Contents

Introduction ...................................................................................................................................................................................................................................... 3
The Need for a Trauma System .................................................................................................................................................................................. 3
What is a Trauma System? .................................................................................................................................................................................................................. 3
Trauma System Components ...................................................................................................................................................................................... 4
Clark County Trauma System .................................................................................................................................................................................. 5
Leadership and Legislation .................................................................................................................................................................................... 6
Trauma System Evaluation and Performance Improvement ...................................................................................................................... 7
Rehabilitation .................................................................................................................................................................................................................. 8
Injury Prevention and Control .................................................................................................................................................................................. 8
Disaster Planning and Management .................................................................................................................................................................. 9
Methodology .............................................................................................................................................................................................................. 9
Limitations ................................................................................................................................................................................................................ 10
Plans for the Future ......................................................................................................................................................................................... 10

CDC – WISQARS 2016 Data .................................................................................................................................................................................. 11-13
Trauma Field Triage Criteria (TFTC) 2017 & Historical Data .................................................................................................................. 14-19
Clark County Trauma Registry 2017 Data .................................................................................................................................................. 20-26
Clark County Injury-Related Hospitalizations 2016 Data ..................................................................................................................... 27-30

Acknowledgments

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- American College of Surgeons Committee on Trauma
- Centers for Disease Control and Prevention
- St. Rose Dominican Hospitals - Siena Campus
- Sunrise Hospital & Sunrise Children's Hospital
- University Medical Center
Introduction

This Clark County Trauma System Report describes the status, activities, and achievements of the Clark County Trauma System. Since its inception in 2005, the trauma system leadership has made significant strides laying the foundation for the development of a comprehensive and well-coordinated trauma system to serve the needs of the residents of Southern Nevada, our bordering states, and the tremendous number of visitors to our community each year.

The Need for a Trauma System

Intentional and unintentional injuries are the leading causes of death and disability for those between the ages of 1 and 44 in the United States each year and generate significant social and economic expenses for medical treatment and lost productivity of victims. Recent events have demonstrated that natural and human-made disasters are capable of producing large numbers of injured patients. The recognition of the significant impact that traumatic injury has on the individual and society has led to a greater emphasis on the development of trauma systems of care as an identified public health problem. Trauma systems conduct daily operations to optimize patient outcome and can readily adapt to manage an influx of injured patients resulting from a mass casualty incident.

What is a Trauma System?

A trauma system is an organized, coordinated, comprehensive injury response network of essential resources that promote injury prevention and control initiatives and provides specialized care for those who are injured. The system facilitates appropriate triage and transportation of trauma patients through the emergency medical services system to designated health care facilities that possess the capability, competence, and commitment to providing optimum care for the victims of trauma. It also promotes rehabilitation services to decrease the likelihood of long-term disability and maximize the potential for injured patients to return to their prior level of functional capacity and reintegration into the community.

The goals of a trauma care delivery system are to:
- Reduce the incidence and severity of injuries
- Improve the health outcome of those who are injured by ensuring equitable access to the most appropriate health care resources promptly
- Promote efficient, cost-effective delivery of care
- Implement performance improvement activities to ensure quality care throughout the system
- Advocate for sufficient resources to meet the needs of the injured in the community
Trauma System Components

The prehospital component of the trauma system is designed to provide initial assessment and management of injured patients at the scene of an emergency and safe and efficient transport to the most appropriate health care facility. In Clark County, six public fire departments provide emergency medical services (EMS): Boulder City Fire Department, Clark County Fire Department, Henderson Fire Department, Las Vegas Fire & Rescue, Mesquite Fire & Rescue, and North Las Vegas Fire Department. The private franchised EMS agencies serving the area are American Medical Response, Community Ambulance, Guardian Elite Medical Services, and MedicWest Ambulance. Air ambulance services are provided by AirMed Response (fixed wing) and Mercy Air Service Inc. (rotor wing).

The American College of Surgeons Committee on Trauma has developed a classification system to identify the necessary resources to provide optimal care to injured patients. It is not a ranking of medical care provided by a health care facility but the recognition of the depth of resources available within the institution.

**Level I**

A Level I trauma center provides comprehensive care for the most severely injured patients. The required clinical resources include emergency medicine, general and subspecialty surgical and anesthesia services. A Level I trauma center is expected to provide leadership in trauma system planning, education, and research. In addition, the center is required to meet certain volume performance standards such as admitting at least 1200 patients annually.

**Level II**

A Level II trauma center provides comprehensive trauma care based on the environment of the region. In population-dense areas, the Level II should supplement the clinical activity and expertise of the Level I facility. A Level II trauma center is expected to provide initial and definitive trauma care for severely injured patients but may not provide all subspecialty services. The required resources include all the clinical services provided by a Level I trauma center except hand and microvascular surgical services.

