California Trauma Center **Level III** Criteria California Code of Regulations, Title 22, Chapter 7 - Trauma Care System with American College of Surgeons (Green Book) references; includes ACS FAQ clarifications

| TRAUMA CENTER REQUIREMENTS | | ACS | Title 22 Section 100263 |
|---|---|---|---|
| **E = Essential Element (Title 22)**<br>**D = Desired Element (ACS)** | | | |
| Shall have equipment and resources necessary for initial stabilization and personnel knowledgeable in the treatment of adult and pediatric trauma. | E | | |
| A trauma center must demonstrate substantial medical, administrative and financial commitment for the level of designation requested. | D | | |
| Trauma centers must be able to provide on their campus the necessary staff and physical resources to properly administer acute care consistent with their level of verification. | D | 2-2 | |
| All trauma centers must participate in the state and/ or regional trauma system planning, development, or operation. | D | 1-1 | |
| Joint Commission Accreditation, or American Osteopathic Association. | E | | 100248 |
| Proof of licensure as a general acute care hospital in the State of California. | E | | 100248 |
| **Administration** | | | |
| The hospital has the commitment of the institutional governing body and the medical staff to become a trauma center. | D | 5-1 | |
| There is a current resolution (reaffirmed every three years) supporting the trauma center from the hospital board. | D | 5-2 | |
| **Medical Staff** | | | |
| There is a current resolution (reaffirmed every three years) supporting the trauma center from the medical staff. | D | 5-3 | |
| **Trauma Program Medical Director** | | | |
| **Qualifications are:** | | | |
| Qualified Surgical Specialist (defined in 100242) | E | | a |
| Is either a board-certified (or elligible) surgeon or an ACS Fellow | D | 5-5 | |
| Is current in ATLS (and dedicated to one Trauma Center) | D | 5-7 | |
| **Responsibilities include but are not limited to:** | | | |
| Recommending trauma team physician privileges | E | | a-1 |
| Must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review. | D | 2-4 | |
| Has the authority to recommend changes for the trauma panel based on performance review. | D | 16-12 | |
| Participates in trauma call. | D | 5-6 | |
| Has the oversight authority for the care of injured patients who may be admitted to individual surgeons. | D | 5-15 | |
| Working with nursing & administration to support needs of trauma patients. | E | | a-2 |
| Developing trauma treatment protocols. | E | | a-3 |
| Authority & accountability for QI peer review process. | E | | a-4 |
| Correct deficiencies in trauma care/exclude team members that don't meet standards of the QI program. | E | 5-9 | a-5 |
| Assisting with the coordination of budgetary processes for trauma program. | E | | a-6 |
| Is involved in the development of the trauma center's bypass protocol. | D | 3-1 | |
| Has responsibility and authority to ensure compliance with verification requirements. | D | 6-1 | |
| **Trauma Nurse Coordinator/Manager** | | | |
| **Qualifications are:** | | | |

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| Registered Nurse (does not need to be full time/dedicated) | E | | b |
| Provide evidence of educational preparation, clinical expertise in care of adult & pediatric trauma patient, & administrative responsibilities. | E | | b |
| **Responsibilities include but are not limited to:** | | | |
| Organizing services and systems necessary for multidisciplinary care. | E | | b-1 |
| Coordinating day-to-day clinical process & performance improvement of nursing and ancillary personnel. | E | | b-2 |
| Collaborating with trauma program medical director to carry out educational, clinical, research, administrative and outreach activities of the trauma program. | E | | b-3 |
| **Trauma Service** | | | |
| Implementation of requirements as specified & provide for coordination with the local EMS agency. | E | | c |
| **Trauma Team** | | | |
| A multidisciplinary team responsible for the initial resuscitation and management of the trauma patient. | E | | h |
| The core group is adequately defined by the Trauma Medical Director. | D | 5-20 | |
| The criteria for a graded activation are clearly defined by the trauma center and continuously evaluated by the Performance Improvement and Patient Safety (PIPS) program. | D | 5-10 | |
| **Responsibilities include but are not limited to:** | | | |
| Capability of providing *prompt (defined in 100241)* assessment, resuscitation & stabilization of patient | E | | d |
