MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1290

2007 HOUSE HUMAN SERVICES

HB 1290

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1290

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 17, 2007

Recorder Job Number: 1261

Committee Clerk Signature

Minutes:

Chairman Price opening HB 1290.

Arnold Thomas, President of the ND Healthcare Association: I am here in support of HB 1290. See attached testimony, along with two maps to assist you in terms of the conversations you will be having. First map identifies hospitals by location and also by designation. The reason this is important to you is for just facts. We have a large geographical distance. The population is moving. It is certainly challenging. The second map is a portrayal of basically how people use hospitals in ND. Stabilization and transport is very important. The majority of ambulance service is volunteer. This is a challenge. We need alternatives to the volunteer system. Not as a replacement, alternatives must also be considered.

Dr. Steve Hamar , I am a surgeon in Bismarck ND, and ND Chapter American College of Surgeons Committee on Trauma Member of the ND Trauma Committee: I support HB 1290. No other states around us currently have an active trauma Legislation. That has improved the care of our trauma patients of ND, but it is time to make some changes. It is time to take a look at what we can do better. See attached.

Shiraz Hyder, neurologist at St Alexius Medical Center: See attached testimony. I urge a do pass on HB 1290. Stroke is the 3rd leading cause of death.

Dean Lampe, Executive Director of NDEMS Association: See attached testimony with purposed amendments.

June Herman, Senior Advocacy Director for the American Heart Association: See testimony with proposed amendments attached.

Harlan Kingsley: I am a stroke survivor. See attached testimony.

Tim Meyer, Director of Emergency Medical Services for the ND Department of Health: See attached testimony.

Chairman Price: Any other in favor of HB 1290? Any opposition to HB 1290? If not we will close the hearing on HB 1290.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1290

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 17, 2007

Recorder Job Number: 1305

Committee Clerk Signature Judy Schock

Minutes:

Chairman Price: The trauma one is separate from EMS.

Representative Porter: I would like to move the EMS Association amendments and the American Heart Association amendments so that the language is clearer. **Representative Conrad** seconds the motion, 12 yeas and 0 nays and 0 absent. **Representative Porter** Move a do pass as amended RR/Appropriations. **Representative Hatlestad** seconds the motion. Vote was 12 yeas, 0 nays, and 0 absent. Representative Porter to carry to the floor.

Date: 1/17
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES HB 1290 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Amendments

Motion Made By Rep Porter Seconded By Rep Conrad

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman			Kari L Conrad		
Vonnie Pietsch – Vice Chairman			Lee Kaldor		
Chuck Damschen			Louise Potter		
Patrick R. Hatlestad			Jasper Schneider		
Curt Hofstad					
Todd Porter					
Gerry Uglem					
Robin Weisz					

Total (Yes) 12 "Click here to type Yes Vote" No 0 "Click here to type No Vote"

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 1/17
Roll Call Vote #: 2

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES HB 1290 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass as Amended R.R./Appr.

Motion Made By Rep Porter Seconded By Rep Hatlestad

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman	✓		Kari L Conrad	✓	
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor	✓	
Chuck Damschen	✓		Louise Potter	✓	
Patrick R. Hatlestad	✓		Jasper Schneider	✓	
Curt Hofstad	✓				
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz	✓				

Total (Yes) 12 "Click here to type Yes Vote" No 0 "Click here to type No Vote"

Absent

Floor Assignment Rep Porter

If the vote is on an amendment, briefly indicate intent:

to Appr
R.R.

REPORT OF STANDING COMMITTEE

HB 1290: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (12 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1290 was placed on the Sixth order on the calendar.

Page 1, line 12, after "medical" insert "services"

Page 1, line 13, remove "and"

Page 1, line 14, after "association" insert ", and the senior policy director of the American heart association, North Dakota"

Renumber accordingly

2007 HOUSE APPROPRIATIONS

HB 1290

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1290

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 1/29/07

Recorder Job Number: 2204

Committee Clerk Signature Louise Wogsland

Minutes:

Chairman Svedjan opened the hearing on House Bill 1290.

Rep. Price described the bill.

Rep. Price: This bill is a trauma bill. In the early 1990's there was an evaluation of our trauma system. A lot of things have changed since then. Number one medicine has changed, we have a lot of new technology and we have all of the critical access hospitals. This means that they don't serve the same purpose or the same level of care that you are going to see in the major hospitals. We have had a reduction in services, time in a hospital for example, in those hospitals out there. This means not every accident or every stroke or every heart attack can be treated in those hospitals. They need to be transported to the best possible hospital to do the work. The bill is to have the Department of Health contract with the national organization in this case The American College of Surgeons to do the evaluation.

End of sound from recording.

A motion was made by Rep. Kerzman, seconded by Rep. Ekstrom to DO PASS AS ENGROSSED House Bill 1290. The committee vote was 21 Yeas, 0 Nays, 2 Absent and Not Voting. The bill will be carried by Rep. Porter.

Date: January 29, 2007
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1290

House Appropriations Full Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number —

Action Taken Do Pass as engrossed

Motion Made By Kempenich Seconded By Ekstrom

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan	✓				
Vice Chairman Kempenich	✓				
Representative Wald	✓		Representative Aarsvold	✓	
Representative Monson	✓		Representative Gulleson	—	
Representative Hawken	✓				
Representative Klein	✓				
Representative Martinson	✓				
Representative Carlson	—		Representative Glassheim	✓	
Representative Carlisle	✓		Representative Kroeber	✓	
Representative Skarphol	—		Representative Williams	✓	
Representative Thoreson	✓				
Representative Pollert	✓		Representative Ekstrom	✓	
Representative Bellew	✓		Representative Kerzman	✓	
Representative Kreidt	✓		Representative Metcalf	✓	
Representative Nelson	✓				
Representative Wieland	✓				

Total (Yes) 21 No 0

Absent 3

Floor Assignment K. Porter

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1290, as engrossed: Appropriations Committee (Rep. Svedjan, Chairman) recommends **DO PASS** (21 YEAS, 0 NAYS, 3 ABSENT AND NOT VOTING). Engrossed HB 1290 was placed on the Eleventh order on the calendar.

2007 SENATE HUMAN SERVICES

HB 1290

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1290

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: February 28, 2007

Recorder Job Number: 4081

Committee Clerk Signature Mary K Monson

Minutes:

Sen. Judy Lee opened the hearing on HB 1290, a bill relating to provided for the state department of health to contract for an evaluation of the state trauma system. All members (6) were present.

Steve Hamar, trauma surgeon, testified in favor of the bill. See attached testimony #1.

Sen. Warner- does EMS services figure into this trauma evaluation?

Steve Hamar- yes they are very heavily figured into that. Having paramedics in the rural community is really where our future is going to be at. We still have 8 hospitals that are not verified trauma centers.

Sen. Dever- I am not quite sure what the scope of this whole issue is, I think that a disaster response plan had to be put together after 9-11, that was kind of a federal kind of thing but it goes beyond that?

Steve Hamar- yes, we throw all this money after disaster management when really we should be throwing it after trauma systems and trauma management to start with. Trauma is a surgical disease, if you don't have a suture around it there are a lot of things that you can't take care of. We are at the point now that we need to do something else, funding has been a real problem for us, we have problems keeping our trauma coordinator because of funding issues.

Steve Hamar passed out a client manual of an overview of what the college is going to do, attachment #2.

Rep. Price, district 40, testified in favor of the bill.

Rep. Price- A little bit of history on this bill back in 1995 there was a bill for an evaluation of our trauma system and we appropriate $100,000 at that time to do it, they had different components at that time laid out in the legislation and through a system plan. We have come a long time since then, our hospitals have changed in their abilities to serve the trauma patients, there is a reduction in serves, surgeons and etc. Our communication systems have changed, we are facing huge challenges in the EMS system. I will hand out a map that shows you where the hospitals are, the levels of their coverage and also some of the feeder systems across the state (see attachment #3) We really need to look at this bill and evaluate our entire healthcare system and what we do provided and don't provide. It is not just a matter of life and death it is a matter of recovery in some cases, it is a huge issue for us to take a look at and not an easy one. I support this bill and think that we definitely need to take a look at this.

Sen. Dever- I know that these things are continually plan and change and all that but this is an attempt to take an arms length to look at things?

Rep. Price- that is part of it and they will bring in some expertise with some outside eyes to take a look at it, it is not that I feel that our people in the state are looking at it continuously but sometimes it is good to have another look at something where there have been evaluations done in other states and say where are our problems where are our strengths and what can we do to make it better.

Sen. Warner- how much of this would you anticipate is going to be onsite in state and how much is going to be done by questionnaires? How would you anticipate this rolling out?

Rep. Price- they are going to do a lot of prep work before they ever come into the state and they will spend a period of time in the state. Different people on the team have different expertise, they kind of split up and look at their own areas of expertise and kind of get back together at the end.

Shiraz Hyder, neurologist at St. Alexius Medical Center, testified in favor of the bill. See attached testimony **#4**.

Sen. Warner- a generation ago it would have been very unusual for an ambulance crew to use a defibulator, do you anticipate that at some point ambulances will be allowed to carry clot busting drugs and with the doctors permission to administer.

Shiraz Hyder- the drugs would not be possible because they require a cat scan to be done before they can be administered but they may come up with a portable cat scanner someday.

Sen. Dever- when you talk about 3-6 hours when it comes to having time to bring someone in because of a stroke, how far are most people into the stroke before people recognize that they have a problem?

Shiraz Hyder- strokes are different from heart attacks, strokes do not cause pain typically. There was a study done in the USA to find out how many people actually know the warning signs of a stroke and when they need to seek medical attention, less then 10% knew. There are 5 key symptoms and most people could not identify one, so there has to be public education and they have to know what services are available to provide them with immediate attention. In our hospital about 20% do come in on time.

Sen. Judy Lee- what are the 5 key symptoms of a stroke?

Shiraz Hyder- the five symptoms are numbness on one side of the face or the body, weakness on one side of the body, slurring of the speech, dizziness and difficulty walking,

confusion. We try to do what we can to educate the public but we need your assistance and support.

Arnold Thomas, President of the ND Healthcare Association, testified in favor of the bill. See attached testimony #5.

Sen. Judy Lee called on **Steve Hamar**.

Sen. Judy Lee- I had a physician that had the idea that so many long term care facilities, is there any merit that we should be putting critical access centers in some of those care facilities to provide growth services?

Steve Hamar- that is an issue because there are a lot of the communities that may lose their hospitals or that have already moved their hospital into more long term care just financially to keep liable, those situations should be at least aid stations where they can get the care they need to stabilize them before they are transported. Then how do you transport the patient? We don't have helicopters in Eastern ND.

Stacey Steriger, testified on behalf of June Herman, see attached testimony #6.

Dave Peske, ND Medical Association, testified in favor of the bill.

Dave Peske- I am in support of this bill.

No opposition to the bill.

Tim Meyer, director of the Human Services Committee, testified neutral to the bill. See attached testimony #7.

Sen. Heckaman- looking at this it says a $100,000 from the general fund but is there a possibility of getting anything from homeland security to help with this because I would think that they would be highly involved in this.

Tim Meyer- I don't know how their funding is distributed I would say there would be an outside chance. You would think that they would support the trauma systems but they have not done that and does not look they will.

Steve Hamar- there dollars are for disaster dollars not for trauma development systems.

Sen. Dever- would the study help pull these things together?

Steve Hamar- one would hope that would happen, the advantage of our state is that everyone knows everyone so it is really easy for us to work close. Some things that we need to be looking at are advanced 911 and that is exactly what this plan is all about.

Sen. Judy Lee closed the hearing.

Sen. Erbele motioned for a do pass and to be rerefered to appropriations and was seconded by **Sen. Dever**, roll call vote 1: 6 yea, 0 nay, 0 absent. **Sen. Erbele** was designated to carry the bill to the floor.

