Trauma System Advisory Committee
3760 South Highland Drive Salt Lake City, UT 84106
5th Floor Board Room
Meeting Minutes
Monday, January 4, 2016

Committee Members:	Craig Cook MD, Don VanBoerum, MD, Holly Burke, RN, Janet Cortez, RN, Jason Larson, MD, Mark Dalley, Rod McKinlay, MD, Grant Barraclough, Karen Glauser, RN, Steven Anderson, Chris Drucker, Clay Mann
Excused:	Hilary Hewes, Matt Birch and Mark Thompson
Guests:	Clay Manning
Staff:	Shari Hunsaker, Peter Taillac MD, Bob Jex, Jolene Whitney, Suzanne Barton, Brittany Huff
Presiding:	Craig Cook, MD

Agenda Topic	Discussion	Action
	Welcome	
Welcome	Craig welcomed the TSAC Committee members to the meeting and acknowledged guests present. Craig welcomed new committee member Christopher Drucker.	
	Action Items:	
Approval of Minutes	The September 21, 2015Trauma System Advisory Committee meeting minutes were reviewed and approved by the Committee.	**Jason Larsen, MD motioned to approve the September 21, 2015 meeting minutes. Mark Dalley seconded the motion. All present members voted in favor of the motion. No one opposed; none abstained. Motion carried.**
	Informational Items:	
Open Meetings Statute Training	Brittany Huff, Assistant Attorney General, gave a presentation on the Open Public Meetings Act. This year there are very few changes made during the 2015 Legislative Session. This training is required to be given yearly by statute. The changes that were made this year are: • Public body now includes an inner local entity or a joint or profited undertaking. • Changed the wording to include school community council or charter trust land council. • Notice of public meetings has to be given to the newspapers. DTS has created a website that the media logs on to the website and can view the meeting notices that have been placed there by the State. If there is a small public body that doesn't have the resources to log on to the website, they can contact archive and records and get the information. Summary of Open Public Meetings Act – The whole point of the Open Public Meetings Act is so committees don't deliberate in secret. It allows the public to come if they are interested and listen to the arguments and hear what other people are thinking about specific topics, track it and be involved. This applies to committee bodies that are created by statute and TSAC Committee meets the requirements of a public body.	

	A quorum or simple majority has to be together in order to discuss or act on a matter. If an emergency meeting is going to be held, there must be a notice published within 24 hours. In the agenda and the minutes it has to be stated why it was an emergency meeting. An electronic meeting is if someone calls in to the meeting. An electronic meeting can only be held if there is a rule and DOH has a default rule. Closed meetings are allowed but you have to ask Brittany. These types of meetings are only for very specific purposes. They are allowed to discuss an individual's character, professional confidence, physical or mental health. You don't want to discuss these types of things in an open meeting. Strategy sessions for collective bargaining, litigation or lease of property, security systems and investigative proceedings are some other items that could be discussed in a closed meeting. You cannot do the following things in a closed meeting: • interview someone • discuss mid-term vacancy • discuss the character of someone who may be filling the mid-term vacancy • approve rules, regulations or ordinances • cannot take final action on a matter Closed meetings have to be recorded. The recording of the open or closed meeting must be posted within 3 business days. Meeting minutes are the official record and must be posted on the public site within 30 days after the meeting in draft form. The approved minutes need to be posted on the public site and the UDOH public site. The recordings and minutes are available under GRAMA requests. Don't violate the act; any person can be removed if they are willfully disrupting the meeting. You can be found guilty of a Class B Misdemeanor.	
Data Systems Update/ Data Release Process – Shari Hunsaker	The draft of the BEMSP data release procedures is going under review. We are proposing at this time is that a data request form would be submitted by the chief medical director for that specific region. We would verify that the data would be used for the purpose it was collected for by the Bureau. We would execute a data sharing agreement and every member of the regional PI committee would have to sign confidentiality agreements agreeing they would protect the data and not discuss the data with other regional entities. We also proposed that if you are requesting information that is hospital specific that we have a data release form from every hospitals in your region before we would give you access to hospital level data. Some hospitals may have issues if their data is released	

