

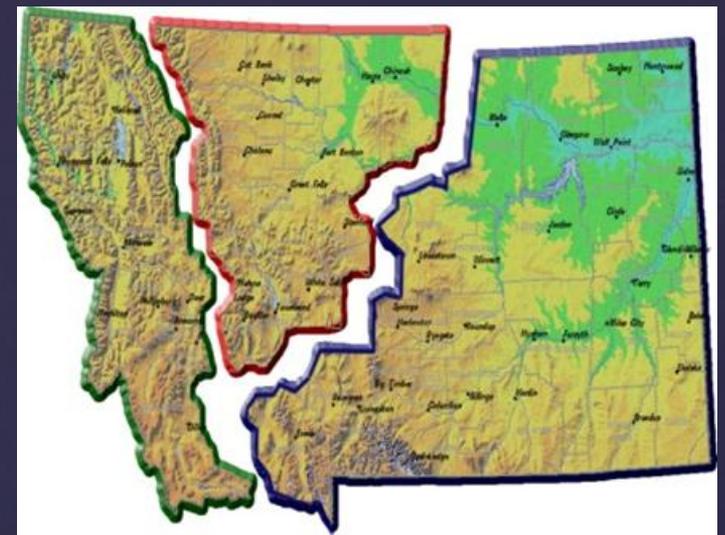
2013 MT Trauma System Conference

{ What's New???

42 facilities designated

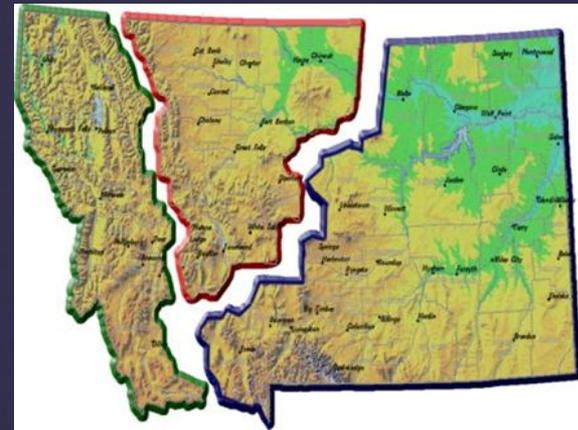
- 13 re-designations to do for FY 2014
- 4 focused reviews

- Thank you to our able designation teams;
- Kim Todd, RN
- Dr. Dennis Maier, Dr. Chuck Rinker and Dr. Doug Schmitz



Designation

9 Non-CAH
32 critical Access Hospitals
1 Clinic



ACS Level II/MT Regional TC: 4
ACS Level III/MT Area TH: 3
MT Area TH: 1
Community Trauma Facility: 8
MT Trauma Receiving Facility: 26

Designation

- ⌘ Include/Submit trauma patient cases meeting inclusion criteria
NOT ONLY Trauma Team Activations!
- ⌘ Same-level fall patients with significant injuries ARE
INCLUDED in the Trauma Registry
unless isolated hip or pelvic ramus fracture
- ⌘ Single-system (extremity) orthopedic injuries are EXCLUDED
except femur fractures

Trauma Registry inclusion & submission of
cases to State Registry;

⌘ ALL Montana facilities treating trauma patients are required
to submit cases to State Trauma Registry
WHETHER DESIGNATED OR NOT

Issues from Designation

& Performance Improvement;

- & Progress beyond monitoring documentation
- & to evaluation of and actions taken
for **CLINICAL CARE ISSUES**



