STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Joe Manchin III
Governor

Patsy A. Hardy, FACHE, MSN, MBA
Cabinet Secretary

MEMORANDUM

TO: All WV Licensed EMS agencies
All Regional Medical Command Centers
EMS Medical Directors
Regional Medical Directors
WV EMS TSN offices

FROM: William D. Rose, MD, FACEP
Interim State EMS Medical Director

DATE: March 15, 2010

RE: New Protocols

At the recent Medical Policy and Care Committee (MPCC) meeting on February 26, 2010, one new protocol was developed and two others were modified that I wish to inform you about. These three polices will take effect **April 1, 2010.**

1.) **Field Trauma Triage Protocol 9103** is a new protocol that the MPCC was asked to develop at the recommendation of the State Trauma Advisory Council (STAC). Over many years, our medical commands have been appropriately directing ambulances with critically ill trauma patients to trauma centers. However, there has never been a specific formal protocol dealing with this. Protocol 9103 addresses this issue by specifying four categories of trauma patients:

> **Immediate Transport Criteria**—those with immediate life-threatening conditions (lack of airway, etc.) that need to go, *by air or ground,* to the nearest facility capable of resuscitation regardless of trauma center designation status, or they will likely die.

BUREAU FOR PUBLIC HEALTH
State Trauma and Emergency Medical System
State EMS Medical Director's Office
NOROP Center
190 Hart Field Road
Morgantown, WV 26505
Telephone: (304) 581-2900 Fax: (304) 285-3148

Category A. Priority 1 Criteria—those meeting P1 criteria that need to go, *by air or ground,* to the highest level trauma center within 30 minutes transport.

Category B. Priority 2 (Anatomic) Criteria—those meeting the P2 anatomic criteria and also needing to go, *by air or ground*, to the highest level trauma center within 30 minutes transport.

Category C. Priority 2 (Mechanism) Criteria—those ***only*** meeting the P2 mechanism criteria and needing to go to the highest level trauma center within 30 minutes *but whom usually don't need flown there.* For aeromedical flight requests for this category, the Medical Command Physician **must** be involved in the decision. The transport of critically ill trauma patients to trauma centers saves lives; however, inappropriate flight requests for patients that do not need air transport exposes patients not only to risks, but also to huge expenses that are not necessary.

Please note: The above P1 and P2 are *Field Triage Criteria* and may not exactly match a given hospital's P1 and P2 Trauma Page criteria.

2.) **Field Aeromedical Protocol 9105** has been revised to reflect those trauma patients meeting either the Immediate Transport Criteria, or Categories A, B, and (occasionally C) that should be considered for air medical transport if the ground transport time to a Level I or Level II Trauma Center is > 30 minutes, or if delays are expected due to extrication.

This protocol specifies medical and environmental criteria ***for consideration of aeromedical evacuation—not that they require to be flown.*** The protocol also has new recommendations regarding night lighting of landing zones that reflects the use of night vision technology by some flight programs.

3.) **Medical Communications Protocol 9106** reflects changes that now ***require EMS personnel doing an inter-facility transport directly to an Emergency Department to contact Medical Command no less than 15 minutes prior to arrival at that facility.*** This hopefully will negate a problem that has arisen where EMS squads have arrived without warning to trauma centers with P1 or P2 trauma patients requiring a trauma page.

If you have any questions or need additional information, please feel free to contact Deron Wilkes by e-mail (deron.e.wilkes@wv.gov) or by telephone at 304-558-3956.

Enc. Protocols 9103, 9105, 9106
Trauma Triage Criteria, appropriate for lamination
Current listing of WV Trauma Centers

cc: Penny Byrnside, Director, Trauma Division, STEMS
Dr. David Kappel, Deputy State Medical Director, Trauma
Dr. Frank Lucente, Chair, STAC

Special Operational Protocol 9103

Field Trauma Triage Protocol

Field triage of critically injured trauma patients and their transport to an appropriate level trauma center is often vital to their survival. Recognition of these patients should be assisted by the Priority 1 (P1) and Priority 2 (P2) criteria recommended by the State Trauma and Emergency Medical System. Patients meeting P1 or P2 criteria should generally be transported to the highest level trauma center within 30 minutes transport time using the algorithm below:

Enroute to scene, consider aeromedical standby alert as per Field Aeromedical Protocol 9105.

