CALIFORNIA TRAUMA REGULATIONS (Title 22) versus ACS RESOURCES FOR OPTIMAL CARE OF THE INJURED PATIENT 2006 (Green Book)

(Level I/II Trauma Centers Only)

Requirement	TITLE 22	ACS GREEN BOOK®
Trauma Medical Director	Board certified surgeon with the following responsibilities: ▪ Recommend trauma team physician privileges ▪ Develop trauma treatment protocols ▪ Determine appropriate equipment and supplies ▪ Policy development for domestic violence, elder and child abuse and neglect ▪ Authority and accountability for PIPS program ▪ Correcting deficiencies or exclude from trauma call if standards not met ▪ Coordinate pediatric trauma ▪ Coordinate with local and state EMS agencies ▪ Budgetary process ▪ Identify representatives to assist in identifying specialty physicians qualified to be members of trauma team *Section 100259 (a) (1)*	Board certified (or board-eligible)surgeon or ACS Fellow ▪ Dedicated to only one Trauma Center ▪ Participate in trauma call ▪ Current in ATLS ▪ Maintain appropriate level of extramural CME ▪ Active participation in regional or national trauma organizations **for Level I – does not include members of state COT other than State Chairs and Vice Chairs** for Level II – may be an active participant in the state COT ▪ Authority to manage all aspects of trauma care ▪ Authorizes trauma service privileges ▪ Support nursing needs ▪ Develops treatment protocols ▪ Coordinates the PIPS program ▪ Correct deficiencies ▪ Exclude from trauma call team members who do not meet specified criteria ▪ Coordinate budget process ▪ Identify representatives to assist in identifying specialty physicians qualified to be members of the on-call panel *Chapter 5, pg. 32*

Requirement	TITLE 22	ACS GREEN BOOK®
Trauma Program Manager	Registered Nurse with evidence of education preparation and clinical experience in the care of the adult and/or pediatric trauma patient, administrative ability, and the following responsibilities: ▪ Organize services necessary for the multidisciplinary approach to the care of the trauma patient ▪ Coordinate clinical process and PI with nursing and ancillary personnel ▪ Collaborate with Trauma Medical Director all educational, clinical, research, administrative and outreach activities of trauma program *Section 100259 (a) (2)*	Usually a registered nurse ▪ Must show evidence of educational preparation and clinical experience in the care of injured patients ▪ 16 hours of trauma related CME each year ▪ Work closely with Trauma Medical Director on all TMD responsibilities ▪ Supervise trauma registry ▪ Organize services necessary for multidisciplinary approach to providing care to injured patients ▪ Responsible for process and PI related to nursing and ancillary personnel ▪ Receives administrative and budgetary support dependent on the size of the program ▪ Collaborate with Trauma Medical Director on educational, clinical, research, administrative and outreach activities of trauma program ▪ Participate in development of trauma system and system planning at the community, regional, state or national levels *Chapter 5, pg. 33* **Level I requirement: 1 FTE dedicated to trauma program** Level II requirement: 1 FTE dedicated to trauma program and may be the Pediatric Trauma Program Manager if TC is also pediatric verified. May also serve as prevention coordinator.

Requirement	TITLE 22	ACS GREEN BOOK®
Surgical Specialties include the following Departments	Surgical Departments: • General • Neurologic • Obstetric/gynecologic • Ophthalmologic • Oral or Maxillofacial or Head/Neck • Orthopaedic • Plastic • Urologic *Section 100259 a. 5.*	Surgical Departments: • General *Chapter 6, Pg. 37* • Neurologic *Chapter 8, Pg. 45* • Orthopedic *Chapter 9, Pg. 49*
Non-Surgical Specialties include the following Departments	Non-Surgical Departments: • Emergency • Anesthesiology • Internal medicine • Pathology • Psychiatry • Radiology *Section 100259 a. 6.*	Non-Surgical Departments: • Emergency *Chapter 7, Pg. 41* • Anesthesiology *Chapter 11, Pg. 63*

