



# Trauma Advisory Council

February 18, 2014

3:00 p.m.

Minutes

## MEMBERS PRESENT

Dr. Mary Aitken  
Terry Collins  
Dr. Janet Curry  
Dr. Clint Evans  
R. T. Fendley  
Dr. James Graham  
John Gray  
Col. Stan Witt (rep. by Sr.  
Cpl. Karen E. Clark)  
Thomas Jenkins  
K.C. Jones  
Dr. Charles Mabry  
Dr. Corey Montgomery  
Michelle Murtha  
Dr. Barry Pierce  
Dr. Michael Pollock  
Freddie Riley  
Dr. Ronald Robertson  
Dr. Nathaniel Smith  
Dr. Viviana Suarez  
Tim Tackett  
Christi Whatley  
Jon Wilkerson

## MEMBERS ABSENT

Kathryn Blackman  
John E. Heard  
Jamey Wallace

## GUESTS

Don Adams  
Deborah Armstrong  
Dr. James Booker  
Jennifer Carger  
Denise Carson  
D'borai Cook  
Kelly Dicks  
Janie Evans  
Teresa Ferricher  
Amber Files  
Robert J. Fox  
Laura Guthrie  
Kelly Hill  
Mack Hutchinson  
Terri Imus  
Carla Jackson  
Monica Kimbrell  
Dr. Scott Lewis  
Paula Lewis  
Dr. Chuck Mason  
Gary Meadows  
Linda Meadows  
Carla McMillan  
Cindy Metzger  
Debbie Moore  
Linda Nelson  
Amy Niemann  
Dr. Joe Olivi  
Donna Parnell-Beasley  
John Recicar  
Barbara Riba  
Velvet Reed-Schultz  
Dr. Mark Sanford

## GUESTS (Cont.)

James M. Smith  
Dr. Michael Sutherland  
Jon Swanson  
Jeff Tabor  
Chris Tarkington  
Annette Tatum  
Cathee Terrell  
Robin Terry  
Allen "Bubba" Usrey  
Tim Vandiver  
Carrie Vickers  
Rodney Walker  
Stacy Wright  
Nasir Zareen

## STAFF

Katy Allison  
Teresa Belew  
Greg Brown  
Jim C. Brown  
Diannia Hall-Clutts  
Rick Hogan  
Margaret Holaway  
Renee Joiner  
Marie Lewis  
Renee Mallory  
Dr. Todd Maxson  
Brian Nation  
Austin Porter  
Donnie Smith  
Karis Strevig  
Bill Temple

## **I. Call to Order – Mr. R. T. Fendley, Chairman**

The Trauma Advisory Council (TAC) meeting was called to order on Tuesday, February 18, 2014, at 3:02 p.m. by Mr. R. T. Fendley.

## **II. Welcome and Introductions**

Mr. Fendley welcomed all guests and members and asked those on the conference call to introduce themselves. He asked that TAC members and guests on the conference call who wish their attendance noted for the official minutes to send the appropriate e-mail.

## **III. Approval of Draft Minutes From January 21, 2013**

The TAC reviewed the January 21, 2013 minutes. A motion to approve the minutes was made by Mr. John Gray and seconded by Dr. Ronald Robertson. The minutes were approved.

## **IV. TAC Schedule for 2014**

Mr. Fendley thanked the TAC members for their faithful participation and hard work and he noted that members are passionate about building an exceptional trauma system. He also noted that significant work is being done in TAC committees. He opened up discussion regarding the possibility of modifying the TAC meeting schedule. He asked for input and shared a suggested schedule in an effort to be more efficient and considerate of TAC members' time. He asked that the TAC meet as usual on March 18, 2014 and that the group then consider going to a quarterly meeting schedule such as: June 17, 2014; September, 16, 2014; a retreat on October 21, 2014; and, a final meeting December 16, 2014. He noted that the TAC may want to start meeting earlier in the day, possibly as early as 1:00 p.m., to allow travel time back home. Some TAC members thought it was a great idea, while others suggested starting with bi-monthly meetings. Questions were raised about how the committee schedule would fit with the proposed changes. Mr. Rick Hogan noted that the statute requires the Council to meet at least four times annually. Mr. Fendley asked that the committee chairs discuss and consider the best options for their committees. After significant discussion, Mr. Fendley asked for the issue to be placed on the March 18, 2014 agenda and that the TAC membership prepare to vote on the best option at the meeting.