	without their knowledge no matter how well the intention is. This is a critical piece that we have in place and there are ways we can release hospital identifiable data and still maintain our statutory requirement to protect the data that we collect. Patient level data would not be released by the Bureau for PI unless it was approved by the IRB. Shari is the data steward and would delegate the approved data requests to the appropriate Bureau staff for data retrieval and the records officer for agency records. The retrieved data comes back to Shari and she compiles the data and sends it to the requester and considers the data release completed and she documents the data release. There is a public fee schedule and a fee has to be charged for data. Peter made comments about the different types of data that might be useful for a PI project on a regional basis. For an example for patient level data, look at all the patients that had a traumatic amputation during the past year. There are two ways you could do this, you could ask Shari for the data or you could go to each hospital in your region by asking the hospitals to give that information to be analyzed for regional PI. You could have audit filters that would have to be approved by each hospital in the region. This way the hospitals would be volunteering their information to be part of that group. Data sharing agreements need to be in place. If there was an agreement in place before-hand it would be helpful. With each hospital they would have gone through the authorization process to bring this to the regional PI. We really want to support he regional PI efforts. Janet made comments about how cumbersome that process would be. Clay made comments in regards to having a data request form for each request. Shari commented that they need a new data request for each submission. Janet made comments on the data. Hard to identify what data is needed. Shari made comments in regards to having a meeting to see who would participate in data sharing. Craig made comments about the frustration and the data not being available and being lost. Shari is a good data steward and is protecting your data from unintentional or unwanted disclosure. Shari cannot do audit filters for single hospitals, only regional for all the hospitals in your region. We need to cooperate as a region and share data whether it's good or	

	bad data. Peter made comments about making this happen and also protect the data. Participating with the PI process is part of the designation requirements for hospitals.	
Rule Change Discussion – Shari Hunsaker	The changes are the new text that is underlined and the old text is struck out on the handout. This allows us to update administrative ICD-10 Codes. Under the council from Brittany, we no longer have to include all of the data elements. We can refer to something posted on our website and as long as we keep that document updated then there is no need to waste four pages. On page 4 of the rule Shari added item (c) The Department adopts by reference the National Trauma Data Standard Data Dictionary for 2016 Admissions published by the American College of Surgeons and the Utah Trauma Registry State Required Elements for 2016 published by the Department. The summary of the changes are the following: • Replace references from ICD-9 to ICD-10. • Removal of list of required data elements; replaced by R426-7(1) (c). • No longer require referring hospital information except hospital transfer indicator and the hospital name. • Replace full Utah Trauma Data Dictionary with addendum that includes only additional elements not included in the NTDS The National Trauma Data Standard does not define the hospital admission. That is left to each state. What the NTDS says is that the patient was admitted following your state trauma registry criteria. We need to define what a hospital admission is because we have a multitude of hospitals that are defining it differently. Do you include a patient that is in observation for 36 hours, do you include a patient that you have a formal admit order on? Jolene did a survey for all the trauma program managers in the country that participate in the NASEMSO and Ohio responded back and shared their inclusion criteria with her. They stated that they include all admissions which was a big change from their previous 48 hour stay rule. Admits are indicated by a physician's order for admission. By using these criteria they get away with problems with ED boarding and ED to OR pack you to home cases. We certainly could adopt this recommendation where admits are by a physician's order which meets the inclusion criteria for the trauma registry. A spreadsheet in the packet was discussed. Shari took the NTDB and Utah and any other state that requested information and examined each of those states and did comparisons for trauma registry inclusion criteria elements. On the spreadsheet if there was an element of their data dictionary that said it had to be a traumatic	

