

Trauma Verification Q&A Web Conference

January 28, 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.*

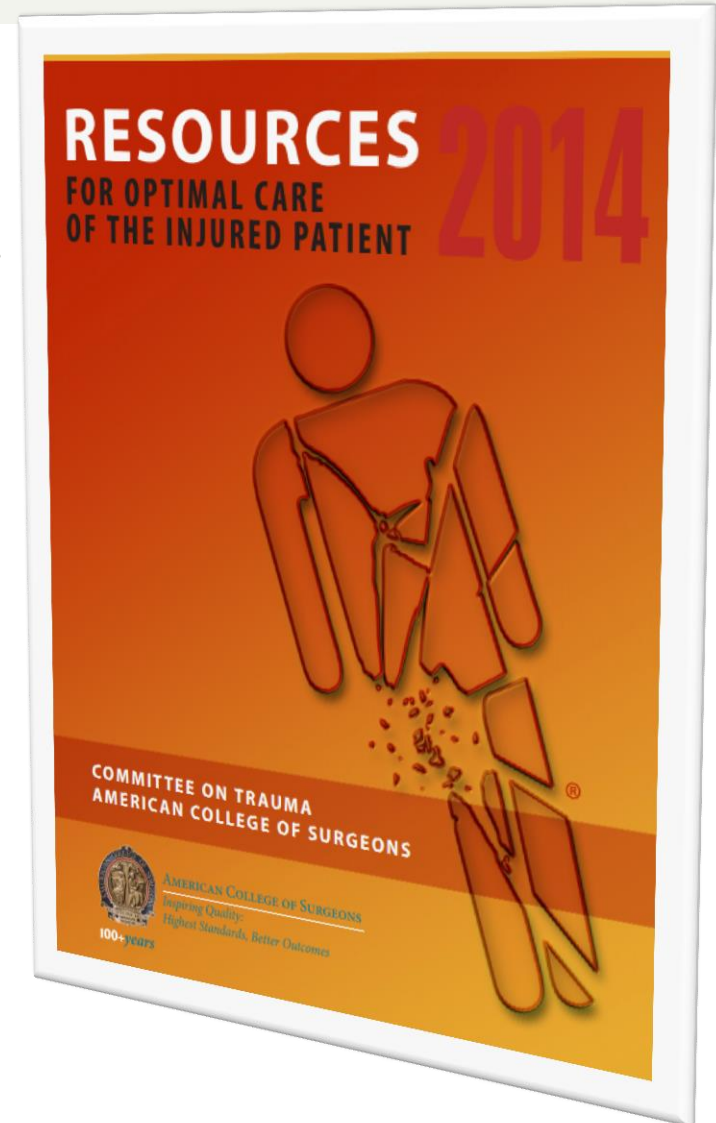
Let's get started!

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/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/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	IV	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	IV	I	II	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 & Updates

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 navigation bar includes: Member Services, Quality Programs, Education, Advocacy, Publications, About ACS. The breadcrumb trail is: American College of Surgeons > Quality Programs > Verification, Review, and Consultation Program for Hospitals > Site Visit Application. The page title is "VRC VERIFICATION REVIEW CONSULTATION for excellence in trauma centers". The main content area is titled "Site Visit Application" and contains the following text: "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." It also includes sections for "Applying for a Site Visit", "Following Your Application Submission", and "Cancellation Policy". A yellow highlight is present over the text: "Access the Site Visit application".

