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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

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
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 clarifications to any criteria will be published in the Clarification Document.
Clarification Document

Updates sent to participants monthly
## 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>
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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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<tr>
<td>1</td>
<td>1-2</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>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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<tr>
<td>1</td>
<td>1-3</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>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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<tr>
<td>2</td>
<td>2-1</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>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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<tr>
<td>2</td>
<td>2-2</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>I</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>
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<td>2</td>
<td>2-3</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>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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<tr>
<td>2</td>
<td>2-5</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>I</td>
<td></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>
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</tbody>
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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
Next Verification Q&A Webinar

Deadline to submit questions: **Wednesday, April 12, 2017**

Webinar date: **Wednesday, April 26, 2017**

Webinar time: **12:00pm - 1:00pm CST**
Resources Revision Process

The Stakeholder Public-Comment website is live:

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

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.
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 May 2018 are closed to scheduling:
  - 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**
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:
Pre-Review Questionnaire (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/

  ▪ 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, contact will be made to the TPM prior to confirm the dates.
General Questions
Payment Schedule and PRQ Submission

Are the PRQ and payment due on the same day (30 days prior to the visit)?” (Level I Center)

No, payment for the Trauma Quality Programs (VRC & TQIP) no longer tied to the date of your site visit. All Trauma Quality Program centers are being aligned to a July 1 invoicing date. Your next invoice will most likely be prorated to align with the July 1 invoicing cycle. Once you are aligned to that cycle, your invoice for the annual Trauma Quality Program fee will be sent May 1.

For more info, please visit our website: https://www.facs.org/quality-programs/trauma/vrc/fees
Reviewers Travel Itinerary

“Should the organization make the travel plans for the reviewers? If so when do we get their name and information to do so?” (Level I Center)

If by ‘organization’ you mean the ACS, yes travel plans will be made by the ACS Travel Agent for the site reviewers.

The TPM or TMD should request a copy of the reviewer’s travel itinerary about 30 days prior to the site visit. You may contact the VRC Office for a copy to be forwarded.

Please note, reviewers often make travel plans approximately 30 days prior to the site visit.
Site Visit: Case Reviews

“Our site visit is in April. We only have 12 deaths and the orange book says "30" Would you recommend we just pull those 12 deaths or should we pull 12 deaths then add 18 cases that underwent PIPS.” (Level * Center)

If the trauma center only has 12 deaths during the reporting year, pull those deaths and have them available at the time of the visit.

If there were deaths that underwent PIPS review outside the reporting year that impacted your program, you may pull a few of those death cases.
Implementation of Weaknesses

“What if there is a weakness in the system that you know will not be solved by the verification date?” (Level I Center)

Not all weaknesses are required to be in place at the subsequent site visit. The expectation is that that trauma program has recognized the weakness in the program and has a plan on how it will be addressed.
Implementation of Recommendations

“How do other centers manage ACS reviewer recommendations that are outside of the orange book requirements? For #2, such as, to include discharges in registry, or to relocate equipment (when we have never had an issue or delay).” (Level I Center)

Great question. We are providing education to our reviewers to not add recommendations that are outside the scope of the standards or the facility such as, the operating room is too far from the emergency department or the hospital should have a helipad. As long as the center is tracking those ‘recommendations’ through the PIPS process for issues or delays in care, it will NOT be cited as a deficiency.
Patient Inclusion: Observation Patients

“Do patients admitted in an observation status count toward admit numbers?” (Level I Center)

If the patient was in observation for less than 23 hours, and discharged, it will not count toward the total number of trauma patients admitted.
Inclusion Criteria: Geriatric Patients

“*Our state does not include patients > 65 who have a ground level fall with an isolated hip fracture in our registry. For our ACS consult visit, should these be included? Also, what about trauma activations who go home from the ER and do not meet our state’s registry inclusion criteria?*” (Level II Center)

The admission policy for elderly patients with single level falls or isolated hip fractures should be set at each individual institution. If these patients meet the NTDS inclusion criteria, they should be captured in your trauma registry, and 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.
Inclusion Criteria: Geriatric Patients – Con’t

For the trauma activation, if those patients met the NTDS inclusion criteria, they should be captured in your registry.

