

# Trauma System Assurance

## *Prevention and Outreach*

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### **Purpose and Rationale**

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Trauma systems must develop prevention strategies that help control injury as part of an integrated, coordinated, and inclusive trauma system. The lead agency and providers throughout the system should be working with business organizations, community groups, and the public to enact prevention programs and prevention strategies that are based on epidemiologic data gleaned from the system.

Efforts at prevention must be targeted for the intended audience, well defined, and structured, so that the impact of prevention efforts is systemwide. The implementation of injury control and prevention requires the same priority as other aspects of the trauma system, including adequate staffing, partnering with the community, and taking advantage of outreach opportunities. Many systems focus information, education, and prevention efforts directly to the general public (for example, restraint use, driving while intoxicated). However, a portion of these efforts should be directed toward emergency medical services (EMS) and trauma care personnel safety (for example, securing the scene, infection control). Collaboration with public service agencies, such as the department of health is essential to successful prevention program implementation. Such partnerships can serve to synergize and increase the efficiency of individual efforts. Alliances with multiple agencies within the system, hospitals, and professional associations, working toward the formation of an injury control network, are beneficial.

Activities that are essential to the development and implementation of injury control and prevention programs include the following:

- A needs assessment focusing on the public information needed for media relations, public officials, general public, and third-party payers, thus ensuring a better understanding of injury control and prevention
- A needs assessment for the general medical community, including physicians, nurses, prehospital care providers, and others concerning trauma system and injury control information
- Preparation of annual reports on the status of injury prevention and trauma care in the system
- Trauma system databases that are available and usable for routine public health surveillance

## OPTIMAL ELEMENTS

I. The lead agency informs and educates state, regional, and local constituencies and policy makers to foster collaboration and cooperation for system enhancement and injury control. **(B-207)**

- a. The trauma system leaders (lead agency, advisory committees, and others) inform and educate constituencies and policy makers through community development activities, targeted media messaging, and active collaborations aimed at injury prevention and trauma system development. **(I-207.2)**

II. The jurisdictional lead agency, in cooperation with other agencies and organizations, uses analytic tools to monitor the performance of population based prevention and trauma care services. **(B-304)**

- a. The lead agency, along with partner organizations, prepares annual reports on the status of injury prevention and trauma care in state, regional, or local areas. **(I-304.1)**

III. The lead agency ensures that the trauma system demonstrates prevention and medical outreach activities within its defined service area. **(B-306)**

- a. The trauma system is active within its jurisdiction in the evaluation of community based activities and injury prevention and response programs. **(I-306.2)**
- b. The effect or impact of outreach programs (medical and community training and support and prevention activities) is evaluated as part of a system performance improvement process. **(I-306.3)**

## CURRENT STATUS

The state is to be commended for recognizing the significant problem and impact of injury on Alaskans. The IPEMS Section within DHSS is the primary focus area for injury epidemiology and injury prevention in the state. Numerous programs and sources of funding from other agencies and from grant funding (e.g., NIOSH, Maternal and Child Health, Department of Highway Safety, Medicaid, and CDC) support injury program efforts. Documents provided to the consultant team identified an injury program manager and 8 additional staff members in IPEMS.

The state has numerous groups with which it works successfully to implement injury prevention programs. The Alaska Native Tribal Health Consortium Injury Prevention Program works to develop and disseminate culturally appropriate injury prevention programs. Acute care facilities were reported to be implementing brief alcohol screening and intervention programs.

The Alaska Injury Prevention Center is an example of a coalition formed to promote injury prevention outreach by the Anchorage acute care facilities. This center has progressed beyond its original Anchorage outreach focus to become a nonprofit organization that can develop, implement, and evaluate injury program interventions across the entire state.

The state has been an acknowledged leader in the development of injury prevention programs, such as the Kids Don't Float program that has reduced drowning deaths among children. This program is now sustained through partnerships with the Coast Guard and SafeKids. The state often serves as a facilitator for injury program implementation through its many partnerships, such as Injury Prevention in a Bag with EMTs in small communities. Information about 16 injury mechanisms, their prevention strategies, and resources for injury prevention programs are available on the IPEMS website.

Several state agencies collaborate with IPEMS in conducting injury surveillance and in implementing injury prevention strategies, such as the Alaska Marine Safety and Education Association, Alaska Highway Safety Office, Alaska Division of Fire and Life Safety.

The EMS Goals document describes the importance of implementing injury prevention programs in all communities across the state. Injury prevention education is targeted to prehospital providers during the annual EMS conference, and continuing medical education units are provided. Prehospital providers have been engaged in implementing the Injury in a Bag program as well as other injury prevention programs.

The focus of the state and its extensive programming for primary injury prevention is exemplary. Injury prevention is an important component of the trauma system. An opportunity now exists to expand the primary injury prevention focus to the broader concept of injury control so that this emphasis can be integrated with the future state trauma system.

## **RECOMMENDATIONS**

- Ensure representation of an injury prevention representative on the Alaska Trauma Advisory Council (ATAC).
- Incorporate the concept of "injury control" into the prevention activities to raise awareness of the need for a comprehensive and integrated trauma system.

## ***Emergency Medical Services***

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### **Purpose and Rationale**

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The trauma system includes, and/or interacts with, many different agencies, institutions, and systems. The EMS system is one of the most important of these relationships. EMS is often the critical link between the injury-producing event and definitive care at a trauma center. Even though at its inception the EMS system was a very broad system concept, over time, EMS has come to be recognized as the prehospital care component of the larger emergency health care system. It is a complex system that not only transports patients, but also includes public access, communications, personnel, triage, data collection, and quality improvement activities.

The EMS system medical director must have statutory authority to develop protocols, oversee practice, and establish a means of ongoing quality assessment to ensure the optimal provision of prehospital care. If not the same individual, the EMS system medical director must work closely with the trauma system medical director to ensure that protocols and goals are mutually aligned. The EMS system medical director must also have ongoing interaction with EMS agency medical directors at local levels, as well as the state EMS for Children program, to ensure that there is understanding of and compliance with trauma triage and destination protocols.

Ideally, a system should have some means of ensuring whether resources meet the needs of the population. To achieve this end, a resource and needs assessment evaluating the availability and geographic distribution of EMS personnel and physical resources is important to ensure a rapid and appropriate response. This assessment includes a detailed description of the distribution of ground ambulance and air medical locations across the region. Resource allocations must be assessed on a periodic basis as needs dictate a redistribution of resources. In communities with full-time paid EMS agencies, ambulances should be positioned according to predictable geographic or temporal demands to optimize response efficiencies. Such positioning schemes require strong prehospital data collection systems that can track the location of occurrences over time. Periodic assessment of dispatch and transport times will also provide insight into whether resources are consistent with needs.

Each region should have objective criteria dictating the level of response (advanced life support [ALS], basic life support [BLS]), the mode of transport, and the disposition of the patient based on the location of the incident and the severity of injury. A mechanism for case-based review of trauma patients that involves prehospital and hospital providers allows bidirectional information sharing and continuing education, ensuring that expectations are met at both ends. Ongoing review of triage and treatment decisions allows for continuing quality improvement of the triage and prehospital care protocols. A more detailed discussion of in-field (primary) triage criteria is provided in the section titled: System Coordination and Patient Flow.

### ***Human Resources***

Periodic workforce assessments of EMS should be conducted to ensure adequate numbers and distribution of personnel. EMS, not unlike other health care professions, experiences shortages and maldistribution of personnel. Some means of addressing recruitment, retention, and engagement of qualified personnel should be a priority. It is critical that trauma system leaders work to ensure that prehospital care providers at all levels attain and maintain competence in trauma care. Maintenance of competence should be ensured by requiring standards for credentialing and certification and specifying continuing educational requirements for all prehospital personnel involved in trauma care. The core curricula for First Responder, Emergency Medical Technician (EMT) Basic, EMT-Intermediate, EMT Paramedic, and other levels of prehospital personnel have an essential orientation to trauma care for all ages. However, trauma care knowledge and skills need to be continuously updated, refined, and expanded through targeted trauma care training such as Prehospital Trauma Life Support®, Basic Trauma Life Support®, and age-specific courses. Mechanisms for the periodic assessment of competence, educational needs, and education availability within the system should be incorporated into the trauma system plan.

Systems of excellence also encourage EMS providers to go beyond meeting state standards for agency licensure and to seek national accreditation. National accreditation standards exist for ground-based and air medical agencies, as well as for EMS educational programs. In some states, agency licensure requirements are waived or substantially simplified if the EMS agency maintains national accreditation.

EMS is the only component of the emergency health care and trauma system that depends on a large cadre of volunteers. In some states, substantially more than half of all EMS agencies are staffed by volunteers. These agencies typically serve rural areas and are essential to the provision of immediate care to trauma patients, in addition to provision of efficient transportation to the appropriate facility. In some smaller facilities, EMS personnel also become part of the emergency resuscitation team, augmenting hospital personnel. The trauma care system program should reach out to these volunteer agencies to help them achieve their vital role in the outcome of care of trauma patients. However, it

must be noted that there is a delicate balance between expecting quality performance in these agencies and placing unrealistic demands on their response capacity. In many cases, it is better to ensure that there is an optimal BLS response available at all times rather than a sporadic or less timely response involving ALS personnel. Support to volunteer EMS systems may be in the form of quality improvement activities, training, clinical opportunities, and support to the system medical director.

Owing to the multidisciplinary nature of trauma system response to injury, conferences that include all levels of providers (for example, prehospital personnel, nurses, and physicians) need to occur regularly with each level of personnel respected for its role in the care and outcome of trauma patients. Communication with and respect for prehospital providers is particularly important, especially in rural areas where exposure to major trauma patients might be relatively rare.

### ***Integration of EMS Within the Trauma System***

In addition to its critical role in the prehospital treatment and transportation of injured patients, EMS must also be engaged in assessment and integration functions that include the trauma system and also public health and other public safety agencies. EMS agencies should have a critical role in ensuring that communication systems are available and have sufficient redundancy so that trauma system stakeholders will be able to assess and act to limit death and disability at the single patient level and at the population level in the case of mass casualty incidents (MCIs). Enhanced 911 services and a central communication system for the EMS/trauma system to ensure field-to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications among all system participants are important for integrating a system's response. Wireless communications capabilities, including automatic crash notification, hold great promise for quickly identifying trauma-producing events, thereby reducing delays in discovery and decreasing prehospital response intervals.

Further integration might be accomplished through the use of EMS data to help define high-risk geographic and demographic characteristics of injuries within a response area. EMS should assist with the identification of injury prevention program needs and in the delivery of prevention messages. EMS also serves a critical role in the development of all-hazards response plans and in the implementation of those plans during a crisis. This integration should be provided by the state and regional trauma plan and overseen by the lead agency. EMS should participate through its leadership in all aspects of trauma system design, evaluation, and operation, including policy development, public education, and strategic planning.

## OPTIMAL ELEMENTS

I. The trauma system is supported by an EMS system that includes communications, medical oversight, prehospital triage, and transportation; the trauma system, EMS system, and public health agency are well integrated.

**(B-302)**

- a. There is well-defined trauma system medical oversight integrating the specialty needs of the trauma system with the medical oversight for the overall EMS system. **(I-302.1)**
- b. There is a clearly defined, cooperative, and ongoing relationship between the trauma specialty physician leaders (for example, trauma medical director within each trauma center) and the EMS system medical director. **(I-302.2)**
- c. There is clear-cut legal authority and responsibility for the EMS system medical director, including the authority to adopt protocols, to implement a performance improvement system, to restrict the practice of prehospital care providers, and to generally ensure medical appropriateness of the EMS system. **(I-302.3)**
- d. The trauma system medical director is actively involved with the development, implementation, and ongoing evaluation of system dispatch protocols to ensure they are congruent with the trauma system design. These protocols include, but are not limited to, which resources to dispatch, for example, ALS versus BLS, air ground coordination, early notification of the trauma care facility, pre-arrival instructions, and other procedures necessary to ensure that resources dispatched are consistent with the needs of injured patients. **(I-302.4)**
- e. The retrospective medical oversight of the EMS system for trauma triage, communications, treatment, and transport is closely coordinated with the established performance improvement processes of the trauma system. **(I-302.5)**
- f. There is a universal access number for citizens to access the EMS/trauma system, with dispatch of appropriate medical resources. There is a central communication system for the EMS/trauma system to ensure field- to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications among all system participants. **(I-302.7)**
- g. There are sufficient and well-coordinated transportation resources to ensure that EMS providers arrive at the scene promptly and expeditiously transport the patient to the correct hospital by the correct transportation mode. **(I-302.8)**

II. The lead trauma authority ensures a competent workforce. **(B-310)**

- a. In cooperation with the prehospital certification and licensure authority, set guidelines for prehospital personnel for initial and ongoing trauma training, including trauma-specific courses and courses that are readily available throughout the state. **(I-310.1)**
- b. In cooperation with the prehospital certification and licensure authority, ensure that prehospital personnel who routinely provide care to trauma patients have a current trauma training certificate, for example, Prehospital Trauma Life Support or Basic Trauma Life Support and others, or that trauma training needs are driven by the performance improvement process. **(I-310.2)**
- c. Conduct at least 1 multidisciplinary trauma conference annually that encourages system and team approaches to trauma care. **(I-310.9)**

III. The lead agency acts to protect the public welfare by enforcing various laws, rules, and regulations as they pertain to the trauma system. **(B-311)**

- a. Incentives are provided to individual agencies and institutions to seek state or nationally recognized accreditation in areas that will contribute to overall improvement across the trauma system, for example, Commission on Accreditation of Ambulance Services for prehospital agencies, Council on Allied Health Education Accreditation for training programs, and American College of Surgeons (ACS) verification for trauma facilities. **(I-311.6)**

**CURRENT STATUS**

The lead agency for Alaska EMS is the IPEMS Section under the authority of the DHSS. The EMS system is comprised of seven EMS regions that span a huge geographic area with extreme terrain and weather variations. These regions receive varying degrees of funding from the state. The state has approximately 3,300 Emergency Medical Technicians (EMTs), 175 Mobile Intensive Care Paramedics (MICPs) and unknown numbers of first responders.

