

**Advisory Committee on Trauma  
Meeting Minutes  
November 7, 2007**

**Attending:** Senator David Haley, Representative Geraldine Flaharty, Roger John, Kris Hill, Dr. Scott Sellers, Dr. Howard Rodenberg, Dr. Paul Harrison, Rosanne Rutkowski, Dick Morrissey, Kendra Tinsley, Dr. Pamela Steinle, Dr. James Longabaugh, Eric Cook-Wiens, Dennis Mauk, Darlene Whitlock, Melissa Hungerford, Dan Leong, Gloria Vermie, Robert Waller

**Absent:** Cathy Heikes, Chris Way, Dr. Stephen Smith, Kimberla Nutting, Terry Siek, Debra Pile, Robert Prewitt, Pam Kemp, Dr. Dennis Allin, Dr. Craig Concannon, Senator Susan Wagle, Representative Brenda Landwehr

**Visitors:** Lois Towster, Elizabeth Carlton, Carolyn Middendorf, Greg Crawford, Scott Harrison, Tara Brown

Dr. Harrison called the meeting to order at 10:09 AM. The minutes were approved as written. ([Click here for a link to the minutes from the last meeting](#))

**Introduction of Members**

As there were several new members of the committee, introductions of committee members were made.

**Election of Chair, Vice Chair**

Per state statute, elections for chair & vice chair are required each year. Dr. Harrison opened up the floor for nominations of the Chair and Vice Chair. He added that, while Dr. Allin was not here at this time, he had not indicated he would not want to serve again. Rosanne invited nominations for the Chairperson and Dennis Mauk nominated Dr. Paul Harrison, with Darlene Whitlock seconding the motion. There were no other nominations and all were in favor. Dr. Harrison thanked the committee and noted the great strides the program has made and especially in the last five years. The floor was opened up for nominations for Vice Chairperson. Dennis Mauk nominated Dr. Dennis Allin and Roger John seconded the motion. There were no other nominations and all were in favor. Thank you to Drs. Harrison & Allin for their service to this committee.

**Program Update**

Rosanne gave the program update and advised the committee of the two subcommittees that have met since the last ACT meeting. Both the Regional Trauma Plan Review Committee and the Kansas Trauma Registry Policy Committee met and reports will be given on their decisions. Robert Waller and the Board of EMS are continuing to work on the prehospital data system. The Joint Legislative Committee on Information Technology requested assurance that the Prehospital & Trauma Registry data collection

systems were not a duplication of efforts. The committee will be meeting again on the issue this Friday and hopefully will give their final recommendations. The designation regulations have been adopted and went into effect on Nov. 2, 2007. There were modifications to the regulations since the committee last met based on changes the ACS made in offering a one or three year certificate. The designation application form is available on the trauma web site.

Dr. Harrison commended the committee for getting the regulations approved in a relatively short period of time. Rosanne added the regulations will need to be modified for the Level 4 designation. The next project on the horizon will be the regional trauma grants. The trauma program is currently receiving additional funding as a result of SB 8 and the work done by the Driving Force which was co-chaired by Darlene W. There will be two focus areas to the grants. Focus area A funds will be awarded to a hospital within each of the six regional trauma councils to help facilitate fiscal operations of their trauma council. Focus area B grant funds are available to help facilitate development of a Level 3 trauma facility within each of the six regions as recommended by the Kansas Driving Force. A timeline for awarding and distribution of the grant funds was included in the meeting packet along with a draft of the grant application form. We would like to have the awards made by February 1<sup>st</sup>, when the KFMC contract expires. The grant program has been discussed with each of the regions and they are aware of the direction KDHE is taking.

Dr. Longabaugh inquired whether the regions themselves would be applying for the grant. Rosanne clarified that a hospital in each region would apply and that hospital would serve as the fiscal agent. Dr. Longabaugh followed up with an inquiry about what would happen if no facility were to step up. Dick Morrissey stated that the regional council would need to work with the area hospitals to come to an agreement.

Rosanne advised the council of staffing changes that will be taking place over the next several months. The position that Kendra currently holds at KFMC will be transitioned to KDHE. Kendra has provided notification that she is taking this opportunity to pursue other opportunities. Kendra reported that this was not an easy decision to make as she has enjoyed the opportunity to work with the regional trauma councils. Included in the meeting packet was a notice of vacancy for that position. Additionally, Rosanne's support staff member, Myriah Bowers, will be finishing her studies at Washburn and taking a position in another state effective early January. Dr. Harrison thanked Kendra for all of her work and noted the progress that has been made by the regional councils as a result of her work.

Next, Rosanne discussed plans to develop an annual report due to legislative inquiries last year. We are working with the same marketing company that developed the trauma logo to help develop a template for annual report. Included in the packet is a list of the committee and subcommittees members that will be included in the report. Rosanne asked everyone to review, advise us of any changes and let us know if they would like to be added to any of the subcommittees. She continued that it is important for the legislature to know there are a lot of people who contribute to the success of the trauma

program. Additionally, it is not just happening in Topeka, but all over and not limited to just the people on this committee.

