Trauma Verification April Q&A Web Conference

April 26, 2017
COTVRC@facs.org
Continuing Education (CE)

- To qualify for CE, you must attend at least 50 minutes of educational content.

- An email will be sent to all attendees who qualify for CE within 24 hours of the webinar ending, with instructions on how to claim CE.

- If you have any questions – please email COTVRC@facs.org.
What is the goal for this Webinar?

- Interpret the standards outlined in the Resources for Optimal Care of the Injured Patient manual to ensure that hospitals have an understanding of the criteria to provide quality care to the injured patient.

- Understand the processes and standards involved in an ACS Trauma Verification Site Visit and how following these will positively impact the quality of care of the injured patient at your center.
Let’s get started!
Orange Resources Book

Available as hard copy or PDF version, it is recommended that you have it available as reference during the **CD-Related Questions** section of this webinar.

Must use the most current **Clarification Document and the Verification Change Log** in conjunction with the manual.

www.facs.org/quality-programs/trauma/vrc/resources
Clarification & Verification Document Updates

The updates for the monthly Verification Change Log and Clarification Document for January have been completed.

These documents may be accessed through the VRC webpage at www.facs.org/quality-programs/trauma/vrc/resources.

Going forward, changes to the criteria will be published in the Verification Change Log, and any clarifications to criteria will be published in the Clarification Document.
Clarification Document

Updates sent to participants monthly
## Verification Change Log

Updates sent to participants monthly

<table>
<thead>
<tr>
<th>Chapter</th>
<th>CD #</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
<th>PTC I</th>
<th>PTC II</th>
<th>Date Change</th>
<th>Criteria</th>
<th>Resources 2014 Orange Book Description of Criteria</th>
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<tbody>
<tr>
<td>1</td>
<td>1-1</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1-1).</td>
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<td>1-2</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>They 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 development (CD 1-2)</td>
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<td>1-3</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>Meaningful involvement in state and regional trauma system planning, development, and operation is essential for all designated trauma centers and participating acute care facilities within a region (CD 1-3)</td>
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<td>2-1</td>
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<td>II</td>
<td>7/1/2014</td>
<td>New</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>
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<td>2-2</td>
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<td>III</td>
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<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>Surgical commitment is essential for a properly functioning trauma center (CD 2-2).</td>
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<td>2-3</td>
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<td>IV</td>
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<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>Trauma centers 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>
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<tr>
<td>2</td>
<td>2-5</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>II</td>
<td>I</td>
<td></td>
<td>7/1/2014</td>
<td>Revised</td>
<td>Through the trauma PIPS program and hospital policy, the trauma 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>
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Recording of Webinars

The webinars are recorded during the session and will be posted within one week on the ACS YouTube channel.

You may also access them via the VRC resources webpage at:

https://www.facs.org/quality-programs/trauma/vrc/resources.
Disclaimer

• All questions are pulled directly from the question submissions. There have been no edits made to the contents.

• If your question is not answered today, the question may require more information, and will receive a response from ACS staff within one week after the webinar.
Announcements
Save the Dates

Abstract submission will open in mid May 2017.

Registration for the TQIP Annual Scientific Meeting and Training and Preconference Workshops will open Summer 2017.

Please let us know if you have any questions.
TQIP Meeting Information

- Hotel reservations are now open
  - For more information visit: [https://www.facs.org/tqipmeeting](https://www.facs.org/tqipmeeting)
- Call for abstracts is scheduled to open Monday, May 1
**TQIP Preconference Courses**

- Registration is open for some workshops.
- Course detail listing available at: [https://www.facs.org/quality-programs/trauma/tqip/meeting/workshops](https://www.facs.org/quality-programs/trauma/tqip/meeting/workshops)
  - AIS and Injury Scaling Uses and Techniques (2-day course)
    - Thursday, November 9 and Friday, November 10
  - TOPIC
    - Thursday, November 9
  - OPTIMAL Course
    - Friday, November 10
  - AIS 15 Update
    - Friday, November 10
Resources Revision Process

The Stakeholder Public-Comment website:

https://www.facs.org/quality-programs/trauma/vrc/public-comment

We strongly encourage everyone to review and comment on the standards. Your input will help guide the revision process to add, modify or retire requirements.

- Current Chapter Revision:
  - Chapter 6 General Surgery

- Upcoming Chapter Revisions (May & June):
  - Chapter 9 Orthopaedic Surgery
  - Chapter 10 Pediatric Surgery
  - Chapter 15 Registry
  - Chapter 19 Research
New Tutorial

• Becoming a Verified Trauma Center: First Steps
  ▪ Designed to guide the Trauma Program Manager or Medical Director in the First Steps in the Consultation and Verification Process.