↓

Immediate Transport Criteria
Patient has an immediate life-threatening condition (lack of airway, uncontrollable massive hemorrhage, etc.)

→ **YES** → ***Contact Medical Command: Consider immediate aeromedical evacuation, or transport the patient to the nearest facility capable of definitive resuscitation, regardless of trauma center designation status.***

↓ NO

Category A. Assess for P1 Criteria
1. Respiratory compromise or intubated
2. Blood Pressure < 90 at any time in adults, or age specific hypotension in children
3. GCS<8
4. GSW to abdomen, neck or chest

→ **YES** → ***Contact Medical Command: Consider immediate aeromedical evacuation, or transport the patient to the highest level trauma center within 30 minutes transport via ground or air. If time is >30 minutes to a designated trauma center, transport the patient to the nearest facility capable of resuscitation and stabilization.***

Request Priority 1 Trauma Team activation

↓ NO

Category B. Assess for P2 (Anatomic) Criteria
1. Respiratory Rate <10 and >29
   Infants with RR<20 if <1 year old.
2. GCS ≥ 8 and <14
3. Penetrating injuries to head, neck, torso or extremities proximal to elbow or knee (other than GSW to abdomen, neck or chest)
4. Flail chest
5. Two or more proximal long-bone fractures
6. Crush, degloved, or mangled extremity
7. Amputation proximal to wrist or ankle
8. Pelvic fracture
9. Open or depressed skull fracture
10. Paralysis
11. Time sensitive extremity injury

→ **YES** → ***Contact Medical Command: Consider immediate aeromedical evacuation, or transport the patient to the highest level trauma center within 30 minutes transport via ground or air. If time is >30 minutes to a designated trauma center, transport the patient to the nearest facility capable of resuscitation and stabilization.***

Request Priority 2 Trauma Team activation

↓ NO

[Continued from prior page]

Category C. **Assess for P2 (Mechanism) Criteria**

1. Falls:
   Adults > 20 feet; Children >10 feet or 2-3 times the height of the child.
2. High Risk Auto Crash
   Ejection
   Intrusion: >12 inches, occupant site
   >18 inches, any site
   Death in same passenger compartment
   Vehicle telemetry data consistent with high risk of injury
3. Auto vs. Pedestrian/Bicyclist thrown, run over, or with significant impact (≥ 20mph)
4. Motorcycle or ATV crash > 20 mph

YES

Contact Medical Command: Transport the patient to the highest level trauma center within 30 minutes transport. If time is >30 minutes to a designated trauma center, transport the patient to the nearest facility capable of resuscitation and stabilization.

Request Priority 2 Trauma Team activation

Field Trauma Triage Guidelines

Patients meeting P1 or P2 criteria should generally be transported to the highest level trauma center within 30 minutes transport time using the algorithm below:

Immediate Transport Criteria

Patient has an immediate life-threatening condition (lack of airway, uncontrollable massive hemorrhage, etc.)

YES → **Contact Medical Command:**

Consider immediate aeromedical evacuation, or transport the patient to the nearest facility capable of definitive resuscitation, regardless of trauma center designation status.

NO

Category A–Assess for P1 Criteria

1. Respiratory compromise or intubated
2. Blood Pressure < 90 at any time in adults, or age specific hypotension in children
3. GCS<8
4. GSW to abdomen, neck or chest

YES → **Contact Medical Command:**

Consider immediate aeromedical evacuation, or transport the patient to the highest level trauma center within 30 minutes transport via ground or air. If time is > 30 minutes to a designated trauma center, transport the patient to the nearest facility capable of resuscitation and stabilization.

Request Priority 1 Trauma Team activation

NO

Category B–Assess for P2 (Anatomic) Criteria

1. Respiratory Rate <10 and >29
   Infants with RR<20 if <1 year old.
2. GCS ≥ 8 and < 14
3. Penetrating injuries to head, neck, torso or extremities proximal to elbow or knee (other than GSW to abdomen, neck or chest)
4. Flail chest
5. Two or more proximal long-bone fractures
6. Crush, degloved, or mangled extremity
7. Amputation proximal to wrist or ankle
8. Pelvic fracture
9. Open or depressed skull fracture
10. Paralysis
11. Time sensitive extremity injury

YES → **Contact Medical Command:**

Consider immediate aeromedical evacuation, or transport the patient to the highest level trauma center within 30 minutes transport via ground or air. If time is > 30 minutes to a designated trauma center, transport the patient to the nearest facility capable of resuscitation and stabilization.

