Trauma Designation Performance Improvement Report

Facility: Benefis Healthcare
Location: Great Falls, MT
Date: November 1 & 2, 2023
Reviewers:
Terry Mullins, MBA, MPH
Carol Kussman, BSN RN

The review team does their best to capture the essence of your trauma care program in an unbiased and factual manner. This report is based on the information in the PRQ, the interviews with participants during the site review, and the reviewer's professional expertise. Although the team does their best to be conclusive and comprehensive during the exit debriefing onsite, they do have the ability to modify the findings prior to submission to State Trauma Care Committee (STCC). The STCC Designation Subcommittee makes a recommendation to Dept. of Public Health and Human Services, EMS & Trauma Systems Section, who ultimately issue the definitive designation decision.

Below is the Performance Improvement Rating & Requirements Framework used to evaluate your facility's ability to comply with the Facility Designation Criteria requirements.

4	**Strong/Excellent (Strengths)**	**Best practice/Excellent** • High level of capability with sustained and consistently high levels of performance • Organizational learning and external benchmarking used to continuously evaluate and improve performance • Systems in place to monitor and build capability to meet future demands
3	**Effective/Good**	**Capable** • Delivering expectations with examples of high levels of performance • Comprehensive and consistently good organizational practices and systems in place to support effective program • Evidence of attention given to assessing future demands and capability needs
2	**Needs Development (Opportunities For Improvement)**	**Developing** • Adequate current performance-concerns about future performance • Beginning to focus on system processes, consistency, dependability, evaluation and improvement • Areas of underperformance or lack of capability are recognized by the agency • Strategies or action plans to lift performance or capability or remedy deficiencies are in place and being implemented
1	**Weak (Criterion Deficiency)**	**Unaware or limited capability** • Significant area(s) of critical weakness or concern in terms of delivery and/or capability • Agency has limited or no awareness of critical weaknesses or concerns • Strategies or plans to respond to areas of weakness are either not in place or not likely to have sufficient impact
0	**Not Rated/Not Applicable**	**There is either:** • No evidence upon which a judgement can be made; or • The criteria is not applicable

REQUIREMENT

E - Essential Criteria for designation of this level of trauma center

D - Desired Criteria are not required for designation but considered advantageous

Requirement Compliance	Resource Criteria	
	FACILITY ORGANIZATION	
E	**Resolution** Demonstrated institutional commitment / resolution by the hospital Board of Directors and Medical Staff within the last three years to maintain the human and physical resources to optimize trauma patient care provided at the facility.	2
E	**Trauma System** Participation in the statewide trauma system including participation in Regional Trauma Advisory Committee; support of regional and state performance improvement programs; and submission of data to the Montana State Trauma Registry.	1
E	**Trauma Service** A clinical service recognized in the medical staff structure that has the responsibility for the oversight of the care of the trauma patient. Specific delineation or credentialing of privileges for the medical staff on the Trauma Service must occur.	2
E	**Trauma Program** There is an identifiable trauma program that has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	1
E	**Trauma Team** A team of care providers is to be identified and have written roles and responsibilities to provide initial evaluation, resuscitation and treatment for all trauma patients meeting trauma system triage criteria. Written trauma system triage criteria must be present and a method to activate the trauma team must exist.	1
E	The trauma team is organized and directed by a general surgeon with demonstrated competence in trauma care who assumes responsibility for coordination of overall care of the trauma patient	2
E	There are clearly written criteria for trauma team activation that are continuously evaluated by the multidisciplinary trauma committee	1
E	Trauma response criteria for general surgeon activation will be specified. The general surgeon is expected to be present in the ED upon patient arrival for those meeting criteria if given sufficient advance notice or within 30 minutes of notification 80% of the time	3
E	**Trauma Medical Director** Physician board-certified or board eligible in surgery with a special interest in trauma care who leads the multidisciplinary activities of the trauma program. The trauma director has the authority to affect all aspects of trauma care including oversight of clinical trauma patient care, recommending trauma service privileges, development of clinical care guidelines, coordinating performance improvement, correcting deficiencies in trauma care, and verification of continuing trauma education.	1
E	The trauma medical director must accrue an average of 12 hours annually or 36 hours in 3 years of verifiable external trauma-related CME or maintain successful completion of most recent edition of ATLS course.	3
E	**Trauma Coordinator** A registered nurse working in concert with the trauma director, with responsibility for organization of services and systems necessary for a multidisciplinary approach to care for the injured. Activities include completion of the on-line trauma coordinator course, clinical care and oversight, provision of clinical trauma education and prevention, performance improvement, provision of feedback to referring facility trauma programs, trauma registry, utilization of the MT Trauma Treatment Manual, and involvement in local, regional and state trauma system activities. There must be dedicated and adequate hours for this position.	1
E	**Trauma Registrar** Identified trauma registrar or trauma coordinator with responsibility for data abstraction, entry into the trauma registry and ability to produce a variety of reports routinely and upon request. There must be sufficient dedicated hours for this position to .to complete the trauma registry for each trauma patient within 60 days of discharge.	1
E	The trauma registrar must attend, or have previously attended, within 12 months of hire a national or state trauma registry course	2

