togetherforbetter

Board of County Commissioners

Clark County, Nevada

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Southern Nevada Health District Board of Health

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Frank Nemec, M.D., At Large Member – Physician
Jim Seebock, City of Henderson Councilman
Tick Segerblom, Clark County Commissioner

The Board of County Commissioners of Clark County, Nevada met in a joint special session with the Southern Nevada Health District Board of Health, in full conformity with law and bylaws of said Boards, at the regular place of meeting in Clark County, Nevada, on Thursday, September 5, 2024:

CLARK COUNTY GOVERNMENT CENTER
COMMISSION CHAMBERS
500 S GRAND CENTRAL PKWY
LAS VEGAS, NEVADA 89106

This document is an uncertified copy of the approved meeting minutes prepared by the Clark County Clerk, Lynn Marie Goya, for the above referenced meeting.

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CALL TO ORDER

The meeting was called to order at 10:01 a.m. by Chair Kirkpatrick with the following members present:

Commissioners Present:	Board of Health Members Present:	Absent:
Tick Segerblom, Chair	Marilyn K. Kirkpatrick, Chair	None
William McCurdy II, Vice Chair *	Scott Nielson, Vice Chair	
Jim Gibson	Nancy Brune *	
Justin Jones	Scott Black	
Marilyn K. Kirkpatrick	Bobbette Bond	
Ross Miller *	Pattie Gallo *	
Michael Naft	Joe Hardy	
	Brian Knudsen	
	Frank Nemec, M.D.	
	Jim Seebock	
	Tick Segerblom	

* Participated via telephone

Also Present:
Kevin Schiller, County Manager
Fermin Leguen, MD, MPH, District Health Officer/Executive Secretary of the Board of Health
Lisa Logsdon, Deputy District Attorney
Heather Anderson-Fintak, General Counsel for the Southern Nevada Health District
Jewel Gooden, Deputy Clerk
Susan Wohlbrandt, Deputy Clerk
Andria Cordovez Mulet, Executive Assistant

SEC. 1. PUBLIC FORUM

MARILYN K. KIRKPATRICK
Good morning. We're going to go ahead and get started. I think there's a couple members that will come. So, we're going to go ahead and get started on the joint meeting of the Clark County Board of Commissioners and the Southern Nevada Health District at 10:00 a.m. This is an informational workshop, so I want to say why we're doing this before we go to the public comment. So, Mr. Schiller, as long as you're good with that? Heather's accustomed to me just doing whatever. I've been working on this for a very long time, because I think that-

AUTOMATED VOICE
Recording in progress.

MARILYN K. KIRKPATRICK
... thank you. Because I think that it's important that we educate the community on everything that is going on with our system, because we have a lot to be proud of. Our system works very well. That was showcased, unfortunately, during 1 October. But we have a unique and a very good system. And the Health District is a big partner of the County Commission, as well as the hospital network. But things are changing, so we wanted to make sure that people have an idea of what to expect, what their rights are. One of the things that people don't realize is if they're not in a trauma situation, they can ask to go to a

specific hospital. That is well within their rights. So, we just want to give an overall view, and that's stuff that we can share with our constituents. So, with that, Mr. Schiller?

TICK SEGERBLOM
If I can just make a comment since this is a joint meeting? Thank you. On behalf of the County Commission, we're happy to be here too, and to learn what Marilyn has in store.

KEVIN SCHILLER
Good morning. I think the first thing we'll do is just do a roll call, so we know who's on the phone, and then we'll move into the first section set aside for public comment.

JEWEL GOODEN
Good morning. We'll begin with the Board of County Commissioners. Chair Segerblom?

TICK SEGERBLOM
Here.

JEWEL GOODEN
Vice Chair McCurdy?

WILLIAM MCCURDY II
Present.

JEWEL GOODEN
Commissioner Gibson?

JIM GIBSON
Here.

JEWEL GOODEN
Commissioner Jones?

JUSTIN JONES
Here.

JEWEL GOODEN
Commissioner Kirkpatrick?

MARILYN K. KIRKPATRICK
Here.

JEWEL GOODEN
Commissioner Miller?

ROSS MILLER
Here.

JEWEL GOODEN
Commissioner Naft?

MICHAEL NAFT
Good morning.

JEWEL GOODEN
For the Southern Nevada Health District Board of Health. Chair Kirkpatrick?

MARILYN K. KIRKPATRICK
Here.

JEWEL GOODEN
Vice Chair Nielson?

SCOTT NIELSON
Here.

JEWEL GOODEN
Nancy Brune?

NANCY BRUNE
Present.

JEWEL GOODEN
Scott Black?

SCOTT BLACK
Here.

JEWEL GOODEN
Bobbette Bond?

BOBBETTE BOND
Here.

JEWEL GOODEN
Pattie Gallo?

PATTIE GALLO
Here. Good morning.

JEWEL GOODEN
Joe Hardy?

JOE HARDY
Here.

JEWEL GOODEN
Brian Knudsen?

BRIAN KNUDSEN
Here.

JEWEL GOODEN
Frank Nemec?

FRANK NEMEC
Present.

JEWEL GOODEN
Jim Seebock?

JIM SEEBOCK
Here.

JEWEL GOODEN
Commissioner Segerblom?

TICK SEGERBLOM
Here.

1. Public Comment

KEVIN SCHILLER
We can now move to the first section set aside for public comment.

MARILYN K. KIRKPATRICK
Okay. And I want to thank all the members. Because it was hard to get everybody together, but it sounds like we have 100% participation, so I appreciate that. The first item on the agenda is public comment. If anybody wants to come up and give any public comment on any of the items that are posted, please feel free to come forward.

CONNOR CAIN
Good morning.

MARILYN K. KIRKPATRICK
You don't have to lean down. You can stand up.

CONNOR CAIN
Stand up? Okay. Good morning. I apologize for being a little bit informal. I want to say, Chair Kirkpatrick, but also Chair Segerblom, it's my first time being at one of these joint meetings and appreciate everyone making time for this today. Obviously, we have a number of really, really important topics. Connor Cain, on behalf of Sunrise Hospital and Sunrise Children's Hospital. And just wanted to say that we appreciate the opportunity to be part of these discussions. As I think many of you know, UMC (University Medical Center) is one of our community's safety net hospital and does tremendous work in our community. Sunrise Hospital and Sunrise Children's Hospital is also one of our community's safety net hospitals and does tremendous work in our community. And as we move forward in addressing the healthcare needs that we have, we would greatly appreciate participating in these conversations. Again, because they are so important. And want to want to thank you all again for being here and making time for this. Thank you, Chair. Thank you, Chairs.

MARILYN K. KIRKPATRICK
Thank you. Next speaker.

STACIE SASSO
Good morning. My name is Stacie Sasso. I'm the executive director for the Health Services Coalition. The coalition represents 25 union and employer sponsored self-funded health plans in southern Nevada, with over 280,000 lives collectively. Our groups include municipalities like Clark County and City of Henderson, police and fire, hospitality workers, including Culinary and MGM, as well as building trade groups like Teamsters and Cement Masons. The coalition and its members have engaged in the regulation and oversight of the Southern Nevada Trauma System for more than 20 years, because an effective trauma system is so vital to our community and injured patients. We want to thank you for holding this joint meeting to ensure our system remains stable and effective, as well as to discuss the growing number of freestanding emergency departments.

The American College of Surgeons Committee on Trauma has underscored that trauma system growth should be based on need identified through data-driven methods, not the market considerations of healthcare and hospital systems. Both our state and local Health District Trauma System Regulations indicate expansion should be based on determination of need or unmet need and will not negatively impact existing trauma centers. We appreciate that you, like us, have noticed the abundance of freestanding emergency departments. We're concerned about their rapid growth in the community, often not far from existing hospitals and in higher income areas. Since 2016, hospitals have opened 12 freestanding emergency departments and six micro or limited hospitals, and there are applications or land holdings for at least five more.

These facilities cause patient confusion. Patients believe they're accessing urgent care when they walk into freestanding emergency room buildings because they look like an urgent care. They're then billed hospital ER (emergency room) rates. On the other hand, if a patient is experiencing a true emergency, they may end up needing to be transferred to a hospital-based ER by ambulance, delaying care and taking patients far from their home. These transports also add to the cost of care. We're also concerned hospitals are focusing on expanding these much higher cost facilities, rather than much more needed urgent and primary care centers. Additionally, there have been changes to EMS (emergency medical service) protocols made by Southern Nevada Health District committees that have had a significant impact on patients and healthcare delivery, such as the freestanding emergency room transport protocols, trauma transport protocols, changes to EMS catchment areas.

Several years ago, the Health District changed the EMS protocols to permit transports to the micro hospitals and freestanding emergency rooms. This has significantly reshaped healthcare delivery in the valley and impacted patients. We urge greater review and analysis of these changes to understand the impact of patient care and the appropriateness, including reporting of these transports, similar to what the Health District does for the trauma system, so we can understand EMS transports, transfers, discharges, admissions, and other information. We urge you to ensure that any growth in trauma centers and off-campus emergency departments is based on what the community needs and does not continue to drive up patient cost with unneeded and much more expensive care. Thank you.

MARILYN K. KIRKPATRICK
Thank you. You timed it just right. You had 10 seconds left. Next speaker, please.

MAYA HOLMES
Good morning, Commissioners and Board of Health members. My name is Maya Holmes, and I'm the health policy director for the Culinary Health Fund. And I've been a payer representative on the Regional

Trauma Advisory Board since 2019. The fund is also a member of the Health Services Coalition, and we share the goals and priorities that Stacie just outlined. Our priority is truly to ensure that the addition of new trauma centers or designation changes for existing trauma centers are based on demonstrated need, solid data and analysis, and consistent with national guidelines and best practices. This will ensure that we do not undermine existing trauma centers and ensure appropriate levels of care are available where and when they are needed. In other communities. We have seen non-data-driven, non-needs-based proliferation of trauma centers that have had negative impacts on the centers themselves.

And we saw that in the mid-2000s in Florida. Research was coming out of there. And we're also seeing that with Phoenix. We're seeing research coming out indicating that the lack of a needs-based system, what the results can be. At our last RTAB (Regional Trauma Advisory Board) meeting in July, the RTAB members reviewed an application from the Sunrise Hospital to change its designation from a Level II to a Level I trauma center. Per the Trauma System Regulations of the Health District, RTAB is required to make a recommendation to the Southern Nevada Health District Board of Health regarding the trauma center applications, and the Board of Health is to approve a trauma center application based on a demonstration of need. And that applies both to new centers and changes in trauma designations. The RTAB, I believe it was a 13 to 3 vote, recommended a denial of the Sunrise application, because neither the impact report nor the annual trauma system report demonstrated a need to expand the trauma system.

The impact report and the annual trauma system report show that our trauma system is performing well overall, and there were no gaps in the system impacting care or a failure to accommodate patient need. Median transport times were excellent. Trauma transports for step one, two, and three patients for the whole system and at Sunrise were down in 2023 from peaks in previous years. They were up for step fours at Sunrise. But these are patients that do not need a Level I or a Level II trauma center.

Additionally, overall historical population growth was 3.81% over the six-year period studied in the report. But it varied throughout the valley. However, population growth does not automatically mean there is a growth in trauma patients. Also, historical growth in the trauma system has been accommodated by our trauma centers, and there is no indication that they do not have the capacity to accommodate future growth. So, thank you.

MARILYN K. KIRKPATRICK
Thank you. Anyone else wishing to speak during public comment? Seeing none, we'll go ahead and close the public comment. Mr. Schiller?

SEC. 2. AGENDA

2. Approval of Agenda (For possible action)

KEVIN SCHILLER
We can now go to your agenda section. Item 2 is approval of the agenda.

ACTION: IT WAS MOVED BY COMMISSIONER SEGERBLOM, SECONDED BY COMMISSIONER NAFT, AND CARRIED BY UNANIMOUS VOTE OF THE MEMBERS PRESENT THAT THE SUBJECT AGENDA BE APPROVED.

Attachment(s) submitted and filed with the County Clerk's Office

MOTION

MARILYN K. KIRKPATRICK
I entertain a motion and a second.

TICK SEGERBLOM
Motion to approve.

MARILYN K. KIRKPATRICK
I have a motion by Commissioner Segerblom. A second by Commissioner Naft. Any discussion? Seeing none, all those in favor, please say, "Aye."

COMMISSIONERS
Aye.

VOTE

VOTING AYE: Tick Segerblom, William McCurdy II, Jim Gibson, Justin Jones, Marilyn K. Kirkpatrick, Ross Miller, Michael Naft, Scott Nielson, Nancy Brune, Scott Black, Bobbette Bond, Pattie Gallo, Joe Hardy, Brian Knudsen, Frank Nemec, Jim Seebock

VOTING NAY: None
ABSENT: None
ABSTAIN: None

MARILYN K. KIRKPATRICK
Opposed? And that motion carries.

SEC. 3. BUSINESS ITEMS

3. Receive a presentation on catchment areas in Clark County. (For discussion only)

ACTION: RECEIVED.

Attachment(s) submitted and filed with the County Clerk's Office

KEVIN SCHILLER
Item 3 is to receive a presentation on catchment areas in Clark County.

MARILYN K. KIRKPATRICK
Start with the easy stuff.

