Minutes

CLARK COUNTY DISTRICT BOARD OF HEALTH
TRAUMA SYSTEM ASSESSMENT CITIZEN'S TASK FORCE

Monday, March 8, 2003
1:30 p.m.

Clark County Health District – Ravenholt Public Health Center
Clemens Room
625 Shadow Lane
Las Vegas, Nevada 89106

MEMBERS PRESENT

Veronica Arechederra-Hall
Richard Bunker
S. Max Doubrava, MD
Robert Forbuss, Co-chair
Merlinda Gallegos
Steve Hill
Rose McKinney-James, Co-chair
Otto Ravenholt, MD
Danny Thompson

MEMBERS ABSENT

JaNell Cook
William McBeath

CCHD STAFF PRESENT

Donald Kwalick, MD, Chief Health Officer
Jane Shunney, RN, Assistant to Chief Health Officer
Rory Chetelat, EMS Manager
Joseph Heck, DO
Jennifer Sizemore, Public Information Officer
Susan Eiselt, Recording Secretary

THE ABARIS GROUP STAFF PRESENT

Mike Williams, President
Jonathan Wills, Research Associate

1. Welcome/Introductions

The Trauma System Assessment Citizen's Task Force convened in the Clemens Room of the Ravenholt Public Health Center on Monday, March 8, 2004. Co-chair McKinney-James called the meeting to order at 1:35 pm.

2. Work Plan Progress

Mike Williams provided an update on the progress of the trauma system assessment. The interview and data collection components of the study are nearly completed and findings are being developed. A town hall meeting was held on February 12 in Boulder City. Additional meetings will be held on March 8 in the City of Las Vegas March 11 in North Las Vegas.

3. Update on Trauma System Site Visits

Mike Williams provided an update on the site visits to San Diego and Phoenix that were discussed at the previous meeting. These are being planned for committee members to learn more about these trauma systems. The first week of April is being considered for San Diego. The hope is that as many committee members as are available will attend. The site visit to Phoenix is being deferred because the State of Arizona's trauma coordinator will be serving on the American College of Surgeon's (ACS) Clark County site visit team that will be evaluating the local trauma system. Regarding scheduling, it was requested that the site visit itineraries be scheduled so that some members could arrive the same morning if they did not wish to fly in the night before.

4. Update on ACS Site Visit

Mike Williams reported that the ACS team will be arriving on April 18 and will conduct its evaluation during the early part of that week. They will likely have a dinner the first night and conduct a series of interviews and discussions over the following days. They will then likely have a closed-door discussion and then present their findings.

Ms. Gallegos raised the topic of interest in EMS ride-alongs expressed at the last meeting, and members were directed to a list of EMS provider contact information that was provided. Mike Williams also notified members that the UMC trauma center had offered to provide tours; specific dates will be provided as options, although members are free to schedule a tour at other times as well. Suggested UMC site visit dates and contact information will be provided to the committee members.

Lastly, before moving to the next agenda item a motion to approve the minutes of the February meeting was inserted by co-chair Forbuss. The minutes were approved unanimously.

5. Facility Presentations

- **a. St. Rose Dominican Hospital, Siena Campus**
- **b. Sunrise Hospital and Medical Center**
- **c. University Medical Center**

Presentations were made by each of the above facilities. These presentations will be available soon at www.cchd.org/trauma. The following discussion also occurred during the presentations:

a. St. Rose Dominican Hospital, Siena Campus

The presentation was made by Renato Baciarelli, who was substituting for Rod Davis. Matt Koscnmann joined Mr. Baciarelli in responding to the committee's questions.

Co-chair Forbuss requested clarification of the rings shown around the facilities in the presentation, asking what they represented and whether they represented a 30-minute transport time. The response was that the lines were intended to reflect the general catchment area and the redundancy allowed by multiple trauma centers but not a 30-minute transport time.

Mr. Forbuss said that it would also be important to consider how many patients there were, where they were coming from, and whether they were arriving by helicopter. St. Rose said that a large number of the cases came from Lake Mead and Interstate 15.