Volume Standards	**Level I Requirement Only:** **One of the following Patient Volumes:** • **Minimum of 1200 trauma program admissions or** • **Minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is > 15 or** • **An average of 35 trauma patients (with an ISS > 15) per trauma program surgeon per year** *Section 100260 a.*	**Level I Requirement Only:** **One of the following Patient Volumes:** • **Minimum of 1200 trauma program admissions (may include 23 hour observation unit) or** • **Minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is > 15 or** • **An average of 35 trauma patients (with an ISS > 15) for the "core" trauma program surgeon per year** *Chapter 2, Pg. 18* Admission of more than 10% of injured patients to non-surgical service shall demonstrate appropriateness through PIPS process
Trauma Team Activation		The criteria for a graded activation must be clearly defined and

		evaluated by PIPS program The following are the minimally accepted criteria for highest activation: • BP <90 in adults/age-specific hypotension in children • GSW neck, chest, abdomen • GCS <8 with trauma mechanism • Transfer from other facilities where blood given to maintain BP • Intubation (not needed if intubated prior to transfer and stable • Respiratory compromise or obstruction • Emergency physician's discretion • Post cardiac arrest • Hanging if meet any of the above
Qualified **Surgical** Specialist Availability	Immediately Available: • General Surgery *Section 100259 a. 8. A.* *(This requirement may be fulfilled by supervised senior residents who are capable of assessing emergent situations in their respective specialties. When a senior resident is utilized the staff surgeon shall be on-call and promptly available, advised of all trauma patient admissions, participate in major therapeutic decisions, be present in the ED for major resuscitations and in the OR for all trauma operative procedures.)*	Immediately Available: • General Surgery *(Dedicated to Trauma Center with published back up schedule. Maximum accepted response time is 15 minutes (for highest level of activation). The surgeon is expected to be present in the OR for all trauma operations.)* *Note: admission count should not include:* • *Isolated hip from same level fall* • *Drowning or near drowning* • *Poisoning* • *Foreign bodies* • *Suffocation* • *DOAs* A resident in postgraduate year 4 or 5 may be approved to begin resuscitation while awaiting the arrival of the attending surgeon but cannot independently fulfill the responsibilities of or substitute for the attending surgeon. The presence of such a resident may allow the attending surgeon to take call form outside the hospital. The trauma surgeon must be present in the OR for all trauma operations. *Chapter 6, Pg. 38* *Trauma Surgeons that admit ≥100 injured children (>15 years)*

		annually shall be credentialed for pediatric trauma care.
	Promptly Available: • General Surgery *(for consultation)* • Neurologic • Obstetric/Gynecologic • Ophthalmologic • Oral or Maxillofacial or Head/ Neck • Orthopaedic • Plastic • Reimplantation/Microsurgery *(May be provided by transfer agreement.)* • Urologic *Section 100259 a.8. B.* *(This requirement may be fulfilled by supervised senior residents who are capable of assessing emergent situations in their respective specialties. When a senior resident is utilized the staff surgeon shall be on-call and promptly available, advised of all trauma patient admissions, participate in major therapeutic decisions, be present in the ED for major resuscitations, and in the OR for all trauma operative procedures.)* **Level I Requirement Only:** • **Cardiothoracic** *Section 100260 b. 1.* • **Pediatrics** *Section 100260 b. 2.*	Available on-call: • Neurosurgery *(promptly available when requested with special consideration for severe TBI and spinal cord injury; back up schedule is ideal)* *Chapter 8, Pg. 45, 46* ○ *May credential both neurosurgeons and orthopaedic surgeons to treat spine injuries or to share spine call* • Orthopaedic *(promptly available when requested with dedicated on-call panel or effective backup call system. An orthopaedic resident at postgraduate year 4 or higher or an orthopaedic trauma fellow may act as a temporary consultant)* *Chapter 9, Pg. 51* ○ *Program needs to assure that "promptly available" expectations are met* ○ *Shall have privileges in general orthopaedic surgery* • Microvascular • Spinal Injury *(may be provided with transfer guidelines to a Level I Trauma Center)* *Chapter 9, Pg. 51* • Thoracic • Plastic • Obstetric and gynecologic • Ophthalmology • Otolaryngology • Urology • Maxillofacial *Chapter 11, Pg. 67* **Level I Requirement Only:** • **Cardiac** • **Hand** • **Microvascular** *Chapter 11, Pg. 67*
	Available for Consultation or consultation and transfer agreements for adults and pediatric trauma patients requiring the following surgical services:	

