

Trauma Verification Q&A Web Conference

March 26, 2019

COTVRC@facss.org



AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality:
Highest Standards, Better Outcomes*

100+years



VRC VERIFICATION
REVIEW
CONSULTATION

for excellence in trauma centers

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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 trauma center.*

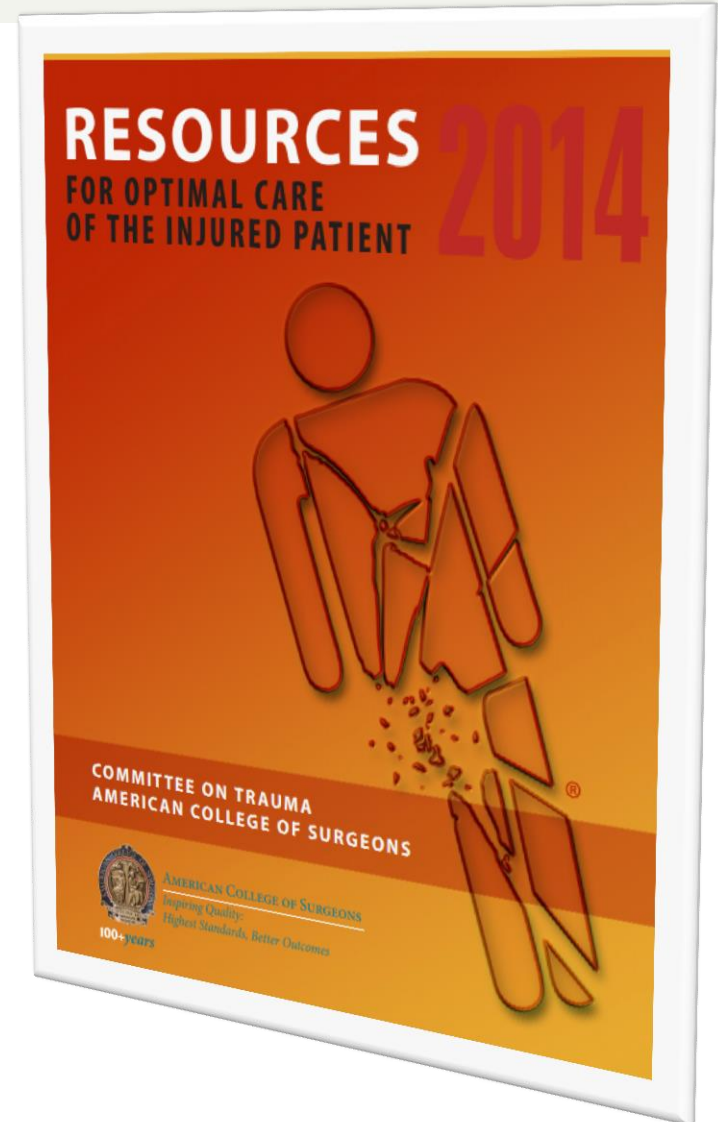
Let's get started!

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/tap/center-programs/vrc/resources



Clarification Document and Verification Change Log

The American College of Surgeons

Clarification Document

Resources for Optimal Care of the Injured Patient

By the Verification Review Committee

V9_9/30/18

2018

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

- Released Monthly
- Change Log – notes criteria updates/changes
- Available for download: www.facs.org/quality-programs/trauma/tap/center-programs/vrc/resources

Chapter	CD #	Level I	Level II	Level III	Level IV	PTC I	PTC II	Date Change	Criteria	Resources 2014 Orange Book Description of Criteria	Clarification	Type
1	1-1	I	II	III	IV	I	II	7/1/2014	New	The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1-1).		TYPE II
1	1-2	I	II	III	IV	I	II	7/1/2014	New	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)		TYPE II
1	1-3	I	II	III	IV	I	II	7/1/2014	New	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)		TYPE II
2	2-1	I	II	III	IV	I	II	7/1/2014	New	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).		Type I
2	2-2	I	II	III		I	II	7/1/2014		Surgical commitment is essential for a properly functioning trauma center (CD 2-2).		TYPE I
2	2-3	I	II	III	IV	I	II	7/1/2014	New	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).		TYPE II
2	2-5	I	II	III		I		7/1/2014	Revised	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).		TYPE II

Website Resources for Trauma Centers

- Recording of Webinars:
<https://www.facs.org/quality-programs/trauma/tap/center-programs/vrc/resources/webinars>
- Stakeholder Public-Comment website:
<https://www.facs.org/quality-programs/trauma/tap/center-programs/vrc/stakeholder-comment>
- Tutorials:
 - Becoming a Verified Trauma Center: First Steps
 - Becoming a Verified Trauma Center: Site Visit<https://www.facs.org/quality-programs/trauma/tap/center-programs/vrc/resources>
- Participant Hub - Account Center:
<https://www.facs.org/quality-programs/trauma/tap/tap-center>
- Expanded FAQ:
<https://www.facs.org/quality-programs/trauma/tap/center-programs/vrc/faq/standards>

Disclaimer

- All questions are pulled directly from the question submissions. There have been no edits made to the contents.
- If your question is not answered today, the question may require more information, and will receive a response from ACS staff within one week after the webinar.

