



**MINUTES**  
**EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM**  
**DIVISION OF COMMUNITY HEALTH**  
**REGIONAL TRAUMA ADVISORY BOARD (RTAB)**

**April 17, 2019 - 1:30 P.M.**

**MEMBERS PRESENT**

John Fildes, MD, Chair, UMC	Lisa Rogge, RN, University Medical Center
Sean Dort, MD, St. Rose Siena Hospital	Kim Dokken, RN, St. Rose Siena Hospital
Chris Fisher, MD, Sunrise Hospital	Kim Royer, RN, Sunrise Hospital
Sajit Pullarkat, Administrator, Non-Trauma Hospital	August Corrales, Paramedic, Private EMS Provider
Billy Meyer, RN, Rehabilitation Services	Mary Martinat, RN, Health Education (Alt.)
Carl Bottorf, General Public	Frank Simone, Paramedic, Public EMS Provider
Jeff Ellis, System Financing/Funding	Erin Breen, Legislative/Advocacy
Scott Kerbs, Public Relations/Media (Alt)	Maya Holmes, Payers of Medical Benefits (Alt)

**MEMBERS ABSENT**

Mike Barnum, MD, MAB Chairman

**SNHD STAFF PRESENT**

John Hammond, EMSTS Manager	Christian Young, MD, EMSTS Medical Director
Joseph P. Iser, MD, DrPH, MSc	Chad Kingsley, Regional Trauma Coordinator
Laura Palmer, EMSTS Supervisor	Annette Bradley, General Counsel
Judy Tabat, Recording Secretary	Lei Zhang, Sr. Informatician
Scott Wagner, EMSTS Field Rep.	

**PUBLIC ATTENDANCE**

Tony Greenway, Valley Health System	Dan McBride, Valley Health System
Karla Perez, Valley Health System	Leonard Freehof, Spring Valley Hospital
Erin Klein, CHHMC	Georgi Collins, HCA
Stacy Johnson, MountainView Hospital	Jeremy Bradshaw, MountainView Hospital
Kelly Kern, MountainView Hospital	Eileen Moynihan, MountainView Hospital
Harsha Dave, MountainView Hospital	Grace Gonzalez, MountainView Hospital
Todd Isbell, MountainView Hospital	Patsy Pulley, MountainView Hospital
Larry Johnson, Community Ambulance	Beatriz Martinez
Stacie Sasso, HSC	Kelly Stout, Bailey Kennedy
Josh Monroe, USAF, Nellis AFB	Stephanie Street, USAF, Nellis AFB
Kim Pietszak, USAF, Nellis AFB	Al Flowers, USAF, Nellis AFB
Bobi Oates, Nellis AFB	Jim Frazee, CCSD
Dan Shinn, HCA	Daniel Llamas, HCA
Brian Brundage, NHP Association	Brett Olbur, Dignity
Kim Cerasoli, UMC	Gail Yedinak, UMC

Douglas Fraser, MD, UMC  
Jeremiah Riesenbeck, CCSD  
Patricia L., Culinary  
Elaine Thomor, NHPA  
James Wight, NHPA  
Georgino Amenta, Culinary  
Tegan Stover, Culinary

Sam Scheller, GEMS  
Jason Kordosky, Culinary  
Jackie Nichols  
Taylor Campese, NHPA  
Melissa Dougherty, NHPA  
David Saba, Culinary

### **CALL TO ORDER – NOTICE OF POSTING**

The Regional Trauma Advisory Board (RTAB) convened in the Red Rock Trail Conference Room at the Southern Nevada Health District, located at 280 S. Decatur Boulevard, on April 17, 2019. Chairman Fildes called the meeting to order at 1:30 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**

Members of the public are allowed to speak on Action items after the Board's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Board on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Board on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Board on behalf of the group. Once the action item is closed, no additional public comment will be accepted.

Chairman Fildes asked if anyone wished to address the Board pertaining to items listed on the Agenda.

The following public comments are verbatim transcription.

Hi, Stacie Sasso, Health Services Coalition, 6655 W. Sahara Ave. We've placed comments on record several times over the last few months with different meetings and we are still really concerned about the discussion on whether or not we need trauma centers being driven by changes to EMS practices and protocols by taking patients to trauma centers. There has been a huge spike in trauma patients and the growth has been in the lower level injured patients, so the step 4s. This appears to be because EMS decided in the last couple years that step 4 trauma patients have to be transported to trauma centers instead of to an ER, even though that is not consistent with national guidelines. This started happening in 2017 and then the Health District changed the protocols in 2018 to become a mandatory transport instead of a may transport. This has driven up the number of trauma transports and making patients get care farther away from their home when an ER could have been closer, and ERs are equipped to be able to take care of these patients. This is not happening in other communities based on the research that we have done. There really needs to be 2 different transport time goals for the most severely injured patient, the step 1s and 2s versus the less severely injured patients, the 3s and 4s otherwise we will end up with more trauma centers than the community really needs. I'm also not clear if it makes sense to lump them altogether and say that they all need to be at a trauma center within 15 minutes when there is no lights and sirens for step 3 or 4 and EMS transports at the posted speed limits and the 4s could again go to a regular ER in their neighborhood like they have in the past. These 2 issues are driving up trauma numbers and trauma transport times are artificially being created and could create an assessment that we need more centers than we actually do. We would like to see a strong trauma center that meets the communities needs and ensures patients are getting the care they need when they need it but we want to be careful that decisions are being made based on the right data and that we are not over-saturating the market. Thank you

Good Afternoon, Beatriz Martinez, 500 S. Grand Central Pkwy, I'm here reading a letter on behalf of Commissioner Tick Segerblom.

RTAB Chair and Board Members,

I am not able to attend today's Regional Trauma Advisory Board meeting, but as a County Commissioner and Southern Nevada Health District Board member, I am following the requests and process for new trauma designations closely.

I want to ensure that we have strong trauma system that meets our community's need and ensures patients are getting the care they need when they need it.

