Trauma Advisory Council Strategic Planning Meeting

October 16, 2012
9:00 a.m.
Attendance

MEMBERS PRESENT
Dr. Mary Aitken
Dr. James Graham
Dr. Charles Mabry
Dr. Barry Pierce
Dr. Paul K. Halverson (rep. by Donnie Smith)
Dr. Clint Evans
Dr. Ronald Robertson
Dr. Michael Pollock
Dr. Viviana Suarez
R. T. Fendley
K. C. Jones
Kathryn Blackman
Terry Collins
Jon Wilkerson
Freddie Riley
Robert T. Williams
Keith Moore

MEMBERS ABSENT
Dr. Victor Williams
Dr. John Cone
Dr. Alvin Simmons
Dr. Janet Curry
John E. Heard
Christi Whatley
Colonel J.R. Howard (rep. by Sr. Cpl. Karen E. Clark)
Carrie Helm
John Gray

GUESTS
Dr. Talmage M. Holmes
Dr. James Booker
Denise Carson
Elizabeth Eskew
Teresa Ferricher
Don Adams
Jon Swanson
Kristin C. Lyle
Leaann Mercer
Andrew Hradesky
Jeff Tabor
Kim Brown

STAFF
Dr. Todd Maxson
Dr. William Mason
Donnie Smith
Bill Temple
Renee Joiner
Renee Mallory
Teresa Belew
Greg Brown
Diannia Hall-Clutts
Joe Martin
Austin Porter
Marie Lewis
Margaret Holaway
Rick Hogan
Terry Love
Melissa Foust
Brian Nation
Steve Whisnant
Micheal Knox
Alyce Wagner
Katy Allison
Debbie Bertelin
Bethay McLaughlin
Jim C. Brown

The meeting began with a review of the priorities established at the October 2011 Planning Meeting. An update on these priorities is included as an attachment to these minutes.

Below are priorities established for the coming year.

Pre-Hospital

1. Review and recommend a cost-effective means for pre-hospital providers, both ground and air, to contact the Arkansas Trauma Communications Center (ATCC) (a call shall be made to the ATCC to determine the most appropriate destination and to the receiving hospital within 10 minutes of arrival to provide a patient report).

2. Modify the current pre-hospital funding formula to better support trauma patient runs.

3. Improve pre-hospital compliance with the requirement to call the ATCC when transporting all major and moderate trauma patients.

4. Improve the percentage of pre-hospital providers that follow the ATCC recommendation for patient destination.

5. Improve pre-hospital data submission, accuracy, completeness and timeliness to the EMS Section.

6. Revise the EMS Rules and Regulations to correspond with the Trauma Rules and Regulations.

7. Develop and implement a method to analyze cost data for pre-hospital trauma care.

7. Increase the percentage of EMS providers with current certification in PreHospital Trauma Life Support.

8. Develop an EMS scorecard.

Hospital

1. Assess the issue of minor trauma patients being transferred to a higher level of care.

    Develop a method to decrease the incidence of over-triage of these patients if needed.

2. Develop a policy to move trauma in-patients to a higher level of care through the ATCC.

    This could be similar to the “urgent trauma patient transfer” policy.

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

4. Identify alternate funding streams for each major component of care for a trauma patient: infrastructure, readiness, and cost to provide care.

5. One year goal: decrease under-designation.

Three year goal: designation level must match capability and capacity.

6. Begin a review of outcome measures at the hospital level to show improvement due to the implementation of the trauma system.

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.

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.

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.

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".

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

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

Rehabilitation

1. Increase accessibility to traumatic brain injury care for ventilator and unfunded trauma patients.

2. Enhance education and training for rehabilitation and acute care professionals in trauma rehabilitation centers.

3. Develop a Brain Injury Registry in order to provide an effective referral system.

4. Define functional outcome measures for acute care and rehabilitation.

5. Develop a Medicaid red flag system that will expedite the Medicaid approval process.

Preparedness

1. Develop a credentialing process for surgeons and other clinicians to use in a mass casualty incident (MCI).

> Note: this process must be pre-approved and recognized by Arkansas designated trauma centers to request surgeons and other clinicians to provide care in facilities other than the facility where they are employed.

2. Integrate the Hospital Preparedness Section (HPP) and the Joint Commission disaster preparedness requirements into the Trauma Rules and Regulations.

3. Create and maintain rapid response teams for traumatic injuries (to include surgeons and other clinicians).

4. Provide education to trauma clinicians and other providers on the National Incident Management System (NIMS).

5. Determine and develop a mechanism for open communication between trauma center clinicians and Bioterrorism (BT) Coordinators and coordination between Trauma Regional Advisory Councils and BT Regional Coordinators and Co-Coordinators.

Advocacy

1. Trauma activation fees – advocate for this funding.

2. Designation of Trauma Rehabilitation Centers.

3. General support for the current trauma funding.

4. Develop support for Medicaid red flag policy opportunities for trauma patients.

5. Possible legislative support for personal identifiers of traumatic brain injury patients provided to the Spinal Cord Commission in order to develop an effective referral system for services.

6. Continue support of already enacted injury prevention legislation (e.g., graduated driver's license and seat belt laws) as well as other needed injury prevention legislation.

