Southern Nevada Health District

MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

DIVISION OF COMMUNITY HEALTH

TRAUMA NEEDS ASSESSMENT TASKFORCE (TNAT)

March 21, 2017 - 2:30 P.M.

MEMBERS PRESENT

John Fildes, MD, Chairman, UMC
Chris Fisher, MD, Sunrise Hospital
Sean Dort, MD, St. Rose Siena Hospital
Sajit Pullarkat, Centennial Hills Hospital
Jason Driggars, Paramedic, EMS Provider (Private)
Jennifer Renner, RN, HCA
Shirley Breeden, Public Representative
Stephanie Miller, Southern Hills Hosp (Alt.)
Frank Simone, Paramedic, EMS Provider (Public) (via phone)
Amy Doane, Vice Chair, Sunrise Hospital
Alma Angeles, RN, Sunrise Hospital
Kim Dokken, RN, St. Rose Siena
Kim Cerasoli, RN, UMC
Gail Yedinak, UMC
Stacy Johnson, RN, Mountain View Hospital
Kelly Taylor, LVMPDEHWT
Danita Cohen, UMC
Dorita Sondereker, Sunrise Hospital (Alt.)

MEMBERS ABSENT

Adam Rudd, Southern Hills Hospital
Deborah Kuhls, MD, UMC
Daniel Llamas, Sunrise Hospital

SNHD STAFF PRESENT

John Hammond, EMSTS Manager
Michael Johnson, PhD, Dir. of Community Health
Scott Wagner, EMSTS Field Rep
Heather Anderson-Fintak, Associate Attorney
Joseph P. Iser, MD, Chief Health Officer
Christian Young, MD, EMSTS Medical Director
Lei Zhang, Public Health Informatics Scientist
Judy Tabat, Recording Secretary

PUBLIC ATTENDANCE

CALL TO ORDER – NOTICE OF POSTING

The Trauma Needs Assessment Workgroup convened in the Red Rock Trail Conference Room at the Southern Nevada Health District (SNHD), located at 280 S. Decatur Boulevard, on March 21, 2017. Chairman John Fildes called the meeting to order at 2:35 p.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law.

I. **PUBLIC COMMENT:** A period devoted to comments by the general public about those items appearing on the Agenda. Comments will be limited to five (5) minutes per speaker. Please step up to the speaker's podium, clearly state your name and address, and spell your last name for the record. If any member of the Board wishes to extend the length of a presentation, this may be done by the Chairman or the taskforce of majority vote.

Chairman Fildes asked if anyone wished to address the Committee pertaining to items listed on the Agenda. Seeing no one, he closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

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

Approve Minutes/Trauma Needs Assessment Taskforce Meeting: February 21, 2017

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

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Review/Discuss Disbanding the Work Subcommittee in Favor of having the TNAT (as a whole) Formulate the Objective Criteria Necessary to Demonstrate the "Need" for Additional Trauma Services in Southern Nevada

Ms. Doane thanked both Dr. Fildes and the Health District for their acknowledgment and response to her letter that she submitted on March 1, 2017 [Attachment A]. She added that speaking for her and on behalf of the other members of the HCA Healthcare System believes that this taskforce is working together not as healthcare systems or individual hospitals but as individuals who each work in the healthcare community in Las Vegas trying to do good work on behalf of their trauma program. She perceives that the purpose of this group is to be the workgroup for Regional Trauma Advisory Board (RTAB) and on behalf of the Health District and there is no need to further call the group any smaller. This is the workgroup per the definition of our objectives. She requested that the letter she submitted be part of the meeting minutes for the record.

Ms. Taylor disagreed and felt that the workgroup was very productive. She added that as a smaller group they had a very logical thought process, it was very objective and everyone spoke.

Ms. Renner questioned if minutes were taken at the workgroup that was held on February 8, 2017. Mr. Hammond stated that minutes were not taken but a summary of the discussion was presented as part of an agenda item at the previous TNAT.

Dr. Fildes recommended that they continue to pursue their objectives through this taskforce which might mean more frequent and longer meetings because larger numbers of people discussing larger numbers of topics takes longer amounts of time.

B. Review/Discuss Presentation of Sample Level III Business Case Analysis

Ms. Doane started off the discussion by stating that she spent a lot of time thinking about this process and looking through past meeting minutes. She stated that on a couple of occasions it was noted that they already have a successful sustainable outstanding Level III program in the community with St. Rose Siena and questioned how they can use that as a benchmark and an example of excellence going forward. She asked everyone to refer to her sample of a Level III business case analysis handout [Attachment B] and said that it wasn't formal but it highlights some of the over arching process questions and then some approach questions as well. The process shows how a hospital will bring their case forward to become a Level III trauma center to the RTAB once a checklist of criteria has been developed by this taskforce. She felt that this process places the burden and the responsibility on individual hospitals to understand their service areas and their trauma needs within those service areas. She added that the hospital review process would include population growth and density factors, trauma volume, community support, and clinical commitment in the hospital service area which would give the Health District an intimate picture of what is occurring in that local community.

Ms. Dokken replied that as a person who has been in the trauma system for over 20 years, she is used to system planning versus business planning. She said the reason St. Rose was approached by UMC to become a trauma center wasn't a business plan, it was system planning and with Siena just being built the location was good. The American College of Surgeons (ACS) document makes more sense because it is looking at system planning and measures what is existing and the service being rendered versus a hospital that wants to be a trauma center. She emphasized that this was her initial thought from a system planning perspective and appreciated all the work that Ms. Doane has done.

