Trauma Verification Q&A Web Conference

February 20, 2019

COTVRC@facs.org

American College of Surgeons
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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 within 24 hours of the webinar ending, with instructions on how to claim CE*
- *If you have any questions – please email COTVRC@facs.org*

What is the goal for this Webinar?

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

- *Understand the processes and standards involved in an ACS Trauma Verification Site Visit and how following these will positively impact the quality of care of the injured patient at your trauma center.*

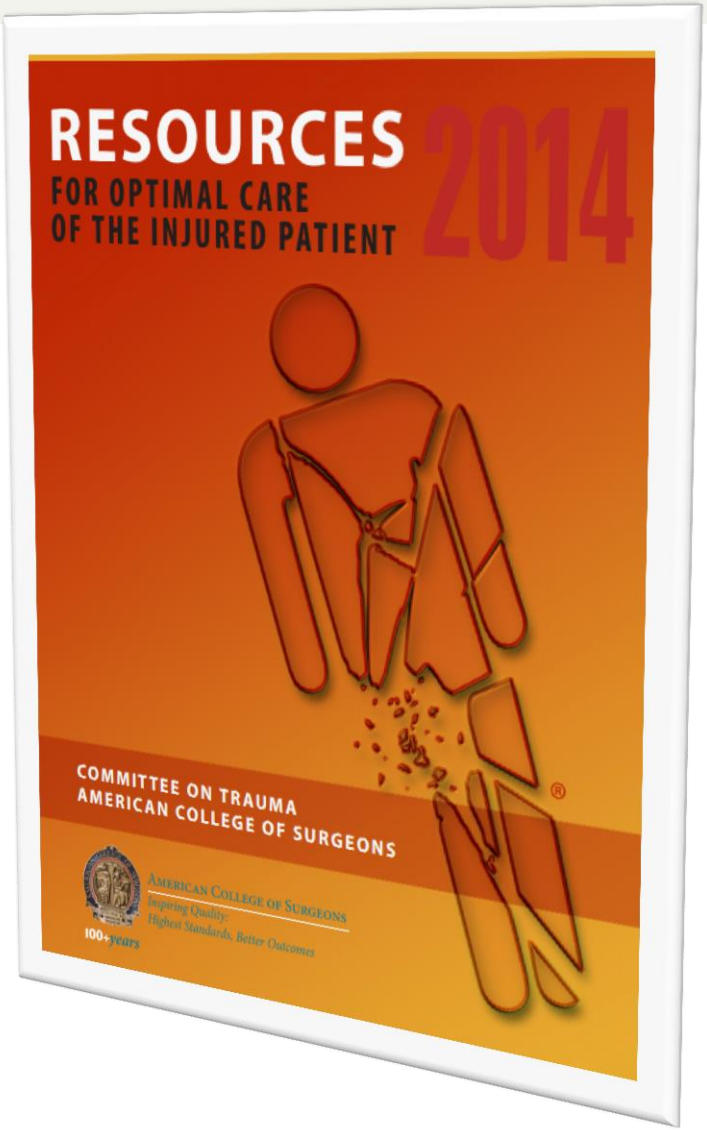
Let's get started!

Orange Resources Book

Available as hard copy or PDF version, it is recommended that you have it available as reference during the **CD-Related Questions** section of this webinar.

Must use the most current Clarification Document and the Verification Change Log in conjunction with the manual.

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



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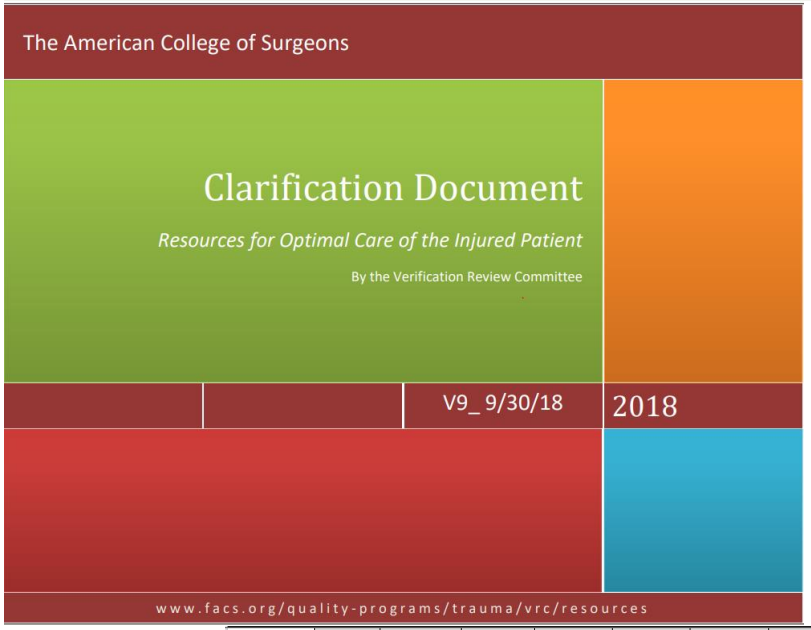
Clarification Document and Verification Change Log



