



MINUTES
EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM
DIVISION OF COMMUNITY HEALTH
REGIONAL TRAUMA ADVISORY BOARD (RTAB)
January 16, 2019 - 1:30 P.M.

MEMBERS PRESENT

John Fildes, MD, Chair, UMC	Lisa Rogge, RN, University Medical Center
Sean Dort, MD, St. Rose Siena Hospital	Chris Fisher, MD, Sunrise Hospital
Kim Dokken, RN, St. Rose Siena Hospital (via phone)	Kim Royer, RN, Sunrise Hospital
Sajit Pullarkat, Administrator, Non-Trauma Hospital	August Corrales, Paramedic, Private EMS Provider
Kelly Taylor, Payers of Medical Benefits	Danita Cohen, Public Relations/Media
Billy Meyer, RN, Rehabilitation Services	Mary Martinat, RN, Health Education (Alt.)
Carl Bottorf, General Public	

MEMBERS ABSENT

Frank Simone, Paramedic, Public EMS Provider	Mike Barnum, MD, MAB Chairman
Jeff Ellis, System Financing/Funding	Erin Breen, Legislative/Advocacy

SNHD STAFF PRESENT

John Hammond, EMSTS Manager	Christian Young, MD, EMSTS Medical Director
Michael Johnson, PhD, Director of Community Health	Chad Kingsley, Regional Trauma Coordinator
Heather Anderson- Fintak, Associate General Counsel	Laura Palmer, EMSTS Supervisor
Judy Tabat, Recording Secretary	

PUBLIC ATTENDANCE

Tony Greenway, Valley Health System	Elliot Malin, Tri-Strategies
Victor Salcido, Tri-Strategies	Susan Rhodes
Georgi Collins, HCA	Stacy Johnson, MountainView Hospital
Jeremy Bradshaw, MountainView Hospital	Matt Cova, MountainView Hospital
John Nanes, MountainView Hospital	Isaiah Zirkle, MountainView Hospital
Jennifer McDonnell, MountainView Hospital	John P. Roberts
Matt Driscoll, R&R	Dave Levinson, HCA
Stacie Sasso, HSC	Kelly Stout, Bailey Kennedy
Josh Monroe, USAF, Nellis AFB	Wade Adair, USAF, Nellis AFB
Scott Hughes, USAF, Nellis AFB	Al Flowers, USAF, Nellis AFB
Dan Shinn, HCA	Daniel Llamas, HCA
Brian Brundage, NHP Association	Brett Olbur, Dignity
Kim Cerasoli, UMC	Maya Holmes, CHF
Ryan Beaman, CCFST	Gail Yedinak, UMC
Ed. Gonzalez	Donna Mack

CALL TO ORDER – NOTICE OF POSTING

The Regional Trauma Advisory Board (RTAB) convened in the Red Rock Trail Conference Room at the Southern Nevada Health District, located at 280 S. Decatur Boulevard, on January 16, 2019. Chairman Fildes called the meeting to order at 1:30 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. Chairman Fildes noted that a quorum was present.

I. PUBLIC COMMENT

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

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

The following public comments are verbatim transcription.

Good afternoon Chairman, Members of the Board, fellow community members. My name is Brian Brundage. Today I am speaking on behalf of the Nevada Highway Patrol Association of which I am a board member. I am the dispatch liaison officer on that board. Today I speak on behalf of myself, sworn officer first responders and the first-first responders, the 911 dispatchers. Today we are talking on the importance of additional trauma centers within the Las Vegas valley. Before I start it has come to my attention that possibly a decision was made to delay application process for the trauma centers and I wanted to express hope that that was not true, and I hope that our combined testimony this afternoon would be heard in earnest. First let me talk about the department I work for is Zero Fatalities Initiative. If you are not familiar with it, it is a united effort combining various agencies, organizations and concerned community members to eliminate fatalities from Nevada's roadways. Now it sounds like that would be an impossible goal with insurmountable odds to achieve it and yeah, I agree it is. However, the consideration should be made what if it was your family member, what if it was your friend. So, progress must be made and considering applications for further trauma centers in the Las Vegas valley would help mitigate that risk. Additional trauma centers would mitigate that. Within the Las Vegas valley, there are a couple and depending on where a crash would occur within the valley, the time it would take to transport someone to the hospital would be increased or not and those precious moments may save lives. But I don't only want to speak toward locally within the Las Vegas valley, there are people who give testimony for that. What I want to talk about is concerns that my members have brought to me. It's crashes that occur immediately outside of the Las Vegas valley that require ground transportation into the Las Vegas valley that an air ambulance might not be appropriate to bring them to a trauma center in town and precious minutes will be saved by additional trauma centers. If a crash occurs at Mt. Charleston an air ambulance will not be landing, there will not be a LZ (landing zone) on the top of the mountain, we will have an ambulance ground transport him in. Blue Diamond and Red Rock, depending, where are you going to land a helicopter? Lake Mead and on the business part of roadway in Nevada, the 27 miles between the California state line and Las Vegas, from Primm to St. Rose, crashes occur there every day. A semi-truck overturned a week and a half ago and closed it for an hour and a half, we had to air ambulance someone in to town. Additional trauma centers would mitigate that. I also want to speak to mass casualty incidents (MCI). On October 1, 2017 we had the largest MCI in the United States. The men and women who were first responders that night worked hard to save as many lives as they could. I was there, I watched it, I saw, I was in the command post at my job. Every little thing that they did to setup a road closure, to stop traffic, to move those pickup trucks and direct them to a hospital to save lives was amazing to watch. It doesn't do us any good to look back with 20/20 hindsight and say hey we should have