Ms. Doane agreed and referred to page 3 of her presentation stating the notes around trauma volume, transport times, incident times, and the volume times as compared to Siena's system would be in the spirit of recognizing that same need.

Ms. Dokken stated that as a first reaction she didn't think that the existing Level III should be the benchmark in deciding where the next trauma center should be.

Dr. Fildes added an historical note to why St. Rose was considered to become a trauma center. It had in large part to do with a policy decision made by Henderson Fire not to move equipment out of zone. UMC realized they hadn't seen a patient from Henderson in a few months and researched their trauma registry and realized that the transports had stopped. Henderson Fire was bringing the patients to Siena so the thought of going forward with formalization didn't seem unusual. The general approach is similar to what this group has been trying to find. General population growth exceeding expected county wide levels and in trying to look for geographically separate service areas that synergize and augment one another as opposed to overlapping each other too strongly.

Ms. Dokken stated that even with the growth in Henderson, trauma volumes are not up. She stated that she tracks step 1s and 2s that are taken to Sunrise and found that those are also not up.

Dr. Fildes agreed adding that they have tracked theirs as well and the only growth has really been in step 3 and 4 transports.

Ms. Renner commented that there is a difference between being reactive and proactive and felt the intent of this group was to take a proactive approach to managing the system. St. Rose Siena becoming a Level III trauma center was a reaction to patients not going to UMC. She expressed the fact that they would want to move into the proactive realm of looking at were the growth patterns are occurring and take that into account.

Dr. Fildes stated that in fact it was years that separated the first observation in the actual moving forward. It really evolved slowly from a recognition that Henderson Fire was keeping patients in Henderson.

Ms. Doane stated that they are setting criteria and then based on that criteria questioned if they are putting the responsibility on the hospitals to monitor what's going on in their service areas and then bring forward to them when they see a need according the criteria that they set.

Ms. Taylor felt that both the hospitals and the Health District should monitor the need. She added that this taskforce is looking at a proactive approach because they are looking at the total system need of our valley and whereas a business approach brings it down to a hyper local sensitivity.

Mr. Hammond stated that the current regulations and procedures were not in effect at the time of the organic development of the St. Rose Siena Trauma center. That actually was the impetus for the development of the regulations and procedures that we currently have in place. Based on regulation, there are two options for hospitals to apply for authorization as a trauma center. A hospital may apply for authorization to seek designation as a trauma center based on their assessment and through the assessment of the TMAC and RTAB. The second is if a need is identified, the Health District shall seek a proposal for the addition of a trauma center. So these processes are already in place, the purpose of the taskforce is placing metrics on some of those things so that we can be a little more proactive rather than a reactive as we would be at least a quarter behind in our data.

Ms. Doane asked for clarification that what they were saying is that they will develop a checklist and the Health District in conjunction with RTAB will review that on a routine basis but that the hospital also bears the responsibility to monitor their own service area and can bring forward a need if they proactively determine one according to the checklist.

Mr. Hammond stated that it would be best if they do it in that particular manner because they can then demonstrate need based on the Nevada Administrative Code (NAC) which is an increase in population in an area that is not served by a trauma system. He felt that was a very broad definition of need but that is the one that is in NAC.

Ms. Angeles commented that the criterion that Ms. Doane presented does create a balance between a system and a financial standpoint because trauma is a large investment for any hospital or system. She added that they need to approach this as a system; it is the only way that they can make sure to protect

the integrity of trauma service and trauma care in the valley. She voiced concern creating criteria or a system that is perceived as exclusive rather than inclusive. If the criteria is tightened so much that it makes it difficult for somebody to be a part of the system, it becomes a disservice by not allowing it to grow and flourish the way that it should. She agreed that they hold on to the reins but on the same token, create a process that will not be perceived as exclusive rather than inclusive to other hospitals who would be interested in the future.

Mr. Hammond commented that the source of the data used for population should be based on the county demographer. Ms. Doane agreed adding that Intellimed is routinely available to them as a hospital system and it was only used as an illustration. Dr. Fildes added that as they go through and decide what will be on the checklist, it will be in (2) columns, what is on the checklist and where to find it so everyone can do it independently and transparently.

Dr. Fisher expressed the fact that they need to start putting concrete criteria on this checklist that everyone agrees on. He suggested certain things like transport time, trauma per population in an area, and then come up with some numbers for those to make some progress on this and have some objective numbers. He added that obviously there needs to be community support but felt this group has been charged from the beginning with creating objective criteria that they are all going to agree on so that no matter who applies for authorization as a trauma center it will be unbiased.

Dr. Iser agreed and stated that his concern would be is there a need and is there capacity to fill that need by the hospital who is putting in the application. He stated that letters from certain areas and political pressure during the previous iteration didn't sway his decision. He added that there may be some levels of those criteria that don't meet the need for a new level III, there is some that do. In this gray zone is where the Health Districts responsibility would be to look at historical data and start to see if we could find a trend that would give them the opportunity to put out an RFP.

Ms. Doane felt those were all excellent points. She suggested this process be thought about in waves. Dr. Fisher has brought forth some very good objective criteria. The community support and gray areas are all broader discussions that should be at the Board of Health (BOH) level.