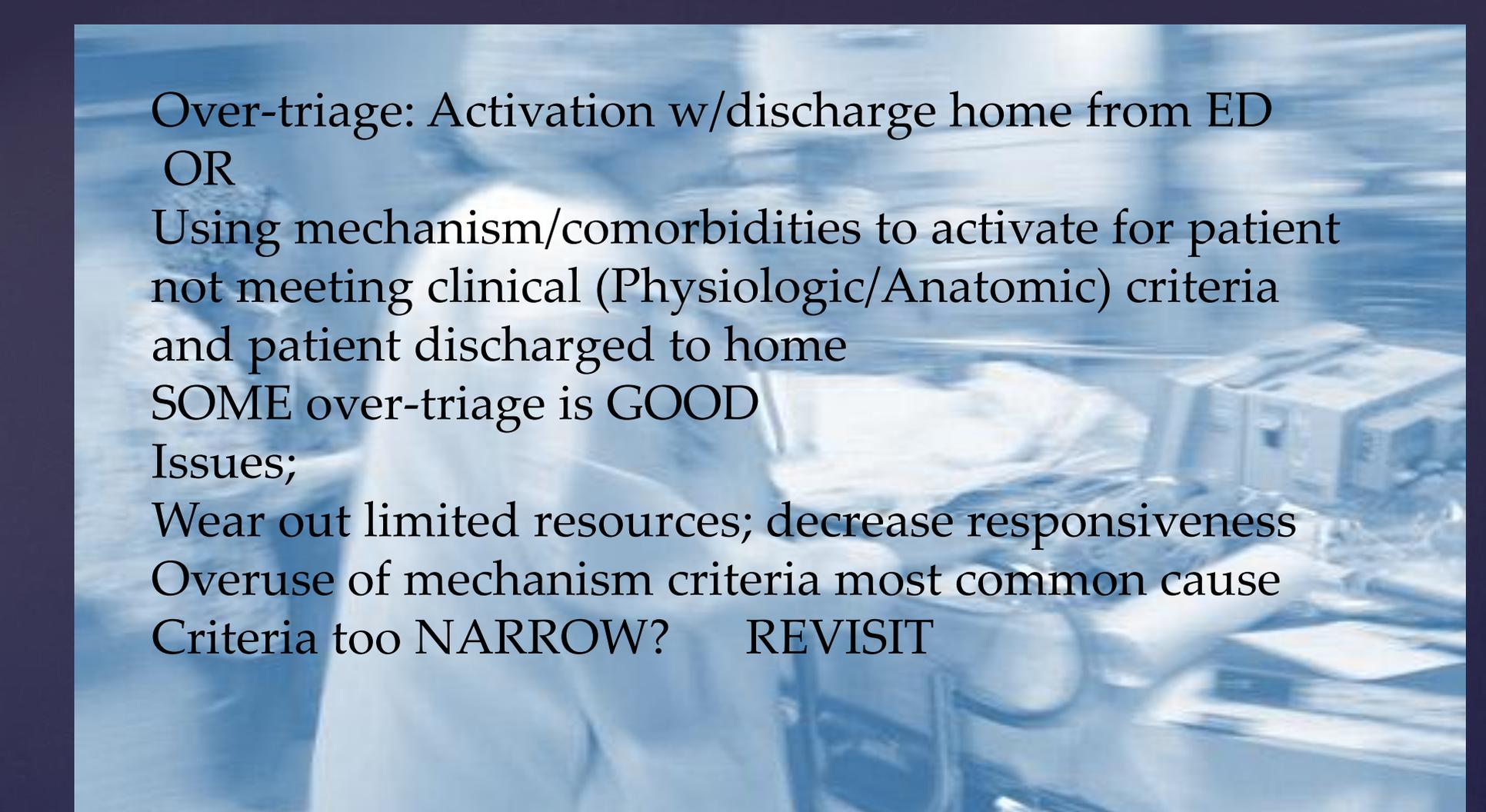
Issues from Designation

- ⌘ Identify issues: BUT keep thinking!
- ⌘ What next? Committee review? Discussion?
- ⌘ Need to demonstrate PLAN to address the issues identified
- ⌘ Implementation of the plan to fix
- ⌘ Evaluation of effectiveness: Is it working? How do we know?

FIND IT, FIX IT or ALL IS LOST!



