



Trauma Advisory Council

November 20, 2012

3:00 p.m.

Minutes

MEMBERS PRESENT

Dr. Mary Aitken
Dr. James Graham
Dr. Charles Mabry
Dr. Barry Pierce
Dr. Viviana Suarez
Dr. Paul K. Halverson (rep.
by Donnie Smith)
Dr. Clint Evans
Dr. Ronald Robertson
K. C. Jones
R. T. Fendley
Kathryn Blackman
Terry Collins
Jon Wilkerson
John E. Heard
Freddie Riley
Robert T. Williams
John Gray
Colonel J.R. Howard (rep. by
Sr. Cpl. Karen E. Clark)
Keith Moore
Jamey Wallace

MEMBERS ABSENT

Dr. Victor Williams
Dr. John Cone
Dr. Michael Pollock
Dr. Janet Curry
Christi Whatley
Carrie Helm

GUESTS

Dr. Michael Sutherland
Dr. James Booker
Terri Imus
Donna Parnell-Beasley
James Smith
Don Adams
Robert Fox
John Recicar
D'borai Cook
Cathee Terrell
Tonya Baier
Sidney Ward
Jeff Tabor
Cheryl Vines
Kim Brown
Steven Webb
Debbie Moore
Kathy Gray
Carrie Vickers
Tim Vandiver
Ron Crane
Teresa Ferricher
Terry Bracy
Carla McMillan
Gary Padget
Ken Kelley
Rodney Walker
Joe Hennington
Lee Lessenberry
Gary Meadows
Shaun Best

STAFF

Dr. Todd Maxson
Donnie Smith
Bill Temple
Rick Hogan
Renee Mallory
Teresa Belew
Diannia Hall-Clutts
Greg Brown
Joe Martin
Austin Porter
Marie Lewis
Margaret Holaway
Terry Love
Jim C. Brown

I. Call to Order – Dr. James Graham, Chairman

The Trauma Advisory Council (TAC) meeting was called to order on Tuesday, November 20, 2012, at 3:05 p.m. by Dr. James Graham, Chairman.

II. Welcome and Introductions

Dr. Graham welcomed all guests and members.

III. Approval of Draft Minutes From October 16, 2012.

The TAC reviewed the October 16, 2012 minutes. A motion to approve the minutes was made by Mr. R. T. Fendley and seconded by Dr. Ronald Robertson. The minutes were approved.

IV. Trauma Office Report – Bill Temple

Personnel

- Mr. Temple said the Registered Nurse/Trauma Nurse Coordinator position has closed and we will be receiving and reviewing those applications.

Hospital Designation

- We have 58 hospitals designated. One site survey has been completed and that designation is in process. We have an additional 14 site surveys scheduled through the end of March, 2013. The total should be 73 designated hospitals by April 1, 2013.

Contracts

- The Quality Improvement Organization RFP protest has been rejected. QSource is the awardee and we will begin contract negotiations with this entity.

Trauma Brochure

- The final trauma brochure draft has been approved and we will be initially printing 2,000 copies. Mr. Temple asked the TAC members to think about who we should send brochures to and how we should handle the distribution.

V. ADH Medical Consultant Report – Dr. Todd Maxson

- Dr. Maxson said there was previous discussion about an advisory group which will begin looking at clinical practice guidelines. The purpose is to publish some consistent guidelines on common issues. He has received some good feedback from hospitals and has a list of about ten items to be included as we begin this process. These items already have published national guidelines for us to evaluate and see what makes sense for

Arkansas. Dr. Maxson asked the TAC for endorsement of this initiative and approval to proceed with this process. After discussion, it was decided to have an ad hoc working group and for this group to propose guidelines back to the TAC for recommendation to ADH. Dr. Graham asked that the ad hoc work group proceed.

VI. Other Reports

Trauma Registry – Marie Lewis

- We continue to plan for the ICD-10 conversion and the possible upgrade to version 5 of NTRACS.
- Work continues with DI to evaluate changes coming for the new year.
- Web Registry training will be held in the Auditorium at ADH on December 14, 2012.
- Submission deadline is the end of November for August, September and October data.

Arkansas Trauma Communications Center (ATCC) – Jeff Tabor

Mr. Tabor reported that we are making progress as a system because EMS minor scene calls are trending downward and major and moderate scene calls are trending upward.

Arkansas Trauma Education and Research Foundation (ATERF) – Claudia Parks-Miller

ATERF began operation on February 1, 2012 and conducted its first course on February 16, 2012. Since that time, they have conducted 52 courses in 26 different counties throughout the state. This included over 900 registrants and over 700 actual attendees representing 63 of the 75 counties in Arkansas. There are seven courses scheduled before the end of 2012 and five already scheduled in different counties for 2013. Planning for Spring 2013 programs is in process and expected to be completed by December 2012.

Trauma Image Repository – Terri Imus

They have 67 sites registered and over 5,000 images have actually come through the repository. The system is now being used every day rather than what was two to three times a week. We continually learn, teach and assist users.

Scorecard Report – Austin Porter

Mr. Porter shared a scorecard handout for TAC members. He discussed some of the demographic trends reflected in the handout charts and graphs. The scorecard report is attached to the minutes.

VII. TAC Subcommittee Meeting Reports

(Note: Summaries are attached; only official action and additional information provided to the TAC is documented in this section.)

- Finance Subcommittee (R. T. Fendley – Chair) (See attached report)

The hospital costing project has been referred to the Arkansas Hospital Association (AHA) as a contractor to the Arkansas Department of Health (ADH). The focus is to obtain the cost of trauma readiness, the cost of participation in the trauma system, and the cost of care to trauma patients. Don Adams, AHA, shared they have an acceptable proposal for the project that is currently being reviewed.

On behalf of the Finance Subcommittee, Mr. Fendley made a motion that the TAC accept and endorse a special project funding request that incentivizes EMS services to utilize data systems for the gathering, compilation and submission of their trauma run data to the ADH. This one-time proposal is called the EMS Data Software Initiative. A hard copy was distributed to TAC members. After Dr. Evans' extensive explanation and discussion, the proposal was endorsed by the TAC.

On behalf of the Subcommittee, Mr. Fendley made a motion that the TAC endorse and support a pay-for-performance initiative that incentivizes EMS services to promote advanced education and certification of their EMS staff. It was presented to the TAC as the FY 2013 Performance Improvement Initiative. Dr. Evans discussed the proposal and answered questions. This initiative involves money over and above what is currently available to EMS providers. The amount of funding would depend on the number of services that would meet the criteria as stated in the proposal. This again is a recommendation to ADH. The motion was approved.

On behalf of the Subcommittee, Mr. Fendley made a motion that the TAC endorse and approve a pay-for-performance proposal for post-acute care related to rehabilitation. The proposal is that the TAC accept and endorse this project that incentivizes a commitment to quality, based on demonstrating accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF). CARF has been around for several years and is more related to services and programs that improve the quality of service to trauma rehabilitation patients. Cheryl Vines explained that the proposal is that if an Arkansas hospital has 11% of their (2011) patients that are trauma patients we would provide a performance incentive (i.e. help them with the actual cost of the CARF survey for accreditation). Mr. Fendley noted that during the American College of Surgeons (ACS) site visit they specifically mentioned CARF accreditation as a recommendation. After discussion, comments, and questions directed to Cheryl Vines, the motion was approved.

On behalf of the Subcommittee, Mr. Fendley proposed that the TAC accept and endorse a pay-for-performance plan that incentivizes rehabilitation facilities using certified Assisted Technology Professionals (ATPs) staff to coordinate evaluations to ensure that trauma patients' needs are met. This proposal would assist hospital staff in sitting for the exam, which typically costs \$500. The motion was approved.

- Hospital Designation Subcommittee and Site Survey/System Assessment Panel (Dr. James Booker, Chair) (See attached report)

Dr. Booker said the Subcommittee met today. McGehee Hospital is recommended to ADH for approval as a Level IV. The Subcommittee has received the official Level II letter of intent application for St. Johns Hospital in Tulsa, OK. They will be listed on the dashboard and we will gather a years worth of data in evaluating their request.

On behalf of the Subcommittee, the Level III Rules were submitted for endorsement by the TAC. As part of this motion, he further requested that the Finance Subcommittee review hospitals that, based on the new Rules, would drop from a Level III to a Level IV so that funding could be considered to continue to support affected hospitals. In discussion it was noted that in evaluating the data the QI/TRAC Subcommittee will review to ensure quality care is still provided in areas served by affected hospitals. Data will also be evaluated for transfers. The motion was approved.

- EMS Subcommittee (Dr. Clint Evans - Chair) (See attached report)

Dr. Evans said the Subcommittee will be meeting in December. Their November strategic planning meeting was a great success. The December meeting will focus on funding and the work started at the planning meeting.

- Rehabilitation Subcommittee (Jon Wilkerson – Chair) (See attached report)

Mr. Wilkerson reported that work continues on implementation of the strategic plan. He also thanked all those who have assisted the Subcommittee with their on-going work and said he is encouraged by the progress. They continue working on outcome measures for evaluation. They have begun getting rehabilitation reports to compare us with the nation and the region. He also specifically thanked Dr. Robertson for his help with training.

- QI/TRAC Subcommittee (Dr. Charles Mabry – Chair) (Did not meet) (No report)

Dr. Mabry, on behalf of the Subcommittee, reported that they did not meet this month.

- Injury Prevention Subcommittee (Dr. Mary Aitken – Chair) (No report)

Dr. Aitken said her committee did not meet this month, but will meet again on December 13, 2012. The Injury Community Planning Group has started meeting again. Dr. Aitken shared a PowerPoint presentation and discussed the slides with the TAC. Although there is still a significant discrepancy between Arkansas and the nation as a whole regarding several key areas, our state is beginning to show positive movement, particularly with respect to injuries from motor vehicle crashes. Our Graduated Drivers License law is one of the key policy changes that has had a positive effect.

