

**Advisory Committee Trauma
Minutes
August 23, 2006**

Present: Pam Kemp, Elaine Becker, Dr. Scott Sellers, Robert Prewitt, Kris Hill, Eric Cook-Wiens, Kendra Tinsley, Darlene Whitlock, Dick Morrissey, Roger John, Kerry Mc Cue, Patricia Dowlin, Leanne Irsik, Cathy Heikes, Dennis Mauk, Debra Pile, Dr. Stephen Smith, Dr. Paul Harrison, Dr. Craig Concannon, Robert Waller, Melissa Hungerford, Dr Howard Rodenberg

Absent: Dr. Dennis Allin, Chris Way, Representative James Morrison, Senator Susan Wagle, Representative Nancy Kirk, Senator David Haley

Dr. Harrison called the meeting to order at 10:10am.

Minutes of the May meeting were approved as written.

Introductions

Dr. Harrison introduced Dr. R. Stephen Smith who was appointed by Gov. Sebelius to fulfill the unexpired term of Dr. Brent Rody. Dr. Smith was appointed as a representative for the Kansas Hospital Association (KHA). Dr. Smith expressed his pleasure to be with the committee.

Program Update

The program update was provided by Richard Morrissey in the absence of Rosanne Rutkowski who was absent due to a family death. The Hospital Designation committee met earlier in August and reviewed designation regulations. Minutes and regulations from that meeting were included in the meeting packet. Federal hospital preparedness funds will be utilized to support the American College of Surgeons (ACS) Consultation program with KHA writing the contract with the ACS. The contract will be for a 1-year period of time so hospitals that want to participate will need to plan accordingly if they want to take advantage of the contract services.

KHA and KDHE sponsored a webinar in July regarding the ACS consultation program for interested hospitals. Dr. Smith who serves on the ACS verification committee and Carol Williams from the ACS office were presenters. Five hospitals indicated at that time they were interested in participating in the project. It is expected that there may be additional hospitals who will want to participate. Mr. Morrissey reiterated the priorities for providing the ACS consultation program will be: 1) top priority will be those facilities in areas of the state that do not have a verified trauma center, 2) volume of trauma patients seen at a facility will be considered 3) those facilities that have documented support for pursuing verification.

Other business included a fall training calendar to be published soon and the rollout of the web-based version of the registry in June. The South Central Regional Trauma Council has proposed a pilot of data linkage utilizing a "trauma bracelet". Kansas Department of Transportation (KDOT) has indicated an interest in this concept for data linkage. The Board of Emergency Medical Services (BEMS) will also need to participate in the process, but there are many details to work out. Mr. Morrissey advised that they hope there would not be rules and regulations required but legal authority needs to be clarified.

Mr. Morrissey also presented the brochure which was developed for the Kansas Trauma Program. The brochure utilized the new trauma logo. An RFP was issued earlier in August for production of a trauma video. KDHE is currently evaluating applications and will be choosing a vendor. It is expected that the video will be completed by this winter. The communications committee has assisted with development of the media campaign. The media campaign has utilized federal grant money for product development and the grant has been extended through December in order to have more development time. Mr. Morrissey advised the committee there were more brochures available and more would be printed.

Lastly, Mr. Morrissey elaborated on the data collaboration project with the Office of Rural Health and Critical Access Hospitals. They are in the early stages of creating a quality improvement process with consultant Darlene Bainbridge, who will be at the November 3 Executive Council meeting. Ms Bainbridge currently works with critical access hospital networks in developing quality improvement programs.

Registry Report

Eric Cook-Wiens provided the report on the registry. Reporting was down slightly for the most recent quarter due to software issues, but those have all been addressed. The KDHE follow up letter for this past quarter was not sent to non-submitting hospitals due to the software glitch. KDHE sponsored trainings on the web application this summer. There were 5 trainings held statewide with representation from 38 hospitals. Of the 57 people who were trained most were from facilities who see less than 5 traumas per quarter. The reaction to the web based software has been very positive. As web based users do not have the flexibility to write their own reports, Eric reported that he has plans in the future to develop reports for the web-based users.

The committee was provided a copy of the “Data Report” which has been developed for hospitals utilizing trauma registry data. The report will be sent in PDF format quarterly to the primary hospital contact. The first distribution should be in a couple of week. If there are no records for that quarter the hospital will receive just region and state data.

