



UTAH
PEDIATRIC
TRAUMA NETWORK

Utah Pediatric Trauma Network

Northwest States Trauma Conference
April 25, 2024

Katie W. Russell, MD



I have no disclosures



*The vision of the Utah Pediatric Trauma Network is to establish a Statewide network, inclusive of **all regions and hospitals in Utah**. The Network will collectively implement injury prevention initiatives, evidence-based best practices, and transfer guidelines **to improve outcomes** for the pediatric victims of trauma, and to **decrease the financial and personal cost** to the citizens and families of the State of Utah.*





ELSEVIER

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Journal of Pediatric Surgery

journal homepage: www.elsevier.com/locate/jped surg



Preventable transfers in pediatric trauma: A 10-year experience at a level I pediatric trauma center[☆]



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Preventable transfers in pediatric trauma: A 10-year experience at a level I pediatric trauma center[☆]



- 10-year retrospective review
- Preventable transfer
 - DC <36 hours without surgery or imaging



Preventable transfers in pediatric trauma: A 10-year experience at a level I pediatric trauma center[☆]



- 1699 preventable transfers (26.6% of total)
- Median distance 37 miles (0.1-603 miles)
- Median ISS 5
- 22% transported by air
 - Mean transport charge \$18,574
- 64% TBIs (25% ortho)
- 62% mechanism fall
- 29% DC from ED

$\frac{1}{4}$

Preventable



UTAH'S TRAUMA SYSTEM:
OUTCOMES AND TRENDS

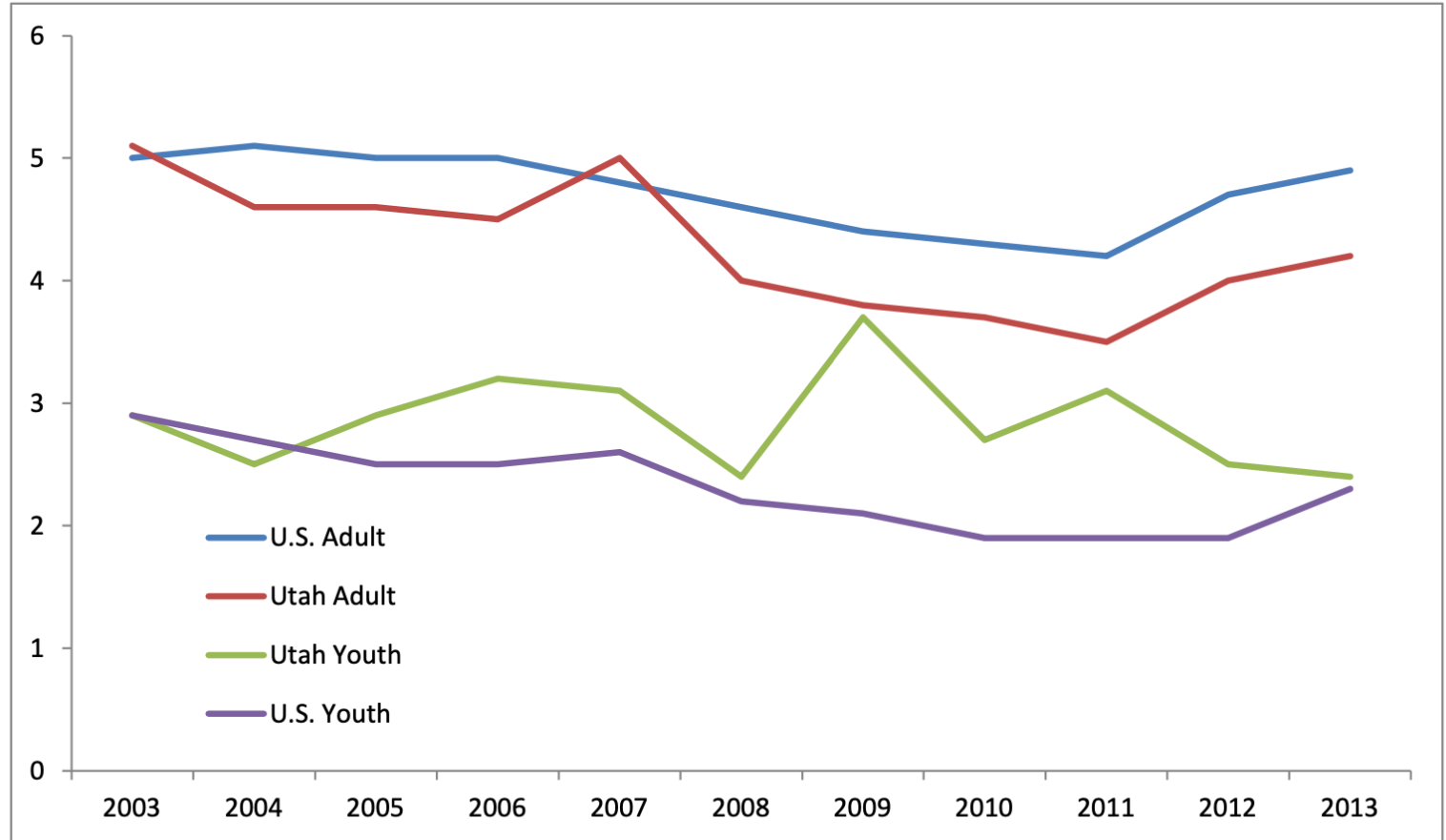


Figure 8. Utah and NTDB CFR Trends by Age Group, 2003-2013

Pediatric case fatality rate higher than the national average, while it was not in adult trauma





2018 Joint Resolution

Bill Sponsor:



Sen. Iwamoto, Jani

Floor Sponsor:



Rep. Ward, Raymond P.

Substitute Sponsor: Sen. Iwamoto, Jani

Drafting Attorney: Daniel M. Cheung

Fiscal Analyst: Gary K. Ricks

Enrolled Copy

S.J.R. 6

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7

**JOINT RESOLUTION ENCOURAGING THE REDUCTION OF
PEDIATRIC DEATHS FROM INJURY AND ILLNESS**

2018 GENERAL SESSION

STATE OF UTAH

Chief Sponsor: Jani Iwamoto

House Sponsor: Raymond P. Ward

“This concurrent resolution of the Legislature and the governor encourages the Utah Department of Health to convene a **multi-stakeholder Pediatric and Trauma Quality Assurance Network** to advise the department on triage, transport, transfer, and treatment of ill and injured pediatric patients in Utah.”





UTAH | PEDIATRIC TRAUMA NETWORK

Public – Private Partnership



Finalized February 2019

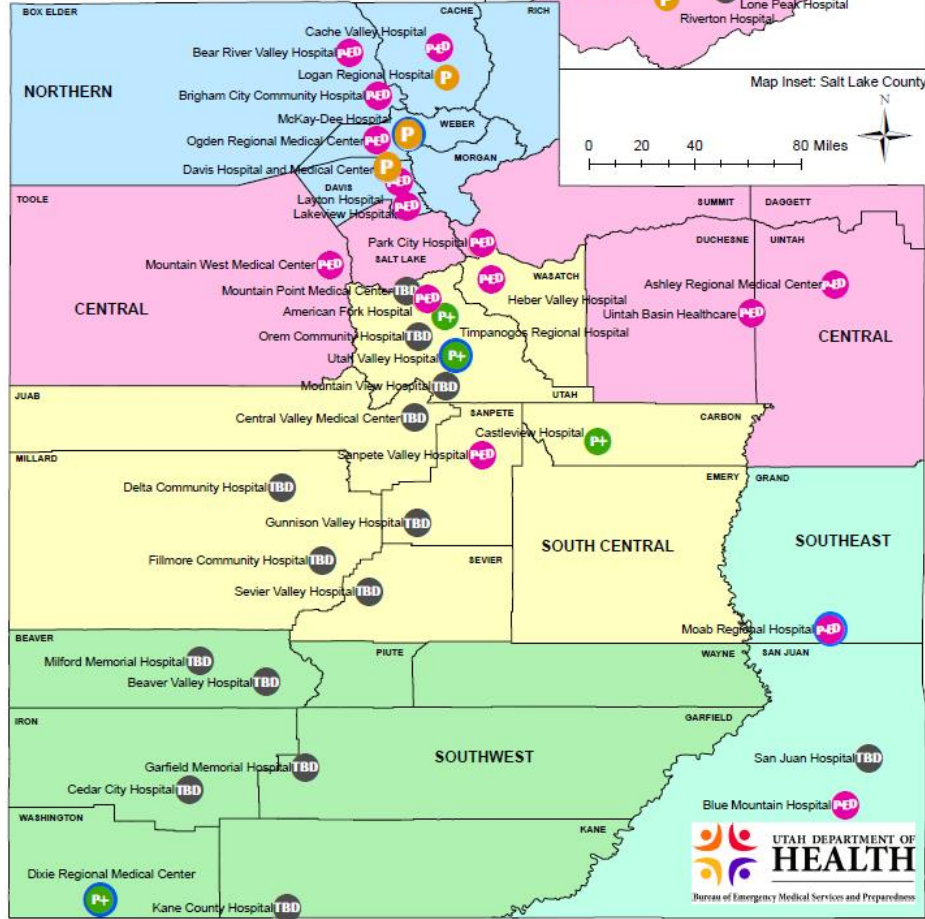
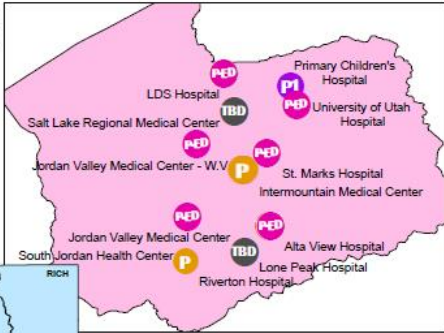


