MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

DIVISION OF COMMUNITY HEALTH

TRAUMA NEEDS ASSESSMENT TASKFORCE

September 20, 2016 - 2:30 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)
Sajit Pullarkat, Centennial Hills Hospital (via phone)
Jennifer Renner, RN, HCA
Kelly Taylor, LVMPDEHWT
Marcia Turner, UMC (Alt.)
Frank Simone, Paramedic, EMS Provider (Public)
Amy Doane, Vice Chair, Sunrise Hospital
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.)

MEMBERS ABSENT

Gail Yedinak, UMC
Danita Cohen, UMC
Deborah Kuhls, MD, UNR/UNLV
Adam Rudd, Southern Hills Hospital
Dale Carrison, DO, MAB Chairman
Abby Hudema, RN, UMC

SNHD STAFF PRESENT

Joseph P. Iser, MD, Chief Health Officer
Michael Johnson, PhD, Dir. of Community Health
Lei Zhang, Public Health Informatics Scientist
John Hammond, EMSTS Manager
Laura Palmer, EMSTS Supervisor
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

Troy Tuke, Paramedic, CCFD
Jeanne Freeman, Div of Public & Behavioral Health (via phone)
Erin Russell, United Health Group

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 September 20, 2016. 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.

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: August 23, 2016

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

III. REPORT/DISCUSSION/POSSIBLE ACTION

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

Dr. Fildes explained that they started their discussion by reviewing the American College of Surgeons (ACS) Needs Based Assessment of Trauma Systems (NBATS) tool. A tool which by their own admission was designed to evaluate the number of centers needed within a trauma service area starting from a clean slate and then making adjustments thereafter. The tool does not attempt to specifically assess the impact of adding additional centers to a trauma service area nor does it attempt to determine the relative merit of a particular facility becoming a trauma center within the trauma service area. They advocate for six domains:

1. Population
2. Median Transport Times
3. Lead Agency/System Stakeholder/Community Support
4. Severely Injured patients (ISS>15) discharged from acute care facilities not designated as Level I, II, or III trauma centers
5. Level I Trauma Centers
6. Numbers of severely injured patients (ISS>15) seen in trauma centers (Level I and II) already in the trauma service area (TSA)

This taskforce has started to create clinically relevant measures to identify experts to manipulate this information and to describe a methodology for the measure. He added that he would like to begin at the first item in the domain of population. His goal would be to complete as many of these as they can and pass them to staff to begin gathering the data.

Ms. Doane commented that since the ACS assessment tool is not meant to be conclusive in nature but that it is merely a tool as a starting point for discussion she suggested researching what other major metro areas of like size and population demographics have done to assess trauma system need in their own community.

Dr. Fildes agreed and stated that in addition to pursuing the measurement parameters in the domains, they agendize the review of published information and professional assessments of other trauma systems and begin to build a small body of literature around their process.

Ms. Palmer asked for clarification on what should be included in the population demographics.

Ms. Doan replied that they should look for similar demographics and similar population size, which she felt would be beneficial for our own assessment.

Dr. Fisher stated that they need to limit the search to the southwest adding that if you look in the northeast their trauma systems are well defined especially university systems that are over 100 years

old. He suggested looking at San Diego and Phoenix since they have both a level I and level II trauma centers.

Ms. Renner suggested Salt Lake City since they have a comparable population and demographic. She added that Centennial Hills Hospital used them in their application as a comparison city.

Dr. Iser suggested staying with the cities mentioned. Dr. Fildes agreed but added that some of these studies are done in other areas and they are germane to the discussion and felt both paths should be followed. As they move forward on some of the measures, Dr. Fildes suggested that a small workgroup be formed to meet with the demographer and see how they would propose to produce information that could be used and bring that information forward in a manner that suits this analysis. Dr. Iser stated that would be up to the taskforce but felt that would be easy information to get online or by calling the demographer.

Ms. Doane emphasized that it was very important moving forward to have population data available by zip code and to have the growth projections available by zip code. This way they are not looking at the valley as a whole but can identify those areas around the valley that are projecting the most growth over time. She advised that they utilize state data through ESRI (geographic information systems mapping software) through Intellimed for market sharing and that information is readily available by zip code.

Dr. Fildes stated that he doesn't oppose the use of zip code data but would caution that it is not always the best for system planning because it doesn't take into account municipal boundaries or boundary core tile growth into prospective.

Ms. Renner questioned if they could layer in freeway boundaries on top of those zip codes to help give a signifier of the freeway access to all those different zip code areas. Dr. Iser stated that they will do the best that they can.