It is critical that we have comprehensive trauma needs assessment in place to identify trauma access shortage areas, based on solid data that is not driven by the trauma applications, but by the needs of our entire community.

The state is currently considering legislation that just passed out of Assembly committee that would require the state to identify trauma shortage areas. We need to hold this process until we know what direction the state takes.

I want an open discussion at the Board of Health on these issues, and I want to work with staff and the Board Chair on the agenda. I am going to pay attention to what is discussed today and will revisit these issues at the Southern Nevada Health District Board meetings.

I also want to ensure there is transparency and the public and stakeholders have the information they need to participate in this process which can be very complicated. Although, I have some concerns about the process and access to information and will be raising these issues at the Board of Health meetings. Thank you, Tick Segerblom County Commissioner.

Good Afternoon, my name is Eileen Moynihan, 89128. You can see by my jacket I'm a volunteer. I do volunteer at MountainView Hospital but I'm here speaking primarily as someone who did suffer a trauma. On Valentine's Day of 2017, valentine's day, adding insult to injury. I fell off a ladder coming down from the roof of my house and landed in rocks and broke my rt radius ulna and rt wrist, and I broke my rt femur, so I was in pretty bad shape. The EMS people, wonderful, I was so pleased with all the 911 response. When they put me in the ambulance I asked which hospital they would be taking me to. I live less than 2 miles from MountainView, so I just assumed that is where I would be going, and I surprised when the ambulance attendant said no we are required to take you to UMC because of the extent of your injuries we must take you to a trauma center and that was the nearest trauma center. I knew that would be a tremendous hardship on my family and my loved ones to try help me and support me through this difficult time. So, I asked again, could you please take me to MountainView and they said if you want to go to MountainView you have sign papers indicating that you know that you should be taken to a trauma center, but you prefer to go to MountainView. I received excellent, excellent care at MountainView and I just want to speak to what it was like for me as a patient. I have so many friends that are my age in their 70s or older in their 80s and I don't know if they would know that they would have that right to request that and the level III designation would allow the ambulance from my understanding to take me to a nearer trauma center rather than to go to UMC. I knew I would have gotten excellent care at UMC, but I would have been denied the one thing that research is very clear leads to better outcomes which is the support system of friends, family, loved ones. The reason I would also like to speak for MountainView as I've said I volunteered there for several years, I've seen from the inside, the tremendous amount of work that MountainView is doing and continues to improve upon all the time. Their goal is always to provide excellent healthcare and they do everything they can to improve that. I had a nurse leader who came every day to check on me. When my surgeries were over, and I had to go to inpatient rehab, my insurance wouldn't allow me to go to the inpatient rehab at MountainView. Again, I voice my concern about friends and family, I cannot tell you the lengths that the people at MountainView went to and they did get my insurance company to approve my inpatient stay at MountainView Rehab. So, for those reasons I highly recommend MountainView and just as a member of the community that had suffered a trauma I would encourage whatever we can do to establish more easy access to closer situations for patients. Thank you so much for listening.

Good Afternoon, my name is Jim Frazee and I'm a high school teacher at Centennial Highschool. I also teach in the inner city in the evenings. When I was informed that we had so few trauma

centers, as a school teacher, my mind unfortunately immediately starts thinking about school shootings and what that would mean to our community. Having someone just arrested or committed suicide today in Colorado looking to do another Columbine effort, my mind goes there quite a bit. Having students who were also involved in the 10/1 shooting, the prevalence of violence in our community makes the lack of trauma centers reckless if you will and irresponsible. The rollover death of a student that I had even in a car accident, I understand that minutes matter and I understand having one and I'm not just saying the northwest part of the valley where I happen to live and teach, but I do strongly urge you to consider expanding throughout our community for our 320,000 students as well as their parents and families. Their needs are not being adequately served if this is the limit that we have. Thank you for allowing me to speak to you today.

Good Afternoon, my name is Jeremiah Riesenbeck, I'm also a teacher here in Clark County. I also speak in support of trauma designation. In my 5 years of teaching I've already had several students who have passed away due to traumatic accidents. I can only think that if they had access to a closer trauma center that they may still be here today. I'm very upset that Mr. Frazee stole my line because I was going to say minutes matter and from Centennial Hills to UMC is about a 20-minute drive give or take. We have done training in our schools this year, the Control the Bleed program that teaches us how to use tourniquets and helps stop the bleeding in the event of a mass trauma incident but good is that going to do if we take these steps and still there is no nearby trauma centers. Thank you

Good Afternoon, thank you for letting me talk to you. My name is Brian Brundage, 89110. I am a Nevada Highway Patrol (NHP) Association executive board member and I'm a dispatcher with the Nevada Department of Public Safety and I want to speak to you in favor of more trauma centers in the valley. The question we have to ask ourselves is will we let past tragedies define us or will our proactive response to preparedness define us. I know we are here today to consider the process that we evaluate the need for trauma care and I would like to make it clear for the record any process that doesn't earnestly consider our system performance under mass casualty situations is incomplete. As a dispatcher with the department and as a member of the NHP Association, I know that trauma doesn't discriminate. I've been acutely aware of the need for access to local trauma care and the fact that trauma can happen to anyone anywhere, but on 1 October, my understanding of that changed and became a little more personal. Many of our members were working the night of that tragedy and as dispatchers we are involved in locking down roadways, coordinating transport to victims and the word quickly spread around the emergency responders that UMC, the only Clark County Hospital with a level I trauma center had called in an internal disaster alert and alert designed to be used in various scenarios where patient care could be compromised to signal emergency room overcrowding. That alert caused confusion among emergency responders including contributing to a transmission stating that the hospital's emergency room was out of beds which caused confusion even though the hospital technically remained open during the mass casualty incident. The readiness to re-route patients stemmed in part from the increasing use of recent years of internal disaster alerts. The alert on that night wasn't a mix up, it is a symptom of a growing emergency care capacity problem. At UMC in 2017, the regions only level I trauma center issued internal disaster alerts on average 4.3 times a week for nearly 630 hours that year. So how are we responding to this tragedy and how will we unite to build something better for the future as we collectively recover. When this board rejected the applications to expand access to trauma care in 2016, the claim was that Southern Nevada Trauma System is working well and there really were no incidents where patients or EMS couldn't get access to trauma center care in a timely manner. Now that the board is faced considering the same decision once again, that claim is no longer the case. Our states only level I trauma facility which frequently opposes any additions to the trauma system posted a presentation online, the after-action from 1 October and in that after-action they stated, many patients with less severe wounds were treated and released quickly, some with bullets still in their bodies. Some patients were released with bullets still in their bodies. So, the board shouldn't need no further evidence to demonstrate that the currently trauma system is