Request Priority 1 Trauma Team activation

NO

Category C–Assess for P2 (Mechanism) Criteria

1. Falls:
   Adults >20 feet; Children >10 feet or 2-3 times the height of child
2. High Risk Auto Crash
   Ejection
   Intrusion: >12 inches, occupant site
   >18 inches, any site
   Death in same passenger compartment
   Vehicle telemetry data consistent with high risk of injury
3. Auto vs. Pedestrian/Bicyclist thrown, run over, or with significant impact (≥20mph)
4. Motorcycle or ATV crash > 20mph

YES → **Contact Medical Command:**

Transport the patient to the highest level trauma center within 30 minutes transport. If time is >30 minutes to a designated trauma center, transport the patient to the nearest facility capable of resuscitation and stabilization.

Request Priority 2 Trauma Team activation

Last revision April 1, 2010

TRAUMA AND EMERGENCY MEDICAL SYSTEM

West Virginia Designated Trauma Centers

As of 3/16/10

Hospital & Address	Current Status
CAMC-General Hospital 501 Morris Street Charleston, WV 25301	**Level I**
WVU Hospitals **Jon Michael Moore Trauma Center** Medical Center Drive Morgantown, WV 26506	**Level I**
Joint Community Trauma Program **Ohio Valley Medical Center** 2000 Eoff Street Wheeling, WV 26003	**Level II**
Joint Community Trauma Program **Wheeling Hospital** 1 Medical Park Wheeling, WV 26003	**Level II**
Tri-State Trauma Center **Cabell Huntington Hospital** 1340 Hal Greer Boulevard Huntington, WV 25701	**Level II**
Tri-State Trauma Center **St. Mary's Medical Center** 2900 1st Avenue Huntington, WV 25702	**Level II**
City Hospital – WVUH East 2500 Hospital Drive Martinsburg, WV 25402	**Level III**
Camden-Clark Memorial Hospital 800 Garfield Avenue Parkersburg, WV 26101	**Level III**
St. Joseph's Hospital 1824 Murdoch Avenue Parkersburg, WV 26101	**Level III**
Raleigh General Hospital 1710 Harper Road Beckley, WV 25801	**Level IV**
Bluefield Regional Medical Center 500 Cherry Street Bluefield, WV 24701	**Level IV**

For the purposes of EMS protocols, Level I and Level II Trauma Centers are assumed clinically equivalent

Hospital & Address	Current Status
Reynolds Memorial Hospital, Inc. 800 Wheeling Avenue Glen Dale, WV 26038	**Level IV**
Wetzel County Hospital 3 East Benjamin Drive New Martinsville, WV 26155	**Level IV**
Boone Memorial Hospital 701 Madison Avenue Madison, WV 25130	**Level IV**
Stonewall Jackson Memorial Hospital 230 Hospital Plaza Weston, WV 26452	**Level IV**
St. Joseph's Hospital 1 Amalia Drive Buckhannon, WV 26201	**Level IV**
Preston Memorial Hospital 300 South Price Street Kingwood, WV 26537	**Level IV**
Minnie Hamilton Health System 186 Hospital Drive Grantsville, WV 26147	**Level IV**
Weirton Medical Center 601Colliers Way Weirton, WV 26062	**Level IV**
Sistersville General Hospital 314 South Wells Street Sistersville, WV 26175	**Level IV**
Roane General Hospital 200 Hospital Drive Spencer, WV 25276	**Level IV**
United Hospital Center, Inc. 3 Hospital Plaza Clarksburg, WV 26301	**Level IV**
Braxton County Memorial Hospital 100 Hoylman Drive Gassaway, WV 26624	**Level IV**
Jefferson Memorial Hosp. – WVUH East 300 South Preston Street Ranson, WV 25438	**Level IV**

