Trauma Verification Q&A Web Conference

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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](http://www.facs.org/quality-programs/trauma/vrc/resources)
Clarification Document and Verification Change Log

- Released Monthly
- Change Log – notes criteria updates/changes
- Available and download: www.facs.org/quality-programs/trauma/vrc/resources

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<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>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>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>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>Surgical commitment is essential for a properly functioning trauma center (CD 2-2)</td>
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<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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<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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Website Resources for Trauma Centers

- Recording of Webinars: [https://www.facs.org/quality-programs/trauma/vrc/resources/webinars](https://www.facs.org/quality-programs/trauma/vrc/resources/webinars)

- Stakeholder Public-Comment website: [https://www.facs.org/quality-programs/trauma/vrc/public-comment](https://www.facs.org/quality-programs/trauma/vrc/public-comment)


- Tutorials:
  - Becoming a Verified Trauma Center: First Steps
  - **New!** Becoming a Verified Trauma Center: Site Visit: [https://www.facs.org/quality-programs/trauma/vrc/resources](https://www.facs.org/quality-programs/trauma/vrc/resources)

- Participant Hub - Account Center: [https://www.facs.org/quality-programs/trauma/tqp/tqp-center](https://www.facs.org/quality-programs/trauma/tqp/tqp-center)
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
Next Verification Q&A Webinar

Deadline to submit questions: May 16, 2018

Webinar date: May 31, 2018

Webinar time: 12:00pm-1:00pm CST
Scheduling Reminders
Site Visit Application

- The application must be received at least 13-14 months in advance of the requested site visit dates and must be before expiration date.

- All Level I Trauma Centers must also complete the Orthopaedic Trauma Liaison (OTL) form with a copy of the OTL’s curriculum vitae when submitting site visit application.

- For trauma centers that have surgeons/physicians who trained, or are board certified overseas, they are required to apply and be approved by way of the Alternate Pathway Criteria. Their name and specialty must be specified on the application.

- We are accepting applications for **February 2019** and the rest of that year.
Providing QTP Contact Updates

• Staffing changes should be updated at the Participant Hub Account Center or notify the VRC office as soon as possible: https://www.facs.org/quality-programs/trauma/tqp/tqp-center

• Challenges with not updating contacts:
  ▪ Consultation, re-/verification and Focused letters and reports have incorrect staff listed
  ▪ Follow-up inquiries from the VRC staff on recent site visits may cause delays receiving the final letter and report

• Site visit applications, note credentials: MD, RN, EMT, NP, PA
  ▪ Combined adult and pediatric verification programs, add contacts for both the adult and pediatric programs
Prereview Questionnaire (PRQ) Online Access

- Once the 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 being scheduled quarterly.

- Center’s are being asked to provide us with the exact dates you would like to have visit. Ideally, the visit will occur on your chosen dates.

- Once the review team has been secured, you will receive a confirmation email which will list your reviewers and their complete contact information.

- Visits will typically be scheduled within 120 days prior to scheduled visit.
Site Visit Preparation with Reviewers

• 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 hospital will arrange and pay for the site reviewers’ hotel accommodations, as well as their ground transportation.

• Please contact the reviewers directly within 30 days of the site visit for their flight Itinerary and any logistical information.
Criteria Updates
Alcohol Screening (CD 18-3)

Universal screening for alcohol use must be performed for all injured patients and must be documented (CD 18–3). Level I, II and III

It is applicable to eligible patients (alive and participatory), regardless of activated or non-activated, who meet inclusion criteria with a hospital stay of >24 hours who are admitted to the hospital and are entered into the registry.

Any patient with an altered mental status (and deaths) should be excluded from the denominator as these can’t get screened.
And now...
Effective Immediately

• The CME requirement has changed to 36 hours/12 annually from 48 hours/16 annually).

• In Level I and II adult and pediatric trauma centers, trauma surgeons, pediatric surgeons and the specialty panel members (emergency medicine, orthopaedic surgery, neurosurgery and ICUs) participating on the trauma call panel must demonstrate evidence of ongoing trauma related education. CD 6-10 Type II
• In Level I and II trauma centers, the trauma medical director (TMD) must fulfill this requirement by obtaining and demonstrating a minimum of 36 hours of verifiable external trauma-related continuing medical education (CME) over a 3 year period. In Level I and II pediatric trauma centers, the pediatric TMD must fulfill the same requirement, of which 9 hours must be pediatric trauma specific. CD 5-7/CD 10-39 Type II
Continuing Medical Education (CME)

- For the trauma surgeons, pediatric surgeons and specialty panel members (emergency medicine, neurosurgery, orthopaedic surgery and ICUs) participating on the trauma call panel, staying current with their board certification meets the CME requirement. CDs 5-24, 7-12, 7-13, 8-14, 8-15, 9-18, 9-19, 10-39, 10-40, 11-63, and 11-64 Type II
Continuing Medical Education (CME)

