

Prehospital Blood Transfusion in Practice — Establishing a Prehospital Blood Transfusion Program

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Gam Wijetunge: Good afternoon and thank you to everyone for joining us for the second installment in our special Prehospital blood webinar series.

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Gam Wijetunge: I'm Gam Wijetunge, Director of the NHTSA Office of EMS, and I'll be moderating the session today. Today's session is Establishing a Prehospital Blood Transfusion Program.

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Gam Wijetunge: So just a few messages up front. We address a number of EMS issues in our long-standing focus... EMS-focused webinar program.

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Gam Wijetunge: And last month, we kicked off our newest series, Prehospital Blood Transfusion in Practice.

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Gam Wijetunge: If you missed our first session, Defining Prehospital blood Transfusion, the recording is now posted on EMS.gov, so please go check that out.

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Gam Wijetunge: On the screen, you'll see a list of the remaining topics addressed by the series. Please scan the QR code on the slide now, and register for the upcoming webinars through December. You'll have to register for each session separately.

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Gam Wijetunge: We look forward to bringing you a variety of experts across different agency structures, different geographies across the country, to share information and potentially to inspire others to consider a blood program in their community.

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Gam Wijetunge: A quick word on this series. EMS Focus gives the EMS community a unique opportunity to learn more about prehospital blood transfusion best practices. It brings federal, state and local leaders directly to you, the listener.

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00:01:53.050 --> 00:02:04.249

Gam Wijetunge: With time for audience Q&A in every session and closed captioning is available throughout. You see here the NHTSA Office of EMS email address...

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Gam Wijetunge: In the last slide. Please do send us your questions and requests for future topics.

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Gam Wijetunge: And next slide. Two housekeeping items. So, during the webinar, you should use the Q&A button on your Zoom control panel to send in questions, anytime.

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00:02:24.890 --> 00:02:37.829

Gam Wijetunge: We'll get to them, at the... towards the end of the webinar today. Captions are also available, just click on the button that says, "Show Captions".

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00:02:40.670 --> 00:02:49.380

Gam Wijetunge: So, some background on the NHTSA Office of EMS. NHTSA's mission is reducing death and disability on our roadways.

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Gam Wijetunge: Within the Office of EMS, we strive to improve patient outcomes in the prehospital setting, focusing on a systems approach to EMS improvement. This ensures that any patient experiencing any medical emergency, whether it's a crash

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Gam Wijetunge: or cardiac arrest or you name it, that our EMS systems and clinicians are prepared to provide effective clinical care to reduce injury and save lives.

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Gam Wijetunge: To support the mission, NHTSA focuses on bringing together data and experts to talk about the critical issues,

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Gam Wijetunge: Providing leadership and coordination to the EMS community, and assessing, planning, developing and promoting comprehensive, evidence-based EMS and 911 systems.

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00:03:39.170 --> 00:03:45.229

Gam Wijetunge: One way we achieve our mission is by providing resources to support EMS leaders and clinicians.

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Gam Wijetunge: The Resources Hub on EMS.gov makes it easy to browse, search, and download documents, reports and guidelines from our office, as well as from members of the Federal Interagency Committee on EMS, or FICEMS, and from partners across the field.

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00:04:01.760 --> 00:04:10.879

Gam Wijetunge: So, scan the QR code on this slide, or simply go to EMS.gov if you'd like to check out any of these resources.

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00:04:13.700 --> 00:04:32.130

Gam Wijetunge: So, before we get into today's topic, I want to highlight some very recent news. Just a few weeks ago, the U.S. Department of Transportation released the 2026 National Roadway Safety Strategy, or NRSS as we call it.

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Gam Wijetunge: The NRSS is Secretary Duffy's strategy for reducing deaths on our roadways and moving towards zero deaths. It focuses on safer people, safer roads, and safer vehicles, with post-crash care and emergency response playing a central role throughout the NRSS.

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Gam Wijetunge: If you take the time to read it, I'd like to call your attention to a specific section within the NRSS titled, "Help First Responders Save Lives", that specifically highlights prehospital blood transfusion as a priority for the Department of Transportation.

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Gam Wijetunge: If you're making the case for a program in your community, this is a resource you can bring into these conversations. So, please scan the QR code on the screen and go take a look at the NRSS, and please share it with your networks and partners.

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Gam Wijetunge: So, with that background out of the way, let's head into today's panel, Establishing a Prehospital blood Transfusion Program.

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Gam Wijetunge: This will start with, during the webinar, we'll start with the history and science behind prehospital blood, including what we've learned from military medicine and how that experience has informed its use in civilian EMS.

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Gam Wijetunge: And then from there, we'll talk about whole blood and blood components, and what EMS agencies need to consider, and who to bring along with them when establishing a program.

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00:06:05.720 --> 00:06:24.019

Gam Wijetunge: So, let me welcome our panelists today, Dr. Randi Schaefer and Dr. John Holcomb. And, just a note, Dr. Don Jenkins was going to be joining us today. He had a last-minute emergency, so

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Gam Wijetunge: He did let us know, unfortunately, he won't be able to make it today, but perhaps we'll get to see, Don in a future webinar.

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Gam Wijetunge: So, with that note, I'd like to ask each of you to briefly introduce yourself and share any disclosures or conflicts of interest. Dr. Schaefer, let's start with you.

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Dr. Randi Schaefer: Hi, I'm Randi Schaefer. It's nice to be able to talk to you all today. My background, I'm a retired Army trauma nurse. I had 3 deployments downrange, which really helped inform my experience in bringing blood to the civilian world, with all the lessons that we learned.

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Dr. Randi Schaefer: I retired, went to work for the Southwest Texas Regional Advisory Council, where I had the opportunity to work with Don in getting prehospital blood rolled out, particularly whole blood, to—I think it was roughly 18 helicopter bases and 12 ground agencies—using a systematic onboarding process for these agencies.

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Dr. Randi Schaefer: I left STRAC, I ventured out on my own, and my disclosure would be that I own my own consulting business now, and one part of that is helping agencies or industry

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Dr. Randi Schaefer: you know, navigate this complex world of prehospital blood. I'm also a member of the Prehospital Blood Transfusion Coalition

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Dr. Randi Schaefer: where we are providing, hopefully, resources to help agencies get these done.

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Gam Wijetunge: And Dr. Holcomb.

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Dr. John Holcomb: Alright, thanks, Gam. Yeah, so, I'm a trauma surgeon. I was in the Army, as Randi was for 23 years. By the way, Randi was my boss on my last deployment to Baghdad in 2006.

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Dr. John Holcomb: She's still my boss today, right? I still do whatever Randi says.

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Dr. John Holcomb: I spent 23 years in the Army. I've since been in the academic trauma surgery kind of medical world since then, now currently at the University of Alabama in Birmingham.

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Dr. John Holcomb: I'm also the Associate EMS Medical Director in Washington County, Texas, a rural county in the central part of Texas.

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Dr. John Holcomb: And I have been involved with prehospital blood for a long time. And, as with Randi, I've helped establish the Prehospital Blood Transfusion Coalition.

