MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

REGIONAL TRAUMA ADVISORY BOARD

December 19, 2007 - 2:30 P.M.

MEMBERS PRESENT

Mary Ellen Britt, RN, Chairman
John Fildes, MD, University Medical Center
Deborah Kreun, ThinkFirst-NV
Kim Dokken, RN, St. Rose Hospital
Sameer Abu-Samrah, MD, Sierra Health & Life
Sajit Pullarkat, Centennial Hills Hospital, Alt
Robert Bursey, General Public Representative
Melinda Hursh, RN, Sunrise Hospital
John Recicar, RN, University Medical Center
Sean Dort, MD, St. Rose Hospital
Allen Marino, MD, MAB Chairman

SNHD STAFF PRESENT

Lan Lam, Recording Secretary
Joseph J. Heck, D.O., Operational Medical Director
Trish Beckwith, EMS Field Representative
Rory Chetelat, EMS & Trauma System Manager
John Hammond, EMS Field Representative

PUBLIC ATTENDANCE

Mike Bernstein, SNHD Health Educator

CALL TO ORDER – NOTICE OF POSTING

The Regional Trauma Advisory Board convened in Human Resources Training Room #2 of the Ravenholt Public Health Center on Wednesday, December 19, 2007. Chairman Mary Ellen Britt called the meeting to order at 2:32 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Chairman Britt noted that a quorum was present.

I. CONSENT AGENDA

Chairman Britt stated the Consent Agenda consisted of matters to be considered by the Regional Trauma Advisory Board (RTAB) that can be enacted by one motion. Any item may be discussed separately per Board member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Minutes Regional Trauma Advisory Board Meeting October 17, 2007

Chairman Britt asked for approval of the minutes of the October 17, 2007 meeting. A motion was made, seconded and passed unanimously to approve the minutes as written.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Recommendation for State Trauma Coordinator Position

Ms. Dokken asked that the RTAB make a recommendation to the State Health Division for a State Trauma Coordinator position. Dr. Marino suggested that the recommendation would be more effective if a job description was included. Ms. Hursh stated that she would be happy to provide a job description for the State Trauma Coordinator position. Ms. Dokken made a motion to recommend a State Trauma Coordinator position. The motion was seconded and passed unanimously.

B. Review of Trauma Transport Data

Ms. Britt reported that the October and November out-of-area transports held steady at 6.5 and 6.6%. Ms. Britt stated that she and Mr. Chetelat reviewed the data and were not able to identify any trends. Dr. Fildes stated that in review of his trend analysis and seasonal variations he identified that the rate of growth and population of injured patients are not parallel. Although there is a higher incidence of trauma related injuries in the summer than in the winter, for whatever reasons, trauma is not growing at the same rate as population.

Dr. Fildes noted that the RTAB has been tasked with compiling data in the form of an annual report that includes not only the transporting of trauma patients, but data from the coroner regarding injury related deaths that occur both in hospital and out of hospital. Ms. Britt stated she would work with the coroner's office on this issue. Dr. Fildes offered technical assistance if needed.

C. Discussion of Current Trauma Field Triage Criteria (TFTC) Protocol

Ms. Britt reported that at the last RTAB meeting Dr. Abu-Samrah asked about the number of patients who are discharged. She stated that in looking at this, the current system was also reviewed. The state law has delegated the responsibility of the trauma system to the Southern Nevada Health District. The Health District has adopted the American College of Surgeons recommendations and the Trauma Field Triage Criteria Scheme that is in the Resources for Optimal Care of the Injured Patient 2006 book. There are steps 1, 2 and 3 patients. At each juncture, a recommendation is made as to where patients should be transported. Ms. Britt noted that this reflects the way the current protocols are written.

Dr. Heck noted that it would be worthwhile to look at how many transported patients fall into the five criteria that are not listed on the Field Triage Decision Scheme to see if it's something that should be omitted from our TFTC Protocol. Dr. Fildes noted that for the past decade there has been an interest in looking at the outcomes for each of these indicators. The treatment areas for trauma have evolved over time resulting in a change in practice as well. Patients who used to come in for x-rays and overnight observation for neurological and abdominal injuries can be completely imaged in under an hour. There has also been a complete evolution in the surgical procedures that are performed. Patients are receiving 6-9 hours of the kind of care that used to take 2-3 days.

