Trauma Advisory Council Strategic Planning Meeting

October 15, 2013
Attendance

MEMBERS PRESENT
Dr. Mary Aitken
Kathryn Blackman
Terry Collins
Dr. Janet Curry
Dr. Clint Evans
R. T. Fendley
Dr. James Graham
K. C. Jones
Dr. Charles Mabry
Michelle Murtha
Dr. Barry Pierce
Freddie Riley
Dr. Nate Smith
Dr. Viviana Suarez
Tim Tackett
Jamey Wallace
Christi Whatley
Jon Wilkerson

MEMBERS ABSENT
John Gray
John E. Heard
Colonel J.R. Howard (rep. by Sr. Cpl. Karen E. Clark)
Dr. Michael Pollock
Dr. Ronald Robertson
Dr. Victor Williams

GUESTS
Dr. James Booker
Jennifer Carger
Denise Carson
Ron Crane
Teresa Ferricher
Jason Gartner
Laura Guthrie
Joyce Jeffries
Karen McIntosh
Linda Nelson
Kenneth Ray
John Recicar
Patti Rogers
Ronald Russell
Dr. Michael Sutherland
Jeff Tabor
Cathee Terrell
Jim Vaughan
Donna Ward
Sidney Ward

STAFF
Katy Allison
Teresa Belew
Debbie Bertelin
Greg Brown
Jim Brown
Jacqlyn Dillard
Melissa Foust
Diannia Hall-Clutts
Margaret Holaway
Renee Joiner
Randy Lee
Marie Lewis
Renee Mallory
Joe Martin
Dr. Todd Maxson
Bethany McLaughlin
Brian Nation
Austin Porter
Bill Temple

Designation Sub-Committee Strategic Planning Retreat

MINUTES 10-15-2013

MEETING CALLED BY	Dr. Jim Booker
TYPE OF MEETING	Strategic Planning Retreat Breakout Session
FACILITATOR	Dr. Jim Booker
NOTE TAKER	Diannia Hall-Clutts

Agenda topics

	WELCOME & MINUTE APPROVAL	Dr. Jim Booker
	Dr. Jim Booker welcomed everyone.	
	Progress Report on CY 2013 Strategic Goals	Dr. Jim Booker

DISCUSSION

1) Assess the issue of minor trauma patients begin transferred to a higher level of care

Status: Ongoing

Assessments:

Karen (Washington Regional) A non-significant number of minor injured patients are being transferred to a higher level of care then discharged from the higher level care trauma center. If the lower level does not have a specialty they stop their evaluation at that point and time so they can get the patient out in the 2-hour time limit. Patients are sent with a suspected neuro surgical injury and they do not have a neurosurgical injury.

OFI: Create more of a guideline (based on data) indemnifying the referring trauma center to keep patients they can keep. Have them calculate a GCS and get a head CT, keep them if they don't send them if they do, push the CT through the TIR. At the TRAC level put up the nominator and denominator, here is how many patient where transferred. We are going to need to get more granular data, why was the patient transferred. The reason usually is to a higher level of care, that's not granular enough. Needs to be transferred for orthopedic care, neurosurgical care. There is good data coming out that says here who can stay in a facility without 24/7 neurosurgical coverage. Under triage benchmarked is 5%, 40% for over triage rate, these are national standards. Neuro seems to be most subjective least objective. This would be a great place to start. Most minor patients transferred are because the need of subspecialist care – ophthalmology, ENT, hand and scene patients when a helicopter is called before the patient has been evaluated.

2) Develop a policy to move trauma in-patient to a higher level of care through the ATCC. This could be similar to the "urgent-trauma transfer" policy.

Status: Not met

Assessment: Dr. Booker felt this had been met. Terry says they are doing this. May not be written but it's being done. But hospitals are following this guideline. Dr. Maxson stated if it would make a physician feel more comfortable than a policy could be written. This should be a goal this year. This needs to be codified in a written statement.

3) Revise the Trauma Rules and Regulations to meet or exceed the American College of Surgeons (ACS) standards.

Status: Ongoing

Assessment: Rules are in the final draft so the opportunity is there to make changes if needed.

