MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

REGIONAL TRAUMA ADVISORY BOARD

January 19, 2011 - 2:30 P.M.

MEMBERS PRESENT

Kim Dokken, RN, Chairman, St Rose Siena Hospital
Kimball Anderson, Southern Hills Hospital
John Fildes, MD, University Medical Center
Gregg Fusto, RN, University Medical Center
Sean Dort, MD, St. Rose Siena Hospital
Yvonne Smith-Hoch, Rehab Without Walls
Barbara Christiansen, Health Services Coalition (Alt.)
Mary Ellen Britt, Regional Trauma Coordinator
Troy Tuke, EMT-P, Clark County Fire Dept
Melinda Case, RN, Sunrise Hospital
Michael Metzler, MD, Sunrise Hospital
David Slattery, MD, MAB Chairman
Wilbert Townsend, SNHD – Epidemiology

MEMBERS ABSENT

Larry Johnson, EMT-P, MedicWest Ambulance
Melissa Vaher, General Public Representative
Leslie Johnstone, Health Services Coalition

SNHD STAFF PRESENT

Rory Chetelat, OEMSTS Manager
Moana Hanawahine-Yamamoto, Recording Sec.
Mike Bernstein, SNHD Chronic Disease Prevention and Health Promotion

PUBLIC ATTENDANCE

Teressa Conley, RN, St. Rose Siena Hospital
Minta Albietz, RN, Sunrise Hospital
Robert Reynoso, RN, Centennial Hills Hospital
Todd Sklamberg, COO, Sunrise Children's Hospital
Abby Hudema, RN, University Medical Center
Brian Rogers, EMT-P, Henderson Fire Department
Deborah Kuhls, University Medical Center

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, January 19, 2011. Chairman Kim Dokken called the meeting to order at 2:37 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Chairman Dokken noted that a quorum was present.

I. CONSENT AGENDA

Chairman Dokken 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: 10/20/10

Chairman Dokken asked for approval of the minutes from the October 20, 2010 meeting. A motion was made, seconded and passed unanimously to approve the minutes.

II. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Sunrise's Application for Renewal of Authorization as a Level II Center for the Treatment of Trauma

Sunrise submitted their application for renewal of authorization as a Level II center for the treatment of trauma and the Health District reviewed their application to determine their compliance with the trauma regulations. Dr. John Fildes asked if the Health District has a plan to monitor the trauma system's resources. Mary Ellen Britt advised that in the Spring of 2010, an expert panel reviewed the data available and determined there was no need to expand the trauma system at the time and the Health District would continue to monitor that data.

Kimball Anderson made a motion to approve Sunrise's Application for Renewal of Authorization as a Level II Center for the Treatment of Trauma. The motion was seconded and passed. Dr. Fildes abstained from the motion.

Mary Ellen Britt mentioned that she will be presenting Sunrise's application to the Board of Health for their approval on Thursday, February 24 at 8:30 a.m.

B. Discussion of Pediatric Trauma Field Triage Criteria Transport Destination

Gregg Fusto remarked that the University Medical Center (UMC) is the only designated pediatric trauma center in Clark County and wanted to discuss the possibility of having a pediatric trauma destination protocol. Currently, all trauma field triage criteria (TFTC) patients (regardless of age) transported by EMS are taken to one of the trauma centers in accordance with the catchment areas in the TFTC protocol. All pediatric patients who do not meet TFTC and are transported by EMS must go to one of the approved facilities listed in the pediatric patient destination protocol.

Dr. John Fildes expressed his concern that if the volume of pediatric trauma patients continues to decline, UMC may lose their ability to be verified and designated as a Pediatric Level II trauma center by the American College of Surgeons (ACS). In 2001, UMC received 350 pediatric trauma admissions and was urged by ACS to consider becoming a designated pediatric trauma center. UMC submitted their application and became designated as a Pediatric Level II trauma center in 2007. Dr. Fildes advised there was a 58% decrease in pediatric trauma admissions from 2001-2010 and a 52% decrease in pediatric transfers from 2003-2010 at UMC. UMC submitted the most recent census data for the Clark County pediatric population and the graph showed no significant change but Dr. Fildes noted that the Clark County School District enrollment had increased. Dr. Fildes advised that he was asked by the ACS review team to propose a pediatric destination where pediatric trauma patients were preferentially transported to the verified designated center for pediatric trauma. Dr. Fildes explained that he brought this issue to the Board to create a framework of questions that can produce decision-making data. If UMC's pediatric trauma admissions fall below 100, they will not be re-verified or re-designated as a pediatric trauma center. Troy Tuke agreed that it is important to protect the viability of the trauma centers and felt it would be beneficial to have a pediatric trauma destination protocol.

Todd Sklamberg, Chief Operating Officer for Sunrise Children's Hospital, explained that Sunrise provides a high level of care for children in Clark County and has dedicated a substantial amount of resources for the treatment of injured children. Sunrise was commended by ACS for their expertise in pediatric trauma and Mr. Sklamberg noted that Sunrise virtually had all of the resources in place for pediatric designation. It was noted that the national field triage decision scheme stated children should be triaged preferentially to pediatric-capable trauma centers. Dr. Michael Metzler clarified that the national field triage decision scheme stated transport to the appropriate level of care and not to the highest level of care. Dr. Metzler also added that Sunrise only receives 25% of the geographical area for trauma transports. Mr. Sklamberg advised Sunrise was opposed to modifying the protocol to include pediatric trauma destination.

