

Trauma Verification Q&A Web Conference

April 30, 2019

COTVRC@facss.org



AMERICAN COLLEGE OF SURGEONS

*Inspiring Quality:
Highest Standards, Better Outcomes*

100+years

The **Committee**
on **Trauma**



VRC VERIFICATION
REVIEW
CONSULTATION

for excellence in trauma centers

Your Trauma Quality Programs Staff



Tammy Morgan
Manager
Trauma Center Programs



Molly Lozada
Program Manager
Trauma Verification



Megan Hudgins
Program Coordinator
Trauma Verification



Bhumi Parikh
Program Coordinator
Trauma Verification

Continuing Education (CE)

- ❖ *To qualify for CE, you must attend at least 50 minutes of educational content*
- ❖ *An email will be sent to all attendees who qualify for CE within 24 hours of the webinar ending, with instructions on how to claim CE*
- ❖ *If you have any questions – please email COTVRC@facs.org*

What is the goal for this Webinar?

- ❖ *Interpret the standards outlined in the Resources for Optimal Care of the Injured Patient manual to ensure that hospitals have an understanding of the criteria to provide quality care to the injured patient.*
- ❖ *Understand the processes and standards involved in an ACS Trauma Verification Site Visit and how following these will positively impact the quality of care of the injured patient at your trauma center.*

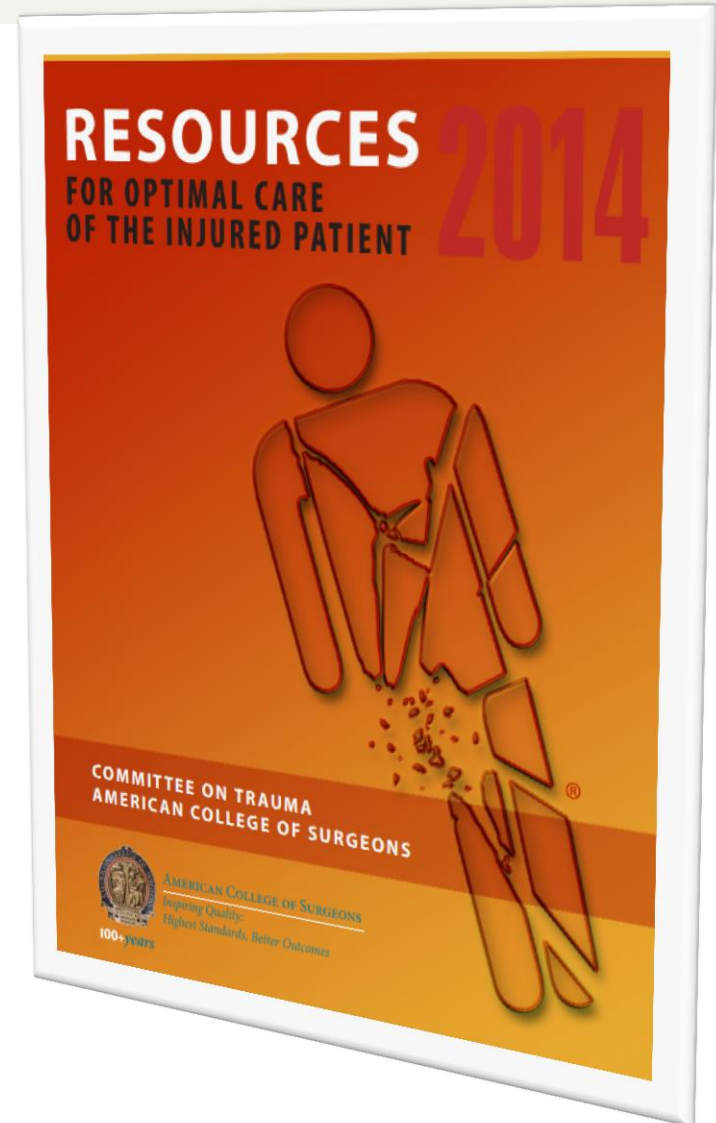
Let's get started!