7. Identify success stories.

8. Complete the Trauma and EMS Rules and Regulations revisions.

Respectfully Submitted,

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

Governor's Trauma Advisory Council
Strategic Goals and Objectives (established September 20, 2011)
January 16, 2012 and October 16, 2012 Progress Reports

Trauma Centers

Overall Designation – October 16, 2012 Progress Report

Looking back:

- In 2010 we had five hospital designations, all Level I and Level II.
- In 2011, 30 hospitals were designated, two each at Level I and Level II, eight at Level III and 18 at Level IV.
- In 2012, hospital designations so far include, one Level II, 10 Level III and 10 Level IV.
- Fifty-Six (56) total hospitals have now been designated.
- Two more hospitals have completed their site reviews.
- We have two Level III and 13 Level IV hospitals that have committed to have their site surveys by the end of FY13.
- By July 2013 we will have 74 hospitals designated.

1. **Rewrite the Arkansas *Rules and Regulations for Trauma Systems* to align, as closely as possible, with the ACS' *Resources for the Optimal Care of the Injured Patient – 2006*, or the updated version of this document when completed. Ensure coordination with the group rewriting the Arkansas *Rules and Regulations for Emergency Medical Services.***

   Responsible entity: Designation Subcommittee; Trauma Section

   Summary of Progress: January 2012
   The Trauma Center Level III and Level IV rules rewrite are completed and ready for review by the Designation Subcommittee. Currently, the administrative section and the checklists are being updated. The rewrite of the Trauma Center Level I and II Rules will be completed when the American College of Surgeons releases the new recommendations for these levels.

   Summary of Progress: October 2012
   Level IV Rules have been presented to the TAC. The Designation Subcommittee has completed the final draft of the Level III and IV Rules (distributed to the TAC members at the October 2012 retreat). Questions and/or issues will be discussed at the November TAC meeting. Work has started on Level I and Level II Rule revisions. We expect progress to move swiftly because Level III and Level IV revisions include the foundations for the other levels. Clinical requirements will be included. ADH is working on the administrative rules that will mesh with these rules and help as we work to establish consistency within all four levels.

2. **Create a strategy to ensure hospital designation at the appropriate level within a geographic region, to include possible use of the following tools:**

a. **pay for performance;**
b. **"play or pay" (Mississippi model);**
c. **use of trauma activation fees;**
d. **creation of an additional level of designation (i.e., "Lead Level III");**
e. **restructuring payment formula based on number of trauma patients seen; and,**
f. **soliciting support from the community, hospitals' boards of trustees, and/or legislators.**

Responsible entity: Designation Subcommittee; Finance Subcommittee; QI/TRAC Subcommittee; EMS Subcommittee

Summary of Progress: January 2012
An initial meeting was held with Dr. Halverson regarding this issue. No final decisions were made. It was decided to take a brief "wait and see" posture regarding problematic areas of the state. It is noted that Washington Regional is now scheduled for a Level II site survey.

The Designation and EMS committees are researching the pay for performance issue. The QI Subcommittee has invited the Georgia Trauma Commission to make an on-site visit to the January TAC meeting. They will meet in the afternoon to discuss how Georgia has developed pay for performance metrics.

Research continues on the issue of trauma activation fees. One major payer has contractually agreed to pay a fee for team activation, but this remains in the purview of the individual facilities.

Summary of Progress: October 2012
Work continues on this issue from a variety of perspectives noted elsewhere within this document.

3. **Examine the financial incentives and disincentives for non-participating hospitals and create a strategy to deal with this issue (three-year goal).**

Responsible entity: Designation Subcommittee

Summary of Progress:
No progress to date.

Summary of Progress: October 2012
No specific progress to report on this issue.

<u>EMS</u>

1. **Rewrite the Arkansas *Rules and Regulations for Emergency Medical Services* and ensure coordination with the group rewriting the Arkansas *Rules and Regulations for Trauma Systems*.**

Responsible entity: EMS Subcommittee and EMS Section

Summary of Progress: January 2012
The EMS Section will soon have a draft for review by the EMS Subcommittee.

Summary of Progress: October 2012
The Governor's Advisory Committee for EMS is reviewing the revision of the Rules and Regulations for EMS. Coordination with the Trauma Section has occurred. After this review, the Rules should be ready to begin the administrative process of review and approval.

2. **Adopt the Centers for Disease Control (CDC) EMS triage criteria.**

Responsible entity: EMS Subcommittee; EMS Section

Summary of Progress: January 2012
A new CDC EMS triage criteria was released January 13, 2012. The Trauma and EMS Sections are currently reviewing it to identify the impact with our current policies.

Summary of Progress: October 2012
This goal has been achieved.

3. **Establish criteria for an EMS Medical Director and ensure his/her participation at the TRAC level.**

Responsible entity: EMS Subcommittee; EMS Section

Summary of Progress: January 2012
The Subcommittee sees this work as included in #4.

Summary of Progress: October 2012
Discussion continues and some models have been proposed. The concept is supported. However, the biggest challenge is finding funding sources for implementation.

4. **Engage an EMS Medical Director, either through the hiring process or as a consultant.**

Responsible entity: EMS Section; Trauma Section

Summary of Progress: January 2012
Funding for a consultant to assist with the development of a job description for a statewide EMS Medical Director has been requested from the Trauma Section. This is to be presented at the February 2012 Finance Subcommittee meeting for discussion.

Summary of Progress: October 2012
Funding for this position remains an issue. There are discussions within the Center for Health Protection concerning this issue.

