Providence

Santa Rosa Memorial Hospital

Holly Love, Trauma Program Manager

Santa Rosa Memorial Hospital
Level II Regional Trauma Center

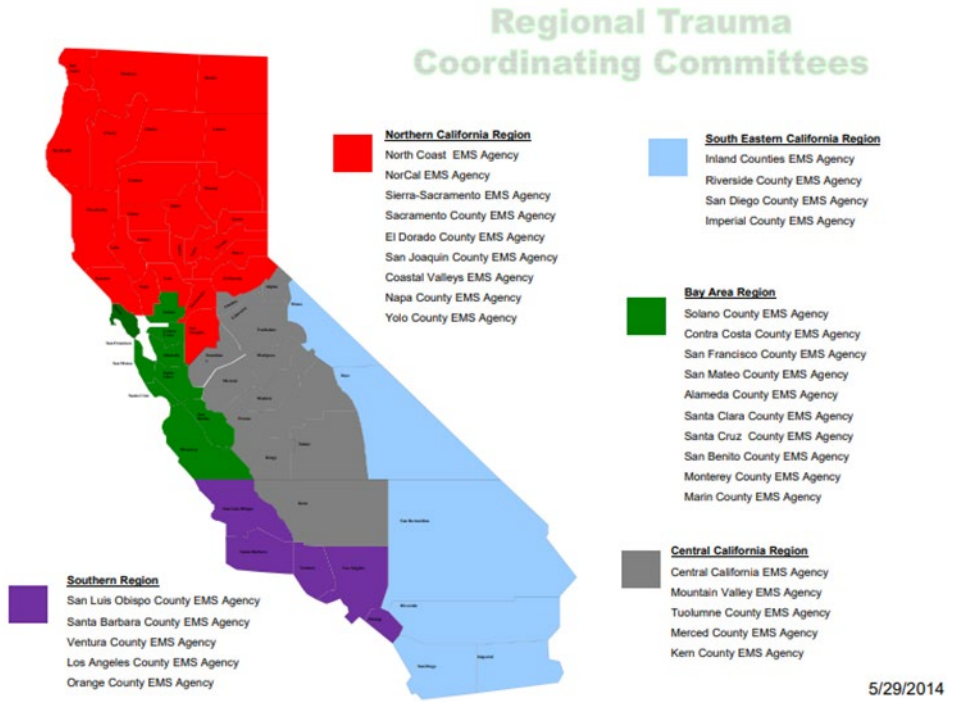
ACS Verified for 27 years

2025:

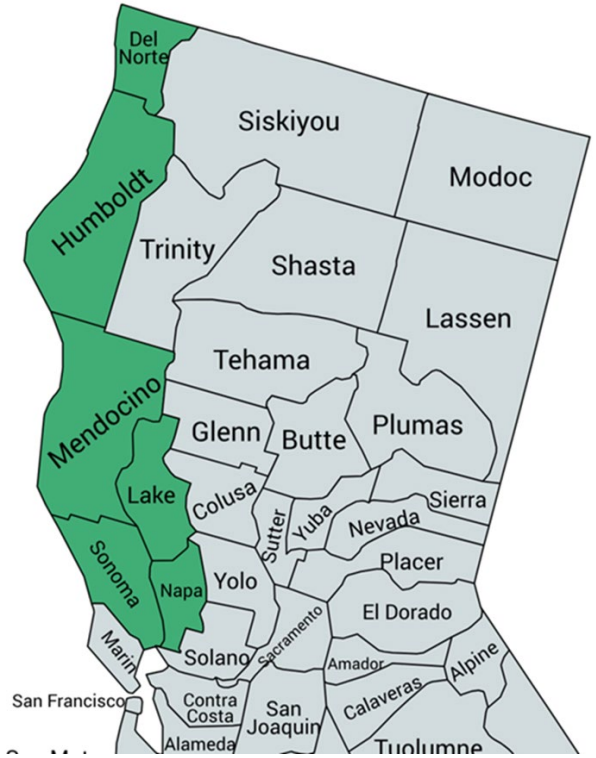
- 52,276 emergency department visits
  - 26 ED beds
  - 2 Resus Bays (w/ 2 beds each)
  - 26 ICU beds
  - 338 Hospital Beds
- 3,609 trauma patients
- 461 Transfers in
- 342 total trauma patients arrived by Air
- 95 Pediatric Trauma Patients (19 Admitted)
- ESO - Digital Imagery (DI) V5 Registry
  - Switching to DI-V7 in 2026

