

TEXAS “J” REGIONAL ADVISORY COUNCIL, RAC, SYSTEM PERFORMANCE IMPROVEMENT PLAN

I. INTRODUCTION

Participating organizations in Trauma Service Area “J” RAC concur that ongoing monitoring and evaluation of the Trauma Care System through a well-defined System Performance Improvement (PI) Program is the primary way to improve trauma / acute patient care thus, ultimately improving survival and reducing morbidity from injury and disease. This is especially important in the predominately rural and frontier areas of TSA-J. Clear communications and rapid transport are crucial in a region with such a large land mass area.

All member organizations agree that both organization based and system based PI are essential. Neither an individual entity’s nor provider’s information will be collected for any internal PI actions including disciplinary actions. Sentinel Events as defined by The Joint Commission will be addressed by the individual entities. While organization based PI focuses primarily on the care rendered to individual patients, system based PI focuses on the overall functioning of the system components and their interactions from prehospital care thru rehabilitation.

By participating in the TSA-J RAC, all of the organizations accept the guiding principles for System PI as outlined by the Texas Department of State Health Services. EMS, Hospital, and System PI programs will be developed in close cooperation to monitor and improve the trauma / acute patient care in TSA-J. Data will be reviewed for trends and identified issues will be reported to the Executive Committee and Board of Directors. The identification of major injury types will be utilized in the development of appropriate Injury Prevention Programs for the region. Data from the trending of predominate disease processes in the region will be utilized in the development of appropriate public education on disease prevention and warning signs.

II. GUIDING PRINCIPLES

- A. Establishment of a PI plan to systematically monitor and evaluate trauma / acute patient care from a system perspective.
- B. Mandatory participation in the PI process by all participating organizations, both EMS and hospitals (designated and non-designated facilities.)

All Texas “J” RAC Participants including Executive and PI Committee members will read and sign a Confidentiality / Nondisclosure Release Form. The Agreement must be reviewed and renewed by signing and dating the form annually at the first Board of Directors Meeting each year. A new member must sign the agreement when attending his/her first meeting.

- C. Performance Improvement process will follow the guidelines as detailed in Section 161.031 – 161.032 and Section 773.092(e) of the Texas Health and Safety Code, which detail the confidentiality afforded activities of this type.

Confidential: This report is prepared pursuant to but not limited to Section 160-007 of the Occupations Code; 161.031 of the Health and Safety Code and Texas Medical Practice Act, Article 447d and Article 4459b SS 5.06 et sq., 1987, all proceedings and records of medical peer review are privileged and confidential. This report is a review function and as such is confidential and shall be used only for the purpose provided by law and shall not be public record and shall not be available for court subpoena.

Prior to submission all documents utilized for Texas "J" RAC Performance Improvement will be stamped **CONFIDENTIAL** and blinded, with all specific patient identifiers removed.

- D. Development of a data gathering system which at a minimum will contain the data points required by the State of Texas for prehospital providers and hospitals treating major or severe trauma and acute patients. The State of Texas defines:

1. Major trauma patient as a person with injuries, or potential injuries, severe enough to benefit from treatment at a trauma facility. These patients may or may not present with alteration in vitals signs or level of consciousness or obvious significant injuries (severe trauma patient), but have been involved in an incident which results in a high index of suspicion for significant injury and/or disability. Co-morbid factors such as age and/or the presence of significant medical problems should also be considered. These patients should initiate a system's or healthcare entity's trauma response, including prehospital triage to a designated trauma facility. For PI purposes, these patients are also identified retrospectively by an injury severity score of 9 or above.
2. Severe trauma patient as a person with injuries that require treatment at a tertiary trauma facility. These patients may be identified by an alteration in vital signs and/or level of consciousness or by the presence of significant injuries and shall initiate a system's and/or healthcare entity's highest level of trauma response including prehospital triage to a designated trauma facility. For performance improvement purposes, these patients are also identified retrospectively by an injury severity score of 15 or above.
3. Data elements will be based on frequent and/or common issues under the direct authority of the State for the care of the critically ill and injured patients within the RAC.

