Trauma Verification Q&A Web Conference

July 26, 2018
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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 center.
Let’s get started!
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](www.facs.org/quality-programs/trauma/vrc/resources)
Clarification Document and Verification Change Log

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

<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 Description</th>
<th>Resources 2014 Orange Book Description of Criteria</th>
<th>Clarification</th>
<th>Type</th>
</tr>
</thead>
<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 The Individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1-1).</td>
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<td>TYPE II</td>
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<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 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>
<td></td>
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<tr>
<td>1</td>
<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 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>
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</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 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>
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<td>2</td>
<td>2-2</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 Surgical commitment is essential for a properly functioning trauma center (CD 2-2).</td>
<td></td>
<td>TYPE I</td>
<td></td>
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<tr>
<td>2</td>
<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 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>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2-5</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td></td>
<td>I</td>
<td></td>
<td>7/1/2014</td>
<td>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).</td>
<td></td>
<td>TYPE II</td>
<td></td>
</tr>
</tbody>
</table>
Website Resources for Trauma Centers

- Recording of Webinars:
  https://www.facs.org/quality-programs/trauma/vrc/resources/webinars

- Stakeholder Public-Comment website:
  https://www.facs.org/quality-programs/trauma/vrc/public-comment

- Frequently Asked Questions (FAQs):
  https://www.facs.org/quality-programs/trauma/vrc/faq

- Tutorials:
  - Becoming a Verified Trauma Center: First Steps
  - Becoming a Verified Trauma Center: Site Visit:
    https://www.facs.org/quality-programs/trauma/vrc/resources

- Participant Hub - Account Center:
  https://www.facs.org/quality-programs/trauma/tqp/tqp-center
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 now **online only** – No more printing.
- Can be accessed on the following ACS Trauma website pages:

**VRC – Site Visit Application**

[Image of VRC – Site Visit Application]

**TQP Participant Hub - Account Center**

[Image of TQP Participant Hub - Account Center]

- [https://www.facs.org/quality-programs/trauma/vrc/site-packet](https://www.facs.org/quality-programs/trauma/vrc/site-packet)
- [https://www.facs.org/quality-programs/trauma/tqp/tqp-center](https://www.facs.org/quality-programs/trauma/tqp/tqp-center)
Site Visit Application

• The ACS Trauma website pages will link to the Account Center page:
• 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 applications for May 2019 and onward.
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](https://www.facs.org/quality-programs/trauma/vrc/fees)
Scheduling Site Visits

• Visits are being scheduled quarterly

• We ask that you provide us with the exact dates you would like to have your site visit. The visit will occur on your chosen dates but we may ask for different dates if the review team cannot attend the requested dates

• Once the review team has been secured, you will receive a confirmation email that will include your reviewers and their contact information

• You will receive the confirmation email approximately 120 days prior to scheduled visit
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.
Site Visit Dates

“I have an application in for a site visit in late Jan 2019. Can I still request specific dates or will it be in the date range?” (Level 1)

• Yes, please email your specific dates to: rtanchez@facs.org
Site Visit Report
How is my site visit report processed?
Peer Review Process

• What does the peer review process do?
  
  • Ensures grammatical/stylistic consistency
  
  • Check-and-balance for deficiencies cited
  
  • Additional strengths, opportunities for improvement, and recommendations
Rough Draft Preparation

Report Writer System (RWS)

- Autofills any deficiencies based on PRQ responses
- Allows reviewers to input strengths, weaknesses (opportunities for improvement), recommendations, and reviewer comments into each chapter
Rough Draft Submission and Proofreading

- Lead Reviewer exports report from RWS and sends to Program Coordinator (PC)

- PC reviews report for:
  - Grammar/spelling
  - Formatting and consistency
  - Factchecking

- Upon completing review, PC will forward report along for additional peer review
Peer Review

- Report is reviewed by:
  - Clinical editor
    - Reviews the content of the report, makes comments and suggestions, and asks questions for clarification
  - Verification Review Committee
    - Reports distributed among 3 subgroups of approx. 18 committee members
    - Subgroup has 1 week to review report and ask questions/make suggestions
  - Verification Review Committee Chairs
    - Review final report and discussion transcripts before making final adjudication
Release of Final Report

