

# Trauma Verification Q&A Web Conference

August 28, 2019

[COTVRC@facsc.org](mailto:COTVRC@facsc.org)



AMERICAN COLLEGE OF SURGEONS

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



**VRC** VERIFICATION  
REVIEW  
CONSULTATION

*for excellence in trauma centers*

# Your Trauma Quality Programs Staff



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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](mailto:COTVRC@facs.org)
- ❖ **CE Eligibility will expire on Sunday, September 15**
  - ❖ You must watch the webinar prior to September 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.*

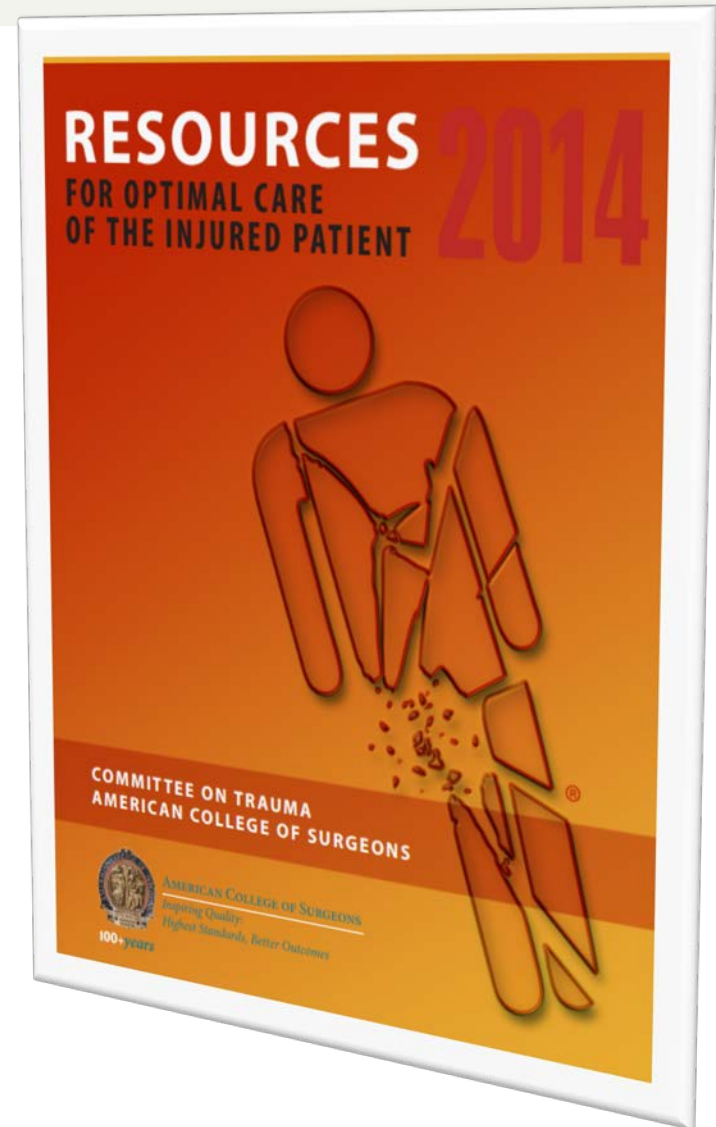
*Let's get started!*

# 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/tqp/center-programs/vrc/resources](http://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

V15\_ 4/15/19 2019

[www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/resources](http://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](http://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 September 2019

# *Announcements*

# TQIP Annual Scientific Meeting and Training

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

**Reserve your hotel room!**

- Make your hotel reservations now at the host hotel, the Hilton Anatole
- For more information, visit the TQIP Annual Meeting website:

[www.facs.org/TQIPMeeting](http://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/tqp/center-programs/tqip/meeting/workshops>

# New Course!!

Introducing a NEW course...



## Advancing Leadership in Trauma Center Management

*A multidisciplinary approach to  
leading your trauma program to excellence*

Launching at the

TQIP Annual Scientific  
Meeting and Training  
November 16-18, 2019 Hilton Anatole, Dallas, TX



100+years

AMERICAN COLLEGE OF SURGEONS  
Inspiring Quality:  
Highest Standards, Better Outcomes

**SAVE  
THE  
DATE!**

**November  
14-15,  
2019**

*Hilton Anatole  
Dallas, TX*

[facs.org/tqip](http://facs.org/tqip)

- [www.facs.org/ALTCM](http://www.facs.org/ALTCM)
- Email us at [ALTCM@facs.org](mailto:ALTCM@facs.org)

# *Next Verification Q&A Webinar*

Webinar Date: **Thursday, September 26th**

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

Deadline to submit questions: **Friday, September 6th**



# *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](mailto:cotvrc@facs.org) with your suggestions today.

Future topics may include:

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

# Reminder

PRQ Question in Chapter IX: Orthopaedic Surgery, question 18.c.

