Kentucky Trauma Advisory Committee

June 15, 2010 – 3 PM (EST)
By videoconference

Members (19)
William Barnes, MD –No
Andrew Bernard, MD –Yes
Dick Bartlett –Yes
Julia Costich, PhD –Yes
Mary Fallat, MD – Yes
Sandy Tackett (for Terence Farrell) - Yes
Glen Franklin, MD – Yes
Lisa Fryman –Yes
Linda Gayheart –Yes (audio only)
Chuck Geveden – No
Sharon Mercer – Yes
Earl Motzer, PhD – Yes
Charlotte O'Neal – Yes (audio only)
Ashley Davis (for Bob Hammonds) – Yes
Carol Wright – Yes (audio only)
Chris Pund, MD -Yes
Susie Starling – Yes (audio only)
Russell Travis, MD - No
William Hacker, MD – No
Trish Okeson (for Dr. Hacker) – Yes

Guests:
Brian Harbrecht, MD - University of Louisville Department of Surgery
John Isfort – Marcum & Wallace Hospital
Diana Jester – KHA
Lisa Gray – St. Mary's, Evansville, IN
Tammy Scott – Pikeville Medical Center
Danny Jazarevic, MD – Pikeville Medical Center
Skip Tinnell, President, CDM
Beverly Tinnell, CEO, CDM
Robin Curnel, Crittenden Health Systems
Susan Zepeda, PhD-Foundation for a Healthy Kentucky
William Millikan, MD, St. Mary's Hospital, Evansville, IN
Scott Rinehart, University of Kentucky
Eddie Napier, KIPRC

The meeting was opened by Andrew Bernard, MD. There were 16 appointed members and 12 visitors. There was a quorum present.

CDM: Skip Tinnell, President and Beverly Tinnell, CEO, of CDM introduced themselves. Both discussed the data received from the Kentucky facilities.

Over 13,000 records have been received. Of the 13,000 records,10,000 data sets are from five (5) hospitals: U of L, U of K, Ephraim McDowell, Kosair Children's and Taylor Regional Medical Center. All 2008 data has been collected from the five hospitals. CDM has 2009 data from all the hospitals except for University of Kentucky. 3,000 of the records were received late yesterday and are not in the repository yet. CDM has some questions for the facility before the data can be analyzed.

Six (6) facilities have been trained on the eTraumaBase or TraumaLite. Of the six facilities, two (2) are actively participating.

Beverly commented that it is time to decide the date for the next sweep of data. September might be a target date for the first sweep for the first half of 2010.

There are six (6) additional facilities that began collecting data late in late 2009. The decision about expanding the data set or keeping with the NTDS set, and the date of the sweep, will affect the next facility or facilities that start collecting data.

The goal for the next few months is to conduct the data analysis and to give some overview of the data and take suggestions as to next steps. KyTAC will guide CDM as to what they want to see out of the system at this stage. With such a small number of data sets, it was not appropriate to look at a lot of clinical items. It was small relative to the rest of the hospitals. CDM can look at items such as mortality analysis, ISS, and age studies.

Skip gave an overview of the types of Information that comes from NTDS. This data includes some demographic information: where the patients live, where injured (zip code; county, including anyone is injured outside the country; some information on the actual location of where injury occurred); transferring hospital; gender, ethnicity, and type of protective devices that might be used. Pre-hospital times and dates are typically the least detailed information in the database.

Evaluations have been conducted on the missing information. It may be advantageous at some point to tighten up on what is going to be acceptable. At this time, CDM is collecting NTDS data and anything else in place when someone had made the NTDS sets. Perhaps some vital signs information such as systolic BP, pulse, and respiratory rate could be added. In many parts of the country, there is quite a bit of interest in looking at pre-hospital and emergency department blood pressures, pulse and respiratory rate as part of a way to establish if proper triage is being performed. There is also some information on Glasgow scores and oximetry.

Disposition information is being collected fairly well. One key quality data measure that is easy to determine is consistency between ED disposition and discharge disposition. For example, if it is noted that a patient is transferred out of an ED, there is a need to make sure that is consistent with a discharge disposition. Another example is if it is noted that a patient expired in the ED, but was transferred out as an inpatient, that's an obvious data quality issue.

Some procedure information has also been collected. At this point, they have yet to see how complete that will be. There is some diagnostic information. Diagnostic information will be one of the best things that the system will collect. Perhaps there could be some data sets like risk factors which could be thought of as co-morbid conditions or pre-existing conditions. There will also be a general list of complications. The list that the NTDS uses for complications and for co-morbid conditions is fairly complete. It has been adopted nationwide.

Hopefully the system will collect the AIS (Abbreviated Injury Score/Scale) information. This is used to give a much more specific assessment of the injury than the ICD-9. With the AIS and ICD-9 together, a good idea of exact injuries can be gathered.

