

Advisory Committee on Trauma
August 22, 2007
Meeting Minutes

Attending: Craig Concannon, Debra Pile, Robert Prewitt, Dennis Mauk, Pam Kemp, Darlene Whitlock, Eric Cook-Wiens, Kris Hill, Dr. Paul Harrison, Cathy Heikes, Representative Geraldine Flaharty, Roger John, Dr. Dennis Allin, Dr. R. Stephen Smith, Senator David Haley, Dick Morrissey, Dan Leong, Dr. Howard Rodenberg, Melissa Hungerford, Robert Waller

Absent: Dr. Scott Sellers, Kerry McCue, Chris Way, Kimberla Nutting, Senator Susan Wagle, Representative Brenda Landwehr

Guests: Lois Towster, Liz Carlton, Dr. Chris Bandy, Caroline Middendorf, Connie Hubbell, Scott Harrison

Meeting called to order by Dr. Paul Harrison at 10:00 am. Minutes were approved as written. [\(Click here for minutes from the last meeting\)](#)

Program Update

Rosanne began by advising the committee that all of the regional trauma plans were submitted on time on July 1 to KDHE. The review of the plans was delayed until the completion of the NHTSA assessment to allow for consideration of those recommendations. The plan review meeting has been scheduled for September 18 at Stormont Vail and feedback will be available at the November ACT meeting.

The federal legislation did not receive any funding. Rosanne stated there is great support from the local legislators, but somehow the message is not getting out at the federal level.

A hearing has been scheduled for Sept. 12 for the trauma center regulations. There was a hearing July 9 with the legislative joint committee. As is procedure, the committee provided KDHE with a letter listing their concerns with the regulations. There were 5 issues the committee identified as concerns. KDHE will prepare a response to their concerns which will be provided as part of the public record. The first issue listed was their concern about monitoring trauma centers and the number of times they go on “by-pass”. This is an issue that the ACS reviews when doing verification visits. The ACS web site says it cannot be more than 5% of the time. Dr. Smith clarified for the committee that the 5% is by time, i.e. 5% of the total number of hours. The second issue was the committee believed the “green book” should be adopted by reference which differs from the recommendation from the AG’s office. They also had questions regarding incomplete applications and ability of a hospital to call itself a “trauma center.” Additionally the legislators believe the regulations should be clearer on use of the terms “desired” and “essential” criteria.

Rosanne also advised the committee that the cost for the ACS state system consultation has increased from last fall when she talked with them from \$40,000 to \$60,000 as of yesterday. The ACS has increased the number of team members to include two consultants for an additional cost

of approx. \$13,000. Last fall when plans were initially discussed regarding the ACS state consultation, Rosanne requested federal grants funds to cover \$20,000 with the remainder anticipated to be covered by any unobligated grant funds KHA currently has for hospital consultations.

Program Budget

Dr. Howard Rodenberg discussed the program budget with the committee. When the legislature authorized passage of Senate Bill 8 it included funding for the Board of EMS, KDOT and the Trauma Program. The bill was passed at the recommendation of the “Kansas Driving Force” which also recommended that a Level III trauma center be supported in each of the six trauma regions. Revenue from fines, fees, and penalties has been estimated to be approx. \$530,000 per year. This increase in funding puts us in an advantageous position to encourage the development of trauma centers and to increase support of the trauma regions. One recommendation is to change how we support trauma councils. Currently each region receives roughly \$6,000 through contract with KFMC. We want to accelerate support of the regions. The draft regional trauma council and trauma facility grant concept paper located in the meeting packet outlines the proposed use of the additional funding. [\(Click here to see the concept paper\)](#) There would be a competitive grant process for funds to help with the verification process. If there is more than one facility in the region that would like to be accredited, the councils would not have to be in the middle of breaking any ties. This provides concrete funding to help verification and education.