## **V. Trauma Office Report – Bill Temple**

Mr. Temple noted that the Trauma Section will be sending an updated contact information form for TAC members and asked that they be returned. He noted that Dr. Booker will be addressing the Rules issues in his report. The FY 2015 budget will be presented to the Finance Committee in March so that we can work to have it ready for the Board of Health in April. Mr. Temple noted that as we anticipated, the carry forward amounts are going down and they will decrease significantly next year. We are in good shape in getting all the contracts and sub-grants in place by July 1, 2014, which will avoid a break in service. We anticipate doing another trauma

brochure this summer and he requested ideas and specifically success stories. Mr. Temple asked if attendees had seen or were aware of the “Toward Zero Deaths” campaign advertisements on television. He noted that response and feedback has been very positive. This is a focused effort to reduce motor vehicle mortality in our state from approximately 500 down to less than 400 by 2017. This campaign will also include some targeted interventions and policy strategies. He shared a four minute video/audio presentation that is near completion. Finally, the 2014 Arkansas Underage Drinking and Injury Prevention Conference will be held on April 14-16, 2014 at the Crowne Plaza in Little Rock, Arkansas. For the first time, there will be a youth track at the conference. Additional information and registration is available on-line at <http://www.udipc.com>.

#### **VI. ADH Medical Consultant Report – Dr. Todd Maxson**

Dr. Maxson shared two items. He noted that some hospitals have taken certain specialty services, such as orthopedics, off the dashboard, thereby indicating that they are not available to take emergency cases that are delivered to the hospital by ambulance. However, they in some cases continue to treat patients that present to the emergency department from their local community or in other ways. The trauma Rules do not speak to this issue but this practice is in fact a violation of CMS/EMTALA guidelines. He stated that he will work on a letter to clarify this issue.

Hand surgery coverage was the second thing Dr. Maxson discussed. He thanked Jeff Tabor, the Arkansas Trauma Communications Center (ATCC) Director, and the hand surgeons in the state for making this happen. Progress is very encouraging and some hospitals have asked that the physicians be credentialed at their hospitals. He stated that this is not necessary because the purpose of the physicians is not to provide care within the hospital, but to give advice to the ATCC for triage decisions and collective decision making.

#### **VII. Other Monthly Reports**

##### **Trauma Registry – Marie Lewis**

- We continue to move toward ICD-10 implementation in October. Some hospitals have already upgraded and we have identified some issues. We have implemented a work group to address the issues.
- The Association for the Advancement of Automotive Medicine course has been rescheduled due to the weather. It is now scheduled for May 6-7, 2014.
- Work with American College of Surgeons (ACS) continues toward finalizing the Trauma Quality Improvement Program contract. We will also be planning for training sessions.
- The next submission deadline is February 28, 2014, for the fourth quarter of 2013 data.

### **Arkansas Trauma Communications Center (ATCC) – Jeff Tabor**

Mr. Tabor shared that average acceptance times for transfers in 2013 was 07:14, up 45 seconds from the previous year but still well within expectations. The hand program continues to progress well. Of the 16 cases in January, none had to leave the state. Mr. Tabor specifically thanked Ortho Arkansas, The Department of Orthopedics at UAMS, Ozark Orthopedics in Fayetteville, Washington Regional, and Baptist in Little Rock for their teamwork. He also noted that ADH assisted with a media release. Mr. John Gray cited a specific instance of how the ATCC and the trauma system functioned extremely well, along with Christus St. Michaels and Dr. James Booker, to provide services for two major trauma patients.

### **Arkansas Trauma Education & Research Foundation (ATERF) – Dr. Michael Sutherland**

Dr. Sutherland shared that registration is open for the Trauma Update that will be held on May 2-3, 2014 at Embassy Suites in Little Rock. Space will be limited and he encouraged early registration on the ATERF website. Capacity is 300 to 350 and we have 116 already registered. A farm medic course and a wilderness medicine course are two new offerings this year. The Trauma Leadership Conference is planned for August 15-16, 2014 at Big Cedar Lodge.

### **Trauma Image Repository (TIR) – Terri Imus**

Ms. Imus reported that in January, the ATCC notified the TIR of 354 transfers that may have images associated with the patient. About 50% actually had images. She noted that the Level II hospitals have a better percentage of getting images with their patients. She shared that since the letter has been sent for the hand trauma program she has received numerous requests for training. Results are encouraging as more hospitals are requesting information and assistance from the TIR.

### **Scorecard Report – Austin Porter**

Mr. Porter shared a hand-out and discussed a brief report focused on comparing Registry data for 2012 with 2013. Copies were distributed at the meeting and the report was sent via e-mail to TAC members prior to the meeting.

