Approved: 2-17-99
Date

MINUTES OF THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE.

The meeting was called to order by Chairperson Sandy Praeger at 10:00 a.m. on February 9, 1999 in Room 526-S of the Capitol.

All members were present except:

Committee staff present: Emalene Correll, Legislative Research Department
Norman Furse, Revisor of Statutes
JoAnn Bunten, Committee Secretary

Conferees appearing before the committee:
Dennis Allin, M.D., KUMC and Chairman, EMS Trauma Task Force
Jerry Slaughter, Executive Director, Kansas Medical Society
Charles Waters, CEO, Newton Medical Center - Kansas Hospital Assn.
Dan Caliendo, M.D., Member of EMS Board
Charles Wheelan, Ks. Association of Osteopathic Medicine
Lynelle Pierce, R.N., Critical Care, KUMC
Jason White, Metro Ambulance Service, K.C.
Joe Conroy, Kansas Association of Nurse Anesthetists
Darlene Whitlock, Kansas Emergency Nurses Association
Connie McAdam, President, Kansas Emergency Medical Services Assn.
Richard Morrissey, KDHE
Tom Pollam, EMS Sedgwick Co.
Terri Roberts, Executive Director, Kansas State Nurses Association

Others attending: See attached list

Hearing on: SB 106 - Emergency medical-trauma board

Dennis Allin, M.D., KUMC, testified before the Committee in support of **SB 106** that would establish the Kansas Trauma System Board. The 14-member board would be located at, and attached to, the Wichita branch of the University of Kansas School of Medicine. The bill outlines appointments to, and lengths of term on the Board. The functions of the board include developing rules and regulations necessary to implement the bill and development of a statewide Trauma System Plan. Dr. Allin recommended the Committee consider the addition of two pre-hospital EMS representatives on the Board as noted in his written testimony. (Attachment 1)

Jerry Slaughter, KMS, expressed his support for **SB 106**, and noted that the key element of this legislation is the development of the trauma registry. Mr. Slaughter noted that it is essential in the development and operation of an effective trauma system that good information be available to the Trauma System Board, and he strongly supports the provisions in the bill which assures the confidentiality of personal information reported to the registry, as well as the funding source which is a $2.00 surcharge on all moving traffic violations. (Attachment 2)

Charles Waters, representing the Kansas Hospital Association, expressed support for the establishment of the Kansas Trauma System Board, and suggested language in the bill be changed that would broaden the scope of reports and data, expressed concern relating to confidentiality issues surrounding release of data in the trauma registry, and the possibility of costs that could be levied against Kansas hospitals as outlined in his written testimony. (Attachment 3)

The following conferees testified before the Committee in support of **SB 106**:

Don Caliendo, M.D., member of EMS Board, (Attachment 4); Charles Wheelen, Kansas Association of Osteopathic Medicine, requesting an amendment for one osteopathic physician as a member of the Board, (Attachment 5); Lynelle Pierce, R.N., Clinical Nurse Specialist in Critical Care at the University of Kansas Medical Center, in agreement with concerns and suggestions offered by the Kansas Hospital Association, (Attachment 6); Jason White, Metropolitan Ambulance Services Trust, suggested that wording in the bill

should include language relating to EMS members of the Board be held by someone from a rural area, (Attachment 7); Joseph Conroy, Kansas Association of Nurse Anesthetists, expressed concerns that the restrictive mandates currently required by the Plan could result in widespread inability of hospitals to meet the surgical recommendations and thereby limit hospital participation, - - representation on the Board was suggested, (Attachment 8); Darlene Whitlock, R.N., Emergency Nurses Association, suggested the Committee (1) consider expanding the membership of the Board, (2) include more components of the Kansas EMS/Trauma Policy Group proposal, and (3) implement actions to prevent injuries and save lives, (Attachment 9); Connie McAdam, Kansas Emergency Medical Services Association, recommended language that would include more representation from rural areas on the Board, (Attachment 10); Richard Morrissey, KDHE, presented background of the Plan and support of the bill, (Attachment 11); Thomas Pollan, Sedgwick County EMS, suggested amendments with representation on the Board and additional language in New Sec. 7 relating to patient's right to choose health care services, (Attachment 12); and Terri Roberts, Kansas State Nurses Association, with an amendment that would add additional nurses to the Board, (Attachment 13).

Written testimony with information and support of **SB 106** was also received from Rosalie Thornburgh, Bureau Chief of Traffic Safety, Kansas Department of Transportation (Attachment 14).

The Chair announced that the bill would be assigned to a subcommittee.

Adjournment

The meeting was adjourned at 11:00 a.m.

The next meeting is scheduled for February 10, 1999.

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-9-99

NAME	REPRESENTING
Tarri Robarts	KSNA
Jason White	MAST / KCK ambulance service
Tom Pollan	Sedgewick County EMS
Darlene Whitlock	Ks Emergency Nurses Assoc.
Rebecca [illegible]	Ks Assn Nurse Anesthetists
Joseph P. Conroy	Ks Assoc Nurse Anesthetists
Wes Draper	KMS
[illegible]	Medimics Consulting
[illegible] Damron	St. Luke Shawnee Mission
Dick O'Morrissey	KDHE
[illegible]	[illegible]
Lynelle Pierce	Univ. of Ks Hospital
Lois Towster	Overland Park Reg. Med Ctr
Michelle R Nasalroad	Life Net Air Medical Transport
Larry Drahota M.D.	OPRMC & Trauma Victims of Kansas
Doug Smith	KAPA
Chip Wheelen	Ks Assn of Osteopathic Med
Jeff Smith	City of Lenexa Fire Dept.
Connie McAdam	Ks EMS Association

