Minutes

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

Monday, June 7, 2004
12:00 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

CCHD STAFF PRESENT

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

THE ABARIS GROUP STAFF PRESENT

Mike Williams, President

1. Welcome and Lunch

The Trauma System Assessment Citizen's Taskforce convened in the Clemens room of the Ravenholt Public Health Center on Monday, June 7, 2004. Co-chair Rose McKinney-James called the meeting to order at 12:10 pm.

2. Approval of May 24, 2004 Meeting Minutes

A motion to approve the minutes was made and seconded. The minutes were approved without changes.

3. American College of Surgeons Consultative (ACS) Summary Report by Dr. Robert Mackersie

Dr. Mackersie gave a PowerPoint presentation review preliminary findings of the ACS survey team. He named staff involved as well as his background and position in the trauma field. He stated this process is not verification, but consultative and multidisciplinary in nature. He also stated the process is consensus based and is encapsulated in the model care system plan from the Health Resources Services Administration (HRSA) document published in 1992 and ACS 'gray book' and forms the basis for the recommendation. The consultation objective is to help promote a sustainable effort and the graduated development of an inclusive trauma system for Clark County.

Dr. Mackersie reviewed data for Clark County as well as the state. Unintentional injury accounts for 32 percent of deaths. This is a major public health problem. Dr. Mackersie stated that this area has a large population with high growth rate, geographically isolated, but resource rich and has relied exclusively on a single, Level I Trauma Center. He also outlined the strengths as well as the challenges of the current system and included opportunities which may present during this period. Some key recommendations include:

- Expand trauma care capacity in Clark County consistent with population growth and location.
- Implement the following steps before trauma center(s) are added to the system:
- Complete a specific needs assessment including the durable commitment to care for the injured patient.
- Complete a trauma system plan.
- Document progress in addressing the off-load dwell times.
- Include in the trauma system plan an "alternative pathway" for designation.
- Create a formal written agreement between the lead agency and the trauma center that clearly articulates the roles and responsibilities.
- Explore a mechanism whereby there can be trauma center proctoring of an applicant hospital by the Level 1 staff.
- Changes in the NAC should be implemented c/w the 'alternative pathway.'

Dr. Mackersie summarized by stating that the system in place is not broken and the Level I facility does an excellent job of taking care of all the patients in Clark County. In conclusion, he offered focused questions as well as principles to consider regarding the system configuration.

Questions from Task Force members:

Danny Thompson asked about the issue of off-load and diversion times that are out of the norm – what have other hospitalsl done to deal with this problem?

Dr. Mackersie said he is not an expert, but what we have seen in Maryland was a back-door issue, that is, patients not discharged. It is not emergency room overload, but patients waiting for beds in ED and waiting for disposition.

Danny Thompson asked for clarification of the term 'alternative pathway.' Dr. Mackersie stated that the logjam needs to be dealt with at some point and that we will exceed our capacity and will need another center. The term 'alternative pathway' is a carefully

regulated pathway that was developed - we may need to change the law or regulation to allow for pre-designation.

Dr. Ravenholt asked if the problem of drop-off times exists in the trauma center. Dr. Mackersie stated that the information they received from providers indicated this was a problem, at least intermittently, but felt it would be better addressed by Dr. Fildes. At this time it was suggested by Co-chair McKinney-James that this question be put in the 'parking lot' and revisited during the workshop.

Member Steve Hill asked for clarification of the issue of resolution of the drop-off times and the designation of additional trauma centers Dr. Mackersie stated that if you have separate receiving components for trauma and everything else, and off load problems exist for everything else and not for trauma then it is a non-issue, but if you're Emergency Department is jammed, it distracts Emergency Room personnel from adequately providing Emergency Room services; it will trigger trauma bypass. You do not want to bring a trauma center online that is bringing seriously injured patients into a deluge of lesser medical and surgical patients.

Dr. Doubrava asked about Baltimore and if there is more than one Level I trauma center and if there were any Level II's. Dr. Mackersie responded that there is more than one Level I, John Hopkins, which is located in close proximity; the volumes are quite different. There is at least one Level II and their volume is very small.

He also asked if there have been any EMTALA (Emergency Medical Treatment and Active Labor Act) consequences in transporting the non-stable patient to the higher level of care. Dr. Mackersie initially stated no, but that he was not necessarily aware of this during his travels.