done that better however that is the only way we move forward. We use those after-action plans to consider if we weren't sending them to just those two trauma centers and those other hospitals that only had ER capabilities, how many more might we have saved that night, the number wouldn't have been 58 people. So I am going to leave you with this, and it is something I tell every new hire we get, this stuff is going to happen out in the world and you can't control it, but we are in a position to help people start picking up the pieces and today we are in the position to help start planning for the next one because it wasn't...it happened to be the biggest but it is not going to be the last and we need to be there for our community. So, if we don't consider it, we will then be responsible for what happens at the next one. Thank you for your time today.

Stacie Sasso, I'm with the Health Services Coalition located at 6655 W. Sahara Ave., Suite C202. The Coalition is comprised of the largest self-funded employer and union-based health funds in Southern Nevada representing just over 280,000 lives. We are here today to remind RTAB that your responsibility is to support an effective trauma system within Southern Nevada and at this point there has been no proven need for additional trauma capacity. A system exists for adding trauma capacity when it is needed only including a formula for assessing trauma need provided by the American College of Surgeons (ACS). The reason for the formula is because when capacity is added that is not needed it will damage the existing system that is in place. Trauma designation is sought by hospitals for two reasons. It will receive its own catchment area and it allow a hospital to bill for a trauma activation fee. That is guaranteed new income for for-profit hospitals and trauma activations are charged higher rates than regular ER visits. This fee is thousands of dollars even when no trauma care is really needed. Trauma activation fees are intended to compensate the hospitals for having 24/7 readiness, however the fees range dramatically, nationally, and locally and can be the same regardless of the severity of the trauma, the scope of medical care rendered and the patient's length of stay at the hospital. We shouldn't rush the process or short change the analysis to hand out trauma center designations because hospital advocates would say, trauma patients are treated faster. I'm asking RTAB to review and recommend applications only after trauma care shortages are identified and since that hasn't happened I'd ask for you delay any decisions. Thank you.

Good afternoon, my name is Maya Holmes and I am here on behalf of the Culinary Health Fund at 1901 S. Las Vegas Blvd. I just want to let you know that we still have the concerns that Bobbette Bond and I raised at the last RTAB meeting regarding the process for taking applications before an overall assessment had been done per the direction of the Board of Health in 2016. We also still have our concerns regarding the Trauma Needs Assessment Tool. We hope those concerns will be addressed today.

For a quick recap, our concerns include:

- The tool does not differentiate between median transport times for Step 1s and 2s versus 3s and 4s. Clearly time is far more critical than it is for Steps 1s and 2s versus 3s and 4s and the tool should address that.
- We are concerned that the tool relies on self-reported data to the state trauma registry and we are concerned about the reliability of that data.
- The tool includes support from a range of advocacy groups and stakeholders but does not address how to weight opposition. Also, we believe determinations should be made based on solid, verifiable data that shows unmet need that cannot be met by existing trauma centers, not who can gin up the most support letters from folks who may lack the level of expertise necessary to determine what is really in the best interests of the community overall.
- We also do not understand why the tool would assess "substantial compliance" with American College of Surgeon guidelines. It should be complete compliance.
- We are also concerned about the change in EMS protocol requiring Step 4s to be transported to trauma centers. This change is not consistent with CDC TFTC guidelines

which state Steps 4s should be transported to a trauma center or a hospital capable of receiving them. We are concerned this could result in inflating the number of trauma transports and lead to over triage.

