Trauma Verification Q&A Web Conference

July 27, 2017
COTVRC@facs.org
Your Trauma Quality Programs Staff

Tammy Morgan
Manager
Trauma Center Programs

Molly Lozada
Program Manager
Trauma Verification

Rachel Tanchez
Site Visit Coordinator
Trauma Verification
 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

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## Verification Change Log

Updates sent to participants monthly

<table>
<thead>
<tr>
<th>Chapter</th>
<th>CD #</th>
<th>Level</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>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1-1</td>
<td>I</td>
<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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<tr>
<td>1</td>
<td>1-2</td>
<td>I</td>
<td>II</td>
<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 promotes 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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<tr>
<td>1</td>
<td>1-3</td>
<td>I</td>
<td>II</td>
<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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<tr>
<td>2</td>
<td>2-1</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
<td>I</td>
<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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<tr>
<td>2</td>
<td>2-2</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td></td>
<td>I</td>
<td>II</td>
<td>7/1/2014</td>
<td></td>
<td>Surgical commitment is essential for a properly functioning trauma center (CD 2-2).</td>
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<tr>
<td>2</td>
<td>2-3</td>
<td>I</td>
<td>II</td>
<td>III</td>
<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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<tr>
<td>2</td>
<td>2-5</td>
<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>
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</tbody>
</table>
**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, August 11, 2017

Webinar date: Wednesday, August 30, 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 will open by mid August

- Hotel reservations are open

- For more information visit: [https://www.facs.org/tqipmeeting](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
  - TOPIC
    - Thursday, November 9
  - OPTIMAL Course
    - Friday, November 10
  - AIS 15 Update
    - Friday, November 10
**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.

- **Current Chapters under revision:**
  - Chapter 9 Orthopaedic Surgery
  - Chapter 10 Pediatric Surgery

- **Next Chapters for Revisions:**
  - Chapter 15 Registry
  - Chapter 19 Research
New *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)

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**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
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 August 2018 are closed to scheduling:
  ▪ [https://www.facs.org/quality-programs/trauma/vrc/site-packet](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

- 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.
Focused Review – Onsite Preparation

The expectations for an onsite Focused Review are as follows:

• One day visit with one of the initial reviewers (2nd reviewer may be a nurse)
• A corrective action plan is required ~30 days prior to the site visit on how the deficiencies were addressed and how the weaknesses were/may be addressed
• A presentation on the corrective actions may be done if desired; but not required
• The review will commence approximately at 0700 unless told otherwise by the ACS office or site reviewers (e.g. travel issues)
• Chart review process/validation
• Closed meeting with the reviewers
• Exit interview - the trauma medical director may extend the invite to other members
Staffing Updates
VRC Staff: Reports and Standard 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
Clarification Document Updates
**Update: CME for ICU Intensivists and Hospitals (CD 11-64)**

If the intensivists are the primary physician responsible for the care of the patients while in the ICU (patients care is transferred to them), they are required to maintain external CME and/or through an IEP process. The VRC does not presently hold a requirement for hospitalists to maintain CME.
Universal screening for alcohol use must be performed for all injured patients and must be documented (CD 18–3)

Revised: All patients that meet NTDS Trauma Inclusion criteria with a hospital stay of > 24 hours, 80% must receive SBIRT screening.
Update: Research Outsourced (CDs 10-9, 10-10, 10-11 and all of Chapter 19)

VRC Statement on requirements for research in a Level I Trauma Center, refer to pages 146-147 in the Resources manual…

The statement implies that the trauma surgeons are actively involved in the creation of new knowledge and the research process. It is also implied that the research is done on-site and not all sent out for performance by an outside group. It is also implied that the facility has provided support and resources other than simply paying for research output form an outside source. Therefore, it does not meet the intent of these requirements to simply pay to outsource research to an independent third party not routinely, clinically, associated with the facility.
General Questions
Chart Categories

“Some of the required charts speak to ISS > 9 or ISS > 25. Does this include the 9 or 25 or does it start at 10 and 26?” (Level 1)

For the site visit chart preparation, it will include charts with an ISS equal to and greater than 9 and an ISS equal to and greater than 25.

