Trauma Verification Q&A Web Conference

September 20, 2017

COTVRC@facs.org

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Continuing Education (CE)

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

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

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

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

- Understand the processes and standards involved in an ACS Trauma Verification Site Visit and how following these will positively impact the quality of care of the injured patient at your center.
Let’s get started!
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
Clarification & Verification Document Updates

The updates for the Verification Change Log and Clarification Document through June have been completed.

These documents may be accessed through the VRC webpage at:

www.facs.org/quality-programs/trauma/vrc/resources.

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

Updates sent to participants monthly

The American College of Surgeons

Clarification Document

Resources for Optimal Care of the Injured Patient

By the Verification Review Committee

V1_ March 2017

www.facs.org/quality-programs/trauma/vrc/resources

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## Verification Change Log

Updates sent to participants monthly

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

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

You may also access them via the VRC resources webpage at:
https://www.facs.org/quality-programs/trauma/vrc/resources.
Disclaimer

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

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

Deadline to submit questions: **Friday, October 6, 2017**

Webinar date: **Thursday, October 19, 2017**

Webinar time: **11:00pm-12:00pm CST**
Save the Dates

Abstract submission will open in mid May 2017.

Registration for the TQIP Annual Scientific Meeting and Training and Preconference Workshops will open Summer 2017.

Please let us know if you have any questions.
**TQIP Meeting Information**

- Registration is currently **open**

- Hilton hotel reservations are **limited**

- Blackstone hotel reservations are now **open**
  - ACS Group Rate is the same
  - Reservation Deadline is October 9

- Visit the TQIP Annual Meeting website at [www.facs.org/tqipmeeting](http://www.facs.org/tqipmeeting) for more information and to register for the meeting.
TQIP Preconference Courses

• Registration is open for all the workshops
• Course detail listing available at: https://www.facs.org/quality-programs/trauma/tqip/meeting/workshops
  ▪ AIS and Injury Scaling Uses and Techniques (2-day course)
    • Thursday, November 9 and Friday, November 10
  ▪ TOPIC
    • Thursday, November 9
  ▪ OPTIMAL Course
    • Friday, November 10
  ▪ AIS 15 Update
    • Friday, November 10
Resources Revision Process

The Stakeholder Public-Comment website:

https://www.facs.org/quality-programs/trauma/vrc/public-comment

We strongly encourage everyone to review and comment on the standards. Your input will help guide the revision process to add, modify or retire requirements.

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<tr>
<th>Upcoming Chapters</th>
<th>Call for Data</th>
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<td>Chapter 9 Orthopaedic Surgery</td>
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<td>Chapter 10 Pediatric Surgery</td>
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<td>Chapter 15 Trauma Registry</td>
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<td>Chapter 19 Research</td>
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Resources for TPMs and TMDs

• Frequently Asked Questions (FAQs)
  • The list will expand over time.
    https://www.facs.org/quality-programs/trauma/vrc/faq

• Becoming a Verified Trauma Center: First Steps
  ▪ Designed to guide the Trauma Program Manager or Medical Director in the First Steps in the Consultation and Verification Process.
    https://www.facs.org/quality-programs/trauma/vrc/resources
Scheduling Reminders
Welcome to the ACS Trauma Quality Programs (TQP) Participant Hub!

If your hospital is a new facility, please click on Join a Program below.

If you are a current participant in one of our Trauma Quality Programs—the National Trauma Data Bank®, Trauma Quality Improvement Program, or Verification, Review, and Consultation Program—you may log in by clicking on Account Center below.

If you are a new user at an existing facility, please contact the Primary Contact for your facility (most often the Trauma Program Manager) to request that you be added to your facility’s contact list.

