Texas TQIP Collaborative Initiative

Texas TQIP Collaborative Initiative

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Texas TQIP Collaborative Initiative Overview

Purpose The Texas Collaborative Initiative provides the opportunity for states or regions to align participating TQIP trauma facilities with the goal of reviewing data to identify high performers with optimal outcomes and to share the best practices learned from these high performers with the TQIP Collaborative members. These identified best practices, processes and strategies will be shared with other Texas trauma centers through TETAF with the aim of 0% preventable death rate from trauma, and improving the quality of trauma care for all injured patients in Texas.

Objectives

1. Each Texas Level I and II participating TQIP trauma centers will have the opportunity to participate in the Texas TETAF TQIP Collaborative Initiative to review selected outcomes.
2. Each participating TQIP trauma center will identify its trauma medical director, trauma program manager and trauma registrar who will participate in the collaborative initiative and provide contact information.
3. Each participating TQIP trauma center will revise its trauma performance improvement and patient safety plan to include the TQIP Collaborative Initiative as a component of the trauma performance improvement initiatives and benchmarking process and state that reports and information shared at these benchmarking collaborative meetings will be in an aggregate format, and deemed confidential documents to be discussed with the group but not disseminated. Reports and data generated from the collaborative meetings will be captured in minutes and aggregate reports may be produced from the Texas Trauma Registry to support the Texas TQIP initiative.

4. Each participating TQIP trauma center will ensure there is a Business Agreement on file with the TQIP and TETAF.
5. Each participating TQIP trauma center will share its protocols, guidelines and best-practice processes that are aligned with TQIP cohort reports as a higher performer with the collaborative members.
6. Each participating TQIP trauma center will receive the TQIP Collaborative Initiative de-identified reports prior to the scheduled meeting. Each facility will review the reports to define its areas of strengths and opportunities prior to the meeting and be prepared for the discussion to identify high performers and best practice care models.
7. Centers that identify themselves as high performers will prepare to discuss their guidelines and share their protocols at the meeting.
8. The TQIP Collaborative Initiative participating members will select a collaborative administrative coordinator who is responsible for the scheduling of the meeting, minutes, report/ document management, agenda and follow up.
9. The TQIP Collaborative Initiative participating members will select a trauma medical director to provide medical oversight of the collaborative process.
10. The TQIP Collaborative Initiative meetings will be held in conjunction with the quarterly Governor's EMS/Trauma Advisory Council meetings (November, February, May, August and at the TQIP Annual Conference).

Texas TQIP Collaborative Initiative

Participating Members

(need names, trauma center and contact information for the Trauma Medical Director, Trauma Program Manager/Director and Trauma Registrar)

Texas TQIP Collaborative Initiative Benchmarking Reports

1. **Texas participating TQIP Collaborative hospitals compared to other Texas TQIP collaborative members.**
2. **Texas participating TQIP Collaborative hospitals as one hospital compared to national TQIP hospital outcomes.**
3. **Texas participating TQIP collaborative hospitals as one hospital compared to other TQIP collaborative states/regions.**

Texas TQIP Collaborative Initiative

Texas EMS, Trauma & Acute Care Foundation Board Advisors

Job Function

The TETAF CEO and Director, TETAF Board Chair and the TETAF Board Vice Chair will serve as the TETAF Board of Advisors to the Texas TETAF TQIP Collaborative Initiative with the goal of ensuring that best practice recommendations gained from the Texas TETAF TQIP Collaboration are produced in a manner that benefits all Level I, II, III and IV trauma centers in Texas. The TETAF CEO, Board Chair and TQIP Trauma Medical Director will update the Regional Advisory Council Chairs quarterly and share the development and status of best practice initiatives.

Actions

1. TETAF Board Advisors will attend the scheduled Texas TQIP Collaborative Initiative meetings.
2. The TQIP Collaborative members will define and prioritize the best practice recommendations, and the TETAF Board Advisors are responsible for the sharing of the defined best practice recommendations with all Level I, II, III and IV trauma centers of Texas.
3. The TETAF Board Advisors and TQIP Medical Director will work with the Texas Trauma Registry to ensure data elements needed to capture the outcomes of these best practice recommendations are integrated into the state registry and reportable.
4. The TETAF Board Advisors will request aggregate data reports defined by the Texas TQIP Collaborative from the Texas Trauma Registry to evaluate progress and

outcomes to share with Texas TQIP Collaborative members and trauma community.

5. Any publications that are produced by the Texas TQIP Collaborative Initiative must be reviewed by the Texas TQIP Medical Director, Administrator, all members of the collaborative and Board Advisors prior to submission. This includes any data submitted for a grant, poster, presentation or publication.

Texas TQIP Collaborative Initiative

TQIP Collaborative Administrative Coordinator

Job Function

Prepares, plans, organizes and coordinates the TQIP Collaborative Initiative with the TETAF staff and TQIP Trauma Medical Director and the participating TTQIPCI members.

Actions

1. Establish a collaborative culture to promote the sharing of information and data.
2. Develops and manages a list-serve for all Texas TQIP participants to facilitate communication and discussion regarding the TQIP initiatives.
2. Schedules monthly conference calls, defines the agenda and records minutes of the discussion in collaboration with the TQIP Collaborative Trauma Medical Director.
3. Schedules quarterly Texas TQIP Collaborative meetings in conjunction with the GETAC meetings (February, May, August and November), defines agenda and records the minutes in collaboration with the TQIP Collaborative Trauma Medical Director.
4. Assists the Texas TQIP Collaborative Initiative Trauma Medical Director in identifying high performers.
5. Works with high performers to share “best practices.”

6. Develops orientation process to welcome new TQIP Collaborative Initiative members.

7. Assists the Texas TQIP Collaborative Trauma Medical Director as needed to facilitate the meetings.

8. Assists the Texas TQIP Collaborative Trauma Medical Director as needed to facilitate presentation and publication of the results of this initiative.

Texas TQIP Collaborative Initiative

TQIP Collaborative Trauma Medical Director

Job Function

Review the data to define high performers and gain insight into best practices. Develop a process to share best practices and strategies to standardize processes with collaborative members. Provide background data and information to support the best practice initiatives.

