Minutes of the Alabama Trauma System

QA/QI Workgroup Meeting
October 25, 2011, 10:00 a.m.
Office of EMS & Trauma (OEMST) Conference Room
Call in Information 1-800-491-4634

In attendance:	William Crawford, M.D., Choona Lang, Michael Minor, Jeremy White, Glenn Davis, Alex Franklin, E. Allan Pace, David Garmon, Robin Moore, Denise Louthain, Verla Thomas, Gary Mackey, Geni Smith, Mark Jackson
Absent:	Joe Acker

Choona Lang opened the meeting with a welcome.

Trauma System Update

Ms. Lang explained that the goal of the QA/QI Workgroup is to achieve consistency in the way the trauma system works. The trauma system is statewide and involves many agencies, so having consistency makes it easier to identify problems that may need to be addressed. The participation of hospitals in this voluntary system is extremely important so each region is given a chance to voice any concerns they may have with the operation of the trauma system. Region One is in the process of developing a comprehensive trauma system operations manual for the entities in that region that participate in the system in an effort to standardize operations and provide guidance on what each entity should do to maintain compliance with the system. This will assist the QA/QI Workgroup lay out an easy to reference process that in the future will assist each region in training their hospitals and pre hospitals on trauma system protocols.

Stroke System Update

The stroke planning committee is continuing to edit the Southeast Regional Pilot Acute Stroke System (SRPASS) plan to meet the needs of Region Five. Another planning meeting has been scheduled for November 7, 2011, and topics of discussion will be: one tier versus a multi-tier system, tPA administration, neurology coverage, telemedicine, and the *Get with the Guidelines* stroke QA program. Ms. Lang will keep the group updated as things progress.

QA/QI Issues and Trauma System Tasks Performed

Mr. Franklin in Region One is currently working on compiling the trauma system operations manual Ms. Lang mentioned in response to the need in his region for a comprehensive document that can be referenced to use for training entities in that region. He is including an overview of the trauma system goals, state law, and hopes to include forms, procedures, and regional responsibilities.

Mr. Franklin typically collects extensive data from LifeTrac and other sources such as: how one hospital compares to another on number of hours turned red due to resource availability, volume of patients, under-triage and the county it occurs in, inter-facility transfers, where transfers are coming from, demographics, entry system criteria, disposition, number of patients sent to ICU's, number of patients that expired in the ED, surgery, or in route, are pre hospitals filling out PCR's, etc. This information is entered into a spreadsheet as a back-up to LifeTrac to get more specific data that hospitals in his region are requesting. This data is compared to LifeTrac data to determine hospital compliance and ensure entry of data. He is currently collecting 100 percent of data for Huntsville Hospital. Unknowns without Alabama Trauma Communications Center (ATCC) numbers are scrutinized further to be sure that all trauma cases are entered and that there are no QI issues. These spreadsheets are then emailed to each hospital trauma coordinator and prehospital. The data has accumulated over time is easily searchable and each entry is checked against PCR's for accuracy. He has also created a log for recordings that is easily searchable and detailed information can be sent to the ATCC as needed. QI issues are handled separately. He makes visits to each trauma center to perform a computer check and determine any problems the center may be encountering. The main problems they are encountering are being sure the most current entry criteria are being utilized and all training is being completed.

Current QI problems are secondary triage and transfer times. He would like to see transfer time increased. Mr. Franklin is concerned about transfer times greater than 25 minutes for trauma patients who should have been airlifted but were not. Also, greater than ten minute on-scene times for trauma patients should be addressed.

Out-of-state doctors that come to work for a week at a time are often not familiar with the trauma system and protocols. It was suggested training for these doctors be included in the MOU's of each hospital in the form of providing them continuing education to be sure they have an understanding of trauma system processes and protocols. There are also out-of-state hospitals that are involved in the trauma system in some degree that need the same training.