- How many of these patients had neurological deficits?
  - *Centers may skip and leave this question blank.*

18. The number of operations performed at this institution during the reporting year for pelvic ring and acetabular fractures secondary to a trauma mechanism, excluding isolated hip fractures:

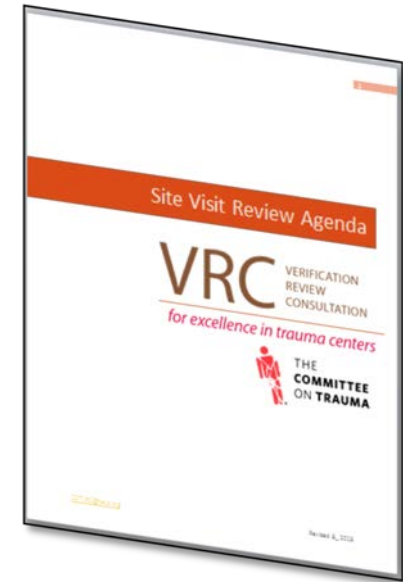
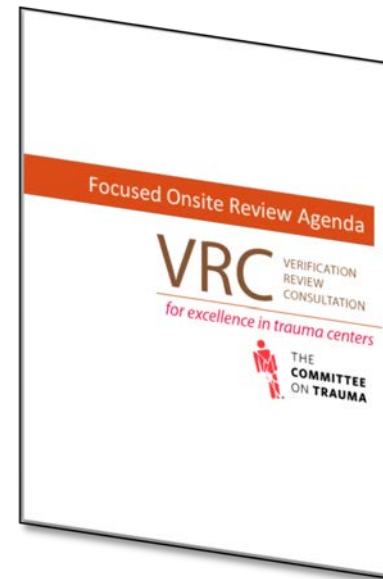
a. Pelvic ring injuries:

b. All acetabular fracture patterns:

c. How many of these patients had neurological deficits?

# Site Visit Review Agenda

- *New look*
- *Updated list of materials required onsite*
- *Revised chart categories (more prescriptive)*
- *Pending VRC approval*
- *Effective after January 2020*



# *Special Segment: PRQ for adult and pediatric admissions*

## *In this segment, we will...*

- Discuss Chapter X: Pediatric Surgery - expectations when completing the PRQ.
  - “What if I’m only pursuing adult verification?”
  - “What if I only admitted a few children?”
  - “What if I had a combined visit?”
  - “What questions do I even answer?”

# Purpose of Site Review

Facility treats what type of patients:

Adult - age = or > 15 years

Children - age < 15 years

Adults only

Children only

Adults and Children

Select One

- **Adults Only** – Program admits only adult patients (15 years old or above), with no pediatric admissions during the reporting year.
- **Children Only** – Program admits only pediatric patients (14 years old or below), with no adult admissions during the reporting year.
- **Adults and Children** – Admitted both adults and pediatric patients during the reporting year.

# Online PRQ

Facility treats what type of patients:

Adult - age = or > 15 years

Children - age < 15 years

Adults only

Children only

Adults and Children

Select One

- Based on the selection above and program level (I, II, or III), the PRQ will display questions that are specific to your program.

## *“What if I’m only pursuing adult verification?”*

- If any pediatric patients (<15) were admitted during the reporting year, the “Purpose of Site Review” selection will be **Adults and Children**.
- All pediatric patients that were admitted to your trauma center during the reporting year must be reported.
- Chapter II statistical tables should contain your *combined* adult and pediatric data. You will report the pediatric-specific data in the statistical tables in Chapter X. Pediatric Surgery.



# *“What if I only admitted a few children?”*

- You must report on pediatric admissions regardless of the number of children admitted.
- If your facility admitted 100 or more injured children during the reporting year and is **NOT** seeking pediatric verification, additional criteria apply.