For clarification regarding medical cases that have multiple injuries, do not duplicate (copy) the chart. Place the chart in one category and tag as ‘multiple injuries.’

In addition, if you are unable to provide the minimum number required, pull what you have available at the time of the site visit.
“When will the revised verification standards be published?” (Level 1)

The plan for the revision process is still undergoing review. There has been one chapter completed as a pilot: Chapter 6 Trauma Surgery. Once the revision process plan has been approve, more information will be provided.
“Why are there so many repetitive criterion deficiencies? It would be much more effective to eliminate the duplicates.” (Level 1)

If you are referring to the Resources manual, the criterion may appear repetitive due to the different specialists. This was done intentionally so that each chapter outlined the criterion for that specific specialist. Chapter 16 is where you may find several that will overlap and again, that was done intentional so that any PI related criterion would be listed in that chapter. We are currently looking at opportunities to make this more efficient as we work through the revision process.
Verification Visits

“When will the ACS begin all electronic verification?” (Level 1)

An electronic Consultation/Verification application is currently being programmed.

If the question is referring to an electronic process where an on-site visit will not be performed, that is not feasible with the current structure. In addition, due to legal matters, reviewing medical records electronically would not be ideal.
“My understanding is that we will need to provide a summary of our TQIP report during our ACS survey. Could you provide a detailed example of what this should look like? What would they like to know? Thank you.” (Level 3)

Hospitals are not required to have received a TQIP benchmark report at the time of their Verification visit. We ask that hospitals have their last TQIP report on hand to discuss with reviewers, if requested. TQIP reports are a good opportunity for hospitals to showcase their PI process. Hospitals are not being penalized or lauded for their TQIP results alone.

TQIP staff provide a summary of the hospital’s TQIP results to reviewers along with an executive summary and explanation of how to interpret results.
Geriatric Trauma Activation

“Does anyone have any activation criteria for geriatric trauma activation?” (Level 3)

At this time, we do not mandate geriatric specific criteria; however, if the center sees a high percentage of these patients, it would be the expectation that there are geriatric specific activation criteria and guidelines.

An example of what it may contain:

- Falls above ground level in age > 65
- Traumatic mechanism in a patient with a known bleeding disorder or use of anti-coagulant/anti-platelet medication
Tax ID Codes

“If you have a level 1 trauma center and 2 other hospitals that are non trauma centers under the same tax ID code will those two other hospitals have to abide by the level 1 trauma regulations?” (Level 1)

The ACS Consultation/Verification process reviews individual trauma centers. It does not look at multiple facilities within the campus or that use the same tax ID code.
Performance Improvement Projects

“What are some PI projects that some level III hospitals are working on?” (Level 3)

There are several examples:

• Nonsurgical admits by having a well-defined and structured admission policy and evaluating those cases. What patients are admitted to the trauma service versus those admitted to medical/hospitalist team.

• Time of trauma consent for intermediate (2\textsuperscript{nd} Tier) level patients; this is often ill defined with wide gaps in trauma evaluation after moving to a hospital bed.

• Geriatric trauma patients where the focus could be on patients with rib fractures, time to the operating room on fracture care, or pain management issues.
Post Site Visit Documentation

If during a verification or reverification site visit, the center is found to have deficiencies and the review team says its okay to forward documentation to resolve/address:

• Confirm timeframe to submit – once the review team submits the report to the VRC office, it is at their discretion whether or not they will accept the documentation before the report is finalized.

• Forward documentation to the review team and also to the VRC office: COTVRC@facs.org
  ▪ The office will ensure the team sees the documentation and is incorporated into the report.
CD-Related Questions
“Activation time is when trauma physician has been notified or when trauma physician return call or when physician actually see patient in ED? If trauma physician is called but no documentation of patient seen by trauma physician in ED, is it still level 3 response activation?” (Level 2)

The time for the provider (trauma surgeon) to respond is when the request is made (call/pager) and ends when the provider responds in person to the bedside.

