

Trauma Verification:

*Criteria, Changes, Future Plans,
and the TMD Perspective After Going Through Site Survey!*

Daniel Margulies, MD FACS

Cedars- Sinai Medical Center, Los Angeles, California

Chair, Verification Review Committee

of the American College of Surgeons Committee on Trauma



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tqip

TRAUMA
QUALITY
IMPROVEMENT
PROGRAM

VRC VERIFICATION
REVIEW
CONSULTATION

for excellence in trauma centers

Connie Stalcup Gagliardo 1959 - 2013

Founding President, **Trauma Managers Association of California**
Founding Chair, Southern California **Advanced Trauma Care for Nurses**



I had the pleasure of working with Connie for almost 12 years delivering ATLS and ATCN

Objectives

- Discuss the implications and impact of the new criteria included in the *Optimal Resources for Care of the Injured Patient*, 6th edition
- Identify the changes included in the Clarification Document of the Optimal Resources for Care of the Injured Patient
- Discuss the process for revising the *Optimal Resources for Care of the Injured Patient*, 6th edition.

But,

What I am really going to talk about is...



- One Trauma Medical Director's perspective on the verification process
- What new criteria are on the horizon for the "Orange Book"
- What its like to go through a site survey as the TMD *and* the VRC Chair

Disclosure: Nothing to Disclose



Resources for Optimal Care of the Injured Patient: 1976-2014


Optimal Trauma Resources for Care of the Seriously Injured

The responsibility for providing optimal trauma resources for the care of the seriously injured patient rests with society as a whole. It is the responsibility of all of us to ensure that the injured patient receives the best possible care. This responsibility is shared by all of us, including the patient, the family, the community, the government, and the medical profession.

The trauma care team is a group of individuals who work together to provide the best possible care for the injured patient. This team includes the patient, the family, the community, the government, and the medical profession.


Committee on Trauma, American College of Surgeons

RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT




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RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT: 1999




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RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT 2014




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Hospital and Prehospital Resources for Optimal Care of the Injured Patient and Appendices A through J




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RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT: 1993



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RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT 2006



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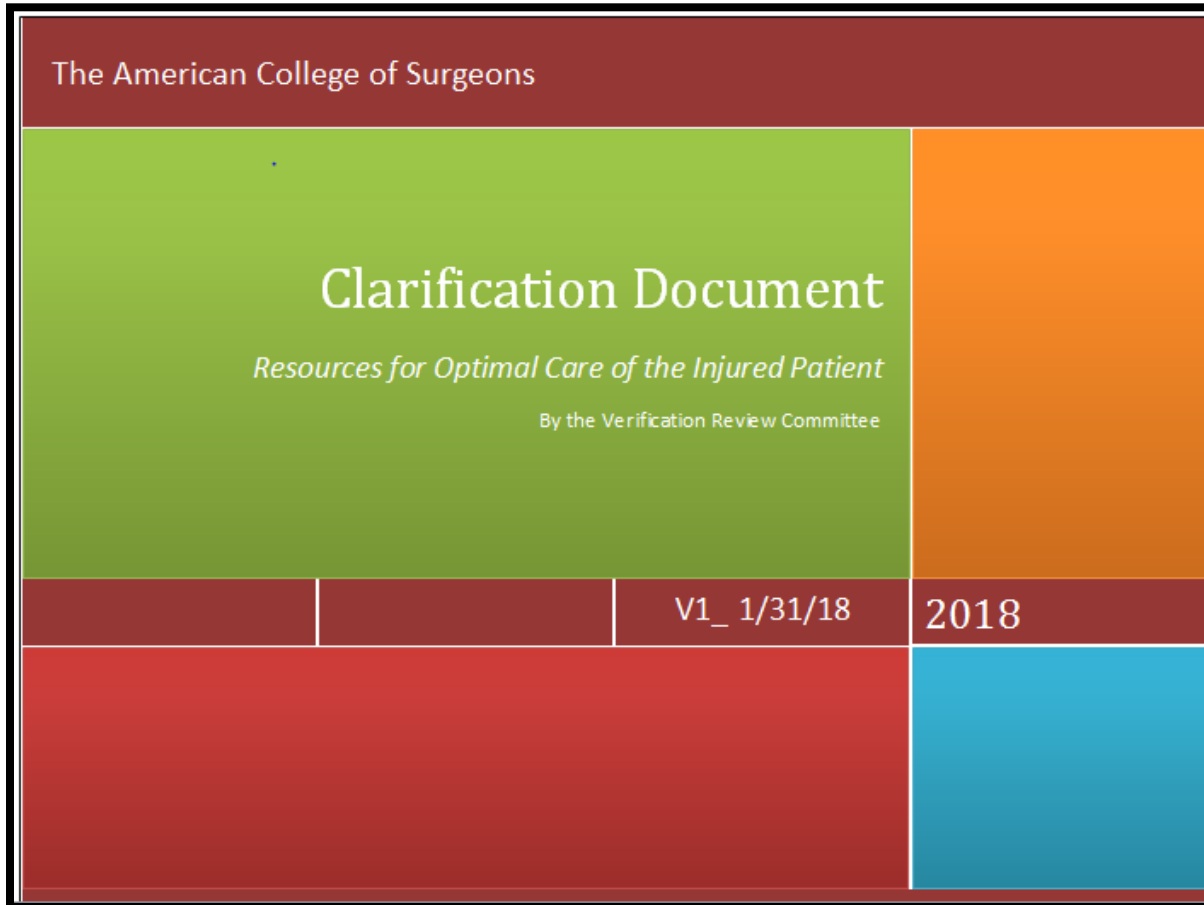
What Have Been the Outcomes?

