Trauma Verification Q&A Web Conference

July 31, 2019

COTVRC@facs.org

American College of Surgeons
Inspiring Quality:
Highest Standards, Better Outcomes
100+years

The Committee on Trauma

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for excellence in trauma centers

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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*
- ***CE Eligibility will expire on Thursday, August 15***
  - *You must watch the webinar prior to 8/15 in order to be eligible to claim CE*

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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.*

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Let's get started!

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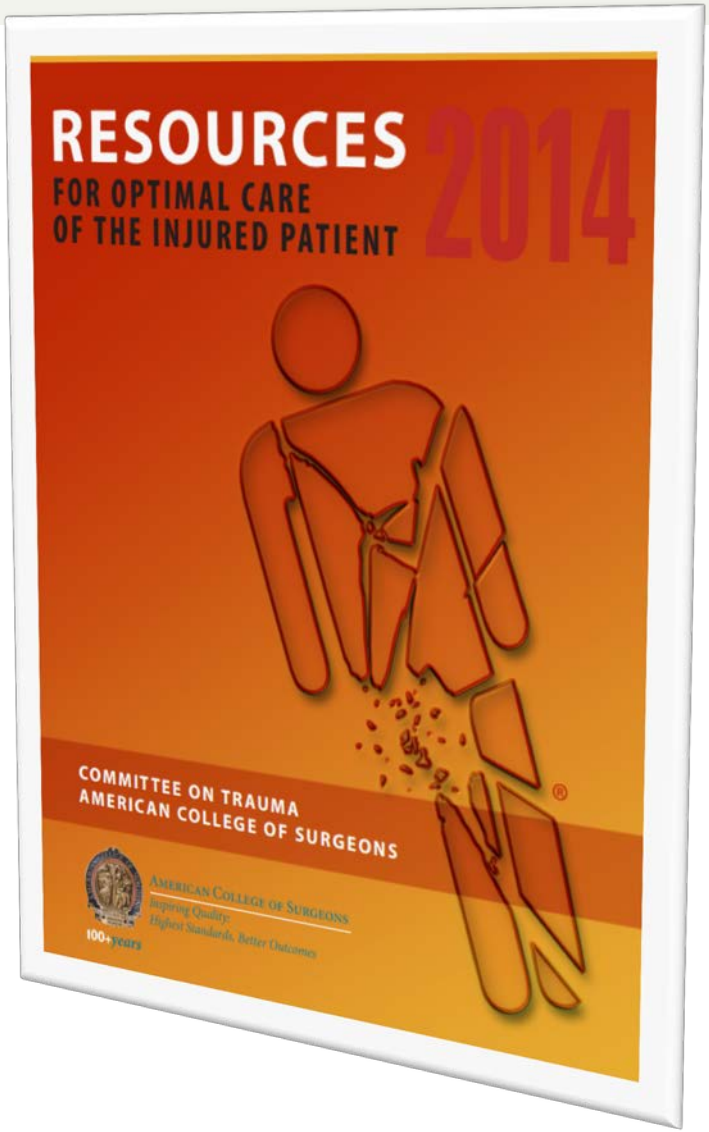
Orange Resources Book

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/tqp/center-programs/vrc/resources

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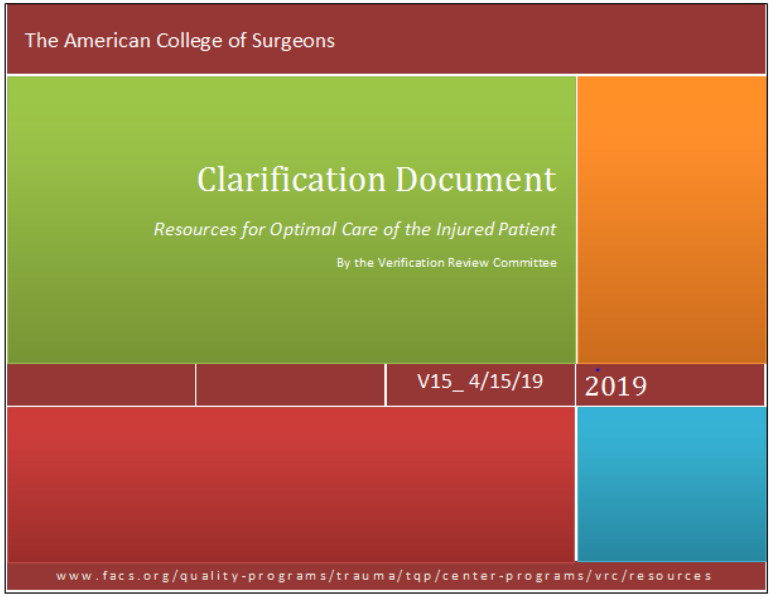
Clarification Document and Verification Change Log



- Released Monthly
- Change Log – notes criteria updates/changes
- Available for download: www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/resources

Chapter	CD #	Level I	Level II	Level III	Level IV	PTC I	PTC II	Date Change	Criteria	Resources 2014 Orange Book Description of Criteria	Clarification	Type
1	1-1	I	II	III	IV	I	II	7/1/2014	New	The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1-1).		TYPE II
1	1-2	I	II	III	IV	I	II	7/1/2014	New	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)		TYPE II
1	1-3	I	II	III	IV	I	II	7/1/2014	New	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)		TYPE II
2	2-1	I	II	III	IV	I	II	7/1/2014	New	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).		Type I
2	2-2	I	II	III		I	II	7/1/2014		Surgical commitment is essential for a properly functioning trauma center (CD 2-2).		TYPE I
2	2-3	I	II	III	IV	I	II	7/1/2014	New	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).		TYPE II
2	2-5	I	II	III		I		7/1/2014	Revised	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).		TYPE II

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Website Resources for Trauma Centers

- Recording of Webinars:
  https://www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/resources/webinars
- Stakeholder Public-Comment website:
  https://www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/stakeholder-comment
- Tutorials:
  - Becoming a Verified Trauma Center: First Steps
  - Becoming a Verified Trauma Center: Site Visit

  https://www.facs.org/quality-programs/trauma/tqp/center-programs/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

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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.

