Trauma Verification
Q&A Web Conference

January 24, 2017

COTVRC@facs.org
Your Trauma Quality Programs Staff

Tammy Morgan
Manager
Trauma Center Programs

Molly Lozada
Program Manager
Trauma Verification

Julia McMurray
Operations Manager
Trauma Quality Programs

Rachel Tanchez
Site Visit Coordinator
Trauma Verification
Continuing Education (CE)

- To qualify for CE, you must attend at least 50 minutes of educational content

- An email will be sent to all attendees who qualify for CE within 24 hours of the webinar ending, with instructions on how to claim CE

- If you have any questions – please email COTVRC@facs.org
What is the goal for this Webinar?

- Interpret the standards outlined in the Resources for Optimal Care of the Injured Patient manual to ensure that hospitals have an understanding of the criteria to provide quality care to the injured patient.

- Understand the processes and standards involved in an ACS Trauma Verification Site Visit and how following these will positively impact the quality of care of the injured patient at your center.
Let’s get started!
If you have your *Resources for Optimal Care of the Injured Patient 2014* (Orange Book) in hard copy or PDF version, it is recommended that you have it available to reference in the CD-Related Questions section of this webinar.

The most current Clarification Document, and the Verification Change Log are available at: www.facs.org/quality-programs/trauma/vrc/resources
Clarification & Verification Document Updates

The updates for the monthly Verification Change Log and Clarification Document for January have been completed.

These documents may be accessed through the VRC webpage at www.facs.org/quality-programs/trauma/vrc/resources.

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

Updates sent to participants monthly
## Verification Change Log

Updates sent to participants monthly

<table>
<thead>
<tr>
<th>Chapter</th>
<th>CD #</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
<th>PTC I</th>
<th>PTC II</th>
<th>Date Change</th>
<th>Criteria</th>
<th>Resources 2014 Orange Book Description of Criteria</th>
<th>Clarification</th>
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<tbody>
<tr>
<td>1</td>
<td>1-1</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1-1).</td>
<td></td>
<td>TYPE II</td>
</tr>
<tr>
<td>1</td>
<td>1-2</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>They must function in a way that pushes trauma center–based standardization, integration, and PIPS out to the region while engaging in inclusive trauma system planning and development (CD 1-2).</td>
<td></td>
<td>TYPE II</td>
</tr>
<tr>
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<td>1-3</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>Meaningful involvement in state and regional trauma system planning, development, and operation is essential for all designated trauma centers and participating acute care facilities within a region (CD 1-3).</td>
<td></td>
<td>TYPE II</td>
</tr>
<tr>
<td>2</td>
<td>2-1</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>This trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care (CD 2-1).</td>
<td></td>
<td>Type I</td>
</tr>
<tr>
<td>2</td>
<td>2-2</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>II</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>Surgical commitment is essential for a properly functioning trauma center (CD 2-2).</td>
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<tr>
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<td>2-3</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification (CD 2-3).</td>
<td></td>
<td>TYPE II</td>
</tr>
<tr>
<td>2</td>
<td>2-5</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>I</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>Revised</td>
<td>Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review (CD 2-5).</td>
<td></td>
<td>TYPE II</td>
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</tbody>
</table>

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Recording of Webinars

The webinars are recorded during the session and will be posted within one week on the ACS YouTube channel.

You may also access them via the VRC resources webpage at:

https://www.facs.org/quality-programs/trauma/vrc/resources.
Disclaimer

• All questions are pulled directly from the question submissions. There have been no edits made to the contents.

• If your question is not answered today, the question may require more information, and will receive a response from ACS staff within one week after the webinar.
Announcements
Next Verification Q&A Webinar

Deadline to submit questions: Friday, February 10, 2017

Webinar date: Wednesday, February 22, 2017

Webinar time: 12:00pm - 1:00pm CST
2017 TQIP Annual Scientific Meeting and Training

Save the date!

November 11-13, 2017

HILTON CHICAGO | CHICAGO, IL
Call for Data

• The next TQIP quarterly Call for Data will open February 1st.

• Please submit your 4th quarter of 2016 data as well as any updates to previous submissions dating back to the 3rd quarter of 2015.

