Trauma Verification Q&A Web Conference

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TQIP  PIPS  Verification
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 is available at this link:

www.facs.org/quality-programs/trauma/vrc/resources
Recording of Webinar

The recording of this webinar will be posted on the ACS YouTube channel at a later date.

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 content and/or misspellings.

• If your question is not answered today, the question is either a duplicate or requires more information, and will receive a response from ACS staff within one week after the webinar.

• Any unanswered questions will be answered within one week after the webinar.
Scheduling
Scheduling

“If we are seeking Adult level 1 and Pediatric Level 1 how many surveyors will be sent for each program?”

If it’s a Verification or Reverification the standard team would consist of:

• 1 pediatric surveyor
• 2 general surgeon surveyors

If it’s a Consultation:

• add a nurse surveyor to the above team.

**Please note: additional reviewers may be required if your state mandates extra reviewers or you have surgeons requiring the Alternate Pathway.”
Focused – Onsite

“What is the schedule for a focused review?”

Day of Site Visit
The review will commence approximately at 0700 with the following:

- Presentation on the corrective actions taken to address the deficiencies and weaknesses
- Chart review process/validation
- Closed meeting with the reviewers
- Exit interview - the trauma medical director may extend the invite to other members

This is listed in the Focused Review Agenda and can be found at:
https://www.facs.org/quality-programs/trauma/vrc/resources
Electronic Medical Record (EMR)

“We use an electronic medical record for most of our patient care documentation. Do reviewers prefer having the EMR printed?”

As mentioned on page 6 in the Reviewer Agenda:

**Important**: Please contact the Lead Reviewer to determine which of the following is preferred during the site visit:

1. Medical records entirely printed, or
2. If EMR, does the reviewer require any additional information printed for the site visit
Site Visit Scheduling

“When will we get our visit dates if we are expired in April 2017”

- The application should be sent in at least 13-14 months in advance of your requested time frame.
- The time frame requested by you (the center) is the month that your visit will be scheduled in.
- We aim to have your visit scheduled by 90 days before your visit.
- For example: If you expire in April 2017, you may have requested a time frame in March on your application. I would aim to have your date for you in December 2016 or early January 2017.
General Questions
Pre-Review Questionnaire

“How are hospitals meeting the requirement for QI of FAST exams?”

Some hospitals have a formal process for credentialing all providers that use ultrasound.

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.
Pre-Review Questionnaire

“If I am **not** a pediatric trauma center, do I still need to have 3 pediatric PI filters?”

*If your trauma center admits pediatric patients, the expectation is that you have pediatric PI filters.*
Pre-Review Questionnaire

“Is the new PRQ (for the 2014 Resources manual) available for review prior to your reverification visit?”

Yes, there are copies of the PRQ in Word document on the Resources webpage. However, there have been changes that are not noted in that format. We are currently working on updating the PRQ in the Word document by level and patient population.
“If we are seeking combined Adult level 1 and Pediatric level 2 do we need separate pediatric committee/meetings/liaisons/PTC?”

Yes, there should be separate minutes with separate start times for the adult committee meeting and pediatric committee meeting.
“In writing minutes for a Trauma M&M is it required word for word with a legend or a summary of each cases in boxes?”

The expectation is that there is a summary for each of the cases that were presented at the M&M/trauma peer review meeting.
“Are the back-up Trauma Surgeons still responsible for attending 50% of Trauma case review meetings? Varying responses rec'd.”

No, there are no requirements for back-up surgeons to meet the 50% attendance at the peer review meeting.
Locums Tenens

“clarify exactly what locums trauma surgeons need to do for attending quality assurance meetings? ie, work 2 days in 2 months?”

Regardless of the frequency, the expectation is that locums must meet the same requirements as the other trauma surgeons on the trauma call panel.
Pediatric Trauma Program Manager (TPM)

“For a center pursuing Level II Peds designation, may the Pediatric Program coordinator also be the peds registrar?”

For Level II pediatric trauma center, the pediatric TPM cannot serve as a registrar but may as the injury prevention coordinator.
"How much incorporation of the new taxonomy is expected in the review?"

Currently, there are no requirements to use a new taxonomy for verification purposes.
Geriatric Admissions

“Some centers are keeping ger. isol. hip fx patients in their registry. Is this going to be requirement in the future for all?”

This patient meets the inclusion criteria for the NTDS. This may differ from your state inclusion criteria. If you are in a highly-populated geriatric area, having this patient demographic in your registry would be valuable for an injury prevention activity.
Dental Surgery Coverage

“Is Dental surgery coverage required for a pediatric level I trauma center.”