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Scheduling Reminders

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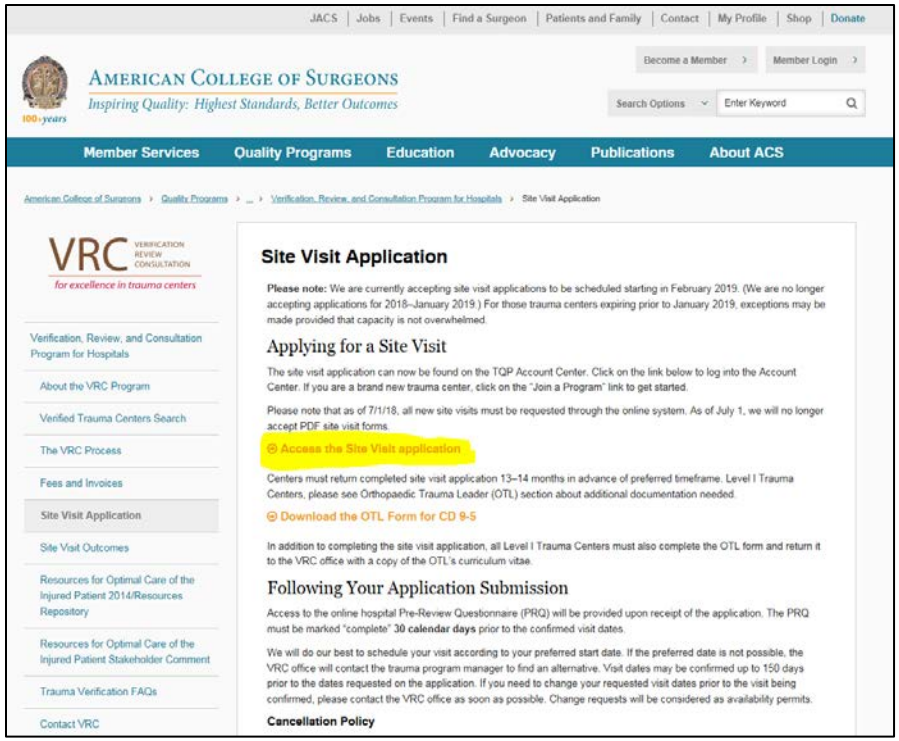
Site Visit Application

- The site visit application is **online only**.
- Can be accessed on the following ACS Trauma website pages:

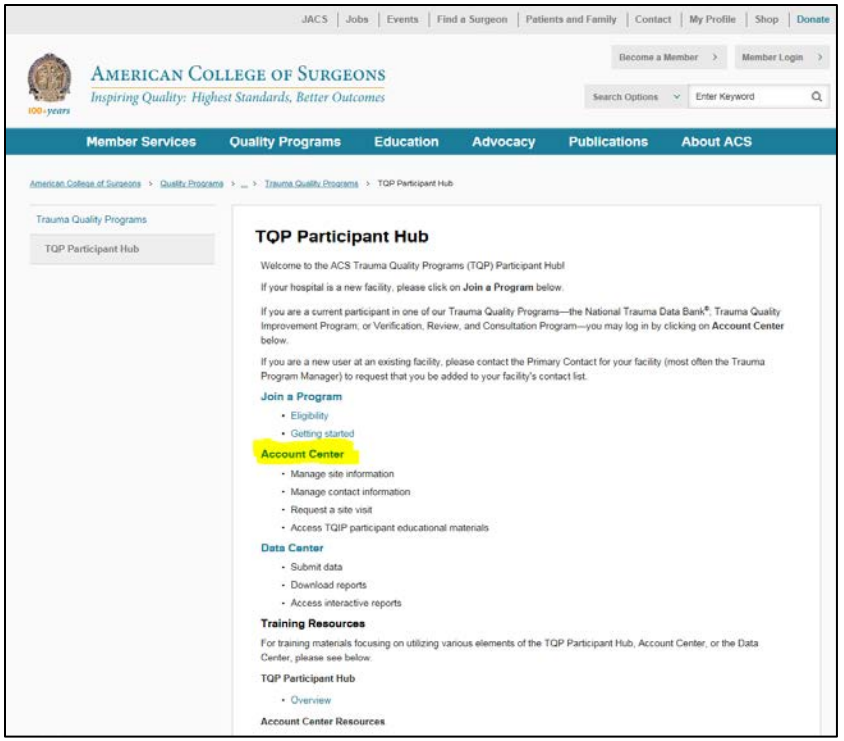
VRC – Site Visit Application

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



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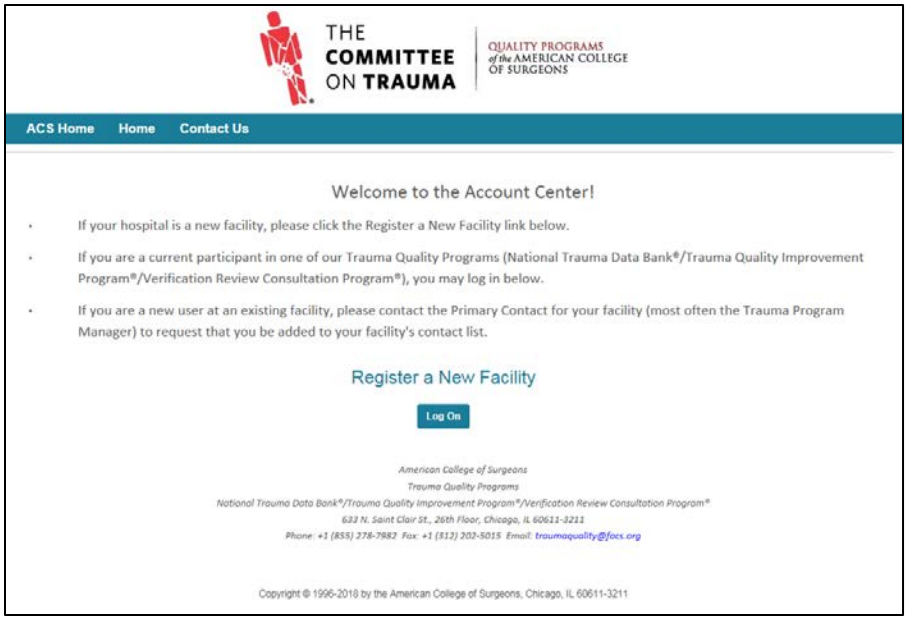
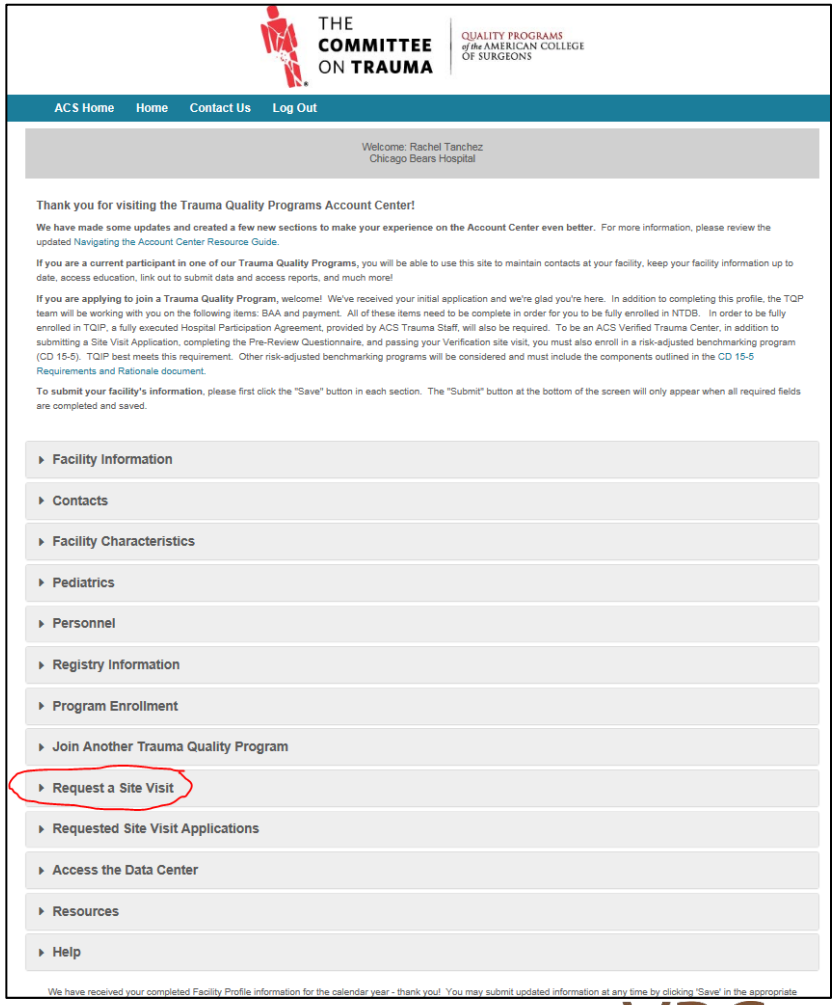
Site Visit Application

- The ACS Trauma website pages will link to the Account Center page:





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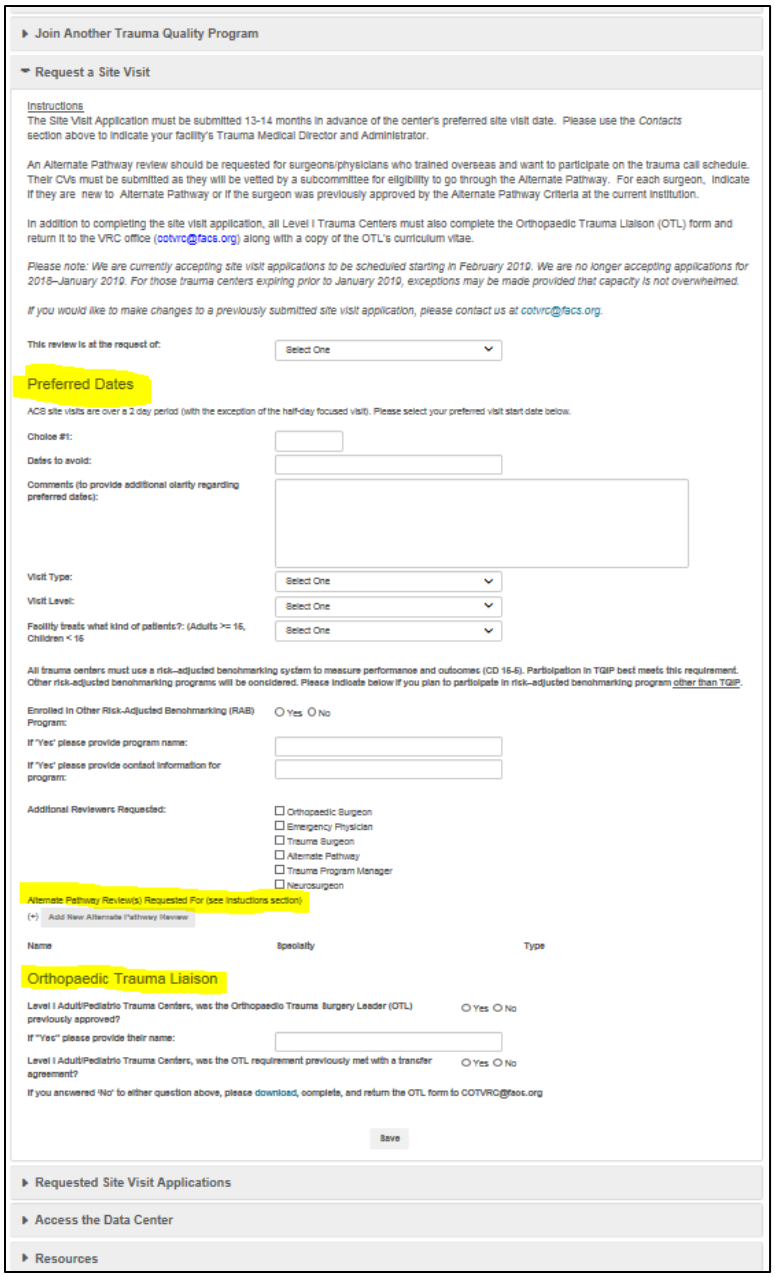