CDM has worked with the Association for the Advancement of Automotive Medicine (AAAM) over the past three (3) years to develop a mapping system between the ICD-9 and the version of the Abbreviate Injury Scale (AIS) 2005. That version is not universally used as yet. CDM can implement this kind of mapping going back to AIS 1998 which is a much more commonly used version.

Two things can happen with that mapping system. It can supply AIS with information for hospitals that may not be able to supply it themselves. A decision can be made on what the AIS would probably be for the patient. That is one possibility.

Another thing for hospitals that are collecting AIS information at their facilities is to compare it with what the expert map system says it should be. That will give information on weaknesses in the coding system. That can drive decisions on education for registrars to improve coding skills. Registrars' skills can be kept up-to-date with periodic meetings with presentations of real data and asking for coding information.

Skip asked the group if there were any questions.

Dr. Bernard commented that he thought the facilities are pretty clear on what to be examining, cataloging, and reporting as individual centers. He asked if CDM could give some guidance on the types of things that Kentucky should be doing as compared to other states' systems or regional systems.

That could be quality assurance within our own facilities to make sure our data quality is good, looking at specific performance measures such as transferring patients to the right facility at the right time, and using the CDC Field Triage system to get patients to a trauma center for first admission.

He also asked about reports that need to be generated and sent to our leadership such as the Commissioner of Health, the Governor and the state legislature. This would give a snapshot of trauma in Kentucky, activities of the trauma system and give details of the deliverables.

Skip reported that CDM could relatively quickly feed data to agencies about the general condition of trauma in Kentucky. Once there is certainty that all 2008 and 2009 patient data is collected, feedback on some general statistics can be provided to KyTAC. Determination can be made what information/reports KyTAC would like generated and passed on to higher level agencies.

Skip replied that the common things that trauma systems want to report at a regional or state level is "the right patient at the right time."

Inherent in the data set is good vital sign information. For example, CDM should be able to determine that people, who meet the clinical criteria for hypertension, come to the right hospital in a reasonable time frame and how long they might spend in the ED, whether they go in a timely manner to surgery or ICU.

The other question about data quality is a very important item. There are issues such as the way systolic BP is collected. Sometimes people put "0" as the systolic BP simply because it is not available. That is a data quality issue and an abstraction issue. CDM can make a variety of reports given the restraints of the data sets. However, we will not have any exact PI outcome here.

Beverly commented that she had sent out a list of data points and hoped that on a state level to expand on the data base. The NTDS does have some limitations in particular with pre-hospital information.

The NTDS is particularly weak in the pre-hospital information and transferring information. For example, it is not known the individual pre-hospital agency and the individual referring hospital or the destination hospital. Those are things that need to be added in as soon as possible. That kind of specific transferring information will help fill the holes. Data could be collected on what agency takes care of a person right at the beginning, what hospital is the initial receiving facility, and what hospital is the tertiary receiving facility. All those kinds of questions can be approached if the data set is added.

There is one other specific kind of technical issue as to the method to identify an individual patient as they move through the system. This needs to be addressed early in the data set process. When information is being collected on patients who may have been to two or three hospitals in the course of their treatment, it will become increasingly difficult to separate out whom the individual patient is. The issue of establishing a mechanism for how an individual patient is known through the data base needs to be addressed early on.

Level I, II, and III trauma centers are utilizing the system to do data quality checks on a monthly basis. Facilities are also using their registry to do some of their CQI or quality improvement analyses and putting their patients through that process. The ACS book has a whole section on guidelines. Those guidelines can assist a facility in getting started in their analysis of the QI issue.

Many facilities will expand their trauma registries to focus on new procedures that they are putting in place or problematic things that are coming up in their responses or activities. Typically those types of things are not exported out of the facilities into a state system. None of those internal things get exported through the NTDS at this point.

There are some quality improvement issues that can naturally be discerned from the NTDS data. People at a hospital level will be doing internal analysis. At the state level, CDM will do overall regional or state level analysis of QI issues.

For any data collected, there will be some data quality reports that will be run and given back to facilities on an individual basis. It's not something that has to be shared among the whole group. It typically is done for the individual hospital so that hospital can see what kinds of problems they are sending through.

Dr. Bernard asked if the hospitals that are currently running TraumaLite understand the reports that they should be generating and the process to generate them. If the hospitals are having problems, what is the process for solving issues?

Beverly responded that those facilities should contact CDM. CDM has been working with Alisha and Trish at the University of Kentucky to get everyone on board and comfortable with CDM.

Later in July, CDM will begin a monthly teleconference and Webex with all the TraumaLite facilities to chat and show them some of the reports as well as new things they can do for their reporting. There are a large group of reports that they can produce at this time. However, the data must be collected and in the system to make sense of the reports. There is not enough data in there yet.

The goal is to get the facilities comfortable with the system. The facilities are to reach the point where the data feedback makes it well worth the time and effort to put the data in.

CDM is hoping to receive an outline on the fields that the state might not be interested in and that the smaller TraumaLite facilities would like to be able to collect. CDM is going to attempt to expand the data set for the TraumaLite facilities so that they can meet their internal reporting needs which may have a different focus than the larger trauma facilities.

