Minutes

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

Monday, June 14, 2004
(Continuation of June 7, 2004 Meeting)
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
S. Max Doubrava, MD
Robert Forbuss, Co-chair
Merlinda Gallegos
Steve Hill
Otto Ravenholt, MD
Danny Thompson

MEMBERS ABSENT
Rose McKinney-James, Co-chair
Richard Bunker

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
Susan Eiselt, Recording Secretary

ABARIS STAFF PRESENT
Mike Williams

Welcome and Lunch
The Trauma System Assessment Citizen's Task Force convened in the Clemens room of the Ravenholt Public Health Center on Monday, June 14, 2004. This meeting is a continuation of the June 7 meeting. Co-chair Robert Forbuss called the meeting to order at 12:12 pm.

Dr. Ravenholt stated that this is a continuation meeting for the record.

Report/Discussion
Mr. Thompson stated we listened to hospitals report on June 7 and other stakeholders would like to speak as well.

D Taylor, of Secretary-Treasurer, Local 226 culinary union, stated it was important to have a stable health care system. He stated that the system is

identified as working and not in crisis. We are lucky that we do not have to fix a system in crisis. He stated that the task force is charged with dealing with facts. We need to look at what works in the community. Health care has never been a free market system. There is no free market when it comes to trauma. One does not get to choose. He reminded the task force that the system should be developed based upon facts and the needs of the community. He stated he believes the urgency to complete this system is artificial and is not based upon the needs of the community. If we have a terrorist attack, a trauma center is not going to solve our problem. We know that the federal government will step in. He stated his admiration of the task force and asked for balance in the decisions of the task force.

Co-Chair Forbuss asked Rory Chetelat to review our progress to date. He began facilitation of this workshop with review of previous meeting. Rory stated the task force made good progress – we do need a system. There was discussion of financing and possible options. Dr. Kwalick discussed the possibility of an interlocal agreement with the State as to delegating some of the authority to Clark County Health District as the lead agency for Southern Nevada.

Dr. Ravenolt asked Rory to that we solved the financing perhaps you mean that we can fund an oversight unit, but not the financing the trauma system. Rory stated that, yes; we have identified some avenues to fund the oversight portion.

Co-chair Forbuss wanted to stress that you can't turn on a switch and suddenly paramedics will go to another hospital – it would seem that you would have to phase that in over a period of time otherwise you may find a situation where one trauma center would be overwhelmed. Dr. Doubrava stated that the paramedics in the field are knowledgeable and would be able to determine if a center is overloaded. In addition, he stated that we should concern ourselves with smaller disaster/terrorist attacks, such as those with 50 – 100 victims. Dr. Ravenholt stated that the injured in a major disaster do not necessarily go to a trauma center and not necessarily by ambulance. Co-chair Forbuss wanted to mention that the Pepcon plant exploded and the injured appeared by pick-up truck to St. Rose de Lima.

Rory stated that there were two questions from last meeting; two questions on hand - designation or system first?

Mr. Thompson wants to restate his position not to have designation before the system; you cannot put the cart before the horse. Mr. Thompson wanted to ask Mike Williams--is he familiar with system in Phoenix? He mentioned, for the record, the article in today's *Las Vegas Review-Journal*.

Max Doubrava stated that the design and implementation can be put together quite rapidly – we can design concurrently and don't need wait for designation. Mr. Williams stated that Abaris was a consultant to Arizona for three years to help them develop a plan. The Arizona governor recently authorized a plan to develop a system – including official designation. This is after 14 years of struggle by the providers themselves, wanting more consistency in their system. There are five trauma centers in Phoenix, one of which has been designated by ACS. They operate as level 1, but actually are a strong level II. They are resistant

to change and have had significant financial difficulties. In his opinion, they are over designated and have more trauma centers than needed. Tucson has self-designated centers, huge financials issues, no planning, no quality review; no way to adjudicate pre-hospital triage issues. There are no components of a system in place first. The state has a line item in the budget, but it is a nominal amount.

