Florida Trauma System Consultation
# Leading Causes of Death – 2007

**United States**

<table>
<thead>
<tr>
<th>Rank</th>
<th>Age Groups</th>
<th>&lt;1</th>
<th>1-4</th>
<th>5-9</th>
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<th>25-34</th>
<th>35-44</th>
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Leading Causes of Death – 2007 Florida

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</table>
Status of Trauma Systems

- Urban and suburban areas are well served
  - Geographic distribution of centers unplanned
  - Excess capacity is common
  - Incentives for trauma center creation are variable

- Rural and frontier areas are a challenge
  - Large geographic area
  - Limited resources
  - Long transport times
Trauma Center Coverage
2000-2006, United States
Age-adjusted Death Rates per 100,000 Population
All Injury, All Intents, All Races, All Ethnicities, Both Sexes, All Ages
Annualized Age-adjusted Rate for United States: 56.22
2000-2006, Florida
Smoothed Age-adjusted Death Rates per 100,000 Population
All Injury, Unintentional, All Races, All Ethnicities, Both Sexes, All Ages
Annualized Age-adjusted Rate for Florida: 43.05
Evolution

- Trauma Systems Consultation Program – 1992
  - Initial principles extended from center verification
  - Development of standards problematic
  - Consultation instead of verification
  - Strategic and tactical aid in system development

- Current Initiatives
  - Consultative visits
    - Comprehensive regional (usually state) visits
    - Problem-focused analyses
  - Trauma system benchmarking
  - Development of advocacy materials
  - International collaboration
February 2012

**Trauma Systems Evaluation and Planning Committee Consultations and Facilitations**

- **Completed Trauma System Consultation**
- **Scheduled Trauma System Consultation**
- **In Discussion**
- **Benchmarks, Indicators, and Scoring Facilitation Completed**
System Consultation

- Consultation, not verification
- Multi-disciplinary team, tailored to needs
- Data collected through:
  - Review of Florida questionnaire
  - Review of other available data
  - Interactive session with stakeholders
System Consultation

- Consensus-based process
- Recommendations derived independently
- Standard is an inclusive trauma system based on public health model (http://www.facs.org/trauma/hrsa-mtspe.pdf)
  - Goal is to decrease overall burden of injury
  - Integrate continuum of care
  - Broad-based regional approach
  - Data driven system evaluation and modification
Observations

- There are broad general principles
- Solutions are unique and local
- System development tools must be adaptable
  - Meet each situation at its own level
  - Allow for particular local solutions
ACS Review Team

- Robert J. Winchell, MD, FACS  Team Leader
- Jane Ball, RN, DrPH  ACS Consultant
- Samir M. Fakhry, MD, FACS  Trauma Surgeon
- Molly Lozada  ACS Staff
- Ronald F. Maio, DO, FACEP  Emergency Physician
- Holly Michaels  ACS Staff
- Drexdal Pratt  State EMS Director
- Nels D. Sanddal, PhD, REMT–B  ACS Staff
- Jolene R. Whitney, MPA  Trauma Program Manager
Florida

- Area – 58,560 sq mi (22nd)
- Population – 19 million (4th)
  - Density 353/sq mi (8th)
- Trivia
  - 27th State – 1845
  - The Sunshine State
  - “In God We Trust”
  - Orange Blossom
  - Sabal Palm
  - State Drink ??
Trauma Centers

Florida’s Verified and Provisional Trauma Centers

- Pensacola:
  1. Baptist Hospital (II)
  2. Sacred Heart Hospital (II, P)

- Tallahassee:
  3. Tallahassee Memorial Hospital (I)

- Jacksonville:
  4. Shands Jacksonville TraumaOne (I)

- Daytona Beach:
  5. Halifax Medical Center (I)

- Melbourne:
  6. Holmes Regional Medical Center (II)

- Orlando:
  7. Orlando Regional Medical Center (I)

- Lakeland:
  8. Lakeland Regional Medical Center (II)