Co-Chair Robert Forbuss asked about penetrating injury which is associated with non-paying patient and the economic impact with respect to designing a trauma system. Dr. Mackersie stated that is a challenge that can be rationalized with best patient outcomes. The trick is not to penalize a center, a high volume center, by providing appropriate center funding to offset and to compensate for care. There is a potential economic pitfall. Mr. Forbuss asked if there was intrinsic costs associated with a stand alone facility, that is, is it an issue of scaling back. Dr.Mackersie stated he did not know the answer to that questions and this question was placed in the 'parking lot' to be addressed at a later time during the workshop.

Co-Chair McKinney James asked about the 'steps' referred to in Dr. Mackersie's presentation as a precursor to moving forward as well as addressing some of the vulnerabilities and in what time frames these might be placed Dr. Mackersie stated this was an important question, a good question, and he was not sure he could give a fully satisfactory answer. He stated that the committee did not feel a sense of urgency or immediacy or that the system was in crisis. He felt that it was more important to pursue the creation of an integrated, comprehensive, inclusive trauma system. Dr. Mackersie stated this was, even with a single center, the most important prerequisite that the committee put forward. The creation of a system should take place before bringing on line another trauma center. Developing a plan can be done in a reasonable period of time, rather than hastily bringing another two or three on line; you must have some of the essential elements before more centers are brought online.

Co-chair McKinney-James asked Dr. Mackersie about the issue of redundancy and 'surge capacity' and asked for clarification. Dr. Mackersie stated surge capacity refers to the ability of a center or system to handle a surge. This may come from a mass casualty event, a natural or man-made disaster. This is something that will be developed within the bioterrorism grant monies. The system should rebound and be able to redistribute the patients to surrounding centers or out of the region. Co-chair McKinney asked if the reference to surge capacity pertained to trauma centers. Dr. Mackersie stated that yes and this would be incorporated into any regional disaster plan.

Co-Chair McKinney-James asked about durable commitment and what mechanisms are in place to ensure this. Dr. Mackersie stated that MOU's or performance agreements between the lead agency and the individual centers and can stipulate a variety of items.

Veronica Arechederra Hall asked about other objective factors that can be used. Dr. Mackersie stated that other agencies verification objectives and those components of verification used by American College of Surgeons are certainly are some of the best measures.

Co-Chair McKinney-James asked about economic impact. Dr. Mackersie stated that economics is beyond the scope of the task force. Dr. Ravenholt stated that there is no mechanism or provision for a new center to be worked into the system. Does a newcomer to the scene automatically assume they will be awarded one-half of the trauma patients?

Co-Chair McKinney-James thanked Dr. Mackersie for his attendance.

4. **Task Force Workshop**

The workshop began with stakeholders' comments and presentations.

Rod Davis, President and CEO and Matt Koschmann, VP Business Development and Planning gave a PowerPoint presentation which outlined its founding, history, and current standing in the community as the only acute care provider in the City of Henderson. It is recognized that there is a growing transport time to reach UMC, are supportive of a collaborative relationship with UMC, supportive of the need for coordinated area "trauma system," have excellent access to the southwest and southeast corridors via I-15 and I-95, the need is greatest in the south part of the region and the number of trauma patients, on average, one per day or 330-350 per year would not significantly erode volume and revenue at UMC, insuring stability of this important resource. St. Rose will continue to work toward meeting the ACS recommendations for a Level III center as well as continuing expansion of facilities. Dr. Doubrava asked what the enthusiasm level of staff was for a Level III trauma center. Mr. Davis stated the initial reaction was mixed; some staff wanted to know of lifestyle impact. Mr. Davis states they continue to dialog with staff. Other groups have indicated they are not interested. Also many good discussions with groups and are confident we can provide physician coverage for a Level III trauma center.

Co-Chair Forbuss spoke of drop times in addition to being a Level III – how will you deal with that. Mr. Davis stated they have success in managing drop times. St. Rose has taken internal space and converted it into surge capacity. Patients shouldn't necessarily

be held in the ER. Mr. Davis stated that St. Rose has set up overflow stations in several of our units where patients can be put while waiting for discharge.

Co-Chair McKinney-James asked Mr. Davis to clarify the fact that they would be able to draw human resources from a variety of locations. Mr. Davis indicated they have 43 hospitals in several states, including St. Joe's in Phoenix and have indicated they would be able to link with them and would capitalize on this as much as possible. Mr. Davis assured Co-chair McKinney-James that St. Rose would provide all of the physician coverage as required by a Level III designation.

