Approved: January 28, 1999
Date

MINUTES OF THE HOUSE COMMITTEE ON HEALTH AND HUMAN SERVICES.

The meeting was called to order by Chairperson Garry Boston at 1:30 p.m. on January 27 in Room 423-S of the Capitol.

All members were present except: Representative Phyllis Gilmore, Excused
Representative Brenda Landwehr, Excused

Committee staff present: Kathy Sparks, Kansas Legislative Research
Renae Jefferies, Revisor of Statutes
June Evans, Secretary

Conferees appearing before the committee: Dennis Allin, M.D., University of Kansas

Others attending: See Attached List

The Chairperson stated the agenda for the week of February 1 was E-mailed today and after February 4 there will only be 9 working days left before turn around. Need to have bills introduced in order to have hearings.

Dr. Dennis Allin, M.D., Chairman, Emergency Medicine, University of Kansas, gave a briefing of the Kansas Trauma System. This process has been on-going since 1994. The Task Force made the following resolutions: (1) Emergency medical care services in Kansas are now fragmented with no central oversight. The efficient and cost effective delivery of care for persons with medical emergencies and victims of trauma would be greatly improved with central coordination. (2) That the Kansas Medical Society develop a task force to study the problem of emergency medical care in Kansas and develop a model for centralized coordination.

Trauma is the leading cause of death in people 1-44 years of age. Previous studies show 30-80% of deaths are preventable in areas with no trauma system. 50,000 a year die on the highway, 70% on rural highways. Need to assist states in developing integrated plans of trauma and emergency care. 80% of traumatized can be taken care of at the local system.

It was determined that a Kansas trauma system board be established.

Level I hospitals have patients to surgery within 10 minutes, II with 20 minutes, III in a timely manner, IV can call physician, V on call physician and VI has no physician available. There are 135 hospitals in the state and one-half are Level IV, V or VI, 35% are level III, 15% level II. There are 3 Level I hospitals in the state. (See Attachment #1 & 2).

The Chairperson asked for bill introductions.

Representative Swenson moved and Representative Morrison seconded a bill introduction requested by the Board of Nursing regarding qualifications of applicants - have graduated from an approved school. The motion carried.

Representative Long moved and Representative Wells seconded a bill introduction requested by the Board of Nursing relating to advanced registered nurse practitioners and mid-level practitioner. The motion carried.

Representative Bethell moved and Representative Swenson seconded a bill introduction to allow non-certified personnel who have been properly instructed to assist residents of long term care facilities with nutrition, hydration and other limited activities of daily living. The motion carried.

Representative Bethell moved and Representative Lightner seconded to clarify a portion of the

background check that deals with allowing convicted felons to volunteer at a long term care facility while the same individual is prohibited from being employed by the facility. The motion carried.

Representative Showalter moved and Representative Storm seconded to introduce the following three bills: (1) Interim payment system under medicare, (2) Interdisciplinary council on seizures and (3) anatomical gifts organ procurement. The motion carried.

The meeting adjourned at 2:30 p.m. and the next meeting will be January 28.

HUMAN AND HEALTH SERVICES

DATE January 27, 1999

NAME	REPRESENTING
Carolyn Middendorf	KSNA
TOM SIPE	KHA
Dick Morrissey	KDHE
Dennis Allin MD	Kansas Trauma Plan
Michelle Peterson	Peterson Public Affairs Group
Derek A. Blaylock	Intern for Teresa Sittenauer
KEITH R LANDIS	CHRISTIAN SCIENCE COMMITTEE ON PUBLICATION FOR KANSAS
Rich Guthrie	Health Midwest
Rebecca Rice	KAHA & KCA
J. Koehn	KAOM
Jennie Folkerts	KSNA
Meg Draper	KMC

Kansas Trauma System Overview

Dennis Allin M.D.
University of Kansas

1994 KMS Resolution

- Emergency medical care services in Kansas are now fragmented with no central oversight
- The efficient and cost effective delivery of care for persons with medical emergencies and victims of trauma would be greatly improved with central coordination

1994 KMS Resolution

That the Kansas Medical Society develop a task force to study the problem of emergency medical care in Kansas and develop a model for centralized coordination

Human & Health Svcs
1-27-99
Atch #1

Scope of Problem

- Trauma the leading cause of death 1-44 yrs old
- Previous studies show 30-80% of deaths preventable in areas with no trauma system

NHTSA Review 1994

- Technical Assistance Team
- 50,000 a year die on the highway
- 70% rural highways
- Assist states in developing integrated plans of trauma and emergency care

NHTSA Review

- Legislate a lead agency with authority to address all aspects of EMS and trauma care
- Develop state EMS plan
- Complete 911 system
- Assure ATLS for rural physicians
- Designate and verify trauma centers

NHTSA Review

- Develop triage and transfer protocols
- Develop public information, education, and prevention program
- Develop statewide trauma plan

Who were we?

