Dear Friends:

Trauma is recognized as one of the most significant threats to public health and safety in the United States. A trauma is a life-threatening occurrence, either accidental or intentional that causes injury or death. It is often serious and causes body-altering physical injury; our trauma victims are reliant upon the strength of our trauma program. We believe by combining healing and hope, the patient achieves a positive outcome.

As the area's only Level I Trauma Center, our multidisciplinary team is dedicated to assuming a leadership role in development, evaluation and continuous quality improvement of trauma care in the region.

Throughout the year, our team stands ready to deliver quality care at a moments notice. We are proud of our favorable outcomes that result from offering our patients up-to-date, technologically advanced care. We are happy to report that our mortality rates, even for those with the most severe injuries, are below the national benchmark average.

Our commitment to the community doesn't stop at providing excellent care. We continue to be active in trauma education and injury prevention throughout the region. Some of our achievements during 2009 include a successful Trauma Symposium attended by more than 240 health care providers, ongoing EMS run reviews, and multiple Trauma Nursing Core Courses.

Annual reports by their nature focus on the facts and figures. Sometimes we lose sight of the fact that these "facts and figures" are real people. Thanks to the expertise of our multidisciplinary team, 97.4% of our patients survived their injuries, which is higher than the national average.

Thank you for your interest in our program and for the opportunity to share the information in our 2009 annual report. We welcome your questions and/or comments. Please feel free to contact us at 330-480-3907.

Sincerely,

Brian S. Gruber, MD, FACS
Director of Trauma/Critical Care Services

Daneen Mace-Vadjunec, RN, BSN, ONC
Program Director of Trauma/Orthopaedic Trauma

St. Elizabeth Health Center
Humility of Mary Health Partners

HMHP Mission Statement

Humility of Mary Health Partners extends the healing ministry of Jesus by improving the health of our communities with emphasis on people who are poor and underserved.

Together We Commit To:

Compassion *– Our commitment to serve with mercy and tenderness.*

Excellence *– Our commitment to be the best in the quality of our services and the stewardship of our resources.*

Human Dignity *– Our commitment to be respectful of all persons.*

Justice *– Our commitment to act with integrity, honesty, and truthfulness.*

Service *– Our commitment to respond to those in need.*

Trauma Services Mission Statement

Trauma Services' mission is to reduce trauma related death and disability and to assume a leadership role in development, evaluation, and continuous quality improvement of trauma care.

To request a patient referral or transfer to the Trauma Center contact: 1-877-966-0662

Table of Contents

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The Level I Difference

Research shows that care at a Level I trauma center lowers the risk of death by 25% for severely injured patients, compared with treatment received at a hospital without trauma care services.

Level I is the highest rating designated to a trauma center by the American College of Surgeons (ACS). It allows for the quickest response possible to treat the severely injured. The trauma team meets or exceeds rigorous criteria and takes an organized and systematic approach to its work. The team is in a constant state of readiness 24 hours a day. Facilities such as a 64-slice CT scanner, surgery suite, and critical care units stand by for the trauma patient. SEHC also has a helipad on campus to accommodate air ambulance traffic.

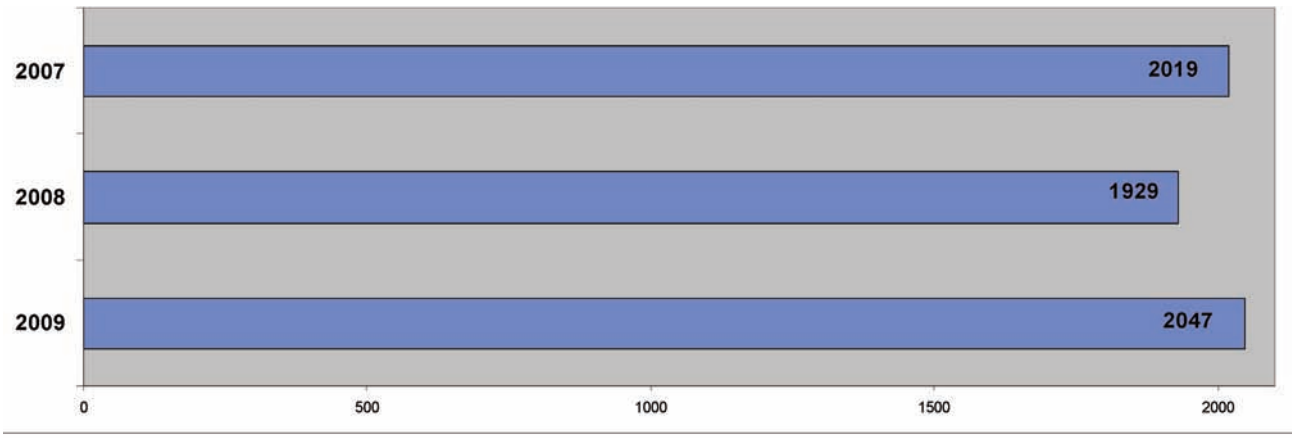
In order to be recognized as a Trauma Center in Ohio, hospitals must comply with sections 4798.01 and 3727.101 of the Ohio Revised Code. American College of Surgeons (ACS) verified Trauma Centers must submit documentation of verification. As of March 2009, there are 11 accredited Level I Adult hospitals in the State of Ohio. Trauma Centers are required by the ACS to continually monitor, evaluate and improve their processes for the purpose of achieving the best patient outcomes.

In addition to acute care responsibilities, Level I trauma centers have a major responsibility of providing leadership in education, research, and system planning. SEHC continues to develop the trauma program in clinical care, performance improvement, functional recovery, research and injury prevention. SEHC remains the only Level 1 trauma center between Cleveland, Pittsburgh and Akron.

Total Volume:

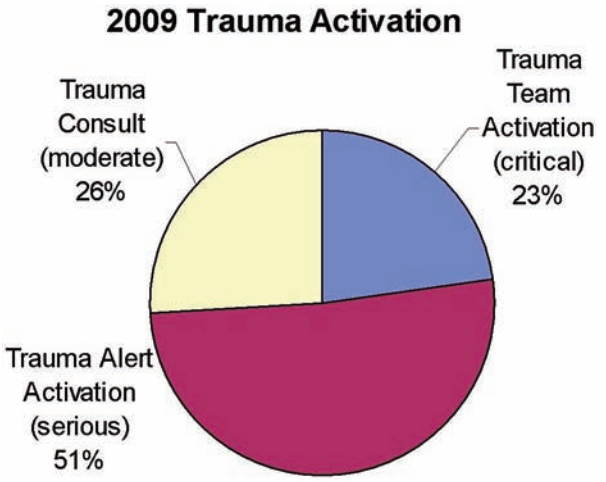
Last year over 2000 trauma patients were treated and admitted to SEHC.

