

**State Trauma Advisory Board Meeting
January 31, 2018 - 1 p.m. to 2:00 p.m. (CT)
Trauma Advisory Board Conference Call**

**Public Conference Call Sites include: CHI Good Samaritan Hospital, Kearney, Regional West Medical Center, Scottsbluff, Nebraska Medicine, Omaha, Bryan West Medical Center, Lincoln
OPEN PUBLIC MEETING**

State Trauma Advisory Board Members Present:

Joseph C. Stothert, MD, Ph.D., State Trauma Medical Director, Omaha
Thomas Sorrell, MD, Region 3 Trauma Medical Director, Kearney Clinic, Kearney
Tami Bokelman, Consumer, Scottsbluff
Michael Schnieders, CHI Health Good Samaritan, Kearney
Mike Bailey, EMS Instructor, EMS Liaison, Westerville
Jessica Summers, Burn Representative, Omaha
Chad Reutlinger, Law Enforcement Representative, Lexington
Pete Festersen, Elected Official, Omaha
Anne Monroe, Mid-Level Practitioner, Omaha
Polly L. Olson, County of Deuel, Chappell
Shahab Abdessalam, MD, Pediatric Representative, Omaha
Curt Smith, Paramedic, Hastings
Rena Jacobsen, Trauma Nurse, Kearney
Thomas Sorrell, Region 3 Trauma Medical Director, Kearney

State Trauma Advisory Board Members Not Present:

Paul J. Schenarts, MD, Region 1 Trauma Medical Director, Omaha
Rommie Hughes, MD, Region 4 Trauma Medical Director, Scottsbluff
Stanley Okosun, MD, Region 2 Trauma Medical Director, Lincoln

DHHS Staff Present

Sherri Wren, Trauma Program Manager, Lincoln
Andrew Ngochoch, Trauma Registrar, Lincoln
Tim Wilson, Emergency Health Systems Program Manager, Lincoln
Debbie Kuhn, EMSC/CISM Program Manager, Lincoln
Teresa Hampton, DHHS Attorney, Lincoln
Rachael Wolfe, Administrative Assistant, Lincoln

Non-Board Members Present:

Diane Yetter, Nebraska Medicine, Omaha
Susan Wilson, Regional West Medical Center, Scottsbluff
Katie Pierce, CHI Health Creighton, Omaha
Jamie Mukerjee, Children's Hospital and Medical Center, Omaha
Tiffany Simon, Children's Hospital and Medical Center, Omaha

1. Meeting Called to Order:

Dr. Stothert called the conference call to order at 1 p.m. Roll was called and it was noted that there was a quorum.

Board members present: Abdessalam, Olson, Bokelman, Bailey, Festersen, Stothert, Summers, Monroe, Smith, Reutlinger, Schnieders, Sorrell, and Jacobsen.

Board members not present: Schenarts, Hughes and Okosun.

2. Approval of January 31, 2018 meeting agenda:

Jessica Summers, MD, moved and Michael Bailey seconded to approve the January 31, 2018 meeting agenda.

Voting Yes: Olson, Bokelman, Bailey, Festersen, Stothert, Summers, Monroe, Smith, Reutlinger, Schnieders, Sorrell, and Jacobsen.

Members not present: Abdessalam had stepped out of the room momentarily, Schenarts, Hughes and Okosun.

3. Approval of draft September 8, 2017 meeting minutes:

Polly Olsen moved and Pete Festersen seconded to approve the minutes from September 8, 2017.

Voting Yes: Members not present: Olson, Bokelman, Bailey, Festersen, Stothert, Summers, Monroe, Smith, Reutlinger, Schnieders, Sorrell, and Jacobsen. (Abdessalam had momentarily stepped out of the room).

Members not present: Schenarts, Hughes and Okosun.

4. Announcements: Sherri Wren announced that the public meeting notice for the call had been published in the Omaha World Herald, and distributed to meeting conference call sites. The open public meeting law and agendas for the public were distributed at the public meeting sites.

5. Draft Trauma Regulations. Sherri Wren provided a brief overview of where the draft regulations are in the regulatory process. We have concluded the drafting stage and the purpose of the call is to vote on the draft regulations. The next step will be the Department review process. Diane Yetter provided an overview of the changes from the October 4, 2017 Regulatory Committee Meeting (handout available on request). She summarized the changes to the regulatory checklist. Diane Yetter then summarized the new questions for the purpose of clarity and the discussion continued (handout available on request). The discussion followed under item #6 below.