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Dr. John Holcomb: Our goal is to put blood on every eligible ground and air ambulance in the United States

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Dr. John Holcomb: so that we can decrease death from hemorrhagic shock, irrespective of the cause.

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Dr. John Holcomb: I have several disclosures, Gam. None really have anything to do with putting prehospital blood on ambulances, so...

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Gam Wijetunge: Good.

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Gam Wijetunge: Randi and John, thank you for joining us today—and before we dive into questions, just allow me to fanboy you, you know, a little bit. When we talk about blood as really a prime example of how we're taking military experience and applying to the civilian environment,

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Gam Wijetunge: the two of you are people who were deeply involved in developing this military experience, and now, of course, are deeply involved in bringing it to the civilian environment.

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Gam Wijetunge: So I'm a big fan of both of you and Don, and I know there's a lot of folks listening in today that are big fans as well, so just really excited to have you join us today.

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Gam Wijetunge: So, on that note, let's kick off the conversation. We're going to keep it pretty informal today, so just feel free to riff off each other and see where the conversation goes.

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Gam Wijetunge: But let's talk about the—kind of the—evidence behind blood and what the military has learned over the past many decades.

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Gam Wijetunge: Can you speak to the military and civilian evidence supporting the delivery of blood and blood components to patients experiencing major blood loss?

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Dr. John Holcomb: Yeah, Randi, if it's okay, I'll start. I first saw, really, you know, crystalloid

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Dr. John Holcomb: for most of my time in the military and most of my time as a doc, crystalloid resuscitation was where we started.

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Dr. John Holcomb: The clear fluid, normal saline, lactated ringers.

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Dr. John Holcomb: The first time I really saw blood take the place of crystalloid was in 1993 in Mogadishu, Somalia.

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Dr. John Holcomb: And we used the walking blood bank, because we were running out of blood and running out of red cells and plasma.

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Dr. John Holcomb: And I had a patient

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Dr. John Holcomb: Who had a horrible, devastating injury, and we gave him a bunch of whole blood versus crystalloid.

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Dr. John Holcomb: It—

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Dr. John Holcomb: I describe that experience as a clinician as somewhat magical.

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Dr. John Holcomb: Coagulopathy stopped, blood pressure came up, urine output came up.

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Dr. John Holcomb: The presser requirements came down. The anesthesiologist could actually dial in anesthesia. This is in the operating room now, not prehospital.

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Dr. John Holcomb: But it was pretty interesting from a physiology point of view what blood versus crystalloid allowed everybody to do.

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Dr. John Holcomb: From 93, for the next decade, we then did a bunch of work in the lab.

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Dr. John Holcomb: Looking at blood product resuscitation versus...

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Dr. John Holcomb: Versus crystalloid resuscitation. And then along came Desert Shield, Desert Storm

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Dr. John Holcomb: going to Iraq, and pretty quickly accelerated that clinical knowledge—taking the knowledge from 1993 and in a small number of cases, taking the knowledge that we gained in the laboratory

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Dr. John Holcomb: in preclinical studies and then applying that

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Dr. John Holcomb: to the large number of casualties that were rolling in, in Iraq early in the war. And that's when this switch happened

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Dr. John Holcomb: pretty quickly, from crystalloid-based resuscitation to blood-based resuscitation. And then over the ensuing years, that moved prehospital

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Dr. John Holcomb: at each step along the way, documenting improved outcomes in patients and decreased complications associated with the crystalloid. So there's improvement with blood and decreased complications by not giving the crystalloid. I'll stop there. Randi, what are your... do you think... what do you want to add to that?

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Dr. Randi Schaefer: I would say you're the science guru. My role was the implementation, and how do we do this—which was important, you know—taking that knowledge we learned and making it work in the real world. On our deployment in 2005 and 2006 when we did need to activate the walking blood bank,

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Dr. Randi Schaefer: you really had to think about who you're going to draw blood from, how do you keep those rosters ready—and that was incredibly insightful of understanding the minutiae behind the scenes in my role there.

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Dr. Randi Schaefer: All the way up to, you know, '16, '17, when I had to roll out blood.

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Dr. Randi Schaefer: I had oversight of Iraq, Syria, parts of Turkey and parts of Jordan, and when you have to put blood out in the field in the prehospital setting, it forces you to think in a systems perspective.

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Dr. Randi Schaefer: So I think all of that knowledge was important. One of the things I do like to highlight is that the vast majority of those prehospital blood transfusions in the military were happening by medics. There was no nurse or physician on scene. So I think it's very easy for folks like Dr. Holcomb and myself to advocate for civilian EMS, because we worked with incredible medics who are doing this every single day.

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Dr. Randi Schaefer: And those are some of the pieces that I think are important—is how do you do this?

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Gam Wijetunge: Randi, you mentioned the term walking blood bank. Can you, can you explain for folks what that term means in the military context?

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Dr. Randi Schaefer: Yeah, that is simply when your needs exceed your resources, so there would be patients where we would blow through everything we had on ourselves, and there was no, you know, supply available for various reasons, so we would turn to each other, draw blood off of ourselves and turn around and put it right into our patients.

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Dr. Randi Schaefer: So we were the storage container for the blood products.

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Gam Wijetunge: It's amazing.

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Dr. John Holcomb: And if I can add to that, you know, the walking blood bank is something that's pretty interesting. It was pretty standard. This is where blood came from in emergency settings up until about the 1970s in the United States.

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Dr. John Holcomb: Walking blood banks have been done in every war; and in the United States was not uncommon up until the 70s.

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Dr. John Holcomb: And people are now starting to talk about this again because there are blood deserts. You don't have to go to Africa to have a blood desert. There are blood deserts in the United States and there are places in the United States that do not have prehospital blood, and the hospitals don't—can't—give balanced transfusion with components.

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Dr. John Holcomb: So there's discussions ongoing about walking blood banks in the United States. I would say we're not there, probably not the topic of the discussion today, but maybe in, you know, 5 years, we can have a webinar about walking blood banks.

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00:16:02.880 --> 00:16:03.720

Dr. John Holcomb: Yeah.

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00:16:03.850 --> 00:16:07.490

Gam Wijetunge: Well, good, you're planning ahead. That's perfect.

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00:16:07.960 --> 00:16:14.149

Gam Wijetunge: So, could we talk a little bit about,

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Gam Wijetunge: Randi, I know you get this question all the time—

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Gam Wijetunge: just the growth in the civilian environment over the last several years,

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Gam Wijetunge: and Randi, everyone's asking you what our count is probably every day of the week, I'm guessing. But what have you seen in terms of the growth over the last few years and what do you think has driven the growth of

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Gam Wijetunge: prehospital blood transfusion programs?

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Dr. Randi Schaefer: Yeah, on the helicopter side, Prehospital blood has been used since virtually its inception on the ground. It was largely in/around 2016, where Dr. Holcomb was able to help an agency in Texas, a couple of agencies in Texas, get rolled out.

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00:17:06.280 --> 00:17:22.849

Dr. Randi Schaefer: So, roughly tracking across the country, now we are close to 450. I think we're 448 by the time I finish my spreadsheet today. The growth, I think, has been attributed to several things.

