Time Critical Diagnosis-Trauma System Task Force
Meeting One, September 18, 2008
Meeting Highlights

Attendees:

Dr. Charlene Adkins, Audrain Medical Center; Paula Adkison, Department of Health and Senior Services (DHSS); Jennifer Aiken, Centerpoint Medical Center; Dr. Lynthia Andrews, State Advisory Council; Brian Banks, Knox County Ambulance District; Bill Bridges, Texas County Memorial Hospital; Adam Bruner, Air Evac EMS; Jen Busby, St. Luke's Hospital; Dr. Naganna Channaveeraiah, Madison Medical Center; Ben Chlapek, Central Jackson Fire Protection District; Karen Connell, DHSS; Colleen Cook, Freeman Neosho Health Center; Jason Cullom, St. Joseph Hospital West; Lori Davis, North Kansas City Hospital; Marcia Dial, Scotland County Memorial Hospital; Dr. Robert Dodson, St. John's Regional Medical Center; Dorothy Dolson, DHSS; Joan Drake, Staff for Life Helicopter Service; George Duff, Atchison-Holt Ambulance District; Joan Eberhardt, Missouri Emergency Nurses Association; Jay Faulkner, Osage Beach Ambulance; Dean Feller, Liberty Hospital; John Fuller, St. Anthony Medical Center; Timothy Gash, Lake Ozark Fire District; Shirley Gastler, DHSS; Pam Golden, St. Louis University Hospital; Randall Graham, St. John's Mercy Hospital; Robert Grayhek, St. Francis Medical Center; Chris Green, SSM Cardinal Glennon Children's Medical Center; Vicki Groce, Andrew County Ambulance District; Paul Guptill, Missouri Hospital Association; Dr. David Gustafson, Odessa EMS, Harrisonville EMS, APSI; Susan Hall, St. John's Regional Medical Center; Heather Hawkins, DePaul Health Center; Dr. Elliott Hix, Scotland County Memorial Hospital; Tami Holliday, Hendren and Andrae LLC; Jody Hyman, DHSS; Dr. Kelly James, Centerpoint Medical Center; Dr. Robert Johnson, St. John's Regional Health Center; Antoinette Kanne, St. John's Mercy Medical Center; Marc Kaufman, Metro Emergency Transport System Ambulance; Dr. Dennis Keithly, St. John's Mercy Medical Center; Dr. James Kessel, University Hospital and Clinics; Jerry Kirchhoff, Air Evac Lifeteam; Mary Kleffner, DHSS; Amy Knoernschild, St. Charles County Ambulance District; Ken Koch, St. Charles County Ambulance District; Dr. Patrice Komoroski, SSM DePaul Health Center; Dr. Stephen Larson, SSM DePaul Health Center; Dean Linneman, DHSS; Dr. Charles Ludy, Capital Regional Medical Center; Candy McClain, St. Luke's Hospital; Rande McCrary, Atchison-Holt Ambulance District; Randy McCullough, Lafayette Regional Health Center; Bryant McNally, Missouri Hospital Association; Deborah Markenson, DHSS; Debbie Mebruer, DHSS; Ruby Mehrer, Life Flight Eagle; Dr. Samar Muzaffar, DHSS; Julie Nash, Barnes-Jewish Hospital; Dr. Daniel Naughton, St. Louis University Hospital; Carol Nierling, University Hospital and Clinics; Patty Parrish, CoxHealth; Bob Patterson, St. John's Emergency Medical Services; Karen Radel, St. Joseph Hospital West; Mat Reidhead, DHSS; Eric Roberts, Research Medical Center; Tracy Rogers, Truman Medical Center; Dr. John Russell, Cape County Private Ambulance Service; Kathe Russo, DePaul Health Center; Dr. Joseph Salomone, Kansas City EMS/SAC; Helen Sandkuhl, St. Louis University Hospital; D.J. Satterfield, St. John's Life Line Air Medical Service; David Seastrom, St. Luke's Hospital; Ted Shockley, St. John's Regional Hospital; Kirk Smith, Lexington Fire and Rescue; Bill Stephens, Phelps County Regional Medical Center; Dr. Alan Umbright, St. Joseph Health Center; Mike Wallace, Central Jackson Fire Protection District; Matt Waterman, University of Missouri Health Care; Dr. David White, Phelps County Regional Medical Center; Linda White; Nathan Williams, Missouri Emergency Medical Services Assn.; Sandy Woods, St. John's Regional Medical Center and Beverly Smith, DHSS.

