



## **TRAUMA SYSTEM UPDATE**

**JANUARY 9, 2014**

### **The Problem:**

In 2008, injury was the number one killer of Arkansans between the ages of one and 44. Arkansas' injury fatality rate was 34% higher than the national average and 73% higher with respect to deaths from motor vehicle accidents. This problem was exacerbated by Arkansas' rural road system, the twelfth largest in the nation. In addition, in a study conducted by the American College of Emergency Physicians in December 2008, Arkansas was cited as having the worst system of emergency care in the nation. Prior to the passage of the Trauma System Act by the Arkansas Legislature in 2009 (see below), Arkansas was one of three states without a trauma system and the only state without a designated trauma center.

### **The Solution:**

Arkansas's new trauma system was authorized by Act 393 (Trauma System Act) of 2009. Funding for the system commenced on July 1, 2009 (Act 1383). Having statewide designated trauma centers within a comprehensive system ensures that victims sustaining traumatic injuries will be transported to definitive care in the shortest possible time and that the treatment they receive is the best available. It is estimated that the new trauma system will save approximately 168 lives a year and \$193 million annually in our state. When combined with our primary seatbelt and graduated driver's license laws, also passed during the 2009 legislative session, the savings estimates go up to 206 lives and \$237 million annually.

### **Implementation:**

The Arkansas Department of Health (ADH) is the agency responsible for implementation of the trauma system. There are numerous components of a successful system. The information below demonstrates the significant progress toward making a trauma system in Arkansas a reality.

**Hospital Designation:** The designation process is intensive for hospitals. A great deal of preparation is required. Seventy-five hospitals have submitted intent applications to become trauma centers (from Level I, the highest level of designation, to Level IV, the lowest level). To date, 70 hospitals have been designated at the following levels:

- Level I (provides comprehensive clinical care and is a community resource; i.e., has education, research, and outreach components): 5
- Level II (provides comprehensive clinical care; from a clinical standpoint, a Level II provides the same care as a Level I): 5
- Level III (provides treatment for mild and moderate single system injuries; most traumatic injuries can be treated at a Level III facility): 22
- Level IV (provides stabilization for severely injured patients; transfer to a higher level trauma center is usually required): 39

It is noted that certain out-of-state hospitals are included in the Arkansas trauma system due to the number of Arkansas trauma patients treated at these hospitals.

**Funding for Hospitals:**

- Level I trauma centers receive between \$1 million and \$1.5 million each year of designation
- Level II trauma centers receive between \$500,000 and \$750,000 each year of designation
- Level III trauma centers receive between \$125,000 and \$187,500 each year of designation
- Level IV trauma centers receive between \$25,000 and \$37,500 each year of designation

For FY 2014, hospitals at the various levels will receive the following amounts:

- Level I trauma centers: \$1,200,000
- Level II trauma centers: \$600,000
- Level III trauma centers: \$150,000
- Level IV trauma centers: \$30,000

The amount of money the hospitals receive for each year of designation is dependent on the amount of “carry forward” funding available in a given year. As the “carry forward” funds will diminish from FY 2013 to FY 2014, principally due to more hospitals being designated and being paid, less money over base funding is available to be distributed to participating hospitals. These funds are designed to support ongoing readiness costs for continued participation in the trauma system rather than payment for uncompensated care of trauma patients.

**Funding for Emergency Medical Service (EMS) Providers:** A total of 114 EMS providers across the state are participating in the trauma system. Like hospitals, participating EMS providers are eligible to receive trauma readiness funds. Each service is funded based on the service area of the provider, the

number of EMS providers in the area, and the type of service (basic life support/advanced life support) afforded. Additional funds are available to providers in rural areas of the state. Finally, for FY 2014, the funding formula also includes incentives for EMS data submission and the number of calls made to the Arkansas Trauma Communications Center for severely injured patients. A total of \$2,639,440 will be distributed to EMS providers this year. Due to the reduction of “carry forward” funds, as noted above, overall funding for EMS providers for FY 2014 is down from the \$3,107,031 available in FY 2013.

**Funding for EMS Training Sites:** Twenty-three training sites are eligible to participate in the trauma system. These sites provide training for new emergency medical technicians (EMTs) and paramedics. A total of \$207,596 is available this year to increase our EMS workforce.

**Funding for EMS Associations:** The Arkansas Ambulance Association and the Arkansas Emergency Medical Technician Association are eligible to receive approximately \$59,261 each to provide advanced trauma-related training to currently licensed EMTs and paramedics.

**Arkansas Trauma Communications Center (ATCC):** The purpose of the ATCC is to ensure that traumatically injured patients are transported to the most appropriate hospital to treat their specific injuries in the shortest time possible. Call center operators (trained paramedics and nurses) triage and advise on transport of major and moderate trauma patients to hospitals with the appropriate capability to provide optimum care.