- Approximately 8 weeks (2 months) from conclusion of site visit

- Upon receiving adjudication from chair, PC will apply cover sheet to report and prepare final letter

- Final letter and report will be distributed by email
  - Notify VRC of staffing changes and updated contact information
Announcements
Next Verification Q&A Webinar

Webinar Date:  **August 30, 2018**

Webinar Time:  **12:00pm-1:00pm CST**

Deadline to submit questions:  **August 15, 2018**
Hotel reservations are now open
Preconference Workshop Registration is now open:
www.facs.org/quality-programs/trauma/tqip/meeting
NTDB Call for Data

• The ACS COT Annual Call for Data is now open and will end October 1, 2018. During this call, we are accepting Admission Year 2017 Data. TQIP Participants are not expected to participate in this call for data and should follow their regular quarterly data submission schedule.

• Centers with upcoming Consultation or Verification visits will not have to pay to submit data.

• For more information or to begin the process of joining the Annual Call for Data, please visit our website: https://www.facs.org/quality-programs/trauma/ntdb/cfd-instructions.
PRQ Updates & Questions
PRQ Online Web Access

Due to scheduled maintenance, the online PRQ and site will not be accessible between 7AM - 11AM CST on Friday, July 27, 2018. Normal access will be restored after this time.
CME for all Specialties & Appendices

• Programming to update the CME questions in the PRQ will take place on Friday, July 27th.

• For the appendices, only enter the CME section for the Adult and/or Pediatric Trauma Medical Director (TMD) and anyone who is new or has previously been approved for the Alternate Pathway (AP).
PRQ - Data Tables

“PRQ instructions state to use NTDS criteria, but that excludes pts discharged from the ED and PRQ asks questions related to these pts. This seems contradictory. How do we reconcile these numbers?” (Level 2)

The PRQ asks the same question. The PRQ has one table that asks for the number of trauma patients discharged from the Emergency Department. Those discharged within 23 hours should not be included in the remaining tables under total of admitted trauma patients.
### PRQ – Section II Data Tables

5. Complete the table below for total number of emergency department (ED) visits for reporting year with ICD-9 code between 800.00 and 959.9.

<table>
<thead>
<tr>
<th>ED Trauma Visits</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted ED Trauma Visits (Regardless of Service)</td>
<td>882</td>
</tr>
<tr>
<td>Blunt Trauma Percentage</td>
<td>85</td>
</tr>
<tr>
<td>Penetrating Trauma Percentage</td>
<td>3</td>
</tr>
<tr>
<td>Thermal Percentage</td>
<td>2</td>
</tr>
</tbody>
</table>

6. Disposition ED Trauma Visits

<table>
<thead>
<tr>
<th>Disposition</th>
<th>ED Trauma Visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged</td>
<td>684</td>
</tr>
<tr>
<td>Transferred Out</td>
<td>96</td>
</tr>
<tr>
<td>Admitted</td>
<td>882</td>
</tr>
<tr>
<td>DIED in the ED Excluding DOAs</td>
<td>1</td>
</tr>
<tr>
<td>DOAs</td>
<td>8</td>
</tr>
<tr>
<td>Total</td>
<td>1070</td>
</tr>
</tbody>
</table>

7. Total Trauma Admissions by Service.

<table>
<thead>
<tr>
<th>Service</th>
<th>Number of Admissions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trauma</td>
<td>259</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>3</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>2</td>
</tr>
<tr>
<td>Other Surgical</td>
<td>2</td>
</tr>
<tr>
<td>Burn</td>
<td>0</td>
</tr>
<tr>
<td>Non-Surgical</td>
<td>216</td>
</tr>
<tr>
<td>Total Trauma Admissions</td>
<td>882</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Nonsurgical admissions (NSA)</th>
<th>0-9</th>
<th>10-15</th>
<th>16-24</th>
<th>&gt; 25</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patients admitted to a non-surgical service (from Table 7)</td>
<td>156</td>
<td>14</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Percent of total NSA</td>
<td>50</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total NSA w/truma consult</td>
<td>14</td>
<td>3</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Total NSA w/truma surgical (including trauma)</td>
<td>168</td>
<td>14</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Total NSA secondary to single-level falls</td>
<td>112</td>
<td>9</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Total mortality (for each ISS category)</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

