CASE STUDY

Reaching trauma operational excellence through performance improvement and interim leadership.

BACKGROUND

As one of the busiest Level 1 trauma centers in the country, this facility draws patients from a 150-mile radius, serving four states. It boasts a dedicated 23-bed Trauma Intensive Care Unit, a 7-bed Trauma Stepdown Unit, and a 26-bed Post-Trauma Unit, with specialists available around the clock.

CHALLENGES

Assist the Trauma Center to improve operational effectiveness and prepare for an American College of Surgeons (ACS) verification survey, as well as assist in addressing three important issues facing the center:

- Readiness for ACS verification and state designation
- Assistance in filling key position vacancies
- Improvement with registry compliance
- Enhanced Performance Improvement processes

SOLUTION

Peregrine Health Services, LLC partnered with the Trauma Center to bring the center to a position of strength. We placed an Interim Trauma Program Manager (TPM) and Interim Performance Improvement (PI) nurse onsite to work closely with trauma center staff. Opportunities for performance improvement in several areas were identified, solutions implemented, and recommendations defined. We worked together to rebuild vital aspects of the trauma program with the goal of securing ACS verification.

RESULTS

At the time of engagement there was a significant backlog in the trauma registry – only 55% of cases were being entered within 60 days of discharge. Overtime pay was granted to improve compliance with data entry.

To improve registry data abstraction processes, the Interim TPM established a procedure for identification of data entry and submission errors. The registrar team continues to make progress and when the Peregrine engagement ended, they were entering cases within 60 days of discharge between 80% to 85%.

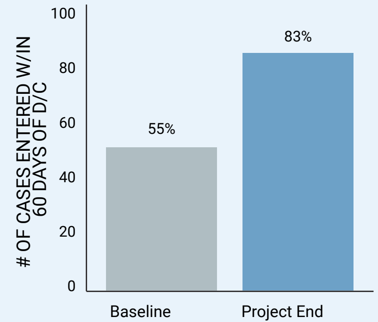
The Interim TPM conducted a high-level trauma financial assessment and determined that the Trauma Center was leaving nearly $5 million in lost charges on the table. In a 12-month period, there were 6,842 patients treated in the trauma center of whom 3,958 required a trauma team response – yet only 2,138 were coded and billed as receiving a trauma team response.

The source of these issues appeared to be a result of improper or omitted coding of the trauma team activation. General coding by the Centers for Medicare and Medicaid (CMS) had been applied instead of trauma specific coding. Remediation recommendations were presented.

Processes, plans and procedures were improved, criterion deficiencies resolved, staffing issues minimized, and registry compliance enhanced. The Trauma Center is expected to drive toward a late 2024 ACS survey for verification of their Level I trauma center status.

Trauma cases closed within 60 days of discharge

51% IMPROVEMENT



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