Trauma Verification
Q&A Web Conference

September 21, 2016

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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
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 July 2017 have been closed to scheduling, August has a few spots available, and September has been closed.
- 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](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
Geriatric Population

“What Is the age for isolated hip fractures resulting from a fall from standing height? 70 or 65? how much of the criteria need to be written down/placed in a binder for the visit, versus things that we can speak to?” (Level III Center)

The cutoff age varies between 65 and 85 years of age.

During a site visit, if the isolated hip fractures are part of your nonsurgical admission (NSA) totals, you will be required to pull medical records for that category. Please refer to the Review Agenda for a complete list of categories.

In addition, you may either speak to, or present your NSA admission policy to the review team.
PRQ: TQIP Data

“Do you know exactly what TQIP data will be incorporated into the Presurvey questionnaire?”
(Level I TQIP) (Level I Center)

We don’t have specific plans for this now. In the future, we may begin to pre-populate the PRQ with data already collected from your hospital through the NTDB/TQIP process. This would hopefully save time and provide consistency in the data used by ACS programs for Verification and benchmarking.
PRQ: ICD-9 Conversion to ICD-10 Codes

“What are the ICD10 codes to replace ED visits coded as ICD9 800-959.9 (Sect II Description/Trauma Lvl and Roles, Question #5)?” (Level I Center)

Currently the NTDS accepts both ICD-9 and ICD-10; however, beginning with 2017 admissions only ICD-10 will be accepted.

For those centers currently using ICD-9 codes, the codes will need to be converted to ICD-10.
National Trauma Data Standard Inclusion Criteria

Did the patient sustain one or more traumatic injuries?

Yes

Is the diagnostic code for any injury included in the following range;

- ICD-9-CM: 800-959.9 or

Yes

Did the patient sustain at least one injury with a diagnostic code outside the range of codes listed below?

- 905-909.9, 910-924.9, or 930-939.9?
- S00, S10, S20, S30, S40, S50, S60, S70, S80, S90

Yes

http://www.ntdsdictionary.org/dataelements/datasetdictionary.html
Compliance with Standards

“Are all sites expected to comply with all Orange Book Standards?” (Level III Center)

Ideally, you would like to be in compliance with all the standards at the type of a site visit.

For a consultation visit, it is expected that a majority of the standards should be in compliance. However, if not all standards are in compliance, it will be cited as a deficiency in the report. This is standard operating procedure.

For a verification visit, all standards must be in compliance at the time of the site visit.
Performance Improvement Plan


The Trauma program performance improvement plan should include, but not inclusive of the following:

- Review of the processes for the care of the trauma patient, identify opportunities to improve and implement actions to correct recognized short falls.
- Review of the current, scientifically all-encompassing, evidence based practice for implementation.
PRQ: Reporting Year

For purposes of pulling medical records as noted in the Review Agenda, the medical records should not be older than 14 months prior to the scheduled site date.

For example: If your site visit is in January 2017, the reporting year may be either of the following:

- October 1, 2015 to September 30, 2016
- November 1, 2015 to October 31, 2016
PRQ: Appendix 2 for Locums

“Locum coverage for general surgery. Should locums be listed on the Appendix #2? Also being it is 4-5 days a month how to document?” (Level II Center)

Locums or Trauma Surgeons who take partial trauma call are required to meet the 50% attendance requirement. An alternative to attending in person is to participate by video or teleconference.

During a visit, the data is reviewed retrospectively; therefore, if the center had locums during the reporting year, and are no longer present, do not list them in the appendices. Only list locums that are currently practicing at your center.
PRQ: 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**
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.
“Do burn patients get included in the total patient list for the PRQ or are the numbers only included in the burn section?” (Level II Center)

Burn patients who are transferred externally to a burn center or internally to a burn service should not be counted in the total trauma population. The center may include these patients in the trauma registry, but will be required to exclude them for the PRQ.

Burn patients with any associated traumatic injuries, should be included in the trauma registry regardless if transferred externally to a burn center or internally to a burn service.
Neurosurgery Care for Level III Trauma Centers

“Still unclear how the changes to the Neuro requirements will affect a Level III center (we have 1 neurosurgeon)” (Level III Center)

We are working with the VRC chairs on refining the expectations on this for Level III centers and will bring this topic back to next month’s webinar:

• Level III with no neurosurgery capabilities
• Level III with limited neurosurgery capabilities
• Level III with full neurosurgery capabilities
CD-Related Questions
Registrar Courses (CD 15-7)

“What happens if a trauma registrar has taken AAA Medicine's Injury Scaling test and failed twice?” (Level I Center)

The requirement is for the registrar to attend or have previously attended two courses within 12 months of being hired: (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 Trauma Registry Medicine’s Injury Scaling Course (CD 15–7).

