MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

TRAUMA PROCEDURE/PROTOCOL REVIEW COMMITTEE

JUNE 13, 2012 - 1:00 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
Mary Ellen Britt, RN, Regional Trauma Coordinator
Melinda Case, RN, Sunrise Hospital
John Higley, EMT-P, Mesquite Fire & Rescue
Michael Metzler, MD, Sunrise Hospital
Todd Sklamberg, COO, Sunrise Children's Hospital
David Slattery, MD, MAB Chairman
Kate Osti, Nevada Disability Advocacy & Law Center
Senator Joe Hardy, MD

MEMBERS ABSENT

Bryan Bledsoe, DO, MedicWest Ambulance
Sandra Tewell, RN, Mesa View Regional Hospital
Chief Troy Tuke, Clark County Fire Department
Teressa Conley, RN, COO, St. Rose Siena Hospital
Chief Scott Vivier, Henderson Fire Department

SNHD STAFF PRESENT

Rory Chetelat, EMSTS Manager
Michelle Nath, Recording Secretary
John Hammond, OEMSTS Field Representative
Rae Pettie, Program/Project Coordinator

PUBLIC ATTENDANCE

Erin McMullen, Snell and Wilmer
Fred Simon, MD
Derek Cox, EMT-P, Las Vegas Fire & Rescue
Frank Simone, EMT-P, North Las Vegas Fire Department

CALL TO ORDER – NOTICE OF POSTING

The Trauma Procedure/Protocol Review Committee convened in Classrooms #1 and #2 at American Medical Response – Las Vegas on Wednesday, June 13, 2012. Dr. Sean Dort called the meeting to order at 1:12 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Dr. Dort 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.

Dr. Dort asked if anyone wished to address the Committee. Seeing no one, he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

The Consent Agenda consists 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.

Approve Minutes: Trauma Procedure/Protocol Review Committee Meeting: 4/18/2012

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review & Approval of Draft Trauma Procedure/Protocol Review Committee (TPPRC) Bylaws

Mary Ellen Britt reported that the draft TPPRC bylaws were approved at the last meeting, with the exception that the Health District would clarify the process for moving items from the TPPRC to the Regional Trauma Advisory Board (RTAB) and to the Medical Advisory Board (MAB). She explained that the MAB was added into the grouping to which the TPPRC will be providing information. Recommendations from the TPPRC will be reported to the RTAB, and recommendations from the RTAB related to the Clark County EMS System BLS/ILS/ALS protocols will be reported to the MAB for consideration and possible action. Ms. Britt added that the MAB was added to Article II for the same reasons. The remaining revisions were related to formatting, along with the addition of enabling each member to designate an alternate to serve in their place should they be temporarily unable to perform the required duties.

A motion was made to approve the revisions made to the TPPRC bylaws. The motion was seconded and passed unanimously by the Committee.

B. Discussion of Draft Trauma Field Triage Criteria (TFTC) Protocol

1. Field Triage Criteria

Ms. Britt related that one of the items referred to the TPPRC from the RTAB was to begin the review of the current TFTC protocol, which is an EMS protocol. She stated that staff created a draft by inserting the language from the new CDC Guidelines for Field Triage of Injured Patients into the existing protocol to use as a starting point for discussion. She suggested the Committee begin by reading through the protocol line by line.

Dr. Metzler noted that the use of "<" and ">" signs throughout the protocol may cause confusion and that perhaps it should be spelled out. Dr. Fildes stated there was discussion on that point by the national EMS leadership panel. For example, they opted to change the verbiage "Glasgow Coma Scale is < 14" to "≤13" because those with a score of 14 were being transported to trauma centers. Dr. Metzler stated that "13 or less" would be clearer than "≤13." Rory stated that there haven't been any issues related to the use of "<" and ">" signs in the past. He agreed to take Dr. Metzler's recommendation to the MAB for consideration.