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Dr. Randi Schaefer: The science, awareness of the problem. It is amazing when you talk to pure lay folks who have no idea about EMS or medicine. It just makes some assumptions that blood is there when they see all these, you know, advanced things that paramedics can do.

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00:17:41.520 --> 00:17:47.050

Dr. Randi Schaefer: The other piece is we had to identify the barriers to implementing programs.

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Dr. Randi Schaefer: And through the work of the coalition and other sources, we've looked at some of those barriers. One is scope of practice. We've still got states that have not quite made the leap into paramedics being able to initiate a blood transfusion.

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00:18:01.880 --> 00:18:06.189

Dr. Randi Schaefer: Other barriers are access to blood supply,

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Dr. Randi Schaefer: which I have to give a lot of credit to our blood colleagues for really stepping up on the blood center side, and also the hospital side in working with EMS agencies to ensure that they can rotate blood products through their hospitals. We have good stewardship.

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00:18:23.830 --> 00:18:35.870

Dr. Randi Schaefer: And I would say the other piece is the economics and figuring out how to fund these programs. So, as we've been able to address some of the barriers, we have been able to implement

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00:18:35.870 --> 00:18:51.099

Dr. Randi Schaefer: program growth. And I do have a copy of the map up there, that's been my passion project for almost 10 years now, and just trying to figure out where programs are. You can see clusters in Texas, Florida, North Virginia.

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00:18:51.170 --> 00:19:06.489

Dr. Randi Schaefer: I'm excited about that, but going back to my military planning mind, I want to know why there's blank spots on the map and what do we need to do to go after those. So this is an interactive map. You can get on the PrehospitalTransfusion.org website, hover over it

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00:19:06.580 --> 00:19:09.889

Dr. Randi Schaefer: and you can see by service model

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00:19:10.150 --> 00:19:13.130

Dr. Randi Schaefer: who supplies their blood, how long they have it.

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Dr. Randi Schaefer: And I do try to keep it updated about once a month, so thank you for your submissions. I've got about 4 or 5 agencies who submitted over the last 4 weeks. You are not on there yet.

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Dr. Randi Schaefer: But I think it's been a real useful tool to be able to visually lay out, you know, as Dr. Holcomb said, we've got blood deserts out there, and I think this map is a great example of that.

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Dr. John Holcomb: Gam, if I can just add to that, you know, 400 and...

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00:19:39.890 --> 00:19:50.680

Dr. John Holcomb: 40 or 450 sounds like a great—it is great—and it's been doubling every year for the past 4 or 5 years, the number of ground agencies that are carrying blood.

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00:19:50.820 --> 00:19:59.969

Dr. John Holcomb: But that's out of about 11,400 eligible, you know, so we're about 4 or 5%.

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Dr. John Holcomb: It has been doubling every year. We hope it'll double again next year, this year, next year. But there's still a ways to go, and as Randi said, there are blood deserts in the United States where it takes hours for a patient bleeding

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Dr. John Holcomb: to get blood into them and help save their life.

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00:20:20.310 --> 00:20:26.450

Gam Wijetunge: Yeah, it's, it has been incredible growth, and

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Gam Wijetunge: Randi and John and many others, your work is really driving this forward and I think the key part is also the folks that are on the line listening.

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Gam Wijetunge: You know, right? This is really much like a local-level effort of establishing relationships, so, you know, I think we rely on

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Gam Wijetunge: the chance to communicate, to really move and help fill in this map even further.

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Gam Wijetunge: When I've talked... like, Randi, you mentioned, sometimes members of the public when they hear about blood they're surprised that

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Gam Wijetunge: paramedics aren't already doing it everywhere in the country. To some degree, it's already a public expectation. But some people might also have an opposite reaction, right? That, "oh my god, you're going to be giving me blood

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Gam Wijetunge: by the roadside or in my home?" And they might not understand what blood means or maybe what some perceived or actual risks are.

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Gam Wijetunge: Can you talk a little bit about what you've heard when interacting with people in terms of perceived risks, and also what are some real clinical risks when you do a transfusion and what you've actually seen in the field?

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Dr. Randi Schaefer: There's a lot of education as you begin this adventure, and not only was it with the lay public, but also with some of our blood colleagues. This is uncrossmatched blood products. So every hospital, you get to use an emergency release blood program. So it's those uncrossmatched products

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Dr. Randi Schaefer: that you can use on any patient type. We have taken that idea and simply pushed it to the prehospital setting, so uncrossmatched blood—largely under implied consent.

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Dr. Randi Schaefer: So there is very little risk for having any of the complications or transfusion reactions. I would say they are exactly the same as the hospital.

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Dr. Randi Schaefer: And actually maybe a little less in the hospital if there is a transfusion error. Often it is due to some administrative typo, you know, it went to the wrong patient. Since we're using all uncrossmatched blood out in the field, I think that decreases some of that risk.

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Dr. Randi Schaefer: Still, it's the same requirements for tracking of the blood products and the patients in the prehospital setting as they do in the hospital.

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Dr. Randi Schaefer: And the AABB, which is the Association for the Advancement of Blood and Biotherapies, last year published their first set of standards for prehospital care. And this is important. If you are a transfusing agency and you don't know what this document is, you must get it. And if you're setting up a program

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Dr. Randi Schaefer: you need to take a look at it because this provides all of the guardrails

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Dr. Randi Schaefer: so that you set up a safe program. And of note, I am a committee member—I don't get a single penny from any sales of the book, even though I think it's probably their best seller in probably decades—I don't get a single penny from that, but it really is important.

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Dr. Randi Schaefer: And I need to make sure we reach out to our early adopters of prehospital blood when this document didn't exist

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Dr. Randi Schaefer: and to go back and cross-check and make sure that your program's meeting all the requirements.

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Dr. John Holcomb: Yeah, Gam, if I would just say for patients in hemorrhagic shock, whether it's a traffic

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Dr. John Holcomb: crash or a gunshot wound or postpartum hemorrhage, which I know is not the topic today, but...

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Dr. John Holcomb: About 50% of the patients who get blood pre-hospital are non-trauma patients. I know we're talking about crash patients today,

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Dr. John Holcomb: but there are a large number of patients in hemorrhagic shock that are in crashes. There are a large number of patients that are in gunshot wounds and hemorrhagic shock. For those patients who are tachycardic and hypotensive,

134

00:24:27.900 --> 00:24:30.229

Dr. John Holcomb: blood is safer than crystalloid.

135

00:24:31.180 --> 00:24:35.860

Dr. John Holcomb: Crystalloid is allowed to be given almost willy-nilly to anybody,

136

00:24:36.010 --> 00:24:38.839

Dr. John Holcomb: but in hemorrhagic shock, blood is safer

137

00:24:39.040 --> 00:24:40.400

Dr. John Holcomb: than crystalloid.

138

00:24:40.860 --> 00:24:43.380

Dr. John Holcomb: That's a... that's a data-driven comment.

