

The Vision of an Inclusive NC Trauma System

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NCOEMS

Division of Health Service Regulation

Where there is no **vision**, the
people perish

Proverbs 29:18

The Vision of a NC Trauma System

Develop a system from 911 to Rehabilitation

North Carolina's inclusive trauma system is an organized, multi-disciplinary, evidence based approach to provide quality care and to improve measurable outcomes for all defined injured patients. EMS, hospitals, other health systems and clinicians will participate in a defined manner through leadership, advocacy, injury prevention, education, clinical care, performance improvement and research resulting in integrated trauma care.

Trauma Agenda for the Future

- Leadership- establish lead State Agency
- Professional Resources- Recruitment and Retention, use of students as interns
- Education and Advocacy-Community Awareness
- Information Management- Research database
- Technology- State Registry and linkages
- Finance-Funding attempt
- Research-Surgeon as Medical Advisor

To Understand the vision
we must first understand
where we are today

Current Facts and Strengths

- 11 Trauma Centers with strong history and experience
- Strong Leadership
- State support of efforts
- Robust pre hospital system
- Legislation and Rules identifying authority, roles, and objectives

Issues We Face

- Trauma Registry fragmented and needs upgrading
- No legislation for funding of an Inclusive Trauma System
- All hospitals with an emergency department not designated as a trauma center need to be a participating hospital
- Provide clinical oversight for the registry to direct and evaluate research and Injury Prevention
- Educate **everyone** of the RAC mission
- Define the role of the STAC

Issues We Face

- Rules outdated and need to be reviewed and revised
- Include data from non trauma centers
- Fragmented IT efforts
- Rehabilitative Services not included in the system
- Change our focus of building trauma centers to the building of an inclusive trauma system

Infrastructure Construction



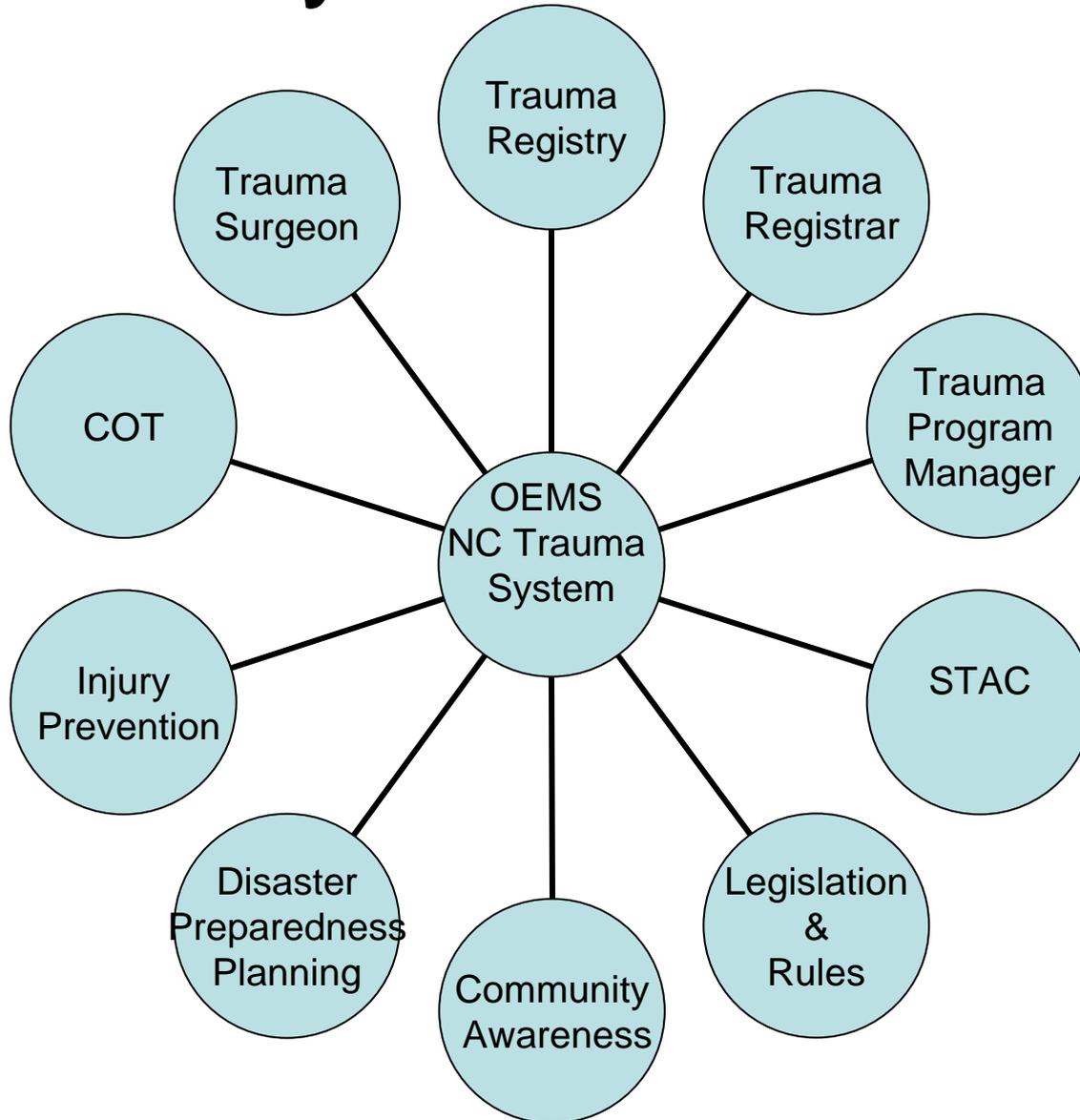
- Upgrade the Trauma Registry
- Provide Clinical Oversight to the registry, research, and review
- Rules are to be revised and in place by January 2009
- Non trauma center data accessed for Injury Prevention and Performance Improvement

Infrastructure Construction



- Define participating hospital
- Identify Realistic System Costs
- Enact Legislation to fund and sustain funding for the system
- Enact Rules to identify participating hospitals
- Enact legislation to clarify access to data

The System Structure



Legislation Required

- To be successful and build a viable system, legislation must be passed to provide the resources necessary to accomplish the vision
- The legislative process is complex and we must work as a team if we truly desire success

The NC General Assembly

Jan. 22, 2008

The NC General Assembly

- How does it really work ?
- Does the activity in Raleigh affect me ?
- What does “long” session and “Short” session really mean ?
- Overview of the process
- What happened in 2007
- Likely 2008 Issues

Which Way will We Go



Where do we Stand ?



QuickTime™ and a
TIFF (Uncompressed) decompressor
are needed to see this picture.