	Two major areas the state is dealing with 1) EMS and a question with 2) the Level III rules. We are going to try to have them ready for the January Board of Health meeting. We need to have them completed by mid-December. They will not include Level I or Level II. The designation subcommittee will work on Level I & Level II rules for the 2013-2014 year. We need to sit down with a focus group and talk about the difficult areas that we are facing (hand, maxillofacial, neurosurgery, ophthalmology). A lot of communities that would otherwise be able to stand up a designated trauma center have issues that they can't, that in a state designation process we can recognize that as an issue and except a slightly lower standard to have better access, or at least have those hospitals engaged in the QI piece actively so that we can drive improvement. More procedures are being done as outpatient procedures that were done in the hospital. We are running out physician especially surgeons very fast. Hospitals in hospital systems are having to accommodate the lack of work force, on the hospital policy side we are seeing, large systems are regionalizing care. The outcomes are excellent. Are goal is to get the level III and IV rules ready for January. Work towards getting level I and II in the same format and make significant changes in certain limited areas hopefully to send those simultaneously. Hospitals have a label that states this level has to meet these requirements. Are we going to call the levels the levels and set standards for the levels stick to them and make the money fit or are we going to pay ala carte services? The finance committee is looking at the current funding for hospitals. We have the opportunity to do something really innovative here in the state. One model they are looking at is the money follows the patients. **Goal:** Set up another Tandberg session to clarify some areas of the rules. 4) Identify alternate funding streams for each major component of care for a trauma patient. **Status:** On-going **Assessment:** One hospital has two major payers that are paying trauma activation it was one last year. The financial survey that is being done is looking at the true cost of the care of the trauma patient verses the cost of responding of a patient coming in. We are hopefully that it will show the true cost. In hopes that this will give us the data needed to start talking to get some kind of trauma response funding. So some progress has been made.
	5) a & b. One year goal: decrease under designation. Three year goal: designation level must match capability and capacity. **Status:** Ongoing **Assessment:** Discussed this in the above in the Rules and Regulations. 6) Begin a review of outcome measures at the hospital level to show improvement due to the implementation of the trauma system. **Status:** Met **Assessment:** We are looking at the quality measures we have and look at more outcome based. When you do that the beneficiary will be the TRAC, local hospital, state QI TRAC committee also will be for the health department to show we have produced a certain outcome for a certain level of trauma. The nice thing is we have the national trauma database that list are given type of trauma in different level of severity ISS score we, have certain outcome. We also have the preventable mortality study on going.
OTHER DISCUSSING	One administrator would like to see more outcome data, developing that further. As an administrator she was ask to defend the trauma program. How in the end are they impacting patients. Mortality data, how is it defined. There are many definitions out there. If a patient is transferred to hospice or they are withdrawing care or a 30 day mortality, it's not always being counted as an in hospital mortality. So those hospitals that count all hospice or 30 day mortality have a lot worse looking numbers than those that transfer to hospice status then don't count it as an in-patient mortality. The definition needs to be the same. One suggestion was also to take one clinical pathway and begin to track it statewide. Then you would be able to show this to our administrators, the impact of that clinical pathway to the patients.

TRAC Sub-Committee of the TAC

MEETING SUMMARY 10/15/2013 9:15 AM – 10:30APM WILDWOOD PARK

MEETING CALLED BY	Dr. Charles Mabry
TYPE OF MEETING	Sub-Committee
FACILITATOR	Dr. Charles Mabry
NOTE TAKER	Marie Lewis
ATTENDEES	Christi Whatley, Dr. James Graham, Linda Nelson, Karen McIntosh, Don Adams, Dr. Viviana Suarez, Terry Collins, Dr. Jamey Wallace, Kathryn Blackman, Margaret Holaway, Diannia Hall-Clutts, Dr. Todd Maxson, Dr. James Booker, R.T. Findley, Dr. Michael Sutherland, Danna Bell, Dr. Barry Pierce, Teresa Ferricher, Joyce Jeffries, John Recicar, Bill Temple, Nancy Archer, Jennifer Carger

Dr. Mabry welcomed everyone to the meeting and explained that, as there was no section on the progress report for QI/TRAC, the discussion would center on developing the vision for a functioning QI process for the state at the pre-hospital, hospital, and post-hospital level. He asked that attendees introduce themselves and give their vision.

