Trauma Verification Q&A Web Conference

October 25, 2018
COTVRC@facs.org

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Your Trauma Quality Programs Staff

Tammy Morgan  
Manager  
Trauma Center Programs

Molly Lozada  
Program Manager  
Trauma Verification

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!
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](http://www.facs.org/quality-programs/trauma/vrc/resources)
<p><strong>Clarification Document and Verification Change Log</strong></p>

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

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<td>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)</td>
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<td>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)</td>
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<td>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)</td>
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<td>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).</td>
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<td>7/1/2014 New Surgical commitment is essential for a properly functioning trauma center (CD 2-2).</td>
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<td>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).</td>
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<td>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).</td>
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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

- **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
New! Frequently Asked Questions

- Expanded FAQ webpage lunched October 2018
  
  https://www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/faq/standards

- Updated quarterly or as needed based on criteria changes or clarification updates

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Chapter 5

For a center pursuing Level II pediatric verification, can the Pediatric Trauma Program Manager/Coordinator also be the pediatric registrar?

If an isolated hip fracture patient requires ICU admission, does the ACS mandate the trauma surgeon admit, or is medicine acceptable?

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CD 5.8: Membership and active participation in regional or national trauma organizations are essential for the trauma director in Level I and II trauma centers and are desirable for TMDs in Level III and IV facilities (CD 5–8).

Please define the TMD being a member and active participation in regional or national trauma organizations.

The TMD must be a member and active participant of regional or national trauma organizations. Regional trauma organizations would include state symposiums. National trauma organizations would include AAST, EAST, WTA, PTS, ACS, etc.

For example, if the surgeon is a Fellow of the American College of Surgeons (FACS) and is an active member on the Committee on Trauma, this would be in compliance with the criteria.
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
• Will be presented every other month

• Next presentation will be November 2018

• Questions regarding, COTVRC@facs.org:
  ▪ Site Visit Applications:
    • Anita Johnson
  ▪ Site Visit Scheduling:
    • Rachel Tanchez
  ▪ Site Visit Reports:
    • Megan Hudgins or Bhumi Parikh
Announcements
Next Verification Q&A Webinar

Webinar Date: **Tuesday, November 27th**

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

Deadline to submit questions: **Monday, November 12th**
Deadlines, Thursday, October 25, 2018:

• Registration cancellation to receive a refund

• Pre-order merchandise through the online meeting registration site

• Hotel reservation at the meeting rate
  □ Reservations received after Thursday, October 25 or after the room block fills, are subject to rate and space availability

• For more information visit: www.facs.org/TQIPMeeting

• Information regarding the preconference workshops visit: https://www.facs.org/quality-programs/trauma/tqip/meeting/workshops
General Questions
Chapter Revisions

“Can you please clarify the update to Chapter XVI?” (Level 2)

Chapter XVI – Performance Improvement and Patient Safety

- Currently under revision
- Maintain TOPIC alignment
- Non-chapter 16 criteria will be moved to its original origin, e.g. Level I volume criteria CD 2-4 moved to Chapter 2
- Develop a process to support PI concepts, issues identification, action plans, loop closure/event resolution
Non-Trauma Center Transfer

“Seeking clarity regarding trauma center to non trauma center if the NTC has neuro capability. Orange book language seems to be no” (Level 3)

The VRC has historically not approved designated trauma centers to transfer trauma patients to non-designated trauma centers.
Anesthesia Requirement

“Is there any change with the anesthesia requirement for level 2?” (Level 2)

There have been no recent changes to the Anesthesia requirements for Level I and II trauma centers. The following still applies:

- In Level I and II trauma centers, anesthesiologist [liaison] taking call must be currently board certified or eligible for certification by an appropriate anesthesia board according to current requirements in anesthesiology (CD 11–11).
Direct Admits

“Are there any rules surrounding Direct Admits? ICU to ICU or floor to floor is permitted but what about transfers from another ED that have already been worked up fully? I am being asked by my throughput committee to gather feedback from you all. I was thinking no since there may be additional testing required or something missed that a full assessment in the ED would catch but wanted to gather your feedback for the committee.” (Level 1)

