Trauma Verification Q&A Web Conference

August 30, 2017

COTVRC@facs.org
Your Trauma Quality Programs Staff

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Continuing Education (CE)

- To qualify for CE, you must attend at least 50 minutes of educational content.

- An email will be sent to all attendees who qualify for CE within 24 hours of the webinar ending, with instructions on how to claim CE.

- If you have any questions – please email COTVRC@facs.org.
What is the goal for this Webinar?

- Interpret the standards outlined in the Resources for Optimal Care of the Injured Patient manual to ensure that hospitals have an understanding of the criteria to provide quality care to the injured patient.

- Understand the processes and standards involved in an ACS Trauma Verification Site Visit and how following these will positively impact the quality of care of the injured patient at your center.
Let’s get started!
Orange Resources Book

Available as hard copy or PDF version, it is recommended that you have it available as reference during the CD-Related Questions section of this webinar.

Must use the most current Clarification Document and the Verification Change Log in conjunction with the manual.

www.facs.org/quality-programs/trauma/vrc/resources
Clarification & Verification Document Updates

The updates for the Verification Change Log and Clarification Document through June have been completed.

These documents may be accessed through the VRC webpage at:

www.facs.org/quality-programs/trauma/vrc/resources

Going forward, changes to the criteria will be published in the Verification Change Log, and any clarifications to criteria will be published in the Clarification Document.
Clarification Document

Updates sent to participants monthly

The American College of Surgeons

Clarification Document

Resources for Optimal Care of the Injured Patient

By the Verification Review Committee

V1 March 2017

www.facs.org/quality-programs/trauma/vrc/resources
## Verification Change Log

Updates sent to participants monthly

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<th>Chapter</th>
<th>CD #</th>
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<td>1-1</td>
<td>I</td>
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<td>III</td>
<td>IV</td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1-1).</td>
<td>TYPE II</td>
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<td>1-2</td>
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<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>They must function in a way that pushes trauma center–based standardization, integration, and PIPS out to the region while engaging in inclusive trauma system planning and development (CD 1-2)</td>
<td>TYPE II</td>
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<td>7/1/2014</td>
<td>New</td>
<td>Meaningful involvement in state and regional trauma system planning, development, and operation is essential for all designated trauma centers and participating acute care facilities within a region (CD 1-3)</td>
<td>TYPE II</td>
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<td>7/1/2014</td>
<td>New</td>
<td>This trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care (CD 2-1).</td>
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<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>Surgical commitment is essential for a properly functioning trauma center (CD 2-2).</td>
<td>TYPE I</td>
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<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification (CD 2-3).</td>
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<td>I</td>
<td>II</td>
<td>III</td>
<td></td>
<td>I</td>
<td></td>
<td>7/1/2014</td>
<td>Revised</td>
<td>Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon’s ability to participate on the trauma panel based on an annual review (CD 2-5).</td>
<td>TYPE II</td>
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Recording of Webinars

The webinars are recorded during the session and will be posted within one week on the ACS YouTube channel.

You may also access them via the VRC resources webpage at:

https://www.facs.org/quality-programs/trauma/vrc/resources.
Disclaimer

• All questions are pulled directly from the question submissions. There have been no edits made to the contents.

• If your question is not answered today, the question may require more information, and will receive a response from ACS staff within one week after the webinar.
Announcements
Next Verification Q&A Webinar

Deadline to submit questions: **Friday, September 8, 2017**

Webinar date: **Wednesday, September 20, 2017**

Webinar time: **12:00pm- 1:00pm CST**
Save the Dates

Abstract submission will open in mid May 2017.

Registration for the TQIP Annual Scientific Meeting and Training and Preconference Workshops will open Summer 2017.