Mr. Thompson asked for clarification about whether St. Rose was proposing building a trauma center. St. Rose responded that they are proposing adding a Level III trauma center to the emergency department at the Siena campus.

Co-chair Forbuss asked what that would require in the way of additional resources, and St. Rose responded that it would require additional physician availability. Mr. Forbuss asked what additional resources would be required to become a Level II center, and St. Rose said that step would also require additional physician availability. It was asked if there were any plans to develop a Level II center. St. Rose responded that there were long range plans to build a new tower at the Siena campus and they were considering a Level II trauma center in the long run.

Mr. Thompson asked how many beds there would be at a St. Rose trauma center, and St. Rose replied that there would be 2-4 resuscitation bays. It was asked what would happen when the ED is full, and St. Rose said it would be the same as currently, that severe patients would be treated first. It was asked whether this was in the protocols, and St. Rose said yes. It was asked how this was enforced, and the St. Rose said by the EMS agency. It was stated that ED overcrowding had long been a problem.

Mr. Bunker said that he did not want for-profit hospitals to cherry-pick trauma patients and leave the rest for UMC. St. Rose indicated that they were not-for-profit and stated that this would not occur and they hoped to participate with a spirit of cooperation.

It was asked how many trauma centers Catholic Healthcare West (St. Rose's parent) has. St. Rose responded that there are 42. It was asked how many are Level I and II, and St. Rose said that there are three Level I centers and three Level II centers.

Dr. Doubrava asked co-chair Forbuss if it was possible to see where trauma patients come from. Mr. Forbuss replied that yes, it would be possible to review locations of trauma transports as well as whether the transport was by ground or air and the time on a 168-hour clock (day of week and time of day).

Following conclusion of the presentation, co-chair Forbuss clarified with Mr. Williams that trauma centers provide coverage for all 168 hours of the week, and Mr. Williams replied that yes, they do. Mr. Williams added that trauma diversion is rare amongst trauma centers nationwide and that will be a consideration as part of The Abaris Group analysis.

b. Sunrise Hospital and Medical Center

The presentation was made by Dr. Michael Metzler.

Mr. Thompson suggested that the presentation's comparison of the number of trauma centers and population in Las Vegas and other locations was like comparing apples and oranges because some trauma centers have many more beds than others, and the number of beds is more significant. Dr. Metzler replied that the comment was noted.

Co-chair Forbuss disagreed with the suggestion that trauma patient arrivals were not predictable, saying that there are predictable trends. Dr. Metzler agreed that there were trends but said that did not make volume totally predictable.

It was asked how many trauma beds Sunrise would have. Dr. Metzler replied that there would be four resuscitation bays.

It was commented that there was concern about cherry-picking, and would Sunrise take all payers? Dr. Metzler said yes, they would.

Mr. Bunker asked if there had previously been a trauma center at Sunrise. Dr. Metzler said he just knew the history that was presented by the Health Department at the first meeting, that there was a trauma center at Sunrise that closed in 1995.

Mr. Bunker asked if Dr. Metzler knew what the cost would be. Dr. Metzler said he did not know, as he does not deal with the financial side.

Mr. Bunker commented that he was concerned that if the trauma beds were not filled, the cost would be paid by increasing rates for other patients. Dr. Metzler said he did not think that would be an issue with an estimated 1,000 annual patients and 4 resuscitation bays and restated that the benefits of resources for trauma care often justify the costs of maintaining them.

It was asked why patients would go to a Level II center when a Level I center was available and there were dedicated resources at UMC. Dr. Metzler replied that there would also be dedicated resources at Sunrise.

Mr. Bunker commented that he noticed in a slide near the beginning of the presentation that Salt Lake City and Arizona have only one trauma center. Dr. Metzler said he did not know the details of those areas but added that the slide only showed Level I and II centers and not Level III and IV centers. Dr. Metzler also restated that there would be a benefit to redundancy of trauma care services.

c. University Medical Center

The presentation was made by Dr. John Fildes.

Mr. Thompson asked if the trauma center was ever full. Dr. Fildes replied yes, but they are never on trauma criteria patient divert. They have internal protocols to handle high census.

