

State Flex Program EMS/Trauma Activities and Integration of Critical Access Hospitals into Trauma Systems

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“Small rural hospitals will always be part of a trauma system by default. But without expectation about their capacities, the system has a great opportunity to fail.” -- State Flex Coordinator

Introduction

Rural residents are twice as likely to die of traumatic injuries as urban residents. Nearly 60% of all trauma deaths occur in rural areas, including approximately two-thirds of all fatal motor vehicle accidents. Thus, organized trauma systems are critical for reducing mortality and morbidity rates in rural areas.¹⁻² Integration of community-based Critical Access Hospitals (CAHs) and emergency medical services (EMS) providers into regional trauma systems is of paramount importance in order to reduce rural disparities in access to trauma care services.¹ However, multiple challenges must be overcome before trauma care systems that include rural areas and CAHs become the norm. This project gathered qualitative and quantitative data to provide an updated portrait of EMS and trauma-related activities in 45 states, with particular focus on designation of CAHs as trauma centers.

Approach

Information on state EMS/trauma activities supported by the 2008-2009 Flex grant was collected in telephone interviews with state Flex Coordinators, State Office of Rural Health (SORH) Directors, and related EMS stakeholders (e.g., CAH trauma coordinators and State Bureau of EMS staff). Data were collected in two phases: 1) telephone interviews with SORH representatives about state Flex Program efforts and state trauma delivery systems (March-April 2009); and 2) interviews with project personnel engaged in activities targeting system development, center designation, and/or trauma team training (June-August 2009).

Key Findings

- Almost two-thirds (62%) of all Flex grantees included at least one trauma-related activity in their 2008-2009 State Flex grant workplans.
- Trauma team training was the most frequently funded workplan activity.
- More than one-third of all Critical Access Hospitals have been designated as trauma centers.
- Education of state agencies, Level I and II trauma centers, and other EMS and trauma stakeholders about the potential role of CAHs and other small rural hospitals is a vital component for successfully integrating CAHs into state trauma care systems.

Results

Many states are working to improve trauma care in rural areas. Almost two-thirds (62%) of all Flex grantees included at least one trauma-related activity in their 2008-2009 State Flex grant workplans. Twenty-four out of the 28 states with trauma-related objectives targeted two or more trauma area objectives, and many states targeted all three trauma area objectives. Those data undercount rural trauma activity, because ten of the states that did not include trauma-related objectives in their 2008-2009 work plans were currently engaged in trauma activities (largely as a carryover from previous year's efforts). Trauma team training was the most frequently funded workplan activity.

More than one-third of all Critical Access Hospitals in the U.S. have been designated as trauma centers. The project team identified a combined total of 560 CAHs designated as trauma centers. (The full report includes state-specific data.)

Conclusions

The results of this study document heightened activity related to designating CAHs as trauma centers. Several states reported that participating in the Flex Grant Program was a key to getting CAHs involved. Norms are changing in some states: Respondents told us that, as more facilities obtained designation status, the remaining facilities found themselves left out of the process and some sought designation to be part of the larger state group again.

However, significant barriers remain. In particular, lack of funding, lack of national standards³ (at present there are no national standards for trauma center designation, system planning, or trauma team training) and lack of available Level IV and V designation in many states all hamper progress toward trauma care systems that serve rural areas effectively.

Respondents emphasized the need to build on existing efforts. They also recommended using trauma registry data as a valuable educational tool. Registry data can convince rural hospitals of the need to improve their trauma care abilities. Equally important, registry data also helps educate state-level policy and program personnel about continuing disparities in rural trauma care and the need to work toward integrated, coordinated systems in which all parties have designated roles to play.

Endnotes

1. National Highway Traffic Safety Administration (NHTSA). *Trauma System Agenda for the Future*. Washington, DC: NHTSA; 2002.
2. Helseth C. Preventing Injuries and Fatalities in Rural Areas. *Rural Monitor*. 2007, Fall (online). <http://www.raconline.org/newsletter/web/fall07.php>
3. Rural Assistance Center. Trauma Frequently Asked Questions. [online].; 2009. http://www.raconline.org/info_guides/trauma/faq.php#have. Accessed August 2009.

This Policy Brief is based on Flex Monitoring Team Briefing Paper No. 27 by Walter Gregg, Nicholas Jennings and Christopher Dickerson, available at www.flexmonitoring.org.

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