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

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 & Updates

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

Announcements

Next Verification Q&A Webinar

Webinar Date: **Tuesday, March 26th**

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

Deadline to submit questions: **Monday, March 11th**

General Questions

PI Coordinator

"Is the Trauma PI Coordinator required to be a nurse?" (Level 3)

While this role is often filled by a nurse, the VRC does not have any requirements regarding the Trauma PI Coordinator position.

Resources for New Trauma Program Manager

"Where is the best place to find resources for a new Trauma Program Manager?" (Level 2)

The VRC Resources webpage has several tutorials that will be beneficial. It also houses all the monthly Verification Q&A webinars.

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

ICU

"For patients admitted to ICU, can an APP see the patient in place of a physician or does it need to be an intensivist? By when?" (Level 2)

An APP cannot take the place of a physician. This role must be performed by a physician who has been credentialed to provide care to the trauma patients while in the ICU. It is required they respond within 15 minutes for a Level II trauma center. Refer to the ICU Coverage Constellations Table in the Resources manual on page 81.

Admission vs. Visit

"Do you consider an ED patient a visit or an admission? In regards to adding patient to the Registry?" (Level 3)

Without having specific data on the patient, if the patient has a mechanism of injury and meets the NTDS Inclusion Criteria, the patient would be an admission and entered into the trauma registry.

Board Certification

"Do any providers (EM, Ortho, Neuro, GS, CC) have to maintain board certification or is it only if in place of CME requirement?" (Level 1)

Maintaining current board certification or eligibility for certification is required for all providers who take trauma call in Level I, II, and III trauma centers.

Guidelines for Transferring Patients - Timeframe

"Is there an acceptable time frame in which an accepting facility should provide feedback to the transferring facility?" (Level 3)

There is no requirement on an acceptable time frame to provide feedback. Ideally, you want to provide or receive feedback in a timely manner.

National Committees

"Can you specify the requirement for leadership roles on national committees? Is this only for the trauma physicians?" (Level 1)

This is only a requirement for the TMD.

- *Membership and active participation in regional or national trauma organizations are essential for the trauma director in Level I and II trauma centers and are desirable for TMDs in Level III and IV facilities (CD 5-8).*
- *Acceptable organizations for Level I and II TMDs are, but not limited to:*
  - *Pediatric Trauma Society (PTS)*
  - *American Association for the Surgery of Trauma (AAST)*
  - *Eastern Association for the Surgery of Trauma (EAST)*
  - *American College of Surgeons Committee on Trauma (ACS-COT)*
  - *Western Trauma Association (WTA)*
  - *Society of Critical Care Medicine (SCCM)*
  - *Regional committees on trauma (including past and present region chiefs, state/provincial chairs and vice-chairs, or international chairs).*

Neurotrauma – Diversion vs. Contingency

"How is the neurotrauma diversion plan different from the contingency plan for times in which a neurosurgeon (NS) is encumbered?" (Level 1)

- *When NS primary and backup are encumbered **prior to the arrival of the NS patient—**whether they are in the Operating Room, tied up with another trauma patient, en route and delayed, or there are no available beds—and the trauma center has alerted EMS that they are unable to accept any NS patients, they will need to be diverted to another facility. In this case, the trauma center will need a contingency plan.*
- *When NS primary and backup are encumbered **upon the arrival of the NS patient**—whether they are in the Operating Room or tied up with another trauma patient—and the trauma center is able to accept NS patients, the contingency plans is activated.*

Nurse Certification

"Is there a percent of RN that need to be TNCC trained in the ED for a Level III? (Level 3)

There is no requirement mandating completion of TNCC. The only requirement (CD 17-4) is that there must be a mechanism in place to allow for trauma-related education for nurses involved in trauma care.

