

PI Subcommittee Meeting - Notes

September 11, 2018 – 10am EST to 11am EST

Call-in number: 1-877-422-1931, participant code is 2271383428# (music will be heard until the moderator joins the call)

a) Welcome & Introductions

Meeting Attendees			
Amanda Rardon-D4	Kelli Vannatter-D6	Dr. Michael Kaufmann- IDHS	
Amelia Shouse-D7	Kelly Blanton-D5	Michele Jolly-D10	
Andy VanZee-IHA	Kelly Mills-D7	Michelle Moore-D6	
Angela Cox-Booe-D5	Kristi Croddy-D5	Michelle Ritchey-D7	
Annette Chard-D3	Latasha Taylor-D1	Missy Hockaday-D5	
Bekah Dillon-D6	Lesley Lopossa-D8	Olivia Roloff-D7	
Brittanie Fell-D7	Lindsey Hill-	Dr. Peter Jenkins-IUH, D5	
Carrie Malone-D7	Lindsey Williams-D8	Regina Nuseibeh-D4	
Christy Claborn-D5	Lisa Hollister-D3	Rexene Slayton-D8	
Chuck Stein-D5	Lynne Bunch-D6	Sarah Hoepfner-D3	
Dawn Daniels-D5	Maria Thurston-D5	Shayla Karlowsky-D1	
Dusten Roe-D2	Marie Stewart-D10	Dr. Stephanie Savage (Chair)-IUH, D5	
Emily Grooms-D2	Mark Rohlfing-D6	Tammy Robinson-D7	
Jennifer Homan-D1	Mary Schober-D5	Tracy Spitzer-D5	
Jennifer Mullen-D1	Dr. Matt Vassy-D10	Wendy St. John-D5	
Jill Castor-D5	Melissa Smith-D5		
Jodi Hackworth-D5	Merry Addison-D7		
ISDH STAFF			
Camry Hess	Katie Hokanson	Ramzi Nimry	

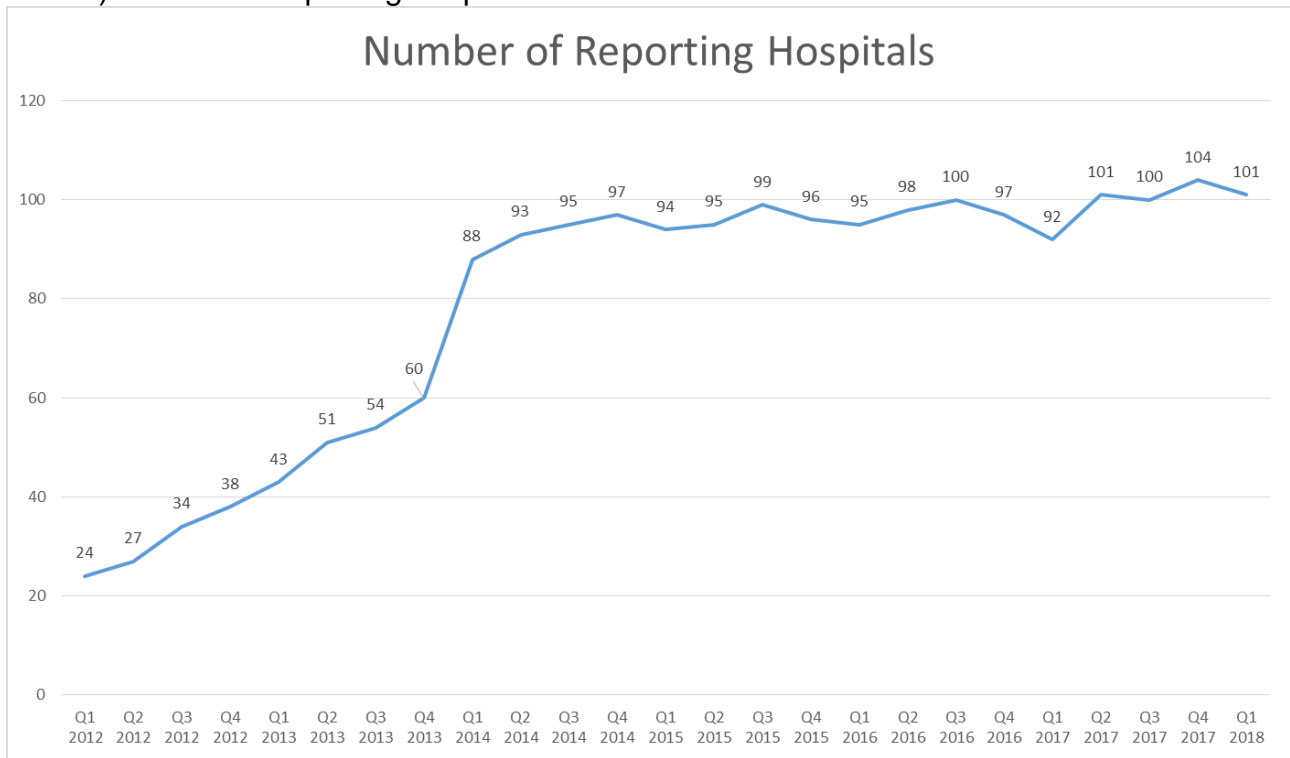
b) 2018 Goals

1. Increase the number of hospitals reporting to the Indiana trauma registry.
2. Decrease Average ED LOS.
 - i. Transfer Delay
 - Pilot Project
 - ii. Letter to hospitals about ED discharge date/time
3. Increasing Trauma Registry quiz participation.
4. Regional TRACs working to establish PI groups.
5. Continued EMS run sheet collection.
6. **ACTION:** We will work on CY 2019 calendar dates and the goals will be on the next agenda.

c) Statewide Trauma Report

1. Increase the number of hospitals reporting to the Indiana trauma registry

A) Number of reporting hospitals



B) Hospitals that did not report for Quarter 1 2018:

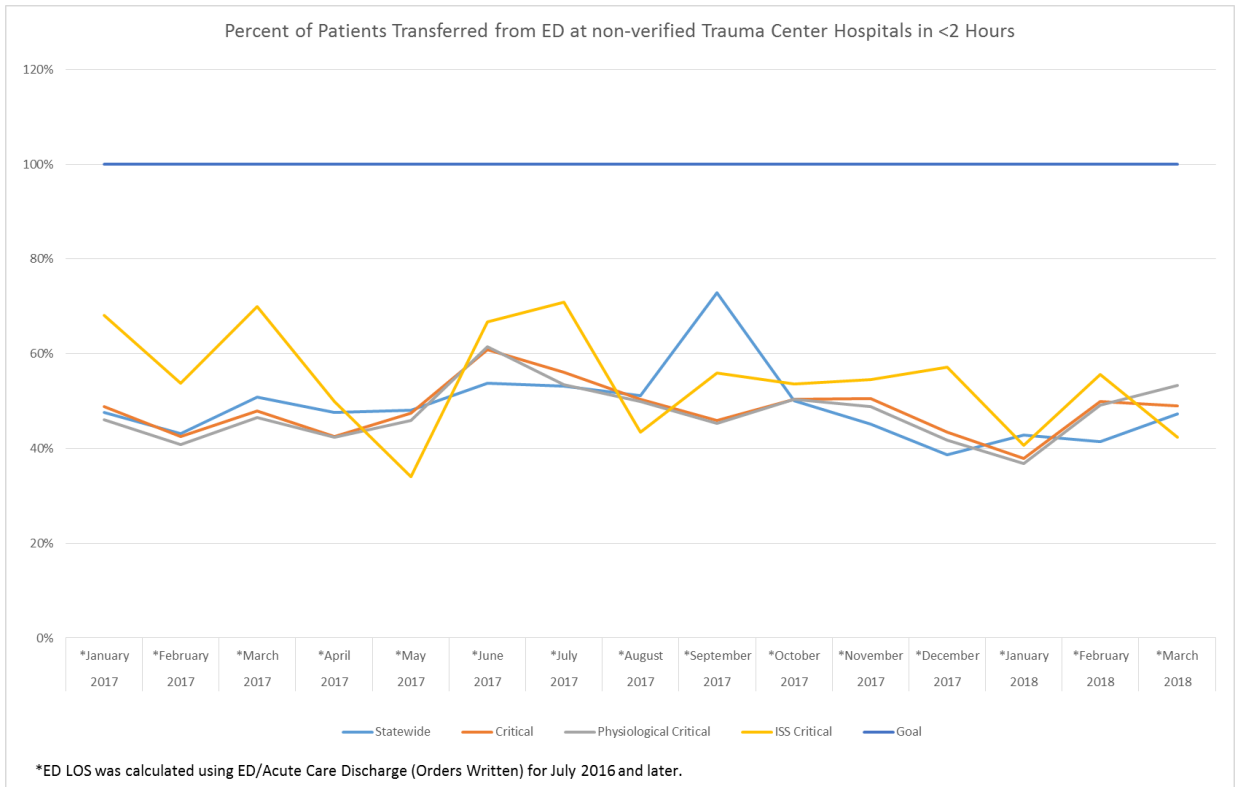
- Adams Memorial Hospital
- Decatur County Memorial
- Fayette Regional Health
- Franciscan Health Dyer
- Franciscan Health Hammond
- Franciscan Health Munster
- Goshen Hospital
- Harrison County Hospital
- IU Health – Starke
- Pulaski Memorial Hospital
- Riverview Health
- St Mary Medical Center – Hobart
- St Vincent – Carmel
- St Vincent – Fishers
- St Vincent – Randolph
- **ACTION:** District 5 hospitals have been reached out to and will report in the future. Franciscan Health Munster will report moving forward.