- Additionally, we understand that the TNAT tool was developed to build off of the ACS Needs Based Assessment of Trauma Systems Tool and to determine where new trauma centers should be located. However, we are concerned that the TNAT focuses too much on areas that are growing and not on what is the maximum number of centers needed for the region overall and how new centers will impact existing centers.
- We do not understand question 5. It is my understanding that that was going to be revised to be clear. That is question 5 on the TNAT.
- We also believe there should be clarity on the difference in care provided by a level 3 trauma center versus an ER.
- We believe the health care price inflation related to trauma activation fees charged by a level 3 trauma center has an enormous impact on the stability of our health system. It is a waste of limited health care dollars and this price gouging strategy by the hospitals should be prohibited. This issue needs to be considered in any new trauma designations.

So, to wrap up, our priority is to ensure that the trauma system grows in a smart way that does not undermine existing trauma centers financially or their ability to provide quality patient outcomes. We want to ensure that patients have access to the right care at the right place and at the right time. We want to avoid the duplication of services. And, we want to prevent over triage, which drives up health care costs. Lastly, there is no way we will have a world class trauma system if we undermine it with an oversupply of low-level trauma centers. Thank you.

Mr. Chair, committee members, Good Afternoon, my name is Susan Rhodes. In September of 2016 I retired from Clark County Social Service where I served 30 years as a Social Work Supervisor, overseeing all long-term care services provided by Clark County. While I could talk to you about the use of trauma center especially Level I trauma centers by many of my clients, I wanted to take a minute to tell you about my personal experience. On December 10th of 2002, I and one of my staff was attacked in one of the offices that I supervised out in Henderson, close to Boulder Highway and Lake Mead, just about right across the street from St. Rose Dominican. I was stabbed in my chest and my upper torso repeatedly, I was beaten, I was hit over the head by the steel end of a chair causing a large head-wound and severing the occipital nerve on the left side of my head. Obviously, I was in pretty bad shape, I survived my injuries, thank you, I'm here, but I was in pretty bad shape. I was taken to obviously UMC which was the only Level I trauma center and while it seemed at the time it took forever I understand the trip at that time took about 20 minutes to get me from essentially where St. Rose is to UMC. I received excellent care, this speaks nothing of the care and obviously I was well cared for because I am here to talk to you today. However, in 2002 there were about a million people in Clark County and today we have about 2.3 million. The number of visitors that come to Las Vegas on a daily basis has grown exponentially and the traffic between the road construction and the number of cars on the road while I won't even begin to try and figure out how long it would take now even in the best of times to get from the corner of Boulder Highway and Lake Mead to UMC. The reason I tell you this is because when you have injuries such as I had minutes mean everything, it makes the difference between surviving and having a positive outcome or not having such a terrific outcome. It gives me a moments pause today, 16 years later to make me think, would I have the same positive outcome and would I be able to stand here and relate this story to you today if that trip had taken 40 or 45 minutes to get from where I was to the center of town. It gives me a moments pause and I hope it gives you a moments pause also to think about whether or not we are best serving not only the needs of the 2.3 million residents of Clark County but the 100 of thousands of persons that come here to visit us and unfortunately may have occasion to use our trauma center. I wanted to share my story with you because I think it is significant, I think when you have deliberations it helps to have some personal insight and personal testimony as to what we are doing and what the best use may be. I want to thank you very much for your kind attention and for your consideration and want to thank

Dr. Fildes who personally took care of me, I don't know if you remember, you do, so I can be here to tell you about this today. Thank you so much.

My name is Donna Mack. I coming to you as a community member. I've been a teacher for 32 years, I'm also a youth mentor and a lifelong resident of our city. 10 years ago, when we were at Centennial High School watching a football game, we watched a boy be transported off the field, he is still paralyzed. Back then you could easily reach UMC within a 20-minute time period. Centennial High School is 16 miles from UMC, if you clock it during rush hour traffic, it is 40 minutes. 20 to 40 minutes is what it takes now to travel from there. Since then in the last 10 years, we've added Providence, Sky Canyon, all of the development off of Snow Mountain exit, plus when you think about all the additional people that use all our recreational facilities on the outskirts of town in the northwest part of town, we need extra services out there, we really do. I am also an exchange coordinator, so I have kids that are in different high schools around the valley that play sports. Did I say that Centennial High School is 16 miles away from UMC, so is Basic High School? So, I hope that my Italian kid and his track and field team do not need any transportation during rush hour traffic from Henderson because even to Sunrise Hospital, it is going to take them a good 40 minutes on rush hour evenings. Also, I have an Italian exchange daughter, when she came to American for this school year her worst fear was gun violence. I said, you go to Centennial High School, it's fine, nothing is going to happen, it's fine, I promise, and I was wrong because the kid that was arrested with the loaded gun in her class, he was in her classroom, he was a student that sits next to her. If something had gone wrong that morning when they arrested that kid, if there was a need for a whole bunch of ambulances to have to be transported during rush hour morning going through the Rainbow curve, the Spaghetti Bowl, or if they wanted to take Rainbow over to Charleston, that is a lot of traffic, it is just an increased amount of traffic. In the last, as you know, and people have stated, 600 thousand people have moved to our city since we have built that trauma center. 600 thousand people, I mean we have to take things like that into consideration I would think as a member of the community, that is what I think when I feel like oh we don't have enough services. It takes a long time. As a teacher, we sit in the teachers' lounge and we complain that other people in the country compare us since we are the 5th largest, compare us to other school districts and we think it is not fair, we are different, and we are special. We have all that transiency, all the volume of people coming and going, and all that transiency and the visitors is what makes us special as a city and it makes us very proud, but then also as we want to talk about October, that uniqueness thank goodness the people at the trauma centers did what they needed to do. But I feel like we were putting all our eggs in one basket because there was human error of course and there was a situation where people didn't think there was going to be enough beds. As I was doing my research, I was going to look through that because from my side it seemed like everything went as smooth as possible with such a traumatic incident. I thought well still, we have all these people that have come to our city and the 600,000 extra residents and we still have not added a trauma center that didn't make sense. Then when I looked to see why, one of the quips that came across was across was the tipping point was that we needed an increase in mortality. We've added 600,000 extra living souls to our city, we don't want to worry about fatalities when we think about what we need to add. So, I beg of you, could you please build something on our side of town, we need that for our students, for our residents. I really appreciate your time. Thank you.

