National Association of State EMS Officials
2014 Annual Meeting
Trauma Managers Council Meeting
October 6-7, 2014

MEETING RECORD

Monday, October 6, 2014

Attendees:

Rob Seesholtz, TN, chair
Carmen Allen, KS (partial)
Chris Ballard, MN
Jon Bouffard, NH
Chrystal Caden-Price, ACS
Wayne Denny, ID (partial)
Tim Erskine, OH
Richard Fenlason, NV
Katie Gatz, IN
Juliet Geiger, PTSF
Jane Guerrero, TX
Candace Hamilton, OR
Tim Held, MN
Ruth Hursman, ND
Amy Krichten, PTSF
Choong Lang, AL
Phyllis Lebo, OR
Art Logsdon, IN
Liana Lujan, NM
Joe Martin, AR
Carol Mays, MD
Steve McCoy, FL
Renee Morgan, GA
Grace Pelley, OK
Kelli Perrotti, WY
Nick Regler, Imagetrend (partial)
Sherry Rockwell, WV
Nels Sanddal, ACS (partial)
Grace Sandeno, CO
Alyssa Sexton, MT
Diane Williams, IA
Robert Winchell, ACS (partial)
Rich Wisniewski, SC
Eileen Worden, MI
Sherri Wren, NE

New Trauma Coordinator Orientation

Grace Sandeno (CO) presented information on what makes a good trauma manager, using her 10 years experience in the field.

- Communication—It is important to know the constituents and make certain they understand the state policy and how it is applied. Constituents must have a way to communicate with each other through list serves or other email groups. Internal communications are equally as important, especially regarding rule interpretation at different levels of management in the hierarchy.
- Collaborate—There is a need to spread out and coordinate resources. Look for other partners, like state hospital associations and other local groups. Don't promise more than you are able to deliver, given finite resources.
- Care—It is important that the trauma manager advocate for the trauma patient who doesn't have a voice in the system. Understand and nurture other stakeholders in their roles.

NASEMSO as an organization provides support to trauma managers through networking and information. The list serve is an important source for learning from colleagues.

MEETING RECORD

Jane Guerrero (TX) provided an example from Texas. There is a lot of turnover in level 4 centers. An annual Trauma Coordinators' Forum is conducted to help orient new employees. There are generally 75-100 attendees, mixing experienced with new.

Phyllis Lebo (OR), who is new to the field, would like to have others post this kind of information to the list serve.

Welcome and Introductions

Chairman Rob Seesholtz (TN) welcomed attendees and asked them to introduce themselves and give some information about their programs. He noted the wealth of experience in the room ranging from new to the job to many years experience. The American College of Surgeons (ACS) is also represented at the council meeting.

Host State Trauma System Spotlight - Ohio

Tim Erskine (OH) gave a presentation on the Ohio trauma system. Ohio is comprised of 44,000 square miles, including part of Lake Erie Islands, bordered by 5 states and shares a water border with Ontario, Canada. The first attempt to organize a state trauma system was in the 1980s by a group of doctors. They did not seek legislative or other support and the effort failed. This attempt was documented in the Journal of Trauma. The second attempt, which had legislative support, was signed into law in July 2000 and defined a trauma victim and a trauma center. There were 21 trauma hospitals in the original designation.

Overview of the Ohio Trauma System

- Funding: EMS funding comes from seat belt fines. There is a trauma research fund to study trauma treatment, injury prevention and trauma rehab.
- The trauma system is EMS centric with exceptions.
- Trauma centers must meet ACS standards and ems cannot transport patients to non-designated centers. EMS can transport to out of state trauma centers.
- Currently there are 50 trauma centers either ACS verified or in a provisional status. There are some competing health systems at this time.
- The trauma registry was established in 1999.
- Geriatric triage rules were enacted in 2008.
- A strategic plan, Framework for Improving Ohio's Trauma System, was written in 2010 and staff increases happened in 2011, adding 2 data managers, an epidemiologist and a statistician.
- In 2013, they began working on legislative changes for Ohio's trauma system, including standards to decertify hospitals.

