Minutes

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

Monday, May 10, 2004
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
S. Max Doubrava, MD
Merlinda Gallegos
Rose McKinney-James, Co-chair
Otto Ravenholt, MD
Danny Thompson

MEMBERS ABSENT

Richard Bunker
JaNell Cook
Steve Hill
Robert Forbuss, Co-chair

CCHD STAFF PRESENT

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

THE ABARIS GROUP STAFF PRESENT

Mike Williams, President
Jonathan Wills, Research Associate

1. Welcome

The Trauma System Assessment Citizen's Task Force convened in the Clemens Room of the Ravenholt Public Health Center on Monday, May 10, 2004. Co-chair Rose McKinney-James called the meeting to order at 1:42 pm.

2. Approval of March 8, 2004 and April 12, 2003 Meeting Minutes

Co-chair McKinney-James asked her fellow Task Force members and the public if there were any comments, which there were not. A motion to approve the minutes was made and seconded. The minutes were approved without changes.

3. Work Plan Progress/Task Force Meeting Schedule

Co-chair McKinney-James asked Mr. Williams of The Abaris Group for an update. Mr. Williams reported that the American College of Surgeons (ACS) trauma system consultation visit will occur Sunday, May 16, through Wednesday, May 19. On Sunday there will be an informal dinner event. Meetings will occur on Monday and Tuesday, and ACS will report their initial findings on Wednesday. Dr. Mackersie, the lead member of the ACS visit team, will also present findings to the Task Force at the June 7, 2004 meeting. ACS is scheduled to provide their final report six weeks after the visit.

Mr. Williams also reported that The Abaris Group has completed all of the town hall meetings and has submitted its report on the current status of the trauma system. (This report will be posted at www.cchd.org/trauma.) A second report from The Abaris Group making recommendations on the needs of the trauma system will be forthcoming.

Dr. Kwalick, Clark County Chief Health Officer, requested to speak. He reminded the Task Force and the public that the May 24, 2004 meeting of the Task Force will be held in the Human Resources Annex (the same location as the first meeting). Dr. Kwalick also reported that the Board of Health would like to receive the Task Force's recommendations at their June 24, 2004 meeting.

Mr. Williams summarized that the Task Force will be able to discuss the findings of The Abaris Group and preliminary findings of ACS at the Task Force's May 24, 2004. As previously noted, the Task Force's June 7 meeting will include a presentation by Dr. Mackersie of ACS. There is the potential for a June 14 if needed. Finally, the recommendations of the Task Force will go to the Board of Health at their June 24, 2004 meeting.

Co-chair McKinney-James suggested that the Task Force clarify the framework of their recommendations. She proposed that the Task Force is one part of the process and should make recommendations on whether a full trauma system would be appropriate, recommendations on location for participation in the system and recommendations on the system itself. All of these recommendations would be made in tandem with the recommendations from ACS and The Abaris Group. Co-chair McKinney-James asked

Mr. Williams for comment. He responded that he agreed and that the Task Force would not be limited to the views or scope of the recommendations made by ACS and The Abaris Group.

Co-chair McKinney James said that the Task Force may need to make recommendations on changing legislation and asked if this would be appropriate. Mr. Williams responded that it would and said that if the trauma system were to be further developed, supporting legislation would likely help.

4. Task Force Report – San Diego Site Visit

Rose McKinney said that the Task Force should discuss whether the San Diego site visit report was accurate and whether it should be added to the Task Force's record. The Task Force members present agreed it was accurate. Ms. Gallegos proposed it be added to the record.

Dr. Doubrava asked how the two Level I trauma centers next door to each other in San Diego distributed patients. Ms. Gallegos said it was based on catchment areas. Dr. Doubrava asked whether the catchment areas were used even when one trauma center got multiple arrivals in a short period. Co-chair McKinney responded that the task members who attended the San Diego site visit did not ask that specific question but were told that the catchment areas and distribution of patients had long been discussed and evaluated in San Diego trauma system.