• Objectives:
  ▪ Optimizing the VRC webpage for documentation to assist in preparing for a site visit
  ▪ What is needed before a visit can be scheduled
  ▪ Requesting a site visit

https://www.facs.org/quality-programs/trauma/vrc/resources
Becoming a Verified Trauma Center: First Steps
A Guide for Trauma Program Managers

Molly Lozada
Program Manager, Trauma Verification
Trauma Quality Programs
COTVRC@facs.org
Scheduling Reminders
Site Visit Application

• The application must be received at least 13-14 months in advance of the requested time frame or current expiration date.
  - This will hold your spot and in addition, provide centers plenty of time to prepare and complete the online PRQ.
• The lead time is required due to the multitude of applications received.
• All of 2017 and up to July 2018 are closed to scheduling:
  - https://www.facs.org/quality-programs/trauma/vrc/site-packet
Additional Information to be submitted with Site Visit Application

The following should be submitted at the time of the site visit application:

- **Orthopaedic Traumatologist Leader (OTL) form**
  - Required for:
    - Level I Trauma Centers
    - Level I Pediatric Trauma Centers
    - Level I Adult and Level II Pediatric Trauma Centers

- Alternate Pathway Request
Orthopaedic Traumatology Leader (OTL) Form

- For Level I adult or Level I pediatric trauma centers (includes combined Level I centers), the OTL form must be completed and submitted with the site visit application.
  - The form is located at: https://www.facs.org/quality-programs/trauma/vrc/site-packet

- For those trauma centers that have separate visits scheduled, but share the same adult and pediatric OTL, the form must be completed entirely for the 1st visit and on the 2nd visit, only answer questions 1-3.
  - If you are unsure if the 1st visit has completed the form, please contact the VRC office at: COTVRC@facs.org.
Alternate Pathway Request

For all trauma centers that have a non U.S. or Canadian board certified/eligible physician or surgeon, and who has trained overseas, must provide the following on the site visit application at the time of submission.

- Applicant’s name and specialty;
- Forward a copy of the applicant’s curriculum vitae (CV).

For information about the Alternate Pathway Criteria, visit:

https://www.facs.org/quality-programs/trauma/vrc/site-packet
Pre-Review Questionnaire (PRQ) Online Access

• Once your application has been received, the VRC office will provide you with an email receipt of confirmation.
  
  ▪ Logins to the online PRQ will be provided within the confirmation of receipt email.
  
  ▪ The online PRQ can be accessed at: http://web2.facs.org/traumasurvey5/
  
  ▪ A copy of the PRQ in Word can be downloaded from: www.facs.org/quality-programs/trauma/vrc/resources
Site Visit Application Payment

- Do not submit payment with the application.

- Your center will be billed annually for the Trauma Quality Program fee
  - This annual fee will not include any additional visit-related fees, such as additional reviewers.

- The fee structure is located at: https://www.facs.org/quality-programs/trauma/vrc/fees
Scheduling Site Visits

• Visits are typically scheduled within 90 days prior to the requested timeframe.

• Ideally, all visits will occur during the center’s preferred timeframe.

• When a lead reviewer is available for your site visit, VRC staff will contact you TPM to confirm the dates prior to finalizing the visit.
Site Visit Preparation

“Should the organization make the travel plans for the reviewers? If so when do we get their name and information to do so?” (Level I Center)

The ACS Travel Agent will arrange the site reviewers’ flights. Reviewers make travel plans approximately 20 to 30 days prior to the site visit.

The reviewer’s contact information will be provided in a confirmation email once the full team has been secured, approximately 90 days before the visit. Please contact the reviewers for their flight itinerary or any logistical information.

The hospital will arrange and pay for the site reviewers’ hotel accommodations as well as their ground transportation.
**Confidentiality Forms**

ACS site reviewers have already signed a Reviewer Agreement (containing a confidentiality clause) and Business Associate Agreement prior to their first site visit. These agreements, in addition to the BA/DUA each hospital has with the ACS, should cover the needs of 98% of all trauma centers regarding confidentiality.

