Minutes

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

Tuesday, June 22, 2004
9:00 a.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
Robert Forbuss, Co-chair
Merlinda Gallegos
Steve Hill
Rose McKinney-James, Co-chair
Otto Ravenholt, MD
Danny Thompson

MEMBERS ABSENT
Max Doubrava, MD

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

THE ABARIS GROUP STAFF PRESENT
Mike Williams, President

Welcome
The Trauma System Assessment Citizen's Task Force convened in the Clemens room of the Ravenholt Public Health Center on Tuesday, June 22, 2004. Co-chair Rose McKinney-James called the meeting to order at 9:20 a.m.

Approval of June 7 and June 14 Meeting Minutes
There is a correction to the minutes of June 14 as requested by Dr. Max Doubrava, page 2 should read "he was concerned with smaller attacks such as 50 – 100 victims." The minutes were approved with correction as noted.

Workshop
Mr. Forbuss asked Dr. Kwalick bring the taskforce up to date. Dr. Kwalick stated the taskforce should finalize its recommendations to be brought to the Board of Health subcommittee on July 15, to the District Board of Health on July 22 and then to the

State Board of Health. **Recommendations thus far have included the development of an interlocal agreement with the State for delegation of authority to plan, develop and implement a regionalized trauma system with the Clark County Health District as the lead agency. The leadership, governance and establishment of a system as well as the oversight should be a Southern Nevada process.**

Co-chair McKinney-James asked whether the taskforce is expected to develop a plan or simply recommend a plan be developed. Dr. Kwalick responded if the District is going to be the lead agency it would be responsible for plan development however, staffing and resources will be needed.

A written statement, submitted by Dr. Max Doubrava, was placed into the record. (Attachment I)

Dr. Ravenholt asked Dr. Kwalick about the issue of designation and how does designation authority correlate with the allocation of territory. Dr. Ravenholt asked if the state retains designation authority, who would make the local destination decision?

Dr. Kwalick responded that issue would be addressed through the interlocal agreement. If the State retains designation authority, destination decisions should be delegated to the local authority.

Rory stated once a system is planned, the system development process would determine the destination policies based upon local data.

Dr. Ravenholt asked who would make that decision. Dr. Kwalick stated that the Chief Health Officer could make the final destination decision with input from the various stakeholders.

Dr. Ravenholt concluded that any discussions regarding designation should include who draws boundaries and how they change over time with the possibility that destination decisions be made at the local level and designation remain at the state level.

Mr. Bunker stated that control should be maintained in our community. He is concerned that serious and critical decisions are made outside the community. Whatever the taskforce recommends, such as a regional oversight committee established by the District Board of Health, the final determination on how the system operates should be local.

Co-chair McKinney-James agreed with Mr. Bunker's statement. Examples have shown that those models work best. Since the Clark County Health District has been responsible for many of the pre-hospital logistical issues, it is best suited to decide on catchment areas and areas of responsibility. Mr. Bunker stated that the regional oversight committee should have a State Board of Health member.

Dr. Ravenholt made a motion to recommend to the State that if the designation process remains at state health division level, that the destination process of

allocating territory among participants be delegated to the Clark County Health District. Motion seconded. Co-chair Forbuss clarified that the Clark County Health District could appoint the regional oversight committee with State representation as advisory to them.

Mr. Bunker concurred, emphasizing again that the final decisions should be left to the Clark County Health District.

Co-chair McKinney-James stated we have two issues, designation and destination. Mr. Bunker stated that one is as critical as the others. The Clark County Health District is better prepared to perform these tasks. Mr. Bunker is not suggesting cutting out the State, they should be included in the regional oversight group.

Dr. Ravenholt amended his motion that the State Board of Health delegate to the Clark County Health District the designation process for trauma centers as well as the development and creation of destination areas and that the fees for trauma system participation also be delegated to the Clark County Health District.