- Significant reductions in complications and deaths
- Improved access to trauma care in many areas
- Increased sophistication of trauma systems
- Increased funding for trauma systems and trauma centers



Out with the FAQ and in with the Clarification

Check often



Verification Change Log

Check it often

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

Participant Education and Web Based Resources

Current:

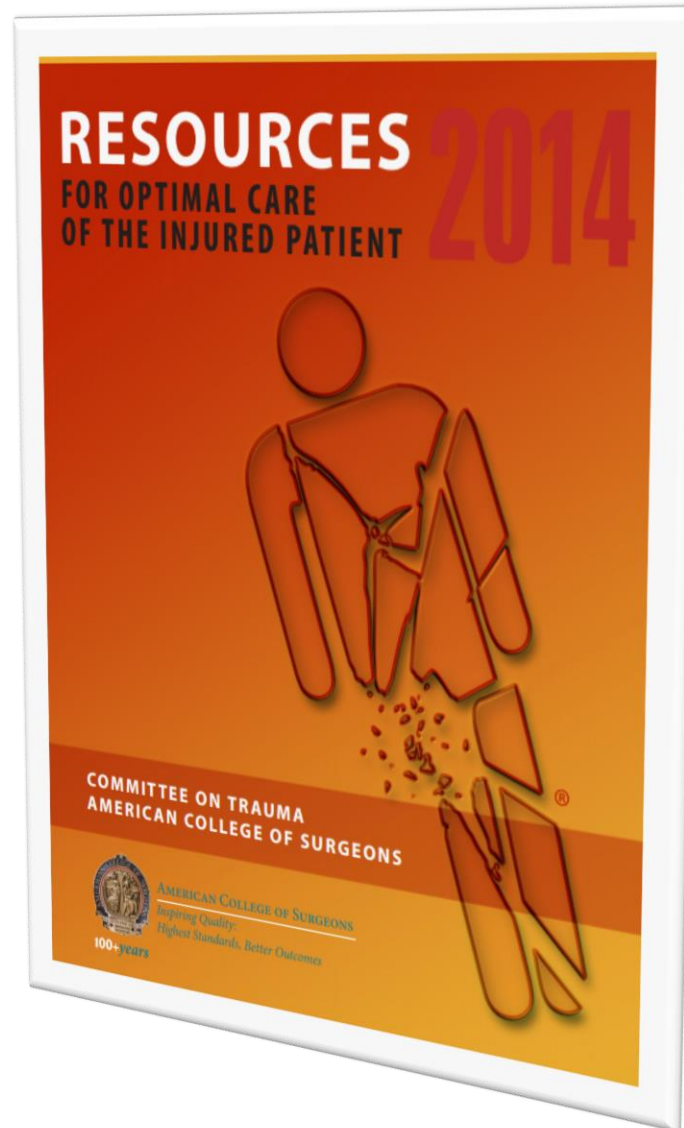
- Becoming a Verified Trauma Center, First Steps... Tutorial
- Monthly Q&A Webinars
- FAQs