Dr. Dort asked whether the CDC guidelines have been adopted universally. Ms. Britt replied that other states are also in the process of reviewing the document and considering what action to take. The Committee agreed that the guidelines need to be adjusted to fit the needs of Clark County's EMS system. Dr. Slattery stated that recommendations from the RTAB will be presented to the MAB for their consideration.

Dr. Slattery expressed concern that elderly patients that have been injured are being seen at non-trauma hospitals and later requiring transfer to a trauma center. He indicated the language in Step 4 did not seem strong enough and that the Board should consider moving elderly trauma patients further up the triage scheme. He suggested using similar verbiage as stated in Step 4(b)(1), "Children should be triaged preferentially to pediatric capable trauma centers," to identify the at-risk elderly patients because of their pre-disposition for severe injury. Melinda

Case stated that Sunrise is looking at this as a performance improvement issue. What they are finding is when these patients are transported as a Step 4 consideration they generally meet one or more of the criteria in Step 1 or 2, or may have other special considerations, such as a history of being on an anti-coagulant. Mr. Chetelat stated that analysis of hospital discharge data from the Center for Health Information Analysis showed some elderly patients with traumatic injuries were transported to non-trauma hospitals. Dr. Dort continued the review of the Step 1 criteria.

Dr. Marino made a motion to approve Step 1 as written. The motion was seconded.

Dr. Metzler expressed concern regarding the draft language, "The pediatric patient MUST be transported to UMC, pediatric Level II center for the treatment of trauma." He stated that Sunrise Hospital is in the process of making an application for designation as a pediatric Level II center. He added that Sunrise currently has a very high capability of caring for pediatric patients, but the draft language may deter the future transport of the pediatric patient population to Sunrise until after they are designated as a Level II center for the treatment of trauma. Based on the TFTC data, Mr. Fusto questioned if Sunrise would be able to meet the volume performance criteria. Dr. Fildes commented it is the responsibility of the American College of Surgeons (ACS) to determine whether a trauma center has adequate volume. Ms. Case stated Sunrise would make sure they could meet the criteria before initiating the process. Dr. Metzler questioned how a new pediatric trauma center can come on board without the ability to have patients transported while still in the application process. Dr. Marino replied it can be accomplished through walk-in and out-of-state patient volume, similar to the stroke center destination process. Todd Sklamberg noted that Sunrise Hospital has invested over the years in a pediatric intensive care unit that is part of their trauma program and has all of the clinical and social services support to continue to provide for these patients. The concern is how to take a step back and just rely on walk-ins or out-of-state volume in order to fulfill the volume performance criteria when clinically the processes and physicians on staff are in place right now.

Commenting on the pediatric Clark County Trauma Field Triage Criteria data, Dr. Fildes reported, "In 2011, 88% of the patients were Step 3 patients; and of the patients that were in Step 1 and Step 2, several were delivered because they were unstable and in proximity of that hospital, and that would continue. And other patients that weren't directed by EMS but were brought by private vehicle would still be delivered in that manner." Dr. Metzler expressed concern that the length of time for Sunrise to get full designation will be protracted.

Dr. Marino withdrew his motion and made a new motion to approve Step 1 as written, with the exception that the last sentence read, "The pediatric patient must be transported to a designated pediatric center for the treatment of trauma." The motion was seconded by Dr. Slattery.

Questions were raised about the process involved in Sunrise Hospital becoming designated as a pediatric Level II center for the treatment of trauma. Ms. Britt outlined the process as follows: 1) Sunrise submits an application for authorization to seek designation as a trauma center which is considered for endorsement by the RTAB; 2) the RTAB recommendation regarding authorization goes to the Board of Health (BOH) for approval; 3) Sunrise takes the approval letter from the BOH to make application to the State Health Division for designation; 4) arrangements for verification through the ACS is done concurrently; and 5) the final decision for full designation is made by the State Health Division. Ms. Britt explained that the term "designated" involves having successfully gone through the entire process of authorization, verification and designation, pursuant to NAC 450B.780 to 450B.785 inclusive, in accordance with the ACS trauma center classification scheme. She noted that NAC 450B.799 defines pediatric center for the treatment of trauma as, "a facility that is designated by the administrator of the Health Division pursuant to provisions of NAC 450B.780 to 450B.785 inclusive, to provide comprehensive surgical, medical and nursing care to persons who are less than 15 years of age."