Skip reported on types of missing data to date. There are probably trends that are not going to go away. These are fields/data that should be focused on in this early stage. Most of the fields have greater than 70% completion which is very good. The fields that have less that 70% completion need follow up and further education on completing these fields.

Some of these missing fields are protective devices. Some of those will be in the type of localizing the patient either to a town where the injury occurred or a residence. Sometimes that information is difficult to get but it can be very important to know actually where these things are happening as precisely as possible.

The field related to presence of complications also has about a 50% completion rate. Completion rate doesn't mean that patients had complications but that the field was filled in. It could have been none or not applicable. That counts towards data completion as well.

The data field for time of injury also has a 50% completion rate and can be very difficult to get. Everyone realizes that and it can be very useful.

The data fields for transportation – whether or not it was an EMS run - has a pretty good completion rate, with room for improvement as well.

Co-morbid conditions had about a 67% completion rate and that will be important as time goes on.

Beverly commented that the plan to give an analysis of data including e-code breakdowns, trauma scores and ISS and all that kind of analysis. Activity reports will be sent to the facilities for review. CDM hopes that as the process moves forward and everyone is engaged with the real data, more questions will be asked regarding research or the system as a whole. CDM can be directed if there are specific goals to move forward towards. Once those goals have been identified, CDM can help you to expand the data set or at least improve the quality.

Ms. Fryman asked if the TraumaLite facilities will be set up for the additional list of data points that was sent to all the other facilities.

Beverly replied that TraumaLite facilities can set up these data points if that is how CDM is instructed to handle it. Their data sets are the NTDS data points. Obviously some of the TraumaLite facilities are not going to have that entire data set for every patient. They move

people along and refer them out. But yes, the short answer is adding the fields that are agreed upon to the TraumaLite system as well.

Ms. Fryman asked if that extra data will start with the 2010 data.

Beverly replied that if CDM starts with 2010, since it is June, it will mean either that some of the of the data coming from the Levels I, II and III facilities will be incomplete unless they go back and fill in the information. She is not sure if all the facilities will agree to do that or whether KyTAC can recommend that the facilities do it. In order to analyze at a deeper level for 2010, to get more complete data would be a better way to implement that. It can certainly be implemented now with the ability for entering the data either backwards or forwards. Then in 2011, it could be the required Kentucky data set. CDM will need guidance on how to proceed with that.

It means that to expand this, CDM needs to define these in order to develop pick lists and definitions of fields. There would be an update for the TraumaBase folks and then applied to the TraumaLite system. CDM could do it retrospectively to the beginning of 2010 or get the update in place the last quarter of the year. That would give CDM time to implement it and for all facilities to participate. More complete data would be collected.

Dr. Bernard commented that it was the opinion at the last committee meeting that this is the data that the group wants to be collected. He thinks that CDM should set it up so that all facilities could all start putting it in the data for the last quarter of 2010. KyTAC could go forward in 2011 to make it mandatory.

Beverly asked several questions. Who specifically will be the contact person for CDM? Will it be Mr. Napier or Ms. Fryman? Who will dictate the pick list for these different fields? CDM certainly can provide standard definitions and pick lists that most of our regional and state systems use. CDM would need to know the entity to agree that those are the correct ones.

Dr. Bernard said that KyTAC had decided that at the last meeting. The contact for CDM will be Eddie Napier. Mr. Napier will take communication back from KyTAC to CDM and vice versa.

Beverly responded that the bigger list that is needed is the agency codes. CDM is having some difficulties nailing that one down.

Dr. Bernard asked if there were additional questions. There being none, he thanked Skip and Beverly for working with the state of Kentucky to get the trauma registry. He also thanked Susan Zepeda from The Foundation for a Healthy Kentucky for the funds to continue this beyond 2010.

Mr. Bartlett commented that he wanted to make sure that Skip and Beverly are aware that there is some dialogue with the Kentucky Board of EMS (KBEMS). KBEMS is in the process of retooling their paperwork data system. They have bids out in order to change from one system to another one. When they get a vendor selected, Bob Hammonds said he would be willing to sit down with KyTAC to discuss some automated data interfacing between the Kentucky EMS data system (KEMSIS) and the CDM system. Mr. Bartlett asked where CDM was in relation to interfacing with the NEMSIS data system.

Skip responded that CDM can take the data in and would need to add one other thing into the data set which gives the run sheet or tracking number. That will be the linking number. CDM will make sure that that happens.

CDM has had an easy time working with the facilities and appreciates the input and cooperation of the facilities submitting their data.

After asking for any additional questions and there being none, Skip and Beverly from CDM thanked the group for their time and signed off from the call.

Trauma Regulations: Mr. Bartlett asked if Mr. Kendall was on the call. Mrs. Okeson reported that he was not on the call due to a meeting at the Governor's Office. He did not have an opportunity to give her an update on the draft trauma regulations as the meeting was called at the last minute.

