MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

TRAUMA PROCEDURE/PROTOCOL REVIEW COMMITTEE

SEPTEMBER 11, 2013 - 2:00 P.M.

MEMBERS PRESENT

Sean Dort, MD, Chairman, St. Rose Siena Hospital
Kim Dokken, RN, St. Rose Siena Hospital
John Fildes, MD, Vice Chairman, University Medical Center
Gregg Fusto, RN, University Medical Center
Melinda Case, RN, Sunrise Hospital
Todd Sklamberg, COO, Sunrise Hospital
Allen Marino, MD, St. Rose Siena Hospital
Eric Dievendorf, EMT-P, AMR-LV
Jo Ellen Hannom, Clark County Fire Department
Kate Osti, Nevada Disability Advocacy & Law Center

MEMBERS ABSENT

Senator Joe Hardy, MD
Chris Fisher, MD, Sunrise Hospital
Chief Scott Vivier, Henderson Fire Department
Chief John Higley, EMT-P, Mesquite Fire & Rescue
Dennis Nolan, Centennial Hills Hospital
Connie Clemmons-Brown, RN, St. Rose San Martin
Amanda Munson, RN, Boulder City Hospital
Sandra Tewell, RN, Mesa View Regional Hospital

SNHD STAFF PRESENT

Mary Ellen Britt, RN, Acting EMS Manager
Christian Young, MD, EMSTS Medical Director
John Hammond, EMS Field Representative
Brandon Bowyer, EMS Field Representative
Michelle Nath, Recording Secretary

PUBLIC ATTENDANCE

Daniel Llamas, Sunrise Hospital

CALL TO ORDER – NOTICE OF POSTING

The Trauma Procedure/Protocol Review Committee convened in Conference Room 2 at SNHD, 330 S. Valley View Boulevard, on Wednesday, September 11, 2013. Chairman Sean Dort, MD called the meeting to order at 2:06 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 (TPPRC) 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: 10/11/2012

Dr. Dort asked for a motion to approve the minutes of the Trauma Procedure/Protocol Review Committee meeting from October 11, 2012. Member Dokken motioned for approval; the motion was seconded by Member Fusto and carried unanimously.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of 2013 Clark County Trauma System Self Assessment Report

Mary Ellen Britt gave a brief overview of the Clark County Trauma System assessment as most of the Board members were active participants of that process which occurred in April. She reported the sixteen indicators that were identified by the American College of Surgeons during their July 2011 consultation visit were utilized as the indicators for the 2013 trauma system assessment. She referred to a handout which listed those indicators and informed the members that discussion will focus on the ones which scored two or lower as recommended by Dr. Fildes during the last Regional Trauma Advisory Board (RTAB) meeting. The scores were to serve as a trigger for facilitating the discussion about developing action steps in those areas in need of improvement.

Indicator 102.2, injury surveillance is coordinated with statewide and local community health surveillance, received a 2.0 score. It was noted that the State trauma registry had not been fully operational since 2007 and currently there is no update from the State as to who is responsible for the trauma registry. Todd Sklamberg raised the question as to whether or not this was related to a funding issue. Dr. Fildes responded there have been a rotation of people overseeing the registry and there has not been a successful attempt to create a statewide registry report. Ms. Britt added there was an attempt to pass Senate Bill 205 (SB205) in the last legislative session but the bill did not pass out of the Senate Finance Committee. The bill was seeking sustainable funding for the State Health Division to fund the trauma registry. She reported funding was one reason for the lack of a functioning registry. She was advised that the State was using monies from a hospital preparedness grant to fund the registry. While there has been no success at the State level to operationalize the registry, Ms. Britt recognized the trauma centers in Southern Nevada have been cooperative and have provided the Health District with a subset of their trauma registry data. This has given the Health District the ability to review the trauma centers' performance however the non-trauma hospitals cannot be evaluated which creates an issue for assessing the entire system.