Senator Haley pointed out the struggle with participation of the fellow legislators assigned to the committee and inquired whether there were any ideas to how we might bring in other legislative members. Senator Haley reminded those present of what an advocate Judy Showalter was and hoped that we could speak with Senator Wagle and Representative Landwehr. Dr. Harrison noted that increased legislative participation was one of the goals of the marketing campaign that we worked on last year. He continued that we sit in our quarterly meetings and do a lot of work and go back to our institutions and work, but we need to make the whole state aware. All the work done made the shock of possibly losing funding even stronger. A lot of folks came to the legislative committee meetings and supported the trauma program and we were able to dodge that bullet. Senator Haley agreed and noted that he was optimistic we will not have the same problem as last year.

## **Committee Reports**

### **Regional Trauma Plan Review Committee**

Rosanne provided the Regional Trauma Plan Review Committee update in Dr. Allin's absence. ([Click here for a link to the minutes from this meeting](#)) All of the regional plans were reviewed by KDHE prior to review by the committee. The committee recommended the plans be approved as written. The committee noted there was a lot of progress, even from two years ago. The committee recommended regions provide a more specific plan for education, field triage guidelines, and encourage follow-up communication between transfer and receiving hospitals. In reference to the education needs the ACS also asks for more specific information, i.e. what kind of education and where it is needed.

Dr. Harrison confirmed that the regional councils can adopt field triage guidelines and will need to work with individual providers as some are still going to the closest hospital and not the closest appropriate. Previously there were no guidelines on this and the hope is as the trauma system develops the need to transfer to the closest appropriate facility will become more apparent. Additionally, he stated this is not something the state can do for each region. Dennis Mauk agreed that the regions can act as a resource for individual development.

Rosanne continued with the recommendations of the committee, who encouraged dialog with other organizations and highlighted the responsibility of the regional representatives to report back to their regions on statewide activities. Additionally the committee recommends the regions review on a regular basis summary EMSsystem logs for any issues related to diversion and identify members who would agree to serve as a liaison with their elected officials regarding trauma system issues. Darlene Whitlock agreed that she has heard from her classes that people want feedback on their patients.

Senator Haley noted that email communication was a fantastic way to get a hold of him and many of the other legislators; while some would even prefer a phone call. He added that as the legislature goes into session in January it becomes a very busy time for them and it would be advantageous to address issues before that time.

### **Kansas Trauma Registry Policy Committee**

Rosanne prefaced the registry report by advising the committee had not met in approximately one year due to wanting to ensure there were several issues to discuss. [\(Please click here for a link to the issues and their recommendations from the committee\)](#) Dr. Harrison suggested the adoption of all the changes as recommended by the committee except for the second issue. Eric advised he is waiting to hear from one more hospital, if they do not need the data element it will be removed but if they do the issue will be addressed again. Darlene moved to adopt the recommendations and Roger John seconded the motion, with all approved.

### **Legislative Report**

Dr. Rodenberg briefly discussed upcoming legislative activity with ties to trauma. There was an interim meeting on graduated driver's licenses, which made it out of the committee in the Senate but got held up in the House transportation committee. The measure was able to be scheduled in a joint committee. We know that graduated licenses work for novice drivers, but there is not a lot of interest in the House on moving this issue forward. We probably won't see a lot of progress on this anytime soon. We had a little victory last year, but we are not where we need to be in terms of seatbelt law. Dr. Rodenberg referenced a USA Today survey documenting where 8 out of the 10 states without a primary seatbelt law had an increase in motor vehicle fatalities.

On another issue, the Kansas Health Policy Authority (KHPA) has been dealing with Medicaid and how to get everyone covered. KHPA wants to promote good health practices and has adopted 21 different recommendations which they will present to the legislature. A lot of those recommendations are in relation to preventative health, smoking cessation, physical activity, etc. Their recommendation on a primary seatbelt law did not make the cut. It was recommended that they look at differential reimbursement for trauma patients, but none of that has happened yet.

Senator Haley inquired on whether we would be reviving the helmet law due to a concern from one of his constituents. Dr. Rodenberg advised he had not heard anything to that effect, but it is part of the Driving Force long term plan. Darlene added that graduated drivers licenses and primary seatbelt law are a bigger saver of lives. Dr. Harrison also noted that one of the two people who spoke against the primary seatbelt law was concerned about the helmet law.

### **EMS/Trauma System Development in FLEX Program 2008**

Rosanne introduced Gloria Vermie, Director of Rural Health in the Office of Local and Rural Health. She had asked Gloria to give an update on the FLEX program due to increased interest in funding. Also, there are some decisions the ACT needs to make about funding related to trauma in the FLEX grant.

Gloria gave an overview of the FLEX program history, its operations in Kansas and the 2007-08 plans. The program was fully funded for the next three years. Gloria expressed her appreciation for all the work done through KRHOP and the program will continue to dedicate whatever it can to support.

