

Trauma Verification Q&A Web Conference

January 30, 2020

COTVRC@facss.org



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

100+years

The **Committee**
on **Trauma**



VRC VERIFICATION
REVIEW
CONSULTATION

for excellence in trauma centers

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 with instructions on how to claim CE
- ❖ If you have any questions – please email COTVRC@facs.org
- ❖ **CE Eligibility will expire on Tuesday, February 18**
 - ❖ You must watch the webinar prior to February 18, in order to be eligible to claim CE

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.*

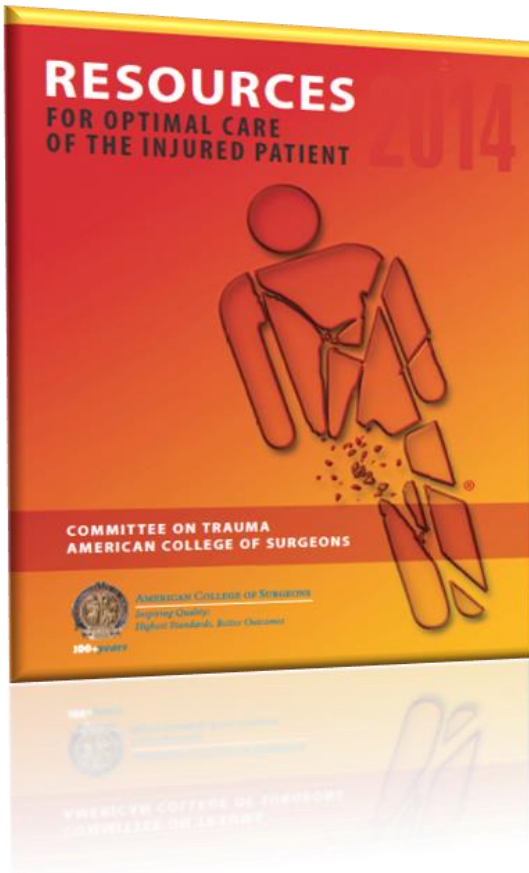
Let's get started!

Orange Resources Book

Available as hard copy or PDF, 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

01/15/20 2020

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

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

- Stakeholder Public-Comment website:

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

- Participant Hub - Account Center:

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

- Expanded FAQ:

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

Site Visit Applications

- Currently, site visit applications are being accepted for **November 2020 and onward**
- **Please Note:**
 - **January – October 2020 is closed**
 - The online application should be submitted at least 13 -14 months in advance of the requested site visit dates and must be before expiration date

Site Visit Application

- The online site visit application can be accessed in the Account Center from the following ACS Trauma website pages:

VRC – Site Visit Application

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

The screenshot shows the VRC Site Visit Application page. The header includes the American College of Surgeons logo and navigation links. The main content area is titled "Site Visit Application" and contains a "Please note" section, an "Applying for a Site Visit" section, and a "Following Your Application Submission" section. A yellow highlight is placed over the link "Access the Site Visit application" in the "Applying for a Site Visit" section.

TQP Participant Hub-Account Center

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

The screenshot shows the TQP Participant Hub Account Center page. The header includes the American College of Surgeons logo and navigation links. The main content area is titled "TQP Participant Hub" and contains a "Welcome" message, a "Join a Program" section, and an "Account Center" section. A yellow highlight is placed over the "Account Center" link in the "Join a Program" section.

Trauma Quality Program Account Center



THE
COMMITTEE
ON TRAUMA

QUALITY PROGRAMS
of the AMERICAN COLLEGE
OF SURGEONS

[ACS Home](#) [Home](#) [Contact Us](#) [Log Out](#)

Welcome: Rachel Sanchez
Chicago Bears Hospital

Thank you for visiting the Trauma Quality Programs Account Center!

We have made some updates and created a few new sections to make your experience on the Account Center even better. For more information, please review the updated [Navigating the Account Center Resource Guide](#).

If you are a current participant in one of our Trauma Quality Programs, you will be able to use this site to maintain contacts at your facility, keep your facility information up to date, access education, link out to submit data and access reports, and much more!

If you are applying to join a Trauma Quality Program, welcome! We've received your initial application and we're glad you're here. In addition to completing this profile, the TQP team will be working with you on the following items: BAA and payment. All of these items need to be complete in order for you to be fully enrolled in NTDB. In order to be fully enrolled in TQIP, a fully executed Hospital Participation Agreement, provided by ACS Trauma Staff, will also be required. To be an ACS Verified Trauma Center, in addition to submitting a Site Visit Application, completing the Pre-Review Questionnaire, and passing your Verification site visit, you must also enroll in a risk-adjusted benchmarking program (CD 15-5). TQIP best meets this requirement. Other risk-adjusted benchmarking programs will be considered and must include the components outlined in the [CD 15-5 Requirements and Rationale document](#).