Mr. Bartlett reported that he sent out a notice dated June 8th with a number of suggestions that had been received. He worked with KHA Senior Vice President, Nancy Galvagni, to delete some items that were unenforceable in regulation as well as clarifying some items. There has been a great deal of discussion about the amount of data in the Level IV data base before the facility could submit. This is on page 5 of the Verification section. Ms. Galvagni made a suggestion that they have 9 months or 3 complete quarters to apply for verification, knowing that it will take 45 to 60 days to get a team scheduled to make the verification visit. By that time, the facility would have a year's worth of data in the data base before the team arrives for the verification visit.

He asked the group for their input as this is a compromise of what had been previously discussed. Dr. Bernard and Dr. Costich both agreed with this compromise.

Dr. Fallat commented that she and Dr. Franklin missed the previous KyTAC meeting where this issue was discussed and asked about the time frame previously discussed. She noted that Dr. Franklin wanted to know why this time frame should not be the same as the Level I, II, and III facilities. She asked for clarification on this issue and why Dr. Motzer wanted to push it back to 6 months. Why would the regulations not hold Level IV facilities to the same standards as Level I, II and III facilities?

Dr. Motzer commented that he was not making a recommendation but raising a question since there are a number of Level IV facilities who are anxious to get started as soon as possible to enhance the quality of care they are providing in their communities. The discussion ensued about the need for the data. He approved of the outcome of the discussion.

Mr. Bartlett asked if the group would like him to change it back to at least 12 months of data before the Level IV facility can apply.

Dr. Franklin commented that in reality, if you don't have a year of data, you don't have a year of data. It would depend on the year that the facility applies since trauma is a seasonal event. In the summer months and early fall, there is a peak at every facility that treats patients. If the facility chose to apply "off season", especially the Level IV facilities, there might not be enough data.

He stated that he had not been present for the discussion and facilities are eager to get verified but it's different than ACS-COT requirements for the other levels. The discussion is about data

collection and not resources in the facility. He understands the compromise but as a site visitor he would want to see 12 contiguous months of data in order to examine how the facility did during the busy and slow months of the year.

The consensus was to be back to 12 months of data. Mr. Bartlett said he would change the draft regulations to reflect the discussion, and send it to Mr. Kendall immediately as well as reposting on the KHA website.

Mr. Isfort commented that his facility has only had ten cases since January. A great deal depends on the hospital, the location and the situation with EMS. A numeric threshold would be difficult to reach. It should be a time frame, the trauma training and scenarios run, etc.

Dr. Bernard asked for any other input from the group. Hearing none, he continued with the next agenda item.

Dr. Bernard asked Mr. Bartlett to gather further information from Mr. Kendall. Mr. Bartlett said he would share any information through the Trauma List Serve.

Relationship with out of state Trauma Centers:

Dr. Bernard requested that the group discuss the relationship with the out-of-state trauma centers. He asked Mr. Bartlett to introduce the subject and to list the issues.

Mr. Bartlett reported that there was a conference call with Dr. Millikan from St. Mary's Medical Center in Evansville, IN. During the conversation, Dr. Millikan raised the question of an out-of-state facility requesting to be a Kentucky designated trauma center. This sounded like a good idea until it was examined more closely. There was a follow-up call with Dr. Hacker.

The issue is going to be a legal one. Our designation process is a process set out in Kentucky regulations governed by Kentucky law. The Commissioner of Health has no authority to regulate a hospital in Indiana. Kentucky can't regulate it, inspect it or follow-up on problems, and has no legal authority to demand records. The question become if this is a really appropriate action to take.

A relationship with out-of-state facilities is important since there are 7 states that border with Kentucky. How do we establish a working relationship, short of designation, with these out-of-state facilities? There are potentials such as cooperative training, injury prevention, and participation in meetings. As their trauma centers develop, discussions are needed to make sure that all are moving in the same direction and exchanging information. If there is a problem/issue, the correct person could be contacted.

Mr. Bartlett stated that once Indiana is set up, he would assume that both St. Mary's and Deaconess would be designated through the Indiana system.

Dr. Costich noted that there are often concerns that the trauma registry is not an accurate reflection of trauma in Kentucky. As much as 20% of Kentucky trauma patients are being cared for out of state, particularly in Cincinnati and Nashville. It would be helpful to get information from the surrounding states. She mentioned that she has been attempting to get the information for years. More success may be possible by working at the state level with the trauma advisory committees rather than the injury centers.

Dr. Millikan stated that there are no trauma centers in the state of Illinois below route 70. All the trauma patients go to St. Louis or Evansville. The only designated trauma centers are in Indiana or Missouri. As a result of that, Indiana sends data to the Illinois data base about Illinois trauma patients. Indiana acknowledges the critical role played by Louisville in taking care of trauma patients from southern and central Indiana. They also acknowledge the critical role of Cincinnati taking care of our patients from SE Indiana. It seems logical to include an exchange of data in the Indiana trauma plan that is evolving. That has already been discussed and it seems that is a very reasonable thing to do just like some of the trauma centers in northwest Ohio. Inclusiveness is the key and data sharing is critical. It is assumed that just as all Indiana data goes through the state trauma data base to the national trauma data base; we would have to contribute our information to the Kentucky trauma date base. This is done in Illinois.