Providence

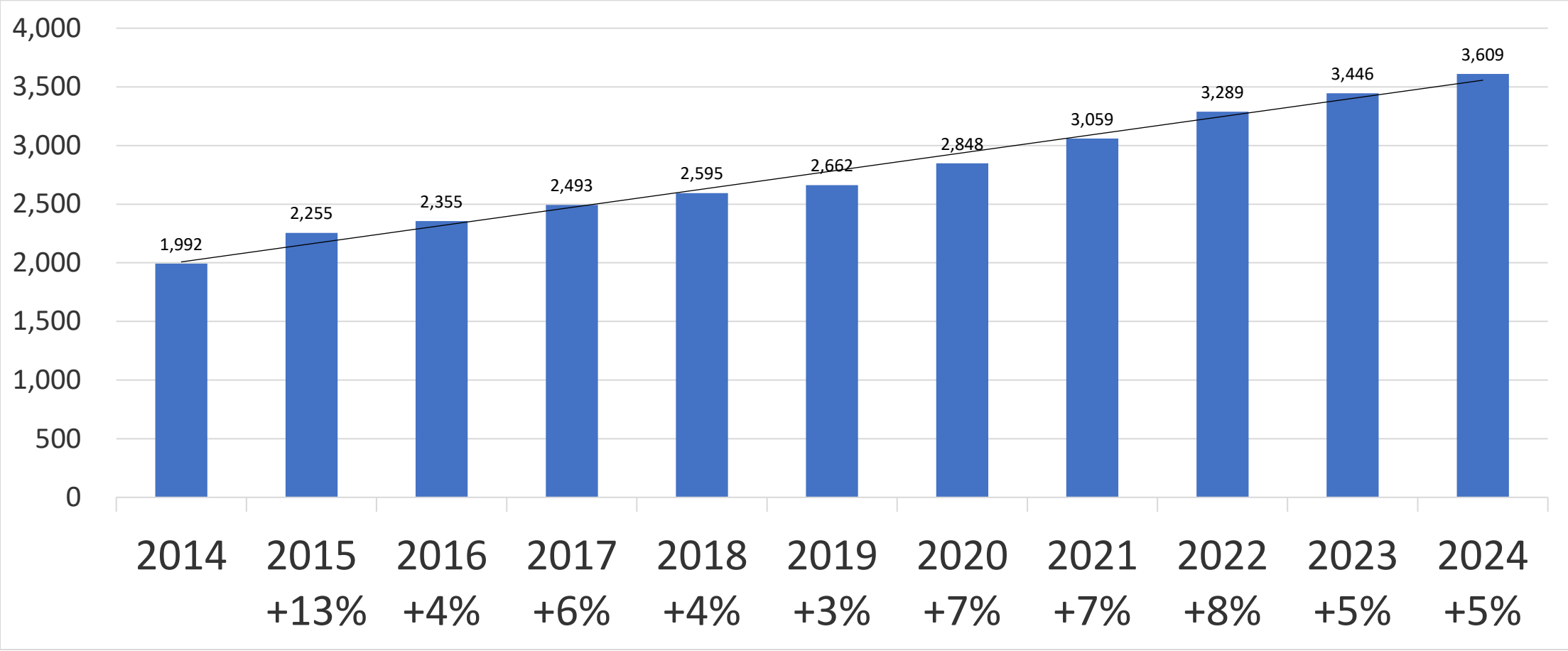
Regional Trauma Coordinating Committees (RTCC)



