Trauma Verification Q&A Web Conference

November 27, 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 trauma 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](http://www.facs.org/quality-programs/trauma/vrc/resources)
## Clarification Document and Verification Change Log

The American College of Surgeons

**Clarification Document**

*Resources for Optimal Care of the Injured Patient*

By the Verification Review Committee

V9_9/30/18 2018

<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>
<th>Type</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>
<td>Type II</td>
<td></td>
</tr>
<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>
<td>Type II</td>
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<td>1-3</td>
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<td>II</td>
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<td>IV</td>
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<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>
<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>
<td>Type I</td>
<td></td>
</tr>
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<td>2</td>
<td>2-2</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>Surgical commitment is essential for a properly functioning trauma center (CD 2-2)</td>
<td>Type I</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2-3</td>
<td>I</td>
<td>II</td>
<td>III</td>
<td>IV</td>
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<td>II</td>
<td>7/1/2014</td>
<td>New</td>
<td>Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification (CD 2-3)</td>
<td>Type II</td>
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<td>2</td>
<td>2-5</td>
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<td>II</td>
<td>III</td>
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<td>7/1/2014</td>
<td>Revised</td>
<td>Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review (CD 2-5)</td>
<td>Type II</td>
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November 27, 2018

**Released Monthly**

**Change Log – notes criteria updates/changes**

**Available for download:**

[www.facs.org/quality-programs/trauma/vrc/resources](http://www.facs.org/quality-programs/trauma/vrc/resources)
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

- 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

- Expanded FAQ:  
  https://www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/faq/standards
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.
Scheduling Reminders & Updates
Scheduling Reminders:

• Will be presented every other month

• After November the next presentation will be January 2019
Site Visit Application

- The site visit application is **online only**.
- Can be accessed on the following ACS Trauma website pages:
  - VRC – Site Visit Application
    https://www.facs.org/quality-programs/trauma/vrc/site-packet
  - TQP Participant Hub - Account Center
    https://www.facs.org/quality-programs/trauma/tqp/tqp-center
Site Visit Application

- The ACS Trauma website pages will link to the Account Center page:
• The online application must be submitted at least 13 -14 months in advance of the requested site visit dates and must be before expiration date.

• An Alternate Pathway review should be requested on the application for surgeons/physicians who trained overseas and want to participate on the trauma call schedule. Their CVs must be submitted to cotvrc@facs.org as they will be vetted by a subcommittee for eligibility to go through the Alternate Pathway.

• All Level I Trauma Centers must also complete the Orthopaedic Trauma Liaison (OTL) form which can be downloaded on the site visit application. Submit form to cotvrc@facs.org with a copy of the OTL’s curriculum vitae.

• We are accepting applications for June 2019 and onward.
Prereview Questionnaire (PRQ) Online Access

• Once the application has been submitted, 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 until you receive an invoice

- 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

• We ask that you provide us with the exact dates you would like to have your site visit. The visit will occur on your chosen dates but we may ask for different dates if the review team cannot attend the requested dates.

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

• You will receive the confirmation email approximately 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.
Announcements
Next Verification Q&A Webinar

Webinar Date: **Wednesday, December 12th**

Webinar Time: **12:00 PM Central Time**

Deadline to submit questions: **Wednesday, December 5th**
General Questions
Pediatric Inpatient Service

“Is a pediatric inpatient service required for a level II adult only facility?” (Level 3)

If this trauma center is an “Adult only” facility meaning no pediatric patients will be received and/or admitted, a pediatric inpatient service is not required.
Acute Stress Disorder Screening Tool

“At my Level II center we are striving to improve on a cited ‘weakness’ which stated: ‘There is no codified process for the evaluation of acute stress disorder in the trauma victim.’ Is there an identified screening tool that can be used in the acute care setting, the screening tools I have been finding have been lengthy cumbersome and often reference ‘in the past 2 weeks’…or ‘in the past month’. Also is this recommendation intended for all trauma patients or just the ones that have complaints such as flash-backs or nightmares?” (Level 2)