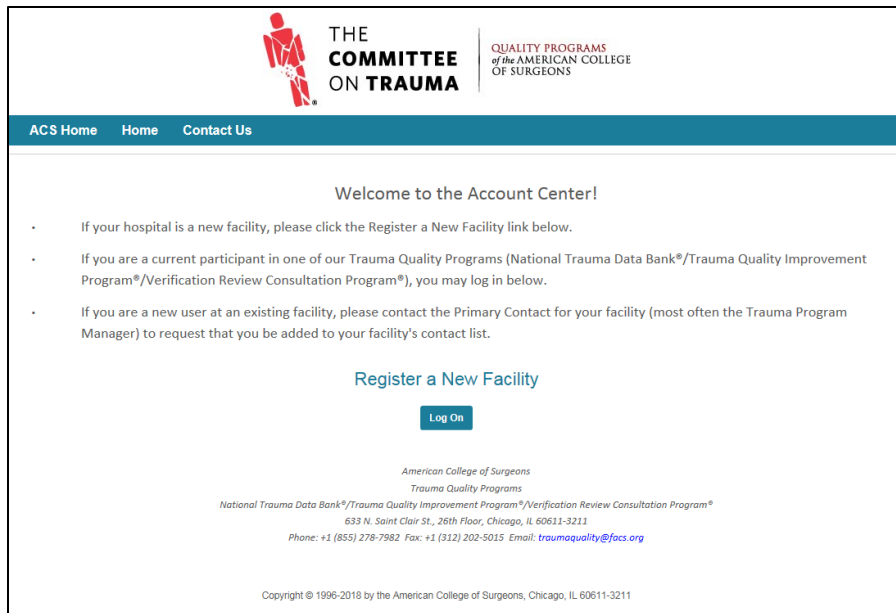
TQP Participant Hub-Account Center

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

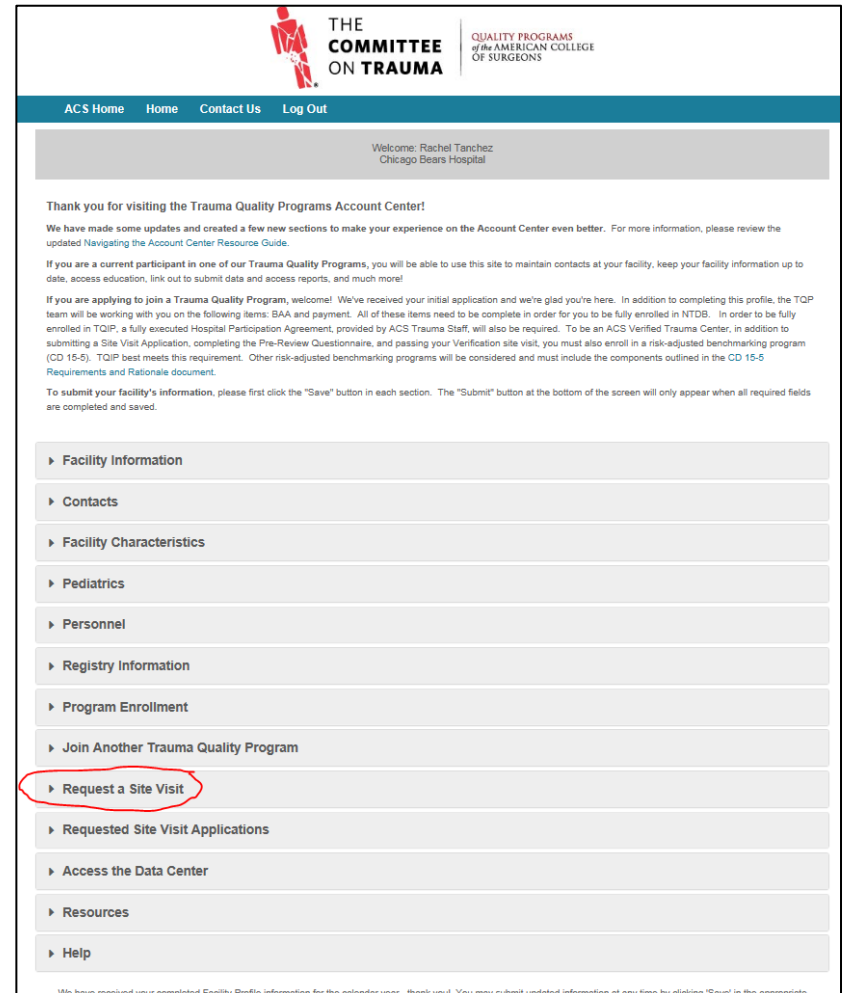
The screenshot shows the American College of Surgeons website with the navigation menu: JACS | Jobs | Events | Find a Surgeon | Patients and Family | Contact | My Profile | Shop | Donate. The main navigation bar includes: Member Services, Quality Programs, Education, Advocacy, Publications, About ACS. The breadcrumb trail is: American College of Surgeons > Quality Programs > Trauma Quality Programs > TQP Participant Hub. The page title is "TQP Participant Hub". The main content area is titled "TQP Participant Hub" and contains the following text: "Welcome to the ACS Trauma Quality Programs (TQP) Participant Hub! If your hospital is a new facility, please click on Join a Program below." It also includes sections for "Join a Program", "Account Center", "Data Center", and "Training Resources". A yellow highlight is present over the text: "Account Center".

