NEBRASKA

Good Life. Great Mission.

DEPT. OF HEALTH AND HUMAN SERVICES

Jim Pillen, Governor

Board of Emergency Medical Services Meeting Agenda

Date: May 6, 2024

Time:
8:30 A.M. – 10:30 A.M.
Committee Meetings
Not held virtually

10:30 a.m. Open Session
10:45 a.m. Closed Session
11:45 a.m. Open Session

Location:
Country Inn & Suites Lincoln North
5353 N. 27th Street
Lincoln, NE

For Information Contact:
Tonja Bohling (402) 471-8129 or
Tonja.Bohling@nebraska.gov

The Board will be working through the lunch break.

All items known at the time of distribution of this agenda are listed. A current agenda is available at the Department of Health and Human Services, Division of Public Health Office of Emergency Health Systems. If auxiliary aids or reasonable accommodations are needed for attendance at a meeting, please call Tonja Bohling at (402) 471-8129 (voice), or for persons who are deaf or hard of hearing, please call the Nebraska Relay System at 711 (TDD), prior to the meeting date. Advance notice of seven days is needed when requesting an interpreter.

2024 Board Meeting Dates:

Friday, July 12, 2024
Monday, September 9, 2024
Friday, December 6, 2024

NOTE: Dates are subject to change

1) Call to Order, Roll Call, and Declaration of a Quorum
   Announcement: "This is a public meeting, and the open meetings law is posted."
2) Adoption of Agenda
3) Approval of February 09, 2024, Minutes
4) Closed Session -
   Announcement: The board will go into closed session for the review and discussion of investigative reports, licensure applications and other confidential information and for the protection of the reputation of individuals.
   a) Investigation Reports
   b) Applications
   c) Other Confidential Information
   Open session will start approximately 11:45 a.m.
5) Board Recommendations from closed session
6) Office of Emergency Health Systems
   a) Licensing (Wilson)
      i) EMT Renewal Audits
   b) EMS Program (Jorgensen)
      i) Statewide EMS Assessment (Wilson)
   c) Education & Training Agency Compliance (Snodgrass)
   d) Emergency Medical Services for Children (Wilson)
   e) Critical Incident Stress Management (Neumiller)
   f) Trauma System (Bailey / Wren)
   g) Stroke/STEMI System (Neumiller)
   h) EHS Data Systems (Steele / Wilson)
      ii) RFP for EHS Data Systems
   i) Statewide Physician Medical Director Update (Ernest)
7) EMS Board Committee Reports
   a) Legislation and Rules and Regulations (Smith)
      i) LB1108 – Increase Fifty Cents
      ii) LB876 – Safe Haven
      iii) LB910 – Canine Care
   b) Scope of Practice (Fiala)
      i) Model Protocol Revision (Fiala/Ernest)
      ii) Proposed changes/additions/deletions (Fiala)
   c) EMS Education (Bowlin/Hovey)
   d) EMS Workforce(Cerny)
8) NSVFA Update (Cerny)
9) NEMSA/NIS (Bowlin)
10) Training Agency Directors (Fuehring)
11) Public Comment
12) Adjourn

EMS Board agenda packet for public use:
https://dhhs.ne.gov/OEHS%20EMS%20Board%20Documents/EMS-Board-Agenda.pdf

JOIN ZOOM MEETING:
https://us06web.zoom.us/j/83963051566?pwd=aPSGcv857yuAhqaCpkSxbcA4tDoRDV.1

NOTE: If you join the meeting and get a message stating, "Meeting is Locked" or "Meeting has not Started", this means the Board is still in closed session. Please try joining in a few minutes.

MINUTES OF THE MEETING
of the NEBRASKA
BOARD OF Emergency
Medical Services

Friday, February 9, 2024

CALL TO ORDER

The meeting of the Nebraska Board of Emergency Medical Services was called to order by Dr. James Smith, Board Chairperson, at 10:40, Friday, February 9, 2024, at the Nebraska State Office Building, Lincoln NE 68508. Copies of the agenda were emailed in advance to the Board members, emailed to interested parties, and posted on the Department of Health and Human Services website on 2/1/2024. Smith announced the location of an available copy of the Open Meetings Act within the room.

ROLL CALL

The following board members were present to answer roll call:

- Michael Bailey
- Ryan Batenhorst
- Dr. Noah Bernhardson
- Randy Boldt
- Karen Bowlin
- Joel Cerny
- Ann Fiala
- Dr. Prince Harrison
- Todd Hovey
- Brent Lottman
- Dion Neumiller
- Carolyn Petersen-Moore
- Michael Sheridan
- Dr. James Smith

The following Board members were absent:

- Linda Jensen
- Jonathan Kilstrom
- Leslie Vaughn

The following staff members from the Department and the Attorney General's Office were also present during all or part of the meeting:

- Tonja Bohling
- Christy Duryea
- Michelle Eutsler
- Trevor Klaassen, *Investigations*
- Debbie Kuhn (attended virtually)
- Becka Neumiller (attended virtually)
- TJ O'Neill, *Assistant Attorney General*
- Diane Schoch
- Wendy Snodgrass
- Sharon Steele
- Danielle Sund, DHHS Legal
- Tim Wilson
- Sherri Wren

A quorum was present, and the meeting convened.

ADOPTION OF THE AGENDA

MOTION: Bailey made the motion, seconded by Fiala, to adopt the agenda for the Friday, February 9, 2024, Board of Emergency Medical Services meeting.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Harrison, Hovey, Lottman, Neumiller, Petersen-Moore, Sheridan, and Smith. Voting No: None. Abstain: None. Absent: Jensen, Kilstrom, and Vaughn. Motion carried.

APPROVAL OF THE MINUTES

MOTION: Bailey made the motion, seconded by Fiala, to approve the minutes of the Friday, December 8, 2023, meeting with the following corrections: correct spellings of stakeholder on Page 4, last paragraph, fourth line from the bottom and Page 5, first word; Page 5, paragraph 5, line 3, change Darrell Cross to Gerald Fraas and line 18 change Cross to Fraas; Page 6, paragraph 10, line 1 "bloodpressure" should be changed to two words; Page 10, second paragraph up from the bottom, line 1, Petesen should be changed to Petersen-Moore; and Page 11, Paragraph 1, line 1, Joseph Keene should be spelled Jozef Kuehn.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Harrison, Hovey, Neumiller, Petersen-Moore, Sheridan, and Smith. Voting No: None. Abstain: Lottman. Absent: Jensen, Kilstrom, and Vaughn. Motion carried.