| Ability to provide treatment or arrange for transportation to higher level trauma center | E | | e |
| Surgeon will be in the ED upon patient arrival, with adequate notification from the field. Maximum acceptable response time is 30 minutes tracked from patient arrival. | D | 2-7 | |
| Program must demonstrate surgeon's presence is in compliance at least 80% of the time. Demonstration of the attending surgeon's prompt arrival for patients with appropriate activation criteria must be monitored by the hospital's trauma PIPS program | D | 2-7 | |
| Trauma panel surgeon's must respond promptly to trauma activations, remain knowledgeable in trauma care principles, whether treating patients locally or transferring them to a center with more resources, and participate in performance review activities. | D | 2-11 | |
| The core group takes 60% of the total trauma call hours each month. | D | 5-21 | |
| **SURGICAL DEPARTMENT(S), DIVISION(S), SERVICE(S), SECTION(S):** | | | |
| Surgical commitment is essential for a properly functioning trauma center. | D | 2-1 | |
| Must have continuous general surgical coverage. | D | 2-10 | |
| There is a Trauma Director approved plan that determines which types and severity of neurologic injury patients should remain at the facility when no neurosurgical coverage is present. | D | 8-6 | |
| **NON-SURGICAL DEPARTMENT(S), DIVISION(S), SERVICE(S), SECTION(S):** | | | |
| An emergency department, division, service, or section staffed so that trauma patients are assured of immediate and appropriate initial care. | E | | f |
| **QUALIFIED SURGICAL SPECIALIST(S):** | | | |
| The roles of trauma surgeons are defined, agreed on, and approved by the director of trauma services. | D | 7-5 | |

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| All general surgeons on the trauma team have successfully completed the ATLS course at least once. | D | 6-11 | |
| **General** | E | | i-1 |
| An attendance threshold of 80% must be met for trauma surgeon presence in the emergency department (80% expected compliance for 30 minute reesponse time). | D | 6-6 | |
| Trauma surgeon must have privileges in general surgery. | D | 6-3 | |
| **Orthopedic** | E | 11-65 | i-2 |
| An orthopaedic surgeon on call and available 24 hours a day. | D | 9-11 | |
| Orthopedic surgeon is identified as the liaison to the trauma program. | D | 9-4 | |
| Orthopedic surgeon has privileges in general orthopedic surgery. | D | 9-15 | |
| **Neurosurgery** | | | |
| There is a performance improvement program that convincingly demonstrates appropriate care in the facility that treats neurotrauma patients. | D | 8-7 | |
| Can be provided through a transfer agreement (may show written IFT Plan). | E | | i-3 |
| **QUALIFIED NON-SURGICAL SPECIALIST(S):** | | | |
| **Emergency Medicine** | | | |
| The roles of emergency physicians are defined, agreed on, and approved by the director of trauma services. | D | 7-5 | |
| Emergency Medicine, in-house and immediately available must have 24-hour emergency coverage by a physician. | E | 2-13 | j-1 |
| Emergency medicine in-house and immediately available (defined in 100237). | E | | j-1 |
| ED has a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients. | D | 7-1 | |
| Emergency physicians cover in-house emergencies with PIPS process demonstrating the efficacy of this practice (must show no untoward events). | D | 7-3 | |
| The physicians who are not board certified in emergency medicine who work in the emergency department are current in ATLS. | D | 7-15 | |
| The physicians who are board certified in emergency medicine who work in the emergency department must successfully complete ATLS at least once. | D | 7.14 | |
| Institutions in which there are emergency medicine residency training programs, supervision is provided by an in-house attending emergency physician 24 hours a day. | D | 7-4 | |
| Emergency physicians on the call panel are regularly involved in the care of injured patients. | D | 7-7 | |
| **Anesthesiology** | E | | j-2 |
| On call and *promptly* (defined in 100241) available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives. This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergency situations in trauma patients and of providing any indicated emergency anesthesia treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist on call shall be advised about the patient, be promptly available at all times, and be present for all operations. | E | 11-1 | j-2 |
| Promptly available for airway problems. | D | 11-2 | |
| Services are available 24 hours a day and present for all operations. | D | 11-7 | |