Dr. Fildes commented that he understood the Health District's position, but felt when it gets to the level of the BOH, an expanded conversation needs to take place. He felt that they are one tweet away from going back to 50% self insured. When that happens, the management of time sensitive injuries and illnesses will collapse as a growth sector in healthcare. If the cost of the care for diagnosis X is a sum of money and it becomes 5 times that sum of money because of unbridled growth or poorly planned development that is not fair to the patients either. Dr. Fildes agreed that is probably at the BOH level and stated that the payors do have a right to weigh in because they represent the people who pay the payors and they already complained about the cost of the affordable care being unaffordable and it has reached the level of the White House.

Dr. Iser agreed and added that they will not want to take the payors concerns into consideration but the BOH should along with the letters and with the politicians. He noticed that someplace it said a business plan. If the Affordable Care Act goes away, whatever business plan someone has developed based on the Affordable Care Act will no longer be a viable business plan.

Dr. Fisher recommended that before the next meeting, each taskforce member have some criteria that they thought should be included, objective numerical criteria that should be included in the decision making to compile a list and come to an agreement as a group as to which should be included and then start to come up with some numbers for those.

Ms. Angeles proposed that they create a timeline to be able to have deliverables made to the people that are looking for those deliverables.

Dr. Young remarked that March 26th marks the 1 year anniversary of the first meeting of this body.

C. Review/Discuss Domain (1) Population and Domain (2) Median Transport Times

Dr. Fildes stated that this is a review of the previous discussions of Domain 1 and 2 with the intention of identifying items within those domains that are relevant and objective and should be included in a checklist. There was discussion about population and different sub populations and felt that they should be able to record a list that is reasonably complete. He stated that the 1st domain talks about general

population in a service area and suggested the population of the relevant service area of the valley be included. He asked the taskforce if they were in agreement that general population be included. The taskforce agreed. He continued with past and projected rates of population which could be analyzed for the entire trauma system area which would be Clark County, or:

- Within the relevant population center which would be the Las Vegas Valley
- Zip codes that reside within that area
- Within the service areas of the existing trauma centers
- Within services areas modeled for applicant trauma centers.

Ms. Doane clarified that the benchmark would be a growing population and then the service area growing at a rate that mirrors or exceeds the overall population growth in the valley. She added that if somebody is falling 3 percentage points below what the valley average is then that is not a population that would need trauma services. She felt that would be the measurement that would be the checkmark on the list.

Dr. Fildes agreed and stated the first step would be just the general population of all individuals so you know who is in the area. The next step would be to look at the population of people who actually access the trauma system which would be those people who meet TFTC. Those could be further subdivided into the step 1 and 2s and then 3s and 4s and then divided by age categories and gender categories to get a better picture.

Dr. Young referred to the NBATS tool and noted that there is no stipulation for growth; it is just the total trauma service area population.

Dr. Fildes remarked that the domains were written at a national level and to be relevant to this trauma service area, he felt they can create the measures in the domains that make sense. He asked the taskforce if there were other additions in this first pass of population measures.

Ms. Dokken noted that population growth is important but that doesn't mean trauma volume. She asked for additional clarification on the population measures.

Dr. Fisher stated that they have 3 separate points:

- Total population
- Population growth as a percentage
- Trauma patients per capita

He emphasized that all (3) population measures will encompass all the population issues that is needed within that domain and each of them will have to have a minimum figure.

Ms. Dokken questioned if they are just talking overall criteria today and not setting the benchmark.

Dr. Fildes answered just the criteria that should be measured. The next iteration of that is where we will have to agree what the acceptable source that we are going to use to get our information for going forward.

Mr. Driggars questioned that if the purpose is to determine the need for a Level III center, would they want to separate out the step1s and 2s to make sure that they don't skew the patient population.

Dr. Fildes answered in the affirmative and added that for someone who sought authorization there would have to be enough 3s and 4s in that area for them to go forward viably.

Mr. Driggars questioned what would be the percentage of trauma patient in the general population and breaking that down what would be the percentage of that trauma population who are step 3 & 4 patients.

Dr. Fildes cautiously answered that it looks like about 1 out of 350 of the general population becomes a trauma patient and felt that 2/3rds of those would be step 3 and 4.

Mr. Driggars questioned if that was the number they want to discover.

Dr. Fildes answered in the affirmative and added that they want to reach a level of confidence in that so it could be predictive, allowing hospitals that would seek authorization to be reasonably confident they will be successful.

Mr. Driggars felt that they just established their objective criteria for dealing with population numbers.

Dr. Fildes answered that they discussed a process that may lead to it.

Mr. Driggars commented that he wasn't talking about establishing a threshold; he was talking about establishing what the end that they are looking at is. End equals step 3 and step 4 trauma patients.

Dr. Fildes stated that is a key driver but there are a lot of other things to think about. He then proposed that at the next meeting they start again in the domains and continue the process of picking the measures until they get to a list that we feel comfortable with and then work to the next level.

Ms. Doane asked the taskforce to look within their area of expertise and bring forward what you would recommend for some of the benchmarks.