- All EMS providers must have Trauma Triage training class and refreshers every 3 years.

Amy Krichten (PA) asked if Ohio was able to collect information about how often patients are not admitted to non-designated centers and how it is enforced. Tim replied that it is left to lawyers to determine if there are problems.

Since EMS providers cannot transport to non-designated centers, it can lead to overuse of transport flights with the related issues of level or rural area service, insurance reimbursement, severity of injury and type of crew on board.

NASEMSO and the American College of Surgeons

ACS updates

Dr. Robert Winchell (ACS) and Dr. Nels Sanddal (ACS) gave an update on COT as it pertains to state EMS systems.

- An MOU that formalized the relationship between ACS COT and NASEMSO was signed in 2014.
- The group was reorganized as the Joint Trauma Council in 2014. The group is smaller. Tim Held and Jolene Whitney are the NASEMSO TPM Council representatives.
- Updated JTC work plan:
  - A webinar was held to roll out the 2014 Resources document was completed. The pre-publication version is available online with the final version expected with in a week and hard copies in November. Trauma centers will be designated using the new guidelines beginning in July 2015. There will be other webinars planned for the first quarter of 2015 geared to different audiences: hospital trauma program managers, ACS site reviewers, and NASEMSO membership. A compendium of changes was distributed and will be posted on the ACS website.
  - The JTC is working on a needs assessment document that will come up with a Top 10 PI systems measurement system. Currently there are no standards, agreement on metrics or benchmarks in place and systems are heterogeneous (geography, structural challenges, data and resource availability). The JTC is trying to develop a set of tools that identify global concepts that can be applied to local goals and resources. Currently they are working to establish an initial set of system metrics to be able to have a uniform approach to data collection. They will use the results to refine assessment tools. To date they have reviewed possible metrics and put them in a standard format, worked on an inventory of potential metrics

and identified the "top ten" elements. Tim Held and Jolene Whitney are the NASEMSO TPM Council representatives. They need feedback from the states by spring and may have some final details by the next NASEMSO Annual Meeting.

- A follow-up project will measure the impact of the trauma system consultation process on system development in states/regions that ACS has visited. Initial visits to 6 systems occurred in 2004 and a baseline was established. Most recently, 21 systems (including the original 6) have been reviewed. About 80% have shown improvement over the years, but of the original 6, only 1 has improved and some have regressed. Conclusion: system consultation has a positive impact, but it deteriorates beyond 5 years. There has been less progress in areas of planning. It indicates that ongoing review and periodic re-evaluation is needed to keep systems going.

Dr. Winchell noted that the power point presentation could be distributed to NASEMSO membership.

Annual Business Meeting

Rob Seesholtz called the annual business meeting to order at 1:09 pm. In addition to the in person attendees, some representatives participated via phone:

- Jolene Whitney, UT
- Julie Rabeau, AK
- Dick Bartlett, KY
- Mary Sue Jones, DE
- Paige

President Jim DiTienne and Executive Director Dia Gainor addressed the council.
Jim noted that NASEMSO is a strong organization and that CAP 1 and other NHTSA grants have helped to fund the activities of the councils. Volunteers are the core of the organization. The leadership needs input from the members about their needs through the council business plans. The next big activity is the Performance Review project developing evidence based guidelines and outcomes.
Dia highlighted some important work of NASEMSO. The Interstate Compact that came out of the Education Council has moved forward. It will license personnel across state lines, reducing liabilities and act as a legal assurance between states. It elevates the regulation to a national level. CAP 7 has been approved. It is NASEMSO's single largest agreement with NHTSA and a 2-year commitment. It will develop meaningful system performance measures using NEMSIS data and allow states to compare data and also at the national level (operational and financial measures). Trauma is a major subset of the

performance measures and will be brought in early in the planning process.