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 is titled 'Welcome to the Account Center!' and contains 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. The top navigation bar includes '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, followed by instructions on how to use the site and how to apply for a new facility. A list of menu items is displayed on the right side, including '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'. The 'Request a Site Visit' item is circled in red. At the bottom, a footer message 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 **June-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/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:
<https://www.facs.org/quality-programs/trauma/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

Announcements

Next Verification Q&A Webinar

Webinar Date: **Wednesday, February 20th**

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

Deadline to submit questions: **Monday, February 11th**

General Questions

Social Worker

“At Erlanger, we have a Trauma Nurse Navigator (TNN) that works closely with case management on DC, SBIRT and ASD. At our consultative visit we have an OFI due to not having a dedicated social worker to the trauma program. Our solution was to restructure some of the responsibilities of the TNN to include oversight of the SBIRT and ASD pieces. We will most likely not receive an assigned SW due to administrative and budget constraints. Will the restructuring of our TNN role suffice?” (Level 1)

Medical Social Workers are an integral part of the multidisciplinary team who are caring for trauma patients and should be available 24 hours a day, 7 days a week at Level I and II trauma centers. It is not required; therefore, a TNN who has been credentialed by the hospital to provide this care is acceptable.

Non-Board Certified Orthopaedic Surgeon

“Non-boarded ortho, does not meet alternate pathway, has been with the facility for 30+ yrs how can they take trauma cases?” (Level 3)

If the Orthopaedic Surgeon is a Fellow of the ACS who was inducted before January 1, 2017, they would be grandfathered into compliance with the criteria.

If the Orthopaedic Surgeon is not board certified, is not a Fellow, and is not eligible to go through the Alternate Pathway, they cannot care for trauma patients; however, they may care for non-trauma patients.

Advanced Practice Clinicians

“Re: APC roles in activations-if current in ATLS, they can provide care but can't fulfill the response time in any situation?” (Level 2)

The criteria is that Advanced Practice Clinicians/Providers (APC/APP) may participate in the trauma team activations in evaluating and providing resuscitations, but cannot fulfil the role of the Attending Surgeon and/or for their response times.

For the Limited Tier we have stated that the APP may be the initial responder based on institutional criteria, but cannot be used in lieu of the Attending Surgeon's role or their response.

Neurosurgical Transfers

“At a level 3 with neurosx capabilities is it appropriate to transfer a pt to a partnered hospital who is a non-trauma center for neurointensivist services if our local level 2 and 1 do not have neurointensivist but the non-trauma center does?” (Level 3)

Without having the specific information, Level III trauma centers with neurotrauma patients are required to be transferred to a similar or higher-level trauma center.

If the neurotrauma patient is discharged and requires specialized care, the patient may be transferred to a non-trauma center.

Non-Board Certified Orthopaedic Surgeon

“If a non boarded ortho doctor does a surgery on trauma pt is this ok if it was requested by patient and the chart is reviewed by TPM and TMD and deemed appropriate?”
(Level 3)

If the non-boarded Orthopaedic Surgeon performed surgery on a trauma patient at the request of that patient, it would be deemed appropriate and this request must be documented, and reviewed through the PIPS process.

Alternate Pathway for Hand Surgeon

“Ortho hand surgeon who takes call a few times a month primarily hand call Trained in Australia. Alternative pathway for survey? If so, when does that have to be submitted to the ACS for our survey in June 2019?”

(Level 2)

The Resources manual does not have requirements for Hand Surgeons to be board certified. The hospital should credential providers who will be providing care to injured trauma patients.

Chapter Revision Updates

“When will Chapter 15 - Trauma Registry revision be published? This relates to the new ratio standards and the need to budget.” (Level 1)

Chapter 15 is pending review by the COT Steering Committee.

Chapters will not be released one at a time or in batches. If the COT Steering Committee believes that a criterion has an immediate impact such as, CME, they can approve early implementation.

The next Resources manual will hopefully be released sometime late 2019 or early 2020. Please note, this is a fluid date and will be based on the progress of having all chapters completed.

Define Death in the Emergency Department and On Arrival

“Define DIE vs DOA” (Level 1)

“How does the ACS define DOA” (Level 2)

The ACS does not define Death in the Emergency Department (DIED) or Death On Arrival (DOA). These terms will vary from center to center. Defining them will be determined by the trauma center or state regulations.