To submit your facility's information, please first click the "Save" button in each section. The "Submit" button at the bottom of the screen will only appear when all required fields are completed and saved.

▸ 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

▸ Help

► 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
 ACS 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		

► Requested Site Visit Applications

► Access the Data Center

► Resources

- 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

Trauma Quality Program Account Center

Guide to ACS Trauma Quality Programs Roles							
ACS Trauma Quality Programs Role	Common Job Titles	Account Center Permissions				Data Center Permissions	
		Edit Own Contact Information	Add/Edit/Delete Other Contacts	Assign Roles to Self and Others	Request to Join Another Program or Request an ACS Site Visit	Submit Data	Access Reports
Data Abstractor	Trauma Registrar, PI Coordinator	X				X	X
Data Primary Contact	Trauma Program Manager/Coordinator/Director	X	X	X	X	X	X
Pediatric Data Abstractor	Trauma Registrar, PI Coordinator	X				X	X
Pediatric Data Primary Contact	Pediatric Trauma Program Manager/Coordinator/Director	X	X	X	X	X	X
Pediatric Trauma Medical Director	Pediatric Trauma Medical Director	X					X
Site Visit Primary Contact	Trauma Program Manager/Coordinator/Director	X	X	X	X		
TQIP Program Contact – Other		X				X	X
TQP Billing	Accounts Payable Department	X					
Trauma Medical Director	Trauma Medical Director	X					X
VRC Program Contact - Other		X					
VRC Hospital Administrator	President, VP, CEO, COO, CNO, etc.	X					

- Centers are responsible for updating and managing their own facility and staff contact information.
- Use the “Guide to ACS Trauma Quality Programs Roles” table to help determine which roles to assign any new contacts.
- ACS Trauma staff will be notified of any additions so that we can connect new users with program education as appropriate.

Current Contacts						
		Add New Contact	Change Primary/Billing Contact			
	Name	Role(s)	Title	Primary Contact	Billing Contact	
Edit Delete	Jake Arrieta	Data Primary Contact, VRC Hospital Administrator	Registrar	No	No	
Edit Delete	Jake Arrieta	Data Primary Contact, VRC Hospital Administrator		No	No	
Edit Delete	Bhumi Parikh	Data Abstractor		No	No	
Edit Delete	Anita Johnson	Data Abstractor, Site Visit Primary Contact		No	No	
Edit Delete	Olivia Matongo	Data Abstractor	Program Manager, PIPS	No	No	
Edit Delete	Yoshi Dinosaur	Data Abstractor, Data Primary Contact, Pediatric Data Abstractor, Pediatric Data Primary Contact	Trauma Registrar	No	No	
Edit Delete	Claire Dooms	Data Abstractor, Data Primary Contact		No	No	

New Participation Fee Schedule

- Effective July 1, 2020, the participation fee will increase.
- For a listing of the new fee structure at:
<https://www.facs.org/quality-programs/trauma/tqip/center-programs/vrc/fees>.
- The Trauma Quality Program includes participation in both TQIP and VRC.
- If you have specific questions about your trauma center's next invoice, please feel free to contact us at:
traumaquality@facs.org.

Reverification Visit

“Concerning re-verification visit. How soon are you informed if you will have your visit on your requested dates?” (Level 1)

The center should expect to receive a confirmation email by approximately 120 days before your center's site visit.

This would be the same regardless of the type of visit:

- *Consultation*
- *Verification*
- *Reverification*
- *Focused onsite*

Verification Visit

“What is the process/requirements for requesting a different reviewer?” (Level 2)

When completing the online site visit application, if there is a reviewer the program believes there is a potential conflict of interest, please add a note in the “comments” section. This will ensure that the reviewer will not be asked to review your program.

Trauma centers are discouraged from requesting reviewers. If a request is made for a specific reviewer, there is no guarantee that that reviewer will be scheduled on the visit.

Announcements

Introducing a NEW Course



Advancing Leadership in Trauma Center Management

*A multidisciplinary approach to
leading your trauma program to excellence*

facs.org/altcm | ALTCM@facs.org



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- May 14-15, 2020 in Chicago, IL at ACS headquarters
- Registration will open mid-March
- Visit www.facs.org/ALTCM for more information

Quarterly Webinar Schedule

VRC Web Conference Schedule

1st Quarter VRC Web Conference

January 30, 2020

2nd Quarter VRC Web Conference

April 30, 2020

3rd Quarter VRC Web Conference

July 2020

4th Quarter VRC Web Conference

October 2020

Next Verification Q&A Webinar

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

Webinar Time: **12:30 PM Central Time**

Deadline to submit questions: **Tuesday, April 14th**

Tell us what YOU want!

Let us know the topics you'd like us to cover in future webinars! Reach out to us at cotvrc@facs.org with your suggestions today, or mention them in your feedback survey for this webinar.