139

00:24:43.490 --> 00:24:53.410

Dr. John Holcomb: And it's not like 10 liters of crystalloid. Every 500ccs of crystalloid is more dangerous to patients in hemorrhagic shock than blood—than blood products.

140

00:24:56.590 --> 00:24:57.640

Gam Wijetunge: Wow, wow.

141

00:24:57.640 --> 00:25:12.979

Dr. John Holcomb: That's a little bit of... throwing everybody on their head—that talks about the safety of blood. But because of our blood suppliers and blood collectors, the blood is extraordinarily safe in the United States.

142

00:25:13.250 --> 00:25:22.540

Dr. John Holcomb: The blood that is supplied to all, whether the hospital or prehospital, is extraordinarily safe. It's not 100%—

143

00:25:22.660 --> 00:25:25.709

Dr. John Holcomb: nothing is—but it is safer than crystalloid.

144

00:25:27.060 --> 00:25:36.160

Dr. Randi Schaefer: I think another piece that gets asked is, is there enough blood out there? Because you always see the calls for, you know, blood from the

145

00:25:36.460 --> 00:25:38.370

Dr. Randi Schaefer: the donor centers.

146

00:25:38.520 --> 00:25:57.730

Dr. Randi Schaefer: And this is where we have to think smart about the products we're going to use. So, is there enough LTOWB or O-positive whole blood to put on every ambulance? No. But, Dr. Holcomb and Dr. Jenkins were part of a paper that just came out looking at modeling the scaling up of programs

147

00:25:57.730 --> 00:26:04.700

Dr. Randi Schaefer: and there is enough liquid plasma out there to meet the need with program growth.

148

00:26:04.700 --> 00:26:20.689

Dr. Randi Schaefer: And liquid plasma, whether it stays liquid, gets converted into freeze-dried plasma, or, you know, fresh frozen plasma—whatever its shape and form—it looks like there will be enough out there to not impact other donor needs.

149

00:26:21.830 --> 00:26:40.319

Dr. John Holcomb: Yeah, I want to follow on what Randi said. We've now published over the last couple years, and this liquid... there's a lot of movement and momentum—and now even tradition—built up about prehospital whole blood. Whole blood is a great product. Love whole blood.

150

00:26:40.390 --> 00:26:55.100

Dr. John Holcomb: But there's not enough to put on every eligible ambulance in the United States. There's just not enough. And we published that now with Dr. Young from the American Red Cross, as Randi said, in the journal Transfusion.

151

00:26:55.290 --> 00:27:02.370

Dr. John Holcomb: There is enough liquid plasma and I think we'll go back to where, at the end of World War II,

152

00:27:02.420 --> 00:27:16.899

Dr. John Holcomb: where the U.S. military ended: with plasma largely covering the prehospital world and whole blood largely in the hospital. Obviously, there's going to be some mixing and matching there,

153

00:27:17.110 --> 00:27:27.450

Dr. John Holcomb: but when you look at supply and logistics and the need and the requirements, and put all of that together, that's where they ended up in World War II, at the end of World War II.

154

00:27:27.540 --> 00:27:40.230

Dr. John Holcomb: I think that's where we will largely end up in the United States. Not 100%, but certainly in the majority of the places in the U.S, is liquid plasma prehospital and whole blood in the hospital.

155

00:27:40.390 --> 00:27:47.870

Dr. John Holcomb: I admit that's a little controversial. I expect that we'll have questions about that at the end, which is great.

156

00:27:50.110 --> 00:27:53.169

Gam Wijetunge: Great. See what the future brings.

157

00:27:53.430 --> 00:27:56.339

Dr. John Holcomb: Yeah, that's a near-future thing, Gam.

158

00:27:57.990 --> 00:28:01.210

Gam Wijetunge: The future is always near, I guess.

159

00:28:01.350 --> 00:28:07.919

Gam Wijetunge: Let's... maybe if we could go, advance to the next slide...

160

00:28:08.320 --> 00:28:17.849

Gam Wijetunge: And Randi, I'm confident we'll also get in the chat folks who want to make sure they get added to your map. We're capturing those.

161

00:28:19.980 --> 00:28:29.889

Gam Wijetunge: So, you were talking about some guidance that the AABB has put out, and up on the screen we have some information that NHTSA put out.

162

00:28:29.940 --> 00:28:39.200

Gam Wijetunge: Just talking generally about, you know, kind of the things you should... you should start with when you're working to set up a program.

163

00:28:39.230 --> 00:28:52.040

Gam Wijetunge: So maybe all, for all of you—for both of you—what benchmarks should EMS agencies look at when they're determining whether to establish their own blood program?

164

00:28:52.040 --> 00:29:00.020

Gam Wijetunge: And, kind of tagged onto that, how can data be used to build support for their program?

165

00:29:00.520 --> 00:29:02.929

Dr. John Holcomb: Go ahead, Randi. This is what you do.

166

00:29:02.930 --> 00:29:18.240

Dr. Randi Schaefer: Yeah, so one is you need to do a needs assessment. When you look at some of the data (the cost, etc.), your agency ultimately may choose not to do this and we have to recognize that fact in your needs assessment.

167

00:29:18.390 --> 00:29:38.120

Dr. Randi Schaefer: It's a three-legged stool of data that you need to look at. One, you need to look at your transfusion criteria as an EMS agency. So whether you're using blood pressure, heart rate, shock index, entitled CO2—whatever those transfusion triggers are—to identify the potential need.

168

00:29:38.120 --> 00:29:43.500

Dr. Randi Schaefer: The other two pieces of data that I encourage you to look at are talk with your local hospitals

169

00:29:43.500 --> 00:29:56.219

Dr. Randi Schaefer: and see what their MTP rates are, or even those patients that needed blood upon arrival at the ED. Chances are, if you reverse engineer it, that patient probably needed blood in the prehospital setting as well.

170

00:29:56.460 --> 00:30:11.730

Dr. Randi Schaefer: And then the third leg, which, Gam, you and your team have been incredible about, is looking at the FARS database. And look at those patients that died either, en route, you know, died on the scene or en route to the hospital.

171

00:30:11.730 --> 00:30:27.720

Dr. Randi Schaefer: That's an important piece of data, looking at the fatalities that occur, and I know that is something in the military we do actually a really good job of. I think it was every Thursday, once a month, Dr. Holcomb, that we would meet with a medical examiner

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00:30:27.720 --> 00:30:34.330

Dr. Randi Schaefer: and talk about those cases, on, you know, what could have been done for some of those preventable deaths.

173

00:30:34.550 --> 00:30:49.259

Dr. Randi Schaefer: So you look at those three pieces of data, and you're able to actually put together a nice heat map of where potential usage might occur, and also get a good number for the estimated number of units per month.

174

00:30:49.290 --> 00:31:09.340

Dr. Randi Schaefer: We've got enough agencies out there doing this that I can, in a pretty quick conversation, give you an estimate of how many blood products you're going to use. So ultimately, if you decide not to carry blood products in your agency, work with your sister agencies on a mutual aid and assist, or even potential intercept models.

