



MINUTES
EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

DIVISION OF COMMUNITY HEALTH
TRAUMA NEEDS ASSESSMENT TASKFORCE

November 30, 2016 - 3:30 P.M.

MEMBERS PRESENT

Amy Doane, Vice Chair, Sunrise Hospital
Sean Dort, MD, St. Rose Siena Hospital
Jason Driggars, Paramedic, EMS Provider (Private)
Kim Dokken, RN, St. Rose Siena
Sajit Pullarkat, Centennial Hills Hospital
Jennifer Renner, RN, HCA
Kelly Taylor, LVMPDEHWT
Kim Cerasoli, UMC
Frank Simone, Paramedic, EMS Provider (Public)
Danita Cohen, UMC

Douglas Fraser, MD, UMC (Alt.)
Chris Fisher, MD, Sunrise Hospital
Alma Angeles, RN, Sunrise Hospital
Dineen McSwain, RN, UMC
Daniel Llamas, Sunrise Hospital
Stacy Johnson, RN, Mountain View Hospital
Shirley Breeden, Public Representative
Stephanie Miller, Southern Hills Hosp (Alt.)
Gail Yedinak, UMC
Deborah Kuhls, MD, UNR/UNLV

MEMBERS ABSENT

John Fildes, MD, Chairman, UMC
Dale Carrison, DO, MAB Chairman

Adam Rudd, Southern Hills Hospital

SNHD STAFF PRESENT

Joseph P. Iser, MD, Chief Health Officer
Michael Johnson, PhD, Dir. of Community Health
Lei Zhang, Public Health Informatics Scientist
Judy Tabat, Recording Secretary

John Hammond, EMSTS Manager
Laura Palmer, EMSTS Supervisor
Heather Anderson-Fintak, Associate Attorney

PUBLIC ATTENDANCE

Carl Bottorf, Life Guard International

CALL TO ORDER – NOTICE OF POSTING

The Trauma Needs Assessment Workgroup convened in the Red Rock Trail Conference Room at the Southern Nevada Health District (SNHD), located at 280 S. Decatur Boulevard, on November 30, 2016. Vice Chair Amy Doane called the meeting to order at 3:33 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Vice Chair Doane noted that a quorum was present.

- I. **PUBLIC COMMENT:** A period devoted to comments by the general public about those items appearing on the Agenda. Comments will be limited to five (5) minutes per speaker. Please step up to the speaker's

podium, clearly state your name and address, and spell your last name for the record. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chairman or the taskforce of majority vote.

Vice Chair Doane asked if anyone wished to address the Committee pertaining to items listed on the Agenda. Seeing no one, she closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Vice Chair Doane stated the Consent Agenda consisted of matters to be considered by the Trauma Needs Assessment Taskforce that can be enacted by one motion. Any item may be discussed separately per taskforce member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes/Trauma Needs Assessment Taskforce Meeting: September 20, 2016

Vice Chair Doane asked for a motion to approve the Consent Agenda. Motion made by Member Driggers, seconded by Member Dokken and carried unanimously.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review of Professional Assessments of Other Trauma Systems

Ms. Palmer stated that she researched Salt Lake City, Phoenix, and San Diego trauma systems and compared them to Las Vegas. Las Vegas falls in the middle as far as population size and square miles. The first thing she noticed was that trauma numbers in Las Vegas were half of what they are in those other areas. Last year Clark County had 6109 trauma patients and the closest to that number was Phoenix with 10,934. She also tried to research the criteria those 3 systems set up to bring in new trauma centers. San Diego just improvised it and then called in an outside consultation group who told them they have 2 trauma centers too many and recommended they close them. Phoenix and Salt Lake City respectively have been letting anyone who wants to become a trauma center become a trauma center. She added that it is leading to problems because with a level I comes teaching responsibilities. They are opening up teaching programs that they have to shut down which is affecting future medical professionals. She felt that these trauma systems are not doing their due diligence.