Scheduling Reminders & Alternate Pathway

Site Visit Application

- The site visit application is **online only**.
- Can be accessed on the following ACS Trauma website pages:

VRC – Site Visit Application

<https://www.facs.org/quality-programs/trauma/vrc/site-packet>

The screenshot shows the American College of Surgeons website with the navigation menu: JACS | Jobs | Events | Find a Surgeon | Patients and Family | Contact | My Profile | Shop | Donate. The main header includes the ACS logo and the tagline "Inspiring Quality: Highest Standards, Better Outcomes". Below the header is a search bar and a navigation menu with options: Member Services, Quality Programs, Education, Advocacy, Publications, and About ACS. The breadcrumb trail reads: American College of Surgeons > Quality Programs > Verification, Review, and Consultation Program for Hospitals > Site Visit Application. The left sidebar contains a list of links: VRC (Verification, Review, and Consultation Program for Hospitals), About the VRC Program, Verified Trauma Centers Search, The VRC Process, Fees and Invoices, Site Visit Application (highlighted), Site Visit Outcomes, Resources for Optimal Care of the Injured Patient 2014/Resources Repository, Resources for Optimal Care of the Injured Patient Stakeholder Comment, Trauma Verification FAQs, and Contact VRC. The main content area is titled "Site Visit Application" and includes a "Please note" section, an "Applying for a Site Visit" section with a link to "Access the Site Visit application" (highlighted in yellow), and a "Following Your Application Submission" section. A "Cancellation Policy" link is at the bottom.

TQP Participant Hub-Account Center

<https://www.facs.org/quality-programs/trauma/tqp/tqp-center>

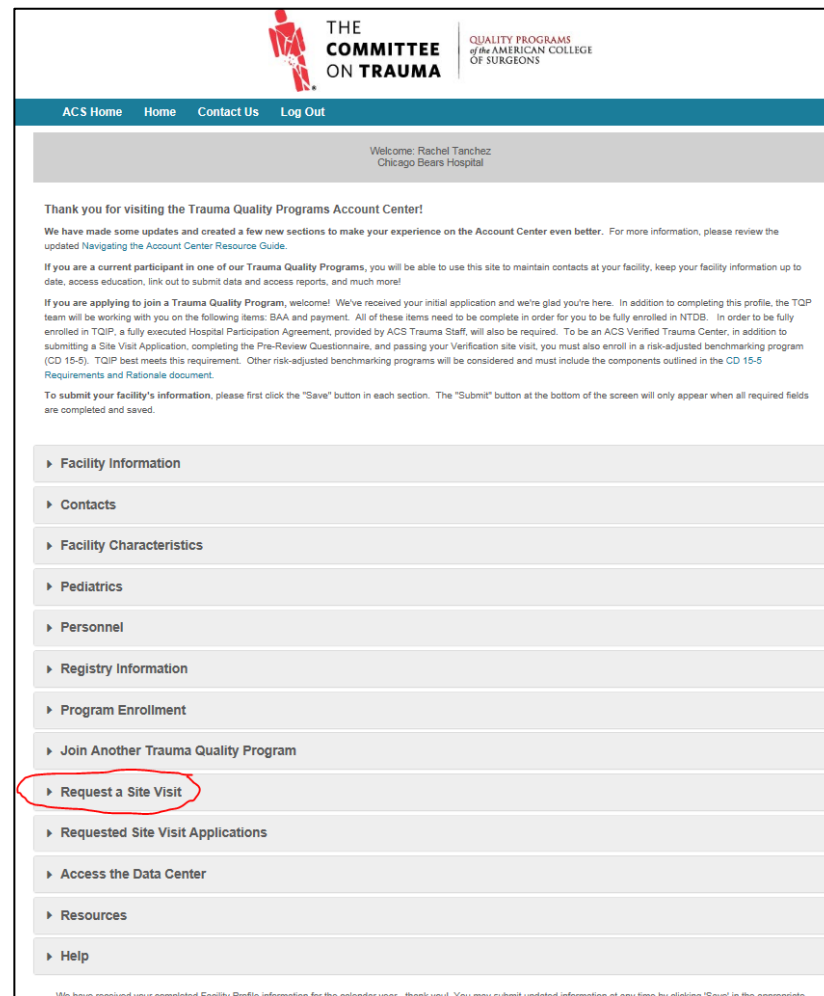
The screenshot shows the American College of Surgeons website with the navigation menu: JACS | Jobs | Events | Find a Surgeon | Patients and Family | Contact | My Profile | Shop | Donate. The main header includes the ACS logo and the tagline "Inspiring Quality: Highest Standards, Better Outcomes". Below the header is a search bar and a navigation menu with options: Member Services, Quality Programs, Education, Advocacy, Publications, and About ACS. The breadcrumb trail reads: American College of Surgeons > Quality Programs > Trauma Quality Programs > TQP Participant Hub. The left sidebar contains a list of links: Trauma Quality Programs and TQP Participant Hub (highlighted). The main content area is titled "TQP Participant Hub" and includes a "Welcome to the ACS Trauma Quality Programs (TQP) Participant Hub!" message. It lists "Join a Program" (Eligibility, Getting started) and "Account Center" (Manage site information, Manage contact information, Request a site visit, Access TQP participant educational materials). It also lists "Data Center" (Submit data, Download reports, Access interactive reports) and "Training Resources". A "TQP Participant Hub" link is at the bottom.