There are no criteria regarding direct admits. The VRC recommends patients who have been transferred in with a full work up at another facility be assessed in your Emergency Department for the opportunity to identify additional injuries.
**Direct Admit - Undertriage**

“Are direct admits supposed to be excluded from the Matrix Method calculations for over/undertriage? I would assume so since we really can’t activate this patients but wanted to check.” (Level 1)

If your trauma center admits a large number of direct admits, it may affect your data and ability to accurately review your activation criteria in the Emergency Department. You may have to do a few matrix methods to see how it will impact your over/undertriage rate. If too large a number, it may skew your data, so you may need to look at the direct admits separately for opportunities for improvement.
Mid-Level Providers

“Please explain criteria (ATLS, etc.) for mid-level providers who don’t respond to trauma resuscitation but participate in rounds” (Level 1)

Midlevel Providers, e.g. Advanced Practice Providers, Nurse Practitioners, etc., who participate in rounds are not required to have ATLS.

Current ATLS status is required of those members of the activation team that participate in the evaluation and resuscitation efforts. (CD 11-86).
Minimum Criteria for Full Trauma Team Activation

“Orange book page 38, Table 2, minimum criteria for Full Team Activation: GCS less than 9 with MOA of trauma; we have GCS MOTOR equal to or less than 5 in our activation criteria. Is that okay or do we need to change our criteria to GCS less than 9?” (Level 2)

If the center’s full trauma team activation minimum criteria as noted in the Resources book does not read the same as in your activation policy, it may likely be cited as a deficiency.

1. Confirmed blood pressure less than 90 mm Hg at any time in adults and age-specific hypotension in children;
2. Gunshot wounds to the neck, chest, or abdomen or extremities proximal to the elbow/knee (the latter was removed);
3. Glasgow Coma Scale score less than 9 with mechanism attributed to trauma;
4. Transfer patients from other hospitals receiving blood to maintain vital signs;
5. Intubated patients transferred from the scene, - OR -
6. Patients who have respiratory compromise or are in need of an emergent airway
   - Includes intubated patients who are transferred from another facility with ongoing respiratory compromise (does not include patients intubated at another facility who are now stable from a respiratory standpoint)
7. Emergency physician’s discretion.
“What do the ACS reviewers look at (form/minutes) to assure OPPE and/or FPPE is taking place for each trauma panel provider?” (Level 3)

The reviewers will review the form and/or minutes that reflect discussions and/or actions regarding, for example, performance or care issues with a member of the trauma team. For the specialists who serve on the trauma call panel, we are asking that the TMD have the ability to have input to those discussions/actions.
OPPE

“In the last webinar you presented responses regarding OPPE, in regards to the annual OPPE assessment for all services (trauma, ortho, NSR, EM, ICU) and the TMD should have oversight) are these OPPE to be generated by the Trauma program for these other services?” (Level 1)

No. The intent is that the TMD have input regarding any issues identified for the specialty members (other services) who serve on the trauma call panel.

It is possible that the Trauma Service or your Credentialing office develop a standardized OPPE template for members serving on the trauma call panel.
In all levels, there must be an OPPE/FPPE process. If a performance issue is identified, it must be documented and available during the site visit for reviewers.

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

- Peer review attendance
- CME if mandated by the center
- Patient Care
- Medical/Clinical Knowledge
- Complications, mortality rates, and participation in evidence-based guidelines, pathways, and protocols
- Interpersonal and Communication Skills
- Professionalism
Pediatric Admissions

“At pediatric trauma centers, who should admit pts who need a lac repair by plastics if plastics won't admit?” (Level 1)

This would be based on your trauma center's admitting policy. If this is something that is not currently in your policy, the TMD and TPM should take the opportunity to review and make adjustments to the admitting policy as it pertains to your program and providing optimal care to the injured patient.
Pediatric Admissions

“How do pts with dog bites to the face needing plastics to repair need to be admitted to trauma or can medicine admit these kids?” (Level 1)

The admission policy will be determined by each individual trauma center.

