Georgia Trauma Commission
GEORGIA TRAUMA CARE NETWORK COMMISSION

Trauma Medical Directors Conference Call: 21 November 2011

Attending:

Dr. Dennis Ashley, Trauma Commisison and MCCG
Dr. Colville Fernando, MCG
Dr. Vince Culpepper, Taylor Regional
Ms. Karen Lowther, Lower Oconee
Mr. Kyle Wilcher, Lower Oconee
Mr. Jim Pettyjohn, Trauma Commission, Director
Ms. Lauren Noethen, Trauma Commision, Office Coordinator
Dr. Vernon Henderson, AMC
Dr. Grace S. Rozycki, Grady
Dr. Chris Dente, GA COT Chair, Grady
Mr. Chad Taylor, Floyd Medical Center
Dr. Tom Hawk, Athens Regional
Dr. Romeo Massoud, Gwinnett
Ms. Jo Roland, Archbold
Dr. Priscilla Strom, Gainesville
Dr. Gage Ochsner, Memorial
Dr. Barry Renz, Kennestone
Dr. John Bleacher, Scottish Rite/Egleston
Mr. Nick Khurana, Morgan Memorial
Dr. Scott Hannay, Columbus Regional
Dr. Paul Brock, Floyd Medical Center

Dr. Dennis Ashley call the meeting to order at 4:05

Trauma Commission Report Dr. Dennis Ashley

Dr. Ashley states that at the Trauma Commission meeting last week two new members were seated, Dr. Fred Mullins from the Burn Center in Augusta, and Dr. Robert Cowles from the Oconee area. Ms. Kelli Vaughn, and Mr. Rich Bias have rotated off. Dr. Ashley states that all the rotating has been completed, as far as the Commission. Ms. Elaine Frantz took Dr. Joe Sam Robinson's place at the Commission meeting in August.

We heard reports from Region 5, which is the Macon region. They have developed their Regional Trauma Advisory Committee, and their regional plan along with Region 6. Region 9 has also started to meet. Dr. Ashley states that about a month ago Mr. Jim Pettyjohn, and he were invited up to Region 1, which is in the Rome Georgia area. They presented regionalization to them and they decided to form an ARTAC and are starting down that path as well. Dr. Ashley has also heard some encouraging reports from Dr. Jeff Salomone, and Dr. John Harvey.
They already have a Regional Trauma Advisory Committee, but there is discussion and interest in joining the system as well.

Trauma Communications Center update Mr. Jim Pettyjohn

Mr. Jim Pettyjohn states that we have hired our Trauma Communications Center Coordinator, Mr. John Cannady. We now have a full contingent of staff working at GPTSC where the TCC building is located. The software, and hardware is installed, and the staff that is currently in place is testing that software. Were are purchasing for, or reimbursing for computers and monitors that are being placed in the hospitals that are in EMS Region 5, and 6, as well all the trauma centers around the state that are participating with the TCC pilot project. These computers, and monitors will act as their resource availability display, and communicate with the TCC. Mr. John Cannady told Mr. Pettyjohn that as of today seven of the nineteen trauma centers are trained on how to use the system. The TCC go-live-date will probably be the first week in December 2011.

Question: What is the name of this system?

Answer: The name of the system is Paratus, which is a software system developed by SAAB. This is an enhancement of a system that they have already had in place in Sweden for many years. It has proven to be quite helpful in making recommendations based on time, travel and distance to trauma centers from EMS units in the field. When an EMS unit calls in they give their call numbers, and if they have one of the AVLS devices in their units they will be able to put in their unit number and be able to find their exact location with longitude and latitude. They will enter that into the system, and based on the triage using basically the CDC triage criteria they will come up with a recommendation of the closest level appropriate trauma center for that injury consolation of the patient.

Question: And we have that in 19 centers already?

Answer: We are going to have the resource availability in all the designated trauma centers, and in 23 hospitals that are not trauma centers, in EMS region 5&6, and when region 9 comes on board we will be working to put it in their community hospitals as well.

Dr. Ashley states that it is real important for all the Medical Directors to know that the TCC is not a dispatch center. However you get an ambulance to the scene in your region is what you would continue to do, whatever your 911 protocols are. It is after you are at the scene and you think you have a really bad patient based on the CDC criteria, you can call the TCC. The plan for the region will come up on the screen, and the TCC agent can make a suggestion in real time to the paramedic. This will empower the paramedic and give him information right at the scene of the accident, as to what might be best for the patient based on that regions plan.

Mr. Pettyjohn states that he will be sending them Mr. John Cannady's PowerPoint presentation that was presented at the last Trauma Commission meeting. This presentation will further explain the purpose of the TCC and how it will work.

TQIP update Dr. Gage Ochsner

Dr. Gage Ochsner states that he just got back from the annual TQIP meeting in Chicago. Dr. Ochsner felt that the meeting was very productive. They had the 2010 data, and analyzed it. We should all be getting reports with our individual numbers, those of us that contributed 2010 data. You can then look at it and see how you plot yourself on the so-called caterpillar grafts of the observed expected ratios that they publish. Dr. Ochsner felt that even more fascinating was the TQIP online, where you as the Medical Director, your registrar, and nurse program manager can go online and access your patients, and you can look at them. One of the things you can pull up that they publish is the probability of survival. They are also going to open up other options so you can look at things and compare.