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/tap/center-programs/vrc/resources



Clarification Document and Verification Change Log

The American College of Surgeons

Clarification Document

Resources for Optimal Care of the Injured Patient

By the Verification Review Committee

V15_ 4/15/19 2019

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

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

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

Website Resources for Trauma Centers

- Recording of Webinars:
<https://www.facs.org/quality-programs/trauma/tap/center-programs/vrc/resources/webinars>
- Stakeholder Public-Comment website:
<https://www.facs.org/quality-programs/trauma/tap/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/tap/center-programs/vrc/resources>
- Participant Hub - Account Center:
<https://www.facs.org/quality-programs/trauma/tap/tap-center>
- Expanded FAQ:
<https://www.facs.org/quality-programs/trauma/tap/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

- Will be presented every other month
- The next presentation will be May 2019

Announcements

Next Verification Q&A Webinar

Webinar Date: **Thursday, May 30th**

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

Deadline to submit questions: **Friday, May 10th**

PRQ Questions

PRQ - Section II Data Tables

5. Complete the table below using the total number of emergency department (ED) trauma visits for the reporting year following the National Trauma Data Standard (NTDS) Trauma Inclusion Criteria.

	Total
Admitted ED Trauma Visits (Regardless of Service)	1846
Blunt Trauma Percentage	85
Penetrating Trauma Percentage	15
Thermal Percentage	0

6. Disposition ED Trauma Visits

Discharged	168
Transferred Out	10
Admitted	1846
DIED in the ED Excluding DOAs	10
DOAs	19
Total	2053

7. Total Trauma Admissions by Service.

Service	Number of Admissions
Trauma	1112
Orthopaedic	236
Neurosurgery	78
Other Surgical	116
Burn	0
Non-Surgical	304
Total Trauma Admissions	1846

Table 5 - Complete the table using the total number of Emergency Department (ED) Trauma visits for the reporting year following the NTDS inclusion criteria or your trauma center's inclusion criteria.

Colored boxes should all match

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

Nonsurgical admissions (NSA)	ISS			
	0-9	10-15	16-24	> = 25
Number of patients admitted to a non-surgical service (from Table 7)	244	27	20	13
Percent of total NSA	77	13	6	4
Total NSA w/trauma consult	67	28	8	6
Total NSA w/any surgical consult (including trauma)	210	47	10	7
Total NSA secondary to single level falls	136	23	1	1
Total mortality (for each ISS category)	4	1	1	4

11. Injury Severity and Mortality.

ISS	(A) Total Number of Admissions	(B) Total Number of Deaths from Admissions by ISS	Percent Mortality (B over A)	Number Admitted to Trauma Service
0-9	1064	7	0.7	484
10-15	354	3	0.8	250
16-24	243	12	5	207
> or = 25	210	59	28	171
Total	1871	81	4.3	1112

PRQ Data Validation

“Wondering what the difference is on the PRQ questions #11 and #12 from Chapter 15? #11 ‘Are there strategies for monitoring data validity for the trauma registry?’ and explain. #12 ‘Describe the registry data validation process used by the center.....’ Understand #12 well, but not sure what they are looking for in question #11.” (Level 1)

The question is asking how or what processes are in place to validate the Trauma Registry data. As examples, you may have registry software that does validation checks on data fields. How often are you performing data validation to ensure information being put into the charts are accurate and complete? How often is data validation done on closed charts to ensure the required data are being captured, is accurate, or catch registrar errors. There are various ways centers do this and we want to know how it's being done at your center.

General Questions

Admissions: Observations < 23 Hours

“23 hr admissions, what category does less than 23 hours go to, if not admission for ED Disposition?” (Level 2)

For verification and completion of the PRQ, if length of stay is < 23 hours and the patient was not admitted to the trauma or nonsurgical service, this would not be counted toward the total trauma admissions. As indicated in the slide titled “PRQ-Section II Data Table,” it will be reportable in the ED Disposition table under “Discharged.”

The trauma center may have a unique code or a customized audit filter to identify these patients within the trauma registry.

Admissions: Hospice

“The hospice deaths are reviewed up to txfr to hospice, do they need to be categorized as deaths do?” (Level 2)

“With the new requirement to review pts discharged to hospice in our mortality reviews, should we also be reviewing patients discharged home or to SNF on comfort care but who are not necessarily on a hospice program?” (Level 3)

*To clarify, this is not a new requirement; however, what we would like programs to do for verification purposes is to review those patients that were discharged or transferred to an inpatient unit or to an external hospice facility or comfort care. The **expectation** is that the care of the patient leading up to the transfer or discharge was evaluated through the PIPS process by the TMD and TPM. If any issues are found, then it may be reviewed at peer review.*

Admissions: Isolated Hip Fractures

“Does a trauma surgeon have to see a Level III isolated hip fracture?” (Level 2)

I believe the question is referring to a Level III activation or consultation tier. So if the question is does a Trauma Surgeon (TS) have to see a patient with an isolated hip fracture during the consultation tier (Level III), the policy for when the TS is expected to see trauma patients will be defined by the institution.

