Kentucky Cabinet for Health and Family Services
Department for Public Health
Kentucky Trauma Advisory Committee
(Teleconference) November 18, 2008, 3 PM ET
MINUTES

Committee Members Present:

Tricia Okeson, for Commissioner of Health
Dr. William Barnes, KMA/Livingston Co Hosp.
Richard Bartlett, KHA
Dr. Andrew Bernard, ACS COT/UK Trauma
Terence Farrell, Pikeville Medical Center
Dr. Glen Franklin, UofL Trauma
Lisa Fryman, UK Trauma
Linda Gayheart, At Large
Dr. Earl Motzer, Haggin Mem Hospital
Charlie O'Neal, KBEMS
Charlotte O'Neal, ENA/Frankfort RMC
Carol Wright, Taylor Reg. Hospital

Committee Members Absent:

Dr. Mary Fallat, At Large/Kosair Children's Hosp
Chuck Geveden, KY Transportation Cabinet
Sharon Mercer, KBN
Dr. Chris Pund, ACEP
Dr. Russell Travis, KBML

Guests Present:

Dr. Julia Costich, KIPRC
Dr. Brian Harbrecht, UofL Trauma Center
John Isfort Marcum and Wallace Hospital
Ron Jackson, Estill Co EMS
Tom Taylor, KBEMS/EMSC
Dr. Jane Trautwein, Fleming Co Hospital

The meeting was called to order by Dr. Bernard, Chair.

The first item of business was a review of the Level-IV draft document, including the suggested changes from Earl Motzer and John Isfort. The draft coming out of this meeting will go back to the next meeting of the Verification Committee for another review, and they will begin looking at the "processes" involved.

The draft Level-IV document looked as follows coming out of the meeting:

Kentucky State Trauma System
Criteria for State Verification: Level IV Trauma Center Draft

Program Component	*Description(s)*	*Specific Criteria*	*Comment*
Trauma Program	The board of directors, administration, medical, nursing, and ancillary staff shall make a commitment to provide trauma care at the level for which the facility is seeking verification. A trauma program shall be created with agreement from the board of directors, administration, and medical staff.		Resolutions supporting the Trauma Program are one example of commitment and agreement.
Trauma Program Medical Director	A trauma program medical director is required and shall be a BC/BE physician on staff at the facility, preferably an EM physician. The job description must include his/her roles and responsibilities for trauma care, such as trauma team formation, supervision/leadership, and continuing education. The medical director shall act as the medical staff liaison to administration, nursing staff, etc. and as the primary contact for that facility with other trauma centers in the region. Required to maintain certification as an ATLS© provider.	ATLS Current PALS Current ACLS Current	
Trauma Program Manager/ Coordinator	The trauma coordinator is required and this person should be an RN with trauma care experience (ICU, ED, or flight experience). Other heath care personnel with trauma care experience (EMT-P, etc) may fill this role if needed. The program manager will work with the medical director to coordinate and implement the facility's trauma care response. The job description should include time dedicated to the trauma program, separate from other duties the program manager may have at the facility.	Trauma Coordinator Required	
Emergency Department Coverage	There should be 24-hour physician coverage of the emergency department. A mid-level provider (NP, PA) may serve as the trauma team leader, but a designated ED physician should be present for immediate consultation during trauma team activations. There must be a designated physician medical director of the ED.	ED Medical Director Required	
Emergency Department Physicians	Preferred BC/BE by the ABEM or AOBEM, but not required. ED physicians shall maintain current ATLS© Provider certification, and should participate in a RTTDC©, preferably at their practice facility.	ATLS Current PALS Current ACLS Current	
Surgical Staff	Orthopedic surgery, plastic surgery, and radiology staff desirable. If staff available, published call schedules are essential. If surgical services will be provided, anesthesia coverage will be essential.		