5. Did your trauma program admit 100 or more injured children younger than 15 years of age during your reporting year? (CD 2–23) Type II / L1-3	<input type="radio"/> Yes <input type="radio"/> No
i. If 'Yes', are the following present (CD 2–24) Type II / L1-3:	
a. a pediatric emergency area	<input type="radio"/> Yes <input type="radio"/> No
b. a pediatric intensive care area	<input type="radio"/> Yes <input type="radio"/> No
c. appropriate resuscitation equipment	<input type="radio"/> Yes <input type="radio"/> No
d. a pediatric-specific trauma PIPS program (CD 10-6 / Type I / PTC1-2)	<input type="radio"/> Yes <input type="radio"/> No

# *“What questions do I even answer?”*

For adult trauma centers that admitted pediatric patients during the reporting year and are **NOT** seeking pediatric verification, the following must be completed in Chapter X. Pediatric Surgery:

- Section A, Question 1: “Define the age of the pediatric patient at your institution”
- Section B, Splenic Injuries
- Section C, Pediatric Trauma Admissions
- Skip all other sections in this chapter and go to Chapter XI. Collaborative Services

## Section A, Question 1: “Define the age of peds patients”

### A. Pediatric Nursing

1. Define the age of the pediatric patient at your institution:

**Note: ACS requirement is less than 15 years of age. For completing of data tables in this section only include pediatric totals for patients < 15 years of age.**

Note:

For freestanding pediatric centers—although we ask to report data for patients admitted less than 15 years of age, we ask that if your center admits patients 15 years of age and older, to include a few of their medical charts during the onsite review.

# Section B, Splenic Injuries

## B. Splenic Injuries

4. Pediatric patients (<15 years of age) admitted with splenic injuries during the reporting year

Grade of spleen Injury	# of Splenic Injuries	# Undergoing (IR) Embolization	# of Splenorrhaphy	# of Splenectomy
Grade I				
Grade II				
Grade III				
Grade IV				
Grade V				
TOTALS				

# Section C, Pediatric Trauma Admissions

## 7. Pediatric Trauma Admissions (CD 2-25, CD 10-1, CD 10-2) Type I / PTC1

Service	Number of Admissions
Pediatric Trauma Surgery	
Orthopaedic	
Neurosurgical	
Other Surgical	
Burn	
Non Surgical	
Total Pediatric Trauma Admissions	

## *Pediatric Care at an Adult Facility (CDs 2-23, 2-24, 2-25)*

If you are an **adult center** that admitted **more than 100 pediatric patients** (not seeking pediatric verification), you must ensure all of the following are available:

- Credentialing process for trauma surgeons to provide care for pediatric patients
  - Examples are, but not limited to: PALS, pediatric trauma CME, pediatric fellowship, or documentation of performance through PIPS
- A pediatric ED area
- A pediatric intensive care area
- Appropriate resuscitation equipment
- A pediatric-specific PIPS process

These resources are not required in **adult trauma** centers that admitted **fewer than 100 pediatric patients**. However, care of injured children must be reviewed through the PIPS process.

## *“What if I had a combined visit?”*

- **Level I Adult, Level I Pediatric** – Separate PRQs will be issued for each of the programs. The adult data must be confined to the adult PRQ, and pediatric data to the pediatric PRQ.
  - The same would be true if the visits were scheduled at different times.
- **Level I/II Adult, Level II Pediatric** – One PRQ will be issued for both adult and pediatric trauma programs. The Chapter II data tables will contain both adult and pediatric data, and the pediatric-specific data must be reported in the statistical tables in Chapter X. Pediatric Surgery, and complete the **ENTIRE** pediatric chapter.

# Correction



# Alcohol Screening

“Last month there were 2 different slides referencing Alcohol interventions and screenings. One stated pt's admitted to medicine for a syncopal workup, and have traumatic injuries does not require an SBIRT evaluation, and the other one states non-surgical admissions require interventions regardless of service if a trauma patient. If both meet criteria for the trauma registry please clarify how one meets criteria for intervention and the other one doesn't. There admission reason has to be for the trauma?” (Level 1)

*Alcohol Screening (CD 18-3)*

“SBIRT: We frequently have patients admitted to medicine for a "syncopal" work-up that may have a diagnosis of laceration, concussion, non-surgical injury that in and of itself would not require admissions. Do these patients still need SBIRT?” (Level 2)