D. Review/Discuss Domain (3) Lead Agency/System Stakeholder/Community Support

Tabled

E. Next Meeting and Agenda Items

Tabled

IV. INFORMATIONAL ITEMS/DISCUSSION ONLY

None

V. PUBLIC COMMENT:

A period devoted to comments by the general public, if any, and discussions of those comments, about matters relevant to the Committee's jurisdiction will be held. No action may be taken upon a matter raised under this item of this Agenda until the matter itself has been specifically included on an agenda as an item upon which action may be taken pursuant to NRS 241.020. Comments will be limited to five (5) minutes per speaker. Please step up to the speaker's podium, clearly state your name and address, and spell you last name for the record. If any member of the taskforce wishes to extend the length of a presentation, this may be done by the Chairman or the Community by majority vote.

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

VI. ADJOURNMENT

As there was no further business on the agenda, Chairman Fildes adjourned the meeting at 3:30 p.m.

ATTACHMENT A

March 1, 2017

Certified Mail – Return Receipt Requested
And
Via E-Mail: amy.doane@hcahealthcare.com

John Fildes, M.D., Chairman
Trauma Needs Assessment Taskforce
Emergency Medical Services & Trauma System
Division of Community Health
Southern Nevada Health District
280 S. Decatur Blvd.
Las Vegas, Nevada 89107

Re: **Trauma Needs Assessment Taskforce (TNAT) – Work Subcommittee**

Dear Chairman Fildes:

I write to memorialize the concerns and frustrations of the members of TNAT affiliated with HCA hospitals[1] over not being notified of the date/time of the first meeting of the Work Subcommittee. I also write to request that certain items (see below) be placed on our agenda for the next TNAT meeting.

Work Subcommittee

Specifically, as you will recall, when the concept of creating a Work Subcommittee—to formulate broad and minimum objective criteria so that applicants would be able to make a business case to satisfy the "need" for additional trauma centers—was first discussed, I and others expressed reservations because we believed the formulation of such objective criteria was what TNAT (as a whole) was specifically charged to do. Nonetheless the members of TNAT ultimately agreed to form a Work Subcommittee. I then expressed my desire to be an active participant on the Work Subcommittee due to my background in business development analysis and strategic planning.

At the Taskforce meeting everyone was told by SNHD staff that we would be receiving a meeting request with the date and time of the Work Subcommittee meeting. Thereafter, unbeknownst to all of the TNAT members affiliated with HCA hospitals (including me), a Work Subcommittee meeting took place a few weeks ago. We were never notified of the Work Subcommittee meeting, while all of the other TNAT members did receive notice. SNHD staff

[1] In addition to me, the members of TNAT affiliated with HCA hospitals are: Adam Rudd, Southern Hills Hospital; Chris Fisher, M.D., Sunrise Hospital; Alma Angeles, RN, Sunrise Hospital; Daniel Llamas, Sunrise Hospital; Stacy Johnson, RN, MountainView Hospital; Jennifer Renner, RN, HCA; and Stephanie Miller, Southern Hills Hospital.

later chalked the notification failure up to an unfortunate oversight. This is of grave concern to us affiliated with the HCA hospitals inasmuch as it could appear that we were intentionally excluded from participating in the Work Subcommittee meeting to the benefit of others.

Subsequently, at the TNAT meeting on February 21, 2017, John Hammond suggested that each group designate two representatives so that we could keep the number of members in the Work Subcommittee small to avoid being subject to the open meeting rules. I, as well as the other members associated with the HCA hospitals, are vehemently opposed to any attempts to avoid Nevada's open meeting laws; particularly since the discussions and deliberations need to be honest and transparent to the public.

Agenda Items

In order to further the work of the TNAT so that it can properly and expeditiously fulfill its responsibilities to the Regional Trauma Advisory Board, I ask that you place the following action items on the next TNAT agenda:

1. Review/Discuss disbanding the Work Subcommittee in favor of having the TNAT (as a whole) formulate the objective criteria necessary to demonstrate the "need" for additional trauma services in Southern Nevada; and

2. Review/Discuss presentation of sample Level III business case analysis by Vice-Chair Amy Doane.

In light of the foregoing, I request that the Work Subcommittee meeting scheduled for March 14, 2017, be cancelled. I have taken the liberty of sending a copy of this letter to the other members of TNAT and certain SNHD staff members. Thank you for your consideration.

Sincerely,

Amy Doane
Vice Chair, Trauma Needs Assessment Taskforce

cc (via e-mail):

Jason Driggars:	jason.driggars@amr.net
Kim Dokken, RN:	kim.dokken@dignityhealth.org
Gail Yedinak:	gail.yedinak@umcsn.com
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Judy Tabat:	tabat@snhdmail.org
Christian Young, MD:	xnyoung@earthlink.net
Sean Dort, MD:	will receive mailed copy

ATTACHMENT A

March 10, 2017

Amy Doane, VP Strategic Planning
Sunrise Hospital & Medical Center
3186 S. Maryland Parkway
Las Vegas, NV 89109

Dear Ms. Doane:

The Southern Nevada Health District Trauma Needs Assessment Taskforce (TNAT) and I are in receipt of your letter dated March 1, 2017. All TNAT members were sent a scheduling request via a Doodle poll on January 23, 2017. As shown on the historical log of the poll HCA representatives were sent the same poll as other members of the committee. The subsequent workgroup meeting was scheduled based on the list of respondents.

At this time the TNAT workgroup subcommittee meeting is cancelled and all work will be shifted back to the TNAT. The agenda items you requested will be placed on the TNAT agenda.

Sincerely,

John Fildes, MD
Chair, Trauma Needs Based Assessment Taskforce.

