

# What's New at CDC



Richard C. Hunt, MD, FACEP

Director, Division of Injury Response  
National Center for Injury Prevention and Control  
Centers for Disease Control and Prevention

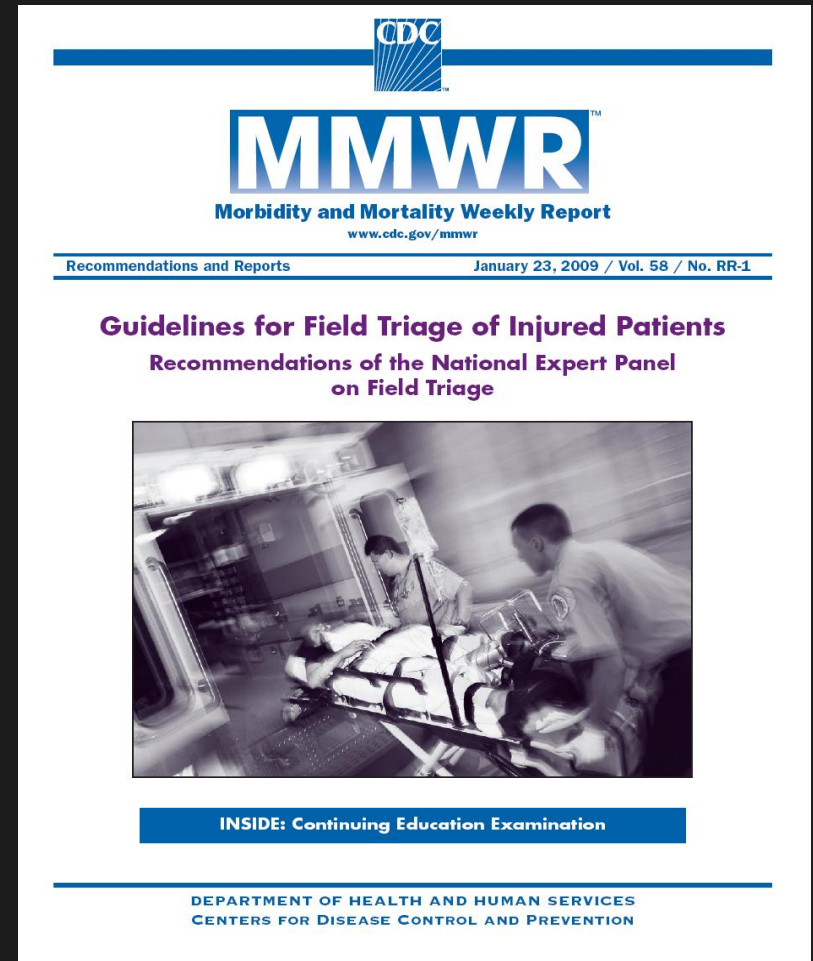
NAEMSO Mid-Year Meeting

June 9, 2009



# Field Triage Decision Scheme

- Successes to Date:
  - Launched in January 2009
  - Approximately 35,000 Web hits
  - 30,000 copies of *MMWR* and field triage materials disseminated
- Next Steps:
  - Special issue in *JEMS* (scheduled for July 2009)
  - Implementation and evaluation studies



For more information, visit: [www.cdc.gov/FieldTriage](http://www.cdc.gov/FieldTriage)

# Advances in Crash Response

RECOMMENDATIONS FROM THE EXPERT PANEL:  
ADVANCED AUTOMATIC  
COLLISION NOTIFICATION AND  
TRIAGE OF THE INJURED PATIENT



—PREPARED BY THE—  
CENTERS FOR DISEASE CONTROL AND PREVENTION,  
NATIONAL CENTER FOR INJURY PREVENTION AND CONTROL, DIVISION OF INJURY RESPONSE

—WITH SUPPORT FROM—  
ONSTAR, THE GENERAL MOTORS FOUNDATION, AND THE CDC FOUNDATION

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention



*"Providing emergency responders with vehicle crash information may help them make the appropriate field triage decisions, so crash victims can get the right type of care, at the right place, at the right time."*

For more information, visit: [www.cdc.gov/injuryresponse/aacn.html](http://www.cdc.gov/injuryresponse/aacn.html)

# Disaster Triage

## Model Uniform Core Criteria

### REVIEW

#### Mass Casualty Triage: An Evaluation of the Data and Development of a Proposed National Guideline

E. Brooke Lerner, PhD, Richard B. Schwartz, MD, Philip L. Cooke, MD, Eric S. Weinstein, MD, David C. Cooke, MD, Richard C. Hunt, MD, FACEP, Scott M. Sasser, MD, J. Marc Liu, MD, Nanci G. Hubel, NREMT-P, CCEMT-P, Ian S. Westman, MD, Jeffrey Harwood, MD, MPH, Glenn M. Sulgan, MD, Jeffrey P. Salomon, MD, Teri L. Sandala, BS, NREMT-B, Graydon C. Lord, MEd, NREMT-P, David Markenson, MD, FAAP, EMT-P, and Robert E. O'Connor, MD, MPH