While there is not a requirement on nursing education, reviewers will often cite a weakness if the threshold is below 30% in the areas where trauma patients are being cared for.

Orange Book Revisions

"How long would centers have to update to any revisions for the new Orange book if released this year? Reverification purposes?" (Level 1)

The VRC provides a 1-year grace period from the release date of the new Resources manual. For example, the manual is released in January 2020 and a center is due for a visit within that year, it will be reviewed under the Orange book.

Per Diem Trauma Surgeon Peer Review Meetings

"If a per diem trauma surgeon is on call once a month, are they exempt from attending Peer Review if the TMD provides reviews?" (Level 2)

No, they will be held to the same standard and will be required to attend these meetings. As a reminder, the peer review meetings may be attended in person or by phone or video conferencing.

PTSD Screening

"Are there any plans for developing requirements for PTSD screenings for trauma patients?" (Level 1)

Chapter 18 is currently under revision by the workgroup. With that said, presently screening for PTSD is not required. However, if your center sees a large number of patients that suffer from PTSD, reviewers may ask questions as to how those patients are managed and whether or not there is a screening tool. To confirm, if there is not a mechanism in place for PTSD, it will not be cited as a deficiency.

PTSD Screening Tool

"Does the ACS have a preferred PTSD screening tool?" (Level 1)

As stated, PTSD screening is not required. However, if your center performs PTSD screening on trauma patients, there is a document on the VRC Resources webpage on diagnostic criteria and a 17-point checklist that can be utilized as the PTSD screening tool.

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

Social Worker

"Do you have to have a dedicated Trauma social worker?" (Level 1)

"Our Trauma Nurse Navigator works with CM on DC, SBIRT and ASD but we do not have a dedicated SW. Is this acceptable?" (Level 1)

A medical social worker should be available 24/7 in Level I and II trauma centers. However, the VRC does not require them to be dedicated to the trauma program.

Trauma Program Manager

"I am the TPM of a level III trauma center that is in the process of building a 13-bed free-standing ED affiliated with the facility. Does this affect the required staffing of the trauma program? Can a TPM for a level III facility cover more than one building?" (Level 3)

When asking does this affect the required staffing of the trauma program, I believe this to mean in the role of the Trauma Program Manager (TPM). If correct, it does not affect the staffing in that sense. In Level III trauma centers, the TPM does not need to be full-time or dedicated to the trauma program.

Direct Admits

"Is there any criteria for trauma patients who are transferred and directly admitted to the floor and bypass the ED?" (Level 2)

There are no criteria regarding direct admits. The VRC recommends patients who have been transferred in with a full work up at another facility be assessed in your Emergency Department (ED) for the opportunity to identify additional injuries. Should these patients be directly admitted, you want to track and monitor them through the PIPS process.

PALS or BLS

"Do general surgeons have to have PALS/BLS current for ACS verification even if it is not required by the hospital?" (Level 1)

No. The VRC does not have requirements for PALS or BLS.

Hospice

"If a patient is discharged and admitted to in patient hospice (same facility) is this a discharge or death?" (Level 1)

If the patient was admitted to an inpatient hospice unit within the hospital or to an external hospice facility, based on your hospital policy it may be considered a discharge or transfer. The expectation for these cases is that the care of the patient leading up to the discharge or transfer is evaluated through the PIPS process by the TMD and/or TPM. If any issues are found, then it may be reviewed at peer review.

If the hospice patient died while in the care of the Trauma Service, it would be reviewed as a death.

ETOH Screening

"Clarification on the ETOH screening tool: if the patient had an etoh level but was not asked about etoh use does this count as a screening?" (Level 3)

Yes, patients that had an ETOH level counts as the alcohol screening tool.

Alternate Pathway Criteria

"If a surgeon is not trained in the US, but has completed several fellowships in the US, can he take trauma call if he is ATLS?" (Level 3)

U.S. or Canadian non-board certified surgeons who did not train in the U.S. or in Canada, but have completed several U.S. fellowships may be acceptable to participate on the trauma call panel if they have been approved by way of the Alternate Pathway Criteria. Please refer to the Alternate Pathway Criteria Document for more information at, https://www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/resources.

