MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

REGIONAL TRAUMA ADVISORY BOARD

November 19, 2008 - 2:30 P.M.

MEMBERS PRESENT

Mary Ellen Britt, RN, Chairman
Jay Coates D.O., University Medical Center (Alt.)
Susan Hilger, General Public Representative
Larry Johnson, EMT-P, MedicWest
Michael Metzler, M.D., Sunrise Hospital
Melinda Hursh, RN, Sunrise Hospital
Allen Marino, MD, MAB Chairman
Kim Dokken, RN, St. Rose Hospital
William Wagnon, MountainView Hospital
Sean Dort, MD, St. Rose Hospital
Dan Petcavage, RN, University Medical Center (Alt.)
Deborah Kreun, ThinkFirst-NV
Brian Rogers, EMT-P, Henderson Fire Dept

MEMBERS ABSENT

John Fildes, MD, University Medical Center
Scott Cassano, Health Plan of Nevada
Gregg Fusto, RN, University Medical Center

SNHD STAFF PRESENT

Rory Chetelat, EMSTS Manager
Moana Hanawahine-Yamamoto, Recording Sec.
Joseph J. Heck, D.O., Operational Medical Director
Mike Bernstein, SNHD Health Educator

PUBLIC ATTENDANCE

Robert Byrd, EMT-P, AMR-Las Vegas
Christy Gray, EMT-P, AMR-Las Vegas
Scott Cinelli, University Medical Center
Donald Hales, EMT-P, MedicWest
Jeremy Hardcastle, EMT-P, AMR-Las Vegas

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, November 19, 2008. Chairman Mary Ellen Britt called the meeting to order at 2:30 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.

Approve Minutes/Regional Trauma Advisory Board Meeting: 9/17/08

Chairman Britt asked for approval of the minutes of the September 17, 2008 meeting. A motion was made, seconded and passed unanimously to approve the minutes as written.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Analysis of 2008 Clark County Trauma System Report Data

There was an overview of the different data sources that were discussed in the report.

CDC National Death data (2005)

- Age group 1-44 years – Leading cause of death was unintentional injury
- Age group 1-14 years – 4th leading cause of death was homicide
- Age group 10-14 years – 3rd leading cause of death was suicide

CDC Nevada Death data (2005)

- Age group 1-44 years – Leading cause of death was unintentional injury
- Age group 1-4 years and 5-9 years – 2nd leading cause of death was homicide
- Age group 10-14 years – 3rd leading cause of death was suicide

CDC National Nonfatal Injury data (2005)

- Leading cause was falls except in the age group 15-24 years which was unintentional struck by or against

National Trauma Data Bank (National data 2002-2006 and Clark County 2006)

- Incidents by age and gender were similar
- Incidents by intent – Leading cause was unintentional; Clark County data showed a higher percentage in assaults than at the national level
- Top 8 incidents by mechanism of injury – Leading cause was motor vehicle traffic; 2nd leading cause was falls in the national data but falls, firearms, cut/pierce, and other transport spread out somewhat equally in the Clark County data
- Case Fatality Rate by intent – Leading cause was self-inflicted
- Top 8 fatalities by mechanism of injury – Leading cause was motor vehicle, traffic.
  - Nationally – 2nd leading cause was falls and 3rd leading cause was firearms
  - Clark County – 2nd leading cause was firearms and 3rd leading cause was falls

State of Nevada data (2000-2004)

- Most recent data available from the State.
- Deaths by Gender – Males 72% and Females 28%
- Race/Ethnicity data was only given as raw numbers. 16% of the injured were from out of state. The race/ethnicity demographics for these individuals were not available.
- Deaths due to Injury – 59% of those injured were from Clark County

Center for Health Information Analysis (CHIA) data (2007)

- This is the inpatient data for injuries. CHIA had a total of 16,468 patients while the trauma registry had a total of 5,497.
- Medicare covers 31% of the trauma patients. The high percentage was attributed to the high number of patients who are 65+ years. It was noted that hip fractures are considered trauma in the CHIA data.

Trauma Field Triage Criteria (TFTC) data (2007)

- Transports to Trauma Centers – 72% UMC, 17% Sunrise and 11% St Rose-Siena
- Transports by TFTC Category – 5% Physiological, 12% Anatomical and 83% Mechanism
- Transports by Disposition (primary disposition from trauma resuscitation) – 62% Discharged, 18% Admitted, 6% OR, 12% ICU, 1% Deceased and <1% Transferred

Clark County Trauma Registry data (2007)

- These were patients who were admitted to the hospital, died as a result of their injuries at the hospital or were trauma activations at the trauma centers.
- Patients by Trauma Center – 59% UMC, 21% Sunrise and 20% St Rose-Siena

- Patients by Gender – 72% Males and 28% Females
- 83% Penetrating trauma and 17% Blunt trauma
- Patients by Mode of Arrival from Scene – 80% Ground, 11% Walk-in, 9% Air and <1% Other
- Transfers from Another Healthcare Facility by Referring Facility Location – 37% Arizona, 35% Clark County, 17% Other Nevada, 8% Utah and 3% California; Mode of arrival 56% Air and 43% Ground
- Patients by Disposition – 25% Home from the ED, 59% Home from Hospital, 6% Rehab from Hospital, 2% Skilled nursing facilities, long term care and nursing homes and 5% Deceased

Clark County Coroner's data (2007)

- Trauma Deaths by Gender – 75% Male and 25% Female
- Unable to do the race/ethnicity breakdown for out of state residents
- Leading causes of death – 1st Firearms, 2nd Motor vehicle and 3rd Falls

One of the most important limitations of the first trauma system report was the lack of consistency in trauma data collection at the national, state and local levels. Variability was noted in disease classification coding, case definitions, and inclusion criteria among the organizations that collect injury data. Currently, we are gaining cooperation with a few of our data sources to have access to the raw data which will give us a better opportunity to analyze the data rather than relying on the analysis given to us.