Mr. Hill asked if there is a checklist for components of the system and time frames for each. Mr. Williams stated they are outlined in his report mimic the national standards. In our report we actually called for additional considerations for things not typically referred to by a survey team such as capacity and hospital diversion problems. Mr. Hill stated that he has heard here that the offload problem does not affect the trauma unit. Mr. Williams responded that it would not affect a free standing trauma center but when you have an existing emergency room resource, and a system that has been compromised in the past, we would recommend that you look very closely at what their new capacity commitments are to meet the new volumes. This is very critical otherwise you are likely to have significant offload problems. Mr. Williams recommends a parallel process, an advisory committee, lead agency such as Clark County Health District, funding tool to support staff and the advisory group which would be set up to advise as to the nuances of triage criteria. Then there is planning an educational process for the EMT's. Mr. Hill asked how good does the triage process have to be to begin. Rory Chetelat responded that you must have a good triage system in place otherwise there will be mass confusion.

Dr. Ravenholt asked Mr. Williams to clarify the Phoenix system and the functioning of their centers at Level II – are you saying they have 24 hour on-call physicians and surgeons ready to receive? Mr. Williams responded that there are four trauma centers in Phoenix proper and they all do operate with in-house surgeon coverage which is a pretty aggressive commitment for a hospital that is not officially designated. St. Joseph does operate as a Level I and has been verified twice by ACS.

Co-Chair Forbuss stated that the trauma centers in Phoenix went to the State for the creation of a system. Why would they do that? There is a lot of integrity of the surgical and nursing community in Phoenix who believe there is a need for a regional trauma system. Co-chair Forbuss stated UMC handles everything in-house, including reviews and it may benefit UMC as well to share their expertise with others.

Mr. Williams mentioned that he thought some members coming back from San Diego were fired up not just from looking at the framework of a system but maybe looking at "best practices." When you add another trauma center, using the triage system as an example, if a medic makes a decision to take a patient to center 'a' instead of center 'b' there may be a challenge – typically from a hospital that is unserved.

Co-chair Forbuss asked that, with respect to the new guidelines in effect, do we have any sign that UMC is handling less patient load. Dr. Fildes was asked if he sees anything different now that the new protocols are in place. Dr. Fildes stated that when the State said that everything under 20 mph had to come into UMC,

they experienced quite a surge – a variance from the State Board of Health restored the mph back to 40 and that corrected our patient population and the response from the local emergency room directors was that the numbers were correct again.

Mr. Hill wanted clarification of creating a system - did Mr. Williams mean the items listed in the ACS report? Mr. Williams stated there are 8 – 15 components of a trauma system- does every element need to be matured? No, but the clinical care and leadership capability should be in place before any additional designations should take place and on the way to maturity before you impact the number of trauma centers.

Discussion ensued regarding finances. Co-chair Forbuss asked about financial onus being placed upon a trauma center and gave an example of ambulance franchises having to place 2.5 million cash and bond and if there was a default he would have had to forfeit equipment, cash and the bond. He wanted to know if anything like this had ever been done. Mr. Williams stated no. The hospitals here have indicated that they are going to self-manage the financial side of this – we will need to review the financial records. There have been many instances where hospitals across the country thought they could handle the finances. Mr. Williams stated that funding verification is an important consideration in the review process and the college (ACS) would handle the clinical side of it. Typically these centers come back to public institutions looking for financial assistance.

Dr. Doubrava stated that we have the ability to create the system quickly he doesn't believe that the revenue is an issue; the tax base is increasing; easy to track payment with trauma registry. Oversight system can be developed concurrently. We also have another trauma surgeon in town that we need to take advantage of.

Mr. Thompson disagreed with Dr. Doubrava. He stated we cannot use a tax or fee. He has been involved with the legislature long term and respectfully states that Dr. Doubrava is not correct. He thought that The Abaris group did a needs assessment and then this task force would follow that needs assessment.

Rory Chetelat stated that he is hearing everyone say we need a system. Is there enough time to develop a system or do we need to designate and develop the system concurrently. Dr. Ravenholt asked what is the urgency factor. The urgency is created by a would-be center that has brought staff to the area – it is not an issue of overload or capacity. I would like to hear from Dr. Kwalick on how soon could the District bring together a system for this purpose?

Dr. Kwalick stated that Clark County Health District could establish an interlocal agreement with the state to allow us to do anything that the state can do. We need to get Clark County District Board of Health approval and then get the State Board of Health administrator approval to delegate authority to Clark County Health District to establish a regional trauma system. Dr. Ravenholt asked Dr. Kwalick what did he believe was the time frame.

