



## MINUTES

### EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM (EMSTS)

#### TRAUMA REHABILITATION COMMITTEE

JULY 12, 2012 - 9:00 A.M.

#### MEMBERS PRESENT

Karyn Doddy, MD, Chair  
Michele Cicogna, RN, Sunrise Hospital  
Elizabeth Snavely, UMC  
Julie Barth, Care Meridian

Bryn Rodriguez, MD, IPC  
Josh Luke, HealthSouth Valley View  
Kim Haley, St. Rose Dominican Hospitals

#### MEMBERS ABSENT

Linn Billingsley, RTAB Rehabilitation Rep.  
Linda Kalekas, RN, RTAB Injury Prevention Rep.

Craig Bailey, Kindred Hospital  
Tracy Jackson, HCA

#### SNHD STAFF PRESENT

Mary Ellen Britt, RN, Regional Trauma Coordinator

Michelle Nath, Recording Secretary

#### PUBLIC ATTENDANCE

Amy Tabor, HSVV

Jennifer Koenig, HSW

#### CALL TO ORDER – NOTICE OF POSTING

The Trauma Rehabilitation Committee convened in the Dining Room at HealthSouth-Valley View on Wednesday, July 12, 2012. Dr. Karyn Doddy called the meeting to order at 9:05 a.m. and the Affidavit of Posting was noted in accordance with the Nevada Open Meeting Law.

#### **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.

#### **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: 6/20/12

Chairperson Doddy asked for approval of the minutes from the June 20, 2012 meeting. A motion was made, seconded and passed unanimously to approve the minutes.

**III. REPORT/DISCUSSION/POSSIBLE ACTION**

**A. Discussion of Draft Trauma Rehabilitation Committee Bylaws**

Dr. Doddy introduced herself to the new people in attendance and asked that everyone do the same. She stated that Craig Bailey, the Vice Chair, was unable to attend the meeting. He and others have contacted her to discuss the ability for teleconferencing in the future.

Mary Ellen Britt referred the Committee to the draft TRC bylaws. She reported that the Committee agreed to the language in the bylaws at their first meeting, but asked if they could revisit Article III, Section 1, TRC Membership at this meeting. It was understood that everyone in attendance at the June meeting would be considered a standing member. She acknowledged potential new members in attendance at today's meeting. Although the TRC membership language was written fairly broadly, she noted the importance of having a consistent group so they can more easily move agenda items forward. She stated that the Committee can leave the language as is, and if someone shows interest in the future and is with a constituency that is not represented, they can allow that person to become a standing member. Dr. Doddy suggested it may be better to designate a type of representative, such as someone from a skilled nursing facility. Ms. Britt replied that the difficulty in identifying a "type" is you don't have a commitment from an individual. You really need the people who are committed to the process and are willing to attend. And if they are unable to attend they can choose an alternate to attend in their place to represent their organization/constituency.

A motion was made to approve the Trauma Rehabilitation Committee Bylaws, including Article III, Section 1, as written. The motion was seconded and passed unanimously by the Committee.

**B. Discussion of Committee Goals and Objectives**

Dr. Doddy referred the Committee to an excerpt from the American College of Surgeons (ACS) Committee on Trauma - 2011 Clark County Trauma System Consultation Report. In the report the consultation team recommended the Committee review rehabilitation data for the purpose of outcomes assessment and performance improvement. The Committee's purpose is based upon the recommendations of the ACS. She related that at the last meeting it was agreed the trauma centers would submit their discharge disposition data, and the rehabilitation facilities would submit their admission data from the trauma centers for the calendar year 2011.

**C. Discussion of Rehabilitation Inpatient Data**

Elizabeth Snavely commented that her vision for the TRC is two-fold. First, the trauma centers have patients that have no medical coverage that end up receiving rehabilitation within their facility because they have no payer source. Not all trauma centers have rehabilitation units. Second, when a patient leaves the trauma center to go to a rehabilitation facility, patient outcome is unknown. Did that patient return to their previous level of functionality? Were they impaired? Were they later transferred to a nursing home? She stated that the trauma centers' previous attempts to get buy-in from the rehabilitation facilities to share that information were met with resistance based on their perception of HIPAA. She noted that there is no violation of HIPAA if a patient goes from one facility to another; it is a continuum of care. Ms. Snavely understands that UMC's issues regarding a patient's lack of medical coverage cannot be solved by the TRC Committee. But it is her goal that the Committee arrive at a solution to the problems related to tracking a trauma patient post-discharge.

Ms. Britt noted that from the perspective of the Regional Trauma Advisory Board (RTAB) the continuum of care is very important. Now that they have opened up the lines of communication they may identify recommended policies or standardize a way of sharing information that is acceptable to their respective compliance officers. Dr. Doddy stated that the Committee represents an opportunity

to have a central repository and coordination point. They can present data and feedback to individual institutions, as well as to the group. Going forward, they will have that information to present to the legislative sector. Ms. Britt noted that the challenge in doing that is that the delegation of authority from the State to the Southern Nevada Health District (SNHD) to provide oversight of the trauma system was an unfunded mandate. It takes money and resources to monitor the system and provide appropriate surveillance. In that respect, it may not be realistic from SNHD's standpoint to become the central repository for case specific information; it may be best to keep that relationship between the trauma centers and the rehabilitation facilities. However, Ms. Britt stated SNHD could assist with generating aggregate reports as needed.