For the purposes of EMS protocols, Level I and Level II Trauma Centers are assumed clinically equivalent

Hospital & Address	Current Status
Logan Regional Medical Center 20 Hospital Drive Logan, WV 25601	**Level IV**
Beckley ARH Hospital 306 Stanaford Road Beckley, WV 25801	**Level IV**
CAMC – Women & Children's Hospital 800 Pennsylvania Avenue Charleston, WV 25362	**Level IV**
Summersville Memorial Hospital 400 Fairview Heights Road Summersville, WV 26679	**Level IV**
Fairmont General Hospital 1325 Locust Avenue Fairmont, WV 26554	**Level IV**
Pleasant Valley Hospital 2520 Valley Drive Pt. Pleasant, WV 25550	**Level IV**
Thomas Memorial Hospital 4605 MacCorkle Avenue South Charleston, WV 25309	**Level IV**
Monongalia General Hospital 1000 J.D. Anderson Drive Morgantown, WV 26505	**Level IV**

For the purposes of EMS protocols, Level I and Level II Trauma Centers are assumed clinically equivalent

Special Operational Protocol
9105

Field Aeromedical Protocol

Field access to aeromedical transport may enhance the probability of survival of a select, small percentage of patients. The objective of a field response to the scene of injury by an EMS helicopter is to utilize the speed of the helicopter or the advanced skills of the medical crew to supplement patient care.

All requests for scene helicopter responses will come through Medical Command. Inappropriate requests for a helicopter subject the flight crew and the patient to needless risk. Medical Command shall deny inappropriate requests for a helicopter. EMS personnel considering the need for a helicopter are encouraged to discuss their situation with Medical Command. **If the drive time to a designated Level I or II Trauma Center is < 30 minutes and there is no extrication delay at the scene, aeromedical transport is rarely indicated**. Appropriate requests for a helicopter include the following:

A. Trauma Criteria:

1. Patient meets **Field Trauma Triage Protocol 9103** Immediate Transport Criteria, ***OR***
2. Patient meets **Field Trauma Triage Protocol 9103 A.** P1 Criteria, ***OR***
3. Patient meets **Field Trauma Triage Protocol 9103 B.** P2 (Anatomic Criteria)

Patients meeting only **Field Trauma Triage Protocol 9103 C.** P2 (Mechanism Criteria) ***may*** need a helicopter, but require that you discuss the details with MCP for approval.

B. Medical Criteria:

Some non-trauma patients with life-threatening medical conditions, far from definitive care, may benefit from air evacuation. Such circumstances may include:

1. Acute stroke patients within the window of opportunity for thrombolytic or endovascular intervention at an appropriate hospital.
2. Acute myocardial infarction patients needing thrombolytics or angioplasty.
3. Major overdose patients with coma.
4. Major burns >20% TBSA (second or third degree) needing flown directly to a Burn Center.

C. Environmental Criteria:

1. Patients in remote locations inaccessible by ground EMS.
2. Mass casualty incidents that totally overwhelm local agency capabilities (industrial accidents, multi-vehicle crashes, hazmat incidents, etc.)

D. Procedure:

1. **Contact Medical Command**. If radio communications or cell phone service are not available, then contact your local dispatch or 911 communications center to contact Medical Command. Discuss clearly the need for the helicopter based on the above criteria with Medical Command. Saying just "I need a helicopter" is inadequate.

2. Identify agency, unit number, incident location, description of incident, and any other information requested.

3. Request either response or standby alert. Request can be made for helicopter to be placed on standby alert even before arrival on scene, which may shorten the helicopter's lift-off time if air transport is deemed necessary. Request response as soon as criteria is identified.

4. Give a brief description of incident and GPS coordinates if available, or an accurate location, including names of roadways, cross streets, and other pertinent landmarks. Names of nearby towns and your location in reference to them is helpful.

5. Advise Medical Command of the agency and radio frequency of the ground contact for the helicopter.

6. Remain in contact with Medical Command for information concerning availability of aircraft, estimated flight time, and/or other special landing zone or scene requirements.

7. Medical Command will coordinate dispatch of the closest appropriate helicopter based on location of incident and will coordinate destination notification.

