1. CALL TO ORDER: The meeting was called to order by Cheryl Wraa at 10:00 a.m.

2. WELCOME & INTRODUCTIONS: All present were introduced.

3. APPROVAL OF MINUTES: The minutes of May 17, 2010, were approved by the committee as submitted.

4. PRESIDENT’S REPORT:

American College of Surgeons (ACS) Rural Trauma Team Development Course (RTTDC®): TMAC to partner with ACS to facilitate the presentation of the RTTDC® to critical access hospitals. Chair – Wendy Hums. Each region will have a TMAC member as a coordinator for the region. Coordinators from the region will schedule the trainers to attend the “Train the Trainer” courses. Instructor criteria are identified by the American College of Surgeons. Instructors should be from Level I and Level II Trauma Centers. Training material will need to be purchased for each region. Limited funding is available through the “Critical Access” program. Host facilities would be responsible for the facility, course material (copying), and food. A course fee was proposed to compensate the trainers for their time, travel, etc. Availability of Hospital Preparedness Program (HPP) funds should be explored for funding the course. If needed, rooms are available in conjunction with the TMAC meetings scheduled for September and December for “Train the Trainer” courses.
TMAC Bylaws: At the recent Board retreat the Strategic Plan and Bylaws were reviewed. TMAC’s Bylaws have been revised and reformatted based upon input from the retreat, to include a broader range of members, and to ensure consistency. The Bylaws have been posted on the website for a 30 day comment period. Goal is to approve the revised Bylaws at TMAC’s meeting in September.

Trauma Program Manager Survival Guide: The Directors at Large were tasked with the creation of a Trauma Program Manager Survival Guide. This has been a long standing project that is nearing completion. Due to the size of the resource document, a decision has been made to distribute it in a locked portable document format (pdf) via a flash drive. A vendor has been located that will include the TMAC logo on each of the flash drives and will load them for $8.00 each. The committee decided that this extensive resource document would only be provided to current and future members. Non-members, or someone from outside the state, should be charged a substantial fee. No decision made on the actual amount.

5. STATE TRAUMA PLAN REPORT: Trauma Advisory Committee (TAC) met on July 7, 2010. Current projects include the following:

TAC Membership: Membership is under revision to include representation from the Regional Trauma Coordinating Committees (RTCC). In addition, applications are now being accepted for the two At-Large positions. Interested candidates are encouraged to submit their curriculum vitae with a cover letter to Dr. Tharrat by July 15, 2010 for consideration. Current membership includes:

- Dr. Robert Mackersie (TAC Chair, Trauma Medical Director)
- Bonnie Sinz (EMS Authority)
- Johnathan Jones (EMSA Trauma Coordinator)
- Gil Cryer (ACS)
- Larry Karsteadt (EMSAAC)
- Cathy Chidester, RN (EMSAAC)
- Debby Rogers, RN (CHA state)
- Judith Yates (CHA local)
- Linda Raby, RN (TMAC)
- Jay Goldman (EMDAC)
- Ed Guzman (California Ambulance Association)
- Cheryl Wraa (RTCC 1# Northern)
- Joe Barger (RTCC #2 Bay Area)
- Jim Davis (RTCC #3 Central)
- Nancy Lapolla (RTCC #4 Southwest)
- To be determined (RTCC #5 Southeast)
- At large position (To be determined)
- At large position (To be determined)

After a lengthy discussion regarding TAC’s membership, the committee decided to send a letter of concern to the state:

- advocating for a Trauma System Program Manager to be added to TAC’s permanent membership for the system to be inclusive; and
• encouraging future consideration as the committee evolves for membership to include representation from the Emergency Nurses Association, Society of Trauma Nurses, and the American Trauma Society.

**California Emergency Medical Services Information System (CEMSIS) Trauma Development:** As of May 2010, over 34,000 records exist in the state registry. Out of the 21 Local Emergency Medical Services Agencies with trauma centers, 15 are now participating. In addition, the CEMSIS Data Committee will be reconvened. The committee’s member will also undergo revision. The committee’s purpose is to ensure consistency and validity of the data, to establish benchmarks, and to ensure the registry works for the benefit of the state system (not individual research projects).

**California Statewide Trauma Plan:** An outline for the State Trauma Plan has been developed. Subcommittees will be formed to draft each section of the plan. Goal is to have a draft for presentation at the Dec. 2, 2010, State Trauma Summit in San Francisco.

