

Trauma Verification Q&A Web Conference

October 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

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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 with instructions on how to claim CE
- ❖ If you have any questions – please email COTVRC@facs.org
- ❖ **CE Eligibility will expire on Friday, November 15**
 - ❖ You must watch the webinar prior to November 15, in order to be eligible to claim CE

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.*

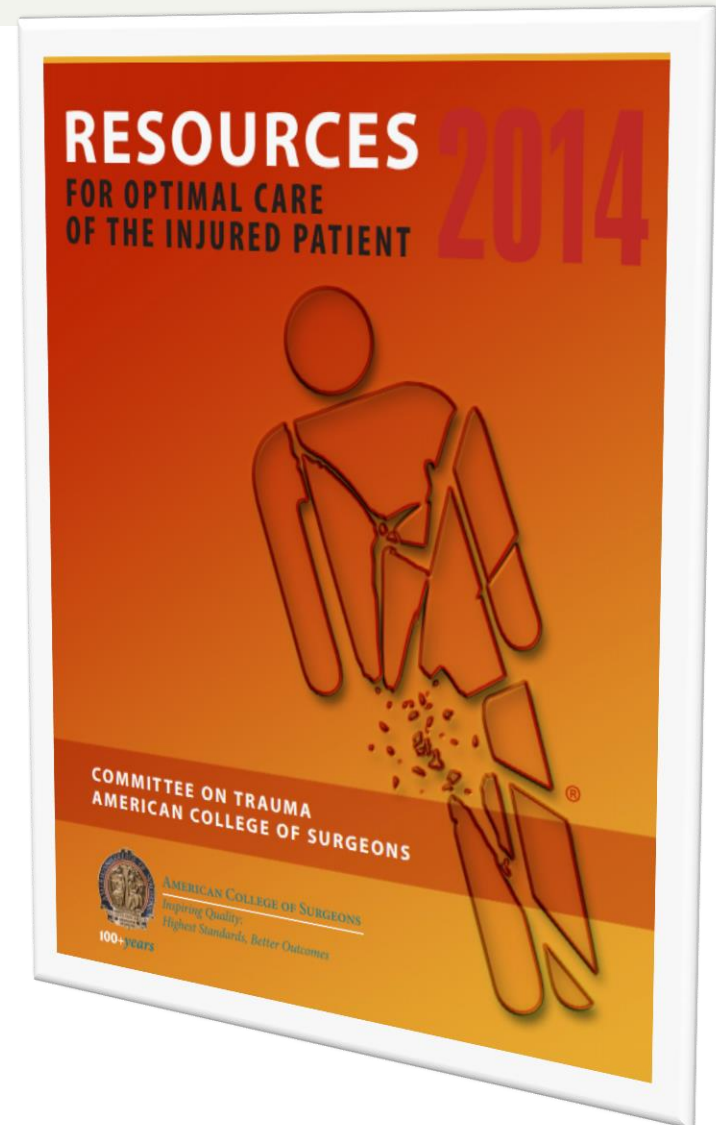
Let's get started!

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/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/center-programs/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

Site Visit Applications

- Currently, site visit applications are being accepted for **May 2020 and onward.**
- **Please Note:**
 - **2019 is closed.**
 - **January – April 2020 is closed.**

New Participation Fee Schedule

- Effective July 1, 2020, the participation fee will increase.
- For a listing of the new fee structure, visit:
<https://www.facs.org/quality-programs/trauma/tqip/center-programs/vrc/fees>.
- The Trauma Quality Program includes participation in both TQIP and VRC.
- If you have specific questions about your trauma center's next invoice, please feel free to contact us at traumaquality@facs.org.

Announcements

TQP Call for Data

- This is a reminder that the TQIP quarterly Call for Data is now open! In this Call, we request that you submit both your **second** and **third quarters of 2019 data**, as well as any updates dating back to January 1, 2017.
- The deadline for submitting your data is **December 4, 2019**.

TQIP Annual Scientific Meeting and Training

November 16–18, 2019 *Hilton Anatole, Dallas, TX*

Reserve your hotel room!

