



Region 8
Trauma Network Board

March 2024



AGENDA

Call to Order & Attendance

Agenda approval

Minutes approval

Public Comment

State and Regional Update

Trauma Center Designation Statuses

- Marshfield Dickinson (Level IV acquired)
- Aspirus Ironwood (redesignation visit scheduled)
- UPHS Marquette (ACS focus visit conducted)
- MyMichigan Sault (redesignation visit requested month early)
- UPHS Bell, Munising, Schoolcraft (queue)

MCA Trauma Triage reports for:

- Houghton Keweenaw MCA
- Gogebic Iron Ontonagon MCA

State and Regional Update

Trauma Center technical assistance

- Orientations
- Criteria explanations
- Opening PowerPoint sample outline
- Mock survey

March 13, 2024

RE: Stop the Bleed Initiative in Michigan

Dear Colleagues,

The Bureau of Emergency Preparedness, EMS and Systems of Care (BEPESoC) has been actively engaged in supporting the American College of Surgeons' STOP THE BLEED® (STB) initiative. This initiative was a recommendation from the Hartford Consensus in 2015 as result of the Sandy Hook shooting. The report notes the intention was to "create[e] a protocol for national policy to enhance survivability from active shooter and intentional mass casualty events."¹ The Hartford Consensus recognized that the lay public could provide effective aid to stop or control life-threatening bleeding until prehospital providers arrive.

Recently, a question was raised about whether Michigan's Good Samaritan law² affords immunity to members of the public who provide bleeding control. Under the current laws, there is no language specifically addressing bleeding control provided by members of the public³; therefore, only certain medical professionals are protected from civil liability for damages that might result from rendering emergency care.⁴ Language to amend has been introduced, however its status has not been determined.

BEPESoC worked with the Office of Legal Affairs to craft language to be used for STB trainings **offered by or lead by** BEPESoC staff. This language should be included in the training presentation, and a set of laminated cards are in production with the language on it. These cards will need to be added to BEPESoC purchased training kits.

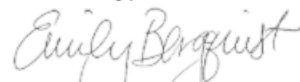
MDHHS makes no warranties, either express or implied, regarding an individual's ability to handle an emergency or critical situation after completing the STOP THE BLEED® training nor is MDHHS responsible for any injuries or damages that may result from the application of information or skills learned from the STOP THE BLEED® training.

Please note:

- 1) This is for Bureau-supported trainings only.**
- 2) STB trainers cannot provide legal advice. Questions about the warranty above or personal liability should be discussed with an individual's own legal counsel.**
- 3) Trainings provided by outside agencies (i.e., those that have obtained their training materials directly from ACS) will not have this language included.**

For questions, please contact the Systems of Care Section Administrative Assistant at strayerj@michigan.gov.

Sincerely,



Emily Bergquist

Stop the Bleed – State Staff

Disclaimer



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R8 MCAN
regional overview of
new protocols

RED CRITERIA

High Risk for Serious Injury

Injury Pattern

- Penetrating injuries to head, neck, torso, and proximal structures
- Skull deformity, suspected skull fracture
- Suspected spinal injury with new motor or sensory loss
- Chest wall instability, deformity, or suspected flail chest
- Suspected pelvic fracture
- Suspected fracture of two or more proximal long bones
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

Mental Status & Vital Signs

All Patients

- Unable to follow commands (motor GCS < 6)
- RR < 10 or > 29 breaths/min
- Respiratory distress or need for respiratory support
- Room-air pulse oximetry < 90%

Age 0–9 years

- SBP < 70mm Hg + (2 x age in years)