Hello, thank you Mr. Chairman and Committee, my name is John P. Roberts, I am a teacher here in Las Vegas, I actually teach at Centennial High School. I know her Italian foreign exchange student that she just mentioned, and she is my class, my psychology class. As a teacher, one of our concerns is the issues of school shootings and fatalities. I wouldn't say it is a fear when we go to school every day, but it is definitely in the back of our mind. There was something like 82 school shootings last year, obviously there were extreme ones like Parkland, but if something like that does happen, what exactly, how quick can we get these young kids to a hospital. Like she mentioned about the child that was paralyzed up at my school 10 years ago, I was there that night and it was very terrifying to see that happen to a young kid. The reality of it is, the reason why I

brought up the foreign exchange in my psychology class is we've had a lot of these conversations and there is anxiety and there a concern among the students at our school or all schools I would assume of what would happen if there is some sort of tragedy like this. We know it does occur, we obviously had the October 1st shootings and like the gentleman said earlier today, this is going to happen again, it has happened in the past, we can't stop all these types of things, but as a community we need to be prepared to take care of our kids and we need to take care of our future. That is pretty much all I wanted to say today. I hope you guys make good decisions on this and I appreciate your time. Thank you.

My name is Ed Gonzalez, the reason I come today is to speak to expanding our trauma centers, especially tier 1. I am also a member of the Henderson Charter Committee, I sit on as a SOT over at Hickey Elementary, that's over on the east side and when you start looking at some of the population growth that's happening especially some of the mental behavioral stuff, some of the speakers talked about some of the shootings that may happen, I know I am trying to work with schools to help prevent that. But as our population growth is happening especially in Henderson, we've seen in the last 5 years not just population growth but EMS services, the calls have gone up 26%. We are trying to locate more fire fighter stations because some of these things. If you look at that, it is not just the population growth, it's the services. So, if we do a needs-based assessment obviously we may find that we need more of these services. I believe that is the case. My fear is I am all the way on the other side from Centennial, I'm over at the 95 and the 215, I have great freeway access, but it takes a while to get to UMC. I think also as well, is that if you are looking through the process of expanding it, my fear is if we could speed up the process by accepting applications, even if you guys haven't finished the assessment simply because if you decide that is the way you are going, you can sit there and get this process going and speed up the process as opposed to you know, and there is no harm in accepting applications if you don't do it. My thing is simply this, we want to make sure people are safe. We don't want to have situations where we have internal structures that don't make people safe. Mr. Chairman, I will be brief on that since I am the last remark so thank you.

Chairman Fildes thanked all the speakers and asked if anyone else wished to address the Board pertaining to items listed on the Agenda. Seeing no one, he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Chairman Fildes stated the Consent Agenda consisted of matters to be considered by the RTAB that can be enacted by one motion. Any item may be discussed separately per Board member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes/Regional Trauma Advisory Board Meeting: 11/28/2018

Chairman Fildes asked for approval of the minutes from the November 28, 2018 meeting. A motion was made by Member Corrales, seconded by Member Pullarkat and passed unanimously to approve the minutes.

III. CHIEF HEALTH OFFICE REPORT

No report.

