

Trauma Verification Q&A Web Conference

June 26, 2019

COTVRC@facss.org



AMERICAN COLLEGE OF SURGEONS

Inspiring Quality:
Highest Standards, Better Outcomes

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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.*

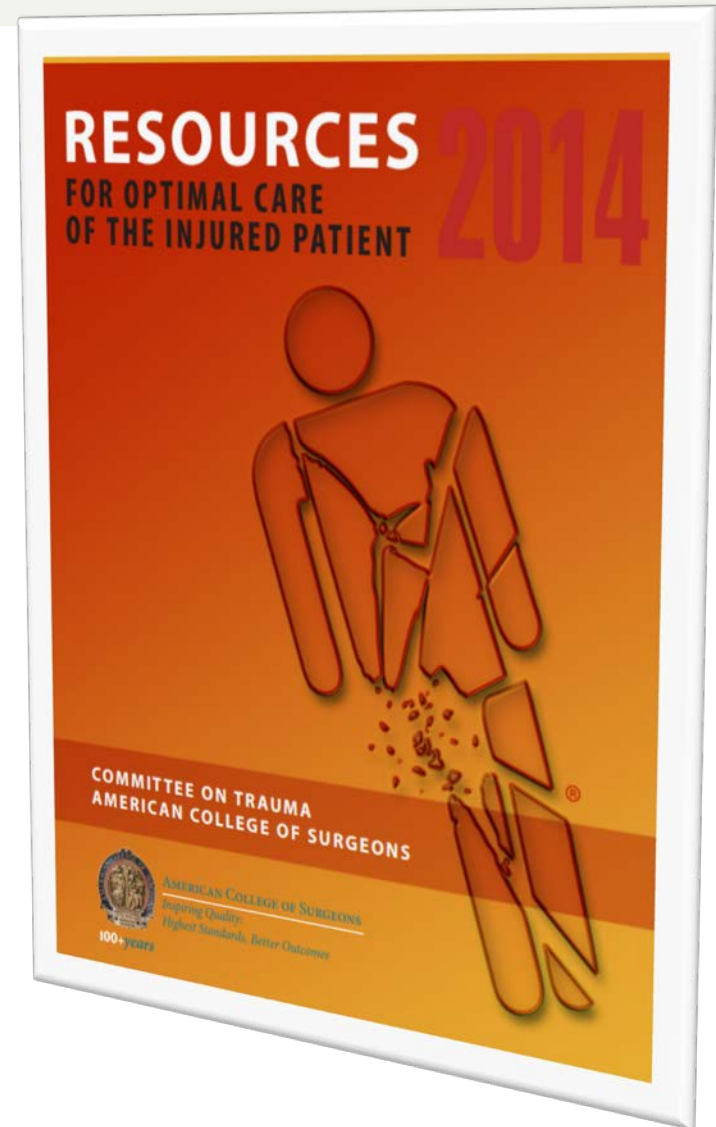
Let's get started!

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/tqp/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

2019

V15_ 4/15/19

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/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

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

Announcements

Call for Data

- The TQIP quarterly Call for Data is open
- In this call, please submit your 1st quarter of 2019 data as well as any updates to previous submissions dating back to the 1st quarter of 2017
- The Call for Data will close Wednesday, July 10th

Next Verification Q&A Webinar

Webinar Date: **Wednesday, July 31st**

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

Deadline to submit questions: **Monday, July 8th**

New Webinar Platform

- July 2019 webinar will be on a new platform
- Same registration and question submission process
- Detailed instructions will be sent by email
- NO option to call in by phone
 - **Only headphones or speakers via computer**
- CE eligibility extended to watching the archived webinar video
 - **CE eligibility will have an expiration date. That date will be communicated via email and on the website.**

Tell us what YOU want!

Let us know the topics you'd like us to cover in future webinars! Reach out to us at cotvrc@facs.org with your suggestions today.

Future topics may include:

- Alternate Pathway
- Specific chapter discussions
- The peer review process for verification reports

PRO Validation

PRQ Validation

- Takes place after submission of the PRQ (30 days prior to the site visit)
- VRC Office will review each PRQ once it's been 'Marked Complete' and will contact the TPM, if necessary, to verify:
 - Any deficiencies that were automatically flagged
 - Consistency of data in the Chapter II data tables
 - All necessary data and information for the site visit is present

Why do we do this?

- To clear up any confusion well in advance of the reviewers arriving onsite.
- To ensure the reviewers arrive with the most complete and accurate illustration of how your trauma program functions.
- To clarify inaccuracies on the front end of the review, allowing for a swifter and more seamless editorial process for the final consultation/verification report.

