Trauma Verification Q&A Web Conference

May 31, 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 Document and Verification Change Log

- Released Monthly
- Change Log – notes criteria updates/changes
- Available and download: [www.facs.org/quality-programs/trauma/vrc/resources](http://www.facs.org/quality-programs/trauma/vrc/resources)

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<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>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>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>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>Surgical commitment is essential for a properly functioning trauma center (CD 2.2)</td>
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<td>7/1/2014</td>
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<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>II</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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Website Resources for Trauma Centers

• Recording of Webinars:  
  https://www.facs.org/quality-programs/trauma/vrc/resources/webinars

• Stakeholder Public-Comment website:  
  https://www.facs.org/quality-programs/trauma/vrc/public-comment

• Frequently Asked Questions (FAQs):  
  https://www.facs.org/quality-programs/trauma/vrc/faq

• Tutorials:  
  • Becoming a Verified Trauma Center: First Steps  
  • Becoming a Verified Trauma Center: Site Visit:  
  https://www.facs.org/quality-programs/trauma/vrc/resources

• Participant Hub - Account Center:  
  https://www.facs.org/quality-programs/trauma/tqp/tqp-center
**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

Webinar Date: June 26, 2018

Webinar Time: 12:00pm-1:00pm CST

Deadline to submit questions: June 13, 2018
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.

- All Level I Trauma Centers must also complete the Orthopaedic Trauma Liaison (OTL) form with a copy of the OTL’s curriculum vitae when submitting site visit application.

- For trauma centers that have surgeons/physicians who trained, or are board certified overseas, they are required to apply and be approved by way of the Alternate Pathway Criteria. Their name and specialty must be specified on the application.

- We are accepting applications for February 2019 and the rest of that year.
Providing QTP Contact Updates

- Staffing changes should be updated at the Participant Hub Account Center or notify the VRC office as soon as possible: https://www.facs.org/quality-programs/trauma/tqp/tqp-center

- Challenges with not updating contacts:
  - Consultation, re-/verification and Focused 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
Prereview Questionnaire (PRQ) Online Access

• Once the 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 being scheduled quarterly.

- Centers are being asked to provide us with the exact dates you would like to have your 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.

- Visits will typically be scheduled within 120 days prior to the 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.
Website Maintenance for Participants & Reviewers

Please be advised that the ACS will perform scheduled maintenance from Saturday June 2, 2018 3pm (CDT) to approximately Sunday June 3, 2018 10pm (CDT). During this time, the Account Center HUB and TraumaSurvey5 (PRQ) may not be accessible.
Announcement
Chairs & Vice Chair, Verification Review Committee

VRC Chair, Daniel Margulies, MD FACS
Chief, Section of Trauma, Emergency Surgery and Surgical Intensive Care
Trauma Medical Director
Cedars-Sinai Medical Center
Los Angeles, California

VRC Vice-Chair, William Marx, DO FACS
Professor of Surgery and Critical Care
Trauma Medical Director
SUNY Upstate Medical University
Syracuse, New York
General Questions
Application for Consultation Visit

“How many months of trauma data are needed before submitting the application for consultation visit?”

(Level 2)

For consultation and/or verification visits, the trauma center must have 12 months of data in the registry. An application may be submitted while the center is collecting data for an upcoming site visit.
“Our level II verification goes through spring 2021. We move into a new medical center in fall 2019. Everything will be the same or enhanced: Staff, providers, equipment, etc. The only thing changing is the physical address. What is the process for verification at that site? A complete verification visit? A focused visit? How does that work?” (Level 2)

If the trauma center or program moves from its current physical location to a new location within 12 months of having its Verification/Re-Verification/Focused site visit, a “Walk-Thru” visit will be required to verify all is in order such as, staffing, equipment, operating suite, emergency room, etc.
Research

What is the difference between a multicenter and Multisystem project?
(Level I)

The multicenter and multisystem are used interchangeably within the verification program. The intent is that if the trauma center is or will be involved in a multicenter research project, that it must involve trauma surgeons and data from its facility in collaboration with the other trauma program centers.
OPPE Documentation

“For the verification visit, do we need copies of the OPPEs for EM, Neurosurgery, Ortho and ICU?” (Level 1)

Have available a copy of the documentation for each of the services. It is not required to have the OPPE documentation for each panel member at this time.
PRQ Guide