Three main topics were identified and discussed by the attendees:

1. Development and implementation of uniform Quality Improvement measures

The need for the development of additional measures of quality was raised by a number of attendees. Two specific areas were noted: timely transfer of patients and helicopter transport. General areas of measures included appropriate trauma field triage, appropriate transfer of patients to higher levels of trauma care, and region-specific transfer measures based on patient population. There was also discussion on the challenges of implementing the quality improvement measure protocols at the local level due to low physician participation in the TRACs and high turnover of the TNCs. It is expected that the TRAC TMDs will take ownership and assist with pushing protocols to physicians.

2. Data quality and reporting

A. Outcomes reporting- Now that system processes are in place and are being measured, the committee members felt that it is a time to shift focus towards outcomes metrics. The committee members noted that the state has made a significant investment in the system and it is an appropriate time to attempt to show a return on the investment.

B. Consistency of data capture and reporting- While four QI filters are currently being tracked, data collection and reporting is still inconsistent across TRACs and hospitals. The committee discussed developing a standard set of measures that can be pulled from the registries combined with a report format developed, with the ultimate aim of having these reports referred to the TRACs for their review. Suggested metrics for this "top-down" reporting would include over and under triage rates, areas of clinical management that need improvement, whether State approved protocols are being followed, and other items that will be identified by the preventable mortality study.

C. Transparency of data and full engagement of trauma community in quality- It was noted that while the items noted above can be done, the ultimate goal of quality improvement are reports that are identified by hospital or EMS provider. This transparency, the committee felt, was essential to drive change and improved patient care. The committee felt that the TAC should adopt a goal to have complete transparency for quality reporting within one year.

D. Process of getting to quality measure transparency- It was suggested that to achieve this data transparency, initially the data at the TRAC level be presented to the specific groups (e.g.- pre-hospital

data presented to only the pre-hospital providers and the hospital data only to the hospital staff). Then once the process is comfortable for everyone, the groups can come together. It was also suggested that for the first two quarters of reporting, that the report will be provided by facility or provider, with each assigned a number known only to the facility or provider. During this time the facility or provider will have an opportunity to work with the registry staff to correct any reporting errors. The third quarter report will show the data identified by facility or provider.

E. EMS data- There was also discussion of the quality of the EMS Registry. At this point, EMS data is either not used or discounted entirely. The Section of EMS is working on this it was noted; the committee requested that a report to the TRAC-QI subcommittee regarding the progress of this data improvement effort would be requested.

3. TRAC model, governance, and participation

The committee discussed two concerns 1) that the regional TRACs are at various levels of maturity, and 2) that the overall TRAC model, charge, and governance structure varies across the state. Dr. Maxon stated that there are two parts to what the TRACs do: 1) development of process and outcomes measurements and clinical guidelines, and tracking and reporting on same, and 2) development of solutions to identified issues. The first item can and should be standard across the state, but the second is where the TRACs need autonomy. How a patient moves through the system in central Arkansas is very different than how a patient moves through the system in northwest or southeast Arkansas After discussion, it was recommended that standardizing the TRAC method of review and performance improvement as well as the governance structure would improve TRAC performance across the state, and assist with the implementation of the state QI efforts.

The other major concern discussed was physician participation at the TRAC level. To this point, physician participation has been limited to a few physicians per TRAC, limiting the effectiveness of TRAC discussions of metrics and cases, and the statewide implementation of developed trauma protocols. Suggestions as to how physician participation can be improved is through the use of data to drive the discussion and decision making at the TRAC meetings. It is expected that the TRAC Medical Directors will assist with this to a great degree. This data-focused approach will provide for meaningful discussions, so that it is in the every providers' best interest to attend, especially so that the providers can both correct data inaccuracies as well as develop educational goals.. It was noted that using data to drive the meetings also increases the objectivity of the meetings, as was pointed out in item # 2, above.

To achieve the above identified goals, a meeting of the TRAC-QI committee will be held to determine metrics that can be measured and pulled from the registries, which will then be provided to the TRACs in a standardized format and process. The metrics will be meaningful, consistent, and based on standardized data collection. The metrics will then be reported to each TRAC, using the discussed approach to move toward transparency.

The TRAC-QI committee (and other interested TRAC members) will also present what processes are working in their TRAC. From the presentations and discussion a uniform TRAC model and governance structure will be developed, along with a plan to educate the TRACs, hospitals, and pre-hospital providers on the new plan.