The patient may be admitted to Trauma or Medicine. This will depend on your admitting policy. If the patient is admitted to Medicine (non-surgical service) and requires a surgical consult, then Trauma or Plastic Surgery may be consulted.
Surgical Admissions

“If a patient is admitted to Plastics, is that considered a Surgical Admission? Is Plastics considered a Surgical Service? If a patient is admitted to Oral Maxfacial, is that considered a Surgical Admission? Is Oral Max considered a Surgical Service?” (Level 3)

Patients admitted to any of the surgical services below would be considered a surgical admission.

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PI Meetings

“What is the ACS position on recording PI meetings and what level of detail from the meeting is being sought by the reviewers? What is the acceptable level of detail, i.e. verbatim or paraphrasing acceptable” (Level 1)

In regard to recording of your PI meeting, I would defer you to your hospital’s legal advisor. Recordings would not be needed by the reviewers.

The PI meeting minutes do not need to be verbatim; however, it may be summarized so that the VRC reviewers can understand what was discussed.
Neurosurgery PI Meetings

"p. 56 The neurosurgeons should have regular meetings (at least quarterly), which should include a neurotrauma-specific PIPS process under the aegis of the multidisciplinary trauma PIPS program. Is this mandatory given the verbiage is ‘should’? And if the neurosurgery liaison isn’t present at trauma peer review, do we table the neurosurgery cases?” (Level 2)

Neurosurgery PI meetings is not mandatory. In some centers, the specialists may conduct their own PI meetings and report issues/opportunities to the Multidisciplinary Trauma PI meeting. In either case, if the Neurosurgery liaison is not able to attend the Trauma PI meeting, she/he may have a predetermined alternate.
PRQ: Burn Transfers

“PRQ: Are there standard definitions for the transfer out categories? i.e. Would a pediatric burn pt fall under pediatric or under bum?” (Level 2)

There are no definitions for the transfer out categories.

It could easily fit in either category, ‘Pediatric’ or ‘Bum’. If the pediatric bum patient is being transferred out for bum care only, it may be captured in the ‘Bum’ category.
“What is the expected response time for surgical sub specialties i.e. Urology, ENT? Can the institution identify situations when a surgical sub specialty is to be at the bedside within 30 min?” (Level 1)

Yes. The institution will define the injuries and time response required at bedside for the other surgical specialists - Urology, ENT, Plastic, etc.
“How is TQIP data going to be used during a reverification site visit? Will the reviewers have reports available to them prior to the site visit? Other than knowing the TQIP website, what is the best way for my center to be prepared with TQIP data during a site visit?” (Level 2)

Reviewers are provided a summary of the hospital's TQIP report to help frame discussion around your results and how those are utilized. We ask trauma centers to have a copy of the full report available at the time of the visit, if available.

In preparation for a visit, reviewers may ask the following:

- Explain why there are outliers – “Walk us through how you sorted a problem identified in your TQIP report?”
- “How long has it been a problem?”
- “How did you drill down?”
- “What opportunities were identified?”
Screenings for Alcohol and Post-Trauma Stress Disorder

“Can you clarify what the expectation is from ACS for Drug and PTSD screenings? What type of documentation and/or intervention?” (Level 2)

“For Level 2 verification is SBIRT specifically required for trauma patients with a positive ETOH?” (Level 2)

There are no ACS requirements for PTSD screening. If your trauma center provides PTSD screening for your trauma patients, the site reviewer may want to see guidelines on your evaluation, treatment and management of those patients.

For Level I, II and III trauma centers, universal screening for alcohol use must be performed for all injured patients and must be documented (CD 18-3).
Screenings cont’d.

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. Any patient with an altered mental status (and deaths) should be excluded from the denominator as these can’t get screened.

At Level I and II trauma centers, those 80% of trauma patients who screened positive must receive an intervention (CD 18-4). Those that are missed would subsequently be documented and reviewed through the PIPS process.
Staffing Ratios

“What is the ideal Trauma Program Manager and Trauma Coordinator ratio in a Level II facility? Is this based on volume?” (Level 2)

If I understand the question correctly, Level I, II and III trauma centers must have a Trauma Program Manager (TPM)/Coordinator/Directors. Titles are interchangeable.

In Level I and II trauma centers, TPMs must be full-time and dedicated to the trauma program.