Re-verification Reporting Year

"Is it possible to change the reporting year for an upcoming re-verification review? The reporting year would still be no older than 14 months. For example, the previous reporting year for re-verification review was August to July, can we change this to September to August?" (Level 2)

This will depend on when the visit is scheduled for. Given the date span above, if the visit is scheduled for October or November, you may use the reporting period of September through August.

This reporting year would be the same for any type of visit, e.g. consultation, verification, or focused.

Verification Site Visit

"Is there a new format for choosing PI charts before the site reviewers visit?" (Level 2)

No. We launched a chart pilot project with a small group of trauma centers. The pilot project concluded in 2018, and results will be presented at the Annual COT Meeting.

Nurse Reviewer on Site Visits

"What is the role of a trauma nurse surveyor ?" (Level 1)

The nurse reviewer or surveyor (terms are interchangeable) on a site visit is typically assigned the following sections of the PRQ: TPM, Trauma Registry, Advanced Practitioners, Education/Outreach, Prevention and PIPS.

Nurse reviewers are detailed oriented and as your peer, they will review:

- *Nursing practice as it pertains to your hospital policy*
- *Shared best practices*
- *Standards of Care*
- *Documentation*
- *Provide recommendations on how to improve the trauma program and performance improvement*

Chart Reviews

"What do you do when you don't have 10 charts for a particular topic (ie Mortality with opportunity) for verification reviews?" (Level 1)

For categories that you do not have a minimum of 10 charts, pull what you will have at the time of the site visit. The charts can be a mixture of those that demonstrate your PI process and some that do not. This is true for all type of site visits, e.g. consultation, re-/verification and focused.

Chart Reviews

"I just wanted to clarify for our upcoming focus review—we need to pull 10 of each of the categories of charts just as we did for the initial review, correct?" (no level)

For focused reviews, the categories and number of charts are dependent on what was cited as deficiencies and when the changes were implemented leading up to the site visit. It is conceivable that the number of charts may be close to that of the initial review.

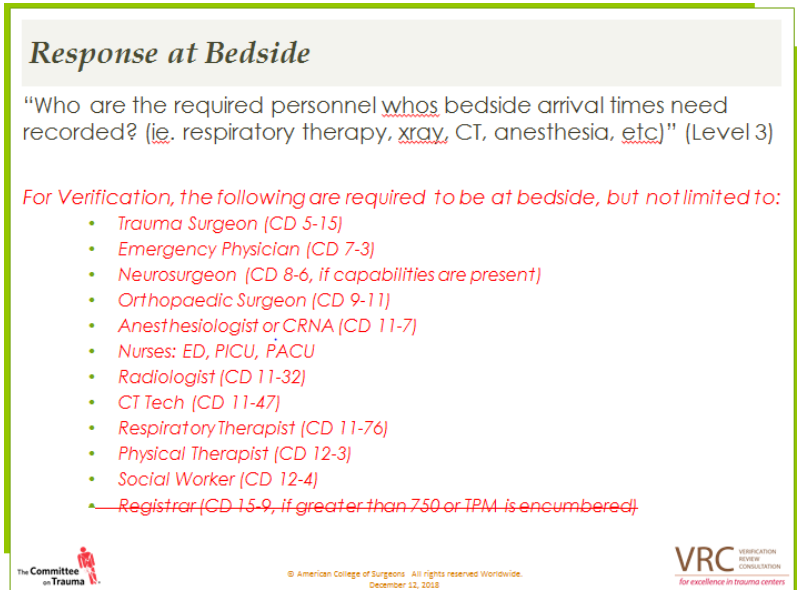
As noted in the previous slide, if you do not have 10 charts for each of the categories, pull what you will have at the time of the focused visit. Additionally, if you have a polytrauma case, do not copy the chart, just flag it and place it in whichever category you believe is most appropriate.

Trauma Alerts

"Is a registrar supposed to attend trauma alerts, as suggested by last month's webinar?" (Level 2)

Who responds to trauma alerts will depend on the hospital's guidelines.

In respect to the question submitted during the December webinar, the question submitted was what personnel arrival times need to be recorded/documented at bedside. The line on the registrar was corrected.



