

Trauma System Advisory Committee
3760 South Highland Drive Salt Lake City, UT 84106
5th Floor Board Room
Meeting Minutes
Monday, March 23, 2015

Committee Members:	Craig Cook, MD, Holly Burke, RN, Janet Cortez, RN, Mark Dalley, Hilary Hewes, MD, Jason Larson, MD, Matt Birch, Rod McKinley, MD, Grant Barraclough, Mark Thompson, Clay Mann, PhD (Ex Officio), Karen Glauser, RN (called in on conference line)
Excused:	Don VanBoerum, MD
Guests:	Kris Hansen, Lyndia Peters, Darlene Erich, Cheyenne Brown, Shawn Nalder, Kristen Gooch
Staff:	Jolene Whitney, Suzanne Barton, Mathew Christensen, Brittany Huff, Bob Jex (called in on conference line), Peter Taillac, MD (called in on conference line)
Presiding:	Craig Cook

Agenda Topic	Discussion	Action
	<u>Welcome</u>	
Welcome and Introduction of Members	Craig Cook welcomed the committee to the meeting and acknowledged new members Matt Birch and Dr. Rod McKinley. Introductions of committee members around the room.	
	<u>Action Items:</u>	
Approval of December 15, 2014 Meeting Minutes	The December 15, 2014 Trauma System Advisory Committee meeting minutes were reviewed and approved by the Committee.	Jason Larson, MD, motioned to approve the December 15, 2015 meeting minutes. Grant Barraclough seconded the motion. All present members voted in favor of the motion. No one opposed; none abstained. Motion carried.
	<u>Informational Items:</u>	
Rule Change R426-9 – Trauma Center Needs Criteria	<p>Jolene Whitney reminded the committee that we have talked about this topic for a long time for a number of years. We had the White Paper on trauma center development that was done in 2012. We have been looking at the designation of trauma centers and if all hospitals should be designated and at what levels and what the impact would be at designating all hospitals. Recently the American College of Surgeons came out with a statement with regards to trauma center designation based on systems need and they are recommending that it is the State’s responsibility to have a clear, strong mandate and statutory authority that is backed up by a transparent and fair process with regard to designation. It’s a state’s responsibility to control the allocation of trauma centers and designation based upon regional population needs. The ACS Committee on Trauma supports the following guidelines:</p> <ul style="list-style-type: none"> • Designation of trauma centers is the responsibility of the governmental lead agency 	Holly Burke, RN, made the motion to approve the stated amendments to Rule R426-9. Mark Thompson seconded the motion. All present members voted in favor of the motion. No one opposed; none abstained. Motion carried.

- The lead agency should be guided by local needs of the region for which it provides.
- Trauma center designation should be guided based on the population being served.
- Trauma centers should be assessed by the following measures:
 - a. Number of level I and Level II centers per 1,000,000 population
 - b. Percentage of population within 60 minutes of a level I and level II center.
 - c. EMS transport times
 - d. Percentage of severely injured patients
 - e. Trauma related mortality
 - f. Inter-hospital transfers
 - g. Percentage of time trauma hospitals are on diversion status
- Allocation of trauma centers should be reassessed on a regular schedule based on an updated assessment of trauma system needs.

Bob stated that when we developed the proposed rule changes, we did it based on the criteria that Jolene just laid out, as well as some input from other areas. The first change to rule R426-9-1 is the addition of (d); a mandate for the department to reassess on an annual basis the need for additional trauma centers based upon trauma system needs as outlined in R426-9-6-4(a) through (i). The next change is to R426-9-3 trauma center categorization guidelines; the criteria for level IV and level V based on the American College of Surgeons document dated 2014, we are doing away with level V designation.

Jolene commented that in regard to the authority and purpose, it appears clear in the statute that the department has been mandate to establish and provide over-site for an inclusive state trauma system and to assess the needs, goals and objectives. The state also has the authority to deny, approve, suspend, and revoke, according to the regulatory standards.

R426-9-4 outlines the process the state will be responsible for in assessing the state trauma system and the need for Level I or II trauma centers. We are also adding the word ‘process’ and adding ‘conduct a quality review site visit’ to (1).