**Join a Program**
- Eligibility
- Getting started

**Account Center**
- Manage site information
- Manage contact information
- Request a site visit
- Access TQIP participant educational materials

**Data Center (coming soon)**
- Submit data
- Download reports
- Access interactive reports

**Training Resources**
For training materials focusing on utilizing various elements of the TQP Participant Hub, Account Center, or the Data Center, please see below.
Site Visit Application

- The application must be received at least 13-14 months in advance of the requested time frame or current expiration date.
  - This will hold your spot and in addition, provide centers plenty of time to prepare and complete the online PRQ.
- The lead time is required due to the multitude of applications received.
- Visits for 2017 and through October 2018 are closed to scheduling:
  - [https://www.facs.org/quality-programs/trauma/vrc/site-packet](https://www.facs.org/quality-programs/trauma/vrc/site-packet)
Additional Information to be submitted with Site Visit Application

• Orthopaedic Traumatologist Leader (OTL) form
  ▪ Required for:
    • Level I Trauma Centers
    • Level I Pediatric Trauma Centers
    • Level I Adult and Level II Pediatric Trauma Centers
  ▪ Combined centers (Level I adult/Level I pediatric) that have separate visits scheduled, but share the same OTL, the form must be completed entirely for the 1\textsuperscript{st} visit and on the 2\textsuperscript{nd} visit, only complete questions 1-3.

• The form is located at: https://www.facs.org/quality-programs/trauma/vrc/site-packet
Alternate Pathway Criteria (APC) Request

- For centers that have a non U.S. or Canadian board certified/eligible physician or surgeon, and who has trained overseas, must note the applicant’s name and specialty on the application.
  - Forward a copy of the applicant’s curriculum vitae (CV)
  - On-site evaluation by a member of the same specialty; assess the 8 criteria (ATLS, CME, meeting attendance, etc), along with review of clinical care

- Those previously approved by way of the APC are not required to have a review by the specialist at the time of the visit. However, they are required to meet the APC.

- The APC is not applicable to U.S. or Canadian residency trained physicians or surgeons.

https://www.facs.org/quality-programs/trauma/vrc/site-packet
Fellow of the American College of Surgeons (FACS)

- 1990’s VRC granted FACS could be used in lieu of board certification.
- FACS exception will likely disappear for trauma surgeons, orthopaedic surgeons, and neurosurgeons.
- Beginning January 1, 2017 all non U.S. or Canadian residency trained surgeons not yet inducted as a FACS will be required to undergo review by way of the alternate pathway criteria (APC).
- Surgeons inducted as FACS prior to 2017 are not required to undergo review by way of the APC.
- Notify the VRC office each time & early.
Prereview Questionnaire (PRQ) Online Access

- Once your application has been received, the VRC office will provide you with an email receipt of confirmation.
  - Logins to the online PRQ will be provided within the confirmation of receipt email
  - The online PRQ can be accessed at: http://web2.facs.org/traumaskesurvey5/
  - A copy of the PRQ in Word can be downloaded from: www.facs.org/quality-programs/trauma/vrc/resources
Site Visit Application Payment

• Do not submit payment with the application

• Your center will be billed annually for the Trauma Quality Program fee
  ▪ This annual fee will not include any additional visit-related fees, such as additional reviewers

• The fee structure is located at: https://www.facs.org/quality-programs/trauma/vrc/fees
Scheduling Site Visits

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

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

• When a lead reviewer is available for your site visit, VRC staff will contact you TPM to confirm the dates prior to finalizing the visit.
Site Visit Preparation with Reviewers

- The ACS Travel Agent will arrange the site reviewers’ flights. Reviewers make travel plans approximately 20 to 30 days prior to the site visit.

- The hospital will arrange and pay for the site reviewers’ hotel accommodations as well as their ground transportation.

- The reviewer’s contact information will be provided in a confirmation email once the full team has been secured, approximately 90 days before the visit.

- Please contact the reviewers directly within 30 days of the site visit, for their flight Itinerary and any logistical information.
General Questions
Alternate Pathway Criteria (APC) for the Pediatric Trauma Medical Director

“Would you please review in detail the alternative pathway for a pediatric trauma medical director? Eligibility, steps, and whether or not we need to ‘register’ an alternative pathway PTMD formally with the ACS in order for them to be official.” (Level 2)

For anyone that is undergoing review by way of the APC, it must be noted on the site visit application or notify the ACS well in advance of the site visit.