- The TMD is expected to assess the individual surgeon’s adequacy of trauma care knowledge in the ongoing professional practice evaluation (OPPE) process and retains the right to require additional CME or internal education process (IEP) that stems from the trauma center’s performance improvement and patient safety (PIPS) process. For the specialty panel members (emergency medicine, neurosurgery, orthopaedic surgery and ICUs), the OPPE may be done by the specialty liaisons with approval of the TMD.
CME Clarification

- Current board certification is applicable to board eligible (recent graduates) and life-time (grandfathered) physicians/surgeons.

- Trauma surgeons and specialty panel members (emergency medicine, neurosurgery, and orthopaedic surgery) who have been previously approved by way of the **Alternate Pathway Criteria**, must meet this requirement by obtaining and demonstrating a minimum of 36 hours of verifiable external trauma-related CME over a 3 year period or by participating in an equivalent number of hours in the trauma center’s internal education process (IEP) or a combination of CME and IEP. The trauma program is expected to have a copy of its provider’s CMEs or IEP documentation at the time of the visit.

- Please note: The PRQ will be updated to reflect the above change. Pending these changes, the trauma program will select ‘Yes’ to the CME questions and leave the CME section blank in the appendices.
General Questions
**TPM Reporting Structure**

“Is it acceptable for the TPM and program staff to report up through nursing and the TMD to the CMO?”

(Level 2)

The Trauma Program Manager’s (TPM) reporting structure will vary based on the institution. However, the reporting structure must allow the TMD and TPM to work side by side to lead the trauma program.
“What is the expectation for the Surgeon admitting 90% of the trauma admits? Is this activations ONLY? Does Orthopedics count?” (Level 3)

The ACS does not have a surgeon/physician admitting threshold.

There is an attending trauma surgeon response expectation of 80% for the highest level of activation.
“Could you give examples of acceptable competencies for FAST exams and the PI process for FAST exams?” (Level 2)

Regular meetings should be conducted to review FAST exams by the ED Emergency Director. Any significant issues associated with the use of ultrasound in trauma patients should be presented at the Emergency Medicine Quality Improvement (QI) meeting or equivalent meeting.

Site reviewers will look through the case reviews for cases that had FAST exams and whether any were presented/discussed at the PI/QI meetings.
PRQ

“How often is the PRQ itself reviewed? May I suggest that when questions in the PRQ changes in any form, posting to the Webinar would be helpful.” (Level 3)

Great suggestion and we will take that into action. We can add a segment as ‘Updated PRQ Questions.’ Thank you!

At this time, no new changes have occurred.
PRQ

“In reference to answering the PRQ, how is 'social worker' defined? Is the question related to d/c planning/referral to services?” (Level 1)

The social worker is defined as a credentialed provider who is capable to perform evaluations and counseling. The credentialing criteria (training, education, etc.) will be determined by the institution.
PRQ

“With regards to PRQ for pelvic ring fx, acetabular fx and with neurological deficit. We are only going to capture those patient that undergo to stabilized the said fx? and for neurological deficit this only relates to lower extremities neurological damage to the nerves causing a problem like foot drop?” (Level 2)

Disregard (skip) question 18.c in Chapter IX (9):

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?
**PTSD Screening**

“Related PTSD screening for trauma patients. what info would surveyors want to see?” (Level 1)

There currently are no ACS standards for PTSD. The reviewer may want to know if the trauma center provides PTSD screening for trauma patients. If the trauma center does, they may want to see your guidelines on evaluating, treating, and managing patients with PTSD.
Verification Site Visit

“If the trauma program is experiencing some personnel changes (TMD, TPM), would you recommend postponing a survey? How long?” (Level 3)

This will depend on the following: 1) is the center currently verified and 2) the type of personnel changes. For example, if the center is currently verified and the TMD or TPM leave unexpectedly, appoint another trauma surgeon or FTE to fill in. This may make the visit a bit challenging as they may be the only person that can speak to specific cases that were reviewed by PIPS. In addition, if the visit is postponed the verification status will lapse and may impact your state designation process.

If the center is not currently verified and the TPM or TMD leave unexpectedly, you may want to: 1) substitute someone in that position and move forward with the visit, or 2) postpone the visit until you have secured someone in that role.
Verification Site-Visit

“This is my first verification - what should I expect? As Injury Prevention, what will the surveyors be looking for?”

