American College of Surgeons/Committee on Trauma

CLIENT MANUAL

GUIDELINES FOR THE HOST AGENCY/TRAUMA MANAGER IN REQUESTING, SECURING AND HOSTING A TRAUMA SYSTEM CONSULTATIVE VISIT

Trauma Systems Consultation

draft
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How to use this Guide

In the following pages the reader will learn about the Trauma Systems consultative process. This guide has been prepared to assist you, the client, in hosting and successfully completing a Trauma Systems consultation visit provided by the American College of Surgeons Committee on Trauma (ACS/COT). Our goal in preparing this guide is to make the process as simple as possible. We want this to be a successful consultation visit for your system and therefore want to ensure that you are: adequately prepared for the visit; understand the consultation visit process; have garnered the necessary trauma system stakeholders to participate in the visit; and clearly understand the expectations of the hosting agency, and the team. This document will help you to better prepare for the consultation visit and will provide guidance to help make your consultation visit a success.

General Information

Overview

History

In 1990, Congress passed the Trauma Care Systems Planning and Development Act that provided states with minimal funding for trauma system development. Administration of the funding rested with the Division of Trauma and Emergency Medical Systems (DTEMS) in the US Department of Health and Human Services. In 1992, DTEMS developed a Model Trauma Care Plan to provide guidance to states in the development of trauma systems, and subsequently began the development of a trauma system evaluation tool. However, Congress eliminated program funding and DTEMS was abolished prior to the completion of the trauma system evaluation document. Concurrently, in 1996, the ACS/COT formed a multidisciplinary “Working Group for Trauma System Evaluation”. The group reviewed several key documents including the Model Trauma Care System Plan and relied on the experience of the NHTSA technical assistance program for assessing EMS systems in refining what has become the Trauma Systems Consultative Process. The charge of the working group was to develop an instrument to facilitate an objective review of a trauma system based on the Model Trauma Care System Plan. The mission was to promote the development and enhancement of trauma systems throughout the United States. Key principles included being consultative in nature and designed to help trauma systems develop and improve including both systems in the early stages of development and mature trauma systems. The group envisioned a multidisciplinary team review/consultation with the end product providing a guide for future trauma system development.
Purpose

The purpose of the ACS Trauma Systems Consultation process is to provide guidance to the development of trauma systems at a community, county, regional or state level. Whereas the ACS trauma center verification process focuses on individual institutions, this effort is far broader and will, most likely, involve multiple facilities as well as other essential trauma system components. The process will provide a broad perspective on all of the components of the system, their integration, function and identify opportunities for performance improvement.

Your trauma system will not be compared against other systems, but against the trauma system consultation goals. The consultation visit emphasis is on providing technical assistance and consultative advice to the requesting trauma system within the framework of the Consultation for Trauma Systems document. Each system has a unique set of strengths and challenges; the consultation visit will highlight the strengths and providing guidance to overcome the challenges.

This voluntary consultation visit will assist the trauma system in identifying needed improvements. However, it is not a verification or designation process, and is distinctly different from the ACS Committee on Trauma, trauma center verification.

How the visit will be conducted

Once a state, region, or local entity (EMS agency) makes a formal request for the ACS/COT to conduct the review, it takes about 4-6 months to gather the materials, confirm a team and complete the review process. However, in certain cases the preplanning phase can be accelerated to meet specific demands of the requesting agency.

Once a request has been made to the ACS/COT, a letter confirming the request and a set of materials, including this manual, will be sent to the requesting agency. The Client Manual and checklist will detail the arrangements to be made for the visit and steps to assuring a successful consultation visit.

A multidisciplinary team will be empanelled for your consultation visit including a trauma surgeon, emergency physician, trauma nurse, state, regional or local EMS director and team leader (usually a surgeon). A technical expert or specialist such as pediatric surgeon, communications, information technology, transportation or other specific issue specialist may also be necessary.

One or more logistical/technical support persons will also on hand to handle special arrangements the team may request, to facilitate the process and to assist in drafting the final report.
Once the team has been identified and confirmed, they will be sent the necessary materials to ensure that they are well prepared in advance of the visit. The key to this process is your completion and return of the Pre-Review Questionnaire (PRQ) at least eight weeks prior to the scheduled visit. Each team member will have read the entire PRQ and will have made notes as to questions, clarifications, and additional needed information. Each reviewer will have a thorough understanding of the section(s) they will be responsible for facilitating including any special questions posed by the requesting agency.