### **Quality Improvement Organization (QIO) – Jennifer Carger**

Ms. Carger shared that requests have been sent for samples of the records to be audited. She was very complimentary of the Trauma Program Managers and the cooperation received from them. An inquiry was made as to the number of data points being verified and Ms. Carger indicated she would share that information with the TAC at the next meeting.

## VIII. TAC Committee Meeting Reports

(Note: Committee minutes are attached, where appropriate; only official action and additional information provided to the TAC is documented in this section.)

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

Mr. Fendley shared that the Committee did not meet in January. The next meeting is scheduled for Tuesday, February 4, 2014 at 3:30 p.m. Work continues with the Arkansas Hospital Association (AHA) regarding the hospital cost study.

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

Dr. Booker shared that the Committee met earlier this afternoon. There were specific discussions about revising the current Rules regarding pediatric trauma centers as well as the ongoing controversy regarding the overall Rules revision. The Committee has three recommendations concerning these issues.

First, he made a motion on behalf of the Committee that a provision be added to the Rules to ensure that Level I and II trauma centers that meet the pediatric standards already set forth in the Rules can be designated as pediatric Level I and II centers as well as adult centers. This could be a dual designation and might include a scenario in which a hospital could be designated as a Level I adult facility and a Level II pediatric center. The motion passed.

Second, on behalf of the Committee, he made a motion that patients under the age of 15 who meet either the trauma center's Level I activation criteria or the CDC's Step I or Step II activation criteria, if transferred, must go to a Level I or II pediatric trauma center. The intent is to ensure that severely injured children are taken to the most appropriate trauma centers. Performance in this regard can be evaluated by the TRACs. Dr. Mabry suggested that this could be added to the existing tracking form. The motion passed.

Third, Dr. Booker, on behalf of the Committee, stated that a recent meeting occurred between ADH and AHA personnel in an attempt to come to some resolution concerning the full-time equivalent (FTE) and Level III orthopedic coverage requirement issues. A middle ground was discussed but the AHA Board later met and voted not to accept a middle ground and instead voted to oppose the FTE and Level III orthopedic requirements altogether. This being the case, he made a motion that the Rules be approved by the TAC as previously written (i.e., including the FTE and Level III orthopedic requirements). The motion passed.

- EMS Committee (Tim Tackett - Chair) (See attached report)

Mr. Tackett shared that the Committee met this morning. There were several EMS funding formulas issues discussed. The first proposal deals with trauma transport and on behalf of the Committee, Mr. Tackett moved that: 1. all license holders making zero trauma transports be funded at the “flat rate” equal to the special services license holders; 2. all license holders making 1-30 trauma transports per year be funded at a “flat rate” of two times the special services license holders; 3. all license holders making greater than 30 trauma transports be funded at the standard provider rate as approved, following the funding formula for all other providers; 4. the Section of EMS and the Trauma Section will have discretionary oversight authority for those license holders currently in the validation process; and 5. trauma transports will be defined as those trauma runs properly recorded and submitted to the EMS Registry via normal protocols and procedures. The motion was approved.

The second motion presented by Mr. Tackett, on behalf of the Committee, concerned the adjustment of the fixed funding formulas related to aeromedical services, special services and all other services/license holders receiving a “flat rate” grant. These adjustments are: 1. modifying monies available in this category with a percentage-based adjustment relative to annual changes in the total available monies; 2. the fixed-funded or “flat rate” grant recipients will have the total amount of dollars available for distribution in this category adjusted by the same percentage as the change in grand total dollars available before distribution occurs; and 3. benchmarks for baseline funding will be based on FY 2014 funding. The motion was approved.

The third motion was to approve the new funding formula (in blue below). The motion was approved.

<b>METRIC</b>	<b>CURRENT</b>	<b>NEW</b>
<b>Base Funding</b>	40%	50%
<b>Population Funding</b>	30%	20%
<b>ATCC</b>	15%	10%
<b>EMS Registry</b>	15%	20%

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

Mr. Wilkerson shared that work continues on the new disability resource website, <http://www.atrp.ar.gov>, which is a clearinghouse of available resources for all Arkansans

with traumatic injuries. The Traumatic Brain Injury Registry is live and we are receiving about one entry a day. There are currently 125 entries in the Registry. They will be supporting a non-profit group, Increasing Capabilities Access Network, with a conference at Pulaski Tech in North Little Rock, Arkansas on April 16, 2014 called "Tools for Life", which will promote technology accessibility. He also noted that the Committee has experienced turnover in voting membership.