ATTACHMENT A

TNAT Work Group

Where: Bristle Cone Trail Conference Room, OEMSTS office

Proposed dates to discuss Domains 1 and 2, Population and Median Transport Times

History

Back

Jan 23, 2017 8:44 AM

Laura Palmer created this poll.

Options:
Tuesday, February 7, 2017 2:00 PM
Wednesday, February 8, 2017 2:00 PM
Thursday, February 9, 2017 2:00 PM

Jan 23, 2017 8:44 AM

Participants have been invited.

Jan 23, 2017 9:00 AM

Kelly participated.

Jan 23, 2017 9:18 AM

Christian Young participated.

Jan 23, 2017 9:32 AM

Sajit Pullarkat participated.

Jan 23, 2017 10:20 AM

ATTACHMENT A

Sean Dort participated.

Jan 23, 2017 10:20 AM

Kim Dokken participated.

Jan 23, 2017 11:52 AM

John Fildes participated.

Jan 23, 2017 7:11 PM

Jason Driggars participated.

SNHD

ATTACHMENT A

Contact participants

Contact participants by adding their e-mail addresses below.

Send Reminder e-mail to

Type the e-mail addresses here:

dkuhls@medicine.nevada.edu stacy.johnson@hcahealthcare.com simonef@cityofnorthlasvegas.com sbreeden@cox.net sajit.pullarkat@uhsinc.com jennifer.renner@hcahealthcare.com tnaik@usacs.com kim.dokken@dignityhealth.org kimberly.cerasoli@umcsn.com kelly.taylor@metrohealthtrust.com john.fildes@umcsn.com gail.yedinak@umcsn.com jason.driggars@amr.net danita.cohen@umcsn.com daniel.llamas@hcahealthcare.com xnyoung@earthlink.net cfisherga@aol.com amy.doane@hcahealthcare.com alma.angeles@hcahealthcare.com

19 / 20

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SNHD

Poll "TNAT Work Group"

http://doodle.com/poll/66s7yua23psvysbd

	February 2017		
	Tue 7	Wed 8	Thu 9
	2:00 PM	2:00 PM	2:00 PM
Kelly	OK	OK	OK
Christian Young		OK	
Sajit Pullarkat	OK	OK	OK
Sean Dort	OK	OK	
Kim Dokken	OK	OK	
John Fildes		OK	OK
Jason Driggars	OK	OK	OK
Count	5	7	4

ATTACHMENT A

Trauma System
Level III Analysis Questions

Data sources: ESRI and Intellimed market share

Community Trauma Assessment Tool checklist:
Process Questions

Hospital Case Analysis

- Hospitals bring forward case for Level III trauma to RTAB according to objective checklist created by TNAT
- Data required in checklist is all publicly available data to non-trauma facilities
- State and county requirements for time to reply to requests for information
- Meeting the checklist = move forward to Board of Health
- Board of Health and applying hospital would then work directly on further details and questions regarding Level III application
- Places responsibility on facilities to understand, monitor, and present case for their local service areas

Community Trauma Assessment Tool checklist:
Process Questions: What a hospital review process could look like

Population Growth **Population Density factor**	Service area growth meets or exceeds market average Use as checkpoint to validate growth percentages
Trauma volume	Request data from state registry: at or -5% St. Rose - Level III volume within proposed service area - Median transport times by zip code for Level III trauma from proposed service area -Overall incident time (dispatch to hospital arrival) for Level III traumas from proposed service area - Hospital review of ICD 10 data to illustrate trauma need
Community Support	Submission of at least three letters of support to move forward
Clinical Commitment	Demonstration of hospital's commitment to emergency and trauma services according to ACS requirements

Example of Population Analysis
St. Rose Siena

St. Rose Siena Community Profile:
Population Growth Data: Las Vegas Market

ESRI Demographic Snapshot — 10/10/2016
INTELLIMED Demographic Profile System — Page 1 of 1
NV State

Zip Code: Las Vegas Market

	Area	USA
2016 Total Population	2,045,895	323,578,126
2021 Total Population	2,210,658	337,323,192
% Change 2016 - 2021	8.1%	4.2%
2016 Average Household Income	$68,927	$76,907
2021 Average Household Income	$76,048	$83,908
2016 Per Capita Household Income	$25,797	$29,471

	2016	2021	% Change
Total Male Population	1,025,093	1,104,213	7.7%
Total Female Population	1,020,802	1,106,445	8.4%
Female Child Bearing Age (15 - 44)	428,101	463,756	8.3%
Male Median Age	35.7	35.8	0.3%
Female Median Age	36.5	36.5	0.0%

