



Trauma Advisory Council

May 15, 2012

3:00 p.m.

Minutes

MEMBERS PRESENT

Dr. James Graham
Dr. Charles Mabry
Dr. Barry Pierce
Dr. Janet Curry
Dr. Ronald Robertson
Dr. Paul K. Halverson (rep.
by Donnie Smith)
Dr. Clint Evans
Dr. Viviana Suarez
Dr. Michael Pollock
R. T. Fendley
Jon Wilkerson
Terry Collins
Carrie Helm
Freddie Riley
John E. Heard
K. C. Jones
Myra Looney Wood
Robert T. Williams

MEMBERS ABSENT

Dr. Victor Williams
Dr. Mary Aitken
Dr. John Cone
Dr. Alvin Simmons
Christi Whatley
Keith Moore
Colonel J.R. Howard (rep. by
Capt. Mark Allen)
Kathryn Blackman

GUESTS

Dr. Chuck Mason
Dr. James Booker
Dr. Marney Sorenson
Dr. Talmage M. Holmes
Dr. Stephen Bowman
Dr. Kristin Lyle
Dr. Scott Lewis
D'borai Cook
Don Adams
Carla Jackson
Janice Burris
Jeff Tabor
Michelle Murtha
Kim Brown
Gary Ragen
Cindy Metzger
Kathy Gray
Joe Hennington
Tim Vandiver
David Aalseth
Teresa Ferricher
Danita Mullins
Carla McMillan
Laura Guthrie
Liberty Bailey
Donna Parnell-Beasley
Jon Swanson
Jodiane Tritt
Tonja Kelly
James M. Smith

GUESTS (Continued)

Ken Mayo
Ron Crane
Jimmy Leach
John Recicar
Carol Cassil
Shaun Best
Leslie Newell Peacock

STAFF

Dr. Todd Maxson
Donnie Smith
Bill Temple
Renee Patrick
Renee Mallory
Diannia Hall-Clutts
Greg Brown
Rick Hogan
Austin Porter
Marie Lewis
Margaret Holaway
Sue Ellen Peglow
Melissa Foust
Jim C. Brown
Joe Martin
Teresa Belew
Lynda Lehing
Lee Crawford

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

The Trauma Advisory Council (TAC) meeting was called to order on Tuesday, April 17, 2012, at 3:09 p.m. by Dr. James Graham, Chairman.

II. Welcome and Introductions

Dr. Graham welcomed all guests and members.

III. Approval of Draft Minutes From April 17, 2012.

The TAC reviewed the April 17, 2012 minutes. A motion to approve the revised meeting minutes was made by Dr. Charles Mabry and seconded by Dr. Ronald Robertson. The minutes were approved.

IV. Trauma Office Report – Bill Temple

Personnel

- On the two Administrative Specialist II positions, we have completed interviews, submitted the hire packets and expect to be hiring within the next couple of weeks.
- The Public Health Educator position posting closed yesterday.
- Paula Duke, one of the Trauma Nurse Coordinators, resigned to accept another position. This position will be filled immediately after the beginning of the new fiscal year (July, 1 2012).
- Ms. Duke's departure means that Diannia Hall-Clutts will work with the Central Arkansas, Northeast and Arkansas Valley Trauma Regional Advisory Councils (TRACs), and Margaret Holaway will work with the Northwest, North Central, Southeast and Southwest TRACs.

Hospital Designation

- Fifty-four hospitals have now been designated, including five Level I, five Level II, 17 Level III and 27 Level IV trauma centers.
- One hospital has been scheduled for its site survey prior to June 30, 2012.

EMS Communication

- A letter was recently sent to all EMS providers and TAC members of you also received a copy of this communication. It was sent as a result of many questions Trauma Section employees received regarding EMS' integration into the trauma system. The new triage guidelines and a frequently asked questions (FAQ) document were also included. This was also sent to hospitals participating in the trauma system.

Contracts

- The revised Quality Improvement Organization Request For Proposal (RFP) is nearing completion and should be on the Office of State Procurement website within the next couple of weeks.

Injury Prevention Initiative

- The Injury Community Planning Group (ICPG) will meet next Tuesday, May 22, 2012 at 1:30 p.m. in the Arkansas Department of Health (ADH) auditorium. Our Injury Prevention Section expects to purchase over 4,800 car seats that will be distributed throughout the state. Trauma funds will be used.

Other

- Mr. Temple said he mailed a letter yesterday to all the hospitals regarding the physician support issue. This says that participating hospitals should target to spend 25% of the trauma funding on physician support. This is a condition of eligibility for the grant. There is a one-page report form that must be returned to ADH by August 15, 2012.
- A letter will be sent to all EMS providers stating that in order to be eligible for continued funding they must submit two backfill agreements as set out in the FY 12 sub-grant agreement. Each service was to submit two completed agreements to the Section of EMS by March 31, 2012. Dr. Graham asked about the compliance rate with this requirement. Mr. Temple and Greg Brown advised that the response was a little less than 50%. Non-compliance will result in funding being withdrawn in future years. Likewise, when backfill agreements are provided they will become eligible for funding. The standard mandated form, available on the ADH website, must be used for all backfill agreements. Jon Swanson asked if the backfill form must be used for all agreements. Joe Martin shared that for consistency purposes we are using this approved form and that the EMS subcommittee will be reviewing this issue soon. Dr. Evans shared that EMS services may work out specific agreements that go further but, that for compliance purposes, we would use this form until it is replaced.

