TCD Data Call

October 19, 2018

Attendees: Pat Mills, Robin Kiser, Sarah Willson, Sabina Braithwaite

Major overarching principles:

1. Do not create a new registry. Create a model that draws data out of the existing data registries (stroke, STEMI, trauma) and marries with EMS database into a common repository without requiring additional work/staff from stakeholders. This would allow a mechanism for all invested stakeholders to query and benchmark as they need to for quality and patient care reasons. Include capability for bidirectional queries that meet the timeliness needs of various stakeholders to better integrate the full continuum of care from first medical contact on. For example, from the EMS perspective, there is utility in EMS having access to some hospital information while on scene caring for a patient, for more rapid reporting capability (rather than delayed), for patient outcomes and quality purposes on an intermittent basis.
2. Whatever data integration model is created should have the following qualities:
    a. Must be sustainable (financially and personnel-wise)
    b. Must have built in national measures / benchmarks (i.e. last known well time to TPA / balloon) and capability to write own custom measures / benchmarks / algorithms
    c. Must be maintained current by vendor when national measures / data points are updated so it does not become obsolete (as ImageTrend has for that reason)
        i. Outdated / meaningless data points and benchmarks have no value to the system and waste effort/time when they are required but do not contribute to system improvement.
    d. Must support input from hospitals that are not registry participant hospitals (i.e. smaller hospitals that can't pay for AHA / trauma accreditation)- a quality in current system but is not functional

    e. Must be functional, functioning, and accessible to all stakeholders. There is an expectation that refinements and further customization will be needed, but whatever the system is must function from the start.

    f. Must receive data from all hospitals in the state, i.e., an inclusive system.

Other followup notes:

There is a national trauma database, TQIP allows reporting currently to individual hospitals in a blinded way to allow comparisons on benchmarks among like hospitals / regional hospitals.

I have reach out to Virginia regarding more specifics on their experience with ImageTrend TCD reporting and capacity for bidirectional information transfer.