- Kansas Hospital Association
- American College of Emergency Phys.
- American College of Surgeons
- American Academy of Family Phys
- Kansas Assoc.. of EMS Administrators
- Kansas Society of Internal Medicine

Who were we?

- Kansas Emergency Nursing Assoc..
- Kansas EMT Association
- Kansas Association of Paramedics
- American Academy of Pediatrics
- Kansas Association of Counties
- Kansas Department of Transportation

Who were we?

- Kansas Nursing Association
- Kansas Board of EMS
- Kansas Department of Health and Environment

What did we do?

- Consulted national experts
- Collected all available data
- Performed 50 community visits
- met every other month for 3 years

What is a trauma system?

- Exclusive-old way of thinking
  - recognize limited number of "trauma centers"
  - designed to care for "trauma patient"
  - distribute regionally
  - rapid transport and bypass of facilities
  - prestige, politics, finance ruled the day

Exclusive System

- Highly regulated
- very few ever achieved
- Didn't fit reality of distribution
- Most patients do not require such specialized care

Inclusive System

- 1990 model trauma care system
- Needs to address
  - medical direction
  - prevention
  - communication
  - triage
  - Prehospital
  - transportation

Inclusive System

- Needs to address
  - Hospital care
  - Rehabilitation
  - Public Education
  - Medical evaluation
- Recognizes that 80%of patients can be treated locally

Lead Agency Role

- Integrate trauma into EMS
- Standardize care of trauma patient
- Collect data for evaluation of system
- Secure funding
- Help plan orderly movement of patients to appropriate trauma facilities

What we came up with

- Administration
  - Lead agency
    - administrate system
    - leadership in planning
    - develop regional infrastructure
    - Maintenance of registry
    - QI of system
    - develop infrastructure needed to carry out SEMAC & REMAC recommendations

Administration

- State oversight committee
  - liaison between lead agency and regions
- REMAC
  - 6 regions
  - direct trauma care in their region

Public information and Prevention

- Collaboration with current activities
- REMAC directed
- Based on registry data

Pre-hospital

- medical direction
- treatment protocols
- transport protocols
- dispatch
- use of CMR
- communication

Hospital Care

Levels of care

Level 1

- directed by Board Certified surgeon with trauma training
- In-house OR, ER physician, Surgeon, Anesthesia, Radiology, CT
- most specialties available on call
- Emergency Physician director of ER
- ICU directed by surgeon certified in critical care

Level 1

- establish outreach training
- research
- full-time nurse coordinator
- multi-disciplinary QI

Level 2

- trauma surgeon on-call
- no research requirement
- ER director need not be Board Certified in Emergency Medicine
- hand and microvascular surgery coverage not required

Level 3

- capacity for initial resuscitation and operative intervention
- surgeon residency trained
- EM in house 24 hours
- OR on-call

Level 4

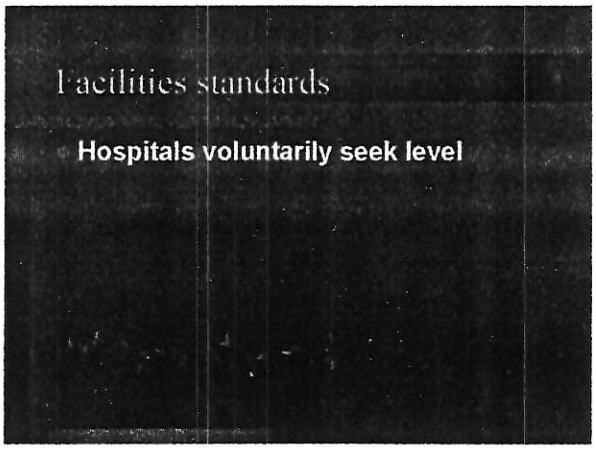
- commitment to resuscitate
- no in-house physician
- surgeon may not be available
- CRNA covers anesthesia