Approximately two weeks prior to the site visit the team leader will conduct a conference call with the reviewers to go over the logistics, the PRQ, report writing and the requesting agency’s focus questions.

The consultation visit usually takes three and a half days with one of those days a travel day. The team will arrive in the early afternoon the day before the formal start of the site visit for a pre-review meeting with the team leader and technical support staff. This meeting usually lasts about 2 hours. On the day of arrival there is a pre-meeting dinner (optional) with system participants. The purpose of this meeting/dinner is to get acquainted with the team and the system stakeholders prior to the more formal briefing sessions that follow. The briefings by systems participants will occur on the evening of the arrival day and for the next 1 ½ days. The final day will be for consensus development, report writing and closing session.

The entire consultation visit is very intense with the team concentrating on the issues, findings and recommendations to assist your trauma system. There will usually not be time for other sightseeing excursions or other leisure activities. Meals should be provided by the requesting agency. During the final day of deliberation and writing the team will be sequestered and meals will be ordered in.

The gathering of information and the meetings with stakeholders is usually in a public forum. The consultative staff has been advised that dress for these briefings should be business attire.

The team will bring several laptop computers on which to prepare the final report. The requesting agency is asked to provide a high-speed/quality printer with appropriate drivers so that the various laptops can be attached to the printer. You will also be asked to provide access to a high speed copy machine. Access to these equipment items streamlines the report writing process.
Guiding Documents

The review is based on the guidelines and principles outlined in the following major trauma system documents:

- *Model Trauma Care System Plan* (DTEMS/DHHS, 1992)
- The requesting agency’s Pre-Review Questionnaire (PRQ)

Other materials that will serve as background information for the consultants include:

- *Trauma System Agenda for the Future* (NHTSA/HRSA)
- Development of Trauma Systems course outline (NHTSA)

The requesting agency and other key trauma system leaders may wish to re-familiarize themselves with these documents.

Advantages

**Broad System Review – According to ACS/COT Consultation for Trauma Systems guidelines**

The importance of a broad system overview consultation cannot be over emphasized. No matter where a trauma system is in its development, the ability to have an outside review team provide additional consultation regarding ways to improve the system and move to the next level of care is essential to the maturing system.

During the evolutionary process of building a trauma care system much of the early focus is on developing capacity within each individual component. As the system reaches a point of early maturity the focus can broaden to the integration and interoperability of these individual components. Individual component problems are, to some degree, easier to fix. The communications and infrastructure necessary to make a “system” work is far more intricate. However, the effort is worth it in the long term. General systems theory suggests that it is not the individual components but the synergy that they combine to create that results in optimal performance.
Most trauma care systems have not reviewed their structure and function from a macro perspective. Various components may have been reviewed and accredited such as individual trauma centers or EMS agencies. Conventional wisdom and experience suggests that a “trauma center does not make a trauma system”. Therefore as a system matures it is essential to review the entire system, looking for areas of strengths, weaknesses, opportunities and threats. Remember that this process is voluntary and designed to help in the ongoing evolution of your system.

**Focused Questions Pertinent to Your System**

The PRQ helps the consultative team focus on your needs. If there is a challenge facing your trauma system upon which it would be helpful to have the team’s expert input, please be sure to provide sufficient information in the PRQ to help focus the dialogue and questions on that issue during the consultation visit. While the team is committed to looking at all aspects of your trauma care system, they will also take the time to address your specific concerns and challenges.

**Outside Experts**

The consultative team brings two unique qualities to your trauma system. First, they are leaders in the field and have experience that may help you look at a particular challenge from a different perspective. They may also have faced similar events within their own system and can share those experiences. However, the consultants are not trying to transport their system and make yours look like it. It is clearly recognized that each system, while possessing similar attributes, will be unique in its resources and attributes. The team will be trying to help you make the most of your available resources.

Second, the team members, individually and collectively, bring credibility. Often the local leaders may have been saying the same thing about a particular issue or problem but when it comes from an “outside expert” it suddenly has more credibility.