If your legal would like ACS reviewers to sign any documents, such as confidentiality forms, prior to coming onsite for a visit, we ask that you please route those agreements through the VRC office at: COTVRC@facs.org.
General Questions
"What are the ACS expectations for FOCUS visits?" (Level II Center)

The expectations for an onsite Focused Review are as follows:

- One day visit with one of the initial reviewers (2\textsuperscript{nd} reviewer may be a nurse)
- A corrective action plan is required 30 days prior to the site visit on how the deficiencies were addressed and how the weaknesses were/ may be addressed
- A presentation on the corrective actions may be done if desired; but not required
- The review will commence approximately at 0700 unless told otherwise by the ACS office or site reviewers (e.g. travel issues)
- Chart review process/validation
- Closed meeting with the reviewers
- Exit interview - the trauma medical director may extend the invite to other members
PRQ

“We are starting to work on our PRQ for a late fall review. I think that some of the answers will be pre-filled by TQIP. Is that true, and could you tell us which questions?” (Level II Center)

At this time, the PRQ will not be pre-filled with TQIP data. It is under consideration for the future update of the PRQ.
PRQ: Orthopaedic Section (CD 9-3)

“ORTHO section of PRQ: what defines an "undue delay" for OR availability for ORTHO trauma cases? Please elaborate expectation?” (Level II Center)

IX. Orthopaedic Surgery, Question #3: Is there a mechanism in place to ensure operating room availability for musculoskeletal trauma cases can be scheduled without undue delay and not at inappropriate hours that might conflict with more urgent surgery or other elective procedures? (CD 9-3) Type II / L1-2

- Must be able to perform immediate open fracture debridement, stabilization and release of compartment syndrome.
- Trauma services needs to have strong relationships with operating room management and personnel.
PRQ: Orthopaedic Section

“Can you clarify what counts as stabilization for the measure: % of femoral shaft fractures stabilized within 24hrs?” (Level II Center)

IX. Orthopaedic Surgery, Question #9: Percent of femoral shaft fractures (defined as intramedullary rod, external fixation or ORIF) stabilized within 24 hours of admission:

Data should include tibial shaft fractures only. Does not include the following:

- Ankle
- Pilon
- Amputations
- Plateaus
“When completing the Payer Mix question on the PRQ, should the primary method of payment as Blue Cross/Blue Shield be categorized as Commercial or HMO/PPO?” (Level III Center)

For the payer mix, I recommend listing Blue Cross/Blue Shield as HMO/PPO since this is how most reviewers recognized the data.
PRQ: Neurological Deficits

“Can you define the orthopedic surgery question #16 asking about neurological deficits relating to question pelvic/acetabular fx?” (Level I Center)

Disregard question 18.c in Chapter IX Orthopaedic Surgery:

Question 18. The number of operations performed at this institution during the reporting year for pelvic ring and acetabular fractures secondary to a trauma mechanism, excluding isolated hip fractures:

a. Pelvic ring injuries:
b. All acetabular fracture patterns:
c. How many of these patients had neurological deficits?
**Board Certification: Vascular Surgeon**

“Does a foreign trained vascular surgeon have to go through alternate pathway since they provide vascular surgery coverage for trauma?” (Level III Center)

There currently are no ACS standards for the Vascular Surgeon who is providing vascular coverage to be board certified. The expectation is that the center has credentialed this surgeon to provide care for those injured patients.

If the Vascular Surgeon serves as a member on the trauma panel (as a Trauma Surgeon), s/he will be required to go through the Alternate Pathway Criteria process.
“Is it acceptable for the Trauma Surgeon to document their own (bedside) arrival time in regards to trauma activations?” (Level I Center)

Yes. There should be a process by which this is validated, e.g. nurse scribe, badge scanner, etc.
Post-Traumatic Stress Disorder

"Is a screening for PTSD required for trauma patients?" (Level I Center)

"Is the ACS requiring two calls (48 hours & 5 days) to follow-up with all Trauma patients to screen for PTSD and Depression?" (Level I Center)

There currently are no ACS standards for PTSD. However, the trauma center should develop guidelines on evaluating, treating, and managing patients with PTSD.
CD-Related Questions
Trauma Peer Review Attendance

“Are physicians assistants and nurse practitioners able to be the alternates for physician liaisons during peer review meetings?” (Level II Center)

Physician Assistants or nurses cannot be an alternate for the physician/surgeon liaisons who are required to attend the Trauma Peer Review meetings.
"When did ACS begin disallowing using observation patients toward the total trauma volume?" (Level I Center)

Patients who do not meet the NTDS Trauma Inclusion criteria and/or are discharged within 23 hours (kept for observation) do not count toward the Trauma Patient Admission total or volume requirement.
"Trauma ctrs w/affiliated free standing ED, can ED nursing and MD documentation continue on same EMR note after transfer to us?" (Level II Center)

Yes, it is acceptable for the trauma center and free standing facility to use the same EMR. The transfer and receiving information must be delineated and clearly documented.
Non-Surgical Admissions (CD 5-18)

“If non surgical admissions rates are over 10% due to very high volume of GLFs, what is recommended for the PI process on those?” (Level II Center)

The admission policy for elderly patients with single level falls and isolated hip fractures should be set at each individual institution. If these patients meet the NTDS inclusion criteria, they should be captured in your trauma registry, and if the center includes them in the volume admission numbers (on the PRQ), then you must follow the rules as any other trauma admission such as, reviewing nonsurgical admissions, PI, etc. (CD 5-18). Refer to page 121.