Presently, screening for acute stress disorder is a recommendation. The trauma program may determine the criteria for when the trauma patient will be evaluated. As with the alcohol screening tool, the trauma program may create its own tool. The VRC webpage has an example of a PTSD screening tool, https://www.facs.org/~media/files/quality%20programs/trauma/vrc%20resources/10_ptsd_checklist_and_scoring.ashx.
“Our in-house CRNAs respond to activations and intubate most of the patients if needed. Are they required to have ATLS?” (Level 2)

CRNAs are not required to have taken ATLS.
**Burn Patients**

“Do burn transfer patients need to be transferred to an ABA verified center or can they be admitted to any hospital burn centers?” (Level 2)

*Burn patients should be transferred to a designated burn center that is capable of managing their injuries. It does not need to be an ABA verified burn center.*
Call Coverage

“Is all call coverage assumed to be 24/7?” (Level 2)

If I understand the question, call coverage is required 24/7 for specific specialties, some are required to be in-house and others are not.
Injury Prevention

“Does the ACS assess a trauma center's evaluation of its injury prevention programs?” (Level 1)

For the purposes of verification, we ask the trauma program through the online PRQ to identify and briefly summarize at least two injury prevention programs that address one of the major causes of [trauma] injury in the community and have the information available for review during the actual site visit. Some programs have this displayed on a storyboard or within a 3-ring binder.
Neurosurgery Criterion

“Level III with Neurosurgery capability: where is standard stating they must meet ALL Level II ACS criterion?”

(Level 3)

There is no criteria that states that a Level III with Neurosurgery capabilities must meet the Level II criteria. Level III with Neurosurgery capabilities are required to meet the standards identified in Chapter 8 and 11 for Level III trauma centers. These include the following:

- CD 8-5, Published contingency plan
- CD 8-6, Backup call schedule when Neurosurgeon covers multiple centers
- CD 8-7, TMD approved plan for which Neuro patients will remain or transferred
- CD 8-8, Transfer agreements w/Level I and II trauma centers
- CD 8-9, Timely and appropriateness of care is reviewed through PIPS
- CD 8-10, Neurosurgeon must be currently board certified/eligible
- CD 8-13, Peer review attendance of 50%
- CD 11-20, Craniotomy equipment
- CD 11-68, ICP monitoring equipment
- CD 6-3, Alternate Pathway for non-U.S. trained Neurosurgeons, if applicable
New TPMs Resources

“Other than the ‘Orange Book’, what are the most important things for new TPMs to review?” (Level 3)

In addition to the Orange book, you will need to review the Clarification and Change log, refer to slide #7 in this presentation.

Additional resources for new TPMs/TMDs, refer to slide #8 in this presentation.
Non-Surgical Admissions

“Non Surgical Services Admit: is rate of greater than 10% the raw (all NSS admits) or adjusted (NSS admits with surgical consults)” (Level 3)

The rate of 10% is based on the raw number of Non-Surgical Admissions (NSA).

For best practices, you want to review all NSA.
Non-Surgical Admissions

“If a patient is admitted to a medicine service but is transferred to a surgical service within 24 hours of admission, do those patients still count in our non-surgical admission numbers?” (Level 1)

If the initial admission was to the Medicine Service, yes it would count towards your NSA numbers.
Non-Surgical Admissions

“Patients admitted to a NSS, reviewed by TMD and deemed appropriate still negatively impact NSS admission rate? (ex: fall with multiple fx. incidental finding noted NSTEMI. Admitted to medicine with ortho consult)” (Level 2)

A trauma center with a NSA rate greater than 10% is not seen as negative. In the scenario above, the admission and review is appropriate.

Please keep in mind that if the trauma program admits more than 10% to a Non-Surgical Service and are reviewed through PIPS for appropriateness of care, it will NOT result in a deficiency. For best practices, you want to review all NSA.
Nursing Turnover Rate

“What is the benchmark nursing turnover rate for ED and ICU? How high is too high?” (Level 2)

Although there is not a VRC benchmark on the turnover rate for nurses working in the Emergency Department and/or the ICU, reviewers [based on VRC reports] use an average of 20% to cite a weakness.