In a Level III trauma center, TPMs do not need to be full-time or dedicated to the trauma program.

In a combined adult Level II and pediatric Level II trauma center, the TPM can oversee both programs. Dependent on volume.

If you are asking about staffing support for the TPM/Coordinator, this will be determined by the institution and the needs of your program.
Nurse Reviewer on Verification Site Visit

“When a nurse reviewer attends the verification survey, what will she be looking at which is different from MD reviewer? Will she be focused on nursing practice as well? Describe her function in survey.” (Level 1)

The nurse reviewer is typically assigned the following sections of the PRQ: TPM, Trauma Registry, Advanced Practitioners, Education/Outreach, Prevention and PIPS.

Nurse reviewers are detailed oriented and as your peer, they will review:

- Nursing practice as it pertains to your hospital policy
- Shared best practices
- Standards of Care
- Documentation
- Provide recommendations on how to improve the trauma program and performance improvement
“Many neurosurgeons have ‘non-time limited’ board certification. Can I assume this is acceptable for our site survey?” (Level 1)

Yes, life-time (grandfathered) physicians/surgeons meet the standard on current board certification.

If you have surgeons/physicians that are currently boarded and do not have a board expiration date, be sure to note that in the PRQ. Also, be prepared should the reviewer ask validation of this by having a copy of the surgeon’s/physician’s board certificate or documentation available onsite.
Trauma Admissions

“When evaluating the 1200 admission criteria for a Level I center, what constitutes an admission? Is it any patient the hospital enters into their registry, or only those that meet NTDS Patient Inclusion Criteria?” (Level 3)

For the purposes of verification, it defines an admission as a patient with a traumatic injury that meets the NTDS or your hospital’s Inclusion Criteria and are captured in your trauma registry.
Transfer Agreements

“Do transfer agreements have to be renewed every 3 years? Is this a deficiency if they are not? (We have transfer agreements in place – they do not have an expiration date and have an auto renew clause in them for each year – is this acceptable?)” (Level II)

It would not be cited as a deficiency if transfer agreements are not renewed every 3 years. It is acceptable if you have established an auto-renewal clause for the agreements. For best practices, we do suggest that agreements be periodically checked for updates such as, current CEO signatures, etc.
CD-Related Questions
"For Level I and II trauma centers, the maximum acceptable response time is 15 minutes; for Level III and IV trauma centers, the maximum acceptable response time is 30 minutes. Response time will be tracked from patient arrival rather than from notification or activation. An 80 percent attendance threshold must be met for the highest-level activations (CD 2-8). My question is why would we consider this a late response for the surgeon? The patient might not meet activation criteria on arrival and thus be activated later and why hold the surgeon to a response time when they have not been activated on arrival? For example, patient arrives at 8:00 and does not meet facility criteria for activation. At 8:30 they have a drop in their B/P and they team is activated I would expect my surgeon at the bedside by not later than 8:45 (15 minutes after activation as we are a level 1 facility). I would review this in PI to ensure the patient did not meet the criteria on arrival. If they did then I would PI this as a delayed activation not a delay in surgeon response time.” (Level 1)

To clarify, the Attending Surgeon’s response time for the highest level of activation will be tracked from the time of patient arrival based on adequate notification from the field.

Patients who arrive in your ED not meeting activation criteria, but during evaluation this changes due to the patient’s B/P dropping, the highest level of activation is called, the Attending Surgeon’s response time will be tracked from the time the activation was called. This would not count as a delay in the Attending Surgeon’s response time; however, this should be reviewed through your PIPS process to ensure the patient did not meet the activation criteria on arrival.
Undertriage Rate (CD 3-3)

“We are over the stated 5% under-triage. We have instituted a change but our reporting year ends 11/30. Will that be sufficient?” (Level 1)

To demonstrate compliance with the standard, the trauma program must monitor and track the undertriage rate during the reporting year. That being said, during your onsite visit, it is important to be transparent and present your reviewers with current data reflecting the changes the program made and how this will be monitored going forward. Based on when the change was implemented to the date of your site visit, it may be possible that the reviewers take the limited data (if not a reporting year) into consideration.
Multidisciplinary Peer Review Attendance (CD 5-10)

“Can the TMD meet one-on-one with liaisons and have it count towards their minimum required attendance to the TPIC meetings?” (Level 1)

“Can teleconference be utilized by surgeons and liaisons to have it count towards their minimum required attendance to TPIC mtgs?” (Level 1)

No. The purpose of this committee is to improve trauma care by reviewing selected deaths, complications, and sentinel events with the objective of identification of issues and appropriate responses in a peer review format.