11. Injury Severity and Mortality

<table>
<thead>
<tr>
<th>ISS</th>
<th>(A) Total Number of Admissions</th>
<th>(B) Total Number of Deaths from Admissions by ISS</th>
<th>Percent Mortality (less than A)</th>
<th>Number Admitted to Trauma Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-9</td>
<td>455</td>
<td>3</td>
<td>6%</td>
<td>355</td>
</tr>
<tr>
<td>10-15</td>
<td>84</td>
<td>0</td>
<td>0%</td>
<td>47</td>
</tr>
<tr>
<td>16-24</td>
<td>50</td>
<td>3</td>
<td>6%</td>
<td>50</td>
</tr>
<tr>
<td>&gt; 25</td>
<td>24</td>
<td>9</td>
<td>38%</td>
<td>42</td>
</tr>
<tr>
<td>Total</td>
<td>882</td>
<td>15</td>
<td>22%</td>
<td>560</td>
</tr>
</tbody>
</table>
General Questions
Alternate Pathway Criteria

“If a Neurosurgeon call panel member is FACS, but NOT US boarded, are they then exempt from the alternate pathway requirements?” (Level 1)

U.S. or Canadian non-board certified surgeons who were inducted as a Fellow of the American College of Surgeons (FACS) prior to January 1, 2017 are not required to meet (exempt from) the APC process and, therefore, will not be required to have an onsite review.
Alternate Pathway Criteria

“If a surgeon is not trained in the US, but has completed several fellowships in the US, can he take trauma call if he is ATLS?” (Level 3)

U.S. or Canadian non-board certified surgeons who did not trained in the U.S. but has completed several U.S. fellowships may be acceptable to participate on the trauma call panel if they have been approved by way of the Alternate Pathway Criteria.
Staffing

“What is the recommended staffing for a level III trauma program for approx. 900 patients per year (including Trauma Program Manager, Trauma PI nurses, Registrars, etc.)?” (Level 3)

The number of staff will vary based on the patient volume at all trauma center levels.

For a Level III trauma center, the Trauma Program Manager (TPM) may also act as the Registrar. However, if the TPM’s role is encumbered by the duties of the registry or if the number of admitted patients in the registry is over 750, there will need to be a separate FTE.

Trauma PI nurses are not required.
FAST Exams

“What is the requirement for performance improvement with FAST exams for Level II and Level III centers?” (Level 2)

There are no requirements regarding FAST exams.

The PRQ does ask to describe the QI (PIPS) process for the Fast exams. This is used to assess the process, but does not infer a criterion deficiency (CD) will be cited.
“For the PRQ, does the washout of open fractures have to occur in the OR to be counted, or can a washout at bedside be used?” (Level 1)

Chapter IX: Orthopaedics, question #16: Average and range of the time to washout of open tibial fractures secondary to a blunt mechanism;

- List as an average with a range for washouts that occur only in the operating room
- Do not include washouts at bedside
“Has the ACS - COT defined any timeline by which Attending Radiologist final reads/reports should be completed on Trauma patients” (Level 1)

A timeline by which the final read must be done has not be established.
“In the ED for activations we are on paper until after CTs at which time they switch to EMR documentation. Is there any recommendation to stay on paper if started that way or length of time to do that? Was sited as a weakness at recent review.” (Level 2)

The VRC's stance on this is that the electronic flowsheets must contemporaneously document the care of the patient. Typically with electronic flowsheets it date stamps at the time of key stroke or an entry is made; therefore, you must be cognizant of the date/time stamp.