- For more information, visit the TQIP Annual Meeting website:
www.facs.org/TQIPMeeting

Preconference Workshops

Courses Offered:

- AIS15 and Injury Scaling: Uses and Techniques—Association for the Advancement of Automotive Medicine
- ATS Trauma Registry Course—American Trauma Society
- Sharper Coding for Trauma with ICD-10-CM & ICD-10-PCS Workshop—KJ Trauma Consulting LLC
- Trauma Advanced Registrar Prep—Pomphrey Consulting
- Optimal Trauma Center Organization & Management Course (OPTIMAL)—The Society of Trauma Nurses
 - Offering two courses: Thursday and Friday, November 14 & 15, 2019
- Trauma Outcomes and Performance Improvement Course (TOPIC)—The Society of Trauma Nurses
 - Offering two courses: Thursday and Friday, November 14 & 15, 2019
- Stop the Bleed Basics—American College of Surgeons Trauma Programs
- Stop the Bleed Instructor—American College of Surgeons Trauma Programs

<https://www.facs.org/quality-programs/trauma/tqip/center-programs/tqip/meeting/workshops>

Quarterly Webinar Schedule

VRC Web Conference Schedule

Last monthly VRC Web Conference

October 30, 2019

1st Quarter VRC Web Conference

January 30, 2020

2nd Quarter VRC Web Conference

April 2020

3rd Quarter VRC Web Conference

July 2020

4th Quarter VRC Web Conference

October 2020

Next Verification Q&A Webinar

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

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

Deadline to submit questions: **Thursday, January 16th**

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

Special Segment Reporting Year

Site Visit Month (2020)	Reporting Year: Option 1			Reporting Year: Option 2	
January	10/1/18	9/30/19		11/1/18	10/31/19
February	11/1/18	10/31/19		12/1/18	11/30/19
March	12/1/18	11/30/19		1/1/19	12/31/19
April	1/1/19	12/31/19		2/1/19	1/31/20
May	2/1/19	1/31/20		3/1/19	2/29/20
June	3/1/19	2/29/20		4/1/19	3/31/20
July	4/1/19	3/31/20		5/1/19	4/30/20
August	5/1/19	4/30/20		6/1/19	5/31/20
September	6/1/19	5/31/20		7/1/19	6/30/20
October	7/1/19	6/30/20		8/1/19	7/31/20
November	8/1/19	7/31/20		9/1/19	8/31/20
December	9/1/19	8/31/20		10/1/19	9/30/20

Reporting Year

- The verification process uses a 12-month period plus a 2-month lag, not to exceed 14 months from time of the visit.
- This is to ensure the trauma center meets the metrics for compliance with the registry and patient volume requirements:
 - *CD 2-4: Admit at least 1,200 trauma patients yearly or admit at least 240 admissions with an ISS higher than 15.*
 - *CD 2-23: Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating their capability to care for injured children.*
 - *CD 2-25: For adult trauma centers annually admitting fewer than 100 injured children younger than 15 years, these resources are desirable. These hospitals, however, must review the care of their injured children through their PIPS program.*
 - *CD 10-1: A Level I pediatric trauma center must annually admit 200 or more injured children younger than 15 years.*
 - *CD 10-2: A Level II pediatric trauma center must annually admit 100 or more injured children younger than 15 years.*

Special Segment Research

Research Requirements

The following are required for Level I trauma centers, to be monitored over a 3-year period:

- (CD 19-1) At least 20 peer-reviewed articles published in journals included in Index Medicus or PubMed
- (CD 19-2) Publications must result from work related to the trauma center
- (CD 19-3) At least one article must be co-/authored by members of the general surgery team
- (CD 19-8) Administration must demonstrate support for the research program
 - Lab space, research equipment, advanced information systems, biostatistical support, etc.

Research Requirements (cont'd)

- (CD 19-4) At least **one** article each from **three** of the following:

- Basic Sciences
- Neurosurgery
- Emergency Medicine
- Orthopaedics
- Radiology
- Anesthesia
- Vascular Surgery
- Plastics/Maxillofacial Surgery
- Critical Care
- Cardiothoracic Surgery
- Rehabilitation
- Nursing

NOTE: This list is not exclusive. It may include other areas that interface with surgery/trauma, such as pharmacy, cardiac surgery, obstetric/gynecology, etc.