6. Board Vote – Dr. Stothert called for a motion for approval of the draft Trauma Regulations. The following discussion was held on new questions pertaining to the draft checklist.

- A. 002.23 “Research Definition.” Should we take the definition of “Research” out of the Definitions section since we no longer have a Research section in the checklist (or referenced anywhere else in the document that can be found. Everyone agreed that this should be taken out.
- B. There was a discussion on the meaning of “Institutional Support.” What is meant by financial support is not defined, how much financial support is there? How do you measure the Trauma Medical Director working with the Hospital Administrator? It was proposed that Institutional Support section be deleted. Heather Talbott remarked that it’s not measurable but should probably be listed. It was stated that the minimum

standard is Board Resolution and Medical Staff Resolution signed. This indicates the hospital has made the commitment to apply for trauma center designation.

Recommendation to delete from one. Heather Talbott is working on the ACS PRQ now and this is exactly how it is worded for them.

Sherri Wren stated we could list Board Resolution and Medical Staff Resolution to be shows there is hospital support. Tammy Bokelman supports this suggestion.

Typically the medical staff signs one document and governing body signs another. DHHS has examples.

Teresa Hampton asked for clarification on what is signed and what the commitment by signing documents. It was remarked that it's an affirmative signature from the hospital specifying that they support trauma.

Sherri Wren referenced what is currently a footnote (page 21); under "Institutional Support" and said that she's been advised to remove footnotes and will be doing so by incorporating these into the body of the document.

Teresa Hampton asked which parts from A –D under "Institutional Support" will be included.

Dr. Summers said that everything under "Institutional Support" should be kept.

Sherri Wren discussed the "Medical Staff Resolution." The Trauma Program has an example and/or hospitals can make their own versions.

It was asked if "financial support" should be removed since there's not a definition associated with it.

Dr. Stothert said that he didn't think it needed to be defined. Teresa Hampton sated that she's looking at it from an enforcement perspective. Dr. Stothert said they haven't had any issues with it as of yet.

Sherri Wren suggested they leave that section the way it's written, just not in footnote form. This was generally agreed on by everyone.

- C. Checklist: Clinical capabilities - Blank Row after Critical Care Medicine - It's supposed to be "Radiology" listed here. Everyone agreed that this is correct and to add Radiology back in.
- D. Checklist: Clinical Qualifications: Do APPs in the ED that take care of "non-activated" trauma patients need ATLS if there is an ATLS MD in the ED at all times? If APP is managing activated trauma patients and trauma patients, then yes. Sherri Wren asked Diane Yetter to send her the appropriate language.
- E. Checklist: Clinical Qualifications: Should we define "representative" attending Peer Review to say "Orthopedic Physician", "Neurosurgical Physician", etc., to avoid someone sending their nurse or APP to the meeting instead of them? Yes, if they are engaged in the care it should be identified. The more specific the better.

- F. Checklist: Clinical Qualifications: Are we really requiring basic trauma centers to have a radiologist at Peer Review meetings? Many use an off-site provider. Probably unrealistic. Delete? Yes, everyone agreed it should be deleted.
- G. Checklist: ED RN education - Footnote 14 – PALS and ENPC have decreased their total # of trauma hours (TNCC 0.5, PALS 1.0, ENPC 0.83). Do we still want 4 hours of pediatric education? Should we drop it to 2 hours? Heather Talbott remarked that they're already struggling to get four.

Should pediatric hours be dropped to two hours?

Children's does 4 hours a year via grand rounds or people can view online at any time, CNE and CME.

2 pediatric hours over the course of four years was suggested.

Debbie Kuhn offers PETS course as well.

It was recommended to keep it at 4 hours.

Dr. Stothert said classes can be posted in the education newsletter.

Susan Wilson said out west it will be hard due to financial and staffing considerations.

There will be a Designation Committee meeting in March to discuss trauma hours. There was discussion about how it's harder to access classes in Western NE, and that there's difficulty with resources. The trainings must often be done on unpaid time.

Mike Bailey remarked that there's not enough training out West. Would like to figure out how to assist with this and thought the education portion should be kept at four hours.

After discussion it was agreed to keep it at four hours.