Trauma Catchment Area



Trauma Volume Year over Year



ACS Survey April 7 & 8, 2025

Level II Renewal Verification for a period of one year through 4/17/2026

ACS Surgeon Site Reviewers

- **Site Reviewer Lead:**
  - **Doug Schmitz**, MD, F.A.C.S. (Cheyenne Regional Medical Center)
    - Assistant Clinical Professor of Family Medicine/General Surgery
    - Senior Physician Reviewer, ACS COT
    - Medical Director Cheyenne AMR and City Fire

- **Site Reviewer Associate:**
  - **Jason Hoth**, MD, PhD, F.A.C.S (Wake Forest University School of Medicine (North Carolina)
    - Professor of Surgery and Internal Medicine
    - Executive Director, Acute Care Surgery Service Line
    - Division Chief, Acute Care Surgery
    - Trauma Medical Director

One Non-Compliant Standard

Standard	ACS Comment
4.7 Emergency Department Physician Requirements	One ED physician has never taken ATLS. He is reportedly scheduled to do so this summer.

ACS Required Corrective Action to Extend Verification Period an Additional Two Years
Standard 4.7: Submit evidence of completion of ATLS for Dr. Ridge Muller no later than 4/8/2026

Opportunities for Improvement

ACS Standard	ACS Comment
1.1 Administrative Commitment	**OFI:** There is no CME budget for trauma related education for the trauma team members which is critical. There is insufficient FTE support for the TMD/ATMD. **Recommendation:** Ensure global financial support to maintain and promote this excellent trauma program addressing educational and leadership personnel issues.
5.1 Clinical Practice Guidelines	**OFI:** Although the trauma program has guidelines for the initiation of VTE prophylaxis, compliance is poor. **Recommendation:** Continue to work collaboratively with surgical subspecialists and hospitalist to improve compliance.

Opportunities for Improvement

ACS Standard	ACS Comment
5.8 Massive Transfusion Protocol	**OFI:** There have been multiple challenges with the MTP and its implementation and documentation. There are plans in the works to correct these issues, but they continue to persist. TEG is available but only used intermittently, and the results are often times not acted on. **Recommendation:** Implement the proposed plans to create smooth activation and implementation of the MTP to include routine use of TEG for multisystem trauma. The implementation of an "MTP" nurse in the ED dedicated solely to the process appears to be part of the solution.
5.10 Pediatric Readiness	**OFI:** The pediatric readiness score is 66.924/100. **Recommendation:** Continue to partner with UCFS Children's Hospital and their ImPACT program to improve pediatric trauma care.

Opportunities for Improvement

ACS Standard	ACS Comment
7.10 Prehospital Care Feedback	**OFI:** With the new prehospital system in place, there is a disconnect with the trauma program PIPS process and the prehospital CQI process. There is a lack of transparency and collaboration. **Recommendation:** Continue to work towards a collaborative and bidirectional PI process to continually monitor and improve prehospital care. Erin Olson, the prehospital liaison, is doing exceptional work in this area and is establishing herself as the key link between the EMS service and the trauma PIPS program. With her emphasis on quality improvement, this issue is showing marked improvement.

Strengths

ACS Standard	Comment
2.1 State and Regional Involvement	The entire trauma team is extensively involved as one of the leaders in California State and Regional trauma activities.
2.2 Hospital Regional Disaster Committee	The regional disaster committee is very strong and is well designed and rehearsed.
2.9 Trauma Medical Director Responsibility and Authority	Dr. Brian Schmidt, the TMD, is experienced and very knowledgeable. He is dedicated to the hospital and the community and provides outstanding leadership to this mature trauma program. There is a succession plan in place for Dr. Keith White to take the reins from Dr. Schmidt probably sometime within the next three years. The mentorship process is strong, and it is critical to support Dr. White as the associate TMD during this time if the program is to maintain its current excellence. This would include increased compensated administration time and financial support for trauma medical direction educational activities.

