

American College of Surgeons Committee on Trauma

Program Update

Jane Ball, RN, DrPH

Nels D. Sanddal, PhD, REMT

Robert J. Winchell, MD, FACS

September – 2013



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Inspiring Quality:

Highest Standards, Better Outcomes

ACSCOT and NASEMSO

- ▶ Partners with a shared mission
- ▶ Formalized relationship in 2011
 - Memorandum of Understanding
 - Joint Operating Committee
 - Shared Goals
 - Development, dissemination and implementation of Optimal Resource Document
 - System development and measurement
 - Data sharing
- ▶ Complementary strengths and areas of focus
- ▶ Relationships are strengthened by familiarity



ACSCOT and NASEMSO

- ▶ Brief historical background
 - ACS
 - COT
- ▶ Organization Structure of the COT
- ▶ Primary initiatives affecting state systems
 - Trauma Center Verification
 - Trauma Systems Consultation
 - Quality and Data programs
 - Educational programs
 - Advocacy



American College of Surgeons

- ▶ Established in 1913 to improve the care of surgical patients by setting standards for education and clinical care
 - Over 75,000 members, including 4,000 international members
- ▶ Major areas of focus
 - Education and training
 - Quality and data systems
 - Advocacy
 - Commission on Cancer
 - Committee on Trauma



Committee on Trauma

- ▶ Established in 1922 as the Committee on Fractures
- ▶ Components
 - Committee on Trauma
 - State and regional Committees on Trauma
 - 65 states, regions and provinces
 - International regions
 - Military regions
- ▶ Mission: Education, Standards of Care, Assessment of Outcomes





Medical Director - *Fildes*
Chair - *Rotondo*
Vice Chair - *Coimbra*
Membership - *Malangoni*

Education

Reilly - Brasel

- ATLS - *Brasel*
- RTTDC - *Sidwell*
- DMEP - *Doucet*
- ASSET - *Bowyer*
- ATOM - *Henry*
- Optimal Center - *Young*
- Congress Courses

Advocacy

Weireter

Quality

Winchell - Cribari

- Systems - *Winchell*
- VRC - *Cribari*
- EMS - *Bulger*
- Rural - *Burton*
- Disaster - *Doucet*
- Prevention - *Kuhls*
- TQIP - *Nathens*

Information Engine

Nance - Enderson

- NTDB - *Nance*
- PIPS - *Enderson*
- Info Tech - *Ashley*



National COT
Carol Williams
Regional Committees
Bridget Blackwell

Education

- *ATLS*
- Monique Evelyn
- Bill Jenkins
- Gerardo Cardenas
- Jena Watson
- Jasmine Alkhatib
- Freddie Scruggs
- Pascale Leblanc
- Sharon Borum
- Casimir Lorenc
- Meg Capshew

Advocacy

Kristin McDonald
Jon Sutton

Quality

- *VRC/TSPEC*
- Nels Sanddal
- Molly Lozada
- Rachel Sanchez
- Holly Michaels
- Anita Johnson

Information Engine

- *NTDB/TQIP*
- Melanie Neal
- Chrystal Price
- Julia McMurray
- Tammy Morgan
- Amy Svestka
- Haris Subacius
- Alice Rollins
- Richard Sallee
- Emmanuel Eklou
- Chris Hoeft
- Sue Bergstrom

COT STAFF

Trauma Center Verification

- ▶ Largest overlap with daily system function in most states
- ▶ Verifies that centers meet criteria established in current edition of the “Resources for the Optimal Care of the Trauma Patient” (ORD)
 - Criteria based on structure and process
 - 3 year verification cycle
 - The COT does not designate centers
 - There are no provisions for interim monitoring
- Ongoing growth in the number of verified centers



Trauma Center Verification

- ▶ Currently Level I, II, and III, but level IV criteria return to newest ORD
- ▶ ORD nearing completion of comprehensive re-evaluation and update
- ▶ Promulgation of trauma center standards is a major focus for COT/NASEMSO cooperation



Verified Trauma Centers 2013

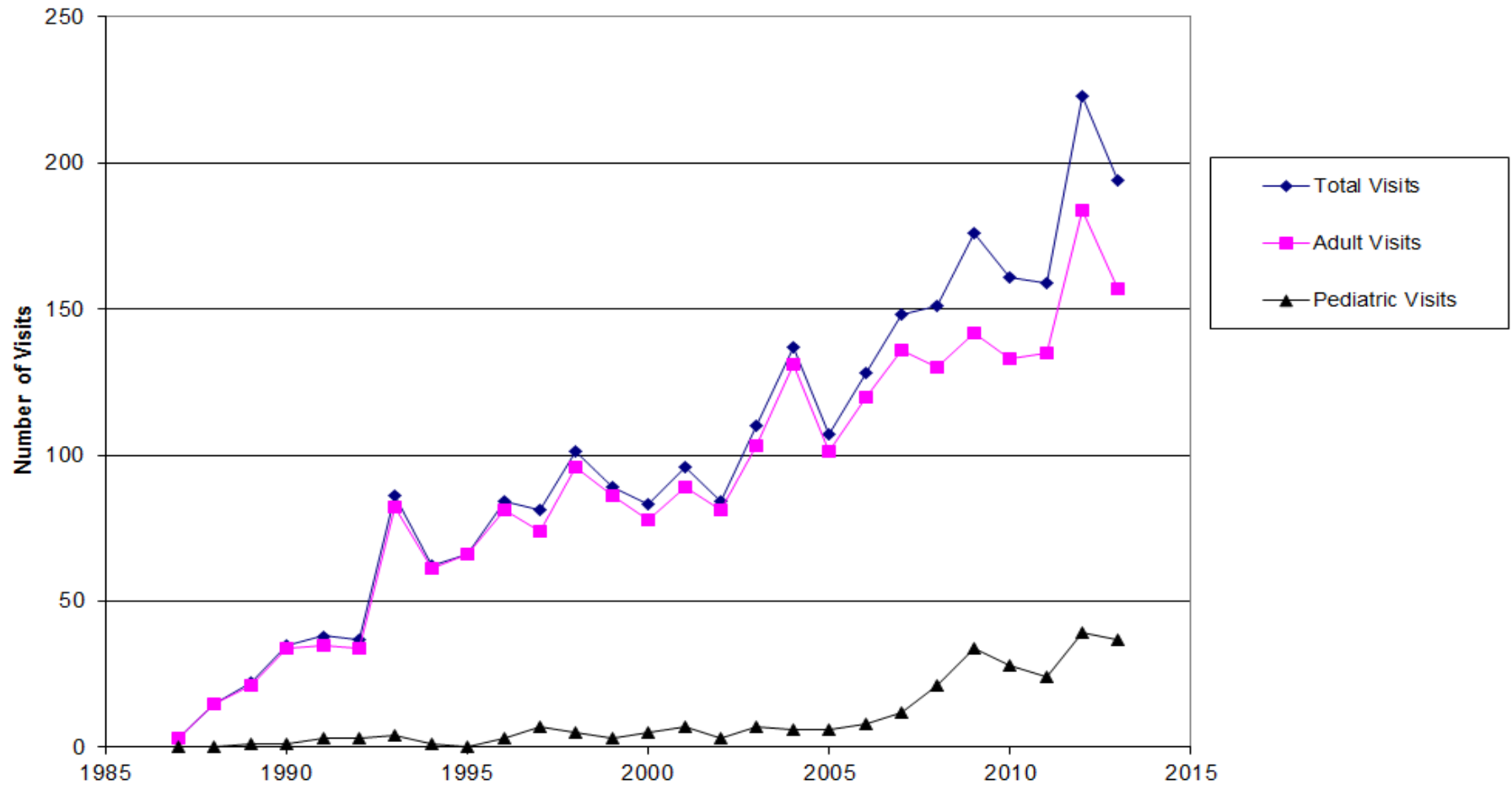
• Level I	76 (13 pending)
• Level II	143 (12 pending)
• Level III	57 (5 pending)
• Level I Pediatric	23 (7 pending)
• Level II Pediatric	6 (1 pending)
• Level I/II Adult w/Level I/II Pediatric	<u>90*</u> (6 pending)
TOTAL	395 (44 pending)



