

Excerpts from the

State Of Maryland

A Reassessment

of

Emergency Medical Services

June 1-3, 2004

By The

National Highway Traffic
Safety Administration
Technical Assistance Team

specialty centers, and there are no provisions for rehabilitation centers provided in the COMAR. There is limited integration of rehabilitation centers into either institutional or system-wide programs. Rehabilitation Directors have limited involvement in the acute care phase except where the facilities are connected. The availability to the EMS system of longer term functional recovery outcomes (beyond acute hospitalization) also appears to be limited. This is inconsistent with the development of disease-based systems of care for several emergency conditions including stroke, neurotrauma, hand injuries, and burns.

The verification / re-verification for specialty centers have been completed for trauma, burn, pediatric trauma, neurotrauma, and perinatal centers. Those for the trauma centers were completed in 2003. The verification process for trauma centers appears to be less stringent than the ACS process and allows for provisional designation in the setting of deficiencies provided that these are corrected within a 12 month time-frame. Focused re-visits to confirm that deficiencies have been corrected are conducted primarily by the state trauma program manager. There has been no direct comparison between the internal MIEMSS verification process and the ACS verification process for any of the Maryland trauma centers.

Diversion policies exist at the state level and for each institution per requirements. A county alert tracking system maintains the status of each hospital and emergency department and is based on hospital notification (web-based). Facility diversion is monitored continuously and tabulated on a monthly basis by MIEMSS and reported back to trauma and emergency department program managers and CEOs at each institution.

Recommendations

- ◆ Incorporate the ACS-VRC trauma verification process into the existing internal process for purposes of validation. Shorten the current 5 year verification cycle for trauma centers to a more conventional 3 year cycle.
- ◆ Reevaluate the current triage criteria with respect to the overtriage rate and potential over utilization of air medical transport. Reevaluate the distribution of trauma patients with modest injuries between PARC and Level 2 facilities in the context of overtriage.
- ◆ Formalize the role of rehabilitation physicians and rehabilitation centers in the relevant systems of care (trauma, burns, etc.) and integrate the post-acute rehabilitation process into the trauma center performance improvement processes and outcomes analyses.
- ◆ Develop and implement standards for rehabilitation hospitals designed to complement existing disease-based systems of care for trauma, pediatric trauma,