Future topics may include:

- Alternate Pathway
- Specific chapter discussions
- The peer review process for verification reports

Special Segment Board Certification

Required Board Certification

- Trauma medical director (TMD)
- General/trauma surgeons
- Emergency Medicine liaison and physicians
- Neurosurgery liaison and neurosurgeons
- Orthopaedic liaison and orthopaedic surgeons
- Anesthesiologist liaison
- Radiologist liaison (Level I-II)
- ICU liaison/director
 - Board eligibility for certification by the American Board of Medical Specialties (aka board eligible)

TMD, Liaisons, and Panel Members

Level I, II, and III Trauma Centers	Current Board Certified	ATLS		CME External (trauma-related) 36 CME	Peer Review Attendance (50%)
		Once	Current		
TMD - Must chair trauma peer review meetings	I, II, and III		✓	I and II	✓
Trauma Surgeons	I, II, and III	✓			✓
Specialty liaisons and panel members:					*
Emergency Medicine Physicians	I, II, and III	✓	(Refer to next slide)		✓
Orthopaedic Surgeons	I, II, and III				✓
Neurosurgeons	I, II, and III				✓
Critical Care	I, II, and III				✓
Anesthesiologist (Liaison only)	I, II, and III				✓
Radiologist (Liaison only)	I and II				✓

* A combined 50% may include liaison and/or predefined alternative representative

Emergency Medicine Physicians

- Advanced Trauma Life Support (ATLS)
 - Physicians boarded in Emergency Medicine (EM) must have taken the ATLS course at least once.
 - Physicians boarded in Family Medicine, Pediatrics, or any other specialty must be current in ATLS.
- The VRC does not recognize boards through the American Board of Physician Specialties (ABPS).
- In Level I and II trauma centers, physicians boarded in Family Medicine or other non-EM specialties who completed primary training in 2016 and beyond are not eligible to serve on the trauma call panel.
 - The above does not preclude the physician from working in the Emergency Department (ED), on other patients, but that particular ED must have someone who meets the requirements seeing trauma patients and responding to trauma team activations.

ICU Surgical Director

- Level I trauma center – The ICU surgical director must be a board-certified general surgeon (i.e., not internist, pulmonologist, orthopaedic surgeon, etc) with current board certification in Surgical Critical Care.
 - Level I Pediatric trauma centers – are required to have a board certified general surgeon, but is not required to be board certified in Surgical Critical Care.
- Level I Pediatric trauma center and Level II trauma centers – The ICU surgical director must be a board certified general surgeon, and should be board certified in Surgical Critical Care.
- Level III trauma centers – The ICU surgical director or the co-director must be a general board certified surgeon.

Alternate Pathway Criteria (APC)

- Providers (surgeons & EM physicians) who are not board certified in the United States or Canada who were inducted as a Fellow of the ACS prior to January 1, 2017 are not required to go through the APC process.
- Providers who are not board certified in the United States or Canada who were inducted as a Fellow of the ACS after January 1, 2017 must apply and have an onsite APC review.
- If a provider at your facility was approved for the APC in a previous review, you will answer the board certification question in the PRQ “Yes.”

15. Are all of the neurosurgeons who take trauma call U.S. or Canadian board-certified/eligible for certification according to the current requirements? (CD 8-10) Type II / L1-3	<input checked="" type="radio"/> Yes <input type="radio"/> No
a. What is the number of neurosurgeons on the call panel?	<input type="text"/>
b. List all neurosurgeons taking trauma call on Appendix #5.	

Alternate Pathway Continued

Providers not board certified in the United States or Canada or not previously approved for the APC at your facility must apply and have an onsite APC review.

- Please indicate on the online site visit application or contact ACS Office if the application has already been submitted.
- Providers who were previously approved through the APC process will not need to repeat the process while at the same facility, but will require 36 hours of external CME and PI case assessment by the TMD.
- Onsite evaluation of the eight criteria will be assessed (ATLS, CME, meeting attendance, etc), along with review of clinical care during verification visit by a member of the same specialty.
- TMD and radiology liaison cannot undergo review by way of the APC.
- Refer to the APC document at: www.facs.org/quality-programs/trauma/tap/center-programs/vrc/resources

PRQ Appendices

Name	Residency - where and when completed		Board Certification (type and expiration year)	
	Where	When	Type	Exp. Year
Surgeon #1	Hospital #1	2019	S	2020 (MO)
Surgeon #2	Hospital #2	2009	DO	2020
Surgeon #3	Hospital #3	1994	CC	2025
Surgeon #4	Hospital #4	2018	S	BE
Surgeon #5	Hospital #5	1995	S	Prev APC

- The American Board of Surgery and American Board of Pediatrics have transitioned its policy to no end date for board certification. If your program has providers that fall under this new policy, add their most recent expiration date in the PRQ and add a note next to the expiration date column to indicate that they are meeting the requirements of continuous certification (CC) or maintenance of certification (MOC).
 - Documentation of participation in MOC/CC must be available onsite.
- Indicate “BE” for providers who are board eligible.
- Indicate “Prev APC” for providers who were previously approved by way of the APC process.