There was discussion on the options to utilize funding. Specifically, the state trauma consultation team has had two additional members added to it, which has increased the cost from \$40,000 to \$60,000. Rosanne referred the committee to the ACS state consultation questionnaire located in the meeting packet. She continued that if this is the direction we want to go, this document will be critical to the consultation. This questionnaire indicates on some level state system standards. For example, education criteria are listed on page 22 and 23, and it is more than just having education classes but defining what the standards are. Dr. Harrison added that it may be outlining how much trauma specific education is expected for physicians if they are at a Level I trauma center.

Rosanne requested to establish a committee that would review the different trauma system assessment models and bring a recommendation back to the ACT. Gloria confirmed that the funding set out in the FLEX grant is not tied to a specific program. Dr. Longabaugh inquired whether the BIS model can be applied at a regional level. Dick replied that is something the committee could find out more about and it should be a priority. Rosanne asked those interested in being on the committee to let her know.

### **Trauma Registry Update**

Eric provided an update on the trauma registry. Current reporting for the second quarter has 118 of 123 facilities reporting. All facilities have reported for 2006. We have updated our database system to CV4, a new version of the software from DI. All local users have switched to the new version. An update is in the mail that will improve keying speed. The data transfer process will be different with the new version and central site data processing will be updated. In general, the new data transfer process has been tested with great success and will be a major improvement for both the central site and for hospitals.

Submission to the National Trauma Database of 2007 records will differ significantly from past practices. In the past, the central site has submitted data for all facilities in Kansas as a 2nd party submitter. However, because of statutory constraints related to confidentiality, the state registry was not able to identify hospitals in its submission to the NTDB. For this reason, the ACS has requested that hospitals do their own submissions. Those facilities that complete the submission process will receive benchmarks from the NTDB which will allow each submitting facility to compare their own data with data from similar facilities across the nation. The state will help to facilitate the transfer

process but hospitals must complete their own submissions. In the spring 2008 Digital Innovation will supply all hospitals with a program, called “Validator”, to map their data to the National Trauma Data Standard Dictionary. Those facilities that complete the submission process will receive benchmarks from the NTDB which will allow each submitting facility to compare their own data with data from similar facilities across the nation.

## **KHA Report**

### **EMSystem Update**

Dan Leong advised the committee on updates to the EMSystem. It is currently a tool all hospitals are using and the company is now employee owned. They have branched out and now offer EMResource, EMCredential and EMTrack. EMResource offers a patient tracking function by using bar code scanners. In Kansas we have been using just EMSystem. There will be updates to the system in November. There has been a lot of work making sure the system is user friendly and is utilized. Funding for the project was provided by KanEd.

### **ACS Consultation Project**

Coffeyville ACS consultation was on October 22. The reviewers have identified PI programs as a need and have suggested that the Level I's offer assistance. The next ACS consultation visit is scheduled for November 25, 26, 27 for Parson followed by Hutchinson. The consultation visit for Hays has been scheduled for January. Hospitals have been getting great feedback and have found the visits beneficial and informative. Any remaining funding will depend on whether Salina would like to go ahead. If there is still funding we would also like to include Garden City. We are working with those facilities to get coverage in all regions. Rosanne added that the region was going to go back to Saint Catherine's and speak with them about a consultation. The hospital administration may be a little reluctant but they have a new surgeon and are making some progress.

Dick inquired about the patient tracking add-on and how that would apply. Dan replied that the South Central region received funding to do patient tracking and the hope is that EMTracking will apply for the RFP. Dick noted that in situations like Greensburg patient tracking becomes an issue. Melissa added that there has been communication with the Missouri Hospital Association who is also looking at patient tracking.

### **Analysis of the SC Triage Tag Linkage Project**

Kris Hill discussed her analysis of the SC triage tag project. . KDOT and the SC KTRC helped fund the trauma tags with the bulk of the tags distributed from mid-July to August. At the end of August a survey was sent to facilities and the results were provided to the committee. Approximately 20% of EMS services responded. Findings include: smaller

facilities had to remind their staff due to lack of quantity, they were easy to write down and document. The biggest concern was the cost of the tags.

Eric reported that within the trauma registry we get records from the receiving and the referring facility, but right now we have no way to figure out which goes with which. We could use other data elements such as date of birth and gender but it has limited success. We don't expect to get a complete data set until the end of November due to the submission deadline. We were able to get records from 20 of 29 facilities. Of those records 67% had missing values in the field for trauma bracelet number, which can be due to a number of issues. Some of those missing values could be due to training issues or running out of tags.

There was some discussion concerning the use of the tags, training of staff, and distribution. Dennis Mauk added that there is just enough complexity to the tag that it is not always used correctly. Dr. Harrison noted that it was a good start and inquired what the next step would be. Dick suggested that once it is a statewide system the training issues will go down, there would be less confusion with a standardized process.

A discussion on the reason for using these tags instead of the original bracelets followed with general agreement that it was important to keep the process as simple as possible and take advantage of tags most EMS services are already using. Kris suggested we wait to get more complete data from the registry once the submission deadline has passed and make decisions on expanding the project at that point.