**Level III**

A Level III trauma center provides trauma care based on the defined scope of care and expertise available at the facility. A Level III trauma center should supplement the clinical activity and expertise of the Level I and Level II trauma centers by providing definitive care to the less severely injured patients in the region, leaving the comprehensive trauma resources available to the most severely injured patients. Level III trauma centers transfer injured patients that exceed the facility resources to Level I and Level II trauma centers. The required resources include emergency medicine and general and orthopedic surgical services. The other subspecialties are desired but not required.

**Pediatric Level I or Level II**

A Pediatric Level I or Level II trauma center is a health care facility that has committed the necessary resources and expertise to meet the specialized needs of the pediatric population. A pediatric trauma center is expected to assume a leadership role in the care of injured children within their community.
Clark County Trauma System

In the Clark County Trauma System, University Medical Center is permitted as a Level I and Pediatric Level II trauma center; Sunrise Hospital is permitted as a Level II trauma center; St. Rose Dominican Hospitals – Siena Campus is permitted as a Level III trauma center. In the interest of facilitating the timely transportation of trauma patients from the scene of an emergency to the closest appropriate trauma catchment center, the Office of Emergency Medical Services & Trauma System (OEMSTS) creates geographic distribution of trauma patients to ensure patients are matched with the appropriate resources while providing sufficient volume to each trauma center to provide stability within the trauma system.

Leadership and Legislation

The Nevada Division of Public and Behavioral Health has the authority to designate a health care institution as a Level I, II or III trauma center or Pediatric Level I or II trauma center based on the American College of Surgeons verification classification system. During the 2005 state legislative session, Nevada Revised Statute (NRS) 450B.237 was promulgated authorizing the Southern Nevada District Board of Health to establish and adopt a comprehensive trauma system plan concerning the treatment of trauma in Clark County. This authorization included, without limitation: consideration of the future trauma needs of the county; consideration of and plans for the development and designation of new trauma centers based on the demographics of the county; and the manner in which trauma services could be provided most effectively.

The Southern Nevada Health District OEMSTS assumed the role of providing administrative oversight of the Clark County Trauma System and with the assistance of local trauma leaders and community stakeholders, developed the Clark County Trauma System Regulations which were adopted by the District Board of Health in May 2007.

To assist the Health District’s Chief Health Officer and OEMSTS in fulfilling the responsibilities defined in the new legislation and regulations, the RTAB was created. The primary mission of the RTAB is to support the Health Officer’s role to ensure a quality system of patient care for the victims of trauma within Clark County and surrounding areas by making recommendations and assisting in the ongoing design, operation, evaluation, and revision of the system from initial patient access to definitive patient care. The members of the RTAB include a trauma surgeon and trauma program manager from each designated trauma center; the chairman of the Health District’s Emergency Medical Services Medical Advisory Board; an administrator from a non-trauma hospital; a person representing the public providers of advanced emergency care; a person representing the private franchised providers of advanced emergency care; a person representing health education and prevention services; a person representing the payors of medical benefits for the victims of trauma; and a person representing the general public. RTAB meets monthly or quarterly according to the trauma system’s needs.
Trauma System Evaluation and Performance Improvement

An essential component of any trauma system is a continuous, comprehensive, multi-disciplinary, evidence-based performance improvement process that monitors and evaluates the structure, process and outcome measures of the trauma system through all phases of care. The trauma system performance improvement process consists of three major elements:

1. An internal performance improvement and patient safety program within each trauma center;
2. An external process that includes periodic audits of each trauma center by the Nevada State Health Division and the Health District; scheduled independent evaluations of trauma care by trauma care experts from the American College of Surgeons; and trauma system review and analysis by the Trauma Medical Audit Committee;
3. Ongoing data collection, management, and analysis at the local, state and national level to ensure system effectiveness and identify trends, gaps and needs within the system.

The cornerstone of the trauma system medical review process is the Trauma Medical Audit Committee (TMAC) which is a peer review committee that meets to review, monitor, and evaluate trauma system performance and make recommendations for system improvements. The TMAC derives its authority and privilege from NRS 49.117 - 49.123; NRS 49.265; and NRS 450B.237. The members of the TMAC include the trauma medical director and program manager from each designated trauma center; the Clark County medical examiner or designee; the Health District’s Regional Trauma Coordinator; a neurosurgeon; an anesthesiologist; an orthopedic surgeon; and an emergency physician not affiliated with a trauma center. The committee meets quarterly and provides important opportunities for the Clark County Trauma System to benefit from the individual centers sharing their clinical care experiences.

The ability to effectively evaluate trauma system performance is contingent upon appropriate data collection, management, analysis, and reporting. Each designated trauma center is required by NRS 450B.238 to provide data on any person who sustains an acute injury which has the potential of being fatal or producing major disability to the state trauma registry managed by the State Health Division, Bureau of Health Planning and Statistics. The trauma registry is one source of valuable information needed to describe the full spectrum of injured patients within a trauma system. The trauma centers also voluntarily provide data to the National Trauma Data Bank maintained by the American College of Surgeons Committee on Trauma.

