MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

TRAUMA PROCEDURE/PROTOCOL REVIEW COMMITTEE

MARCH 13, 2012 - 2:30 P.M.

MEMBERS PRESENT

Gregg Fusto, RN, University Medical Center
John Fildes, MD, University Medical Center
Connie Clemmons-Brown, RN, St. Rose San Martin
Kim Dokken, RN, St. Rose Siena Hospital
Sean Dort, MD, St. Rose Siena Hospital
Eric Dievendorf, EMT-P, AMR-LV
Allen Marino, MD, St. Rose Siena Hospital
Dennis Nolan, Centennial Hills Hospital
Senator Joe Hardy, MD
Mary Ellen Britt, RN, Regional Trauma Coordinator
Kelly Buchanan, MD, University Medical Center (Alt.)
Teressa Conley, RN, COO, St. Rose Siena Hospital
Michael Metzler, MD, Sunrise Hospital
Todd Sklamberg, COO, Sunrise Children's Hospital
Jo Ellen Hannom, RN, Clark County Fire Department
Kate Osti, Nevada Disability Advocacy & Law Center
Derek Cox, EMT-P, Las Vegas Fire & Rescue
Kimball Anderson, CEO, Southern Hills Hospital

MEMBERS ABSENT

Bryan Bledsoe, DO, MedicWest Ambulance
Lars Blomberg, MD, Centennial Hills Hospital

SNHD STAFF PRESENT

Rory Chetelat, OEMSTS Manager
Moana Hanawahine-Yamamoto, Recording Secretary
John Hammond, OEMSTS Field Representative
Patricia Beckwith, OEMSTS Field Representative

PUBLIC ATTENDANCE

Jennifer Renner, RN, Sunrise Hospital
Brendan Bussman, University Medical Center
Erin McMullen, Snell and Wilmer
Elizabeth Snavely, University Medical Center
Melinda Case, RN, Sunrise Hospital
Patrick Foley, EMT-P, Clark County Fire Department

CALL TO ORDER – NOTICE OF POSTING

The Trauma Procedure/Protocol Review Committee convened in the Clemens Room of the Ravenholt Public Health Center on Tuesday, March 13, 2012. Rory Chetelat called the meeting to order at 2:31 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Mr. Chetelat noted that a quorum was present.

I. PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted.

II. CONSENT AGENDA

The Consent Agenda consisted of matters to be considered by the Trauma Procedure/Protocol Review Committee that can be enacted by one motion. Any item may be discussed separately per Committee member request. Any exceptions to the Consent Agenda must be stated prior to approval.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Trauma Procedure/Protocol Review (TPPR) Committee Bylaws

At the February Regional Trauma Advisory Board (RTAB) meeting the members discussed the 2011 American College of Surgeons Trauma System Consultation Report recommendation to broaden the group of stakeholders involved in the trauma system through the creation of subcommittees. Four new standing committees were formed: the Trauma Procedure/Protocol Review (TPPR) Committee, Trauma Rehabilitation Committee, Trauma Research Committee, and Trauma Advocacy Committee. The RTAB delegated the responsibility of approving committee bylaws to each committee.

Each article of the TPPR bylaws was discussed, beginning with the purpose of the TPPR which is to assist the Southern Nevada Health District's Office of Emergency Medical Services and Trauma System, the RTAB, and the Trauma Medical Audit Committee (TMAC) in reviewing, researching, editing and/or developing new and existing procedures and/or protocols. Mary Ellen Britt advised the members that the TPPR is a standing committee and will consistently meet throughout the year to discuss trauma-related protocols and procedures. Recommendations from the committee will be reported to the RTAB for consideration and possible action. After review by the RTAB, trauma-related EMS protocols will be referred to the Medical Advisory Board (MAB) for their consideration and possible incorporation into the *Clark County EMS System BLS/ILS/ALS Protocol Manual*.

Currently, the TPPR membership consists of 19 individuals who responded to an email invitation distributed to a broad group of EMS and health care partners in the community. The composition of the membership was the first point of discussion in the bylaws and it was agreed that it would be best to have an inclusive multi-disciplinary committee representing stakeholders in the trauma system. Voting rights were also discussed.

A motion was made to have the membership include representatives from each designated trauma center, non-trauma center hospitals, permitted EMS agencies, and at-large members representing other interested stakeholders in the EMS and trauma system. One vote shall be cast by a person representing each of the designated trauma centers, two votes by persons representing two different non-trauma center hospital systems; one vote by a person representing a permitted public EMS agency, one vote by a person representing a permitted private EMS agency, one vote by a person representing a permitted non-urban EMS agency, and up to three votes by the at-large members. The motion was seconded and passed unanimously.

There will be no limitation to the number of members who can sit at the member table but voting will be limited to the number approved in the above motion. Alternates will be selected by the members. The participation of the non-trauma hospital system representatives will be limited to the UHS system, North Vista Hospital, Boulder City Hospital, and Mesa View Regional Hospital. The non-urban EMS permitted agency representative will be from Boulder City Fire Department, Clark County Fire rural services and/or Mesquite Fire & Rescue. It was also clarified that the at-large members cannot be affiliated with any of the other member groups.