C) Who can reach out to non-reporting hospitals by district? What are the hospital's barriers to reporting?

2. Decrease average ED LOS at non-trauma centers

- i. Review of current average ED LOS

- Quarter 4 2017: 3 facilities responded so far (sent out letters to 17 facilities)
 - Quarter 1 2018: 2 facilities responded so far (sent out letter to 16 facilities)
 - **NOTE:** Low response is due to letters just being sent out.
- ii. ED LOS (Orders Written)



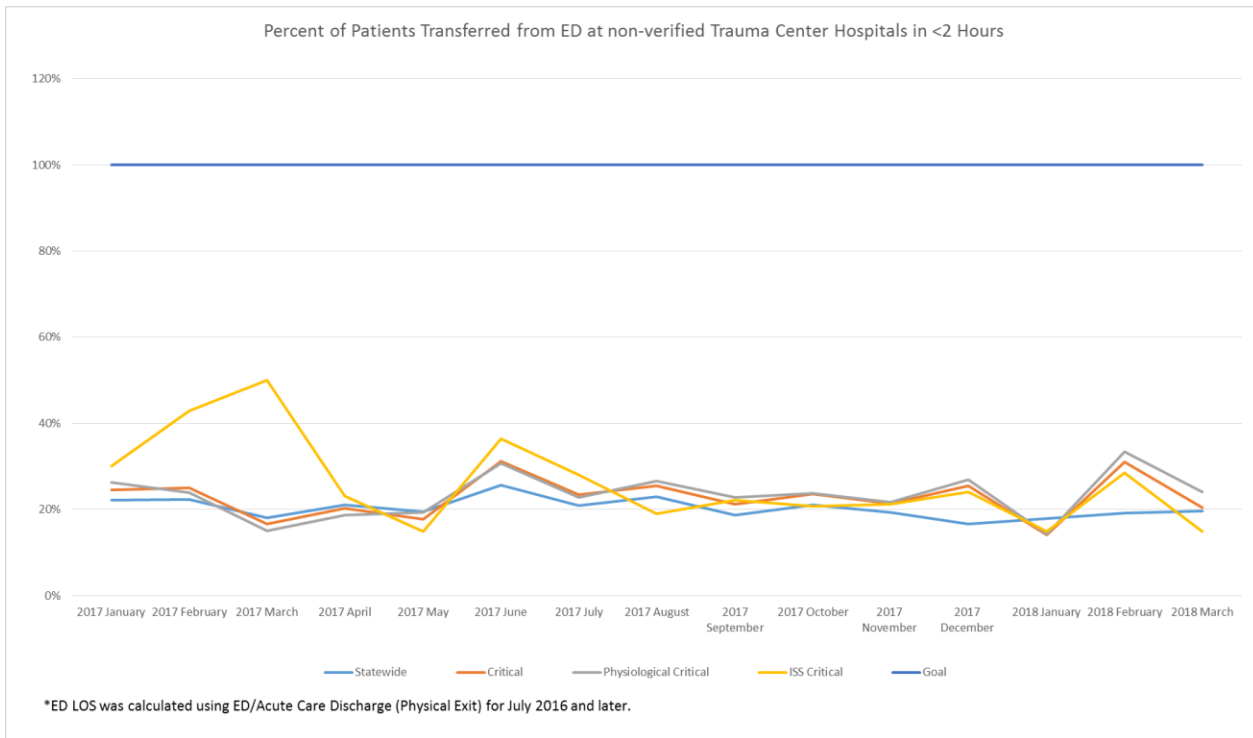
*****Definitions of critical categories*****

*Critical patient: had a GCS \leq 12 or shock index $>$ 0.9 or ISS $>$ 15

*Physiological critical patient: GCS \leq 12 or shock index $>$ 0.9

*ISS critical patient: ISS $>$ 15

iii. ED LOS (Physical Exit)



*****Definitions of critical categories*****

*Critical patient: had a GCS <= 12 or shock index > 0.9 or ISS > 15

*Physiological critical patient: GCS <= 12 or shock index > 0.9

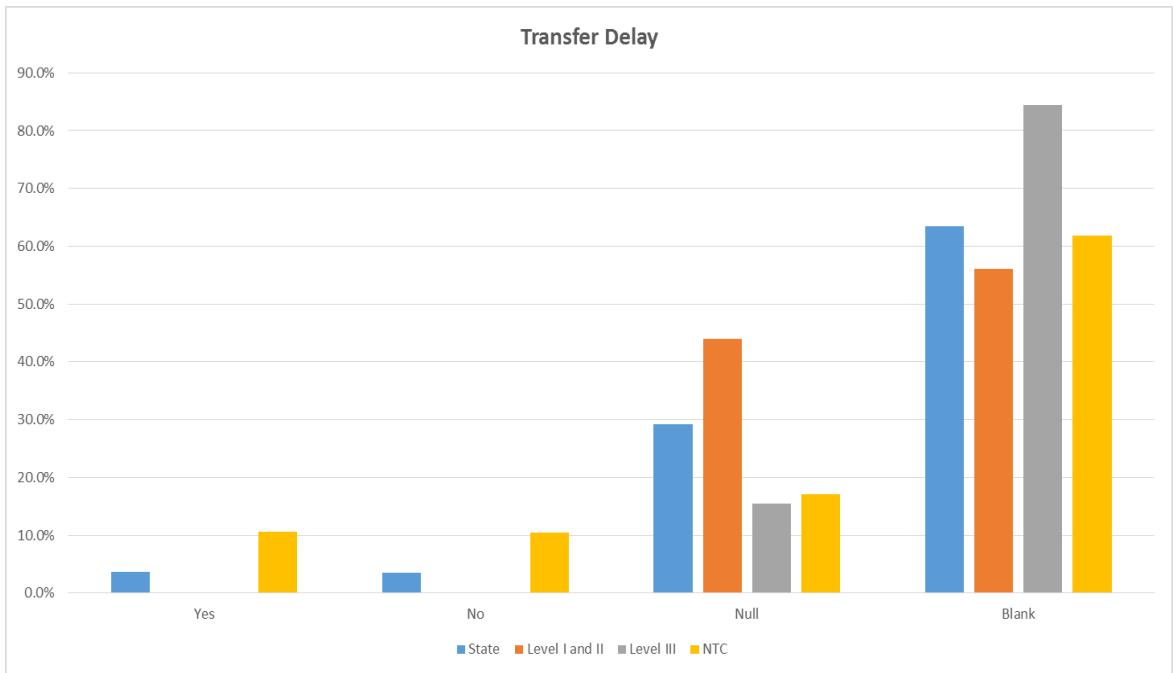
*ISS critical patient: ISS > 15

ED LOS Discussion – Capturing the reasons for transfer delay and addressing those reasons at the regional level will help lower ED LOS. Capturing the reason for the delay at the point of care is critical. The contract with ImageTrend was changed in summer 2018 to include the new reasons for delay. The user can put in multiple reasons. Lack of documentation is a barrier. What about having a standardized response sheet (paper copy) that can be sent back to the first hospital? **ACTION:** Develop a standardized form and send it out to hospitals. **ACTION:** Ramzi will send out the reasons for transfer delay to all the hospitals.

