Trauma Verification
Q&A Web Conference

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Your Trauma Quality Programs Staff

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Continuing Education (CE)

- To qualify for CE, you must attend at least 50 minutes of educational content.
- An email will be sent to all attendees who qualify for CE within 24 hours of the webinar ending, with instructions on how to claim CE.
- If you have any questions – please email COTVRC@facs.org.
What is the goal for this Webinar?

- Interpret the standards outlined in the Resources for Optimal Care of the Injured Patient manual to ensure that hospitals have an understanding of the criteria to provide quality care to the injured patient.

- Understand the processes and standards involved in an ACS Trauma Verification Site Visit and how following these will positively impact the quality of care of the injured patient at your center.
Let’s get started!
If you have your Resources for Optimal Care of the Injured Patient 2014 (Orange Book) in hard copy or PDF version, it is recommended that you have it available to reference in the CD-Related Questions section of this webinar.

The most current Clarification Document, and the Verification Change Log are available at:

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

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

All of our Resources are located on this webpage:
https://www.facs.org/quality-programs/trauma/vrc/resources
Disclaimer

• All questions are pulled directly from the question submissions. There have been no edits made to the 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.
Announcements
For more details visit: www.facs.org/tqipmeeting

Questions? Please email: ACSTQIPmeeting@facs.org
Analytics Resource Station and Staffing

(10 Minute Sessions) located by the registration area
Saturday: 7:45-8:15am & 12:45-1:15pm
Sunday: 7:45-8:15am & 12:35-1:05pm
Monday: 7:45-8:15am

The Analytics Staff Resource Station will be staffed by Chris, Ryan M., Haris, and Nam

• Sign-in sheets
• First come basis
The TQIP quarterly Call for Data will open November 1, 2016.
Next Verification Q&A Webinar

Questions cutoff date: November 18, 2016

Date: December 7, 2016

Time: 11:30a-12:30pm CST
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.

• The lead time is required due to the multitude of applications received.

• For example, the months of January 2017 through November 2017 have been closed to scheduling.

• In addition, the lead time is required to help centers prepare and complete the online PRQ, whereby logins, will be provided upon receipt of the application.

https://www.facs.org/quality-programs/trauma/vrc/site-packet
Site Visit Application Payment

- Do not submit payment with the application.
- 60 to 90 days before your visit, your center will be invoiced for the Quality Program fee that includes the fees for both the site visit and TQIP.
- Centers will then be invoiced annually for the Quality Program fee for the remainder of the verification cycle.
  - This annual fee will not include any additional visit-related fees, such as additional reviewers.
- The fee structure is located at: https://www.facs.org/quality-programs/trauma/vrc/fees
Scheduling Site Visits

• Visits are typically scheduled within 90 days prior to the requested timeframe.

• Ideally, all visits will occur during the center’s preferred timeframe.

• When a lead reviewer is available for your site visit, contact will be made to the TPM prior to confirm the dates.
Review Agenda - Chart Review

“What should be expected regarding chart reviews for a level III center applying for level II?”

(Level II Center)

For Case reviews, there is no difference with the exception that the center is in compliance with the criteria for a Level II, e.g. trauma surgeon response time to the highest activation of 15 minutes.
Onsite Review

“What is the length of time (hours or days) and how many surveyors should a facility expect for an ACS survey? What is the general workflow/agenda for a typical ACS survey?” (Level I Center)

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

- 2 general surgeon surveyors (pediatric centers will have 1 peds surgeon)

If it’s a **Consultation**:

- add a nurse surveyor to the above team.

Note: additional reviewers may be required if your state mandates extra reviewers or you have surgeons requiring the Alternate Pathway.
Onsite Review (Con't)

1st Day of Site Visit

• Team arrives at noon
• Introduction
• Chart review process/validation
• Pre-review working dinner (6pm)

2nd Day of Site Visit

• Team arrives at (0700)
• View ambulance bay
• Hospital tour
• Closed meeting with the reviewers (1000)
• Exit interview (1100)

The above is noted in the Review Agenda:
https://www.facs.org/quality-programs/trauma/vrc/resources
General Questions
Recordings of Past Webinars

“Are we able to access previously held webinars?”
(Level II Center)

Yes. All previous recordings of the Verification webinars are located on the VRC webpage at:

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

“Any plans to simplify the PRQ?” (Level I Center)

Yes, there are current business plans for a new PRQ that will incorporate pre-populated TQIP data fields.
Pre-Review Questionnaire

“Is the interim PRQ online the same PRQ that we will get sent to us via email?” (Level II Center)

We will begin to release new versions of the PRQ in word. This new Word document will coincide with the online PRQ. If you have recently received access to the online PRQ and would like a copy of the updated Word version, please contact the COTVRC@facs.org.

