Draft Minutes of Meeting – Subject to Change Upon Approval by the Trauma Needs Assessment Taskforce at Their Next Regularly Scheduled Meeting.

MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (OEMSTS)

DIVISION OF COMMUNITY HEALTH

TRAUMA NEEDS ASSESSMENT TASKFORCE (TNAT)

February 22, 2018 - 2:30 P.M.

MEMBERS PRESENT

John Fildes, MD, Chairman, UMC
Karen Port, MountainView Hospital (Alt.)
Amy Doane, Vice Chair, Sunrise Hospital (via phone)
Stacy Johnson, RN, MountainView Hospital
Stephanie Miller, RN, Southern Hills Hospital (Alt.)
Kim Royer, RN, Sunrise Hospital
Sajit Pullarkat, Centennial Hills Hospital
Kim Cerasoli, RN, UMC
Georgi Collins, HCA
Kelly Taylor, LVMPD HWT
Danita Cohen, UMC
Gail Yedinak, UMC

MEMBERS ABSENT

Chris Fisher, MD, Sunrise Hospital
Kim Dokken, RN, St. Rose Siena
Jason Driggars, Paramedic, EMS Provider (Private)
Frank Simone, Paramedic, EMS Provider (Public)
Sean Dort, MD, St. Rose Siena Hospital
Deborah Kuhls, MD, UMC
Shirley Breeden, Public Representative

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Joseph Iser, Chief Health Officer
Annette Bradley, Attorney
Rae Pettie, Recording Secretary
Laura Palmer, EMSTS Supervisor
Michael Johnson, PhD, Dir. of Community Health
Heather Anderson-Fintak, Associate Attorney

PUBLIC ATTENDANCE

Lisa Rogge, UMC

CALL TO ORDER – NOTICE OF POSTING

The Trauma Needs Assessment Taskforce convened in the Red Rock Trail Conference Room at the Southern Nevada Health District (SNHD), located at 280 S. Decatur Boulevard, on February 22, 2018. Chairman John Fildes called the meeting to order at 2:30 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Chairman Fildes 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

taskforce wishes to extend the length of a presentation, this may be done by the Chairman or the taskforce by majority vote.

Chairman Fildes asked if anyone wished to address the taskforce 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: 2/8/2018

A motion to approve the Consent Agenda was made by Member Cerasoli, seconded by Member Pullarkat and carried unanimously.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review/Discuss Data Dictionary

Dr. Fildes reported that the revisions to the draft Data Dictionary were made following the February 8th meeting and sent out for further review prior to today's meeting. He related that when they first met, the taskforce discussed and described measures they felt were credible and relevant to need. It became clear that defining them in a Data Dictionary would be the optimal path to take. Data will be collected from the same sources, and in the same way, to reveal the same data from year to year. The next generation will have the Data Dictionary to guide them through the process.

Dr. Fildes stated he would guide the taskforce through the Data Dictionary and stop for discussion as needed. The five major domains are: 1) Population; 2) Transport Times; 3) Lead Agency/System Stakeholder/Community Support; 4) Severely Injured Patients (ISS>15) Discharged from or Seen at Non-Trauma Centers; and 5) Historical Southern Nevada Trauma Center Volume and Acuity by Center.

Dr. Fildes explained that the first three elements under "Population" were sequenced to first see whether the county is growing, then to see whether the county growth was anticipated to be sustained, and then to a more regional analysis to look for pockets of growth within the county itself. Next, they would look at the fourth element to see whether that projected local growth increase within Clark County demonstrated a comparatively faster growth rate as predicted to continue to do so.

Dr. Fildes next discussed the fifth element under "Population" that begins to describe the population of patients who experience trauma. He stated the intent of the fifth element is to examine the volume of Trauma Field Triage Criteria (TFTC) patients being treated at a non-trauma facility seeking trauma destination to determine if the volume is increasing in a statistically significant manner. Ms. Johnson asked if they would utilize the Nevada State Trauma Registry since non-trauma hospitals don't submit TFTC data. Dr. Fildes acknowledged that in previous meeting minutes they discussed that there are patients who go to a non-trauma hospital who may not have been transported by EMS or even have access to the 911 system. They may have an injury diagnosis that is at, or near, the threshold for trauma center care, but can be cared for appropriately at a non-trauma center hospital; that's the number they're looking for.

Dr. Fildes next discussed the sixth element under "Population." He stated the intent of the sixth element is to determine if the area of the county demonstrating a comparatively faster growth rate in population is also demonstrating a statistically significant increase in TFTC incidents. It's not enough for you just to have a population increase; the population increase also needs to include an increase in the number of patients who would require trauma care.

