Trauma Verification
Q&A Web Conference

March 15, 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](http://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).

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

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>
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<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 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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<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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<td>2</td>
<td>2-2</td>
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<td>II</td>
<td>III</td>
<td>I</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>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>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 – New web link!

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/webinars
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:  April 13, 2018

Webinar date:  April 25, 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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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

• **Account Center**, [https://www.facs.org/quality-programs/trauma/tqp/tqp-center](https://www.facs.org/quality-programs/trauma/tqp/tqp-center)
  - 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](mailto:tqip@facs.org)

• **Data Center**
  - Submit data
  - View reports
All trauma centers must use a risk-adjusted benchmarking system to measure performance and outcomes (CD 15-5).

Effective for visits scheduled after August 1, 2018: Participation in TQIP best meets this requirement. Other risk-adjusted benchmarking programs will be considered and must include the components outlined in the CD 15-5 Requirements and Rationale document, https://www.facs.org/~/media/files/quality%20programs/trauma/CD_15_5_Reqs_Rationale.ashx.
Minimum Criteria for Full Trauma Team Activation (CD 5-15)

1. Confirmed blood pressure less than 90 mm Hg at any time in adults and age-specific hypotension in children;
2. Gunshot wounds to the neck, chest, or abdomen “or extremities proximal to the elbow/knee” (removed effective immediately);
3. Glasgow Coma Scale score less than 9 with mechanism attributed to trauma;
4. Transfer patients from other hospitals receiving blood to maintain vital signs;
5. Intubated patients transferred from the scene, – OR –
6. Patients who have respiratory compromise or are in need of an emergent airway
   a) Includes intubated patients who are transferred from another facility with ongoing respiratory compromise (does not include patients intubated at another facility who are now stable from a respiratory standpoint)
7. Emergency physician’s discretion
Scheduling Reminders
Site Visit Application

- The application must be received at least 13-14 months in advance of the requested site visit dates and must be before 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 December 2018, and all of 2019. Please note: we still have some openings for July, August & September 2018.
Providing QTP Contact Updates

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

• 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 letter and report

• 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
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)
OTL Form

• 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 be reviewed at each subsequent visit, unless they move to a new center. However, they are required to maintain the APC criteria.

• 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/](http://web2.facs.org/traumasurvey5/)
  - A copy of the PRQ in Word can be downloaded from: [www.facs.org/quality-programs/trauma/vrc/resources](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 - New Process!

• Visits are being scheduled quarterly.

• Center’s are now being asked to provide us with the exact dates you would like to have visit. Ideally, the visit will occur on your chosen dates.

• Once the review team has been secured, you will receive a confirmation email which will list your reviewers and their complete contact information.

• Will typically be scheduled within 120 days prior to scheduled 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.

- Please contact the reviewers directly within 30 days of the site visit for their flight Itinerary and any logistical information.
General Questions
PRQ

“We recently completed our first Level II pediatric site visit. Now we are scheduled for our Level II (Adult) reverification visit in December. Do we omit all pediatric questions on the upcoming PRQ?” (Level 2)

If this portion of the review will focus on the adult review, for the patient type select ‘adult only.’ This will ensure that only questions that pertain to the adult program will be displayed. In addition, section X. Pediatric Surgery will not be displayed.
Patient Admission Policy

“Can a Level III hospital define minor injury patients (skin tears, etc) admitted to medicine as excluded from trauma registry?” (Level 3)

“Is there an ACS definition on an admission with inclusion/exclusion criteria?” (Level 1)

The ACS does not set the admission policy for trauma centers. Each trauma center will set its own admission and registry entry policies.
“How much weight is given to Trauma Center accreditation Level by the annual volume of Trauma patients? A Trauma Center has Level 2 accreditation, can they be awarded Level 3 on the site visit without having applied for that level. Can a Trauma Center apply for both Level 2 and Level 3 at the same time and take which ever they are approved for?” (Level 2)