At the regional level, the trauma centers submit data to the Health District related to patients who have sustained injury and meet the trauma field triage criteria used to evaluate the patient’s condition in the field based on physiological conditions, anatomical considerations, and the mechanism of injury as outlined in the Clark County EMS System Trauma Field Triage Criteria Protocol (TFTC). In addition, inpatient injury data from the Center for Health Information Analysis at the University of Nevada, Las Vegas and injury mortality data provided by the Clark County Coroner’s Office are used to evaluate trauma system resource utilization and in planning for improved system effectiveness and efficiency.
Rehabilitation

The continuum of care provided in a trauma system includes access to appropriate rehabilitation services. Injury produces enormous direct and indirect costs. Consideration of the injured patient’s need for rehabilitation should begin early in the treatment plan to decrease the likelihood of long-term disability and maximize the potential for the individual to return to optimum functional capacity. It is not only important for the patient and their family to have the ability to live independently and enjoy a good quality of life, but it also reduces the significant economic burden on society.

Injury Prevention and Control

Data collected in the trauma system can be used to plan, devise, and implement prevention strategies to reduce the incidence and severity of injury. In 2006, the Southern Nevada Injury Prevention Partnership (SNIPP) was created under the authority of the RTAB to facilitate and promote collaboration and coordination of injury prevention resources in Southern Nevada. The members of SNIPP include representatives from established injury prevention groups in Clark County and the health education and prevention services representative on the RTAB and acts as a liaison between the partnership and the Board.

The purpose of SNIPP is to:

- Advise and assist the RTAB in the structure and development of the injury prevention component of the Southern Nevada Trauma Plan;
- Assure the provision and/or initiation of a full spectrum of injury prevention efforts in Southern Nevada with emphasis on those that directly impact the trauma system;
- Develop quantitative community health and injury assessment to provide evidence-based and specific injury prevention program recommendations targeted to Southern Nevada;
  - facilitate and promote collaboration and coordination of available resources to meet identified needs;
  - facilitate and promote coordination and collaboration to evaluate program outcome data to modify existing programs and create new programs to meet identified needs; and
  - promote a heightened awareness of injury prevention issues and concerns to the community and recognition of injury prevention as a legitimate public and governmental service.
Disaster Planning and Management

Terrorism and mass casualty events present unique triage, transport, treatment, and surge capacity challenges and have the potential to impact public health systems and emergency medical response capability. One of the responsibilities of the Southern Nevada Health District is to collaborate with members of the public safety, public health, and emergency medical care communities to plan a systematic response to natural or human-made disasters. The trauma centers in Clark County have actively participated in activities to promote disaster preparedness.

Methodology

The data presented in the Clark County Trauma System Report is the most current information available from the identified sources chosen to provide an overview of injury and trauma system utilization at a national, state and local level. Cells with counts less than 5 are suppressed per Southern Nevada Health District policy and are denoted with an asterisk (*).

**CDC – WISQARS 2016 Data**

Injury data from the Centers for Disease Control and Prevention (CDC) are available through the Web-based Injury Statistics Query and Reporting System (WISQARS). The CDC defines injury as bodily harm resulting from severe exposure to an external force or substance (mechanical, thermal, electrical, chemical, or radiant) or a submersion. The cause or mechanism of injury is the way in which the person sustained the injury; how the person was injured; or the process by which the injury occurred. The intent of injury is whether an injury was caused by an act carried out on purpose by oneself or by another person with the goal of injuring or killing. Both fatal and nonfatal data are reported in WISQARS.

Injury mortality data are obtained from death certificates filed by state vital statistics offices which include causes of death reported by attending physicians, medical examiners, and coroners. This national mortality database is compiled by CDC’s National Center for Health Statistics.

The nonfatal injury data presented in WISQARS are national estimates based on weighted data obtained from the National Electronic Injury Surveillance System - All Injury Program operated by the U.S. Consumer Product Safety Commission in collaboration with the National Center for Injury Prevention and Control. The data include all types and causes of nonfatal injuries treated in a representative sample of U.S. emergency departments.
Trauma Field Triage Criteria (TFTC) 2017 Data
The three trauma centers in Clark County submit data to the OEMSTS related to patients transported according to the criteria outlined in the Health District’s EMS Operations Trauma Field Triage Criteria Protocol. The TFTC algorithm is a triage decision scheme developed by the American College of Surgeons Committee on Trauma.

Prehospital professionals are trained to perform a physical assessment of trauma patients and to recognize specific injuries and mechanisms of injury that are likely to cause severe injury. Patients are then transported to area trauma centers based on these criteria:

**STEP 1 (PHYSIOLOGICAL)** — A trauma patient whose injury is so severe that their vital signs or level of consciousness are abnormal.

**STEP 2 (ANATOMICAL)** — A trauma patient whose vital signs and level of consciousness are within normal limits, but they have sustained an obvious serious injury; for example, an open or depressed skull fracture, pelvic fracture or paralysis.

**STEP 3 (MECHANISM)** — A trauma patient whose vital signs and level of consciousness are within normal limits and they do not appear to have an obvious serious injury, but they have experienced high energy impact to the body that may have caused a serious injury that is not immediately obvious.

