

**Kansas Regional Trauma Council Meeting
Wesley Medical Center
Wichita, Kansas
October 8, 2003
8:00 to 4:00**

Welcome

Paul Harrison, M.D.

**Chairperson,
Advisory Council on
Trauma**

Dr. Harrison was introduced. Dr. Harrison is the Kansas Medical Society's nominee to the Advisory Council on Trauma (ACT) and he is the Chairperson of the ACT.

Dr. Harrison Discussed:

This was the first planning committee meeting for the regional trauma councils. Members of the planning committee were thanked for their planning efforts. The planning committee members included Ted McFarlane, NE, John Hultgren, NC, Kim Nutting, NW, Jeff Landgraf, SW, Diana Lippoldt, SC, Chris Way, SE.

Dr. Harrison applauded the efforts of the RTCs and those individuals committed to excellent trauma care for patients. The improvement of trauma care is the crux of the trauma program and all contributions are essential to the improvement of trauma care. Without the efforts of individuals such as those attending this meeting, minimal progress in trauma professions and in trauma care delivery would take place.

The Kansas Legislature funded the trauma system when trauma system development was authorized through legislation. In the initial years of the trauma program, funding was not expended as rapidly as it has been today, due to the fact that the infrastructure for the trauma program was under development with fewer projects within which to expend the funds.

Now is the time to request additional funding for the trauma program as the needs are rapidly exceeding the resources. It might take several years to persuade the legislature to increase funding. It will be crucial to talk to local representatives and educate and inform them about trauma care in Kansas. Let them know what can be done for every Kansan with additional funding.

Regional Updates

NE RTC

Dr. Michael Moncure, Chair NE RTC has been the Trauma Medical Director at KU Medical Center for the past five years.

Dr. Moncure commended the NE regional executive committee members for their hard work and diligence and for taking on a number of projects in a short period of time.

On May 5, the NE RTC hosted their first general meeting where Dr. Tom Foley from Iowa spoke about the trauma system in Iowa. Drug companies sponsored Dr. Foley. Dr. Foley also presented on an American College of Surgeons course that is under

development for rural hospitals that care for trauma patients. The course is taken to the rural facility and all trauma care personnel take the course together. The course lasts for one day and includes, interactive, as well as lecture content. Also, on May 5, an EMS informational meeting was conducted.

Dr. Michael Craun, Trauma Medical Director of Swedish Hospital in Denver, Colorado will be presenting at the November 6, 2003 general meeting.

The NE region has three very active committees including prevention-education, pre-hospital-communications and acute care-rehab. A survey was developed and a good response to the survey was received. Data is currently being compiled. The pre-hospital communications sub-committee has been hard at work and five PHTLS instructors have been trained and five more instructors will be trained soon. The Education-Prevention sub-committee has been compiling data and banking resources to market. The Acute Care-Rehab sub-committee has been identifying issues and waiting on survey data to move forward with goal setting. The NE would like to identify level 2 and 3 facilities in the region.

NCRTC

Dr. Bob Gaekwad, Chair NCRTC was introduced. He expressed his gratitude for the NC executive committee's hard work and commitment to donate their time to go to Salina for the executive meetings.

On May 8, the NC held their annual meeting where the primary goal was to spread the word about improving trauma care. A survey was developed and completed to determine the resources and abilities the hospitals and EMS networks have in the NC region. 100% of hospitals responded to the survey and the NC enjoyed an overall survey response rate of 63%. Specific education needs were identified with a priority established to increase the number of ATLS providers and instructors within the region. Currently, the NC region has only one ATLS instructor and three or four active providers. The goal is to increase the number of providers and instructors in the region in order to host ATLS courses in the region. The NC region has an education-prevention sub-committee and bylaws-communication. Currently, the executive committee is very involved in the education sub-committee in an effort to establish accessible trauma education courses for all providers.

NWRTC

Duane Wright, Vice Chair NWRTC and nurse manager at Citizens Medical Center in Colby provided the report as Dr. Schultz was running late.

