Trauma Verification Q&A Web Conference

June 26, 2018

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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 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>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>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
- Stakeholder Public-Comment website: https://www.facs.org/quality-programs/trauma/vrc/public-comment
- Tutorials:
  - Becoming a Verified Trauma Center: First Steps
  - Becoming a Verified Trauma Center: Site Visit: https://www.facs.org/quality-programs/trauma/vrc/resources
- Participant Hub - Account 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.
Scheduling Reminders & Updates
The site visit application is now **online only** – No more printing.

Can be accessed on the following ACS Trauma website pages:

- **VRC – Site Visit Application**
- **TQP Participant Hub - Account Center**

Visit the following sites for more information:

- [VRC – Site Visit Application](https://www.facs.org/quality-programs/trauma/vrc/site-packet)
- [TQP Participant Hub - Account Center](https://www.facs.org/quality-programs/trauma/tqp/tqp-center)
Site Visit Application

- The ACS Trauma website pages will link to the Account Center page:
• The online application must be submitted at least 13-14 months in advance of the requested site visit dates and must be before expiration date.

• An Alternate Pathway review should be requested on the application for surgeons/physicians who trained overseas and want to participate on the trauma call schedule. Their CVs must be submitted to cotvrc@facs.org as they will be vetted by a subcommittee for eligibility to go through the Alternate Pathway.

• All Level I Trauma Centers must also complete the Orthopaedic Trauma Liaison (OTL) form which can be downloaded on the site visit application. Submit form to cotvrc@facs.org with a copy of the OTL's curriculum vitae.

• We are accepting applications for May 2019 and onward.
Prereview Questionnaire (PRQ) Online Access

Once the application has been submitted, 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 until you receive an invoice.

- 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.

• We ask that you provide us with the exact dates you would like to have your site visit. The visit will occur on your chosen dates but we may ask for different dates if the review team cannot attend the requested dates.

• Once the review team has been secured, you will receive a confirmation email that will include your reviewers and their contact information.

• You will receive the confirmation email approximately 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.
Announcements
Next Verification Q&A Webinar

Webinar Date:  July 26, 2018

Webinar Time:  12:00pm-1:00pm CST

Deadline to submit questions:  July 12, 2018
Abstract deadline extended thru June 30, 2018  
Hotel reservations are now open  
Preconference Workshop Registration is now open:  
www.facs.org/quality-programs/trauma/tqip/meeting
PRQ Updates
Chapter 19 – XIX. Research

Questions have been aligned
With the chapter requirements.

You may now select which research category your center
will participate in: either 20 Research Articles or the Alternate Pathway (refer to questions 5a-b).
CME for all Specialties & Appendices

- Programming to update the CME questions in the PRQ are currently underway. Pending these updates, please respond to the CME questions within each of the sections as ‘Yes.’

- For the appendices, leave the CME section blank except for the Adult and/or Pediatric Trauma Medical Director (TMD) and anyone who is new or has previously been approved for the Alternate Pathway.
Updates
Research Form for Level I Adult or Pediatric Programs

Converted into an Excel Worksheet

Added a field for PMID Number

May use one Excel Worksheet to catalogue all articles by using ‘sheets’

Submit a copy of the Excel Worksheet to the VRC Office at the time of the PRQ Submission
Form is located at:

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

Under the heading:

Preparing for your Site Visit

- Review Agendas
  - Standard/combined visits
  - Focused visits
- Summary Form for Research Articles Submitted for Site Visit
- Data Use Agreement
“Is there a reference for ‘Appropriateness and timing of intravenous antibiotics for all open fractures’? (Pg 125 of Orange Book)” (Level 2)

Response:

The recommended time for the first antibiotic administered for an open fracture to the trauma patient that arrives in your Emergency Department is 90 minutes. Times that exceed beyond this will be cited as a weakness.

The correct response time is 60 minutes.
For Level I and II adult or pediatric trauma centers, the TPM must show evidence of educational preparation, with a minimum of 12 hours (internal or external) of trauma-related continuing education per year and clinical experience in the care of injured patients (CD 5-24). Type II

This has been added to the Change Log and Clarification Document.
General Questions
Focused Review Onsite

“How do I know what charts to pull for a focused review when the deficiency was PI related?” (Level 2)

For a Focused review, you will pull the chart categories that reflect the deficiencies cited during the initial visit. The time period will commence from the time the corrective actions were implemented to that requirement. There will be far fewer charts at the Focused review than there were at the initial visit. You may not have charts in each of the categories so pull what you have available at the time of the Focused visit.
Transfer to Non-Trauma Center

“Is it ever ok to transfer to a non-trauma center within system if only injury is neuro and NTC has neuro capability?” (Level 3)

Without having the specific details, if the patient was stabilized at your trauma center by the Trauma Surgeon or a Neurosurgeon, and the decision was made to transfer, the patient must be transferred to a similar or higher-level trauma center that is able to provide care to the neurotrauma patient.
“Several criteria state that a trauma surgeon caring for pediatric trauma patients in an adult facility needs to be credentialed for pediatrics. Can this be done as a statement that they can provide all credentialed items on pediatrics or do they need a separate credentialing packet completed for pediatric patients? What is the best format? Will this be the same for a combined pediatric and adult facility?”