5. **Develop a joint committee of the Governor's EMS Advisory Council and the TAC.**

   Responsible entity: EMS Subcommittee

   Summary of Progress: January 2012
   By-laws to establish this committee have been developed and approved by the EMS Subcommittee. The by-laws are with the Department of Health's legal team for review. The by-laws identify the number of committee members and the organizations they are to represent.

   Summary of Progress: October 2012
   This goal is achieved. The subcommittee is functioning under by-laws which include thirteen voting members. Member attendance is good and goals are being met.

6. **Begin a QI program.**

   Responsible entity: EMS Subcommittee

   Summary of Progress: January 2012
   Pre-hospital performance improvement filters are currently being discussed in the EMS Subcommittee. The document is close to being finalized. The Subcommittee is working closely with the ATCC, the Trauma Registry Section and the Injury Prevention Epidemiologist to assure that the QI filters chosen are clearly defined and meet the needs of the Subcommittee.

   Summary of Progress: October 2012
   Work continues on the QI program. Data elements for inclusion have been developed and we will continue work on the QI process. In addition, an EMS Scorecard is being developed.

7. **Develop a process to validate the accuracy and completeness of EMS data, and ensure linkage between this data and the Trauma Registry.**

   Responsible entity: EMS Section; Injury Prevention Epidemiologist; Trauma Registry Section

   Summary of Progress: January 2012
   The Injury Prevention Epidemiologist is currently validating the results from the new linkage software. The EMS Section is contacting services when needed to complete data submission. On-site monitoring visits will be scheduled to assure the accuracy of the Registry data.

Summary of Progress: October 2012
This is an on-going effort and we have a proposal with the Finance Subcommittee that we think will help progress tremendously. Dr. Evans complimented Greg Brown, EMS Section, for the work he has accomplished toward this goal and specifically on the implementation of data audits.

8. **Investigate the possibility of having a National Highway Traffic Safety Administration assessment conducted for Arkansas.**

   Responsible entity: EMS Subcommittee; Trauma Section

   Summary of Progress: January 2012
   The Trauma Section was requested to make arrangements for this review by the EMS Subcommittee during the January 2012 meeting. The Trauma Section will begin the process.

   Summary of Progress: October 2012
   This was a recommendation of the ACS site review. The goal has been endorsed by the EMS Subcommittee and the issue has been recommended to ADH with the expectation that it will happen in the future. The timeframe may be years down the road as this includes an extensive application process.

9. **Develop a standardized EMS Registry that is amenable to QI studies (three-year goal).**

   Responsible entity: EMS Subcommittee; EMS Section; Trauma Registry Section

   Summary of Progress: January 2012
   No progress to date.

   Summary of Progress: October 2012
   Work continues on this 3-year goal. Progress is currently being made in the area of timeliness and completeness of data submissions.

10. **Improve the accuracy and completeness of data in the EMS Registry (three-year goal).**

    Responsible entity: EMS Subcommittee; EMS Section

    Summary of Progress: January 2012
    No progress to date.

    Summary of Progress: October 2012
    Resources are currently being devoted to evaluation of data submission timeliness and completeness. Some progress has been made on data completeness.

11. **Develop a routine, systematic method to modify data elements collected for the EMS Registry (three year goal).**

    Responsible entity: EMS Subcommittee; Trauma Registry Section

    Summary of Progress: January 2012
    No progress to date.

    Summary of Progress: October 2012
    Data element progress continues as we work on accuracy, completeness and the overall process. Greg Brown shared that this is a major undertaking. A workgroup has been established and data comparison does show progress. Each individual record is now being reviewed to ensure we are getting the required data.

Quality Improvement/TRAC

1. **Develop a Quality Improvement Organization (QIO) Request for Proposal (RFP) and award a contract to a qualified entity.**

    Responsible entity: Trauma Section

    Summary of Progress: January 2012
    Two applications were received for the QIO RFP released on November 14, 2011. The review of these applications is scheduled to take place the last two weeks of January 2012. A contract award date of May 1, 2012 is anticipated.

    Summary of Progress: October 2012
    A notice of intent to award has been posted on the Office of State Procurement website. A competitor has filed a protest to the notice and the intent to award is under review.

2. **Develop a QI "scorecard" for distribution to stakeholders at the state, TRAC, and hospital/agency levels.**

    Responsible entity: QI/TRAC Subcommittee

    Summary of Progress: January 2012
    The QI/TRAC Subcommittee is in the final stages of completing a QI Scorecard. The QIO contractor will be tasked with addressing issues identified by the scorecard.

    Summary of Progress: October 2012
    This goal has been achieved and is being piloted at the CATRAC level. It is ready for statewide implementation at all TRACs.

3. **Develop a process for the TAC to review QI "benchmarks" by each TRAC.**

   Responsible entity: QI/TRAC Subcommittee

   Summary of Progress: January 2012
   No progress to date.

   Summary of Progress: October 2012
   Process of QI review of benchmarks and individual case concerns: This has been accomplished and the process is working at the TRAC level. Dr. Mabry said this could not have happened without the QI/TRAC Subcommittee and ADH Staff. He shared a PowerPoint reflecting the data points being used in the CATRAC. He said it would be shared with each TRAC and he encouraged them to modify it according to their needs and provide feedback to the Subcommittee. The next major step is to develop consistent quality measurements and methodology across the trauma system.
   Statewide uniform Trauma QI / Safety Plan document and processes: He also shared the QI plan/process at the hospital, TRAC and state levels to improve patient care. The items developed for trauma center and TRAC QI use included:
   - TRAC QI reporting form
   - Timeline format and process
   - QI /TRAC subcommittee questionnaire
   - PI/ QI protective "boilerplate" language for confidentiality and HIPAA protection

   Finalized structure and membership of State QI/TRAC Subcommittee: He noted that Dr. Graham has appointed specific QI members from each TRAC, and that the Subcommittee had met and reviewed one case referred from a TRAC.