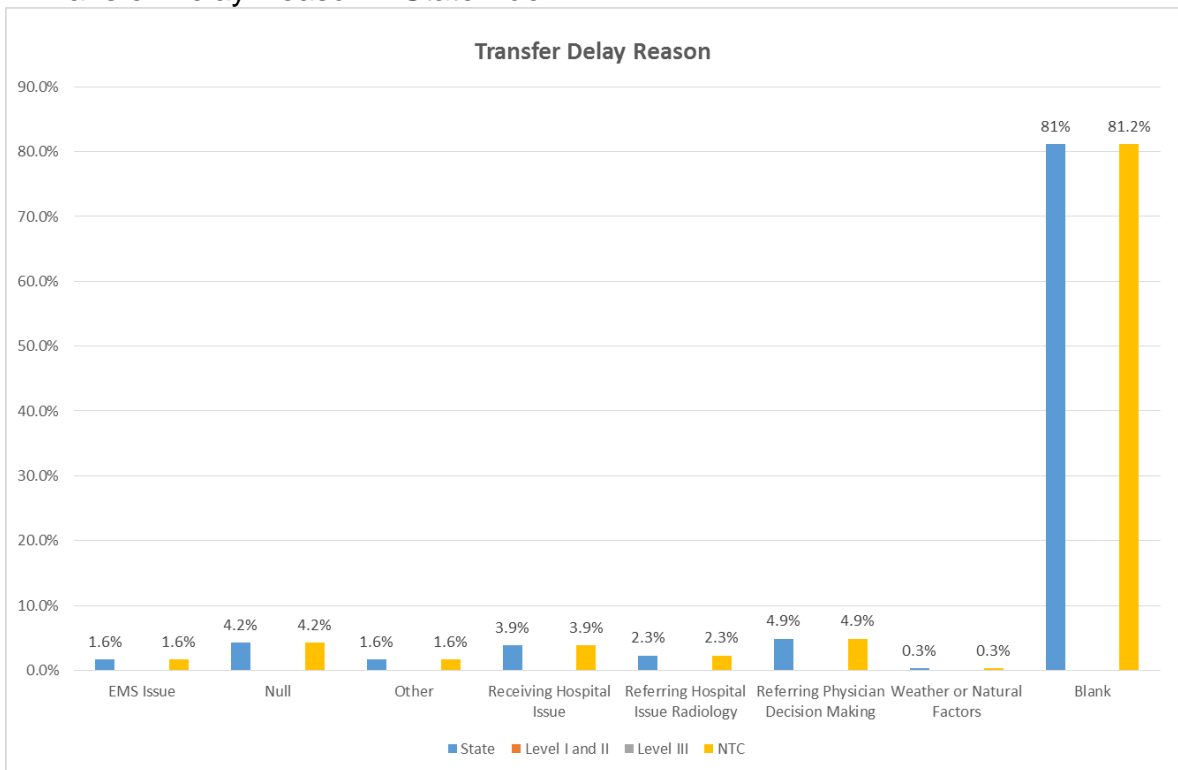
B) Transfer Delay Charts

i. Transfer Delay – statewide

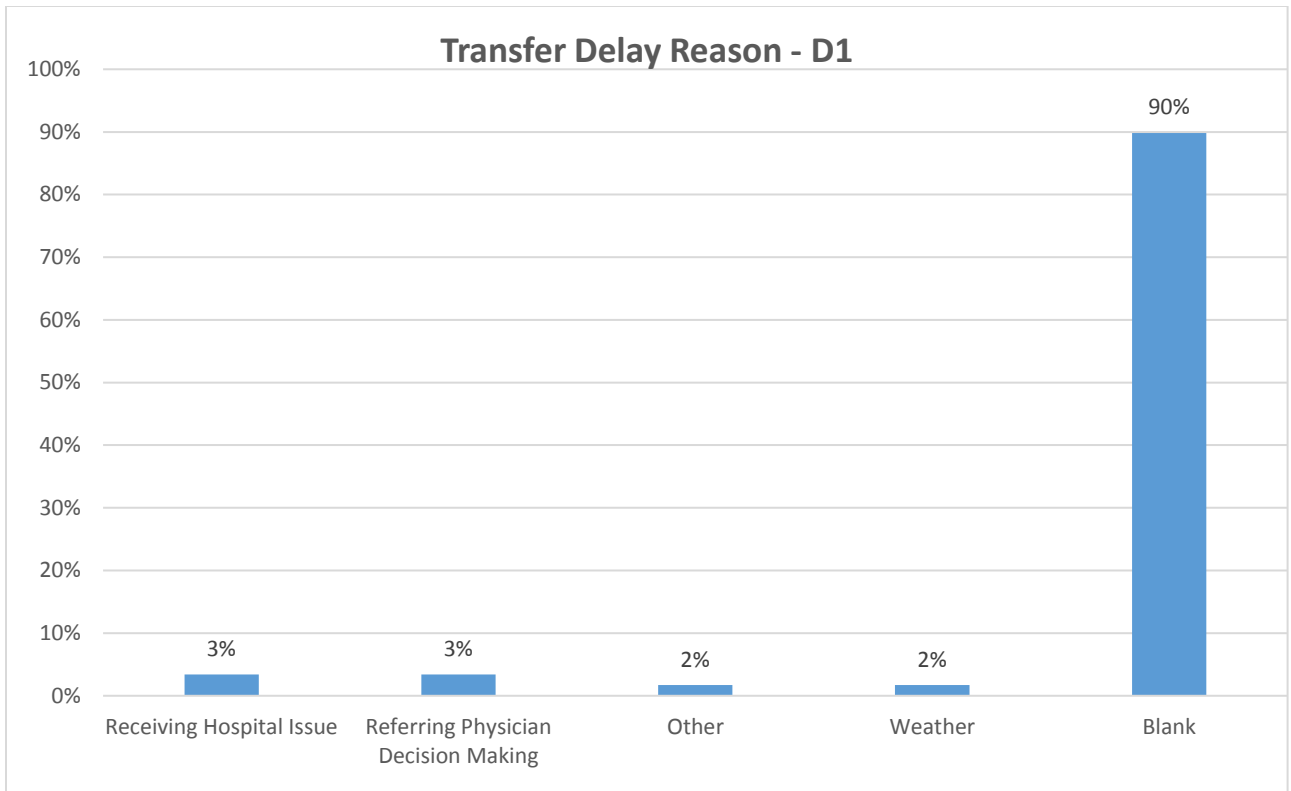
- 308 out of 8,357 said 'yes'