If reviewers see a number of instances where the date/time is not accurately documented, they may site this as a weakness and recommend to revert back to the paper flowsheet or further education regarding the electronic flowsheet.
Transfer to Non-Trauma Center

“During the June webinar, it was stated that it was acceptable for a Trauma Center to transfer neuro trauma- please clarify!” (Level 1)

In the June webinar, the response was for a Level III trauma center transferring patients. Level III trauma centers are not required to have neurosurgery capabilities.

As a Level I trauma center, it would be a rare event that the trauma center would transfer a neurotrauma patient unless patients were being diverted based on your contingency plan or diversion policy such as, flooding, equipment repair, etc., or discharged and transferred to a neuro facility for specialized care.
Referring Facility Feedback

“What specific information from referring facilities is to be in patient's chart for transfers to the trauma center?”

(Level 2)

Although this is not a requirement, it is an essential responsibility of a tertiary facility to provide specific feedback to referring facilities and prehospital providers. The feedback should include final diagnosis; the general course and outcome of the patient, and any PI issues that the tertiary facility identified in the care provided prior to arrival and/or transfer.
Transfer Agreements

“Are transfer agreements required between facilities that operate under the same corporate umbrella?” (Level 3)

Patients who are transferred to or from another facility whether that is a sister hospital operating under the same license, a transfer agreement is required. The transfer agreement may include all of the facilities that it will transfer trauma patients to and from.
CD-Related Questions
“Is it required that the TMD also take trauma call?” (Level 1)

Yes. The Trauma Medical Director (TMD) must participate in trauma call.
“Is a departmental summary of OPPE’s sufficient for the ACS review or do you need an individual provider’s OPPE’s available for each department?” (Level 2)

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. If the question is referring to the TMD signing off on the FPPE/OPPE for specialty providers, the expectation is that the OPPE for all specialists should be performed by their respective directors, with oversight from the TMD. Have available a copy of the documentation for each of the services. It is not required to have the OPPE documentation for each panel member at this time.

https://www.facs.org/quality-programs/trauma/vrc/resources
Activation Criteria (CDs 5-13/5-16)

“If an incoming pt is a traumatic arrest, should that pt be made a full activation or is the activation level up to MD discretion” (Level 2)

The activation for a traumatic arrest will depend on your trauma center’s activation policy. Most often if it is a traumatic arrest due to a penetrating injury to the chest, it may fall under the highest level of activation.
"If you are a combined Level 1 Adult and Level 2 Pediatric, do you have to have 2 separate Program Managers?" (Level 1)

Yes. In verified adult Level I and Level II pediatric trauma centers, there must be 1 FTE Trauma Program Manager dedicated to each program. The pediatric program may have a Pediatric Trauma Coordinator (TPC) and this person may have additional duties as long as it does not encumber their duties as the TPC such as, Trauma Registrar for the pediatric program or the Injure Prevention Coordinator.
Trauma Program Manager (CD 5-24)

“cd 5-24. define clinical experience in the care of the injured patient? are you requiring we become bedside clinicians?” (Level 1)

No. The expectation is that the trauma center will credential the candidate to have clinical experience in the care of the injured patients. This may include job experiences, education or training such as, Emergency Medical Technician, Paramedic, Registered Nurse, etc.

It is not required that the candidate be a Registered Nurse.

On page 42 in the Resources manual under Clinical activities it lists the following: Coordinate management across the continuum of trauma care, which includes the planning and implementation of clinical protocols and practice management guidelines, monitoring care of in-hospital patients, and serving as a resource for clinical practice.
“Are there any caveats regarding peer review attendance for rotating military trauma surgeons?”