#### ABSTRACT

Mass casualty triage is a critical skill. Although many systems exist to guide providers in making triage decisions, there is little scientific evidence available to demonstrate that any of the available systems have been validated. Furthermore, in the United States there is little consistency from one jurisdiction to the next in the application of mass casualty triage methodology. There are no nationally agreed upon categories or color designations. This review reports on a consensus conference process used to evaluate and compare commonly used triage systems, and to develop a proposed national mass casualty triage guideline. The proposed guideline, entitled SAK (Sort, Assess, Reassign, Reorient, Reorder, and/or Resupply) triage, was developed based on the best available science and consensus opinion. It incorporates aspects from all of the existing triage systems to create a single overarching guide for linking the mass casualty triage process across the United States. (Disaster Med Public Health Preparedness. 2008;2(Suppl 1):S25-S34)

**Key Words:** triage, trauma and injury, emergency medical services

The original concept and advancement of mass casualty triage has largely resulted from the need of military to efficiently and effectively treat multiple battle casualties.<sup>1</sup> Many of the strategies used to triage and treat wounded soldiers have been advocated for the civilian setting, and the ability of civilian emergency medical services (EMS) providers to prioritize patients for treatment and transport during a mass casualty incident is viewed as an essential skill. However, within the United States, the specific system of mass casualty triage that a prehospital care provider uses or has been dependent largely on local or regional protocols, with little consistency or interoperability between jurisdictions. Large scale disasters require cross-jurisdictional cooperation and highlight the need for a national, standardized approach to mass casualty triage.


Triage occurs at different times, performed by different types of health care providers for a variety of reasons during the provision of emergency care. Examples range from emergency medical technicians determining whether an injured patient needs to be transported to a trauma center, to emergency department nurses determining which patient needs to be placed in a treatment room first. These decisions incorporate much of the same information as is used for mass casualty triage and are made by most emergency providers every day. However, during mass casualty triage the decisions must be made more quickly, leaving providers with less time to gather the information upon which to base their decisions. Furthermore, in the mass casualty situation, the emphasis shifts

from ensuring the best possible outcome for each individual patient to ensuring the best possible outcome for the greatest number of patients. In the United States, outside of drills or other artificial training scenarios, EMS providers rarely have the opportunity to make mass casualty triage decisions.


The new emphasis on community preparedness in the United States has led to greater efforts to improve and develop local EMS providers' skills in mass casualty triage, including tremendous investments of time and money. Unfortunately, many communities have had little assistance in approving the initial triage system that are available on the market. Many of these systems use only slightly modified criteria for assigning triage priorities and are based on proprietary triage systems. Selecting the proper triage system is not an inconsequential decision. In a synthesis of available evidence, Parkrey<sup>2</sup> found that during a mass casualty incident there is a nearly linear relation between coverage and poor patient outcome.

This project enlisted a multidisciplinary committee (see Appendix) to review the available triage systems and evaluate the scientific evidence available for each system. The committee was then charged with determining whether a national guideline could be developed for mass casualty triage that would allow interoperability between jurisdictions and systems. In general, the committee worked to identify a standardized set of triage priority

# Responding to Terrorist Bombings



Centers for Disease Control and Prevention  
National Center for Injury Prevention and Control  
Division of Injury Response



## EMERGENCY

*Hand deliver to Emergency Physician Immediately!*


### BLAST INJURY CLINICAL INFORMATION

You may verify the authenticity of this FAX by calling  
The CDC Director's Emergency Operations Center at (770) 488-7100

Date: \_\_\_\_\_

Number of pages including cover sheet: 3




Additional information: [www.bt.cdc.gov/masstrauma/index.asp](http://www.bt.cdc.gov/masstrauma/index.asp)



## Bombings: Injury Patterns and Care

PowerPoint Presentation  
Curriculum Guides with Teaching Points  
Blast Fact Sheets  
Other Resource Materials

VERSION 2.0



[www.acep.org/BlastInjuries](http://www.acep.org/BlastInjuries)

For more information, visit: [www.emergency.cdc.gov/BlastInjuries](http://www.emergency.cdc.gov/BlastInjuries)

# Responding to Terrorist Bombings:

## *Implications for EMS*

- Secondary explosions
- LARGE numbers of patients
- Vast majority of patients arrive at closest hospital
- Closest hospital overwhelmed
- **NEED FOR REDISTRIBUTION!**

For more information, visit: [www.emergency.cdc.gov/BlastInjuries](http://www.emergency.cdc.gov/BlastInjuries)

# Sowing the Seeds of the APPLESEED PROJECT



THE APPLESEED PROJECT

Bringing EMS and Public Health Together

# Thanks for What You Do! You Save Lives Everyday!



For more information on CDC's activities, visit:  
[www.cdc.gov/Injury](http://www.cdc.gov/Injury) or call 1-800-CDC-INFO