Merlinda Gallegos asked Mr. Davis what is the time frame that you would be able to meet to move to a Level III. Mr. Davis stated that this could be accomplished within the next several months.

Co-Chair McKinney-James thanked Mr. Davis. Co-Chair McKinney-James asked if the task force members had received the documents submitted by Sunrise Hospital which included a videotape – all responded positively. Co-chair then called upon Sunrise Hospital for comment.

Sunrise Hospital staff Dr. Michael Metzler and Mr. Brian Robinson began their comments. Although Dr. Metzler stated that he agreed with a number of the recommendations made by the Abaris Group report, he said that the report contained several erroneous assumptions which do not address the current public health needs. First, he disagreed with the projection of the increase in the rate of trauma cases. In 2002, the NHTSA stated that Nevada was second in the nation for increase of fatal car crashes. That increase was 21 percent. If the stated motor vehicle accident rates for Nevada and if the 3.9 case per day growth rate is accurate and Sunrise comes on line and absorbs additional 2 -3 cases per day; UMC has lost little if anything over a period of time. UMC would maintain trauma patient caseload and would likely see one additional trauma patient per day even during the startup period for Sunrise. Their competence and teaching programs would be maintained and not be threatened and the income derived from trauma would continue. Dr. Metzler stated that the area would gain redundancy, surge capacity, back-up and the beginning of the development of a trauma system which really takes more than one center to develop. None of these considerations which were addressed by the ACS were considered in the Abaris report.

The second problem in the Abaris report relates to the 'catchment areas.' The Abaris Report divided Las Vegas in half, giving Sunrise a hypothetical area of about 50 percent of the region. Sunrise requires only about 25 percent of the area to properly apportion trauma cases. It is agreed that Sunrise will need to build, over time, to about 1,000 – 1,200 cases to gain competency and maintain it. Build is a key word –it was projected about 900 cases for the first year, fewer than three cases per day. This would leave 75 percent of UMC catchment area unaltered. At the present growth rate and with lack of a strong desire by the legislature to decrease injury through unpopular legislation such as primary seat belt laws, gun control and 55 mph speed limits, it is unlikely that trauma will decrease over a period of time and is likely that three admissions per day will be sustained.

Dr. Metzler's third point of disagreement is the financial impact on UMC. Conservative estimates of injuries have become the basis for the report's suggestion that Las Vegas cannot afford a second trauma center until the year 2009. There is no data in the Abaris

report that supports this. This proposal suggests that Las Vegas cannot afford a second upper tier trauma center. UMC would be financially unstable and its ability to provide care would come into question. The cost to UMC during this five year period is not addressed in the report.

Additionally, the Abaris report recommended against provisional designation as a way to address the 'catch 22' in the EMS transport regulation. The ACS, to the contrary, proposed this as a safe way to bring an upper tier trauma center online using provisional designation once all non volume dependent trauma criteria were met, followed by establishing an oversight committee that dealt with performance issues and patient safety. The Abaris report fails to recommend a plan to effectively deal with the issues of redundancy, backup and surge capacity. The proposal that brings St Rose online as a Level III is not reasonable because a Level III does not adequately provide backup or surge capacity for a Level I.

In summary, Dr. Metzler agrees with the goals of trauma system development as contained in the ACS summary and many of the Abaris group recommendations as they pertain to system development. Dr. Metzler does, however, disagree with trauma growth projections, and conclusions that an additional upper tier trauma center is unnecessary and financially impossible anytime soon.

Mr. Thompson indicated that he felt the data regarding population versus number of beds, rather than number of centers is accurately stated in the Abaris report. Mr. Thompson asked what was being done at Sunrise to handle diversions and lengthy drop-off times. Dr. Metzler stated the number of bays is one way to look at this; this is not the way it is viewed across the country. Even if you double the size of UMC, you do not get around the fact that it is a single source provider with all potential problems of being the only game in town for 400 miles. Our intent was to be a back-up for a Level I center, not to challenge UMC but to support it.

Mr. Thompson stated there has been a long adversarial history in the legislature between UMC and Sunrise. Dr. Metzler stated he was recruited from an academic medical center and he would not have come here if he thought his job would have been to be at odds with an academic medical center. He restated his goal, to take an institution that is not a trauma center to a Level II, supportive of the existing trauma center.