	• Burns • Cardiothoracic (Level II) • Pediatric (Level II) • Reimplantation/Microsurgery • Spinal cord injury *Section 100259 a. 8. D.*	
Qualified **Non-Surgical** Specialist Availability	Immediately Available: • Emergency Medicine *(This requirement may be fulfilled by supervised senior residents, who are assigned to the emergency department and are serving in the same capacity. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine shall not be required by the LEMSA to complete an ATLS course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine.)* *Section 100259 a. 9. A.*	Present in the ED at all times **Level I Requirement Only:** • **Emergency Medicine** • Emergency Medicine (Level II) *(May occasionally support in-house emergencies but cases must be reviewed as part of PIPS)* In institutions in which there are emergency medicine residency training programs, supervision must be provided by an in-house attending emergency physician 24 hours per day. *Chapter 7, Pg. 41* The designated ED director for trauma liaison may be fulfilled by a surgeon who is in charge of the surgical side of the ED.
	Promptly Available: • Anesthesiology (*Shall be Promptly Available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives. May be fulfilled by supervised senior residents or certified registered nurse anesthetist who is capable of assessing emergent situations in trauma patients and of providing any indicated treatment. 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.)* *Section 100259 a. 9. B.* **Level I Requirement Only:**	• Anesthesiology *(Must have anesthesia services available 24 hours a day with call permitted to be taken outside the hospital. The attending anesthesiologist on-call must be promptly available at all times and present for all operations.)* May be fulfilled by anesthesiology chief residents or CRNAs with staff anesthesiologist advised, promptly available, and present for all operations. CRNA response shall be documented in the PI process Anesthesiologists must respond to Level I activations in a timely fashion and documented in the PI process *Chapter 11, Pg. 63* Designate a liaison to the trauma program.

	• **Anesthesiology** ***(May be fulfilled by supervised senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of providing any indicated treatment. 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.)*** *Section 100260 d.*	**Level I Requirement Only:** • **Anesthesiology** ***(The anesthesia services must be available in-house 24 hours a day.)*** *Chapter 11, Pg. 63*
	Available for Consultation: • Cardiology • Gastroenterology • Hematology • Infectious Diseases • Internal Medicine • Nephrology • Neurology • Pathology • Pulmonary Medicine *Section 100259 a. 9. D.*	**Level I Requirement Only:** **Medical specialists on staff must include:** • **Cardiology** • **Infectious disease** • **Pulmonary medicine** • **Nephrology** *Chapter 11, Pg. 67* *Available for Consultation* • Internal Medicine • Pulmonary Medicine • Cardiology • Gastroenterology • Infectious Disease
Service Capabilities - **Radiology Services**	Radiological Services: • Immediately Available: a radiological technician capable of performing plain films and computed tomography (CT) imaging *Section 100259 b. 1.* • Promptly Available: - Angiography - Ultra Sound *Section 100259 b. 1. A. & B.*	Radiological Services: • Conventional radiography and in-house radiographer (may be fulfilled by an x-ray technician) • CT capability (*CT technologists may be on call for Level II with response times documented*) • Conventional catheter angiography and sonography • Radiologist in person or by teleradiology when requested for interpretation of imaging studies or interventional procedures *Chapter 11, Pg. 64-65* **Level I Requirement Only:** • **In-house CT technologist** • **MRI capability must be available 24 hours per day.**