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

Dr. Mabry said the Committee did not meet. They will, however, meet in March.

- Injury and Violence Prevention Committee (Dr. Mary Aitken – Chair) (See attached report)

Dr. Aitken reported the Committee did not meet in February. However, she noted much activity and training opportunities. A needs assessment survey will go out this spring. She also noted that the 2014 Arkansas Underage Drinking and Injury Prevention Conference will be held at the Crowne Plaza in Little Rock on April 14-16, 2014. Registration is available on-line at <http://www.udipc.com>.

## **IX. Other**

Dr. Maxson discussed designation of out-of-state hospitals. He noted that ACS and Arkansas designation can occur at the same time. One pre-review questionnaire is acceptable and both ACS and Arkansas reviewers can be present during the survey. He also noted that substantive changes in hospital trauma programs, such as a change in ownership of the hospital or changes in the Trauma Medical Director or Trauma Program Manager, must be submitted to the Trauma Section via letter to outline what those changes are and the impact on the trauma system. The Trauma Section reserves the right to require a new site survey within one year of the changes, depending on the nature of the changes and their potential impact on the system.

Dr. Smith, Director of the ADH and State Health Officer, revisited the situation with the AHA regarding the trauma Rules revision and said dialogue will continue. He noted a conversation with a hospital CEO who expressed tremendous appreciation for the trauma system and the support his hospital has received. The CEO also expressed concern about more requirements being placed on hospitals with possible fewer resources to meet the requirements. Work and dialogue with the AHA will continue in an attempt to resolve this issue.

## **X. Next Meeting Date**

The next regularly scheduled meeting is on Tuesday, March 18, 2014 at 3:00 p.m.

**XI. Adjournment**

Without objection, Mr. Fendley adjourned the meeting at 4:56 p.m.

Respectfully Submitted,

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Nathaniel Smith, MD, MPH

Secretary Treasurer of the Trauma Advisory Council

Director and State Health Officer, Arkansas Department of Health

# Meeting Title Designation Sub-Committee of the TAC

MINUTES 02-18-2014

<b>MEETING CALLED BY</b>	Dr. Jim Booker
<b>TYPE OF MEETING</b>	Sub-Committee
<b>FACILITATOR</b>	Dr. Jim Booker
<b>NOTE TAKER</b>	Diannia Hall-Clutts
<b>COMMITTEE MEMBER ATTENDEES</b>	Dr. Jim Booker, Dr. Todd Maxson, Dr. Michael Sutherland, Dr. Barry Pierce, Dr. Scott Lewis, Tandberg, Carla Jackson, Tandberg, Carla McMillian, D'borai Cook, Paula Lewis, John Recicar, Tandberg, Donna Parnell-Beasley, Teresa Ferricher, Tandberg, Terry Collins, Karen McIntosh – Tandberg, Don Adams

## Agenda topics

### WELCOME & MINUTE APPROVAL

Dr. Jim Booker

Dr. Jim Booker welcomed everyone. Minutes were reviewed and approved.

### OLD BUSINESS

Dr. Jim Booker

### DISCUSSION

**Proposed Rules and Regulations update-** The designation subcommittee has spent countless hours getting the rules to the point we took them to the TAC for approval, and they were approved. There were last minute changes before going to the Board of Health. Before they went to the Board of Health last month the AHA (Arkansas Hospital Association) objected to three of the rules: 1) the TPM FTE, 2) the registrar FTE and 3) the continuous orthopedic coverage at level IIIs. The Health Department with discussions with the AHA had planned to go ahead and take the rules to the Board of Health with those three requested suggested changes. This was discussed at last month TAC and many of the stakeholders withdrew support of the rules if those changes were going to be made as did the TAC as a whole. Since then there have been several meetings between the Health Department and the AHA. The last update was that the AHA was not interested in compromising or meeting somewhere in the middle; they would oppose the rules unless all three rules were changed. The last meeting was attended by three CEO long with representation from the AHA. The three rules were discussed.(compromises were only discussed not offered):