actually at or overcapacity and second chances are rare when it comes to trauma, but here we have one, a second chance to get it right and put patients first. So, I earnestly urge the board to consider the applications with an eye to putting patients first and not protecting the profits of insurance companies. Thank you for your time.

My name is James Wight, 89117. I'm a member of the Nevada Highway Patrol Association and a dispatcher with the Department of Public Safety. The need for emergent care has grown, our trauma system has not. I'm tasked daily with the NHP to EMS triage teams. I'm on the front line, trauma care coordination day in and day out and the recent headlines about Nevada's 10-year high death rate from accidents cannot and should not be ignored in our conversation today about trauma care. Zero Fatalities has been Nevada's official traffic safety goal since 2010 and we've made great progress. We've drastically lowered the rate of bicycle fatalities and pedestrian deaths but despite law enforcement efforts and aggressive public service campaigning, some crashes are unavoidable and last year was the deadliest year for motorists on Nevada roads in the last decade. 331 people died last year, that is a 10-year high for the state's population of 3 million and the population has also increased by about 400,000 in the last decade. Across the county it is estimated that 40% of traffic fatalities die at the hospital, not on the scene of the crash. Our troopers are patrolling Nevada's roadways every day to reduce these fatalities with an ultimate goal of zero, but we can't do it without expanding access to trauma care. As these numbers can attest, Las Vegas has the 5<sup>th</sup> highest motor vehicle fatality rate of the nation's top cities. As our fatality rates have grown, our access to trauma care has not. Patients are being underserved by the currently trauma system. Changes to the Trauma Field Triage Criteria (TFTC) have increased the need for level III trauma centers, but Nevada has failed to expand access to meet that need. In 2013 the RTAB board updated the TFTC to match national standards. This added new criteria determining trauma patients and recommendations that step 4 patients should be transported to a designated trauma facility, not an ER and further grew the needs of Clark County but our system has again failed to grow and meet this need. This need is clearly demonstrated in the increase of out of area transports reported. RTAB set the standard that the percentage of 5% was acceptable, but in the October RTAB meeting minutes, the trauma transport data for the 2<sup>nd</sup> quarter of 2018 saw an increase in the out of area transports from 8% to 12%. Having another center here will mean faster treatment for trauma patients which could be the difference between life and death. When evaluating the process for determining trauma need some claim time and transit is only critical for critical patients, however we count down the seconds until trauma care arrives, we can tell you time and transit is not only critical for every patient but also critical for the department of public safety members being dispatched to provide care. Try telling our troopers who are routinely in danger waiting at the scene of an accident for an ambulance to arrive that time and transit doesn't matter. As first responders, the dedicated women and men of the NHP Association take the responsibility to our public health system seriously. When the system is broken, we must all work together to ensure a reliable system for our citizens and our visitors. On a personal note, good luck finding a dispatcher in the state of Nevada who doesn't recognize the need for another trauma center in Southern Nevada. Thank you.

Good Afternoon, my name is Melissa Dougherty, 89015. I am from Nevada Highway Patrol (NHP) Association, I am an executive board member and a support staff at parole and probation. The current system is not working. Transport times for half of our region are too long and each minute wasted by traveling further from the incident is a minute that a life could be saved which is unacceptable when we have multiple hospitals ready, equipped and applying to open more trauma centers. Rising rates of tourism, drivers on the road, service calls for emergency responders and general population growth create significant capacity challenges. From 2006 to 2018, the population in our state has increased by 20% and the number of visitors to Nevada grew 11.5% as a result. NHP service calls have increased 26.2%, NHP crashes grew a record of 35.6%. According to the most recent Nevada trauma registration report, this state experienced 9,768 total trauma cases, an increase of more than 10% from the previous year. Among the unintentional trauma incidents 25.1 were motor vehicle incidents. We have not added a new trauma center since 2004, though our population has grown 76% in the last 16 years. This is proof that our community needs

more care. When first responders arrive at the scene, they have to assess whether the injured patient should go for treatment. If you have a 30 minutes transport time to a trauma center, the traffic if heavy or a route is closed, you could be reducing travel rates just in transit. Likewise, the number of out of state transfers is far too high. Last year alone the number grew to 12% which is far beyond the 5% that the RTAB said is acceptable. If people on the front lines are telling you that we need more trauma care, shouldn't this be the time to do so? Patients treatment in a trauma center have a 25% higher survival rate compared to patients with similar injuries or illness seen on hospitals without those services. According to a recent New England Journal of Medicine study, if a private company wants to provide the funds to train trauma nurses and doctors, provide more lifesaving equipment, and upgrade their hospital emergency rooms into trauma centers ensuring more lives are saved, then we should not stand in their way. Thank you, Sir

Good Afternoon, my name is Taylor Campese, 89002. I am a Nevada Highway Patrol (NHP) Association member and like Brian and James I am also a dispatcher with the Nevada Department of Public Safety. I want to first thank Mr. Kingsley for his report on the trauma system assessment, a willingness to look at both tools and get out in front and establish need. The Needs Based Assessment of Trauma system or NBATS by the American College of Surgeons (ACS) for the Clark County Trauma System, indicated that our county would need 5 trauma centers for our trauma system to be able to meet the communities need. This would require the addition of at least 2 new trauma centers presumably level III and maybe more. Two separate studies indicate the NBATS under indicates by 20% suggesting that the Clark County Trauma System would actually need 6 trauma centers to meet the needs. We should embrace that the question of is there a need for more trauma care in Clark County has already been answered by this assessment and the answer is unequivocally yes. Thank you

Chairman Fildes thanked all the speakers and asked if anyone else wished to address the Board 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 RTAB that can be enacted by one motion. Any item may be discussed separately per Board member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes/Regional Trauma Advisory Board Meeting: 01/16/2019

Chairman Fildes asked for approval of the minutes from the January 16, 2019 meeting. A motion was made by Member Corrales, seconded by Member Rogge and passed unanimously to approve the minutes.