Strengths

ACS Standard	Comment
2.11 Trauma Program Manager Responsibilities and Reporting Structure	Holly Love RN, the TPM, has enabled this program to mature since the previous verification visit in concert with Dr. Schmidt and her excellent team. She is dedicated and knowledgeable and a very strong leader.
2.12 Injury Prevention Program	Brooke Brand RN, the injury prevention coordinator, has developed a comprehensive program addressing the local injury patterns and has associated with multiple community enterprises to assist in this effort. Attention to distracted driving initiatives has been exceptionally effective.
3.5 Medical Imaging	FAST QPI and ongoing education programs are robust and involves radiology, emergency medicine, and surgery.

Strengths

ACS Standard	Comment
4.6 Emergency Department Director	Drs. Ferrari and Holt, both ED physicians, are very supportive of the trauma program and work hand-in-hand with all of the surgeons. They both actively attend the trauma committee meetings.
4.10 Neurotrauma Care	There are 5 dedicated and very active neurosurgeons providing comprehensive care.
4.12 Specialized Orthopedic Trauma Care	There are 4 OTA trained orthopedic surgeons. Dr. Tabrizi is very supportive of, and active, within the trauma program and is an ATLS course director.
4.17 ICU Physician Coverage	There is 24/7 in-house intensivist coverage.
4.26 Medical Specialists	Dr. Downing, the hospitalist liaison and geriatric specialist, is very supportive of the trauma program and works hand-in-hand with the trauma surgeons. She is very complimentary of the surgeons.

Strengths

ACS Standard	Comment
5.2 Trauma Surgeon and Emergency Medicine Physician Shared Responsibilities	Very collaborative working relationships exist between the ED physicians and all of the surgeons.
7.1 Trauma PIPS Program	The PIPS program is thorough and well documented. Most issues are being identified with development of action plans and documentation of LOOP closure. This program is mature.
7.3 Documented Effectiveness of the PIPS Program	There are multiple PI projects that have been accomplished and several that are current. These are well thought out and designed using TQIP data and issues identified internally. Part of the trauma surgeons' ongoing professional performance improvement /education includes assisting on cardiac cases to maintain intrathoracic and cardiac skillsets.
7.4 Participation in Risk-Adjusted Benchmarking Programs	TQIP data is extensively analyzed and used to drive multiple PI projects. The results have been dramatic at times.

ACS Overall Comments

This outstanding Level II trauma center continues to provide state of the art trauma care to Northern California.

The staff is knowledgeable and dedicated to the community and the entire region. They are one of the leaders and go-to trauma centers in California's statewide trauma system.

Survey Preparation

- **Circulated Reviewer Questions:** Distributed TCAA sample questions to department heads 6 and 3 months prior to the survey. Emphasized the importance of staff preparation for the ACS tour during monthly PIPs meetings. Encouraged leaders to contact TPM for clarifications, without providing answers.

- **Tracked Progress:** Maintained an ACS Survey Timeline Dashboard in the Trauma Office to monitor progress. Regularly shared updates with the Executive Leadership Team and during PIPs meetings.

- **Weekly Planning Meetings:** Starting 8 months prior to the survey, TPM and Trauma Admin conducted weekly meetings to review the Planner and assess each standard for follow-up and progress.

ACS Survey Important Dates

January 7 – Last day to submit policies through PolicyStat

January 13-17 – Holly/Rocco to meet with Department Leaders

January 29 – Run Final Data Reports for PRQ

February 19th – Goal to have PRQ done

February 26th – PRQ Submission Deadline (40 days before survey)

March 7th – PRQ Charts Submission Deadline (No later than 30 days before survey)

March 18th – Medical Records – completed & bookmarked in Adobe Acrobat

March 24th – Medical Records Submission Deadline (No later than 14 days prior to the virtual visits)

March 5th – Video Practice Walkthrough #1

April 2nd – Video Practice Walkthrough #2

SURVEY April 7 & 8

Survey Preparation

What We Will Do Differently:

- **Draft Reviewer Question Answers:** Consider providing drafted responses to sample reviewer questions for clearer guidance.
- **Improve Breakout Room Scheduling:** Address scheduling confusion by practicing breakout room navigation.
- **Enhance Executive Participation:** Plan personal 1:1 meetings to emphasize the importance of executive attendance at ACS meetings.
- **Optimize Meeting Schedule:** Initiate regular TPM and Trauma Admin meetings to review PRQ/Standards 2 months before the survey year begins. Gradually increase frequency, moving to weekly meetings 4-6 months before the survey.