Duties currently performed under contract with KFMC would be assumed in-house because there are certain economies in function that can happen when program staff are located together. In addition, regions have been asking for regional quality improvement initiatives. KDHE in consultation with the ACT needs to develop a plan for what and how quality improvement should be at the regional level. Once the process is formulated, regulations will need to be written. It is recommended that KDHE contract with KFMC to provide “consultation” services on developing a plan for regional quality improvement. KFMC’s expertise is QI and we would like to take advantage of that resource.

Darlene Whitlock began the discussion by bringing up that several years ago the thinking was to outsource staff as an efficiency. Dick Morrissey responded that there was a time when adding staff was critically evaluated but this will put us in a position where we can look long-term. He also stated this seems like a logical next step in program development. Dr. Harrison added that this concept is seen in trauma system development where initially staff is borrowed from other departments but as the program grows it evolves to where they have their own dedicated staff.

Darlene brought up another concern of losing the identity of Kendra as one of the faces of trauma in the state with folding her position under the big umbrella of KDHE. Dr. Harrison responded that he thinks the trauma program will be able to develop more of an identity with staff being located together. Dr. Rodenberg stated that the footprint of the program has a lot to do with its prominence, similar to bringing together a trauma team. He added he was comfortable the position was not going to get buried as it has a big advocacy proponent in the regions. Dick noted that the program has an independent funding source but understood that if it

was competing for State General Funds it might get lost. Melissa Hungerford applauded the growth of the program to the point where this move becomes necessary and feasible. A lot of activity needs to be coordinated with other agencies and it is good to have the political commitment from the department.

Dr. Smith inquired about the details of the QI program and if the composition of reviewers was passed through the ACT for review. Dick said the ACT or a committee within would be necessary for the regulations and implementation of the program and KFMC would become consultants in the process of creating a structure to do this.

Melissa asked Kendra if the regions were working at the level they can utilize the money. Kendra advised that the regions have done an excellent job and often have found independent funding sources. Kendra firmly believes the regions will grow from this. She added there has been increased buy-in and quality improvement is high on their list.

Pam Kemp inquired where the prevention funds were in the proposed budget and Dr. Harrison stated that prevention is still and would continue to be a part of the trauma program. The charge was to regions in using data to find ways to do prevention. Other prevention programs are ongoing. Dick mentioned that there are regional trauma groups, preparedness groups and several others, and we don't have an answer on how to integrate them. But there are ways to reduce some of the duplication and we are looking at ways to get the most effective use out of people. Robert Prewitt stated that the same people are often on all of those committees. Dick agreed that it is a fundamental issue across the board and the move is to consolidate resources.

Rosanne mentioned that the position has been established at KDHE and the background work has been laid. The next steps are to establish grant criteria and the hope is to have that laid out by the time the legislature is in session again in January.

ACS Consultation Project

Dan Leong reported on the status of the ACS Consultation Project. There were six hospitals who originally expressed interest in the ACS consultation project and five of those decided to proceed including Hutchinson, Hays, Pittsburg, Parsons and Coffeyville. Despite staffing changes at several of the hospitals there is buy-in from their administration. The hospitals are aware they should expect deficiencies when reviewed.

Dr. Harrison wanted to point out that they will be getting a lot of deficiencies. Dr. Smith added that the average is 20-40 for any new first-time program. Melissa stated that they do know they will receive deficiencies and the real issue is they don't want to waste anyone's money or time. Dr. Smith confirmed the purpose of the consultation visit is to help the facility move toward trauma center verification. Melissa also expressed that facilities can improve services as they move to Level III.

Dan specified that Coffeyville will have their consultation October 21 and 22 and Mt. Carmel was August 21 & 22. In the interim a plan is needed to keep the facilities going and moving

towards taking the next step to verification. Dan is working with the ACS to get all consultations done by December. There was a brief discussion of staff changes and man power issues.

Dr. Chris Bandy introduced the idea of moving forward on Level IV designations. Dr. Harrison posed the question of when the ACT wanted to address Level IVs with the understanding we would need to have our own designation team. Dr. Smith confirmed that the College has never verified a Level IV. Dr. Harrison advised that Level IVs have always been planned but a process has not been set up, with a state team and a fee schedule.