Mr. Thompson stated that trauma injury has been driven back by injury prevention and the ACS summary report indicates that. Dr. Metzler stated that we have high speed crashes; and, as Dr. Mackerise stated, that we do not have a good handle on the exact slope of the curve between total population and increase in injury.
Dr. Doubrava asked if three to four beds are adequate – what did Dr. Metzler propose. Dr. Metzler stated that the Sunrise plan included four resuscitation beds. Dr. Doubrava again asked what kind of support do you have from medical staff, not the recruited staff. Dr. Metzler stated some staff is very supportive and other staff will have to be recruited, such as trauma surgeons. Orthopedic surgeons have said they will assist, as well as anesthesiologists will assist. Dr. Venger, a neurosurgeon, responded that his specialty is difficult to recruit and they will be here for both UMC and Sunrise as they currently are. Previously patients would go out of state, now they come here.

Brian Robinson of Sunrise spoke to the members and thanked them for their time and what the members are doing and what has been done. Mr. Robinson addressed Mr. Thompson's concerns regarding drop-off and wait times. Since April 1 Sunrise no longer diverts. All of the hospitals began a no-divert policy. Sunrise has increased holding areas and the size of the Emergency Department (ED)by utilizing other areas, creating new places, new holding areas. There is a contract underway to expand the ED by nearly 20 percent in terms of bed size. Sunrise also participates in national endeavors to analyze their throughput into the ED and is in the process of hiring physician extenders to assist medical staff in ED positions and to assist in the offload process.

Mr. Robinson spoke of three issues: patient access to care, collaboration, in terms of working with UMC, and funding. He stated that he envisioned UMC as the hub and Sunrise and St. Rose and others to join work together as the spokes. In terms of durable commitment, if an MOU needs to be signed, if need be for five years out, Sunrise will sign it.

The Sunrise presentation continued with Senator Richard Brian and Greg Bishop. Senator Brian shared his perspective on Las Vegas and its' growth. He mentioned homeland security and reviewed terrorist activities around the world and a letter from Congressman Jim Gibbons. He quoted from various news agencies. His point was not to suggest an attack was imminent, but to point out our vulnerability. He suggested that we cannot be unmindful about our vulnerability.

Dr. Doubrava asked if Senator Bryan was suggesting that Federal funding may be available. Senator Bryn stated that Congressman Gibbons, as noted in the quotation, has been successful in appropriating additional homeland security funding.

Co-chair McKinney-James indicated that those two documents will become a part of the record. Co-chair McKinney-James asked Mr. Bishop to state his remarks.

Mr. Bishop stated that off-load times have been discussed and are really an issue of a much larger flow of emergency patients. Mr. Bishop stated that Sunrise staff asked him to help them about a year ago. He chose to work with Sunrise as they have come up with an imaginative and innovative way to solve this problem. They proposed a Level II center, coupled with an emergency surgery program. The problem is not the number of beds, but having available doctors willing to treat patients and then nurses and beds, etc. The issue is the physicians in general and each trauma center requires 15 specialists on-call at all times. Sunrise is proposing is to use the Level II trauma center as an anchor to build a cadre of ER trauma physician support. Sunrise hospital has excellent resources. There is substantial volume of trauma injury levels to financially support trauma at UMC. Mr. Bishop showed a document which reflects the catchment areas of Los Angeles and stated that you can simply design a catchment area to produce the volume that is appropriate for the level of trauma center. Mr. Bishop indicated that the task force had a rare window of opportunity in that typically a hospital does not step up especially one with the resources that Sunrise has to offer.

Ms. Gallegos stated that after the San Diego site visit, it was noted that we have an incredible opportunity to design a 'system' and that, beyond even ACS standards, we have an opportunity to raise the bar. Ms. Gallegos asked Mr. Bishop why did he choose to use non ACS verified or designated Level I and Level II trauma centers when using

the Phoenix illustration. Mr. Bishop stated that in Phoenix you have non designated centers, there is no system, no ACS verification, yet they function as trauma centers. It is important to include those when you are looking at capacity. They have not pursued ACS verification.

Mr. Thompson asked Mr. Bishop when he wrote the documents that were hand delivered were written. Mr. Bishop stated he has written a series of documents throughout the process with Sunrise. Mr. Thompson stated that his concern was the timing of these documents and asked if Mr. Bishop has ever been to UMC. Mr. Bishop stated he had visited many centers throughout the country, but not UMC.

