TIME SENSITIVE EMERGENCY SYSTEM OF CARE FOR IDAHO
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BACKGROUND

The Health Quality Planning Commission asked the 2013 Legislature to adopt a concurrent resolution and during the legislative session. The Idaho Legislature passed House Concurrent Resolution 10 directing the Department of Health and Welfare to convene a working group to define the elements of, funding mechanisms for, and an implementation plan for a comprehensive system of care for time-sensitive emergencies in Idaho. The workgroup will also be responsible for drafting legislative language for the 2014 legislative session.

Time-sensitive emergencies include trauma, stroke and heart attack; three of the top five causes of deaths in Idaho in 2011. Idaho remains one of only a few states without organized systems of care for trauma, stroke and heart attack. Numerous studies throughout the U.S. have demonstrated that organized systems of care improve patient outcomes, thus reducing the frequency of preventable death and improving the functional status of the patient.

A coordinated and comprehensive system of evidence-based care addresses: public education and prevention, 911 access, response coordination, pre-hospital response, transport, hospital emergency/acute care, rehabilitation and quality improvement. By creating a seamless transition between and among each level of care and integrating existing community and regional resources will support achieving improved patient outcomes and reduce costs. It will get the right patient to the right place in the right time.

The Time Sensitive Emergency (TSE) Workgroup is comprised of a variety of stakeholders, including emergency medical service providers, hospitals, healthcare providers, public health, health insurers, rehabilitation, legislators, community members and others, moving toward the development of a statewide, evidence-based system of care in which all Idahoans and people visiting Idaho can expect standardized protocols and consistent care within the limitations and parameters of local available resources. Consideration will be given to the needs of all local hospitals, physician groups, emergency medical service providers, etc and the sensitivity of the financial implications.

The following guiding principles have been adopted to help support the development of the comprehensive system of care for Idaho:

- Provide nationally accepted evidence based practices to time sensitive emergencies
- Ensure that standards are adaptable to all providers wishing to participate
- Ensure that designated facilities institute a practiced, systematic approach to time sensitive emergencies
- Reduce morbidity and mortality from time sensitive emergencies
- Design inclusive systems for time sensitive emergencies
- Participation in the designation process is voluntary
- Data are collected and analyzed to measure the effectiveness of the system
TIME SENSITIVE EMERGENCY WORKGROUP

What is the process the workgroup is taking to do their work?
The TSE Workgroup has met eight times, to date. At each of the meetings, a topic or milestone is addressed. The table below shows the meeting topics and the schedule and location. Subcommittees have been formed, as needed, to tackle specific issues in between meeting dates. TSE Workgroup members who reside out of Boise are traveled in for the meetings. All meetings are professionally facilitated.

<table>
<thead>
<tr>
<th>Meeting Topic/Milestone</th>
<th>Schedule</th>
<th>Locations</th>
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<tbody>
<tr>
<td>Kickoff Meeting</td>
<td>May 14, 2013</td>
<td>Oxford Suites Overland Road, Boise</td>
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<tr>
<td>System Design: Part I</td>
<td>June 11, 2013</td>
<td>Saint Alphonsus Regional Medical Center, Boise</td>
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<tr>
<td>System Design: Part II</td>
<td>July 9, 2013</td>
<td>St. Luke’s Regional Medical Center, Boise</td>
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<td>Statewide Registry and Performance Measures</td>
<td>August 6, 2013</td>
<td>Qualis Health, Boise</td>
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<tr>
<td>System Funding and Other Supports</td>
<td>September 4, 2013</td>
<td>Qualis Health, Boise</td>
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<tr>
<td>Recommendations, Legislation and Implementation Plan</td>
<td>September 30, 2013</td>
<td>Saint Alphonsus Regional Medical Center, Boise</td>
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<tr>
<td>Report and Presentation Development</td>
<td>October 30, 2014</td>
<td>Saint Alphonsus Regional Medical Center, Boise</td>
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<tr>
<td>Report Finalization</td>
<td>November 19, 2013</td>
<td>Ada County Paramedics Boise</td>
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<tr>
<td>Presentation of Recommendations</td>
<td>TBD</td>
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How does the TSE Workgroup get its work accomplished with only meeting monthly?
Because the TSE Workgroup is only able to meet on a monthly basis to accomplish a large amount of work, it is utilizing ad hoc subcommittees to accomplish tasks in between meetings. Eight subcommittees have been formed. Participation is voluntary and active participation is expected. Upon occasion, the subcommittees will merge to complete their assigned tasks. The subcommittees are:

- Communications
- Funding
- Framework
- Legislation
- Region Definition
- Stroke & Heart Attack Rules
- Registry & Data
- Trauma Rules
Is there a website about Idaho’s time sensitive emergency system of care?
The website is [www.tse.idaho.gov](http://www.tse.idaho.gov). This site will continue to be updated with the latest information about the TSE Workgroup, FAQs, resources, etc.

How can I submit questions and comments to the TSE Workgroup?
A mailbox has been established that will be regularly monitored for the public’s use. Questions and comments can be submitted to: tse@dhw.idaho.gov.

Who do I contact if I want to have a conversation about TSE in Idaho?
While there are many dedicated professionals working on the development of a TSE System of Care for Idaho, the following people may be contacted to discuss the work that is being conducted.

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
<th>E-mail</th>
<th>Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wayne Denny</td>
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<td>208-381-4818 208-861-0142</td>
</tr>
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**STAKEHOLDER INVOLVEMENT**

How are the interests of ALL stakeholders identified and addressed?
Every effort has been made to ensure that a diversity of stakeholders are involved in the creation of the framework, legislation, and process. However, the TSE Workgroup members
are conscientious about ensuring that a variety of opportunities for input must be provided. Currently, Workgroup members utilize a SharePoint site to distribute and comment on materials. The Communication Subcommittee is creating talking points for Workgroup members to be able to share with their constituents. The website (www.tse.idaho.gov) contains information about the Workgroup’s progress and to post documents for public comment. A mailbox has been established for comments and questions to be submitted (tse@dhw.idaho.gov).

TSE Workgroup members are also sharing the products of their work with their colleagues, constituents and members to ensure they are being provided ample opportunities to be involved. New TSE Workgroup members continue to be identified and recruited to ensure representation. An example of an opportunity to provide input was in the form of a survey the Idaho Hospital Association recently routed to its’ member hospitals. The survey informed the hospitals of the TSE Workgroup activities as well as solicited their input on specific topics around protocols, capacity and capabilities, barriers, and coverage. There were multiple open-ended questions to allow for additional feedback.

TSE SYSTEM OVERVIEW

What does a comprehensive, time sensitive emergency system of care “look” like? The following graphic represents the components of a time sensitive emergency system of care. It denotes that it is a system that is a continuous process deploying such aspects as prevention of an emergency to emergency response to medical care to rehabilitation to quality improvement.
How will the system be governed and where will it be housed? Who/what will be the designating body or authority?

Through the Framework Subcommittee, a comprehensive system of care is being proposed back to the TSE Workgroup for consideration. Elements of the system will include an administrative state agency, such as the Idaho Department of Health and Welfare; a system of care state council appointed by the Governor that consists of experts in trauma, stroke and heart attack response direction-setting and policy; and regional committees comprised of representatives from local emergency medical services, hospitals, public health and others. The regional committees will be the venue in which a wide variety of work is conducted such as education, technical assistance, coordination, and quality improvement. The system may look something like the following graphical representation. However, until the system is thoroughly designed and vetted this is only a representation.
The framework, as discussed at the July 9 TSE Workgroup meeting, would build off existing models for a trauma system of care to address trauma first and later incorporate stroke and heart attack.