**Leveraging Resources**

It is the hope of the ACS and the consultative teams that the consultation process, and the product (final report and recommendations), will be useful in improving your trauma system including, if appropriate, the leveraging of additional resources.
Who Participates

The consultative team comprises both expert trauma system specialists and additional facilitative and support staff. However, the key to the successful consultative visit lies in the selection, orientation and participation of the local participants. In selecting and inviting these participants, remember that the team will be looking for information on the following system components and, in particular, how well integrated the individual components are into the overall trauma care system.

- Leadership
- System development
- Legislation
- Finances
- Injury prevention and control
- Human resources
- Emergency medical services
- Ambulance and non-transporting medical unit guidelines
- Communications
- Emergency disaster preparedness plan
- Trauma care facilities
- Inter-facility transfer
- Medical rehabilitation
- Information systems
- Research and evaluation

While the presence of key leaders and policy makers is important, it is essential that the people that regularly provide care or services within each of those components are also in attendance. Sometimes the leadership has a completely different perspective on the issues and challenges than does a “provider”. A broad range of system providers from multi-agency and multidisciplinary groups representing all components of the trauma system will provide the best overall assessment of the current trauma system and allow development of recommendations for future system enhancements.
Cost

Sample Budget

ACS Administrative fee $13,500
Honorarium 1,000 per day per site reviewer
  Travel day 700 per day per site reviewer
Travel
  Airline x 5 reviewers
Hotel accommodations
  Rooms and meals x 5 reviewers

Logistical costs
Hotel
  Meeting rooms
    1 large conference room for open meeting
    1 smaller conference room for the team to meet
Equipment
  Copy machine
  Computer printer
  Laptop connections
  Dinner meeting for all participants (optional)
  Lunch meeting the first day
  Meals for reviewers when sequestered

Potential Sources of Funding

Both traditional and non-traditional sources of revenue may be available to offset the consultation visit costs. The trauma authority at a county, regional or state level may have funds through their general revenue streams or specific grants. City, county or state governments may be willing to allocate specific resources outside of the normal trauma budget. Federal agencies may identify a trauma system consultation visit as part eligible grant expenses for trauma system assessment. Grants earmarked for bioterrorism or general emergency preparedness may be appropriate sources of revenue. Non-governmental sources might include private foundations or membership organizations. A group of facilities and agencies may choose to each contribute some portion of the cost.
Requesting a Trauma System Consultation

Who May Request a Consultation?

ACS will accept applications from any trauma system, local (city or county), multi-county regional, or statewide in nature. However, the requesting party needs to have the authority to speak on behalf of the system that is being reviewed. For instance, it would be inappropriate for a trauma director at a specific trauma institution to request a consultative visit for an entire county that involves multiple facilities and numerous other agencies. It would, however, be appropriate for the county trauma authority, or a group representing all of the trauma facilities in the area, to make such a request. Collaboration at the outset is one of the keys to a successful visit.

How to Request a Consultation

Requests should be made on a specific Trauma System Consultation Application Form. This form is included as Appendix A of this document and is also available from the ACS at the following address.

American College of Surgeons – Trauma Department
Michelle Wielgosz, Program Administrator
633 N. Saint Claire Street
Chicago IL 60611-3211
Phone: 312.202.5340
Fax: 312.202.5005
Email: mwielgosz@facs.org

Who Should Be Involved in Making the Request

Applications will only be accepted from agencies or individuals that have the authority to make such a request on behalf of their trauma system.

To Whom Should the Request be Sent

The application should be returned to Michelle Wielgosz at the address listed above.

Where Should Questions Be Directed

During the application process and up to the confirmation of the consultative team all questions should be directed to Ms. Wielgosz at the above contact points. She should continue to be your primary contact point for questions of process and logistics throughout the planning process.

Once the consultative team has been identified, limited contact with the team leader may be appropriate.

Gail Cooper and Nels D. Sanddal
Preventing for a Trauma System Consultation Visit

Client Checklist

A copy of the following checklist is included as Appendix B of this document. It is designed to assist you in preparing for a successful trauma system consultative visit. Comments after each time delimitation are provided here to help identify key concepts, points or activities.

