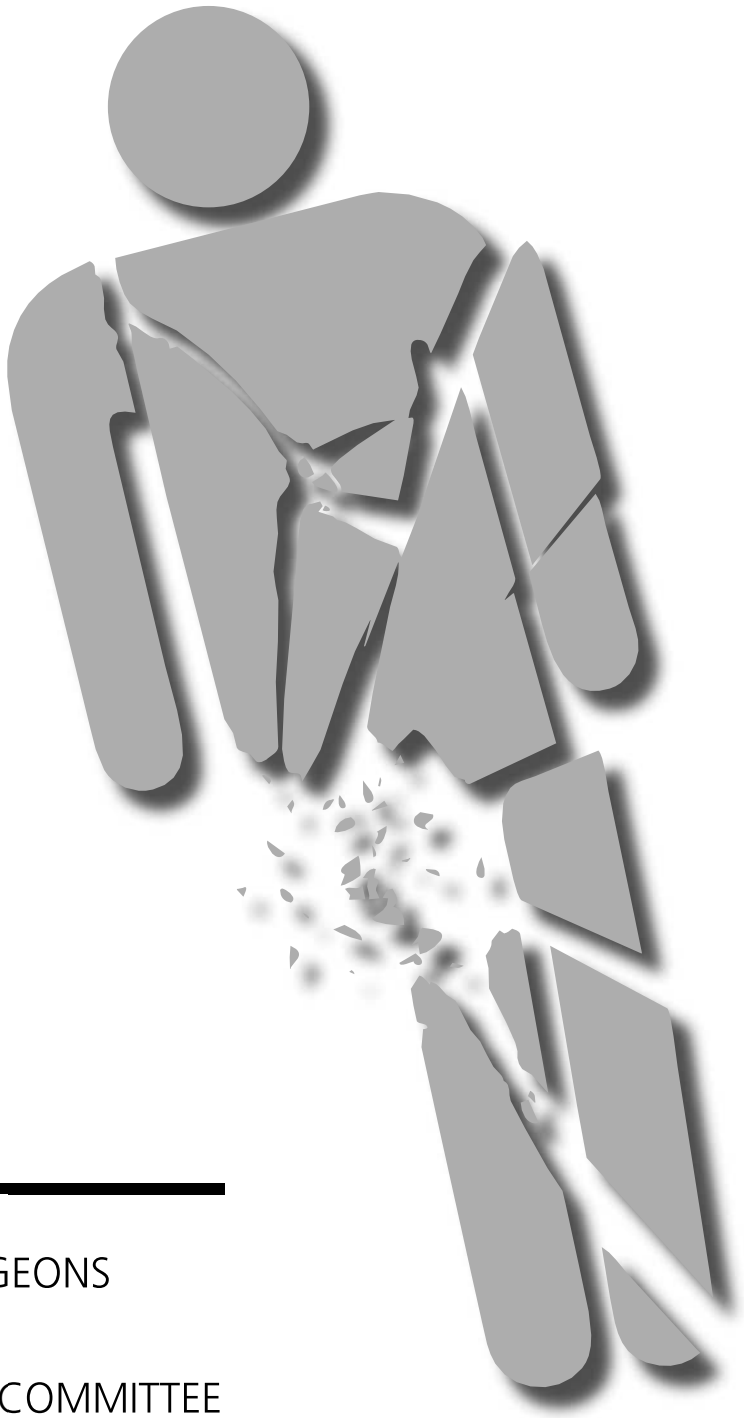
CLIENT MANUAL

Guidelines for the Host Agency/Trauma Manager for Requesting, Securing, and Hosting a Trauma System Consultative Visit



COMMITTEE ON TRAUMA
AMERICAN COLLEGE OF SURGEONS

TRAUMA SYSTEM
EVALUATION AND PLANNING COMMITTEE

The Client Manual has been prepared to assist the host agency to request, secure, and plan a successful assessment of the agency's trauma system. *Regional Trauma Systems: Optimal Elements, Integration, and Assessment, American College of Surgeons Committee on Trauma: Systems Consultation Guide* is intended as an instructive and evaluation tool to assist surgeons, health care institutions, and public health agencies in improving trauma systems and the care of injured patients. It is not intended to replace the professional judgment of the surgeon or health care administrator in individual circumstances. The American College of Surgeons and its Committee on Trauma cannot accept, and expressly disclaim, liability for claims arising from the use of this work.

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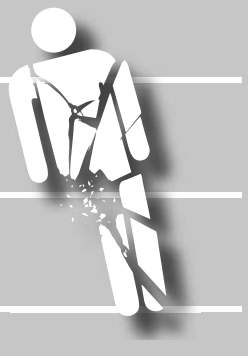

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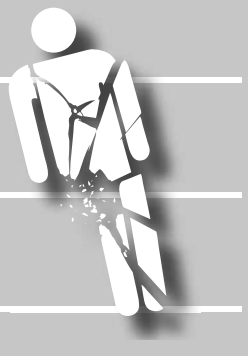


Overview

In the following pages, you will learn about the Trauma Systems Consultation Program of the American College of Surgeons (ACS)-Committee on Trauma (COT). This manual has been prepared to assist the host agency to request, secure, and plan a successful assessment of the agency's trauma system. The goal in preparing this guide is to make the process as simple as possible. We want this to be a successful system consultation visit for your agency, and, therefore, we want to ensure that you

- understand the expectations of the requesting agency and the consultation team;
- prepare adequately for the visit;
- meet key timelines important for planning;
- understand the consultation visit process; and
- enlist the necessary trauma system stakeholders to participate in the visit.