## **III. CHIEF HEALTH OFFICE REPORT**

Dr. Iser reported that the Health District's budget is balanced and was presented to the Board of Health (BOH) last month. He added that the final increment that the County identifies for all the cities, county and for the Health District goes to the BOH for approval this month and he didn't expect there to be any issues.

He stated that they are sponsoring a public health residency and general preventative medicine (GPM) program. The Health District has a site visit next week for the GPM and public health residency and they expect to be fully accredited with the next month after that visit.

He reported that there was a relatively significantly down turn in influenza cases, hospitalizations, and deaths this past year. He added that they are also starting into the vector season to survey mosquito populations for diseases to include West Nile.

Dr. Iser gave updates on the legislative session for the following:

- There is a proposal in front of the legislature to allow raw milk sales throughout the state of Nevada. He feels this is not a smart move adding that raw milk can carry dangerous bacteria.
- AB97 which revises provisions relating to certain expenditures of money for public health. He felt this would help all 4 of the jurisdictions, the 3 locals and the state allowing them to expand their reach into other communicable diseases.
- AB317 is a proposal to take away the authority of the RTAB and the Health District's Board of Health from designating trauma centers. He doesn't believe this is a smart move and wanted that on the record.

Chairman Fildes asked if there are any questions or comments for discussion with Dr. Iser.

Ms. Dokken stated that the proposed bill for trauma has significantly changed since it was first introduced. Originally it read that Level III trauma centers could no longer charge activation fees. The newest format amended that bill to read as Dr. Iser said and felt that it needs to be brought to everybody's attention the danger of that bill. She felt that this would take them back to everything that they have been building upon since 2004 for their Southern Nevada Trauma System.

Ms. Breen urged everyone to read the bill, understand what the bill is saying and to contact your legislature with your opinion. Understand that if you go to a level III trauma center without lights or sirens meaning that it is not a huge emergency, that a trauma activation fee will be able to be charged. She added that before they are reckless about how many centers there are, everyone needs to understand what this bill would do if the authority is taken away from this board and given to the state.

Chairman Fildes stated that he was aware that AB317 was being crafted but was not involved. He informed the board that in 1996 he was working in Carson City and helped draft language for NRS 450B because the state legislature voted to exclude counties with population more than 350,000 people which indicated to him that they were not interested in the complexity of the decision making in Clark County. He added that this board and his colleagues have worked tirelessly over the years to provide smart growth, not uncontrolled growth, not unwise growth but smart growth for the population of the valley and will continue to do so and he preferred that it be done locally than by people in Carson City. He stated that there are a lot of emotions in this room and a significant amount of disinformation and conflicted interests and pledged to try to navigate through them as fairly and transparently as they can to see that smart growth occurs here and that they are not tripling the number of trauma centers and dismantling existing resources to create an oversupply of inexperienced new trauma centers.

Dr. Iser commented that he has absolute faith and trust in this board and cares about the outcomes here in Clark County. He stated that he also would like to publicly thank his staff who he has absolute confidence in and who have worked tirelessly to support the RTAB with these deliberations over the past several years.

#### **IV. REPORT/DISCUSSION/POSSIBLE ACTION**

##### **A. Committee Report: Southern Nevada Injury Prevention Partnership (SNIPP) 02/11/2019 & 04/15/2019**

Mr. Corrales related that they had 2 meetings, one in February and then one just recently in April. He thanked the board for adopting their bylaws which allows them to look at data driven reports and focus on their efforts. They were able to look at and discuss certain groups out in the community that are supporting the efforts of SNIPP that include Andrew Bennett from the state of Nevada, and Erin Breen from UNLV's Vulnerable Road Project. In the most recent meeting they were able to set up talks for fall prevention, suicide review and then child death review which will be heard at their July meeting.

##### **B. Committee Report: Trauma System Advocacy Committee (TSAC) 10/16/2018**

Ms. Breen reported that they did not get a bill together to support trauma services nor could they find someone to carry a bill if one had been developed. She added that they will continue to work on that. She advised that she attended a fund raiser earlier in the day for a young man that was killed crossing Fort Apache at the end of March. The next large event will be at the Boulevard Mall on May 24, 2019 that will focus on the 100 deadliest days of the year which is Memorial Day through Labor Day.

Ms. Breen reported on the following legislative bills that promote safety and help saves lives: Ignition interlock devices – language issues and responsibilities

- Pedestrian Safety bill
- Requiring helmets on moped riders
- Raise graduated drivers licensing to include every new driver under the age of 21 to receive 75 hours of behind the wheel practice with 15 hours at night before they could test for their driver’s license.
- Gun Safety bills / unsecured weapons
- State taking oversight of trauma center applications

C. Committee Report: RTAB Member Nominating Committee

Chairman Fildes stated that the RTAB member Nominating Committee met prior to review the applications received and to make their recommendations to the RTAB. He then directed staff to share the recommendations of the RTAB Member Nominating Committee and state the results of the deliberations.

Mr. Kingsley reported the following:

Administrator from a non-trauma center hospital system: Sajit Pullarkat

Public providers of advanced emergency care: Frank Simone

Private franchised providers of advanced emergency care: Larry Johnson

Rehabilitation services: Amy Henley

Knowledge of system financing/funding: Jessica Colvin

Chairman Fildes asked if anyone had any questions. Hearing none, he moved on from this agenda item.