		Technologist may be on call (PIPS program must document and review timeliness of response) *Chapter 11, Pg. 64-65*
Service Capabilities – **Laboratory Services**	Laboratory Services: • Comprehensive blood bank or access to a community central blood bank • Clinical laboratory services immediately available *Section 100259 b. 2.*	Laboratory Services: • Must be available 24 hours per day for the standard analysis of blood, urine and other body fluids, including micro-sampling. • Blood bank capable of blood typing, cross-matching with adequate supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate and appropriate coagulation factors(platelets should be available in less than 1 hour) • Coagulation studies, blood gases, and microbiology available 24 hours per day *Chapter 11, Pg. 67*
Service Capabilities - **Surgical Services**	Surgical Services: • OR suite available or being utilized for major trauma patients *Section 100259 b. 3.* • OR staff who are Promptly Available unless operating on trauma patients and back-up personnel who are Promptly Available *Section 100259 b. 3. A.* • Appropriate surgical equipment and supplies as determined by the trauma program medical director *Section 100259 b. 3. B.* **Level I Requirements Only:** • **OR staff who are Immediately Available unless operating on trauma patients and back-up personnel who are Promptly Available** • **Cardiopulmonary bypass equipment** • **Operating microscope** *Section 100260 c. 1.-3.*	Surgical Services: • OR staffed and readily available in a timely manner • Mechanism for providing additional staff to staff a second room • Relevant OR equipment for the patient populations served: - Rapid infusers - Thermal control equipment - Resuscitation fluids - Intraoperative radiologic capabilities - Fracture fixation equipment - Endoscopic evaluation equipment - Craniotomy equipment *Chapter 11, Pg. 64* *PI data must show no delays in obtaining an OR* **Level I Requirement Only** • **OR staffed (dedicated) and immediately available** • **Cardiopulmonary bypass or emergency plan with transfer agreement and PI the process (not required to have actual agreement at time of site visit but must have written transfer plans)** • **Operating microscope** *Chapter 11, Pg. 64*

Additional Services – **Post Anesthesia Care**		Post Anesthesia Care • PACU available and staffed 24 hours per day with the necessary equipment to monitor and resuscitate patients *Chapter 11, Pg. 64*
Additional Services - **Emergency Department**	Emergency Department: • Staffed with qualified specialists in emergency medicine who are immediately available & in-house at all times. *Section 100259 a. 7.* • Designate an ED physician to be a member of the trauma team. *Section 100259 c. 1.* • Provide emergency medical services to adult and pediatric patients *Section 100259 c. 2.* • Appropriate adult and pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director *Section 100259 c. 3.*	Emergency Department • Appropriate number of emergency medicine physicians to ensure immediate care for injured patients. • ED physician to be a member of the trauma team. *Chapter 7, Pg. 41-43*
Additional Services - **Intensive Care Unit**	Intensive Care Unit: • Qualified specialist <u>Promptly Available</u> to care for trauma patients in the ICU. *Section 100259 d. 1. B.* • Appropriate equipment and supplies as determined by the physician responsible for the ICU and the trauma program medical director. *Section 100259 d. 1. A.* • Qualified specialist shall be a member of the trauma team. *Section 100259 d. 1. C.* **Level I Requirement Only:** • **Qualified specialist in-house and <u>Immediately Available</u> to care for trauma patients in the ICU.** *Section 100260 e.*	Intensive Care Unit: • Surgeon serves as co-director or director of ICU • Physician coverage promptly available 24 hours per day (In a busy Level II there will be in-house physician—trauma surgeon, hospitalist, anesthesiologist or pulmonologist—for immediate response) • Equipment - Pulse oximetry - En-tidal CO2 detection - Arterial pressure monitoring - Pulmonary artery catheterization - Patient rewarming - Intracranial pressure monitoring *Chapter 11, Pg. 65-66* *Qualified RN who meets the hospital's criteria to work in an ICU* **Level I Requirement Only** • **Surgically directed ICU in-house physician team** • **Surgical Director must be trained/credentialed as an**

		ICU Director or trauma surgeon with 6 weeks per year of trauma care or a trauma fellowship • **May utilize the ACS alternate pathway for board certification** • **Physician available at all times—may be resident or in-house attending** *Chapter 11, Pg. 65*
Additional Services - **Rehabilitation Services**	Rehabilitation Services: • Physical therapy • Rehabilitation Center *(May be provided by transfer agreement)* • Occupational therapy • Speech therapy *Section 100259 d. 3 – 9* • Acute spinal cord injury management capability. *(May be provided by transfer agreement)* *Section 100259 e. 2.*	Rehabilitation Services • must be available within the hospital's physical facilities or as a free standing rehabilitation hospital (with transfer agreement); **(not required to have actual agreement at time of site visit but must have written transfer plans)** *Chapter 12, Pg. 73* Additional services that must be provided (available during acute phase, including ICU) include: • Physical therapy • Social services • Occupations therapy • Speech therapy *Chapter 12, Pg. 73*
Additional Services – **Burn Center**	Burn Care may be provided through a written transfer agreement with a Burn Center. *Section 100259 d. 2.*	• Burn Care in-house or transfer agreement with Burn Center. **(not required to have actual agreement at time of site visit but must have written transfer plans)** *Chapter 14, Pg. 79*
Additional Services - **Pediatric Care**	Pediatric Care: • Pediatric Service - providing in-house pediatric trauma care shall have appropriate pediatric equipment and supplies and be capable of initial evaluation and treatment of pediatric trauma patients. *Section 100259 a.* • Pediatric ICU approved by the California State Department of Health Services= California Children Services (CCS); or a written transfer agreement with an	Pediatric Care: *Required for any adult trauma center that annually admits 100 or more injured children younger than 15 years of age, and desirable for even those with <100 pediatric patients:* • Pediatric Emergency Department Area *Chapter 2, Pg. 20* • Trauma Surgeon credentialed for pediatric trauma care by the hospital's credentialing body *Chapter 10, Pg. 59*