Dick noted that if the project were to be expanded at some point there would need to be regulations adopted on using the tags. Rosanne noted that KDOT would possibly be interested in offering additional funding due to their ongoing Traffic Records project. Dr Longabaugh offered that a number could be assigned retrospectively to patients and there would not have to be a tag at all. A lengthy discussion followed on establishing a retrospective number that would not be linked to personal identifier which could not be used due to HIPPA regulations. Melissa inquired whether it would be a HIPPA violation because the number would not be given publicly, only to another facility that already has a complete set of personal information. Eric suggested we seek the advice of legal counsel to determine if that course would be available.

## **Board of EMS Report**

### **Prehospital Data Collection**

Robert Waller provided the committee with an update on the prehospital data collection project. He advised there were five vendors that responded to the RFP. There was a small snag with the legislative joint committee on information technology due to a misunderstanding of where EMS fits in between traffic records and the trauma registry. We will be going back and providing more education on what EMS is. They are a couple of weeks from deciding on the vendor and then implementing the pilot. As long as the legislative joint committee releases the project BEMS will be on schedule.

Rosanne added that it was important for everyone to know the answer to the question of why we can't use one vendor for both systems. DI did not respond to the RFP. One thing in the RFP was the importance of having an interface between prehospital and trauma data. Dick added that our practical experience is that every vendor says they can do it, but the questions becomes when it will happen.

### **Regional Reports**

**NE** – Dr. James Longabaugh and Darlene Whitlock gave the Northeast regional report. They reported on the prevention workshop (train the trainer model) held on October 29, 2007. Scholarships were provided for the first person registered from each facility in the region and sixteen attended. Each attendee agreed to teach a prevention workshop in the regions. A RTTDC course was held at Jefferson County Hospital on November 1 and was funded by KRHOP. The committee continues to work on education for EMS medical directors from the NE region and is developing a 2-3 hour pediatric training workshop. The education subcommittee is about to release their first quarterly newsletter that will be emailed throughout the region. Topics will include such items as trauma tips, regional activities and hospital resource features. Chris Keeshan of Chris Keeshan and Associates in Topeka spoke to the executive committee on grant writing at the October 1 meeting. The committee continues working on developing a quality improvement project. They will determine goals that are more specific and develop this over time. The next executive committee meeting has been scheduled on November 12 at the Pozez Education Center, Carkhuff Room.

Dr. Longabaugh added that the committee would like to expand their funding and the grant writing professional said their receiving would be greatly expanded if at least some element of the council is a 501(c) 3. He continued that they would also be able to apply for more grants and expand their work.

**NC** – Dr. Pamela Steinle reported for the North Central region. There was a TNCC course held at Ellsworth County Hospital and ten attended. The committee has been working with Smith County on an EMD training project which could also include Cloud and Jewell counties. Smith County Hospital will host a RTTDC this spring using RTC funds. The next executive committee meeting will be held on January 16, 2008, at Clay County Medical Center.

**SC** – Kris Hill provided the report for the South Central Region. A follow-up survey was distributed to all EMS agencies and hospitals in the region for the triage tag project. Overall the results of the survey were favorable. A RTTDC has been scheduled for November 20 at Edwards County Hospital and District #1 of Rice County hosted TNCC October 8 & 9 where 9 attended. The executive committee has scheduled a strategic planning meeting on December 13 in Wichita. The committee will consider the next steps and goals related to the regional trauma system plan. Requests for project funding were e-mailed last week. The next executive committee meeting has been scheduled for

December 13 at Via Christi-St. Francis in Wichita. Kris also requested that there be a blurb in the minutes recapping any legislative issues.

Kendra Tinsley gave the report for the Northwest, Southeast and Southwest regions. The Northwest region sponsored and ATLS course at Hays Regional Medical Center on October 12 and 13. The class was full and had a waiting list. 16 attended the PHTLS course held at Phillips County Hospital on September 27 and 28; 8 attended the TNCC held at Logan County Hospital on October 3 and 4. The committee is collaborating with the EMS region on EMT scholarship disbursement. Their next executive committee meeting has been scheduled for January 23, 2008, at Hays Regional Medical Center.

The Southeast region annual meeting was held on September 6 at Labette County Medical Center with thirteen attending. ACS green books (60) were purchased for distribution throughout the region. TNCC has been scheduled for February 27 & 28, 2008, at Wilson County Hospital. The next executive committee meeting has been scheduled on December 20 at Labette County EMS.

The Southwest region has scheduled RTTDC at Hodgeman County Health Center on November 20, 2007 and TNCC at Western Plains Medical Complex on January 7 & 8, 2008. Their next meeting has been scheduled on January 23, 2008, at Finney County EMS.

### **2008 Meeting Dates**

Rosanne directed the committee members to the listing of the 2008 meeting dates located in the meeting packet. Chris Way had inquired about changing the date of the November meeting in 2008 to the second or third week. The second week in November is used for the KHA conference and there are occasional conflicts with the holidays in the third week. The committee discussed having the November ACT meeting and the Regional Executive meeting in different weeks. Rosanne stated it would be taken under advisement.

### **Other business**

Darlene asked for support of the members of the committee on the primary seatbelt law. Dr. Harrison wondered if there was a query that could be run to find out how many people have died in motor vehicle crashes since the last legislative session that failed to pass the bill. Representative Flaharty noted that it would be a very effective tactic to present that information to committee along with relatives of those who died.

