Con: Verification Should Only Be Based on Outcomes

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Verified Trauma Center
## Trauma Center Verification Criteria

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Level of Center</th>
<th>Criterion</th>
<th>Type of Deficiency</th>
<th>Documented Evidence</th>
<th>Element</th>
<th>Status</th>
<th>Responsible Individuals</th>
<th>Clarification</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I, II, III, IV</td>
<td>The individual trauma center and their health providers are essential resources that must be active and engaged participants (CD 1-1).</td>
<td>Type II</td>
<td>Documents demonstrate an overall commitment to meet or exceed the defined criteria for verification. Evidence of signed Board Resolution, Medical Staff Resolution and commitment of resources to provide optimal care as well as address areas of weakness or issues defined through the PI process.</td>
<td>C</td>
<td>Administration &amp; Trauma Medical Director &amp; Trauma Program Manager</td>
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<td></td>
<td>I, II, III, IV</td>
<td>Trauma center must function in a way that pushes trauma center-based standardization, integration, and PIPS out to the region while engaging in inclusive trauma system planning and developing (CD 1-2).</td>
<td>Type II</td>
<td>Evidence of engagement and regional participation in the system PI process, supports educational endeavors, injury prevention endeavors.</td>
<td>S</td>
<td>Administration &amp; Trauma Medical Director &amp; Trauma Program Manager</td>
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<td>I, II, III, IV</td>
<td>Meaningful involvement in state and regional system planning, development, and operation is essential for all designated centers and acute care facilities within a region (CD 3-1).</td>
<td>Type II</td>
<td>Evidence of engagement and participation in regional and state trauma system meetings, submission of data to regional (if available) and state trauma registry, participation in requested surveys that assist in defining regional and state needs.</td>
<td>S</td>
<td>Administration &amp; Trauma Medical Director &amp; Trauma Program Manager</td>
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<td>2</td>
<td>I, II, III, IV</td>
<td>This trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care (CD 2-1).</td>
<td>Type I</td>
<td>Documented PIPS plan that defines the Administrator, Trauma Medical Director and Trauma Program Manager have the authority and oversight of the trauma program, trauma continuum of care and PIPS process with evidence that PI events are defined during the patient’s phases of care and addressed.</td>
<td>PI</td>
<td>Administration &amp; Trauma Medical Director &amp; Trauma Program Manager</td>
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<td>I, II, III</td>
<td>Surgical commitment is essential for a properly functioning trauma center (CD 2-1).</td>
<td>Type I</td>
<td>Evidence of adequate trauma surgeon and trauma specialty coverage to ensure 24/7/365 commitment and timely response to the injured patient, and the administrative needs of the trauma center such as time for attendance at system operations meeting, PI meetings, peer review meetings, regional participation, injury prevention and outreach education.</td>
<td>SC</td>
<td>Administration &amp; Trauma Medical Director &amp; Trauma Liaisons</td>
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<td>I, II, III</td>
<td>Trauma center must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification (CD 2-3).</td>
<td>Type II</td>
<td>Evidence of a budget to support the trauma program/trauma center to ensure all criteria are addressed as well as a concurrent PI and trauma registry process, injury prevention, outreach education and regional participation.</td>
<td>R</td>
<td>Administration &amp; Trauma Medical Director &amp; Trauma Program Manager</td>
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<tr>
<td>3</td>
<td>I</td>
<td>A Level I trauma center must admit at least 1,200 trauma patients yearly or have 240 admissions with an Injury Severity Score of more than 15 (CD 2-4).</td>
<td>Type I</td>
<td>Documented evidence of the admission criteria. Injury Severity Scores must have a validation process. Evidence of trauma registrar or program managers completion of AAAM Injury Scoring Class.</td>
<td>V</td>
<td>Administration &amp; Trauma Medical Director &amp; Trauma Registry</td>
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<td>I, II, III</td>
<td>Through the trauma PIPS program the hospital policy, the trauma medical director must have responsibility and authority for determining each general surgeon’s ability to participate on the trauma panel based on an annual review (CD 2-5).</td>
<td>Type II</td>
<td>Evidence of documented criteria to participate on the trauma panel and that the trauma medical director has the authority to monitor these criteria and take action as appropriate. Evidence of monitoring through a monthly or quarterly score card that evaluates the defined criteria for participation. Activity must be written and included in the PIPS plan.</td>
<td>C</td>
<td>Administration &amp; Trauma Medical Director &amp; Trauma Program Manager</td>
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Outcomes
Structure
Process
Culture
System Integration

- 911 / Dispatch
- EMS – Ground or Air Medical
- Field Triage Criteria
- Prehospital Care Guidelines
- Transfer Process
- Communication
- Education
- Injury Prevention
- Coalition Development
- DATA
- EMS – Trauma Center Integration
Trauma Care

- Trauma Team Activation
- Team Response
- Evidence-Based Practice
- Timely Care
- Efficient Care
- Effective Care
- Coordination of Care
- Oversight / Authority
- Multidisciplinary
- Holistic
- Case Review
- Performance Measures
- Peer Review
- Continuous Learning
- DATA
Verification Review Process

- Every 3 years
- Criteria compliance
- Validate processes
- Evaluate outcomes
- Compliance to evidence-based practice
Strengths of Trauma Center
(Klein’s Personal Perspective)

- Concurrent PIPS
- Concurrent Registry
- Leadership
- Commitment
- Engaged Team
Threats To Trauma Center

- Criteria too complex
- Criteria too lax
- Cost of trauma center
- Staffing Shortages
  - Trauma Surgeons
  - Specialist
  - Nursing
  - Support Services
- Increased competition
  - Stroke / Cardiac
- Decrease in volume
- Academic training

Turnover / Vacancies
Fragmented Process – Broken Culture

How do you build it without criteria?
Performance Changes
Which Criteria Matter?
Current Verification Process

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<tr>
<th>Good VRC Processes and Structure</th>
<th>Good (risk adjusted) Outcomes</th>
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<td>Poor VRC Processes and Structure</td>
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- Good VRC Processes and Structure: Good (risk adjusted) Outcomes
- Poor VRC Processes and Structure: Poor (risk adjusted) Outcomes
Potential Solutions

- Crosswalk between CMS, Joint Commission / ACS
- What is common?
- What is repeated?
- Pre-Review of TQIP Reports
- Should there only be 2 levels: academic and other
- CRITERIA MAKES A Difference