



MINUTES

SOUTHERN NEVADA DISTRICT BOARD OF HEALTH MEETING

September 24, 2026 – 9:00 a.m.

Meeting was conducted In-person and via Microsoft Teams

Southern Nevada Health District, 280 S. Decatur Boulevard, Las Vegas, NV 89107
Red Rock Trail Rooms A and B

MEMBERS PRESENT: Scott Black, Chair – Mayor Pro Tem, City of North Las Vegas (*in-person*)
Frank Nemec, Vice-Chair – At-Large Member, Physician (*in-person*)
Nancy Brune, Secretary – Council Member, City of Las Vegas (*via Teams*)
April Becker – Commissioner, Clark County (*in-person*)
Bobbette Bond – At-Large Member, Regulated Business/Industry (*via Teams*)
Pattie Gallo – Mayor Pro Tem, City of Mesquite (*via Teams*)
Joseph Hardy – Mayor, City of Boulder City (*in-person*)
Monica Larson – Council Member, City of Henderson (*via Teams*)
Scott Nielson – At-Large Member, Gaming (*in-person*)
Shondra Summers-Armstrong – Council Member, City of Las Vegas (*via Teams*)

ABSENT: Marilyn Kirkpatrick – Commissioner, Clark County

ALSO PRESENT: Linda Anderson, Nicole Baumgartner, Christopher Boyd, Chase Cates, Deb
(In Audience) Dort, Sean Dort, Maya Holmes, Deborah Kuhls, Donna Laffey, Andrew Leavitt,
Dennis Neuhausel, Andrew Pastwick, Cameron Pfand, Janice Phillips, Jasmin
Valdivieso Sanches, Paul Williams

EXECUTIVE SECRETARY: Cassius Lockett, PhD, MS, District Health Officer

LEGAL COUNSEL: Heather Anderson-Fintak, General Counsel

STAFF: Kevin Abbott, Emily Anelli, Tawana Bellamy, Cory Burgess, Daniel Burns,
Victoria Burris, Nancy Cadena, Andy Chaney, Andria Cordovez Mulet,
Rebecca Cruz-Nanez, Liliana Davalos, Brandon Delise, John DeWolff, Aaron
DelCotto, Amanda DiGoregorio, Lauran DiPrete, Lisa Falkner, Kimberly
Franich, Monica Galaviz, Sarah George, Tamara Giannini, Tina Gilliam, Xavier
Gonzales, Jacques Graham, John Hammond, Heather Hanoff, Maria Harris,
Raychel Holbert, Carmen Hua, Dan Isler, Jessica Johnson, Rabea Johnson,
Rebecca Johnson, Stacy Johnson, Christina Joshua, Horng-Yuan Kan, Bob
Kingston, Nami Kremer, Theresa Ladd, Annie Lin, Josie Llorico, Randolph
Lockett, Sandy Lockett, Cassondra Major, Blanca Martinez, Roni Mauro, Alicia
Mitchell, Kimberly Monahan, Corey Morrison, Brian Northam, Veralynn
Orewyler, Laura Palmer, Kyle Parkson, Neleida Pelaez, Kaylina Penksa, Luann
Province, Katarina Pulver, Yin Jie Qin, Emma Rodriguez, Alexis Romero,
Francisco Ruelas, Chris Saxton, Dave Sheehan, Jennifer Sizemore, Bruno
Stephani, Erik Sumera, Ronique Tatum-Penegar, Candyce Taylor, Will
Thompson, Rebecca Topol, Greg Tordjman, Renee Trujillo, Carlos Vargas,
Donnie Whitaker, Tiana Wright, Edward Wynder, Lourdes Yapjoco, Lei Zhang

I. CALL TO ORDER and ROLL CALL

The Chair called the Southern Nevada District Board of Health Meeting to order at 9:03 a.m. Andria Cordovez Mulet, Executive Assistant, administered the roll call and confirmed quorum.

II. PLEDGE OF ALLEGIANCE

III. OATH OF OFFICE

Ms. Cordovez Mulet administered the Oath of Office to Secretary Brune.

IV. RECOGNITIONS

1. CARE Coalition – Embracing Life as Women

- Katarina Pulver

The Chair recognized the Katarina Pulver, Health Educator in the Office of Disease Surveillance, for receiving an award from the CARE Coalition in recognition of her outstanding contributions and achievements toward education around opioids and other substances, along with programming and training to help ensure a healthier, safer Southern Nevada. On behalf of the Board of Health, the Chair congratulated staff on these well-deserved awards.

Member Nielson joined the meeting at 9:08 a.m.

2. Southern Nevada Health District – August Employee of the Month

- Erik Sumera

The Chair recognized the August Employee of the Month. The Health District, and the Board of Health, recognize employees that are nominated by their colleagues for going above and beyond for the Health District and our community, and best represented the Health District's C.A.R.E.S. Values. On behalf of the Board of Health, the Chair congratulated the employee on this recognition.