Future:

- Becoming a Verified Trauma Center, The Site Visit Tutorial
- Expand FAQs
- Guidelines for Completing the PRQ
- Criteria Revision

Orange Book Revisions

Ongoing



New PRQ - Update

Continuous updates to online PRQ

- Based on hospital and reviewer feedback
- In sequence with chapter (follow the manual)
- Goal: A living document which populates all the time



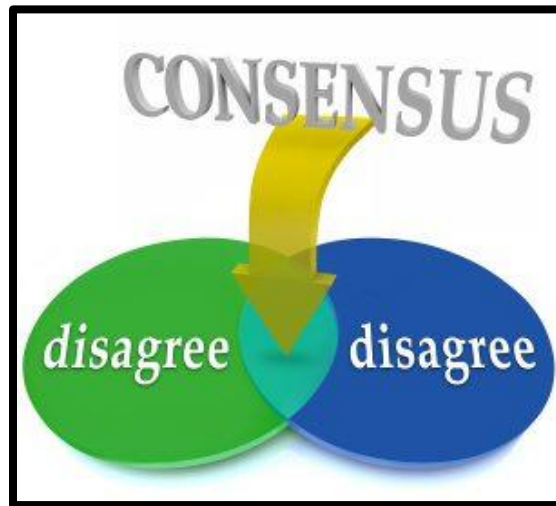
Goal: Integrated Quality Program

- VRC: standards and verification
- PIPS: engine for quality improvement
- TQIP: dashboard for quality outcomes and best practices
- Development of integrated trauma quality program with stakeholder feedback



Physician and Nurse Leadership are Critical

- Commitment to the Trauma PIPS Process at the hospital level
- Commitment to improving the verification process consistent with optimum patient care (at the COT level)



Build consensus around the doing the right thing for the patient



Criteria Summary – Overview



- Covering only a few criteria during today's lecture
- Refer to the Update Document and Change Log frequently
- The criteria contained in this power point is directly from the Update Document

Chapter 5: Hospital Organization and the Trauma Center

- The trauma program must involve multiple disciplines and transcend normal departmental hierarchies (CD 5–4)
- Activation criteria clarifications and guidelines
- Multiple changes and clarifications regarding responsibilities and qualifications of trauma medical director and trauma program manager



Admission of Injured Patients to Non-Surgical Services

- Programs that admit more than 10% of injured patients to non-surgical services must review all non-surgical admissions through the trauma PIPS process
- Centers admitting < 10% *should still review* patients with ISS>15 admitted to non-surgical services
- Same level falls/isolated hip fractures:
 - if these patients meet the NTDS Trauma Inclusion criteria, they should be captured in your trauma registry, and if the center includes them in the volume admission numbers (on the PRQ), then you must follow all the rules of any other trauma admission (like reviewing nonsurgical admissions)
 - This may differ from your state inclusion criteria - therefore, you may have to capture 2 sets of data points

Transfers

- A very important aspect of interhospital transfer is an effective PIPS program that includes evaluating transport activities (CD 4–3).
 - Perform a PIPS of all transfers out during the acute phase of hospitalization.



Transfers

- Perform a PIPS review of all transfers (CD 4–3)
 - What is the responsibility of the accepting institution to transferring institution?
 - It is the responsibility of the transferring institution to request the information
 - Any issues identified by the accepting institution should be relayed
 - If no issues identified, a discharge summary may suffice



Transfers for Specialty Care

For all patients being transferred for specialty care, such as burn care, microvascular surgery, cardiopulmonary bypass capability, complex ophthalmologic surgery, or high-complexity pelvic fractures, agreements with a similar or higher-qualified verified trauma center should be in place. If this approach is used, a clear plan for expeditious critical care transport, follow-up, and performance monitoring is required (CD 8–5). If complex cases are being transferred out, a contingency plan should be in place and must include the following:

- A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the patient.
- Transfer agreements with similar or higher-verified trauma centers.
- Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.
- Monitoring of the efficacy of the process by the PIPS programs.
- The expectation is that Level I and II trauma centers will have the listed specialties other than burns and replantation.

