



MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

DIVISION OF COMMUNITY HEALTH

TRAUMA NEEDS ASSESSMENT TASKFORCE (TNAT)

January 18, 2017 - 3:30 P.M.

MEMBERS PRESENT

John Fildes, MD, Chairman, UMC
Sean Dort, MD, St. Rose Siena Hospital
Jason Driggars, Paramedic, EMS Provider (Private)
Kim Dokken, RN, St. Rose Siena (via phone)
Gail Yedinak, UMC
Jennifer Renner, RN, HCA
Shirley Breeden, Public Representative (via phone)
Stephanie Miller, Southern Hills Hosp (Alt.)
Frank Simone, Paramedic, EMS Provider (Public)

Amy Doane, Vice Chair, Sunrise Hospital
Chris Fisher, MD, Sunrise Hospital
Alma Angeles, RN, Sunrise Hospital
Kim Cerasoli, RN, UMC
Daniel Llamas, Sunrise Hospital
Stacy Johnson, RN, Mountain View Hospital
Kelly Taylor, LVMPDEHWT
Danita Cohen, UMC
Erin Klein, Centennial Hills Hospital (Alt.)

MEMBERS ABSENT

Adam Rudd, Southern Hills Hospital
Deborah Kuhls, MD, UNR/UNLV

Sajit Pullarkat, Centennial Hills Hospital

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Michael Johnson, PhD, Dir. of Community Health
Lei Zhang, Public Health Informatics Scientist

Laura Palmer, EMSTS Supervisor
Heather Anderson-Fintak, Associate Attorney
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Carl Bottorf, Life Guard International
Frank Malle, Henderson Fire

Jennifer Lopez, R&R Partners
Dan McBride, MD, CMO Valley Health System

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 January 18, 2017. Chairman John Fildes called the meeting to order at 3:30 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law.

- 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.

Chairman Fildes asked if anyone wished to address the Committee pertaining to items listed on the Agenda. Seeing no one, he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Chairman Fildes 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: November 30, 2016

Chairman Fildes asked for a motion to approve the Consent Agenda. Motion made by Member Dort, seconded by Member Fisher and carried unanimously.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review of Trauma Needs Assessment Taskforce Bylaws

Ms. Palmer stated that the TNAT bylaws were presented to the RTAB and approved. The bylaws have been brought back to this meeting because the taskforce requested to make a change in Article V, Section 4. Currently the bylaws read that "Each member may designate an alternate member to serve in their place should they be temporarily unable to perform the required duties. Any alternate must be submitted to OEMSTS a minimum of 48 hours prior to scheduled taskforce meetings." She advised the taskforce that they removed the second sentence and replaced it with "All requests must be made in writing to the Health Officer."

Chairman Fildes asked for a motion to adopt the Trauma Needs Assessment Taskforce Bylaws as written. Motion made by Member Taylor, seconded by Member Angeles and carried unanimously.

B. Review of Professional Assessments of Other Trauma Systems

Ms. Palmer reported that at the previous meeting they discussed (3) other trauma systems that they compared to this system. At the end of that discussion there was a request for members to research other systems.

Dr. Fildes asked if she could review what systems were included in that discussion.

Ms. Palmer stated that she researched Salt Lake City, Phoenix, and San Diego trauma systems and compared them to Las Vegas. What she found was those systems are not doing their due diligence in granting a facility the ability to become a trauma center and it is having negative effects on their trauma systems. She felt that what is being done here is ground breaking work because no other places are really looking at the needs of their system.

Dr. Fildes thanked the taskforce for their work and suggested that this be written up someday in a proceeding since it has not been done before. He felt that somebody would like to read about it as they go down the same path. Dr. Fildes asked the members if there were any other trauma systems other than those mentioned that should be considered. Hearing none he stated there will be no action on this item and accept this as information.

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

Ms. Palmer asked the taskforce to refer to their handouts that map out TFTC run volume by zip code 2013-2016; estimated 2015 and projected 2020 population density by zip code; and median EMS transport time by zip code 2013-2016. She then turned the meeting over to Lei Zhang.

Mr. Zhang stated that at the last TNAT meeting he was asked to come up with run volume and

population density by zip code. He explained each map and added that his data source for the TFTC run volume by zip code and Median ESM transport time by zip code was from the SNHD TFTCF Database 2013-2016. His data source for the population density maps was from the Clark County Department of Comprehensive Planning; Southern Nevada Consensus Population Estimate 2010-2015.

Ms. Doane voiced her concern that there wasn't an expert looking broadly through this raw data to pull out important points. She felt that reports are being produced based on a criterion that hasn't been setup.

Mr. Zhang questioned whether they should have criteria measurement first and do the analysis later or just produce the results and then from the results come up with some measurement.