E	**Trauma Committees** *Multidisciplinary Trauma Committee* functions with a multidisciplinary committee which includes representation from all trauma related services to assess and correct global trauma program process issues. This committee meets regularly, takes attendance, has minutes, and works to correct overall program deficiencies to optimize trauma patient care.	1
E	*Trauma Peer Review* functions with a multidisciplinary committee of medical disciplines (including the trauma coordinator) involved in caring for trauma patients to perform confidential, protected peer review for issues such as response times, appropriateness and timeliness of care, and evaluation of care priorities. This committee under the auspices of performance improvement meets regularly takes attendance and documents performance improvement evaluation and agreed upon action plans.	1
E	The trauma medical director ensures dissemination of information and findings from the trauma peer review meetings to the medical providers not attending the meeting.	1
E	**Diversion Policy** A written policy and procedure to divert patients to another designated trauma care service when the facility's resources are temporarily unavailable for optimal trauma patient care	3
E	All trauma patients who are diverted to another trauma center, acute care hospital or specialty center must be subjected to performance improvement case review.	0
E	**Prehospital Trauma Care** The trauma program reviews pre-hospital protocols and policies related to care of the injured patient.	2
E	The trauma program reviews pre-hospital protocols and policies related to care of the injured specialty patient: Pediatrics, Geriatrics, Obstetrical	2
E	Trauma team activation criteria have been provided to EMS and are readily available to allow for appropriate and timely trauma team activation.	2
E	EMS has representation on the multidisciplinary trauma committee or documentation of involvement where perspective and issues are presented and addressed.	2
E	EMS is provided feedback through the trauma performance improvement program.	2
E	**Inter-Facility Transfer** Inter-facility transfer guidelines and agreements consistent with the scope of the trauma service practice available at the facility	1
E	Signed inter-facility transfer agreements in place for transfer of special population trauma patients to a higher level of care	1
E	**Burn Care – Organized** In-house or transfer agreement with Burn Center	1
E	**Acute Spinal Cord Management** In-house or transfer agreement with Regional Trauma Center	1
E	**Pediatrics** In-house or transfer agreement with Regional Trauma Center or Pediatric Hospital	1
E	Feedback regarding trauma patient transfers shall be provided to the trauma program at the transferring hospital in a timely manner after patient discharge from the receiving hospital. The trauma coordinator at the transferring hospital is encouraged to contact the Regional Trauma Center/Area Trauma Hospital coordinators for verbal feedback.	1
E	All trauma patients who are transferred during the acute hospitalization to another trauma center, acute care hospital or specialty center must be subjected to performance improvement case review.	1
E	**Trauma System Participation** There is active involvement by the hospital trauma program staff in state/regional trauma system planning, development and operation	2
E	**Disaster Preparedness** There is a written disaster plan that is updated routinely.	2
E	Active hospital representation on the Local Emergency Planning Committee (LEPC)	3
E	Ability to decontaminate single and multiple injured patients prior to entry to the facility.	3
E	Routine participation in community disaster drills. At least 2 drills per year. One must be live, one with an influx of patients and one that involves the community plan	2

A review team consisting of American College of Surgeons reviewers, David Plurad, MD and Saman Arbabi, MD along with state reviewers/representatives Terry Mullins MBA, MPH and Carol Kussman BSN, RN conducted a re-designation virtual review of Benefis Healthcare (Benefis) on November 1-2, 2023. The last designation review occurred in 2019, when the hospital met Montana Trauma Facility resource criteria to remain a fully designated Regional Trauma Center (RTC). Benefis received an ACS and State COVID extension in 2020.