Action items:

Invite Greg Brown to present on the progress of the improvements to the EMS Registry	Dr. Charles Mabry	11/08/13
Call a meeting of the TRAC PI Chairs to develop a TRAC Model and Governance Structure	Dr. Charles Mabry	11/19/13
Call a meeting to develop a standard set of outcome metrics and a report format	Dr. Charles Mabry	11/19/13

Rehabilitation Sub-Committee Strategic Planning Retreat

Strategic Plan Overview

1. Increase accessibility to Traumatic Brain Injury care and unfunded trauma patients **Goal 1A: Goal 1E:**
   Status: Ongoing

2. Enhance education and training for rehab and acute care professionals in trauma rehab centers **Goal 3A: Goal 3B: Goal 3C:**
   Status: Ongoing

3. Develop a brain injury registry in order to provide an effective referral system. **Goal 4A: Goal 4B:**
   Status: Ongoing

4. Define functional outcomes measures for acute care and rehab centers. **Goal 2A: Goal 2B**
   Status: Met/Ongoing

5. Develop a Medicaid red flag system that will expedite the Medicaid approved process. **Goal 1E:**
   Status: Ongoing

Goal 1: Rehab Access

A: Vent dependent
- Challenges: Finding a partner to facilitate a vent unit

B: Designation
- Challenges: Legislation will not allow designation

C: Step down facility
- Challenges: Finding a partner

D: Best Practices
- Accomplishments: Kim visited Craig hospital

E: Adequate funding
- Challenges: Healthcare system change due to ACA

Goal 2: Outcome Metrics

A: Identify metrics and capture
- Accomplishments: Capture 1 year of FIM data and have begun to monitor trends
- Challenges: Improve acute care metrics (Rule Change) Hospital rules and regs

B: Obtain rehab outcomes

- Accomplishments: Capture 1 year of FIM data and have begun to monitor trends
- Challenges: Unhappy with some of the trends

C: Community based follow-up
- Accomplishments: Compiled working parts for TBI registry
    - Established TRIUMPH program with UAMS
- Challenges: Need to analyze longitudinal data such as Quality of Life 1 year post discharge

Goal 3: Building capacity of providers

A: B: C: Training and education for rehab and acute care professionals
- Accomplishments: Annual conference and TBI conference both growing unexpectedly
    - In conversation with UDS for FIM training
    - CBIS training
    - ATP training: seating evaluation

Goal 4: Community Integration

A: Registry utilization
- Accomplishments: TBI registry ready in November
- Challenges: Implementation and surveillance

B: Community support plan
- Accomplishments: Hired Health Educator
    - FTE
- Challenges: Long term plan/Personnel

C: Return to work
- Accomplishments: Law passed securing benefits for disabled citizens returning to work
- Challenges: Long term plan

D: Assistive Technology
- Accomplishments: Trained ATPs
- Challenges: Long term plan

Breakout Session: Injury Prevention and Control

In attendance: Dr. Mary Aitken (moderator), Teresa Belew, Randy Lee, Andy Ridgeway, Vicki Witcher, Shaun Best, Janet Curry, Michelle Murtha, Talmage Holmes, Katy Allison

Review of last year's goals/TAC Retreat Recommendations for Injury Prevention

1. **Improve the coordination of injury prevention planning by creating an Injury Prevention Steering Committee and integrating functions of the TAC Injury Prevention Subcommittee with the Injury Community Planning Group.**

   A Steering Committee that consists of funded partners (SIPP and HHI), and the Rape Prevention Education (RPE) grant being managed through the IVP Section meet monthly to with staff to integrate programs, planning and priorities.

2. **Develop a strategic planning process by reviewing the recommendations from the 2011 Safe States Alliance State Technical Assessment Team (STAT) visit and by developing a five year strategic plan.**

   The recommendations have been reviewed, were utilized as part of a survey sent out to more than 500 partners/stakeholders, meetings have been held to gather data, topics to be included in the Strategic Plan have been identified, a draft is in process, and final format for the publication is being prepared.

   Meeting notes: ADH Injury and Violence Prevention has been working on a statewide strategic plan that should be ready to share with partners within the next few months.

3. **Continue goals of last year such as: support of the Statewide Injury Prevention Program (SIPP) training development goals and a statewide injury prevention conference of stakeholders.**

   A partnership with an existing conference was integral to the implementation of the Arkansas Underage Drinking and Injury Prevention Conference that was held in July, 2013. A two and a half day conference with national speakers, 72 classes offered and an attendance of 400 made this a very successful first event of its kind.