Actions

1. Establish a collaborative culture to promote the sharing of information and data.
2. Review site reports to identify high performers and format meeting discussions around strategies to standardize best practice models across Texas.
3. Facilitate discussions of evidence-based practice to improve trauma care in Texas, based on information gained from the TQIP reports
4. Facilitate the rollout of the TQIP Best Practice guidelines to ensure all Texas TQIP Collaborative members have access to the guidelines and all supporting documents.
5. Makes recommendations to the TETAF Board Advisors, the GETAC Trauma System Committee, the North and South Texas Chapters of the American College of Surgeons, and RACs regarding the Texas TQIP Collaborative findings and opportunities to standardize practice.

6. Lead the quarterly Texas TQIP Collaborative meetings and the annual Texas TQIP Collaborative meetings at the Annual TQIP Conference.

Texas TQIP Collaborative Initiative

Texas TQIP Collaborative Operating Procedures

Purpose: To outline the operating procedure of the Texas TQIP Collaborative Initiative meetings to ensure there is organization, secure data sharing and goal directed decision making that has the opportunity to improve overall trauma care in Texas.

Aim: Ensure all individuals of Texas who are injured receive optimal care.

0% Preventable Death Rate in Texas

Procedure:

1. The Texas TQIP Collaborative meetings will be scheduled a minimum of 60 days out.
2. The Texas TQIP Collaborative members will receive their reports from the TQIP office.
3. The Texas TQIP Collaborative members will define the decimal point that defines high performers.
4. The Texas TQIP Collaborative members will review their reports, identify their strengths and weaknesses, and be prepared to openly discuss their related issues with the Texas TQIP Collaborative members.
5. Facilities that identify themselves as high performers (as defined by the set decimal point) will be prepared to share their practice-guidelines and experience with the process with the Texas TQIP Collaborative members.
6. The Texas TQIP Trauma Medical Director and Administrator will organize the meeting agenda, space and timelines to foster healthy secure discussion.
7. The TQIP Trauma Medical Director will open the meeting and read the confidentiality statement.
8. All documents of the meeting and sign-in sheet will have the defined protective language on the first page. All performance improvement activities at the local, regional and state must follow:
   Health and Safety Code Chapter 773.995
   a) The proceedings and records of organized committees of hospitals, medical societies, emergency medical services providers, emergency medical services and trauma care system, or its responder organizations

relating to the review, evaluation, or improvement of an emergency medical services provider, a first responder organization, an emergency medical services personnel are confidential and not subject to disclosure by court subpoena or otherwise.

b) The records and proceedings may be used by the committee and the committee members only in the exercise of proper committee functions.

c) This section does not apply to records made or maintained in the regular course of business by and emergency medical services provider, a first responder organization, or emergency medical services personnel.

Pursuant to Section 160.007 of the Texas Occupations Code, the following information relating to trauma performance improvement review is confidential and privileged.

9. Individuals signing into the meeting are agreeing to maintain the confidentiality of the topics discussed and reports that generate the discussion cannot be disseminated or distributed outside of the meeting.
10. Breach of confidentiality matters will be addressed by the TETAF Board Advisors, Texas TQIP Collaborative Trauma Medical Director and Administrator.
11. Minutes from the meeting are confidential and will not be distributed or disseminated outside of the collaborative members.
12. The action plan from the meeting will be summarized in a separate document from the minutes and will serve as a guide for best-practice development.
13. The Board Advisors, TQIP Trauma Medical Director and collaborative members will use the Texas TQIP Collaborative action plan to share activities with the TETAF Board and members, the GETAC Committees and the RAC Chairs.
14. Items will be tracked for completion and re-monitored with data obtained from the Texas Trauma Registry and following Texas TQIP Collaborative meetings.
15. Questions regarding the Texas TQIP Collaborative Initiative will be directed to the Trauma Medical Director
16. All participating Texas TQIP Collaborative members have the opportunity to review the operational guidelines and make comments and recommendations for improvement to the identified Administrator and Trauma Medical Director.

TQIP Responsibilities of the Trauma Center Trauma Medical Director (TMD)

The Trauma Medical Director (TMD) is responsible for the oversight and authority of the trauma center's performance improvement and patient safety plan development, implementation, and evaluation of the trauma program's outcomes. The success of the center's TQIP program is a primary function of the performance improvement and trauma registry initiatives of the trauma center. The trauma program manager manages the daily activities of these job functions in collaboration with the TMD. The trauma medical director is responsible for ensuring the oversight along with ensuring the organization of services and systems necessary for a multidisciplinary approach to providing optimal care to injured patients within the trauma center are met. As the authority and oversight for Performance Improvement (PI) initiatives, the TMD is the leader for quality improvement initiatives, fostering integration of TQIP outcomes into the hospital performance improvement initiatives. This role covers all aspects of oversight for the phases of care and multidisciplinary interactions within the trauma center. This individual evaluates the TQIP initiatives and leads the discussion to identify opportunities, benefits and compliments of the ACS TQIP to the established TPIPS initiatives of the trauma center in collaboration with the TPM.

Key Responsibilities include:

- Provides the authority for the ACS TQIP program integration into the trauma center, directs trauma care improvements.
- Identify and engage TQIP PI stakeholders.
- Provides the authority for the implementation and administration of ACS TQIP initiatives.
- Leads the review, and discussion of the TQIP benchmark reports.
- Leads the review of the TQIP reports and TQIP Best Practice Guidelines with the trauma liaisons of anesthesia, emergency medicine, radiology, orthopedics, neurosurgery and critical care to identify opportunities.
- Defines the priorities for sharing of finding of the TQIP reports to relevant hospital stakeholders:

    - Provides education regarding the impact all departments have on trauma patient outcomes and documentation, promoting ownership of data
    - Identify high performers and develops strategies to improve performance where needed
- Use TQIP results to identify areas for improvement and focus PI efforts.
- Authorative leader regarding sharing of PI activities; ensuring successful integration of TQIP into hospital quality programs, continuously looking for opportunities for improvement.
- Leads in the development and planning of PI goals and best practices related to trauma care.
- Leader in championing TQIP and Trauma Center Verification education within facility and trauma center.
- Oversees the TQIP deliverables in alignment with TPM.
- Monitors data validation to ensure accuracy of your hospital trauma registry data.
- Share TQIP data and performance improvement lessons and solutions with collaborative partners.
- Share high performance outcome best practice models with ACS TQIP collaborative partners.
- Defines selected outcome measures for the trauma patient population based on the TQIP findings; coordinating data TPM.
- Contributes as requested to ACS TQIP committees.
- Participates in the Texas TQIP Collaborative Initiative
    - Reviews TQIP Collaborative Reports to define areas of high performance and areas of low performance.
    - Works with TPM to share high performance contributing factors with other collaborative members.
    - Ensures confidentiality for all meeting discussion and reports shared at the collaborative meeting.