• The Call for Data will close on Wednesday, March 1st.
Stop the Bleed website is now live!
Scheduling Reminders
Site Visit Application

• The application must be received at least 13-14 months in advance of the requested time frame or current expiration date.

  - This will hold your spot and in addition, provide centers plenty of time to prepare and complete the online PRQ.

• The lead time is required due to the multitude of applications received.

• All of 2017 and January 2018 are closed to scheduling, [https://www.facs.org/quality-programs/trauma/vrc/site-packet](https://www.facs.org/quality-programs/trauma/vrc/site-packet)
Orthopaedic Traumatology Leader (OTL) Form

• For Level I adult or Level I pediatric trauma centers, the OTL form must be completed and submitted with the site visit application.

  ▪ The form is located at: [https://www.facs.org/quality-programs/trauma/vrc/site-packet](https://www.facs.org/quality-programs/trauma/vrc/site-packet)

• For those trauma centers that have separate visits scheduled, but share the same adult and pediatric OTL, the form must be completed entirely for the 1st visit and on the 2nd visit, only answer questions 1-3.

  ▪ If you are unsure if the 1st visit has completed the form, please contact the VRC office at COTVRC@facs.org.
PRQ Online Access

• The VRC office will provide you with an email receipt when the application is received.

  - Logins to the online PRQ will be provided within the context of the email.

  - The online PRQ can be accessed at: http://web2.facs.org/traumasurvey5/.
Site Visit Application Payment

- Do not submit payment with the application.
- 60 to 90 days before your visit, your center will be invoiced for the Quality Program fee that includes the fees for both the site visit and TQIP.
- Centers will then be invoiced annually for the Quality Program fee for the remainder of the verification cycle.
  - 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](https://www.facs.org/quality-programs/trauma/vrc/fees)
Scheduling Site Visits

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

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

- When a lead reviewer is available for your site visit, contact will be made to the TPM prior to confirm the dates.
General Questions
New Trauma Centers Seeking Verification

“How much lead time would you advise for a hospital to prepare to become a Level 2 trauma center ‘right out of the gate?’ Is an ACS Consultation Visit recommended prior to an Initial Verification Visit? Are there consequences if this is not obtained?” (Level II Center)

The timeline will vary based on the progress of the trauma center such as, having the infrastructure, resources for staffing/surgeons/specialists, equipment, registry software, trauma data, compliance with the standards, etc. For example, a center that has been actively functioning as a trauma center for a period of time (3 years) may choose to seek a verification visit if they are in compliance with all the standards. For a trauma center that is newly developed, it may take 3 years or more to be fully functioning and able to pursue a verification visit.
New Trauma Centers Seeking Verification

A consultation visit is not required for verification.

The benefit of having a consultation visit for any trauma center, new or existing, is that it will assess your trauma care and confirm compliance with the requirements. It will identify areas for opportunities and provide guidance in being successful during a verification visit. Some trauma centers treat the consultation visit as a mock survey to verification.
New Trauma Centers Seeking Verification

“Please confirm how long a level III should be in pursuit of level II trauma status before ACS consultation and then verification.” (Level III Center)

The timeframe between a consultation and a verification visit will vary based on the progress the trauma center is able to make following a consultation visit. Changes or modifications to a standard or a current process will require the trauma center to implement, track and monitor it through the PIPS process to ensure there are no adverse outcomes.

For a successful verification, a trauma center should have a verification visit 18 months following a consultation visit.
“Have there been any additional updates to the Q&A document?” (Level II Center)

We are currently developing a Verification Frequently Asked Question document.

We provide monthly updates of the Clarification Document and the Verification Change Log. There may be times where there will not be any updates for either of these documents. This will be noted in the body of the email.

Updated Word versions of the PRQs that match the online versions are located at: www.facs.org/quality-programs/trauma/vrc/resources.
Tiered Activations

“A third level of activation exists here that is deemed ‘consult’. A 6 hr response time max was set. Comment?” (Level II Center)

It is appropriate to have multiple tiers and it is common for the 3rd tier to be identified as the consult tier.