Reviews Focused Onsite Versus By Mail

“I have heard that there may be an option to send information to the reviewers for a focused review instead of a visit. True? If true to first question, how do we ask or apply for this option?” (Level 2)

I believe this is referring to the Focused by mail versus the Focused onsite review. Focused review types, onsite or by mail, are based on the individual criteria regardless of Type I or II, the number cited, and/or severity. Additionally, any criterion deficiency (CD) that necessitates review of medical records requires an onsite Focused visit. Focused by mail option is only for CDs that can be addressed with submitting documentation (i.e. ATLS certification, boards, peer review attendance, etc).

Non-Surgical Admissions (NSA)

“If a patient is initially admitted to a non-surgical service (PICU), but the service is changed within 24 hours, is it still NSA” (Level 1)

If the patient was initially admitted to a Non-Surgical Service and the admission service changed for example to a surgical service, this case would still be a NSA and be required to be reviewed through the PIPS process to ensure the initial admission was appropriate and if not, it is an opportunity for improvement.

Non-Surgical Admissions

“Should all NSA be reviewed by the TMD even if they were appropriate?” (Level 2)

Not all Non-Surgical Admissions (NSA) need to be reviewed by the TMD. The TPM or PI Coordinator or clinical staff may do a primary review to determine the rationale for admission to a Non-Surgical Service. If there were any adverse outcomes, e.g. complications or death, you may consider a second level of review by the TMD for missed opportunities.

OPPE

“What is the ACS looking for in the OPPE review? It is not clear in the Orange Book.” (Level 2)

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

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

To clarify, the TMD is not required to perform an OPPE on all the other surgeons who provide trauma call such as, Orthopaedics, Neurosurgery, etc. The Directors or Liaisons from those service are expected to perform an OPPE for their panel members. With this said, the TMD should have oversight on what the OPPE process contains relative to the trauma program.

Orthopaedic Trauma Leader (OTL) Questionnaire

“How soon can I submit the OTL questionnaire/documents?” (Level 1)

The OTL questionnaire and a copy of the OTL's curriculum vitae should be submitted along with the site visit application ~ 14-15 months. However, if you want to ensure the OTL's fellowship is acceptable, you may submit the questionnaire in advance by email to the COTVRC@fac.org. Anita Johnson will forward to the Orthopaedic subcommittee for review.

Peer Review Committee

“What criteria is needed for EMS representative for Peer Review Committee?” (Level 1)

There are no requirements for the EMS representative to attend peer review. With that said, if there is a case that requires EMS representation, it is acceptable to request their attendance at the peer review meeting and/or systems meeting depending on the situation.

Peer Review Committee

“Can the Radiology Fellow serve as the delegate on the committee when the Radiology liaison cannot attend?”

(Level 1)

If the Radiology Fellow is appointed as the pre-determined alternate, then s-/he may attend the peer review meeting.

As stated in the Clarification Document, a Liaison or representative (one pre-determined alternate) is acceptable to attend the peer review meeting in place of the liaison.

PRQ – Trauma Admission

“On the PRQ-how is a ‘trauma admission’ defined? all registry pts, pts admitted to trauma service, admitted to any service etc?” (Level 2)

“Is the ACS definition of ‘admission’ defined by the NTDS standards, or is it determined by the hospital?” (Level 1)

For Verification purposes, to meet the requirement (CD 2-4) and to complete the online PRQ data tables, we want the number of admitted trauma patients that meet the NTDS Inclusion Criteria or your trauma center’s admission inclusion criteria.

PRQ

“Could you please clarify for completing the PRQ which patients are to be counted in ‘Total Trauma admissions by service’ Box 7” (Level 2)

LOS	ICD10 within range	Admit service	Admit location	Include in PRQ??
Less than 23 hours	yes	medicine	Observation unit	
Less than 23 hours	yes	Trauma(TRS/Ortho/NRS)	Observation Unit	
Less than 23 hours	yes	None-not admitted to an observation unit	Monitored in ED	

Regarding Box 7 in the PRQ, the data must represent those trauma patients that were admitted to a service. Patient that were discharged less than 23 hours would not be included in the PRQ. As you will see in the next slide, the admissions numbers need to match in all the data tables.

PRQ - Section II Data Tables

5. Complete the table below using the total number of emergency department (ED) trauma visits for the reporting year following the National Trauma Data Standard (NTDS) Trauma Inclusion Criteria.

