Trauma Verification Q&A Web Conference

October 19, 2017
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Your Trauma Quality Programs Staff

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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 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
## Verification Change Log

Updates sent to participants monthly

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<thead>
<tr>
<th>Chapter</th>
<th>CD #</th>
<th>Level I</th>
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<th>Level IV</th>
<th>PTC I</th>
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<th>Resources 2014 Orange Book Description of Criteria</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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<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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<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>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>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

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, November 3, 2017

Webinar date: Thursday, November 16, 2017

Webinar time: 11:00am-12:00pm CST
2017 TQIP Annual Scientific Meeting and Training

November 11-13, 2017
HILTON CHICAGO | CHICAGO, IL

https://www.facs.org/tqipmeeting
TQIP Meeting Information

• Registration is currently **open**

• Hilton hotel reservations are **limited** *

• Blackstone hotel reservations are **limited** *
  
  *ACS Group Rate of $249 is good through October 19

• Visit the TQIP Annual Meeting website at [www.facs.org/tqipmeeting](http://www.facs.org/tqipmeeting) for more information and to register for the meeting.
**TQIP Preconference Courses**

- Workshop registration is open for:
  - AIS15 Update Course
    - Friday, November 10, 8 am-12 pm
  - Bleeding Control Basics
    - Friday, November 10
      - Session I: 2:00 pm – 3:30 pm
      - Session II: 4:00 pm – 5:30 pm
  - ICD-10 Refresher Course
    - Friday, November 10, 8 am-4 pm
  - Trauma Registry Course
    - Thursday, November 9, and Friday, November 10,
      - Both days: 8 am-5 pm
  - 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)
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
Scheduling Reminders
TQP Participant Hub

Welcome to the ACS Trauma Quality Programs (TQP) Participant Hub!

If your hospital is a new facility, please click on Join a Program below.

If you are a current participant in one of our Trauma Quality Programs—the National Trauma Data Bank®, Trauma Quality Improvement Program, or Verification, Review, and Consultation Program—you may log in by clicking on Account Center below.

If you are a new user at an existing facility, please contact the Primary Contact for your facility (most often the Trauma Program Manager) to request that you be added to your facility’s contact list.

Join a Program

- Eligibility
- Getting started

Account Center

- Manage site information
- Manage contact information
- Request a site visit
- Access TQIP participant educational materials

Data Center (coming soon)

- Submit data
- Download reports
- Access interactive reports

Training Resources

For training materials focusing on utilizing various elements of the TQP Participant Hub, Account Center, or the Data Center, please see below.
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.
- Visits for 2017 and through October 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

• 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
Alternate Pathway Criteria (APC) Request

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

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

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

https://www.facs.org/quality-programs/trauma/vrc/site-packet
Prereview Questionnaire (PRQ) Online Access

- Once your application has been received, the VRC office will provide you with an email receipt of confirmation.
  - Logins to the online PRQ will be provided within the confirmation of receipt email
  - The online PRQ can be accessed at: http://web2.facs.org/traumasurvey5/
  - A copy of the PRQ in Word can be downloaded from: www.facs.org/quality-programs/trauma/vrc/resources
Site Visit Application Payment

• Do not submit payment with the application

• Your center will be billed annually for the Trauma Quality Program fee
  
  ▪ This annual fee will not include any additional visit-related fees, such as additional reviewers

• The fee structure is located at: https://www.facs.org/quality-programs/trauma/vrc/fees
Scheduling Site Visits

• Visits are typically scheduled within 90 days prior to the requested timeframe.

• Ideally, all visits will occur during the center’s preferred timeframe.

• When a lead reviewer is available for your site visit, VRC staff will contact your TPM to confirm the dates prior to finalizing the visit.
Site Visit Preparation with Reviewers

- The ACS Travel Agent will arrange the site reviewers’ flights. Reviewers make travel plans approximately 20 to 30 days prior to the site visit.

- The hospital will arrange and pay for the site reviewers’ hotel accommodations, as well as their ground transportation.

- The reviewer’s contact information will be provided in a confirmation email once the full team has been secured, approximately 90 days before the visit.