Pre-Review Questionnaire

What We Did:

- **Implemented Microsoft Planner:** to track standards, action items, and gaps, enhancing communication and organization. Leveraged labels for filtering key focus areas efficiently.
- **Focus Labels:**
  - Template
  - GAP
  - New ACS Standard
  - Guidelines
  - Data
  - Type I
  - Summary Needed
  - TMD

My Plans > ACS PRQ 2025 | Grid | Board | Schedule | Charts | Share

Filters | Group by Bucket

PRQ Section 1-2

+ Add task

Completed tasks 13

- ~~Toni to pull previous survey~~

Completed by Torres, Toni on 07...

Type I TMD

- ~~1.1 Administrative Commitment~~

3 5 / 5

Completed by Torres, Toni on 02...

Summary Needed TMD

- ~~2.1 State & Regional Involvement~~
- Final Review - Holly

8 / 9

PRQ Section 3

+ Add task

Completed tasks 8

Data Type I TMD

- ~~3.1 Operating Room Availability~~
- Upload Documentation of time of notificatic

5 / 6

Completed by Love, Holly on 05...

policies Summary Needed TMD

- ~~3.2 Additional Operating Room~~
- Write up summary

4 / 5

Completed by Torres, Toni on 02...

NEW ACS Standard Summary Needed

PRQ Section 4 (4.01-4.15)

+ Add task

Completed tasks 15

TMD

- ~~4.1 Trauma Surgeon Requirements~~
- Fill out Template - awaiting CKW ATLS

9 / 10

Completed by Torres, Toni on 02...

Type I

- ~~4-02 Trauma Surgeon Coverage~~

2 / 2

Completed by Torres, Toni on 02...

- ~~4.3 Trauma Surgery Backup Call Schedule~~

PRQ Section 4 (4.16-4.36)

+ Add task

Completed tasks 23

GAP TMD

- ~~4.16 ICU "Surgical" Director~~
- Upload P&P & PI initiatives specific tc
- Upload proctols/pathways & PI initiat

7 / 9

Completed by Torres, Toni on

NEW ACS Standard

- ~~4.18 Intensivist Staffing~~

3 / 3

Completed by Torres, Toni on

- ~~4.19 Not applicable~~

My Plans > ACS PRQ 2025

Grid | Board | Schedule | Charts

Share

Filters | Group by Labels

GAP

Add task

Completed tasks 14

GAP

~~2.11 Trauma program manager responsibilities and reporting structure~~

PRQ Section 1-2

Relevant org chart for our trauma center - Tc

1 / 2

Completed by Torres, Toni on 02...

NEW ACS Standard

Add task

Completed tasks 24

NEW ACS Standard | Type I | TMD

~~2.7 Trauma Multidisciplinary PIPS Committee~~

PRQ Section 1-2

3 / 3

Completed by Torres, Toni on 02...

NEW ACS Standard | Summary Needed | TMD

~~3.3 Operating Room for Orthopaedic Trauma Care~~

PRQ Section 3

New Periop policy will be available in Augus

1 / 2

policies

Add task

Completed tasks 26

policies

~~2.13 Organ Procurement Program~~

PRQ Section 1-2

1 | 5 / 5

Completed by Torres, Toni on 02...

policies | Summary Needed | TMD

~~3.2 Additional Operating Room~~

PRQ Section 3

Write up summary

4 / 5

Completed by Torres, Toni on 02...

Data

Add task

Completed tasks 21

GAP | Data | Type I

~~2.6 Adult Center Admitting Pediatric Patients~~

PRQ Section 1-2

2 | 2 / 5

Completed by Love, Holly on 05...

