Draft Minutes of Meeting – Subject to change upon approval by the Trauma Rehabilitation Committee at their next regularly scheduled meeting.

MINUTES

EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

TRAUMA REHABILITATION COMMITTEE

FEBRUARY 14, 2013 - 9:00 A.M.

MEMBERS PRESENT

Karyn Doddy, MD, Chair
Julie Barth, Care Meridian
Craig Bailey, Kindred Hospital
Deanna Martin, HealthSouth

MEMBERS ABSENT

Linn Billingsley, RTAB Rehabilitation Rep.
Linda Kalekas, RN, RTAB Injury Prevention Rep.
Michele Cicogna, RN, Sunrise Hospital
Betsy Aiello, DHFP
Paul D'Ambrosio, Complex Care
Bryn Rodriguez, MD, IPC
Tracy Jackson, HCA
Kim Haley, St. Rose Dominican Hospitals
Elizabeth Snavely, UMC

SNHD STAFF PRESENT

Mary Ellen Britt, RN, Regional Trauma Coordinator
Michelle Nath, Recording Secretary

CALL TO ORDER – NOTICE OF POSTING

The Trauma Rehabilitation Committee convened in the Human Resources Conference Room # 2 at the Southern Nevada Health District on Wednesday, February 14, 2013. Dr. Karyn Doddy called the meeting to order at 9:13 a.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law. It was noted there was not a quorum of members present and those in attendance would not be able to take action on any matter.

I. PUBLIC COMMENT

Members of the public are allowed to speak on action items after the Committee's discussion and prior to their vote. Each speaker will be given five (5) minutes to address the Committee on the pending topic. No person may yield his or her time to another person. In those situations where large groups of people desire to address the Committee on the same matter, the Chair may request that those groups select only one or two speakers from the group to address the Committee on behalf of the group. Once the action item is closed, no additional public comment will be accepted. Seeing no one the Chair closed the Public Comment portion of the meeting.

II. CONSENT AGENDA

Chairperson Doddy stated the Consent Agenda consisted of matters to be considered by the Trauma Rehabilitation Committee (TRC) that can be enacted by one motion. Any item may be discussed separately per Board member request. Any exceptions to the Consent Agenda must be stated prior to approval.

Approve Minutes/Trauma Rehabilitation Committee: 10/11/12

Lacking a quorum of members, Dr. Doddy tabled the approval of the minutes from the October 11, 2012 meeting.

III. REPORT/DISCUSSION/POSSIBLE ACTION

A. Discussion of Rehabilitation Inpatient Data

The representatives of the rehabilitation facilities stated they have not received requests from the trauma centers for follow-up information on patients who were transferred to their facilities from a trauma center. Mary Ellen Britt commented that in previous meetings two different mechanisms were discussed to identify patients; the first was to have the rehabilitation centers identify the patients they received from a trauma center and report outcome information back to that center, or the second was to have the trauma centers provide a list of patients to the receiving rehabilitation center and request outcome data on those patients. Deanna Martin reported she was able to retrieve patient specific outcome data on trauma patients she identified from the national Uniform Data Set (UDS) database; however, she was uncertain which information would be most beneficial to report back to the trauma centers. Julie Barth added that the UDS is national database where all inpatient rehabilitation facilities submit required data. She indicated she is also able to extract specific patient outcome data based on diagnosis codes and report it back to the trauma centers.

Ms. Martin asked for clarification of the purpose of the data collection process. Ms. Britt stated there was a twofold purpose: 1) the trauma centers were interested in outcome data for patients who are transferred to rehabilitation facilities; 2) the data could be aggregated, analyzed, and reported on from a system's perspective. Ms. Britt explained that not all patients with a traumatic injury meet the criteria to be placed into the trauma registry. Consequently, a comparison of the patients identified by the rehabilitation facilities versus those identified by the trauma centers could differ. Mr. Bailey commented it would be beneficial to initially track patient outcomes for the patients established in the trauma registry. All agreed having the trauma centers identify the patients of interest would be the best approach. Dr. Doddy stated there needs to be an established point person at each of the rehabilitation facilities for the trauma centers to contact. Ms. Martin suggested the Case Management and Discharge Planning Manager/Director for each of the facilities would be the most appropriate person.