The Client Manual accompanies the ACS-COT's *Regional Trauma Systems: Optimal Elements, Integration, and Assessment, American College of Surgeons Committee on Trauma: Systems Consultation Guide,* which represents the guidelines under which the trauma system will be reviewed. The Trauma Systems Consultation Guide has been revised to correspond to the *Model Trauma System Planning and Evaluation* document developed by the Health Resources and Services Administration (HRSA) of the US Department of Health and Human Services. The Trauma Systems Consultation Guide is the template used by the consultation team for conducting the trauma system review, and it contains the Prereview Questionnaire and on-site documentation requirements to be prepared by the requesting agency.

The mission of the Trauma Systems Consultation Program is to promote the development and enhancement of trauma systems throughout the United States. A history of the Trauma Systems Consultation Program is provided in the Trauma Systems Consultation Guide.

The Trauma Systems Consultation Program is not a verification or designation process, and it is distinctly different from the ACS-COT verification process for individual trauma centers. The trauma systems consultation process provides a broad perspective on all components of the trauma system and their integration and function, leading to the identification of opportunities for trauma system development and enhancement.

The process involves a multidisciplinary team review and technical assistance consultation performed at the request of a state, regional, or county trauma program. The trauma systems consultation is a voluntary program to assist the state or regional trauma system in making needed improvements. The process is consultative, and it is equally valuable for trauma systems in the early stages of development as for mature trauma systems. The report prepared following the consultation provides a current assessment of the trauma system and recommendations for future trauma system development.

Your trauma system will not be compared with other trauma systems, but with the benchmarks in the *Regional Trauma Systems: Optimal Elements, Integration, and Assessment, American College of Surgeons Committee on Trauma: Systems Consultation Guide*. The consultation team uses this framework to provide technical assistance and consultation to the requesting agency. Each trauma system has a unique set of strengths and challenges; the consultation visit will highlight the system strengths and provide guidance to overcome the challenges.

Benefits of a Trauma System Consultation

Having a consultation that provides a broad trauma system overview is of great benefit for system improvement. Most trauma systems have not reviewed their structure and function from a "macro" perspective. Various components may have been reviewed and credentialed, such as individual trauma centers or emergency medical services (EMS) agencies.

As a system matures, it is important to review the entire system and all of its components, looking for strengths, weaknesses, opportunities, and threats. Regardless of the stage of trauma system development, there is great value in having an external team of experts provide consultation on methods to improve the system.

The consultation team brings two unique qualities to your trauma system. First, the team members are leaders in the field and have experience that enables them to examine a system challenge from different perspectives. These leaders may have addressed similar issues within their own systems and can share their experiences. The team will try to help you make the most of your available resources. Second, the team members, individually and collectively, bring credibility. Often, local trauma system leaders have tried to address a system issue without success, but when an "outside expert" verifies the issue, suggestions for change suddenly have more credibility.

It is hoped that the consultation process and the final report with recommendations will be useful as you work to improve your trauma system and, potentially, leverage additional resources.

Requesting a Trauma System Consultation

ACS will consider requests for a state, multicounty regional, or local (city or county) trauma system consultation from any agency with the authority to speak on behalf of the system to be reviewed. For example, it would be inappropriate for a trauma center director to request a consultation visit for an entire county that involves multiple facilities and numerous other agencies. It would, however, be appropriate for the county trauma authority or state agency responsible for the trauma system to make such a request.

To request a consultation, submit a formal letter of intent to the ACS Trauma Systems Consultation Program Coordinator at the following address:

Program Coordinator
American College of Surgeons – Trauma Systems Consultation
633 N Saint Clair St
Chicago, IL 60611-3211
Phone: 312.202.5340
Fax: 312.202.5005
e-mail: hmichaels@facs.org

The ACS Program Coordinator will be the primary contact person throughout the trauma system consultation planning process.

The formal letter of intent is considered the requesting agency's initial commitment for a trauma system consultation. Once ACS-COT receives a letter of intent, it is reviewed, and, in some cases, a discussion is initiated with the requestor.

Contract for Services

Once ACS has agreed to conduct the consultation visit, the requesting agency should initiate a contract with ACS to facilitate payment for the consultation. The requesting agency's contract should specify the scope of work to be performed by the ACS consultation team, what the requesting agency will provide (for example, prereview system information and documents, all on-site meeting rooms and equipment for the visit and the team) and the budget. Any agency requests, such as an additional consultant to address a specific content area, should also be itemized. The contract must be accepted and signed by the requesting agency and ACS no later than 4 months before the visit, or planning will be placed in a holding pattern until the contract is signed.

Cancellation Policy

Consultation visits can be cancelled or postponed or rescheduled up to 30 days before the visit with the understanding that the requesting agency will be responsible for any expenses incurred that cannot be refunded owing to policies or procedures outside the control of ACS (for example, airline tickets, hotel reservations). Visits that are cancelled and not rescheduled are subject to a cancellation fee of $2,000 in addition to unrecoverable direct costs.

Preparation for the Consultation

Tasks of the Requesting Agency

Once a state, region, or county agency (the lead agency for trauma) makes a formal request for ACS-COT to conduct the consultation, it takes about 6 months to plan, prepare the information for the consultation team to review, confirm the consultation team members, and complete the consultation process. However, in certain cases, the planning phase can be accelerated to meet specific needs of the requesting agency.

Once ACS agrees to conduct a consultation visit, a letter confirming the request and a set of materials, including the *Regional Trauma Systems: Optimal Elements, Integration, and Assessment, American College of Surgeons Committee on Trauma: Systems Consultation Guide* and this manual will be sent to the requesting agency. The timeline in Appendix A lists the important steps in the planning process to ensure a successful

consultation visit. The list should be reviewed frequently to track important tasks and timelines.