The criteria for the consult tier must be established by the institution. The time expectation for the types of injuries the Emergency Medicine Physician or Trauma Surgeon or Advance Practice Provider is expected to respond to will be determined by the institution. The most important thing will be to follow the metrics through the PIPS process.
Coordinating Reporting Period to Site Visit Date

“Could you review determining the Review Year Dates / Interval related to the Scheduled Visit Date? This can seem tricky if you don’t have a clear review date until 60 days prior to the visit. (Level III Center)

The trauma center will indicate when it would like the visit scheduled by providing us with a 2 month timeframe on the site visit application. The trauma center will then base the reporting period from that timeframe with a 2 month lag. For example, timeframe provided on the application is March-April 2018, reporting period could be one of the following: January 2017-January 2018 or February 2017-February 2018.
Coordinating Medical Cases to Site Visit Date

“Do the pulled cases for the Verification Visit have to come from the Review year, or can they be more recent and fall outside of that year interval?”

If the minimum medical cases cannot be met for the reporting year as listed in the Review Agenda, the center may pull medical cases outside the reporting period if it impacted the center’s performance improvement (PI) process. In addition, if there were medical cases that impacted a change in the PIPS process, you may have those onsite for the review team.

The Review Agenda is located at: www.facs.org/quality-programs/trauma/vrc/resources.
Pediatric Medical Cases

“For chart categories for an adult center review, is ‘pediatrics’ category included if center has separate peds designation?” (Level II Center)

If the adult trauma center admits pediatric patients, it is required to pull the pediatric cases as noted on the Review Agenda: www.facs.org/quality-programs/trauma/vrc/resources.

If the adult trauma center does not admit pediatric patients and/or transfers those patients to the pediatric trauma center, it is not required to pull pediatric cases. However, all transfers must be reviewed through the PIPS process (CD 4-3).
EMS Feedback

“I struggle with certain fire departments for run sheets. I am wondering if there is a law or rule that I can quote with yet another plea for their compliance. I feel as though I otherwise have no leg to stand on except for nagging which is time consuming.” (Level III Center)

There is a requirement that a representative from the Emergency Department must participate in the prehospital PIPS program (CD 7–8). This person can be your champion to facilitate feedback from the EMS agency to assure continuity of care for those patients. The feedback will vary from state to state and from EMS agency to EMS agency. There are various forms of receiving the information for example,

- Encrypted Email feedback,
- Feedback built into EMS electronic documentation,
- EMS portals/websites.
Membership to an Organization

“Also, how important is it to be an associate member of AAAM as a level III trauma center?” (Level III Center)

For Trauma Verification it is not a requirement for the registrar or someone in the trauma service to be an associate member of the Association of the Advancement of Automotive Medicine (AAAM).
Pre-Review Questionnaire: Payor Mix

“In regards to the Trauma Center Payor Mix: are you looking for all patients seen at (both inpatient and outpatient)? Or just all patients that came in through the ED (whether they ended up as an inpatient admission or an outpatient visit)?” (Level Unidentified)

For Trauma Verification, all patients seen as an inpatient and outpatient admission.
Pre-Review Questionnaire: Reporting Year

“When completing my PRQ for a survey in May, do they want the peer review attendance for my PRQ reporting year, March 2016–March 2017, or can I present it as we monitor in a calendar year form, Jan-Dec? I suppose the same goes for other things we monitor like CME requirements...can we present in calendar year form?” (Level I Center)

For upcoming scheduled visits, the data and documentation must reflect the reporting year. The documentation will vary for the liaisons to Orthopaedic, Neurosurgery, Emergency Medicine and Critical Care who require 48 hours of external trauma-related CME over the course of 3 years.
Pre-Review Questionnaire: Neurosurgery Coverage

“Regarding neurosurgical coverage at a level 1 adult, level 2 pediatric trauma center (Section VIII Neurosurgery, question 11, section i and ii: Can coverage/response by a chief neurosurgical resident be considered an adequate back-up to the neurosurgeon attending who may be encumbered if in another emergency? Or is the encumbered neurosurgeon required to have an attending neurosurgeon as the backup contingency?” (Combined Center)

It is acceptable if there are agreed upon guidelines between the Trauma Medical Director and the Neurosurgeon liaison for the types of injuries the Resident or Physician Assistant will respond to. There must be clear documentation with the attending specialist surgeon on the plan of care.
“Each webinar has had a question about FAST exam physician credentialing and QI - Is there a CD in the Orange book about this?” (Level II Center)