- St. Petersburg:
  9. Bayfront Medical Center (II)
  10. All Children’s Hospital/Bayfront Medical Center (P)

- Tampa:
  11. St. Joseph’s Hospital (II, P)
  12. Tampa General Hospital (I, B)

- Ft. Pierce:
  13. Lawnwood Regional Medical Center & Heart Institute (II)

- Ft. Myers:
  14. Lee Memorial Hospital (II)

- West Palm Beach:
  15. St. Mary’s Medical Center (II, P)

- Delray:
  16. Delray Medical Center (II, P) (Provisional I)

- Pompano Beach:
  17. Broward Health North (II)

- Ft. Lauderdale:
  18. Broward Health Medical Center (I)

- Hollywood:
  19. Memorial Regional Hospital (I)

- Miami:
  20. Jackson Memorial Hospital/Ryder Trauma Center (I, B)
  21. Miami Children’s Hospital (P)
  22. Kendall Regional Medical Center (Provisional II)

- Gainesville:
  23. Shands at the University of Florida (I, B)

- Bradenton:
  24. Blake Medical Center (Provisional II)

- Orange Park:
  25. Orange Park Medical Center (Provisional II)

- Hudson:
  26. Regional Medical Center
  27. Bayonet Point (Provisional II)

- Panama City:
  28. Bay Medical Center (Provisional II)
Regional Domestic Task Force Regions

This map shows the relationship between Florida's hospitals, trauma centers, and aeromedical resources.
Current Status

- Long history of trauma system development
- Strong historical high-level centers
  - Located in urban areas
  - Align with majority of population
- Commitment to data-driven decisions
- Substantial funding
- Recent increase in trauma center designation
- New challenges with center distribution
- System structure has not been updated
Current Status

- Inclusive system by intent
- Still an exclusive system in operational reality
- No strong central control of trauma system
  - Lack of clinical experience in system management
  - EMS protocols controlled at agency level
  - No system-wide process improvement
- Aggregate metrics suggest majority well served
- Some underserved areas likely exist
- No definitive data to define performance
Current Status

- Ongoing legal challenges to rules
- Trauma center designation based on 1990 plan
  - Regional structure mostly non-functional
  - No consensus around current needs
  - Financial model creates adverse incentives
  - Factions polarized
- Singular focus on trauma center distribution
- Adversarial relationships between some parties
- Planning and development activity suspended
- System development at an impasse
Our priority:
The best interest of the patient
Advantages and Assets

- Long history of dedicated participation
  - Institutions
  - Trauma leadership
  - People
- Long-standing support from state government
- Substantial funding
- Department of Health leadership committed
- Strong historical trauma centers
- Increasing interest in new center development
- Detailed trauma plan
Advantages and Assets

- Overall good coverage of population
- No major geographical challenges
- Commitment to data driven solutions
- Strong system legislation
- Reorganization of DOH to improve integration
- Good injury epidemiology
- Strong disaster and mass casualty programs
- Strong historical SCI/TBI rehab program
- Strong injury prevention programs
Challenges and Vulnerabilities

- Adversarial relationships between stakeholders
  - Deepen divisions
  - Induce stasis
- Win/lose mentality as to outcome
- Too much focus on center distribution
- Outdated vision for system growth
- Outdated advisory board structure
- Regional design never fully implemented
- Lack of inclusive stakeholder involvement
Challenges and Vulnerabilities

- Trauma plan does not address difficult issues
- Incomplete application of inclusive system principles
- Distribution of trauma center funds creates adverse incentives
- Inability to define current system needs
- Inability to designate centers based on needs
- Lack of clear destination protocols
- Immature processes for system monitoring
- Limited utilization of available data
Themes

- Make peace. You are all committed to the same goals and a collaborative solution is needed for the benefit of your patients
- There must be a clear vision and a clear plan for future direction, embraced by all stakeholders
- Department of Health needs to have clear support from stakeholders to lead, backed up by consistent statutory and regulatory authority
- Advisory committee must be reconfigured to provide broader stakeholder participation and establish clear acceptance as balanced policy development group
Themes