No, it is not required.
Thromboelastography (TEG)

“Is TEG Required. Yes or No.”

No, it is not required.
“Does the Surgical Director of ICU have to be Boarded in Critical Care. Yes or no?”

For Level I trauma centers, the ICU Surgical Director must be board certified in surgical critical care.
Documenting Response Time

“What methods are institutions using for reporting NSG and Ortho response? Is self reporting acceptable?”

No, self reporting is not acceptable. It is recommended that a scribe or key scanner is used to document the response time.
Arrival Time versus Outcome

“Why is the emphasis on subspecialty arrival time in the ED versus outcome in those patients?”

The focus is on getting optimal care at the bedside as soon as possible.

Patient outcome is benchmarked through the TQIP process.
Non-Core Surgeons

“‘Non Core Surgeons’ are these NOT being allowed? Is there a difference between Adult and Pediatric Programs?”

Yes, they are allowed. ACS no longer differentiates between non-core and core. All trauma surgeons are now considered core if they are on the trauma call schedule.
"If our facility admits low acuity 16 and 17 year olds, do we include these patients in our numbers or stick with <16 years of age which is our high acuity cut off?"

For verification purposes, if the pediatric volume is met with the high acuity of less than 16 years of age, then the low acuity 16 and 17 year olds should be included.
"Peds Level II clarify: Child Protective Services program = PROGRAM with board certified physicians with Child Abuse specialty"

ACS does not have specific requirements on the physicians with child abuse specialty. Ensure you have the right resources that you an adequately investigate these cases.
Trauma Call vs. Trauma Panel

“Define trauma call and trauma panel as it relates to pediatric/general surgery, neurosurgery, ortho, peds EM, PICU?”

**Trauma call:** any surgeon who has been identified to respond to trauma codes.

**Trauma panel:** can be defined as the trauma/general surgeons.

Terms may be interchangeable.
30 Minute Consults

“The new ‘Guideline’ mentions a ‘30 minute response time’ for urgent consults to Neurosurgery, Orthopedics and Angiography. What exactly needs to be accomplished at the 30 minute mark?”

The 30 minute requirement is for their response to come to the bedside. Assessing the trauma patient.
Level III Consults

“In a level III facility is there a time frame the trauma service must see the patient when consulted from ER for admit?”

This will depend on the following:

- The trauma center will define the policy for trauma admission.
- During a site visit, the review team will verify that the trauma center is adhering to its admission policy.
Dead on Arrival (DOA)

“If patient arrives to ED w CPR in progress, has brief ROSC (couple minutes), more CPR and dies in ED is this considered DOA?”

DOA is defined by the hospital.
“Is a separate call schedule mandatory for ENT or is OMFS combined trauma panel meet ACS expectations?”

Yes, it can be combined.
GAP Analysis

“Is there a GAP analysis available for Level 3 and Level 2 trauma centers?”

No, there is no GAP analysis currently available.
“When will the ACS be looking for antibiotics within 24 hours after arrival for open fracture as a TQIP benchmark?”

The NTDS Work Group is working with a group of Orthopaedic Surgeons to determine the needs for benchmarking this patient population.
“Will you be using the TQIP date during our re-verification visit even though it is old information?”

Yes, a summary of your TQIP report is provided to the review team. The trauma center may have a copy of its TQIP report readily available onsite.
CD-Related Questions
“what is the best method for validating the registrars?”

Good question! You must determine what is best for your center.

What’s important…?

• Chart abstraction
• Registry entry
• Coding

Examples:

• Re-abstraction
• Reports
  o Your trauma registry
  o Use your validation reports!
  o Determine important fields from your TQIP Benchmark Report!
Direct Physician-to-Physician Contact (CD 4-1)

“Please clarify the requirement there must be a physician to physician discussion on all transfers - ED physician? Trauma Surgeon?”

It depends. In most centers, if a patient is being transferred, there should be direct communication between the ED physician and/or trauma surgeon.

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.
Second Tier Trauma Activation (CD 5-16)

“What is the expectation for Trauma Surgeon response with level 2 activations, no clear timeframe in orange book.”

There is not a requirement for the second tier activation. The hospital must define the types of injuries for when the trauma surgeon will respond.

- Depends on your policy
- Know and enforce your policy
- Monitor through PIPS
- Updated based on PI/triage outcomes
Alternate Pathway Criteria (APC) (CD 6-3)

“Alternate Pathway Surgeons: we currently have two: will they be ‘grandfathered’?”