BUILT RELATIONSHIPS



- Pediatric Trauma Network Hospital Type**
- PED-ED
 - PED-ED Region Lead
 - PED
 - PED+
 - PED+ Region Lead
 - PED1
 - To be defined

- Trauma Performance Improvement Regions**
- NORTHERN
 - CENTRAL
 - SOUTH CENTRAL
 - SOUTHEAST
 - SOUTHWEST



Bureau of Emergency Medical Services and Preparedness February 2020



**100%
PARTICIPATION**



SELF-CATEGORIZATION



	PED-ED	PED	PED+	PED1
Pediatric equipment in the Emergency Department “Essential Pediatric Equipment” > 90%	X	X	X	X
PALS credentialed staff and providers (or equivalent / Board Certification)	X	X	X	X
Designated Pediatric Emergency Care Coordinator	X	X	X	X
Completes National Pediatric Readiness Assessment every 4 years	X	X	X	X
Hospital disaster plan includes pediatric components	X	X	X	X
Pediatric-specific inpatient rooms in hospital		X	X	X
Pediatric providers; pediatricians, general practitioners		X	X	X
Ability to observe < 24 hours		X	X	X
Pediatric Emergency Care Coordinator (MD or RN)		X	X	X
Pediatric Emergency Care Coordinator (MD and RN)			X	X
Pediatric inpatient unit			X	X
Pediatric Hospitalists			X	X
Pediatric Radiologist available			X	X
Child Life			X	X
Admit \geq 24 hours			X	X
Peds ICU capabilities			X	X
Board-certified physicians who are proficient in pediatric care as it pertains to their specialty. (e.g., EM, surgery, ortho, anesthesia, neuro, radiologist, ICU MD)			X	X
Trauma surgeon dedicated to a single center while on-call				X
Board-certified child abuse pediatricians on medical staff				X
ACS Verified Level I or II Pediatric Trauma Center				X

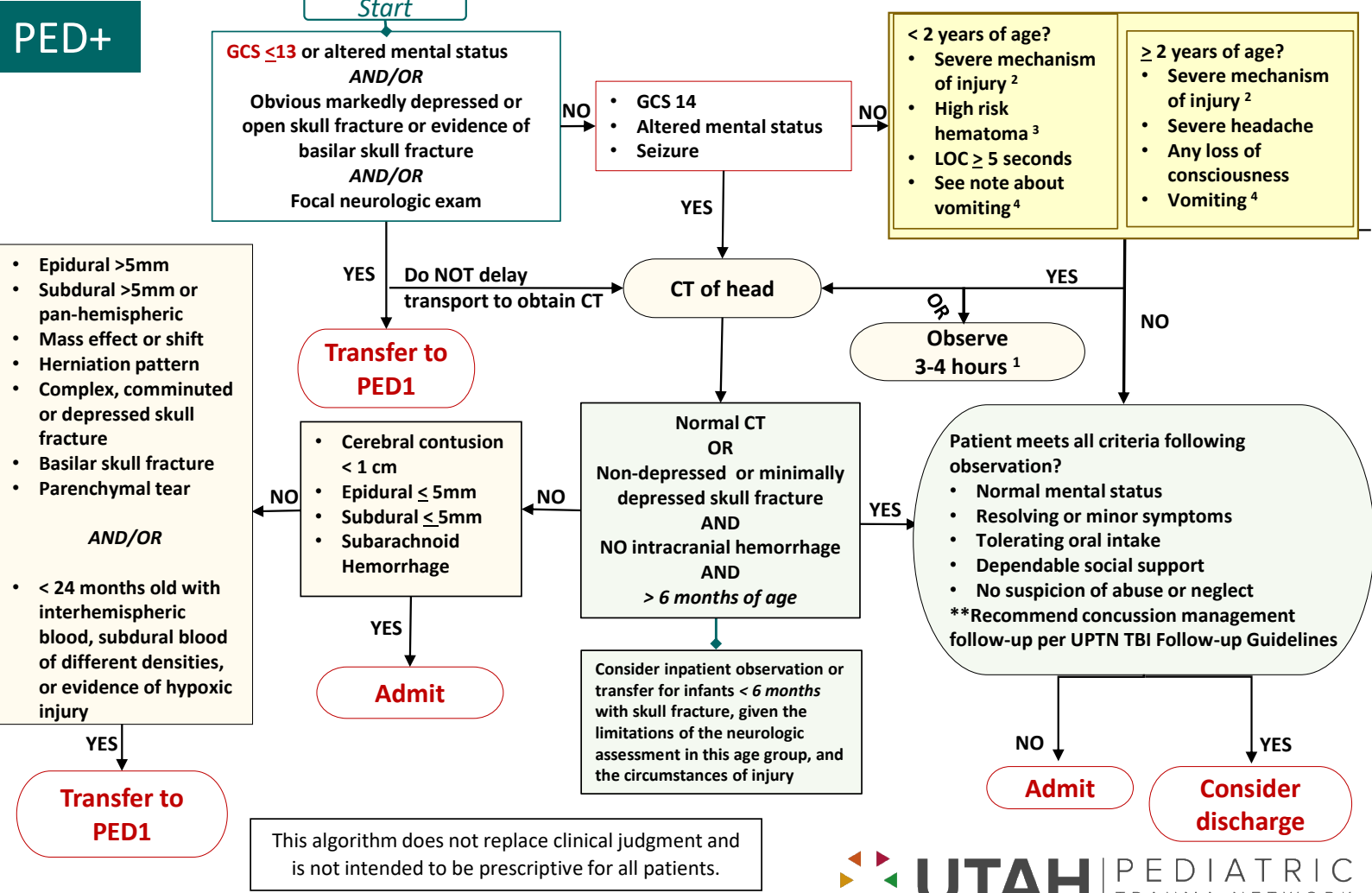
GUIDELINE CREATION



2023 Pediatric Traumatic Brain Injury (TBI) Clinical Guideline

Isolated Blunt Head Injury*

PED+



This algorithm does not replace clinical judgment and is not intended to be prescriptive for all patients.



EAST 2017 PLENARY PAPER

Big for small: Validating brain injury guidelines in pediatric traumatic brain injury

Asad Azim, MD, Faisal S. Jehan, MD, Peter Rhee, MD, Terence O’Keeffe, MD, Andrew Tang, MD, Gary Vercruyse, MD, Narong Kulvatunyou, MD, Rifat Latifi, MD, and Bellal Joseph, MD, Tucson, Arizona



Brain Injury Guidelines			
Variables	BIG 1	BIG 2	BIG 3
LOC	Yes/No	Yes/No	Yes/No
Neurologic examination	Normal	Normal	Abnormal
Intoxication	No	No/Yes	No/Yes
CAMP	No	No	Yes
Skull Fracture	No	Non-displaced	Displaced
SDH	$\leq 4\text{mm}$	5 - 7 mm	$\geq 8\text{ mm}$
EDH	$\leq 4\text{mm}$	5 - 7 mm	$\geq 8\text{ mm}$
IPH	$\leq 4\text{mm}$, 1 location	3 – 7 mm, 2 locations	$\geq 8\text{ mm}$, multiple locations
SAH	Trace	Localized	Scattered
IVH	No	No	Yes
THERAPEUTIC PLAN			
Hospitalization	No Observation (6hrs)	Yes	Yes
RHCT	No	No	Yes
NSC	No	No	Yes

Propensity score matching 160 BIG 1 kids with and without NSG

-No surgery
-Less repeat CT in no-NSG





Abdominal Injury Guidelines

[MORE DETAILS →](#)



Brain Injury Guidelines

[MORE DETAILS →](#)



Burn Injury Guidelines

[MORE DETAILS →](#)



Cervical Spine Injury Guidelines

[MORE DETAILS →](#)



Chest Injury Guidelines

[MORE DETAILS →](#)



Child Physical Abuse Guidelines

[MORE DETAILS →](#)



Facial Trauma Guidelines

[MORE DETAILS →](#)



