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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!
If you have your Resources for Optimal Care of the Injured Patient 2014 (Orange Book) in hard copy or PDF version, it is recommended that you have it available to reference in the CD-Related Questions section of this webinar.

The most current Clarification Document, and the Verification Change Log are available at: www.facs.org/quality-programs/trauma/vrc/resources
The updates for the monthly Verification Change Log and Clarification Document for October and November 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 clarifications to any criteria will be published in the Clarification Document.
Clarification Document

Updates sent to participants monthly
**New! 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>
<th>Clarification</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>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>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>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>7/1/2014</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>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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<td>III</td>
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<td></td>
<td>II</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 Webinar

The recording of this webinar will be posted, within 1 week, on the ACS YouTube channel.

All of our Resources are located on this webpage:

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 misspellings and/or content.

• 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:  **Friday, January 13, 2017**

Webinar date:  **Tuesday, January 24, 2017**

Webinar time:  **12:00pm- 1:00pm CST**
2017 NTDS Data Dictionary now available!

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 has been closed to scheduling.

  https://www.facs.org/quality-programs/trauma/vrc/site-packet
Orthopaedic Traumatology Leader (OTL) Form

• For Level I adult or Level I pediatric trauma 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.
PRQ Online Access

• The VRC office will provide you with an email receipt when the application is received.

  ▪ Logins to the online PRQ will be provided within the context of the email.

  ▪ The online PRQ can be accessed at: http://web2.facs.org/traumasurvey5/.
Site Visit Application Payment

- Do not submit payment with the application.
- 60 to 90 days before your visit, your center will be invoiced for the Quality Program fee that includes the fees for both the site visit and TQIP.
- Centers will then be invoiced annually for the Quality Program fee for the remainder of the verification cycle.
  - 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, contact will be made to the TPM prior to confirm the dates.
General Questions
Recording of Webinars

“Do you record these sessions and can they be accessed at a later time?” (Level II Center)

Yes, they are recorded and can be viewed typically after the scheduled web conference on the VRC webpage at: https://www.facs.org/quality-programs/trauma/vrc/resources.

The following is a snippet from the web page of how the links will appear:

- June 2016 Trauma Verification Q&A Web Conference
- July 2016 Trauma Verification Q&A Web Conference
- Orthopaedic Trauma Association
- August 2016 Trauma Verification Q&A Web Conference
- September 2016 Trauma Verification Q&A Web Conference
How to use TQIP data

“What is the best method for demonstrating the use of our TQIP data?” (Level II Center)

• Are you using TQIP enhancing your current PI?

• Have you used your reports to ID areas for improvement and worked on those areas?

• Are you sharing your data beyond your core trauma team? (Specialists, hospital QI, etc.)
Incorporation of TQIP data in the PRQ

“Is there a timeframe for when TQIP data will be incorporated into the PRQ?” (Level I Center)

This process will begin over the next two years with the next iteration of the PRQ.
**Peds TQIP requirement**

“For a combined Adult Level 1 and Pedi Level 2, when will Pedi TQIP become a requirement?”

(Level I Center)

- Adult Level I or II combined with a Peds Level II are not required to join both adult and peds TQIP, though you are welcome to do so.
- These combined centers already meet CD 15-5 through their adult center. The requirements for being a combined Level II peds center do not include CD 15-5; therefore, participation in Peds TQIP is not required for these centers.
- Centers that are Adult Level I or II and Peds Level I are required to be in adult and peds TQIP as CD 15-5 is required to be a Verified Level I Peds center.
Common Criterion Deficiencies

“what are the top five weaknesses or CDs that trauma centers are experiencing with the Orange Book from site visits thus far?” (Level II Center)

Deficiencies:

• CME
• Peer review attendance
• Universal screening for alcohol use
• Loop closure (CD 16-2). Problem resolution, outcome improvements, and assurance of must be readily identifiable through methods of monitoring, reevaluation, benchmarking, and documentation.
“Do all APRN's/PA's need to have ATLS, regardless if they participate in activations?” (Level II Center)

The APRN’s/PA’s who are not involved in the trauma team activation, are not required to be current in ATLS.