	Total
Admitted ED Trauma Visits (Regardless of Service)	1846
Blunt Trauma Percentage	85
Penetrating Trauma Percentage	15
Thermal Percentage	0

6. Disposition ED Trauma Visits

Discharged	168
Transferred Out	10
Admitted	1846
DIED in the ED Excluding DOAs	10
DOAs	19
Total	2053

7. Total Trauma Admissions by Service.

Service	Number of Admissions
Trauma	1112
Orthopaedic	236
Neurosurgery	78
Other Surgical	116
Burn	0
Non-Surgical	304
Total Trauma Admissions	1846

Table 5 - Complete the table using the total number of Emergency Department (ED) Trauma visits for the reporting year following the NTDS inclusion criteria or your trauma center's inclusion criteria.

Colored boxes should all match

8. Based on the number of Non-surgical admits (NSA) from Table 7, please complete the following:

Nonsurgical admissions (NSA)	ISS			
	0-9	10-15	16-24	> = 25
Number of patients admitted to a non-surgical service (from Table 7)	244	27	20	13
Percent of total NSA	77	13	6	4
Total NSA w/trauma consult	67	28	8	6
Total NSA w/any surgical consult (including trauma)	210	47	10	7
Total NSA secondary to single level falls	136	23	1	1
Total mortality (for each ISS category)	4	1	1	4

11. Injury Severity and Mortality.

ISS	(A) Total Number of Admissions	(B) Total Number of Deaths from Admissions by ISS	Percent Mortality (B over A)	Number Admitted to Trauma Service
0-9	1064	7	0.7	484
10-15	354	3	0.8	250
16-24	243	12	5	207
> or = 25	210	59	28	171
Total	1871	81	4.3	1112

PRQ

“On the PRQ, if a board certification for a physician has no expiration date, what should be listed?” (Level 1)

The American Board of Surgery and American Board of Pediatric have transitioned its policy to no end date for board certification. If your center has providers that fall under the new policy, add their most recent expiration date in the PRQ and add a note next to their name as “meeting the requirements of maintenance of certification (MOC).”

PTSD Screening

“PTSD screening and Level III Trauma Centers, Where does this need to take place? In Rehab or prior to?” (Level 3)

PTSD screening is not required for trauma patients. As noted in Chapter 18 and in the Clarification Document, PTSD screening should be done on trauma patients that may be afflicted from PTSD. The reviewer may want to know if the trauma center provides PTSD screening for trauma patients. If so, they may want to see your guidelines on evaluating, treating, and managing patients with PTSD. Where the screening tool is performed will be determined by the trauma center.

Resident Requirement

“What is the minimal # of general surgery residents required per year to demonstrate ‘continual coverage’?”
(Level 1)

The ACS does not have a requirement for the minimum number of residents.

To clarify, the intent of the continuous rotation is not about having a resident on every day or every month, but more about having the resident education experience with a full (printed) curriculum and a dedicated teaching staff for a period of time over the course of the year. What is not acceptable is having residents who are on the service as an elective.

Neurosurgery Response Time

“If Neurology makes a determination of care over the phone does this count as response time?” (Level 1)

Consult by phone is not an acceptable means of meeting the neurosurgical 30 minute response criteria. The expectation is that the Neurosurgeon and/or resident/APPs must be available in person at bedside within 30 minutes for the injuries established by the guidelines.

Trauma Bay Room Temperature

“What are the minimum and maximum temperatures that are acceptable for room temperature in trauma bays?”

(Level 2)

As there are no requirements on this topic, we recommend following literature on acceptable room temperatures in the trauma bays.

Trauma Staff

“Do you need to record names of ancillary staff's arrival to trauma bays or just their time and position (xray, lab, etc)?” (Level 3)

Documenting the ancillary staff's time and position in the trauma bay are acceptable.

Interventional Radiology and Vascular Surgery Coverage

“What are the specific requirements for call/coverage and availability for IR and Vascular surgery. Is there acceptable interruptions to the coverage?” (Level 2)

The Vascular Surgeon is not required inhouse 24/7, but there must be a surgeon consultant available to respond, in person, when requested by the Attending Surgeon by an established predetermined time for those patients.

The Interventional Radiologist is not required inhouse 24/7, but must be present within 30 minutes.