At this time, consequences will need to be determined by the hospital.
“Once a neurosurgeon, orthopaedic surgeon or emergency medicine surgeon has gone through the initial approval process for the alternate pathway, do they need to maintain current ATLS status or has that requirement been removed with the latest update to the clarification document (8/18/16)?”

Surgeons who were previously approved by way of the Alternate Pathway, must meet a new set of criteria required at subsequent site visits. The criteria are listed on the next slide.

An onsite review by the specialist will not be required on subsequent visits.

Please refer to the Alternate Pathway Criteria on page 4 at: https://www.facs.org/quality-programs/trauma/vrc/resources
Alternate Pathway – Previously Approved Criteria

Surgeons who have previously been approved by the alternate pathway at their current institution, during subsequent visits, the following 5 criteria from the Alternate Pathway document, must be available at the time of the visit:

• Criteria #2-Documentation of current status as a provider or instructor in the ATLS program.

• Criteria #3-A list of 48 hours of trauma-related CMEs during the past 3 years. This can be met by participation in the center’s IEP.
Alternate Pathway – Previously Approved Criteria

- **Criteria #4**- Documentation that the surgeon is present for educational and at least 50% of the trauma performance improvement meetings.

- **Criteria #5**- Documentation of membership or attendance at local and regional or national trauma meetings during the past 3 years.

- **Criteria #7**- Performance improvement assessment by the TMD that the M&M results for patients treated by the surgeon compare favorable with the M&M results for comparable patients treated by other members of the trauma call panel.
“Do internal CME count toward the requirements for CME per year for re-verification?” (Level II Center)

No, verifiable external CME for the TMD and liaisons are obtained from attending state, regional or national conferences or participating in online courses.
“CME requirements for someone that just finished residency and/or fellowship and waiting to take boards?”  (Level II Center)

For centers undergoing verification for the 1st time, and existing trauma centers that have new physicians (recent graduates/residency or new hire), CMEs will be prorated.

- Prorated CMEs should be equivalent to 16 hours annually.
CME and Research

“How do you define three years for the CMEs and Research? Is it from the time of the Consultative Visit?” (Level I Center)

As mentioned, in previous slide, CMEs will be prorated if the center is seeking verification for the first time, and/or have new hires or graduates.

Research is not prorated. It is based on 36 months leading up to the site visit.

• Articles approved, but not yet published will be accepted.
CME: Non-liaisons (CDs 6-11, 7-13, 8-15, 9-19, 11-64)

“Can the educational requirement of the non-liaisons physicians be met by a combination of internal and external CME hours?” (Level I Center)

Yes. Trauma Panel members (non-liaisons) may meet the requirement by having combined external and internal CMEs. There must be a summary page for each physician with clear and supporting data that contains the course topic, location, dates, type of CME (external versus internal), and the number of hours obtained.
“Does ACS related course's (i.e. DMEP) count as external CME's for the liaison from emergency medicine, Ortho, and Neuro?” (Level I Center)

If the CMEs are relevant to the management and care of the trauma patient, it will be count to meet the requirement. Currently, the following courses provide Trauma related CMEs:

- **Advanced Surgical Skills for Exposure in Trauma (ASSET)**
  - 6 hours
- **Rural Trauma Team Development Course (RTTDC)**
  - 9 hours
- **Surgical Education and Self-Assessment Program (SESAP)**
  - 6 hours
- **Disaster Management and Emergency Preparedness (DMEP)**
  - 8.25 hours
- **Advanced Trauma Operative Management (ATOM)**
  - 7.5 hours
CME: ATLS Courses

### 8th edition

**TABLE 8-1 Category 1 Credits**

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<td>Student Refresher, 1-day schedule</td>
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<td>Student Refresher, ½-day schedule</td>
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<tr>
<td>Instructor, 1½- or 2-day schedule</td>
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<td>Instructor 1-day schedule</td>
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### 9th edition

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“What is the role of the PGY-4 or 5 surgery resident in a level I trauma center? What documentation other than call schedules will the review team require for the PGY 4-5 rotations on the Trauma Service?” (Level I Center)

A resident in PGY 4 or 5 who is part of the trauma team may begin resuscitation while awaiting the arrival of the attending surgeon, but cannot independently fulfill the responsibilities of, or substitute for the attending surgeon (CD 2–6).