The credentialing process will differ among trauma centers; however, if the provider is caring for adult and children, there should be criteria for credentialing both types of patients and it could be done all within the same process or in one “packet.”
Activations

“Can you tell me what activation level should be given when an upgrade or downgrade happens. The initial activation or the final activation.” (Level 2)

If the trauma patient met an upgraded or downgraded activation, ultimately both will need to be documented. The final activation would be specified in the medical record.

In either scenario, these instances must be tracked and reviewed through the PIPS process to ensure that the activation criteria are appropriate. If the call occurs from the field and it is causing the center to upgrade or downgrade activation, it may be a matter of educating the EMS personnel of your activation criteria. Furthermore, these occurrences may impact your under/overtriage numbers.
Orange Book Revisions

“When is the new ‘Resources for optimal care of the injured patient’ anticipated to come out?” (Level 3)

The next edition of the Resources for Optimal Care of the Injured Patient is anticipated to be released sometime next year. A date has not been selected.
Revised PRQ

“When will the revised PRQ be available on-line? If we have information already in the PRQ before the revision will we have to re-do that entry?”

As you all know, we are currently revising the Resources for Optimal Care of the Injured Patient manual. In conjunction with the manual, a new PRQ will be programmed to coincide with the updates. Trauma centers that may be impacted by the new manual/PRQ will be notified well in advance.

For all upcoming site visits through the end of 2020, continue to use the current PRQ.
PRQ - ATLS Certificates

“Do we need to have copies of each ATLS certificate available, or is the information in the PRQ exhibit sufficient?” (Level 2)

You will need both. Enter the ATLS information in the PRQ and have copies of the certificates available at the time of the onsite visit.
PRQ – Board Certification Dates

“The American Board of Pediatrics (Peds critical care, peds em docs) no longer issues an end date. Instead, it is a continuous cycle. What do we put as the end date on the PRQ? The ABP web site allows you to verify if they are current.” (Level 1)

The American Board of Surgery and American Board of Pediatric have transitioned its policy to no end date for board certification. If your center has providers that fall under the new policy, add their most recent expiration date in the PRQ and add a note next to their name as “meeting the requirements of maintenance of certification (MOC).”
PRQ and OPPE

“For ortho docs, are the PRQ and OPPE requirements for just those taking trauma call or for everyone who takes even a minor trauma?” (Level 2)

When completing the PRQ, you must list all providers who are on the trauma call schedule who see patients with all trauma injuries.

The OPPE will be performed for all providers on the trauma call by their respective directors/liaisons such as, the Orthopaedic liaison will perform an OPPE for members of his/her service that are on the trauma call panel.
PRQ – Wash Outs & Antibiotics for Tibial Fractures

“Just to clarify, the only patients we need to collect wash out and antibiotic times on are open tibia from blunt mechanism?” (Level 1)

In Chapter IX. Orthopaedic Surgery in the PRQ, there are two questions regarding “wash out” times and one for antibiotics:

• Q15.3 - Average wash out time for open fractures
• Q16 - Average time to wash out of open tibial fractures secondary to a blunt mechanism
• Q17 - Average time to first antibiotic administration for open tibial fractures secondary to a blunt mechanism
Dictated Response Times

“Will reviewers accept physician dictation times to meet time requirements for consultations or emergent consultations if the time falls into the (60-30 min time range) according to our written guidelines for consultations and emergent consultations. Thanks!”

(Level 2)

If the times were dictated and transcribed into the medical records, that would be acceptable.
Neurosurgery/Orthopaedic Surgery Response Time

“In previous webinars it was noted that a physician cannot self report the time they arrived to the ED for a trauma, however, to monitor response time for NSR and ORTHO, can an ER attending note be used if they clearly report what time NSR or ORTHO arrived in the ED/at bedside?” (Level 1)

Following the release of the Resources manual, the VRC Chairs have permitted self-reporting. It would be ideal to have a scribe or in this case, an Emergency Medicine Physician to document the Neurosurgery/Orthopaedic Surgery Specialist’s arrival time.
**Auto-Renewal Transfer Agreements**

“Is it adequate for transfer agreements to have auto-renewal clauses within them?” (Level 1)