Note: The online PRQ is programmed to display questions relative to the center’s level and patient population.
Pre-Review Questionnaire: Open Fractures

“Should we track all open fractures (ex. facial) or just certain open long bone fractures for antibiotics given in 60min?” (Level III Center)

For the verification and the question in the PRQ, in section 9. Orthopaedic Surgery, question in regard to washouts should read as follows: Time to first operative washout of open tibial shaft fractures from presentation to your ED.
If NOT seeking separate verifications for the adult program and the pediatric program, skip and go to section B. Splenic Injuries table and all of section C. Pediatric Trauma Admissions and ONLY answer questions 5 (I-II, a-d) and question 6, then go to XI. COLLABORATIVE CLINICAL SERVICES.
Pre-Review Questionnaire: Adult versus Pediatric Data

“Adult Trauma Centers don't have to complete any part of the PRQ section on Pediatrics. Am I right?” (Level I Center)

For centers that admit ‘adult’ trauma patients only, and the following section should not be displayed:

- **X. PEDIATRIC TRAUMA SURGERY**
Pre-Review Questionnaire: Adult versus Pediatric Data

Complete section **X. PEDIATRIC TRAUMA SURGERY**, if:

1. The center admits ‘adult and pediatric’ trauma patients and *is not* seeking pediatric verification, only complete:
   - **B. Splenic Injuries** Table;
   - **C. Pediatric Trauma Admissions** (entire section);
   - Use only pediatric statistical numbers.

2. The center admits ‘adult and pediatric’ trauma patients and *is* seeking pediatric verification, must complete all of section **X. PEDIATRIC TRAUMA SURGERY**.

Note: For scenarios 1 & 2, the data tables in section **II. DESCRIPTION/TRAUMA LEVELS AND ROLES** must include both adult & pediatric statistical numbers.
“TQIP yearly conference requirement.”
(Level II Center)

The TQIP Hospital Participation Agreement requires hospitals to provide funding for staff to attend the TQIP annual conference. However, we recognize that not everyone will be able to attend the conference every year and are not penalizing centers who cannot attend annually.
“This is the first time we have been asked for the facility TQIP report ID. Can you talk about how this ID will be used?” (Level II Center)

If you are referring to the field on the VRC site visit application, listing your TQIP report ID on the application allows the VRC staff handing applications to easily determine if your center participates in TQIP and meets CD 15-5. This ID is confirmed internally with TQIP staff to ensure TQIP participation.
“What role will the TQIP report play in the Verification Visit?” (Level I Center)

In order to meet CD 15-5, hospitals must only be enrolled in TQIP. Hospitals are not required to have received a TQIP benchmark report at the time of their Verification visit. We ask that hospitals have their last few TQIP reports on hand to discuss with reviewers if requested. TQIP reports are a good opportunity for hospitals to showcase their PI process. Hospitals are not being penalized or lauded for their TQIP results alone. TQIP staff provide a summary of the hospital’s TQIP results to reviewers along with an executive summary and explanation of how to interpret results.
Adverse Events

“One of the categories for medical records to review during site visit is "Adverse event/death in the SICU or unexpected return to the SICU –or- OR." What qualifies as an adverse event? Would this include all NTDB complication such as VAP, unplanned intubation, or AKI? Or does adverse event indicate something more severe?"

Adverse event is defined as anything that may have resulted in a death or a major complication.
Trauma Admission

“Does ACS recognize/measure the time for admission as the time of the order for admission to critical care/ICU, OR is it the time the patient physically leaves the emergency department for transport to the ICU? Which of these two times is an ACS surveyor going to consider as the time the patient is admitted? Is this measurement the same for all trauma patients regardless of admission level of care or location?”

(Level Unidentified)

There are no questions in the PRQ that asks about time of admission.
“Can you provide ICD10 Codes for questions in the PRQ for example isolated hip fractures or complex pelvic fx?” (Level I Center)

For verification, the injury codes are not defined. We will take this into consideration for the next revision of the PRQ.
“Besides working with the TMD, who optimally should the TPM report to within the hospital?” (Level I Center)

The reporting structure will vary among trauma centers. The expectation is that the trauma program manager has oversight and authority of the trauma program.
“Is the ISS required on the Trauma H&P, knowing that it may change if more injuries are discovered after initial assessment?” (Level I Center)

The ISS is not required on the H&P. However, it is required at the time of the case reviews. Where it is documented will be determined by the trauma center.
CD-Related Questions
Registrar (CD 15-9)

“Will the VRC change the trauma registrar FTE requirement with the additional burden of ICD-10 and TQIP data points?” (Level I Center)