Overview & Program: Benefis is in Great Falls, MT and is licensed for 275 beds and staffed for 220 patients. The facility employes 3,300 people, 829 are nurses and 354 are providers.

There are signed resolutions supporting the trauma program and trauma center designation, the resolutions do not state there is support for the human resources and budgetary needs of the trauma program.

The Trauma Coordinator (TC), in place during the review year under evaluation, retired in early September 2023. She had been in that position for many years and was active in state and regional activities. The TC was an Advanced Trauma Life Support (ATLS) coordinator and trauma nurse reviewer for the State designation review process and also served as chair of the State Trauma Care Committee education sub-committee. There is evidence that the TC was unable to accomplish internal responsibilities required in the program, potentially due to having to cover the work of other un-filled positions within the trauma program. There is an interim TC who has received registry training, however she will return to the PI Coordinator role once a new TC is in place.

Dr. Chad Engan, the Trauma Medical Director (TMD), has served this role for many years but intends to step down from this position imminently. There is little evidence that the TMD has been involved in state and regional system activities. Dr. Engan is an ATLS instructor/director but did not instruct during the review year. He also serves as a trauma reviewer for the state but only performed one trauma designation this year and has indicated that he will no longer be performing state trauma designation reviews. Dr. Engan indicated that that he does not have the organizational authority needed to develop/improve the Benefis trauma center and ensure that the regional trauma system can provide high quality care. As TMD, Dr. Engan is allocated 10 hours/month to perform all administrative duties required of the TMD, including, but not limited to. chart review, policy development, peer review, outreach and performance improvement. Benefis indicated that they intend to replace Dr Engan with two physicians that will serve as co-TMD, however during the site visit, Benefis indicated that Dr. Jensen will be the TMD.

There is no Trauma Registrar employed at the time of the review. The TC was responsible for entering cases into the registry since January 2023 when the previous trauma registrar resigned. Of note, two previous site visits have highlighted and recommended the need for additional FTE's be assigned to the trauma program. These recommendations were not implemented.

The trauma registrar position has been unfilled since January 2023 with contract work occurring with the previous registrar in late summer to get "caught up" with year 2022 registry cases. Benefis is out of compliance with statutorily required data submission for the State. The Optimal Care of the Injured Patient 2022 Standards lists a 1.0 FTE for every 200-300 patients entered into the trauma registry. The facility has contracted with Qcentrix for 3 positions to assist in becoming compliant with state requirements.

There was no trauma team activation criteria submitted in the PRQ. There was a document explaining what disciplines should respond to a trauma team activation and instructions for responders to an activation. During the review, a document describing new trauma team activation criteria was provided to the reviewers.

The multidisciplinary trauma committee is in place and meets regularly, however minutes of the meetings are poorly recorded making assessment impossible. There were handwritten notes identifying PI issue identification but there was no record of PI action plans, or discussions between providers. There was no documentation that peer review is occurring, little of no evidence of formal provider response time or appropriateness and timeliness of care were discussed, and no plan for how PI will be monitored and evaluated. There was no documentation indicating that peer review information and findings were shared with trauma team participants beyond occasional emails from the TMD requesting that a provider provide additional information during the committee meeting.

The facility has a Do Not Divert policy for trauma patients. There were no transfer agreements provided, though an incomplete list of facilities that receive Benefis transports was provided. There was no document describing which patients can remain at the facility or that should be transferred to another facility.

The facility had 745 admissions for the reporting period. 264 or 35% of patients went to other non-trauma services and it is unknown how many were non-surgical admissions. There is no documentation showing that these cases were reviewed for appropriateness. There is a document/policy that states patients with an ISS >9 will be admitted to trauma services, which was not the case upon review.