	approved PICU. - Multi-disciplinary team to manage child abuse and neglect. *Section 100259 e. 1. A. & B.* • Hospitals <u>without</u> a Pediatric ICU shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care. *Section 100259 a.*	• Pediatric appropriate resuscitation equipment *Chapter 10, Pg. 59* • Pediatric-Specific Trauma PIPS program *Chapter 2, Pg. 20* • Pediatric ICU *Chapter 10, Pg. 59*
Additional Services – **Miscellaneous**	Support Services: • Respiratory care • Acute hemodialysis capability • Social service *Section 100259 d. 3 - 9* • Protocol to identify potential organ donors *Section 100259 e. 3.* • Outreach program: - Capability to provide both telephone and on-site consultations with physicians in the community. - Trauma prevention *Section 100259 e. 4. A. & B.* • Inter-facility transfer agreements. *Section 100259 e. 5.*	Support Services: • Respiratory therapist in-house 24 hours per day • Acute hemodialysis capability or transfer agreement **(not required to have actual agreement at time of site visit but must have written transfer plans)** • Nutrition support services *Chapter 1, Pg. 67* • Established relationship with an organ procurement organization *Chapter 21, Pg. 133* **Level I Requirement Only:** • **Acute hemodialysis capabilities in-house 24 hours per day** *Chapter 11, Pg. 67*
Board Certification	Qualified Specialist - General surgeon, neurosurgeon, orthopaedic surgeon, anesthesiologist, and emergency medicine physician, who is licensed in California and is board certified in a specialty by: • the American Board of Medical Specialties • the Advisory Board for Osteopathic Specialties • a Canadian Board • or other appropriate foreign specialty board as determined by the American Board of Medical Specialist for that specialty *Section 100242* A non-board certified physician may be recognized as a qualified specialist by the local EMS agency upon substantiation of need by a trauma center if all of the below can be	Alternate Pathways available and supersedes the green book; a copy of the physicians CV must be sent to the VRC office for approval; on the pathway list, #1-8 must be submitted to the VRC office at least 1 month prior to visit; #9 requires onsite review. See http://www.facs.org/trauma/sitepacket.html General surgeon[1], neurosurgeon[2], orthopaedic surgeon[3], and emergency medicine[4] physician who are board certified by: • American Board of Medical Specialties • Bureau of Osteopathic Specialists • Royal College of Physicians and Surgeons Non-boarded surgeon may be included if all the following are met (alternate pathway): • Critical need indicated by Trauma Director[1234]