- Robert Williams asked about the status of helicopter communications. Mr. Temple said that hand held radios will be tested in a limited number of helicopters. This solution is being considered due to the exorbitant costs associated with installing mobile radios.

Arkansas Trauma Communications Center (ATCC) Report – Jeff Tabor

In comparing this year's statistics to last year, we have experienced over a 300% increase in volume. ATCC personnel are still educating at the TRAC meetings in a effort to reduce the number of calls for minor trauma injuries. The initiative to provide improved hand care in the state is progressing well. The participating hand surgeons have received a letter informing them that the ATCC is ready to start a call schedule.

V. ADH Medical Consultant Report – Dr. Todd Maxson

Dr. Maxson thanked Jeff Tabor and the ATCC for the work on the hand contract. He reminded everyone that a year ago we had 23 hospitals designated and now we have 54. Much credit goes to the Trauma Nurse Coordinators, the designation site reviewers, and other staff at ADH. The image repository project is progressing and the Center for Distance Health has worked out a process to allow images to be pushed into hospital systems. Dr. Maxson further shared that three more sites have been added within the last week. Along with the backfill agreements, there is an issue of balancing patient needs with EMS service needs in getting the right patient transferred out to the most appropriate hospital. He said this involves many issues and we will be working on a process for urgent transfers.

VI. Trauma Registry – Marie Lewis

- Update on the recommendation from the American College of Surgeons about starting to use the registry data:
 - The state PI filters and audit measures that were approved by the TAC are being provided to each hospital after the quarterly data submission. We do ask that if the hospitals identify any errors or areas of concern that they bring them to our attention. We will use this to identify any problem areas.
 - Per the policy that went into effect in March, the data is also being used for the designation site visits.
 - We are working with Austin Porter, Epidemiologist, to evaluate linkage of trauma bands within the system to see how the process is going. There was some concern about numbers being used on more than one patient or being duplicated. This was evaluated and we determined that in less than ½ of 1% of the cases there are potential duplicates. We are checking to see if this is because a name was

- misspelled and it is actually the same patient or possibly a trauma band number was typed in incorrectly. This information will be going back to the hospitals for verification.
- We are also starting to get requests for data for research and policy decisions. We are evaluating these requests and responding appropriately.
- Dr. Maxson complimented the work being done with our data and said this is impressive progress.
- The next submission deadline is the end of this month, May 30, 2012 for data for January, February and March. Reports will be distributed next month.

VII. TAC Subcommittee Meeting Reports

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

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

The first issue Mr. Fendley discussed is that the Subcommittee is struggling a bit with the cost studies that are currently underway. We are discovering that hospitals are less than enthusiastic about sharing cost information. EMS is also struggling as they continue working on a plan and are experiencing a little push back from EMS providers. Mr. Wilkerson is also working on a rehabilitation cost study. The second issue discussed relates to a pay for performance plan that is being developed. The Subcommittee believes it may be a good idea to “marry the two.” That is, we could incentivize participants in the system and reward those willing share cost data by making it a component of the pay for performance process. On behalf of the Finance Subcommittee, Mr. Fendley made a motion that the TAC endorse the Subcommittee considering ideas it has already developed for hospitals and soliciting input from the EMS and Rehabilitation Subcommittees regarding their ideas concerning sharing cost data for the studies. In addition, he asked that the TAC endorse the Finance Subcommittee developing a recommendation for introducing a pay for performance program in fiscal year 2013 that, among other things, will incentivize sharing cost data. The motion was seconded by Dr. Charles Mabry. The motion was approved. The next meeting of the Finance Subcommittee will be June 5, 2012.

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

Terry Collins reported for Dr. Booker. Ms. Collins said the Subcommittee started work on the Rules revision for Level III hospitals. They will bring a recommendation for approval to the TAC when their work is completed.

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

Dr. Evans reported the Subcommittee did meet this month and they discussed the timely transfer of patients and backfill agreements. The backfill agreements must be provided to ADH and non-compliance will be addressed. Backfill agreements are not all of the solution but they will help. Education to hospitals needs to be improved and we are still receiving many transfers from Level III and especially Level IV hospitals that need to stay where they are instead of being transferred. Dr. Evans also discussed an Advanced Procurement and Logistics System (APLS) service for ambulance units. This is basically a system that allows a control station, such as the ATCC, to know in real time the physical location of ambulances. There is a monthly cost as well as initial installation and software and hardware expenses. Myra Wood shared that the cost is more expensive for instantaneous data availability. Dr. Evans made a motion that the TAC endorse the ATCC and ADH investigating the cost for implementing an APLS type service for ambulances. Dr. Viviana Suarez seconded the motion. The motion was approved.