OPPE and FPPE

The TMD must perform an annual assessment of the trauma panel providers in the form of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) when indicated by findings of the PIPS process (CD 5-11).



Alternate Pathway

- Review the update document carefully
- Contact the VRC office early with questions

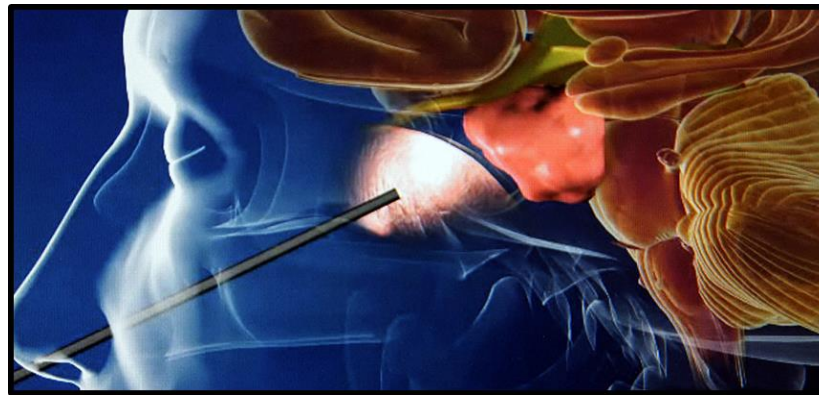


Surgeon Attendance: Multidisciplinary Peer Review Committee

- Each member of the group of general surgeons must attend at least 50 percent of the multidisciplinary trauma peer review committee meetings (CD 6–8).
- All general surgeons who participate in trauma care (core surgeons no longer exists).
- As of July 1, 2015 any surgeon previously designated as non-core must begin attending at least 50% of multidisciplinary conferences to meet the attendance requirement. (rv 9/4/15)
- Attendance may be met through teleconferencing or videoconferencing participation.
- Audio conferencing should be limited.
- Peer review meeting attendance may be waived for deployment, medical leave and missionary work. The center must provide documentation to support the absence. (rv 11/9/16)

Neurotrauma Care: 30 Minute response

- Neurotrauma care must be continuously available for all TBI and spinal cord injury patients and must be present and respond within 30 minutes based on institutional-specific criteria (CD 8–2).
- The intent is that neurosurgical care is promptly available for the acute care of the brain injured and spinal cord injured patient to include an in-person evaluation within 30 minutes.
- The time should start when the request is made to the neurosurgeon (time of page or call).
- The specific types of patients or clinical scenarios should be developed by each institution and agreed upon and documented by the PIPS process.



Neuro: Published Contingency Plan

A formal, published contingency plan must be in place for times in which a neurosurgeon is encumbered upon the arrival of a neurotrauma case (CD 8–5). The contingency plan must include the following:

- A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the neurotrauma patient.
- Transfer agreements with a similar or higher-level verified trauma center.
- Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.
- Monitoring of the efficacy of the process by the PIPS program.
- Every case in which the neurosurgeon is encumbered and entails transfer of the patient must be reviewed by PIPS.

Chapter 9: Orthopaedic Traumatologist

- Level I: the orthopaedic care ***must be overseen by an individual who has completed a fellowship in Orthopaedic Traumatology approved by the OTA*** (CD 9-5)
- Those who have not completed OTA Fellowship reviewed by ***COT Orthopaedic Specialty Work-group*** – all but one have been approved
- PTC Level I, the above requirement may be met by having a formal transfer agreements – transfers (or potential transfers) are reviewed as part of the performance improvement process. (CD 9-5) Type I

Ortho-Trauma & Operating Room

- In Level I and II trauma centers, a system must be organized so that musculoskeletal trauma cases can be scheduled without undue delay and not at inappropriate hours that might conflict with more urgent surgery or other elective procedures (CD 9–3).
- This requirement is best met by maintaining a dedicated trauma orthopaedic room.