- Please contact the reviewers directly within 30 days of the site visit for their flight Itinerary and any logistical information.
General Questions
Combined Level II Adult & Level II Pediatric

“Does a Level II adult and Level II peds center have to have separate policies/guideline for everything? MTP, Ortho, etc?” (Level 2)

No. Combined trauma centers, Level II pediatric trauma centers, and Level I or II adult trauma centers may share the same protocols/policies/guidelines as long as language speaks to both types of patients.
**Trauma Surgeon Oversight**

“Surgeons want to know how long they must follow a patient if the patient has a single system injury. For example, the patient has an epidural bleed, and the patient met stepdown activation criteria, how long must the general/trauma surgeon follow the patient if there are no other apparent injuries? Is there a set time period the ACS states they must follow the patient or can the surgeon sign off after 24 hours?” (Level 3)

There is not a criterion for the length of time the attending must follow the patient. However, the expectation is that the attending oversees the care for the patient while under their care. Once the patient is handed over or signed off to another service, e.g. orthopaedic, etc, the trauma attending no longer has oversight of that patient.
“During the recent Optimal Course (4/8/17) in Module III (PIPS and Data), a clarification between missed injury and delayed diagnosis was provided. However, upon return to my facility, I was unable to locate supporting documentation of this clarification within the Clarification Document (v10.2), the Verification Change Log, or the NTDS data dictionary. Historically, these critiques have been internally defined within our facility as: 1. Delayed Diagnosis – any injury identified from 24-72 hours from presentation, during hospitalization or 2. Missed Injury – any injury identified greater than 72 hours from presentation or after time of discharge. Do these clarification definitions from the Optimal Course have to be adopted by our program? 1. Delayed Diagnosis – injury ID’d after resuscitation while still hospitalized 2. Missed Injury – ID’d after discharge.” (Level 1)

These will not be found in the Clarification or Change Log. The missed injury diagnosis from the Optimal Course were examples of the type of injuries that should be monitored through the PIPS program at your facility.
Alternate Pathway: Previously Approved Surgeon

“Although this question was discussed; please clarify if possible. If you have a non-boarded U.S. trained physician who was previously provided alternate pathway by being current in ATLS, attending in-house trauma meetings, education, will they be grandfathered in?” (Level 2)

If the surgeon previously was approved under the alternate pathway, an onsite visit is NOT required, but the surgeon must meet the same criteria as the other members of the trauma panel: CME, OPPE, peer review attendance (if trauma surgeon) and:

- PI assessment by the TMD to ensure patient outcomes compare favorably to other members of the trauma call panel.
- The surgeon will be grandfathered in at your institution.
Alternate Pathway: Non-Approved Surgeon

“We have had a non-US boarded NSR @ our L1 verified TC for 15 yrs. Is he ‘grandfathered’ or has to do alt path?” (Level 1)

Based on the information provided here, I take NSR to mean a neurosurgeon. If this is correct and if the NS is taking trauma call and assuming the role/functions of a neurosurgeon, they must have gone through the Alternate Pathway criteria (APC) process at some point. If the NS did not go through the APC process, I would question what his/her role is on the trauma service, and why has this surgeon not gone through the APC process if they’ve been at an ACS Level I center for 15 years.
“Can you clarify question #16 on pg. 24 of the Interim PRQ re. ICU panelist non-liaison in regard to trauma call? Is this talking about the Trauma Surgeons or the Critical Care docs in question #1?” (Level 1)

To clarify, question #16 is regarding peer review attendance and question #18 is regarding CME for the ICU panelists. ICU panelists are the ICU physicians (not the trauma surgeons) that provide care for the trauma patients in the ICU.
PRQ: OTA Leader Leaving Institution

“We have an Orthopedic surgeon that we completed the OTA form for and he leaves the institution 2 months before our site survey, do we submit another OTA form before the survey for another Orthopedist?” (Level 1)

Yes, as soon as possible! If the OTA leader for which the form was submitted will no longer be working at the institution at the time of the visit, you must submit another form with the name of his/her replacement. There is a process by which the OTA leader’s fellowship must be approved prior to the site visit taking place.
PRQ: Listing Prior Deficiencies and Weaknesses

“In the PRQ, when it asks about last survey date, weaknesses & deficiencies, etc., should a state site visit be included?” (Level 2)

No, this question refers specifically to past VRC visits. If this is the first site visit for your institution, leave these questions blank.
CD-Related Questions
Transfers Out (CD 4-3)

“CD 2-25. My TMD wants clarity if pedi trauma admitted, transferred or died are reviewed or just admitted to our Level III.” (Level 3)

Whether the trauma center admits pediatric patients or they are transferred to an appropriate verified trauma center, those cases must be reviewed through the PIPS process (CD 4-3). There may be times when the trauma surgeon should become involved if there is an injury that needs dealing with or there is a delay or difficulty transferring the patient.
“Do Trauma APPs need annual OPPEs? If yes, must these OPPEs be completed by the TMD? Or would it be permissible for another trauma surgeon (who is also our SICU Director) to complete the OPPE?” (Level 3)

If APPs are involved in the initial evaluation of the trauma patient, they would need to receive annual OPPE. The TMD is not expected to complete the evaluation personally. The OPPE for all specialists should be performed by their respective directors with oversight from the TMD.
Non-Surgical Admissions (CD 5-18)