As mentioned, this may differ from your state’s inclusion criteria. Therefore, you may have to capture 2 sets of data points.
“PRQ question: If we do not admit burns to our Trauma service (but we have a burn center) do we need answer section XIV?” (Level I Center)

If the center does not admit bum patients, skip section XIV.

However, bum patients with a traumatic injury will be included regardless if the hospital is verified by the American Burn Association.
"When will TCRN (Trauma Certified Registered Nurse) be added to the extra certifications for ED, PACU and ICU nurses in the PRQ?" (Level I Center)

TCRN can be added to the ‘Other’ line item.
Transfer of care

“Can isolated neuro trauma pts be transferred to medical ICU service after 24h in ICU with NS following? (NS cannot admit to ICU)” (Level II Center)

Yes, if no other traumatic injuries were found, care may be transferred to the neurosurgeon and the patient moved to the medical ICU service.
Review Agenda: Documentation for Board Certification

“Does proof of board certification have to be available during the site review for a level II facility?” (Level II Center)

During the onsite visit, it is required that all hospital policies/protocols/plans, board certification, CMEs, etc., are available for the review team. These documents may be kept in a binder that are labeled accordingly.
Review Agenda: Trauma Medical Director

“Does the TMD have to present during the entire ACS consultation and/or verification visit for a Level 3 Facility?” (Level III Center)

It is essential that the TMD is present during all site visits performed by the ACS. This will demonstrate the TMD’s commitment to the program.
PRQ: Neurological Deficits

“How are "neurological deficits" defined for the purposes of answering PRQ question IX Orthopedics, Q17 (pelvic ring/acetab fx)?” (Level I Center)

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

Question 18. The number of operations performed at this institution during the reporting year for pelvic ring and acetabular fractures secondary to a trauma mechanism, excluding isolated hip fractures:

a. Pelvic ring injuries:
b. All acetabular fracture patterns:
c. How many of these patients had neurological deficits?
**PRQ: Support for Requirements**

“Is there any future plan to prioritize criterion deficiencies by data which support that they improve care for the trauma pt?” (Level I Center)

Yes. There are current plans for the revision process to look at the current standards to determine if there is evidence based data to support the standard.

Please visit the Stakeholder Public-Comment website to provide feedback on standards that may not necessarily impact the care of the injured patients.

https://www.facs.org/quality-programs/trauma/vrc/public-comment
PRQ: Upload Button

“Should I be using the “upload” (Office use only) PRQ feature to upload documents for the reviewers to look at, such as policies?” (Level II Center)

No. The button is for office use only. Any documentation that is referenced throughout the PRQ that reads ‘label as attachment X’, have a copy available onsite for the review team.
SBIRT: Alcohol Screening Notes

“1. Alcohol screen for all injured patients >12 years of age.

a. Can this be part of the Medical Record? Either Yes or No, and positive or negative screen? Or do we need to document a risk score? I was told this is supposed to be separate from the medical record but it makes it challenging to track. I just want to know the standard and expectations.” (Level II Center)

There should be a screening toolkit developed and used by the hospital. The hospital may establish a risk score as part of the toolkit. The data (yes/no/score) must be documented in the progress notes/medical record.
CD-Related Questions
“Does the Trauma Surgeon have to provide an assessment of the patient before transfer to higher level of care?” (Level II Center)

The ED physician has discretion to transfer patients; however, there should be communication between the ED physician and attending so they are in agreement on the plan of care. All transfers are required to undergo a PIPS review (CD 4-3).