Three-Year Comparison of Total Trauma Patients



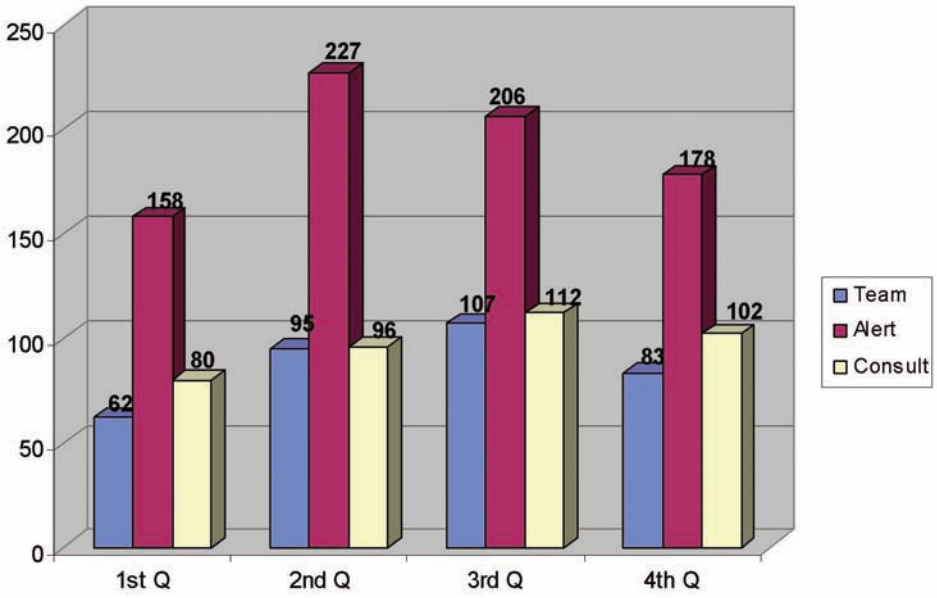
Three-Tier Response to Trauma

The appropriate activation is crucial to the trauma patient. The emergency medicine physician is responsible for deciding which level of response is warranted based on the information provided by the pre-hospital care providers. Pre-hospital triage and transfer criteria are based on guidelines established by the American College of Surgeons and the State of Ohio.



The trauma program monitors appropriate level of activation to reduce the potential of inappropriate use of resources that may affect patient outcomes.

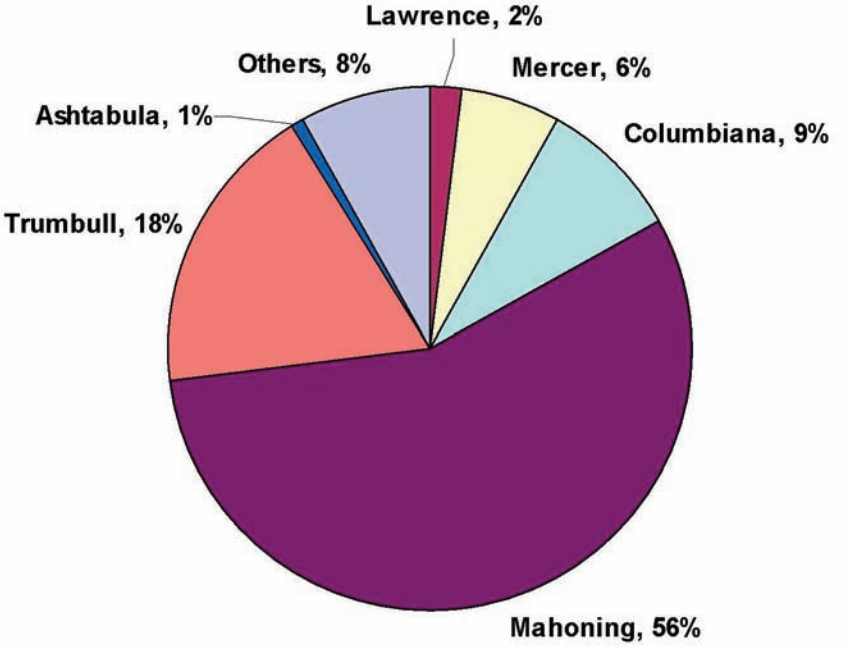
Trauma Volume by level of activation and quarter



Patients Served at the Trauma Center

The Mahoning Valley makes up 83% of our trauma population.

The Mahoning Valley has a population census of nearly 600,000 residents.



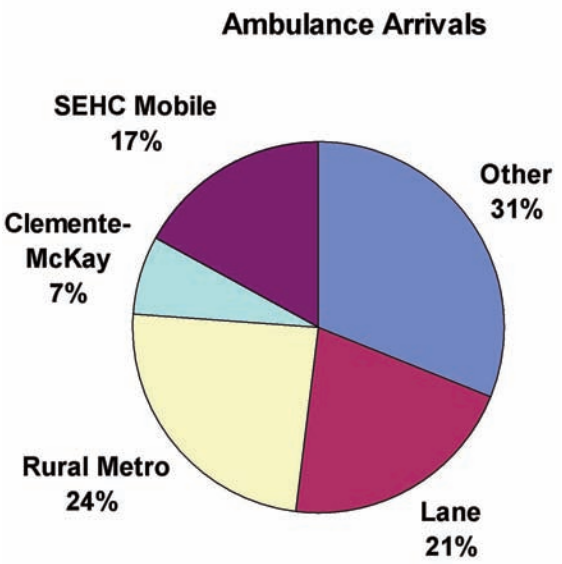
Transport Method

At the core of the SEHC trauma system are clinical and operational elements that provide direct patient care once an injury has occurred. These consist of hospitals and EMS providers that have a preplanned response to caring for an injured patient. They require the use of coordinated communication, accurate identification of the level of care needed by an injured patient, and rapid transport to the trauma center.

Ground transport

Ground transport brings 82% of the patients to the trauma center.

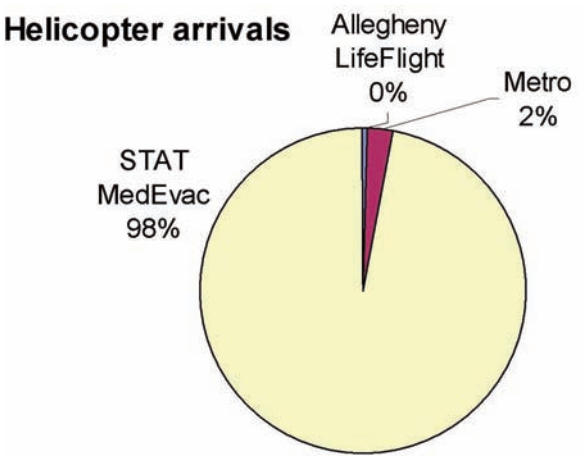
Four companies transported 70% of the patients to the trauma center. 43 different companies transported the remaining 30% of patients.



Air Medical Access

Air Medical Access brings 10% of the patients to the trauma center.

STAT MedEvac, which bases an aircraft at the Youngstown Eliser Airport, transports the vast majority of our patients arriving by aircraft. These aircraft are equipped with the latest in lifesaving and advanced aviation technologies.

