

FY2010 Trauma Care Trust Fund General Guidelines

Trauma Care Trust Fund (TCTF) distribution will be provided only to designated Level I, II, III Trauma Centers and EMS providers. TCTF distribution will be made through the Trauma Care Regions.

Designated Level IV Trauma Centers shall not receive TCTF distribution, however, will receive \$10,000 annually for administrative support for participation in the Mississippi Trauma Care System.

TCTF distribution is determined using the TCTF Distribution Model published in the Mississippi Trauma Care System Regulations, Chapter 4 and Appendix D.

Trauma Centers will receive 85% of the TCTF distribution; 35% from the Fixed Distribution and 50% from the Variable Distribution. No less than 30% of the total distribution to a Trauma Center must be used to fund physician payments.

EMS providers will receive 15% of the TCTF distribution, which will be computed based on county census data.

Definitions:

Designated Trauma Center:

A hospital designated by the Mississippi State Department of Health as a Trauma Center that provides care to trauma patients. Trauma Centers in the Mississippi Trauma Care System care for a variety of injured patients. These patients are provided immediate resuscitation and stabilization, and definitive acute care. There are rules and regulations mandated by the MSDH with which compliance is necessary to be a designated Trauma Center.

Eligible Physician:

The attending or admitting emergency room physician(s), trauma/general surgeon(s), orthopedic surgeon(s), neurosurgeon(s), anesthesiologist(s), or any other physician specialty, who provides health care service to a patient whose condition and/or circumstances qualifies the patient for entry into the trauma registry, and such service is to be directly related to the medical treatment of the trauma case. Services must be delivered at a designated trauma center.

EMS providers:

Ambulance services licensed by the MSDH that are designated to provide 9-1-1 response. All services must abide by the rules, policies, and guidelines, and be active participants of, their respective Trauma Care Region and the State Trauma Plan. This participation shall include, but is not limited to, the Performance Improvement process and destination guidelines.

Trauma:

MSDH has developed the following criteria for inclusion of a patient's condition into the trauma registry:

1. All state designated patients must have a primary diagnosis of ICD-9 diagnosis code 800-959.9;
2. Only burn patients with an ICD-9 Code of 940-949 qualify for inclusion into the trauma registry. Qualifying burn patients must also meet one of the following criteria:
 - Transferred between acute care facilities (in or out).
 - Any patient that has sustained an injury (ICD-9: 800.0 - 959.9) and is referred from a trauma center or transferred to a trauma center qualifies for inclusion into the trauma registry.
 - Admitted to critical care unit (no minimum days).
 - Any injury that a patient has sustained in which the patient is admitted to a critical care unit qualifies for inclusion into the trauma registry.
 - Hospitalization for three or more calendar days.
 - Any trauma patient hospitalized for three or more calendar days due to injuries sustained qualifies for inclusion into the trauma registry.
 - Died after receiving any evaluation or treatment. (All deaths due to an injury that receive an evaluation or treatment in the Emergency Department qualify for inclusion into the trauma registry.)
 - Admitted directly from Emergency Department to Operating Room for major procedure, excluding plastics or orthopedics procedures on patients that do not meet the three day hospitalization criteria. (Any trauma patient that is admitted directly from the Emergency Department to the Operating Room for a major procedure qualifies for inclusion into the trauma registry. Plastics and/or orthopedic procedures that do not meet one of the other criteria for inclusion into trauma registry are EXCLUDED and do not qualify for inclusion into the trauma registry.)
 - Triaged (per regional trauma protocols) to a trauma hospital by pre-hospital care regardless of severity. (Any trauma patient that is triaged to a trauma center by pre-hospital care providers, per regional trauma protocols, qualifies for inclusion into the trauma registry. Documentation verifying that this criteria was used must be present in the patient's hospital chart to qualify for inclusion.)
 - Treated in the Emergency Department by the trauma team regardless of severity of injury. (Any trauma patient that arrives at a trauma center and is treated by a trauma team as delineated by hospital policy qualifies for inclusion into the trauma registry. Documentation verifying a trauma team activation and response must be present in the patient's hospital chart to qualify for inclusion.)