Admissions: Non-Surgical

“Do non-surgical admissions without trauma consult count in the alcohol screening/SBIRT requirements?” (Level 1)

Yes, trauma patients admitted (> 24hours) would be subject to the alcohol screening/SBIRT requirement.

Orthopaedic Surgery: Time to Antibiotics

“Which abx times for open fxs does ACS want collected? i.e. only ortho, or skull fxs & nasal bones as well.” (Level 1)

“Discuss req to report 1st abx for open fx. Is this for ortho fx only, or others like complex nasal fx... also considered open?” (Level 1)

The PRQ question is asking for Orthopaedic tibial shaft fractures only. Do not include any fractures for the following: ankle, pilon, amputations, plateaus, skull, nasal, etc.

Tracking Attending Arrival Times

“Should we be tracking all attendings arrival times (trauma, Ortho, neuro). How do you recommend tracking and documenting the times?” (Level 1)

Yes, your center must track all attending arrival times. Following the release of the Resources manual, the VRC Chairs permitted self-reporting. It would be ideal to have a scribe or a badge scanning system.

Trauma Surgeon Backup Call Coverage

“With the understanding that the primary attending must be dedicated to one center and we must have a back up call schedule published, does that provider for back up call need to be dedicated to one center or can he/she cover 2 centers, if there is a third tier to the back up call schedule to have someone respond if that person happens to be in the OR at the other center? This is for a Pediatric Level I Trauma Center.” (Level 1)

This is an acceptable practice. The backup Trauma Surgeon does not need to be dedicated to one facility as long as the center has a third backup surgeon or as noted in this scenario, third tier.

Neurosurgery Consult

“If GCS is 13 or less and trauma surgeon and a mid level NP/PA respond to neuro consult can telemedicine evaluation be done by a neurosurgeon -dictated subsequently be satisfactory- GCS is less than 13 would be in person neurosurgery consult?” (Level 3)

The VRC does not approve of telemedicine in lieu of an in-person consultant at bedside. The Neurosurgery NP/PA may respond to Neurosurgical consults if there are established guidelines in place for when s/he may respond to a Neurosurgical consult. Following the evaluation, it would be acceptable for the Trauma Surgeon and/or Neuro NP/PA to discuss the plan of care with the Attending Neurosurgeon by telemedicine – this must all be documented.

Performance Improvement (PI) Coordinator

“Does the PI person have to be a nurse? For example we have one PI Nurse Coordinator and are looking to acquire a 2nd for support.” (Level 3)

To clarify, there currently is not a requirement for a PI coordinator position. Thus, this position may be filled by a qualified candidate as determined by the trauma center.

Combined Pediatric Programs Staffing Requirements

“Could an adult level II also become a pedi level II with a TPM for each program and a single Director overseeing both programs?” (Level 2)

“Does an adult & pedi level II require completely separate registry, IP, and PI staff or does that depend on program volumes?” (Level 2)

Adult Level II with pediatric Level II verified programs may share many of the same resources such as, TMD, TPM, Injury Prevention Coordinator, PI coordinator/staff and the registry.

The TMD and TPM positions should be monitored to ensure they are not encumbered from performing their daily duties.

Thromboelastography

“Need clarification on TEG - the book say TEG ‘should’ be available at Level I and II centers- but our TMD feels its a CD.” (Level 1)

This is not a deficiency. Thromboelastography should be available at a Level I or II center, but not required.

Activations: Limited Tier

“Should trauma be seeing every Tier II activation? fall with SDH? isolated hip? Or just a surgical service?” (Level 3)

For the Limited Tier activations, the trauma center must determine the criteria for patients who require an evaluation by the Trauma Surgeon. The site reviewers will confirm that the institution adheres to its own criteria, and that these criteria are routinely evaluated by the PIPS process.