Rosanne inquired what would lie beyond a Level IV. Dr. Harrison stated the regions may say that facilities be at least a Level IV. Dr. Smith inquired if a potential Level IV hospital like Beloit could handle the patient load if patients were funneled there. Dr. Concannon noted that in real terms Beloit has been able to stabilize patients and transfer when needed. He also proposed the Level IVs may spur the Level IIIs to get going. Dr. Bandy voiced that Beloit could easily be a Level IV. Patients are often times transferred to a hospital with limited resources, but the goal is that they should be transferred to the closest hospital that meets the needs of the injured patient. Dr. Harrison stated that an issue often times is transport.

Melissa inquired if we should change our strategy and encourage those facilities who can not commit to a Level III start with Level IV. Dick noted that we did not want to close the door on Level IIIs. Darlene Whitlock added that having Level IVs may raise the bar.

Dr. Harrison refocused the discussion on having the regions develop triage guidelines. Cathy Heikes concurred that the goal is to have patients transferred to the most appropriate facility. Pam Kemp noted that it comes down to regional trauma protocol. Dr. Concannon answered affirmatively to Dr. Harrison's question of whether we want to start working on Level IVs and stated he would be personally going to Salina to work with them. Dr. Allin wondered if there was any reason not to do Level IVs and while it might be a complicated process, he saw no reason not to move forward. Dick reminded the committee of the practical problem of not having the regulations in place.

Rosanne inquired if there was another level past IV and Dr. Harrison advised that at one time there were Levels I – VII. Melissa discussed that we were still talking about education, participation and implementing regional plans and there was some value to identifying expectations of those below a Level IV. Dr. Harrison asked if there were time and resources available to have a group look at potential Level IVs. Melissa responded that the regions would be the most capable of identifying those facilities.

Dr. Smith noted that we needed to be careful in how we proceed. Rather than stimulating Salina, they could decide just to become a Level IV and would that not undercut our push to encourage a Level III in each region. Dr. Concannon wondered how to stimulate commitment to the trauma system when a facility is short staffed? Someone has to light the fire and say this is an important issue for the state. Dr. Bandy stated that a similar situation happened in Texas, but Dr. Smith added that in Texas funding was tied to verification at any level. Dr. Bandy stated that even being verified at a Level IV raises the level. Dr. Smith noted that in West Virginia verification was used as a means to give hospitals and providers breaks on their malpractice insurance. Dr.

Bandy added that one benefit of an established trauma system, is insurance carriers should see a decrease in long-term disability and death. There could also be a movement to reimburse at 100% for trauma patients, which might encourage surgeons in rural Kansas.

Dr. Smith suggested and the committee agreed to waiting until the Level III consultations are done before moving forward with Level IV work. Dan stated that all of the consultations would be completed by December. Dick said we would still move ahead with the grant process of three years of funding. Rosanne stated she will work on getting a committee together and will pull Level IV criteria from the gold book.

Regional Report

NE – Darlene Whitlock presented the report for the Northeast region. The regional trauma plan was approved by the general membership at the annual meeting on April 30 and submitted to KDHE by the July deadline. A PHTLS instructor update was held on June 11 (5 attended). The RTC did not receive enough registrations to hold the instructor and provider courses (on June 28 and 29). A RTTDC course was held at Ransom Memorial Hospital on May 23 (KRHOP). The executive committee reviewed 2007 KRHOP trauma education funding applications. The following were selected: PHTLS-Miami County EMS; RTTDC-Jefferson County Hospital (scheduled on November 1, 2007); TNCC-Morris County Hospital. The committee has started to work on education for EMS medical directors from the NE region for a formal CME.