Ms. Doane requested that this taskforce be inclusive of other demographic and population information that the demographer's office or the ESRI might be able to make available. She added that she would rather see a broader body of work inclusively than not know about information that might be beneficial because it wasn't specifically asked for on the front end. The taskforce agreed.

Dr. Fildes stated that the next domain is median transport times. Dr. Iser reported that in terms of transport times the Health District is getting real close to having a functional trauma registry. Dr. Fildes asked if it was reasonable to have a "go forward" on the transport times or would that be something that they can put off until the trauma registry is a little further along. Dr. Iser suggested they get the trauma registry up and functional which should be by end of year.

Dr. Fildes stated that the next domain is lead agency/stakeholder/community support and noted that he wasn't sure how to go forward with this domain.

Ms. Doane felt it would be beneficial as part of the discussion for the Health District as they make these decisions based on the criteria. She added that she would like the Health District to consider community support as part of their decision making process.

Dr. Fildes agreed stating this domain is a hard one to put a number scale against adding that everybody would make their case to the Health District.

Dr. Iser stated that they took all of that into consideration as well but when you get conflicting letters of support that makes it very difficult.

Ms. Doane proposed that this domain be classified as phase II. Look at the data and then take into consideration the community input.

Dr. Fildes stated that the next domain which looks at the number of severely injured patients treated and discharged from facilities that are not designated trauma centers and asked the taskforce how they would like to proceed.

Dr. Iser reported that Lei Zhang is developing a program which would use the same parameters that Digital Innovation (DI) has programmed for the state and asked Lei for comment.

Mr. Zhang stated that non-trauma center hospitals enter their trauma data to the state system. The Health District gets that data from the state for Clark County and based on the ISS, location, and/or

demographics they can analyze that data. They can analyze the coroner office data, death certificate data and hospital discharge data and if needed, they can combine multiple data sources together to analyze patients treated at non-trauma center hospitals.

Ms. Renner questioned why both domains are looking at the severely injured patients and not the lower acuity type patients that would be seen at the level III.

Dr. Fildes agreed adding that the problem with the ISS is that it is not determined until all the CAT scans and physical exams are finished. When you default to the trauma field triage criteria (TFTC) as what drives patients to a destination, the analysis could look a bit different. This analysis has been done several times over the last two decades and very small numbers of those patients tend to fall out in general hospitals. He felt it is not as relevant here as it might be in states with less developed trauma systems.

Ms. Taylor questioned what the equalizer would be since there are two different data methodologies, one of which is done post service and the other is done in the field.

Dr. Fildes believed that two balance one another

Dr. Fisher felt that the question that they are trying to answer is how many trauma patients that come in by private vehicle or were triaged by EMS ended up in the non-trauma centers because it was the closest facility. He added that he was not sure how important the staging of the ISS of 15 is since most of the patients that are severely injured in valley are making it to a trauma center.

Ms. Taylor questioned if the data includes the mode of transportation at the non-trauma.

Ms. Angeles replied that it depends on the database. If you are looking at TFTC database, mode of transportation is included in that data. She added that trauma centers are required by the ACS to have dedicated registrars to input that data which are clinical personnel or at least clinical personnel that validate the data. She voiced concern with regard to the true quality of the data that they are receiving from non-trauma centers and how that information is being validated.

Mr. Zhang responded by stating that transport mode is a data field in the trauma registry for both the trauma centers and non-trauma centers. In answer to the data quality, the trauma registrars in the trauma centers go through training and get certified. He felt that for the non-trauma centers, they probably use a dedicated trauma nurse or the coders to enter data. He added that right now all the hospitals use the ICD-10 code.

Ms. Doane questioned if it would be better to look at the ICD-10's of the patients that are going to non-trauma centers.

Ms. Johnson stated that she has previously entered data into the state trauma registry and if a patient is entered into that state registry that doesn't fit their criteria, it will be rejected. She felt that instead of focusing on ISS, it would make more sense to look at hospital "A" to see how many patients are being treated that meet NTDB criteria which would be very simple to get that information from the state registry.

Dr. Fisher stated that ISS is important however it doesn't tell the whole story. The other information we need to find is how many traumatic injury patients are being seen at non-trauma hospitals and how many are being transferred from those non-trauma centers to the trauma centers.

Ms. Doane stated that it sounds like for the discussion there is an agreement that all of that criteria should be brought in for an evaluation and not just the ISS.

Dr. Fildes summarized that from past discussions and this discussion this taskforce talked about looking at the coroner's data for out of system deaths which is done on a regular basis in the TMAC. Accessing the state trauma report understanding that it has some weaknesses but it has some descriptors as well. Look at the raw number of transports that are step 3 and 4 TFTC and the transfers from non-trauma centers to trauma centers. He questioned if there are other things that should contribute to this measure.