(Level 2)

Please refer to the two tutorials available at:
https://www.facs.org/quality-programs/trauma/vrc/resources

• Becoming a Verified Trauma Center: First Steps
• Becoming a Verified Trauma Center: Site Visit

In respect to injury prevention, the reviewers will review how the trauma center is helping the community. Examples may include, going out to venues and provide education to senior citizens on preventing falls and risk factors.
Verification Site Visit

“To clarify, we can submit exact request dates for re-verification visit? Rather than a ‘range’ of dates?”

(Level 2)

Correct. The Site Visit Coordinator, Rachel Tanchez, will schedule your site visit on the 2 dates provided on the application. You may want to provide additional dates just in case it falls on a holiday or during a conference. We make an effort not to schedule visits around holidays and national conferences (EAST, WST, Clinical Congress, PTS, STN, etc.)
Verification Site Visit

“Please clarify the status of a trauma center when they have a site visit that results in a ‘one year focused review’. Are they considered a ‘verified’ trauma center during that year prior to the date of the focused review?”

(Level 3)

Yes. If the trauma center received a ‘one year’ verification, they are verified through the expiration date or through the resolution process (final letter). The focused period is the same as the one year verification period. To extend the verification period an additional two years, the trauma center is required to either: 1) provide documentation by mail, or 2) schedule an onsite Focused site visit.
CD-Related Questions
“CD 2-8: For the Surgeon's response to the highest level of activation are pt's who arrive via private auto in the measure?” (Level 2)

Yes, if the highest level of activation was triggered upon assessment of the patient.
Transfers (CD 4-3)

“Does the trauma surgeon have to be contacted on a Level 2 activation before the pt is transferred or can the ERP manage it?" (Level 3)

This will depend on your Level 2 activation criteria and protocols. If the protocols calls for the Emergency Room Physician to transfer without consent or with consent of the trauma surgeon, it should be documented in the EMR and reviewed through the PIPS process.
Adult Trauma Centers Admitting Children (CD 2-23)

“As an adult Level II center treating and admitting some minor pediatrics cases, what are the credentialing, education, or other requirements for the trauma surgeons or APP providers?” (Level 2)

For the non-pediatric trained providers/APPs managing pediatric patients, the credentialing process may consist of Pediatric Advanced Life Support (PALS) certification, annual pediatric trauma continuing medical education (CME), or pediatric-specific content covered in the internal education process (IEP).

For the APPs, if they are part of the trauma activation team; provide evaluation and assessment, they are required to be current in ATLS.
**TMD Authority (CD 5-11)**

“What level of involvement should the TMD have in the 'trauma certification' of medical practitioners in the ED, Neuro, Ortho.” (Level 1)

The TMD must have the authority to provide input in the credentialing of providers who will be involved in the care of trauma patients.
Ongoing Professional Practice Evaluation (CD 5-11)

“Should the profession evaluation of Trauma Surgeons performed by the TMD be shared with the individual practitioner?” (Level 1)

If the question is should the TMD share the OPPE evaluation with the individual practitioners? Absolutely, the TMD should share that information to address any performance or patient care issues.
Limited Trauma Team Criteria (CD 5-16)

“Does the trauma surgeon need to see all mid-level activations or can the trauma service advanced practice provider see the patient in place of the attending trauma surgeon?” (Level 2)

For the limited tier, the APP may be the primary responder as long as the hospital has credentialed them to do so and they must be current in ATLS (CD 11-86). With this said, the limited tier criteria/protocols must clearly speak to this (the APP responding) and in addition have language for the type of injuries and time expectation for when the trauma surgeon is expected to respond. All must be monitored through the PIPS process to ensure there are no delays.
“Can a trauma patient with injuries noted for multiple rib fractures and scalp laceration be seen in consultation by any surgeon or does it have to be a trauma surgeon (General Surgeon)?” (Level 2)

For the consultation tier, the primary responder may be a credentialed provider (General Surgeon, Emergency Physician, Advance Practice Provider, etc.) as long as the hospital has credentialed them to do so and they have either taken ATLS once and for the APP current in ATLS (CD 11-86).
If an ER provider is board certified in Family Medicine before 2016, is he eligible to take trauma patients?"