Date: 2-28-07
Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1290

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do Pass / refer

Motion Made By Sen. Erbele Seconded By Sen. Dever

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Erbele

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1290, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1290 was rereferred to the **Appropriations Committee.**

2007 SENATE APPROPRIATIONS

HB 1290

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1290

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 03-06-07

Recorder Job Number: 4484

Committee Clerk Signature Alice Delzer

Minutes:

Chairman Holmberg opened the hearing on HB 1290 at 3:30 pm on March 6, 2007 regarding Department of Health to contract for an evaluation of the state trauma system.

Representative Clara Sue Price, District 40, Minot Co-sponsor of the bill gave oral testimony in support of HB 1290. The bill in front of you will no doubt result in a contract with American College of Surgeons based out of Chicago. They are the group nationally that has the expertise to do this type of thing. Many things have changed in our state since 1995 when this was first implicated. Many of our hospitals now are critical access hospitals, we have new technology, our demographics have changed, so it is with that the House Human Services and the House itself said it is time to take a look at this issue and what is best for our citizens if they find themselves in that unfortunate situation.

Senator Lindaas you said the American College of Surgeons are they are people that were involved before and are they the only ones on the list.

Rep. Price stated she does not know who all was involved the first time and there is someone here that can do that. They are the ones who would come on a team, and to give you an example who would come on a team would be a surgeon on trauma, trauma evaluator, data system annalist representative, a surgeon from a representative state and someone from public Health Services, 2 consultants, one from California and one from Montana and they

have a lot of experience in the trauma system. The actual review is 4 to 6 months long. They come and take a look at our whole state.

Senator Holmberg stated as we get into the second part of the session and we are looking at all budgets as you folks in the House are doing, and I am not suggesting that we are going to do this but what would happen if we would fund this out of the Health Care Trust Fund. This is a one-time request. He stated this would be the health care trust. That is not your problem. You would like us to pass the bill and find the money.

Rep. Price asked if he was talking the tobacco settlement dollars or the community health. Further discussion followed regarding the trust fund.

Arnold Thomas, **President of the North Dakota Healthcare Association** presented written testimony (1) and oral testimony in support of HB 1290. He described the reason why the bill and asked them to consider why this assessment is needed. He felt the next two years is very critical. The reason being the demographics of North Dakota in a great state of flux and will continue to be so at least over the next decade. People are moving primarily from west to east and then people in more rural areas are also moving closer and closer to where critical centers happen to be located. We have 43 hospitals in North Dakota, 33 of whom are critical access. The first question is what happens in a case of emergency and what this bill does is enable us to bring a neutral, outside group of experts into North Dakota and take a hard look at what we need in the ultimate infrastructure to take care of people should an emergency occur. What we hoping to do in the event that should a local community decide it is no longer able to sustain a facility and that facility's mission and purpose needs to change the people in that geographical area understand that elective medical matters they may be unconvinced in terms of transport by themselves, that would be their responsibility, but in the event of a trauma situation that there would be a system in place that would get them to the appropriate place in an

appropriate amount of time. And that is what this bill is designed to do. The funding is dependent on two factors: 1. What we estimate the cost to be to retain the American College of Surgeons to come in and do the study and 2. to provide the necessary resources to the Department of Health to enable them to staff that enterprise until it's closure. The outcome would be basically a chart of the future with recommendations, most of which will be of policy nature, that would be brought back to you to ensure that as the medical service delivery system changes that you would have the comfort of knowing that emergency services are in place for border to border access. He then gave an example (10.13)

Senator Bowman asked if most of those conclusions haven't already been determined by the smaller hospitals. When ever there is a serious accident that is going to require immediate attention from a hospital that has the adequate tools to work with they are not going to keep that person any longer than they absolutely have to only long enough to stabilize them enough so the ambulance can transport them to the proper hospital. He stated he's been down both of those roads himself, and I am glad we have that little hospital when I needed it.

My point is you already know the results of this because they do this everyday. You are trying to have the ambulance driver take them to the big hospital, that is the way it came across to me. He commented more about his little hospital and the investments they have made to update their equipment and was told by the physician in Bismarck that is was the best decision they could make to ensure that people get help in an emergency situation as soon as possible, stabilized and then sent on to the larger hospital to continue the proper treatment.

He was told it is working in the southwest part of North Dakota the way it should. The reason that we asked this bill to be introduced was in an evaluation of others across North Dakota where we are finding that 20% of our hospitals are not necessarily in compliance with the prodigals. This is not a big hospital, small hospital issue, this is you, the accident victim, that

needs to be taken, and if we do it now, if we don't follow a prodigal based on what the capacity is of the facilities in the geographical area, proximity becomes a principle and that is not in the best interest of the individual who is in a trauma situation. We want to be sure the patient is taken to the best possible treatment center.

Chairman Holmberg stated we won't pass the bill out today. We will take up this bill another time. He stated this bill goes through Human Services. The hearing on HB 1290 closed.

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1290

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 03-21-07

Recorder Job Number: 5426

Committee Clerk Signature Janet B Pinks

Minutes:

Chairman Holmberg opened the hearing on HB 1290 re: the trauma system.

Senator Kilzer HB 1290 is through the Department of Health and would engage the American College of Surgeons to investigate the statewide trauma system. He indicated this is well and good but outside the Department of Health there are other things more pressing.

Senator Kilzer moved a DO NOT PASS on HB 1290, Senator Grindberg seconded. A roll call vote was taken resulting in 11 yes, 3 no and 0 absent. The motion passed and Senator Robinson will carry the bill.

Chairman Holmberg closed the hearing on HB 1290.

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1290

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 03-28-07

Recorder Job Number: 5586

Committee Clerk Signature

Minutes:

Chairman Holmberg opened the hearing on HB 1290.

Senator Robinson moved to reconsider the actions on HB 1290, Senator Bowman seconded.

An oral vote was taken resulting in a do pass.

Chairman Holmberg indicated there were no amendments on HB 1290. Amendments .0201 were distributed.

Allen explained the amendments indicating it would remove a general fund appropriation and provide a $100,000 with $50,000 from the health care trust fund and $50,000 from grants and donations or other sources to do the review of the state trauma system.

Chairman Holmberg indicated in discussions with the proponents of the bill, they didn't appear to have problems with the direction of this bill. The question was asked of Allen as to what is the latest with the health care trust fund.

Allen indicated this fund is regenerating itself with about $800,000 a biennium in loan repayments.

Senator Grindberg moved a do pass on HB 1290 as amended with .0201, Senator Robinson seconded. No discussion was held. A roll call vote was taken resulting in 14 yes. The motion pass and Senator Robinson will carry the bill.

Chairman Holmberg closed the hearing on HB 1290.

Date: 3/21
Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1290

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DNP ~~as amended~~

Motion Made By Kilzer Seconded By Grindberg

Senators	Yes	No	Senators	Yes	No
Senator Ray Holmberg, Chrm	✓		Senator Aaron Krauter	✓	
Senator Bill Bowman, V Chrm	✓		Senator Elroy N. Lindaas	✓	
Senator Tony Grindberg, V Chrm	✓		Senator Tim Mathern	✓	
Senator Randel Christmann	~~✓~~	✓	Senator Larry J. Robinson	✓	
Senator Tom Fischer	✓		Senator Tom Seymour		✓
Senator Ralph L. Kilzer	✓		Senator Harvey Tallackson		✓
Senator Karen K. Krebsbach	✓				
Senator Rich Wardner	✓				

Total (Yes) 11 No 3

Absent _____

Floor Assignment Robinson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1290, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO NOT PASS** (11 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1290 was placed on the Fourteenth order on the calendar.

70577.0201
Title.0300

Prepared by the Legislative Council staff for
Senator Holmberg
March 27, 2007

3-28-07

PROPOSED AMENDMENTS TO ENGROSSED HOUSE BILL NO. 1290

Page 2, line 5, replace "in the" with "from special funds"

Page 2, line 6, remove "general fund in the state treasury, not otherwise appropriated," and replace "$100,000" with "$50,000"

Page 2, line 7, after the comma insert "from the health care trust fund and $50,000, or so much of the sum as may be necessary, from gifts, grants, donations, and other special fund sources"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment changes the appropriation for an evaluation of the state trauma system from the general fund to the health care trust fund and gifts, grants, donations, and other special funds sources.

Date: 3/24
Roll Call Vote #:

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1290

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken DP as amend

Motion Made By Grindberg Seconded By Robinson

Senators	Yes	No	Senators	Yes	No
Senator Ray Holmberg, Chrm	✓		Senator Aaron Krauter	✓	
Senator Bill Bowman, V Chrm	✓		Senator Elroy N. Lindaas	✓	
Senator Tony Grindberg, V Chrm	✓		Senator Tim Mathern	✓	
Senator Randel Christmann	✓		Senator Larry J. Robinson	✓	
Senator Tom Fischer	✓		Senator Tom Seymour	✓	
Senator Ralph L. Kilzer	✓		Senator Harvey Tallackson	✓	
Senator Karen K. Krebsbach	✓				
Senator Rich Wardner	✓				

Total (Yes) 14 No

Absent

Floor Assignment Robinson

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1290, as engrossed: Appropriations Committee (Sen. Holmberg, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (14 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1290 was placed on the Sixth order on the calendar.

Page 2, line 5, replace "in the" with "from special funds"

Page 2, line 6, remove "general fund in the state treasury, not otherwise appropriated," and replace "$100,000" with "$50,000"

Page 2, line 7, after the comma insert "from the health care trust fund and $50,000, or so much of the sum as may be necessary, from gifts, grants, donations, and other special fund sources"

Renumber accordingly

STATEMENT OF PURPOSE OF AMENDMENT:

This amendment changes the appropriation for an evaluation of the state trauma system from the general fund to the health care trust fund and gifts, grants, donations, and other special funds sources.

2007 HOUSE HUMAN SERVICES

CONFERENCE COMMITTEE

HB 1290

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1290

House Human Services Committee

☑ Check here for Conference Committee

Hearing Date: April 12, 2007

Recorder Job Number: 5961

Committee Clerk Signature Judy Schaak

Minutes:

Chairman Price: Would the Senate explain the amendments.

Representative Erbele: As the amendment was changed removes the 100,000 to 50,000. We have amendment with concerns that were brought up as we found out we need about 50,000 to do the survey and 25,000 to cover mileage and administrative costs. See attached proposed amendments. The money is taken from the health care trust fund.

Chairman Price: How much is left in there?

Senator Erbele: I don't know.

Senator Lee: This left the policy with 100,000 in there. It came out of appropriations which made us a little anxious. We were hoping to salvage it on the floor and Senator Nething thought there might be some danger of loosing it. So he asked it go back to appropriations see if they would consider studying the appropriations. That is why it came out as a 50 plus and there was no lead on any gift. That was a way to save the bill. It is important in my opinion for us to be able to fund that. The health department, in addition to the cost of the survey, which the charge is 50,000, and they would be able to do the work that they need to do for 25,000, so that is where the 75,000 number comes in.

Senator Erbele: passes out proposed amendments with changes. See attached. The 75,000 will be adequate for what is needed, and line 7 won't be there.

Chairman Price: Any more discussion or are you okay with the amendment?

Senator Erbele: Ii make a motion the Senate recede form its amendment and amend as follows, seconded by **Representative Uglem**. The role was 6 yeas, 0 nays, and 0 absent.

Chairman Price will carry the bill to the floor.