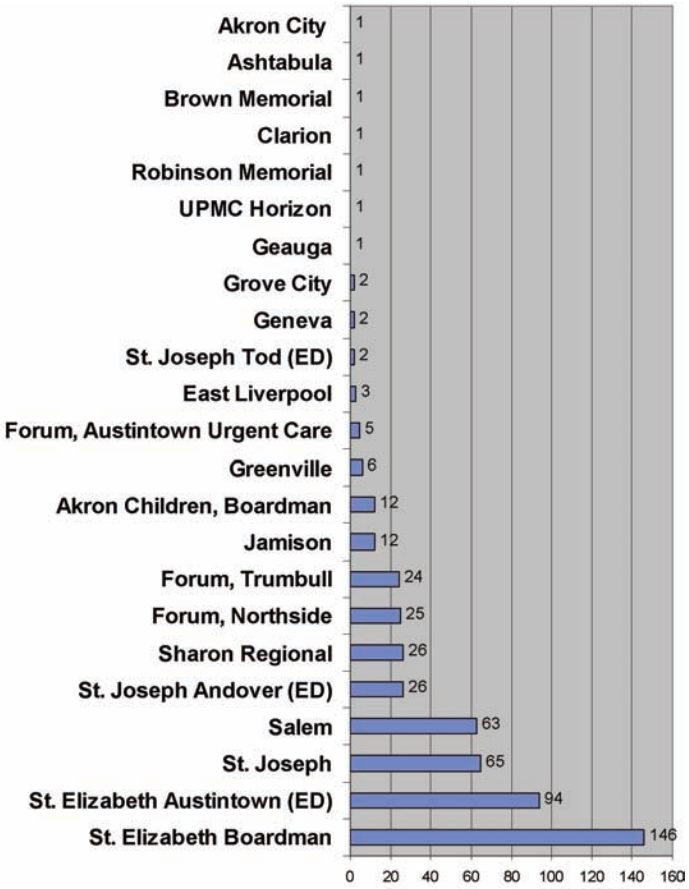


HMHP Mobile ICU (MoICU)

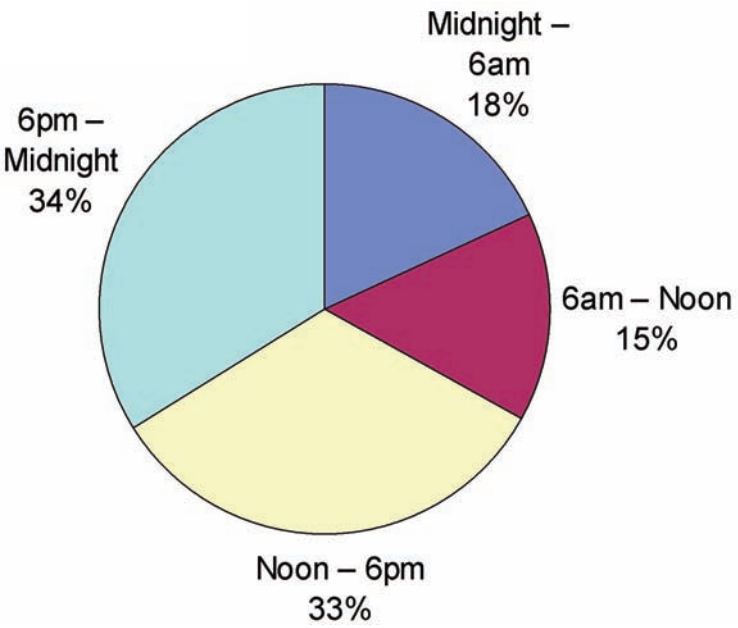
SEHC cares for critically injured patients throughout the region. As SEHC is a tertiary care facility, one out of every five patients is transferred in from another facility. In 2009, the MoICU transported 17% of our patients to the trauma center. The MoICU staff consists of specially trained advanced life support personnel (paramedics and mobile intensive care nurses) dedicated to providing our community with the best healthcare possible.

The MoICU provides services 24 hours a day, 7 days a week to our community since December of 1985. Our staff of highly skilled nurses and paramedics brings a unique blend of technology, professional expertise, human care and concern directly to the community hospital for transfer to the trauma center. The MoICU consists of four advanced life support units that are centrally stationed in Youngstown.

In 2009, 520 patients were transferred to the Level 1 Trauma Center from another facility (25%).



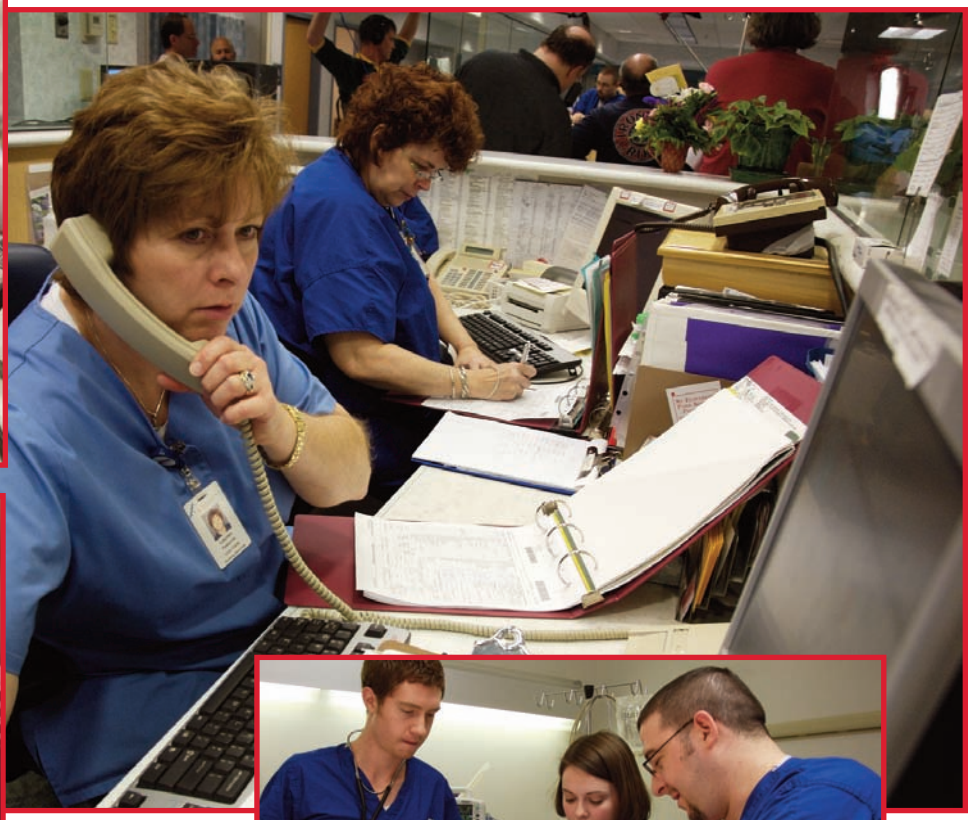
Arrival Times



Not every emergency department is a trauma center and equipped for the best treatment of the injured. The emergency department at SEHC is a vital part of the Level I trauma center. Board certified emergency physicians and staff treated more than 41,000 patients in 2009. Our over 20,000 square-foot emergency department is a full-service resource dedicated to providing compassionate care to our community.