Yes. The Emergency Medicine Physician boarded in Family Medicine is eligible to care for trauma patients. The change speaks to those physicians who completed primary training in 2016 and after.
Neurosurgery (CD 8-5)

“Is it acceptable for a credentialed trauma surgeon to manage a neurotrauma pt. until the neurosurgeon arrives as part of the routine neurosurgery response not a contingency plan? (CD-8-1, 8-2)” (Level 1)

Yes. The trauma surgeon may be credentialed to manage the neurotrauma patient while awaiting for the Neurosurgeon to respond. However, the Trauma surgeon cannot account for the 30 minute specialty response.
Neurosurgical Response (CD 8-2)

“Can the surgical critical care intensivist fulfill the 30 minute neurosurgical response if they are in contact with neurosurgeon” (Level 1)

To clarify, if this is the Neurosurgical Intensivist, yes they may respond when consulted for neurosurgical care. If that is the case, there must be guidelines for the types of injuries they are approved to respond to and there must be clear documentation of the discussion with the surgeon specialist on the plan of care.
Neurosurgeon Backup Call Schedule (CD 8-3)

“If a Neurosurgeon is on call for both trauma and the stroke center at the same facility, is a back-up NS call schedule required?” (Level 2)

Yes. Trauma and stroke are separate programs so there must be either a backup schedule or contingency plan in case the neurosurgeon becomes encumbered with a stroke patient.
Pediatric PIPS Process/Transfers (CD 10-6 / CD 4-3)

“In an adult center should we review only pediatric admissions to the hospital or all pedi trauma pts who come to ED and transfer” (Level 2)

The center must review both. The pediatric admission and those pediatric patients that were transferred.
“CD 11-33 When does the clock stop for IR (radiologist)? At bedside, or getting the patient to the table? Does the Radiology Attending need to be the one to respond or is evaluation by resident appropriate?” (Level 2)

Clock starts when the call is made requesting the service and ends at bedside.

The Radiologist Resident may provide the evaluation as long as the hospital has credentialed them to do so.
ICU Director (CD 11-49)

“Can the medical director of the SICU be a pulmonologist? Can a pulmonologist supervise PGY 4 or greater surg res from home?” (Level 1)

No. The Surgical ICU Director at a Level I trauma center, must be a surgeon who is currently board certified in Surgical Critical Care.

The PGY 4 and greater residents must be under the supervision of the trauma service.
ICU Liaison (CD 11-61)

“Does the designated ICU liaison to the trauma service need to be an ICU intensivist?” (Level 2)

No. The ICU liaison is typically the ICU Director who is a board certified General Surgeon.
Advance Practice Providers Credentialing (CD 11-86)

“What policies if any exist for credentialing of advanced practitioner staff?” (Level 1)

The credentialing process for APPs will differ by trauma centers. There is currently one criteria for APPs in regard to their participation on the trauma team during activation and who provide evaluation and resuscitation efforts to the trauma patient, must be current in ATLS. Some credentialing examples could be based on ATLS/PALS, trauma CME, or documentation of performance as measured by PIPS.
CRNAs (CD 11-3)

“Is it a requirement for the CRNA's to take ACLS? One time or ongoing?” (Level 3)

No. There are no requirements for CRNAs to take ACLS.
Death Categorization (CD 16-6)

“Please clear up some confusion on the exact terminology for the PIPS process in reviewing deaths: Mortality with opportunity for Improvement and/or Mortality without Opportunity for Improvement and/or Unanticipated with Opportunity for Improvement Or other terminology?” (Level 3)

The death categories did not change and remain as follows:

- Mortality with opportunity for improvement
- Mortality without opportunity for improvement
- Unanticipated mortality with opportunity for improvement
“People who are terminally weaned and expire, when they are reviewed at M and M, would this be an anticipated mortality because we know when we pull support they will not survive or do we look at with would they have survived the injuries if family had decided not to pull support and see it as unanticipated?” (Level 1)

This can be reviewed both ways. You want to ask the questions, would the patient have survived the injuries if the family had not decided to withdraw support, and how long would the patient have survived.
Hospice Case Reviews (CD 16-6)

“Do hospice d/c cases without issues need to be presented at a PIPS meeting, or is it OK to peer-review outside of the meeting?” (Level 2)

If d/c is discharged, just as with any other discharged trauma case, the care will be reviewed by the TMD and TPM. If any issues are found, then it can be reviewed at peer review.
Continuous Rotation (CD 17-3)

“In CD 17-3 what is meant by continuous rotations in Trauma Surgery for senior residents PGY 4-5? Is this 24/7? Does a Level II Trauma center have to have residents and specifically PGY 4 or PGY 5?” (Level 1)

Level II trauma centers are not required to have residents.

The continuous rotation is not about having a resident on every day or every month, but more about having the resident education experience with a full (printed) curriculum and a dedicated teaching staff for a period of time over the course of the year. What is not acceptable is having residents who are on the service as an elective.
Alcohol Screening Tool (CD 18-3)

“Does screening for drugs and alcohol on trauma patients require documented lab levels, or will a screening interview suffice?” (Level 3)

Screening for drugs and alcohol does not require lab levels. A screening tool or metric will suffice. This must be documented.
Alcohol Screening Age (CD 18-3)

“What is the minimum age requirement for Alcohol SBIRT?” (Level 2)

The minimum age for screening and intervention will be defined by the trauma center.
Thanks for your participation!