General Membership Meeting

November 15, 2018

Long Beach Memorial Medical Center
08:30-14:00

MINUTES

Topic	Discussion	Action / Assigned
Call to Order	Meeting called to order at 08:50	
Welcome and Introductions	Welcome. Round-table introductions conducted.	**34** individuals present, 8 via teleconference
Approval of Minutes Meeting: *July 16*	Meeting minutes from *July 16, 2018 Santa Clara* general membership meeting displayed and reviewed .	Minutes approved and seconded as written.
Rapid Fire Hot Topic	"Everything you have ever wanted to know about the Orange Book but were afraid to ask" (see attached presentation) Key Points: • Transfers out for acute care: need to have some form of follow up to asses if the transfer was appropriate, how the patient faired and for Kaiser- ascertain if they were sent too soon • OPPE and FPPE: TMD should be identifying where you have an issue, and this should be addressed. With removal of CME requirement, this is very important. Should keep records on this and will be looked at during verification • Attendance at meetings- 50% requirement, no longer a "core" ALL Trauma surgeons providing care required, teleconference acceptable, but audio alone should be limited • Neurosurgery- available within 30 minutes, based on institutional criteria, must monitor	Daniel R. Margulies, MD, FACS

	• Ortho- care must be overseen by an individual who has completed a fellowship in Orthopaedic Traumatology approved by the OTA, for pediatric centers can have formal transfer agreements reviewed through peds process • Cases must go when best for patient, not when most convenient for surgeon- best served by dedicated ortho room • Ortho response 30 min for institutional specific criteria, must track and monitor • Complex imaging studies- radiologist must be available within 30 min, "qualified" IR or vascular, clocks tarts when you call • Changes in interpretation between preliminary and final as well as missed injuries should be monitored through PIPs process, rates looked at and calculated. RADPEER or other similar criteria used • Advanced Practitioners: ATLS required, if responding to traumas • Patients transferred to hospice care should be reviewed as deaths through PIPS process • PIPS- response parameters for consultants addressing time sensitive critical injuries should be determined and monitored, consultants can be residents or APPs if documentation of consultation with attending • TMD at L I and II must participate in regional and national organizations state COT does not count: ex AAST, EAST, WTA, PTS, COT- Desired for LIII • CME- with loss of requirements, the TMDs and Liaisons should look for knowledge deficits and address in annual review (OPPE/ FPPE). TMDs still need external trauma related CME- 12hr annually. Pediatric TMD- 9 of those hours must be peds specific • Trauma specialists- TMD must assess the liaisons knowledge through OPPE process and have this documentation available at review. • SBIR- 80% of all patients included in registry, not just trauma admissions. Exclude AMS and deaths from the denominator when calculating percentage	
Break		
Board of Directors Reports All Board Members		
President's Report	• Next meeting February 8th Sacramento, focus on legislation and will be hosted by CHA • Conference at Long Beach Memorial July 11, 2019, thinking about combining General Membership meeting with the conference. Invite your PI coordinators!	Heather

	• Nominations complete, voting opens today for open positions • Memberships expire March 31st, drive will begin in January	
Past President Report	• TQIP poster complete, accepted and will be presented at TQIP this week • Final work will be to finish up the updates for the Trauma Resource Manual. We will be asking some of our experienced TPMs and LEMSA managers to edit chapters, please let Des know if you are interested in helping • Infographic for public education on trauma systems and trauma centers complete, next steps include educational material for the public to go with the logo	Des
President Elect	How to Improve TMAC • Survey monkey sent and reviewed at last general membership meeting- summarized in minutes from July meeting Methods that are/ will be employed: • "Did you know" emails from Directors at Large • Posting sample Job descriptions • Increase LEMSA participation • Contracting with a conference coordinator to increase attendance and marketing for conference • Provide early meeting dates, agendas, emails, survey monkey regarding topics • Leverage technology- conference calls, social media, TMAC website update	Georgi
Secretary	• No report	Denise