Dr. Marino commented that the submission of data is denoted in State legislature yet there is no mechanism for submitting it. Ms. Britt agreed the NRS and NAC define the parameters pertaining to the submission of data and furthered there has been conflicting reports as to whether or not the non-trauma hospitals have been successful in uploading their data to the State. She remarked there is no one currently available to clean the data, analyze it or generate reports and there has not been a statewide trauma data report since 2006. Kim Dokken recommended the Trauma System Advocacy Committee (TSAC) proceed with efforts to refine SB205 and to utilize the two year time frame to prepare for the next legislative session. Ms. Britt replied the TSAC convened the month prior and discussed educating the legislators on the value of the trauma system followed by the importance of a functioning State trauma registry. The talking points identified by the Trauma Association of America (TAA) were identified as a tool to be utilized in the education process. However, they will need to be modified to reflect those issues pertinent to Nevada because the TAA used national data to frame their points.

As discussion ensued it was noted that another action item will be to gain the support of the Nevada Hospital Association (NHA). Ms. Britt informed the Board that during the first Senate hearing the

NHA didn't directly oppose SB205 but they were not supportive either and tried to amend the language which would have been in contradiction to the bill's initial intent. The amendment would have changed the NRS to no longer require non-trauma centers to submit data to the State. Melinda Case suggested communicating with the lobbyists for the NHA and targeting them as another focus group. Educating the lobbyists in conjunction with legislators would be beneficial. Ms. Britt reported that lobbyists for University Medical Center as well as the Health District assisted with damage control following Bill Welch's testimony in order to address some of the issues that arose following the initial hearing. While the bill moved out of the Senate Health and Human Services Committee to the Senate Finance Committee, the bill did not pass. Mr. Sklamberg, a member of the NHA Board, informed the committee of an upcoming NHA Board meeting in October to discuss legislative priorities. He remarked this would be an opportune time to frame the discussion for SB205. Ms. Dokken concluded that these action steps were to be delegated to the Advocacy Committee.

The second indicator, 102.3, measured if trauma data are electronically linked from a variety of sources. The score was 1.9. While intermittent funded projects have demonstrated proof of concept in some areas, results have not been generalized. Dr. Marino posed the question if this indicator was referring to real time patient data or surveillance data. Ms. Britt responded the indicator refers to the ability to link various data sources, like EMS pre-hospital records, inpatient records and crash data. She explained that there are many data sources but they exist in silos. Dr. Fildes expanded on this concept with the example of the drowning data. If a child expires as a result of a drowning incident then he or she is transported to the medical examiner's facility. However, if that child is sent to a hospital then an in-patient record is generated. There may also be a near drowning patient that might be transported to a hospital and is treated and discharged. While a record will be generated for the near drowning patient, if there's no ability to link the different data sets then determining the denominator for children drowning, or near drowning, becomes a challenge. He provided another example which required linking the hospital costs for motorcyclists with helmets and without. This project necessitated the Department of Transportation to release their crash data to be linked with the hospital inpatient files. While there have been some funded studies from Nevada Highway Traffic Safety Administration and the Office of Traffic Safety to create data linkages, these studies have been very limited.

As the discussion of data linkage continued it was noted that the trauma field triage criteria (TFTC) data submitted by the trauma centers is compared to the EMS First Watch database. While the data has been mapped and used in the discussion of catchment areas, there are limitations in the data analysis like the inability to link to outcome data. There have been various attempts to link trauma patient data between the EMS agencies and the trauma centers' records but these attempts have not yielded successful results. Dr. Fildes commented that the georeferencing is quite impactful and previously trauma data was linked to pedestrian injury sites, particularly with concentrations on Las Vegas Boulevard. The mapping of these sites resulted in the building of the current overpasses throughout the Las Vegas Boulevard "Strip" area.