STACY JOHNSON
Good morning.

MARILYN K. KIRKPATRICK
Good morning.

STACY JOHNSON
Hi. Thank you for having me. I'm Stacy... Oh, is it working? Got to get closer. I'm Stacy-

MARILYN K. KIRKPATRICK
You can also use the handheld one if you walk and talk like I do.

STACY JOHNSON
I'm not going to walk and talk.

MARILYN K. KIRKPATRICK
Okay.

STACY JOHNSON
I'm the regional trauma coordinator at the Southern Nevada Health District. So, thank you for having me here today to talk to you about our trauma catchment in our community. Is the presentation up? There it is. So, before we dive in, I just want to do a quick review of the trauma hospitals that are already verified and designated within our community. Our current hospitals are UMC, Sunrise, St. Rose Siena, and most recently Michael O'Callaghan Military Medical Center.

So, at the Office of EMS and Trauma, one of our primary goals is to ensure that injured community members are transported to the right hospital with the appropriate resources in the optimal timeframe. We achieve this through the use of geographical catchment areas for our trauma patients. Our Southern Nevada Trauma System has been utilizing catchment areas since 2004. This is when we expanded the trauma system into having more than one trauma center. These areas help guide EMS in transporting traumatically injured patients based on their injury and where their injury occurred, ensuring that they get to the most appropriate facility in the quickest amount of time.

Our initial catchment areas, again established in 2004, those remained unchanged until 2022, when Michael O'Callaghan entered the system as a Level III trauma center. At that time, the catchment was designated to them with the understanding or looking at some data and hoping to give them about 30 patients a month. So that entered. And then in about February of 2024, they were really much lower than that 30. And in order to keep a trauma center open and sustained, they needed some more volume. So, they collaboratively worked with UMC. They worked out an agreement, where UMC was going to give them some additional areas of their catchment. That was brought to our office, and the Southern Nevada Health District reviewed the data, reviewed the proposal, and then later approved that expansion and catchment.

So, going along with catchment, how does it work? Well, these patients, you may have heard of the Trauma Field Triage Criteria before broken down into steps 1, 2, 3, and 4. That most recently changed. Now, it's a red and yellow criteria. So red is basically one and two, yellows is the old three and four. So, the way we determine that is the American College of Surgeons are now in charge of updating Trauma Field Triage Criteria. They most recently made an update in 2021, and we updated ours for our 2024 protocol. So, the red and yellow is kind of new to our system. But again, the red is the old one and two, and the yellow is the old three and four.

So, as you can see on the slide, red patients are the more sick. The more highly injured. They need to go to a closest Level I or Level II trauma center. Some examples of a red criteria patient would be penetrating injuries to the head, neck, torso, upper extremities or proximal extremities, their skull, their spinal cord, their chest, or suspected pelvic fracture. Our red criteria patients, they still have a serious injury and should be transported to a trauma center, but they don't require the upper level. They can go to any level

of trauma center. So, examples of that would be a high-speed automobile crash, auto versus pedestrian, a bicycle crash, things like that.

So, here's a picture of our current catchment map. I'll walk you through that. The baby blue area, that's Michael O'Callaghan's catchment area. So, any yellow criteria patient would go to that center. If it were a red criteria patient, those patients would go to UMC. Moving down is the yellow. All the patients that get injured in that area go to Sunrise, regardless of step, because Sunrise takes all levels of injury.
Moving down, Siena. Siena gets that. If they're a yellow criteria, they get that green and that blue area. The red criteria would go to, that light green area goes to Sunrise and that blue area would go to UMC. And then the remainder of that map, all of the pink is UMC's catchment area for all levels of trauma patients.

So, how do we keep an eye on this? Every month, each trauma center sends all of their patients that come into them by ambulance, they send a spreadsheet of that to our office. We dig through it and get it ready for presentation to RTAB. Every quarter, it's presented to the RTAB. It's reviewed there quarterly, and they review it and make sure it's all looking okay. That is the end of my presentation. I'm happy to take any questions that you may have.

MARILYN K. KIRKPATRICK
Does anybody have any questions? I'm going to start at the far end. Anybody on this end have any questions? Ms. Bond?

BOBBETTE BOND
Thank you. Bobbette Bond for the record if I need that. Is there a process where you have a public step in the designation of catchment area changes? Is there any public review of that?

STACY JOHNSON
That's outlined in our Trauma Regulations 200.000. And that states that catchment is determined by the Southern Nevada Health District.

BOBBETTE BOND
So, no?

STACY JOHNSON
Currently, no.

BOBBETTE BOND
Thank you.

MARILYN K. KIRKPATRICK
Anyone else have any questions on this side? So, can I just ask a couple of questions then on the catchment? So where does the MAC come in, the Medical Advisory Committee? So, they never look at the catchments, or is it just the RTAB and the Health District?

STACY JOHNSON
Current regulations do not say that RTAB or MAB or any board reviews it. It's just determined at the level of the Southern Nevada Health District.

MARILYN K. KIRKPATRICK
And what is that criteria?

STACY JOHNSON
There is no outlined criteria in the regulation.

MARILYN K. KIRKPATRICK
Okay. But RTAB sees the numbers and sees what type of trauma? So, if we wanted, from the Health District, if I wanted to see what that looks like, you already have something that shows me what kind of patients that we're moving?

STACY JOHNSON
Correct. It's presented every quarter at RTAB. And then it's also all in the annual trauma report that's posted online.

MARILYN K. KIRKPATRICK
Okay. No one else has any questions?

JIM SEEBOCK
Just one more follow-up. Is there a numeric threshold to determine those hospitals for those areas?

STACY JOHNSON
In terms of catchment?

JIM SEEBOCK
Mm-hmm.

STACY JOHNSON
No.

JIM SEEBOCK
Okay, thanks.

MARILYN K. KIRKPATRICK
Dr. Nemec, and then Commissioner Gibson.

DR. FRANK NEMEC
[inaudible]

STACY JOHNSON
They originally developed that in 2004, which was way before my time. So, I'm not sure what the justification was of how they did that. I can't speak to that. I can just say that it hasn't been changed until we got a new trauma center in 2022. And that was based on trying to get them the amount of volume that they would need to sustain a Level III Trauma Center.

MARILYN K. KIRKPATRICK
Commissioner Gibson?

JIM GIBSON
You indicated to us that, and I think the page indicated, that Sunrise and UMC meet all criteria, so anything that happens there. Is there anything that really distinguishes then between a I and a II?

STACY JOHNSON
There are when it comes to accepting the TFTC (Trauma Field Triage Criteria) patients. The red or the yellow, no, it does not. There are –

JIM GIBSON
Say that again, the what?

MARILYN K. KIRKPATRICK
We can't use acronyms. Because maybe the Health District folks might know this –

STACY JOHNSON
- I'm so sorry.

MARILYN K. KIRKPATRICK
- but for everybody else, we got to be mindful.

STACY JOHNSON
Sorry, I apologize. So, when accepting the patients from an ambulance, as far as injuries, there's no differentiation. There are a few differences between a Level I and a Level II. Mainly that when it comes to the level of care, a Level I is required to have a couple additional specialty physicians more immediately available. But when it comes to taking patients from the scene, there's no difference.

JIM GIBSON
Okay. Thank you.

MARILYN K. KIRKPATRICK
Anybody else have any questions? So, I have one. I try to watch the RTAB meetings and the MAC meetings. And at one point there was a request to change the encatchment areas. But based on what you said, we haven't done that, with the exception of O'Callaghan, in the last 10 years?

STACY JOHNSON
That's correct.

MARILYN K. KIRKPATRICK
And so, nobody does have the ability to put that on their agenda? I just know that encatchment areas are super important in the grand scheme of how we get people to the right place. So, no one else besides the Health District can change those, besides your department?

STACY JOHNSON
It could absolutely be discussed at any level, as far as RTAB. But per the current regulation, that is where it lies, is at Southern Nevada Health District.

MARILYN K. KIRKPATRICK
Okay, All right. No other questions?

JOE HARDY
Over here.

MARILYN K. KIRKPATRICK
Oh, Dr. Hardy.

JOE HARDY
Thank you

MARILYN K. KIRKPATRICK
Mayor Hardy.

JOE HARDY
So, if there is a trauma center that does all red and all yellow, what's the differentiation between all red and all yellow and everything?

STACY JOHNSON
So, for instance, Michael O'Callaghan is a Level III, so they take all yellow patients. So, if there were a red injured patient within that catchment, they go to UMC.

JOE HARDY
So, what I'm saying is if a hospital, let's say Siena for instance, it takes all yellow and all red, what's the difference between the Level I and the Level II?

STACY JOHNSON
So, Level I and Level II can take red and yellow. And Level III hospitals, which are Siena and Michael O'Callaghan, can only take yellow injured patients. Is that answering your question?

JOE HARDY
So, what's the differentiation between Level I and Level II if Level II can take all red and all yellow?

DR. FRANK NEMEC
That was my question.

STACY JOHNSON
So, without getting too far into the weeds-

DR. FERMIN LEGUEN
I can answer that question if you wish.

JOE HARDY
So, I'm restating it in doctorese.

MARILYN K. KIRKPATRICK
I think Dr. Leguen's going to answer it. But I also think that when Dr. Files does his presentation, he might get more into the weeds.

DR. FERMIN LEGUEN
The difference between Level I and Level II is more about the academic capabilities of the center. So, Level I is a trauma center that has a highly specialized medical residency programs related to trauma. In terms of service to the patient, the general population, there is not a difference between Level I and Level II, except for some various specific patients. Which is a very limited number of patients that some of the specialists here could describe better than me. But in terms of service to the population, there is really no difference between Level I and Level II, except for those very specific cases that I mentioned. It is more about the academic capability of the center.

JOE HARDY
So, for instance... If I may?

MARILYN K. KIRKPATRICK
Mm-hmm.

JOE HARDY
So, for instance, if a Level II that accepted all red and all yellow wanted to become a Level I, they would have to jump through a hoop of getting certain specific specialties that would be on site and available? Or how does that work?

DR. FERMIN LEGUEN
Well, for a Level II to actually jump into a Level I, they would have to actually upgrade their academic capabilities to that level. That's a requirement. It is not a requirement about services, it's a requirement about academic capabilities.

MARILYN K. KIRKPATRICK
It's about having that teaching school. But I think, Dr. Files, when he goes through the history of it, he'll be able to give a better rundown. But encatchment areas do matter when it comes to the trauma, which is why we wanted to have this discussion. But I think maybe we might invite you back at the end if we have some more questions. Did you want to ask anything else, Doctor?

JOE HARDY
Yeah.

MARILYN K. KIRKPATRICK
Okay, go ahead.

JOE HARDY
So, for instance, I've been interested in medical education for some time.

MARILYN K. KIRKPATRICK
Shocking. I would have never thought that.

JOE HARDY
And so, pretend that a Level II wanted to become a Level I, then they would have to have a commitment of education, teaching, et cetera, which is what we would want in our milieu of everybody. We need everybody, we need all sorts of education. So, if we said, "All you have to do is become a educational institution with the following residencies, et cetera," would that be something that we can outline that they could do, and therefore we would get more?

DR. FERMIN LEGUEN
Again, this is Dr. Leguen. Moving from Level II to Level I, the requirement is to actually match the academic requirement from the trauma center designation authorities. So yes, it is about being able to deliver those academic services.

JOE HARDY
So, there is a path?

MARILYN K. KIRKPATRICK
So, there is a path. And I think that Dr. Files, when he gives this presentation, will go through that, because it is... But it's a regional conversation. So, you have to make sure, as to her point, that everybody can survive with whatever trauma level that they are. Because in some cases, I use Florida, they had 11 trauma centers and nobody was surviving. And you just had a bunch of closed up hospitals. But I think Dr. Files can probably circle it back.

JOE HARDY
Thank you, Madam Chair.

JIM GIBSON
Can I just ask one other question?

MARILYN K. KIRKPATRICK
Yes, Commissioner Gibson.

JIM GIBSON
I have a catchment area question. So, when a patient is picked up by an ambulance, is there a center, is there somebody somewhere that is making a determination as to the level of care that this patient is going to require? Or is that just something that the EMTs are trained in, and they make that determination while they're on the road or as they pick the patient up?

STACY JOHNSON
Yes, it is part of their protocols that they follow. And if that patient meets very specific criteria based on their assessment on the scene, they decide that they meet which criteria and where they need to go based on the catchment.

JIM GIBSON
And then, is there a way that that is reported, so that somebody takes a look at it and says, "These guys are doing it right, maybe these guys aren't?" Is there an assessment or a way that we evaluate what the performance of those companies is, in terms of making those determinations?

STACY JOHNSON
I can't speak to each individual in a facility's internal process. But each hospital, each trauma center, every month sends those patients, a list of those patients that come to them, to our office. And then we go through each one of those individually.

JIM GIBSON
So, we do take a look at those decisions that are made on the run?

STACY JOHNSON
We do.

MARILYN K. KIRKPATRICK
Any other questions? I just have one final question. So, you referred more than once to the regulations. So, are those regulations determined by the State Board of Health or are they determined on the local level? And what is the process to change those regulations? Are those in the NACs (National Advisory Council) And you can get me the answer later if you don't have it.