D. Trauma Field Triage Criteria (TFTC) Data Report for 4<sup>th</sup> Quarter 2018

Mr. Kingsley reported on the trauma transport data for 4<sup>th</sup> quarter 2018. There was considerable discussion regarding the high percentage of out of area transports.

Ms. Dokken stated that she was in favor of making sure that anytime they go above the 10% total out of area they review the cases.

The board asked staff to pull the last 6 months of out of area cases for review.

Chairman Fildes commented that the growth factor in the trauma system has been mostly Step 4 trauma field triage criteria (TFTC) patients. Reviewing the total transports for the final quarter of 2018, it is depicted that the discharge rate for those is 2 out of 3 patients delivered to a trauma center goes home within hours. While over triage doesn’t harm anyone, it does take them away from their home, it does take EMS crews out of their zones and it does cost more money. He felt that if it doesn’t improve their outcomes, there needs to be a discussion. He advised that the Step 4 was specifically written to support the concept of an inclusive trauma system. A trauma system where every hospital sees patients who are injured but not every hospital is a trauma center. When you think about emergency department in general, the admission rates for an average ED is 18 to 22% and the trauma centers are starting to close in on that same number which begins to indicate that we may be seeing patients that are not as appropriate for trauma centers.

#### E. Review of Trauma System Assessment

Mr. Kingsley presented the 2018 Clark County Needs Assessment Review ([Attachment A](#)). This is the evaluation of the current level of performance of the Southern Nevada Trauma System to understand and assess the community as they move forward. He took a moment to thank much of the staff at SNHD including Informatics, Epidemiology, PIO, and the OEMSTS staff for their diligence in helping put this report together. He also thanked the fruits of the RTAB and trauma centers by recognizing more data was needed to be able to understand the system and for providing that data. Mr. Kingsley stated that this report consists of the trauma needs assessment tool (TNAT) for Clark County, and then one for each of the applications with a 4-year progression. He reviewed the TNAT for Clark County that includes 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 a trauma center; 5. Trauma centers currently in the Las Vegas valley (2013-2018); and 6. Any center seeking for an upgrade in designation must demonstrate substantial compliance with the requirements of the American College of Surgeons (ACS) Resources for The Optimal Care of Patients.

Chairman Fildes asked if question 4A used state trauma registry data. Mr. Kingsley answered in the affirmative.

Dr. Fisher asked if those transfers into Southern Nevada Trauma Centers from non-trauma centers in question 4B are from only Nevada non-trauma centers because they seem very low. Mr. Kingsley believed they include out of state as well.

Ms. Dokken felt it was also reflective of non-trauma center data. Being from a hospital system that has 2 non-trauma centers she felt that data is not as accurate as it should.

Dr. Iser questioned how well the state is doing in training the registrars to put in accurate data.

Ms. Dokken stated that speaking just from their 2 non-trauma centers, the registrars from both of those facilities feel very supported by the state helpdesk but noted that they must ask the questions.

Mr. Kingsley referred to the Appendix A through G starting on page 138 of the Needs Assessment. Appendix A shows a general heat map displaying the average 5-year population growth rate in Clark County from 2012 to 2017.

Appendix B shows the average annual 5-year growth rate by zip code from 2012 to 2017.

Appendix C, D, and E show TFTC transports by Step for 2015 to 2018 for each trauma center. This shows a significant jump in 2017 and 2018 for Step 4s.

Appendix F displays trauma registry patients living outside of Clark County from 2014 to 2018.

Appendix G is the Needs Based Assessment of Trauma Systems (NBATS) by the American College of Surgeons for Clark County Trauma System including results.

Chairman Fildes commented that the NBATS is a tool, not a rule. It is meant to estimate how an area should go forward if it has an immature trauma system. He added that the tool does not take in account the capacity of the existing centers. The existing centers meet 100% of the current demand. He explained that what they are looking at is future demand and where do they put assets in play that serve future demand.

Mr. Kingsley referred to the maps in the Needs Assessment Review that show TFTC transport time by Step. He added that to protect PHI, the streets are not listed but each one of these dots is a trauma case that occurred in the Las Vegas valley in 2018. This report can be found on the Southern Nevada Health District website at: <https://www.southernnevadahealthdistrict.org/programs/emergency-medical-services-trauma-system/southern-nevada-trauma-system/>

These maps are interactive by using the “layers” button and then clicking expand/collapse to open the folder and view all the layers.

Chairman Fildes questioned if this is total transport time or is that scene to facility time.

Mr. Kingsley stated that it was decided in the TNAT that the determining time would be from time leaving the scene to the hospital.

Chairman Fildes felt it was also important to add a discussion that is in the minutes of the Trauma Needs Assessment Task Force deliberations that read, if your goal is to approach a 15-minute transport time, and Step 3 and 4 patients are transported without lights or sirens at street speeds of 45 mph, then you should be concentrating on an 8-mile radius around each center that is applying. Not only to look at their affective service areas, but also to look at overlaps, redundancies, and their ability to serve unique areas.

Ms. Holmes stated that there is a lot of information to digest and added that she had a couple of suggestions. She felt in the percentage increases on the zip codes, it would be helpful to have the absolute population numbers. She also suggested breaking down the median transport times for each Step level. About issues raised around the state registry data and its reliability, she was unclear how useful that data is to try and look at trends. She pointed out that Appendix G specifies that in two separate studies (Uribe-Reitz California Test and Evaluation of the Georgia trauma system) it would indicate the NBATS under indicates by 20%. She looked at both studies and even though they are not strong studies she didn't think that 20% is definitive in either study.

Mr. Kingsley stated that he wanted to give a basic round range but acknowledged that this is not something that is definitive in that sense.

Chairman Fildes declared these are tools, not rules that people have used to try and study and try to create relevant decision-making tools for their region, just as they have with our Trauma Needs Assessment Taskforce. He then questioned if in question 1E on page 8 the number of TFTC Incidents in Service area is synonymous with the Las Vegas valley.

