**Trauma Program Performance Improvement Plan (PIP)**

The goal of the Trauma Program’s Performance Improvement Plan (PIP) is to provide the structure to ensure the most effective care is delivered to injured patients. Injured patients require a complex network of people working together as a team. This goal will be achieved through continuous evaluation of quality and systematic care is provided within \_\_\_hospital\_\_\_. When deficiencies are found, a plan is based upon those findings to address, improve and maintain optimal care. Event identification, but also why the issue existed and the mediation of such to sustain outcome improvements. Trauma care is multi-disciplinary and for that reason performance improvement must lean upon all its team members for their expertise, inclusion, and active participation in action plans. Therefore, the net result of their involvement is increased effectiveness, efficiencies, and optimal patient care.

Efforts will also be undertaken to act on potential opportunities for improvement outside the Hospital System, with referring facilities, pre-hospital providers, and the Regional Trauma Network.

1. **Authority to Monitor**

The Hospital Board of Trustees has delegated the responsibility for overseeing trauma performance improvement to the hospital trauma medical director and the designated trauma peer review process contained herein.

The hospital has tiered performance improvement measures, a Trauma Peer Review Committee, and a Trauma Committee. The Trauma Peer Review Committee has been delegated the authority to monitor, review, deem judgment and develop corrective actions, pertaining to the evaluation of the care related to the trauma service population. The trauma service population for this Level IV facility is defined, minimally, as injured patients who met National Trauma Data Standard inclusion criteria, had a trauma activation or missed activation, admitted to the hospital, transferred to a higher level of care, or died in the emergency department or hospital. The multi-disciplinary Trauma Committee decides upon and enacts requests by the Trauma Peer Review Committee, in addition to monitoring all trauma center criteria.

1. **Data Sources for Performance Improvement**

Data sources include but are not limited to the following:

1. Trauma Registry Analysis
   1. Audit Filters
   2. Complications
   3. Mortality
   4. Special Studies / Focused audits
   5. Select Department data bases/hospital databases.
2. Special Studies conducted by other disciplines/departments/services
3. Evaluation of compliance with outcomes from clinical guidelines, protocols, and/or benchmark data
4. Risk and Compliance
5. System Analysis and/or referrals from but not limited to:
6. Emergency Department
7. Nursing
8. Respiratory Care
9. Radiology
10. Rehabilitation
11. Laboratory
12. Social Work
13. Trauma Rounds
14. Trauma Medical Director
15. Trauma Program Manager
16. Trauma Registrar
17. Any health care provider
18. Patient and or family
19. **The Trauma Peer Review Committee (TPC)**
20. **Membership:** The Trauma Medical Director (TMD) will serve as the chair. The multispecialty committee will include representatives of every department that provides care to an injured patient, such as: emergency medicine, radiology, orthopedics, general surgery, anesthesia, other physician specialties, laboratory, pharmacy. The Trauma Program Manager (TPM) and Hospital representative from the Quality Department will serve as a non-voting member of the committee. Ad hoc members will serve as necessary.
21. **Committee Responsibilities’ Duties:**
    1. Monitor and review mortality, morbidity, operative cases, variance reporting, clinical indicators, quality concerns, peer review and other studies as needed.
    2. Communicate with individual physicians to obtain additional data required to complete a review, if requested by TPM or TMD.
    3. Request additional data from the sources of data to completely answer any questions/area of concerns.
    4. When reviewing consider:
       1. Impact (physical, psychological, legal, socio-economic)
       2. Type (communication, patient management, clinical performance)
       3. System factors
       4. Human factors
    5. Assign Event Determination
       1. Without Opportunity for Improvement
       2. With Opportunity for Improvement
       3. Unanticipated with Opportunity for Improvement
       4. Anticipated with Opportunity for Improvement
    6. Assign Case Determination
       1. Case Appropriate
       2. Case Not Appropriate
    7. Assign Determination Factors
       1. Disease related
       2. System related
       3. Provider related
    8. Assign Harm Impact
       1. No harm
       2. Minimal
       3. Moderate
       4. Severe
       5. Temporary
       6. Permanent
       7. Death (event directly contributed to death)
    9. Communicate the findings, recommendations, results and corrective action plans to the applicable hospital department, personnel, or Trauma Committee, as it applies.
    10. Assure complete and detailed minutes of peer protected meetings.
    11. Evaluate the Performance Improvement Plan (PIP) and enact necessary changes.
22. **Chair Responsibilities –** See Trauma Medical Director’s Responsibilities in section IV. 1.
23. **Physician Committee Members’ Responsibilities:**
    1. Attend at least 50% of scheduled meetings.
    2. Share responsibility in the chart review process for presentation/discussion at the meeting.
    3. Participate in the peer review discussions and conclusions
    4. Provide routine input.
    5. Annually sign a confidentiality agreement.
24. **Ad Hoc Representatives’ Responsibilities:**
    1. Provide perspective/input relative to their specialty.
    2. Accountable to the committee to provide follow-up on issues of concerns identified and provide.
    3. Annually sign a confidentiality agreement.
25. **Meeting Frequency:** 
    1. The committee will meet monthly if agenda items warrant but not less than quarterly.
    2. The Trauma Medical Director will determine need based agenda items.
26. **Trauma Program Personnel Responsibilities**