Craig Bailey inquired if it was necessary to set up a business agreement for data sharing between facilities. Ms. Martin responded an agreement currently exists between Health South and the trauma centers. All agreed those in attendance at the meetings were familiar with the data collection plan, however there are acute rehabilitation facilities that are not aware of the Trauma Rehabilitation Committee or the plan to collect data. It was recommended that letters be sent to inform the other facilities of the plan, advise them they may be contacted by a trauma center to provide outcome information on patients transferred to them, and to ask them to provide the best point of contact for their facility. After reviewing the list of acute rehabilitation facilities, the decision was made to send letters to Sherry Speece for the St. Rose Hospitals, Tracy Jackson for Sunrise and MountainView Hospitals, and Allyson Hoover for the Valley Health System Hospitals. It was also recommended that the hospital administrators be advised so they can support the effort.

To clarify, the data collection process will initially involve only individuals identified by the trauma centers as trauma patients. For the collection of inpatient data the trauma centers will initiate the process by generating a monthly patient report for the rehabilitation facilities. The rehabilitation centers will collect three data points to include: 1) name of rehabilitation facility to which the patient was discharged; 2) discharge date from the rehabilitation facility; and 3) disposition from the rehabilitation facility. This discharge data will be reported back to the trauma centers where the patient originated and then the trauma centers will forward the de-identified aggregate data to the Health District on a quarterly basis. Mr. Bailey inquired if the trauma centers would be providing discharge disposition for the patients that are not discharged to acute rehabilitation centers. Ms. Britt

responded the trauma centers are currently reporting length of stay details and patient discharge disposition in their quarterly report to the Health District which could be shared with the committee.

Discussion ensued about the patients who cannot be discharged from the trauma centers to rehabilitation facilities as a result of psychiatric, social, or other confounding issues. Mr. Bailey expressed concern as to whether or not the length of stay was appropriately reported for these patients. Ms. Britt remarked that the trauma centers have a mechanism for recording the length of stay for patients who are released from trauma services but remain hospitalized. Julie Barth inquired if the trauma centers would be willing to negotiate a contract with the rehabilitation facilities for assuming care of these patients as opposed to keeping the patients' long term. There was further discussion regarding the cost effectiveness of developing this type of contract between the rehabilitation facilities and trauma centers and the issues arising with patients who require long term custodial care.

In addition, Ms. Barth commented that there are times when it is in the best interest of the patient to be admitted to a long term acute care facility or skilled nursing facility prior to an acute rehabilitation facility because they are not ready for the rigors of a rehabilitation program. She feels it would be valuable to monitor patients' progress through the whole system of care.

Dr. Doddy emphasized the importance of clearly defining the levels of care (skilled nursing facility, long term acute care facility, rehabilitation facility) when discussing "rehabilitation facilities." Mr. Bailey added data integrity will be compromised if the trauma centers and rehabilitation facilities are not in agreement on the definitions and how the data are reported. Ms. Britt commented that this topic could be presented for discussion and direction during the committee's next report to the Regional Trauma Advisory Board.

B. Discussion of List Regarding Rehabilitation Resources

The committee reviewed the "Southern Nevada Rehabilitation Facilities" resource list created by Lynn Billingsley and Dr. Doddy in January 2012. Those present agreed there were 10 acute inpatient rehabilitation facilities in the community and the list should be updated to include the inpatient rehabilitation facilities at St. Rose-Siena and Desert Springs hospitals. Dr. Doddy also noted that Henderson Healthcare should be changed to Clearview Healthcare and that a few other minor edits would need to be made to the list.

III. INFORMATIONAL ITEMS/DISCUSSION ONLY

Ms. Britt reported the Southern Nevada Health District will be conducting a trauma system self assessment on April 17th. The HRSA *Model Trauma System Planning and Evaluation* benchmarks, indicators, and scoring process will be used to evaluate the current status of the Clark County trauma system. The members of the committee were invited to participate and provide input from their perspective.

IV. PUBLIC COMMENT

Public comment is a period devoted to comments by the general public, if any, and discussions of those comments, about matters relevant to the Committee's jurisdiction will be held. No action may be taken upon a matter raised under this item of this Agenda until the matter itself has been specifically included on an agenda as an item upon which may be taken pursuant to NRS 241.020. All comments are limited to five (5) minutes. Seeing no one, Dr. Doddy closed the Public Comment portion of the meeting.

V. ADJOURNMENT

As there was no further business on the agenda, Dr. Doddy called for a motion to adjourn. The motion was seconded and passed unanimously to adjourn at 10:16 a.m.