2007 Session

2007-2008 Biennial

- Primary Purpose of the “long” session is to develop the biennial budget
- January thru Aug, has gone to December
 - New bills are introduced and the new budget is developed

2007 Budget

- State Budget Total 2007-2008-\$20,690,890,000 (20 Billion)
- DHHS--\$4.6 billion
- Education-- \$11.3 billion
- Justice and Public Safety--\$2.1 billion =18 B
- Many line up

2007 budget

- 3,645 Bills Filed in 2007
- Budget line items
- Only 500 Bills Passed
- Nothing is done without collaboration with other advocacy Groups
- Very few things happen without the Departments approval DHHS, DPI, DOT

Perceptions and Agenda

- Leadership, where you stand depends on where your seat is
- Senate -50 members
- House -120 members
- Governor
- Department Heads
- Hospital Association - Many
- Many non profits -Domestic Violence
- Citizens

What will we see in 2008

- Budget is corrected based on actual revenue numbers, not projected numbers
- Primary focus is to “adjust” the second year of the two year budget
- Normally no Controversial issues and No new issues, unless public demands it
- Public Demands - Death of Marine ???
- Election year, Primary in May and election in November

Possible Budget issues for 2008

- There is a projection of 65 billion in differences over the next two decades for the highway and public transportation fund
- Remember the current budget is 20 billion
- Panel recommendations are expected in a couple of months - higher taxes and fees.

Possible budget issues for 2008

- Governor will have further Expansion in 2008 for his educational programs
- Governor's budget - Gov. Perception
- Senate's budget - Perception
- House's budget - Perception

Other likely 2008 Issues

- Community College mandating the admission qualified immigrants
- The “Frayed” Mental Health system and reimbursement for those services

2008 Issues

- Gang prevention, Crime Control
- School drop out rates / Education
- How the lottery money is spent

- Election year for all 170 seats, plus the Governor, Lt. Governor and most of the Council of state members

Bills that did not pass in 2007

- Example of bills that didn't pass that may be Back
- “I’11 BE BACK”

BILLS THAT DID NOT PASS

- HB 92 (SB 110) would have directed DHHS to study options for increasing Medicaid medically needy income limits.
- HB 103 would have permitted physicians to notify the parent or guardian of a minor after treating the minor for venereal disease, pregnancy, abuse of controlled substances or alcohol or emotional disturbance.

BILLS THAT DID NOT PASS

- HB 122 would have required hospitals to provide the flu vaccine at no cost to all employees having direct patient contact, to report influenza vaccination rates of employees to the state, and to provide education to hospital employees about the risks of influenza and benefits of immunization; and it would have required nursing homes and adult care homes to report

BILLS THAT DID NOT PASS

- HJR 136 would have authorized a study of the incidence of medical errors in health care settings, the impact medical errors have on patient safety, and the benefits of mandatory reporting of medical errors.

BILLS THAT DID NOT PASS

- HB 155 would have allowed any healthcare provider (current law is physicians and nurses) to conscientiously object to performing or assisting in or providing medication for an abortion.
- HB 245 would have created a rating plan for medical malpractice insurance premiums for physicians, with ratings set without regard to specialty.

BILLS THAT DID NOT PASS

- HB 259 would have prohibited smoking in restaurants, with some exceptions, and in state government buildings. The bill was defeated on second reading in the house.
- Rep. Holliman

BILLS THAT DID NOT PASS

- HB 263 would have provided that a person who commits murder or manslaughter of a pregnant woman is guilty of a separate offense for the resulting death of the unborn child

BILLS THAT DID NOT PASS

- HB 337 would have provided reimbursement for dental services under the Medicaid program at the same reimbursement level as for other medical services.

Written Bills

- Who Writes them
- They never come out the way they went in
- Oppositions comes from places one would never expect
- Money is a big deal, Many have needs and only a few are funded
- Many have good ideas

Our State Symbols



State Fruit

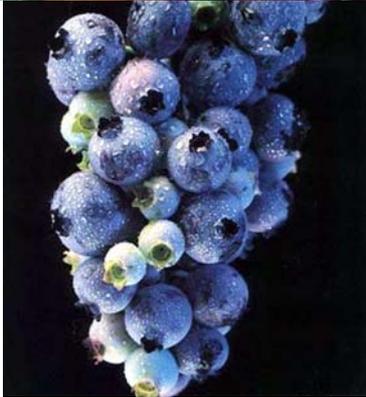


Blueberries





Our State Fruits



What have we Got?



Questions

- The people's health should be the highest law of the land
 - » Thank you for your attention
 - » Joanne Schoen Stevens, MSN, RN

