Trauma Verification June Q&A Web Conference

June 28, 2017

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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
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

The American College of Surgeons

Clarification Document

Resources for Optimal Care of the Injured Patient

By the Verification Review Committee

V1_ March 2017

www.facs.org/quality-programs/trauma/vrc/resources

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## 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>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1-1</td>
<td>I</td>
<td>I</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>
</tr>
<tr>
<td>1</td>
<td>1-2</td>
<td>I</td>
<td>I</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>
</tr>
<tr>
<td>1</td>
<td>1-3</td>
<td>I</td>
<td>I</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>
</tr>
<tr>
<td>2</td>
<td>2-1</td>
<td>I</td>
<td>I</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<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>
</tr>
<tr>
<td>2</td>
<td>2-2</td>
<td>I</td>
<td>I</td>
<td>III</td>
<td>IV</td>
<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>
</tr>
<tr>
<td>2</td>
<td>2-3</td>
<td>I</td>
<td>I</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<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>
</tr>
<tr>
<td>2</td>
<td>2-5</td>
<td>I</td>
<td>I</td>
<td>III</td>
<td>I</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>
</tr>
</tbody>
</table>

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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 open

• Abstract submission closes at 11:59 pm CST Friday, June 30

• Registration will open the first week in August

• For more information visit: https://www.facs.org/tqipmeeting
**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
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 Chapters under revision:**
  - Chapter 9 Orthopaedic Surgery
  - Chapter 10 Pediatric Surgery

- **Next Chapters for Revisions:**
  - 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
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](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 for new applicants
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 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.

- 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 directly within 30 days of the site visit, for their flight Itinerary and any logistical information.
The expectations for an onsite Focused Review are as follows:

- One day visit with one of the initial reviewers (2nd 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
General Questions
Consultation Application & Alternate Pathway

“For the consultative visit application, does the alternate pathway information have to be submitted when application is submitted?”

The alternate pathway information is not required at the time of a consultation visit. The alternate pathway will be conducted at the time of the re/verification site visit.
Deficiencies and Outcomes

“If you only have 1 level 1 deficiency and no level 2 deficiencies, will the trauma center still be able to be verified? Please provide info on how the tally of deficiencies work.”

If a Type I deficiency is identified, this will result in ‘no re/verification’ regardless of additional deficiencies.

If there is no Type I deficiency, but have up to 3 Type II deficiencies identified, this will result in a ‘one year re/verification.’

In both of these scenarios, a Focused visit will ensue. The type of the Focused visit, onsite or by mail, will be based on the type of deficiencies identified.
PRQ: Tibial Washout Times

PRQ Question: Average time to wash out of open tibial fractures secondary to a blunt mechanism; report as average and range:

Response/clarification: Time to first operative washout of open tibial shaft fractures from presentation to your ED (time to formal OR washout).

The recommendation is within 24 hours.

Clarification: For the first antibiotics administered upon the patient presented in the emergency department, the recommendation is typically within an hour.
PRQ

“Can ED discharges (i.e.: ankle fx) who were subsequently admitted via ASU for surg be counted in the numbers on the PRQ?”

The trauma center will define the patient admission policy. So if the center includes the ‘isolated’ foot and ankle injuries, and it meets the NTDS inclusion criteria, it should be captured in your trauma registry. If the center includes them in the total number of trauma patients admitted (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’s inclusion criteria. Therefore, you may have to capture 2 sets of data points.
PRQ: Table 5 Total Trauma Admissions

“In the section "Description/Trauma Level and Roles" does the table related to total number of ED visits refer to all ED patients”

No it does not. Table 5, data field labeled ‘Admitted ED Trauma Visits (regardless of Service)’ should contain the number of trauma patients that were admitted from the emergency department. Do not include all hospital emergency department visits.
“In that same section does the ED disposition refer to all ED patients or just trauma service patients?”

Table 6, Disposition is for those trauma patients that were admitted who met NTDS inclusion criteria.

Tables 5 thru 8 and 11 must match as depicted in the following slide.
5. Complete the table below for total number of emergency department (ED) visits for reporting year with ICD-9 code between 800.00 and 959.9.