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

Mr. Wilkerson reported that the Subcommittee sent a group to Florida and they have assimilated that data and it will be provided with the minutes. Another group will be going to North Carolina to study their systems. The three-year strategic plan is still being prepared and a progress report will be made to the TAC at the July meeting. The costing study is also continuing and will take longer than initially anticipated. They are continuing work on outcome measures and had a productive meeting with Dr. Stephen Bowman last week.

The Trauma Rehabilitation Symposium/Conference will be held on June 14 - 15, 2012 at Baptist Rehabilitation Center. The cost is \$25.00. Ten continuing education units are anticipated for conference attendance. Dr. Maxson is the keynote speaker. Dr. Graham noted that this is the first of its kind in Arkansas.

- QI/TRAC Subcommittee (Dr. Charles Mabry – Chair) (See attached report)

Dr. Mabry said the Subcommittee discussed procedures for conducting a QI meeting as well as a calendar for systematic review so that significant items are not left out of the process. They also discussed how to request information from hospitals and EMS providers. Finally, the Subcommittee decided to have a general meeting and then a QI (executive session/closed meeting) afterward to discuss quality improvement processes, peer review and patient care.

- Injury Prevention Subcommittee (Dr. Mary Aitken – Chair) (Did not meet) (No report)

Gary Ragen reported for Dr. Aitken that the Subcommittee now meets quarterly. Work continues with the TRAC Injury Prevention Subcommittees as they develop their priorities and strategic plans. They will also be working to develop a database to consistently collect data on best practices to evaluate the programs. TRAC strategic annual plans are expected to be developed by July 1, 2012.

VIII. Next Meeting Date

The next meeting will be Tuesday, June 19, 2012 at 3:00 p.m. The meeting will be held in Room 906 (Boardroom) at Freeway Medical Tower.

IX. Adjournment

Without objection, Dr. Graham adjourned the meeting at 4:27 p.m.

Respectfully submitted,

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

Trauma Advisory Council Finance Sub-Committee

May 1, 2012

Attending: R.T. Fendley, Chairman; Dr. Todd Maxson; Mr. Jon Wilkerson; Ms. Renee Patrick; Mr. Bill Temple; Dr. Charles Mabry, Mr. Don Adams, Ms. Cheryl Vines, Ms. Terry Collins

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

II. Old Business:

The FY 13 Trauma Budget was approved by the Arkansas Board of Health

III. New Business:

Cost Reporting, EMS and Hospitals. R.T. Fendley provided an update on the cost reporting project for EMS and Designated Hospitals. He related that there are some concerns about confidentiality and competition amongst the various groups. Dr. Mabry recommended a financial incentive for hospitals and EMS for participation in the reporting of data. Committee members discussed voluntary cost data reporting for this year with movement toward mandatory reporting next year. Cheryl Vines discussed the methodology for measuring post acute care costs in addition to the determination of unmet needs in Rehabilitation.

Action Item: The committee will recommend to the TAC that participation in the cost study be on a voluntary basis for year 1 with movement toward mandatory participation in year 2.

Action item: The committee will recommend to the TAC that participation in the Trauma Cost Analysis be included in the pay for performance program for FY 2013.

Implementation of Pay-For-Performance. The group discussed the implementation of pay for performance in relation to participation in the trauma cost study. It was determined these monies would support participation by EMS, Hospitals, and Rehabilitation. Dr. Maxson shared with the group his discussions with the ACS regarding the Trauma Quality Improvement Program for hospitals. TQIP provides risk-adjusted benchmarking of designated trauma centers to track outcomes and improve patient care. Participation in this program would allow Arkansas to benchmark with other states.

Action item: The committee will consider including TQIP participation in the pay for performance program for FY 2013.

Action item: The committee will solicit input from EMS and Rehabilitation for P4P projects.

Action item: The committee will review submitted ideas and develop metrics and budgets for these programs at the June meeting.

Trauma Activation Reimbursement. R.T. Fendley shared that UAMS has 1 commercial payer that has agreed to pay a fee for trauma activations. Dr. Maxson suggests that the state partner with the Trauma Centers of America group for assistance with commercial payers.

Action item: Dr. Maxson will contact the TCAA to discuss a statewide collaboration.

The meeting was adjourned at 5:30 p.m.

Meeting Title Designation Sub-Committee of the TAC

MINUTES 05-15-2012

FREEWAY MEDICAL BUILDING – BOARD ROOM

MEETING CALLED BY	Dr. Jim Booker
TYPE OF MEETING	Sub-Committee
FACILITATOR	Dr. Jim Booker
NOTE TAKER	Diannia Hall-Clutts
COMMITTEE MEMBER ATTENDEES	Dr. Jim Booker, Dr. Barry Pierce (by phone), Terry Collins, John Recicar, Donna Parnell-Beasley, Teresa Ferricher(by phone), Carla Jackson (by phone),Kathy Gray for Keith Moore, Paula Lewis (by Phone)