Bringing Order to Chaos

Strengthen Daily Operations

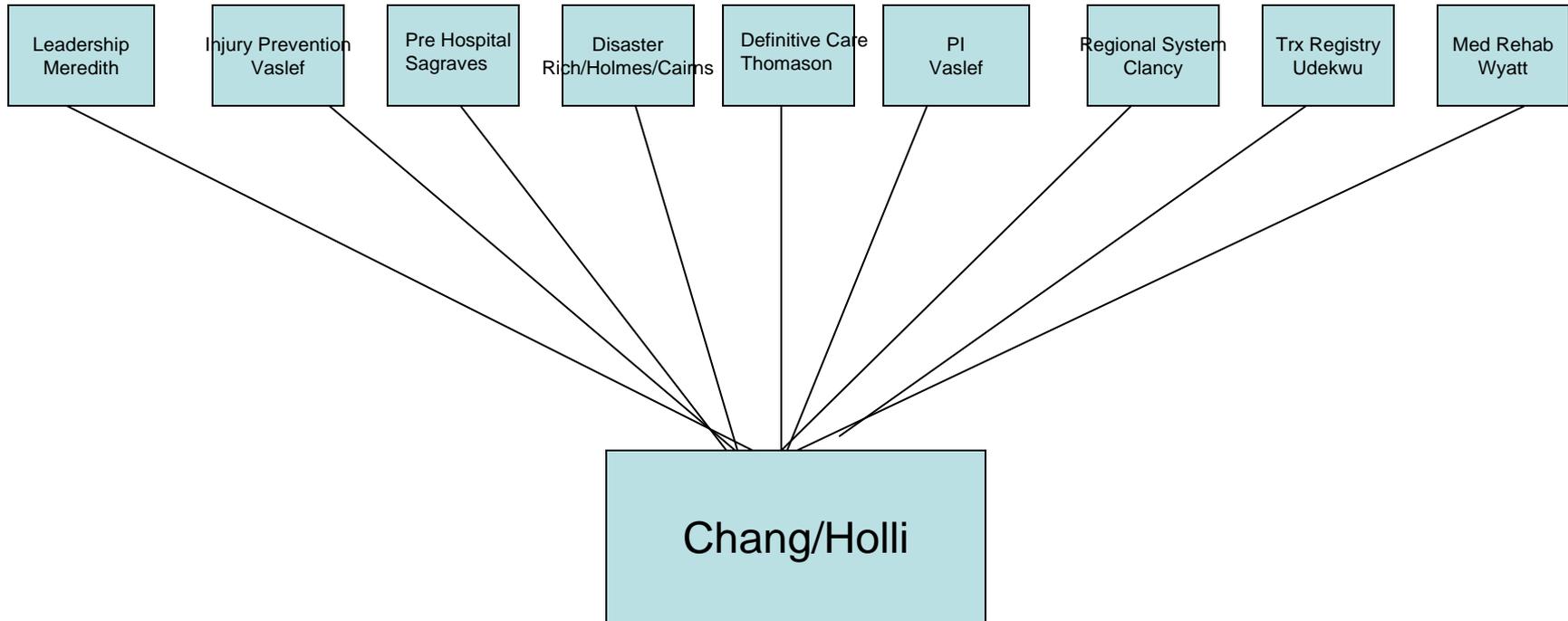
Focus on the true mission

Collect partners- strength in
numbers

Task #1

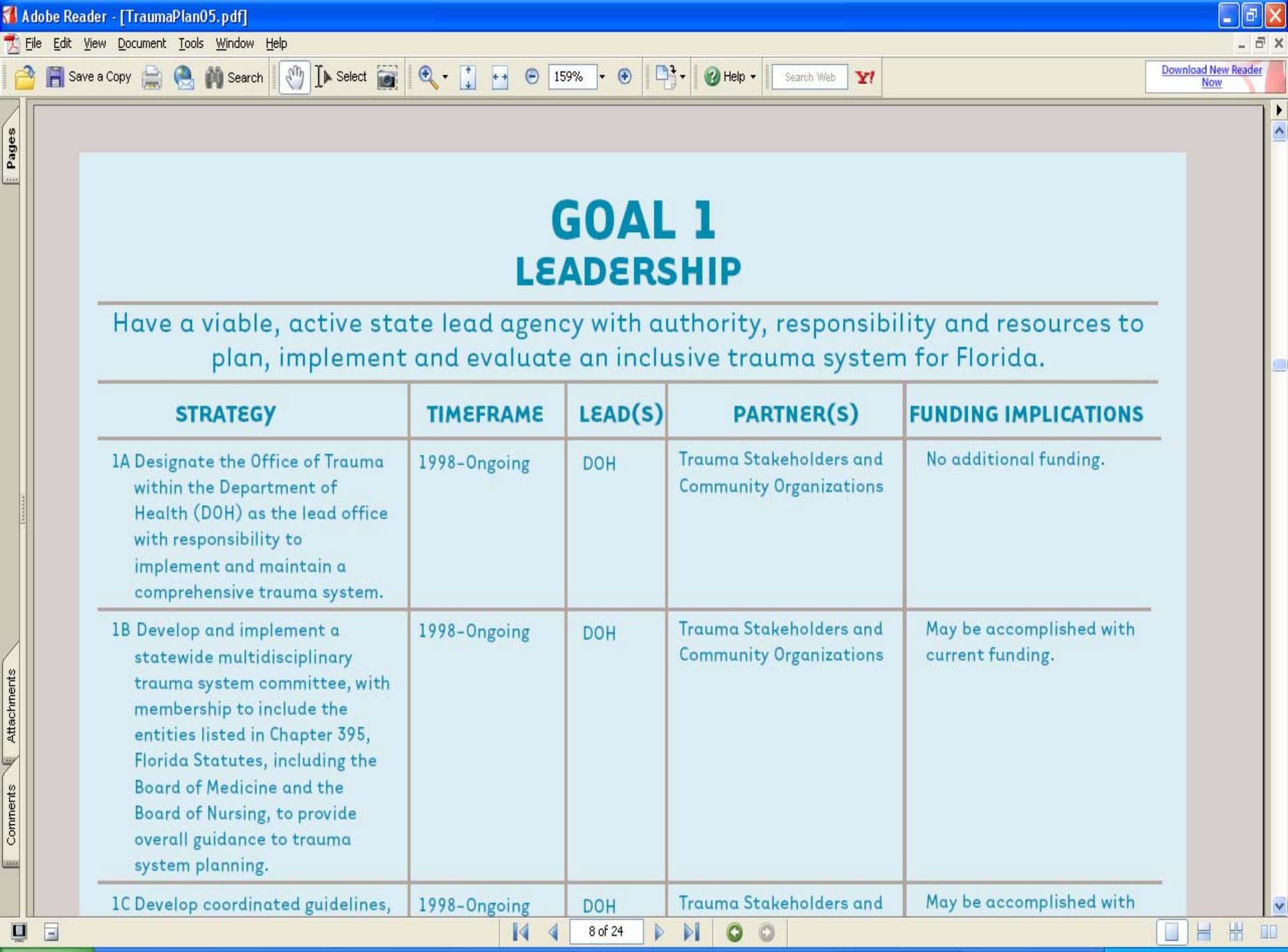
- Sub Committees get started writing the 5 year plan by taking all guidance documents and condensing the recommendations into one NC specific and measurable road map

NC Trauma State Plan Implementation Committee



The 9 Cores

- **Goal 1 Leadership:** Have a viable, active state lead agency with authority, responsibility and resources to plan, implement and evaluate an inclusive trauma system for Florida.
- **Goal 2 Injury Prevention and Control:** Have a state trauma system that is an active partner in a state-coordinated system for reducing injury-related morbidity and mortality.
- **Goal 3 Emergency/Disaster Preparedness Plan:** Have a trauma system prepared to respond to emergency and disaster situations in coordination with state disaster plans.
- **Goal 4 Pre-Hospital Care – Transport:** In coordination with the goals of the Emergency Medical Services (EMS) State Plan, to establish guidelines specific to the transport of trauma patients that result in timely and safe delivery to trauma care.
- **Goal 5 Definitive Care – Trauma Centers:** Establish a statewide network of trauma centers, meeting minimum state standards for operation and provision of quality trauma care, in coordination with all other trauma system participants.
- **Goal 6 Definitive Care – Medical Rehabilitation:** Establish rehabilitation centers as active participants in Florida’s inclusive trauma system, resulting in coordinated post-acute care for trauma victims.
- **Goal 7 Evaluation, Quality Management & Performance Improvement:** Establish a statewide system evaluation, quality management, and performance improvement process.
- **Goal 8 Regional System Evaluation:** Establish regional system evaluation, quality management, and performance improvement in areas without a trauma agency.
- **Goal 9 Trauma Registry:** To provide an accurate and accessible trauma registry to support trauma system evaluation, performance improvement, public health planning, injury prevention, and outcomes research.