4. **Development of one or two statewide injury prevention initiatives. An example could be a statewide media campaign around motor vehicle accidents called "Toward Zero Deaths".**

   The "Toward Zero Deaths" campaign is set to launch in January of 2014. Meetings, logo development, and campaign distinctive are well underway.

   Meeting notes: Highway Department and Highway Safety Office of State Police all agree that this community level unified effort is the way to go. TZD will be a marketing/public awareness campaign/strategy. Teen driving motor vehicle crash rates

declined in 2010. After the implementation of the Primary Seatbelt Law, seatbelt use was at 79%, up from 72%. Low seatbelt use in the rural counties has brought seatbelt use rates down statewide.

5. **Continue the implementation of the CDC CORE VIPP grant goals.**

These goals are part of the dedication of resources and effort taken up by staff and programs. Examples include:

1. MVC/Occupant Protection – Support of CPS initiatives with programs and product.
2. Unintentional Poisoning – Obtained National Governor's Association (NGA) funding, held stakeholders meeting, MedReturn Drug Collection Units in all but 5 Arkansas counties.
3. Intentional Injury – Submitted a comprehensive application to SAMSHA for funding to support statewide suicide prevention program implementation.
4. Sports/Recreational Injury – Convened a concussion prevention policy subcommittee to review and advise on legislative issues. Protocols related to 2013 legislation are in draft and pending review and approval.

Meeting notes: Added 60 drug drop boxes on October 1, 2013 and five more boxes have been ordered for the five remaining counties. Now there are over 130 drop boxes throughout the state. Suicide prevention grant submitted to SAHMSA and SIPP working to get suicide education into target areas. Protocols are in development for concussion prevention.

6. **Develop a community injury prevention designation program for communities that put injury prevention programs in place.**

Identified Safe Communities America, a program of the National Safety Council, as a proven approach to community injury reduction structured around a broad coalition of community partners - involving business, civic organizations, local government, non-profits, and local residents. Safe Communities America is affiliated with the World Health Organization (WHO) Collaborating Centre on Community Safety Promotion (CCCSP). IVP Section Chief has met twice with key leaders at Safe Communities to discuss process for community application. At this time, there are no Safe Communities in Arkansas either Designated or Affiliated. The Safe Communities designation is awarded to communities that have demonstrated leadership in promoting safety, reducing injuries, and preparing their citizens for natural and man-made disasters. This would be a long range goal and will be included in the state strategic plan. Communities seeking National designation must meet the following four Areas of Competency, established by the National Safety Council:

1. Sustained collaboration.
2. Understanding of their community data.
3. Offering of programs that address the intentional and unintentional injury patterns in their community.
4. Demonstrate an understanding of evaluation.

Meeting notes: Not a single designated community in Arkansas (different than Safe Communities funding).

Expectations Met
Increased awareness among children about usage of helmets
Increased internal capacity at ADH, which is critical for the use of statewide network and applying for federal grants.
Field learned how to fill out application for trauma system program, benefit internally to learn how to access capacity for training technicians
Coalitions are aware of injury, yet community members are not
Increased focus on evidence based programs and interventions
Increased evaluation of programs
Increased collaboration between HHI and IVP
Getting money out to the communities

Expectations Not Met
Slow capacity building for car seat installation at the hospitals. Wants all of her ED staff and first responders trained to install car seats, requires several people
Decline in seatbelt use rates
We have the policies in place for injury prevention but they are not being enforced
Well defined or known metrics – need inclusion in the strategic plan
Not enough public awareness – Expect safety
Slow getting money out to the communities – slow process
No sense of urgency to address the problem
Need access to educators to present information, more digital support for programs for her to use with populations, SIPP has PSAs for distribution, need for template messaging or short videos to use for presentations

Barriers/Challenges
Conceptual blocks on "trauma system," suggests need for branding or awareness-raising
Need more community pride in having a trauma center or an injury prevention program, need more positive stories and outcomes. It is time to do education for institutions. It is hard to incorporate change
Utilization of new technology for information dissemination
Silos – money, time, stakeholders
Fixing medical reimbursement for prevention
Data systems
Hard to do evidence-based evaluation across the lifespan

Solution(s)