When injured or ill patients require treatment not available locally, they may be transported by ground (ambulance, privately owned vehicle, snow machine, dog sled), by water (U.S. Coast Guard, fishing boat) or air (rotor or fixed wing, medical private or commercial). EMS ground services in Alaska include five BLS, 39 ALS with occasional BLS, and 33 ALS services. Air medical services include eight Medevac and 10 Critical Care Air Ambulance services with one service also certified as a Perinatal Specialty Air Medical Transport Service. Each of the regional hub cities has at least one air medical service. There are approximately



180 certified and uncertified first responder services across the state, however not all communities are covered.

EMT levels are as follows:

- EMT I (EMT Basic, 1994 U.S. Department of Transportation (DOT) National Standard Curriculum (NSC) with medication module but not manual defibrillation or advanced airway module);
- EMT II (EMT I plus 50 additional hours of training; exceeds EMT Intermediate 85, can administer intravenous fluids (5% dextrose in water, crystalloid volume-replacement solutions) and selected medications (50% dextrose in water and naloxone hydrochloride);
- EMT III (EMT I plus EMT II plus 50 hours of additional training; can administer EMT II medications plus lidocaine, atropine, morphine, and epinephrine 1:1000/1:10,000; apply electrodes, monitor cardiac activity and provide countershock for ventricular fibrillation and pulseless ventricular tachycardia).
- Defibrillator Technician training is available for EMT I and II levels that allows them to perform manual defibrillation.

EMT levels II and III function under direct or indirect supervision of a physician, and if they do not have a medical director they must function at the EMT I level. EMT I, II and III personnel are certified by the IPEMS Section. The local medical director may expand the scope of an EMT I, II or III after approval by the IPEMS Section and submission of a training and evaluation plan. The local medical director is responsible for the expanded care provided.

The Mobile Intensive Care Paramedic (MICP) is licensed by the Alaska State Medical Board which requires completion of training that follows the U.S. DOT NSC for paramedics, successful completion of the National Registry paramedic examination, and obtaining a physician sponsor approved by the Alaska State Medical Board.

First Responders are not certified by the state, including the Alaska Emergency Trauma Technician (ETT). The ETT is trained via a 44 hour course developed by the Public Safety Academy to cover emergency trauma care, medical communication, and Medevac preparations.

Most isolated communities have Community Health Aids (CHA) who are trained and function as the primary care provider either under the distant supervision of a physician or the direct supervision of a nurse practitioner or physician assistant located in the community. CHA's are First Responder or ETT trained with many at the EMT I level or higher. Due to the limited access to roads and a transportation system that depends on air or water and good weather, the injured

patient may be in the care of the CHA for up to 72 hours. It is essential that these communities have optimal communications capabilities for access to physicians and regional medical facilities. Due to the high turnover rate of the CHAs, the state will need to continue to make training programs available so this level of care can continue to be provided in these isolated communities.

The state contracts with an emergency physician on an as needed basis to perform selected duties of the state EMS medical director, and a federally-funded Alaska Native Health Service Medical Director oversees the Indian Health Service/Public Health Service medical directors. Regional and local physician medical directors are largely volunteers. A regional or local medical director for state certified EMT II or III personnel, training programs or courses (EMT II, EMT III or manual defibrillator technician training) or for a service (basic life support (BLS), advanced life support (ALS) or air medical) must be an Alaska licensed physician or a physician working in the regular medical service of the U.S. Armed Services or the U.S. Public Health Service. The medical director must participate in an orientation provided by the IPEMS Section within one year after accepting the responsibility of medical direction. Medical directors of an ALS ground service or air medical service have additional requirements.

Medical director responsibilities for the certified EMT include the following:

- supervise the medical care,
- establish and annually review treatment protocols,
- approve advanced life support standing orders for each state-certified EMT,
- provide quarterly critiques of patient care,
- schedule quarterly on-site supervision, and
- approve a program of continuing medical education for each state-certified EMT supervised.

The licensed MICP functions under a physician sponsor as noted above. While the responsibilities of the medical director of an MICP service are defined, the responsibility of the physician sponsor for the individual MICP is not. The IPEMS Section suggests that the MICP physician sponsor should follow the guidelines outlined for medical directors of certified EMTs. Local and regional EMS medical directors are provided liability coverage for their EMS duties, but their time is not compensated by the state.

Resources for regional and local EMS medical directors include an Alaska Medical Director's Handbook, a physician track during the annual State EMS Symposium, and an EMS Medical Directors' meeting during the symposium, both facilitated by the state EMS medical director.

Online medical direction for EMS providers in rural and remote locations is provided by the hospital or clinic in that region via phone (some locations have limited telemedicine capability). Often the communications system is solely dependent on satellite access. The regional facility will decide on patient disposition and help arrange transport to the most appropriate health care facility. Patient transport may involve multiple transfers requiring various modes of travel.

Alaska's 27 largest communities have Enhanced 911 services. Wireless E-911 is available in Anchorage and Juneau with limited availability in Fairbanks and Kenai. The service is Phase II compliant (Phase II rules require wireless carriers to begin providing more precise Automatic Location Identification). Alaska has uniform minimum standards for training and certification of Emergency Medical Dispatchers.

## RECOMMENDATIONS

- **Develop a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (i.e. load capacity, instrument rating, landing requirements, etc); and to monitor the availability and location of air resources.**
- Continue to support the Emergency Trauma Technician training and maximize course availability.
- Develop a program of prehospital continuing education for trauma that includes special populations such as geriatrics and pediatrics.
- Develop a medical director's listserv as a method to disseminate information in a timely manner and encourage interaction among medical directors.
- Continue to develop a National EMS Information System (NEMSIS) - compliant electronic EMS database to support evaluation of the EMS system and as a quality improvement tool for patient care.

## ***Definitive Care Facilities***

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### **Purpose and Rationale**

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Inclusive trauma systems are the systems that include all acute health care facilities, to the extent that their resources and capabilities allow and in which the patient's needs are matched to hospital resources and capabilities. Thus, as the core of a regional trauma system, acute care facilities operating within an inclusive trauma system provide definitive care to the entire spectrum of patients with traumatic injuries. Acute care facilities must be well integrated into the continuum of care, including prevention and rehabilitation, and operate as part of a network of trauma-receiving hospitals within the public health framework. All acute care facilities should participate in the essential activities of a trauma system, including performance improvement, data submission to state or regional registries, representation on regional trauma advisory committees, and mutual operational agreements with other regional hospitals to address interfacility transfer, educational support, and outreach. The roles of all definitive care facilities, including specialty hospitals (for example, pediatric, burn, severe traumatic brain injury [TBI], spinal cord injury [SCI]) within the system should be clearly outlined in the regional trauma plan and monitored by the lead agency. Facilities providing the highest level of trauma care are expected to provide leadership in education, outreach, patient care, and research and to participate in the design, development, evaluation, and operation of the regional trauma system.

In an inclusive system, patients should be triaged to the appropriate facility based on their needs and facility resources. Patients with the least severe injuries might be cared for at appropriately designated facilities within their community, whereas the most severe should be triaged to a level I or II trauma center. In rural and frontier systems, smaller facilities must be ready to resuscitate and initiate treatment of the major injuries and have a system in place that will allow for the fastest, safest transfer to a higher level of care.

Trauma receiving facilities providing definitive care to patients with other than minor injuries must be specifically designated by the state or regional lead agency and equipped and qualified to do so at a level commensurate with injury severity. To assess and ensure that injury type and severity are matched to the qualifications of the facilities and personnel providing definitive care, the lead agency should have a process in place that reviews and verifies the qualifications of a particular facility according to a specific set of resource and quality standards. This criteria-based process for review and verification should be consistent with national standards and be conducted on a periodic cycle as determined by the lead agency. When centers do not meet set standards, there should be a process for suspension, probation, revocation, or dedesignation.

Designation by the lead agency should be restricted to facilities meeting criteria or statewide resource and quality standards and based on patient care needs of the regional trauma system. There should be a well-defined regulatory relationship between the lead agency and designated trauma facilities in the form of a contract, guidelines, or memorandum of understanding. This legally binding document should define the relationships, roles, and responsibilities between the lead agency and the medical leadership from each designated trauma facility. The number of trauma centers by level of designation and location of acute care facilities must be periodically assessed by the lead agency with respect to patient care needs and timely access to definitive trauma care. There should be a process in place for augmenting and restricting, if necessary, the number and/or level of acute care facilities based on these periodic assessments. The trauma system plan should address means for improving acute care facility participation in the trauma system, particularly in systems in which there has been difficulty addressing needs.

### ***Human Resources***

The ability to deliver high-quality trauma care is highly dependent on the availability of skilled human resources. Therefore, it is critical to assess the availability and educational needs of providers on a periodic basis. Because availability, particularly of subspecialty resources, is often limited, some means of addressing recruitment, retention, and engagement of qualified personnel should be a priority. At this time, there are no fellowship trained trauma surgeons in Alaska. Periodic workforce assessments should be conducted. Maintenance of competence should be ensured by requiring standards for credentialing and certification and specifying continuing educational requirements for physicians and nurses providing care to trauma patients. Mechanisms for the periodic assessment of ancillary and subspecialty competence, educational needs, and availability within the system for all designated facilities should be incorporated into the trauma system plan. The lead trauma centers in rural areas will need to consider teleconferencing and telemedicine to assist smaller facilities in providing education on regionally identified needs. In addition, lead trauma centers within the region should assist in meeting educational needs while fostering a team approach to care through annual educational multidisciplinary trauma conferences. These activities will do much to foster a sense of teamwork and a functionally inclusive system.

### ***Integration of Designated Trauma Facilities Within the Trauma System***

Designated trauma facilities must be well integrated into all other facets of an organized system of trauma care, including public health systems and injury surveillance, prevention, EMS and prehospital care, disaster preparedness, rehabilitation, and system performance improvement. This integration should be provided by the state and/or regional trauma plan and overseen by the lead agency.

Each designated acute care facility should participate, through its trauma program leadership, in all aspects of trauma system design, evaluation, and operation. This participation should include policy and legislative development, legislative and public education, and strategic planning. In addition, the trauma program and subspecialty leaders should provide direction and oversight to the development, implementation, and monitoring of integrated protocols for patient care used throughout the system (for example, TBI guidelines used by prehospital providers and nondesignated transferring centers), including region specific primary (field) and secondary (early transfer) triage protocols. The highest level trauma facilities should provide leadership of the regional trauma committees through their trauma program medical leadership. These medical leaders, through their activities on these committees, can assist the lead agency and help ensure that deficiencies in the quality of care within the system, relative to national standards, are recognized and corrected. Educational outreach by these higher level centers should be used when appropriate to help achieve this goal.

#### **OPTIMAL ELEMENTS**

I. Acute care facilities are integrated into a resource efficient, inclusive network that meets required standards and that provides optimal care for all injured patients. **(B-303)**

- a. The trauma system plan has clearly defined the roles and responsibilities of all acute care facilities treating trauma and of facilities that provide care to specialty populations (for example, burn, pediatric, SCI, and others). **(I-303.1)**

II. To maintain its state, regional, or local designation, each hospital will continually work to improve the trauma care as measured by patient outcomes. **(B-307)**

- a. The trauma system engages in regular evaluation of all licensed acute care facilities that provide trauma care to trauma patients and of designated trauma hospitals. Such evaluation involves independent external reviews. **(I-307.1)**

III. The lead trauma authority ensures a competent workforce. **(B-310)**

- a. As part of the established standards, set appropriate levels of trauma training for nursing personnel who routinely care for trauma patients in acute care facilities. **(I-310.3)**
- b. Ensure that appropriate, approved trauma training courses are provided for nursing personnel on a regular basis. **(I-310.4)**

- c. In cooperation with the nursing licensure authority, ensure that all nursing personnel who routinely provide care to trauma patients have a trauma training certificate (for example, Advanced Trauma Care for Nurses, Trauma Nursing Core Course, or any national or state trauma nurse verification course). As an alternative after initial trauma course completion, training can be driven by the performance improvement process. **(I-310.5)**
- d. In cooperation with the physician licensure authority, ensure that physicians who routinely provide care to trauma patients have a current trauma training certificate of completion, for example, Advanced Trauma Life Support® (ATLS®) and others. As an alternative, physicians may maintain trauma competence through continuing medical education programs after initial ATLS completion. **(I-310.8)**
- e. Conduct at least 1 multidisciplinary trauma conference annually that encourages system and team approaches to trauma care. **(I-310.9)**
- f. As new protocols and treatment approaches are instituted within the system, structured mechanisms are in place to inform all personnel about the changes in a timely manner. **(I-310-10)**

## **CURRENT STATUS**

### **Facilities**

Alaska has an inclusive, voluntary trauma system. There are 24 hospitals, two of which are military facilities. Five hospitals are certified/designated trauma centers:

- Level II trauma center: Alaska Native Medical Center
- Level IV trauma centers : Norton Sound Regional Hospital  
Yukon Kuskokwim Delta Regional Hospital  
Mt. Edgecumbe Hospital  
Sitka Community Hospital

Harborview Medical Center in Seattle, WA is the Level I trauma center that supports Southeast Alaska, and often patients from other areas of the state.