To clarify, a Level II and III do not have a volume requirement. The trauma center cannot apply for multiple levels at the time of the site visit. With this said, if a trauma center requests a visit as a higher level and it is determined that the center does not meet all the requirements, it may ask the reviewers to add a note for consideration to be verified as a Level II or III, or the TMD may submit a written request to the VRC office. The type of visit and the level of the visit cannot be changed during the onsite visit. In addition, the PRQ should not be changed if the type or level also changes. Please contact the VRC office.
“Is there a published list of recommended ACS audit filters for Trauma Registry/PI?” (Level 1)

Process and outcomes measures are also referred to as audit filters may be found in the Resources manual in Chapter 16. There are several required defined criteria and metrics as noted on pages 119 thru 127. The center may also add additional audit filters it would like to track and monitor.
PIPS Loop Closure

“How do the reviewers like to see loop closure demonstrated?” (Level 1)

“Is there a specific PI process format that the reviewers prefer?” (Level 1)

Have the PI records attached to the chart, or have it flagged to direct the reviewer to the electronic PI record. The reviewers would like to see how the problem was found (routine auditing, a report by a nurse, a patient complaint, etc.), what the initial investigation consisted of, who that was presented to and what the recommendations were, and the corrective action plan and closure.

Some recommend having a spreadsheet that have columns titled ‘corrective action plan’, ‘responsible person’, and ‘evidence of loop closure’ or something along those lines.
“Are there any plans to create or revise any nursing documentation within the new book, especially on the Trauma flow sheet?” (Level 2)

There have not been any discussions regarding the nursing documentation or trauma flow sheet at this time; however, this certainly can be submitted for consideration through the Stakeholder Website.

We have STN nurses on the chapter revision workgroups and are reviewing all feedbacks for consideration.
Transfers

“Our health system has a single call/transfer center for all three hospital campuses. When a request for transfer is made to the call center, for example, a same level fall with an isolated hip injury, is the request required to be admitted to the trauma center, or is it allowable to be excepted at an orthopedic hospital in the same health system, same geographical region?” (Level 1)

This will depend on the hospital’s admitting policy. If the policy calls for these patients to be admitted to the trauma center, then the transfer center should direct the patient to that center.
Transfers & Volume

“Transfers in by EMS/Air need to be included in NTDS data, do they count toward trauma center volume numbers even if not admitted?” (Level 1)

If length of stay is < 23 hours and the patient was not admitted to the trauma service, this would not be counted in the volume numbers. For completing the PRQ, the volume is based on the number of trauma patients admitted to a surgical service, e.g. trauma, orthopaedic, neurosurgery.
CD-Related Questions
Admission Volume (CD 2-4)

“During Feb webinar you mentioned 23hr LOS rule to count as admit (slide 44). NTDS does not have a LOS rule. Can discrepancy be addressed so ACS VRC & NTDS are in agreement?” (Level 1)

Correct, there are several differences within the 2 programs. During the chapter revision process we will be working on aligning the VRC and NTDS definitions.
Attending Surgeons Immediate Presence (CD 2-7)

“Can you please define CD 2-7? And give some examples that would meet this criteria.” (Level 2)

“The presence of such a resident or attending emergency physician may allow the attending surgeon to take call from outside the hospital. In this case, local criteria and a PIPS program must be established to define conditions requiring the attending surgeon’s immediate hospital presence (CD 2–7).”

The trauma center must have established and defined criteria for when the trauma attending is required to be present within 15 minutes for the highest level of activation. The highest level of activation must include the minimum criteria noted on page 38 of the Resources manual and as noted on the following slide along with additional criteria based on the center’s demographics.
Minimum Full Trauma Team Activation Criteria

The Minimum “7”

1. BP <90 in an adult & age specific hypotension in children
2. GSW to neck chest or abdomen or extremities proximal to the elbow/knee
3. GCS <9
4. Transfers with blood
5. Scene intubated
6. Respiratory compromise
7. ED physician discretion

Additional criteria may include criteria:

- **Anatomic**
  - Suspected two or more long bone fractures (i.e. humerus, femur, tibia)
  - Amputation proximal to wrist or ankle
  - Suspected pelvic fracture
  - Open or depressed skull fracture

- **Mechanism of Injury**
  - Ejection from vehicle
  - Death in same passenger compartment
  - Vehicle telemetry data consistent with high risk of injury
  - Pedestrian or bicyclist thrown, run over, or with significant impact
Transfers (CD 4-3)

