting, patients will go to non-trauma centers. Dr. Ibrahim stated that Susan suggested looking at the courses for rural areas. Susan stated that we can adapt the rural trauma course to focus on multiple trauma patients. She suggested that we begin with a communication from the regional trauma advisory board re the importance of the acute care hospitals engaging in care for mass casualty incidents. We can provide education on the types of injuries they might see, the triage of multiple trauma patients, and transfers. She suggested that we team up with other trauma centers to develop and deliver this, making assignments based on proximity (e.g. if non-trauma center is within your system, you are responsible for them). There are only a few hospitals that are not part of a large system such as Health First or Advent Health. Lynne can provide a list of hospitals within the region and our preparedness contact. Susan stated that we can reach out to the trauma medical directors and trauma program managers for these systems, and assign the non-affiliated hospitals by proximity. Susan stated that we need to develop communications tools first. She asked what mechanisms currently exist. Lynne stated that we have a hospital distribution list and can use Constant Contact and Everbridge as communications mechanisms. Susan stated that to begin we can reach out to all involved in the April exercise and offer trauma experts. Dr. Ibrahim asked how we communicate across hospitals and to EMS. Matt stated that in the state and county emergency management plans, communication is addressed. During a disaster, the focus is on the county level first, and then the state. He stated that WebEOC can help share information across the region and we can develop pages specific to an event. He stated that if the group can identify their communication needs, the coalition can help find the right mechanisms for sharing information.

Dr. Ibrahim agreed stated that he did some research and Texas has identified four foundations. Lynne stated that these are the ASPR capabilities, and she will share these. She stated that they outline the requirements, but not how we achieve them. ASPR-TRACIE is a resource for best practices.

The group agreed to these actions:

- Communicate about the April exercise. Susan will draft a letter. Eric suggested adding the triage sheets to this.
- Work on identifying communications, triage, equipment.
- Share with Executive Committee and seek additional volunteers to work on this.

1-8-19 Trauma Preparedness Committee Call

Participating: Dr Bilski, Lynne Drawdy, Dr. Ibrahim, Lindsey Martin, Matt Meyers, Adriana Patel, Andy Watts

Updates:

Lynne reported that she sent out a request to all trauma stakeholders requesting best practices in mass casualty communications but has received no responses. Dr. Bilski asked if we have any in place and do we have capacity across the region apart from med com? She stated this is a key point to a joint respond. She asked if we need an ad hoc committee for this? Lynne advised that this can be raised to the Coalition. The Coalition is required to prepare a response plan this year and has two response roles: resource coordination and situational awareness. Matt suggested that we look at county level coordination first. Lynne stated that the regional incident management team is participating in this year's regional mass casualty exercise and we could ask if they can test this during the drill. Dr. Ibrahim volunteered to work with the IMT on this. He asked if the region has a communication plan. Lynne will ask the RDSTF. She stated that the Coalition uses Constant Contact to communicate with members during blue skies and Everbridge during grey skies.

Lynne sent out to the Preparedness Committee members the federal ASPR language regarding clinician engagement. The committee agreed to send out something to region's healthcare system encouraging physician engagement in exercises. Dr. Ibrahim stated that it is a challenge to get physicians engaged. Dr. Bilski stated they recently did a mini MCI drill and stated that the key is to make sure that all in proximity to the drill are notified before and during that this is happening and that all have a role to play. Dr. Ibrahim agreed, and stated that physicians and social workers facilitate the ability to discharge patients to increase capacity. Dr. Ibrahim volunteered to share a letter written by Eric Alberts encouraging physicians to participate. He stated that this is a good time to reach out and ask all clinicians at our facilities to participate in the April exercise.

Lynne advised that we have the final pediatric/adult mass casualty triage form and these will be used in April mass casualty exercise.

Lynne reported that the EDC AAR almost ready -will send to committee.

Lynne reminded the committee that at the last meeting they discussed the need to provide guidance to acute care hospitals who may receive trauma patients. Dr. Bilski stated this is a trauma system outreach problem and we should look at the principles from the rural trauma course on how to be ready. Dr. Ibrahim stated this is a big undertaking and suggested this be a project for the trauma advisory council. He suggested that this be raised to the Executive Committee. The group agreed that we should also reach out to other nearby trauma centers (e.g. Lakeland and Ocala).

Dr. Ibrahim will give a committee update on the Executive Committee call