Research Requirements for Pediatrics

- All CDs referenced in the previous slides apply to **both** adult and pediatric trauma centers (CD 10-10).
- For pediatric trauma centers and combined programs, the research may contain both pediatric and adult publications. However, in combined programs such as, adult Level I and pediatric Level I, half of the research must be specific to the pediatric program (CD 10-11).

Alternate Pathway for Research

Must submit **10 peer-reviewed articles**, provided the center meets **4 of the 7** trauma-related scholarly activities listed below:

1. Evidence of leadership in major trauma organizations, which includes membership in trauma committees of any of the regional or national trauma organizations.
 - *Active membership and committee work such as, ACS-COT, AAST, EAST, WTA, etc.*
2. Demonstrated peer-reviewed funding for trauma research from a recognized government or private agency or organization.
 - *Government agencies, private agencies (foundations, commercial – injury prevention efforts), internal sources, e.g. HCA research consortium*
3. Evidence of dissemination of knowledge that includes review articles, book chapters, technical documents, Web-based publications, videos, editorial comments, training manuals, and trauma-related educational materials or multicenter protocol development.
 - *Dissemination of knowledge includes, but is not limited to the following: publication of review articles, book chapters, technical documents.*

Alternate Pathway for Research (cont'd)

4. Display of scholarly application of knowledge as evidenced by case reports or reports of clinical series in journals included in MEDLINE.
 - *This can be achieved through case reports, or reports of clinical series in a Medline publication. There are critical scholarly activities necessary for further development of trauma care.*
5. Participation as a visiting professor or invited lecturer at national or regional trauma conferences.
 - *A trauma surgeon is invited to the trauma center as a visiting professor.*
6. Support of resident participation in mentoring scholarly activity, including laboratory experiences; clinical trials; resident trauma paper competitions at the state, regional, or national level; and other resident trauma presentations.
 - www.facs.org/quality-programs/trauma/about-trauma/trauma-papers
7. Mentorship of fellows, as evidenced by the development or maintenance of a recognized trauma, critical care, or acute care surgery fellowship.
 - *Mentorship of fellows participating in trauma, critical care, or acute care surgery fellowships would be acceptable.*

Research Validation

- Form provided upon receipt of a site visit application – also available on the webpage:
<https://www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/resources>
- Must be submitted at the same time of the online PRQ or within **5 days**.
- The VRC Office will ensure necessary information provided for each article and verify PMID.
- Reviewers will validate further onsite.

American College of Surgeons Committee on Trauma
Verification/Consultation Program

Level I Adult and/or Pediatric Trauma Center
Summary Form for Research Articles

This form is intended to cover the following criteria: 19-1, 19-2, 19-3, 19-4, 19-7, and 19-8, as well as 10-10 and 10-11 for pediatric centers. Please complete this "Summary Form for Research Articles" for each peer-reviewed article your trauma program would like considered for your Level I adult or pediatric trauma center's trauma research requirement. Have a copy of each summary form and article available at the time of the site visit in order for the site reviewers to complete this portion of the review. In addition, a copy of this form should be submitted to the VRC (cotvrc@facs.org) and reviewers upon completion of the PRQ.

For combined Level I adult and pediatric trauma centers, please be advised that as noted in the current version of the Verification Change Log, half of the research requirement must be fulfilled using pediatric research.

Three Year Time Period for Research Articles: The trauma program must choose one of the two following options as the 3-year time period during which all articles must have been published. Please pick one of the two options, and complete the time period:

→ _____

Select One:

a. 36 months, ending the last day of the "reporting year" for this review

b. 36 months, ending the first day of the site visit

Name of Article:
→ _____

PMID Number
→ _____

Date of Publication
→ _____

*If article has been approved, but not yet published, please have the approval letter available onsite.

What counts? What doesn't?