- Participates in workgroups and strategies to move identified best practice models to all trauma centers in Texas.
- Serves as a champion in their regional system and shares information in the regional performance improvement meetings.

TQIP Responsibilities of the Trauma Center Trauma Program Manager

The Trauma Program Manager (TPM) is fundamental to the development, implementation, and evaluation of the trauma program. The success of the TQIP program is a primary function of the TPM, along with the obligation for the organization of services and systems necessary for a multidisciplinary approach to providing optimal care to injured patients within the trauma center. TPM is an authoritative leader in the process for Performance Improvement (PI) initiatives; the TPM fosters positive outcomes for the trauma patient and system. This role is critical to the success of the trauma center's performance improvement and patient safety processes. This role covers all aspects of the phases of care and multidisciplinary interactions for successful trauma outcomes. This individual evaluates the TQIP initiatives and reports to identify opportunities, benefits and compliments of the TQIP process to the established TPIPS plan of the trauma center in collaboration with the TMD. The TPM is responsible for the oversight, coordinating/engagement and outcomes of the facility's TQIP team.

Key Responsibilities include:

- Primary lead and ACS TQIP program spokesperson/advocate, directs trauma care improvements.
- Identify and engage TQIP PI stakeholders in conjunction with the trauma medical director.
- Leads sharing the TQIP reports with the nursing leaders for the emergency department, OR, ICU, inpatient setting and clinical support departments.
- Oversee implementation and administration of the center's ACS TQIP initiatives.
- Review, understand, and share TQIP benchmark reports.
- Disseminate TQIP reports to relevant staff at hospital in conjunction with the TMD:
    - Provides education regarding the impact all departments have on trauma patient outcomes and reporting, promoting ownership of data
    - Identify high performers and define strategies to improve performance where needed

- Use TQIP results to identify areas for improvement and focus PI efforts.
- Share responsibility for PI; ensuring successful integration of TQIP into the center's hospital quality programs, continuously looking for opportunities for improvement.
- Works in collaboration with the TMD regarding development and planning of the trauma center's PI goals and best practices to foster optimal outcomes.
- Participate in and champions TQIP and Trauma Center Verification education within facility.
- Manages the center's TQIP deliverables in collaboration with the TMD.
    - Abstraction
    - Registrar compliance
    - Registrar education and development
    - Performance Improvement initiatives
    - Complications and co-morbidities review
    - TQIP offered tutorials and engage the registrars and medical staff
    - Attend and monitor the registrar's participation of the TQIP Monthly Educational Experiences
    - Attend and monitor the registrar's participation in the Monthly registry staff web conference
    - Attend and monitor the registrar's participation in the TQIP online course
    - Integrate data validation reports to performance evaluations
    - Attend and participate in the TQIP Annual Conference (funding made available by hospital)
- Through data validation ensure accuracy of hospital trauma registry data.
- Work with vendor for timely upgrades, data capture for required fields and field values.
    - Coordinate with trauma registry vendor for mapping and NTDS compliance
    - Work with registry staff to ensure that data is submitted quarterly to TQIP

    - Work with registry staff to ensure that Validator and Submission Frequency reports are an accurate representation of the data in your trauma registry.

- Share TQIP data and performance improvement lessons and solutions with other TQIP Centers.
- Share high performance outcomes with ACS TQIP and collaborative partners.
- Facilitate the measurement of selected outcomes for the trauma patient population; coordinating data with TQIP staff.
- Participates in the Texas TQIP Collaborative Initiative
    - Reviews TQIP Collaborative Reports to define areas of high performance and areas of low performance.
    - Works with TMD and registry staff to share high performance success with other collaborative members.
    - Responsible to maintain confidentiality of all meeting discussion and reports shared at the collaborative meeting.
    - Participates in workgroups and strategies to move identified best practice models to all trauma centers in Texas.
    - Serves as a champion in their regional system and shares information in the regional performance improvement meetings.
- Contributes as requested to ACS TQIP committees.

TQIP Responsibilities of the Trauma Program Registrar (TPR)

The trauma program registrar (TPR) is fundamental to the trauma center's performance improvement process of evaluation of trauma patient outcomes. The success of the TQIP program is a primary function of the TPR with the obligation to provide high quality and timely data within the trauma center. The trauma registry is a direct link in the process for Performance Improvement (PI) initiatives. The TPR serves as a leader in quality data abstraction, data entry, coding and data validation to submission. This role is critical to the success of the trauma center's performance improvement and patient safety processes. This role manages the data integration for the trauma registry and performance measures. This individual captures data for the TQIP initiatives and assists in identify opportunities by reviewing the ACS TQIP reports and feedback. TPR role is instrumental in capturing data to reflect outcomes of new initiatives and practices implemented as a result of the TQIP reports. TPR is responsible for the oversight, coordinating/engagement of the data validation reports for the trauma center.