Darlene also asked if it was possible to make our meetings a little "greener." Rosanne advised we would take steps to increase our recycling and invited those in attendance to leave their packets if they wanted us to recycle them.

The meeting was adjourned at 2:28 PM.

**Advisory Committee on Trauma  
Regional Trauma Plan Review  
September 18, 2007  
Stormont Vail Pozez Education Center**

**Members present:** Dr. Dennis Allin, Debra Pile, Darlene Whitlock, Robert Waller, Dan Leong, Eric Cook-Wiens, Kendra Tinsley, Rosanne Rutkowski, and Dr. Paul Harrison. By phone: Cathy Heikes, Dennis Mauk

The meeting was called to order at 10am. Introductions were made by the committee members present.

**Regional Plan Process:** Rosanne Rutkowski briefly provided an update and reviewed the regional plan review process. The regional plans have been reviewed for content internally by the trauma program staff and their respective reports were provided to the committee. As part of the regional trauma plan review process, the purpose of this committee is to review and make recommendations back to the ACT and regions on the regional plans. The recommendations will be reported back to the ACT in November.

**Regional Trauma Plan Development:** Kendra Tinsley provided an overview of the process the regions went through in updating their plans. The plans were mailed to every regional trauma council member representative. Each trauma council scheduled time during their annual meeting this spring to review, discuss and approve their regional trauma plan. Very few comments were provided during those meetings. The regional plans were submitted to KDHE by July 1<sup>st</sup>. As part of the internal review process, Kendra provided an “At-A-Glance” review of changes between 2005 and 2007. ([Click here for a link to Kendra’s report](#))

**Review of 2005 recommendations:** Rosanne provided a brief review of what the recommendations of the committee were in 2005 regarding the regional plans. Please see list from the August 2005 minutes. ([Click here for a link to the August 2005 minutes](#))

**NHTSA Assessment Recommendations:** Rosanne provided the committee a review of the recommendations from the NHTSA reassessment where there was overlap with the regional trauma plans. ([Click here for a link to a review of the NHTSA Reassessment Recommendations](#))

**Analytical Review of the Plans:** Eric Cook-Wiens provided an overview of the regional plans related to references of trauma data collection. ([Click here for a link to Eric’s report](#))

Eric reported that expectations of the data were more realistic in the 2007 plans than in 2005. Trauma registry data is designed to be utilized first and foremost by the hospitals collecting the data. Eric cited the example of rehabilitation data. The state data system is not designed to look at rehabilitation needs, but individual hospitals can evaluate those needs for their hospital. The state registry staff is willing to help hospitals with any specific data requests they may have to enable them to better utilize their registry data.

Eric did point out that there are certain limitations to the state central site data. We are working with hospitals to ensure the quality of the data, but we are limited in our ability to ensure that all patients who meet case criteria are reported.

Dr. Harrison asked if it was possible to do an analysis of trauma registry data to hospital discharge data set as one means of determining data capture. Dennis Mauk asked if zip code and county level data analysis could be done.

### **Committee Review & Discussion:**

Dr. Allin stated that he felt there were several areas of the regional plans that overlapped with issues broader than just trauma

*Communications:* Communications is one area identified in each of the plans. The NHTSA assessment identified this as an area where EMS needs to be an active player. EMS and trauma need to be at the table with KDOT when communications issues are discussed.

*Education:* Regions have identified in their plans that they have education needs but they lack the resources to address them. The committee discussed the need for regions to be more specific in what those education related needs are. For example: How many more ATLS classes do they need? And, should they be provided in the rural or urban areas? The committee is recommending that the regions provide a more defined action plan on how to support education.

*Global issues:* Darlene recommended that regions devise a means by which transfer and receiving facilities communicate.

*Field Triage:* Field Triage in the green book recommends patients are transferred to “highest” level of trauma care within the trauma system without consideration for what the time or distance might be. Regions are recommending having a more specific action plan. The committee discussed how local EMS protocols are approved and by who. Is it the medical director? Or, are those decisions made at the county commissioner level? What should be contained in the model protocols? And, what is the role of the medical directors? Several of the regions are requesting that copies of the trauma plan be provided to the medical directors.

The committee briefly discussed what the role of bioterrorism and hospital preparedness professionals should be in the process and the need to be communicating with the various disciplines.

*Medical Dispatch:* Medical dispatch related to the trauma plans was discussed. Dr. Allin asked if the state of Kansas is ready for the regional plans to say they need EMD training. The committee discussed barriers related to EMD training. Several regions are to be commended on their efforts in collaborating with law enforcement to promote EMD training. Kendra will provide an updated list of who has participated in state sponsored EMD training.

Robert Waller reminded the committee that the Kansas Highway Patrol is key in central dispatch services.

It was recommended that ACT present at the APCO conferences which are held each year.

*Pediatric Protocols:* It was recommended that we continue collaboration efforts with the EMSC project and that we encourage the EMSC pediatric guidelines be made available as model protocols for local agencies to adopt, modify and use. Members of the committee need to continue to serve as liaisons with EMSC and promote these types of activities when the occasion arises.