A total of 85 attended the first Time Critical Diagnosis (TCD)-Trauma System Task Force meeting. The group was welcomed by Dean Linneman, Missouri Department of Health and Senior Services (DHSS) and Dr. Lynthia Andrews, Chair, State Advisory Committee.

Dr. Samar Muzaffar gave a PowerPoint presentation on the TCD system and the history and role of the trauma model. The term TCD was adopted by Dr. Bill Jermyn, the former Medical Director of the Emergency Medical Care Office, DHSS, for describing the system that delivers care to the time-dependent diagnoses, which currently include trauma, stroke and STEMI. The framework for the system builds on the well-established

trauma model designed to deliver the trauma patient to the right place, in the right time and for the right care. The system reflects the continuum of care from prevention and public education through out-of-hospital emergency services to hospital, rehabilitation and quality improvement. Key concepts embraced by the TCD system include, but are not limited to, parallel processing, moving care forward, using time saving measures, shared resources, and legislative base.

The priority TCD components on which the Trauma Task Force will focus include pre-hospital, hospital, quality improvement, public education and professional education. Issues related to the 911 and financial/payer elements will be addressed at a later stage. Data on motor vehicle traffic mortality rates indicate that Missouri has an overall flat trend with some improvements in 2007 and 2008. The three-year moving average rate in 1991-1993 was 18.4 deaths/100,000 compared to 18.9 deaths/100,000 in 2004-2006. This factor underscores the importance of the task force's purpose to identify what issues should be priorities to improve health outcomes for trauma patients, including motor vehicle accidents.

Findings from a recent trauma pilot survey indicated the following issues as important to the trauma community: lack of established protocols on helicopter early launch and field triage and transport, problems with hospital selection and diversion, trauma center access, communication, quality improvement, staffing, and professional education. The task force will use the series of scheduled meetings to compile formal recommendations to DHSS to improve the system components. In addition, the task force will review the regional committee structure and function, update protocols, establish approaches for increased use of on-line and off-line medical control for out-of-hospital emergency medical care, review need for level IV trauma centers, update QI and evaluation processes, and establish a consistent state classification scheme with regional variables.

The **meeting process** was reviewed. For each meeting there will be select focus issues for discussion. These issues will be discussed by regional work groups and their recommendations will be synthesized for a statewide overview. The guiding principles were explained as a philosophical base to guide the task force's decisions. Members represent a broad range of perspectives and all opinions need to be represented in the discussions. Final decisions will generally reflect compromise and group consensus in order to achieve what is best for the patient in the TCD system of care.

It is understood that not all people can attend each meeting. Regional chairs are to select alternates for facilitating their group's discussion when they are absent. It is also expected that those who miss a meeting and then attend a subsequent meeting will come prepared to work by reviewing the highlights and work documents completed at prior meeting(s). Prior meeting highlights and next meeting agendas will be distributed prior to each meeting so groups can avoid repeating discussions and review of issues already addressed.

A Steering Committee has also been established to advise DHSS on the meeting process, help engage meeting participation, and resolve problems or issues that may arise from the full task force.

The first focus issue discussed by the regional work groups was the **current regional committee purpose and function**. An overview of the regional committees was presented by Paula Adkison, DHSS. The Task Force then subdivided into six regional work groups and the following issues were collectively reported from the regions.

1. **What is working?**
   - Sharing information and educational opportunities.
   - Sharing protocols, mutual aid agreements.
   - Attendance by DHSS staff to serve as resource to committee.
   - Meeting after State Advisory Committee (SAC) to disseminate information.
   - Networking and providing assistance to each other.
   - Participation by experienced and seasoned individuals who can share and guide best practices.
   - Changing meeting location within the region to provide opportunity for seeing other facilities.
   - Integration of EMS out-of-hospital services.