	Age Distribution					USA
Age Group	2016	% of Total	2021	% of Total	% Change	% Change
Age 0-4	141,514	6.92%	154,012	7.0%	8.8%	2.8%
Age 5-9	137,998	6.75%	147,605	6.7%	7.0%	0.1%
Age 10-14	134,788	6.59%	144,686	6.5%	7.3%	2.4%
Age 15-19	127,152	6.21%	133,036	6.0%	4.6%	1.7%
Age 20-24	138,866	6.79%	138,151	6.2%	-0.5%	-5.8%
Age 25-29	156,172	7.63%	171,072	7.7%	9.5%	3.0%
Age 30-34	156,195	7.63%	176,752	8.0%	13.2%	7.6%
Age 35-39	147,502	7.21%	169,016	7.6%	14.6%	10.7%
Age 40-44	143,547	7.02%	150,823	6.8%	5.1%	2.7%
Age 45-49	134,369	6.57%	135,267	6.1%	0.7%	-2.8%
Age 50-54	131,966	6.45%	130,459	5.9%	-1.1%	-6.0%
Age 55-59	122,612	5.99%	125,744	5.7%	2.6%	-1.3%
Age 60-64	109,585	5.36%	119,395	5.4%	9.0%	9.8%
Age 65-69	96,680	4.73%	105,648	4.8%	9.3%	13.3%
Age 70-74	69,711	3.41%	88,887	4.0%	27.5%	28.7%
Age 75-79	45,641	2.23%	58,328	2.6%	27.8%	24.7%
Age 80-84	28,212	1.38%	34,461	1.6%	22.2%	13.9%
Age 85+	23,385	1.14%	27,316	1.2%	16.8%	7.0%
Total	2,045,895	100.00%	2,210,658	100.0%	8.1%	4.2%

	Race / Ethnicity Distribution				
Race / Ethnicity	2016	% of Total	2021	% of Total	% Change
American Indian/Alaska Native	14,716	0.7%	15,688	0.7%	6.6%
Asian	206,455	10.1%	251,109	11.4%	21.6%
Black/African American	237,153	11.6%	269,154	12.2%	13.5%
Other Race	301,927	14.8%	351,500	15.9%	16.4%
Pacific Islander	15,084	0.7%	17,065	0.8%	13.1%
Population of 2 or More Races	117,515	5.7%	136,530	6.2%	16.2%
White	1,153,045	56.4%	1,169,612	52.9%	1.4%
Total	2,045,895	100.0%	2,210,658	100.0%	8.1%
Hispanic	649,097	31.7%	742,093	33.6%	14.3%

	# of Households				
Household Income	2016	% of Total	2021	% of Total	% Change
< $15,000	84,047	11.4%	88,619	11.2%	5.4%
$15,000 - $24,999	75,332	10.2%	75,836	9.6%	0.7%
$25,000 - $34,999	82,018	11.1%	93,210	11.8%	13.6%
$35,000 - $49,999	105,087	14.3%	68,302	8.7%	-35.0%
$50,000 - $99,999	245,576	33.4%	275,518	34.9%	12.2%
Over $100,000	143,626	19.5%	187,794	23.8%	30.8%
Total	735,686	100.0%	789,279	100.0%	7.3%

St. Rose Siena Community Profile:

Population Growth data: St. Rose Siena Service Area

ESRI Demographic Snapshot
INTELLIMED Demographic Profile System

3/9/2017
Page 1 of 1
NV State

Zip Code: 13 Selected

	Area	USA
2016 Total Population	542,675	323,578,125
2021 Total Population	587,393	337,323,192
% Change 2016 - 2021	8.2%	4.2%
2016 Average Household Income	$74,192	$76,907
2021 Average Household Income	$82,077	$83,908
2016 Per Capita Household Income	$28,793	$29,471

	2016	2021	% Change
Total Male Population	268,765	290,381	8.0%
Total Female Population	273,910	297,012	8.4%
Female Child Bearing Age (15 - 44)	109,750	118,776	8.2%
Male Median Age	38.2	38.5	0.8%
Female Median Age	39.5	39.7	0.5%