The hospitals caring for the largest volume of trauma patients are concentrated in Anchorage:

- Alaska Native Medical Center (certified/designated Level II)
- Providence Alaska Medical Center (not designated), private not-for-profit
- Alaska Regional Hospital (not designated), for-profit

The only other community with more than one hospital is Sitka (Sitka Community Hospital and Mt. Edgecumbe Hospital, both level IV trauma centers).

Large portions of the state are in remote, austere areas with low population, no roads and minimal health care availability. These areas are essentially isolated in periods of bad weather and must rely on local resources for emergency care for extended periods of time.

For purposes of health care delivery, the two distinct populations in Alaska (not including the military), are Native Alaskans and all other Alaskans. Native Alaskans generally receive care via the Alaska Tribal Health System/Alaska Native Tribal Health Consortium, an integrated network of facilities and providers that deliver care to defined beneficiaries. At the local level, community clinics staffed by Community Health Aides or mid-level providers are sources of healthcare in small communities. These clinics are part of an established referral relationship that includes mid-level providers, physicians, regional hospitals, and the Alaska Native Medical Center (Level II trauma center), providing the entire spectrum of acute trauma care. The community clinics and Community Health Aides/mid-level providers assume a significant role for the stabilization and early management of trauma patients prior to transport, and when patients cannot be transported out to larger facilities because of weather or other conditions.

Perception of incentives for hospitals to become certified/designated as trauma centers vary. The Alaska Tribal Health System/ Alaska Native Tribal Health Consortium has recognized the burden of injury on Native Alaskans, leading to the support of trauma center certification/designation of the Alaska Native Medical Center and some level IV facilities. Despite the financial costs associated with verification and certification, participants reported collateral benefits of trauma center certification/designation, including contributing to an overall elevation of the quality of care at that institution and providing service to their community. Although the private non-profit hospitals that serve Alaskans recognize that trauma care is an important contribution to the community, these facilities are reluctant to pursue certification/designation without the support of their medical staffs.

### **Human Resources**

Human resources are limited, and significant problems exist for recruitment and retention of physicians and nurses. The shortages of physicians and nurses will likely worsen in the coming years (Alaska Physician Supply Task Force report, 2006). Since Alaska has no medical school, the option of “growing our own” which has been somewhat successful for other states, will not work without strong collaboration with the University of Washington’s WWAMI program, partnership between the University of Washington School of Medicine and the states of Wyoming, Alaska, Montana, and Idaho. For example, there are currently no trauma fellowship trained general surgeons in the state, in any facility. There are surgeons who do trauma surgery. Alaska Native Medical



Center has 3 surgery residents rotating from Phoenix. Providence Alaska Medical Center has family practice residents on rotation.

Several surgical specialties are in jeopardy including pediatric surgery and vascular surgery. One of 2 pediatric surgeons in the state has recently retired, prompting the remaining pediatric surgeon to make tentative plans to leave Alaska. The situation for neurosurgery and orthopedics appears more stable with sufficient numbers in Anchorage to support current volumes. Patients requiring re-implantation and many requiring burns are transported to centers outside Alaska. Among general surgeons taking emergency department call in non-designated hospitals with significant trauma volumes, participants expressed concern regarding the burden of trauma call and identified emerging requests for financial support for taking trauma call.

Among nurses, high turnover rates and staffing with travelers are commonplace challenges. Given the national outlook for nursing shortages, this will likely worsen with time. Critical care nurse staffing levels are especially low and contribute to bypass decisions.

#### **Integration of Designated Trauma Facilities Within the Trauma System**

Diversion or inability to accept trauma patients reportedly occurs regularly and appears most often due to emergency department capacity issues, ICU bed availability, or the lack of staffed beds secondary to nursing shortages. On occasion, all 3 emergency departments in Anchorage have closed for trauma at the same time, which prompts the automatic re-opening of all the facilities and trauma patient transports in rotation. No state data are available to describe the frequency of such closings. The impact on EMS has been significant by their report, and this is compounded by challenges in communication about the rotation schedule.

Nondesignated hospitals provide the majority of trauma care in Alaska. Significant concerns were expressed by Fire and EMS crews regarding challenges they have faced when delivering patients to high-volume, nondesignated hospitals in Anchorage. Among these concerns expressed were that the nondesignated hospitals do not have the “system” in place to bring in the personnel resources needed for optimal care in a timely and efficient manner.

#### **RECOMMENDATIONS**

- **Establish, as soon as practical, a second Level II Trauma Center in Anchorage in accordance with American College of Surgeons Committee on Trauma (ACS-COT) verification criteria to meet the existing volume and acuity demands.**

- **Require participation of all acute care hospitals in the trauma system within a 2 year time frame with trauma center designation appropriate to their capabilities.**
- **Study pediatric trauma care needs with the goal of establishing one or more centers of excellence in pediatric trauma care.**
- Develop a memorandum of understanding between certified/designated hospitals and the state lead agency describing mutual roles and responsibilities.
- Support designated trauma center and affiliated physician readiness/standby costs and uncompensated trauma care costs through an identified state funding mechanism.
- Establish a mechanism to routinely track data on emergency department closures or bypass, and develop notification plans that include EMS and hospital stakeholders.
- Pursue a focused, well-funded strategy to recruit trauma surgeons and trauma prepared nurses to the state.
- Increase the number of physician resident positions at Alaska hospitals to encourage potential candidates to relocate to the state.

## ***System Coordination and Patient Flow***

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### **Purpose and Rationale**

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To achieve the best possible outcomes, the system must be designed so that the right patient is transported to the right facility at the right time. Although on the surface this objective seems relatively straightforward, patients, geography, and transportation systems often conspire to present significant challenges. The most critically injured trauma patient is often easy to identify at the scene by virtue of the presence of coma or hypotension. However, in some circumstances, the patients requiring the resources of a Level I or II center may not be immediately apparent to prehospital providers. Primary or field triage criteria aid providers in identifying which patients have the greatest likelihood of adverse outcomes and might benefit from the resources of a designated trauma center. Even if the need is identified, regional geography or limited air medical (or land) transport services might not allow for direct transport to an appropriate facility.

Primary triage of a patient from the field to a center capable of providing definitive care is the goal of the trauma system. However, there are circumstances (for example, airway management, rural environments, inclement weather) when triaging a patient to a closer facility for stabilization and transfer is the best option for accessing definitive care. Patients sustaining severe injuries in rural environments might need immediate assessment and stabilization before a long-distance transport to a trauma center. In addition, evaluation of the patient might bring to light severe injuries for which needed care exceeds the resources of the initial receiving facility. Some patients might have specific needs that can be addressed at relatively few centers within a region (for example, pediatric trauma, burns, severe TBI, SCI, and reimplantation). Finally, temporary resource limitations might necessitate the transfer of patients between acute care facilities.

Secondary triage at the initial receiving facility has several advantages in systems with a large rural or suburban component. The ability to assess patients at non-designated or level III to V centers provides an opportunity to limit the transfer of only the most severely injured patients to level I or II facilities, thus preserving a limited resource for patients most in need. It also provides patients with lesser injuries the possibility of being cared for within their community.

The decision to transfer a trauma patient should be based on objective, prospectively agreed-on criteria. Established transfer criteria and transfer agreements will minimize discussions about individual patient transfers, expedite the process, and ensure optimal patient care. Delays in transfer might increase mortality, complications, and length of stay. A system with an excess of transferred patients might tax the resources of the regional trauma facility. Conversely, inappropriate retention of patients at centers without adequate

facilities or expertise might increase the risk of adverse outcomes. Given the importance of timely, appropriate interfacility transfers, the time to transfer, as well as the rates of primary and secondary overtriage and undertriage, should be evaluated on a regular basis, and corrective actions should be instituted when problems are identified. Data derived from tracking and monitoring the timeliness of access to a level of trauma care commensurate with injury type and severity should be used to help define optimal system configuration.

A central communications center with real-time access to information on system resources greatly facilitates the transfer process. Ideally, this center identifies a receiving facility, facilitates dialogue between the transferring and receiving centers, and coordinates interfacility transport.

To ensure that the system operates at the greatest efficiency, it is important that patients are repatriated back to community hospitals once the acute phase of trauma care is complete. The process of repatriation opens up the limited resources available to care for severely injured patients. In addition, it provides an opportunity to bring patients back into their local environment where their social network might help reintegrate patients into their community.

#### **OPTIMAL ELEMENTS**

I. The trauma system is supported by an EMS system that includes communications, medical oversight, prehospital triage, and transportation; the trauma system, EMS system, and public health agency are well integrated. **(B-302)**

- a. There are mandatory systemwide prehospital triage criteria to ensure that trauma patients are transported to an appropriate facility based on their injuries. These triage criteria are regularly evaluated and updated to ensure acceptable and system-defined rates of sensitivity and specificity for appropriately identifying a major trauma patient. **(I-302.6)**
- b. There is a universal access number for citizens to access the EMS/trauma system, with dispatch of appropriate medical resources. There is a central communications system for the EMS/trauma system to ensure field-to-facility bidirectional communications, interfacility dialogue, and all-hazards response communications among all system participants. **(I-302.7)**
- c. There is a procedure for communications among medical facilities when arranging for interfacility transfers, including contingencies for radio or telephone system failure. **(I-302.9)**

II. Acute care facilities are integrated into a resource-efficient, inclusive network that meets required standards and that provides optimal care for all injured patients. **(B-303)**

- a. When injured patients arrive at a medical facility that cannot provide the appropriate level of definitive care, there is an organized and regularly monitored system to ensure that the patients are expeditiously transferred to the appropriate system-defined trauma facility. **(I-303.4)**

## CURRENT STATUS

In Alaska, prehospital trauma care and patient triage is highly variable and dependent on location of injury, regional resources and local protocols. As stated in the PRQ:

*“There are no statewide protocols for prehospital triage. The Trauma Triage, Transport & Transfer Guidelines developed by the Trauma System Planning and Development Task Force in 1993 and revised in 2002, offers guidelines to assist local EMS agencies and hospitals in developing local protocols. The protocols themselves are developed locally and approved by their medical director.”*

Trauma care delivery (as most health care in Alaska) is closely tied to geographic location which dictates resources, communication, and transportation. At least three distinct areas are identified based on models of trauma care delivery:

- *Bush area:* these remote areas are geographically isolated and have unique challenges including weather, no roads, and basic health care capabilities with few hospitals.
- *Anchorage area:* this urban environment is the major population center of the state and has several acute care hospitals, advanced infrastructure, and system redundancy in several segments. It is the primary health care referral area for the state for all Alaskans.
- *Southeast:* this area has intermediate capabilities compared to the 2 areas listed above and has a special relationship with Harborview Medical Center (Level I trauma center) in Seattle.

In addition to the geographic differentiation mentioned above, Alaska health care delivery can also be viewed in the context of populations (excluding the military):

- *Native Alaskans:* health care delivery to this population occurs across all geographic regions and is organized and administered by Alaska Tribal Health System/ Alaska Native Tribal Health Consortium, an integrated network of facilities and providers that deliver care to Native Alaskans as defined beneficiaries.

- Alaskans: health care delivery to this population occurs along more typical lines and involves a variety of hospitals and providers in varying density dependent on location and funding source.

Care to Native Alaskans and other Alaskans in the bush is overlapping, as many Alaskans receive primary and emergency care in Alaska Native clinics and hospitals when they are the only resources available. To a degree, some overlapping of trauma care for Native Alaskans and other Alaskans occurs within the Anchorage hospitals when by-pass or diversion causes a trauma patient to be directed to Alaska Native Medical Center or one of the non-certified/designated hospitals.

Many remote areas of the state are faced with unique challenges in the provision of trauma care. Providers and facilities have demonstrated creativity and resourcefulness in their attempt to overcome the problems of distance, limited resources, and communication challenges. This innovation and flexibility is to be commended, and it has been valuable and necessary.

In the more urban regions, such as Anchorage, the transition to more organized, efficient and coordinated systems of patient flow has not been complete. This has been reflected in frustrations expressed by local EMS services, referring physicians from outlying facilities, and members of the local physician provider community. Physicians described the problem of making multiple calls for transfer of a patient to an Anchorage hospital. In some cases Anchorage is by-passed and the patient is sent to Seattle. While there are two pediatric intensive care units in Anchorage hospitals, beds are sometimes unavailable, and children are sometimes sent to Seattle as well.