Regional Rep reports

East—Tim Erskine reported that the East has had regular phone contact but not much regional activity. They have also had round robin discussions.
North Central—Chris Ballard noted a similar pattern of activity as the East region. There has been a high turnover in the region.
South Central—Renee Morgan said their activity levels are similar to East and North Central and there has also been a high turnover of representation.
West—Jolene Whitney reported that the West region is an engaged group and has held quarterly conference calls with networking and shared resources. They are looking at ways to share data and training in the future.

Strategic Plan Update

Rob reviewed the Trauma Managers Council Strategic Plan mission, vision and progress towards goals:

- **Leadership**—The council has actively worked to engage membership and provide guidance and mentorship.
    - Mentoring tool kit—Sherri Wren has been active in posting materials on the website. Members should provide additional materials to Sherri. Feedback is needed from new members to see if the information is relevant and helpful.
    - Listserv—the council has worked to maintain active listserv discussions.
    - Joint Trauma Council has been reconstituted as a smaller, more collaborative group with representatives from NASEMSO and ACS. They are working on the development of state toolkit resources in support of the Orange book.
- **Data Integration Task Force**—will be lead by Jim DeTienne. The first meeting was held on October 5 to determine what information will be collected and housed in NASEMSO's database. Kelli Perrotti (WY), Rich Wisniewski (SC), Sherry Rockwell (WV), and Alyssa Sexton (NM) volunteered to be part of the working group.
- **Webinars**—one held to date. The goal is to hold at least 2 per year. Ideas for webinars should be passed on to the steering committee.
- **Best practices**—ongoing.

Suggested priorities for the next 2 years are:

- Performance improvement priorities. This is ongoing through the JTC and Data Integration Task Force.

MEETING RECORD

- Ongoing benchmarking and mentoring.
- Marketing-- developing a public awareness of trauma through defining what trauma is and why it is important and creating a national identity and logo.
    - Tim Erskine (OH) suggested approaching a university about marketing. Their agency was successful in engaging a team competition to create plans for internal and external marketing.
    - Collaboration with other organizations:
      --Participate in Trauma Awareness Day with American Trauma Society (ATS).
      --Partner with the Trauma Center Association of America (TCAA) on a certification course.
    - --Develop official relationships with disaster preparedness organizations that utilize trauma systems.
    - Branding—Rich Wisniewski (SC) noted that there is not a common logo for trauma. Messaging, like PSAs, can show how trauma systems work, from the first call to 911. The NASEMSO Board executive committee will need to provide guidance on branding.

It was noted that trying to accomplish this within the scope of a 2-year strategic plan would be a monumental task. The objectives and measureable outcomes need to be defined in 2-year, 5-year and 10-year plans.

Action: 2 groups were tasked with developing 5-10 outcomes (Rob Seesholtz, Sherri Wren, Grace Sandeno) and stronger collaborations (Alyssa Sexton, Jane Guerrero, Rob Seesholtz, Sherri Wren, Tim Erskine) for the next strategic plan.

Election of Officers

New officers are the conduit of information between the leadership and the membership. Rob Seesholtz presented the slate:
East—Tim Erskine (OH), primary; Rich Wisniewski (SC), secondary
North Central—Marty Link (SD), primary; Chris Ballard (MN), secondary
South Central—Joe Martin (AR), primary; Renee Morgan (GA), secondary
West—Julie Rabeau (AK), primary; Alyssa Sexton (MT), secondary
Steering Committee—Secretary: Ruth Hursman (ND), Chair-elect: Carole Mays (MD)
There were no other nominations.
A motion to accept the slate was made by Liana Lujan (NM) and seconded by Tim Erskine (OH). The council voted unanimously to accept the slate.

Tim Held thanked Rob Seesholtz for his leadership on the council.