The regional trauma plan will be discussed and promoted in the training to get more people involved. Additional topics for the training might include a coroner presentation along with a transplant presentation. The Pediatric Education sub-committee has been working on developing a 2-3 hour pediatric training in conjunction with Children's Mercy Hospital. The education sub-committee has started work on a quarterly newsletter that will be E-mailed in the NE region. Topics will include such items as pediatric trauma tips, RTC activities including education, hospital resource features, etc. The sub-committee hopes to have the first newsletter distributed in one to two months.

The Midwest Trauma Society will be hosting an AAST Injury Scoring Course on September 13 and 14, 2007 at KU's Westwood Center at 63rd and Rainbow in Kansas City. Chris Keeshan of Chris Keeshan and Associates in Topeka will attend the October 1, 2007 meeting for a brief presentation and Q and A on grant writing. The committee has been working on developing a quality improvement project. At the August 13 conference call, Eric Cook-Wiens provided a mock report of Glasgow Coma Scale in ED trended over several months. The committee will determine goals that are more specific and targets and develop this work over time. The next executive committee meeting has been scheduled on October 1, 2007 at Pozez Education Center, Centennial A.

SW – Cathy Heikes updated the committee on the Southwest Region. The annual meeting was held at Finney County EMS on June 6, 2007 where 15 attended. The regional trauma system plan was approved by the general members and submitted to KDHE by the July 1, 2007 deadline. The executive committee reviewed 2007 KRHOP trauma education funding applications and the following were selected: PHTLS-Lane County Hospital; RTTDC-

Hodgeman County Health Center; TNCC-Western Plains Medical Complex. Lane County Hospital will host a PHTLS instructor course in conjunction with the provider course (RTC sponsored).

The committee has started development of a 4-5 hour trauma patient care training program that can be conducted through ITV. CE will be offered. The RTC has provided bicycle helmets for a community driving awareness week in August. The event is in conjunction with several businesses including BP America. The committee is considering meeting by ITV starting in 2008. Cathy added the Region hopes to improve participation with the transition to ITV making it easier for those in outlying areas to participate. Many facilities already have the equipment already set up and available. The next meeting has been scheduled on October 24, 2007 at Finney County EMS.

SC – Kris Hill provided the update for the SouthCentral region. The regional trauma plan was submitted by the July 1, deadline. The executive committee agreed to continue the triage tag tracking pilot project. The committee will continue to find ways for funding it. Another round of tags was distributed in July and a survey was conducted two weeks ago. Kris is looking for less expensive tags as expense is the biggest issue.

The executive committee reviewed 2007 KRHOP trauma education funding applications. The following were selected: PHTLS-Edwards County Hospital; RTTDC-Edwards County Hospital; TNCC-District #1 of Rice County. The education and prevention sub-committees are in the process of developing a needs survey. The sub-committee will use the information to establish goals that are more specific.

The executive committee will here a presentation on October 18 about Acute Alcohol Intervention for Trauma Patients. The ACS has always encouraged verified trauma centers to counsel patients (where alcohol has been involved in the injury) on acute alcohol intervention at the hospital. Now, the ACS is requiring formal treatment when a patient presents and alcohol has been a factor. Nurses have been trained in the region to provide intervention. Trauma centers are doing the education. The committee believes the education might be beneficial to all facilities in the region and will be considering this in October.

Providers from Pratt Regional Medical Center presented to the executive committee on July 12 at Memorial Hospital in McPherson. The executive committee has scheduled a strategic planning meeting on December 13, 2007, in Wichita. The committee will consider next steps and goals related to the regional trauma system plan. The next executive committee meeting has been scheduled on October 18, 2007, at Hutchinson Hospital.

Rosanne referred to the compiled regional reports located in the meeting packet for the NorthCentral, NorthWest and Southeast region reports. [\(Click here for a link to those reports\)](#)

Eric Cook-Wiens spoke briefly about his follow-up with Pratt Regional Medical Center on entering trauma cases from Greensburg. He will develop a tool for them to track all patients that were seen that day and asked the committee what kind of data they wanted to see. Dr. Smith stated he would be most interested in transport distribution patterns. Dr. Harrison and Pam

Kemp wanted to know if the plans in place prior to the tornado were the ones put in place for distribution of patients. Melissa Hungerford offered information from the hospital discharge data collected by KHA to get a larger picture of all patients treated within a two or three day period after the storm.