If the rate is too high, it will not result in a deficiency.
Orange Book Revisions

“Is there a projection for the next Orange Book edition or update other than the clarification documents?” (Level 2)

Ideally we will do away with the Clarification document with the next edition of the “Orange book.” The next Resources manual will hopefully be released sometime late 2019 or early 2020. Please note, this is a fluid date and will be based on the progress of each chapter.
Orange Book Revisions

“Have publication requirements for Level I centers been revised?” (Level 1)

I believe this refers to Chapter 19, Research. At this time, no updates have been released. The revised chapter is pending final approval.
Orange Book Revisions

“What is the status of Chapter 16 Orange Book changes!” (Level 2)

“When do you anticipate requiring the new taxonomy for PI?” (Level 2)

Chapter 16, Performance Improvement and Patient Safety is still under revision. This Revision Workgroup will incorporate and/or edit standards based on best practices, evidence-based and Stakeholder feedback.
Staffing

“Need specific direction on ACS rules for appropriate trauma staffing that include full program support not just a number in reg.” (Level 3)

Aside from those requirements noted in the Resources manual for the medical and surgical specialists, TPM, TMD, Registrars, Injury Prevention, etc., the additional staffing will be determined by the institution based on the trauma program needs.

Presently, the Revision Workgroup assigned to each of the chapters will identify and incorporate the staffing needs based on best practices, evidence-based and Stakeholder feedback.
Trauma Team Activation and EMS

“Is it a requirement to have the ability for EMS to call a Trauma Activation from the field in writing?” (Level 2)

That is not a requirement. There are some instances where the EMS will call an activation from the field based on predefined protocols.
Verification Status

“What happens to a facility should they not pass a verification survey? Probationary period, or stripped of trauma center status?” (Level 3)

Re-/Verification is granted for a 3 year period if there are no deficiencies cited.

If the center was cited less than 3 Type II deficiencies and no Type I deficiencies, Re-/Verification will be granted for a period of 1 year with a Focused review pending (12 months from the date of the initial visit).

If the center was cited more than 3 Type II deficiencies and/or any Type I deficiencies, the center would not be verified. However, in either instance, the center can achieve Verification with a Focused review (12 months from the date of the initial visit).
Verification Site Visit

“Do we need to provide actual copies of the board certification certificate? Would you accept copies of the verification obtained from the board certifying body's website? (I.e American board of surgery)?” (Level 2)

We do ask that Board Certification type and expiration dates are provided on the online PRQ.

Copies of verification from the specialty boards are acceptable to have onsite visit.
Verification Site Visit

“Is it necessary to make an entire hard copy printout of your registry chart for your review charts?” (Level 2)

If using paper medical records, you will be required to print the entire chart for the onsite visit.

If using electronic medical records, you will only print specific components of the chart for the onsite visit as follows:

- Prehospital:  a) EMS run sheet, and b) Transferring facility ED info
- Trauma Flow Sheet
- H&P
- Consult Notes
- Operative Report/ Notes
- Discharge Summary
- Autopsy Report, if available
- Copies of PIPS documentation and other related information, if applicable

Refer to the Review Agenda for further details.
Verification Site Visit

“Could you ever see where an entire state would move from state verification to all ACS verified centers?”
(Level 3)

Absolutely. The states of Georgia and New York were the most recent to move from state process to ACS verification. There are exceptions based on state statutes. Some states will review their own Level IVs since ACS does not consult/verify Level IVs, and in other states, they may perform their own Level III reviews, whereas ACS will review the Level I and II trauma centers.
Verification Site Visit

“How will the ED & hospital discharge info be review during the verification?” (Level 2)

“Is inpatient admission info under review during the verification, and if so are there any specific criteria?” (Level 2)

The objective of the medical record review is to allow the review team to glean a logical flow of care, including assessment findings, interventions provided capability of trending for vital signs, fluid, responses to intervention, timing of care (Trauma Surgeon arrival, level of alert, prehospital care, etc). There is no specific criteria other than ensuring appropriateness of care was provided.
CD-Related Questions
Level I Trauma Admission Volume (CD 2-4)

“Is the volume requirement for an Adult Level I trauma center 1200 trauma patients or 240 admissions with ISS >15 based on trauma registry definition (which is NTDB based)? Are there any additional caveats such as remove ground level falls, drownings, etc?” (Level 2)

The volume criteria is based on either the NTDS Inclusion Criteria or that of your state if different than the NTDS. In some instances, your State Inclusion Criteria may include additional data fields than the NTDS.