Dr. Marino withdrew his motion.

Dr. Fildes commented that he supports the growth of pediatric trauma centers in Clark County. He noted that if the draft Step 1 language was operating as stated in 2011, EMS would have delivered 42 instead of 48 patients to Sunrise.

Dr. Fildes made a motion to approve Step 1 as written, with the exception that the last sentence read, "The pediatric patient must be transported to a pediatric center for the treatment of trauma." The motion was seconded and passed unanimously by the Committee.

Dr. Dort read through Step 2 verbatim and asked if there was any discussion.

A motion was made to approve Step 2 as written, with the exception that the last sentence read, "The pediatric patient must be transported to a pediatric center for the treatment of trauma." The motion was seconded and passed unanimously by the Committee.

Dr. Dort read through Step 3(a) verbatim and asked if there was any discussion. The Committee discussed that 3(a)(2) "Children: >10 feet or two to three times the height of the child" may be ambiguous. Dr. Fildes noted that the data from the National Trauma Data Bank shows the majority of falls in children are in the first and second year of life, where standing heights are not likely to be more than three feet. So, two times the height would be about a 6-foot fall. The Committee discussed different scenarios and agreed it would be best to support "two times the height" so the child can be evaluated at a trauma center.

Dr. Fildes made a motion to approve 3(a), with the exception that 3(a)(2) read, "Children: >10 feet or two times the height of the child." The motion was seconded and passed unanimously by the Committee.

Dr. Dort read through Step 3(b) verbatim and asked if there was any discussion. Kim Dokken noted that the verbiage "High-risk auto crash" is nebulous. Dr. Marino commented that the draft language in 3(b)(4) "Vehicle telemetry data consistent with high risk of injury" should be removed because the data is not readily available. It was agreed that the TFTC protocol is a fluid document and the enabling language can be added when the technology is available.

With regard to the draft language in 3(b)(1), Mr. Fusto and Ms. Dokken discussed the presentation they witnessed regarding the stronger steel that is being used in the newer makes and models of cars. The stronger steel better protects the passenger compartment of the car and may decrease the depth of intrusion. Mr. Fusto noted that EMS needs to use discretion since they are first on scene. The Committee continued its discussion regarding the need to keep the current verbiage until the system can better assess the vehicle telemetry data. Frank Simone, a paramedic for North Las Vegas Fire Department, was asked about the need to remove the extrication verbiage that reads, "The period required to extricate the patient from the motor vehicle was more than 20 minutes." Mr. Simone felt that utilizing a timeframe of 20 minutes for extrication is a poor indicator of the acuity of the patient. John Higley agreed, and added that rollovers should also be removed from the protocol. He stated that EMS takes patient presentation into consideration more so than mechanism of injury. Dr. Slattery noted that the higher risk patient is the one who is unrestrained in a vehicle that has rolled over.

There was a motion to approve 3(b) as written, with the following exceptions: include "The motor vehicle was traveling at a speed of at least 40 miles per hour immediately before the accident occurred;" and add "unrestrained occupant of a motor vehicle rollover." The motion was seconded and passed unanimously by the Committee.

Dr. Dort read through the revised Steps 3(c) and 3(d) verbatim and asked if there was any discussion.

There was a motion to approve 3(c) and 3(d). The motion was seconded and passed unanimously by the Committee.

Dr. Dort read through Step 4 verbatim. There was discussion about the verbiage in 4(b)(1) "Children should be triaged preferentially to pediatric capable trauma centers." The consensus

was to change the verbiage to read, "Children should be triaged preferentially to a trauma center."