Poster Presentation – Public Awareness of State Trauma System

MEETING RECORD

Tim Erskine presented the results of a survey on awareness of the trauma system. Attendees at the Ohio State Fair were asked to take a survey about their understanding of the trauma system. The Ohio State Fair was chosen to conduct the survey because attendees closely match the demographics of the state, except in income levels. More than 800 people participated. Results were presented on a poster. Most people knew that crashes are the leading cause of trauma and most had a general awareness of level 1, 2, and 3 trauma centers. Participants tended to overestimate their proximity to trauma center and thought that their local hospital was a trauma center. 67% thought it was extremely important to be transported to a trauma center and more than 22% said they were willing to spend $25 or more to have proximity to a trauma center; others said lesser amounts. The survey cost no money (gift cards purchased with a donation). They now know they need to provide more information about where trauma centers are and to push for more money with the legislature. The next step is to work on a logo.

Action: Tim will send the survey results to the council.

Renee Morgan noted they had conducted a similar survey about funding in Georgia, got a positive response and added legislature to the ballot for a $5 one-time tax, but it was defeated. People in close proximity to a level 1 trauma center voted against the tax.

Hospital Programs

Carole Mays presented an overview of the MIEMSS health facilities and special programs. The motto for the program is "The right patient to the right facility, in the right time, with the right care." Maryland has more than 9 million square miles and almost 6 million residents, in a geographic area that covers mountains to the west and the Atlantic Ocean on the east. The trauma system was first established in the early 1980s and re-organized in 1993. MIEMSS is the main liaison organization.

Overview of the Maryland System

- Five regional, geographic systems. Patients are taken to the most appropriate facilities based on the patient's condition and the resources available.
- The systems approach co-locates EMS services: trauma, burn, stroke, STEMI, OHCA and perinatal care. The results in efficiencies of staff, resources and regulations under the MIEMSS umbrella. The EMS Board has the regulatory authority to develop trauma and specialty centers.
- MIEMSS does its own verification following ACS guidelines.
- Standardization of programs includes: a 5 year verification schedule, legal and admin support, invoicing and procurement services, an advisory committee, data systems and QA/PI confidentiality. There are mous with surrounding, out-of-state, specialized hospitals.

MEETING RECORD

- MIEMSS collects data from the Maryland Trauma Registry, burn TRACS, Hand/eye registry, and NTDB for trauma centers.
- Trauma performance improvement is tracked through the Trauma Quality Improvement committee (TQIP), the Maryland Trauma Registry, MTR Education and Prevention Committee (MTREP) and Maryland TraumaNet.
- Trauma quality improvement is monitored through ACS audit filters, TJC clinical indicators, TQIC scorecard, and Maryland initiatives.

The meeting adjourned at 4:35 pm.

Tuesday, October 7, 2014

Attendees:

Rob Seesholtz, TN, Chair
Carmen Allen, KS
Chris Ballard, MN
Jon Bouffard, NH
Chrystal Caden-Price, ACS (partial)
Wayne Denny, ID (partial)
Tim Erskine, OH
Richard Fenlason, NV
Katie Gatz, IN
Juliet Geiger, PTSF
Jane Guerrero, TX
Tim Held, MN
Ruth Hursman, ND
Amy Krichten, PTSF
Choong Lang, AL
Phyllis Lebo, OR
Art Logsdon, IN
Liana Lujan, NM
Joe Martin, AR
Carol Mays, MD
Steve McCoy, FL
Renee Morgan, GA
Grace Pelley, OK
Kelli Perrotti, WY
Sherry Rockwell, WV
Grace Sandeno, CO
Nels Sanddal, ACS (partial)
Dana Selover, OR (partial)
Alyssa Sexton, MT
Eileen Worden, MI
Diane Williams, IA
Rich Wisniewski, SC
Sherri Wren, NE

Site Visit Surveyors – Panel discussion on training, cost, etc.

Sherri Wren (NE) and Chris Ballard (MN) presented.