Dr. Kwalick responded that the State administrator successor should be aboard in the next few months. The District Board of Health here will meet on June 24. The decision as to an interlocal agreement would hinge upon the State Board of Health and the Clark County Board of Health approval. This could be accomplished in the next couple of months. The Board of Health at the State level meets every other month, the Clark County Board of Health meets monthly.

Co-Chair Forbuss mentioned the financial impact to UMC and asked them to present financials to the members. Mike Walsh CFO and Lacy Thomas, CEO, distributed the financial information requested from the June 7 meeting and indicated the reduction of revenue based upon the loss of 1,000 trauma cases. Mr. Thomas stated the first page is a summary of the document you received at the last meeting. The revenue decrease would be approximately $12 million, direct costs would go down by about $8 million and the net revenue loss would decline by about $4 million. Reductions would have to be made in many programs to keep the trauma center functioning at some level. Mr. Forbuss asked for the total net revenue for UMC. Mr. Walsh stated it would be a little over $400 million.

Mr. Thompson asked of UMC officials what do you do if your loss exceeds what the County sets aside? Mr. Walsh stated they are committed to operate under the budget constraints of the County – we have a responsibility to the taxpayers and citizens. We would have to figure out how to maintain that service to the community. Mr. Thompson stated the taxpayers of Clark County would have to pay.

Mr. Thomas was asked by Mr. Forbuss to review other programs that are offered at UMC. He responded that they are the only burn center in Southern Nevada and in fact in the State. The new Nevada Cancer Institute, HIV services, transplantation program are the Centers of Excellence, in conjunction with the University School of Medicine. This is where we focus our resources on providing the highest quality of care. We provide cardiovascular, oncology, emergency pediatrics and adult emergency services as well.

Mr. Hill asked if the costs that are unrelated to trauma--then why haven't you cut that already. Mr. Thomas stated that we have to move resources away from other aspects of the hospital. Trauma does not stand alone and does not stand alone in the hospital. Mr. Walsh equated possible reductions to 30 – 50 FTE's. Co-chair Forbuss then called upon Sunrise to address the members.

Mr. Robinson of Sunrise Hospital provided financial summary overview proforma to the members for the operation of the trauma center. This covers a three year period and is based upon 756 trauma patients. This represents 25 percent of the high end trauma patients, not based upon a geographic location. Co-chair Forbuss stated that first year numbers would be 756, not 1,000. Mr. Thompson asked how you arrived at that number. Mr. Robinson stated that initially the catchment area would be 25 percent with a ramping up phase. Some cases will continue to be better served at UMC. Mr. Thompson asked what the catchment area would look like. Mr. Robinson stated that would have to be created. H estimated that trauma patients would generate just over $12 million in uncompensated care, bringing net revenue in the amount of $9.4 million. Co-

chair Forbuss asked about uncompensated care – is that contractual allowances also. No, that is straight uncompensated care. Co-chair Forbuss stated this is for pure uncollectible debt. Mr. Thompson stated that number is pretty subjective depending upon what the catchment area looks like. Mr. Thompson stated that depending upon the communities – if there are a lot of gunshot wounds which generally are not compensated. Mr. Robinson stated that it is fairly reflective of our existing experiences and that it is not an exact science, but it is reflective of the population around the hospital.

Co-chair Forbuss asked what would be the projections over the next three years for additional trauma. Dr. Doubrava then asked if Sunrise received any disproportionate share (DSH) compensation from the county for indigent care. Mr. Robinson replied no. Mr. Chris Taylor, CFO, Sunrise stated that Sunrise did receive it for FY ending June, 2003. He believed it was approximately $ 800,000. The legislature changed its policy and Sunrise is no longer receiving these funds. Sunrise receives Federal DSH for the Medicare program, but not State DSH. Co-chair Forbuss asked if Sunrise anticipated going to the legislature in a year and asking for those funds based upon the numbers indicated. Mr. Robinson anticipated pursuing all funding options available. Sunrise also offers unique services. Sunrise has a commitment to continue to provide access to these services as well as any other types of services available through Sunrise today.

Co-chair Forbuss asked if Sunrise is willing to make long term commitment as well as a commitment to care for high risk non-paying patients. Mr. Robinson stated they will sign a 5 year commitment letter which contractually binds them. Sunrise will build an integrated yet separate trauma area with equipment and, as a community resource, will continue to take care of uninsured patients into the future and is committed to being a durable, long-term player.