During a visit, the review team will review medical records that contain the PGY 4-5’s involvement in the care of trauma patients.
Direct physician-to-physician contact (CD 4–1)

“Direct Physician to Physician contact is essential. Concerning interfacility transfers. Would it be acceptable for the Advanced Practitioner (AP) on the Trauma/Acute Care Service to accept a transfer after discussing with the trauma surgeon? There would not be direct physician to physician contact, but would certainly save time in the process by not requiring the trauma surgeon to repeat a call after the AP already has.” (Level Center)

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

In some states, there are referral centers that have been credentialed to receive and relay the communication to the ED physician and/or trauma surgeon. This is acceptable.
“What is the best answer for transfers out if we do not transfer out?” (Level I Center)

As a Level I center, not many transfers will occur. However, if you are transferring for specialty care, such as burns, microvascular, re-implantation, those will be considered as transfers out in the PRQ tables. In addition, all transfers out must be reviewed through the PIPS process.
“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.

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.
“Do annual reviews need to be done on ER physician assistants (PAs) if they do not participate in the initial care of trauma alert patients? (They participate in the care of minor injuries only)” (Level III Center)

The TMD is expected to perform an OPPE on the Advanced Practice Providers (APPs) on the Trauma service providing care to trauma patients. However, the APPs on the other services, e.g. ED, Neurosurgery, Orthopaedic Surgery, etc., should be performed by their respective directors with oversight by the TMD.
Focused Professional Practice Evaluation (CD 5-11)

“For a new TMD, does his/her initial FPPE need to be trauma surgical cases or are non-trauma surgical cases acceptable?” (Level II Center)

Per the requirement, an annual assessment of the trauma panel providers in the form of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) when indicated by findings of the PIPS process (CD 5–11).
Limited Tier Activations (CD 5-16)

“Is the trauma service expected to evaluate tier 2 activations discharged from the ED prior to departure?” (Level II Center)

The trauma activations for the limited tier will be defined by the trauma center. The limited tier must have defined criteria for the type of injuries the trauma surgeon is expected to respond to and when.

There must be a continual assessment of the trauma activation tiers to capture over/under triage rates (CD 16-7).
Nonsurgical Admissions (CD 5-18)

“Elderly with single level falls with hip or leg Fxs. Are we allowed to admit them to Medicine? What are the rules on this?” (Level III Center)

Isolated hip fractures and/or single level falls may be admitted to medicine with a surgical consult.

If these patients are captured in the trauma registry, they will count toward your nonsurgical admission (NSA) rate.

Note: Capturing these patients in the trauma registry are based on your state/local or institution admitting policy. If they are captured in the registry and will be used in completing the PRQ, they are subjected to follow the NSA formula on page 121.
Peer Review Attendance for Locums (CD 6-8)

“Are locums included in meeting attendance requirements like staff surgeons are for committee meetings?” (Level II Center)

Yes. Locums or Trauma Surgeons who take partial trauma call are required to meet the 50% attendance requirement. If unavailable to attend in person, they may participate by video or phone conferencing.
“Can a TPM oversee more than one program (e.g., trauma and burns; trauma and surgical ICU)?”
(Level II Center)

For a Level II trauma center, the Trauma Program Manager (TPM) must be dedicated to the trauma program. Therefore, the TPM cannot assume other responsibilities outside the trauma program.

The TPM may have other responsibilities within the trauma program such as, the Injury Prevention Coordinator. Refer to Chapter 5, Table 4 on page 42, of the Resource manual.
“How should conference calls be tracked for System Meetings and Peer Review meeting?”  
(Level II Center)

Tracking attendance for video or phone conferencing would be documented by the Trauma Medical Director or Trauma Program Manager on the sign-in sheet or by electronic signature.
“Clarification on CD 5-16 if the ED MD is non board certified, can they still evaluate non trauma activations?” (Level I Center)

If the Emergency Department physician is not board certified, but is board eligible, they may evaluate trauma patients and respond to trauma activations.

If the Emergency Department physician is not board certified for reasons of not completing a U.S. or Canadian residency, or has exceeded the allotted number of attempts to become board certified, or just never took the certification exam, they may only evaluate non trauma patients.
Orthopaedic Traumatologist Leader (CD 9-5)

“How should a pediatric trauma center be prepared to answer questions related to the new orthopedic trauma fellowship question on the new PRQ? We do have transfer agreements in place; we did submit the questionnaire to ACS; but this fellowship did not exist until 2013. How are reviewers dealing with this new requirement?”

(Level Unidentified)

Pediatric centers may meet the requirement with the following:

• Transfer agreement
• If combined with an adult center, share OTL resources, must still complete the OTL form

Approved OTL:

• COT Orthopaedic committee reviews/approves
• Review team/hospital is advised if approved/denied
For selected isolated ortho injury our ortho service has their NP eval the pt. The attending does not eval. Is this an issue?” (Level III Center)

It is not an issue. The expectation is for the specialists or Advanced Practice Providers (APPs)/residents* on that service to respond when the request is made by the attending surgeon.