Key Responsibilities include:

- Collaborates with the TPM to define optimal processes for data abstraction and measures to ensure data timeliness, accuracy and completeness for trauma registry inclusion and participation in TQIP.
- Primary lead for data extraction and validation for the ACS TQIP program.
- Participates in the review of the TQIP benchmark reports.
- Use TQIP results to identify areas for improvement in data validation and management.
- Participate in and champions TQIP and Trauma Center Verification education.
- Actively engage in the center's TQIP deliverables in alignment with TPM hospital role
    - Abstraction
    - Data compliance
    - Participates in the registrar education and development opportunities

    - Captures data to support the performance improvement initiatives
    - Captures data for review of complications and co-morbidities review
    - Attends the TQIP offered tutorials and engage all registrars
    - Attend the registrar's TQIP Monthly Educational Experiences
    - Attend TQIP monthly registry staff web conference
    - Attend the registrar's TQIP online courses
    - Integrate data validation reports into performance opportunities
    - Attend and participate in the TQIP Annual Conference (funding made available by hospital)
- Ensures data accuracy of trauma center's trauma registry data.
- Work with vendor for timely upgrades, data capture for required fields and field values.
    - Assist with the trauma registry vendor for mapping and NTDS compliance
    - Ensure that data is submitted quarterly to TQIP
    - Ensure that Validator and Submission Frequency reports are an accurate representation of the data in your trauma registry.
- Share TQIP data solutions with other TQIP Centers.
- Participates in the Texas TQIP Collaborative Initiative
    - Participates in the review of TQIP Collaborative Reports to define areas of high performance and areas of low performance.
    - Works with TPM to prepare to share high performance success with other collaborative members.
    - Responsible to maintain confidentiality for all meeting discussion and reports shared at the collaborative meeting.
    - Participates in workgroups and strategies to move identified best practice modes to all trauma centers in Texas.
    - Serves as a champion in their regional system and shares data management successes.
- Contributes as requested to ACS TQIP committees.

Example Trauma Performance Improvement and Patient Safety Plan Integrating TQIP and the Texas TQIP Collaborative Initiative

Example TPIPS Plan

Anytown in Texas Trauma Center

Trauma Performance Improvement & Patient Safety Plan

Trauma Program Philosophy

DEFINE

Mission

DEFINE

Vision

DEFINE

Aim Optimal outcomes for all individuals injured and cared for in this trauma center

0% Preventable mortality and morbidity

Authority

The Board of Managers and the Medical Staff Committee have documented their commitment to the trauma center through signed Resolutions. The Chief Executive Officer, Chief Operating Officer, Chief Medical Officer and Chief Nursing Officer have defined an organizational structure and job descriptions that define the authority of the Trauma Center. The senior vice presidents, the trauma medical director

and the nursing director of the trauma program are accountable for the oversight of the trauma center. In this capacity, these individuals have the authority and oversight for the trauma performance improvement and patient safety program, TQIP deliverables, the trauma registry data management, injury prevention programs, outreach education, research and regional integration. These individuals are responsible for establishing the structure and process of the trauma performance improvement patient safety plan. This plan defines the criteria for review, data definitions, levels of review and the processes for review. The job descriptions for these three individuals define that they are responsible for the management and oversight of Parkland's XXXXXX compliance with the American College of Surgeons' Committee on Trauma's level X trauma center criteria, as well as the Texas regulations for a trauma center.

The outcomes of the trauma performance improvement and patient safety plan are reported monthly through the Trauma System Operations Committee and bi-annually to the hospital quality committee. The trauma performance improvement and patient safety plan is integrated with the institutional Performance Improvement Program, Risk Management and Medical Staff Peer Review Process. The Chief Medical Officer has the ultimate authority for all medical care within XXXXX in collaboration with the TMD.

The trauma performance improvement process and patient safety plan follows the Texas regulations regarding confidentiality, which are listed below.

Health and Safety Code Chapter 773.995

Records and Proceedings Confidential

a) The proceedings and records of organized committees of hospitals, medical societies, emergency medical services providers, emergency medical services and trauma care system, or its responder organizations relating to the review, evaluation, or improvement of an emergency medical services provider, a first responder organization, an emergency medical services personnel are confidential and not subject to disclosure by court subpoena or otherwise.

b) The records and proceedings may be used by the committee and the committee members only in the exercise of proper committee functions.

c) This section does not apply to records made or maintained in the regular course of business by and emergency medical services provider, a first responder organization, or emergency medical services personnel.

Pursuant to Section 160.007 of the Texas Occupations Code, the following information relating to trauma performance improvement review is confidential and privileged.

All documents and reports generated through the review process are defined as confidential and cannot be disseminated or shared outside of the trauma performance improvement process and patient safety plan. Reports are reflected in aggregate data without identifiers.

Scope

The trauma performance improvement process and patient safety plan (TPIPSP) reviews all trauma team activations and the care of trauma patients admitted to Anytown trauma center. Inclusion criteria for the TPIPSP process begins with meeting trauma team activation criteria. Trauma activations are screened for compliance of the activation protocol, timeliness of response and dispositions. Trauma activations that are admitted and those that expire or are transferred out of Anytown Trauma Center are reviewed through the TPIPSP process. The TPIPSP process reviews all phases of care from pre-hospital, resuscitation, operative intervention, critical care, stabilization, general care and movement to rehabilitation. Each trauma admission is screened for compliance to trauma center verification criteria, variation from the defined standard of care or protocols, morbidity, mortality, system expectations, and patient safety goals.

The TPIPSP primarily focuses on those patients that have an ICD.9 of 800-959, excluding the following

- 905-909 or late effects of injury
- 910-924 or blisters, contusions, abrasions and insect bites
- 930-949 or burns without trauma
- Patients who are evaluated, resuscitated, treated and released
- Patients who are treated and released from the Ambulatory Surgical Center
- Patients who are OB patients with no defined trauma injury
- Patients who are admitted for cellulitis from IV drug abuse
- Patients who are admitted whose injury is secondary to a primary medical diagnosis which caused the event

The trauma center participates in national quality data projects to ensure trauma outcomes are comparable to national outcomes. This is through participation in the NTDB, TQIP and the Texas TQIP Collaborative Initiative which provides national and regional benchmarking comparison data that is used to define opportunities for improvement.

Credentialing

The senior vice president for surgical services is responsible for ensuring the administrative leadership team is knowledgeable of the current trauma center criteria and trauma center needs. The senior vice president is responsible to ensure trauma center criteria across the hospital divisions meets expectations and ensures all medical staff contracts that support the trauma center are in compliance and reviewed annually.

The trauma medical director's job description defines the performance requirements and responsibilities of the trauma medical director. The trauma medical director is responsible for the core trauma surgeons and trauma liaison's credentialing to participate in the Trauma Program and trauma call schedule. The trauma surgeons' and liaison's role in the TPIPSP are defined in their credentialing process.

The trauma surgeons credentialing process include the following:

DEFINE

The trauma liaisons for emergency medicine, neurosurgery, orthopedics, interventional radiology, surgical critical care and anesthesia credentialing process include the following:

DEFINE

The trauma program manager is responsible for the education, training and competency of the trauma program staff. In addition, the director ensures that all level I trauma center criteria, across all departments are met and trauma patient care meets the national standards of care. The trauma program manager has direct oversight of the trauma performance improvement process, TQIP deliverables, trauma registry, data management, injury prevention, outreach education, and compliance to trauma center criteria.