Common Corrections

- Section 'Purpose of Site Visit'
 - Indicating that a facility admits "Adults Only," but parts of the PRQ indicate they also admitted some pediatric patients as well.
 - Adults Only – admits no children
 - Adult and Children – admits children regardless of number
 - Pediatric Only

Facility treats what type of patients: Adult - age = or > 15 years Children - age < 15 years	Select One ▼
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- Portions of Chapter X must be completed if any pediatric patients were admitted during the reporting year:
 - Section A, Question 1
 - Section B
 - Section C

Common Corrections

- Level III - Neurosurgery
 - Not answering the following question accurately in the Purpose of Site Review section will generate the incorrect questions in Chapter VIII:

Does the level III center provide Neurosurgery capabilities?

Yes No

- Chapter IX, Open Tibial Fractures
 - Average and range needed

- Average time to wash out of open tibial fractures secondary to a blunt mechanism; report as average and range **192 m**

PRQ - Chapter 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

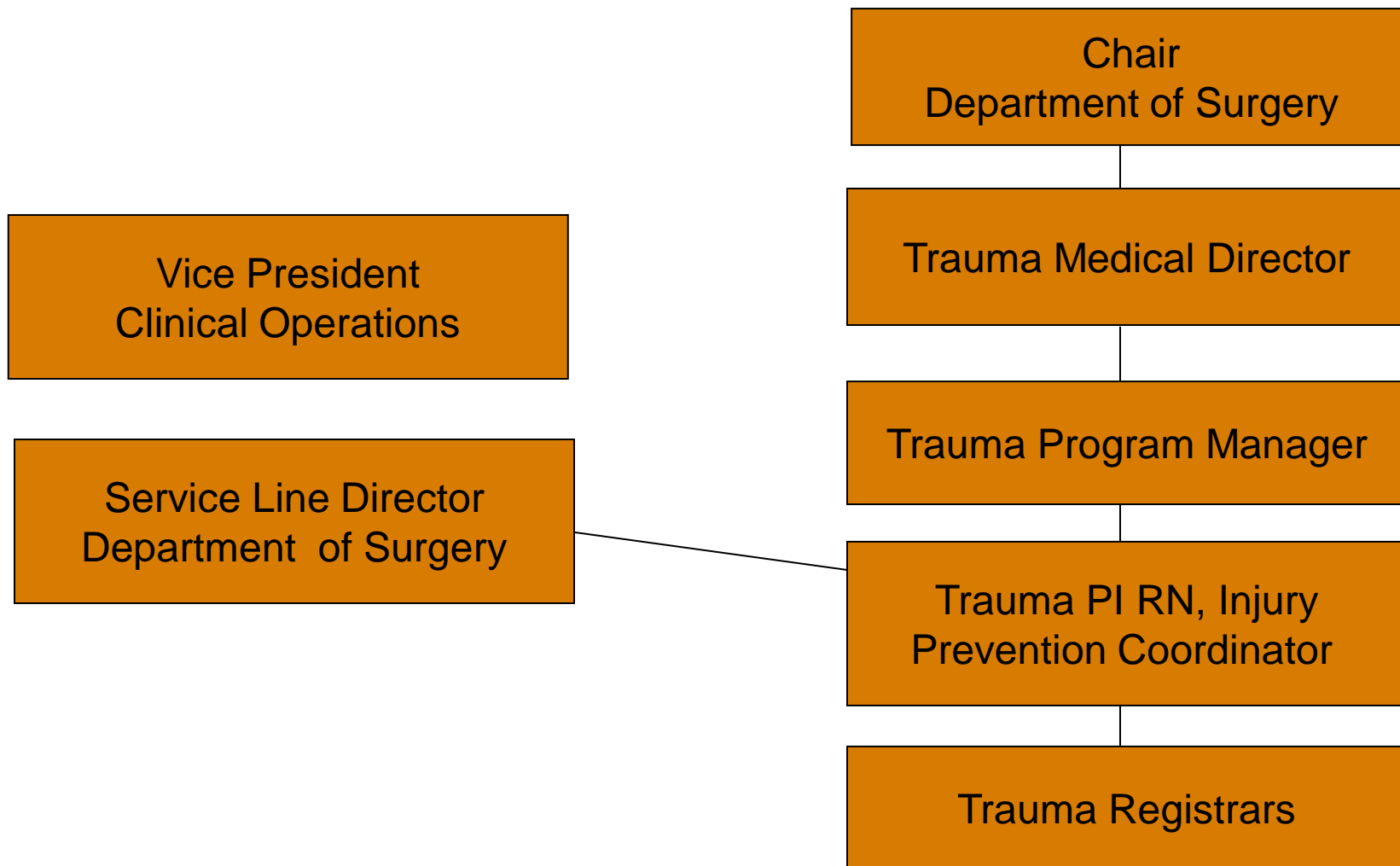
General Questions

Trauma Reporting Structure

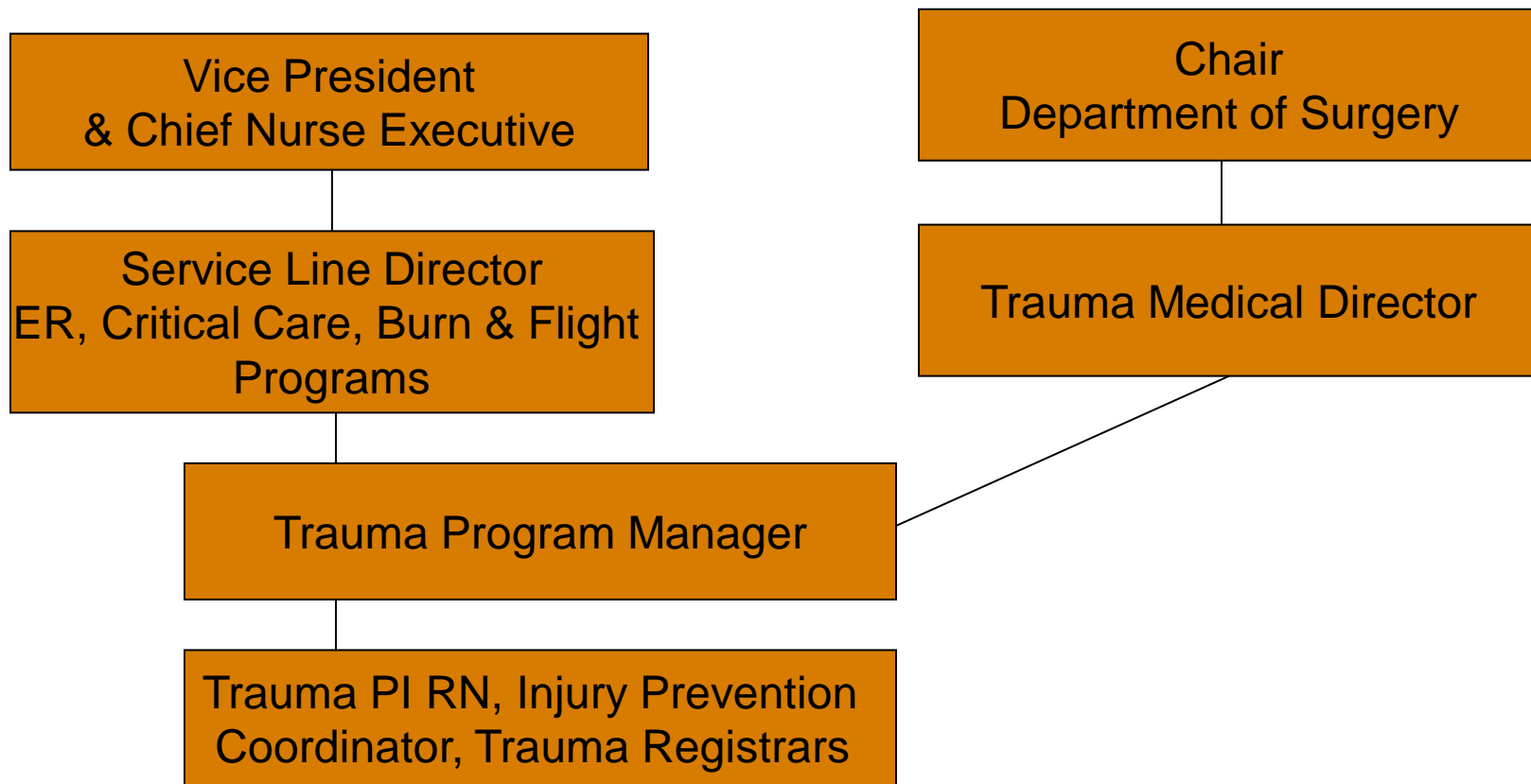
“ Our administration is trying to move the reporting structure for trauma from surgical services to emergency medicine. Is there any verbiage to prevent this other than trauma is a surgical service? It would be good if the ACS would require Level I and II centers to be under surgical services to prevent this.” (Level 2)

While we do not have a standard on the reporting structure, what we can do is provide examples. The ACS is looking to see that the reporting structure allows the Trauma Medical Director (TMD) and Trauma Program Manager (TPM) the ability to run their program and that their reporting structure allows them to address issues across the spectrum of the hospital. Refer to the next few slides on examples.