Draft - November 18, 2008

	16 hours of annual trauma-related CME for surgeons is desirable. Participating surgical specialties must have one representative attend at least 50% of multi-disciplinary trauma conferences.		
Trauma Nursing Education	Nurses responsible for trauma care at the facility shall have completed one of the professional education courses specific to trauma care (Trauma Nursing Core Course TNCC, Advanced Trauma Care for Nurses ATCN, etc). TNCC is the preferred course.	TNCC Required	
Transfer Protocol	The facility shall have a written protocol describing the method to rapidly and effectively transfer the trauma patient requiring a higher level of care. The protocol must address: Available ground/air transport services (with contact information), alternative transport services, receiving trauma centers/trauma surgeons contact information, what supplies/records/resources may be utilized to effect the transfer, and specific anatomic and physiologic criteria that if met, will immediately initiate transfer to definitive care. This should ideally be written with involvement of the local ground EMS provider(s) and regional air medical provider(s) to assure seamless patient care during transfer.		
Transfer Agreement	The facility shall have a written agreement with a regional Level I or II trauma center regarding transfer/care of the trauma patient that exceeds the capabilities of the Level IV facility. It is recommended that a back-up transfer agreement be obtained specifically for burn patients, in the event the primary regional receiving facility does not have the required capacity.	Transfer Agreements: 1. Level I or II 2. Burn Care	
Radiology	The facility shall have a Radiologic Technologist in-house 24-hours a day for basic plain films used in the evaluation of trauma patients. In the event a technician is not in-house, a 20-minute response time from trauma team activation is required. Response times shall be documented and monitored by the trauma program manager.	1. Rad Tech <20min for activations 2. CT desired 3. Sonography desired	
Clinical Laboratory	The facility shall have a Lab Technician in-house 24-hours a day capable of performing basic studies used in the initial evaluation of trauma patients: CBC, typing, coagulation profile, and ABG. In the event a technician is not in-house, a 20-minute response time from trauma team activation is required. Response times shall be documented and monitored by the trauma program manager. Cross-matching is desired but not required. The lab (or blood bank) shall have at least two units of O-negative blood available for trauma patients, to be infused at the facility or while en-route to definitive care. There should be a mechanism in place to rapidly access blood/blood products during emergency situations when the lab is not staffed.	Required: 1. Lab Tech <20min for activations 2. Standard chemistry 3. ABG 4. Hematology 5. Coags 6. Blood typing 7. Blood storage 8. Two units O- PRBC 9. Access to blood from community center Desired 1. Cross-matching	

Respiratory Therapy	The facility shall have a Respiratory Care Practitioner in-house 24-hours a day to respond to the ED in the event of a trauma team activation. Other health care personnel (RN, EMT-P) can fulfill this role provided they have documented internal training and continuing education regarding the use of mechanical ventilation.	Response within 20min of activation required Available 24rs/day desired	
Rehab Services	Physical therapy, occupational therapy and social services are desirable but not required.	PT, OT, SW desired.	
Trauma Team Activation	The facility shall have a trauma team activation protocol that addresses the following: • Members of the team and their response requirements once the team has been activated. • Criteria (based on severity, anatomy, and/or physiology of the injury) for trauma team activation and the person(s) authorized to activate the trauma team.	Presence of the ED physician at trauma activations is required.	
Intensive Care Unit	If an ICU is present and trauma patients will be admitted to the ICU, involvement of a surgeon as Director or Co-Director of the ICU is desired.	Surgeon Director/ Co-Director Desired	
Performance Improvement	It is required that all trauma centers have an in-house Trauma Registry and contribute to the State Trauma Registry. The facility shall have a written policy outlining the performance improvement portion of the trauma program. This shall include: • Person(s) responsible for performing PI reviews • Minimum cases to be reviewed: Patients requiring transfer, all trauma deaths, non-compliance of trauma team members to response time requirements, trauma care provided by physicians not meeting minimal education requirements • Frequency of meetings • Multidisciplinary physician involvement (Program Director, Radiology, Surgeon if involved) • Attendance minimums for members (50%) • Evidence of loop closure and resolution The ultimate responsibility for concurrent or retrospective review of trauma patient care lies with the trauma program medical director and program manager. Feedback or assistance from the facility's regional Level I or II trauma center should be available when requested.	Required 1. PI Program 2. In-house Registry 3. Contribution to state registry 4. Audit of all trauma deaths 5. Morbidity review 6. Multi-disciplinary trauma conference 7. Minimum conference attendance (Emergency Medicine 50%; General Surgery 50%-if involved) 8. Audits of nursing care 9. Audit of pre-hospital trauma care 10. Review of times 11. Review of bypasses 12. Review of transfers Patient care	
Morbidity and Mortality Review	A mechanism shall be established by which all physicians participating in trauma patient care are involved in a confidential peer review in accordance with medical staff policy. Meetings must regularly review and discuss: Results of peer review activities, problematic cases including complications, and all trauma deaths- classified as		