	demonstrated: • the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada; or • the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the quality improvement program; and • the physician has successfully completed a residency program *Section 100242 a. 1. - 3.*	• Completed residency training in that specialty[1234] • Current status with ATLS[1234] • 48 hours trauma CME in past 3 years[1234] • 50% attendance at trauma PI meetings[1234] • Membership or attendance at local, regional or national trauma meeting in past 3 years[1234] • List of patients with ISS and outcome data[123] • Favorable PI assessment by the Trauma Director[1234] • Approved for full and unrestricted privileges[123] *Chapter 6[1], Pg. 37-38* *Chapter 7[4], Pg. 41-42* *Chapter 8[2], Pg. 46-47* *Chapter 9[3], Pg. 52-53* Board Certification is desirable for anesthesiologists. *Chapter 1, Pg. 63* **Level I Requirement Only** **If non-boarded general surgeon, all 4 criteria must be met if alternate pathway is incomplete:** • **Provided exceptional care of trauma patients** • **Numerous publications and presentations** • **Published excellent research** • **Documented to provide excellent teaching** *Chapter 6, Pg. 37*
Trauma Registry	Trauma Registry - The local EMS agency shall develop and implement a standardized data collection instrument and implement a data management system for trauma care. The minimum hospital data shall include: • Time of arrival and treatment in: - ED or trauma receiving area - OR • Dates for: - Initial admission - Intensive Care - Discharge • Discharge data including: - Total hospital charges - Destination	Trauma registry: • Data must be collected, analyzed and submitted to the NTDB *Chapter 15, Pg. 87* • The trauma registry is essential to the PIPS program *Chapter 15, Pg. 87* • Measures shall be in place to meet the confidentiality requirements *Chapter 15, Pg. 89* • Strategies are essential for monitoring data validity *Chapter 15, Pg. 90* • State registries are a valuable component of an effective efficient trauma system.

	- Discharge diagnosis *Section 100257*	*Chapter 15, Pg. 90*
Trauma System Evaluation	The local EMS agency shall be responsible for periodic performance evaluation of the trauma system, which shall be conducted at least every two (2) years. *Section 100258 c.*	Trauma center verification is the process by which the ACS confirms that the hospital is performing as a trauma center and meets the criteria contained in the Resources for Optimal Care of the Injured Patient, and is required every three years to maintain verification. *Chapter 22, Pg. 135*
Quality Improvement Process	Quality Improvement Process: • to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process • detailed audit of all trauma related deaths, major complications and transfers • multi-disciplinary trauma conferences • participate in the trauma system data management system *Section 100265*	Performance Improvement and Patient Safety Program: • Shall be supported by a reliable method of data collection with analysis including multidisciplinary review that occurs at regular intervals with defined/documented corrective strategies • May have a mechanism for initial review by individual specialties; however, identified problem trends must undergo multidisciplinary peer review by the trauma peer review committee • Shall be able to demonstrate that the trauma patient population can be identified for separate review (usually through the trauma registry) • Must have a process to address trauma program operational issues • Must have multidisciplinary peer review committee with participation by the Trauma Medical Director or designee and representatives from general surgery, orthopaedic surgery, neurosurgery, emergency medicine, and anesthesia to review selected deaths, complications and sentinel events (limited use may be accomplished with the use of web conferencing tracked by electronic sign in) • Representatives from general surgery, orthopaedic surgery, neurosurgery, emergency medicine, and anesthesia shall have a minimum of 50% attendance • When a consistent problem or inappropriate variation is identified, corrective actions must be taken and documented • Deaths must be categorized as: ○ Unanticipated mortality with opportunity for

		improvement ○ Anticipated mortality with opportunity for improvement ○ Mortality without opportunity for improvement *Chapter 16, Pg. 101-110* *If pediatric (<15 years) admissions are <100 annually, review of admissions shall be done through the PIPS program*
Continuing Education	Continuing Education in trauma shall be provided for: • staff physicians • nurses • allied health personnel • local EMS personnel • other community physicians and health care personnel *Section 100259 e. 6.*	Continuing Education: • Must provide a mechanism to offer trauma-related education to nurses involved in trauma care • General surgeons and Emergency Medicine physicians shall successfully complete ATLS at least once • The Trauma Director and liaison representatives from neurosurgery, orthopaedic surgery and emergency medicine must accrue an average of 16 hours annually or 48 hours in 3 years of external trauma-related CME • Other members of the general surgery, neurosurgery, orthopaedic surgery and emergency medicine who take trauma call must be knowledgeable and current in the care of injured patients and have 16 hours annually or 48 hours in 3 years of trauma-related CME (may be internal) or an internal educational process conducted by the trauma PIPS program • CME will be prorated for surgeons new to the trauma service *Chapter 17, Pg. 112* **Level I Requirement Only** • **Must provide or participate in an ATLS course at least annually (may participate in another institution)** *Chapter 17, Pg. 112*
Prevention		Prevention: • Trauma Prevention Coordinator may also be the Trauma Program Manager • All Trauma Centers must be involved in prevention activities, some of which involve public education