There is one caveat that Verification differs from the NTDS Inclusion Criteria such as, 23 hours observation patients who are discharged and not admitted to a service. For Verification purposes, patients admitted to a service count toward the volume criteria.
"If the ED is on diversion & another ED calls to transfer a pt. for orthopedics, but not trauma surgery is that trauma diversion?" (Level 2)

That would not count towards the diversion rate. Diversion or bypass is defined as the Emergency Department not accepting patients from the field (by EMS).
“Where is the standard stating you cannot transfer a stable patient with a hip fracture to a non trauma center due to insurance?” (Level 3)

If the patient is being transferred to a non trauma center for specialized care or insurance purposes, that is appropriate as long as there are transfer agreements in place. These instances must be reviewed through the PIPS process.
Call Schedule (CDs 5-7/6-8)

“Are the requirements for trauma surgeons taking backup call the same as primary call (i.e. 50% attendance at Peer Review)?” (Level 2)

If the backup call schedule is comprised of Trauma Surgeons/General Surgeons and they alternate with primary call, they are required to meet the same requirements.
Trauma Team Activation Limited Tier (CD 5-16)

“is there a surgeon response time required for level 2 trauma activations” (Level 2)

The institution will define 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 monitor your metrics through the PIPS process.
"Is there a time limit a program can be without a TPM dedicated to the trauma program before it is a deficiency?" (Level 2)

It would be concerning not to have a TPM for any period of time specifically during the reporting period as it may impact the program’s site visit.

If during the onsite review, there is not a TPM who is full-time and dedicated to the trauma program, it would be cited as a deficiency.
“General surgeons (who do not routinely take primary trauma call but maintain current ATLS certification) covered about 8-9 calls over a 60 day period due to an unanticipated leave of absence. Would they be required to attend 50% of the PIPR meetings for that timeframe? Or would face to face review of their activations/admissions with the TMD suffice?” (Level 2)

General Surgeon locums who provide care to trauma patients are required to meet the same requirements as the other trauma panel members such as, board certification, OPPE and attend trauma peer review meetings either in person, via teleconference or video.

While it is ideal to be current in ATLS, they are not required to do so.
Emergency Physician Coverage (CD 7-2)

“Is it acceptable for the trauma surgeon to cover ED for inhouse pediatric emergencies when only 1 ED provider is scheduled?” (Level 2)

There must be an Emergency Physician in the Emergency Department at all times at a Level I and II trauma center. Therefore, it is not acceptable for the Trauma Surgeon to cover the Emergency Department for when the Emergency Physician covers an in-house emergency.
"We are a level 1 pediatric trauma center. I am looking into CD's 10-17, 10-33, 11-48, & 11-49. Can you please elaborate so I have a better understanding of these CDs. We currently have our PICU staffed with faculty who are all ABP certified in pediatric critical care but not ABS certified. Our surgeons are not certified in critical care. When our patients are admitted, the attending is the pediatric surgeon (trauma). They work collaboratively with the critical care physicians to care for the patients while in the PICU. They co-manage the patients, with final decisions done by the pediatric surgeon. Do we meet the standards for the aforementioned CD's?" (Level 1)

It appears that you are in compliance with the above criteria. A Level I pediatric trauma center is not required to have a Surgical Director boarded in Surgical Critical Care, thus this satisfies CDs 10-33, 11-48 and 11-49. However, there must be 2 Physicians who are boarded in Pediatric Critical Care Medicine, it appears that you meet this criteria (CD 10-17).
ICU Coverage (CD 11-51)

“CD (11-51) addresses ICU coverage within 15 minutes, appropriately trained physicians, can PGY 4/5 residents serve in this role?” (Level 1)

This coverage may be performed by an appropriately supervised Senior Surgery Residents (PGY4-5) or an in-house Trauma Attending credentialed to provide critical care.
Surgical Critical Care Director (CD 11-53)

“Please explain the role of the CC surgical co-director. What evidence needs to be available during the review related to this?” (Level 2)

In Level II and III trauma centers, the co-director or director of the ICU must be actively involved in, and responsible for, setting policies and administrative decisions related to trauma ICU patients. In some instances, this role may also be served by the TMD in which their information, e.g. Curriculum Vitae, must be available onsite and also noted in the online PRQ.

