Trauma Verification
Q&A Web Conference

December 15, 2017
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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!
Orange Resources Book

Available as hard copy or PDF version, it is recommended that you have it available as reference during the CD-Related Questions section of this webinar.

Must use the most current Clarification Document and the Verification Change Log in conjunction with the manual.

www.facs.org/quality-programs/trauma/vrc/resources
Clarification & Verification Document Updates

The updates for the Verification Change Log and Clarification Document through December have been completed.

These documents may be accessed through the VRC webpage at:

[www.facs.org/quality-programs/trauma/vrc/resources](http://www.facs.org/quality-programs/trauma/vrc/resources).

Going forward, changes to the criteria will be published in the Verification Change Log, and any clarifications to criteria will be published in the Clarification Document.
Clarification Document

The document has been shortened to display only those requirements with a clarification (down from 90 pages to 44 pages).

The American College of Surgeons

Clarification Document

Resources for Optimal Care of the Injured Patient

By the Verification Review Committee

V1_ March 2017

www.facs.org/quality-programs/trauma/vrc/resources
## Verification Change Log

<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>
<th>Clarification</th>
<th>Type</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>I</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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<td>TYPE II</td>
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<td>1-2</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>I</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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<td>TYPE II</td>
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<td>1-3</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>I</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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<td>2-1</td>
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<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>I</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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<td>2-2</td>
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<td>III</td>
<td></td>
<td>I</td>
<td>I</td>
<td>7/1/2014</td>
<td></td>
<td>Surgical commitment is essential for a properly functioning trauma center (CD 2-2).</td>
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<td>TYPE I</td>
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<td>2-3</td>
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<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>I</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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<td>TYPE II</td>
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<td>I</td>
<td>II</td>
<td>III</td>
<td></td>
<td>I</td>
<td></td>
<td>7/1/2014</td>
<td>Revised</td>
<td>Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon’s ability to participate on the trauma panel based on an annual review (CD 2-5).</td>
<td></td>
<td>TYPE II</td>
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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: January 11, 2018

Webinar date: January 25, 2018

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

The Stakeholder Public-Comment website:

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.

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<th>Upcoming Chapters</th>
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<td>Chapter 19 Research</td>
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Resources for TPMs and TMDs

• Frequently Asked Questions (FAQs)
  • The list will expand over time.
    [Link](https://www.facs.org/quality-programs/trauma/vrc/faq)

• Becoming a Verified Trauma Center: First Steps
  ▪ Designed to guide the Trauma Program Manager or Medical Director in the First Steps in the Consultation and Verification Process.
    [Link](https://www.facs.org/quality-programs/trauma/vrc/resources)
Scheduling Reminders
TQP Participant Hub

Welcome to the ACS Trauma Quality Programs (TQP) Participant Hub!

If your hospital is a new facility, please click on Join a Program below.

If you are a current participant in one of our Trauma Quality Programs—the National Trauma Data Bank®, Trauma Quality Improvement Program, or Verification, Review, and Consultation Program—you may log in by clicking on Account Center below.

If you are a new user at an existing facility, please contact the Primary Contact for your facility (most often the Trauma Program Manager) to request that you be added to your facility's contact list.

Join a Program

- Eligibility
- Getting started

Account Center

- Manage site information
- Manage contact information
- Request a site visit
- Access TQIP participant educational materials

Data Center (coming soon)

- Submit data
- Download reports
- Access interactive reports

Training Resources

For training materials focusing on utilizing various elements of the TQP Participant Hub, Account Center, or the Data Center, please see below.
TQP Participant Hub

• Account Center
  ▪ Manage facility information
  ▪ Manage contact information

  • If the Primary Contact at your facility has left and you need assistance accessing the Account Center, please email tqip@facs.org

• Data Center
  ▪ Submit data
  ▪ View reports
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.

• Visits for 2017 and through November 2018 are closed to scheduling:
  ▪ [https://www.facs.org/quality-programs/trauma/vrc/site-packet](https://www.facs.org/quality-programs/trauma/vrc/site-packet)
Proving QTP Contact Updates

- Staff changes should be reported as soon as possible
  - TMD/TPM/Administrator (President, Vice-President, CEO)

- Site visit applications, note credentials: MD, RN, EMT, NP, PA
  - Combined adult and pediatric verification programs, note contacts for both the adult and pediatric programs

- Challenges with not updating contacts:
  - Consultation/Verification/Reverification letters and reports have incorrect staff listed
  - Follow-up inquiries from the VRC staff on recent site visits may cause delays receiving the final report
Additional Information to be submitted with 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
  ▪ Combined centers (Level I adult/Level I pediatric) that have separate visits scheduled, but share the same OTL, the form must be completed entirely for the 1\textsuperscript{st} visit and on the 2\textsuperscript{nd} visit, only complete questions 1-3

• The form is located at:  https://www.facs.org/quality-programs/trauma/vrc/site-packet
OTL Form – Under Revision

• Trauma centers that have previously completed an OTL form and has had no change in the OTL, are not required to complete another form; however, you will be asked to indicate his/her name on the site visit application.