- The online application must be submitted at least 13 -14 months in advance of the requested site visit dates and must be before expiration date
- An Alternate Pathway review should be requested on the application for surgeons/physicians who trained overseas and want to participate on the trauma call 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 **2020 Site Visits. 2019 is now closed.**

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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 5-7 business days
  - 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/tqp/center-programs/vrc/resources

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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:
  www.facs.org/quality-programs/trauma/tqp/center-programs/vrc/fees

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Scheduling Site Visits

- Visits are being scheduled quarterly.

- We ask that you provide exact dates you would like the visit scheduled.
  - The visit will occur on your chosen dates, but may ask for different dates should the review team be unavailable on the requested dates.

- Once the review team has been secured, you will receive a confirmation email, approximately 120 days prior to the scheduled visit. This will include your reviewers and their contact information.

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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.

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Announcements

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- Make your hotel reservations now at the host hotel, the Hilton Anatole
- For more information, go to the TQIP Annual Meeting website:
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Preconference Workshops

Courses Offered:

- AIS15 and Injury Scaling: Uses and Techniques—*Association for the Advancement of Automotive Medicine*
- ATS Trauma Registry Course—*American Trauma Society*
- Sharper Coding for Trauma with ICD-10-CM & ICD-10-PCS Workshop—*KJ Trauma Consulting LLC*
- Trauma Advanced Registrar Prep—*Pomphrey Consulting*
- Optimal Trauma Center Organization & Management Course (OPTIMAL)—*The Society of Trauma Nurses*
  - *Offering two courses: Thursday and Friday, November 14 & 15, 2019*
- Trauma Outcomes and Performance Improvement Course (TOPIC)—*The Society of Trauma Nurses*
  - *Offering two courses: Thursday and Friday, November 14 & 15, 2019*
- Stop the Bleed Basics—*American College of Surgeons Trauma Programs*
- Stop the Bleed Instructor—*American College of Surgeons Trauma Programs*

https://www.facs.org/quality-programs/trauma/tqp/center-programs/tqip/meeting/workshops

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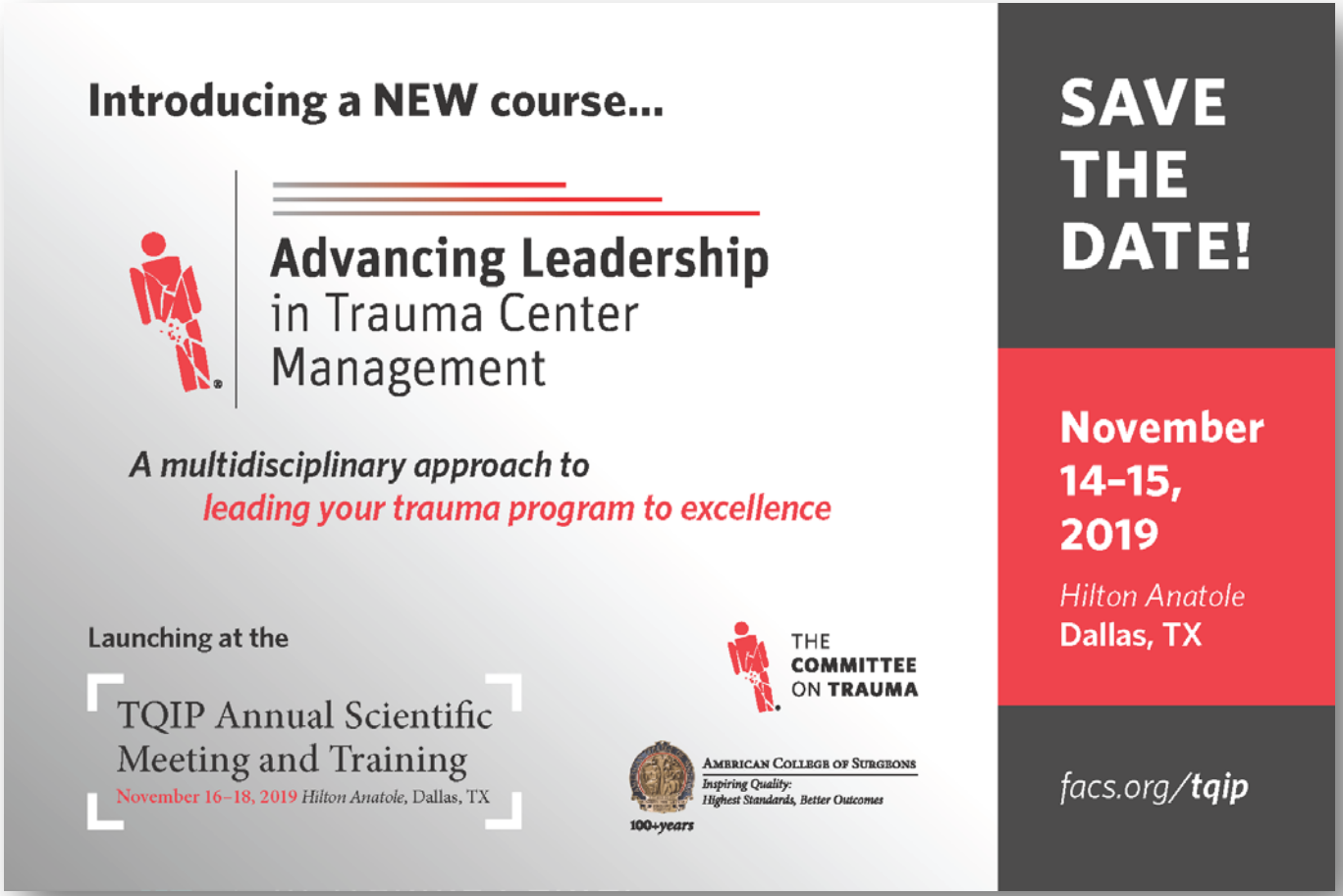
New Course!!