**STEP 4 (SPECIAL CONSIDERATIONS)** — A trauma patient whose circumstances merit special considerations, for example, older adults, children, anticoagulants/bleeding disorders, and pregnancy.

Clark County Trauma Registry 2017 Data
On a quarterly basis, the trauma centers in Clark County provide the OEMSTS with a subset of trauma registry data identified by the RTAB as basic descriptive information to be used to assess trauma system resource utilization. The trauma registry data are based on the same definition used by the National Trauma Data Bank.

Clark County Injury-Related Emergency Departments 2017 Data
The Clark County injured-related Emergency Department visits to non-federal care hospitals is through discharge billing data provided by the Center for Health Information and Analysis, UNLV. Injury is defined as having one of the following ICD-10-CM diagnosis codes in the principal diagnosis field: All S codes for anatomic injuries, T07-T34.
Limitations

One of the most important limitations of the trauma system report is the lack of consistency in trauma data collection at the national, state, and local levels. Variability was noted in disease classification coding, case definitions, and inclusion criteria among the organizations that collect injury data. There is also a lack of data provided by all participants, including non-trauma hospitals and emergency medical services agencies, which mean the data reported are not representative of all trauma cases in the system.

It is the desire of the OEMSTS and members of the RTAB to be evidence-based in making decisions regarding future planning, development, and modification of the Clark County Trauma System. The stakeholders are working diligently to improve needs assessment activities specific to Clark County.

Plans for the Future

The purpose of the Clark County Trauma System Report is to provide a snapshot of the status and evolving trauma system, unique to the county. The plans include developing a needs assessment tool to represent the trauma system specific to Clark County more accurately. More detailed and in-depth analysis of injury data will help us achieve our goal of preventing injury, improving access to quality trauma care when the need arises, and facilitating rehabilitation to maximize the potential for patients to achieve the highest level of functional ability following their injury.

Future evolution of the trauma system depends on a reliable surveillance system to monitor trends, identify problems, and provide valuable information to health care leaders, emergency managers, and policy-makers. Access to quality data contributes to the accurate assessment of current resources and assists in the development of comprehensive, evidence-based, and integrated strategic plans to promote the delivery of effective and efficient emergency medical care of injured patients. It is also important to have the ability to expand the capability and capacity of existing resources and adapt daily operations to manage an influx of multiple trauma patients resulting from a human-made or natural mass casualty event.

The Southern Nevada Health District appreciates the contributions and support of our community partners who have assisted in maintaining the Clark County Trauma System and have committed to building on the achievements to date.
10 Leading Causes of Death, Nevada  
2016, All Races, Both Sexes

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WISQARS™

Note: For leading cause categories in this State-level chart, counts of less than 10 deaths have been suppressed (---).

Produced By: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
Data Source: National Center for Health Statistics (NCHS). National Vital Statistics System
### 10 Leading Causes of Death, United States 2016, All Races, Both Sexes

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WISQARS™ Produced By: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
Data Source: National Center for Health Statistics (NCHS), National Vital Statistics System
## 10 Leading Causes of Nonfatal Injury, United States
### 2016, All Races, Both Sexes, Disposition: All Cases