VIII. Next Meeting Date

Dr. Clint Evans made a motion to cancel the December meeting. It was seconded by Terry Collins. The motion passed. The next regularly scheduled meeting will be January 15, 2013.

IX. Adjournment

Without objection, Dr. Graham adjourned the meeting at 4:39 p.m.

Respectfully Submitted,

Paul K. Halverson, DrPH, FACHE
Secretary Treasurer of the Trauma Advisory Council
Director and State Health Officer, Arkansas Department of Health

ARKANSAS TRAUMA SYSTEM



Scorecard

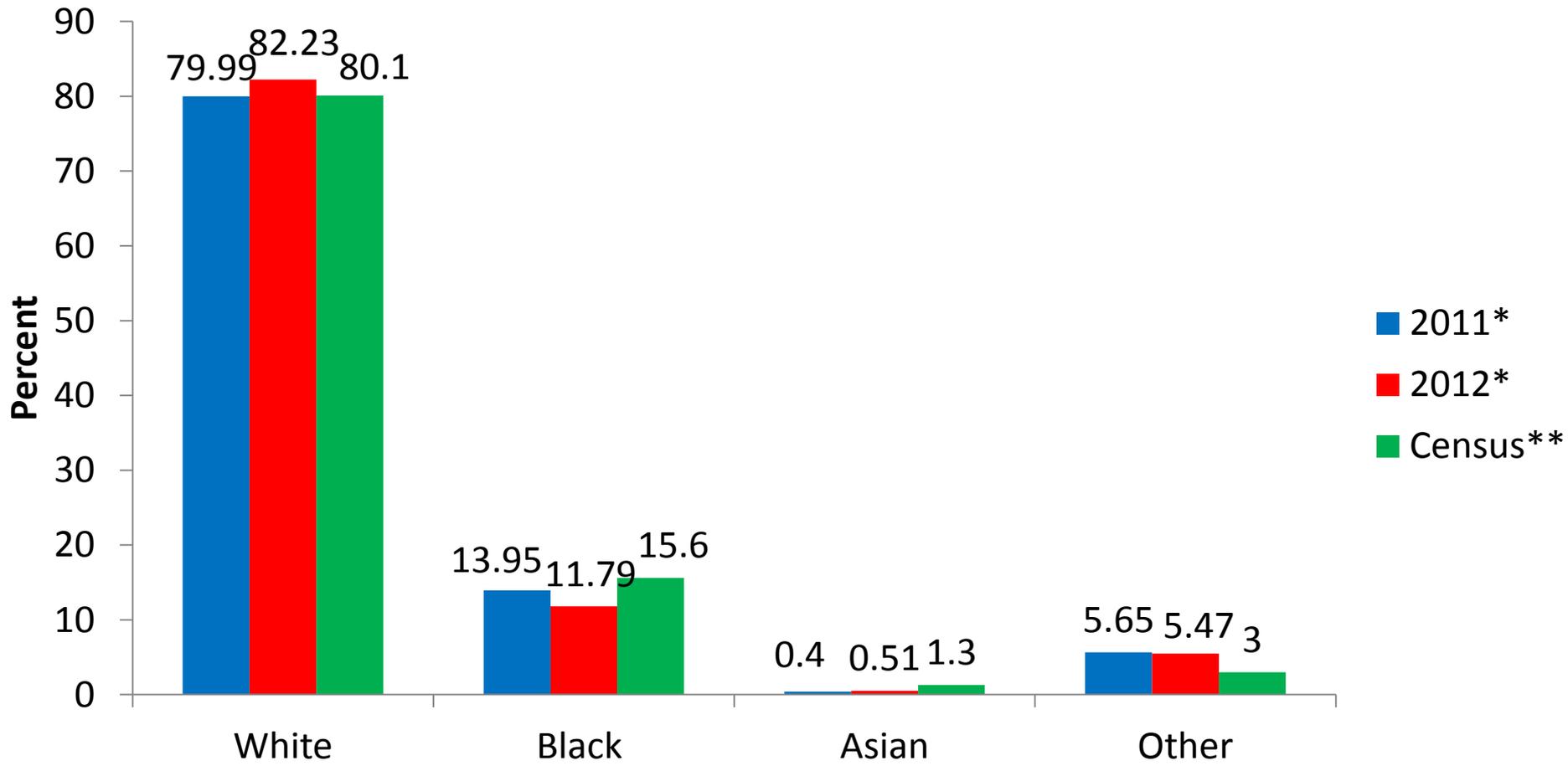
Trauma Advisory Council

November 2012

Methods

- Data may contain duplicate entries as individuals may be admitted and transferred to another hospital for complications from an injury
- Time period for reporting 2011 data was from January 1 through June 30
- Time period for reporting 2012 data was from January 1 through June 30
- Time period for reporting NTDB data was from 2010, unless otherwise specified
- Census data comparisons was from 2011 population estimates