For more information, refer to page 33 in the Resources manual under the subject titled: Guidelines for Transferring Patients.
"Can there be a trauma medical director and trauma medical co-director for a level II facility? TMD work 90% and Co-TMD work 10%?" (Level II Center)

No. For Level I, II and III trauma centers, the TMD must be dedicated to a single trauma center. The TMD must be a full time/permanent position.
Limited Tier Response (CD 5-16)

“Is it appropriate for a trauma surgeon to consult on trauma patients within 24 hrs?” (Level III Center)

“Per the ACS, what is an acceptable time frame for a Peds Trauma Surgeon to see a Level 2 trauma?” (Level I Center)

The institution will establish the time and injury expectation for when the trauma surgeon (adult or pediatric) will respond for the limited tier. Most centers have a metric between 2 and 6 hours based on the type of injury. The most important thing will be to follow the metrics through the PI.
Nonsurgical (CD 5-18)

“Which standard speaks to the length of time a patient needs to be admitted to the Trauma service. For example would a patient that has one rib fracture and a hip fracture need to stay on the Trauma Service? or a patient with a hip fracture and an ankle fracture?” (Level * Center)

The trauma center will define the patient admission policy. So if the center includes the ‘isolated’ foot and ankle injuries and/or ‘hip fractures’, and they meet the NTDS inclusion criteria, they 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.
"Is the neuro response within 30 minutes specific to the resuscitation area or inpatient as well?" (Level II Center)

The Neurosurgeons must be available in the trauma resuscitation area within 30 minutes of notification by the surgical trauma team.
“In a level 3 center, can the TMD also hold the role as a co-director of the ICU?” (Level III Center)

In Level II and III trauma centers, the TMD may also serve as the co-director of the ICU.
ICU Coverage (CD 11-60)

“Can you clarify the timeliness of coverage being provided in the ICU? Does that mean arrival time or call back within 15 min.?” (Level II Center)

“Which providers are included in the ICU timely response requirement?” (Level II Center)

The intent is for an attending or credentialed provider to respond (arrive at bedside) within 15 minutes for critical situations, and that it is documented. Any delays that impact care must be reviewed through the PIPS process.

The institution will credential those able to provide care in the ICU. This may include residents and intensivists.
Advance Practice Providers (11-86)

“Patient arrives by POV. Seen by the ED PA who then activates an internal trauma alert. Does this PA have to have ATLS?” (Level III Center)

The emergency department APRN’s/PA’s who provide evaluation during the consult phase and who are not involved in the trauma team activation, are not required to be current in ATLS.
Chart Abstraction \textit{(CD 15-6 and 15-10)}

“What are sites doing that are behind in chart abstractions due to ICD-10 and what does that do to their verification visits?” (Level I Center)

It will impact the trauma center being successful in the verification process. There are a couple of deficiencies that will be cited if the abstraction is delayed beyond the standard.

- At a minimum, 80 percent of cases must be entered within 60 days of discharge \textit{(CD 15-6)}.
- Monitoring data validity are essential \textit{(CD 15-10)}. 

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Registrar Annual Admission Criteria (CD 15-9)

“Why is "admissions" used to determine the appropriate number of Registrars vs total Registry entries?” (Level * Center)

We are encouraging all participants to visit the Stakeholder Public-Comment website to provide feedback on the standards. All comments will be reviewed by the Revision Workgroups to determine if the requirement should be amended.

https://www.facs.org/quality-programs/trauma/vrc/public-comment
Overtriage (CD 16-7)

“Requirement for over and undertriage. Is the Cribari method best to use or can facilities use their own process?” (Level II Center)

The trauma center is not required to use the matrix (Cribari) method noted in the Resources manual. Facilities may use its own process as long as it’s monitored and reviewed quarterly (CD 16-7).
**Transfers within the Institution (CD 16-8)**

“CD 16-8 Would this include patients we put in our 23.9 hour obs? Often they bridge to admit, for ECF/consults/pain control.” (Level II Center)

This does not include patients who are discharged; however, if the patient was admitted to another service, they should have a primary review for appropriateness.
Universal Screening for Alcohol (CD 18-3)

“Define ‘universal screening for alcohol use’. At the TQIP conference there were 3 posters with very different definitions.” (Level I Center)

For verification, universal screening for alcohol use must be performed for all injured patients and must be documented (CD 18–3) L1-3.