GOAL 1 LEADERSHIP

Have a viable, active state lead agency with authority, responsibility and resources to plan, implement and evaluate an inclusive trauma system for Florida.

STRATEGY	TIMEFRAME	LEAD(S)	PARTNER(S)	FUNDING IMPLICATIONS
1A Designate the Office of Trauma within the Department of Health (DOH) as the lead office with responsibility to implement and maintain a comprehensive trauma system.	1998-Ongoing	DOH	Trauma Stakeholders and Community Organizations	No additional funding.
1B Develop and implement a statewide multidisciplinary trauma system committee, with membership to include the entities listed in Chapter 395, Florida Statutes, including the Board of Medicine and the Board of Nursing, to provide overall guidance to trauma system planning.	1998-Ongoing	DOH	Trauma Stakeholders and Community Organizations	May be accomplished with current funding.
1C Develop coordinated guidelines,	1998-Ongoing	DOH	Trauma Stakeholders and	May be accomplished with

Task #2

- Produce Strategic Plan and convert into a measurable document to score trauma system progress.
 - This can serve as a report card to the General Assembly if necessary
 - We need to be able to account for any funding we receive and show progress towards goals

Task #3

- Rule Revision need to be completed and ready for January 2009
 - The trauma system needs to be more solid and up to date before we begin seeking funds

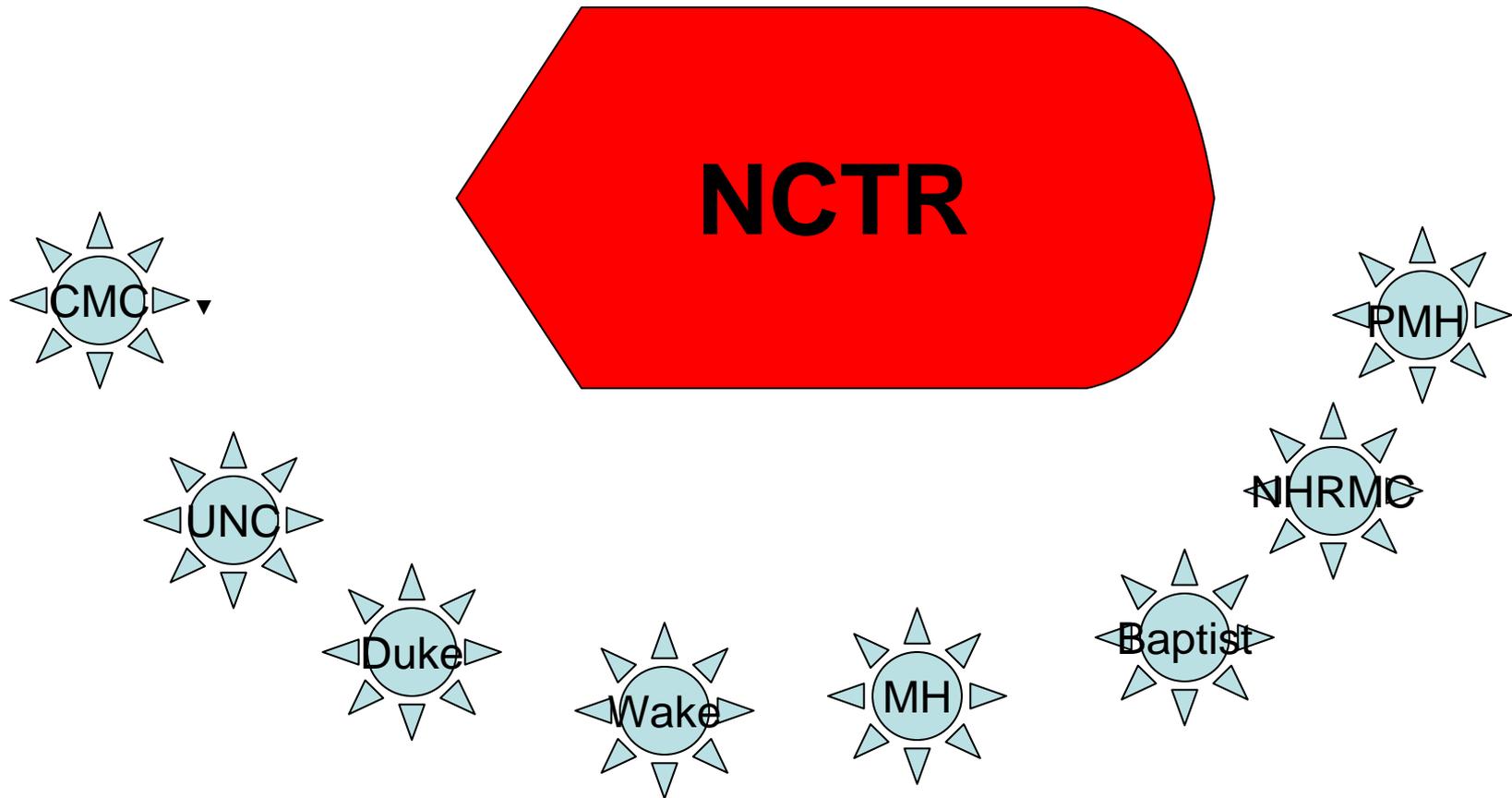
Examples

- Needed language for progress such as “Participating Hospital” and Level III clearly defined

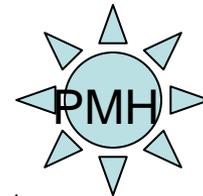
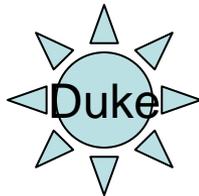
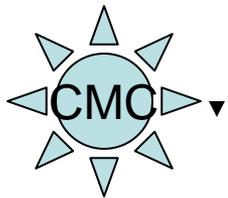
Task #4

- Data integration between Premis, NCTR, NCDETECT, and Crash Data must be completed
- Epidemiologist from CDC must be in place for statistics, research and Injury Prevention

Trauma Data



NCTR



Name	Description	Values	Format
Hosp_No	ID number of the receiving hospital, as assigned by the state.	10 digit hospital ID number Not Recorded (V) Not Available (X). Default = V (Not Recorded).	C10
MedRecNo	Patient's medical record number at the initial hospital	MR number up to 15 char Not Available Not Recorded (Default)	C15
VisitNum	A counter identifying a unique visit for a patient	Whole number	N4
SSN	Patient's social security number.	###-##-#### V = Not Recorded (Default) X = Not Available	C11
Lname	Patient's last name.	up to 15 char Not Available Not Recorded (Default)	C15
Fname	Patient's first name	up to 15 char Not Available Not Recorded (Default)	C15
MI	Patient's middle initial	1 char Default = blank.	C1