“What is the VRC doing to improve the clarity of the PRQ - we found it very vague and hard to interpret. We got things wrong” (Level 1)

“The PRQ is ambiguous in places. what is being done to make it more clear?” (Level 1)

We are continuously reviewing the PRQ for clarity based on feedback and recommendations from trauma programs. Based on those recommendations, a PRQ Guide was developed and is provided when the login information is forwarded to the Trauma Program Manager. If you did not receive a copy of the PRQ Guide, please email us at COTVRC@facs.org so that we may provide you with one.
“Is there a reference for ‘Appropriateness and timing of intravenous antibiotics for all open fractures’? (Pg 125 of Orange Book)” (Level 2)

The recommended time for the first antibiotic administered for an open fracture to the trauma patient that arrives in your Emergency Department is 90 minutes. Times that exceed beyond this will be cited as a weakness.
Trauma Liaisons - Certifications

“Life Support Certificates (ACLS/PALS): Is it mandatory for the Trauma Liaisons (Trauma Core group, Critical Care, Neuro, Ortho etc) to have BCLS, ACLS and PALS” (Level 2)

For all trauma centers, the Trauma Surgeons are required to have taken the ATLS course at least once.

For all other specialists, BCLS, ACLS and PALS are not required for verification. However, the institution may require the additional certificates as part of the credentialing process.
"If you are verified as an ACS level III and have a Level II verification visit after, does Level III stay in effect if not passed?" (Level 3)

It does not. If the trauma center that is currently verified and requests a visit at a higher level as in this example, Level II, and it does not pass, the trauma center would no longer be verified. However, if the trauma center met the Level III criteria at the time of the visit, a written request (signed by the TMD and CEO) may be submitted to the Verification Review Committee requesting to be verified as a Level III.
Advanced Practice Providers

“Are APP’s eligible for the shortened recertification ATLS course or must they attend a full 2 day course each certification cycle? (Level 2)

The Advanced Practice Providers (APPs) and Physician Assistants are welcome to take the ATLS Student Refresher Course. That would meet their requirements for maintaining current in ATLS.
CD-Related Questions
Level I Volume Criteria (CD 2-4)

“Is there any consideration to dropping the volume to 1000) instead of 1200?” (Level 1)

There have not been any discussions on revising this criteria.

If you have not already done so, you may submit your recommendations with supporting literature through the Stakeholder Public-Comment website:

https://www.facs.org/quality-programs/trauma/vrc/public-comment
Diversion (CD 3-7)

“Does diversion include redirection as well if the hospital tells EMS that we still accept traumas when we are on redirection?” (Level 2)

Bypass or diversion is based on when the trauma center will not accept trauma patients from the field (EMS).
Non-Surgical Admissions (CD 5-18)

“Can you please clarify what is meant by CD 5 – 18? It states: Programs that admit more than 10% of injured patient to non-surgical services must review all non-surgical admissions through the trauma PIPS process. It was clarified in the March Q & A that a non-surgical admission was a patient who was admitted but did not have surgery. It would also be assumed that a non-surgical service would be a physician service/group that does not perform surgery. Our program has been reviewing patients admitted to a non-surgical service but our trauma/ortho/neuro surgeons often admit patients that have a traumatic injury but do not require surgery upon secondary assessment, family consultation, or complete work-up. Based on this CD, which patients are subject to PIPS review, patients admitted to the non-surgical service or patients admitted to the surgical service but do not have surgery or BOTH?” (Level 2)

Following the algorithm on page 121, if the remaining patients are admitted to a non-surgical service and did not receive a consult by one of the surgical services, those patients are subjected to be reviewed.
Physicians in the Emergency Department (CD 7-6)

“If only Peds BC vs. EM BC, can they care for trauma patients including trauma activations?” (Level 1)

For Level I and II trauma centers, physicians who completed primary training in 2016 and after must be board certified or board eligible by the appropriate emergency medicine or pediatric emergency medicine board according to the current requirements.

Physicians who completed primary training in 2016 and after who are not board certified or board eligible by the appropriate emergency medicine or pediatric emergency medicine board may provide care in the emergency room but cannot participate in trauma care.
Physicians in the Emergency Department (CD 7-6)

“ER MD who graduated after 2016 that are not ER board, can they take care of ER patients and not trauma or is this a deficiency?” (Level 3)

For a Level III trauma center, physicians who are not board certified or board eligible by the appropriate emergency medicine or pediatric emergency medicine board, but are board certified in another specialty such as, Family Medicine, Internal Medicine, etc., may provide trauma care in the emergency room. These physicians must maintain current status in ATLS.