Sherri presented an overview of the Nebraska system of reviews:

- Level 3 and 4 centers are reviewed every 4 years. ACS designates level 1 and level 2 centers.
- State process:
  - The process is very labor intensive and not automated;
  - Reviewers can only review outside their home region;

MEETING RECORD

- Review team is made up of a trauma surgeon or trauma regional medical director, trauma nurse and other team members such as ems. Reviewers are paid by the state on a fee for service or contract basis. Expenses are reimbursed.
- Team members are recruited from Level 1 and 2 hospitals or are retired. They are required to orient themselves to the state regulations. Older team members mentor the new participants.
- Reporting is done with a state checklist of regulatory requirements and chart review by a surgeon, peer review from a State and Designation committee, and the Director of Public Health and Trauma Board Chairman signs off.
- Challenges include consistency in review and report writing, geography/weather, resources (time, money, staff); hospital staff turnover/lack of resources, and communication.
- Lessons learned include: recruitment should be ongoing, it is important for reviewers to know the regulations and statute, the team must match the hospital staff to engender trust, there are conflict issues with surgeons and nurses in the role of regulator, and communication and interviewing skills are very important.

Chris presented an overview of the Minnesota system of reviews:

- Minnesota is mostly rural and level 1 and 2 centers are primarily in urban areas. There are many trauma centers bordering the state. ACS designates level 1 and 2 centers.
- State process:
  - Level 3 and 4 are designated every 3 years. Total annual budget is $105,000.
  - Trauma surgeons review level 3; emergency room surgeons review level 4.
  - MN has a comprehensive life support class (CALS) to educate level 4 centers about the trauma needs. Level 4 reviewers are CALS instructors and receive an orientation to the level 4 hospitals, including how the hospitals work so they are familiar with the hospital before they review.
  - The review process is streamlined: a flow sheet guides the review and provides trauma performance standards so that the reviewer is prepared, a standard review template is used and the review coordinator takes extensive notes.
  - Minnesota is piloting an electronic application to reduce paper usage. Hospitals apply online and the reviewer can add the report to the application. To date, a site visit has not been done with the new

application.

- Dana Selover (OR) said that nurturing hospitals through the designation process has not resulted in improved performance on Oregon and asked for guidance. Sherri thinks they have had success in Nebraska, but it is not necessarily quantifiable. Chris noted that Minnesota needs to nurture Level 4 centers because they don't need the designation.

Systems Development – How to Engage Stakeholders

Discussion with examples from Texas, Pennsylvania and Idaho

System development of trauma, stroke, STEMI

- Jane Guerrero (TX) provided an example of a successful system. Elements include:
  - Texas has a government appointed advisory council (RAC), with standing committees, that meets quarterly.
  - Quarterly meetings are open to everyone and attract as many as 300 participants.
  - Meetings focus on a systems perspective and includes stroke, STEMI and neonatal.
  - Hospitals that are interested in designation are required to participate in meetings.
  - Some participation (neonatal) is funded through hospital licensing.
- Juliet Geiger (PA) reported that the Department of Health was initially the agency that designated centers. Her non-governmental agency, PTSF, is the current designator.
  - There are 20 Board members with prominent hospital association and other organizational representation.
  - The Board has a 3-year planning timeline.
  - Board membership is open to all stakeholders.
- Wayne Denny (ID) said that Idaho has recently developed a new statewide trauma and stroke systems program.
  - Workgroups include representatives from all stakeholders.
  - The group met once a month to write legislation for the system. They looked at many different state models.
  - Funding is an ongoing problem. They have used general funds for a few years and now need to look for other sources.
  - Stroke and STEMI designation criteria are set; the last components of trauma should be finalized on a month.

Choong Lang (AL) said that an issue in Alabama is that trauma surgeons do not want stroke and STEMI together with trauma in a single council. They are moving toward legislation to have separate councils.