Trauma Registry Scorecard, Patient Demographics By Race, Statewide

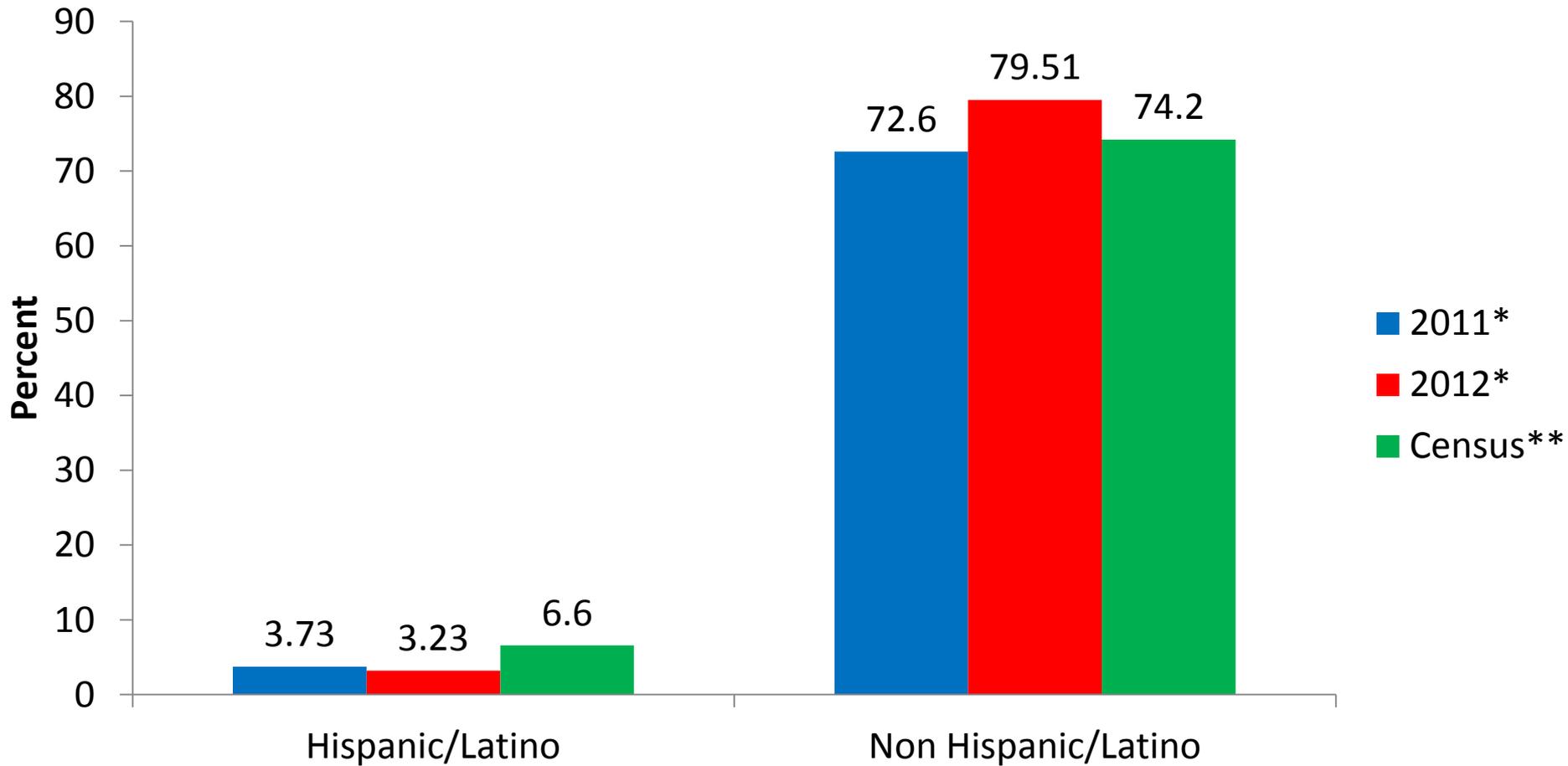


* Reporting time frame Jan 1 through June 30

**2011 Census population estimate

Source: Arkansas Trauma Registry

Trauma Registry Scorecard, Patient Demographics By Ethnicity, Statewide

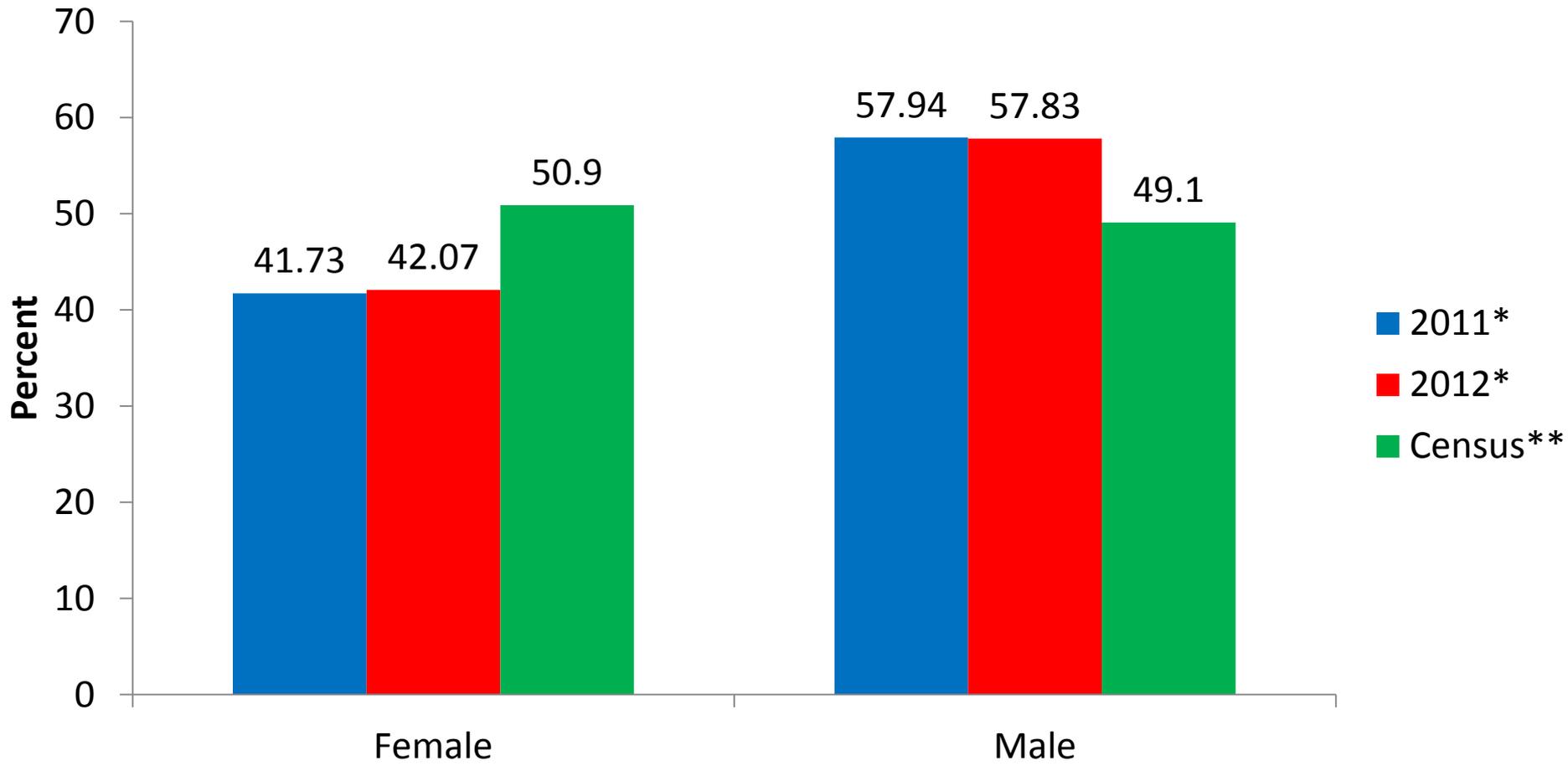


* Reporting time frame Jan 1 through June 30

**2011 Census population estimate

Source: Arkansas Trauma Registry

Trauma Registry Scorecard, Patient Demographics By Gender, Statewide



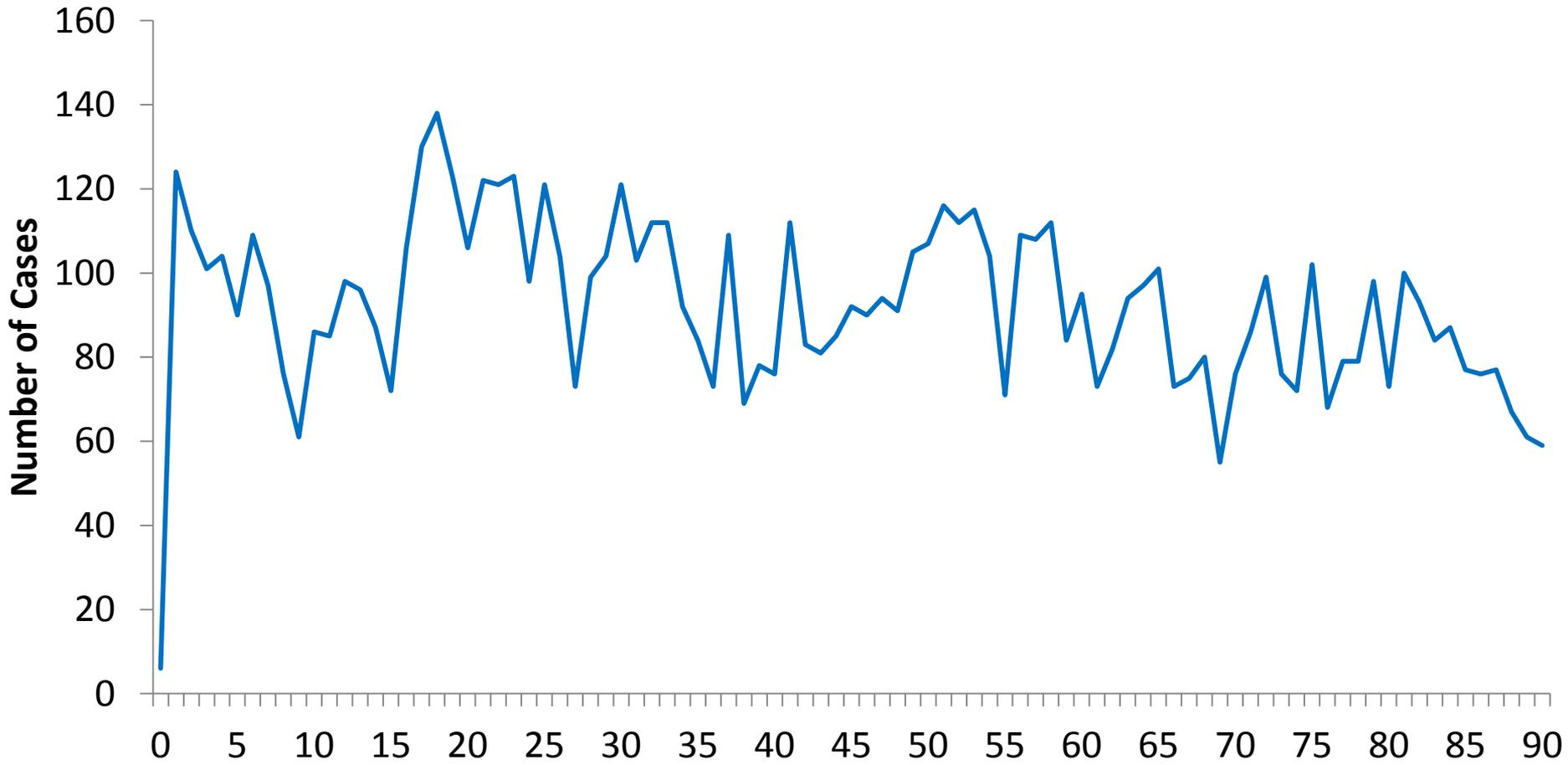
* Reporting time frame Jan 1 through June 30