Data | Type I | TMD

~~3.1 Operating Room Availability~~

PRQ Section 3

Upload Documentation of time of notificat

5 / 6

Completed by Love, Holly on 05...

ACS PRQ 2025

~~5.17 Neurosurgeon Response~~

Completed on 02/14/2025 by Torres, Toni

NEW ACS Standard | policies | Data

Bucket
PRQ Section 5 (5.16-5.30)

Progress
Completed

Priority
Medium

Start date
05/10/2024

Due date
01/27/2025

Repeat
Does not repeat

Notes Show on card

- Emergent Consult policy pending final approval - posting in July
- 9/4: policy in folder
- PRQG_0517_NEURO_RESP
- PRQG_0517_NEURO_RESP_SU
- 10/2/24 - Holly/Meaghan/Steve/Toni reviewed report
  - Need a category for each person.
  - Meaghan working on understanding how the report was written.

Checklist 3 / 3 Show on card

- [x] Provide a report of neurosurgical response times for patients meeting the criteria in the stand...
- [x] Upload relevant policy that outlines criteria and requirements for NSG response time.
- [x] Pending updated policy with Neisa's changes
- [ ] Add an item

Attachments

Pre-Review Questionnaire (PRQ)

What We Will Do Differently:

- **Prepare ACS Planner Earlier:** Set up the ACS Planner 2–4 months before the survey year starts to ensure readiness.

- **ACS Data Reports:** Moving forward, we are utilizing ACS PRQ data reports that update monthly on our dashboard. This approach will ensure our data is consistently survey-ready each year.

- **Optimize Document Storage:** Upload attachments to a SharePoint folder for easier retrieval when submitting documents to the PRQ, rather than using Planner.

- **Familiarize Teams with Planner:** Given Planner's novelty for the team, encourage team interaction with the tool at least 4–6 months before the survey year begins.

ACS Charts – Chart Review Process

Built Excel Spreadsheet for ACS Review that included the following:

- **Quarterly Report Generation:** We utilized a report generated from the Registry (V5) on a quarterly basis. This report included patient information, PI RN data, filters flagged, and the meetings attended (e.g., P2, P3).
- **Case Selection:** Each PI RN reviewed the report and selected cases that aligned with ACS categories. Emphasis was placed on cases demonstrating effective loop closure or a strong PI process.
- **Filtering and Categorization:** The selected cases were further filtered to ensure comprehensive coverage of all ACS chart categories.
- **IRR Assignment:** Subsequently, each team member was assigned IRRs. These involved a secondary review to update timelines and verify loop closure, ensuring thorough assessment and documentation.

Patient Name	Date printed	Trauma Number	Admit Date	DOB	Age	MRN	ISS	LOS	Activation Level	Dispo	MOI	Injuries	IR, OR, Trach and PEG Procedures exclude images	Guidelines needed for Chart Pull	PI Filters Flagged	Hospital Events (NTDB ONLY)	OR Y/N	IR Y/N	Original PIRN	ACS PIRN
							10	5	Full	Acute Care Facility	MVC	OPEN COMMINUTED FX R DISTAL FIBULA OPEN DISPLACED TRANSVERSE FX R	None	10-11, Trauma Transfer-Out to Higher Level of Care Guideline; 10-15 Emergent Time	Transfer out to HLOC >2hrs, transfer to HLOC, other-misc	None	N	N		

