Trauma Verification Q&A Web Conference

December 12, 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 trauma 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)
### Clarification Document and Verification Change Log

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

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

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

• Stakeholder Public-Comment website:
  https://www.facs.org/quality-programs/trauma/tqp:center-programs/vrc/stakeholder-comment

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

• Participant Hub - Account Center:
  https://www.facs.org/quality-programs/trauma/tqp/tqp-center

• Expanded FAQ:
  https://www.facs.org/quality-programs/trauma/tqp:center-programs/vrc/faq/standards
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

• The next presentation will be January 2019
Announcements
Next Verification Q&A Webinar

Webinar Date: **Monday, January 28th**

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

Deadline to submit questions: **Monday, January 14th**
General Questions
Prehospital Report

“Does ACS address utilizing a specific acronym for prehospital report? (ie: M.O.V.I.N.G. or MIST)” (Level 2)

The VRC has no stance on what the Prehospital report is called.
Advanced Practice Providers

“Do L - II adult trauma providers who once in a while see peds trauma always with peds ER MD must have PALS or is it optional?” (Level 2)

Advance Practice Providers (APP) who see pediatric trauma patients with the ER Attending during the consult tier or non-activation phase are not required to have ATLS or PALS.

Current ATLS status is required for those members on the activation team that participate in the evaluation and resuscitation efforts (CD 11-86).
Admitting Policy

“Should all elderly patients with isolated injuries or brain bleeds post fall from standing position be admitted to trauma?” (Level 2)

The admitting policy will be determined by the trauma center. For best practices, admitting to the Trauma Service with a Neurosurgery consult for the first 24 hours is acceptable.
Admitting Fractures

“Does ACS address anything about which specialty should be consulted (ortho or trauma) for fractures admitted to medical?” (Level 2)

The admitting policy will be determined by the trauma center. For best practices, patients who meet trauma inclusion criteria should be admitted to the Trauma Service for 24 hours to rule out any other injuries with an Orthopaedic Surgery consult. With this said, it would also be acceptable to admit to the Orthopaedic Service with a Trauma consult.
Response at Bedside

“Who are the required personnel whose bedside arrival times need recorded? (ie. respiratory therapy, xray, CT, anesthesia, etc)” (Level 3)

For Verification, the following are required to be at bedside, but not limited to:

• Trauma Surgeon (CD 5-15)
• Emergency Physician (CD 7-3)
• Neurosurgeon (CD 8-6, if capabilities are present)
• Orthopaedic Surgeon (CD 9-11)
• Anesthesiologist or CRNA (CD 11-7)
• Nurses: ED, PICU, PACU
• Radiologist (CD 11-32)
• CT Tech (CD 11-47)
• Respiratory Therapist (CD 11-76)
• Physical Therapist (CD 12-3)
• Social Worker (CD 12-4)
• Registrar (CD 15-9, if greater than 750 or TPM is encumbered)
Backup Call Schedule

“Are Level 1 Centers required to have a back-up schedule for Ortho-Spine and/or Neurosurgery covering spine call?” (Level 1)

If the question is asking must there be a separate backup call schedule for Spine call, it does not. In Level I or II trauma centers, Spine call may be shared between the Neurosurgery and the Orthopaedic Surgery group. Therefore, if one of these groups is covering Spine call, then the backup call/system or contingency plan will be triggered as noted below.

A Level I and II trauma center must have the following:

- Neurosurgery contingency or backup call schedule
- Orthopaedic dedicated call schedule or backup system
Backup Call Schedule

“We are pursuing a Level III. Do we need a back up call schedule for trauma surgeons?” (Level 3)

A Level III trauma center is not required to have a backup call schedule for Trauma Surgeons.
“Is it mandatory to provide EMS agencies a follow up letter on every patient they transport to your center?” (Level 2)

While it is not required to provide a follow-up letter to the EMS agencies, it would be good to share information or best practices that resulted from something positive or negative.
“With a focused review at a Level II, if all prior deficiencies and recommendations were appropriately addressed, but there is a deficiency identified, will there be a second focused review, or is verification retracted?” (Level 2)

If during an onsite Focused Review a different deficiency is identified or if any of the identified deficiencies were not addressed, a second Focused Review would not be given. Therefore, verification will not be granted for the full 3 years or extended (if previously received a one year verification).
M&M Review