175

00:31:09.630 --> 00:31:16.620

Dr. Randi Schaefer: And that's the first place to start. Before you go talk to the blood centers, before you talk to anybody, is do your internal needs assessment.

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00:31:17.370 --> 00:31:20.250

Dr. John Holcomb: I would add to that.

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00:31:20.530 --> 00:31:34.770

Dr. John Holcomb: For our EMS colleagues that are out there, you all know that the patient, you arrive on the scene, they're hypotensive, tachycardic, pale, diaphoretic, and en route you end up doing CPR and they arrive dead at the hospital.

178

00:31:35.020 --> 00:31:39.120

Dr. John Holcomb: These are patients who don't show up in many registries.

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00:31:39.180 --> 00:31:44.120

Dr. John Holcomb: Right? And yet these are the patients who actually likely

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00:31:44.180 --> 00:31:47.979

Dr. John Holcomb: can be converted from dead

181

00:31:48.000 --> 00:32:07.430

Dr. John Holcomb: to still arriving in shock, but not with ongoing CPR. And now the hospital docs, nurses, that team has a chance to save that life. That's what we're seeing across the country; is those people are living and waking up, right? As opposed to having CPR en route, they're waking up

182

00:32:07.800 --> 00:32:13.970

Dr. John Holcomb: and talking whether they get whole blood or plasma—some kind of blood product is going into their system.

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00:32:18.100 --> 00:32:19.139

Gam Wijetunge: It's great.

184

00:32:19.140 --> 00:32:19.760

Dr. John Holcomb: Yeah.

185

00:32:21.850 --> 00:32:27.389

Gam Wijetunge: Oh, so, let's,

186

00:32:27.560 --> 00:32:36.940

Gam Wijetunge: So Don, of course, wasn't able to join us today, and he was going to talk about some things that folks can do to get started today, but

187

00:32:36.940 --> 00:32:52.729

Gam Wijetunge: of course, Randi and John, you work very closely with Don Jenkins, have known him for a long time, so I'm glad you're, you're here to fill in any, to provide any answers that he would.

188

00:32:52.760 --> 00:33:06.169

Gam Wijetunge: So, let's talk a little bit about stakeholders. You know, who... When you're... when an agency is putting together a list of stakeholders, which I hear again and again is a really critical piece, who should...

189

00:33:06.580 --> 00:33:09.320

Gam Wijetunge: Who should be in that stakeholder group?

190

00:33:10.160 --> 00:33:11.090

Dr. John Holcomb: Go ahead, Randi.

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00:33:11.780 --> 00:33:31.709

Dr. Randi Schaefer: I'll take this one. So, the big stakeholders—and it's a Venn diagram effect—is, you know, the blood community, the prehospital setting and then the hospital, all overlapping to help meet that patient's need. But you need to think about expanding that stakeholder group. Everything from

192

00:33:31.960 --> 00:33:34.620

Dr. Randi Schaefer: getting 911 dispatch involved.

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00:33:34.900 --> 00:33:35.490

Gam Wijetunge: Mhm.

194

00:33:35.490 --> 00:33:45.890

Dr. Randi Schaefer: You know, it's the quicker you can identify that a patient needs blood, the quicker either that ambulance or the sprint vehicle, however you want to, you know, whatever model you use.

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00:33:46.050 --> 00:33:53.689

Dr. Randi Schaefer: I would say reach out to law enforcement. They're often the first responders that can really help identify these patients.

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00:33:53.750 --> 00:34:00.660

Dr. Randi Schaefer: You know, within your agency, make sure that you get your logistics folks, your operations folks,

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00:34:00.660 --> 00:34:18.470

Dr. Randi Schaefer: your QA, QI, and I also say get your public information officer, your PIO, involved so that they can start helping develop this information campaign, which we've seen a great... some great examples on social media of programs launching.

198

00:34:18.920 --> 00:34:30.420

Dr. Randi Schaefer: At the hospital, it's a... there's a tendency to think that your stakeholder is just the trauma bay or the ED, and that is incorrect. The people you really need to communicate with about

199

00:34:30.420 --> 00:34:52.459

Dr. Randi Schaefer: emergency uncrossmatched blood being given in the prehospital setting is the blood bank and transfusion service in the hospital. And our traditional ways of communicating through the EPCR don't meet that need for real-time communication, so working with those receiving facilities to make sure that that information does get to that transfusion service.

200

00:34:52.460 --> 00:34:56.549

Dr. Randi Schaefer: And particularly, maybe we'll talk a little bit later about,

201

00:34:56.590 --> 00:35:03.250

Dr. Randi Schaefer: females with childbearing potential, you know, getting an RH-positive product. So it's a patient safety issue.

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00:35:03.410 --> 00:35:06.680

Dr. Randi Schaefer: As far as community stakeholders,

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00:35:06.680 --> 00:35:27.149

Dr. Randi Schaefer: we talked a little bit about the lay folks who have no idea that this is a need. I would also reach out to your politicians pretty early. This is a win for them if we are going after some of the disparities in healthcare, when we are starting to take care of not only, you know, inner-city penetrating trauma.

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00:35:27.150 --> 00:35:37.139

Dr. Randi Schaefer: But, we have some horrible maternal fatality rates due to postpartum hemorrhage, and especially in the rural settings, what's the first service line that gets cut?

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00:35:37.380 --> 00:35:45.679

Dr. Randi Schaefer: It's often L&D and access to prenatal care, so we've got a lot of women that have actually benefited from getting a prehospital blood transfusion.

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00:35:46.100 --> 00:36:04.480

Dr. Randi Schaefer: So it's important to bring them together, especially if you're a fire-based service and they control your budget. It's always nice to win friends and, you know, in the city government. So there's a long list of stakeholders that I really want agencies to think about as they sit down at the table.

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00:36:04.480 --> 00:36:13.500

Dr. Randi Schaefer: Department of Transportation, Gam I gotta give it to your folks, right? Sit down with your State Department or county department of transportation and making sure that they're involved early.

208

00:36:14.870 --> 00:36:22.230

Dr. John Holcomb: Yeah, Gam, I just... just to add to that exhaustive list that Randi articulated, you know,

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00:36:22.900 --> 00:36:38.269

Dr. John Holcomb: we were part of the process... part of the team that moved blood from the blood bank, hospital blood bank, to the emergency department. That was a big deal. But that is now kind of standard around the country in a lot of places. Now we're moving it from the ED to prehospital.

210

00:36:38.480 --> 00:36:57.189

Dr. John Holcomb: And our ED folks need to communicate with the blood bank, as Randi said, the blood suppliers, the ED. There's multiple people to communicate here, and many of the times, our prehospital folks have not communicated with the hospital folks.

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00:36:57.710 --> 00:37:03.889

Dr. John Holcomb: farther in the hospital than the ED, and so they're just not used to doing that. They don't have those lines of communications.

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00:37:03.940 --> 00:37:16.790

Dr. John Holcomb: This requires a line of communication that extends well beyond the emergency department, and in places I just haven't done before. And the blood banks have not talked to EMS providers before, either.