Mr. Kingsley stated that it includes the entire Clark County.

Chairman Fildes stated that in question 1E, when you get to the 4<sup>th</sup> grouping, Step 4 special considerations, you can see the spike in 2017, 2018 that the system experienced when Step 4 was made a mandatory transport criterion as opposed to the guidance written by the CDC. The CDC describes special populations of patients who are either older, who are children, who may be on anticoagulants, who may have burns or who may be pregnant, and it says that EMS provider judgment should be used. And the direction is to either transport to a trauma center or to a hospital capable of timely and thorough evaluation in the initial management of potentially serious injuries. Consider consultation with medical control. So that is how this filtered down through the CDC and the ACS and on a local level the decision was made to assist EMS by removing the decision-making process for Step 4 and it may have had untoward consequences.

Mr. Kingsley stated that the Medical Advisory Board (MAB) reviewed the Trauma Field Triage Criteria protocol in July 2018 changing the language to read "The patient must be transported to a Level I, II or III Center for the Treatment of Trauma". Looking at the data we see the increase in Step 4 patients in 2017. He looked at the Nevada Trauma Data Base and the CDC and falls for both were the number one indicator for a national increase. He questioned if this is part of the aging population with the baby boomers hitting 65+. The CDC data is showing a 4% increase from 2015 to 2016 and it is jumping around across the nation as well. The EMS community decides to transport on a lot of different conditions to a certain hospital and if that patient had a bad outcome it would then be reviewed by the peer review committee questioning their decision. Changing the language in the protocol to "must" makes it black and white.

Mr. Simone commented there is no gray area in EMS and having it as an option in the protocol caused confusion.

Mr. Kingsley explained that in July of 2018 when the protocol changed, it wouldn't have gone into effect until October of 2018 to allow the EMS Agencies 90 days for training so that data

wouldn't be available yet to compare to the previous year. He felt that for the increase in 2017 and 2018 they are looking at an EMS bias. He added that there is a national standard that uses "may" and that is following CDC guidelines and we are going against the grain by changing it to "must". He added that there are a lot of issues that are lengthy to debate.

Ms. Holmes emphasized that this is a critical issue that really needs to be dug into and understood. She agreed that EMS is vital and critical but felt that it may be driving too much of the trauma burden. She questioned that if they are not following the CDC recommended guidelines, if that is the right choice for their patients. That is an issue that needs to be investigated much more closely.

Chairman Fildes felt Mr. Kingsley's comments were quite clear and illustrates the complexity of the decision. In the simplistic way you could say that by opening the triage criteria to include all these patients and direct them all to trauma centers, we've relieved some problems and created some problems. There may be unintended consequences such as there may be a decrease in the number of patients seen in emergency departments or there are patients who are transported far from their home who don't want to be transported far from their home who can appropriately be seen in the emergency department and if something were found they could be transferred to a trauma center. But when 2 out of 3 patients are going home within hours of arrival, and there has been no increase in the preventable death rate, you must begin to wonder what are the outcomes that we are managing to.

Mr. Kingsley stated that they have debated over that and compared that with the analogy that a trauma center is like a cardiac center. A patient states they have chest pain, but it could just be a panic attack or gall bladder and that is a gray area that EMS deals with. If someone says chest pain, they are going to go to a cardiac center. A percentage of those patients are only having an anxiety attacks, but they had to have that fast pass to be assessed to say you are not having a heart attack. The trauma center Step 4s deal with the same issue. The mortality rate is low but people do die from falls and that is why they need to be assessed and also why we do see a predominately higher number of them released.

Chairman Fildes thanked Mr. Kingsley and said that he has done a very good job in framing the complexity of the discussion.

Mr. Kingsley proposed 2 additional meetings. He added that currently the BOH has tentatively stated that they would be hearing the applications in June. He stated he would like to meet with the board on Tuesday, May 21<sup>st</sup> and Tuesday, June 18<sup>th</sup> to allow more discussion on the 2018 Clark County Needs Assessment Review. He added that he did provide a 2019 Needs Assessment questionnaire in their handouts. This handout is something that they will review at the next meeting and asked the members to arrive prepared to answer those questions. He added that he will send out a follow up email as a reminder.

Chairman Fildes stated that they will take a 10-minute break before hearing the trauma center applicant presentation. He asked that the presentations run for 10 to 15 minutes with 5 minutes for questions. Our first presenter today is applicant hospital from Centennial Hills.

F. Centennial Hills Hospital Medical Center Application for Initial Authorization as a Center for the Treatment of Trauma

Sajit Pullarkat introduced himself as the CEO of Centennial Hills Hospital and provided the Board a presentation ([Attachment B](#)) to support their application for initial authorization as a center for the treatment of trauma. He discussed population growth and development in the northwest and explained that Centennial Hills Hospital would create a trauma program to enhance the current trauma system by serving the expanding patient needs in this area.

Upon conclusion of the presentation, Chairman Fildes thanked Mr. Pullarkat for the presentation and inquired if their anesthesia and general surgery cadre is big enough or was he confident that it will grow.

Mr. Pullarkat advised the board that they have inhouse anesthesia services, so they do feel confident there and from a general surgery perspective, they have support for moving that as well.

Chairman Fildes observed in their application that they have neurosurgical services and questioned if it is his intent to apply as a level III that offers neurosurgical services and if they have adequate staff.

Mr. Pullarkat answered in the affirmative.

Ms. Breen questioned the difference between the activation fees and why they were not increasing for intermediate and full activation.

Mr. Pullarkat stated that when you have an activation you are activating a trauma team which is a compilation of nurses as well as physicians that are helping to respond to that call. His understanding of the intermediate and the full level activations are reserved for the Level II and the Level I trauma facilities. As a Level III they should be all low activations.