Leanne Irsik asked Eric if it was possible for hospitals that report a low volume of trauma to have cumulative data reported rather than just data for the previous quarter. In response, Eric advised that the report will be quarterly with hopes to implement an annual report in order to take a broader look at trends. Dr. Harrison inquired if it was possible for hospitals themselves to gather cumulative data. It is possible for them to do that, but it may be difficult, said Eric. Dr. Smith added that in performance improvement the sooner you have access to the data the better. Darlene Whitlock pointed out the ACS looks at individual patients, how you have cared for this particular patient, not just the overall trend. The data reports will include case numbers so that a hospital can refer back to a particular case if needed for follow up. Cathy Heikes reinforced the report is a starting point for local hospitals who have been putting in data for years and can now see results of what they’ve been doing.

Dr. Harrison clarified the report serves two functions; 1) to help us identify where we need to focus education and resources on the state level; 2) for individual hospitals to identify situations which may need further investigation within their institutions. Cathy added that the more hospitals put in, the more they will get out of the report. Eric advised Dr. Harrison that he could develop a report for hospitals to run cumulative data from their own registry data.

Kansas Registry Subcommittee (KTRS) Issue review. Minutes from the July KTRS meeting were reviewed.

Issue One:

There is a national initiative to adopt a standard data dictionary. The Kansas data dictionary is currently very close to the National Trauma Registry (NTR) data dictionary, but is missing several crucial fields. The Kansas Trauma Registry Subcommittee (KTRS) were in favor of moving the elements to the core dataset. The motion to accept the subcommittee's recommendation was moved and seconded, with all in favor.

Issue two:

The second issue reviewed involves adding 'Occupation' to the core dataset. KTRS were not in favor of this change, specifically due to concerns over the number of facilities that do not ask for occupation and the categories in the NTR being confusing, as well as not as expansive as would be necessary. Dr. Smith inquired if adding occupation would be a useful tool in directing education. Cathy Heikes responded that the categories are still too vague for the coders. The motion to accept the subcommittee's recommendation was moved and seconded, with all in favor.

Issue three:

The third issue addressed the protective devices pick list in-use by the NTR which is more substantial than the one currently in use. KTRS was in favor of adding this element to the core dataset, with the addition of the parenthetical phrase "either deployed or not deployed" after the field value "Airbag."

Issue four:

An additional menu items would be required when the protective device "Airbag" is selected; specifically, no airbag deployed, airbag deployed front, side, or other. KTRS was in favor of adding these elements to the core dataset with the following changes: field one: airbag equipped vehicle, not deployed; and adding field five: airbag deployed, unspecified.

Issue five:

In order to adhere to the NTR the data element "child specific restraint" should be added to the dataset. If 'Child Specific Restraint' is selected and the patient is a child (age ≤ 14) the following field values will be available to choose from: child car seat, infant car seat and child booster seat. KTRS recommended that those values be added with a modification in the order to infant car seat, child car seat, child booster seat, and the addition of child seat, unspecified. Eric provided the committee with a visual showing what Digital Innovations (DI) is currently working on, which follows the KTRS recommendations fairly closely. The motion to accept the DI working outline was moved and seconded, with all in favor for Issues 3, 4 and 5.

Issue six:

The data element "GC Assessment Qualifier" should be added to the dataset. KTRS were in favor of adding these elements, with the modification of field value 2 to state 'chemically altered mental status' and the addition of another field 'patient intubated and chemically altered mental status'. The motion to accept the subcommittee's recommendation was moved and seconded, with all in favor.

Issue seven:

In order to adhere to the NTR the element "co-morbid condition" should be added to the core state-required dataset. KTRS was not in favor of including the element "co-morbid condition," but recommended moving the current co-morbid conditions field in the comprehensive dataset (which takes ICD9 code values) to the core state required dataset. The motion to accept the subcommittee's recommendation was moved and seconded, with all in favor.

Issue eight:

In order to adhere to the NTR registry the QA/QI element “non-injury-related occurrences” should be removed from the core dataset but preserved in the comprehensive dataset. KTRS recommended adding this element with modifications of removing certain field values and grouping certain field values together. Eric provided a visual showing the new groupings: bleeding, infections/wound, organ failure, cardiovascular and other. There was brief discussion of consequences of non-compliance, with the committee in general agreement that once hospitals start to see the Data Report compliance will increase. The motion to accept the subcommittee’s recommendation was moved and seconded, with all in favor.