3. Southern Nevada Health District – September Employees of the Month

- Monica Galaviz and Randy Lockett

The Chair recognized the September Employees of the Month. The Health District, and the Board of Health, recognize employees that are nominated by their colleagues for going above and beyond for the Health District and our community, and best represented the Health District's C.A.R.E.S. Values. On behalf of the Board of Health, the Chair congratulated the employee on this recognition.

V. FIRST PUBLIC COMMENT: A period devoted to comments by the general public about those items appearing on the agenda. Comments will be limited to two (2) minutes per speaker. Please clearly state your name and address and spell your last name for the record. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

Seeing no one, the Chair closed the First Public Comment period.

VI. ADOPTION OF THE SEPTEMBER 24, 2026 MEETING AGENDA *(for possible action)*

A motion was made by Member Nielson, seconded by Member Nemec, and carried unanimously to approve the September 24, 2026 Agenda, as presented.

VII. CONSENT AGENDA: Items for action to be considered by the Southern Nevada District Board of Health which may be enacted by one motion. Any item may be discussed separately per Board Member request before action. Any exceptions to the Consent Agenda must be stated prior to approval.

- 1. APPROVE MINUTES/BOARD OF HEALTH MEETING:** August 27, 2026 *(for possible action)*
- 2. PETITION #04-27: CCOCME Approval of the Amendment A01 to the Interlocal Agreement between the Southern Nevada Health District and the Clark County Office of the Coroner/Medical Examiner (CCOCME) to collaborate on the abstraction of sudden unexpected infant death (SUID)/sudden death in the young (SDY) data and improve SDY data on febrile seizures and priority fields for entry into the National Fatality Review Case Reporting System (NFR-CRS);** direct staff accordingly or take other action as deemed necessary *(for possible action)*

A motion was made by Member Hardy, seconded by Member Nielson, and carried unanimously to approve the September 24, 2026 Consent Agenda, as presented.

VIII. PUBLIC HEARING / ACTION: Members of the public are allowed to speak on Public Hearing / 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 public hearing is closed, no additional public comment will be accepted.

- 1. Variance Request for an Existing Septic System, SNHD Permit #ON0007752, located at 3114 Sorrel St., Las Vegas, NV 89146 to allow existing trees to encroach on the septic system;** direct staff accordingly or take other action as deemed necessary *(for possible action)*

Dan Isler, Environmental Health Engineer Supervisor, presented a variance request for a tenant improvement project at 3114 Sorrel St., Las Vegas, NV 89146. The variance was requested to allow trees located within 10 feet of the septic tank and leach field to remain in place as part of a proposed detached garage project. Mr. Isler noted that the trees were planted prior to the current owner's purchase of the property and that the petitioner reported previous leach field issues that resulted in an unpermitted extension. Mr. Isler further noted that public sewer service is available nearby and that the property may qualify for a septic-to-sewer conversion reimbursement program. Based on the proximity of sewer service, the property's history of septic system issues, and the location of the trees, staff recommended

denial of the variance. However, Mr. Isler also outlined recommended conditions should the Board choose to approve the request.

Member Summers-Armstrong joined the meeting at 9:14 a.m.

Nicole Baumgartner, the petitioner, requested approval of the variance, stating that she was unaware a permit was required for the leach field work completed after purchasing the home. She explained that addressing septic system issues was a significant undertaking at the time and requested the Board's support to allow her to continue the permitting process for a proposed detached garage.

The Chair opened for Public Comment. Seeing no one, the Chair closed the Public Comment.

Member Nielson expressed concern regarding the failed and expanded unpermitted septic system and noted the property's proximity to a municipal sewer connection. He asked whether financial assistance programs were available to support a sewer connection.

Mr. Isler advised that the Southern Nevada Water Authority (SNWA) Septic-to-Sewer Conversion Program may cover up to 85% of eligible costs, up to \$40,000, and stated that the petitioner may qualify for assistance depending on the project's final scope and application status.

Chair Black encouraged the petitioner to explore the SNWA program, noting that the property's location within 30 feet of an available sewer connection made it an ideal candidate for septic-to-sewer conversion. He offered assistance in connecting the petitioner with SNWA representatives to better understand the costs, timeline, and available financial assistance.

Ms. Baumgartner stated that she had not completed the SNWA application process because she was unfamiliar with the required steps and was handling the matter on her own. She expressed appreciation for the guidance and assistance offered.

Member Hardy, Member Larson, and Member Summers-Armstrong agreed that additional information regarding the sewer connection option was needed before the Board could make an informed decision and supported allowing the petitioner additional time to work with SNWA.

Chair Black proposed postponing the matter for 30 days to allow the petitioner to fully evaluate the sewer connection option. He stated that if the option proved feasible, it could resolve the issue without further Board action; otherwise, the petitioner could return to the Board for further consideration. The petitioner agreed with the proposed approach.

Ms. Anderson-Fintak advised that the matter could be formally postponed and reheard at the October Board meeting.

