Trauma Verification Q&A Web Conference

January 25, 2018

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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!
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 December 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

The document has been shortened to display only those requirements with a clarification (down from 90 pages to 44 pages).
## Verification Change Log

Download and SAVE as an excel file. Can filter by any of the columns.

<table>
<thead>
<tr>
<th>Chapter</th>
<th>CD #</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV</th>
<th>PTC I</th>
<th>PTC II</th>
<th>Date Change</th>
<th>Criteria</th>
<th>Resources 2014 Orange Book Description of Criteria</th>
<th>Clarification</th>
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<td>II</td>
<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>
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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>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>
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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>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>
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<td>III</td>
<td>IV</td>
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<td>II</td>
<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>III</td>
<td>IV</td>
<td>I</td>
<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>
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<td>IV</td>
<td>I</td>
<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>III</td>
<td>I</td>
<td></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>
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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:  **February 9, 2018**

Webinar date:  **February 22, 2018**

Webinar time:  **12:00pm-1:00pm CST**
Resources Revision Process

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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<thead>
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<th>Upcoming Chapters</th>
<th>Call for Data</th>
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Resources for TPMs and TMDs

• Frequently Asked Questions (FAQs)
  • The list will expand over time.
    https://www.facs.org/quality-programs/trauma/vrc/faq

• 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.
    https://www.facs.org/quality-programs/trauma/vrc/resources
TQP Participant Hub

  - Manage facility information
  - Manage contact information

  - If the Primary Contact at your facility has left and you need assistance accessing the Account Center, please email tqip@facs.org

- Data Center
  - Submit data
  - View reports
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.
- We are accepting applications for November and December 2018, and all of 2019:

  https://www.facs.org/quality-programs/trauma/vrc/site-packet
Proving QTP Contact Updates

- Staff changes should be reported as soon as possible
  - TMD/TPM/Administrator (President, Vice-President, CEO)

- Site visit applications, note credentials: MD, RN, EMT, NP, PA
  - Combined adult and pediatric verification programs, add contacts for both the adult and pediatric programs

- Challenges with not updating contacts:
  - Consultation/Verification/Reverification letters and reports have incorrect staff listed
  - Follow-up inquiries from the VRC staff on recent site visits may cause delays receiving the final report
Additional Information to be submitted with 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
  ▪ Combined centers (Level I adult/Level I pediatric) that have separate visits scheduled, but share the same OTL, the form must be completed entirely for the 1st visit and on the 2nd visit, only complete questions 1-3

• 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)
• Trauma centers that have previously completed an OTL form and has had no change in the OTL, are **not required** to submit another form; however, you will be asked to indicate his/her name on the site visit application.

• Trauma centers who have had a change or are new to the process, must complete and submit an OTL form with the site visit application.
Alternate Pathway Criteria (APC) Request

• For centers that have a non U.S. or Canadian board certified/eligible physician or surgeon, who has trained overseas, must note the applicant’s name and specialty on the application.
  - Forward a copy of the applicant’s curriculum vitae (CV)
  - On-site evaluation by a member of the same specialty; assess the 8 criteria (ATLS, CME, meeting attendance, etc.), along with review of clinical care

• Those previously approved by way of the APC are not required to have a review by the specialist at the time of the visit. However, they are required to meet the APC.

• The APC is not applicable to U.S. or Canadian residency trained physicians or surgeons.

https://www.facs.org/quality-programs/trauma/vrc/site-packet
Prereview 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 your 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.
“Does an informal washout in the trauma bay count as a ‘washout’ when presenting data to the ACS via the PRQ. We have to report an average time to washout of open fractures. I am just trying to clarify what the definition of a washout is for those standards. If the wound is cleaned out in the trauma bay and splinted then taken to OR later, does that count as the initial washout time? Or does the washout have to be a formal, preop washout in the OR in order to be captured for reporting?” (Level 1)

Time to first operative washout of open tibial shaft fractures from presentation to your ED (time to formal OR washout).
General Questions
“Does the ACS recommend having a consultation prior to verification survey?” (Level 1)

Although not required, the ACS does recommend having a consultation visit prior to a verification for new trauma centers seeking verification for the first time or that have had significant changes in their program.