<table>
<thead>
<tr>
<th>ED Trauma Visits</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted ED Trauma Visits (Regardless of Service)</td>
<td>582</td>
</tr>
<tr>
<td>Blunt Trauma Percentage</td>
<td>95</td>
</tr>
<tr>
<td>Penetrating Trauma Percentage</td>
<td>3</td>
</tr>
<tr>
<td>Thermal Percentage</td>
<td>2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Disposition ED Trauma Visits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged</td>
<td>394</td>
</tr>
<tr>
<td>Transferred Out</td>
<td>88</td>
</tr>
<tr>
<td>Admitted</td>
<td>582</td>
</tr>
<tr>
<td>DIED in the ED Excluding DOAs</td>
<td>1</td>
</tr>
<tr>
<td>DOAs</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>1070</td>
</tr>
</tbody>
</table>

7. Total Trauma Admissions by Service.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma</td>
<td>359</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>3</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>2</td>
</tr>
<tr>
<td>Other Surgical</td>
<td>2</td>
</tr>
<tr>
<td>Burn</td>
<td>0</td>
</tr>
<tr>
<td>Non-Surgical</td>
<td>216</td>
</tr>
<tr>
<td>Total Trauma Admissions</td>
<td>582</td>
</tr>
</tbody>
</table>

8. Based on the number of Non-surgical admits (NSA) from Table 7, please complete the following:

<table>
<thead>
<tr>
<th>Nonsurgical admissions (NSA)</th>
<th>0-9</th>
<th>10-15</th>
<th>16-24</th>
<th>&gt;= 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients admitted to a non-surgical service (from Table 7)</td>
<td>155</td>
<td>14</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Percent of total NSA</td>
<td>90</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total NSA w/trauma consult</td>
<td>14</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total NSA w/any surgical consult (including trauma)</td>
<td>158</td>
<td>14</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Total NSA secondary to single level falls</td>
<td>132</td>
<td>9</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Total mortality (for each ISS category)</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

11. Injury Severity and Mortality

<table>
<thead>
<tr>
<th>ISS</th>
<th>(A) Total Number of Admissions</th>
<th>(B) Total Number of Deaths from Admissions by ISS</th>
<th>Percent Mortality (B over A)</th>
<th>Number Admitted to Trauma Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>415</td>
<td>3</td>
<td>0.1%</td>
<td>269</td>
</tr>
<tr>
<td>10-15</td>
<td>83</td>
<td>0</td>
<td>0%</td>
<td>47</td>
</tr>
<tr>
<td>16-24</td>
<td>58</td>
<td>3</td>
<td>6%</td>
<td>20</td>
</tr>
<tr>
<td>&gt;= 25</td>
<td>26</td>
<td>9</td>
<td>35%</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>582</td>
<td>15</td>
<td>2.6%</td>
<td>359</td>
</tr>
</tbody>
</table>
Deaths - Hospice

“Should we be entering a pt as a death or as live if discharged to hospice?”

For verification purposes, if the hospice patient was still alive when discharged, it would not be counted as a death. If the center received information following the patient’s death, then you may count it as a death.
Self Reporting

“Trying to track when surgeons see admitted trauma activations. Is it acceptable for them to document ‘examined patient at (time) on (date)’ or is that considered self reporting?”

It is acceptable to self report. There should be a process by which this is validated, e.g. nurse scribe, badge scanner, etc.
Physician Assistant Evaluation

“Can an ATLS certified surgical PA respond and complete an initial evaluation for a trauma modified or consult patient?”

The Physician Assistant (PA) may respond and provide initial evaluation for the limited (mid) activation tier or consult level. For the limited activation tier, the PA must be current in ATLS.
Physician Assistant Evaluation

“If the PA is able to complete the initial mod/consult evaluation of a trauma patient are the trauma surgeon standard response times for those tiers able to be delayed, or deferred if the patient is to be transferred. Obviously with the understanding that the transfer would not be delayed waiting for the surgeon even under normal circumstances.”

If the PA is providing initial evaluation for the limited or consult tier, there must be communication with the attending surgeon prior to the patient being transferred. Transfer of a patient should not be delayed while waiting for the attending. This practice is not an excuse for the surgeon not to respond, these instances must be documented and reviewed through the PIPS process.
CD-Related Questions
Pediatric Patient Admission (CDs 2-23/2-24)

For verification and completion of the PRQ, the pediatric age is defined as less than 15 years old and who meet the NTDS Trauma Inclusion criteria.

Your local and/or state inclusion measures may differ and require the center to capture a different set of patients and criteria.
Transfers (CD 4-3)

“Are pts that drive themselves from an outside hospital considered transfers, even if arranged by the physicians?”