Publications that **won't** apply:

- Non-trauma related research
- Case studies
- Research that includes your patient data, but is *not* co-authored by any of your clinicians
- Research by clinicians at your facility, but that does *not* contain your patient data
 - Backup or locums surgeon conducting research for another facility
 - Surgeon conducting research at another hospital during prior employment
- Outsourcing research

NOTE: You *may* count research done by clinicians who are no longer at your facility.

Timeline of Submission

- Timeframe for acceptable publications begins **following your previous re/verification site visit**, up to the time of your upcoming visit.
 - Research published during the lag time between the end of your reporting year and the date of your site visit **will count** towards your total.
- Articles accepted for publication, but not yet printed, **will count** towards your total. The center must provide a letter confirming acceptance onsite.

General Questions

Advanced Practice Providers (APPs)

“APP’s/physician extenders in the ED, with ATLS certification are able to do the initial eval of a injured patient w/ activation. Are they allowed to see autonomously? Meaning, does an ED physician need to evaluate as well? Additionally, is the ED APP allowed to sign the activation sheet or must that be an ED physician?” (Level 2)

For the Limited Tier Activation, APPs may be the initial responder if they have been credentialed by the hospital to do so. The APPs cannot respond in lieu of the trauma surgeon’s role or response. In these instances, the APP may sign off on the activation.

For the Highest Tier Activation, the APPs cannot be the initial responder. They may work in conjunction with the emergency medicine provider/trauma surgeon.

Death Admissions

“Is death in the ED considered an admission or die in the ED after resuscitation?” (Level 1)

Each trauma center will define the admission policy, as well Death on Arrival (DOA) and Died in the Emergency Department (DIED).

The Resources manual (page 119) provides some examples:

- *DOA (pronounced dead on arrival with no additional resuscitation efforts initiated in the emergency department).*
- *DIED (died in the emergency department despite resuscitation efforts).*
- *In-hospital (including operating room).*

Back-up Call Schedule Response Time

“Does the ACS have any requirements on when the back-up trauma surgeon on call must come in to the hospital? If the overnight trauma surgeon is in the OR, does the backup trauma surgeon need to be in house during that time?” (Level 1)

The time frame by which the back-up trauma surgeon on call must arrive at bedside will be determined by the trauma center. The intent of the requirement is to ensure that the back-up surgeons are meeting the response criteria put into place by the trauma center.

Massive Transfusion Protocol (MTP)

“Massive Blood Transfusion protocol question? Does it have to be 1:1:1 ratio. Our protocol includes the release of 4 units of PRBC initially, and the second cooler will have 4 unit PRBC and 2 units plasma. The rest is 1:1:1 ratio. Would that be an issue for re-verification review?” (Level 1)

The VRC does not have a specific requirement regarding the MTP ratio. Blood products should be available to meet the needs of the injured patient.

Pediatric Surgery Coverage

“Is a Chief Resident defined by the ACS as a PGY4 or 5? For lowest level of trauma activation for Pediatric Level I, is it acceptable to utilize a PGY 3 as the Chief Resident responding or must it be a PGY4 or 5?” (Level 1)

The Verification program uses the term senior resident, and they are defined as PGY 4-5 for all trauma programs.

For the lower or Limited Tier Activation, a PGY 3, 4, or 5 may be utilized (for any program) as long as they have been credentialed by the hospital to do so. They cannot be used in lieu of the attending trauma surgeon.

PRQ Clarification

“Our hospital had a verification visit in November 2018 followed by a focuses site visit November 2018 in which all deficiencies were found to be resolved by the reviewers. We are scheduled to have our next verification visit November 2020. The PRQ is asking for: Number of deficiencies cited at the last review (consultation, verification, reverification or not the focused review). Briefly list any deficiencies and how they were corrected (list by bullets or numbered points): Number of weaknesses found at last review: Briefly list any weaknesses and how they were addressed (list by bullets or numbered points) Please define last review in this case. Is it the most recent focused site visit or the original verification visit the year prior?” (Level 1)

In this instance, you would list the focused visit as your previous site visit, but do not list the deficiencies that were found in the prior verification since those were resolved.

The reviewers will receive a copy of the initial and focused reports as reference.