(Level 1)

Peer review meeting attendance may be waived for deployment, medical leave and missionary work. The center must provide documentation to support the absence.
“I have a two-part question for the upcoming July webinar. We are a Level 1 Pediatric Trauma Center attached to a separately verified Level 1 Adult Trauma Center. If adult trauma surgeons are primary responders for peds trauma activations above a certain age at night and on weekends, are all of the adult trauma surgeons required to attend the peds peer review conference at least 50% of the time? What about if the peds trauma surgeons are primary responders for all peds activations 24/7 and the adult trauma surgeons are only providing backup coverage?” (Level 1)

Peer review attendance for combined programs are as follows: there must be a representative (TMD or designee) from the adult program or from the pediatric program, attend the others program meeting, and ensure dissemination of communication is sent to the other panel members.
Neurosurgery Coverage (CDs 8-3/8-4/8-5)

“In a Level 1 trauma center, is a second call neurosurgeon required or is a contingency plan sufficient?” (Level 1)

A Level I trauma center must have a published neurosurgery call schedule. If the primary neurosurgeon is encumbered such as, with a trauma activation or in the operating room, the contingency plan is activated or the back-up neurosurgeon is called.
“Does the ICU staffing patient ratio requirement apply to those patients that are held (boarded) in the ED? Example is a patient came in and is to go to ICU for their injuries. ICU is full and not accepting any admissions. Pt is held in ED until a bed is open. Does the ICU staffing ratio apply to the ICU admitted pt physically in the ED?” (Level 3)

No. The patient-to-nurse ratio of 2:1 is for patients while in the ICU floor/unit.
“What place, if any, does or should cardiothoracic surgery have in the trauma PIPS program?” (Level 3)

Level III trauma centers are not required to have Thoracic Surgery capabilities.
Hand Surgery (CD 11-71)

“As a Level 2 program, is it essential that we have Hand Surgery Service? Or is it adequate if we have a solid transfer plan?” (Level 2)

A Level II trauma center is required to have hand surgery capabilities. The center may have a transfer agreement in place for implantations, but must have a hand surgeon available to consult at bedside for all other hand injuries.
Continuous Rotations for PGY 4-5 (CD 17-3)

“Please define ‘continuous rotations’ for PGY4-5 for Level 1 facilities criteria. Specifically the expectations. Do they need to round daily, attend trauma conferences, respond to resuscitations. Thank you.” (Level 1)

The requirement is that there is a PGY 4-5 resident rotating on the Trauma Service. They should be rounding on patients, and any other requirements will be determined by the trauma center such as, attending trauma conferences, meetings, etc.
Alcohol Screening (CD 18-3)

“Is it a requirement for all injured patients to get a Universal screening for alcohol or only admitted patients?” (Level 2)

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 all admitted trauma patients including orthopaedic and neurosurgery.
Injury Prevention (CD 18-5)

“What are the expectations for the number of injury prevention projects/activities at a Level III facility?”
(Level 3)

For Level III trauma centers, there is no defined required number of injury prevention projects. The reviewers will ask how the center is helping the community with the most common causes of injury. Examples may include, alcohol or drug use among adolescents, elderly care & prevention, seatbelt safety, etc.
“Research Requirements: Please clarify for a Level 1 seeking initial verification. If an author is no longer with the organization, can we still use if published within 3 year period?” (Level 1)

If the author is no longer with the organization, the research publication may be used if it contained your hospital’s data.

If the author moves, the research publication does not move with them if the data used was from a specific hospital.
If a physician is not board certified in Emergency Medicine, but is currently board certified in Family Medicine or Internal Medicine or another specialty, they are not required to obtain CME.
CME - Certificates

“please clarify do we need to make copies of each providers CME certificates or just have a listing available?” (Level 2)

The requirement has changed to the following:

In Level I and II trauma centers, the Trauma Medical Director and/or pediatric Trauma Medical Director must have 36 hours of external trauma related CME*. The certificates must be available at the time of the site visit.

*The pediatric TMD must have 9 hours dedicated to pediatric trauma.
“With new IEP rules for ortho, neuro and ED, our visit is Oct 2018, do we have to show proof of IEP completion for last 3 years?” (Level 1)

No. However, if there were performance issues with any of those panel members, and it was rectified through an internal education process, you do want to make sure you have that available at the time of the site visit.
"How should we address Neuro Critical Care doctors with regards to CME? They are non-ABME.” (Level 1)

Neurocritical Care physicians are not required to comply with the CME requirement.
Thanks for your participation!