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE
GUEST LIST

DATE: 2-9-99

NAME	REPRESENTING
Deb Williams	KDHE
Barbara Walden-Hiebert	Board of EMS
Dick Bauman	KDOT
Stacey Soldan	Hein + Weir Chtd.
Elaine Frisbie	Div. of the Budget
Carolyn McGinnis	KSNA

SB 106
Testimony of Dennis Allin M.D.
Chairman, Statewide EMS/Trauma Task Force

am

I would like to begin with a true story that occurred several years ago in a community just outside of Kansas City. Five teenage young people were involved in a motor vehicle crash just outside this town, with several requiring up to 1 hour of effort just to extricate them from the vehicle. By protocol, the local EMS agency transported all the patients to the local hospital, overwhelming the medical resources of this institution. The medical personnel struggled to deliver care as they frantically made transfer arrangements for these patients. Ultimately, four of the patients died with the last dying during transport two hours after he had arrived at the local hospital and nearly 4 hours after the accident. He bled to death from a ruptured spleen.

Feeling that some of these deaths had been preventable, I, along with representatives of the flight and trauma services in Kansas City, travelled to this community to meet with local medical representatives. As we walked into the local high school we were met by an entire auditorium full of people stilled stunned by their loss and searching for solutions. We talked that night about the capabilities of their local facility, mechanisms of transferring patients more efficiently, and protocols which would allow for the flight of patients directly from the scene to a facility of greater trauma resources. Since that time it has become a common occurrence for patients with severe injuries to be transported by air from this community to the University of Kansas, while the majority of trauma continues to be transported to, and care for at, the local hospital.

This is what trauma systems are all about, the matching of facility resources with the needs of the injured patient. The trauma plan for Kansas was written by a task force of 30 people, urban and rural, care providers and administrators, all with the common goal of creating a state wide system that would allow every community the forum with which to look at their resources for trauma care before suffering such a horrendous loss of life. This plan called for a regional committee structure with the regions based on existing referral patterns. A state committee would oversee the system and support the regions through expertise, technical support, and supplying data from the trauma registry.

The bill before you would allow for a state committee that would implement the trauma plan along with providing funding and authority for a state wide trauma registry. The proposed state committee would assure the proper scope of input as the trauma plan is implemented and the trauma registry would supply the data on accidents and injuries that is so vital in trauma planning and system assessment but so profoundly lacking in our state. The drafters of the trauma plan are pleased to see that SB106 calls for the use of the plan as a blueprint for implementation, especially in the use of a regional infrastructure. This would allow for the local and regional assessment and oversight of trauma care, as prescribed by the above mentioned task force that met over a three year period. This was considered vital since the task force understood that the majority of trauma in Kansas would still be transported to local hospitals and that transport and transfer protocols would be most appropriately developed locally. The development of a trauma system in any state is an active, but gradual process of implementation based on appropriate input and refining based on data and regional assessment. This bill is an excellent initial step towards the goal of a full, mature trauma system that serves all Kansans and the acceptance of this bill by the Kansas Hospital Association and the Kansas Medical Society is indicative of the need for an organized trauma system in this state.

As a representative of the trauma task force I would however ask that you consider the addition

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of 2 pre-hospital EMS representatives. In the deliberations of the task force, we found the input of our EMS representatives to be invaluable and their frame of reference is represented by no other group with any effectiveness.

I commend the Senate on this bill and I look forward to the opportunity, provided by this bill, to conquer our number 1 killer of Kansans ages 1-44, trauma.

KMS

KANSAS MEDICAL SOCIETY

February 9, 1999

To: Senate Public Health & Welfare Committee

From: Jerry Slaughter
Executive Director

Subject: **SB 106; creating a statewide trauma system and registry**

The Kansas Medical Society appreciates the opportunity to appear today in support of SB 106, which begins the process of creating and coordinating a statewide trauma system and related components.

Kansas does not currently have an organized trauma plan that integrates all components of the medical, emergency, communications and transport resources which exist at the local, regional and state level. Studies have shown that traumatic injury is a significant cause of deaths and long-term disability, both nationally and in Kansas. There is evidence from other states that an organized trauma system can significantly reduce the incidence of those outcomes.

A little over a year ago a broadly based group of individuals representing the spectrum of professionals and institutions involved in trauma care completed a report it spent three years developing in order to design a statewide trauma system. Funded by a grant from the Kansas Health Foundation, the Kansas EMS/Trauma Planning Project Policy Group actually submitted its plan to the legislature last year, which was then referred to the Health Care Legislative Oversight Committee. SB 106 is the result of the Oversight Committee's work this summer and fall.

As a result of our meetings and discussions with physicians over the last several months, we believe the vast majority of physicians statewide support the idea of an organized trauma system. The benefits for improved patient care because of better coordination of resources, improved communication, better data and enhanced professional education are recognized by all. However, there is some concern among physicians in small to medium sized communities about the impact such a plan could have on their hospitals and communities. Some of the concern is that their hospital will suffer economically if it is bypassed in favor of larger, higher level trauma facilities as a result of such a plan. Other concerns relate to the perception that the system will result in a reduction of the readiness of physicians and nursing staff in smaller hospitals to stabilize or manage trauma patients if they see fewer patients because the system either categorizes them too low or they are bypassed in favor of larger facilities. We believe those fears can be addressed adequately by the new trauma system board, particularly because it must develop the plan pursuant to specific guidelines found in New Section 3, page 3, lines 7-18.

623 SW 10th Ave. • Topeka KS 66612-1627 • 913.235.2383 • 800.332.015(
Western Kansas office • 108 E 12th St. • Hays KS 67601 • 913.625.8215 • 800.2(

Senate Public Health and Welfare
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Attachment No. 2

A point needs to be made about the process for developing the trauma system plan contained in SB 106. Some may wonder why the board doesn't just implement the plan developed by the EMS/Trauma Policy Group last year. We believe the more appropriate course is that contained in the bill, which directs the board to use the plan as a guide, but does not limit its authority to design a system that makes sense to it. While the plan submitted by the Policy Group is well done and represents the work of numerous committed individuals and organizations, the new board ought to have the freedom, and responsibility, to help design the system that ultimately it will be responsible for administering.