Dr. Fisher asked Mr. Pullarkat to talk about some of the infrastructure changes within the hospital that he's done to be a trauma center

Mr. Pullarkat responded that they have been meeting and talking about the requirements from a trauma service perspective. They already have a trauma medical director on board and they have looked at their individual policies regarding process times and response times. They have gone through the Orange Book which details what is needed to become a verified trauma center. He felt that having anesthesia inhouse with some of those other key services that are already readily available has really made a huge difference in terms of being ready to move forward in that endeavor.

Dr. Fisher questioned if their inhouse anesthesia is currently for OB/Gyn and that they would add on to that.

Mr. Pullarkat answered in the affirmative.

Ms. Dokken stated that to answer Mr. Breen's question, the levels of activation, full, intermediate and level III at our facility bring in different resources and it is based on the orange book. It is what providers you need based on the level of activation.

Dr. Dort added that at the top levels you are going to need that response time. For the centers that do stratify it, its increasing levels of resources that must be there. He informed the board that ACS is going to want to see that the people dedicated to the trauma is different than the people dedicated to the inhouse for the other services.

Chairman Fildes asked if there were any other questions or comments. Hearing none, he thanked Mr. Pullarkat.

G. MountainView Hospital Application for Initial Authorization as a Center for the Treatment of Trauma

The presentation ([Attachment B2](#)) for the MountainView Hospital application for initial authorization as a center for the treatment of trauma was presented by Jeremy Bradshaw, CEO of MountainView Hospital. He discussed the center's resources which detailed MountainView Hospital's trauma services capabilities. Following the completion of Mr. Bradshaw's presentation, the Chairman inquired if the Board had any questions for Mr. Bradshaw.

Ms. Holmes commented that the statement in the presentation that stated Nevada ranked last among U.S. states in preparedness for health disasters was a study from 2014. She added that it was her understanding of the study that the report did not include any claim that Nevada was ranked last because of a lack of trauma centers. She noted it ranked last because of a severe shortage of specialists, financial barriers for care, only 8.7 emergency departments per 1 million people which was below the national average and a small nursing population. She noted that since 2014, Nevada has had Medicaid expansion, added 9 new emergency departments between additional hospitals, free-standing ERs and the micro hospitals. They also found that 94.2% of

the population was within 60 minutes of a Level I or Level II trauma center which was above the national average of 82.1%. She questioned if there was a more currently study because she is trying to understand how trauma fits into that statement.

Mr. Bradshaw stated that in terms of the emergency preparedness, looking at unfortunate events like October 1<sup>st</sup> and what happened here in the community, having other trauma centers that could offload from a Level I and Level II when you are seeing that type of population would benefit. He felt that the comment regarding emergency preparedness was a general statement in terms of where Nevada had ranked at that time. He added that they sourced this with the National Health Security Preparedness index and could certainly produce that report for you to have the detail.

Mr. Holmes stated that she would like to see that report.

Ms. Breen stated that with everything you have put into place already, are your future plans in the not too distant future to try to be a level II trauma center.

Mr. Bradshaw stated that they are focused on becoming a level III and they believe that is what is appropriate for MountainView Hospital.

Ms. Breen asked that if we were looking to the northwest as an area in need of a trauma center, why MountainView over Centennial Hills.

Mr. Bradshaw stated that they are very proud of the work that is being done especially when you look at the quality and quality outcomes that is coming from MountainView compared to other hospitals throughout the valley. MountainView has received an "A" rating for patient safety. He added that they already have the resources in place and are already seeing over 500 trauma admissions a year for the past two years.

Ms. Breen noted that MountainView is already seeing roughly 500 Level III patients a year and questioned how many of those do you anticipate would not be eligible for the trauma activation fee.

Mr. Bradshaw stated when they looked at the number of patients that would not meet the criteria for an activation fee, they anticipate that the high end of that number would be less than 25%, and it could be as low as 15%.

Chairman Fildes remarked that you've seen 500 trauma patients and that you are increasing at 13% a year. State trauma registry shows that you are seeing 500 patients and you are the only non-trauma center hospital in valley with that many patients. He questioned if these are coming to you as EMS delivered Step 3 and Step 4 patients.

Mr. Bradshaw answered that most of those patients are arriving by private vehicle.

Chairman Fildes added if it would be fair to say that many of them are injured patients and being in a trauma environment as opposed to multiple injured trauma patients.

Mr. Bradshaw answered in the affirmative adding what they are typically seeing in terms of the acuity are elderly person who falls and hip fracture.

Chairman Fildes asked if there are other questions or comments. Seeing none, he thanked Mr. Bradshaw

#### H. Mike O'Callaghan Military Medical Center Application for Initial Authorization as a Center for the Treatment of Trauma

Colonel Alfred K. Flowers Jr., Commander and CEO with Mike O'Callaghan Military Medical Center laid out his presentation ([Attachment B3](#)) and plans for delivering trauma services to the community. He emphasized that the addition of trauma services would be mutually beneficial to their active duty staff as it further expands their wartime skills and currency for deployments.

Mr. Corrales asked Colonel Flowers if he could elaborate on your multi-service in-patient unit as he is unfamiliar with that terminology.

Colonel Flowers stated that was their medical surg unit.

Ms. Breen asked if they currently treat civilian injuries.

Colonel Flowers stated that they have a partnership with the Veterans Administration (VA) but they are willing to open the doors to extend that partnership based on the permissions of the National Defense Authorization Act. He added that they will receive patients through EMS through their doors. He stated that they have about 49 million dollars of construction that is currently underway to prepare for this.

Chairman Fildes questioned that in the event that there was a major mobilization would you have enough staff to continue the mission of a Level III.

Colonel Flowers informed the board that they have the commitment from the Airforce Surgeon General, and they have a staff mix of active duty, Department of Air Force civilians and contractors. They have a healthy mix if someone who was indeed mobilized or taxed for deployment they would be able to shore up those gaps and it would be seamless to the patients in providing that care.

Chairman Fildes asked if there were any other questions. Hearing none he thanked Colonel Flowers for his presentation.