The 2016 primary training language does not apply to Level III. This will not be cited as a deficiency.
Neurosurgeon (CD 8-5)

“In Level III center- I am dropping to one neurosurgeon in July. Please explain call and back up requirements” (Level 3)

With one Neurosurgeon, you must have a contingency plan that includes the following:

- A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the neurotrauma patient.
- Transfer agreements with a similar or higher-level verified trauma center.
- Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.
- Monitoring of the efficacy of the process by the PIPS program.
Orthopaedic Back-up Call Schedule (CD 9-6)

“If there's 24/7 orthopedic trauma call does a hospital need an orthopedic backup call schedule? Refer to CD 9-5” (Level 2)

To clarify, the back-up call system is CD 9-6. A back-up call system is not required if the program has dedicated Orthopaedic Surgeons on call at all times.
“What are the FTE requirements for a Level 2 Pediatric Trauma Program Manager?” (Level 2)

A Level II pediatric trauma center must have a dedicated Trauma Program Manager. Depending on the patient volume of the trauma center, this person may also serve as the pediatric registrar or the pediatric injury prevention coordinator.
Continuous Rotation (CD 17-3)

“Continuous rotations in trauma for residents (PGY 4-5), does this incl general & ortho surgery and emergency medicine residents?” (Level 1)

The continuous rotation requirement is for trauma surgery. Postgraduate training and education may also include, but is not required, emergency medicine and the other surgical specialty residency programs.
"Can you please clarify what is meant by CD 11-14? It states: An operating room must be adequately staffed and available within 15 minutes at Level 1 and Level II trauma centers. Does this mean the patient must be in the room within 15 minutes? Can you provide any options for tracking the availability and staffing of an OR within the timeframe?" (Level 2)

The expectation is that the operating room (OR) team is notified when a trauma patient is going to be sent to the operating room. The initial call and the team members response must be tracked. This can be documented on a logbook, EMR, or by badge swipe.
Interventional Procedures (CD 11-33)

“Is the interventional radiology requirement referring specifically to embolizations?” (Level 2)

It refers to all interventional procedures which may include embolization.
“CD 11.33 states that for ‘level 1 and 2 centers’, a qualified radiologist must be available within 30 minutes to perform complex imaging studies or interventional procedures’. It is too vague and nonspecific enough to hold IR responsible. If it takes 20 minutes to reach and speak with the IR attending, technically the clock does not start until communication is established however care is delayed during that time. The word ‘available’ leaves too much to interpretation. It does not say in person and as such the IR can say they were available within 30 min by phone. Please advise at next VRC webinar.” (Level 1)

The criteria reads that the IR must be available (respond) within 30 minutes to perform (in person) complex imaging studies, or interventional procedures. The clock starts when the call is made that the patient will be taken to the operating room to perform the procedure.
“In reference to CD 16-6: Please clarify ‘patients transferred to hospice care should be reviewed as deaths’. When a patient is discharged from our hospital alive to hospice care are we supposed to review these patients as a death even though the patient is alive? If so, how do we PI a survivor as a death?” (Level 1)

If the patient was transferred to a hospice service within the hospital or a hospice facility, the expectation is that the care leading up to the transfer is evaluated through the PIPS process by the TMD and TPM. If any issues are found, then it can be reviewed at peer review.
Trauma Systems and Peer Review (CD 16-15)

“Do Advanced Practitioners need to attend 50% of Trauma Systems and M&M committee meetings? Even if per diem?” (Level 1)

Advanced Practice Providers (APPs) are not required to attend the trauma systems and/or the peer review meetings. However, based on institutional guidelines, they may be required attend the trauma systems and/or the Morbidity & Mortality (M&M) meetings.

Note, if the M&M and peer review meeting are one in the same, again the APPs are not required to attend.
Alcohol Screening (CD 18-3)

“On admission, patients are asked about alcohol use as part of the nursing admissions history. Is this sufficient screening to meet the requirement of screening 80% of admitted trauma patients?” (Level 1)

It is applicable to eligible patients (alive and participatory), 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. This includes activations or all admitted trauma patients including orthopaedic and neurosurgery.
CME
Continuing Medical Education (CME)

Effective Immediately

• The CME requirement changed to 36 hours over 3 years, in which, 12 hours may be accumulated each year.

