Statewide Trauma Advisory Council Meeting

December 3, 2008
10:00 a.m. – 12:00 p.m.

Alabama Department of Public Health
The RSA Tower
Conference Room 1586
Montgomery, Alabama

Members Present	Dr. Rony Najjar, Dr. Alzo Preyear, Chief Billy Pappas, Dr. John Mark Vermillion, Dr. John Campbell, Dr. Donald Williamson
Member Absent	Mr. Gary Gore
Members by Phone	Dr. Loring Rue, Beth Anderson, Allen Foster, Bryan Kindred
Staff Present	Dennis Blair, Choona Lang, Verla Thomas, Tammie Yeldell, Robin Moore, Brian Hale, Katherine Hert
Guest	Joe Acker, Danne Howard, Denise Louthain, E. Allan Pace, Alex Franklin, Spencer Howard, David Garmon

Welcome

Dr. Williamson called the meeting to order with a welcome and roll call.

Consideration of Minutes of October 6, 2008

The Council recommended approval of the minutes of October 6, 2008, as distributed; the motion carried unanimously.

RTAC Meeting Update/Trauma Plans for each Region

Dr. Campbell gave a brief overview of the Regional Trauma Advisory Council meetings and trauma plans with a PowerPoint presentation. (See attached)

Chattanooga-Hamilton County Hospital d/b/a Erlanger Health System has agreed to be part of the Alabama Trauma System.

Regional Trauma Plans

The Council recommended approval of the Regional Trauma Plans for each region, as distributed; the motion carried unanimously.

Trauma System Update

Trauma System/ATCC Operation Update

Joe Acker, Region 3 Director, gave a brief update on the Trauma System stats for North and BREMSS with a PowerPoint presentation (See attached).

Dr. Campbell gave a brief update of the trauma system workgroups.

QI Workgroup

The trauma registry software is currently in testing stage. Projected online date is March 2009. (See attached stats of Trauma System)

Pediatric Workgroup

Pediatric Workgroup is sorting through minimal equipment for pediatric care. Through research, there are courses for pre-hospital and nurses on pediatric care, but no courses available for physicians.

Trauma Funding

Dr. Campbell gave a brief interpretation of the Georgia Trauma Funding distribution (see attached). Dr. Campbell also made the observation that there may be some useful material to help with developing funding for our state.

Neurosurgeon Workgroup

The neurosurgeons will meet regionally and compile a report to be added to the regional trauma plans. This group will be headed by Dr. Bart Guthrie.

Trauma Rules

The Council recommended approval of Trauma Rule 420-2-2-.02 wording, as distributed; the motion carried unanimously.

The Council recommended approval of Trauma Rule 420-2-2-.03 with an amendment to letter F #2 and #3, as distributed; the motion carried unanimously.

Trauma Rule 420-2-2-.05 was tabled until the wording is established.

The Council recommended approval of Trauma Rule 420-2-2-.06 with additions of Responsibilities and QA/QI committees, as distributed; the motion carried unanimously.

The Council recommended approval of Trauma Rule 420-2-2-.09, Trauma Registry, as distributed; the motion carried unanimously.

The Council recommended approval of Trauma Rule 420-2-2-.10, Centralized Dispatch and Communication System, with change from Alabama TCC Operations Manager to Alabama TCC Operations Director, as distributed; the motion carried unanimously.

The Council recommended approval of Trauma Rule 420-2-2-.12, QA/QI, as distributed; the motion carried unanimously.

The Council recommended approval of Trauma Rule 420-2-2-.13, Confidentiality, as distributed; the motion carried unanimously.

All rule modifications will go to the State Committee of Public Health December 17, 2008.

New Business

The Council recommended approval to move DeKalb County from East Region to North Region, as distributed; the motion carried unanimously.

Dr. White rejected appointment to Region 2 RTAC. The Council recommended approval of adding Dr. Holley to East RTAC replacing Dr. White and replacing Dr. Holley with Dr. Cross on BREMSS RTAC, as distributed; the motion carried unanimously.

Dr. Alzo Preyear's appointment was renewed.