*Diversion:* It was recommended that a common language be adopted at the regional level. For example: by-pass and diversion can have different meanings depending upon the area or region. By-pass might mean the hospitals can provide the services, but EMS chooses to transfer the patient somewhere else. Diversion might mean that the hospital cannot provide the services and EMS transports the patient elsewhere.

It was recommended that summary EMSsystem report logs be provided at regional trauma council meetings so they can be reviewed.

It was suggested that if regions look at under- and over-triage that they have protocols they can refer to. Dennis Mauk suggested that facilities be reminded that when they are evaluating the process they should expect to have a higher number of over-triage.

Meeting adjourned at 11:45

### **Summary of Committee Recommendations:**

- 1) The plans should be approved as written.
- 2) The regions should be acknowledged for the work they put into developing the plans.
- 3) The following items were recommended for follow up by the regions:
  - a. More specific action plans need to be developed for:
    1. Education
    2. Field triage guidelines
    3. Encourage follow up/communication between transfer & receiving hospitals
- 4) The committee recommends the ACT encourage dialogue with organizations such as APCO and EMSC. It is the responsibility of the regional ACT representatives to report back to the RTC membership or organizations on statewide activities.
- 5) The regions should review on a regular basis summary EMSsystem logs for any issues related to diversion.
- 6) It was recommended that regional councils identify members who would agree to serve as a liaison with their elected officials regarding trauma system issues.

**Kansas Trauma Program  
Regional Trauma System Plans  
"At A Glance"  
September 18, 2007**

Overview

The 2007 Kansas regional trauma system plans were developed by a committee of Kansas Trauma Program staff and by committees of the six regional trauma councils. While they may appear similar to the plans of 2005, several revisions have been included. The format and font of the document was changed to reflect a more professional appearance and to reduce paper use. The regional trauma councils and KDHE accomplished many goals over the past two years and those are reflected throughout the documents. Basic facts, data and programs have changed and updates were included based on the latest information that could be obtained at the time of writing. Major revisions that may not be readily noticeable include fewer references and goals related to the legislature and funding. Through education and collaboration with KDHE and others, the plan reflects a more realistic and optimistic view of the future. The goal of all committees is to create a more refined and useful document over time.

Included in this document are specific revisions related to needs and goals found in the 2007 plans. Many of these have been added as new items or have been significantly revised from the 2005 plan. Not all plans are the same, however, they hold many similarities. The SCKTR plan was reviewed for this document. On a final note, most RTCs recommend use of the "green book" in development of field triage decision scheme criteria. The NEKRTC maintained the 2005 field triage decision scheme criteria.

B. Communications

- **Added:** Support of KDOT Communication on Wheels Trailers and support of Statewide Interoperable Communications System
- Retained the goal of maintaining two EMD instructors for the Southern Trauma Regions (B (d)). No dedicated funding source.
- **Added:** Development of interfacility transfer agreements (B (e)).
- **Added:** Development of minimum scene time standards (B (e)).
- **Added:** PI regulations developed (B (e)).

C. Field Triage Guidelines

- Revised entire document to reflect the revision of the 1999 "Gold Book" to the (Committee on Trauma (2006), *Resources for Optimal Care of the Injured Patient: 2006*, American College of Surgeons, Chicago.)
- **Added:** Over and under triage information needed as it applies to referral of trauma patients.
- **Added:** Promote use of an identification number with the trauma registry to establish patient flow patterns.

- **Added:** Develop Level IV trauma center criteria.
- **Added:** EMSsystem® will be used to establish a regional baseline to emergency department status trends.
- **Added:** Develop and disseminate an Inter-facility transfer guideline/agreement template to all hospitals and EMS agencies and encourage each facility/agency to develop and implement inter-facility transfer guidelines/agreements specific to their facility/agency and region (C c(2)).
- **Added:** Obtain data from EMSsystem® regarding hospital emergency department status episodes (C c(2)).
- **Added:** A standard patient classification system will be developed.
- **Regional 800 Number:** Most plans refer to 800 numbers established at trauma centers or other larger facilities (C (e) 3).
- **Added:** Increase the number of facilities with written transfer agreements.
- Related to the 2005 plan, there remains little mention of medical control in the 2007 plan. There is a plan to distribute trauma plans and sample protocols to medical directors.

#### D. Healthcare Facilities

- Continued support of Level III designation.
- **Added:** Explore relationships with EMSC through use of subcommittee (the purpose of this subcommittee is to develop guidelines in accordance with the "green book").
- **Added:** Review of "green book" pediatric guidelines is needed.
- **Added:** Designation of Level III trauma centers to include all pediatric criteria as recommended by the ACS.
- **Added:** Complete rehabilitation survey.