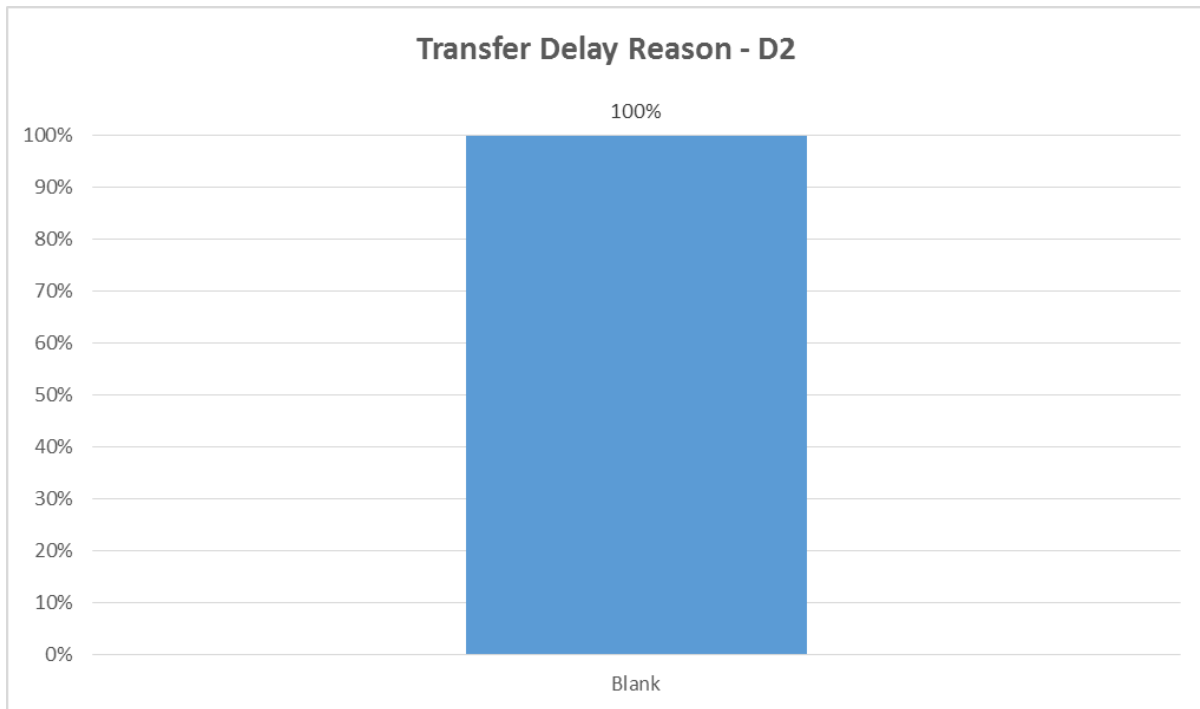
ii. Transfer Delay Reason – Statewide



iii. Transfer Delay Reason by District

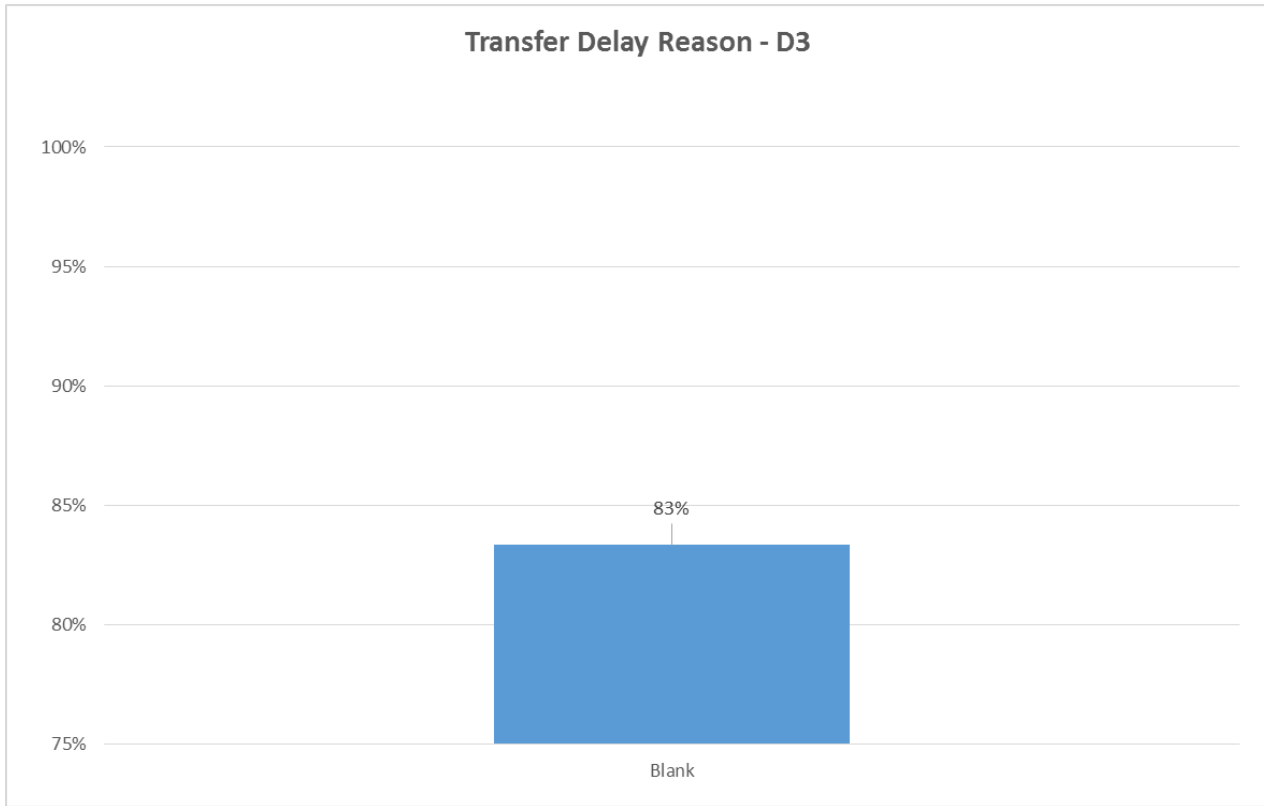


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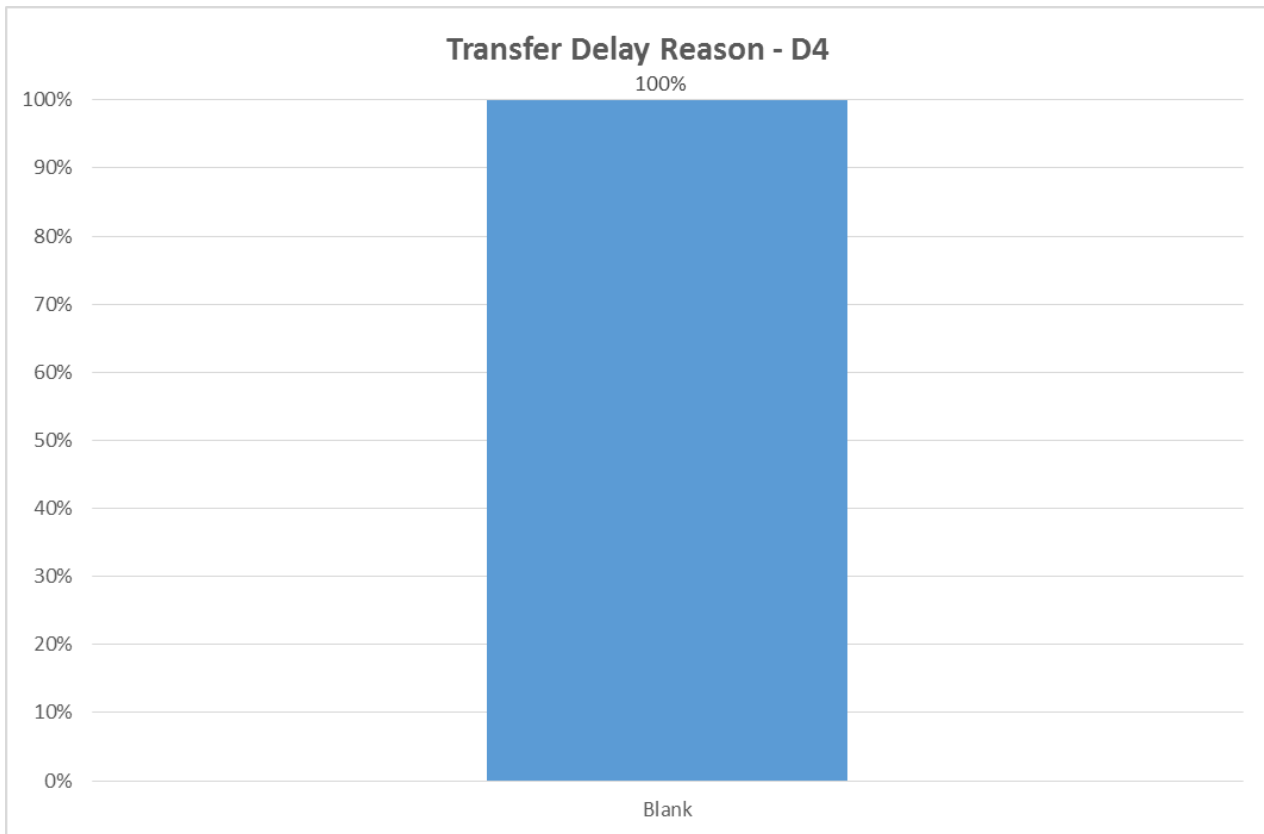
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Transfer Delay Reason - D3