	preventable, potentially preventable, or non-preventable.		
Trauma Registry	Collect data via in-house registry and submit to statewide trauma system within 60 days of patient encounter.	In-house Trauma Registry Contribution to State Registry	
Rural Trauma Team Development Course©	The facility shall host or participate in a joint RTTDC©, as outlined by the American College of Surgeons Committee on Trauma. Participation of physicians, members of administration, nursing, ancillary support staff, and local pre-hospital providers is strongly encouraged.	RTTDC Participation	
Outreach Education	Conduct of ATLS, TNCC (or equivalent) and ITLS/PHTLS courses is desirable. Conduct of trauma-related CME for physicians, nurses, pre-hospital and other personnel is desirable.		
Injury Prevention	The facility shall participate in injury prevention programs. These may be organized by the facility or in cooperation with law enforcement, fire, EMS, etc. Documentation of activities should be available for review during the verification/re-verification process. Collaboration with other institutions is desired. Monitoring of progress and efficacy of the prevention program(s) is desired.	Injury Prevention Activities Required	
Emergency Department Equipment			
Operating Room	It is desirable that an operating room be available for emergency procedures within the scope of practice of the physicians on medical staff. If an operating room is available and the trauma center elects to us that facility for the surgical care of victims of trauma at ANY time, the following are required: 1. Operating room staff available within 30 minutes of notification 2. Anesthesia staff within 30 minutes of notification 3. Age specific equipment including: thermal control equipment for patients and fluids/blood products. Also DESIRABLE are endoscopes, bronchoscopes, equipment for long-bone fixation and rapid infusion equipment. 4. If orthopedic procedures are to be performed, C-arm capability is required. 5. Post-anesthetic recovery MUST contain: equipment for monitoring and resuscitation, pulse oximetry, thermal control		
Resuscitation Equipment for All Ages	Required resuscitation equipment includes: airway and ventilation, pulse oximetry, suction, ECG, defibrillator, IV administration sets, large bore vascular catheters, cricothyroidotomy, thoracostomy, emergency drugs, Broselow tape, fluid warmer, qualitative CO2 detector, EMS communication equipment Desirable resuscitation equipment includes: venous cutdown, peritoneal lavage, rapid infuser		

Data Committee

There was a review of a proposed budget submitted by Julia Costich for expanded operation of the Kentucky Trauma Registry at KIPRC.

Trauma registry software packages	
6 Level II or III @ $7000	42,000
4 Level IV @ $5500	22,000
Computer systems for reporting facilities	22,000
Program support for new reporting facilities	
Staff support	15,000
Software	7,000
Trauma registry data management, analysis, reports	40,500
TOTAL:	**148,500**

Procurement of ten (10) trauma registry software packages ($64,000). (AEL/SEL 13IT-00-DEXC).

Final vendor to be selected by KyTAC, but pricing is based on National TRACS (package sponsored by ACS COT). Six licenses for Level-II or III @ $7,000 ($42,000); four licenses for Level-IV @ $5,500 ($22,000).