Massive Transfusion Guidelines

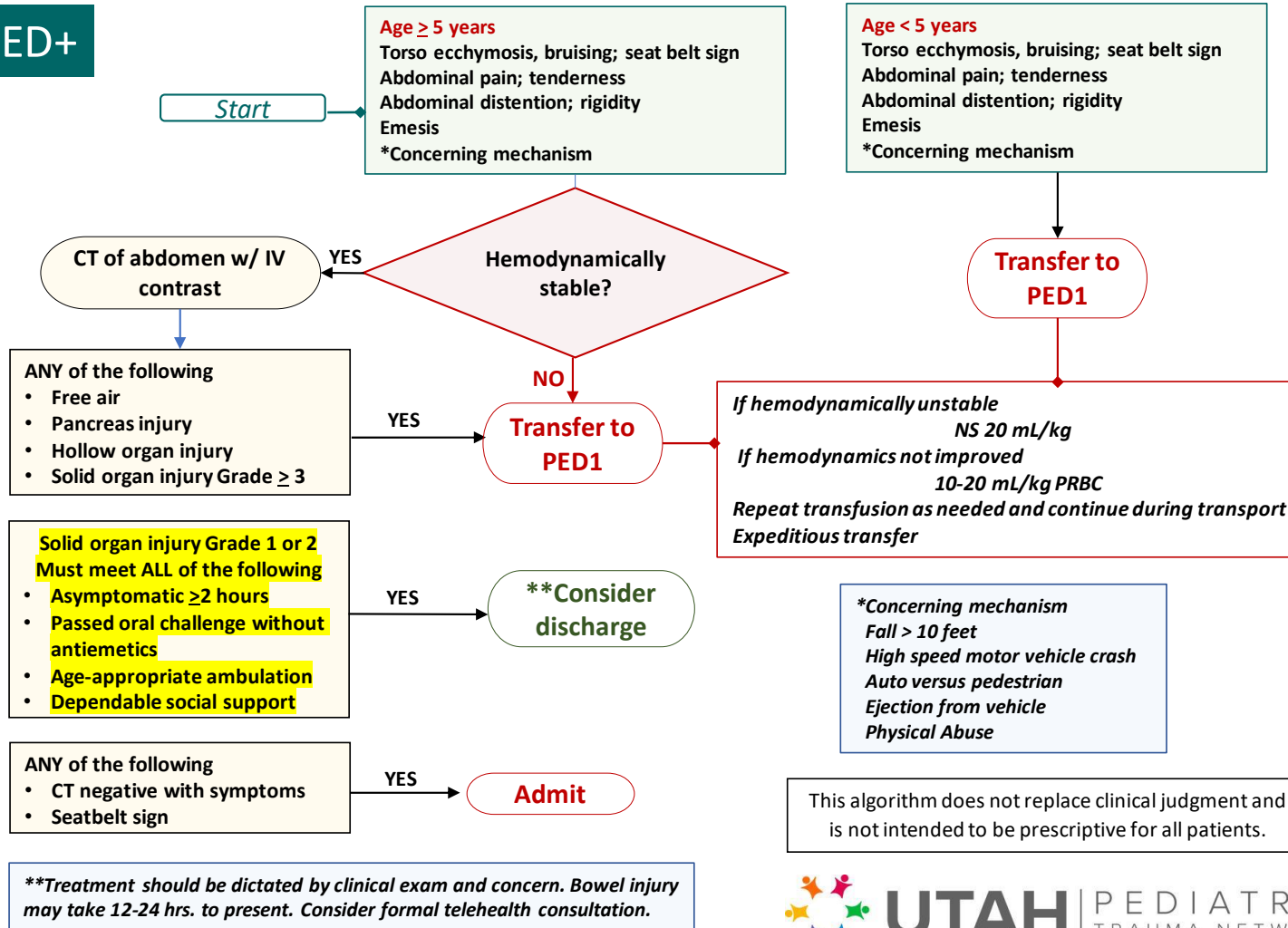
[MORE DETAILS →](#)



2023 Pediatric Abdominal Injury Clinical Guideline

Isolated Blunt Abdominal Injury

PED+



2023 Pediatric Abdominal Injury Clinical Guideline

Isolated Blunt Abdominal Injury

Updated APSA Blunt Liver/Spleen Injury Guidelines

Admission

- **ICU Admission Indicators**
 - Abnormal vital signs after initial volume resuscitation
- **ICU**
 - Activity - Bedrest until vitals normal
 - Labs – q6hour CBC until vitals normal
 - Diet – NPO until vital signs normal and hemoglobin stable
- **Ward**
 - Activity - No restrictions
 - Labs - CBC on admission and/or 6 hours after injury
 - Diet – Regular diet

Procedures

- **Transfusion**
 - Unstable vitals after 20 mL/kg bolus of isotonic IVF
 - Hemoglobin < 7
 - Signs of ongoing or recent bleeding

Angioembolization or Operative Exploration

- Signs of ongoing bleeding despite pRBC transfusion
- Angioembolization is not indicated for contrast blush on admission CT without unstable vitals
- Operative exploration may be indicated when additional procedures or information needed

Set Free

- Based on clinical condition **NOT** injury severity (grade)
- Tolerating a diet
- Minimal abdominal pain
- Normal vital signs

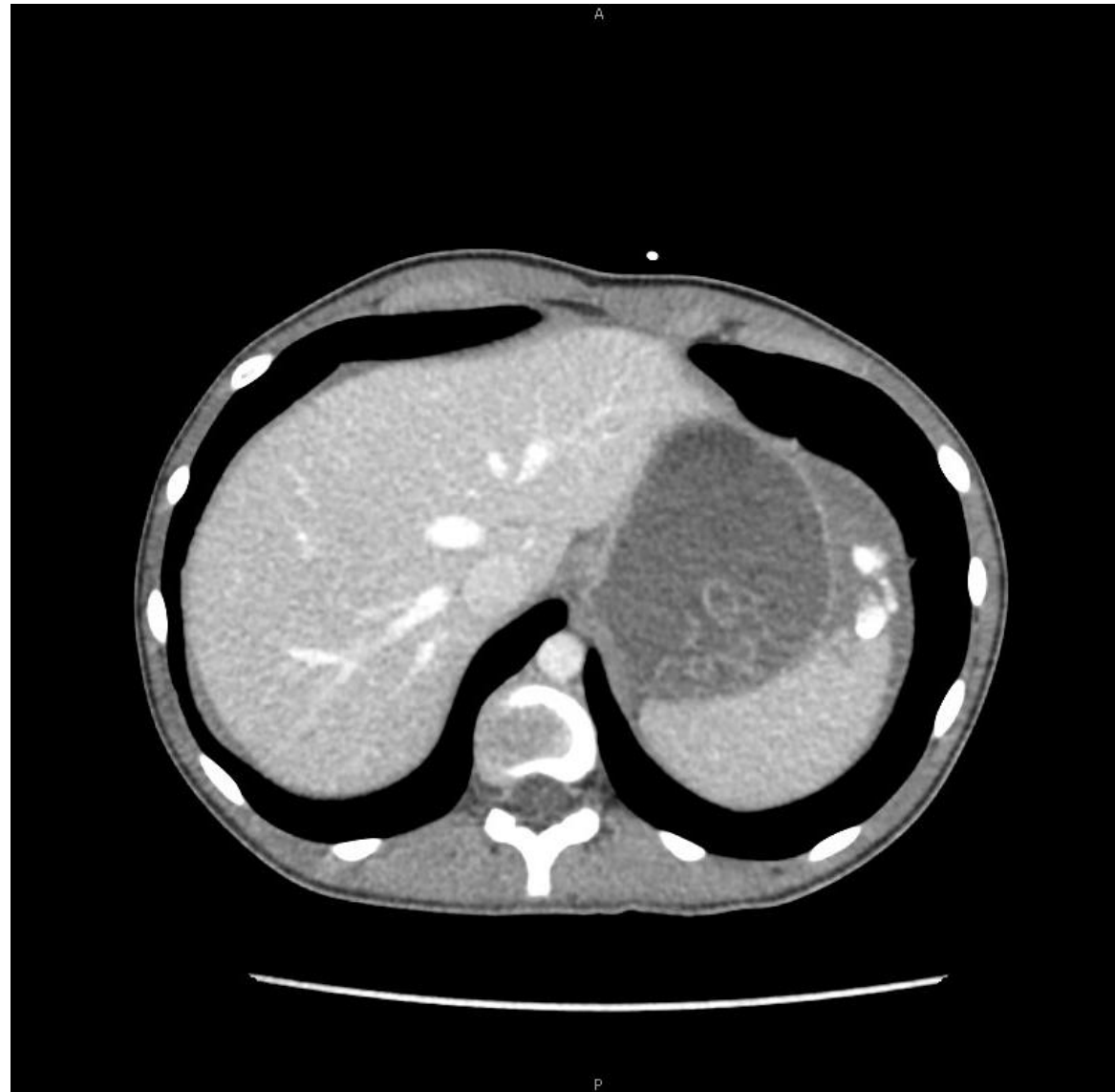
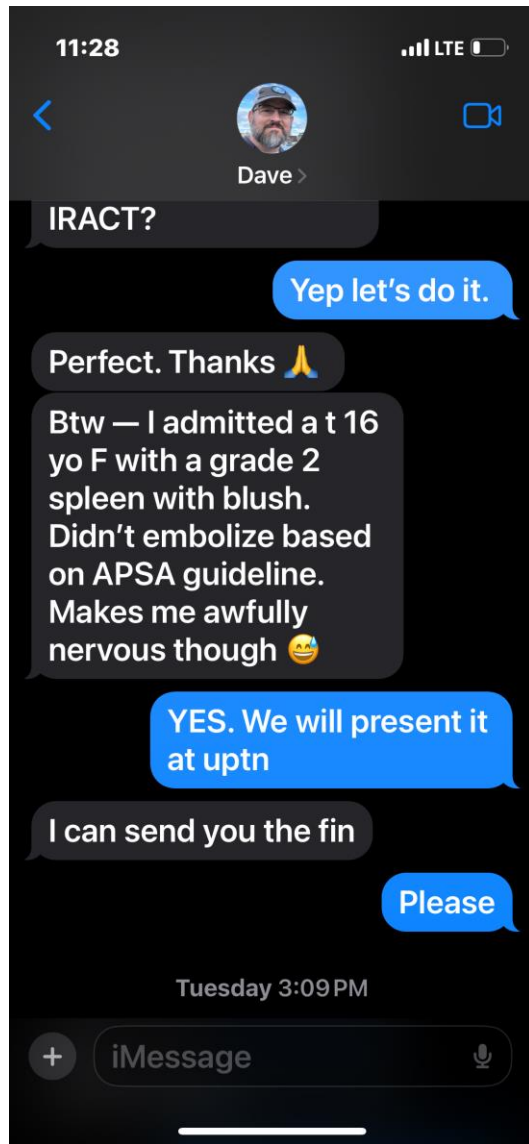
Aftercare

- **Activity Restriction**
 - Restricting activity to grade plus 2 weeks is safe
 - Shorter restrictions may be safe but there is inadequate data to support decreasing these recommendations
- **Follow up Imaging**
 - Routine imaging is not indicated in asymptomatic patients with low grade injuries
 - Consider imaging for **symptomatic** patients with prior high grade injuries