Ortho Response

- Must be available in the trauma resuscitation area within 30 minutes after consultation has been requested by the surgical trauma team leader for multiply injured patients (CD 9-7) based on institution-specific criteria.
- The hospital must develop its own criterion for time-sensitive consults and monitor through PIPS.
- Orthopaedic evaluation may be done by an Orthopaedic resident at any level or Orthopaedic mid-level provider as long as the patient was initially evaluated by an EM physician, trauma surgeon, or senior Orthopaedic resident.
- There must communication and documentation with the attending Orthopaedic. (rv 6/8/15)

Complex Imaging Studies

- In Level I and II trauma centers qualified radiologists must be available within 30 minutes to perform complex imaging studies, or interventional procedures (CD 11-33).
- Qualified radiologists = Interventional Radiologist for interventional procedures or Vascular Surgeons are acceptable. (rv 10/26/16)
- Clock starts when the call is made requesting the service.



Radiology: Changes in Interpretation

- Changes in interpretation between preliminary and final reports, as well as missed injuries, must be monitored through the PIPS program (CD 11–37).
- Rates calculated and reviewed with radiology
- Changes categorized by RADPEER or other similar criteria.

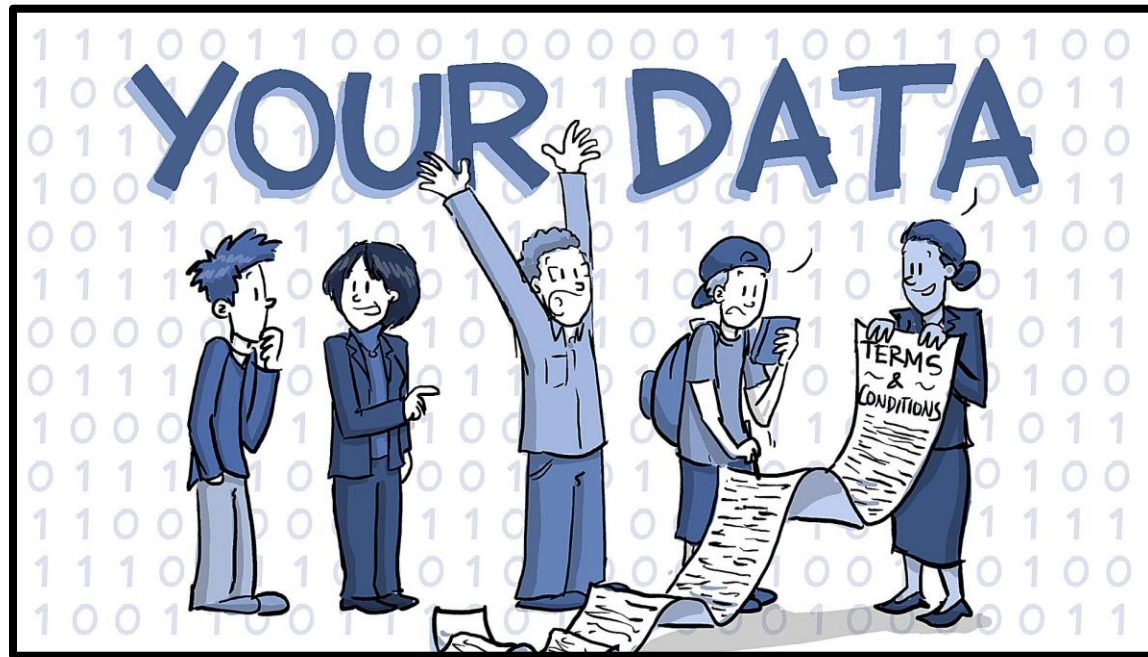


Advance Practitioners

- Advanced practitioners who participate in the initial evaluation of trauma patients must demonstrate **current** verification as an **Advanced Trauma Life Support**® provider (CD 11–86).
- This would therefore include ED and trauma Advanced Practice Providers (APPs). It does not include orthopaedic and neurosurgery practitioners who are consulting. (rv 6/8/15)
- Trauma and/or Emergency Department APPs that function as a member of the team caring for trauma activation patients via assessment or interventions must be current in ATLS.
- If the Trauma and/or ED APPs only role is as a scribe or entering orders they would not need to meet the ATLS requirement.
- This does not include the consult tier or Fast-Track. (rv 4/14/16)
- ATCN **cannot** be used to meet the requirement. (4/5/16)