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Verification Site Visits Growth (Includes consultations and onsite focused visits)



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100 years

Total “New” Verified Trauma Centers

▶ <u>Year</u>	<u>“New” Consultation/Verified Centers</u>
2005	13/7
2006	6/0
2007	23/6
2008	36/15
2009	30/13
2010	29/12
2011	33/17
2012	38/9
2013	39/21*

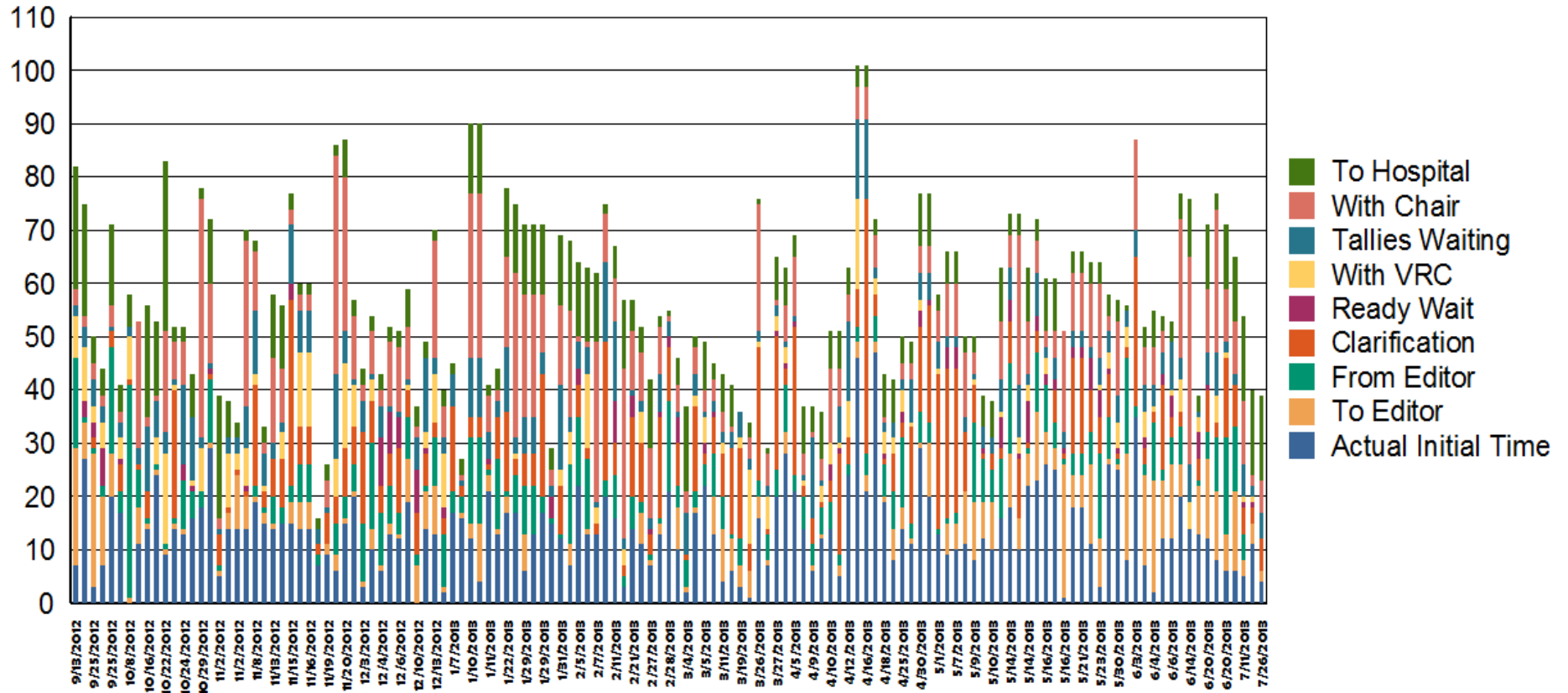


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100 years

Other PI Initiatives



In Days From End of Site Visit



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Resources for Optimal Care of the Injured Patient – Revision Update

- ▶ All chapters have undergone:
 - Input solicitation
 - Initial writing/revision
 - 3 editorial reviews/revisions
- ▶ Evidence-based linkage to criteria is underway
- ▶ Preparation to provide the ACS/NAEMSO Trauma JOC with advanced copies
 - Allow for development of materials to assist states with transition/implementation
- ▶ Anticipated final delivery date: Early 2014



Clarification of State Relationship

▶ **SITE REVIEWER'S MEETING***

- Closed meeting. This session involves only the review team unless representation from the agency that designates trauma centers (based on required ACS verification) is present at the review. If present, the session should also include at least one representative from that agency, typically the agency's trauma program manager or trauma medical director.

- ▶ From: Conducting Verification and Consultative Reviews: A Staff and Consultant's Guide



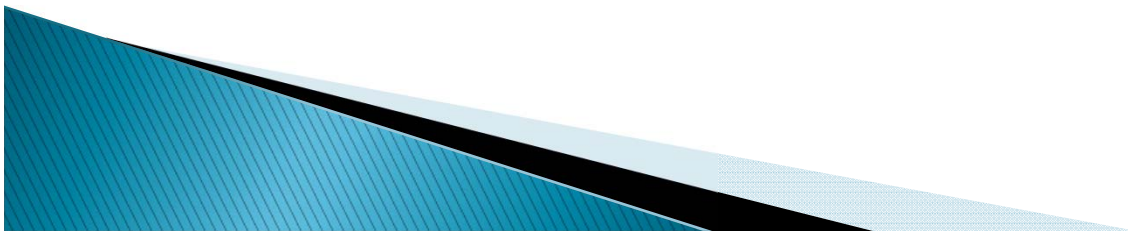
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Trauma Center Verification

- ▶ Questions?
- ▶ Points for discussion?



Trauma Systems

- ▶ Mission is to promote development and optimization of regional trauma systems
- ▶ Areas of focus
 - Consultation visits, both global and focused
 - Development of tools for system measurement and needs assessment
 - Inventory of system resources
 - Development of international relationships
 - Specific systems oriented research



Climate Change

- ▶ Primary questions arising in recent consultations focus on the “how”
 - How should a needs assessment be done?
 - How many trauma centers are needed?
 - How should performance be measured?
 - How does a lead agency arbitrate contentious issues?
- ▶ A pure, objective data-driven answer is a mythical beast
- ▶ One solution still will not fit all situations



The Challenge... and the Opportunity

- ▶ Develop a set of concrete recommendations and examples to guide regional systems in needs assessment and resource allocation
 - Inventory and assessment of current practices
 - Identification of potential metrics for structure, process and outcome
 - Establish a range of potential benchmarks
 - Acknowledge the lack of a single best practice
- ▶ Empower regional systems to choose their metrics and their targets
 - Consensus-based process with stakeholder buy-in



The Challenge... and the Opportunity

- ▶ Collect data in regular fashion
 - Work with existing data sources
 - Utilize regional strengths to collect specific data
- ▶ Adjust regional metrics and benchmarks based on progress
- ▶ Adjust overall approach based on experience within regions.