STACY JOHNSON
I will say they were updated in 2022, but I wasn't here for the entire process of that. So, I don't want to speak out of place and say the process of it, because I have not been involved in that. But I believe it's at the local level.

MARILYN K. KIRKPATRICK
Okay. Commissioner Naft?

MICHAEL NAFT
Thank you, Chairwoman. When you are doing, I guess, these audits, has there been massive number of inappropriate transports, or significant or noteworthy? Can you walk us through that on average? I know I'm speaking to a long period of time.

STACY JOHNSON
So, we compile that data, and then we present it to the RTAB and the TMAC. And they have not noted anything out of the ordinary.

MICHAEL NAFT
That would be the only body –

STACY JOHNSON
No trends that they're concerned about.

MICHAEL NAFT
... that'd be the only body that would, right?

STACY JOHNSON
Yes.

MICHAEL NAFT
Okay, thank you.

FRANK NEMEC
Okay. Thank you.

MARILYN K. KIRKPATRICK
Any other comments or questions? All right. Thank you very much.

STACY JOHNSON
Thank you.

MARILYN K. KIRKPATRICK
And if you could just get me the regulation process, just kind lay it out for me, that'd be great.

STACY JOHNSON
Sure.

4. Receive a presentation on off-campus emergency departments. (For discussion only)

ACTION: RECEIVED.

Attachment(s) submitted and filed with the County Clerk's Office

KEVIN SCHILLER
Item 4 is to receive a presentation on off-campus emergency departments.
MARILYN K. KIRKPATRICK
Okay. Who's giving this one? Good morning.

PAUL SCHUBERT
Good morning.

MARILYN K. KIRKPATRICK
Thank you for coming again.

PAUL SCHUBERT
Thank you for asking. So good morning, Commissioners, Board Members. I'm Paul Schubert with the Bureau of Healthcare Quality and Compliance in the Division of Public and Behavioral Health, and I was asked to revisit this presentation that was given a couple of months ago to the Southern Nevada Health District.

So, let me just get started here. A little bit about the Division of Public and Behavioral Health. Of course, we have a mission and a vision, and our purpose is to make everyone's life healthier, happier, longer, and safer, of course. So this is our objectives or my objectives today: to discuss statutory authority of off-campus emergency departments, provide an overview of the regulations for off-campus emergency departments, explain the difference between an urgent care, quick care clinic, an independent center for emergency medical care, and off-campus emergency departments, and then provide an overview of the licensing process for off-campus emergency departments, and finally, provide information regarding the total number of off-campus EDs (emergency departments) and our pending applications. And for many of you, you've seen this presentation, but there has been a correction and certainly some updates.

So, I'll start with the statutory definition of an off-campus location, and that means a facility with operations that are owned or controlled by a hospital or which is affiliated with a hospital, that is located more than 250 yards from the main campus of the hospital, that provides services which are organizationally and functionally integrated with the hospital, and that is an outpatient facility providing ambulatory surgery, an urgent care, or emergency room services. And of course, I did this one a little bit in reverse. There's also a requirement for the National Provider Identifier (NPI) to be unique for each off-campus location.

MARILYN K. KIRKPATRICK
Can I ask a question? What does that mean? In layman's terms.

PAUL SCHUBERT
The National Provider Identifier being unique?

MARILYN K. KIRKPATRICK
Uh huh.

PAUL SCHUBERT
Hospitals have an identifier that is nationally recognized for that particular facility and that they bill under. And for any off-campus location, they need to obtain a separate identifier so that the billing is separate, and usually is provider-based for that hospital.

MARILYN K. KIRKPATRICK
Okay.

PAUL SCHUBERT
Okay. Hospital outpatient services. These are the regulations. In part, they indicate that services must be in accordance with national standards, integrated with the inpatient services, sufficient personnel available to provide those services, equipment and supplies necessary to meet the anticipated needs, and finally, they must have laboratory radiological pharmaceutical services available in the outpatient unit. And that's an administrative code.

And this is a busy slide, but if you'll bear with me, I'll kind of read through it because it does differentiate some of the facilities and their unique circumstances. So urgent or quick care clinics are not regulated as healthcare facilities by our agency. That's the same for physician offices. HCQC (Healthcare Quality and Compliance) does not have licensure authority in these clinics. The local municipality is responsible for business licensing and the medical professionals are regulated by their licensing boards. These facilities may set their own hours of operation, and while these entities may be associated with hospitals, they're not subject to EMTALA (Emergency Medical Treatment and Labor Act) rules because they're not considered part of the hospital's emergency services and are not regulated, again, by our agency.

Then independent centers for emergency medical care are specifically defined in the statutes as a facility structurally separate and distinct from a hospital which provides limited services for the treatment of a medical emergency. And then the regulations restrict licensure of facilities located to more than 30 minutes by ground transportation from a facility which is licensed to provide higher level of emergency medical care. Currently, there's only one licensed independent center for emergency medical care in Nevada. It's up in Minden. These facilities also may set their own hours of operation. Independent centers are also not subject to EMTALA rules because they are distinct facilities licensed separately from the hospital and ICs (Independent Centers) are state licensed only. There are no federal certification standards for these facilities.

So, this kind of just tells you a little bit about what goes on with all of these different choices. There are several different types of facilities that can confuse the healthcare consumer, as you can see. Some are regulated as healthcare facilities, others are not. Some must comply with EMTALA requirements for emergency medical care, others do not. Some are 24/7 operations, others are not. Some have federal certification standards as well as licensure standards, and others only licensure standards. These differences may appear subtle, but the billing and insurance acceptance, and moreover, consequences of arriving at a facility that cannot provide necessary services can be devastating, and one of your public comments illustrated the issues of the consequences of actually arriving at the wrong facility.

Okay. I'll talk just a little bit about the licensure process for off-campus emergency departments. The hospital must submit an application for an endorsement to add an off-campus ED and fulfill documentary requirements. Along with the endorsement application, the hospital must submit construction plans, and once the application is complete and all the construction is complete, HCQC will conduct an on-site inspection to determine compliance. When it is determined that the off-campus ED is in substantial compliance with regulatory requirements, the location will be added as an endorsement for the hospital license. So, all of those off-campus locations are actually on the on-campus hospital license. They don't

get a license themselves. And then off-campus EDs must meet the 2022 (FGI) Federal Guidelines Institute Guidelines for Design and Construction of Outpatient Facilities, Section 2.8, which is specific requirements for Freestanding Emergency Care Facilities.

And then this is just a list of the currently licensed off-campus emergency departments. There are 15 total currently licensed. And as you can see, Northern Nevada Sierra has one, Southern Hills has three, so on and so forth. And finally, these are our pending applications for off-campus EDs. There's currently four of those. And this is where the correction to the slide is. We had Renown Medical Center as requesting a off-campus ED. They have not and have no desire to, but you can see that Summerlin Hospital has an application, Northern Nevada has another application, Southern Hills has another application, and Sunrise has an application.

And so that concludes my presentation of the slides. We were asked during the Southern Nevada Health District meeting to generate some geo-mapping of the locations and we're working on that. That's sort of the easy ask. Then we had a more difficult ask, which was to generate public information and find a way to express the types of things one should go to the different facility levels for and that explains the cost consequences of the different levels, and that, we're working with our public information office to try and generate some educational information that would hopefully accomplish all of those things, pursuant to your questions.

MARILYN K. KIRKPATRICK
Okay, does anybody - Dr. Nemec, and then Ms. Bond, and then Dr. Hardy?

DR. FRANK NEMEC
My question has to do with the unique NPI for the freestanding ER. Presumably, that could create a situation where the freestanding ER would be out of network when the mother hospital would be in network. And are there any safeguards for patients to understand that, if they go to a freestanding ER with that hospital's name on it, they may be out of network when ordinarily they would be in network?

PAUL SCHUBERT
Thank you for the question. I am not aware of any safeguards that are in place. It's certainly something that we could attempt to address as we're looking at providing some education to the public about the different facility types and the consequences, again, the financial consequences of arriving at a particular facility.

BOBBETTE BOND
Thank you. I have two questions. One, what would prevent a process to license these facilities separately then the hospital itself? What would be involved in that

PAUL SCHUBERT
Licensing the –

BOBBETTE BOND
To develop.

PAUL SCHUBERT
-Remote EDs as a hospital itself?

BOBBETTE BOND
Yeah, removing them from the acute care hospital definition, and having a separate licensing scheme for them.

PAUL SCHUBERT
Understood. We would necessarily need a statutory change that would define the remote emergency departments as a specific facility type that we could license separately so that we could actually view them as an independent facility rather than as a part of the on-campus hospital.

BOBBETTE BOND
Okay. And secondly, are there, at any level of the government that you're aware of, any restrictions on how many of these can be built, or where they can be placed, or how far apart they need to be from each other at all?

PAUL SCHUBERT
I am not familiar with any restrictions that may come from either local ordinances that could be generated or even a state rule or law that could be put in place. But currently I'm not familiar with any that restrict them.

BOBBETTE BOND
Thanks.

MARILYN K. KIRKPATRICK
Dr. Hardy.

JOE HARDY
Thank you. So, the state, do they not have a responsibility to license the lab that the pseudo doctor's office, urgent care, the pharmacy, outpatient, dispensing, the X-rays, the mammograms... Do they not have an interest in that and do that?

PAUL SCHUBERT
If I may? Yes, we do actually separately license the laboratory that is at the remote ED as we would separately license laboratories even within a hospital, depending on where they're located, because some hospitals have multiple. So yes, we do do that. And I believe the Board of Pharmacy gets involved with the issuance of their permit for pharmaceutical services at the remote ED as well.

JOE HARDY
So does the state, then, not have their hand already in the process of "licensing", in some way that would be easier to, if you wanted to do a statute change, would be involved with that?

PAUL SCHUBERT
Absolutely. I mean, we're extensively involved in the licensure process, whether it's to put the endorsement on the current hospital license or, as you've indicated, with regards to the laboratory and pharmaceutical services. So yes, we would be able to at least comment on legislation that would make that change.

JOE HARDY
All right, thank you. Thank you, Madam Chair.

MARILYN K. KIRKPATRICK
Councilman Black.

SCOTT BLACK
Thank you. I have two questions on the slide that indicated the requirements to establish an off-campus emergency department. Two of them said, "Offer surgical procedures." So, I was curious what type of surgical procedures is a facility like that prepared to perform? And my second question is, under "personnel supplies necessary to perform services," are there compliance measures in place to assure that those service levels and/or supplies are present to provide the services at those facilities?

PAUL SCHUBERT
Yes. If I may answer the second question first?

SCOTT BLACK
Sure.

PAUL SCHUBERT
As was indicated by Dr. Hardy, we are looking at the availability of the services and requirements for providing laboratory, pharmaceutical, other services in that remote location. So yes, we do look at that, and we look at whether or not the credentialing of the personnel that are working in that remote location are appropriate for providing the services that they plan to provide. Your first question with regards to... I'm sorry.

SCOTT BLACK
Types of surgeries.

MARILYN K. KIRKPATRICK
What kind of surgeries?

SCOTT BLACK
Procedures.

PAUL SCHUBERT
Okay. Yes. And actually, that's a description or it's a statutory definition of off-campus facilities. So, there may be some that provide surgery, others that do not. In particular to the emergency department, it may have surgical ability or it may not. So, it's really based on what services that particular facility desires to provide, not necessarily based on a requirement that you must provide surgical services or other types of services. It's emergency services, but those are different than, obviously, surgical.

MARILYN K. KIRKPATRICK
You have a question? Commissioner Segerblom.

TICK SEGERBLOM
Thank you. So, if someone goes to one of these freestanding emergency rooms and that's related to a hospital, if they need further care, can that emergency room refer to one of their hospitals, or they have to refer it within the catchment basin?

PAUL SCHUBERT
Oh, that's a question that I'm not sure that I could answer, but maybe the person who presented on catchment could. Just very basically I would say that if the facility, the off-campus ED, doesn't have the

capacity or ability to provide the appropriate services, then that person does get transferred. And it could be within the hospital system to a hospital within the system, or it could be to another hospital that can appropriately provide those services. But I think it more depends on the needs of that patient. So, if they're a trauma patient and the emergency, the off-campus ED is not able to provide trauma, then I think it would go back to catchment.

TICK SEGERBLOM
Maybe we could follow up on that because I could see one hospital setting up emergency rooms all around the County and then having all those people referred to them even though they're outside the catchment basin.

PAUL SCHUBERT
Understood.

MARILYN K. KIRKPATRICK
So, I have about 10 questions, so let me just tell you the whole thing. One, as I said at the Health District, I did a little bit of research on the standalone EDs around the country. And Texas, that is basically their model. They don't have a lot of hospitals. But, most importantly, constituents are paying triple to go to that standalone ED as opposed to, maybe, an urgent care or, quite frankly, the actual ER hospital. So, I did mention it to Mr. Kipper, who's the insurance commissioner, to ensure that - we have to have a balance, because at the end of the day, what stops someone from only building standalone EDs as they've done in Texas. And then we say that they have to have these things, but I, for one, know a person that went to a standalone ED and they had to take their X-rays to somewhere else to be read because somebody was not on staff.

