Tuesday, March 13, 2018

PI Notes

Dr. Kauffmann

He introduced himself. He is taking over for Dr. Ollinger. He trained as an EM physician. He has worked on the north side for 17 years. He would like to move forward with data analysis now that EMS is on V3. He would like to think of solutions to transfer delays.

Dr. Savage

Data-
I went through new data

Transfer delay project-
Savage: how many districts are represented? All districts except 9.
Ramzi: I could send out another e-mail to get more hospitals in the pilot.
Katie: We are talking with ImageTrend to get a permanent solution for transfer delay options.
Dr. Kaufmann: Shortage of ground transport is the highest response. Can you parse that out?
Katie: Gave background on the purpose of the pilot

Quiz participation –
Pravy: They are on a new platform which will decrease participation until people become comfortable with it. I sent out a PPT on how to sign up and use the new platform. It is more user friendly but people have to sign up.

EMS run sheet collection –
Katie: We sent this to the EMS commission. Send this information to Murray.

Jenkins' project –
Jenkins: We have been working on this. He got feedback on the project and to incorporate patient co-morbidities for risk of mortality and risk of not being transferred. He will present the preliminary findings at NIH. **Make OPA aware**.

Statewide report –
Katie: Are there parts of the report that are value added? Are there parts that do not need to be part of the meeting (report on an annual basis)?
Dr. Savage: **Put things you want to move to the annual report at the top of the agenda.** We will get feedback and decide what to move.
Mary on west side: I didn't see the annual report to the Governor. Katie: **It was at the ISTCC meeting. I will send one to you.**

District: What are your transfer delays, what you are doing about them, PI initiative that you will work on and we can help you with

D1 – Regina Nuseibeh has been working with Rensselaer. We have identified that there are 5-7 calls to EMS before they find an ambulance to transfer. Sometimes they bypass the local areas and go straight to calling Indy. We are working on ED transfers in our facility.

D2 – No one was on.

D3 – No one was on.

D4 – Regina. We do have a transportation issue on our end and are drilling down on that. EMS comes to our TRAC and we have looked at this. We found that they don't have an ALS truck available when we need it and cannot fly out the patient. The number of patients doesn't justify getting another truck. We monitor this on a monthly basis.

D5 – Jill Castor. We don't have a large barrier on getting our patients out. Savage – what about delays to transfer in? Jill – that depends on what resources have coming in. Melissa Smith – I agree with Jill.

D6 – Michelle Moore. We have an ALS truck at Ball. They try to be here 24 hours. Our issue is transferring via ground. Mark Rohlfing – we had a TRAC meeting and EMS/ambulance folks were there. Critical care ground was there. We are trying to parse out which time chunks are giving us trouble. There is a challenge in pulling the trigger at the level III centers. As soon as the stable patients get in the CT scanner and we discover they are hurt/sick that ruins your transfer time. The patients that require critical care are the ones bumping up our time.
Savage – these are good discussions. I don't have a problem with patients that have no indication that they are severely injured taking longer, but the ones that are more obvious (tachycardic) that should have a shorter time.
Kaufmann – there are opportunities to improve this metric. Somebody mentioned encouraging EMS to participate in district discussions. This will help find solutions at the district level. Something we have been lacking for a while is quality improvement metrics for EMS. I want to bring this to the table on a consistent basis (maybe quarterly). How are EMS using the transfer guidelines? We want the trauma activation process to be activated early. We want EMS to be activated early. We want the physician providers to activate EMS early (could be before the patient gets to you). It could take an EMS provider an hour to get there. When people call for a truck, provide defined terminology. Don't say, "We need a truck." Provide information on how the patient is doing. Each area should have a preferred provider list. This way you are not scrambling to find what each service provides and what they phone numbers are. In the future, we should put in place a new air medical triage protocol. There could be more appropriate

utilization (we're not going for more utilization, but better). Lastly, for those that have BLS but not ALS resources. Use a hospital-based provider with BLS to fill that gap.

D7 – Amelia Shouse. Many of our delays are due to losing an ambulance service in town. The other are with EMS delays. Savage – have you looked at air medical? Amelia – we fly when we can. We have Lifeline and MediVac. We only want to use it when it is appropriate.

D8 – Lindsey Williams. We had our revamped D8 meeting at the end of February. There were 3 facilities represented. The physiologically unstable patients were not having delays. The other delays are due to having 2 trucks in the county. It's difficult to pull one truck out. The smaller facilities do not feel like they are having delays with unstable patients. Katie – these data are on what is in the registry; most of these data are from NTCs. Ramzi – if you import it will not go through because it is not required.

D9 – No one was on.

D10 - No one was on.

Savage – is there anything else where we can focus our efforts? No feedback.

Dr. Kaufmann – I wanted to offer assistance to districts if you are having transfer delay. We can see what resources are in your area to minimize delays.