Additional Notes

- Locum tenens must meet the same requirements (board certification, OPPE, peer review attendance, etc).
- Board eligibility will meet the requirements.
- Continuous certification (CC) or maintenance of certification (MOC) meets CME requirements for all providers except for the TMD and APC provider.
- The American Academy of Neurologic Surgery is not recognized as a board certifying organization.
- The VRC will only monitor the compliance of providers who are involved in the treatment of trauma patients.

General Questions

New TMD

“If there is potential to train an incoming TMD is it possible to have them review charts with auditing from the current TMD?” (Level 3)

This would be an acceptable practice.

ATLS Requirement

“Does the Critical Care liaison for trauma have to be current in ATLS?” (Level 3)

There are currently no ATLS requirements for the critical care (ICU) liaison.

Provider Contracts

“Does the TMD need a separate agreement/contract with the organization or can the role be included in the original provider agreement? We currently have them as two separate contracts but would like to consolidate if possible.” (Level 2)

The VRC does not have any requirements for the TMD or for any of the providers to have separate agreements and/or contracts. This will be determined by the hospital’s Medical staff office.

Diversion

“I am from a Level II freestanding Pediatric Trauma Center. During respiratory season we have limited PICU resources so trauma patients are handled on a case by case basis. We accept all EMS ground scene runs for evaluation, stabilization then consideration for transfer if needed. All aeromedical scene runs are diverted to avoid double transfers. Trauma patients at an outside ED are accepted/diverted on a case by case basis with input from the Trauma surgeon, ED physician, PICU attending and nursing bed control. During the last month we have diverted a handful of medical patients and 1 trauma patient from another facility. When I fill out the Trauma Bypass Occurrences form what should I put for the time the bypass ended?” (Level 2)

Based on the limited information provided, if the trauma center, as an example, is unable to accept PICU patients due to no bed availability, the end time would be based on when it opened back up to accept patients.

Diversion

“There are differing opinions on whether we have to go on diversion when MRI is down. We would like clarification from ACS and the Chair of the VRC committee.” (Level 1)

The reason for diversion can vary by trauma center. Some common reasons for diversions include lack of resources, equipment failure, internal hospital disaster, etc. Having said this, MRI capability is a requirement and it must be available 24 hours per day at Level I and II trauma centers (CD 11–45). If the MRI equipment is down, this would be a reason for the trauma program to go on diversion.

Trauma Peer Review Meeting Attendance

“What is the PIPS attendance requirement (in percentage) for the TMD?” (Level 1)

To clarify, Peer Review meetings are also referred to as the PIPS meetings.

The TMD cannot appoint an alternate, so they must chair and attend 50% of the peer Review/PIPS meetings. For example, the trauma center has 12 meetings per year, the TMD must chair and attend six of those meetings to be compliant. The Associate TMD, which is typically another trauma surgeon, may chair the other six meetings, but that surgeon's attendance cannot be combined with the TMD's attendance.

Trauma Peer Review Meeting Attendance

“Do physicians that have met APC requirements at a prior survey have to maintain 50% meeting attendance even if they are not a specialty liaison? For example we have 2 neurosurgeons that have been approved through the alternate path in previous surveys. Do both need to maintain 50% meeting attendance on an ongoing basis?” (Level 1)

No, the previously approved APC Neurosurgery providers or any other specialty providers are not required to meet the 50% Peer Review meeting attendance on an ongoing basis. Since they were previously approved, they will only need to meet criteria #3 (CME) and #7 (PIPS case review) as noted on the APC document at all subsequent site visits.

<https://www.facs.org/-/media/files/quality-programs/trauma/vrc-resources/alternate-pathway-criteria.ashx>

Trauma Peer Review Meeting Attendance

“Is there a meeting attendance requirement for trauma mid-level providers who are actively & consistently involved in the trauma resuscitation and care of trauma patients?” (Level 1)

There are no Peer Review meeting attendance requirements for trauma Advanced Practice Providers (APP/mid-level providers) providers. Although not required, it would be recommended for the APPs to attend the Systems/Operational Committee meetings as trauma topics may be discussed.

Trauma Systems/Operations Committee Meeting

“At our recent review we were told that the liaisons **MUST** attend the Multidisciplinary Operations meeting (not the PI meeting). This is not in either the Orange Book or the Clarification documents and there has been webinars where we were told there was not an attendance requirement. Is there now an attendance requirement for Ortho/NSR etc. to attend the programs operations meetings?” (Level 1)

The multidisciplinary Systems/Operations Committee meeting does not have an attendance requirement. It is typically attended by various medical staff members. It is strongly recommended for liaisons to attend, but not required.