ISSAC
Information System for the State Advisory Committee
Data Dictionary

Name	Description	Values	Format
Insurance	The insurance provider for this incident.	Auto Commercial HMO/Managed Care Medicare Medicaid Military/Champu None/Self Pay Not Available Not Recorded (Default) Other Private Charity Shriners State Health Plan Workers Comp	C15
PreMIS_ID	A number assigned by the PreMIS system.	##### Not Recorded (Default) Not Available	C25
ProvNumb	EMS provider number for this patient for this incident.	##### V = Not Recorded (Default) X = Not Available	C7
ProvName	EMS Provider Name, as assigned by state.	up to 25 char Not Recorded (Default)	C15

ISSAC
Information System for the State Advisory Committee
Data Dictionary

Name	Description	Values	Format
ED_ArrTime	Time of patient's arrival at ED.	HH:MM Not Recorded (:-4) (Default) Not Available (:-5)	C5
InjDate	Date of the injury/incident. Date 8	MM/DD/YYYY Default = blank.	Date 8
E_Code	E codes for the incident. E codes are external causes of injury and poisoning.	###.# -4 = Not Recorded (Default) -5 = Not Available	C5
ED_Disposition	Disposition status of patient from ED.	Death Death(DOA) Floor Hosp Transfer Transfer Trauma Transfer Burn ICU OR Telemetry Not Recorded (Default) Not Available	C15

Information System for the State Advisory Committee
Data Dictionary

Pages

Attachments

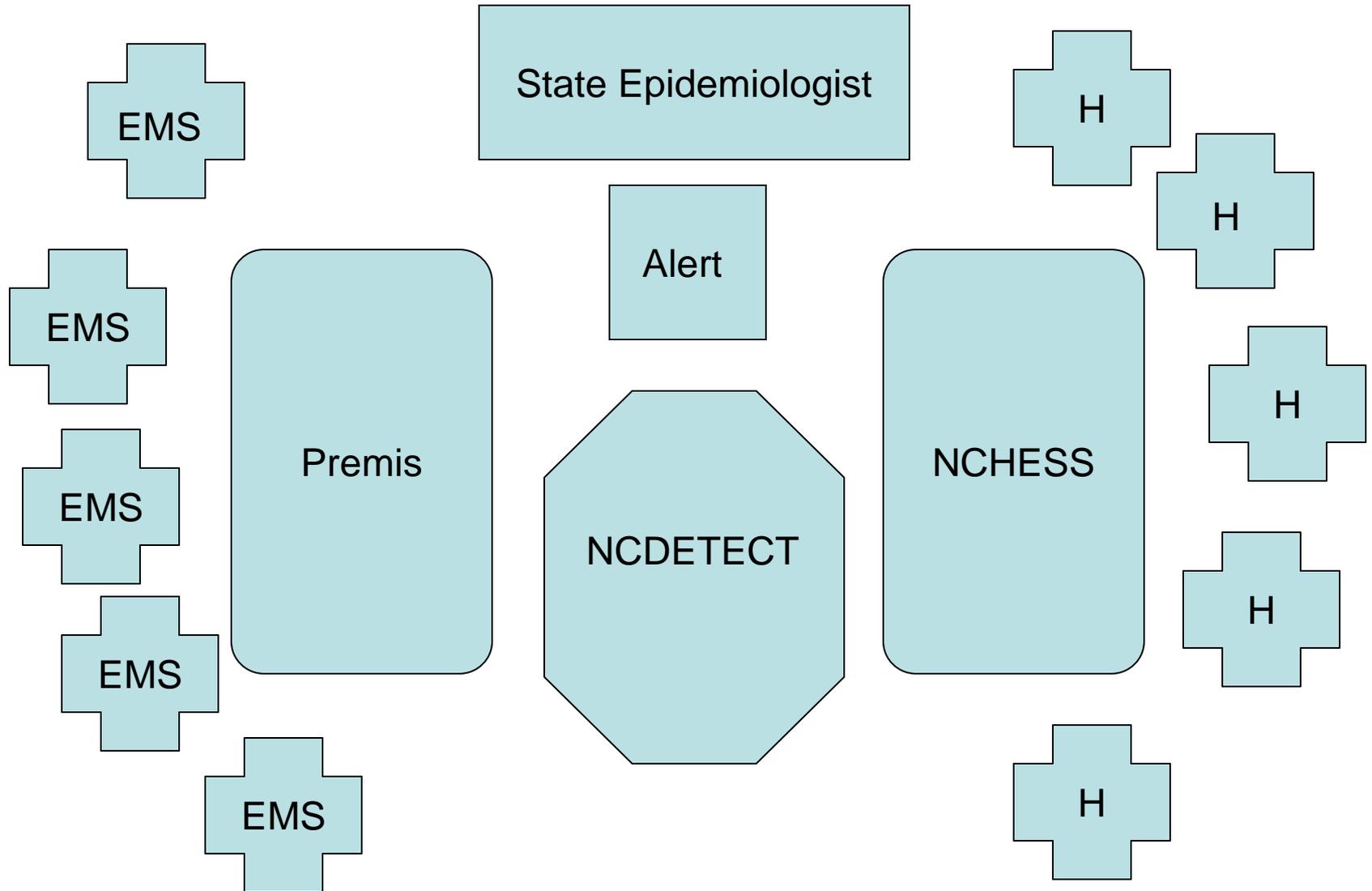
Comments

Name	Description	Values	Format
ICD9_CODE	ICD-9-CM codes for the incident. ICD-9 codes are classification codes for diseases and injuries.	###.## None NR = Not Recorded (Default) NA = Not Available Multiple entries allowed.	C6
P_Code	Procedure codes for the incident.	##.## None NR = Not Recorded (Default) NA = Not Available Multiple entries allowed.	C5
Hosp_Dis	Disposition status of patient from hospital.	Death Death(DOA) Home Home Health Hosp Transfer Transfer Trauma Transfer Burn Jail Nursing Home Rehab Not Recorded (Default) Not Available	C15
Hosp_DCDate	Date of patient's discharge from hospital.	MM/DD/YYYY Default = blank	Date 8

**ISSAC
Information System for the State Advisory Committee
Data Dictionary**

Name	Description	Values	Format
Hosp_Chrg	Total charges for patient for this visit.	in dollars -4 = Not Recorded (Default) -5 = Not Available	N10
Trans_Hosp	Hospital to which patient is transferred, if applicable.	up to 25 char Not Recorded (Default) Not Available	C25
Trans_Reas	Reason patient was transferred to another hospital, if applicable.	Definitive treatment/diagnostics required (lack of specialty resources) Repatriation (Patient/Family/Patient's Physician request) Payor request (Managed Care, Military) Hospital on bypass/diversion Not Recorded (Default) Not Available	C72