- The state agency, Idaho Department of Health and Welfare, would provide oversight of the state system of care for time sensitive emergencies and the Department would provide the process and standards for the system, including the promulgation of rules.

- The state council would be composed of voting members appointed by the Governor and equitably represent stakeholders (geographic, rural, urban, medical disciplines, etc). The council would establish the various designation and certification levels for the time sensitive emergencies, standards, procedures and duration of designation and certification. It would provide criteria for designation/certification as well as revocation. The state council would establish quality improvement standards as well as criteria for the operation of the regional committees.

- The regional committees would be established based on health care delivery patterns. The specific number of regional committees has not been determined. A Region Definition Subcommittee was created to address this issue. Each regional committee will have one representative that sits on the state council. The regional committees will be educational in nature and provide technical support as needed. The regional committees could potentially prioritize health resource allocations, conduct training, conduct regional quality improvement initiatives, conduct quality improvement activities, make recommendations to facilities within their respective regions, and advise the state council about the overall system in an effort to meet the criteria established by the state council.

Between the July 9 TSE Workgroup meeting and the August 6 TSE Workgroup meeting, the Framework Subcommittee, Region Definition Subcommittee, and the Legislative Subcommittee continued to work on elements of the system design focusing heavily on the structure of the regional committees. It was determined that instead of defining the make-up/structure of the regional committees in statute or code, it would be best to leave the structure and region definition to the state council, once operational, because there are currently many variables not well defined without the state council in place. The state council will have the authority over the regional committees.

During the September 3 TSE Workgroup meeting the Region Definition Subcommittee presented a framework for what the regions might look like. The purpose of continuing to address the structure was to leave a legacy for the state council, when operational, to use as a foundation for making decisions about the regional committees. The following is the final draft region map created by the Region Definition Subcommittee.
Will facilities be able to participate in one or more component of the system but not all, i.e. stroke and trauma? If so, how will the system address non-participating facilities?
Participation in the TSE system of care is voluntary, but the goal is for every facility to want to participate up to their abilities and resources. It is not necessary for hospitals to participate at the highest designation level for any of the components; stroke, heart attack or trauma. Discussion about what this would look like will continue after the legislation has passes and rules are developed.

What is the role of telemedicine in the system? If it is supported, will it be a reimbursed activity?
The use of telemedicine in the TSE system has been discussed in several subcommittees, as well as by the TSE Workgroup, and its use is supported. Exploration into how telemedicine and other technologies can best be used within the TSE will continue as the state council is established and the TSE system develops.

STATE COUNCIL, DESIGNATION AND CERTIFICATION

What will criteria for designation look like for the state of Idaho and what about leveraging national standards?
Whenever possible, national standards will be considered for adoption to create Idaho-specific best practices.

During the August 6 TSE Workgroup meeting, there was further discussion about, and support for, utilizing national standards and best practices for trauma, stroke and heart attack. This was further reinforced by a presentation given by the State of Utah’s manager of time sensitive emergencies system of care and a CEO of a Utah critical access hospital. The representatives from Utah presented the group with their guiding principles that articulate the importance of national standards and best practices as well as the designation and certification criteria for the components of time sensitive emergencies.

REGIONAL COMMITTEES

What is the purpose of defining regions for the TSE system? Are they aligned with referral patterns? Will they change existing referral patterns?
The proposed regions are intended to establish administrative structure for the TSE system of care and do not dictate referral patterns or existing transport/transfer patterns.

What is the role of the existing EMS regional councils in relation to the TSE committees?
The role of the regional committees is to provide a venue for communication between EMS providers and hospitals to address performance improvement. It is the hope of the TSE
Workgroup that existing regional councils, such as the Ada and Canyon County Regional Interagency Committee for EMS (RICE), will participate in, partner with, or could even become the TSE regional committees in order to address best practices and optimal patient outcomes.