Trauma Systems/Operations Committee Meetings

“We will have a separate Peds Peer Review committee, however, is it appropriate to have a combined Adult/Peds Hospital Operations committee? (Do they need to be separate meetings?) Re: ATCTC” (Level 3)

Yes, the Systems/Operations Committee meetings may be held together.

Mortality Classification

“When determining Mortality with or without OFI: If there is an opportunity noted with systems or other PI issue that does not relate to the mortality, should the overall determination for mortality be w OFI or w/o OFI?” (Level 1)

This is what we sometimes call a “gray zone.” The best way to look at this is to not categorize the case, but look at it from the point of whether there was an opportunity for improvement (OFI). Virtually every case one can find some OFI. However, if every death that was expected did not list some OFI the program would be missing many OFIs.

It is recommended that if you do find OFIs, err on the side of making it a Mortality with OFI rather than not. This leads to both a discussion and learning tool during the peer review committee meeting, but also serves as a method for your PI coordinator (if you have one) to track what the OFI was.

If there is a consistent issue with poor scribing for instance, this may be easily noticed and eventually lead to action and improvement if it were categorized as an OFI.

Remember that lack of event identification is itself a CD (CD 16-10, also relevant are CDs 16-18 and 16-19).

If reviewers don't see that you are looking for and identifying issues, they can cite the above CDs.

Mortality Review

“Who is the best person/service to review off service deaths? A recent webinar said that hospital quality was not, but currently they review all hospital mortalities. EX- an elderly pt with a hip fx never on trauma service dies. Who decides the classification of the mortality?” (Level 1)

If the patient met NTDS Inclusion Criteria and was not admitted to the Trauma Service, but instead to, for example, Medicine, the mortality would be reviewed by the Trauma Service.

It is reasonable for all mortalities to be reviewed by the Hospital's QA once the Trauma Service has signed off, or vice versa.

Nursing Education

“What is specifically required for nursing education? We currently TNCC for the ED nurses, and an alternative plan for ICU and the inpatient units. During our review in 2019 the lead reviewer indicated that TNCC wasn't required and we could develop our own nursing education plan, please provide guidance as to what the education should look like.” (Level 3)

The VRC does not have a requirement regarding TNCC completion. While there are no specific education/certification requirements for nurses caring for trauma patients, the trauma center must provide a mechanism to offer trauma-related education to nurses (CD 17-4). Therefore, the trauma center may develop its own nursing education plan that follows the TNCC curriculum or similar.

OPPE Template

“Is there a template for OPPE process?” (Level 2)

There are a few OPPE templates on the VRC Resources Repository website.

To clarify, the expectation is that the TMD is conducting an OPPE for their panel members and has oversight over what the OPPE process contains relative to the trauma program. This may be in the form of a score card, template, or report.

The data points should include, but are not limited to:

- *Peer review attendance*
- *CME if mandated by the trauma center*
- *Patient care*
- *Medical/clinical knowledge*
- *Complications, mortality rates, and participation in evidence-based guidelines, pathways, and protocols*
- *Interpersonal and communication skills*
- *Professionalism*

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

OPPE For Providers

“Is there a specific, finite list of Trauma Program personnel on whom OPPE must be documented and available to reviewers during a site visit? Is this posted somewhere on the ACS website? I have templates, but am still confused about exactly who needs to have an OPPE form completed (e.g. all ED providers, or just the liaison? All Orthopaedists, or just the Ortho liaison? All Trauma Surgeons? All MDQA liaisons, including Critical care, Radiology, Anesthesiology? Thank you, I know you frequently get questions about OPPE.” (Level 1)

All providers and APPs who are involved in the care of the trauma patients are required to have an OPPE. This includes, the following:

- *Trauma surgeons*
- *Orthopaedic surgeons*
- *Neurosurgeons, if applicable*
- *Emergency Medicine providers*
- *ICU*
- *Radiology*
- *Anesthesia*
- *APPs for EM and Trauma Services*

PI Process

“During a recent site visit, the reviewers recommended to add hospital medicine to the peer review process related to perioperative management of isolated geriatric hip fractures that die or have withdrawal of care. All trauma deaths [including isolated hip fractures] are reviewed through the trauma PIPS process. All hospital deaths are reviewed by the medicine quality process. This information is shared between trauma and medicine. Would the medicine quality review fulfill this recommendation?” (Level 2)

If the information is shared between the Trauma Service and Medicine Quality process, this practice is acceptable. However, all trauma mortalities must still be reviewed by the Trauma Service for OFIs.

PI Process

“Are there mandatory cases for review at the multidisciplinary PIPS meeting? Do all transfers out, all mortalities, all transfers in, etc. require discussion at PIPS if there are no identified OFIs during primary or secondary review?” (Level 2)

In addition to requiring all trauma mortalities to be reviewed at the Peer Review meetings, this would include any medical cases in which an OFI was identified.