8. Landing zone preparation:
   a. Secure a level 100' X 100' area clear of power lines, trees, debris, and other obstructions.

   b. Ensure all bystanders and personnel remain at least 100 feet from aircraft at all times.

c. At night, use of flashing blue, green, or amber lights is encouraged to mark the landing area since they interfere less with night vision technology. Red lights of an emergency vehicle may be used; but use only the red lights on the vehicle--no white lights or flood lights. Do not shine any lights at the aircraft either on approach or while on the ground. High intensity light sticks may be used but no flares.

d. After landing, do not approach the aircraft.

9. Communications:

a. Designate one individual to monitor ground contact radio frequency and communicate with the aircraft. Do not change frequency unless instructed to do so by aircraft or Medical Command.

b. Establish radio and visual contact with the aircraft and give quick update of any LZ changes, hazards, and patient update information.

c. When aircraft is making final approach to land, keep radio traffic to a minimum so as not to distract the pilot. Alert pilot immediately if new hazard or situation develops. Follow directions given by pilot.

Special Operational Protocol 9106

Medical Communication Policy

The West Virginia OEMS protocols are designed to allow EMS personnel the ability to provide a wide variety of treatments to many types of patients by utilizing off-line protocols. However, since protocols cannot cover all situations, on-line medical direction is essential to a quality EMS system.

EMS personnel are expected to contact Medical Command for on-line medical direction as outlined in the protocols or anytime additional consultation is needed by the provider. Additionally, EMS personnel should notify Medical Command on inter-facility transports being transferred to the emergency department - no less than fifteen (15) minutes prior to arrival. All ALS treatment rendered, even by off-line protocol, requires notification of medical command. In order to provide for the most efficient and accurate communication between the provider and the Medical Command Operator, the following procedures will be used when communicating with Medical Command.

A. **Call-in Status Level:** In order to quickly and effectively identify the level of interaction required to properly manage the patient, the following terminology will be used:

1. **Status 3** - Provider has provided care to patient following off-line protocol and no further consultation or orders are required at this time. Medical Command is being notified to receive a report on the patient, to confirm the treatment given, to identify which protocol was used, and to allow notification of appropriate destination facility.

   Note: Even if treatment was rendered fully by off-line protocol, notification and report are still required. Medical Command Operator will also confirm that proper protocol procedure was followed and request additional information as required.

2. **Status 2** - Provider has provided care to patient and has followed protocol to the point where contact with Medical Command is now required in order to proceed with additional off-line treatment or treatments found in the protocol. These treatments within the protocols will include the words...***"by order of Medical Command"*** or ***"in consultation with Medical Command"*** or ***"contact Medical Command".*** Status 2 consultation allows the provider and the Medical Command operator to confer and confirm that the next steps in treatment are appropriate by jointly interpreting that section of the protocol. If they both agree, then Medical Command will provide the necessary confirmation to proceed. If they do not agree, then consultation with the Medical Command Physician

(MCP) is indicated.

3. **Status 1 Charlie** ("C" signifies "Consultation"): Provider has provided care to patient and has followed protocol to the point where consultation with Medical Command Physician (MCP) is now required in order to proceed with additional treatment or treatments. These orders or treatments within the protocols will include the words....***"by order of MCP"*** or ***"by MCP order"*** or ***"in consultation with MCP"***. The Medical Command Operator is permitted to relay the consult information between the provider and the MCP and communicate the orders back to the provider from the MCP. If any uncertainty exists during this process, then the provider, operator, or MCP may upgrade the call to a Status 1 Delta.

4. **Status 1 Delta** ("D" signifies "Direct"): Provider has provided care to patient and has followed protocol to the point where **direct voice** communication with Medical Command Physician (MCP) is now required in order to proceed with additional treatment or treatments. These orders or treatments within the protocols will include the words...."***by direct order of MCP"*** or ***"by direct MCP order"*** or ***"in direct consultation with MCP".*** There are only a few situations where direct communication with MCP is required in the protocols (i.e. *Cease-Efforts Protocol 9102* requires direct consultation with MCP to discontinue efforts in the field). Occasionally field providers will encounter patients who, in their opinion, require direct consultation with the MCP in order to formulate the proper care plan for the patient. Additionally, there may be situations which are so complex that direct consultation with the MCP is critical for proper resolution of the situation (i.e. discussion with family concerning a certain therapy, physician on the scene who wishes to take control of the patient, etc.). In these situations, field providers can request a **Status 1 Delta** to speak **directly with the MCP**. In addition, Medical Command Operators or MCPs can also upgrade any call to a Status 1 Delta if they feel the situation dictates.