- Trauma program manager FTE – discussion points
  - There is such a variable of the volume of patients, hospitals that have a large volume really have a dedicated person and the low volume hospitals might be able to do the work without a dedicated FTE.
  - The understanding needs to be clear that the QI process will be verified during surveys and it is a critical deficiency for which a hospital will not pass if QI is not done correctly. The rules were written based on past experience and data on turnover and is believed they probably will not be successful without a dedicated FTE.
  - The department's middle ground position is that hospitals with low volume have less than a FTE and moderate and high volume had greater than an FTE. The number that was discussed was 500 trauma patients.
- Registrar FTE – discussion points
  - The hospital CEO perspective was that they believe they may have technology that will allow them to do more of this work more efficiently and they prefer the state not to prescribe FTEs.
  - They understand the goal of accurate, reliable, timely complete data, abstraction, and entry, and the importance of the data to the PI program.
  - They understand how they would be judged and are willing to do it correctly
  - FTEs are how it is prescribed nationally.
- Level III Orthopedic coverage- discussion points
  - “What are you trying to accomplish with this rule” Trying to get community hospitals to keep people in their communities, care for people and reserve transfers for patients that needed tertiary care at level Is and IIs and not burden our EMS with unnecessary transfers of people who can be cared for within their communities.
  - What would be a reasonable percentage of transfers for orthopedic patients?

The AHA took these discussions back to their board and their response back was that they are not interested in any compromise. It was brought up in discussion that the AHA has more representation on the TAC than any other

organization yet there is no one at this meeting and has not been anyone at these meeting through this entire process other than Don Adams representing the views of the AHA. Mr. Adams felt the hospital administrators did not know that these rules exist. He felt there had been poor communication back to them. That they were not made aware of these rules. Hospitals are under intense financial pressures and they were not comfortable with the rules required FTEs and continuous orthopedic coverage.

**Dr. Sutherland made a motion to submit to the TAC that this committee doesn't see any compelling reason to change any of the previous recommendation to the rules except as noted from the previous discussion today regarding pediatric trauma centers. Dr. Maxson seconded the motion. All committee members were in favor, the motion carried.**

## NEW BUSINESS

Dr. Jim Booker

## DISCUSSION

- 1. Transferring of Pediatric Patients** - In our rules we created very specific criteria for pediatric trauma centers we split them into Level I and II, what we didn't make clear was the process that a hospital would go through to be designated as a Pediatric Trauma Center. When we put those rules into place there was an assumption in putting them in place that there would be a piece called a Pediatric Trauma Center. But we didn't say that in the rules, we designation as trauma centers. A hospital can be both if they met the criteria. The levels don't have to match. The ACS designates both Adult and Pediatric Trauma Centers. The members of the committee understanding were that a hospital could be designated as an Adult or a Pediatric Trauma Center. No rule changes need to be made just a clarification. **A motion was made by Dr. Sutherland to use the existing language of the proposed rule to offer a change in the name of designated facilities to include an adult level I-IV and Pediatric Level I and II hospitals and not preclude and entity from being dual designated in adult and pediatric at the same or different levels. Terry Collins seconded the motion. All members were in favor, the motion carried.** Under Section VIII., B.,4.,a and b it discusses FTEs for pediatric TPM and registrars. The way that it is address at the national level is that if you are designated as a Level I adult and Level I pediatric trauma center those are separate entities, if you are designated a Level I or Level II adult and a Level II pediatric then one person can oversee the whole program and there has to be job description for a person that does pediatrics it does not have to be a defined FTE. The only requirement needs to be a full FTE allocated to level I pediatric trauma centers with they are coexisting with an adult level I trauma center there has to be two separate FTEs. Dr. Sutherland made a motion to add to the proposed rules under Section C Level II Pediatric Trauma Center add an item 6. **Under circumstances of dual designation a facility with a level II designation can have less than a FTE for the TPM for the pediatric designation. The TPM and registrar should be resource efficient to accomplishment tasks and could continent less than one FTE each when appropriate resources are present. Dr. Maxson seconded the motion. All members were in favor, motion carried.** The second issue that needs to be discussed is that do we want critical injured pediatric patients to go to a non-designated pediatric center. The feeling is that they go to a non-designated pediatric center for stabilization but should not be admitted. **A pediatric patient (under the age of 15) who met the CDC field triage criteria step 1 or 2 or highest level of a trauma team activation in a facility who are transferred go to a designated pediatric trauma center. The motion was made by Dr. Maxson, seconded by Terry Collins. All members were in favor, motion carried.** This needs to be added to the proposed rules. A new state quality filter needs to be added to include Pediatric patient (under the age of 15) who met the CDC field triage criteria step 1 or 2 or highest level of trauma team activation who is not transferred to a designated pediatric trauma center.
- 2. Freestanding ER – Urgent Care Centers** – They will be licensed and EMS will be able to transport. They will not admit. The question that came was would they need to use the call center. They will have the same equipment as a functioning ER. The benefits would be: 1) data collection, 2) ensure a level of training and education standards and 3) it mandates the use of the call center. The consequence is that we end up licensing urgent care centers all over the state which would hurt the system. We don't know what the volume and acuity is going to be, we don't know how it's going to be perceived by the EMS community and we don't really know how this fits in the system. On the dashboard it would be two boxes ED and CT scanner. It would have to be an extension of a designation trauma center. It was recommended by the committee to let White River pilot this. This will allow White River to use this satellite facility as an extension the present ER same requirement hold true we will evaluate both site's care. The dashboard will show it for what it is a ED with a CT scanner. Connie Melton needs to be involved because there are requirements in operating a free standing emergency department, there are certain requirements that have to be met. Stacy Wright feels like all that has been done. This will go under White River's designation and ask that the same processes and requirements be at both places, we will go in and look at it in a year and see how it's going and truly see if we have the need for another level of designation.
- 3. DI – NTRAC Version 5 software update** – As we move towards implementing IDC 10 across the hospital system including the registry. Marie talked to DI, and the option that given to her were we could upgrade our current system, which would require dual storage for all the hospitals so they would have to have two databases and run the same software against both data bases. Also any enhancements we wanted moving forward would all be charged to us for all the enhancements. The other option given to us was to move V5, that would incorporate ICD10 into the software, eliminate the need for dual storage and would provide a number of enhancements and additional functionalities we knew we needed. Marie told DI that we wanted to move to V5. It would be available January 1<sup>st</sup>, if hospitals wanted to move to it at that point knowing that implementation in order to get the ICD10 functionality would be to come sometime prior to January 1, 2015. Marie said that talking to users it is not how it was presented to them. The users said that their understanding