- www.facs.org/ALTCM
- Email us at ALTCM@facs.org

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Next Verification Q&A Webinar

Webinar Date: **Wednesday, August 28th**

Webinar Time: **1:00 PM Central Time**

Deadline to submit questions: **Friday, August 9th**

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Tell us what YOU want!

Let us know the topics you'd like us to cover in future webinars! Reach out to us at cotvrc@facs.org with your suggestions today.

Future topics may include:

- Alternate Pathway
- Specific chapter discussions
- The peer review process for verification reports

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Focused by Mail

- What kind of document do I need to submit?
  - PI attendance - sign in sheets
  - Alcohol screening – spreadsheet/graph
  - Updated back up plans/ guidelines
  - New hires/ change of job description – letter signed by leadership, job description, welcome letter
  - Boards
  - ATLS Certification
- Do I need to submit a cover letter?
  - Preferred- Please address a letter to the VRC chairs and how your center addressed the CDs.
- When is my corrective documentation due?
  - Refer to Verification letter
- Where should I send the documentation?
  - COTVRC@facs.org

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General Questions

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ISS Admission

"Is ISS score a component of who needs to be admitted to trauma MD."(Level 2)

No it does not. The ISS should not affect the management of the patient with traumatic injuries.

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Charts

"Charts have always been able to cover more than one category. When did this change? We would have the full chart in one category and a shadow chart in the secondary category." (Level 2)

"Practice, to date, included making a shadow chart with a label notifying Reviewers what other category they can find this patient. The nature of the categories required to be presented/pulled most like will result in overlap (TBI, SDH-EDH, Death, AE, etc)." (Level unidentified)

To clarify, a shadow chart should not be prepared. For best practice, keep the patient chart with the multisystem injuries in what you believe to be the most appropriate category. In the event of a trauma mortality, the most appropriate category would be in death.

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Registry Inclusion

"Do you place all activated patients into registry?"

(Level 1)

For best practices, all trauma activations should be captured in the trauma registry. However, what data should be captured in the trauma registry will be based on your institution's inclusion policy.

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Geriatric Care

"Do we have to establish a criteria and/or protocol specific to the care of our geriatric trauma population?" (Level 1)

"Is a separate geriatric activation protocol recommended?" (Level 1)

Geriatric-specific criteria/protocols should be present, especially for centers with a large volume of geriatric patients. This is not a requirement, but may be cited as an opportunity for improvement for the management of these patients.

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Over/Undertriage

"If your treated and released cases (ED visits) are not collected in the registry, how valid is the over/under triage?" (Level unidentified)

To clarify, the data entered into the trauma registry will be defined by the trauma inclusion policy. If these patients are not captured in the trauma registry, are they being captured separately in a Excel spreadsheet? There should be a process to review and monitor these cases to determine if they should have been a trauma admission.

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Direct Admissions

"Slide 15 admissions by service does not account for direct admissions." (Level 2)

For verification, the inclusion of direct admits may be reported at the TPM's discretion either in the PRQ's Total Admissions by Service data table or in the "Direct Admit" line.

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Trauma Audits Filters

"Are there specific registry audit indicators that must be reviewed by TPM/TMD/Peer Committee? (i.e.-craniotomy, SCI, etc.)" (Level 1)

Specific registry audit indicators will vary by institution.

Audit filters may include Trauma activations, ED length of stay, over/undertriage, washout times for open fx's, etc.

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ACGME Program

"For Level I, does the GME program have to be owned by the facility or can there be an affiliation with another academic program?" (Level 2)

I believe the term GME is meant to be ACGME. If this is correct, the ACGME program may be in conjunction with or have an affiliation with another academic program. Both programs must be listed on the Residency Application Process.

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Anesthesiologist Backup

"For anesthesia response: Once you have 1 patient in the OR with the 24/7 Anesthesiologists, do you then need to call in another?"(Level 2)

If the anesthesiologist are doing an Appy (appendectomy) or gallbladder in the middle of the night, the expectation is not to call in a backup. The program should however PI this to be sure that the provision of acute surgical care does not lead to a patient not being able to access immediate care.