| In trauma centers without in-house anesthesia services, protocols are in place to ensure the timely arrival at the bedside of the anesthesia provider. | D | 11-8 | |
| In a center without anesthesia services, there is documentation of the presence of physicians skilled in emergency airway management. | D | 11-9 | |

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| Availability of anesthesia services and the absence of delays in airway control or operations are documented in the hospital PIPS process. | D | 11-6<br>11-10 | |
| There is an anesthesiologist liaison designated to the trauma program, and identified. | D | 11-3<br>11-12 | |
| **Other Specialties** | | | |
| Internal Medicine Specialist must be available. | D | 11-69 | |
| **SERVICE CAPABILITIES:** | | | |
| **Radiologic Service** | | | |
| Conventional radiography and CT in all trauma centers. | | 11-36 | |
| The trauma center has policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the radiology department. | D | 11-35 | |
| Shall have a radiological technician *promptly* (defined in 100241) available, in person or by teleradiology, when requested, for interpretation of radiographs, performance of complex imaging studies, or interventional procedures. | E | 11-28 | k-1 |
| Diagnostic information is communicated in a written form and in a timely manner. | D | 11-29 | |
| Critical information is verbally communicated to the trauma team. | D | 11-30 | |
| Final reports accurately reflect communications, including changes between preliminary and final interpretations. | D | 11-31 | |
| Changes in interpretations are monitored through the PIPS program. | D | 11-32 | |
| When the CT technologist responds from outside the hospital, the PIPS program documents the response time (arrive at hospital). | D | 11-39 | |
| **Respiratory Service** | | | |
| There is a respiratory therapist available and on call 24 hours a day. | D | 11-71 | |
| **Clinical laboratory Service** | E | | k-2 |
| Comprehensive blood bank or access to community central blood bank. | E | | k-2 |
| Clinical laboratory services *promptly* (defined in 100241) available. | E | | k-2 |
| Laboratory services are available 24 hours per day for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate. | D | 11-75 | |
| The blood bank must be capable of blood typing and cross matching. | D | 11-76 | |
| The blood bank must have an adequate supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients. | D | 11-77 | |
| The capability for coagulation studies, blood gases, and microbiology must be available 24 hours a day. | D | 11-78 | |
| **Other Services** | | | |
| The hospital must provide physical therapy services. | D | 12-2 | |
| The hospital must provide social services. | D | 12-3 | |
| **Surgical Services** | | | |
| Shall have an operating suite available or being utilized for trauma patients. | E | 9-2 | k-3 |
| Operating room staff, *promptly* (defined in 100241) available. | E | 11-18 | k-3-A |
| A mechanism for documenting trauma surgeon presence in the operating room for all trauma operations is in place. | D | 6-8 | |
| The operating room has the essential equipment. | D | 11-20 | |
| There is craniotomy equipment that offers neurosurgery services. | D | 11-22 | |
| Appropriate surgical equipment and supplies which have been approved by the EMS Agency. | E | | k-3-B |
| The PIPS program evaluates operating room availability and delays when an on-call team is used (PI data must show no delays in obtaining an OR). | D | 11-19 | |

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| The PACU has qualified nurses available 24 hours per day as needed during the patient's post-anesthesia recovery phase. | D | 11-24 | |
| The PACU is covered by a call team from home with documentation by the PIPS program that PACU nurses are available and delays are not occurring. | D | 11-25 | |
| The PACU has the necessary equipment to monitor and resuscitate patients. | D | 11-26 | |
| The PIPS process ensures that the PACU has the necessary equipment to monitor and resuscitate patients. | D | 11-27 | |
| **Intensive Care Service** | | | |
| The trauma center has a surgical director or co-director for the ICU who is responsible for setting policies and administration related to trauma ICU patients. | D | 11-45 | |
| The surgical director or the co-director must be a surgeon, who is credentialed by the hospital to care for ICU patients, and who participates in the PIPS process. | D | 11-52 | |
| The trauma surgeon remains in charge of patients in the ICU. | D | 11-46 | |
| The trauma services retains responsibility for patients and coordinates all therapeutic decisions appropriate for its level. | D | 11-53 | |