Trauma Patient Population Criteria

As previously stated, the TPIPSP primary focuses is on the admitted trauma patients that have an ICD.9 code of 800-959, excluding the following

- 905-909 or late effects of injury
- 910-924 or blisters, contusions, abrasions and insect bites
- 930-949 or burns without trauma
- Patients who are evaluated, resuscitated, treated and released
- Patients who are treated and released from the Ambulatory Surgical Center
- Patients who are OB patients with no defined trauma injury
- Patients who are admitted due to cellulitis from IV drug abuse
- Patients who are admitted whose injury is secondary to a primary medical diagnosis which caused the event

All trauma patients that meet the inclusion criteria and are admitted to the hospital, expire or are transferred out are included in the review of the trauma performance improvement and patient safety process. In addition, all trauma team activations are reviewed for compliance to activation protocols, correct levels of activation and timeliness of activation.

EMS Collaboration

Each patient that arrives by EMS from the scene or is transfer is reviewed to ensure the completed EMS patient care record is available. Records that do not have the EMS patient care records, or have incomplete EMS patient care records are defined and trauma program staff will call the agency to obtain the record. This data is tracked and shared as needed with the various EMS agencies and the Regional Advisory Council. Care prior to arrival is reviewed for compliance to national and regional standards of care.

EMS agencies can request feedback regarding trauma patients by contacting the trauma office. This can be done in a formal letter or by utilizing a referral or by emailing XXXXXXXX. Information is provided for continuum of care and education only. Information is only provided to the agency that transported the trauma patient. Shared information includes the patient's mechanism of injury, identified injuries, injury severity score, and ED disposition.

Trauma Patient Transfers

Each trauma patient that is transferred to Anytown trauma center is screened for care prior to the transfer, timeliness of transfer, completion of the memorandum of transfer, complete hospital records, and transfer notification. Issues identified are tracked through the TPIPS process. Identified variances are referred back to the transferring facility.

Each referring facility receives transfer follow up from Anytown trauma center. The follow-up includes the identified injuries, injury severity score and disposition from the trauma resuscitation bay as well as care within the first twenty four hours of admission. In addition, any opportunities for improvement are forwarded back to the transferring facility. All documents are defined as confidential and sent back to the identified trauma program manager. If the facility is a non-designation facility the information is sent to the hospital risk manager.

Trauma patients that are transferred out of Anytown's trauma center are screened for reason for transfer, location of transfer (trauma resuscitation bay verses inpatient setting), timeliness of transfer, complete memorandum of transfer, transfer check list, transfer consent, physician communication and documentation sent with the patient. Issues identified are processed through the TPIPS process and then forwarded to regulatory for review.

Data Collection and Review

Each trauma patient that meets criteria for review in the TPIPSP is screened for variations in the defined national trauma standards of care, morbidity, mortality, system variances, patient safety goal performance, financial measures and clinical outcomes. This process encompasses all phases of care

from pre-hospital, resuscitation through hospital admission to discharge and their follow-up clinic visits, or their expiration or transfer to another acute care facility. All documentation in the medical record is reviewed during this process.

The review includes the following documents but is not limited to these documents:

EMS Patient Care Records / Air Medical Reports

Facility Transfer Documents (Transferred Patients)

Trauma Nursing Assessment (trauma flow sheet)

Trauma History and Physical

Admission Notes / Physician Admission Orders

Emergency Physician Assessment

Consultation Notes

Radiology Notes / Reports

Pathology Reports

Respiratory Therapy Notes

Progress Notes

Operative Records

Operative Summaries

Anesthesia Records

All consents

Critical Care Nursing Documentation

Critical Care Physician Documentation

General Care Nursing Documentation

Physical Medicine and Rehabilitation Assessment and Notes

Nutritional Services Notes

Financial Notes

Interdisciplinary Education Notes

Trauma Psychosocial Team Notes

Discharge Planning Notes

Discharge Notes

Discharge Summaries

Medical Examiner Summary

System documents that assist in defining the timeliness and coordination of care issues

Patient Grievance Reports / Patient Complaints

Patient Call Back Reports

Patient Safety Reports

Referrals from Risk Management

The review process begins on admission with review of the pre-hospital records and daily through the patient's sequence of care or continuum of care through to discharge or death. All performance and safety goal events that are identified are documented appropriately for the TPIPSP. Each event is validated by documentation and meeting the NTDB data definitions for the event. (See attachment DEFINE.)

Data Definitions

TPIPSP data elements are defined. The trauma medical director and trauma program manager are responsible for the data definitions and compliance with the NTDB. The trauma medical director is responsible to ensure all trauma surgeons and trauma liaisons are updated on the data definitions and have access to the definitions. The trauma program manager is responsible for the staff education, knowledge and competencies utilizing the data. The trauma registry manager is responsible for all registrars' compliance with the NTDB data definitions. The Trauma System Operations Committee is responsible for approval of all revisions to ensure all departments are aware of the changes.

The Trauma Program has data definitions for all events that are reviewed through the performance review process.

The following list defines the categories for events:

- Medication error
- Adverse Drug reaction
- Equipment, supply device event
- Complications

- Treatment or diagnostic procedure event
- Transfusion related event
- Delayed, missed injury diagnosis
- Variance to the standard of care, protocol compliance
- Premature removal of device (PROD)
- Unplanned ICU admission
- Unplanned readmission
- Unplanned operative intervention or unplanned return to the OR
- Loss of body part, function of organ not related to the initial injury
- Loss of vision, hearing, sight not related to the initial injury
- Loss of mobility: paraplegia or quadriplegia not related to the initial injury
- Injury occurrence in hospital
- Wrong site surgery
- Disruptive behavior
- Mortality
- Diversion hours
- Trauma center criteria compliance
- Regulatory compliance
- Staff satisfaction
- Patient satisfaction

The National Data Bank Standards provides the data definitions for the complications and co-morbidities.

In addition, the TQIP process measures and definitions are integrated into the TPIPSP data definitions.