Issues from Designation



Over-triage: Activation w/discharge home from ED
OR

Using mechanism/comorbidities to activate for patient
not meeting clinical (Physiologic/Anatomic) criteria
and patient discharged to home

SOME over-triage is GOOD

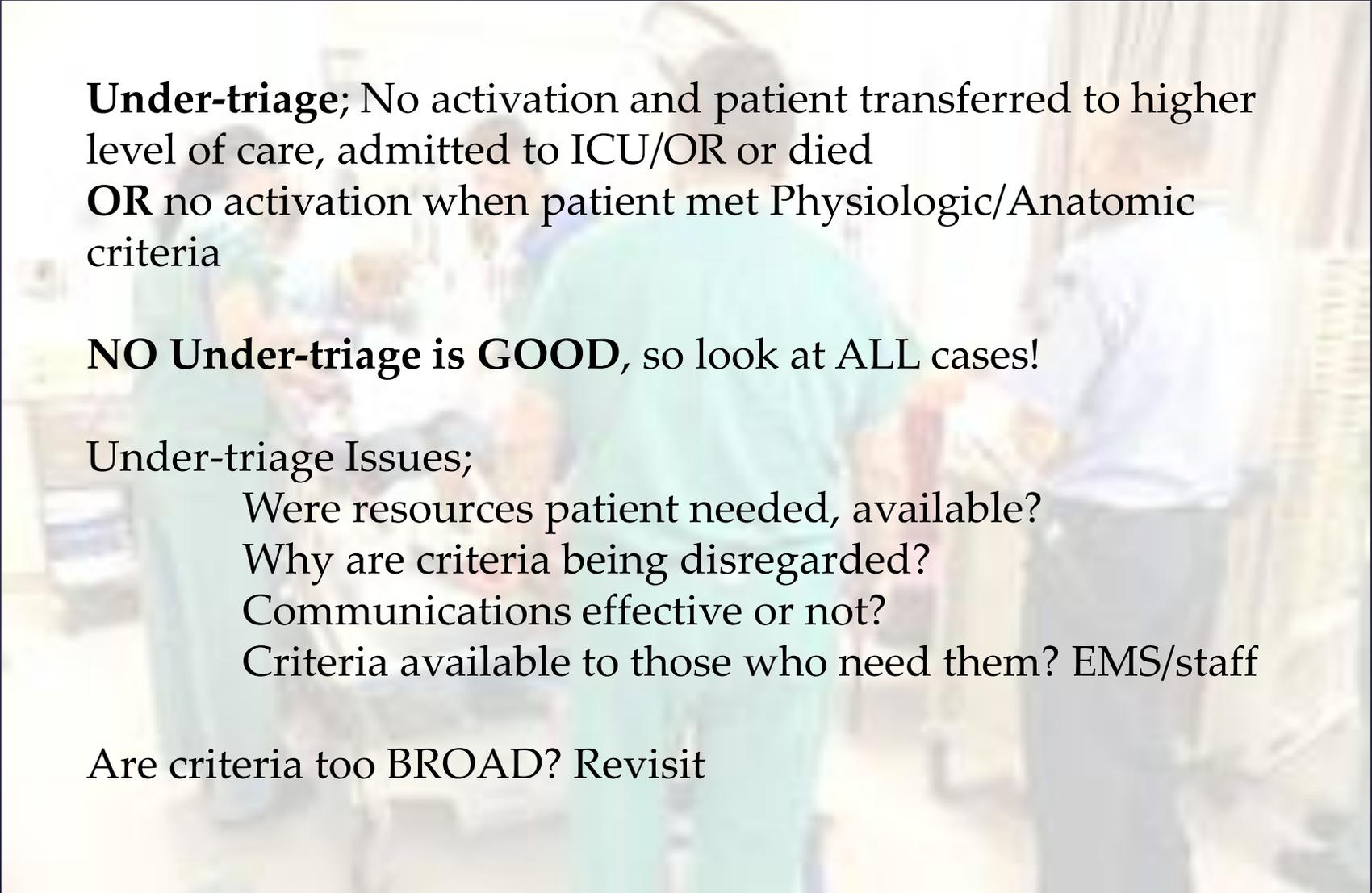
Issues;

Wear out limited resources; decrease responsiveness

Overuse of mechanism criteria most common cause

Criteria too NARROW? REVISIT

Issues from Designation



Under-triage; No activation and patient transferred to higher level of care, admitted to ICU/OR or died

OR no activation when patient met Physiologic/Anatomic criteria

NO Under-triage is GOOD, so look at ALL cases!