	CLINICAL CAPABILITIES	
E	**General/Trauma Surgeon**	
E	Published back-up schedule and dedicated to a single hospital when on call or performance improvement process in place to demonstrate prompt general surgeon availability	2
E	Process in place to assure the on-call general surgeon is notified and responds to the ED within the required time frame for trauma patient resuscitation. The trauma performance improvement process will monitor each surgeon's notification and response times.	2
E	**Anesthesia – MD or CRNA**	
E	The availability of Anesthesia and the absence of delays in airway control and operative anesthesia management must be identified and reviewed to determine reasons for delay, adverse outcomes and opportunities for improvement	2
D	**Cardiac Surgery**	2
E	**Critical Care Medicine**	3
E	**Hand Surgery**	3
E	**Neurologic surgery**	3
E	Dedicated to one hospital or performance improvement process in place to demonstrate prompt neurosurgeon availability	2
E	**Obstetric/Gynecologic surgery**	3
E	**Ophthalmic surgery**	1
E	**Oral/maxillofacial surgery**	1
E	**Orthopaedic surgery**	2
E	**Plastic surgery**	1
E	**Pediatric service or Pediatrician availability**	1
E	**Radiology**	2
E	**Thoracic surgery**	2
E	**Urologic surgery**	2
E	**Vascular surgery**	2
E	Institutionally defined, response parameters for consultants addressing time-critical injuries should be determined and monitored. Variances should be documented and reviewed regarding reason for delay, opportunities for improvement and corrective actions.	1
	CLINICAL QUALIFICATIONS	
	General / Trauma Surgeon	
E	Full, unrestricted general surgery privileges	3
E	Board-certified or board eligible	3
E	ATLS course completion	3
E	Must remain current in board-certification to satisfy CME requirements.	3
E	Attendance of the general surgeons at a minimum of 50% of the trauma peer review committee meetings.	3
	Emergency Medicine	
E	Physicians are board-certified or board eligible	3
E	Emergency Department covered by medical providers qualified to care for patients with traumatic injuries	3

	who can initiate resuscitative measures.	
E	Must remain current with board certification to satisfy CME requirements. If functioning as an ED provider or providing care in the ED for patients outside of current board-certified specialty and/or are an Advanced Practice Practitioner, current ATLS is required.	3
E	Emergency Department trauma liaison	3
E	Attendance of an emergency physician representative at a minimum of 50% of the trauma peer review committee meetings	3
	Anesthesia – MD or CRNA	
E	Board certified or board eligible	3
E	Anesthesia trauma liaison	3
E	Attendance of anesthesia representative at a minimum of 50% of the trauma peer review committee meetings	3
	Neurologic Surgery (if available)	
D	ATLS course completion	2
E	Must remain current in board-certification to satisfy CME requirements.	3
E	Neurosurgical trauma liaison	3
E	Attendance of a neurosurgery representative at a minimum of 50% multidisciplinary peer review committee meetings.	3
	Orthopaedic Surgery	
E	Board certified or board eligible	3
D	ATLS course completion	2
E	Must remain current in board-certification to satisfy CME requirements.	3
E	Orthopaedic trauma liaison	3
E	Attendance of an orthopaedic surgery representative at a minimum of 50% of the trauma peer review committee meetings.	3
	Radiologist	
E	Board certified or board eligible	3
E	Radiologist trauma liaison	3
E	Attendance of a radiologist representative at a minimum of 50% of the trauma peer review committee meetings	3
	ICU Physician	
E	ICU/Hospitalist trauma liaison	3
E	Attendance of an ICU physician representative at a minimum of 50% of the trauma peer review committee meetings	3
	FACILITIES RESOURCES / CAPABILITIES	
	Emergency Department	
	Personnel:	
E	Designated physician medical director	3
E	Emergency Department coverage by in-house physician	3
E	If the in-house emergency medical provider must be temporarily out of the department to cover in-house emergencies, there must be a PI process in place to assure that care of the trauma patient is not adversely affected	0
E	Emergency Department staffing shall ensure nursing coverage for immediate care of the trauma patient	3
E	Trauma nursing education: Maintenance of TNCC/ATCN or equivalent.	2
E	Trauma nursing education: 6 hours of verifiable trauma-related education annually or trauma-related skill competency through internal or external educational process	2
E	Nursing personnel to provide continual monitoring of the trauma patient from hospital arrival to disposition to ICU, OR, floor or transfer to another facility	3
	Equipment for resuscitation for patients of ALL AGES	
E	Airway control and ventilation equipment including laryngoscope and endotracheal tubes, bag-mask	3