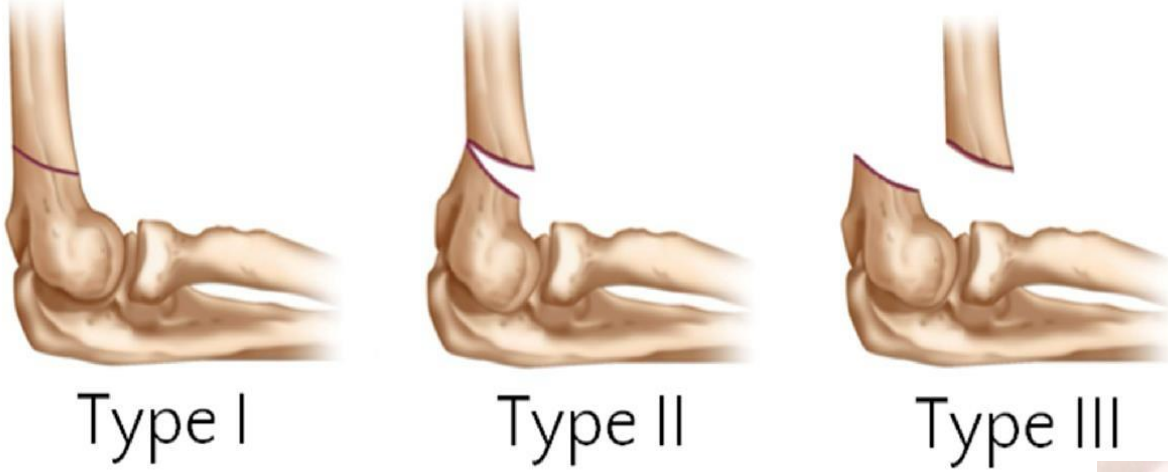
<https://doi.org/10.1016/j.jpedsurg.2023.03.012>

[https://www.jpedsurg.org/article/S0022-3468\(23\)00225-7/fulltext#%20](https://www.jpedsurg.org/article/S0022-3468(23)00225-7/fulltext#%20)





2023 Supracondylar Humerus Fracture Clinical Guideline

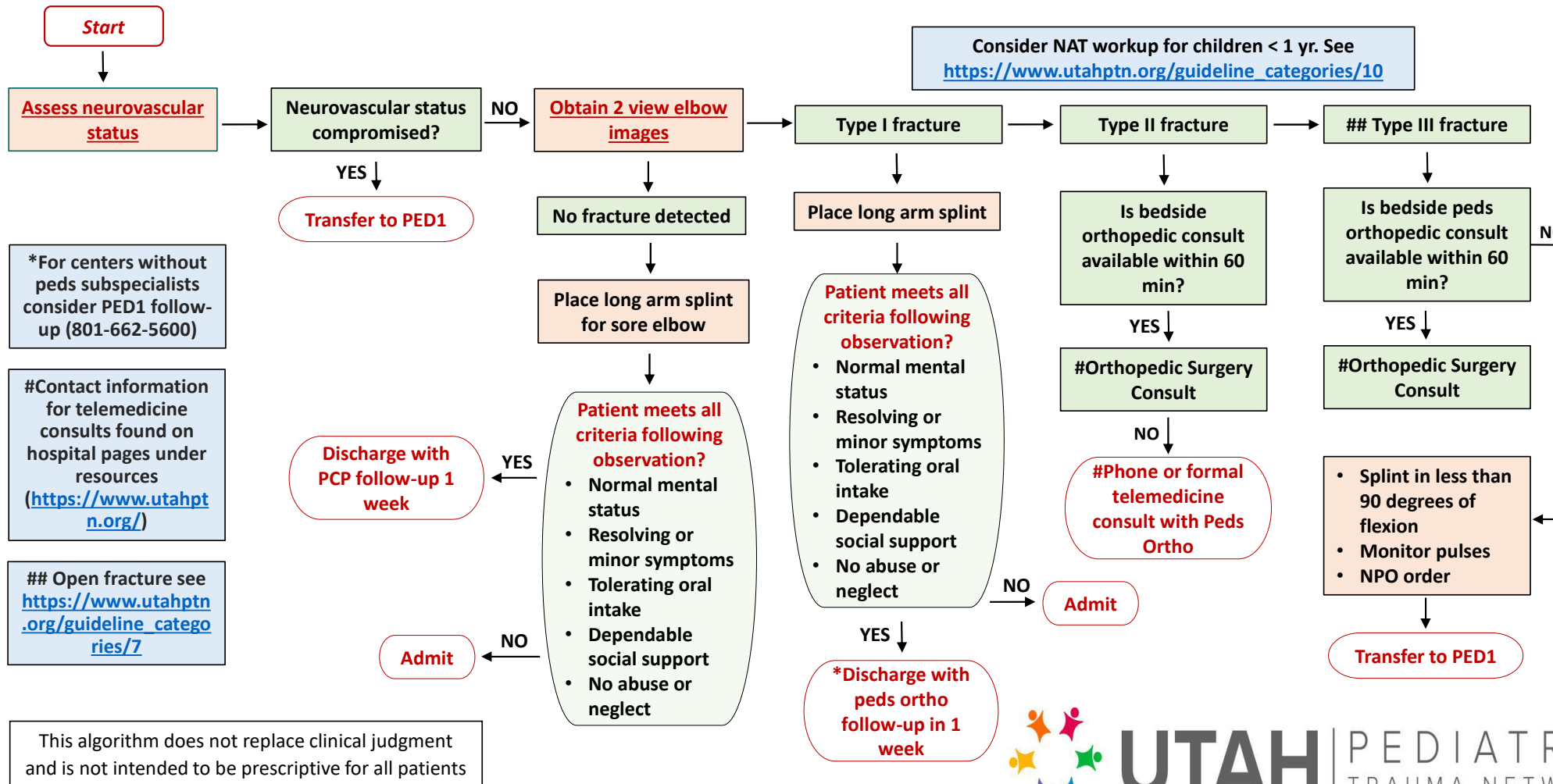


Type I	Non-displaced
Type II A	Intact posterior cortex, hinged in extension. No rotation or translation.
Type II B	Intact posterior cortex, hinged in extension, with some degree of rotational displacement or translation.
Type III	Complete displacement.

Assessing the reliability of the modified Gartland classification system for extension-type supracondylar humerus fractures
 T. Teo, E. Schaeffer, +8 authors C. Reilly
 Published 1 December 2019
 Medicine
 Journal of Children's Orthopaedics

[DOI:10.1302/1863-2548.13.190005](https://doi.org/10.1302/1863-2548.13.190005) [Corpus ID: 209892435](#)





INFORMATION SHARING



Top Hits

- utsurg.uth.tmc.edu — utsurg.uth.tmc.edu
- [UT Houston](https://utsurg.uth.tmc.edu/pedisurgery/) — utsurg.uth.tmc.edu/pedisurgery/

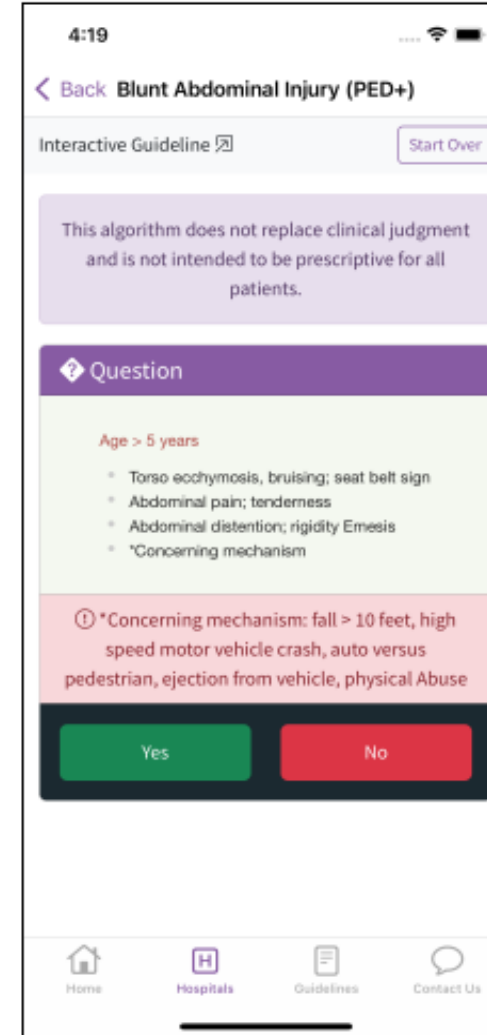
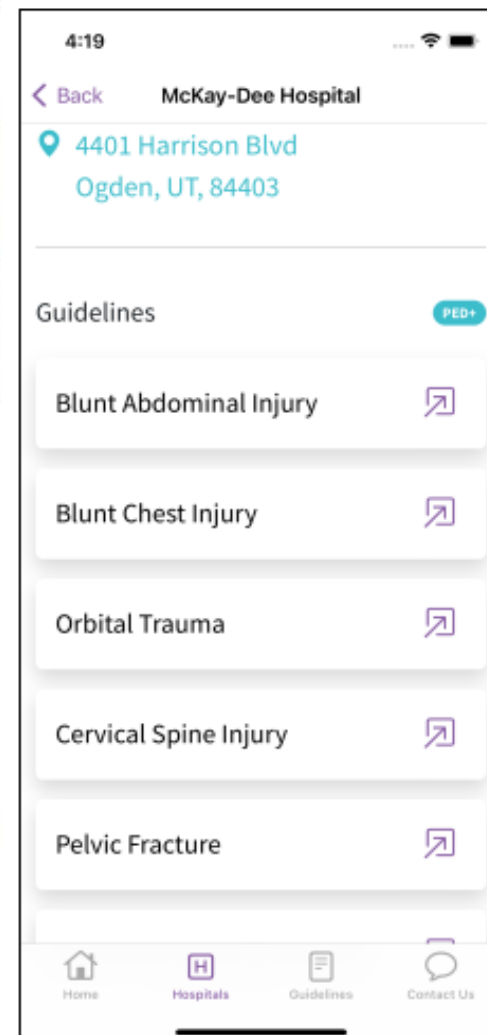
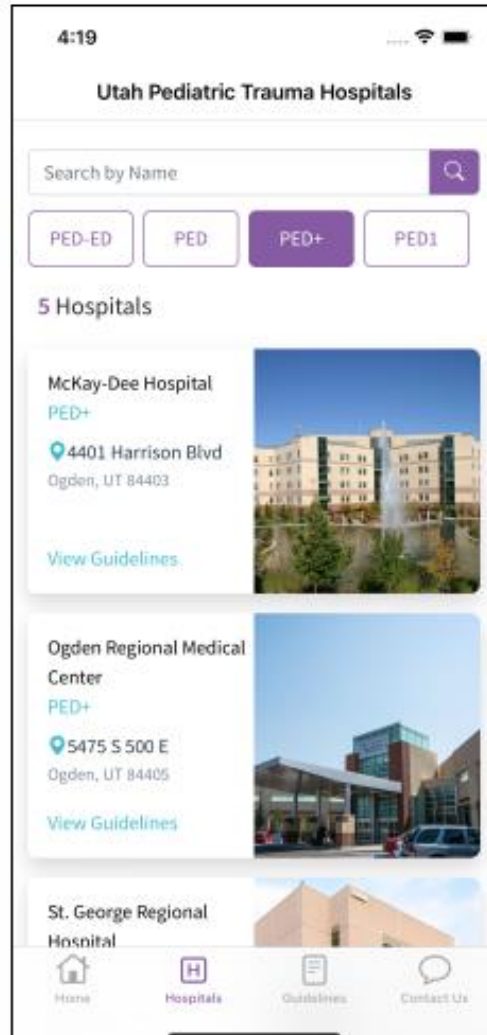
Google Search