	injury they got an X in that column. If there was an element that includes diagnostic codes they would get an X. The only state that mirrors the NTDB is California. Every other state that responded had subtle differences. Almost every state surveyed indicated if the patient died, that met their inclusion criteria. Craig asked if we need to make a recommendation if we are to make a change to the inclusion criteria. Shari commented that TSAC needs to make a recommendation on how we would change the administrative rule and if we are going to change the inclusion criteria in any way other than what the draft currently is it would be to define what the admission to the hospital was and was it a doctor's order or ED admission. The other one is they were transported to the hospital via air ambulance at any point in time and then transported via ground ambulance. It was proposed by the trauma program manager's quorum to remove that requirement if they were transferred via air ambulance so that it would meet the inclusion criteria. Shari said the trauma managers requested that we define hospital admissions so that every hospital is using the same criteria and that we remove the air ambulance transfer at any point. They want the hospitals to mirror the NTDB. We will stick to the administrative draft and then take the time to analyze the volume increases and make changes to the definition for hospital admission effective January 1, 2017. We can discuss the impact of this at the next meeting. Clay will do the data analysis and will look at AIS, type of injury, diagnosis scores, severity score, age, percentage of patients and total volume. He will email the information to Shari.	**Jason Larson proposed that we accept the rule change as presented with an additional request that we apply the proposed admission criteria to existing data to measure the impact on volumes. Motion seconded by Don VanBoerum. All voted in favor of the recommendation. No one opposed; none abstained. Motion carried.**
ACSIII and IV Criteria Challenges – Bob Jex	We found that the application of the ACS criteria at level 3 facilities was dramatic. It has differentiated level 3's and level 4's more dramatically than what it was in the past. Level 3's look more like level 2's with some of the requirements for definitive care. Level 4's criteria has been reduced quite a bit to include what we originally had at a level 5. Bob has shared this analysis with all the level 3 and level 4 facilities so they know that coming in to their new surveys, particularly the level 3's, that the bar is being raised substantially. We had one level 3 designation visit in the last year and with the new criteria they probably would not have passed. The new criteria is a good thing because you have some level 3 facilities that have substantial volumes and substantial resources in their facilities. Originally the main difference between a level 3 and a level 4 was the 24-7 coverage. The new criteria has increased the monitoring of PI activities substantially as well as the requirements for a trauma surgeon and handling the response times and the requirements for	

	liaisons.	
Development of Trauma Regions Discussion – Bob Jex	We have had quite a lot of discussions on regional performance improvement regions and regionalization guidelines. The handout shows a summary of that as well as an updated regional map. Our original discussion centered around seven regions utilizing EMS and Preparedness regions. Clay was instrumental in giving him documentation on referral patterns for level 1 and level 2 facilities in regions, and based on that we structured the regional map from seven down to four. The fifth region is the Southeastern region that all goes to Colorado. Shari commented that there are three hospitals and EMS agencies in that region that could participate in regional PI. The difference structurally for us is they would conduct regional PI in conjunction with the hospital. The total transfers from all three of those facilities in to level 1 and level 2 facilities in Utah is less than 25. One hospital had over 30 trauma referrals in to Grand Junction. We will proceed with this. The regionalization guidelines will provide a good start to accomplish the core purposes which include: • Working with local health departments to education, injury prevention and coordination with COT review of patient care under state guidelines. • EMS participation in regional trauma councils is a central to the inclusionary philosophy of regional trauma councils. Patient care review and discussion should also include EMS providers in the region. • Regional Performance Improvement should be consistent with the Regional Trauma Performance Improvement Algorithm. Comments made by Craig about a discussion with Mark Dalley about combining the five hospitals and adding in Castleview as the sixth region. The key with adding all those smaller hospitals below the prior Utah/Wasatch region comes down to surgical direction and what we may do is have two separate groups representing urban and rural with surgical leadership. Bob commented that the hospitals that have the surgical direction are Price, Sevier and Sanpete.	
Status on Free Standing ED Role	Agenda item tabled until next meeting because of time constraints.	**Agenda item tabled**
Status on Designations	Agenda item tabled until next meeting because of time constraints.	**Agenda item tabled**
Status on Needs Criteria for Trauma Centers	Agenda item tabled until next meeting because of time constraints.	**Agenda item tabled**
Next Meeting	March 14, 2016	
2016 Meeting Schedule	March 14, 2016, June 13, 2016, September 12, 2016, December 12, 2016	
End of Meeting		**Meeting Adjourned**