- Clarified as all patients that meet NTDS registry inclusion criteria with a hospital stay of > 24 hours.
- For pediatric patients, the age should be defined by the center.
Injury Prevention Programs (CD 18-5)

“What is a reasonable number of Outreach Injury Prevention a Level II should perform annually when function is covered by TPM.” (Level II Center)

This has been clarified as allowing two projects related to local issues, e.g. two projects on one issue or two projects on two issues.
Injury Prevention *(CDs 18-5 and 18-6)*

“A weakness in our program in our last review was a lack of injury prevention focused on our own trauma center mechanisms of cont’d: injury. If we worked in an organized trauma system; do those programs count?” (Level II Center)

The center may collaborate in an organized trauma system; however, at least one injury prevention initiative must be based on a major cause of injury in the community (CD 18–5).

In addition, the center must also include and track partnerships with other community organizations on its prevention program (CD 18–6).
Disaster Drills (CD 20-3)

“RE: Chapter 20 - Disaster drills- please clarify if a functional exercise would be acceptable along with a full scale?” (Level II Center)

The disaster drill may be modified, but must be conducted at least twice a year.
CME: Internal Education Process (Hours)

“Can you be more specific to the new CME requirements? For example, if a neuro or ortho surgeon want credit for reading a journal? how is that proven? How many hours would they receive? How many hours of external v internal do they need?” (Level II Center)

The best method to demonstrate compliance with external CME is with the course/meeting certificate. Reading journals will count as part of the Internal Education Process (IEP). The number of hours are based on the time required to complete the activity.
**CME: Internal Education Process (Hours)**

For example, a provider produces a journal that contains an article that is associated with a CME activity. Twenty physicians read the article, reflect on the content, and complete questions related to the content of the article. The physicians spend 1 hour on this activity. The provider would report this as a Journal-Based CME activity with 1 hour of CME, [http://www.accme.org/ask-accme/how-do-i-report-journal-based-cme-pars](http://www.accme.org/ask-accme/how-do-i-report-journal-based-cme-pars)

For topic and tracking examples, refer to the August Q&A webinar located on the resources webpage: [www.facs.org/quality-programs/trauma/vrc/resources](http://www.facs.org/quality-programs/trauma/vrc/resources).
CME: External versus Internal

“Can you please clarify what can be included in an IEP vs. CME tracking. If we create an IEP, do we stop collecting CME’s?” (Level II Center)

For the non-liaisons, if your hospital process uses the Internal Education Process (IEP), you will not need to collect CME certificates.

For topics and tracking examples, refer to the August Q&A webinar located on the resources webpage: www.facs.org/quality-programs/trauma/vrc/resources.
“If a surgeon has CME related to general surgery (i.e. liver surgery) can that count towards the trauma CME requirement?” (Level I Center)

If the topic is relevant to the management of the trauma patient, e.g. abdominal trauma. It may be counted to meet the CME requirement.
“Other than the TMD, what are the CME requirements for other surgeons at a Level 3 facility? Is it encouraged?” (Level III Center)

Level I and II trauma centers are required to meet the CME requirements.

Level III trauma centers are not required to meet the CME requirement for any of the TMD/physicians/surgeons.
CME: Specialty Surgeons

“Are CME's required for all call members for specialty services? specifically ortho/ neuro?” (Level II Center)

“Do CME have to be available for review for facial trauma (OMFS, ENT, Otolaryngology) for a level II facility?” (Level II Center)

For Level I and II trauma centers, the TMD and liaisons for Emergency Medicine, Orthopaedic Surgery, Neurosurgery and Critical Care, are required to obtain external trauma-related CME.

For all other members (non-liaisons) for the above mentioned services, are required to obtain either external trauma-related CME or through an Internal Education Process (IEP).
CME: Certificates and Transcripts

“Could you please clarify if transcripts and generated online lists of accrued CMEs suffice or are CME certificates needed, too?” (Level I Center)

Transcripts are acceptable; however, the center must provide detail of the hours that are trauma-related. This can be demonstrated with the course outline or brochure.
CME

“If someone claims the 32 hours of trauma CME for board cert/recert, can they also claim hours from board review courses?” (Level I Center)

The 33 hours of CME that are acceptable for external trauma-related CME is inclusive of board review courses and/or board certification.
Thanks for your participation!