3. The following primary ICD-9 diagnosis codes are excluded and should NOT be included in the trauma registry:
 - o ICD9 Code 905-909 Late Effects of Injuries, Poisonings, Toxic Effects, and Other External Causes.
 - o ICD9 Code 930-939 Effects of Foreign Body Entering Through an Orifice.
 - o Extremities and/or hip fractures from same height fall in patients over the age of 65.

Trauma Patient:

An injured patient who presents at a Trauma Center, whose condition is qualified for entry into the hospital's Trauma Registry, and who is included in the Trauma Registry. A patient must be included in the Trauma Registry in order to be considered for distribution from the Fund.

Physician Charges:

The gross charges for the professional component of eligible physicians associated with treatment of trauma cases. This does not include laboratory, x-ray, facility fees, drug or supply charges, hospital visits included in a global surgical fee, or any other charges that do not fall under the scope of the professional component.

Eligible Expenditures:

1. Trauma Centers:
 - a. Physician compensation, including stand-by, call-back, or trauma team activation pay. (Must be a minimum of 30% of the total Trauma Center distribution).
 - b. Medical staff compensation, including nurses, nurse-practitioners, CRNA, radiology technicians, laboratory technicians, etc. May also include stand-by, call-back, or trauma team activation pay.
 - c. Non-medical staff compensation including administration, security, maintenance, or other function that directly supports the trauma care program of the facility.
 - d. Training and associated travel costs for trauma education including, but not limited to, ATLS, ABLIS, ACLS, ATCN, ENPC, PALS, and TNCC.
 - e. Equipment directly related to the immediate resuscitation and stabilization, and definitive acute care, of trauma patients.
 - f. Commodities directly related to the immediate resuscitation and stabilization, and definitive acute care, of trauma patients.
 - g. Capital investments directly related to the immediate resuscitation and stabilization, and definitive acute care, of trauma patients, i.e., expansion of emergency treatment rooms, expansion of OR, ICU, etc.

2. EMS providers:
 - a. Compensation for Paramedics, EMTs, and EMS drivers, including stand-by or call-back pay.
 - b. Compensation for other employees including administration, dispatchers, maintenance, or other function that directly supports trauma response.
 - c. Training and associated travel costs for trauma education including, but not limited to, PHTLS, BTLs, BEMS approved defensive EMS driver training, equipment familiarization, proficiency training/testing/certification.
 - d. Equipment, to include:
 - i. Ambulances
 - ii. Defibrillators
 - iii. Ventilators and airway equipment
 - iv. Patient monitoring equipment
 - v. Spinal/orthopedic immobilization devices
 - vi. Suction units
 - vii. Stretchers/wheeled cot
 - viii. Communications equipment, including mobile/portable radios and repeaters, laptop computers/mobile data terminals, GPS units, cellular telephones, satellite radios
 - ix. Generators for base station back-up capability
 - x. Safety equipment, including reflective clothing
 - e. Commodities associated with the operation of the EMS service, i.e., fuel, oil, maintenance, district fees, utilities, etc. Commodities charged to patients cannot be purchased with TCTF funds.
 - f. Capital investments directed related to providing service, i.e., expansion/conversion of existing stations, construction of new stations, etc.

TCTF funds that are not expended by the end of the semester following the distribution must be returned to MSDH for return to the TCTF. Example: If the TCTF distribution is made to the Regions between the months of January through June (calendar quarters 1 and 2), it must be expended by the Trauma Centers and EMS providers by December 31 (end of calendar quarter 4). If the TCTF distribution is made to the Regions between the months of July through December (calendar quarters 3 and 4), it must be expended by the Trauma Centers and EMS providers by June 30 (end of calendar quarter 2).

Expenditure of TCTF payments may be escrowed for up to three (3) years to accumulate sufficient funds to purchase equipment or capital investments. (Note: All escrowed funds must be in an interest bearing account; any interest must be expended in accordance with TCTF guidelines.) Extensions beyond three (3) years must be approved by the Region. Facilities and/or EMS providers desiring to escrow expenditure must present a purchase plan to the Region no later than

one (1) month prior to the time limit on expenditure, i.e., November 30 or May 31, as described above.