There is a lot of pediatric data out there but it is not really risk adjusted, and so this year they are going to start collecting data from the freestanding pediatric trauma centers. They are going to try to come up with enough data to do some analysis for the 2012 annual meeting. Those of us with additional qualifications at some point in the future should be able to contribute to that, and make a robust risk adjusted database that we can all look at, and also look at within our state.

Dr. Ochsner states that the hardest part about this process is working with the registry. The registry is pretty big, one of the larger ones around, which means it takes much more time to complete it. Dr. Ochsner states that he would like to purpose a recommendation to form a subcommittee of which he would be a member, to take a look at the current registry points, and opportunities to decrease the overall volume.

Dr. Henderson, and Dr. Dente agreed to work with Dr. Ochsner on that proposal. Dr. Ochsner is going to start with asking his registrar what she thinks needs to be eliminated. Then they are going to review what is left and put together a proposal and email it to all the directors. Dr. Ochsner asks Dr. Ashley how to proceed with making this recommendation to the State Office of EMS and Trauma.

Dr. Ashley states that since there is NTVB, TQIP, State Office of Registry Data Points and what each of the individual centers do, that is four things. Dr. Ashley thinks it would be a great idea if Dr. Ochsner could look at what they are all doing, and then make some recommendations to guide with these four things. Dr. Ashley thinks that the state office would be willing to listen to us. Dr. Ashley does not think anything is written in stone, but everyone would have to look at it and agree on it.

Dr. Ochsner states one more thing to look at as far as what goes into TQIP; it is patients with an ISS score greater than nine. For instance last year we had a little over 1600-registry patients, but only 820 of those were put into the TQIP database, because we had almost 50% that were less ISS than 9. They do also include deaths, so you should not lose a death with less than 9. That is something important to look at that they are going to exclude anything that does not meet those perimeters.

Question: There are some centers that do not have a registrar, and he was wondering that if the Trauma Commission because they are supplying each one of these centers with the TQIP software, if a strong recommendation for a registrar would be inappropriate?

Answer: Dr. Ashley does not think it would be inappropriate, but he thought most hospitals had registrars.

Dr. Henderson states that they do not have one at AMC. They have trauma nurse coordinators but they spend their time abstracting the charts. They do not really have a person dedicated to putting the data in. They made the point that the person who puts the data in was directly related to the quality of data.

Dr. Ochsner states there are two parts, the abstracter and the one that enters it. They were recommending that for every 750 patients you need a registrar. So if have over 1500 you should have two registrars.

Question: Where do you see this going in a year or two from now?

Dr. Ochsner thinks that there are multiple opportunities. Number one is that he thinks that it is a great idea that the state is paying for it. We could get together and have an annual meeting of the program directors, sit down and look at, and analyze the data. This would allow us to see where there are opportunities to improve, affording us an honest look in a protected environment. Then we could run our own reports, and if we see areas of concern look at those areas. This will give us a much more reliable tool to use however we want to. Number two the online TQIP offers you an incredible opportunity to drill down into your own data and make some differences. You can download it to an Excel spreadsheet and look at everything. As the system matures and we have the centers we need, then you could look at regional data, as will as statewide, and individual.

Dr. Ochsner states that they had there first Regional Trauma Advisory Council meeting at the end of October, and it was wonderful. Dr. Ochsner states that they had representation from 18 hospitals, which included physicians, hospital administrators, nursing, and EMS. They went through the questionnaire, filled

it out and formed committees. Dr. Ochsner states that they are doing something different in their region, in that they will not be reporting to the EMS Council. It is his belief that everybody is equally important, so he thinks they should report to the Office of EMS & Trauma, and to the Georgia Trauma Commission. Dr. Ochsner also states that he did not know that you cannot be designated a trauma center unless the EMS Regional Counsel in your region recommends you.

Georgia Committee Trauma update Dr. Chris Dente

Dr. Chris Dente states that the COT is looking to hopefully being a big part in infrastructure to a lot of the things that were are talking about, so that we can discuss those things outside of the public domain. Dr. Dente states that his initial role again for 2011 was just to get people involved, and officially on the Committee. We sent out several letters, and two thirds of the medical directors are now official members of the COT. He is going to reach out next again to a couple of people who have not responded. Dr. Dente has the eventual goal of probably early 2013 making accommodations with one of the EMS educational meetings to have a face to face sit down session that could involve things like early evaluation of the state wide TQIP data. Basically he is working on increasing the infrastructure. Dr. Dente mentions he attended region 4 COT paper competition. There were a lot of good papers presented. Eric Long from Dennis's group placed 2nd in the basic science competition.

New Business

Dr. Ochsner states that Erlanger hospital up in Tennessee receives money from the state of Georgia to have air medical services at the town of Blueridge GA, and they get reimbursed, and last year their funds were appropriated and distributed and apparently they have been this year also to the tune of $600,000.

Dr. Ashley states that he heard about it, and that the Commission did not appropriate the money. It was outside the Commission. The Commission was not consulted, or asked if this would help build the system.

Mr. Pettyjohn states that Erlanger has agreed to share their trauma registry data for all patients with injuries originated in Georgia that they receive in transfer from the state. Also Erlanger has developed a long-term management contract with a local hospital up here in North Georgia, Hutchinson Memorial, that at one time was a level 3. They have asked that EMS Region 1which is here in north Georgia to allow Hutchinson Medical Center to come on as a Level 4, and they have agreed. Erlanger representatives said that they were hoping to bring that up to a level 3. They are also participating with the EMS Region 1 RTAC development activities as well.

Meeting adjourned 4:56

Minutes crafted by Lauren Noethen