He said that there will be cooperation in whatever Kentucky wants to do. He noted that St. Mary's was re-verified. ACS said St. Mary's needs to provide more closure with pre-hospital people in both Kentucky and Illinois. That just reinforced the fact that St. Mary's needs to be part of the continuum of care. In terms of the educational process, a lot of their students in ATLS are from Kentucky, and their Rural Trauma Development Program will go to Paducah tomorrow. They have already been to Madisonville. They think that the best care means participating in the program actively. They feel like a designation would be a reasonable thing as happens in Illinois.

Dr. Bernard commented that he thought that the plan Dr. Millikan outlined makes sense and is logical. That is the optimal system. The question we have to decide as a group on the verge of drafting these regulations is how much, if any of that, needs to be in the regulations.

Dr. Millikan stated that Illinois had no trauma centers and there definitely was a need. There is a template for the legal aspects. He stated that all their air carriers are credentialed, and all their pre-hospital people are credentialed in Kentucky, Indiana and Illinois. They have even considered many of their physicians applying for state licenses in Kentucky and Illinois.

He felt it would seem reasonable that if ACS wants the facilities to be designated by the Green book, they want to form a "seamless" system by which patients that come from Illinois would move through a single system. Indiana should be part of the Kentucky system and Kentucky should be part of the Indiana system. We are fortunate that the Indiana state trauma system plan is evolving just as the Kentucky trauma system plan is evolving. Both states can learn from the problems that the Illinois trauma system is continuing to have. St. Mary's feels that if they are part of the Kentucky program, they could be better mentors to places such as Henderson, Owensboro and Madisonville to help develop their efforts to become Level III and IV centers. At this point, they are part of St. Mary's peer review process, and come to their trauma rounds each week by webcam or in person.

Dr. Bernard stated that Danny Jazarevic is the new trauma director at Pikesville. He has experience with trauma systems in Pennsylvania that he might be able to share.

Dr. Jazarevic commented it could be called "Tri-State Trauma Consortium System" – maybe Illinois, Indiana and Kentucky. A group would develop the guidelines for this consortium. It can't be regulations but guidelines. Each state would have its own regulations. The Consortium coordinates all 3 states as an entity and decides on protocols for all three states to follow: prehospital, hospital and post-hospital care and outreach programs. Then there would be a joint system.

Dr. Bernard asked Dr. Fallat if the ACS-COT has any sort of overarching plan.

Dr. Fallat said that there is precedent for some trauma centers on state borders to be members of a system in another state. She didn't have enough details to discuss and is researching it. She will send more information and contacts.

Dr. Millikan stated that Texas, Oklahoma and New Mexico are a trauma consortium. It all evolved due to a desperate need. The classic case is between Gary and Chicago. Hospitals in Illinois have closed their hospitals to patients from Gary. Indiana is taking patients from Southern Illinois. The consortium is working in Ohio. The only problem with that model is that the guidelines evolving within the consortium have to be blended and melded to existing guidelines in all the states. It was problematic in Texas and Ohio, since each state had published and put into law the pre-hospital guidelines. He believes the groups in Akron and Cleveland have done that. The feeling was that the more that the states can develop an active interface at the clinical level between the hospitals in bordering states, the better.

Dr. Bernard commented that there is obviously a geographic relationship with Indiana by definition, and the system takes a tremendous amount of patients from Southern Indiana at U of L. The question being discussed here is not about cooperative agreements, it's about regulations. He does not think that Kentucky needs to be in the business of verifying or designating facilities in other states.

Cincinnati and Evansville, Nashville, West Virginia, Charleston & Huntingdon -- these places are linked to our borders. Patients are being shared across those borders. Cooperative agreements with the trauma centers are good things. Both of the trauma centers in Evansville have a transfer agreement with the U of L as their designated Level 1 center when they feel that the patient exceeds their resources. Those things need to continue.

Dr. Bernard stated he would strongly recommend that this not be addressed in regulations because of the difficulty and challenges that may occur in the future as tax dollars may be wrapped up in the system. KyTAC is lobbying for money and if there is an impression that the money may or may not have the potential to cross the border, it might make Kentucky law makers less enthusiastic about revenue. He assumes that the hospitals seeking trauma verification in northern Kentucky will have agreements with Cincinnati. He assumes that those in eastern Kentucky will have to decide whether they are closer to UK or whether they are closer to Charleston, West Virginia, or trauma centers in Tennessee.

Dr. Bernard believes a method can be discovered to get data from Cincinnati and Evansville since Kentucky should know where its citizens are hurt and what happens to them.