The meeting requirement of 50% attendance may be met either in person, via teleconferencing, or by video.
Limited Tier Activation (CD 5-16)

“The rule is that the physician be at bedside within 15 minutes of patient arrival. For patients meeting lower level of activation, can the hospital use the activation time to measure physician response rather than the arrival time. For example, patient arrives via POV and enters waiting area for triage. Triage does not recognize that pt meets activation criteria (level II or III) for 10 minutes. Team activated and physician arrives 6 minutes later. Time from pt arrival to physician – 16 minutes, Time from activation to physician – 6 minutes. The first would be a fallout due to processing time for walk in triage but if measured from activation, would meet criteria. This would not pertain to the highest level – that is measured from arrival to physician response.” (Level 1)

Based on the example provided, review of the fallout due to processing time for the walk-in triage would be reviewed, the Attending Surgeon’s response time to the limited tier activation would be measured from when the activation was called. Not from when the patient arrived in the ED or waiting area.
Trauma Backup Call Schedule (CD 6-6)

“Level III - Do we need a backup trauma call schedule if our trauma surgeons take call at other hospitals at the same time?” (Level 3)

Level III trauma centers are not required to have a trauma backup call schedule.
Prehospital PIPS Program (CD 7-8)

“For CD 7-8, does the rep. need to be from the peds ED to qualify the requirement for peds trauma ctr? (currently adult EM attend)” (Level 1)

If this is an adult Level I and a pediatric Level I, the pediatric representative from the Emergency Department must participate in the prehospital PIPS program.

If this is a combined adult Level I and a pediatric Level II, either the adult or pediatric representative from the Emergency Department must participate in the prehospital PIPS program.
Neurosurgery Response Time (CD 8-2)

“If a Neurosurgical Department at a Level 1 Trauma Center does not have a residency and the Trauma Surgeons are credentialed by neurosurgery, does that qualify for our key performance indicators that we have established for the 30 minute attending arrival (we would use the trauma attending arrival)” (Level 1)

If the Level I trauma center does not have Neurosurgery Residents or Advanced Practice Providers, the Trauma Surgeon may be credentialed to manage the neurotrauma patient while awaiting for the Neurosurgeon to respond. However, the Trauma Surgeon cannot account for the specialist’s 30 minute response. The expectation is for the Attending Neurosurgeon to meet the 30 minute response time for patients who require a neuro consult.
Orthopaedic Surgery Backup Call Schedule (CD 9-12)

“Level III - Do we need a backup ortho call schedule if our ortho surgeons take call at other hospitals at the same time?” (Level 3)

In Level III trauma centers, if the Orthopaedic Surgeon is not dedicated to a single facility while on call (on call at multiple trauma centers), a published backup call schedule is required.
Pediatric Trauma Medical Director (CD 10-25)

“At an adult level I with pediatric level II does the pediatric trauma come under the purview of the adult TMD?” (Level 1)

It may. The adult TMD may also serve as the pediatric TMD. In most institutions like this, a pediatric co-TMD is appointed.
“Level 2 center, with only 10 ophthalmology patients in a year, and transfer agreements in place. The CD would still be a Type 1?” (Level 2)

It is a Type I, regardless of the number of patients needing Ophthalmology services. A Level II trauma center is required to have Ophthalmology capability. This means that there is a surgeon available in person within a specific time frame who can provide an ophthalmologic consult when requested by the Attending Surgeon. Patients who require complex ophthalmologic surgery may be transferred to another center that can manage those patients.
“Are Trauma Centers (Level 1 Peds) Required to have a Physiatrist if they have Speech, PT, and OT and Transfer agreements to Inpatient Rehabilitation Centers?” (Level 1)