III. THE PI COMMITTEE

- A. PI Committee will be composed of participants from all disciplines (i.e. EMS providers; hospital representatives; nursing; and physicians.) in the Texas "J" RAC. Participants will attend 75% of the Quarterly PI Meetings.
- B. PI Sub-committee members will:
1. sign a commitment to serve a minimum of two (2) years to provide confidentiality and consistency in the PI process.

- a. Each committee member is responsible for:
 - 1) maintaining professionalism and confidentiality
 - 2) defining areas where "conflict of interest" is a potential.
 2. members may attend the PI Sub-committee Meetings in person or via conference call. A Quorum is when four members are in attendance in person with each discipline i.e. Prehospital and Hospital equally represented.
 3. assist in the development of appropriate topics for ongoing study within TSA-J.
 4. annually review and revise the PI Plan and forms.
 5. develop, revise and update goals.
- C. PI Committee chair must actively participate in the care of trauma and acute patients and actively participate in the RAC.
1. Chair's term of office will be a minimum of two (2) years.
 2. Chair will represent the PI Committee on the Executive Committee of the RAC.
 3. Chair will set monthly dates and times for PI Committee meetings. For the 2010 Fiscal Year:
 - a. PI Committee will meet quarterly on the third Tuesday of the month in conjunction with the Board of Directors Meeting.
 - b. PI Sub-committee will meet monthly as necessary at Medical Center Hospital.
 4. Chair will record minutes of each PI meeting and forward a copy to the Texas "J" RAC Office.
- D. RAC Physician Advisors will:
1. review medical issues and make recommendations to the PI Committee and/or Executive Committee as needed or requested.
 2. meet quarterly as necessary to review all deaths and other referred cases from the region utilizing the **Physician Advisory Committee Case Review** document to identify system improvement opportunities.
 - a. Following internal review, Hospital will complete the top portion of the form for each case and submit the cases with the forms attached at least quarterly to the PI Committee.
 - b. Physician reviewing the case will complete the form at the time of review.
 - c. Recommendations will be reviewed by the PI Committee and the appropriate follow-up actions will be implemented.
 - d. Copy of the report will be sent back to the submitting Hospital for their PI loop closure file.

IV. PI Process

A. Scope

1. PI Committee will review all aspects of the trauma and acute care system, including access, dispatch, pre-hospital management, transport, hospital access, hospital management, transfers, access to rehabilitation, continuing education

- opportunities, prevention initiatives, and disaster response.
- 2. Performance Standards will be developed and maintained for each area.
- 3. All performance standards and expectations will be communicated to all EMS providers and hospitals.

B. Performance Standards

1. **Communication Specialist**

- a. All individuals responsible for communication will have appropriate training defined by their job description.
- b. All communication agencies will have systems in place to monitor compliance to established procedures.
- c. Communications will maintain a current disaster response plan.

2. **EMS**

Exclusion: First Responders are required yearly to submit a First Responder Form identifying their status to the RAC. First Responders do not transport patients thus do not have Quarterly PI to submit. If their status changes at any time the First Responder must immediately submit written notification to the RAC.

- a. EMS scene time goal is to not exceed twenty minutes.
- b. EMS will maintain and follow trauma and acute care management protocols throughout the continuum of care.
- c. EMS will communicate patient reports to the receiving facility, directly or through dispatch.
- d. **EMS will complete the EMS run sheet and leave in the emergency department at the time of service.**
- e. EMS will maintain a performance improvement process.
- f. EMS will maintain a current disaster plan / mutual aid agreement.
- g. EMS providers will maintain appropriate credentialing process for EMS providers.
- h. EMS providers will have appropriate training, and access to continuing education.
- i. **EMS will submit required statistical data and trauma registry data to the RAC Office.**