Those APRN’s/PA’s that function as a member of the trauma team activation and are caring for trauma activation patients via assessment or interventions must be current in ATLS. If the Trauma and/or ED APP’s only role is as a scribe or entering orders they would not need to meet the ATLS requirement.
Advanced Practitioners

“If your ED PAs are ATLS certified, not part of your trauma team activation (TTA) response team, and involved in the care of traumatically injured patients who don’t meet TTA criteria. Do you expect them to get the ED physician involved and do you expect to see documentation in the form of an attestation by the ED doctor that they were made aware of the patient, reviewed the care/plan, and agree with the plan/management along with the time they were made aware?” (Level II Center)

If the PAs/APPs are managing trauma patients during the non TTA tier, it is required to document any discussions involving the patients care/plan with the physician.
Pre-Review Questionnaire: TBI

“PRQ - page 11 what is the % of TBI patient is taken to the OR in 24 hours what would you consider the denominator? all tbi?” (Level III Center)

From the PRQ, question #6 asks: what is the percentage of severe TBI patients having ICP monitors inserted within 48 hours of admission during the reporting period?

The denominator would be all TBI patients during the reporting year.
“Pediatric admissions for PRQ volume - does this include peds with single system ortho injuries that go to the OR then home?” (Level III Center)

If the single system injury meets the NTDS inclusion criteria, it should be counted toward the PRQ volume requirement.
Pre-Review Questionnaire: Pediatric Surgery

“If we occasionally admit peds to our adult ICU do we need to answer the PICU PRQ questions?”
(Level III Center)

Yes. For those trauma centers that are not seeking a separate pediatric verification, but do admit pediatric patients, in the PRQ for section Purpose of Site Visit, if the following is true:

• Level of Review: **Level I, II or III Trauma Center**
• Facility treats what type of patients: **Adults and Children**

• Only complete the following:
  ▪ Section A. question #1
  ▪ Section B. Splenic Injury table
  ▪ Section C. Pediatric Trauma Admissions—entire section and **ONLY** enter the pediatric data
  ▪ Skip to XI. Collaborative Services
Pre-Review Questionnaire: Contingency Plan

“The PRQ questions under the Neurosurgery section regarding neurotrauma diversion plans (Questions 10 & 11) require extensive...contingency plans including credentialing for trauma surgeons. We are a Level 1 TC and do not divert or transfer out. Do we need extensive contingency plans also?” (Level I Center)

Yes it is required even though it may occur on rare occasions. These contingency plans are required in the event the neurosurgeon on call is encumbered, e.g., in surgery, the CT scan is down, there are no beds, flooding, etc. You would need to transfer or divert patients to another trauma center.
Pre-Review Questionnaire: Appendix 1 versus 14

“PRQ: Please confirm, can Level 1 Pediatric Trauma Centers disregard Appendix 1: TMD if Appendix 14: Pediatric TMD is to be used?” (Level I Center)

Yes. However, we prefer the trauma center use Appendix 1. It’s the first appendix and would eliminate the possibly of not completing Appendix 14 later in the PRQ.
Documentation for Consult Times

“what is the best method for capturing consult times and urgency.”

This depends on your system. Some trauma centers are having the physician/resident APP document both the time of notification and time of bedside assessment along with documentation on the trauma flow sheet. A trauma center should develop a plan where the information can consistently be retrieved by the registry staff.
VRC Updates
Update: CME from Board Re-/certification

To meet the external CME requirement, 33 hours from the initial board certification or recertification will be allowed to count as trauma or critical care external CME for all specialties:

• Trauma Surgeons
• Orthopaedic Surgeons
• Neurosurgeons
• Emergency Medicine

Clarification: The program is not required to itemize the 33 hours of CME.
Update: CME

- All Critical Care CME count.

- Internal Education Process (IEP) time must be equivalent to 16 hours annually or 48 hours in three years.

- Must be TRAUMA or Critical Care Medicine related (not cancer!!).

- Proration
  - New Physicians must have one year of CME (16 hours).
  - New trauma centers: all providers must have one year of CME (16 hours) minimum.
Update: Peer Review Attendance for Combined Programs

There must be a representative (TMD or designee) from the adult program or from the pediatric program that may attend the other program’s meeting, and ensure dissemination of communication is sent to the other panel members.
Exemptions for CME and Peer Review Meeting

An exemption is permitted for surgeons and/or physicians who are on Military deployment, medical leave or missionary work. The trauma center that has an impending visit must provide documentation (letter) to support the absence.
In a Level I trauma center, a surgeon with current board certification in surgical critical care must be designated as the ICU director (CD 11–49).