Please let us know if you have any questions.
TQIP Meeting Information

• Registration is currently open

• Hotel reservations are open

• For more information visit: https://www.facs.org/tqipmeeting
TQIP Preconference Courses

- Registration is open for some workshops.
- Course detail listing available at: [https://www.facs.org/quality-programs/trauma/tqip/meeting/workshops](https://www.facs.org/quality-programs/trauma/tqip/meeting/workshops)
  - AIS and Injury Scaling Uses and Techniques (2-day course)
    - Thursday, November 9 and Friday, November 10
  - T O P I C
    - Thursday, November 9
  - O P T I M A L Course
    - Friday, November 10
  - A I S 1 5 Update
    - Friday, November 10
The Stakeholder Public-Comment website:

https://www.facs.org/quality-programs/trauma/vrc/public-comment

We strongly encourage everyone to review and comment on the standards. Your input will help guide the revision process to add, modify or retire requirements.

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Updates: Frequently Asked Questions Link

New link for Frequently Asked Questions (FAQs).
• This will expand over time so check frequently
  ▪ Applicable level and grouped by category
• [https://www.facs.org/quality-programs/trauma/vrc/faq](https://www.facs.org/quality-programs/trauma/vrc/faq)

Can members attend the Trauma peer review meeting by phone?

The panel members required to attend the Trauma peer review meeting may attend in-person or by teleconference or skype [video].

Category: Multidisciplinary Trauma Peer Review Meeting

Level: I, II, III
Updates: Tutorial

• Becoming a Verified Trauma Center: First Steps
  ▪ Designed to guide the Trauma Program Manager or Medical Director in the First Steps in the Consultation and Verification Process.

• Objectives:
  ▪ Optimizing the VRC webpage for documentation to assist in preparing for a site visit
  ▪ What is needed before a visit can be scheduled
  ▪ Requesting a site visit

https://www.facs.org/quality-programs/trauma/vrc/resources
Scheduling Reminders
Site Visit Application

- The application must be received at least 13-14 months in advance of the requested time frame or current expiration date.
  - This will hold your spot and in addition, provide centers plenty of time to prepare and complete the online PRQ.
- The lead time is required due to the multitude of applications received.
- All of 2017 and up to September 2018 are closed to scheduling:
  - https://www.facs.org/quality-programs/trauma/vrc/site-packet
Additional Information to be submitted with Site Visit Application

The following should be submitted at the time of the site visit application:

- **Orthopaedic Traumatologist Leader (OTL) form**
  - Required for:
    - Level I Trauma Centers
    - Level I Pediatric Trauma Centers
    - Level I Adult and Level II Pediatric Trauma Centers

- **Alternate Pathway Request for new applicants**
Orthopaedic Traumatology Leader (OTL) Form

- For Level I adult or Level I pediatric trauma centers (includes combined Level I centers), the OTL form must be completed and submitted with the site visit application.
  - The form is located at: [https://www.facs.org/quality-programs/trauma/vrc/site-packet](https://www.facs.org/quality-programs/trauma/vrc/site-packet)

- For those trauma centers that have separate visits scheduled, but share the same adult and pediatric OTL, the form must be completed entirely for the 1st visit and on the 2nd visit, only answer questions 1-3.
  - If you are unsure if the 1st visit has completed the form, please contact the VRC office at: COTVRC@facs.org.
Alternate Pathway Request

• For all trauma centers that have a non U.S. or Canadian board certified/eligible physician or surgeon, and who has trained overseas, must provide the following on the site visit application at the time of submission.
  - Applicant’s name and specialty;
  - Forward a copy of the applicant’s curriculum vitae (CV).

• For information about the Alternate Pathway Criteria, visit:

https://www.facs.org/quality-programs/trauma/vrc/site-packet
Pre-Review Questionnaire (PRQ) Online Access

- Once your application has been received, the VRC office will provide you with an email receipt of confirmation.
  - Logins to the online PRQ will be provided within the confirmation of receipt email
  - The online PRQ can be accessed at: http://web2.facs.org/traumasurvey5/
  - A copy of the PRQ in Word can be downloaded from: www.facs.org/quality-programs/trauma/vrc/resources
Site Visit Application Payment

- Do not submit payment with the application

- Your center will be billed annually for the Trauma Quality Program fee
  - This annual fee will not include any additional visit-related fees, such as additional reviewers

- The fee structure is located at: https://www.facs.org/quality-programs/trauma/vrc/fees
Scheduling Site Visits

- Visits are typically scheduled within 90 days prior to the requested timeframe.