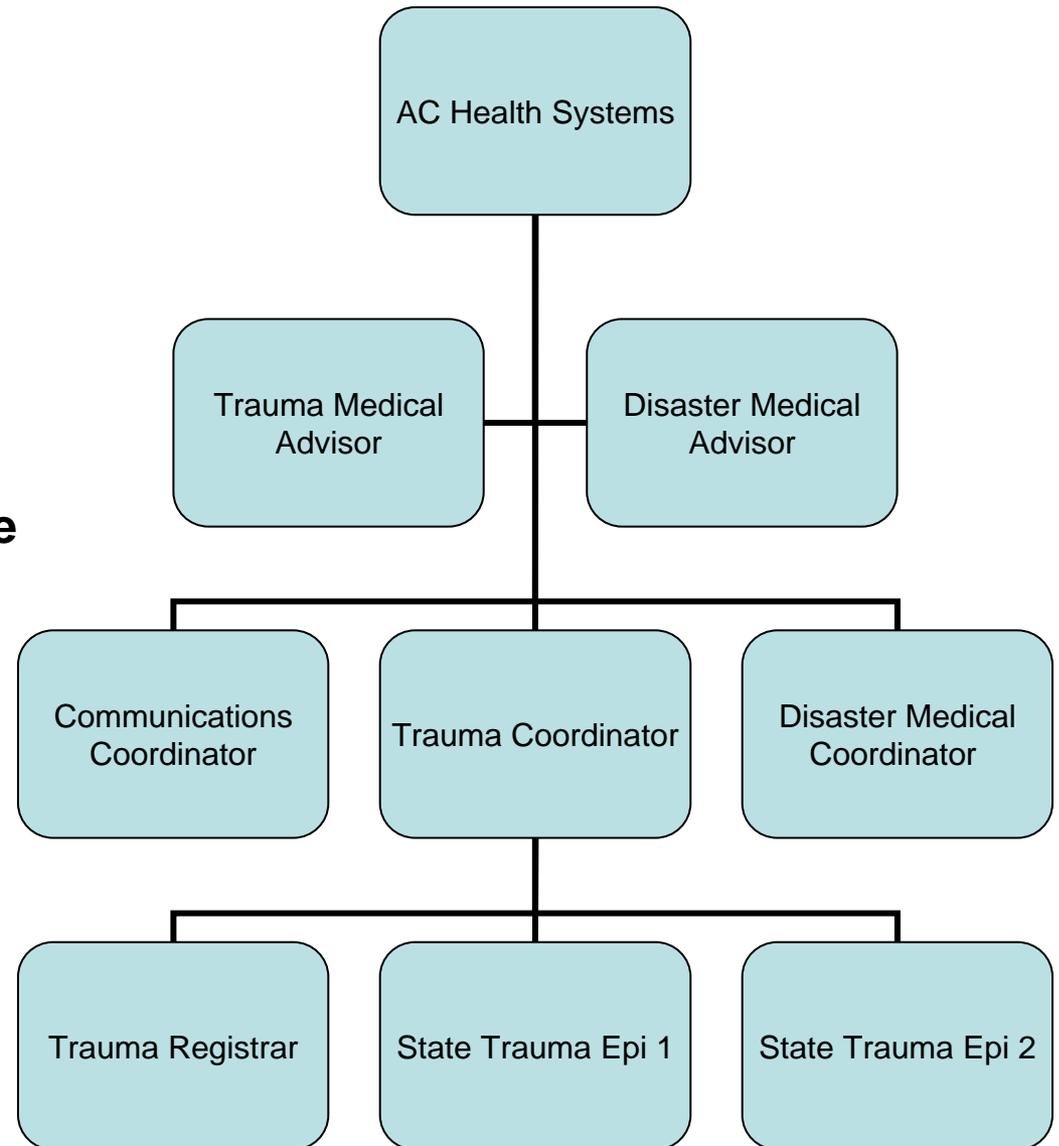
Hospital and EMS data



Task #5

Write Applications for state positions and structure as follows:

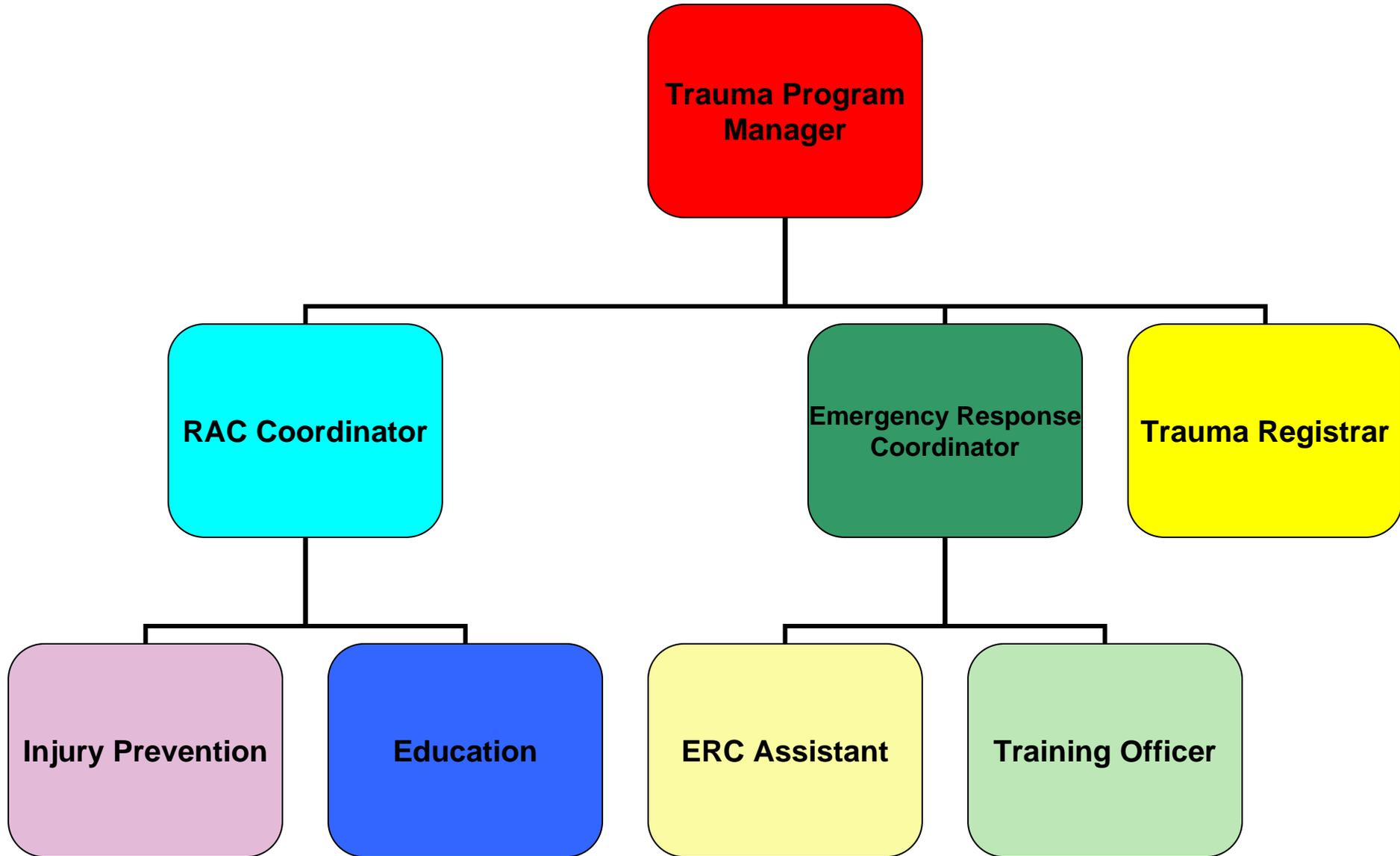
- **NC State Registrar- funding source identified**
- **NC State Trauma Advisor- funding source identified**
- **NC Trauma Registry Epidemiologist- funding source identified**
- **NC Trauma Epidemiologist #2 Liaison- funding source identified**
- **NC Trauma Program Manager- funding source identified**