Mr. Pace in Region Two is continuously monitoring QI issues and makes hospital and pre hospitals in this region are aware of all trauma system protocols and system entry criteria. He agrees that having a comprehensive source for trauma system guidelines and procedures would be convenient but does not think everyone involved would need that detailed information such as out-of-state hospitals that will simply be transferring.

Mr. Pace would like to see the resource display explain why a hospital has had to go to red. He also suggested some consistency on who in each trauma center is allowed to change the display since there are currently no specific guidelines or rules on this.

Michael Minor in Region Three currently collects data on reroutes when hospital resource displays turn red or are on trauma system or traumatic brain overload. This is mainly a level I problem and is reported to the RTAC. QI meetings are scheduled as-needed and there is no dedicated QI committee appointed at this time.

Mr. Minor feels that a few hospitals are requiring reports that no other region requires. He feels that the burden should be placed back on the hospital requesting the reports.

The ATCC send QI forms and recordings directly to the regional coordinators in raw form to give them the opportunity to decide which qualifies as a QI issue, which do not, and how they would like to proceed. QI's that involve a hospital automatically go to the STAC.

The ATCC is currently routing 20-30 patients every 12 hours. Hospitals needs outcome data at their workstations and can get it by reprinting the PCR immediately or pulling it after the next data push. PCR duplications are occurring because the communicator that enters the original report also enters the outcomes and there is a box that you must check so the report is not sent again. This problem will continue to occur because of the way the system is set up and basic human error. However, if the PCR is for a new patient the report will be followed by a phone call confirming this.

Mr. Minor gave a report on the LifeTrac upgrade that is correcting the 30-40 issues that have been identified. Please see attached list. The remaining corrections are being worked on. Also, Mr. Minor would like to see a move to the internet as another form of communication with LifeTrac. Workstations will need to be updated to the Windows Seven operating system and a dedicated internet line installed.

Mr. Davis in Region Four has not had any trouble getting the reports they need. He runs his reports every 12 hours and does not file call recordings anymore. If a QI issue is identified he requests the call recording in question. Under-triage at hospitals and pre hospitals is a problem because the patient is not entered into the system and often sent to the wrong level of hospital for care. Also, ATCC numbers are not being written on the PCR's by prehospital staff.

Vaughn Regional has still not decided what level they intend to operate at in the trauma system. Also, training needs to be done in Wilcox and Dallas counties for EMS providers now that they are back in Region Four.

Mr. Garmon in Region Six indicated that most hospitals are cooperative so there are few problems. The only concern he has is routing and nurses' understanding as to why patients are routed to other hospitals. The main problem in Region Six is between hospitals and doctors. Many administrators do not see their hospitals joining the trauma system in the near future.

Mr. Jeremy White listens to all call recordings and reads all reports and then files them by ATCC number and agency. PCR's are treated the same and emailed to the agency trauma coordinator and then followed-up on in two days. He handles QI issues by getting a written statement from the EMSP and the PCR, which he compares to the recording. If there is an issue he sends it to Mark Jackson in OEMST and then follows-up to be sure it is resolved.

Trauma Registry Update

Ms. Thomas indicated that the trauma registry is currently accepting requests for reports to be sure they are collecting the right data. There are many standard reports already available. However, the registry has low counts of ATCC patient numbers because they are not being entered, and some pre hospitals are simply not reporting the numbers. Eliminating this problem is important because if the ATCC patient number is not entered then patient outcomes cannot be tracked. Also, hospitals are having trouble getting ATCC numbers for transfers, which are sometimes not provided.

New Business

- What percentage of over-triage, under-triage, or EMT discretion in QI issues is acceptable? Ten percent to 40 percent of total QI issues? What is the benchmark? (ACS says 38 percent is acceptable.)
- The comprehensive trauma system operations manual that Region One is developing will be further considered for use by the trauma system.
- The new trauma designation rules go into effect October 26, 2011.

Next Meeting

The next meeting is to be determined at a later data.

Adjournment

The meeting was adjourned at 12:47 p.m.