- Ideally, all visits will occur during the center’s preferred timeframe.

- When a lead reviewer is available for your site visit, VRC staff will contact you TPM to confirm the dates prior to finalizing the visit.
Site Visit Preparation with Reviewers

- The ACS Travel Agent will arrange the site reviewers’ flights. Reviewers make travel plans approximately 20 to 30 days prior to the site visit.

- The hospital will arrange and pay for the site reviewers’ hotel accommodations as well as their ground transportation.

- The reviewer’s contact information will be provided in a confirmation email once the full team has been secured, approximately 90 days before the visit.

- Please contact the reviewers directly within 30 days of the site visit, for their flight Itinerary and any logistical information.
Staffing
VRC Staff: Reports and Standards Questions

For site visit report questions/clarification and status:

- Megan Hudgins - Trauma Verification Coordinator
- Bhumi Parikh - Trauma Verification Coordinator

Questions – COTVRC@facs.org:

- Kendra Marbly - (Temp) Trauma Verification Assistant
General Questions
Reverification Annual Fee

“Just to clarify...should centers expect VRC reverification fee the same year of the site survey is scheduled?” (Level 1)

The center should expect an invoice for their VRC reverification visit approximately 60 days before their scheduled site visit. The invoice will include the annual fee for reverification and TQIP.
“What's the definition of ‘operative cases’ for trauma surgeons in the PRQ? Do any procedures outside of the OR count?” (Level 2)

This is found in appendix 2 for trauma surgeons. The question is asking for the number of trauma and non-trauma operative cases for each trauma surgeon serving on the trauma call panel. Operative cases is defined as those that require general anesthesia in the operating room.
"Is it acceptable for trauma surgeons on the on-call panel to exclusively take back-up call only and never take primary call?" (Level 2)

I’m not certain if this is referring to an actual back-up call schedule or the primary on-call schedule with the surgeon acting as a back-up when the primary is encumbered. If the question is regarding the back-up call schedule and not the on-call schedule, yes it would be acceptable for those surgeons to simply provide coverage when needed.
EMS Communication

“What feedback is required for EMS? Privacy officer does not want outcomes or hospital care discussed with EMS.” (Level 3)

It is an essential responsibility of a tertiary facility to provide specific feedback to referring facilities and prehospital providers. The feedback should include final diagnosis, the general course and outcome of the patient and any PI issues that the tertiary facility identified in the care provided prior to arrival.
Deaths - Hospice

“After listening to the last webinar about hospice discharges, would you do the same for ED discharge to hospice or just the inpatients discharged to hospice?” (Level 3)

For verification purposes, if the hospice patient was discharged from the ED to an external hospice facility or transferred to an internal hospice unit (not under the care of the trauma service), that case would not be reviewed.
Isolated Hip Fractures and Same Level Falls

“Do we have to keep isolated, fall from standing hip fractures in our registry. I am told by ‘everyone’ that we must, but there really is no single straightforward answer. It is usually, ‘depends’. Is the decision left up to the individual hospital? Our state does not want these patients submitted to them. Does TQIP require it?”

(Level 2)

Correct, the decision to capture these patients in the trauma registry will be defined by each individual hospital as part of the admission policy. In some instances, the state will want the center to capture these patients in which the center may need to capture 2 sets of data points.
"What is the acceptable percentage of travel nurses staffing in the ED or ICU?" (Level 2)

Currently, the number of nurses (travel or otherwise) that is acceptable or required to staff the ED has not been established. However, the patient-to-nurse ratio in the ICU (travel nurse or otherwise) must not exceed two to one (CD 11–66). If travel nurses are used to provide care for trauma patients, they are required to meet the same requirements as the other nurses that are employed by the hospital, e.g. undergo nursing credentialing process (training, certification, education, etc).
Verification Site-Visit

“What happens after our level II initial verification site visit? What is process and how long does it take?” (Level 3)

If this is referring to when the center will receive its official notification of verification following a site visit, this process will vary and is dependent on the steps involved. The following is a brief overview of the report process: review team submits report to the VRC office within 10 business days, edited by the VRC staff and clinical editors, follow-up questions/clarifications, peer review by the Verification Review Committee, and final adjudication (approval) by the VRC Chairs. This process can take up to 12 weeks.