“Our admit to non surgical service remains over 10%. We do complete PIPS review on all cases. Are we in jeopardy of a deficiency?” (Level 1)

No. Having non-surgical admission (NSA) in excess of 10% is not a deficiency, provided that the facility completes PIPS review on all cases. With this said, if the center admits more than 10% of NSA and **DOES NOT** review all cases for appropriateness through the PIPS process, this is what prompts a deficiency.
“Can a Level 1 PTC transfer ortho patients to a level 2 PTC if the Ortho traumatologist is unavailable?” (Level 1)

I would be concerned as to why a Level I trauma center is transferring a patient to a Level II. A Level I trauma center must have dedicated orthopaedic call or a backup call system. The traumatologist is not required to care for all injured trauma patients. I would recommend reviewing the instances of these transfers and why they are occurring.
Orthopaedic Trauma Backup Schedule (CD 9-6)

“Does a level II program need a back-up orthopedic call schedule? My orthopedic surgeons only take call at one facility.” (Level 2)

Level I and II trauma programs must have either dedicated orthopaedic surgeons OR a published backup call schedule. If your orthopaedic surgeon is dedicated to your institution, a published backup call schedule is not required.
“Pg 67 of the Orange book, ‘Child maltreatment assessment capability:’ Does that mean a Child Abuse Pediatrician available 24/7?” (Level 2)

No. It refers to having a mechanism in place to assess the maltreatment in children. This may be accomplished by having guidelines/protocols for screening, treatment, and referral for children injured as a result of maltreatment. All patients who have an acute injury as the reason for hospital admission should be assessed by the trauma team and admitted to the appropriate surgical service.
“Level I adult, Level II Peds: for CD 10-29 is there minimum # hours for pediatric anesthesia & radiology provided by the pediatric specialist in their specialty? Or is it at the pedi specialist discretion?” (Level 1)

To clarify, there are no CME requirements for the anesthesia and radiology providers. However, there must be specialty-specific pediatric education made available by the pediatric specialists at their discretion.
Radiologist Response for Interpretation and Intervention (CD 11-33)

“CD11-33 must be available within 30 minutes to perform interventional procedure. Is this from time of call to start of procedure? How are institutions meeting this? In house 24 hour IR physician?” (Level 1)

This is from time of call of requesting service. Not from the time of procedure/incision.

Some centers are able to meet this by having qualified radiologists or vascular surgeons that are trained to perform interventional procedures.

In some instances, if the center credentials fellows to independently perform an angiogram/embolization or at least to start it, then they can qualify for the 30 minute rule.
ICU Emergency (CD 11-56)

“For a Level III facility, can you clarify the requirements for the ICU. ‘In Level III trauma centers, physician coverage of the ICU must be available within 30 minutes, with a formal plan in place for emergency coverage’ 30 min from when? the decision to admit? patient arrival?”

(Level 3)

To clarify, the 30-minute response is for when the trauma patient is in the ICU and there is an emergency. The clock begins when the call is made to the credentialed provider (this may be the ED physician).
Registrar Training (CD 15–7)

“What are the requirements, per ACS, for trauma registrar education? I'm not looking for the number of hours required, but what is the regulatory body that would approve of the content for this education?” (Level 2)

Registrars must attend or have previously attended two courses within 12 months of being hired: (1) the American Trauma Society’s Trauma Registrar Course (ATS) or equivalent provided by a state trauma program, and (2) the Association of the Advancement of Automotive Medicine’s Injury Scaling Course (AAAMIS).

Equivalent programs would be based upon the ATS or AAAMIS objectives. The administration or learning sequence and format, e.g. 1 day versus multiple shorter time frames, is flexible.
Loop Closure (CD 16-2)

“Are there specific details or requirements that the surveyors will be using in order to determine proper loop closure for PI?” (Level 1)

Steps/discussion reviewers use for loop closure. If there is a PI issue with the care of the patient:

Did the program identify it during the PI process?
   – If so, reviewer needs to see the records
     • It is important that it’s documented, not a verbal history
   – If not,
     • Be honest, why was it not caught during the PI process?
     • How will you change things to find something like this in the future?
     • If you don’t think its important, why?
Universal screening for alcohol (CD 18-3)

“Is a level II trauma center required to screen all injured patients for drugs of abuse?” (Level 2)

Yes. For Level I, II and III trauma centers universal screening for alcohol must be performed for all injured that meet NTDS Trauma Inclusion criteria with a hospital stay of > 24 hours, of which 80% must receive a screening.
Universal screening for alcohol (CD 18-3)