Chapter 15: Registry

- One full-time equivalent employee dedicated to the registry must be available to process the data capturing the NTDS data set for each 500–750 admitted patients annually (CD 15–9)
- Chapter 15 revised: approval by the COT Executive Committee *pending*



Trauma Registrars

- They must attend or have previously attended two courses within 12 months of being hired:
 - the American Trauma Society's Trauma Registrar Course or equivalent provided by a state trauma program;
 - and the Association of the Advancement of Automotive Medicine's Injury Scaling Course (CD 15–7).
- The objectives for the ATS Trauma Registrar Course may be found at: <http://www.amtrauma.org/courses/trauma-registrar-council/trauma-register-courses/trauma-register-course-live/index.aspx>.
- Equivalent programs would be based upon the ATS objectives, the administration or learning sequence and format, e.g. 1 day versus multiple shorter time frames, is flexible. (rv 6/8/15)
- Hires after July 1, 2014, must have attended or previously attended a training course at the time of the site visit.
- New registrars must have the training within one year of hire.

PIPS

Patients transferred to hospice care should be reviewed as deaths.



PIPS

- Response parameters for consultants addressing time-critical injuries (for example, epidural hematoma, open fractures, and hemodynamically unstable pelvic fractures) must be determined and monitored (CD 5–16).
- The types of time-critical injuries requiring prompt care by consultants should be defined and monitored.
- Consultation may be met by residents or APs if there is documentation of communication with the attending.



Chapter 16: PIPS

- Comprehensively revised
- Clarified process structure and incorporation of outcomes
- There must be adequate administrative support to ensure evaluation of all aspects of trauma care (CD 5–1)
- Both core and non-core surgeon participation
- Mortality Review-all trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement identified for peer review (CD 16–6)



Trauma Peer Review Meeting

- ***Liaisons for EM, neurosurgery, orthopaedic, anesthesiologist, radiology, and ICU: liaison changed to the liaison or a single pre-determined*** representative to the multidisciplinary peer review committee must attend a minimum of 50% of these meetings
- Attendance may be met through teleconferencing or videoconferencing participation.
- Audio conferencing should be limited
- Excused absences for deployment, medical leave and missionary work
 - Must have documentation to support the absence



Process Improvement: Includes the Following

- Describes PI event / concern
- PI levels of Review:
 - Level 1: TPM
 - Level 2: TMD with TPM
 - Level 3: Multidisciplinary Peer Review
 - Level 4: External, e.g., system peer review
- Action Plan
- Education, guideline, practice changes
- Loop closure



Process Improvement

- Practice guidelines, protocols
- Compliance and outcomes are tracked
- TQIP
- Prescriptive



Chapter 5: Trauma Medical Director

- Level I and II TMD: membership and participation in regional and national trauma organizations membership.
 - Desired at a level III
 - Membership in the State COT does not qualify
 - Examples:
 - AAST
 - EAST
 - WTA
 - PTS
 - COT





Continuing Medical Education

- Level I and II – TMD, 4 OS, NS and CC
- 48 hours of training are required for 3 year period on average 16 hours should be completed annually
- New members coming to service, it would be expected that they have the required CME since they are more than likely coming from another trauma center. For some reason they do not because they were brought on in the beginning of your review cycle or later, then CME must be prorated based on when they started
- New graduates should begin the process to acquire CME right away, however if they are also brought in midway through your review cycle, CME must be prorated based on when they started.
- 16 hours is the average number of CME that is required annually, not the mandatory minimum

TMD CME

- The TMD must maintain an appropriate level of trauma-related extramural continuing medical education (16 hours annually, or 48 hours in 3 years). (CD 5–7) Type II
 - The CME requirement has changed to 36 hours/12 annually from 48 hours/16 annually. (4/13/18)
 - In Level I and II trauma centers, the trauma medical director (TMD) must fulfill this requirement by obtaining and demonstrating a minimum of 36 hours of verifiable external trauma-related continuing medical education (CME) over a 3 year period.
 - In Level I and II pediatric trauma centers, the pediatric TMD must fulfill the same requirement, of which 9 hours must be pediatric trauma specific. CD 5-7/CD 10-39 Type II (4/13/18)
 - Will accept 33 hours from board certification or recertification to count as trauma or critical care external CME for all specialties: trauma surgeons, orthopaedic surgeons, neurosurgeons, emergency medicine and ICU. (rv 11/9/16)
 - For new centers seeking consultation or verification, the TMD must have one year (12 hours) minimum of CME. (rv 11/9/16, 4/13/18)

Trauma Physician Specialists—Instead of CME –

- The trauma director is expected to assess individual surgeon's adequacy of trauma care knowledge in the OPPE process and is expected to make specific recommendations for any individual to fill knowledge gaps during the OPPE process.
- For the specialty panel members (emergency medicine, neurosurgery, orthopaedic surgery and ICU), this may be done by the specialty liaisons with approval of the trauma medical director.