• Trauma centers who have had a change or are new to the process, must complete an OTL form.
Alternate Pathway Criteria (APC) Request

• For centers that have a non U.S. or Canadian board certified/eligible physician or surgeon, who has trained overseas, must note the applicant’s name and specialty on the application
  ▪ Forward a copy of the applicant’s curriculum vitae (CV)
  ▪ On-site evaluation by a member of the same specialty; assess the 8 criteria (ATLS, CME, meeting attendance, etc), along with review of clinical care.

• Those previously approved by way of the APC are not required to have a review by the specialist at the time of the visit. However, they are required to meet the APC

• The APC is not applicable to U.S. or Canadian residency trained physicians or surgeons

https://www.facs.org/quality-programs/trauma/vrc/site-packet
Prereview Questionnaire (PRQ) Online Access

• Once your application has been received, the VRC office will provide you with an email receipt of confirmation.

  ▪ Logins to the online PRQ will be provided within the confirmation of receipt email

  ▪ The online PRQ can be accessed at: http://web2.facs.org/traumasurvey5/

  ▪ A copy of the PRQ in Word can be downloaded from: www.facs.org/quality-programs/trauma/vrc/resources
Site Visit Application Payment

• Do not submit payment with the application

• Your center will be billed annually for the Trauma Quality Program fee
  ▪ This annual fee will not include any additional visit-related fees, such as additional reviewers

• The fee structure is located at:
  https://www.facs.org/quality-programs/trauma/vrc/fees
Scheduling Site Visits

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

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

• When a lead reviewer is available for your site visit, VRC staff will contact your TPM to confirm the dates prior to finalizing the visit.
Site Visit Preparation with Reviewers

• The ACS Travel Agent will arrange the site reviewers’ flights. Reviewers make travel plans approximately 20 to 30 days prior to the site visit.

• The hospital will arrange and pay for the site reviewers’ hotel accommodations, as well as their ground transportation.

• The reviewer’s contact information will be provided in a confirmation email once the full team has been secured, approximately 90 days before the visit.

• Please contact the reviewers directly within 30 days of the site visit for their flight Itinerary and any logistical information.
Clarification
As noted in Chapter 12. This is not a requirement; however, centers should develop a plan to evaluate, support, and treat PTSD as part of your rehabilitation program for injured patients.

“Does Acute Stress screening count as PTSD screening?”
(Level II)

Yes. Screening for Acute Stress Disorder may be counted as Post Traumatic Stress Disorder. This was added to the Clarification Document.
Universal Alcohol Screening (CD 18-3)

For Level I, II and III trauma centers universal screening for alcohol must be performed for all injured that meet NTDS Trauma Inclusion criteria with a hospital stay of > 24 hours, of which 80% must receive a screening. This does include all injuries, ortho and neuro.
General Questions
Hospice Patients

“Are patients dispo’d to hospice reviewed/counted as a death for peer review and PI purposes?” (Level I)

For verification purposes, a living patient discharged to hospice should not be counted as a death. This should be captured in your transfer numbers and reviewed with all other transfers. Information concerning the patient after their passing can be captured in your registry.
**Locums**

“Use of locums 2-3 days a month for gen surgery and neurosurgery. What is locums attendance requirement for Peer Review?” (Level 2)

Regardless of the frequency of using locums for coverage, if they are treating trauma patients, they are required to meet the same requirements as the other trauma panel members. This includes current board certification in their specialty, CME (internal/external), peer review meetings (for trauma surgeons), and evaluated through the OPPE process.
**General Surgery Backup Coverage**

“Can General Surgery Attending covers as Trauma on call BACK-UP, providing he has ATLS and has Trauma experience in the past?” (Level 2)

Yes, it is acceptable as long as the general surgeon has been given privileges and credentialed (ATLS, training, etc.) to provide backup to the trauma service. These instances should be monitored through the PIPS process.

If the general surgeon is occasionally put on the trauma call schedule (similar to locums) to provide coverage (not only as backup), they are required to meet the same requirements as the other trauma panel members.
Resources Manual Revisions Release

“Will the Resource Guide be released as chapters are updated? or are you waiting until all are completed?”