Site Visit Application

- The ACS Trauma website pages will link to the Account Center page:



The screenshot shows the top navigation bar with 'ACS Home', 'Home', and 'Contact Us'. The main content area features a 'Welcome to the Account Center!' message and three bullet points: 1) 'If your hospital is a new facility, please click the Register a New Facility link below.' 2) 'If you are a current participant in one of our Trauma Quality Programs (National Trauma Data Bank®/Trauma Quality Improvement Program®/Verification Review Consultation Program®), you may log in below.' 3) '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.' Below the text is a 'Register a New Facility' link and a 'Log On' button. At the bottom, contact information for the American College of Surgeons is provided, including the address '633 N. Saint Clair St., 26th Floor, Chicago, IL 60611-3211' and email 'traumaquality@facs.org'.



The screenshot shows the Account Center dashboard with a navigation bar containing 'ACS Home', 'Home', 'Contact Us', and 'Log Out'. A welcome message reads 'Welcome: Rachel Tanchez Chicago Bears Hospital'. Below this is a 'Thank you for visiting the Trauma Quality Programs Account Center!' message and a paragraph about updates. A list of menu items is displayed on the right, with 'Request a Site Visit' circled in red. The menu items are: Facility Information, Contacts, Facility Characteristics, Pediatrics, Personnel, Registry Information, Program Enrollment, Join Another Trauma Quality Program, Request a Site Visit, Requested Site Visit Applications, Access the Data Center, Resources, and Help. At the bottom, a small note states: 'We have received your completed Facility Profile information for the calendar year - thank you! You may submit updated information at any time by clicking "Save" in the appropriate'.

► Join Another Trauma Quality Program

▼ Request a Site Visit

Instructions
The Site Visit Application must be submitted 13-14 months in advance of the center's preferred site visit date. Please use the Contacts section above to indicate your facility's Trauma Medical Director and Administrator.

An Alternate Pathway review should be requested for surgeons/physicians who trained overseas and want to participate on the trauma call schedule. Their CVs must be submitted as they will be vetted by a subcommittee for eligibility to go through the Alternate Pathway. For each surgeon, indicate if they are new to Alternate Pathway or if the surgeon was previously approved by the Alternate Pathway Criteria at the current institution.

In addition to completing the site visit application, all Level I Trauma Centers must also complete the Orthopaedic Trauma Liaison (OTL) form and return it to the VRC office (cotvrc@facs.org) along with a copy of the OTL's curriculum vitae.

Please note: We are currently accepting site visit applications to be scheduled starting in February 2019. We are no longer accepting applications for 2018-January 2019. For those trauma centers expiring prior to January 2019, exceptions may be made provided that capacity is not overwhelmed.

If you would like to make changes to a previously submitted site visit application, please contact us at cotvrc@facs.org.

This review is at the request of:

Preferred Dates
ACB site visits are over a 2 day period (with the exception of the half-day focused visit). Please select your preferred visit start date below.

Choice #1:

Dates to avoid:

Comments (to provide additional clarity regarding preferred dates):

Visit Type:

Visit Level:

Facility treats what kind of patients?: (Adults >= 16, Children < 16)

All trauma centers must use a risk-adjusted benchmarking system to measure performance and outcomes (CD 16-6). Participation in TGIP best meets this requirement. Other risk-adjusted benchmarking programs will be considered. Please indicate below if you plan to participate in risk-adjusted benchmarking program other than TGIP.

Enrolled in Other Risk-Adjusted Benchmarking (RAB) Program: Yes No

If "Yes" please provide program name:

If "Yes" please provide contact information for program:

Additional Reviewers Requested:

Orthopaedic Surgeon
 Emergency Physician
 Trauma Surgeon
 Alternate Pathway
 Trauma Program Manager
 Neurosurgeon

Alternate Pathway Review(s) Requested For (see instructions section)
 (+) Add New Alternate Pathway Member

Name	Specialty	Type
Orthopaedic Trauma Liaison		
Level I Adult/Pediatric Trauma Centers, was the Orthopaedic Trauma Surgery Leader (OTL) previously approved? <input type="radio"/> Yes <input type="radio"/> No		
If "Yes" please provide their name: <input type="text"/>		
Level I Adult/Pediatric Trauma Centers, was the OTL requirement previously met with a transfer agreement? <input type="radio"/> Yes <input type="radio"/> No		
If you answered 'No' to either question above, please download, complete, and return the OTL form to COTVRC@facs.org		
<input type="button" value="Save"/>		