American College of Surgeons – Trauma Center Needs Assessment Tool		
Category - Access	Desired State	xx % of all injured patients meeting step one or two field triage criteria will receive care at a LI or LII trauma center within yy minutes of injury.
	Parameters	xx - No data available for percentage of injured patients, suggested range 80%-100% yy - No data available for correct time to arrival, suggest 60 min
	Current State	Determine: <ul style="list-style-type: none"> • Injury time • Field triage step • Arrival time at facility • Destination facility, if other than level I or level II center, then need time to transfer <ul style="list-style-type: none"> ○ Arrival time at 2nd facility
	Data Sources	<ul style="list-style-type: none"> • EMS registry • Trauma registry at receiving trauma centers • Trauma data from intermediate facilities: <ul style="list-style-type: none"> ○ Trauma specific data ○ HDD or EDD data
	Gaps	<ul style="list-style-type: none"> • Delay in EMS dispatch • Delay in EMS arrival • Long transport time • No appropriate center
	Strategies	Include both ground and air medical transport time/ distance in calculations (add no-fly days into the calculations)
	Trade-Offs	Over designation likely to improve access but increases cost and volume at individual trauma centers Under-designation will maintain higher volume at individual trauma centers but potentially decreases access and places greater burdens of transport resources, both for field and inter-facility transports.

American College of Surgeons – Trauma Center Needs Assessment Tool		
Category - Access	Desired State	xx% of injured patients with ISS > 15 treated without transfer at facilities other than designated trauma centers
	Parameters	xx - no data, suggest < 5%
	Current State	Determine: <ul style="list-style-type: none"> • % of patients with ISS > 15 treated in designated trauma centers compared with total number of injured patients with ISS >15 in the state
	Data Sources	<ul style="list-style-type: none"> • State trauma registry • Facility trauma registries • Hospital discharge data • Vital records (death certificates)
	Gaps	Limited enforcement of system guidelines for interfacility transfer
	Strategies	Identify hospitals not appropriately transferring seriously injured patients on a consistent basis (e.g., keep paying patients or neurosurgeon available daytime hours only). Identify as a potential location where trauma center or trauma participating hospital is needed. Monitor and enforce transfer guidelines and policies.
	Trade-Offs	In rural areas access to specialty care, e.g. neurosurgeon, may be occasionally life-saving. However, the resources supporting that sporadic care such as a qualified ICU may be lacking and the lack of their inclusion in the trauma center through a designation/verification process reduces oversight and performance improvement monitoring. Selective triage by ability to pay places a greater burden on higher level centers. Failure to recognize that all acute care facilities treat some level of injury negates the opportunity to collect data from those facilities and to more fully integrate them into an inclusive trauma system designed to meet the needs of the entire spectrum of injured patients.

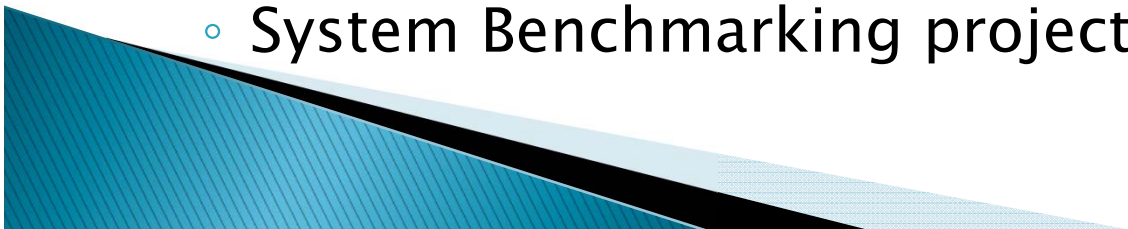
American College of Surgeons – Trauma Center Needs Assessment Tool		
Category – Training Mission	Desired State	Each level I center will see a sufficient volume of injured patients to support continued competence of trauma staff and the training mission of the center
	Parameters	<ul style="list-style-type: none"> • Limit by admissions: COT 1200 • Limit by severe injuries: COT 250 with ISS > 15 • Limit by geographical proximity: One LI per region or catchment area
	Current State	Determine: <ul style="list-style-type: none"> • Required volume for competency mission • Required volume for training mission
	Data Sources	<ul style="list-style-type: none"> • EMS registry • Trauma registry at receiving trauma centers • Trauma data from intermediate facilities: <ul style="list-style-type: none"> ○ Trauma registry specific data ○ Hospital discharge or ED discharge data
	Gaps	<ul style="list-style-type: none"> • Over-triage to LI center • Underutilization and commensurate experience at LII-III trauma centers
	Strategies	If the training need cannot be met by standard patient flow, the field triage criteria may need to be adjusted to ensure the agreed upon volume. If patient transport is determined by geographic catchment area, boundary modifications may be necessary. The training mission should be factored into the model for trauma center number, location, and level.
	Trade-Offs	May result in under-designation of supporting facilities that would be necessary for surge or large scale events. This could, potentially, reduce redundancy in the event of a LI facility catastrophe such as a flood, tornado, earthquake, fire or act of terrorism.

American College of Surgeons – Trauma Center Needs Assessment Tool		
Category – Discovery/ Dispatch	Desired State	xx% of population covered by E911 or Next Generation 911, yy% of geographical coverage by E911 or Next Generation 911
	Parameters	xx - no data available, suggested 95-100% of population yy - no data available, suggested >90% of geography
	Current State	Determine: <ul style="list-style-type: none"> • % of population covered • % of geography covered
	Data Sources	<ul style="list-style-type: none"> • State 911 Office • Regional/Local 911 Offices
	Gaps	<ul style="list-style-type: none"> • Delay in ability to notify dispatch by cell phone • Inability to locate caller results in delayed response
	Strategies	Continued national and statewide efforts to upgrade 911 capacity is ongoing. Trauma stakeholders should be knowledgeable of such efforts in their state or region and should support legislative or grant efforts to secure sufficient funding for such improvements.
	Trade-Offs	While delays in discover do occasionally occur, delays in notification are far more common and may affect need for additional trauma centers in order to meet time to definitive care guidelines. Failure to identify caller location (E911 and Next Gen 911) may delay response times and may also suggest the need for additional trauma centers.