Under-triage Issues;

Were resources patient needed, available?

Why are criteria being disregarded?

Communications effective or not?

Criteria available to those who need them? EMS/staff

Are criteria too BROAD? Revisit

Issues from Designation

⌘ Differentiating PI from Peer Review

⌘ Performance Improvement- the process whereby an organization monitors, assesses, and modifies the current level of performance in order to achieve better outcomes

“ We always want to make it better for the next patient” John Bleicher

Issues from Designation

- ⌘ Trauma Program Performance; assess & correct trauma program process issues including review/documentation of identified QI/PI;
- ⌘ Implementation of timely trauma case reviews for identification and documentation of issues in all phases of care and for all levels of care providers, potential solutions for improvements, corrections/strategies for improvement implemented, effectiveness of the corrections/strategies that were implemented and methods for monitoring recurrence of identified (or new) issues (loop closure).

Multidisciplinary Trauma Committee

⌘ Medical Staff Trauma Care Peer Review;

The process whereby physicians/medical providers evaluate the quality of work performed by their colleagues

⌘ Response, appropriateness, timeliness of care,
evaluation of care priorities

⌘ Should be conducted as confidential provider process without general committee attendance and reflected in minutes, but keep Peer Review minutes separate from PI minutes

Issues from Designation

& The Trauma Coordinator should be present whenever trauma care is discussed, whether Trauma Committee PI or Medical Provider Peer Review



Issues from Designation

- ‡ Implemented 2006
- ‡ Current criteria revision review by STCC PI Subcommittee (PI subcommittee of STCC completed revisions)
- ‡ Public Rules process
- ‡ Clarify criteria, improve (not increase) requirements to reflect changing care culture over time

MT Trauma Resource Criteria

& Goals;

- ⌘ Eliminate paper abstract submission process
- ⌘ Improve data accuracy
- ⌘ Provide method for internal data reporting
- ⌘ NHTSA Funds obtained
- ⌘ Working on finalizing product