“Is trauma M and M an adequate tertiary review of a trauma case that falls out due to audit filters?” (Level 1)

Just want to point out that many trauma centers use many different titles for their Peer Review Meetings. If the Trauma M&M meeting noted here is a separate meeting from the Peer Review Meeting, it is probably not the best place to discuss or review trauma cases that fall out due to audit filters such as, Trauma activations, Emergency Department length of stay, over/undertriage, washout times for open fx’s, etc.
OPPE for Advanced Practice Providers (CD 11-87)

"Can the OPPE for Trauma/SICU APPs be completed by our SICU Director/Trauma Surgeon with TMD oversight, or does the TMD have to do the OPPE independently?"

(Level 3)

The OPPE may be completed by the SICU Director. We simply ask that the TMD is involved by having oversight in the OPPE process.
Overtriage and Undertriage

“Does a center have to use the Cribari method to assess over- and under-triage at their facility?” (Level 3)

No it does not. The Cribari matrix is just one method to evaluate its over/undertriage rates, but it is not required.
Overtriage and Undertriage

“We meet with 2 of our largest transport agencies each month and review patients for under/over triage etc, is that adequate?” (Level 2)

This is a good idea; however, you still want to have a mechanism available to track and evaluate the over/undertriage rates to ensure the center is in compliance with the standard (CD 3-3).
# Triage Criteria (ISS Method)

<table>
<thead>
<tr>
<th>Activation Level</th>
<th>ISS 1 - 15</th>
<th>ISS 16 - 75</th>
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<tr>
<td>Full / Highest</td>
<td>10</td>
<td>20</td>
<td>30</td>
<td>10/30 = 33%</td>
</tr>
<tr>
<td>Limited / No Team</td>
<td>185</td>
<td>15</td>
<td>200</td>
<td>15/200 = 7.5%</td>
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<tr>
<td>Total</td>
<td>195</td>
<td>35</td>
<td>230</td>
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Isolate and analyze transfers-in separately

Use results to update/educate on activation criteria
Peer Review Meeting

“In trauma peer review, can only the TMD or associate TMD sign off on the chart review?” (Level 1)

Medical records presented at the Peer Review Meeting should be signed off by the TMD and/or associate TMD. It demonstrates his/her responsibility for the case review.
Discoverability Peer Review Minutes

“Our corporate risk/compliance division has reached to many of our subsidiaries regarding the amount of detail we are putting into our peer review minutes and have concerns from a legal standpoint.” (Level 2)

For Verification purposes, you do not want a transcript of the medical record. It should be a case summary. Avoid patient identification such as, specific age over 89, or other identifying information. Refer to the HIPAA guidelines, for more information on what specific data filters should be exclude.

A clause will be added to the Review Agenda that will read, “Peer Review minutes are not discoverable.” Please be advised that most states have a protected Peer Review process.
“Any updates on the use of TEG? Will it convert from should to must have?” (Level 1)

At this time, there is no update regarding TEG. This chapter is still under review.
Anesthesia Waiver

“Is there a waver that can be submitted for the requirement of in-house Anesthesia for level 2 trauma center?” (Level 2)

Presently, there is not a waiver for Anesthesia at rural Level II trauma centers.
Non-Surgical Admissions

“Please explain the intent of capturing non surgical admit data. Shouldn't it measure how many patients were not seen by Trauma or surg specialties, either by consult or eval, instead of counting how many were admitted to a non surg service? Seems as though the group we're trying to capture here are injured pts without Trauma/surgical specialty involvement.” (Level 1)

Ideally this will be how this criteria will be rewritten for the next edition of the Resources manual. However, the current criteria is asking for the number of patients who are admitted to a Non-Surgical Service be reviewed for appropriateness of care.
Non-Surgical Admissions

“Has the ACS Re-defined what nonsurgical admission means? We have always taken it to mean any injured pt admitted to medicine.” (Level 3)

Non-surgical admissions are patients who meet the NTDS or your trauma center’s inclusion criteria and are admitted to a Non-Surgical Service.