For Level I and II pediatric centers, if the pediatric TMD is board certified in general surgery, but not board certified in pediatric surgery, s-/he must meet the pediatric APC at the site visit.
1. Be credentialed by the hospital to provide pediatric trauma care;

2. Be a member of the adult trauma panel;

3. Participate in trauma call;

4. Accrue an average of 16 hrs annually or 48 hours in 3 years of verifiable external CME, of which at least 12 hours (in 3 years) must be related to clinical pediatric trauma care;

5. Be current in PALS or have taken the Society of Critical Care Medicine Fundamentals of Pediatric Critical Care course;

6. Formal relationship with a pediatric TMD at another verified level I or II PTC.
Copies of On-Call Schedules

“How many months do we need on-call schedules for Trauma, Orthopedics, and Neurosurgery? Three years from survey?” (Level 2)

For centers undergoing a site review for consultation, verification or reverification, it is required to have the on-call schedule and backup schedule, if applicable, for the reporting year (12 months).
EMS Communication

“I see no specific standard or CD related to providing feedback to EMS- why was it mentioned as a requirement at the last webinar” (Level 1)

This is not a requirement; however, this should be an essential responsibility of a tertiary facility to provide specific feedback to referring facilities and prehospital providers. The feedback should include final diagnosis, the general course and outcome of the patient and any PI issues that the tertiary facility identified in the care provided prior to arrival.
Electronic EHR

“There is no standard in the Orange book relating to the use of an electronic version of the EHR, so why does ACS have a stance?” (Level 1)

This is not a requirement, however, for best practices use of the electronic flowsheet must *contemporaneously* document the care of the patient. Typically the electronic flowsheet denotes the date when a key entry is made; therefore, you must be cognizant of the date/time stamp. If reviewers see a number of instances where the date/time is not accurately documented, they may recommend to revert back to the paper flowsheet, if applicable, until the programming of the electronic flow sheet has been addressed.
Onsite Focused Review

“What is the process for a focused review? As far as PRQ, cases and dates?” (Level 1)

For an onsite Focused Review the following are not required: PRQ, prereview dinner and the facility tour.

A site visit application must be submitted shortly after receiving the verification letter. The visit must take place on or before the date noted in the letter, typically a year from the date of the initial visit.

A block of 5 hours will be required for reviewers to review medical charts (limited quantity) commencing with the changes that have impacted the deficiency(ies) identified.
Schedule for Onsite Focused Review

- One day visit with two surgeons, one of the initial reviewers may return (2nd reviewer may be a nurse)
- A corrective action plan is required approximately 30 days prior to the site visit on how the deficiencies were addressed and how the weaknesses were/may be addressed
- A presentation on the corrective actions may be done if desired; but not required
- Review will commence approximately at 0700 unless told otherwise by the ACS office or site reviewers (e.g. travel issues)
  - Typically reviewers arrive the evening before the visit requiring hotel accommodation
- Chart review process/validation
- Closed meeting with the reviewers
- Exit interview
“Can you provide some examples of OPPE that the College think are best practice?” (Level 2)

The OPPE may be designed by the institution and should include criteria for each provider and it may include: peer review attendance, CME, performance evaluation, etc.
Outreach

“Level I fac-Is it a critical deficiency if Trauma/EMS Outreach is housed within centralized Outreach Dept rather than Trauma dep. Is it a Critical Deficiency if no EMS Liaison, but Trauma Outreach filling that role for EMS?” (Level 2)

Q1-It is not a critical deficiency if trauma/EMS outreach is housed within a centralized Outreach Department rather than in trauma. With this said, there must be a direct link and resources dedicated to the ‘trauma’ outreach program (CD 17-2).

Q2-the criteria does not state it must be an EMS liaison; however, there must a representative from the Emergency Department that participates in the prehospital PIPS program (CD 7–8).
“Can you please give an example of the FAST exam competency requirements for a level II?” (Level 2)

There are no CDs or requirements regarding FAST exams.

The PRQ does ask to describe the QI process for the Fast exams. This is used to assess the process, but does not infer a criterion deficiency (CD) will be cited.
PRQ: Examples of Loop Closure for System Issues

“Could you help give examples for the PRQ where they are requesting 2 examples of loop closure for a systems issue?” (Level 2)

Examples of system issues may include:

- Prolonged transfer times from regional facility
- Prolonged EMS scene times for ISS > 15
- ED nursing inadequate use of rapid infuser
- Inconsistent CT tech staffing
- OR delays in obtaining blood products
- Anticoagulant reversal: times to head CT
- Transfers back from rehab
- NS call schedule miscommunication
- Crowding in the trauma resuscitation bay
PTSD Screening

