2018 STATE TRAUMA CONFERENCE
MEDICAL DIRECTOR TRAINING

Gary T. Hemann, DO, FACP, FACEP
Co-Chair, TSAC Verifications Subcommittee

Margot McComas BSN, CCRN
State Trauma Nurse Coordinator

Danny Dowd
Statistical Research Analyst

Guest Speakers
Ramona Zimbeck, RN, BSN
Kerri Nowell, MD, FACS
Barb Devaney, RN
Erica Albaugh
10 MINUTE BREAKS FIRST TWO HOURS

1. Trauma Criteria
2. Data Training
3. Performance Improvement
Emergency / Trauma

Other Sections

Quality Management

TMD and EMMD

Trauma Nurse Coordinator

Registrar

Education and Outreach

Injury Prevention Coordinator

Registrar Education and Outreach
Level III Only

- Chair and attend at least 50% of multidisciplinary trauma peer review committee (MDPR) meetings (5 – 10)
- Annual Assessment of Trauma Panel (2 – 5)
  - OPPE and FPPE when indicated (5 – 11)
- Cannot direct more than one trauma center (5 – 12)
- Must be a board certified general surgeon or an American College of Surgeons Fellow and must participate in trauma call (5 – 5)

Level III and Level IV

- The MDPR must meet regularly, with required attendance of medical staff active in trauma resuscitation (2 – 18)
- Annual Review of Advanced Practitioners (11 – 87)
Level III Only

- Administrative support for the trauma program must be reaffirmed every 3 years (5–2)
- The medical staff support must be reaffirmed every 3 years (5–3)
- The trauma program must involve multiple disciplines and transcend normal departmental hierarchies (5–4)
- The ICU director or co-director must be surgeon (11–53,54)
- In-patient management (11–59, 69)

Level III and Level IV

- Trauma Centers must be able to provide the necessary human and physical resources to properly administer acute care (2–3)
- Facility participation in regional disaster management plans and exercises (2–22)
- Team must be fully assembled within 30 minutes; tracked from patient arrival (5–15)
REGIONAL TRAUMA Care Coordination

Level I & Level II

Level III

Level IV
Level III

- TMD must be involved in the development of the bypass protocol (3 – 4)
- A trauma surgeon must be involved in the decision regarding bypass each time the center goes on bypass (3 – 5)
- A surgeon must serve as co-director of the ICU and be actively involved in, and responsible for, setting policies and administrative decisions related to trauma ICU patients (11 – 53)
- The hospital must provide a mechanism to offer trauma-related education to nurses involved in trauma care (17 – 4)

Level III and Level IV

- The trauma program must participate in training of prehospital personnel, the development of and improvement of prehospital care protocols and PI in patient safety programs (3 – 1, 2)
- A massive transfusion protocol must be developed collaboratively between the trauma service and the blood bank (11 – 84)
- A trauma program must use clinical practice guidelines, protocols, and algorithms derived from evidence-based validated resources (16 – 4)
- Must have a written protocol defining the clinical criteria and confirmatory tests for the diagnosis of brain death (21 – 3)
Well-defined transfer plans are essential (2 – 13)

Collaborative treatment and transfer guidelines reflecting the level IV’s capabilities must be developed and regularly reviewed with input from higher-level trauma centers in the region. (2 – 13)
The trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care (2 – 1).

The trauma medical director and trauma program manager knowledgeable and involved in trauma care must work together with guidance from the trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking (2 – 17).

The multidisciplinary trauma peer review committee must meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvement to the care of the injured (2 – 18).
Primary Review (TPM)

Opportunity for Improvement/Validation

Secondary Review (TPM + TMD)

Adverse Event/Audit Filter Review

Tertiary Review

Prehospital Trauma PIPS

Trauma Morbidity and Mortality

Trauma Multidisciplinary Committee

Trauma Peer Review

Trauma Systems/Operations

External Peer Review

Hospital Quality Committee

Actions

Education

Counseling

Track/Trend

Guideline Development

PIPS Team Project

MULTI-DISCIPLINARY PEER REVIEW

As with PIPS, need to have a well written plan describing the facility-specific Multi-Discipline Peer Review process (MDPR)
Hospital Administration and Board

- Medical Staff
  - Quality Management
    - PIPS
    - MDPR

Hospital Administration and Board

- Medical Staff
  - Hospital’s Quality Committee, or Med Staff Subcommittee

Keep the peer review separate

Hospital Administration and Board

- Medical Staff
  - PIPS
  - MDP
MULTI-DISCIPLINARY PEER REVIEW

Level III TCF

- Have Surgical Support
  - General and Orthopedic
  - Some may have occasional Neurosurgery
- Some critical capabilities
  - IM and some IM Subspecialties
- EM
  - EMRT or PC
MULTI-DISCIPLINARY PEER REVIEW

Level IV TCF
- May or may NOT have General Surgery support
- General Medicine
- EM coverage
  - may be APC, and
  - possibly telemedicine support
MULTI-DISCIPLINARY PEER REVIEW

Level III TCF

- Have Surgical Support
  - General and Orthopedic
  - Some may have occasional Neurosurgery
- Some critical capabilities
  - IM and some IM Subspecialties
- EM
  - EMRT or PC

Level IV TCF

- May or may NOT have General Surgery support
- General Medicine
- EM coverage
  - may be APC, and
  - possibly telemedicine support
Multi-Disciplinary Peer Review

Closed Session
- Includes professional staff involved in patient care
- Surgeons, Physicians, Advanced Practice Clinicians (NPs, PAs, CRNAs)
- Does not include ancillary staff: nursing, EMS
- Does include the TPM and Quality Improvement
Multi-Disciplinary Peer Review

► Closed Session
  ► Includes professional staff involved in patient care
  ► Surgeons, Physicians, Advanced Practice Clinicians (NPs, PAs, CRNAs)

► A learning process, not meant to be punitive
Multi-Disciplinary Peer Review

► Closed Session
  ► Includes professional staff involved in patient care
  ► Surgeons, Physicians, Advanced Practice Clinicians (NPs, PAs, CRNAs)

► A learning process, not meant to be punitive

► Analyze cases with respect to optimizing patient care
  ► Education, address gaps in understanding pathophysiology
  ► Improve patient transition of care
  ► Coordination of patient care throughout the trauma system
  ► Provide feedback and implement plan
  ► Follow up
1. **Know the team:**

   A. **Surgeons**
      i. **Specific credentialing criteria**
      ii. **Peds-specific language**

   B. **EM Providers**
      i. **Current ATLS, still required, for non EM boarded**
      ii. **Annual APC assessment sign-off**
2. Understand the referrals out:
   A. Injury process
      i. Where to, and to whom
      ii. Transfer alliances and agreements
3. Know what you keep / who manages
   A. Who is providing care
   B. Is the surgeon involved?
4. Conduct robust / good peer review

A. Include all members of the medical team

B. Essentially need 50% participation by all
5. Be involved with your regional team
   A. Those to whom you refer.....
   B. Those who send patients to you
6. Review / Update policies every 2-3 yrs

A. Make it a part of standard PIPS discussion

B. Seek input from your regional partners especially
7. Utilize data to drive education for staff, and outreach to community
8. Provide direction to the Pre-hospital team
   A. Education
   B. Feedback
   C. Diversion / By-pass protocol
9. Access and Utilize state resources for program development
10. Work collaboratively with TPM

A. Advocate for your patients
B. Advocate for your ancillary staff