#### E. Evaluation

- **Added:** EMS agencies need to improve the quality, completeness and timeliness of run reports needed by facilities for patient care and to improve data quality.
- **Added:** Facilities need to use data reports to drive performance improvement in their individual facilities.
- **Added** several more specific long term goals to include the following:
  - 100% of hospitals and EMS agencies in SCKTR will report Kansas Trauma Registry data.
  - 100% of hospitals will report trauma data to the state registry within the quarterly deadlines.
  - 90% of the trauma reports will contain Glasgow Coma Score, respiratory rate, and systolic blood pressure values for prehospital.
  - 90% of the trauma reports will contain Glasgow Coma Score, respiratory rate, and systolic blood pressure values for ED.
  - 100% dispatch time will be reported by prehospital.
- **Added:** More specific regional performance improvement and feedback loop goals to include the following:

- SCKTR will assist and support efforts of the Kansas Trauma Program by providing input into the development of a regional PI program.
- Facilities are encouraged to develop a process for reviewing trauma case records.
- Facilities are encouraged to use their trauma registry to support the PI process.

#### F. Injury Prevention and Control

- **Added:** Support of the Driving Force.

#### G. Human Resources

- **Added:** The Kansas Trauma Program does not require trauma education for all providers who treat trauma patients.
- Retained need for education funding, i.e., Demand and need for courses outpaces resources.

**Advisory Committee on Trauma  
Regional Trauma Plan Review Committee  
Minutes  
August 4, 2005**

Members present: Dennis Allin, Dennis Mauk, Darlene Whitlock, Melissa Hungerford, Kendra Tinsley, Eric Cook Weins, Rosanne Rutkowski, John Araujo Cathy Heikes( by phone)

Guests: Chris Bandy, Chris Tilden

**Call to Order:** The meeting was called to order by the Chair, Dr. Dennis Allin. Dr. Allin provided an overview of the process and expectations for the meeting.

**Regional Plan Process:** Rosanne Rutkowski briefly reviewed the approval process for the regional plans as approved by the Advisory Committee on Trauma.

**Regional Plan Development:** Kendra Tinsley provided an overview of the process that the regions underwent to develop the plans. KFMC staff coordinated meetings with the regions to develop the various components. Once the plans were written, they were mailed to the regional trauma general membership which included all hospitals, EMS, health departments and their member representatives. The regional trauma plans were recommended to be approved by the general membership at each of the respective regional trauma councils general membership meetings held this spring.

**Analytical Review:** An indepth analytical review was done of the South Central Plan with the assumption that all plans were similar but knowing there would be some variations among the plans. Please see attached document for summary analysis of issues to be identified through trauma registry data. Currently 9 of the 22 issues can be addressed with the data collected.

Melissa stated that hospitals need to use the data before it can be used at the regional level for system performance. She reported that the data completeness reports currently provided to the hospitals do little to encourage compliance with reporting. Hospitals need to use the data so that it is of benefit to them. They want to benchmark data at the local level and compare themselves to aggregate data collected at the state and regional level. Something that is not currently available. Hospitals need more education to understand how the data can be used. There are three audiences for the data, local user, regional and state. We need to make the data useful at the local level before compliance will increase.

**Points for consideration:**

1) EMD training and education varies by region. The question was posed to what role the ACT might play in promoting EMD training.

Communication was another area where gaps were identified. It was recommended that in an effort to address this issue, the statewide communication committee continue to function in an effort to address the needs identified.

2)Medical Control: little was mentioned in any of the plans regarding medical control.

3)Comprehensive data collection: There was discussion regarding working with the Board of EMS with their pre-hospital data collection system in an effort to avoid duplication of data entry. Even if the core registry data set were expanded, it might be a challenge to collect certain data elements such as EMS response times. The question was raised regarding changing the requirements for transferring hospitals to report data and requiring receiving facilities to report data from time of injury to final receiving hospital.

4) Performance Improvement: Before hospitals will support or participate in a regional PI process, they want to use the data for their own quality improvement. Most hospitals do not know how to utilize the data currently being collected. The person doing the registry data collection is often not the same person that would use the data for quality improvement.

5) Legislation: All of the plans included language related to going to the legislature for additional funding and /or approval for development of a quality improvement process. It was pointed out that it will be important to have full support before approaching the legislature.

6) Funding issues: Support for trauma education was mentioned in all the plans as well as support for a regional 800 number for coordination of patient transfers.

7) Some items in the plan are not realistic. An example provided was reference to using the EMS system for evaluation and to establish baseline information.

**Recommendations:**

1) It is recommended that the regional plans be approved as written with the notation that it be recognized that this is a preliminary first step.

2) It is recommended that the regions be thanked for their efforts in developing the regional plans.

3) After review, we have identified gaps and issues that need to be addressed. There were expectations identified in the plans that are not realistic with the current resources.

4) It is recommended that hospitals be provided training and education related to using data internally and that they be provided a means by which they use the data to compare themselves against regional or state aggregate data.

5) It is recommended that the regions focus their efforts on 1) defining triage guidelines for the region 2) identifying education needs related to improving trauma care and data collection 3) promote injury prevention efforts based on data collected.

