



K A N S A S

RODERICK L. BREMBY, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

DEPARTMENT OF HEALTH AND ENVIRONMENT

Testimony on House Bill 2752

To:

House Health and Human Services Committee

By:

Presented by Dr. Howard Rodenberg, MD, MPH
Director, Division of Health

Kansas Department of Health and Environment

Date: February 15, 2006

Chairman Morrison and Members of the Committee, I am Dr. Howard Rodenberg. I serve as Director of the Division of Health within the Kansas Department of Health and Environment, and as Kansas State Health Officer. I am pleased to appear before you today to support HB 2752.

Last year, over 1,100 Kansans died from unintentional injuries suffered on the road, the farm, or in the home. Many of these victims are young people. Unintentional injury is the leading cause of death in Kansans less than 34 years of age. Kansas ranks in the top twenty states in death rates from injuries in general, and 16th in death rates from motor vehicle crashes (Health Care State Rankings, Morgan Quitno, 2005). The rural nature of our state, and the absence of comprehensive health care facilities in those rural areas, means that Kansans living in rural areas have a higher death rate from trauma than urban residents. Approximately two-thirds of all fatal motor vehicle crashes occur in rural areas.

In 1999, the Kansas legislature recognized that injuries were a significant public health issue in Kansas and established the Kansas Trauma Program. The Secretary of Health and Environment was directed to develop and implement a statewide trauma system, including a Kansas Trauma System plan, to include system components such as hospital designation, regional trauma councils, quality improvement programs, and a statewide trauma data collection system. The legislation established an Advisory Committee on Trauma (ACT) to provide input to KDHE on the development of the statewide trauma system.

OFFICE OF THE DIRECTOR OF HEALTH
CURTIS STATE OFFICE BUILDING, 1000 SW JACKSON ST., STE. 300, TOPEKA, KS 66612-1368

Voice 785-296-1086 Fax 785-296-1562 <http://www.kdhe.state.ks.us/>

As one of the key steps in developing a comprehensive trauma system, the ACT recommended that hospitals in the state be categorized according to the level of trauma care resources they are able to provide. However, while the original legislative intent may have been to include statutory authority for hospital designation, interpretation by KDHE program and legal staff is that the language in the statute did not give clear authority to the agency to perform such designations.

Kansas has three level one trauma centers located in Wichita and Kansas City respectively. While most Americans believe that specialized trauma centers encompass the entirety of a trauma system, it is truly but one component of a well-coordinated system. In rural states such as Kansas, the trauma system extends well beyond the walls of the large, urban center. Three hospitals in the State (two in Wichita and one in Kansas City) have sought and received national recognition as trauma centers under the auspices of the American College of Surgeons (ACS) Trauma Center Verification Program. This bill will allow the Kansas Trauma Program to recognize ACS verification for Level I and Level II facilities (Level I being the highest level of care), and to undertake a state-directed hospital designation process for Level III facilities. A checklist of required facility resources and a verification process has already been identified for Level III trauma facilities. Due to the rural nature of our state, where just over half the population can currently reach a trauma center within the “golden hour” of mortality, the establishment of additional Trauma Centers throughout the state will increase the number of Kansans with access to trauma expertise in their time of need.

There is strong evidence that outcomes for injured patients are better if they are treated at a trauma center (MacKenzie *et al.*, 2006). Numerous states have already adopted trauma systems that have legal authority to designate hospitals (Nathens *et al.*, 2000). These systems have been shown repeatedly to improve patient outcomes such as survival and disability (for example, see Mullins *et al.*, 1996, for analysis of the Oregon Trauma system).

Trauma centers do more than look good on paper. In my career as an emergency physician, I’ve worked at hospitals with equivalent levels of resources, one that assumed the role of a Trauma Center and one that did not. The differences in attitudes towards both trauma patients, and emergency care in general, were astounding. A heightened awareness of the time-critical nature of trauma meant that patients were assessed sooner, treated faster, and had more clinician expertise available to them as they reached the door of the ED. There was a drive to provide continuing education to staff at all levels, and focused reviews of what went right and what went wrong with individual cases, lessons we could then apply to later cases. And while the focus of the effort was on trauma care, we found that our abilities to care for all kinds of emergent patients expanded as we become more confident in our critical care skills and more used to working as a multidisciplinary team.

While individual facility designation is an important step, evaluation of statewide trauma system effectiveness, accessibility, cost, and quality of care is essential. It is the role of the state trauma program to assure consistency in the strategies used for process improvement statewide, and to monitor, analyze and report improvements in the system along with deficiencies needing to be addressed. However, a statutory barrier exists to the use of system data for quality management and performance improvement. While the regional trauma plans already contain recommendations for quality improvement processes, use of the trauma registry data for quality improvement process is not occurring at this time because existing statute does not include peer

review protections in the use of this data for quality purposes. Patient records are essential to analyzing performance and identification of opportunities for improvement. These medical records must be accessible for these purposes, while being protected from inappropriate disclosure. The contents of this bill will accomplish this purpose.

The trauma system should provide optimal care given available resources, for all trauma patients no matter where they are injured or treated. Trauma is truly a matter of life or death.

We ask that you support HB 2752. I'll be happy to answer any additional question you might have.