| When a critically ill trauma patient is treated locally, there must be a mechanism in place to provide prompt availability of ICU physician coverage 24 hours per day. | D | 11-49 | |
| The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team. | D | 11-54 | |
| Coverage of emergencies in the ICU does not leave the emergency department without appropriate physician coverage. | D | 11-56 | |
| Qualified specialist (defined in 100242) *promptly* (defined in 100241) available to care for trauma patients ICU. | E | | g |
| Qualified specialist may be a resident with 2 years of training who is supervised by staff intensivist or attending surgeon who participates in all critical decision making. | E | | g-2 |
| Qualified specialist (defined in 100242) shall be a member of the trauma team. | E | | g-3 |
| Appropriate equipment and supplies determined by physician responsible for intensive care service and the trauma program medical director. | E | 11-60 | g-1 |
| There is intracranial pressure monitoring equipment if the center admits neurotrauma patients. | D | 11-62 | |
| A qualified nurse (meets hospital criteria to work in ICU) is available 24 hours per day to provide care during the ICU phase. | D | 11-58 | |
| The patient / nurse ratio does not exceed 2:1 for critically ill patients in the ICU. | D | 11-59 | |
| **Burn Center** - In House or Transfer Agreement (may show written IFT Plan) | E | | j-3-A |
| **Pediatric Care** | E | | j-3-B |
| **Rehabilitation Center** - May be provided by written transfer agreement (may show written IFT Plan). | E | | j-3-C |
| **TRAUMA CENTERS SHALL HAVE THE FOLLOWING SERVICES AND PROGRAMS (special license or permit not required):** | | | |
| **Pediatric Service** | | | |
| **Any adult center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating their capability to care for injured children:** | | | |
| Trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body. | D | 2-14<br>10-30 | |
| There must be a pediatric emergency department area. | D | 2-15<br>10-31 | |
| A pediatric intensive care area. | D | 2-15<br>10-31 | |
| Appropriate resuscitation equipment. | D | 2-15<br>10-31 | |

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| A pediatric-specific trauma PIPS program. | D | 2-15<br>10-31 | |
| **For adult trauma centers admitting fewer than 100 injured children younger than 15 years, the above resources are desirable. The hospitals must, however, review the care of their injured children through their PIPS program.** | D | 2-16<br>10-32 | |
| Written interfacility transfer agreements (may show written IFT Plan) with Level I and Level II trauma centers , Level I or II Pediatric Trauma centers or other specialty care centers, for the immediate transfer of those patients for whom most appropriate medical care requires additional resources. | E | 8-8 | I |
| **Outreach Program** | | | |
| Telephone and on-site physician consultations with physicians in the community and outlying areas. | E | | m-1 |
| Trauma prevention for general public. | E | | m-2 |
| The trauma center is involved in prevention activities, including public educational activities. | D | 17-3 | |
| The trauma center participates in injury prevention. | D | 18-1 | |
| **Continuing Education** | | | n |
| Staff physicians: | E | | n-1 |
| All general surgeons and emergency medicine physicians on the trauma team have successfully completed the ATLS course at least once. | D | 17-7 | |
| Staff nurses: | E | | n-2 |
| The hospital provides a mechanism for trauma-related education for nurses involved in trauma care. | D | 17-6 | |
| Staff allied health personnel | E | | n-3 |
| EMS personnel | E | | n-4 |
| Other community physicians and health care personnel | E | | n-5 |
| Must engage in public and professional education. | D | 17-1 | |
| **Disaster Preparedness** | | | |
| The hospital meets the disaster-related requirements of the Joint Commission. | D | 20-1 | |
| A trauma panel surgeon is a member of the hospital's disaster committee. | D | 20-2 | |
| Hospital drills that test the individual hospital's disaster plan are conducted at least every 6 months. | D | 20-3 | |
| The trauma center has a hospital disaster plan described in the hospital disaster manual. | D | 20-4 | |
| **Organ Procurement** | | | |
| The trauma center has an established relationship with a recognized Organ Procurement Office (OPO). | D | 21-1 | |
| There are written policies for triggering notification of the OPO. | D | 21-2 | |
| The PIPS process reviews the organ donation rate. | D | 21-3 | |