3. **Hospital**

- a. Hospitals will meet the EMS provider, accept the patient, and transfer the patient to a hospital stretcher.
- b. Hospitals will maintain and follow trauma and acute care management protocols throughout the continuum of care.
- c. Hospitals will maintain a current disaster plan and mutual aid response agreement.
- d. Hospitals will maintain a performance improvement process to review all aspects of trauma and acute care.
- e. Hospitals will communicate diversion status.
- f. Hospitals will initiate trauma and acute care transfers within one hour of arrival.
- g. Trauma and acute patients will be transferred within two hours of arrival.
- h. Stabilized trauma and acute care patients will only be transferred one time

- to the appropriate tertiary facility.
 - i. Receiving hospitals will accept the trauma or acute care patient within an average of thirty minutes.
 - j. Receiving hospitals will provide transferring facilities with feedback after patient's final disposition.
 - k. Hospital providers will have appropriate training and access to continuing education.
 - l. **Hospitals will submit required statistical data and trauma registry data to the RAC Office.**
4. **Pediatric Standards**
- a. Hospitals will review all pediatric deaths.
 - b. Hospitals will initiate transfer of the pediatric patients within 1 hour.
 - c. Stabilized pediatric patients will only be transferred one time to the most appropriate facility.
 - d. Pediatric patients in need of ICU care will be transferred to a tertiary care center with pediatric ICU capability.
 - e. Hospital providers will have appropriate pediatric specific training and access to pediatric specific education.
5. **Air-Medical Services**
- a. Air-Medical Service scene time goal is to not exceed twenty minutes.
 - b. Air-Medical Service will maintain and follow trauma and acute care management protocols throughout the continuum of care.
 - c. Air-Medical Service will communicate patient reports to the receiving facility, directly or through communications.
 - d. **Air Medical Service will complete the run sheet and leave in the Emergency Department at the time of service.**
 - e. Air-Medical Service will maintain a performance review process.
 - f. Air-Medical Service will maintain a current disaster plan / mutual aid agreement.
 - g. Air-Medical Service providers will maintain appropriate credentialing process for Air-Medical Services providers.
 - h. Air-Medical Service providers will have appropriate training and access to continuing education.
 - i. **Air-Medical Service will submit statistical data and trauma registry to the RAC Office.**
6. **Transfers**
- a. ED to ED trauma and acute care transfers will be initiated within one hour of arrival.
 - b. Receiving hospitals will accept the patient within an average of thirty minutes.
 - c. Stabilized trauma and acute care patients will only be transferred one time to the most appropriate facility.
 - d. Ground transport will commit within thirty minutes for transfer.
 - e. Air-Medical Services will commit for transport within sixty minutes.
 - f. All in-patient trauma and acute care transfers will be reviewed through both hospitals' trauma performance improvement process.
 - g. All trauma and acute care patients transferred into or out of the region will be reviewed by the PI Committee.

7. **Rehabilitation**

Trauma and acute care patients will be appropriately discharged to rehabilitation.

8. **Disaster Response**

- a. All entities within the RAC will have a disaster plan / mutual aid agreements.
- b. All facilities within the RAC will have an organized disaster management plan that defines their hospital incident commander / leader.
- c. Communication tracks status of all entities.
- d. System de-activation meets overall needs.
- e. Critique of system response is completed within thirty days of incident.