- Q ut
- Q utah fetal center



Google Search I'm Feeling Lucky

Mobile App





Utah Pediatric Conference 2023

Pediatric trauma care providers including physicians, clinical nurses, nursing leadership, administrators, emergency medical services providers, data analysts and registrars are invited to join us for the one-day conference.

When is the conference?

Friday, October 27, 2023

Where is the conference?

Blair Education Center

 900 Round Valley Dr,
Park City, UT 84060

173
Attendees



ANALYSIS





Logged in as kris.hansen@imail.org
Log out

My Projects
Project Home or Project Setup
REDCap Messenger
Project status: **Production**

Data Collection

Manage Survey Participants
Record Status Dashboard
Add / Edit Records

1. Record ID 150 [Select other record](#)

Data Collection Instruments:

Trauma Network Entry Form

Applications

Calendar
Data Exports, Reports, and Stats
Data Import Tool
Data Comparison Tool
Logging
Field Comment Log
File Repository
User Rights and DAGs
Data Quality

Reports

[Edit reports](#)

1) Primary Cases
2) all cases

Help & Information

Help & FAQ
Video Tutorials
Suggest a New Feature

[Contact REDCap administrator](#)



Utah Department of Health
Health Informatics Program (HIP)

Pediatric Trauma Registry

Actions: [Download PDF of instrument\(s\)](#) [Share instrument in the Library](#)

[VIDEO: Basic data entry](#)

Trauma Network Entry Form

Assign record to a Data Access Group?

Adding new 1. Record ID 150

1. Record ID	150
2.1 Hospital State <i>* must provide value</i>	<input checked="" type="radio"/> Utah <input type="radio"/> Other State reset Was the patient receiving care at a hospital located in Utah or in another state?
3. FIN or Encounter #	<input type="text"/> Enter the patient's financial identification or encounter number.
4. Patient last name	<input type="text"/> Enter the patient's last name.
5. Patient first name	<input type="text"/> Enter the patient's first name.
6. Patient alias name	<input type="text"/> Enter the alias name used for the patient.
7. Mode of Arrival <i>* must provide value</i>	<input type="radio"/> Private vehicle <input type="radio"/> Emergency medical transportation <input type="radio"/> Transferred from another hospital in Utah <input type="radio"/> Transferred from a hospital outside of Utah reset How did the patient get to the above hospital?
8. Date and time of arrival <i>* must provide value</i>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter date / time patient arrived at your hospital or if case is telehealth then time arrived at Hospital (MM-DD-YYYY HH:MM).
9. Date and time of discharge	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Enter date / time patient was discharged from your hospital or if case is telehealth then time discharged from Hospital (MM-DD-YYYY HH:MM).

Save & Exit Form
Save & ...
-- Cancel --



The Utah Pediatric Trauma Network, a statewide pediatric trauma collaborative can safely help nonpediatric hospitals admit children with mild traumatic brain injury

Stephen J. Fenton, MD, FACS, FAAP, Robert A. Swendiman, MD, MPP, MSCE, Matthew Eyre, MSN, Kezlyn Larsen, BS, and Katie W. Russell, MD, Salt Lake City, Utah



The Utah Pediatric Trauma Network, a statewide pediatric trauma collaborative can safely help nonpediatric hospitals admit children with mild traumatic brain injury



- Retrospective review UPTN database 2019-2021
- Compare very mild/mild/complicated mild TBI admitted to PED 1 and non-PED 1 centers



The Utah Pediatric Trauma Network, a statewide pediatric trauma collaborative can safely help nonpediatric hospitals admit children with mild traumatic brain injury

- More children admitted to non-PED 1 centers
- Those children are getting younger over time
- Less very mild TBI coming to PED 1



USE OF A STATEWIDE SOLID ORGAN INJURY PROCOTCOL TO OPTIMIZE TRIAGE, TREATMENT, AND TRANSFER FOR PEDIATRIC ABDOMINAL TRAUMA

Robert A. Swendiman, MD MPP MSCE^a, Katie W. Russell, MD^a, Kezlyn Larsen, BA^a,

Matthew Eyre, MSN^b, Stephen J. Fenton, MD^a



USE OF A STATEWIDE SOLID ORGAN INJURY PROCOTCOL TO OPTIMIZE TRIAGE, TREATMENT, AND TRANSFER FOR PEDIATRIC ABDOMINAL TRAUMA

- 172 blunt solid organ injuries
- 48 low-grade injuries
 - 16 stayed at non-PED1
- 124 high-grade injuries
 - 39 stayed at non-PED1
 - 6 angioembolization, 1 transfusion prior to procedure
 - 5 splenectomy (NS compared to PED1, 10.3% v 4.8%)