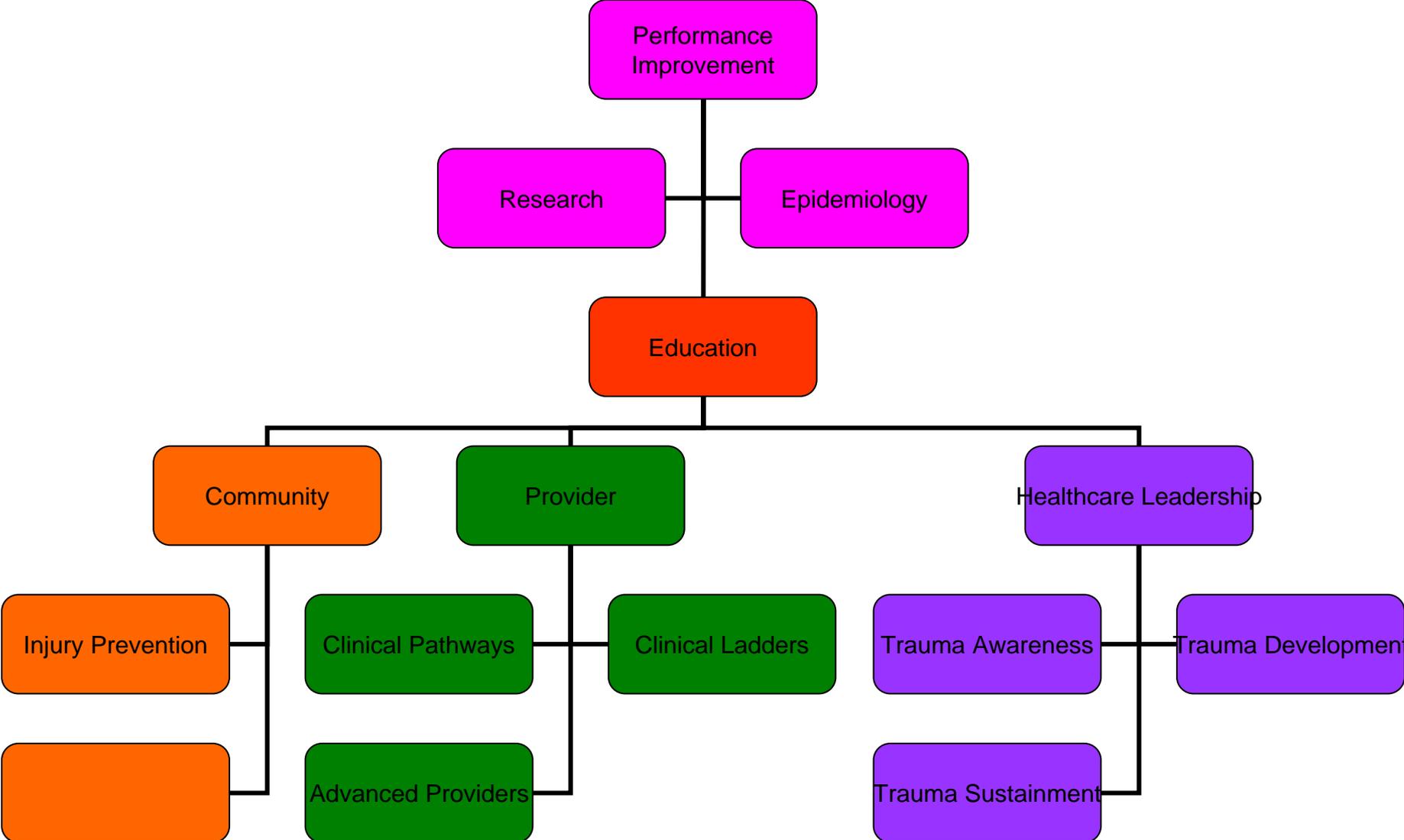
Task #6

- Define Roles of all current positions in the existing infrastructure
 - Enables us to think through all possibilities clearly and answer key questions that may come up

