

Webinar Questions Log

Clarification Document link: www.facs.org/quality-programs/trauma/vrc/resources

Q: It would be helpful to have copies of these slides. Will they be available to participants?

A: The full webinar presentation will be on YouTube, along with the Q&A, on the VRC resources website.

Q: In terms of interfacility transfers, what is the ACS requirement for acute transfer of patients to the same level? For example, a Level II facility sending a patient with a complex pelvic fracture to another Level II due to orthopaedic resources not being available.

A: This is described in the Orange Book, and is particularly applicable to some Level II centers. As an example, there is a verified, very highly functioning Level I center that on a fairly frequent basis transfers complex hand injuries to another center nearby, which is essentially the center for all hand surgery in that particular metropolitan area. This center has a process in place that describes which patients will be transferred, and has a PIPS process in place to monitor the outcome of these patients. So on a case-by-case basis, this kind of arrangement is acceptable, and in the patient's best interest. Obviously, however, every significantly injured patient cannot be transferred to another center by a hospital wanting to be a trauma center.

Q: Are there any CDs for Level II centers transferring down to Level III?

A: This is really outside the range of acceptable activities. The PIPS process should identify this as being inappropriate, and that particular center should correct the process. It is not acceptable to send a patient from a higher level to a lower level of trauma center verification.

Q: How do I inform anesthesia personnel in a community Level II center that they have to be in house, and that I, as TMD, may stay at home or outside the hospital and respond appropriately? Anesthesia is rarely needed and responds within 15 minutes, following the same criteria as the trauma surgeon.

A: The criteria are fairly clear on this point. The anesthesiologist doesn't necessarily need to be in house, but anesthesia *providers* need to be in-house 24/7. The required anesthesiologist response time is 30 minutes, while the trauma surgeon response for a Level II center is 15 minutes.

Q: How can we allow an anesthesiology assistant to initiate anesthesia in a critically injured patient, when we require all other physicians who care for the trauma patient to be board certified?

A: This would only be acceptable at Level III centers, where the state regulations permit this type of care. Please refer to the Clarification Document.

Q: Is an anesthesiologist the only option as the liaison at a Level III?

A: No, in those states that allow CRNAs or C-AAs to provide coverage, they may be the liaison. Please refer to the Clarification Document.

Q: Would an anesthesia provider who was boarded in Britain and accepted by the Center in compliance with ACS guidelines?

A: To clarify, if they will be the liaison, this person must be U.S. or Canadian boarded. The other members of the anesthesia do not have to meet this requirement. This was a change from the printed Resources manual and is noted on the Clarification Document.

Q: If a trauma center transfers patients to a non-reviewed orthopaedic specialty hospital, would this be acceptable under ACS guidelines?

A: Transfers to acute care hospitals are acceptable by ACS standards, as long as it was an appropriate transfer and well documented.

Q: CD 8-5 seems a little soft with respect to burns. Since there is an entire orange book chapter committed to burns, it would seem that the management of burns at an ACS verified trauma center would follow the recommendations in the burn chapter.

A: There are requirements specified by the ACS that the adult and/or pediatric trauma center must meet if they are managing burn patients.

Q: Regarding CD 3-7, notifying dispatch and EMS agencies of diversion/advisory status. If your state has a web-based system where diversion status is posted and monitored by EMS agencies and all trauma centers, is this acceptable?

A: This would be acceptable.

Q: It is my understanding there is no board certification in surgical critical care for pediatric surgeons. How do we resolve this issue when the surgical director of the ICU is required to be board certified in surgical critical care?

A: For Level I and II pediatric centers, the surgical director of the ICU does not need to be board certified/eligible in SCC. This was changed after the Resources 2014 manual was printed, and is noted in the Clarification Document.

Q: Is certification from osteopathic boards acceptable?

A: This would be acceptable.

Q: Would a hospital that only does orthopaedic elective cases and transfers trauma cases be in compliance with ACS guidelines?

A: This would be problematic. If the facility is a verified trauma center, they must have OS capability, they should not be transferring.

Q: The risk-adjusted benchmarking requirement can only be satisfied by TQIP, correct?

A: TQIP is a risk-adjusted benchmarking program (RAB) which will meet the criteria. Others will be judged acceptable on a case-by-case basis. For non-TQIP centers that are using a RAB program, there is a metric these programs must meet, which is submitted to the VRC-TQIP for approval.

A copy of the alternate RAB program's report must be submitted to the VRC-TQIP office within 6 months of the site visit.

Q: For second-tier trauma alerts and attending surgeon response, is the expectation to describe the attending surgeon response to the trauma room?

A: For the second-tier or lower-tier activations, the trauma center must set the guidelines at which the trauma surgeon is expected to evaluate that patient. This will be an institution-specific criterion. It does not necessarily need to occur in the trauma bay, but it must be timely and monitored by the PIPS process.

Q: Do orthopaedic PAs count for initial response to trauma patients in the ED? Do they require ATLS, or just those responsible for the primary resuscitation?

