Trauma Performance Improvement Committee Meeting
May 18, 2017
12:00 PM - 1:00 PM

Members Present:	Members Absent:	OEMS Staff:	Others:
Forrest Calland	Anne Mills	Dwight E. Crews	
Gary Critzer	Marilyn McLeod	Timothy Erskine	
John Hyslop	Emory Altizer		
	T. J. Novosel		
	Shawn Safford		
	Greg Stanford		
	Mike Aboutanos		
	Valeria Mitchell		
	Lou Ann Miller		

	Discussion	Recommendations, Action/Follow-up; Responsible Person
2016 TPIC Annual Report	Dwight gave an update with the 2016 Annual Report. Dwight made the changes from committee members from the last meeting. Then, the report was reviewed internally here at OEMS. Cam provided comments that the new trauma centers needed to be added to the maps. The report was updated and then sent to the Medical Direction Committee (MDC) with a deadline as 5/23/2017 for comments. After that date, the report will be considered final. Dwight will email the final report out to everyone after the deadline.	**Email Final Report to Committee. (Dwight)**
Quarterly Report	Dwight reported that he is working on compiling the data for the quarterly report. Target date for the 1st Qtr. 2017 report is 6/15/2017. The format for the report will be the same, but there will be trend data added to the report showing the data by quarter.	
Data Quality Report	Dwight stated that the report is done, but the shared report that would enable agencies to see their trauma records was not available. Issues have been corrected with the report as of today. Currently, the report is available and the shared report is now ready. Dwight reported that he will do some additional testing. But, the report should be able to send out before our next meeting on 6/1.	
Risk-Adjusted Mortality By Region	Forrest stated that we lack the ability to link the pre-hospital registry to the hospital registry. Linking the two systems would be the key to producing risk-adjusted outcomes by region. Dwight reported that we are making progress and working towards the goal of establishing the linkage. Forrest stated that we have trauma deserts in Virginia. Demonstrating that it is associated with an increased risk-adjusted mortality may be important to catalyzing system change.	

	Discussion	Recommendations, Action/Follow-up; Responsible Person
Risk-Adjusted Mortality By Center / TQIP Collaborative	Forrest reported that we will shortly have the ability to compare outcomes at the TQIP centers. Individual centers will have to sign an addendum to the operating agreement to participate in a Region III TQIP collaborative. Then, Forrest would theoretically have access to the data file and we can together look at the risk-adjusted outcomes with the Level I trauma centers and participating Level II centers. And, then we could have quarterly discussions on state protocols and why some trauma centers are out performing other centers.	
Hospital Access to Pre-Hospital Reports When Patient is Transferred	Gary Critzer brought up an issue from a recent meeting with UVA trauma associates. The issue was about access to the pre-hospital reports for patients that they are not initially brought to their hospital. For example, when a patient in the Valley goes to Augusta first and then they are transferred to UVA. Augusta has access to the pre-hospital report, but UVA does not have access. If Augusta doesn't download and send the report along with the patient, then UVA does not capture that information. Gary asked Dwight if the state system has the ability to give the trauma centers broader access to pre-hospital patient reports. Dwight reported that we do have hospital hub that lets hospitals see pre-hospital patient records. He would have to check with the state system coordinator to see if we could setup our system to allow the additional access. Forrest commented that this is a critical issue that has been present for a decade and is critical because we need the patient information from the scene. Tim Erskine commented that he views the issue as if he is setting up a trauma system. Technically, it is feasible. Practically, he didn't know. He commented that trauma centers need the report sooner than 5 days for the patient. Forrest stated that Level I and Level II trauma centers need access to pre-hospital records with all agencies that primarily transfers patients to them. Tim also mentioned that in Ohio they are looking at a unique identifier on a wrist band. For example, an agency shows up and sees that the patient has a traumatic injury. Agency puts a trauma wrist band on the patient with a number. They enter the number on their record. When the patient is taken to a non trauma center, the non trauma center documents the number. Then, when the patient is transferred to the trauma center, then the trauma center records the number as well. The number tracks the patients and creates linkage in the systems. Tim mentioned that the wrist bands are 0.15-0.20 cents each. Forrest mentioned that this could be the innovative solution that we need. You can track and link the patient from the pre-hospital system thru to the trauma system. Tim mentioned that he can look up the details with the study in Ohio. He mentioned that Oregon implemented the trauma wrist bands. Forrest recommended budgeting for the solution at OEMS. Tim stated that he can get the contact information for contacts in Oregon.	**Research Details with Ohio Study and Obtain Contacts in Oregon. (Tim)**
PUBLIC COMMENT	n/a	
UNFINISHED BUSINESS		
NEW BUSINESS		
Adjournment	1:00 PM	