Mr. Hammond expressed that fact that this taskforce has struggled to determine decision thresholds. Having reviewed maps that show measures and population growth, the next step is to determine those dashboard values. He agreed that they do need that person who will be assessing those dashboard values, but they need to tell that person what they are looking at first. Moving forward he felt that should be the focus of the taskforce.

Ms. Taylor questioned if this taskforce was created to pinpoint the proposed trauma centers or as a group try to establish where the next trauma center needs to be placed.

Dr. Fisher stated that this taskforce will have to make criteria decisions based on a multiple number of factors and then placement of a new trauma center would have to satisfy all those factors. This taskforce first has to identify what factors are important and he felt some of those have already been identified such as transport time and high TFTC transport volume.

Ms. Taylor questioned if the average transport time is going to be based on the appropriate trauma center level. She felt that if they are determining where to place the next trauma center and its level of care it would make sense that a reasonable transport time should be developed for each potential level.

Dr. Fisher commented that he doesn't know of anyone who has come up with a transport time per ACS level of hospital that is acceptable. He felt that you have to look at what is acceptable in Las Vegas. He reiterated that they are not doing their criteria on just one factor like transport times; they are doing it on the number of calls and traumas that occur in that area regardless of population. It is not going to be any one thing, it is going to be several, we will have to set the criteria and I think to put a new center there they are going to have to meet each and every one of those criteria otherwise, they will put them in the wrong place.

Ms. Dokken remarked that in answer to Ms. Taylors original question on what the purpose of this taskforce was, she said that it states in the bylaws that "The TNAT is a taskforce with a primary purpose of advising and assisting the RTAB in developing objective criteria to assess the future need for the expansion of the Clark County trauma system".

- a) Evaluate the effectiveness of the trauma system based on statistical analysis of EMS/trauma data collected.
- b) Evaluate the need to revise the NBATS tool to make it more applicable to the needs of Clark County.
- c) Develop objective criteria to assess the need for the designation of new centers
- d) Assess the demographics of the county, and the manner in which the county may most effectively provide trauma services to its residents and visitors.

She added that this taskforce is supposed to be developing criteria to assess, not make decisions.

Mr. Hammond agreed and added that what Mr. Zhang has done here is given us a baseline to move forward to the next step.

Ms. Angeles adding that they had a list of specific criteria that needed to be validated. In reviewing what Mr. Zhang has presented, she felt that they now have supportive data to say this is acceptable criteria to include in the determination for the need of an additional trauma center.

Ms. Doane remarked that this taskforce is developing criteria but is not responsible for the actual analysis and packaging of those criteria. Mr. Hammond answered in the affirmative.

Dr. Fildes stated that they started by discussing the NBATS tool and its 6 domains. The 1st domain was population, and he thanked Lei Zhang for the depictions of population viewed through several lenses that are important to trauma care. The next domain was median transport times, and again felt that has been depicted very nicely. He added that the conversation about what is an acceptable transport time for somebody with normal vital signs who is fully awake and alert is different from somebody who is hypotensive or suffering from altered mental status. The 3rd domain is lead agency/system stakeholder/Community Support is one that needs to be addressed soon. The 4th domain was severely injured patients (ISS > 15) discharged from acute care facilities not designated as trauma centers. He felt that as a group they are at a point believing that that number is extremely small. Similar to that they have arrived at a point where they know that the number of visitors that are injured is quite small and they usually occur in-between Sunrise and UMC, where the strip is located.

Function and operation of the existing level I center and the number of severely injured patients seen among all centers have been looked at and he felt that they have a pretty good handle on that. He added that the number ISS > 15 is not growing as quickly as those patients with minor to moderate level injuries with an ISS < 15. Blend that together with the regulations stating that initial authorization shall be granted at Level III only and then progress from there. He identified that you now begin to see a framework developing where the impact of patient density, EMS transport times and injury severity score would allow them to start to pick some landing sites that would be considered more critically by the RTAB.

Ms. Doane commented that analysis inflection would be a function of the RTAB and not a function of this group to make those recommendations.

Dr. Fildes felt it would be easier for them to send it to the RTAB as interpretable as possible.

Ms. Doane felt that they are on the precipice of concluding that they do have an agreed upon set of criteria for RTAB to consider and questioned what happens next.

Dr. Fildes suggested looking at the system volume as a whole over the last 3 to 5 years. The County has been slowly growing and therefore the trauma system should grow as well.

Ms. Doane complained that her continued frustration is setting parameters to the idea of criteria. She felt it is more of a holistic process than just setting parameters because if one doesn't meet one certain parameter but 4 other ones meet exceedingly above a parameter they won't qualify.

Dr. Fisher remarked that if you have a high acuity number of patients, high transport times, but your volumes are 5 a year that would not make them a good candidate. He felt that they were all in agreement for transport times and how we break that down will be a factor. The next step to look at is how many of those patients meet TFTC or higher ISSs coming out of those areas. He felt that this group needs to start proposing what categories they feel are important in the decision making process and then look at each one and determine what is acceptable criteria.