I. St. Rose Dominican-San Martin Campus Application for Initial Authorization as a Center for the Treatment of Trauma

Lawrence Barnard, President/CEO of St. Rose Dominican, San Martin presented their efforts in their bid to become a Level III trauma center ([Attachment B4](#)). He advised that St. Rose San Martin Campus is dedicated to a long-term commitment for providing trauma care and participating in the Southern Nevada trauma system.

Chairman Fildes asked if Mr. Barnard if he and his medical staff in the areas of general surgery, anesthesia, and emergency medicine are prepared to go deep enough to staff this should it come to fruition.

Mr. Barnard answered in the affirmative adding that because of the relationships that we have obviously with Siena, they know how to do that effectively.

Charmin Fildes asked if it is his intent to provide neurosurgical services.

Mr. Barnard stated that they have neurosurgical call, but don't intend to provide neurosurgical services or to go to a trauma Level II. Theirs is just to meet the needs of the community.

Chairman Fildes informed the audience that Level III has an option of offering neurosurgery. He then asked if there are any other questions or comments. Hearing none, he thanked Mr. Barnard for his presentation.

J. Spring Valley Hospital Medical Center Application for Initial Authorization as a Center for the Treatment of Trauma

Leonard Freehof, CEO of Spring Valley Hospital presented his platform on seeking approval to become a Level III trauma center ([Attachment B5](#)). He focused on the hospital's comprehensive services to the southwest Las Vegas valley as well as commitment to support the growing community and provide a culture of excellence.

Ms. Breen stated that the San Martin campus is further south and further west and asked if we were looking for placement of a trauma center in the southwest, why your hospital over theirs.

Mr. Freehof declared that they get significantly more EMS volume currently. He felt that it is because of the infrastructure and the services that they provide. He added that they are more prepared and are already taking care of a number of those types of patients. They are a full-service hospital in terms of taking care of any type of injury that might come to them from a Level III perspective. Spring Valley is very accessible and felt the infrastructure speaks to itself.

Chairman Fildes asked how he felt about the depth of his general surgery and anesthesia coverage.

Mr. Freehof remarked that he feels very strong. They are very committed to support this and providing services already. They are prepared to comply with all the requirements from the ACS.

Chairman. Fildes said they Spring Valley saw 193 trauma patients. He asked if those patients were delivered by EMS after being identified as satisfying TFTC or were they self-delivered.

Mr. Freehof stated that those were patients that accessed the hospital separate and aside from EMS.

Chairman Fildes asked if there were any other comments. He thanked all the presenters and added that their applications are all worthy and strong.

#### **V. INFORMATIONAL ITEMS / DISCUSSION ONLY**

##### **A. Report from Public Provider of Advanced Emergency Care**

Mr. Simone stated that there were no items to report.

##### **B. Report from Private Provider of Advanced Emergency Care**

Mr. Corrales reported that Donna Miller has assumed regional manager duties for AMR and MedicWest replacing Scott White.

##### **C. Report from General Public Representative**

Mr. Bottorf reported that four of their own providers are going to be recognized by the State Legislature tomorrow. Leslie Shaffer and Callie Fraser for training 10,000 people in Stop the Bleed. Flight Paramedic Chris Clark and Flight Nurse Sarah Allen for supporting the lack of a hospital in Nye County with emergency and trauma services.

##### **D. Report from Non-Trauma Center Hospital Representative**

Mr. Pullarkat stated there were no items to report.

##### **E. Report from Rehabilitation Representative**

Mr. Meyer stated there were no items to report.

##### **F. Report from Health Education & Injury Prevention Services Representative**

Ms. Martinat stated that there were no items to report.

##### **G. Report from Legislative/Advocacy Representative**

Ms. Breen had no further items to report.

##### **H. Report from Public Relations/Media Representative**

Mr. Kerbs stated there were no items to report.

##### **I. Report from Payer of Medical Benefits**

Ms. Homes stated there were no items to report.

##### **J. Report from System Finance/Funding**

Dr. Fildes stated that Mr. Ellis had nothing to report.

#### **VI. PUBLIC COMMENT**

Public comment is 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 include on an agenda as an item upon which may be taken pursuant to NRS 241.020.

All comments are limited to five (5) minutes. Chairman Fildes asked if anyone wished to address the Board.

The following public comment is verbatim transcription.

Good Afternoon, my name is Bobi Oates, I am retired Air Force. I retired out of Nellis several years ago. I've been in the valley since 1994. That is when I arrived here, and I have seen the Nellis Hospital grow from a little hospital to a huge hospital. But the main thing is national security our national defense. We need to keep our military personnel trained and if we could have a trauma center out at the Mike O'Callaghan Hospital that would be training our medics to go to war, to go to respond to other events. But it is for our national security, it is to protect our sons and daughters because you want those medics trained if they are down range and something happens you want to have a medic there that has been properly trained. By having a trauma center here at Nellis, that would ensure that our medics are constantly trained on all different types of medical emergencies. It is fine to do simulations but unless you are actually working with people, it is not the same. I was an aircraft mechanic, you learn a lot on the books and stuff and you have simulators, but once you are actually out there working on the air frame, and doing it, that is when you get your training and that is what sticks, the actual demonstration and actually doing the training. The fact that the Department of Defense is strongly supporting this and will continue to fund this to make sure that Nellis turns into the greatest medical hospital we have, it's one of the largest ones, but it is important. The main thing is our national security and plus the area around Nellis is growing. I got there in 94, there wasn't a whole lot out there, you could get to UMC in 10 minutes. Now you can't do that and with all the warehouses that are going up, there are all those homes that are going up around by the VA Hospital and the fact that the base does work with the VA Hospital on a good partnership to take of our veterans too. So, it is really important that some of the veterans that may not have the capability to come to the Nellis Hospital that they will be able to do that for their trauma cases. Thank you.

Chairman Fildes asked if anyone else wished to address the Board. Seeing no one, he closed the Public Comment portion of the meeting.

## **VII. ADJOURNMENT**

There being no further business to come before the Board, *Chairman Fildes adjourned the meeting at 4:59 p.m.*