*No. As these are not trauma patients, these would not require evaluation under SBIRT to maintain compliance.*

the Committee on Trauma

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*If these patients met your center's inclusion criteria and were admitted with a stay >24 hours, they would be required to receive a screening for alcohol use. Additionally, if the patient is unresponsive or in an altered mental status, the patient would not be required to receive a screening for alcohol use.*

# *General Questions*

# *Combined Trauma Centers*

“What is the difference between a combined adult and pediatric trauma center and a separate Adult and separate Pediatric trauma center (when all in same building)?” (Level 1)

*The terms “combined” and “separate” both refer to an adult and pediatric program that are independently verified. This can be achieved during a simultaneous visit (referred to as a “combined” visit) or as separate visits.*

*Combined trauma centers are defined as adult/pediatric facilities that are either housed in the same building or connected (via a tunnel, walkway, or short distance).*

# *Open Fractures*

“When looking an the open fracture/IV antibiotic time, should I be tracking all open fractures such as fingers and facial bones, or just the tib/fib, as asked for in the PRQ? Thank you!” (Level 3)

*For purposes of reporting this data in the PRQ, the data that is being requested is for tibial shaft fractures only. It does not include ankle, facial, nasal, finger, pilon, amputations, plateaus, etc.*

# *Transfers Feedback*

“Is follow up/ feedback information still required for patient/family request for transfers to another trauma center? What is the standard surrounding patient request for transfer? Requests for patient clinical information is being asked by the receiving trauma center on transfers initiated by the patient. Shouldn't the receiving hospital request for patient's consent first? Thank you.” (Level 1)

*Currently, there are no standards regarding feedback to or from the receiving facility. In this scenario, you may want to check with the medical staff bylaws and/or your transfer protocols.*

# *Site Visit Reporting Period*

“If the ACS survey is due December 2020, when would the record review period start in 2019?” (Level 2)

*Per the verification process, it is defined as a 12 month period plus a 2 month lag, which should not exceed 14 months from time of the visit. For example, a visit in December, 2020, the reporting period would be any of the following:*

- October 1, 2019, to September 30, 2020*
- September 1, 2019, to September 1, 2020.*

# *Site Visit Reporting Period*

“If my survey is the first week of the month of November and PRQ due October 4, would you consider the data period from Aug 1 2018-July 31 2019 or would it be acceptable to use July 1, 2018- June 30, 2019? This would give us a month to get the data in for patients admitted on June 30th and possibly not discharged for a few weeks and be able to perform the calculations/charts on those admissions.” (Level 1)

*Per the verification process, the acceptable timeframe for a visit in November would be any of the following:*

- *August 1, 2018 to July 31, 2019*
- *September 1, 2018 to August 31, 2019.*

## *Site Visit Medical Record (Chart) Prep*

“If 10 medical records for a specified category are not available, I.e. we only had 7 patients with "Spleen and liver injuries: Grade III or higher and requiring surgery, embolization, or transfusion." Will the reviewer need to pull from a longer time period than the reporting year?” (Level 2)

*No, this will not be necessary. For each category, you will only pull the number of cases that you actually had during the reporting year even if it is not the quantity being requested.*



## *Activations - Limited Tier*

“Can an advanced practitioner respond to a limited-tier trauma activation in lieu of the trauma surgeon?” (Level 2)

*No, this would not be admissible. To clarify, the trauma APP may serve as the initial responder as long as they are credentialed to do so per your institutional criteria, but cannot be used in lieu of the attending surgeon. The attending surgeon must still respond at bedside within the time frame set by the institution.*

# *Activation Criteria*

“Patient has an isolated hip fracture but upon Ortho evaluation there is a possible facial fracture and the Ortho surgeon calls the Trauma surgeon for evaluation. Can this scenario be charged as a Level II activation because the Ortho surgeon called the Trauma surgeon and the Trauma surgeon came to evaluate the patient.” (Level 2)

*The VRC cannot speak to activation fees. However, if the question relates to triggering activations, then the following applies.*

*Based on the description provided, the patient came in with an isolated injury, was seen by the orthopaedic surgeon, whereby additional injuries were identified, and the attending surgeon was called to perform a surgical evaluation. This sounds more like a consultation and not a Level II activation.*

## *Activation Tier – Cancel*

“Once a Trauma is activated, can you cancel it?” (Level 3)

*While the VRC acknowledges that “cancelling” or “downgrading” activations may occur, this practice and occurrences must be closely monitored and reviewed through the PIPS process. Additionally, the program must continuously evaluate activation criteria for appropriateness and effectiveness. If this is a recurring issue, it may be indicative of opportunities for improvement with the center’s activation criteria.*