**CDC – WISQARS 2016 DATA**

### Age Groups

<table>
<thead>
<tr>
<th>Rank</th>
<th></th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
<th>10-14</th>
<th>15-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>55-64</th>
<th>65+</th>
<th>All Ages</th>
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<td>Unintentional Fall</td>
<td>122,266</td>
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<td>750,052</td>
<td>Unintentional Fall</td>
<td>588,689</td>
<td>Unintentional Fall</td>
<td>490,255</td>
<td>Unintentional Fall</td>
<td>718,186</td>
<td>Unintentional Fall</td>
<td>661,809</td>
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<td>2</td>
<td>Unintentional Struck by/ Against</td>
<td>28,224</td>
<td>Unintentional Struck by/ Against</td>
<td>282,087</td>
<td>Unintentional Struck by/ Against</td>
<td>348,333</td>
<td>Unintentional Struck by/ Against</td>
<td>482,632</td>
<td>Unintentional Fall</td>
<td>742,092</td>
<td>Unintentional MV-Occupant</td>
<td>592,609</td>
</tr>
<tr>
<td>3</td>
<td>Unintentional Other Bite/ Sting</td>
<td>10,649</td>
<td>Unintentional Other Bite/ Sting</td>
<td>137,409</td>
<td>Unintentional Other Bite/ Sting</td>
<td>98,268</td>
<td>Unintentional Other Bite/ Sting</td>
<td>250,247</td>
<td>Unintentional MV-Occupant</td>
<td>665,419</td>
<td>Unintentional Struck by/ Against</td>
<td>590,710</td>
</tr>
<tr>
<td>5</td>
<td>Unintentional Other Specified</td>
<td>8,857</td>
<td>Unintentional Cut/Pierce</td>
<td>70,899</td>
<td>Unintentional Overexertion</td>
<td>80,651</td>
<td>Unintentional MV-Occupant</td>
<td>71,252</td>
<td>Unintentional Cut/Pierce</td>
<td>387,016</td>
<td>Unintentional Other Specified</td>
<td>454,527</td>
</tr>
<tr>
<td>6</td>
<td>Unintentional Fire/Burn</td>
<td>7,081</td>
<td>Unintentional Overexertion</td>
<td>67,790</td>
<td>Unintentional MV-Occupant</td>
<td>60,722</td>
<td>Unintentional Unknown/ Unspecified</td>
<td>66,312</td>
<td>Unintentional Other Specified</td>
<td>348,726</td>
<td>Unintentional Cut/Pierce</td>
<td>408,160</td>
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<td>7</td>
<td>Unintentional Inhalation/ Suffocation</td>
<td>5,111</td>
<td>Unintentional Other Specified</td>
<td>59,635</td>
<td>Unintentional Foreign Body</td>
<td>54,978</td>
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<td>60,262</td>
<td>Other Assault Struck by/ Against</td>
<td>333,051</td>
<td>Other Assault Struck by/ Against</td>
<td>333,051</td>
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<tr>
<td>8</td>
<td>Unintentional Unknown/ Unspecified</td>
<td>5,002</td>
<td>Unintentional Unknown/ Unspecified</td>
<td>39,644</td>
<td>Unintentional Pedal Cyclist</td>
<td>48,196</td>
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<td>Other Assault Struck by/ Against</td>
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<tr>
<td>9</td>
<td>Unintentional Cut/Pierce</td>
<td>4,465</td>
<td>Unintentional Fire/Burn</td>
<td>39,079</td>
<td>Unintentional Other Bite/ Sting</td>
<td>36,934</td>
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<td>10</td>
<td>Unintentional MV-Occupant</td>
<td>3,879</td>
<td>Unintentional Poisoning</td>
<td>30,671</td>
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<td>Unintentional Unknown/ Unspecified</td>
<td>131,119</td>
<td>Unintentional Unknown/ Unspecified</td>
<td>106,005</td>
</tr>
</tbody>
</table>

**WISQARS™**

Produced By: Office of Statistics and Programming, National Center for Injury Prevention and Control (CDC)

Data Source: NEISS All Injury Program operated by the Consumer Product Safety Commission (CPSC)

* The ‘Other Assault’ category includes all assaults that are not classified as sexual assault. It represents the majority of assaults.
### 2017 TFTC Transports by Month to each Trauma Center

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Rose — Siena</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>N</td>
<td>61</td>
</tr>
<tr>
<td>Sunrise</td>
<td>106</td>
<td>91</td>
<td>167</td>
<td>144</td>
<td>139</td>
<td>113</td>
<td>137</td>
<td>117</td>
<td>121</td>
<td>145</td>
<td>130</td>
<td>135</td>
</tr>
<tr>
<td>UMC</td>
<td>620</td>
<td>609</td>
<td>743</td>
<td>776</td>
<td>819</td>
<td>811</td>
<td>737</td>
<td>814</td>
<td>757</td>
<td>774</td>
<td>702</td>
<td>670</td>
</tr>
</tbody>
</table>

### 2017 TFTC Transports by Percentage to each Trauma Center

<table>
<thead>
<tr>
<th>Destination</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Rose — Siena</td>
<td>683</td>
<td>6.18</td>
</tr>
<tr>
<td>Sunrise</td>
<td>1545</td>
<td>13.97</td>
</tr>
<tr>
<td>UMC</td>
<td>8832</td>
<td>79.86</td>
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</tbody>
</table>
## TFTC Transports by EMS Agency

<table>
<thead>
<tr>
<th>Agency (with combined fields)</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boulder City Fire Department</td>
<td>42</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Blue Diamond</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Community Ambulance</td>
<td>952</td>
<td>9%</td>
</tr>
<tr>
<td>Cal-Nev-Ari</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>City of Las Vegas</td>
<td>1180</td>
<td>11%</td>
</tr>
<tr>
<td>Clark County</td>
<td>121</td>
<td>1%</td>
</tr>
<tr>
<td>Cold Creek</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>EMS</td>
<td>7583</td>
<td>71%</td>
</tr>
<tr>
<td>Henderson Fire</td>
<td>570</td>
<td>5%</td>
</tr>
<tr>
<td>Logandale</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>MFR</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Mercy Air</td>
<td>10</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Moapa</td>
<td>5</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Mount Charleston</td>
<td>6</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Mountain Springs</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>North Las Vegas</td>
<td>198</td>
<td>2%</td>
</tr>
<tr>
<td>Other Air</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Other Ground</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Overton</td>
<td>11</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Sandy Valley</td>
<td>*</td>
<td>*</td>
</tr>
</tbody>
</table>

Frequency Missing = 363
## 2017 TFTC by TFTC Category

<table>
<thead>
<tr>
<th>Category</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anatomical</td>
<td>811</td>
<td>7.33</td>
</tr>
<tr>
<td>Mechanism</td>
<td>4761</td>
<td>43.05</td>
</tr>
<tr>
<td>Physiological</td>
<td>509</td>
<td>4.6</td>
</tr>
<tr>
<td>Special Considerations</td>
<td>4979</td>
<td>45.02</td>
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</table>