Dr. Doubrava said that he was concerned about "wallet biopsies" (determination of patient destination based on the ability of the patient to pay for care) in Las Vegas. Co-chair McKinney responded that in San Diego, all trauma centers had agreed to see all patients. Dr. Doubrava said he was concerned about all penetrating injury patients going to one trauma center and all blunt injury patients going to another. Dr. Kwalick asked to speak. He reported that in order for a trauma center to be designated, it would need to accept all comers, regardless of ability to pay. Dr. Doubrava said he was not concerned with that, but rather what happens in transport and whether one trauma center might be overloaded. Dr. Kwalick said that that is what the Task Force will need to consider and plan to address.

Dr. Ravenholt reported that Dot Kelley, the trauma program manager at Scripps Mercy Hospital, the hospital visited in San Diego, indicated that the San Diego experience has been centered on the system rather than individual hospitals. As part of that approach, a committee including the directors of all of the trauma programs meets monthly and reviews cases in a collaborative environment.

Mr. Thompson said he agreed and that the San Diego trauma system worked because there was a governing agency (the county EMS agency) and the trauma centers were not-for-profit. Mr. Thompson said that in Southern Nevada there has not been that level of cooperation, and he would propose that UMC manage the system and act as the "traffic cop".

Ms. Gallegos said that one recommendation received from San Diego was that given UMC was a Level I trauma center, the system should be built around them. However, she stated concern about having UMC in the management role given they are also a provider participant in the system. She said that San Diego provided a model of an independent agency (the county EMS agency), but she did favor the idea of the system design occurring around the Level I trauma center.

Dr. Ravenholt said that one difference in California is that contracts exist between the trauma center hospitals and the county, rather than the state. As a result, there is more direct oversight. Co-chair McKinney-James noted that San Diego also had licensing, enforcement and management all linked through the county.

Dr. Doubrava said he agreed with Dr. Ravenholt's comment and that CCHD had become the reviewer for EMS. He suggested CCHD as a possible manager for the trauma system. He said he would add that profit hospitals in the Las Vegas area have not turned down prior requests for assistance, so he did not see a difference from an all non-profit system.

Dr. Ravenholt said that in San Diego the trauma center hospitals pay $50,000 each year to be in the system, which is used for ongoing system programs. Co-chair McKinney-James said that the Task Force would need to consider the issue of self-sufficiency. She suggested looking at the San Diego recommendations and considering whether to accept the recommendations.

Co-chair McKinney said that Dr. Sise of Scripps Mercy Hospital in San Diego had indicated that the Task Force could ask him additional questions if desired. Mr. Williams said he could deliver those questions.

The Task Force approved inclusion of the San Diego site visit report in the Task Force's record.

5. Emergency Medical Services Panel Discussion and Q & A

The following people came before the Task Force: Rory Chetelat, CCHD EMS Manager; Tim Crowley, Las Vegas Fire and Rescue EMS Battalion Chief; Julian Genilla, Southwest Ambulance Administrative Supervisor; and Derek Cox, AMR Clinical Manager.

Mr. Chetelat reported that the county has oversight over EMS but not trauma because trauma is exempted and authority lies with the state. He reported that the trauma triage criteria were recently changed to the Nevada Administrative Code (NAC) version. The CCHD EMS Office does regulate trauma transport but now uses the NAC standards for trauma triage/patient destination. Mr. Chetelat reported that the EMS Office had asked for an emergency variance to change the vehicle crash speed for trauma transport from 20 mph to 40 mph.

Co-chair McKinney-James asked what the applicable section in the Nevada Administrative Code (NAC) was. Mr. Chetelat said that the applicable section in the Nevada Revised Statutes (NRS) was NRS 450B.237 and that he would provide the applicable section in the NAC.

Chief Crowley of Las Vegas Fire and Rescue said that his only concern would be designation of a Level II or III trauma center in the wrong area. He said that the growth is in the north and west. He said that if Sunrise or St. Rose Siena were to become a trauma center, the question would be whether Las Vegas Fire and Rescue would have to pass UMC to transport patients to them. Chief Crowley said he would recommend a trauma center in the northwest because there is growth and activity there.

Dr. Doubrava asked Chief Crowley if he was saying that if Las Vegas Fire and Rescue had to transport to St. Rose that would be a problem. Chief Crowley said yes and that from the northwest it would be a very long transport.