Issue nine:

The pick list for “ED Discharge Disposition” should be changed. The NTR pick list is significantly smaller than the current pick list and KTRS recommended querying larger trauma centers to see if this element is currently being used as it reads. Eric advised the committee that he had discussed the element with the Level I facilities and they advised him they do use the current pick list extensively and KTRS recommendation was to leave the list as it is if larger facilities are using it.

Issue ten:

The last issue involved acute transfers by adding “other acute care hospital” to the element “discharge to” in order to indicate transfers for non-medical purposes, such as insurance transfers. KTRS were in favor of adding this field value in order to properly identify transfers of this nature. The motion to accept the subcommittee’s recommendation was moved and seconded, with all in favor.

The last thing Eric presented on was research currently being done on medical costs related to safety belt non-usage by Indike Ratnayake and Sunanda Dissanayake, at the Department of Civil Engineering Kansas State University (KSU). They are planning to compile a report for the Kansas Department of Transportation (KDOT). Eric showed the committee a couple of graphs depicting the variance in seat belt usage among age and gender groups, and also a chart comparing the mean, median and minimum values of hospital charges for restrained versus unrestrained patients. Pam stated that this information would have been good to have when testifying in front of the legislators for the primary seatbelt legislation.

Board of EMS Report

Robert Waller provided the Board of EMS report. He informed the committee they are working on an RFP to hire a project manager for their data collection system. They have recognized the work is too big to do all in house. They have created a steering committee with three representatives from the regions, three from the MidAmerican Regional Council, two from KDHE, the Highway Patrol and others. They have also included an expert in HIPPA to ensure compliance as the system is developed. The August meetings were cancelled due to the project potentially exceeding the \$250,000 mark which then requires additional steps and paperwork. The next meeting with the data steering committee is scheduled for September 18th and 19th at the training center in Salina.

Regional Reports

NE: Elaine Becker reported for the NERTC. Mary Glover, Medical Priorities instructor candidate, is completing her final team teach at Jackson County EMS this week. Jackson County Communications Center was the recipient of five EMD scholarships through the RTC.

The region surveyed all EMS agencies in the region regarding use of EMSytem®, GCS, RTS, field triage decision scheme, among other things. Also, agency readiness was surveyed to implement elements of the trauma plan. Overall, there were very positive results from the survey and 82% were returned. The RTC will be working with aero medical services to provide education to EMS agencies based on survey results.

Members of the sub-committee will be presenting at the EMS Educators workshops in Pittsburg, Garden City and Salina this fall. Also in education, the RTC sponsored a PHTLS course at Seneca EMS on July 21 and 22 with twenty-four people attending. A course has been scheduled at Coffey County EMS on September 12 and 13, which is already reached its cap of 20 participants. A TNCC course has been scheduled at Nemaha Valley Hospital October 3 and 4, and also has reached its cap of 25 participants. A Kansas Rural Health Options Project (KRHOP) funded TNCC course has been scheduled at Ransom Memorial Hospital on October 12 and 13; KRHOP has also funded a RTTD class in November at Ransom Memorial Hospital.

The committee will begin regional trauma system plan review with a report on the current status of the plan goals and activities during the October 2 executive committee meeting. Elizabeth Carlton added that there were almost 50 participants at the “Train the Trainer” class.

NC: Pat Dowlin gave the NCRTC report. The general meeting was held May 24 at Republic County Hospital, where elections were held. The new chairperson is Emma Doherty from Salina Regional Health center and vice-chairperson is Charlie Grimwood from Salina Regional Health Center. The RTC purchased 140 booster seats for distribution to coincide with recent passage of the booster seat law. They are collaborating with the Sunflower Network to distribute the seats with education through member hospitals.

KRHOP funding went to Ellsworth County EMS for PHTLS, Cloud County Health Center for Rural Trauma Team Development Course and Republic County Hospital for TNCC. The RTC is sponsoring a TNCC course at Clay County Medical Center December 7 and 8. They are also sponsoring a PHTLS class in the Smith County area, with attendance expected from Jewell, Republic, Osborne, Mitchell and Cloud counties.