(Level 1)

The revised/new Resources for Optimal Care of the Injured Patient manual will be released once all chapters have been updated. It will be released at a predetermined time, e.g. January 20xx, this will give trauma centers that are undergoing review a year post release to implement the changes, if any.
Social Worker

“What is the recommended ratio for # of trauma patients to social worker for Trauma level I pediatric center? Level I adult?” (Level 1)

There is not a requirement for the number of trauma patients assigned to a social worker.
“In a previous webinar, hip fractures were not reported in the PRQ unless they were required by the State to be reported. In the past webinar, it was stated that they should be reported. Reporting hip fractures and including them in the PRQ will add hundreds of hours of work to our abstractors. I am confused about whether they should or should not be included.” (Level 1)

These patients may not be required based on your state and/or hospital admission inclusion criteria. If these patients are not part of your admission inclusion criteria, they are not to be reported in the PRQ.

For verification purposes, if you are in a state or at a hospital that includes these patients as part of your admission inclusion criteria and are entered into the registry, and will be used in the data collection for the PRQ, they are to be reported on the PRQ.
PRQ: Next Verification Following a Focused Visit

I have a question about filling out my PRQ after a focused visit. In 2015 we had our verification visit and got a CD 16.7 deficiency. In March 2016 we had a focused visit which was successfully resolved. Many of the weaknesses cited in the 2015 visit were related to the CD and were resolved. So how do I address my 2018 PRQ. List the deficiency and the weaknesses and full address them, including the focused visit. List the CD, with focus visit date and address weaknesses more fully. Limit discussions to things that fall out of the identified CD?

For the PRQ where it asks to list the most recent visit, deficiencies (CDs) and weaknesses, list the date of the Focused visit; however, do not list the CD (since it was resolved), and only list those weaknesses that were not related to the CD.

Trauma centers that have not undergone an ACS review, do not list your state visit as the last visit, keep all these questions blank.
Transfer Agreement

“Is a transfer agreement a LEGAL, SIGNED document between 2 entities or an informal agreement and hospital procedure?” (Level 1)

A transfer agreement or contract is a formal and legal document signed by the 2 entities.
Transfers

“Could you please clarify what is considered a transfer? You mentioned ER to ER, but also about free-standing clinics. And are PCP offices included, especially if they call a report to the receiving facility?” (Level 1)

For verification purposes, a transfer from another facility (regardless if under one license) such as, a hospital/trauma center, free standing/satellite ER and/or from a primary care physician office are considered interfacility transfers (transfers-in).

All transfers must be evaluated as part of the receiving trauma center’s PIPS process (CD 4–3), and feedback should be provided to the transferring center.
A Level III trauma program manager (TPM) is not required to be dedicated and/or full-time at a trauma center. The time allotted to his/her role will be based on their responsibilities such as, is the TPM also acting as the registrar, PI coordinator, doing injury prevention, etc. These additional duties and taking into consideration the volume of trauma patients the trauma center admits, may hamper his/her duties to function as the TPM.
“Why isn't there a standard format for corrective action plans that are to be submitted 30 days prior to the visit?” (Level 2)

Most trauma centers develop its own because the deficiencies and weaknesses will vary; however, we will add this to our list of ongoing projects to standardize a corrective action plan template. More to come at a later date.
Requirements for Nurse Practitioners and Physician Assistants

“Are NP’s and PA’s assigned to the trauma service and participating in the resuscitation of acute trauma patients required to meet any specific CME standard (16 per year, 48 in a cycle) similar to that of their attending and sub-specialty colleagues?

Also, are NP’s and PA’s primarily assigned to the trauma service required to meet any specific meeting attendance threshold - similar to the 50% threshold for attending staff and liaisons? ” (Level I)

There are no CME or peer review attendance requirements for NPs and PAs who are members of the trauma team activation or who are assigned to the trauma service.
Example of Tracking ICU Response

During the September 2017 a question was asked on how does a center track the trauma surgeon’s response times to the ICU. I received permission from an ACS verified trauma center to use their ‘tracking’ sheet as an example.

Per the TPM, the sheet on the following slide is copied and placed in a binder. The sheet is given to the charge nurse in the ICU who is responsible for completing it and returning it to the TPM. This demonstrates if the surgeon is responding timely to pages. The TPM then collates the data into a log and graph to demonstrate compliance for the onsite review team. Again, this is just one example of how compliance may be tracked.
Date: ____________  Time Called: ____________  Time Answered: ____________

☐ Surgeon 1  ☐ Surgeon 2  ☐ Surgeon 3  ☐ Surgeon 4  ☐ Surgeon 5  ☐ Surgeon 6  ☐ Surgeon 7  ☐ Surgeon 8

- Urgent (airway, breathing, circulation, neuro change, other)
- Routine

SURGEON RESPONSE:
- Orders
- Surgeon coming in: Time arrived ____________
- Delegated response (who) ___________________________  Time arrived ____________