One of the more contentious issues during the development of the original plan was the designation of a "lead agency" that would be responsible for running the system. We had concerns that the system could become overly bureaucratic, highly regulatory, costly, and inflexible, if it were operated by a "lead agency" in the manner of a traditional agency of state government. The decision of the interim committee to instead vest policymaking authority in a quasi-freestanding board seems to us to be a much better approach. While the board and its staff will have to hire staff, be attached to a state agency and housed somewhere, it will clearly be run by the board, and not lost in the state bureaucracy. We support that concept, and do not oppose it being attached to the medical school branch in Wichita, as the bill currently provides. The important point is that the politics, and the baggage, of the "lead agency" concept are not in this bill.

A key element of this legislation is the development of the trauma registry, found in New Section 5, beginning on page 4 of the bill. It is essential to the development and operation of an effective trauma system that good information be available to the trauma system board. We strongly support the provisions in the bill which assure the confidentiality of personal information reported to the registry.

We also support the funding source for the board and the registry, a $2.00 surcharge on all moving traffic violations. Since much of the trauma in our state is caused on our streets and highways, it seems reasonable to use revenue derived from traffic violations to support a system designed to improve the care of trauma patients.

This bill is a big step forward for our state. It has the strong potential for producing better outcomes, fewer deaths and improved trauma care for all Kansans. The bill sets in motion a process that builds a trauma system from the ground up, based on good data. This process should help gain the confidence, support and involvement of all stakeholders in the end product. We urge your favorable consideration of SB 106. Thank you.

KANSAS HOSPITAL ASSOCIATION

Memorandum

am

Donald A. Wilson
President

To: Senate Public Health and Welfare Committee

From: Kansas Hospital Association

Date: February 9, 1999

Subject: Testimony on Senate Bill 106 – Kansas Trauma Service Board
Provided by: W. Charles Waters, CEO; Newton Medical Center

The Kansas Hospital Association appreciates the opportunity to comment regarding the provisions of SB 106, which creates the Kansas Trauma System Board. We recognize that while this legislation is still not perfect, it represents a great deal of time, effort and compromise by many organizations and individuals. We hope our comments will further the goal of reaching consensus on the development of trauma legislation in Kansas.

KHA is pleased to support the establishment of the Kansas Trauma System Board. This board will provide the leadership necessary to promote sound planning for the prevention and treatment of trauma victims in our state. However, we do have some concerns and suggestions.

1. The creation of a trauma registry that will document the types of trauma and characteristics of trauma victims in Kansas will be an important aspect of trauma system planning and quality improvement. We have some language suggestions that would assure the appropriate use of these data and they are attached to this testimony.

2. We are extremely concerned about the confidentiality issues surrounding data that reside in the trauma registry, specifically, the exception which allows release of the data "to protect the public health". This could be very broadly interpreted. We feel very strongly that any release of trauma registry data should only be in aggregate for planning and quality improvement purposes. Identification of specific providers, both physicians and facilities, should be restricted for use at the facility or medical staff level.

3. The location or connection of the new board with the University of Kansas School of Medicine in Wichita provides both a positive educational environment and recognition of rural and urban needs across the state. We continue to be concerned, however, about the ongoing operational cost of the organization, especially the possibility these costs could be levied against Kansas hospitals. While the study proposes a "voluntary" system, we would like to see cost impact and justification before hospitals are required to implement any unfunded mandates.

In conclusion, we appreciate the opportunity to comment in support of the creation of the Trauma System Board and voice our concerns and suggestions. A trauma system designed to meet the unique needs of Kansas is an important goal and has the potential to benefit both public and health care providers. I would hope, however, that the plan never becomes a cost burden to Kansas hospitals, and that it never results in the loss of local control of health care.

215 S.E. 8th • P.O. Box 2308 • Topeka, Kansas 66601-2308 • (785)

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Attachment No. 3

Senate Bill 106 – Kansas Trauma System Board
Recommended Changes Submitted by the Kansas Hospital Association

We would suggest that the language in SB 106 New Sec. 3 (g) be amended to broaden the scope of the reports to be generated in two ways:

- First, we believe that the term "quality management reports" is limiting, and that other types of reports such as those that document patient flow are needed. Therefore, we would request that the words "quality management" be deleted.

- Second, we would respectfully suggest that one of the most important uses of the data will be the direct use by hospitals and physicians at the facility level. Toward that end, we recommend that trauma providers (those who report data into the registry) be added into the language as the primary recipients of the reports generated from the registry in addition to the regional councils.

We would suggest that the language in New Sec. 5 (3) be amended limiting release to aggregate data that do not identify a provider or facility.

Ike Calvert

Senate Bill No. 106

Thank You for the opportunity to speak. The statewide plan is a project close to my heart from 3 different directions:

As a member of the Board of EMS I recognize that this your opportunity to help us take a big step forward in caring for the injured patients of our state. For several years many of us who see and care for these patients have recognized the need for an organized plan that would maximize the use of our medical resources. The Kansas Medical Society passed a resolution in the early 1990's asking for such a plan. In 1994 the National Highway Traffic Safety Administration assessed trauma care in Kansas and stated: "Kansas Now needs to broaden its focus to encompass a comprehensive EMS system - from prevention and emergency access through acute care and rehabilitation."