213

00:37:16.790 --> 00:37:24.289

Dr. John Holcomb: So it's emerging of cultures that haven't—in the past—talked to each other that are now talking.

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00:37:24.440 --> 00:37:26.770

Dr. John Holcomb: The sooner that happens, the better.

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00:37:27.010 --> 00:37:33.829

Dr. John Holcomb: It requires several, I'll put air quotations around "several" meetings

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00:37:34.020 --> 00:37:40.030

Dr. John Holcomb: to get beyond, you know, the initial, "we can't do this" kind of response.

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00:37:40.180 --> 00:37:52.529

Dr. John Holcomb: So, it happens, and we're not at the ones and twos anymore, we're at 450. And so, I would recommend, in addition to everything that Randi said, which is right on target,

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00:37:52.670 --> 00:37:57.050

Dr. John Holcomb: is talking to an agency who's done this

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00:37:57.320 --> 00:38:04.960

Dr. John Holcomb: already—you know, in your area—and basically copy what they've done, if they've been successful.

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00:38:07.320 --> 00:38:17.050

Gam Wijetunge: And Randi, I want to touch on something you mentioned because we're getting some questions in the feed about this. You mentioned Rh-positive.

221

00:38:17.310 --> 00:38:27.510

Gam Wijetunge: Could you talk a little bit about, I guess we're talking about alley immunization, and what that means, and how we... how we deal with that?

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00:38:28.590 --> 00:38:35.920

Dr. Randi Schaefer: I'll kick that one to Dr. Holcomb to talk about the science, and I'll talk to you about what we need to do to make sure that communication happens.

223

00:38:36.280 --> 00:38:36.940

Dr. John Holcomb: Fantastic.

224

00:38:36.940 --> 00:38:37.610

Dr. Randi Schaefer: That's the key of it.

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00:38:37.720 --> 00:38:42.660

Dr. John Holcomb: Alright, Randi, thank you very much for that. So...

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00:38:42.680 --> 00:38:59.330

Dr. John Holcomb: In the old days, because I'm old, and I can say that, I was taught in medical school that if I gave an Rh-positive blood to an Rh-negative woman of childbearing age, all her babies in the future would die.

227

00:39:00.170 --> 00:39:02.289

Dr. John Holcomb: And so we were taught not to do that.

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00:39:03.080 --> 00:39:07.839

Dr. John Holcomb: As it turns out, as with many things, that teaching was wrong.

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00:39:08.140 --> 00:39:10.060

Dr. John Holcomb: Right? It's... it was wrong.

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00:39:10.490 --> 00:39:18.100

Dr. John Holcomb: There is not enough Rh-negative blood. Rh-negative blood in the United States largely is about 4% of the population.

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00:39:18.260 --> 00:39:29.539

Dr. John Holcomb: And so there's no way that we can have Rh-negative blood to give to everybody, whether they be males or females of childbearing age. There's just not enough.

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00:39:29.860 --> 00:39:43.299

Dr. John Holcomb: And so, the universal donor products that are available prehospital and in the ED are largely Rh-positive. It gets pretty technical pretty quick with immunization, alloimmunization.

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00:39:43.300 --> 00:39:54.429

Dr. John Holcomb: The bottom line is that the Allo Hope organization, women who have been immunized and have had healthy babies,

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00:39:54.600 --> 00:40:00.550

Dr. John Holcomb: are highly supportive of prehospital blood—Rh-positive blood—across the United States.

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00:40:00.690 --> 00:40:06.930

Dr. John Holcomb: They're very supportive of that. We've done a lot of work with that group. They've been very easy to work with

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00:40:07.030 --> 00:40:21.409

Dr. John Holcomb: and support giving Rh-positive blood products pre-hospital to women of childbearing age. Now, you have to then notify that woman and make sure she gets checked afterwards for 3 to 6 to 9 months afterwards,

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00:40:21.470 --> 00:40:33.059

Dr. John Holcomb: right? So that if that alloimmunization does happen, that that woman can have healthy babies later under a good physician care.

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00:40:33.640 --> 00:40:36.520

Dr. John Holcomb: Is that... is that okay?

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00:40:36.520 --> 00:40:50.249

Gam Wijetunge: Yeah, that's perfect, and I, you know, I hope we have future conversations about this, potentially in future webinars as well. Yeah. And it's great to hear about the work that Alo Hope is doing as well.

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00:40:50.310 --> 00:41:07.109

Gam Wijetunge: You know, along those lines, you mentioned, when we give blood, we have to ensure that we have appropriate follow-up with these patients, and I know we got a question in the chat, and both of you have touched about the

241

00:41:07.110 --> 00:41:11.570

Gam Wijetunge: importance of documentation, of patient documentation,

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00:41:11.570 --> 00:41:19.890

Gam Wijetunge: and maintenance of records and linkage records as well. We did get a question in the chat from, Bruce Evans—Hi, Bruce—

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00:41:19.900 --> 00:41:29.359

Gam Wijetunge: about the electronic patient... the prehospital, electronic patient care reporting data.

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00:41:29.360 --> 00:41:41.820

Gam Wijetunge: And both of you were involved in this effort as well, as well as a slew of our national partners, when prehospital blood transfusion really started kicking into high gear around the country.

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00:41:41.820 --> 00:41:57.180

Gam Wijetunge: Our team here at NHTSA, Jeremy Kinsman leads our, is the federal program manager for, the National EMS Information System and works on a day-to-day basis with the team at the University of Utah

246

00:41:57.180 --> 00:42:08.960

Gam Wijetunge: running the NEMSIS Technical Assistance Center, and they put together a large team of folks, including outreach, to the EPCR vendors on how we

247

00:42:09.100 --> 00:42:21.699

Gam Wijetunge: adequately document administration of blood in the civilian setting. And I always make this plug. I made it... this plug in the kickoff of our webinar series:

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00:42:21.700 --> 00:42:35.160

Gam Wijetunge: When clinicians are documenting blood administration in the field, within a NEMSIS-compliant record, it needs to be entered as both a procedure

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00:42:35.170 --> 00:42:51.959

Gam Wijetunge: and a medication. So, under the e-procedures code, you need to record that you're administering a transfusion, and then under e-medications, you need to capture what type of blood product is being administered. We pay very close attention to that data

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00:42:51.960 --> 00:43:03.929

Gam Wijetunge: at the national level, here at NHTSA and with our federal partners, and that helps drive our policy decisions. And of course, it is critically important at that local patient level.

251

00:43:04.150 --> 00:43:17.799

Gam Wijetunge: Up on the screen, we had, because we've gotten some questions about some of the FARS data that you all talked about earlier—the fatality data—and,

252

00:43:17.800 --> 00:43:27.500

Gam Wijetunge: if, maybe y'all could talk about this, I'm gonna mispronounce the, the SRFTAC, I think, is the pronunciation of the acronym there?

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00:43:27.500 --> 00:43:30.550

Gam Wijetunge: Could you talk a little bit about that resource?

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00:43:30.550 --> 00:43:37.150

Dr. John Holcomb: Yeah, Randi, if it's okay, I'll jump in here. So, this is where Don Jenkins—Dr. Jenkins—would have really jumped in pretty heavily.