Ms. Hursh recommended putting together a group to conduct a prospective study for 90 days to look at some of the data points. It would be necessary to have the collaboration and cooperation of the EMS agencies as well. Ms. Dokken stated that over triage should not be viewed as a negative number because patients with injuries should go to trauma centers. Dr. Heck stated that although it should not be viewed as a negative number, the acceptable rate is 25-50% and our system is at 64%. Dr. Heck agreed that although people are assessed and discharged faster, the current protocols include five determinates that are not included in the ACS criteria that deserve further examination.

Dr. Abu-Samrah stated it is important to determine whether EMS is following the criteria and that it is appropriately documented because there is a significant deviation from the national

average. Dr. Marino suggested developing a form where EMS crews can check a box to specify which criteria was met to transport a patient to a trauma center.

Ms. Hursh noted that the medics are the first experts in the field and the criteria they choose may be generally obtained from what was told to them on scene from a bystander. Dr. Abu-Samrah stated that the medics should be held accountable for the documentation.

Dr. Marino stated that patients brought to the trauma center who don't meet the TFTC criteria are not subject to trauma team activation. Dr. Fildes asked whether we have the ability to get an admitted/discharged list for each of the criteria listed. He said there are probably a large number of admissions for the anatomic and physiologic categories, and if so, the energy of the study should be invested in the mechanism category. Ms. Britt replied in the affirmative, and that in looking at mechanism only criteria, 67% of those were discharged.

Dr. Heck clarified that since the Southern Nevada Health District adopted the ACS criteria by reference it would follow that we should now change our protocols to match theirs. However, we should look at the criterion that was changed to ensure we're not missing something greater that we may lose by blindly updating our protocols.

Ms. Britt agreed with the suggestion to look at the current data and try to identify the mechanism only patients along with the five criteria not currently listed in the ACS Field Triage Decision Scheme and see if we could break that out better. She surmised that the process will be fairly labor intensive because of the way the current database is created, especially if other variables need to be discounted. A prospective study may be more feasible. It was agreed that a group will be formed to put together a prospective study and report back to the RTAB for further discussion.

D. Report on Out-of-Catchment Area Transports

Ms. Britt reported on the results of the 90-day study that took place August 1st through October 31st 2007. The purpose of the study was to describe the reasons why trauma field triage criteria patients are transported out of their assigned catchment areas. The participants included the three trauma centers, AMR, MW, BCFD, CCFD, LVFD, HFD, and EMSTS staff. The inclusion criteria were all patients who met TFTC criteria and were transported to one of the three trauma centers during the study period. The exclusion criteria were patients that did not meet TFTC criteria.

The EMSTS Office looked at all the out-of-catchment transports and provided that information to each of the transporting agencies and asked them to provide justification behind the decisions they made. This justification was broken into three categories. (1) Knowledge deficit. This included lack of knowledge of boundaries, patient request, and inappropriately assessing patients; (2) Clinical judgment; and (3) Border calls or traffic issues. During this period, the out-of-areas were 107 out of 1,611 TFTC patients or 6.6%. 28% of the out-of-areas resulted because they didn't know the boundary or were confused about the criteria. From an overall perspective, this occurred 2% of the time. Patient request was 27% of the out-of-areas or 2% of the overall number. Assessment issues occurred in 6% of the out-of-areas or less than 1% of the overall number. Border or traffic issues occurred in 23% of the out-of-areas or 2% of the overall number. About 60% of the time, it was judged to be knowledge deficit; however, Ms. Britt stated that this study was performed before the rollout of the protocols so some of the numbers are expected to drop. The TFTC protocol allows for clinical judgment and border/traffic considerations, so 40% of the time, EMS is making the decision to transport outside the catchment area and they were justified in making that decision based on the documents they've provided.