- H. Do we need a footnote for RN travelers, same as with locum tenens physicians? Yes. The less than a year rule to obtain TNCC should be removed and not pertain to traveling nurses. Traveling nurses should have TNCC
- I. Checklist: ED Equipment: ETCO2 – "Qualitative" - Qualitative means "waveform". Quantitative is "colometric." Is quantitative acceptable in a Basic center? Yes. "Qualitative" for Advanced and "Quantitative" for Basic.
- J. Checklist: PACU: Should we change "ICU" under the "Post Anesthesia Recovery Room (ICU is acceptable)" to "(CCU is acceptable)" since we changed the definition of ICUs to CCUs? Yes, everyone thought this sounded fine, the language should be changed.
- K. Checklist: OR: Is OR change for general level to 30 minute response ok? (matches the ACS requirement). It was agreed this is ok to change general to 30 minutes.
- L. Checklist: Blood Bank: What does "Access to Blood Bank" mean? Is there a specific time to this. Can the nurses get blood without having to wait for lab?

Advanced and General: do they have access?

What is comprehensive?

What is access to blood bank? This language should be taken out as it is hard to define.

Add back in "Two or more Units of O Negative Blood Available or Rapidly Released in an Alternate System." It was accidentally dropped from list.

Heather Talbott stated she was under the impression it means you have a key to blood storage/"can the nurses get blood when they need it"?

Dr. Stothert said there should be "a provision for massive transfusion response."
Does there need to be a minimum or just a requirement for the ability for massive transfusions?

Dr. Stothert said that smaller places just need to have O Neg. as stated above. It was recommended to delete comprehensive blood bank and add the O neg blood availability requirement back in.

- M. Checklist: Rehabilitation Services: What does "in-house" Rehabilitation service mean? CARF center? Swing bed? SNF? There was some discussion about what this meant and it was determined that in-house means acute rehab but does not have to be CARF.

Tammy Bokelman said it doesn't need to be CARF. It should be in-house acute rehabilitation or access to or transfer w/EMTALA

PT, OT, Speech is listed separately.

- N. 005.01(A)(i) Pediatric Trauma Center - States "demonstrate its ability to prove the highest level of definitive, comprehensive care for children with complex traumatic injury" then 005.01(A)(ii) "earn and maintain verification from ACS". "Highest level of definitive and comprehensive" would be Level 1 (per our definitions). Should re-word this to "at a minimum provide an advanced level of care"?

005.01(A)(iii) As well, the section under Admit and treat - are we ok with this list?

It was agreed to drop the word "comprehensive."

- O. 007.04 letter h - Registry section. Unplanned Readmission within 30 days. Do we really want these entered? It's a PI issue, not a new injury. NTDB does not collect this. Everyone agreed to remove it.
- P. 008.04 PI section - What does this mean? Bullet points under #5 make no sense. This section was numbered incorrectly and will be corrected.

Heather asked if it's ever been considered that a trauma nurse coordinator could be the coordinator over more than one hospital. It was determined that this could be a conflict of interest and there

was concern that they wouldn't be engaged with both hospitals. It was stated that this can't be put in regulations, but it is a recommendation the board can make.

Teresa Hampton had a question about what EMTALA meant? Sherri Wren said that hospitals are asked for their plans for transferring patients to a higher level of care. Transfer agreements are no longer required. A discussion continued about what trauma referral patterns mean. Teresa Hampton said that a general written plan might be required. There was discussion about what this plan would look like and if the EMTALA referral patter rewording could be removed from the regulations. Tim Wilson stated that he would like to see it left in because the EMSC program has this as a grant requirement. Others agreed that it was important to leave this in.

Dr. Stothert proposed that the basic statement should be that when a patient can't get adequate care where they've been brought, there should be a plan to transfer them to a place where they can get the services they need. He specified that this may not be a higher level, just the level that meets criteria of illness.

Teresa Hampton will think about what language to use here.

Shahab Abdessalam motioned and Mike Bailey seconded to approve the Trauma Draft Regulations.

Voting Yes: Shahab Abdessalam, Polly Olsen, Tammy Bokelman, Mike Bailey, Pete Festersen, Joseph Stothert, Jessica Summers, Anne Monroe, Curt Smith, Chad Retlinger, Michael Schnieders, Thomas Sorrel, Renae Jacobsen.

Members not present: Schenarts, Hughes and Oklosun.

Diane Yetter will incorporate these changes and get a new copy to Sherri Wren who will the meet with Teresa and Tim to finalize. The Legal/Department review process is the next step in the process.

Sherri Wren thanked everyone for their dedication and hard work for the Trauma Program.

7. Next Meeting/Adjourn

Next Meeting: The next meeting of the State Trauma Board will be May 11, 2018 at CHI Good Samaritan Hospital, Kearney.

Dr. Stothert adjourned the meeting.