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00:43:37.500 --> 00:43:49.730

Dr. John Holcomb: We'll try to do him and his group credit. What they have done is taken the FARS database, which is a database of all crashes, right, Gam? That has run out of your office?

256

00:43:49.730 --> 00:43:50.690

Gam Wijetunge: Yeah.

257

00:43:51.120 --> 00:43:53.370

Dr. John Holcomb: Yeah, and then

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00:43:53.710 --> 00:44:11.710

Dr. John Holcomb: taking that down, every state has state-level data. So, if you're in Alabama, which is up on the screen, or Arkansas, or Alaska, or Arizona, there's state-level data that you can use to help document the need in your state.

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00:44:11.920 --> 00:44:28.210

Dr. John Holcomb: That, of prehospital blood, they've taken the FARS database of the folks who are alive at the scene and die en route, etc., and taken the survival benefit of prehospital blood in high-quality data

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00:44:28.210 --> 00:44:40.459

Dr. John Holcomb: and apply that at the state level to show what the survival impact would be just in crash victims. You can actually double that because of the postpartum hemorrhage and the GI bleeding and that kind of thing we talked about.

261

00:44:40.540 --> 00:44:53.589

Dr. John Holcomb: But it gives you state-level data. This is available to everybody. It's updated often. This is an all-volunteer effort led by Don Jenkins, medical students, residents, and fellows at UT

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00:44:53.590 --> 00:45:03.310

Dr. John Holcomb: San Antonio. It's a wonderful, wonderful, asset as you advocate at your state level with your state data

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00:45:03.310 --> 00:45:12.340

Dr. John Holcomb: for state funding and establishing state coalitions to deploy blood across your state prehospital. Randi, anything to add to that?

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00:45:13.510 --> 00:45:26.209

Dr. Randi Schaefer: We had the opportunity to visit some folks on Capitol Hill a couple months ago, and this was incredibly impactful, particularly when, if you're looking for a sponsor, and they can even look at their own state data.

265

00:45:26.210 --> 00:45:45.659

Dr. Randi Schaefer: I won't say politicians have FOMO, but they have FOMO. I had one state go, how come I only have this many and this state has this many? That's a great question to ask. The data, in terms of number of agencies in the state is changing quite rapidly, so if you pull up a packet and

266

00:45:45.660 --> 00:45:48.640

Dr. Randi Schaefer: they will adjust any of the numbers

267

00:45:48.860 --> 00:45:57.470

Dr. Randi Schaefer: for that state as needed, but this is a great... I think it's only 3 or 4 pages by the time you double-side print it.

268

00:45:57.730 --> 00:45:59.080

Dr. Randi Schaefer: It's a nice resource.

269

00:45:59.560 --> 00:46:00.110

Dr. John Holcomb: Yeah.

270

00:46:02.190 --> 00:46:03.650

Gam Wijetunge: Wonderful, wonderful.

271

00:46:04.680 --> 00:46:08.929

Gam Wijetunge: And I'll just, you know, I'll add in that,

272

00:46:09.170 --> 00:46:25.599

Gam Wijetunge: we, NHTSA, on our end, very soon, we should have some additional publications out there on, on NEMSIS data and estimating the number of patients that are out there that need blood.

273

00:46:25.740 --> 00:46:34.190

Gam Wijetunge: So moving on, of course, I always get too deep into these conversations, because they're a lot of fun.

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00:46:34.340 --> 00:46:53.389

Gam Wijetunge: Why don't we just spend a minute now? I'll spend a minute now talking about what NHTSA is doing in this space moving forward. I mentioned the National Roadway Safety Strategy that was released by the Secretary of Transportation just a few weeks ago.

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00:46:53.390 --> 00:46:56.150

Gam Wijetunge: And

276

00:46:56.150 --> 00:47:15.699

Gam Wijetunge: Here at the NHTSA level, so within our agency, we're within the Department of Transportation. Our administrator is really leading the charge and has made prehospital blood transfusion a priority in NHTSA's Pathways to Safer Streets plan.

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00:47:15.890 --> 00:47:31.810

Gam Wijetunge: So we're working on a bunch of new tools and resources that we can strengthen the collaboration that the EMS community has with state highway safety offices in particular.

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00:47:31.810 --> 00:47:47.330

Gam Wijetunge: Ultimately, getting blood to—not obviously—not only penetrating injuries and GI bleeds and obstetric bleeds, but really important for improving, crash survival.

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00:47:47.890 --> 00:47:51.189

Gam Wijetunge: Next slide. So,

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00:47:51.290 --> 00:48:07.869

Gam Wijetunge: Again, as mentioned, we're doing a number of things to support prehospital blood transfusion at the direction of our bosses. We're increasing national visibility on prehospital blood transfusion. We're doing constant outreach, not just to our traditional public safety partners.

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00:48:07.880 --> 00:48:17.800

Gam Wijetunge: But beyond that as well. And we're, providing education and best practices and fostering collaboration wherever we can.

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00:48:17.870 --> 00:48:36.799

Gam Wijetunge: And partnering with long-time stakeholders that we've worked with and finding new ones as well. We have a number of resources that are already available out on our websites, and obviously we're going to continue to do these webinars, but we have much more that's under development with our partners.

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00:48:36.870 --> 00:48:53.310

Gam Wijetunge: And, we are acutely focused—our leadership is acutely focused on—federal funding as well, so that we can get—where possible—we can get federal funding out there to support scalable programs.

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00:48:53.310 --> 00:49:01.250

Gam Wijetunge: You know, this is one of the most transformative, EMS interventions in at least a generation.

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00:49:01.420 --> 00:49:14.559

Gam Wijetunge: So right now, between over really the next 2 to 3 years, our aim is to accelerate adoption as much as we can, because it's such a powerful, life-saving intervention.

286

00:49:16.460 --> 00:49:29.609

Gam Wijetunge: I'll mention the resources that we have available on the web. Just go ahead and you can scan this QR code, it'll take you to EMS.gov and these are really useful resources when you're doing outreach.

287

00:49:29.760 --> 00:49:37.069

Gam Wijetunge: Let's see if we can get to one last,

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00:49:37.220 --> 00:49:42.749

Gam Wijetunge: One last question, because we're running up against time

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00:49:43.160 --> 00:49:49.989

Gam Wijetunge: and we have a long, long list, of course, so we won't be able to get to all of them.

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00:49:50.320 --> 00:49:56.610

Gam Wijetunge: This is an interesting one.

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00:49:56.890 --> 00:50:00.150

Gam Wijetunge: "After doing this for nearly 10 years,

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00:50:00.670 --> 00:50:04.829

Gam Wijetunge: have you found it has gotten easier to get buy-in from all the stakeholders?

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00:50:05.110 --> 00:50:07.609

Gam Wijetunge: Or is it still just as challenging?"

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00:50:09.560 --> 00:50:15.909

Dr. John Holcomb: Yeah, I'll give a short intro. I think it's easier. It was hard the first couple.