There was a motion to approved Step 4, with the exception that 4 (b)(1) be changed to read, "Children should be triaged preferentially to a trauma center." The motion was seconded and passed unanimously by the Committee.

Dennis Nolan asked if an exception report is utilized to capture the instances where EMS transports to a different facility than is required by protocol. Eric Dievendorf replied there are eight parameters where EMS may deviate from the trauma protocol. A report outlining the reason(s) for each occurrence must be submitted to the Health District.

Dr. Dort suggested the Health District make the necessary revisions to the TFTC protocol and bring it back for review at the next meeting. Dr. Fildes noted that the boundary for Step 1 and 2 patients between Paradise Road and the I-15 south of the airport is not included in the current UMC catchment area description. Dr. Dort added that Step 4 also needs to be included under St. Rose Siena Hospital's catchment area. Ms. Britt agreed to include those revisions to the draft TFTC protocol.

2. Review of Southern Nevada Trauma Catchment Areas

Todd Sklamberg, interim CEO of Sunrise Hospital and COO of Sunrise Children's Hospital, reported that following the release of the ACS Trauma Report recommendations the previous year, Sunrise answered the call for leadership from the trauma centers and made a commitment to participate in the design, development, evaluation, and operation of the regional trauma system as the report specified. They called upon attorneys from Snell & Wilmer to assist. Their team then contacted Dr. Brent Eastman, one of the co-founders of San Diego County's trauma system, a recognized leader in developing trauma systems throughout the US and the world. Dr. Eastman is now president-elect of the ACS and referred them to Dr. Fred Simon, today's guest speaker. Mr. Sklamberg introduced Dr. Simon, noting that he worked with Dr. Eastman for many years; and for 12 years served as the medical director of trauma at Scripps Memorial Hospital in La Jolla, California. Dr. Simon has extensive experience in the development of trauma systems, and is currently developing a trauma system for 25 hospitals in the Indian health service system.

Dr. Simon stated that he was very impressed at how the Committee is working through the TFTC protocol with collegiality and collaboration. He related that he has been working in the San Diego system, as well as in Southern California and they have been engaging in the same process. Dr. Simon stated that Sunrise Hospital asked him to evaluate the ACS report and recommendations. He reviewed some of the minutes from past RTAB and TPPRC meetings, as well as transport data and mapping. He's also looked at the catchment areas and has had the pleasure of reviewing the Level II and Level III hospitals. He's also looked at some travel time studies done by GC Wallace, including a preliminary and secondary study that looks at the time relationship from the catchment areas to the appropriate trauma centers. He stated that the ACS' focus question directed to most systems is to look at volume in relationship to quality and expertise. Also, they want to ensure that all the hospitals that participate continue to have appropriate volumes so that their expertise stays at the level that remains top quality for everyone in the institution. The patient is the primary concern; quality is the number one concern for everyone, at every level. He is also looking at the growth of the community. As the community continues to grow, how does the community accommodate the volume? How does that work with the catchment areas? With the quality that comes from appropriate response times at the scene, transport time, and the care of the patient at the trauma centers? Dr. Simon stated he has been looking at all of those things. He would like to look at more data and spend more time with the community and make some very independent, objective recommendations to Sunrise Hospital and Dr. Metzler in relationship to things he has seen and has done elsewhere. He stated that he appreciates the opportunity to work with everyone in this setting.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

The Committee agreed to meet again on August 15th at 1:00 p.m. Mr. Chetelat stated the location will be announced at a later date. Ms. Britt thanked Eric Dievendorf and American Medical Response for offering their building as a venue for meetings. Ms. Britt also announced the first Trauma Rehabilitation Committee meeting will be held on June 20th at 8:00 am.

IV. 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.

Dr. Dort asked if anyone wished to address the Committee. Seeing no one, he closed the Public Comment portion of the meeting.

V. ADJOURNMENT

As there was no further business on the agenda, Dr. Dort called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 2:26 p.m.