► Requested Site Visit Applications

► Access the Data Center

► Resources

- The online application must be submitted at least 13 -14 months in advance of the requested site visit dates and must be before expiration date
- An Alternate Pathway review should be requested on the application for surgeons/physicians who trained overseas and want to participate on the trauma call schedule. Their CVs must be submitted to cotvrc@facs.org as they will be vetted by a subcommittee for eligibility to go through the Alternate Pathway
- All Level I Trauma Centers must also complete the Orthopaedic Trauma Liaison (OTL) form which can be downloaded on the site visit application. Submit form to cotvrc@facs.org with a copy of the OTL's curriculum vitae
- We are accepting limited applications for **July-September and December 2019. October & November are closed.**

Prereview Questionnaire (PRQ) Online Access

- Once the application has been submitted, the VRC office will provide you with an email receipt of confirmation
 - Logins to the online PRQ will be provided within the confirmation of receipt email
 - The online PRQ can be accessed at:
<http://web2.facs.org/traumasurvey5/>
 - A copy of the PRQ in Word can be downloaded from:
www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/resources

Site Visit Application Payment

- Do not submit payment until you receive an invoice
- Your center will be billed annually for the Trauma Quality Program fee
 - This annual fee will not include any additional visit-related fees, such as additional reviewers
- The fee structure is located at:
www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/fees

Scheduling Site Visits

- Visits are being scheduled quarterly
- We ask that you provide exact dates you would like the visit scheduled
 - The visit will occur on your chosen dates, but may ask for different dates should the review team be unavailable on the requested dates
- Once the review team has been secured, you will receive a confirmation email, approximately 120 days prior to the scheduled visit. This will include your reviewers and their contact information

Site Visit Preparation with Reviewers

- The ACS Travel Agent will arrange the site reviewers' flights. Reviewers make travel plans approximately 20 to 30 days prior to the site visit
- The hospital will arrange and pay for the site reviewers' hotel accommodations, as well as their ground transportation
- Please contact the reviewers directly within 30 days of the site visit for their flight Itinerary and any logistical information

Previously Approved Alternate Pathway Surgeons

“Do you have to resubmit the same names and CV's for the alternate pathway doctors on your reverification visit application.” (Level 1)

After the candidate's initial approval, you do need to provide their name on the application, but do not need to submit their CV. You would only need to provide the following at the time of the subsequent site visits:

- A list of 36 hours of trauma-related CMEs during the past 3 years. This can be met by participation in the center's Internal Education Process.*
- Performance improvement assessment by the Trauma Medical Director (TMD) to ensure that patient outcomes compare favorably to other members of the trauma call panel.*

Multiple Alternate Pathway Surgeons

“If I have multiple surgeons going through the APC, how should I include their info on the PRQ?”

Currently, the PRQ allows for only 1 surgeon to be added on the Appendix #6-1 page. Add one to the PRQ and if there are multiple surgeons applying for the alternate pathway or who were previously approved, please download a copy of the Appendix #6-1 form, on the ACS website and submit the form and the surgeons CVs to COTVRC@facs.org. A copy should be available onsite for the team.

<https://www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/resources>

Announcements

Next Verification Q&A Webinar

Webinar Date: **Tuesday, April 30th**

Webinar Time: **12:00 PM Central Time**

Deadline to submit questions: **Thursday, April 11th**

General Questions

Drowning Patients

“Can near-drownings be included in the total number of admitted patients if they are consulted by the pediatric trauma service?” (Level 1)

For verification purposes as noted on page 67 of the Resources manual, the volume admission should exclude patients admitted for drowning, poisoning, foreign bodies, asphyxiation, or suffocation.

In regard to the Trauma Surgeon’s involvement in these types of cases, they should be involved early to evaluate whether there are any traumatic injuries and also the added benefit for rapid resuscitation if needed.

Advanced Practice Providers (APPs)

“Are trauma Advanced Practice Clinicians (APC) required to see and perform tertiary exams on patients admitted to ortho surgical services?”

(Level 2)

No, this is not a requirement for Advanced Practice Clinicians/APPs. However, they may participate in the PI process.

Advanced Practice Providers

“Can APPs perform the daily rounding on ICU trauma patients after the plan of care is established by the surgeon?” (Level 2)

There is no specific requirement for APPs performing the daily rounding on ICU patients. The APP may round on the ICU trauma patients with a physician who is responsible for signing off on notes/examinations.

ATLS Certification Status

“Does ‘current in ATLS’ mean being current as of the date on the card or within the allowed 6mo grace period after expiration?” (Level 1)

For verification purposes, current status is based on the date noted on the ATLS card.

ATLS Certification for Trauma Surgeons

“Is there any projection that Optimal Resources revisions will require all general trauma surgeons to be current in ATLS?” (Level 2)

In respect to the chapter revision process and this particular question, we can say that current ATLS certification will not be mandated for all Trauma Surgeons.