# *Backup Trauma Surgeon*

“If a Trauma surgeon is on back-up call at a Level II center, can they be primary call at a non-trauma at the same time?” (Level 2)

*Yes, they may be on call at a non-ACS or non-trauma center. The center must ensure it has a second backup call in the event the “backup surgeon” is encumbered at the non-trauma center.*

# *Trauma Surgeon Response*

“Level 1 or 2 Does the arrival time of the mid-level provider count as the trauma surgeon, ortho surgeon, or neuro surgeon arrival time for level I or II activations?” (Level 2)

*No, this will not count for the attending surgeon's response. As previously reported, for the highest tier of activation, the attending surgeon must respond within 15 minutes. For the limited tier of activation, the trauma APP (mid-level provider) may be the initial responder, as long as they are credentialed to do so based on the center's policy. However, based on the set policy, the attending surgeon must still respond to injuries that require a surgical evaluation within a predetermined time for specific injuries.*

# *PIPS Review*

“Level I or 2 If a patient presents with a traumatic injury, a level III consult is activated, the patient is evaluated in the ED by the neuro surgeon and the patient goes home from the ED and does not meet the hospital inclusion criteria but does have a neuro dx, does this record need to be reviewed by the PIPS process as those that were admitted and met inclusion criteria?” (Level 2)

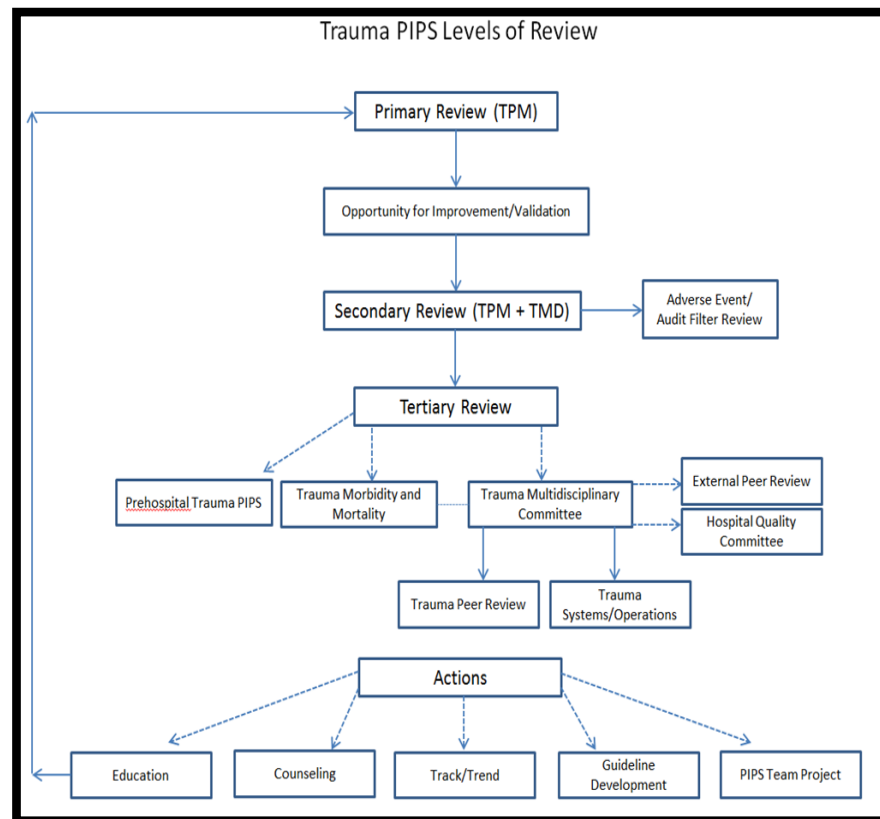
*For verification purposes, you want to ensure all patients that have been activated are reviewed through the PIPS process to ensure appropriateness of care. A primary review may be performed by the TPM and/or PI coordinator, and may not necessarily rise to the level of the TMD's review unless there was an opportunity for improvement.*

# Trauma Mortality Review

“We participate in a hospital-wide mortality review. Do we still need to generate a hard copy and have the Trauma Medical Director sign a copy for our surveys?” (Level 1)

*For best practices, the trauma program must conduct a review of all trauma deaths (CD 16-6). Following this review it may be reported to or integrated with the hospital-wide mortality review.*