**2011 Census population estimate

Source: Arkansas Trauma Registry

Trauma Registry Scorecard, Patient Demographics

Incidents by Age, Statewide 2012

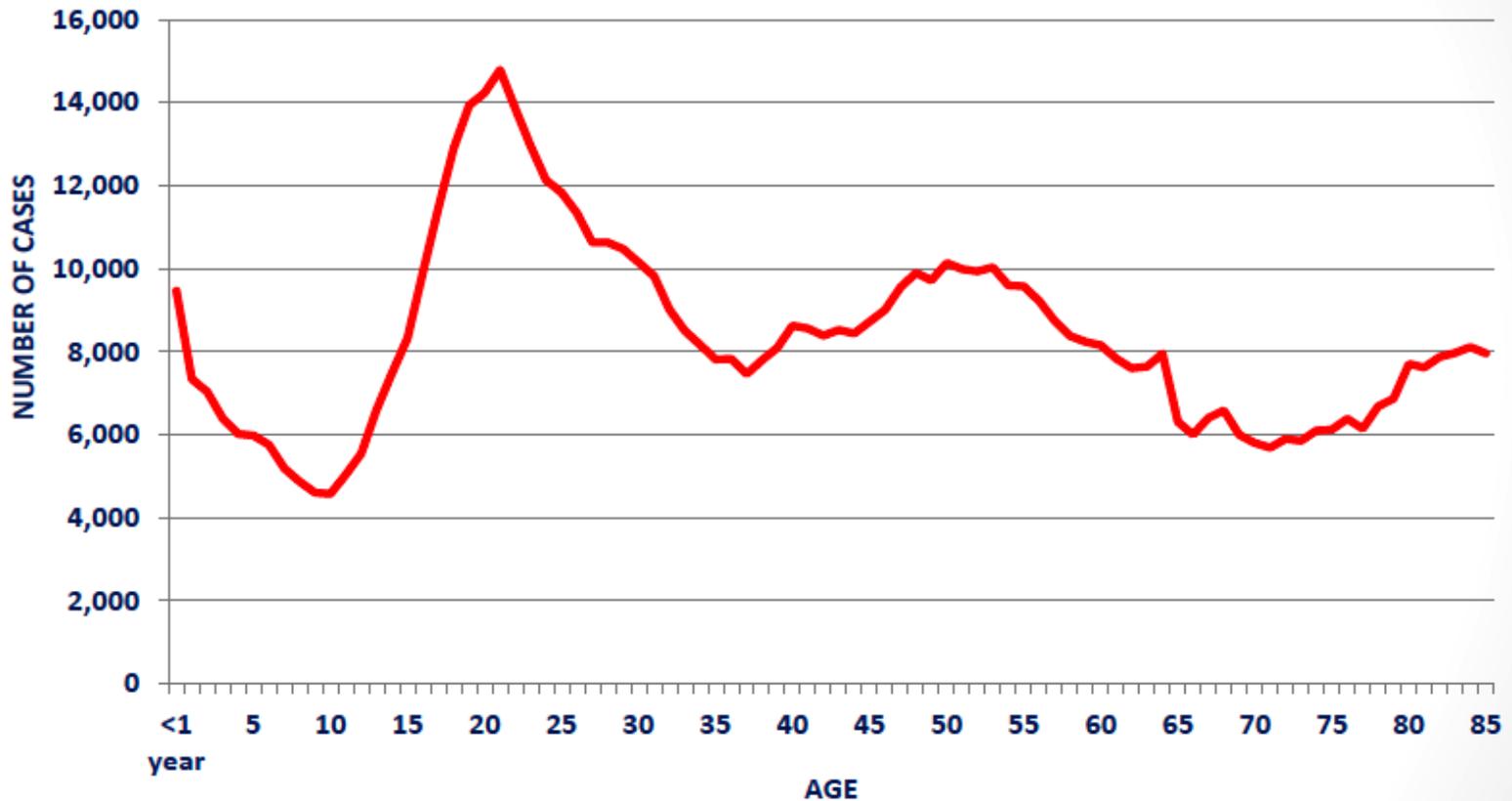


* Reporting time frame Jan 1 through June 30

Source: Arkansas Trauma Registry

Figure 11

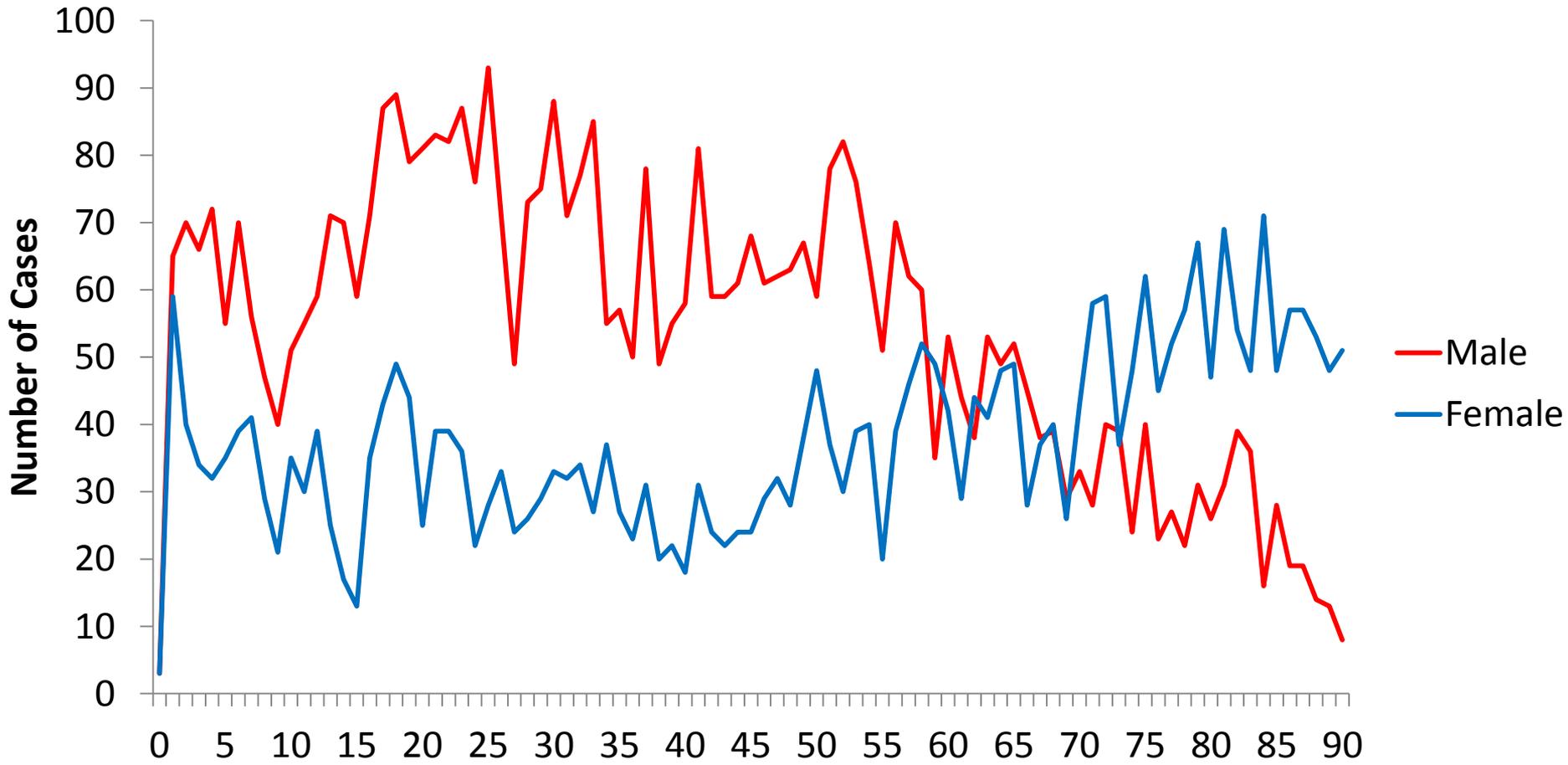
Incidents by Age



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

Trauma Registry Scorecard, Patient Demographics Incidents by Age and Gender, Statewide 2012