Use of non-medical settings, like schools, churches, community organizations
Increase communication with HHI and public health – HHI has an army of local educators in the schools
Targeted interventions – TZD, target program within the TRACs (mostly MVC), reinforce in the community and HHI
Stay on the message, injury prevention and education takes time
Need an identifiable brand for injury prevention to unify the statewide effort
Identifying gaps in policy, increase enforcement, increase public awareness
Continue data-driven targeting
Education delivery – multimedia, social media, etc.
Look at each community and determine the best way of getting information out, whether it is through the coalitions, churches, schools, etc.
Get the appropriate education tools on the frontline
Death reviews – specific data reviews on suicide – identifying root causes
Improve access to educational materials for communities to use, especially digital/online

EMS Subcommittee Meeting TAC Retreat

15 Oct 2013
Little Rock, Arkansas

Breakout Session: Prehospital / EMS Subcommittee / Interested Parties

1. In what areas have your expectations been met?

Level 4 hospitals are doing a better job.
Majority of trauma patients are getting to higher level more rapidly AEMTA and AAA has pushed out more education for providers Successfully deployed AWIN radios and using the ATCC Dashboard
EMS is working with the TRACS very well; TRAC has created a forum for Hospital/Pre Hospital relations QI has help to identify opportunities for improvement
Funding is being utilized by most EMS services very well
Trauma grants to schools have helped get more students to EMT/Paramedic courses, and producing better personnel. AWIN radios are being placed in most Arkansas Air Ambulance to allow better coordination with ATCC
ATCC is activated and has been a major accomplishment
Major trauma patients are being treated faster and more appropriately than before the system.

2. In what areas have your expectations not been met?

Expectation	Barrier/Challenge	Solution(s)	Comment(s)
Hospital utilize the transfer policy correctly	Misuse of the urgent trauma transfer policy Hospitals are holding patients in triage and then wanting to urgently transfer patients because of the 2 hour window, Over triage is hurting EMS with keeping coverage. Patients are not ready for transfer The policy is not completely functional because it is waiting on the rules and regs rewrite.	Utilize the trauma registry and ATCC data to find out what hospitals are by-passing the ATCC. Educate the hospitals of proper utilization of urgent policy. EMS should contact the ATCC to ask if the hospital contacted the ATCC to set up an urgent transfer. This will be replaced when the rules and regs are in place.	Fine tune the utilization of the urgent trauma transfer policy. Sister hospitals may not be using ATCC for transfers. Over triage is common in a trauma system. EMS is forced to hurry for minor trauma patients, in order to not hit the pi filter. Hospital education is not where it needs to be yet.
	Funding is not enough in order to keep	Funding to enhance	Longer transports are stressing

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Funding	ambulance services from losing cost based on the perimeters of the trauma system. Hospital/EMS Agencies may drop out due to funding.	reimbursement for long distance travel. Special project/trials funding for missed calls due to longer transports. Third party payers should want to pay more for longer transports because it will save cost in the long run. Meeting with third party payers to explain costs and work out a more appropriate reimbursement. Incentive based versus outcome based	coverage. When you cut the number of calls or double billing, the service and hospital loses money.
Education	Personnel are not getting the correct training on ATCC usage because of continual changes in ATCC policy. Personnel do not understand the Trauma System.	Continued education for personnel. ATCC should continually train its dispatchers. Training should be completed during "refreshers" and during University classes. Online training module for trauma. Video training Training on the trauma system	Personnel are still contacting ATCC for minor pts.

EMS Subcommittee Meeting TAC Retreat

15 Oct 2013
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Breakout Session: Prehospital / EMS Subcommittee / Interested Parties

		begins at the University. Pass/Fail test before re-licensure. Trauma System Training is made as a deliverable to training sites.	
Data	EMS data is still not coming in appropriately – Poor quality data. Not in depth enough for trauma system. Some points being entered incorrectly. EMS office is now sending this bad data back to services for correction. Some runs aren't being submitted.	Efforts need to be made to improve data linkage between EMS and Trauma registry Third party data is better – project to get services to move to third party to improve data. Some efforts being made to match data with ATCC to check data that should be coming in. EMS will be rolling out a new software package/tool that will hopefully help personnel enter data more accurately and correctly.	Personnel are not receiving the information on how to improve data entering. Personnel still do not understand the trauma system. Ryan calls services to help them submit data daily.
Communications	Lack of communication with local EMS and Hospital Quick turnaround for lower level hospital assessment to higher level care How do we get information to field personnel	Mitigate some cost with hospitals in order to help with EMS TRAC is the forum for conversation between EMS and Hospitals. Allow EMS to take patient to a	It's hard for hospitals to quickly let a patient move in and move out. It usually takes the hospital between 30 minutes and 2 hours to allow the patient to leave based on EMTALA guidelines.