Board of EMS Update

Robert Waller updated the committee on the pre-hospital data collection project. After several months of budget writing the Board held a vendor fair and got a request for information to outline what each vendor can produce. The request for proposal (RFP) is complete and will be available within the next 30 days, with a vendor decision by early October. There will be a small pilot project and decisions are being made on who will be buying software and hardware. The hope is to start services on the system by November or December. They have requested 30 services sign on to the project and have already received inquiries from 60. They are pairing down the list and will notify those services soon. The Board plans a three year rollout of the software.

NHTSA Assessment.

Robert also reported on the NHTSA assessment completed in July. The results have been posted on the BEMS web-site. NHTSA assigned five content experts to serve on the assessment team to review EMS and trauma in Kansas against national standards. Robert stated that at times the review was harsh and at times brutal. Some things in their report relate to what was in the 1994 assessment. Robert reported that they recognized the work that the trauma program has accomplished since 1994 and noted the ACT's accomplishments in developing a statewide trauma system. Robert opened the discussion up to questions from the committee.

Dr. Allin expressed that the report is an interesting document and although it is supposed to be 13 years of history it had a present flavor in both things that have gone on in Kansas and agendas that have been changed around the country. He continued that it was clear that in the future the agenda is standardization in practice and testing. Some of these things are counter to what the BEMS plan has been: how can we help communities deliver care? What can we do to assist rural communities to deliver care? The plan has not been to control medical dispatch or standardize certification. Dr. Allin stated that it is difficult to apply national standards to every facility. The report is really a call to the state to clarify what the Board of EMS is. Is it the lead agency of EMS? And if yes, to outline what that means. If they are not to be the lead agency then what are the expectations. Dr. Allin noted that a lot of the issues addressed in the assessment called on the BEMS to take action on issues for which they don't have the statutory authority. The two most immediate things to be addressed are control over non-transporting agencies and communications. The Board has taken a subordinate role in state-wide communications and he asked Robert to clarify how that occurred.

Robert referenced 2003 SB 2756 KDOT communications bill that created the KDOT communications system as it now stands. The process was started and controlled by KDOT and rolled-out on I-35, I-70, Kansas City area and the Wolf Creek area. They have not progressed further west of Topeka due to funding. As things progressed over the years, a communications

committee was put together at BEMS. At this point, BEMS continues to talk and be involved but in the end the decisions are made at KDOT.

Dick countered that the Highway Patrol has been involved in the implementation, as well. Robert stated the final word is by the KDOT secretary. He continued that as things progress with the interoperability grant the issues in EMS communications lie between rural and metro, 400 and 800 MHz, and most especially funding. It can cost \$4000 to get on the 800 MHz system and requires a 10 year lease. A lot of services don't want to spend the funds and have connectivity issues.

Pam Kemp added that local systems are built around 400 MHz and it doesn't make any sense to move outside the local system in the off chance we move to multi-jurisdictional. She continued that a lot of services have just one radio and communicate on it every day. Also, homeland security regions have taken on the communications project. Pam pointed out that we may see services like hers that have 2 800 MHz radios that can be used, but for daily operations they stick with the 400 MHz. Robert Waller stated that some services are buying cell phones or being trained on ham radio. Dr. Harrison stated there is not enough infrastructure for services to operate in the 800 MHz system. Robert Prewitt noted that if his service went to 800 MHz they would be the only ones operating on it.

Dr. Allin agreed that the point was that most of the issues raised have the expectation that BEMS would be overseeing them. The question becomes how BEMS stays at the table, understands and helps organize what is in everyone's best interest.