P1 Review Date	P2 Review Date	P3 Review Date	Other "Meetings"	PI Status	Loop Closure	Overall Outcome	ACS Final Chart Category	Schmidt Cases	Holly's notes	EDH/SDH + OR	Severe TBI (GCS ≤ 8) admitted to an ICU, excluding the mechanism of NAT	Spinal cord injury with neurologic deficit	Supracondylar elbow fractures with neurovascualr compromise	Amputation	Acetabular fractures and any pelvic fractures +IR, Blood, OR	Open femur or tibia fracture	Thoracic/cardiac injuries (include aortic), AIS ≥ 3 or requiring intervention (intubation, surgery, IR)	Solid organ injuries: spleen, liver, kidney, and pancreas: ≥ Grade III or requiring intervention (transfusion, embolization, surgery)	Penetrating neck, torso, proximal extremity trauma, with ISS ≥ 9, or requiring intervention (transfusion, chest tube, IR, surgery)	all NSA ISS >=9 no abuse	sus/conf NAT w/ ISS >=9	NSA with ISS ≥ 9 for geriatric hip fractures	Tx to HLOC	Admitted NSA ISS >=9	Unplanned return to OR / ICU	ISS > 25 with survival, without severe TBI (Head AIS < 3)	Any major complication, or unexpected return to the SICU/PICU or the OR	MTP	Hospice	Death	Mortality with OFI	Mortality without OFI	Physical child abuse (suspected and/or confirmed) with an ISS ≥ 9
5/22/2024	6/20/2024	7/2/2024	N/A	Closed	Referral to P2, Referral to Peer, Referral to Lifewest Ambulance for external review, Provider counseling (plastics)	Event/Mortality with an Opportunity for Improvement	**Open femur or tibia fracture**	**Given to review 12/13/24**	Reviewed							*						*											

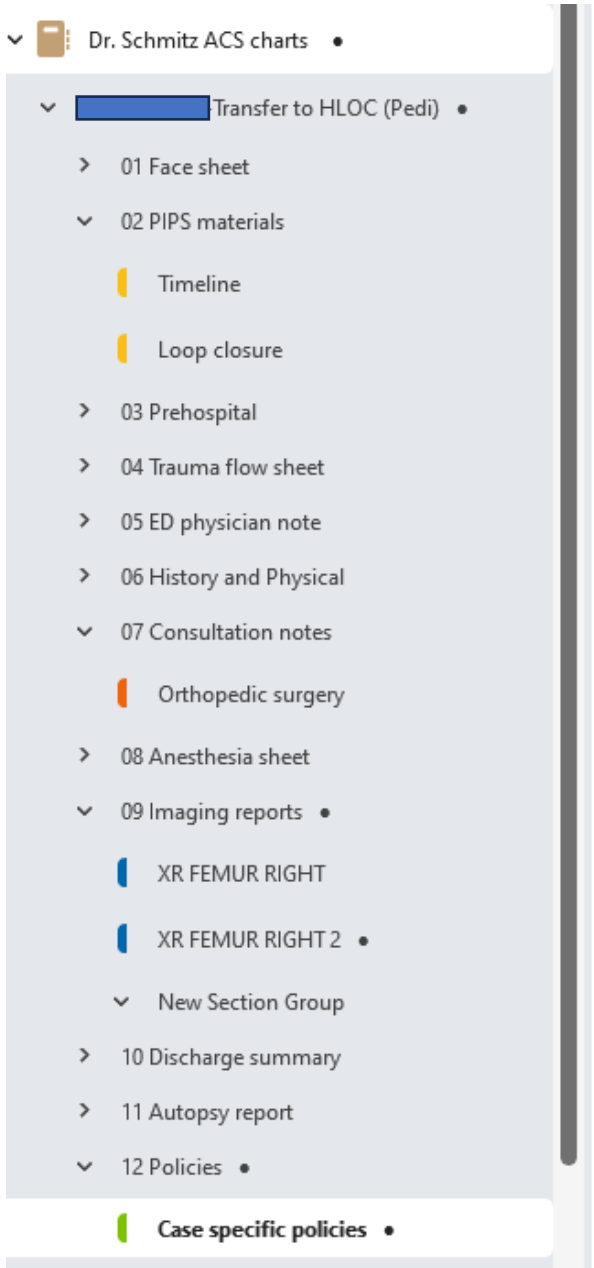
ACS Charts - OneNote

What We Did:

- **Utilized Microsoft OneNote:** for document storage due to file size constraints, assigning each Surgeon Reviewer their own notebook.

- **Structured ACS Categories:** as "section groups" in OneNote, including Face Sheet, PIPs materials, Pre-hospital, Trauma Flow Sheet, Imaging Reports, etc.