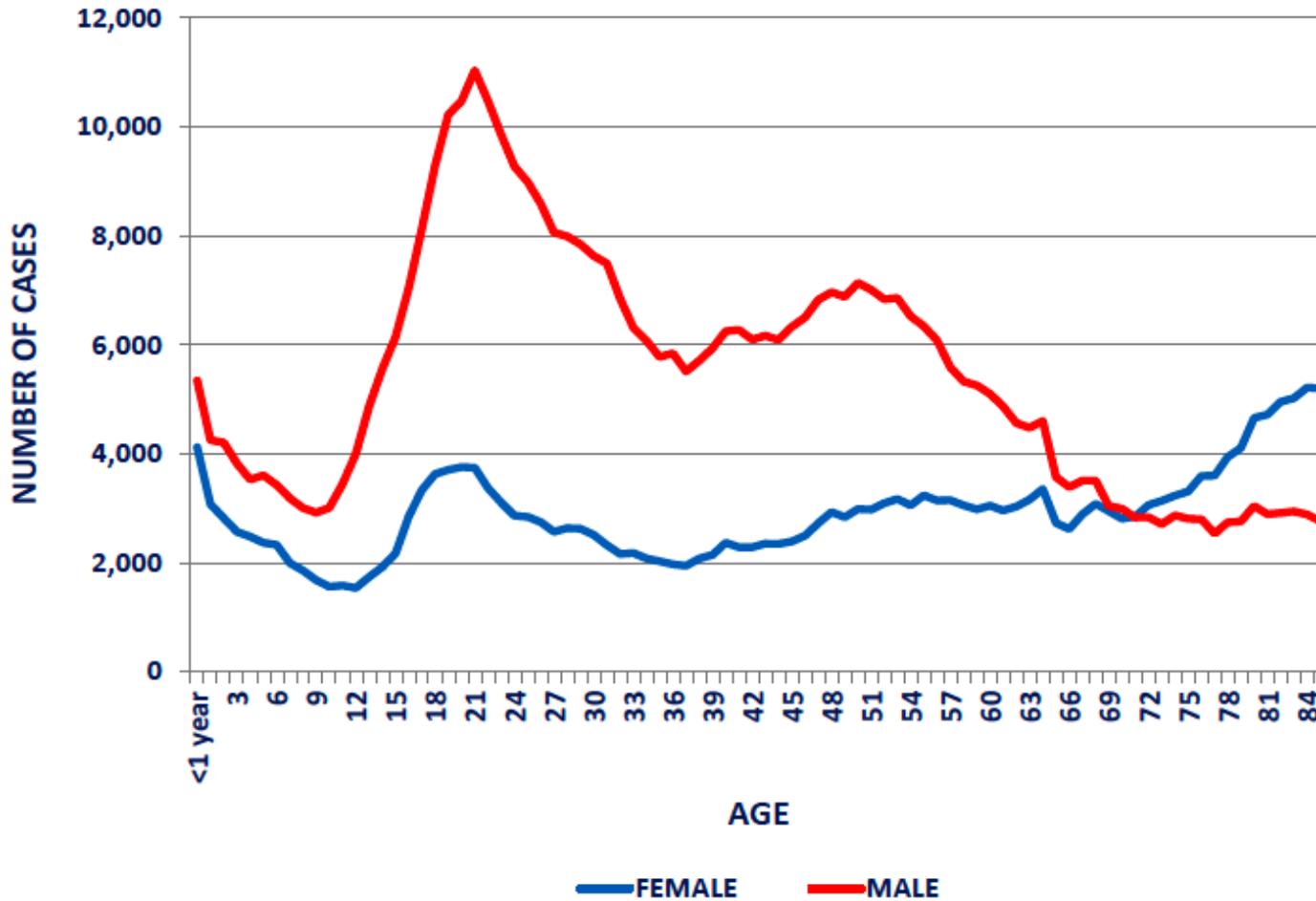


* Reporting time frame Jan 1 through June 30

Source: Arkansas Trauma Registry

Figure 13

Incidents by Age and Gender

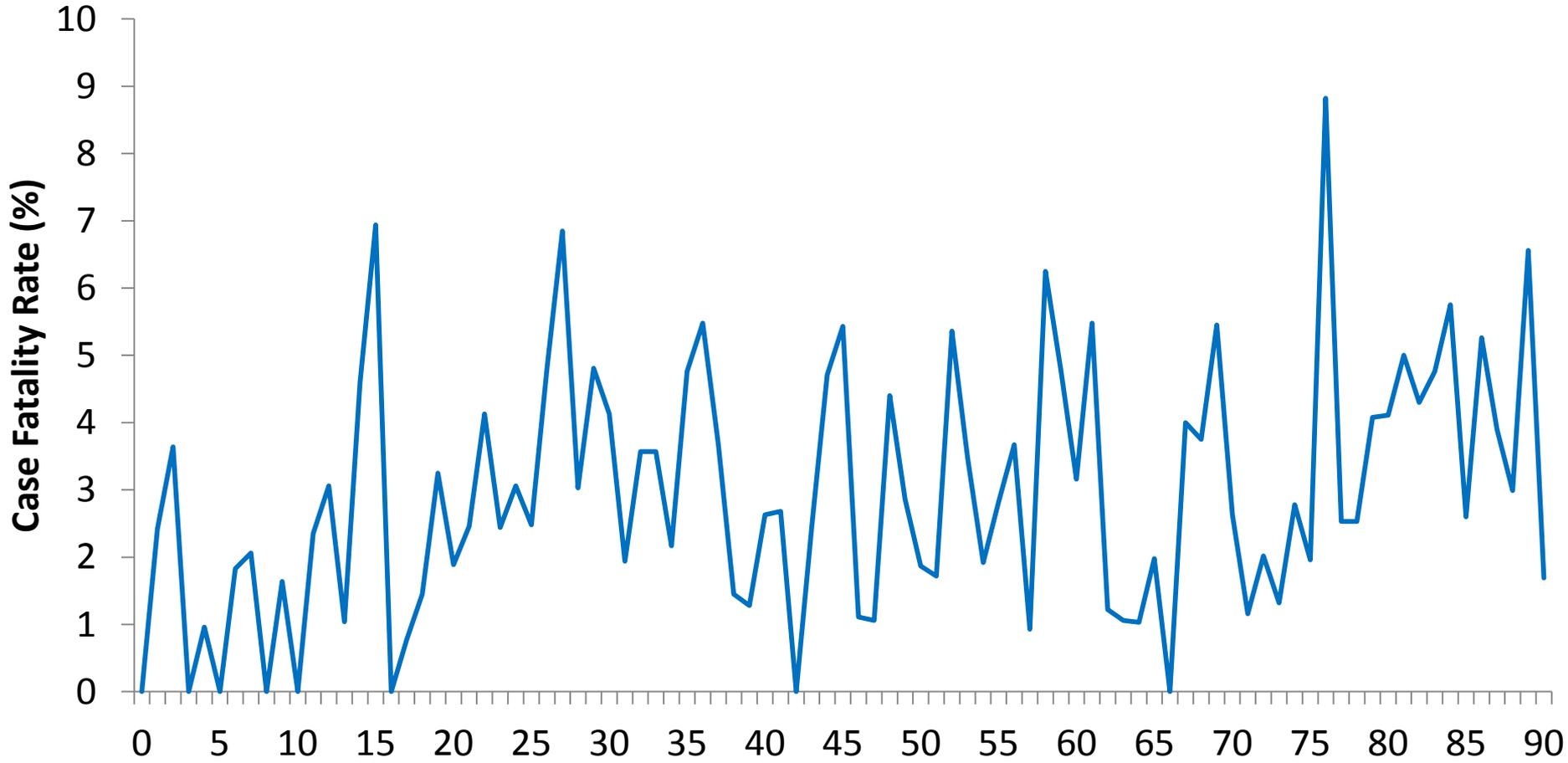


AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

Trauma Registry Scorecard, Patient Demographics

Case Fatality Rate by Age, Statewide 2012

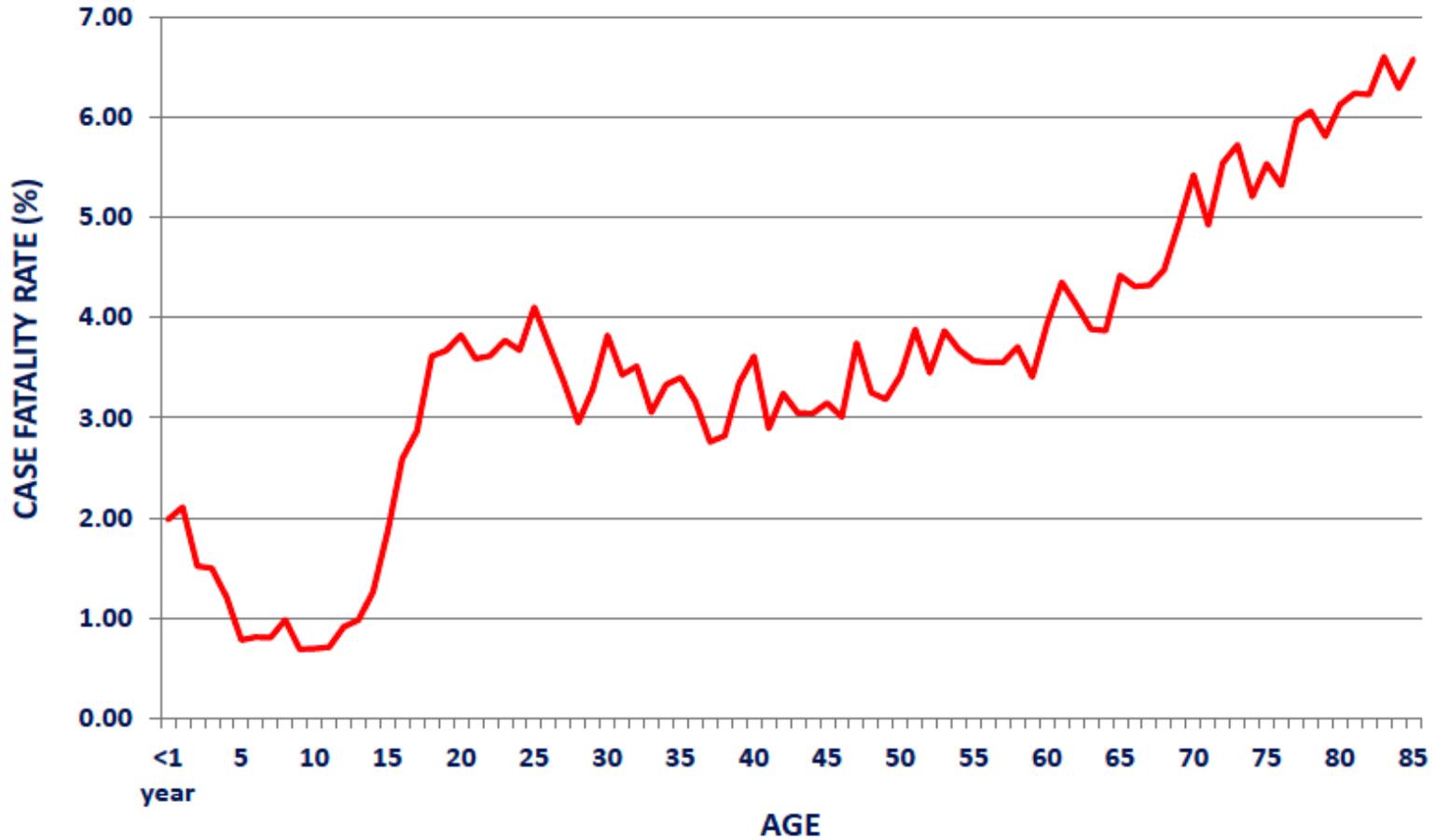


* Reporting time frame Jan 1 through June 30

Source: Arkansas Trauma Registry

Figure 12

Case Fatality Rate by Age



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Inspiring Quality:
Highest Standards, Better Outcomes