Mr. Bartlett pointed out that the proposed regulations were written without specifically inserting the protocols and the transfer agreement. They were in the Trauma Hospital Manual so it could be flexible. Some other states did include the protocols in their regulations and this locked them in tight. Because protocols have been included in a reference document as guidelines, it gives Kentucky the flexibility to work with our neighbors across borders. KHA is gathering some hospital admissions and discharge data from our neighboring states using the data system that KHA has contracted with the state. KHA has agreements with the seven surrounding states to bring in the ED discharge data, admissions data, hospital admissions and discharge data.

Dr. Costich was asked if it is possible to extract data on trauma from our neighboring states through the national trauma data base and use that as a clearing house like some of the other

professions do. Dr. Costich said that they have tried to do that and was told that it could not be done because there are no geographic identifiers.

Dr. Millikan that the best way to do this is to work through the state trauma data base because it is set up that way to monitor care, reduce the common denominator of injury severity scores and other co-morbid factors.

Dr. Bernard said that the group seems to be agreeing that the regulations should be left as is. There is a need to have a broader perspective that begins reaching out to the centers and states that border Kentucky. There is a need to begin organizing ourselves through a regional system similar to other areas of the country.

Dr. Bernard added that Kentucky can't have any regulatory authority over what happens outside of the state. It needs to be considered and formalized. If undertaken now, it will delay getting the regulations on trauma designation and become a major stumbling block to getting the regulations passed which the Level IV's are waiting for.

Dr. Costich agreed that the regulations as are the momentum at this juncture and to pursue these discussions with individual facilities as well as the state groups on a parallel track and without letting that derail the need to get these regulations on the books.

It was agreed that the major focus here is to get Kentucky hospitals up to speed on trauma care and to create a defacto system that works in our state, recognizing that there are border centers that are helping Kentucky. The plan is to focus our regulatory and our designation process on Kentucky hospitals and encourage the counties that already have relationships to firm those up as best as they want to.

Mr. Bartlett suggested that we consider a working group or the verification committee look at this subject with the goal of developing a potential chapter or section for our trauma hospital manual that would be guidelines for developing relationships with trauma centers in adjacent states. Some facilities on the border can be asked to participate in that. Those guidelines could be added to future revisions of the trauma hospital manual for guidance.

Dr. Millikan said they would be glad to participate.

Dr. Bernard stated that he agreed with Mr. Bartlett and suggested a guide for developing transfer relationships, transfer agreements, etc. That is required by the Green Book of Level II, III and IV centers. The point would be if the nearest Level II center is across a river or state line, then that is where the facility should look to develop a relationship.

Mr. Bartlett also noted the guidance is going to want to include things like regulations that might create problems. An example would be a Kentucky ambulance going in emergency mode to a facility in Nashville.

Dr. Franklin agreed. KBEMS once spent half a meeting arguing about whether a nurse practioner on the back of a helicopter from Vanderbilt could fly into Kentucky to pick up a dying child and take them back to the Vanderbilt Children's hospital which was much closer than coming to Louisville. The real issue on the table was the paramedics in the room didn't see a nurse practioner equivalent to their level of training for pre-hospital care. These regulatory events that affect nurses and pre-hospital personnel are real events between different boards of

EMS and boards of nursing. The regulations sometimes bog people down so that is a very good point about EMS agreements and nursing agreements.

Dr. Bernard stated that next item on the agenda was to nominate and select a Vice Chair as well as someone to chair the Protocols Sub-committee.

At Dr. Bernard's request, Mr. Bartlett gave the list of committee members and their terms:

Costich-June 2013
Starling-June 2013

Barnes – October 2012
Bernard- October 2012
Hammonds-October 2012
Gayheart-October 2012
Hacker-October 2012
Travis-October 2012

Bartlett – October 2011
Farrell-October 2011
Geveden-October 2011
Mercer-October 2011
Charlotte O'Neal-October 2011
Wright-October 2011

Franklin-October 2010
Fryman- October 2010
Fallat-due for appointment or some action in October 2010
Motzer-October 2010
Pund-October 2010

The EMS position is set up so the KBEMS Board will have to name someone else to KyTAC if they do not name Bob Hammonds.

Dr. Bernard asked that the nominations be opened for the Vice Chair for KyTAC. He stated he thought it might be best to not consider people who are rotating off KyTAC in October 2010.

Mr. Bartlett asked Mrs. Okeson if there had been any discussion in the Secretary's office about the reappointments that are coming up in October. She stated that she was not aware of any discussions at this time.

Dr. Franklin reported that he thought the original intent was that different organizations were going to recommend their slate to the Secretary's Office. For instance, the candidate from the COT is selected by the COT chair.

Mr. Bartlett replied that he was correct and that the same was true for ACEP, the Board of Medical Licensure, the Board of EMS, the Board of Nursing, and the Transportation Cabinet. Those are appointed positions.