70577.0203
Title.0400

Prepared by the Legislative Council staff for
Senator Erbele
April 12, 2007

Conference Committee Amendments to Engrossed HB 1290 (70577.0203) - 04/12/2007

That the Senate recede from its amendments as printed on pages 1283 and 1284 of the House Journal and page 1092 of the Senate Journal and that Engrossed House Bill No. 1290 be amended as follows:

Page 2, line 5, replace "in the" with "from special funds"

Page 2, line 6, remove "general fund in the state treasury, not otherwise appropriated," and replace "$100,000" with "$75,000"

Page 2, line 7, after the comma insert "from the health care trust fund and $25,000, or so much of the sum as may be necessary, from gifts, grants, donations, and other special fund sources"

Renumber accordingly

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1290 (, as (re)engrossed): Date: 4/12

Your Conference Committee House Human Services

For the Senate:	YES	NO	For the House:	YES	NO
Sen Erbele			Chairman Price		
Sen Lee			Rep Uglem		
Sen Pomeroy			Rep Conrad		

recommends that the (SENATE/HOUSE) (ACCEDE to/RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) 1283 - 1284

____, and place _____ on the Seventh order.

____, adopt (further) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: 4/12
CARRIER: Rep Price

LC NO.	of amendment
LC NO.	of engrossment
Emergency clause added or deleted	
Statement of purpose of amendment	

MOTION MADE BY: Sen Erbele

SECONDED BY: Uglem

VOTE COUNT 6 **YES** 0 **NO** 0 **ABSENT**

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE

HB 1290, as engrossed: Your conference committee (Sens. Erbele, G. Lee, Pomeroy and Reps. Price, Uglem, Conrad) recommends that the **SENATE RECEDE** from the Senate amendments on HJ pages 1283-1284, adopt amendments as follows, and place HB 1290 on the Seventh order:

That the Senate recede from its amendments as printed on pages 1283 and 1284 of the House Journal and page 1092 of the Senate Journal and that Engrossed House Bill No. 1290 be amended as follows:

Page 2, line 5, replace "in the" with "from special funds"

Page 2, line 6, remove "general fund in the state treasury, not otherwise appropriated," and replace "$100,000" with "$75,000"

Page 2, line 7, after the comma insert "from the health care trust fund and $25,000, or so much of the sum as may be necessary, from gifts, grants, donations, and other special fund sources"

Renumber accordingly

Engrossed HB 1290 was placed on the Seventh order of business on the calendar.

2007 TESTIMONY

HB 1290

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

Same sum to Senate Appropriations

TESTIMONY FOR
HB 1290
JANUARY 17, 2007

Madame Chairman, members of the committee:

I am Arnold Thomas, President of the North Dakota Healthcare Association. I am here in support of HB 1290.

Bill elements

- Requires the Department of Health to contract with a professional organization, one national in scope, with expertise in trauma system evaluation to evaluate the current state wide trauma system.
- The evaluation is to produce recommendations for system improvement and enhancements, including an analysis of the current trauma program, its relationship to the state emergency management system and homeland security all-hazard planning and program efforts.
- Requires the State Health Officer to report the findings along with department response and recommendations to the legislative council no later than July 1, 2008.
- The scope of the study will be defined in a request-for-proposal developed by the Department of Health with advice and consent of an advisory committee made of representatives from the Emergency Medical, Medical and Healthcare Associations.
- The appropriations are for the cost of the study and administrative costs incurred by the department.

Why is this assessment needed?

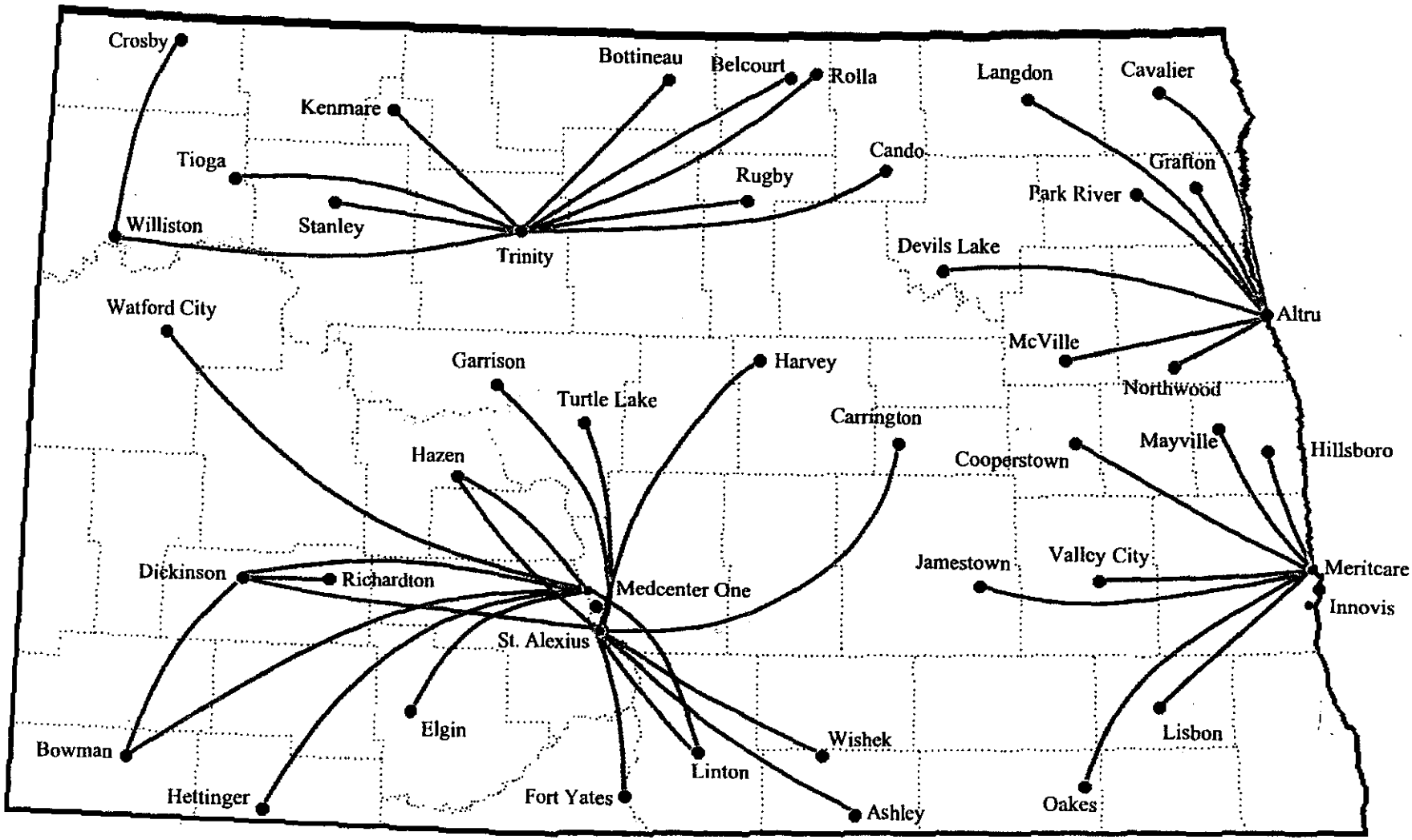
The current volunteer state trauma system has not been formally evaluated since its inception in the early 90's. A number of items challenge the current system: trained and available manpower; adoption and use of protocols for on site medical assessment, stabilization and transport; secure and uninterruptible communications; and capital.

With national priority on state wide emergency planning, the role and response of the state wide trauma system at a regional or state wide level adds complexity to the list of challenges outlined.

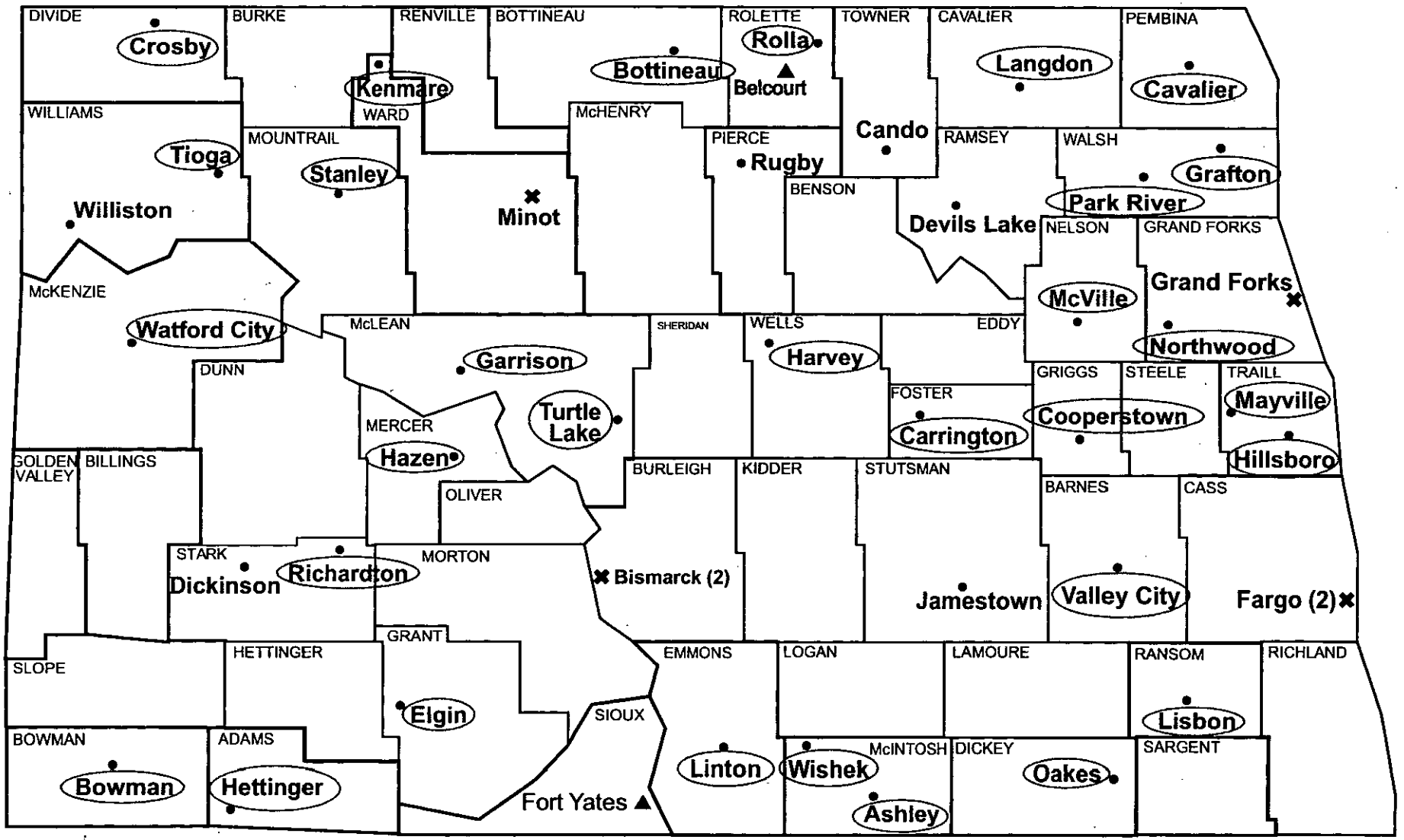
The findings and action recommendations by outside trauma system experts as a result of this bill will provide direction for sustaining a state wide trauma system in this period of challenge.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

North Dakota Hospitals – Primary Referral Relationships



North Dakota Hospitals and Critical Access Hospitals



Center *for* Rural Health

University of North Dakota School of Medicine and Health Sciences

- Rural Hospital
- ▲ Indian Health Service Hospital
- ✖ Tertiary Hospital-CAH Network
- ⬭ Critical Access Hospital

04/05

Testimony
House Bill 1290

House Human Services Committee
Wednesday, January 17, 2007

S. Shiraz Hyder, MD
Neurologist and Vice President of Medical Affairs
St. Alexius Medical Center

Good morning, Chairman Price and members of the House Human Services Committee. My name is Shiraz Hyder and I am a neurologist at St. Alexius Medical Center. I am here today to testify in support to House Bill 1290, and ask for a "do pass" recommendation from this committee.

Stroke is the third leading cause of death and the leading cause of disability in the United States. Each year about 700,000 people experience a stroke in the United States. On average, a stroke occurs every 45 seconds, and every 3.1 minutes someone dies of a stroke. Americans will pay about $51 billion for stroke-related medical costs and lost productivity. North Dakota's aging population will lead to an increased incidence of stroke. Last year in North Dakota, there were 4200 admissions to long term care facilities following stroke and approximately 80% of those could end up on Medicaid.