Dr. Metzler was surprised that only 6% of trauma patients go to a rehabilitation facility from the hospital. The feeling was that most patients do not have the opportunity to go to a rehabilitation facility due to insurance limitations and/or no other financial source of payment.

It was also clear that prevention was an area that needed attention. The Coroner's data showed 56% of all trauma deaths in Clark County were on scene. These patients did not even make it to a treatment center. Yet, in the Clark County Trauma Registry data there is only a 5% mortality rate out of the trauma patients who were treated at a trauma center. Dr. Metzler also mentioned that the TMAC will be drilling down all of the trauma deaths within a twelve month period with the hope of identifying specific areas for prevention.

B. Review of Trauma Transport Data

The trauma transport data for September and October 2008 as well as the trend line analysis from October 2007 to October 2008 were reviewed. Ms. Britt reported that the trauma patient volume has increased from 393 to 486.

The out of area (OOA) transports were 6.1% for both months. If the OOA transports are greater than the Board's tolerance of 5%, the EMS agencies will be asked to provide additional information regarding why the call was transported outside of the catchment area as defined by the TFTC protocol.

In the month of August, there were 29 OOAs. Ms. Britt provided the information from the EMS agencies. Their reasons were standardized to make the reporting easier.

- Clinical Judgment – 14%
- Knowledge deficit (boundaries and/or criteria) – 14%
- Patient request without a signed AMA form – 24%
- Traffic – 17%
- Multiple family members – 7%
- Difference between prehospital and trauma center patient assessment – 3%
- Border calls (< 1 mile from boundary) – 3%

Ms. Britt added that there were two remaining calls but the transporting agencies could not be identified.

Based on the information gathered from the August OOAs, Larry Johnson, Brian Rogers and Dr. Marino all agreed that if the EMS agencies focus on re-education of the TFTC protocol and catchment areas, the overall OOA would be below the Board's 5% tolerance.

C. Demonstration of Quicnet Data Collection Process

American Medical Response and MedicWest ambulance instituted Quicnet, a quality assurance tool that will provide more timely access to EMS data. They submitted preliminary data reports to the Health District, University Medical Center Trauma and Sunrise Trauma for review as they continue to work on refining the data.

Dr. Allen Marino noted that inconsistencies have been detected and that they have assigned a person from each agency to review every chart with the bubble sheet to see if there is a problem with the software or an input error from the crews. Don Hales has also been working on a procedure manual for the crews which will define each field on the form.

Ms. Britt advised that once this data has been refined it will be very useful in finding the unknown locations on the TFTC data as well as providing information on the out of area transports. She also mentioned that it would be helpful if the crews would check the Trauma Triage option on the form regarding the reason for transport to simplify the identification of a trauma patient. Currently, the crews have the option to choose protocol or trauma triage and both of these selections are correct.

D. Report on Southern Nevada Injury Prevention Partnership Meeting (SNIPP)

SNIPP held its quarterly meeting in the month of October. The Clark County Child Death Review was reported by Tara Phebus from the Nevada Institute for Children's Research and Policy at the University of Nevada, Las Vegas. Ms. Britt presented the 2008 Clark County Trauma System report at this meeting as well. Deborah Kreun mentioned that the group was pleased that prevention was mentioned in the trauma report. Ms. Kreun stated that the next meeting will be in January and her hope is to have specific areas in prevention to focus on in 2009 from the trauma system's perspective.

Mike Bernstein indicated that due to the reorganization in the Nevada State Health Division, Andrea Rivers is the new person in charge of the Injury Prevention Task Force.

E. Discussion of Draft Conflict of Interest Policy

Mr. Chetelat reported that the Medical Advisory Board asked if it was necessary to have the Board members sign a conflict of interest statement. After some research, the Health District's legal counsel identified that Nevada Revised Statutes (NRS) chapter 281A entitled "Ethics in Government" covers conflict of interests for members of a Board. It was also determined that any person speaking under public comment do not have to disclose if he/she has a conflict of interest. Conflicts of interest statements only apply to voting members making decisions in a regulatory position. The Office of Emergency Medical Services and Trauma System is discussing the possibility of including a conflict of interest statement in the EMS and Trauma Regulations.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

Community Needs Assessment of Physical Rehabilitation Services

Desert Canyon Rehabilitation hospital mailed out a survey to various members of the community asking about the rehabilitation needs in the community. Since we have identified that accessing rehabilitation services in this community is a problem, Ms. Britt wanted to make sure that the trauma centers received the survey.

IV. PUBLIC COMMENT

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 3:18 p.m.