• In Level I and II trauma centers, the Trauma Medical Director (TMD) must fulfill this requirement by obtaining and demonstrating a minimum of 36 hours of verifiable external trauma-related continuing medical education (CME) over a 3 year period.

• In Level I and II pediatric trauma centers, the pediatric TMD must fulfill the same requirement, of which 9 hours must be specific to pediatric trauma. CD 5-7/CD 10-39 Type II
For the Trauma Surgeons, Pediatric Surgeons and specialty panel members (emergency medicine, neurosurgery, orthopaedic surgery and ICUs) participating on the trauma call panel, staying current with their board certification satisfies the CME requirement. CDs 5-24, 7-12, 7-13, 8-14, 8-15, 9-18, 9-19, 10-39, 10-40, 11-63, and 11-64 Type II

- In other words, if all trauma panel members are current in their respective board certifications, it satisfies the CME requirements at this time.
Continuing Medical Education (CME)

• The TMD is expected to assess the individual surgeon’s adequacy of trauma care knowledge in the ongoing professional practice evaluation (OPPE) process and retains the right to require additional CME or internal education process (IEP) that stems from the trauma center’s performance improvement and patient safety (PIPS) process.

• For the specialty panel members (emergency medicine, neurosurgery, orthopaedic surgery and ICUs), the OPPE may be done by the specialty liaisons with approval of the TMD.
CME Clarification

• Current board certification is applicable to board eligible (recent graduates) and life-time (grandfathered) physicians/surgeons.

• Trauma Surgeons and specialty panel members (emergency medicine, neurosurgery, and orthopaedic surgery) who have been previously approved by way of the Alternate Pathway Criteria, must meet this requirement by obtaining and demonstrating a minimum of 36 hours of verifiable external trauma-related CMEs over a 3 year period or by participating in an equivalent number of hours in the trauma center’s internal education process (IEP) or a combination of CME and IEP. The trauma program is expected to have a copy of its provider’s CMEs or IEP documentation at the time of the visit.

• Note, the PRQ will be updated to reflect the above change. Pending these changes, the trauma program will select ‘Yes’ to the CME questions and leave the CME section blank in the appendices.
Maintenance of Certification (MOC)

“ED docs that are family or internal medicine boarded- is MOC sufficient?” (Level 2)

“Can you further clarify how reviewers will want trauma centers to prove that providers are current with MOC requirements?” (Level 1)

“Please clarify the requirements for MOC for non-liaison physicians.” (Level 3)

We are not collecting MOC documentation or verifying if the providers are actively enrolled in MOC. At this time, maintaining current board certification satisfies the CME requirement.
Continuous Medical Education (CME)

“How do we best demonstrate physicians' compliance with maintaining board certification according to the new CME criteria?” (Level 1)

To demonstrate compliance with the change in the CME requirement, the board certification on the appendices for all providers must be current and accurate. In the areas asking for ‘Board Certified...year of current certification’ and ‘Year/Recertified,’ enter the expiration date of when the boards expire or are valid through. The following appendices will be impacted by this change: 1-2, 4-9 and 13-14.

For appendices that have a column for CME, leave it blank.
CME TMD and Alternate Pathway

“In addition to TMD, does specialty panel members (Emergency Med, Ortho, Neurosurgery, ICU) need 36 external CME over 3 years?” (Level 1)

No they do not. External CMEs are only applicable to the TMD or pediatric TMD and any provider who is or has undergone review by way of the Alternate Pathway.
CME Liaisons and Non-Liaisons

“Please clarify the changes to CME and verify that CME is NOT needed for physicians that maintain their board certification.” (Level 2)

“Please discuss the new CME requirements for specialty panel members and physicians who take trauma call.” (Level 1)

“Per new Orange Book CD, all liaisons at Level 1, 2 trauma centers will be considered up to date with CME If Board Certified?” (Level 1)

CMEs are not required for the liaisons and non liaisons who maintain current board certification.