- System vision and structure are out of date
  - Trauma centers ≠ Trauma system
  - Inclusive system ≠ Unregulated system
- Trauma center designation should be based on need
  - Consistent and objective data should be used
- An updated regional structure is needed
- Good enough isn’t good enough
- There is still a great deal of work to be done
- Change is painful, but stagnation is worse
Key Recommendations
Statutory Authority

- Convene a small multi-disciplinary work group to analyze all existing statutes and regulations pertaining to the trauma system, including, methodology for needs assessment, process for trauma center designation based on system needs, and control of patient flow (field triage criteria/destination protocols).
System Leadership

- Appoint a new Florida Trauma System Advisory Council (FTSAC) to provide input to policy development for the trauma system.
  - Broad multidisciplinary representation
  - Include both trauma centers and non-center hospitals
Establish and fund a statewide performance improvement coordinator position to lead the development of a statewide performance improvement process.

Contract for the state trauma medical director position and provide compensation for his/her time.
Revise the Florida trauma system plan to address key issues necessary for the further development of the regional and statewide trauma system.

- Begin immediately, this is a key element in defining a common vision for system development.
System Integration

- Use the Domestic Security Task Force Regions as the TSA regions.
  - Develop a strong regional structure based on the 7 RDSTFR that enables the integration of trauma centers with EMS, disaster preparedness, and other regional activities.
Financing

- Revise the distribution method of the trauma center fund.
  - Change the distribution method for the fund to ensure that designated trauma centers receive level-appropriate support for the “cost of readiness”.
Collaborate with the Florida Department of Transportation, Highway Safety Office to initiate and conduct a National Highway Traffic Safety EMS Reassessment.
Definitive Care

- Conduct an assessment of the current system, including the parameters outlined in Florida statute 395.402, to inform decisions regarding the location and level of new trauma center designations.

- Establish a transparent, broadly accepted process for future provisional trauma center designation based upon both capacity and system need.
Definitive Care

- Establish a transparent, broadly accepted process for initial full designation and ongoing re-designation based upon system participation, center performance, and participation in quality improvement programs.

- Impose a moratorium on any new provisional or full trauma center designation until these new processes are in place.
Definitive Care

- Require that all acute care facilities participate in the inclusive and integrated trauma system as a condition of licensure.
  - Designate, at an appropriate level, either as a trauma center or a participating facility
  - Require all facilities to submit at least a minimal set of data on every injured patient to the state registry.
System Coordination & Patient Flow

- Evaluate the content, implementation, and method of enforcement of trauma transport protocols (TTPs) to assure uniformity and efficiency of patient flow both within trauma regions as well as statewide.
Task the Trauma Program with annual reporting on trauma center and non-trauma center destination and patient outcomes (initial destination and transfer)
Disaster Preparedness

- Develop the healthcare coalitions and align with the seven Domestic Security Task Force Regions.
  - Ensure the disaster medical response plans are integrated through regional planning between members of the healthcare coalition (hospitals, EMS, fire, public health, dispatch, emergency management and law enforcement).
System-Wide Evaluation & QA

- Reactivate the Performance Improvement Committee under the aegis of the FTSAC to develop a statewide performance improvement plan that outlines the PI process at the provider, regional and state levels and includes process, structure and outcome measures.
  - Search other states to identify PI plan templates.
  - Include all aspects of trauma care and system performance.
Trauma MIS

- Complete the implementation of the NGTR and ensure participation by all hospitals.
Observations

- This is a consultative process
  - The recommendations offered are based on broad general principles and experiences in other regions
  - The solutions will be unique and specific to Florida
- Change is always difficult
- Progress will require a renewed commitment to ongoing collaboration by all stakeholders
- The solutions will be created by all of you
- Audentes fortuna iuvat
Closing Comments

- Robert J. Winchell, MD, FACS  Team Leader
- Jane Ball, RN, DrPH  ACS Consultant
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