The intent of the final element under "Population" titled "Are the Type of TFTC Incidents in the Area of Population Growth Increasing as Related to Trauma Center Type" is to determine if the TFTC

increases being seen in an area of increased population growth are also relevant to trauma system growth, i.e. a proposed new trauma center would need an increase in Step III and Step IV patients, and a Level III or Level II trauma center seeking a higher level of designation would need an increase in Step 1 and Step 2 patients. Dr. Fildes stated that the element was added to differentiate the types of applicants that may apply. An initial application would be for a Level III center, a second level application would be from a Level III or Level II center, and the next level to increase would be from a Level II to a Level I center. This measurement would use the Nevada State Trauma Registry and SNHD Informatics analysis to determine whether the correct field triage patient increases were associated with the request. He noted that the discussion and minutes from the past match what they are reading, both by letter and intent.

Ms. Johnson expressed discomfort that the Nevada State Trauma Registry will not reflect TFTC data. Ms. Palmer stated that both data sources will be utilized; the District's Informatics Department will take the Nevada State Trauma Registry data and turn it into steps by diagnosis. Ms. Johnson asked what would happen if they check the "TFTC criteria met" box with a "No" because it wasn't check marked on the run sheet. Ms. Palmer replied that they will go by injury. Dr. Fildes explained they will be able to capture whether the TFTC is increasing in a certain geographic area that has growth. It will determine the number of Step 3 and Step 4 patients, and the number of patients who accessed care for injuries that did not use EMS. He gave an example where someone is gardening and he trips and falls. He goes to the hospital and stays for 24 hours to get an operation. That individual may end up in the NTDB (Nevada Trauma Data Bank). Dr. Fildes stressed, "That's not the stuff from which trauma centers are made."

Dr. Fildes shared that he wrote the Data Dictionary for the National Trauma Data Bank. He wrote the NTDB reports for five years for the American College of Surgeons, and sat on the expert panel of the CDC that created TFTC and published it in the MMWR. He expressed confidence that their approach is correct.

Member Taylor made a motion to approve the first domain titled "Population" in the Data Dictionary. The motion was seconded by Member Pullarkat and carried unanimously.

The taskforce moved to the second domain titled "Transport Times" in the Data Dictionary. Dr. Fildes stated that the intent for the element "Median Transport Times" is to evaluate the current median transport times for all four levels of trauma within the Southern Nevada Trauma System. The taskforce has proposed 15 minutes as the standard. Dr. Fildes reiterated discussion from past minutes that Step 3 and Step 4 transports don't require lights or sirens. Those patients must, by definition, be entirely awake, alert and oriented, with stable vital signs. Transport time in that category is not as critical to life saving, but is important in terms of operational characteristics such as EMS vehicle demand and relocation times for return to service. However, for Step 1 and Step 2 patients who have altered mental status, changes in blood pressure and visible trauma, lights and sirens would be used and the expectation in all cases would be that transport times will be 15 minutes or less.

Ms. Collins asked whether they should include the Nevada State Trauma Registry as a data source to capture those patients who don't meet TFTC and end up at a non-trauma center hospital, but are later found to meet TFTC. Dr. Fildes commented that they have been monitoring trauma patients treated at non-trauma center hospitals for many years, and it's a rare occurrence. Those instances are discussed at the Trauma Medical Audit Committee. Ms. Cerasoli noted that non-trauma center hospitals have people entering information into the state's data repository who are not trained trauma registrars, so their ability to accurately decipher ICD and AAAM coding is suspect. In her opinion, the fact that it's both a rare occurrence and not entirely accurate or reliable is a slippery slope.

Dr. Fildes shared that for many years injured patients were shunned by general emergency departments. EMS crews were conditioned not to take injured patients to general emergency departments if they could avoid it. Over-triage was enormous during the years 2003-2005. Trauma centers turned into injury centers; they would receive patients with lacerations and small fractures. He stated that this system has experienced more of the opposite than you would find in a less mature system where badly injured patients are delivered to non-trauma hospitals as a regular occurrence. He reiterated that it is a rare

occurrence in this system.

Ms. Collins asked whether the data is validated. Ms. Palmer replied that the OEMSTS matches all calls possible, and handles out of area transports at an agency level. She added that the error rate for validating calls is less than one percent. The Taskforce continued its discussion of the relevance of adding the Nevada State Trauma Registry as a data source. Ms. Doane agreed that any hospital serious about becoming a trauma center should have an ACS appropriate data collection already in place that will appropriately identify patients to be reported to the registry. Ms. Cerasoli replied that the Nevada State Trauma Registry collects data from every hospital, not just the non-trauma hospitals. She reiterated that the state does not validate their data, and there is no risk adjustment.