Note: This may differ from your state inclusion criteria. Therefore, you may have to capture 2 sets of data points.
“Level II: Is there a requirement to have a dedicated ORTHO trauma OR available 24/7 just as a major trauma room is?” (Level II Center)

Operating rooms must be promptly available to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization, external fixator placement, and compartment decompression (CD 9–2).
“Can specialty PA's be included as backup call for those services that cover more than one hospital? (ie ortho and neurosurgery)?” (Level III Center)

It is acceptable if there are agreed upon guidelines between the TMD and the Neurosurgeon/Orthopaedic liaison for the types of injuries the Resident or Physician Assistant will respond to when a consult is requested. There must be clear documentation with the attending specialist surgeon on the plan of care.
Neurosurgery Contingency Plan (CD 8-5)

“Can you clarify the neurosurgery backup call requirements for Level 3 facilities if the neurosurgeons only cover one facility?” (Level III Center)

Level III trauma centers are not required to have a backup Neurosurgery schedule. However, if the Level III trauma center that has Neurosurgery capabilities in which the Neurosurgeon is encumbered, there must be a contingency plan where by:

- Credentialing process to allow the trauma surgeon to provide initial evaluation/stabilization of the neurotrauma patient
- Transfer agreements with a similar or higher-level verified trauma center
- Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support
- Monitored through the PIPS process
“For an adult level I and pediatric level II trauma center, can the adult TMD also hold the title of pediatric TMD?” (Level I Center)

For a Level II Pediatric trauma center with a Level I or II Adult trauma center, the role of the TMD may be served by the same person. However, as the Pediatric TMD, if not board certified in Pediatric Surgery, s/he will need to meet the alternate criteria outlined in the Clarification Document.
“Are APP's considered credentialed providers for ICU coverage to provide critical care?” (Level III Center)

The intent is for an attending or credentialed provider to respond (arrive at bedside) within 15 minutes for critical situations, and that it is documented. Any delays that impact care must be reviewed through the PIPS process.

Credentialed providers may include residents and intensivists.
“Is the radiology rep required to have 50% attendance at the Peer Review meetings?” (Level II Center)

For Level I and II trauma centers, the radiologist liaison or predefined alternate must attend the peer review meeting at least 50% of the time.
“What are acceptable ways to meet the requirement for hand coverage at a Level II trauma center? Does it have to be separate call; can it be covered by plastics or orthopedics; other options?” (Level II Center)

Hand coverage may be covered by Plastics, OMFS or Orthopaedic Surgery.

The capability for re-implantation is not expected, this can be met by having a transfer agreement.
“Do all PA/NPs need to be current in ATLS?” (Level I Center)

The Trauma and/or Emergency Department (ED) Advanced Practice Providers (APPs/Physician Assistants (PAs) who function as a member of the team caring for trauma activation patients (excludes consults) via assessment or interventions must be current in ATLS. If the Trauma and/or ED APPS’s/PA’s only role is as a scribe or entering orders they do not need to meet the ATLS requirement.
Advanced Practice Providers (CD 11-86)

“If Trauma asks for Neurosurgery consult on a patient and this is done by a NP--is that NP required to have ATLS?” (Level I Center)

Neurosurgery and/or Orthopaedic Surgery consultants (APPs/PAs) who respond to the trauma for a consult are not required to be current in ATLS.

This would also be true for CRNAs.
Registrar (CD 15-9)

“1 FTE trauma registrar is required for every 500/750 pts. can that include several staff entering data, dividing the 40 hrs up?” (Level III Center)

The time may be shared between multiple staff to meet the 40 hours; however, you must ensure each staff member meets the training requirement.

To see a detailed description of the requirements, refer to pages 110-112 in the Resources manual.
“Do all hospice cases have to be presented at monthly trauma M and M, or just a case review?” (Level I Center)

If the death occurred while under hospice care at your facility, then that case will be reviewed.

If the patient is transferred to another facility/hospice care center, those cases would not be reviewed.