PI Template

“Is the ACS developing a PI template that we all can use?” (Level 3)

With the new Resources revision process, we hope to develop a guide on PIPS best practices.

PRQ Burn Patients

“For trauma centers that have a burn center within the same facility, how should we respond to the PRQ questions below?
4. Number of burn patients transferred for acute care during reporting year. • Transferred In: • Transferred Out: 5. Does the trauma center that refer burn patients to a designated burn center have in place a written transfer agreement with the referral burn center? (CD 14–1) Type II / L1-4 (Yes/No)” (Level 1)

CD 14-1 would not be applicable to your program since there is a burn center within the same facility and transfer agreements are not needed.

If there were burn patients with a mechanism of injury (MOI) that required to be transferred out for acute care to a specialty hospital, those should be reported in the “Transfer Out” data field.

PRQ Reporting Year

“If our PRQ questionnaire will be over 2 reporting years what do we use as the inclusion criteria. Ours will be over 2019 and 2020.” (Level 1)

My understanding of this question is that the verification reporting year falls within the use of both the 2019 and 2020 NTDS Inclusion Criteria, and you want to report the appropriate data for the PRQ. In this instance, you want to identify the reporting year and run two sets of reports based on the number of months you were using the 2019 and the 2020 NTDS Inclusion Criteria. For example, if the reporting year is 6/1/19 – 5/31/20, you will need to run two registry reports based on the following dates:

- 1. 6/1/19-12/31/19*
- 2. 1/1/20-5/31/20*

PRQ Reverification

“For re-verification, how far in advance does the PRQ need to be submitted? Is there a difference in submission lead time for re-verification at a higher level versus if re-verifying at the same level?” (Level 2)

The completed “Marked Closed” PRQ must be submitted 30 days in advance of the scheduled site visit regardless of the level or the visit type (i.e. consultation, verification, or reverification).

Other Surgical Services

“Please clarify which specialties below are considered ‘Surgical’ vs ‘non-Surgical’: Dental, ENT, Hand, OB-Gyn, Ophthalmology, Oral Surgery, Plastic Surgery, Urology”
(Level 3)

Based on the options provided, the following are surgical services:

- *Otolaryngology (ENT)*
- *Hand*
- *OB-GYN*
- *Ophthalmology*
- *Oral-Maxillofacial*
- *Plastic*
- *Urology*

Taxonomy

“How is the ACS-COT reviewing taxonomy for trauma PI? Is it strongly encouraged for our PI plans?” (Level 2)

Currently, there are no requirements to use taxonomy for verification purposes.

Tertiary Exam

“Tertiary exam - when should the tertiary exam be performed? Would like to know the earliest and the latest timeframe this should occur.” (Level 2)

My understanding of this question is that this is a tertiary exam of a trauma patient. For best practice, the patient should be admitted to the Trauma Service for the first 24 hours to undergo a tertiary exam, and then transferred to a different specialty, if needed, once it is known that there were no other injuries.

Transfer

“What is the ACS guideline regarding the obtainment of diagnostic tests (i.e. CT scans) prior to transferring a pediatric trauma patient to a receiving hospital? With the capability to share radiographic images between hospitals; is there a change in previous recommendation to stabilize and send so as not to delay transfer?” (Level 1)

Depending on the injury, best practice would still be to stabilize and transfer the patient as to not to delay care (especially if transport is ready).

Washout Guidelines

“What is the ACS time interval in hours between arrival and initiation of debridement on an open tibial fracture?” (Level 2)

“There is conflicting information regarding definitive treatment in the OR for Open Tibia fxs. I have heard 8hrs, 12hrs, 24hrs, and that it is not required for Grade 1 & 2 fractures. Can you please clarify the expectation for ACS?” (Level 2)

From the COT-VRC orthopaedic group's standpoint, they expect to see that trauma centers are getting open tibias operatively debrided within 24 hours as a standard. In contrast, antibiotics should be given within 1 hour.

Geriatric Trauma Activation Criteria

“Our geriatric trauma activation criteria includes the same criteria for highest TTA and midlevel TTA. We also have any identified injury on patients that are on anticoagulants/antiplatelet agent who do not meet the highest or midlevel criteria are to be evaluated by trauma. What other activation criteria would you suggest?” (Level 2)

We often recommend trauma centers that see a fairly large number of geriatric patients to develop activation criteria. What you have noted is acceptable, and you may also want to consider the following:

- *Falls above ground level in age > 65*
- *Traumatic mechanism in a patient with a known bleeding disorder or use of anti-coagulant/anti-platelet medication*

For additional information, refer to the TQIP Geriatric Trauma Management Guidelines: https://www.facs.org/-/media/files/quality-programs/trauma/tqip/geriatric_guidelines.ashx

Trauma Admissions

“Can you provide some clarity on isolated injuries (hip vs petechial bleed) with regards to trauma admission.”