As a practicing Emergency Medicine physician I can assure you that the statistics you are going to hear from Connie about preventable deaths are a reality. Over the years I have personally seen many patients who should have lived and/or should have had a better outcome had the resources available been used more efficiently. In the past few months we have had a patient injured near Kingman, taken to Kingman where it was recognized he needed more care than they could offer and transferred to Pratt, then Hutchinson, and then to a neurosurgeon in Wichita. The injury occurred 20 minutes from Wichita but it took over an hour for him to get there. In Manhattan an elderly woman bled to death before a surgeon could get to her: they have 3 surgeons in Manhattan; but one was on vacation and the other two were involved in a difficult case that neither could leave for nearly 45 minutes. With an organized plan this scenario could have been recognized and the patient taken directly to Topeka. And I suspect you have all heard of the multiple pediatric trauma patients that overtaxed the system just north of here a few months ago.

And finally, **as a patient** that most likely would have died had my accident occurred in rural Kansas, I have seen the need firsthand for such a plan and experienced the benefits of a well trained trauma team who get to the patient before it is too late.

I hope you will give this bill your careful consideration and support it. It will save Kansas lives and save dollars at the same time. An offer to good to refuse!

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Attachment No. 4

Kansas Association of Osteopathic Medicine

1260 SW Topeka Boulevard
Topeka, Kansas 66612

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Fax (785) 234-5564

Testimony
to the
Senate Public Health and Welfare Committee
by Charles Wheelen
February 9, 1999

am

Thank you for the opportunity to comment on SB106. Many osteopathic physicians are members of hospital medical staffs and either serve as full time emergency physicians or take call when an emergency arises. Because of the potential impact of SB106, particularly in rural areas of the State, our members remain somewhat apprehensive about the creation of a centrally controlled statewide trauma system plan. It is for this reason that we wish to request an amendment which would provide for our representation on the Board.

As you probably know, both medical doctors (MDs) and doctors of osteopathy (DOs) are licensed to practice medicine and surgery under the Kansas Healing Arts Act, and there are two principal organizations which represent physicians in this State. But SB106 provides for exclusive nomination of three physician members of the Trauma System Board by the Kansas Medical Society. We're simply asking for the opportunity to submit nominations for one osteopathic physician member of the Board. A copy of our draft amendment is attached.

Thank you for considering our request.

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Attachment No. 5

Session of 1999

SENATE BILL No. 106

By Committee on Public Health and Welfare
(By Request of the Health Care Reform
Legislative Oversight Committee)

1-21

AN ACT concerning emergency medical and trauma services; creating a board; establishing a trauma registry; amending K.S.A. 20-2801 and K.S.A. 1998 Supp. 8-2106, 12-4117, 12-4214 and 12-4305 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) There is hereby established the Kansas trauma system board which shall be located at and attached to the Wichita branch of the university of Kansas school of medicine, Wichita, Kansas.

(b) The board shall be composed of ~~14~~ 15 members appointed as follows:

(1) Three members shall be persons licensed in medicine and surgery appointed by the governor from a list of six who shall be nominated by the Kansas medical society;

(2) three members shall be representatives of hospitals appointed by the governor from a list of six who shall be nominated by the Kansas hospital association;

(3) one member shall be a licensed professional nurse specializing in trauma care appointed by the governor from a list of two who shall be nominated by the Kansas state nurses association;

(4) one member shall be a doctor of osteopathy licensed to practice medicine and surgery in this state and shall be appointed by the governor. In making such appointment, the governor shall consider nominations submitted by the Kansas association of osteopathic medicine.

(4) one member shall be a representative of the department of transportation appointed by the secretary thereof;

(5) one member shall be a representative of the department of health and environment appointed by the secretary thereof;

(6) one member shall be a representative of the board of emergency medical services appointed by the board of emergency medical services;

(7) two members shall be public members appointed by the governor. One member shall be from rural Kansas. The other member shall be from urban Kansas; and

(8) two legislators, one from the house of representatives and one from the senate shall be members of the board. The speaker of the house shall appoint one member and the president of the senate shall appoint the other member. The appointees from the legislature shall be from

[and renumber ensuing items]

drafted by C. Wheelen, KAOM

5-2

5-2

Senate Hearing: Senate Bill No. 106.

Tuesday, February 09, 1999

My name is Lynelle N.B. Pierce RN, MS, CCRN. I am the Clinical Nurse Specialist in Critical Care at the University of Kansas Hospital, Kansas City. I previously represented the University of Kansas Medical Center (KUMC) as a member of the EMS/Trauma Policy Group therefore; I actively helped formulate the consensus document, the 1998 Kansas EMS-Trauma Systems Plan referenced in line 42 and 43 of Senate Bill 106.

I stand here today to support Senate Bill 106 as a citizen of Kansas and as a nurse who has worked in the specialty of trauma and critical care for 18 years. I believe the establishment of the Kansas trauma systems board will provide the leadership needed to move the trauma plan forward. Without this leadership, and the funding provided in the Bill, an organized statewide trauma system is not likely to become a reality. The cost of no trauma plan would be measured in an ongoing loss of lives and disability in Kansas. It is well documented that trauma systems reduce morbidity and mortality due to injury.

A key point in Bill 106 is the insistence on the reliance on accurate data as the basis for system planning and development. The formulation of a statewide trauma registry will ensure cost effective planning. Injury data will direct prevention programs geared toward the epidemiology of trauma in our state and even more specifically in the geographic areas overseen by the regional councils. Compilation of data pertaining to trauma care will provide quality management designed to push for the most optimal patient outcome. As a nurse and a former Trauma Nurse Coordinator I know that all individuals who provide care to victims of injury will be assured by the provisions in the Bill that protect the health care provider who in good ~~fail~~ faith reports trauma information for quality management.