EMS Subcommittee Meeting TAC Retreat

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Breakout Session: Prehospital / EMS Subcommittee / Interested Parties

		lower level facility in order to get everything lined out, no more than 15 minutes at the facility before transfer. Social media	
State vs. Local	State versus local regulations	More local control that work on business models? Should the community have a say what type of medical coverage they want? Education for the community Develop a marketing plan to present to judges/mayors. Discussions with County Judges and city mayors. Feedback at the local level, because some are worried that they might be skipped over constantly.	
Special Project	Investigate tiered system	Tiered system for EMS rural/urban	
Backfill Agreements	Backfill doesn't work as intended	Still need to work on this.	Operational piece that is dysfunctional.
	Centralized Air Coordination		

EMS Subcommittee Meeting TAC Retreat

15 Oct 2013
Little Rock, Arkansas

Breakout Session: Prehospital / EMS Subcommittee / Interested Parties

Extra Notes from TAC Report:

Hospitals and QI understand that over triage burdens the EMS System. RTTDC has incorporated training in order to lessen over triage, and to also know in a quicker fashion when the hospital knows it needs to transfer the patient, instead of holding on to them.

Let's talk to insurance commission and to legislators to solve the problem of ambulances not being reimbursed for longer transports.

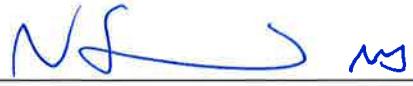
TRAC offers a great forum to invite local mayors/judges in order to discuss the issues that are in the state vs. local category.

Surgeons also fear the trauma system thinking it is punitive and is too forceful. However, like hospital trauma medical directors the owner/operators should be engaging its ems field personnel.

Video of how PI works.

Some states trauma systems allow the ems provider to have a statute of limitation legal protection if they follow the states triage protocol.

Respectfully Submitted,



Nathaniel Smith, MD, MPH
Secretary Treasurer of the Trauma Advisory Council
Director and State Health Officer, Arkansas Department of Health

TAC Rehabilitation Subcommittee
1:30 p.m. Thursday, October 24, 2013
Arkansas Spinal Cord Commission Conference Room
1501 N. University, Room 411

MINUTES

Members Present: Dana Austen (BIA-AR)*, John Bishop (BHRI)*, Kim Brown (ATRP/ASCC – Alternate for Patti Rogers), Sara McDonald (NeuroRestorative Timber Ridge), Alan Phillips (ARS/ACTI)*, Stacy Sawyer (St. Vincent-NLR)*, Aleecia Starkey (Dawson Education Cooperative), Dr. Esther Tompkins (ACH), and Jon Wilkerson (Chair).

Staff and guests present: Heather Browning (ATRP), Brad Caviness (ATRP), and Jason Francis (ASCC).

Members not present: Letitia DeGraft (ADH), Patti Rogers (ASCC)

Welcome, Call to Order, and Introduction of guests – J. Wilkerson
Mr. Wilkerson called the meeting to order at 1:34 p.m. He welcomed everyone present and asked everyone to introduce him and/or her self.

Approval of previous meeting's minutes
Mr. Wilkerson asked for a motion to approve the minutes of the previous meeting as distributed. Dr. Tompkins made the motion. Ms. Starkey seconded the motion. The motion was approved on a voice vote.

Trauma Rehabilitation Program Update – K. Brown
Ms. Brown began her report by introducing Ms. Browning and Mr. Francis who demonstrated the Traumatic Brain Injury Registry, how to search for specific data and how data will be exported to the registry.

Ms. Brown explained that data from the TBI Registry will be cross checked quarterly against data from the Trauma Registry to make sure it is capturing everyone. This will begin once six months of data are available. Dr. Tompkins asked if out of state residents will be listed on the registry, if they are injured in Arkansas or come to Arkansas for care. Ms. Brown explained they may be at first, but will be separated out over time as they return to their home state, and Arkansas residents that injured out of state will be registered once they return home.

Ms. Brown said the TBI resource packet will be ready for delivery soon. It contains a lot of very useful information for new TBI patients and is very well designed.