   Future plans for QI/TRAC Subcommittee for CY2013:
   - Development of quality metrics for:
     - pre-hospital care, inter-hospital transport, and communications
     - trauma center care
     - post-hospital / rehabilitation phase of trauma
   - Ensuring effective and equal methodology for TRACS / QI across Arkansas for TRACS and TAC
     - Link together databases and analyze results for QI opportunities and quality metrics
   - Develop ability to refine and improve quality metrics in order to better measure differences in trauma quality of care in order to develop public healthcare policy

<u>Finance</u>

1. **Investigate and, if possible, secure supplemental revenue streams (e.g., trauma activation fees, etc.)**

   Responsible entity: Finance Subcommittee

Summary of Progress: January 2012
Research continues on the issue of trauma activation fees. One major payer has contractually agreed to pay a fee for team activation, but this remains within the purview of the individual facilities.

Summary of Progress: October 2012
Overall, we do not have support from the commercial payers within the system. Other states have demonstrated that a trauma activation fee is a good source of revenue. This may need to be an advocacy issue for next year.

2. **Develop metrics and benchmarks for a pay for performance system.**

   Responsible entity: Finance Subcommittee; QI Subcommittee

   Summary of Progress: January 2012
   The Finance Subcommittee has asked the Designation and the EMS Subcommittees to make recommendations for pay for performance metrics. Both subcommittees are researching this issue. The QI Subcommittee has invited the Georgia Trauma Commission to make an on-site visit to the January TAC meeting. They will meet in the afternoon to discuss how the Georgia Trauma Commission has developed pay for performance metrics.

   Summary of Progress: October 2012
   Work continues on the pay for performance system, in conjunction with the EMS, Rehabilitation and Designation Subcommittees. Proposals will be presented to the TAC at the November 2012 meeting.

3. **Collect and analyze data on the cost of trauma care.**

   Responsible entity: Finance Subcommittee

   Summary of Progress: January 2012
   The EMS Subcommittee is researching pre-hospital cost methods. The Arkansas Hospital Association (AHA) has agreed to assist in the development of a common methodology for hospital (and potentially rehabilitation hospital) cost calculations. The AHA will convene a group of hospital CFOs as a work group.

   Summary of Progress: October 2012
   An agreement has been developed between ADH and AHA to contract with an independent company to collect and analyze this data. A report is expected in early spring 2013.

4. **Analyze the allocation of trauma funding vs. the cost of trauma care at the EMS, hospital, and rehabilitation levels and modify funding allocation levels if necessary (three year goal).**

   Responsible entity: Finance Subcommittee

Summary of Progress: January 2012
The Subcommittee sees this work as dependent upon the outcome of #3. This task is in the queue.

Summary of Progress: October 2012
See #3.

5. **Enhance/modify pay for performance metrics and benchmarks (three-year goal).**

   Responsible entity: Finance Subcommittee

   Summary of Progress: January 2012
   No progress to date.

   Summary of Progress: October 2012
   As we continue to make progress on the previous goals, progress will be made toward achieving this goal.

Injury Prevention

October 2012 Update – Dr. Aitken

To facilitate Injury Prevention at the state level, we have established the Statewide Injury Prevention Program (SIPP) program with the following deliverables:

1) to identify and train staff to provide technical assistance and disseminate information on best practices and programs;
2) to review and update the TRACs on regional specific data and do training, and;
3) to provide specific technical assistance as needed.

Update:

1) SIPP has a fully trained staff in motor vehicle and intentional injury prevention. A variety of materials have been researched and made available through the trauma system as to what can be used in clinical settings so that people do not "recreate the wheel." Best practices, or at least evidence based practices, are available that can used as a gauge for developing specific strategies. A great deal of material and useful informatiion is about to be launched on the ADH website for use throughout the state.
2) Austin Porter has provided very good region specific data which has been summarized and presented to each TRAC by staff. TRAC Injury Prevention Subcommitties have been formed in six of the seven TRACs. Five of the six are very active and already implementing programs based on their regional data.
3) Child passenger technician training by our motor vehicle training specialist has been conducted across the state. We have supported ADH in the child motor vehicle safety program through car

seat distribution. Sixty-six new child passenger technicians have been trained. There is now a child passenger training technician specialist in each TRAC.

1. **Establish a discrete injury prevention infrastructure within the Arkansas Department of Health (ADH).**

   Responsible entity: ADH Injury Prevention and Control Branch

   Summary of Progress: January 2012
   An Injury Prevention Grants Manager will begin work on January 23, 2012. This is a key position in the establishment of infrastructure for an Injury Prevention Section within the ADH.

   Summary of Progress: October 2012
   This goal is accomplished with the hiring of Teresa Belew, Injury Prevention Section Chief and Terry Love, Public Health Educator.

2. **Secure, at the appropriate level, an Injury Prevention Section Chief.**

   Responsible entity: Injury Prevention and Control Branch

   Summary of Progress: January 2012
   ADH is considering a request for Direct Assistance from CDC for this position.

   Summary of Progress: October 2012
   This goal is accomplished.