Agenda topics

WELCOME & MINUTE APPROVAL		Dr. Jim Booker
	Dr. Jim Booker welcomed everyone. A motion was made by Terry Collins to approve the April minutes, seconded by Dr. Donna Parnell-Beasley. The motion carried.	
	HOSPITAL INTENT APPLICATIONS	Dr. Jim Booker
DISCUSSION	None	
	NEW BUSINESS/HOSPITAL DESIGNATION	Dr. Jim Booker
DISCUSSION	<p>Mercy Hospital Paris – Provisional Designation to Full Designation – The committee reviewed the activities of the hospital’s response to the corrective action plan and determined that the action plan had been met. Terry Collins made a motion to recommend them for a full designation; John Recicar seconded the motion, the motion passed.</p> <p>Mercy Springfield – Provisional Designation to Full Designation – The committee reviewed the activities of the action plan and determined that the action plan had been met. Terry Collins made a motion to recommend them for a full designation; Donna Parnell seconded the motion, the motion passed.</p> <p>Cox Health Springfield – Cox has asked for consideration to participate in the Trauma System in Arkansas. The process has been explained to them. We have asked them to submit their data of Arkansas resident patients, and will ask each TRAC involved that would be transferring to that facility to submit a letter of endorsement to the designation subcommittee. The committee will need to receive the letters of endorsement from the TRACs before going forward with a committee recommendation.</p>	

	RULES AND REGULATIONS REVISION –LEVEL III	Dr. Jim Booker
DISCUSSION	The committee spent the remainder of the meeting reviewing and making comments and recommendations on the revision of the Level III Rules and Regulations.	
ADJOURNMENT	Designation Sub-Committee meeting adjourned at 2:50 p.m.	
GUESTS		
OBSERVERS	Diannia Hall-Clutts, Margaret Holaway, Don Adams	
NEXT MEETING	June 19, 2012, 10:00-12:00p.m. @ Freeway Medical Building Rm # 906	

EMS Trauma Subcommittee
Meeting Summary
May 8th, 2012 - 3:00 PM

The EMS Trauma Subcommittee met on May 8th at 1500. There were 12 people in attendance, with 5 people on the conference call.

A recent patient transfer issue has been discussed extensively in the media. There was a delay in ground transportation, as one truck was out of the service area, and the service did not wish to leave their service area uncovered to arrange the transfer. The details of this specific issue were being discussed in more detail by the North Central TRAC PI committee. However, we used this opportunity to review and discuss backfill agreements, as well as discuss system ideas to reduce the likelihood of similar incidents occurring in the future. After much discussion, we came up with four ideas.

1. Implement the existing backfill agreements, and utilize them as intended. Apparently, the deliverable calls for two written backfills to be submitted by March 31st of this year. Joe presented a list of the existing backfill agreements, and less than 50% of services have actually submitted written agreements so far. We will ensure that all services get backfill agreements, and make it clear that they will not be eligible for additional funding until these are on file. We did review the backfill agreements, and we do feel these are still a workable solution.
2. Improve education of the hospitals, particularly the level 3's and 4's. There continues to be unnecessary transfers which are placing a burden on local EMS agencies. We discussed numerous examples of patients being sent long distances by ambulance, only to be discharged from the ED after their minor problem was addressed. Also, Jon pointed out that hospitals need to work with their local EMS agencies as partners, and not treat them like a tool. If a local hospital has a patient that they know will need transport, it would be ideal for them to at least give the local service a "heads up." Many hospitals seem to sit on patients until all transfer arrangements have been made and the chart is copied. They then call and expect the unit to be there promptly. Earlier notification would allow services to mobilize additional resources or utilize a backfill agreement, reducing delays.
3. Investigate the cost and feasibility of adding an AVL system to all units statewide. There are proprietary companies such as Fleeteyes that offer this, and many services already have existing GPS systems. This would offer many benefits to the trauma system, but specifically related to this issue, there would be a possibility that an empty truck from some service might be passing through an area on their way back from an out of town transfer. If ATCC was aware of a delay, they could facilitate discussion between the two agencies, and the available truck could potentially take the transfer.
4. As more of a long term goal, investigate adding a definition and rules for urgent transfers to the EMS rules and regs. Currently, interfacility transfers are not covered at all by the EMS rules and regs. Greg mentioned that there has been much discussion about this on the national level. Several states have added similar rules. There are fairly strict definitions as to what would qualify, as there are few transfers that are truly time sensitive enough to be treated like an emergency

The question was posed as to whether there is a standard for what the minimum coverage should be in an area. Jon pointed out that this is multifactorial, and there is no standard amount of units per population or other method to determine what staffing should be in an area. This depends on agreements with municipalities and counties, as well as cost, although there is certainly the expectation that services should do what it takes to cover their service area.

The group felt strongly that local hospitals should not call another service to arrange a transfer without going through the local provider first. Many services have franchise agreements to provide the non-emergent transports from their service area. These runs are typically an important source of income for the service. Should a service not be able to respond to a transfer in a timely manner, it should be up to them to provide an alternative, and not the local hospital.