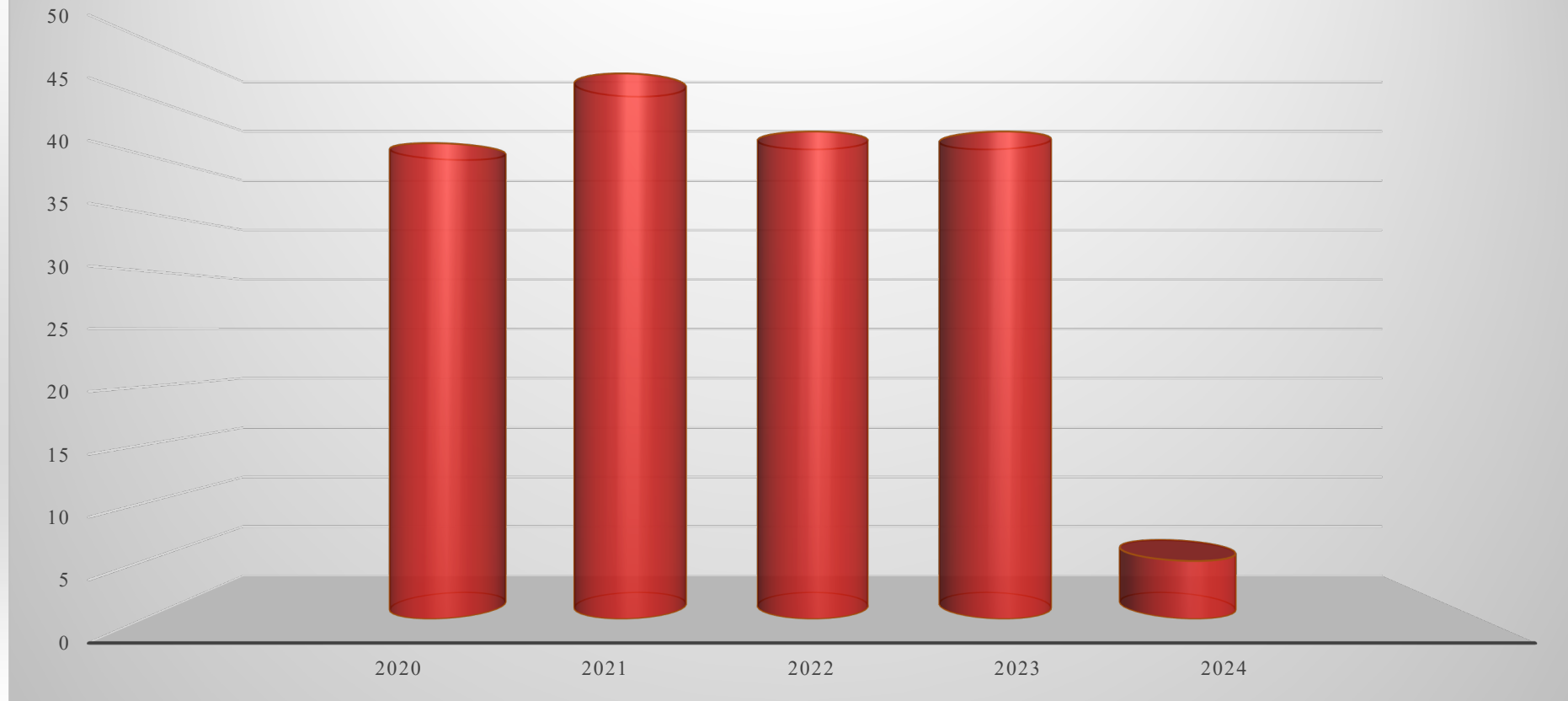
Age 10–64 years

- SBP < 90 mmHg or
- HR > SBP

Age ≥ 65 years

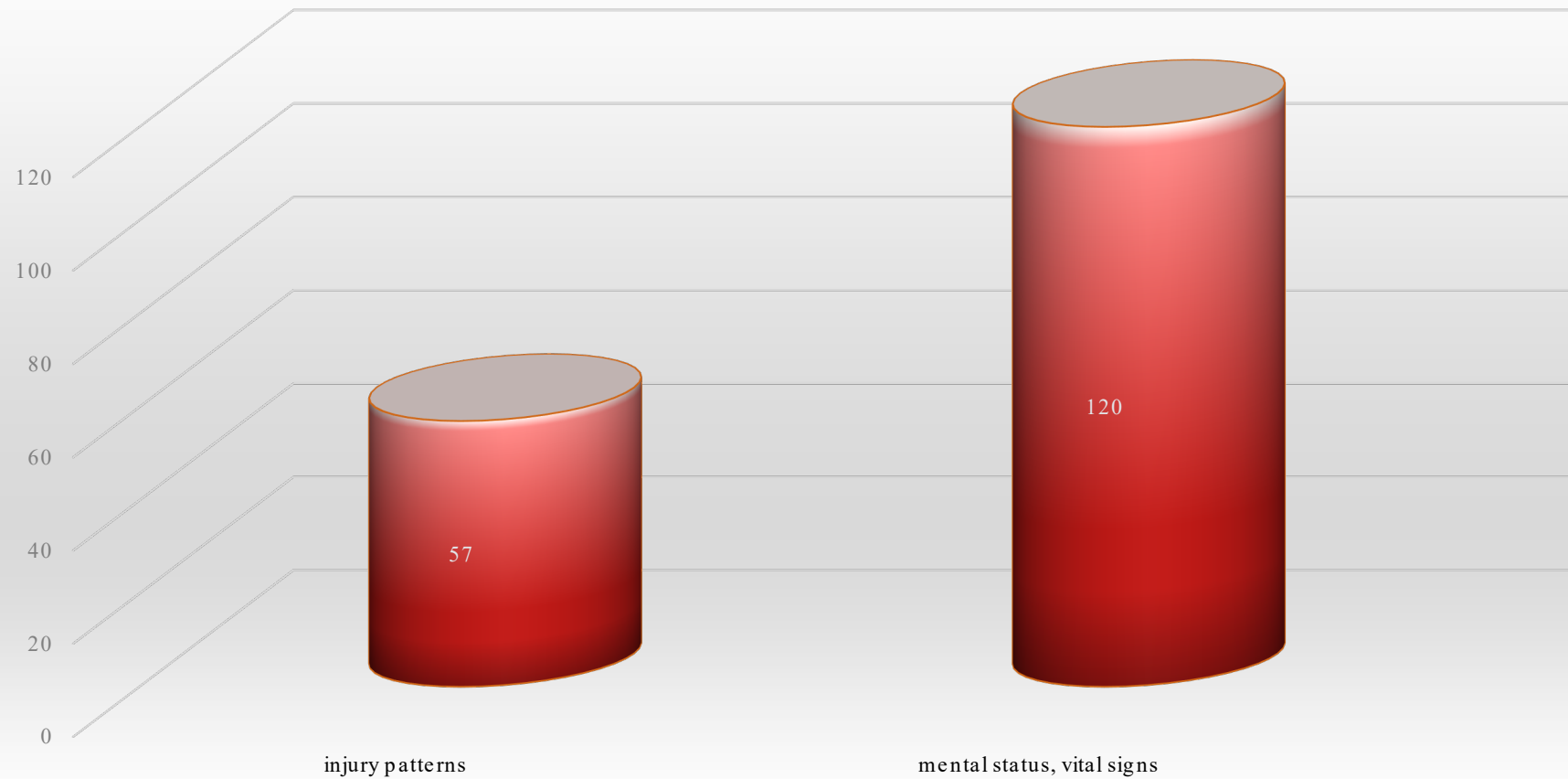
- SBP < 110 mmHg or
- HR > SBP

Patients meeting Red Trauma Triage & Transported to Aspirus Ontonagon



Source: biospatial, created 3/5/2024; filters 1/1/2020-3/4/2024; ACS 2021 injury patterns, mental status, vital signs, transported to AOH