Ms. Turner stated mode of transportation to the hospital should be added.

Ms. Doane stated that the volume that is entered into the NTDB criteria system regardless of the ISS results would be beneficial to have.

Ms. Renner stated that would probably be the ICD-9 and ICD-10 codes.

Dr. Fildes stated that is a fairly full list of descriptors to try and identify. One thing that the discussion ventured into but didn't define is the injury pyramid. When the CDC went back at re-writing the TFTC, they were actually charged by the federal government with reducing over triage so that they would save the same number of lives and limit the disability at the better than historic levels but at lower costs. He added that they want to be careful not to be exaggerating transport criteria and over triaging the patients and driving up healthcare costs without improving survival or disability pre outcome.

Ms. Renner questioned if there is a mechanism for calculating the percentage of over and under triage in the system that is available to review.

Dr. Fildes answered in the affirmative and stated that it is an ACS requirement for each trauma center. The next 2 domains; the level 1 trauma center and number of severely injured patients seen in all trauma centers should be fairly straight forward, that data can be supplied on request.

Ms. Renner questioned if the time frame has been determined for the population data.

Dr. Iser stated that he would not suggest going backwards more than 5 years and anything beyond 5 years in the future would be totally inadequate. He stated 5 years to 5 years. The taskforce agreed.

Dr. Fildes summarized the tasks for each domain:

1. Population
    - "go forward"
2. Median Transport Times
    - on hold
3. Lead Agency/System Stakeholder/Community Support
    - Phase II
4. Severely Injured patients (ISS>15) discharged from acute care facilities not designated as Level I, II, or III trauma centers
    - Came up with locally relevant analysis
    - "go forward"
5. Level I Trauma Centers
6. Numbers of severely injured patients (ISS>15) seen in trauma centers (Level I and II) already in the trauma service area (TSA)
    - 5 & 6 can go forward by request
    - Data can be provided however it is being requested

Ms. Doane stated that for domain 5 & 6 it would beneficial if they can pull several years of data to note the growth within the existing trauma system over time.

Dr. Iser stated that they actually have that data so that should be immediately available

Dr. Fildes stated that he also did that analysis and really the only growth in this system is really been in Step 4 patients. He stated that this discussion gives us clear direction on how to proceed with the data collection.

Chairman Fildes asked for a motion to go forward with Domain 1, 4, 5, & 6. Motion made by Member Taylor, seconded by Member Doane and passed unanimously.

B. Next Meeting and Agenda Items

Ms. Palmer stated that the next meeting is slated for October 18th at 2:30pm.

Dr. Dort reported that the TMAC and RTAB are meeting the next day on the 19th and he will be in Washington DC. Dr. Fildes noted that he will be in Washington DC as well.

After considerable discussion with regards to the next TNAT, TMAC, and RTAB meetings, it was

suggested to do another survey for the last week in October.

Dr. Fildes asked everybody to research the professional literature and gather up supportive materials they would like reviewed and funnel them to the Health District to be reviewed.

IV. INFORMATIONAL ITEMS/DISCUSSION ONLY

Report on ACS Collaboration

Ms. Palmer reported that she did speak with the American College of Surgeons (ACS) about coming down and looking at our system. They requested some information which has been submitted and they will submit a price quote. Ms. Palmer stated that in speaking with them they informed her that they will not only look at the presentation that was done with the 3 applications that were submitted but moving forward they will look at how we analyze data and the system we have in place. ACS stated they would also be happy to come before the Board of Health, the RTAB and this group to speak on the NBATS tool itself. Ms. Palmer stated that she will inform this taskforce when they have the price quote.

Ms. Palmer welcomed Frank Simone as the representative for the public emergency medical services providers. She added that since Mr. Simone was not at the first meeting where membership was declared and the RTAB has not approved the bylaws for this taskforce he will be unable to vote.

Ms. Angeles stated that since the bylaws have not been approved at the RTAB, she recommended that they change the 24 hour notice of an alternate to a standing alternate. Dr. Iser stated that they can't adjust it in this meeting because it is not agendized. He added that it would seem that if there was consensus from this group to do that that you are on the RTAB anyway, you can change those bylaws but then they would have to be re-approved at the next meeting here.
Dr. Fildes suggested that request be received in writing

Dr. Iser reminded the taskforce that the Health District does have a 501C3 that can work with us on EMS & Trauma Systems. He added that the Health District itself is the equivalent of a 501C3 so if anyone wants to donate to doing something like this they would be happy to take those donations and lock them away.

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. 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 3:30 p.m.