I’m going to assume this means there is no expiration date or there is a written clause that stipulates ‘auto-renew’ on the transfer agreement. If correct, this would be acceptable; however, it is advised that the agreements be reviewed periodically for updates.
Staffing Ratio

“Is there a recommended staffing ratio for trauma programs besides one registrar 500-750 patients per year?” (Level 3)

Currently, there are two staffing ratios noted, 1) Trauma Registry support, and 2) ICU nurses (patient-to-nurse ratio in the ICU must not exceed two to one CD 11–66).
Injury Prevention Coordinator Education

“Are there any specific certification or education requirements for a designated injury prevention staff member/nurse?” (Level 2)

There are no certification or education requirements for the Injury Prevention Coordinator.
“Please delineate guidance that signifies the difference in DOA and ED death when a patient arrives with CPR in-progress and ED interventions are initiated. Thus, are peripheral IV’s, and transition to endotracheal intubation performed in the ED considered an ED death regardless of rhythm? (CD 16-6)"

Dead on arrival will vary from center to center. Defining DOA will be defined by the trauma center or state regulations.
CD-Related Questions
OPPE CD 5-11

“Regarding OPPEs for the subspecialists, the liaisons can complete these, correct? How often should the OPPEs be completed?” (Level 2)

The requirement speaks to an annual assessment. However, the trauma center can impose check-ins such as, quarterly or bi-annually.
“Do the 'Board Eligible' Emergency Medicine physicians continue to need current ATLS? Or, do they just need to have had it once? (Did not know with the change in CME requirements if the 'Board Eligible' Emergency Medicine physician is now treated the same as a 'Board Certified' Emergency Medicine physician.)” (Level 2)

Emergency Medicine Physicians who are board certified or board eligible in Emergency Medicine are required to have taken ATLS once.

Emergency Medicine Physicians who are board certified or board eligible in something other than Emergency Medicine such as, Family Medicine, Internal Medicine, etc, are required to maintain current ATLS status.
Neurosurgery (CD 8-2) and Orthopaedic Surgery (CD 9-7)

“Can you share examples of time critical injuries requiring a 30 minute response by the subspecialists?” (Level 2)

**Neurosurgery**
- Penetrating injury to head with altered mental status
- TBI with emergent surgical intervention
- TBI with emergent EVD monitoring

**Orthopaedic Surgery**
- Fracture with vascular compromise
- Complex pelvic injuries with limb/life threat
- Multiple open long bone fractures
Non-Surgical Service (CD 5-18)

“Do you add into your %s for Non-Surgical Services admission those that have a Surgical Services Consult?” (Level 2)

Yes. For the Non-Surgical Services admission table, you do want to account for all patients who were either admitted with a surgical service consult and those that did not.
Non-Surgical Admits (CD 5-18)

“For our hospital it seems that Internal medicine will admit the patient for the orthopedics service. So this now becomes a Non Surgical admit for us. Is this common and is it ok being that they are all evaluate by the TPM?”

(Level 2)

If the patient meets your trauma inclusion criteria, it is best to admit to the Trauma Service for the first 24 hours. There may be unknown injuries that the surgical service will pick up.

The following is an example of managing NSA: 43 year old, fall 10 ft from ladder; small subdural, external abrasions, diabetic:

1. Cleared by EM, admit Medicine (Avoid) → PIPS
2. Cleared by Trauma in ED, admit Medicine/Hospitalist with NS consult (Better)
3. Admit Trauma with NS consult (Best) - OR -
4. Admit Trauma first 24 hours → (Tertiary Exam) acceptable, transfer to Family Physician with NS on consult (Best)
“What does the ACS consider ‘an appropriately trained’ PACU nurse? Does this mean they must have taken TNCC or ATCN?” (Level 1)

“What are the education requirements for PACU nurses? The PRQ ask for ed/cert percentages, but what are the expectations?” (Level 1)

Qualifications for the PACU nurses will be defined by the trauma center. This may include specific certification and training for managing patients in their respective areas.

If the nursing certification and training percentages are low, the review team may cite it as a weakness. Not a deficiency.
Radiology Communication (CD 11-35)

“CD11-35 should radiology notify the ED physician or the surgeon with critical findings?” (Level 1)

“CD 11-35 clarification - our trauma team consists of ED attending, if the call goes to the ED MD will that suffice this CD?” (Level 1)

Without having the specific details, for the highest level of activation, critical information deemed to immediately affect patient care must be verbally communicated to the Trauma Team. If the call goes to the Emergency Medicine Physician on the Trauma Team and that information is relayed to the Trauma Surgeon, that would be acceptable.
“Need clarification on the CD-11-35, in our trauma activation policy, the ed attending is part of the trauma team. Currently our process is, when a critical finding is noted, the radiologist usually sends communication to the ed physician. Will this process meet this criteria?” (Level 1)