3. **Establish an injury prevention training program for staff and other stakeholders.**

   Responsible entity: Injury Prevention and Control Branch

   Summary of Progress: January 2012
   A sub grant with the Arkansas Children's Hospital's Injury Prevention Center is in place which includes this goal as a grant deliverable. The SIPP has developed an Injury Prevention 101 training which has been offered to most TRACs and to the Injury Prevention and Control Branch. Many Branch personnel have already taken advantage of this training. The Injury Prevention Grants Manager will work with SIPP to research additional staff training needs.

   Summary of Progress: October 2012
   Progress is being made by developing and providing the Injury Prevention 101 Course, which is a full day course overview of public health approaches to injury prevention. This course is a good way to start focusing on injury prevention. Seventeen of the Injury Prevention 101 Classes has been held in numerous locations throughout the state and 238 individuals have been trained. Others have been trained in a variety of specific areas. Work continues on strategies to make

training more efficient and effective. Injury prevention topics continue to be included in existing programs such as the Telemedicine program, specifically Ed's Place and Pete's Place at UAMS. Information is being desiminated through the Arkansas Safety newsletter that notes all of the education and training opportunities.

4. **Reestablish the Injury Community Planning Group (ICPG).**

Responsible entity: Injury Prevention and Control Branch

Summary of Progress: January 2012
The ICPG's first meeting was held on November 16, 2011. Thirty members attended the first meeting and all were enthusiastic to help re-build this important entity. The next meeting is scheduled for January 26, 2012.

Summary of Progress: October 2012
The ICPG was a major component of the CORE Grant from the Centers for Disease Control (CDC). However, due to lack of CDC funding several states, including Arkansas, lost this grant funding. The ICPG remains a priority for injury prevention efforts and we expect to continue working on the priorities established by the ICPG.

5. **Form a Policy Subcommittee of the ICPG.**

Responsible entity: ICPG

Summary of Progress:
ICPG members volunteered to serve on the Policy Subcommittee during the November meeting. This subcommittee of the ICPG will be formalized during the January 2012 meeting.

Summary of Progress: October 2012
This Policy Subcommittee has been formed and the committee has focused on the 4 focus areas chosen by the CORE VIPP Program.

6. **Update the Injury Prevention Strategic Plan.**

Responsible entity: Injury Prevention Section; ICPG; Injury Prevention Subcommittee

Summary of Progress: January 2012
No progress to date.

Summary of Progress: October 2012
The SIPP program has specific plans for each of its program staff. The Injury Prevention Center strategic plan is expected to be completed by November. This plan will be used as a basis to develop priorities for the overall statewide strategic plan, which is currently being revised.

Advocacy/Public Awareness/Education

1. **Award a trauma education contract to a qualified entity.**

   Responsible entity: Trauma Section

   Summary of Progress: January 2012
   An education contract has been awarded to the Arkansas Trauma Education and Research Foundation (ATERF) effective February 1, 2012. Courses are currently being scheduled.

   Summary of Progress: October 2012
   The ATERF received this contract. Forty-five courses have been conducted throughout the state with over 700 participants (physicians, nurses, etc.) trained. ATERF is presenting the courses outside the metro area as needs are identified.

2. **Develop and implement a public and legislative education/advocacy plan.**

   Responsible entity: Injury Prevention and Control Branch

   Summary of Progress: January 2012
   No progress to date.

   Summary of Progress: October 2012
   A new brochure demonstrating the progress toward trauma system implementation is being finalized. A draft copy was shared with the TAC membership present and feedback was requested. Katy Allison was recognized for putting the brochure together for the Branch. A request went out to all participants for success stories about the trauma system. Dr. Graham asked about distribution plans and Mr. Temple said those were yet to be developed.

   Other education/advocacy initiatives include past media success. Governor Beebe highlighted a specific part of the trauma system on one of his weekly radio addresses. There was also an excellent series of articles in the Arkansas Democrat Gazette about trauma system progress, specifically highlighting the Arkansas Trauma Communications Center (ATCC). We have responded to other timely issues as requested by the press. We have also attended, along with Dr. Aitken, some press events including Graduated Drivers License press conference. We now have the pieces in place to make significant progress.

   Finally, the focus going forward is to identify root causes of injury through data and then pursue evidence-based programs that can make a difference. This will occur through legislation, advocacy and a rules and regulations revision.

Rehabilitation

1. **Create a rehabilitation strategic plan for the state.**

Responsible entity: Rehabilitation Subcommittee

Summary of Progress: January 2012
The Spinal Cord Commission (SCC) serves as the fiduciary agency for trauma rehabilitation efforts effective January 1, 2012. The SCC will coordinate the development of the strategic plan with the Rehabilitation Subcommittee in the next six months.

Summary of Progress: October 2012
A documented Rehabilitation Strategic Plan was presented to the TAC at the June 2012 meeting. Specific workgroups have been established to follow up on action plans with a goal of implementation in January, 2013.

2. **Determine what rehabilitation outcome data should be linked to the Trauma Registry and, if possible, begin the process to link the data.**

Responsible entity: Rehabilitation Subcommittee; Trauma Registry Section

Summary of Progress: January 2012
Research of different methodologies to collect this information is complete. The Rehabilitation Subcommittee and the Trauma Registry Section will use an abbreviated Glasgow Coma Scale for this purpose.

Summary of Progress: October 2012
Work continues on the methodology for outcome data and the process toward linking data. One key aspect is to determine how to get data on those who are released to home and do not go to a rehabilitation facility. Another challenge is to gain cooperation from the acute care hospitals.