These patients would not be considered transfers into your facility. The transportation method must meet the patient needs (equipment and all care providers on board) and maintain continuity of care.
Hospital and Medical Staff Resolution (CDs 5-1/5-2)

“Ch 5, table 1, liaison commitment. Good until that liaison resigns or must be renewed every 3 yrs like the other resolutions?”

The Hospital Commitment and Medical Staff resolutions must be current every 3 years at the re/verification site visit. A separate Physician Liaison Commitment is currently not required; however, it could be incorporated into the Medical Staff resolution in the event there is a change in liaisons.
Criteria for a graded activation (CD 5–13)

“What are some examples of geriatric specific TTA criteria?”

At this time, we do not mandate geriatric specific criteria; however, if the center sees a high percentage of these patients, it would be the expectation that there are geriatric specific activation criteria and guidelines.

An example of what it may contain:

- Falls above ground level in age > 65
- Traumatic mechanism in a patient with a known bleeding disorder or use of anti-coagulant/anti-platelet medication
Alternate Pathway Criteria (CD 6-3)

Trauma surgeons who have trained outside the United States or Canada may participate in the trauma call panel if approved by the Alternate Pathway Criteria (APC), www.facs.org/trauma/verification/resources.

Only surgeons who were inducted as a Fellow of the American College of Surgeons (FACS) prior to January 1, 2017 are exempt from the APC process.

For surgeons who were previously approved by the APC process at their current institution, an onsite visit will NOT be required; however, the following criteria will be required at the time of every subsequent reverification visit:

7. Performance improvement assessment by the Trauma Medical Director (TMD) to ensure that patient outcomes compare favorably to other members of the trauma call panel.

Therefore, if there are any U.S. or Canadian trained surgeons who were never or not currently board certified/eligible cannot be reviewed by the APC process or be part of the trauma call panel.
Emergency Physicians ATLS (CDs 7-14/7-15)

“need to clarify the ED physician who is board cert'd but not current in ATLS. It was cited as a weakness on our last visit - so what will we need to do for our next visit?”

Without knowing the specifics of this site visit, the current requirement is if the emergency department physician was boarded in emergency medicine, they are not required to maintain current ATLS, but must have taken the course once. However, this would not be true if the physician was boarded in another specialty such as, internal medicine, family practice, pediatric, etc. This physician would be required to be current in ATLS.
Neurosurgery (CD 8-2)

“The Neurosurgeons employ a hospitalist who functions like a PA or NP for them. This MD rounds on their inpatients. Can this physician see the consults initially? The Orange book allows for mid levels that work under a neurosurgeon. please advise”

It is acceptable for the Hospitalists, Physician Assistants or Advanced Practice Providers (APP) to respond for the neurosurgical service. In this case, there must be agreed upon guidelines between the TMD and the Neurosurgeon liaison for the types of injuries the Hospitalists, Physician Assistant or APPs will respond to as a consult. There must be clear documentation with the attending specialist surgeon on the plan of care.
“OTA fellowships- All of my attendings completed their training prior to 2013. Also, ped's ortho MDs complete a peds ortho fellowship not an OTA fellowship. That seems more adult focused. How are we supposed to be compliant with this rule?”

The Orthopaedic Trauma Association (OTA) has an approved list of fellowships that were done prior to 2013 and are now grandfathered in. For pediatric programs, there is not an OTA fellowship; therefore, this requirement may be met with a formal transfer agreement or in some instances, the OTL is shared from an adult trauma center. In this case, we would require the form to be completed with the adult OTL’s information. Refer to earlier slide discussing the OTL form.
“Review of MTP requirement, will ACS only accept 1:1:1 ratio?”

We do not have a defined ratio for the massive transfusion protocol (MTP).
“Does NP meet requirements for timing if when a patient is seen by admitting team in limited tier activation?”

It is acceptable for the Nurse Practitioner (NP) to respond to the limited tier activation and provide assessment or interventions to trauma patients. In this scenario, the NP must be current in ATLS.
Burn Patients (CD 14-1)

“CD 14-1: Can it be included in defined process for which pts will be transferred or do we need a legal transfer agreement?”

The center must have a written transfer agreement or contract (some center call it different things) with the referral burn center.
Trauma Registrars (CD 15-9)

“Can a hospital system place all registrars together to work in multiple registries as a separate cost center from trauma?”