My follow-up question to this would be, if the Emergency Medicine Physician receives the information, is that relayed to the Trauma Surgeon? If yes, that would meet the requirement. Ultimately, it is the Trauma Surgeon that must receive the communication.
“I am seeking clarification on requirements of a level 2 for surgical specialties. Does a level 2 have to have ENT on call? I have a center that I am working with that has a face call panel that is made up of OMF and Plastics. They are under the assumption that as long as they have a face call panel they don't have to have an ENT call. Can you please provide clarification on this for me?” (Level 2)

For Level I and II trauma centers, the ability to care for patients with facial trauma is the requirement. The specialties vary by center and may include plastics, OMFS, or ENT as long as the center can provide a facial trauma call schedule that includes any or all of the specialties that is acceptable. These specialists are not required to be in-house 24/7; however, based on institutional guidelines, the specialists must be available in-person at bedside at a predetermined time when the consult is requested.
Ophthalmology (CD 11-71)

“We are currently in pursuit to be a Level II, will it be a major criteria deficiency if we do not have Ophthalmology on call? We have transfer agreements with our sister facility who does have Ophthalmology.”

(Level 2)

Not having Ophthalmology capabilities is a Type I critical deficiency.
Advanced Practice Providers (CD 11-86)

“Are ED APP's who evaluate non-activated trauma patients required to take and pass ATLS or can they audit the course?” (Level 2)

The Emergency Medicine APPs/NPs/PAs may evaluate non-activated trauma patients such as, during consultations or fast-track and are not required to have ATLS certification.
Physician Assistant ATLS (CD 11-86)

“Can you define ATLS cert surgical PA role in trauma. First to respond to activation, do these times count for trauma or just TS?” (Level 3)

Trauma and/or Emergency Medicine APPs/NPs/PAs who function as members of the team caring for trauma activation patients via assessment or interventions must maintain current status in ATLS.

For the highest level of activation, the APPs/NPs/PAs response time cannot count for the Trauma Surgeon. However, the APPs/NPs/PAs time may be documented for the limited tier activation if s-/he has been credentialed to do so.
Injury Prevention Coordinator (CD 18-2)

“At a Level II trauma center can the Injury Prevention / Outreach coordinator be Trauma and Stroke Coordinator?” (Level 2)

In a Level II trauma center, the roles of the Trauma Program Manager (TPM) and the Injury Prevention Coordinator may be shared as long as it does not negatively affect the TPM’s role.

This role cannot include Stroke as that is a separate program.
Alcohol Screening (CD 18-3)

“regarding patients admitted to a non-surgical service and SBIRT, how are the patients to be identified for screening?” (Level 1)

The requirement is for any trauma patient (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. This includes patients admitted to the Orthopaedic Surgery and Neurosurgery services.
**Alcohol Screening (CD 18-3)**

“I am hoping for some further clarification in regards to CD 18-3 (Universal Screening for Alcohol). In the Clarification document it states:

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. 80% of these patients must be screened. This includes activations or all admitted trauma patients including orthopaedic and neurosurgery. (rv 11/30/17, 4/18/18)

Any patient with an altered mental status (and deaths) should be excluded from the denominator as these can’t get screened. (4/18/18)

If the only patients we need to audit for compliance with the screening are those who are eligible. By that, I mean, if the patient is not eligible, for instance, due to Altered Mental Status and are not able to be participatory their entire hospital stay and are discharged still not being able to participate, do we automatically exclude those patients because we know they do not meet criteria, or must the nurse have documented that they did not attempt the screen due to the altered mental status (in other words, if the patient is altered, can we assume that is why a screen is not done, or must the nurse document screen not done due to patient being altered).” (Level II)

It cannot be assumed otherwise it could potential contribute to a deficiency, It must be documented that the patient was not screened due to ‘not eligible’ or ‘altered mental status.’
CME
CME - Trauma Medical Director

“For clarification on CME changes, is it just the TMD who needs trauma specific CME? Do the liaisons need them?”

(Level 2)

Correct, only the Trauma Medical Directors at Level I and II adult and/or pediatric trauma centers require external trauma related CMEs.
“Can you clarify the CME requirements for Trauma Program Managers (CD 5-24)?” (Level 1)

The Trauma Program Manager must show evidence of educational preparation, with a minimum of 12 hours (internal or external) of trauma-related continuing education (CME) per year and clinical experience in the care of the injured patient.
“Can you explain the MOC process for CME? Also how should we obtain/provide documentation in our CME tracking?” (Level 2)

As of now, we are not asking for MOC documentation. As long as the providers are currently board certified or board eligible, it satisfies the CME requirement.
Thanks for your participation!