RURAL ISSUES

If my hospital chooses not to participate in this voluntary system, does that mean my hospital will be bypassed?
This system is not only looking at time sensitive emergencies but also patient centeredness to ensure appropriate care during an emergency as well as for after-crisis-care in the patient’s community. Idaho hospitals are likely already being bypassed in some instances. A coordinated and comprehensive system will help ensure that patients can receive care in their community when the hospital is capable of providing the level of care needed, and when that is not possible, are returned to their community for post-care. For trauma, the TSE Workgroup has recommended a Level V designation so that small hospitals have further opportunities to participate. If a hospital chooses not to participate, the system is being designed to provide them with appropriate support to participate to the extent they are able.

Can my hospital participate if I am not Joint Commission certified?
There are some rural hospitals that might not be accredited or certified by national organizations, but through this system of state designation and certification the hospitals will be deemed to meet appropriate standards by the state if they don't already meet the national standards.

I am concerned that the proposed TSE system of care will result in fewer patients coming to rural critical access hospitals. Will patients who are transported to a local critical access hospital today be taken to a larger hospital once the TSE system of care is implemented?
The proposed TSE system of care will provide a venue wherein all of the healthcare professionals who are involved in the treatment of trauma, stroke and heart attack patients can collaborate to make sure that the decisions made about the destination of trauma, stroke and heart attack patients are the best for the patient and the system. The community hospitals and clinics that serve rural Idaho communities are critical to the stability of the overall healthcare system in Idaho. A goal of the proposed TSE system of care is to develop and share practices that will enable community healthcare facilities to remain viable so that they can continue to provide the best possible patient care.

Getting the right patient to the right place in the right time is a widely accepted goal in the treatment of time sensitive emergencies and is a foundational tenet of the proposed Idaho TSE system of care. While there are many confounding issues that can prevent a patient from getting to the right facility in a timely fashion, under-triage and over-triage are two issues that similar systems of care have proven to mitigate.
Under-triage is when a seriously ill or injured patient is taken to a facility that is not appropriate to the seriousness of the illness or injury. Under-triage can lead to negative patient outcomes due to the increased time until critical patients can receive the needed care in a facility that is prepared to treat their specific illness or injury.

Over-triage refers to situations when patients with less severe illness or injuries are taken to a larger medical center instead of a smaller local facility. Over-triage is problematic because treating patients with less severe illness and injuries ties up available resources that could otherwise be available for the more critical patient.

Under-triage and over-triage are both issues that, if left unaddressed, represent inefficient use of resources that may ultimately affect patient outcomes. The proposed TSE system of care will help to avoid unnecessary costs, provide a venue where decisions can be made on how best to use all of the available resources in a community with positive patient outcomes as the overarching goal. The member organizations of the TSE regions will collaboratively develop protocols that will help assure that the right patients are treated in the right place at the right time.

For more information on the issue of under and over triage, see the 2007 fact sheet from the Utah Department of Health: Over/Under Triage in Utah and the June 2013 Journal of the American Medical Association article: Secondary Over-triage, The Burden of Unnecessary Interfacility Transfers in a Rural Trauma System.

**What are the potential implementation costs for rural facilities?**
Until the system design is complete, it is unclear what the implementation costs to rural facilities may be. The goal is to assure that funding sources are available to lessen the financial impact on rural facilities wherever possible.

**How do we ensure adequate coverage, training and education in rural areas?**
This activity will be conducted through the regional committees.

**OTHER STATE SYSTEMS AND SUPPORTING STUDIES**

The Utah Time Sensitive Emergency System of Care was mentioned. What does it look like?
The Utah system was described during the August 6 TSE Workgroup meeting in a presentation by Robert Jex, Utah Bureau of EMS and Preparedness, and Jim Beckstrand, CEO of the Delta Community Medical Center and Fillmore Community Medical Center, both critical access hospitals in Utah. The presenters described the foundation of their work – the Guiding Principles – that are the underpinnings of the work they do and help create the foundation from which all participants work. They described the three components of their time sensitive
emergency system of care: heart attack or STEMI, stroke and trauma. In Utah, their comprehensive system began with trauma and subsequently added heart attack and stroke; however, the presenters praised Idaho for beginning the discussion with all three components of the system up front.