We have added (3) to R426-9-4 which states “the Department shall convene a work group to review and evaluate the findings of the trauma review process outlined above. The work group shall consist of 1 trauma medical director, 1 trauma program manager, 1 administrator of a designated trauma center, 1 EMS provider and 1 EMS medical director. Upon review of the evaluation in R426-9-4, the work group shall advise the Department on the designation or re-designation of trauma

centers based upon compliance with criteria outlined in R426-9-3 and R426-9-6 and need based upon the following:

- (a) Current diversion status defined in R426-9-6-b-iii
- (b) Admission data defined in R426-9-6-2-b-ii
- (c) EMS transport times
- (d) Trauma related mortality
- (e) Frequency and nature of inter-hospital transfers
- (f) Projected impact on the existing trauma system. The additional trauma center may not reduce volumes below ACS standards and volumes outlined in R426-9-6-b-ii
- (g) Ratio of total trauma admissions per 100,000 population in a geographic region based upon zip codes
- (h) The number of Level I or II trauma centers within 25 mile radius. New Level I or II designation may not reduce the ability of current Level I or II trauma centers to support continued competence of the trauma staff and the training mission of the trauma center
- (i) Other guidelines determined by the department such as access, volume/outcome, staffing, healthcare finance or other measures suggested by the ACS.

Janet Cortez asked how the work group would meet; an actual meeting or a conference call? Bob said they would prefer that the workgroup meet face to face because they would be looking at identifiable data that they would be considering and this information cannot be sent via email or discussed in a conference call. Bob stated that this language will be added that the meeting will be convened in person to R426-9-4 (3).

Janet Cortez asked how long the terms would be for the work group. Jolene commented that the workgroup would consist of seven members and the Department (Bob and Jolene) will make the final decision.

R426-9-6 for the Trauma Center designation process we have under (2):

- (a) Hospitals not previously designated as a Level I trauma center will be considered for designation if the following criteria are met.
 - (i) be currently designated as a Level II trauma center
 - (ii) submit to a consultative review by the American College of Surgeons.
 - (iii) be verified as a Level I trauma center by the American College of Surgeons Committee on Trauma with no deficiencies and no focused visit required.
- (b) Hospitals not previously designated as a Level II trauma center will be considered for designation if the following criteria are met:
 - (i) be currently designated as a Level III trauma center
 - (ii) have at least 300 inpatient trauma admissions

	<p>annually of which 100 patients annually must have an ISS greater than 15 for the full designation cycle prior to Level II application.</p> <p>(iii) all other Level I or Level II trauma centers within a 25 mile radius must be on trauma diversion at least 5% of the time for one year.</p> <p>(iv) all other Level I and Level II trauma centers within a 25 mile radius must continue meeting minimum admission criteria defined in R426-9-6-2 or ACS criteria for Level I verification.</p> <p>(v) be verified as a Level II trauma center by the American College of Surgeons with no deficiencies and no focused visit required.”</p> <p>Trauma centers shall be designated for a minimum of three years unless the designation is rescinded for non-compliance. There was discussion in regards to trauma diversion of 5%. Bob commented that they are succeeding the 5% and they definitely can look at lowering the number to 2% or 3% that could be more reasonable. Craig Cook stated that even though the ACS level is 5% he recommended that the number be changed to 1%.</p> <p>Changes to R426-9 per the TSAC Committee will be the following:</p> <ul style="list-style-type: none"> • Authority change – reassess on an annual basis • Add in person for the meetings • Workgroup be changed from 5 to 7 to include 2 trauma surgeons, 2 trauma program managers, 2 trauma facility medical directors and 1 EMS medical directors • Change trauma diversion from 5% to 1% • Add system evaluation by workgroup 	
TC Designation Update	Bob Jex commented that we have a designation survey at Jordan Valley in January and 2 deficiencies were found and we gave them some directions and recommendations on correcting those deficiencies and within the next 6 months we will do a full review and those will be resolved. Heber Valley has a Level V visit. There will be no more Level V designations after July 1, 2015. All Level V’s will be grandfathered to Level IV’s.	
Future Training (registry and TOPIC)	There will be future training on registry and TOPIC. The Bureau is working on the TOPIC Course with the Western Pediatric Conference at Deer Valley in July.	
Status of the Trauma Report	The annual report is still in review and will be coming up shortly.	
2015 Meeting Schedule	<ul style="list-style-type: none"> • September 14 • December 14 	
End of Meeting	Next meeting is scheduled for Monday, June 15, 2015 from 1:00-3:00 p.m. at the Highland Building, 5 th Floor Boardroom.	Meeting Adjourned