By Level 3 response activation, I’m assuming this to mean a consult tier and if so, the institution will define the types of injuries for when the trauma surgeon is expected to respond. This must be documented and reviewed through your PI process. If you have a lot of instances where response times are not documented, this may be cited as a weakness or deficiency.
“For a level 1 trauma center do you have to have 24/7 in-house coverage of trauma surgeons?” (Level 1)

The manual does not state that trauma surgeons must be in-house. With this said, for the highest level of activation, the response threshold is 15 minutes for the attending trauma surgeon to respond and be present at bedside from the time of notification. The ideal method to meet this response time is by having the trauma surgeon in-house.
Trauma Surgeon Dedicated (CD 2–10)

“We are a level II trauma center. Our town has a second (smaller) hospital that has no trauma center designation (neither ACS or state) Can our primary on call trauma surgeon ALSO be primary ‘general’ call for this smaller hospital at the same time? Orange book only refers to 'dedicated to a single ‘TRAUMA’ center.' The second hospital has no trauma center designation.” (Level 2)

The trauma surgeon on call must be dedicated to one trauma center while on call. This practice would not be acceptable.
Neurosurgeon Response (CD 8-2)

“The regs speak to the facility setting up a 30 min response time for certain ortho and neuro diagnoses. Is this sufficient for neuro (Large traumatic hematoma resulting in >5mm shift and/or compression of the basilar cisterns) and ortho (Orthopedic injuries that necessitate a prompt response include the mangled extremity with associated vascular injury, a pulseless extremity believed related to fracture/dislocation, complex pelvic/acetabular fractures with bleeding, or those with concern for compartment syndrome)?” (Level 1)

The intent is that the TMD and liaisons develop guidelines for which types of critical and complex injuries the neurosurgeon and/or orthopaedic surgeon will respond to [in person] within the 30 minute timeframe. If they send the PA/APP, there must be guidelines that speak to this and clear documentation that there was a discussion with the surgeon specialist on the plan of care.
“Does the 30 minute OR availability refer to having an open room or a room that is fully ‘OR ready’?” (Level 3)

In Level III trauma centers, an operating room must be adequately staffed and available within 30 minutes. This means that there must be an operating room available, and staff to prepare the room and patient while waiting for the anesthesiologist [or CRNA, where permitted by state laws] to arrive.
"Regarding CD11-17: Is there an acceptable threshold for meeting the 30 minutes (similar to 80% surgeon timeliness for top TTAs)" (Level 3)

There is not a threshold for meeting this requirement. If during a site visit, it is found that there were delays and it was not picked up through the PIPS process, it would be cited as a deficiency.
"Regarding CD11-18: What is considered timely for starting operations?" (Level 3)

The intent is that the OR room and staff are ready to go at the 30 minute mark. My concern is that there may be some issues at this center with having the room and staff ready at the start time. If this is the case, the program must identify those issues by continuously monitoring the start times through the PIPS process to ensure there are no adverse outcomes due to delays.
Registrar (CD 15-9)

“What are the staffing guidelines after the first 500-750 cases?” (Level 3)

“If vol. is 700, 1 registrar to complete all tasks, when would you recommend increasing staff?” (Level 3)

The requirement is that there is one FTE [registrar] for every 500-750 trauma patients admitted to be entered into the registry. If the center exceed this threshold, the expectation is that there is another FTE to manage the overflow.

For example, if the center admitted 2,300 trauma patients, the expectation would be that there are a total of 3.5 FTEs.
Mortality Review (CD 16-6)

“Clarification: The new categories of mortality review are: Mortality without opportunity for improvement & Mortality with opp” (Level 1)

There are 3 mortality categories:

- Mortality with opportunity for improvement
- Mortality without opportunity for improvement
- Unanticipated mortality with opportunity for improvement
Injury Prevention (CD 18–1)

“What are other Level III hospitals doing for injury prevention in the community?” (Level 3)

Select a target injury population.
- Develop intervention strategies
- Develop /Implement the IP Program
- Partner with community resource
- Monitor and support
- Evaluate and revise results – changes made in community
- Outcome driven
- Consider publishing results (Research)
- Measurable outcomes
Alcohol Screening (CD 18-3)

“I understand that there have been changes to the SBIRT, can you share the changes?” (Level 1)

The change has been to add a threshold versus having to screen ALL trauma patients that meet inclusion criteria.