Activations: Transferring Patients

“Our trauma center will not admit any pediatric patients. Does the surgeon have to evaluate the high level activation pediatric patient prior to transfer?” (Level 3)

For the highest level of activation, the Trauma Surgeon is required to respond within 30 minutes from patient arrival. We certainly do not want to delay care if the patient has been stabilized and is ready to be transported before the TS arrives. These occurrences should be documented and monitored through the PIPS process.

Activations: Highest and Limited Tiers

“The attending surgeon needs to be present within 30 minutes?? I thought it was 20 minutes. Please clarify. Thank you.” (Level 1)

In Level I and II trauma centers, the acceptable response time for the highest-level activation tracked from patient arrival is 15 minutes, and 30 minutes for Level III trauma centers.

For the Limited Tier, each institution will develop its own criteria for when the Attending Surgeon is required to be present in the emergency department. Therefore, if your center has established a 20 or 30 minute response for this tier, the reviewers will confirm that the institution adheres to its own criteria, and that these criteria are routinely evaluated by the PIPS process.

Volume: Transfers Out and Deaths

“We use the NTDB inclusion criteria for our trauma volume requirement? Do we need to exclude transfer outs and ED deaths?” (Level 1)

For verification purposes, if the transfers out and/or ED deaths were admitted as trauma patients to the hospital, they would be included in the volume requirement.

If the transfers out and/or ED deaths occurred prior to being admitted as trauma patients to the hospital, they would not be counted in the volume requirement.

Upgrading from a Level III to a Level II

“Can you highlight the main focuses when transitioning from Level III to Level II.” (Level 3)

I recommend using the Change Log Document to do a gap analysis. The following are a few of the major focuses to upgrade to a Level II trauma center.

- *Highest activation Trauma Surgeon response of 15 minutes*
- *Surgical specialist available in person when consulted, e.g. thoracic surgery, vascular surgery, hand surgery, etc.*
- *TMD and TPM CME requirement*
- *Trauma Surgery backup call schedule*
- *ED physician present in the department at all times*
- *Neurosurgery requirements*
- *Anesthesiologist in-house*
- *Operating room staffed within 15 minutes*
- *Injury prevention - alcohol intervention*
- *Pediatric criteria , if admitted*

Site Visits for Level IV and V Centers

“We are currently a level 4. does ACS review level 4 and 5 centers in Alaska or is it done by the state?” (Level 2)

The ACS does not currently conduct site visits for Level IV and V centers. In most states, Level IV and V reviews are done by the Department of Health (DOH). It is recommended you contact your DOH for more information.

Site Visit Chart Review

“If the TMD is also the treating surgeon, who reviews the chart for the second level of review after the TPM?”

(Level 3)

Great question. You may have another Trauma Surgeon review his/her medical record or in some instances, centers will send it out for an independent review by their peer, e.g. someone within the same region or in the same health system.

Site Visit Chart Review

“When preparing charts for an ACS verification site visit, should the charts only be the last 10 of each category, or is it preferred to have charts from the survey year that have been through the PIPS process that meet the criteria in addition to those 10?” (Level 2)

It should be the last 10 charts [most recent] from the reporting year that underwent a PIPS review and also some cases that did not warrant a PIPS review.

As a reminder, during the site visit, reviewers are conducting a sampling of your medical records so they'll want to see cases that did or did not have a PIPS review.

Site Visit Chart Review Agenda

“Where can we find the list for chart reviews? I understand that has changed.” (Level 1)

No changes have been made to the chart review categories. Upon receipt of the site visit application, a copy of the Review Agenda is provided. The agenda lists the categories for the chart review.

You may also find a copy on the VRC Resources webpage at:

<https://www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/resources>

Site Visit Chart Preparation

“How far in advance do you recommend preparing ACS charts for reverification?” (Level 2)

This will vary based on your center and when charts are closed. Typically, we have seen centers begin to prep charts 30-60 days in advance of the site visit.

Site Visit Consultation

“We are preparing for a consultative Level III visit in July. Is there a minimum number of activations required?” (Level 3)

For any type of site visit, there is not a minimum number of activations required.

Site Visit Reporting Year

“Historically, our trauma program is reverified in October and our reporting year has always been July-June (this was also our reporting year for our visit Oct, 2017). Will the reporting year timeframe of July-June not be adequate for a site visit in October? Our next visit will be October 2020, so I am trying to see if our reporting year can start July 2019-June 2020.” (Level 2)

The reporting year is defined as 12 months with a 2 month lag and not older than 14 months from the date (more like the month) of when the visit is scheduled. So for a visit scheduled in the month of October, the appropriate reporting period would be August 1, 2019 through the end of July 2020.