“More questions r/t patients from a physician's office being a transfer - more detail please?” (Level 1)

I realize there are differences between the NTDS and the verification program in regard to what constitutes an interfacility transfer. At the present moment, those centers that will be undergoing a consultation or re-/verification visit and are 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.
“Is there a maximum amount of time the Trauma Surgeon has to see limited tiered trauma patients that are admitted?” (Level 2)

The limited tier criteria depends on your hospital policy. It must have defined response times for when the attending surgeon is required to respond to the patient at bedside. This must be monitored through the PIPS process to ensure there are no delays. In addition, you want to continuously review and update the criteria based on the PI/triage outcomes.
Limited Tier Response by PAs (CD 5-16)

“Can an ED PA act as the primary provider for trauma patients?” (Level 2)

For the limited tier, the PA may be the primary responder as long as the hospital has credentialed them to do so and they must be current in ATLS (CD 11-86). With this said, the limited tier criteria/protocols must clearly speak to this (the PA responding) and in addition have language for the type of injuries and time expectation for when the trauma surgeon is expected to respond. All must be monitored through the PIPS process to ensure there are no delays.
Non-Surgical Admits (CD 5-18)

“Ortho patients and many light trauma patients (cracked rib, minor lac) go to medicine admit, is a consult from ortho/GS ok?” (Level 3)

*If the patient met trauma inclusion criteria and was admitted to medicine with an orthopaedic consult, that is acceptable.*
Non-Surgical Admissions (CD 5-18)

“What is the ACS definition of ‘non-surgical’ with regard to non-surgical admissions?” (Level 2)

These are patients that meet trauma inclusion criteria and are non-operative. They may be kept by the trauma service for 24 hours and transfer care to hospitalists, medicine, family physician, etc.

For example: 43 year old, fall 10 ft from ladder: small subdural, external abrasions, diabetic

1. Cleared by EM, admit medicine (Avoid) → PIPS
2. Cleared by trauma in ED, admit medicine/hospitalist with NS consult (Better)
3. Admit trauma with NS consult (Best) - OR -
4. Admit trauma first 24 hours → (tertiary exam) acceptable, transfer to family physician with NS on consult (Best)
Pediatric Critical Care Medicine (CD 10-17)

“CD10-16 & 17, Peds Surgical Critical Care Board Cert or eligible, are you required to have 2 or 2 between critical care and surgical? Define board eligible? is that 10 yrs? If they don't take those boards, are they no longer considered eligible?” (Level 1)

In a Level I pediatric trauma center these may be pediatric BE/BC surgeons (2) with additional certification in medical or surgical critical care.

The board eligibility period varies by specialty. If it is 10 years and the provider did not take their boards within that timeframe, but was granted an extension, they must produce documentation from their boards attesting to this. If they were not granted an extension or have exceeded the allotted number of attempts, they are no longer board eligible.
Backup Surgeons and Pediatric CME (CD 10-40)

“CD 10-40 Are general surgeons in a LI combined center required to have 4hr cme/annually if are backup for peds trauma at night?” (Level 1)

There are no pediatric CME requirements for the adult surgeons who act as backup for the pediatric trauma service.
“Regarding CD 11-10 & -11, does ‘taking trauma call’ mean the anesthesiologist on call team or any caring for trauma patient?” (Level 2)

To clarify, the Resources manual refers to the ‘anesthesiologist taking call.’ If the word ‘trauma’ was added in error to the submitted question, the statement in the manual refers to the anesthesiologist who is taking trauma call, e.g. caring for the trauma patients.
Operating Room Team (CD 11-14)

“Level II Trauma Center: CD 11-14. An operating room must be adequately staffed and available within 15 minutes at a Level I and II.

a. What is considered an adequately staff operating room and what team members make up a complete OR team?