*There must be documented sign-off by the TMD on the trauma death cases.*



# *Patient Mortality - Hospice*

“If a patient is admitted to the trauma service and is discharged to hospice, is that patient a mortality for the trauma service?” (Level 1)

*Patients discharged to hospice after admission to the trauma service may be reported as a discharge/transfer (based on your hospital's policy) since the patient technically did not die while on the Trauma Service. If the patient died while in the care of the Trauma Service, it would be reviewed as a death.*



# *Alcohol Screening*

“Can you clarify the SBIRT for non-surgical admissions? If the patient meets inclusion criteria to the registry shouldn't they be screened?” (Level 2)

*Yes, this is correct. Any trauma patient admitted with a stay > 24 hours, regardless of the service they are admitted to, must receive a screening for alcohol use. This would extend to non-surgical patients with a traumatic injury.*

# *Alcohol Screening Report*

“Is it acceptable to have the InSight Department report out percentages of screening completion or does this need to be entered into and query able through the registry?” (Level I)

*If the InSight Department’s program is integrated with the trauma program this is acceptable. You may want to consider how easily accessible the data is when you are running reports on the patients that received an alcohol screening. If this practice impedes the trauma program from accessing the data or running reports, it may not be the ideal situation.*

# *Acute Transfers*

“Can you clarify 'acute transfers out' please. We do not transfer out for any services, or any acute issues. All transfers are patient/family request. but they may occur from ICU to ICU. Should we consider these acute transfers or not?” (Level 1)

*Based on this description, these would not be considered acute transfers out. Ideally, Level I trauma centers would not necessarily transfer patients out for acute care, unless the center did not have specialized equipment or services to care for the patient, such as burn services, reimplantation, or pediatric trauma care.*

# *Podiatry*

“Our trauma center has a new podiatry service, and has surgery and admitting privileges. Orthopedic surgery services are also available, with an identified liaison as required. This has created some discourse between the two surgical services. I see no reference regarding podiatry in the Orange book; would podiatry be considered a surgical service?” (Level 3)

*The verification program's position is that podiatry is not a surgical service.*

# *Response Time Documentation*

“Our ICU Physicians are in-house 24/7. They respond immediately to ICU patients/issues. How does one demonstrate this? they may not always write a note to indicate that they were at the bedside.” (Level 1)

*In addition to self-reporting, a scribe or a badge scanning system are potential options to demonstrate physician arrival.*

# *Chapter Revision*

“My TMD is stating the requirement to document arrival of neurosurgery will be changing to reflect time from arrival to time to OR for emergent procedure rather than MD arrival to bedside. Can you clarify this?” (Level 1)

*With regard to the chapter revisions, we cannot confirm any changes to the standards as they need to go through an approval process.*

*All information regarding new standards will be distributed after the chapter review process has been completed.*

# *Chapter Revision*

“Any idea when new registry staff ratio's and requirements will be out?” (Level 2)

*We do not have a date to provide at this time. All information regarding new standards will be distributed after the chapter review process has been completed.*

# *Death on Arrival (DOA)*

“The Orange book defines DOA as ‘pronounced dead on arrival with no additional resuscitation efforts initiated in the emergency department’. The trauma verification Q&A web conference on June 8, 2016 says DOA is defined by the hospital. If we were to define DOA it would include CPR in progress on arrival and continued in the ED, verifying or placing a definitive airway, needle decompression as indicated, FAST for cardiac activity followed by cessation of effort for lack of ROSC and time of death. Would CPR, intubation and needle decompression not be considered additional resuscitation efforts in the ED and the patient would become DIED as opposed to DOA based on the definitions in the Orange book?” (Level 2)

*The intent of the statement in the Orange Book was to provide a basic guideline to define DOA. However, each trauma center will define its criteria for classifying DOA.*



# DOA

“Scenario: A patient arrives to the ER with CPR in progress, and while in the ER, we achieve ROSC but minutes later the patient again goes into cardiac arrest and is eventually pronounced dead. For death data purposes, should this patient be deemed as "dead on arrival"? Thanks!” (Level 2)

*How this patient would be categorized would be determined by the trauma program's DOA criteria. The VRC does not have a specific requirement on this issue.*

## *Social Worker*

“Looking for clarification on the requirement for social worker/case manager dedication to the Trauma Service as part of the multidisciplinary team. Is this a must have or a nice to have?” (Level 2)