Date: ____________  Time Called: ____________  Time Answered: ____________

☐ Surgeon 1  ☐ Surgeon 2  ☐ Surgeon 3  ☐ Surgeon 4  ☐ Surgeon 5  ☐ Surgeon 6  ☐ Surgeon 7  ☐ Surgeon 8

- Urgent (airway, breathing, circulation, neuro change, other)
- Routine

SURGEON RESPONSE:
- Orders
- Surgeon coming in: Time arrived ____________
- Delegated response (who) ___________________________  Time arrived ____________
CD-Related Questions
The Orange Book states that the trauma program manager “…must be full-time and dedicated to the trauma program” (Level 1 and II Centers). Does this mean the TPM cannot take on other responsibilities within an organization (i.e. Title = Director of Trauma Program and Critical Care Units)? Other dedicated coordinator resources (3.5 FTE’s) are available within the program (PI Coordinator (1.5 FTE), Outreach (1 FTE), Education Coordinator (1.0)).

The expectation is that the TPM is dedicated to the trauma program and not have oversight of other programs such as, Emergency Department, Children's Surgery program, etc. TPM titles will vary among all trauma centers; however, the job description must ensure that the responsibilities for the TPM are under the scope of the trauma program and are not encumbered by additional duties that fall under another service.
Neurosurgeon Response (CD 8-2)

“Can a Trauma Senior Resident respond at bedside for Neuro trauma activations/consult the Neuro Attending w/in 30min/documents it?” (Level 2)

This practice is acceptable. The intent is that the TMD and neurosurgeon liaison develop guidelines for which types of critical and complex injuries the neurosurgeon will respond to [in person] within the 30 minute timeframe. If they send the PA/APP, there must be guidelines that speak to this and clear documentation that there was a discussion with the surgeon specialist on the plan of care.
"Does the ACS have recommendation: who has the ultimate responsibility for the patient and decision-making in the operating room?" (Level 1)

If the trauma patient is under the care of the trauma surgeon, and he/she has not signed care over to another service, the trauma surgeon would retain responsibility for the patient.
ICU Patient-to-Nurse Ratio (CD 11-66)

“Relating to standard 11-66: The patient to nurse ratio in ICU must not exceed two to one. Is it OK to have 4:1 if the patients are designated as ‘ward status’? We have a shortage of acute care beds, so sometimes ICU patients awaiting transfer to the floor are designated ‘ward status’ while waiting for an acute care bed. The typical nurse to patient ratio on the ward is 1:4.” (Level 1)

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.
“(CD 11-86) If ED APPs only care for ‘non-trauma activation’ injured patients, are they required to maintain a current ATLS cert?” (Level 2)

If the advance practice providers are solely seeing and treating non-trauma activation injured patients such as, those that come in for a consultation or through fast-track, are not required to be current in ATLS. It would be ideal, but not required.
“For Level I research article requirements, do review articles count?” (Level 2)

Review articles do count toward the Research alternate pathway criteria as noted on page 145, under item 2.b.

- Evidence of dissemination of knowledge that includes review articles, book chapters, technical documents, Web-based publications, videos, editorial comments, training manuals, and trauma-related educational materials or multicenter protocol development.
Research for Combined Programs (CD 19-7)

“We are currently a Level II Adult and Level II Pediatric Trauma Center. We will be seeking verification as a Level I Adult and remain a Level II Pediatric Trauma Center. My question is about research. Will an article or case study of a pediatric topic count for the adult trauma center since there is no research requirement for the Level II pediatric trauma center?”

Yes, it may count for the research alternate pathway. In combined Level I adult and pediatric centers, you may have a combination of adult and pediatric research articles.
CMEs from Board Certification - Proof

“Is proof of board re-cert sufficient enough evidence for the 33 allowed CME's for board recertification?” (Level 1)

Yes, the surgeon/physician’s copy of their board recertification would suffice. It may also be listed in a copy of his/her transcript as board re-/certification.
CMEs from Board Certification

“Please clarify the difference in claiming trauma CME for initial board certification vs re-certification. Thank you.”

(Level 1)

There is no difference. Trauma related CME for either the initial board certification or recertification may be claimed to meet the requirement at least once during the 3 year verification cycle leading up the site visit.
CME

“How do you calculate the 3 year timeframe for CME? Does 1 of 3 years include the year you are surveying?”

(Level 2)

A total of 48 hours of external trauma-related CME over a period of 3 years leading up to the site visit must be acquired. This can be obtained by having the providers obtain 16 hours of CME for each year.
"Will the CME requirements be going away?" (Level 1)

No. During the chapter revision process, the focus will be centered on making it easier, but not do away with CMEs entirely.
Thanks for your participation!