Ms. Doane reported that she did find a Phoenix Health District report from a couple of years ago where the American College of Surgeons (ACS) came in and told them they need to re-evaluate their system and get some tighter control on how they are going about bringing in new trauma centers. She stated that she will take a closer look at this report to look for recommendations that they could perhaps use for some knowledge and benefit.

Ms. Palmer stated that there was a lot of stress on transport times and that with Arizona especially because so much of their area is rural. She felt that was the premise behind letting anybody become a trauma center but it wasn't a very productive answer. Ms. Doane agreed adding that they trauma centers were placed in the metropolitan areas.

Dr. Fisher asked if she had the numbers for San Diego and Maricopa County. Ms. Palmer stated that San Diego has 3.21 million people; with 2 level Is and 3 level IIs. Maricopa has 4.12 million people with 8 level Is (7 adult, 1 pediatric); 1 level II pediatric and then they have 3 level IIIs. She added that Vegas have 2.19 million people.

Dr. Fisher felt those numbers were misleading for San Diego county because a lot of those traumas are border crossers. So their population is much bigger and their trauma population is much bigger.

Dr. Kuhls stated that San Diego really struggles with numbers because of their trauma centers and believes the whole state of California just underwent a systems review by the ACS.

Ms. Doane stated that it feels like they are conducting a very academic exercise here. She recommended that they continue to mine for those best practices and other guidance that they can possibly find from other markets as they keep going through this process.

B. Further Develop Standardized Measures for Assessing the Needs of the Trauma System

Ms. Doane referred to the handout included in their packet and stated they are going to attempt to move forward with some population data.

Ms. Palmer stated that Lei Zhang, the Health District's Public Health Informatics Scientist, put all of this together. He's pulled population numbers and projected population numbers with his source list at the bottom of each page. His data did not show dramatic amounts of growth between 2010 and 2020. The second page shows population density in Clark County by Tract. The next 2 pages show estimated growth by zip code. The first one is growth from 2015 to 2020 and the second one was showing the growth from 2010 to 2015. Lei also pulled historical Las Vegas visitor statistics for 2010 thru 2015 and those are posted.

Ms. Dokken questioned if there were any statistics on visitors who are traumas.

Ms. Cerasoli stated she pulled 3 years of statistics on visitors who she could isolate outside of local zip codes that were not homeless. The results were not even a negligible percentage of visitor population; 2013 there were 140 patients, 2014 had 73 patients and 2015 had 124 patients.

Ms. Palmer pointed out that item # 6 on the final page is median transport times for Clark County and it is segregated by triage criteria step levels for 2013 through 2016. She added that 2016 is going to be incomplete.

Dr. Fisher remarked that the problem with the median transport time chart is that it includes the whole valley. It is not looking specifically in the areas where new centers would be applying. He added that the transport times may be getting much worse in the northwest but it is such a small population compared to the whole city and those numbers would not be changing very much.

Ms. Dokken stated that they haven't been out of area for more than 5% of the time for a long time which tells them that EMS is bringing patients to the right trauma centers.

Dr. Fisher argued that the transport time for example is 20 minutes in the northwest, but it is 7 minutes in the central valley. There are more people that live in the center portion of the city that those numbers could be skewed. He felt that transport time by zip code would let them know if people in those areas are suffering from a longer transport times versus those closest to the trauma centers.

Mr. Zhang suggested grouping zip codes by areas because there may not be enough data for a single zip code.

Dr. Fisher agreed and stated they should group some areas around the 3 centers that applied. He felt that will give more information for comparison.

Ms. Doane questioned what factors should be taken into consideration.

Dr. Fisher suggested using the same zip codes and color code it for the longest transport times. He added that it doesn't necessarily have to be around the 3 centers that applied. He suggested looking at the zip codes and transport times for the 4 categories, step 1 through 4 and map it the way Mr. Zhang color coded the population chart

Dr. Fraser added that the obvious flip side of this is we have to decide what we consider a long transit time because fast ambulances and running red lights saves 2 ½ minutes.

Ms. Palmer felt that some of these maps are a little misleading. When you look at the northwest side of town you can show a huge growth percentage that's going from nothing to 2,000 people.