Prior to the trauma system, EMS providers transported trauma patients to the nearest hospital regardless of that facility’s ability to care for the injury. In many cases the patient needed a higher level of care. Through receiving guidance from the ATCC, ambulances are now able to bypass those lower level facilities and quickly deliver patients to definitive care. If for some reason a trauma patient in a lower level facility is determined to need a higher level of care, the ATCC can also assist with the hospital-to-hospital transfer. Prior to the trauma system, the receiving hospital’s emergency department would often spend several hours to arrange the acceptance of the traumatically injured patient at a higher level facility. Now, with the resources of the ATCC and the cooperation of the state’s hospitals and EMS providers, the average time of acceptance for all trauma patients (major, moderate, and minor) has been reduced to six minutes and 44 seconds.

Three major changes in our medical delivery system were necessary for this to be possible:

- (1) Real-time notice of hospital capability and capacity to care for trauma patients (room availability and medical specialty services) is monitored 24/7 through an internet-based “Trauma

Dashboard” that was developed for the Arkansas Trauma System. The ATCC is able to instantly see what hospital has what services available immediately upon notification of an injured patient.

- (2) State-wide capable communications infrastructure (trauma radios) have been provided to over 500 ambulances to enable our EMS providers to call the ATCC from the scene of an accident for assistance in selecting the most appropriate hospital for the injured patient. This has proven to be effective in allowing ambulances the ability to bypass the closest hospital by providing them with information needed to make the decision to transport to a hospital that can treat specific injuries. This now makes getting trauma patients to definitive care in the shortest possible time a reality in Arkansas.
- (3) Hospitals had to change long-standing policies to allow medical staff in the emergency department the ability to accept patients rather than requiring an admitting specialist to be notified and, after sometimes lengthy discussions, making the decision to either accept or reject the patient.

Since January 3, 2011, the hospital destination of 45,399 trauma patients has been coordinated through the ATCC (29,297 EMS calls from the scene of an accident and 16,102 hospital-to-hospital transfers). Increased volume and experience continues to indicate specific areas where further improvement opportunities exist. One specific example involves serious hand injuries, in particular amputations of fingers where reattachment may be possible. Several meetings with hand specialists have been held to specifically identify hospitals where the capability and capacity exists to treat these patients, both in-state and out-of-state. Contracts have been executed with seven Arkansas hand surgeons, who will utilize telemedicine to initially evaluate these injuries and ensure the patient is transported to the most appropriate location as expeditiously as possible. In addition, the ATCC will begin a new practice of confirming that a hospital-to-hospital transfer is urgent in order to make the most effective use of our limited EMS resources.

**Trauma Image Repository (TIR):** The creation of the TIR is yet another important development as we implement our trauma system. Seventy-seven hospitals across the state are now able to send radiological images to a secure, centrally located repository. Any physician or specialist who will provide care at the receiving facility (i.e., a higher level trauma center) can access these images, either through a web-based application or by having them sent directly to their hospital’s “Picture Archiving and

Communication System.” Since the system’s inception in July 2011, records for 6,238 trauma patients have been entered into the repository ( the total number of images sent to the repository is 2,213,825). This system will speed up treatment from the point of injury to definitive care and will decrease the number of radiological studies performed. This is especially important for pediatric patients.

The following is a recent experience with TIR: *“TIR saved a life! A young person struck by a car while on a bicycle had an epidural hematoma and was changing neurologically. TIR pushed the films from a Level III Trauma Center to a Level I Trauma Center. The images were downloaded (within 1 min.) and the receiving trauma center was able to have an entire operating crew with neurosurgeons available when she arrived. She spent 13 minutes in the trauma room and went up to the OR where she had her epidural evacuated safely and she is doing very well. A life was saved tonight!”* Todd Maxson, MD; September 28, 2012.

**Governor’s Trauma Advisory Council (TAC):** The TAC and its six subcommittees (Finance, Hospital Designation, Quality Improvement/Trauma Regional Advisory Councils, Injury Prevention, EMS, and Rehabilitation) meet on a monthly basis and furnish valuable guidance to ADH on development of the trauma system. This statutorily-mandated 23 member committee of experts is invaluable to the success of the system.

**Trauma Regional Advisory Councils (TRACs):** There are seven TRACs throughout Arkansas. All meet routinely to address local needs such as injury prevention and other issues like performance/quality improvement. All participating hospitals, EMS providers and other local stakeholders are active on these councils.

**Performance/Quality Improvement (QI):** The Trauma Section has developed a robust QI State Plan that both guides trauma system policies and improves the care for patients suffering traumatic injuries. The Plan includes five distinct projects which, in combination, create a comprehensive review of the care provided to a trauma patient.

- (1) The TAC's QI/TRACs Subcommittee has developed a process in which health care providers who are involved in cases with opportunities for improvement in patient care are required to attend a focused QI meeting with all providers to discuss the issues. These discussions are protected from disclosure and the outcomes are designed to be educational in nature rather than punitive.