So, my first question is who stays on top of that? So, I'm going to give you three questions at a time. So, then my second question is I have to be mindful of the rural communities as a whole because their hospitals are barely hanging on and I don't remember you telling me if there's a geographical part where someone has to be. So, do we limit it to a certain area? Could a Southern Nevada hospital go and build something in Lincoln County and compete with their actual hospital? And then who tells the ambulance drivers what the standalone EDs offer? So those are my first three. I did a lot of research on this since our last meeting.

PAUL SCHUBERT
So, the first one was whether or not, or who –

MARILYN K. KIRKPATRICK
Who's managing the insurance? Because someone's got to pay for that when we're paying triple at a standalone ED.

PAUL SCHUBERT
And, obviously, we don't regulate the insurance, but –

MARILYN K. KIRKPATRICK
But are you looking at it? Are you noticing that through claims?

PAUL SCHUBERT
I hate to say it's not in our lane, but it...

MARILYN K. KIRKPATRICK
That's okay.

PAUL SCHUBERT
It's not part of our regulatory oversight of facilities so it would not be something on our radar.

MARILYN K. KIRKPATRICK
Maybe it should be. Okay. Second question.

PAUL SCHUBERT
And the second question was... Help me out.

MARILYN K. KIRKPATRICK
What happens if someone is not at these facilities that they're supposed to be providing the service?

PAUL SCHUBERT
Ah, okay. And in that case, we would be involved. It would be a complaint to our agency and we would investigate to determine, again, whether or not the proper personnel or the proper services, whatever they need to be, were available for the licensure that's in place. So, if we determine that, yes, you needed to provide radiological services and you didn't have somebody to do that, then it would be a citation for that facility.

MARILYN K. KIRKPATRICK
So then is there any geographical area? So, could a Southern Nevada hospital open one of these in another county?

PAUL SCHUBERT
There's not with regards to licensure. However, again going back to the NPI issue, for a hospital to bill provider-based services under CMS (Centers for Medicare and Medicaid Services), under federal regulations, those provider-based services have to be within 30 miles of the on-campus hospital.

MARILYN K. KIRKPATRICK
So, I actually looked, and I was trying to update our zoning code to put in - because I'm nervous about who are we taking? I get everybody wants to drop people and go to the closest service, but what I hear more often than not is they're not really getting a service and then they got to go somewhere else anyways. And so, who's training those folks? How does that work? I mean, how does the ambulance folks know that you can go to this? I feel like it's nowhere in our network. And as I said when we started, we have a phenomenal network. We know how all of it works. We have a divert system, we have all those things.

But now you have these standalone EDs with, in my opinion, very little regulation, right? Outside of the licensure component. I'd hate for an incident to happen, and then we drop people off at all of these standalone EDs, but now we're going push them to the hospitals who are already inundated in that case. And so how does all that work? I tried to put in zoning, it falls under the same category as hospitals. I don't really call it a hospital, so –

PAUL SCHUBERT
Well, but I think, if I'm not wrong, what you're asking about is who's training those ambulance personnel so that they will know which facility is appropriate for that patient? And of course, in terms of trauma, I'm

sure there's training that occurs with regards to which catchment area are you in and what facilities would you take them to.

With regards to non-trauma patients that require care and transport, I don't know what training is available, whether the ambulance services themselves are providing that. I know Clark County licenses their ambulance services separately from other portions of the state, where actually the division licenses those ambulances, but I think it's Clark County that we're looking at. So perhaps somebody from the ambulance services could provide that response? I do not have it.

MARILYN K. KIRKPATRICK
Okay. But there's no one else in the state. This is a relatively new thing in our community, right? I feel like we started with the leads, then we meet them, get in line, and lo and behold, guess what? Everybody else popped up. So, I just worry about getting people to the right place and not just - I don't want to say the word dumping, but just dropping them at the closest. It may not be the best.

And honestly, I can't even tell you what any of them have. I feel like there needs to be a notification on the door that you walk in, "We have no beds." Or "We can only perform labs or radio." I just feel like there needs to be a notification as you walk up to the door. In Washoe, they do do that. They have some type of notice, but I've not seen one here.

Okay. Anyone else have any questions? Commissioner Jones.

JUSTIN JONES
Can I, and maybe this isn't much of a question, but I guess I'm still struggling a little bit with this discussion on Freestanding Emergency Departments. And I totally agree that there needs to be more education, but to present a contrary view, that if, for example, my wife chops the top of her finger off, I might be more interested in going to the freestanding ED that's three minutes from my house as opposed to sitting in UMC or Sunrise's ER for two to three hours competing with those Level I trauma patients. And so, there is a reason why these freestanding EDs exist and it's because they're serving some sort of need within the community that isn't being served by others. So, I guess, back to your slide about educating the public, what are you doing now and what more needs to be done?

PAUL SCHUBERT
Well, I think we're just in the rudimentary stages of generating some education, but I think that, within that education, we need to address all of these things. And it's difficult to do that in, if you will, a one-page process where you're just, "Here, look at this. This'll tell you what to do." Even signage sometimes isn't necessarily delivering the message about where a person should go. So, I think, as we develop that education, we need to find a way. And certainly, there are several mechanisms to provide it to the public, so we'll need to do our due process in getting it out to everyone.

But I think the important thing is that we find a way to address the different concerns such as, is this a minor injury that can be taken care of in this type of facility, or is it a more major injury? And how do you define that for everybody across the board? If you ask three different people, "Well, what do you think of a finger being cut off? How bad is that?" You're probably going to get three different answers about where that person should go or how they should get it taken care of. So, I don't know that that answers your question, but I think what we need to do is be diligent in providing some education that will help people understand.

JUSTIN JONES
Can you also just go back to the distinction between a freestanding ER versus a mini hospital? Because I have those both down the street from my house.

PAUL SCHUBERT
Okay. Yeah. And in the freestanding ED, there are no beds. In a - I think what you're referring to is sort of a micro-hospital, which is 10 beds or fewer. In a micro-hospital, there are beds and the full range of services for a hospital. So, the difference is one is for –

JUSTIN JONES
But what does full mean? That's my point.

PAUL SCHUBERT
I'm sorry?

JUSTIN JONES
What does full services mean? Saint Rose?

PAUL SCHUBERT
It means that they can actually admit inpatients and provide continuing care to those patients versus, in the remote ED, it's an outpatient clinic. And EDs in general, even on the campus, are outpatient. A person comes in, they receive care and services, and they're discharged. Or a person comes in, they receive care and services, and they require inpatient care, and so they're admitted to the hospital. So, in the remote ED, it's just an extension of that outpatient service, whereas if somebody actually did need to be admitted to the hospital, they would either have to be transferred or go to an on-campus ED.

JUSTIN JONES
And then, my last question is in terms of, we're talking about regulations of these freestanding EDs. What I saw from your slides is that urgent cares, quick cares, et cetera, are not regulated by you at all.

PAUL SCHUBERT
Correct. Correct.

MARILYN K. KIRKPATRICK
Okay. Councilman Seebock, and then Ms. Bond.

JIM SEEBOCK
In a previous meeting at the Health District, it was discussed about that same material.

MARILYN K. KIRKPATRICK
You need your microphone.

JIM SEEBOCK
Sorry.

MARILYN K. KIRKPATRICK
You want to be on the record.

JIM SEEBOCK
In the previous meeting at the health district, there was a discussion similar to today as far as, "Hey, you're getting with your PIO (Public Information Officer)," or to push out language in regards to billing the difference between a stand-alone and a quick care. And even now, you're talking about describing that difference of services. So, what is a timeline for that to be accomplished?

PAUL SCHUBERT
Well, without sounding bureaucratic, I would say that we want to do it as soon as we can. Unfortunately, it's going to take some time to develop that messaging. We would want to put it out as quickly as possible, and maybe we need to do it in segments, or in parts wherein we discuss the different types of facilities initially, and then we discuss the different levels of care, and then we discuss the different payment issues and sources. I can't give you a "It's going to happen tomorrow, it's going to happen a month from now," but we want to do it as soon as possible.

MARILYN K. KIRKPATRICK
Okay. Ms. Bond. And then, if anyone else doesn't have questions, I know that Commissioner Gibson has a hard stop. I want to get to kind of the trauma stuff.

BOBBETTE BOND
Thank you. Just to follow up on Commissioner Jones's comment about the cut finger, I think it's a good example of why it would be nice to have some segmentation of the licensing. If somebody goes into the freestanding ER down the street, they very well could think it's a quick care because it looks like a quick care. It does not look like a hospital. It's a one-story, two-story building. It's never going to look like a hospital to people no matter how many signs you put up.

But the cut that didn't sit in the ER for three hours is still charged and paid for the same way as the freestanding ER, even though if that cut was serious, the patient's going to be transported to a hospital. But it'll be, in our experience, a hospital that is also owned by that freestanding ER, which could be kind of supporting Commissioner Jones' statement that it's down the street. The hospital could be miles away from where the freestanding ER was, and the miles away from where that patient lives. It's not that they go to the closest hospital and keep in the neighborhood, in our experience.

MARILYN K. KIRKPATRICK
Okay. With that, thank you very much for coming. And if we have any further calls, I think you have your contact information in there. We appreciate that.

PAUL SCHUBERT
Thank you.

MARILYN K. KIRKPATRICK
Okay.

5. Receive a presentation regarding the history, optimal configuration and operation of the Southern Nevada Trauma System; and receive an overview of the process for trauma center provisional authorization. (For discussion only)

ACTION: RECEIVED.

Attachment(s) submitted and filed with the County Clerk's Office

KEVIN SCHILLER
Okay. Item 5 is to receive a presentation regarding the history optimal configuration operation of the Southern Nevada Trauma System and receive an overview of the process for trauma center provisional authorization.

MARILYN K. KIRKPATRICK
Good morning, Dr. Files.

DR. JOHN FILES
Good morning.

MARILYN K. KIRKPATRICK
And the reason I invited you, because you were the brainchild behind this in our community years and years - well, not too many years ago, I don't want to age us, but I thought that you could do the best job to kind of explain where we're at.

DR. JOHN FILES
Well, thank you. For the record, my name is John Files, I'm a retired surgeon, residing in Las Vegas for almost three decades. I was present for much of what has happened here over the last three decades, and will try to summate that, and I'm happy to get deep in the weeds with you.

To begin, I have nothing to disclose, and all the information presented today comes from identifiable public sources. If there is opinion, I will note it. I was asked to do a number of things. The hardest thing was to make a 20- or 30-minute presentation that summarizes three to four hours of material. So let me begin.

First, I'm going to define what trauma is. It's more than a cut finger. I'm not going to compare it to heart disease, cancer, and COVID as a burden of illness that all communities must deal with. I'll give you an overview of trauma care both in the United States state and Nevada and in Southern Nevada in a historical perspective. I'm going to discuss the Southern Nevada Trauma System in general terms, things that amplify concepts you've already heard, and I'll present them at a conceptual and decision-making level and less at a regulatory level. I was asked to define what the differences between the trauma centers I, II, and III, how people move from one to the other. What's the role of emergency departments? And talk about how trauma systems get good outcomes. Is it the product of more centers or is it the product of better care? I also will describe the optimal configuration operation of the Southern Nevada Trauma System, which is a very complex task. I'll just do my best with that, the purpose of the catchment areas and talk about the spectrum –

AUTOMATED VOICE
Recording stopped.

MARILYN K. KIRKPATRICK
We need to restart that recording.

DR. JOHN FILES
Shall we continue?

MARILYN K. KIRKPATRICK
Yep.

DR. JOHN FILES
And I'll talk about the spectrum of what a trauma system is called upon to do, and that would include everything from injury recognition, prompt access through 911, emergency medical services, definitive care at acute care facilities, rehabilitation, return to home, family, and work. All of this under the guise of the lead governmental agency that has the ultimate authority to make decisions, and it has widespread social and financial impacts in terms of costs, not only monetary costs, but human costs.

Let's begin with the definition of trauma. Sudden forceful injury to living tissue that is caused by extrinsic agents and overwhelms the person's ability to respond to it. These injuries can be intentional or unintentional. Self-harm, assault, homicide, and suicide are examples of intentional injuries. Car crashes, industrials, gunshots, stab wounds. I should say car crashes and industrials and pedestrian injuries are usually considered unintentional. These acts can injure people one at a time or they can injure many people at a time, as occurred on 1 October. These agents are mechanical or thermal in nature. Mechanical agents such as automobiles, bullets, knives, construction equipment, and so forth. Thermal would be explosive, caustics, and other sorts of things that produce burns. And finally, trauma causes intense physical and psychological stress reactions that usually overwhelm the patient and render them unable to give self-care.

This comes from the CDC (Centers for Disease Control and Prevention) from their Web-based Injury Statistics Query Reporting System. It's a very busy slide. I am going to focus on the top five rows. This is the State of Nevada for the most recent year of reporting, and it looks at all causes of death. If you look across the top, you see the age categories in black, and if you look down the extreme right column, you see the totals for all ages. In blue are unintentional injuries, in green are suicides, and in salmon, is homicide. We consider the sum of those three to be the burden of trauma medical care.