*There must be guidelines for the types of injuries the APPs will respond to, and have clear documentation with the attending specialist surgeon on the plan of care.
“Can a CRNA be the designated alternate for meeting attendance?”  (Level III Center)

In general, the CRNA cannot be an alternate to meet the anesthesiologist peer review attendance. This must be a physician representative.

In states that have Level III centers where CRNAs are licensed to practice independently, they may be designated as the anesthesia liaison.
Images from Referring Centers (CD 11-41)

“Are referring hospitals still to defer obtaining CT scans prior to sending patients even with the advent of sharing rad. images?” (Level I Center)

No. The referring center may share via telemedicine or by other imaging source.
“CD 11-60 if trauma surgeon documents in their note the time paged & the time they arrived at bedside does this suffice?” (Level II Center)

The trauma program must track the time the trauma surgeon or consultant was paged/called to the ICU for emergent issues related to the trauma patient, and document the response time at the bedside. Any issues or delays in care must be reviewed through the PIPS process by the trauma program.
“Can the TMD also serve in the role as ICU Liaison? What are the responsibilities in this role?”

(Level III Center)

For a Level III center, the Trauma Medical Director may also serve as the ICU Director or co-Director/liaison.

The ICU liaison must be actively involved in, and responsible for, setting policies and administrative decisions related to trauma ICU patients (CD 11-53).
ICU Nursing Ratio (CD 11-66)

“For review purposes, how is the nurse-patient ratio for trauma patients in the ICU calculated?”

(Level I Center)

Patient/nurse ratio must not exceed 2:1. This is defined as, for every 2 ICU patients there is a minimum of 1 nurse.

For example: If you have a 10 bed ICU, you should have 5 nurses to take care of 10 patients.
“What constitutes hand and “microvascular” coverage required by L2 centers?” (Level II Center)

Hand surgery may be covered by plastics and/or OMFS.

The capability for re-implantation is not expected, this can be met by having a transfer agreement.
“What constitutes Microvascular Surgery?”

Must have a Microvascular surgeon, or coverage may be satisfied by having a surgeon who uses an operating microscope for nerve repair, free tissue transfer, etc. The microvascular capability is not required inhouse 24/7, but must have a surgeon consultant available to respond, in person, when requested by the attending surgeon.
“Does EM, Neurosurgery and Ortho providers and mid-level providers need to be current in ATLS certification?”
(Level I Center)

The Trauma and/or Emergency Department (ED) APPs that function as a member of the team caring for trauma activation patients 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.

Neurosurgery and Orthopaedic Surgery APPs who respond when consulted by the attending during an activation, are not required to meet the ATLS requirement.
“In the new clarification document, please explain further the death classifications CD 16-6.”

(Level II Center)

There is a typo in the Clarification Document v8, and has been addressed with the next edition. The death categories did not change and remain as follows:

• Mortality with opportunity for improvement
• Mortality without opportunity for improvement
• Unanticipated Mortality with opportunity for improvement
Universal Screening for Alcohol (CD18-3)

“Please clarify the requirements for SBIRT.” (Level II Center)

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

For Level I and II trauma centers, all patients who have screened positive must receive an intervention by an appropriately trained staff, and this intervention must be documented (CD 18–4).

- All patients that meet ACS registry inclusion criteria with a hospital stay of > 24 hours.
- Pediatric patients, age should be defined by the center.
“Please further explain the reports that need to be available during the review for SBIRT for alcohol/drug screening for LI/LII.” (Level II Center)

Depending on your trauma center’s process for documenting the SBIRT results, most are either noted in the flowsheet, or some place in the patients medical record, or have available the screening tool/report within the medical record.
**Intervention (CD 18-4)**

“What is the expectation for this CD 18-4? Is 100% of patients to be screened and intervention completed before discharge?” (Level II Center)

All admitted trauma patients must be screened, and those that screen positive must receive an intervention by appropriately trained staff, and this intervention must be documented.

The Trauma Program should track results on those patients that received an intervention, or were referred to an inpatient rehab program or a structured outpatient program.
“Trauma panel surgeon as a member of the hospital’s disaster preparedness committee. We seeking verification as a Level II pediatric trauma center with a Level I Adult trauma center. One of our adult trauma surgeons is a member of the hospital’s disaster preparedness committee as well as our pediatric PIPS liaison physician from PICU. Would this meet the requirement?” (Level I Center)

It is acceptable for the adult and/or pediatric trauma surgeons to be members of the hospital’s disaster committee.
Thanks for your participation!