There are **no** CDs or requirements regarding FAST exams.
Ongoing Professional Practice Evaluation (CD 5-11)

“Could you please elaborate on the TMD responsibility to perform an annual assessment of the trauma panel providers and does this Q1 include Surgeons and ED Practitioners?” (Level III Center)

The Trauma Medical Director (TMD) is responsible for conducting an OPPE for the Trauma Surgeons and Trauma Practitioners. The TMD is not expected to perform an OPPE on the specialists for the ED Physicians or ED Practitioners, Neurosurgeons, Orthopaedic Surgeons, etc. The OPPE for these specialists should be performed by their respective directors with oversight by the TMD.
“Is it acceptable to define and design our own trauma nursing educational program? Are TNCC®, TCAR®, etc. required for nursing education? We are finding it more and more difficult to maintain these programs.”

(Level III Center)

Training and certification in other programs such as TNCC™, TCAR®, etc., should be available to nurses working in critical areas such as the Emergency Department and the Trauma Intensive Care Unit. While there is no requirement for nurses to have education, all trauma center levels must provide a mechanism to offer trauma-related education to nurses involved in trauma care (CD 17-4).
Performance Improvement Coordinator

“Why has the ACS-COT not made it a requirement to have Adult Trauma Process Improvement Coordinators?” (Level I Center)

Currently there is not a requirement for any trauma center to have a Performance Improvement Coordinator.

The stakeholder public-comment website has been launched. We encourage you to comment on these types of requirements that will help your trauma program be successful.

https://www.facs.org/quality-programs/trauma/vrc/public-comment
Free standing ED Facilities

“What are the requirements for tracking trauma's seen at an off campus ED if the main campus is a level III Trauma Center? If you are a level III Trauma Center and have an off campus ED, is the off campus ED included in the re-verification process? Would the off campus ED data be submitted with the main campus ED data, do you have to identify which ED the patient was seen in?” (Level III Center)

The free standing Emergency Department (ED) facility is seen as a separate entity from that of the trauma center. During a consultation or re-/verification visit, the facility will not be included in the review process. However, patients presented there will be viewed as an interfacility transfers to the trauma center.
Triage: Over/Under Rates

“Can you explain and provide an example of the over/undertriage tool utilization for correct implementation.” (Level III Center)

Overtriage

- Minimally injured patients taken to highest level of care (25-35% acceptable)

Undertriage

- Severely injured patients taken to lower level of care (optimal goal <5%) (CD 3-3)
### Triage: Monitor Activations

**The Required Minimum “7” Refer to page 38**

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<table>
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<tr>
<td>1. BP &lt; 90</td>
<td>Additional criteria</td>
</tr>
<tr>
<td>2. GSW to trunk or extremities proximal to the elbow/knee</td>
<td>Reassess annually</td>
</tr>
<tr>
<td>3. GCS &lt; 9</td>
<td>Use your registry data</td>
</tr>
<tr>
<td>4. Transfer with blood</td>
<td>Compare to your under/over triage rates</td>
</tr>
<tr>
<td>5. Scene intubated</td>
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</tr>
<tr>
<td>6. Respiratory compromise</td>
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<tr>
<td>7. ED physician discretion</td>
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# Triage: Example of ISS Method

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<th>Activation Team / Level</th>
<th>ISS 1-15</th>
<th>ISS 16-75</th>
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<td>10</td>
<td>20</td>
<td>30</td>
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<td></td>
<td>10/30= 33% Overtriage</td>
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<tr>
<td>Limited / No Team</td>
<td>185</td>
<td>15</td>
<td>200</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15/200= 7.5% Undertriage</td>
</tr>
<tr>
<td>Total</td>
<td>195</td>
<td>35</td>
<td>230</td>
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CD-Related Questions
Level I Volume Requirement (CD 2-4)

“Our facility is considering seeking verification as a Level I (presently Level II), this question is about the volume requirement. Does the volume of 1,200 admissions need to be sustained for 3 continuous years prior to requesting a Level I consultation or site visit or can one request a visit after a one or two years at the 1,200 volume?”