New treatments in addressing stroke emergencies make the effectiveness of a stroke trauma response system even more critical. Every day I see patients with different outcomes based on how well the chain of survival system works in response to a stroke emergency.

We have had patients that presented to emergency services paralyzed and unable to talk who walked out of the hospital talking with a smile on their face. We have also had patients that came in on a stretcher and left on a stretcher to a long-term care facility depending largely on how soon they received medical attention.

Testimony
House Bill 1290

S. Shiraz Hyder, MD

North Dakotan's are very stoic people. They do not seek timely medical attention particularly when it comes to stroke. Stroke can be a preventable or curable condition if medical intervention is timely. This is where North Dakotans are at a disadvantage. Timely intervention requires public awareness, education, efficient EMS and good communication between healthcare providers in rural and urban medical centers.

For the past year, I have served on a regional stroke advisory committee for the American Stroke Association, a division of the American Heart Association, in order to help guide possible improvements in our stroke care delivery system. While a number of strategies were discussed, from public education, EMS training, primary stroke centers, availability of neurologists, and a statewide stroke registry, we saw this trauma study as a positive step forward to provide both assessment and recommendations. This spring, the American Stroke Association will publish a white paper, providing guidance on stroke trauma systems. This national step, in conjunction with our state step to assess our trauma system, could lead to consensus, effective policy recommendation for next session that can establish a stronger stroke system of response.

I welcome your "do pass" recommendation for this bill.

Executive Offices
1622 E. Interstate Ave.
Bismarck, ND 58503

(701) 221-0567 Voice
(701) 221-0693 Fax
(877) 221-3672 Toll Free
www.ndemsa.org

HB 1290

January 17, 2007

Testimony – House Human Services Committee
North Dakota EMS Association
Dean Lampe, Executive Director

Good Morning, Chairman Price and members of the committee. My name is Dean Lampe, and I am the Executive Director of the North Dakota Emergency Medical Service (EMS) Association. Thank you for the opportunity to testify in support of HB 1290.

North Dakota's trauma system was formally initiated with legislation in 1995. Because the vast majority of trauma patients first present to the healthcare system through EMS, the North Dakota EMS Association is pleased to support this bill and we would also be pleased to take part in the evaluation of the state's trauma system.

I have provided a suggested amendment with my testimony which would simply correct the name of our organization as it reads in the bill to the North Dakota Emergency Medical Service Association.

Madam Chair, thank you for introducing this bill, and thank you for this opportunity to testify in support. I would be happy to answer questions the committee may have.

70577.0100 January 17, 2007

Prepared by the North Dakota Emergency Medical Service Association

PROPOSED AMENDMENT TO HB 1290

Page 1, Line 12, after "medical" insert "service"

Renumber accordingly

Heart Disease and Stroke. You're the Cure.

American Heart Association®
Learn and Live℠

American Stroke Association.
A Division of American Heart Association

Testimony
House Bill 1290

House Human Services Committee
Wednesday, January 17, 2007

June Herman
Senior Advocacy Director
American Heart Association

Good morning, Chairman Price and members of the House Human Services Committee. My name is June Herman, and I am the Senior Advocacy Director for the American Heart Association. I am here today to testify in support of House Bill 1290, and ask for a friendly amendment to the bill.

American Heart Association and American Stroke Association science-based guidelines serve as the foundation for cardiovascular and stroke trauma response. This spring, a new stroke trauma white paper will be released nationwide. The timing of this science based document and the study proposed by HB 1290, represents a significant springboard for North Dakota in aligning its trauma response for the two leading health issues in our state – heart disease and stroke.

AHA/ASA participated in early discussion on this bill, as part of determining a process to establish stroke trauma guidelines for the state. Our intent with this amendment is to utilize available AHA/ASA representation with expertise especially in the field of stroke, to help guide in implementation of what is proposed by HB 1290.

Two regional stroke task groups are assisting AHA/ASA with our stroke trauma work – one based in Fargo and the other Bismarck based. Attached to my amendment please find the suggested amendment to this bill. Our objective in including a representative from our organization is to continue the work we have already started with the groups already listed within the bill.

American Heart Association • Advocacy Department
PO Box 1287 Jamestown, ND 58402
Phone 701-252-5122 or 1-800-437-9710 • Fax 701-251-2092
www.americanheart.org

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1290

Page 1, line 13, after "association" delete "and"

Page 1, line 14, after "association" insert "and Senior Policy Director of the American Heart Association, North Dakota"

Testimony
House Bill 1290

House Human Services Committee
Wednesday, January 17, 2007

Harlan Kingsley
Stroke Survivor

Good morning, Chairman Price and members of the House Human Services Committee. My name is Harlan Kingsley and I am stroke survivor having benefited from effective trauma response related to my stroke. I am here today to testify in support to House Bill 1290, and ask for a "do pass" recommendation from this committee.

The status of my community's trauma response system was not a "top of mind" issue for me prior to November 13, 2006. On that date, I was driving a vehicle when suddenly my arm and leg went limp. My arm fell off the steering wheel. I was able to drive back to work at which time my coworkers, recognizing the warning signs of stroke, called 911.

I was transported to St. Alexius Medical Center where there is an established stroke trauma team. This team assessed my situation and through rapid intervention were able to administer the clot-busting drug t-PA. Within an hour I was able to move my arm and leg and my symptoms resolved almost completely. As a result, I am able to be present in front of you today with my ability to stand and speak about my personal experience.

As a result of my personal experience, stroke is top of mind for me today. If my stroke had occurred in any other location, however, would the trauma response system have been similar? If you or I were to travel down I-94 or perhaps down a more remote highway in North Dakota, what level of response capability would exist?

Living, working, hunting, or traveling in ND takes North Dakotans and visitors to all areas of our state. I encourage this trauma bill to make stroke trauma response a key component of its study. It's more than "peace of mind" for survivors like me.

Testimony

House Bill 1290

House Human Services Committee

Wednesday, January 17, 2007; 8:30 a.m.

North Dakota Department of Health

Good morning, Chairman Price and members of the Human Services Committee. My name is Tim Meyer, and I am director of the Division of Emergency Medical Services for the North Dakota Department of Health. I am here today to provide information on House Bill 1290.

Trauma is a significant public health problem in the state of North Dakota and is the leading cause of death for people age 35 and younger. Nearly 400 North Dakotans die each year as a result of traumatic injuries such as falls, car accidents or drownings. Nationally, trauma results in a greater loss of productive work years than both cancer and heart disease combined. Each year, more than 140,000 Americans die and more than 80,000 are permanently disabled due to traumatic injuries. This equates to $100 billion a year in lost productivity and increased health-care costs in the U.S.

The North Dakota Trauma System began in 1993 with the development of a trauma system plan that identified the need for an organized trauma system for the state. In 1995, legislation was passed that allowed for the development of a trauma system that included (1) a state trauma committee and regional trauma committees, (2) a trauma center designation system, (3) a statewide trauma registry system with a quality improvement process, and (4) pre-hospital trauma transport plans. Administrative rules were enacted in 1997 and were further revised in 2001.

House Bill 1290 would bring in a multidisciplinary team of national trauma system experts to conduct an independent assessment of the North Dakota Trauma System. Its intent would be to formulate recommendations for logical next steps in trauma system development. The credibility of the members and the objectivity of the process would assist the North Dakota Trauma System in facilitating improvements to and growth of the existing trauma program.

The North Dakota Trauma System would have the ability to customize the review by asking the team to address specific areas of interest. The expert team would provide a critical analysis of the current system status and formulate recommendations for system improvements and enhancements. A detailed consultation report would be prepared and provided to the state. The visit would provide the North Dakota Trauma System with valuable feedback to expand and improve the existing program.

This concludes my testimony. I am happy to answer any questions you may have.

North Dakota Chapter American College of Surgeons

1622 E Interstate Ave • PO Box 1198 • Bismarck ND 58502-1198 • (701) 223-9475 • fax: (701) 223-9476

January 17, 2007

Clara Sue Price, Chairman
House and Human Services Committee
House of Representatives
State Capitol
600 East Boulevard
Bismarck, ND 58505

RE: House Bill 1290 (Trauma System Review)

Dear Chairman Price:

Thank you very much for hearing our testimony on the morning of 01/17/2007 regarding House Bill 1290. You had asked questions regarding the eight representatives that would be coming from the American College of Surgeons. Team members would include:

1. A surgeon from the System Review Committee of the American College of Surgeons Committee on Trauma.
2. A trauma nurse coordinator with system experience.
3. An EMS director from a state with a functioning system and experience in evaluating the same.
4. A data systems analysis representative which we sorely need.
5. A surgeon from a representative state.
6. If requested, a person with Indian health service or public health service experience and participating in systems particularly regarding our reservations within the state.
7. Two consultants, one from Montana, whose name is Nils Sanddal and
8. Gail Cooper, who is from California. These two individuals have had a tremendous amount of experience in trauma systems both on large and small scales.

The actual review takes 4-6 months to prepare the pre-review questionnaire done by Amy Eberle, the State Trauma Coordinator. This is a fairly lengthy questionnaire and application process. Once the college receives the questionnaire, the college puts together a System Review Team. The entire process should be completed within eight months and certainly not longer than a year once it has started.

Once they arrive it is a four-day event beginning Sunday and ending on Wednesday. They give an exit interview with a power point presentation of pluses and minuses for our system and areas that we need to concentrate on. This is followed up with approximately a 100 page report covering similar information.

As I mentioned at the committee, this legislation is only geared to look at trauma. The College of Surgeons really doesn't focus on stroke or heart attack as was suggested by other testimony at the committee meeting. While I have no quarrel or problem with supporting those efforts, the College would not be looking at those systems specifically. That being said, beefing up your trauma system or making it more functional certainly makes everything else work better including disaster planning. It is amazing to me how we are so focused on disasters, yet a number of our hospitals still can't take care of major trauma victims and if they can't take care of major trauma victims, they certainly are not going to be able to take care of disasters.

My sincere thanks for your support of this bill. I look forward to its passage.

Sincerely,

Steven K. Hamar, M.D., FACS
Chairman
North Dakota Chapter American College of Surgeons Committee on Trauma
Member of the North Dakota Trauma Committee

#1

Mid Dakota Clinic
PrimeCare

February 28, 2007

Senator Judy Lee
Chairman of the Senate Human Services Committee
State Capitol
600 E Boulevard
Bismarck, ND 58505

Dear Madam Chairman:

This testimony is in support of House Bill #1290 providing funding for evaluation of the North Dakota state trauma system. Our trauma system has been in effect for more than ten years now. We do have some problems with it, particularly with funding with participation from some of our hospitals with staffing. Our system is probably functioning the best it probably can at this point in time and we should be able to do much better.

Diaster planning and management since 2001 has been a priority for hospitals yet many of them aren't prepared to take care of trauma patients, yet alone diaster situations. In order to help us evaluate and remedy this situation we have asked that House Bill #1290 be passed in order to provide funding for the American College of Surgeons to evaluate our North Dakota state trauma system.

The College sends out a team of seven members, two surgeons from the American college of Surgeons, a trauma nurse coordinator involved with trauma systems, an EMS provider who is heavily involved in systems management, a representative from the Indian reservation system, and two system representatives from a large metropolitan system area as well as from a rural system area. As a matter of the fact, the representative from the rural system area I believes comes from Montana. Prior to this team arriving a prereview questionnaire must be prepared by our State Trauma Coordinator. The preparation of this document will take anywhere from 4-6 months. It is a very detailed document, not looking at specific hospitals but at systems problems that the state is encountering, and looking actually at our whole system and where it can be corrected.

This review will look at trauma and its interaction with communication, transportation whether it be air or ground transport, EMS systems, reservation systems, communications between hospitals, law enforcement, EMS, fire, etc. It is approximately a four-day evaluation in front of a panel that the state would recommend and participate with. They look primarily at system issues, and again deal primarily from a trauma/disaster management perspective.