Five months prior

- Submit Application for Site Visit to ACS COT office
- Receive and review the Site Visit packet from ACS/COT
  - Client manual
  - Client checklist
  - Pre-review Questionnaire
  - Trauma System consultation manual
- Review materials with appropriate trauma system participants
- Determine several different dates that would be acceptable
- Preliminary discussion of the city in which the review will be conducted, and the meeting facility

It is important that sufficient lead-time be provided to ACS to ensure that a qualified team can be empanelled. Five months lead time also provides sufficient time for the exchange of information and for pre-event activities at the local level.

Four months prior

- “Negotiate” dates for site visit with team leader and in conjunction with ACS staff.
- Determine who will complete and review the Pre-Review questionnaire
- Begin discussions of who will participate in the site review
  - Assure inclusion of ACS COT chair and of state EMS/Trauma Office
- Begin discussions of who will attend the faculty pre-meeting/dinner (Optional)
- Preliminary work on meeting facility and on-site logistics
- Begin working on the Pre-Review Questionnaire
- Receive notification from ACS/COT about the team members and the staff
- Receive a preliminary budget for ACS/COT site visit costs
- Begin working with system participants to formulate focused area questions
The consultative visit can only be as successful as the quality of the information and discussion provided to the consulting team by the participants. Key system leaders often have schedules that are booked months in advance. It is essential to plan far enough ahead to accommodate those schedules. Additionally, early pre-planning and preparation will help avoid miscommunications and the ensuing confusion and frustration as the date approaches.

Three months prior

- Finalize the location (city), hotel and meeting facilities and notify the team leader/staff
- Finalize other logistics including:
  - Flip charts
  - Multi-media projector and screen
  - Copy machine
  - Printer (for computer)
  - Power strips for laptops
  - Refreshments for break
  - Meals for site visit
  - Pre-meeting/Dinner on first evening
  - Site reviewer meeting room
- Arrange conference call among select surgical and trauma leaders in your system and the team leader/staff to review your consultation visit expectations
- Receive a draft site visit agenda from the Team leader/staff
- Invitations to participate in the site visit and in the faculty dinner (Suggested letters are included in this manual as Appendix C)
  - Include draft site visit agenda and list of review team members

The consultative process is very output and outcome oriented. To achieve the goal of having a nearly final draft of the findings and recommendations completed by the time the team departs, it is essential that meeting room logistics and equipment support be provided according to specifications.

The conference call among system leaders and the consultative team leader and support staff is designed to assist the team in better meeting your needs. Each system has different challenges and needs specialized input.

Early invitations to site visit participants are essential to gain good participation from informed trauma system participants.
Two months prior

- Complete the Pre-Review Questionnaire and Focused Questions (electronically) and submit them to the team leader/staff. The PQR should also be sent to system participants who will be attending and presenting information at the consultative visit.
- Submit your trauma system law and administrative rules to the team leader/staff (electronically, if possible)

The importance of the PRQ cannot be overstated. This document will serve as the orientation that each team member will have about your system. The better prepared the team members are, the more responsive they can be to your needs. Likewise the rules and regulations pertaining to your system are essential to the team member orientation.

One month prior

- Confirm all logistics for meeting rooms, audio-visuals, and other support
- Reminder letter/e-mail to all system participants and to persons participating in the first evening dinner/meeting
  - Suggest again including the draft meeting agenda
- Visit with ACS staff and Team Leader to review all logistical issues including:
  - Meeting room arrangements
  - First evening dinner/meeting – who will be attending
  - System participants – who will be participating

Follow-up with both local participants and team leaders/staff is essential.

Two weeks prior

- Notify Team leader or ACS staff about any last minute changes

While the consultative teams are used to last-minute changes, the more notice that they receive the better able they will be to adapt and adjust.

One week prior

- Notify team leader/staff about any last minute changes
- Phone call/e-mail reminder to all system participants and persons participating in the first evening pre-meeting/dinner
Friendly reminders and updates.

The day of the site visit

- Arrive early and complete the on-site checklist (See Customer Manual)
- Assure someone is available to meet with the review team, to answer questions and to manage on-site logistical challenges.

Having a specific person on site throughout the process to serve as a liaison between the local host and the team leader/staff will help facilitate the resolution of unanticipated changes or unexpected needs. Having the rooms prepared in the specified manner and the necessary equipment resources on-site is required.