UPTN IN ACTION

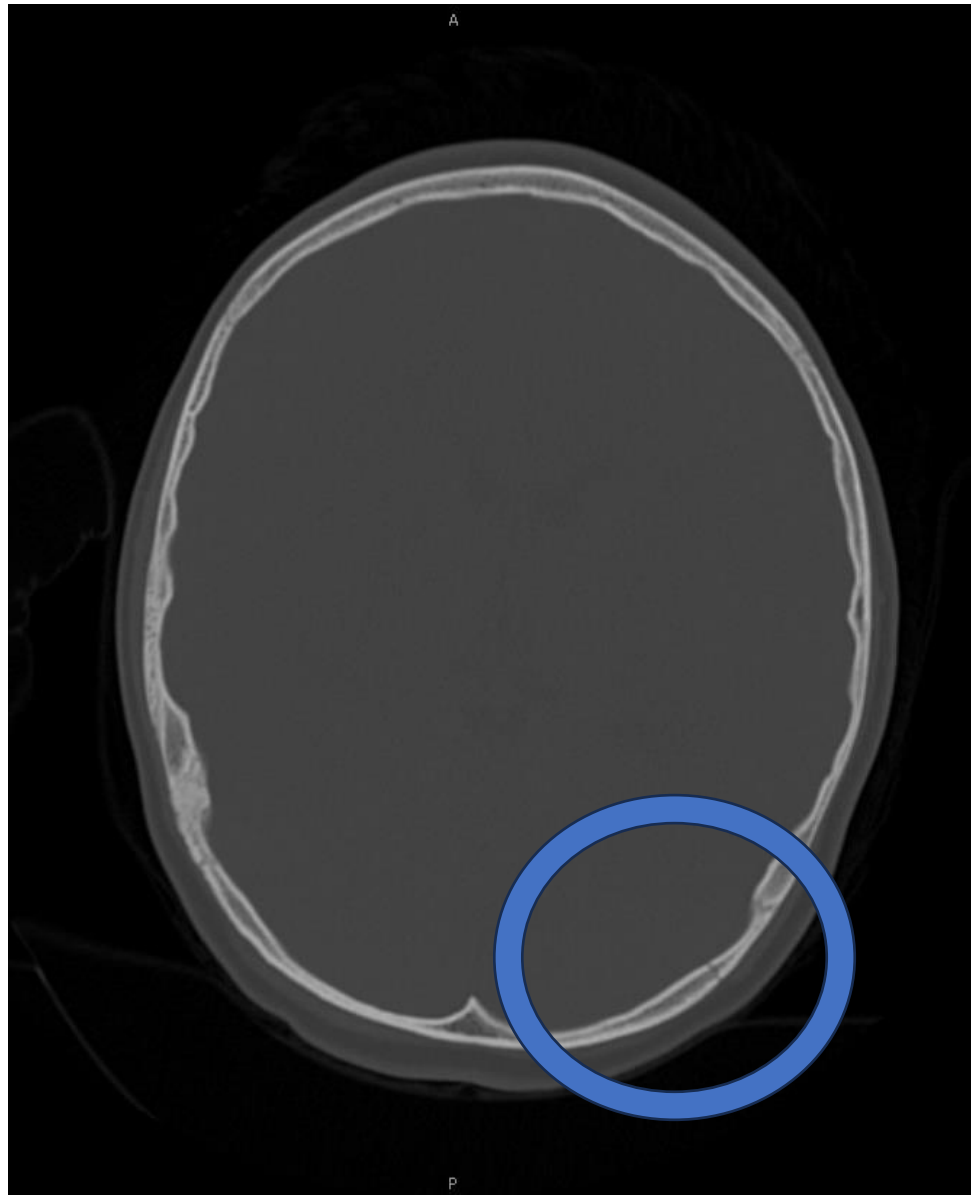




6 YO male was opening a new box of Legos and the scissors slipped and cut his finger

Neuro intact



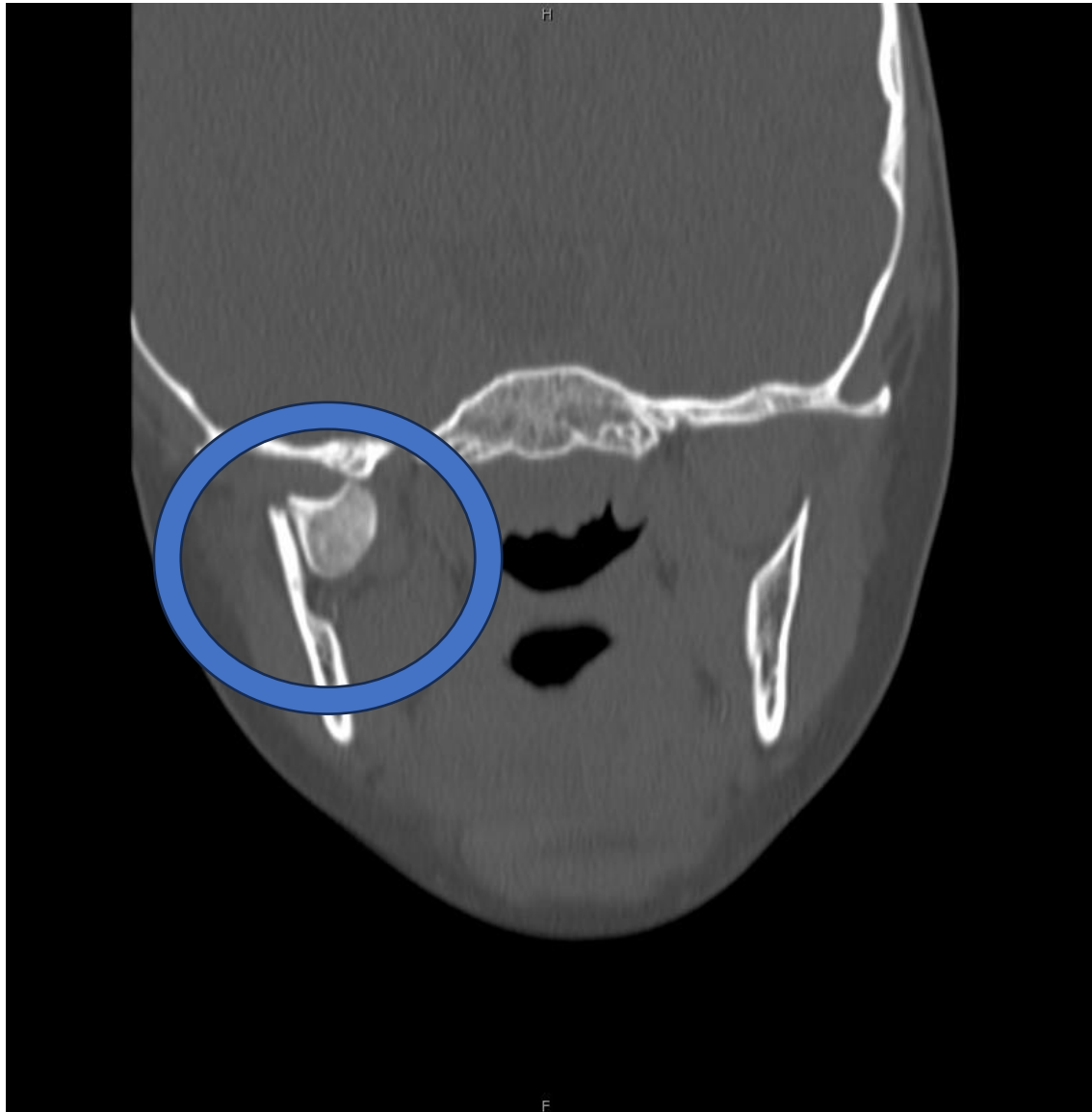


6 YO male fell of his
bike and hit his head
with +LOC

GCS 14

Boggy hematoma





4 YO male fell off her brother's shoulders

GCS 15

TMJ pain



SISTER PROGRAM

Teletrauma



A Pediatric Teletrauma Program Pilot Project: Improves Access to Pediatric Trauma Care and Timely Assessment of Pediatric Traumas

R. Scott Eldredge^{abc} MD, Zachary Moore^d, Julia Smith^e MSN, CPNP, Kasey Barnes^e MS, Sidney P Norton^e MBA, Kezlyn Larsen^a, Benjamin E. Padilla^c MD, Robert A. Swendiman^a MD, Stephen J. Fenton^a MD, Katie W. Russell^a MD



A Pediatric Teletrauma Program Pilot Project: Improves Access to Pediatric Trauma Care and Timely Assessment of Pediatric Traumas



151 consults
Median age 8 years
[IQR:3 -12]
62% (93/151) Male

Injury subtype



70% Head trauma



18% Abdominal Trauma



24% Other Trauma



A Pediatric Teletrauma Program Pilot Project: Improves Access to Pediatric Trauma Care and Timely Assessment of Pediatric Traumas

Discharge PH

54 patients

36%



Admitted PH

43 patients

29%



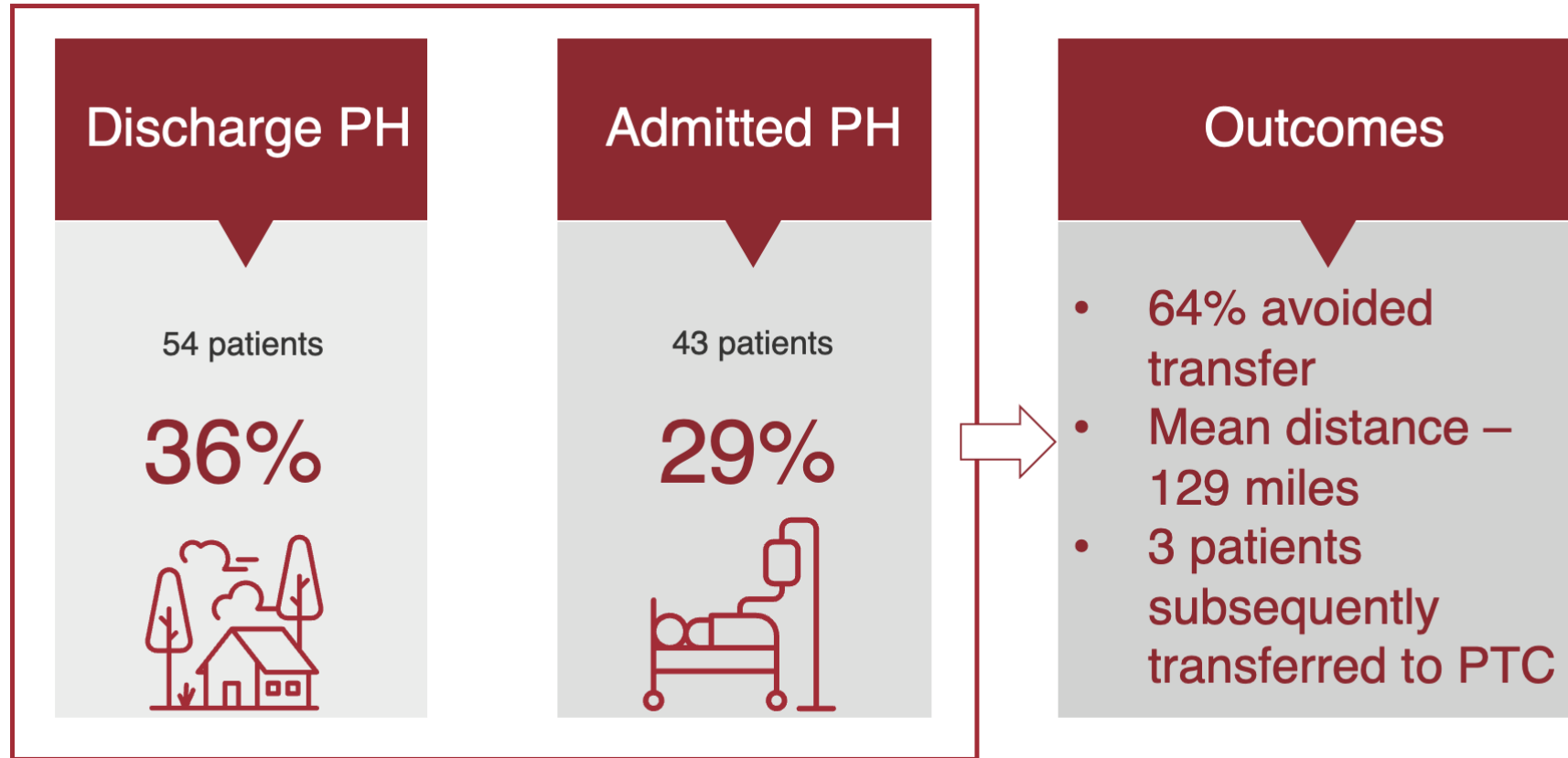
Transfer PTC

54 patients

36%



A Pediatric Teletrauma Program Pilot Project: Improves Access to Pediatric Trauma Care and Timely Assessment of Pediatric Traumas