IV. REPORT/DISCUSSION/POSSIBLE ACTION

A. Committee Report: Southern Nevada Injury Prevention Partnership (SNIPP) 10/15/2018

Mr. Corrales related that a SNIPP Workgroup was formed and met on December 11th to identify existing groups within the valley with similar goals of the SNIPP committee. Their ideas were to identify these groups and perhaps provide a forum or be able to address those initiatives. He added that will be an ongoing process for the SNIPP committee.

Mr. Corrales referred to the SNIPP Bylaws in the member packets and noted the suggested language changes either stricken or placed in red. These following changes were made to help improve the scope of the SNIPP committee and with membership and quorum.

Article I, Purpose

- Item 2: strike (i.e. motor vehicle related injuries) to just expand the scope of the impact that we are going to look at for the trauma system and not just to focus on motor vehicle accidents.
- Item 3: We suggested to strike the words evidence based and use data driven so that would also include studies and statistical reports from epidemiology.

Article III, Members

- Section 1: SNIPP membership, we suggested that we delete the word shall and introduce may. So that allows a greater flexibility for additions on to the SNIPP committee.
- Section 5. Vacancies. We suggest striking the term three to two regularly scheduled meetings and within a term year striking calendar so that applies for attendance for the SNIPP committee.

A motion was made by Member Corrales to accept the discussed changes made to the Southern Nevada Injury Prevention Partnership Bylaws. Seconded by Member Taylor and passed unanimously.

B. Committee Report: Trauma System Advocacy Committee (TSAC) 10/16/2018 & 01/15/2019
Tabled

C. Review/Discuss Revisions to the Trauma Needs Assessment Tool (TNAT)

Mr. Kingsley noted that in previous meetings, there were discussions to develop new language for question 4A of the TNAT that is more appropriate for upgrades from a Level III to a Level II or a Level II to a Level I. He noted that questions 1 through 3 are weighted for initial applicants while questions 4 through 6 are weighted for trauma centers already established seeking an upgrade.

Dr. Fildes asked for a better description or instruction above Section 1 so that this document is clear and readable to anyone. He felt that there should be complete transparency about why the measurements are taken and where and when they will be considered. The board agreed.

Mr. Kingsley informed the board the he made the following changes to Section 4 of the TNAT.

- Added “in addition to question one to three” as clarifying language to the instructions above Section 4.
- 4A: struck non-trauma center and added level II or level III trauma
- 4A: added 10% or higher
- 4A: added “In the injury mortality from non-trauma hospitals increasing?” as another discussion option to use instead of measuring ISS>15, they could measure injury mortality rate from non-trauma hospitals.
- 4B: struck non-trauma and added level II or level III trauma
- 4B: struck State and added SNHD Informatics

Dr. Fisher stated that they were struggling with that 10% and felt that number was extremely high. He questioned if that is describing patients that come to the hospital with an ISS>15 never admitted and discharged from the emergency room. Mr. Kingsley answered in the affirmative.

Dr. Fildes agreed and stated that in a moment they are going to be looking at system wide data which shows a mortality rate of 2% which means a 10% increase would be huge jump back in system wide efficiency. When ACS comes to verify trauma centers, Level I and Level II trauma centers have to offer equivalent levels of clinical care with equivalent outcomes and should be

considered together in that role. Level I trauma centers have the additional responsibility of teaching and training, research publications, community outreach, and injury prevention and control. To that point, he felt what the committee has been trying to ask and have answered is whether injured patients die in non-trauma center hospitals. That is a reliable piece of data that the coroner produces, and it is not controversial. He added that they already know about the activity in the Level III trauma center at St. Rose. They report their data which is reviewed by the RTAB. He asked the board to reconsider whether they should try and stay with an ISS measurement which by itself the calculation of ISS requires training and has some difficulty to be accurate and reliable as to opposed to counting deaths in non-trauma center hospitals which is reliable.

Ms. Royer questioned why they are doing a percentage and not following ACS guidelines.

Mr. Hammond explained that question is based on the NBATS tool, and there was a decision during the creation of this tool to quantify that number.

Ms. Royer questioned how they know the non-trauma center hospital patients ISS and who is calculating the ISS for those non-trauma center hospitals.

Mr. Hammond replied that they receive this data from the Nevada Trauma Registry (NTR).

Dr. Fildes pointed out that that data is voluntary in nature and many of the entries are coming from people without training in ISS calculation. He added that the discussion wouldn't be about upgrading from a Level II to a Level I, because that requires no additional discussion. To qualify for that you would have to have the volume and the outcomes as judged by the ACS. He felt the question should be framed to identify whether a level III is mature enough to rise to a Level II or I and I'm not quite sure that this tool is the tool to use because the ACS verification committee is stringent enough on that matter. Dr. Fisher agreed.