The Utah heart attack system requires the following: ninety minute door-to-balloon time; 12 lead ECG capability in the field; thrombolytic therapy if appropriate; the development of treatment guidelines for heart attack in critical access hospitals and rural hospitals; and requires performance improvement with hospitals and EMS. The heart attack system has the ability to review the performance of hospitals by patient. Responding agency, dispatch times, EMS run times, patient arrival and treatment times and case details are able to be extracted for review. The Utah Hospital Association Foundation provided funding for 12 lead capabilities for EMS in every county in Utah. Additionally, the Utah heart attack system covers an estimated 80% of the population, mostly along the Wasatch front.

The Utah stroke system is an inclusive system that addresses the fact that all primary stroke centers are located in the urban areas of Utah, creating a need in the rural parts of Utah. It is impossible to transport all stroke patients to urban centers, so the goal of their system is to improve the level of stroke care at all community emergency departments. Utah is the first state to adopt an inclusive approach compared to other states that are based on by-passing smaller hospitals. The Utah stroke system uses a hub and spoke system. The hubs are the primary stroke centers that offer referral and consultation to the stroke receiving facilities and are accredited by a national body (JCAHO/DNV, etc). The spokes are the stroke receiving facilities that utilize the primary stroke centers for consultation, they utilize phone and telestroke to support their capabilities, they may transfer their patients, if they desire, and they are verified by the Utah Department of Health. There are a total of 28 of the 43 Utah hospitals voluntarily participating so far. Of the 28 participating hospitals, eight are primary stroke centers and 20 are stroke receiving facilities, three of which are also critical access hospitals. Utah developed a stroke receiving facility toolkit that each participating facility is required to utilize (https://health.utah.gov/ems/stroke/toolkit.pdf). The standards the stroke receiving facilities are required to meet, if they choose to participate, are: stroke team available 24/7; phone or telestroke consultation with the primary stroke centers available; 24 hour MD and RN in the emergency department authorized to begin the stroke protocol using standard forms and protocol; CT and lab available 24/7 and results in 45 minutes; thrombolytics (rt-PA) available in/to the emergency department; stroke coordinator and administrative support; site visit by the Utah Department of Health team to verify stroke protocols, etc, and if verified, the local EMS agencies are notified that the hospital is “stroke ready” to receive patients via EMS. With the Utah stroke system and subsequent data collection and verification, they are able to show that 85% of patients taken by EMS are going to a stroke receiving facility or primary stroke center within the national guideline of sixty minutes or less.
The Utah trauma system is an inclusive system that includes approximately 95% of minor and moderate traumas. The 5% of traumas classified as severe are part of an exclusive system because they require specialized care. There are five levels of trauma designation in the Utah system: Level I through Level V. Of particular note is the Level V created by the Utah Department of Health. There are currently a small number of Level V-designated hospitals in Utah. Designation requirements for a Level V trauma center in Utah are:

- Hospital must have the ability to provide initial evaluation, stabilization and transfer to a higher level of care;
- Hospital must be a generally licensed, small rural facility with a commitment to the resuscitation of the trauma patient;
- Hospital may be staffed with a physician’s assistant or nurse practitioner rather than a trauma-trained physician; and
- Hospital’s major trauma patients are resuscitated and transferred.

The supporting evidence behind Utah’s trauma system is that 85% of traumas involve motor vehicle crashes. The outcomes are strongly influenced by the initial care delivered in the “golden hour” – the period of time when 60% of trauma deaths occur. Twenty-five percent of all motor vehicle accidents occur in rural areas accounting for 66% of motor vehicle deaths. Thirty-five percent of trauma deaths are preventable by proper assessment and resuscitation.