If they have previously gone through the APC at your center and have been approved, an on-site visit will not be required. However, from the AP criteria (www.facs.org/quality-programs/trauma/vrc/resources) the following criteria must be available on site:

- **Criteria 3**: A list of 48 hours of trauma-related CMEs during the past 3 years. This can be met by participation in the center’s Internal Education Process (IEP);
- **Criteria 4**: Documentation that the surgeon is present at least 50% of the trauma performance improvement meetings;
- **Criteria 5**: Documentation of membership or attendance at local and regional or national trauma meetings during the past 3 years;
- **Criteria 7**: Performance improvement assessment by the Trauma Medical Director (TMD) to ensure that patient outcomes are compared favorably to other members of the trauma call panel.

Criteria 1, 2, 6, 8, and 9 have been met by the initial approval process.
“Peds Level II - Peds TMD must work at trauma center where program is located and take trauma call at a Level I or II hospital”

The pediatric TMD or an adult TMD must be dedicated to a single facility. This means they cannot take call at two different centers/hospitals.
ED Department Coverage (CD 7-2)

“what is expected by ACS for tracking when the ED physician leaves the ED for an in house emergency?”

For Level I & II trauma centers, an emergency physician must be present at all times and cannot leave to cover in-house emergencies.

For Level III trauma centers, it is acceptable to leave the emergency department to address in-house emergencies. In these instances, there should be a logbook and these frequencies should be reviewed through the PIPS process.
“ATLS: ER physicians are now being hired WITHOUT EVER TAKING ATLS: is this an issue?”

Yes, all Emergency Medicine (ED) physicians who are board certified or board eligible in Emergency Medicine must have taken ATLS at least once.

Physicians who are board certified or board eligible in something other than Emergency Medicine such as Family Practice, Internal Medicine, Pediatrics, etc., must have current ATLS status.
Neurosurgery Chapter 8

“Clarify Neurosurgery criteria for Level III trauma centers that also have Neurosurgery capabilities”

For Level IIIs that have Neurosurgery capabilities and equipment, the expectation is that these centers meet the same standards as a Level II.
Neurosurgery Diversion (CD 8-4)

“Do we have to divert EMS when our neurosurgeon is in surgery or just known head injury transfers?”

If the on-call neurosurgeon is encumbered, the trauma center must have a diversion plan to divert the patients:

- Emergency medical services notification of neurosurgery advisory status/diversion.

- A thorough review of each instance by the performance improvement and patient safety (PIPS) program.

- Monitoring of the effectiveness of the process by the PIPS program.
Orthopaedic Coverage (CD 9-9)

“Orthopedic Response to Consults: states “PGY-4 or above”: we currently have PGY-2’s responding. Can this need be met by having a Trauma Attending, credentialed through Orthopedics, to respond with the PGY-2?”

The intent is that it’s not a general surgeon, but an orthopaedic surgeon of the trauma panel that responds to the trauma consult.
“Can you provide examples of internal education programs that meet the ACS requirement for trauma related education for MD's.”

Examples of internal CME include the following: 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.

The expectation during a site visit is for the center to demonstrate what mechanism is being used to track the IEP, what documentation was provided for the IEP, and tracking who on the trauma panel participated.
“Does a read receipt email with an attached Journal article count for Internal Education hours for Physicians?”

This may count for the IEP process as long as the program can demonstrate how the documentation is being tracked. Examples of systems that are able to capture this type of information is something like SurveyMonkey, hospital based Intranet, or some type of worksheet that contains the information.
“How is CME prorated?”

Based on several instances, such as...

For an existing verified trauma center, CMEs will be prorated based on the new-hire start date or at the start of being added to the trauma call schedule.

For new trauma centers who have not been verified, CMEs will be prorated for the reporting year (16 hours of CME).
“The IEP now has to be worth 16 CMEs; I currently do one quarterly, but how do I know if it is equivalent to "4 CMEs"?"

This **should** be equivalent hour by hour.

For example, if your IEP includes a trauma article with quiz questions, and it is determined that it will take 1 hour to complete, this equates to 1 hour of internal CME.
Operating Room (OR) Availability (CD 11-14)

“How should trauma centers measure or prove: An operating room must be adequately staffed and available within 15?”

The expectation is that the operating room (OR) team is notified when a trauma patient is going to be sent to the OR. That initial call and the team members response must be tracked. This can be documented on a logbook, EMR, or badge swipe.
“What types of interventional radiology procedures fall under the 30 minute rule for response time?”

ACS does not define types of interventional procedures.
“When does the clock start and the clock stop for the 30 minute response time for interventional radiology response?”

The clock starts when the request/call is made.

The clock stops when the radiologist arrives.
“If the committee member cannot attend the meeting, what is an acceptable alternative to participate in the committee meeting?”