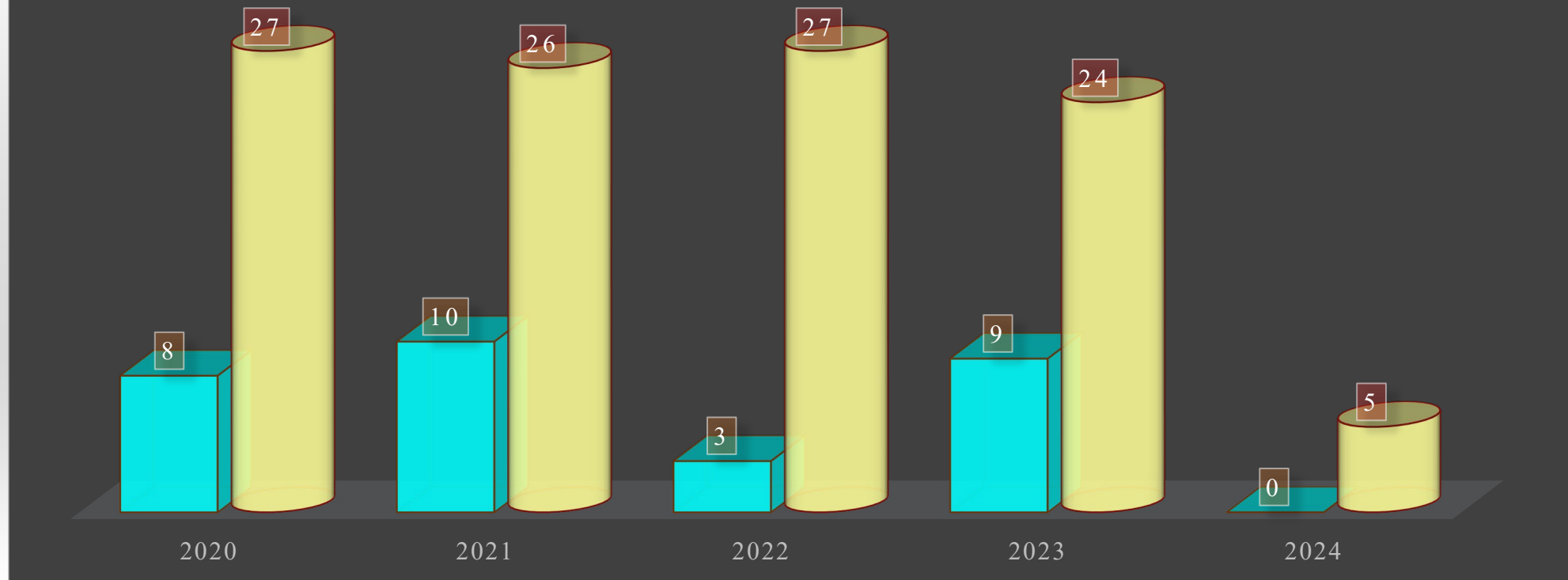
Red Trauma Triage Criteria Met



Source: biospatial, created 3/5/2024; filters 1/1/2020-3/4/2024; ACS 2021 injury patterns, mental status, vital signs, transported to AOH