The composition of the operating room team will vary by institution. This may include but is not limited to the following: operating room nurse, scrub nurse, surgical tech, surgeon, anesthesiologist, CRNA, etc.
Operating Room Availability (CD 11-14)

b. Also it says operating room must be available. Please clarify what this means. Does this mean having an available room (open OR suite) or staffed and has all the necessary equipment ready to go?” (Level 1)

There are many ways to demonstrate immediate availability for an operating room. Some examples:

- Designated Trauma Room
- Staggered starts in the morning
- Direct to OR with unstable patient – that bypasses the ER
- Demonstration that there are enough operating rooms during various times throughout the day so that an emergency procedure can “bump” a case
- There needs to be policies and procedures in place that assures this process when needed
Define Death on Arrival (DOA) (CD 16-6)

“What do you use as a DOA definition is it asystole or PEA, any procedures done?” (Level 1)

For verification purposes, we do not have a definition for DOA. The DOA will be defined by the institution.
Alcohol Screening (CD 18-3)

“Do Cage Aide requirements include pediatric patients? What age is considered not applicable?” (Level 1)

I am not sure if Cage Aid includes pediatric patients.

The age for alcohol screening for pediatric patients will be defined by the institution. Typically the age is set at 12, but this will vary by institution.
Alcohol Screening (CD 18-3)

“Is the ‘80% of Injured Patients must be screened for ETOH/Substance Use’ apply to ALL patients in registry or just activations?” (Level 1)

It is applicable to patients (regardless of activated or non-activated) who meet inclusion criteria with a hospital stay of >24 hours who are admitted to the hospital and are entered into the registry.
CME: Invited Speakers

“In a previous web conference, it was stated that visiting speakers conducting grand rounds or speaking at a symposiums, unaffiliated with the host trauma center, would not count towards external CME. However, Page 136-137 of the orange book states: ‘Programs given by visiting professors or invited speakers are considered external CME.’ Can you clarify as to why an outside speaker at grand rounds or a hosted symposium would not count as external CME based on this statement?”

(Level 1)

To clarify, if the center was approved by the ACCME to grant external CME for the invited speaker and/or visiting professor, that is acceptable and we would need documentation to verify this, e.g. certificate or transcript.
CME: Collection Cycle

“When calculating physician CME, is the reporting cycle the same as the survey reporting year, or end of last survey month?” (Level 1)

CME collection is based on a 3 year cycle typically starting from the time of the last visit (month) up to the time of the upcoming visit or ending with the reporting year (there is a 2 month lag).
CME: CRNAs

“Are there CEU requirements for CRNAs and what is the difference between internal and external CME for physicians?” (Level 2)

CRNAs are not required to obtain CEUs.

External CMEs are approved by the ACCME and obtained through attending national or regional conferences or by way of online courses.

Internal CMEs are usually provided internally by the institution such as, M&M meetings.
CME: Liaisons and Non-Liaisons

“Please review who needs CME's for orthopedic, neurosurgeons and anesthesia. Thanks!” (Level 2)

“Are Orthopaedic physicians taking trauma call required to have 16 hrs CME yearly or 48 hrs every 3 years? Orange book has yes. Clarification only list Ortho Liaison. If yes it is same for Neurosurgery and Emergency?” (Level 2)

Anesthesia and radiology panel members are not required to have CME.

Liaisons for orthopaedic, neurosurgery and emergency medicine are required to obtain 48 hours of external trauma-related CME over the course of 3 years. This may be done by obtaining 16 hours of CME each year.

Non-liaisons (other panel members) who take trauma call are required to obtain 48 hours of external trauma-related CME over the course of 3 years or may be met with internal CME or through an internal education process. A combination of all of the above may be used.
“Many of our Ortho surgeons complete ortho self assessments for CME. Is there a guideline we can use for how many hours to give?” (Level 1)

“Can physicians use self-assessment examinations for trauma CME?” (Level 2)

Based on the information provided, I understand this to be a self assessment for preparing for the board certification. If true, the maximum number of CME the provider can apply toward the CME requirement for both preparing and taking their board certification is 33 hours within the 3 year period for verification.
“Do all Pediatric Surgeons still need the required CMEs if they are not seeing patients during the initial resuscitation? -Ped L2” (Level 2)

“What is the CME req for PICU attendings in house 24,7 in peds L1 facility only treating age 14 younger traumas?” (Level 1)

If the pediatric surgeons and/or PICU attendings manage and/or provide care to the pediatric patients, they are required to meet the CME requirement as noted in CDs 10-39 and 10-40.
Thanks for your participation!