Senate Bill 106 states the Kansas trauma system board shall use as a guide in developing the statewide trauma system plan the 1998 Kansas EMS-Trauma Systems Plan. The trauma plan is an inclusive plan meaning that no facility will be excluded from the provision of trauma care. Indeed, under the plan, all facilities that currently care for trauma patients will continue to care for trauma patients, but they will also be tied into a well organized system that is designed to get the patient to the appropriate facility in the most time efficient fashion. An appropriate facility is one that has health care providers capable of managing the presenting injuries and the diagnostic and treatment equipment to assist in that management. All hospitals in Kansas are likely to continue to receive trauma patients. This plan ensures those facilities are tied into a larger network of patient-care resources, without dictating physician referral patterns. Very importantly too, the patient maintains the right to choose health care providers and centers.

Trauma care is not the best it can be in the State of Kansas. I have seen patient's puddle jump from facility to facility across a region until they finally arrive, hours after injury, to the appropriate facility. Time is critical in trauma care. I urge you to move forward will Senate Bill 106.

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Attachment No. 6

METROPOLITAN AMBULANCE SERVICES TRUST
4521 Metropolitan Avenue, Kansas City, KS 66106-2551
Telephone (913) 384-3911 • Fax (913) 384-7396

Testimony from Jason White, MAST concerning SB 106
February 9, 1999

SB 106 is a good bill and should be adopted into law.

Many states presently have statewide trauma systems established through law that improve the survival of trauma patients. Arkansas, North Dakota, Missouri, Iowa, Nebraska, Montana, Colorado, Oregon and Washington (this list is not complete).

Trauma is the leading killer of young Kansas's citizens and travelers.

Numerous clinical studies published since the early 1980's in various scientific and medical journals have validated that trauma systems save lives.

The idea expressed in SB 106 to create regions as the controlling entities is very good. This should lead to an inclusive program bringing all of the players together to make collaborative decisions on how to conduct the trauma system instead of a top-down system driven by a bureaucracy. The system envisioned in SB 106 creates an integrated system that is not designed to alienate any of the various groups that have a stake in the care of the trauma patient.

The group that developed the state trauma plan included 6 Emergency Medical Services individuals. SB 106 needs to be amended to include representation from EMS personnel. All trauma patients spend time with EMS either during initial treatment and transport to a nearby hospital or during an interfaculty transfer.

This law will need adjustments in the future, this is the first stage not the final version of a trauma system in Kansas.

The Interim Committee that developed this bill should be congratulated in finding a bill that the various stake holders could embrace and will begin the development of a quality trauma system in Kansas.

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Attachment No. 7

Jason who am.

9) One member shall be an attendant as defined in 65.6129 (this citation should be confirmed) appointed by the governor from a list of four, two who shall be nominated by the Kansas emergency medical technician association and two who shall be nominated by the Kansas emergency medical services association.

10) One member shall be an administrator of an ambulance service appointed by the governor from a list of four, two who shall be nominated by the Kansas emergency medical technician association and two shall be nominated by the Kansas emergency medical services association.

Wording should be included that assures that one if not both of these positions should be held by someone from a rural area.

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

February 9, 1999

Senator Sandy Praeger
Chairperson, Senate Public Health and Welfare
State Capitol Building
Topeka, Kansas 66612

Senator Praeger and Members of the Committee,

My name is Joseph P. Conroy, and I am a Certified Registered Nurse Anesthetist from Emporia, KS., representing the Kansas Association of Nurse Anesthetists.

I am here to provide testimony on S.B. 106, EMS/Trauma Services. Our Association is generally supportive of the concept behind S.B. 106, establishing a coordinated trauma system for the state of Kansas. As anesthesia providers, we are aware of the essential role anesthesia plays in any trauma system, from airway management and stabilization to surgical procedures.

But we have concerns with language contained in Kansas EMS/Trauma System Plan, as developed by the policy group formed to develop this Plan. Specifically, we oppose the language in the Plan requiring anesthesiologist/physician supervision of CRNA services at all levels of trauma care. This supervision language is inconsistent with our state statutes governing services provided by nurse anesthetists and is more restrictive than any language currently in place at the federal or state level.

Our Association realizes that this bill does not specifically address the "Trauma System Plan", other than note on page 2, lines 42 and 43, that the Kansas trauma system board shall develop a statewide plan using the 1998 Kansas EMS-Trauma Systems Plan study as a guide.

But unfortunately, our Association was neither invited nor had the opportunity to provide input when the Plan was developed by the policy group. As such, we wish to make the Committee aware of our concerns with the language provided in the Plan and request the opportunity to be included in any final decision on Plan language.

We have been in contact with the Kansas Hospital Association and the Kansas State Nurses Association and provided them with suggested changes in order to make the language consistent with our own state statutes, K.S.A. 65-1158, where we "function in an interdependent role as a member of a physician or dentist directed health care team".

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Attachment No. 8

KANSAS ASSOCIATION OF NURSE ANESTHETISTS

We strongly feel that a statewide plan should be consistent with existing state law. There should not be an anesthesiologist/physician supervision mandate at any trauma level I-IV. Each individual facility should be allowed to address anesthesia services under hospital bylaws. This would be more consistent with the Plan's stated intention to write standards that allow each facility to "determine individual goals based upon the unique resources available in its community". The restrictive mandates currently required by the Plan could result in widespread inability of hospitals to meet the surgical recommendations and thereby limit hospital participation.

CRNAs are the sole providers of anesthesia care in 83% of hospitals in Kansas providing surgical, obstetrical, and trauma care. CRNAs have also been the primary provider of anesthesia services in combat areas in every war since WWI. In WWII, there were 17 CRNAs to every one anesthesiologist. In Vietnam, the ration was 3 CRNAs to 1 anesthesiologist. We believe our ability to function in a trauma system is well documented.