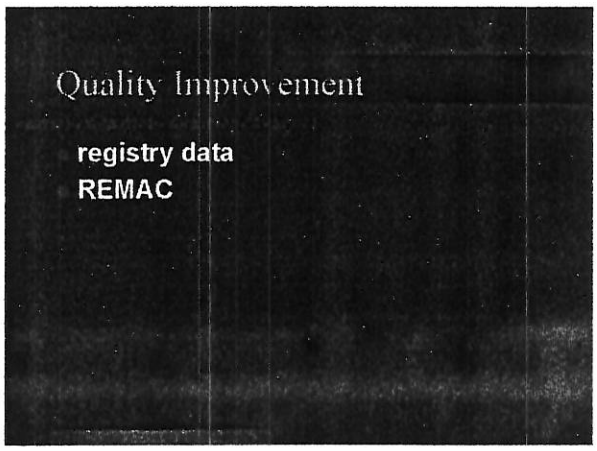
Level 5

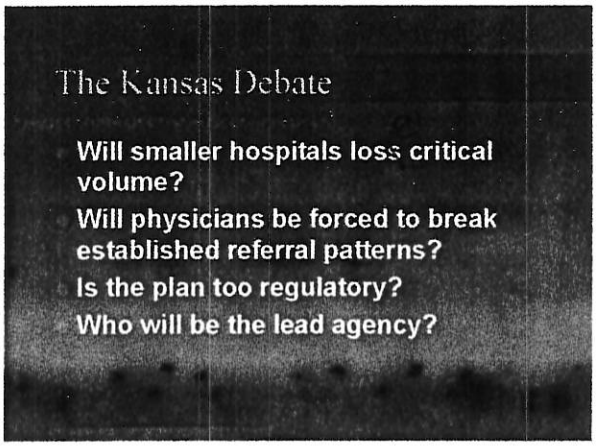
- stabilization and transport
- no emergency surgery
- on-call physicians
- no available surgeon

Level 6

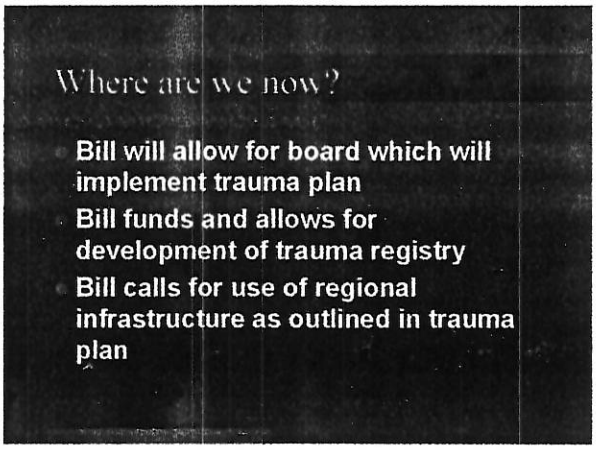
- no available physicians
- PA or NP staffed ED


Facilities standards
Hospitals voluntarily seek level


Quality Improvement
registry data
REMAC


The Kansas Debate
Will smaller hospitals loss critical volume?
Will physicians be forced to break established referral patterns?
Is the plan too regulatory?
Who will be the lead agency?

lose


Where are we now?
Bill will allow for board which will implement trauma plan
Bill funds and allows for development of trauma registry
Bill calls for use of regional infrastructure as outlined in trauma plan

KANSAS EMS/TRAUMA SYSTEM PLAN

"Working together to save lives"

FOR MORE INFORMATION CONTACT:

Kansas EMS/Trauma Planning Project
Landon State Office Building
900 SW Jackson, Room 665
Topeka, Kansas 66612
Phone (785) 296-1200 Fax (785) 296-1231

The Kansas EMS/Trauma Systems Plan was developed through the Kansas EMS/Trauma Planning Project. Funding for this Project was provided by the Kansas Health Foundation, Wichita, Kansas. The Kansas Health Foundation is a philanthropic organization whose mission is to improve the quality of health in Kansas.