was that it was required for them to move to it January 1<sup>st</sup> of this year. This has caused a number of issues. There is a good bit of difference between the systems. In order to deal with the issues a weekly conference call has been set up. The first meeting was held last week. Marie will also have a conference call with DI weekly. There is talk about implementing a registry work group. Concerns voiced were:

- the need to work with two difference systems for a hospital survey.
- it will not support the new 2014 NTDS data elements.
- becoming behind in their registry.
- totally new system

Having in users involved in the decision making related to major changes to the registry would have prevented a lot of the problems. DI has not come out and said that they will stop supporting V4 but that is the impression they are giving. They are pushing everyone to V5. Everyone is going to have to do it. We need an education process that everyone attends. Dr. Sutherland made a suggestion that a registry committee get together, meet and let the designation committee know what they need. The designation committee needs a report with bullets stating what the problems are and what can be done to fix them. Marie will take the lead to get the committee together and report back to this committee next month.

4. **Out-of-State Surveys** – If a hospital is going through an ACS survey along with an Arkansas survey will we accept the ACS PRQ? There are a few areas that differ from the college. An Arkansas representative has to attend the survey. The committee discussed and decided that we would accept an ACS PRQ but not another state’s PRQ. Arkansas needs to send at least one team member plus an ADH representative to each out-of-state review. The hospital needs to make sure in advance that the other state or ACH agrees to let Arkansas participate in the full review (to include chart reviews, closed discussion, tour and exit interview.) The Arkansas team member would be considered a lead reviewer. The data needs to include all patient data not just Arkansas patients. Reviewer will not just review Arkansas patient’s charts; we will evaluate any care they provide. All care is subject for review.
5. **ATCC Physician Credentialing** – There has been some questions from hospitals about the hand surgeons that are participating in the hand call program being credentialed in their hospitals. The hand surgeon is not directing care. The hand surgeons should say these are my recommendation. The physicians have solicited their opinion. The purpose is to aid the ATCC in triage, if the treating physician asks for an opinion of the hand surgeon the hand surgeon can render an opinion but should not direct care. The physician caring for the patient has the ultimate decision whether to take the recommendation or not. ADH will send something out to everyone about what the hand service is so they understand from a credentialing point of view.
6. **Change of Ownership** – Mercy Hospital Hot Springs and Hot Spring Co. Medical Center. – We need to receive a letter that states their intent and commitment. A timeframe needs to be added when that letter is to be received. A re-designation survey needs to be completed one year after the changeover.
7. **CMS’s response** – It is an EMTALA violation to list yourself as not being on call on the dashboard and yet you continue to accept those similar type patients from local traffic. Example: 1) Orthopedics – I don’t want to be on the dashboard for orthopedics but I am going to take care of people who walk into my facility. This is an EMTALA violation. 2) We are willing to be on call for our community but we don’t want to be on call for the trauma center or system, this is a federal mandate (EMTALA violations). If a hospital can make a prevision to treat someone it doesn’t matter how they come in (EMS, POV) it’s irrelevant. If you make prevision to treat somebody you have to make prevision to treat everybody.
8. **Opting out of system** – A trauma center has to give the Department of Health a 30 day notice of a decision to no longer participate in the trauma system. This is written in their contract.
9. **Magnolia Regional Medical Center – Change from Level III to a Level IV** – Magnolia lost general surgeon last April. They have been notified that they will go down to a Level IV.
10. **Designation dates**- Whenever the rules are adopted this committee talked about a 6 month grace period. If a hospital would come up for designation during that 6 month grace period, an offer to postpone their survey would be offered. If they wanted it, they don’t have too. If a hospital designates under the existing rules and fails any criteria deficiency they would be given a provisional designation (Any single criteria deficiency would lead to a provisional designation). If it’s a requirement it has to be met, if not met it has to be corrected.

