
Trauma Watch

A publication of the Trauma Information Exchange Program

Monday, January 19, 2009

SPOTLIGHT

Arkansas governor calls for cigarette tax to fund establishment of trauma system

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Palm Beach County floats \$1.1 million plan for neurosurgical coverage

In light of a shortage of neurosurgeons willing to provide ED and trauma center call coverage, the Health Care District of Palm Beach County has outlined a \$1.1 million plan under which county hospitals would pool resources to secure shared access to specialists' services, the *Palm Beach Post* reported.

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IN THE JOURNALS

Study finds pediatric TBI patients may not need repeat CT scans

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➤ SPOTLIGHT

1 Arkansas governor calls for cigarette tax to fund establishment of trauma system

In a “State of the State” address last week, Arkansas Gov. Mike Beebe (D) called for the Legislature to prioritize the establishment of a statewide trauma system this session, outlining a proposal to fund the network through a 56-cent increase to the state cigarette tax, for a total of \$1.15 per pack, the Associated Press reported. According to state Surgeon General Joe Thompson, the tax increase would generate \$87.8 million for health care programs in fiscal year 2010, of which \$25 million would be allocated for trauma care; the state would also receive \$25 million in federal matching funds. However, Beebe anticipates that it will be an “uphill battle” to secure the required three-fourths majority in both the 35-member Senate and the 100-member House. Republicans are gathering support for an alternative funding stream through increased fees for drunken and reckless driving convictions—a plan that Beebe has said would not generate enough revenue to fully fund a trauma system and other health care programs. Currently, Arkansas is one of just three states without a trauma system and the only state without a Level I trauma center (*AP/Arkansas Business*, 1/14, available through www.arkansasbusiness.com; *Arkansas Business*, 1/13, available through www.arkansasbusiness.com).

2 Palm Beach County floats \$1.1 million plan for neurosurgical coverage

In light of a shortage of neurosurgeons willing to provide ED and trauma center call coverage, the Health Care District of Palm Beach County has outlined a \$1.1 million plan under which county hospitals would pool resources to secure shared access to specialists’ services, the *Palm Beach Post* reported. Currently, the taxpayer-financed health care district allocates \$20 million annually to run a countywide trauma system that provides 24-hour specialist call coverage at **Delray Medical Center** and at West Palm Beach-based **St. Mary’s Medical Center**—both Level II trauma centers. However, with area neurosurgeons already committed to the trauma centers, other county EDs are often unable to secure the specialists for other emergencies, such as strokes and aneurysms, sometimes necessitating the transfer of patients to other counties. Under the new model, one hospital would serve as the “safety net” for neurosurgical emergencies, while the other hospitals would pay—based on their needs and ED volume—for that coverage. County hospitals would collectively contribute \$1 million annually, and the health care district would supplement that with an additional \$145,000. The funding, officials said, would be enough to pay \$2,250 daily for on-call neurosurgeon services, plus \$822 per day to cover medical malpractice insurance costs. Hospital CEOs and physicians did not voice opposition to the plan when it was presented in a district advisory committee meeting last month, although some hospitals questioned the district’s estimate of \$2,250 daily rate for an on-call neurosurgeon, saying that \$1,500 would be more reasonable. However, HCA Inc.—which owns three Palm Beach County hospitals—indicated it is waiting to “learn further details” before making a commitment. Meanwhile, Mitch Feldman, CEO of **West Boca Medical Center**, said he would have liked the health care district to assume a greater portion of the funding. Looking ahead, the health care district will host a forum this month where county hospitals can discuss the merits of the plan; officials also plan to survey hospitals to identify gaps in ED coverage (*Galewitz*, 12/22/08, available through www.sun-sentinel.com).

➤ IN THE JOURNALS

3 Study finds pediatric TBI patients may not need repeat CT scans

An unchanged or improved neurological examination of pediatric traumatic brain injury (TBI) patients may be adequate to rule out neurosurgical intervention, eliminating the need for repeat cranial CT scans, according to a study in the December, 2008 *Journal of TRAUMA Injury, Infection, and Clinical Care*.

Noting that repeat CT scans are resource-intensive and may be associated with adverse events—such as extubation, cardiopulmonary events, and long-term cognitive defects into adulthood—researchers from the Hospital do Servidor Publico Municipal in Sao Paulo, Brazil, sought to determine the test’s value for the pediatric TBI patient population. For the study, they analyzed the records of 63 pediatric TBI patients who were treated between January 2000 and December 2006 and survived the first 24 hours following admission, had a Glasgow Coma Score (GCS) ≤ 12 , had at least one serial CT scan performed after the initial scan, and underwent a follow-up CT within the first 48 hours.

