Georgia Trauma Commission

GEORGIA TRAUMA CARE NETWORK COMMISSION

"Right patient, Right hospital, Right time, Right means"

Trauma Medical Directors Conference Call: 19 November 2012

Attending:

Dr. Dennis Ashley, Trauma Commission and MCCG
Dr. Mark Gravlee, North Fulton
Dr. Mark Benak, Clearview
Dr. John Bleacher, Scottish Rite/ Egleston
Dr. Paul Parker, Egleston
Dr. John Cascone, Archbold
Dr. Gage Ochsner, Memorial
Dr. Scott Hannay, Columbus
Dr. Vince Culpepper, Taylor
Dr. Fred Mullins, Still Burn Center
Dr. Colville Fernando, MCG
Dr. Clarence McKemie, Rome
Dr. Jeffrey Nicholas, Grady
Dr. Paul Parker, CHOA
Ms. Kim Brown, Hamilton
Dr. Regina Medeiros, MCG
Dr. Chris Dente, Grady
Dr. Priscilla Strom, Gainesville
Ms. Karen Lowther, Lower Oconee
Dr. Brian Siddall, Lower Oconee
Ms. Brandy Holton, Phoebe Putney
Ms. Shanna Stubbs, Morgan Memorial
Dr. Dennis Spencer, Morgan Memorial
Ms. Kathy Sego, Athens Regional
Dr. Vernon Henderson, Atlanta Medical
Dr. Barry Renz, Kennestone
Ms. Laura Garlow, Kennestone
Ms. Jo Roland, Archbold
Dr. Jill Mabley, OEMS/T & EMSMDAC
Mr. Courtney Terwilliger, EMSAC
Ms. Bambi Bruce, Clearview
Mr. James Sargent, North Fulton
Mr. John Cannady, Trauma Commission staff

Meeting Began: 4:03 PM

Meeting Notes:

Dr. Dennis Ashley welcomed everyone to the meeting.

TRAUMA COMMISSION UPDATE

Dr. Ashley reported regarding the recent Trauma Commission meeting advising that the projected funds from the Super Speeder were greater than anticipated, and Mr. Jim Pettyjohn is working to ensure that these funds are included in the Commission budget.

The Commission further examined the possibility of forming a Trauma Foundation under Senate Bill 60. This foundation will have the ability to enter into the private sector for the purpose of raising funds for research and education. There is currently a subcommittee that has been formed to create this foundation, and the Commission has voted to move forward with this.

TRAUMA COMMUNICATIONS CENTER UPDATE

Dr. Ashley asked Mr. John Cannady to give the update for the TCC.

Mr. John Cannady reports that since the last meeting the TCC has handled a total of 616 calls, 568 of which met the trauma entry criteria. 592 of those calls received were from EMS providers, 44 were inter-facility transfers. Regions 5 and 6 as a part of the Pilot received the most calls, 452 calls came from Region 5 and 72 from Region 6. The TCC became available to all Regions beginning July, 2012; since this time the numbers have increased in Region 4, and as of this date the only Regions that have not participated are Regions 1 and 2. 478 of the patients have been transported to a level 1 trauma center. The TCC would like to see an increase in the inter-facility transfers. Mr. Pettyjohn has supplied a Participation Agreement to be signed once everyone has a chance to review.

HOSPITAL PARTICIPATION AGREEMENT - OPEN DISCUSSION

Dr. Ashley advised that this document has been emailed to everyone, and welcomed questions regarding its contents.

Question 1:

Page 7 No. 11 Indemnification – Does this indemnifying the Trauma Communications Center against any mistakes, thus making the hospitals responsible for any type of errors made by the Trauma Communications Center?

Dr. Ashley responded that he did not believe that was what it meant to say, but that this question has arisen previously and will need to be further clarified with the Attorney General's office.

Question 2:

Page 4 No. 2, D – "Acknowledge and except incoming qualifying trauma system patients", Does this mean 'accept' as in 'accepting transfer' or just clicking accept on the RAD screen?

Mr. Cannady responded that the intended purpose of this was for the receiving trauma center to accept the incoming patient when they show through the RAD that they are available and when the patient meets TSEC criteria. Recommendations to for a destination trauma center are based on the trauma center's self-reported availability, the location of the patient and the qualification of that patient as having met TSEC criteria.

Question 3:

Does the patient still have the right of refusal if they should choose to go somewhere else?

Dr. Ashley responded that the state law takes precedence, in the ambulance the patient can choose where they want to go if they are alert enough to make the decision. Mr. Cannady added that the TCC does not direct patient destination, but provides a recommendation. The medic is responsible for the final transport decision and patient request goes into that decision. Dr. Ashley continued by stating that we have reached a point where we have a communication network among trauma centers, where hospitals have the ability to log onto the TCC system and verify that a hospital is available for receiving a patient who meets the CDC criteria. By signing this agreement, you agree, that in the event you receive a call from the TCC regarding the transfer of a trauma patient you will accept this patient. Each hospital displays its own availability as indicated by the green readiness alert on the RAD, which is updated every eight hours.