(Level 3)

The admitting 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 the potential of additional injuries. However, the center may admit the patient to Medicine Service with a surgical consult. Both methods are acceptable. The take away is that all nonsurgical admissions are evaluated for appropriateness of care.

Trauma Consults

“Do trauma consults that are admitted with isolated head injury require trauma surgeon evaluation and should they be admitted to trauma for 24 hours?” (Level 3)

For best practices, if the patient meets NTDS Inclusion Criteria, they should receive a trauma surgeon evaluation to rule out any other injuries. If no other injuries are identified, the patient may be handed over to the Neurosurgery Service.

Volume Requirements

“With the 2020 changes to the NTDS inclusion criteria, will trauma activations that are discharged home be counted in the 1200 volume requirement?” (Level 3)

For the verification program, if the patient is admitted with a stay equal to or greater than 24 hours, that patient admission will count to meet the volume requirement.

Massive Transfusion Protocol (MTP)

“Please discuss the MTP requirements ?” (Level II)

All trauma centers must have a MTP developed collaboratively between the Trauma Service and the Blood Bank.

The VRC does not require specific criteria for the MTP. However, it should provide, but not limited to, the following:

- *Role of the attending*
- *Role of the RN in charge*
- *Role of the Blood Bank*
- *What blood and/or plasma is available*
- *Procedure for use of blood and/or plasma components*
- *Patient management during MTP*
- *Terminating the MTP*

CD-Related Questions

Trauma Attendings (CD 2-6)

“Can the surgical fellow be on call as the trauma attending in a level 1 trauma center?” (Level 1)

If the surgical fellow is board certified or board eligible, they may act as the attending surgeon.

Diversion (CD 3-6)

“CD 3-6 Are you looking at overall EMS diversion (medical, trauma, stroke, stemi, all) to be less than 5%. Or, are you looking at trauma specific diversion to be less than 5%? For example: Occasionally, we go on EMS bypass/diversion for medical patients only and still accept trauma, stroke and stemi patients. Would this count towards the 5% or not?” (Level 3)

The tracking and reporting of the diversion rate only refers to the trauma occurrences. To answer your question, you would not count medical patients diversion occurrences toward the 5%.

Trauma Medical Director (TMD) (CD 5-5)

“In CD 5-5 ‘The TMD must be a current board-certified general surgeon (or a general surgeon eligible for certification by the American Board of Surgery according to current requirements) or a general surgeon who is an American College of Surgeons Fellow with a special interest in trauma care and must participate in trauma call.’ Clarification was added that stated ‘TMD must be full-time, permanent, dedicated to one trauma center.’ What does ACS mean by dedicated to one center. Does that mean they cannot take call at another facility?” (Level 1)

This is correct. The TMD can only direct one trauma center/program. They cannot take call at another facility while on call. It is conceivable that the TMD, when off duty, could take call at another trauma center.

Orthopaedic Surgery Backup Call Schedule (CD 9-12)

“Question about CD 9-12. Do trauma centers need to have a back-up orthopedic call schedule for this scenario? The same orthopedic provider is on-call for 2 sister hospitals simultaneously (a Level III and a non-trauma center). An in-person response IS required for the Level III center and NOT the non-trauma center hospital. The non-trauma center will transfer to the trauma center after calling/consulting the on-call ortho provider. Does this scenario need a published back-up schedule?”
(Level 3)

In Level III trauma centers, if the orthopaedic surgeon is not dedicated to a single facility while on call (is on call at multiple facilities), a published backup call schedule is required.

ICU Coverage (CD 11-51)

“CD11-51 Appropriately trained physicians must be available in- house within 15 minutes to provide care for the ICU patients 24 hours per day. Does this require the ICU attending to be in house 24/7, or just available within 15 minutes of being called? Additionally, does ‘after hours’ coverage by a midlevel provider satisfy this as long as there is an on call physician as well?” (Level 2)

The ICU attending must respond within 15 minutes at bedside of being requested (paged). APPs cannot be used to qualify for the in-house ICU physician’s bedside response time. This coverage may be performed by an appropriately supervised senior surgery residents (PGY4-5) or an in-house trauma attending credentialed to provide critical care.

Microvascular Surgery (CDs 11-70/11-71)

“On the clarification document, (CD 11-70, 11-71) it discusses microvascular requirements. Can you clarify this statement, ‘Furthermore, the microvascular capability is not required 24/7, just that it is available when a consult is requested’.” (Level 1)

The facility must have a microvascular surgeon, or coverage may be satisfied by having a surgeon who can use an operating microscope for nerve repair, free tissue transfer, and so forth. The Microvascular Surgery capability is not required in-house 24/7, but there must be a surgeon consultant available to respond, in person, based on the institution’s predetermined response time for the consultation. This standard is applicable to both Level I and II trauma centers.