CLOSED SESSION

MOTION: Boldt made the motion, seconded by Sheridan, for the Board to go into closed session for the purpose of reviewing and discussing investigative reports, licensure applications, and other confidential information, and for the prevention of needless injury to the reputation of the individuals.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Harrison, Hovey, Lottman, Neumiller, Petersen-Moore, Sheridan, and Smith. Voting No: None. Abstain: None. Absent: Jensen, Kilstrom, and Vaughn. Motion carried.

10:47	*Meeting went into closed session.*
10:49	*Karen Bowlin left.*
11:07	*Karen Bowlin returned.*
11:15	*Klaassen left.*
11:41	*Meeting returned to Open Session.*

OPEN SESSION

MOTION: Bowlin made the motion, seconded by Petersen-Moore, for the Board to go into open session.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Harrison, Hovey, Lottman, Neumiller, Petersen-Moore, Sheridan, and Smith. Voting No: None. Abstain: None. Absent: Jensen, Kilstrom, and Vaughn. Motion carried.

LICENSURE RECOMMENDATIONS

– GUARDIAN FLIGHT APPLICATION

MOTION: Lottman made the motion, seconded by Bernhardson, to recommend the Department waive Title 172 NAC 12.11.02 (B) and issue a license for Guardian Flight.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Harrison, Hovey, Lottman, Neumiller, Petersen-Moore, Sheridan, and Smith. Voting No: None. Abstain: None. Absent: Jensen, Kilstrom, and Vaughn. Motion carried.

AGENDA ITEM: Office of Emergency Health Systems

Program reports were submitted for Board review prior to the meeting and were in the portal.

a. Licensing: Wilson reported no significant changes beyond what was submitted. Renewal's for EMT's are in progress and postcards were sent out last week.
b. EMS Program: No significant changes from what was submitted. Dr. Smith added the Telehealth Beta Project is going on regarding e-care. Wilson also added several are already installed. The Department will gather data on the usage, how the services are responding to it, and if they find it as a beneficial tool. The Department is finalizing things now regarding the listening sessions on the EMS assessment and a draft should be ready in March or April, 2024.
c. Education and Training Agency Compliance: Snodgrass reported Cognitive Pass Rates Report were attached to the Agenda Packet and sent out. Corrective actions letters were sent out to those who fell below the 75% two-year pass rate. They have one month to send in a corrective action plan.
d. Emergency Medical Services for Children (EMSC) Program: Kuhn went over the report that was submitted with nothing new. Debbie Kuhn will be retiring March 1, 2024. Secession planning is in progress and may take a couple of months due to a reclassification of this position. Applications from services for EMSC will go to Wilson until someone is hired.
e. Critical Incident Stress Management (CISM) Program: Kuhn reported they are at 15 debriefings for this year. CISM Trainings will be held next week in Scottsbluff and Columbus.
f. Trauma Program: Wren reported work on a new process for rehabilitation designation for trauma centers. A meeting has been scheduled with Tim Bokelman from Regional West to review this process. There are approximately thirteen Trauma Centers eligible for this designation. The Trauma Board has vacancies so please reach out to Sherri if you know someone who would be a good fit for any of these open vacancies.
g. Stroke/STEMI Program: B. Neumiller reported nothing beyond what was submitted.
h. EHS Data Systems: Steele reported they are working on adding rehabilitation designation to the Trauma system and are reviewing the data elements to be added to the system. Wilson gave an update on the Request for Proposal (RFP) for a new electronic reporting system. This is a two-year process. The Department is having to repost for the third time due to an administrator error. This process is being expedited and the posting will only last 3 weeks. The reporting site of ImageTrend is in the process of a revamp. Work is also being done on updating the shared reports.
i. Statewide Physician Medical Director Update: Dr. Ernest reported final revisions for State Model Protocols have been sent to the Office of Emergency Health Systems. Next steps will be looking at: Physician Medical Director (PMD) training, the fellowship side with EMS Fellows, and the Prodigy System put out by the National Association of EMS Physicians (NAEMSP).

AGENDA ITEM: EMS Committee Reports

a. Legislative/Rules and Regulation Committee Update
    i. Meeting with the Governor – After the last Board meeting, Smith and Fiala met with the Governor's PR office person and Maureen Larson to discuss the RFP Data system.
    ii. LB 1108 – Increase Fifty Cents for Life to Dollar for Life – LB1108 was at committee hearing on February 5, 2024. Boldt and Cerny were in attendance. LB1108 is stalled as of today in the Transportation Committee. There was no opposition or neutral testimony, and the Governor supports it. However, it is moving toward mid-February and this bill has not been selected as a priority bill. It probably won't pass this session unless it is included in another bill. Discussion was held. Hard evidence of budgetary data is needed. The Legislative Committee can request a financial breakdown from the OEHS, and the Board can request a financial status update from the Department. Smith requested the Board be given a financial status update at each Board meeting.

MOTION: Cerny made the motion, seconded by Bailey, for the Board to receive, at each Board meeting, a financial report from the Office of Emergency Health Systems. Discussion was held. It was suggested to also send the report to Senator Dorn. Wilson will run this request up the chain for review/approval.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Harrison, Hovey, Lottman, Neumiller, Petersen-Moore, Sheridan, and Smith. Voting No: None. Abstain: None. Absent: Jensen, Kilstrom, and Vaughn. Motion carried.

(1) State Trauma Board Meeting – Bailey reported Emily Cantrell, Trauma Board Chairperson, testified in support of the increase of Fifty Cents for Life. The Executive Committees of both the EMS and Trauma Boards met via Zoom to discuss how the Boards can work together to support this bill.

iii. LB 876 – Safe Haven –this law is changing some of the safe haven requirements and involve fire and EMS. Wilson raised concerns about language in bill that allows for having a baby dropped off at fire and EMS stations that are "manned". The main concern is how does someone who is traveling, not familiar with the area, know if the station is manned or not? This will be addressed through public education.

iv. LB 910 – Canine Care – Gerald Fraas, Senator Riepe's aid spoke – this bill was introduced last week. The hearing was successful with only one opposition testimony. There are two proposed amendments to the language: 1) DHHS wants an effective date, and 2) good faith waiver language. An effective date will be set. Good faith language will not be changed, and a statement was given to Fiala regarding the duties of EMS to treat human beings before any treatment to law enforcement canines. There will be a push to vote this bill out of committee next week. The Veterinary Board has been consulted with and they raised scope of practice concerns. Other states have educational models, model protocols, and military protocols that can be used. Education for EMS providers will be needed if this bill passes.

v. Other bills being watched: LB1417 – CISM changes, to clean up the Statutes, were introduced; LB1320 – addresses overdose information from an EMS perspective, how services report overdoses to the Department, and how the Department reports this information to the OD Map.