Co-Chair McKinney-James asked Dr. Ravenholt if his motion includes the regional oversight issue. Co-Chair Forbuss asked for clarification of this second motion – he asked Dr. Kwalick to clarify his earlier statement that designation could be kept at the State level. Dr. Kwalick stated that designation of trauma centers at various levels could remain with the State. Mr. Forbuss stated that Dr. Ravenholt's motion would not be doing this; it would recommend designation of authority to the local level. Co-chair Forbuss stated there is a motion on the table. The motion was seconded and passed unanimously.

Co-chair McKinney-James moved to the discussion of durable commitment and funding. An application fee is currently payable to the State. There is no fee structure in place for trauma system development. Fees typically come from trauma center applicants. A fee structure or resource base needs to be identified. Mr. Bunker stated that participants should assist in funding and that each jurisdiction of the Health District be responsible financially in the event there is not enough revenue generated from the participants. Ms. Gallegos stated that not everyone was willing to pay voluntarily into the system and gave the homeless issue as an example. Mr. Bunker stated that the selling issue would be easier with health care than homelessness. Mr. Forbuss stated the bulk of fees could come from participants. Co-chair McKinney James stated the taskforce should not get into this level of detail. The taskforce should recommend that there is adequate funding to support this system.

Dr. Ravenholt stated that it would be a less divisive issue if the system could rely on single source funding. Mr. Forbuss stated if the motion referenced "adequate funding" only contentious issues would be avoided. Mr. Thompson stated that we should get as specific as we can. He agreed with Mr. Bunker to provide detail even with the back-up system of funding. Dr. Kwalick stated the local Board of Health may be able to establish a fee for participation in the system. The system should include all providers: pre-hospital, hospital, trauma center, rehab center, etc. and a schedule

of fees for each player be developed that could support the entire process on a continuing basis. This is a community-wide system that affects everyone.

Co-Chair Mc-Kinney-James stated that the focus is to assure adequate support of system. In the event that resources are not adequate, the Health District has flexibility to seek other funding to support the system, such as through bioterrorism grants.

Co-chair Forbuss made the motion to recommend that there be adequate resources to develop and implement the system plan in Southern Nevada and that those funds be collected from participants as well as exploring other funding opportunities. The motion was seconded and carried unanimously.

Co-chair McKinney-James moved to the issue of 'durable commitment' as recommended by ACS. Any center that enters the system needs to have a commitment. Do we need to specify a number of years? Mr. Hill stated he agreed with that concept of durable commitment and added the concept of bonding. Mr. Williams of the Abaris Group was asked to share his opinion regarding a bond, and stated there is no penalty imposed anywhere in the country to preclude the dropping of a designation. Typically, the portal for reviewing durable commitment is the application process and vigorous review. Mr. Williams stated that it goes beyond the ACS review. Co-chair Mc-Kinney stated the notion of a durable commitment goes well beyond a single component; it is a much more comprehensive analysis. Mr. Williams stated there are no guarantees; the applicants do have in place contingency plans. Co-chair McKinney-James feels that this is a serious point that the taskforce is obligated to explore. Co-chair McKinney-James stated Dr. Mackersie quantified durable commitment in terms of years. Rory Chetelat stated that this taskforce can make recommendations both ways, through the interlocal agreement with a bond or without.

Dr. Ravenholt asked how would the system handle "probationary status," because applicants are not fully staffed or equipped. Mr. Williams gave the example of a global group coverage issue – citing a hospital with a 14-year designation with unquestionable commitment and resources. They had contract issues and could not work it out and ultimately the physicians and surgeons backed out.

Mr. Forbuss stated that bonds are done in the ambulance system, but not in the trauma system. It is impossible to cash in a bond. Mr. Hill stated he views this from two different and opposite directions. The taxpayer will have an investment in this and it should not default. The applicant could be bonded against default. However, the real problem sets up an artificial and substantial pawn in labor-management situations. Co-Chair McKinney-James stated that the taskforce is charged with the creation of a framework and others will determine the detail. Mr. Thompson stated there should be a penalty for not performing. Health care is not a free market issue. If a hospital is serious about commitment; it should be difficult to default and there should be ramifications for not performing.