UPTN SUMMARY



15

Protocols

Website

7

Videos

Funding

Teletrauma Program

Program Manager

100%

Participation

12

Meetings

3

Publications

5

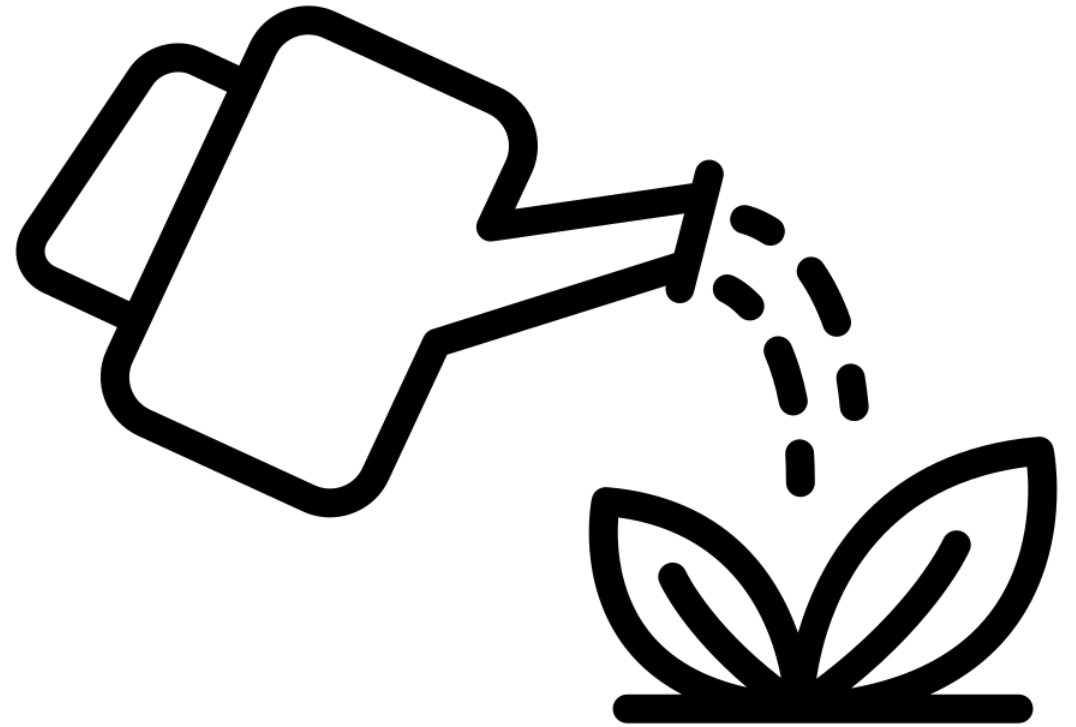
Conferences

Mobile App



Next Steps

- Grow the local Network
- Optimize the data
- Find partners
- Funding
- Create national program





United States of America

- State Boundary
- Road
- River
- ★ National Capital
- ★ State Capital
- City or Town

0 300 KM
0 300 Miles

© 2007 Geology.com

Montana Preventable Transfers

- 10-year retrospective review of all transfers from MT
- Preventable
 - DC <48 hours without surgery or imaging
- Possibly preventable
 - DC <7 days with injuries that could have been managed with resources at the level 1 adult center with pediatric capabilities
 - We reviewed these patients with the local Trauma Medical Director