Dr. Ravenholt asked if there were any pre-hospital triage guidelines that cut up the community as to destination. Mr. Bishop stated it was unusual to have well defined catchment areas across the country.

Co-chair McKinney-James stated her perspective regarding receipt of the documents she and the other task force members received from Sunrise as well as the fact that a press conference was held and obviously the task force has been doing their best to be vigilant in expediting this process so that recommendations can be forthcoming. Mr. Bishop stated that the objective is to get to the right outcome and that sometimes these issues can be highly charged. Co-chair McKinney-James referred to the 4 page document and the paragraph which refers to national crisis in trauma care and a need to take corrective action. Was there something in particular with respect to ACS recommendations that you wanted to point out? Mr. Bishop stated that there is a national crisis in trauma care. Co-chair McKinney-James stated a reference was made to the UMC strike and did Mr. Bishop think that if, hypothetically, Sunrise was a Level I trauma center, would there be a different outcome. Mr. Bishop felt that yes, he believed so. He stated that trauma centers are closing. Co-chair McKinney-James asked Mr. Bishop to clarify in his document as to why Nevada was 'red' and the use of this document in what we are looking at now. Mr. Bishop stated that this document was used to highlight that trauma has been overlooked in the scramble for resources.

Dr. Doubrava indicated that the document referred to UMC as enjoying strong physical capacity for trauma while it's overall trauma medical staff remains weak and unstable. How do you arrive at that? Mr. Bishop stated resources for trauma care in this community have diminished over time and focused on a small set of physicians; the history of a strike by physicians indicates a weak medical staff structure. It is a national problem. The Sunrise proposal represents thinking for the next decade in building a strong trauma and emergency surgery program. Co-chair McKinney-James stated that if those physicians (at Sunrise) had to deal with medical malpractice insurance issues there would be the same perspective as any other physician, regardless of where they come from.

Mr. Bishop stated that we have medical malpractice crisis affecting centers across the nation and they do not close the trauma centers. Sunrise would take responsibility to make sure physicians were economically viable.

Dr. Ravenholt stated that to characterize UMC trauma staff as 'weak and unstable' represents an unfair bias.

Mr. Thompson indicated that the physicians did not want to quit; some physicians had to quit delivering babies. How do you wash your comments with those of Dr. Mackersie with respect to the quality of UMC? Physicians are able to respond within 5 minutes and are able to accept any case proposed to them.

Mr. Bishop stated that as the county, looking at this situation…Co-chair McKinney-James states we are not the county, Mr. Bishop states, as the county health care district, Co-chair McKinney-James states, we are not the district…we are working on behalf of the public, we are a citizens task force, we do represent the county, we do not represent the health district, we are a separate entity and have been given a mission and we are doing our best to discharge that mission. Let the record be very clear in that regard.

Discussion ensued regarding the reasons the report stated the UMC medical staff was characterized as weak and unstable. Dr. Ravenholt asked Mr. Bishop what drew him to that conclusion. Mr. Bishop stated that a trauma center has never closed. Mr. Thompson stated the legislative fix was a cap of $250,000. Mr. Thompson indicated he was upset that he was informed of a press conference and not given any opportunity to reply to charges in the document. Mr. Bishop stated all the members were invited. Co-chair McKinney-James indicated that the invitation was received after the fact and that there would have been no way to participate, no opportunity to observe the press conference.

Dr. John Fildes and Mr. Lacey Thomas from Sunrise began their comments. Dr. Fildes indicated he spent considerable time reviewing the Abaris and ACS reports. He stated the ACS report provides a compass and the Abaris report provides a map. Our system is not in crisis; our system is serving the community needs. The urgency being created is coming from other forces rather than from patient need. We need to expand our system with caution and before adding new centers we will need to have an organized trauma system. The 'parking lot' question about off-load times; there are no delays in off-load. There are no waiting times, 99 percent of the times this occurs instantaneously and there are no waiting times. There must be demonstrated need for new trauma centers based upon growth. It is also required to have durable commitment as well as a strategic location. It needs to be financially self-supporting and economically viable. We have a center that satisfies most, or many of these. The needs for a second center, should it be placed in city center would not meet the needs of the people in the southern end of the valley. There is enough growth in our area to support the startup of new trauma centers in areas of increasing population and distance from UMC. As the system grows, we must not damage the parts that are working well.

Dr. Ravenholt stated that problems with off-loading patients do not relate to the trauma centers and it is an important distinction.