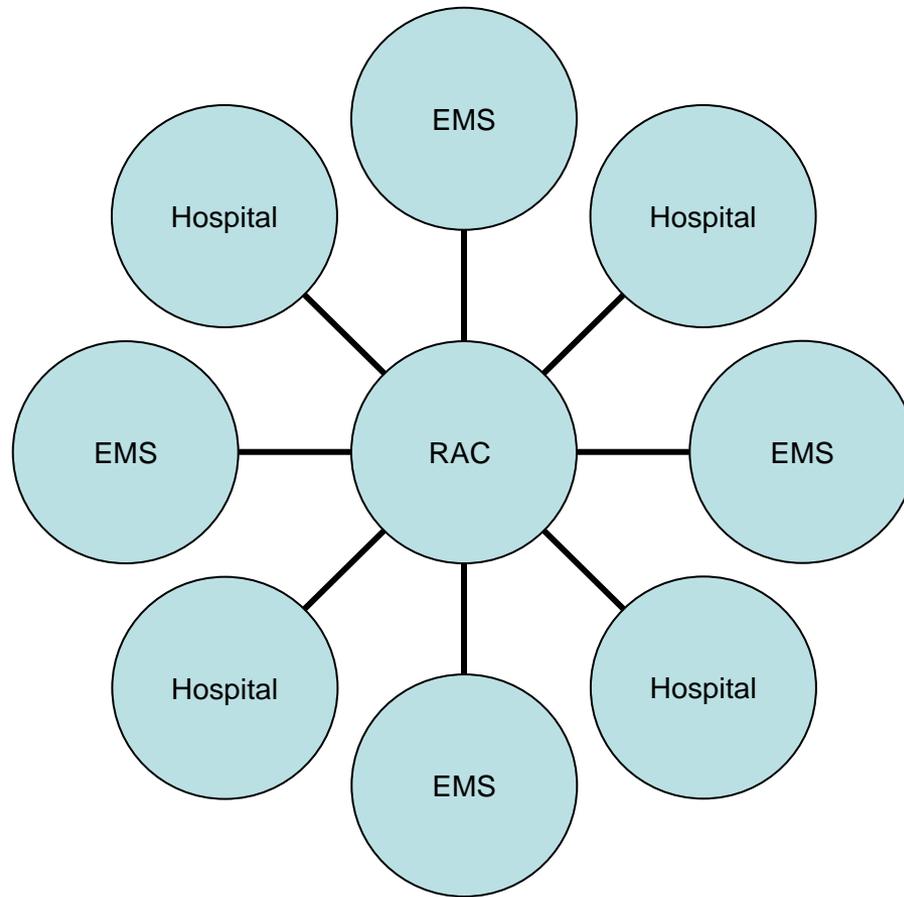
Trauma Structure



RAC Mission



RAC Target Audience

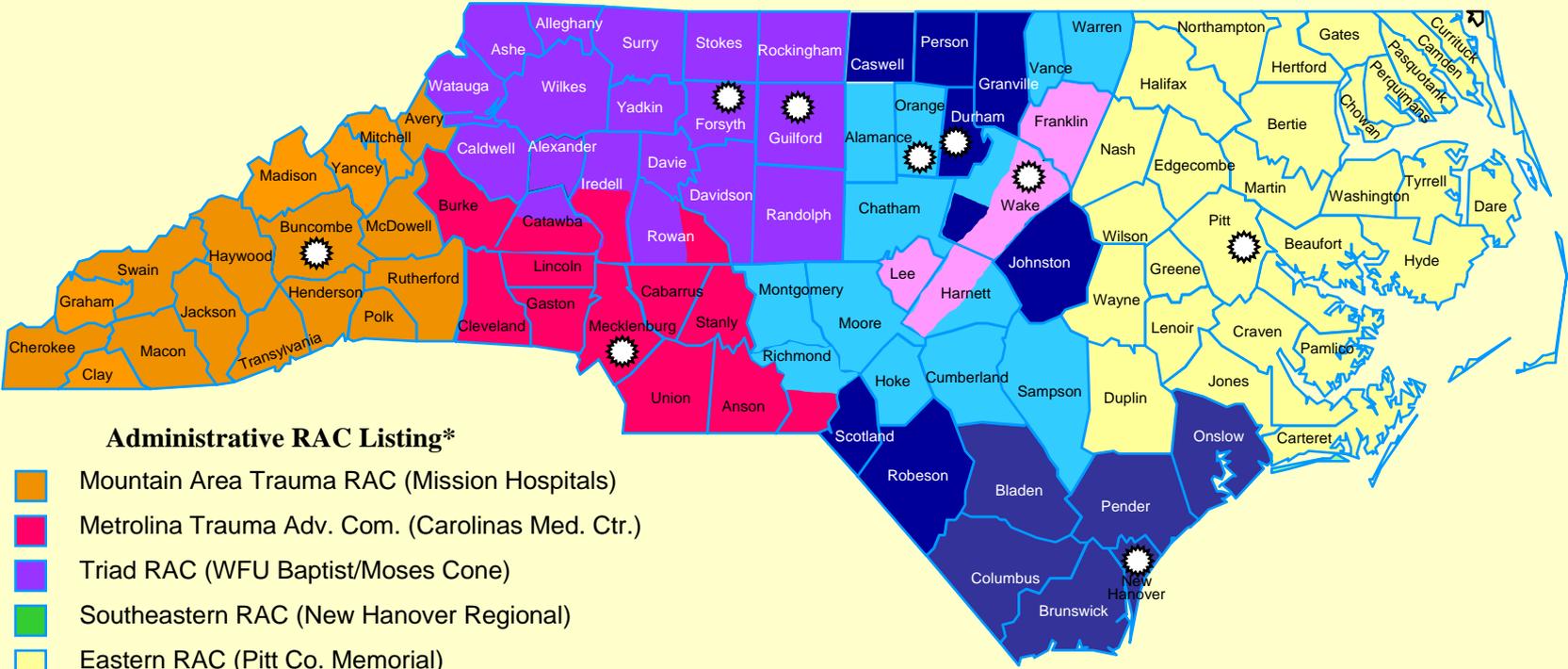


Where are we?

- One Chair and 9 focus areas all chaired by trauma surgeons completed
- Rules Revisions have begun and are on schedule
- Disaster Study is completed
- Trauma Eco study task force is being created to begin the study
- AHA and other stakeholders have been informed of the movement in trauma and asked to join the movement
- RAC mission has been defined and group is ready to begin meeting to develop a more comprehensive MGO document for the RAC
- Project Manager has been contracted and has started
- State Epi application to CDC has been completed and submitted
- Office of Rural Health meeting is set with objectives
- Four meetings with Academic institutions have been set for integration of their programs into trauma and pre hospital (interns)
- Trauma Registrar interviews have been set
- Trauma Surgeon interviews are almost completed with the exception of 1
- State Trauma Coordinator Statement of Work is written and ready for interviews when ok is given
- Pediatric Patient names are ready to be submitted for ambassador to be selected has been selected

Map of Regional Advisory Committee (RAC) Affiliations

June 2005



Administrative RAC Listing*

- Mountain Area Trauma RAC (Mission Hospitals)
- Metrolina Trauma Adv. Com. (Carolinas Med. Ctr.)
- Triad RAC (WFU Baptist/Moses Cone)
- Southeastern RAC (New Hanover Regional)
- Eastern RAC (Pitt Co. Memorial)
- Duke RAC (Duke Univ. Hospital)
- MidCarolina Trauma RAC (UNC)
- Capital RAC (WakeMed)

Indicates a Level I or II Trauma Center

* A county's RAC is determined by its hospital's RAC selection or, if no hospital in the county, by selection of a RAC by the primary EMS provider. A county with different colors indicates two or more hospitals with different RAC affiliations.

Questions