PRQ Clarification

"I would like clarification regarding the death classifications. The verbiage and philosophy have changed over the past few years and we have gotten varying messages regarding how they expect us to classify deaths. The PRQ (at least at our last review) still lists deaths as non-preventable, potentially preventable, and preventable. The new verbiage for classification, however, is without opportunity, with opportunity, and unanticipated. While these may seem to map straight across, it seems that the approach to the middle category (with opportunity = potentially preventable) is variable. Identifying opportunities for improvement that 'do not rise to the level of preventability' happens often, but that does not make the death 'potentially preventable'. Can you please help us understand how to reconcile the verbiage from the classifications to the PRQ and how we are expected to treat the 'with opportunity' deaths? We are able to find lots of minor opportunities for improvement in our case reviews, but that is very different from saying a death is 'potentially preventable', which creates a significant discrepancy in the numbers in this group." (Level 1)

Since the release of the Resources 2014 manual, the death categories have been as follows:

- *Mortality without Opportunity for Improvement (OFI)*
- *Mortality with Opportunity for Improvement*
- *Unanticipated mortality with Opportunity for Improvement*

It would be advisable to get away from using the old classifications and try to determine whether there were any OFIs. The intent is that the program is able to identify the potential of OFIs and whether they had an impact on the patient's outcome.

PRQ Clarification

“Can we please have clarification on the ICU Death count requested in the PRQ? Specifically, the PRQ inquires how many of the ICU deaths were transfers to Hospice. Because of how these are captured in the registry, hospice dispositions are not considered patient outcomes of death. However, if for this question we include hospice dispositions as deaths, all other death counts in the PRQ will not coincide.” (Level I)

For verification purposes, list the number of hospice patients who did not die but were transferred. Many programs leave this blank because of how these patients are captured in their registry. It is acceptable to leave this line blank.

2. Does your institution have palliative care available?

a. If 'Yes', describe how this palliative care team is incorporated into end of life issues.

b. Total number of Trauma related ICU deaths:

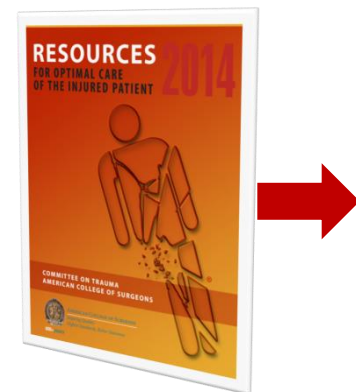
c. Of these deaths, # of withdrawal of care:

d. Of these deaths, # transferred to hospice care:

Response Time Requirements

“When it comes to activating trauma alerts and notifying the trauma surgeons, when you have a patient that gets activated after they arrive it occasionally looks like the trauma surgeons are not timely. They arrive to the patient within the 15 minutes notification time, but it looks as if they are not timely because they are not at the bedside within the first 15 minutes of the patient's arrival. Is there a different way to document this in the registry? Or are they still not timely? Thank you.” (Level 2)

“Could you please go over physician timeliness for Level 1 & 2 activations. The Orange Book states to determine if the physician is timely it is based off the patient's arrival time. But what happens when an activation is after the patient's arrival? Example 1: Patient arrives to Sunshine hospital POV from an MVC at 1500 gets triaged at 1520 and gets activated due to injuries, trauma physicians arrive at 1522. Example 2: Pt arrived by EMS presented and arrived with no signs of injuries, patient was found to have internal injuries and was immediately activated. By Orange book guidelines the physician is considered not timely in both cases. Please advise.” (Level 2)



Response Time Requirements - Response

For patients who arrived as a non-activation, but subsequently met criteria for the highest level of activation once the patient was evaluated, the response time would be tracked from the time of that activation. This means that the attending trauma surgeon would be in compliance as long as they arrived at bedside within 15 minutes of activation.

How these patients are captured in the registry will be determined by your policy.

Trauma Activation

“If a trauma is activated internally; as the patient arrived, do we classify it as a trauma activation or are activations recorded only from the field?” (Unknown)

All activations that meet trauma activation criteria, whether they were called from the field or at the hospital, should be classified as such.