<b>ADJOURNMENT</b>	Designation Sub-Committee meeting adjourned at 2:55 p.m.
<b>OBSERVERS/ GUESTS</b>	Donnie Smith, Bill Temple, Renee Joiner, Diannia Hall-Clutts, Margaret Holaway, Karis Fleming, Jeff Tabor, Marie Lewis, Janie Evans, Stacy Wright, Dr. Trey Eubanks, Jennifer Carger, Monica Kimbrell, Robin Terry, Tandberg.
<b>NEXT MEETING</b>	TBA

**EMS/Trauma Subcommittee**  
**Tuesday, February 18, 2014**  
**EMS Conference Room 801, Freeway Medical Building**  
**Little Rock, AR**  
**1000-1200**

1. Call to Order at 1000 -- Tim Tackett, Chair

Tim mentioned about the online Trauma System Information Resources that are available on the Arkansas Department of Health, Section of Trauma's website.

2. Welcome and Introductions -- Group
3. Approval of Draft Minutes From January Meeting

The date was changed from 2013 to 2014.

Mack made a motion to accept the minutes and there was a second. There was discussion regarding the minutes. Tim requested to amend a section of the meeting minutes on the 3<sup>rd</sup> page, 2<sup>nd</sup> paragraph. The statement "Tim brought up the idea to make the funding for the volunteer services the same as special purpose services." Tim stated that this was not exactly correct; he wanted to clarify the statement and make the change to the minutes to clarify that "The option was brought before the group to possibly consider a flat rate for volunteer and special purpose services." This option does not mean these services would get the same amount of money, it would mean each type of service would get a flat rate that would be decided by the committee. The statement as it was written originally appears that both types of services were getting the same amount. Ronnie clarified that the committee had discussed setting the amount for Special Purpose at \$1000.00 and Volunteer at \$2000.00. Tim stated that this was correct and that is why he wanted to amend the above sentence in the minutes so it would be clear and there would not be any misunderstandings. Mac made a motion that we accept the minutes with the amended section; there was a second by Ronnie and the motion carried.

4. Old Business

I. Open items progress reports from August 20, 2013 meeting

A. EMS Trauma Standards

Greg Brown reported that they are making some final changes to the online CEU course/module related to the EMS data. Greg stated that the online course will be going out soon and should be active by our next EMS Sub Committee meeting in March. He stated that they could not make it mandatory but that they would be looking at the possibility of including it in the re-licensure process. Each service could make it mandatory for their employees. Greg felt that we could mark this item as complete. Tim suggested not taking it off our agenda until it has been completed.

B. Out of State Trauma Patient Banding

Joe Martin stated that Bill Temple suggested that we change a couple of sentences in the letter. A copy of the letter was provided to the group and will be sent out to all services. Tim stated that we could mark this item off our agenda as complete.

II. Open items progress reports from September 17, 2013 meeting

A. Aeromedical Response and Coordination

Tim gave an update on the group meeting between the EMS Sub Committee and Air Ambulance Sub Committee. There was a lot of good information that was shared between the two groups. There were a lot of places that the group felt that they could work together to improve the process and help improve the trauma patient's outcome. Tim stated that there will be a work group formed from the 2 committees and that they will continue to work on the issues and concerns that have been identified.