Acceptable interruptions would fall under the diversion policy, e.g. equipment failure, clinician encumbered, etc.

Verification Site-Visit

“How many type 2 deficiencies can you have and still pass a verification?” (Level 3)

A center can have up to 3 Type II CDs (no Type I CDs) and still pass with a one-year verification.

- *If the CD relates to PI, this requires case review and an onsite visit.*
- *If the CDs are related to certifications or peer review meetings – things that can be corrected with documentation – the center will be required to submit documentation by email to the COTVRC@facs.org inbox.*

Verification Site-Visit

“If you have an issue that would qualify as a deficiency, how soon before your survey does it need to be corrected in order for it to be considered fixed and therefore will not count as a deficiency?” (Level 2)

All potential deficiencies must be resolved by the day of the site visit. Deficiencies may be elevated if the reviewers do not believe there is sufficient evidence of compliance at the time of review.

Hospice

All trauma deaths discharged to Hospice have to be reviewed as a trauma death. I understand that to mean that they have to be assigned reviewed and assigned one of the 3 categories regarding opportunities for improvement. Do they have to be counted as deaths in the trauma statistics or can they be counted as a discharge to Hospice? (Level II Adult)

For Verification purposes, not all trauma deaths discharged to Hospice are required to be reviewed as a trauma death and counted in the trauma statistics. These patients may be counted as a discharge since the patient did not die while on the Trauma Service.

If the patient was discharged or transferred to a hospital inpatient unit or to an external hospice facility, the expectation is that the care of the patient leading up to the transfer or discharge is evaluated through the PIPS process by the TMD and TPM. If any issues are found, then it may be reviewed at peer review.

CD-Related Questions

PGY 4-5 Residents(CD 2-6)

“Level I/II. PGY 4or 5. Does this CD refer to only the highest level TTA or does this include limited tier as well?” (Level 1)

This criteria refers to the highest level of activation where the PGY 4-5 may begin resuscitation efforts while waiting for the Attending Surgeon to arrive. To clarify, the PGY 4-5 cannot take the place of the Attending Surgeon or their response time.

The PGY 4 or 5 may also participate in the Limited Tier; however, they cannot take the place of the Attending Surgeon or their response time.

PGY 4-5 Residents (CD 2-6)

“Limited Tier activations: If you have PGY 4-5s in your facility and they see and evaluate the limited tier (tier 2) patients within 20 minutes of arrival, what is a reasonable time for the trauma attending to see these patients? Thanks!” (Level 1)

The time expectation for the Attending Surgeon to respond to the Limited Tier will be based on the criteria the trauma center established. It is recommended to follow best practices.

Transfers (CD 4-1)

“For interfacility transfers does the direct communication between facilities have to be trauma surgeon to trauma surgeon?” (Level 1)

In most trauma centers, if a patient is being transferred, there must be direct communication between the Emergency Department (ED) Physician and/or Trauma Surgeon and in some centers the PA/APP has been credentialed to do this. The intent is that there is a line of communication between the ED and Trauma so patients are not double transferred due to lack of a bed or specialty services, etc, or an increased length of stay.

Some states have referral centers that have been credentialed to receive and relay the communication to the ED Physician and/or Trauma Surgeon.

Transfers (CD 4-1)

“If a patient is at a level 1 trauma center with an isolated injury, and needed a higher level of plastic surgery then could be provided, is it appropriate to transfer them (once stable) to a non-trauma center hospital (with an appropriate surgeon) within the level 1 centers network? Would this be considered an issue if a site surveyor reviewed this case?” (Level 1)

This practice would be acceptable. If the patient required specialized care that cannot be provided at the trauma center, the patient may be transferred to a non-trauma center once s-/he is stabilized.

Peer Review Meetings (CD 5-25)

“When a TMD goes on vacation and there is no appointed Associate TMD, can a trauma surgeon run Peer Review or should we resched.” (Level 1)

There is no predetermined alternate for the role of the TMD. The chair must meet the same requirements as the other panel members by attending the meetings 50% of the time. With this said, if your trauma center has a high volume of cases, it may be appropriate to keep the meeting and appoint another Trauma Surgeon to lead the meeting or if you prefer, the meeting may be rescheduled.

Pre-Hospital Meeting (CD 7-8)

“CD 7-8 Prehospital PIPS Meeting: Does the pre-hospital PIPS meetings have to be a separate meeting on its own? Does the representative from the Emergency Department have to be a physician?” (Level 2)

The VRC does not have a requirement for the prehospital PIPS meeting other than there must be an Emergency Department Physician identified as the representative in attendance.