A motion was made by Member Nielson, seconded by Member Nemec, and carried unanimously that the Variance Request for an Existing Septic System, SNHD Permit #ON0007752, located at 3114 Sorrel St., Las Vegas, NV 89146 to allow existing trees to encroach on the septic system, be continued until a future Board of Health meeting.

2. Variance Request for an Existing Septic System located at APN 129-36-11-108 to serve a single-family residence on the adjacent lot at 4770 Knotty Pine Way, Las Vegas, NV 89124; direct staff accordingly or take other action as deemed necessary (*for possible action*)

Mr. Isler presented a variance request for an existing septic system located at APN 129-36-11-108 to serve a single-family residence on the adjacent lot at 4770 Knotty Pine Way, Las Vegas, NV 89124. Mr. Isler advised that the variance request was for two adjacent properties on Mount Charleston owned by the petitioner. A residence is located on one parcel, while most of the septic system, including the leach field, is located on the adjacent parcel. Applicant's previous efforts with the Clark County Assessor's Office to reconfigure the parcel lines were not approved due to concerns about creating irregular lot shapes. Mr. Isler advised that staff recommended denial of the variance because the existing arrangement could create future property and public health concerns if the parcels were sold separately, as the undeveloped parcel contains the septic system serving the residence. Mr. Isler indicated that staff suggested either combining the parcels into a single lot or relocating the septic system so that it is located on the same parcel as the residence. Mr. Isler further advised that should the Board choose to approve the variance, staff recommended conditions including recording reciprocal easements for the septic system within one year, recording an amended final map within one year, complying with maintenance and operation requirements, and connecting to a sewer system if service becomes available in the future.

The petitioner was not in attendance.

The Chair opened for Public Comment.

Mr. Andrew Leavitt, representing prospective buyer Janice Phillips, spoke in support of the variance request. He stated that the residence, septic system, and leach field configuration had existed since the original permit was approved in 1984 and that no physical changes are being proposed. He argued that the system has operated in its current location for decades without issue and should be considered a legal existing condition. Mr. Leavitt noted his understanding that a related plot plan had already received county approval and emphasized that the request was intended to preserve the existing arrangement. He further stated that his client had no objection to staff's recommended conditions, including recording reciprocal easements for the septic system across both parcels. He asserted that such easements would address concerns regarding future property ownership and disclosure to potential buyers, and he requested that the Board approve the variance.

Seeing no one further, the Chair closed the Public Comment.

Member Hardy sought clarification on what was being sold and expressed concerns about future ownership conflicts involving the septic system and leach field. Mr. Leavitt explained that the cabin parcel was being sold, while the septic system and leach field encroached onto the adjacent parcel. The sales contract has been in litigation for several years. His client seeks to enforce the purchase of the parcel with the residence, and it is his understanding that the petitioner/current owner will maintain the parcel with the septic system. He stated that a recorded reciprocal easement would permanently address access, maintenance, and ownership concerns for future property owners. Ms. Phillips noted that both the septic system and part of the cabin currently extend onto the adjacent parcel and referenced prior efforts to redraw the property boundaries. Member Nielson raised concerns that retaining the

vacant parcel could create future development challenges due to the location of the septic system.

Chair Black and Mr. Isler discussed whether the remaining smaller parcel could still support future development, with Mr. Isler noting that additional site-specific information would be needed to make that determination.

Member Summers-Armstrong questioned whether the existing septic system had sufficient capacity for future development and later expressed concerns about potential legal and regulatory implications of approving the variance. Mr. Isler stated that future use of the septic system for another structure had not been contemplated and would require separate consideration.

Member Becker emphasized that the variance request was limited to allowing the existing situation to continue through a parcel map adjustment and that future buyers would be responsible for conducting their own due diligence regarding development potential and utility service. The Board members discussed the importance of a properly drafted and recorded reciprocal easement to ensure continued access, operation, maintenance, and repair of the septic system. Member Brune, Member Bond, and Member Nielson stressed the need for clear easement language that would remain effective through future ownership transfers. Member Hardy continued to express concerns that future disputes could arise between separate property owners despite the easement.

At the Board's request, Ms. Anderson-Fintak advised that approval of the variance, together with appropriate easement conditions and disclosure requirements, would likely not expose the Health District to significant legal liability, although future disputes between property owners could still occur.

*A motion was made by Member Becker, seconded by Member Nielson, and **failed** by a vote of 4-6 to approve the Variance Request for an existing septic system located at APN 129-36-11-108 to serve a single-family residence on the adjacent lot at 4770 Knotty Pine Way, Las Vegas, NV 89124.*

AYES

-
1. Becker
 2. Black
 3. Nemec
 4. Nielson

NAYS

-
1. Bond
 2. Brune
 3. Gallo
 4. Hardy
 5. Larson
 6. Summers-Armstrong

IX. REPORT / DISCUSSION / ACTION

There were no items heard.