Ms. Britt stated that the EMSTS Office will continue to monitor the out-of-area transports and continue to reinforce the educational programs. She also stated that if the out-of-areas in

February are still greater than 5%; which is the threshold for tolerance, a snapshot study should be done in March requiring the EMS crew to complete a protocol deviation report.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

A. Update on EMSystem Contact

Ms. Britt reported that the Nevada State Health Division, Office of Public Preparedness has taken the lead over EMSystem. The person to contact is Kate Heeran. Ms. Britt announced that she would be e-mailing Ms. Heeran's contact information to the members so that they may contact her directly with any issues.

B. Update on Transfer of Care Data Collection Procedure

Mr. Chetelat reported that the EMSTS Office has been collecting data for over 2½ years. There are some regulatory and legislative issues still pending, but the software is being updated and should be effective January 1st.

Ms. Britt reported that a training video, Transfer of Care Data Collection Procedure, was distributed and the upgraded software should fix all the glitches that were identified over the course of the last year. Ms. Britt noted that including the trauma center data will help the hospitals as most of them have immediate offloads.

C. Report on Terrorism Injuries: Information, Dissemination and Exchange Grant

Ms. Britt stated that terrorism and mass casualty events have the potential to seriously impact public health systems and emergency medical response capability. These events present unique triage, diagnostic treatment and surge capacity challenges. The TIIDE grant is funded through the Cooperative Agreement Award from the U.S. Department of Health and Human Services and the Centers for Disease Control and Prevention. The funding is for $70,000 a year for the next three years starting September 1, 2007 until August 31, 2010. The purpose of this grant is to generate and disseminate critically needed information to prepare for and respond to terrorist events, especially explosions. The Health District will work collaboratively with the CDC and our TIIDE partners to develop a field triage protocol for mass casualties. Clinical references and blast injury training for health professionals will become best practice models for civilian injury care based on recent military experience. Dr. Jeff Hammon with ACSCOT (American College of Surgeons Committee on Trauma) is the liaison to this group.

The organizations that were funded in this grant cycle were the American Medical Association, the American Trauma Society, the American College of Emergency Physicians, the National Association of EMS Physicians, National Association of County and City Health Officials, and the Southern Nevada Health District.

Ms. Britt reported that the reason the Health District applied for the grant was to enhance the community's ability to assess current resources, plan for future needs, link data sources, provide meaningful information for the community partners, share data to assist in the revision of coordination of existing emergency management plans and to strengthen the daily operations of the EMS and trauma system and identify strategies to adapt daily operations to handle large influxes of injured patients.

The program goals in the first year are to create automated linkages and identify data sources to provide timely access to the number and types of patients who access the system. Ms. Britt announced that the data sources have been identified; it's now a matter of gaining access to them. The plan for the second year is to analyze data and assess the current baseline status for the EMS agencies, hospitals, trauma centers, who manage the transportation and emergency care of traumatically injured individuals. The plan for the third year is to develop

and disseminate relevant, timely, evidenced-based information regarding pre-hospital, hospital, and trauma care capacity and capability to provide care for these patients.

Ms. Britt remarked that the reason the Southern Nevada Health District received funding is because of the experience in working collaboratively with partners in emergency care, emergency management, and public safety communities. SNHD was identified as a model community in 2005. SNHD also has experience in dealing with real events including hotel fires, Pepcon, flash floods, and the annual New Year's Eve celebration showing capability of managing large numbers of patients. The Health District also has experience with setting up inter-operability of communications, experience with First Watch which is real-time data analysis of patterns, trends, or selected triggers in EMS dispatch data. SNHD also has experience with EMSystem. The next steps will be to work with local EMS, emergency care, and emergency management partners to achieve the goals for the community and also collaborate with national partners to meet the larger objectives of the TIIDE project.

IV. PUBLIC APPEARANCE/CITIZEN PARTICIPATION

None.

V. ADJOURNMENT

As there was no further business, Chairman Britt called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 3:33 p.m.