MAILING
PO Box 5538
Bismarck, ND 58506-5538

PHONE
701-530-6000
1-800-472-2113

LOCATIONS:
Main Clinic, 401 N. 9th Street, Bismarck
Center for Women, 1000 E. Rosser Avenue, Bismarck
University of Mary Student Health Clinic, Bismarck
Kirkwood Mall Clinic, 828 Kirkwood Mall, Bismarck
Gateway Mall, 2700 N. State Street, Bismarck
• Mid Dakota Clinic
• Gateway Dermatology
• Dermatologic Surgery, Cosmetic & Laser Center

I wholeheartedly endorse this bill. It is one that the State needs. Currently we have a functioning trauma system in our State but it is floundering and we need some assistance in shoring up our plan. We look forward to your recommending a do pass of this bill.

Sincerely yours,

Steven K. Hamar, M.D., FACS
Chairman, ND American College of Surgeons
Committee on Trauma
Vice-Chair of the ND State Trauma Comm.

SKH/mbk

D: 02/27/2007 17:30:00
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#2

American College of Surgeons/Committee on Trauma

CLIENT MANUAL

GUIDELINES FOR THE HOST AGENCY/TRAUMA MANAGER IN REQUESTING, SECURING AND HOSTING A TRAUMA SYSTEM CONSULTATIVE VISIT

Trauma Systems Consultation

draft
January, 2004

Gail Cooper and Nels D. Sanddal

Table of Contents

How to use this Guide

In the following pages the reader will learn about the Trauma Systems consultative process. This guide has been prepared to assist you, the client, in hosting and successfully completing a Trauma Systems consultation visit provided by the American College of Surgeons Committee on Trauma (ACS/COT). Our goal in preparing this guide is to make the process as simple as possible. We want this to be a successful consultation visit for your system and therefore want to ensure that you are: adequately prepared for the visit; understand the consultation visit process; have garnered the necessary trauma system stakeholders to participate in the visit; and clearly understand the expectations of the hosting agency, and the team. This document will help you to better prepare for the consultation visit and will provide guidance to help make your consultation visit a success.

General Information

Overview

History

In 1990, Congress passed the Trauma Care Systems Planning and Development Act that provided states with minimal funding for trauma system development. Administration of the funding rested with the Division of Trauma and Emergency Medical Systems (DTEMS) in the US Department of Health and Human Services. In 1992, DTEMS developed a Model Trauma Care Plan to provide guidance to states in the development of trauma systems, and subsequently began the development of a trauma system evaluation tool. However, Congress eliminated program funding and DTEMS was abolished prior to the completion of the trauma system evaluation document. Concurrently, in 1996, the ACS/COT formed a multidisciplinary "Working Group for Trauma System Evaluation". The group reviewed several key documents including the *Model Trauma Care System Plan* and relied on the experience of the NHTSA technical assistance program for assessing EMS systems in refining what has become the Trauma Systems Consultative Process. The charge of the working group was to develop an instrument to facilitate an objective review of a trauma system based on the *Model Trauma Care System Plan*. The mission was to promote the development and enhancement of trauma systems throughout the United States. Key principles included being consultative in nature and designed to help trauma systems develop and improve including both systems in the early stages of development and mature trauma systems. The group envisioned a multidisciplinary team review/consultation with the end product providing a guide for future trauma system development.

Purpose

The purpose of the ACS Trauma Systems Consultation process is to provide guidance to the development of trauma systems at a community, county, regional or state level. Whereas the ACS trauma center verification process focuses on individual institutions, this effort is far broader and will, most likely, involve multiple facilities as well as other essential trauma system components. The process will provide a broad perspective on all of the components of the system, their integration, function and identify opportunities for performance improvement.

Your trauma system will not be compared against other systems, but against the trauma system consultation goals. The consultation visit emphasis is on providing technical assistance and consultative advice to the requesting trauma system within the framework of the ***Consultation for Trauma Systems*** document. Each system has a unique set of strengths and challenges; the consultation visit will highlight the strengths and providing guidance to overcome the challenges.

This voluntary consultation visit will assist the trauma system in identifying needed improvements. However, it is not a verification or designation process, and is distinctly different from the ACS Committee on Trauma, trauma center verification.

How the visit will be conducted

Once a state, region, or local entity (EMS agency) makes a formal request for the ACS/COT to conduct the review, it takes about 4-6 months to gather the materials, confirm a team and complete the review process. However, in certain cases the preplanning phase can be accelerated to meet specific demands of the requesting agency.

Once a request has been made to the ACS/COT, a letter confirming the request and a set of materials, including this manual, will be sent to the requesting agency. The Client Manual and checklist will detail the arrangements to be made for the visit and steps to assuring a successful consultation visit.

A multidisciplinary team will be empanelled for your consultation visit including a trauma surgeon, emergency physician, trauma nurse, state, regional or local EMS director and team leader (usually a surgeon). A technical expert or specialist such as pediatric surgeon, communications, information technology, transportation or other specific issue specialist may also be necessary.

One or more logistical/technical support persons will also on hand to handle special arrangements the team may request, to facilitate the process and to assist in drafting the final report.

Once the team has been identified and confirmed, they will be sent the necessary materials to ensure that they are well prepared I in advance of the visit. The key to this process is your completion and return of the Pre-Review Questionnaire (PRQ) at least eight weeks prior to the scheduled visit. Each team member will have read the entire PRQ and will have made notes as to questions, clarifications, and additional needed information. Each reviewer will have a thorough understanding of the section(s) they will be responsible for facilitating including any special questions posed by the requesting agency.

Approximately two weeks prior to the site visit the team leader will conduct a conference call with the reviewers to go over the logistics, the PRQ, report writing and the requesting agency's focus questions.

The consultation visit usually takes three and a half days with one of those days a travel day. The team will arrive in the early afternoon the day before the formal start of the site visit for a pre-review meeting with the team leader and technical support staff. This meeting usually lasts about 2 hours. On the day of arrival there is a pre-meeting dinner (optional) with system participants. The purpose of this meeting/dinner is to get acquainted with the team and the system stakeholders prior to the more formal briefing sessions that follow. The briefings by systems participants will occur on the evening of the arrival day and for the next 1 ½ days. The final day will be for consensus development, report writing and closing session.

The entire consultation visit is very intense with the team concentrating on the issues, findings and recommendations to assist your trauma system. There will usually not be time for other sightseeing excursions or other leisure activities. . Meals should be provided by the requesting agency. During the final day of deliberation and writing the team will be sequestered and meals will be ordered in.

The gathering of information and the meetings with stakeholders is usually in a public forum. The consultative staff has been advised that dress for these briefings should be business attire.

The team will bring several laptop computers on which to prepare the final report. The requesting agency is asked to provide a high-speed/quality printer with appropriate drivers so that the various laptops can be attached to the printer. You will also be asked to provide access to a high speed copy machine. Access to these equipment items streamlines the report writing process.

Guiding Documents

The review is based on the guidelines and principles outlined in the following major trauma system documents:

- *Model Trauma Care System Plan (DTEMS/DHHS, 1992)*
- *Consultation for Trauma Systems* (ACS/COT) (available fromhttp://www.facs.org/trauma/systems.pdf)
- The requesting agency's Pre-Review Questionnaire (PRQ)

Other materials that will serve as background information for the consultants include:

- *Trauma System Agenda for the Future* (NHTSA/HRSA)
- Development of Trauma Systems course outline (NHTSA)
- Skamania Symposium. Trauma Systems, Evidence, Research and Action. *J Trauma*. 1999:47 (3), Supplement.

The requesting agency and other key trauma system leaders may wish to re-familiarize themselves with these documents.

Advantages

Broad System Review – According to ACS/COT *Consultation for Trauma Systems* guidelines

The importance of a broad system overview consultation cannot be over emphasized. No matter where a trauma system is in its development, the ability to have an outside review team provide additional consultation regarding ways to improve the system and move to the next level of care is essential to the maturing system.

During the evolutionary process of building a trauma care system much of the early focus is on developing capacity within each individual component. As the system reaches a point of early maturity the focus can broaden to the integration and interoperability of these individual components. Individual component problems are, to some degree, easier to fix. The communications and infrastructure necessary to make a "system" work is far more intricate. However, the effort is worth it in the long term. General systems theory suggests that it is not the individual components but the synergy that they combine to create that results in optimal performance.

Most trauma care systems have not reviewed their structure and function from a macro perspective. Various components may have been reviewed and accredited such as individual trauma centers or EMS agencies. Conventional wisdom and experience suggests that a "trauma center does not make a trauma system". Therefore as a system matures it is essential to review the entire system, looking for areas of strengths, weaknesses, opportunities and threats. Remember that this process is voluntary and designed to help in the ongoing evolution of your system.

Focused Questions Pertinent to Your System

The PRQ helps the consultative team focus on your needs. If there is a challenge facing your trauma system upon which it would be helpful to have the team's expert input, please be sure to provide sufficient information in the PRQ to help focus the dialogue and questions on that issue during the consultation visit. While the team is committed to looking at all aspects of your trauma care system, they will also take the time to address your specific concerns and challenges.

Outside Experts

The consultative team brings two unique qualities to your trauma system. First, they are leaders in the field and have experience that may help you look at a particular challenge from a different perspective. They may also have faced similar events within their own system and can share those experiences. However, the consultants are not trying to transport their system and make yours look like it. It is clearly recognized that each system, while possessing similar attributes, will be unique in its resources and attributes. The team will be trying to help you make the most of your available resources.

Second, the team members, individually and collectively, bring credibility. Often the local leaders may have been saying the same thing about a particular issue or problem but when it comes from an "outside expert" it suddenly has more credibility.

Leveraging Resources

It is the hope of the ACS and the consultative teams that the consultation process, and the product (final report and recommendations), will be useful in improving your trauma system including, if appropriate, the leveraging of additional resources.

Who Participates

The consultative team comprises both expert trauma system specialists and additional facilitative and support staff. However, the key to the successful consultative visit lies in the selection, orientation and participation of the local participants. In selecting and inviting these participants, remember that the team will be looking for information on the following system components and, in particular, how well integrated the individual components are into the overall trauma care system.

- Leadership
- System development
- Legislation
- Finances
- Injury prevention and control
- Human resources
- Emergency medical services
- Ambulance and non-transporting medical unit guidelines
- Communications
- Emergency disaster preparedness plan
- Trauma care facilities
- Inter-facility transfer
- Medical rehabilitation
- Information systems
- Research and evaluation

While the presence of key leaders and policy makers is important, it is essential that the people that regularly provide care or services within each of those components are also in attendance. Sometimes the leadership has a completely different perspective on the issues and challenges than does a "provider". A broad range of system providers from multi-agency and multidisciplinary groups representing all components of the trauma system will provide the best overall assessment of the current trauma system and allow development of recommendations for future system enhancements.

Cost

Sample Budget

ACS Administrative fee	$13,500
Honorarium	1,000 per day per site reviewer
Travel day	700 per day per site reviewer
Travel	
Airline x 5 reviewers	
Hotel accommodations	
Rooms and meals x 5 reviewers	

Logistical costs
- Hotel
- Meeting rooms
  - 1 large conference room for open meeting
  - 1 smaller conference room for the team to meet
- Equipment
  - Copy machine
  - Computer printer
  - Laptop connections
  - Dinner meeting for all participants (optional)
  - Lunch meeting the first day
  - Meals for reviewers when sequestered

Potential Sources of Funding

Both traditional and non-traditional sources of revenue may be available to offset the consultation visit costs. The trauma authority at a county, regional or state level may have funds through their general revenue streams or specific grants. City, county or state governments may be willing to allocate specific resources outside of the normal trauma budget. Federal agencies may identify a trauma system consultation visit as part eligible grant expenses for trauma system assessment. Grants earmarked for bioterrorism or general emergency preparedness may be appropriate sources of revenue. Non-governmental sources might include private foundations or membership organizations. A group of facilities and agencies may choose to each contribute some portion of the cost.