KEY FINDINGS

- The time between the first and second CT scans averaged 25.78 hours \pm 13.75 hours.
- Reasons for ordering repeat CT scans included follow-up (78%), neurological deterioration (20.4%), and increased intracranial pressure (1.6%).
- Compared with the initial CT scan, 41.2% of repeat scans showed improvement, 36% showed no change, and 23.8% showed deterioration. Between the initial and repeat CT scans, GCS score improved in 66.6% of patients, remained the same in 15.9%, and worsened in 17.5%.
- There was a significant association between GCS and changes in the findings of repeat CT scans ($p=0.000009$).
- Only one patient with a worsened GCS required surgical intervention based on the repeat CT scan.

In light of the findings, the study authors concluded that “stable patients or those improving and being adequately monitored do not benefit from a second CT”; instead, the GCS score serves as an accurate predictor of the need for neurosurgical intervention, they said. Study limitations identified by the researchers include the small sample size from a single institution, the lack of blinded and standardized cranial CT scan interpretation, and the failure to correlate injury progression with long-term outcomes—considerations that could inform future study (Lucas da Silva et al., “Value of repeat cranial computed tomography in pediatric patients sustaining moderate to severe traumatic brain injury,” *Journal of TRAUMA Injury, Infection, and Critical Care*, December 2008, available through www.jtrauma.com).

➤ TRAUMA HEADLINES

4 Newly reopened John Sealy Hospital (Texas) plans to restore trauma services

After several months of closure following Hurricane Ike last September, Galveston-based **University of Texas Medical Branch’s** (UTMB) **John Sealy Hospital** earlier this month reopened as a “sharply downsized facility” with 200 beds, the *Galveston County Daily News* reports. Pediatric, medical-surgical, transplant, and critical care services, as well as acute-care services for the elderly, are now available; additionally, the hospital has opened its cardiac catheterization laboratory, an ICU for burn patients, and hemodialysis and pharmacy services, among others. However, the hospital’s ED—previously a Level I trauma center—is still functioning on a treat-and-release or treat-and-transfer basis. Still, UTMB President David Callender asserted his commitment to restore trauma services, noting that medical branch officials hope to reopen the trauma center within the next couple months. Funding will be an issue, though, as Callender recently asked the state Legislature for \$335 million in emergency funds to help cover projected business losses resulting from Hurricane Ike. According to the *Daily News*, UTMB is also seeking a \$134 million baseline appropriation to fund its hospitals and clinics across the next two years (Elder, 1/7, available through www.galvestondailynews.com; Jones, 8/8, available through www.galvestondailynews.com; Haurwitz, *Austin-American Statesman*, 1/5, available through www.statesman.com; Lozano, *Associated Press/Houston Chronicle*, 1/7, available through www.chron.com).

5 New Sharp Memorial Hospital (Calif.) opens with expanded ED, Level II trauma center

Kearny Mesa, Calif.-based **Sharp Memorial Hospital**—one of five trauma centers in San Diego County—earlier this month opened a new \$195 million, 334-bed acute-care tower that expanded its ED and Level II trauma center to include 37 treatment bays and observation beds, SanDiego6 reported. The new facility also houses 48 intensive care rooms and 10 state-of-the-art surgery suites. The seven-story, 315,000-square-foot glass and steel building replaces a 54-year-old structure, which will be used for outpatient services (SanDiego6, 1/8, available through www.sandiego6.com; Darce, San Diego *Union-Tribune*, 1/8, available through www3.signonsandiego.com; Sharp Memorial website, accessed 1/9, available through www.sharp.com).