If the TMD meets the above requirements then s/he may fulfill both roles.
Stop the Bleed may be used as an outreach and education activity.
CD-Related Questions
Meeting Requirements Following Updates

“Currently our facility serves as a Level 1 Pediatric Trauma Center: Will trauma centers be responsible for clarification document updates once the final PRQ is submitted?” (Level Unidentified)

The trauma center will not be held to the new updates that are released after their PRQ has been submitted.
Response Time for Trauma Team Activation (CD 2-8)

“pg 15 of update: Is the response time from patient arrival for only the highest activations? Or the partial activations as well?” (Level II Center)

For both the highest or partial tier of the trauma team activation, the response time must be tracked from the patient’s arrival time.
Trauma Team Activation (CD 2-8)

“I heard a comment at the TQIP conference that it is okay to activate after arrival as long as it is within the first hour. True?” (Level II Center)

The patient may be activated after arrival, if the patient did not arrive as a trauma team activation (TTA), but is evaluated and is determined to meet TTA criteria.

In this scenario, the trauma attending’s response time will be tracked from the time the activation was called/triggered.
Direct physician-to-physician contact (CD 4–1)

“Transfer out - what is meant by physician to physician response time, most facilities have transfer call center who take the info.” (Level III Center)

In most trauma centers, if a patient is being transferred, there must be direct communication between the ED physician and/or Trauma Surgeon of the receiving/accepting center.

In some states, there are referral centers that have been credentialed to receive and relay the communication to the ED physician and/or Trauma Surgeon. This is acceptable.
Examples of 30 minute response time (CD 8-2)

“30 min response time for neuro surgery, are there specific conditions you are looking for?”
(Level III Center)

- Penetrating injury to head with altered mental status
- TBI with emergent surgical intervention
- TBI with emergent EVD monitoring
“For Level III facilities seeking Level II designation, is it acceptable for the on-call neurosurgeon to perform surgical cases at another facility if there is a published back-up neurosurgery call schedule?”
(Level III Center)

Yes. If there is one Neurosurgeon that covers two trauma centers in the same geographical location, there must be a published backup call schedule.
Operating Room (OR) Availability (CD 11-15)

“CD: 11-14 – 11-15: An operating room must be adequately staffed and available within 15 minutes at Level I & II Trauma Centers. This is met by having an operating room team in the hospital 24/7. If the operating room is occupied, an adequately staffed additional room must be available. Does the 2nd call team OR room need to be available in 15 minutes as well?” (Level I Center)

No, there is not a defined time for when the 2nd OR team (backup) must respond when requested. The institution must establish a response time and monitor the team’s response times for any delays through the PIPS process.
Anesthesiologist Backup (CD 11-5)

“At a Level II trauma center, what is the expectation for anesthesia response in the event of a second trauma requiring surgical intervention with regard to time? The backup anesthesiologist has 30 minutes to arrive so is it acceptable for a CRNA to start a trauma case while the in-house anesthesiologist is encumbered?” (Level II Center)

Yes, this is acceptable. When Anesthesiology senior residents or CRNAs are used to fulfill availability requirements, the attending Anesthesiologist on call must be advised, available within 30 minutes at all times, and present for all operations (CD 11–5).
Peer Review Attendance for Anesthesia (CD 11-13) and Radiology (CD 11-39)

“Advise on radiology and lab liaisons expectations to attend peer review.” (Level I Center)

For Level I, II and III trauma centers, the Anesthesiologist and/or pre-determined liaison must attend a minimum of 50% of the trauma peer review meetings.

For Level I and II trauma centers, the Radiologist liaison and/or pre-determined physician must attend a minimum of 50% of the trauma peer review meetings.
Peer Review Attendance

“Are there guidelines for the number of times teleconference can be used to meet the 50% attendance for Peer Review?” (Level I Center)

The expectation is for teleconferencing to be used on a limited basis.
Peer Review Attendance

“Do resident liaison require the same 50% Peer Review attendance?” (Level I Center)

At Level I, II and III trauma centers, all appointed liaisons must be surgeons for the required specialties. For Emergency Medicine, Anesthesia and Radiology (Level I and II), it must be a physician.

All Trauma Surgeons on the trauma panel must attend 50% of the trauma peer review committee.
“In the OR at a Level II trauma center, what is the expectation regarding who should be covering the case for which the backup team was called in? Should the in-house team continue the trauma case and the backup team remain available for potential in-coming cases? Or is the backup team expected to take over the trauma case to allow the in-house team to be available for additional in-coming cases.” (Level II Center)

If the 2nd OR team (backup) was called in for a trauma case because the inhouse team is encumbered, the expectation is that the backup OR team should cover the trauma case they were called in for.
Operating Room (OR) Availability (CD 11-17)

“Define Level III OR staffing expectations during off shifts (onsite staffed vs on call staff) and on-call backup expectations.” (Level III Center)

In Level III trauma centers, an operating room must be adequately staffed and available within 30 minutes. A backup OR team is not required.