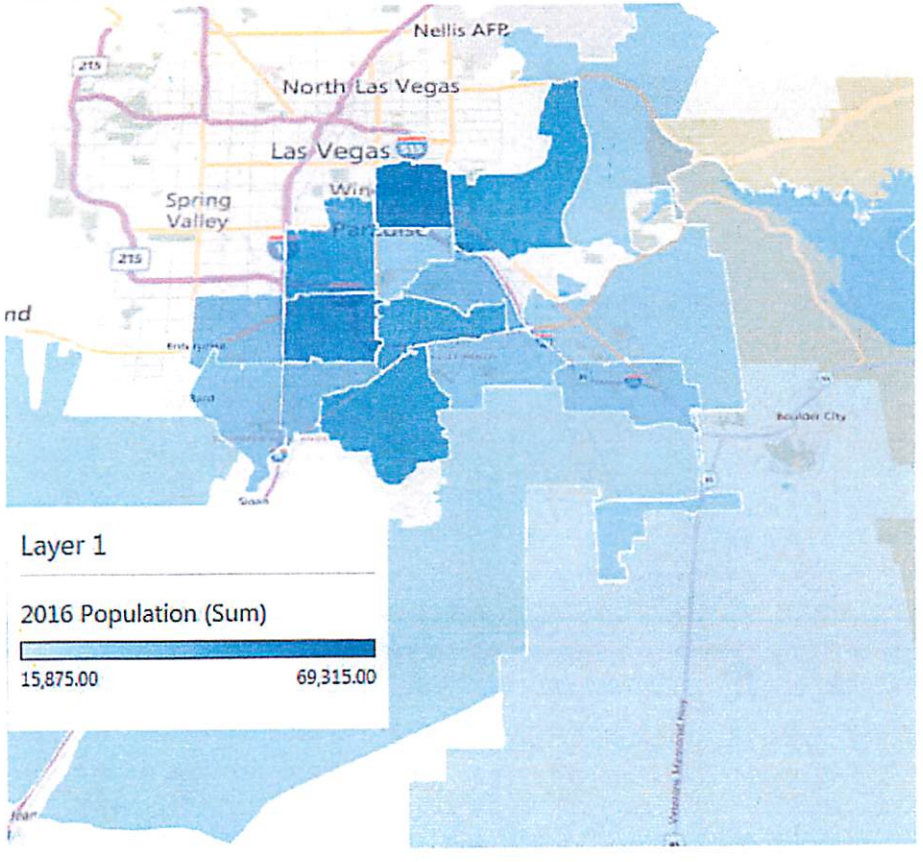
	Age Distribution					USA
Age Group	2016	% of Total	2021	% of Total	% Change	% Change
Age 0-4	33,031	6.09%	35,911	6.1%	8.7%	2.8%
Age 5-9	33,235	6.12%	35,440	6.0%	6.6%	0.1%
Age 10-14	33,130	6.10%	35,503	6.0%	7.2%	2.4%
Age 15-19	30,676	5.65%	32,466	5.5%	5.8%	1.7%
Age 20-24	33,147	6.11%	33,074	5.6%	-0.2%	-5.8%
Age 25-29	39,513	7.28%	42,740	7.3%	8.2%	3.0%
Age 30-34	40,266	7.42%	45,325	7.7%	12.6%	7.6%
Age 35-39	38,445	7.08%	44,086	7.5%	14.7%	10.7%
Age 40-44	38,111	7.02%	39,814	6.8%	4.5%	2.7%
Age 45-49	36,027	6.64%	36,384	6.2%	1.0%	-2.8%
Age 50-54	35,759	6.59%	35,585	6.1%	-0.5%	-6.0%
Age 55-59	35,153	6.48%	35,307	6.0%	0.4%	-1.3%
Age 60-64	33,371	6.15%	35,486	6.0%	6.3%	9.8%
Age 65-69	30,806	5.68%	33,243	5.7%	7.9%	13.3%
Age 70-74	22,272	4.10%	29,182	5.0%	31.0%	28.7%
Age 75-79	14,193	2.62%	18,706	3.2%	31.8%	24.7%
Age 80-84	8,564	1.58%	10,836	1.8%	26.5%	13.9%
Age 85+	6,976	1.29%	8,305	1.4%	19.1%	7.0%
Total	542,675	100.00%	587,393	100.0%	8.2%	4.2%

	Race / Ethnicity Distribution				
Race / Ethnicity	2016	% of Total	2021	% of Total	% Change
American Indian/Alaska Native	3,931	0.7%	4,283	0.7%	9.0%
Asian	56,020	10.3%	69,231	11.8%	23.6%
Black/African American	40,820	7.5%	47,639	8.1%	16.7%
Other Race	51,906	9.6%	62,752	10.7%	20.9%
Pacific Islander	4,368	0.8%	5,009	0.9%	14.7%
Population of 2 or More Races	31,868	5.9%	37,812	6.4%	18.7%
White	353,762	65.2%	360,667	61.4%	2.0%
Total	542,675	100.0%	587,393	100.0%	8.2%
Hispanic	126,562	23.3%	149,842	25.5%	18.4%

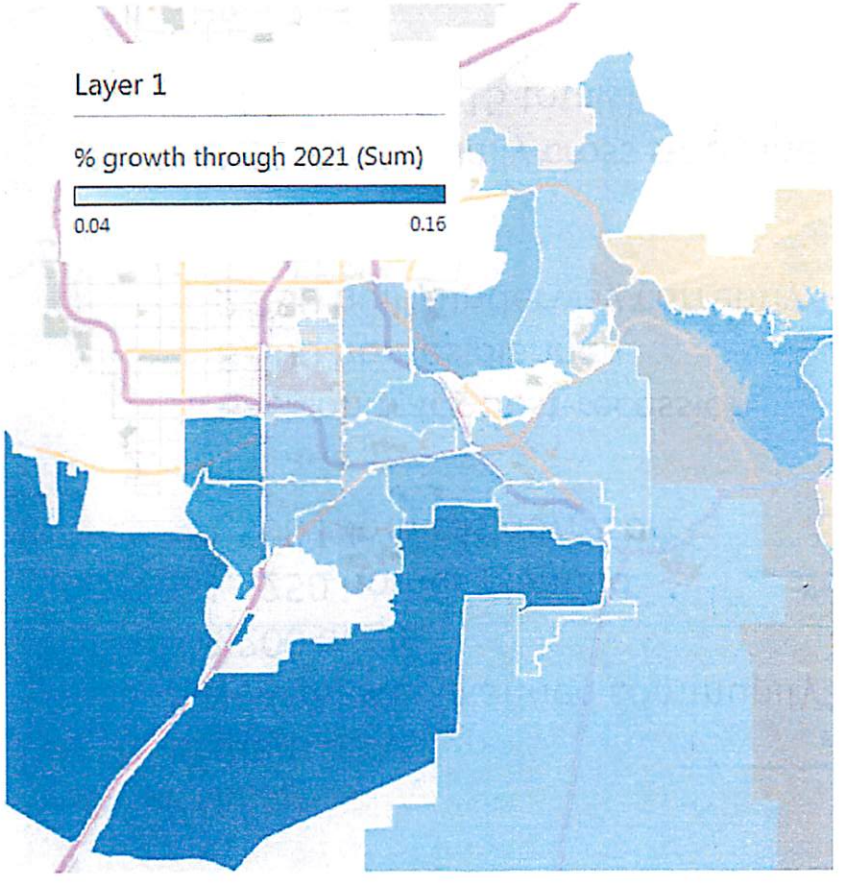
	# of Households				
Household Income	2016	% of Total	2021	% of Total	% Change
<$15,000	20,650	10.0%	21,640	9.7%	4.8%
$15,000 - $24,999	19,252	9.3%	19,311	8.7%	0.3%
$25,000 - $34,999	21,511	10.4%	24,603	11.0%	14.4%
$35,000 - $49,999	28,035	13.5%	17,817	8.0%	-36.4%
$50,000 - $99,999	71,747	34.6%	79,224	35.6%	10.4%
Over $100,000	46,297	22.3%	60,096	27.0%	29.8%
Total	207,492	100.0%	222,691	100.0%	7.3%