- X. **BOARD REPORTS:** The Southern Nevada District Board of Health members may identify and comment on Health District related issues. Comments made by individual Board members during this portion of the agenda will not be acted upon by the Southern Nevada District Board of Health unless that subject is on the agenda and scheduled for action. **(Information Only)**

There were no items raised.

XI. **HEALTH OFFICER & STAFF REPORTS (Information Only)**

- DHO Comments

In addition to his written report, Dr. Lockett advised that two new physicians have joined the Health District in the Southern Nevada Community Health Center (SNCHC): Dr. Amanda Koziel, who joined in July and has interests in integrated primary care and HIV care, and Dr. Karina Luera, a board-certified family medicine physician and Las Vegas native who joined in September.

Dr. Lockett advised that SNCHC was awarded a highly competitive HRSA New Access Point Grant totaling \$650,000 annually to support the establishment of a third clinic location. Site selection is underway, with operations required to begin by December 10. The new clinic is expected to serve approximately 2,560 patients annually through primary care and mental health services, with grant funding supporting staffing, facility costs, equipment, supplies, and related startup expenses.

The Board was informed of the Health District reported the first influenza-related death of the 2026-2027 season, involving an individual with underlying health conditions. Dr. Lockett took the opportunity to emphasize the importance of seasonal influenza and COVID-19 vaccinations, noting that the updated influenza vaccine includes enhanced protection against a strain that was widespread during the previous season.

Dr. Lockett advised that, as of September 23, the Health District was conducting active Ebola symptom monitoring of 13 travelers returning from Uganda, while 50 additional travelers had completed monitoring. Dr. Lockett reported that the Southern Nevada Public Health Laboratory has the capability to test for all strains of Ebola virus and can perform up to 20 tests per day if needed.

- Presentation on the 2025 Southern Nevada Trauma System Annual Report

Stacy Johnson, Regional Trauma Coordinator, provided an overview of the 2025 Southern Nevada Trauma System Annual Report.

[At the conclusion of this item, the Chair requested that the presentation and discussion be captured verbatim in the Minutes.]

STACY JOHNSON

Good morning. I am Stacy Johnson, Regional Trauma Coordinator here at SNHD Office of EMS and Trauma. Today I'm going to give you an overview of our 2025 Annual Trauma Report, but rather than going through every data point, I want to focus on what the data tells us about our overall performance and the readiness of our trauma system. I'll highlight the major trends, and the important change and how we collected the data in 2025, and what we need to do,

continue watching as Southern Nevada grows. The full annual report, as all of our previous reports are also available on our website.

When we hear the word “trauma,” most of us just think about an ambulance taking an injured patient to a trauma center. But it is so much more than that, as you can see up here on the screen. It includes injury prevention, our EMS system, the hospital care, our rehabilitation centers, and the ongoing performance improvement. All of these pieces work together to make sure our patients receive the right care, at the right time, and at the right level of care.

Trauma is unique because it happens without warning. Someone can be completely healthy one minute and critically injured the next. The trauma system exists to make sure that when that happens, our EMS system and our hospitals are prepared to move that patient quickly to the resources they need. In 2025, more than 12,600 patients entered the Southern Nevada Trauma System through our EMS providers after meeting Trauma Field Triage Criteria. That gives us just a sense of how frequently our system is being used.

One important point to remember about our trauma centers is that higher trauma designation does not necessarily mean better care. The levels described in resource describes the resources and capabilities that are immediately available to treat our increasingly complex traumatic injuries. Our system depends on having different levels of trauma care working together. The goal is not for every patient to go to the highest-level trauma center. The goal is for each patient to reach the trauma center that is equipped for their injuries in the most timely manner.

A little bit about our data before we get into the numbers specifically is a really important distinction between the two data resources that we utilize. We use two primary sources, our state trauma registry and our TFTC data. The state trauma registry follows national trauma database criteria and captures patients who meet very specific criteria, that requires the patient to be admitted into the hospital for at least 24 hours to either get transferred out due to their injuries or die due to their injuries. This dataset does not include any patient that is discharged from the emergency room. So, remembering that when we look at our TFTC data, it starts early in the process. This data set captures patients identified by EMS in the field that are transported to a trauma system, regardless of whether they get admitted, they get discharged, or they die. These datasets do answer different questions, and the numbers will not always be the same. Neither dataset captures every patient within our system, and the distinction becomes particularly important when we look at our data trends.

A little bit of background about 2025. We did have an important year. Previously, our trauma field triage information was captured by our trauma centers, sent to our office, and then compiled into a report. In 2025, it was a long time coming. The trauma centers were asking for it for many years. Our office was able to take over extracting that data out of our EMS electronic patient reports, following their review and sending it back to us. This now gives us one standard source and one standard process to capture our data. So as we collect additional years using this method, we will have a much stronger foundation for identifying the trends over time.

I’m looking first at population growth. This is a big one that we look at when we’re analyzing our trauma data. So between 2021 and 2025, Clark County added approximately 140,000 residents, which represents about a 6% growth. This growing population means more traffic, more construction, more recreational activity, and ultimately more demand in our emergency

rooms and our trauma system. This is why we look at where the trauma incidences are actually occurring.