Dr. Dort commented that looking for an increase in level, he understands that the ISS is generally less accurate than a mortality rate. But in moving levels at least they are dealing with a center that has the expertise to assign an ISS. Level III centers tend to see mostly mechanisms where mortality rates are extremely low so that single death can raise you 10% if not 100%. It seems like a silly number to use to judge whether a level III should be going to a Level II. In some ways if the death rates start increasing that much at a level III, that could almost be a reason to not let them elevate to a Level II if they are having troubles with mortality. He felt the ISS would be a better gauge. He added that when it comes down to the nuts and bolts of lifting a III to a II, he felt a lot of what they are going to be looking at is the number of patients being transferred out of that area because a level II doesn't exist.

Dr. Fildes stated that to your point, item 4B states "Are the number of severely injury trauma patients being treated in this case the Level III trauma center increasing".

Dr. Dort felt that is a much more accurate predictor. He believed that question 4B would be a heavily weighted answer because that would be crux of why you would want to increase. He added that question 4B and 4D go together because if you are going to have one you are going to have the other.

Dr. Fildes stated that D is not incorrect. This goes to the point of one of our public speakers, if the number of severely injured patients around a Level III happens to be increasing then that's a sign for us to consider upgrade. Step Up, that is what D is saying. He felt that as written "B" might say are the number of severely injured trauma patients being treated at a level III which would be the most reasonable and relevant answer.

4C: seems to be a reasonable as described by Dr. Dort.

4D: Are the step I and/or Step II TFTC incidents for the current Level III center increasing? Those 3 appear to be postdated and relevant.

Ms. Dokken expressed the fact that in question 4D, it asks if the number of severely injured patients at a level III is increasing. A Level III can't get step 1 and step 2 patients by catchment zone definition so it would have to be the number of patients coming out of that area.

Dr. Fildes felt that is a reasonable clarification. What Ms. Dokken is saying is “D” might read a little differently. It might say “Are Step I and/or Step II TFTC incidents in the area served by the current Level III increasing. So that brings us to B, C, & D.

Mr. Kingsley stated that question 4B C & D are weighable, but 4A is either reword or strike.

Dr. Fisher felt that with question 4A, ACS has very specific criteria for Level I, II, and III, and that might suffice better in 4A then what is listed in the TNAT.

Dr. Fildes proposed that they look at questions B, C, & D to read:

- B: It might be reasonable to consider “Are the number of severely injured trauma patients being treated at a Level III center increasing” which means from self-delivery or from any other means, you are treating a larger number of patients.
- C: Are transfers in to the Southern Nevada Trauma centers from non-trauma center hospitals increasing? That would speak to seriously injured patients being received at non-trauma centers being transferred into trauma centers, that would mean they are not being captured and directed.
- D: Might be our Step 1 and/or Step II TFTC incidents in the area served by the current level III increasing.

Dr. Fisher agreed on how those are worded.

Dr. Fildes remarked that they have 3 out of 4 and focused back on 4A. He suggested that 4A state the Level III center must be able to satisfy ACS verification criteria to step up since the College of Surgeon’s deliberations are more robust.

Mr. Kingsley noted that is repetitive of question 6.

Dr. Fildes suggested that in the spirit of preserving all of this, but making it as clear as possible, might it be that letter B becomes A, letter C becomes B, and letter D becomes C and number 6 becomes the new 4D. Then in one statement set you’ve got the criteria for a step up from III to a higher level.

Dr. Fisher agreed that 4B, C, & D become A, B & C but felt that 6 remain as a mandatory stand-alone criterion.

Dr. Fildes stated that they can step away from 6 since there is no motion on that matter. Returning to Section 4 and asked if A gets re-written or does it get deleted and we carry only B, C, & D under 4.

Ms. Taylor stated it gets deleted and you re-letter.

Dr. Dort agreed and added he would certainly get rid of the option part and if you look at A & B, they are very similar. One is numbering the ISS and one is just a vague general increase in serious injuries, but it is saying the same thing.

Dr. Young question whether they should add the mortality into question A to read “Are the numbers of severely injured trauma patients or number of deaths being treated at Level III trauma center increasing?”

Dr. Fildes stated that the introductory of question 4 reads “Severely injured patients (ISS>15) discharged from Acute Care Facilities not designated as a Trauma Center”. Since this is only for consideration for step up from a Level III to a II or a I, that language would have to change to read: Severely injured patients (ISS>15) discharged from Level III trauma facilities. The intent of the board would be to delete A. B would now become A and would read: Are the number of severely injured trauma patients being treated at a Level III center increasing?

C: Would read: Are transfers in to So NV trauma centers from non-trauma centers increasing?

D: Are Step I and/or Step II TFTC incidents in the area served by the current level III catchment are increasing?

And the intent of that item would be to find need for a step up from a III to a II or a I.