Primary Review: Issue Identification, Validation, Documentation

Each trauma patient admitted to the trauma center is screened daily for variations from the standard of care or events. Events identified are validated by documentation in the medical record or appropriate

records. The event is then documented in the trauma registry PI section. . Documentation defines the time sequence of the event, process of events, who was involved and location. All documentation is objective and subjective information is avoided. These events may be related to the patient, practitioner/provider, system or operational events, financial or clinical events. Review of the event begins with patient background information and a patient history. The impact of the event and level of harm are defined first. The type of event and where the event occurred (domain) are identified and documented.

Process for Performance Improvement and Patient Safety Review

The timeline for events, morbidity and mortality reviews are weekly, from 0700 XXXX through to O700 the following XXXXX. The primary review is with the trauma program manager and trauma program staff. If the issues is a system related issue with no defined harm to the patient, the trauma program manager is responsible to manage the action plan notify the TMD. All other events are prepared for further levels of review. All issues are then reviewed each XXXXX by the trauma medical director / designee and the director of the trauma program / designee. The trauma program manager and staff are responsible for preparing all identified events for review and screening.

Levels of Review

Primary Review: Issue identification, validation, and documentation.

The trauma program manager and staff are responsible for the issue identification, validation and time sequence documentation of the event and linkage to pertinent patient records.

The trauma program manager has the authority to manage the action plan for system related events, delays, and documentation issues that do not cause harm to the patient. These defined action plans are then reviewed with the Trauma Medical Director.

Secondary Review: Defines the cause and action plan or prevention measures to reduce the incidence and effects of the events.

All variances to the standard of care that cause harm to the patient and all morbidity and mortality cases identified are validated and documented and prepared for the secondary level of review with the TMD. The review process serves as a screening process for all identified case reviews and. Members present include the TMD, TPM, TPR, trauma surgeons, orthopedics, neurosurgery and representatives from the emergency department, radiology, operating suite, and inpatient units. The trauma medical director defines the cause and preventative action for each identified issue. The medical director may define action plans, refer them to specialty services/departments for additional information, refer them to the Regional Advisory Council for review through the System Performance Improvement Meeting, or request the case to be presented at the trauma multidisciplinary peer review committee. The trauma program manager is responsible for the follow up activities of the meeting. The medical director is

responsible to notify all services requested to present at the trauma multidisciplinary peer review committee.

The trauma program manager prepares the performance improvement documents for data entry into the patient's trauma registry profile. The trauma registrar attending the multidisciplinary trauma performance improvement meeting notifies all trauma surgeons and trauma liaisons of the targeted cases for peer review. The trauma program manager is responsible for tracking all referrals and follow up of all preventative measures.

Tertiary Review: Trauma Multidisciplinary Peer Review Committee

The Trauma Multidisciplinary Peer Review Committee is chaired by the Trauma Medical Director/designee. Minutes reflecting the critical discussion, judgment and actions from the discussion are recorded by the trauma program manager / designee. The trauma medical director leads the critical discussion with the trauma surgeons, trauma liaisons from emergency medicine, orthopedics, neurosurgery, surgical critical care, interventional radiology, anesthesia, and other invited faculty or fellows. The trauma surgeons, trauma liaisons and the SICU team participate in the review, judgment and action plan recommendations for each case. In addition, specialty services participate in the review process as requested. It is the responsibility of the trauma medical director to define the judgment and overall action plan for each case. The trauma medical director and trauma program manager are responsible to track identified issues and the outcome of the defined action plans.

Identified needs or action plans are then listed on the agenda of the Trauma System Operations Committee under the performance improvement section to facilitate tracking of the action plan and resolution of event(s).

The Trauma Multidisciplinary Peer Review Committee is held every XXXX from XXXXX in the XXXXXX Conference Room. The committee may be cancelled at the discretion of the trauma medical director. Selected cases for discussion will be listed on the following week.

The trauma medical director may request a case referred to the Medical Staff Peer Review Committee. The trauma program manager will prepare all documents and share all findings with the coordinating office. A cover letter requesting the date of review is sent back to the trauma program manager serves as follow-up of the referral.

All meeting discussion, minutes and activities are confidential and protected. Visitors are not permitted during the peer review discussion and must be approved by the trauma program manager and TMD. Sign-in attendance must be maintained.

Taxonomy Utilized for Trauma Performance Improvement and Patient Safety

Event or deviation from the standard of care occurs

Event impact causes a level of harm to the patient. Review will define the level of harm.

Levels of Harm

1. No harm
2. No detectable harm: practice guidelines followed but with deviations from protocols or delays in care with no detectable harm; event occurred but did not reach the patient
3. Minimal: Noninvasive intervention but does not impact morbidity or mortality or require higher level care; resolves prior to discharge
4. Temporary: Condition resolves prior to discharge from the trauma admission or there is an expectation that it will resolve within 6 months of discharge from the trauma admission
5. Permanent: Condition is present at discharge and does not resolve within 6 months of discharge from the trauma admission
6. Moderate: Invasive intervention and/or higher level of care (e.g., transfer to ICU, higher level center, specialty center, or need for surgery, interventional radiology, etc.)
7. Severe: Organ failure and/or prolonged (>48hours) need for higher level of care
8. Death: event linked to the patient's death.

Impact

The event defined what impact on the patient. Impact is the outcome or effects of a potential or real adverse or system event.

Medical Impact

The most severe level of harm identified should be recorded. Final determination of temporary vs permanent harm should be assigned at the time of trauma center discharge

Physical

- Defined by the levels of harm.

Psychological

- No Harm -Sufficient information or able to determine that no harm occurred
- No Detectable Harm-Insufficient information or unable to determine any harm
- Minimal-Temporary Harm- Requires little or no intervention
- Minimal-Permanent Harm-Requires initial but not prolonged intervention
- Moderate-Temporary Harm- Requires initial but not prolonged hospitalization
- Moderate-Permanent Harm-Requires intensive but not prolonged hospitalization
- Severe-Temporary Harm-Requires intervention necessary to sustain life but not prolonged hospitalization

- Severe-Permanent Harm- Requires intervention necessary to sustain life and prolonged hospitalization, long-term care
- Profound Mental Harm

Non-Medical

Legal

- Risk management contacted
- Complaint registered
- Discussion of Suit filed
- Other _____

Social

- Change in mobility and independence
- Satisfaction with care
- Other _____

Economic

- Prolonged hospital stay
- Unnecessary hospital admission
- Improper admission : full admission vs observation
- Unnecessary EMS or Aeromedical Transport
- Unnecessary transfer
- Unnecessary procedure or care
- Access to rehabilitation care
- Loss of property
- Difficult placement
- Other _____

TYPE

The implied or visible processes that were faulty or failed (and thereby led to the sentinel event).