Trauma Activation Roles

“In our ED, the ED board certified physicians are not required to stay current in ATLS. Therefore, our Trauma resuscitations can sometimes be inconsistent when run by an ED physician. To fix this, we've proposed a Trauma Advanced Practice Provider (who is required to stay current in ATLS) be the team lead in these resuscitations since the APP is in house 24/7 and the surgeon is not. The Trauma surgeon performs assessment and procedures along with the ED physician. Is this an acceptable solution to providing consistent resuscitation or does ACS make another role recommendation for Trauma activation roles?” (Level 2)

This method would be acceptable for the Limited Tier of activation, since the APP may be the primary responder, but they cannot take the place of the attending trauma surgeon.

To clarify, and without having a lot of information, physicians who are board certified in emergency medicine and working in the ED are required to have taken ATLS once but not hold current certification. Those physicians who are board certified in another specialty are required to be current in ATLS.

Verification Site-Visit

“Does the ACS come and look at the primary review sheets completed from prior months? Do they offer suggestions for improvement?” (Level 3)

The review team will only be looking at data from the reporting period.

Yes, the reviewer will provide opportunities for improvement. In addition, if there is something you would like for them to provide input, you can certainly draw their attention to it.

Verification Site-Visit

“During the last call, there was mention of providing copies of physician's board certifications. This is not listed in the PRQ as a required attachment and is not in the "Review Agenda and Logistics" document. Is this required? If so, should copies of board certification be provided for all specialties (Nsgy, Ortho, EMed) or just surgeons taking trauma call? Thank you!” (Level 1)

To clarify, the PRQ has text fields throughout wherein you should provide the most current expiration dates for providers across all specialties. You should also have proof of their certification available onsite for those who participate in trauma call, to present to the reviewers if asked.

Verification Site-Visit

“Does the ACS look at all the Trauma meeting minutes and attendance that you have had since the last re-verification and specifically at the peer meeting minutes and outcomes from the meetings if any?” (Level 3)

The review team will only be looking at data from the reporting period.

Washout Guidelines

“What is the expected time for definitive I&D for open tibia fxs? We have heard 8 and 12 hours and have also heard that the washout in the ER counts as the I&D, which I have heard the opposite. Can you please clarify?” (Level 2)

To clarify, washouts in the emergency room do not count.

“Patients with open fractures should be taken to the operating room for irrigation and debridement within 24 hours of initial presentation whenever possible.” – ACS TQIP Best Practices in the Management of Orthopaedic Trauma, https://www.facs.org/-/media/files/quality-programs/trauma/tqip/ortho_guidelines.ashx.

CD-Related Questions

Transfer Agreements (CD 4-3)

“If we are transferring a trauma patient from one trauma center to a sister facility in which we operate under the same license, are we required to have a transfer agreement with that facility?” (Level 2)

A transfer agreement with the sister facility practicing under the same license would not be required. Having said this, your program would need to track those patients who are transferred out and monitored through the PIPS process.

Activation Response (CD 5-14)

“If we had a patient arrive as a Level 2 at 02:48 in stable condition, but get upgraded to a Level 1 (highest) activation at 02:57 due to discovered injuries, and the attending trauma surgeon arrives at 03:07, does that count against the trauma surgeon since he arrived well within the mandated time of the level 2, and within 10 minutes of the upgraded activation?”
(Level 2)

The surgeon in this example would be in compliance of the mandated and upgraded activation. The clock would start from the time the activation was upgraded.

Activation Response (CDs 5-14/2-8)

“If we had a patient who arrived to ED at 04:02, but the covering trauma surgeon wasn't notified of the patient's arrival or the Level 1 (highest) activation until 4:07, and he arrived at 04:20, does that count as a miss for him if he arrived within 15 minutes of notification, but was outside the window from arrival time due to not being aware a Level 1 was in the hospital?”
(Level 2)

Based on this scenario and the fact that the surgeon “wasn't notified”, it appears that the activation was called after the patient arrived. In this case, the response time would be tracked from the time the activation was triggered.

If the activation was triggered from the field and the attending trauma surgeon for whatever reason did not receive the notification, and they responded greater than 15 minutes, it would be a miss. This would need to be documented and reviewed through PIPS process.