# NHTSA REASSESSMENT & KANSAS REGIONAL TRAUMA PLAN REVIEW

## STANDARD

### 1) Facilities:

#### NHTSA Recommendation:

- 1) Examine & evaluate the existing regional triage and transfer protocols for appropriateness & correlation w/ facility care capabilities:
- 2) Arrange a multiregional representative meeting to develop cross regional min. standards for triage & transfer
- 3) *Work with KHA to obtain information regarding ED capabilities of all Kansas hospitals & utilize this information in the development of triage protocols.*

#### Regional Trauma Plans

- NE: Developed triage guidelines based on ACS
- SW, NW, SE, SC, NC: Triage protocols are responsibility of each organization & developed w/ local medical advisors  
Recommends field triage guidelines but every agency is responsible for developing their own.

### 2) Public Information, Education & Prevention:

#### NHTSA Recommendation:

- 1) Support information dissemination to EMS agencies, providers.....

#### Regional Plans

Regional Plans recommend support of prevention efforts based on registry data  
Increase awareness of resources such as the injury resource guide

### 3) Medical Direction:

#### Regional Plans

- NE: Establish an annual CME or training for medical directors
- NC: Encourage medical director's participation in RTC activities
- NW: Distribute trauma plans to medical directors
- SE: “ ”
- SC: “ ”
- SC: Will also provide protocols if requested
- SW: “ ”

#### **4) Communication**

##### Regional Plans

NE: EMD training site  
SE,SW, SC: EMD training site

Pre-arrival card sets have been distributed to dispatch centers,  
Education about importance of EMD training.

## **2007 Regional Trauma Plans**

### **Review of Expectations for Kansas Trauma Registry Data Analysis**

**DRAFT: 8/29/2007**

The 2007 update for the Kansas Regional Trauma Plans contains several references to specific uses for trauma registry data. These analytical needs will support decision-making for trauma system issues, either at a regional level or at a statewide level. This document is intended to clarify the expectations for data analysis from the trauma registry and, where applicable, note current initiatives being supported by the central-site registry as they apply to the plans. Comments are categorized according to the organization of the regional plans. Sections of the plans that do not refer to the trauma registry are omitted.

#### **B. Communications**

*(e) Response and Scene times.* Previously, this analytical need could not be met because only two pre-hospital data elements were included in the state-required core dataset. The newest version of the registry software will require additional pre-hospital date/time elements. The registry will now support analysis of response-time, scene-time and other pre-hospital care measures.

Some of the plans refer to specific guidelines for response times categorized by population density. This analysis refers to the specific circumstances of the injury scene (rural vs. urban) that cannot be determined with registry data.

It is important to note that trauma registry data are not collected from or reported back to EMS agencies. Therefore, programs or interventions that are initiated as a result of trauma registry analysis will likely be targeted to pre-hospital providers that may not be acquainted with the trauma registry and its uses.

#### **C. Field Triage Guidelines**

*(c) Resource Utilization.* Efficient resource utilization is an important motivation for establishing trauma systems, particularly in rural areas. Evaluation of data to maximize efficiency through the system should be understood as a long-term goal that will rely not only on trauma registry data, but on EMS system data, EMS registry data (KEMIS), weather data and other data sources. At this time, the analytical needs alluded to in this section cannot be met with current data systems.

*(d) Facility Triage Criteria.* As a hospital-oriented database, the trauma registry is well equipped to address facility triage questions. However, these questions will be different in each facility depending on adopted protocols, trauma activation procedures and facility designation. Therefore data analysis of the trauma registry for facility triage questions will continue to be primarily a within-facility process that will not rely on the state trauma registry.

*(e) Inter-Hospital Transfers.* The Kansas Trauma Registry has implemented data reports that include statistical summaries for several quality indicators related to decisions to transfer and timeliness of transfer. However, it should be noted that these quality

indicators do not take transfer agreements, diversion circumstances or availability of transportation into account because those data are not available within the trauma registry.

#### **D. Healthcare Facilities**

*(d) Trauma Rehabilitation Services.* The trauma plans suggest that the trauma registry support needs assessment for rehabilitation services. The central site trauma registry can be used to monitor the volume of discharges directly to rehabilitation services and can provide statistical summaries on disability at discharge. However, the trauma registry is not designed to be a data resource for this type of needs assessment.

#### **E. Evaluation**

*(a) Data Collection.* Current registry procedures include frequent feedback on data quality. A quality and completeness report is returned to each facility after each submission highlighting missing data and obvious inaccuracies. In addition, quarterly data reports contain information on data completeness for crucial physiologic measures and for data elements necessary to evaluate quality indicators. However, it should be noted that the completeness of the central site registry is unknown because eligibility of patient records for the state registry is ascertained and records are abstracted within each facility. Through reporting and training, we strive for complete and reliable data, but this responsibility is fundamentally one of facilities.

*(b) Regional Performance Improvement.* Processes for regional performance improvement are under consideration in some regions.

#### **F. Injury Prevention & Control**

*(a) Identification of resources within the region to address identified risk areas.* This analytical need requires central site registry analysis. Currently, results are disseminated in routine reports from KDHE, newsletters or presentations at regional meetings. Further specific analyses to support development of regional injury prevention plans should be requested from the Kansas Trauma Registry central site.