The general meeting was held on April 11. The effort was to inform the membership of the purpose of the RTC and to update regarding current projects and sub-committees. A priority has been placed on EMS education. The NW region has predominantly BLS volunteer services, therefore, the executive committee started with EMS education. The survey focused on education and equipment needs. All but two services responded to the survey. The NW region has recently started working on the improvement of pre-hospital care. The NW in conjunction with the SW region sponsored a couple of PHTLS courses. The EMS services have been grateful for the education and

have put the education into service and improvements have been evident. The NWRTC sponsored an EMS trauma education program at Hill City where Darlene Whitlock spoke about triage, Glasgow Coma Scale and trauma care.

The NWRTC has three sub-committees: bylaws, staff education-prevention and EMS education. Dr. Michael Craun from Swedish Medical Center in Denver, Colorado presented during the August meeting. He provided valuable information regarding regional trauma systems development and regional quality improvement. Many patients from the NW region are transferred to Denver and Dr. Craun has been a valuable asset. Duane thanked the executive committee for the time they have donated to the NWRTC and the Kansas Trauma Program.

SWRTC

Cathy Heikes, Chair SWRTC and nurse in Dodge City was introduced.

The first executive committee meeting was held in October 2002 and many meetings have been centered on the direction to take as a council. The SWRTC has three sub-committees: bylaws, education and communication. The first annual meeting was held in March 2003 at St. Catherine Hospital in Garden City where the bylaws were approved. The education sub-committee has worked to identify needs through a survey developed for hospital and EMS. The response to the survey was good. A priority based on the survey data was a need for EMS trauma education. The SW region has many EMS providers that are BTLT trained. The education sub-committee researched PHTLS and BTLT and the RTC decided to increase the number of PHTLS providers and instructors in the region. Jeff Landgraf has worked to provide the PHTLS education in the SW region and has moved into the NW region to assist with their PHTLS education goals. A primary goal is to increase the providers and instructors toward regional self-sufficiency. The survey also suggested a need to increase the TNCC providers and ultimately instructors. A similar shortage exists with ATLS providers and instructors and these will be addressed in time. The SW region has mailed letters to all hospitals and providers to increase membership.

Dr. Craun from Swedish Hospital, Denver, Colorado spoke to the executive committee in July. He provided good information about the Colorado and Texas trauma systems. The SWRTC has been considering the development of an education presentation to increase awareness and participation in the region.

SCRTC

Dr. Scott Clarke, Vice-Chair SCKTR, presented in the absence of the Chair, Dr. Diane Hunt. Dr. Clarke is a general surgeon in Hutchinson, KS.

On June 4, the general membership convened. The focus of the meeting was to encourage members to get involved at the sub-committee level. The response was favorable. Three sub-committees have been formed including staff education, prevention, and bylaws. Bylaws were adopted during the general meeting. The education sub-committee is very active and they have completed a survey. There was a 97% response rate from hospitals and 65% response rate from pre-hospital providers. The SCKTR has a broad set of demographics. The region has two level 1 trauma centers

and many very small, rural hospitals. A high level of variance exists with regard to educational needs. During the August 28 executive committee meeting, the executive committee started to establish more specific goals based on the survey data. In Wichita, ATLS is heavy, however, outside of Wichita there are very few ATLS providers. The initial goal is to increase the number of ATLS providers and instructors in rural areas. Another goal is to increase access to ATLS for mid-level providers as they are on the front line in the rural areas. There is a need to increase the number of PHTLS providers. TNCC is well represented across the board. The executive committee has experienced considerable turnover in health department representation and this needs to be addressed, as prevention is vital.

SERTC

Chris Way, SERTC Chairperson, SERTC ACT Representative and Director of EMS at Labette County Medical Center was introduced. Chris expressed appreciation for the executive committee members and their commitment to excellent trauma care.

The region has two general membership meetings per year and just completed one in August. The meetings are moved around to increase membership and awareness. The next step will be to develop a regional trauma plan. The plans will affect all people in the area and input will be needed. The committee has started to create a “road show” and this will be taken to the organizations that have not participated. It is challenging for smaller facilities to attend meetings.

There are three subcommittees in the SE region. There is a bylaws committee and the bylaws were adopted last February. The Education sub-committee is chaired by Susan Souders. An educational needs assessment was completed and goals have been established based on information provided from the survey. In addition, an education resource brochure was created. TNCC and PHTLS are provided regularly. The region is working on coordinating a TNCC instructor course. The next PHTLS class for instructors will be on November 17 in Parsons. ATLS is needed and this is difficult without a Level 1 trauma center in the region. An ATLS course has been scheduled on February 27 and 28 in Parsons. Wesley Medical Center has agreed to assist with the course in February. Contact Chris Way, (620) 421-2401 or Susan Souders, (620) 421-4881 if interested in attending the course. Twelve physicians and four mid-level practitioners will be needed to fill the class.