Features include:

1. Board-certified emergency and specialty physicians
2. Subspecialist on-call every hour of every day to include: general surgeons, orthopaedics, neurosurgeons, neurologists, pulmonologists, anesthesiologists, radiologists, and board-certified critical care physicians
3. Dedicated trauma rooms with state-of-the-art radiology digital radiography system that is fully integrated with the hospital's picture archiving communication system (PACS)
4. 24-hour sexual assault nurse examiner (SANE) coverage providing specialized nursing care with a focus on the medical-forensic examination
5. Nursing staff that maintains certification in Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS), Trauma Nursing Core Course (TNCC), and Emergency Nurses Pediatric Course (ENPC). In 2010, our goal is to have 50% of emergency nurses pass the Certified Emergency Nurse Exam, and 100% in 2011.



Orthopaedic Trauma Services

Many patients admitted as traumas have some type of musculoskeletal injury. Motor vehicle and motorcycle crashes, industrial accidents, and falls from a significant height can cause major pelvic and complex extremity fractures. Orthopaedic Trauma Service is responsible for care and treatment of these injuries as well as post-traumatic sequelae such as deformities, nonunions, malunions, and osteomyelitis.

SEHC provides orthopaedic coverage around the clock to manage these orthopaedic injuries. This takes a variety of specialized surgeons, residents, and midlevel providers to assure the trauma patient gets appropriate orthopaedic care. Hospital-based orthopaedic surgeon Dr. James Shaer, as well as community-based orthopaedic surgeons, are on-call 24-hours a day should a trauma patient need emergent surgical intervention. To assist the surgeons, the orthopaedic residents and orthopaedic physician assistants (PA-C) are also able to provide hands-on care when a trauma patient arrives in the trauma bay with orthopaedic injuries. Whether they are reducing a fracture or dislocation, managing an open fracture, or dealing with complex pelvis fracture, their expertise in the evaluation and management of musculoskeletal trauma injuries provides the patient with quick and efficient care.

A majority of trauma patients have severe or multiple injuries. Polytraumatized patients are those unique patients with numerous skeletal injuries. Not all orthopaedic surgeons are equally prepared to manage those with severe injuries or the polytrauma patient. The care of these types of patients has become a subspecialty within orthopaedics (orthopaedic traumatologist). Drs. John Sontich and Brendan Patterson are "super-specialists" available to care for these complex injuries.

The orthopaedic clinic located in the outpatient surgery area, provides continued care once patients are released from the hospital. Drs. Shaer, Sontich, Patterson, and James Boniface provide follow-up care with the help of a multiple-disciplinary team, which includes physician assistants, a nurse practitioner and others.

Surgical Suites

State of the art operating suites are designed for the patient with multiple injuries. There is a surgical suite, as well as anesthesia staff, available to the trauma patient 24 hours a day, 7 days a week, and 365 days a year. During the year, there were 757 patients who went to the operating room.

SICU provides a state-of-the-art Surgical/Trauma Intensive Care Unit specifically for our trauma patients who require fast-paced, high-acuity, specialty critical care. It is a 12 bed unit, 2 of which are dedicated to the pediatric trauma patient. Trauma is the most common reason for admission to the SICU, 27% of our trauma patients were admitted to SICU in 2009.

The intensivist-led multidisciplinary team work together with the common mission of providing excellent care. The unit is adjacent to the emergency department, operative suites and PACU, and is equipped with the most sophisticated life support technology available. Hemodynamic monitoring is the cornerstone of patient management in the intensive care unit. Sophicastic technology allows for continuous monitoring of essential hemodynamic patient information. Clinical studies show that these types of monitoring systems significantly improve patient outcome.

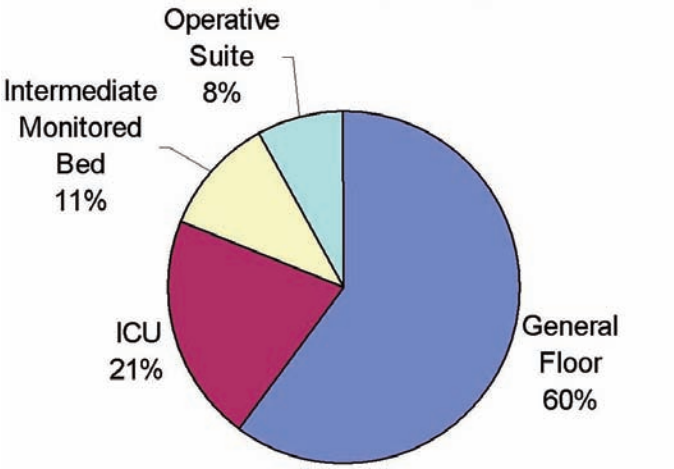
All the services and professionals necessary to treat the critically injured trauma patient are readily available 24/7. All registered nurses have advanced training; mandatory skills lab are available monthly to our health care professionals.

Having a loved one in the SICU can be a difficult and trying time. Our staff recognizes the families' contribution to the team and how important their visit is to the patient's recovery. "Family Friendly" visiting hours are now available to our patients' families.

In addition, there is a new unit specializing in neurosurgical trauma patients, which encompasses a full range of contemporary neurosurgical practices. A multidisciplinary approach is used to provide a complete range of services for the diagnosis, treatment and rehabilitation of patients with neurosurgical injuries.

Admitted Trauma Patients Distribution

In 2009, patients were admitted to the following areas from the emergency department.



Acute Rehabilitation Unit

The rehabilitation unit at SEHC is a 30-bed unit that provides services seven days a week to individuals with complex rehabilitation needs. Following their acute hospitalization, 126 trauma patients were admitted to the rehabilitation unit prior to transitioning home. The unit is CARF accredited.

Physical therapy helps with mobility, balance, and safe transfer skills. Treatments are scheduled twice daily, and consist of exercise to gain strength and restore muscle function, and ambulation to improve balance and gait.

Occupational therapy helps to develop skills in self-care, homemaking, recreation, school and work.

Speech/Language therapy assists with speech, language, memory, thinking and swallowing disorders.

Recreational therapy develops strength in social, emotional, and physical skills. This therapy helps with communication of thoughts and feelings and also develops self-awareness.

Rehabilitation nursing provides 24-hour-a-day nursing care, with ongoing assessment, planning, intervention and evaluation of patients, providing individualized care for (but not limited to) bowel and bladder, education, medications, pain management, skin integrity, medical issues and carry over of therapy interventions.

Rehabilitation physicians provide expertise in medical functional issues and direct the interdisciplinary team in coordinating the patient and family plan

Case management and social services provide individualized discharge planning and assistance with insurance needs.

Psychology services are available for patient and family regarding adjustment issues related to diagnosis.

Outpatient Rehabilitation

Our outpatient physical therapy program provides services for patients with orthopaedic, neurologic and post-surgical diagnoses. To better serve our patients, we also offer specialty programs in sports medicine, aquatic therapy, pediatrics, industrial rehab, and women's health. Our outpatient services are offered in the Youngstown, Warren, Austintown, and Boardman areas for convenience of our patients.

Trauma Registry

Trauma services maintains a complex database of all information gathered during the treatment of each trauma patient. The registry contains data on demographics, mechanism, pre-hospital care, emergency department, inpatient care, performance improvement issues and outcome information.