6. **REGIONAL TRAUMA COORDINATING COMMITTEES (RTCC) UPDATES:** Tabled due to time constraints.

7. **LESSES IN LEADERSHIP AND SUCCESSION PLANNING:**

   *Lessons in Leadership and Succession Planning* a presentation by Susan Cox, Director of Trauma, Rady Children's Hospital, San Diego. Refer to Attachment I.

8. **DISASTER PREPAREDNESS – LOS ANGELES COUNTY PERSPECTIVE:**

   *Medical, Trauma, and Burn Surge Capacity* a presentation by Jacqueline Rifenburg, Program Manager Disaster Services, Los Angeles County Emergency Medical Service Agency. Refer to Attachment II.

9. **TMAC BOARD & STANDING COMMITTEE REPORTS:** Tabled due to time constraints.

10. **OPEN FORUM:**

    Multiple educational opportunities announced, please visit the TMAC website for additional information on upcoming events.

11. **NEXT MEETING:** The next meeting is scheduled for September 10, 2010 in Riverside. The meeting will focus on data. Please encourage your data registrars to attend.

12. **ADJOURNMENT:** The meeting was adjourned at 3:00 p.m. by Cheryl Wraa.
LESSONS IN LEADERSHIP &
SUCCESSION PLANNING

Lessons in Leadership......

Leadership points to ponder....

Never doubt that a small group of thoughtful, committed
people can change the world. Indeed, it is the only thing
that ever has.
Margaret Mead

There are risks and costs to a program of action. But they
are far less than the long-range risks of comfort and
calculating inertia.
JFK

Life does not cease to be a fun when people die any more
then it ceases to be serious when people laugh.
George Bernard Shaw

Lincoln on Leadership.......

Leadership points to ponder....
1. Get out of the office
and circulate among the
troops...
MBWA Tom Peters 1980s
Rounding Studer 2000's

Leadership points to ponder....
Build strong alliances...

Leadership points to ponder....
Pursue rather than
coerce...
Leadership points to ponder....
Honesty and integrity are the best policies...

Leadership points to ponder....
Never act out of vengeance or spite...

Leadership points to ponder....
Have the courage to Handle Unjust Criticism...

Leadership points to ponder....
Be a master of paradox...

Leadership points to ponder....
Exercise a strong hand-be decisive...

Leadership points to ponder....
Led by being led...
Leadership points to ponder....
Set goals and be results oriented...

Leadership points to ponder....
Keep searching until you find your "Grant"...

Leadership points to ponder....
Encourage innovation...

Leadership points to ponder....
Master the Art of Public Speaking...

Leadership points to ponder....
Influence people through conversation and storytelling...

Leadership points to ponder....
Preach a vision and continually reaffirm it...
Many leaders exist in nursing....

2010 Trauma Leadership Recipient

Role Model  
Mentor  
Visionary  
Risk Taker  
Advocate

Shifting Gears to Succession Planning

Why expend energy on succession planning?

Succession Planning: Perspectives of Chief Operating Officers in US Hospitals

Collins, S. 2004, Health Care Manager, 24(3) 268-283

Mailed surveys developed by content experts to a total of 1000 US Hospital CEOs. Response rate =18.4%

Leaders are born, not made
Key Factors in Identifying Successor

Building the Leadership Development Pipeline: A 5-step Succession Planning Model

Succession Planning:
The process of identifying and preparing suitable employees through mentoring, coaching and job rotations to replace key organizational members due to retirement, resignations or other factors.

Step one
Addresses organizational factors, incorporates the key elements of commitment, vision and assessment.
Ideal is create a vision of perpetual succession planning where the organization is viewed as filled with leaders regardless of their title in the organization.

Step two
Identification of an individual for a targeted role in the organization.
Individual who best exemplifies the fundamental talents or skills set needed for an organizational role is recruited.

Step three
Development of the individual
Great emphasis placed on mentoring, coaching and job rotation within the framework of a career continuum.
Mentoring relationship should benefit more than the dyad since mentor passes on mentor's kindness and experience to others.
Step four
Executing a specific and focused plan for implementing leadership development efforts.
Development of metrics to measure what success should look like. Optimally metrics should align what is good for the organization with what is good for the employee.