The committee will begin regional trauma system plan review with a report on the current status of the plan goals and activities during the September 20 executive committee meeting. The executive committee really got out and traveled the region this year. Meetings were held in Clay County, Republic County, Saline County and the final meetings of the year will be held in Sedgwick County and Mitchell County.

Pat also wanted to add that she has been on the committee for several years and in that time we have been working towards public information and safety. She wanted to note that many facilities are small and have limited funds for public education. Dick responded that the trauma regions are one way for small population health departments to group together and hospital preparedness and emergency management/homeland security regions are also based on trauma regions. Dr. Harrison added that we have focused a lot of our efforts on education, almost exclusively for health care providers and have not developed a plan for public education. Pat concluded that we haven’t developed statistics to know where to focus public education funding but with the registry we can now pin-point that.

NW: Kimberla Nutting reported for the Northwest Regional Trauma Council. In the area of injury prevention, the RTC will sponsor AgraSafe First on the Scene and Professional courses in Gove County in September. A TNCC course has been scheduled on September 28 and 29 at Sheridan County Hospital, sponsored by KRHOP, with many first time providers scheduled to attend. EMT scholarships were provided to Colby Community College. The RTC is sponsoring the Hays Regional Medical Center ATLS course scheduled on October 13 and 14. A Review of the regional trauma system plan is on the October 25 executive committee agenda scheduled at Hays Regional Medical Center.

SC: Kris Hill provided the report for the South Central Regional Trauma Council. A KRHOP funded TNCC course has been scheduled at Medicine Lodge Memorial Hospital on September 11 and 12. The RTC is sponsoring two TNCC instructor candidates through Pratt Regional Medical Center. The goal is to increase TNCC instructor capacity in the region. The committee will begin review of the regional trauma system plan during the October 19 executive committee meeting at Hutchinson Hospital. The executive committee would like to pursue a beta test for trauma bands in the South Central region. Kris added the RTC would like to “work out the bugs.”

Kerry McCue inquired about the status of the project and Kris responded they are currently in the discussion phase. Dr. Harrison added that there have to be some protocols and they are in the process of getting legal opinions. Dick stated the process cannot be done independently as KDHE and Board of EMS will ultimately be responsible.

SW: Cathy Heikes reported for the South West Regional Trauma Council. The RTC sponsored two PHTLS classes in Grant County on May 6 and 7 and June 10 and 11. They were open to the SW trauma region and thirty-two people successfully completed the courses. The executive committee approved purchase of booster seats for a large even including Wal-Mart, law enforcement, EMS, hospitals and health departments in the region. The event will be scheduled this fall. The RTC will be sponsoring 2 PEPP courses for the region that will be held in Grant County. The RTC purchased books for the course that would be “librariated” for future use and the RTC also assisted with instructor expenses. The next executive committee meeting has been scheduled on October 25 at Finney County EMS.

SE: The regional report was provided in the meeting packet. Kendra highlighted the ATLS course at Coffeyville Regional Medical Center has been scheduled on September 8 and 9.

Fall Meeting RTC Executive Councils

Kendra advised the committee the fall meeting of the Regional Executive Councils will be held at Wesley Medical Center in the Cessna room on November 3. Darlene Bainbridge will be the speaker. Darlene has been working with smaller hospitals to gather data and put together a great presentation. Eric will also be presenting. Lodging will be provided November 2 from the Kansas Trauma Program.

Hospital Designation Committee Report

Dr. Rodenberg discussed the ACS consultation contract and the regulations on designation. In reference to the ACS consultation contract he referred the committee to the subcommittee meeting minutes provided in the meeting packet. Dr. Rodenberg stated we’ve established priorities for the grant funding with the expectation that the consultation project will help hospitals realize what resources are required for Level 3 designation. The contract with the ACS for consultation services includes all expenses except for the lodging expenses for the ACS surveyors.

Darlene inquired if there was any funding to help prepare for the consultation and stated we should strongly consider level 4 again. Dr. Smith responded that with the ACS consultation visit there is no “you win or lose”. It identifies areas for improvement in order to pass and there is a pre-review questionnaire that spells out what is required for the various levels. He suggested letting others who have been through the designation process serve as a resource. Some facilities are gung-ho and if some still need help there may be the possibility of a day-long workshop.