With this said, there are several state statutes that require the trauma center to have a consultation visit prior to verification. Please be sure to check with your designating authority to ensure you are in compliance with your state process.
Consultation Visit

“If it is mentioned in the H&P and/or D/C summary that a surgical service was consulted and recommended non-operative management of an injury but there is no written/electronic consult note by the surgical specialists, can we still count this as a consult?” (Level 2)

This may be counted as a consult; however, a good admission H&P will often document the process of care and the injuries. By not having this documented, it will be impossible to do effective PI on that case.
Performance Improvement

“What is the most important aspect of the performance improvement process that the surveyors will be looking for?” (Level 1)

“What does ‘good PI’ look like?” (Level 2)

The most important aspect of the PI process is the documentation and whether issues with a case, i.e., delays in care, surgeon care, etc., were identified and if yes, how was it identified (routine auditing, a report by a nurse, a patient complaint, etc.), what the initial investigation consisted of, who the issue was presented to and what the recommendations were, and the corrective action plan and [loop] closure.

In cases with an issue, and that underwent PI review, have the PI record attached to that chart, or have a flag to direct the reviewer to the EMR PI record. This will demonstrate a tight PI program.
Event Identification and Review

“What type of format do the surveyors prefer to see the event resolution of cases?” (Level 1)

Reviewers like to see a spreadsheet with columns titled “corrective action plan”, “responsible person”, and “evidence of loop closure” or headings along those lines. If your PI process did not find the event, tell the reviewer how you found the event, and the likely reason this did not pop.

If you disagree with the reviewer as to whether this was a significant event, just ask them to explain their reasoning and discuss it in a civil manner. A contentious discussion will almost certainly be indicated in the report.
“Is there an anticipated date for viewing the new (purple?) book draft?” (Level 1)

I love the color suggestion 😊. There is not an official release date. As mentioned early on, only 1 chapter has been completed. There are a couple of chapters that are “tentatively” in the process of completion by the March meeting.
Past Webinar Slides

“Can you make a book out of the slides from the webinars and organize them by orange book chapter?” (Level 2)

Presentations from past webinars may be released upon request. We are in the process of having these presentations available on the VRC Resources webpage soon.
Peer Review Minutes

“How to handle review of Peer Review minutes when the physician is absent? Electronic OK with read receipt?” (Level 1)

“Besides your call panel, who else should get the peer review minutes?” (Level 1)

Response to question 1 – this will vary by institution; however, a secured email with read receipt is acceptable; however, that will not count toward their 50% peer review meeting requirement. The only excused absences are due to military deployment, medical leave and missionary work – all require documentation.

Response to question 2 – essentially all members of the trauma panel should receive documentation (not necessarily minutes) regarding event resolution. Again, this should be monitored and tracked.
PRQ

“We obviously review all deaths whether it occurred here or after transfer, but for the PRQ question how many trauma deaths were there during the reporting year and for the purpose of the category deaths for the ACS review is that only referring to deaths that occurred here, not deaths that occurred after a transfer?” (Level 3)

For purposes of the PRQ and onsite visit, only report those deaths that occurred during the reporting year in the PRQ and have them available at the time of the site visit.
**PTSD screening**

“Is screening for PTSD in trauma patients required the same way alcohol intervention screening is required? What tools are available to screen and monitor PTSD in trauma patients admitted gt 24 hours? (Ch. 18 Clarification Document)” (Level 1)

“We are trying to understand the PTSD assessments and requirements therein...what is the position of the ACS?” (Level 1)

**PTSD screening is not required for trauma patients.** As noted in Chapter 18 and in the Clarification Document, PTSD screening ‘should’ be done on trauma patients that may be afflicted from PTSD.
Verification Documents

“Should we have CMEs, ATLS, privileging, etc., in hand at survey for: locums who worked a few shifts, and/or docs who have left?” (Level 1)

For those locums that are no longer on the service, do not enter any data in the PRQ and do not have any documentation at the time of the visit.

For those locums that are still on the trauma service at the time of the visit, enter their data in the PRQ and have documentation. Copies of their board certification, CMEs (external, internal, internal education process), privileges, etc., must also be included in the appropriately labeled binders (by service).
Orthopaedic Trauma Care

“A portion of our Ortho MD's don't take trauma call but do end up operating on trauma patients later in their care. Is this ok?” (Level 1)

If the patient is still under the care of the trauma service, those orthopaedic surgeons who are providing care to the trauma patient must adhere to the same criteria (CME, OPPE, board certification, etc). Refer to page 60 in the Resources manual for the description of the orthopaedic trauma care.
CD-Related Questions
“1200 trauma admission as CD 2-4. Is this referring to actual inpatient admissions or NTDB registry admissions?”