SUMMARY OF PROPOSED TRAUMA FACILITY LEVELS

Level I Trauma Center

- Full service teaching institution with residency training programs
- In-house coverage of the Emergency Department, Trauma Team, general surgery, and anesthesia
- Availability, based on predetermined criteria for call and response time, of neurosurgery and critical care with all support services
- Operating Suites staffed and available 24 hours a day
- Productive research programs
- Frequently maintain speciality care (i.e. burn and replantation)

Level I Trauma Center with Pediatric Commitment

- Meet all Level I Standards
- Designated, identifiable ED area staffed/equipped to respond to children
- Separate PICU
- Availability of specialists with experience in and commitment to pediatric trauma care

Level II Trauma Center

- Full service acute care facility
- In-house coverage of the Emergency Department
- Availability, based on predetermined criteria for call and response time, of a Trauma Team, general surgery, anesthesia, neurosurgery and critical care with all support services
- Operating Suites available with on-call staff 24 hours a day

Level III Trauma Center

- Community Hospital with full service Emergency Department including in-house coverage of the Emergency Department by an ATLS-certified physician
- Availability, based on predetermined criteria for call and response time, of a Trauma Team, general surgery, anesthesia, and critical care with all support services
- Operating Suites available with on-call staff 24 hours a day
- Many surgical subspecialties with the exception of neurosurgery

Level IV Trauma Center

- Community Hospital with an ATLS-certified physician on-call from outside the hospital with a system for early notification of the on-call physician to assure timely emergency response based on local criteria
- Surgeon available in the community the majority of the time with arrangements to divert patients during the surgeon's absence
- Commitment to the resuscitation, stabilization and transport of trauma patients as appropriate

Level V Trauma Center

- ATLS-certified physician on call from outside the hospital with a system for early notification of the on-call physician to assure timely emergency response based on local criteria
- Designated physician Medical Director
- Commitment to the resuscitation, stabilization and transport of trauma patients as appropriate

Level VI Trauma Center

- Emergency Department covered by an on-call qualified mid-level practitioner dedicated to the facility with a system for early notification of the on-call practitioner to assure timely emergency response based on local criteria
- Designated physician Medical Director
- Commitment to the resuscitation, stabilization and transport of trauma patients as appropriate

All trauma facilities participate with the following:

- Data collection/ trauma registry
- Maintain a trauma nurse coordinator function commensurate with volume
- Participate in local, regional and statewide quality assurance activities
- Assist with professional education
- Participate in public education and prevention programs

STRUCTURE OF THE KANSAS EMS/TRAUMA SYSTEM

- **Administration of the system**
  - ▶ The EMS/Trauma Lead Agency will offer leadership and coordination of the EMS/Trauma System, provide technical assistance for the Regional Councils, and collect and analyze trauma data to produce information for quality improvement activities and prevention programs.
  - ▶ Six Regions have been proposed to offer a structure that allows local solutions for local EMS/Trauma problems.
- **Components of the system**
  - ▶ Public Information/Education and Prevention - The plan will support state and local programs to reduce the incidence of trauma and injury.
  - ▶ Prehospital Care - The plan identifies needs for regional planning for medical direction, triage, continuing education, communication, transportation and regionally centralized dispatch.
  - ▶ Hospital Care - All hospitals are encouraged to participate at one of the Trauma Facility Levels summarized in this brochure. Each hospital will choose the level at which they participate. The proposed trauma facility levels will be used as guidelines for 2 to 5 years. The lead Agency will offer technical assistance to hospitals requesting it during this time. After that time, the Lead Agency will begin a verification process of participating hospitals.
  - ▶ Quality Improvement - Regional quality improvement activities will be supported by information from a statewide trauma registry. Regions will identify local problems and work together across disciplines to solve those problems. Regional quality improvement activities will be conducted by representatives from hospitals and ambulance services, physicians, physician extenders, nurses, and prehospital personnel with a commitment to EMS/trauma care.

ABOUT THE KANSAS EMS/TRAUMA SYSTEM

- **Will reduce incidence of trauma-related injury in Kansas through prevention activities.**
- **Will reduce trauma-related morbidity and mortality in Kansas.**
- **Will be based on a regional structure that allows local solutions to local problems.**
  - **Will offer a multidisciplinary format**
  - **Will not dictate referral patterns**
  - **Will not interrupt current networks**
  - **Will not offer centralized decisions/solutions**
- **Will have a phase-in implementation schedule with technical assistance available.**
- **Will expand training opportunities for physicians, nurses, and prehospital personnel.**
- **Will include a trauma registry to provide information related to trauma in Kansas to support decisions**
- **Will include ongoing system quality improvement activities**
- **Will support statewide communication and cooperation**

KANSAS EMS/TRAUMA SYSTEM PLAN

Problem: Preventable deaths and injuries from trauma are occurring in Kansas.

Solution: Decrease deaths from trauma and improve trauma outcomes by implementing a statewide trauma system to coordinate appropriate use of trauma care resources in Kansas. Studies have shown that the implementation of a statewide trauma system in other states has reduced deaths and improved outcomes from traumatic injury.

WHAT IS AN EMS/TRAUMA SYSTEM?