- (2) The Section is conducting a population-based trauma preventable mortality study. This review will examine trauma deaths prior to the trauma system and those that have occurred since the system's inception in 2009. The results will inform trauma system stakeholders regarding the value of the system and what improvements might need to be made in prevention efforts as well as patient care.
- (3) TRACs are beginning to document the occurrence of certain "critical events" that take place along the continuum of care for trauma patients. All seven TRACs are trending the same five critical events. Health care providers who are involved in these events will be asked to furnish information to their respective TRACs for discussion and possible referral to the TAC's QITRACs Subcommittee. Again, the purpose is to improve the quality of care for these patients.
- (4) The Section has contracted with a Quality Improvement Organization (QIO) (Qsource) to validate and analyze data related to each component of the trauma system. The QIO's focus will be on system issues such as complete and accurate data submitted to the trauma registry.
- (5) The Section will contract with the American College of Surgeons to participate in its Total Quality Improvement Program (TQIP). The focus of TQIP is trauma service improvement within a trauma center or EMS service.

**Trauma Education:** A contract in the amount of \$1,046,788 is in place for FY 1014 with the Arkansas Trauma Education and Research Foundation (ATERF). The Foundation will provide 18 trauma-related courses to a wide variety of physicians, nurses, and emergency medical services professionals. This was identified by the TAC as being a much needed service in our state and the availability of these courses is expected to dramatically improve trauma care. A significant change has been made in the way these courses have traditionally been delivered. Prior to this contract, most courses were offered in Little Rock. Since the date of the first class on February 16, 2012, ATERF has conducted 114 courses in 46 cities and towns across the state. Over 2,000 health-care professionals, representing 70 of the 75 Arkansas counties, have attended these advanced trauma courses.

**Trauma Registry:** The Trauma Registry is operational statewide, recording and tracking individual cases of traumatic injury from their inception through all phases of acute treatment. Reports are being run to identify performance/quality improvement issues and trends in trauma treatment. To date, 77 hospitals are participating in the Registry and have submitted 53,053 records.

**Website Development:** ADH's website at [www.healthy.arkansas.gov](http://www.healthy.arkansas.gov) includes a robust section on the trauma system and injury/violence prevention. It can be accessed by clicking on Trauma System under "Quick Links" on the left side of the ADH home page. Viewers can quickly obtain information on the various aspects of the system that have been implemented since the system's inception in 2009, to include videos, maps, and graphics. Minutes from past TAC meetings and future schedules for a wide variety of trauma-related meetings are frequently updated.

**Injury and Violence Prevention (IVP):** The Trauma System Act mandates that ADH allocate funds for the development of injury prevention programs. Arkansas is fortunate to have available funding in place, as well as several components which will move IVP forward in our state. The IVP Section at ADH funds and manages these components. First, the Injury Prevention Center at Arkansas Children's Hospital has been the recipient of trauma system grant funding since FY 2011, and for FY 2014 is funded at \$578,000. It has implemented the Statewide Injury Prevention Program (SIPP), which includes personnel who are experts in various aspects of IVP. These employees provide technical assistance to a variety of people who implement IVP interventions. Another important component that is linked with ADH's IVP Section and SIPP personnel is ADH's Hometown Health Improvement (HHI) Initiative. A Memorandum of Agreement (MOA) between ADH's IVP and HHI Sections provides funding in the amount of \$500,000 per year for HHI employees in each of Arkansas' 75 counties to engage in IVP activities. These "boots on the ground" personnel will be invaluable in working with communities to conduct a variety of evidence-based IVP interventions. These programs/interventions are known to be effective and will attack those injury mechanisms having the highest mortality and morbidity rates in our state (i.e., motor vehicle crashes, suicide, unintentional poisoning, falls, and concussions).

**Rehabilitation:** Rehabilitation is a critically important component of a successful trauma system. Beginning January 1, 2011, the Arkansas Spinal Cord Commission (ASCC) began a statewide needs assessment for rehabilitation. The results of this assessment allowed necessary strategic planning to occur. The "Trauma Rehabilitation Strategic Plan 2012-2015" presented to the TAC includes four major goals: to ensure Arkansans who sustain traumatic disabling injuries have access to high quality, comprehensive rehabilitation in our state, to create a systematic approach to capture acute, rehabilitation, and community data metrics to determine areas of improvement in trauma patient outcomes, to build the capacities of healthcare providers to deliver quality rehabilitative care, and to increase individuals' options to integrate successfully into the community. An MOA between ADH and the ASCC provides \$500,000 to this agency in FY 2014 to implement the strategic plan.

**Burns:** Grants for burn treatment readiness in the amounts of \$250,000 per year have been made to the Burn Center at Arkansas Children's Hospital for FYs 2011-2014. These grants allow the Burn Center to increase education to trauma centers across the state on the treatment of burns and to purchase needed equipment.

**Upcoming Initiatives for FY 2014:**

- Update the Arkansas *Rules and Regulations for Trauma Systems* to ensure they are in compliance with American College of Surgeons' standards
- Conduct a preventable mortality study that will identify areas for improvement in our trauma system
- Initiate the Emergency Physician Rural Residency Rotation Program
- Provide trauma radios for air ambulances
- Provide on-going funding for hospitals, EMS providers, and EMS training sites
- Ensure the continued development of the seven TRACs to provide meaningful, beneficial impact on the trauma system
- Work with the Governor's TAC to develop strategies for continued trauma system development and improvement
- Monitor grants to ensure proper utilization of funds and accountability