We did discuss adding a deliverable to address the urgent transfer issue. If we did this, the sending hospital would declare the transfer time sensitive and urgent. We would then ask the local service to treat this like any other emergency. There is concern that this would be abused by hospitals, so we would need a mechanism such as having the ATCC medical director agree that the transfer is urgent. However, there is no regulation to address non-compliance to this request. We could add it as a deliverable, but would a service forfeit all of their funding if they were unusually busy and took a few minutes too long to get a truck to the hospital, and who defines how long is too long? Ultimately, it was felt best not to pursue this option, except for with the regulation changes as mentioned above.

The finance subcommittee is expected to announce a deadline of June 1st to submit proposals for FY13 performance based incentive proposals. We discussed a proposal which we will bring to the committee. We would like to reward services for having their providers certified in PHTLS or ITLS. We will suggest a future date, such as March 31st of 2013. All services that have at least 85% of their personnel certified would be eligible for funding. To avoid potential loss of funding for a service that happened to hire several new employees near the deadline, the 85% would be comprised of personnel who have been employed at least six months. The total amount of funding is unknown, but the thought is the amount that goes to each service would be proportionate to the number of providers they have certified. This includes both paramedics and EMT's, but the EMT's could substitute the basic PHTLS or ITLS.

An additional performance based incentive will possibly be offered to services that participate in the cost analysis survey. This survey was initially sent out to a select few services as a survey monkey. The feedback was that the survey was too difficult and needs some redesign. If funding will be an option for completing the survey, it will need to be sent to all services, and it will be important to know how much funding is involved.

Our next meeting will be June 12th at 1500.

Trauma Advisory Council
Rehabilitation Subcommittee

Meeting Minutes
1:30 p.m. Thursday, May 24, 2012

Freeway Medical Tower Board Room
5800 W. 10th Street, Room 906
Little Rock, AR 72204

Members in attendance: Dana Austen (BIA), John Bishop (BHRI), Elizabeth Eskew (DRC), Cheryl Vines (ASCC), Jon Wilkerson (Chair).

Members not in attendance: Letitia DeGraft, Yousef Fahoum, Alan Phillips

Others in attendance: Kim Brown (ASCC), Vicki Finch (St. Vincent's - sitting in for Stacy Sawyer), Marie Lewis (ADH), Austen Porter (ADH), John Riggins (Riggins Group),

Via speakerphone: Bettye Watts (IPC)

Welcome and Introductions

Mr. Wilkerson called the meeting to order and thanked everyone for his or her attendance.

Florida Work Group

Ms. Vines shared a summary of the workgroup trip to Florida and demonstrated the client resource packs that Florida traumatic brain injury and spinal cord injury patients are given.

Ms. Vines announced that Yousef Fahoum passed his doctoral dissertation defense.

Strategic Plan

Mr. Riggins presented the preliminary findings of strategic plan interviews that were conducted with a wide variety of medical professionals from all areas and levels of care across the state (attached). The interviews used the recommendations of Arkansas Spinal Cord Commission 2011 hospital survey and American College of Surgeons Committee on Trauma 2011 recommendations to guide the discussion.

Mr. Wilkerson noted that acute care hospitals that receive TAC funding are required to use 25 percent of that funding to support physicians providing trauma care. Adopting a similar approach for rehab centers might be an avenue to overcome the funding barrier for staffing and educational issues.

The first draft of the strategic plan is due June 8. The final draft is due June 26. The final plan will be presented at the July TAC meeting.

Education

Mr. Bishop distributed brochures for the Trauma Rehab Symposium. Attendees may register up to the beginning of the symposium through Baptist's Healthline.

System Analysis

Ms. Vines reported that the work group trip to North/South Carolina trip is July 12-13. The work group contains a large contingent of people from BHRI and a few from Trauma Advisory Committee. The group will be studying rehab facilities with ventilator units.

Ms. Vines said that the subcommittee should discuss how to designate rehab hospitals under the trauma system. She offered some points to consider as the discussion begins:

- Identify key players through strategic planning process,
- Observe the designation process in Florida,
- Determine how many levels of designation should be created, and if there should be any specialty designations,
- Identify stakeholders,
- Continue to monitor progress.

Traumatic Brain Injury Registry

Ms. Vines said work is still being done to determine how the TBI registry will look. The legislative mandate to operate the registry lies with Brain Injury Association. Some questions remain regarding the operation of the new registry:

- Will a new registry have to be created through the trauma system,
- Can the BIA registry be adapted for the trauma system's purposes, and
- How will data from the registry be used?

Mr. Wilkerson said that many states are scaling back TBI registries and services. Arkansas needs a registry because the state has no linear data to draw from to determine services. Data has to be collected and kept in a formalized manner so it can be studied in the future. If the state cannot maintain a permanent registry, perhaps it can track enough information to draft an annual report to examine trends and sort ISS codes.

Ms. Vines said it might be necessary to use funding for the registry to create a separate surveillance piece to get a picture of TBI injury in the state, and a service piece to deliver services to clients.

Ms. Lewis said the Trauma Registry tools are not linked to track TBI injury. She said the subcommittee has to determine what information needs to be tracked and to examine the existing registry to see what is not being tracked. She added there is nothing specifically related to TBI in trauma registry

Mr. Wilkerson suggested finding personnel from the national Brain Injury Association to determine the most important information to track in a longitudinal study for epidemiology.