As soon as the letter and report are released, the center is listed on the verified trauma webpage.
“Electronic Trauma Flowsheet if meets requirements for auditing why are reviewers stating you need to go back to paper?” (Level 1)

The VRC's stance on this is that the electronic flowsheet must contemporaneously document the care of the patient. Typically with electronic flowsheets it date stamps when a key entry is made; therefore, you must be cognizant of the date/time stamp. If reviewers see a number of instances where the date/time is not accurately documented, they may recommend to revert back to the paper flowsheet until the programming of the electronic flow sheet has been addressed.
Inpatient Beds

“Are Level 4 facilities required to have inpatient beds?” (Level 1)

There are no requirements regarding inpatient beds at a Level IV trauma centers.
CD-Related Questions
Ongoing Professional Practice Evaluation (CD 5-11)

“OPPE: Does the TMD review only general and trauma surgery or do they review ED, Rad, Anesth, Neuro, and Ortho providers as well” (Level 2)

The TMD is not expected to perform an OPPE on the specialists, e.g. ED physicians, Neurosurgeons, Orthopaedic Surgeons, Anesthesia, Radiology, etc. The OPPE for these specialists should be performed by their respective directors with oversight by the TMD.

The depth of the OPPE will vary, but should include the surgeon’s performance activities. This may include attendance to peer review meetings, CME tracking, any corrective action review, etc.
Alternate Pathway (CD 6-3)

“Do none boarded physicians previously approved through alternate pathway require to redo alternate pathway? If not required to do alternate pathway again do we have to pay for specialty reviewers?” (Level 1)

Surgeons or physicians who were previously approved by way of the Alternate Pathway Criteria (APC) at your trauma center are not required to repeat the APC process. Therefore, a specialty reviewer will not be required at the time of the site visit and a charge will not be incurred.

Should the surgeon or physician move to a new facility, they will be required to repeat the APC process and will incur a fee.
ATLS for Emergency Physicians (CDs 7-13/7-15)

“Can you please clarify the ATLS/CME requirement for Pediatricians (not board certified in EM) working in the ED? Do they only need to meet these requirements if they respond to trauma team activations? What about treating injured children? Can they be oversighted by an EM physician and still be involved in the care of injured children without ATLS and CME?” (Level 2)

In Level I, II and III trauma centers, physicians who provide care to trauma patients (adult and/or children) regardless of TTA, must be current in their board-certification. If boarded in another specialty such as, Family Practice, Internal Medicine, Pediatrics, etc., the physician is required to be current in ATLS (CD 7-15) and meet the CME/IEP requirement (CD 7-13).
“Can you explain/breakdown the research requirement for a Level I Trauma Center?” (Level 1)

The Level I trauma center must have 20 peer-reviewed articles published (or accepted) within the 3-year period leading up to the visit.

- At least one article must be authored or co-authored by general/trauma surgery
- Articles authored or co-authored from at least three of the disciplines noted in the table.

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Research Alternate Pathway (CD 19-7)

“Explain the alternate pathway research requirement?” (Level 1)

As an alternative to meeting the 20 peer-reviewed articles, the trauma center can meet this requirement with 10 peer-reviewed articles published (or accepted) within the 3-year period and demonstration of trauma-related scholarly activity in 4 of the following areas:

- Leadership in major trauma organizations
- Peer-reviewed funding for trauma research
- Evidence of dissemination of knowledge
- Published trauma-related case reports
- Visiting professorships or invited lectures
- Resident participation in scholarly activity
- Trauma, critical care, or acute surgery fellowship
# Table 1: Research Requirements for a Level I Trauma Center