6 Northern California hospitals work to improve medical flight safety

As hospitals in the Sacramento, Calif., region plan for additional helicopter landing sites, area pilots are working to reduce the risk of air medical crashes by urging hospitals and public agencies to better track flights, the *Sacramento Bee* reported. The effort comes as the number of U.S. deaths from air medical crashes continues to grow, reaching at least 25 during 2008. While federal officials have scheduled safety hearings for February, California helicopter operators have sought to address the problem on a local level, spurred by two close encounters between aircraft in 2008 and a recent casino bus crash that caused an air traffic jam at Level I **University of California (UC) Davis Medical Center**, which averages between 45 and 50 emergency helicopter landings monthly. Specifically, representatives from the medical helicopter company California Shock Trauma Air Rescue (CALSTAR) and the California Association of Air Medical Services (CAAMS), among others, have held “anxious meetings” to address the issue. While saying that overall, air medical transport is “very safe,” the airborne emergency medical services coordinator for the California Highway Patrol (CHP) identified communications among medical helicopter services and hospital monitoring of helicopter landing sites as two key areas for improvement. Currently, the three Sacramento hospitals with helicopter landing pads defer to pilots to coordinate arrivals and departures. According to pilots, medical helicopters in the absence of oversight sometimes do not communicate on the same radio frequencies, may cross paths with fire or law enforcement aircraft, or may not be aware of other helicopters approaching the same site. To assist UC Davis and the Level II **Sutter Roseville Medical Center**—which “scores of helicopters fly into and out of”—in better managing the flow of aircraft, CALSTAR says it is developing a proposal to oversee their air traffic control at no charge. In addition, CHP and REACH Air Medical Services have entered into an interim agreement to use the same air-to-air frequency. Meanwhile, the vice chairman of CAAMS—which issued a two-page memo last fall proposing hospital helipad policies—said that hospitals’ reliance on pilots to sort out flight paths is “not good enough,” adding that hospitals should “get more involved in air traffic control, keep a log where anyone who answers a radio can easily spot it, and help pilots stay aware of incoming and outgoing flights” (Dahlberg, *Sacramento Bee*, 1/8, available through www.sacramentobee.com).

7 Bozeman Deaconess Hospital (Mont.) reverified as Level III trauma center

Montana-based **Bozeman Deaconess Hospital** was recently reverified as a Level III trauma center, the *Bozeman Daily Chronicle* reported. Bozeman Deaconess has received ACS verification three times by maintaining the level of care required to stabilize severely injured patients for transfer to a Level II trauma center in Great Falls, Missoula, or Billings. The closest Level I facilities are located in Seattle and Salt Lake City (1/10, available through bozemandailychronicle.com).

8 LSU Health Sciences Center (La.) in second phase of ED, trauma center expansion

Shreveport-based **Louisiana State University Health Sciences Center (LSUHSC)** announced the second phase of its \$8 million ED and Level I trauma center expansion, slated for completion this summer, the Shreveport *Times* reported. Since October of last year, the ED has inhabited the portion of the facility completed in the first phase of the construction project, which features 26 beds, including two trauma bays, a nine-bed observation unit, and a four-chair asthma unit. In the end, the fully expanded, 38,600-square-foot ED will have 56 beds—more than double its previous size—with four trauma bays, and will feature \$7.5 million in new equipment and supplies. The updated design incorporates “an inner working corridor accessible only to physicians and other staff, with doors leading to each treatment room,” the ED department chief said, noting that it will separate traffic flow and increase efficiency. In addition, a pediatric/fast-track unit is expected to help speed throughput for low-acuity patients. LSUHSC is the only Level I trauma center in the region, and its ED serves approximately 56,000 patients annually (1/1, available through www.shreveporttimes.com; LSUHSC website, accessed 1/14, available through www.ems.lsuhs.edu).

9 High Point Regional (N.C.) relinquishes Level III trauma designation

North Carolina’s High Point Regional Health System voluntarily surrendered its Level III trauma center designation following a site visit from the North Carolina Office of Emergency Medical Services, the *Greensboro News and Record* reported. According to hospital officials, the visit surfaced gaps in the system’s documentation of response times and medical and nursing staff trauma education. Officials at the hospital—which treated 775 trauma patients last year—emphasized that the review “showed no problems with the level of medical care” delivered at the facility, merely administrative deficiencies stemming from staff turnover and inadequate clerical processes. They added that the change will not affect the level of care provided to patients or ambulance routes. The system intends to remedy the documentation issues and eventually will seek to re-establish its trauma certification (Seagraves, 1/7, available through www.news-record.com).

➤ GENERAL HEALTH CARE HEADLINES

10 N.Y. Times highlights efforts to reduce ‘lingering effects’ of ICU stays

Noting that researchers are “alarmed” by observations that ICU patients may be weak for months or years after intensive care treatment, the *New York Times* recently highlighted efforts at some hospitals to reduce sedation and encourage ICU patients to walk, even as they remain tethered to ventilators, feeding tubes, and intravenous lines. According to the *Times*, the push to encourage early mobility and determine why ICU stays “can be so devastating” is increasingly important as the population ages and more people are admitted to ICUs, and as technological advances increase patient survival rates. While it remains unclear whether persistent disabilities, such as difficulty thinking or prolonged weakness, following ICU stays stem from patients’ illnesses or their time in the ICU, researchers “have been particularly surprised by how quickly patients ha[ve] lost strength,” which may never completely be restored. In nascent efforts to understand the causes of weaknesses, disabilities, and weight loss resulting from ICU stays, researchers are examining the effects on patients of, for example, being on a mechanical ventilator or receiving doses of sedatives, narcotics, or anesthetics. Although early mobility efforts are not always feasible for ICU patients—in part because such efforts often require a team of nurses, physical therapy specialists, and mechanical ventilator specialists to walk with ICU patients—ICU providers who have attempted ICU patient mobilization have found that it is helpful in patients’ recoveries.