Montana Preventable Transfers

40%

132

total transfers

22

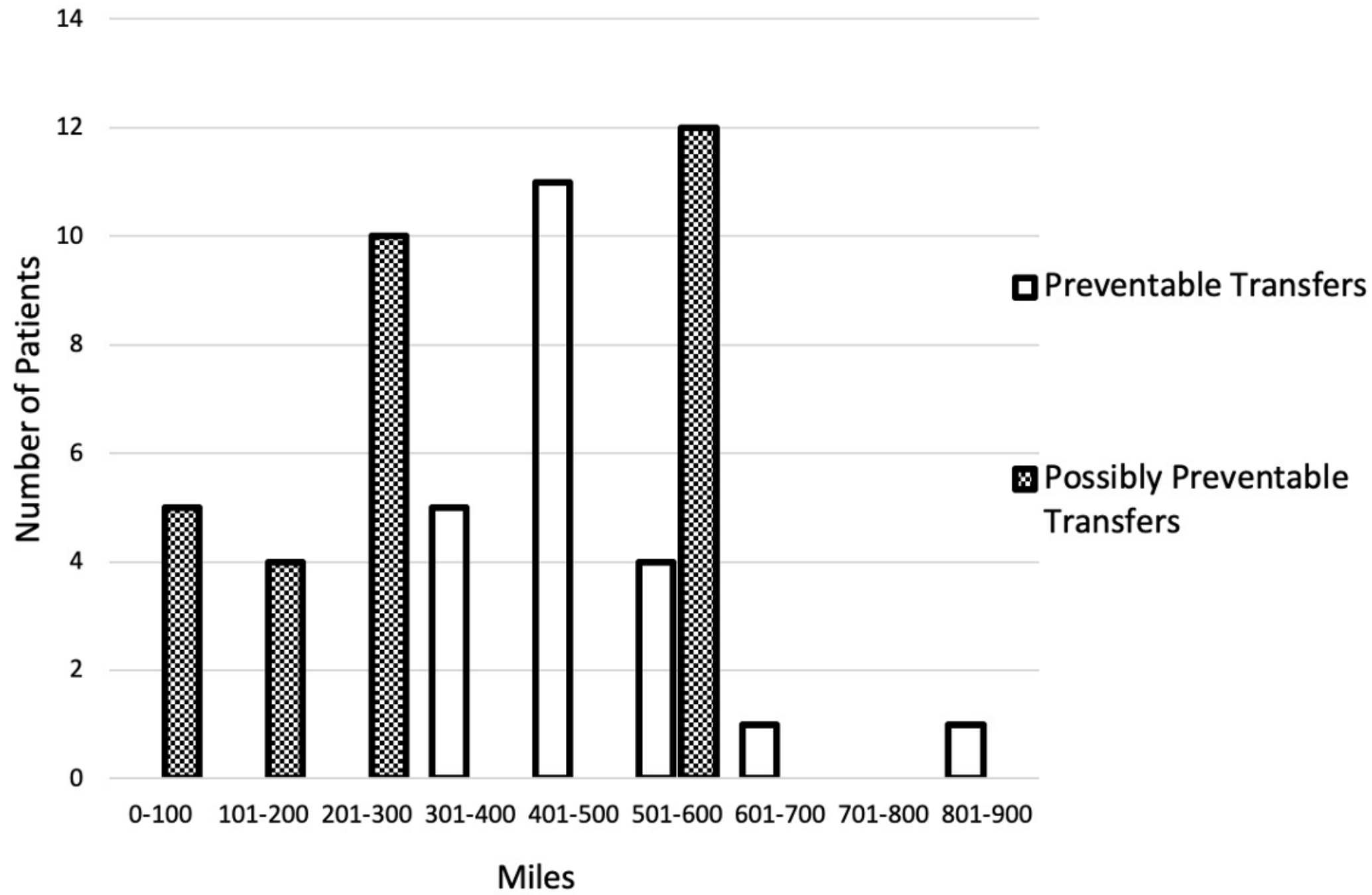
preventable transfers

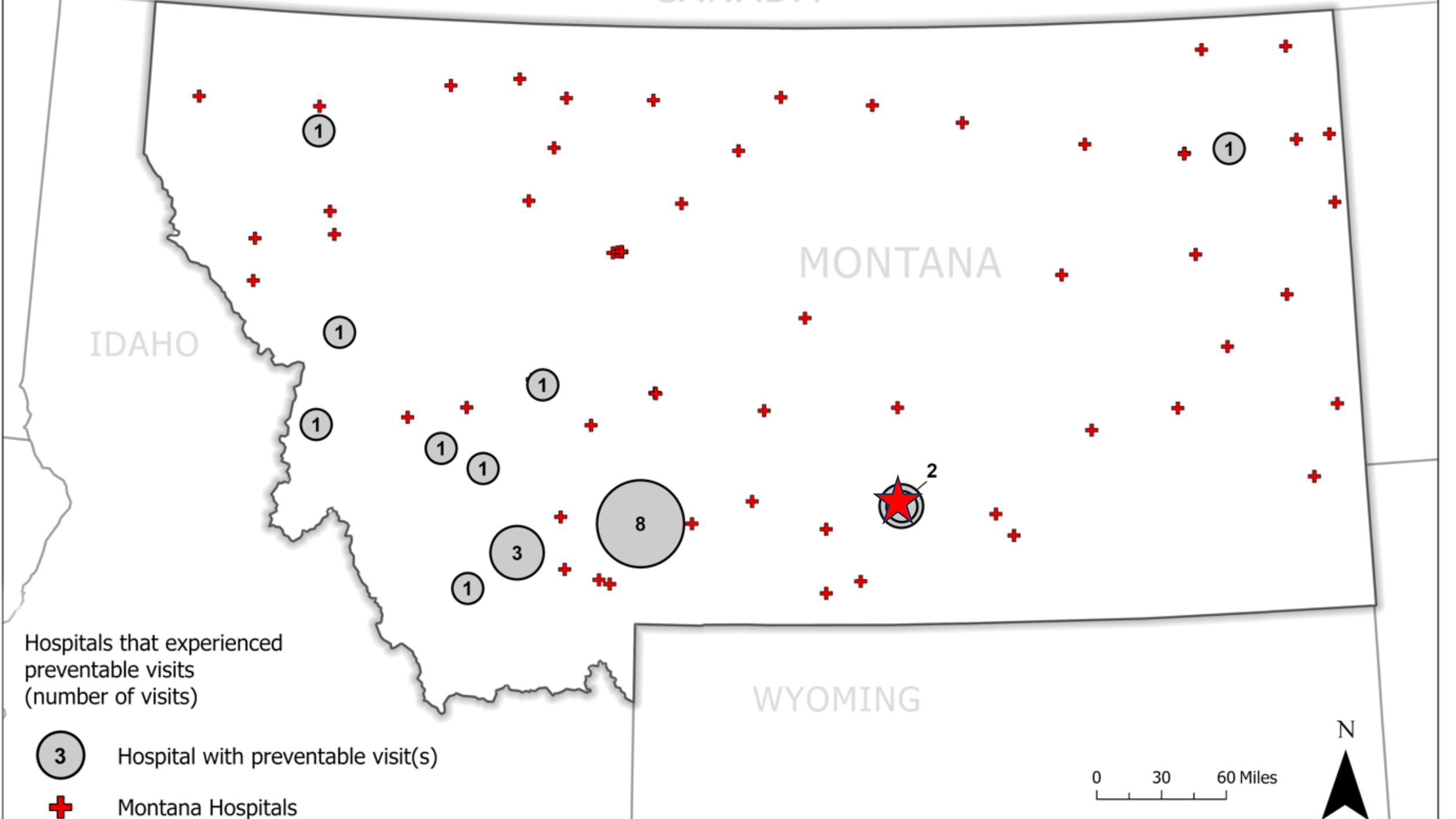
31

possibly preventable transfers



Excess Miles Traveled





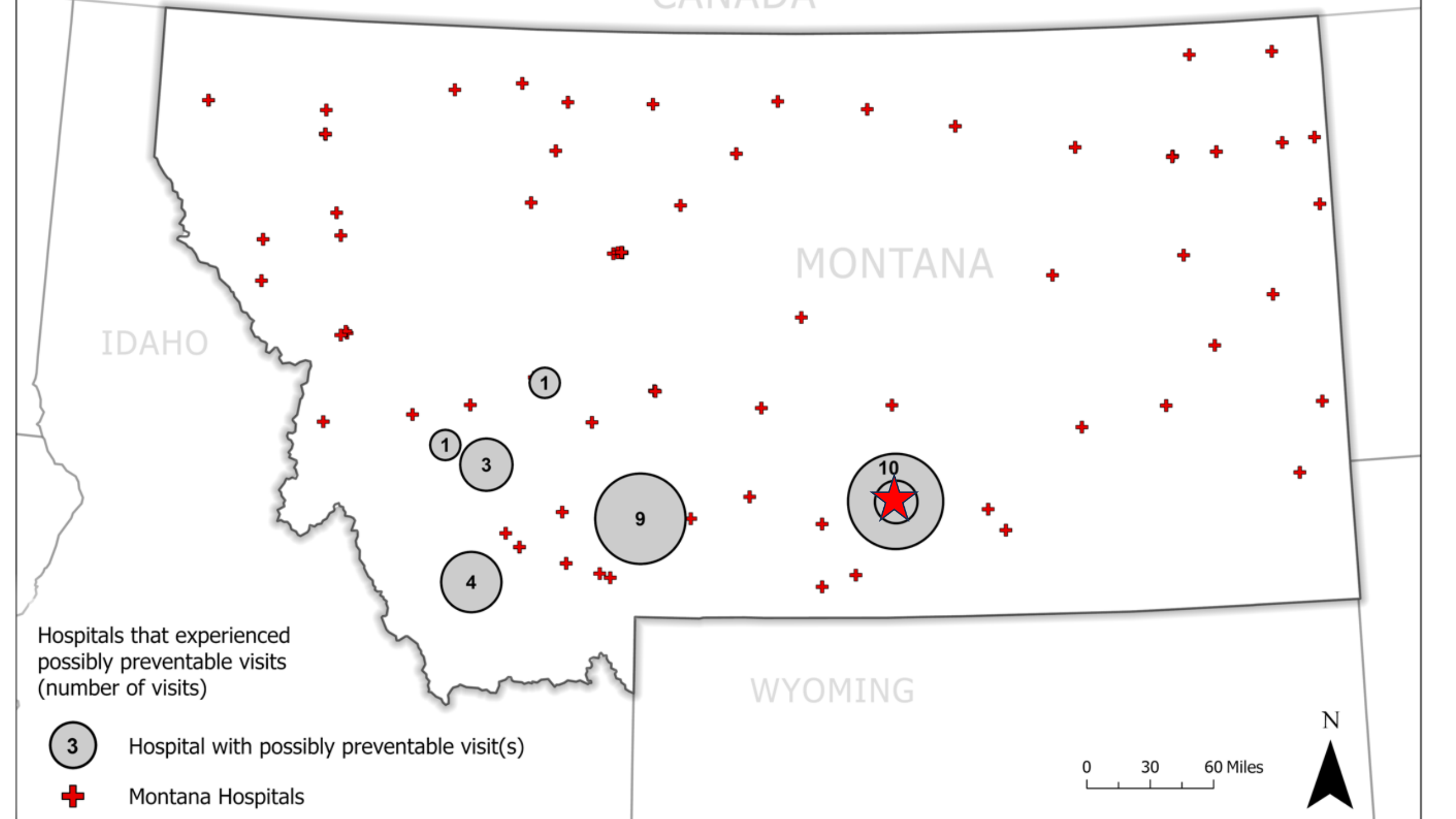
Hospitals that experienced preventable visits (number of visits)

3 Hospital with preventable visit(s)

+ Montana Hospitals

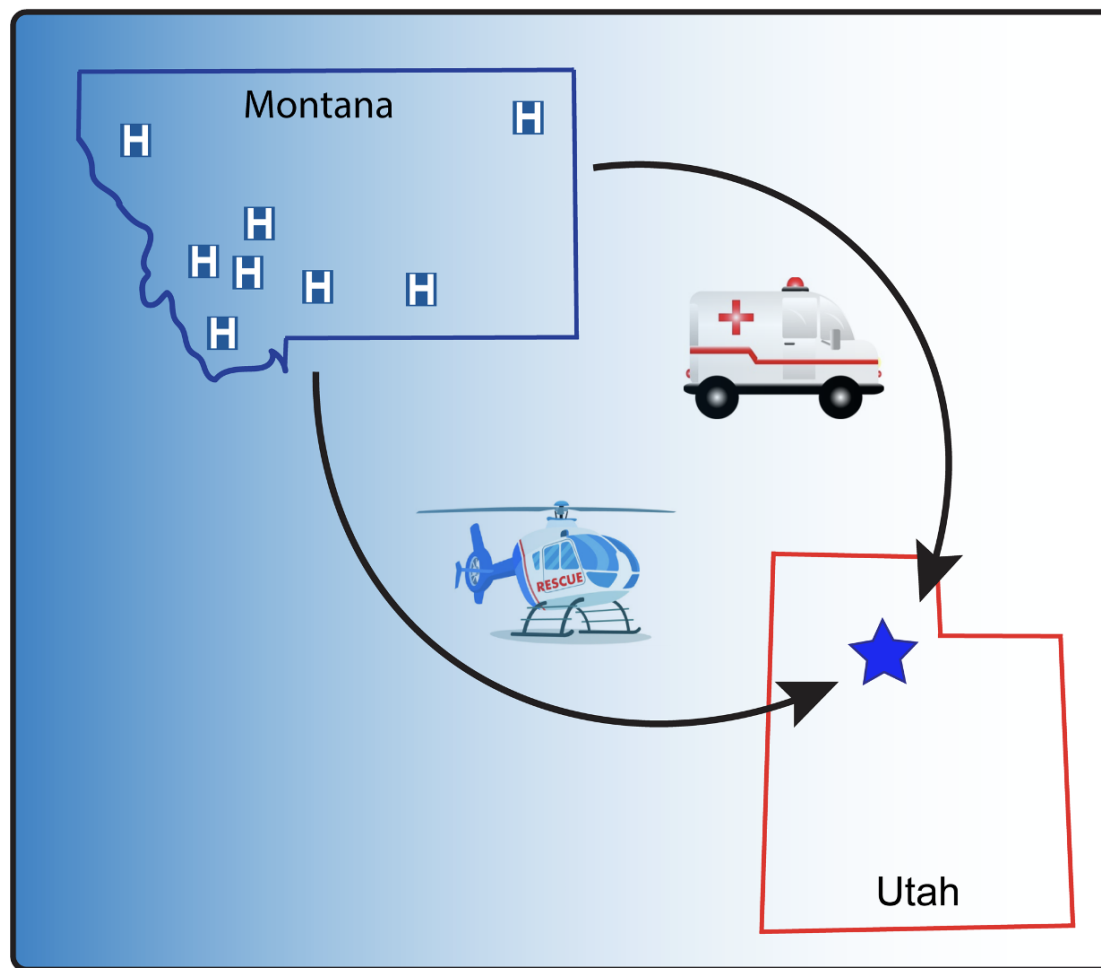
0 30 60 Miles

N



Analysis of preventable transfers of pediatric trauma patients to a Tertiary Level I Pediatric Trauma Center

Analysis of long-distance transfer of pediatric trauma patients from Montana to Level I Pediatric Trauma Center in Utah.



39% of patients who underwent transfer could have received appropriate care at in-state facilities.

Alexander et al. *Journal of Trauma and Acute Care Surgery*.
Month Year [doi]

@JTraumAcuteSurg

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The Journal of
**Trauma and
Acute Care Surgery**[®]





UTAH | PEDIATRIC TRAUMA NETWORK



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