The requesting agency should then initiate the planning process for the consultation visit. The provided materials should be reviewed with the trauma system stakeholders, and potential dates for the site visit should be discussed. Begin discussions with system stakeholders to formulate special focused questions for consultation team discussion (see page 8).

The requesting agency should also develop the plan for completion of the Prereview Questionnaire (PRQ) and required documentation included in the trauma systems consultation guide. (See pages 7 and 8 for more information.) The PRQ and required documentation must be submitted to ACS at least 8 weeks before the scheduled visit to allow the consultation team adequate time to prepare for the visit. If the requesting agency is unable to submit the PRQ on time, the site visit will be postponed.

The city and hotel location for the consultation visit should be selected in consultation with the Program Coordinator. The requesting agency is responsible for the logistics and costs associated with the hotel meeting rooms, group meals, and the team work room. Guidelines for meeting room and team work room logistics are provided on pages 5 and 6.

Planning for the provision of meals and breaks for participants is important. A social hour or dinner with *nonalcoholic* beverages should be scheduled to introduce the team informally to key leadership in the trauma system. Dinner on the first evening is strongly encouraged but optional. Beverage breaks and lunch should be provided to the participants on day 2 because the day is heavily scheduled to gather information about the trauma system.

Inviting Trauma System Stakeholders

One key to a successful consultation visit lies in the selection, orientation, and participation of local stakeholders. Collaboration by system participants is important to provide accurate information about system components and for their later support of the implementation of recommendations made by the team. When identifying system participants to invite, keep in mind that the team members will be seeking information about the following system components and how well the individual components are integrated in the overall trauma system.

- Injury epidemiology
- Indicators as a tool for system assessment
- Statutory authority and administrative rules
- System leadership
- Coalition building and community support
- Lead agency and human resources within the lead agency
- Trauma system plan
- System integration
- Financing
- Prevention and outreach
- Emergency medical services
- Definitive care facilities
- System coordination and patient flow
- Rehabilitation
- Disaster preparedness
- System-wide evaluation and quality assurance
- Trauma management information systems
- Research

Although the presence of key leaders and policy makers is important, it is essential that the people who regularly provide care or services within each of the listed components are also in attendance. Sometimes providers have a perspective on the issues and challenges that is completely different from that of the leadership. A broad range of system providers from multiagency and multidisciplinary groups representing all components of the trauma system will facilitate the best overall assessment of the current trauma system, leading to the development of recommendations for future system enhancements. (See Appendix C for a suggested list of participants to invite.) Invitations should be sent 3 months before the visit to gain the best participation.

ACS Preparation

Once the contract has been submitted to and signed by ACS, a multidisciplinary team will be selected for your consultation visit. The team includes a trauma surgeon, emergency physician, trauma program coordinator, EMS director (state, regional, or local), and the team leader (usually a surgeon). The requesting agency may identify the need for one or more additional team members to address a specific issue (for example, pediatrics, communications, information technology, transportation, or finance). Two technical support persons and the Trauma Systems Consultation Program Coordinator will be present for the consultation visit to facilitate the process and to assist in writing the final report. An additional team member being oriented to

the trauma systems consultation process may also be in attendance (at no cost to the requesting agency).

The Program Coordinator will make frequent contact with the requesting agency to answer questions and check on the status of planning. The final agenda for the consultation visit will be jointly developed by the ACS Program Coordinator and the requesting agency.

ACS will send the PRQ, submitted documentation, and other appropriate materials to the selected team members, enabling them to prepare for the consultation. Each team member (reviewer) will develop a thorough understanding of the section(s) for which they have technical assistance responsibility and address any special focused questions posed by the requesting agency. Team members will make notes about questions to ask and additional information to obtain.

Approximately 2 weeks before the site visit, the team leader will conduct a conference call with the reviewers to go over the logistics, the PRQ, report writing, and the requesting agency's focus questions. Following that conference call, the requesting agency may be asked to provide additional information that would be helpful to team members.

How the Consultation Is Conducted

The Consultation Visit

The consultation visit usually takes 3.5 days, with a half day of travel on each side of the visit. The team will arrive at the hotel in the early afternoon before the formal start of the site visit for a 2-hour prereview meeting with the team leader and technical support staff. A sample agenda for the consultation visit is provided in Appendix B. The schedule for the visit is generally as follows:

Day 1: This evening, the team will meet with system stakeholders. Although a kick-off dinner is optional, a social hour should be arranged before briefing sessions begin. This is typically a more relaxed occasion and sets the tone for the rest of the site visit.

At the opening of the meeting, an agency representative should present an overview of the trauma system, the history, its current status, strengths and weaknesses, special issues or problems, and other information thought to be pertinent to the review process. The team leader will then provide an overview of the consultation process and its purpose and introduce the team members. One or two sections, such as statutory authority and administrative rules or lead agency and human resources are usually discussed following the introductory session.

Day 2: Briefings by trauma system participants occur throughout the day.

On day 1 and day 2, one team member will be assigned to lead the discussion for each section. This team member will come to the consultation visit prepared with questions that will help guide the discussion and briefing by agency representatives and stakeholders. He or she will be assisted by a team member who will be primarily responsible for recording the essence of the discussion and key points on a laptop computer. The section leader may ask questions of the participants in general or direct questions specifically to individuals with expertise on that subject. The host should help identify individuals who can provide information on specific topics or sections. Efforts are made to adhere to the schedule, so participants may be asked to make brief comments if little time remains in a session. Ideally, participants should feel free to express their concerns about system issues and to offer opinions from their own experiences and perspectives, including opinions that differ from those of others.