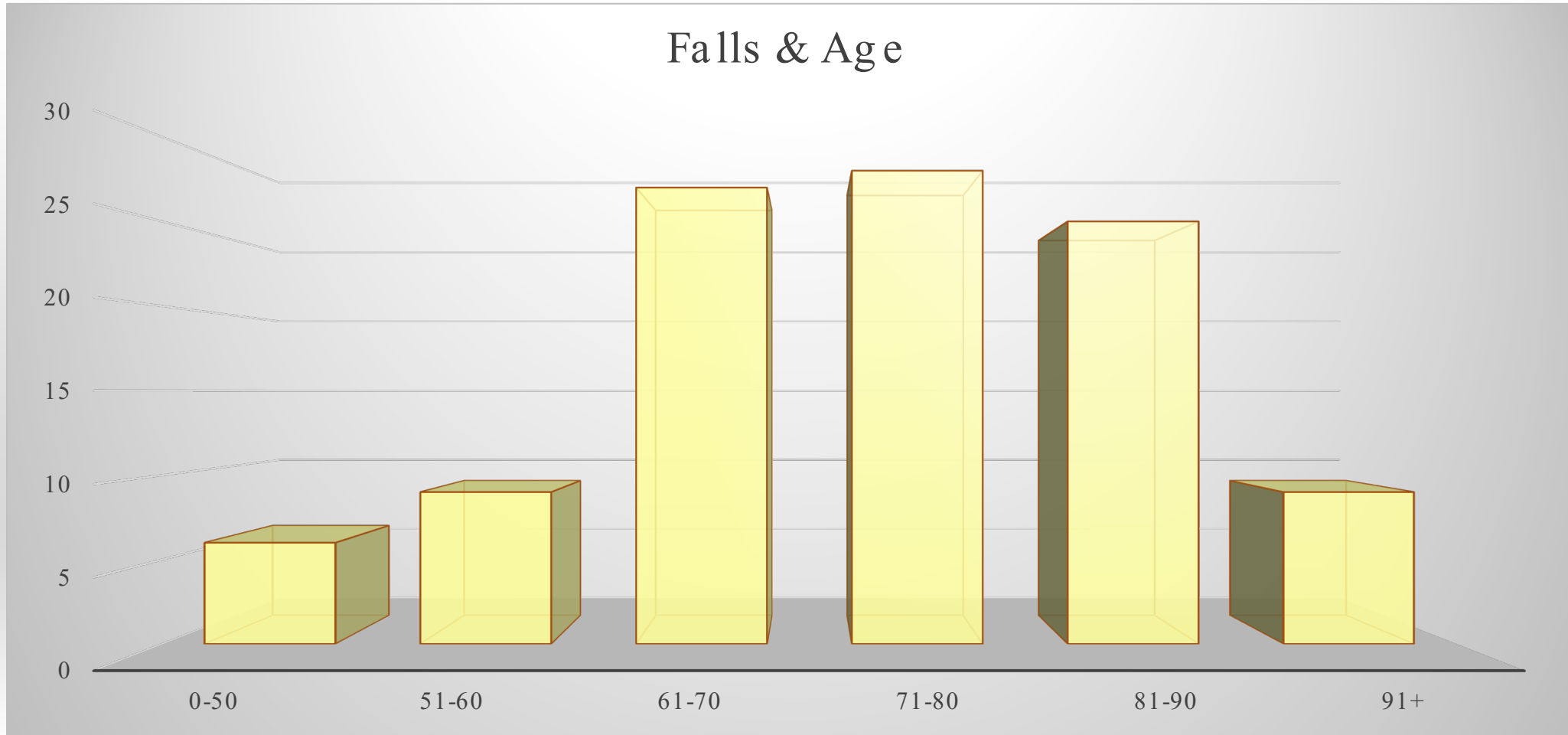
TOP 2 CAUSES OF INJURIES

■ Transport ■ Falls



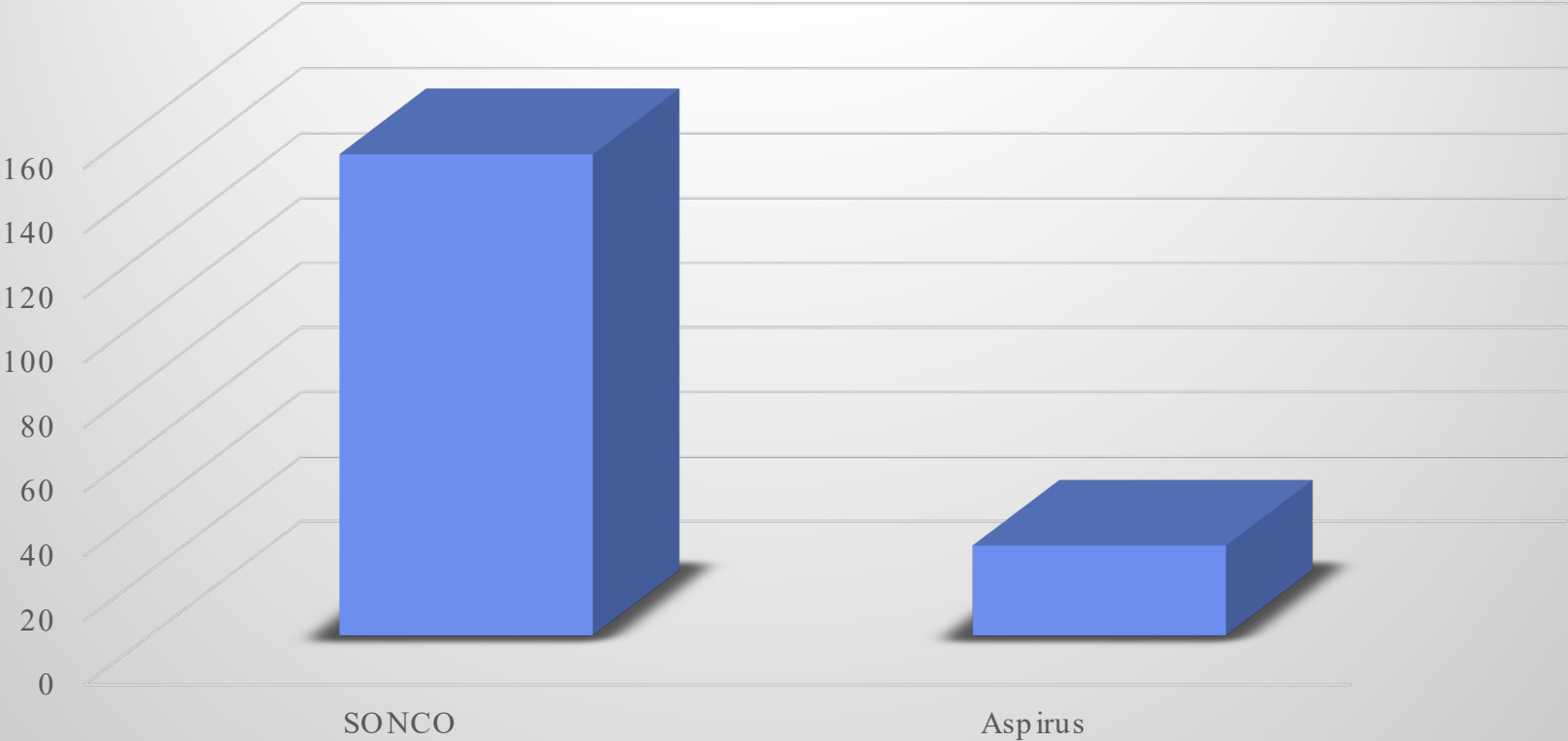
Source: biospatial, created 3/5/2024; filters 1/1/2020-3/4/2024; ACS 2021 injury patterns, mental status, vital signs, transported to AOH

Falls & Age



Source: biospatial, created 3/5/2024; filters 1/1/2020-3/4/2024; ACS 2021 injury patterns, mental status, vital signs, transported to AOH

EMS Agency



Source: biospatial, created 3/5/2024; filters 1/1/2020-3/4/2024; ACS 2021 injury patterns, mental status, vital signs, transported to AOH

New Business



RPSRO appointments



RTAC appointments



Geriatric Best Practices

RPSRO appointments



Name	Role	Name	Role
Austin Badeau ?	ED provider/TMD ?	Paula Rechner, MD	Surgeon/TMD LIII
Ed Bigsby, MD	MCA Coordinator	Sarah Niemela	TPM LIII
Bob Kirkley	ALS provider	Shelly Reeves	TPM LIV
Caleb Chestnut	Air medical	Steve Vix	ED provider/MCA MD
Cindy Gurchinoff	Registry	Wade Liston, MD	TMD LIII
Curt LeSage	ALS provider	Jodi McCollum	TPM LII
Gina Kasten	BLS provider	Sara Herrera, MD	Surgeon
Mike Mlsna, MD	MCA MD	Vacant	TMD LIV