Six SE counties border other states. It is a longer distance for most of SE Kansas to transfer patients to Kansas City or Wichita, therefore, many patients go out of state. There are two Level 2 facilities in Joplin, Missouri. The Triage, Transport and Transfer sub-committee have been developing guidelines and recommendations based on the American College of Surgeons.

The SE region has excellent working relationships with Missouri and Oklahoma. Dr. Kurt Dandridge, M.D. Trauma Medical Director at St. Johns in Joplin sits on the Triage, Transport and Transfer sub-committee. He spoke in August at the general membership meeting about rapid triage and transfer assessment. Dr. Dandridge has experience with SW Missouri Trauma System development and has been supportive of Kansas Trauma Systems development.

The education sub-committee along with the executive committee will be developing prevention initiatives and both of the health department representatives are present today.

Kansas Trauma Program Update

**Rosanne Rutkowski
Trauma Program Director**

Rosanne applauded the organization and development of the regions thus far.

She provided the trauma program update. The Emergency Medical Dispatch report has been completed and will be available on the KDHE website. In addition, the report will be available on CD. KDHE was approved for year two funding to focus on emergency dispatch training. The Executive Summary from the survey is available.

Deb Williams, KDHE Bureau of Health Promotion, recently received approval from CDC for a cardiovascular prevention grant. The grant includes an emergency medical services component. Funding may be available for ACLS.

Kay Swietek, Trauma Education Coordinator was introduced. Kay has been working on a series of checklists to assist in organizing for TNCC, ATLS and PHTLS courses.

In November, thirty-eight additional hospitals are scheduled for trauma registry training. Following the training, only nine hospitals in the state will have not been trained. Currently, Sherry Davis, has been working on data completeness reports that should be provided to the RTCs this fall.

The Emergency Medical Services for Children conference has been scheduled on October 9 and 10 at the Hyatt in Wichita.

The ACT approved a total of \$60,000 funding for systems development at the regional level. A Finance Sub-Committee of the ACT will convene on October 21 in Salina to develop criteria for spending.

The Governor's Office announced the appointments to the ACT. Those present for this meeting included Chris Way (SE), Debra Pyle (KSNA), Paul Harrison, MD (KMS). Brent Rody (KHA) was appointed and Bob Orth (KEMSA) was appointed.

Kansas Trauma Registry Update

**Sherry Davis
Kansas Trauma Registrar**

Sherry commended the RTCs for their efforts and diligence in developing the regional side of the trauma system. Phase 1 of the trauma registry development has been completed. The hospitals currently trained are focused on reporting complete and validated information, which will be a learning process.

Rosanne and Sherry recently returned from the Collector Conference in Nashville. Digital Innovations is responsible for 800 registries in the world. Kansas is the Digital Innovation's largest user of Collector Software. In the future, validated and reliable data may be used for quality improvement efforts. However, for now, the focus will be on getting the data points needed to move forward. The Glasgow Coma Scale has been identified as under-reported.

Breakout Reports:

Ted McFarlane facilitated the following breakout sessions reporting segment.

Communications Facilitators: Jeff Landgraf and Duane Wright

Jeff Landgraf, Chair of Communications in the SW region provided the Communications break out report. The group identified a major problem in that an organized statewide communications plan does not exist in Kansas. Effective regional programs exist in the KC and Wichita areas of Kansas; however, the remainder of the state has ineffective and unreliable systems.

The lack of interoperability between communication systems is a significant problem. A comprehensive statewide communications system is achievable, however, funding for the system is essential. Approximately, 90% of the necessary communications infrastructure currently exists with the KDOT system, but local entities cannot afford the equipment necessary to interact with the system.

There is a need for Emergency Medical Dispatch training.

Another issue effecting communications has been the current focus on public safety vs. healthcare. Public safety has resources and healthcare has the funding.