Mr. Allen Foster's, Administrator, Mizell Memorial Hospital, one-year appointment ended in October 2008 and is currently waiting on a replacement.

Admission packets and Q&A will be on the trauma system website soon.

Meeting adjourned 11:35 a.m.

Next meeting February 6, 2009, Teleconference 10 a.m. – 12 p.m.

Donald E. Williamson, M.D., Chairman
Statewide Trauma Advisory Council

Crystal L. Fountain, Administrative Assistant II
Statewide Trauma Advisory Council

Approved March 23, 2009

Trauma System Stats

Trauma Regions	March	April	May	June	July	August	September	October	November
BREMSS Total	321	314	333	324	358	341	314	273	321
UAB	232	252	258	230	242	230	228	195	233
TCH	29	22	14	19	36	38	27	21	18
Level IIs									
Level IIIs	62	42	67	69	70	65	55	57	24
NATS Total	66	73	178	197	192	155	139	148	109
Huntsville Hospital	60	64	134	138	124	104	99	105	71
Level IIs	2	1	11	10	4	10	5	4	4
Level IIIs	4	6	39	34	51	31	26	39	24
Erlanger									3

As of December 3, 2009

420-2-2-.02 Trauma Center Standards: Verification

Upon the receipt of advice and approval of the council, the board had adopted rules for verification and certification of trauma center status as set out in Appendix A.

Author: John Campbell, M.D.
Statutory Authority: Alabama Legislature, Act 299, Regular Session, 2007 (Code of Alabama 1975, §22-11D-1, et seq.)
History: Filed March 20, 2008; Effective April 24, 2008

Approved by STAC 12/03/2008
Approved by SCPH 02/18/2009

420-2-2-.03 Trauma Center Designation

(1) Types of Designation.

(a) Regular Designation. A regular designation may be issued by the Board after it has determined that an applicant hospital has met all requirements to be designated as a trauma center at the level applied for and is otherwise in substantial compliance with these rules.

(b) Provisional Designation. At its discretion, the Board may issue a provisional designation to an applicant hospital that has met all requirements to be designated as a trauma center at the level applied for, with exception to minor deviations from those requirements that do not impact patient care or the operation of a trauma region.

1. The provisional designation may be used for an initial designation or for an interim change in designation status to a lower level due to a trauma center's temporary loss of a component necessary to maintain a higher designation level.

2. A trauma center must submit a written corrective plan and interim operation plan for the provisional designation period including a timeline for corrective action to the Office of EMS and Trauma within 30 days of receiving a provisional designation.

3. A provisional designation shall not extend beyond 15 months.

4. A trauma center may submit a written request to the Office of EMS and Trauma that a provisional designation be removed once all components of its corrective plan have been achieved. Following its receipt of such a request, the Department will conduct a focused survey on the trauma center. A regular designation shall be granted in the event it is confirmed that all components of the corrective plan have been achieved.

(2) Levels of Designation. There shall be three levels of trauma center designation. The criteria of each level is set out in Appendix A.

(3) Application Provision. In order to become a trauma center, a hospital must submit an application (attached to these rules as Appendix B) and follow the application process provided in paragraph (4) below.

(4) The Application Process. To become designated as a trauma center, an applicant hospital and its medical staff shall complete the Department's "Application for Trauma Center Designation". An applicant hospital shall submit the completed application via mail or hand delivery to the address listed on the application. Within 30 days of receipt of

the application, the Department shall provide written notification to the applicant hospital of the following:

(a) That the application has been received by the Department;

(b) Whether the Department accepts or rejects the application for incomplete information;

(c) If accepted, the date scheduled for hospital inspection;

(d) If rejected, the reason for rejection and a deadline for submission of a corrected "Application for Trauma Center Designation" to the Department;

(e) Upon receipt of a completed application by the Department, an application packet containing a pre-inspection questionnaire will be provided to the applicant hospital. The pre-inspection questionnaire must be returned to the Department one month prior to the scheduled inspection.