“Is the Registrar requirement per 500-750 admissions or per registry entries?”

The budgetary process may differ for many trauma centers; however, there must be one full-time equivalent employee dedicated to the [trauma] registry to process the data capturing of the NTDS data set for each 500–750 admitted patient annually.
Registrar (CDs 15-9/15-7)

“We are a Level 3 Trauma Center and enter > 800 pts per year into the registry. Our administration recently laid off our trauma registrar and the plan is to have multiple staff from our PI department enter the trauma data for us. From what I read this will result in a level 1 or 2 deficiency and prevent us from being completely verified. Can you comment?”

This potentially may be cited as a Type II deficiency at the time of the site visit and may not necessarily keep the center from achieving re/verification. Refer the slide on ‘Deficiencies and Outcomes.’ As the requirement states, there must be one FTE for every 500-750 patients admitted annually. Having > 800 will require 1.5 FTEs to comply with the standard. Furthermore, if other staff will provide this service, they must attend or have previously attended 2 courses within 12 months of being hired or new their role: (1) the American Trauma Society’s Trauma Registrar Course or equivalent provided by a state trauma program and (2) the Association of the Advancement of Automotive Medicine’s Injury Scaling Course (CD 15–7).
Core Measures (CD 16–5)

“PI Core Measures, do we have to report all the findings to either Peer Review and/or Systems or can we report by exception? by exception, attending arrival time below 80%, increase in the incidence of VAP.”

All core measures established by the program are not required to be reported out. However, if there are any core measures that result in an opportunity for improvement, there must be a process to review, document and report out as part of your hospital’s PIPS plan.

- PIPS plan must be updated and reviewed annually
“Hospice Discharges - Are hospice discharges expected to go under the same review process as a Expired patient does in the trauma program? Example: presented at MM/Peer review meeting?”

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

If the patient is transferred to a hospice care facility, those cases would not be reviewed as part of the death cases.
Can you clarify for Pediatric Level II centers that care for adults- do all adult trauma surgeons need to attend the Pediatric Peer review meeting or can there be a designee from the adult group that attends?

There may be a designated member from the adult panel that attends the pediatric multidisciplinary peer review meeting. Ideally, it should be the adult TMD; however, it may be another member from the adult panel. Meeting information must be disseminated to the other adult panel members.
Nursing Education (CD 17-4)

At a recent verification visit at one of our sister hospitals (Level 3), they were told the nurses needed 8 hours CEU yearly. Is this not the case?

The requirement is for Level I, II, and III trauma centers, to provide a mechanism to offer trauma-related education to nurses involved in trauma care (CD 17–4). Currently, the VRC does not hold a requirement for nurses to maintain CEs.
SBIRT: Alcohol Screening Tool (18-3)

"Is there a preferred / required substance screening tool? SBIRT/ CAGE. Is there a preferred / required tool for pediatric pts?"

There is not a preferred tool to screen for either adult or children. The institution will define which tool works best for its patients.

The institution will define the age for children who will be screened.
“The PRQ has an additional question whether there is one article from three of six disciplines (and is listed as Type 2 deficiency) but this is not a deficiency in the orange book: Of the 20 articles (10 articles if 4 of 7 scholarly activities are demonstrated), is there at least 1 article with authorship or co-authorship from 3 of these 6 disciplines? neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, and rehabilitation” (CD 19-7, CD 10-10, CD 10-11) Type II / LI / PTCI. What is the requirement? It is significant to eliminate critical care, nursing, OMFS, etc from the disciplines that may help meet the requirement.

There is a discrepancy in the PRQ and is pending programming. Please refer to the Resources manual and Clarification/Change Log Documents as the following disciplines are acceptable: basic sciences as related to injury, neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, vascular surgery, plastics/maxillofacial surgery, critical care, cardiothoracic surgery, rehabilitation, acute care surgery, and nursing.
CME – ICU Intensivists and Hospitalists

After further discussion with the VRC chairs, the following will be provided to all trauma program participants and site reviewers.

- If the intensivists are the primary physician responsible for the care of the patients while in the ICU (patients care is transferred to them), they are required to maintain external CME and/or through an IEP process.
- The VRC does not presently hold a requirement for hospitalists to maintain CME.
- The above will be added to the Clarification Document.
Thanks for your participation!