Web-based Collector



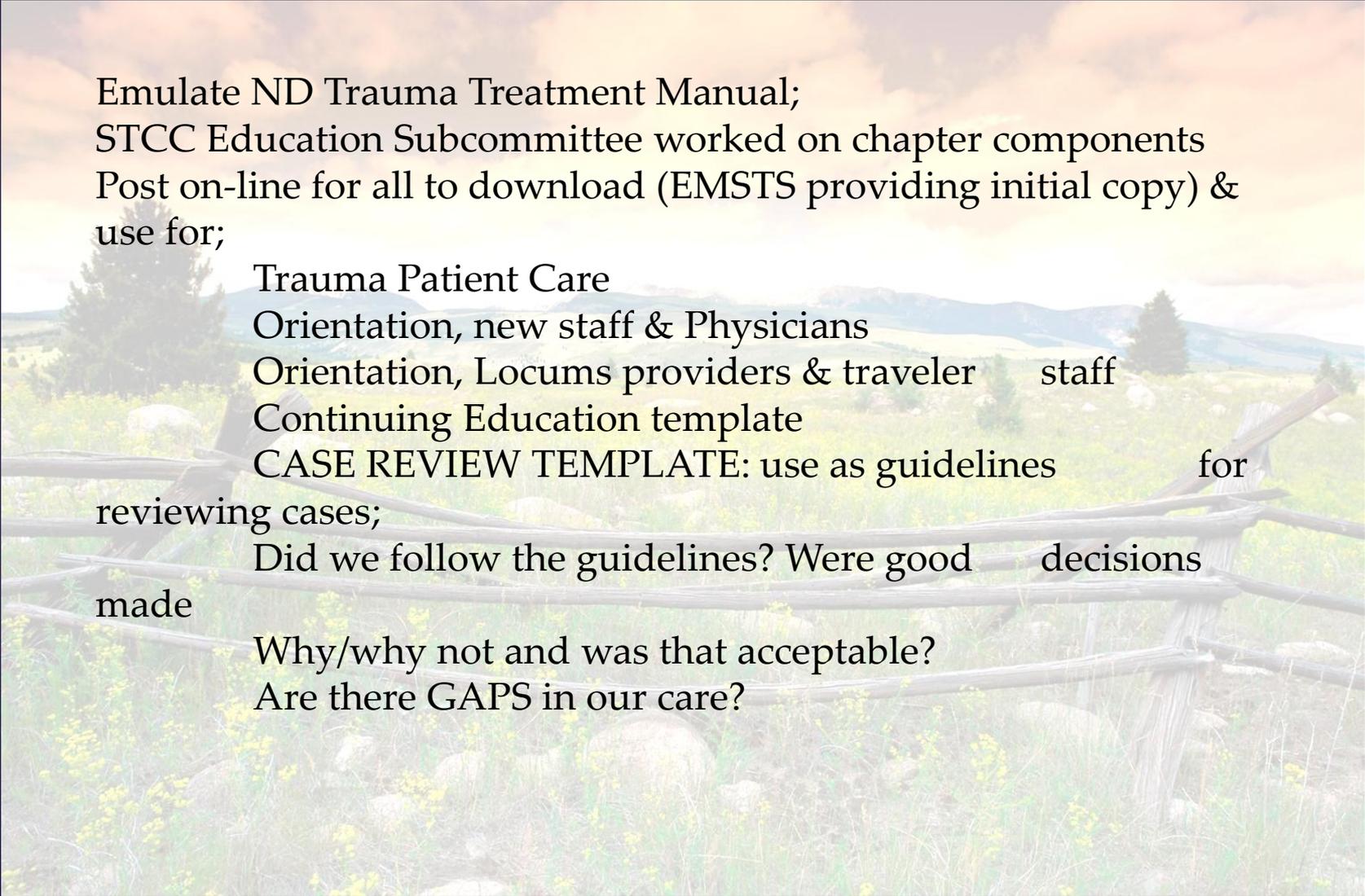
- ⌘ Digital Innovations designed the slightly abbreviated web-based version of Collector
- ⌘ Orientation of regional “super-users”
- ⌘ Product Implementation to follow this Fall or early Winter, (I hope)
- ⌘ Facilities not currently submitting will be expected to implement process now that there’s a better tool



Web-based Collector/Trauma Registry

- ⌘ Coding Modules for:
 - ⌘ E-Coding
 - ⌘ ICD9, Procedures (cheat sheet) & diagnoses
 - ⌘ WebEx sessions
 - ⌘ Post on website for all
-
- ⌘ Support for surgeon site reviews for CAHs
 - ⌘ Printing of the Montana Trauma Treatment Manual
 - ⌘ Help fund the ATLS Instructor Course in Billings, September 27 & 28, 2013

Rural Flex Grant Funds



Emulate ND Trauma Treatment Manual;
STCC Education Subcommittee worked on chapter components
Post on-line for all to download (EMSTS providing initial copy) &
use for;

Trauma Patient Care

Orientation, new staff & Physicians

Orientation, Locums providers & traveler staff

Continuing Education template

CASE REVIEW TEMPLATE: use as guidelines for
reviewing cases;

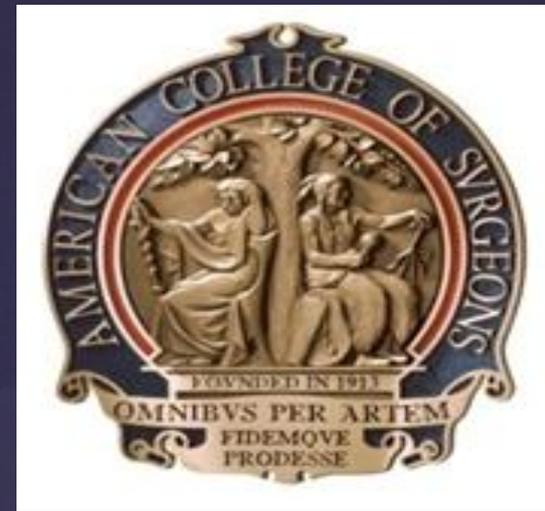
Did we follow the guidelines? Were good decisions
made

Why/why not and was that acceptable?