- **EMS/Trauma Systems get the right patient to the right place at the right time.**
  - Most patients are treated at their local hospital.
  - Pre-approved plan will be developed **locally** for those patients who may require transfer. Local planning includes hospitals, ambulance services, physicians, physician extenders, nurses, and prehospital personnel.
  - Regional quality improvement activities allow local solutions and improved coordination of resources.
  - **ALL** hospitals will be encouraged to participate at a level they choose.
- **EMS/Trauma Systems use a multidisciplinary approach to develop a seamless continuum of care that includes prehospital, acute care, and rehabilitation. An emphasis on prevention is included.**
- **EMS/Trauma Systems reduce trauma care costs through optimal use of resources and prevention activities to reduce the incidence of trauma-related injuries.**

DEVELOPMENT OF THE KANSAS EMS/TRAUMA SYSTEM PLAN:
KANSAS EMS/TRAUMA PLANNING PROJECT

- April 1994 - National Highway Traffic Safety Administration (NHTSA) Assessment of EMS in Kansas recommends development of a statewide EMS/Trauma system in Kansas
- November 1994 -Partnership formed among:
  - Kansas Department of Health and Environment
  - Kansas Board of Emergency Medical Services
  - Kansas Medical Society
- Spring 1995 - 17 organizations with a stake in trauma care appointed representatives to the Kansas EMS/Trauma Planning Project Policy Group to develop recommendations for an EMS/Trauma System Plan
- April 1995 to November 1997 - Proposed Kansas EMS/Trauma System Plan developed through a consensus process by Policy Group members with experience in urban and rural trauma care and policy development in Kansas
- Funding for this project was provided by the Kansas Health Foundation, Wichita, Kansas. The Kansas Health Foundation is a philanthropic organziation whose mission is to improve the quality of health in Kansas

KANSAS EMS/TRAUMA PLANNING PROJECT POLICY GROUP MEMBER LIST

Kansas Academy of Family Physicians

Alan W Adams, MD, Hays KS
John M Ryan, MD, Marysville KS

Kansas Association of Counties

William P. Bunger, Beloit KS
Ethel Evans, Ulysses KS

Kansas Association of EMS Administrators

Tom Pollan, Wichita KS
Kerry McCue, Hays KS

Kansas Association of Paramedics

Connie McAdam, Greeley KS
Dale Long, Arkansas City KS

Board of EMS

CHAIR
Dennis Allin, MD, Lenexa KS
Daniel Caliendo, MD, Andover KS

Kansas Chapter - American Academy of Pediatrics

Adam Schwarz, M.D., Kansas City, KS
Curtis B Pickert, MD, Wichita KS

Kansas Chapter - American College of Emergency Physicians

John H Jeter, MD, Hays KS
Richard Vopat, MD, Wilson KS

Kansas Chapter - American College of Surgeons

R. Stephen Smith, MD, Wichita KS
Harl G Stump, MD, Hays KS

Kansas EMT Association

Diana Lippoldt, Wichita, KS
Robert Orth, Sublette KS

Kansas Emergency Nurses Association

Jayne Cunningham, Phillipsburg, Kansas
Darlene Whitlock, Silver Lake KS

Kansas Hospital Association

John Broberg, Salina KS
VICE CHAIR
Jim Chaddic, Goodland KS

Kansas Society of Internal Medicine

Daniel N Pauls, MD, Parsons KS
Roger Peck, MD, Great Bend KS

Kansas State Nurses Association

Gwen Philbrook, Salina KS
Gloria R Solis, Wichita, Kansas

KUMC

Ed Childs, MD, Kansas City KS
Lynelle Pierce, Kansas City KS

PROJECT MANAGEMENT COMMITTEE

Richard Morrissey, Director
Kansas Department of Health & Environment
Local & Rural Health Systems

Meg Draper
Kansas Medical Society

Robert McDaneld
Kansas Board of EMS

Melissa Hungerford
Kansas Hospital Association

Rosalie Thornburgh
Kansas Department of Transportation
Office of Traffic Safety

Rosanne Rutkowski
Kansas Department of Health & Environment
Bureau for Children, Youth & Families

CONSULTANT

Robert W Heilig & Associates
Incline Village NV

FOR MORE INFORMATION:

PROJECT COORDINATOR

Deborah M Williams
KDHE
Local & Rural Health Systems
900 SW Jackson, Room 665
LSOB
Topeka KS 66612-1290
(785) 291-3773 Fax (785) 296-1231