Requesting a Trauma System Consultation

Who May Request a Consultation?

ACS will accept applications from any trauma system, local (city or county), multi-county regional, or statewide in nature. However, the requesting party needs to have the authority to speak on behalf of the system that is being reviewed. For instance, it would be inappropriate for a trauma director at a specific trauma institution to request a consultative visit for an entire county that involves multiple facilities and numerous other agencies. It would, however, be appropriate for the county trauma authority, or a group representing all of the trauma facilities in the area, to make such a request. Collaboration at the outset is one of the keys to a successful visit.

How to Request a Consultation

Requests should be made on a specific Trauma System Consultation Application Form. This form is included as Appendix A of this document and is also available from the ACS at the following address.

American College of Surgeons – Trauma Department
Michelle Wielgosz, Program Administrator
633 N. Saint Claire Street
Chicago IL 60611-3211
Phone: 312.202.5340
Fax: 312.202.5005
Email: mwielgosz@facs.org

Who Should Be Involved in Making the Request

Applications will only be accepted from agencies or individuals that have the authority to make such a request on behalf of their trauma system.

To Whom Should the Request be Sent

The application should be returned to Michelle Wielgosz at the address listed above.

Where Should Questions Be Directed

During the application process and up to the confirmation of the consultative team all questions should be directed to Ms. Wielgosz at the above contact points. She should continue to be your primary contact point for questions of process and logistics throughout the planning process.

Once the consultative team has been identified, limited contact with the team leader may be appropriate.

Preparing for a Trauma System Consultation Visit

Client Checklist

A copy of the following checklist is included as Appendix B of this document. It is designed to assist you in preparing for a successful trauma system consultative visit. Comments after each time delimitation are provided here to help identify key concepts, points or activities.

Five months prior

- ☐ Submit *Application for Site Visit* to ACS COT office
- ☐ Receive and review the Site Visit packet from ACS/COT
  - Client manual
  - Client checklist
  - Pre-review Questionnaire
  - Trauma System consultation manual
- ☐ Review materials with appropriate trauma system participants
- ☐ Determine several different dates that would be acceptable
- ☐ Preliminary discussion of the city in which the review will be conducted, and the meeting facility

It is important that sufficient lead-time be provided to ACS to ensure that a qualified team can be empanelled. Five months lead time also provides sufficient time for the exchange of information and for pre-event activities at the local level.

Four months prior

- ☐ "Negotiate" dates for site visit with team leader and in conjunction with ACS staff.
- ☐ Determine who will complete and review the Pre-Review questionnaire
- ☐ Begin discussions of who will participate in the site review
  - Assure inclusion of ACS COT chair and of state EMS/Trauma Office
- ☐ Begin discussions of who will attend the faculty pre-meeting/dinner (Optional)
- ☐ Preliminary work on meeting facility and on-site logistics
- ☐ Begin working on the Pre-Review Questionnaire
- ☐ Receive notification from ACS/COT about the team members and the staff
- ☐ Receive a preliminary budget for ACS/COT site visit costs
- ☐ Begin working with system participants to formulate focused area questions

The consultative visit can only be as successful as the quality of the information and discussion provided to the consulting team by the participants. Key system leaders often have schedules that are booked months in advance. It is essential to plan far enough ahead to accommodate those schedules. Additionally, early pre-planning and preparation will help avoid miscommunications and the ensuing confusion and frustration as the date approaches.

Three months prior

- ☐ Finalize the location (city), hotel and meeting facilities and notify the team leader/staff
- ☐ Finalize other logistics including:
  - Flip charts
  - Multi-media projector and screen
  - Copy machine
  - Printer (for computer)
  - Power strips for laptops
  - Refreshments for break
  - Meals for site visit
  - Pre-meeting/Dinner on first evening
  - Site reviewer meeting room
- ☐ Arrange conference call among select surgical and trauma leaders in your system and the team leader/staff to review your consultation visit expectations
- ☐ Receive a draft site visit agenda from the Team leader/staff
- ☐ Invitations to participate in the site visit and in the faculty dinner (Suggested letters are included in this manual as Appendix C)
  - Include draft site visit agenda and list of review team members

The consultative process is very output and outcome oriented. To achieve the goal of having a nearly final draft of the findings and recommendations completed by the time the team departs, it is essential that meeting room logistics and equipment support be provided according to specifications.

The conference call among system leaders and the consultative team leader and support staff is designed to assist the team in better meeting your needs. Each system has different challenges and needs specialized input.

Early invitations to site visit participants are essential to gain good participation from informed trauma system participants.

Two months prior

- ☐ Complete the Pre-Review Questionnaire and Focused Questions (electronically) and submit them to the team leader/staff. The PQR should also be sent to system participants who will be attending and presenting information at the consultative visit.
- ☐ Submit your trauma system law and administrative rules to the team leader/staff (electronically, if possible)

The importance of the PRQ cannot be overstated. This document will serve as the orientation that each team member will have about your system. The better prepared the team members are, the more responsive they can be to your needs. Likewise the rules and regulations pertaining to your system are essential to the team member orientation.

One month prior

- ☐ Confirm all logistics for meeting rooms, audio-visuals, and other support
- ☐ Reminder letter/e-mail to all system participants and to persons participating in the first evening dinner/meeting
  - Suggest again including the draft meeting agenda
- ☐ Visit with ACS staff and Team Leader to review all logistical issues including:
  - Meeting room arrangements
  - First evening dinner/meeting – who will be attending
  - System participants – who will be participating

Follow-up with both local participants and team leaders/staff is essential.

Two weeks prior

- ☐ Notify Team leader or ACS staff about any last minute changes

While the consultative teams are used to last-minute changes, the more notice that they receive the better able they will be to adapt and adjust.

One week prior

- ☐ Notify team leader/staff about any last minute changes
- ☐ Phone call/e-mail reminder to all system participants and persons participating in the first evening pre-meeting/dinner

Friendly reminders and updates.

The day of the site visit

- ☐ Arrive early and complete the on-site checklist (See Customer Manual)
- ☐ Assure someone is available to meet with the review team, to answer questions and to manage on-site logistical challenges.

Having a specific person on site throughout the process to serve as a liaison between the local host and the team leader/staff will help facilitate the resolution of unanticipated changes or unexpected needs. Having the rooms prepared in the specified manner and the necessary equipment resources on-site is required.

Pre-Review Questionnaire (PRQ)

Basis

The questions in the PRQ were compiled directly from the *Consultation for Trauma Systems Handbook*. The PRQ is a separate document and is included in your consultation packet. Your responses to these questions serve as the basis for understanding your system and for the customization of the consultative visit, allowing the team to "hone in" on the issues that are unique to your trauma care system.

The importance of this document cannot be overstated. It is advisable that you assemble a working team to complete the document to assure a variety of perspectives are represented. Using a team approach it should take approximately 2-3 months to complete the PRQ in sufficient detail to be of maximum value to the consultative team. Each team member will review the PRQ prior to arrival.

Completion

The PRQ should be completed not less than two months prior to the scheduled site visit. It should be submitted both in six hard copies and in an electronic format (MS Word). The PRQ should be submitted to Michelle Wielgosz at the ACS address listed earlier.

Additional Materials

In addition to the PRQ other materials are essential to the team's understanding of your system, including: the laws, administrative rules and contractual agreements that govern your system, policies and procedures that provide guidance to providers, and any other documentation to demonstrate your system's structure, functionality, and operations. These materials can generally be provided on-site, however, if a review of the material is essential to the understanding of the system (such as the legislation authorizing the trauma system) it should be provided at the same time as the PRQ.

Questions About the PRQ

If you encounter questions concerning the completion of the PRQ, your point of contact should, once again, be Michelle Wielgosz. In many cases, she may choose to refer your questions to the consultative team leader or another staff member.

Focused Questions – What Are They; How To Submit

The consultation visit is a review of the current status of your trauma system with an emphasis on next steps to improve or enhance system performance. It is also a time for you to ask critical focused questions of the reviewers regarding unresolved system concerns. These questions can be issues raised by stakeholders, political leaders, consumers or others about any area of trauma system development. Focused questions are often ones that have been controversial among system participants, need more critical thinking by outside reviewers, provide additional expertise to resolve, or require reinforcement of a strategy in order to implement a needed change. Examples of focused questions could include a broader discussion of triage guidelines in an area of low volume, the need for a helipad at a hospital in a rural area, or the need for a helipad in an area of heavy congestion where neighbor opposition is high. The focused questions should be specific to your system's critical issues and ones that would benefit from a multidisciplinary, open dialogue.

The focused questions should be submitted with the PRQ. There may need to be additional discussion with the team leader to be sure that the questions are clear and that the team thoroughly understands the nuances of each question. To the extent possible, the focused questions should fit within the Trauma Systems Consultation document PRQ.

Meeting Facility

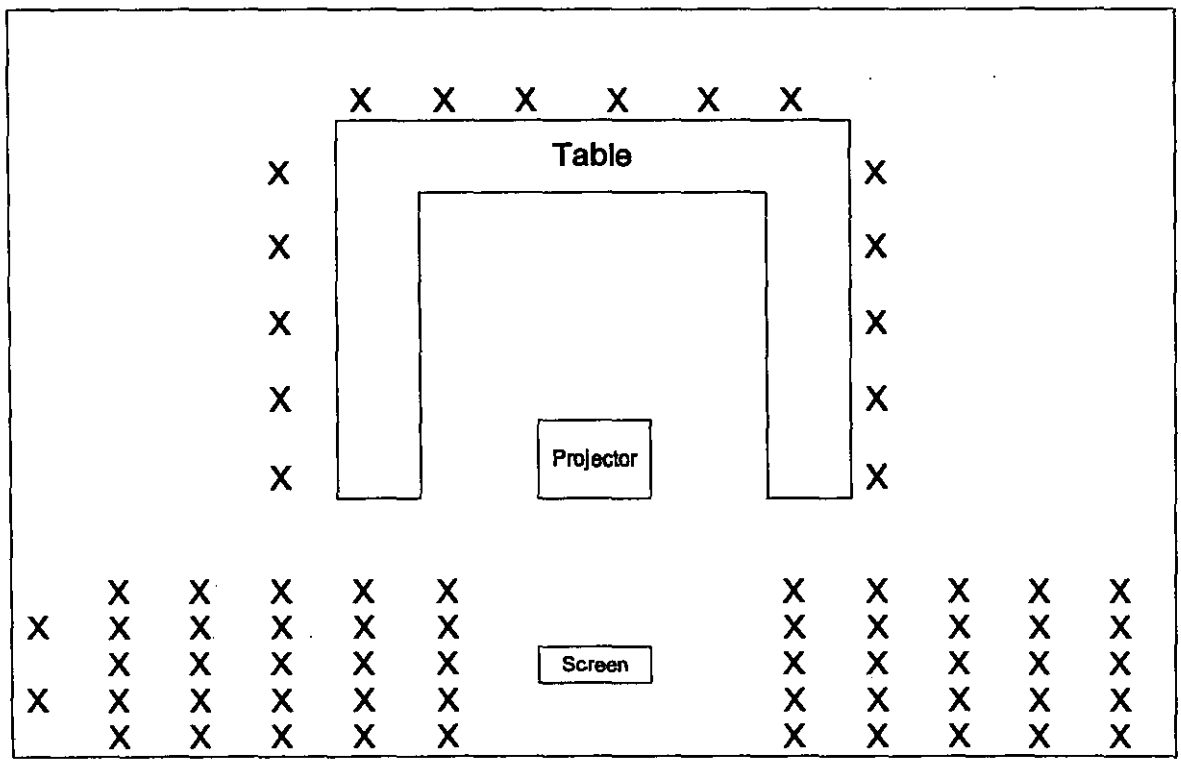
Integrated Meeting/Sleeping Facility

Ideally, the meeting room and the sleeping rooms for the consultation team should be in the same facility. Given the intense nature of the deliberations and the report completion process unnecessary travel between facilities is inefficient.