Are these pediatric trauma patients being treated at non-trauma centers? Rory Chetelat stated that if pediatric patients are being transported to a non-trauma center by private vehicle, these transports would be out of the control of the Health District and EMS. Have the number of pediatric patients transported to pediatric emergency departments increased? One of the greatest challenges the Health District faces in analyzing system utilization is the lack of important information. Mary Ellen Britt stated that the data for both questions are not available because the State does not have a functioning trauma registry and EMS is unable to provide this information as well. Ms. Britt advised that the Office of Epidemiology has also encountered limitations with the Center for Health Information Analysis (CHIA) and National Trauma Data Bank (NTDB) data. The CHIA data is de-identified and the use of ICD-9 codes is not sensitive enough to filter out duplicate records. Dr. John Middaugh, Director of Community Health, is an experienced epidemiologist and Ms. Britt advised that he is concerned about using the CHIA data for decision-making. There also seems to be some inconsistencies in the 2007, 2008 and 2009 NTDB data; therefore, making it difficult to trend. Ms. Britt added that the NTDB data does not include data from non-trauma centers. Data analysis at the Health District has been on-going and new data sources have become available but it is important that the data is clean and validated.

Rory Chetelat noted that if there continues to be limitations in the data analysis, the Health District is considering the option of having a follow-up ACS visit to assist with the assessment of the decline in trauma patient volume and to create evidence-based strategies to address the related issues.

Dr. Fildes advised that the lead agency in charge of the trauma system may need to begin to look into contracting the system as a possibility. He also reiterated that even without the data, he would like this issue to be on the next agenda and will make a motion for a vote to be taken.

A motion was made to create a workgroup with representation from the Medical Advisory Board (MAB) and Regional Trauma Advisory Board (RTAB) to review the data available and to report back to the RTAB. The motion was seconded and passed unanimously.

Ms. Britt asked that all interested participants email the Office of Emergency Medical Services and Trauma System (OEMSTS).

C. Discussion of Difference Between Mass Casualty Incident (MCI) and Multiple Casualty Incident

When an all hospital call is given, the notification of a potential MCI does not differentiate between mass casualty incident and multiple casualty incident. Dr. Metzler expressed the importance of knowing the difference between a mass casualty incident and a multiple casualty incident because internally, each incident has their own operational procedures. A mass casualty incident may require a hospital to discharge patients who are able to leave.

Mr. Chetelat explained that the Incident Command System (ICS) defines a MCI as anything that overwhelms the initial resources on-scene. It may also take some time before the Incident Commander can assess the situation and report back definitive patient numbers. Mr. Tuke explained that an emergency operations center (EOC) is activated when there are more than 50 patients. Dr. David Slattery suggested it would be best to set the threshold at 50 patients or more for a mass casualty incident because it make it easier for dispatch to relay if an EOC had been activated or not.

Ms. Dokken noted this would be a change in communication between dispatch, EMS and the hospitals. Mr. Chetelat added that the Health District has been tasked with reviewing the EMS section of the Clark County Emergency Plan over the next six months and asked that the Board allow that plan to develop. He also asked Mr. Tuke to inquire about when MCI alerts are given by dispatch and the possibility of communicating patient numbers once the incident has been assessed.

D. Update on Transfer of Radiological Studies Between Healthcare Facilities

There are issues with delays in care and additional expenses incurred when radiological studies performed at the sending facility need to be repeated because they were unable to view the imaging at the receiving facility. The memorandums of understanding (MOU) have been received from UMC and St. Rose Siena and the office is waiting for Sunrise's MOU. The hope is that if the problem with viewing medical imaging can be resolved within the three trauma centers, the proof of concept can be used for the other hospitals in Clark County and out of state.

E. Discussion of Revision to Notification Process for Declaration of TO/ID in Trauma Bypass Plan

The trauma bypass plan requires a trauma center who has declared a trauma overload (TO) to notify all of the dispatch centers as well as the other two trauma centers. This notification process consists of nine phone calls that need to be made during a time when the trauma center is extremely busy. The trauma program managers asked if it would be possible to make only one phone call for the dispatch centers rather than seven. Mr. Tuke remarked about the difficulty of changing processes in the fire alarm office (FAO) especially with the lack of participation by the hospitals in the all call radio check days. Ms. Dokken acknowledged the importance for all of the hospitals to participate and requested that this issue be taken to the Emergency Department (ED) Nurses' Meeting. She also encouraged the hospital administrators to support their personnel to attend those meetings.

F. Review of Trauma Transport Data

As requested by Dr. Fildes, the trauma transport data has been separated out into adult and pediatric (less than 15 years of age) patients. There was a problem with the formula in the month of August so that information will be forwarded to the Board after the meeting.

The out of area (OOA) percentage for July was 7.6% and 5.8% in August. EMS agencies will be required to provide justification for the OOA transports in July and August and the data will be reported back to the Board when all of the justifications have been provided to the office. Dr. Fildes requested a review of the trauma catchment map at the next meeting.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

Report on Southern Nevada Injury Prevention Partnership (SNIPP) Meeting

Wilbert Townsend advised the last meeting was held on January 13, 2011 and one of the discussions was about the annual drowning prevention campaign. Since the implementation of the prevention campaign, there has been a decline in the number of mortalities. Mike Bernstein noted that the national drowning death rate is approximately 3 and the number locally is about 4.9. There have been some budget shortfalls but Mr. Bernstein stated that even with the front loading advertising last year, the actual submersion incidents into the 911 system was significantly lower than the previous year. Finally, the Office of Epidemiology is preparing the report about injury and mortality in Clark County. The next meeting is scheduled for April 14, 2011.

IV. PUBLIC COMMENT

None

V. ADJOURNMENT

As there was no further business on the agenda, Chairman Dokken called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 3:35 p.m.