The Trauma Medical Director will still be required to be current in ATLS.

Free Standing Emergency Department (ED)

“Our facility is looking to acquire and take over operations of a free standing ED that will become a provider based ED. If a patient was to walk in the offsite, provider based ED and meet the highest trauma team activation criteria, would the trauma surgeon on call be expected to evaluate the patient at the off-site facility? If not, what would be the expectation for care for cases like this example?” (Level 3)

The Attending Surgeon is not expected to travel to the offsite facility to manage that patient. The free standing ED should have guidelines in place to stabilize the patient and expedite transfer to the nearest verified trauma center that is capable of managing the patient's injuries.

Free Standing Emergency Department (ED)

“When patients are initially treated at a free-standing, provider based ED and are then admitted to the main campus for definitive care, is that considered a transfer, direct admit, or admission?” (Level 3)

For verification purposes, if the patient was transferred from the offsite facility (free standing ED) to the main trauma center, this patient would be considered a transfer. To clarify, interfacility or interhospital transfers is defined as patients who are transferred in/out to/from another facility whether that is a sister hospital, free standing ED, private physicians office, etc.

As a reminder, all transfers must be reviewed through the PIPS process (CD 4-3).

Nonsurgical Admissions

“Do ED OBS admits count as non-surgical admissions? If so, is there a minimum length of stay time required to count towards an admission?” (Level 2)

For verification purposes, patients who do not meet the NTDS or your trauma center's Inclusion Criteria and observations discharged within 23 hours cannot be counted toward the trauma patient admission total/requirement in the PRQ.

Patients who meet NTDS or your trauma center's Inclusion Criteria and are admitted to a surgical service or a non-surgical service with a stay > 24 hours may count towards the admission total/requirement in the PRQ.

Nonsurgical Admissions

“Do non-surgical admissions need to be reviewed at the time of admission or can the TMD review them post discharge?” (Level 1)

The nonsurgical admissions may be reviewed post discharge, so that the entire scope of care is evaluated.

Nonsurgical Admissions

“We recently had a verification visit (Feb 2019). The lead reviewer indicated that NSA were acceptable under certain circumstances (low impact mechanism, isolated injury i.e. fractures). All were to be reviewed, should ensure that consults are appropriate and timely and care was appropriate. Based on direction from ACS in the past our trauma committee has always tried to steer admissions to the surgical service with a consult to medicine unless medical priorities existed. Has ACS loosened its stance relative to NSA?” (Level 3)

The service for nonsurgical admissions will differ by trauma centers based on the institution's admission policy. Ideally, patients with isolated injuries or injuries due to low impact mechanism should be admitted to a surgical service to rule out any additional injuries. However, the center may admit the patient to Medicine with a surgical consult. Both methods are acceptable. The take away is that all nonsurgical admissions are evaluated for appropriateness of care.

Peer Review Meeting

“Does there need to be a separate sign in sheet for PIPS committee meeting and M &M conference for facilities that are peds/adult?” (Level I)

For combined adult and pediatric trauma centers, the peer review meetings may be held on the same day; however, there must be clear start and end time for each meeting and have separate minutes.

Trauma panel member are not required to attend both meetings. There may be a representative (TMD or designee) from the adult program or from the pediatric program, who attends the other program's meeting. In these instances, the TMD must ensure information is disseminated to the other panel members.

Peer Review Meetings

“What's the best way to differentiate between PI/operations if the meetings are held together or consecutive?” (Level 3)

For the purposes of a site review, a second sign in sheet or a clear delineation in the minutes between PI/operations will be sufficient.

OPPE

“Besides Trauma, Emergency Medicine, Orthopaedic and Neurosurgery OPPEs, do the trauma centers need to do OPPEs for Anesthesia, Radiology and PM&R?” (Level 1)

As these clinicians provide care to trauma patients, the TMD must have input to ensure they are in compliance with the verification standards. These clinicians should have their OPPE conducted by their specialty director and signed off by the TMD. In some centers, this may be managed by the Medical Staff office.

PRQ

“If you had weaknesses/deficiencies in your verification visit that cleared w/ the focus visit - how do you list them in your PRQ?” (Level 2)

The focused visit is “tied to” your original re-/verification visit. If your deficiencies and weaknesses were addressed during the focused visit, you are not required to list the deficiencies and weaknesses from the original visit. Reviewers will receive copies of the initial and the focused reports.

For focused by mail resolutions, reviewers will receive copies of the initial report and the corrective action.

PRQ – Pediatric Section

“Peds PRQ- how do we fill out seemingly duplicate areas? (ED nursing/Pediatric nursing, ICU/PICU). Need to enter adult unit info?” (Level 1)

Trauma centers seeking separate adult Level I and pediatric Level I site visits are required to complete separate PRQs. Some of the data in regard to staffing may overlap with the adult and/or pediatric programs. The Level I pediatric PRQ will consist of questions related to the pediatric program. The ICU/PICU sections do not repeat; however, they contain different questions and should be answered in accordance with pediatric data.