B. **Communication Procedures:** When communicating with Medical Command, the provider should use the following designations:

1. Unit with an EMT-P level of ALS care should be designated as a "Medic" Unit. (For example: "*Oakland County* ***Medic*** *690 calling Charleston MedBase on Call 9.*)"

2. Unit with an EMSA-I level of ALS care should be designated as an "ALS" Unit. (For example: "*Oakland County **Intermediate** 690 calling Charleston MedBase on Call 9.*)"

3. Unit with an EMT-B level of BLS care should be designated as an "EMT" Unit. (For example: *"Oakland County **EMT** 690 calling Huntington MedCom on Call 9."*)

4. Unit with a CCT-Paramedic or CCT-Nurse should be designated as a "CCT" Unit. (For example: "*Oakland County **CCT** 690 calling WVU MedCom on 340"*.)

C. **Methods for contacting Medical Command:** There are three (3) general methods for contacting Medical Command:

1. Telephone (landline): Should be used whenever the patient's location and condition permit. It offers the best quality communication available and keeps radio frequencies less congested. It also provides a greater amount of security for discussion of sensitive patient information. Providers may use the local phone number of the Medical Command Center or the toll free 800 number of the specific center.

2. Cellular Phone: Cell phone is an acceptable method of contact if landline is not available and sensitive information needs to be given, however, when in a mobile unit, it is not a substitute for radio contact if the coverage is available.

3. UHF or VHF Radio: Direct radio contact with Medical Command is the preferred method of contact while responding to a call, transporting a patient, or on the scene of an MVC or other non-residential incident. Depending on the area of the state, this may best be accomplished by either UHF or VHF frequencies.

D. **Inability to contact Medical Command:** If the provider is unable to make contact with Medical Command by any of the above means, properly authorized EMS personnel may continue to follow the appropriate protocol(s) in the best interest of the patient. However, the provider must then:

1. Immediately upon arrival at the receiving facility, contact Medical Command by phone and provide a full patient report **and** the method, time, and location of the unsuccessful efforts to reach Medical Command.

2. If this report is made prior to leaving the receiving facility, no further reporting is required by the provider.

3. If Medical Command is not contacted prior to leaving the receiving facility, by law the provider must submit a report to the State Office of Emergency Medical Services on the appropriate form within 48 hours. Failure to do so may be grounds for suspension or even legal action.

E. **Details of Call-in:** When contacting Medical Command the following specific procedures should be followed:

1. In establishing initial contact, EMS personnel shall identify their unit with the proper designation as above.

2. After Medical Command has answered, provide the following information:

   Unit ID
   EMSP last name and certification number
   Age and sex of patient
   Chief complaint
   Status of call
   Destination if Status 3
   Break

3. Medical Command will then determine priority of call if other calls are also occurring.

4. **If Status 1 Delta,** Medical Command will alert the MCP and establish contact between provider and MCP.

5. **If Status 1 Charlie,** Medical Command will take information and consult with MCP for further orders.

6. **If Status 2,** Medical Command will take information and either concur with further treatment by protocol or consult with MCP for further orders.

7. **If Status 3,** Medical Command will take information for report, clarify details, confirm protocol usage, and notify the receiving facility. If there is increased traffic during this time, the Medical Command Operator may ask the provider to continue transport and call by phone after arrival at the receiving facility, and give complete report at that time.

8. When Medical Command is prepared to receive the full report, the provider will give the following pertinent patient information:

    Age and sex of patient
    Chief complaint/mechanism of Injury
    Brief history of present condition
    BREAK
    Past medical history
    Medications
    Allergies
    Vital signs, GCS, and ECG
    Assessment
    BREAK
    Treatment given and in progress (include protocol # (s))
    Treatment and orders requested
    Updated ETA and destination

9. If the patient's condition changes or new complaints develop, Medical Command shall be recontacted with updated findings and treatment.

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