So, taking a look outside of that population and look at where is trauma occurring geographically, an interesting picture emerges. So the southwest area was the only area showing growth in TFTC incidents compared with 2021. The Metro, the Southeast, Northwest, and Southwest areas all showed a decrease over that same period. So, while Southern Nevada is growing overall, trauma growth isn't occurring uniformly across the region. That is really important for system planning. We need to look at the actual trauma volumes as well as geographic access, and available resources, not just the population alone.

So, putting that all together, one of the easiest ways to put this into perspective is that in 2025, with more than 12,600 patients entered the trauma system through EMS, that's approximately one patient every 42 minutes. That means every hour of every day, EMS providers, emergency rooms, trauma teams, ORs, blood banks, and critical care resources must be ready. And again, this represents patients entering through the EMS system. It does not represent every patient that's treated in our region.

So, what causes their injuries? We need to look at mechanisms so that we can know where to put our prevention efforts. Falls accounted for 61% of all traumatic injuries, according to our state trauma registry data. Motor vehicle crashes came in second at 15.1%, and other leading mechanisms included struck by or against, cutting or piercing injuries, or firearm injuries. This pattern helps our trauma centers look at injury prevention. It helps us determine what our EMS education should be, our hospital preparedness, and our future system planning.

So, a little bit about how EMS identifies a trauma patient and how they get them to a trauma center. So, as you guys have probably heard before, we have our red and our yellow criteria. So red criteria identifies patients with the most serious signs of injury. Examples are active bleeding, difficulty breathing, just to name a few of those. Our yellow mechanism criteria identifies high-risk events where the mechanism is what they're looking at. That mechanism raises concerns, such as motor vehicle crashes, auto pedestrians auto versus bicycles, things like that. And then our last category is our yellow judgment. This is where EMS providers use their clinical assessment skills when they're looking at the patient to identify significant injury that may not be immediately obvious. Patients that fall into this criteria are high alerts for order adults, our children, our pregnant patients, and our patients taking blood thinners. In 2025, a little over 2,200 patients met red criteria, as you can see on the slide. Over 2,800 met our yellow mechanism criteria, and our largest group at over 7,500 fell into that yellow clinical judgment.

So, this is the same, here we're seeing the same data that we did on the last slide. This is just our five-year trend. Our annual report looks at a trend of five years. So, this number equates to approximately 35 patients every day or 1-2 patients every hour.

We also, an important key that we look at is our EMS transport times. We need to know how quickly our patients are getting from the scene to our designated trauma centers. So in 2025, our median transport time was approximately 16 minutes, and over the last five years, that trend you see up there, the number has remained remarkably consistent, ranging from 15.7-16.6 minutes. So, despite our continued population growth, we're not seeing evidence in this measure of worsening access or increasing transport times.

But transport time is more than just a transportation measure. Care begins at the scene. So EMS assesses the patient, determines the appropriate destination, and communicates with the receiving hospital, and begins care before the patient ever makes it to the trauma center. And meanwhile, that trauma center is preparing their appropriate team before the patient even arrives. The goal is simple: get the right patient to the right trauma center as quickly as possible.

So, breaking this down a little bit into our four different trauma centers of where did the patients receive their care. Our designated trauma centers play an important role in maintaining our regional access and readiness. UMC continues to receive the highest volume of our EMS identified trauma patients or TFTC. Sunrise, St Rose Siena and Michael O'Callahan each contribute to that regional system and provide important geographic access to trauma care. The numbers on this slide also illustrate why it's important with those two datasets that we already discussed. So, the blue bar up there is our Trauma Field Triage Criteria, and the red bar is the National Trauma Data Bank and the state criteria. So, both datasets are valid, they simply just answer different questions.

So, what is happening after our patients arrive at a trauma center? That level of care is going to depend on the severity of their injury. And in 2025, 59% of the patients were ultimately discharged from the emergency room. Others required hospitalization, going to the ICU, the OR, or they were transferred to a higher level of care. The important point is that discharge does not mean the patient didn't meet trauma care. Every patient requires evaluation, treatment, and clinical decision-making before a safe disposition can be determined. Deaths also occur on scene without transfer to the hospital, don't get included into this dataset but they are reviewed quarterly by our Trauma Medical Audit Committee. The 2025 committee reviewed, they did not identify any concerns related to our out-of-hospital trauma deaths.

We also include our non-trauma hospitals as part of our trauma support system. Some injured patients will initially arrive at non-trauma centers either by not utilizing EMS or not being recognized as meeting trauma field triage criteria in the field. In 2025, we had 1,192 patients that required transfer from a non-trauma hospital into a designated trauma center. This number does include transfers that occurred from out-of-state as well. These hospitals provide an important first step by evaluating and stabilizing our patients and then coordinating the transfer to a higher level of care.