The situation is further complicated by the co-existence in the Anchorage area of a higher level of organized trauma care at the Alaska Native Medical Center (including a pediatric ICU), while the private not-for-profit hospitals (Providence Alaska Medical Center and Alaska Regional Hospital) maintain non-certified/designated trauma care facilities. All three hospitals serve as regional referral facilities for large areas of the state with Providence Alaska Medical Center receiving the largest volume of patients, including pediatrics. Local EMS as well as referring facilities throughout the state are faced with at least two differing sets of referral guidelines and triage criteria (for Native Alaskans and other Alaskans), as well as varying abilities to provide care to special populations (including burns, pediatrics, and vascular surgery).

In addition to the lack of statewide triage protocols, the flow of patients within the major treating facilities varies greatly. Available trauma registry data from 2006 show that at the designated Level II hospital, Alaska Native Medical Center, the majority of patients are admitted to surgical services. In contrast, at hospitals serving Alaskans, such as Providence Alaska Medical Center, which has the largest trauma patient volume, substantial numbers of patients are admitted to

non-surgical services. With the increase in hospital-based medical specialists (e.g., hospitalists), these trends are likely to have become pronounced. The care of trauma patients on non-surgical services without an organized trauma service is inconsistent with national guidelines, and it likely contributes to inferior outcomes such as longer ICU and hospital stays, higher complication and mortality rates, lower patient and provider satisfaction scores, and increased costs.

Significant divergence of opinion is apparent among providers at the private nonprofit hospitals in Anchorage regarding the need for, and value of, trauma center certification/designation and an organized trauma system. Emergency physicians expressed the opinion that they are able to deliver all aspects of initial care and obtain prompt surgical support, as well as the opinion that there were significant deficiencies in the availability and involvement of surgical specialists. As noted above, EMS services and referring physicians at outlying facilities participating in the TSC supported the latter perspective. Surgeons also expressed divided opinions regarding trauma center designation – surgeons at designated trauma centers are supportive while those at the non-designated facilities expressed serious concerns. Participants indicated that the provision of financial support for on-call responsibilities would facilitate the participation of private surgeons in meeting the certification/designation standards. The support of these groups of physicians would likely facilitate improvements in system coordination and patient flow.

It is recognized that Harborview Medical Center in Seattle provides important referral care for Alaska, especially for special populations (e.g., pediatrics, burns, reimplantation, and rehabilitation). Patient flow to Harborview appears to be relatively straightforward thanks to significant efforts by the receiving facility to treat Alaska patients preferentially and by the placement of fixed-wing aircraft in Southeast Alaska.

Within the state there are 79 ground ambulance units, 19 primarily fixed-wing air services, as well as civilian, Coast Guard, and military helicopters. Many of these units function under very difficult circumstances and succeed because of experience and innovation. No central coordinating agency or mechanism to manage these resources exists, and no easily accessible resource describing runways and equipment that can be used in each location is available.

Repatriation rarely occurs in this system, particularly for patients treated in Seattle.

## RECOMMENDATIONS

- **Implement standardized prehospital triage and trauma activation protocols customized to the three response areas (Anchorage, Southeast, and the bush).**

- Preserve the flexibility and encourage the innovation for trauma care that exists in the remote regions of the state.
- Develop an online resource describing available patient transport resources across the state.
- Encourage the adoption of standardized, evidence-based, in-hospital trauma team activation protocols.
- Develop inter-facility transfer criteria to ensure that patients with specialized needs are sent to facilities with matching resources.
- Maintain the existing effective relationship with Harborview Medical Center and develop strategies to improve Medicaid funding for transfers.



## ***Rehabilitation***

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### **Purpose and Rationale**

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As an integral component of the trauma system, rehabilitation services in acute care and rehabilitation centers provide coordinated care for trauma patients who have sustained severe or catastrophic injuries, resulting in long-standing or permanent impairments. Patients with less severe injuries may also benefit from rehabilitative programs that enhance recovery and speed return to function and productivity. The goal of rehabilitative interventions is to allow the patient to return to the highest level of function, reducing disability and avoiding handicap whenever possible. The rehabilitation process should begin in the acute care facility as soon as possible, ideally within the first 24 hours. Inpatient and outpatient rehabilitation services should be available. Rehabilitation centers should have CARF (Commission of Accreditation of Rehabilitation Facilities) accreditation for comprehensive inpatient rehabilitation programs, and accreditation of specialty centers (SCI and TBI) should be strongly encouraged.

The trauma system should conduct a rehabilitation needs assessment (including specialized programs in SCI, TBI, and for children) to identify the number of beds needed and available for rehabilitation in the geographic region. Rehabilitation specialists should be integrated into the multidisciplinary advisory committee to ensure that rehabilitation issues are integrated into the trauma system plan. The trauma system should demonstrate strong linkages and transfer agreements between designated trauma centers and rehabilitation facilities located in its geographic region (in or out of state). Plans for repatriation of patients, especially when rehabilitation centers across state lines are used, should be part of rehabilitation system planning. Feedback on functional outcomes after rehabilitation should be made available to the trauma centers.

#### **OPTIMAL ELEMENTS**

- I. The lead agency ensures that adequate rehabilitation facilities have been integrated into the trauma system and that these resources are made available to all populations requiring them. **(B-308)**
  - a. The lead agency has incorporated, within the trauma system plan and the trauma center standards, requirements for rehabilitation services, including interfacility transfer of trauma patients to rehabilitation centers. **(I-308.1)**

- b. Rehabilitation centers and outpatient rehabilitation services provide data on trauma patients to the central trauma system registry that include final disposition, functional outcome, and rehabilitation costs and also participate in performance improvement processes. **(I-308.2)**
- II. A resource assessment for the trauma system has been completed and is regularly updated. **(B-103)**
  - a. The trauma system has completed a comprehensive system status inventory that identifies the availability and distribution of current capabilities and resources. **(I-103.1)**

## CURRENT STATUS

While rehabilitation resources are available in Alaska, they are relatively limited in scope and capacity. The 20 inpatient rehabilitation beds in Alaska are all in the Anchorage (10 at Alaska Regional Hospital and 10 at Providence Alaska Medical Center). No pediatric rehabilitation beds for children under age 14 years exist in the state. Limited individual outpatient rehabilitation programs exist to support defined patient groups (e.g., traumatic brain injury [TBI]) at hospitals and in the community.

Patients with traumatic brain injury (adult and children 14 years and older) commonly utilize these rehabilitation beds in Anchorage, while most patients with spinal cord injury (SCI) are sent to spinal cord rehabilitation facilities in the lower 48 states. It was reported that patients wait approximately two days for an inpatient rehabilitation bed for TBI, and about 20 days for SCI; however this varies by patient status and availability of a funding source.

Harborview Medical Center in Seattle, WA provides significant support for rehabilitation services to injured patients from Alaska, including pediatric patients. This relationship is longstanding and well-developed, especially with acute care facilities in the Southeastern Alaska. Because Alaska Medicaid reimbursement rates are reportedly lower than Washington Medicaid rates, much of the care provided to patients with Alaska Medicaid transferred to Seattle is uncompensated or undercompensated.

Repatriation of patients transferred to rehabilitation centers is difficult and complicated by many variables (e.g., the cost of travel home, finding a physician to assume care responsibility). It was reported that patients transported out-of-state for rehabilitation frequently do not return to Alaska and that patients who are brought to Anchorage for rehabilitation services are likely to remain in the area.

No state data are available to evaluate the status of rehabilitation in Alaska. No needs assessment has been conducted to identify the rehabilitation needs of trauma patients in the state. Few data describe utilization, ultimate outcomes and dispositions of trauma patients requiring rehabilitation services. It is not clear that efforts are being made to include rehabilitation data and patient outcomes in the state trauma registry.

No rehabilitation specialist (physiatrist) sits on the TSRC.

## **RECOMMENDATIONS**

- Include rehabilitation outcomes in the trauma registry.
- Perform a needs assessment for rehabilitation of trauma patients in Alaska.
- Develop a comprehensive plan to provide a continuum of rehabilitation services from acute care settings to inpatient rehabilitation to outpatient services, especially for traumatic brain injury, spinal cord injury, and pediatric trauma.
- Appoint a rehabilitation specialist to membership in the newly formed Alaska Trauma Advisory Committee (ATAC).
- Encourage rehabilitation centers to attain CARF (Commission of Accreditation of Rehabilitation Facilities) accreditation.
- Evaluate repatriation options for patients transferred to Anchorage or out-of-state.

## ***Disaster Preparedness***

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### **Purpose and Rationale**

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As critically important resources for state, regional, and local responses to MCIs, the trauma system and its trauma centers are central to disaster preparedness. Trauma system leaders need to be actively involved in public health preparedness planning to ensure that trauma system resources are integrated into the state, regional, and local disaster response plans. Acute care facilities (sometimes including one or more trauma centers) within an affected community are the first line of response to an MCI. However, an MCI may result in more casualties than the local acute care facilities can handle, requiring the activation of a larger emergency response plan with support provided by state and regional assets.

For this reason, the trauma system and its trauma centers must conduct a resource assessment of its surge capacity to respond to MCIs. The resource assessment should build on and be coupled to a hazard vulnerability analysis. An assessment of the trauma system's response to simulated incident or tabletop drills must be conducted to determine the trauma system's ability to respond to MCIs. Following these assessments, a gap analysis should be conducted to develop statewide MCI response resource standards. This information is essential for the development of an emergency management plan that includes the trauma system.

Planning and integration of the trauma system with plans of related systems (public health, EMS, and emergency management) are important because of the extensive impact disasters have on the trauma system and the value of the trauma system in providing care. Relationships and working cooperation between the trauma system and public health, EMS, and emergency management agencies support the provision of assets that enable a more rapid and organized disaster response when an event occurs. For example, the EMS emergency preparedness plan needs to include the distribution of severely injured patients to trauma centers, when possible, to make optimal use of trauma center resources. This plan could optimize triage through directing less severely injured patients to lower level trauma centers or nondesignated facilities, thus allowing resources in trauma centers to be spared for patients with the most severe injuries. In addition, the trauma system and its trauma centers will be targeted to receive additional resources (personnel, equipment, and supplies) during major MCIs.

Mass casualty events and disasters are chaotic, and only with planning and drills will a more organized response be possible. Simulation or tabletop drills provide an opportunity to test the emergency preparedness response plans for the trauma system and other systems and to train the teams that will respond. Exercises must be jointly conducted with other agencies to ensure that all aspects of the response plan have the trauma system integrated.

#### **OPTIMAL ELEMENTS**

I. An assessment of the trauma system's emergency preparedness has been completed, including coordination with the public health agency, EMS system, and the emergency management agency. **(B-104)**

- a. There is a resource assessment of the trauma system's ability to expand its capacity to respond to MCIs in an all-hazards approach. **(I-104.1)**
- b. There has been a consultation by external experts to assist in identifying current status and needs of the trauma system to be able to respond to MCIs. **(I-104.2)**
- c. The trauma system has completed a gap analysis based on the resource assessment for trauma emergency preparedness. **(I-104.3)**

II. The lead agency ensures that its trauma system plan is integrated with, and complementary to, the comprehensive mass casualty plan for natural and manmade incidents, including an all-hazards approach to planning and operations. **(B-305)**

- a. The EMS, the trauma system, and the all-hazards medical response system have operational trauma and all-hazards response plans and have established an ongoing cooperative working relationship to ensure trauma system readiness for all-hazards events. **(I-305.1)**
- b. All-hazards events routinely include situations involving natural (for example, earthquake), unintentional (for example, school bus crash), and intentional (for example, terrorist explosion) trauma-producing events that test the expanded response capabilities and surge capacity of the trauma system. **(I-305-2)**
- c. The trauma system, through the lead agency, has access to additional equipment, materials, and personnel for large-scale traumatic events. **(I-305.3)**

## **CURRENT STATUS**

Alaska has an active geological environment with frequent earthquakes, extensive volcano eruptions, huge avalanches, periodic flooding and large expanses of fresh and salt water, all of which invite potential disaster. Two-thirds of Alaska is without roads and Alaskans are dependent on air travel for routine and emergent travel. Communication capabilities and disaster resources decrease as distance from population centers increases.

The lead agency for disaster preparedness is the Division of Emergency Services which resides within the Department of Military and Veterans Affairs, Division of Homeland Security and Emergency Management. The DHSS has primary functional responsibility for mass casualty events. Both agencies recognize the need for an effective trauma system as an integral component of disaster capability.

A recent full scale exercise, Alaska Shield/Northern Edge 2007 demonstrated strengths that included effective local interoperable communications equipment. However this interoperability does not necessarily transfer to the majority of the state. Weaknesses identified were lack of coordination of air transports and local/state/military resources, as well as lack of interagency coordination for resource requests and allocation during mass casualty events.

The state has no registry for volunteer medical providers, except for the Alaska Board of Nursing that maintains a registry of nurses who would volunteer to respond to a disaster. There are two Medical Reserve Corps in Alaska, but they are not functional due to lack of funding.

Some EMS providers have received disaster training, but they are not required to obtain or maintain such training.

## **RECOMMENDATIONS**

- **Integrate all components of the trauma system into state and local disaster planning activities.**
- Perform a detailed statewide communication assessment.
- Provide basic all-hazards disaster training for all prehospital providers that can be delivered via a variety of formats.