Our Association appreciates the opportunity to address the Committee and I would like to thank the Members of Senate Public Health and Welfare for their time and consideration. We hope the Committee will address our concerns and consider our input for any statewide trauma system plan developed by the Kansas trauma system board, as proposed in this bill.

Sincerely,

Joseph P. Conroy

Joseph P. Conroy, CRNA
Kansas Association of Nurse Anesthetists
2614 Apple Drive
Emporia, Kansas 66801
316-342-0856

Position Statement
Senate Bill 106
Darlene S. Whitlock, R.N.
Board Member and President-elect
Kansas State Council Emergency Nurses Association

Madame Chairman and Committee Members:

The Kansas State Council Emergency Nurses Association appreciates the opportunity to address the committee on this very important issue. We recognize that without the leadership of this group, Trauma System development might have been delayed past this session.

While we are in generally in favor of SB106, we would like you to consider several areas. One would be to consider expanding the membership of the proposed committee, another to include more components of the Kansas EMS/Trauma Policy Group (Policy Group) proposal. Finally, we are anxious to implement actions that would more immediately prevent injuries and save lives in Kansas.

Although small committees are perceived to be more productive, we feel the current committee composition should be expanded to include two (2) nurses, one each from rural and urban areas, nominated by KSNA and ENA. We also would ask to increase EMS representation. A broader perspective by committee composition would help for many reasons.

It is important to remember that the purpose of the Policy Group plan was to develop a trauma system, not just trauma centers. However, it became more of a facility standard plan. As a member of the Policy Group, I feel that is where our consultants could have given us better direction. A broad spectrum of professionals involved in EMS/trauma care spent considerable time in its development. That plan involved much thought and discussion. Although it is not perfect, it could be used as a template.

Trauma systems (as opposed to trauma centers) involve a continuum of care. It begins with prevention, such as primary seat belt laws like the one currently being discussed. It includes the vital link of EMS communication and care. Hospital involvement is not limited to the emergency department but to virtually all areas. Rehabilitation of the trauma patient may occur in yet another facility. Repatriation of the patient back to their local setting is of primary importance to their family and friends. This system must also be inclusive, giving all hospitals, and even clinics, the ability to participate on the level

they choose. Regional councils would allow local control, yet give guidance and direction to "raise the bar" for the delivery of trauma care.

Finally, other states have demonstrated that mortality from trauma could decrease as much as 30% with system development. You will hear different statistics about how many Kansas that might be. One source notes that approximately 1,500 die each year in Kansas from trauma. So perhaps as many as 500 could be saved. These numbers are only estimates by population or retrieved from death certificates or traffic records. Some deaths may not be attributed to trauma because there is not even a definition of what trauma is. The trauma registry addressed in SB 106 would provide this data and could be used to improve quality of care. However, while it is a vital component of a trauma system, the registry will only help identify information retrospectively. It is a part of a beginning system but it will not help those 500 people who will die next year. While more young people die of trauma, the elderly are more likely to die of less serious injuries, so it affects us all. We would like this bill to include some immediate interventions.

There has been criticism of the cost associated with the proposed Kansas EMS/Trauma Plan. The criticism that most offended me was the cost of nursing education. Because the proposed course was administered by ENA, the accusation was of a conflict of interest involving the fees. ENA would receive less than $100 for a four-year verification process. A portion of that is returned to the Kansas Council of ENA and we have provided scholarships to areas without instructors. The most rewarding experience I have ever had as an educator was when a rural nurse approached me at a grocery store to tell me that the TNCC class helped her give better care to a trauma patient and she thought it made a difference in the outcome. Kansas ENA has made a real effort to increase the availability of this course in all areas of the state. No concern was voiced regarding the cost of educating of physician and pre-hospital care providers.

Currently there are only three (3) verified trauma centers in Kansas, all in Wichita; KUMC is currently preparing to seek verification. The only method of this type of review is through the American College of Surgeons. With the proposed trauma plan, this review could be done at some levels with our own state resources. High level, verified centers are required to provide education, research and leadership to outreach hospitals. They have demonstrated a willingness to do that.

While we all know the personal cost of trauma, it is also a tremendous financial expense. A system could help reduce those costs in a variety of ways. One example would be by the promotion of prevention devices such as bicycle helmets. The National Safe Kids Campaign sells bike helmets for under $10. They report that every bicycle helmet saves this country $395 in direct medical costs and other costs to society. Other organized prevention campaigns would decrease personal and societal costs.

There are many stories I could share with you to demonstrate why Kansas ENA feels so passionately about this cause. I am sure each of you have either had experiences with your family or friends being involved in a terrible motor vehicle crash or you have feared it. In the future, you have an awesome opportunity to impact not only the care they might receive but perhaps even whether they live or die. Do we want to take only a small step towards reducing mortality?

Position:
The Kansas State Council of Emergency Nurses Association supports SB106 but would suggest the above mentioned additions.

Thank you,

Darlene S. Whitlock, RN

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Testimony

To the Senate Public Health & Welfare Committee
February 9, 1999
By Connie McAdam, President

Regarding SB 106 "The Trauma Bill"

Unintentional injury is the leading cause of death for Kansas Citizens between the ages of 1 and 44 years. No one knows how many total trauma related injuries deaths occur in Kansas because there is no system for collecting and processing that information.

National studies indicate that states without trauma systems have preventable death rates as high as 30% and that effective trauma systems reduce those preventable deaths by as much as 25%. Preventable deaths are those that occur because of omission or commission of care. These deaths occur both in pre-hospital and hospital settings. They do not happen because we have poor providers. They occur in trauma because we have no statewide or regional systems for appropriate care.