3. **Hold a statewide Trauma Rehabilitation Conference.**

Responsible entity: Rehabilitation Subcommittee

Summary of Progress: January 2012
A statewide trauma rehabilitation conference will be held at Baptist Medical Center in Little Rock on June 14-15, 2012. The conference will focus on RNs, LPNs, and Social Workers. The conference will start with a national keynote speaker and will cover spinal cord injury, prosthetics, assistive technology, brain injury, and trauma and will have a spinal cord injury case study ending with an address from Dr. Maxson. It will offer about 10-11 CEUs and the cost will be nominal (free to $20) to cover the expense of the keynote speaker, local travel and the meal. The conference site can host up to 300 participants.

Summary of Progress: October 2012

The first statewide Trauma Rehabilitation Conference was held in June of this year with great success. In 2013, the conference will be held in April.

4. **Create a Traumatic Brain Injury Registry (three-year goal).**

   Responsible entity: SCC on behalf of the Rehabilitation Subcommittee

   Summary of Progress: January 2012
   No progress to date.

   Summary of Progress: October 2012
   To this point, we have gathered focus groups and worked hard toward deciding the best way to accomplish this goal.

5. **Study the feasibility of developing a comprehensive adult rehabilitation center within the state (three-year goal).**

   Responsible entity: Rehabilitation Subcommittee

   Summary of Progress: January 2012
   No progress to date.

   Summary of Progress: October 2012
   Subcommittee members have visited Florida and North Carolina to gain insight and study models of comprehensive rehabilitation facilities.

6. **Assess the need for rehabilitation centers in the state to have "Commission of Accreditation of Rehabilitation Facilities" (CARF) accreditation and fund appropriate centers (three-year goal).**

   Responsible entity: Rehabilitation Subcommittee

   Summary of Progress: January 2012
   No progress to date.

   Summary of Progress: October 2012
   We have reviewed this and agree there needs to be a method for designation of rehabilitation centers and CARF accreditation appears to be the best way. We hope to implement a pay for performance process to accomplish this goal.

Hand: Develop and implement a triage protocol for hand injuries.

Responsible entity: Trauma Section; ATCC

Summary of Progress: January 2012
The Trauma Medical Consultant is currently in discussion with several hand specialists to develop a hand injury triage protocol and to establish a network for follow-up care.

Summary of Progress: October 2012
The Trauma Imaging Repository (TIR) contract includes hand as part of its scope of work. The ATCC has recruited a group of hand surgeons willing to take call through TIR. These surgeons will make one of the following recommendations: 1. the patient with a hand injury needs immediate surgery at the current emergency department; 2. the patient should be flown to a specialty center; or, 3. the injury requires cleaning and can be seen the next day in clinic. The ATCC has used this system successfully. An amendment to the ATCC contract to fully implement this system is in process.

Trauma Advisory Council Finance Sub-Committee

October 2, 2012

Attending: R.T. Fendley, Chairman; Mr. Jon Wilkerson; Ms. Renee Patrick; Mr. Donnie Smith; Mr. Don Adams; Ms. Terry Collins; Dr. Clint Evans; Mr. John Gray; Mr. John Recicar; Dr. David Grimes; Ms. Kim Brown

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

II. Old Business:

Pay For Performance Proposals- R.T. Fendley suggested scheduling two hour working sessions for each group to discuss and finalize their proposals.

EMS-Dr. Clint Evans described two potential EMS projects. The membership needed for this work group include Clint Evans, Greg Brown, Mike Sutherland, Renee Patrick, Bill Temple, Todd Maxson, Denise Carson and Laura Guthrie.

Hospital- Don Adams reported that the ADH Trauma Section has completed the contract justification for sole source use of the Arkansas Hospital Association to perform the hospital trauma cost data analysis. The work group membership has previously been determined.

Rehabilitation- Jon Wilkerson announced the retirement of Ms. Cheryl Vines. The membership needed for this group were discussed and identified. They are Cheryl Vines, Bill Temple, Renee Patrick, Todd Maxson, Jon Wilkerson, and Kim Brown

Action Item: Two potential meeting dates were suggested for the EMS Pay for Performance Proposal Meeting-October 9th or October 16th. Renee Patrick will discuss with Dr. Graham the potential October 16th date and get back with the group.

Special Project Funding Proposal, EMS- Dr. Clint Evans reviewed with the group the EMS data software initiative. Deliverables would include a completed application process, and written business plan by each service. Mr. Fendley inquired about the process for those services that currently use an Electronic Patient Care Record. This reimbursement would be based on run volume. Mr. Fendley related that he and Dr. Maxson felt it would be prudent to compensate services for completion and quality of data after validated with submission to the state EMS registry. This recommendation received a consensus of support from the group.

Action Item: Dr. Evans will discuss the group's recommendations with Greg Brown and the EMS leadership.

Special Project Funding Proposal, Trauma Research- Dr. Mabry was out of town and not available for presentation and further discussion of this proposal was deferred. Donnie Smith reminded the group that any proposal that includes data mining of the state registry must be presented to the Science Advisory Council of the Arkansas Department of Health and a data sharing agreement would be required. In addition, services costing more than $5,000.00 must be bid or a sole source justification must be obtained.

Action Item: Dr. Mabry will present his proposal at the November meeting.