Day 3: Following the briefing sessions on days 1 and 2, the team will sequester itself to deliberate and achieve consensus on its findings and recommendations and to draft the report. These deliberations are private and confidential. Hosting staff will not be participants to the final deliberations, but they should be available by phone should questions arise.

Day 4: Team members are sequestered for consensus development and report writing throughout the morning. In the early afternoon, the team presents an oral summary of the visit and key recommendations. Following this meeting, the team members return home.

Information gathering and briefings by system participants are in a public forum. With the exception of the time when the team is sequestered, the briefing sessions should be open to the public in accordance with the jurisdiction's open meeting laws. The consultative staff has been advised that dress for these briefings should be business attire.

The entire consultation visit is intense, with the team concentrating on the issues, findings, and recommendations to assist your trauma system. There is no time for sightseeing excursions or leisure activities. While the team is sequestered, meals are ordered in to maximize time for team deliberations.

Guiding Documents

The trauma system review is based on the guidelines and principles outlined in the following major trauma system documents:

- *Regional Trauma Systems: Optimal Elements, Integration, and Assessment, American College of Surgeons Committee on Trauma: Systems Consultation Guide*
- HRSA's *Model Trauma System Planning and Evaluation* document. An electronic copy of this document can be downloaded from http://www.hrsa.gov/trauma/model.htm.
- American College of Surgeons' *Resources for the Optimal Care of the Injured Patient, 2006*

The requesting agency and other key trauma system leaders may want to familiarize themselves with these documents.

Role of the Host During the Meeting

The host has an important role during the system consultation visit. The host helps set the tone for the consultation visit by introducing the team leader to the stakeholders during the social hour at the opening session on the first evening. The team leader will have the team members introduce themselves and state their qualifications. The host should set the tone for the visit by giving stakeholders a brief overview of why the consultation was requested and the agency's hopes and expectations for the visit. On the final day, the host also should provide concluding remarks following the team's presentation of findings.

The host should welcome the ACS team, any prominent guests, and system stakeholders and make key introductions to the team leader and team members. The consultation team finds it helpful to be informed of specific local expertise that should be queried during specific sessions. The host should contribute to, but not dominate, the briefing sessions.

One or more designated liaisons between the consultation team and agency should be available to assist the team during its closed meeting time. For example, the team members may need access to a document, have some additional questions, or need support with the provided equipment. Contact information for the liaisons should be provided to the team at the beginning of the consultation.

Meeting Facility and Logistics

Ideally, the meeting rooms and sleeping rooms for the consultation team should be in the same facility. Given the compressed time for briefings, the intense nature of the deliberations, and completion of the report, travel between facilities is inefficient.

Main Meeting Room Setup

A good room configuration is a head table (straight or U-shaped) with adequate space for 7 or 8 team members to have their computers and notebooks. Two or more microphones should be available for team members to use during the discussion. Ample power outlets should be near the team members for laptop computers. The agency representatives and stakeholders should be seated classroom or conference style with a couple of microphones placed in a center aisle. This room will be needed for days 2 and 4 and, potentially, for day 1, depending on the arrangements for the social hour and/or dinner.

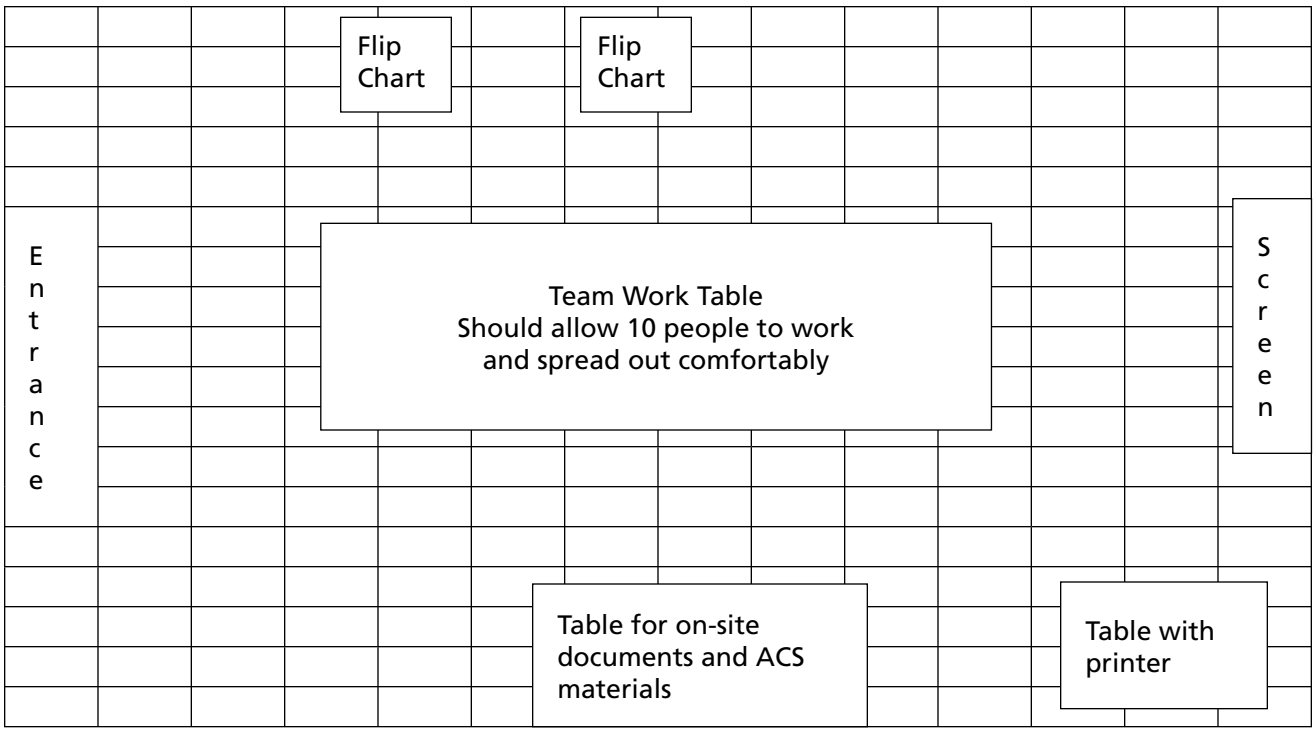
If preferred, the day 1 social hour and/or dinner meeting and briefing may take place in a different meeting room. Round tables may be used for dinner, if desired. A head table should be arranged as described in the preceding paragraph with power cords and microphones. A couple of microphones should be distributed in the room for participants.