This will be taken into consideration with the rewrite of the Resources manual.
“Reference Orange Book page 38, please define ‘confirmed blood pressure’ in Table 2.”
(Level II Center)

As a point of preference, these criteria are based on the Centers for Disease Control field triage criteria. The ‘confirmed blood pressure’ means obtaining the accurate blood pressure in the field.
Limited Tier

“Is a midlevel activation required in level-III trauma centers?” (Level III Center)

The limited tier is not required. However, there must be a clearly defined response expectation for the trauma surgical evaluation of those patients that have some anatomic and high-risk mechanisms of injury. (CD 5-16)

Rigorous multidisciplinary performance improvement is essential to evaluate overtriage and undertriage rates to attain the optimal goal of less than 5 percent undertriage (CD 3–3).
CME Update

Update from the Verification Review Committee meeting during Clinical Congress.

**CMEs from Board Re-/certification**

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

- Trauma Surgeons
- Orthopaedic Surgeons
- Neurosurgeons
- Emergency Medicine
CME Update

- All Critical Care CME count.

- IEP time must be equivalent to 16 hours annually or 48 hours in three years.

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

- Proration
  - Physicians must have one year (16 hours).
  - New centers: all providers must have One Year (16 hours) minimum.
“Are Critical Care/Pulmonary Medicine Intensivists required to have trauma-related CME tracked?”
(Level I Center)

There are no standards specific to Intensivists. However, if they are used to provide coverage for trauma patients in the ICU, they are expected to meet the same standards as the other surgeons, e.g. participate in an internal education program that is case based learning or obtain 16 hours of CME.
“ICU Liaison’s required trauma CME, in pediatric trauma centers. The clarification that ICU trauma team members can have critical care CME as long as 20% is related to injured patients, appears to be related to the “trauma team” not the ICU liaison. In our pediatric trauma center, and I believe most children’s hospitals, there is not a separate trauma ICU, so the physicians are therefore not part of the trauma team. Given this, for the Pediatric Critical Care Liaison, how much external CME is required that must be trauma specific? Does the 20% apply to them as well? Can the ACEP review count for CME for emergency department physicians?”

For Level I centers, adult or pediatric, there must be a separate ICU liaison from the TMD. In this scenario, the ICU liaison must accrue 48 hours of critical care CMEs. All other ICU physicians treating trauma patients must also have either external CME or through an internal education process (IEP).

The 20% from the clarification document will be eliminated because all critical care CMEs awarded can be attributed to trauma.
CME: Pediatrics

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

The pro-rated requirement for new centers or anyone new to the service will be pro-rated for one year equivalent to 16 hours of external trauma related CME.
“What are ACS recommendations for OPPE?”
(Level I Center)

There are a few examples for OPPE on the VRC resources repository website. The expectation is that the Trauma Medical Director (TMD) is conducting the OPPE and has a process (score card/template/report) available to present on site, if asked.

https://www.facs.org/quality-programs/trauma/vrc/resources
“Please clarify CD 5-11. Does an OPPE need to be done on every physician annually or only when there was an issue?” (Level I Center)

The TMD is not expected to perform an OPPE on the specialists, e.g. ED physicians, Neurosurgeons, Orthopaedic Surgeons, etc. The OPPE for these specialists should be performed by their respective directors with oversight by the TMD.
Limited Tier Response (CD 5-16)

“On 2nd tier activation we have a 12hr response time for the trauma surgeon, is this too long? If so, what's a better time range?” (Level I Center)

For the limited tier team activation, most centers may stratify by ICU and floor admissions. The time expectation for the types of injuries/patients the surgeon will respond to will be determined by the institution. Most centers chose somewhere between 2 and 6 hours. The most important thing will be to follow the metrics through the PI.
“Talk about the ACS view on the on-call trauma surgeon also covering another service at the same time.” (Level II Center)

The on-call surgeon may also provide coverage for general surgery or ICU. There must be a back up call schedule in the event a trauma alert is activated.

This is not ideal if the trauma center is in a geographical high volume area.
“Chapter 16, page 123 refers to evaluation with the BTF guidelines. How is that being evaluated by review teams?” (Level I Center)

Neurotrauma care should be routinely evaluated to be in compliance with the Brain Trauma Foundation guidelines. This process will be evaluated during the case review.
“Is a Pediatric Trauma Manager necessary in a Level II Pediatric Trauma Center?” (Level II Center)

In a Level II pediatric trauma center, a pediatric trauma program manager (TPM) is required.