Non-Surgical Services may include:

• Medicine
• Geriatrics
• Neurology
• Neurocritical Care
• Pediatrician
• Intensivist (pulmonary, anesthesia or medicine)
Neurosurgery Capabilities

“If a Level III program has 10 days of neurosurgery emergency call, would you consider that a Level III with or without neuro?” (Level 3)

This would be considered a Level III with Neurosurgery capabilities. The requirements outlined in Chapter 8 for Level Ills must be in compliance at the time of the visit.
Registrar Continuing Education

“Are trauma registrars still required to have trauma-related continuing education credits? If so, how many per year.” (Level 1)

Presently, there is no requirement for Registrars to have Continuing Education (CE).

As noted on page 111 of the Resources manual, it reads as follows, “Registrars should complete a minimum of 8 hours of registry-specific continuing education per year.”
Registrar Qualifications

“Share how on the Registrar level there are many projects that can be shared, they don't have to be a nurse.” (Level 2)

There is no requirement that the Registrar must be a Nurse. The Registrar should receive initial training and is required to attend two courses within 12 months of being hired (1) ATS Registrar Course or equivalent and (2) the AAAM Injury Scaling Course (CD 15-7).

Hires after July 1, 2014, must have attended or previously attended a training course at the time of the site visit. New registrars must have the training within one year of hire.

Those hired prior to July 1, 2014, are grandfathered in this criteria.
**DIED and DOA**

“Can you provide some guidance on DIE vs. DOA, any procedure/intervention in ED makes it DIE, ie. epi admin, bedside xray, FAST?” (Level 3)

The VRC does not define Death in the Emergency Department (DIED) or Death On Arrival (DOA). These terms will vary from center to center. Defining them will be determined by the trauma center or state regulations.
Geriatric Patients

“I am interested in information surrounding Geriatrics/Trauma and what specifics will be reviewed/required for ACS verification?” (Level 1)

Trauma centers are not required to have a Geriatric Service. It would be ideal to have one if the trauma center sees a high volume of these patients. The expectation is for the program to have a process or guidelines in place to manage these patients. If you have developed guidelines for Geriatric patients, have that information readily available at the time of the visit.
Locums

“Are per diem surgeons (who live in other states) required to attend 50% of PIPS meetings?” (Level 3)

Yes. For all trauma centers, locums who are treating trauma patients must meet the credentialing process and same requirements as the other physicians/surgeons, e.g. board certification, OPPE, and attendance at the Peer Review Meeting.

As a reminder, the Peer Review Meeting can be attended in person, by teleconference or video.
PRQ: Washouts

“Does an I&D in the OR for open fxs count as a wash out as referred to in the PRQ for ‘Average time to wash out’?” (Level 2)

An I&D in the Operating Room will count toward the “average time to washout” question in the PRQ:

16. Average time to wash out of open tibial fractures secondary to a blunt mechanism; report as average and range.

An I&D in the Emergency Department will not count.
Verification Site Visit

“We are due to be re-verified in Spring 2020- if the updated ‘Resources for Optimal care’ book is due out at the same time, which standards will we be evaluated with for the verification review?” (Level 3)

Trauma center will be provided a grace period of 12 months starting from the date the new Resources manual is released to implementation of any new or edited standards.
Verification Site Visit

“The ACS requests specific parts of the EMR to be printed and have on hand at the time of the site visit. Can the ACS tell us in advance which charts they will be reviewing to eliminate the need for unnecessary printing and expense to do so?” (Level 1)

The Review Agenda has a list of the medical records by category and minimum number required at the time of the visit. For a copy of the Review Agenda visit: https://www.facs.org/quality-programs/trauma/tqp/tqp-center.

Unfortunately, we cannot tell a trauma center which medical records will be reviewed because they are randomly selected by the Review Team. With this said, we have an ongoing medical record pilot that will end this year in which it decreases the number of medical records during a visit. The data from these visits will be presented to the VRC and the Executive Committee for approval during the 2019 COT Annual Meeting in March. More information will be provided thereafter.
“Rural EMS departments often do not send us reports, patient goes to a fixed wing medivac and no report, will we get a deficiency?” (Level 3)

The trauma center will not be cited a deficiency if there is no EMS report. With this said, you want to ensure that an effort was made to obtain a copy of the EMS report. These efforts along with a note that a report was not received should be documented in the medical record.
Verification Site Visit

“If we have an EMR, can the items requested for review be generated into a pdf file/folder per patient...or must we paper print?” (Level 1)

If the trauma center has an Electronic Medical Record (EMR), it is not required to print the entire medical record. However, the EMR software must be easily tabulated to display the contents listed below. If the EMR software is not able to display the information, then the following contents must be printed for the reviewers.