Co-chair McKinney James asked if in discussion of trauma system development the Task Force might consider Chief Crowley's recommendation that the system include a trauma center in the northwest. Chief Crowley said yes.

Mr. Chetelat said that the current regulation that patients be transported to the highest level trauma center within 30 minutes addressed the concern of patients passing the UMC Level I trauma center to go to a Level III trauma center at St. Rose Siena.

Co-chair McKinney-James asked about geographic catchment areas. Mr. Chetelat responded that the regulation that patients be transported to the highest level trauma center within 30 minutes created a catchment system linked to geography.

Co-chair McKinney-James asked how the piloting of a no-diversion policy has worked. Chief Crowley said that there has been a great improvement and that it has level-loaded the emergency departments. He said that it was previously a big problem getting personnel out. Mr. Cox of AMR said it has been great. Mr. Genilla of Southwest said that the pilot policy has helped a lot. He said that there had been a glitch with some hospitals regarding the way they indicated their availability but the situation was better.

Co-chair McKinney-James clarified that ambulance diversion was not specific to trauma. Chief Crowley commented that it does impact the entire system.

Mr. Thompson said that currently the 30 minute rule doesn't mean anything because there is only one trauma center. But if there were other trauma centers it would mean a lot. He asked what kind of challenges this would present. Chief Crowley said destination decisions when unclear would be made based on the paramedic's best judgment. Mr. Thompson asked if there was any further clarification in the regulations. Mr. Chetelat said no, but that the decision was best based on paramedic judgment. Mr. Thompson said that it would mean a lot given that a patient near the 30 minute mark might or might

not receive a higher level of care. Chief Crowley said he sense was that EMS would "fudge" if they believed it was in the best interest of the patient. Mr. Chetelat clarified that in cases of an obstructed airway, etc., the patient goes to the closest hospital regardless of whether it is a trauma center.

Mr. Gallegos asked if there was a difference between blunt and penetrating patients in the likelihood they would need immediate care. Dr. Ravenholt said there was a wide range of injuries among the categories of blunt and penetrating. Ms. Gallegos said she was concerned that a financial imbalance could occur if penetrating patients were less able to pay and were more often transported to a particular trauma center. Mr. Williams said he could help address the distribution of blunt and penetrating injuries in his presentation. Co-chair McKinney-James tabled Ms. Gallegos' question until then.

Co-chair McKinney-James asked the representatives from AMR and Southwest if they had additional comments. Mr. Genilla of Southwest said a lot of decisions were based on patient specifics. He said it was good to be able to make judgments in the field and that was the biggest concern. Co-chair McKinney-James said she envisions having EMS outline and participate in any future changes to criteria. Mr. Cox of AMR said that AMR does not have any hidden agendas and that they want what is best for their patients. He said they eagerly await the findings of this process, which are very important. He said he would be concerned about having different levels of trauma centers without fully understanding the differences and resulting destination criteria between them. He said that regarding the concern about "wallet biopsies," EMS are following CCHD protocols and not basing destination on payer.

Dr. Doubrava asked Chief Crowley what percentage of crashes were under 20 mph. Chief Crowley said he did not know and referred the question to Mr. Chetelat. Mr. Chetelat said it was difficult to measure and that the determination was generally based on roadway type. He said it was one of many criteria. Chief Crowley agreed.

Mr. Thompson asked whether, if on the border between a Level I and Level II trauma center, the EMS provider knows in advance if a hospital is on diversion. Chief Crowley said there were a couple ways of knowing. First, personnel can check diversion status at the start of their shift on EMSystem, a web-based interface used system-wide. While in the field, personnel can call dispatch to determine hospitals' diversion status. Soon this information will be available on handheld computers. Mr. Thompson asked when this would be, and Chief Crowley said it would be in mid-June for the fire departments. He added that until then, dispatch is just a quick call away.

Co-chair McKinney-James thanked the Chief Crowley and Mrs. Chetelat, Cox and Genilla. Mr. Williams also offered thanks for the help provided by EMS providers throughout the study.