So, looking ahead, our focus is on maintaining a trauma system that can meet the needs of a growing Southern Nevada. We will continue monitoring trauma volumes and where injuries are occurring, along with EMS transport times, our geographic access, our trauma center capacity, and the quality of our data. It is important to recognize that trauma system expansion is not something that happens quickly. Changes require planning, regulatory review, hospital investment, staffing, and infrastructure. Our responsibility is to continue evaluating the system today so that we're prepared for the needs of the community tomorrow.

So, in summary, there are four things I'd like the Board to take away from this report. First, more than 12,600 patients entered our trauma system through EMS. Second, our access does remain stable, with our median EMS transport times being about 16 minutes. Third, we have a way of collecting our TFTC data that has improved significantly in 2025, giving us a more standardized foundation for future trended data. And finally, Southern Nevada continues to grow. So, ongoing monitoring and long-term trauma system planning remains important. But most importantly, every number in this report represents a person who needed our trauma

system to be ready when they needed it. Our goal is to make sure the system remains ready, accessible, and sustainable for Southern Nevada. When someone experiences the worst day of their life, we want to remain ready. Thank you for your continued support and leadership, and I'm happy to answer any questions. I also have members from our epidemiology department, as well as the OEMSTS supervisor with me.

CHAIR BLACK

Thank you for sharing your presentation with us this morning. What I'll do is, I'll start with our Board members online and we'll just go, you know, did anyone raise their hand first? Who's first?

ANDRIA CORDOVEZ MULET

No one has their hand.

CHAIR BLACK

No one? Okay, who?

MEMBER LARSON

I would like, I have a couple questions. I didn't press it. Sorry. This is Dr. Monica Larson.

CHAIR BLACK

Yes, yes, Councilwoman Larson, thank you. Go ahead.

MEMBER LARSON

Thank you. I have a few questions. So, are we planning for tomorrow's trauma needs or only measuring today's utilization? Because the report acknowledged, you know, that we added approximately 140,000 residents from 2021 to 2025. That population growth is a strong predictor of future emergency and trauma demand and that trauma center expansion takes years of planning. I understand that. But when evaluating, as I presented last time about Siena's Level II application, how is the Health District accounting for projected population growth in the years required to develop Level II capacity rather than relying primarily on current utilization?

CHAIR BLACK

Future planning projections, what are we doing to stay ahead of this as needed?

STACY JOHNSON

Well, RTAB and TMAC do look at this data on a quarterly basis. If they identify any trends that they find are out of norm, increasing, or that they're concerned about, they push that forward and have us do additional data analysis and tools or possibly work groups or whatever the RTAB and TMAC recommend.

MEMBER LARSON

For now, yes, I have a couple other questions. So, does the regional median transport time tell us enough about Henderson residents? Because the presentation did address approximately 16 minutes or so. But I wanted to, what are the transport time specifically for patients originating in Henderson in the Southwest Valley who require Level I or Level II care, particularly the most seriously injured red criteria patients.

STACY JOHNSON

Those are definitely numbers that I believe our Epidemiology Department would be able to pull out of the data that we have. So, we could take the patient specifically going to Siena and track those times if that was needed.

MEMBER LARSON

Yeah, because for a time-sensitive trauma patient, I believe we should examine the community-specific data, not simply valley-wide.

STACY JOHNSON

And we can break those numbers down into specific areas if we need to, absolutely.

DR. CASSIUS LOCKETT

Yeah, we'll perform those analysis. Our Epidemiology team can do that. And then we will send that out to the Board.

MEMBER LARSON

Okay. Thank you. I have three more if that's okay. What does, what does Siena's existing trauma volume tell us about its role in the system? Because, in particular, Siena has already designated a Level III trauma center, and the report states that it continues providing trauma services for the Southeast Valley while maintaining consistent patient volume. The report also defines Level II as providing initial and definitive care for severely injured patients and says that in population dense areas, Level II centers should supplement Level I clinical activity and expertise. But given Siena's established role, patient volume, infrastructure and location, what specific system Level evidence demonstrates that allowing it to pursue Level II designation would adversely affect the trauma system?

STACY JOHNSON

That is not data that we have here today for this conversation as far as the annual report. The annual report does break down a trauma or Siena specific volume, but the data that you're asking for, that is not stuff anything that we have prepared for today.

MEMBER LARSON

Okay.

CHAIR BLACK

If I may, Councilwoman Larson and also all the Board members, I just want to remind you or let you know if you're not aware, in anticipation of this presentation today, this presentation, I believe, is intended to kind of just give us a synopsis, an overview. We have the detailed report at our disposal to read through. And our intention is to encourage each Board member to familiarize themselves with the report. And then there will be a briefing, a briefing schedule put out after this meeting for three time points that our staff will make themselves available for Board members to sign up so we can truly take this deep dive that you're speaking to, you know, you represent Henderson, I represent North Las Vegas. We have a collective trauma system that needs to meet the demands of our entire growing community. However, we'll have this opportunity for each Board member that wants to really dig in on Trauma 101 with the staff, with experts here at the District will have that. So those dates will be put out, but I'll just let you know right now that there will be on October 12th, October 16th, and October 20th. Those are the time points that you'll be able to really, really take. We're going to each do our homework to the level that you need to, to have a, because this is critically important to

our community that we have a sound understanding as a Board so we can make good policy decisions moving forward to meet the needs of our community, as was stated, the right patient, you know, right trauma center, and the, you know, in as quickly as possible. I just want to interject that so all the Board members can know what's coming. We're not going to be able to solve and answer every question today because of the data that, the information that's available for this presentation. But please prepare yourselves and I encourage every Board member to sign up for one of these briefings. Okay, sorry.