New clarification: All patients that meet NTDS Trauma Inclusion criteria with a hospital stay of > 24 hours, 80% must receive SBIRT screening.
“The Orange book states that ‘Universal screening for alcohol use must be performed for all injured patients and must be documented.’ (CD 18–3). Can you comment on the necessity of this as we get continual resistance to do drug & alcohol screen on traumas other than MVA Drivers.” (Level 2)

It is recognized that alcohol is a significant risk factor for trauma and the effects of alcohol use has been well documented in trauma literature.

It is required for all trauma centers to screen for alcohol use on patients that meet ACS registry inclusion criteria with a hospital stay of greater than 24 hours in which 80% must receive SBIRT screening.

- Facility to determine screening tool (BAC, Consumption questions, AUDIT, CAGE, CRAFFT, Others)
Alcohol Screening (CD 18–3)

“For alcohol screening, we use blood alcohol to screen and social services documents the counseling. Is this sufficient?” (Level 1)

That is an acceptable process. To clarify, the program must document the screening process as well as the social services.
“Do all research papers need to be PUBMED searchable as of 30 days prior to site visit? IE multicenter trails from AAST EAST etc” (Level 1)

Manuscripts that have been accepted, but not yet published or searchable through PubMed Central, will meet the research requirement. The trauma program must provide documentation that the manuscript has been accepted.

Manuscripts that are part of a multicenter trial are acceptable.
CME: State Requirement versus Verification

“The state requires an average of 8 trauma CME/ per year over a 3-year period, which is a total of 24. As we go towards our consultative visit, is it 16 this year and 8 the other years for a total of 32 in the 3 year period. What do we need to have?” (Level 1)

Great question. In this scenario and as a new trauma center for ACS, you will be required to follow your state requirements because it exceeds those of the ACS. If it were the other way around, where the ACS holds the trauma center to a higher standard, you would be required to comply with the ACS. For new centers seeking a consultation or verification, all providers must have one year (16 hours) minimum of trauma-related CME.
CME: Trauma versus Critical Care

This is in regards to 11-64 and the new listing from the ACS which states: If the intensivists are the primary physician responsible for the care of the patients while in the ICU (patients care is transferred to them), they are required to maintain external CME and/or through an IEP process. The VRC does not presently hold a requirement for hospitalists to maintain CME. (6/30/17) Does the CME have to be strictly trauma or trauma critical care CME? Can it be just critical care CME to count?” (Adult Level 1, Pediatric Level 2)

The CME may be either trauma or critical care. As a point of reference, critical care CMEs are equivalent to trauma CME.
CME: Number of Trauma Related CMEs

“For CME, the regs speak to the liaisons having 16 hours, but elsewhere it also talks to all the neurosurgeons and other specialists having 16 hours of trauma CME also. Please clarify.” (Level 1)

Correct, the Trauma Medical Director and Liaisons must have a total of 48 hours of external trauma-related CME over a period of 3 years leading up to the site visit. This can be obtained by having the providers obtain 16 hours of CME for each year.

The non-liaisons (trauma service, neurosurgery, orthopaedic surgery, emergency medicine and ICU), may use a combination of external and/or IEP to meet the CME requirement. This must also be obtained as 48 hours over a period of 3 years/16 hours annually of CME each year.
“Is it still a requirement that all physicians who take care of trauma patients in the ICU have 48 hours of trauma-related CMEs? If yes, do they have to be external, internal or both?” (Level 1)

The ICU liaisons must have a total of 48 hours of external trauma-related CME over a period of 3 years leading up to the site visit. This can be obtained by having the providers obtain 16 hours of CME for each year.

The ICU non-liaisons, may use a combination of external and/or IEP to meet the CME requirement. This must also be obtained as 48 hours over a period of 3 years/16 hours annually of CME each year.
CME: Internal Education Process

“For the IEP, does the yearly 16 hours need to be offered to every non-liaison or based on specific recommendations from the PIPS?” (Level 2)

The IEP does not need to be offered to every non-liaison provider. The non-liaison providers may use a combination of external and/or IEP to meet the CME requirement. If the trauma program is going to follow the IEP, it is recommended that the content be based on issues identified through the PIPS process. There are other examples of internal CME as noted in the Resources manual on pages: 47, 51, 57, and 64.
Thanks for your participation!