	resuscitator and oxygen source	
E	Rescue airway devices	3
E	Pulse oximetry	3
E	Suction devices	3
E	end-tidal CO^2 detector	3
E	Cardiac monitor and defibrillator	3
E	Internal paddles	3
E	Standard IV fluids and administration sets	3
E	Wave form capnography	3
E	Large bore intravenous catheters	3
	Sterile surgical sets for:	
E	Airway control/cricothyrotomy	3
E	Thoracostomy (chest tube insertion)	3
E	Central line insertion	3
E	Thoracotomy	3
E	Peritoneal lavage or ability to do FAST ultrasound exams	3
E	Arterial catheters	3
E	Ultrasound availability	3
E	Drugs necessary for emergency care	3
E	Cervical stabilization collars	3
E	Pelvic stabilization method	3
E	Pediatric equipment appropriately organized with current pediatric length based resuscitation tape	3
E	Intraosseous Insertion Device	3
E E E	Thermal control equipment: • Blood and fluids • Patient • Resuscitation Room	3 3 3
E	Rapid infuser system	3
E	Communication with EMS vehicles	3
	Operating Room	
E	Adequately staffed and available in a timely fashion 24 hours / day.	2
E	Trauma performance improvement will monitor operating room availability and on-call surgical staff response times must be routinely monitored and any case which exceed the institutionally agreed upon response time must be reviewed for reasons for delay and opportunities for improvement	2
	Age-specific Equipment	
E	Equipment for monitoring and resuscitative	3
E E E	Thermal control equipment: • Blood and fluids • Patient • Operating Room	3 3 3
D	Craniotomy instruments	3
E	X-ray capability	3
E	Endoscopes, bronchoscopes	3
E	Equipment for long bone and pelvic fixation	3
E	Rapid infuser system	3
	Postanesthetic Recovery Room (ICU is acceptable)	
E	Registered nurses available 24 hours / day	3
	Age-Specific Equipment	

E	Equipment for monitoring and resuscitation	3
E	Pulse oximetry	3
E	Thermal control (blood, fluids and patient)	3
	Intensive Care Unit	
E	Registered nurses with 6 hours trauma education annually	1
E	Designated surgical director or surgical co-director	3
E	Designated Physician/APC director	3
E	ICU service physician in-house 24 hours / day	3
E	Trauma surgeon remains in charge of the multiple trauma patient in the ICU	2
	Age-specific Equipment	
E	Equipment for monitoring and resuscitation	3
E	Intracranial pressure monitoring equipment	3
E	Pulmonary artery monitoring equipment	3
E	Thermal control (blood, fluids and patient)	3
	Respiratory Therapy Services	
E	In-house respiratory therapist	3
	Radiological Services (Available 24 hours / day)	
E	In-house radiology technologist	3
E	Radiologists are promptly available for interpretation of radiographs, CT scans, performance of complex imaging studies and interventional procedures.	2
E	Radiologist diagnostic information is communicated in a written form in a timely manner	2
E	Final radiology reports accurately reflect communications, including changes between preliminary and final interpretations.	2
E	Angiography	3
E	Ultrasound	3
E	Computed Tomography	3
E	In-house CT technologist	3
E	CT has pediatric dose reduction protocols/policies	3
E	Magnetic Resonance Imaging	3
E	Must routinely monitor on-call radiology, CT and MRI technologist institutionally agreed upon response times and review for reasons for delay and opportunities for improvement.	2
	Clinical Laboratory Service	
E	In-house laboratory technician	3
E	Must routinely monitor on-call technician institutionally agreed upon response time and must be reviewed for reasons for delay and opportunities for improvement	2
E	Standard analysis of blood, urine, and other body fluids, including micro sampling	3
E	Blood typing and cross-matching	3
E	Coagulation Studies	3
E	The blood bank has an adequate supply of packed red blood cells, fresh frozen plasma, platelets, and cryoprecipitate or coagulation factors to meet the needs of the injured patient.	3
E	Massive Transfusion Policy (clinical and laboratory)	2
E	Process of care for rapid reversal of anticoagulation	2
E	Blood gases and pH determinations	3
E	Microbiology	3
E	Drug and alcohol screening	3
	Rehabilitation Services	
E	Physical Therapy	4
E	Occupational Therapy	4
E	Speech Therapy	4

E	Social Services	4

Emergency Dept.
No documentation of the required trauma education for emergency department RNs was provided. There was evidence of some previous monthly competency education, but that had not occurred for several months. The new ED Medical Director was present for this review, but all the documents and certifications uploaded in the PRQ were for the previous ED Medical Director, who has also resigned recently.