FIM/Outcome Measures

Ms. Vines reported that agreements with UDS are nearly complete with UDS to produce ongoing quarterly reports and use existing data to produce reports for 2010-2011.

Ms. Vines reported that she visited with Steve Bowman of John Hopkins regarding outcome measures. He collects data that tracks patients post-acute care and rehab, to a year or more beyond hospitalization. He also looks beyond functional outcomes to quality of life, i.e., have patients returned to work or school.

Mr. Wilkerson said this work has the potential to make Arkansas a model for other states. Information goes in August to be implemented Jan1, 2013.

Financial Analysis

Ms. Vines reported that Dr. Tilford's contract has been submitted to the Office of Procurement for approval. It will be presented to the legislative council on June 8 for approval. If approved, Dr. Tilford's first deliverable will be to produce a data request to Arkansas Medicaid and begin an analysis of that data to assess post-acute care costs. The study will take up to a year to deliver a final report.

Pay for Performance

Mr. Wilkerson said the TAC Finance Subcommittee is interested in pay for performance projects. Ideas for pay for performance projects have to be proposed to the TAC Finance Committee by June 1 to be submitted for budget requests from a fund of \$660,000.

Mr. Wilkerson shared the following ideas as possible pay for performance proposals:

- Incentivize hospital systems that have rehab centers associated with their acute care hospitals to adapt acute care hospital cost analysis tool through to track rehab costs and outcomes.
- Develop an outcome measure that could be administered across facilities to collect data for trauma registry.
- Incentivize rehab hospitals to seek and maintain CARF accreditation or an equivalent to determine its designation.
- Create targeted regional adaptive driving centers.
- Incentivize rehab hospitals to offer wheelchair seating evaluations, especially in areas of the state in which no hospital offers such a service.
- Create Trauma Outpatient Rehabilitation Facilities. Give incentives to outpatient facilities willing to have PT, OT, and ST on staff with contracted behavioral therapy, neuropsychology and/or other services deemed necessary to provide "one stop shopping" for those people with traumatic injuries, especially TBI.

The following issues and considerations were discussed regarding seating evaluation and adaptive driving implementation:

- Start up cost for services (staff training, certification, vehicles, screening devices),
- Accurately measure performance at facilities that have a low volume of patients requiring these services,

Mr. Wilkerson will work with Ms. Vines and Ms. Brown to complete a Trauma Rehab Subcommittee proposal.

Other

Ms. Vines presented the proposed budget for FY 2013 with the caveat that it may undergo some modifications before its submission to ADH on June 1.

The next meeting will be held at 1:30 p.m. Thursday, June 28, 2012, at the Freeway Medical Center Board Room, 5800 W. 10th Street, Room 906.

Adjournment

The meeting adjourned at 3:17 p.m.

Respectfully submitted,

Bradley Caviness
Administrative Specialist III
Trauma Rehabilitation Program
Arkansas Spinal Cord Commission



Strategic Plan Update

May 24, 2012

 Data Collection Phase: 90% complete

 Completed Interviews:

Rehabilitation Facilities	Physicians
Baptist Health Rehab (NLR)	Dr. Kiser
Baptist Health Rehab (LR)	Dr. Means
St. Vincent Rehab (Sherwood)	Dr. Thompkins
St. Edward Mercy (Fort Smith)	Dr. Lindberg
Baxter Regional Medical (Mountain Home)	Dr. Doss
White River Medical (Batesville)	Dr. Stefans
White County Medical (Searcy)	Dr. Kiplinger
HealthSouth Rehab (Jonesboro)	Dr. Wren
Northwest Medical (Springdale)	Dr. Schroeder (TBD)
Jefferson Regional Medical (Pine Bluff)	Dr. Brown (6/4)
Medical Center of South Arkansas (El Dorado)	
Christus St. Michael's (Texarkana, TX)	
Rehabilitation Hospital of Memphis	
Timber Ridge Ranch (Benton)	
Arkansas Rehabilitation Hospital (TBD)	

 Preliminary Findings

- All facilities, with one exception, are planning to grow their rehabilitative services over the next three years
- Additional recommendations:
 - Several facilities and physicians indicated the need for a “step-down” rehab facility that would provide services to patients leaving acute care but who are not medically ready for beginning an inpatient rehab program.

- High priorities
 - Delivering education and training for both rehabilitative care professionals and acute care professionals; many respondents felt continuity of care was a critical issue; respondents also mentioned the need to educate acute care professionals to recognize rehabilitation issues early in the treatment process and involve a rehab physician as early as possible
 - Providing community support for individuals, families, and caregivers, including support groups
 - Providing basic rehabilitation care for under- and uninsured patients
 - Improving consult services
 - Providing adult ventilator care – physicians felt strongly about this; most rehab facilities did not
- Other priorities (important but not critical)
 - CARF certification – most facilities felt the standards are reasonable goals to strive for, but the certification and maintenance process was unnecessary
 - Vocational Rehab – few respondents felt this was a critical issue; the difficulty in getting an individual approved through the Hot Springs Rehab facility was cited as an issue
 - Trauma registry: most respondents felt the registry is a good step and that it will enhance care if used consistently