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Nursing Turnover

"Nursing turnover rate, is this a requirement?" (Level 1)

There is not a deficiency related to nursing turnover rate.

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

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Orthopaedic Injuries

"Can you elaborate on the orthopedic criteria regarding definitive repair and application of an external fixator?" (Level 2)

"Is skeletal traction or an external fixator not considered a timely, definitive ortho procedure if the patient has other issues ongoing, preventing ortho surgery within 24 hours?" (Level unidentified)

There are no criteria for external fixator application. The only pertinent criteria is that femur fracture fixation has to happen within 24 hours and this includes definitive fixation or external fixation.

For femur fractures, skeletal traction is not considered definitive, but an external fixator is.

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Trauma Activation Downgrading

"If a trauma is activated but the ED and/or surgical PA evaluates the patient before the trauma surgeon arrival and the case can be downgraded would this still be considered a fallout since it activated the system and the trauma surgeon did not evaluate. Or, does outcome play a role (ie. if discharged not a fallout, but if transfer or admitted then a fallout)?" (Level 3)

Yes, this would be a fallout because it was activated and the surgeon did not evaluate the patient. The VRC discourages the use of downgrading. However, there are going to be instances of it occurring. In those instances, we ask that it is closely monitored and reviewed through the PIPS process.

If trauma activations are continuously being downgraded, there may be some underlying issues with the program or from the field. Downgrading may impact the over/under triage rate; it certainly can be attributed to the activation criteria. As a requirement, the activation tiers must be continuously evaluated to ensure the appropriate injuries are being captured in the appropriate activation tier. It could also be a system (EMS) issue where patients are being activated inappropriately, and the most concerning would be that its occurring so that the attending surgeon does not have to come in.

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Observations

"Can you review examples of 23 hour Observation patients that would be included on the PRQ?" (Level 2)

For verification purposes, patients that are held for less than 24 hours and discharged would not be included in your PRQ data.

Please keep in mind that this may differ from what is captured in your trauma registry.

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Mortality Classification

"Is it acceptable to use Unanticipated Mortality with OFI as a determination? We have heard this was going away." (Level 2)

There have been no changes to the mortality classifications. They remain as follows:

1. Mortality without Opportunity for Improvement
2. Mortality with Opportunity for Improvement
3. Unanticipated mortality with opportunity for improvement

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Upgrading Trauma Center Level

"Please explain the process from going from a level 1 trauma center to a lesser designation if it's between the 3 year review. Does the center need a visit from the ACS to go to level 2? Or level 3?" (Level 1)

To clarify, the ACS does not designate but verifies that centers meet the standards set forth for the level it is practicing. The state will designate the trauma center, in some instances, on the outcome of the verification.

This depends on the circumstances. For example, if currently verified as Level I or Level II and the center lost its neurosurgery capabilities, the center may request to be verified as a Level III.

If the center's due for reverification, it can apply for a different level and this does require an onsite visit.

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ICU Physician Coverage (CD 11-51)

"Ref: ICU Organization and Physician. Can a board certified surgeon without critical care certification serve as the in-house coverage of ICU with help from a PGY4 surgical resident? One surgeon is ABOS certified but is not boarded in critical care. He has been grandfathered by administration to provide critical care and coverage." (Level 1)

Yes this is acceptable. Only the surgical director must be boarded in surgical critical care. All other providers in the ICU have to be currently boarded in their respective specialty and credentialed by the hospital to provide care for trauma patients while in the ICU. These providers are not required to be boarded in SCC.

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Webinar Information

"At times, the information in the webinars appears to increase/add to the regulatory requirements of a CD. Are the webinars to be considered an extension of the Resources clarification document /change log? When they contradict (webinar vs Resources), which source is to be followed?" (Level 1)

Without knowing what specific content in past webinars is being referred to, the responses in these webinars is intended to reflect the criteria as they currently exist. Hence, they will be most in line with any revisions made in the VRC Change Log, and serve as elaborations on existing criteria, in the same manner as the Clarification Document.

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Massive Transfusion Protocol (CD 11-84)

"Why does there have to be a physician order to mark MTP as yes, because during critical situations when MTP is frequently used the order rarely gets entered, therefore our MTP is being answered no and is lacking?" (Level 2)

There is no requirement for a physician to mark the MTP order as yes. This may be a registry software tool or hospital protocol. The only requirement we have on this is that an MTP is developed between the trauma service and the blood bank.

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Trauma Activation Response

"Can advanced practitioners respond to the highest tier of trauma activations in lieu of the trauma surgeon?" (Level 2)

No. The APP may be a member of the highest tier of trauma activation team, but cannot respond in lieu of, or substitute for the attending surgeon.

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PTSD Screening

"Do we need something in place/protocol related to screening patient for PTSD prior and/or post discharge?" (Level 1)

No, screening for PTSD is not a requirement. However, it is recommended by the VRC that if your center sees a large number of patients that suffer from PTSD, reviewers may ask how those patients are managed and whether or not there is a screening tool.

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Non-Surgical Admissions

"During our verification visit in February the lead reviewer provided direction relative to nonsurgical admissions that was quite different from the feedback we have received in the past. He indicated that admissions to a medical service were acceptable as long as1. timely and appropriate surgical consults were obtained 2. the injuries were isolated, low impact mechanism, with low suspicion for significant injury. Is ACS changing their stance on non-surgical admissions? Will clearer guidelines be coming?" (Level 3)

There have been no changes to this standard. What is noted above is an acceptable practice and is in accordance with what has been stated in recent webinars. Yes, clearer guidelines will be forthcoming.

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Transfer Agreements

"If transfer agreements were put in place by previous administrators who are no longer employed, do new ones need to be signed and implemented by current administration before ACS review?" (Level 2)

Yes, we would like the new administrators to be aware of all transfer agreements.