Rehabilitation Services (CD 12-1)

“CD 12-1 Are you looking for the usual rehab services: Occupational therapy, Physician Therapy, Speech Therapy, Social services, etc. within the hospital or, are you expecting a full Rehabilitation unit with patient beds within the hospital structure?” (Level 3)

To clarify, “Rehabilitation Services” is defined as occupational therapy, speech therapy, and physical therapy. In Level III, only physical therapy is required.

Rehabilitation Services are required for all trauma centers. However, this could be met with a full rehabilitation unit (i.e., beds) within the hospital, or through a transfer agreement with an outside rehabilitation facility.

Trauma Registry Closed Cases (CD 15-6)

“Since 80% of cases are due within 60 days of discharge, when is the remaining 20% due?” (Level 1)

The 80% is a threshold to ensure that the trauma cases are closed within 60 days of discharge. It is expected that the remaining cases will follow suit.

Critical Care Surgery Fellowship (CD 17-3)

“Does/Will the ACS COT consider a critical care surgery fellowship program to be equivalent to a surgical residency program for purposes of meeting Level I requirements?” (Level 2)

This will not be accepted. The expectation is that the Level I trauma center must have a continuous rotation in General Surgery for senior residents (PGY 4–5) on the Trauma Service.

In Level I Pediatric trauma centers, this may be met with a PGY 3-5 on the Trauma Service.

Injury Prevention Coordinator (CD 18-2)

“Is a dedicated, fulltime injury prevention FTE/position required for Level I verification? Can that person have other duties/responsibilities such as performance improvement and registry work?” (Level 2)

For a Level I trauma center, the injury prevention coordinator does not need to be a full-time position or dedicated to the trauma program. This individual may be shared with the Trauma Service and hospital's prevention activities. This role cannot be shared with the TPM.

Alcohol Screening (CD 18-3)

“If another trauma center completes the alcohol screening questionnaire before transfer out, is the receiving facility also required to complete an alcohol screening after patient arrival?” (Level 2)

Yes. All patients that are admitted to the trauma center (with a stay equal to or greater than 24 hours) must receive an alcohol screening.

CME

CME (CD 6-10)

“Could you please clarify the most recent CME requirement changes for the Trauma Liaisons? CD 6-10”

(Level 2)

“Do all surgeons (Neurosurgery, Orthosurgery, Trauma) need 36 hours/3 years of external CME or just the TMD?” (Level 2)

“What is the recommended/required CME for staff at a Level I center? (staff: Liaisons, AP, ED physicians)” (Level 1)

“What additional services; if any, (i.e.: Anesthesia, Radiology) must have 36 hours of external trauma related CME for the purposes of the ACS Re-verification Site Survey?” (Level 2)

CME Requirements

Levels I and II trauma centers	<u>MEETS CME REQUIREMENT</u> Through current Board eligibility Life-time Boards (grandfathered) Board certification (MOC/CC)	REQUIRE 36 External CME (External trauma-related)*
TMD / Pediatric TMD		✓
Alternate Pathway		✓
Trauma program manager (CE)		✓
Liaisons and all specialty panel members (trauma/pediatric trauma, neurosurgery, orthopaedic, emergency medicine, ICU, anesthesia, and radiology)	✓	
Panel Surgeons/Physicians	✓	

- Required for TMD, TPM, Alternate Pathway
 - TMD is required to have 36 hours of CME within 3 years
 - TPM is required to have 36 hours of CE within 3 years
 - Prorated CMEs (12 hours) for new hires (based on hire date)
 - Any surgeon who previously was approved by way of the APC is required to have 36 hours of CME within 3 years
 - Prorated CMEs (12 hours) for new providers undergoing review through the APC

External CME

“Can the Trauma Morbidity & Mortality Committee Meeting count as external CME?” (Level 2)

Trauma-related CMEs are acquired through programs approved to provide CME, such as an offsite conferences, online courses or webinars produced and distributed by outside organizations.

CME

“At our recent review I was asked to show the reviews CME for all our physicians .All ours docs are Board Certified and in the MOC program in their specialties - The reviewers seemed surprised we were not collecting CME's. Should we still be collecting CME?” (Level 1)

For verification or consultation visits, maintaining board certification/eligibility/lifetime boards all satisfy the CME requirement.

If there are any questions during a site review regarding CME, please contact the VRC office.

CME

“If there is a newly appointed Liaison (less than one year), how many CME hours are they required to have?”

(Level 2)

For the trauma surgeons, pediatric surgeons, liaisons, and specialty panel members (emergency medicine, neurosurgery, orthopaedic surgery, ICU, anesthesia, and radiology) who are participating on the trauma call panel, maintaining current board certification satisfies the CME requirement.

Thanks for your participation!