1. **The Trauma Medical Director (TMD) Peer Review Responsibilities:**

1. The Trauma Medical Director shall have ultimate responsibility for the performance improvement functions of the trauma program.
2. The Trauma Medical Director will serve as the Chairperson of the Trauma Peer Review Committee. The Chair has the following responsibilities
   1. Coordinate and review all physician issues
   2. Coordinate peer reviews of deaths and complications
   3. May delegate some special studies/activities to the Trauma Program Manager
   4. Will assign another physician to review care rendered by TMD
3. Conduct credentialing activities for providers who are involved in the initial trauma resuscitations.
4. Initiate a physician peer review, if the Trauma Peer Review Committee thereby indicates such, for any aspect of clinical care of a specific patient, or an identified subset of trauma patients related to a specific care item.
5. Trauma Medical Director has the authority on behalf of the Trauma Peer Review Committee members to initiate performance improvement activities in all departments involved in trauma care including, but not limited to: nursing, laboratory, radiology, intensive care units, perioperative services, physical therapy, respiratory therapy.
6. Enforce approved privileges for providers who are involved in the initial resuscitation of trauma patients, interpreting boundaries and limits, as indicated, for quality patient care
7. Perform other responsibilities and duties as described in the Medical Staff Bylaws.

2. **The Trauma Program Manager (TPM) Performance Improvement Responsibilities**:

1. Establish a process to identify, capture, monitor, and address all adverse events to include:

* Activations / Missed activations / Over and under triage
* Transfers
* Admissions
* Deaths
* Response times
* Clinical practice variation from standard
* Missed injuries
* Diversion / bypass
* Delays (team, diagnosis, bed assignment, transfer, etc.)
* Complications
* Readmission related to trauma event
* Registry issues
* Committee attendance
* Any other trauma specific projects

1. Develop collaborative relationships with providers involved in the initial resuscitation of trauma patients and those who have trauma patients admitted to their service to ensure continuous linear care throughout the patient stay.
2. Support appropriate education for providers involved in trauma care.
3. Attend various Hospital and/or patient care committees representing the Trauma Program, e.g. Emergency Department, Quality Improvement.
4. Coordinate all trauma system issues throughout the levels of performance review.
5. Implement action plans in collaboration with appropriate individuals and departments.
6. Ensure trauma registry data collection is complete, accurate and current.
7. Develop and annually review the audit filters and provide those to the Peer Review and Trauma Committees.
8. Develop and analyze indicator reports and refer issues of concern to the Trauma Medical Director.
9. Prepare Peer Review meeting materials
10. Ensure complete and accurate minutes from the Peer Review meetings.
11. Maintain records of all communication to and from the Peer Review and Trauma Committees.
12. Maintain all performance reports, action plans, and findings in original or digital format.
13. Annually complete a confidentiality agreement.
14. **Levels of Review**

The Trauma Peer Review Committee is recognized as the highest level of review for the Trauma Services. In order to maximize the use of the TPC and to assure issues and concerns are addressed in a concise manner the following levels of review have been established.