Step five
Evaluation and dissemination of results
Comparison of actual outcomes with predetermined metrics and the development plan.
Successful outcomes can become "best practices" and results need to be disseminated through publications, presentations and involvement in professional organizations.

Sue's advice on succession planning
Based on a lot of thinking at this point but not much action..............

Start communicating with staff well in advance of the time you want to hand off your role/position

Show interest in others' career aspirations and in their interest in pursuing a leadership position.

Make leadership recruitment an ongoing activity for yourself. Network with others internally and externally regarding needs and staff aspirations.
Stay involved in staff development by functioning as a mentor to staff members and students.

Encourage shadowing or "trying out" roles and responsibilities for those who show interest.

Ensure that you value your existing staff and leaders—they are your best team recruiters.

Avoid the comments about the "overwhelmth" of your workload, even if it's true. (Just share them with other TPMs)

If you identify a successor who is willing to "learn the ropes" focus on the outcomes you want achieved, not on "how you do it"

Good Luck!!

Questions??
MEDICAL, TRAUMA, & BURN SURGE CAPACITY

Medical, Trauma and Burn Surge Capacity

Los Angeles County Healthcare System At-A-Glance

- Over 100 Acute Care Hospitals
  - 74 Hospitals with Basic Emergency Departments in 2002
  - 15 are designated as Trauma Centers
  - 5 of these are public County-owned and operated facilities.
- > 40 public and private community clinics, some with multiple sites.

Health Services Responsibilities

EMS Agency Disaster Coordinator for Health Services
  - Coordination with Field EMS
  - Patient Control
  - Transportation Coordination
  - Disposition Determination
  - Triage and Recordkeeping
  - Hospital Status & Assessment
  - First Available "Burn Capacity" (RESCUE & EUH)
  - Trauma and Special Needs
  - Emotional & Hospital Environment

Los Angeles County
Health Services
Medical Surge Capacity

- National Goal: Planning used in Hospital Preparedness Program
  - 500 victims / million population for Biological/Communicable Diseases
  - 50 victims / million population for Chemical, Radiological, Trauma and Bioterrorism
- woefully inadequate for Catastrophic Events and Pandemic Influenza

Current Medical Surge Capacity

- Surveyed hospitals that participate in the Hospital Preparedness Program regarding their capacity:
  - 17,166 Licensed Beds and 12,946 Staffed Beds
- Meet Surge demands by:
  - Uncapacitated licensed beds except operations = 37,422
  - Early discharges / and or cancellations of elective admissions = 2251
  - Convert non-patient care areas to inpatient care = 28,058
- Total Surge Beds = 5599

Medical Surge Capacity

- Surge is more than just "beds" it also includes:
  - Supplies
  - Equipment
  - Personnel
  - Specialty capabilities
What Los Angeles County has done to address Surge Capacity

- Disaster Resource Centers
- Trauma Surge Capacity
- Burn Resource Centers
- Mobile Medical System (MoMS)

What are DRC's?

- There are 13 DRC's, geographically located throughout the county.
- The DRC's will be used to address 'surge capacity' in cases of disaster and as a resource for extra equipment, supplies and pharmaceuticals.
- Used as a starting point to develop plans, relationships and procedures for responding to a natural or man made event.

Who are the DRC's?

- California Hospital Medical Center
- Cedars Sinai
- Children's Hospital of Los Angeles
- Henry Mayo Newhall Memorial Hospital
- Kaiser Foundation - Sunset
- LAC Harbor - UCLA Medical Center
- LAC USC Medical Center

- Long Beach Memorial Medical Center
- Pomona Valley Hospital Medical Center
- Presbyterian/University Hospital
- Providence St. Joseph Medical Center
- St. Mary Medical Center
- Ronald Reagan - UCLA Medical Center
Disaster Resource Center Program
Each DRC has a cache of equipment and supplies

- Ventilators (21 full functional and RO disposable)
- Pharmaceutical cache including at least two CHEMTAX
- Medical supplies
- Tents, tents, and more to house at least 40 patients
- Generators, lights, fuel tanks, etc.
- Handwashing & porta potty stations
- Initial site plans to contain capacity
- Trailer to contain supplies
What else do they offer?
- Taking the lead in planning and communication with ‘umbrella’ hospitals
- Hosting meetings and crises
- Shared disaster plans
- Create and share surge capacity plans