SBIR

- Universal screening for alcohol use must be performed for all injured patients and must be documented (CD 18–3)
- It is applicable to eligible patients (alive and participatory), regardless of activated or non-activated, who meet inclusion criteria with a hospital stay of >24 hours who are admitted to the hospital and are entered into the registry, 80% of these patients must be screened. This includes orthopaedic and neurosurgery. (rv 11/30/17, 4/18/18)
- Any patient with an altered mental status (and deaths) should be excluded from the denominator as these can't get screened. (4/18/18)



SBIR Continued

- At Level I and II trauma centers, all patients who have screened positive must receive an intervention by appropriately trained staff, and this intervention must be documented (CD 18–4)
- Those 80% of patients that received an alcohol screening (CD 18-3), are expected to receive an intervention 100% of the time (CD 18-4).
- Those that are missed would subsequently be reviewed through the PIPS process.
- ‘Appropriately trained staff’ will be determined and credentialed by the institution.
- This may be an RN, Social Worker, etc.

Chapter 10: Pediatric Trauma Care

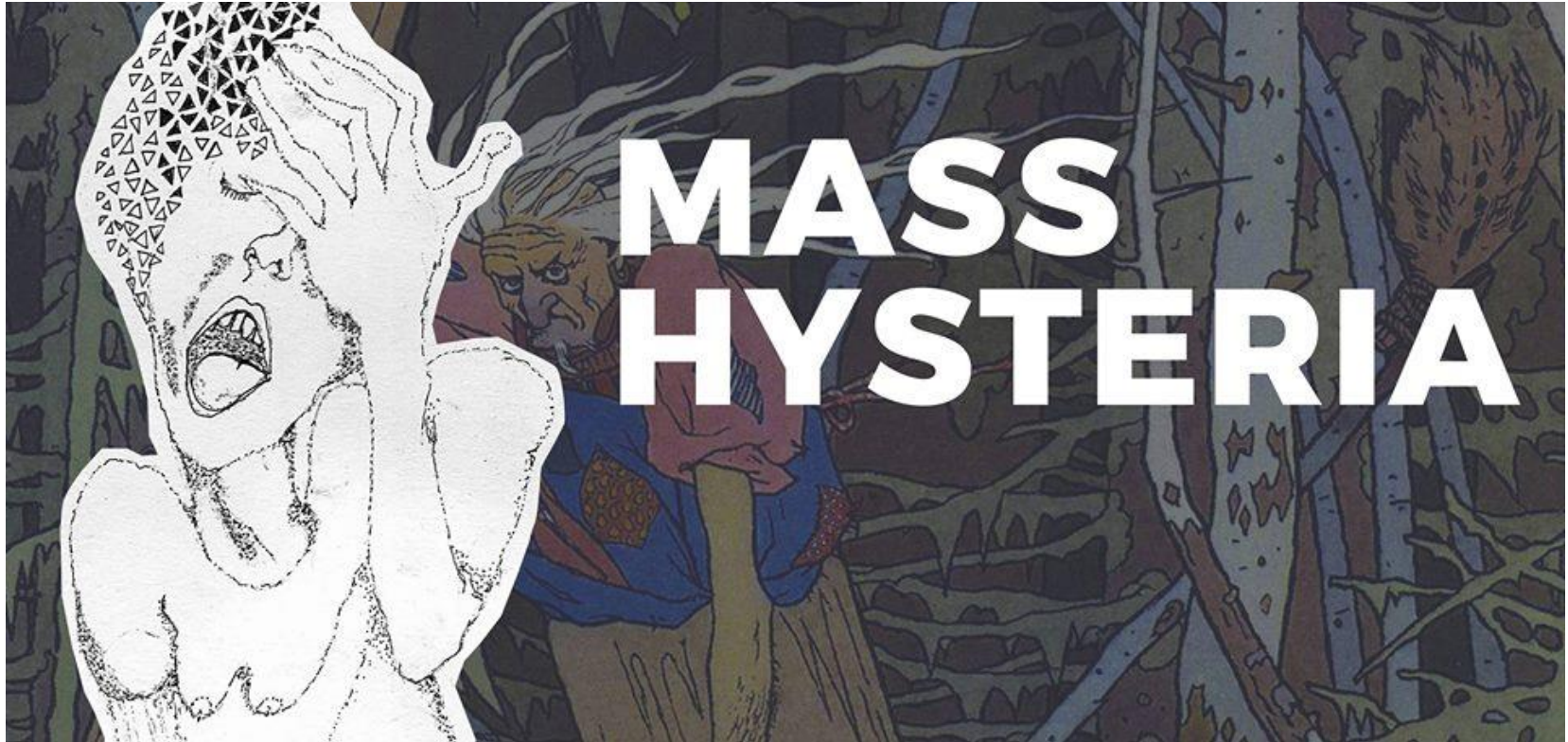
- All Level I and II pediatric trauma centers must have a **dedicated** pediatric trauma program manager (CD 10–3)
- Pediatric Level II trauma center must have one Pediatric Surgeon on staff
- The pediatric Level I center's research requirement is equivalent to that of adult Level I trauma centers (CD 10–10)
- In combined Level I adult and pediatric centers, half of the research requirement must be pediatric research (CD 10–11)