American College of Surgeons – Trauma Center Needs Assessment Tool		
Category – EMS Response	Desired State	xx% of population covered by advanced life support personnel within zz minutes; yy% of population covered by basic life support ambulance within aa minutes
	Parameters	xx - no data available, zz - in urban systems fractal response time of < 9 minutes >95% yy - no data available aa - in rural systems fractal response time of <20 minutes >90%
	Current State	Determine: <ul style="list-style-type: none"> • % of urban population covered by ALS within established response times parameters • % of rural population covered by ALS within established response times parameters • % of rural population covered by BLS within established response time parameters
	Data Sources	State EMS Office: <ul style="list-style-type: none"> • State NEMSIS databases • Computer aided dispatch (CAD) databases
	Gaps	<ul style="list-style-type: none"> • Limited availability of ALS resources in rural areas <ul style="list-style-type: none"> ○ Can be of high value due to extended transport or transfer times. • Local agencies may be reluctant to transport patients to distant trauma centers <ul style="list-style-type: none"> ○ Takes limited resources out of primary response area ○ If volunteer staffed takes people away from primary vocations
	Strategies	Computer aided dispatch may help identify the correct response type/mode. Pre-arrival instructions are essential in areas with extended response times but rural dispatch centers often do not have the resources to provide certification for their dispatchers. Trained emergency medical responders (EMR) such as law enforcement, fire department or freestanding quick response units may be essential to provide immediate medical care prior to the ambulance arrival in rural and remote areas.
	Trade-Offs	Properly positioned EMS agencies reduce response time. It may not be practical to expect high level prehospital resources in every community. Regionalization of EMS systems may help control costs and helps keep local resources within standard response areas. ALS rendezvous and hand-offs may improve system efficiency.

Inventory and Assessment

- ▶ Trauma Center Inventory Project
 - Provides number, level, and location of centers
 - Expanding data set to include capacity measures
 - Possible linkage to TQIP, NTDB or other potential sources of outcome data
- ▶ Identification of sources for EMS inventory
- ▶ Catalog of needs assessment methodologies used in different regions
- ▶ Catalog of regulatory approaches
- ▶ Catalog of potential system metrics
 - System Benchmarking project



International Efforts

- ▶ Two international visits done
 - Combination of VRC and Systems process
 - Rigshospitalet, Copenhagen, Denmark – July 2012
 - Hamad General Hospital, Doha, Qatar – March 2013
- ▶ Great untapped need
- ▶ Open consultative approach is essential
 - Broad concepts can be generalized
 - Specific standards poorly generalized
 - Individual solutions inherently local



International Efforts

- ▶ Working in coordination with new I2C2
- ▶ Plan to gather information on current status
- ▶ Work to establish criteria for international hospital verification/accreditation/?? Term
 - Adhere to broad principles
 - Establish applicable standards
 - Separate from US-based VRC
- ▶ Work to aid system development
 - Collaboration with WHO and other organizations
 - Creation of system development tools
 - Establishment of an international trauma data set



Trauma JOC

- Empanelment of joint operations NASEMSO/COT Committee
- Early areas of collaboration that impact systems committee:
 - Systems Benchmarking
 - Model system/regionalization
 - Air/ground transportation
 - Definitive care standards
 - Collaboration w/state COT/state EMS



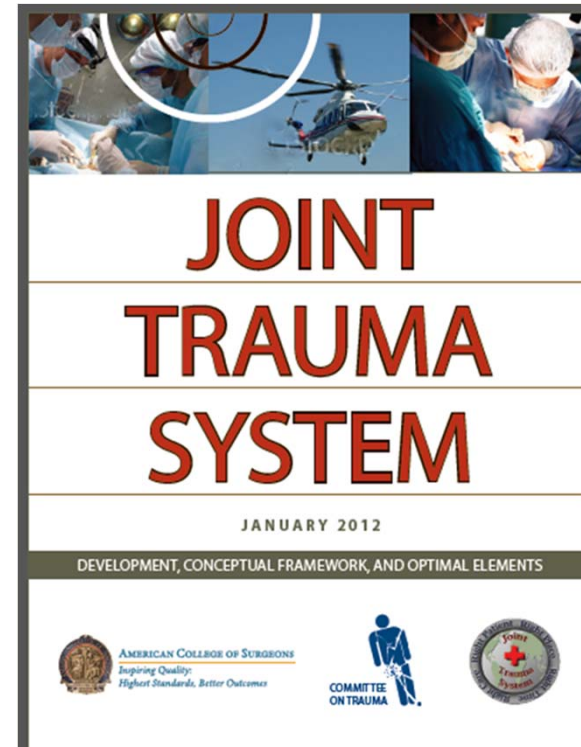
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US Military Document

- Approved by Board of Regents



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Follow-up Project

- Measuring the impact of the trauma system consultation process on system development in states/regions we have visited
 - 16 indicators from HRSA's 2006 *Model Trauma System Planning and Evaluation, Benchmarks, Indicators, and Scoring* tool used to measure progress
 - Scoring of current status of priority recommendations from report
- Data Collection Complete
- Analysis of data and reporting of findings to follow



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EMSC Targeted Issues Grant

- Three abstracts have been developed and submitted
- Multiple articles in process
- No cost extension until November 30, 2013



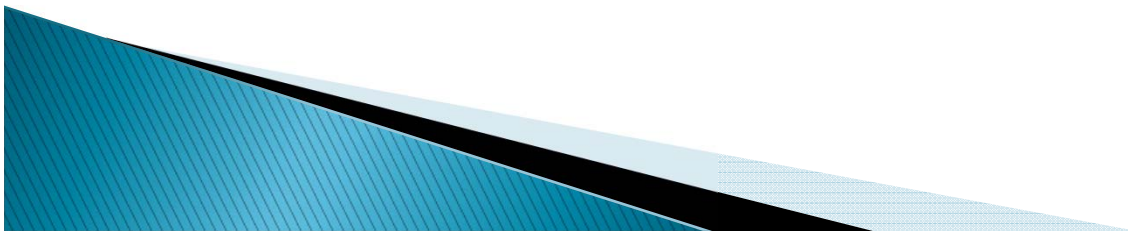
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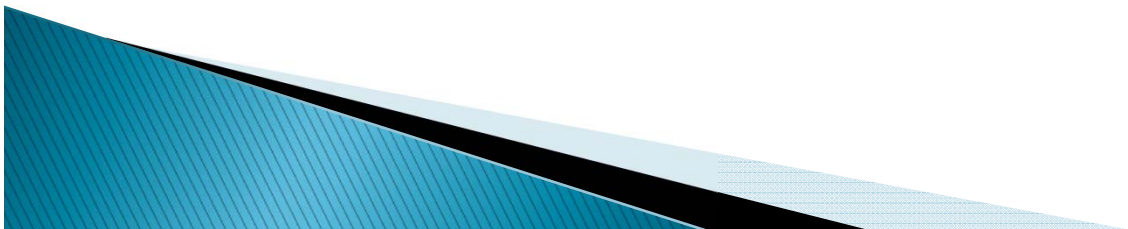
Trauma Systems Program

- ▶ Questions?
- ▶ Points for discussion?



Data and Quality Programs

- ▶ National Trauma Data Bank
 - Continued improvements in data quality
 - Changing submission time frame
 - Linkage with NEMESIS
 - Trauma center inventory project
- ▶ Trauma Quality Improvement Project (TQIP)
 - Improved data quality and benchmarking
 - Refining methodology
 - Working on linkage to verification process



NTDB Update

- ▶ The Annual Report will be presented at the AAST Annual Meeting featuring 773,299 records from 744 hospitals
- ▶ NTDB is moving to a more concurrent data collection model, with enhanced online reports
- ▶ We are developing an online course on NTDB/NTDS

NEW!!!