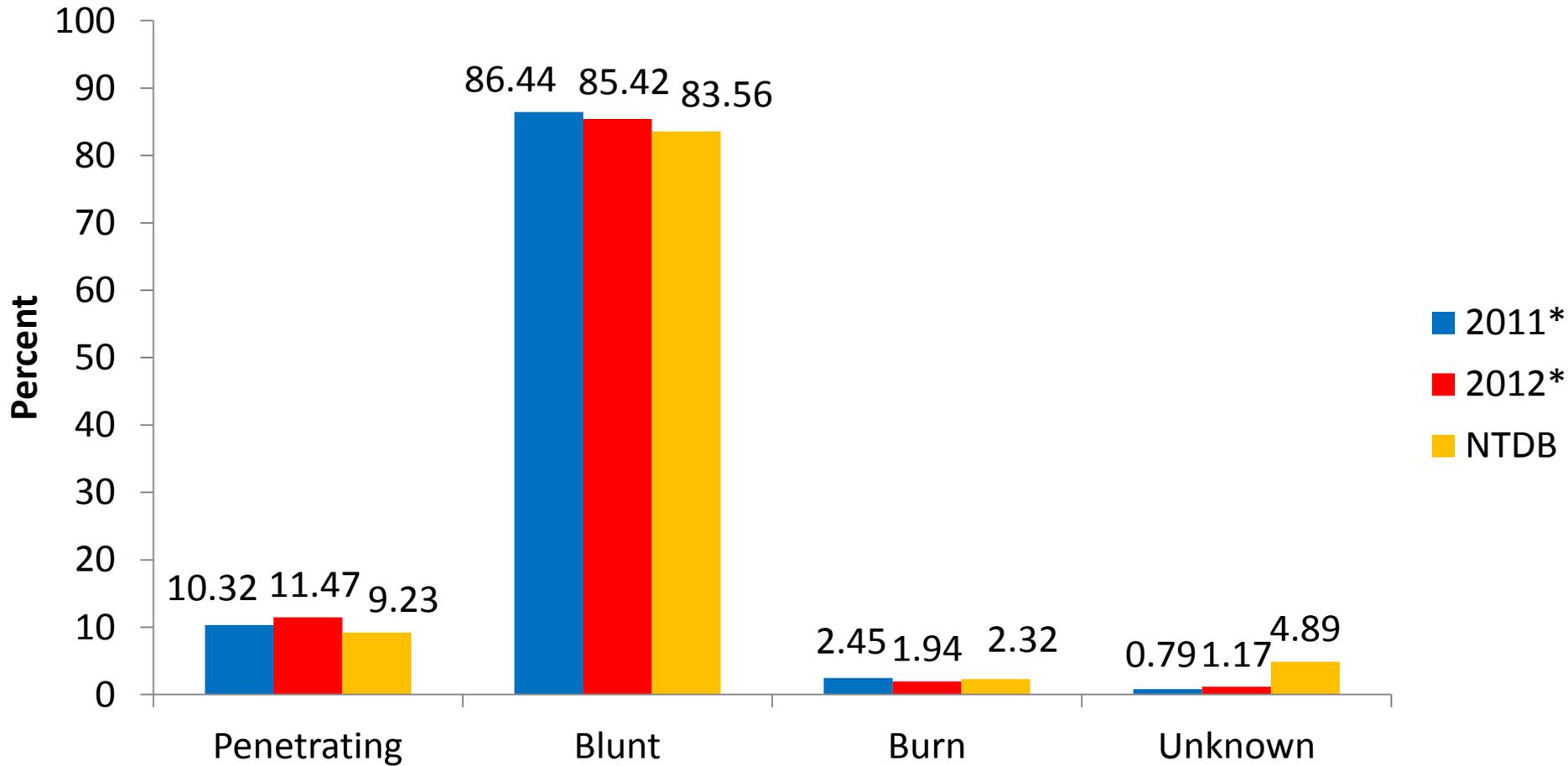
Trauma Registry Scorecard, Patient Demographics Average and Mean Age, Statewide

Average and Median Age				
	Average 2011	Average 2012	Median 2011	Median 2012
Statewide	44.02	44.6	43	44

* Reporting time frame Jan 1 through June 30

Source: Arkansas Trauma Registry

Trauma Registry Scorecard, Patient Demographics By Injury Type, Statewide



* Reporting time frame Jan 1 through June 30

Source: Arkansas Trauma Registry

Trauma Registry Scorecard, Patient Demographics By Age Group and Mechanism, NTDB vs Statewide

Age by Mechanism – Statewide 2012

	0-19		20-44		45-64		65+		All	
	NTDB	State*								
Fall	32.36%	31.88%	13.92%	15.56%	38.56%	39.36%	75.45%	78.14%	39.05%	41.33%
Gunshot	3.73%	3.16%	8.73%	8.29%	2.93%	2.61%	0.55%	0.56%	4.24%	3.80%
MVC	26.54%	25.20%	34.68%	34.46%	23.06%	21.73%	12.10%	8.64%	24.55%	22.61%
Motorcycle	1.82%	1.05%	6.23%	7.80%	7.53%	8.82%	1.27%	1.90%	4.33%	4.96%
Other	30.70%	33.67%	27.59%	25.92%	22.58%	22.91%	9.11%	9.07%	22.50%	22.43%
Pedestrian	2.41%	2.58%	1.83%	1.75%	2.16%	1.90%	0.64%	0.65%	1.74%	1.67%
Stabbing	1.85%	2.31%	6.74%	5.97%	2.76%	2.51%	0.25%	0.69%	3.12%	2.97%

* Reporting time frame Jan 1 through June 30

Source: Arkansas Trauma Registry, National Trauma Database (2010)

Trauma Registry Scorecard, Patient Demographics By Age Group and Mechanism, Statewide

Age by Mechanism – Statewide 2012

	0-19	20-44	45-64	65+	All
Fall	31.88% (-1.06%*)	15.56% (1.08%)	39.36% (2.18%)	78.14% (2.35%)	41.33% (1.74%)
Gunshot	3.16% (-0.64%)	8.29% (-0.79%)	2.61% (-0.62%)	0.56% (-0.03%)	3.80% (-0.59%)
MVC	25.20% (-1.25%)	34.46% (-0.12%)	21.73% (-2.12%)	8.64% (-4.00%)	22.61% (-2.06%)
Motorcycle	1.05% (-0.41%)	7.80% (1.4%)	8.82% (0.78%)	1.90% (0.83%)	4.96% (0.66%)
Other	33.67% (4.04%)	25.92% (-1.31%)	22.91% (0.64%)	9.07% (0.88%)	22.43% (0.72%)
Pedestrian	2.58% (0.02%)	1.75% (-0.19%)	1.90% (0.04%)	0.65% (0.06%)	1.67% (-0.04%)
Stabbing	2.31% (0.03%)	5.97% (-0.06%)	2.51% (-0.58%)	0.69% (0.33%)	2.97% (-0.09%)

*Numbers in parentheses indicate change from 2011 to 2012

** Reporting time frame Jan 1 through June 30

Source: Arkansas Trauma Registry

Trauma Registry Scorecard, Patient Demographics By Age Group and Mechanism, Statewide

Age by Mechanism – Statewide 2012					
	0-19	20-44	45-64	65+	All
Fall	606	383	768	1809	3567
Gunshot	60	204	51	13	328
MVC	479	848	424	200	1951
Motorcycle	20	192	172	44	428
Other	640	638	447	210	1935
Pedestrian	49	43	37	15	144
Stabbing	44	147	49	16	256

* Reporting time frame Jan 1 through June 30

Source: Arkansas Trauma Registry

Trauma Advisory Council Finance Sub-Committee

November 6, 2012

Attending: R.T. Fendley, Chairman; Mr. Jon Wilkerson; Ms. Renee Patrick; Mr. Donnie Smith; Mr. Don Adams; Dr. Clint Evans; Mr. John Gray; Mr. Bill Temple; Ms. Cheryl Vines; Mr. Greg Brown; and Dr. Charles Mabry

I. Call to Order at 3:30 p.m. by Mr. R.T. Fendley, Chairman

II. Update, Hospital Costing Project

Don Adams reported on the meeting between BKD and representatives of participating trauma center financial staffs hosted by the Arkansas Hospital Association (AHA). Adams believes BKD has sufficient information to prepare a project proposal and submit it to AHA along with a project fee proposal.

Action Item: Don Adams will receive the proposal from BKD and have it reviewed by the work group from the trauma centers. All parties are hopeful to complete the project by the end of the first quarter of calendar 2013.

III. Finalization, Special Project and P4P Plans

Special Project Funding Proposal, EMS- After modifying the plan pursuant to the last sub-committee meeting, Dr. Clint Evans presented the proposal for the trauma system to incentivize the use of IT systems for the collection and reporting of trauma patient information.

Action Item: R.T. Fendley, on behalf of the sub-committee, will move that the TAC accept and endorse the special project funding for the EMS proposal. Dr. Clint Evans, Mr. John Gray and Mr. Greg Brown will be present to answer questions and provide details as needed for the TAC discussion.

Pay-For-Performance Project, EMS- After modifying the plan pursuant to sub-committee discussion and feedback in prior meetings, Dr. Clint Evans presented a P4P plan to incentivize EMS services to promote advanced education and certifications of their staffs, under the premise that the result will be improved trauma care for patients cared for by EMS services.

Action Item: R.T. Fendley, on behalf of the sub-committee, will move that the TAC accept and endorse the P4P project funding for this EMS proposal. Dr. Clint Evans, Mr. John Gray and Mr. Greg Brown will be present to answer questions and provide details as needed for the TAC discussion.

Pay-For-Performance Project, Rehabilitation-After modifying the plan pursuant to sub-committee discussion and feedback in prior meetings, Ms. Cheryl Vines and Mr. Jon Wilkerson presented a P4P plan to incentivize inpatient rehabilitation facilities to achieve accreditation from the Commission on the Accreditation of Rehabilitation Facilities. The only issue raised concerning this proposal relates to the particular accreditation specified, and whether other accrediting bodies might be acceptable.

Action Item: Dr. Charles Mabry will follow up with The American College of Surgeons, to determine that organization's position on CARF versus other accreditations.

Action Item: Assuming a positive response from the ACS relative to CARF as the “gold standard” of rehabilitation accreditation, R.T. Fendley will propose to the TAC, on behalf of the sub-committee, that the TAC accept and endorse the P4P proposal. Mr. Jon Wilkerson and Ms. Cheryl Vines will be present to answer questions and provide details as needed for the TAC discussion.

Pay-For-Performance Project, Rehabilitation-Ms. Cheryl Vines and Mr. Jon Wilkerson presented a P4P plan to incentivize inpatient rehabilitation facilities to utilize certified individuals when fitting patients with durable medical equipment. The rationale is that the use of more highly trained staff will improve the quality of care for trauma patients. This proposal will be to begin this project as a pilot.

Action Item: R.T. Fendley, on behalf of the sub-committee, will propose that the TAC accept and endorse this as a funded P4P project. Ms. Cheryl Vines and Mr. Jon Wilkerson will be present to provide details and answer questions.

Meeting was adjourned at approximately 4:50 p.m.