1. Prehospital
   a) EMS Run Sheet
   b) Transferring facility ED info, if applicable
2. Trauma Flowsheet
3. H&P
4. Consult Notes
5. Operative Report/Notes
6. Discharge Summary
7. Autopsy Report, if available
8. Copies of PIPS documentation, if applicable
Verification Site Visit

“During the Nov web conference, it was stated that an OTL form & CV must be submitted for all Level I centers with the site visit application. I thought if it was previously submitted and had not changed, you did not need to re-submit. Has this changed?” (Level 1)

To clarify, for the Orthopaedic Traumatology Leader (OTL) process, we do not require a copy of the CV. The CV is applicable to the Alternate Pathway Criteria process. If an OTL form was previously submitted and there has not been a change, a new form is required to be resubmitted, but only answering questions 1, 2 and 3.
Verification Site Visit

“During Chart selection, if there are not 10 charts in a category-is that acceptable or should you fill the remainder with others?” (Level 2)

If you do not have the minimum number (10) of medical records in any of the categories, pull what you’ll have available at the time of the visit. If there happens to be a category with less than the minimum or even zero medical records, do not fill the balance with other medical records. Also, if you have a multisystem injury, do not copy the medical records, place it in the most appropriate category.
Verification Site Visit

“During a verification review, how do you present PI you have done that is not directly related to a particular patient chart?” (Level 2)

If you have done PI on an audit filter or something that has positively impacted your PIPS process, you can present this to the Review Team during the medical record review discussion or possibly at the review dinner.
Verification Site Visit

“If there are open positions for Neuro surgeons at the verification visit, will the center fail reverification to a Level II?” (Level 2)

Having open positions for Neurosurgery is not a deficiency. However, if there are no Neurosurgeons currently on the trauma call panel that can consult/manage trauma patients, this will be cited as a Type I deficiency – no verification will be granted.

Without having the details of the circumstances, the trauma center may be able to address this deficiency with a Focused Review.
CD-Related Questions
TMD Authority and Responsibilities (CD 2-5)

“CD 2-5. How exactly is it expected that the TMD have responsibility & authority for determining each surgeon's ability?” (Level 1)

For Surgeons serving on the trauma panel, the TMD has the:

- Authority and administrative support to lead program (Level I-IV CD 5-1)
- Authority to manage all aspects of trauma care (Level I-III CD 5-9)
- Authority to include/exclude from trauma call the trauma team members who do not meet specified criteria (Level I-III CD 5-11)
- Performs annual assessment of trauma panel (Level I-III CD 5-11) & consider liaisons feedback
- Determine qualifications (Level I-III CD 5-12)
“I have a question regarding PGY 4 and 5 Resident requirements. I was not able to locate any defined requirements/information on this in the clarification document nor FAQ, but need to ensure this is being correctly interpreted. In reference to PGY4 and PGY5, are there specific requirements for trauma call coverage 24/7? Is there a difference between night and day if there are specific requirements? I can only find specific requirements that they may begin the resuscitation while waiting on the Attending (CD-6). I see there is verbiage regarding the senior residents having a continuous rotations in trauma surgery, but do not see this specifically delineated. Is this a correct interpretation?” (Level Unidentified)

Your interpretation is correct. In Level I and II trauma centers, the PGY 4-5 may begin resuscitation efforts but cannot independently fulfil the Attending Trauma Surgeon’s role or response time for the highest level of activation. In a Level I and II pediatric trauma center, this includes PGY 3-5.
Direct Physician Contact (CD 4-1)

“Please clarify if an MD is needed or if an APP can perform CD 4-1” (Level 2)

CD 4-1 Not all facilities have physicians for the interhospital conversation. Can our level II acceptance be by an NP?

An Advanced Practice Provider or Nurse Practitioner is acceptable to perform this task.
Transfers (CD 4-3)

“The statement that all transfers must be reviewed in the PIPS program. Is it referring to transfers in or transfers out?”