Mr. Thompson asked if the trauma center was the first to get blood. Dr. Fildes said they stock some of their own blood as a trauma center and get priority access after that. Mr. Thompson asked if it would pose a challenge to blood distribution if there were other trauma centers. Dr. Fildes said that the number of trauma patients would not change, and blood would still go where it was needed.

Co-chair McKinney-James asked what the person-power was at the trauma center and said she thought that total resources including staffing were a more important consideration than just beds. Dr. Fildes listed the personnel required for each phase of the patient's stay at the trauma center.

Mr. Thompson asked whether the UMC trauma center used traveler nurses. Dr. Fildes said yes, they do, and they often have traveler nurses who have a specific interest in trauma care.

Co-chair Forbuss asked for clarification between the lines in a volume chart shown in the presentation. Dr. Fildes clarified that the difference between the higher and lower volumes shown represented less-severely injured patients treated at the UMC trauma center who did not meet the trauma team activation criteria.

Mr. Thompson asked if the UMC trauma center was ever full with 11 real trauma patients. Dr. Fildes said no.

Co-chair Forbuss said that in addition to the locations at which patients were picked up, he would also like to see their home zip codes, in order to determine how many were travelers. Dr. Fildes said that information was available.

It was asked how many of approximately 4,000 activations arrived by air, and Dr. Fildes said it was about 800.

It was asked what definition was used to compute transport time. Dr. Fildes said they used the NHTSA definition of the time from when the wheels of the ambulance start to spin away from the scene to when they stop spinning toward the trauma center.

Mr. Thompson asked for confirmation that there was no medical facility in Pahrump, an example of an outlying area. Dr. Fildes said that yes, all serious injuries were transported to the UMC trauma center.

It was asked whether in the maps Dr. Fildes showed the growth areas indicated were tied to volume. Dr. Fildes said that the growth of volume along with population by sub-region was not shown in the map and was hardest to discern.

Dr. Ravenholt asked Dr. Fildes what the differences were between Level I, II, and III trauma centers. Dr. Fildes described these, including the leadership, teaching, and research functions of a Level I center, and the likelihood of transfer of some patients from a Level III to a Level II or I. Dr. Fildes also described the NAC sections that call for patients to be directed to the highest level trauma center available within 30 minutes.

Dr. Ravenholt said that Dr. Fildes had been at a Level II and asked what the difference was. Dr. Fildes said that UMC was a Level II when he arrived and described their development into a Level I, including a research program that is just in its early stages.

It was asked why the trauma volume growth shown was only half that of the population growth. Dr. Fildes said he thought it could be partly a result of differences in application of the triage criteria and that it could also be partly due to success with injury prevention, such as seat belt programs.

Co-chair McKinney-James asked Mr. Williams how the committee relates to the State statutes. Mr. Williams said that a discussion of that will be included in the next meeting.

Ms. Gallegos asked that The Abaris Group add the number of beds to the table provided per Dr. Doubrava's request that showed trauma centers per population for selected regions. Mr. Williams agreed to do this and said that other information including transport data by location, injury by blunt or penetrating, and payer mix would be included in the final report. It was asked that patient home zip codes also be analyzed to determine which patients were travelers, and Mr. Williams said that would also be done.

It was asked if EMTALA was an issue. Mr. Williams replied that he has heard concerns here, and The Abaris Group will discuss this in their report.

Mr. Williams reminded the committee that they were given EMS provider contact information for ride-alongs and added that The Abaris Group would be happy help with scheduling if needed.

6. Workshop C – Trauma Systems 301 and
7. Summary of surveys, focus groups and public hearings

Mr. Williams said that he had a presentation and summary which he could give or defer to the next meeting. It was agreed by the Committee to defer the presentation. He also said that the summary of surveys, focus groups and public hearings would be available in writing in the form of an "As-Is" report at the next meeting.

8. Citizen Participation

Co-chair Forbuss asked if anyone from the public wished to speak. No one from the public indicated a desire to speak.

9. Conclusion

Co-chair Forbuss adjourned the meeting at 3:30 p.m.