Mr. Hill stated we do not wish to harm UMC - it is in the best interest of the taxpayer to protect the quality of services at UMC. He is not convinced UMC will go out of business, but is concerned about the level of care. Mr. Robinson stated they are comfortable designing catchment areas and are knowledgeable about Sunrise own capabilities and that 25 percent is acceptable. Mr. Hill stated that it is in the best interest of the patients in Southern Nevada to add centers to the system and to have a system.

Dan Musgrove from Clark County manager's office stated that the Clark County budget is lean - Metro asked for $20 million – we gave them $10 million. We have augmented UMC and will continue to do so. County commission must decide what programs will not be funded because we augment UMC. Mr. Thomas said that he asked for $15 million – we gave him $10 million. Mr. Musgove stated that revenue has been flat over the last 10 years – the cost of goods, etc. – based upon a per person, per capita. Perhaps in 2005 – 2006 the county may see increased revenue from the recent building boom. Mr. Hill stated that if you assume we are going to add another center then the question for the taxpayer is timing. Mr. Thompson asked if the County commitment had to double what would happen. Mr. Musgrove stated some other program would suffer. We can raise fees. If we increase taxes we have to go to a vote of the people.

Ms. Gallegos stated her concern of the number of Sunrise cases. At one point it was recommended that 1,200 cases was a minimum. Mr. Williams stated that ACS removed the requirement for Level II. The Abaris report recommended 1,200 cases. Mr. Williams indicated that it was based upon standards of care. Mr. Williams indicated that 1,000 – 1,200 as the sweet spot. It is very difficult for a Level II to make it on less than 1,000 cases. Co-Chair Forbuss stated that is probably why Sunrise is showing such a loss. Dr. Doubrava stated that you are also addressing the loss of proficiency. Mr. Williams said the ACS does not weigh in on the minimum number for a Level II; it is actually based upon a cardiac surgery model. Dr. Metzler stated that the numbers are targeted and not exact. Some Level I centers see very few patients, but handle them well.

Ms. Pilar Weiss, Local 226, culinary union, asked to be allowed to comment at this time. Ms. Weiss stressed task force deliberations should focus on developing a system.

Rory Chetelat resumed the meeting after a break and asked the members if we should designate first or build the system. A motion was made by Mr. Hill that we recommend that we build the system first and build it expeditiously. The motion was seconded by Ms. Gallegos. Co-chair Forbuss stated we do not have two members with us today, including the Co-chair and he believed she wanted to weigh in on this. Rory stated that only designation in the State is ACS designation. Rory stated that perhaps we should work on processing plan recommendations for the sub-committee.

Dr. Kwalick stated that the only designation that can be made is after verification by the ACS. That is the process according to the current legislation. The State is charged with planning for a system and the designation. Designation may remain at the State level; they may not give that up. Part of the interlocal agreement could assure that we receive that delegated authority and with that we include assurances of funding, leadership, governance, etc.

Co-chair Forbuss asked Dr. Kwalick if it was possible to set up motions for the task force for the June 22 meeting. Co-chair Forbuss indicated that not all the members will agree – we will probably have a majority or minority opinion. Dr. Doubrava stated he will submit a report for the record. He stated that the task force was charged to investigate needs of the county and make recommendations. We can develop a system in an efficient and timely manner and to revisit provisional designation as long as UMC is not impacted. The recommendations should be to give provisional designation to Sunrise and if there is harm to UMC we should be able to remove that designation.

Co-chair Forbuss asked whether staff could put these questions in a neutral way for our members to consider on June 22. The motion was called for a vote and carried 6 - 1.

Ms. Gallegos stated that she would like to recommend that the State Health Division should prepare a statewide trauma plan as recommended by the Abaris Group.

Dr. Kwalick stated that it could be put in on the Board of Health agenda – that he would pursue an interlocal agreement for delegation of authority from the State for the development of a trauma system. The Clark County Board of Health meets on June 24 and the State Board of Health meets on June 25.

Dr. Doubrava stated that are we going to have a system put together with no financing because there are no players except UMC who will now be responsible for the whole operation? Ms. Gallegos recommended as submitted by Sunrise Hospital that all of the regional hospitals invest in the system. Part of the selling point of that would be injury prevention, training and a continuum of care from the pre-hospital on out. There should be graduated levels of buy-in.