Dr. Smith reported that in April of every year, the Department of Labor and Statistics comes out with a report of the relative worth of a volunteer hour. This currently is at $31.80 per hour. There are approximately 380 services in Nebraska. If they are staffed 24/7 for 365 days with two volunteers, it equals over $211 million saved by volunteers in Nebraska in 2023.

The Board took a short break at 12:24, resumed at 12:44. Working through lunch.

b. Scope of Practice – Fiala reported.

i. Model Protocol Revision – The Committee determined protocols will be disseminated to stakeholders (EMS Board members, service leaders, training agencies, and PMDs) across the State. OEHS will send out protocols to stakeholders via Constant Contact. People will have one month to respond. Responses may be submitted through Redcap.
Wilson has three leads on using mobile applications for protocol reference. He will pull in other staff members to evaluate and review the applications. A goal of July 1, 2024, was given for a completion date for the application with a statewide roll out date of the July Statewide EMS Conference.

ii. Proposed changes/additions/deletions – Smith introduced the topic of Zofran (Ondansetron) being added to the EMT scope of practice.

MOTION: Sheridan made the motion, seconded by Harrison, to propose adding Zofran (Ondansetron) oral disintegrating tablets to the scope of practice for EMTs. Discussion was held.

Voting Yes: Bailey, Batenhorst, Boldt, Bowlin, Cerny, Fiala, Harrison, Hovey, Lottman, Neumiller, Petersen-Moore, Sheridan, and Smith. Voting No: None. Abstain: Bernhardson. Absent: Jensen, Kilstrom, and Vaughn. Motion carried.

iii. Ketamine – Dr. Smith discussed a Colorado legal case involving a Ketamine death. It was suggested for the Board to make a statement supporting the safe use of Ketamine regarding appropriate weight-based dosing and appropriate monitoring. Nebraska protocols on Ketamine have been reviewed and found to be appropriate and evidence based. The literature also points to Ketamine being an appropriate medication.

MOTION: Bernhardson made the motion, seconded by Fiala, for members of the Board to draft a formal statement in support of the use of Ketamine. Discussion was held.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Harrison, Hovey, Lottman, Neumiller, Petersen-Moore, and Smith. Voting No: None. Abstain: Sheridan. Absent: Jensen, Kilstrom, and Vaughn. Motion carried.

c. EMS Education – Bowlin reported. This committee will try finding an educator that has classes on better practices for teaching EMS. Discussion was held regarding education in rural areas. Workforce continues to be a big issue with many educators being rural and agricultural workers. Barriers for rural EMS, including the time commitment, travel commitment, and lack of consistent hours were discussed. Hybrid vs. in-person vs. online classes were discussed. Hybrid classes can be more successful than in-person and online classes. This type of class also makes a class more available to more people. Lab is key to the success of hybrid classes with 2/3 of the class online and 1/3 being a hands-on in-person lab. Discussion was also held on how to promote educators. The idea was proposed to the Education and Workforce Committees to explore the possibility to hold an Educational Summit. Cherri Fuehring, with the Nebraska Training Agency Directors Association, will send to Bowlin a list of key individuals within each training agency who could be brought into the Educational Summit. The Education Committee was asked to come up with a way to recognize EMS instructors.

d. EMS Workforce – Cerny gave an update on the Workforce Committee. This committee is still waiting to see the results of the survey that was sent out last fall and items discussed during the open forums. The Committee discussed leadership training. There may be a Flex Grant available to assist with workforce development and the Committee encouraged the Office of Emergency Health Systems to apply for it. There is also a SAMHSA Grant that services can apply for (but not the State) to get funding to help locally. The Committee also looked at the need to get EMS classes available for smaller groups.

AGENDA ITEM: REVIEW SOUTH DAKOTA AMBULANCE STUDY

Michael Dwyer shared the South Dakota Ambulance study at the last Board meeting. Smith reviewed and discussed the South Dakota best practices: Flexible state staffing requirements, telemedicine in motion, upgrade of all ambulance heart monitors/defibrillators, statewide electronic prehospital patient care reporting system, remote EMT training, low cost & no cost EMT training, and allowing ambulance services to teach EMRs and EMTs internally. Many of these are already in place in Nebraska.

AGENDA ITEM: MEETING DATE CHANGE – MAY 13, 2024

Smith announced the need to change the date of the May 13, 2024 EMS Board meeting due to the National Association of State EMS Officials (NASEMSO) Annual Meeting being held that week. Department staff will not be available to attend a Board meeting that week.

MOTION: Bowlin made the motion, seconded by Boldt, to change the date of the May EMS Board Meeting to Monday, May 6, 2024.

Voting Yes: Bailey, Batenhorst, Bernhardson, Boldt, Bowlin, Cerny, Fiala, Harrison, Hovey, Lottman, Neumiller, Petersen-Moore, Sheridan, and Smith. Voting No: None. Abstain: None. Absent: Jensen, Kilstrom, and Vaughn. Motion carried.

AGENDA ITEM: NEBRASKA STATE VOLUNTEER FIRE ASSOCIATION (NSVFA)

Cerny gave an update on NSVFA. Through the NSVFA SAFER Grant 4, they will be sending Firefighter/EMTs to attend the National Volunteer Fire Council's Training Summit in Buffalo, NY on June 21 and 22, 2024, where they will take classes on Recruitment and Retention and upon return, help teach classes across the State. Those that attend will have all their expenses paid. All the Firefighters/EMTs that have attended past National Volunteer Fire Council's (NVFC)Training Summits and the Volunteer & Combination Officers Section (VCOS) are available to go out and teach. If you know a department that would like someone to present, please contact the NSVFA office.

The next leadership training sponsored by Nebraska Fire Chief's Association will be held in Norfolk at the Norfolk Lodge and Suites March 16, 2024. Tiger Schmittendorf will be the instructor and if you follow recruitment and retention nationally, he is one of the premier speakers on the subject.