Are there GAPS in our care?

MT Trauma Tx Manual

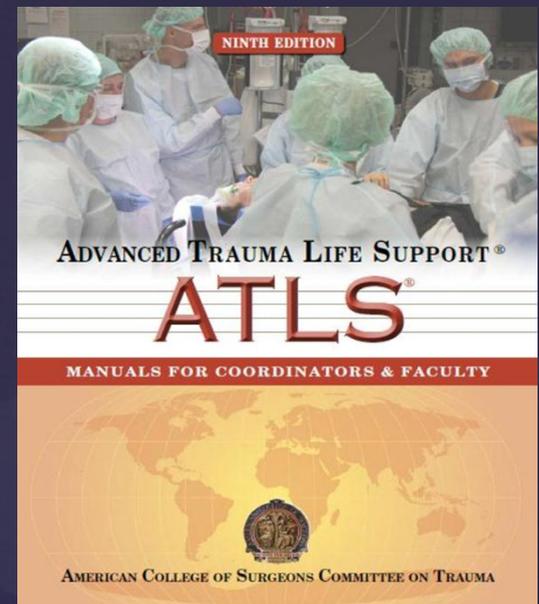
- ⌘ All chapters have undergone:
- ⌘ Input solicitation, initial writing/revision
- ⌘ 3 editorial reviews/revisions
- ⌘ Evidence-based linkage to criteria
- ⌘ Preparation to provide the ACS/NAEMSO Trauma JOC with advanced copies
- ⌘ Anticipated final delivery date.... ????



Resources for Optimal Care of the Injured Patient
“Green Book” to Gradient Orange”

Addition of heat injuries to
thermal chapter
Balanced resuscitation
Initial Assessment including
FAST
New Triage Scenarios

ATLS 9th Edition



- ⌘ Provides centers with an indication of their performance relative to other centers (Level I, II, III)
- ⌘ Benchmarks for Mortality, resource utilization, specialized care processes
- ⌘ What does TQIP provide?
 - ⌘ Low performing centers: “dashboard warning light”
 - ⌘ Average centers: “are we as good as we could be?”
 - ⌘ High performing centers: “best in class”
 - ⌘ Identifies innovators, who share their best practices

What is the ACS Trauma Quality Improvement Program (TQIP)



- ⌘ Provide for outcome-based trauma center verification/designation process
- ⌘ Strategic planning underway
 - ⌘ Business model development & Functional impact analysis
 - ⌘ High performing centers
 - ⌘ Low performing centers
 - ⌘ On site verification reviews vs documentation-based for mature programs demonstrating quality excellence
- ⌘ Phased-in process



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:

Highest Standards, Better Outcomes

Merging TQIP and Trauma Center Verification

⌘ Traumatic deaths for 2008

⌘ 1008 initial cases

⌘ Excluding for Non-mechanical trauma,

Non-trauma, suicides not surviving to hospital,
isolated hip fx, late effects;

⌘ ALL cases in-put into study Collector = 430

⌘ Results presented tomorrow about OFI (opportunities
for Improvement) in phases of care, types of care



Montana 3rd Preventable Mortality Study

- & Tom Esposito, MD, FACS, MPH, IL
- & Stu Reynolds, MD, FACS, Havre
- & Chad Engan, MD, FACS, Great Falls,
- & Andy Michel, MD, Helena
- & Freddy Bartoletti, MD, Anaconda
- & Sam Miller, RN, Bozeman
- & Chris Benton, RN, Red Lodge
- & Megan Hamilton, RN, EMT-P, Missoula
- & Francine Giono, EMT-B, Whitehall
- & Lauri Jackson, RN, NP, Great Falls
- & Kim Todd, RN, Willow Creek
- & Jennie Nemec, RN, Helena
- & Carol Kussman, RN, Helena



Preventable Mortality Study Panel

& Alyssa Sexton, RN

Trauma Program Manager