Meeting Title Designation Sub-Committee of the TAC

MINUTES 11-20-2012

FREEWAY MEDICAL BUILDING –
BOARD ROOM

MEETING CALLED BY	Dr. Jim Booker
TYPE OF MEETING	Sub-Committee
FACILITATOR	Dr. Jim Booker
NOTE TAKER	Diannia Hall-Clutts
COMMITTEE MEMBER ATTENDEES	Dr. Todd Maxson , Dr. Jim Booker, Dr. Barry Pierce, Dr. Michael Sutherland, Terry Collins, John Recicar, Teresa Ferricher, Donna Parnell-Beasley,Paula Lewis (by Phone),

Agenda topics

WELCOME & MINUTE APPROVAL		Dr. Jim Booker
	Dr. Jim Booker welcomed everyone.	
	HOSPITAL INTENT APPLICATIONS	Dr. Jim Booker
DISCUSSION	None	
	OLD BUSINESS	Dr. Jim Booker
DISCUSSION	<p>RULES AND REGULATIONS REVISION –LEVEL III REVIEW AND APPROVAL</p> <p>Dr. Jim Booker -When you look at the Level IIIs in the state the capability and capacity are different even though they are classified as the same level. The Level IIIs that these rules will affect are the ones that tend to have a limited number of general surgeons, they tend not to have ICU care, they don't have back up from pulmonary and cardiology. It's a different level of care and what we had said was that for Level III we wanted general and orthopedic coverage. Level IVs would have no surgical coverage and we also made a suggestion that we would recommend to the finance committee that a level IV center that had general surgery would get some kind of stipend for having that coverage. No matter what we call level IIIs that provided the different levels of care the finance committee is going to have to decide how we pay these different facilities. Out of the current 23 level III facilities, there are 6 that don't have orthopedist; there is a seventh that has not designated which would fall into that category. The data shows (attachment not included due to patient confidential) that the 6 hospitals the total number of trauma patients that they submitted to the registry in the last fiscal year versus the average for level III that have general and ortho are dramatically lower. If you look at the 6 centers and look at the percentage of patients that they transfer out versus the average of all level IIIs it is much higher. That group is providing a different level of service than the others. It's semantics on what we want to call them.</p> <p>Dr. Mabry – He is in agreement with Dr. Booker's statement. He doesn't think anyone is against separating hospitals out by the capabilities they have, but when it comes to rules propagations you have to think of the impact. The top 5 hospitals are low impact, very few number of trauma patients. There is one hospital that kept 2/3 of their patients. Should we have exceptions to rules? Because this hospital is different than the others. So there are two questions 1) is the intent of the rule in regards to ortho coverage to ask the hospitals to keep the patients and treat them appropriately or is the intent to have a artificial level like a board certification that you have to get over to start worrying about quality measures. The hospital that kept 2/3 of their patients would object because they have a better</p>	

	<p>performance than the other hospitals that are shipping most of their ortho patients. This is just something to think about. Dr, Booker – No matter how you make the rules if you are going to pay centers by the level of designation you are always going to have this. There is always going to be a hospital that sees more patients in the same level. Dr. Mabry- it’s the impact of the patient having to travel some distances by our new triage guidelines. Dr. Maxson – the hospital that keeps 66% of their patients will continue to keep 66% of their patients. Dr. Sutherland – we need to make sure the data is valid. The ISS scores concerns me in this data. The facility that keeps 66% has to have had partial ortho coverage. If one of the 6 hospitals have ortho coverage just 50% of the time, this may be sufficient to be a Level III. Dr. Robertson – We have to make sure that the hospital is not cherry picking and sending the patients that don’t have coverage and keeping patients with coverage. Dr. Maxson – These arguments have happened all across the country the last 20 years, that’s why when the college came to visit they said Level really does matter. We have talked about leaving the Level III and making a Level IV or something in between. Something in between could be if you can clear a threshold of “X” 50% or 70% than you could get .7 of the level III and .3 of the level IV as long as you represent yourself accurately on the dashboard. This may solve some of our problems in areas that are hard or would be detrimental to the patient if we couldn’t fill them.</p> <p>Dr. Mabry – It’s good to have this discussion and think about it so we can say we discussed all of this, it might be that if you have a way to mitigate the financial impact then this would be a good way to do it. Should this not be part of the QI/TRAC quality measures, how many patients you ship out what’s the financial category of the patients that you are shipping out versus what you keep? These are very valid quality measure that the QI/TRAC subcommittee should be looking at because that does impact everyone’s bottom line.</p> <p>Dr. Sutherland – I think having this ortho as a requirement is fine, whether you want to address this as a FAQ that goes with that rule or whether you want a footnote to the rule or whether you want to have a subtab .A. in circumstances whether the following criteria is meet this is how we would handle it, all those would be reasonable ways to address it. It really needs to go back to impact on the care of the patient in the region. We don’t want to create a situation where we are adversely designation a hospital resulting in patient movement that otherwise would not happen. Make them a Level IV and reward them for the extra service or make them a Level III and penalize them for not full coverage. You could make the money work out the same.</p> <p>Dr. Mabry- Does level matter on local referral patterns as far as hospitals?</p> <p>Dr. Sutherland- I think it does matter in certain circumstances – if you are a Level IV and you have a Level II very close I think it makes a real big difference. Two hospitals an hour apart it does not matter as much. This becomes a regional or geographic discussion and the impact becomes regional and geographic.</p> <p>Dr. Mabry made a motion to accept the level III rules with a further request that the finance subcommittee review hospitals that, based on the new Rules, would drop from Level III to Level IV so that funding could be considered to continue to support affected hospitals. That the QI/TRAC subcommittee will review to ensure quality care is still provided in areas served by affected hospitals. Data will also be evaluated for transfers.</p>	
	NEW BUSINESS	Dr. Jim Booker
DISCUSSION		
		Dr. Jim Booker
ADJOURNMENT	Designation Sub-Committee meeting adjourned at 12:00 p.m.	

GUESTS	
OBSERVERS	Bill Temple, Diannia Hall-Clutts, Margaret Holaway, Don Adams, Dr. Charles Mabry, Marie Lewis
NEXT MEETING	January 15, 2012, 10:00-12:00p.m. @ Freeway Medical Building Rm # 906

EMS Trauma Subcommittee Meeting Minutes
Bill and Margaret Clark Multi-Purpose Room
430 President Clinton Ave, River Market District
Little Rock, AR 72201
November 13th, 2012 – 11:00am-3:00 pm

Topic	Discussion
Called to order	Meeting was called to order by Dr. Clint Evans
Welcome Introduction of Members and Guests	Clint welcomed everyone and introductions were made.
ATCC Report	Handouts were provided (see attached) Jeff commended the EMS services and their owners/operators on what a good job they were doing. He is seeing a gradual trend upwards in the number of calls to the call center on the moderate and major traumas and a drastic trend downward of the minor calls. If there are any questions regarding a category of a specific trauma patient, you can email Jeff with the trauma band number, date of service and the any further information that you deem necessary and he will review and get back to you. Please do not email any patient names. He will also make changes as needed. Jeff went over the handouts.
Old Business: AWIN for Helicopter	Cathee gave update from last weeks Air Ambulance Sub Committee meeting. The services are in the process of completing a cost survey for the state in relation to the installation of the AWIN radios in the aircrafts. After getting the survey completed, the committee will bring it to the EMS sub-committee to review and discuss.

Old Business:
Pay for Performance Initiative

The PHTLS pay for performance initiative has been checked off and approved by the Finance Committee and will be presented to the TAC at next weeks meeting. The deadline for participation is 4/1/2013. (see attached handout)

It was also brought up that the ATERF has scheduled 10 PHTLS courses in all of the trauma regions. There has been difficulty in filling these classes so please spread the word. The classes are \$25.00 for EMS providers and \$50.00 for RN's.

Just a reminder: It was decided for this fiscal year was that every service that has 85% of their personnel (full time, part time, and pm) certified in PHTLS, ITLS or the basic version for the EMT's by 4/1/2013, will be able to participate in this incentive. The question was raised on how we are making sure that all of the services are aware of this initiative. Greg stated that the Section of EMS office could send out a letter to every ambulance service/operator. Greg also suggested sending it out to all of the TRACS.

Old Business:
EMS Data Software Initiative

The EMS Data Software Initiative was also approved by the finance committee and will be presented to the TAC at next weeks meeting. Dr. Evans thanked Greg for all of his hard work. A copy of the final version is attached.

<p>Old Business: AWIN for Ground</p>	<p>Joe stated that all of the unused AWIN radios have been collected and you can notify the him at the trauma section if you need one and they will set up the installation.</p>
<p>TAC Retreat</p>	<p>Dr. Evans reported on the TAC retreat last month. He went over and reviewed the TAC Strategic Priorities for Pre-Hospital agencies. (see copy attached) Dr. Evans discussed some concern that he received from the retreat about Air Ambulance services not having the capability to call the call center (refer to priority #1 on the handout attached). There was concern also about air not notifying the hospital in enough time for the hospital to activate the trauma team and prepare to take care of the patient. The Air Ambulance Sub Committee discussed both of these issues in their last meeting and plans to give feedback to the concerned parties.</p> <p>Priority #2 is what we will be discussing today regarding the EMS funding for fiscal year 2014.</p> <p>Priority #3, refer to #1.</p> <p>Priority #4, we have already been working on with the Section of EMS.</p> <p>On priority #5, Greg states that the EMS Rules and Regulations have been posted on the EMS website for review and comments.</p> <p>Regarding priority #6, there was also a lot of discussion on how to analyze the</p>

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cost for pre-hospital trauma care.
Priority #7: Refer to the pay for performance initiative that has been approved by the Finance Committee.

Priority #8: Austin is already working on the scorecard. Greg is communicating with Austin on this. Some of the things that they are considering to be on the scorecard are: EMS provider calling the call center, the EMS provider considering the call center's destination recommendation, etc.