Response at Bedside

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

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

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

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CD-Related Questions

Transfers (CD 4-3)

"The Dec webinar slide 54 says to review transfers in and out, but the clarification document p4 states 'transfers out' - help!"(Level 2)

The trauma center must perform a PIPS review of all transfers (CD 4-3).

- *All transfers in & out must be reviewed*

The list on page 33 of the Resources manual titled receiving physician responsibilities provides a general framework for a PIPS process, including feedback to the referring facility. Key elements of review might include:

- *Communication (MD – MD) prior to transfer*
- *Trauma team response, e.g. awaiting upon patient arrival*
- *Any OFI occurring at the sending hospital, en route, or at your facility*
- *Feedback to the sending hospital regarding care rendered prior to transfer, and outcome at your facility*

These are only possible examples. The PIPS process should be developed in a manner that best suits the needs of both the transferring and receiving facilities.

OPPE (CD 5-11)

"Regarding the OPPE slide in the January webinar, what services would you expect to see an OPPE on: NRS, ORT? What about RAD, ANES and EM?" (Level 1)

Great question. The intent is that all panel members who care for trauma patients have an OPPE conducted. That will include Radiology, Anesthesia and Emergency Medicine. The TMD does not need to perform the OPPE on these panel members, but s-/he must have oversight in the process to ensure they are compliant with verification requirements.

Highest Level of Activation (CD 5-14)

"Who is required to respond to the highest level of activation?" (Level 1)

- *The team composition for the Highest Level of activations will vary by Institutions and may be comprised of any of the following, but not limited to:*
  - *ED physician*
  - *Trauma Surgeon (required)*
  - *Nurses*
  - *Scribe*
  - *Resident*
  - *Anesthesia*
  - *Pharmacists*

Limited Tier Activations (CD 5-16)

"For the Level II activations, once the trauma surgeon is notified, do they have 30 minutes to respond to the bedside?" (Level 2)

The institution will define the time and injury expectation for when the Trauma Surgeon (adult or pediatric) will respond for the Limited Tier activations, that being your Level II activations. Most centers have a metric between 30 minutes up to 6 hours based on the mechanism of injury. The most important thing will be to monitor the metrics through the PIPS process to ensure the center is adhering to its policies.

Limited Tier Activations (CD 5-16)

"Do surgeons need to see Level II trauma activations within 30 minutes, if the patients has been in the ED for a period of time and the workup has already been completed, when they are notified?" (Level 2)

As previously mentioned the institution will define the response time for the Limited Tier activation for the Trauma Surgeon (TS) to respond to injured patients. If the trauma center imposed a 30 minute response time for the TS to respond to your Level II activations, then it will be expected that the TS sees the patient within that timeframe.

Limited Tier Activations (CD 5-16)

"For Level II activations, is it ok to have the ED physician respond and only page out trauma surgeon if needed?" (Level 2)

It is perfectly acceptable for the Emergency Department Physician to respond to the Limited Tier (Level II activations). However, the center must have criteria for when the Trauma Surgeon is expected to respond to the Limited Tier activations.

TPMs for Combined Centers (CD 5-23)

"If you are a combined Level 1 Adult and Level 2 Pediatric, do you have to have 2 separate Program Managers?" (Level 1)

Yes. In verified adult Level I and Level II pediatric trauma centers, there must be 1 FTE Trauma Program Manager dedicated to each program. The pediatric program may have a Pediatric Trauma Coordinator (TPC) and this person may have additional duties as long as it does not encumber their duties as the TPC such as, Trauma Registrar for the pediatric program or the Injure Prevention Coordinator.

Chair of Trauma Peer Review Meeting (CD 5-25)

"Dec webinar says TMD or assoc TMD must chair all PI meetings, but Jan states TMD has to be at 50% of meetings. - please clarify"(Level 2)

Let us clarify, the December webinar said "The TMD or Associate TMD must chair the Trauma Peer Review Meeting. There is no alternate representative that will satisfy this criteria." For the other specialty members, an alternate member of their team may be appointed to attend the peer review meetings in which their combined attendance must equal 50%. Whereas, the TMD cannot appoint an alternate so s-/he must chair and attend 50% of these meetings. For example, the trauma center has 12 meetings a year, the TMD must chair and attend 6 of those meetings to be compliant. The Associate TMD which is typically another Trauma Surgeon may chair the other six meetings, but that surgeon's attendance cannot be combined with the TMD's attendance.