When you look at this, it's stunning that from age 1 to 44, trauma's the leading cause of death among Americans and Nevadans. It's stunning to know that more years of lost life and more years of productive life are attributed to trauma than the combination of heart disease and cancer. Because as you can see, heart disease and cancer occurs, and affects people in the later years of their life. When you slide over to the extreme right-hand column, you'll see that unintentional injury is number four. But when you add suicide and homicide to it, it moves up to number three, right behind cancer and heart disease. That's the burden of illness that injury produces in the state of Nevada.

So how are we doing? Well, this is actually good news. We're often hearing that Nevada's 48th out of 50 in one thing or another. In terms of preventable injury-related deaths, Nevada's number 17 in the United States. So, what we're doing is working.

Let's move to section two, the history of the trauma center in the United States. This simple white paper published in 1966 by the National Academy of Sciences is called Accidental Death and Disability: The Neglected Disease of Our Modern Society. In the early 60s, it became apparent that there was a rapid spike in fatal and in disabling injuries caused by motor vehicles and in the workplace. And this was a call to action. If you had to put a date on a calendar, this is actually the starting point of modern trauma care in our country. It caused our federal government to appropriate funding through the Department of Transportation to create EMS systems throughout the United States, which then in turn, specialized treatment hospitals for trauma and other sorts of things. They haven't been silent on this issue because the issue didn't resolve itself in the 60s. Here in 1985, 1999, and 2007, three more very important reports by the Institute of Medicine cataloging what we had accomplished but what more we had to do.
Most recently, this has been published in 2016. This is the proposal for a National Trauma Care System, integrating military and civilian trauma system to achieve zero preventable deaths after injury. This is an

outgrowth not only of the civilian but of the military experience from Afghanistan and advances in technology and medicine that took place in the 2000s. This is really the benchmark that we should aspire to.

Let's just walk through the history, kind of in a chronologic way. So, in the 60s, and some of this is a verbal history that's passed on me by Dr. John Batdorf, who really is truly the original surgeon who started trauma care in Nevada. The rise in injuries and motor vehicle crashes was alarming. This is before Ralph Nader, this is before seatbelts, this is before OSHA (Occupational Safety and Health Administration), this is before any of that, and emergency medical systems had to be developed. Nevada was a rural and a frontier state. And literally, the surgeons and physicians in our state would drive around every small town and teach the emergency medical technician course and encourage them to buy an ambulance and start a service. And that's how EMS got started in Nevada.

In the 70s, Vietnam, it emphasized that rapid stabilization and transport saves lives. That was the most important thing that we learned, and that early on-scene interventions made the big difference. And so, by the 70s, the American College of Surgeons got heavily involved, and started to implement things like the Advanced Trauma Life Support course, which followed with the Pre-Hospital Trauma Life Support course. EMS began to expand. Emergency rooms around the country and busy urban centers started to organize themselves into trauma units, so that those trauma patients didn't interfere with the flow of emergency department patients, much as OB (Obstetrics) had done a few years earlier.
And most of the trauma in Las Vegas that time was just preferentially taken to Southern Nevada Memorial, which went on to become UMC. That's what was going on back in the 70s. In the 80s, the American College of Surgeons, now with a lead from the federal government, became a body of content experts who generated standards and guidelines for the promotion of injury care. And in doing so, they started a verification program for trauma centers. And part of the bedrock of that movement was that they are not a designating organization, but they are a professional organization who only sets standards and gives opinion. They will help you, but you have to build what you want. They do not have the authority to designate anything.

So, this is in red because this is the single most important date in our state. This is 1988, NRS 450B is enabling legislation for trauma system care in our state. And this has been revised numerous times, and I've had the opportunity to work with it. But it's very, very clear that the Department of Health and Human Services has the final authority on what happens in terms of planning, designating, and legislating. And regulating trauma care.

Now, UMC in 1988 was designated as a Level II trauma center. And shortly after that, the explosive population growth in our valley during the seventies and the eighties caused some strategic thinking, that if UMC was going to be receiving trauma patients in increasingly larger numbers, that they would have to go out and build a suitable trauma facility, which is what they did. They actually copied Maryland Emergency Services in Baltimore. I visited that center, and it's like walking into the building at UMC. It's almost identical. So, they came back here, and they built it, and then they needed somebody to run it, so I was hired in 1995 to come out here and start work. I was at Cook County Hospital at the time.

Later on, we became involved in other things like the National Trauma Data Bank, a steppingstone to the quality assurance projects that reduced the variability that all of you've been asking about. How many out of area transfers are there? How many patients live and die? How many patients get to the operating room within one hour? All of these things are under a very tight quality improvement rubric.

Then in 2003, it was time for us to grow. Sunrise and St. Rose joined the trauma system, and we began to see changes at the local level. Board of Health created the Clark County Trauma System, which grew into

the Southern Nevada Trauma System, the Regional Trauma Advisory Board, and we had to begin work on Trauma Field Triage Criteria to help EMS identify patients in need of trauma care, and destinations for delivery to centers for the care of trauma patients. And we had to go on further to write regulations. But first shift of authority to Clark County from the state came about when NAC 450B.237 was passed. So, with that, there was more authority to create regulation, more authority to create structure and function. And all of that occurred at the local level.

The Southern Nevada Health District expanded, the Office of EMS and Trauma Systems was created, and properly staffed and resourced so that we could do this work now. It was kind of a home rule situation. The original NAC language was that something like, "Counties with populations greater than 1 million should take care of their own trauma." And it was a way of them allowing Clark County to take care of their own trauma.

So, for the next few years, the three trauma centers diligently worked with the lead agencies, worked with the Southern Nevada Health District, worked with professional organizations inside and outside the state to put together a model trauma system, to monitor its function, and to be sure that we deliver to the people of this valley and this state, something to be proud of. And I will tell you that as I traveled in those days, I would go to the CDC in Atlanta, I would go to Washington DC to give testimony in Congress, I'd go to Chicago to the College of Surgeons, I'd go to Los Angeles. I would go to different places, and people would go, "Where are you from?" I'd say, "Well, I'm from Las Vegas." They go, "Oh, that's a trauma town." Las Vegas became known in the medical culture largely for trauma.

Other events you've heard of today. The Trauma Field Triage Criteria had a step four, added to the transport requirements for EMS, and that created a stark increase in the number of patients delivered to trauma centers, a question many of you had, and I'd be happy to delve into that in the Q&A section. And then in 2019, ABA 317 shifted responsibilities back to the state. And so that's where they reside now. However, city, county, state are agencies working in concert with one another as well as Board of Health and Southern Nevada Health District. All are agents of the same designation process.

In 2020, COVID shifted resources in a way that we'd never seen before, and little was done for a while until 2021. The Michael O'Callaghan Medical Hospital was approved to be a Level III trauma center. And over the last two years, there have been more conversations, which I must admit are confusing at time, but are reminiscent of old conversations. And I'll go on to give you some conceptual framework that we all can use to discuss ways to solve new issues.

All right, section three, the Southern Nevada Trauma System. In the lower right-hand corner, you see a challenge coin. Those of you with military experiences will know that these are given as an honor. I received mine in Landstuhl, Germany when I served in 2009 as a invited consultant to the US military in Germany and Afghanistan. My role was in trauma education, trauma care provision, and trauma systems planning for the military. It tells us that the Joint Theater Trauma system, which is composed of Army, Navy, and Air Force, has one motto, and that motto is get the right patient to the right place for the right care in the right time. That's all you need to know. We can stop there. That's all you need to know. When you're navigating a complicated discussion about trauma care, this is your compass when you're lost in the woods. This will take you to the correct answer.

Oh. Excuse me. So, with this comes the definition of a trauma center, which is an organized system of care, for a defined geographical area that gives a full spectrum of care to injured patients from the time of injury through rehabilitation. That's been the overarching definition from the beginning. When it works perfectly, it's like the gears in a watch. It's perfect. The full spectrum of care, though, requires everything. From legislation of safety; public education; injury control methods; outreach to EMS services through

911 and dispatch; system triage in the field to local hospitals, EDs, and trauma centers; and definitive care for all types and all specialties; followed by rehab, so patients can return to home and family and work and become productive again. These tend to occur in their early life, and these people need to return to productive life. System integration with the lead agency is a key feature, and the lead agency has the authority to make the unpopular decisions and the popular decisions that guide the growth, development, and strategic direction of the trauma system.

So how does a trauma system save life? I get asked this question all the time. It's a long answer. It does it by a lot of things. You can do it by harm reduction legislation. You can do it through safety legislation, things like seatbelts, airbags, motorcycle helmets. You can do it through injury prevention, back to school. You drink, you drive, you lose. Drunken driving. You can do it through flash flood programmings and public - all these things. If the patient doesn't get injured, they don't need to be treated. We're the only specialty that I know of that's trying to put ourselves out of business.

Rapid access through EMS is not just 911, but now it's advanced technologies. It's cell phone technology with GPS locations, it's Starlink, it's all sorts of things. There's a lot going on in that area. So rapid identification, rapid transport are key to the reason why trauma systems save lives. Integration of care, integrated at the scene with rapid transport to appropriate medical facilities. I'm asked this all the time. I have a hospital down the street, it's five minutes away, and a trauma center that's 15 minutes away. Why won't I go to my local hospital? Well, it's better to go to a trauma center if it takes 15 minutes, where they're waiting at the door to transfuse blood, and they have an open OR, then it is to go five minutes to a local hospital. That'll take 30 minutes to give you those things. And that's the bottom line.

The sophisticated critical care that's been developed throughout the hospital system in our community and the early entry into rehabilitation has achieved statistical significance in that of patients who arrive alive at any one of the trauma systems, the likelihood that they will go home is over 90%. And you can't say that about heart disease and cancer.

Participation of all providers in systematic quality improvement reduces variation and is a backbone of what the Southern Nevada Health District does through the Regional Trauma Advisory Board and the Trauma Medical Audit Committee. They monitor dozens of key indicators to make sure that this care is delivered as designed, and they collaborate with the lead agencies and partners. That's what we're doing today. That's why we're here. So, it's the quality of the trauma system, not just the number of trauma centers, it's the quality of the trauma system that improves the outcomes and saves lives.

Excuse me. All right, get ready, this is Trauma Field Triage Criteria. All of you had questions. All right. I'm going to take you to the World Health Organization. They have fashioned this for global health, and this is called the Injury Pyramid. At the bottom, there are a lot of patients. At the top, there are a smaller number of patients. Injuries can be mild, moderate, severe, or fatal. And we know that. Most fatal injuries actually occur without medical intervention. Most fatal injuries are at the scene, either in a home or at the roadside. The majority of fatal injuries do not ever receive care. And the only thing you can do to reduce that is injury prevention, injury control, police enforcement, safety regulations. Of those who are alive at the scene and transported, they do very, very well. They need to go to specialized facilities because minutes matter because life is dwindling.

Now those would be the patients in red, and the majority of them are Coroner's cases. And the Coroner is part of the process of the trauma system. in black are injuries resulting in hospitalization. These patients have complex life-threatening injuries that need to be taken to trauma centers where there's resources, expertise, capacity to treat these patients without disruption to the rest of the flow of the hospital. And then, less serious injuries can be treated and discharged from emergency departments, quick cares,

clinics, doctors' offices. And there's a whole host of these that are injuries that never come to medical attention because your next-door neighbor knocks on your door and asks if you have band-aids, or, "What should I do? Put ice and take aspirin, right?" So many injuries are actually minor injuries that are actually dealt with home remedy and self-care.

So, this is the injury pyramid. Let's see what you can do to translate this into a modern trauma system. Oh boy, that slide's tough. So here, the CDC, last time in 2011, convened an international group of people who did a needs-based and evidence-based assessment, and created the guidelines for field triage of injured patients.

I will just summarize it as the following.

- Step one are patients who have physiologic derangements, like loss of consciousness, low blood pressure, rapid heart rate, they're not breathing. Those patients are really an extremis, and they need to be moved on fast. That's step one.
- Step two are patients who have obvious anatomical injuries such as missing limbs, fractured pelvis, gunshot wound to the chest. Those patients need to be moved on right away. That's why Level I and Level II patients need to go the highest level of care right away.
- Level III are patients who have experienced a significant mechanism of injury consistent with significant injury.

All right, let me walk that back. They don't have any physiologic markers. They don't have low blood pressure, they don't have changes in heart rate, they don't have changes in breathing. They're fully awake and alert, stable vital signs. They don't have exterior evidence of dramatic and traumatic injury, but they've been exposed to an injury mechanism that's dangerous. So, they're fully awake, alert, and stable, and they can be transferred to trauma centers. But the level of acuity is less. This is going to translate into that red and yellow slide that you saw a few minutes ago. The third step is the mechanism of injury.

- And the fourth step are special situations, whether it's advanced age or children or pregnant women or burns or other sorts of things.

So, you can see the next one with the green heading on them, the next two pages are what we came up with in Clark County. So, we went from what was very simple from the World Health Organization to what was very complicated, but it worked. And now, re-reviewed by the American College of Surgeons and an expert panel of people that looked at all the evidence, they've come up with the red criteria and the yellow criteria, which this newer concept's being blended into the Trauma Field Triage Criteria. There's no need for the paramedic to call this in. This is really a paramedic discretion decision. At the scene, they identify these things, and when they do, they know where they need to go because they know where the pickup point is. So, all of this is pre-programmed in their training.