Note: what we are asking the center to do is review the hospice care up to the time the patient went into hospice. There could have been major issues, e.g. no neurosurgeon, that may have led to the decision to put the patient in hospice.
“The orange book does not specify nursing staffing. If an ER does not have a dedicated trauma nurse is that a deficiency?” (Level II Center)

“Are there educational requirements for RNs caring for trauma patients?” (Level I Center)

There is not a specific requirement for having a dedicated trauma nurse in the ED. The requirement is for the hospital to provide a mechanism to offer trauma-related education to nurses involved in trauma care (CD 17-4).
Universal Screening for Alcohol (CD 18-3)

“ETOH levels and screening for ALL trauma patients, or just trauma team activations for Level IIs?” (Level II Center)

Universal screening for alcohol use must be performed for all patients that meet the NTDS Trauma Inclusion criteria with a hospital stay of > 24 hours.

For pediatric patients, the age will be defined by the trauma center.
CME: Panel Member No Longer on the Schedule

“Regarding CME hours, trauma call panel, PRQ and site visit. If the surgeon is no longer taking call within the PRQ and site visit time frame, however was on the call panel during the survey year time frame, are CME hours for the surgeon who is no longer on the call panel required?” (Level I Center)

For the PRQ, the data is reviewed retrospectively; therefore, if the center had locums or panel members during the reporting year who are no longer present, do not list them in the appendices. Only list panel members that are currently practicing at your center.
CME: Board Certification

“Level II: For board (re)certification, may 33 hours of CME be credited for either or is it partial CME if it's board recert?” (Level II Center)

“Can you describe more completely how Board Certification is used for CME? Is this a one time thing?” (Level I Center)

Thirty-three (33) hours of CME obtained from either the initial board certification or recertification may be used to meet the CME requirement. This may be used once during the 3 year verification cycle leading up to the site visit.

• If double boarded, only 33 hours of CME will be permitted.
• Not required to provide breakdown; however, must provide documentation of board certification.
“Is there any discussion related to the future requirements and collection process of physician CME?” (Level I Center)

Yes, we just started the revision process for the next manual. We are encouraging all participating centers including reviewers to visit the Stakeholders Public-Comment website to provide feedback, evidence and/or literature to support changes to any of the standards, e.g. CMEs, nursing education, etc.

https://www.facs.org/quality-programs/trauma/vrc/public-comment
"We just learned that our Neurosurgery liaison will be leaving 6 months prior to our reverification visit. Will his replacement be required to have 48 hrs of external CME?" (Level I Center)

For the new liaison, the CMEs may be prorated as 16 hours of external trauma-related. This may include CMEs obtained from board certification.
Locums: Requirements

“If a level 2 trauma center is in need of a locum surgeon for a few shifts, what are the requirements if it is acceptable?” (Level II Center)

For Level I, II and III trauma centers, locums who are treating trauma patients must go through the hospital’s credentialing process and meet the same requirements as the other trauma panel members, e.g. board certification, and for Level I and IIs that includes CME and/or an Internal Education Process, peer review attendance and OPPE process.

The above is true regardless of the number of shifts.
“The IEP process is not well defined to us, could you provide more examples of how to set this up within an organization?” (Level I Center)

The following 3 slides will provide an overview of IEPs that may be used.

The Committee on Trauma’s Information Technology Committee is currently developing a tool on how centers should develop its IEP. More information will be released as it becomes available.
IEP: Should Reflect Topics Based On:

- Quality issues identified in your peer review, systems meetings, nursing & physician chart audits.
- Based on regulatory mandates: joint commission, pain assessment, falls, medication, VAP.
- Evidence based practice through journal or national meeting information.
- Case-based learning that identifies issues through the PIPS.
- Must be able to document the activity.
- Approved by TMD.
- Should be quarterly, at a minimum, and functionally equivalent to 16 hours of CME - verifiable by provider.
Internal Education Program

What does it look like?

• In-service, case-based learning; educational conferences; grand rounds; internal trauma symposia; and in-house publications disseminating information gained from a local conference or an individual’s recent participation (through trained analysis) reviewing a trauma center.

• Does not require CME’s.

• Attendance/communication of information must be documented.
IEP Checklist

Determine what platform or program will be used to document and capture the IEP.

- Sharepoint, SurveyMonkey, Intranet

Define the subject matter.

- Conferences: local, regional or national
- Peer Review articles, Webinar, Courses

How often is the IEP utilized?

- Weekly, Bi-Monthly, Monthly, Quarterly, Bi-Annually, Annually.

Must track participation from the members.

Ability to present the hospital’s IEP for the site reviewers.
Thanks for your participation!