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Trauma Center Inventory

- ▶ One of the primary cooperative projects between NASEMSO and COT
- ▶ 2000 + records so far
- ▶ Data collected through current, updated infrastructure
- ▶ Optimization of data capture essential
- ▶ Ongoing development will
 - Review and refine data dictionary
 - Consider data uses and future goals



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TQIP Status Report

- ▶ 180 current participants
- ▶ Rolling enrollment – join any time during the year
- ▶ Developing TQIP participation for states/systems
 - Five states at various stages of participation
- ▶ Pediatric TQIP pilot with 38 centers
- ▶ Beginning to identify high performers
- ▶ External data validation



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TQIP deliverables

2013 :

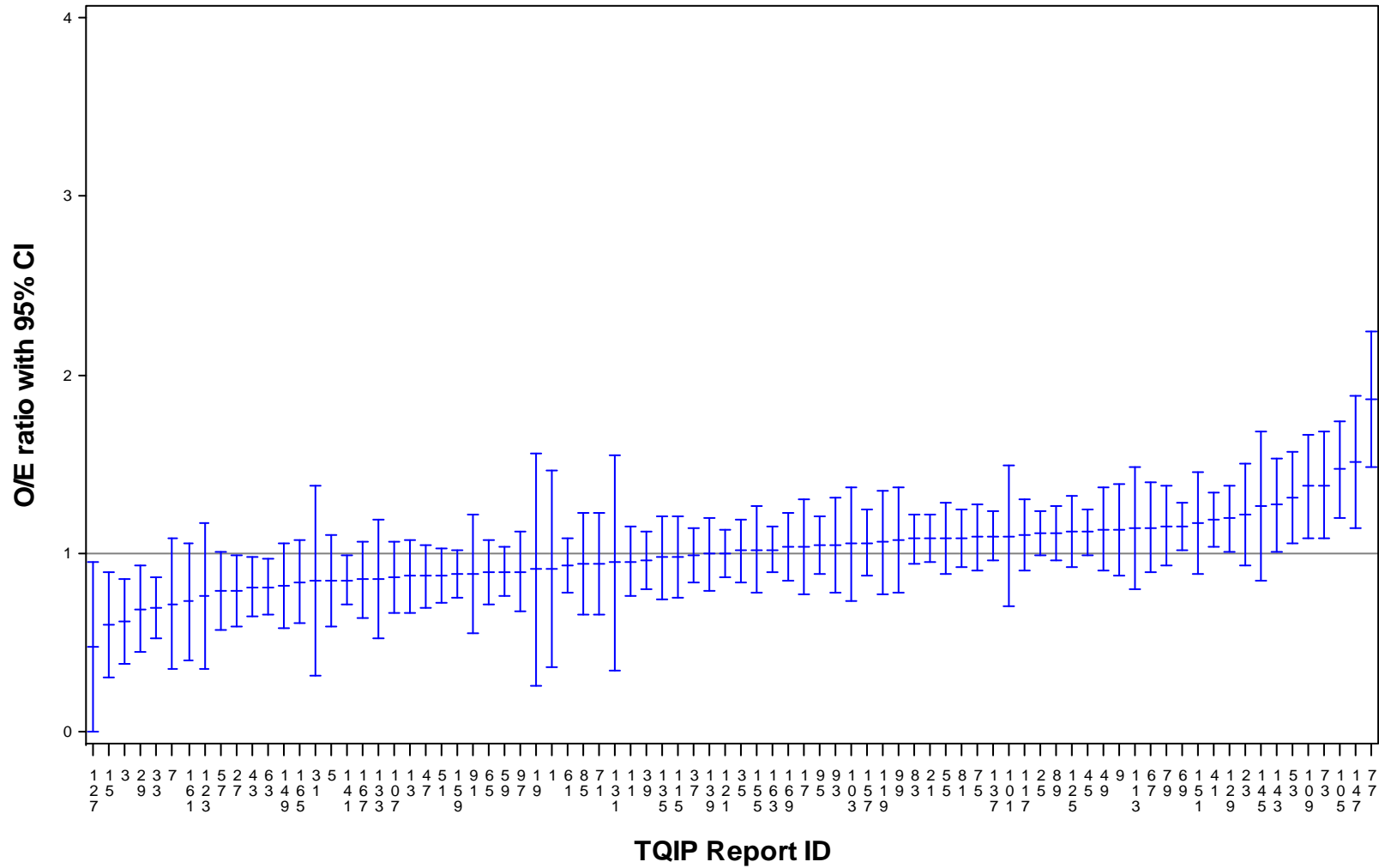
- Risk adjusted benchmark reports
- Web conferences
- Quarterly data quality check
- Online course
- Monthly educational experiences
- Online data analysis tool
- Web conferences
- Annual meeting



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Risk Adjusted Mortality: All Patients (Odd # centers)



* indicates that the center has no deaths.
 # indicates that the center has an O/E ratio above 4.

Merging TQIP and Verification

- ▶ Provide for outcome-based trauma center verification/designation
- ▶ Strategic planning underway
 - Business model development
 - Functional impact analysis
 - High performing centers
 - Low performing centers
- ▶ Phased in process



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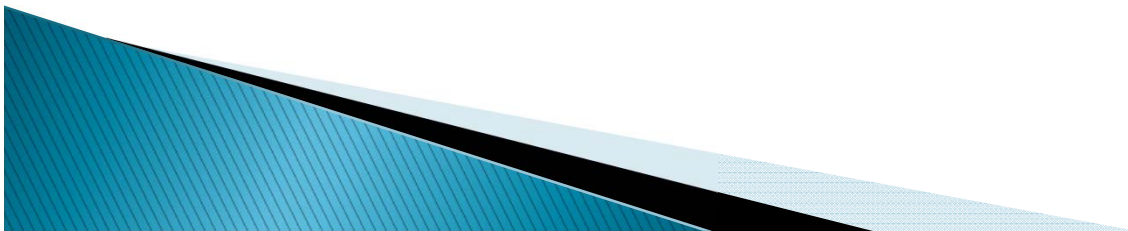
Data and Quality Initiative

- ▶ Questions?
- ▶ Points for discussion?



Educational Programs

- ▶ A major focus of COT activity since its inception
- ▶ Several new courses developed, aimed both at providers and facilities
- ▶ Development of electronic platforms and new modes of course delivery



Current Courses

- ▶ Advanced Trauma Life Support Course – ATLS
- ▶ Prehospital Life Support Course – PHTLS *
- ▶ Rural Trauma Team Development Course – RTTDC
- ▶ Trauma Outcomes and Performance Improvement – TOPIC*
- ▶ Disaster Management and Emergency Preparedness – DMEP
- ▶ Advanced Surgical Skills for Exposure in Trauma – ASSET
- ▶ Advanced Trauma Operative Management – ATOM
- ▶ Trauma Evaluation and Management – TEAM
- ▶ Optimal Trauma Center Organization and Management Course