“When's the right time during admission to screen for PTSD. Psych here said that everyone will be (+) if screened within 30 days? We developed a tool for PTSD to screen all trauma pts within the admission stay and if (+) a refer to Psyche box is checked off. Some centers said its the Provider's discretion to screen for PTSD, is it? Psych recommends screening after 30 days, pls clarify” (Level 2)

There currently are no ACS standards for PTSD screening. The VRC’s stance is that the trauma center should develop guidelines internally regarding the evaluating, treating, and managing patients with PTSD.
Inclusion Criteria: Geriatric Patients

“Is it required to include patients greater than 65 years of age with same level fall and isolated hip fracture in registry?” (Level 1)

The admission policy for elderly patients with single level falls or isolated hip fractures should be set at each individual institution. If these patients meet the NTDS inclusion criteria, they should be captured in your trauma registry, and if the center includes them in the total number of trauma patients admitted (on the PRQ), then you must follow the rules as any other trauma admission such as, reviewing nonsurgical admissions, PI, etc. (CD 5-18). Refer to page 121.
ICU Physician Response (CD 11-51)

“What suggestions do you have to capture the trauma surgeon's response to the ICU within 15 minutes of being called?” (Level 2)

The response time may be captured by the nurse, self-report or by an electronic badge scanner.
Trauma Backup Surgeon Response

“Is the Trauma backup surgeon required to be within 15 minutes of the hospital and held to the same response time for high level activations?” (Level 2)

If the primary attending is tied up on another trauma case or in the OR, and the ‘backup’ trauma surgeon is activated, the ACS has not mandated a response time. The institution should monitor the response times through the PIPS process to ensure delays do not impact patient care.
CD-Related Questions
Trauma Volume (CD 2-4): Observing Patients

“Does the ACS take a specific position on the admission of trauma patients to an ED/Obs unit? Would this be considered a non-surgical admission…and are there specific PI/Review ramifications?“ (Level 1)

For verification purposes, patients who do not meet the NTDS Trauma Inclusion criteria and/or are discharged within 23 hours (kept for observation) do not count toward the Trauma Patient Admission total or volume requirement and would not fall under the non-surgical admission category.
“Is there an exact formula to calculate over or under triage” (Level 2)

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

- **Undertriage**
  - Severely injured patients taken to lower level of care (Optimal Goal < 5%) (CD 3-3)
# Triage (ISS Method)

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<td>20</td>
<td>30</td>
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<tr>
<td>Limited / No Team</td>
<td>185</td>
<td>15</td>
<td>200</td>
<td>15/200=7.5% Undertriage</td>
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<tr>
<td>Total</td>
<td>195</td>
<td>35</td>
<td>230</td>
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Use results to update activation criteria
Commitment Letters (CDs 5-1, 5-2 and 5-3)

“CD 5-1, 2-3, 2-2. Does this require signatures from all depart. chiefs or is a signature from CMO & Dept Chairs aqeuqate. Does a hospital with Adult and Pediatrics Prog need a separate signed Commitment Letter for each or can one letter cover both.” (Level 2)

The commitment letters may be signed, if authorized, by the CMO and chairs for all the departments.

There may be one commitment letter that includes both the adult and pediatric programs.
“Is it a deficiency to have greater than 10% NSA if all are appropriate with low ISS and have been PI?” (Level 1)

The deficiency is not on the program having greater than 10% non-surgical admissions. The deficiency is based on the center having greater than 10% non-surgical admissions and not reviewing those cases through the PIPS program for appropriateness of care.
“Who all need to have or be current in ATLS? Do PA/NP Need ATLS certification? Do PGY 1, 2, and 3 Need to be ATLS certified?” (Level 1)

The following providers require ATLS certificates:

- TMD must be current (CD 5-6)
- Trauma surgeons must have successfully completed it at least once (CD 6-9)
- Physicians board certified or board eligible in emergency medicine must have successfully completed it at least once (CD 7-14)
- Physicians boarded certified or board eligible in specialties other than emergency medicine such as, family practice, internal medicine, etc., and provide care to trauma patients in the ED must be current (CD 7-15)
- Advance practice providers who are members of the TTA, evaluate and resuscitate trauma patients, must be current (CD 11-86)
**Neurosurgery Backup (CD 8-3)**