## 2017 TFTC Transports by Disposition from Trauma Centers

<table>
<thead>
<tr>
<th>Disposition</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted</td>
<td>2341</td>
<td>21.17</td>
</tr>
<tr>
<td>Deceased</td>
<td>172</td>
<td>1.56</td>
</tr>
<tr>
<td>Discharged</td>
<td>7291</td>
<td>65.92</td>
</tr>
<tr>
<td>ICU</td>
<td>745</td>
<td>6.74</td>
</tr>
<tr>
<td>OR</td>
<td>431</td>
<td>3.9</td>
</tr>
<tr>
<td>Transferred</td>
<td>80</td>
<td>0.72</td>
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</table>

![Graph showing TFTCcategory and Disposition counts]
### TFTC Transports to each Trauma Center by Year

<table>
<thead>
<tr>
<th>Destination</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Rose – Siena</td>
<td>421</td>
<td>612</td>
<td>683</td>
</tr>
<tr>
<td>Sunrise</td>
<td>1001</td>
<td>1322</td>
<td>1545</td>
</tr>
<tr>
<td>UMC</td>
<td>4687</td>
<td>4836</td>
<td>8832</td>
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</tbody>
</table>

### TFTC Transports Under Each Step by Year

<table>
<thead>
<tr>
<th>Category</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Physiological</td>
<td>645</td>
<td>522</td>
<td>509</td>
</tr>
<tr>
<td>Step 2: Anatomical</td>
<td>625</td>
<td>787</td>
<td>811</td>
</tr>
<tr>
<td>Step 3: Mechanism</td>
<td>3992</td>
<td>4324</td>
<td>4761</td>
</tr>
<tr>
<td>Step 4: Special Considerations</td>
<td>847</td>
<td>1137</td>
<td>4979</td>
</tr>
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</table>
### St. Rose – Siena TFTC Transports by Step

<table>
<thead>
<tr>
<th>Category</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Physiological</td>
<td>11</td>
<td>*</td>
<td>5</td>
</tr>
<tr>
<td>Step 2: Anatomical</td>
<td>6</td>
<td>*</td>
<td>*</td>
</tr>
<tr>
<td>Step 3: Mechanism</td>
<td>373</td>
<td>507</td>
<td>460</td>
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<tr>
<td>Step 4: Special Considerations</td>
<td>31</td>
<td>102</td>
<td>206</td>
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</tbody>
</table>

### Sunrise TFTC Transports by Step

<table>
<thead>
<tr>
<th>Category</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Physiological</td>
<td>166</td>
<td>170</td>
<td>80</td>
</tr>
<tr>
<td>Step 2: Anatomical</td>
<td>158</td>
<td>209</td>
<td>223</td>
</tr>
<tr>
<td>Step 3: Mechanism</td>
<td>533</td>
<td>679</td>
<td>802</td>
</tr>
<tr>
<td>Step 4: Special Considerations</td>
<td>144</td>
<td>264</td>
<td>440</td>
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</table>
### UMC TFTC Transports by Step

<table>
<thead>
<tr>
<th>Category</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1: Physiological</td>
<td>468</td>
<td>351</td>
<td>424</td>
</tr>
<tr>
<td>Step 2: Anatomical</td>
<td>461</td>
<td>576</td>
<td>576</td>
</tr>
<tr>
<td>Step 3: Mechanism</td>
<td>3086</td>
<td>3138</td>
<td>3499</td>
</tr>
<tr>
<td>Step 4: Special Considerations</td>
<td>672</td>
<td>771</td>
<td>4333</td>
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</table>

![Bar chart showing UMC TFTC transports by step from 2015 to 2017]
### 2017 Clark County Trauma Registry Patients by Trauma Center

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Rose Dominican Hospital</td>
<td>648</td>
<td>12</td>
</tr>
<tr>
<td>Sunrise Hospital Medical Center</td>
<td>1265</td>
<td>23</td>
</tr>
<tr>
<td>University Medical Center</td>
<td>3566</td>
<td>65</td>
</tr>
</tbody>
</table>

![Bar Chart](chart.png)

![Pie Chart](chart.png)
# 2017 Clark County Trauma Registry Patients by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>&lt;1</td>
<td>95</td>
<td>1.28</td>
</tr>
<tr>
<td>1-5</td>
<td>167</td>
<td>2.25</td>
</tr>
<tr>
<td>6-17</td>
<td>442</td>
<td>5.97</td>
</tr>
<tr>
<td>18-24</td>
<td>616</td>
<td>8.31</td>
</tr>
<tr>
<td>25-34</td>
<td>1008</td>
<td>13.61</td>
</tr>
<tr>
<td>35-44</td>
<td>710</td>
<td>9.58</td>
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<tr>
<td>45-54</td>
<td>798</td>
<td>10.77</td>
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<tr>
<td>55-64</td>
<td>974</td>
<td>13.15</td>
</tr>
<tr>
<td>65-74</td>
<td>1003</td>
<td>13.54</td>
</tr>
<tr>
<td>75-84</td>
<td>929</td>
<td>12.54</td>
</tr>
<tr>
<td>85+</td>
<td>667</td>
<td>9</td>
</tr>
</tbody>
</table>
## 2017 Clark County Trauma Registry Patients by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>2997</td>
<td>40.45%</td>
</tr>
<tr>
<td>Male</td>
<td>4408</td>
<td>59.5%</td>
</tr>
<tr>
<td>Unknown</td>
<td>4</td>
<td>0.05%</td>
</tr>
</tbody>
</table>