MEETING RECORD

Training and Educational Programs

- Juliet—Pennsylvania focus areas are:
  - Registry education (ICD 10 webinar series);
  - In person registry validation training and feedback in major cities;
  - State wide conference every year, with local and national speakers;
  - Universities and other training programs;
  - Statewide ems offerings;
  - Accreditation training for hospitals seeking accreditation to help them prepare, relying on trauma centers to mentor.
- Wayne—Idaho's system is young and there is not much direct training. However, the hospital association that manages the registry does training, and hospitals seeking designation do outreach to EMS. Continuing education is a primary concern. They are challenged to motivate the EMS volunteers with providing training from the hospital so that they can see the outcomes and engage them as part of a system, show them the protocols, etc., particularly in rural areas.
- Jane—Texas has a wide variety of educational opportunities:
  - A statewide annual ems conference has been held for 25 years, using primarily state speakers but with some national figures. It is supported by the advisory council and attracts 2500-3000 attendees. Workshops provide CE and councils meet prior to the start of the meeting.
  - Regions (22 areas) are required by contract to do education and training. Regions often partner with each other and attend training outside the region.
  - Most regional training is related to trauma and done on an annual basis. The biggest challenge is how to train registrars. In 2015, they are partnering with trauma registry and Techstart to bring in a beginner course.

Policy development at local, state and national levels

- Wayne—Idaho is currently working to finalize regulations to submit to the legislature. They need a lot of stakeholder buy-in. Regions are in formation. They are developing a standards manual.
- Jane—Texas does not have rules and statutes, it has an administrative code and then develop rules for the admin code. The difference is: statutes are law, but administrative codes can be changed without going through legislature. There is an involved process of engaging stakeholders in rule changes. An advisory board (for ems and trauma) makes the change.
- Juliet—In Pennsylvania, PTSF can revise regulations. An example is that with the

publication of the orange book, they have created work groups to align standards with ACS standards (legislated) and have them approved by December 2015. They rely on hospital associations to push for legislative changes. A challenge is that hospital association staff that knows the history of PTSF is gone and incoming staff needs reeducating about their role.

The group shared information and debated the merits and drawbacks of:

- A single council encompassing trauma, stroke, STEMI vs. separate councils;
- Council size—small vs. large;
- The amount of time to set up systems and enact change—roughly 2-5 years—and the need to identify a champion to help move the process forward.

Trouble Shoot Your Challenges Round Robin

1. Observation status vs. length of stay in the emergency department—The patient is placed in an observation status until a determination is made for discharge transfer to a higher level of care or admission, In the trauma registry, how is this data input?
    - Liana Lujan (NM)—Registrars are not creating patient records. They should include information about why a patient is under observation. The information is to provide feedback on how they did, so it doesn't need to be defined as ed or obs, they are the same. This could be a PI measure—was obs a correct order?
    - Emergency department to admittance is recorded. Observation can be done after admittance. Time should be recorded when they leave emergency department.

2. As Pennsylvania is supporting development of L4 trauma centers, we are encountering larger hospitals with surgical services pursuing L4 accreditation. If an L4 uses surgeons, how stringent are your requirements for transfer out and surgeon involvement in performance improvement. Similarly, how do you handle hospitals designated as a 4 but mostly functioning as a 3 or a 3 mostly functioning as a 2?
    - Phyllis Lebo (OR)—Oregon has this issue as well. They try to be consistent with ACS, so designation should be at the highest level of classification.
    - Alyssa Sexton (MT)—Some level 4s don't have surgeons all the time, but require a backup if surgeon is not there. Level 5 does not have surgeons. Montana has levels 2-5.
    - Sherri Wren (NE)—Similar to MT. Surgeon must have continuing education requirement, if more than non-elective surgery.
    - Sherry Rockwell (WV)—Surgeons must be on call and respond within 30 minutes.