Peer Review Meeting

“How do we capture Peer Review meeting attendance for a trauma surgeon that will be out on extended maternity leave (7+ months)?” (Level 1)

To clarify, a waiver is acceptable for medical leave (maternity). If you have a meeting attendance roster (paper or electronic), you can indicate that the Trauma Surgeon's attendance is waived. In this instance, you will need to have supporting documentation during the site visit for the reviewers.

Peer Review Meeting

“Does ‘peer review’ only apply to the PIPS meeting?”
(Level 3)

Generally speaking, the term peer review meeting is synonymous with the Performance Improvement and Safety Program (PIPS). Some centers may have a different name for these meetings which is acceptable; however, the main agenda is to review medical cases for opportunities for improvement.

Chapter Revisions: PI Coordinator

“Will the Performance Improvement Coordinator position be in the new "orange" book as a required position for Level 1 centers?” (Level 1)

“Are there changes to the Neurosurgery response requirements planned?” (Level 1)

Any changes will be disseminated upon the completion of the chapter revision process.

CD-Related Questions

Peer Review Meetings (CD 2-18)

“What timeframe does the ACS-COT consider a timely case review? When is a case review considered not timely? (Referring to CD 2-18)” (Level 1)

CD 2-18 reads as follows:

*In Level I, II, III, and IV trauma centers, the multidisciplinary trauma peer review committee must **meet regularly**, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured (CD 2-18).*

This requirement is in conjunction with CDs 16-15 and 16-16. It is in regard to the peer review along with attendance from the required providers and how often you should meet to review medical cases. The intent of ‘timely case review’ will vary by each institution and the frequency of those meetings may be impacted by the volume. There certainly are cases that you’ll need to review sooner than later due to critical issues or opportunities for improvement that may impact patient care or surgeon performance.

Transfers (CD 4-3)

“For a Level 3 trauma center that will primarily transfer injured pediatric patients, it is acceptable to let the ED physician manage the injured pediatric patient and the surgeon defer judgement to the ED providers?” (Level 3)

“Is it required that the surgeons evaluate pediatric trauma patient in an adult center prior to transfer?” (Level 3)

Management of pediatric patients at adult facilities will be based on your trauma center's guidelines. Transfer of a patient should not be delayed while waiting for the Attending Surgeon. If the ED Physician communicated with the Attending, it would be acceptable to transfer. This practice is not an excuse for the Attending Surgeon not to respond based on your guidelines, these instances must be documented and reviewed through the PIPS process.

Activations: Limited Tier (CD 5-16)

“Clarification of CD 5-16: Does trauma surgery APP response meet the trauma surgical evaluation requirement for limited tier act” (Level 2)

Yes, for the Limited Tier it is acceptable for the Advanced Practice Provider (APP) or Nurse Practitioner (NP) to be the initial responder based on institutional criteria, but cannot be used in lieu of the Attending Surgeon's role and their response.

Activations: Limiter Tier Response Time (CD 5-16)

“CD 5-16: What is the acceptable time response for trauma surgical evaluation for limited tier activations?”
(Level 2)

This would be determined by institutional criteria. The ACS does not indicate a strict time requirement for Limited Tier activation, however, it verifies the facility is adhering to its own criteria.

Bypass/Divert (CD 4-3)

“We have 2 level II Trauma Centers in our city. No level I or III. Do we still count divert hours if both hospitals in the city are on divert at the same time?” (Level 2)

Yes, both centers will be required to report, track, and monitor the bypass/divert hours.

OPPEs (CD 5-11)

“Do OPPEs need to be done on all ED providers that might come in contact with trauma patients or only MDs involved in activations” (Level 1)

The OPPE will be performed for all providers on the trauma call by their respective directors/liaisons such as, the Orthopaedic liaison will perform an OPPE for members of his/her service that are on the trauma call panel.

Activations: Highest Level Criteria (CD 5-13)

“GSW to extremities proximal to the elbow/knee has been removed from six required criteria. Can center keep it as is?” (Level 1)

*This is correct, the criteria for ‘Gunshot wounds to the neck, chest, or abdomen’ was amended by having the following removed ‘**or extremities proximal to the elbow/knee.**’*

It is acceptable for the trauma center to keep it part of your activation criteria. The list we provide are required as a minimum, but the center may include more.