Co-chair Mc-Kinney James stated that the taskforce support the recommendation coming from ACS that a durable commitment measured in years be determined by the regional oversight committee once established. Mr. Bunker stated there are

several other items of import – ongoing commitment, corporate mentality, financial, etc. Mr. Thompson stated that past performance is also very important.

Co-chair Mc-Kinney James moved that the taskforce support the recommendation coming from ACS regarding that a durable commitment measured in some years, to be determined by the regional oversight committee, be adopted and that the taskforce recommend substantive analysis of financial, medical and operational issues consistent with other designation undertakings as well as the past performance of any entity seeking designation. Motion was carried unanimously.

Co-chair McKinney-James stated we have addressed the issues of leadership, oversight, funding, and offered recommendations regarding designation.

Discussion of redundancy and the 'catch-22' issue followed: Co-chair Mc-Kinney-James stated the heart of this issue is in statute rather than regulations. Her understanding is the authority for designation rests with State and is in statute. Dr. Metzler had said a trauma center has to be designated first in order to see patients, yet you must see patients in order to begin the process of verification by ACS. If another hospital wishes to become a trauma center, currently no alternative mechanism exists in statute or regulation.

Dr. Kwalick stated statute 450B.237 states, "…the state board of health shall adopt regulations which establish the standards for the designation of hospitals as centers for treatment of trauma…" The regulations are adopted by the Board of Health as to the designation process and that includes the ACS surveys, etc. This taskforce could recommend that certain alternative activities could be done relevant to the designation process.

Dr. Kwalick was asked where the authority comes from to promulgate additional regulations that Nevada Administrative Code can be changed by the State Board of Health. Dr. Kwalick stated ACS is asked by the applying agency, consistent with the state regulations, to verify the capacity and capability of the applying agency for trauma center designation. Up to that point, the applying center cannot be a trauma center accepting trauma patients because they have not been designated. What ACS looks at is their capacity to perform once they are verified. At this point the State Health Administrator entertains designation.

Rory Chetelat stated that Dr. Mackersie said there are certain volume criteria – however, the majority of requirements could be met without any volume.

Mr. Bunker stated that we are very fortunate to have UMC in its present condition while at the same time having a corporation that is willing to fund and establish a trauma center. However, he is concerned that if we suggest that a catchment area is designated before an overall plan is in place, there could be the possibility of a serious problem with UMC. Dr. Ravenholt asked Dr. Kwalick if a Level III designation includes a territorial area or it is just a level of trauma case management. Dr. Kwalick believes it's the latter within a certain period of time. Upper levels of trauma go to a Level II or a Level I; the patient could be stabilized at a Level III. Rory Chetelat stated that the current EMS language is based upon 30 minutes concentric

circle. Patients would go to a Level III unless the Level II or Level I is closer. Appropriate language could be developed using either patient status or incident location.

Mr. Hill moved to recommend to the State Board of Health that the appropriate changes be made in the administrative code to allow applicant's access to patients based on recommendations of the Clark County Health District. Co-chair McKinney James asked Mr. Hill if that included "graduated designation," that allows us to examine verification, and issues relative to adequacy of volume, location and system performance. Mr. Hill responded yes. Rory Chetelat stated that decisions regarding graduated designation should include that a hospital begin as a Level IV or Level III. That hospital would then begin to increase their volume and step up to a Level II – without having to have immediate volume.

Mr. Thompson stated that if you provide designation; you can never go back. The ability for the system to survive is most important. He stated he agreed with the needs assessment as presented by the Abaris Group and it is based upon the needs of the community.

Mr. Hill explained his motion further, stating his intent was to recommend that the State Board of Health "clear" the administrative code. This would allow the local agency, once authority has been delegated, to start with a clean slate when promulgating regulations. This motion was presented to the taskforce because the taskforce voted earlier to develop a system before designation. His motion was meant to address the problem that may exist in the future with the existing Administrative code and to assure decision-making authority by the Clark County Health District. The motion was seconded.