Dr. Fildes expressed concern with respect to the injury pyramid, the public health description of injury as a disease entity. At the very top of the pyramid are deaths; the next level down are people who risk death or permanent disability; that's the group you try to send to trauma centers. The next level down are emergency departments and outpatient clinics, and below that first aid and self-care. He stated they could expand the pyramid further down, but the further you get away from the work of trauma centers, the more you start discussing the work of an emergency department. Dr. Fildes stated he is not opposed to including the data for conversation, but his concern is that it will be interpreted as a need for more trauma centers when what it is demonstrating is that an inclusive trauma system must have robust emergency departments operating throughout it. He explained that they have already established that TFTC Step 3 and Step 4 patients that arrive at a Level III trauma center in greater than 15 minutes are not a high-risk group. His concern is that they will expand the discussion, or a population of patients for discussion, that will become less precise, making deliberation more difficult.

Ms. Cerasoli asked whether the transport times are validated. Ms. Palmer stated that that data is tied directly to the computers on the rescue vehicles. Unfortunately, there is no way to control human error such as someone forgetting to push a button. Ms. Cerasoli asked if we compare what the EMS provider enters for transport times with what the trauma centers enter. Ms. Palmer answered in the affirmative. Ms. Cerasoli noted that Clark County transport times are validated, but at the state level, they are not, so we're taking information that has been validated and adding other information that is uncertain and trying to compare them as equals.

Ms. Collins stated when looking at the system and the need for a new trauma center there could be instances where EMS does not identify a trauma patient. The patient goes to a non-trauma center, is entered in the registry, and the information goes directly to the Nevada State Trauma Registry. Since NTDB is not risk adjusted it's just another level to identify if there is a need. Ms. Taylor asked for clarification on whether all patients go to the closest emergency department, regardless of a misdiagnosed trauma patient on scene. Ms. Palmer stated that if a patient is not identified as a trauma patient they may not go to the closest emergency department; they may go by patient choice. It may be a 40-minute transport, depending on the hospital and the time of day.

Ms. Cerasoli questioned whether having the information from the Nevada State Trauma Registry helps them to decide the need for another trauma center, or does it help them to identify that EMS providers need to be better trained? Ms. Taylor stated that the growing number of incidents is more an indicator of need than a potential transport time that was misidentified. However, referring to educating EMS providers, she asked whether the OEMSTS looks at the out-of-area transports, i.e. trauma patients that have been transported to non-trauma centers. Ms. Palmer replied that they do, and that the majority are Step 4 patients. Ms. Taylor commented that it would be more prudent to re-educate the EMS providers than to use a data source that has not been validated.

Dr. Fildes clarified that there was a suggestion to add the Nevada State Trauma Registry as a second source for second analysis. Ms. Royer asked if it would be compared to the rest of the state. Dr. Fildes stated that it would be irrelevant to impossible because the rest of the state is frontier. Ms. Taylor stated she is not comfortable with utilizing the Nevada State Trauma Registry as a data source for two reasons: 1) It has not been validated; and 2) It includes patient choice as a mechanism to decide if the transport time is appropriate.

A motion was made by Member Collins to add the words "and Nevada State Trauma Registry" to the data sources for all elements listed in the domain titled "Transport Times." The motion was seconded by Member Johnson. The vote was 6-6 and the motion did not pass.

The taskforce moved to the third element in the second domain titled "Median Transport Times Increase in Areas of Increased Growth" in the Data Dictionary. Dr. Fildes stated the intent is to determine if step level appropriate TFTC incident transport times from an area of increased population growth are increasing. He stated the point will be to find unique population growth areas that have increases in TFTC with simultaneous increases in transport times. He explained that the final addendum, or attachment, that will be included in the section on transport times will be a map that will depict the 15-minute transport times emanating from acute care facilities in the valley demonstrating either their unique geographic distribution, or their redundancies, to be used as a reference.

Member Taylor made a motion to approve the third element in the second domain titled "Median Transport Times Increase in Areas of Increased Growth" in the Data Dictionary. The motion was seconded by Member Pullarkat and carried unanimously.

The taskforce moved to the third domain titled "Lead Agency/System Stakeholder/Community Support" in the Data Dictionary. Dr. Files stated that the intent of the first element "Lead Agency Support" is to demonstrate if supporting data is present for lead agency support. The intent of the second element "System Stakeholder Support" is to demonstrate support from key system stakeholders for trauma system growth. The intent of the third element "Community Support" is to demonstrate support from key community members for trauma system growth.