Admissions: Non-Surgical (CD 5-18)

“On non-surgical admits, its acceptable to exclude those admitted to Ortho and same level falls correct? Once you exclude as above, is it the totat# left that are non-surgical admits in Numerator or is it those reviewed/deemed approp” (Level 3)

Refer to the table on page 121 of the Resources manual. Keep in mind that the CD is not that the center admitted > 10% of NSA. The CD will be cited if the center does not perform a PIPS review on those patients that did not receive a surgical consult to determine if they were appropriately admitted.

For best practices all non-surgical admissions should be reviewed.

TPM Experience (CD 5-23)

“The TPM must show evidence of clinical experience in the care of injured patients. Please explain how to show the evidence.”
(Level 1)

Without clinical knowledge and experience in trauma care, leading initiatives such as, PIPS projects, participating in peer review for physicians and nurses, developing practice management guidelines would be challenging. The following represents a list of qualifications for the TPM:

- Must have 12 hours of trauma-related continuing education per year*
- The TPM works collaboratively with the TMD; this is essential*
- The philosophy of the TMD and TPM must be in-sync otherwise the program may suffer*
- Organizes services and systems for a multidisciplinary approach to trauma care*
- Leads the day-to-day PIPS processes and ensures that timely identification, review, and loop closure are occurring*

ATLS for Trauma Surgeons (CD 6-9) and Intensivists

“Is ATLS required for a surgeon/intensivist who only provides coverage of the Trauma ICU?” (Level 1)

All board-certified General/Trauma Surgeons caring for trauma patients must have completed the ATLS course at least once. (CD 6-9).

We do not have a standard for the Intensivists to require ATLS certification.

Neurosurgery Call Schedule/Backup (CDs 8-3 and 8-5)

“CD 8-3 Please clarify. The PRQ is a yes or no for this CD but the Clarification Document offers other options” (Level 2)

To clarify, if there is not dedicated neurosurgery coverage at the institution, there must be a backup call schedule in place. If dedicated neurosurgery coverage is present, there must be either a backup call schedule or a contingency plan with the following in place:

- A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the neurotrauma patient*
- Transfer agreements with a similar or higher-level verified trauma center*
- Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support*
- Monitoring of the efficacy of the process by the PIPS program*

The PRQ is programmed to work in conjunction with CDs 8-3 and 8-5.

Orthopaedic Surgeon Consult (CD 9-7)

“For a Level III consult to Ortho for a hip fracture, how long does the Ortho surgeon have to arrive at bedside?”

(Level 2)

This would depend on the response criteria set by your facility for this set of patients and their injuries . As per CD 9-7, the Orthopaedic Surgeon must respond within 30 minutes based on institutional criteria.

Volume: Pediatric Trauma (CDs 10-1 and 10-2)

“Is there a pediatric volume requirement for an adult level I/II facility to become a pediatric level I/II facility?”

(Level 2)

Yes, for a center to be verified as a pediatric trauma center the following are required based on the level:

- A Level I pediatric trauma center must admit 200 or more injured children younger than 15 years annually (CD 10-1).*
- A Level II pediatric trauma center must admit 100 or more injured children younger than 15 years annually (CD 10-2).*

Anesthesia Services – CRNA (CD 11-8)

“Can a CRNA cover call for the OR without an anesthesiologist on site?” (Level 3)

As noted in the Clarification Document, in Level III facilities, operative anesthesia may be provided by a CRNA under on-site physician supervision. The specialty of the supervising physician should follow state and local/institutional practices. In states where CRNAs are licensed to practice independently, CRNAs should follow local or institutional practices and may not require physician.

Operating Room Team (CD 11-14)

“What does the ACS define as a complete Operating Room team? Which members comprise the complete team?” (Level 1)

To clarify the standard, it reads as, ‘an operating room must be adequately staffed...’ The composition of the operating room team will vary by institution. This may include but is not limited to the following: operating room nurse, scrub nurse, surgical tech, surgeon, anesthesiologist, CRNA, etc.