Additional audiovisual support is needed on days 1 and 4, including an LCD projector, screen, and podium. The requesting agency's representative will provide a PowerPoint presentation that gives an overview of the trauma system to start the consultation on day 1. On day 4, the ACS team leader will provide a report to the requesting agency and stakeholders that usually includes a PowerPoint presentation. The screen and LCD projector should be positioned to be seen well by the majority of participants.

Team Meeting Room

A separate meeting room for the team is required for all 4 days of the consultation. This room, which can be substantially smaller, may be set in boardroom style with one large table. See the proposed schematic. There should be ample room for 10 people, enabling the team to spread out as necessary during deliberations. Adequate power strips for the team and equipment should be provided. Other resources needed include the following:

- Internet connection
- An LCD projector, connector cable, and screen, beginning on day 2



- Power strips for laptops
- A printer on a separate table
- Two reams of paper
- A table for the on-site documents detailed in the PRQ
- Two flip chart easels, paper, and markers

Estimating Cost

The cost for the trauma system consultation includes the fees charged by ACS and the requesting agency's (host's) on-site costs for the meeting facility and meals (see further explanation later in this section). The fee charged by ACS is $65,000.

Explanation of the ACS Fee

The trauma systems consultation process typically involves 5 reviewers (a trauma surgeon; emergency physician; trauma nurse; state, regional, or local EMS director; and team leader, usually a surgeon). Two technical support consultants plus the Trauma Systems Consultation Program Coordinator accompany the team to provide on-site support, provide expertise to the consultation process, and prepare the final report. Reviewers and technical support consultants receive payment for their services. Travel, meals, and lodging expenses are included in the ACS fee for each of the 8 members of the team. ACS also includes various administrative costs in this fee.

Some states request an additional team member to address a specific issue (for example, data systems, finance, or pediatrics). If a sixth reviewer is requested to address a specific issue, an additional $5,000 is added to the ACS fee.

Other Expenses for the Consultation Visit

The requesting agency (host) must also include expenses associated with the meeting facility and meal functions when considering the total cost.

Hotel meeting rooms must be rented for the open meeting sessions with participants and for a review team work room. Audiovisual support for these meeting rooms should include microphones (open meetings only), LCD projector, screen, and power strips for team member computers. The team work room should also have flip charts, a computer printer, and Internet access. See the guidelines for main meeting room and team meeting room planning.

Meals for meeting participants should also be factored into the budget. A social hour with nonalcoholic beverages should be planned for the first evening. A group dinner the first evening for all stakeholders is encouraged, but optional. Lunch for all stakeholders

on the day 2 and beverage breaks should be provided. Some economies regarding meeting room rental may be gained when meals are provided by the hotel's banquet service.

Payment Expectations

ACS expects to receive one third of its fee within 30 days of contract signing. Another third is *due 1 month* before the consultation visit. The final third is due on delivery of the final report.

If the consultation is cancelled and not rescheduled, all fees paid, less $2,000 and unrecoverable direct costs, will be reimbursed. Consultation visits can be cancelled up to 30 days before the visit and rescheduled with the understanding that the requesting agency will be responsible for any expenses incurred that cannot be refunded owing to policies and procedures outside the control of ACS (for example, airline tickets for the review team and hotel reservations).

Potential Funding Sources for the Consultation

Traditional and nontraditional funding sources may be available to offset consultation visit costs. The requesting agency may have funds through general revenue streams or specific grants. City, county, or state governments may be willing to allocate specific resources outside the normal trauma budget. Federal agencies may identify a trauma system consultation visit as part of eligible grant expenses for trauma system assessment. Grants earmarked for bioterrorism or general emergency preparedness may be appropriate sources of funding. Nongovernmental sources might include private foundations or membership organizations. A group of facilities and agencies may also choose to each contribute some portion of the cost.

Prereview Questionnaire (PRQ) and Important Documents

The questions in the PRQ were compiled directly from the *Regional Trauma Systems: Optimal Elements, Integration, and Assessment, American College of Surgeons Committee on Trauma: Systems Consultation Guide.* These questions were developed to help solicit the information needed by the team members to understand and "hone in" on the issues that are unique to your trauma system. Documentation includes information such as the laws, administrative rules, and contractual agreements that govern your system, policies and procedures that provide guidance to providers, and materials that demonstrate your system's structure, functionality, and operations. The final section of the preparatory information is 16 indicators from the Benchmarks, Indicators, and Scoring Assessment Tool.

The PRQ includes a list of questions that should be answered as completely and honestly as possible with regard to the current status of the agency's trauma system. Documentation has also been specifically identified to help team members to complete the analysis of each section. Follow guidelines for the documents that should be sent with the PRQ and remaining documents to provide on-site. The outcome of the consultation visit is tied directly to the quality of the information provided in the PRQ and documentation.