A notable point from the Utah presentation was about the potential/projected rural hospital revenue. The system of care allows designated hospitals to offset the costs associated with activating a trauma team to appropriately respond to an incoming trauma case.

Per the Utah presentation, the Utah trauma system is funded through a percentage of fines and forfeitures (8%), not including the trauma registry. They do not use grant funding. They also charge $3,000 per hospital initial designation for three years of designation and $2,500 for redesignation. The designation and redesignation fees provide the funding necessary for site and compliance visits and support to the hospitals to provide data for performance management and quality assurance. Funding for the education and resource component was not mentioned during the presentation. Their stroke and heart attack system is free for participation. In Utah, there are currently three separate state level committees overseeing the systems, respectively but are all managed out of the same Department of Health office. Only the trauma committee is designated in statute. However, during the presentation made by Utah, it was recommended that Idaho consider only one state level committee. Utah has only one registry – trauma - and none for stroke or heart attack due to lack of support. Utah had a fully operating trauma system (including a trauma registry) in place before it established the stroke and heart attack components. The presenters recommended that Idaho consider building the stroke and heart attack registries into this work from the outset to avoid the possibility of the registries never being created.
Are there data on trauma designation in rural states that shows trauma systems make a difference?

Esposito, TJ, et al. in the Journal of Trauma, 39:955-62, 1995 reviewed trauma in the state of Montana and then later evaluated trauma in the same state (Esposito, TJ, et al., American Association of Surgical Trauma, September 2002). The table below shows key highlights from the Esposito studies that demonstrate significant improvements in outcomes after the establishment of the trauma system in Montana.

<table>
<thead>
<tr>
<th>Esposito 1995 Findings Publication</th>
<th>Esposito 2002 Findings Publication</th>
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<tbody>
<tr>
<td>Retrospective panel review of 324 deaths attributable to mechanical trauma in the state of Montana</td>
<td>Retrospective panel review of 347 blunt trauma deaths in Montana; comparison to pre-system study</td>
</tr>
<tr>
<td>Preventable deaths – 13%</td>
<td>Preventable deaths – 15% to 8% (p&lt;0.02)</td>
</tr>
<tr>
<td>Preventable hospital deaths – 27%</td>
<td>Preventable hospital deaths – 27% to 16%</td>
</tr>
<tr>
<td>Pre-hospital deaths – extended response time 40%; on-scene time greater than 20 minutes – 23%</td>
<td>Inappropriate pre-hospital care – 37% to 22%</td>
</tr>
<tr>
<td>Inappropriate care in ER – 68% (Inappropriate airway management, failure to diagnose and treat chest injuries, inadequate volume resuscitation, delays to operating room)</td>
<td>Inappropriate care in ER – 68% to 40% (Inappropriate airway management, failure to diagnose and treat chest injuries, inadequate volume resuscitation, delays to operating room)</td>
</tr>
<tr>
<td>Inappropriate care post-ER – 49%</td>
<td>Inappropriate care post-ER – 49% to 29%</td>
</tr>
</tbody>
</table>

DATA AND QUALITY MEASURES

What data will be collected, how will it be collected and how will it be shared? How will trust be created to share data?

The data to be collected is being discussed during the development of the system. In addition, a Registry & Data Subcommittee was formed to take deliberate action on what data are needed for collection and how that data will be collected.

Currently data are already collected through the trauma registry. However, how data will be collected for stroke and heart attack is still to be determined. There will be a delicate balance to ensure participation and collection of adequate information to ensure performance measures are effectively being evaluated so that Idaho can be compared to the national efforts. As of the August 6 TSE Workgroup meeting, it was determined that the collection and analysis of data to measure the effectiveness of the system is imperative and is a guiding principle of the group. However, the TSE Workgroup is very cognizant of the potential burden of data collection and reporting and will continue to keep this in mind moving forward.
What will the data be used for?
The data collected will be used to further improve quality healthcare within individual communities. The data will establish a baseline of the delivery of the time sensitive emergency system of care and help monitor how the system of care is operating. The data can help determine health resource allocations that are needed in individual communities and regions when resources are scarce. For example, in county X, there might be only three staffed ambulances. During a high casualty trauma incident, there might be patients waiting for medical care in the hospital emergency rooms because there are not enough local resources to handle the situation. However, in county Y, there might be more ambulances than they need. Data may help determine where the high volume of time sensitive emergencies exist and have the resources deployed to that area.