Leanne added looking at Medicare criteria helps you get ready and she also suspects that any facility that has looked at level 3 will not go in to the process naively. She continued that her facility has made contact with a level 1 facility which has agreed to serve as a mentor. Dr. Smith confirmed that verified trauma centers can serve as a mentor and in many instances the consultation visit can be a stimulus to move forward with designation. He stressed that a consultation visit is not the same as a verification visit.

Melissa Hungerford reported the contract is between the Kansas Hospital Education and Research Foundation, through KHA, and ACS. She also stated they would not be sending money to ACS for consultation visits until the hospital has made efforts toward designation. One of the things most challenging is raising the bar for hospitals; it is a slow process to get everyone on board. Melissa also stressed how the consultation is a huge educational process and if all that process does is take a facility up the ladder a little; they will understand much better what it takes. Dr. Rodenberg said that each hospital has to make that decision on designation for themselves. He asked the committee to defer further discussions on the consultation process and move to regulations. Dr. Rodenberg stated they have gone through KDHE’s legal process and he wanted to take the committee through section by section.

Section 100 deals with definitions, such as ACS, department, performance improvement and trauma. Liz Carlton, trauma coordinator at KU, brought up the burn registry, which is currently separate from the trauma registry. Dr. Harrison noted that there is a difference between the trauma registry and the burn registry. Darlene inquired about the alternative process to ACS verification teams for level 1 or 2 designation and Dick advised that information was not in this section.

Section 101 adoptions by reference the standards set out in the ACS “Resources for Optimal Care of the Injured Patient” and those developed by the Kansas Trauma Program in “Kansas trauma care facility categorization criteria for level III.” This section also sets out that designations shall not be based on criteria that place practice limitations on registered nurse anesthetists which are not required by state law.

Section 102 establishes that hospitals designated by the ACS can provide a copy of their verification certificate to KDHE along with an application fee to be designated. This section also provides that hospital seeking designation have the option of requesting verification through ACS or by a survey team appointed and approved by the secretary of KDHE.

Section 103 defines the designation term as three years and that applications for renewal must be submitted six months in advance of the expiration date.

Section 104 states the application and verification survey fees. Dick added that we are looking at ways we would be able to provide assistance to facilities in the first round and will continue to look at ways to offset the cost with dollars in the trauma budget. This scenario would not be long term as the purpose is to get statewide coverage of verified trauma centers and there is not the same incentive once those are established.

Section 105 provides for voluntary termination of trauma center designation by a hospital administrator and Section 106 specifies that designation does not apply to satellite facilities of designated trauma centers.

Darlene inquired again about where the option of not using the ACS verification team was spelled out in the regulations. Dick referred her to Section 102 and continued that within the state you can't mandate private entities. He stated it is not KDHE's intent to develop designation survey teams.

Melissa asked why hospitals would feel motivated to get state verification if they are already ACS verified and if there was anything that required them to participate in the state system. Dr. Smith answered that those not participating in the state trauma system would be deficient in ACS requirements.

Dick advised the next steps are to submit the regulations to the Department of Administration (DOA), and then they would go to the Attorney General. There is a certain amount of back and forth revision and negotiation of language before it would then be scheduled for a public hearing and comment period. After that time the Secretary makes any changes and adopts the regulations. The timing is in place to hopefully be completed by the end of the year.

Other Items

Darlene updated the committee on Driving Force. She said they are doing an excellent job getting public support for preventive activities and would like to have ACT and KDHE more visible. Dr. Harrison stated Driving Force efforts are clearly part of the trauma system and believes we'd want to support those efforts. Dr. Rodenberg added that once Driving Force report comes out a number of different groups will sign on to different provisions, and all of them may not adopt all but would support certain items. Robert Waller also added that recommendations have to be based off data, which legislators will understand and drive changes.

Kerry asked Eric to further clarify a point from the slides he presented on the medical costs related to seat belt non-usage. The last chart showed charge data for only 28% of those cases used in analysis. Kerry inquired if it was reasonable to assume that figure will improve. Eric answered that figure won't change until more facilities decide to report charge data. Melissa pointed out three reasons charge data is not there. One, charge is not a reflection of reality. Two, access to that data from the registrars perspective. Three, some facilities won't report that information anywhere for a number of reasons. She suggested everyone to pose that question internally to their particular facility as the most effective means of increasing participation.

Dr. Harrison also pointed out the handout from Pam Kemp. She attended a conference where this material was distributed and wanted the committee to review it.

The meeting was adjourned at 2pm.