(Level 1)

This is referring to both: transfers in and transfers out.
Call Schedule (CDs 5-7/6-8)

“Are the requirements for trauma surgeons taking backup call the same as primary call (i.e. 50% attendance at Peer Review)?” (Level 2)

If the backup call schedule is comprised of Trauma Surgeons/General Surgeons and they alternate with the primary call schedule, they are required to meet the same requirements.
Response Times (CDs 5-14/5-15)

“If an ATLS certified PA completes the initial evaluation for a modified trauma patient, does the PA’s arrival time take the place of the Trauma Surgeons 30 minute response time?” (Level 2)

If I understand this question correctly, for the highest level of activation for a Level I and II trauma center, the response time is 15 minutes; for a Level III trauma center it is 30 minutes. The PA’s response time for any of these levels cannot take the place of the Attending Trauma Surgeon’s response time.

If this is referring to the Limited Tier of activation where the institution has defined a 30 minute response time for the Attending Trauma Surgeon, again the PA’s response time cannot take the pace of the Attending Trauma Surgeon’s response time.
Limited Tier Activation (CD 5-16)

“For 5-16, ‘Other potential criteria...’ what would like reviewers like to see the trauma center has done to meet this criteria?” (Level 3)

This standard may impact the over/undertriage rates. Reviewers want to know that you are reviewing your under/over triage rates. Are you monitoring and reviewing your activation policy on an ongoing bases through the PIPS process to capture any outliers. If there are outliers, have there been any updates based on PI/triage outcomes made to your activation policies.
Non-Surgical Admits (CD 5-18)

“We have a recurring scenario of ambulating elderly patients falling, hitting their head, and has a brain bleed or other isolated injury. We are looking for an official answer on these patients being admitted to the trauma service. We understand that it brings up the question, which came first, the chicken or the egg? I know that it typically is for the physician to err on the side of caution if the brain bleed is remotely related to the fall (i.e. occurring as a result of head being struck) and admit to trauma. We are a designated FL DOH Level II trauma center, not ACS-verified, and we do have nonsurgeons (medical intensivits) admitting such patients as well as the trauma service. Neurosurgery is consulted in both scenarios. We understand that best practice is to admit to general trauma surgeon in these cases, because of the potential for identifying other injuries (rib fractures, C-spine injuries, abdominal bleeding, etc.), especially in the first 24 hours. Please let me know which route I should go with this question.” (Level 2)

As you noted best practices would be to admit to the Trauma Service for a period of time and then transfer to Medicine with a Neurosurgery consult. It would also be acceptable to admitted to Medicine with Trauma and Neurosurgery consults. Again, both are acceptable methods.
Non-Surgical Admits (CD 5-18)

“ACS expectations for non-surgical admits??  1) Determine the per. of non-surgeon admits. 2) Review each case ISS 9 3) Care approp? if Ortho admits vs Gen surgery, this is acceptable? Those non Ortho, review all records or just ISS 9?” (Level 3)

You do not want to review just those with an ISS of 9, you’ll want to follow the grid on page 121 in the Resources manual on reviewing these patients. Patients admitted to the Orthopaedic Service are acceptable and would not count as a non-surgical admission. If the admission was to a Non-Surgical Service, did that patient receive a surgical consult and if not, you’ll want to review that record through your PI process to determine if it was appropriate.
Trauma Program Manager (CD 5-23)

“Are Level III centers required to have a Trauma Program Manager? If they don't is it a deficiency?” (Level 3)

“I work at a level 3 Trauma Center, My question is do we have to have a full time Trauma Manager?” (Level 3)

For Verification purposes, the titles of Trauma Program Manager or Coordinator or Trauma Director are all interchangeable.

A Level III trauma center is required to have a TPM or coordinator, but is not required to be full-time.

If the trauma program does not have a TPM or Coordinator, it will be cited as a deficiency.
Chair of Trauma Peer Review Meeting (CD 5-25)

“Who can chair trauma peer review in the TMD or associate TMD absence?” (Level 1)

The TMD or Associate TMD must chair the Trauma Peer Review Meeting. There is no alternate representative that will satisfy this criteria.
Neurosurgery Response (CD 8-2)

“Can the resident, fellow or Attending be the responding physician for the 30 minute Neurosurgery response (similar to ortho)” (Level 1)

The Neurosurgery Resident, Fellow, Attending or PA/APP may be the responder for the 30 minute response based on conditions defined by the trauma program; however, there must be clear documentation with the Attending Neurosurgeon on plan of care.
Neurosurgery Contingency Plan (CDs 8-3/8-5)