Information from this database enables staff to pinpoint areas that need to be improved in the medical process and facility; identify system-related, provider-related and disease-related issues that can be addressed.

The registry contributes data annually to American College of Surgeons, National Trauma Data Bank. The NTDB is the largest aggregation of US trauma data ever assembled. Data is aggregated and used to produce annual reports, hospital benchmark reports, and data quality reports.

Ohio hospitals are authorized by Ohio Law ORC 4765.06, Senate Bill 98 to submit trauma data to the State Trauma Registry. Data is submitted electronically quarterly, 90 days following the end of each quarter. The goal of the Ohio Trauma Registry is to provide data for development of public policy, healthcare education, injury prevention, and research. Hospitals must participate in order to be eligible for the EMS/Trauma grant program, or to participate in DEMS funded programs.

Trauma Patients Scales

Injury Severity Score (ISS)

ISS is an anatomical scoring system to provide an overall score for trauma patients. The injury severity score is the sum of squares of the three highest abbreviated injury scale scores for injuries to different body regions (head/neck, face, thorax, abdomen, and pelvic content, extremities, and external). ISS takes values from 1 to 75, 1 being a minor injury and 75 being a lethal injury.

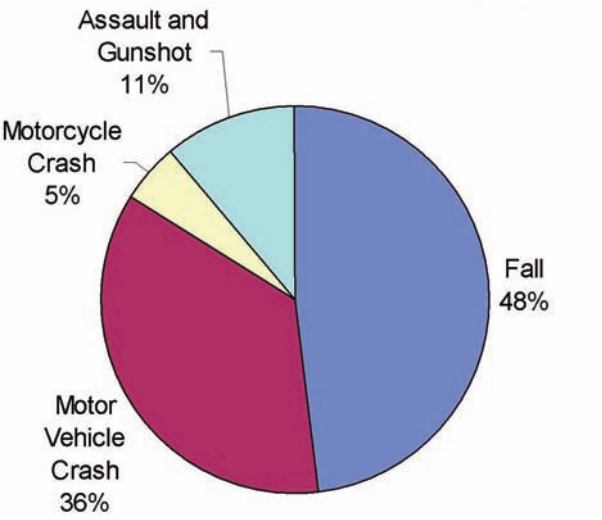
Glasow Coma Scale (GCS)

It is a standard measure used to quantify level of consciousness in head injury patients. It is composed of three parameters: best eye response, best verbal response, and best motor response. The lowest GCS total would be a 3 and the best score would be 15.

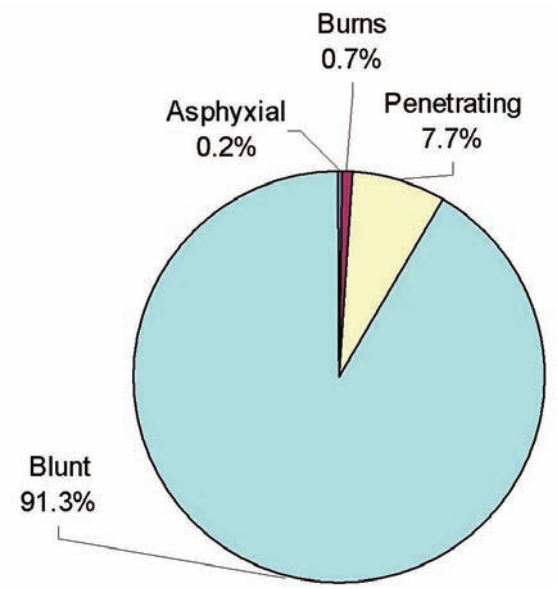
Individuals who drive while sending or reading text messages are 50% more likely to be in a motor vehicle crash.

Mechanism of Injury

Most common Mechanism of Injury for the 1888 adult trauma patients seen in 2009 were:



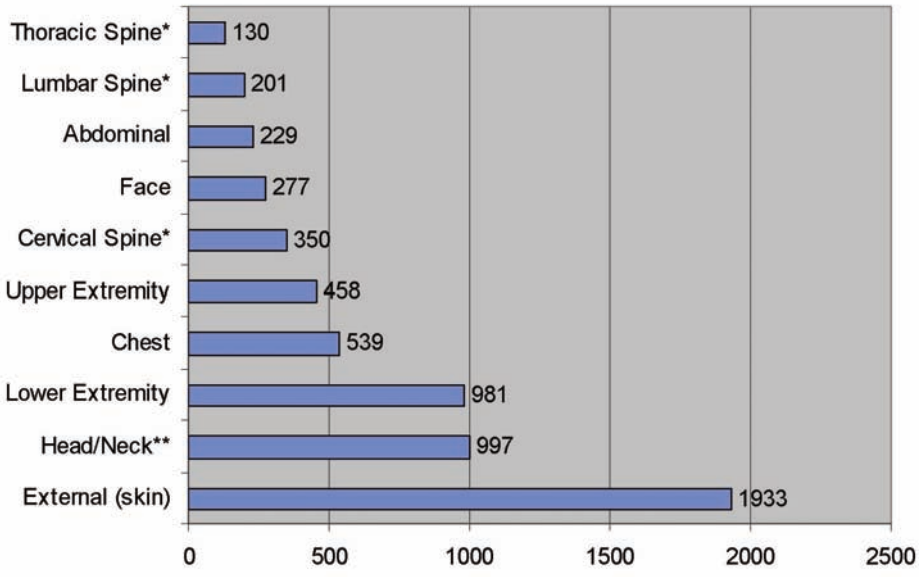
Taking all trauma patients into consideration, their injuries were:



Penetrating trauma is an injury that pierces the skin (such as a bullet or knife).
Blunt trauma is caused to a body part by impact, injury or physical attack that does not penetrate the skin (such as a steering wheel impact in a car crash).

Injuries by Body Region

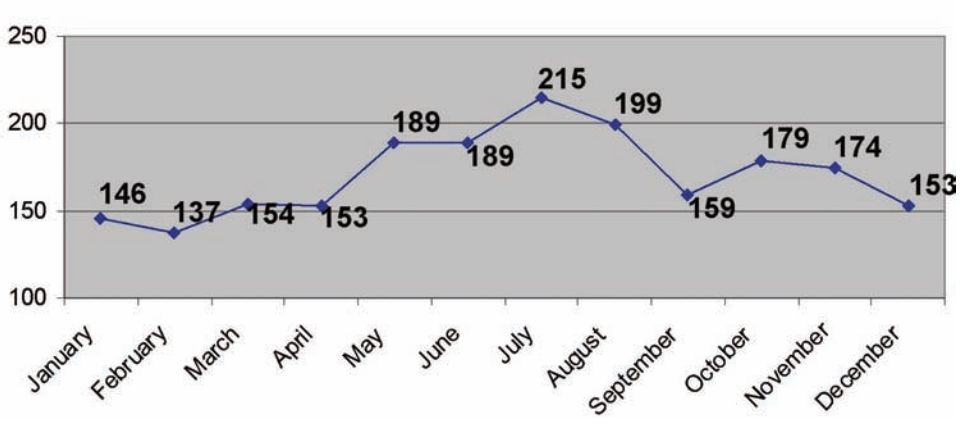
5714 Body Regions were evaluated:



* includes sprains and strain
** includes concussion

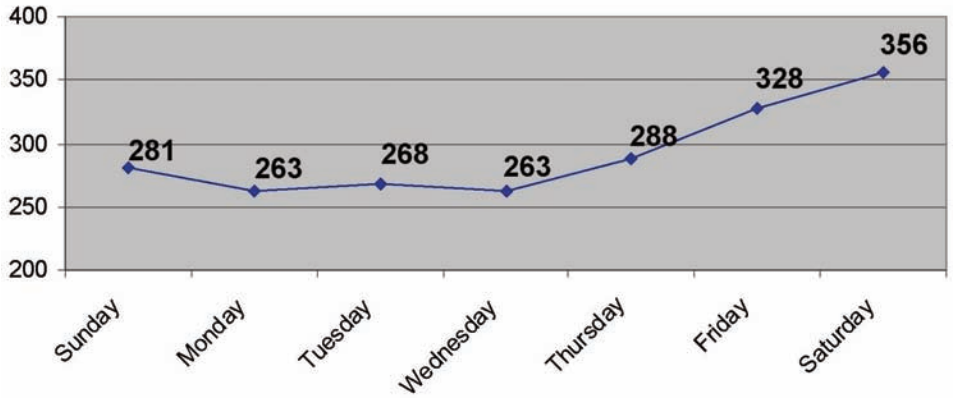
Month Activity

Trauma admissions were higher in the warmer months, with a peak in June.



Day of Arrival

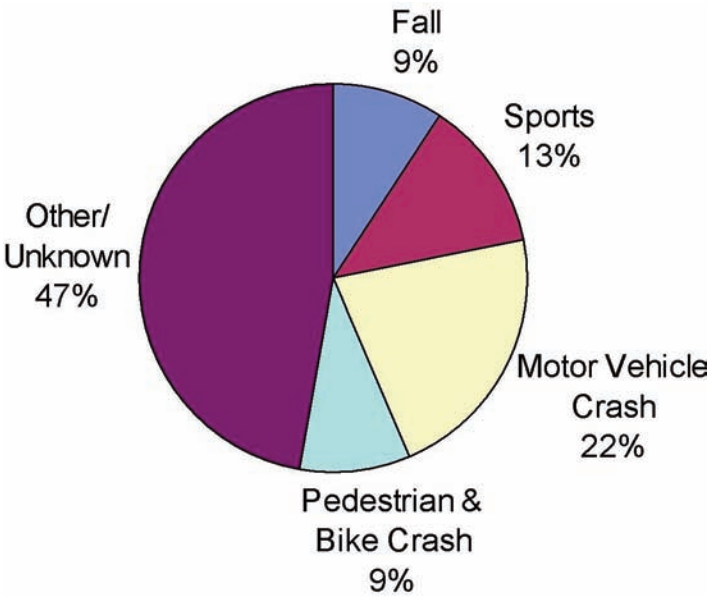
Saturdays were the busiest day of the week at the Trauma Center.



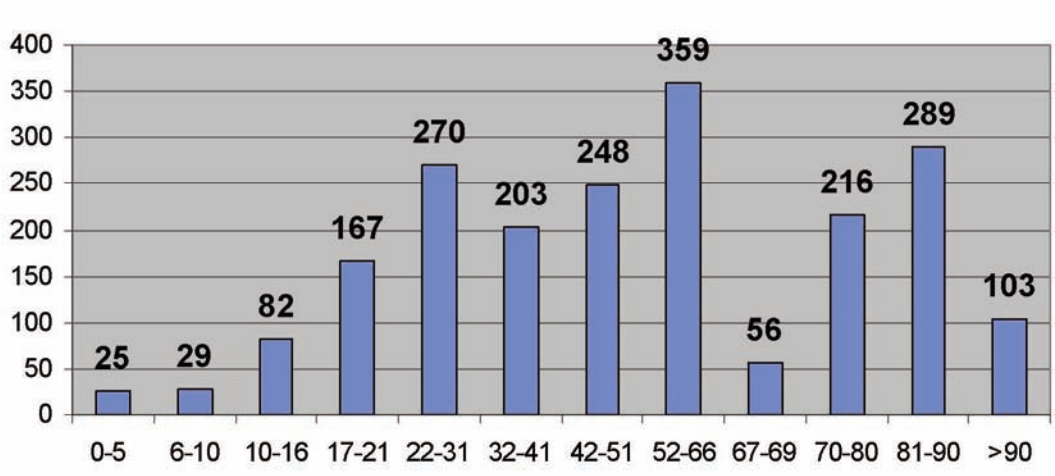
Special Populations

Special populations react uniquely to a traumatic event. Pediatric patients are not just "little adults." There are important differences in the assessment of the traumatically injured child.

Pediatric Trauma (<=16 years of age)
10% of all Trauma Patients are classified as pediatric.



Trauma Patients by Age Group

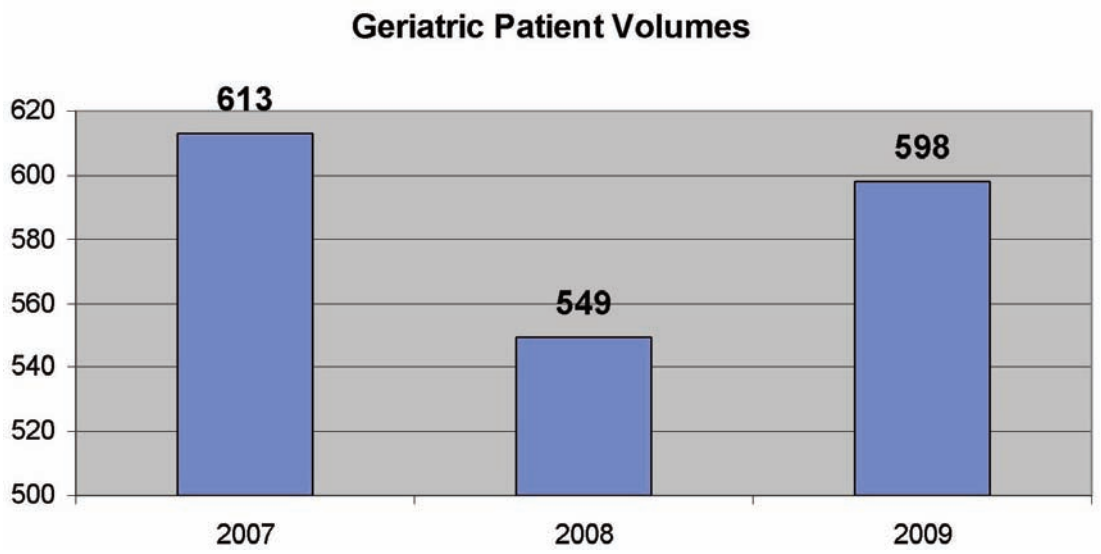


The geriatric population locally, as well as nationally, has increased over the years. The US Census Bureau reported nationally the geriatric population represents 12% of the total population. The Mahoning Valley is made up of 17% geriatrics. Through scientific and statistical analysis of the Ohio Trauma Registry data, the state EMS committee found a need for specific geriatric criteria regarding the care of these individuals. This population has a broad spectrum of injury patterns and a higher mortality from similar injuries.