		• Must be able to demonstrate evidence of a job description and salary support for a prevention coordinator • Must demonstrate collaboration with or participation in national, regional, or state programs • Must have a mechanism to identify patients who are problem drinkers *Chapter 18, Pg. 115-116* **Level I Requirement Only** • **Trauma Prevention Coordinator** • **Must demonstrate the presence of prevention activities that center on priorities based on local data** • **Must have the capability to provide an intervention for patients identified as problem drinkers *(should be monitored through the registry by documenting alcohol test/results)*** *Chapter 18, Pg. 115-116*
Trauma Research	**Level I Requirement Only:** **Trauma research program** *Section 100260 f.*	**Level I Requirement Only:** **Trauma research program** **Administration must demonstrate support for the research program such as by providing basic laboratory space, research equipment, information system, biostatical support, salary support for basic and social scientists or seed grants for less experienced faculty** **Fulfill research requirements through one of 2 methods:** **Method 1 (a trauma surgeon's research cannot be counted at another center)** • **Must have 20 peer-reviewed articles published in journals included in *Index Medicus* or *Medline* in a 3 year period (or prove it was from a peer reviewed journal)** - **Must result from work related to the Trauma Center** - **At least 1 must be authored or coauthored by**

		members of the general surgery trauma team and at least 1 exam form 3-6 disciplines is required (neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia and rehabilitation) **Method 2 (a trauma surgeon's research cannot be counted at another center)** • **Must have 10 peer-reviewed articles published in journals included in *Index Medicus* or *Medline* in a 3 year period (or prove it was from a peer reviewed journal)** - **Must result from work related to the Trauma Center** - **At least 1 must be authored or coauthored by members of the general surgery trauma team and at least 1 exam form 3-6 disciplines is required (neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia and rehabilitation)** - **Articles authored by members of other disciplines or work done in collaboration with other trauma centers and participation in multicenter investigations may be include in the remainder AND** • **4 of the following must be demonstrated:** - **Leadership in major trauma organizations (may include trauma committees of any of the regional and national trauma organizations** - **Peer-reviewed funding for trauma research** - **Dissemination of knowledge to include review articles, book chapters, technical documents, web-based publication, editorial comments, training manuals and trauma-related course material** - **Scholarly application of knowledge as evidenced by case reports or reports of clinical series in journals** - **Participation as a visiting professor or invited lecturer at national or regional trauma**

		conferences - **Support of resident participation in institution-focused scholarly activity** - **Mentorship of residents and fellows** **Residents' papers that are not published can be counted only as scholarly activity NOT research.** *Chapter 19, Pg. 121-131*
Residency Program	**Level I Requirement Only:** **ACGME (Accreditation Council on Graduate Medical Education) approved surgical residency program.** *Section 100260 g.*	**Level I Requirement Only:** • **ACGME (Accreditation Council on Graduate Medical Education) continuous rotation in trauma surgery for senior residents as part of the surgical residency program**. - **in at least the general surgery, orthopaedic surgery or neurosurgery disciplines or** - **support an acute care surgery fellowship consistent with the education requirements of the American Association for Surgery of Trauma** • **Continuous rotation in trauma surgery must be 12 month rotation and must fill 2 of the 3 years prior to the site visit** • **Fellowships may be trauma, neurosurgery, orthopaedic or critical care-approved by national professional society of ACGME** *Chapter 17, Pg. 112*
Helicopter Landing Site	A local EMS agency may require trauma centers to have helicopter landing sites. If helicopter landing sites are required, then they shall be approved by the Division of Aeronautics, Department of Transportation pursuant to Division 2.5, Title 21 of the California Code of Regulations. *Section 100254 c.*	
Disaster Planning		A surgeon from the trauma panel must participate on the hospital's disaster committee. Disaster drills every 6 months.

Trauma Diversion		Maximum amount of time on trauma diversion is 5%

Requirements specific to Level I Trauma Centers are noted in Bold
Requirements specific ONLY to Title 22 and not found specifically in ACS Green Book in red
A "Criteria Quick Reference Guide" is found in Chapter 23 of the ACS Green Book (attached) and detailed by Trauma Center level at http://www.facs.org/trauma/verifivisitoutcomes.html
FAQs - Changes/additions/clarifications of the Green Book (found at http://www.facs.org/trauma/optimalcare.pdf for additional clarification)