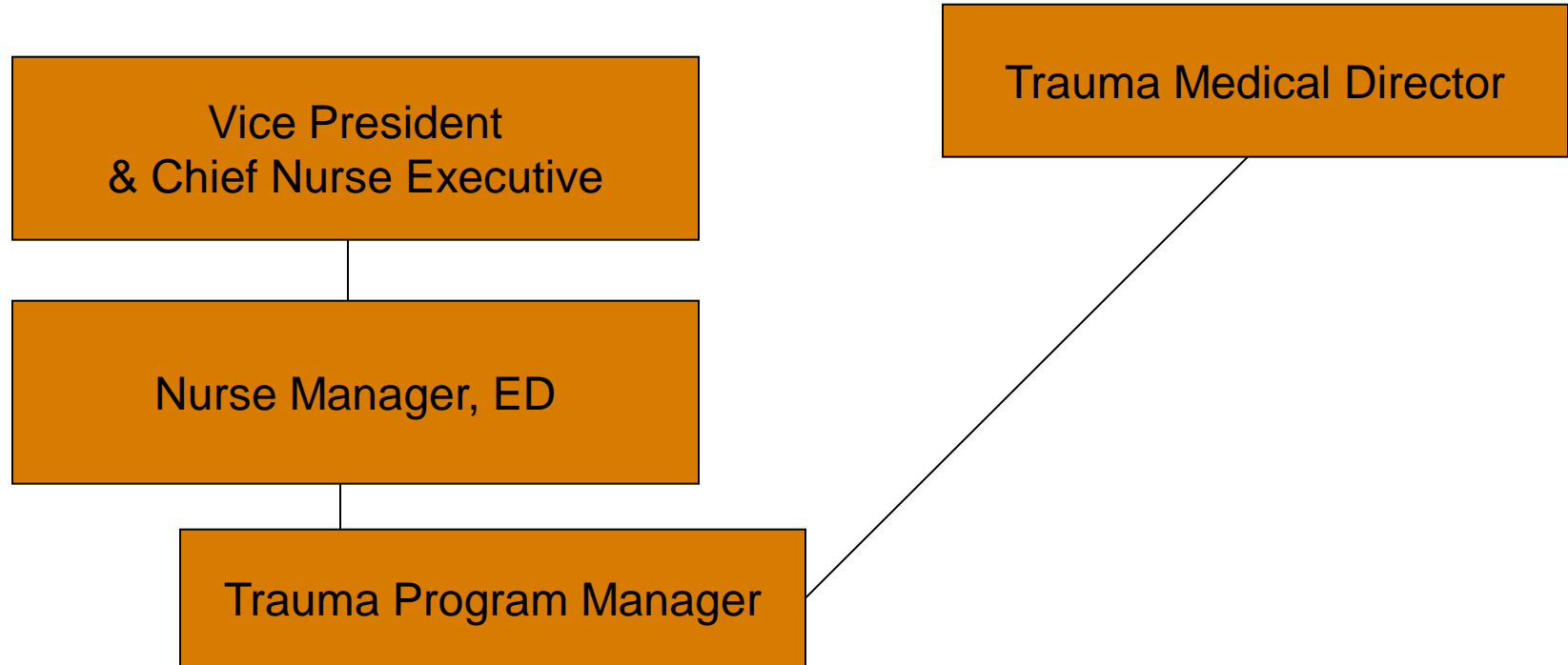
Example of a Trauma Program Organizational Chart: Level I or II Trauma Centers



Example of a Trauma Program Organizational Chart: Level I or II Trauma Centers



Example of a Trauma Program Organizational Chart: Level III & IV Trauma Centers



Type II Deficiencies

“Is there a limit to number of Level II deficiencies a facility can have and still be verified as a trauma center?(Level 2)

Yes. If up to three Type II deficiencies are identified during the initial re-/verification visit, the trauma center will be verified for a period of one year. If more than three Type II deficiencies or any Type I deficiencies are present at the time of the initial re-/verification site visit, the hospital will not be verified. A successful Focused Review would be required in order to achieve the additional two or full verification period.

Antibiotics

“Antibiotics given for tibia shaft fractures only?” (Level unidentified)

“...when referring to the standard of administering antibiotics within an hour for open fractures....does this only apply to open long bones? What about open nasal fractures? fingers? ect.” (Level unidentified)

For verification purposes, the data that is being requested in the PRQ is only for tibial shaft fractures. It does not include the following: ankle, pilon, amputations, plateaus, nasal, finger, etc.