Geriatric trauma patients have their own set of differences that can make a geriatric call challenging and, if not considered correctly can lead causing them more harm then good. To properly handle a geriatric trauma patient we have re-evaluated and modified standard assessments and triaging techniques for this special group of patients. Specifically, focusing on pre-existing medical conditions that affect their trauma care.

Effective December of 2008, the state EMS committee published pre-hospital guidelines for patients greater han 70 years old. These guidelines demonstrate when a trauma patient should be transported directly to a trauma center for treatment.

Comparing 2008 to 2009 there has been an 8% increase in geriatric trauma patients.



By the year 2040, 20% of the U.S. population will be over age 65

ONGOING CARE

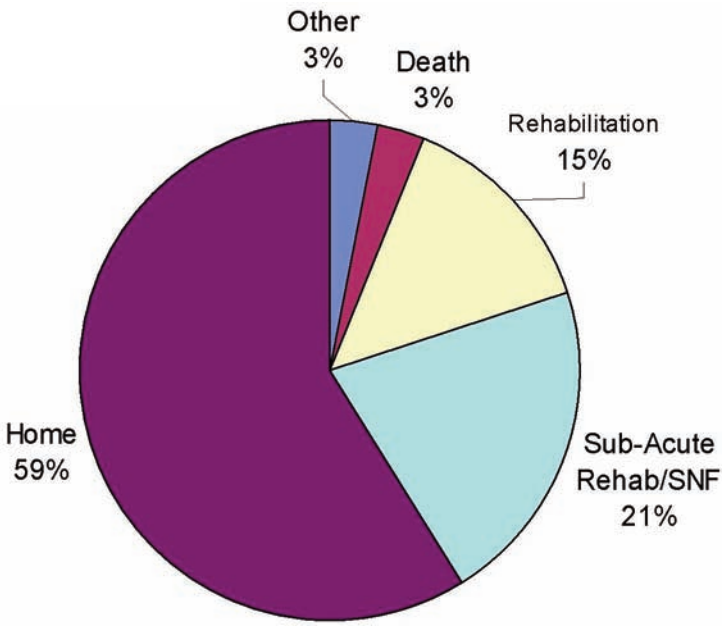
Trauma Clinic

To provide ongoing care to trauma patients, the trauma surgeons and advanced practice nurses provide follow-up care at the Ambulatory Care Center at St. Elizabeth Health Center. This provides continuity of care and allows the patient and family to return to a familiar setting for outpatient treatment, which may include post-discharge wound care, medications or other services as needed.

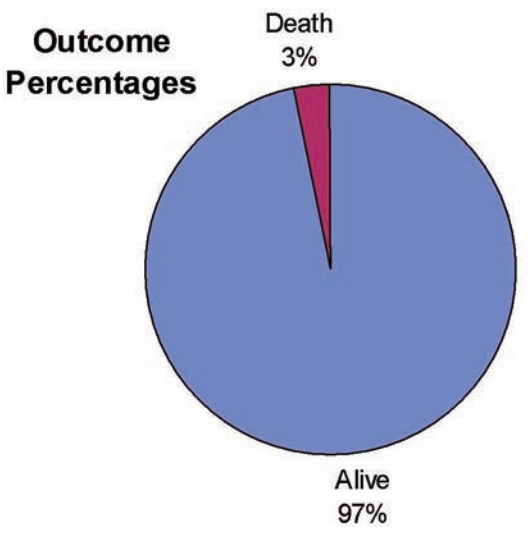
Wound Care Center

The wound care center is a team of doctors and nurses dedicated to treating wounds. Many of our patients have wounds from an injury that resist healing by the traditional treatment. Hyperbaric Oxygen Therapy, a treatment that uses pressurized oxygen to aid in healing wounds, is available to our patients. HBOT increases the amount of oxygen in your blood and oxygen-enriched blood can offer distinct benefits in the healing of wounds.

DISCHARGE DISPOSITION



Our patient survival exceeds the national average 2.6% of traumas resulting in death and remains below the national standard of 4.4%.



While traumatic injury continues to occur in the community, the good news is that education does make a difference. One injury prevention program constantly targets the teen population in our five county area. The Students Against Violence Education Program (S.A.V.E.) takes at-risk teens and exposes them to the workings of the Level I Trauma Center, touring the trauma bay, intensive care area, and the morgue. The goal is to make them aware of the ramifications of making "wrong choices" and the eventual outcome.

We also work with other community agencies and organizations, such as the Victim Impact Panel held in Canfield every month. M. Ben Melnykovich, RN, presents a graphic program on impaired drivers to those who are court mandated to attend. This is done in cooperation with the local MADD chapter and the Mahoning County Sheriff's office. Pre-prom activities are key in reaching teens before a fatal event occurs. Various pre-prom assemblies, programs and mock crash presentations are a few of the strategies employed to achieve this goal.

The injury prevention program collaborates many of these events with the Mahoning County Safe Communities Coalition, as well as a variety of local EMS, fire and police agencies. Since "falls" rate as our number one mechanism of injury, we plan to implement a Falls Prevention program for the elderly in our community. This consists of a 45 minute lecture followed by a short screening test done on the participants. This qualifies the risk level each person is for falling and sustaining an injury. Falls among the senior population have devastating effects and major consequences for the health care system. We anticipate our new program will have a positive impact on this problem.

We also participate and attend a variety of health fairs and exhibitions with trauma prevention information for the general public. A major event is "Trauma Day" at the Canfield Fair. This gives a wide variety of individuals the opportunity to learn about injury prevention strategies that can be incorporated into daily life. The main goal is to decrease the morbidity and mortality associated with trauma in our local population.

Professional Education

Physicians and nurses presented results of studies at national conferences:

1. Dorion HA. Abdominal Wall Reconstruction Following Complex Pelvic Fracture. Georgetown University, Washington D.C., June 2009.
2. Kupensky D, Marchetto K, Noble B, Pauvlick C, Puet T, Novakovich B, Melnykovich MB, Katradis A, Luchs B, Mace D. Mild Traumatic Brain Injury In Adults: Patient/Family Education. Society of Trauma Nurses, Phoenix, AZ, April 2009.
3. Ziran BH, Hileman BM, Little JE. Effective External Fixator Pin Care is Literally Skin Deep. AAOS, Las Vegas, NV, March 2009.
4. Ziran BH, Smith WR, Rao N, Barrette-Grischow MK. Hemipelvectomy: Why do Such a Morbid Procedure? AAOS, Las Vegas, NV, March 2009.
5. Ziran BH, Hileman BM, Little JE. Effective External Pin Care is Literally Skin Deep. OTA, San Diego, CA, October 2009.
6. Dorion HA, Marchand TD, Williams MD. Falls from standing height in the elderly: a coming trauma epidemic. Western Surgical Association November 2009. Podium Presentation.
7. Kupensky D, Mace-Vadjunec D. Euvolemia: Fluid Management in Patients with Multiple Trauma and Traumatic Brain Injury. Society of Trauma Nurses. April 2009. Poster presentation.
8. Dunham CM, Katradis AD, Williams MD. The Bispectral Index, a Useful Adjunct for the Timely Diagnosis of Brain Death in the Comatose Patient. Southwestern Surgical Congress. March 2009. Podium presentation.