Social Worker

“Social worker is required for Level 1 trauma center? Do they need to be in the hospital 24/7 or as long as we have the ability to access them. We have SW 24/7 in our psychiatry unit, can be our resource during MN shift?”
(Level 1)

A social worker should be available 24/7 in Level I and II trauma centers. However, the VRC does not require them to be dedicated to the trauma program so the above practice is acceptable.

Specialty Services

“Level II, if they lose a specialty service (ex. OMF) when do they report the change to ACS and what is the process? If specialty service not available would it be appropriate to hire locums and have an contingency plan for short time?” (Level 2)

Credentialed Locums may provide coverage for the required specialty services. A contingency plan is not acceptable. As a reminder, these clinicians must be available at bedside within a specified time when the Attending Surgeon requests a consult.

Program changes of the TMD and TPM must be reported to the ACS as soon as it occurs.

State Representative

“Will the state ACS representative be able to answer question or who would be a contact person? Is there a state representative from the ACS?” (Level 2)

Perhaps this was meant for an ACS staff member.

The ACS does not have a state representative. We do have state Committee on Trauma representatives; however, they do not attend site visits. You may invite them, but not required.

A staff member occasionally attends site visits, but it is not the norm. The center will be notified in advance if an ACS staff member will be attending.

If there are any questions regarding your trauma center's designation process or status, contact your state Department of Health official. Questions regarding the verification process and/or standards, contact the COTVRC@facs.org.

Direct Admits

“Should transfers coming from inpatient status at one center go through the ED at the higher level of care receiving facility?” (Level 2)

The VRC recommends patients who have been transferred in with a full work up at another facility be assessed in your Emergency Department for the opportunity to identify additional injuries.

Trauma Activations

“We are preparing for a consultative visit for a Level III. Is there a minimum number of trauma activations required?”
(Level 3)

There is not a minimum number of activation categories. Most trauma centers have 3 activation tiers; this may include the consultation level/tier.

- *Highest Activation*
- *Limited Activation*
- *Consultation*

Trauma Activations

“Is there a requirement for someone from the PICU to attend highest level of activations in a Pediatric Level 1 Trauma Center?” (Level 1)

No there is not. The composition of the activation teams will vary by trauma centers. Who participates on the team will be defined by each trauma center.

Trauma Activations

“For limited tier activations, if trauma PA responds with trauma surgeon, can he document surgeon response in his note?” (Level 2)

Yes, this would be acceptable.

Trauma Activations

“Has the following level 1 activation criteria be removed by ACS: GSW of extremities proximal to the elbow or knee?” (Level 1)

Yes—Gun shot wounds (GSW) of extremities proximal to the elbow or knee are no longer a part of the requirement for the highest level of activation.

Trauma Activations

“Does the trauma surgeon on call have to see every trauma activation, regardless of level of activation?”

(Level 3)

The Attending Surgeon (TS) on call must respond to the highest level of action within 30 minutes.

The Attending Surgeon (TS) on call must respond to the limited level of activation based on your institution's guidelines. These guidelines must include the injuries the TS is expected to respond (at bedside) within a specified time.

Trauma Call

“We have a vascular surgeon who is also boarded in general surgery who takes call for us. Is he required to do general surgery cases other than emergent GS while on call to continue to be eligible for trauma call?” (Level 2)

No, that is not a requirement. The Trauma Medical Director will determine who will participate on the trauma call panel in accordance with the verification standards.

Trauma Registry

“A patient is activated as a level I-MVC Unresponsive. Patient experienced V-Fib arrest prehospital with ROSC. Patient was resuscitated by the trauma team with a full workup and no identifiable injury. Patient was sent to the cath lab and expired one week later. Made comfort care only. Should this patient be included in the registry? Should it be an attributed trauma death?”
(Level 2)

Entry into the registry will be based on your hospital policy. If the patient was discharged and expired a week later, it would not be counted as a death. If the patient was admitted to the hospital and died while on a surgical or a nonsurgical service, it would be reviewed as a death.

Trauma Registry

“The FTE for trauma registrar of 500-750 for admitted patients, this does not make sense because there is still a lot of time and effort on non admitted patients?” (Level 2)

There has been a lot of discussion on this requirement and it is currently being reviewed by the Chapter Revision Core Group and potential changes may be coming.

Trauma Staff

“Is it possible for a Trauma Registrar to hold the position of PI Coordinator or does the PI Coordinator have to be a nurse?” (Level 1)

The VRC does not have any requirements regarding the Trauma PI Coordinator position. A Trauma Registrar may hold the position of the PI Coordinator. Having said this, it would be advised to not have the same person in both positions as it may impact the registry support staff requirement (1 FTE for 500-750 trauma patients admitted).