Supplemental Trauma Funding –Renee Patrick asked for the committee's recommendation for the following administrative rule: Hospitals and EMS agencies receiving trauma grant funds will be eligible for supplemental trauma funding (i.e. pay for performance, special project, and/or system enhancement funding) only if they are currently meeting grant deliverables.

Action Item: The finance committee will recommend this administrative rule to the TAC.

Meeting was adjourned at 5 p.m.

EMS Trauma Subcommittee Meeting Minutes
Freeway Medical Tower, Room 801
October 9th, 2012 - 3:00 pm

Topic	Discussion
Called to order	Meeting was called to order by Dr. Clint Evans
Backfill Agreements	Have 5 services left without backfills. Joe stated one of the five have one agreement on file and waiting on the other one. He has also talked with two other services and they were hoping to have theirs soon. Hoping to be down to 2-3 services by next week.
EMS Data Submission	ADH presently doing audits. Ryan is requesting logs from the services and double checking to make sure that the number of runs on the service's log matches the number of runs submitted to the state. Ryan stated that they had one service that had submitted their log and had roughly 700 runs and when they looked at the data submitted, they had only one service that submitted approximately 44% of their runs. Ryan stated that they have had good feedback from the services about the audits. Some services stated that they are submitting the runs but are not going back and double checking that they have actually been submitted to the state by their service. Greg stated that some of the services did not respond to the audit and if they do not, they will do a personal site audit at the end of the year at their location. Ryan stated that the data was getting better.

Meeting with Finance Committee	<u>Paid for Performance:</u> Dr. Evans attended the Finance Committee concerning the paid for performance project money which this year for EMS is approximately $100,000. Finance committee wanted us to come up with a cost analysis for what it cost us to provide trauma care, but for this year we are not going to pursue that, we are going to go back to the PHTLS piece that we have talked about. What was decided for this fiscal year was that every service that has 85% of their personnel (full time, part time, and prn) certified in PHTLS, ITLS or the basic version for the EMT's by 4/1/2013, will be able to participate in this incentive. It was decided that instead of paying each individual person that was certified, which would be approximately $20.00/per person, the funds will be divided amongst the number of services that choose to participate. This incentive would be added to the EMS grant funding for the next fiscal year. The next item we discussed was if this paid for performance measure would become a new deliverable then each service would need to maintain the 85% certification of their personal to be able to participate and be eligible for their trauma funding. There was a lot of discussion and concern that services would not participate in the trauma system if this became one of the deliverables. The concern was the cost of the class and covering staff to obtain and maintain the certification.

Meeting with Finance Committee (con't)	Renee Patrick spoke to the rationale of adding this as a deliverable and that it was felt that this would help to develop a standard of care and help to improve trauma care in Arkansas. She also stated that the services could use their grant funding to cover the costs of obtaining and maintaining the certifications. Others voiced the concern that we are still adding deliverables and that the services would have to use their funding to meet these deliverable. There was also the concern that the cost of trucks are going up next year and that would be an additional cost to the services. Renee requested to hear from the services other ideas to improve and standardized trauma care in Arkansas. <u>Special Project:</u> Dr. Evans thanked Greg for all of his hard work on the EMS Data Software Initiative. Greg presented this last month to the finance committee and overall there were pretty good feelings. They requested that it be tied to deliverables. Greg provided the finance committee with a copy of the initiative that is attached. The process would first be initiated with a letter of intent to participate in the initiative. Each service will be responsible in contracting with their vendor of choice and paying for installation. After installation, the service would then start submitting data to the state. After the state validates the service's data, the state EMS office would send a validation letter to the service and the service would then submit the letter to the Section of Trauma to receive funding as outlined in the EMS Data Software Initiative.

Meeting with Finance Committee (con't)	There was a concern that some companies might not be able to fund the cost upfront. It was stated that some of the vendors will work with services so they do not have to come up with all of the funds up front. This initiative has been expanded to all services. For services that already have ePCR's in place, they will need to submit a validation letter from the state EMS office to be eligible for funding. A deadline for the software initiative was set for 10/31/2013. This deadline may be extended for folks that are in the validation process. The services must submit their letter of intent to participate in the software initiative by 4/01/2013.
Scheduling a Retreat	Cathee and Denise will plan our November retreat/meeting for November 13, 2012 from 12pm-4pm. Details will follow and be emailed. Renee Patrick stated that the Section of Trauma might be able to pay for lunch. Cathee and Denise will check out locations and costs and be in touch with Renee.
Fiscal Year 2014 Funding	There was a lot of discussion concerning the EMS funding for 2014. Discussed getting away from using population modifiers and not using trauma runs. Dr. Evans gave an overview of how the funding is distributed Some went to associations, training facilities and then to the services. There is a fixed amount that the services get: $4000.00 for BLS, $8000.00 for ALS, $4000.00 for transport only, $2000.00 for special purpose and $2000.00 for volunteer services. Also talked about the rural modifier and how we could use