Emergency Medicine and ATLS (CD 7-15)

“Could you confirm/clarify the ATLS requirement for ED providers?” (Level 1)

For Level I, II and III trauma centers, physicians must be:

- 1. Board certified or board eligible in Emergency Medicine must have taken ATLS at least once.*
- 2. Board certified or board eligible in something other than Emergency Medicine such as, Family Practice, Internal Medicine, Pediatrics, etc., must have current ATLS status.*
- 3. The American Board of Physician Specialists (ABPS) is NOT recognized by the ACS.*

Emergency Medicine and ATLS (CD 7-15)

Change in the Clarification Document:

For Level I and II trauma centers, physicians who completed primary training in 2016 and beyond:

- 1. Must be board certified or board eligible by the appropriate Emergency Medicine/Pediatric Emergency Medicine board according to the current requirements.*
- 2. Who are not board certified or board eligible by the appropriate Emergency Medicine/Pediatric Emergency Medicine board may provide care in the Emergency Room, but cannot participate in trauma care.*

Orthopaedic and Neurosurgery Coverage (CD 8-2 and CD 8-3)

“Is an orthopedic PGY 4/5 covering spine an appropriate responder to a 30 minute neurosurg case(i.e. incomplete SCI?” (Level 1)

If SCI is Spinal Cord Injury, it would be acceptable in Level I or II trauma centers for the institution to credential both Neurosurgeons and Orthopaedic Surgeons to treat spine injuries or to share spine call. Therefore, if one of these groups is covering spine call, then the backup call/system or contingency plan will be triggered.

Orthopaedic Surgery Backup Call Schedule (CD 9-6)

“Could you please clarify whether or not a ortho back-up call schedule is required if a contingency plan is in place?” (Level 2)

The Orthopaedic Trauma Service must have either dedicated Orthopaedic Surgeons or have a published backup system. The backup system or contingency plan may be in the form of a backup call schedule.

Pediatric TPM (CD 10-3)

“Does an Adult level 2 Peds level 2 center need both adult and pediatric trauma program managers/coordinators?”

a. If only one TPM/Coordinator is needed is there a requirement for a separate peds PI nurse?” (Combo Level I, Level 2 peds)

There currently is no requirement for any program to have a separate PI Nurse Coordinator.

In combined Adult Level II and Pediatric Level II centers, the TPM may oversee both programs. However, if the TPM's duties are encumbered by this or additional roles, e.g. PI Nurse, it may rise to the level of a weakness or deficiency.

Anesthesia Services (CDs 11-4/11-5)

“The criterion says anesthesia services must be ‘available’ in-house 24-7. Is it implied that anesthesia will RESPOND to activations or just be ‘available’. Would this criterion be met by using say in-house CRNA's on OB who are ‘available’ but do not respond to trauma activations?”
(Level 2)

I would not say it is implied that Anesthesia Services will respond to activations. Some trauma centers have policies or criteria that require Anesthesia Services to respond to the all activations or a subset of the activation. This will be determined by the institution.

Utilizing in-house CRNAs for OB are acceptable.

Surgical Director (CD 11-48)

“Can a non-surgeon be an associate director of the SICU”
(Level 1)

A Level I must have a Surgical Director who is board certified in Surgical Critical Care. There is no criteria for an Associate Director at a Level I trauma center.

ICU Physicians (CD 11-51)

“CD 11-64 ICU Physicians: If trauma surgeons manage the trauma service patient in the ICU, do other ICU physicians need to have proof of board certification for those patients not admitted or being followed by the trauma service?” (Level 2)

To clarify, CD 11-64 refers to CMEs.

The VRC only monitors the compliance of physicians in the ICU who are involved in the treatment of trauma patients. If the physicians provide care to the trauma patients while in the ICU, they are expected to meet the same requirements, e.g. board certification.