Trauma Center Surge Capacity
- LA County needs to establish systems that can provide triage, treatment, and initial stabilization to at least 500 severely injured adult and pediatric patients
- LA County’s Trauma Hospital Advisory Committee (THAG) formed a working group to develop this work plan
- Recommended that funding should be provided to all Trauma Centers to develop plans and coordinate surge capacity activities at each Trauma Center and as a countywide trauma system

Trauma Center Surge Capacity
Each Trauma Center has cache of equipment & supplies
- All Trauma Centers
  - Ventilators
  - Staff and basic notification system
  - Basic equipment, supplies & pharmaceuticals
  - Fetal/GO patient location
- Non-ORC TC
  - Suction function monitors
  - Blood work and units of blood
  - Gastroenteritis: iodine, heparin, and neos
  - Trauma shears & polypharmacy
  - NEPA filters for resuscitation
  - Tripler: contains supplies

Trauma Managers Association of California
July 8, 2010
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Who are the Trauma Centers?

- Antelope Valley Hospital
- California Hospital Medical Center
- Cedar Sinai
- Children's Hospital of Los Angeles
- Henry Mayo Newhall Memorial Hospital
- Huntington Memorial Hospital
- LAC Harbor - UCLA Medical Center
- LAC USC Medical Center
- Long Beach Memorial Medical Center
- Marin General Hospital Medical Center
- Providence Holy Cross Medical Center
- St. Pancras Medical Center
- St. Mary Medical Center
- Ronald Reagan - UCLA Medical Center

Burn Resource Centers

- Hospital Preparedness Program (HPP) critical benchmark states - 50 cases per million population for patients suffering burn or trauma. . . .
- LA County has a little over 10 million residents, therefore needing to surge for 500 burn patients.
- "Literature shows that only 30% of these 500 patients would require Burn Center Care = 150 patients"

Burn Center Capacity

- Local (LA County)
  - 3 Burn Centers = 59 burn beds
- Regional (Greater LA Area)
  - Additional 3 Burn Centers = 36 burn beds
- State of California
  - 13 Burn Centers = 202 burn beds
- National
  - 128 Burn Centers = 1,828 burn beds
LA County Burn Surge Plan

- LA County Burn Resource Center (BRC)
  - 12 designated Burn Resource Centers
  - All LA County Trauma Centers
  - Trauma Surge Coordinators
- Each Burn Resource Center will adopt temporary care for 12 burn patients
- Uptakes and activations through:
  - Electronic burn care training to start
  - Manual supplies to provide burn care
- 13 houses x 13 surge burn patients = 169 burn beds

LA County Burn Surge Plan

- Why Trauma Centers (TC)?
- What about non-Trauma Centers?
- What are the expectations of the BRC?

Burn Education for Hospitals

- Six 3-hour training courses: "Multi-Casualty Burn Disasters: Hospital Management"
- Three 2-hour material role out training courses: "Burn Resource Manual: Roll Out and ED Management of Burn Patients"
- Currently researching a web based training
Equipment & Supplies for Trauma Centers

- Thermal Blankets
- Fluid Infusion Warmers
- Multi-channel IV pumps
- Bronchoscopy w/VidScope capability
- Electrocautery
- Burn debridement Trays
- Burn dressings – varying types & sizes
- Silvadene
- Pharmaceuticals
  - Morphine, Versed, FOL, Bicarb, CaCl2, NaHCO3, Soreno, Ketorol, MgSO4
- IV fluids
  - LR & D/LR

Mobile Medical System (MoMS)
Mobile Medical System (MoMS)

- 2 Tractor Trailers
  - Support Trailer (staff, support and equipment/supplies)
  - Emergency Room/ICU/ICU OR

- 4 Crew Cab Duty Trucks with Trailers
  - Each contains a portion of the tents system (26 beds)

The Future of Surge

- Mass Medical Surge Model Grant from CDC/ORE - Public Health Grant
  - Currently working with hospitals to develop a Model for other large urban areas

- Pediatric Surge
  - Specifically Pediatric ICU
  - Working with GHA to develop a plan and tiered system with hospitals
Questions?

Jacqueline Rifenburg RN
Program Manager – Disaster Services
Los Angeles County EMS Agency
irifenburg@bhs.lacounty.gov
(562) 347-1545

Los Angeles County
Health Services