Pre-Review Questionnaire (PRQ)

Basis

The questions in the PRQ were compiled directly from the Consultation for Trauma Systems Handbook. The PRQ is a separate document and is included in your consultation packet. Your responses to these questions serve as the basis for understanding your system and for the customization of the consultative visit, allowing the team to “hone in” on the issues that are unique to your trauma care system.

The importance of this document cannot be overstated. It is advisable that you assemble a working team to complete the document to assure a variety of perspectives are represented. Using a team approach it should take approximately 2-3 months to complete the PRQ in sufficient detail to be of maximum value to the consultative team. Each team member will review the PRQ prior to arrival.

Completion

The PRQ should be completed not less than two months prior to the scheduled site visit. It should be submitted both in six hard copies and in an electronic format (MS Word). The PRQ should be submitted to Michelle Wielgosz at the ACS address listed earlier.
Additional Materials

In addition to the PRQ other materials are essential to the team’s understanding of your system, including: the laws, administrative rules and contractual agreements that govern your system, policies and procedures that provide guidance to providers, and any other documentation to demonstrate your system’s structure, functionality, and operations. These materials can generally be provided on-site, however, if a review of the material is essential to the understanding of the system (such as the legislation authorizing the trauma system) it should be provided at the same time as the PRQ.

Questions About the PRQ

If you encounter questions concerning the completion of the PRQ, your point of contact should, once again, be Michelle Wielgosz. In many cases, she may choose to refer your questions to the consultative team leader or another staff member.

Focused Questions – What Are They; How To Submit

The consultation visit is a review of the current status of your trauma system with an emphasis on next steps to improve or enhance system performance. It is also a time for you to ask critical focused questions of the reviewers regarding unresolved system concerns. These questions can be issues raised by stakeholders, political leaders, consumers or others about any area of trauma system development. Focused questions are often ones that have been controversial among system participants, need more critical thinking by outside reviewers, provide additional expertise to resolve, or require reinforcement of a strategy in order to implement a needed change. Examples of focused questions could include a broader discussion of triage guidelines in an area of low volume, the need for a helipad at a hospital in a rural area, or the need for a helipad in an area of heavy congestion where neighbor opposition is high. The focused questions should be specific to your system’s critical issues and ones that would benefit from a multidisciplinary, open dialogue.

The focused questions should be submitted with the PRQ. There may need to be additional discussion with the team leader to be sure that the questions are clear and that the team thoroughly understands the nuances of each question. To the extent possible, the focused questions should fit within the Trauma Systems Consultation document PRQ.
Meeting Facility

Integrated Meeting/Sleeping Facility

Ideally, the meeting room and the sleeping rooms for the consultation team should be in the same facility. Given the intense nature of the deliberations and the report completion process unnecessary travel between facilities is inefficient.

Main Meeting Room Set-Up

A good room configuration is a U-shaped table arrangement. The team members will be seated along the base of the U and the main local presenters along either leg of the U. Additional seating for other local contributors should be at the open end of the U. The projector should be situated in the gap between the two legs of the U. It should be arranged in such a manner that most all of the consulting team and the remainder of the audience can see it. There should be ample power outlets near the team members to facilitate the use of laptop computers during the discussions. An alternate design is to have the consulting team seated along a long table facing the audience. Each speaker will come to a podium to contribute. This configuration allows more room for movement and interaction between the audience and the consulting team during breaks.

The following diagram represents a useful room configuration.

![Diagram of a U-shaped table arrangement with team members seated along the base, main local presenters along either leg, additional seating for other local contributors at the open end, and a projector situated in the gap between the two legs. There are ample power outlets near the team members to facilitate the use of laptop computers during the discussions. An alternate design is to have the consulting team seated along a long table facing the audience. Each speaker will come to a podium to contribute. This configuration allows more room for movement and interaction between the audience and the consulting team during breaks.]
**Team Meeting Room**

A separate meeting room for the team is required. This room, which can be substantially smaller, may either be set in a U-shape or in a boardroom style with one large table. There should be ample room for 8-10 people. Easy access to ample power supplies is essential. The printer and the copy machine should be set up in this room.