## 2017 Clark County Trauma Registry Patients by Race

<table>
<thead>
<tr>
<th>Race</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian</td>
<td>31</td>
<td>0.42%</td>
</tr>
<tr>
<td>Asian</td>
<td>326</td>
<td>4.4%</td>
</tr>
<tr>
<td>Black or African American</td>
<td>919</td>
<td>12.4%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>38</td>
<td>0.51%</td>
</tr>
<tr>
<td>White</td>
<td>4595</td>
<td>62.02%</td>
</tr>
<tr>
<td>Other Race</td>
<td>1102</td>
<td>14.87%</td>
</tr>
<tr>
<td>Unknown/Non-Applicable</td>
<td>398</td>
<td>5.37%</td>
</tr>
</tbody>
</table>
2017 Clark County Trauma Registry Patients by Penetrating vs. Blunt Trauma

<table>
<thead>
<tr>
<th>Trauma</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blunt</td>
<td>6171</td>
<td>83.29%</td>
</tr>
<tr>
<td>Burn</td>
<td>53</td>
<td>0.72%</td>
</tr>
<tr>
<td>Other</td>
<td>130</td>
<td>1.75%</td>
</tr>
<tr>
<td>Penetrating</td>
<td>1002</td>
<td>13.52%</td>
</tr>
<tr>
<td>Unknown/Non-applicable</td>
<td>53</td>
<td>0.71%</td>
</tr>
</tbody>
</table>

2017 Clark County Trauma Registry Patients by Mode of Arrival on the Scene

<table>
<thead>
<tr>
<th>Mode of Arrival</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground Ambulance</td>
<td>5357</td>
<td>72.3%</td>
</tr>
<tr>
<td>Helicopter Ambulance</td>
<td>449</td>
<td>6.06%</td>
</tr>
<tr>
<td>Other</td>
<td>27</td>
<td>0.16%</td>
</tr>
<tr>
<td>Private Vehicle or Walk-in</td>
<td>1539</td>
<td>20.77%</td>
</tr>
<tr>
<td>Unknown/Non-applicable</td>
<td>37</td>
<td>0.50%</td>
</tr>
</tbody>
</table>
2017 Clark County Trauma Registry Patients Received by Transfer from Another Healthcare Facility by Referring Facility State

<table>
<thead>
<tr>
<th>Incident State</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arizona</td>
<td>354</td>
<td>87</td>
</tr>
<tr>
<td>California</td>
<td>42</td>
<td>10</td>
</tr>
<tr>
<td>Utah</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Nevada</td>
<td>1016</td>
<td>69</td>
</tr>
<tr>
<td>Other States</td>
<td>15</td>
<td>1</td>
</tr>
<tr>
<td>Unknown/Not Applicable</td>
<td>43</td>
<td>3</td>
</tr>
</tbody>
</table>

2017 Clark County Trauma Registry Patients Received by Transfer from Another Healthcare Facility by Referring Facility Location in Nevada

<table>
<thead>
<tr>
<th>Incident Area</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clark County, NV</td>
<td>897</td>
<td>88</td>
</tr>
<tr>
<td>Other Nevada</td>
<td>119</td>
<td>12</td>
</tr>
</tbody>
</table>
### 2017 Clark County Trauma Registry
Interfacility Transferred Patients by Mode of Arrival

<table>
<thead>
<tr>
<th>Mode of Arrival</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ground Ambulance</td>
<td>1145</td>
<td>78.86%</td>
</tr>
<tr>
<td>Helicopter Ambulance</td>
<td>282</td>
<td>19.42%</td>
</tr>
<tr>
<td>Other</td>
<td>18</td>
<td>0.14%</td>
</tr>
<tr>
<td>Unknown</td>
<td>7</td>
<td>0.48%</td>
</tr>
</tbody>
</table>
# 2017 Clark County Trauma Registry Patients by Disposition