*cosponsored with other organizations

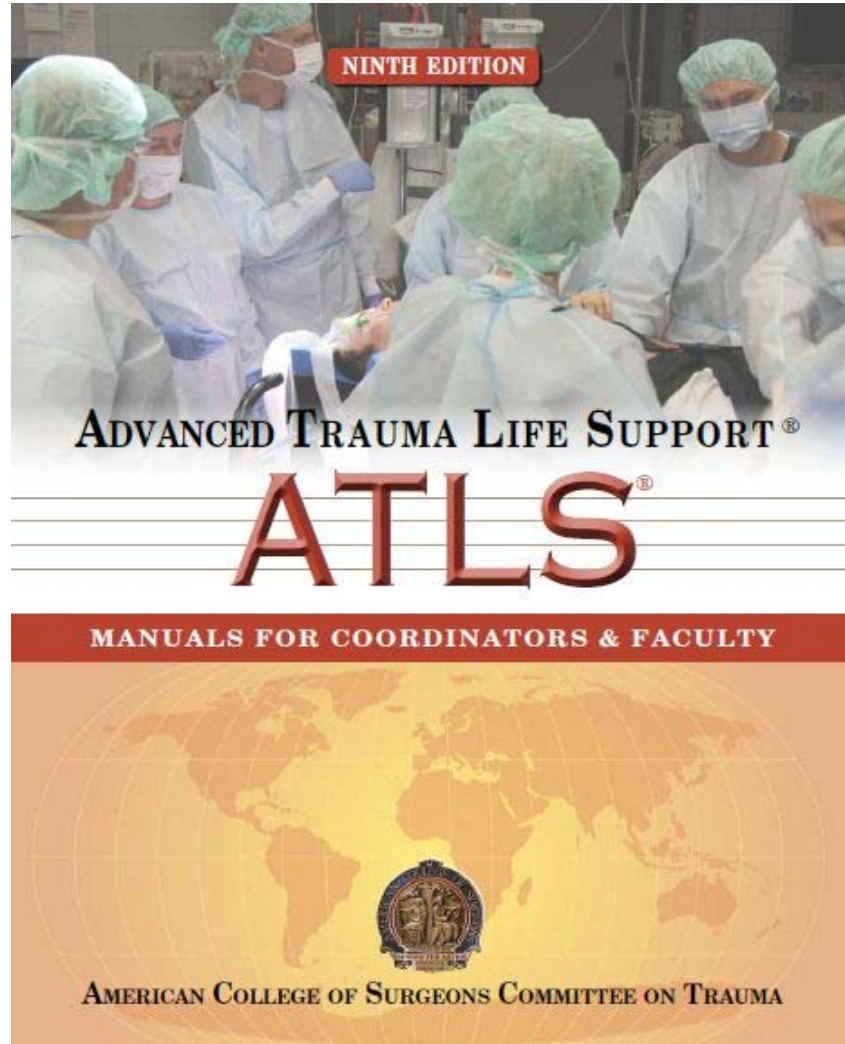
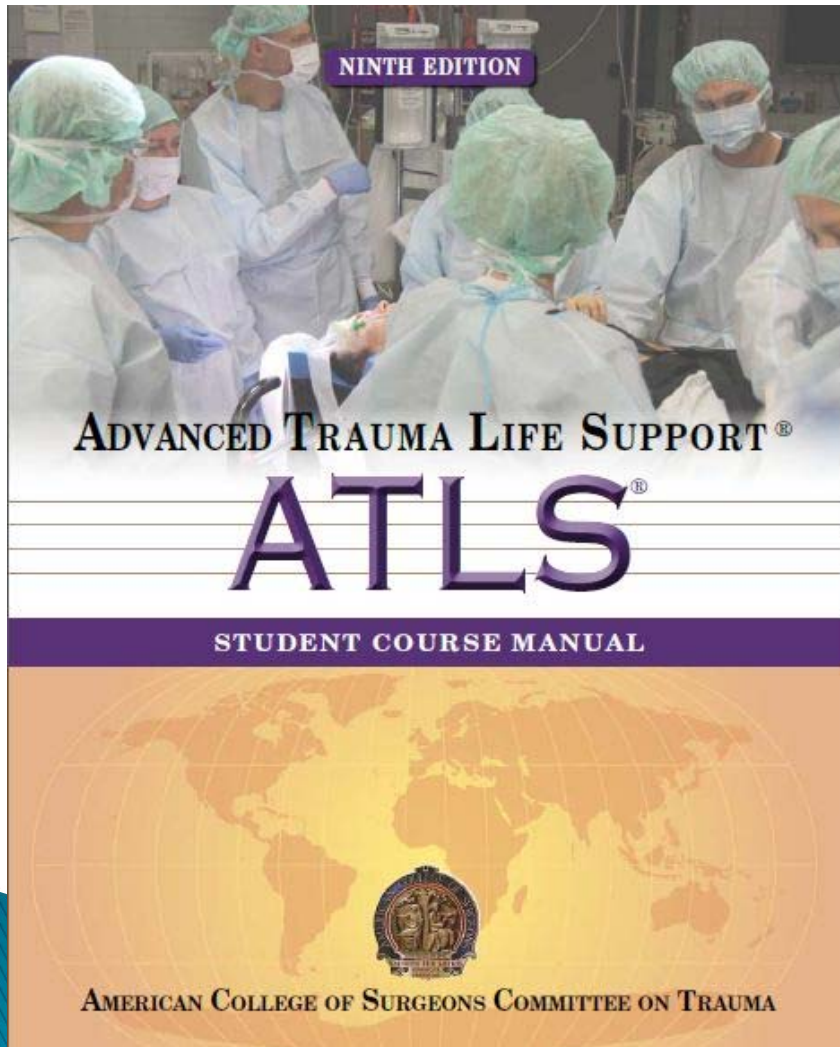


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ATLS – in the 9th Edition



ATLS Promulgation

*Czech Republic
Iran
Libya
Philippines*



ATLS[®]
ADVANCED TRAUMA LIFE SUPPORT



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100years

Approved Applications: Bangladesh, Belize, Bosnia, Croatia, El Salvador, Georgia, Ghana, Honduras, Iraq, Mongolia, Philippines, and Poland

ATLS APP Completed

- ▶ Total of 11, 121 downloads
- ▶ Number of countries that have downloaded the APP: 121

Welcome!



Welcome to the Advance Trauma Life Support® for Doctors Guide

Correct Method for Assessment Management.



This video demonstrates the correct method for Assessment Management.

Incorrect Method for Assessment Management.



This video demonstrates the incorrect method for Assessment Management.

Airway Management Tips



Tips for airway management.

Bag Mask Usage



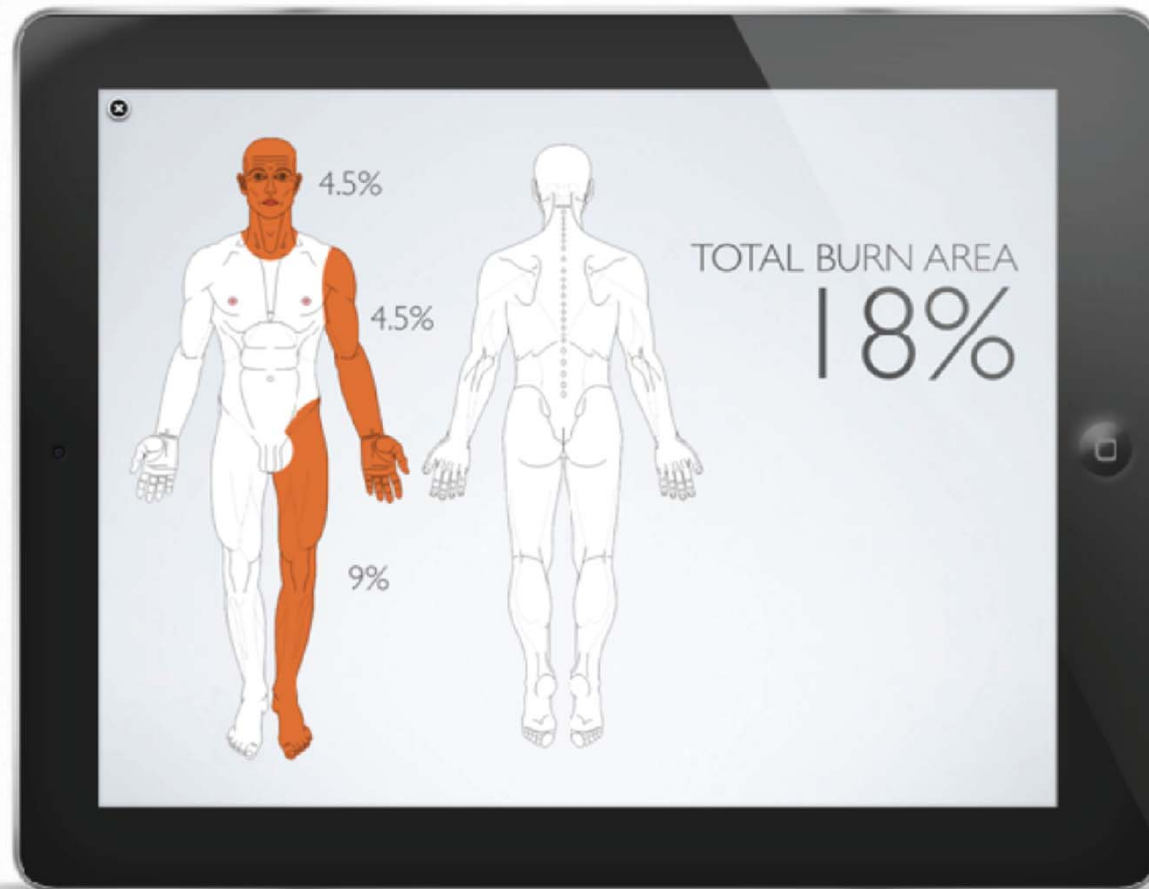
Demonstration of the usage of a bag mask device.