“Are there any other examples of approved contingency plans aside from the published backup neurosurgery call schedule for CD 8-3?” (Level 2)

*Table is noted in the Clarification Document, https://www.facs.org/quality-programs/trauma/vrc/resources*

### Chapter 8 Neurosurgery: Table 1 Expected Neurosurgical Coverage

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<th>NSG Liaison</th>
<th>NS</th>
<th>Emergency Coverage</th>
<th>Initial Eval</th>
<th>Backup</th>
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<tr>
<td>Level I</td>
<td>Board-Certified NSG</td>
<td>BC NSG or alt pathway</td>
<td>Immediately available 24/7</td>
<td>NSG Sr NSG resident Trauma surg EM phys APP</td>
<td>NSG Sr NSG resident Transfer agreement</td>
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<tr>
<td>Level II</td>
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Initial Evaluation means who initially saw the patient in the ED. If the patient was first seen by the ED physician or trauma surgeon and NSG was consulted, then acceptable for junior neurosurgery resident to perform consult. There must be documentation though of discussion with attending.
“Does all anesthesiologist have to be board certified?” (Level 2)

No. Only the anesthesiologist liaison must be U.S. or Canadian board certified or board eligible.

This is a change from the Resources manual and it is noted in the Clarification Document and Change Log at, https://www.facs.org/quality-programs/trauma/vrc/resources.
Radiologist Response for Interpretation and Intervention (CD 11-33)

“Can fellows/residents provide for the 30 minute radiologist response requirements for interpretation and/or intervention?” (Level 1)

As only an IR trained radiologist can do the procedure, it is the IR radiologist that must be present.

If your institution credentials fellows to independently perform an angiogram/embolization or at least to start it, then they can qualify for the 30 minute rule.
ICU Liaison (CDs 11-49 and 11-61)

“Can the trauma director also be the sicu director and if so who will be the liaison for critical care at peer review meetings?” (Level 1)

For a Level I adult or pediatric center, the TMD may also be the ICU liaison. Since the role will be served by the same person, s/he will meet the requirement for the TMD and ICU at the trauma peer review committee meeting. For a Level I adult center, if the TMD will serve both roles, s/he must be board certified in surgical critical care (CD 11-49).

The TMD may also appoint a predetermined ICU designee to attend the trauma peer review committee meeting as the ICU representative.
Microvascular Capabilities (CD 11-71)

“Regarding surgical specialists, are Level I centers required to have 24/7 coverage for microvascular? In relation to above question, can there be a transfer agreement as indicated in CD 8-5?” (Level 1)

Level I and II trauma centers must have microvascular capabilities. Microvascular coverage may be satisfied by having a surgeon who uses an operating microscope for nerve repair, free tissue transfer, etc. These specialists are not required to be inhouse 24/7, but must be available in person to consult when requested by the attending surgeon. The center may have transfer agreements in place for complex injuries (CD 8-5).
“For the trauma registers. Will the number of transcriptions be updated from the current 500-750 to reflect current requirements?” (Level 1)

At this time, there are no revisions to update the number of transcriptions/cases. As mentioned earlier in this webinar, we are encouraging participants to visit the Stakeholder Public-Comment website to provide feedback on the current standards for possible updates.

https://www.facs.org/quality-programs/trauma/vrc/public-comment
Prevention Activities (CD 18-1)

“For injury prevention (CD 18–5), should the major mechanisms of injury be developed from the trauma center’s registry, state epidemiology statistics for specific counties or a combination of both?”

(Level 1)

Level I, II and III trauma centers must use their trauma registry and epidemiologic data to drive the center’s injury prevention activities (CD 18-1). The program and intervention strategies should then be selected based on the data.
Research (CDs 19-1, 19-3, and 19-7)

“Does there need to be a trauma surgeon as a author/co-author on all of the 20 research articles? Manuscripts as a result of a multi-center study- do all contributing centers get to count the manuscript as part of their 20? If going the alternative route for research- are only scholarly activities of the trauma surgeons allowed?”