6. Review of Draft Current Trauma Status Report (As Is Report)

Mr. Williams gave a presentation on The Abaris Group's completed As Is Report. Copies of the report were distributed to the Task Force. Mr. Williams said that the report would be posted on the study web site (www.cchd.org/trauma).

Following Mr. Williams' description of comparative trauma utilization and capacity in Southern Nevada and in other communities, Mr. Thompson said that the data supported what he has been saying, which was that by number of trauma centers Southern Nevada appears underserved, but by number of trauma care beds it comes out very well.

Following Mr. Williams' description of the percentages of patients that have blunt injuries and penetrating injuries, Ms. Gallegos reintroduced her question of whether there is a trend of penetrating injuries needing more immediate care. Mr. Williams said that was a perfect clinician question, but from a system standpoint he would not base the system on the rate of penetrating injuries. He said that issue could be discussed in a future meeting with clinicians. Co-chair McKinney-James said that would be good.

Ms. Gallegos noted that the projections showed approximately two additional patients per day for the trauma system over the next six years. She was surprised by this. Mr. Williams confirmed that was the projection. Ms. Gallegos asked whether, given that finances were important, two more patients per day were enough to support more than one trauma center. Mr. Williams said that now there was real data to analyze, there was an awareness of the history of trauma center closures, and that The Abaris Group would be reporting its findings in a report in a few weeks.

Ms. Arechederra Hall asked if the Sunrise Hospital and Medical Center ACS visit report was available. Mr. Williams said he believed it was not available yet. Dr. Metzler of Sunrise confirmed that was the case.

Dr. Ravenholt said he found the presentation very enlightening. He said the valley has grown more than all earlier projections. He said that Las Vegas residents have not liked governance. He said there is a coordinated system with genuine participation from for-profit hospitals, for example with ED physician involvement. He said he had heard that they received some pressure from administration about patient distribution but that was a long time ago. He asked Mr. Thompson if state authority and enforcement would require legislation. Mr. Thompson said yes, it would take a legislative act.

Co-chair McKinney-James said that the Task Force does not have to fill in the details of its recommendations. She said the Task Force can make broad recommendations, but someone will have to make those decisions. She confirmed that the May 24 meeting is scheduled to include a preliminary ACS executive summary, a preliminary report from The Abaris Group, and Task Force discussion. She said she hoped that the Task Force would have a real dialog and that Task Force members should come with recommendations they feel strongly about.

Co-chair McKinney-James said she does not want to rely too heavily on one site visit and asked if there were recommendations on that. Dr. Ravenholt responded that time is limited. He said he was not sure that the Task Force would gain that much from additional visits. He said that for the issues of authority and funding, San Diego was a great example. He said that $100,000 per trauma center would provide for earmarked funding which would be better than funding from the general fund. Dr. Doubrava said that a fee would be equivalent to a "sick tax" because presumably the charge would be passed to patients, whereas funding from the general fund would come from all residents. He recommended a combination of funding from the trauma center(s) and the general fund. He added that the insurance issue was also a big concern.

7. Update on ACS Site Visit

Mr. Williams said that some of the update had occurred under agenda item 3. He said that the visit would be held at the Embassy Suites, with a dinner event Sunday, meetings on Monday and Tuesday, and recommendations on Wednesday.

Co-chair McKinney-James suggested that the time for the Task Force meeting and work session on May 24 be extended. It was concluded that the meeting would go from 1:30 pm to 4:30 pm or as long as needed.

Dr. Kwalick requested to speak and asked when the final report from The Abaris Group would be provided to the Task Force. He suggested that if it were provided before the May 24 meeting, the Task Force could examine it along with the preliminary ACS findings before the meeting. Mr. Williams said The Abaris Group would provide the report by the end of the week before the Monday, May 24, meeting.

Co-chair McKinney inquired about the copies of Reader's Digest provided to the Task Force. Mr. Williams said that they were provided because they included a photo story on the R. Adams Cowley Shock Trauma Center in Baltimore.

8. Public Participation

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

9. Conclusion

Co-chair McKinney-James adjourned the meeting at 3:45 pm.