FAST exams are being done, however these are not recorded in the patient chart, and there is not any quality/performance improvement evaluation being performed. The ED physician manager stated that the information must be manually entered into the medical record. It is unknown if they are charging for FAST exams. Best practice would include a quality review of FAST exams done in the ED and these saved to the medical record, especially if the patient is being charged for this procedure.

OR/PACU
Surgery is located one floor up from the ED. The operating rooms are staffed until 11:30 PM M-F and otherwise on call. There is a dedicated ortho OR available. There is documentation of response times for surgeon and staff for Level 1 activations, but there was evidence that there was fall out of those expected times and there was no PI process developed to remedy this situation. The PACU has 13 beds. There are no trauma education requirements for the PACU staff, even though they potentially could keep a ventilated trauma patient if needed, or one in which they were awaiting a transfer.

ICU
The open unit ICU has 21 beds. The ICU nursing education for trauma was not provided. It was noted that ETCO2 monitoring is not available in the ICU. ICU staff will assist go down to the PACU to assist in recovering complicated trauma patients.

Radiology
Radiology has the required and desired equipment and has in-house staffing most of the day with call coverage for ultrasound and MRI. Radiologists are in-house during the daytime and an afterhours service interprets films during the night. Staff indicate that film overreads are performed the next morning. The radiologist will respond to the hospital for trauma patients during the night. Benefis reported that provider response time documentation was inadequate and that this is a PI target. This needs to be monitored and an action plan developed to identify issues of why the interventional radiology response times of call-to-needle times fall out of compliance.

Lab/Blood
The laboratory is well staffed, equipped and stocked and can provide all the necessary testing. It is noticed in chart reviews that resuscitations involving blood products or when MTP initiated, that the recommended ratio of 1:1:1 was not being met. This may be related to the inability of the lab to thaw FFP in a timely manner, even after the implementation of thawed plasma. There is also evidence of consistent use of albumin in blood product administration which is an outdated practice and no longer supported with evidence-based guidelines. It was also recognized that there were delays in initiating blood resuscitation for patients who required it. These ongoing blood resuscitation issues have continued despite being mentioned in the previous review.

Rehab
The CARF accredited inpatient rehabilitation facility is located on the west campus and is one of health systems greatest strengths. The consultation for rehabilitation most often occurred within 24 hours of patient admission.

Ortho/Neuro
It is not clear whether neuro response times are met and Benefis reported that provider response time documentation was inadequate and that this is a PI target. There is an inadequate anticoagulation protocol with a list of antidotes, not a treatment protocols. The DVT prophylaxis policy does not include processes to be used for head and spinal cord injured patients after 48 hours.

The orthopedic group consist of nine providers, five of whom take call. One provider is on medical leave. The group is in the process of hiring another provider. Benefis reported that provider response time documentation was inadequate and that this is a PI target. Orthopedic response time criteria of 30 minutes should also be instituted and monitored for identified patients including hemodynamically unstable pelvic fractures, compartment syndrome, and peripheral vascular injuries due to an orthopedic injury.