The NSVFA Fire School book just came out this week and there will be 32 classes that will be held on the State Fair Grounds. There will be a Recruitment and Retention class and there will be three different 12-hour segmented EMS Classes and one set will be paramedic-based training.

The NSVFA Board, with their Lobbyist, Jerry Stilmock, have been actively working with Senators to get bills that affect EMS either passed or eliminated. Probably the one that we have been pushing the most is LB1108 which will get more money to be used in EMS division of HHS.

AGENDA ITEM: NEBRASKA EMERGENCY MEDICAL SERVICES ASSOCIATION (NEMSA)

Evon Koeppen, VP with NEMSA, reported. NEMSA has been busy in the last couple of weeks testifying in support of some legislative bills and will continue monitoring these bills: LB1108 – the increase of fifty cents for life to one dollar and LB1391 – requiring AEDs to be placed within 3 minutes of high school athletic facilities (they sent a letter of support). NEMSA will host a legislative breakfast from 7:30am - 9:00am on March 15, 2024 at Zulkoski Weber Lobbyist Office in Lincoln.

NEMSA President, Sandy Lewis, was interviewed in support of telemedicine technology for rural Nebraska squads. Sixteen state-level rural EMS departments are being equipped with this technology for the trial.

A mini conference was hosted by NEMSA on January 23, 2024 in Broken Bow at Mid Plains Community College. Over forty EMS providers were in attendance. Also offered in Broken Bow was a three-hour EMS Medical Director Training presented by Dr. Shaila Coffey and Dr. Abraham Compos. They are looking for additional options for one-day mini conferences. If any areas are interested in hosting one, please contact NEMSA.

The NEMSA Super Conference will be from March 8-10, 2024 in Kearney with the NIS Day on March 7, 2024. The class schedule is on their website. A full-day EMS Medical Director Training presented by Dr. Coffey and Dr. Compos will be offered at the NEMSA conference held Friday, March 8, 2024. This training is offered free to all Medical Directors or their liaisons with lunch provided. PMDs will also receive CMEs for their time.

AGENDA ITEM: TRAINING AGENCY DIRECTORS

Cheri thanked the Board for being invited to speak. This group is working on getting information updated and completed. They are working on getting reports in from all the agencies and keeping training agency information updated quarterly. They will include continuing education classes as well.

AGENDA ITEM: PUBLIC COMMENT

1:54 pm *Ryan Batenhorst left.*
2:01 pm *Ryan Batenhorst returned.*

John Bomar, with Saving Rural EMS, commented that on March 13, 2024 at 7:00 pm Mike Bailey will be doing a Zoom program. Also there will be a grant class held on February 16, 2024 in Gibbon. He also touched on the EMS Workforce Report.

Michael Dwyer spoke and encouraged EMS Board's work. He is optimistic regarding LB1108 with an amendment proposed to look at other sources for funding besides Fifty Cents for Life. Dwyer offered his time and energies to help the EMS Board. He also suggested for Board members to do a Legislative Resolution (LR) for training and education issues.

Jozef Kuehn asked for thoughts on reaching out to younger people coming out of school and entering the workforce. It was suggested to challenge the groups like the Workforce Committee, agencies, and professional organizations to get the younger generation involved.

CONCLUSION AND ADJOURNMENT

There being no further business, Smith adjourned the meeting. The meeting adjourned at 2:15 p.m.

Respectfully submitted,

Tonja Bohling
OEHS Administrative Technician

Attachment A

State Trauma Board Meeting, April 15, 2024
Office of Emergency Health Systems Reports

a) EMS Program (Jorgensen)

- During the first quarter of 2024, the EMS Program made 840 individual EMS contacts. (These counts do not include others assisted such as hospitals, EMS training agencies, etc.) These individual contacts are largely due to their need for technical assistance.
- The number of licensed EMS services are below:

Western	68
Central	102
Northeast	121
Southeast	130
Total	421

- We have hired Darla Hopwood as our Northeast Region EMS Specialist. Darla is located in Shelby and is an Emergency Medical Technician (EMT). We are very excited that she has joined our team.
- We are anxiously awaiting the final report from the Nebraska EMS statewide assessment that was conducted by SafeTech Solutions. Thank you to all that completed the surveys or attended a listening session.
- A Telehealth in EMS Pilot Project began in Nebraska last December. Avel eCare is the company that has been installing equipment in the back of ambulances and conducting training for those services. Currently, there are ten EMS services with 23 ambulances utilizing telehealth in the back of their ambulances. Ten more services are in the process of having equipment installed into 19 more ambulances. Those are scheduled to go live before the end of April, 2024. The EMS services are participating in a one-year project. We look forward to getting results back to quantify the benefits of an EMS telehealth system in Nebraska.
- Preventive Health and Health Services (PHHS) Block Grant: Funding cycle began on 10-1-2023 and goes through 9-30-2024. We are approved for $30,000 to fund community paramedicine training.
- EMS service periodic inspections are continuing across the state. We continue doing some initial inspections of a few services that are changing license levels or changing ownership.

b) Education and Training Agency Compliance (Snodgrass)

- Six training agency inspections to be scheduled this year.
- A contract is in place to produce a pre-course video outlining the requirements and expectations of completing an EMS initial course. This will be made available on a website link for the public.

- The Leadership Academy is scheduled for June 26-30, 2024, at Central Community College (CCC) – Columbus. Contact Wendy Snodgrass for registration information.
- The EMS Education Program is applying for Preventive Health and Health Services (PHHS) grant funds for online training program accounts, leadership training, and an EMS Instructor workshop.
- Five of the six immersive simulation sites have equipment installed. Reach out to Western Nebraska Community College (WNCC), Mid-Plains Community College, Central Community College (CCC) – Grand Island, Creighton, or Northeast Community College (NECC) to schedule time for training. These rooms are open to all healthcare professions for initial and continuing education.