Orange Book: The Future







General Principles

- Evidence based: need the best evidence available for new criteria
- Minimize impact – burden on trauma hospitals
- But, trauma centers need to be in alignment with the minimum standards
- Minimize additional / new criteria unless absolutely necessary
- Chapter revisions and revision process:
 - VRC & STN Partnership for chapter revisions
 - Public comments are seriously considered during revision process



*What its like to go through a site survey as a
TMD and the VRC Chair*



NOWTHEENDBEGINS.COM

This is **NOT** my Trauma Program Manager...





PRIDE IS
CONCERNED WITH
WHO IS RIGHT

HUMILITY
IS CONCERNED WITH
WHAT IS RIGHT

– EZRA T. BENSON –

Yvette

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Yvette



- Do not lie, hide cases, or falsify data
- Every trauma hospital has *“those tough cases”*
- Ensure you have solid PIPS processes in place so the same error does not happen again
- Show this in your trauma PIPS documentation/packet



- All charts that are pulled / prepared for site survey reviewers are FIRST reviewed by:
 - Trauma PI Coordinator
 - Trauma Medical Director
 - Final review before “lockdown”: Trauma Program Manager
- A few words about our chart review / preparation process...

A few words about our chart review / preparation process...

- It is time consuming for the TMD, but necessary
- It is stressful because:
 - We review all the “tough” cases first
 - Psychologically and emotionally, it has an impact
 - You find that perhaps the loop is not closed as tight as it should have been





- Continuous readiness culture
- I never cancel meetings with my Trauma PI Coordinator
- Consistency with Trauma PI Processes
 - All PRQ reports are just what we do, every day, every month, year
- Concurrent with trauma registry data
 - Contemporary data processes
- Accountability for each participating department – clear advance communication
- Trauma admin staffing:
 - Staying afloat but still 2 FTE's short based on exit survey
 - Lean methodology in place for all work processes
 - Experience helps!
 - Clearly defined plans and staff roles for site survey prep – geared up 1 year prior



- Triage non-essential trauma program items to the “after survey list”
 - Stick to this rule and do not feel guilty about voicing your need to prioritize
 - TMD: delegate so he is available to assist with site survey prep
- All hands on deck – site survey is the priority
- Trauma Educator blocked schedule to help everyone out
- TPM can allocate / reallocate resources as needed



Do not rest on your laurels
Keep your trauma program contemporary

No detail too small
Check, check, recheck
Over-prepare
Trust but verify
Leave no stone unturned

*The burden of trauma hospital site survey weighs heavily on the shoulders of the
Trauma Program Manager*



THANK
YOU
for all you do