The regional TSE committees will review de-identified data and determine what can be done at the community level to improve outcomes. It is important for all hospitals and TSE system providers to report data to see the whole picture of the broader regional community. If one hospital in a TSE region does not participate in the data collection and sharing, it could create a hole in the map of Idaho’s needs and will not accurately account for the much needed resources and education in the local areas. Data will support areas where tool kits and training efforts are needed for improved care and will help measure challenges and successes as comprehensive coordinated systems of care are implemented regionally and statewide.

FINANCING

How will this system be funded and how will funding be sustained?
This is a fundamental question for the system of care development and deployment. The funding source needs to provide for both immediate and long-term solutions. To this end, a Funding Subcommittee was established to determine not only how much the system would cost, but also identify potential funding sources. This subcommittee has begun to work on identifying options for funding and will continue to provide options back to the TSE Workgroup. It is important to know what the system design will be in order to estimate the cost of the system.

LEGISLATION AND RULEMAKING

What is the process for developing the TSE system of care authorizing legislation, as well as rulemaking?
The TSE Workgroup had many decisions to make about the framework for the system of care, the budget, the creation of the state council membership, etc before the enabling legislation or draft rules could be created. The draft legislation was created based on the work of the TSE.
Workgroup. The draft legislation describes what the system will look like. The fundamental concepts for the rules that describe how the system will work (the nuts and bolts) were created tangentially to the legislation so that the TSE Council will have a foundation on which to draft rules.

During the September 4 TSE Workgroup meeting, the decision was made to create talking points about the trauma, stroke and heart attack components. The talking points can then be the basis for the development of rules in subsequent legislative sessions. The talking points will provide enough detail so that decision-makers can “see” better what the system of care will look like beyond the detail provided in the legislation.

What are the components or guidelines needed to develop rules for the trauma element of the system?
The framework used to create rules for trauma may include but is not limited to the following types of considerations:

- Does the hospital meet the American College of Surgeons criteria for a Designated Trauma Center?
- Does the hospital meet the criteria for the level of care required for their specific designation level (i.e. Level I, Level II, Level III, Level IV etc.)?
- Is the hospital applying for Level I, Level II or Level III trauma center designation in compliance with national standards published in the American College of Surgeons document: Resources for Optimal Care of the Injured Patient 2006?
- Is the hospital applying for Level IV and Level V trauma center designation in compliance with the American College of Surgeons document: Resources for Optimal Care of the Injured Patient 1999 (exception: a Level V trauma center will not need to have a general surgeon on the medical staff and may be staffed by nurse practitioners or certified physician assistants)?
- Does the hospital follow appropriate designation requirements and state guidelines for triage of trauma patients?
- Does the hospital follow appropriate designation requirements and state guidelines for treatment of trauma patients?
- Does the hospital follow appropriate state guidelines for the transport and transfer of trauma patients to the most appropriate health care facility?
- Does the hospital assist physicians in selecting the most appropriate physician and facility based upon the nature of the patient’s critical care problem and the capabilities of the facility?
- Does the hospital have the ability to collect and submit data to the Idaho Trauma Registry?
What is the application process for designation and how long will it take? How long will the designated period? When will hospitals have to re-apply?