Co-chair Forbuss asked Dr. Fildes to respond to comments such as putting all your eggs in one basket as it relates to a community under a perceived potential mass trauma. Dr. Fildes stated that in responding to a mass casualty we have not formed an inclusive trauma system and we have not developed a decentralized plan to move patients out of the valley. Adding hospital beds is not even close to being able to respond to one of these events.

Co-chair Forbuss asked about financial impact to UMC. Mr. Thomas from UMC stated that for every 600 patients we move out of the trauma center, it will cost UMC 2.2 – 2.5 million dollars. We would have to make adjustments or the Clark County Commission would have to give us more money. Co-chair Forbuss stated this is an important component of the decision making process and wanted to know if these were obstacles that could be overcome.

Member Steve Hill asked questions about revenue and fixed and variable costs. Mr. Thomas indicated that there is a minimum fixed cost.

Co-chair McKinney-James asked Dr. Fildes that if patient load doubled could you or could you not absorb the possible 3.9 patient growth rate that was in the Abaris report. Dr. Fides indicated that certainly, three. He stated that 6 would certainly make it more difficult. In 5 – 10 years, he believed that the system would expand itself due to population movement and movement out of the city center.

Member Steve Hill asked questions regarding financial impact and comments that a hospital can fill in with other types of patients. Financial documents were distributed and reviewed and summarized by Mr. Thomas and Mr. Mike Walsh, CFO of UMC. These documents included number of cases, revenue, total direct costs, net revenue before indirect, indirect cost and net revenue/loss. Documents indicated a loss of $11,931,045. Co-chair Forbuss stated that when he was on the other task force, UMC trauma center was a profit making area for the hospital. Mr. Walsh stated that this was being looked at from direct costs. Co-chair Forbuss wanted to clarify that there is a loss of revenue of $2.2 million for every 600 patients reduced or roughly $4.4 million if UMC were to lose 1,200 patients. Mr. Walsh stated it would be difficult to cut $4.4 million from operating costs. Co-chair Forbuss asked Mr. Walsh if they could arrive at cost reduction items and the time frame for same. Mr. Walsh indicated he could have something for next meeting.

Co-chair McKinney-James stated the members will now move into the workshop portion of the meeting. The questions for the members to consider in order to bring recommendations to the Board of Health were reviewed and Rory Chetelat, EMS Manager with facilitation.

Dr. Doubrava asked if Sunrise Hospital could put together a report such as the one received from UMC based upon costs. Mr. Robinson stated the Sunrise does not see trauma patients, according to EMS protocol they are required to be sent to UMC. Mr. Robinson stated that yes, as a forward basis they would be able to provide that type of report.

The key questions were displayed on an overhead screen and television monitor. Rory Chetelat stated that he is there to facilitate the questions and answers. Some questions were reviewed by members.

Key Questions
Trauma System Assessment Citizens Taskforce

1. Is there a need to develop a comprehensive regional trauma system for Clark County and the surrounding region?
   Yes

2. Should the number of trauma centers be increased?
   Yes
   a. Why (volume, population, geography, surge capacity and redundancy, financial impact to UMC)?
3. How would additional designations impact the current Level I trauma center at University Medical Center?

   a. Financial vulnerability?
      Waiting for financial information from UMC and taxpayer impact
   b. Quality of care?
      Pending further analysis; difficult to determine without a system in place

   c. Human resources?
   d. System development?

4. What level(s) should be designated and where?

5. Should the components of a trauma system, as identified by organizations such as the American College of Surgeons, be developed for Southern Nevada?
   Members stated yes

   a. Trauma registry?
   b. Quality improvement initiatives?
   c. Research?
   d. Training and continuing education?
   e. Injury prevention programs?
   f. Triage?
      Yes to above

6. What entity should take the lead and how could this be accomplished?
   The State of Nevada should designate operational control to Clark County Health District through (MOU)

7. How should the lead agency for trauma system development be funded?
   Designation fees; review technical assistance report from Washington, DC
8. Is provisional designation necessary?
9. Should authority exist for regional system development?