Dr. Fildes added that the other thought that has to be coupled is that an inclusive trauma center means that there will be injured patients throughout the community and not every injured patient is seen in a trauma center. In fact the majority of injured patients are seen in emergency departments. They are seen for things like isolated wrist fractures, or an isolated laceration. An exclusive trauma system would mean that every injured patient anywhere would go to a trauma system and that would be a hardship on patients and it would also be a hardship on the hospitals that deliver that care.

Dr. Fisher felt that is why you might want to add in an ISS for those patients or as a factor. He suggested coming up with some concrete categories and then discuss what those cutoffs are going to be in that area.

Dr. Fildes suggested using the low hanging fruit approach by taking the 6 domains and assemble their ideas that they have consensus on and put them into a table. Once they have a framework they can start to fill in the middle. That should be enough guidance to pass on to RTAB and other bodies for consideration. He stated that right now he is hearing frustration that there is a whole lot of information that hasn't mended together yet. The best way to mend it together is to put the easy pieces together first.

Ms. Yedinak questioned if they are speaking only to level III or are they going to take each one of those domains and slice it up by what is pertinent to each level.

Mr. Hammond felt that initially they should discuss it specific to a level III because that is how a new trauma center comes into this system. He added that the this data set is expandable so that they can determine whether or not is the level II or a level III existing need to be up to a level II as well because of that same volume.

Dr. Fildes remarked that as a point in history here, it was anticipated that the level II and level III in the system now would eventually elevate themselves.

Dr. Dort commented that some of the criteria they are looking at are almost diametrically opposed. If transit time is selected then those are going to be far away and are not going to be the areas with the high ISSs over 15. If you find an area with high transit times and lots of patients with ISS > 15, then there is an argument for a higher level. If we are looking at the level IIIs then they might decide that the time and population are more important than the high ISS. He felt that they need to put a weight on some of criteria they are looking at.

Ms. Doane agreed stating they need to start considering things in conjunction with each other.

Dr. Dort stated that they have to decide what each of the parameters mean as far as level and as far as what they are going to weigh them as. Then the final point is the system asking for help if it needs it or not.

Dr. Fildes suggested bringing a small number of people to work together to bring back suggestions. He felt they could get a few of these thoughts worked into a table in the 6 domain areas starting with population with some of the relevant comments that we've heard and then bring that back and advance that.

Ms. Taylor questioned if this group will be continue to look back at data for POV arrivals that should have been traumas.

Dr. Fisher stated that patient population by POV is usually pediatrics or penetrating trauma. He added that if they were considering a pediatric trauma center then they would want to look at pediatric patients going by POV to non trauma centers. The numbers for adults going by POV to non trauma centers would be very small and felt they didn't need to look at that.

D. Update on SNHD Trauma Registry

Ms. Palmer stated that they are still presenting the portal that the Health Districts Informatics Department has developed to individual hospitals. There is going to be a meeting January 31st with the State and all stakeholders involved where there will be a formal presentation.

Ms. Taylor asked for clarification with regard to the non-trauma centers and trauma centers using the SNHD Trauma Registry.

Ms. Palmer stated that the current state of the trauma registry is only non-trauma but when it is all done it will be a combination of non-trauma and trauma.

E. Next Meeting and Agenda Items

Dr. Fildes stated that the next TNAT meeting is Tuesday, February 21, 2017 at 2:30pm. The workgroup will meet prior to try and create the new agenda item for tabulation of findings to date.

Mr. Hammond stated that the workgroup will need to meet with enough time that they can publically notice the TNAT agenda. He stated that his office will send out a meeting notice.

IV. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

- 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.

Chairman Fildes asked if anyone wished to address the taskforce.

Dr. Dan McBride, Chief Medical Office for the Valley Health System commented that he was very interested in listening to the comments about population, expectations, and growth patterns. He stated that when they were presenting their reasoning behind the application for a level III trauma center, he felt the most important issue was that they were supplementing the existing trauma system in the Las Vegas community. Allowing the existing trauma centers to do what they do best but supplement the care in the more local areas where these less severely injured patients reside and where they can get the same level of care that they would at one of the Level I or Level II centers. He added that sending all low level trauma to a Level I center is an overuse of that system and it does not argue to the efficiency and the best service of that system which is geared up towards higher acuity patients. He believed that this will not negatively impact any of the existing trauma centers and emphasized that they want to keep those as strong as they are but felt that you have to consider in addition to just strict data what the service for the community is and what the service of a trauma system truly is.

Chairman Fildes thanked Dr. McBride and asked if anyone else wished to address the taskforce. Seeing no one, he closed the Public Comment portion of the meeting.

VI. **ADJOURNMENT**

As there was no further business on the agenda, Chairman Fildes adjourned the meeting at 4:33 p.m.