What are the components or guidelines needed to develop the rules for the stroke and heart attack elements of the system?
The framework used to create rules for stroke and heart attack may include the following types of considerations:

- Is the hospital accredited by existing nationally recognized accrediting body, such as the Joint Commission on Accreditation of Healthcare Organizations, or the Society of Cardiovascular Patient Care?
- Is the hospital a receiving and/or treatment center for stroke and/or heart attack?
- What are the staffing requirements needed for the Emergency Department for stroke and heart attack treatment?
- What are the on-site and/or response time requirements for physicians?
- Does the hospital use a standardized assessment tool for ischemic stroke and heart attack patients?
- Does the hospital maintain and utilize thrombolytic medications?
- Does the hospital have the ability to receive 12 lead EKG from EMS agencies?
- Does the hospital have Percutaneous Coronary Intervention (PCI) capability? If so, is there a protocol in place to treat patients within the nationally recommended time limits?
- Does the hospital have national standardized acute stroke and heart attack protocol and have staff to implement the protocol?
- Does the hospital maintain ancillary equipment and personnel to diagnose and treat stroke and heart attack patients?
- Are there transfer transport protocols in place?
- Does the hospital have a functioning performance improvement program for acute strokes and heart attacks?

Is the development of a time sensitive emergency system of care part of the Affordable Care Act?
No, this is not part of or mandated by the Affordable Care Act, sometimes referred to as health care reform. This work is being done in response to the direction of the 2013 Legislature’s passage of the joint resolution, HCR10, directing that this work be done.
The development of this system of care stems from a need for better health outcomes for conditions that require a timely and emergency response; in this case trauma, heart attack and stroke particularly for Idahoans. All three of these conditions require treatment within a narrow window of time and creating a coordinated system within the state will provide better results for these patients by creating a statewide, evidence-based system of care in which all Idahoans and people visiting Idaho can expect standardized protocols and consistent care with the limitations and parameters of locale available resources. It is about getting the right patient to the right place at the right time.

**TRAUMA, STROKE, HEART ATTACK**

*Where can I find more resources on trauma systems of care?*
Resources for a trauma system development through the American College of Surgeons can be found at: [http://www.facs.org/trauma/tsepc/pdfs/regionaltraumasyystems.pdf](http://www.facs.org/trauma/tsepc/pdfs/regionaltraumasyystems.pdf).

*I understand the concept of a trauma system but am unclear what a heart attack system of care looks like. Where can I get more information?*
The American Heart Association has Mission: Lifeline to help promote heart attack or STEMI systems of care. STEMI stands for ST-Segment Elevation Myocardial Infarction, a type of heart attack that is particularly life-threatening and in need of more urgent treatment. The goal of Mission: Lifeline is to provide guidance for developing systems between EMS, referring and receiving hospitals, allowing for seamless and effective treatment to all STEMI patients. More information can be found at: [http://www.heart.org/HEARTORG/HealthcareResearch/MissionLifelineHomePage/LearnAboutMissionLifeline/STEMI-Systems-of-Care_UCM_439065_SubHomePage.jsp](http://www.heart.org/HEARTORG/HealthcareResearch/MissionLifelineHomePage/LearnAboutMissionLifeline/STEMI-Systems-of-Care_UCM_439065_SubHomePage.jsp).
How is Idaho currently performing with regard to stroke compared to other states?

COMMUNICATION AND OUTREACH

Where and how has this work been communicated?
A wide variety of communication and outreach activities have occurred by TSE Workgroup members since this work began in May 2013. Communication and outreach is on-going on both a peer to peer level, in addition to formal presentations in addition to the development of the website. Physician champions have been identified, informed through the process and engaged to provide input on TSE Workgroup deliverables. Presentations have been made at the Idaho Medical Association and Idaho Hospital Association board and regional constituent meetings. EMS personnel and directors have received communication through peer publications, in-person regional meetings and through email. TSE Workgroup members have provided updates to the Idaho Association of Cities and Idaho Association of Counties. The Governor’s office, legislators, the Health Quality Planning Commission and the Health Care Task Force have all received or are scheduled to receive updates. Communication and outreach will continuously be provided throughout the process.