Trauma System Advisory Committee

3760 South Highland Drive Salt Lake City, UT 84106
Conference Room 342
Meeting Minutes
Monday, June 12, 2017

Committee Members:	Craig Cook, MD; Holly Burke, RN; Janet Cortez, RN; Hilary Hewes, MD; Jason Larson, MD; Clay Mann, PhD; Mark Dalley, and Steven Anderson.
Excused:	Matt Birch, Don VanBoerum, MD, Rod McKinlay, MD, Grant Barraclough, Annie Relph, RN; Mark Thompson, and Christopher Drucker.
Guests:	Kristen Gurn, Megan Shaw, Shawn Evertson, and Zach Robinson.
Staff:	Jolene Whitney, Yukiko Yoneoka, Peter Taillac and Annalyn Beers.
Presiding:	Craig Cook, MD

Agenda Topic	Discussion	Action
	Welcome	
Welcome and Introduction of Members	Dr. Cook welcomed everyone to the meeting.	
	Action Items:	
Approval of March 2017 Meeting Minutes	The March meeting minutes were reviewed and a motion was made to approve the minutes as written.	**Holly Burke, RN made the motion to approve the March meeting minutes. Jason Larson, MD seconded the motion. No members opposed, none abstained; motion carried.**
Rule Change Discussion	Jolene Whitney went over the rule changes to be submitted. **a. Use of SSN and Adding Name Field** The Trauma Registry requires submission of social security numbers for collecting data. It is a challenge to link Department data and Trauma Registry data without these fields. There are several patients who do not provide a SSN. The Committee is proposing the requirement of the patient name and the last 4 digits of the SSN in lieu of the complete SSN. There was discussion on the proposal. Having equal identifiers across the field would be ideal to link information for accuracy and data purposes. The Trauma Registry does not currently require a name. Pediatric social security numbers would be a challenge to obtain. The Committee decided requesting the name is important and the last 4 digits of an SSN is reasonable with the protected database. The Committee discussed prehospital requirements and presenting institutions with this approach. Janet Cortez, RN will approach the University of Utah regarding required fields that are currently in use. Information will be brought back to the TSAC meeting in September, if a motion is passed at that	**Janet Cortez, RN made the motion to change the "focused visit" to "a consultation" and the timeframe from "90 days" to "6 months" in proposed rule R426-9-600 (f). Jason Larson, MD seconded the motion. No members opposed, none abstained; motion carried.** **Janet Cortez, RN made the motion to change the verbiage of "monthly" to "quarterly" and "Trauma Registry information" to "State Data Requirements" in**

	time, rule implementation may take place in January 2018. **b. Implementation of Data Submission Timeframe** The proposed rule R426-9-700 (1) reads: (1) "All hospitals shall collect, and ~~monthly~~ quarterly submit to the Department, ~~Trauma Registry information~~ State Data Requirements necessary to maintain an inclusive trauma system. Designated trauma centers shall provide such data in a standardized electronic format approved by the Department. The Department shall provide funds to hospitals, excluding designated trauma centers, for the data collection process. In order to ensure consistent patient data collection, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria:" Jolene Whitney stated the trauma registry should be concurrent and at a minimum of 80% cases entered within 60 days of discharge, according to the American College of Surgeons Guidelines which the Department has adopted. Jolene asked the Committee what recommendations they have. There was discussion of how centers are being monitored which are not submitting trauma data within the required timeframe and what action should be taken. Hilary Hewes, MD recommended adding the wording to match ACS standards. It was determined to change the verbiage of "monthly" to "quarterly" in proposed rule R426-9-700 (1). Incorporate registry in the same bullet and quarterly data will be submitted at the end of the next quarter. The verbiage of "State Data Requirements" will take the place of "Trauma Registry information". A motion was made to finalize the decision. **c. Changes in Trauma M.D., Trauma RN or Ownership** Jolene Whitney reviewed the proposed rule changes with the Committee. R426-9-600 (b) is proposed as: (b) "a letter from the hospital administrator of continued commitment to comply with current trauma center designation standards as applicable to the applicant's designation level; within 60 days of a change in ownership a new letter of commitment to comply with current designation standards shall be required." R426-9-600 (f) has been proposed as: (f) "a change of Trauma Program Director or Trauma Program Manager shall require a ~~focused visit~~ consultation within ~~90 days~~ 6 months of the change to insure that designation standards applicable to the trauma center's level of designation are maintained." A motion was made for the above listed proposed rule changes.	**the proposed rule R426-9-700 (1). Holly Burke, RN seconded the motion. No members opposed, none abstained; motion carried.**