Dr. Fisher agreed and added that the growth rate is important but felt the differential in the transport times maybe more important.

Ms. Palmer felt that they should look at the number of trauma calls in those areas. It was also suggested to take the growth rate and do it in expected density.

Dr. Fisher felt that is a good point and that way they could compare those 2 maps.

Ms. Cerasoli stated that Dr. Fildes wanted to look at this population growth map included in the handouts and compare it to ISS. She added that they are getting more people but not as sick. They looked at their data and in 2010 their average ISS was 11.5. Over the last 5 years it has inched down

and this year they are sitting at 9.686. She felt that just because there are more people doesn't all mean they need trauma center.

Dr. Fisher suggested that they see where the people are less serviced, break down that population and then find out how many trauma calls they are receiving for those areas. The problem with ISS is unfortunately a lot of their sickest patients have a low ISS because they are deaths and they get an external autopsy. He wasn't saying that it is not worthwhile but felt ISS can be misleading.

Mr. Driggars suggested that another map that would be beneficial along with the median transport time would be call volume for those same zip code blocks.

Ms. Doane summarized the criteria requested:

- Transport times by zip code and create a color coded map for shortest to greatest transport times.
- Consider how to establish proposed service areas for future applicants for population, density and transport time considerations.
- Need an extra map for expected density based on a 5 year growth projection.
- For the areas that see the most propensities for population growth and density growth, look at additional isolation to dig further into demographic considerations, ISS trends and also EMS call volume by zip code.

Dr. Fisher questioned if they could separate out penetrating from blunt injuries when looking at ISS trends. Neighborhoods that are affected more by violent crime are going to light up as huge ISS scores which may skew those numbers.

Dr. Dort brought up the fact that all the trauma center applications received were for level III trauma centers. He added that discussing penetrating from blunt injuries that will be going to a level I or II hospital doesn't seem practical.

Ms. Johnson stated that there is a lot of talk about EMS data which is important but felt that they need to account for patients who arrive by a privately owned vehicle (POV). She added that a lot of the traumatic injuries that they are seeing are arriving via POV and not EMS.

Ms. Renner stated that along those same lines she thought that they were going to look at the amount of level III trauma that was falling out into non trauma hospitals at some point with this data.

Mr. Hammond stated that the aggregate data received from the state for the year was less than 150 calls for all non-trauma centers in Clark County which was well below the threshold that the NBATS tool indicated.

Ms. Renner questioned if they can see which hospitals are seeing the trauma in the non-trauma hospitals. She added that she would like to know volume and what their mode of arrival to have a better idea of where the level III trauma population is sitting.

Dr. Dort commented that they could look at numbers for private vehicles but they have no way of controlling that and no matter what we build or setup it is never going to affect where those people go.

Ms. Renner stated that it may not but if you have a high amount of level III type traumas going to non trauma hospitals, wouldn't those patients benefit from a process internally that is geared towards treating those types of injuries.

Ms. Palmer stated that there is already a process where they refer people out to trauma centers.

Ms. Johnson stated that the information Ms. Renner is looking for is already in the 2015 state report. It lists out every single hospital within and the number of trauma cases they had for the year of 2015.

Ms. Dokken stated that when designing a trauma system, it is EMS. If Boulder City Hospital is getting a lot of trauma because it is in a rural area then their ER should be setting up those practices. She stated that when you think about a trauma system and where trauma centers need to be, it would be nice if you set them up for all the private vehicles patients but that is not what a trauma system is based on.

Ms. Doane felt that Ms. Renner's point is looking at it from a patient perspective. If a patient has a low level traumatic injury that may or may not be a trauma activation by EMS, they are not thinking that

they need to go to a trauma center. They are thinking that they need to get to the ER. So that is where she is trying to identify how can we objectively look at our non-trauma center ER's and see what they are getting to see if the population is going to that center by personal vehicle for emergent care that could be trauma.

Ms. Taylor agreed and added that this trauma issue is played out in the media and with our community. Our community is looking at it not just by EMS but from a private vehicle standpoint and felt that they need to educate the community.