ATLS APP

Feature Packed

The Parkland calculator, re-imagined



ATLS mLearning Structure

Course will still meet in person for skill stations 1.5 days which will include 90 minutes of lecture

- Book will be available online
 - ibook and other platforms
- Hybrid course
 - **Optional**
 - Chapters Blueprints for mLearning complete
- Media Development
 - Animations
 - Video
 - Gaming
 - Simulation



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ATLS mLearning Features

Course Participants

- Thirteen modules to coincide with chapters
- PowerPoint , videos, animations, games, and simulations
- Self-assessment quizzes
- Discussion boards
- Secure log in and time out feature

Faculty, Coordinators, Staff

- Analytic Reports (more data)
- Tracking on participant time spent
- E-Commerce System
- Capability for document upload
- User profile linked



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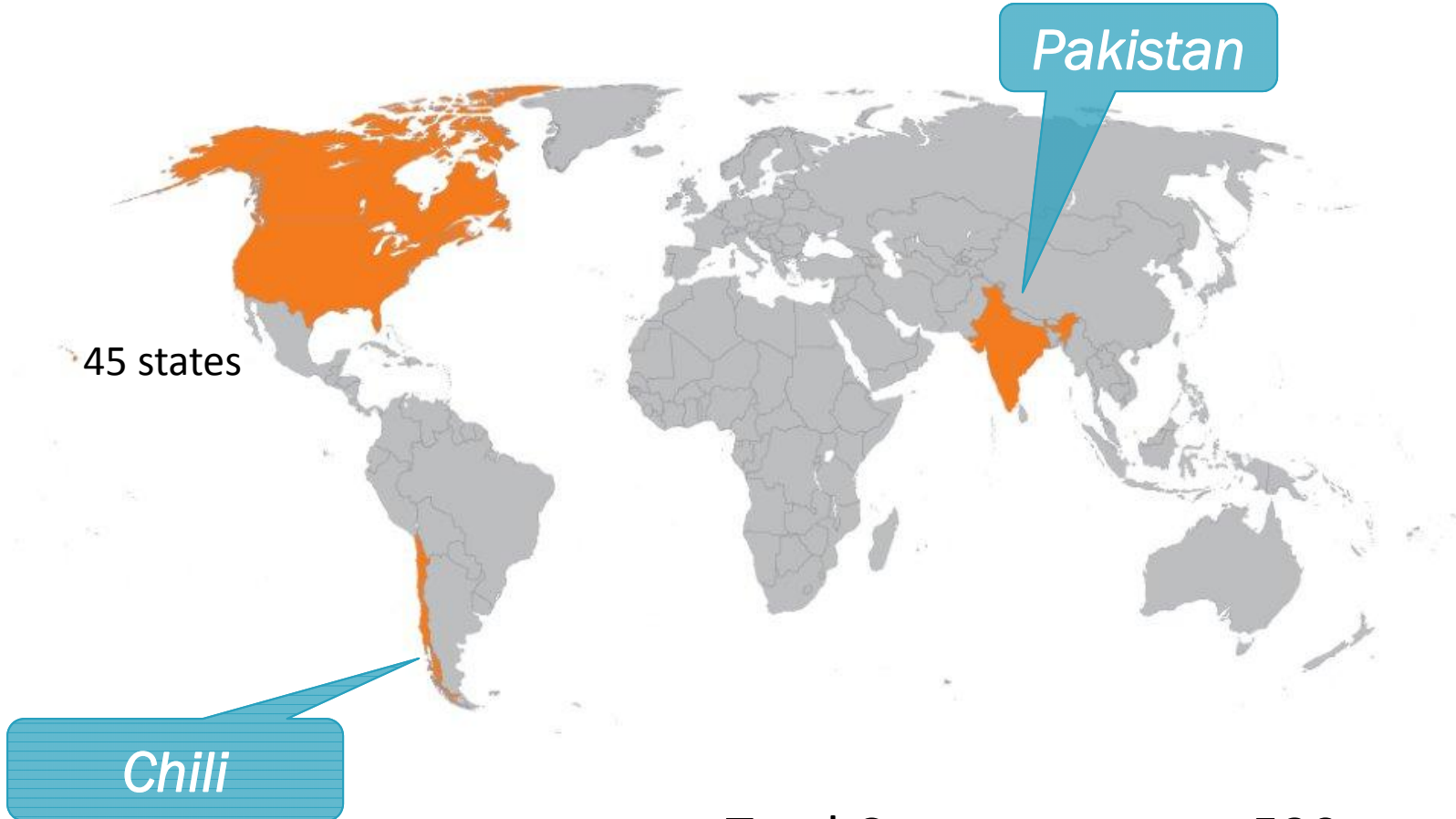
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ATLS mLearning Timeline

- 20% of the media completed and ready for review at congress
- Content layout and Media finalized by January 2014
- LCMS vendor selected by January 2014
- Pilot testing Spring of 2014



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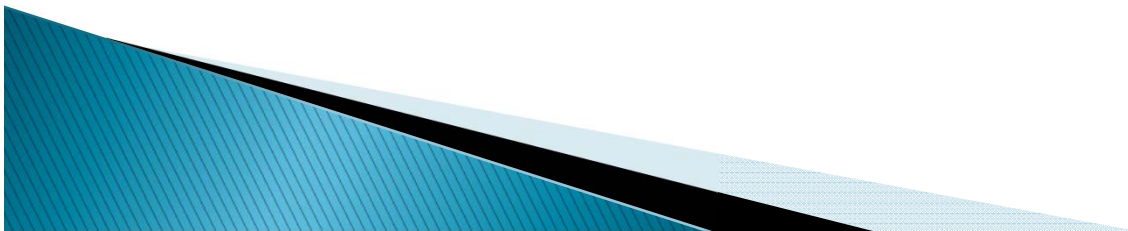


Total Courses	530
2012 Completed	40
Students trained	7000
Instructors	125

3rd edition Spanish, French

Educational Programs

- ▶ Questions?
- ▶ Points for discussion?