Neurosurgery Diversion (CD 8-4)

"If the facility does not have a neurosurgeon available, does the facility need to go on diversion?" (Level 2)

If the on-call neurosurgeon is encumbered, the trauma center must have a diversion plan to divert the patients. This must include:

- *Emergency medical services notification of neurosurgery advisory status/diversion.*
- *A thorough review of each instance by the performance improvement and patient safety (PIPS) program.*
- *Monitoring of the effectiveness of the process by the PIPS program.*

Neurosurgery Board Certification (CD 8-10)

"We are considering onboarding another neurosurgeon that is boarded through AANS (American Academy of Neurologic Surgery) and not through the American Board of Neurological Surgery or American Osteopathic Association as referenced on pg 55 in the orange book. Does the ACS recognizes the American Academy of Neurologic Surgery for board certification? I verified it is recognized by the ABMS but wanted to make sure the ACS didn't exclude it." (Level 2)

The AANS is recognized as a surgical membership organization rather than a certifying body. As such, it would not satisfy the requirement for neurosurgical board certification.

Orthopaedic Surgeon Board Eligible (CD 9-17)

"If an Orthopedic Surgeon is board certified eligible, is this acceptable for caring for trauma patients?" (Level 2)

Yes, having a board eligible for certification for any of the specialty panel members and trauma surgery are expectable to care for trauma patients.

Board Certification Anesthesia and Radiology (CDs 11-11 and 11-43)

"Do all the anesthesiolgist and radiologist have to maintain board certification in a Level I center or just the liaision?" (Level 1)

It is not required for all members of the Anesthesia and Radiology panel to maintain board certification. Board certification or eligibility for certification is required for the Anesthesiologist Liaison (CD 11-11) and the Radiologist Liaison (CD 11-43) who take trauma call in Level I and II trauma centers. Refer to the Verification Change Log for updates on these two standards.

ICU Director (CD 11-53)

"Must the TMD also be medical director over the ICU?" (Level 2)

The TMD is not required to also be the director of the ICU. In a Level II trauma center, there must be a board certified [general] surgeon appointed as the ICU director. This surgeon is not required to be boarded in Surgical Critical Care.

ICU Director (CD 11-53)

"Our facility has a separate trauma ICU, with occasional overflow from the med-surg ICU. Daily rounds and administrative decisions are managed by trauma surgeons that are boarded in critical care. Regarding CD 11-53, can the TMD also serve as the surgical director of the ICU or does it have to be a separate surgeon?"

(Level 3)

In Level II and III trauma center, the TMD may also serve as the ICU director. The TMD is not required to be boarded in Surgical Critical Care.

ICU Emergencies (CD 11-56)

"Can telemedicine ICU and hospital medicine meet initial response to trauma emergency in ICU while surgeon is enroute?" (Level 3)

Telemedicine is not an acceptable method of consult. The requirement is that a credentialed provider must be available in person at bedside within 30 minutes at a Level III trauma center. Refer to the ICU Coverage Constellations Table in the Resources manual on page 81.

Microvascular Surgery (CDs 11-70 and 11-71)

"Please clarify the criteria for microvascular surgery since there is no board certification for this specialty. Is this under the purview of plastic surgery, hand surgery, vascular surgery, or any surgical specialty that utilizes a microscope during surgery? Are there any particular requirements, such as a certificate or proof of education in microvascular surgery? This surgical specialty is required for Level I and Level II centers and is a Type II deficiency."

(Level 2)

The intent is that the center have microvascular capability. The requirement is satisfied if the center has a surgeon who can use an operating microscope for nerve repair, free tissue transfer, free flap, 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 within a predetermined time.

Ophthalmology (CD 11-71)

"As a level II, is it acceptable to have only partial call for Ophthalmology if there are transfer agreements in place?" (Level 2)

I'm not entirely sure what partial call is so we will be contacting this person for more information.

The requirement for other surgical specialists, e.g. Ophthalmology, is that there must be a provider available to respond in person when requested by the Attending Surgeon within a predetermined time. The capability is not required in-house 24/7.