## ***Systemwide Evaluation and Quality Assurance***

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### **Purpose and Rationale**

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The trauma lead agency has responsibility for instituting processes to evaluate the performance of all aspects of the trauma system. Key aspects of systemwide effectiveness include the outcomes of population based injury prevention initiatives, access to care, as well as the availability of services, the quality of services provided within the trauma care continuum from prehospital and acute care management phases through rehabilitation and community reintegration, and financial impact or cost. Intrinsic to this function is the delineation of valid, objective metrics for the ongoing quality audit of system performance and patient outcomes based on sound benchmarks and available clinical evidence. Trauma management information systems (MISs) must be available to support data collection and analysis.

The lead agency should establish forums that promote inclusive multidisciplinary and multiagency review of cases, events, concerns, regulatory issues, policies, procedures, and standards that pertain to the trauma system. The evaluation of system effectiveness must take into account the integration of these various components of the trauma care continuum and review how well personnel, agencies, and facilities perform together to achieve the desired goals and objectives. Results of customer satisfaction (patient, provider, and facility) appraisals and data indicative of community and population needs should be considered in strategic planning for system development. System improvements derived through evaluation and quality assurance activities may encompass enhancements in technology, legislative or regulatory infrastructure, clinical care, and critical resource availability.

To promote participation and sustainability, the lead agency should associate accountability for achieving defined goals and trauma system performance indicators with meaningful incentives that will act to cement the support of key constituents in the health care community and general population. For example, the costs and benefits of the trauma system as they relate to reducing mortality or decreasing years of productive life lost may make the value of promoting trauma system development more tangible. A facility that achieves trauma center verification/designation may be rewarded with monetary compensation (for example, ability to bill for trauma activation fees) and the ability to serve as a receiving center for trauma patients. The trauma lead agency should promote ongoing dialog with key stakeholders to ensure that incentives remain aligned with system needs.

## OPTIMAL ELEMENTS

- I. The trauma MIS is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the trauma system, including a cost-benefit analysis. **(B-301)**
  - a. The lead trauma authority ensures that each member hospital of the trauma system collects and uses patient data, as well as provider data, to assess system performance and to improve quality of care. Assessment data are routinely submitted to the lead trauma authority. **(I-301.1)**
- II. The jurisdictional lead agency, in cooperation with other agencies and organizations, uses analytic tools to monitor the performance of population based prevention and trauma care services. **(B-304)**
- III. The financial aspects of the trauma system are integrated into the overall performance improvement system to ensure ongoing fine tuning and cost-effectiveness. **(B-309)**
  - a. Financial data are combined with other cost, outcome, or surrogate measures, for example, years of potential life lost, quality-adjusted life years, and disability adjusted life years; length of stay; length of intensive care unit stay; number of ventilator days; and others, to estimate and track true system costs and cost- benefits. **(I-309.4)**

## CURRENT STATUS

According to the PRQ, the TSRC is charged with “ongoing monitoring and evaluating of the trauma system”. Even though the actions of the TSRC are exempt from discovery, it is unclear that the TSRC has truly been empowered or authorized to perform its system evaluation and quality improvement functions. No clear line of authority could be identified in provided documentation for the TSRC to recommend or impose system change. The PRQ illustrates this challenge in the following statement:

“The TSRC has reported findings to the Lead Agency, ACEMS and liaisons, EMS regional coordinators, and trauma care providers via the Annual EMS Symposium... In special circumstances, such as the advancement of a Trauma System Improvement Act, members of the TSRC have shared information with legislators... The TSRC may make recommendations to the Lead Agency and constituent members of the trauma system”.



The uncertainty of lines of authority is further exacerbated by the fact that the TSRC formally operates under the aegis of the Alaska State Medical Board.

When asked about specific evaluation and quality assurance processes, the stakeholders present acknowledged that they have neither determined Alaska's preventable mortality rate nor quantified the opportunities for improvement by phase of care.

The TSRC has made significant contributions to the standardization of care through the development of documents such as "Guidelines for the Management and Transfer of Head Injury Patients in Remote and Rural Alaska". However, the impact of this and other guidelines has not been monitored, and adherence to the guidelines was reported as variable. There has not been "loop closure" on these efforts.

The TSRC identified nine indicators of interest and initiated efforts to examine the data necessary to determine the status of those indicators. However, during the first pass of the data, it was reported that the data were of insufficient quality to answer the questions posed by the indicator. Additional data cleaning was needed.

While it was reported that a major impediment to system evaluation and quality assurance was either the lack or quality of data, the ACS team was able to request and receive trauma registry data (2006) that was sufficiently detailed to engage in rudimentary evaluation processes, e.g., stratification of trauma patients by facility and by ISS. While the data are aging, these data serve as a fundamental building block of a system evaluation process.

## RECOMMENDATIONS

- **Develop an initial set of 3-5 statewide system performance indicators from among the list of 9 provided in the Pre-Review Questionnaire (PRQ).**
- Examine available data points and definitions, and develop indicators for performance improvement that can be determined on the basis of those data points.
- Formally review the data associated with each indicator on a quarterly to annual basis and start a benchmarking process.
- Report the results of all evaluation and quality assurance processes in an annual report that is presented to all system stakeholders, including the new Alaska Trauma Advisory Committee (ATAC) and Alaska Council on Emergency Medical Services (ACEMS).

## ***Trauma Management Information Systems***

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### **Purpose and Rationale**

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Hospital-based trauma registries developed from the idea that aggregating data from similar cases may reveal variations in care and ultimately result in a better understanding of the underlying injury and its treatment. Hospital-based registries have proven very effective in improving trauma care within an institution but provide limited information regarding how interactions with other phases of health care influence the outcome of an injured patient. To address this limitation, data from hospital-based registries should be collated into a regional registry and linked such that data from all phases of care (prehospital, hospital, and rehabilitation) are accessible in 1 data set. When possible, these data should be further linked to law enforcement, crash incident reports, ED records, administrative discharge data, medical examiner records, vital statistics data (death certificates), and financial data. The information system should be designed to provide systemwide data that allow and facilitate evaluation of the structure, process, and outcomes of the entire system; all phases of care; and their interactions. This information should be used to develop, implement, and influence public policy.

The lead agency should maintain oversight of the information system. In doing so, it must define the roles and responsibilities for agencies and institutions regarding data collection and outline processes to evaluate the quality, timeliness, and completeness of data. There must be some means to ensure patient and provider confidentiality is in keeping with federal regulations. The agency must also develop policies and procedures to facilitate and encourage injury surveillance and trauma care research using data derived from the trauma MIS. There are key features of regional trauma MISs that enhance their usefulness as a means to evaluate the quality of care provided within a system. Patient information collected within the management system must be standardized to ensure that noted variations in care can be characterized in a similar manner across differing geographic regions, facilities, and EMS agencies. The composition of patients and injuries included in local registries (inclusion criteria) should be consistent across centers, allowing for the evaluation of processes and outcomes among similar patient groups. Many regions limit their information systems to trauma centers. However, the optimal approach is to collect data from all acute care facilities within the region. Limiting required data submission to hospitals designated as trauma centers allows one to evaluate systems issues only among patients transported to appropriate facilities. It is also important to have protocols in place to ensure a uniform approach to data abstraction and collection. Research suggests that if the process of case abstraction is not routinely calibrated, practices used by abstractors begin to drift.

Finally, every effort should be made to conform to national standards defining processes for case acquisition, case definition (that is, inclusion criteria), and registry coding conventions. Two such national standards include the National Highway Traffic Safety Administration's National Emergency Medical Services Information System (NEMSIS), which standardizes EMS data collection, and the American College of Surgeons National Trauma Data Standard, which addresses the standardization of hospital registry data collection. Strictly adhering to national standards markedly increases the value of state trauma MISs by providing national benchmarks and allowing for the use of software solutions that link data sets to enable a review of the entire injury and health care event for an injured patient.

To derive value from the tremendous amount of effort that goes into data collection, it is important that a similar focus address the process of data reporting. Dedicated staff and resources should be available to ensure rapid and consistent reporting of information to vested parties with the authority and vision to prevent injuries and improve the care of patients with injuries. An optimal information reporting process will include standardized reporting tools that allow for the assessment of temporal and/or system changes and a dynamic reporting tool, permitting anyone to tailor specific "views" of the information.

#### **OPTIMAL ELEMENTS**

I. There is an established trauma MIS for ongoing injury surveillance and system performance assessment. **(B-102)**

- a. There is an established injury surveillance process that can, in part, be used as an MIS performance measure. **(I-102.1)**
- b. Injury surveillance is coordinated with statewide and local community health surveillance. **(I-102.2)**
- c. There is a process to evaluate the quality, timeliness, completeness, and confidentiality of data. **(I-102.4)**
- d. There is an established method of collecting trauma financial data from all health care facilities and trauma agencies, including patient charges and administrative and system costs. **(I-102.5)**

II. The trauma MIS is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the trauma system, including a cost-benefit analysis. **(B-301)**

- a. The lead trauma authority ensures that each member hospital of the trauma system collects and uses patient data, as well as provider data, to assess system performance and to improve quality of care. Assessment data are routinely submitted to the lead trauma authority. **(I-301.1)**

- b. Prehospital care providers collect patient care and administrative data for each episode of care and not only provide these data to the hospital, but also have a mechanism to evaluate the data within their own agency, including monitoring trends and identifying outliers. **(I-301.2)**
- c. Trauma registry, ED, prehospital, rehabilitation, and other databases are linked or combined to create a trauma system registry. **(I-301.3)**
- d. The lead agency has available for use the latest in computer/technology advances and analytic tools for monitoring injury prevention and control components of the trauma system. There is reporting on the outcome of implemented strategies for injury prevention and control programs within the trauma system. **(I-301.4)**

### **CURRENT STATUS**

The State of Alaska has worked diligently over several decades to develop, maintain, and improve a systemwide trauma registry. This has meant an evolutionary process involving at least two vendors and substantial challenges in linking disparate computer languages that exist in the Native Alaskan and other Alaskan record keeping systems. The State is to be commended for its persistence in this regard.

The lead agency maintains a full-time trauma registrar which represents, in fact, the most significant personnel commitment dedicated to the trauma program. Funds to support this position come from external sources (NIOSH).

Currently all hospitals contribute to the statewide trauma registry. For the larger facilities, this involves electronic data transfer. However, for the smaller facilities, the process involves on-site abstraction of records, completion of a data abstract summary, and manual input into the system. A contract employee is assigned the responsibility of facilitating this process. She described multiple challenges at some of the smaller hospitals, such as limited personnel resources for abstracting, enormous travel distances and costs for her to visit the hospitals, a reluctance by the hospitals to ask for or accept consultative help, and persistent turnover of data registrars at the hospitals. These challenges result in a significant delay (up to 2 years) in acquiring trauma data from all acute care facilities. In some cases, the consultant performs data abstraction at some of the smaller hospitals in an effort to get data submission caught up.

A second contract employee is used to clean and validate the data. She demonstrated significant adeptness with the system registry data by fulfilling several requests of the ACS team during their deliberations. For example, she was able to easily stratify injury severity by hospital and track transfers in and out of each facility. The contract employees are responsible for an annual training of trauma registrars.

During the discussion of the management information system, it was revealed that recently a new trauma registry vendor has received the Alaska contract. There was substantial discordance with the manner in which the vendor was selected, with the end-users (e.g., registrars, trauma managers, trauma directors, and the TSRC) having little to no input into the process. While data input into the new system is tentatively scheduled to begin January 1, 2009, concern was expressed by participants that during the transition period there was the potential for data to be delayed or, perhaps, even lost. Several participants suggested that they might maintain their current system in lieu of using the newly acquired system.

One of the perceived advantages of the new trauma system is that it can, and will, be linked with electronic prehospital data since the same vendor holds a single contract for the provision of both systems. The effectiveness of this linkage could not be fully ascertained at the time of the ACS visit since the systems were only then “coming on-line”. However, it is important to note that similar efforts by other states to link the trauma registry and prehospital data systems have not been universally successful, even when the same vendor has been used for each system. The IPEMS Section will need to work closely with the vendor to monitor progress in meeting contract expectations. The state is to be commended for obtaining a grant that will enable the lead agency to perform additional linkage with other, free standing, data sets such as the traffic crash database.

Alaska has a data rich environment. Numerous other databases exist and have been used for epidemiologic and prevention activities. However, they have only been used in a limited capacity to help steer and manage the trauma system.

Specific policies and procedures have been developed by the TSRC concerning the release of trauma registry data. Several researchers have accessed the data system following these guidelines.

## RECOMMENDATIONS

- **Ensure that all elements considered essential to system development, evaluation and performance improvement in the State of Alaska are evident and working in the new trauma registry and are consistent with the National Trauma Data Standard (NTDS) definitions.**
  - This should be tasked to a peer review protected subcommittee, (e.g. the Trauma System Review Committee) of the Alaska Technical Advisory Committee (ATAC), in collaboration with the trauma registrar, trauma registrar contract employees, and the vendor.
- Safeguard the legacy data by maintaining the current software system separately and discretely from the new system until a legacy data transfer has occurred and validation queries have been completed.