If an on-call team is used (CD 11–18):

• Timeliness must be ensured to start operations,
• Response is continuously monitored through PIPS,
• Measures must be implemented to ensure optimal care.
ICU Coverage (CD 11-60)

“CD 11-51: Appropriately trained physicians must be available in-house within 15 minutes to provide care for the ICU patients 24 hours per day TYPE I. CD 11-60: In all Level I, II, and III trauma centers, the timely response of credentialed providers to the ICU must be continuously monitored as part of the PIPS program TYPE II. Is the intent here that bedside nurses are to document response times of providers to pages akin to the response times of ortho and neurosurgery to the ED for specific conditions? Time to call back? Time to bedside? Only in critical situations? Then the program has to monitor these times? Or can it be more general?” (Level Unidentified)

The intent is for an attending or credentialed provider to respond within 15 minutes for critical situations, and is documented. Any delays that impacts care would be reviewed through the PIPS process.
CME for ICU (CD 11-64)

“For Level II trauma centers, are Intensivists, working in the ICU, required to have 16 hours of trauma-related CME?” (Level II Center)

There are no standards specific to Intensivists. However, if they are used to provide coverage for trauma patients in the ICU, they are expected to meet the same standards as the other surgeons, e.g., participate in an internal education program that is case based learning, or obtain 16 hours of external trauma related CME.
Blood Bank: Red Blood Cells/Frozen Plasma (CD 11-83)

“CD 11-83: "In Level III Centers, the blood bank must have an adequate supply of packed red blood cells and Fresh Frozen Plasma available within 15 min. Does this need to be thawed and to the bedside in 15 min or does this mean available and being thawed. Currently we do not have access to 24hr thawed FFP at our center.” (Level III)

They are not required to be thawed and at bedside within 15 minutes; however, it must be available when requested.

A Level III trauma center should have a process in place to assure platelets and fresh frozen plasma are available in a timely fashion.
“Is a Pediatric Trauma Manager necessary in a Level II Pediatric Trauma Center?” (Level II Center)

In Level II trauma centers that are free standing, there must be a dedicated pediatric TPM. This person may serve as the injury prevention or performance improvement coordinator; however, they cannot also serve as the registrar.

Clarification: In a combined Level II adult trauma center with a Level II pediatric trauma center, a separate dedicated pediatric trauma program manager (TPM) is not required.
Registrar Requirements (CD 15-9)

“How strict are the registrar guidelines? (500-750 abstractions each)?” (Level II Center)

We hold trauma centers to the standard.

To see a detailed description of the requirements, refer to page 112 in the Resources manual.
Registrar Requirements (CD 15-9)

“Can you clarify registrar FTE requirements? I have a 0.8 registrar for 500+ patients entered on reg and other expected duties.” (Level III Center)

One full-time equivalent employee dedicated to the registry must be available to process the data capturing of the NTDS data set for each 500–750 admitted patients annually (CD 15–9).

Additional tasks for the registrar may include, but not limited to, running reports, validating the data, NTDB/TQIP data submission, etc. These other functions may impact the registrar's ability to perform other duties outside of the registry.
CME: Prorated Pediatrics

“The clarification document states “first ACS site visit or members who are new to the trauma service for verified trauma centers,” CME may be prorated. How will you handle pro-rating for centers like us who are undergoing our first pediatric site visit, and our liaisons were appointed anywhere from 1-2 years ago? They are starting to get trauma-related CME but the amount they have already acquired varies.”

The prorated requirement for new trauma centers or anyone new to the service will be prorated for one year as 16 hours of external trauma related CME. The prorated amount will vary and be based on when the physician was hired. In this situation, it will then be prorated further from the 16 hours.
“CD 5-7 11/9 update: New members to the service must have one year *16 hours* of CME. Does that mean we no longer pro rate them?” (Level I Center)

If there are new hires within the reporting period of the review cycle, the CMEs will be prorated. For example, if the trauma center is using the reporting period from January 2016 to January 2017, whereby a physician was hired July 2016, it is expected the physician have some CME.
“For Level 1 CD 19-7 ‘evidence of leadership...regional and national trauma organization’, would State TMD count as one criteria? and For Level 1 CD 19-7 participation as visiting professor...national or regional", please define regional, ie at state level?”

Recognized regional or national organizations are defined as, the American College of Surgeons, the Eastern Association for the Surgery of Trauma, the American Association for the Surgery of Trauma, the Western Trauma Association, the Pediatric Trauma Society, etc.
Thanks for your participation!