Ms. Dokken expressed concern regarding the limitations to electronically linking the pre-hospital data to the trauma data. Daniel Llamas, EMS Liaison for Sunrise Hospital, spoke about the ESO ePCR software and that their programmers are currently developing methods to link EMS data to hospital patient outcome data. He referenced technology currently being used in central Texas which uploads EMS data to the trauma registry and therefore is optimistic that there will be resolution in the near future. Mr. Fusto opined that the data should be generated by EMS but currently the trauma centers are assigning the task of TFTC data collection to dedicated FTE's. The purchase of new software or modifications to existing software is a decision to be made by the respective EMS agencies as the data is generated pre-hospital. Ms. Dokken expressed interest in the new ESO software and recommended that they be contacted to schedule a presentation on the software's capabilities, to which Mr. Llamas replied there is a presentation scheduled at the next Medical Advisory Board meeting. This was followed by a question posed to Jo Ellen Hannom, the Clark County Fire Department representative, as to whether or not Sansio has the ability to link to inpatient

records. Ms. Hannom responded there are current discussions taking place with a co-owner of the Sansio software and this was one topic of conversation. Dr. Marino expressed concern regarding the type of data linkage being discussed and whether it would be an attainable goal. He then provided the example of the transfer or radiological images which has been a work in progress for almost two years. He recommended researching the Health Information Exchange as another possibility noting that the Nevada Hospital Systems are beginning to allocate funds to the program.

There are two current projects whereby prehospital data from two different agencies are to be compared to the trauma centers' TFTC data, and those results will be reported at the next Regional Trauma Advisory Board meeting. In previous data collection pilots the tests did not yield positive results. Ms. Britt commented part of the problem has been how the programs are configured. The question posed by Dr. Fildes almost seven years ago about creating a Yes/No field for flagging a record for TFTC has not been fully realized. There are many variations for identifying a trauma patient and the trauma plan specifies those cases are to be validated by the trauma centers. Dr. Fildes discussed the NEMSIS project and how it could be used to link the prehospital data with the trauma center data. There are standardized trauma data fields of which approximately nineteen of those fields are prehospital data. If those fields were completed by the EMS agencies and then forwarded to the trauma center it would create a mechanism for deterministically linking the patient. He viewed a demonstration project utilizing this concept by the state of Kansas and furthered it would be beneficial to see this capability. Ms. Hannom recommended conducting another pilot with Clark County Fire TFTC data. She remarked there has been more education in this area since the last data collection pilot was conducted, and there is a possibility for more favorable results. Ms. Britt agreed to conduct another study and to continue researching a more efficient manner to streamline the data collection process.

The next two indicators, 204.2 and 204.3, were related to funding, and Dr. Dort remarked they could be discussed concurrently. Indicator 204.2 states financial resources exist in support of planning, implementation and management of the trauma system; whereas 204.3 relates to funding for the trauma system infrastructure support, specifically referring to the lead agency. Dr. Young emphasized the keyword "infrastructure" in 204.3 and added the intent of the indicator is to demonstrate long-term, stable funding for trauma system development, management, evaluation and improvement. He further explained the score of 2.0 for indicator 204.2 which denotes that some funding for trauma care within the 3rd party reimbursement structure has been identified, but ongoing support for administration and clinical care outside the 3rd party reimbursement structure is not available. Ms. Britt added that there have been financial resources committed to the management of the trauma system, and the Health District has supported two full time positions for seven years out of its general fund to sustain the unfunded mandate from the State. Ms. Dokken questioned whether there would be long-term commitment from the Health District to fund the 2 FTEs as specified in indicator 204.3. Ms. Britt replied that the current administration is supportive and the assumption is that the new Chief Health Officer will continue that commitment.