(f) The trauma center post-inspection process will proceed as listed below:

1. The inspection report will be completed two weeks after completion of the inspection.
2. A State and Regional review of the inspection report and a recommendation for or against designation will be made thirty days after completion of the inspection.
3. A final decision will be made known to the applicant hospital within x weeks of the completion of the inspection.
4. Focus visits may be conducted by the Department as needed.

(5) The Inspection Process. Each applicant hospital will receive an onsite inspection to ensure the hospital meets the minimum standards for the desired trauma center designation level as required by these rules. The Department's Office of EMS and Trauma staff will coordinate the hospital inspection process to include the inspection team and a scheduled time for the inspection. The hospital will receive written notification of the onsite inspection results from the Office of EMS and Trauma.

(6) Designation Certificates.

(a) A designation certificate will be issued after an applicant hospital has successfully completed the application and inspection process. The designation certificate issued by the Office of EMS and Trauma shall set forth the name and location of the trauma center, and the type and level of designation. The form of the designation certificate is attached to these rules as Appendix C.

(b) Separate Designations. A separate designation certificate shall be required for each hospital when more than one hospital is operated under the same management.

(7) Designation for Contract.

(a) A designation contract will be completed after the hospital has successfully completed the application and inspection process. The designation contract shall be issued by the Office EMS and Trauma. It shall set forth the name and location of the trauma center and the type and level of designation.

(b) Separate Designation Contracts. A separate designation contract shall be required for each hospital when more than one hospital is operated under the same management.

(c) The form of the designation contract is attached to these rules as Appendix D.

(8) Basis for Denial of a Designation.

The Department shall deny a hospital application for trauma center designation if the application remains incomplete after an opportunity for correction has been made, or if the applicant hospital has failed to meet the trauma center designation criteria as determined during the inspection.

(9) Suspension, Modification, and Revocation of a Designation.

(a) A trauma center's designation may be suspended, modified, or revoked by the Board for an inability or refusal to comply with these rules.

(b) The Board's denial, suspension, modification or revocation of a trauma center designation shall be governed by the Alabama Administrative Procedure Act, §41-22-1, et seq., *Ala. Admin. Code.*

(c) Hearings. Contested case hearings shall be provided in accordance with the Alabama Administrative Procedure Act, §41-22-1, et seq., and the Board's Contested Case Hearing Rules, Chapter 420-1-3, *Ala Admin. Code.*

(d) Informal settlement conferences may be conducted as provided by the Board's Contested Case Hearing Rules, Chapter 420-1-3, *Ala. Admin. Code.*

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority*: Code of Alabama, 1975*, §22-11D-5
History:

Approved by STAC 12/03/2008
Approved by SCPH 02/18/2009

420-2-2-.06 Regional Trauma Advisory Councils.

(1) Creation. Regional councils are established to advise, consult with, and accommodate specific regional needs. Each regional council shall provide data required by the Department or the Council to assess the effectiveness of the statewide trauma system

(2) Membership. Each regional council shall have a minimum of 10 members. The membership of the regional councils shall be appointed in the same manner as the Council is appointed and shall be composed of representatives of the same groups. The chair of each regional council shall be elected by its members to serve for four year term. The members shall represent the demographic composition of the region served, as far as practicable. Regional trauma advisory council members shall be entitled to reimbursement for expenses incurred in the performance of their duties as the same rate as state employees.

(3) Responsibilities. The regional trauma council is responsible for direct oversight and management of its specific regional trauma system. The regional council shall review the entire regional trauma program activities for appropriateness, quality, and quantity to include pre-hospital and hospital care. The regional trauma council shall decide the appropriate secondary patient care triage criteria for their specific region to ensure patients are routed to the closest and most appropriate hospital according to their injuries.

In addition, the regional council shall fulfill the responsibilities as listed below:

1. Maintain standards;
2. Collect data;
3. Evaluate data-determine audit filters;
4. Re-evaluate to determine effectiveness of corrective action;
5. Participate on Regional Trauma QI Committee;
6. Devise plan of corrective action for QI issues;

(4) Committees.