Chairman Fildes asked for a motion to approve the following changes to question 4 of the Trauma Needs Assessment Tool (TNAT):

- Reword introduction to question 4 to read “Severely injured patients (ISS>15) discharged from Level III trauma facilities”
- Reword question B to read “Are the number of severely injured trauma patients being treated at a Level III trauma center increasing?”
- Reword question D to read “Are Step I and/or Step II TFTC incidents in the area served by the current level III catchment increasing?”
- delete question A
- questions B, C, & D become questions A, B, & C.

Motion made by Member Corrales, seconded by Member Dort and passed unanimously

Mr. Kingsley noted that in the scoring needed per section it required a minimum of 1 “yes” answer for Section 5. Since Section 5 was not in a form of a question, they changed it to read “Is the number of trauma cases increasing at Trauma Centers currently in the Las Vegas valley?”

Dr. Fildes felt that was a straight forward wording change.

Mr. Kingsley stated that he added “the essential Type I and Type II criteria” as a clarification language for Section 6 to read: Any Center seeking an upgrade in designation must demonstrate compliance with the essential Type I and Type II criteria requirements of the American College of Surgeons (ACS) Resources for The Optimal Care of Patients.

Ms. Royer suggested adding the word “injured” to Resources for The Optimal Care of *Injured* Patients.

Dr. Fildes suggested it should say current edition of.

Chairman Fildes asked for a motion to approve the discussed changes made to Section 5 and Section 6 of the Trauma Needs Assessment Tool (TNAT). Motion made by Member Fisher, seconded by Member Rogge and passed unanimously.

Dr. Young stated that in question 5 it asks if the number of trauma cases increasing and questioned if there is not a consistent increase, is it any increase at any of the trauma centers.

Dr. Fildes stated that this is an assessment tool and not a regulation. A board like ours in the future might look at this and say there is some ups and some downs but across the board we are flat so there for our assessment is that there is no change.

Mr. Kingsley asked the board if they feel the TNAT is adequate to take it to the BOH or would you like to meet one more time to review these changes.

Speaking for the board, Dr. Fildes stated that they have deliberated on this tool for quite a while and are satisfied. However, as it goes forward he felt it will be available for public comment.

D. Discussion on Trauma System Annual Report

Mr. Kingsley referred to the 2017 Clark County Trauma System Report that is in the members packet. He stated that the last time this report was produced was in 2008 and as part of his position it was his job to bring back the Trauma System Annual Report. This becomes a great educational piece for anyone wishing to understand the current trauma system. This will be done on an annual basis around July or August of every year. He stated that there is room for improvement and welcomed everyone’s input.

Dr. Fildes congratulated Mr. Kingsley on pulling together this document. He added that there is a lot of material here to digest, perhaps in subsequent meetings they could capsulize some of these findings into important trend information.

E. Trauma Field Triage Criteria (TFTC) Data Report for 3rd Quarter 2018

Mr. Kingsley reported on the trauma transport data for 3rd quarter 2018 stating that the out of areas are still in marginable parameters.

Dr. Fildes pointed out that of the total transports for 3rd quarter the report shows 92% adults and 8% pediatric. He emphasized that would speak to SNIPP and the effect of injury prevention especially for children in this county. That is an unusual low number for the national picture and deserves to be noted. He brought up the fact that step 3 and step 4 categories, typically the types of patients that can be seen at all trauma centers make up 88% of patients and only 11% are in a category for step 1 and step 2, the kinds of patients seen only at Level Is and IIs. He added that 64% of patients are discharged on the day of evaluation which is nearly 2 out of 3 patients transported for trauma care. This begins to approach an adult emergency department that would characteristically discharge 80% and only admit 20% of their patients. He felt that was a little higher than expected and added some of those drivers create a bigger denominator and the mortality rate is 1% for that 3rd quarter which is absolutely an astonishing mortality rate. At the national level, the national trauma data bank and the trauma improvement project publishes about 96% survival 4% mortality at major trauma centers across the united states. That calculation may be weighted by large number of patients with minimal injuries.

F. Nominations for Non-Standing RTAB Member Seats for Terms Expiring June 30, 2019

Dr. Files referred to the RTAB Nomination form in the boards packet. He added that everybody should take that with you and share this in the community and throughout the institutions where you work and support good patient care. These nominations are due back by April 30th and they will be deliberated on after that date.

G. Discussion on the Development of Catchment Areas

Mr. Kingsley stated that the importance of catchment areas has been a large part of the trauma system. Currently with regulations it states that it is the responsibility of the OEMSTS to establish, review and adjust areas as needed. With that he stated he would like a type of process or procedure that would reflect this board and the community of working together to decided how best to implement catchment areas here in Las Vegas. He added that they are looking at a year and a half, to two years before that catchment area would have to be implemented just because ACS currently has an 18-month waiting time for accreditation. He felt it appropriate to start the discussion here in RTAB and asked the board how they felt he should proceed forward with development of catchment areas.