Ms. Dokken agreed and felt that it was the Regional Trauma Advisory Board's responsibility then to provide that education to the community.

Mr. Driggars stated that one of the major problems that they will probably have looking at those patients that come in by POV is there is no guarantee that the patient was driven to the nearest hospital from where the incident occurred. A lot of times it could have happened right across the street from Southern Hills but they prefer Summerlin so that is where they went. It would be a little difficult to plot that geographically.

Dr. Fisher felt that was a good point especially for the minor child. A child fell off the swing and broke his arm; their doctors are at Summerlin so they would go there even if they are closer Spring Valley. He added that he understood what Ms. Renner was saying, if Southern Hills Hospital is transferring out a 100 patients a month that were trauma patients and St. Rose deLima is transferring out 10, then they know there is a problem in the southwest.

Ms. Doane stated that part of the purpose of our process here is to gather everything and rule it in or rule it out as useful.

Dr. Dort agreed and stated that he would like to see the number of trauma patients from non-trauma centers being transferred to trauma centers.

Ms. Doane questioned if there are any other points of discussion around population and transports times, mechanisms of injury data at this point. Hearing none, she added that at the last meeting they discussed item #3 in the NBATS tool with regard to Lead Agency/Community support. The decision was to table that consideration as a second phase for RTAB after they look at the objective data to take into consideration community letters of support and opposition. She asked if the taskforce was in agreement with that decision. The taskforce agreed.

Ms. Doane stated that at the last meeting they discussed item #4 in the NBATS tool with regard to severely injured patients (ISS>15) discharged from acute care facilities not designated a Level I, II or III centers. The decision was to come up with locally relevant analysis and asked the taskforce how to move forward with that evaluation.

Ms. Johnson stated that data should be pretty easy to get from the state registry for the non-trauma centers.

Ms. Dokken added that the breakdown of that should include private vehicle and EMS.

Ms. Doane stated that looking at items #5 (Level I Trauma Centers) and #6 (Numbers of severely injured patients (ISS>15) seen in trauma centers (Level I and II) already in the trauma service area) it seems like we already addressed some of that criteria. She asked the taskforce if there was any further discussion.

Ms. Dokken questioned why Level III trauma centers were not included in Item #6, Numbers of severely injured patients seen in trauma centers (Level I and II).

Dr. Fisher felt that it was important and that it should be included.

Mr. Hammond stated that was taken right out of the NBATS tool.

Ms. Doane asked the taskforce if out of consideration they would also like to look at the data for Level III. The taskforce answered in the affirmative.

C. Update on SNHD Trauma Registry

Tabled

D. Next Meeting and Agenda Items

Ms. Taylor stated that she was under the impression that at the last meeting they had decided to mimic one of the other subcommittee's provisions on alternates. These bylaws state 48 hours.

Ms. Angeles stated that it was decided that because this was already put forward on the RTAB that lets' go ahead and put this through and make an addendum to it so that will go towards the January meeting. We have a bylaws approved and we could move forward but we have the addendum to present at the next meeting.

Ms. Doane requested that they bring the wording from other subcommittee bylaws for review.

Ms. Palmer stated that the next meeting is slated for January 18, 2017.

IV. INFORMATIONAL ITEMS/DISCUSSION ONLY

Report on ACS Collaboration

No report given

- V. **PUBLIC COMMENT:** A period devoted to comments by the general public, if any, and discussions of those comments, about matters relevant to the Committee's jurisdiction will be held. No action may be taken upon a matter raised under this item of this Agenda until the matter itself has been specifically included on an agenda as an item upon which action may be taken pursuant to NRS 241.020. Comments will be limited to five (5) minutes per speaker. Please step up to the speaker's podium, clearly state your name and address, and spell you last name for the record. If any member of the taskforce wishes to extend the length of a presentation, this may be done by the Chairman or the Community by majority vote.

Vice Chair Doane asked if anyone wished to address the taskforce. Seeing no one, she closed the Public Comment portion of the meeting.

VI. ADJOURNMENT

As there was no further business on the agenda, Vice Chair Doane adjourned the meeting at 4:26 p.m.