Ms. Dokken referred back to indicator 204.2 and questioned the viability of a State trauma fund noting other trauma systems have one in place but Nevada does not. Ms. Britt responded that was the purpose of SB205. The bill would have created a trauma fund from which the trauma registry would have been funded. As the bill did not pass, there was reference to the previous TSAC meeting discussion about creating a 501(c)(3) trauma foundation as a funding mechanism. Ms. Dokken commented SB205 was limited to data and reported states like Pennsylvania and Washington have created systems for hospitals to be reimbursed for the treatment of unfunded patients which is perhaps more in line with indicator 204.2. Ms. Britt clarified that SB205 would have created a trauma fund that would have allowed for donations, grants or monies to be placed into a special fund for trauma. While there was not a clear definition of how the monies were to be spent, the first proposition was to fund the trauma registry. In regards to developing a 501(c)(3), similar to the San Diego County Trauma Foundation, it is pending a legal opinion.

Dr. Fildes commented on the various funding mechanisms for trauma systems nationally. He

remarked most common types of financial resources include fines or fees from moving violations; vehicle registration; cigarettes tax; gambling tax and surcharges on 911 calls. He referred to the State of Washington reporting their use of moving violations and DMV fees to support their trauma system. Additionally, there are non-for-profit organizations that are unaccounted for which support various trauma systems. Ms. Britt had previously reported the same findings to the TSAC and added the committee had reviewed all possibilities including the use of fees and fines. However, the Legislative Counsel Bureau (LCB) opined that the Nevada Constitution prohibits those monies from being used for anything other than road maintenance or education. The committee is continuing to research the use of fees and fines to verify if the LCB's interpretation is accurate. Dr. Dort remarked the marketing of an additional surcharge to DMV fees would be the most plausible. Dr. Fildes commented a charge of .25 cents on all DMV transactions would be a good method for raising monies. Dr. Marino posed the question of how the Constitution defines education, and perhaps there is a component of education that can be related to trauma. Ms. Britt stated that Senator Woodhouse, sponsor of SB205, would work on obtaining a clear interpretation of how education is defined. This research and the other assigned tasks were identifies as action items for TSAC, and their findings will be reported back to RTAB.

The final indicator, 308.1, states the lead agency has incorporated, within the trauma system plan and the trauma center standards, requirements for rehabilitation services including interfacility transfer of trauma patients to rehabilitation centers. The plan includes references to the use of rehabilitation services, but the routine use of these facilities has not been fully realized. The Trauma Rehabilitation Committee was created to address these issues. The committee explored means of collecting patient outcome data on patients discharged from the trauma centers and it continues to be a work in progress. HealthSouth in particular was prepared to provide patient outcome data; however, the mechanism to establish the list of those patients discharged from the trauma centers has not been established. Dr. Fildes remarked that the rehabilitation data linkage is another example of inadequate data linking capabilities. Ms. Britt replied that the committee made a tremendous effort in their attempts to open the lines of communication and they did manage to create a resource list to help identify existing services in the community. She added one specific measure the ACS asked to research was to identify the facilities which specialized in spinal cord injuries and traumatic brain injuries. During the process, it was determined that the interpretation of those services is subjective and it would require further investigation which will be resumed.

B. Discussion of 2011 American College of Surgeons Trauma System Consultation Priority Recommendations

Ms. Britt reported there is a scheduled conference call on September 23, 2013 with members of the consultation team from the American College of Surgeons that were part of the July 2011 system consultation visit. Many of their priority recommendations were discussed during the first agenda item. In sum, five of the fifteen priority recommendations have been accomplished, and the remaining ten are pending due to lack of funding and data.

C. Discussion of Action Steps Related to Addressing the Clark County Trauma System Assessment

Dr. Dort reported this agenda item had been accomplished during the discussion of the 2013 Clark County Self Assessment Report. He asked if there were any other items to come forward, and Ms. Britt referred the members to the Clark County Trauma System Plan handout. As part of the discussion during the live session of the trauma system assessment, it was noted that many of the participants were unaware that a trauma plan existed. Ms. Britt remarked the document was created in 2006 at the very beginning of the development of the trauma system and it would be an opportune time to review and update the document. The trauma plan is posted on the Health District's website, and the members agreed that they will begin to review it and come back with recommendations for revisions.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

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 adjourned the meeting at 3:10 p.m.