MEMBER LARSON

And I appreciate, I appreciate that, Chair Black. I definitely, because this is very important. And so I just want to make sure that that data is reflective for all.

CHAIR BLACK

Yes, yep. And I, okay, yeah, so I just wanted to let the Board members know that this, we're receiving this presentation today in connection with the release of the 2025 trauma report. We need to all familiarize ourselves with it, participate, really be up to speed as Board members so we can make the absolute best decisions moving forward. Okay. So enough about me, let's talk about trauma. Any other comments or questions online before we go to those that are in the room today? Oh, Bobbette, yes, go ahead. Thank you.

MEMBER BOND

Thank you. Am I off mute? Can you hear me?

CHAIR BLACK

Yes, we can hear you. Yes, thank you.

MEMBER BOND

Okay, great. Thanks for the time. Yeah, I think this is so complicated because, I'm appreciate Councilwoman, Miss Monica asking for details about the area. I think some of the things that are going on in the community are statements that aren't necessarily true. So, it would be good to have a little more drill down on that on the data, but it is hard to ask for that in this meeting. So, I have a couple of issues that I'd like to see us drill down on very similar to what Councilwoman Larson just did. But I think it would be great if we had a day when you need all the questions to you so that the presentations that are giving us and training that's going to be given to us, they have time to pull that data. Otherwise, I think we're going to, none of us are going to feel like our answers are getting questions. Our answers are, our questions are getting answered.

CHAIR BLACK

I think that's a really great point, Bobbette. I think we'll be able to achieve that with these briefings initially, so we can have some really meaningful conversations. But the point you just made is to pre-submit through Andria what questions and data you would like to see so our staff can be fully prepared for your specific briefing or anybody's briefing. So I think we have a mechanism in place to do that, because it is very important.

MEMBER BOND

Okay, and so my other comments are, I think the presentation was helpful. I think that focusing on population growth has been a discussion point in the community for a long, long time. And it's interesting that the Trauma Department is leading with that when you finally get to another slide showing that there isn't a growth, right? So, in trauma cases. So, I think that

we should have a conversation about where is trauma cases itself, what you should be paying attention to, because population can grow. But if trauma isn't growing with it, I think that it's a different conversation we should be having, right? Populations increase 6%. But those same years, several years, trauma cases have decreased. And you can see on that next slide that there's only one, there's only one area of town where the growth is even 6% and everywhere else it's gone down on trauma cases. So, I want that to be a piece that we look at. I think there's also this longstanding issue of what's now called the yellow judgment. The trauma centers are lined up the way that was told today, like Level I, Level II, Level III centers, but the patients are lined up on a slightly different scale, which used to be step 1, step 2, step 3, step 4. I'm not sure why those were collapsed. But I think what would be helpful to us and everything that Councilwoman Larson has said in my presence is to understand those hard, you know, those cases that really, really have to go to a trauma center. And so, I would like us to pull out the judgment yellow because it's way more than 50% of the cases and very few of the actual hospitalizations. And if we're going to have conversations about who's not getting to a trauma center in time, and this is somebody dying, you know, on a gurney not able to get to trauma, that's not in those yellow cases. And so, I think we're polluting the data a little bit. So, I'd like us to, if possible, pull that out and then look at the cases that are more relevant to the conversations we've been hearing. Not to say we shouldn't be planning for the future. I think that's really important. The last thing I want to just get in front of you is these transfers. I can't tell when there's a transfer, if the transfer is going from an existing hospital or an existing trauma center or an existing freestanding ER. I really would like us to be able to see if there's, in that in that transfer data, is someone going to Dignity and then getting transferred to Sunrise and it's not and it didn't go well? Are there cases where the patient couldn't get there? What is the barrier that we're hearing about it? I would really like to understand who's leaving one trauma center and going to another trauma center and why. Because that shouldn't be happening at all, really, right, if possible. So, it clarifies the conversation about why that would happen, because the criteria is being triggered at when the patient gets in the ambulance. So, they should go to the right place. So that's it. And then finally, it would be awesome if you guys would include in their reports, how many bays these hospitals have to take care of trauma patients. I know UMC has 12 bays to take care of patients, so they just don't run out of capacity. But I don't know how many are at Sienna and I don't know how many are at Sunrise and I don't know how many are at O'Callahan and that might be easily available, but I think it would help us think. And making sure if patients are going to freestanding ERs for trauma, we know that and where they're going and what happens to them next. So, a lot, but I'll try to distill it into a set of questions so you have enough time to look at the data.