All right, I'll answer more questions about Trauma Field Triage Criteria in the Q&A. Next thing I was asked to address is the levels one, two, and three, and what do they mean? This has been cut and pasted from the American College of Surgeons document on trauma centers. It's also in the Southern Nevada Trauma System's Annual Report 2023, which many of you I believe have, and it's on page seven. So, what it says is, "The Level I trauma center must be capable of providing, one, system leadership comprehensive trauma care, that's comprehensive clinical, and has a central role in other activities with resources and personnel." I'll enumerate them on the next slide. "Level II trauma centers expected to provide initial definitive trauma care for a wide range of injuries and severe injuries." To Dr. Hardy's question earlier, the clinical capabilities of a Level I and Level II are nearly identical. They resemble each other, but the leadership education research roles of a Level I are different. And that's why you can take the step one,

step two red patients to Level I and Level II centers. If you look at the United States, there are a lot of fine hospitals who service communities in need who do a wonderful job at trauma, but they don't educate residents, they don't do research. They're just interested in the clinical aspects of trauma care, and they do it very well.

Level III trauma centers can provide definitive care to patients with mild to moderate injuries. That's the step three, step four yellow, allowing patients to be cared for closer to home, which is an attribute that people like. These centers have a process in place to promptly move these patients up to a higher level of care if they discover that they have or need more care.

Level I and II trauma centers, as I said, have nearly equivalent clinical capabilities. There are some differences. However. Level I trauma centers are required, like this is cut and pasted from the Optimal Care of Injured Patients resource document. They have to meet an annual volume requirement. It is very important that you don't have a system with too many trauma centers where each doesn't see enough patients to be any good at what they do. Nobody wants to go for open heart surgery at the hospital that does one a month. You want to go where they do three a day.

We meet that. And the Regional Trauma Advisory Board has been very careful to protect the volume criteria for the three centers. You can't build a world-class trauma system by dismantling the well-functioning and loyal trauma centers in your system to make room for new trauma centers. That doesn't make sense. You add them because there's need. They have to maintain an expanded surgical specialty coverage. I know there was some questions about, well, what are those? And those are centered around things like craniofacial reconstruction and complex soft tissue injury reconstruction including replantation of digits and extremities. Those are the two most specific examples.

MARILYN K. KIRKPATRICK
So, in layman's term, what does that mean? You're going to give plastic surgery and something else, reconstructive?

DR. JOHN FILES
That would mean if your face was not just injured but destroyed.

MARILYN K. KIRKPATRICK
Okay.

DR. JOHN FILES
That would mean that at work your arm was severed and had to be reattached. They also, Level I trauma centers have to generate meaningful research and demonstrate scholarly activity and dissemination at national, international meetings and publications and journals. This is costly and time-consuming. They have to meet additional requirements for disaster management in the region which they serve. So those are cut and paste. Level II trauma centers may take on any of these additional requirements, but they are not required to do so. They are required though to provide equivalent clinical care.

To summarize our Trauma Field Triage Criteria and how it applies in the Nevada Trauma System. Level I trauma centers take all steps one, two, three, and four. Level II trauma centers take all steps one, two, three and four. Level III trauma centers take steps three and four and emergency departments take none of them. So, what do emergency departments do? I want to thank the American Trauma Society for creating this depiction, which shows the difference between trauma centers and trauma systems and emergency departments. They play a vital role. Remember that injury pyramid down the bottom is wide. There's a lot of patients down there and a lot of patients need a few stitches. A lot of patients have a

broken bone that needs a splint. These sorts of things are appropriately dealt in emergency departments. And if it were not for the maintenance of expertise in injury care, the valley-wide response to the 1 October shootings would not have gone as well as it did because the emergency departments filled that vital role.

Again, what's the optimal configuration of the Nevada Trauma System? This is my final section before Q&A. I would say look to the joint theater trauma system motto. It's the compass for you to navigate the difficult discussions we're having. Look at the American College of Surgeons Trauma Systems Program. They provide consultation. We've actually had those consultations and continue to build our system based on their recommendations. These will inform and advise, but here it is. We must build it. We have to make the final decisions. And when I say we, us, it's the community directed by the lead agency.

The designation of trauma centers is the responsibility of governmental agency and trauma center designation should be guided by a regional plan, which we have. It needs to serve the population rather than needs of individual healthcare organizations, which I believe it does. Trauma system needs to be assessed using measures of trauma system access and quality of care, population mortality data, trauma system efficiencies. And in 2016; when the trauma system advisory group was convened, we used extremely sophisticated, statistical and geo-mapping technologies to identify the flow of what patients came from, where did they go, how long did it take, and we were able to identify strengths and weaknesses. So, the technology exists and the expertise exists.

Let me just show you what we are up against here. So, this is, I'll take you into space. This is from the Space Shuttle looking down on the Earth. And if you look at the confluence of Arizona, California and Nevada, you actually see a bright light there. I'm sure all of you can find home. And if you slide over, that's enlargement of that bright dot. And it points out that Southern Nevada has three separate and distinct areas for trauma management. It has a dense urban core, has a growing urban suburban neighborhood with defined boundaries. Once you're outside the boundaries of the city, you are in rural and frontier areas. And so, these require three different service models. The Southern Nevada Health District responded to that by creating this map. This map is a again a conceptual piece and what it has is the metro area where a corridor is formed with the Resort Corridor on Las Vegas Boulevard. There's the highway and then there's the railway that vector up and down in a north-south direction. There's a Level I and a Level II center on either sides of that. And that's the densest area and it has very appropriate coverage, very strategic coverage. Then in the south we have St. Rose, and then north, we have Mike O'Callaghan Federal Hospital.

The purpose of the catchment areas is to do a number of things. It's to be based upon optimal EMS access, trauma center capacity capability servicing a defined area. And so you'll go, "Well, why are these so angular?" Well, the reason is because we worked with UNLV Traffic Research Center and with EMS providers and actually created traffic flow models that used major thoroughfares highways and other sorts of dividing lines for the most efficient movement of patients throughout the valley. And that's why they ended up shaped the way they are shaped.

We also had geo-referenced maps to know where the patients were coming from, so we knew which areas had higher and lower demands. Each center requires the adequate volume to achieve optimum outcomes. Our system has done a very good job of looking after that. So, this is not all opinion, but some of this you may have heard before, and this is based upon current events and current thinking about trauma systems. Now the optimum configuration of a trauma system is complicated, it really should resemble the Olympic rings. Now they don't have to be circles, they can be angular, but you want this overlapping map where you don't have duplication, you don't want it to look like a stack of coins. You want this to be spread out. You want this to look like the Olympic rings. You want to make sure that

everybody is covered adequately, and you want to base this upon EMS pickup and drop-off time, transport time. You want to base it upon individual systems size, capacity, capability.

Some of our trauma centers like UMC are huge. They're an entire building and others are very modern, very well-constructed, but they have different operational characteristics. You have to match those operational characteristics of capacity, capability, to the size and volume of patients. It doesn't mean every circle is equal. We also need to protect the civilian-military partnership we have with the U.S. Air Force. They're very much a part of our community and very much in need of training and readiness. All of their medics from lab techs, X-ray, nursing, surgeons, critical care personnel need to be ready for battlefield deployment. And the only way they can get that is collaboration with our trauma system.

The lead agency should have direct and comprehensive needs assessments and strategic planning initiatives whenever changes are requested or whenever changes are anticipated. Much of the decision-making in my history here has been reactive based upon complicated requests as opposed to strategic. And so having a proactive strategic way of looking at data and planning ahead would be preferable than having complicated and sometimes emotional reactive decision-making.

These plans have far-reaching social and financial implications. The monetary costs, the human costs are enormous. When someone's care results in saving a life, but then living on with lifelong disability, that's a terrible burden. On the other hand, we don't want a trauma system that sends the wrong patient to the right place for the right care at the right time. An example would be if every patient who got into an ambulance with a headache went to a stroke center and got a CAT scan, you would exhaust the medical capability of the community and you'd put a burden on the payers. That's unnecessary. So, like Goldilocks said, too much, too little, just right. There is a band of just right mixed into all of this. Remember that it's the trauma system, not just the number of trauma centers that saves lives. More is not always better. Better is what's better.

In summary and conclusion, educational studies have shown that a year from now that none of you will remember any more than three things I said. I'm an emeritus professor and I've been in education for decades. So, I'm going to give you the three things I want you to remember. This is it. So, if you've been snoozing, this is the time to wake up. All right? And let's get this done. Southern Nevada Trauma System is mature and well-functioning. Future growth and development should be strategic and based on needs. Lead agency should direct comprehensive needs assessments and strategic planning initiatives when changes are requested, needed or anticipated. Finally, your compass for all of this is to get the right patient the right care in the right place at the right time. I'd like to thank you for inviting me.

MARILYN K. KIRKPATRICK
Thank you, Dr. Files, that was a lot. Does anybody have any questions? Commissioner Jones and then Mayor Hardy.

JUSTIN JONES
Thank you so much for your presentation. I think this was a lot, but very helpful. Sorry, Dr. John Files. Going to the Level I trauma center requirements where you said they need to meet an annual volume requirement and that's something that RTAB's definitely been involved in. Is there a specific national criteria of what volume is required?

DR. JOHN FILES
1,200 a year and I believe it's 200 with an ISS, Injury Severity Score of over 15. Most of our centers surpassed that, well surpassed that.

JUSTIN JONES
Okay. So UMC got its Level I trauma designation in 1999, 25 years ago. So, they met the criteria then?

DR. JOHN FILES
By a factor of three or four.

JUSTIN JONES
Okay.

DR. JOHN FILES
Remember UMC was designed and configured as a single center system, serving not only Southern Nevada but the three-state area.

JUSTIN JONES
Understood. So, I guess I'm trying to understand, at some point where do you get to, there's a need. You've emphasized the need. What time is the need for another Level I trauma center, which would - If you're saying that in 1999, they were three X of what the minimum volume was, we've doubled in population since then. So, I guess I'm confused.

DR. JOHN FILES
You've asked a question that requires opinion, so let me just note that. I believe that the trauma centers in our system are operating well above the minimum criteria. This is a good thing. If pushed too far, then they begin to become overcrowded, which we've seen in emergency department deliveries, where emergency departments were pushed to the brink. I do not recall this ever happening. In fact, and again, this is opinion, I believe that most of the trauma centers in our system probably have excess capacity that's unused. All of them have facility updates and new staff and are operating very robust programs. And so, when the needs assessment is done, one of the findings could be, well no, we don't need more centers. The centers we have are absolutely more than satisfactory. That could be one of the findings.

JUSTIN JONES
Okay. I guess my other question is, you emphasize that minute's matter, which I think obviously is part of this whole discussion. When I look at the map, I'm a westsider, that's my District and we don't have anything. So, is part of this review that's going to happen in terms of needs assessment, whether there's a need for Level III and Level II trauma centers on the westside of town?

DR. JOHN FILES
Yes. In fact, in 2016, that was a very important question that we considered and looked at all the transport data, looked at the level, whether it was Level I, Level II, III and IV. What we found is that Level I and two patients with lights and sirens had an average transport time of around 15 minutes. That has been not fairly, but very consistent over about a 10-year period. Those transport times have not increased, but some of the Level III and level IV patients were experiencing longer transports. Again, Level III and level four patients are fully awake and alert with stable vital signs with suspected injuries. So that important group, the step one, step two red patients, they are still arriving at trauma centers from both the Eastside, the Westside, and from the South within an average of 15 minutes or thereabouts. So that is one of the key indicators that would likely lead to the need for additional resources is if the population density and traffic dynamics continue to change.

JUSTIN JONES
Thank you.

MARILYN K. KIRKPATRICK
Dr. Hardy.

JOE HARDY
Thank you. So, this is a unique group for me. So, what's the lead agency that should direct comprehensive needs assessment strategic planning? Is it this group or is it the SNTS (Southern Nevada Trauma Systems)? From where we sit here, where do we go and who do we go with? And that's a question. I don't know if it's for you or the Chair.

MARILYN K. KIRKPATRICK
Well, I think that currently there's a process. For me, the reason that I wanted to do this is because the Valley is growing and there needed to be some education component. And the Health District currently with the RTAB board, that's where most of that discussion starts. And then the Board of Health makes a determination or not and then it goes to the state. So that's the current process.

I was there in 2016 when we talked about doing a regional study and kind of determining, because at that point we could see that there was growth happening. And to Commissioner Jones's point is population is only one driver of the three-legged stool that they look at. But I think the key is strategically, we've got to ensure that people are in the right place and we've grown east, west, north, and south and are we still meeting up. But that's really what the RTAB has been doing. I think that there was some legislation that kind of slowed things down and then I think everybody was regrouping and then we've seen these standalone EDs.

So today I think this Board between the two of us, one the Health District is a representation of regionally, Boulder City, Mesquite, Las Vegas, North Las Vegas, and the County, that for sure that they got it here. And then Clark County also is a partner with UMC. So, this is why I thought this level-headed group of people should come together to chart the future for a well-balanced health awareness. Is that not the answer you wanted? It was a long-winded answer. Everybody's on a lot of boards, but I think that these two boards together represent 2.4 million people in the best way.