Fiscal Year 2014 Funding (con't)	trauma runs to also distribute funding. Every service will still get their base. Concerns were voiced that using the trauma bands for funding will lead to services banding some patients even if they didn't fit into the minor guidelines. Dr. Evans suggested using the states EMS data for trauma banded runs for each service. There was much discussion on the trauma band issue and we will discuss this further in our Nov meeting. There was a suggestion made to decrease the base rate from $4000.00 to $2000.00 for transport only services. Greg stated there is not a license for "transport only" services, so it would be hard to say how many services in the state do transports only. Dr. Evans stated that using the trauma bands would help to distribute the funding fairly. Dr. Evans suggested that we have the information put into a spread sheet for our November so everyone can see how it would impact the services. Greg will also get trauma data from the state to help with our decision. We will discuss the funding for 2014 further at the November meeting/retreat.
First Responders	The question was raised concerning how do we incorporate the first responders in the trauma system? A concern was brought up about agencies doing extrication that are not properly trained, do not have proper equipment or do not maintain their equipment. The concern is that these extrication issues are affecting the outcome of the trauma patient. An example of the concern was given. Dr. Evans brought up the idea of ATERF providing extricating classes throughout

	the state. It was stated that AEMTA just completed 4 extrication classes and had minimal to no attendance from areas that are in need of the education. There was much discussion about this issue. Greg reinforced that it is a state requirement that each service have a letter in their file regarding the agency that will be providing the extrication for each EMS service. It was also brought up that it should be the responsibility of the EMS service to discuss any issues or problems that might occur with their extrication provider and work the problem from there.
Meeting Adjournment Next Meeting	The meeting was adjourned with no objections. Our next meeting will be November 13, 2012. Details to be announced at a later date.

Trauma Advisory Council Rehabilitation Subcommittee Meeting
1:30 p.m. Thursday, October 25, 2012
Arkansas Spinal Cord Commission Conference Room
1501 N. University Avenue, Suite 411, Little Rock

MINUTES

Members present: Dana Austen (BIAA)*; John Bishop (BHRI); Latitia DeGraft (ARS)*; Cheryl Vines (ASCC); Jon Wilkerson (Chair)

Observers, guests, and/or staff present: Kim Brown (ASCC); Bradley Caviness (ASCC); Jessica Hestand (ACPB); Monica Kimbrough (UAMS - on behalf of Terry Collins); Terry Love (IPC/ADH); Bettye Watts (IPC/ADH)*.

Members absent: Elizabeth Eskew (DRCA)°; Yousef Fahoum (BIAA); Sara McDonald (NeuroRestorative-Timber Ridge)°; Alan Phillips (ACTI); Stacy Sawyer (St Vincent Rehab).

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

Welcome, Introductions, and Call to Order
Mr. Wilkerson called the meeting to order at 1:41 p.m. He asked everyone present to briefly introduce him or herself.

Approval of previous meeting minutes
A motion was made to approve the minutes the meeting held on September 27, 2012. The motion was seconded and approved by a voice vote.

Trauma Rehabilitation Program Report
Ms. Brown briefly recounted the activities of Program staff since the last meeting, including efforts to draft bylaws, work to implement a modified FIM scoring system at trauma facilities, and progress developing the program's strategic action plan.

Discussion of By Laws
Ms. Brown briefly reviewed the draft bylaws document and asked the Subcommittee for revision, corrections, and comments. Revisions were made to Articles III.A.5, III.A.6, III.A.7, and III.D.

These revisions will be implemented and distributed to subcommittee members for review. An action item to send the bylaws to the TAC for approval will be on the agenda for the next meeting.

Pay for Performance Projects
Ms. Vines reported on the three projects being developed for a pay for performance proposal to present to the TAC for approval. The first is to perform a cost study of rehab hospitals in the trauma system to determine to true cost rehabilitation care for trauma patients. The second is to reimburse rehab hospitals that gain or maintain Commission on the Accreditation of Rehabilitation Facilities (CARF) accreditation. The third is to offer financial assistance to hospitals that recruit, train, and/or retain Assistive Technology Professional certified staff. Ms. Vines will present the proposal as an action item to send to the TAC for approval on the agenda of a future meeting.

Education Committee
Mr. Bishop reported that the 2013 Trauma Rehabilitation conference will be held May 2-3 in the Gilbreath Conference Center on the Baptist Health Medical Center campus. The conference will have the same day-and-a-half format and target audience as the 2012 conference. The committee is recruiting speakers for topics focusing on rehab care. Mr. Wilkerson suggested partnering with Arkansas Trauma Education and Research Foundation (ATERF) to develop a continuing education or conference track for ATPs, and developing online training modules on telemedicine and rural health for rehab professionals.

System Analysis
Ms. Brown reported she is going to Florida first week of November to observe a hospital designation site visit. Ms. Vines reported she is meeting with personnel at ADH to discuss legislative issues.

Traumatic Brain Injury (TBI) Registry
Ms. Vines reported that work continues to craft a proposal to modify the existing TBI registry to monitor care and outcomes of TBI patients. She briefly explained how ASCC registry works and described the goals for TBI registry. When it is complete, she will ask for an action item on the agenda of a future subcommittee meeting to send the TBI Registry proposal to the TAC for approval.

Functional Independence Measures (FIM)
Ms. Brown reported that UDS has delivered its first report based on FIM data from 15 hospitals. She is working on getting data from E-Rehab that the trauma rehab program can then provide to UDS to include in future reports.

Financial Analysis
Ms. Vines reported that Dr. Tilford is continuing work on the cost study. He hopes to have the data he requested from Medicare by the end of the year.

Other Business
Mr. Wilkerson announced that, due to the Thanksgiving holiday, the next Subcommittee meeting will take place at 1:30 p.m. Thursday, November 29, 2012. He added that there will be no meeting in December. Ms. Vines asked that discussion of the 2013 meeting schedule be added to the November 29 agenda.

Adjourn
With no further business to consider, a motion was made, seconded, and approved by a voice vote to adjourn the meeting at 3:15 p.m.