“The chapter 8 VRC standard FAQ states that in regards to copies of neurosurgery back-up call schedules, the center is required to demonstrate compliance with all standards. This includes documentation such as call schedules, back-up call schedules, trauma protocols, administrative commitment letters, etc. CD 8-3 states the trauma center must provide a reliable, published neurotrauma call schedule with formally arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed. A published neurosurgeon backup call schedule is the best method to meet this requirement. However, because of the significant shortage of neurosurgeons in many hospitals and regions of the country, other creative methods to ensure timely and appropriate care may be used. Could you please clarify whether or not a neurosurgery back-up call schedule is required if a contingency plan is in place? If there is a contingency plan in place and no formal backup call schedule, how do we answer question number 8 in the neurosurgery section of the PRQ without automatically creating a criteria deficiency?” (Level 2)

A Neurosurgery backup call schedule is not required if there is a contingency plan available, and vice versa. The PRQ regarding these questions have been programmed to not trigger a deficiency if question 8 is answered as “No” or “Yes” and question 10 is answered as “Yes” or “No.”
Neurosurgery Liaison (CD 8-10)

“Is it acceptable to have a liaison from Neurosurgery who is BOARD ELIGIBLE but not yet board certified” (Level 2)

Yes it is. A Neurosurgeon who is current in their board certification or eligibility is acceptable to be the liaison.
Orthopaedic Traumatology Leader (CD 9-5)

“Please clarify the following CD (2-6): In a Level 1 trauma center the orthopaedic care must be overseen by an individual who has completed a fellowship in orthopaedic traumatology approved by the Orthopaedic Trauma Association (OTA) (CD 9-5). Does the “overseen by” imply a position of medical directorship or does this simply mean that a provider who has completed an approved fellowship cares for and generally directs the clinical care of trauma patients with orthopedic injuries?” (Level 2)

The intent of the OTL criteria is that there is a provider who has completed an Orthopaedic Traumatology Fellowship on the trauma call panel. This person should direct the clinical care of the trauma patient with orthopaedic injuries.
“If the adult trauma surgeons provide back up call coverage on certain days but do not participate in primary call, do the adult surgeons need to participate in Pediatric Trauma Peer Review Meetings? Our pediatric surgeons cover all primary call and meet the requirements mandated for those that cover trauma call. The adult surgeons only provide back-up call when needed.”

(Level I Peds)

All of the adult Trauma Surgeons are not required to participate in the Pediatric Peer Review Meeting. The Peer review Meeting for programs that are combined may have a representative (TMD or designee) from the adult program or from the pediatric program, attend the other program’s meeting, and ensure dissemination of communication is sent to the other panel members.
Admitted ICU Patients (CD 11-58 and CD 11-59)

“Is the trauma surgeon required to be primary attending on all trauma ICU admissions throughout their ICU LOS? CD 11-58, 11-59” (Level 2)

The admitting Trauma Surgeon is responsible for the patient and coordinate all therapeutic decisions while in the ICU. The dedicated ICU team may collaboratively manage daily care requirements with the admitting Trauma Surgeon being kept informed and concur with major therapeutic and management decisions.
“What does the college deem is an ‘adequate supply’ of packed red blood cells and FFP (11-83)?” (Level 3)

The VRC does not define “adequate supply” of packed red blood cells and FFP. The intent is that the trauma center have blood products available to meet the needs of the injured patient.
Injury Prevention Education (CD 18-1)

“For a Level III center what is the requirement for injury prevention education.” (Level 3)

All trauma centers must have an organized and effective approach to injury prevention and prioritize based on local trauma registry and epidemiologic data. There may already be programs established in your community that you can join and participate in such as, Safe Kids, Think First, Stop the Bleed, etc.
Universal Screening for Alcohol (CD 18-3)

“How does ACS identify trauma patients needing the CAGE assessment. Is it by + ETOH in ED? Or suspected problem?“ (Level 2)

The requirement is that all trauma 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 in the registry.

The screening method (CAGE, ETOH) will be determined by the trauma center.
CME
CME for Liaisons

Do liaison's to the trauma committees still need externally verified CME with the new changes?

Liaisons who are current in their specialty MOC are not required to have CMEs.
Thanks for your participation!