CHAIR BLACK

Thank you so much, Ms. Bond. And I'm hopeful that you're, because that was a great deal of questions. I mean, if this team here wants to try to address...

MEMBER BOND

No...

CHAIR BLACK

...them now. Are you okay for us to capture, your okay...

MEMBER BOND

Yes.

CHAIR BLACK

Because that's what my anticipation was, but I don't want to, you know, speak for you. I think if we can capture what she said and be prepared for that so when those briefings occur, you'll be able to speak to those points.

STACY JOHNSON

Yeah, that's great.

CHAIR BLACK

Okay, excellent. Thank you, Bobette.

MEMBER BOND

Yeah, and there might be more. So we do want a date when we should get our proposals to you. So thank you.

CHAIR BLACK

Certainly. Councilwoman Summers Armstrong.

MEMBER SUMMERS-ARMSTRONG

Thank you, Chair Black. I would like that things that have been raised today by both Councilwoman Larson and Bobbette, Member Bobbette, are part of our briefings. So everything that's been asked for, that it is prepared with answers, the data to be presented regardless of which day a member attends the briefings and that when we have questions, whatever day you have them in there to be submitted, that all those questions and the data that is requested are shared across all three briefings. That's it.

CHAIR BLACK

That's an excellent suggestion and we'll make certain that it's comprehensive in nature. So we all know what everyone's questions are and we all have that same information. So we're well informed as board members and policy makers. Thank you. Any other comments online before I go to our members here in the Red Rock conference room? Don't see any. All right, who wants? Mayor Hardy.

MEMBER HARDY

This is a great day. I find myself agreeing with Bobbette Bond.

MEMBER BOND

Oh, twice.

MEMBER HARDY

Wow, I feel better already. So, looking at the transfers from two to one, three to one, burns to UMC, the grade of care, the success of care, all of those things I think are wrapped up in what we're trying to do with trauma centers and, you know, what are we using and how are we using it. So, I think I look forward to the briefings and I think we'll be able to get some of those answers and be able to make decisions that are based on reality. So, thank you.

CHAIR BLACK

Thank you, Mayor Hardy. Anyone else in the room? All right. I'll circle back one more time to the Board members online. Otherwise, really thankful for your presentation today. We look forward to the dialogue that we'll have in these briefings over the next couple of weeks, and

that will give us the basis for continuing to navigate the important matters that are before us regarding our trauma system. So, thank you so much. Really appreciate you.

I think one thing I would add, and you're good, but I just want to say to our team here, since we talked about, we had a nice two-way dialogue with our Board members. Stacy laid out a great presentation from her slides and articulated very well in her words. So, I would ask that the staff capture that presentation and the questions from the Board and the back and forth verbatim word for word for the minutes and also for us to have, just as so we don't lose anything in translation as we move forward to the briefing. So, can we do that, Dr. Lockett?

DR. CASSIUS LOCKETT

We will take care of that.

CHAIR BLACK

Okay, thank you, sir, very much.

XII. INFORMATIONAL ITEMS

1. Administration Division Monthly Activity Report
2. Community Health Division Monthly Activity Report
3. Community Health Center (FQHC) Division Monthly Report
4. Disease Surveillance and Control Division Monthly Activity Report
5. Environmental Health Division Monthly Activity Report
6. Public Health & Preventive Care Division Monthly Activity Report

XIII. SECOND PUBLIC COMMENT: A period devoted to comments by the general public, if any, and discussion of those comments, about matters relevant to the Board's jurisdiction will be held. Comments will be limited to two (2) minutes per speaker. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chair or the Board by majority vote.

Dr. Sean Dort, Trauma Medical Director at St. Rose Siena, long-standing member of the RTAB, and State Chair of the American College of Surgeons Committee on Trauma, emphasized the importance of the trauma discussion. He recognized the significant effort involved in collecting and maintaining trauma system data, noting that thousands of patient records are carefully tracked and validated each year, and commended the teams responsible for preparing the 2025 Southern Nevada Trauma System Annual Report. Dr. Dort stated that the system is strong, performs well nationally, and is highly valued by participating hospitals and providers. He stressed the importance of proactive planning and preparedness to meet future trauma care needs, noting that building system capacity takes years. Dr. Dort emphasized that protecting public safety and ensuring high-quality trauma care should remain the top priority. He advocated for thoughtful, collaborative growth that strengthens the system without creating unnecessary financial burdens, while preserving the integrity of the trauma system and the Board's decision-making authority.

Jasmin Valdivieso Sanches, Strategies 360, inquired whether a recording of the meeting would be made available.

Seeing no one further, the Chair closed the Second Public Comment portion.

XIV. ADJOURNMENT

The Chair adjourned the meeting at 10:54 a.m.

Cassius Lockett, PhD, MS
District Health Officer/Executive Secretary
/acm

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