### Level 1 – Trauma Program Manager (TPM)

* + - 1. Issue(s) can be forwarded directly to the Trauma Program Manager (TPM) from any of the sources of data/referral and can be addressed immediately by the TPM with no further review in the system deemed necessary.
      2. The TPM can refer an issue to the Trauma Medical Director.

3. The TPM can refer an issue to the Trauma Peer Review Committee.

### Level 2 – Trauma Medical Director (TMD)

1. Issue(s) can be forwarded to the Trauma Medical Director (TMD) directly from a data source or the TPM.
2. The TMD can implement action, without formal referral to the Trauma Performance Committee.
3. The Trauma Medical Director can render a decision and assign a conclusion on a Trauma Performance Committee Peer Review Worksheet (create specific to individual hospital) without a vote by the TPC. The cases in which the Trauma Medical Director and/or physician reviewer deem “No TPC action required” will be reported to the Peer Review Committee and in aggregate to the Trauma Committee.
4. The Trauma Medical Director can also begin action(s) on behalf of the Peer Review Committee after consent from \_x\_ administration for issues found to be egregious. Action will be brought to the next scheduled Peer Review Committee meeting.
5. The Trauma Medical Director can forward an issue to the Trauma Peer Review.
6. Trauma Medical Director’s individual cases review will be reviewed by a separate identified physician.

**Level 3 – Trauma Performance Committee**

Cases prescreened by the TMD and/or TPM in which it has been determined the case/issue requires review by the Peer Review Committee.

1. Opportunity for multidisciplinary education input and discussion will be held within the forum of Level 3.
2. Multidisciplinary mortality and morbidity forum will be initiated at this level of review.
3. **Action Plans**

Prevention and mitigation corrective action must be specific, measurable, attainable, realistic and timely. They must match the specific issue, be appropriate and safe for patient care and prevention of future occurrences. Examples are: guidelines/protocol development or revision, policy revision or creation, education, system enhancements, counseling, peer review presentations, external review, focused workgroups, ongoing professional practice evaluation, change in provider privileges, regional system referral.

The goal for the action plan is to stimulate change for decreased variation in practice and outcomes. Action plans are to be evidence-based, formally structured, specific solution oriented with a timeframe and accountability. The action plans must be monitored, re-evaluated and confirmed resolution in order to achieve loop closure of the identified issues.

1. **Hospital Trauma Committee**

In addition to ensuring the trauma program is fulfilling trauma center criteria, the Trauma Committee shall analyze system issues not directly related to providers that are necessary components of the Trauma Services. The committee will accomplish review by:

1. Evaluate the care of the trauma patient from a systems perspective by use of dashboards.

2. Evaluate established criteria used to identify levels of reviews.

3. Examine reports generated from the activities of data collection from the Trauma Registry, continuous audit filter, focused audit filters, and referrals from other system related committees throughout the institution.

4. Recommend actions where areas of improvement are indicated in the system.

5. Document and report conclusions of the recommendations and action taken as a result of the Peer Review and Trauma Committees.

6. Evaluate annually the Performance Improvement Plan and enact necessary adjustments to the program.

**Meeting Frequency:** Determined by hospital.

1. **Confidentiality**

All participants involved in peer review activity will sign a peer review confidentiality agreement. These agreements will be re-signed annually.

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| **Author:** |  |
| **Reviewed by:** |  |
| **Approved by:** |  |
| **Revised:** |  |
| **Due to Revision:** |  |

Attachments could be:

Flowchart for reviews

Event resolution flowchart

Trauma Performance Committee Peer Review Worksheet

Levels of Harm tool

OPPE form

Trauma Program monthly dashboard

Spreadsheet tracking system of PI projects

Confidentiality form

You may want to include a list of every trauma protocol/policy that you have and where to find it also.