MEETING RECORD

- Diane Williams (IA)—In Iowa, a Level 4 center acts like Level 5.
- Liana Lujan (NM)—A center must be designated at the level of care a place can provide.
- Katie Gatz (IN)—If a hospital is under designated, can hold to a higher PI standard.
- Carmen Allen (KS)—An ACS verified hospital cannot transfer to a non-designated hospital.
- Tim Held (MN)—A hospital self determines which level they want to apply for and Minnesota holds them to that level criteria.
- Jane Guerrero (TX)—Texas rules for level 4 are generic enough, that if reviewers identify care that is deficient on PI measures, the agency can say that what they are doing does not meet the standard. A patient must receive the care that they would receive if they were transferred to a higher-level facility.

3. What are some funding streams?
   - Choong Lang (AL)—Alabama is a volunteer state. They reimburse for travel.
   - Rob Seesholtz (TN)—In Tennessee, the cigarette tax generates 8.5-9 million per year. It goes to hospitals for uncompensated care. Hospitals are responsible for own certification costs. State designation costs are about $4500/hospital. Nothing is provided for system development costs.
   - Sherri Wren (NE)—1.2 million from motor vehicle registration and funds other things like ems as well as trauma. Funds meetings, some education, and regional support of registry. Looking for other sources.
   - Rich Wisniewski (SC)—South Carolina has some dedicated funds. They are trying to get a fee like the 911 charge added to cell phone charges. Also, looking for fees from moped registration to go toward trauma care.
   - Joe Martin (AR)—Funding comes from tobacco tax.
   - Renee Martin (GA)—The state office does not get the trauma fund—it goes to trauma commission. Emergency preparedness funds pay for registry.
   - Grace Pelley (OK)—The tobacco tax goes to uncompensated care and some to fund her office (7.5% of tobacco tax). Other sources include tribal compact and a speeding tax.
   - Diane Williams (IA)—The funding for Iowa is broken down as: $100,000 from legislation, $150,000 from rural health (pays for site visit, data registry, trauma coordinator), and a small amount for emergency preparedness. They are looking to increase funding.
   - Katie Gatz (IN)—Indiana's situation is similar to IA—they receive small pots of money from federal and state.

MEETING RECORD

4. Overutilization of air medical transportation, affecting trauma, stroke and STEMI patients.
   - Joe Martin (AR)—Arkansas did a study of utilization of aircraft and found both over and under utilization and not always transporting patients with the appropriate means of transport. A big issue is bypassing level 2 centers to go to a level 1, when a level 2 center could handle the injury. They are working to have the call center do flight tracking at the time of the call. The ground crew can start transporting by road and let helicopter catch up to them.
   - Carole Mays (MD)— A crash 5 years ago resulted in a helicopter utilization database. Shock traumas are the only ones who can authorize a flight.
   - Liana Lujan (NM)—Liana presented a case of a recent crash transporting a hip fracture. New Mexico can't regulate when a helicopter is called. They are working to develop a process for identifying appropriate transfer options.
   - Nels Sanddal (ACS)—ACS and NAEMSP collaborated on a study about utilization of air transport. The results were published in the Journal of Trauma, October 2013. The Trauma Council should have a liaison to the Air Medical Committee.

     Action: Nels will send the link to the Journal of Trauma article to Rob to post on the resources guidelines page.

     Action: Grace Pelley (OK) will be the Trauma Council liaison to the Air Medical Committee.

5. How to jump start regional trauma system development? How do you get regions to engage with other regions?
   - Katie Gatz (IN)—Indiana has an issue in that higher level hospitals don't engage with other regions.
   - Kelli Perrotti, WY—Wyoming approaches level 3 and 4 centers to see if they will host a regional meeting.
   - Rich Wisniewski (SC)—The state works region by region to get them active. Lower level and non-designated hospitals are more motivated to meet.
   - Alyssa Sexton (MT)—Level 2 centers get a stipend for training and scholarships. Video conferencing enables greater regional participation.
   - Sherri Wren (NE)—Nebraska holds regional trauma performance review meetings.
   - Carmen Allen, KS—Kansas has a well-developed regional council system.
   - Chris Ballard (MN)—Regional councils have to meet in order to get funding for projects they are required to do.
   - Tim Erskine (OH)—Regions have to be shown definitive concrete evidence that it makes a difference. Require education.