Question 4:

Could we add a statement to clarify that this is according to regional guidelines?

Dr. Ashley agreed, and Mr. Cannady advised he would make a note of this.

Question 5:

Clarifying; this is a voluntary agreement which states that if our hospital is contacted by the TCC and asked to take a patient, and we were open, we would agree to do this?

Dr. Ashley responded that this was correct. If the TCC calls the hospital, the hospital agrees to accept the patient. Dr. Ashley further explained that if the hospital calls another hospital directly they risk not knowing who is on diversion; whereas they can call the TCC and they will know who is on diversion and can contact the receiving hospital. What is being asked is that the receiving hospital agrees to take the patient when contacted by the TCC.

Question 6:

Since patient acceptance may be mandated by EMTALA, does this make this portion of the agreement superfluous?

Dr. Ashley responded that was not sure on this, but did not believe so since the TCC is not a hospital; however this will need to be taken to legal counsel to be answered accurately. Mr. Cannady advised he would make a note of this.

Question 7:

Page 4, Compliancy with HIPAA/Patient Injury Information & Disposition – Is there a time frame in which that would be expected, such as an annual or monthly report?

Mr. Cannady responded, indicating the current patient report screen is undergoing changes that would provide fields on the hospitals screen to return the information back to the TCC. There is no time frame indicating when this will be complete.

Question 8:

What type of patient injury information is being collected and what is the purpose of sending the information to the TCC if it is already available in the registry?

Mr. Cannady responded that this is for basic injury information upon examination. For example, EMS will first report their initial assessment, the hospital would then provide follow up information with a potential ISS score. Currently the TCC has no access to the registry; one of the future performance measures of the TCC is the decrease in time by ISS scores for patients reaching trauma centers.

Dr. Henderson commented in support of the agreement, stating that this a big step forward and is how a trauma system should work. Many small hospitals that do not have trauma centers in their area often have problems finding trauma care in their area, and this idea will help formalize this and provide regional trauma care at every level.

Question 9:

Regarding inter-facility transport procedure with TCC – If our hospital chooses to sign this document, how will this impact current relationships that are already in place?

Mr. Cannady replied that this agreement is intended for the designated trauma centers, there will be a separate agreement in the future for those hospitals which are not designated but are participating with their regional plans. Concerning pre-established relationships that the hospitals already have in place, it is not the TCC's goal to eliminate those associations; but it is the goal of the TCC to assist hospitals who may not have those relationships established to allow them to be able to find a trauma center, and reduce the time that that it takes to do so.

Dr. Ashley inquired as to whether or not there were any further questions, and thanked everyone for their comments.

ACS COT UPDATE

Dr. Dente reported that the Region 4 COT paper competition was last weekend, and was well represented; the winning paper came from Tennessee. The first set of TQIP reports have been received, and a TQIP Subcommittee conference call has been scheduled for next week. The reports have been briefed but have not yet received a detailed analysis. This will be reviewed over the winter, and possibly ready for presentation by spring or summer. Another project for the next year, will be to create some infrastructure within the committee; creating a subcommittee or committee infrastructure for the COT, and possibly bylaws.

Dr. Ashley commented that this was great work, and requested that Dr. Dente consider a COT Research Committee. Dr. Dente responded that this would be included on the Committee infrastructure.

Discussion ensued regarding the type of data that is collected and specific data for Georgia, as well as implementing the $10 fee, that was viewed as a tax previously, brought back as a voluntary donation. Further discussion included how the data is collected and what it is being used for.

NEW BUSINESS

A new document for OEMS/T was submitted by email for each of the Medical Directors to review. Discussion ensued regarding which items were added back to the report, and which items needed to be removed. Concerns arose regarding the amount of data that was added back that had been previously been removed, the amount of time that it take to gather this data, and that the data elements should be more streamlined and eliminate those things which do not apply to trauma patients. Dr. Ashley reminded

the Medical Directors that this did not need to be voted on today, but that the Doctors should review the document.

Suggestions arose regarding the formation of a new document, as well as the possibility of EMS gathering those elements which pertain to pre-hospital elements of the data.

The question arose regarding the decision for the cut of trauma registry of a 24 or 48 hour cut off. Dr. Ochsner advised that the subcommittee recommended to the Trauma Commission that anything over 23 hours to be considered trauma. Dr. Ashley advised that the actual hours did not come up but the data set was voted on and approved, but it was not specific to the time. Dr. Ochsner ascertained if the Trauma Directors had a consensus, and Dr. Ashley agreed they should decide.

The question was presented to the Medical Directors, In Georgia you are not considered a trauma patient if you are discharged in less than 48 hours, and are not included in the registry. Many of those patients have significant injuries but because they are discharged they are not considered a trauma patient. This is unique to Georgia, as many other states use a 24 hour cut off. Therefore it is recommended that the changes be made to include patients who are discharged at 23 hours. 23 hours and 1 minute will be considered a trauma registry patient. All members agreed.

Dr. Ashley adjourned the meeting at 5:14 PM.

Meeting Notes Crafted By Tammy Smith