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00:50:16.070 --> 00:50:31.279

Dr. John Holcomb: I'm not saying it's easy, but I think it's easier, because there are multiple... there are about 4 or 5 different models around the country. Out of those 450 ground agencies, I think they've tried all of those.

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00:50:31.400 --> 00:50:41.409

Dr. John Holcomb: And you can pick one, and Randi knows all of them, and she can guide you to the one that's most like yours, and then you can just copy that. Randi?

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00:50:42.480 --> 00:51:07.210

Dr. Randi Schaefer: Yes, and I see Daniel DeLeon answered that question. Hello, Daniel! I want to give him credit in front of the whole world that he worked at hospital services at South Texas

Blood and Tissue Center, and was in the room when these crazy ideas of, you know, providing blood and having paramedics stop by the blood center at 2 AM for a refill.

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00:51:07.520 --> 00:51:13.340

Dr. Randi Schaefer: Daniel is the guy that made that happen. So, to directly answer the question,

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00:51:13.460 --> 00:51:26.209

Dr. Randi Schaefer: it is easier depending on where you are in the country. And I think the map—the clusters—show that. So, if there's a lot of blood going on in your area, a lot of the barriers have already been removed.

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00:51:26.210 --> 00:51:51.189

Dr. Randi Schaefer: It's really challenging in those states that are in that, you know, one to two to three agencies, trying to figure out what model works for them, what's their access to the blood supply, how do they work those relationships? And I did see that Julie Cruz, another blood hero from Versity—she is the chief medical officer there—She's a great example of, if you don't know who to contact in your hospital

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00:51:51.190 --> 00:51:56.919

Dr. Randi Schaefer: blood bank, reach out to the blood collector in the area, and they can help facilitate those relationships.

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00:51:57.060 --> 00:52:14.189

Dr. Randi Schaefer: It's all about relationship building. We are going on a first date with each other in a lot of this stuff, so you gotta do a little bit of your homework, feel each other out a little bit, not literally, but... see how it's gonna work. It really is about relationship building.

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00:52:15.000 --> 00:52:17.529

Dr. John Holcomb: Hey, Gam, can I answer the question about DoD?

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00:52:18.790 --> 00:52:20.079

Gam Wijetunge: Sure, I won't stop you.

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00:52:20.480 --> 00:52:30.199

Dr. John Holcomb: So the Department of Defense—Department of War—just recently said, starting in 2027, that they will pay for

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00:52:30.420 --> 00:52:49.620

Dr. John Holcomb: prehospital blood in TRICARE patients. TRICARE is kind of a military insurance program. And starting in 2027, the DoD's going to do a pilot study for 5 years, and pay for prehospital blood for TRICARE patients that are transported by ambulance. So

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00:52:49.740 --> 00:52:56.990

Dr. John Holcomb: the DoD has put their—not just dip their toe—I mean, they're leading the way

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00:52:57.020 --> 00:53:10.670

Dr. John Holcomb: as an insurance agency in paying for prehospital blood. They're the first one. They're doing that because, as we started off this discussion, prehospital blood came from the military, and it's now going into the civilian world.

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00:53:11.880 --> 00:53:29.850

Gam Wijetunge: Right, right. Yeah, very exciting to see, and yeah, Randi, you may have made this point on a call before, that, yeah, the TRICARE beneficiaries are not just on military bases, they're everywhere in the country.

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00:53:29.850 --> 00:53:32.490

Dr. John Holcomb: 2 million of them in every second. Yeah. Yeah.

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00:53:32.650 --> 00:53:48.309

Dr. Randi Schaefer: And what's of note of the TRICARE, I think this is the first time an insurance payer has recognized the level of care that is being delivered in the back of an ambulance. So they will reimburse you not only for that ALS2 bundle rate,

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00:53:48.310 --> 00:53:59.789

Dr. Randi Schaefer: but they will reimburse you the cost of the blood products. So you need to make sure you have access to those invoices and receipts. And also, they're going to give you a transfusion fee—

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00:53:59.790 --> 00:54:13.420

Dr. Randi Schaefer: \$40 for the procedure. So this is, I think, pretty groundbreaking. And Gam, you probably know more than I do in the history that, kudos to TRICARE for recognizing the care that happens in the back of the ambulance.

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00:54:13.420 --> 00:54:20.549

Dr. John Holcomb: And we hope that other insurance agencies will follow. If anybody on the line—all 241 people—know an insurance

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00:54:20.660 --> 00:54:25.530

Dr. John Holcomb: CMO that we can talk to, please send their name and contact info.

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00:54:29.190 --> 00:54:45.950

Gam Wijetunge: Great. We're at 1:54 and we usually cut off at 1:55, so unfortunately, we're gonna run out of time for questions. There's just, again, as always, a long list of questions. We'll try to get to them in the future.

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00:54:46.680 --> 00:54:51.000

Gam Wijetunge: Appreciate everyone tuning in.

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00:54:51.560 --> 00:55:07.910

Gam Wijetunge: We'll try and get responses out to any questions that we didn't get to today. As predicted, we ran up right against the clock. Dr. Schaefer, Dr. Holcomb,

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00:55:07.910 --> 00:55:25.419

Gam Wijetunge: thank you for joining us. Always insightful and just great to have you here. And thank you for all the work that you continue to do to get this practice out in the field, where we know it is saving lives as we speak.

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00:55:25.420 --> 00:55:34.479

Dr. John Holcomb: Yeah, let me... I think I can speak for Randi. We thank you guys. You guys are really spearheading this effort. We're your backup, and

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00:55:34.640 --> 00:55:45.679

Dr. John Holcomb: we appreciate the leadership position you guys have taken in all respects—to include financial—but more importantly, spreading this word like you're doing. It's great.

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00:55:47.060 --> 00:55:48.760

Gam Wijetunge: No, thank you, thank you.

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00:55:50.320 --> 00:56:06.629

Gam Wijetunge: So, this is episode 2 of 6 sessions we have scheduled. The ones that we have coming up in the future are gonna go deeper on operational and clinical and logistical sides of doing prehospital blood transfusion.

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00:56:06.770 --> 00:56:14.200

Gam Wijetunge: Just a reminder to folks, I think I probably already said it 10 times already, you can sign up for the rest of the series on EMS.gov.

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00:56:14.330 --> 00:56:24.890

Gam Wijetunge: Our next scheduled session is September 22nd. It is going to be Working with a Blood Supplier in Your Prehospital Blood Program.

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00:56:24.890 --> 00:56:41.180

Gam Wijetunge: We encourage everyone on this series to pass along this series to your leadership, medical directors—hey, you run into someone on the street, share it with them, too. That communication is really what is accelerating this movement across the entire country.

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00:56:41.310 --> 00:56:47.159

Gam Wijetunge: The recording of today's session, will be posted on EMS.gov soon.

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00:56:47.200 --> 00:57:01.660

Gam Wijetunge: I want to thank John and Randi for joining us today, and thank everyone for listening in and putting your questions in the chat. So, we'll see you at the next one. Thank you, everyone.

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00:57:02.610 --> 00:57:03.450

Dr. Randi Schaefer: Thank you.