“What is the ACS requirement for social work response to trauma team activations?” (Level 2)

*While medical social workers should be available 24/7 at Level I and II trauma centers, this is not a requirement for verification. Therefore, there is not a requirement for social worker response times.*

# *Advance Practice Providers (APPs) ATLS*

“Do ED APs need to be current in ATLS if they are responding to second tier trauma activations?” (Level 1)

*For any tier of activation, all trauma APPs who participate in the initial evaluation and resuscitation of trauma patients must demonstrate current certification as an ATLS provider.*

# *Surgical Coverage*

“What is the expectation for Surgical coverage for a Level 3 facility? How many days out of the month?” (Level 3)

*A Level III trauma center must have continuous general surgical coverage (CD 2–12). There is no set number of cases, but it must be continuously (24/7/365) available when needed.*

# PRQ - Payer Mix Table

“ Could you please clarify the use of "Medicare" or "Commercial" when a patient has Medicare Advantage (not straight Medicare) insurance? Which do we choose? Thank you.” (Level 3)

*For verification, the payer mix will be updated following the chapter revision process. For the time being, if the insurance does not fit any of the options provided, you may select what you believe to be the most appropriate.*

**B. What is the hospital Payer Mix (use whole numbers, do not include percent sign):**

Payer	All Patients (%)	Trauma Patients (%)
Commercial	<input type="text"/>	<input type="text"/>
Medicare	<input type="text"/>	<input type="text"/>
Medicaid	<input type="text"/>	<input type="text"/>
HMO/PPO	<input type="text"/>	<input type="text"/>
Uncompensated/Indigent	<input type="text"/>	<input type="text"/>
Other	<input type="text"/>	<input type="text"/>
Total	100%	100%

## *PRQ - Burn Patients*

“According to the Orange Book, bottom of pg 100, it states “Burn patients who are transferred externally to a burn center or internally to a burn service should not be included in the trauma registry or be counted in the total trauma population”, but the PRQ asks questions pertaining to Burn pts. If we are not capturing this data in the registry, how are those PRQ questions going to be answered? Should we keep a separate spread sheet with this information? My facility doesn't have a burn center, so all of our burn pts get transferred out.” (Level 3)

*The expectation is that burn patients with a mechanism of injury (MOI) should be captured in the trauma registry and may be included in the total trauma [admission] volume. If your center does not admit burn patients, we would like you to report the number of those patients that were transferred out for burns in the reporting period recorded in the “Transfer Out” table.*

# *CD-Related Questions*

# OPPE (CD 5-11)

“What does the ACS expect/require from Level 2 centers regarding FPPE/OPPE. I know this is a repeat question, still unsure how to meet this requirement.” (Level 1)

*There are a few examples for OPPE on the VRC resources repository website. The expectation is that the TMD is conducting the OPPE and has a process (score card/template/report) available to present on site, if asked.*

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

*To clarify, the TMD is not required to perform an OPPE on all the other surgeons who provide trauma call, such as Orthopaedics, Neurosurgery, etc. The Directors or Liaisons from those service are expected to perform an OPPE for their panel members. With this said, the TMD should have oversight on what the OPPE process contains relative to the trauma program.*

*An alternative that some centers have is by asking MedStaff to incorporate some trauma audit filters to its process. This will avoid the redundancy if MedStaff is already conducting an OPPE.*



## *Neuro Response Time (CD 8-2)*

“Can a surgical/trauma resident (who receives our own in-house training/credentialing and operates within developed guidelines) respond to the bedside, on behalf of the attending neurosurgeon, for the 30 minute cases?”  
(Level 3)

*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.*

## *PI Meeting Attendance (CD 8-13)*

“Does a mid-level provider count toward the neurosurgery liaison attendance requirements for the trauma quality and multi-disciplinary peer review meetings?” (Level 3)

*The predefined alternate liaison must be a surgeon/physician. The neurosurgery liaison may utilize an alternate for multidisciplinary PI attendance. This must be one predefined alternate, whose attendance combined with the neurosurgery liaison's must reach at least a minimum of 50%.*