Dr. Franklin replied that he thought that the universities did appointments as well. The Secretary can't be expected to select a doctor off a list of 500 physicians from U of L and to

know anything about trauma unless it was a very narrow slate of people. He assumes that the same is true at the University of Kentucky.

Mr. Bartlett replied that the Level One trauma center can designate someone.

Dr. Franklin said that is what he thought KyTAC had originally agreed upon. He asked if the committee chairs have to be members.

Mr. Bartlett stated that KyTAC does not have any by-laws at this time.

Dr. Franklin nominated Brian Harbrecht to be the Protocol Chair.

Mr. Bartlett replied that he thought KyTAC had already volunteered Dr. Harbrecht to be the chairman of the Process Improvement/Quality Improvement Committee.

Dr. Bernard said that Dr. Harbrecht agreed to do that. It is timely that someone be designated to do PI because someone is needed to work with Eddy and CDM as KyTAC gets moving with the Kentucky state registry and the state performance improvement. He has no arguments if the group thinks Dr. Harbrecht would be better suited to do protocols, and if he would rather do that.

Dr. Franklin stated that he didn't think any of these jobs are a "rather". Dr. Harbrecht will do an excellent job at either one. He thinks that right now more efforts need to be focused in the protocol arena than in the PI arena because there is not a lot of PI data. Dr. Harbrecht would certainly do a good job in either way. There is more work to do on one instead of the other.

Dr. Bernard agreed with Dr. Franklin. He asked if there any other nominations for the Chair of the Protocols Sub-committee.

Hearing no nominations, Dr Bernard moved that the nominations be closed for Dr. Harbreacht to chair the Protocols Sub-committee.

It was seconded and there being no other nominations, Dr. Bernard said that Dr. Brian Harbrecht is the chair of the Protocols Sub-committee.

Dr. Bernard opened nominations for Performance Improvement Sub-committee Chair. This position doesn't have to be an individual that is a sitting member of the committee. This is best suited for someone who is a medical director, or a trauma coordinator, or someone who is heavily involved in data.

Dr. Franklin stated that he thought it should be a physician since it will be peer review on medical care.

Dr. Pund stated that since his term is over in October, he will go back to ACEP and ask for an emergency physician to get involved in this.

Dr. Bernard stated that the KyTAC can consider putting the ACEP member as the chair for the subcommittee on statewide Performance Improvement. There was no more discussion on nominations for that chair position.

Dr. Bernard asked for nominations for the vice-chair for KyTAC. This position had been filled by Mr. Charlie O'Neal.

Mr. Barltlett asked Dr. Fallat if she would be interested in accepting the nomination.

Dr. Fallat stated that she assumed she was eliminated since her term expired in October 2010.

Dr. Bernard agreed that Dr. Fallat would be a good choice having the most experience with the national COT and trauma systems of anyone on this conference call.

Dr. Franklin mentioned two options. The committee can nominate Dr. Fallat and wait to see if she is reappointed or hold off until the reappointments are made. He thought it is a decision of the chair.

Dr. Bernard stated that Dr. Fallat's nomination be accepted and asked if there were any other nominations.

Mr. Bartlett moved that Dr. Fallat be nominated as vice-chair of the Kentucky Trauma Advisory Committee.

It was seconded.

There being no other nominations, Dr. Fallat is vice-chair of KyTAC.

Dr. Bernard asked if there was any other business.

Mr. Bartlett reminded the group of the two courses being offered on August 4. A flyer with details is attached to these minutes.

Mr. Bartlett distributed other information regarding the trip to Israel to Western Galilee Hospital. For those who are interested, there is a conference call on July12 to discuss the details. The participants of the trip will be paired with your counterpart from an Israeli hospital as part of the training. If there is an event, participants will work with their counterpart to respond to the event. After the conference, Mr. Joe Magana is scheduling a guided trip to the Holy Land for the end of the trip. There are some stipends that have been arranged for those participants who might need financial assistance to attend.

The Kentucky EMS Conference and Expo is September 14-17 in Lexington. Conference information can be found at: http://hultgren.org/conference/

Dr. Franklin stated that on Thursday, September 15, there is a whole day of programming for Medical Directors of EMS. All physician members on the Kentucky Board of EMS will be directing the course and there is a special emphasis on trauma.

Next meeting: The next meeting will be held on Tuesday, August 17th at 3:00 PM EST. (**There is no July meeting.)**

There being no further business, the meeting was adjourned.