A: Orthopaedic and neurosurgery providers are not required to have ATLS—only those PAs involved in the initial activation process, which excludes orthopaedic and neurosurgery.

Q: Has there been any consideration of whether being current in ATCN or PHTLS is an acceptable surrogate to being current in ATLS?

A: At this time, only ATLS is acceptable. It is possible that this be a consideration for the next iteration of the Resources manual.

Q: What is the requirement for APPs in Level III and IV trauma centers that lack ATLS resources, who may be seeing patients that come in as non-activations, but may have significant issues.

A: For Level IVs, if the APP is the sole provider, they will be required to be current in ATLS.

Q: With the large numbers of advanced practice providers (APPs) that will need to take ATLS to meet requirement 11-86, is there a plan to relax the rule where by 75% of the class must be physicians?

Yes, this requirement can be waived with course director approval. In addition, a site may ask to host a course for APPs only.

Q: If centers are not able to get APPs into courses due to lack of course availability, will they still be cited for the Type II CD?

Yes, this will still be cited as CD.

Q: If an APP is not doing procedures, but is responding to trauma activations in a support role (assessing patients, interpreting diagnostic tests, and so forth) can they meet this requirement by being an ATCN provider?

Yes, if they are not directly involved in immediate resuscitation and care of patients.

Q: We just hired a new trauma registrar and our visit will be February, 2016. She is scheduled for the AIS course; will this be sufficient prior to the visit?

A: The registrar would have to have taken the course prior to the site visit. Please refer to the clarification document.

Q: Is the VRC requiring surgical direction in the pediatric ICU?

A: Level I and II pediatric trauma centers are required to meet the same requirements as the adult Level I and II trauma centers.

Q: There are Level I and II centers that transfer patients after ICU and acute care to Level III centers for ongoing acute care, such as for osteomyelitis. Would this be acceptable?

A: This is acceptable.

Q: If we are planning a pediatric Level II verification in 2016 and are not currently enrolled in pediatric TQIP, will this be a deficiency if we enroll in fall, 2015 to begin data collection in January, 2016? We would not be collecting any data during the review period of 2015.

A: Currently, for those programs that are not TQIP participants, an exception will be made if you have a contract signed with TQIP.

Q: How should the surveyors regard surgical house physicians as members of the trauma team? Like house staff?

A: House surgeons must have full general surgery privileges to be considered part of the trauma surgeon response, and must meet the same requirements (such as boards, CME, PI attendance, and so forth) as the other members of the trauma call panel.

Q: Is the response time for high level alert determined from patient arrival rather than notification?

A: This remains the time from patient arrival to arrival of the surgeon.

Q: Can you clarify the neurosurgical presence? Is there a role for the junior resident to see the patient and staff with attending?

A: The junior resident may respond to consults; however, documentation must be noted that they've spoken with the chief neurosurgical attending.

Q: For the internal education process, the criteria now states that continuing medical education (CME) should be equivalent to 16 CME hours. How are different people fulfilling this requirement?

A: This can include periodic updates, reading newsletters, grand rounds, and trauma lectures at the facility, to list a few examples.

Q: For the fulfillment of requirements for Level I trauma center, a 4th- or 5th-year general surgery resident needs to be in continuous rotation. Does this mean that a 4th- or 5th-year resident needs to be on call every day?

A: This would depend on the number of residents available to the trauma center. If resources are adequate, it is expected that a 4th- or 5th-year resident would be on call every day. If resources do not allow for this, then the requirement does not apply, so long as the facility still has coverage.

Q: Regarding the criteria that transfers out must be reviewed by the performance improvement and patient safety (PIPS) process: Does this only apply for transfers for trauma services? For example, we are Level I, and only transfer back to another facility once the patient is cleared by our trauma service.

A: No. Transfers back or repatriations do not need to be tracked by the PIPS process.

Q: In instances where the emergency department (ED) physician has evaluated a patient, and has determined with the trauma surgeon that the patient should be admitted, is the timeliness of the trauma surgeon's arrival to bedside based on the patient's initial arrival or the time of determination that patient should be admitted?

A: It is the patient's arrival to hospital and/or the surgeon being notified of the activation being called that determines the timeliness of the surgeon's arrival at bedside.

Q: Can the external CME for surgeons include online courses?

A: Yes, this is acceptable if the course is accredited.

Q: In a Level III hospital, if the trauma medical director (TMD) is the intensive care unit (ICU) co-director, can they serve as the PIPS ICU liaison? Would they have to be board certified in surgical critical care?

A: Yes, if the TMD is the ICU co-director, they can also serve as the ICU liaison. For a Level III facility, they would not have to be board certified in surgical critical care.