Surgical Director or Co-Director (CD 11-53)

“In Level II and III trauma centers, ‘a surgeon must serve as co-director or director of the ICU and be actively involved in, and responsible for, setting policies and administrative decisions related to trauma ICU patients (CD 11-53)’. Our critical care committee does not meet regularly at our facility - one time for 2018. The ICU director is the liaison that comes to our Trauma Committee meeting (peer review/PIPS) that is held monthly. On our agenda, we have included a critical care portion, where any concerns are addressed during our trauma meeting. Our Trauma Medical Director leads this meeting and our core trauma surgeons take part in the discussion as well. Could this suffice for the above?” (Level 3)

It may; however, what the criteria is referring to is that there is a Surgical Director or Co-Director that is involved and oversees the care for trauma patients in the ICU. Such as, if there are any issues or concerns with those patients, the providers can go to the Surgical Director or Co-Director for medical management and/or decisions in their care.

Patient to Nurse Ratio (CD 11-66)

“CD 11-66 Patient to Nurse Ratio: If a patient is being held in the emergency department for an ICU bed, can the nurse take the ICU patient and two step-down patients and still be compliant with a 2:1 ratio?” (Level 2)

I see this as a total of 3 patients. If the patient is waiting in the ED for an ICU bed and one patient is taken to step-down, that is being compliant with the ratio.

Blood Bank (CD 11-83)

“CD 11-83 FFP: For FFP, is the 15 minute requirement for the administration of FFP to a patient or just having it available in the blood bank within 15 minutes?” (Level 2)

The expectation is for the blood products be available within 15 minutes. Not administered.

Deaths (CD 16-6)

“Should all deaths be reviewed by the TMD even the anticipated without opportunity for improvement?”

(Level 2)

The TPM may perform a primary review of the deaths. Any deaths with an adverse event or an opportunity for improvement must be reviewed by the TMD and need to undergo peer review.

Alcohol Screening and Intervention (CDs 18-3/18-4)

“Alcohol Screening requirements for a Level III Trauma Center are confusing with the Level I & II Center requirements” (Level 3)

The screening criteria is the same for Level I, II and III trauma centers: There must be a process, mechanism (tool) and documentation for patients who meet NTDS inclusion criteria (activated or non-activated) that are admitted with a hospital stay of > 24 hours, of which 80% of these patients must receive a screening (CD 18-3).

The intervention is not applicable to Level III trauma centers. In Level I and II trauma centers, those patients who have screened positive must receive an intervention by appropriately trained staff, and this intervention must be documented (CD 18-4).

Alcohol Screening Tools (CD 18-3)

“Please clarify about using ETOH level as a screening tool for SBIRT. Can it be used in place of a CAGE, AUDIT screening tool?” (Level 1)

The screening method used will be determined by the trauma center. Using ETOH level is an acceptable method, as are CAGE and AUDIT.

Need more info

“The suggestion of 5-10% of charts for IRR in Registry is of the total #charts in Registry, or only those that are NTDB-inclusive” (Level 1)

The ACS does not specifically define this. The center can make that decision although the center might be best served to spend their chart validation time on charts that would be submitted to the NTDB and TQIP.

Need more info

“Please define 'undertriage' and exactly what events trigger it. Should humerous fx to OR from ED be counted as undertriage?” (Level 2)

The matrix method on pages 28, 120-121 in the Resources manual defines undertriage. Many centers do a comparison or second under and over triage method by evaluating compliance of the center's own trauma activation criteria. This method also helps the center in identifying educational needs of staff in correctly activating their patients.

CME

CME Requirements

“Can you please clarify the CME requirements for all that take call for the trauma service?” (Level 2)

The CME requirement changed to 36 hours over 3 years, in which, 12 hours may be accumulated each year. This is applicable to the adult and/or pediatric TMD, TPM and alternate pathway candidates.

For the Liaisons, Trauma Surgeons, Pediatric Surgeons and specialty panel members (Emergency Medicine, Neurosurgery, Orthopaedic Surgery and ICUs) participating on the trauma call panel, staying current with board certification satisfies the CME requirement.

Level III trauma centers are not required to comply with the CME standard.

CME for Grandfathered Board Certified Surgeons

“I am currently reviewing CME requirements for our trauma panel and one of our Ortho surgeons was grandfathered in many years ago and does not have to recertify for his boards. How will this affect our site visit when he does not do MOC?” (Level 2)

“One of our orthopedic docs is Board Certified, but by grandfathering (and thus does not require MOC per se). Does he need CME?” (Level 2)

If the Orthopaedic Surgeon or any other Surgeon is grandfathered in their board certification/MOC, please have documentation by their appropriate boards available during the site visit. This would be acceptable and satisfies the CME requirement.

Thanks for your participation!