DR. JOHN FILES
If I may Dr. Hardy, I would say that there already is a process in place. These sorts of needs assessments are performed on an annual basis and are published as annual reports of the trauma system. And then amplified reports can be called for by the Health District or at the request of City Council, County Commissioners, all of which feeds up to the state who would be the final decider.

MARILYN K. KIRKPATRICK
Anybody else have any questions? Ms. Bond.

BOBBETTE BOND
Mostly I just had to say it's really nice to see you, Dr. Files.

DR. JOHN FILES
Thank you. Nice to be seen.

BOBBETTE BOND
Appreciate everything you did to build this and talking about it today. Sorry, I've got my phone here. But I would like it if you could just highlight again the dangers of over-designation really quickly. I just would like to say for the record, trauma is regulated for a reason. There's a reason because over-designation risks damage. And so, I think that we should just make sure that people understand why new trauma

centers are based on need, not on a hospital wanting one. But I think the reason we're seeing so much activity is if a hospital wants one, they start the process. We can't do anything about preventing the hospital from starting the process, it's just that it has to go somewhere where there's some final clarity about what designations should really be about. So, my comment is that, but can you highlight over-designation risks?

DR. JOHN FILES
Again, the analogy I used is that if you needed open heart surgery, you'd go to the hospital that does three a day, not one a month. So, when you over-designate, you begin to have large numbers of centers seeing smaller numbers of patients. When you over-designate, each of those facilities needs to have a staff including things like general surgery, orthopedics, nursing, blood bank and so forth, all the way up and down the line while we're in the midst of a physician shortage. So, there's a supply chain problem with that as well, trying to get personnel in place. More is not better in every case. So, over-designation has, the first time I saw it happen was Illinois Department of Public Health opened up designation to all hospitals in Chicago. They went from three trauma centers that were taking care... Huge trauma centers, three big ones, Cook County being one of them. They went from three to 12 and within three years they were to nine and then a couple of years later to six and then back to three. We're also seeing that happening in Phoenix. That's been happening to some extent in San Diego. California was investigating whether the number of trauma centers per capita in San Diego is appropriate. The same thing in Florida.

To your point, there is no simple equation about one trauma center per 100,000 because not all trauma centers are the same size, same capability or same location. So, it's a more nuanced conversation. So, I'll just leave it at that. There's more that goes with that conversation. But I don't think the Southern Nevada Trauma System is overpopulated right now. I think it has three centers that have shown strong longitudinal commitment and excellent record of performance and are valued assets. And adding new assets to the system has to be done strategically to not damage the existing assets.

MARILYN K. KIRKPATRICK
Does anybody else have any questions? So, I have one, Dr. Files. So, I've at least learned that Level IIIs are sometimes probably overutilized when urgent care could probably handle the same thing, right? You don't always have to go to the ER and maybe can go somewhere different. But do you think that as we talk about a regional approach and what this looks like, do you think that the standalone EDs get in the way of any more Level IIIs? I mean, do you think that they're kind of cutting their nose to spite the face to you offering the same service? Because a Level III, sure, you could be admitted, but a standalone ED, we heard today that you could be transported to be admitted as well. I'm curious.

DR. JOHN FILES
Again, I'll venture an answer, but I'll just preface by saying I'm going to have to base it on opinion.

MARILYN K. KIRKPATRICK
Correct. No, no, no.

DR. JOHN FILES
I don't have the data for this. I would say that as that injury pyramid broadens at the bottom, you need assets that see low level injuries and you need assets that see mild to moderate level injuries. You need assets to see severe injuries. Getting the right patient in the right place, the right time for the right care is not as easy as it sounds. That's why it's the system that saves the lives because all of the pieces have to work together. And the research looking at the data and demonstrating the operational characteristics may lead to new regulation. I'll just leave it at that.

MARILYN K. KIRKPATRICK
No, I know what you said so I get it. Commissioner Segerblom and then Councilman Seebock.

TICK SEGERBLOM
I think you've said this, but just to verify, so there are cost efficiencies in the more patients that UMC would see that ultimately we're going to all pay for this. So, is it beneficial to have more at one location for cost purposes?

DR. JOHN FILES
Well, let me reframe that if I may. So, the business case for operating a trauma center is not unlike any other business. There's fixed and variable costs that have to be met and volume is at least one of the factors that helps the hospital break even or create some profit for future investment in development. And so, I will tell you that trauma is not like plastic surgery. It's not a big moneymaker and it's very expensive to provide. And so, the Southern Nevada Health District and the three collaborating trauma centers have been aware of this and try to ensure that there's adequate volume in all centers so that the mission can be accomplished, that the fixed and variable costs can be met and that patients can be treated with good quality outcomes.

MARILYN K. KIRKPATRICK
Okay. Anyone else have any questions? Well, I thank you very much for that very thorough explanation and kind of the history. It's probably important. I would bet two thirds of the people in this room weren't here in the beginning. So, I think it's helpful for everybody. So, I appreciate that.

DR. JOHN FILES
Thank you.

MARILYN K. KIRKPATRICK
Thank you. You can go back to retirement and have a great time with all that traveling you're doing.

DR. JOHN FILES
I'm leaving this afternoon.

MARILYN K. KIRKPATRICK
See? I knew it. The wheel's up. All right. Mr. Schiller.

6. Receive a presentation from the University Medical Center of Southern Nevada regarding the services provided to the Southern Nevada community. (For discussion only)

ACTION: RECEIVED.

Attachment(s) submitted and filed with the County Clerk's Office

KEVIN SCHILLER
Item 6 is to receive a presentation from the University Medical Center of Southern Nevada regarding services provided to the Southern Nevada community.

MARILYN K. KIRKPATRICK
Good morning, Mason. And the reason that I asked you to be on this agenda because you serve a unique purpose as the County hospital. It's a little bit different than the other hospitals. And you are the only trauma one at this time.

MASON VANHOUWELING
Well, good morning Commissioners and good morning, Health District Board Members. My name is Mason VanHouweling. I have the honor of being the chief executive officer of University Medical Center. I'm just going to take you through some of the capabilities of UMC, the largest public hospital in the state. We've been around for a long time, and we love our history here in UMC. We started out in 1931, right on Charleston. Was started with one doctor and one nurse taking care of the workers of the Boulder Dam at the time. For two years, they operated by themselves until they finally got some help. And kind of fast-forward to through the decades, Clark County Indigent Hospital, Clark County General Hospital, many still refer to us as Southern Nevada Memorial Hospital. And then in 1986, we changed our name to reflect our academic and teaching mission as UMC.

Again, fast-forward to today, we are the highest level of care in the state of Nevada. The Level I Trauma Center, Level II Pediatric Trauma Center, the only verified burn center in the state, the only transplant center where we do kidneys and pancreas. We're looking forward to doing liver transplants next year. Dr. Files mentioned cardiac thoracic surgery. We are the heart hospital of Nevada. We did about 600 heart cases last year. Nobody's doing that type of volume and preparedness.

I'm going to talk a little bit about our sacred military and civilian partnership. The only one of its kind in the United States. Again, I reference that we are the largest public hospital. We also are a very large teaching hospital and academic medical center. These are just some of the facts and volumes at UMC. I'll kind of go from left to right on the top. We see hundreds of thousands of patients, even though we have 26 acres, only a few miles away from here. And God forbid if anybody has to go to UMC, we're glad that resource is there. But most of our volume is seen outside the hospital. Again, couple hundred thousand just in our Quick Cares. We do close to a hundred thousand in primary care visits. We do 16,000 surgeries annually, lots of ER visits, and UMC has got three unique emergency departments on our campus. We have an adult emergency room, separate from the trauma center, which I'll explain. We also have a dedicated pediatric emergency department, so our pediatric patients aren't mixing in with adult patients. If you heard the volume numbers, we see 14,000 trauma patients annually, 22,000 kids in our ER, admit 23,000 patients. We've done 184 transplants in the last year. And all in, all employees, full-time, part-time, per diem, takes about 4,700 employees to run the UMC Enterprise.

I'm going to walk you through the levels of care at UMC. Again, we're very proud of our ambulatory division. I get the honor to go out and speak to a lot of groups and communities. And this is one thing that people talk to me about the most, our outpatient setting, whether it's a primary care or quick care. They were in our Quick Care at Sunset last night, had a great experience. But primary care is the doctors that you know and love. Your annual visits, your routine visits, medication management. And so, I'm going to show the map on all where of our locations are. But we are in the primary care business. Not too many hospitals are in that business. And again, trying to keep people out of hospitals. That's the goal.

Our online care, we are now ... And month over month, we continue to grow our online care visits. This really gave birth during the pandemic. We were not in the online care business, but we know we needed to quickly react. So again, I am seeing the volume shift to online care. In fact, I was just sitting in the audience. We've got two doctors with no waits ready to go right now, and often this is backed up by our ER physicians. So, it's a very high level of care. They can take care of a lot of things. All five-star reviews.

And again, we continue to promote this line of business that UMC – Again, reducing travel times, reducing times away from work, reducing cost as well.

Our UMC Quick Cares. This is kind of where we take care of those sudden aches, pains, bumps and bruises. We operate ours from eight to eight. Again, we've got a lot of good presence in the community trying to offer value to our patients and access.

So, here's kind of the map of Las Vegas. And as you can see, we've got 16 distinct locations. Some of those are co-located. We've got a primary care and a Quick Care in some of those locations. And we continue to look at the map and where we can grow where there's not access. Reference a particular road. We were out there first. Blue Diamond was one road. Now you go up along that street, there's a micro-hospital and three freestanding ERs. But we identified that long ago as an area of growth. We're looking at Inspirada, looking back at Laughlin. Other areas, Mesquite, other areas where we can provide access to our patients because patients do like choosing UMC.

A couple other things. We've got Orthopedic Spine Clinic, Aliante is new, Quick Care and primary care. As we saw that area grow, we've worked with each of you to be able to strategically grow that and with our County Managers here.

So, lots of talk about Quick Cares, Urgent Cares versus the ER. And as Chief Schubert put up his slide, we are not regulated by that group. And you heard the words EMTALA, but we have self-imposed EMTALA on our Quick Cares. We treat everyone that walks through our doors regardless of their ability to pay. Again, this has been a great asset for us, keeping patients out of the emergency department. You see the freestanding ER locations that are in the pipeline, and I'm sure there's more to come. We have just stuck with this model. People ask me, "Why aren't you putting those up?" We just feel like we have an obligation to reduce the cost of care, reduce the cost to patients, reduce the cost to employers, the payers. And this is a great alternative.

Our Quick Cares can take care of a lot of things. Everything from asthma, COPD, pneumonia, lacerations, abscess drainages, IV fluids, pediatric illnesses, flu, bronchitis, Covid, other traumas, sprains and fractures. We have x-ray technology in here. So again, we were sticking with this model and we're going to continue to grow this throughout the valley to provide access to our community.

A little bit about UMC and the unique relationship we have with the Lions Burn Center. Over 50 years, we've partnered with the Lions Burn Center here locally. Obviously, they often deal with glasses and other things for patients, but we've been nationally recognized, internationally recognized, and we're the only verified burn center. So, we've gone through rigorous surveys and accreditations to be able to be a verified burn center. So, very proud and lots of great technology therapies and treatments that are happening in the burn center at UMC. The Center for Transplantation, very proud of this. Last year we were recognized as the number one ranked transplant center in the nation. There's three categories, two that I think they're most important, time to transplant and survivability. And the third category in third place. But again, we're very focused on doing liver transplants, being able to keep those patients in the community next year.

Pediatric trauma. We do have a Children's Hospital of Nevada at UMC. The nice thing about our unit is it’s round-the-clock board certified pediatric critical care and emergency physicians. We do burns as well there. We've got a unique pediatric sedation unit that's well known in the community, be able to help some of our most vulnerable get through some of their procedures healthily.

Okay, military medicine. So, we again have a - right now, I probably have about 60 Air Force medics back at the hospital. You see me in a suit. But I did for 25 years wear a different uniform. Many of you don't know that. I was a Air Force medic, first in Afghanistan. Dr. Files mentioned that. I was a war planner. And so, I come from another perspective when we talk about trauma and how that all comes together. But again, this is a unique program that we have with the military. It is a marquee program that the United States Air Force. And even though we've got Nellis Air Force down the street - and that's mostly healthy, 18- to 24-year-olds. They're not seeing the things that they would see on the front lines in a combat situation. Penetrating trauma, burns, other things that Dr. Files referenced. So, that partnership is sacred. That doesn't happen, we cannot keep the Air Force ready. And every day I get to see them take care of our community. And again, I was there the night of October 1, and our Air Force medics saved a lot of lives that night.

Academic medicine. As you all know, we are partnered with UNLV as our exclusive partner. We're training medical students there at UMC. We've got 340 residents that pass through our doors in 20 different accredited programs. And again, UMC is committed, as you all know, to address some of the shortages that we have related to physicians.

Okay. So, this building is the UMC Trauma Center. This is a unique building. It's a freestanding trauma center, the only one of its kind. You've heard Baltimore. That's shock trauma. Everybody had heard that name. That's where this was modeled after. Again, very unique.

So, this building is not taking care of anything else except for trauma patients. Very proud of the survivability rate. We run about 97% chance of surviving, if you arrive to us alive and some of those patients had a 1% chance of surviving. We pull from that 10,000 square mile radius. In this building, we have 11 recess rooms, 14 ICUs. We can flex up to 18 if we need to. We have angiography, CT, we have a pre and post. We've got three operating rooms, anesthesia standing by.