Main Meeting Room Set-Up

A good room configuration is a U-shaped table arrangement. The team members will be seated along the base of the U and the main local presenters along either leg of the U. Additional seating for other local contributors should be at the open end of the U. The projector should be situated in the gap between the two legs of the U. It should be arranged in such a manner that most all of the consulting team and the remainder of the audience can see it. There should be ample power outlets near the team members to facilitate the use of laptop computers during the discussions. An alternate design is to have the consulting team seated along a long table facing the audience. Each speaker will come to a podium to contribute. This configuration allows more room for movement and interaction between the audience and the consulting team during breaks.

The following diagram represents a useful room configuration.



Team Meeting Room

A separate meeting room for the team is required. This room, which can be substantially smaller, may either be set in a U-shape or in a boardroom style with one large table. There should be ample room for 8-10 people. Easy access to ample power supplies is essential. The printer and the copy machine should be set up in this room.

Required Equipment

The following equipment must be available in the main meeting room:

- LCD projector with power, connector cable, software drivers
- Screen
- A minimum of three power strips/surge protectors accessible from the head of the meeting table.
- Flip chart and pens

The following equipment must be available in the team meeting room.

- Printer, power cord, connector cable, software drivers
- Copy machine
- Minimum of 2 reams of paper
- At least three power strips/surge protectors accessible from the tables
- LCD projector with power, connector cable, software drivers

Other Logistic Considerations

- Meals, refreshments for breaks, etc.
- Dinner on the first evening (optional)
- Airport transportation
- Payment of hotel/meals
- Payment for the visit
- Upfront payment of administrative costs
- Who should be invited? Who should invite them? What should they be told (consider a sample letter of invitation)

The Consultation Visit

Role Of The Host During The Meeting

The host will assist the team during the course of the system consultation visit including:

- Welcoming the guests and system participants
- Introducing the team leader at the meeting/dinner and help set the "tone" for the consultative visit. The team leader will introduce the rest of the team members.
- Reintroducing the team leader at the beginning of the main session and help set the "tone" for the consultative visit. The team leader will have the team introduce themselves and state their qualifications.
- Making key introductions to the team leader and/or members
- Informing the team leader and/or section leader of specific local expertise that should be queried about each section
- Designating someone to serve as a liaison with team members and staff to assist with meeting unforeseen needs, e.g. broken printer.
- Providing concluding remarks following the presentation of findings on the final day.
- Contributing to, but not dominating, the briefing session.

Process Overview

One team member will be assigned to lead each section of the discussion. He or she will be assisted by a back-up member who will be primarily responsible for capturing the essence of the discussion and key points on a laptop. The section leader will ask questions of the group in general or direct his questions specifically to individuals with expertise on that subject. The host will help identify those individuals who are there specifically to provide information on specific topics or sections. The section leader or the team leader may ask participants to limit their presentations if necessary because of time limitations.

Kick-Off Dinner/Meeting

The first evening meeting (dinner optional) on the night prior to the briefing session is critical to the success of the visit. At the opening of this meeting, the team leader will provide an overview of the process stressing the purpose of the consultation site visit, introduce the team members and provide information on their credentials. This meeting, which typically occurs over dinner, is an important part of the review process and should include a discussion/presentation of an overview of the system by the involved stakeholders, along with its perceived strengths and weaknesses, special issues or problems, and other information felt to be pertinent to the review process. This is typically a more relaxed occasion and acts to set the tone for the rest of the site visit. Section A on Leadership is usually covered during this session.

Public Participation

With the exception of the closed customer session described in the preceding section the remainder of the fact finding session must be open to the public in accordance with the jurisdictions open meeting laws

Team Deliberations

Following the briefing session, the team will sequester themselves to deliberate and achieve consensus on its findings and recommendations and to draft the report. These deliberations are private and confidential. Hosting staff will not be participants to the final deliberations except to be available by phone should questions arise.

Sample Agenda

The following sample agenda is provided to give the planning personnel a clearer understanding of the process and flow of the site visit. A specific agenda will be developed for each site consultation.

Travel Day-first half day

Team arrival in early afternoon

Team meets with Team Leader to review documents	2-4pm
Dinner meeting/social hour with participants	5-6pm
Welcome, Introductions, Expectations, and Timeline for Completing Review	6-6:30
Overview of the Trauma System and System Briefing Section A. Leadership	6:30-9pm

Full Day One System Briefing Continues 8am – 5pm

Briefing (approximately one hour per section)	
Prehospital Care	8-9am
Definitive Care Facilities	9-10am
Break	10-10:30
Information Systems	10:30-11:30
Lunch	11:30-1:00
Injury Control and Prevention	1-2pm
Human Resources	2-3pm
Break	3-3:30pm
Evaluation	3:30-4pm
Research	4-5:00pm
Team retreats for deliberations and report writing	6-?

Day Two

Team gathers to complete briefing by client if necessary	8-10:00am
Team retreats for initial deliberations and report writing	10- 6:00

Day Three

Team gathers to complete report writing and findings	8-10am

Stakeholders gather for summary report/comments	11-12pm
Team departs for home	1:00pm

Post Consultation Visit

Evaluation

By requesting and participating in a trauma systems consultation the local representatives agree to assist in an evaluation of the consultation process. This will consist of both written feedback and exit interviews of select participants by ACS staff.

Sharing your system's successes

From time to time, the ACS may request permission to use portions of your report to help other systems overcome similar challenges. In such cases, ACS would request written permission from the lead agency to share the information contained in your report. ACS is very sensitive to issues of confidentiality and political realities. In all cases, information would be stripped of specific identifiers. Again, ACS will never share your information without your express permission.

Payment to ACS

SECTION TO BE ADDED.

Frequently Asked Questions

How long before I receive the report?

The goal of ACS is to have a final and formally approved report back to the requesting agency within six weeks of the visit.

Who should invite people to the visit?

In most cases it will be the requesting agency. However, if there are certain segments of the trauma system that might be more amenable to an invitation by someone else such as the COT chair, then by all means the invitation should be extended by the appropriate party.

Why the Sunday night meeting/dinner?

The dinner meeting provides a more informal atmosphere to start the session. It helps to establish the tone, allows the team members and local personalities to meet and get to know each other before the formal briefings begin. It also provides a selected forum to discuss the first section on leadership and Administrative components.

What role will I have in the selection of team members?

The primary responsibility for team selection rests with ACS. The selection will be based upon matching your systems needs with the expertise of various consultants. However, the requesting agency does have the power to suggest that a team member might not be appropriate based on previous history or other factors.

Why do I have to have a complete review? Why can't we just target the problems we are experiencing?

Sometimes the apparent problems are not the only problems. Additionally, in order for the consultative team to provide your system the best possible service it is essential that they come to know the strengths, weaknesses, opportunities and threats across the entire system. Targeting one area only tends to diminish the term "system" within the trauma care system. Without knowing the history and current status of the trauma system, reviewers may miss critical information necessary to make an informed judgment on a specific targeted area. Outside experts may identify opportunities for system improvement that are not readily apparent to the system participants or administrators.

Who do I deal with in making the arrangements and getting questions answered?

The primary point of contact is:

Michelle Wielgosz
American College of Surgeons – Trauma Department
633 N. Saint Claire Street
Chicago IL 60611-3211
Phone: 312.202.5340
Fax: 312.202.5005
Email: mwielgosz@facs.org

Who provides the final debriefing and who should attend?

The consulting team leader will provide the final report. The report, while highlighting on key findings, will be general in nature. It will provide the listeners with the general flavor of the findings and recommendations. The details of the final report cannot be released until it has been approved by the ACS Committee on Trauma.

Certainly the key players within your trauma system should plan on attending. This would include the state/local COT chairman, the state/local trauma system coordinator, key regulatory officials and so on. The list will look similar to the list of persons who provided comment during the site review process.

What if we don't agree with the final report?

The consultative team will do their best to capture the essence of your trauma care system in an unbiased and factual manner. What you do with the report once it is provided to you is up to you. You may choose to release it as is and circulate it widely. You may choose to circulate it only among members of the trauma care community, or you may choose to create an addendum that addresses any points that you disagree with. However, the report, after approval by the ACS, will generally not be modified once issued. Remember the report is based on the information in the PRQ, the interviews with participants, and the reviewer's professional expertise, 80-90% of the report will have been completed prior to the departure of the team and you will get some sense of its contents during the exit debriefing.

Who drafted the PURPOSE statements in the document?

The purpose statements for each section come from the DHHS Model Trauma Care Plan. The purpose statements were originally drafted by an expert working group representing both clinical and administrative expertise in trauma systems.

Who should we invite to the consultation? How do I deal with the politics?

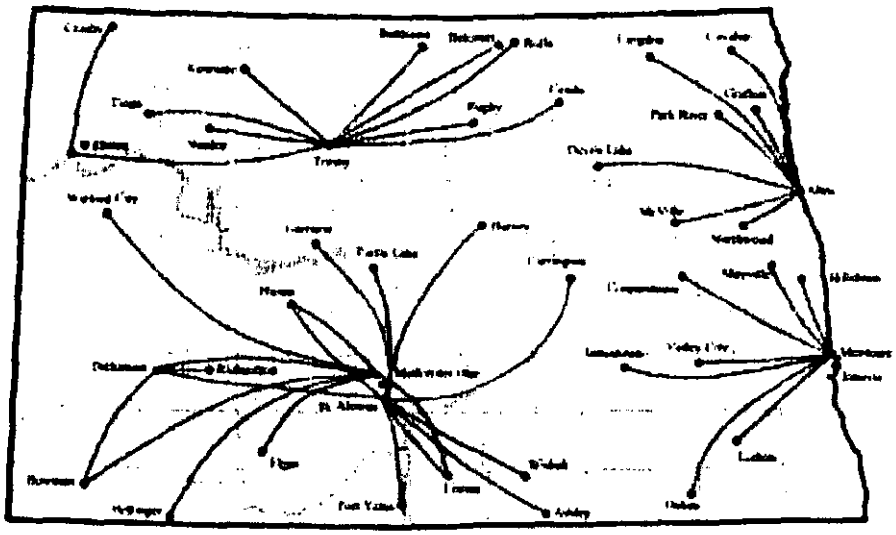
A small working planning committee may be useful in identifying the key players who need to contribute to each section. Invitations should be extended by the requesting agency or another person in authority. It is important that all "players" be at the briefing even if there is animosity among certain members. The role of the team leader will be, among many other things, to keep order and decorum during the briefings. The only way to begin to unravel "politics" is to make sure that all parties are heard; often the presence of an independent third party makes the process more civil and credible.

Should I invite the press?

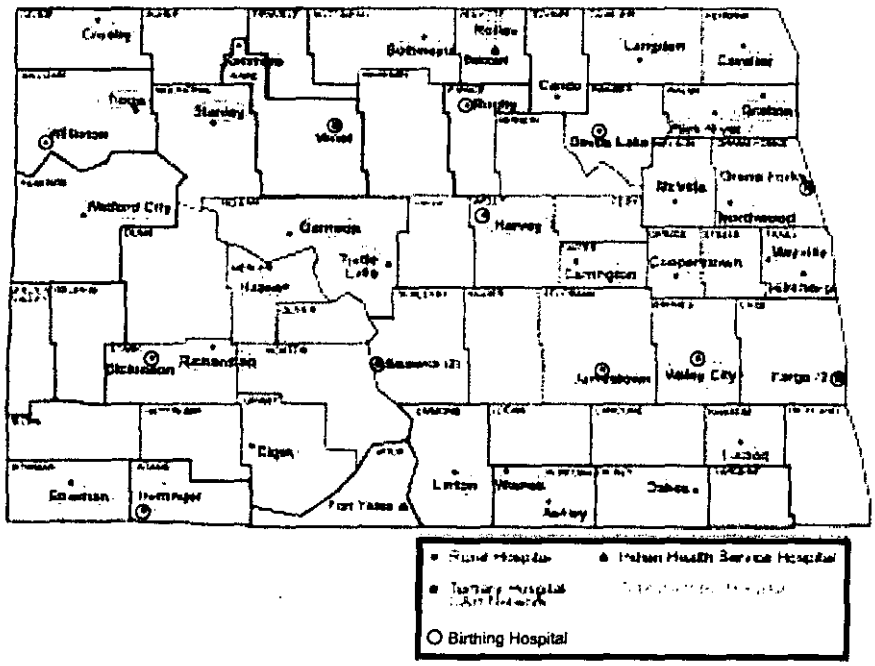
The main briefing sessions are open meetings. Again, the fact that the trauma system has matured enough to be willing to undertake such a wide-sweeping examination speaks highly. The concluding de-briefing may be the best place for the press. Participation should be followed-up with a copy of the final report if appropriate.