<table>
<thead>
<tr>
<th>Disposition (combined fields)</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Facility</td>
<td>1067</td>
<td>14.4</td>
</tr>
<tr>
<td>Correctional Facility</td>
<td>60</td>
<td>0.81</td>
</tr>
<tr>
<td>Home or Self Care</td>
<td>3192</td>
<td>43.08</td>
</tr>
<tr>
<td>Home with Services</td>
<td>373</td>
<td>5.03</td>
</tr>
<tr>
<td>Hospice</td>
<td>76</td>
<td>1.03</td>
</tr>
<tr>
<td>Left Against Medical Advice</td>
<td>90</td>
<td>1.21</td>
</tr>
<tr>
<td>Skilled Nursing Facility, Long Term Care, Nursing Home</td>
<td>906</td>
<td>1.27</td>
</tr>
<tr>
<td>Mental Health/Psychiatric Hospital (Inpatient)</td>
<td>75</td>
<td>1.01</td>
</tr>
<tr>
<td>Deceased</td>
<td>236</td>
<td>3.19</td>
</tr>
<tr>
<td>Rehab (Inpatient)</td>
<td>1107</td>
<td>14.94</td>
</tr>
<tr>
<td>Other</td>
<td>47</td>
<td>0.03</td>
</tr>
</tbody>
</table>

![Bar chart showing the distribution of patients by disposition]
### Injury-Related Emergency Department Discharges by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Native American or Alaskan</td>
<td>381</td>
<td>0.25</td>
</tr>
<tr>
<td>Asian or Pacific Islander</td>
<td>6615</td>
<td>4.25</td>
</tr>
<tr>
<td>Black</td>
<td>30539</td>
<td>19.64</td>
</tr>
<tr>
<td>White</td>
<td>74359</td>
<td>47.82</td>
</tr>
<tr>
<td>Hispanic</td>
<td>31864</td>
<td>20.49</td>
</tr>
<tr>
<td>Other</td>
<td>10191</td>
<td>6.55</td>
</tr>
<tr>
<td>Unknown</td>
<td>1539</td>
<td>0.99</td>
</tr>
</tbody>
</table>

### Injury-Related Emergency Department Discharges by Gender

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>76792</td>
<td>49.39</td>
</tr>
<tr>
<td>Male</td>
<td>78652</td>
<td>50.58</td>
</tr>
<tr>
<td>Unknown</td>
<td>44</td>
<td>0.03</td>
</tr>
</tbody>
</table>
### Injury-Related Emergency Department Discharges by Age Group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 1 year</td>
<td>1840</td>
<td>1.18</td>
</tr>
<tr>
<td>1 to 4 years</td>
<td>10649</td>
<td>6.85</td>
</tr>
<tr>
<td>5 to 14 years</td>
<td>17900</td>
<td>11.51</td>
</tr>
<tr>
<td>15 to 24 years</td>
<td>23589</td>
<td>15.17</td>
</tr>
<tr>
<td>25 to 34 years</td>
<td>27240</td>
<td>17.52</td>
</tr>
<tr>
<td>35 to 44 years</td>
<td>20514</td>
<td>13.19</td>
</tr>
<tr>
<td>45 to 54 years</td>
<td>18400</td>
<td>11.83</td>
</tr>
<tr>
<td>55 to 64 years</td>
<td>14530</td>
<td>9.34</td>
</tr>
<tr>
<td>65 to 74 years</td>
<td>10355</td>
<td>6.66</td>
</tr>
<tr>
<td>75 to 84 years</td>
<td>6727</td>
<td>4.33</td>
</tr>
<tr>
<td>85 years and over</td>
<td>3744</td>
<td>2.41</td>
</tr>
</tbody>
</table>

![Bar chart showing injury-related emergency department discharges by age group.](chart.png)
### 2017 Clark County Injury-Related Emergency Departments by Payer

<table>
<thead>
<tr>
<th>Payer</th>
<th>Count</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>13760</td>
<td>8.85</td>
</tr>
<tr>
<td>Charity</td>
<td>3744</td>
<td>2.41</td>
</tr>
<tr>
<td>CHAMPUS or CHAMPVA</td>
<td>2426</td>
<td>1.56</td>
</tr>
<tr>
<td>Nevada Medicaid</td>
<td>13410</td>
<td>8.62</td>
</tr>
<tr>
<td>Other Medicaid</td>
<td>1306</td>
<td>0.84</td>
</tr>
<tr>
<td>Self Pay</td>
<td>13412</td>
<td>8.63</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>3823</td>
<td>2.46</td>
</tr>
<tr>
<td>Commercial Insurer</td>
<td>19516</td>
<td>12.55</td>
</tr>
<tr>
<td>Negotiated Discounts (e.g., PPO)</td>
<td>10772</td>
<td>6.93</td>
</tr>
<tr>
<td>HMO</td>
<td>22434</td>
<td>14.43</td>
</tr>
<tr>
<td>County Indigent Referral</td>
<td>293</td>
<td>0.19</td>
</tr>
<tr>
<td>All Workers Compensation (e.g., SIIS)</td>
<td>5380</td>
<td>3.46</td>
</tr>
<tr>
<td>Medicare HMO</td>
<td>7407</td>
<td>4.76</td>
</tr>
<tr>
<td>Nevada Medicaid HMO</td>
<td>37693</td>
<td>24.24</td>
</tr>
<tr>
<td>Unknown/Non-applicable</td>
<td>112</td>
<td>0.07</td>
</tr>
</tbody>
</table>
2017 Clark County Injury-Related Emergency Departments by Payer
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