Preparing the PRQ

The PRQ is a separate document in your consultation packet. The document is also available electronically in template format for use in providing responses to the questions. It is important that questions and responses remain in the order of the PRQ so that team members do not need to spend time searching for information as they review and analyze the agency responses.

The requesting agency is encouraged to assemble a working team to complete the PRQ and prepare needed documents so that all can be completed during a 2- to 3-month period. One individual should have the responsibility of compiling responses on behalf of the requesting agency. For example, if the trauma system is organized into regions, regional responses would need to be compiled, or individual trauma center queries may be compiled. The working team should include representatives who can provide good information and the broad perspectives of the trauma system stakeholders. Remind the working team that responses should reflect the current trauma system status, not the status of individual components of the system.

The PRQ should be completed not less than 2 months before the scheduled site visit. It should be submitted in 8 hard copies and in an electronic format (Microsoft Word). The PRQ should be submitted to the ACS Program Coordinator at the ACS address listed earlier.

Contact the ACS Program Coordinator if you encounter questions concerning the completion of the PRQ. When necessary, the Program Coordinator will refer your questions to the team leader or another ACS staff member to provide the most helpful response.

Benchmarks, Indicators, and Scoring Assessment Tool

Sixteen indicators from HRSA's *Model Trauma System Planning and Evaluation* document's Benchmarks, Indicators, and Scoring appendix have been selected for

current and future evaluation of the requesting agency's trauma system development. The requesting agency should work with key leadership of trauma system committees to develop a consensus score for each of the indicators of the Benchmarks, Indicators, and Scoring Assessment Tool. The scores for these indicators should be submitted with the PRQ.

Focused Questions

The requesting agency has an opportunity to ask critical focused questions of the reviewers about unresolved trauma system concerns. These questions can be issues raised by stakeholders, political leaders, consumers, or others about trauma system development. Although the team is committed to looking at all aspects of the trauma system, it will also address specific concerns and challenges when requested.

Issues that have been controversial among system participants are often the basis for focused questions. Such issues often need more critical thinking by outside reviewers or additional expertise to resolve, or they require credible support for a strategy before a needed change is implemented. Examples of focused questions could include a broader discussion of triage guidelines in an area of low volume, need for a helipad at a rural hospital, or methods to address the needs of special populations (for example, children, elderly people). The focused questions should be specific to your system's critical issues and questions that would benefit from a multidisciplinary, open dialogue. Most agencies submit 2 to 4 focused questions.

The focused questions should be submitted with the PRQ. Discussion may be needed with the team leader to be sure that the questions are clear and that the team thoroughly understands the nuances of each question. Sufficient information should be provided in the PRQ to help focus the dialogue and questions on the issue during the consultation visit.

Postconsultation Follow-up

The Report

When the team leaves the site at the end of the consultation, a rough draft of the report will have been written with recommendations developed through consensus with all team members. The report will be refined, checked for accuracy against the submitted PRQ and documentation, and edited by the team leader and technical support consultants. The final draft report is then sent to all participating team members for review.

ACS will send a draft report to the requesting agency within 4 weeks of the last day of the consultation visit. The agency has 1 week to review the draft for any factual errors. The analysis and recommendations within the report cannot be changed by the requesting agency. Once the requesting agency returns the report to ACS, final edits of factual errors will be made, and the final report will be returned to the requesting agency within 2 weeks.

Sharing Your System's Successes

From time to time, ACS may request permission to use portions of your report to help other systems overcome similar challenges. In such cases, ACS will request written permission from the lead agency to share the information contained in your report. ACS is sensitive to issues of confidentiality and political realities. In all cases, information would be stripped of specific identifiers. ACS will never share your information without your permission.

Evaluation

ACS is committed to ensuring that the trauma systems consultation process accomplishes its goals in assisting agencies to improve or enhance their trauma systems. By requesting and participating in a trauma systems consultation, the requesting agency agrees to assist in an evaluation of the consultation process. This evaluation consists of written feedback and exit interviews of select participants by ACS staff.

ACS is also interested in determining whether the consultation process helps trauma systems that have had a formal review to make improvements and enhancements to their systems. Approximately 1 to 2 years after the site visit, ACS will contact the lead agency to schedule a conference call with key system leaders to discuss the system's current status. Discussion will focus on scoring the same 16 indicators from the Benchmarks, Indicators, and Scoring Assessment Tool used during the consultation visit. This conference call will enable a comparison of trauma system status and development over time.

Frequently Asked Questions

Whom should we invite to the consultation? How do we deal with the politics?

A small working planning committee may be useful in identifying the key participants to invite and share their

perspectives with the review team. Invitations should be extended by the requesting agency or another person in authority. It is important that all "players" be at the briefing even if there is animosity among certain members. One role of the team leader is to maintain order and decorum during the briefings. The only way to begin to unravel "politics" is to make sure that all points of view are heard. Often the presence of an independent group makes the process more civil and credible.

Who should invite people to the visit?

In most cases, it will be the requesting agency. However, if certain segments of the trauma system might be more amenable to an invitation by someone such as the COT chair, the invitation should be extended by the appropriate party.

What role does the requesting agency have in the selection of team members?

The primary responsibility for team selection rests with ACS. The selection will be based on matching your system's needs with the expertise of various consultants. However, the requesting agency has the right to suggest that a team member might not be appropriate based on history or other factors.

Who drafted the PURPOSE statements in the document?

The purpose statements for each section were drafted by an expert working group of the ACS Trauma Systems Consultation Committee, representing clinical and administrative expertise in trauma systems. The foundation for the purpose statements came from the HRSA's *Model Trauma System Planning and Evaluation* document.

Why is a complete review needed? Why can we not just target the problems we are experiencing?