Dr. Ravenholt stated that was not reasonable because of hospital licensure and fee collection as a state function and would be very cumbersome to change. The way to anticipate the flow of funding to support the oversight of a trauma system is the interlocal agreement and the contractual agreement of the local unit and the participating hospitals in the trauma system. Ms. Gallegos stated that perhaps a voluntary fee. Dr. Doubrava stated that you cannot change the way the license was issued.

Dr. Doubrava stated if you do not like the word provisional designation then choose another term. He stated that that there needs to be provisional designation that should be made available to willing players with the overriding proviso that if there is damage to UMC we could abandon it. We are all in agreement that St. Rose should be a level III designation.

Mr. Hill asked when Sunrise could be ready to open as a Level II trauma center. Mr. Robinson said that he certainly felt Sunrise could be ready in a time frame that would run concurrently with the development of this plan. Mr. Robinson stated that he felt they could meet all non-volume related criteria as surveyed by the ACS and as pertaining to Nevada law, in addition, would have all the medical staff here.

Mr. Thompson stated he is opposed to provisional designation. He stated that if you have a durable commitment; it isn't going to go away in a couple of months. If a hospital is committed, then they will be committed after the system is in place.

Dr. Ravenholt stated that that we may over-conceptualize what the trauma system may look like. From what he has heard and seen it is primarily a method tying together service providers with quality improvement, quality assurance, oversight, etc. It is not going to add what the Abaris Group did in reviewing the trauma needs. They have produced a report that addresses those issues. We are still left with the value judgments and decisions that go beyond whether to designate St. Rose a Level III trauma center. He stated that he doesn't know whether waiting for the development of the trauma system improves our ability to make these kinds of value judgments. Matt Koschmann, VP Planning, St. Rose stated they are looking at a January time frame and will have the pieces in place. Mr. Koschmann stated that St. Rose has waited on some of the position recruitments to hear the outcome of this taskforce and the recommendations being made to the State. Despite there being a documented need in Henderson,

being the second largest city in the State of Nevada – from a community needs perspective a need for a level III trauma center. They wish to work with UMC and if another designation is made with Sunrise – to create the right trauma system in this community. They are looking at having an ACS site visit next January.

Dr. Fildes gave a brief history of the reasoning behind a large free-standing trauma center, citing it was in response to a willing provider who chose not to remain in the system. At the time that was Sunrise Hospital. He stated that he does not feel there is any wisdom in throttling back or diminishing UMC to soothe the needs of new willing providers. They should get to join in a graduated designation. This is what you see around the country – EMS will be bringing them in lower, soft trauma. They will develop excellence in that – training and CME's to staff as well as systems and documentation. Dr. Fildes stated the numbers mentioned by Sunrise, 700 a year; is two a day. There should be on staff physicians to handle two a day. You should not need to recruit from the outside. It is not uncommon around the country to have a graduated designation- then perhaps they are asked to become Level III's or IV's strategically placed around the community as the needs arises and graduate up to Level II. It is very difficult to come out of the box at a Level II. Washoe couldn't do it and UMC couldn't do it either. It took both years to do it.

Dr. Metzler stated that it was his understanding that at the time Sunrise Hospital gave up its Level III designation, it was to support UMC becoming the center that it is and solely for that support. That is not an abandonment of designation status. Co-chair Forbuss stated that it was his understanding as well because he was here at that time. Dr. Metzler stated that no matter how large UMC is, it is still the single source provider and you do not have any back-up. If Sunrise comes on board as a Level II and tops out at 1,000 – 1,200, and if growth continues, then you have capacity at UMC to go beyond that. Sunrise will be pretty much topped off. In the process you have some back-up and redundancy, surge capacity and you have hospitals working together to provide an inclusive system. That is what you gain.

Co-chair Forbuss stated that the members have reached the limits of discussion today and that the Clark County Health District Trauma subcommittee will meet tomorrow, June 15. The next meeting will be held on June 22 at 9 a.m.

Public Participation
Ms. Bobbette Bond, Local 226, culinary union, had a question regarding the number of trauma patients that Sunrise would be seeing, was that 1,000 – 2,000? Dr. Metzler stated it was 1,000 – 1,200.

Adjournment
The meeting adjourned at 4:05 p.m.