(Level II Center)

The Level I trauma center must admit at least 1,200 trauma patients yearly or have 240 admissions with an Injury Severity Score of more than 15 during the reporting year. The reporting year is the timeframe leading up to the site visit for either a consultation or re-/verification. The volume is not cumulative over the 3 year period.
“As a Level III Trauma Center, do we need transfer agreements with Level I facilities that we transfer to a couple times a year?” (Level III Center)

In Level III trauma centers, there must be a transfer agreement or policy (as it is often referred to) for when a patient will be transferred to another institution, even if in rare cases.
Trauma Surgeon Back-up Call Schedule (CDs 5-7/6-8)

“Do surgeons covering back-up to the call schedule, have to meet all of the same requirements as surgeons taking call? CD6-8/5-7?” (Level I Center)

There are no requirements for the back-up trauma surgeons to meet the CME requirement (CD 5-7) or the peer review attendance (CD 6-8).
“CD 5-8 What is considered ‘active participation’ – does attendance at the yearly conference constitute active participation?” (Level I Center)

Yes, active participation is defined as attending a course or conference.
Limited Tier Response (CD 5-16)

“Is there a guideline about how long trauma patients ED LOS by category, FTTA, modified, consults (or however each org tiers them). I had an inquiry about the need/rationale for transfer agreements since by EMTALA laws they should accept.” (Level III Center)

For the limited tier team activation, the time expectation for the types of injuries/patients the surgeon will respond to will be determined by the institution. Most centers chose somewhere between 2 and 6 hours. The most important thing will be to follow the metrics established by the trauma center and monitor them through the PIPS process.
“Do allied health providers (midlevels, NP's, PA's) count as the surgeon response when responding to the lower level activations?” (Level III Center)

It is acceptable for the Allied Health Provider (AHP) to respond to the limited or consult tier. For the limited tier, the AHP must be current in ATLS. It is required that there be documentation where the AHP notifies/discusses care with the attending and that there is a clear expectation that is followed for compliance on admitted patients.
Board Certification for Emergency Physicians (CD 7-14)

“Will it be a CD if the board cert'd ED physician liaison is not current in ATLS? (suggested at our last visit)”

(Level II Center)

In Level I, II and III trauma centers, if the liaison is board-certified in Emergency Medicine, s/he is required to have successfully completed the ATLS course at least once (CD 7-14).

In Level I, II and III trauma centers, if the liaison is board-certified in something other than Emergency Medicine, such as Family Practice, Internal Medicine, etc., s/he is required to be current in ATLS (CD 7-15).
"What are examples of emergent and non-emergent neurosurgery consult criteria? What is an acceptable time parameter for non-emergent orthopedic consult?" (Level II Center)

The liaisons from Neurosurgery and Orthopaedic Surgery along with the Trauma Medical Director will define the emergent and non-emergent criteria and who is acceptable to respond, e.g., Neurosurgeon, Physician Assistant or Resident.

The following slide will provide some examples for Neurosurgery and Orthopaedic Surgery emergent criteria.
Examples of 30 minute response time patients

**Neurosurgery**
- Penetrating injury to head with altered mental status
- TBI with emergent surgical intervention
- TBI with emergent EVD monitoring

**Orthopaedic Surgery**
- Fracture with vascular compromise
- Complex pelvic injuries with limb/life threat
- Multiple open long bone fractures
Neurosurgery Contingency Plans (CDs 8-3, 8-4, 8-5)

“Does a ‘formally arranged contingency plan’ for Neurosurgery backup have to be a second person on call? What is an alternative?” (Level I Center)

Neuro Contingency Planning (CD 8-5) Level I, II

- Published back up call schedule (CD 8-3)
- Diversion plan: primary & backup Neurosurgeon is encumbered (CD 8-4)
- EMS notification of diversion
- PIPS review of each instance & process
Neurosurgery Contingency Plans (CD 8-5)

“Would like an example of contingency plan for neuro with credentialing for TS - can ACS publish one please.”