Barriers to achieving the strategic plan goals

- Lack of Medicaid funding; also, how do we get insurance companies to focus and approve rehabilitative services?
- Shortage of trained rehabilitation professionals in the medical / nursing school and therapy pipeline
- Lack of knowledge across all non-rehab professionals regarding what rehab is and where to go for help

Next steps

- Analyze input and draft strategic initiatives
- Create first draft (due June 8)
- Final report (due June 26)

**Trauma Advisory Committee TRAC/QI Subcommittee
May 15, 2012 Minutes**

Members/Guests Present:

Charles Mabry, MD
Renee Patrick, RN
Todd Maxson, MD
Marie Lewis
Carla Jackson, RN
Teresa Ferricher, RN
Mike Sutherland, MD
Don Adams
John Recicar, RN
Greg Brown
Margaret Holaway, RN
Diannia Hall-Clutts, RN
Bill Temple, JD
Jim Booker, MD

Phone:

Paula Lewis, NC PI Chair
Karen McIntosh, NW PI Chair

I. Call to Order –Charles Mabry, M.D., Chairman

II. Old Business: None

III. New Business:

TRAC/QI Subcommittee Portfolio and Processes

Goal of the TRAC/QI Subcommittee is to reduce mortality and morbidity in trauma patients.

Dr. Mabry reviewed a power point presentation that outlines the duties and actions of both the state level TRAC/QI Subcommittee and the TRAC PI Committees and which serves as the committee charter.

Terry Collins made a motion to accept the following as the TRAC/QI Subcommittee Charter. Carla Jackson seconded the motion. There was no discussion and the motion passed.

TRAC/QI Subcommittee Charter r:

- State TRAC / QI subcommittee is advisory to the TAC, which in turn is advisory to the ADH and Board of Health
- Review data from the individual TRACs and state trauma system to identify trends and opportunities for improvement

- Review concerns / problems referred by TRACs and others to the sub-committee
- Propose PI plans for state and TRACs based upon the TRAC/QI sub-committee review of data and information.
- Review progress of PI plans sent out by TAC / ADH for state and TRAC level quality improvement

Performance Improvement Process:

Committee Process: Data Review

- ADH delivers data to TRAC for analysis and review
- TRAC will submit data corrections back to ADH
- Each TRAC will develop a calendar for systematic review of data and quality audit filters so that all data is reviewed over time in an organized fashion
- Data and recommendations for PI will then be sent to state TRAC/QI Subcommittee for review
- Other pertinent cases identified from data will also be referred to state TRAC / QI Subcommittee for review and consideration of quality action items.

Committee Process: Case Referral from TRAC:

- Material from pre-hospital, hospital, providers, and other data used in the TRAC review process will be submitted
- TRAC summary form [Appendix F] will also be completed and attached
- Chair and ADH staff will review material, agree on subcommittee review process, request other pertinent information and prepare subcommittee report
- This combined material will be reviewed by subcommittee members
- On occasion, selected guests will be invited to appear before the subcommittee to participate in the committee review and discussion.
- A judgment will be rendered by the committee with regards to the appropriateness of the issue referred according to the following three metrics:
 - Opportunity for Improvement-
 - Survival with Opportunity for Improvement (OFI) in the care
 - Unanticipated Mortality with Opportunity for Improvement (OFI)
 - Anticipated Mortality with Opportunity for Improvement (OFI)
 - Mortality without Opportunity for Improvement (OFI)
 - System Process Improvement- issues identified in the review that deal with the system of care.
 - Provider Process Improvement- issues identified in the review that deal with specific cases and provider issues that arise.

Potential Action Items- Performance Improvement Action Plans may also be developed and may include the following actions:

- Trending of Issue
- Policy or Guideline Development / Revision
- Education
- Resource Enhancement

- Counseling / Collegial Intervention
- Development of Provider-Specific Performance Improvement plan with scheduled report back to TRAC and Subcommittee for review
- Referral to appropriate ADH Regulatory Sections for review
- Referral to appropriate State licensing Boards for review

Trauma Risk Matrix:

The Trauma Risk Matrix may be used by the individual TRACs, the TRAC / QI sub-committee, or the TAC to assist in determining which cases and concerns need committee level investigation or action. In general, any case or concern rated by the various committees at a level of 6 or above should merit review. Those items rated below 6 should merit trending and tracking to see if patterns of improvement exist.

		Severity			
		Catastrophic	Major	Moderate	Minor
Frequency / Ability to Impact Change	Frequent- High Probability of Change	16	12	8	4
	Occasional - Good Probability of Change	12	9	6	3
	Uncommon- Lower Probability of Change	8	6	4	2
	Remote- Unlikely Probability of Change	4	3	2	1

ADH/TRAC Calendar for Data Submission and Reports to TAC TRAC/QI Subcommittee:

Discussion of how to review data to assure it is correct. Audit filters can be modified by each TRAC. Each TRAC should determine a calendar to review data.