St. Rose Siena Community Profile:
Population

2016 Population around St. Rose PSA/SSA

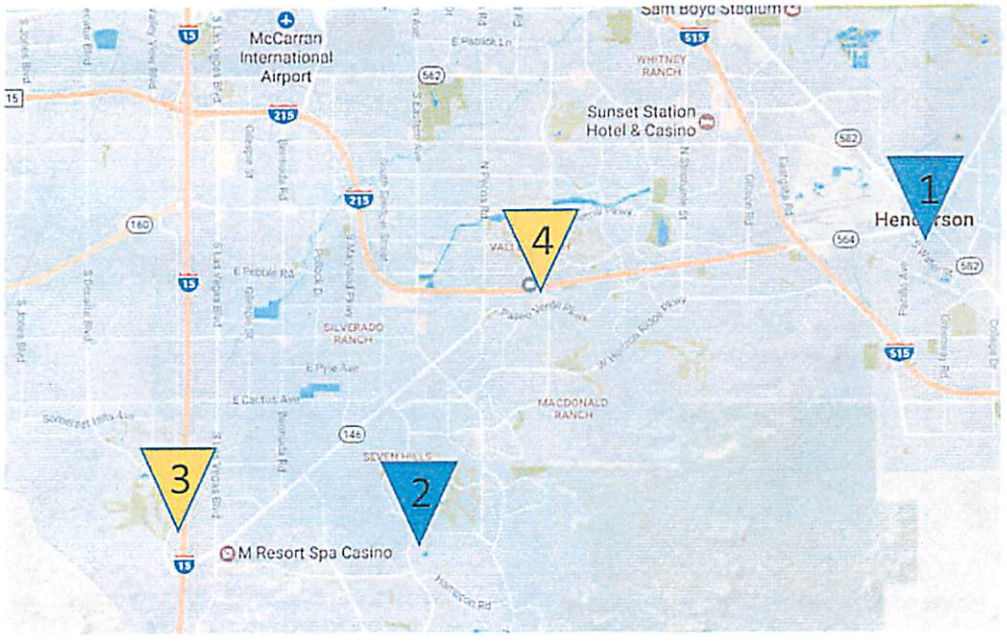


% Growth Through 2021 by Zip Code



St. Rose Siena Community Profile:

Population Growth and Traffic patterns



1. Cadence
   - New master-planned community
   - 2,200 acres
   - 13,250 homes planned
   - 1,500 room casino/resort
2. Inspirada
   - Back on track post-recession
   - 8,500 homes planned
   - 2,250 built/underway currently
3. Interest 15
   - 44,000 cars daily cross state line at Primm (2015 totals)
4. Hwy 215
   - 98,000 cars daily on Hwy 2015 at Green Valley Parkway exit
   - 100,000+ daily near the I-15 interchange

St. Rose Siena Community Trauma Assessment Tool checklist:

Population and Density by Zip code

Serv Area	Zip Code	2010 Population	2016 Estimated Population	2021 Projected Population	Land Sq Mi	Density 2016
PSA	89002 Henderson	31,897	34,137	36,507	8.7	3,924
PSA	89011 Henderson	19,349	23,463	26,295	17	1,380
PSA	89012 Henderson	28,270	31,505	34,773	11	2,864
PSA	89014 Henderson	37,013	38,965	41,563	7.6	5,127
PSA	89015 Henderson	39,528	41,365	43,819	37.5	1,103
PSA	89044 Henderson	14,169	18,181	21,132	31.4	579
PSA	89052 Henderson	48,216	53,624	58,084	51.9	1,033
PSA	89074 Henderson	46,951	49,530	52,546	9	5,503
PSA	89121 Las Vegas	66,007	69,315	73,484	9.2	7,534
PSA	89122 Las Vegas	47,499	52,798	57,538	9.1	5,802
PSA	89123 Las Vegas	56,450	60,589	65,154	10.7	5,663
PSA	89141 Las Vegas	25,156	30,393	34,464	10.7	2,840
PSA	89183 Las Vegas	36,371	38,810	42,034	7	5,544
			542,675		221	2,458
SSA	89005 Boulder City	15,074	15,875	16,860	122.4	130
SSA	89110 Las Vegas	71,844	73,720	76,800	11.1	6,641
SSA	89119 Las Vegas	49,273	50,244	52,276	12.9	3,895
SSA	89120 Las Vegas	23,196	24,320	25,733	7	3,474
SSA	89139 Las Vegas	30,298	36,694	41,503	10.6	3,462
SSA	89142 Las Vegas	32,969	34,847	36,859	4.8	7,260
SSA	89178 Las Vegas	26,801	34,546	40,045	19.1	1,809
			270,246		188	1,438