Sometimes the apparent problems are not the system's only problems. So that the consultation team can provide your system the best possible service, it is essential that team members learn about the strengths, weaknesses, opportunities, and threats across the entire system. Targeting one area tends to diminish the term "system" within the trauma care system. Without knowing the history and current status of the trauma system, reviewers may miss critical information necessary to make an informed judgment on a specific targeted area. Outside experts may identify opportunities for system improvement that are not readily apparent to system participants or administrators.

Who provides the final debriefing, and who should attend?

The consultation team leader will present the final debriefing. The presentation will be general, highlighting key findings. It will provide listeners with the general flavor of the report findings and recommendations. The details of the final report cannot be released until it has been approved by the ACS-COT.

The key players within your trauma system should plan on attending the final briefing. These players would include the state and local trauma system leadership, state and local COT chair, and key regulatory officials. The attendee list will look similar to the list of persons who provided comment during the briefing sessions.

What if we do not agree with the final report?

The consultative team will do its best to capture the essence of your trauma system in an unbiased and factual manner. What you do with the final report once received is up to you. You may choose to release it as is and circulate it widely. You may choose to circulate it only among members of the trauma care community, or you may choose to create an addendum that addresses points with which you disagree. However, the report, after its approval by ACS, will generally not be modified once issued. The report is based on the information provided by the requesting agency in the PRQ, interviews with participants, and reviewers' professional expertise. You will get some sense of its contents during the final debriefing.

Should I invite the press?

The main briefing sessions are open meetings. The fact that the trauma system has matured enough to be willing to undertake such a wide-sweeping examination speaks highly. The concluding debriefing session may be the best place for the press. Press participation should be followed up with a copy of the final report, if appropriate.

APPENDIX A

Trauma System Consultation Planning Timeline for the Requesting Agency

The timeline identifies key activities for which the requesting agency has responsibility during the planning for a successful trauma system consultation. Comments within each month provide the rationale for the importance of completing key activities within the designated timeline.

Six months before the visit

☐ Submit *Letter of Intent for Site Visit* to the ACS-COT office:

Program Coordinator
Trauma Systems Consultation
American College of Surgeons
633 N Saint Clair St
Chicago, IL 60611

☐ Initiate the contract process within state or local agency (see page 2).

☐ Review the Consultation Visit packet from ACS-COT (available electronically and in hard-copy format):

- Client manual
- PRQ and list of documents to be submitted, found in the *Regional Trauma Systems: Optimal Elements, Integration, and Assessment, American College of Surgeons Committee on Trauma: Systems Consultation Guide*

☐ Review consultation visit materials with your trauma system stakeholders.

☐ Identify several potential dates for the consultation visit.

☐ Begin discussions (with ACS and system stakeholders) regarding the city location for the site visit and the meeting facility.

☐ Develop a plan for completion of the PRQ and needed documentation.

Six months provides sufficient time for the requesting agency to develop and finalize the contract with ACS, to plan and generate support for the consultation visit, and to develop the PRQ for the consultation visit.

Five months before the visit

☐ Submit the contract to ACS for review and approval.

☐ Negotiate possible dates for the site visit with ACS.

☐ Begin development of the list of participants to invite to the site review (see Appendix C for participant suggestions).

- Ensure inclusion of ACS-COT chair, state EMS director, and the state trauma manager.

☐ Begin discussions of who will attend the social hour or dinner and initial briefing.

☐ Begin working on the PRQ.

☐ Begin discussions with system stakeholders to formulate special focused questions for review team discussion.

Key system leaders often have schedules that are booked months in advance. It is essential to plan far enough ahead to accommodate their schedules so that the best informants will be present for the briefing sessions. Including stakeholders from all aspects of the trauma system in the consultation process will help ensure development of an inclusive system. Early planning and preparation will help avoid miscommunication, confusion, and frustration as the date approaches.

Four months before the visit—Critical Planning Benchmark

☐ Complete contract process with ACS—until the contract process is completed, planning is on hold, including consultation date selection and recruitment of review team members.

☐ One third of the ACS fee is due within 30 days of contract execution.

☐ Set a date for the trauma system consultation.

☐ After the contract is executed, work with the ACS Trauma Systems Program Coordinator to select a hotel for the consultation visit.

☐ Negotiate with the hotel facility for sleeping rooms, meeting rooms, audiovisual support, banquet

services, and other on-site logistics. ACS will pay for hotel sleeping rooms for the consultation team.

It is important that ACS has sufficient lead time to recruit the consultation team. ACS will put a hold on all planning until the contract is fully executed.

Three months before the visit

- ☐ Receive consultation visit team member list and biographic information from ACS.
- ☐ Inform ACS of potential conflicts or concerns with team members selected.
- ☐ Finalize the location (city), hotel, and meeting facilities, and notify the ACS Program Coordinator.
- ☐ Finalize other meeting logistics, including equipment for the team work room and the larger meeting room. See pages 5 and 6 for specific equipment and resources needed for both rooms.
- ☐ Arrange a conference call among select surgical and trauma system leaders and the team leader and ACS staff to review your consultation visit expectations.
- ☐ Receive a draft site visit agenda from the ACS Program Coordinator.
- ☐ Send invitations to participants for the briefing sessions and premeeting social hour or dinner.
  - Include draft site visit agenda and list of review team members.

To support optimal productivity of the consultation team, meeting room logistics and equipment need to be provided according to specifications.

The conference call among system leaders and the consultation team leader and ACS support staff is designed to assist the team in better meeting your needs. Each system has different challenges and needs specialized input.

Early invitations to site visit participants are essential to gain good participation from informed trauma system participants.