Open Fractures

“It would be great if TQIP/VRC keep moving toward aligning definitions- for example how open fractures are dealt with- only tibias vs. all open fx's (except maybe ribs?)” (Level unidentified)

With the next revision of the Resources for Optimal Care manual, we are working in aligning definitions with the NTDS/TQIP.

Alternate Pathway

“Is there an alternate pathway for ER MD's who were prev board certified but did not renew because they are close to retirement?” (Level 3)

There is not an Alternate Pathway for these physicians. If the physician is not current in their board certification, they would need to be removed from the trauma call panel in order to maintain compliance. They may see other patients, but not trauma patients.

Isolated Hip Fractures

“Clarification regarding Geriatric isolated hip fractures: last webinar, it was mentioned that these patients should be reviewed for non-surgical admission or death (if applicable). In our region, these patients are not included in our trauma registry inclusion criteria. Thus, they are not seen by the trauma service, are not reported to NTDB, and also not tracked by our PIPS process. Are you expecting us to PI these cases even if we don't see them and don't keep track/report their data?” (Level 2)

The inclusion of these types of patients vary based on the institutions policy on admission, and also state inclusion criteria. Therefore, if your trauma policy excludes these patient and are not reported to NTDB, you would not track/report this data.

Non-surgical Admissions

“Can you please clarify review of non surgical admissions in regards to what is in the Orange book and on the PRQ? The orange book (page 121) says that we need to review by exception, i.e. those patients who didn't have a surgical consult, single level fall or drowning, poisoning, or hanging or ISS < 9, 'all remaining trauma patients admitted to a non-surgical service should be reviewed', but the PRQ doesn't state that. We have looked at both the clarification document and the Change document and do not see this addressed. We were cited at our reverification for not having documentation on every NSA, even those with multiple surgical consults.” (Level 2)

To clarify, a deficiency will not result by having a high number of NSA. The deficiency will be cited when the center has a high number of NSA (greater than 10%) and does not review the cases to ensure the patients received an appropriate surgical evaluation. What is noted in the Orange book on page 121 is the metric on how and when to perform a review of the NSA. Based on this metric, the first PRQ question asks if the center admitted greater than 10% of NSA (yes/no), and the second question asks, was a PIPS review done by the TPM and TMD, the answer should always be 'yes' here. Typically, all the NSA cases are reviewed in some fashion by the TPM, and if they are not, then a deficiency will result. If the center is unable to demonstrate or provide the reviewers with the documentation on how those cases were reviewed, it would be cited as a deficiency.

OPPE

“Who should complete the trauma medical director's OPPE?” (Level 1)

Each institution has a process for who performs the TMD's OPPE. Typically it would come from MedStaff or Chief of Surgery.

Pediatric Admissions

“As an adult center, if we admit more than 100 peds pts a yr, do we have to have dedicated peds program staff or just PI points?” (Level 1)

To clarify, centers admitting pediatric patients are not required to be a verified pediatric trauma center. As per CDs 2-23 and 2-24—adult trauma centers admitting more than 100 pediatric patients per year must demonstrate the presence of:

- *Credentialing of the trauma surgeons for pediatric trauma care*
- *Pediatric emergency department area*
- *Pediatric intensive care area*
- *Appropriate resuscitation equipment*
- *Pediatric-specific PIPS program*

PI Charts

“Is it best to pull charts with PI concerns to showcase our process for resolution and prevention?” (Level 3)

Based on this question, this appears to be for a focused review. In preparation for an upcoming focused site visit, you must include charts that contain PI discussion, in order to demonstrate your PI process to the reviewers.

On the other hand, if this is not regarding a focused review but preparing for a verification visit, you do want to pull charts where an issue was identified and the center made improvements to address those concerns.

PI Forms

“Are there any ACS specific forms used to capture PI to the college's expectations?” (Level 3)

The VRC does not have any specific forms that are used to capture PI. There are several different methods to PI:

- *Customize trauma registry audit filters*
- *Perform random chart audits*
- *Review all deaths*
- *Perform concurrent PI*

PRQ - Deaths

“ Define means of reporting deaths in the PRQ please. DOA (without signs of life only), Death in ED, and Death in Hospital?” (Level 2)

The VRC does not have definitions for Dead on Arrival (DOA), Death in the ED (DIED), and In-Hospital Death. These would be determined by the hospital or the state regulations.

In completing the PRQ, you would use the death data based on your institution's definitions.