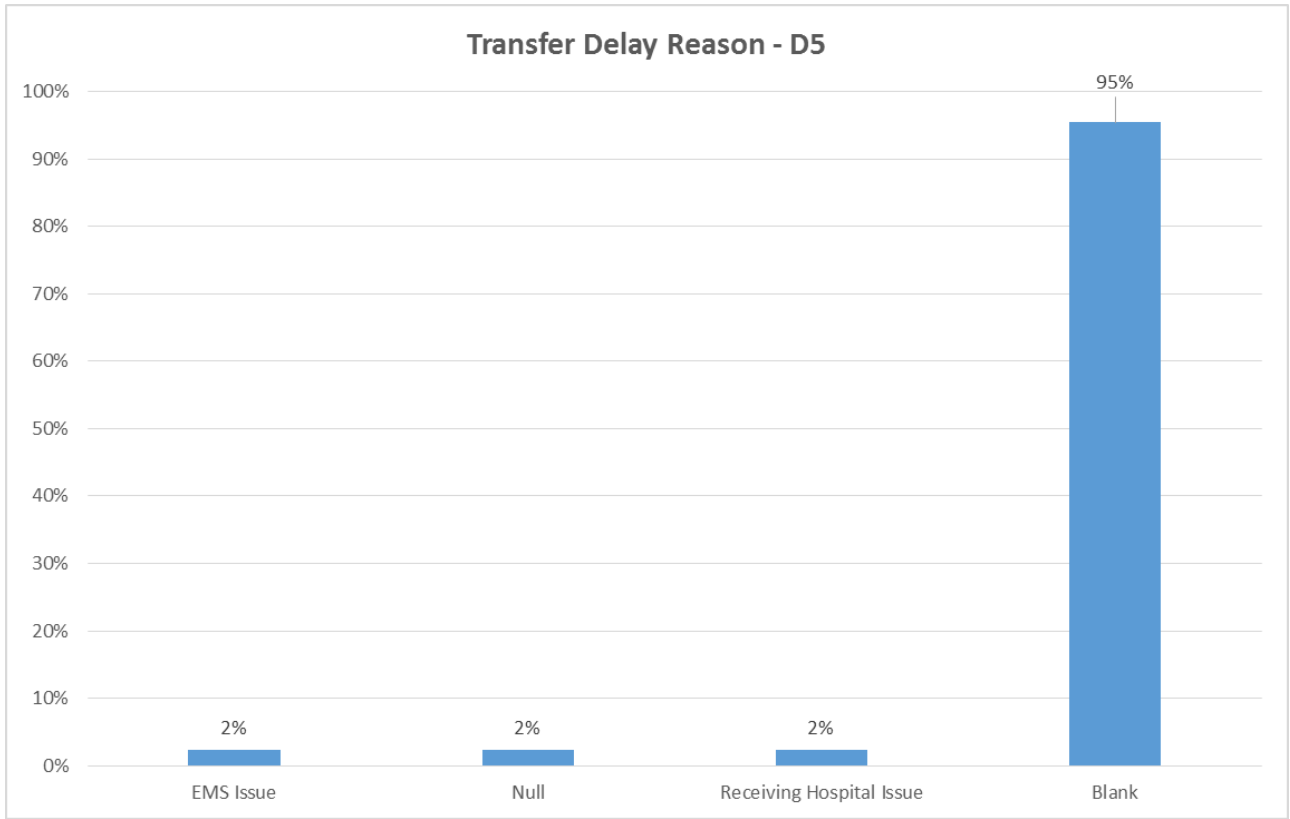


N=6

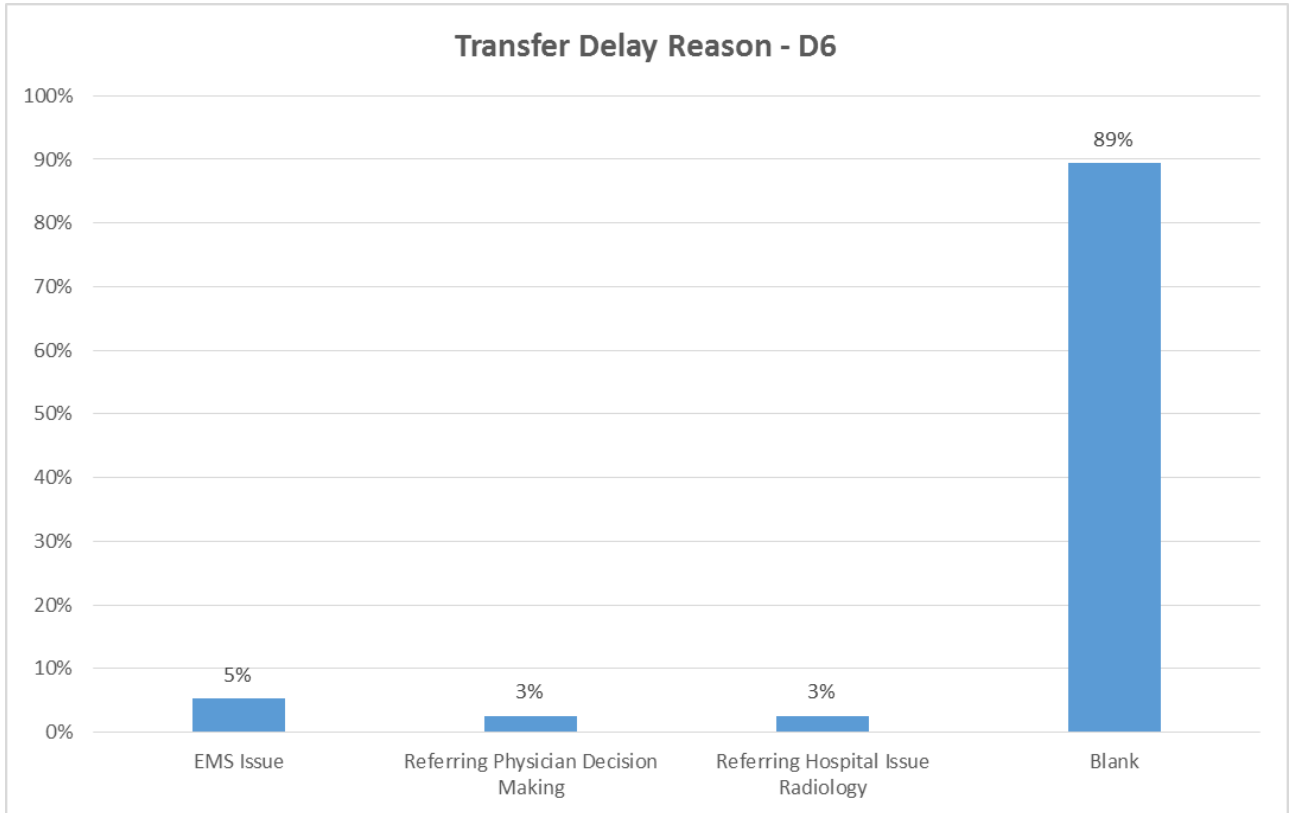
Transfer Delay Reason - D4



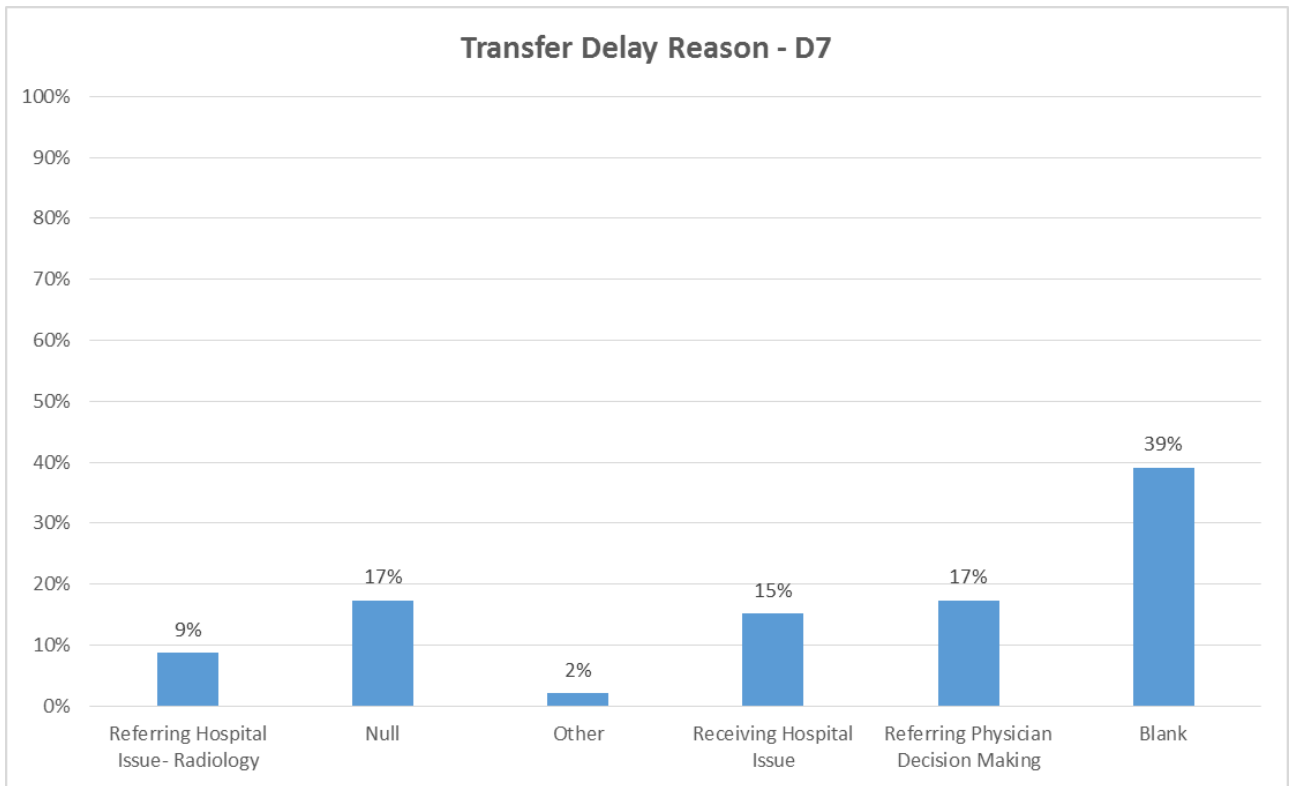
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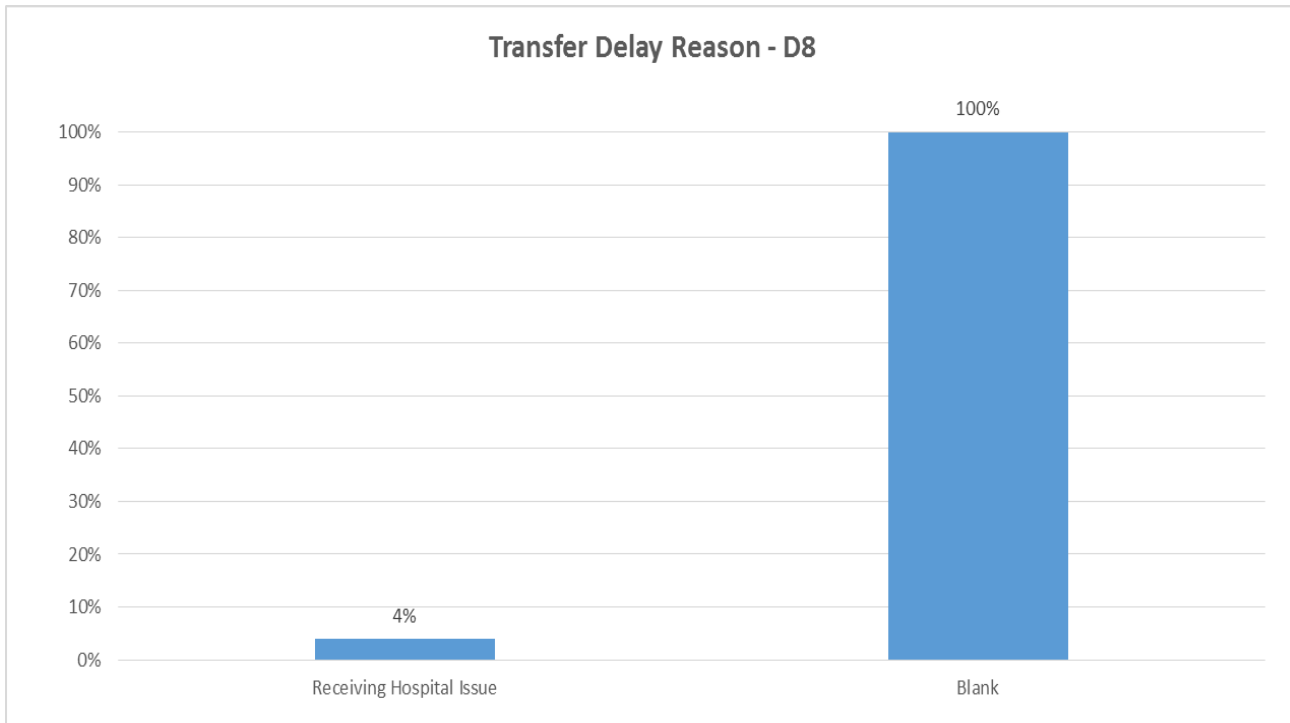