Robert Waller posed the question of whether it was necessary for Pam and Bob to talk to each other. Darlene offered that EMS service transporting a long distance would need contact in route if they need assistance. There is currently no method of saying "turn the dial here to get medical assistance." Robert noted that it was similar to law enforcement issues. Darlene continued that communication is always implicated in large disasters. Dr. Allin added that BEMS needed to figure out how to get back into the game.

Darlene directed the committee to the next issue of where EMS fits within the state structure. Dr. Allin began that there would need to be a change in thought processes. Robert Waller concurred that there would also need to be a change in protocols. Dr. Harrison mentioned that the previous assessment wanted the state to set triage criteria in the regions rather than the regions set their own criteria but the statute is not set up that way. NHTSA would like more oversight overall on the top.

Dennis Mauk inquired what the next step will be. Robert stated that the Board will be reviewing the assessment along with the BEMS strategic plan. Dr. Allin added they need to decide what issues they can address and use this assessment as leverage to attain those goals. The assessment can be used as a benchmark on what can be fixed and what we agree to address as a state agency. Robert stated that some of the pieces will be directly addressed and some will take lengthy conversations.

Dick expressed that this assessment is an opportunity to revisit some of the policy issues. Dr. Harrison added that we can either take or leave the assessment or decided what issues need to be addressed. The NHTSA assessment can be utilized as part of the documentation that we take to the legislature to promote policy change. Dr. Allin stated the Board will sit down and see how the assessment affects the Board's 1, 3 and 5 year plans. There will be discussion on how things can be done and some issues are non-starters. The Board will need to figure out where each of the recommendations falls and what is going to work. Robert Waller advised the committee that the Board will be reviewing the assessment on September 15.

Rosanne briefly discussed the trauma portion of the assessment with the committee. She first wanted to thank those who presented for the Trauma Program: Dr. Rodenberg, Dr. Harrison, Dr. Bandy, Darlene Whitlock, Robert Prewitt and Dan Leong. There were two reviewers assigned to the trauma piece – Dr. Stuart Reynolds, trauma surgeon from Montana and Dr. Bill Jermyn, an emergency room physician at Washington Hospital in St. Louis. Within the report, the bolded recommendations are those that the group strongly recommended. The first recommendation is to complete Level III designation within one year and the second is to begin designation of qualified Level IV facilities. Rosanne added she was pleased to see funding as one of the recommendations.

Melissa asked for clarification on the meaning of having the Level IIIs complete within one year. Dr. Harrison clarified that the state is the designating agency and to have designation within one year. Melissa inquired further on whether the group meant to have the process complete or whether to have some designated within that time. Additionally, Melissa added that with the new grant process for the additional funds we are able to work on the first two funding recommendations in addition to funding ongoing improvements.

Recommendations from the 1994 assessment were included in the meeting packets so that the committee might compare 1994 recommendations to the 2007 recommendations and note the progress that has been made since the initial assessment. Within the facility section of the assessment, the trauma program will be working with KHA to update ER department capabilities. Dr. Smith inquired where the program stood on including out-of-state facilities. Rosanne responded that we are working with select out of state facilities that provide care to patients transferred from Kansas to report data to the Kansas Trauma Registry.

Dick brought up the recommendation of the mandatory autopsies of trauma deaths and proposed that the costs may be prohibitory. Dr. Harrison noted that it can really only be accomplished in a medical examiner system rather than a coroner system. Dr. Smith added that it is a funding issue but he would encourage mandatory autopsies as an excellent teaching tool. Dr. Harrison added that there is legislation in place that requires it in all pediatric deaths but it is not done all the time and districts stop doing it when they run out of funds.

Other Business

Rosanne reminded the committee to “Save the Date” for the Kansas Regional Trauma Council Meeting of Executive Committees on November 9 at Wesley Medical Center. Kendra did a quick over view of the draft agenda which currently includes: a NHTSA, Legislative and ACS update; a survivor’s story; regional integration of Level III Trauma Centers; a session on Kansas disasters of 2007 – Trauma Lessons Learned; and a Regional Resources Case Review by the five trauma centers medical directors.

Meeting adjourned 1:42 pm.