**Option 1**
- 20 trauma-related, peer-reviewed articles in journals listed in Index Medicus or PubMed in a 3-year period
- At least one article with a general surgery author or co-author
- Trauma-related articles from at least three of the following disciplines:
  - Basic sciences
  - Neurosurgery
  - Emergency medicine
  - Orthopaedics
  - Radiology
  - Anesthesia
  - Vascular surgery
  - Plastic surgery or maxillofacial surgery
  - Critical care
  - Cardiothoracic surgery
  - Rehabilitation
  - Nursing

**Option 2**
- 10 trauma-related, peer-reviewed articles in journals listed in Index Medicus or PubMed in a 3-year period
- The same specialty authorship requirements as in Option 1, plus:
- Demonstration of trauma-related scholarly activity in at least 4 of the following areas:
  - Leadership in major trauma organizations
  - Peer-reviewed funding for trauma research
  - Evidence of dissemination of knowledge
  - Published trauma-related case reports
  - Visiting professorships or invited lectures
  - Resident participation in scholarly activity
  - Trauma, critical care, or acute surgery fellowship

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*Refer to Chapter 19, page 146*
“What time should the TTA arrive to a level 2 activation?” (Level 1)

The institution will establish the time and mechanism of injury for when the trauma surgeon (adult or pediatric) will respond for the limited tier and/or the consultation tier. Most centers have a metric between 2 and 6 hours based on the mechanism of injury at that facility. Response times for these tiers must be reviewed through the PIPS process to ensure there are no delays in care.
Orthopaedic Back-up Call Schedule (CD 9-6)

“Are we required to have a back up orthopedic call schedule if we have a contingency plan to transfer?” (Level 2)

Orthopaedic team members must have dedicated call at their institution or have an effective backup call system (CD 9-6). The call system may include an orthopaedic PGY 4 or higher, an orthopaedic trauma fellow or advance practice provider may act as a temporary consultant, as long as this participation is acceptable to the surgical trauma team leader and it is documented. It would be of concern if cases that should be managed at a Level II are routinely transferred out unless it is for specialty/complex injury. All transferred cases must undergo PIPS review (CD 4-3).
“Are Level III Centers that keep minor neurosurgical trauma responsible to have ICP monitoring capability?” (Level 3)

Intracranial pressure monitoring equipment is required in Level III trauma centers with neurosurgical coverage that admit neurotrauma patients.

If by minor it is meant the patient is kept for 23 observation and discharged, it would not be required.
“We have plastic surgery coverage, however do we need to have plastic surgery call coverage 24/7?” (Level 2)

“We have the specialties listed, however as we are a smaller Level II facility we only have 1 plastic surgeon so we do not have continuous plastic coverage. ENT does help with some of this. Are we required to have plastic on-call 24/7?” (Level 2)

The expectation is that the center has plastic surgery coverage. The surgeon is not required to be in-house; however, there must be a consultant available at all times within a pre-determined time of notification by the surgical trauma team. For facial trauma, OMFS and ENT are acceptable for plastic surgery coverage.
Alcohol Screening (CDs 18-3/18-4)

“Can you please clarify CD 18-3 All patients that meet NTDS Trauma Inclusion criteria with a hospital stay of 24 hours, 80 perc Universal is not the full brief screening, is this correct?” (Level 1)

“When auditing for SBIRT screening does length of stay for admission start when they are registered in the ED or admitted in-patient?” (Level 1)

Level I, II and III trauma centers, all patients that meet NTDS Trauma Inclusion criteria with a hospital stay of greater than 24 hours, at least 80% must receive screening for alcohol and it must be documented.

Level I and II trauma centers must ensure those patients who screened positive receive an intervention (CD 18-4).
CME: Conferences

“A reviewer told us we can accept 1/3 of conference CME's for trauma if we can't verify the exact number. Is this correct?” (Level 1)

This is not correct. All CMEs must be verifiable as external or internal trauma-related. The review team may have confused the allowance of 33 hours from preparing/taking their board certification within the rolling 3 years to count towards the 48 hours of external trauma-related CME.
“A reviewer told us non-liaisons must have at least 50% of their CMEs as external. Is that correct?” (Level 1)