The majority of the evidence will be noted within the medical records.
Hand Coverage (CD 11-70)

“Is a call schedule the preferred way to demonstrate hand call is available?” (Level 2)

A hand call scheduled may be the best method; however, it is not required. The trauma program must be able to demonstrate who is providing hand coverage when requested.
Mortality Review (CD 16-6)

“Do all mortalities need to be reviewed at trauma peer review or only those cases where an opportunity for improvement was found?” (Level 2)

All trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement should be identified for peer review.
Nursing Certification (CD 17-4)

“Please define advanced nursing certification/education - We currently have nurses who are CPAN (certified post anesthesia nursing), ENLS (emergency neurologic life support), CNOR, CCRN, CEN. We understand that TNCC, TCAR and ENPC are recognized.” (Level 1)

Correct, all of the above are recognized by the Verification program as nursing certification and education. While there are no specific education/certification requirements for nurses caring for trauma patients, the trauma center must provide a mechanism to offer trauma-related education to nurses.
“Please clarify ‘universal screening’ for alcohol use. Does the ED triage assessment of asking the pt if they drink/how much, qualify?” (Level 3)

If the ED triage assessment tool captures the information necessary to determine alcohol use, that will qualify.
Injury Prevention (CD 18-5)

“Is the Injury Prevention Program the totality of injury prevention events or does a facility need specific programs in place?” (Level 2)

Ideally, the trauma program should capture the totality of injury prevention events. For Verification purposes, we ask Level I and II trauma centers to demonstrate at least two programs that address one of the major causes of [trauma] injury in the community. This may be equivalent to projects related to local issues, i.e. two projects concerning one issue or two projects concerning two issues: alcohol use among adolescents, elderly fall prevention, Stop the Bleed, etc.
“Level 1 Adult, Level 2 Pediatric - Please clarify the amount of pediatric specific CME required for the TMD, TPM and Liaisons.” (Level 1)

The CME requirement changed to 36 hours over 3 years, in which, 12 hours may be accumulated each year. This is applicable to the adult and/or pediatric TMD, TPM and alternate pathway candidates.

In Level I and II pediatric trauma centers, the pediatric TMD must fulfill the same requirement, of which 9 hours must be pediatric trauma specific.

For the Trauma Surgeons, Pediatric Surgeons and specialty panel members (Emergency Medicine, Neurosurgery, Orthopaedic Surgery and ICU) participating on the trauma call panel, staying current with board certification satisfies the CME requirement.
"Does the MOC requirement have any stipulation for trauma-specific continuing education for surgeons or physicians?" (Level 2)

My understanding is that MOC/Continuing Certification (CC) does not or is not, categorizing CME as trauma-specific. Therefore, the Verification program will honor those Surgeons/Physicians who are currently participating in their specialty board MOC/CC as meeting the trauma-specific CME requirement.
CME

“We are an Adult Level 1 and Pediatric Level 2- Are CME required for adult providers that may come in contact with Pediatric pts?” (Level 1)

There are no CME requirements for the adult providers caring for pediatric patients. They must be currently participating in their specialty board MOC/CC.
CME

“Given the change to CME requirements, will centers going for PTC status need to show pediatric specific CMEs on any providers?” (Level 2)

In Level I and II pediatric trauma centers, the pediatric TMD must fulfill 36 hours of CME in which 9 hours must be pediatric trauma specific.

The TPM and alternate pathway candidates, if applicable, must have 36 hours of trauma related CE/CME.

For the Pediatric Surgeons and pediatric specialty panel members (Emergency Medicine, Neurosurgery, Orthopaedic Surgery and ICU) participating on the trauma call panel, staying current with board certification satisfies the CME requirement.
CME and Nursing Certification

“With TMD exception Physicians only need take ATLS once to be counted in review as having had the course. What about Nurses and courses such as TNCC must their card be current in order to counted as having had the course?” (Level 1)

Also an exception to maintaining current ATLS are the following:

1. Physicians who work in the Emergency Department who are not board certified/eligible in Emergency Medicine, but who are in another specialty such as, Family Practice, Medicine, etc.

2. Advanced Nurse Practitioners who are members of the activation team, and participate in the evaluation and resuscitation efforts.

There are no requirements for Nurses to maintain current status in their TNCC or any other certifications.
Thanks for your participation!