Professional Education

SEHC is responsible for providing regional leadership on trauma prevention and professional education. The Trauma Center offers many educational programs for both healthcare professionals and the community, including:

- Quarterly EMS Trauma Run Review – targeted education for EMS/Fire providers
- Advanced Trauma Life Support (ATLS) courses – trauma care updates for physicians
- Trauma Nursing Core Courses (TNCC) – continuing trauma education for nurses
- Emergency Nursing Pediatric Course (ENPC) – enhanced pediatric care for emergency nurses
- ENCARE – trauma nurses helping teens understand the dangers of alcohol use
- Trauma Nurses Talk Tough – program for alcohol, drug, and auto safety for all ages

Physicians and Nurses presented at St. Elizabeth Health Center:

1. Novak C., Talboo N. Crucial Race Against Time: Management of Open Fractures. Quality Olympics, SEHC, 2009
2. Kupensky D, Marchetto K, Noble B, Pauvlick C, Puet T, Novakovich B, Melnykovich MB, Katradis A, Luchs B, Mace D. Mild Traumatic Brain Injury In Adults: Patient/Family Education. Quality Olympics, SEHC, 2009.
3. Mace D, Flowers L, Kupensky D, Katradis A, Parish L. Innovations in Trauma Care: Implementation of a 'Blood Bank Alert' in a Level I Trauma Program. Quality Olympics, SEHC, 2009.
4. Sontich JK. Femur Fractures. SEHC. Grand Rounds Presentation. May 2009.
5. Joseph T. Non-Arthroplasty Treatment of Proximal Humerus Fractures. SEHC. Grand Rounds Presentation. August 25, 2009.
6. Flowers, L. To Reverse or Not to Reverse: Warfarin Reversal in the Traumatic Brain Injured Patien. Quality Olympics, SEHC, 2009.

Trauma Research

Research is required by the American College of Surgeons Committee on Trauma to maintain a Level I Trauma Center accreditation. Trauma Services conducts prospective and retrospective research studies and case reports. The main goals of the research are to standardize care, disseminate results to other health care providers, and improve mortality, morbidity, and outcomes. Research is conducted in the areas of trauma practices and surgery, orthopaedics, neurosurgery, radiology, emergency medicine, nursing, and rehabilitation.

Trauma-Related Publications- 2009:

1. Ziran BH, Barrette-Grischow MK, Hull T. Hidden burdens of orthopaedic injury care: the lost providers. J Trauma. 2009Feb;66:536-549.
2. Dunham CM, Katradis DA, Williams MD. The bispectral index, a useful adjunct for the timely diagnosis of brain death in the comatose trauma patient. Am J Surg. 2009Dec;198(6):845-851.
3. Husari AW, Belzberg H, Kassak K, Dunham CM. Relationship between intensive care complications and costs and initial 24 h events of trauma patients with severe haemorrhage. Emerg Med J. 2009 May;26(5):340-343.

Over $70,000 Studies funded in 2009:

1. Patel J, Grimmett T. Evaluation of HMHP's 2010 Tobacco Use Prevention and Cessation Program. Funded by the Ohio Department of Health.
2. Patel J, Grimmett T. Commit to Quit – American Legacy Foundation Program Evaluation. Funded by the American Legacy Foundation.
3. Dorion HA, Gruber B, Puett T. Functional Outcomes after Geriatric Spinal Column Injuries. Funded by Ohio Department of Public Safety, Division of Emergency Medical Services.
4. Dorion HA, Flowers L, Carter N, Gruber B. Do Patients with an Isolated Intracranial Hemorrhage Become Hypercoagulable Within 7 Days as Demonstrated by Thromoboelastography (TEG®)? Funded by the Humility of Mary Health Partners Medical Research Committee.
5. Shaer J, Hileman B. Fixation Using Alternative Implants for the Treatment of Hip Fractures: A Multicenter Randomized Trial Comparing Sliding Hip Screws and Cancellous Screws on Revision Surgery Rates and Quality of Ufe in the Treatment of Femoral Neck Fractures.

Disaster Preparedness

In 2009, SEHC utilizes an 'All Hazards Approach' for managing disaster situations related to patient surge influx related to mass causality, mass fatality, contaminated patients, contagious patients, structural facility damage and/or loss of business operations. Intentional disasters example include biological, chemical, nuclear, radiological, explosives, bomb threat, civil disturbance, hostage, cyber attack, violence in the workplace and terrorist events. Unintentional disasters examples include earthquake, flood, hurricane, tornado, winter storm, extreme heat.

Trauma services plays a vital role in disaster preparedness, continually working with local public and private entities to establish mutual aid agreements of understanding for obtaining disaster support, supplies and equipment. SEHC also has established a collaborative and functional working relationship with the Mahoning and Trumbull County Emergency Management Agencies (EMA) for disaster response support. We conduct several exercises per year and participate with other area hospitals as a region.

Finally, SEHC staff continues to receive additional training for the decontamination process and weapons of mass destruction education.

Regional Physician Advisory Board (RPAB), Region 10

As the only Level 1 trauma center in the region, SEHC takes the lead role to further develop a regional trauma system. In 2009, Dr. David Levy, Emergency Medicine Physician became the interim chair of Region 10.

The Region 10 Physicians Advisory Board council continues to strive to work within the guidelines as presented by the State of Ohio. The region is large and stretches from Lake Erie in Ashtabula County in the north down to the Ohio River in Columbiana County in the south and has a variety of typographies of urban, sub-urban, agriculture, and rural areas. Input is gained from many individuals, institutions, physicians, nurses, EMS, firefighters, administrators, helicopter services and a variety of other individuals involved in this process.

Data References:
SEHC Trauma Registry
National Trauma Data Bank
Center for Disease Control and Prevention
Office of Technology Assessment, U.S. Congress

KES Foundation

Kyrsten Elizabeth Studer's short life was taken fourteen days before her 15th birthday. She was walking with friends on a Friday night, when she became the victim of a pedestrian/motor vehicle crash. The shock and sadness affected her family, close friends, and the entire community.

Kyrsten played soccer, danced, cheered, and sold Girl Scout cookies. She became a high school cheerleader through absolute dedication and perseverance. She tried to be the best student she could and she succeeded. Her life was full of goodness!

Her death provoked response from every neighboring community. Kyrsten's positive life spirit continues to benefit others. The KES Foundation funds and, in conjunction with the trauma services department, distributes animals, blankets, pillows and wrist bands to our trauma patients.

Shortly before her death, Kyrsten wrote down these words from "I Hope You Dance," written by Mark D. Sanders and Tia Sillers, and recorded by country singer Lee Ann Womack

"I hope you still feel small when you stand beside the ocean,
Whenever one door closes I hope one more opens,
Promise me that you'll give faith a fighting chance,
And when you get the choice to sit it out or dance"

Dance…..I hope you dance"

2nd Annual Trauma Service Golf Outing