I am speaking to you today as President of the Kansas EMS Association as well as a full time practicing field paramedic in a system that responds to over 20,000 911 calls for help each year. I have been involved in the delivery of Emergency Medical Care in Kansas since 1982, when I began working as a volunteer EMT in rural southeast Kansas.

The Kansas EMS Association believes that trauma systems save lives by decreasing preventable deaths. We believe that a statewide trauma system in Kansas will save lives. It is the intention of the Kansas EMS Association to participate in the education of EMS providers, medical providers and legislators about the value of a statewide trauma system.

We believe SB 106 is the foundation necessary for building a trauma system. The trauma registry will provide valuable information necessary for system development and prevention efforts throughout the state. The proposed state trauma board will provide the leadership needed for implementation of the system.

During the past months KEMSA has published information related to trauma systems in it's newspaper, *"The Kansas EMS Chronicle"*, which is mailed to all 10,000 EMS attendants in Kansas. The consistent feedback I have received on the content of SB 106 is a concern about attendant level representation on the state trauma board. We would like to see an addition of a position for an RN as well as an EMS Attendant.

✓ Our recommended language change for Section 1, (6) would read "two members shall be attendants as defined in K.S.A. 65-6112. One attendant shall be appointed by the Board of Emergency Medical Services and one shall be appointed by the Governor from a list of three nominated by the Kansas Emergency Medical Services Association. One of these should be from a rural area of the state".

I appreciate your consideration of this small language change and assure you that KEMSA feels strongly about the value the proposed statewide trauma system.

"Unity Is Strength"

Senate Public Health & Welfare
Date: 2-9-99
Attachment No. 10

KANSAS
DEPARTMENT OF HEALTH & ENVIRONMENT
BILL GRAVES, GOVERNOR
Clyde Graeber, Acting Secretary

Testimony presented to

Senate Committee on Public Health and Welfare

by

Kansas Department of Health and Environment

February 9, 1999

Senate Bill No. 106

Madame Chairperson, committee members, I appreciate the opportunity to appear before you on behalf of the Department of Health and Environment in support of Senate Bill No. 106.

KDHE was active in a partnership with the Kansas Board of Emergency Medical Services and the Kansas Medical Society that formed the coalition of seventeen organizations and developed the Kansas EMS/Trauma Systems Plan. The partnership organized in 1994 and applied for and received grant funds to support the project from the Kansas Health Foundation. A list of all of the organizations that participated and the individuals who represented them on the Policy Group is in the program brochure that you received with this testimony.

All of the organizations and individuals that came together to work on this project over the last three years did so out of a shared conviction that the real burden of trauma in Kansas, the number of deaths, the severity of injuries and the long term impact on the quality of people's lives, could be reduced through improved planning and communication. The Kansas EMS/Trauma Systems Plan is the result of that effort.

The Policy Group met every other month for most of three years, gathering information, debating the issues and striving for consensus on key points of the plan. The project contracted with national trauma experts who had worked with a number of states and localities in developing trauma systems. Those consultants facilitated the Policy Group process and provided information and expertise in the development of the plan. The Kansas EMS/Trauma Systems Plan before you was completed in January 1998.

The Health Care Reform Legislative Oversight Committee held hearings on the plan and

developed Senate Bill No. 106 which is before you today.

There are three key principles reflected in the plan that should be emphasized. First, unlike earlier trauma plans developed in many other states over the last 15 years, the Kansas plan is inclusive - no hospital or medical provider is prevented from participating in the system. To the contrary, the system is designed to assure that all providers are able to participate in the system at the level they choose.

Second, the Kansas plan takes a voluntary, not a regulatory approach to developing a statewide system. The system will allow providers to decide the level of resource commitment they wish to make, or can make, to providing trauma services.

The third principle is perhaps the most important. The Policy Group wrestled with the need to keep decision making at the local level and settled on the regional approach as the best alternative. Planning to identify necessary resources will occur in regional structures with participation by all the stakeholders in the system. The recommended system of regional councils is intended to allow the necessary system development to improve patient care and outcomes while assuring that a "top- down" approach is not applied. The focus of the process is on quality improvement.

The consequences of trauma in Kansas represent a critical public health issue that can be addressed to save lives and reduce the severity of injuries. Information and planning can be applied to prevent many of the situations that cause traumatic injury. Senate Bill No. 106 represents a measured and reasonable step to realizing these goals.

The Kansas Department of Health and Environment respectfully recommends that the Committee recommend Senate Bill No. 106 favorably for passage.

Testimony presented by: Richard J. Morrissey, Director
Office of Local and Rural Health

Sedgwick County, Kansas

Emergency Medical Service

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February 8, 1999

To: Chairperson Praeger and Committee Members
Senate Committee on Public Health and Welfare

From: Tom Pollan, Director

Re: SB 109 (Emergency Medical and Trauma Services)

Subj: Support with Amendments

I am in full support of creating a board and registry for trauma services provided in our great State. Sedgwick County has recognized the need for specific trauma protocols to facilitate rapid assessment, treatment, and transportation of critically injured patients since 1982. In 1988, a formal plan was adopted by both the City of Wichita and Sedgwick County to direct critically injured victims to verified trauma centers. Having been involved from the beginning in the Sedgwick County trauma system I offer the following amendments to assist in the facilitation of a state-wide trauma system:

New Section 1. (B) (3) ***two*** *member****s*** *shall be a licensed professional nurse specializing in trauma care appointed by the governor from a list of* ***four*** *who shall be nominated by the Kansas state nurses association;*

(B) (6) ***two*** *member****s*** *shall be* ***attendants as defined by K.S.A. 65-6112 who are on the roster of an ambulance service permitted by the board of emergency medical services.*** *One* ***attendant*** *shall be appointed by the board of emergency medical services.* ***One attendant shall be appointed by the governor from a list of three who shall be nominated by Kansas emergency medical service association.***

New Section 7. Nothing in the trauma system act shall limit a patient's right to choose the physician, hospital, facility, rehabilitation center, specialty level burn or pediatric trauma center, or other provider of health care services ***unless the local component medical society and municipality establish a trauma system.***

Thank you for allowing me your time and this input. I am available for questions.