C. Data Collection

1. Each EMS system will be responsible for:
 - a. completing a Texas "J" RAC PI COMMITTEE **EMS SUMMARY REPORT** for each quarter. Enter the total number of patients for each category and/or subcategory listed on the form (refer to attached form).
 - b. completing a Texas "J" RAC PI COMMITTEE **EMS DATA FORM** for each run requiring an explanation of variances & occurrence / problems.
 - c. **forwarding the EMS Summary Report and appropriate EMS Data Forms to the RAC Office by the dates outlined for each quarter.**
2. In designated and non-designated trauma facilities, the facility will be responsible for:
 - a. completing a TEXAS "J" RAC PI COMMITTEE **HOSPITAL SUMMARY REPORT** for each quarter. Enter the total number of patients for each category and/or subcategory listed on the form (refer to attached form).
 - b. **forwarding the Hospital Summary Report to the RAC Office by the dates outlined for each quarter.**
3. Required audit filters to be reported to the TSA-J PI Committee:
 - a. EMS:
 - 1) All trauma patients.
 - 2) All suspected stroke patients and their facility destination.
Number of Cincinnati Prehospital Stroke Scale that are Positive and Negative.
 - 3) Number of Suspected MI
Number of STEMI Protocol Activations
 - b. Hospitals' minimum reporting requirements:
 - 1) All hospital trauma deaths.
 - 2) All trauma transfers to or from another hospital. This includes patients who are transferred but not admitted with ICD-9 codes 800-959.9.
 - 3) All trauma patients **admitted to the hospital from the Emergency Room or as direct admissions, to include 23-hour Observations.** This includes ICD-9 codes 800-959.9, excluding 905 – 909 (late effects of injuries), 910 – 924 (blisters, contusions, abrasions, and insect bites), 930 – 939 (foreign bodies); with ISS greater than or equal to 9, or RTS <11.

- 4) **Do not include patients admitted only to the Emergency Room.**
- 5) All suspected stroke patients and their facility destination.
Number of Cincinnati Prehospital Stroke Scale that are Positive and Negative.
- 6) Number of Suspected MI
Number of STEMI Protocol Activations
4. Data collected for the preceding quarter will be delivered to the RAC Trauma Services Offices according to the following schedule.

1st Quarter, September thru November, 2009	02/28/10
2nd Quarter, December, 2009 thru February, 2010	05/31/10
3rd Quarter, March thru May, 2010	08/01/10*
4th Quarter, June thru August, 2010	11/30/10.

5. The **Trauma System Performance Improvement Occurrence / Problem** form will be completed whenever a hospital has an **occurrence / problem to report to the Texas "J" RAC PI Committee**. All entities will complete the top portion of the form. Under the "Type of Occurrence / Problem":
 - a. the transferring hospital will complete the "Transferring Hospital" area.
 - b. the transferring hospital will complete the "EMS Delay / Refusal" area.
 - c. the receiving hospital will complete the "Receiving Hospital" area.
 - d. any issue not reported above should be documented under "Other issues for review" area.

The form should be forwarded with all appropriate support documents, i.e. blinded chart to the Texas "J" RAC PI Committee at least quarterly via email or at a meeting. The PI Committee will review the concern and document the recommendations for future action.

D. Data Analysis

1. Data may be utilized to determine several parameters of use in improving the quality and availability of care in the region.
 - a. Injury patterns and distribution – types and locations of trauma injury
 - b. Morbidity and mortality – severity of injuries
 - c. Availability of services – timeliness and access to care
 - d. Quality of services – review of patient outcomes as related to care received.
2. Data submitted to the PI Committee on a quarterly basis will be used for identification of system wide and provider specific technological, communication, and educational needs, and opportunities for improvement in trauma and acute patient care or system processes.
3. Provide a summary presentation of the trended and blinded data analysis of the participating EMS services and hospitals data submissions, and PI activities at the quarterly PI Committee meetings.
4. Provide appropriate feedback / education in opportunities for improvement to the PI participants.
5. Issues will be addressed within the region by using alternative dispute resolution methods, i.e. facilitation and grievance resolution. If regional methods are unsatisfactory then the issue would be referred to the Texas Department of State Health Services.

6. Current Limitations: Primary and most daunting limitation to the PI process is the process' dependence on the manual collection of the meaningful data for analysis of systems- based issues. Until this is accomplished in a manner that would allow for the tracking of cases through the entire system, the PI Committee's function will be limited.

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