- Minimize gaps and delays in data during the trauma registry transition process by maintaining dual systems until the transfer of legacy and concurrent data has been completed and validated.
- Establish mechanisms for capturing data from remote facilities in a timely manner, e.g., provide scanners and/or encrypted methods of electronic transmission of records in lieu of travel to each facility.
- Submit statewide trauma registry data to the National Trauma Data Bank (NTDB) on an annual basis.
- Achieve linkage and integration with other data sets, specifically, prehospital and hospital discharge data (UB 92/04).
- Use existing data, beginning immediately, for system development and quality improvement activities, in spite of its acknowledged imperfections.
- Provide reports on at least a quarterly basis to all stakeholders.

## **Research**

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### **Purpose and Rationale**

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#### ***Overview of Research Activity***

Trauma systems are remarkably diverse. This diversity is simply a reflection of authorities tailoring the system to meet the needs of the region based on the unique combination of geographic, economic, and population characteristics within their jurisdiction. In addition, trauma systems are not fixed in their organization or operation. The system evolves over years in response to lessons learned, critical review, and changes in population demographics. Given the diversity of organization and the dynamic nature of any particular system, it is valuable when research can be conducted that evaluates the effectiveness of the regional or statewide system. Research drives the system and will provide the foundation for system development and performance improvement. Research findings provide value in defining best practices and might alter system development. Thus, the system should facilitate and encourage trauma-related research through processes designed to make data available to investigators. Competitive grants or contracts made available through lead authorities or constituencies should provide funds to support research activities. All system components should contribute to the research agenda. The extent to which research activities are required should be clearly outlined in the trauma system plan and/or the criteria for trauma center designation.

The sources of data used for research might be institutional and regional trauma registries. As an alternative, population-based research might provide a broader view of trauma care within the region. Primary data collection, although desirable, is expensive but might provide insights into system performance that might not be otherwise available.

#### ***Trauma Registry-based Research***

Investigators examining trauma systems can use the information recorded in trauma registries to great advantage to determine the prevalence and annual incidence rate of injuries, patterns of care that occur to injured patients in the system's region, and outcomes for the patients. These data can be compared with standards available from other trauma registries, such as the NTDB. Such comparisons can then enable investigators to determine if care within their region is within standards and can allow for benchmarking. Initiating and sustaining injury prevention initiatives is a vital goal in mature trauma systems. Investigators can take a leadership role in performing research using trauma registry data that identify emerging threats and instituting public health measures to mitigate the threats. For example, a recent surge in death and disability related to off-road

vehicles can be identified and the scope of the problem defined in terms of who, where, and how riders are injured, and then, through presentations and publications, the public can be informed of a new threat.

Trauma system administrators have a responsibility to control investigators' access to the registry. The integrity and reliability of data in a trauma systems registry are essential if accurate research and valid conclusions are to be reached using the data. Trauma system administrators should have a process that screens data entered into the system's composite registry from individual institutions. There should be a mechanism that ensures that the information is stored in a secure manner. Investigators who seek access to the trauma registry must follow a written policy and procedure that includes approval by an authorized institutional review board. Trauma registry data may include unique identifiers, and system administrators must ensure that patient confidentiality is respected, consistent with state and federal regulations.

### ***Population-based Trauma System Research***

A major disadvantage of using only trauma registry data to conduct research that evaluates injured patients in a region is the bias resulting from missing data on patients not treated at trauma centers. Specifically, most registry data are restricted to information from hospitals that participate in the trauma system. Although ideally all facilities participate in the form of an inclusive system, many systems do not attain this goal. Thus, a population-based data set provides investigators with the full spectrum of patients, irrespective of whether they have been treated in trauma centers or nondesignated centers or were never admitted to the hospital owing to death at the scene of incident or because their injuries were insufficiently severe to require admission. The state and national hospital discharge databases are examples of population-based data. These discharge databases contain information that was abstracted from medical records for billing purposes by hospital employees who enter these data into an electronic database. For investigators seeking a wider perspective on the care of injured patients in their region, these more inclusive data sets, compared with registries, are essential tools. Other population based data that may be of help include mortality vital statistics data recorded in death certificates. Selected regions might have outpatient data to capture patients who are assessed in the ED and then released.

Investigators can use these population-based data to study the influence of a regional trauma system on the entire spectrum of patients within its catchment area.



### ***Participation in Research Projects and Primary Data Collection***

Multi-institutional research projects are important mechanisms for learning new knowledge that can guide the care of injured patients. Investigators within trauma systems can participate as co-investigators in these projects. Investigators can participate by recruiting patients into prospective studies, being leaders in the design and administration of grants, and preparing manuscripts and reports. Evidence of this collaboration is that investigators within a trauma system are recognized in announcements of grants or awards. Lead agency personnel should identify and reach out to resources within the system with research expertise. These include academic centers and public health agencies.

### ***Measures of Research Activity***

Research can be broadly defined as hypothesis-driven data analysis. This analysis leads the investigators to a conclusion, which might become a recommendation for system change. Full manuscripts published in peer reviewed research journals are an exemplary form of research activity. Research reported in annual reviews or in public information formats intended to inform the trauma system's constituency can also be considered legitimate research activity.

#### **OPTIMAL ELEMENTS**

- I. The trauma MIS is used to facilitate ongoing assessment and assurance of system performance and outcomes and provides a basis for continuously improving the trauma system, including a cost-benefit analysis. **(B-301)**
  - a. The lead agency has available for use the latest in computer/technology advances and analytic tools for monitoring injury prevention and control components of the trauma system. There is reporting on the outcome of implemented strategies for injury prevention and control programs within the trauma system. **(I-301.4)**
- II. The lead agency ensures that the trauma system demonstrates prevention and medical outreach activities within its defined service area. **(B-306)**
  - a. The trauma system has developed mechanisms to engage the general medical community and other system participants in their research findings and performance improvement efforts. **(I-306.1)**
  - b. The effect or impact of outreach programs (medical community training/support and prevention activities) is evaluated as part of a system performance improvement process. **(I-306.3)**
- III. To maintain its state, regional, or local designation, each hospital will continually work to improve the trauma care as measured by patient outcomes. **(B-307)**

- a. The trauma system implements and regularly reviews a standardized report on patient care outcomes as measured against national norms. **(I-307.2)**

#### **CURRENT STATUS**

A specific research agenda has not been developed for the Alaska trauma system. However, a reasonable representation of trauma-related literature can be found using an electronic medical literature search. Several articles use the trauma registry as a basis of data. Unfortunately, most of the articles are aging. Several are published in *Alaska Medicine*, which reportedly is changing from a quarterly publication to an annual publication.

A wealth of scientific and technical publications has been produced in the Alaska injury prevention literature. Again several of these publications use trauma registry data, at least partially, as a basis for the publications.

The University of Alaska – Anchorage currently offers a Master of Public Health (MPH) degree within its Department of Health Sciences. Linkages between the MPH program and the trauma system were not discussed. The lead agency has direct access to a staff epidemiologist.

#### **RECOMMENDATIONS**

- Establish a collaborative relationship between the University of Alaska-Anchorage's public health program and the lead agency's epidemiologist and the Alaska Trauma Advisory Committee (ATAC).
- Develop, jointly, a research agenda that can build on the current trauma registry data and expand to include more rigorous research projects.
- Attempt to minimize Institutional Review Board approval challenges while still maintaining full protection of any/all subjects.

## Focus Questions

### 1. How can Alaska attain full participation of hospitals in the statewide trauma system?

Trauma centers and trauma systems have been demonstrated to decrease mortality following injury.<sup>1,2,3</sup> All of the acute care hospitals in Alaska are currently providing care for injured patients. However; trauma patients in Alaska who are not Native Alaskans do not have routine access to a verified/designated Level I or II trauma center. A trauma system will fully attain the benefits of improved patient care and superior outcomes only when all facilities institute and follow evidence-based guidelines to decrease variability in care and deviations from the standard of care. Central to this evolution is the implementation of a rigorous, multidisciplinary performance improvement program. A coordinated system of trauma care within acute care facilities accomplishes the following:

- improved communications,
- streamlined coordination of care issues,
- increased physician satisfaction,
- a sense of pride in trauma care providers throughout the facility, and
- the community is reassured that everything possible is being done to provide them state-of-the art trauma care.

Trauma systems have been well studied, and these studies form the basis for the recommendations and guidelines found in the ACS-COT *Resources for Optimal Care of the Injured Patient* document.

Hospitals, healthcare providers, and physicians in Alaska are already providing trauma care. The adoption of an inclusive trauma system with verified/designated trauma centers would enable facilities in the state to provide trauma care to all Alaskans with less variability in care, better patient outcomes, lower resource utilization, and higher patient and provider satisfaction. In many cases, trauma care within an organized and verified trauma center also results in lower costs as evidence-based practice replaces less efficient practice patterns.

Only five hospitals are currently verified/designated trauma centers in Alaska. Reasons expressed by participants for not becoming verified and designated are varied but fall into two main categories:

- Administrator's concerns regarding increased costs to be borne by the hospital and the potential impact on the medical staff
- Lack of broad physician support

### **Administrators' concerns**

Administrators' concerns involve a number of issues related to trauma center verification:

- Multi-system trauma patients require an organized system of care for optimal outcomes which increases institutional readiness costs.
- "Poor" uninsured case mix of trauma patients.
- Effect on hospital operations such as disruption of operating room schedules, filling ICU beds, etc.
- Physicians tend to be reluctant to participate and may elect to abandon a hospital that seeks designation.

### **Lack of physician support**

Medical staff support for trauma center verification tends to be lukewarm at private hospitals for a number of reasons:

- Trauma patients have higher rates of uncompensated care than "elective" patients.
- Trauma patients are more likely to sue a physician (unfounded).
- The care of trauma patients imposes undue burdens including night and weekend work, and this care is generally disruptive of elective practices.

To address the above mentioned concerns, a number of issues should be openly discussed by key representatives of the identified groups, and a variety of solutions should be considered. It is likely that no one answer fits every situation and a combination of flexibility and transparency is needed.

While it is true that verification/designation as a trauma center requires commitment by administration and medical staffs, the benefits in improved patient outcomes, decreased complication rates and length of stay, and increased patient and provider satisfaction can outweigh the costs. In the case of the hospitals and physicians in Alaska who are already providing trauma care, an inclusive trauma system would likely make trauma care easier and less costly.

The cost of readiness is significant in trauma centers and may be addressed through several means. The recently introduced trauma activation fees using the 68x designation on the UB 92/UB 04 form can relieve a significant portion of these costs. Trauma activation fees can only be submitted if the center is verified/designated. A number of states have provided financial support to their trauma centers through legislation or appropriations. State financial support for trauma care is usually linked to trauma center verification/designation and continued participation in an organized trauma system. Trauma center verification/designation carries important benefits to hospitals in terms of disaster

preparedness, and this may be especially relevant in Alaska given its unique geography and circumstances.

The issues of poor case mix and disruption of hospital operations are best addressed by considering the impact of verification/designation on hospital functions. For a hospital that is already caring for trauma patients, the introduction of a trauma system will likely mean an overall increase in the efficiency of caring for these patients, secondary to improvements required in the verification process. Decreased ICU and hospital length of stay, lower resource consumption and lower rates of complications will improve hospital bottom lines while increasing patient and provider satisfaction.

Physician concerns should be carefully addressed as a functional trauma system requires broad physician support. This is especially true for the specialties of general surgery (including pediatric surgery), orthopedic surgery, neurosurgery, anesthesia and emergency medicine. The Anchorage area hospitals have ample physician specialization to provide optimal care with the following estimated numbers:

- 30 surgeons, many sub-specialized.
- 40 orthopedists
- 6 neurosurgeons
- 4 cardiac surgeons
- 2 pediatric surgeons

Education can alleviate the concerns that trauma patients are more litigious than average.

The concerns regarding reimbursement and work hours are real and require more focused solutions. Trauma patients do, in fact, have higher rates of uncompensated care than elective patients in almost all regions of the United States. They are also more likely to arrive during evening and night hours.<sup>4</sup> The specific concerns of physicians should be acknowledged and actions should be taken to address them. For hospitals, actions may include one or more of the following options:

- Provide an on-call stipend to cover the perceived burden of trauma call. This would include high volume specialists who are not ordinarily in-house and who agree to participate in the activities of the trauma center, including performance improvement and continued medical education (CME). Most frequently this would include general surgery, orthopedics, and neurosurgery.

- Recruit one or more trauma/surgical critical care specialists to provide the core trauma care functions. Such individuals would support the private physicians and decrease their burden by providing back-up, assuming the care of patients admitted to the hospital, and taking responsibility for organizing the requisite activities for verification. By providing an actual trauma service with a specialized team led by a trauma/surgical critical care boarded specialist, the community surgeon can transfer patient care the following morning and feel confident the patient will receive state-of-the-art care. This frees the private physician to continue with his/her surgical practice. The specialist-led trauma service would improve care by decreasing variability, complications, length of stay and dissatisfaction.
- Support the private physicians through CME expenses, liability coverage, or a fund to cover a portion of uncompensated care exposure.

While this will require substantial financial support from hospital administration initially, the improvement in outcomes and the increase in patient and provider satisfaction should return at least a portion of the investment. Additional revenue through activation fees and state support would also contribute to deferring any start-up and readiness costs. Providing hospitals and physicians with financial support as part of a proposed inclusive trauma system plan will likely facilitate the adoption of trauma center verification/designation.