RTAC members



Hospital	Rep	Hospital	Rep
Aspirus System	Cindy Gurchinoff	OSF	Terra Ison Dr. Benkendorf
AIW	Deb Trekas Scott Novascone Dr. Covington	SCMH	Hailey Watchorn
AIR	Scott Kataja Dr. Mahana	UPHS Bell	Mel Perry Keith Kangas
AKH	Christina Verran	UPHS Marquette	Jodi McCollum Ann Clancy-Klemme Dr. Petrin / Dr. Herrera Alyson Sundberg
BCMh	Sandy Peltola Nathan Lahti	UPHS Portage	Sarah Niemela
HNJH	Shelly Reeves	MM-S	Stephen Carlson Dr. Rechner
MMH	Christi Salo	MM-D	<i>vacant</i>

MCA	Rep	EMS	Rep
Baraga	Gary Wadaga	Guardian	Caleb Chestnut
Delta	Dr. Bigsby	SONCO	Gina Kasten
Dickinson	Scott Westman	Aspirus Medevac	Bob Kirkley
Eastern	Deanna Knopp		
GIO	Joel Bach	Regional Preparedness	Ed Unger
Houghton Keweenaw	Pat Boberg	Consumer	Gail Brandly
Luce	(see hosp rep)		
Marquette Alger	Dr. Mlsna Curt LeSage		
Schoolcraft	Elizabeth Ross		

Geriatric Trauma

Ad hoc committee:

- Jodi McCollum
- Shelly Reeves
- Cindy Gurchinoff
- Dr. Benkendorf

BEST
PRACTICES
GUIDELINES

**GERIATRIC TRAUMA
MANAGEMENT**

November 2023

ACS Trauma
Programs

American College of Surgeons

New Business



Bystander Care Course



Trauma Center Awareness Toolkit



Trauma Transfer Guidelines

Bystander Care

- Office of Highway Safety Planning funded
- Until Help Arrives curriculum
- Cadre of instructors needed
- Kits to give to students



UNTIL HELP ARRIVES INSTRUCTOR GUIDE



Version 2.0

Region 8 Trauma

Trauma Center Toolkit

[Document subtitle]

Lyn L. Nelson, R8 Trauma Coordinator
3-13-2024

What is trauma?

In the case of a trauma center, *trauma* refers to any injury to the body. The most common causes of injury that bring patients to a trauma center in the Upper Peninsula are falls, motor vehicle crashes, and other types of land transport crashes such as ORVs and snowmobiles. These events can cause mild to life-threatening trauma in multiple areas of the body.

What is a trauma system?

A trauma system, unlike a trauma center, is a network of trauma hospitals and many additional services including emergency medical services (EMS), rehabilitation facilities and trauma prevention organizations. Research shows that in states where there is a trauma system in place, the death rate is drastically reduced.

A trauma system is a predetermined and organized response to managing and improving the care of severely injured people. It spans the continuum-of-care from prevention and emergency care to rehabilitation. Best practice standards guide each stage of trauma care to ensure that injured people are promptly transported to and treated at facilities appropriate to the severity of their injury.

A trauma system also provides a foundation for disaster preparedness and response. As part of its day-to-day activities, a trauma system coordinates the movement and care of severely injured people. Thus, a trauma system expands and contracts based on the needs and resources available at the moment.

What is a trauma center?

A trauma center is a hospital capable of providing specialized medical services and resources to patients suffering from traumatic injuries. Appropriate treatment by specially trained staff has been shown to reduce the likelihood of death and permanent disability to injured patients. Designated trauma centers must be continuously prepared to treat the most serious life threatening and disabling injuries. Even though trauma centers are within hospitals, they are not intended to replace the traditional hospital and its emergency department for minor injuries.

How many levels of trauma centers are there in Michigan?