Discussion ensued regarding detail and Co-chair McKinney-James suggested that there are limitations to what the task force can do. Members Danny Thompson and Dr. Doubrava disagreed with respect to building a system concurrently, or before a plan is in place. Task force member Richard Bunker indicated that we are willing to go forward as long as UMC is not damaged. He stated the taxpayers have been subsidizing this institution. If adding another trauma center can be established that under the guidelines of not depriving the financial stability of UMC that is agreeable to him. Discussion continued regarding financial impact and Mr. Thompson stated that his experience in the legislature showed that no monies will be awarded in the form of a tax or fee. Dr. Doubrava indicated that history is that we had one ambulance service, and then there were two, etc. Further discussion regarding financial liability continued. Dr. Ravenholt stated that financial analysis is often difficult to interpret.

Co-chair Forbuss stated that you can draw a line on a map to configure distribution of payers and payees. Co-chair McKinney-James stated that perhaps we should start with question 9. Rory stated that perhaps questions number 5 which address the system components – should those components of the system be developed first and members stated yes.

With respect to question 6, Dr. Kwalick agreed that Clark County Health District was the logical choice as lead agency. He also stated that designation fee, not only designation fee for those wishing to participate, but really for the entire acute care system. Our area has twelve hospitals. It would seem logical everyone should contribute a community-wide system, not just trauma center designees. We are talking about the entire community. Mr. Thompson stated there is a constitutional prohibition against raising a fee or a tax unless there is a two-thirds vote of the legislature. The Clark County Air Pollution Board wanted to increase the fees for permits for dust control and it was a difficult situation. Rory asked if the members now want to discuss provisional designation. Co-chair McKinney-James asked if the members wish to support the ACS recommendation for an alternative pathway. Discussion ensued regarding terminology. Rory stated there are two questions – should there be some other means that is currently not available through legislation, and if so, what would that process be?

Dr. Ravenholt suggested there should be a graduated, incremented provisional designation to allow other participants- there is a real problem with present regulations not having this avenue available. Dr. Kwalick explained that there is an opportunity to enter into an interlocal agreement with the State that could be tailored in such a way there could be regionalization in the southern part of the state for trauma system development. All the details could be spelled out by the local board of health. That could be wide-ranging and could lead into the Board of Health making regulations for the health of the public. Rory stated that the questions were guidelines and were written in a vague way to allow you to expand and interject your knowledge, experience and information from reports.

Dr. Kwalick wanted to review the process. He stated that this body is to make recommendations to the Trauma committee of the Board of Health. Those recommendations would go to the District Board of Health at this June 24 meeting, which, in turn would go to the State Board of Health whenever appropriate. The questions were developed to help you discuss what you feel is important to trauma system development. The authority rests with the Division of Health administrator for designation. The Division of Health asked us to make recommendations as to what should happen in Southern Nevada. The Division of Health administrator may choose to act independently in this matter. Yvonne Sylva, current administrator is on terminal leave and a search for a replacement is in progress.

Co-chair McKinney-James restated the fact that Dr. Mackersie indicated there was no sense of urgency and that although we are anxious to reach closure there are a host of issues which need analysis. She did not feel that our charge was to resolve all the issues. Nor did she believe that even if we recommend x, y and z, that was not going to happen tomorrow. We do not need to rush through this and making a mistake, making a decision that is not well-formed. We recognize a system needs development and that there is no financial hardship to UMC.

Rory recapped the progress and that it is necessary to develop a system, the Health District is the likely lead agency for the operational control, that MOU's need to be developed between the state and the local entities, fees through designation, all components will be part of the system development.

Dr. Doubrava restated his opinion that some kind of provisional designation be given to Sunrise Hospital so that they can step up and play. They have funding and are willing to become a player. Mr. Thompson disagreed stating there is a lot more at stake than money. If we hurt UMC and make care more expensive than it already is. The people I represent do not get a raise; the money goes to health care.

Co-chair McKinney-James stated that perhaps we need to agree, at least from the perspective of the citizens task force, that agree or don't agree that a plan needs to precede any discussions regarding designation, a fundamental starting point. Others have to make compelling arguments relative to provisional process or alternative pathway. We need to recommend a plan must be in place.

Ms. Arechederra Hall requested a copy of the model plan as referred by Dr. Mackersie.

Merlinda Gallegos concurred with the ACS recommendations that before adding centers to the system, we complete the specific needs assessment about durable commitment, that we complete a trauma system plan and to document progress on the off-loading times before we add more centers to the system.

Dr. Kwalick stated that any time line is artificial and if the members need more time for more information they should do so. Co-chair McKinney-James stated we need more time to review certain aspects and the meeting was continued.

Adjournment
The meeting ended at 6:05 and continued to Monday, June 14, 2004.