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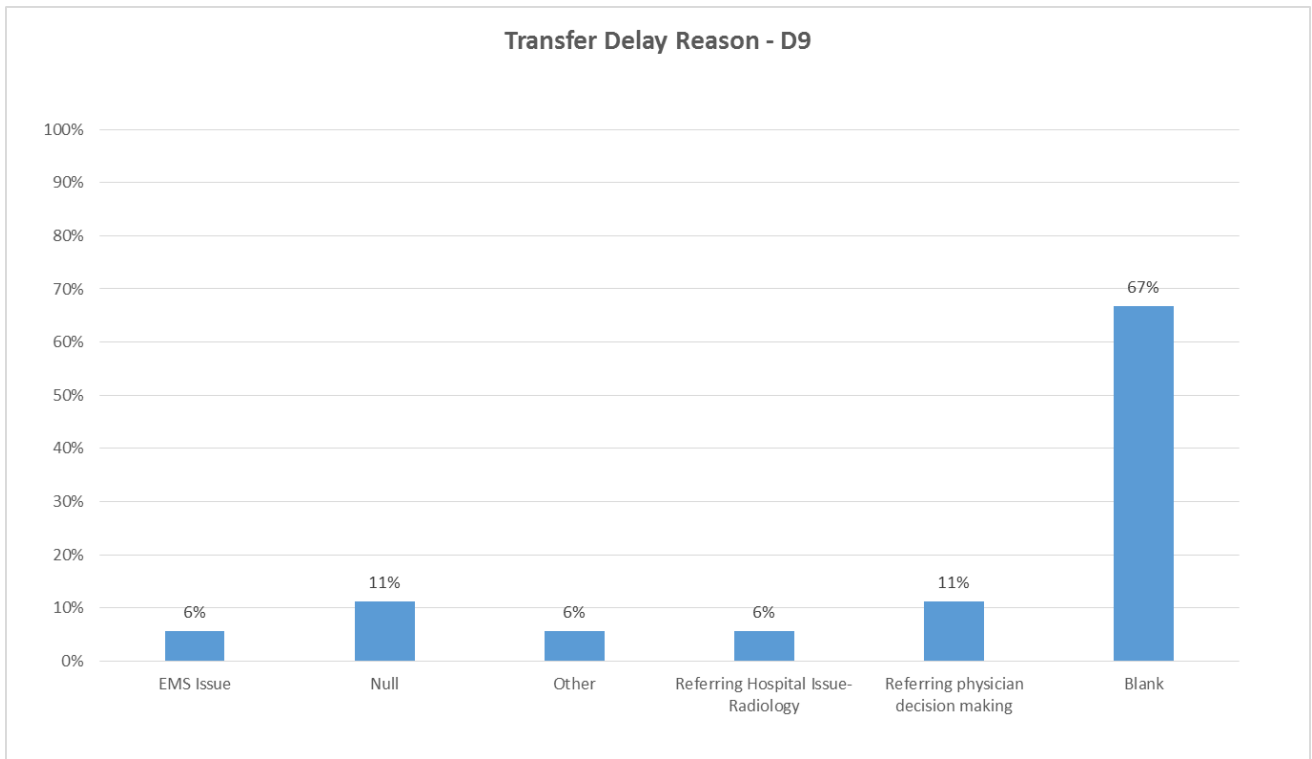
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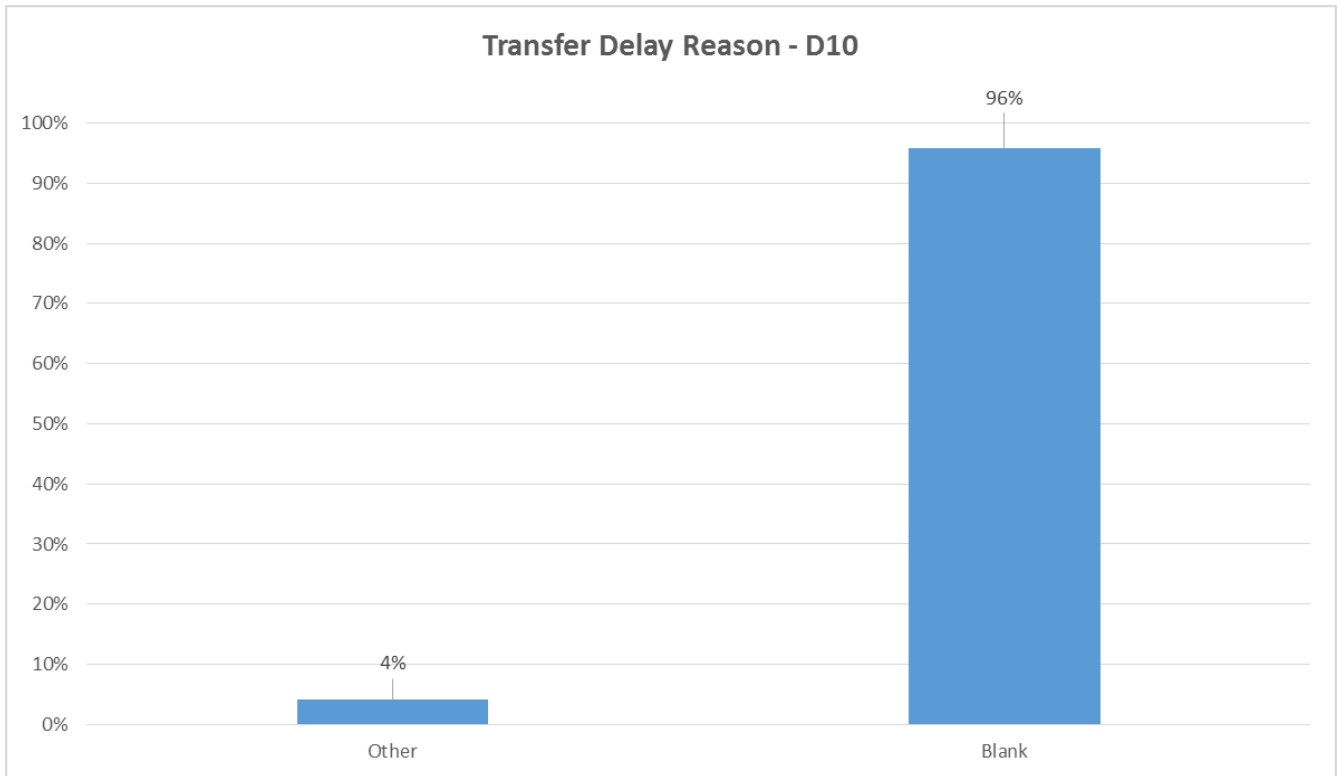
N=46