Mr. Wilkerson said the Program should consider taking recommendations from hospital trauma coordinators and case managers for additional data fields to track on the TBI Registry Referral Form once each year, like the Trauma Registry does. Mr. Francis said it is easy to add new fields, but attention must be paid to not segregate data.

*Attended via conference call

Ms. Brown reported that she attended the ASCIP conference in September. She was able to network with model center staff and VA SCI Center staff from around the nation, hear presentations on best practice measures and view new assistive technology available for patients with SCI. She said she would like ASCIP to have a booth at next Trauma Rehabilitation conference to begin getting Arkansan trauma care providers involved with other SCI professionals in the country.

Ms. Brown reported that she spent a week observing at Craig Hospital, a model system for SCI and TBI care in Colorado. She held substantive meetings with hospital staff at all levels from the CEO to PTAs. She said the hospital takes an anatomical approach to TBI, and they continuously evaluate their process. The hospital administration is politically involved and was very involved in developing Colorado's insurance exchanges. They hired an actuarial firm that determined the cost to insure patients for 90 days of rehabilitation care versus 30 days is an additional $0.29 per patient per month. Ms. Brown would like to see ATRP collaborate with the Insurance Commission in order to get this information out to insurance companies that provide coverage for Arkansans.

Dr. Tompkins pointed out that Craig's outcomes are skewed because they are selective about patients they accept.

Mr. Bishop said he was curious about Craig's coverage cost figures. He asked if they figured per diem payments or a negotiated percentage that ordinarily would not cover that amount of time. Ms. Brown indicated that they negotiated percentages with payers.

Ms. Brown said that 15 people have signed up to take the Certified Brain Injury Specialist exam at a training hosted by ATRP and NeuroRestorative on December 5 and 6, 2013. There was sufficient interest that a second session is being planned for Spring 2014. Ms. Brown said she was contacted by representatives from ICAN about holding an assistive technlogy fair next year to demonstrate state-of-the-art equipment to patients, rehabilitation professionals, and hospitals. She said she is also finalizing plans for an advanced seating workshop in March 2014.

Education Workgroup Report – J. Bishop

Mr. Bishop reported that the Trauma Rehabilitation Conference will be held May 22 and 23, 2014, at Embassy Suites-Little Rock. All of the speakers for the conference have been confirmed. The Save the Date will be sent out on November 4. The brochure will be distributed in January 2014. He said he is expecting 250 people to attend the conference. Dr. Brent Masel from the Transitional Learning Center in Galveston, Texas, will be keynote speaker and will deliver two presentations. This year's conference is expanding to include clinical breakout sessions on the second day. He added the planning committee's next meeting is on October 31.

New Member Recruitment – J. Wilkerson

Mr. Wilkerson announced that Elizabeth Eskew resigned her position at Disability Rights Center of Arkansas which opens an advocacy position on the Subcommittee. Mr. Wilkerson asked Subcommittee members to send recommendations to fill that position to him before the next Subcommittee meeting.

Meeting Schedule – J. Wilkerson

Mr. Wilkerson noted that that the next Subcommitee meeting is scheduled for the day after Christmas. He proposed postponing the December meeting until January 23, 2014, and holding the subsequent meetings on March 27, 2014, May 22, 2014, July 24, 2014, September 25, 2014, and November 20, 2014. Ms. Starkey made a motion to adopt the proposed meeting schedule. Ms. McDonald seconded the motion. The motion was approved on a voice vote.

Other Business

Mr. Wilkerson announced he will be giving a lecture on November 7 to Physical Therapy students at UCA on the subject of accurate FIM scoring. He wants UDS to come in and re-train personnel at facilities that provide rehab services and report to UDS. If ATRP pays for it, he hopes facilities will be open to it. Ms. Sawyer noted that St. Vincent holds FIM training for its staff every year in a webinar with trainers from UDS. Ms. McDonald asked Mr. Wilkerson to adapt and give his lecture to Speech and Language Pathology schools. Mr. Wilkerson said he would like to adapt it for all nursing and allied health programs. Ms. Starkey suggested he also consider presenting the lecture at conferences.

Announcements

The next Subcommittee meeting will be held at 1:30 p.m. Thursday, January 23, 2014.

Adjourn

With no further business to consider, Mr. Wilkerson asked for a motion to adjourn. Dr. Tompkins made the motion to adjourn the meeting. Ms. Starkey seconded the motion. The meeting was adjourned at 2:34 p.m.