Co-chair McKinney-James noted that we recommend through this motion to the Clark County District Board of Health that the steps necessary are taken to clarify and modify the Nevada Administrative Code to allow the Clark County Health District to execute decisions. Further clarification was asked by several taskforce members. Mr. Thompson stated that the code should be changed to allow that the region adopt a plan. Mr. Thompson stated the taskforce needs to be clear with recommendations. Dr. Kwalick stated that if an interlocal agreement between the Clark County District Board of Health and the State is accomplished, then part of that agreement is that the Clark County District Board of Health can pass regulations concerning trauma system development in Southern Nevada. The motion passed unanimously.

Rory Chetelat asked about the possibility of decisions to be made regarding graduation or alternative pathway. Co-chair McKinney-James stated that while we have two requests before the Health District which served as the motivating factor to create the taskforce, neither the Abaris nor ACS reports suggests that we have an immediate need other than to put into place a process that allows those decisions to be made.

Dr. Kwalick was asked to provide input regarding the recommendations presented. He stated the report to the board of health subcommittee would include having a strong local agreement that gives authority to the District Board of Health that now resides with the State Board of Health and the State Division of Health

Administrator. The recommendations include implementing regulations that will give us a strong, comprehensive regional trauma system in Southern Nevada. This system will include the leadership, governance, and funding. He stated he feels comfortable with what has been recommended.

Mr. Thompson asked that the members review the process. The members were appointed by the District Board of Health to the committee, asked to deliberate on the issues, an expert was hired -the Abaris Group. A needs assessment was done with community input. Mr. Thompson is comfortable with the recommendations from the Abaris Group. Mr. Thompson made the motion that the Board of Health adopts the recommendations of the Abaris Group report.

Co-chair McKinney-James stated the taskforce was faced with a difficult decision because of certain actions that had already taken place. Dr. Metzler has stated that Sunrise was ready to go and is fully qualified. His view from the beginning is that this is a no-brainer and they should be allowed to move forward. She continued that the decision was made to make the process a public one so we could rely on experts from the medical field as well as the technical community to give us a feel for decisions that needed to be made. She is not prepared to make specific designation level decisions; she does not feel the taskforce has the information available unless the taskforce simply accepts the report as it was developed which is what is being suggested. The taskforce has established the right framework to ensure the appropriate individuals are involved in making these decisions. The taskforce has done what is in the best interest of the public.

Mr. Bunker restated his original position, that is, he is not in favor of anything that would diminish one of the top five trauma centers in the United States – UMC. Mr. Thompson withdrew his earlier motion and instead **strongly recommended the ACS and Abaris reports be considered by the Clark County District Board of Health in their deliberations. Taskforce members indicated their concurrence.**

Mr. Hill asked if it was the taskforce mission to give opinions from a diverse group of citizens, some with little or no knowledge of trauma or were the members expected to offer recommendations regarding designation. Co-chair McKinney-James stated that she felt the members were being asked to weigh in from a citizen's standpoint, to make recommendations regarding trauma system development, to discuss location, and any other issues deemed helpful to the Board of Health.

Dr. Ravenholt stated the needs assessment study completed by the Abaris group is a rational document. The input from Mr. Bishop representing Sunrise Hospital included a bogus representation that the existing Level I trauma center has a "weak and unstable medical staff." Nothing supports that conclusion. This should not have been brought up as serious discussion. In the Sunday edition of the *Las Vegas Review-Journal* the article, on the pros and cons of additional trauma centers, Dr. Metzler referred to a well-developed trauma system which can save 20-40 percent of injured patients. Dr. Ravenholt stated that it depends on what you compare it to. Here in Las Vegas the figure is much lower, perhaps 3 percent.

Co-Chair Forbuss asked if the taskforce members wished any further discussion. A motion was made to adjourn the meeting and was seconded.

Public Participation
Mr. Robinson from Sunrise Hospital expressed his appreciation for the taskforce efforts and thanked them for their time.

Adjournment
A motion was made to adjourn the meeting and was seconded. The meeting adjourned at 12:10 p.m.