**Required Equipment**

The following equipment must be available in the main meeting room:

- LCD projector with power, connector cable, software drivers
- Screen
- A minimum of three power strips/surge protectors accessible from the head of the meeting table.
- Flip chart and pens

The following equipment must be available in the team meeting room.

- Printer, power cord, connector cable, software drivers
- Copy machine
- Minimum of 2 reams of paper
- At least three power strips/surge protectors accessible from the tables
- LCD projector with power, connector cable, software drivers

**Other Logistic Considerations**

- Meals, refreshments for breaks, etc.
- Dinner on the first evening (optional)
- Airport transportation
- Payment of hotel/meals
- Payment for the visit
- Upfront payment of administrative costs
- Who should be invited? Who should invite them? What should they be told (consider a sample letter of invitation)
The Consultation Visit

Role Of The Host During The Meeting

The host will assist the team during the course of the system consultation visit including:

- Welcoming the guests and system participants
- Introducing the team leader at the meeting/dinner and help set the “tone” for the consultative visit. The team leader will introduce the rest of the team members.
- Reintroducing the team leader at the beginning of the main session and help set the “tone” for the consultative visit. The team leader will have the team introduce themselves and state their qualifications.
- Making key introductions to the team leader and/or members
- Informing the team leader and/or section leader of specific local expertise that should be queried about each section
- Designating someone to serve as a liaison with team members and staff to assist with meeting unforeseen needs, e.g. broken printer.
- Providing concluding remarks following the presentation of findings on the final day.
- Contributing to, but not dominating, the briefing session.

Process Overview

One team member will be assigned to lead each section of the discussion. He or she will be assisted by a back-up member who will be primarily responsible for capturing the essence of the discussion and key points on a laptop. The section leader will ask questions of the group in general or direct his questions specifically to individuals with expertise on that subject. The host will help identify those individuals who are there specifically to provide information on specific topics or sections. The section leader or the team leader may ask participants to limit their presentations if necessary because of time limitations.

Kick-Off Dinner/Meeting

The first evening meeting (dinner optional) on the night prior to the briefing session is critical to the success of the visit. At the opening of this meeting, the team leader will provide an overview of the process stressing the purpose of the consultation site visit, introduce the team members and provide information on their credentials. This meeting, which typically occurs over dinner, is an important part of the review process and should include a discussion/presentation of an overview of the system by the involved stakeholders, along with its perceived strengths and weaknesses, special issues or problems, and other information felt to be pertinent to the review process. This is typically a more relaxed occasion and acts to set the tone for the rest of the site visit. Section A on Leadership is usually covered during this session.
Public Participation

With the exception of the closed customer session described in the preceding section the remainder of the fact finding session must be open to the public in accordance with the jurisdictions open meeting laws.

Team Deliberations

Following the briefing session, the team will sequester themselves to deliberate and achieve consensus on its findings and recommendations and to draft the report. These deliberations are private and confidential. Hosting staff will not be participants to the final deliberations except to be available by phone should questions arise.

Sample Agenda

The following sample agenda is provided to give the planning personnel a clearer understanding of the process and flow of the site visit. A specific agenda will be developed for each site consultation.

Travel Day-first half day

Team arrival in early afternoon

Team meets with Team Leader to review documents 2-4pm
Dinner meeting/social hour with participants 5-6pm
Welcome, Introductions, Expectations, and Timeline for Completing Review 6-6:30
Overview of the Trauma System and System Briefing Section A. Leadership 6:30-9pm

Full Day One System Briefing Continues 8am – 5pm

Briefing (approximately one hour per section)
Prehospital Care 8-9am
Definitive Care Facilities 9-10am
Break 10-10:30
Information Systems 10:30-11:30
Lunch 11:30-1:00
Injury Control and Prevention 1-2pm
Human Resources 2-3pm
Break 3-3:30pm
Evaluation 3:30-4pm
Research 4-5:00pm
Team retreats for deliberations and report writing 6-?

Day Two

Team gathers to complete briefing by client if necessary 8-10:00am
Team retreats for initial deliberations and report writing 10- 6:00

Day Three
Team gathers to complete report writing and findings 8-10am
Stakeholders gather for summary report/comments  11-12pm
Team departs for home  1:00pm
Post Consultation Visit

Evaluation

By requesting and participating in a trauma systems consultation the local representatives agree to assist in an evaluation of the consultation process. This will consist of both written feedback and exit interviews of select participants by ACS staff.