Communication

Communication between provider and patient, patient surrogate, multidisciplinary team and other providers. Includes unavailability of information.

- Inaccurate & Incomplete Information
- Questionable advice or Interpretation
- Questionable consent process
- Questionable disclosure process
- Questionable documentation
- Other _____

Patient Management

- Questionable Delegation
- Questionable Tracking or Follow-up
- Questionable Referral or Consultation
- Questionable Use of Resources
- Other _____

Clinical Performance

The range of actual or potential clinical care rendered (activities and/or decisions) that led to the event.

Pre-Intervention

- Correct Diagnosis Questionable Procedure
- Inaccurate Diagnosis
- Incomplete Diagnosis
- Questionable Diagnosis
- Missed injury[1]
- Delayed diagnosis[2]
- Delayed transfer
- Decision making prior to arrival
- Patient refused care
- Other _____

Intervention

- Correct Procedure with Complication
- Correct Procedure, Incorrectly Performed
- Correct Procedure, But Untimely
- Omission of Essential Procedure
- Procedure Contraindicated
- Procedure Not Indicated
- Wrong Patient
- Other _____

Post-Intervention

- Correct Prognosis
- Unexpected Outcome
- Inadequate post-procedure/discharge instructions
- Inadequate discharge planning
- Other _____

[1] Missed injury: An injury discovered after the patient is discharged or after death (includes those found on autopsy).

[2] Delayed diagnosis: An injury found after completion of a trauma tertiary survey, but before the patient leaves the hospital.

DOMAIN

The characteristics of the setting in which an incident occurred and the type of individuals involved*.*

Setting

- Scene
- Ground Transport
- Air Transport
- Transferring Facility
- Emergency Department
- Trauma Resuscitation Bay
- Radiology
- Interventional Radiology
- Operating Room
- Post Anesthesia Care Unit
- Intensive Care Unit
- Step Down Unit
- Floor
- Rehabilitation
- Outpatient (Clinic)
- Other _____

Phase

- Evaluation
- Resuscitation
- Acute Care
- Post Discharge
- Other _____

Time

- Weekday
- Weekend/Holiday
- Day
- Night
- Shift Change
- Other _____

Staff

Providers

- Trauma Surgeon
- Fellow

- Resident
- Advanced Practice Provider
- EM Physician
- Intensivist
- Neurosurgeon
- Orthopedic Surgeon
- Anesthesiologist
- CRNA
- Radiologist
- OMFS
- Plastic Surgeon
- Ophthalmologist
- PM&R
- Referring Physician
- Other _____

Nurses

- Registered Nurse
- LPN
- Nursing Assistant
- Float Staff
- Other _____

Therapists

- Physical Therapist
- Occupational Therapist
- Respiratory Therapist
- Speech Therapist
- Respiratory
- Other _____

Other Disciplines

- Pharmacist
- Radiology Technician
- Lab
- Catheterization Team
- Blood bank/perfusion
- Emergency Medical Service Providers
- Medical Control
- Other _____

Patient

These data are probably in the registry and should be populated from the registry wherever possible

- Age

- Gender
- Diagnosis
- Coexisting Conditions
- Anticoagulation Therapy
- History of family / partner violence
- Alleged Criminal Assault
- Pre-existing spinal cord injury
- Pre-existing amputation
- Duration of Disease
- Socioeconomic Status
- Educational Level
- Race & Ethnicity
- Transfer From Out of RAC
- Transfer From Out of State
- From Jail
- 72 Hour Bounce-Back
- Readmission
- Floor to ICU admission
- Community Acquired Event Prior to arrival (Pneumonia, UTI, etc…)
- Alleged Criminal Assault
- Other _____

Cause

The factors and agents that were associated with an event.

System Factors

Structures and/or processes not under the direct control of the clinician. These may involve design, organization, orientation, training, maintenance, availability of information, staffing levels, physical environment, alarm systems, etc.

- Electronic Medical Record
- Registration
- Schedules
- Resource Availability
    - Equipment
    - Personnel
    - Other _____
- Hand-off process
- Multiple Casualty Incident
- Inadequate or absent Policy or Patient Management Guideline
- Diversion
- Referral Process
    - Incorrect service or consultation
    - Incorrect transfer team
    - Surgeon not available to speak with referring physician
    - Other _____

- Trauma Team Activation
    - Short notification
    - Page confusing
    - Incomplete page
    - Other _____
- Care Prior to Arrival

Human Factors

Practitioner Factors

- Skill-based (Failure in execution of "preprogrammed" and stored instructions or routine tasks)
- Rule-based *(Failure in retrieval and usage of stored instructions or in performing familiar tasks)*
- Knowledge-based *(Failure due to resource limitation [e.g., insufficient time to learn], and incorrect or incomplete knowledge)*
- Negligence *(Failure to perform at the level of competence consistent with professional norms of practice and operation)*
- Recklessness *(Intentional deviation from professional norms of good practice and operation without cause)*
- Intentional Rule Violation *(Knowingly violates a rule or procedure)*
- Other _____

Patient Factors

Failures related to patient characteristics or actions that are beyond the control of the practitioner

- Arrived with no signs of life
- Arrived with signs of life
- Resuscitation attempts failed
- Advanced Directive in place
- Family withdrew care
- Injury Severity
- Event due to consequences of injury
- Palliative care admission
- Uncooperative/Non-compliant
- Left against medical advice
- Left without being seen
- Left before treatment completed
- Family issues
- Suicidal
- Family related needs
- Translator needs
- Difficult placement
- Homeless
- Other _____

Social Factors

- Family issues

- Suicidal
- Psychiatric emergency detention
- Behavioral issues
- Family related needs
- Translator needs
- Difficult placement
- Homeless
- History of interpersonal violence in home
- Other _____

PREVENTION AND MITIGATION

(Determination and action plan)

Determination

- Event with Opportunity for Improvement
- Event without Opportunity for Improvement
- No Error
- Mortality without Opportunity(ies) for Improvement
- Anticipated Mortality with Opportunity(ies) for Improvement in Trauma Center
- Unanticipated Mortality in Trauma Center
- Mortality with Opportunity(ies) in the Regional System
- Other _____

Action Plan

Action plan will be written in SMART Goal format with defined outcome measures.