Trauma Program Manager (TPM) (CDs 5-23/10-3)

“Please clarify Trauma Program Manager Commitment: For a Level 1 Adult center Level 2 Pediatric center do you need a separate pediatric TPM or will a separate coordinate suffice the requirements.” (Level 1)

In an adult Level I and pediatric Level I trauma center, there must be separate and dedicated TPMs. However, for a combined adult Level I or adult Level II and pediatric Level II trauma center, one TPM may oversee both programs as long as their primary role is not encumbered.

Board Certification Requirements (CD 7-6)

“Do Emergency Room Doctors have to stay current in their board certifications? If they let their boards lapse, is this a criteria deficiency? I have two ER doctors who have been practicing for years and have recently let their board certifications lapse as it is not required in our bylaws.”
(Level 3)

Yes, as per CD 7-6, physicians staffing the emergency department (ED) and caring for trauma patients must maintain current board certification. If these practitioners' boards have lapsed, they do not meet the requirements for inclusion on the trauma panel. That does not preclude them from working in the ED, on all other patients, but that particular ED must have someone else see trauma patients meeting the requirements.

Board Certification and CME (CD 7-15)

“Could you please confirm that Internal Medicine and Family Practice boarded physicians are recognized specialties by ABMS and maintenance of Board Certification is recognized by ACS and they would not need the annual CME?” (Level 2)

Yes, the American College of Surgeon recognizes board certification through the American Board of Medical Specialties.

In Level I, II, and III trauma centers, maintaining current status in the clinician’s board certification/maintenance of certification (MOC) satisfies the CME requirement.

Note: *Board certification through the American Board of Physician Specialists (APBS) are not recognized by the American College of Surgeons.*

ATLS (CD 7-15)

“Can you please clarify CD 7-15 for me? If anesthesiologists respond to our highest trauma activations, are they required to be ATLS certified for Level 2 or 3 centers? They are not working in the ED, they respond for the resuscitation of the patient along with the ED physician and trauma surgeon. We have differing interpretations of this chapter 7 statement.” (Level 2)

CD 7-15 applies to physicians who are board certified or eligible in another specialty (other than emergency medicine) and work in the ED caring for trauma patients. These physicians must have current ATLS certification.

Anesthesiologists who participate in trauma activations are not required to have taken ATLS.

Neurosurgeon/Orthopaedic Surgeon Response (CDs 8-2/9-7)

“Orthopedics and Neurosurgery response - example: Patient arrived to facility at 19:30 as a transfer from another facility. Ortho was notified at 19:09 but did not arrive to the ED until 19:45 (44 min). In this situation can we use the patient arrival time (19:30) as the notify time so they do not fall out of the 30 minute response time because the patient wasn't there yet? Response time would then be 15 min. Similar to Trauma surgeon response - tracked off patient arrival time. Only for the scenario of when transferred in and notified prior to patient arrival.”
(Level 1)

In this scenario, using the patient's arrival time to track the orthopaedic surgeon's or the neurosurgeon's response would be acceptable.

Neurosurgeon/Orthopaedic Surgeon Response (CDs 8-2/9-7)

“There was a discrepancy to the answer in the following question: “Level 1 or 2. Does the arrival time of the mid-level provider count as the trauma surgeon, Ortho Surgeon, or Neurosurgeon arrival time for Level I or Level II activation?” While the MLP clearly does NOT substitute for the arrival of a trauma surgeon during activations, it is my understanding that residents and APPs may respond for Neurosurgery and Orthopaedics. The clarification document supports this. This response was also in conflict with the following reply later in the webinar: “The surgical/trauma resident cannot act or respond on behalf of the attending neurosurgeon for the 30 minute bedside response. It may be either the attending neurosurgeon or the neurosurgeon resident or APP.” I believe, per the clarification document, the same applies to Ortho response times.”
(Level Unknown)

The question referenced from the previous webinar referred to a “surgical/trauma resident,” which was interpreted by the VRC office as a trauma surgical resident (PGY 4-5). To clarify, the orthopaedic or neurosurgical resident or APP may respond on behalf of the attending orthopaedic/neurosurgeon for the 30-minute bedside response based on institution guidelines.