Dr. Fildes stated that an applying center needs to know what are the calendar of events that takes place and the determination of a catchment area is one of those events. When they went through the deliberative process to create the TNAT, they talked about finding needs in the community in terms of injured patients who have needs or in operational efficiencies that need to be served like what we heard in the public comments about time and distance of travel. He asked the RTAB to share their thoughts about what might be some starting points or some concepts that we would like to work on to help staff create a guidance document for this.

Ms. Royer questioned if the catchment area would change if their Level changes. Mr. Kingsley answered in the affirmative.

Mr. Kingsley asked the board if they would be interested in developing a taskforce to work on policy and procedure.

Ms. Taylor felt that would be a duplicative process and that it should remain with the RTAB.

Dr. Fisher declared that this will be a large task if they keep it at the RTAB level and they should dedicate a certain amount of limited time, so they don't neglect other proceedings and business of this committee.

Dr. Fildes stressed that is was important to have community input and go through a robust period of public scrutiny. He felt that they can put into place some conceptual boulders that guide the fine tuning through public comments to get to a place where this document can be

acceptable. To build a world class trauma system you want to make sure that your current assets are not damaged as you add new high-quality assets. You want to make sure that the needs of the patients are served first and that you try to eliminate or reduce to as much as possible duplication of services. Just improve access to care. Those are some of the guiding principles around creating catchment areas. This group here will have to anticipate step up and growth strategies and protect existing centers while adding new high-quality centers.

V. INFORMATIONAL ITEMS / DISCUSSION ONLY

A. Status Update on Trauma Center Applications

Mr. Kingsley reported they still have just the 5 applications. Previously, a special meeting was setup for RTAB on February 19, 2019 to listen to presentations by the 5 applicants. Mr. Kingsley stated that he has received direction from the CHO and the BOH that they would like to change that date to the next RTAB quarterly meeting on April 17th at 1:30pm. The idea for that is to allow the BOH to have the time to understand the Trauma System. There are new members on the BOH that feel they need to be properly educated so that when these applications do present to the BOH they have all the information needed from the RTAB as well as the TNAT. At this time, I am informing the board that the applications will be heard on April 17th.

Dr. Fildes questioned if there has been a decision about convening the special meeting in February.

Mr. Kingsley stated that the room is still reserved if needed.

Dr. Fildes asked the board for their thoughts. It was decided that the RTAB will not meet in February.

B. Report from Public Provider of Advanced Emergency Care

No report

C. Report from Private Provider of Advanced Emergency Care

Mr. Corrales reported that the EMS systems in conjunction with the fire department agencies utilize the M-Track for tracking patients involved with New Year's Eve for both the Las Vegas strip and downtown Fremont Street Experience. They were able to capture 9 patients and we look forward to more continued exercises so that the M-Track system can be fully implemented in the valley.

D. Report from General Public Representative

Mr. Bottorf stated there were no items to report.

E. Report from Non-Trauma Center Hospital Representative

Mr. Pullarkat stated there were no items to report.

F. Report from Rehabilitation Representative

Mr. Meyer stated there were no items to report.

G. Report from Health Education & Injury Prevention Services Representative

Ms. Martinat reported on the following events:

- There is going to be a Search International event in conjunction with the Nevada Child Seekers on January 31 – February 2, 2019. Their goal is to try and locate the top 30 missing kids in the country. There is an orientation on January 30th for community members that are interested. Please email search@freeinternational.org for more information.

- The Trauma Prevention Coalition's 5th Annual Injury Prevention Professionals Symposium is on April 28 - 30, 2019 at the Luxor Hotel and Casino. You can register for the symposium as a pre-conference to TCAA's conference.
- Prevent Child Abuse Nevada Safety Conference will be held on June 6th at the Henderson Convention center in Henderson, NV

H. Report from Legislative/Advocacy Representative

No report

I. Report from Public Relations/Media Representative

Ms. Cohen stated there were no items to report.

J. Report from Payer of Medical Benefits

Ms. Taylor stated there were no items to report.

K. Report from System Finance/Funding

No report

VI. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public, if any, and discussions of those comments, about matters relevant to the Committee's jurisdiction will be held. No action may be taken upon a matter raised under this item of this Agenda until the matter itself has been specifically include on an agenda as an item upon which may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Chairman Fildes asked if anyone wished to address the Board.

Seeing no one, he closed the Public Comment portion of the meeting.

VII. ADJOURNMENT

There being no further business to come before the Board, Chairman Fildes adjourned the meeting at 2:49 p.m.