Research

“Please clarify the Research PRQ question: Publications are a result from work related to the trauma center or the trauma system.” (Level 1)

The research publication must involve members of your trauma program and result from data collected at your facility or within the health trauma system (that includes your facilities' data).

Research

“Is it acceptable to include research published by an on call physician based on the data from another center?”
(Level 1)

“Is it mandated that the research studies need to be based on the center's own data?” (Level 1)

*To answer the first question, no, this practice would not be acceptable. The center may only use research data from **their own facility and own providers** to meet the Level I research requirements.*

Research

“Our program mentors a critical care fellow 3 months out of each year. Does that count toward the alternate research method?” (Level 1)

Yes, this would suffice as one of the 7 scholarly activities for the research alternate method. Refer to page 145 in the Resources manual.

Resources for Optimal Care Book Updates

“When do you anticipate the Cranberry Book coming out? When would sites be required to meet the criteria in it? will there be a PI coordinator requirement in the cranberry book?” (Level 1)

Chapter revisions are currently ongoing. We do not have a firm release date on the new edition, or specifics to provide regarding the exact changes, but will disseminate any new information as soon as it becomes available.

As with the transition from the Green to the Orange manual, there will be a 1-year grace period from the official release of new criteria to give centers the opportunity to adjust/implement the changes.

Focused Site Visit

“Scheduled for a ‘focused review’ in September because of a Type II deficiency. Please explain the severity of a Type II.” (Level 3)

*While a Type I deficiency will automatically result in the trauma center losing verification status, a center may have a total of three Type II deficiencies while still maintaining a one year verification status. It is important to note that all deficiencies represent an issue that **must** be corrected in order to gain or maintain full verification.*

Focused Site Visit by Mail

- Tutorial coming soon...
- When is my corrective documentation due?
 - Refer to Verification letter
- Where should I send the documentation?
 - COTVRC@fac.org

Site Visit Report

“Is there somewhere that provides examples/scenarios of reports the ACS will ask the registrar for, to practice for a site visit” (Level 3)

No, there is not since this will vary by the reviewer.

Site Visit Combined Programs

“Site visit in Dec for peds and adult; new info released states added surgeon for peds; do we need separate dinners now?” (Level 1)

A separate dinner is not required. However, keep in mind that having one dinner for a concurrent Level I Adult and Level I Pediatric review may run slightly longer.

Site Visit Combined Programs

“If site visit is for peds and adult verifications, and state requires nurse reviewer, do we need two nurses?” (Level 1)

No, the same nurse reviewer can serve on both site visits if they are being done concurrently.

Site Visit Dates

“When do you verify the exact dates of the consult or site visit with the facility?” (Level 1)

Confirmation of the site visit dates regardless of type of visit will be received 120 days prior to the requested dates.

Staffing Changes

“If your TPM, TMD & Registrar change in a 3-6 mth. period, does ACS require notification and a consultative visit?”
(Level 3)

The ACS will not require a consultative visit, but we would advise notifying the VRC office (cotvrc@fac.org) as soon as possible, and also updating all contact information in the TQP Participant Hub.

Transfer Agreement

“Are we required to have written transfer agreements for survey purposes?” (Level 1)

As required, the center must have written transfer plans in place regardless of an impending site visit. Please have any and all transfer agreements for trauma patients in written form and available at the time of the site review.

Transfers of Patients

“Can the care of a patient be transferred to the medical service before 24 hours with a documented tertiary exam?” (Level 2)

There are no guidelines of when care of a patient must be transferred to another service.

Trauma Activations

“Scenario: A patient falls 25 ft., EMS is on scene and notifies ED that pt. has AMS. The patient arrives without formally being activated as a Level II but is worked up by the ED physician, goes to CT, lab is completed, and the ED physician calls the Trauma surgeon after results show acute traumatic injuries. The process takes less than 1 hour from time of pt. arrival to trauma surgeon arrival. Can you put this patient in the registry as a Level II activation because the trauma surgeon came to assess the patient? Can you charge this as a Level II activation if it was not formally activated as a Level II upon arrival of the patient?” (Level 2)

The entry into the trauma registry will be based on your policy.

Without having more specifics of this case, if the patient was not activated from the field, but was activated once the results showed an acute traumatic injury, this patient may be entered into the registry.

If the patient was not activated from the field or from the time the results showed an acute traumatic injury, this patient may be entered into the registry and identified as an undertriage.

The VRC cannot speak to the billing aspect.