	Informational Items:	
Geriatric Trauma	Yukiko Yoneoka presented data from Geriatric Trauma research. After reviewing the geriatric trauma guidelines from Washington state at the previous TSAC meeting, the Department wanted to know if Utah is in need of a geriatric trauma care guidelines. Yukiko reported the findings of her research of hip fracture and head injury statistics among the elderly of age 65. Over 1/3 of the trauma patients in our Utah Trauma Registry are geriatric patients. Dr. Peter Taillac recommends looking at implementing Geriatric Guidelines. Approximately 87% of geriatric patients have had falls, 97% were accidental falls. There were twice as many females as males having accidental falls. Around 38% of geriatric patients with accidental falls experienced a hip fracture. There were 24% of geriatric patients who experienced head injuries as a result from an accidental fall. Yukiko then went over the mortality rates. Greatest patient risk factor is heart disease. DNR's were involved in the mortality rates. Ages 85 and older had a higher risk of death from hip fractures. Older age groups are at greater risk (74% increase) of death for head injuries due to accidental falls. Dr. Cook stated there has been supportive surgical data to prove time frames matter and the sooner the fracture is repaired the better the patient does. Yukiko found that mortality rates were 40% higher with transfers. With that, when head injury patients are transferred to a Level I or II Trauma Center, the choice of treatment is affected and it can save lives. On the contrary, transferring hip fractures can have a negative outcome. Dr. Taillac said the transfer and care of head injury patient outcomes can be due to receiving neurosurgical care and that with hip fractures, the outcome could be due to the delay in care. Dr. Cook followed up with how the data outcomes reflect the overall patient care and are good indicators of Performance Improvement. The handout went over protective effect factors in comparison to risk factors. Gender, ISS, Comorbidity, and Transfer Status were among the factors. Dr. Cook would like to see outcomes of patients who are not transferred into Level I or II hospitals; transfer vs. non-transfer, also time to OR from the time of the hip fracture to see if there is a significant difference. Dr. Taillac stated the statistics attribute to location- urban versus rural and why the patient was or was not transferred to a Level II. Most Level II's receive hip fractures. Dr. Cook pointed out that these patients who have accidental	**Yukiko will gather the necessary data the committee is requesting and bring it back to the committee at the next meeting.**

	falls are generally going to be patients that are already sick to begin with. Additional possible contributing factors to explain the gender mortality offset outcomes with head injuries verses hip fractures could be dementia (due to atrophy of the brain) in support of male outcomes. Women are more likely to have a lesser bone density and could in turn cause the greater female ratio of hip fractures. Dr. Hilary Hewes mentioned if the males suffering from dementia are in care centers then the time to contact care and transfer could be an additional contributing factor. The Committee expressed gratitude for Yukiko's research and extraordinary work. Dr. Taillac suggested reviewing Washington's guidelines to establish our own. Dr. Cook agreed that geriatric guidelines are needed. The data is imperative as support and worth looking at to be pushed out based on our data received.	
Stop The Bleed Collaboration	Kristen Gurn with Intermountain Medical Center and Zach Robinson with University of Utah Hospital, Steering Committee of COT, introduced Stop The Bleed. Kristen acknowledged other steering committee members also working on this collaboration: Dr. Stephens, Dr. Morris, Dr. Calona, Dr. Fenton, and Chris Hansen who is from Primary Children's Hospital. Stop The Bleed is a hemorrhage control course-like training primarily aimed for lay providers. It covers packing a wound, applying tourniquets and other initial life-saving steps. ACS is endorsing and sponsoring Stop The Bleed. Anyone can be certified and instructors include: EMS, Nurses, MP's, PA's, and Physicians. The goal is to educate as many people as possible. Kristen introduced the kit to be rolled out to the state by funding received from legislature. The kits were created as an educational training to be distributed to participating centers. The kits are $60.00 each and are available on the ACS website. Kits have been made available to every center in the state, however, since kits are limited Kristen and Zach are focusing on providing the education to make the situation more of a Train The Trainer. Stop The Bleed was presented to The Trauma Program Manager Meeting with 90% of the managers trained and kits distributed. Each lead trauma center in the region will be over the central region. Zach Robinson noted the collaboration between trauma centers for this roll out has been incredible. EMS providers will be receiving Stop The Bleed information as they are interested. Zach encouraged the TSAC members to push information out to their facilities. Dr. Taillac stated West Valley Fire has received the training	