Mr. Luke related that HealthSouth is glad to share data and work collaboratively with the trauma centers. He noted there is frustration on the side of the free standing rehabilitation facilities because the county hospital interprets the choice legislation more strictly than some of the private hospitals. Trauma patients should be transferred to a facility that specializes in rehabilitation related to trauma. He is hopeful that the outcome data they collect can be used to form a true partnership with the State to deal with these types of issues in the future.

There was much discussion regarding the importance of identifying pertinent information to answer specific questions. It will be necessary to standardize the types of information that will be collected. Ms. Snavelly stated that UMC, Sunrise and St. Rose Dominican Hospitals are interested in outcome data for patients who are transferred to rehabilitation facilities. They are able to track three fields of data via the trauma registry: 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. Mr. Luke noted that it will be necessary to define the disposition categories. Ms. Snavelly stated that the trauma registry lists disposition as: 1) home; 2) death; 3) transfer to rehabilitation facility; 4) transfer to skilled nursing facility (SNF)/long term acute care (LTAC)/nursing home (NH); and 5) transfer to acute care facility. Mr. Luke stated that HealthSouth does not currently categorize trauma vs. other patients that come from the trauma centers. Dr. Doddy noted that another issue occurs when patients go to long term acute care prior to being transferred to a rehabilitation facility. Mr. Luke stated that the rehabilitation facilities will need a patient identifier in order to track the necessary information. Ms. Snavelly responded that she may not be able to provide that information due to the difficulty in tracking patients and sheer volume. She asked whether the rehabilitation facilities could provide her with a list of patients they receive from UMC. It was noted that the patients who are initially transferred to a facility other than a rehabilitation facility may not be tracked. Dr. Rodriguez suggested they place a form in the patient's chart to track when and where the patient goes. The form can include contact information for the receiving facility to notify the person responsible for collecting the data. Julie Barth commented on the importance of obtaining information on the flow of patients as they move from one facility to another. She added that when there is a really good flow and the outcomes are successful, you want to be able to pattern that flow for certain types of patients.

Mr. Luke noted that after reviewing the 2011 Trauma Registry Disposition data depicting that 163 patients were transferred to a rehabilitation facility, he realized the numbers HealthSouth submitted were too low. He stated that unless he is granted access to the trauma database he won't be able to obtain the information they need. Without an identifier, he doesn't have the resources to track the patients. He added that although HealthSouth can identify all patients that are transferred from UMC, they don't know which unit the patient came from in the hospital. Michelle Cicogna stated that the patient is labeled as "trauma" originally, but with each disposition change that patient identifier may be lost. Ms. Snavelly noted the difficulty of sending a whole list of patients that were transferred to each rehabilitation facility. Mr. Luke stated that if the rehabilitation facilities can't obtain that information from the trauma centers they won't be able to provide the patient disposition data. The Committee discussed different tracking mechanisms and methods for identifying trauma patients at the time of trauma center discharge so rehabilitation facilities can provide outcome data. Ms. Britt commented on the value of the trauma centers taking the lead on identifying trauma

patients based on the accepted definition within the trauma community.

Dr. Doddy stated that although they have identified there are severe limitations with data collection, there is a need to at least try to gather some information to meet the ACS recommendations. Dr. Doddy noted that she and Linn Billingsley came up with a list of rehabilitation resources for the community. She stated that it can be used as a baseline and revisions can be made utilizing the information they collect. She noted that that we have a wonderful trauma system in place, and our system needs to mature to where we can obtain patient outcome information. Mr. Luke asked whether the rehabilitation facilities were interviewed for the ACS report. Dr. Doddy responded in the affirmative. Mr. Luke remarked that no one from his facility recalls being interviewed. He noted that the recommendations in the report are good, but there are also gaps from their facility's perspective.

The Committee was in agreement to start with the three data points Ms. Snavely mentioned earlier in the meeting. She agreed to check with UMC's Case Management and Information Technology departments to research whether they can easily obtain patient disposition. If they can do that, then she has no doubt Sunrise and St. Rose Dominican hospitals can obtain the information as well. Dr. Rodriguez asked who will be collecting all of the information. Ms. Britt responded that all information will go back to the trauma centers who will in turn report it back to SNHD. Prior to the next meeting, Ms. Snavely agreed to prepare a sample report which will be distributed for review.

Mr. Luke remarked that the Committee seems to be data driven up to this point. Data tell one story, but personalizing the message could also be effective. He stated HealthSouth has taken a more singular approach in that they distribute posters of success stories. This approach could potentially better inform the community and address gaps identified in the ACS report. Ms. Britt noted that Kim Haley, as an alternate on the RTAB, will be working on media and public relations issues. These activities will provide an opportunity to educate the public about the trauma system as a whole. Dr. Doddy commented that although a small percentage of the total patients come from the trauma centers, as the rehabilitation facilities improve the care and quality of their services, and information is shared about patient outcome, this will improve rehabilitation services for the entire community.

### **III. INFORMATIONAL ITEMS/DISCUSSION ONLY**

The Committee agreed to meet again on October 11<sup>th</sup> at 9:00 am. Ms. Britt informed the Committee that Betsy Aiello, the Deputy Administrator of the Division of Healthcare Funding and Policy, expressed interest in becoming a member of the Committee. However, Ms. Aiello is from Northern Nevada which makes it difficult for her to attend the meetings. The location of the meeting will be determined at a later date so they can research a venue that can accommodate for tele- and video-conferencing.

### **IV. PUBLIC COMMENT**

None

### **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 10:08 a.m.