MEETING RECORD

- Eileen Worden (MI)—Michigan has legislated regions with staff and facilities assigned to a region. Each region has a stake in review, education, staff, etc. and participation is mandatory.
- Grace Pelley (OK)—Participation is mandatory and regulated by license.

6. How does each state train trauma medical directors?
   - Alyssa Sexton (MT)—In Montana, levels 3, 4, 5 centers struggle to get medical directors for trauma because there isn't any training.
   - Sherri Wren (NE)—advanced center medical directors mentor the lower level directors; small center needs to go to lead center
   - Juliet Geiger (PA)—PTSF teaches a performance measures course.
   - Sherry Rockwell (WV)—West Virginia has an orientation book.
   - Tim Held (MN)—They track training and provide CME for medical director training but have had limited success. They also provide onsite training at the centers.
   - Renee Morgan (GA)—Georgia has a pay for performance policy—medical directors must participate in conference calls. They have an open session for trauma directors at meetings.

7. How do you get stakeholders and advisors to think on a systemic systems level?
   - Tim Erskine (OH)—He finds that stakeholders and advisors give hospital level solutions to system level problems.
   - Grace Sandeno, CO—Suggests having people go out and do reviews and training in rural areas. Assign a level 1 doctor with a rural review team.
   - Diane Williams (IA)—Iowa teaches a Rural Trauma Team Development Course. Levels 1 and 2 go out and train the smaller facilities, all levels including EMS services train together. Provides guidance on how the small centers feed into the large centers.

8. How do you avoid a conflict of interest with surveyors from the same region?
   - Grace Sandeno, CO—Don't use folks from the same region. Colorado rules forbid that. Find out where people have worked before to avoid a conflict. Let facilities know who will be reviewing.
   - Kelli Perrotti, WY —Provide facilities with information on who is reviewing.
   - Sherri Wren (NE)—In Nebraska, the contracts have a conflict of interest clause.
   - Renee Morgan (GA)—Similarly, Georgia has conflict of interest forms for the sites.
   - Tim Erskine (OH)—In Ohio, using in state reviewers may violate state ethics codes so they use reviewers from other states.

10. How to say "no" in the role of trauma manager when responsibilities keep increasing.
    - Jane Guerrero (TX)—Seek clarification of the job description.

Measuring success in your own programs

Regional Trauma System: Optimal Element, Integration Guide"
Sherri Wren (NE) and Tim Held (MN)

Sherri conducted a self-evaluation of the Nebraska program:

- Policy Development
    - Trauma office has little interaction with emergency preparedness and emergency planning.
    - Office has little interaction with policy leaders and does not do constituent education.
    - No formal evaluation method or strategic plan.
- Trauma System Plan
    - Plan has not been updated in many years.
    - No integration between trauma, public health and emergency preparedness
- Conclusion—The data is strong but the policy components are weak.

Tim gave a presentation on sustaining trauma programs:

- Current reality is that funding and staff levels are reduced and not likely to increase.
- In order to justify continuation, programs have to make a case for funding and back it up with numbers. Need to have strong performance measures in place.
- Minnesota has done a good job of getting the trauma system in place, but is finding it difficult to move beyond a start up phase.
- The state has recently begun to demonstrate success with performance measures and has received more funding. The performance measures are:
    - Number of days post site visit to final report
    - Number of days STAC material is available pre-meeting
    - Post site visit survey—customer satisfaction
    - Service outputs—number of TA calls; number of designations processed per quarter; number of PI reports; and number of classes and attendees.

The meeting adjourned at 5:15 p.m.

National Association of State EMS Officials
2014 Annual Meeting
Trauma Managers Council Meeting
October 6-7, 2014

MEETING RECORD