| There are written protocols for declaration of brain death. | D | 21-4 | |
| **Performance Improvement** | | | 100265 |
| Must have a quality improvement process in place must be consistently functional, with structure, process and outcome evaluations for the trauma population (PIPS). | E | 16-1<br>16-27 | |
| Must have improvement process in place to identify root causes of problems. | E | | |
| Must have interventions to reduce or eliminate the causes. | E | | |
| Must take steps/actions to correct the problems identified. | E | | |
| A detailed audit of all trauma -related deaths, major complications and transfers. | E | | |
| Programs that admit more than 10% of injured patients to nonsurgical services have demonstrated the appropriateness of that practice through the PIPS process. | D | 5-11 | |

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| There is a method to identify injured patients, monitor the provisions of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners. | D | 5-16 | |
| The PIPS program is supported by a reliable method of data collection that consistently gathers valid and objective information necessary to identify opportunities for improvement. | D | 16-2 | |
| The program is able to demonstrate that the trauma registry supports the PIPS process. | D | 16-3 | |
| A designated emergency physician is available to the trauma director for PIPS issues that occur in the emergency department. | D | 7-9 | |
| The process of analysis includes multidisciplinary review. | D | 16-4 | |
| The process of analysis occurs at regular intervals to meet the needs of the program. | D | 16-5 | |
| The results of analysis define corrective strategies. | D | 16-6 | |
| The results of analysis and corrective strategies are documented. | D | 16-7 | |
| The trauma program is empowered to address issues that involve multiple disciplines. | D | 16-8 | |
| The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care. | D | 16-9 | |
| The trauma program has a medical director with the authority and administrative support to lead the program. | D | 16-10 | |
| The Trauma Medical Director has sufficient authority to set the qualifications for the trauma service members. | D | 16-11 | |
| The Trauma Medical Director has sufficient authority to recommend changes for the trauma panel based upon performance reviews. | D | 16-12 | |
| Deaths are systematically categorized as:<br>1. Unanticipated mortality with opportunity for improvement<br>2. Anticipated mortality with opportunity for improvement<br>3. Mortality without opportunity for improvement. | D | 16-25 | |
| When a consistent problem or inappropriate variation is identified, corrective actions are taken and documented. | D | 16-26 | |
| Identified problem trends undergo multidisciplinary peer review by the Trauma Peer Review Committee. | D | 16-13 | |
| A multidisciplinary trauma peer review committee that includes all members of the trauma team and chaired by the Trauma Medical Director. | E | 5-18<br>6-9<br>16-19 | a |
| The multidisciplinary trauma program continuously evaluates its process and outcomes to ensure optimal and timely care. | D | 5-4 | |
| There must be a Trauma Program Operational Process Performance Improvement Committee. | D | 5-23 | |
| The trauma center is able to separately identify the trauma patient population for review. | D | 16-14 | |
| There is a process to address trauma program operational issues. | D | 16-15 | |
| There is documentation reflecting the review of operational issues and, when appropriate, the analysis and proposed corrective actions. | D | 16-16 | |
| The process identifies problems. | D | 16-17 | |
| The process demonstrates problem resolution (loop closure). | D | 16-18 | |
| Participation in the trauma data management system. | E | | b |
| Participation in the local EMS Agency trauma evaluation committee. | E | | c |
| Have a written system in place for patients, parents of minor children who are patients, legal guardians of children who are patients, and or primary care givers of children who are patients to provide input and feedback to hospital. | E | | d |

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| The criteria for the highest level of activations are clearly defined and evaluated by the PIPS program. | D | 6-7 | |
| The following criteria must be included in the highest level of activation:<br>1. BP <90 and age specific for pediatrics<br>2. GSW neck, chest, abdomen<br>3. GCS <8 with trauma<br>4. IFT receiving blood<br>5. Intubated at scene<br>6. Respiratory compromise<br>7. ED Physician's discretion<br>8. Cardiac Arrest<br>9. Hanging if meets 1-6 | | | |