Communication Recommendations

1. Communications Interoperability between systems.
2. Bring all parties involved in communications to the same table including KDHE, BEMS, ACT, PSWIN, KHP, KDOT, etc. The committee would determine the current resources and ways to get the most value from the current system. This process should also be completed at a regional and local level.
3. The ACT should take a leadership role in standardizing all regions such as EMS to be consistent with the trauma and bio-terrorism regions.
4. Funding. More than \$1 from every moving violation is needed to fund a comprehensive and inclusive trauma system.
5. Professional recognition for dispatchers is needed

Chair/Vice Chair Facilitator: Chris Way

1. Resources and budget. Transfer the entire education budget to the regions to manage by a lead organization in the following way.
 - \$50,000 should be set aside for hospital verification
 - \$25,000 should be allocated for each trauma region for ATLS, TNCC, PHTLS and other educational topics deemed appropriate by the RTCs.
 - \$50,000 should be allocated for another regional coordinator.
 - \$67000 should be pooled for cooperative efforts between regions that the regions may apply for. A panel of 6 RTC members, 6 RTC Vice Chairs and 2 ACT members would approve the projects.

A quorum of 10 would be necessary for project approval. The priority should remain with the rural areas.

- 80% of trauma education tuition should be paid to rural providers regardless of healthcare profession.
 - 50% of trauma education tuition should be paid to urban providers regardless of profession.
 - The \$10,000 allocated to the regional trauma councils during the August ACT meeting was supported and the regions should modify their budgets based on the guidelines provided by the ACT Finance Sub-Committee. Regional plan activities and projects related to subcommittees would be given preference in funding.
2. The State Trauma Plan included hospital verification in the current implementation schedule. The State should complete the verification site visits and no one from the regions should complete the site visits. A Self-Survey should be completed prior to the verification with a consistent level of service as the goal. Each trauma plan from each region should include:
- The transfer of patients to the appropriate facility with the appropriate resources.
 - Triage criteria should be based on physiological and mechanism of injury.
 - A listing of criteria should be made available to inform providers of when to go on diversion. A reporting mechanism should be created for the referring centers that inform them of when a facility has gone on or off of diversion.
 - Certification levels for all providers should be defined and implemented for EMS, nurses, physicians, and mid-level practitioners providing trauma care.
3. The regions should be required to demonstrate to the ACT progress on their regional plans by June 30, 2004.

Trauma Triage, Transfer, and Transport Facilitator: John Hayworth
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Emergency Medical Services personnel travel long distances with patients including out-of-state. Issues faced by EMS include multiple agency involvement, transportation, and weather. The triage, transfer and transport sub-committee agreed with the recommendations of the communications sub-committee.

Sub-Committee Goals Include:

- **Data Collection:** Identify data that EMS should be responsible for and expand this beyond the state required trauma registry data elements. EMS must be required to be responsible for getting trauma registry data to the hospital. Education will be key to the effectiveness of this recommendation.
- **Standard Assessment of Trauma Patients:** By next year, a triage system will be identified that would be effective statewide and this should be

implemented statewide. Education will be necessary for all providers in the state.

- Education should be expanded and flexible. A box has been created that includes the three core trauma courses. Using standards, expand the educational courses funded through the trauma program without creating a bigger box that restricts educational efforts. The ACT should know that “it is okay” for the RTCs to determine their education needs and follow standardized education courses and quality education courses.
- Educate hospitals and EMS agencies that there will be a trauma plan in this state and it will be followed. All organizations need to know the importance of involvement in this process, as they will be affected by the plan. The help of everyone will be needed to provide this important message and education.

Prevention Facilitator: Pam Kemp

Injury is predictable and preventable. The impact of trauma is great. Four people die from trauma everyday in Kansas. We fail to remember the number of permanently injured, disabled individuals and the financial losses that result from recovery time and other factors. Trauma and injury have a ripple effect on society and the economy that is never ending and this message must get out to local partners. Local individuals with a stock in injury prevention need to sit down at the same table and define injury prevention goals. Partners have varying motivations including public service, public education, and public relations to name a few. Community Needs Assessments are essential to determine what type of prevention is needed in each region. Community assessments already exist rural health options projects. It is important to tie into the existing data and not tie up funding with those types of assessment activities. Tap into existing data that local agencies share. Don't get bogged down in the assessment and evaluation process. Injury programs are available. Partner with SAFE KIDS, Kansas Department of Transportation, Kansas Safety Belt Education Office, Kansas Department of Health and Environment, Kansas Highway Patrol, and other local and regional partners. These organizations are already implementing effective programs and they are available statewide. (Several handouts available).