Operating Room Equipment (CD 11-19)

“Is a rapid infuser needed in a Level 3 Center?” (Level 3)

Yes, as per CD 11-19, all trauma centers must have:

- *Rapid fluid infusers*
- *Thermal control equipment and resuscitative fluids*
- *Intraoperative radiologic capabilities*
- *Equipment for femur fixation*
- *Equipment for bronchoscopy and gastrointestinal endoscopy*

Peer Review Attendance for Radiologist (CD 11-39)

“Please clarify CD 11-39. Is the Liaison required to attend a minimum of 50% of the meetings or if the combination of attendance between the Liaison and his/her specific alternate is a minimum of 50% attendance, does this meet the CD. (The note on the clarification document for CD 7-11 that says ‘No longer must be the designated liaison’ has confused the 11-39 requirement.)” (Level 2)

The Radiologist Liaison may have one pre-determined alternate to attend peer review meetings. The total of the liaison and alternate’s combined attendance must add up to 50% or greater.

The above would be true for all other specialty liaisons.

ICU Credentialed Providers (CD 11-52)

“Is a hospitalist who is credentialed in our ICU allowed to see an admitted ICU trauma patient in place of the intensivist?” (Level 2)

Yes, a Hospitalist credentialed to provide care to trauma patients in the ICU may meet this requirement.

Peer Review Meeting (CD 11-62)

“Does the ICU liaison have to meet the 50% attendance requirement to peer review/multi-disc meetings in a Level 3 center?” (Level 3)

Yes, the ICU Liaison or designated alternate must attend a minimum of 50% of all Trauma Multidisciplinary Peer Review Meetings.

To clarify, if the TMD also serves as the ICU Liaison, the attendance will be counted simultaneously.

Surgical Specialists (CDs 11-70 and 11-71)

“Do L2 centers need to have microvascular service and microscope available with on call schedule.” (Level 2)

Yes, Level II centers must have a Microvascular Surgeon, or coverage may be satisfied by having a surgeon who uses an operating microscope for nerve repair, free tissue transfer, etc. The microvascular capability is not required inhouse 24/7, but there must be a surgeon consultant available to respond, in person, when requested by the Attending Surgeon. Therefore, the name of the surgeon that will be providing coverage for that specialty should be listed on the call schedule.

Surgical Specialists (CDs 11-70 and 11-71)

“Surgical specialty requirements for Level II - is Ophthalmology, Urology etc. required 24hours/day?” (Level 2)

Coverage by the surgical specialists are not required 24/7 or inhouse. The intent is that the consultant must be available when a consult is requested based on your center's guidelines. Reviewers will want to see the provider's name on the call schedule for that service.

Surgical Specialty (CDs 11-70 and 11-72)

“For non-essential call coverage, like ophthalmology or psych, if our policy states a 48 hour response time, is this acceptable?” (Level 2)

Yes, the response time for (Ophthalmology) surgical specialists can be based on your institution’s policy and guidelines. As a note, the specialist must be available in person at bedside when a consult is required by the trauma attending.

Psych is not a required specialty.

Registry Cases (CD 15-6)

“Regarding Trauma Registries, 80 percent of cases must be entered within 60 days of discharge. Does that infer cases must be closed within 60 days or just started and in the registry?” (Level 2)

*In total, 80% of charts must be **closed** within 60 days of the patient being discharged.*

Trauma Peer Review and Operations Meetings (CD 16-15)

“Is it possible to have your M&M and your Operations meeting all in the same meeting?” (Level 2)

If M&M in this question refers to the Peer Review meeting, these meetings should be kept separate as they differ based on requirements.

The purpose of the Multidisciplinary Peer Review meetings which requires attendance (at minimum 50%) by the TMD, all Trauma Surgeons, and Liaisons (CD 16-15), is to improve trauma care by reviewing selected death cases, complications, and sentinel events with objective identification of issues and appropriate responses. Minutes are required.

The Operational meeting does not require attendance by the liaisons and is typically attended by hospital and medical staff members. The exact format may be hospital-specific in which it examines trauma-related hospital operations/functions.

Nursing Education (CD 17-4)

“Staff turnover has plummeted our TNCC rates in the ED - I can't find a CD - but our TMD feels there is a CD attached to this.” (Level 1)

The ACS does not have a requirement regarding TNCC completion. With this said, you must ensure that there is mechanism available to offer education to nurses who care for trauma patients.