1. QA/QI Committees. The regional trauma advisory councils shall document the effectiveness of hospital and emergency medical service QA/QI evaluations through routine reports of these QA/QI activities provided by each trauma system entity in their specific region. The regional trauma council will routinely perform focused review of specific QA/QI items of pre-hospital and hospital trauma care activities as determined appropriate by the regional trauma council. Recommendations for action will be developed by the committee based on analysis of data/information evaluated during committee function. The regional trauma council will submit quarterly compliance

reports to the Office of EMS and Trauma for review to ensure the system process is followed.

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

Approved by STAC 12/03/2008
Approved by SCPH 02/18/2009

420-2-2-.09 Statewide Trauma Registry

(1) Creation. There is established a Statewide Trauma Registry to collect data on the incidence, severity, and causes of trauma, including traumatic brain injury. The registry shall be used to improve the availability and delivery of pre-hospital or out-of-hospital care and hospital trauma care services.

(2) Data Elements. Each designated trauma center shall furnish the following data to the registry. *See Appendix G for data elements.*

(a) Injury Case Criteria for State Trauma Registry.
1. ICD-9 diagnosis code 800.00 – 959.9 and
2. Assigned an ATCC number
3. Admitted to hospital for 24 hours or greater or
4. Transferred from one hospital to another hospital or
5. Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status

(b) Excludes the following isolated injuries:
1. 905 – 909.9 (late effects of injury)
2. 910 – 924.9 (superficial injuries-including blisters, contusions, abrasions, and insect bites)
3. 930 – 939.9 (foreign bodies)

(3) Reporting. All cases of traumatic injuries meeting the trauma admission criteria, diagnosed, assigned an ATCC number or treated and admitted to a level I, II, or III trauma facility shall report to the Alabama Trauma Registry within 90 days of ED visit or facility admission or diagnosis as prescribed by these rules. Reports are to be submitted on a monthly basis.

(4) Confidentiality. All registry data shall be held confidential pursuant to state and federal laws, rules, and policies.

Authors: John Campbell, M.D. and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

Approved by STAC 12/03/2008
Approved by SCPH 02/18/2009

420-2-2-.10 Centralized Dispatch and Communications System. Communications are critical to the function to the Trauma System.

(1) The Alabama TCC will be staffed 24-hours-a-day by personnel with specific in-depth knowledge of the Trauma System design, function, and protocols.

(2) It will be primary responsibility of the Alabama TCC to coordinate the Trauma System activities by maintaining, providing information and recommendations whenever needed to the field staff and hospital personnel in providing care to patients meeting the trauma system entry criteria. Oversight of day-to-day operations of the Alabama TCC will be responsibility of the Alabama TCC Operations Director.

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

Approved by STAC 12/03/2008
Approved by SCPH 02/18/2009

420-2-2-.12 Quality Assurance/Quality Improvement. Quality Assurance and Quality Improvement (QA/QI) activities are a vital component of the Trauma System. They are used to document and foster continuous improvement in performances and the quality of patient care. In addition, they will assist the Department in defining standards, evaluating methodologies, and utilizing the evaluation results from continued system improvement. The department shall develop guidelines for the state and regional level trauma staff in regarding QA/QI activities.

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

Approved by STAC 12/03/2008
Approved by SCPH 02/18/2009

420-2-2-.13 Confidentiality

(1) State and Regional Trauma QA/QI members shall be provided access to all information, reports, statements, or memoranda reviewed by or furnished to the State and Regional Trauma QA/QI workgroups members; and any discussion, findings, conclusions or recommendations resulting from the review of the records by the State and Regional Trauma QA/QI workgroups are declared to be privileged and confidential. All information, reports, statements, or memoranda reviewed by or furnished to the State and Regional Trauma QA/QI workgroups shall be used only in the exercise of proper functions and duties of the State and Regional Trauma QA/QI workgroups.

(2) All information furnished to the State and Regional QA/QI workgroups shall include pertinent safety and health information associated with the case summary. All identifying patient information will be removed before preparing case summary.

(3) All information and records acquired or developed by the State and Regional Trauma QA/QI workgroups shall be secured and have restricted access and shall be destroyed when no longer of use.

(4) Statistical information and data may be released by the State and Regional Trauma QA/QI as long as no identifying patient information is provided.

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

Approved by STAC 12/03/2008
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