GEORGIA TRAUMA COMMISSION

Georgia Trauma Commission Trauma System Metrics & Data Committee
Meeting Minutes
January 6, 2022
Microsoft Teams

COMMITTEE MEMBERS PRESENT	COMMITTEE MEMBERS ABSENT
James Dunne	Courtney Terwilliger
Marie Probst	
Renne Morgan	
Kelli Vaughn	
Danlin Luo	
David Newton	
Gina Soloman	
Tracy Johns	

OTHERS PRESENT	Representing
Elizabeth V. Atkins	Georgia Trauma Commission
Gabriela Saye	Georgia Trauma Commission
Cassie Longhart	Office of EMS and Trauma
Kelly Joiner	Office of EMS and Trauma

Agenda Overview *Discussion led by: Liz Atkins*

L. Atkins reviewed the agenda for the meeting. David Newton will present the armband update, and Marie Probst will review the recent data pull.

Armband Project Update *Discussion led by: David Newton*

Supply Chain

The vendor is having supply chain issues, and the first order should be delivered by February. J. Dunne asked for clarification if the delivery date is firm for February. D. Newton answered that February was the last date given by the vendor.

Funding

There is an unforeseen funding issue; the armbands are funded by a grant provided by the Governor's Office of Highway Safety, a part of the federal grant from the National Highway Transportation Safety

Administration (NITSA). NITSA has recently disclosed we can only give agencies armbands specifically for trauma-related vehicle crashes and no other trauma-related injuries. 350,000 armbands were ordered and delivered for the pilot in region 10. We don't have the funding to purchase the armbands past the pilot phase. We hope that part of our Commission allocation could be increased to buy the additional armbands for our agencies.

L. Atkins asked if we can give the armband to everyone in the pilot phase. D. Newton answered we can distribute it to everyone for the pilot. However, continuing with future orders, funding is only available to support armbands for vehicle crashes; if we look at the EMS data, about 24.14 % of calls will get an armband. The system of care armband was intended for all trauma patients. If we don't have additional funding, we could give agencies armbands based on the average amount of crashes they run. Then the agencies would have to purchase anything additional for other trauma-related injuries.L. Atkins asked if there was other funding available such as emergency preparedness or federal funding. D. Newton answered, not right now.

D. Dunne stated we would have to wait until we get the first order for deployment. We have a host of other issues to iron out once those arrive.

Training and Preparation

D. Newton mentioned we are holding off training until we have the armbands in hand to show people how to use them.

Some suggestions and concerns were discussed at length regarding the location of the armband number in the hospital's EHR:

- Have we figured out where the armband number would be recorded in the hospital EHR? T. Johns stated we need to start the process because it takes a long time to get something input into a hospital's EHR.
- J. Dunne suggested including it in the trauma flow sheet.
- T. Johns noted that they still rely on paper for trauma codes in her facility, and it's going to vary at every hospital.
- J. Dunne added there's still a problem linking hospitals without a trauma registry.
- D. Newton stated that the armband number would be located in the PCR. We need to think about how the armband process works with POV and walk-ins.
- How will the registrar get the armband number from the ER?
- T. Johns considered if the Central Electronic Data for healthcare exchange would have a field for the number.

Review Trauma Registry Data *Discussion led by: Marie Probst*

M. Probst shared the Trauma Registry Report, April- June 2021 (Attachment A). She mentioned the data is not as complete as we thought. We will continue to collaborate with the GCTE Registry Subcommittee members to complete the required data fields needed for this analysis.

Overall, there were not many changes in numbers compared to the previous report. M. Probst referenced page 1 and stated that everything seems stable with data requests, 1-3, and we want to

focus on data request 4 today.

M. Probst quickly reviewed the data requests 1-3 within the report. During the review of table 3B, page 6, Dr. Dunne asked what is an acceptable scene time: 30, 20, 15 minutes cut off? L. Atkins stated she spoke with Courtney about scene times; the target would be 20 minutes. Anything over 20 would need review, excluding delay due to extrication. D. Dunne asked for clarification for scene arrival terminology; is it when they show up at the scene or when they arrive at the patient? Do we have that data? D. Newton clarified that the data is currently arrival at patient; however, most states calculate actual on-scene time, not just at the patient time; it might behoove us to stick with that so that we can compare. In addition, other states like Florida use 20 minutes or less. We definitely want to bring this up with our Medical Directors for EMS agencies if we vary from that 20 minutes.