Member Yedinak made a motion to approve the third domain titled "Lead Agency/ System Stakeholder/Community Support" in the Data Dictionary. The motion was seconded by Member Taylor and carried unanimously.

The taskforce noted that a housekeeping change needed to be made throughout the Data Dictionary from "Nevada Trauma Registry" to "Nevada State Trauma Registry" under each appropriate "Data Source." Dr. Fildes noted that the housekeeping change will clarify the percentage of patients that are seriously injured as opposed to patients that are included in the NTDB criteria.

The taskforce moved to the fourth domain titled "Severely Injured Patients (ISS>15) Discharged from or Seen at Non-Trauma Centers." in the Data Dictionary. The first element discussed was "Percentage of Patients with an ISS>15 Discharged from a Non-Trauma Center >XX%." Dr. Fildes explained that the "XX%" of patients with an ISS>15 discharged from a non-trauma center without entering the Southern Nevada Trauma System will be calculated by staff using Nevada State Trauma Registry data. Ms. Palmer explained that once the tool is approved, the OEMSTS will run a baseline, and anything after that such as the submission of an application, or updated annual reports, will be compared to the baseline. Ms. Doane asked how many years of data they will utilize. Ms. Palmer recalled they had agreed to five years. Mr. Hammond cautioned the taskforce that the Nevada State Trauma Registry has only been active since 2014 and the first two years may not be accurate, so there will be limitations to that data for the next couple of years. He noted we will work with what we have.

Ms. Royer inquired about the method the non-trauma centers use to submit data. Ms. Cerasoli replied they use a web platform version of V5 similar to the trauma centers; however, she reiterated that the individuals entering the data are not trained registrars. Ms. Collins noted that she receives reports from the state that demonstrate error rate. Ms. Cerasoli explained it is an error rate in relation to what they expect to find in the data fields, but they can't compare it to the actual data for the patient. They don't compare outcomes to presentation, so they are just encapsulating figures.

The taskforce moved to the second element of the fourth domain titled "Increase in Patients with an ISS>15 Treated at a Non-Trauma Center." Dr. Fildes stated the intent is to determine if the number of patients with an ISS>15 is increasing significantly. He stated the intent of the third element titled "Change in Transfer Volume to Southern Nevada Trauma Centers from Non-trauma Centers" is to determine if transfers in to local trauma centers from local non-trauma centers is increasing significantly.

Dr. Fildes explained that the three elements should give a picture of patients with injury severity scores greater than 16 that may have been discovered or treated outside of trauma center hospitals.

Member Taylor made a motion to approve the fourth domain titled "Severely Injured Patients (ISS >15) Discharged from or Seen at Non-Trauma Centers" in the Data Dictionary. The motion was seconded by Member Yedinak and carried unanimously.

The taskforce moved to the fifth domain titled "Historical Southern Nevada Trauma Center Volume and Acuity by Center." Dr. Fildes stated the intent is to demonstrate historic system high and low numbers where facilities were able to function. He explained that all the listed trauma centers had fragile startups, no matter who they were or when they started. The operational characteristics for that level of stability is implied by the numbers. As decision making moves forward, one grows a trauma system by smart growth; not by dismantling existing resources but by adding new, fresh, vibrant resources.

Ms. Cerasoli questioned the data showing UMC's highest annual number of trauma registry patients as 8,832. Ms. Palmer stated the numbers are current. Ms. Cerasoli stated the number is double what her record shows. Ms. Palmer explained that the numbers depict what was submitted. Dr. Fildes stated that if the method of analysis creates a difference in numbers it is likely the same for the other trauma centers. He noted they will need to work on the analysis area in the future; however, he believes the measurement is fundamentally sound and he plans to support it.

Member Yedinak made a motion to approve the fifth domain titled "Historical Southern Nevada Trauma Center Volume and Acuity by Center." The motion was seconded by Member Royer and carried unanimously.

B. Discuss Need for Another Meeting

Dr. Fildes stated the taskforce was created to give a voice to all participants in the community to bring ideas about how to demonstrate in a fair, consistent, and relevant way the need for new trauma centers in a growing system. He explained the Data Dictionary will go to the RTAB for further deliberation. Ms. Palmer thanked the taskforce for their participation and work throughout the process.

Member Yedinak made a motion to disband the taskforce. The motion was seconded by Member Royer and carried unanimously.

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 taskforce'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 taskforce by majority vote.

Chairman Fildes asked if anyone 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, Chairman Fildes adjourned the meeting at 3:23 p.m.