Some of the issues that we need to consider are the services that do not make emergency calls, they just do transfers and the volunteer services that in a very rural area that may do "1" call a year but they are getting the same funding that others are in the same county. We want to try to incorporate trauma run volume and get away from population. Just a review of the breakdown of the EMS funding (copy is also attached):

87% goes to the services

7% goes to the training sites

4% goes to the associations

(The committee agreed on the percentages with no objections.)

Base Rates:

--\$8000.00 for ALS (committee agreed, no changes made)

--\$4000.00 for BLS (committee agreed, no changes made)

Old Business (con't)
Fiscal Year 2014 Funding

--\$2000.00 for Special Purpose (Committee requested to look at lowering it to \$1000.00. There were two recommendations made: one to reduce their base to \$1000.00 from \$2000.00 and another to not fund these services at all. It was also brought up that these services do need some readiness funding. There was much discussion concerning this base rate. Dr. Evans called for a vote on this issue. John Swanson made a motion to reduce the base rate for Special Purpose Services to \$1000.00 from \$2000.00. Denise Carson seconded the motion, the motion passed with no objections.)

--\$10,000 for in state Air Ambulance (Committee agreed, no changes made)

--\$5,000 for out of state Air Ambulance (within 10 miles of the Arkansas state border) (Committee agreed, no changes made)

If you were in a rural area serving:
--< 10,000 or more population, you received an extra \$4000.00

--10,000-25,000 population, you received an extra \$2000.00

--We also had the population modifier of \$0.5912481147.

There was a lot of discussion on the population range and modifier. There was concern that the rural areas might suffer if we did away with these and we want to make sure that the rural areas are taken care of adequately. Dr. Evans proposed using a percentage formula,

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Fiscal Year 2014 Funding

i.e. 60/40 for the 89% allocated for EMS services. The 40% being used for base rates and the other 60% being divided equally between our population calculation and the identified performance measure (i.e. trauma bands/runs, etc.) The 40% would be divided equally between the 75 counties then divided amongst the services within those counties. ALS services will receive twice as much as the BLS services. This should increase the base amount that the rural counties are receiving. Many other ideas were suggested and it was requested to see spread sheets utilizing these ideas/suggestions. There was much discussion on making sure that every county is rewarded equally and fairly.

Joe shared the spread sheet that they have been working on with the trauma runs being utilized as a modifier. He shared the spread sheet using the number of times each service contacted the ATCC with moderate or major traumas and calculated a dollar amount (\$492.00) for each trauma run (moderate or major) using a 1:1 ratio calculation. The spread sheet revealed that when a service did not call the ATCC, they would not receive extra funding. Those services that did call the ATCC have the opportunity to receive more funds. This calculation was figured on taking the population modifier out of the calculation and using those monies to calculate the amount paid per trauma patient. There was a lot of discussion concerning

Old Business (con't)
Fiscal Year 2014 Funding

utilizing the ATCC data regarding moderate and major trauma calls Dr. Evans suggested using the state EMS data for reimbursement in regards to trauma calls. He states that this would hopefully improve the EMS data that the state is getting from the services. He also suggests using minor trauma calls also. Using all trauma calls from the EMS data will alleviate the possibility of services upgrading a minor to a moderate for reimbursement. This would also reward the providers and promote trauma readiness.

There was more discussion on the percentage break down of the 89% EMS services funding. Some want 50/50, some want 60/40 and some want 70/30.

Lee will input these ideas/suggestions into spread sheets so that we can see and we can meet to discuss further and hopefully finalize our EMS 2014 funding in our December meeting.

Adjournment

Meeting was adjourned by Dr. Evans

Next Meeting

Our next meeting will be Tuesday, December 11, 2012 at 3:00pm at the Section of EMS, Suite 801

Trauma Advisory Council – Rehabilitation Subcommittee Meeting
1:30 p.m. Thursday, November 29, 2012
Arkansas Spinal Cord Commission Conference Room

Minutes

Members in attendance: John Bishop (BHRI), Letitia DeGraft (ADH)*, Gary Graham (NeuroRestorative-Timber Ridge - proxy for Sara McDonald)*, Alan Phillips (ACTI)*, Cheryl Vines (ASCC), and Jon Wilkerson (Chair).

Members not in attendance: Dana Austen (BIAA), Elizabeth Eskew (Disability Rights Center of Arkansas)°, Yousef Fahoum (BIAA)°, and Stacy Sawyer (St. Vincent Rehabilitation Hospital).

Staff, guests, and/or observers in attendance: Kim Brown (ASCC), Bradley Caviness (ASCC), Marie Lewis (ADH), and Keith Moore (BHRI).

Welcome, Introductions, and Call to Order

Mr. Wilkerson welcomed everyone, called the meeting to order, and asked everyone to introduce him or herself.

Approval of previous meeting minutes

Mr. Bishop made a motion to approve the minutes of the previous meeting as distributed. Ms. Vines seconded the motion. The motion was approved on a voice vote.

Trauma Rehabilitation Program Report

Ms. Brown gave a summary of the program's activities since the last meeting. She and John Riggins are continuing to meet with stakeholders to operationalize the strategic plan. The first outcomes data report covering 2011 has been received from UDS, and UDS will send quarterly reports covering 2012 outcomes.

Subcommittee Bylaws

Ms. Vines made a motion to accept the bylaws as discussed at the previous meeting. Mr. Bishop seconded the motion. The motion was accepted on a voice vote.

Pay for Performance Projects

Ms. Vines reported that the pay-for-performance projects were approved by TAC. The first project will provide financial assistance to rehabilitation hospitals to offset the fees for CARF accreditation and maintenance. To qualify, at least 11% of the patients admitted to the rehab hospital in 2012 must be trauma patients. The TAC Finance Committee will reimburse rehab hospitals for: half of the CARF site visit fees for hospitals that obtain new comprehensive accreditation, all of the site visit fees for obtaining new specialty accreditation, half the site visit fees for hospitals who are applying for re-accreditation. Ms. Vines said she is also seeking a Memorandum of

* Attended by teleconference. ° Notified Chair of absence prior to meeting.

Understanding with CARF to provide training for facilities that want to apply for accreditation.

The second project, Ms. Vines said, will provide financial assistance to cover the cost of testing fees for rehabilitation hospitals to obtain RESNA Assistive Technology Professional certification for one qualified employee in FY 2013. To qualify, at least 11% of the patients admitted to the rehab hospital in 2012 must be trauma patients.

Education Workgroup Report

Mr. Bishop reported that the Trauma Rehabilitation Conference Planning Committee's next meeting will be held on December 7. The group has made significantly more progress planning the 2013 conference than it had by this time last year planning the 2012 conference. Mr. Bishop stated that the Committee will also be looking at offering other rehabilitation training opportunities. Mr. Phillips requested that the work group conduct a training or workshop to help ATPs meet continuing education requirements. He noted that training for vehicle modification is a specific need. Mr. Phillips will send Mr. Bishop the criteria for maintaining ATP certification.

System Analysis Workgroup Report

Ms. Vines reported that Ms. Brown observed a hospital designation site visit in Florida. She said that further action is on hold because the trauma system is not legislatively mandated to designate rehabilitation centers. Ms. Vines has met with the attorney at ADH. He said that his opinion is that for the Trauma Rehab Program to do rehabilitation facility designation, the Act would need to be modified. Ms. Vines is meeting with our attorney at the Attorney General's office for further clarification.

TBI Registry Workgroup Report

Ms. Vines reported that the TBI Registry plans are also under attorney review. Two ideas are being explored on how to implement the registry: as a tool to collect data, or to provide services. If it is only used to collect data, it can be operated through the trauma registry, but the information it provides won't be timely. The Brain Injury Alliance of Arkansas is legislatively mandated to provide the service component. ADH attorney Rick Hogan suggested the Trauma Rehabilitation Program might draft a memorandum of understanding with BIAA to collect the data on its behalf. Ms. Brown said once we have ER and discharge data, we will have an indication of the number of patients we are dealing with. Mr. Wilkerson asked that a feasibility study be done once those numbers are available.

FIM Outcomes Workgroup Report

Ms. Brown distributed the first outcomes report from UDS containing 2011 data. Arkansas is doing well with certain indicators, including length of stay, Length of stay efficiency, FIM total change, and discharge to community. Ms. Vines said UDS staff

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could possibly conduct training on reporting FIM data for hospital staff and this would be another good education opportunity for the Trauma Rehabilitation Subcommittee.

Financial Analysis Workgroup Report

Ms. Vines said Dr. Tilford has completed a draft of his request for data and is waiting on a reply from Medicaid. If the draft is okayed, an official request for data will be sent by Ms. Vines.

Other Business/Announcements

Ms. Vines said she attended a presentation by Dr. Thompson on the Affordable Care Act at the Clinton School. She learned at that presentation that rehab care is covered under the act. She will get more information and bring it back to the subcommittee at a future meeting.

Since the Subcommittee's workgroups are taking on more work, Ms. Vines suggested that the Subcommittee meet bimonthly in the New Year. An email will be sent out to subcommittee members with this suggestion. If consensus is received, a 2013 schedule can be sent out with all meeting dates. Mr. Wilkerson reminded everyone that electronic votes have to be confirmed at the next meeting.

Mr. Wilkerson said he is going to visit with his state legislators to bring them information about the trauma system and trauma rehabilitation program. He encouraged those committee members who can to do likewise.

Adjournment

With no further business to consider, Ms. Vines made a motion to adjourn the meeting. Mr. Bishop seconded the motion. The members present voted to adjourn.

The next meeting is scheduled for 1:30 p.m. Thursday, January 24, 2013.

Respectfully submitted,

Bradley S. Caviness
Administrative Specialist III