Trauma centers vary in their specific capabilities and are identified by Level designation. In Michigan there are four levels of trauma centers:

Level I trauma centers provide multidisciplinary treatment and specialized resources for trauma patients, require trauma research, and a surgical residency program.

Level II trauma centers provide similar specialty medical services and resources, but do not require the research and residency components.

Level III trauma centers are typically smaller community hospitals that have services to care for patients with moderate injuries and rapidly stabilize and transport the severely injured trauma patient to a higher-level trauma center.

Level IV trauma centers, often smaller in size and located in a rural area, can provide initial care and stabilization of traumatic injuries while arranging transfer to a higher level of trauma care.

Hospitals treating adults can be designated Adult Level I-IV Trauma Centers. Hospitals treating children can be designated Pediatric Level I-II Trauma Centers.

How do trauma centers differ from regular hospitals?

The major difference between a regular hospital and a trauma center is the required processes to assess and treat a critically injured patient in addition to 24-hour availability of a team of specially trained healthcare providers. These team members vary depending upon the trauma center level. They may include emergency department physicians with advanced trauma life support training, trauma surgeons, neurosurgeons, orthopedic surgeons, cardiac surgeons, radiologists, and nurses. Specialty resources may also include 24-hour availability of a trauma resuscitation area in the emergency department, an operating room, laboratory testing, diagnostic testing, blood bank, pharmacy and inpatient units with specialty trained care teams.

Hospitals who pursue trauma center accreditation must comply with the Standards of Accreditation. An aggressive accreditation process is required to assure trauma care is delivered according to established standards of care.

Region 8 Trauma Transfer Guidelines



Goals of Care

- Do notify EMS early to facilitate timely transport
- Do communicate to destination Trauma Team if you need guidance
- Do not delay transfers for unnecessary studies

All trauma transfers are reviewed for optimal care and timely transport to destination. Feedback to facilities will include recommendations from trauma team and team debriefing. Both facilities are encouraged to discuss for ongoing improvement.

EMERGENT TRANSFER (GOAL WITHIN 1 HOUR OF ARRIVAL)

- Systolic BP < 90mmHg
- Labile BP despite 1L of IV fluids or requiring blood products to maintain blood pressure
- GCS \leq 8 or lateralizing signs
- Penetrating injuries to head, neck chest or abdomen
- Fracture / dislocation with loss of distal pulses and/or ischemia
- Pelvic ring disruption or unstable pelvic fracture
- Vascular injuries with active arterial bleeding

Treatment & Diagnostics following ATLS

- Airway interventions
- Portable Chest & Pelvis X-ray
 - Decompression/Chest Tube
 - Pelvic Binder
- FAST (if + w/SBP < 90, give blood)
- Fluid Resuscitation (if necessary)
 - Consider TXA, if bleeding susp
 - Blood Products
- Additional Studies *(ONLY if no transport delay)*
 - Head, C-Spine CT
 - Chest/Abd/Pelvis
- All further diagnostics and treatments facilitated with discussion of accepting trauma team

URGENT TRANSFER (GOAL WITHIN 2 HRS OF ARRIVAL)

Physiologic

- Systolic BP \leq 110mmHg may represent shock in patients > 60 yo

Neurologic

- Worsening GCS since initial presentation
- Spinal cord injury

Extremity Injuries

(Antibiotics for open fractures!)

- Amputated extremity proximal to wrist or ankle
- Open long bone fractures
- Two or more long bone fracture sites
- Crush injury

DRAFT

Thoracic & Abdominal Injuries

- Major chest wall injury:
 - Multiple rib fractures in a patient > 65 yo, pulmonary contusions, flail chest.
- Free air, fluid, solid organ injury noted on diagnostic testing

Burns

- Follow burn center criteria for transport to appropriate facility (michiganburn.org)

Special Considerations

- Adults > 60 yo
- Pediatric
- Pregnant
- Anticoagulant / Antiplatelet use
- Advance disease (cardiac, resp, diabetes, ESRD)



Agenda

Public Comment

Member Comment

Next Meeting

Adjournment