- This includes the software, first year of vendor-level support, and the enhanced report writer.
- Procurement of ten (10) desktop PC packages with operating system, printer with cable, MS Office Professional Plus and shipping (estimate $2200 list each, or $22,000 for ten system packages). (AEL/SEL 04HW-01-INHW)
- KIPRC program support for software procurement, hardware and software configuration, training, and network support (including coordination with the software vendor) is estimated at $15,000.
- Additional copy of NTRACS for data management estimated at $7000
- KIPRC Trauma Registry data management, compilation and reporting is estimated at $40,500

Julia also noted that Eddie Napier, the technical person at KIPRC who handles the It aspects of the Kentucky Trauma Registry, is looking at the software packages. They would like to select one for use by the state registry.

There was a general discussion about the data flow, and how KIPRC gets ED data, how they get trauma data, and where it goes. Some facilities are currently submitted data to the National Trauma Database (NTDB), but some states collect the information and then submit consolidated data for the state from their registry. It was felt that a flow diagram on how this currently works so KyTAC can make good decisions on what they would like to see going forward.

Education Committee

Carol Wright reported for the Education Committee. There was a document circulated by email that summarized the key points.

Minimal Educational Requirements: TNCC, RTTDC, ATLS. PHTLS/ITLS, ACLS, PALS

Additional Education: ENPC, ABLS

TNCC & ENPC have an average cost of $3000.00 (depends on how large the class and must meet instructor to student ratio of 1:4 with a maximum of 1:6). Cost includes book fee, indirect fees paid to ENA per student, course director and instructor fees at approximately $125.00/day for 2 days. May have to include travel and overnight stay expenses.

Course Directors: there are course directors located in all parts of the state with the exception of far Eastern Kentucky to my knowledge.

Course Options: Facilities can host the course and pay instructor fees or course directors can conduct courses at their facilities and interested facilities would send their participants to these courses and pay cost for own employees.

RTTDC has an average cost of $3500.00. There have been a total of 8 courses conducted since 2006 (Three by Taylor Regional Hospital; and four by UK). One course was conducted at the 2006 Trauma Symposium. Presently these courses are coordinated by the hospital's trauma coordinators.

Instructors for the course must be ATLS Instructors and Trauma Coordinators as designated by State Trauma Chairman. The State COT has the purchased CD's and Educational materials for the course. Lisa Fryman and Carol Wright have coordinated courses conducted in the state except for the 2006 course. There is an ACS fee of $100.00. This must be paid up front by the requesting facility unless grant money is being utilized. In addition, course instructors are paid a $500.00 stipend plus travel and lodging costs. This is paid by the hosting facility.

The hosting facility is responsible for providing the classroom space to conduct the course. This requires an open class room setting with at least 3-4 rooms for breakout sessions. Host facility is also responsible for providing copying of materials, providing breakfast and lunch for participants, and CEU or CME credits. Previously in courses that have been conducted in the state there were no provisions made to reimburse the coordinators of this program. If these courses are to be done at the request of hosting facility there will have to be a set stipend fee for course coordinators. Recommend: $800.00. This covers activities on the day of course, and all pre and post course preparation/follow-up. In addition, there would be reimbursement for all travel costs.

In order to successfully provide the RTTDC courses this committee should make a requirement, that there must be commitment of instructor's participation before the class is scheduled.

ATLS has an average cost of $9000.00 for a class of 16 MDs. This includes rental for the TraumaMan @ $2800.00 for 2, meals and faculty stipend.

The State COT establishes the course fee which is paid by the participant. Course requires qualified ATLS Course Coordinator and Course Director.

ITLS has an average cost of $3000.00

ACLS and ***PALS*** courses are conducted for free by some flight services. Courses are also provided by AHA Facilities.

Grant monies may be available for the various courses. However, should be up to the requesting facilities to secure those funds. For example, if a Host Facility wants to have a TNCC or ENPC course it would be up to them to contact the state ENA for possible funding assistance.