ICU Response (CD 11-60)

“Is there a specified response time for 11-60 related to the timeliness of the ICU team? We were thinking it was either 15min or 30min (at a Level I) but couldn’t find confirmation in the book/clarification document.” (Level 1)

There is no defined response time for “timely.” Timely will be defined by the trauma center and response times monitored through the PIPS process.

We have defined “immediate” as 15 minutes, and “promptly” as 30 minutes.

APPs ATLS (CD 11-86)

“If an APP assists with minor laceration repair or splinting of an extremity, but is not involved in the actual assessment and resuscitation of a trauma patient do they need ATLS?” (Unknown)

No, they are not required to hold current ATLS certification. Our standards state that APPs who participate in the initial evaluation of trauma patients must demonstrate current certification as an ATLS provider (CD 11-86). We further clarify that APPs who are clinically involved in the initial evaluation and the resuscitation of trauma patients during the activation phase are required to have current ATLS certification. This would therefore include ED and trauma APPs. If the APPs are acting as a scribe or entering orders, they are not required to have ATLS.

OPPE for APPs (CD 11-87)

“In reference to CD 11-87 that states that all mid-level providers involved in the care of trauma patients must undergo credentialing and OPPE with the TMD involved, is this in reference to all specialties or only a select group of specialties? Trauma, neurosurgery, orthopedics, emergency, medicine, anesthesia?” (Level unknown)

An OPPE must be conducted for all specialties that care for trauma patients. This includes all of the specialties listed in this question. While the TMD must have some oversight/sign-off on the evaluation, the OPPE and credentialing would be conducted by the director of each respective specialty.

Alcohol Screening (CD 18-3)

“Can a positive blood alcohol be considered a positive screening for SBIRT purposes, or does another screening tool still need to be utilized?” (Level 1)

Yes, a patient's BAC is one possible metric trauma centers may use to screen for alcohol use. An alternative screening is not required.

Alcohol Screening (CD 18-3)

“Is substance abuse screening required for Level 3 trauma centers?” (Level 3)

“Does the Audit-C meet the alcohol screening requirement for Level 3 centers?” (Level 3)

In response to the first question, yes, all trauma centers must conduct an alcohol screening for at least a minimum of 80% of trauma patients. However, only Level I and II trauma centers are required to provide an intervention for all patients who screen positive—though this is certainly encouraged in all trauma centers.

In response to the second question, screening can be conducted in a number of ways, including Audit-C.

Alcohol Screening (CD 18-3)

“Related to CD 18-3 (Universal screening for alcohol use must be performed for all injured patients and must be documented), the Clarification Document states ‘Any patient with an altered mental status (and deaths) should be excluded from the denominator as these cannot be considered ‘participatory’.’ Will you please clarify if this applies to patients who present with altered mental status initially, but then later have improved mental status and would be considered able to participate from a neurologic standpoint (i.e. intoxicated with altered mental status initially who have normal mental status the following day)?” (Level 1)

We do not expect trauma centers to re-test for patients whose mental status changes over the course of care. If the patient cannot be considered participatory at the time the test is administered, this will not need to be counted towards the 80% requirement.

CME

MOC

“Is a letter from a specialty board with verification of fulfillment of all requirements of MOC with a date of expiration sufficient to demonstrate board certification or do we actually need a copy of the certificate?” (Level 1)

Yes, an official correspondence from a specialty board indicating compliance with the MOC and an expiration date will be sufficient to meet the requirement.

Note: *Some boards have moved from using the term MOC to Continuous Certification.*

CME – Level III

“For a Level 3 facility, do we have to show proof of trauma related CME's for the liaison's or just the TMD?” (Level 3)

There are no CME requirements for Level III trauma centers.

Update: Resource Manual Chapter Revisions

OPTIMA Book

“When do we get the updated OPTIMA book or is it going to be electronic format?” (Level 1)

Assuming this is the updated version of the Resources for Optimal Care of the Injured Patient, the new book is currently undergoing chapter revision. We will announce the launch date once the revisions have been completed.

Thanks for your participation!