“With regard to Universal screening for alcohol (CD 18-3) for pediatric patients (those less than 15); is there any age limit to this expectation or is it still required for ‘all patients that meet ACS registry inclusion criteria with a hospital stay of greater than 24 hours’ regardless of their age? For example would it be expected to be completed for a 2 year old?’ (Level 2)

The VRC does not have a mandatory age range for universal screening for children. This should be determined by the trauma center. During the site review, the review team will ensure the trauma center adheres to its policy.
Brief Intervention (CD 18–4)

“In regards to SBIRT... does a full AODA referral count towards a brief intervention? Example: a person has both a positive blood alcohol level and positive Audit-C. In such cases our social workers would provide a full AODA assessment and provide AODA resources. Are they also required to provide a separate brief intervention? If so, do we need to chart the actual words ‘brief intervention completed’ or does any wording which addresses alcohol resources qualify?” (Level 2)

The Alcohol & Other Drug Abuse (AODA) assessment will count toward brief intervention and in addition, as the assessment tool. The center may use whichever wording is appropriate to document the process.
CME: Invited Speaker

“If we have an invited Speaker - Trauma Surgeon (Trauma-related topics) from other state, can we count that CMEs as external?” (Level 2)

As the facility arranged for the speaker in this example, this would count as internal CME.
CME: Sub-Specialists (Liaisons and non-Liaisons)

“Please explain the CME requirement for the Subspecialty Liaison to the Trauma Service. Please explain the CME requirement for all other Subspecialty physicians to the Trauma Service. are there specific requirements for nursing education in the trauma unit, or, icu, stepdown?”

(Level 1)

There are no nursing requirements at this time. The center must ensure nurses are provided nursing education (CD 17-5).

Sub-specialty liaisons are required to have a minimum of 48 hours over 3 years (16 per year) of external trauma-related CME.

Other sub-specialty surgeons may supplement the CME requirement with IEP credits which should be equivalent to 16 hours per year, or with internal and/or external trauma-related CME or a combined with all. If using a combination of CME, ensure there is appropriate detailed documentation.
CME: Internal Education Process

“Please provide detailed examples, suggestions and ideas for internal educational programs.” (Level 2)

Acceptable Internal Education Process (IEP) activities include the presentation or discussion of trauma-related topics in the following settings: in-service lectures, educational conferences, grand rounds lectures, an internal trauma symposium, or in-house publication and dissemination of information gained from a conference or peer-reviewed publications. The total hours acquired through the IEP should be functionally equivalent to 16 hours of CME.
CME: Maintenance of Certification

“Many surgeons utilize The American Board of Surgery maintenance of certification CME repository to organize their CME. Is this appropriate for verification of attendance or do they have to have a certificate?”

(Level 1)

Any assessments done for maintenance of certification can be counted towards a total of 33 external trauma-related CME. With this said, the surgeon must be able to provide a list from the repository that would outline the trauma related subject matters.
CME: Maintenance of Certification

“What form of documentation do we provide to count for 33 CME hours for board preparation/certification?” (Level 2)

The surgeon that is going to use 33 hours from his/her board prep/certification, must provide documentation to substantiate the hours.
“If a faculty member starts in September 2015 after finishing a fellowship, how many CME are required for the survey period that runs from 2015-17? (Does fellowship count for any of the 2015 CME)” (Level 1)

Using this example, CME would be prorated based on when the surgeon started taking call at the institution. Fellowship training would not count towards CME requirements.
CME: Level III Trauma Centers

“Are there currently any criterion deficiencies linked to Level 3 trauma centers and annual physician CME's?” (Level 3)

There are no specific CME requirements for Level III trauma centers.
“We are nearing the end of our 3 year verification cycle. Up until the last 6 months, we had the same Neurosurgery liaison who was accruing the appropriate number of external CME. In July he left for another position. Our new Neurosurgery liaison (who has been on staff for many years) has trauma related CME, but not external. Would it be helpful at our upcoming review to show/use the previous liaison’s external CME or just make sure that our new liaison has 8 hrs of external CME? Our reverification is due Jan. 2018.” (Level 1)

Have data for the new liaison from the time they started their role as liaison. Use the internal trauma-related CME and any external that was obtained from the time he/she started. Do not include the previous NS liaison’s information during the site visit or within the PRQ.
CME: Board Certification

The Thirty-three (33) hours of CME obtained from either preparing for the boards or initial board certification or recertification may be used to meet the CME requirement. This may be used once during the 3 year verification cycle leading up to the site visit.

- If the provider is double boarded for example in general surgery and surgical critical care, only 33 hours of CME will be permitted.

- Not required to provide breakdown; however, must provide documentation of board certification.
Thanks for your participation!