Non-Accidental Trauma

“What are the requirements for the Trauma Service in the care of pediatric non-accidental trauma cases? Does the Trauma Service need to remain on the case until discharge or may they sign off after medically cleared (these patients can remain in-house for a length of time due to social issues)?” (Level I)

The VRC agrees that this would be reasonable once the injuries have been identified and treated by the trauma team, to sign off or formally transfer when the acute injury is no longer the reason for the pediatric patient being in the hospital.

Site Visit

“So I am asking if we have a patient who has an ISS >25, with pulmonary contusions, pneumothorax, grade III liver laceration, and splenic laceration. So this would be a patient that fits in more than one category for review, ISS>25, liver-spleen injuries, and thoracic. Which is the most appropriate category for this chart to be placed in? How do you decide?” (Level 2)

If the case resulted in a mortality, it should be categorized as a mortality for case review purposes, regardless of any other potential classification. If not, the chart may be placed in whichever category seems most appropriate. Do not “double dip” by placing the same chart in multiple categories. As a recommendation, you could flag it as a multisystem injury.

Site Visits

“Must a center ‘level up’ in succession ie, 3, 2, 1, or can a center go directly to Level I from Level III? Does ACS recommend?” (Level 2)

A center could theoretically go from a Level III to a Level I, though this would be substantially a big leap than going from a Level III to a Level II, or Level II to a Level I. The ACS (VRC) does not have specific recommendations regarding this; however, it is advisable to undergo a consultation review beforehand, to ensure that the facility is in compliance with all Level I criteria during the verification site visit.

Site Visits

“Do the reviewers pull the data on elderly with mechanical fall and isolated hip fracture as they are admitted on Hospitalist svcs” (Level 2)

Reviewers do not pull data so this may refer to the medical records for nonsurgical patients admitted to the Hospitalist. If elderly patients with mechanical falls and isolated hip fractures meet the NTDS Inclusion Criteria and are part of your admission policy, the medical records for these patients will be reviewed at the time of the site visit and data on these patients will be reported on the PRQ.

Site Visits

“For verification visits, is it necessary to have all meeting handouts and minutes, or can we simply log on to our web based site and show the handouts to the reviewers when asked?” (Level 3)

You are certainly welcome to have digital copies of meeting and minutes documentation available for reviewers at the time of the site visit.

Site Visits

“We will not have our first TQIP report until March, our verification visit is early July. We have two trauma meetings in between this time, how much of a drill down is expected with that timing?” (Level 3)

The purpose of the TQIP Primer (report) is to help frame discussions about TQIP participation and results, and to foster consistent understanding among reviewers and hospitals about the components of TQIP. Your center will not be required to do a drilldown prior to the site visit; however, you want to ensure you can speak to your center's TQIP report (outliers, if any).

CD-Related Questions

Trauma Admissions (CD 2-4)

“Do admissions that are less than 24hrs still count toward our total number of admissions for one year?” (Level I)

For the verification reporting period, if the length of stay is < 23 hours and the patient was not admitted as a trauma patient, this would not be counted in the trauma admission volume numbers.

Patient Arrival Time (CD 2-8)

“The Patient Arrival time is when the patient arrives in the ED, or when the trauma team starts to treat the patient?”

For verification purposes, if this is referring to the highest level of activation for when the Attending Surgeon is required to respond, it is tracked from patient arrival in the Emergency Department.

Diversion (CD 3-6)

“When reporting the time the hospital ED is on diversion, what should be reported? And is this just for the reporting year?”
(Level 2)

For each instance of diversion, the program should document:

- *Trauma Surgeon involvement (CD 3-5)*
- *The reason for the diversion (lack of resources, equipment failure, internal hospital disaster, etc)*
- *Documented start/end dates/times of notification to EMS, hospital personnel, and other trauma centers in the area*
- *The above will be asked in Appendix 3-Trauma Bypass Occurrences in the PRQ*

Per CD 3-6, all instances of diversion must be reviewed through the PIPS process, with the goal of maintaining a rate < 5% based on the reporting year.

Transfer Agreements (CDs 3-7, 8-5, 12-1, 11-22, and 14-1)

“Are level 1s that rarely transfer out (2 specialized cases/year) required to have transfer agreements with receiving facility?” (Level 1)

While the occurrences of transfers will be very limited for Level I trauma centers, transfer agreements are still required.

There may be one all encompassing transfer agreement that specifically addresses the noted standards.

Limited Activation Tier (CD 5-16)

“Once the Level II is activated and the ED physician receives the head CT scan that shows small SDH as the only injury can The ED physician just notify Neurosurgery or does the Trauma surgeon need to be notified as well and be responsible for showing up in 30 minutes?” (Level 2)

In this scenario, the injuries and response time for when the Attending Surgeon and/or Neurosurgeon will be required to respond will be based on your institution's guidelines for the Limited Tier (Level II activation). All occurrences must be monitored through the PIPS process.