Q: We are Level I adult and Level I pediatric center. However, the pediatric hospital is separately licensed as a different hospital, but has no ED—hence why the Level I pediatric verification belongs to the main adult hospital. Both hospitals are physically connected by a hallway on all floor levels. Therefore, are we in compliance if we continue to transport pediatric patients from main ED (at adult hospital) to the pediatric hospital by gurney transport, and not emergency medical services transport?

A: Yes, this facility would be in compliance with VRC criteria. For more information, please refer to the Clarification Document.

Q: For the 30-minute response required for interventional radiology (IR), is this from time of call to arrival at hospital or time of call to IR suite/bed?

A: This would be tracked to the time of arrival at the hospital.

Q: Will stakeholders get a heads up for new verification standards in a timeframe they will be able to implement them?

A: Yes, this information will be distributed through the Clarification Document.

Q: Can liaison absence from a PIPS meeting ever be considered excused and not tallied toward their 50% requirement?

A: A liaison can only be considered excused from a PIPS meeting and not have this counted towards the 50% requirement in the event of military deployment or extended medical leave (FMLA).

Q: Do the two courses required for registrars have to be the ATS registrar course and an AAAM AIS course? Would an AIS course and an ICD-10 course be sufficient?

A: An AIS course and an ICD-10 course would be sufficient to satisfy this requirement.

Q: If a data registrar was hired in 2007, do they need both courses? They had the AIS course and maintain yearly education requirements.

A: The two-course requirement will only apply to data registrars hired after July 1, 2014.

Q: As a Level III trauma center, what are the CME requirements for the trauma surgeons and the liaisons? The orange books says this is a requirement for Level I and II facilities, but the prereview questionnaire asks about it for all faculty, not just the TMD.

A: There are no specific CME requirements for Level III trauma centers.

Q: Does the hospital commitment statement have to be current throughout the review period, or just current at the time of site visit?

A: The hospital commitment statement must be current at the time of the site visit.

Q: Are there trauma-specific CME requirements for the critical care liaison to the PIPS committee?

A: Yes, the same trauma-specific CME requirements apply for the critical care liaison. Surgical critical care CME will also apply.

Q: Will there be an expectation for trauma PIPS programs to incorporate the taxonomy that is being taught in the TOPIC course?

A: There is not an expectation for this at present.

Q: Do transfer agreements need to be updated on a scheduled basis? How long are transfer agreements considered current?

A: Transfer agreements should have a set re-review date or an expiration date, and would remain current until that date.

Q: We are a Level III verified center with one ED physician per 12-hour shift. We have one non-board certified emergency physician, who has been well-established in this community for over 25 years, working in the ED and as medical director. Will experience be a consideration and found acceptable, or is this a type II CD?

A: Experience would not be sufficient to satisfy the requirement. However, if the physician is not boarded in emergency medicine, but is boarded in another discipline—such as internal medicine or pediatrics—the surgeon would only need to be current in ATLS to comply with VRC guidelines. In addition, if the non-boarded EM physician is a Fellow of the ACEP, that would be acceptable to continue to take trauma call.

Q: Is there a full-time requirement for the trauma coordinator or trauma program manager in a Level III trauma center?

A: No, this is not a requirement for Level III facilities.

Q: Regarding the requirement elements for activation criteria, can these be modified according to the patients seen at that institution, or does the verbiage need to be exact, as it is in the book?

A: At a minimum, the activation criteria for the highest level of activation must include the six criteria specified by the COT. Additional criteria can be applied by the facility.

Q: Are there any exceptions to the criteria that the trauma surgeon does not need to see patients with isolated head injuries before they are transferred out of a Level III trauma center?

A: For all transfers out, the trauma surgeon would be expected to respond. The rationale for this is that the patient may have other injuries beyond the head injury, and their status may change before leaving the facility. If transfer resources arrive prior to the trauma surgeon's arrival, the activation would be canceled en route.

Q: Is the injury prevention coordinator a separate role from the trauma coordinator in a Level III trauma center?

A: Yes, though these roles can be combined if needed.

Q: CRNAs respond to our level 1 activations to manage/assist with airway control. They are not responsible for management of initial evaluation and resuscitation. The attending trauma surgeon is always present. Must they be current in ATLS?

A: Yes, they are required to be current in ATLS.

Q: According to CD 11-33, in Level I and Level II trauma centers, a qualified radiologist must be available within 30 minutes to perform complex imaging studies or interventional procedures. Are we allowed to use the response time of the in-house radiology resident PGY III, while the attending radiologist is en route, to meet this standard?

A: The in-house radiologist can be covered by a resident, but the radiologist must be present within 30 minutes.

Q: Is it accurate that the TMD for a Level I pediatric trauma center does not have a specific requirement to be board certified in surgical critical care?

A: The TMD for a Level I pediatric trauma center does not have to be board certified in critical care. If they are the director of the PICU, however, then they would need to have those credentials.

Q: Has the definition of EMS scene time changed? Our previous understanding was that this was tracked as time of EMS scene arrival to scene departure.

A: EMS scene time is defined as arrival of EMS at the scene to departure time from the scene.