- **Organized Documents by Section:** For each "section group," added "sections" for required documents. For example, multiple imaging reports were organized under the Imaging Report section group.



10-11- Trauma Transfer-Out to Higher Level of Care •

Sedation for Procedures- Moderate and Deep, B3-18 •

ACS Charts

What we will do differently

- Moving forward we are now uploading key documents for all trauma cases undergoing PEER Review directly to their respective SharePoint e-files. This will make uploading the required ACS documents for the selected 25 charts for survey significantly less burdensome.

PCR	**OP Note**
Trauma Flow Sheet	**Anesthesia Record**
MTP Sheet (if applicable)	**Radiology Report(s) in ED only**
H&P	**CAD (if applicable)**
ED Note	**Autopsy (if applicable)**
Consult Notes	

ACS Charts – What we will do differently cont.

- **Save PI Emails as PDFs:** Previously, patient-related PI emails were saved in SharePoint and later converted to PDFs for chart building during surveys, creating extra work. Now, they are directly saved as PDFs, simplifying the survey process.

- **Facilitate Remote Access for ACS Reviewers:** Organize practice sessions as soon as possible with ACS reviewers that include access to OneNote outside of the hospital network to prevent access issues when working remotely.

ACS Reviewer Hospital Tour - Remote

What We Did:

- **Meticulous Tour Planning:** Scheduled department visits with specific times, identifying primary contacts and backups, complemented by two practice sessions prior to the survey.

- **Optimized Audio Setup:** Initially purchased Bluetooth microphones for iPads, but due to Bluetooth security limitations, we used iPads for video and iPhones with Microsoft Teams for audio—this setup proved effective.

- **Enhanced Equipment Mobility:** Practice tours revealed issues with existing iPad carts, leading to the purchase of new carts that greatly improved navigation and flow during tours.

Tour Schedule

ACS Tour Day 2 (Tuesday, April 8th) 08:00-09:30

ED	Meaghan & Odessa (iPad #5)	Time	Primary Contact	Cell Phone #	Secondary Contact	Cell Phone #
1st Stop	Walk through ED	8:00	Amy Ware (ED Manager)	707-779-9691	Adam Harris	707-481-5432
2nd Stop	Ambulance Bay	8:15	Amy Ware	707-779-9691	Adam Harris	707-481-5432
3rd Stop	Trauma Bay	8:30	Amy Ware	707-779-9691	Adam Harris	707-481-5432
4th Stop	Decon Area	8:45	Brian Seekins (Principal Safety Officer)	707-331-7937	Lane Moody	707-322-9969
OR/PACU/BB/ICU	**Laura & Kaylee (Holly iPad)**	**Time**	**Primary Contact**	**Cell Phone #**	**Secondary Contact**	**Cell Phone #**
1st Stop	PACU	9:00	Brittney Hoffman		Talia Haro	
2nd Stop	OR	9:10	Patrick Phoenix		Tia Sonesouphab (Director)	206-310-6336
3rd Stop	Blood Bank	9:20	Marylynn Lewiston (Blood Bank Supervisor)	707-217-1139		
4th Stop	ICU	9:30	Sandy Karren (Manager)	707-867-3767	Roz Hart	707-480-5134

Notes		Primary Contact	Cell Phone #	Secondary Contact	Cell Phone #
No plan to walk through Radiology but Radiology Primary Contact needs to be in the ED during ED tour		Radiology - Jose Villagomez	707-484-3590	Tara Flinn	707-623-6540
		Hospital Quality - Lisa Hazelton	707-548-2846		

ACS Reviewer Hospital Tour - Remote

What We Will Do Differently:

- **Request In-Person Survey:** We plan to request an in-person visit for our next survey to enhance engagement and effectiveness.

- **Encourage Staff Interaction:** ACS stressed the importance of direct interaction between reviewers and bedside staff rather than managers. We will strongly discourage leadership attendance during the next survey to facilitate this engagement.

Thank you

Questions?