	and they are certified to teach Stop The Bleed in their community. Dr. Peter Taillac encouraged agencies to do the same. Zach Robinson strongly encouraged working together to get the information distributed quickly. Several ideas were discussed to assist with collaboration such as regions having access to a kit through their EMSC Coordinator to help disseminate to other agencies or hospitals partnering with EMS agencies to hold trainings. Data is being tracked through the ACS website. Work and partnership in Utah is being recognized on a National level. With data, they have some sort of way to monitor which areas have been taught. Dr. Taillac asked if the hospitals have looked into training the high schools. Kristen's response was the medical staff is currently being trained at IMC and then the instructors will be able to go out to high schools, churches and community. Zach states this is what the regions need to discuss. The Steering Committee holds quarterly meetings with Trauma Center leads to be able to extract that data. There was also discussion of tracking tourniquet usage in the data registry, as well as stabbings, shootings, loss of limb, and excessive blood loss to support Stop The Bleed collaboration. There is currently data in NEMSIS on tourniquet use. Dr. Cook applauded the steering committee for their hard work. He also expressed the concern of inappropriate use of tourniquets and how with more use of tourniquets there will be more errors when using them. Stop The Bleed education holds valuable information of packing a bleeding wound and how to appropriately use a tourniquet. The Trauma System Advisory Committee may need to make a motion of support for Stop The Bleed in the future due to the legislature process. Dr. Peter Taillac asked to be informed on any agencies resisting the Stop the Bleed training. Dr. Cook recommended Don VanBoerum as the point of contact for delivering information from the COT to the Trauma System Advisory Committee and vice versa. Jolene Whitney concluded from the State perspective; TSAC is looking forward to collaborating and working with Stop The Bleed's Steering Committee. The Trauma System Advisory Committee can make a recommendation that Stop The Bleed should be funded and is highly recommended for adoption by the legislature. Dr. Cook asked Bob Jex to write up a statement of support and send to the Trauma System Advisory Committee members over email for a vote of approval. Support from UHA was favorably	

	recommended.	
Recognition of Retiring Committee Members	Jolene Whitney recognized retiring members Dr. Craig Cook as Chair of the Trauma System Advisory Committee and Dr. Jason Larson having served as Vice Chair of TSAC and both individuals fulfilling two terms. Jolene and the Committee expressed gratitude for their dedication.	
Elections	Dr. Craig Cook nominated Don VanBoerum, MD for the position of the Committee Chair and Janet Cortez, RN as the Vice Chair. The Committee members supported the nominations. Janet Cortez, RN agreed to accept the position of Vice Chair. Dr. Don VanBoerum was absent and will be given the opportunity to accept or refuse the position.	**Mark Dalley made the motion for Dr. Don VanBoerum to take the position of Chair of the Trauma System Advisory Committee and Janet Cortez, RN as the Vice Chair. Hilary Hewes, MD seconded the motion. No members opposed, none abstained; motion carried.**
Next Meeting	The next meeting will be held September 11, 2017. The remainder 2017 calendar meetings: September 11, 2017 December 11, 2017	
End of Meeting	Meeting Adjourned.	