MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

REGIONAL TRAUMA ADVISORY BOARD

November 16, 2011 - 2:30 P.M.

MEMBERS PRESENT

Gregg Fusto, RN, Chairman, University Medical Ctr
John Fildes, MD, University Medical Center
Kim Dokken, RN, St. Rose Siena Hospital
Sean Dort, MD, St. Rose Siena Hospital
Eric Dievendorf, EMT-P, AMR-LV
David Slattery, MD, MAB Chairman
Kimball Anderson, Southern Hills Hospital
Linn Billingsley, Rehabilitation Services Representative
Mary Ellen Britt, Regional Trauma Coordinator
Melinda Case, RN, Sunrise Hospital
Michael Metzler, MD, Sunrise Hospital
Mike Bernstein, SNHD – OCDPHP (Alt.)
Brian Rogers, EMT-P, Henderson Fire Dept. (Alt.)
Melissa Vaher, General Public Representative
Leslie Johnstone, Health Services Coalition

MEMBERS ABSENT

Scott Vivier, EMT-P, Henderson Fire Dept. (HFD)
Wilbert Townsend, SNHD – Epidemiology

SNHD STAFF PRESENT

Lawrence Sands, DO, MPH, Chief Health Officer
John Hammond, OEMSTS Field Representative
Moana Hanawahine-Yamamoto, Recording Secretary
Rory Chetelat, OEMSTS Manager
Patricia Beckwith, OEMSTS Field Representative
Kelly Buchanan, MD, EMS Fellow

PUBLIC ATTENDANCE

Melody Talbott, RN, University Medical Center
Elizabeth Snavely, University Medical Center
Karyn Rae Doddy, MD, PM&R
Neal Tomlinson, Sunrise Hospital
Allen Marino, MD, St Rose Hospital
Andrea Pernell, MD
Teressa Conley, RN, St. Rose Siena Hospital
Stephen Johnson, EMT-P, MedicWest Ambulance
Jennifer Renner, RN, HCA
Christopher Mowan, COO, Sunrise Hospital

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 16, 2011. Chairman Gregg Fusto called the meeting to order at 2:33 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Chairman Fusto noted that a quorum was present.

I. PUBLIC COMMENT

Members of the public are allowed to speak on Action items after the Board's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Board 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 Board on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Board on behalf of the group. Once the action item is closed, no additional public comment will be accepted.

II. CONSENT AGENDA

Chairman Fusto 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: 10/19/11

Chairman Fusto asked for approval of the minutes from the October 19, 2011 meeting. A motion was made, seconded and passed unanimously to approve the minutes.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Prioritizing Recommendations from the American College of Surgeons' (ACS) Clark County Trauma System Report

1. Creation of Short Term Goals
2. Creation of Long Term Goals
3. Creation of Financial Impact Goals

Dr. Lawrence Sands thanked everyone for their participation in the ACS consultation visit in July. Dr. Sands felt ACS recognized how well Clark County was developing as a trauma system. There are a number of recommendations. The Board must focus on what is best for the trauma system as a whole and must help rebuild the relationship and trust among all of the trauma system partners.

Mr. Chetelat explained that the Health District organized all of the ACS recommendations from the 109 page document and outlined them into general themes with comments. The recommendations highlighted in red are items that require funding. Mr. Chetelat advised the Board members to review the recommendations and prioritize them into short-term, mid-term or long-term goals. Mr. Chetelat reminded the Board to be realistic about the time frame when assigning the priority for each recommendation. Short-term goals should be accomplished within 12 months. Mid-term goals should be accomplished between 13-36 months and long-term goals should take 37+ months and some will probably require funding. All of the members' prioritizations will be compiled into a consensus document and reviewed at the next meeting in January 2012.

A motion was made to categorize all of the ACS recommendations into short-term, mid-term and long-term goals. The motion was seconded and passed unanimously.

Mary Ellen Britt added that the handout would be emailed to the Board members.

B. Discussion of Possible Revision to the Regional Trauma Advisory Board (RTAB) Membership

1. Creation of Sub-Committees
2. Creation of Workgroups
3. Creation of Stakeholder/Advisory Groups

ACS suggested integrating additional stakeholders into the RTAB. Examples included individuals from disaster preparedness, aeromedical services, pediatric professionals, the media and elected officials or other affiliated government agencies. Ms. Britt explained additional members could be added to the RTAB and/or the membership could be expanded through the use of subcommittees.

ACS also suggested, for example, research and rehabilitation subcommittees. Workgroups could be utilized as well. Subcommittees would have ongoing responsibilities while workgroups would be task driven with defined timelines. Currently we have the Trauma Medical Audit Committee (TMAC), the Pre-TMAC review team, the Trauma Registry User Group and the Southern Nevada Injury Prevention Partnership committee.

Dr. Michael Metzler felt the prioritization of the ACS recommendations needs to be completed before subcommittees and/or workgroups can be formed. The need for specific subcommittees and/or tasks for workgroups will be determined by the consensus document.

Michael Bernstein noted that he would utilize the recommendations from the prevention and outreach section to develop a survey to help re-energize the SNIPP members. These recommendations could be delegated to a workgroup to investigate.

C. Discussion of Medical Advisory Board Process for Revisions to the Trauma Field Triage Criteria Protocol

Dr. David Slattery provided the Medical Advisory Board's (MAB) timeline for the annual revisions to the Clark County EMS System BLS/ILS/ALS Protocols. Every January, the Drug/Device/Protocol subcommittee begins to review the protocol manual and separates them into three bundles. The committee meets on the first Wednesday of every month and their recommendations are reported back to the MAB in June or July for their final approval. The new protocols will then become effective in January of the following year.

Dr. Metzler voiced his concern about not having adequate input regarding trauma related prehospital protocols and noted that the ACS recommended having a trauma representative on the MAB. Dr. Slattery mentioned that most of the work regarding protocol revisions is completed at the subcommittee level and advised that there is always an open invitation for participation on the Drug/Device/Protocol subcommittee. In the past, the MAB has referred all trauma protocols to the RTAB for their input and consideration and Dr. Slattery advised that this practice will continue.

D. Review of Trauma Transport Data

The out of area (OOA) EMS transports percentage for September was 2.4%. Ms. Britt commented the Computer Aided Dispatch notes advising the EMS crews about which trauma center to transport to based on their location may have contributed to the increased compliance with the Trauma Field Triage Criteria (TFTC) catchment areas.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

Dr. Slattery mentioned that his agency has identified the need for special consideration of geriatric patients with low energy mechanism injuries and are in the process of educating their EMS personnel on the importance of transporting these patients to a trauma center. The trauma centers were in agreement that trauma center involvement is needed earlier than later in this population. Dr. Fildes added that it is also important to recognize mental status changes in all patients with low energy mechanism injuries. This mental status change could be attributed to a physiological or anatomical criteria in the TFTC thus warranting transport to a trauma center. Kim Dokken stated her support of adding Step 4 into the TFTC protocol so there will be additional consideration for specialty patient populations and will continue this discussion in the appropriate subcommittee or workgroup.

IV. PUBLIC COMMENT

None

V. ADJOURNMENT

As there was no further business on the agenda, Chairman Fusto called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 3:12 p.m.