(Level II Center)

The following is an example from a Level III Neurosurgery contingency plan for credentialing of the Trauma Surgeon:

Patients with the following injuries or findings will be consulted by the Trauma Surgeon on-call and may be admitted to the X Hospital Trauma Service for management. Patients with recent mechanism of injury and:

- Sub-acute (2 days – 3 wks) or chronic (>3wks old) intracranial hemorrhage with no evidence of recent expansion
- Small acute subarachnoid or subdural hemorrhage:
  - causing no mass effect on CT, and
  - in patients with GCS ≥ 14, and
  - without evidence of expansion on repeat CT within 12 hours of admission.
- Acute intracranial hemorrhage but with advanced directives or family decisions indicating non-operative management and palliative care provision
- Stable vertebral column fractures
“Must a level II trauma center have complex orthopedic capabilities (acetabulars/open book pelvic fxs) OR can they transfer these pts?” (Level III Center)

There must be protocols for the type and severity of pelvic and acetabular fractures that will be treated at the institution, as well as those that will be transferred out for care and these protocols must be part of the PIPS process (CD 9-14). Refer to Chapter 9, pages 61 in the Resources manual for more information.
Board Certification for Anesthesiologist (CD 11-11)

“Is the board certification requirement for all anesthesiologist taking call or just the liaison?” (Level II Center)

Board certification or eligibility for certification is essential for the Anesthesiologist liaison who participates in trauma call at Level I and II trauma centers (CD 11-11).

This was a change from the Resources manual. Refer to the Verification Change Log, www.facs.org/quality-programs/trauma/vrc/resources.
Operating Room Backup Team (CD 11-15)

“CD 11-15; If the first OR is occupied, an adequately staffed additional room must be available. Is there a time requirement?” (Level II Center)

No, there is not a defined time for when the 2nd Operating Room team (backup) must respond when requested. The institution must establish a response time and monitor the team’s response times for any delays through the PIPS process.
“Will it be acceptable for interventional cardiologist and cardiovascular surgeons to perform interventional procedures?” (Level II Center)

Yes, this is acceptable. These specialists are trained and skilled in interventional procedures.
Board Certification for ICU (CD 11-49)

“The ICU team may be staffed by critical care physicians from different specialties but must remain surgically directed, as noted above (CD 11–49). The ICU physicians should all be currently board certified or eligible for certification by the American Board of Surgery according to current requirements in critical care - Orange Book, page 81 at the top. These are contradictory sentences. Can the ICU physicians be from different specialties OR do they all need certification by ABS?”

(Level I Center)

Typically the ICU team will be comprised of members from various specialties and residents as long as it is surgically directed by a Trauma Attending who is board certified in Surgical Critical Care (CD 11-49). The ICU members are required to be board certified by their respective boards, but are not required to be board certified in Critical Care.
ICU Coverage (CD 11-51)

“Does the PIPS program have to have an exact response time of the ICU physician for each time they are called for a critical trauma patient? What level of documentation is required for this? Does 24/7 ICU in-house attending coverage satisfy this?” (Level Unidentified)

 Appropriately trained physicians must be available in-house within 15 minutes to provide care for the ICU patients 24 hours per day (CD 11-51). This coverage may be performed by an appropriately supervised Senior Surgery Resident or an in-house Trauma Attending credentialed to provide critical care.

Since there is a response time, documentation of the Trauma Attending’s arrival at bedside should be documented in the H&P or in the chart.
“Is microvascular surgery still a required specialty for a Level II Trauma Center?” (Level II Center)

Yes, a Level II trauma center must have a Microvascular Surgeon, or coverage may be satisfied by having a surgeon who uses an operating microscope for nerve repair, free tissue transfer, etc. The microvascular capability is not required inhouse 24/7, but must have a surgeon consultant available to respond, in person, when requested by the attending surgeon.
"Do all APRN's/PA's need to have ATLS, regardless if they participate in activations?" (Level II Center)

The APRN’s/PA’s who are not involved in the trauma team activation, are not required to be current in ATLS.