Limited Tier (CD 5-16)

“On a Level II activation, if the ED physician calls the Trauma surgeon to discuss a patient in the ED but does not request his presence at bedside, can the Trauma surgeon not come or would this be considered a fall out of the Trauma surgeon?” (Level 2)

As reported in the previous slide, requiring the Attending Surgeon's response will be based on your institution's guidelines for the Limited Tier. These guidelines must include the type of injuries and time for when the Attending Surgeon is required to respond. Phone consults are not acceptable. These occurrences must be reviewed through the PIPS process.

Trauma Program Manager (CD 5-22)

“For hospitals that hold separate Level 1 Adult and Level 1 Pediatric verifications, are there specific criteria that surveyors will be looking for to demonstrate that each program has a separate and dedicated TPM? Is it acceptable for both programs to share one budget and staff, with one TPM overseeing/supervising the entire department?” (Level 1)

It is acceptable for combined centers to have a shared trauma budget; however, there should be delineations between the adult and pediatric programs.

Adult Level I and pediatric Level I trauma centers are each required to have a fulltime and dedicated Trauma Program Manager. These positions cannot be shared.

Neurosurgery Backup Schedule (CDs 8-3 & 8-5)

“Neurosurgery is dedicated to the facility (Level I) with in NSR residents in house 24/7-is a back-up call schedule required?” (Level 1)

“If you have a dedicated neurosurgeon covering only one hospital do you need a published back up call schedule?” (Level 1)

If there is dedicated neurosurgery call, there must be a published back-up call schedule or a contingency plan.

Pediatric Trauma Surgeons (CDs 10-21/10-12)

“Do PTCs require pediatric trained surgeons or can a credentialed general surgeon willing to provide surgical services suffice?” (Level 2)

- *A Level II Pediatric Trauma Center (PTC) must have at least one surgeon who is board-certified or eligible for certification by the American Board of Surgery (ABS) according to current requirements in pediatric surgery (CD 10-21).*
- *In Level I PTCs, there must be two surgeons who are board-certified or eligible for certification by the ABS according to current requirements in pediatric surgery (CD 10-12).*
- *All other surgeons may be credentialed by the institution to provide care to the pediatric population.*
- *The above is also applicable to combined centers.*

Cardiopulmonary Bypass (CD 11-22)

“Can a Level II facility ask for a waiver for CV surgery and bypass equipment?” (Level 1)

The VRC does not grant waivers. In Level I and Level II trauma centers, if Cardiopulmonary Bypass equipment is not available or present, the trauma center must have a contingency plan that includes immediate transfer to an appropriate center. These occurrences must be reviewed through the PIPS process.

Radiologist Liaison (CD 11-39)

“I'm hearing conflicting information regarding if a radiologist liaison needs to sit on the peer review group for a Level 3.” (Level 3)

This is not required at Level III trauma centers.

In Level I and II trauma centers, the Radiology Liaison is required to attend 50% of the peer review meetings.

ICU Coverage (CD 11-51)

“Follow up to February webinar regarding patients admitted to the ICU needing to be seen by a credentialed provider within 15 minutes; would a hospitalist, credentialed to provide care in our ICU meet this criteria?” (Level 2)

Yes, a Hospitalist credentialed to provide care to trauma patients in the ICU may respond to the 15 minute requirement.

ICU Coverage (CD 11-51)

“Level II: Can Trauma APP qualify for 15-minute ICU bedside response? (Both surgeon and Trauma APPs are in house 24/7)?” (Level 2)

The APPs cannot be used to qualify for the in-house ICU physician's bedside response time. This coverage may be done by an appropriately supervised senior surgery resident or an in-house Trauma Attending credentialed to provide critical care.

Advanced Practice Providers (CD 11-86)

“Must APPs have current ATLS if not providing initial trauma assessment?” (Level 2)

If the APP is not clinically involved in the initial evaluation and the resuscitation of trauma patients, there is no requirement to have current ATLS certification.

Universal Alcohol Screening (CD 18-3)

“Do you have to run an alcohol on ALL trauma patients, including ground level falls with head bleeds?” (Level 3)

If these patients are part of your institution's Inclusion Criteria, yes, they must receive a screening for alcohol.

Universal Alcohol Screening (CD 18-3)

“If a patient has documented SBIRT but it states unable to assess and no further interventions, does this attempt count?” (Level 2)

Yes, this attempt does count and must be documented. As noted in the Clarification Document and the Verification Change Log, screening is applicable to eligible patients who are defined as participatory. These occurrences must be monitored through the PIPS process.

Universal Alcohol Screening Tool (CD 18-3)

“When screening for alcohol is it acceptable to use the urine screen instead of blood?” (Level I)

Both are acceptable to be used as a screening tool. The alcohol screening tool will be determined by the institution.

Screening Brief Intervention (CD 18-4)

“For Level 1 & 2 centers, does the ACS specify the % of trauma patients that must receive SBIRT?” (Level 2)

As noted in the Clarification Document and the Verification Change Log for CD 18-3, at least 80% of all trauma patients who are admitted with a stay > 24 hours must receive an alcohol screening. Any of those patients with a positive screening must receive an intervention.

Thanks for your participation!