- Periodic Report
- Develop Practice Management Guideline or Policy
- Education
- Peer Review Committee
- Strategic Planning Needs
- Refer for Hospital Performance Improvement Review
- Refer to EMS for Review
- Refer to EMS Medical Director for Protocol Review
- Refer to Regional System for System PI
- Counselling
- Ongoing Professional Practice Evaluation (OPPE)
- Change in Privileges
- Other _____

Monthly Dashboard

DEFINE

Trauma System Operations Committee

The trauma system operations committee serves as the administrative oversight and system operational committee for the trauma program. The committee is chaired by the trauma medical director. The committee has membership from the various disciplines and departments that impact trauma care. The committee's primary focus is to review the trauma dashboard, trauma statistics, trauma outcomes and compliance to trauma center criteria to ensure Parkland is consistently meeting the requirements for a level I trauma center. The objectives of the committee are to ensure that Anytown Hospital is meeting trauma center verification criteria, provide administrative leadership and oversight for performance improvement initiatives and to define improvement opportunities in the system, ensure that changes in the system are appropriately communicated to all disciplines. The committee is charged with ensuring there is a coordinate effort for strategic planning for injury prevention, outreach education, patient safety and trauma related research. Members must maintain a minimum of 50% attendance at the scheduled meeting.

Committee Members:

Trauma Medical Director

Trauma Program Manager

SICU Medical Director

Orthopedic Liaison

Neurosurgery Liaison

Surgical Critical Care Liaison

Emergency Medicine Liaison

Anesthesia Liaison

Interventional Radiology Liaison

Out Reach Education / Injury Prevention Coordinator

Trauma Advanced Practice Provider Representative

Trauma Registry

In-Patient Director / Representative

Clinical Education

Social Services / Care Management

EMS / EMS Medical Control

Admissions/Discharge/Transfer

Pathology

Blood Bank

Rehabilitation

Infection Control

Meeting Schedule

DEFINE

Hospital Integration

DEFINE

Confidentiality

All documents that support the Trauma Performance Improvement and Patient Safety Plan are confidential and maintained by the trauma program manager. These documents are filed and secured behind locked doors.

The trauma medical director reviews the Health and Safety Codes that define the confidentially protection before each meetings. Participants sign in and agree to the confidentiality of the meeting and associated discussion. Individuals that do not follow the confidentiality standards are addressed for individual performance standards.

All trauma program staff signs an annual confidentiality statement and agreement. Issues of breach of confidentiality are subject to disciplinary action.

Registry Integration

DEFINE

Benchmarking

Anytown hospital submits data to the American College of Surgeons (ACS) NTDB each quarter. In addition, ATH participates in the Trauma Quality Improvement Program (TQIP) which is sponsored by the ACS. The annual report received from the NTDB is used to compare ATH's outcomes to the outcomes reported through the NTDB. Variances or outcomes where ATH's performance is below the national outcomes are targets for performance improvement projects.

The reports received from the TQIP program are reviewed for opportunities for improvement. The medical director and/or the trauma program manager have the authority to develop performance improvement workgroups to address specific patient populations or injuries. The activities of all assigned performance improvement activities are reported through the Trauma System Operations Committee and included in summary reports to the hospital's Quality XXXXXX. TQIP's Best Practice Guidelines are reviewed for potential opportunities for improvement and integration into the trauma center's trauma protocols. These best practice guidelines are then integrated into the trauma performance improvement reviews to monitor compliance. Variations are processed through the standard levels of review.

The trauma medical director will define the plan for the review of the TQIP reports in conjunction with the trauma program manager and define the attendees for the meetings. All meetings discussion, minutes and activities are confidential. Reports are not disseminated outside the scheduled meetings.

Texas TQIP Collaborative Initiative Benchmarking Reviews

The trauma medical director, trauma program manager and trauma program registrar will review the Texas TQIP Collaborative Initiative reports and define their performance as a component of the trauma center's performance improvement and patient safety plan. The areas of high performance will be targeted for sharing information regarding trauma protocols and practice with other collaborative members. Areas of low performance are targeted to gain information from other collaborative members. Information is shared through conference calls, teleconferences, WebEx or scheduled meetings with other collaborative members. Each collaborative member must sign a confidentiality statement and agreement at the meeting. All information, minutes and reports are confidential and are not disseminated. Each participating member is responsible for maintaining their reports in a secured locked environment.

External Review / Verification

Anytown Hospital's Board of Managers have a documented and signed Board Resolution that supports ATH in maintaining its level X trauma center verification by the ACS and designation as a Level X trauma center by the Texas Department of State Health Services. This verification / designation process is re-verified every three years. All criteria and essential personnel responses are reviewed through the performance improvement activities. The review activities are coordinated by the trauma medical director, trauma program manager and the senior vice president for trauma in collaboration with regulatory management.

The site survey activity and all associated reports, including the American College of Surgeons Committee on Trauma's pre-review questionnaire and survey summary report are components of the trauma performance improvement and patient safety plan. All documents are considered confidential and protected. All reports are secured and maintained by the trauma program manager and are not disseminated outside the performance improvement meetings. Summary briefings are used to communicate findings.

Conclusion

The trauma medical director, trauma program manager and the senior vice president have the authority, oversight and responsibility for the trauma program at ATH, along with the responsibility of trauma patient care from pre-hospital notification to hospital discharge. In addition, these individuals are responsible for the trauma program's integration with the regional trauma system development initiatives. Events identified with opportunities for improvement must have defined action plans that are tracked through the TPIPS process to ensure event resolution. Outcomes are compared to the national outcomes for level X trauma centers through benchmarking data. Activities are integrated with the hospital quality initiatives and plan. This ensures that the hospital, senior leaders of the hospital and eventually the Board of Managers are aware of the overall trauma outcomes and continual compliance to the trauma center criteria.