In regard to your TMD's concern, if nursing education was previously cited as a weakness and continues to be an issue, the review team and/or the VRC Chairs may elevate this to CD 17-4.

Injury Prevention FTE (CD 18-2)

“Do a Level 1 adult and peds center EACH require a FT Injury prevention FTE? Or can they share one for both programs?” (Level 1)

Yes, an adult Level I trauma center and a pediatric Level I trauma center must each have an Injury Prevention Coordinator. This person must be fulltime with a job description and salary support. This person must be separate from the TPM position.

Alcohol Screening (CD 18-3)

“If SBIRT is attempted but not completed due to patient being comatose or sedated for intubation, does this attempt count?” (Level 2)

As noted in the Clarification Document and the Verification Change Log, screening is applicable to eligible patients who are defined as participatory. These occurrences must be monitored through the PIPS process.

Alcohol Screening Pediatric Patients (CD 18-3)

“In completing alcohol screening on all trauma patients how is this handled for pediatric patients? Is it required?”
(Level 3)

The minimum age by which pediatric patients must receive an alcohol screening will be determined by the trauma center. In total, 80% of all patients above that age must receive a screening for alcohol.

Alcohol Screening Tool (CD 18-3)

“Do you have to do an Audit C or alcohol screen on Level III consult for isolated hip fracture?” (Level 2)

A screening tool of some sort (i.e., Audit C) must be conducted on at least 80% of all admitted trauma patients and must be documented.

Alcohol Screening and Intervention (CDs 18-3 and 18-4)

“There is some confusion regarding sbirt - can you clarify please.” (Level 2)

To clarify, a screening must be conducted on at least 80% of all trauma patients that are admitted > 24 hours and must be documented in the medical record. This includes patients admitted to other surgical services such as, Orthopaedic Surgery and Neurosurgery. Furthermore, the type of screening tool used will be determined by the trauma center. While the following is not required for Level III trauma centers, all patients within that 80% who screened positive must receive a documented intervention (CD 18-4). Refer to the Clarification Document and Change Log.

Research (CDs 19-4 and 19-7)

“Is there a “grace period” for implementing new guidance on use of vendors for research or is it meant to be retroactive? Can we take a hybrid approach (leverage previous studies and new go forward structure) as we build up to 20 publications?” (Level 1)

This is in reference to the Clarification Document where it has an excerpt taken from the Resources manual in which some are interpreting as new guidelines. The excerpt and following language were added for additional clarification. No grace period will be granted.

The statement in the **Resources for Optimal Care of the Injured Patient** implies that the trauma surgeons are actively involved in the creation of new knowledge and the research process. It is also implied that the research is done on-site and not all sent out for performance by an outside group. It is also implied that the facility has provided support and resources other than simply paying for research output from an outside source.

Therefore, it does not meet the intent of these requirements to simply pay to outsource research to an independent third party not routinely, clinically, associated with facility.

CME

CME Documentation

“Do we have to provide copies- CME or maintenance of certification (MOC) for providers who are board certified in their specialty? i.e. ED physicians, Orthotrauma physicians, trauma surgeons...etc” (Level 2)

“At verification time, evidence of CME must be provided for - TMD? TPM? All surgeons? All ED providers?” (Level 2)

For the TMD, TPM, and anyone who has previously gone or will be going through the Alternate Pathway, it is required to have copies of their CMEs available at the time of the visit.

For all other panel members taking trauma call such as, Trauma Surgeons, Neurosurgeons, Orthopaedic Surgeons, Emergency Medicine, etc., documentation validating their active participation in Maintenance of Certification will suffice.

CME

“Emergency Medicine are no longer required any CME?”
(Level 1)

Only EM physicians who have undergone or are currently undergoing review by the Alternate Pathway Criteria are required to present proof of CME. For all other surgeons, board certification or eligibility is sufficient to meet the criteria.

Clarification from March Webinar

Direct Admits

“Should transfers coming from inpatient status at one center go through the ED at the higher level of care receiving facility?” (Level 2)

The VRC recommends patients who have been transferred in with a full workup at another facility be assessed in your Emergency Department for the opportunity to identify additional injuries.



© American College of Surgeons. All rights reserved. Worldwide.
April 30, 2019



To clarify the question regarding transfer of patients with an 'inpatient status', these patients are not required or do not need to be evaluated through the ED at the higher level of care.

Thanks for your participation!