(Level 1)

- Of the 20 research articles, at least one must be authored or co-authored by members of the general surgery trauma team (CD 19–3).
- For multi-center research articles, if the authors contributed and are listed, it will count for all centers.
- For the seven Scholarly activities, it may include members of other disciplines for trauma.
- Case reports are not acceptable.
- Refer to pages 144-146 in the Resources manual for details.
**Table 1**  
Research Requirements for a Level I Trauma Center

**Option 1**
- 20 trauma-related, peer-reviewed articles in journals listed in Index Medicus or PubMed in a 3-year period  
- At least one article with a general surgery author or co-author  
- Trauma-related articles from at least three of the following disciplines:  
  - Basic sciences  
  - Neurosurgery  
  - Emergency medicine  
  - Orthopaedics  
  - Radiology  
  - Anesthesia  
  - Vascular surgery  
  - Plastic surgery or maxillofacial surgery  
  - Critical care  
  - Cardiac surgery  
  - Rehabilitation  
  - Nursing

**Option 2**
- 10 trauma-related, peer-reviewed articles in journals listed in Index Medicus or PubMed in a 3-year period  
- The same specialty authorship requirements as in Option 1, plus:  
- Demonstration of trauma-related scholarly activity in at least 4 of the following areas:  
  - Leadership in major trauma organizations  
  - Peer-reviewed funding for trauma research  
  - Evidence of dissemination of knowledge  
  - Published trauma-related case reports  
  - Visiting professorships or invited lectures  
  - Resident participation in scholarly activity  
  - Trauma, critical care, or acute surgery fellowship
CME: Board Certification

“33 hours CME from board certification counts as external trauma CME, does that include any pediatric trauma CME?” (Level 1)

Yes, it will count for pediatric trauma CME.
CME: Board Eligible Providers

“How many CMEs are brand new ED MDs supposed to accrue when they are board eligible but have not taken boards yet?” (Level 2)

This would be based on their date of hire and/or completion of residency. For new members on the service and present for the reporting year (or longer), it is expected they have accrued 16 hours of CMEs annually.

Providers who are board eligible are not exempted from meeting the CME requirement.
CME: Internal

“External CME: if your facility provides CME for quality meetings, grand rounds, etc., and the CME program is accredited by an external body, do these activities and hours count as ‘external CME’ or would they only count towards internal education process hours?” (Level 2)

These types of conferences and meetings are considered internal trauma CME, and are acceptable to use for the non-liaisons.
CME: Level III to Level II Verification

“If you are changing from an ACS verified Level III to and ACS verified Level II, what is the expectation for CME requirements?” (Level 3)

The expectation would be that the trauma center must be in compliance with the CME requirement. There are no CME exemptions or proration for centers that are currently ACS verified as a Level III and moving toward Level II verification.
CME: Alternate Liaisons

“Do alternate liaisons have the same CME requirements of 16 external a year?” (Level 3)

By alternate liaison, I am going to assume this means the predetermined designee at the trauma peer review committee meeting. If this is correct, the alternate liaison is required to meet the CME requirement through any of the following or a combination of, external trauma related CME, internal trauma CME or through an internal education process.


**CME: Self Assessment Tests**

“The physicians can count 33 hours from board certification or recertification as trauma/critical care external CME’s. As part of their MOC (maintenance for certification) the physicians take self-assessment tests for which they receive CME’s. Are these CME’s counted as separate from the 33 CME’s they are allowed to count as board cert/recert CME’s OR do they count as part of the 33 CME’s that are counted as board cert/recert CME’s?” (Level 1)

The self-assessment tests for board re-/certification are part of the 33 hours that is permitted.
CME: Tracking on PRQ

“When tracking CME's, if an ER physician left the organization in the reporting year do we need to include them in the report?” (Level 1)

No. If the provider was present during the reporting year and is no longer at the institution or on the trauma call panel at the time of the site visit, do not include their information on the PRQ. If they listed on the PRQ and are short in meeting the trauma peer review committee meetings and/or the CME requirements, it will result in a deficiency.
CMEs Annual versus Total

“Does avg. of 16 hrs. CME annually still mean must have 48 in 3 years or if close to 16 avg. per year...Is it an absolute on #hrs” (Level 1)

The TMD and liaisons must accrue a total of 48 hours of external trauma-related CME over a period of 3 years leading up to the site visit. It would not be based on the calendar year or by an absolute number of 16 hours annually.
Thanks for your participation!