This is not correct. The non-liaisons may demonstrate trauma education by acquiring a minimum of 48 hours of trauma-related verifiable external or internal trauma-related CME over a 3 year period or by, participating in the trauma center’s internal education process (IEP) or a combination of CME and IEP.
“Can CME count as external if the hospital is the one who grants it but does not facilitate, contribute to content or plan it?” (Level 1)

This will be acceptable for the non-liaisons as internal CME. The topic must be trauma-related. These usually fall into one of the following settings: in-service lectures, educational conferences, grand rounds lectures, an internal trauma symposium, or in-house publication.
CME: Documentation

“Does proof of CME have to include the actual certificate or can it be just a log of the titles and credits for that class/course?” (Level 1)

At the time of the visit, it is required that the trauma center provide copies of the trauma-related CME certificates along with the conference brochure. Transcripts are acceptable; however, the center must provide detail of the hours that are trauma-related. This can be demonstrated with the course outline or brochure. The above may be supported with a log of the session titles and credits for each one.
CME: Pediatric Liaisons

“Please discuss the CME requirements for Pediatrics, booth Liaisons, and ‘Others’. (Level 1)

The pediatric non-liaison CME will be covered in the next slide.

Level I and II pediatric trauma centers, the TMD and liaisons must demonstrate trauma education by acquiring a minimum of 48 hours, of which 12 hours must be related to clinical pediatric trauma care, of external trauma-related CME over a 3 year period (CD 10-39).
CME: Pediatric Non-Liaisons

“Our next Peds Level II re-verification visit will be in May 2018. How many pediatric CMEs will the non-liaison physicians need?” (Level 1)

Level I and II pediatric trauma centers, the non-liaisons may demonstrate trauma education by acquiring a minimum of 48 hours, of which 12 hours must be related to clinical pediatric trauma care, of external or internal trauma-related CME over a 3 year period, or by, participating in the trauma center’s internal education process (IEP) or a combination of CME and IEP (CD 10-40).
CME: Prorated

“We had an ED provider just start a month before our review cycle ends. What is his CME requirement? 16 or prorated to 1.3?” (Level 2)

“Please specify different ways to pro-rate CMEs.” (Level 2)

If the ED provider started a month before the review cycle ended, they would need 1 hour of CME. Ideally if the ED provider came from another trauma center, they would have acquired CME in which it can be used in combination with the time the provider started on the service. If no CMEs were acquired, his/her CME will be prorated based on the time present at your facility.

For recent graduates or absences for military duty, medical leave and missionary work CMEs may be prorated.
“If an ED MD is a brand new MD (2016) and our verification dates are 2015-2018 how many CMEs are collected from this physician.” (Level 2)

As noted in the previous slides, CME may be prorated based on the time the new provider started on the service leading up to the site visit. Based on the timeframe provided and following scenario: provider started July 2016 and the visit takes place December 2018, the breakdown would be:

- 2016 – 6 hours
- 2017 – 16 hours
- 2018 – 16 hours
“If a newly boarded ED MD started in 8-2017 and our dates are 2015-2018 how many CMEs are collected?” (Level 2)

Based on this timeframe and assuming the visit will take place December 2018, the new provider would need the following CME hours:

- 2017 – 5 hours
- 2018 – 16 hours
**CME: Locums**

“Please review locums provider requirements for critical care and trauma surgery pertaining to CME and trauma meeting attendance.” (Level 2)

If I understand correctly, trauma surgery locums who provide care to trauma patients are required to meet the same requirements as the other trauma members such as, board certification, OPPE, attend trauma peer review meetings, and acquire CME. Locums proving care in the ICU, this will exclude attending trauma peer review meetings (ICU liaison or pre-determined provider is required to attend).
“Would you please elaborate on the 6/30/17 Clarification Document in regards ICU MD, ‘pt care is transferred to them’.” (Level 2)

If the intensivist is the primary physician responsible for the care of the patient while in the ICU (meaning the patient’s care is transferred to the Intensivist), they are required to maintain external trauma-related CME and/or through an IEP process or a combination of both.

Intensivists that are in the ICU managing pulmonary or medical issues to a trauma patient are not required to meet the CME requirement.
Thanks for your participation!