M. Probst continued to review data request 4. Due to the small sample size we are receiving, we will provide the registry subcommittee and GCTE with education on the required data elements that need to be completed. We will also offer them a sample report that they can run in their Report Writer. Depending on their volume, they will QA their data weekly or monthly. As a result, facilities will be able to clean up their data before sending it to the state and NTDB, which will help our analysis and improve patient care.

There was a robust discussion regarding the tables in 4D, pages 12-13. M. Probst mentioned that OEMST, GQIP, and GCTE highlight these times and encourage the facilities to make quick transfers and not hold the patients. J. Dunne added this is important information to get in front of the legislature. What I've seen from my trauma center is that the critical access hospitals are contacting the trauma center for transfer in an appropriate time frame, but they have no method to transport them in a quick time frame because they're waiting on on EMS or a central ambulance to transport.

L. Atkins added that even if we drill into these patients, we couldn't say it's a trend since the data only represents 16% of the transfers. COVID has magnified transport challenges, and patients have gone across state lines to receive care. Could we pilot having some sort of backup call ambulance? Currently, a 9-1-1 service responsible for inter-facility transfer will say that they can't transfer a sick patient because they have to cover the 9-1-1 zone. Many counties have mutual aid agreements with other entities that cover, but they only cover if they have a truck available too. We discussed this with Dr. Ashley, and he proposed that if a patient needs to get to me, maybe my service or somewhere in my area could dispatch a truck to cover while that extended transport will leave their area and come to us. There might not be simultaneous coverage, but there would be some level of it.

L. Atkins continued by stating that we have to focus on getting more data. We probably need to take this to important advisory committees like MSAC, MSDAC, GCTE, or TMD for review. J. Dunne agreed and stated we have a sample size problem, and we're trying to make decisions based on 15% of the entire data set. That's not ideal, but I would be surprised if the number significantly drops once we get that other 85%; this number feels right as the median time.

J. Dunne asked if we can get visualization from the data to figure out additional details such as time of acceptance or waiting for transport? M. Probst stated we couldn't pull those little details out; those are not fields in the trauma registry. G Solomon mentioned she put together a pilot PI sheet for transfers out because there are so many pieces that you're not gleaning from the trauma registry. We can't see the back story, such as weather was bad or no ground transport available; maybe if we can

find a way to standardize, we can identify barriers when we have these prolonged times.

M. Probst added several years ago, our OEMST review included reasons for delayed transfers. We compiled that review into graphs and presented it to GCTE and the Commission. The same reasons for the delays are the same reasons we have today. COVID has compounded the delay reasons. J. Dunne asked to send the graphs to the group for reference (Attachment B). He stated once the patient arrives at the initial hospital, there are three-time delays: delay to get an acceptance of a transfer, time for the rig to show up, and then the travel time from point a to point b.

M. Probst re-emphasized a possible solution for obtaining more data would be outreach and education to the GCTE registry subcommittee. We need clean and complete data. We need to identify barriers to the registrar or the trauma program manager with obtaining the required fields. J. Dunne asked the timeframe for the outreach to GCTE and when we can anticipate date improvement. M. Probst stated right now, we're waiting for ESO to give all of the v5 users the capability to download to our new central site. We will give the facilities this time to reevaluate the July through September data that they have not downloaded to us yet. We're rolling out the data dictionary and introducing the QA report to run in their registry. The data comes to the central site 90 days in arear so we can start looking in the summer at the data to see if it has improved. Realistically, the fall of this when Danlin runs the analysis on the new data that comes in, I'm hoping that we'll be able to see the difference.

L. Atkins asked if we needed to meet again before the Commission meeting? We won't have another data set. J. Dunne stated he would love to present this data at the Commission Meeting. R. Morgan said she's sure they can get something together and talk with D. Newton about it. L. Atkins added that maybe we could include Marie's notes along with the tables to present.

The next meeting is anticipated for early April, pending Dr. Dunne's schedule.

Minutes by G. Saye