	QUALITY/PERFORMANCE IMPROVEMENT	
E	The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	1
E	There is a clearly defined performance improvement program for the trauma patient population	2
E	There is a process to identify the trauma patient population for performance improvement review.	2
E	Active and timely participation in the State Trauma Registry (cases should be current per ARM 37.104.3014, which is 60 days following close of the quarter)	1
E	All trauma deaths are reviewed with analysis done to identify opportunities for improvement	2
E	There is a process where clinical care issues are discussed in confidential, protected trauma care peer review with analysis at regular intervals to meet the needs of the trauma program	2
E	There is a process where operational issues are discussed in the multidisciplinary trauma committee for analysis at regular intervals to meet the needs of the trauma program	2
E	The results of issue analysis will define corrective action strategies or plans that are documented.	1
E	The results or effectiveness of the corrective action plans/strategies are documented	1
E	Use of telehealth for collaborative care of the trauma patient requires inclusion of the off-site service in the PI process.	0
E	Review of prehospital trauma care is included in the trauma performance improvement program.	1
E	Programs that admit more than 10% of trauma patients to nonsurgical services should be subject to individual case review to determine rationale for admission onto a non-surgical service, adverse outcomes and opportunities for improvement.	1
E	Neurotrauma care should be routinely evaluated as to compliance with the Brain Trauma Foundation Guidelines	1
E	All transfers of trauma patients to a higher level of care within the hospital must be routinely monitored and identified cases reviewed to determine rationale for transfer, adverse outcomes and opportunities for improvement	1
E	The trauma program will participate in benchmarking with other facilities of the same designation level to identify how the trauma center performs compared to others	1
	CONTINUING EDUCATION/OUTREACH	
	Clinical trauma education provided by hospital for:	
E	Physicians, physician assistants & nurse practitioners	3
E	Nurses	1
E	Allied health personnel	2
E	Prehospital personnel	2
	PREVENTION	
E	The trauma center participates in injury prevention	2
E	Designated injury prevention coordinator (can be the trauma coordinator for ATH, CTH & TRF) with adequate hours to perform duties	1
E	Identified injury prevention spokesperson which could be the trauma coordinator or designee	1
E	Injury prevention priorities are based on local/state data	1
E	Collaboration with existing national, regional, and state programs	1
E	Monitor progress / effect of prevention program	1
E	There is a mechanism to identify trauma patients with alcohol and drug misuse issues	1
E	The trauma center has the capability to provide intervention or referral for trauma patients identified with alcohol and drug misuse issues	1

Performance Improvement

There were 745 trauma patients submitted during this review period, 264 of whom were admitted to other services. It is difficult to determine if non-surgical admits were reviewed by the TC in a primary review and if they were reviewed at all by the TMD in a secondary review.

There are neurosurgical and orthopedic patients admitted to the intensivists or hospitalist with the surgical specialty consulting – an inadequate practice previously identified in a previous review.

There is very limited performance improvement documentation provided. There is a list of trauma care guidelines and dates of review, however many of the guidelines were not included in the PRQ.

Occasionally, the minutes and primary/secondary reviews by the TC and TMD, do capture handwritten issue identification, but then there is no action plan, implementation, evaluation, or loop closure. There is no record of discussion documented in trauma committee, nor in peer review. There were no peer review minutes to review.

There was no documentation on how or when trauma rounds occur, and testimony suggests that the trauma surgeon and intensivist round at a different time than the multidisciplinary team.

The TC was the only FTE assigned to the trauma program for the last 6 months of the review year and was performing registry input, running reports, and participating in state and regional system development activities in addition to her normal duties.

There was no documentation that clinical and PI outreach to the facilities transferring patients to the center.

Previous site reviews had highlighted the need for additional to support the program.

Injury Prevention

Alcohol screening is at 67%, below the required 80% threshold. The alcohol misuse intervention is less than one-third of the 67% who screened positive for alcohol. These patients must receive a brief intervention by appropriately trained staff prior to discharge. There is also no evidence of mental health screening for patients at high risk for psychological sequelae with a subsequent referral to a mental health provider after discharge.
Injury prevention/community outreach is minimal, consisting of providing helmets for bicycle and snow related injuries at the local ski hill and was done by the previous trauma registrar at the end of 2022 and early 2023, prior to her resigning her position as trauma registrar and injury prevention coordinator.

DEFICIENCES

[redacted]

[redacted]

STRENGTHS

[redacted]

OPPORTUNITIES FOR IMPROVEMENT

[redacted]

[redacted]

RECOMMENDATIONS

[redacted]

[redacted]

DESIGNATION RECOMMENDATION

The reviewers have determined the facility **does not** meet the Montana Trauma Facility Resource Criteria to remain a Regional Trauma Hospital at the current time.

We recommend that the facility **not be** designated as a Regional Trauma Hospital but as a Community Trauma Hospital provisionally for 1 year. There will be an opportunity to upgrade to an Area Trauma Hospital within 6 months. Please see the corresponding letter for additional information. A full team focus review will be required to review the center in one year as an Area Trauma Hospital.

REVIEWERS:
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Post note: During the verbal exit interview at the conclusion of the review, it was suggested that a recommendation of designating the facility as an Area Trauma Hospital would be made to the Designation Subcommittee. That recommendation was made and taken into consideration by the subcommittee. Ultimately, the subcommittee felt that a designation as a Community Trauma Hospital was more appropriate at this time.