TWP:twp

Senate Public Health & Welfare
Date: 2-9-99
Attachment No. 12

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February 9, 1999

S.B. 106: EMS Trauma

Chairperson Praeger and members of the Senate Public Health and Welfare Committee, I am Terri Roberts, the Executive Director of the KSNA here to testify in support of S.B. 106.

KSNA is very supportive of the state of Kansas moving forward in a deliberate and focused manner to implement a statewide trauma system with a trauma registry component. The three years of work by the Kansas EMS/Trauma Policy Group has set the stage for continued dialogue, refinement and implementation for a system that meets the publics needs and addresses logistical and mechanical concerns by the various provider groups.

The bill before you proposes a Kansas trauma system board with a composition that includes only one registered nurse. We'd like to note that the RN is the only provider whose qualifications are specified in the bill, requiring a "licensed professional nurse specializing in trauma care". While we understand and support the effort to recruit a RN in trauma care, we also believe that there need to be two more RN's added to the trauma system board. RN's outnumber all other healthcare providers in the state by a very wide margin (27,000 RN's licensed in Kansas), and they are responsible for triage and stabilization at hospitals, the care of trauma victims in trauma centers, and the rehabilitation of these same clients. In order to be fair and reflective of the health providers involved with and responsible for trauma care, the number of RN's on the board must be increased. With this change we are also recommending that the qualification language be modified slightly to include RN's specializing in emergency nursing or trauma care. There are so few trauma centers in Kansas, that to limit the RN to only those "specializing in trauma care" would exclude consideration of RN's working in emergency rooms in hospitals throughout Kansas. The RN's participating in emergency room triage, stabilization and transport have a perspective that would be very helpful in the design of the Kansas statewide trauma system.

Thank you.

Senate Public Health and Welfare
Date: 2-9-99
Attachment No. 13

Kansas State Nurses Association
February 9, 1999

13-2

Session of 1999

SENATE BILL No. 106

By Committee on Public Health and Welfare
(By Request of the Health Care Reform
Legislative Oversight Committee)

1-21

AN ACT concerning emergency medical and trauma services; creating a board; establishing a trauma registry; amending K.S.A. 20-2801 and K.S.A. 1998 Supp. 8-2106, 12-4117, 12-4214 and 12-4305 and repealing the existing sections.

Be it enacted by the Legislature of the State of Kansas:

New Section 1. (a) There is hereby established the Kansas trauma system board which shall be located at and attached to the Wichita branch of the university of Kansas school of medicine, Wichita, Kansas.

(b) The board shall be composed of ~~14~~ 16 members appointed as follows:

(1) Three members shall be persons licensed in medicine and surgery appointed by the governor from a list of six who shall be nominated by the Kansas medical society;

(2) three members shall be representatives of hospitals appointed by the governor from a list of six who shall be nominated by the Kansas hospital association;

(3) ~~one~~ members shall be a licensed professional nurse specializing in trauma care appointed by the governor from a list of ~~two~~ three emergency nursing or six who shall be nominated by the Kansas state nurses association;

(4) one member shall be a representative of the department of transportation appointed by the secretary thereof;

(5) one member shall be a representative of the department of health and environment appointed by the secretary thereof;

(6) one member shall be a representative of the board of emergency medical services appointed by the board of emergency medical services;

(7) two members shall be public members appointed by the governor. One member shall be from rural Kansas. The other member shall be from urban Kansas; and

(8) two legislators, one from the house of representatives and one from the senate shall be members of the board. The speaker of the house shall appoint one member and the president of the senate shall appoint he other member. The appointees from the legislature shall be from

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E. Dean Carlson
SECRETARY OF TRANSPORTATION

Bill Graves
GOVERNOR

TESTIMONY SUBMITTED TO THE SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE

REGARDING SENATE BILL 106
EMERGENCY MEDICAL AND TRAUMA SERVICES
February 9, 1999

Madam Chairman and Committee Members:

I am Rosalie Thornburgh, Bureau Chief of Traffic Safety in the Department of Transportation. On behalf of the Department of Transportation, I am submitting testimony on Senate Bill 106 regarding the establishment of a statewide Emergency Medical Services/Trauma System.

As indicated on the Kansas EMS/Trauma Systems Plan Report, dated January 1998, I was pleased to serve as part of the management committee on this project and I wish to comment on that relationship to this project.

The Kansas Department of Transportation, as I am sure you are aware, receives funds from the U.S. Department of Transportation for transportation programs, including highway safety. Funding from the National Highway Traffic Safety Administration is specifically directed at the human factors element of transportation safety, administered by the KDOT Bureau of Traffic Safety.

The objective of the state's highway safety program is, of course, to reduce the number of motor vehicle crashes and the injuries and fatalities resulting from those crashes. An integral part of the injury prevention program is quick emergency response, or emergency medical services, acknowledging the fact that motor vehicle crashes are a significant contributor to the unintentional injury toll in this state.

In April of 1994, the Kansas Department of Transportation funded a state assessment, performed under the auspices of National Highway Traffic Safety Administration and conducted by a professional team of experts. The assessment was coordinated through the Department of Health and Environment and the Board of Emergency Medical Services. The assessment looked at several system components and offered several recommendations, some of which are reflected in the EMS/Trauma Systems Plan.

In closing, from a transportation safety and injury prevention perspective, a systemic and comprehensive approach to improving emergency medical response, medical care, and the data collection of injury causes and injury costs could provide long-term benefits toward improved transportation safety.