For example, a pilot study by an ICU physician at N.C.-based **Wake Forest University Baptist Medical Center**—a Level I trauma center—found that ICU patients who are mobilized appear to recover more quickly and spend less time in the ICU and in the hospital. A critical care physical rehabilitation physician from Johns Hopkins Medicine added that “patients like [the early mobility efforts],” even if “some doctors and nurses...just shake their heads.” Noting that there is a lot of room for improvement in ICU patient outcomes, the Wake Forest physician added that he and other researchers are planning to conduct clinical trials to measure the helpfulness of early mobility efforts (Kolata, 1/11, available through www.nytimes.com).

11 Preventive antibiotic use associated with lower ICU mortality rate, study finds

Administering antibiotics to ICU patients as a preventive measure increases their chances of survival, according to a recent *New England Journal of Medicine (NEJM)* study. For the study, researchers from the University Medical Center Utrecht in the Netherlands randomized 5,939 patients treated in 13 ICUs in the Netherlands between 2004 and 2006 to receive selective digestive tract decontamination (SDD), selective oropharyngeal decontamination (SOD), or standard care; patients with an expected duration of intubation of more than 48 hours or an expected ICU stay of more than 72 hours were eligible. The SDD treatment involved administering four days of intravenous and oral antibiotics, while the SOD group was given oral antibiotics only. At 28-day follow-up, the researchers found that the mortality rate associated with standard care patients was 27.5% and that the mortality rate was reduced by an estimated 3.5 percentage points among SDD patients and by 2.9 percentage points among SOD patients. Meanwhile, the number of antibiotic-resistant bacteria did not increase among patients being treated with antibiotics. According to the researchers, the findings suggest that the benefits of administering antibiotics to ICU patients immediately—before an infection develops—outweigh the risks of patients developing antibiotic resistance. In light of concerns about antibiotic resistance, however, the study authors noted that the SOD regimen is preferred to the SDD regimen since it involves administering a lower volume of antibiotics, “thus minimizing the risk of selection for and development of antibiotic resistance in the long term.” Recognizing that the study did not provide insight as to how antibiotic resistance develops in the long term, the study recommended further research into this matter (de Smet et al., 1/1, available through content.nejm.org; *ScienceDaily* release, 1/4, available through www.sciencedaily.com; Kahn, Reuters, 1/2, available through www.reuters.com).

12 HHS unveils action plan to reduce HAIs

HHS earlier this month issued a plan establishing national goals and outlining key actions for coordinated agency efforts to reduce and prevent health care-associated infections (HAIs). The Action Plan to Prevent HAIs identified six categories of HAIs—including central line-associated bloodstream infections, *Clostridium difficile*, catheter-associated urinary tract infections, methicillin-resistant *Staphylococcus aureus*, surgical site infections, and ventilator-associated pneumonia—outlined 17 potential metrics and associated measurement systems and identifies five-year prevention targets. Highlighting opportunities for collaboration with national, state, and local organizations, the plan recommended the development of clinical guidelines, coordinated research efforts that address specific knowledge gaps, and an integrated strategy for information systems that accelerates electronic reporting by health care facilities. Furthermore, the plan recommended improving regulatory oversight of hospitals by adding sources and use of infection-control data to the accreditation process, continuing to incorporate infection prevention measures and outcomes in hospital value-based purchasing plans, and expanding CMS Hospital Compare measures to provide increased transparency of care and quality to consumers. Additionally, the plan encouraged efforts to “increase knowledge and awareness of key messages and prevention practices among providers [and] consumers.” HHS will accept comments on the plan through Feb. 6 and will hold meetings this spring to solicit public input (HHS plan, accessed 1/6, available through <http://www.hhs.gov/ophs/index.html>; HHS release, 1/6, available through <http://www.hhs.gov/news>; Goedert, *Health Data Management*, 1/6, available through www.healthdatamanagement.com; *AHA News Now*, 1/6, available through www.ahanews.com).

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