Emergency Medical Services for Children Program (Wilson)

- No Report

c) Trauma System Program (Wren)

- *Trauma Center Designations:*
  - 53 Trauma Centers Designated
    - ❖ 2024 Designations:
      - ➢ Phelps Memorial Health Center, Holdrege (Basic) – Region 1
    - ❖ 2024 Upcoming Trauma Center Designation Visits:
      - ➢ Genoa Community Hospital, Genoa (Basic) – Region 1
      - ➢ Nebraska Medicine, Omaha (Comprehensive) – Region 1
      - ➢ Pawnee County Memorial Hospital, Pawnee City (Basic) – Region 2
- *Grants*:
  - Nebraska Preventive Health and Health Services Block Grant (PHHSBG): 2023-2024 Grant Award = $60,000. The funds will be used for the trauma registry, prevention, and leadership training.
- *Trauma Advisory Board Vacancies:*
  - EMS Agency Professional (Urban) – One vacancy
  - Physician practicing in emergency medicine (Rural level 3 or 4) – One vacancy
  - Region 2 Trauma Medical Director – One vacancy
- *Trauma Advisory Board Appointments:*
  - UNMC Trauma Nurse Coordinator Appointment: Ashley Farrens, MSN, MBA, RN, UNMC
- *Request for Proposal:*
  - Trauma Registry Request for Proposals are pending.
- *Trauma Registry Trainings (1:00 p.m. to 4:00 p.m.):*
  - April 18, 2024 – North Platte ***In-person only (Flyers were sent out via email to register)
  - April 19, 2024 – Zoom – Lunch and Learn – Trauma Collaborative.
  - May 3, 2024 – Zoom – Registry Basics
- *TNC Conference: (In-Person and on Zoom)*
  - June 6, 2024, 9:00 a.m. to 4:00 p.m. – North Platte.
- *Next Trauma Advisory Board Meeting (In-person):*
  - April 15, 2024, 10:30 a.m. to 2:00 p.m. – Lincoln (see website for location).

d) Stroke/STEMI System Program (Neumiller)

- *Stroke:*
  - This year the focus of the State Stroke Task Force is on women and their unique stroke risks. Trying to help them identify female specific symptoms to help them advocate for themselves and their loved ones.
  - To achieve this goal the task force members have:

        - ❖ Manned a booth at the Lincoln Women's Exposition where they were able to connect with over 350 women that visited the booth. They handed out quick reference guides for stroke recognition and were able to really take the time to talk to women, answer questions and provide support, direction, and resources for those who asked.
        - ❖ Manned a booth at the Brain Injury Alliance Conference in Kearney. Many people stopped to ask questions and to get the resources we had on hand.
    - The stroke task force is also in the process of planning a one-day Stroke Symposium (September 20, 2024). The symposium will focus on women in stroke, post-acute and rehab considerations for women after stroke. The day will conclude with stroke survivors discussing the challenges they have faced post-stroke and how they have dealt with those.
- *STEMI:*
    - Continuing to work with law enforcement with the Helmsley AED grant.
    - Officers have used their AEDs 44 times this year resulting in 3 known saves.

e) Critical Incident Stress Management Program (Neumiller)

- March 1, 2024, Debbie Kuhn retired from the Office of Emergency Health Services (OEHS), Becka Neumiller has assumed Debbie's position as the CISM program manager and is in the process of learning the program.
- Plans are in motion for a CISM 2-day conference to be held in Kearney September 13 & 14, 2024, look for forthcoming details.

f) EHS Data Systems Program (Steele)

- The Request For Proposal (RFP) is in the process of being reviewed.
- The data elements and codes within the current Trauma Data Dictionary have been reviewed and appropriate corrections have been documented.
- Meetings with the Rehabilitation Committee have been progressing. There are three rehabilitation data elements that have been activated in Patient Registry, however, those specific data elements have not yet been placed on a form. Those three rehabilitation data elements are currently in the Trauma Data Dictionary.
- Progress on reports that are related to the Ambulance Telehealth project are being put in place. There are a few Ambulance Services in the State of Nebraska that now have Telehealth capabilities in their Ambulances.
- Sharon Steele and Tim Wilson continue to work with the QA/Data Committee.
- Mason Holmes and Sharon Steele have assisted Ambulance Service personnel by answering questions and conducting training as is needed.

Board of Emergency Medical Services

Scope of Practice Review Request

EMS Service Name: LifeNet Air Medical Services 5030, StarCare 5152, TriCity LifeNet 5186

Contact Name: Shane Mohr

Contact Email: smohr@airmethods.com

Contact Phone: (402) 290-8705

What is request:

Air Methods Flight program is seeking to add to the NE EMS scope of practice the ability for its paramedics to perform a tube thoracostomy procedure in pediatric and adult patients.

What is the intended use or outcome?

Improve patient outcomes by preventing potential hemodynamic instability associated with a suspected or known pneumothorax. Additionally, improves patient ventilation thereby reducing hypoxia and potentially associated acidosis.

What Level of Emergency Care Provider will this impact:

EMT Unchecked

AEMT Unchecked

EMTI Unchecked

Paramedic Checked

Why does the request fall within the scope of the Emergency Care Provider(s) selected above?

We are noticing an increasing trend in rural healthcare providers who are uncomfortable performing a tube thoracostomy procedure for various reasons. Our flight clinicians can safely perform this potentially life-saving procedure. Needle thoracostomy may be adequate to temporize a tension pneumothorax,

however, not the preferred solution when transferring a patient from a rural setting to a higher level of care. Additionally, needle thoracostomy catheters tend to be misplaced, occlude, become displaced, and or bend rendering them ineffective therefore resulting in the healthcare provider having to "re-needle" the patient.

Does current education and training within the initial course of an Emergency Care Provider adequately prepare providers to perform this request?

Yes

If no, what education or training is lacking?

How will personnel maintain education on this request?

Our flight clinicians complete didactic and hands-on tube thoracostomy training twice per year under the direct supervision of a Medical Director and Clinical Education Manager. At a minimum, our flight clinicians perform the procedure on a cadaver once per year and the second hands-on training occurs using a Trauma-Man trainer. Our Clinical Education team tracks each clinician's training records to ensure compliance with this training requirement.

How will the organization ensure the maintenance of proficiency and competency of personnel (both existing and new)?

All new and existing clinicians are required to complete didactic and hands-on thoracostomy training twice per year. At a minimum, our flight clinicians perform the procedure on a cadaver once per year and the second hands-on training occurs using a Trauma-Man trainer. Our Clinical Education team tracks each clinician's training records to ensure compliance with this training requirement. Clinical Leadership is required to follow up with the received healthcare providers to ensure the tube thoracostomy was performed correctly and the patient did not suffer any consequences post-procedure.