A Physiatrist is not required.
“Is there a required amount of trauma registrars for a Level 1 trauma or is that based on volume?” (Level 1)

The number of registrars a trauma program is required to have is based on the trauma center’s admission volume. There must be one full-time equivalent employee dedicated to the registry available to process the data capturing of the NTDS data set for each 500–750 admitted patients annually. Staffing needs may increase if additional validation and data elements are collected, e.g. NTDB, TQIP and/or state data sets.
CMEs Board Certification

“Does board certification or board eligibility count as a provider's 48 external CME hours?” (Level 2)

“Please review CME requirements for physicians on call panels, at the AAST, the STN track did not review the latest CME status” (Level 3)

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 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.

For Level I and II trauma centers 33 hours from board certification / recertification may be used as external CME towards this requirement.

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

“The trauma medical director still needs external trauma CME education (36 hrs/3 yrs). Do the liaisons still need external CME's” (Level 1)

CMEs are not required for the liaisons and non-liaisons (other panel members).
CME and MOC

“Can you clarify the CME Changes. Do all of the Multidisciplinary attendees still need CMEs above their MOC?” (Level 2)

Except for the TMD and TPM (and alternate pathway panel members), all other trauma panel members do not require CME. At this time, maintaining current board certification satisfies the CME requirement.
CME Board Eligible

“As long as a provider is board eligible (does not matter length of time), will still fulfill changes to CME requirements as 5/18” (Level 1)

Yes. Current board certification satisfies the CME standards for board eligible (recent graduates) and life-time (grandfathered) physicians/surgeons.
Non-Surgical Admissions
Non-Surgical Admission

“Do all non-surgical admissions require TMD review or can those meeting a specified criteria be closed at primary level?” (Level 2)

The TPM or PI Coordinator or clinical staff can 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 review level by the TMD for missed opportunities.
Non-Surgical Admission

“Patients with an isolated injury (ortho/neuro) that are admitted to medicine with consult to appropriate surgical service count as a NSS admission?” (Level 2)

Yes, it would count as a non-surgical admit and is appropriate.
Non-Surgical Admission

“When reporting NSAs, are the percentages based on national registry inclusions, or total state and national registry inclusion?” (Level 2)

This would be based on your institution’s registry Inclusion Criteria. If you capture 2 sets of data points, one for the NTDS or your center’s Inclusion Criteria and the other for the state, we only want those captured by your center, not the state.
Non-Surgical Admission

“When admitting a pediatric patient, does having the peds Assistant Medical Director as a Surgeon negate the admit as a NSA?” (Level 2)

If I understand the question correctly, the Assistant Medical Director is surgeon, this scenario would not be a non-surgical admission.
Non-Surgical Admissions

“What do we need to track (thru PI Process) & aim to reduce (keep under 10%): Non-Surgical Admissions? Or Non-Trauma Admissions?” (Level 3)

“Please clarify non-surgical and non-trauma admits.” (Level 3)

To clarify, some centers use the term non-trauma admissions. For Verification, we refer to these as non-surgical admissions.

Many centers have revised their Trauma Surgery service or Orthopaedic Surgery service admission guideline to include some sub-sets of trauma patients that have traditionally been admitted to a Hospitalist/Internal Medicine Service. For example, some have moved isolated hip fractures admitted to Orthopaedic Surgery with a consult with Medicine or rib fracture patients are admitted to the Trauma Surgical Service with a Medicine Consult.
Non-Surgical Admission

“In past webinars, it appears some institutions collect non-surgical admits as those patients that do not have a surgical intervention. At our hospital, we consider non-surgical admits according to the service that admits them to the hospital, since it is very appropriate to have some patients that do not require surgery. Can you please review the definition of non-surgical admits?” (Level 1)

Correct, it is not based on whether the patient needs surgical intervention, it’s what service they were admitted to. Sorry for the confusion.

Non-surgical admits are patients who meet the NTDS or your Trauma Inclusion Criteria policy and are admitted to a non-surgical service (Medicine, Geriatrics, Neurology, Intensivists, etc.).
Thanks for your participation!