Treasurer			Shelly

Trauma Managers Association of California
2018 Income Statement as of 10/31/18

	October 2018	Year-To-Date
Revenue		
Membership Dues		6,075.00
Plus Prepaid 2018 Dues		1,975.00
Less Set Aside for 2019 Dues		675.00
2018 TMAC Conference		9,800.00
Total Revenue	**$ -**	**$ 17,175.00**
Expense		
Advertising and Promotions		625.00
Annual Conference	580.96	8,440.15
Awards, Recognition and Gifts		
Bank Service Charges		30.00
Stripe Account Payment Processing Charges		160.28
Directors and Officers Liability Insurance	1,330.00	1,330.00
Executive Assistant	131.25	1,400.00
Financial Audit		
ListServe Hosting		540.00
Meeting Guest Speakers		
Meeting Supplies		797.06
Non-Profit Status Filing		
Office Supplies		
Postage/Shipping		
Retreat		
Tax Preparation/Filing		450.00
Website Hosting/ Updates	350.00	350.00
Total Expense	**$ 2,392.21**	**$ 14,122.49**
Net Income/Loss	**$ (2,392.21)**	**$ 3,052.51**

Bank Account Balance as of October 31, 2018 $ 23,764.04

EMS Director at Large	• Completing TRM EMS chapters • BOD nominations complete, will be sent to membership today for voting	
Lunch and Networking		

Breakout:	• How do you manage over/under triage?
	  ○ Show a monthly report at Trauma PI committee, with a focus on undertriage
	  ○ Problem with Cribar is that the methodology is retrospective using ISS and does not take into account field activation criteria, or comorbidities (esp in geriatric patients)
	  ○ Review both over and under triage patients from Cribari matrix, and drill down on to each one specifically
	  ○ Not use Cribari, use NFTI and STAT, presented monthly at PI meeting
	  ○ Use Cribari, and review every patient to determine if the hospital level activation was accurate with the pre-hospital report and field criteria
	  ○ Use Cribari, then evaluate those same patients to drill down if any of the major/high activations had an ED dispo of home, or the minor/low activations had an ED dispo of ICU or OR.
	  ○ Use McGonigal's calculator, available on his blog
	  ○ MICN's using new tool to review every activation to state why they activated a patient at a specific activation level
	• How do you manage educational programs/CME, especially in light of new ACS requirements of less CME?
	  ○ Kept the requirement for all to maintain the CME
	  ○ Many concerned about the MD's being able to stay up to date on trauma evidenced based practice, which puts onus on TMD and liaisons
	  ○ Keep the requirement for trauma surgeons and liaisons, expect the liaisons to bring back education to the specialties.
	  ○ Using a tracking methodology for board recertification
	  ○ Removed the requirement for ED MD's
	  ○ San Diego contract has not changed, so currently keeping the requirement the same
	  ○ Medical Staff Office (MSO) helped with this a little in the last survey, but TPM had to spend a lot of time verifying and checking back
	  ○ Many are continuing with continuing education process of weekly or monthly conferences/rounds/M&M's, using video resuscitations for case conferences to maximize opportunities.	

	• How do you manage OPPE/FPPE for trauma surgeons and APP's?
	  ○ TMD performs OPPE on trauma surgeons and reviews for sub-specialists PRN
	  ○ Trauma surgeon OPPE provides service level data and compares to individual surgeon data, to provide a comparison
	  ○ Integrate OPPE for sub-specialist into hospital OPPE through MSO
	  ○ Review trauma registry data for all sub specialists, do not integrate with MSO
	  ○ Provide a monthly dashboard to all trauma surgeons, with de-identified data. Info includes percentage compliance with SBIRT order, response times, how long keeping patients in the trauma bay
	• TPMs Survey Prep Dos/ Donts:
	  ○ **DO-** Homework, have all your reports and an organized dashboard
	  ○ Be able to run reports on the fly
	  ○ Check numbers often
	  ○ Know your overtriage and be able to speak to how you monitor this
	  ○ Do all of McGonigal's tips
	  ○ Be organized
	  ○ TQIP Best Practices
	  ○ Know you PRQ
	  ○ **DON'T-** have different forms for PI
	  ○ Don't be afraid to ask questions
	• What LEMSA want trauma centers to know:
	  ○ Help with coordinating TMD/TPM support with ACS
	  ○ TAC regional letters from TAC chair, loop closure	

Standing Committees		
State TAC	Deferred	
EMS Challenge Area		
Legislation		
Trauma Regulation/Title 22		

RTCC Reports	Deferred	
Meeting Evaluation		
Adjournment		

Minutes taken and transcribed by *Denise Greci Robinson*
The Board of Directors and invited speakers have no financial arrangements or affiliation with any commercial organization that sells or develops products or drugs regarding any of the information presented at this meeting.