For example:

- Q1 review of process measures and determine a plan for improvement
- Q2 review of outcome measures
- Q3 review of state vs. TRAC performance
- Q4 follow up on all PI plans for the year to determine improvement

TRAC Summary Form will be completed and sent to the State level committee for review. A case review will normally require several meetings. The committee will determine what additional information is needed and request a report of that information. The committee may request guests to provide input and advice. Once information is discussed the committee then:
Identify an opportunity for improvement

IV. Action Items:

1. Ask ADH Legal If the TRAC/QI Subcommittee of the TAC has the authority to require hospitals or EMS agencies to submit data for PI review. (ref: AR Code Ann., 20.13.819.2)
2. Request the TAC Chair to appoint the official membership of the TRAC/QI Subcommittee.
3. Rewrite the PI confidentiality statement to serve as a standard form that TRACs and state level performance improvement review committees will use. This form will be signed once a year rather than at each meeting.
4. Submit TRAC / QI sub-committee charter to TAC for review and approval

V. The meeting was adjourned.

Respectfully submitted,

Charles D. Mabry, M.D. FACS

Committee Chair

CONFIDENTIALITY AGREEMENT

REGARDING QUALITY OR SYSTEM ASSESSMENT AND IMPROVEMENT

As a member or participant of the Arkansas Department of Health's Trauma Regional Advisory Council /Quality Improvement (TRAC-QI) Subcommittee of the Trauma Advisory Council's (TAC), or other entity authorized by the statute referred to below, you may have access to information which has been compiled for quality improvement purposes. There are two sections of the Trauma System Act (Ark. Code Ann., Section 20-13-801 et seq) which relate to this access and need for confidentiality.

Section 20-13-816 (b) (1) (A), gives Trauma Regional Advisory Councils the authority to engage in quality improvement activities and reads, in part, as follows: "An established trauma regional advisory council may be eligible for a sustaining grant if the trauma regional advisory council: has achieved the status as the trauma regional advisory council for its region of the trauma system and is currently providing trauma planning and quality improvement services to its region of the trauma system."

Section 20-13-819, outlines the confidential nature of quality improvement data. The pertinent parts of this Section read as follows:

1. Section 20-13-819 (a) (1): " Any data, records, reports, and documents collected or compiled on behalf of the Department of Health, the Trauma Advisory Council, or other entity authorized under this subchapter for the purpose of quality or system assessment and improvement of the trauma system shall not be subject to disclosure under the Freedom of Information Act of 1967, Section 25-19-101 et seq, to the extent that it identifies or could be used to identify any individual patient, provider, institution, or health plan."
2. Section 20-13-819 (a) (2): "For purposes of this section, "data, records, reports, and documents" means recordings of interviews and all oral or written proceedings, reports, statements, minutes, memoranda, data, and other documentation collected or compiled for the purposes of trauma system quality review or trauma system assessment and improvement pursuant to a requirement of or request by the department, the council, or other entity authorized by this chapter."
3. Section 20-13-819 (b) (1): "Any data, records, reports, and documents collected or compiled by or on behalf of the department, council, or other entity authorized under this subchapter for the purpose of quality or system assessment and improvement shall not be admissible in any legal proceeding and shall be exempt from discovery or disclosure to the same extent that records of and testimony before committees evaluating the quality of medical or hospital care are exempt under Section 16-46-105 (a) (1)."
4. Section 20-13-819 (c): "All information shall be treated in a manner that is consistent with all state and federal privacy requirements, including without limitation the federal Health and Portability and Accountability Act of 1996 privacy rule, 45 C.F.R. Section 164.512(i)."
5. Section 20-13-819 (d): "The department or other entity authorized to provide services to the trauma system may use any data, records, reports, or documents generated or acquired in its internal operations without waiving any protections under this section."

Information data, records, reports, or documents generated or acquired pursuant to quality or system assessment and improvement shall not be disclosed to unauthorized parties, and additionally shall not be utilized in any fashion which may further proprietary interests of any individual or organization you work for or are associated .

Furthermore, in the event that access to information data, records, reports, or documents generated or acquired may result in a conflict of interest regarding any matter being discussed for quality or system assessment and improvement, this conflict shall be disclosed to the Department of Health, including the Chairs of the TAC QI/TRAC or TRAC QI Subcommittees. If necessary, the individual with the conflict may be required to recuse himself/herself from any deliberations regarding the specific matter in question.

Violations of privacy and security requirements may lead to civil and criminal penalties pursuant to state and federal laws and regulations.

I hereby acknowledge that I have read and understand the foregoing CONFIDENTIALITY AGREEMENT. I agree not to disclose any information I obtain from either the TAC QI/TRAC or TRAC QI Subcommittees, whether verbally or in written format, to persons outside the meeting or committee who have not been previously authorized and approved by the Department. I further understand that should I violate this Confidentiality Agreement, I will be subject to disciplinary action by the appropriate Subcommittee, to include my immediate suspension and termination from the Subcommittee. I also acknowledge that any violations by me of privacy and security requirements may lead to civil and criminal penalties pursuant to state and federal laws and regulations.

TAC QI/TRAC or TRAC QI member / participant signature

Date

Printed name