Those APRN’s/PA’s that function as a member of the trauma team activation and are caring for trauma activation patients via assessment or interventions must be current in ATLS. If the Trauma and/or ED APP’s only role is as a scribe or entering orders they would not need to meet the ATLS requirement.
Registrar Training (CD 15-7)

“ATS recommends at least 2-3 years trauma registry practice before sitting for CSTR. Why does ACS demand passed within 1 year?” (Level I Center)

To clarify, we are not asking the registrar to sit for the Certified Specialist in Trauma Registries (CSTR). The expectation is for new 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. Please refer to the Clarification Document, www.facs.org/quality-programs/trauma/vrc/resources.
Universal Screening Interventions (CD 18-4)

“What do you consider ‘appropriately trained’ staff when talking in reference to CD 18-4 providing brief intervention.”  (Level I Center)

“Does SBIRT screening compliance need to be monitored and run by Case Management/Social Worker or can it be the IP Coordinator?”  (Level II Center)

The requirement reads as: ‘appropriately trained staff’ must conduct the SBIRT. It refers to ‘should’ be someone with training in intervention. Someone trained in SBIRT will suffice.
What exactly is ‘trauma related’ CME?”  (Level I Center)

Trauma-related CME is defined as attending a course (online/in-person) or national/regional conference that are relevant to the management of a trauma patient and their care.
“Can attendance at grand rounds presentations of a trauma related topic be counted for CME? Do journal club discussions of trauma topics count for external or internal CME?” (Level I Center)

As mentioned in the previous slide, external-trauma related CME is defined as attending a course (online/in-person) or national/regional conferences that are relevant to the management of a trauma patient and their care.

Acceptable Internal Education Process (IEP) activities include the presentation or discussion of trauma-related topics in the following settings: in-service lectures, educational conferences, grand rounds lectures, an internal trauma symposium, or in-house publication and dissemination of information gained from a conference or peer-reviewed publications. The total hours acquired through the IEP should be functionally equivalent to 16 hours of CME.
CME: Pediatric (CDs 10-29, 10-40)

“Why do we need to track CD 10-29 if all physicians need pediatric trauma CME (CD 10-40)?” (Level II Center)

CD 10-29 refers to providing pediatric specific education to non-trained pediatric specialists such as Anesthesiology, Neurosurgery, Orthopaedic Surgery, Emergency Medicine, Radiology, and Rehabilitation externally or internally.

CD 10-40 quantifies the number of external trauma-related CMEs required for panel members such as, other General Surgeons, Orthopaedic Surgeons, Neurosurgeons, Emergency Medicine Physicians, and Critical Care Physicians. This may be met acquiring 16 hours of CME per year, on average, or by demonstrating participation in an Internal Educational Process (IEP) conducted by the trauma program based on the principles of practice-based learning and the PIPS program [equivalent to 16 hours annually].
“ACS offers up to 90 CMEs for SESAP (Surgical Education Self-Assessment Program). Can trauma surgeons use any or all of these CME? For new ED physicians that just completed residency, are they required to have CMEs also?” (Level II Center)

SESAP only awards 6 hours of external trauma-related CME.

For new physicians/surgeons who have just completed residency, they are required to have CME. However, if they are new to the service within the reporting year, their CMEs will be prorated. For example, if they were there just 4 months leading up to your visit, their CMEs will be prorated.
“How many trauma related CME’s can we give our physicians for taking the SESAP in addition to the trauma specified? Our MD's state that there are trauma related questions in other sections such as vascular, abd & head & neck in the SESAP. Our Trauma M&M is accredited for CME, can I give our non-liaison trauma surgeons credit for attending?” (Level II Center)

Refer to previous slide, SESAP awards 6 hours of external trauma-related CME.

Credit for the Trauma M&M may be awarded to meet the Internal Education Process (IEP) requirement.
“Do non-liaison ICU providers that potentially take care of trauma patients need trauma CME?” (Level II Center)

Yes, providers used to provide coverage for trauma patients in the ICU are expected to meet the same standards as the other surgeons, e.g., participate in an Internal Education Program that is case based learning, or obtain 16 hours of external trauma-related CME.
"The liaisons to the trauma program (emergency medicine, neurosurgery, orthopaedic surgery, critical care) have to have external CME’s. The ACS now allows one ‘alternate’ person to attend the multidisciplinary peer review meetings when the liaison is not available to attend the meeting. Does this ‘alternate’ person have to have external CME’s as well OR can their CME’s be all internal?"  (Level Unidentified)

For the peer review meeting, the noted alternates above are required to meet either the external trauma-related CME or the Internal Education Process (IEP) requirement.
Thanks for your participation!