(Level 1)

The Level I trauma center admission volume criteria is for the reporting year based on the NTDB inclusion criteria, with some exceptions, in the trauma registry.
Trauma Team Highest Activation (CD 2-8)

“If the ED provider calls the trauma surgeon while he or she is on rout to the hospital to notify him/her that they do not need to come (patient died or no longer on site; transferred) do we still count this as an activation and if so do we count it as being compliant?” (Level 3)

This can be a slippery slope. If a trauma activation was called, the criteria clearly states the trauma surgeon must arrive within 30 minutes from patient arrival. If the patient expires or is transferred while waiting for the attending, you want to track, monitor and review these instances through the PI process to ensure. This will count toward the 80% compliance threshold.
“While a trauma doc is the scheduled back-up call, must that doc be dedicated to the facility & the trauma service?” (Level 2)

Trauma surgeons who service as a backup are not required to be dedicated to one hospital. With this said, the trauma center may have to have a 3 or 4 deep backup schedule so in the event the backup trauma surgeon is encumbered at the “backup” hospital, there is another trauma surgeon that is called in to serve as backup.
Pediatric Criteria (CD 2-23)

“My facility is a level II adult center. 2017 is the first year that we have admitted 100 kids. I have been reading the orange book about the changes that need to be made and I wondered if you have any direction regarding Peds credentialing for the trauma doctors.” (Level 2)

When completing the PRQ, be sure to select adult + children Level II trauma center. With this said, as a Level II trauma center that is not seeking pediatric verification and admitted fewer than 100 children during the reporting year, the program is required to credential the trauma surgeons. Examples of credentialing may be ensure the panel has certification in Pediatric Advanced Life Support, pediatric trauma CME, completion of a pediatric fellowship, or documentation of performance as measured by PIPS.
"On the December webinar, the topic of ‘Transfers’ was presented: I just need to confirm, the NTDB does not count transfer in from centers that are not considered hospitals to be ‘transfers’. But you are saying for verification, they are considered transfers and must be reviewed through the PIPS process?" (Level 2)

Correct, for verification purposes and completing the PRQ, patients who are transferred in or out to/from another facility whether that is a sister hospital, free standing ED, private physicians office, etc., are considered interfacility transfers.
“On Level II activations when a trauma surgeon is consulted for admission, what is the required time for them to arrival to the ED?” (Level 2)

The institution will establish the time and injury expectation for when the trauma surgeon (adult or pediatric) will respond for the limited tier. Most centers have a metric between 2 and 6 hours based on the mechanism of injury. The most important thing will be to follow the metrics through the PI.
“What are the reviewers thoughts on having mechanism of injury in your lower tiered activation criteria?” (Level 3)

Refer to page 39 of the Resources manual. The table provides examples of the types of mechanism of injuries acceptable for the limited tier.
Orthopaedic Surgery and Neurosurgery (CDs 8-2 and 9-7)

“I was left very confused by one of the answers to the questions in the December webinar. It was stated that for the 30 minute response time for neurosurgical patients, it is OK for the resident or APP to be the first responder, but there must be a clear discussion of the plan of care within 30 minutes with the attending neurosurgeon. In reviewing both the Orange book and the most recent clarification document, I see this requirement for Orthopedic response (CD 9-7) but nothing like this for Neurosurgery. Can you please clarify where this standard comes from. Perhaps I missed it.” (Level 1)

To clarify, the intent is that the TMD and liaisons for orthopaedic surgery or neurosurgery, develop guidelines for which types of critical and complex injuries the orthopaedic/neurosurgeon will respond to [in person] within the 30 minutes. If they send the specialty resident/PA/APP, there must be guidelines for the types of injuries they are approved to respond to and there must be clear documentation of the discussion with the surgeon specialist on the plan of care.
"CD 11-17 Please clarify this - Are we timing from the First call to OR by Surgeon to the incision time? to the enter OR time?" (Level 3)

The clock starts from the time the OR is notified a case needs to be done.
“At a L2 Trauma center is it ok for the ICU co-directors if neither are board certified in surgical critical care?”

(Level 2)

Yes, that is acceptable. The requirement speaks to the ICU director or co-director being a currently board certified general surgeon.
ICU Coverage (CD 11-55)

“Do ICU physicians need to be in house if they can meet the 15 minute response time?” (Level 2)

Refer to page 81, Table 1, in the Resources manual. For Level II trauma centers, the coverage by the credentialed provider must be available within 15 minutes.
Alcohol Screening (CDs 18-3 and 18-4)

“Explain the alcohol screening requirement. All patients are asked if they use or not and offered resources. Is this enough?” (Level 3)

“Rectn clarifying documents states SBIRT to includes activations OR all admitted trauma patients. Is this a choice?” (Level 2)

For Level I, II and III trauma centers, there must be a process, mechanism (tool) and documentation for patients who meet NTDS inclusion criteria (activated or non-activated) that are admitted with a hospital stay of > 24 hours, of which 80% of patients must receive a screening (CD 18-3).