There was discussion about TPPR meeting frequency and times. The time will be based on room availability and if the meeting day falls on the same day as the TMAC and RTAB, the meeting would have to be held in the morning or after the 2:30 p.m. RTAB meeting.

A motion was made to hold the meetings quarterly on the third Wednesday of the month, or more or less frequently as determined by the RTAB or TPPR. The motion was seconded and passed unanimously.

The next item discussed was the length of committee member terms and voting rights for members and their alternates. The proposed language was adopted with minor revisions.

A motion was made for members to serve a two year term, from July 1 through June 30 of the second year with no term limits and for a word change under Article III Section 5: Voting. The new language would read, "In the event that the standing member is not available, the alternate member may cast the vote." The motion was seconded and passed unanimously.

Drs. Fildes, Marino and Metzler asked for clarification of the path for moving a protocol through the subcommittee, RTAB and MAB process. Rory Chetelat responded that one of the reasons for seeking broad representation in committees from the trauma system was to encourage EMS involvement at this level so they can provide the EMS perspective. The RTAB and MAB are at the same level within the SNHD EMS & Trauma System organization. Each has different functions, RTAB advises on the regulation of the trauma side and the MAB advises on the regulation of the EMS side. The intent is to have some cross pollination between the groups. RTAB subcommittees report to the RTAB and recommendations are made to the Office of EMS & Trauma System. Those recommendations related to EMS protocols would go to the MAB for their consideration and possible action. It shouldn't be necessary for a protocol to be reviewed again by another committee before the MAB acts on it.

B. Election of Chairman and Vice Chairman

The Committee felt it would be best to table the election of a Chairman and Vice Chairman until all of the members identified in the first agenda item were in attendance.

C. Discussion of Possible Revisions to the Trauma Field Triage Criteria Protocol

The newly revised 2011 "Guidelines for Field Triage of Injured Patients" were published in the January 13, 2012 issue of the CDC *Morbidity and Mortality Weekly Report*. In the guidelines, Steps One (Physiologic criteria) and Two (Anatomic criteria) attempt to identify the most seriously injured patients and advise that these patients should be preferentially transported to the highest level of care within the defined trauma system. The National Expert Panel recommends that the highest level of trauma care should be determined by the regional/state trauma system authority and the guidelines should be adapted to fit the specific needs of the local environment. Therefore, the first question Mr. Chetelat asked the Committee was if the Level I and Level II designated trauma centers provide the same level of clinical care?

Dr. Michael Metzler commented that the only difference between Level I and Level II trauma centers is that a Level II is not required to teach or do research. Dr. John Fildes noted, historically the Level I and Level II trauma centers in Clark County have treated patients with the most common injuries in the same way with no negative outcomes. He feels the Level I and Level II trauma centers do differ in subtle ways. Level I and Level II trauma centers should supply similar or equivalent care for the most common injuries, but a Level I is charged to have a deeper group of subspecialists for things like replantations and burns and is expected to educate the next generation of doctors, nurses, technicians, and surgeons to go out and work in the community. Dr. Metzler added that the Level II trauma center has the same type of subspecialists available but noted there is a difference in capacity. He felt capacity could be addressed by adjusting the Southern Nevada Trauma Catchment Areas.

There was also discussion that a properly functioning trauma system should be able to move patients among and between trauma centers. Dr. Fildes commented it would be better if every patient, 100% of the time, found the place where they could receive their definitive care but that is probably not practical. He asked, "Do we expect patients to be delivered to the trauma center that can provide the specialty care needed or do we expect patients to be transferred between trauma centers that can provide the specialty care?" Dr. Metzler added that EMS should not be burdened with the decision of whether to transport patients to the Level I or Level II trauma centers since the expectation of patient care is the same at both facilities.

Senator Hardy made a motion to forward this Committee's intent that Level I and Level II trauma centers offer equivalent clinical care with the exception of specific specialties of care to the newly selected TPPR members at their next meeting. The motion was seconded and passed unanimously.

Mr. Chetelat explained there were three other aspects that need to be considered regarding the TFTC protocol:

1. Are we going to adopt the new 2011 "Guidelines for Field Triage of Injured Patients" as written or are we going to modify them based on the specific needs of the Clark County Trauma System?
2. Should all pediatric patients who meet TFTC be transported to the designated pediatric Level II trauma center or should they be transported to one of the three designated trauma centers in Clark County in accordance with the current EMS TFTC protocol?
3. Should the Southern Nevada Trauma Catchment Areas be modified to support all three trauma centers with regard to skills sets and trauma patient volumes?

Dr. Marino made a motion to discuss the new guidelines, the question about pediatric trauma patient transports, and catchment areas with the newly selected TPPR members at their next meeting. The motion was seconded and passed unanimously.

Ms. Britt noted the Health District's desire to move this agenda forward and asked the group if they would be willing to meet before the next RTAB meeting on April 18. Based on room availability, an email will be sent out to schedule the day/time for the next TPPR meeting.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

IV. PUBLIC COMMENT

None

V. ADJOURNMENT

As there was no further business on the agenda, Mr. Chetelat called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 4:43 p.m.