Trauma Registry Inclusion – Burn Patients

“If a Burn Patient is activated as a Trauma, and our Trauma Team turns care to Burn Service, are they to be entered into our Registry? If there is a Burn Patient that is transferred to our facility and meets our inclusion criteria, but Trauma Team does NOT treat the patient, do they go in our registry? The other question that has been brought up was if we do decide to put all burn patients in our trauma registry, is that data used for ACS Reports? Should this data be marked as not uploadable and only used for our own data? We have heard multiple variations and would like to hear what ACS would recommend for the entering of burn patients into our trauma registry!” (Level 1)

The entry into the trauma registry will be based on your policy. In regard to reporting data for the PRQ, patients admitted to the Burn Service would not be reportable for the PRQ. However, burn patients with any associated traumatic injury should be captured in the trauma registry and should be included in the total trauma volume.

Hospice

“When completing the death section of the PRQ does the VRC expect you to report patients with a hospital disposition like hospice (house, in hospital, or home w/hospice) as a death in hospital? TQIP defines hospice strictly as a hospital dispo not a death?” (Level 2)

For Verification purposes, not all trauma deaths discharged to Hospice are required to be reviewed as a trauma death and counted in the trauma statistics. These patients may be counted as a discharge if the patient did not die while on the Trauma Service.

If the patient was discharged or transferred to a hospital inpatient unit or to an external hospice facility, the expectation is that the care of the patient leading up to the transfer or discharge is evaluated through the PIPS process by the TMD and TPM. If any issues are found, then it may be reviewed at peer review.

Hospice

“More information regarding the hospice would be great. I.E. if they were admitted to a memory care facility with hospice - does this count?” (Level unidentified)

This would be acceptable. The expectation is that the trauma program reviews the care leading up to the patient being transferred through the PIPS process by the TMD and TPM. If any issues are found, then it can be reviewed at peer review.

Trauma Medical Director as Liaison

“Can the TMD at another facility be the liaison for the peds surgery team? The TMD is still dedicated as the TMD at the Level I ACS verified center.” (Level I)

The TMD from the ACS verified center may act as the pediatric liaison at your trauma center as long as his/her primary duties are not encumbered. With this said, the TMD cannot be on call at the same time for both trauma centers. The TMD must be dedicated to one center while on call.

CD-Related Questions

Arrival Times (CD 2-8)

“ Does the 30 min. arrival time for the OR start with the patient arrival/page or the notification by Trauma Surgeon?” (Level 3)

“ Are OR times tracked from decision to wheels in the door or decision to incision?” (Level 3)

The clock starts from the time the OR is notified that a case needs to be done.

TMD Participation (CD 5-8)

“I could not find a CD related to mandatory participation in a RTO- but that's what we're told - is there such a CD?” (Level 1)

As per CD 5-8, membership and active participation in regional or national trauma organizations are essential for the TMD (not necessarily all trauma surgeons) in Level I and II trauma centers and are desirable for TMDs in Level III and IV facilities (CD 5-8).

Examples include:

- *AAST*
- *EAST*
- *ACS – COT*
- *WTA*
- *SCCM*

Non-US Boarded (CD 6-3)

“We have a question regarding the last part of CD 6-3. This regulation states that ‘If a physician has not been certified within the time frame by the certifying board after successful completion of an ACGME or Canadian residency, the surgeon is not eligible for inclusion on the trauma team. Such as surgeon may be included when given recognition by a major professional organization (for example, the American College of Surgeons (CD 6-3)’. If a surgeon is not board certified, but has been a fellow of the ACS in good standing for some time, would they meet the criteria for recognition by a major professional organization?” (Level 2)

Yes. However, if the surgeon is foreign trained, this would not be applicable. For more information about the foreign trained physician criteria refer to the Alternate Pathway document.

Neurosurgery Response Time (CD 8-2)

“Re CD 8-2, Neurosurgery (NRSG) 30 min response-can a surgical resident, scheduled to cover NRSG, qualify for 30 min BS eval?” (Level 1)

The intent is that the TMD and liaisons for orthopaedic surgery or neurosurgery, develop guidelines for which types of critical and complex injuries the orthopaedic surgeon/neurosurgeon will respond to [in person at bedside] within the 30 minutes. If they send the specialty resident/PA/APP, there must be guidelines for the types of injuries they are approved to respond to and there must be clear documentation of the discussion with the surgeon specialist on the plan of care.

Neurosurgery Response Time (CD 8-2)

“Is there any change to the neurosurgery response requirement?” (Level 1)

There have been no changes at this time.

Neurosurgeon PI Meeting Attendance (CD 8-13)

“In regards to CD 8-13, please clarify the requirements of neurosurgical attendance at the trauma multidisciplinary and peer review meetings. Does only the liaison have to attend at least 50% of the time, or do all neurosurgeons on the trauma call panel have to meet the 50% attendance requirement?” (Level 3)

This refers to the neurosurgical liaison or the predetermined alternate neurosurgeon. It is based on their combined total attendance. This requirement does not extend to all neurosurgeons on the trauma call panel.