## *Backup Anesthesiologists (CD 11-1)*

“There is one anesthesiologist on-call who is designated for trauma 24 hrs/day, but from 11pm-5am, this is the ONLY in-house anesthesiologist, and this anesthesiologist may be called to another non-trauma emergency. In this case, does the backup anesthesiologist have to be called in for the CHANCE that a/another trauma will occur, or is it ok to have this backup anesthesiologist available to arrive within 30 minutes of notification if a trauma arrives. (30 min is the contracted anesthesia time). Room and staff are available at 15 minutes or less in this situation and can staff two rooms at all times.” (Level unknown)

*The VRC does not have specific requirements regarding backup anesthesiology coverage. Therefore, the backup anesthesiologist responding from home would be acceptable. These occurrences with response times should be monitored through the PIPS process.*

## *Anesthesia Response (CD 11-2)*

“CD11 - 2 Anesthesiology services availability within 30 minutes for the management of airway - is this a metric that should be documented and tracked in the registry similar to the times of consult arrivals as in CD 8-2 and 9 - 7?” (Level 1)

*Yes, these metrics must be tracked. There may be a function for this data to be tracked within the trauma registry. However, the mechanism by which this data will be tracked will be determined by the center.*

## *Qualified Radiologists (CDs 11-32 & 11-33)*

“CD 11-32 & 11-33 does the term “qualified radiologist” refer only to attending radiologists, or can a resident or fellow meet this criteria?” (Level 1)

*The radiologist resident or fellow may provide the evaluation as long as the hospital has credentialed them to do so.*

# *Trauma Registry Staffing (CD 15-9)*

“How closely will the registrar - patient ratio be scrutinized in the survey?” (Level 2)

*We ask centers to be honest and transparent with reporting all information, specifically when it may impact personnel. The reviewers are able to verify this information based on the data reported for the total trauma admissions.*

## *Alcohol Screening (CD 18-3)*

“When performing SBIRT and CAGE on a patient with a positive ETOH does this include anyone with ETOH or those who test above the legal limit?” (Level 2)

*If our interpretation of this question is correct, and the patient is presented in the ED with a positive ETOH (above the legal limit), the trauma program still must conduct its own screening to ensure compliance.*

# CME



## *Continuing Education (CE)*

“What is the view of the ACS for continuing education for the Trauma Service staff?” (Level 2)

*If this is related to CE and not CME, the only requirements are that the TPM maintains an average of 12 hours per year, with a total of 36 hours over 3 years.*

## *Continuing Education (CE)*

“Please discuss Trauma Registrar education and any continuing education.” (Level 3)

*As noted in Chapter XV, the trauma registrar must complete the following courses within 1 year of hire:*

- *The American Trauma Society’s Trauma Registrar Course, OR equivalent provided by a state trauma program*
- *The Association of the Advancement of Automotive Medicine’s Injury Scaling Course.*

*There currently is not a standard for registrar’s to obtain CE.*

# CME

“ During the July verification webinar, the CME requirements for TMD/TPMs were reviewed; however, there was no mention of trauma center level. What are the current CME requirements for the TMD of a Level 3 trauma center? There have not been any CME requirements for TMD of Level 3s up to this point, just making sure this is still the case. Thank you.” (Level 3)

“ For a level 3 verification, must I track and report CMEs for all medical staff or just the TMD? Thank you!” (Level 3)

*There are no CME requirements for Level III trauma centers.*

# CME

“What is the definition of External CME?” (Level 1)

*“External CME” are CME credits acquired through programs not directly offered by the hospital, such as an offsite conference or webinar produced and distributed by an outside organization.*

# CME

"Please clarify the CME requirements, 12/yr. total of 36 over 3 years but from who. I understand that I will need it from the Director/Associate Director of the Emergency Departments, TMD and who else? Also, If I am in my verification year, when do I start to count the CME's? Our Verification, which is for both peds and adults, is July of 2020. Your clarification would be greatly appreciated."  
(Level 2)

*There is no CME requirement for the Director/Associate Director of the ED. The CME standard apply only to the TMD, TPM (for CE), and any Alternate Pathway surgeons.*

# CME

“Is there a maximum ratio for CME?” (Level 1)

*If our interpretation is correct of this question, prorating is acceptable based on the date of hire. For example, if the TMD starting sometime in the middle of the reporting year, the CME would be prorated based on the time of hire. Ideally, for new trauma centers seeking verification and new hires, the VRC would like to see 12 hours of external trauma related CMEs during the reporting year.*

*There is no limit to the number of external trauma-related CMEs a provider may acquire.*

# *Update: Resource Manual Chapter Revisions*

*Thanks for your participation!*