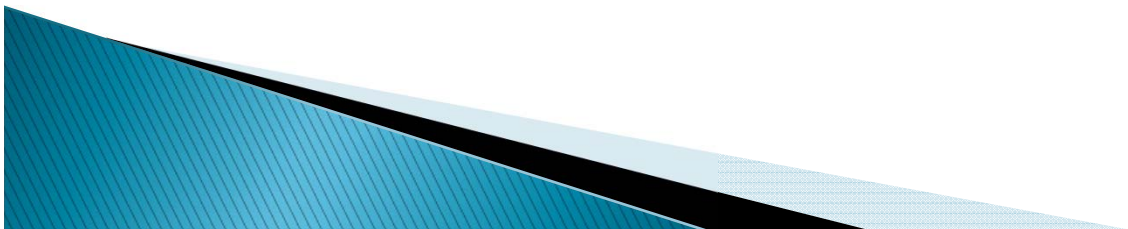
Advocacy

- ▶ ACS has a large advocacy commitment, broad set of priorities including trauma
 - Permanent staff in Washington
 - Separated out as a separate COT function
- ▶ Monitor legislation
- ▶ Coordinate grass-roots efforts
 - National level
 - Regional level



Advocacy

- ▶ Comprehensive Federal legislation and funding for trauma systems not yet established
- ▶ Trauma system development and operation is a state and regional initiative
 - Development of strong regional support essential
 - Target advocacy at state and regional level



Trauma Legislative Priorities

- ▶ Trauma Funding
 - The College supports efforts to raise revenues to alleviate some of the funding problems. Funds exclusively allocated to trauma care.
 - Currently only 24 states have a funding mechanism in place for trauma care.
- ▶ Injury Prevention
 - Support a number of injury prevention bills including: graduated drivers' licenses; seatbelt requirements; child restraint systems; youth athlete concussion education and prevention; programs to prevent falls by the elderly; motorcycle and bicycle helmet requirements; and all terrain vehicle regulation.
- ▶ State Bill Tracker Available on ACS Website:
<http://www.cqstatetrack.com/texis/viewrpt?event=4b7adbb620d>



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Advocacy Resources: State Affairs Staff

- ▶ Staff is available to:
 - Draft legislation/provide model bills
 - Provide background and/or issue briefings
 - Provide advocacy training
 - Provide testimony
 - Plan lobby days
 - Help plan chapter's legislative agenda
 - Connect chapter with other groups/organizations

Jon Sutton
Manager, State Affairs
312/202-5358
jsutton@facs.org

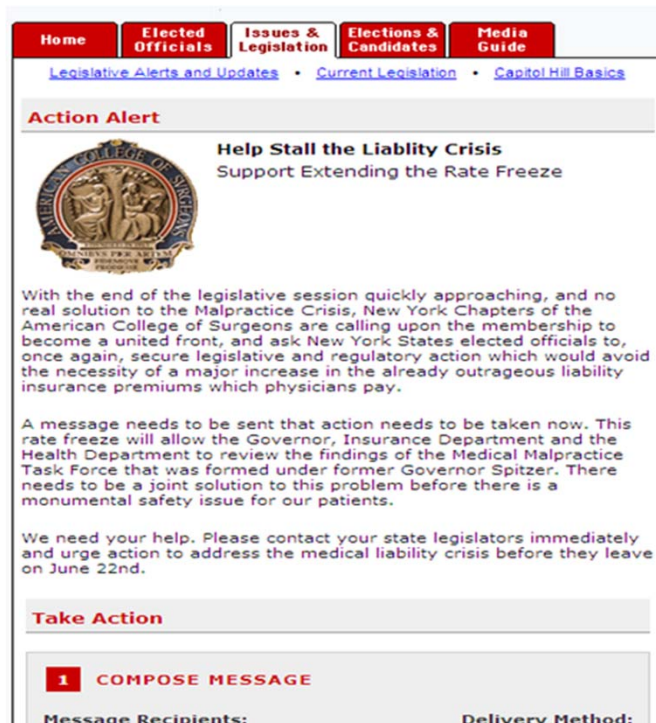


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Advocacy Resources: SSLAC

▶ Surgery State Legislative Action Center (SSLAC)

- www.facs.org/sslac
- Website to help with grassroots advocacy efforts and compendium of state resources.
- Open to Fellows and non-Fellows



The screenshot shows the SSLAC website interface. At the top, there are navigation tabs: Home, Elected Officials, Issues & Legislation, Elections & Candidates, and Media Guide. Below these are links for Legislative Alerts and Updates, Current Legislation, and Capitol Hill Basics. The main content area features an "Action Alert" with the American College of Surgeons logo and the title "Help Stall the Liability Crisis: Support Extending the Rate Freeze". The text explains the urgency of the malpractice crisis and calls for legislative action. At the bottom, there is a "Take Action" section with a "COMPOSE MESSAGE" button and fields for "Message Recipients:" and "Delivery Method:".



The screenshot shows the "Elected Officials" section of the SSLAC website. It includes a search bar for "Search By ZIP Code:" and "Search By Last Name:". The "Search By Last Name" section has radio buttons for "Congress:", "State:", and "Local:". Below this is a "Select State" dropdown menu and a "GO" button. A map of the United States is displayed, with state abbreviations listed on the right: RI, MA, CT, NYC, DE, DC, and Territories: AS, GU, PR, VI. At the bottom, there is a "Tell A Friend" link and a footer that says "powered by Capitol Advantage ©2009".



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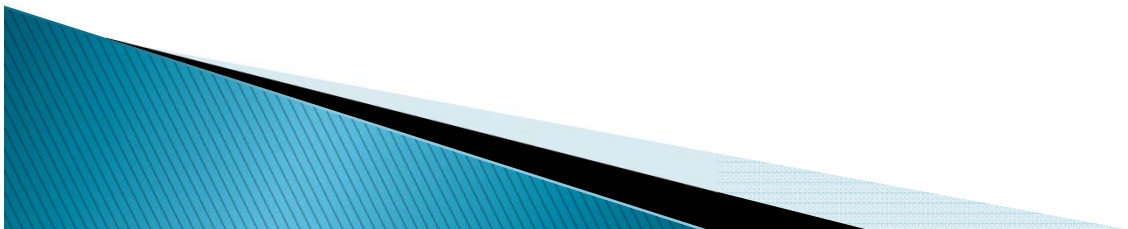
Advocacy

- ▶ Questions?
- ▶ Points for discussion?



Quality Pillar Committees

- ▶ EMS
 - PHTLS
 - Aeromedical standards
 - Field triage standards
 - Coordination with other organizations
- ▶ Rural Trauma
 - Level IV standards
 - Staffing issues
 - Educational challenges



Quality Pillar Committees

- ▶ Disaster
 - Coordination with other resources
 - Education
- ▶ Prevention
 - Building of inter-organizational coalition
 - Development of tools for prevention activities



Contact Information

Advocacy Pillar

- ❖ Kristen McDonald– kmcdonald@facs.org 202-672-1509

Information Engine

- ❖ Melanie Neal– mneal@facs.org 312-202-5536

Education Pillar

- ❖ Monique Evelyn– mevelyn@facs.org 312-202-5365

Quality Pillar

- ❖ Nels D Sanddal– nsanddal@facs.org 312-202-5469



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