Operating Room Team (CD 11-15)

“According to CD 11-15, criterion is met by having a complete operating room team in house at all times for expeditious OR care for the trauma patient. Is it acceptable to have a primary OR team on-call if response times are tracked for compliance?” (Level 2)

The requirement is for the OR team to be available within 15 minutes. The best method to meet this requirement is to have the OR team in-house. With this said, if the trauma program can demonstrate the OR team is assembled within 15 minutes with an on-call team outside the hospital, this is acceptable. It must be met 100% of the time.

OR Response Time (CD 11-17)

“Is allowing the on-call OR team 30 mins from notification to arrival too long? Level III Center” (Level 3)

While the OR response requirement is 15 minutes for Level I and II trauma centers, this requirement extends to 30 minutes for Level III trauma centers. Hence, a maximum of 30 minutes from notification to arrival would be appropriate.

Interventional Radiology (CD 11-33)

“IR response time of 30 mins: Is the resp time calculated from initial call to radiologist arrival? Or rad phone resp to arrival?” (Level 2)

The interventional radiologist is not required in-house 24/7, but must be present at bedside within 30 minutes.

The clock starts when the request/call is made.

The clock stops when the radiologist arrives at bedside.

Interventional Radiology (CD 11-33)

“Re CD 11-33 & 30 minute IR response - which ‘complex imaging & interventional procedures’ require 30 minute response by IR?” (Level 1)

ACS does not define the types of complex imaging interventional procedures. This will be determined by your institution.

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

“ Define what "available" means for the different specialty service providers at a Level II center. 24/7 call? Transfer?”
(Level 2)

The surgical specialties are not required to be in house 24/7, but there must be a surgeon consultant available to respond, in person, when requested by the attending surgeon within a predetermined time. The trauma program must be able to demonstrate who is providing the coverage when requested.

Transfer agreements are acceptable for complex injuries.

ICU Nurse Ratio (CD 11-66)

“CD11-66 patient/nurse ratio in ICU must not exceed 2:1. Is this for the entire ICU or only those nurses caring for trauma pts?” (Level 1)

The patient-to-nurse ratio of 2:1 is for the trauma patients in the ICU and/or waiting for an ICU bed, the guidelines for the patient-to-nurse ratio in these instances will be determined at each individual trauma center.

Trauma Registry (CD 15-6)

“CD 15-6: If registry has charts not closed from 2017 but current data year is 80% closed within 60 days, are there consequences?” (Level 1)

“Are charts to be closed within 60 days of discharge?”
(Level unidentified)

For the reporting year, the expectation is that 80% of the cases are closed within 60 days of discharge.

Alcohol Screening (CD 18-3)

“We have a group of patients that had some type of traumatic injury that our trauma team does not treat, or consult. We track them through our trauma data base. Is this group included in the SBIRT compliance of 80%? In other words do these patients need to have a blood alcohol level done and SBIRT if they test positive? Thank you.” (Level 2)

Yes. If the patient was still admitted with a traumatic injury and included in your admission numbers, even if they went on to be treated by neurosurgery/orthopaedics/other subspecialty, any of those patients that would be considered alive and participatory would be included in the 80% minimum for SBIRT compliance. Any such patients who receive a positive screen must receive an intervention.

CME

CE Credits

“Do trauma registrars need trauma-related continuing education credits. If so, how many?” (Level 1)

There are currently no requirements regarding CE credits for trauma registrars. The Orange book provides a recommendation of a minimum of 8 hours of registry-specific continuing education per year.

CME Requirements

“We had a new TMD take over in October of 2018 and have a site visit coming up in September of 2019. Will they have to have the full 32 hours of CME or is it prorated?” (Level 1)

The required amount of CME would be prorated based on the TMD's start date. The reviewers would be looking for a minimum of 12 hours of CME total, to cover their first year.

CME/CE Requirements

“Regarding CMEs/CEUs: Are these webinars (Verification and TQIP) offered by ACS COT VRC considered as trauma-related CE’s and can be counted towards the required CE’s for the TMD and the TPM?” (Level 2)

*To clarify, the TMD must have 12 hours per year of **CME**, which is separate from **CE**. As such, the TMD would not be able to use viewing the VRC monthly webinars to count towards their CME requirement.*

*The education requirement for the TPM is 12 hours per year of **CE**, meaning that viewing the monthly webinars would count towards their total.*

Thanks for your participation!