| Follow applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality. | E | | e |
| The Trauma Medical Director documents the dissemination of information from the peer review committee. | D | 16-23 | |
| In circumstances when attendance is not mandated (non-core members), the Trauma Medical Director ensures and documents dissemination of information from the peer review committee. | D | 5-22<br>16-22 | |
| The trauma multidisciplinary peer review committee attendance by the Trauma Medical Director and specialty representatives is at least 50%. | D | 16-20 | |
| The PIPS process reviews the appropriateness of the decision to transfer or retain major orthopedic trauma. | D | 9-10 | |
| Orthopedic services participates actively with overall trauma PIPS program and the Trauma Program Operational Process Performance Committee. | D | 9-12 | |
| Adequate (>50%) attendance by general surgery (core group) at the multidisciplinary peer review committee is documented. | D | 5-19<br>6-10<br>16-21 | |
| Orthopedic trauma liaison or representative attends a minimum of 50% of the multidisciplinary peer review meetings. | D | 9-13 | |
| The anesthesia resident participates in the trauma PIPS process. | D | 11-13 | |
| The anesthesiology representative or designee to the trauma program attends at least 50% of the multidisciplinary peer review meetings. | D | 11-14 | |
| A representative from the emergency department participates in the pre-hospital PIPS program. | D | 7-8 | |
| There is emergency physician participation with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee. | D | 7-10 | |
| The emergency medicine representative or designee to the multi-disciplinary peer review committee attends a minimum of 50% of these meetings. | D | 7-11 | |
| Evidence of appropriate participation and acceptable attendance is documented in the PIPS process. | D | 16-24 | |
| **Interfacility Transfer of Trauma Patients** | | | 100266 |
| Transfers shall be medically prudent as determined by the trauma surgeon of record. | E | | a-1 |
| Shall be in accordance with the local EMS Agency interfacility transfer policies. | E | | a-2 |
| The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient; for example, payment method is not considered. | D | 4-2 | |
| Well defined transfer plan. | D | 2-13 | |
| Written transfer agreements exists with receiving trauma centers; with appropriate Level I and Level II centers. | E | 8-8 | b |

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| Shall have written criteria for consultation and transfer of patients needing a higher level of care. | E | | b |
| Hospitals which have repatriated trauma patients from a designated trauma center will provide the trauma center with all required information for the trauma registry, as specified by local EMS policy. | E | | c |
| Hospitals receiving trauma patients shall participate in system and trauma center quality improvement activities for those trauma patients they have transferred. | E | | d |
| A mechanism for direct physician to physician contact is present for arranging patient transfers. | D | 4-1 | |
| The PIPS program reviews admissions and transfers to ensure appropriateness. | D | 11-57 | |
| **Pre-Hospital Care** | | | |
| The Trauma Medical Director is involved in the development of the trauma center's bypass protocol. | D | 3-1 | |
| Cannot exceed the maximum divert time of 5%. | D | 3-4 | |
| The trauma surgeon is involved in the decisions regarding bypass. The surgeon should be actively involved in prehospital personnel training, the PIPS process, and development of trauma components of EMS. | D | 3-2 | |
| The trauma program must participate in the development and improvement of pre-hospital care protocols and patient safety programs. | D | 3-3 | |
| **Trauma Registry** | | | |
| Participate in the local EMS agency data collection effort in accordance with local EMS agencies policies and procedures. | E | | 100257 a-3 |
| Trauma registry data are collected and analyzed. | D | 15-1 | |
| The data are submitted to the National Trauma Data Bank. | D | 15-2 | |
| The trauma center uses the registry to support the PIPS process. | D | 15-3 | |
| The trauma registry has at least 80% of the trauma cases entered within 60 days of discharge. | D | 15-4 | |
| The trauma program ensures that trauma registry confidentiality measures are in place. | D | 15-5 | |
| There are strategies for monitoring data validity for the trauma registry. | D | 15-6 | |
| | | | |
| **Note: If ACS has a requirement that is not listed in Title 22 it is noted as a "D" for desirable.** | | | |