One "System" TPM/TC

7-Mar-16

State	Has not been addressed to date	Allowed	Share Registry	Going Well	Is a Problem
Alabama					
Alaska	X	X			
Arkansas					
Arizona		X	X	X	
California					
Colorado		X	X		X
Connecticut					
Delaware					
Florida					
Georgia	X				X
Hawaii					
Idaho					
Indiana					
Illinois					
Iowa					
Kansas		X			
Kentucky		X	X		
Louisiana					
Maine					
Maryland					
Massachusetts					
Michigan					
Minnesota		X		X	X
Mississippi					
Missouri					
Montana					
Nebraska					
Nevada					
New Jersey					
New Hampshire					
New Mexico					X
New York					
North Carolina					
North Dakota					
Oklahoma					
Oregon					
Pennsylvania					
Rhode Island					
South Dakota					
South Carolina					

Tennessee		X	X		
Texas					
Utah					
Vermont					
Virginia					
Washington		X			
Washington, D.C.					
West Virginia					
Wisconsin					
Wyoming		X			X

Renee Morgan: Georgia
We do not currently have the situation in GA but it is being discussed. We have a 3 TC's now owned by the same corporation and the mothership want to do this. Their proposal however is that they will take the lead over the other Level I and II (they are a Level II and new kid on the block). This is not going well. I am interested in the feedback from everyone as well.

Tim Orcutt: Washington
Washington has only one program manager per facility. That being said, there in nothing in rule from preventing them from doing so. There is the ACS standard that applies to level I and II facilities that the manager has to be full-time and dedicated to the trauma program. My only concern would be if the level III has a large patient volume the level IV may not get the attention it needs. If the level III manager has the time to dedicate to the level IV their experience could be very valuable to them.

Rob Seesholtz: Tennessee
Here in Nashville HCA is using a similar model but only with a centralized registry. Each hospital has their own program manager but the registry for multiple facilities is managed at one location.

Kelli Perrotti: Wyoming
It could be worth a shot, it really depends on the registry requirements and the expectations of a Level III in MT. I have one hospital system who thinks they can do this exact scenario, but without a full time FTE (the ED manager is expected to do TC at both hospitals. I seriously do not think it will be successful as the great majority of WY "Level IIIs" have a full time FTE for the coordinator (who also does registry). Do the hospitals 'share' medical staff? Our registry requirements are the same for all facilities regardless of size (sans the TQIP additions).

Chris Ballard: Minnesota
We have several of these arrangements in Minnesota. Some work well; some not so well. In some cases, we have two critical access hospitals—level 4s—with the same TPM. As long as the TPM has a sufficient portion of their FTE dedicated commensurate with the volume of cases they have to review, it has worked fine. But we have another situation where the TPM is managing three sizable level 3s. Obviously the volume of cases for one person to review is insurmountable. In fact, it may cost them their designations at our council meeting tomorrow.
As the belts tighten around our hospitals' waists, I expect to see more of this practice. I don't think we have to discount it outright. But it does require close scrutiny.

Dick Bartlett: Kentucky
Not sure that is a good idea. I could see perhaps someone at the smaller ED, like the lead ED

charge nurse, being the designated local trauma lead; working with the trauma system coordinator at the mothership.
I have something close to this where the anchor level III is about 15-20 miles away from an owned Level -IV. I have a designated person at both, and they work together with administration at the system. They use CDM licensed registry software at the main hospital, and the Level-IV is a sub-license off the main software license.

Grace Sandeno: Colorado
Well, we have a system that currently has two level IIIs and two level IVs (both free-standing EDs) with the same trauma nurse coordinator. The level IIIs have some help with registry. Level IVs are not required to participate in the full registry. We aren't very long into this arrangement, but I can't imagine that it will last long. It's impossible.

Noreen Adlin: Arizona
In Arizona we have a hospital system with two very high functioning level IV's which share the same TPM. The facilities are about a mile apart and share the same medical and nursing staff. Although not required, the hospitals individually participate in our registry full data set. Presently, they transfer all trauma surgical cases with the exception of isolated ortho. He is an active participant in all our system trauma meetings and mentor to other fledgling programs. I guess my point is, under ideal conditions and with the right TPM it could work. I wish we had ten of him.

Liana Lujan: New Mexico
We had a similar situation where a new facility wanted to become a trauma center and they were run by the same board as our Level I trauma center. They requested that the Level I trauma program manager handle the Level III trauma center as well. We (the State Trauma Program) firmly denied them to share the coordinator. Our regulations state that each facility must have a full time trauma coordinator for a Level III trauma center. Also, I have 3 or 4 CHS facilities, and each facility must have their own trauma coordinator based on the same regulations.
I would highly recommend that you not let them extend the services of one trauma coordinator to their sister Trauma centers.

Julie Rabeau: Alaska
Alaska has only one trauma program manager per facility. It is not in our regulations with the exception the trauma centers follow the most current standard of the ACS-COT "resources" book. At the Level IV's, the TPM wears many hats and divides their energy amongst those multiple jobs.