#3

North Dakota Hospitals – Primary Referral Relationships



North Dakota Hospitals and Critical Access Hospitals



#4

Testimony
Senate Bill 1290

Senate Human Services Committee
Wednesday, February 28, 2007

S. Shiraz Hyder, MD
Neurologist and Vice President of Medical Affairs
St. Alexius Medical Center

Good morning, Chairman Judy Lee and members of the Senate Human Services Committee. My name is Shiraz Hyder and I am a neurologist at St. Alexius Medical Center. I am here today to testify in support to House Bill 1290, and ask for a "do pass" recommendation from this committee.

Stroke is the third leading cause of death and the leading cause of disability in the United States. Each year about 700,000 people experience a stroke in the United States. On average, a stroke occurs every 45 seconds, and every 3.1 minutes someone dies of a stroke. Americans will pay about $51 billion for stroke-related medical costs and lost productivity. North Dakota's aging population will lead to an increased incidence of stroke. Many of these will end up at long term care facilities following stroke and approximately 80% of those could end up on Medicaid.

New treatments in addressing stroke emergencies make the effectiveness of a stroke trauma response system even more critical. Every day I see patients with different outcomes based on how well the chain of survival system works in response to a stroke emergency.

We have had patients that presented to emergency services paralyzed and unable to talk who walked out of the hospital talking with a smile on their face. We have also had patients that came in on a stretcher and left on a stretcher to a long-term care facility depending largely on how soon they received medical attention.

Testimony
House Bill 1290

S. Shiraz Hyder, MD

Stroke can be a preventable or curable condition if medical intervention is timely. This is where North Dakotans are at a disadvantage. Timely intervention requires public awareness, education, efficient EMS and good communication between healthcare providers in rural and urban medical centers.

For the past year, I have served on a regional stroke advisory committee for the American Stroke Association, a division of the American Heart Association, in order to help guide possible improvements in our stroke care delivery system. While a number of strategies were discussed, from public education, EMS training, primary stroke centers, availability of neurologists, and a statewide stroke registry, we saw this trauma study as a positive step forward to provide both assessment and recommendations. This spring, the American Stroke Association will publish a white paper, providing guidance on stroke trauma systems. This national step, in conjunction with our state step to assess our trauma system, could lead to consensus, effective policy recommendation for next session that can establish a stronger stroke system of response.

I welcome your "do pass" recommendation for this bill.

#5

NDHA
North Dakota Healthcare Association

Vision
The North Dakota Healthcare Association will take an active leadership role in major healthcare issues.

Mission
The North Dakota Healthcare Association exists to advance the health status of persons served by the membership.

TESTIMONY FOR
HB 1290
February 28, 2007

Madame Chairman, members of the committee:

I am Arnold Thomas, President of the North Dakota Healthcare Association. I am here in support of HB 1290.

Bill elements

- Requires the Department of Health to contract with a professional organization, one national in scope, with expertise in trauma system evaluation to evaluate the current state wide trauma system.
- The evaluation is to produce recommendations for system improvement and enhancements, including an analysis of the current trauma program, its relationship to the state emergency management system and homeland security all-hazard planning and program efforts.
- Requires the State Health Officer to report the findings along with department response and recommendations to the legislative council no later than July 1, 2008.
- The scope of the study will be defined in a request-for-proposal developed by the Department of Health with advice and consent of an advisory committee made of representatives from the Emergency Medical, Medical and Healthcare Associations and the American Heart Association.
- The appropriations are for the cost of the study and administrative costs incurred by the department.

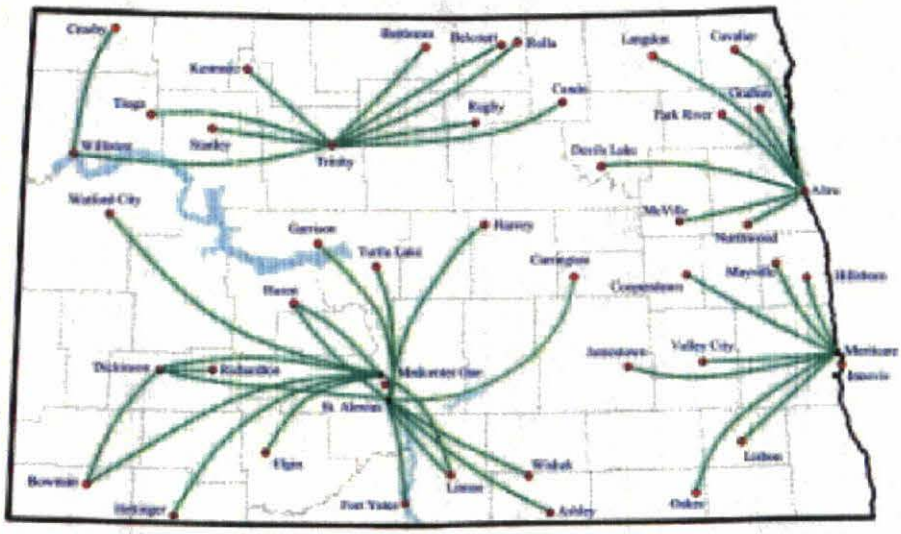
Why is this assessment needed?

1. The current volunteer state trauma system has not been formally evaluated since its inception in the early 90's. A number of items challenge the current system: trained and available manpower; adoption and use of protocols for on site medical assessment, stabilization and transport; secure and uninterruptible communications; and capital.
2. With national priority on state wide emergency planning, the role and response of the state wide trauma system at a regional or state wide level adds complexity to the list of challenges outlined.
3. The findings and action recommendations by outside trauma system experts as a result of this bill will provide direction for sustaining a state wide trauma system in this period of challenge.

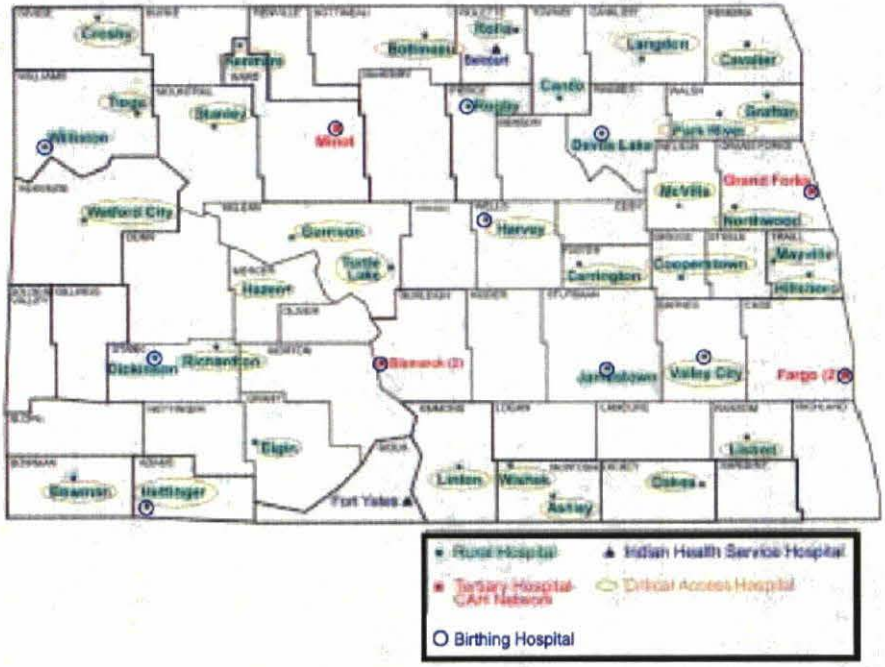
Madame Chairman, I would be happy to answer questions you or members of the committee might have regarding HB 1290. We ask for a "Do Pass" recommendation.

PO Box 7340 Bismarck, ND 58507-7340 Phone 701-224-9732 Fax 701-224-9529

North Dakota Hospitals – Primary Referral Relationships



North Dakota Hospitals and Critical Access Hospitals



#6

Testimony
House Bill 1290

Senate Human Services Committee
Wednesday, February 28, 2007

June Herman
Senior Advocacy Director
American Heart Association

Good morning, Chairman Judy Lee and members of the Senate Human Services Committee. My name is June Herman, and I am the Senior Advocacy Director for the American Heart Association. I am here today to testify in support of House Bill 1290.

American Heart Association and American Stroke Association participated in early discussion on this bill, as part of determining a process to establish stroke trauma guidelines for the state. science-based guidelines serve as the foundation for cardiovascular and stroke trauma response. This spring, a new stroke trauma white paper will be released nationwide. The timing of this science based document and the study proposed by HB 1290, represents a significant springboard for North Dakota in aligning its trauma response for the two leading health issues in our state – heart disease and stroke. We appreciate ND Healthcare Associations offer to include stroke into the scope of this work, with recommendations to help guide interim discussions.

Two regional stroke task groups are assisting the American Stroke Association, a division of the American Heart Association, with our stroke trauma work. One team is based in Fargo and the other Bismarck based. When meeting with the collaborative partners listing in this bill, we all agreed it would aide with important data for the development of a statewide stroke emergency response plan.

#7

Testimony

House Bill 1290

Senate Human Services Committee

Wednesday, February 28, 2007; 11:15 a.m.

North Dakota Department of Health

Good morning, Chairman Lee and members of the Human Services Committee. My name is Tim Meyer, and I am director of the Division of Emergency Medical Services for the North Dakota Department of Health. I am here today to provide information on House Bill 1290.

Trauma is a significant public health problem in the state of North Dakota and is the leading cause of death for people age 35 and younger. Nearly 400 North Dakotans die each year as a result of traumatic injuries such as falls, car accidents or drownings. Nationally, trauma results in a greater loss of productive work years than both cancer and heart disease combined. Each year, more than 140,000 Americans die and more than 80,000 are permanently disabled due to traumatic injuries. This equates to $100 billion a year in lost productivity and increased health-care costs in the U.S.

The North Dakota Trauma System began in 1993 with the development of a trauma system plan that identified the need for an organized trauma system for the state. In 1995, legislation was passed that allowed for the development of a trauma system that included (1) a state trauma committee and regional trauma committees, (2) a trauma center designation system, (3) a statewide trauma registry system with a quality improvement process, and (4) pre-hospital trauma transport plans. Administrative rules were enacted in 1997 and were further revised in 2001.

House Bill 1290 would bring in a multidisciplinary team of national trauma system experts to conduct an independent assessment of the North Dakota Trauma System. Its intent would be to formulate recommendations for logical next steps in trauma system development. The credibility of the members and the objectivity of the process would assist the North Dakota Trauma System in facilitating improvements to and growth of the existing trauma program.

The North Dakota Trauma System would have the ability to customize the review by asking the team to address specific areas of interest. The expert team would provide a critical analysis of the current system status and formulate recommendations for system improvements and enhancements. A detailed consultation report would be prepared and provided to the state. The visit would provide the North Dakota Trauma System with valuable feedback to expand and improve the existing program.

This concludes my testimony. I am happy to answer any questions you may have.