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Trauma Registrar Oversight

"What do the Trauma Site Surveyors look for to ensure appropriate oversite of the Trauma Registrars by the TPM (per page 110 in the Orange book) when the Registrars do not report directly to the TPM?" (Level 2)

If the registrars do not directly report to the TPM, there should be clear pathways of communication to the TPM to ensure proper data validation for the trauma program.

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TQIP Benchmark Report

"What part is our TQIP Benchmark Reports going to play during future verification site visits?" (Level 2)

Reviewers are provided a primer. The primer is a summary of the hospital's TQIP benchmark report. We ask that hospitals have their last TQIP report on hand to discuss with reviewers, if requested. TQIP reports are a good opportunity for hospitals to showcase their PI process. Specifically if there are any outliers. This may be an opportunity to discuss how the trauma program plans on addressing those outliers. Hospitals are not being penalized or lauded for their TQIP results alone.

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Reporting Year

"When referring to reporting year, does this mean a literal 12 months prior to the ACS survey? I know there is an allowance for a few months to prepare, so would Feb 2019-Feb 2020 be an appropriate reporting year for a June 2020 survey?" (Level 2)

Our process uses a 12 month period plus a 2 month lag, not to exceed 14 months from time of the visit. For a visit in June 2020, the ideal reporting period would be April 1, 2019 to March 31, 2020 or March 1, 2019 to March 1, 2020.

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Overtriage

"If the trauma surgeon realizes upon arrival to ED for a trauma activation that the case is an overtriage is the expectation that they still complete a full evaluation and document an H&P?" (Level 3)

The trauma patient should still receive an evaluation and have that information documented in the H&P. Whether the patient should receive a surgical evaluation at that point would be determined by your hospital's guidelines.

More importantly is to look at why the patient came in as an activation. Was this triggered by the EMS? If yes, would this be an opportunity to meet with the EMS and go over your center's activation criteria. Use it as a teaching opportunity.

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CD-Related Questions

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Trauma Activation Response (CD 2-8)

"When calculating the trauma surgeon response time to highest level trauma activations, do you include traumas that were activated but were not included in the trauma registry (i.e. discharged from the ED or have no injury)? Are these included in the 80% requirement for response less than 15 minutes?" (Level 2)

Yes, all trauma activations must be included in the total. Again, more importantly, you want to review the activation criteria and determine if there are issues with triggering these when they should not be. Is it an issue internally with the criteria or at the EMS level? Is there an opportunity to review and tweak the activation criteria to make sure patients are being activated appropriately?

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Pediatric Trauma Surgeon Coverage (CD 2-8)

"For a level I pediatric trauma center, does a pediatric surgery attending have to be in-house 24 hours or can they take call from home as long as they arrive within 15 minutes of patient arrival?" (Level 1)

The best method to meet this requirement is by having the attending in-house. However, it would be acceptable for the attending to take call from home as long as they meet the 15-minute time requirement 80% of the time for the highest tier of activation.

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Neurosurgery/Orthopaedic Response (CD 8-2/9-7)

"Does there have to be attending physician to attending physician communication when there is a TCD for ortho/NS 30min response times? Or can a nurse call on behalf of the trauma surgeon to ortho/NS liaisons and have that call count for the time that 30min starts?" (Level 1)

There are no requirements on who should call for the specialty consult. Therefore, if the APP/nurse calls for the specialist that time will start the clock.

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Neurosurgery Response (CD 8-2)

"NSR 30 minute response must be at the bedside, correct? We are receiving backlash from our NSR, because they are not always (per them) needed at the bedside if they can review the films and could we not track by film viewing. My understanding is it is response to bedside." (Level 2)

Yes, the intent is that the neurosurgeon responds within 30 minutes at bedside. The neurosurgery resident, fellow, attending or PA/APP may be the responder for the 30 minute response based on conditions defined by the trauma program; however, there must be clear documentation with the attending neurosurgeon on plan of care.

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Pediatric-Trained Orthopaedic Surgeons (CDs 10-13 & 10-15)

"What is the required number of pediatric trained orthopaedic surgeons for a level 1 pediatric trauma program?" (Level 1)

As per CD 10-13 and 10-15, a Level I PTC must be two board certified or eligible for certification orthopaedic surgeons credentialed to provide pediatric trauma care, at least one of whom is pediatric orthopedic surgery fellowship trained.

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IR Response Times (CD 11-33)

"How do facilities track the IR doctors times if they go directly to radiology and wait for the patient from OR?" (Level 3)

In this instance, they would self-report the time they arrive at the bedside.

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Interventional Radiology (CD 11-33)

"Is Interventional Radiology considered a surgical service?" (Level 2)

No, IR is not a surgical service.

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ICU Nursing Ratio (CD 11-66)

"We are wondering if there is a percentage we need to comply with for nursing ratio in the ICU? We meet the 2:1 ratio most times." (Level 1)

Compliance with this requirement must be met at all times. In the instance of an ICU nursing staff shortage, the center must have a plan to acquire more nursing coverage.

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Microvascular Surgery (CD 11-70)

"What kind of procedures would we need for Microvascular if we transfer our reimplantations? Requirement to have subspecialty?" (Level 3)

There are no microvascular capability requirements for a Level III center.

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Specialty Services (CD 11-70 & 11-71)

"What is the opinion about Specialty Services: Hand or Re implantation and whether they should have a back-up call schedule?" (Level 1)

Back-up schedules are not required for these specialists. The specialty services are not required in-house 24/7, but there must be a surgeon consultant available to respond in person when requested by the Attending Surgeon within a predetermined time.