N=25



N=36



N=24

C) Transfer Delay Pilot

- **Next steps**
 - a. Speaking with ImageTrend on the cost and the development of a mock up (example below)
 - i. Working its way through the contract process
 - b. **Do we start requiring this field for non-trauma centers?**

The screenshot shows a web form with the following fields:

- ED Disposition:** Transferred to another hospital
- Destination Determination:** Specialty - Neurosurgery
- Hospital Transferred To:** Favorites (MN) Minnesota Facility
- Transport Mode:** Ambulance
- Transfer Delay:** Yes
- Reason for Transfer Delay:** A multi-select dropdown menu with options: Communication Issue, EMS Issue, Equipment Issue, and Receiving Facility Issue. A callout box asks, "Should these be single selects or multi-select fields?"
- EMS Issue:** A dropdown menu with options: Air Transport ETA > Ground Transport ETA, Air transport not available due to weather, Out of county, and Shortage of ground transport availability. A callout box notes, "The Reason for Transfer Delay selections opened additional data sections".
- Receiving Facility Issue:** A dropdown menu with options: Bed availability, Difficulty obtaining accepting facility/hospital, New ED Staff, and Other. A callout box notes, "EMS Issue and Receiving Facility Issue were selected in the Reason for Transfer Delay multi-select".

iv.

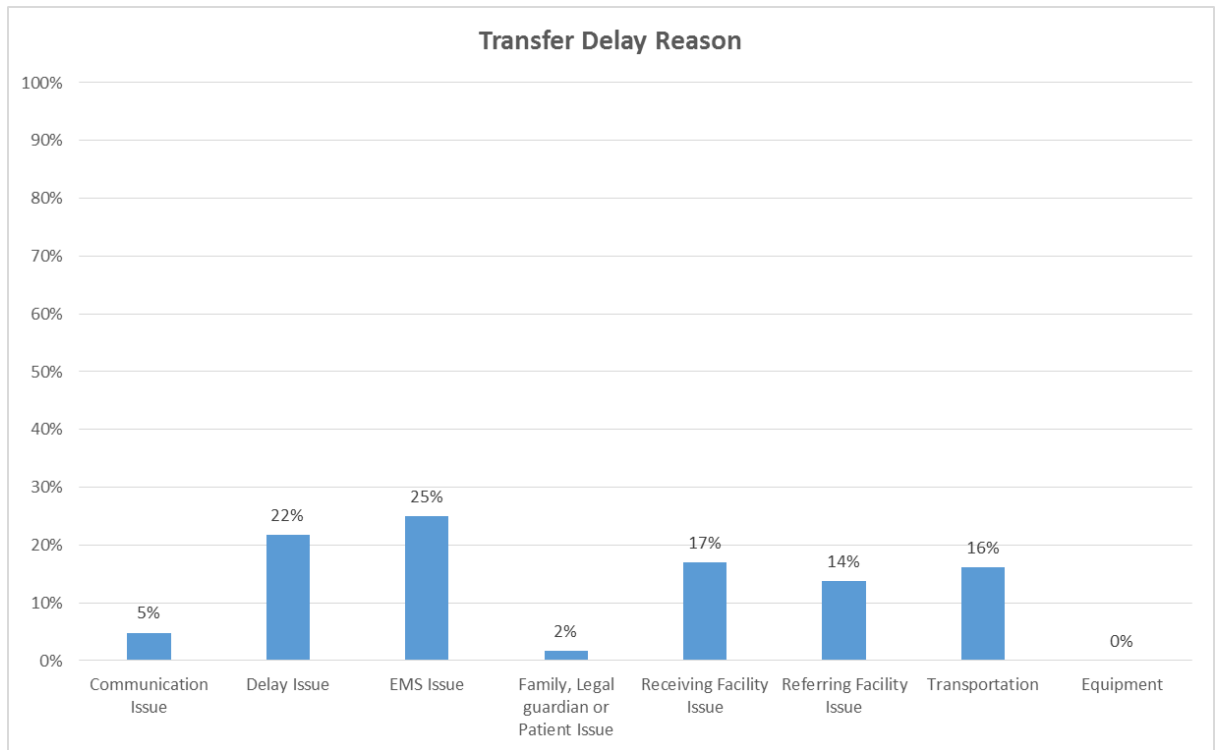
- 19 hospitals were identified and have agreed and continue to participate (Community East, IU Health North, Methodist Southlake, St. Vincent Kokomo and Schneck Medical Center) and **recruited 14 more** (Community North and South, Daviess Community, Bluffton Regional, Franciscan Health Mooresville, Franciscan Health Rensselaer, IU Health Bedford, IU Health Morgan, IU Health Tipton, Kosciusko Community, Marion General, Porter Regional, St. Vincent Williamsport and Union Hospital Clinton) that were collected for Q3 2017 data via the pilot selections as well:

The screenshot shows a form titled "Facility Questions" with the following fields:

- *NEW* Reasons for Transfer Delay (PILOT)- Communication Issue
- *NEW* Reasons for Transfer Delay (PILOT)- EMS Issue
- *NEW* Reasons for Transfer Delay (PILOT)- Error Issue
- *NEW* Reasons for Transfer Delay (PILOT)- Receiving Facility Issue
- *NEW* Reasons for Transfer Delay (PILOT)- Transportation Issue
- *NEW* Reasons for Transfer Delay (PILOT)- Delay Issue
- *NEW* Reasons for Transfer Delay (PILOT)- Equipment Issue
- *NEW* Reasons for Transfer Delay (PILOT)- Family, Legal Guardian or Patient Issue
- *NEW* Reasons for Transfer Delay (PILOT)- Referring Facility Issue
- *NEW* Reasons for Transfer Delay (PILOT)- Weather or Natural Factors Issue

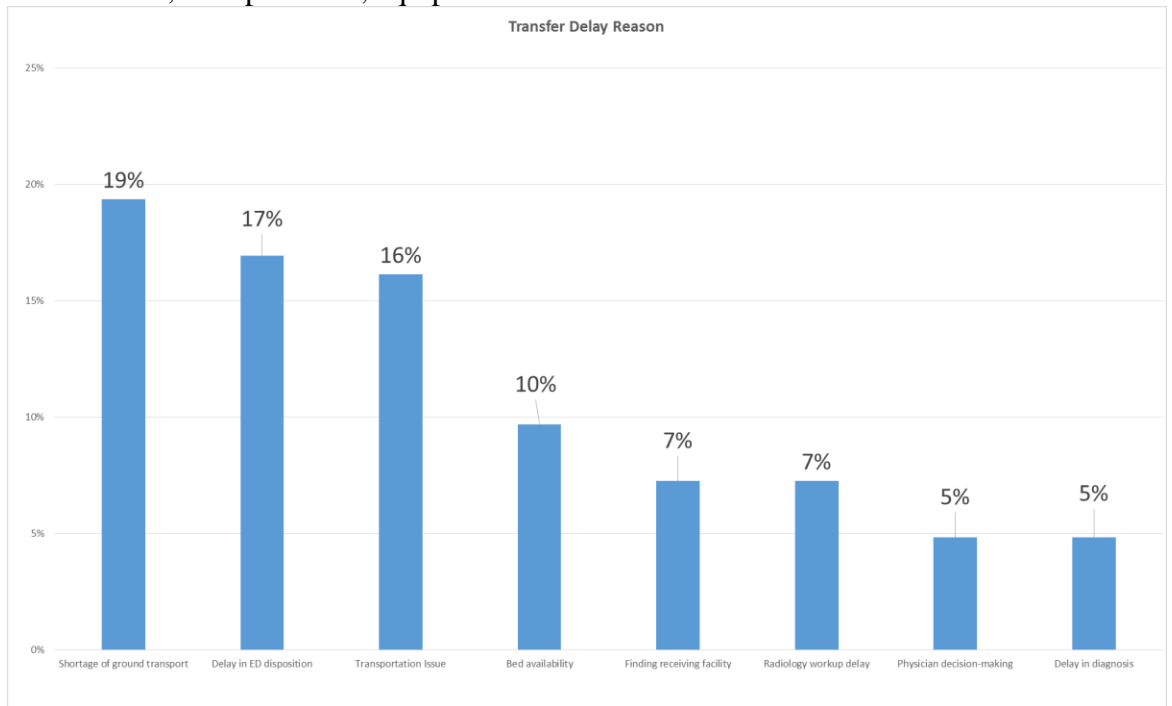
Buttons: Back, Save, Save and Continue

- Asking hospitals to take note of what works, what doesn't, what's missing, etc.
- 18 hospitals answered this question, N=146 responses



v.

- Responses from left to right: Communication issue, delay issue, EMS issue, Family legal guardian or patient issue, receiving facility issue, referring facility issue, transportation, equipment. N=124



vi.

- Responses from left to right: Shortage of ground transport, delay in ED disposition, transportation issue, bed availability, finding receiving facility, radiology workup delay, physician decision-making, and delay in diagnosis.
- Responses under 5% include: Air>ground transport ETA, MD response delay, CPS, out of county, miscommunication between transfer/receiving hospital, surgeon availability, and priority of transfer.

- Responses with 0% include: Nursing delay in calling/arranging transport, change in patient condition, family requested transfer, delay in trauma team activation, nursing delay in contacting EMS, and patient requested transfer.

3. Increasing Trauma Registry participation (past 12 months)

- Looked at all September 2017 to August 2018 quizzes
- 49 people took the quiz at least 5 times (the quiz goes to 71 people)
 - Result: 69% (was 80% last meeting)
 - Fluctuation in numbers due to some factors.
- NOTE:** Trinh Dinh will be doing the quizzes. She starts next Monday. **ACTION:** Talk with your registrars and encourage them to participate in the quiz.

4. Regional TRACs working to establish PI groups

a. Update by district

D1 – We have our meeting on Thursday

D2 – We have our meeting next week. We will pull ED LOS from our registry and will have a discussion on delays. We want the district with hospitals (blinded).

D3 – We want to have ED LOS by randomized hospital

D4 – We are organizing our district.

D5 – Our last meeting was cancelled.

D6 – We met last week with EMS and trauma centers at IU Tipton. We continue to work on transfer delay reasons. We have issues with EMS availability creating delays. There is an event in October. There is a critical care conference at IU Ball. This is good for ER nurses, EMS folks. This is geared towards nursing. It will be held October 4. We also have an active shooter event on October 4 drill. If folks want to observe or participate please join At 6 pm. We joined D6 healthcare coalition to help with mass casualty planning.

D7 – No report

D8 – No report

D9 – No report

D10 - No report

5. **Reminder:** Increase EMS run sheet collection

- ACTION:** Please send Murray Lawry (mlawry@isdh.IN.gov) a list of EMS providers not leaving run sheets.

6. Non-transferred patients with high injury severity score (>15 ISS)

d. Top 5 causes of injury

e. Counts

i. Levels I and II

ii. Level III

iii. Non-trauma centers

- ACTION:** Dr. Jenkins – I presented at the last ISTCC meeting. We identified issues on data quality and I will present in October at the ISTCC meeting.

7. Statewide Trauma Report

- Changes will be made with Q1 2018 reports

8. Annual entry of hospital variables

a. TQIP collects the following variables: # of beds, # of ICU beds, # of surgeons, # of orthopedic surgeons, # of neurosurgeons, profit status, teaching status

b. Make these variables mandatory for annual entry?

c. Dr. Jenkins would like hospital level factors for research. **ACTION:** There will be a request 1x a year sent to ED managers, trauma managers and trauma registrars. They will give the hospital level information to the registrar who will update it in the registry. Do not have your vendor build out this information; this will not be part of the schema. **ACTION:** Dr. Jenkins will send Katie his

final list of hospital level factors. **NOTE:** Be careful on the # of ICU beds because that includes NICU beds in a pediatric facility. For surgeons, neur, etc. for peds ask for pediatric neurosurgeons, etc.

ACTION: Katie will see if we can get this information from the acute care regulatory division.

ACTION: We can check with a few facilities and see if this is what you are reporting to TQIP.

9. Data validation

a. Signs of life

b. Dr. Jenkins looked at 2013-2015 data and found that about 250 patients came in with no signs of life but 40% were discharged alive. He would like to give feedback to hospitals. Is data quality improving over time? Do you think feedback on data quality would be helpful? People agreed that feedback would be useful. Looking at signs of life with disposition is one place to look at, another is missingness of data. Dr. Savage recommended choosing one or two things to focus on. The first two are signs of life with alive disposition and missingness in vital signs.

c. Dr. Jenkins would like to look at data at the ISDH and then put together a preliminary report and bring it to the PI subcommittee. **ACTION:** The ISDH will support Dr. Jenkins with the report.