The barriers to success include lack of prevention funding, conflicting motives, and hard to reach rural areas. In addition, the failure to recognize the extent of commitment necessary in injury prevention represents a barrier. Often, individuals have a resistance to change, an “Always done it that way” mentality. Prevention success is challenging to define. The registry may be very crucial in measuring injury prevention outcomes. Establish good goals for measurable outcomes.

Recommendations:

1. Prevention should be a required element of all trauma council plans with funds and planning dedicated to prevention.
2. Develop regional needs assessment based on trauma registry data and identify and educate RTC partners to reduce duplication of efforts and resources.

3. Develop a list of prevention resources at the regional level and identify mission and motive

Education Facilitator: Diana Lippoldt
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Based on reports from the regions every location needed more ATLS, PALS, TNCC, ENPC, PHTLS, etc. One of the major barriers to getting education right now involves the fact that 10-12 classes were not applied for last year for financial aid. Instructor availability is a barrier.

Many people have indicated that they don't know how to complete the paperwork. To meet the trauma education program goals the RTCs need to take the message to the communities. The same people are at the same meetings and more people need to know about the trauma program and education in a very precise, explicit and targeted presentation. A common agenda should be developed and used by all regions with the option of customizing certain areas based on the unique aspects of the regions. The presentation should be no longer than two hours. All education information should be available at one centralized website similar to the American College of Surgeons education website.

The agenda for the standard education course should include triage and transport information, GCS and trauma registry elements and the meaning of verification and levels of trauma care.

Continuing education credits should be provided along with food. To invite participation, physician-to-physician letters maybe useful. The program needs to be developed by April 2004.

A significant barrier includes identifying the person who would complete the education presentations. Likely, nineteen 2-hour meetings would be needed in the SC region alone. The regions should decide who would complete the project. The regions may need to take on some responsibility for this because the state is slow.

Recommendations:

1. Develop a standardized educational program to be presented by each region with supportive funding.

Ted McFarlane instructed the group to develop a consensus position based on the top three recommendations, which were voted on, by the entire group. The information will be recommended to the ACT.

Summary of Recommendations

Communications

1. Interoperability between systems (statewide communications system)
2. Funding

3. Dispatchers need professional recognition
4. Standardize regional boundaries

Trauma Triage, Transport, Transfer

1. Standardized statewide triage system implemented.
2. Data collection for EMS: Identify data that EMS should be responsible for expanding beyond the state required elements. EMS must be responsible for getting the data to the hospitals
3. Expand education and streamline with ongoing regional efforts (flexible). Allow the regions to determine their own education needs based on standards using (surveys) and trauma registry data. Support is needed for the regions to present education about the regional trauma plans and state plan to providers and the public in each region.

Education

1. Develop a standardized educational program to be presented by each region with supportive funding.

Prevention

1. Prevention should be a required element of all trauma council plans with funds and planning dedicated for prevention.
2. Develop regional needs assessment based on trauma registry data to identify and educate RTC partners to reduce duplication of efforts and resources.
3. Develop a database of prevention resources at the regional level.

Chair and Vice Chair

1. Regionalize education projects. \$25,000 should be allotted to each region for ATLS, TNCC, PHTLS and other educational topics. \$50,000 should be allotted for an additional coordinator that manages the finances, coordinates development of the regional plans and assists with education coordination. \$67,000 should go into a pool for regions to apply for once the \$25,000 has been expended. The ACT would establish criteria with regard to ways the funding should be spent. A committee of six RTC representatives, six RTC Vice Chairs and two ACT representatives would determine who received the funding.
2. Regional trauma plans and hospital verification, transfer, triage and diversion guidelines completed.
3. Support the recent approval of \$10,000 dollars to the regions.

Generally speaking, it was recommended that the regions send a Chair or Vice-Chair to an ACT meeting, at least, one time per year.

In addition, the regions would like to have a statewide RTC meeting on an annual basis. The feedback was very positive including an individual who indicated a “year or two worth of work was accomplished in one day.” The regions agreed that the future of this meeting would depend on the response of the ACT to the report drafted from this meeting. As one RTC member stated, “We don’t want the RTCs to walk away because the ACT ignored them.”