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OPPE (CD 11-87)

"Do advance practice providers in the ED, who see patients with injuries, but don't meet activation criteria require an OPPE to be done? Or is it only if the ED APP is caring for the patients in the resuscitation bay that they need an OPPE?" (Level 1)

An OPPE will be performed for all APPs who are managing trauma patients regardless of non/activation tier. The OPPE will be performed by their respective directors.

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Mortality Review (CD 16-6)

"In reference to CD 16-6, do all trauma deaths (surgical service and NSSAs) require a TMD review and/or a "traditional M&M review" (Secondary or higher)?" (Level 1)

Yes. All trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement identified for peer review.

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Alcohol Interventions (CD 18-3)

"Are non-surgical admissions included in the 80% compliance minimum for SBIRT? Is there a required intervention for those who receive a positive screen, or if it's documented that a patient states they don't want any interventions, can this count as compliant due to an attempted intervention?" (Level 1)

Yes. Any trauma patient admitted, regardless of the service they are admitted to, must receive a screening for alcohol use. This excludes any patients that cannot be considered participatory.

If a patient refuses intervention, this would still count as it was an attempted intervention.

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Alcohol Screening (CD 18-3)

"SBIRT: We frequently have patients admitted to medicine for a "syncopal" work-up that may have a diagnosis of laceration, concussion, non-surgical injury that in and of itself would not require admissions. Do these patients still need SBIRT?" (Level 2)

No. As these are not trauma patients, these would not require evaluation under SBIRT to maintain compliance.

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Alcohol Interventions (CD 18-4)

"If a center is not providing interventions to 100% of patients who screen positive for problematic alcohol use (CD 18-4), but is reviewing each patient who did not get an intervention through the PI process and is working on a process for universal intervention, would that center still get a deficiency at the time of their review?" (Level 2)

As per CD 18-4, all patients who screen positive for alcohol use must receive an intervention. However, if there are any outliers that do not receive a screening, there must be documented PI review for these cases. If this is limited to only one or two cases, it would not necessarily result in a CD, but if a larger number were missed (i.e., 10%), this would likely be cited as a deficiency.

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Research Publications (CD 19-1)

"Have any revisions been made to the publications requirement for Level 1 centers?" (Level 1)

The chapter revision process is still undergoing review. Changes made to this standard or any others will be made available when the entire next edition of the Resources manual has been completed.

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CME

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MOC

"How do we document that Physicians are complying with maintenance of certification requirements?" (Level 1)

A copy of the physician's official MOC participation record demonstrating current board certification status should be available onsite at the time of review.

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CME

"Is there a continuing education requirement for the Trauma Process Improvement Coordinator?" (Level 2)

No, there are no education requirements for the Trauma PI Coordinator.

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CME Requirements

"If a surgeon is only taking BACK-UP trauma call, are the CME requirements and multidisciplinary trauma peer review attendance of 50% still required?" (Level 2)

It is important to note that the CME requirement will only apply to a non-boarded surgeon undergoing the Alternate Pathway. That said, all surgeons taking trauma call (whether they are taking backup call, are locum tenens, etc) must attend at least 50% of the multidisciplinary peer review meetings.

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Alternate Pathway

"We have several orthopedic surgeons undergoing the Alternate Pathway (non-US boarded). Our verification visit is approximately 1 year away. Do they need to have all 36 hours of trauma-related CME by that visit?" (Level 3)

A minimum of 12 hours of CME must be present for any new surgeons undergoing the Alternate Pathway process.

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Alternate Pathway

"Regarding orthopedic surgeons undergoing the Alternate Pathway. Does attendance at our Trauma Peer meeting count towards their 36 hours of required CME?" (Level 3)

No. The Trauma Peer meeting will not count towards the CME requirement.

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CME/CE Review

- Required for TMD, TPM & Alternate Pathway
- New trauma centers undergoing verification for the first time CMEs may be prorated to 12 hours
- Any new members to the trauma panel CMEs may be prorated to 12 hours (exception based on hire date)
- Any surgeons undergoing review through the Alternate Pathway (AP)CMEs may be prorated to 12 hours
- TMD is required to have 36 hours of CME within 3 years
- Any surgeon who previously was approved by way of the AP is required to have 36 hours of CME within 3 years
- The TPM is required to have 36 hours of CE within 3 years

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CME Requirements

Levels I and II trauma centers	MEETS CME REQUIREMENT Through Board eligibility Life-time Boards (grandfathered) Board certification (MOC)	REQUIRE 36 External CME (trauma-related)*
TMD / Pediatric TMD***		X
Alternate Pathway**		X
Trauma Program Manager (CE)		X
LIAISONS OR REPRESENTATIVE:		
• Emergency Medicine Physician	X	
• Orthopaedic Surgeon	X	
• Neurosurgeon	X	
• Critical Care	X	
• Anesthesiologist	X	
• Radiologist	X	
PANEL SURGEONS/PHYSICIANS		
• Trauma Surgeons	X	
• ED Physicians	X	
• Orthopaedic surgeons	X	
• Neurosurgeons	X	
• Critical Care Physicians	X	
• Anesthesiologists	X	
• Radiologists	X	

*Pro-rated to 12hrs CME for:
- first time verification and consultation visits
- surgeons undergoing review through the Alternate Pathway (AP)
- new TPMs & TMDs

**Any surgeon who previously was approved by way of the AP is required to have 36 hours of CME within 3 years
***The Pediatric TMD must fulfill the same 36 hrs CME, of which 9 hours must be pediatric trauma specific

The Committee on Trauma

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VRC VERIFICATION REVIEW CONSULTATION
for excellence in trauma centers

Site Visit Appendix

- Lifetime boards
  - When completing the online PRQ appendices, list the board expiration date as “indefinite” for those surgeons who have lifetime board certification (grandfathered).

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Thanks for your participation!

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