Registrar Education (CD 15-7)

"Do trauma registrars at Level 1 trauma centers need continuing education credits? Or is it just TMDs and TPMs." (Level 1)

Trauma registrars should have continuing education, but are not required to have it.

Yes, the TMD and TPM are required to have continuing medical education/continuing education.

Registrar Admissions (CD 15-9)

"Is the FTE requirement for registrars pertaining just to data submitted to NTDB/TQIP, or all patients entered into the registry?" (Level 3)

Currently, the requirement is based on the number of trauma admissions. It is not based on data points for submission to NTDB or TQIP.

Alcohol Screening (CD 18-3)

"Level III SBIRT - does there just need to be a question for consumption? Does the question need to pertain to current intoxication" (Level 3)

"Could the physicians dictated note----'patient denies ETOH use' be used in place of the CAGE screening?" (Level 2)

For all trauma centers, the facility will determine a validated screening tool.

Having a physician's dictated note will not be acceptable. The screening tool does not need to be CAGE, but must be done by a validated screening tool.

Research *(CDs 19-1 and 19-4)*

"Research requirement- if there is a multisite study can both sites use the paper to count towards the research requirement?"(Level 1)

"If clinicians from multisites participate in research but the patient population is only from one site- can it count for both?" (Level 1)

The terms multicenter and multisystem are used interchangeably within the verification program. The trauma centers that will be involved in a multicenter/multisystem research project, must involve members of the trauma team or specialty surgeons and include data from both facilities. The Trauma Surgeons or specialty surgeons from both facilities must be listed as authors.

Research (CDs 19-1 and 19-4)

"At a combined Adult and Pediatric Center where they wish to be Adult Level I and Pediatric Level I, can you explain the criteria for research?

The Clarification Document notes…

- '10 PTC I - In combined Level I adult and pediatric centers, half of the research requirement must be pediatric research (CD 10–11). TYPE II Refer to the VRC research statement at the end of the document'

If a center desires to use the alternate method of 10 peer-reviewed articles and 7 scholarly activities, would this mean that there would need to be 5 articles for Pediatrics and 5 from Adults?

Also should we assume that none of these articles can overlap (one article count twice, once for adults and once for pediatrics) even if the study includes pediatric and adult patients?" (Level 1)

Research (Continued)

To clarify "combined" centers, these are hospital within a hospital or connected via a tunnel or walkway.

In a combined adult Level I and a pediatric Level I center, each program must have 20 peer-reviewed articles published in journals included in PubMed in a 3-year period. For the pediatric program half must be pediatric specific and the other half may overlap with the adult articles.

In a combined adult Level I and a pediatric Level I center utilizing the Research Alternate Pathway, each program must have 10 peer-reviewed articles published in journals and 4 scholarly activities. The articles cannot overlap; however, it is conceivable that the scholarly actives may overlap between the two programs.

Research (CDs 19-1, 19-4 and 19-7)

"Can the ACS further clarify CD 19-4? The clarification document states, '…may include 1 article from Acute Care Surgery.' How many articles count towards the requirement from Acute Care Surgery? Is it unlimited like the other disciplines? We have an two separate articles on general surgery topics that do not include trauma patients that originated at an AAST & EAST meeting. Would we be able to include both of them or only one?" (Level 1)

Only 1 article from Acute Care Surgery may be counted towards the requirement. All the research articles must result from work related to the trauma center or the trauma system in which the trauma center participates.

Research (CD 19-7)

"Can you comment on alternate pathway for research requirement? How many of those alternate requirements must be fulfilled?" (Level 1)

For the Research Alternate Pathway, the center must have 10 peer-reviewed articles authored by members of the trauma team and specialty members, and must include 4 scholarly activities, refer to page 145 for the listing.

CME

MOC

"What evidence is required during the site survey to confirm MOC compliance? Does the current board cert satisfy this requirement" (Level 1)

Yes, current board certification or eligibility is sufficient.

CME

The reviewer suggested there be CME/IEP however this is no longer a requirement. Is the expectation we go above and beyond what is now required because it was a weakness on our review in 2016 ? (Peds, Level II)

You will not be cited a CD for not having CME/IEP (excluding TPM, TMD, and alternate pathway). To address this weakness, you can exclude the CME/IEP component and say how the trauma center addresses lapse of knowledge in the care of pediatric trauma patients.

Thanks for your participation!