   There was variance in where, when and the benefits of each region's meetings.

2. **Are there additional functions that Regional Committee should or could be doing?**
   - Conduct additional education with focus on what is required by the rules and regulations.
   - Improve quality improvement functions with benchmarks for facility/region/state.
   - Share best practices.
   - Improve meeting participation to assure participation from all areas within region.
   - Improve regional communication among stakeholders.
   - Work on triage and transport for the region.
   - Work on role of small hospitals.
   - Review regional practices based on American College of Surgeons (ACS) trauma criteria.
   - Explore authority base and roles for medical directors within region.
   - Review and approve protocols for care.
   - Enhance network development.
   - Coordinate prevention education on a regional basis.

   Participants requested an overview of functions and expectations of the regional committees. Those new to the process are unclear about functions. It was discussed that it would be helpful to have information on regional committees readily available, including placement on the DHSS web site. It was also discussed that some of the

functioning regional boundaries used by the respective committees is different than what is reflected on the DHSS Regional Committee map.

3. What could be done better?

- Disseminate information about the existence of the regional committees, their functions and benefits.
- DHSS needs to define its mission and vision for regional committees.
- Increase the diversity of membership.
- Increase involvement and participation from the region's medical directors.
- Use tools, such as teleconferencing, to conduct meetings to decrease time and driving burdens for members.
- Coordinate the hosting of regional committee meetings with other stakeholder groups from within the system to leverage the impact.
- Establish and maintain standard meeting time (e.g., fourth Tuesday afternoon of every month).
- Provide updated and readily accessible regional committee membership listings.

4. Are there barriers to making changes in the Regional Committees?

- Lack of understanding of regional committees' purpose. (Would like DHSS direction on this).
- Lack of EMS peer protection for effectively using and sharing data across components for QI. Lack of cross-tabulation between EMS and hospital data which limits ability to do system QI functions.
- Inadequate communication. Lack of timely updates. Lack of information on important topics, such as funding opportunities.
- Lack of data availability, no feedback or reports from registry data.
- Lack of funding, unfunded mandates. Inadequate funding for regional committee support and professional education.
- Shortages of critical resources including workforce.
- Delay in member appointments to regional committees.
- Medical directors not always meeting with regional committees.
- Limited opportunities for involvement unless you invest considerable time and money to travel to state meetings.

5. Are there specific actions that can be taken to move around these barriers?

- Explore avenues to improve communication or expand dissemination of information about the system. For example, compile, analyze and create a report that shows the accomplishments, and issues or problems being addressed or needing to be addressed through the trauma care delivery system.
- Provide clear direction to regional committee members regarding their roles and responsibilities. DHSS provide orientation and training to regional committee members.

- Demonstrate the value and benefits of the regional committees to attract participation and funding.
- Respect members' time constraints by providing timely and succinct information.
- Would like to have universal and accessible website for regional updates.
- Revisit the vision and purpose of regional committees.
- Provide orientation for new members.

The second focus for discussion by the group was **current role of small and rural hospitals and review of need for Level IV Centers**. Marcia Dial, Scotland County Memorial Hospital in Memphis presented highlights from Dr. Michael Rotondo's PowerPoint on *The Rural Trauma Imperative: Silent Killer in America's Heartland*. The regional work groups then began discussion on a range of questions that will be continued and finalized at the next meeting.

Groups were asked if additional information is needed for the discussion on Level IV trauma centers. A resource map has been compiled by the DHSS GIS staff and is available on the website at www.360365.org A request was made for data on location of trauma incidents and health care patterns of care.

The focus issues for the next meetings include completion of the discussion on level IV trauma centers, protocols for triage, transfer, helicopter early launch, PAI/EMD, and current medical control both on-line and off-line for EMS. Comments indicated the importance of keeping the number of issues to be discussed at any one meeting manageable and realistic for a one day discussion.