External CMEs are only applicable to the TMD or pediatric TMD and any provider who is or has undergone review by way of the Alternate Pathway.
“Staying current with board certification (10 years) will satisfy trauma call panel CME, with the exception of the above?” (Level 1)

CMEs are not required for the liaisons and non liaisons who maintain current board certification.
CME Level III Trauma Centers

“CME requirements for Level III-I know there were changes. CME requirements for trauma surgeons and ED docs.” (Level 3)

“Is there a CME requirement for general surgeons taking trauma call at a Level III facility?” (Level 3)

Level III trauma centers are not required to meet the CME criteria. However, all trauma panel members must maintain current board certification.
“Is it only the TMD that need 12 hours of CME for first time verifying centers or do all doctors need them for the first cycle.” (Level 2)

For trauma centers seeking verification for the first time, CMEs for the TMD or pediatric TMD will be prorated as 12 hours. In a pediatric trauma center, of the 12 hours required, 3 hours must be specific to pediatric trauma. All other trauma providers must maintain their board certification.
Current board certification is applicable to board eligible (recent graduates) and life-time (grandfathered) physicians/surgeons. They are in compliance with the CME criteria.
CME Advanced Practice Providers (APPs)

“What are the new requirements for mid level practitioners? Do they need 36 hrs of cme over 3 years?” (Level 1)

The Advanced Practice Providers (APPs) are not required to meet the CME criteria.
CME Radiology or Anesthesia Liaison

“Are there new requirements also for radiology liaison and anesthesia liaison?” (Level 1)

There are no CME requirements for the radiology or anesthesia liaisons.
“In addition to accepting MOC as CME evidence, is this sufficient for pediatric centers or is pediatric CME still required?” (Level 1)

We are not collecting or verifying MOC documentation at this time. Maintaining current board certification satisfies the CME requirement.

In Level I and II pediatric trauma centers, the pediatric TMD must fulfill this requirement by obtaining and demonstrating a minimum of 36 hours of verifiable external trauma-related CMEs over a 3 year period, of which 9 hours must be specific to pediatric trauma. CD 5-7/CD 10-39 Type II
CME Lapsed Board Certification

“CMEs: So we do not need to collect CMEs for anyone who is not a liaison to the Trauma Program as long as they are current with their Board certification or do we need to have their CMEs present for the site visit?” (Level 1)

Correct. Only have CME documentation onsite for the TMD/P-TMD. For all others, do not collect or print the CME certificates. The requirement is that all trauma panel members must maintain current board certification. If anyone has lapsed and does not recertify their boards, this will be cited as a deficiency.
CME Board Certification

“The April 2018 release of the clarification document indicates the VRC will accept 33 hours from board certification or re-certification toward the 36 hour trauma CME requirement. How is this 33 hours determined?” (Level 2)

In Level I and II trauma centers, the TMD or pediatric TMD are required to have a minimum of 36 hours of verifiable external trauma-related continuing medical education (CME) over a 3 year period. For the pediatric TMD, of the 36 hours required, 9 hours must be pediatric specific. In this instance, if the TMD recertified during the 3 years leading up to the site visit, he/she may utilize 33 hours toward this requirement.
CME vs OPPE

“Can you give examples of the ongoing professional practice evaluation process that is now being required for emergency medicine, neurosurgery, orthopaedic surgery and ICU?” (Level 2)

Ongoing professional practice evaluation process is not a new criteria. It is listed under CD 5-11.

Examples of OPPE are listed on the VRC webpage: www.facs.org/quality-programs/trauma/vrc/resources.
CME OPPE

“Do the specialty panel members (emergency medicine, Neurosurgery, orthopaedic surgery, ICU) that are not a liaison still need to participate in the IEP if they are maintaining their board certification? (Level 1 Pediatric Trauma Center)” (Level 1)

If the TMD and specialty liaisons are expected to assess the individual surgeon’s/physician’s adequacy of trauma care knowledge in the ongoing professional practice evaluation (OPPE) process and retains the right to require additional CME or internal education process (IEP) that stems from the trauma center’s performance improvement and patient safety (PIPS) process.
CME External vs Internal

“I received the email regarding the Change Log pertaining to the External CMEs. My TMD and I are hoping to get some resolution on this. Could you explain the latest update to the change log, specifically the External CMEs? Do the changes to the External CMEs eliminate the Internal Trauma Related CME Credits?” (Level 1)

The change does not affect the CME type (external versus internal). The TMD or pediatric TMD must accrue 36 hours of external CME. For the pediatric TMD, 9 hours must be pediatric specific of external CME.

The IEP plays a roll during the OPPE process as described in the previous slide.
Thanks for your participation!