Does the organization have support of the Physician Medical Director?

Yes

How will the Physician Medical Director determine competency?

Our Medical Directors review the didactic and hands-on training requirements to ensure a standard of care for performing a tube thoracostomy procedure. Our Medical Directors are required to be present during a minimum of one didactic and hands-on training session per year. During the second training session, a Clinical Education Manager is present.

What are the health, safety and welfare concerns for patients?

In failing to perform this procedure, patients often suffer from hemodynamic instability, inadequate oxygenation/ventilation, hypoxia, acidosis, and the need to repetitively perform needle thoracostomies. Doing so increases procedural risk and the potential complication of infection leading to poor patient outcomes. Additionally, healthcare providers, most often in rural emergency departments, who are not adequately trained or skilled in performing this procedure are often reluctantly attempting to do so at the request/direction of receiving facilities further placing these patients at risk for serious complications.

How would patient health, safety and welfare benefit from this request?

By adding tube thoracostomy to the scope of practice, a trained flight paramedic could safely perform a tube thoracostomy in a controlled environment reducing the potential for hemodynamic instability, improving oxygenation/ventilation, mitigating potential acidosis for poor ventilation, reducing the potential for inducting an infection, and ultimately promoting an improved patient outcome.

What are the risks involved with this request?

As with any invasive procedure, there is a risk of not performing the technique correctly resulting in potential patient harm. We believe our training requirements promote a safe mitigation strategy to reduce potential harm to a patient. In addition, part of our Quality Improvement process includes follow-up with the receiving healthcare providers to ensure the procedure was performed correctly and there were no associated complications. If any issues are identified, we will debrief the case with our clinicians to identify a potential process gap and/or education need and adjust accordingly.

What reputable evidence supports this request? (Include links to articles, studies, web addresses, etc.)

Please see attached.

INTERNATIONAL TRAUMA LIFE SUPPORT

SIMPLE THORACOSTOMY FOR TRAUMATIC ARREST IN THE PREHOSPITAL SETTING

The guidelines and references contained in this document are current as of the date of publication and in no way replace physician medical oversight.

INTRODUCTION

According to the WHO, fatalities from trauma account for 27% of the world's deaths.[1] Tension pneumothorax is the leading cause of preventable death following thoracic trauma which is directly responsible for more than 20% of all traumatic deaths.[2,3] The incidence of tension pneumothorax in traumatic arrest varies from study to study, but is thought to be approximately 6-8%.[4] The UK Trauma Audit and Research Network (TARN) data on frequency of chest injuries in major trauma patients indicate an incidence of tension pneumothorax of 1 in 250 (0.4%) major trauma patients.[5] Tension pneumothorax can be identifiable by clinicians in the field although field diagnosis is difficult when classic signs of decreased air entry, hyper-resonance, and tracheal shift are not present. It is routinely treated prophylactically in traumatic arrest patients by either bilateral needle decompression or simple thoracostomy. Chest decompression in traumatic arrest can identify a high number of potentially life-ending injuries and should be considered as part of the resuscitation effort of all patients in cardiac arrest from trauma.[6] Unfortunately, problems with needle decompression (high failure rates, short catheters, kinking catheters, and improper location) makes it a less reliable procedure when compared to simple thoracostomy.[7,8,9,10,11] As an alternative to needle decompression, the simple thoracostomy, also known as finger thoracostomy, can quickly be performed by prehospital providers to reverse trauma arrest secondary to tension pneumothorax. The simple thoracostomy allows maximum release of air and blood from the pleural cavity, thus allowing full re-expansion of the lung. Multiple studies have shown the safety and efficacy of the procedure in the prehospital setting and has even been associated with a ROSC amongst 24% of patients.[2,12,13,14,15] Prehospital thoracostomy has been found to be a strong predictor of survival and was significantly associated with increased survival in traumatic arrest.[2,16] Although relatively new to some ground transport EMS services in the U.S. and UK, simple thoracostomies are a standard treatment to many air medical services in many countries.[17,18]

BACKGROUND

Tension pneumothorax is the progressive buildup of air in the pleural space. As air continues to accumulate in the pleural space, pressure or 'tension' develops that pushes the mediastinum toward the unaffected side, displacing the heart, trachea, and large vessels.[3,19] This ultimately results in a decrease in cardiac output, ventilation, etc. If left untreated, it can result in cardiac arrest. The standard (initial prehospital) treatment for this is a needle thoracostomy (NT).[19] Simple thoracostomy (ST) is another procedure to treat or reverse tension pneumothorax that has been used by many progressive services. Instead of fully placing a chest tube, a quick incision and blunt dissection is made into the chest wall, thus relieving the pleural cavity of any pressure from air or blood.[20]

CONSIDERATIONS

The simple thoracostomy is a simple, quick, and easily learned procedure that can efficiently be done in cases of traumatic arrest. It is more effective at removing air and blood than needle decompression.[7] Thoracostomy in traumatic arrest has been found to be statistically significant in increasing the probability of survival.[4] In one study, it was discovered that there was a small but significant group of patients that ended up surviving because of the procedure.[21] Current literature also supports its use in the field with respect to diagnostic accuracy, efficacy, and safety of performing the procedure.[13] In patients with tension pneumothorax, fewer were pronounced dead with thoracostomy vs. needle decompression. There were no cases of lung damage associated with prehospital thoracostomy; the rate of complications is low and shown to be equivalent to that of in-hospital procedures.[2,22,23] In a 2-year retrospective study, no cases of major bleeding, lung laceration, or infection were recorded from prehospital use.[15, 24] A recent best evidence topic report on prehospital finger thoracostomy in traumatic cardiac arrest patients indicated improved clinical status and safety in performing the procedure in the prehospital environment.[25]

As for needle decompression, multiple studies have found several points of failure in the procedure. A comprehensive clinical review on complications of needle thoracostomy outline the failure to evacuate the pneumothorax to several factors: inadequate catheter length, misidentification of site, improper placement technique, clot/tissue within the catheter, kinking/compression of catheter, and air leak greater than air evacuation rate by catheter.[11] Several other publications support the findings of this review.[2,8,9,10] Patients flown by air

medical crews that received chest tubes, were reported to have had failed needle decompression attempts in up to 38% of patients.[23]

PROCEDURE

The simple (finger) thoracostomy is the first part of the chest tube procedure. Local anesthesia can be used, but generally is not due to the emergency nature of the procedure.