In addition, the implementation of an inclusive trauma system in Alaska with broad hospital participation would provide a critical element in disaster preparedness.<sup>5</sup> The vital role of trauma centers in support of disaster management should also be a central part of any funding requests to the legislature.

#### **RECOMMENDATIONS:**

- Verify/designate all the medical facilities in Anchorage who wish to provide trauma care at levels commensurate with these resources and commitment
- Develop city-wide trauma triage guidelines for Anchorage with further application to the needs of in-coming transfer patient.
  - Establish a predetermined plan that accounts for subspecialty needs of the patient matched with the hospitals' capabilities.
  - Establish trauma diversion guidelines with back-up plans.

- Develop evidence-based trauma team activation criteria
  - Use the “status 1” only when there is prehospital physiologic evidence that the patient requires an immediate surgical response.
  - Start tracking surgical response times for “status 1” patients from time of notification. Benchmark to the ACS verification guideline of a surgeon being present on arrival of patient or within 15 minutes of notification. The threshold is to meet this 80% of the time.
  - Study outcomes associated with use of the criteria to further refine them for optimal patient outcomes with minimal physician encumbrance.
- Identify physician leadership – trauma champions
  - Encourage Level II trauma centers (or hospitals that seek to become Level II trauma centers) to consider recruiting a trauma/surgical critical care specialist who can provide a knowledgeable back-up for sub-specialized surgeons who may or may not be comfortable with caring for a multi-system critically injured patient.
- Develop trauma chart forms
  - Establish standardized trauma patient admission orders. Establish automatic orders for glucose monitoring and control, peptic ulcer prophylaxis, deep vein thrombosis prophylaxis and surveillance, head injury protocols, etc.
  - Ensure that trauma history and physical forms have prompts for problem documentation areas such as Glasgow Coma Scale scores, procedures performed, notification and arrival times, critical care times, etc.
- Address finance issues
  - Encourage medical facilities to invest in the trauma service to obtain and maintain verification/designation.
    - Recruit and retain trauma/critical care specialists.
    - Initiate discussions with general surgeons to identify their needs to be able to provide the call coverage and to identify patient care issues.
    - Track costs that can be recouped by improved patient length of stay, decreased cost of care, and the value of improved medical staff satisfaction.
  - Charge trauma activation fees (can only be charged by verified/designated centers).
  - Seek legislation to include assistance for uncompensated care and readiness fees for verified/designated trauma centers.

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## **2. How can Alaska better coordinate resources, especially air medical, for every day trauma responses, as well as disaster response?**

### Assessment:

Alaskans depend on aircraft for routine travel and medical transport, especially those who reside in the isolated two-thirds of the state without roads. At any given place or time, local providers are familiar with local resources available, but may not know about back-up resources available in the region. Local providers may then be challenged to make multiple calls when their primary local air medical resource is not available.

Coordinating trauma care resources in the state of Alaska requires current knowledge of the status of those resources, e.g., personnel, equipment, communication, facilities. To date, a comprehensive needs or resource assessment of the trauma system has not been conducted. While some of this information is available, such as for facilities, it is lacking for other aspects of the trauma system, such as air medical resources.

### Policy Development:

Once an air medical resource assessment has been completed, information collected about all trauma system resources (including military, National Guard, and Coast Guard) should be organized by region and made available to users in an easily retrieved format. A central coordination center could then be created to track the air medical assets available and in use throughout the state, and this information could potentially be available on-line. Likewise, the EMS regions could develop and maintain a regional resource information database that could be updated regularly.

The next step could be the establishment of a regional “one call does all” service. Such services could assist a referring provider to obtain the aircraft that matches the patient’s need and local landing restrictions. The regional service could also help direct community-based air medical resources to available and appropriate facilities and assist in the coordination of ramp transfers. The “one call does all” concept includes the identification of the receiving trauma facility that best matches the patient’s needs.

The regional centers would feed information about the aircraft deployed to the central coordination hub. This coordination hub would be useful in a state disaster, and could potentially be maintained by the state’s emergency management system. This type of statewide system status coordination hub would need to be operable and accessible at all hours and be updated in near real-time.

Another problem that the state faces is the lack of comprehensive guidelines for the indications of air medical transport. The reality is that urgent or even routine, non-emergent medical care not available in the local community may require air

travel. Development of guidelines will help ensure the optimal use of the air resources in a safe and efficient manner.

Assurance:

This service could optimize resource utilization locally and statewide on a continuous basis. Performance improvement could be conducted using trauma registry data to determine changes in time to transfer, and appropriateness of facility selection.

**Recommendations**

- Decrease patient transfer times by developing a central coordination center for statewide air medical resources that will maintain an updated registry of all medical aircraft to include medical services and flight characteristics (e.g., load capacity, instrument rating, and landing requirements).
  - Monitor the availability and location of air resources.
  - Provide availability status to users.
  - Coordinate air medical resources in a disaster situation.
- Develop regional system status databases of current trauma resources that are utilized to provide a 'one call does all' service for referring providers and support a statewide trauma resources data bank.
- Develop a state registry for disaster volunteers, similar to the Emergency System for Advanced Registration of Volunteer Health Professionals.
- Update and keep current the Trauma Triage, Transport and Transfer Guidelines.
- Use the Guidelines for the Management of Head Injuries in Remote and Rural Alaska as a template to develop other transport guidelines to optimize resources.
- In more populated areas with more than one healthcare facility, develop a tracking system of real time bed capacity for time sensitive diseases (trauma, ST elevated myocardial infarction [STEMI], stroke, etc.) and share that information with EMS dispatch in order to prevent delays or mistakes in patient destination (right patient to right facility).

## **Acronyms and Glossary**

AAC - Alaska Administrative Code  
ACEMS - Alaska Council on Emergency Medical Services  
ACS – American College of Surgeons  
ACS-COT- American College of Surgeons Committee on Trauma  
ALS – advanced life support-+  
ATAC - Alaska Trauma Advisory Committee  
ATLS – Advanced Trauma Life Support

BIS – Benchmarks, Indicators, and Scoring  
BLS – basic life support

CARF - Commission on Accreditation of Rehabilitation Facilities  
CDC – Centers for Disease Control  
CHAs – Community health aides  
CME – continuing medical education

DHSS – Department of Health and Social Services  
DOT – US Department of Transportation

EMS – Emergency Medical Services  
EMSC – Emergency Medical Services for Children  
EMTs – Emergency medical technicians

FTE – full-time equivalent

HRSA - Health Resources and Services Administration

ICU – intensive care unit  
IPEMS – Injury Prevention and Emergency Medical Services Section

MICPs – Mobile intensive care paramedics  
MPH – Master of Public Health degree

NEMSIS – National EMS Information System  
NIOSH - National Institute for Occupational Safety and Health  
NSC – National Standard Curriculum for EMTs  
NTDB – National Trauma Data Bank  
NTDS – National Trauma Data Standard

PHTLS – Prehospital Trauma Life Support

SCI – spinal cord injury  
STEMI - ST-Segment Elevation Myocardial Infarction  
STIPDA – State and Territorial Injury Prevention Directors Association

TBI – traumatic brain injury  
TNCC – Trauma Nurse Core Curriculum  
TSC – Trauma system consultation  
TSRC - Trauma System Review Committee

## **Alaska Council on Emergency Medical Services (ACEMS)**

The mission of the Emergency Medical Services program in Alaska is to reduce both the human suffering and economic loss to society resulting from premature death and disability due to injuries and sudden illness. The Governor's Alaska Council on Emergency Medical Services, also known as "ACEMS," provides the Commissioner of the Department of Health and Social Services and the Governor with recommendations related to all aspects of EMS, including distribution of funding, and policy development. The Council:

- brings together technical resources, experience, and knowledge to assist and advise on the continued development of the EMS and trauma system in Alaska;
- advises the state EMS staff and EMS regional directors regarding public education and generation of broad community support for the goals of the EMS program;
- provides recommendations regarding EMS program policy and priorities; and
- reviews EMS or EMS-related program proposals on request of the Commissioner of the Department of Health and Social Services, the Director of the Division of Public Health, and Section of Injury Prevention and EMS staff.

ACEMS was established by Alaska Statute 18.08 and meets two times a year to take action on issues affecting EMS in Alaska.

# Alaska Council on Emergency Medical Services

As of 9/2008

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<b>Terry Smith</b> Department of Veterans Affairs Division of the Emergency Services P.O. Box 5750 Fort Richardson, AK 99505 PH# FAX# _____@_____._____ Appointed: 10/4/02	Division of Emergency Services
<b>Ken Zafren, MD</b> 10181 Curvi Street Anchorage, AK 99516 PH# FAX# <a href="mailto:zafren@alaska.com">zafren@alaska.com</a> Appointed: 10/21/01	State EMS Medical Director



## **Appendix A: Site Visit Team Biographical Sketches**

**REGINALD A BURTON, MD, FACS- TEAM LEADER**

Dr. Burton started his Trauma career while in high school when he got his first EMT certification. He worked as an EMT throughout college and medical school to offset his tuition. He and his wife, Dr. Snyder, moved to Ohio after finishing his residency in Surgery in 1992.

Dr. Burton was very active in the establishment of the Trauma System in Ohio. He developed and was the Trauma Director of the first ACS verified level III trauma center in Ohio, while continuing to participate in trauma call at the Level I trauma center in Dayton. He gave numerous lectures throughout the state on trauma center development, trauma center Performance Improvement programs, and EMS/Hospital integration of trauma plans. He became the medical director for the Fire/EMS services in two surrounding cities and sat on the regional EMS Council. He was the Co-Chairman of the Southwest Ohio Regional Trauma System from 1997 until 2002. He was the Chairman of the Region 2 Physician Advisory Board to the Ohio State Trauma Board for 5 years until he moved to Nebraska. He sat on the Data Committee of the Ohio Trauma Board during the statewide trauma registry development, and helped work out many issues enabling it to start functioning 2000.

Dr. Burton took a sabbatical and did a Trauma/Surgical Critical Care Fellowship at the renowned R. Adams Cowley Shock Trauma Center in Baltimore Maryland in 2006-7, and is currently the Director of Trauma and Surgical Critical Care at Bryan LGH Medical Center in Lincoln, Nebraska. He is a Clinical Associate Professor in Surgery at the University of Nebraska. He is the Medical Director of Region 2 in the Nebraska Statewide Trauma System, Chair of the Nebraska Statewide Trauma Data and Performance Improvement Committee, and the author of the Nebraska Trauma Performance Improvement training workshop. His team developed a web-based trauma registry reporting system that has enabled small critical access hospitals in rural Nebraska to report their trauma data to the Nebraska Statewide Trauma Registry, and thus also to the National Trauma Data Bank.

Dr. Burton has been a site visitor for the ACS Verification Committee since 2000. He became the Chairman of the Nebraska ACS Committee on Trauma in 2002, and is the current Regional Chief of Region 7(Nebraska, Kansas, Missouri, and Iowa). Dr. Burton was also involved in the ACS Political Action Taskforce briefing on trauma issues to state senators and congressmen in Washington, D.C. in March, 2005. He was the ACSCOT representative to the National EMS Workforce Stakeholders Meeting and the HHS State Trauma Leadership meeting in 2006. He represented rural trauma physicians in the National Rural Health Association's meeting with federal partners in Washington, D.C. this year. Dr. Burton has always been an outspoken advocate for Trauma System Development.

**JANE W. BALL, RN, DRPH**

Dr. Jane W. Ball served as the Director of the National Resource Center (NRC) at the Children's National Medical Center in Washington, D.C. from 1991 through 2006. The NRC provided support to two Federal Programs in the U. S. Department of Health and Human Services' Health Services and Resources Administration (HRSA): the Emergency Medical Services for Children (EMSC) Program and the Trauma-Emergency Medical Services Systems Program. As director of the NRC, she coordinated the support provided to the Federal Program Directors as well as the provision of technical assistance to state grantees. Support to the Federal Program Directors often included meeting facilitation, preparation of special reports (such as the Model Trauma Systems Evaluation and Planning document), and consultation on Program issues. Technical assistance often included strategic planning, providing guidance in securing funding, developing and implementing grants, developing injury prevention plans and programs, building coalitions, shaping public policy, conducting training, and producing educational resource materials.

Dr. Ball has authored numerous articles and publications as well as several health care textbooks, including Mosby's Guide to Physical Examination (6 editions), Child Health Nursing (first edition), Pediatric Nursing: Caring for Children (4 editions), Maternal and Child Nursing (2 editions), and Pediatric Emergencies: A Manual for Prehospital Care Providers (2 editions). One of these texts, Pediatric Nursing: Caring for Children, received the 1999 and 2001 Robert Wood Johnson Foundation Last Acts Coalition Outstanding Specialty Book Award. As an expert in the emergency care of children, Dr. Ball has frequently been invited to join committees and professional groups that address the unique needs of children.

Dr. Ball recently completed her term as the President of the National Academies of Practice, an organization composed of distinguished health care practitioners from 10 disciplines that promote education, research, and public policy related to improving the quality of health care for all through interdisciplinary care. She currently serves as the organization's Immediate Past President.

Dr. Ball graduated from the Johns Hopkins Hospital School of Nursing. She obtained her master's degree and doctorate in Public Health from John Hopkins University School of Hygiene and Public Health. She is a Certified Pediatric Nurse Practitioner.