Two months before the visit—Critical Planning Benchmark

- ☐ Complete and submit the PRQ, required documentation, and focused questions to the ACS Program Coordinator. If the requesting agency cannot complete the PRQ within this timeline, the consultation visit will be rescheduled.
- ☐ Send the PRQ responses to system participants who will be attending and presenting information at the consultative visit.

The importance of submitting the PRQ and required documents on time cannot be overstated. This documentation serves as the foundation for the visit and recommendations team members will make to assist future trauma system development. Team members need sufficient time to review and identify questions that will help them identify opportunities and recommendations for your trauma system.

One month before the visit

- ☐ Confirm all logistics for meeting rooms, audiovisuals, and other support.
- ☐ Submit a second payment for the consultation visit to ACS.
- ☐ Identify the trauma system representative who will provide an overview of the trauma system. Provide support as needed for this individual's presentation (often done in PowerPoint).
- ☐ Send a reminder letter or e-mail with the draft meeting agenda to all system participants and to persons participating in the first evening social hour or dinner and meeting.
- ☐ Talk with ACS staff and the team leader to review all meeting logistics including the following:
  - Final agenda
  - Meeting room arrangements
  - First evening social hour or dinner and meeting: who will be attending
  - List of trauma system participants

Follow-up with local participants and ACS team leader and staff will improve the outcome of the consultation visit.

Two weeks before the visit

- ☐ Notify team leader or ACS staff about last-minute changes.
- ☐ Create name tags for each ACS reviewer and other individuals attending the consultation visit.

Although consultative teams are used to last-minute changes, the more notice they receive, the better able they will be to adapt and adjust.

One week before the visit

- ☐ Notify team leader and staff about last-minute changes.
- ☐ Call or send an e-mail reminder to all system participants and persons participating in the first evening activities.

☐ Create a sign-in sheet for each day of the consultation (this sign-in sheet will be given to the ACS Program Coordinator after the consultation visit).

☐ Identify one or more agency representatives to serve as contact persons for questions and on-site logistical challenges.

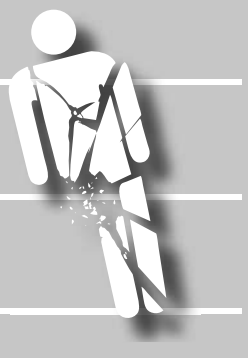
Day 1 of the site visit

☐ Provide agency representative contact information to the ACS Program Coordinator and team leader.

☐ Participate in a "walk through" of all meeting rooms with key consultation team members and coordinate last-minute changes to meeting logistics.

A designated contact person to serve as a liaison between the local host and the team leader and Program Coordinator helps facilitate the resolution of unanticipated changes or unexpected needs. Having the rooms prepared in the specified manner and the necessary equipment resources on-site will facilitate a more successful visit.

APPENDIX B



Sample Agenda

This agenda is intended to provide planning personnel with an understanding of the process and flow of the site visit. A specific agenda will be developed for each site consultation.

SAMPLE AGENDA

Day 1

Team arrival in early afternoon

2:00-4:00 PM	Consultation team meets with team leader to review documents
5:00-7:00 PM	Dinner or social hour and meeting with participants
7:00-7:10 PM	Introduction to the consultation process by team leader
7:10-7:40 PM	Trauma system overview presentation by requesting agency

Begin briefing

7:40-9:00 PM	• Statutory authority and administrative rules
	• System leadership
	• Coalition building and community support

Day 2

7:30-8:00 AM	Coffee and participant registration
8:00-9:00 AM	• Lead agency and human resources within the lead agency
	• Trauma system plan
	• System integration
	• Financing
9:00-9:45 AM	• Injury epidemiology
	• Prevention and outreach
9:45-10:15 AM	Break
10:15-11:30 AM	• Emergency medical services
	• System coordination and patient flow
	• Disaster preparedness
11:30-1:30	Lunch
1:30-3:00 PM	• Indicators as a tool for system assessment
	• System-wide evaluation and quality assurance
	• Trauma management information systems
	• Research
3:00-3:30 PM	Break
3:30-5:00 PM	• Definitive care facilities
	• Rehabilitation
6:30-9:30 PM	Team retreats for initial deliberations and report writing

Day 3

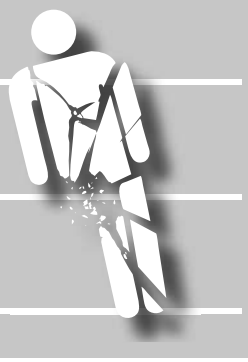
8:00 AM-6:00 PM	Team meets for deliberations and report writing

Day 4

8:00 AM-1:00 PM	Team meets to complete report writing and findings
1:00-2:00 PM	Team leader presents summary report and comments to requesting agency and stakeholders
2:15 PM	Team departs

APPENDIX C

Suggested Participant Invitation List



State Health Commissioner

Health department leadership

State EMS Medical Director

State Trauma Medical Director

State EMS Director

Trauma Advisory Committee and subcommittee members

EMS Advisory Committee members

State trauma registrar

Trauma program epidemiology and statistics representatives

Office of Rural Health representative(s)

Disaster and emergency management representatives

Governor's Highway Traffic Safety Representative

State legislators

Emergency Medical Services for Children, state program director/coordinator

State Hospital Association

American College of Emergency Physicians, state chapter

Emergency Nurses Association, state chapter

Committee on Trauma, state chapter

Surgeons

Nurses

Rehabilitation representatives

Injury prevention program leaders and advocates

Trauma center administrators

Trauma center directors

Trauma program managers and trauma registrars

Representatives from hospitals without trauma centers

Representatives from rural and critical access hospitals

EMS regional coordinators

EMS agency managers

EMS medical directors, regional, and local

Prehospital providers

Aeromedical service representatives

EMS dispatch and Public Service Access Point representatives