And then on the top of the building, we're actually in the process of converting those floors into more medical care, particularly around rehab, to be able to help rehab some of our trauma patients. So again, you heard Dr. Files talk about capacity. We have capacity at UMC. And again, in this building too, we open up our Incident Command Center. So anytime there's January 1, New Year's Eve, July 4, F1, around the clock, that Incident Command Center is ready to go. And you talked about system leadership and infrastructure, UMC is that hospital for the community.

A little bit about the trauma center. Again, I think Dr. Hardy mentioned about education and is it additive? I think with our physician shortage and be able to create synergies, it dilutes education. Right now, at UMC, we've got things as plastics, ENT, ER residents, surgery fellows. We've got 20 orthopedic fellows. We've got a traumatologist at UMC, to be able to take care of these patients. So again, you'll see others that talk about community outreach. How do we reduce violence? How to reduce accidents, injury prevention? Talk about academics. But I believe they're touching the fringe of that and not to the commitment that UMC has been able to do.

I won't exhaust this map any longer because I think you've seen it multiple times and the explanation around it. But we've been through this conversation over the years. Some of it is repetitive, but as I look at the healthcare needs in Nevada, we struggle in many areas. But you saw today, and we've seen over the decades, this is not one of them. We got challenges in diabetes, cardiovascular care, pediatrics. I sat through a presentation yesterday where we're working together to address pediatrics, but the trauma system is working really well. And I have the trauma annual report here. And I'll save you the 60 pages of reading. But go to page 59. And I'm going to throw out an acronym, TMAC. Trauma, the Audit Committee,

they basically say the system is working well, there's no deficiencies. Back to the question of transport times.

The helicopter pad is right by my office at UMC. We get one helicopter a day roughly, because you could still get around to Las Vegas with lights and sirens flying to the right trauma center. And again, I think we've got bigger needs in the community than addressing the trauma system and perhaps diluting it. So, with that Mr. Chair, Madam Chair, I'd be glad to answer any questions.

MARILYN K. KIRKPATRICK
Does anybody have any questions? I think we're trauma-ed out today.

MASON VANHOUWELING
Yeah, yeah. I was trying to –

MARILYN K. KIRKPATRICK
Commissioner Jones, did you have something?

JUSTIN JONES
[inaudible]

MARILYN K. KIRKPATRICK
I thought Commissioner Naft pointed your way.

JUSTIN JONES
I'll just return back to Blue Diamond. I've spent many, many hours in the Blue Diamond Quick Care facility with family and friends. And I appreciate all you do. My primary care doctor is at UMC. There's a reason, though, why the freestanding ERs are popping up over there is because you don't provide 24-hour care, and I wish you did so that I didn't feel compelled to go to any of these facilities. And I don't want to drive 30 minutes to UMC to be in the ER for hours. That's just the reality that I and many, many, many people face. And so strong encouragement to consider the 24-hour operations because I think it would be tremendously beneficial to people that live across the valley.

MASON VANHOUWELING
And just a response, Commissioner. We are looking at that seriously. And part of our strategic plan, we've also trying to work with some of the payers too, because they've asked for that as well as an alternative to some of the free-standing ERs. And also, we've been working with UNLV to provide a pediatric urgent care dedicated for pediatrics. So that is in the horizon. So, we will work with each and every one of you to be able to provide that and putting in the right place. But that is something that we are looking at. We've extended our hours over the years to be able to accommodate more, but we're seeing that request as well.

MARILYN K. KIRKPATRICK
Mayor Hardy?

JOE HARDY
Thank you. I guess this is a wrench in the works. We've talked about trauma, but you open the door for pediatrics and etc., etc., etc., etc. So, is there a secret entity other than trauma that says something about the level of care for hearts and strokes? And is there not that that plays a role in this whole process as well that has to be taken into account, the 30 a day versus three a month kind of thing?

MASON VANHOUWELING
Sure, Mayor. And one of the things that each and every hospital in the community does a really good job is distinguishing their services, whether it is stroke or cardiology care, other things, oncology as well, through the community. So, there are those hospitals that are designated. Some are regulated as far as destination protocols, stroke in particular. You've got primary and comprehensive stroke centers. So that is a separate conversation away from trauma, but it falls in the same category of expanding services and making sure that we're delivering the highest care in Clark County. But there are those designations that come through the American College of Surgeons or the American Heart Association, American Stroke, those type of things. And many of the hospitals in our community have those designations. Hopefully that answers –

MARILYN K. KIRKPATRICK
Councilman Black?

SCOTT BLACK
I think we all are going to take away a pretty clear understanding of the differential between one and two. Level I and II service levels are the same. Capacities are relatively the same. There's a commitment to leadership in the academic side. Is there a plan to elevate the pediatric trauma Level II to a Level I by virtue of leadership and/or academic specifically geared towards pediatric trauma?

MASON VANHOUWELING
Right now, UMC is the pediatric trauma center, Level II Pediatric Trauma Center. So that Dr. Files mentioned and the RTAB and the TMAC look at those type of things as part of the subcommittees of the Health District Board. I know that they in their annual reports, but right now the system's working well and we're able to provide those services from a pediatric trauma center. There are other hospitals that give great care, have given great care for decades, around pediatrics. But when it comes to accidents, all those services are centralized at UMC to be able to take care of those, whether it is neurosurgery, orthopedics, ENT and other things.

MARILYN K. KIRKPATRICK
Anyone else? Commissioner Segerblom?

TICK SEGERBLOM
So, I'm not totally clear. Is there anyone or anyone specific injury that would go to UMC as opposed to Sunrise in the Sunrise area?

MASON VANHOUWELING
So, Commissioner, again, I think one of the things - and again, I know Sunrise is here. We collaborate every single day. They give great care at Sunrise. Again, comes back to the catchment areas that have been determined that Dr. Files walked us through. The difference is that leadership, the research, the community outreach. Are we reducing violence, injury prevention? And I think those things are working well today in the community.

Again, Sunrise gives great care. We collaborate every single day. We're working together. And I think through the last RTAB that I watched, and somebody that's in this room, and I'm going to quote him said it right. This unfortunately has become a competition versus collaboration in some points. And I'm hoping you all are seeing that. But again, we have to collaborate together and be able to work together. As the city grows. We need to do that in a prudent and strategic way. Dr. Files has always said, "While more sounds better in anything." Not when it comes to trauma. We want to be able to make sure that we are

giving the right care at the right time and saving lives. And we've got a great survivability rate at Sienna, Sunrise and UMC and Michael O'Callaghan.

MARILYN K. KIRKPATRICK
Okay. And no other questions? Thank you, Mason, for that.

MASON VANHOUWELING
Thank you.

MARILYN K. KIRKPATRICK
All right. It's lunchtime.

PUBLIC COMMENTS

KEVIN SCHILLER
So that concludes your agenda. Just second section set aside for public comment.

MARILYN K. KIRKPATRICK
Okay. This is the second time set aside for public comment. I do have a couple cards that people that would like to speak on anything that we discussed today or anything that revolves around the topics we discussed. Come on, Todd.

TODD SKLAMBERG
Thank you, Madam Chair. My name is Todd Sklamberg. I have the privilege of being CEO at Sunrise Hospital and Medical Center. And thank you Commissioners and Board Members for two minutes and 55 seconds to share a couple of comments.

First, Sunrise Hospital's been in our community for 65 years and we are very pleased along with UMC to be one of the two safety net hospitals here in southern Nevada. We take that role very responsibly. Over the last 20 years, as you heard Dr. Files share, we had a very active trauma program. In addition to trauma, we care for over 190,000 patients in our emergency room, 45,000 admissions and have over 4,000 employees.

We'd like to share in the next two minutes just a little bit about that trauma because we heard a lot here today. First, want to break trauma into two pieces. Okay. The role of the American College of Surgeons, who is the verifying body. And then we can talk about catchment area.

Sunrise Hospitals you heard, has been a Level II center. We see 3,500 patients every year in our Level II center. What we're proposing today is not to add another trauma center, not to dilute any volume, but to move from a Level II center to a Level I center.

What have we done over the last 20 years? You've heard today a lot about research and about education. Sunrise Hospital over the last five years has invested in graduate medical education, residents. We've added 86 residents that are now part of the trauma program. We've published papers in nationally recognized journals, which has allowed the American College of Surgeons on July 9th to come to Sunrise Hospital and provide the preliminary verification of a Level I trauma center, saying that we have met all of the criteria.

You heard earlier that the yellow and the red today go to Sunrise, regardless of Level I or Level II. What we're proposing here is no change in the catchment area, no change. The Southern Nevada Health

District put together an independent report that showed the volume impact of Sunrise going to Level I would be zero. Zero.

So, appreciate Dr. Files and his decades of development of a robust trauma system here and agree with what he shared. Okay, more is not better. We're not asking for more. We're just looking for the verification and validation of what we've invested in our community over the last 20 years and more so the last five years, by adding residents, building our academic profile within Southern Nevada. I know I'm at the three-minute mark and (inaudible).

MARILYN K. KIRKPATRICK
And we can't even respond to you so there you have it. Okay. thank you. Anyone else wishing to speak on public comment?

DEBORAH KUHLS
Good afternoon. It's actually turned from morning to afternoon. I'm Deborah Kuhls. I'm the current chief of Trauma at University Medical Center. I want to just impart a couple of things. I moved to Nevada from Baltimore where I did my fellowship. I did it at the University of Maryland Shock Trauma and it was a transformative experience for me. So, I was looking for a trauma center like UMC when I moved here. And I've stayed here for a little over 24 years. It is unique as described by both Dr. Files and Mason.

I want to bring your attention again to a statement from the American College of Surgeons. I brought a copy of it for you if you'd like it. It's called Trauma Center Designation Based Upon System Need and the Economic Drivers Impacting Trauma Centers. This statement was revised recently in 2021 to indicate that a change in the level of existing trauma centers, as well as a change in the number of trauma centers, should be based upon need and need alone.

And I think that is something for all of you to really keep in mind. This is an organization that I think is very thoughtful and has guided trauma system development throughout the country and beyond. The comments made about training in conjunction with the School of Medicine at UNLV are really significant. We have a total of 341 residents and fellows in multiple disciplines that all see our trauma patients, 42 of which are active-duty military. They, along with all of the other military personnel that have been mentioned earlier. They also not only are getting ready in case they're needed for combat, but they're providing services to our community.

We were recently inspected or visited, I should say, by the American College of Surgeons in Joint Trauma System. And they were very complimentary of not only the readiness but the contribution to our community. So, I appreciate the opportunity to give public comment, and I trust that this group and other groups will make the right decision for our community. Thank you.

MARILYN K. KIRKPATRICK
Thank you. Anyone else wishing to speak during public comment? Seeing none. I'm going to go ahead and close the public comment. And does that conclude our meeting? Okay. And I want to say thank you to everybody that came. Those are on the phone and it's a lot, but if you have questions, happy to connect you with folks that can directly answer them. So, thanks for participating.

TICK SEGERBLOM
Before we close, I just want to make a comment about Dr. Leguen. Dr. Leguen has announced he's retiring at the end of the year, so I'm not sure. Those of us on the Health Board, we'll see you again, but those of us that are just on the County Commission may not see you again. So just want to thank you so

much. You've served admirably through Covid, which no one has ever seen before. So just on behalf of the County Commission, we want to thank you so much.

DR. FERMIN LEGUEN
Thank you, Commissioner. My pleasure. Thank you.

MARILYN K. KIRKPATRICK
All right.

END PUBLIC COMMENTS

There being no further business to come before the Board at this time, at the hour of 12:12 p.m., Chair Tick Segerblom and Chair Marilyn K. Kirkpatrick adjourned the meeting.

PLEASE NOTE: THE COUNTY CLERK KEEPS THE OFFICIAL RECORD OF ALL PROCEEDINGS OF THE COUNTY COMMISSION, THE CCWRD BOARD OF TRUSTEES, THE UMC HOSPITAL BOARD OF TRUSTEES, THE CLARK COUNTY LIQUOR AND GAMING LICENSING BOARD, AND THE CLARK COUNTY REDEVELOPMENT AGENCY. TO OBTAIN A COMPLETE AND ACCURATE RECORD OF ALL PROCEEDINGS, ANY PHOTOGRAPH, MAP, CHART, OR ANY OTHER DOCUMENT USED IN ANY PRESENTATION TO THE BOARD/TRUSTEES, REQUESTS SHOULD BE SUBMITTED TO THE COUNTY CLERK.

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ONLINE MEETING LINK

APPROVED: /s/ Tick Segerblom
TICK SEGERBLOM, CHAIR
CLARK COUNTY BOARD OF COMMISSIONERS

ATTEST: /s/ Lynn Marie Goya
LYNN MARIE GOYA, CLARK COUNTY CLERK

APPROVED: _____
MARILYN K. KIRKPATRICK, CHAIR
SOUTHERN NEVADA HEALTH DISTRICT BOARD OF HEALTH

ATTEST: _____
FERMIN LEGUEN, MD, MPH
DISTRICT HEALTH OFFICER/EXECUTIVE SECRETARY