Sharing your system’s successes

From time to time, the ACS may request permission to use portions of your report to help other systems overcome similar challenges. In such cases, ACS would request written permission from the lead agency to share the information contained in your report. ACS is very sensitive to issues of confidentiality and political realities. In all cases, information would be stripped of specific identifiers. Again, ACS will never share your information without your express permission.

Payment to ACS

SECTION TO BE ADDED.

Frequently Asked Questions

How long before I receive the report?

The goal of ACS is to have a final and formally approved report back to the requesting agency within six weeks of the visit.

Who should invite people to the visit?

In most cases it will be the requesting agency. However, if there are certain segments of the trauma system that might be more amenable to an invitation by someone else such as the COT chair, then by all means the invitation should be extended by the appropriate party.

Why the Sunday night meeting/dinner?

The dinner meeting provides a more informal atmosphere to start the session. It helps to establish the tone, allows the team members and local personalities to meet and get to know each other before the formal briefings begin. It also provides a selected forum to discuss the first section on leadership and Administrative components.
What role will I have in the selection of team members?

The primary responsibility for team selection rests with ACS. The selection will be based upon matching your systems needs with the expertise of various consultants. However, the requesting agency does have the power to suggest that a team member might not be appropriate based on previous history or other factors.

Why do I have to have a complete review? Why can’t we just target the problems we are experiencing?

Sometimes the apparent problems are not the only problems. Additionally, in order for the consultative team to provide your system the best possible service it is essential that they come to know the strengths, weaknesses, opportunities and threats across the entire system. Targeting one area only tends to diminish the term “system” within the trauma care system. Without knowing the history and current status of the trauma system, reviewers may miss critical information necessary to make an informed judgment on a specific targeted area. Outside experts may identify opportunities for system improvement that are not readily apparent to the system participants or administrators.

Who do I deal with in making the arrangements and getting questions answered?

The primary point of contact is:

Michelle Wielgosz
American College of Surgeons – Trauma Department
633 N. Saint Claire Street
Chicago IL 60611-3211
Phone: 312.202.5340
Fax: 312.202.5005
Email: mwielgosz@facs.org

Who provides the final debriefing and who should attend?

The consulting team leader will provide the final report. The report, while highlighting on key findings, will be general in nature. It will provide the listeners with the general flavor of the findings and recommendations. The details of the final report cannot be released until it has been approved by the ACS Committee on Trauma.

Certainly the key players within your trauma system should plan on attending. This would include the state/local COT chairman, the state/local trauma system coordinator, key regulatory officials and so on. The list will look similar to the list of persons who provided comment during the site review process.
**What if we don’t agree with the final report?**

The consultative team will do their best to capture the essence of your trauma care system in an unbiased and factual manner. What you do with the report once it is provided to you is up to you. You may choose to release it as is and circulate it widely. You may choose to circulate it only among members of the trauma care community, or you may choose to create an addendum that addresses any points that you disagree with. However, the report, after approval by the ACS, will generally not be modified once issued. Remember the report is based on the information in the PRQ, the interviews with participants, and the reviewer’s professional expertise, 80-90% of the report will have been completed prior to the departure of the team and you will get some sense of its contents during the exit debriefing.

**Who drafted the PURPOSE statements in the document?**

The purpose statements for each section come from the DHHS Model Trauma Care Plan. The purpose statements were originally drafted by an expert working group representing both clinical and administrative expertise in trauma systems.

**Who should we invite to the consultation? How do I deal with the politics?**

A small working planning committee may be useful in identifying the key players who need to contribute to each section. Invitations should be extended by the requesting agency or another person in authority. It is important that all “players” be at the briefing even if there is animosity among certain members. The role of the team leader will be, among many other things, to keep order and decorum during the briefings. The only way to begin to unravel “politics” is to make sure that all parties are heard; often the presence of an independent third party makes the process more civil and credible.

**Should I invite the press?**

The main briefing sessions are open meetings. Again, the fact that the trauma system has matured enough to be willing to undertake such a wide-sweeping examination speaks highly. The concluding de-briefing may be the best place for the press. Participation should be followed-up with a copy of the final report if appropriate.