**SAMIR M. FAKHRY, MD, FACS**

Dr. Fakhry graduated from the American University of Beirut, School of Medicine in 1981. He completed his residency in general surgery and his fellowship in critical care and trauma at the University of North Carolina at Chapel Hill and North Carolina Memorial Hospital, Chapel Hill, N.C. in 1987.

From 1988 until 1991 he led the trauma program as Director for Trauma Services at George Washington University Medical Center in Washington D.C. In 1991, he accepted a position as Director, Surgical Critical Care Services at UNC Hospitals in Chapel Hill, NC. While at UNC, he rose to the rank of Associate Professor of Surgery with Tenure and was awarded several teaching awards by the medical students and the surgical residents. He remained there until 1997 when he was recruited to the Inova Regional Trauma Center at Inova Fairfax Hospital in Falls Church, Virginia as the Chief of Trauma Services.

Since 1997 he has held the position of Chief, Trauma and Surgical Critical Care Services at the Inova Regional Trauma Center. Additionally, he holds the positions of Associate Chair for Research and Education, Department of Surgery; Medical Director for the Inova Regional Trauma Center Injury Prevention Program; Professor of Surgery, VCU, Inova Campus; Clinical Professor of Surgery at Georgetown University School of Medicine; and is the immediate past Chair of the American College of Surgeons Washington DC Committee on Trauma.

Dr. Fakhry has been heavily involved in trauma and surgical critical care research. He has numerous peer-reviewed publications, abstracts and book chapters to his credit. He is a member of many national societies and serves on several national committees and boards. He is a frequent speaker locally as well as nationally.

Dr. Fakhry maintains a high interest in all aspects of trauma. He has been Principal Investigator (PI) for the Crash Injury Research and Engineering Network (CIREN) Center at Inova Fairfax Hospital since May, 2000. With injury prevention as a goal he has worked closely with The National Highway Traffic Safety Administration (NHTSA), automobile manufacturers and bio-engineers to help produce safe vehicles. In addition to the CIREN project, he has been awarded funding for numerous projects in areas of injury prevention, surgical critical care and trauma. These include medical informatics applications, head trauma, intestinal injury, aggressive driving, teen DUI prevention and surgical education.

#### **DREXDAL PRATT**

Chief Drexdal Pratt heads the Office of Emergency Medical Services in the Division of Health Service Regulation of the North Carolina Department of Health and Human Services. His agency manages Emergency Medical Services and Trauma and the Assistant Secretary for Preparedness and Response (ASPR) Hospital Preparedness Cooperative Agreement.

Mr. Pratt is a graduate of the Institute of Government at the University of North Carolina at Chapel Hill, the EMS Management Institute at the University of North

Carolina at Charlotte, and Forsyth Technical Community College. He is also a Certified Emergency Manager (CEM) and a Certified Public Manager (CPM).

Mr. Pratt joined the North Carolina Office of Emergency Medical Services in 1987 as a Regional Coordinator. He was promoted through the ranks, first to Regional Supervisor, and then to Chief of the agency in 1999.

Mr. Pratt served two terms as Chair of the Region I EMS Advisory Council. He received the National Association of County Commissioner's Achievement Award for coordinating the development of the Stokes County NC computer-aided dispatch program.

Currently, Chief Pratt serves as a Commissioner on the Governor's State Emergency Response Commission and serves as Chairman of the Commission's Homeland Security Medical Committee. In addition, Mr. Pratt serves as Chairman of the NC Hospital Preparedness Committee.

**NELS D. SANDDAL, MS, REMT-B**

Mr. Sanddal is currently the president of the Critical Illness and Trauma Foundation (CIT), in Bozeman, Montana. CIT is a non-profit organization dedicated to improving the outcomes of people who are injured in rural America through programs of prevention, training, and research. He recently completed a detachment as the Director of the Rural EMS and Trauma Technical Assistance Center which was funded by the Department of Health and Human Services, Health Resources and Services Administration. Mr. Sanddal worked as the training coordinator for the EMS and Injury Prevention Section of the Montana Department of Public Health and Human Services in the late 1970's. He has served as the Chairperson of the National Council of State EMS Training Coordinators and as the lead staff member for that organization, as well as the National Association of EMT.

Mr. Sanddal has been a co-investigator for six state or regional rural preventable trauma mortality studies and has conducted research in the area of training for prehospital and nursing personnel as well as in rural injury prevention and control. He is a core faculty member for the NHTSA Development of Trauma Systems course and has conducted several statewide EMS assessments for NHTSA. Mr. Sanddal served on the IOM Committee on the Future of Emergency Care in the U.S.

He received his EMT training in Boulder, Montana, in 1973 and has been an active EMT with numerous volunteer ambulance services since that time. He currently responds with the Gallatin River Ranch Volunteer Fire Department where he serves as the Medical Officer and Assistant Chief.

He completed his undergraduate work at Carroll College, received his Master's degree in psychology from Montana State University and is currently completing his doctorate in Health and Human Behavior from Walden University.

**JIM UPCHURCH, MD, MA, REMTP**

Dr. Upchurch began his medical career in 1971 as a Special Forces Medic courtesy of the US Army. He graduated from the University of Texas Medical Branch at Galveston in 1982 and completed a Family Practice residency from the University of Oklahoma in 1985. Since 1985, he has served as an Indian Health Service (IHS) Physician on the Crow Indian Reservation in Montana. The majority of his clinical practice involves emergency medicine (EM), Emergency Medical Services (EMS), surgery and obstetrics. He maintains current National Registry certification and state licensure as a paramedic. In 2003, he completed a masters degree in educational technology from George Washington University.

Dr. Upchurch is a long-standing member of the National Association of EMS Physicians and the American College of Emergency Physicians. Since 1986, he has functioned as EMS medical director for Big Horn County in Montana and guided their basic care program to the advanced life support level, including critical care interfacility transport. He also provides EMS medical direction for Big Horn Canyon National Park and the Incident Medical Specialist Program, US Forest Service, Region I.

Dr. Upchurch is director of a small non-profit organization, EMS Education & Training. They offer distance and face-to-face educational opportunities to rural and frontier EMS personnel in Montana who desire to advance their level of care. He is an active ACLS, ACLS EP, ATLS and PHTLS instructor. Recently, he authored the Geriatric chapter for the sixth edition of *Nancy Caroline's Emergency Care in the Streets*, released in 2007.

Although Montana has no recognized state EMS medical director, Dr. Upchurch has served in that function for many years and represents Montana on the National Council of State EMS Medical Directors of the National Association of State EMS Officials. He functions at the IHS national level as a consultant on EM and EMS issues. He also sits on the Montana Board of Medical Examiners and on the board for the Critical Illness and Trauma Foundation.

**JOLENE R. WHITNEY, MPA**

Jolene R. Whitney has worked with the Bureau of Emergency Medical Services, Utah Department of Health for 27 years. She spent the first 6 years of her career as a regional EMS consultant. She became Assistant Training Coordinator in 1986. She has been a program manager for EMS systems and trauma system development since 1991. She is currently a Deputy Director for the Bureau of EMS and Preparedness, which includes Trauma System Development, Chemical

Stockpile Emergency Preparedness, Hospital Disaster Planning, ED, Trauma and Pre-hospital databases, EMS Licensing and Operations, CISM, and EMS for Children.

She spent 250 hours in the Olympic Command Center, serving as an EMS liaison for the 2002 Winter Olympics in Salt Lake City, Utah. She has been involved with all aspects of EMS including ambulance licensure, EMS councils, certification and training, computer testing, and curricula development. She has experience in statute and rule development, grant writing, system plan development, coalition building, and disaster preparedness. She has served on several national committees and teams, including a state EMS system assessment for NHTSA, reviewing rural trauma grant applications, developing the HRSA model trauma system plan and the NASMESO trauma system planning guide, and the NHTSA curriculum for an EMT refresher course.

Jolene has a Masters in Public Administration from Brigham Young University and a B.S. in Health Sciences, with an emphasis in Community Health Education from the University of Utah. She was certified as an EMT-Basic in 1979. She also obtained certification as an EMT instructor and became certified as an EMT III (Intermediate) in 1983. She has attended numerous conferences, courses, and workshops on EMS, trauma and disaster planning and response. She also completed a course for investigator training from CLEAR. Jolene is a co-author of three publications on domestic violence and hospital surge capacity planning.

She is the current Chair for the National Council of State Trauma System Managers/NASEMSO. She is a member of the American Trauma Society, previous member of the National Association of State EMS Training Coordinators.

In 2005, she was nominated by her staff and received a Utah Manager of the Year Nominee Award from the Governor. She also received recognition from the Utah Association of Emergency Medical Technicians in 2006.

## **Appendix B: List of Participants**



# TraumaSystems evaluation & planning committee



American College of Surgeons  
Trauma Systems Consultation  
November 2<sup>nd</sup>-5<sup>th</sup>, 2008

Name	Title	Organization
Abbott, Sally	SOA Preparedness Coordinator	SOA (State of Alaska)
Allard, Faith	RNFP Director	SOA
Andraschko, Andrea	Communication Specialist	ARH (Alaska Regional Hospital)
Barros, Nancy	SOA Program Manager	SOA
Bowman MD, J. Dani	Pediatrician	ANMC (Alaska Native Medical Center)
Brown MD, Ken	Planning Manager	BRH (Bartlett Regional Hospital)
Bryson, George	Staff Writer	Anchorage Daily News
Bundy, Tim	Section Chief, EMS	IPEMS (Injury Prevention & Emergency Medical Services) SOA
Butler MD, Jay	Chief Medical Officer	SOA- DHSS
Carr, Pat	Section Chief	SOA Health Planning and Systems Development
Chennault MD, Regina	Surgeon	ANMC
Coopes MD, B.J.	Director of Pediatric ICU	TCHAP (The Children's Hospital at Providence)
Crum RN, Bev	ER Manager	Ketchikan General Hospital
Davis, Rick	COO	ARH (Alaska Regional Hospital)
Derring RN, Shelly	Director of Clinical Operations	Airlift Northwest
DeGreef RN, Margie	Assistant with Administrative Services	PKIMC (Providence Kodiak Island Medical Center)

<b>Name</b>	<b>Title</b>	<b>Organization</b>
Fisher, Bryan	Chief of Operations	ADHSEM (Alaska Division of Homeland Security and Emergency Management)
Funk, Beth	State Epidemiologist	DHSS (SOA Department of Health and Social Services)
Gariepy RN, Debbie	TNC- Nurse	ARH
Gilkey, Ed	Chief Physician Executive	ANMC
Godfrey, Gerad	Chair	Violent Crimes Compensation Board
Goodrich, Craig	Fire Chief	Anchorage Fire Department
Greenberg MD, Matt	ED Director	YKHC (Yukon Kuskokwim Health Corporation)
Hecks, Sue	Director	Southern Region EMS
Hilgendorf, Rebecca	Acting Director	DSDS (Division of Senior and Disabilities Services) SOA
Hoebelheinrich MD, S. Roger	MD	CPGH (Central Peninsula General Hospital)
Hull-Jilly, Debra	IPU Unit Manager	IPEMS (Injury Prevention & Emergency Medical Services) SOA
Ives, George	Program Manager	PH- SOA
Jessop, Dan	Administrator	ANMC
Johnson, Mark	Volunteer	Former SOA Section of Community Health and EMS
Lamb, Ed	CEO	ARH
Lamoureux, Bruce	Senior Administrator	PAMC (Providence Alaska Medical Center)
Leemhuis RN, Mary	Trauma Program Manager, Nurse	ANMC
Leighty, Bobbi	Director of SE Region EMS	SEREMS (S.E. Region EMS)
Lerner MD, Deborah	Pediatrician	PAMC
Levy MD, Mike	Emergency Medicine Physician	ARH
Mackin, Jim	Preparedness Director	SOA/DHSS

<b>Name</b>	<b>Title</b>	<b>Organization</b>
Mandsager MD, Richard	TCHAP Director	PAMC
Maskay, Raj	Public Health Specialist	Section of Injury Prevention and EMS, SOA
Molitor RN, Jeanne	Course Director	SOA
Olliff, Terry	EMS Unit Manager	SOA IPEMS
Parks MD, Stephen	MD	PAMC/Lifemed
Poggi, Stephen R.	EMS	AFD (Anchorage Fire Department)
Potashnik, Dave	Emergency Medical Service Officer/Assistant Chief	North Slope Borough Fire Department- Barrow
Potts, Joanne	Program Manager	ARH
Robinette MD, Danny	MD	Northern Alaska Medical Surgical
Sacco MD, Frank	Trauma Systems Review Committee Chair/Surgeon	ANMC
Scandling, Bruce	Program Manager/Legislative Liaison	SOA Division of Public Health
Searles MD, Grant	MD	Anchorage Surgical and Bariatric
Simonsen RN, Barb	State Trauma Analyst/Nurse	IPEMS
Smith MD, Linda	ED Physician	ARH
Somervell, Philip	Epidemiologist	NIOSH (National Institute for Occupational Safety and Health)
Thompson RN, Mary	Trauma Program Manager	PAMC
Wilder MD, Norman	Chief Medical Officer	ARH
Wooley, Bev	Director PH, DHSS	SOA
Zafren MD, Ken	SOA EMS Medical Director	SOA