There has been a recent change to this requirement that either the liaison or an appointed designated alternate (same person) may attend the meeting.

An acceptable alternate to in-person attendance is video conferencing or teleconferencing.
“For Level III center's: Can the surgical critical care liaison to the trauma program be trauma medical director?”

Yes, the director or co-director for the ICU may also serve as the Trauma Medical Director (TMD).
“Re: CD 11-55, can you give us some examples of situations where a "credentialed provider" has to be available within 15 mins?”

Scenario:
The patient returns from an OR post operatively, nurse notices the abdomen is swollen, patient’s blood pressure drops, the goal is that you want to get someone to the bedside immediately.

For the above scenario, you would need to get the trauma attending to evaluation that patient.
Other Surgical Specialists (CDs 11-70 and 11-71)

“If there is no subspeciality coverage (i.e. vascular) should the institution divert”

Level I and II trauma centers must have all the subspecialists described on page 83 (for the exception of cardiac surgery for Level II), available in person when a consult is requested by the trauma attending.
Transfers for Specialty Care (CD 8-5)

“How will you define an acute transfer?”

Please refer to page 84.

Specialty care is defined as those patients being transferred for burn care, microvascular surgery (replantation), cardiopulmonary bypass capability (CBP), complex ophthalmologic surgery, or high-complexity pelvic fractures.
Advanced Practitioners (CD 11-86)

“clarify PA/atls if they only help a bit with minor traumas”

ACS uses the following provider terms interchangeably: Advanced Practitioner (AP), Physician Assistants (PA), and Mid-level provider.

If these providers participate in your trauma tier activation (excludes consult) in evaluating and resuscitating the trauma patient, they must be current in ATLS.
Universal Screening for Alcohol (CD 18-3)

“What SBIRT information do surveyor want to is review?”

Reviewers will review the reports for patients who were:

- Admitted
- Screened
- Received intervention

“What is the age cut off for NOT having to do an SBI?”

The hospital will define the age for screening in children. There is no cut off age for the elderly.
“If we are seeking combined Adult level 1 and Pediatric level 2 do we need 50% of the publications requirement in pediatrics?”

For combined trauma centers, a combination of adult and pediatric publications may be used to meet the requirement. There is not a set number of pediatric publications required for these types of visits.
NTDS Patient Inclusion Criteria (pgs. iv-v)

“I heard there are changes in how the patient data is reported and would like to know what information I need.”

For verification purposes, the trauma center should follow the National Trauma Data Standard (NTDS) dictionary for patient inclusion criteria.

Non-Surgical Admissions  (CD 5-18)

“If an isolated hip fx patient requires ICU admission, does the ACS mandate the Trauma Surgeon admit or is medicine acceptable?”

The admitting policy is defined by the intuition.

For this scenario: Consider using best practices in terms of a consult with the trauma service or surgical service. These are the usually the same group of physicians.
Non-Surgical Admissions (CD 5-18)

“Please explain how we are to use the page 121 non-surg admits to answer our % non-surgical admissions for the PRQ’

H. Trauma patient admissions (NTDS definition) to a nonsurgical service is higher than 10 percent (Levels I, II, and III: CD 5-18).

Percentage = Trauma Patient Admissions to Nonsurgical Service × 100
Total Trauma Patient Admissions

Trauma centers admitting more than 10 percent of trauma patients to nonsurgical services must assess the following criteria related to these admissions:

1. Number with a trauma consultation _______
2. Number with other surgical service consultation _______
3. Number with mechanism of injury (MOI) = same-height falls _______
4. Number with MOI = drowning, poisoning, or hanging _______
5. Number with ISS 9 or lower (and who do not meet the criteria in 3 and 4) _______

All remaining trauma patients admitted to a nonsurgical service should be subjected to individual case review to determine the rationale for admission to a nonsurgical service, adverse outcomes, and opportunities for improvement.
### Non-Surgical Admissions: Monthly/Annually

**Example: 104/832 total admits = 12.5%**

<table>
<thead>
<tr>
<th>#</th>
<th>Running Total 104</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. # with trauma consult</td>
<td>43</td>
</tr>
<tr>
<td>2. # with other surgical consult (i.e. plastic, ENT, etc)</td>
<td>22</td>
</tr>
<tr>
<td>3. # same height falls</td>
<td>15</td>
</tr>
<tr>
<td>4. # drowning, poisoning, hanging</td>
<td>8</td>
</tr>
<tr>
<td>5. # with ISS ≤ 9 and not meeting #3 or #4</td>
<td>5</td>
</tr>
</tbody>
</table>

- **PI Case Review:** rationale, adverse outcomes, opportunities to improve
Thanks for your participation!