The pediatric TPM cannot serve as a registrar, but may as the injury prevention coordinator or performance improvement coordinator.
Pediatric ICU

“We were trying to identify if we should be pursuing a pediatric trauma center and identified the following question: Do the physicians in the Peds ICU need to be board certified in pediatric critical care or is it okay for them to have a dual board certification in critical care and one in peds?”

The physicians and surgeons working in the pediatric ICU must be board certified/eligible in general surgery. However, they are not required to be board certified in pediatric critical care/critical care. Having dual boards in critical care and pediatrics are acceptable.
Peer Review Attendance

“We have ortho and anesthesia groups that only do single system injuries. We do collect CME from them? Are they required to attend trauma committee meetings? If so would a liaison suffice?"

For Level I, II and III centers, orthopaedic surgeons on the trauma call panel must acquire either CME or through an Internal Education Program (IEP).

• CMEs are not required for the anesthesia service.

The orthopaedic and anesthesia liaisons are required to attend at least 50% of the peer review meetings. A pre-defined designated alternate may attend in their place.
An operating room (OR) must be adequately staffed and available within 15 minutes at Level I and II trauma centers (CD 11-14).

The best method to meet this time requirement is by having the OR team in-house. If tracking the response times for each of the team members from outside the hospital, you must demonstrate that the response time of 15 minutes is met all of the time. There is no variance for this.
Operating Room (OR) Availability (CD 11-17)

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

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

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

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

“CD 11-60 reference response of providers to the ICU, what does this look like? What is being asked to be monitored?” (Level I Center)

For all levels, the PIPS program must document that timely, and appropriate ICU care and coverage are being provided (CD 11–60).

Coverage can be met with the trauma surgeon, Intensivists, or PGY 4-5 residents.
“Please elaborate on the "Other Surgical Specialists" (Chap 11, pg 83 of orange book) that are required for a Level II center.” (Level II Center)

For Level I and II trauma centers, Microvascular, Vascular Surgery, ENT, OMFS and Plastic Surgery must be available at all times within a pre-determined time of notification by the surgical trauma team.

Patients that require specialty care such as replantation or burn care may be transferred. These transfers must be reviewed through the PI process (CD 4-3).
Advanced Practitioners (CD 11-86)

“Would like clarification on requirements of having/maintaining current ATLS for mid-levels that work in the emergency department.” (Level II Center)

The Trauma and/or Emergency Department (ED) midlevel providers that function as a member of the team caring for trauma activation patients (excluded consults) via assessment or interventions must be current in ATLS. If the Trauma and/or ED midlevel’s only role is as a scribe or entering orders they would not need to meet the ATLS requirement.
“What would cause a deficiency in the PI chapter (Chapter 16)? I have heard of several centers getting deficiencies d/t PI.” (Level II Center)

Problem resolution, outcome improvements, and assurance of safety (“Event Resolution”) must be readily identifiable through methods of monitoring, reevaluation, benchmarking, and documentation.
Nursing Education (CD 17-4)

“Please discuss the nursing education requirements for a Level II and Level III facility. Is there a defined % of nursing that is expected to have current ATCN or TNCC, PALS or ENPC, & ATLS?” (Level Unidentified)

In Level I, II, and III trauma centers, the hospital must provide a mechanism to offer trauma-related education to nurses involved in trauma care (CD 17–4).

The VRC has partnered with STN to develop nursing education guidelines. At this time, the study results are pending.
Mortality Classification (CD 16-6)

“Is Unanticipated Mortality with opportunity for improvement no longer a category for PI mortality review?” (Level I Center)

The Clarification Document has been addressed. The death categories remain the same as follows:

• Mortality without opportunity for improvement.
• Mortality with opportunity for improvement.
• Unanticipated mortality with opportunity for improvement.
Outreach and Education (CD 17-1)

All verified trauma centers, however, must engage in public and professional education (CD 17–1).

Bleeding Control Course (B-Con) is available through the ACS site at:  [www.bleedingcontrol.org](http://www.bleedingcontrol.org), and is now acceptable as an outreach activity.
Level I and II trauma centers must implement at least two programs that address one of the major causes of injury in the community (CD 18–5).

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.
Disaster Planning (CD 20-3)

“We are looking for clarification regarding disaster planning. The PRQ asks Is there at least one drill that involves the community plan? What specifically does this mean community plan? We are a level III in pursuit of a level II.” (Level III Center)

Disaster Response Drills & Exercises:

- The role of the trauma center is critical for management of disasters.
- Drills should be based on possible realities within your area.
- Drills will never be perfect. The goal is to identify any weaknesses or areas for improvement.
- A follow-up debriefing or critique is essential to discuss any weaknesses and how those deficiencies can be corrected.
- Proper planning and preparation to allow communities to address devastation and death when faced with a disaster.
Thanks for your participation!