1. With arm abducted, find and mark the area over the fifth rib at the midaxillary line (within the *triangle of safety*).[20]
2. Clean the area as best as possible with an antiseptic swabstick.
3. Make a 1-2" (3-5 cm) transverse incision through the skin over the 5th rib at the marked location just anterior to the mid axillary line.
4. With a large forceps, rapidly dissect over the rib and through the intercostal muscles.
5. Push through the pleura and open the forceps.
6. With the forceps open, retract from the chest.
7. Insert finger along the track into the pleural cavity and perform sweep.
8. Assess for release of air or blood.
9. Each wound should be circled with a permanent marker and labeled EMS-R or EMS-L to identify incisions made by EMS in the event of autopsy or criminal investigation.

MEDICAL OVERSIGHT

Medical oversight should review current standards and literature before developing prehospital protocols regarding the procedure. Adequate training and education should take place before deployment. Implementation of this procedure should be monitored and supervised through a quality assurance/improvement program. Data collection and reporting should also take place.

CONCLUSION

ITLS believes that there is sufficient evidence to support the use of simple (finger) thoracostomy in traumatic cardiac arrest. During the immediate resuscitation of the trauma arrest patient, consideration should be given to a bilateral simple thoracostomy. The procedure has been shown to be quick, safe, and more effective than the alternative. Several helicopter emergency medical services have incorporated this procedure in the algorithm and SOP in the management of traumatic cardiac arrest.[17]

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Current Thinking

Simple Thoracostomy for Traumatic Arrest in the Prehospital Setting

International Trauma Life Support

The guidelines and references contained in this document are current as of the date of publication and in no way replace physician medical oversight.

Abstract

This is the current thinking of International Trauma Life Support (ITLS) with regard to the usefulness of simple thoracostomy in the management of trauma cardiac arrest patients.

Current Thinking

It is the position of International Trauma Life Support that:

1. There is sufficient evidence to support the use of simple thoracostomy in the prehospital management of the trauma cardiac arrest.
2. Classical management of tension pneumothorax in the prehospital arena is needle decompression, but this is an imprecise technique that may be ineffective and potentially dangerous. Bilateral simple thoracostomies are advocated in the early management of trauma cardiac arrests.
3. There is a potential to widen its use in a patient with tension pneumothorax, particularly if positive pressure ventilation is contemplated; many physician/paramedic-led HEMS services have, in fact, adopted its use.

Maximizing Thoracostomy Success: Evidence-Based Insights

AMC Stance on Tube Thoracostomy Placement

While research indicates the safety and efficacy of thoracostomy in prehospital settings, AMC maintains a cautious approach to these procedures to prioritize patient safety. Tube thoracostomies are utilized during on-scene interventions and interfacility flights, particularly in cases of suspected tension pneumothorax or hemothorax accompanied by persistent severe shock, when needle thoracostomy proves insufficient or requires multiple attempts for tension relief. However, not all AMC rotor and fixed wing bases perform tube thoracostomy, as this decision is influenced by the local medical director's input and the local/state scope of practice.

To ensure proficiency, flight clinicians at AMC undergo rigorous training, including two annual sessions for tube thoracostomy credentialing supervised by physicians. These sessions involve hands-on experience in a cadaver lab and direct instruction from the base medical director.

Following each tube thoracostomy procedure, clinical leadership, local medical directors, and national clinical leadership conduct comprehensive reviews to evaluate efficacy and impact on patient outcomes. Furthermore, post-encounter debriefings with flight crews allow for a thorough assessment of clinical decisions leading to tube thoracostomy placement, enabling continuous improvement in patient care protocols.

Research-Based Thoughts

- Laan, D. V., Vu, T. D., Thiels, C. A., Pandian, T. K., Schiller, H. J., Murad, M. H., & Aho, J. M. (2016). Chest wall thickness and decompression failure: A systematic review and meta-analysis comparing anatomic locations in needle thoracostomy. Injury, 47(4), 797–804. https://doi.org/10.1016/j.injury.2015.11.045

Failure Rates of Needle Thoracotomies – A change from 2nd Intercostal Space Midclavicular Line to 4th – 5th Mid-Axillary Line Supported for Needle Thoracostomies.

Introduction: Current Advanced Trauma Life Support guidelines recommend decompression for thoracic tension physiology using a 5-cm angiocatheter at the second intercostal space (ICS) on the midclavicular line (MCL). High failure rates occur. Through systematic review and meta-analysis, we aimed to determine the chest wall thickness (CWT) of the 2nd ICS-MCL, the 4th/5th ICS at the anterior axillary line (AAL), the 4th/5th ICS mid axillary line (MAL) and needle thoracostomy failure rates using the currently recommended 5-cm angiocatheter.

Methods: A comprehensive search of several databases from their inception to July 24, 2014 was conducted. The search was limited to the English language, and all study populations were included. Studies were appraised by two independent reviewers according to a priori defined PRISMA inclusion and exclusion criteria. Continuous outcomes (CWT) were evaluated using weighted mean difference and binary outcomes (failure with 5-cm needle) were assessed using incidence rate. Outcomes were pooled using the random-effects model.

Results: The search resulted in 34,652 studies of which 15 were included for CWT analysis, 13 for NT effectiveness. Mean CWT was 42.79 mm (95% CI, 38.78–46.81) at 2nd ICS-MCL, 39.85 mm (95% CI, 28.70–51.00) at MAL, and 34.33 mm (95% CI, 28.20–40.47) at AAL (P = .08). Mean failure rate was 38% (95% CI, 24–54) at 2nd ICS-MCL, 31% (95% CI, 10–64) at MAL, and 13% (95% CI, 8–22) at AAL (P = .01).

Conclusion: Evidence from observational studies suggests that the 4th/5th ICS-AAL has the lowest predicted failure rate of needle decompression in multiple populations.

- Sharrock, M. K., Shannon, B., Garcia Gonzalez, C., Clair, T. S., Mitra, B., Noonan, M., Fitzgerald, P. M., & Olaussen, A. (2021). Prehospital paramedic pleural decompression: A systematic review. Injury, 52(10), 2778–2786. https://doi.org/10.1016/j.injury.2021.08.008

Needle thoracostomy and Open thoracostomy are effective treatments for Tension Pneumothorax. Open thoracostomy may be superior for pleural decompression, but the literature is not conclusive. Needle thoracostomy is associated with factors that frequently render them ineffective and iatrogenically harmful.