For Level I and II trauma centers, all patients who have screened positive must receive an intervention by appropriately trained staff, and this intervention must be documented (CD 18–4).
“Can the SBIRT duties be part of social work, or does it need to be trauma such as TPM or injury prev. job description?” (Level 2)

In Level I and II trauma centers, the screening may be performed by someone in social work. The trauma center will define the training, skills and experience for what constitutes ‘appropriately trained staff.’
CME: Internal and External Examples

“Is there an extensive list of CME examples that fulfill the Trauma requirements?” (Level 2)

Examples of internal CME are found in each of the chapters under Continuing Medical Education: in-service, case-based learning; educational conferences; grand rounds; internal trauma symposia; and in-house publications disseminating information gained from a local conference or an individual’s recent participation (through trained analysis) reviewing a trauma center.

External trauma-related CMEs, the next 2 slides will list some examples, and attendance at national/regional conferences that provide courses relevant toward the management and care of trauma patients.
Currently, the following courses provide Trauma related CMEs:

- **Advanced Surgical Skills for Exposure in Trauma (ASSET)**
  - 6 hours
- **Rural Trauma Team Development Course (RTTDC)**
  - 9 hours
- **Surgical Education and Self-Assessment Program (SESAP)**
  - 6 hours
- **Disaster Management and Emergency Preparedness (DMEP)**
  - 8.25 hours
- **Advanced Trauma Operative Management (ATOM)**
  - 7.5 hours
### CME: ATLS Courses

#### 8th edition

**TABLE 8-1 Category 1 Credits**

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#### 9th edition

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CME: Critical Care Board Certification

“Does taking general pediatric board re-cert exam count as 33 hours CME for my peds critical care MD's?” (Level 1)

Yes, it does count to meet the CME requirement.
CME: Pediatric Verification

“How many pediatric trauma CME are required for physicians in a pediatric Level II TC that is being verified in May 2018?” (Level 1)

For new centers seeking verification for the 1st time, CMEs will be prorated as 16 hours for the year. Of those 16 hours, 4 must be pediatric trauma care.
CME: Vent Management

“If pulmonary crit care is consulted for vent management only, does the med critical care physician need trauma related CME?” (Level 2)

If the pulmonary critical care physician is only providing vent management, they are not required to meet the CME requirement.
CME: Pediatric CME

“Please clarify- Do trauma surgeons on the call panel have to have 12 hours of pediatric CME or only medical directors/liaisons?” (Level 1)

“In a level I pediatric center, what is the CME expectation for the pediatric ICU attendings who staff the PICU 24 hr/day.” (Level 1)

If seeking pediatric reverification, the trauma medical director and liaisons must accrue 48 hours in 3 years of verifiable external CME, of which at least 12 hours must be related to clinical pediatric trauma cares.

The other panel members can have a mixture of external and internal CME of 48 hours in 3 years of verifiable external CME, of which at least 12 hours must be related to clinical pediatric trauma cares. Refer to the Clarification Document.
CME

“Are CME still pro-rated based on start date of hire? Clarification document says new physician needed 16 CME, even new grads.” (Level 1)

The requirement is 48 hours of trauma-related CME. On average, 16 hours should be acquired annually. If not, then over the span of 3 years they must have acquired 48 hours of trauma-related CME. They may acquire more than the 16 in a year, or they may have less than the 16 in one year, but made up for it in the following year, so long as in the 3 year span they have acquired the mandatory 48 hours of trauma-related CME.

For new members to the service, it would be expected that they have the required CME since they are more than likely coming from another trauma center. If for some reason they do not because they were brought on in the middle of the review cycle, then at that time, it will be prorated based upon the start date.

New graduates should begin the process to acquire CME right away; however, if again they are brought on midway through the review cycle, their CME will then be prorated based on their start date.
CME: New Residents

“We have an Emergency Center physician (not the trauma liaison, but cares for trauma patients in the EC) who started at the facility in July 2017. He is a new graduate and is questioning 1. How much CME can he ‘count’ from his schooling and 2. Can his CME requirements be prorated from 16 hours to 8 hours?”

(Level 1)

We do not accept medical school to count to meet the CME requirement.

If he came on the service July 2017, and depending on when the centers visit is scheduled, CME will be prorated based on when he came on the service.
"For a Level II Trauma Center do you HAVE TO (CD) have an internal education process and must it equal 16 CME/Year?" (Level 2)

An internal education process is not required. This will mean that all trauma panel members must have external trauma-related CME in order to be in compliance with the requirement.

The TMD and liaisons must have external; however, the other members can have either or a mixture of external or through an internal education process.
CME: Level III

“In a Level III center, do neurosurgeons have to have 16 hr/yr of trauma education?” (Level 3)

Level III trauma centers are not required to have CMEs.
Thanks for your participation!