Surge Capacity and Hospital Evacuation Training Event
Wednesday, August 4, 2010
8:00 AM to 4:00 PM
Department of Public Health – Conference Rooms A&B
Videoconferencing on Kentucky Department for Public Health Distance Learning Network (KEN-NECT)
Webcast Accessible

Morning Course (8:00 AM to 1:30 PM)

National Center for Injury Prevention & Control, Centers for Disease Control & Prevention
In A Moment's Notice: Surge Capacity for Terrorist Bombings

Register to participate at http://ky.train.org, Course #1020025

Explosive devices and high-velocity firearms are the terrorists' weapons of choice. The devastation wrought in two European capitals, Madrid and London, demonstrate the impact that can be achieved by detonating explosives among densely packed civilians. In an instant, an explosion can wreak havoc—producing numerous casualties with complex, technically challenging injuries not commonly seen after natural disasters such as floods, tornadoes, or hurricanes. Because many patients self-evacuate after a terrorist attack, and prehospital care may be difficult to coordinate, hospitals near the scene can expect to receive a large influx—or surge—of victims after a terrorist strike. This rapid surge of victims typically occurs within minutes, exemplified by the Madrid bombings where the closest hospital received 272 patients in 2.5 hours. In addition, injuries to workers involved in recovery procedures can lead to a secondary wave in surge.

To address the challenges posed by such an event, CDC's National Center for Injury Prevention and Control convened an expert panel in October 2005 and January 2006. The panel included experts in the areas of emergency medical services, emergency medicine, trauma surgery, burn surgery, pediatrics, otolaryngology, intensive care medicine, hospital medicine, radiology, pharmacology, nursing, hospital administration, laboratory medicine (blood bank), and public health. The panel was charged with identifying creative strategies that could be adopted in a timely manner to address surge issues from terrorism.

This document, which is the result of the expert panel meetings, reflects the opinions and recommendations of the experts. It includes a description of system-wide and discipline-specific challenges as well as recommended solutions to address these challenges. The proposed solutions for the discipline-specific challenges have been incorporated into easy to use templates that can assist various disciplines in managing surge needs for injuries.

In 2008-2009, the American College of Emergency Physicians (ACEP) through a cooperative agreement with the Centers for Disease Control and Prevention (CDC), conducted pilot tests of the surge planning templates. Two Level 1 trauma centers (WakeMed, Raleigh, NC and University Medical Center, Las Vegas, NV) and one community hospital (Baylor Regional Medical Center of Grapevine, Grapevine, TX) not only used the templates to ascertain their readiness for surge capacity but evaluated the templates for thoroughness. While these templates are modeled around a terrorist event, they would be equally applicable to other events causing a large number of mass casualties such as an explosion, building collapse, or earthquake.

Both national and international experts as well as representatives from the pilot test hospitals met in June 2009. The templates were edited, revised and updated based on the pilot test experiences and other real world experiences. The revised document was released in April 2010.

Kentucky Hospital Research & Education Foundation, a subsidiary of Kentucky Hospital Association, is conducting a free training and orientation on these templates. Hospitals interested in participating are asked to identify two (2) representatives, either one from their hospital trauma team or emergency preparedness team and one of their local EMS management team to attend the meeting. The project team leaders from the hospitals/EMS systems in Las Vegas, Raleigh and Grapevine will participate in the meeting through videoconferencing, as well as ACEP staff. Follow-up conference calls in November 2010 and February 2011 will offer an opportunity to check progress, discuss problems the participants may be experiencing and exchanging ideas among participants.

Afternoon Course: 1:30 PM to 4:00 PM

*Hospital Evacuation: Principles and Practices During A Disaster**
DHS/FEMA course

Register to participate at http://ky.train.org, Course #1019964

Evacuation of the healthcare facility is the last resort of a delivery system in danger of collapse from an impending natural disaster, physical damage to the facility or a lack of critical resources which so severely impact the environment of care that there is no other option. Patient safety, continuity of care, and staff and visitor safety during a disaster depends on planning, preparedness, and mitigation activities performed before it occurs. Evacuation is a rare event and a worst case scenario. It is a rarely or inadequately planned for event.

This DHS/FEMA course takes the participant through the evacuation process starting with an assessment of the resources determined to be critical to the decision making process. The learner then walks through the development of a functional plan for a healthcare facility in the first module. In the second module, the learner focuses on the critical decisions and trigger points that guide the incident management team in making the decisions leading to a possible facility evacuation. The importance of planning for recovery and the importance of actions critical to recovery that must occur concurrently with the disaster response are addressed.

The course relies on the input of hospital planners, administrators and key staff members who have experienced the need to evacuate a hospital facility. The course is presented in a lessons learned format based on actual experiences.

Along with the course, a survey tool is provided to assess a facility's preparedness and available resources for a possible evacuation. The completed survey is designed to be added to the facility emergency operations plan to serve as a resource for the incident management team.

This is the first pilot presentation of the DHS/FEMA course. Feedback and evaluation from participants will be an integral part of this training event, and will help improve the program for future presentations.

*CEU credits for nurses and EMS personnel will be available.

Registration:
Participants must register for each course separately. Participants can register for the morning course, the afternoon course or both courses. Registration is available through http://ky.train.org along with instructional materials to download for remote viewers.

To schedule viewing of the courses by video-conference at a non-KEN-NECT (KY Public Health) location, contact Diana Jester at the Kentucky Hospital Research & Education Foundation (KHREF) at djester@kyha.com or 502/992-4351.

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