Background*:* Tension pneumothorax (TPT) is a frequent life-threat following thoracic injury. Time-critical decompression of the pleural cavity improves survival. However, whilst paramedics utilise needle thoracostomy (NT) and/or finger thoracostomy (FT) in the prehospital setting, the superiority of one technique over the other remains unknown.

Aim: To determine and compare procedural success, complications and mortality between NT and FT for treatment of a suspected TPT when performed by paramedics.

Methods: We searched four databases (Ovid Medline, PubMed, CINAHL and Embase) from their commencement until 25th August 2020. Studies were included if they analysed patients suffering from a suspected TPT who were treated in the prehospital setting with a NT or FT by paramedics (or local equivalent nonphysicians).

Results: The search yielded 293 articles after duplicates were removed of which 19 were included for final analysis. Seventeen studies were retrospective (8 cohort; 7 case series; 2 case control) and two were prospective cohort studies. Only one study was comparative, and none were randomised controlled trials. Most studies were conducted in the USA (n=13) and the remaining in Australia (n=4), Switzerland (n=1) and Canada (n=1). Mortality ranged from 12.5% to 79% for NT and 64.7% to 92.9% for FT patients. A higher proportion of complications were reported among patients managed with NT (13.7%) compared to FT (4.8%). We extracted three common themes from the papers of what constituted as a successful pleural decompression; vital signs improvement, successful pleural cavity access and absence of TPT at hospital arrival.

Conclusion: Evidence surrounding prehospital pleural decompression of a TPT by paramedics is limited. Available literature suggests that both FT and NT are safe for pleural decompression;

however, both procedures have associated complications. Additional high-quality evidence and comparative studies investigating the outcomes of interest is necessary to determine if and which procedure is superior in the prehospital setting.

- Hannon, L., St Clair, T., Smith, K., Fitzgerald, M., Mitra, B., Olaussen, A., Moloney, J., Braitberg, G., Judson, R., Teague, W., Quinn, N., Kim, Y., & Bernard, S. (2020). Finger thoracostomy in patients with chest trauma performed by paramedics on a helicopter emergency medical service. Emergency Medicine Australasia, 32(4), 650–656. https://doi.org/10.1111/1742-6723.13549

Flight Paramedics Performing Thoracotomies is safe

Abstract

Objective: To determine the frequency of finger thoracostomy performed by intensive care flight paramedics after the introduction of a training program in this procedure and complications of the procedure that were diagnosed after hospital arrival.

Methods: This was a retrospective cohort study of adult and pediatric trauma patients undergoing finger thoracostomy performed by paramedics on a helicopter emergency medical service between June 2015 and May 2018. Hospital data were obtained through a manual search of the medical records at each of the three receiving major trauma services. Additional data were sourced from the Victorian State Trauma Registry.

Results: The final analysis included 103 cases, of which 73.8% underwent bilateral procedures with a total of 179 finger thoracostomies performed. The mean age of patients was 42.8 (standard deviation 21.4) years and 73.8% were male. Motor vehicle collision was the most common mechanism of injury accounting for 54.4% of cases. The median Injury Severity Score was 41 (interquartile range 29–54). There were 30 patients who died pre-hospital, with most (n = 25) having finger thoracostomy performed in the setting of a traumatic cardiac arrest. A supine chest X-ray was performed prior to intercostal catheter insertion in 38 of 73 patients arriving at the hospital; of these, none demonstrated a tension pneumothorax. There were three cases of potential complications related to the finger thoracostomy.

Conclusion: Finger thoracostomy was frequently performed by intensive care flight paramedics. It was associated with a low rate of major complications and, given the deficiencies of needle thoracostomy, should be the preferred approach for chest decompression.

- Massarutti, D., Trillò, G., Berlot, G., Tomasini, A., Bacer, B., D'Orlando, L., Viviani, M., Rinaldi, A., Babuin, A., Burato, L., & Carchietti, E. (2006). Simple thoracostomy in prehospital trauma management is safe and effective: a 2-year experience by helicopter emergency medical crews. European journal of emergency medicine : official journal of

the European Society for Emergency Medicine, 13(5), 276–280. https://doi.org/10.1097/00063110-200610000-00006

Flight Paramedics Performing Thoracostomies are safe.

Abstract

Objective: To evaluate the effectiveness and potential complications of simple thoracostomy, as first described by Deakin, as a method for prehospital treatment of traumatic pneumothorax.

Methods: Prospective observational study of all severe trauma patients rescued by our Regional Helicopter Emergency Medical Service and treated with on-scene simple thoracostomy, over a period of 25 months, from June 1, 2002 to June 30, 2004.

Results: Fifty-five consecutive severely injured patients with suspected pneumothorax and an average Revised Trauma Score of 9.6±2.7 underwent field simple thoracostomy. Oxygen saturation significantly improved after the procedure (from 86.4±10.2% to 98.5%±4.7%, $P<0.05$). No difference exists in the severity of thoracic lesions between patients with systolic arterial pressure and oxygen saturation below and above or equal to 90. A pneumothorax or a haemopneumothorax was found in 91.5% of the cases and a haemothorax in 5.1%. No cases of major bleeding, lung laceration or pleural infection were recorded. No cases of recurrent tension pneumothorax were observed. Forty (72.7%) patients survived to hospital discharge.

Conclusions: Prehospital treatment of traumatic pneumothorax by simple thoracostomy without chest tube insertion is a safe and effective technique.

- ITLS. (n.d.) Simple Thoracostomy for Traumatic Arrest in the Prehospital Setting. ITLS. https://www.itrauma.org/wp-content/uploads/2017/12/Simple-Thoracostomy-for-Trauma-Arrest-FINAL-11-17.pdf

ITLS position statement on thoracostomy provided during traumatic cardiac arrest.

CONCLUSION

ITLS believes that there is sufficient evidence to support the use of simple (finger) thoracostomy in traumatic cardiac arrest. During the immediate resuscitation of the trauma arrest patient, consideration should be given to a bilateral simple thoracostomy. The procedure has been shown to be quick, safe, and more effective than the alternative. Several helicopter emergency medical services have incorporated this procedure in the algorithm and SOP in the management of traumatic cardiac arrest. – ITLS Position Statement Provided Separately.