This committee attempted to obtain statistical data for the State of Kentucky but was not completely successful. It was our goal to obtain totals for active RNS in the state and the number who are current in TNCCC and ENPC, total MD's with current ATLS, and total for ITLS. The only numbers received were for RNs, which is 51,721.

Dr. Bernard emphasized that somehow we need to get a handle on the number of people who need to be trained at the various levels, and where they are.

There was a discussion about a survey KHA had done a few years ago to get information on the numbers of doctors and nurses who needed to be trained. This was related to a study on the preparedness of the hospital Emergency Departments. There was also discussion about John Isfort doing a quick survey at the hospitals on his list of potentially interested hospitals.

Dr. Fallat said that the EMSC program will offer PALS to emergency department doctors and nurses for free. This is in next year's grant request. It will be done geographically.

There was discussion about EMS Medical Directors not needing to take specific courses if they are board certified, or are certified in ATLS, ACLS and PALS. Having EMS people get ITLS or PHTLS has been problematic. 15-20% probably have it now. The delivery system is not in place. PHI (helicopter service) is offering ITLS; and Air Methods (helicopter service) is offering PHTLS.

Dr. Jane Trautwein (Fleming County Hospital) noted that there are still some county EMS services with just BLS service in her region (HPP Region 8).

Carol Wright said that her committee would continue to investigate and report back.

Protocols

Charlie O'Neal said that the protocol committee has not met. He was waiting on the final Level-IV criteria. He will follow the same example for development of transfer and transport protocols, though the latter will require modification to the ambulance regulations. They currently allow the ambulance to select whatever destination they want. The previous version included:

1. Most appropriate facility
2. Patient choice
3. Patient's family or physician choice

Dr. Bernard suggested that we could start with guidance on who needs to be flown. Mr. O'Neal noted that there are 48 licensed rotor craft, and they all are trying to fly a fixed number of cases per month to make expenses. This results in flying those who need it, but also flying a number who probably don't need to be flown. He suggested that we start with guidance to hospitals first on who needs to go, where they should go, and when.

There was general discussion that there needs to be guidance to ground providers. Dr. Fallat reported that ACS COT is considering criteria on who should be flown, and there is CDC guidance on destination in the verification book. This was also published at some point in their MMWR.

Dr. Bernard and Charlie discussed drafting some sample criteria as guidelines on transport to a Level-I facility, transport by air, and transport to a trauma center. Mr. O'Neal noted that in the end, there will need to be a change to the ambulance service regulations.

Liaison to Frankfort

Dr. Bernard, and the group consented, to have Linda Gayheart serve as the KyTAC liaison to the Governor's Office and the General Assembly. Linda said that she would work closely with KHA. This was converted into a motion by Dr. Barnes, and seconded by Mr. Farrell. The vote was unanimous.

Letter to Governor

Dr. Fallat and Linda have been working on a letter to the Governor to follow-up on the question of potential funding.

Report to the General Assembly

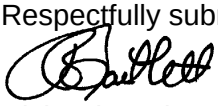
Mr. Bartlett reported that a draft has been circulated of a report to the General Assembly, as required by the law. If members of the group have suggestions for changes they are encouraged to pass them along. The report is due December 1st. Mr. Bartlett, indicated that he will have Dr. Hacker put a cover letter with it, and transmit the final report.

The committee chairs should note that the point of contact for scheduling future teleconferences is Danny Robinson, and his email address is: Danny.Robinson@ky.gov. Please be sure to give him adequate lead time to set-up the sites, and make sure the network is available.

The next meeting will be December 16 at 3 PM.

There was no further business, and the meeting was adjourned.

Respectfully submitted,



Richard Bartlett
Emergency Preparedness/Trauma Coordinator
KY Hospital Association

Public viewing/participation site:

KY Cabinet for Health and Family Services
Department for Public Health Conference Center
Health Services Building, Floor 1R (Center)
275 E. Main Street
Frankfort, KY