1. Response Times
2. Quickest Aircraft- the closest might not be the quickest
3. Hospital to Hospital Transfers- look at the possibility that the local ground unit could get the patient to the receiving facility quicker depending on the location of the responding aircraft.
4. Centralized Dispatch
5. Satellite Tracking for all AR Rotor Wing Aircraft located in the ATCC

### III. Open items progress reports from December 17, 2014 meeting

#### A. Prehospital Trauma Funding: The Future

Tim did a quick review of the 3 Prehospital Trauma Funding formulas that were narrowed down by the work group. Sid suggested making a change on option 2 to total 100% not 90%. Tim stated that in option 2 on the agenda that the EMS registry was suppose to be 20% not 10%. Denise questioned the services that are getting their full base funding but don't have any dollar amounts in the ATCC or EMS data sections. Some are volunteer services but there was a lot of discussion and questions that were ask amongst the group. There was a question that if these services are not transporting trauma patients and not submitting the data, then why are they getting funding? Some services also have dollar amounts in the EMS data but nothing in the ATCC column.

Jon Swanson brought up the suggestion that the services receiving a set amount for their base, i.e. Air Medical Services and special purpose, be adjusted just like the BLS and ALS services as the funding percentages change from one fiscal year to the next. Ronnie brought up that there were 19 services on the grid that had no dollar amounts in either the ATCC or EMS data sections. Six of these services are volunteer services, which leaves 13 services that are receiving their full base funding but are not calling the ATCC nor submitting data to the state. There was also a question on how the training sites are funded. Renee went over this process with the group. There was a lot of discussion regarding services that are receiving funding but are not meeting the deliverables. There was a question raised of why there are services that have dollars in ATCC but nothing for EMS data. Greg reminded the group that there could have been services that were going through their data validation during this data collection period and that could answer services with no EMS submission on the grid.

Jon made a motion that the AR licensed services that do not report any runs into the EMS registry receive the same amount as a special purpose service (\$1000.00), those services that report 1-30 runs will receive double the special purpose amount (\$2000.00), and those that report > than 30 runs will receive full funding. Denise seconded the motion. There was discussion on the motion. Sid brought up the point that this motion would not exclude anyone and it would also open up opportunities for improvement for some services. Donnie ask about the services that are going through the validation process and wanted the committee to be consistent on where to draw the line as far as participation for these services. Jon made an amendment to his motion to include that the Section of EMS has the authority to include services that are actually doing transports but are in the process of going through the validation process. The point was made about services that

are going through the validation process can still enter their runs into the EMS state registry to get credit for their runs until their validation is completed. Greg stated that he has informed services that they need to continue to enter their runs into the state EMS registry until their validation is completed. Robert seconded the motion. Jon restated the motion for clarification. There was much discussion on this issue. Tim asked for the ADH staff to comment on this motion and get their thoughts and opinions. Role call vote was done, the motion carried.

Jon made a motion that with respect for those services that are getting fixed amounts in the formula (air ambulance, special purpose licenses, etc); these amounts will be adjusted proportionally to reflect the change in the total amount of grant dollars available. These amounts will be adjusted just like the BLS/ALS services are currently in relation to the changes in funding available with each FY. There was a second on the motion and discussion. Role call vote was done, the motion carried.

Jon proposed option 1 (current formula) and shared his thoughts and support of this option. Sid and Denise proposed option 3 and stated that it gives some credit for calling the ATCC and EMS data submission. Jim proposed option 2 since it puts a heavy weight on the ATCC and EMS data submission. There was much discussion on these options within the group. Jon suggested to look at another option which would be option #4 with 50% base, 30% population, 5% ATCC and 15% EMS Registry. Denise brought up the problem with suggesting another option is the fact that we don't have the numbers to go with the formula. KC brought up the fact that we have already had the AdHOC committee work on this and they have narrowed the options down to 3 to be discussed and voted on this meeting. We also have a deadline that is fast approaching. Tim pointed out that the committee had decided that if they cannot decide on an option, then we would default to the current funding formula. Denise made a motion to accept option 3, John seconded the motion; there was discussion and comments made by the group. Jon and Cathee spoke against option 3. KC stated that we could table Denise's motion and call for a straw vote. Jon withdrew his option 4 for the vote. A straw vote was done and the results were:

Option 1 – 1 vote  
Option 2 – 7 vote  
Option 3 – 3 vote

Vote called to adopt option 3 as was stated in Denise's motion, motion failed to carry. Jon made a motion to adopt option 2, KC seconded the motion; the motion carried.

5. New Business – Open Forum

Tim ask that we look at the below items and discuss

1. Use of Air National Guard
2. Enforcing the Deliverables
3. What can we do to improve trauma care in Arkansas?

6. Next Meeting

Tuesday, March 18th, 2014  
10:00am – 1200pm  
Freeway Medical Tower, Room 801.

7. Adjournment

KC Jones made a motion to adjourn, Cathee Terrell seconded and the motion carried with no objections.