Trauma Verification Q&A Web Conference

February 22, 2017

C O TVRC @facs.org
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Continuing Education (CE)

❖ To qualify for CE, you must attend at least 50 minutes of educational content

❖ An email will be sent to all attendees who qualify for CE within 24 hours of the webinar ending, with instructions on how to claim CE

❖ If you have any questions – please email COTVRC@facs.org
What is the goal for this Webinar?

- Interpret the standards outlined in the Resources for Optimal Care of the Injured Patient manual to ensure that hospitals have an understanding of the criteria to provide quality care to the injured patient.

- Understand the processes and standards involved in an ACS Trauma Verification Site Visit and how following these will positively impact the quality of care of the injured patient at your center.
Let’s get started!
Orange Resources Book

If you have your Resources for Optimal Care of the Injured Patient 2014 (Orange Book) in hard copy or PDF version, it is recommended that you have it available to reference in the CD-Related Questions section of this webinar.

The most current Clarification Document, and the Verification Change Log are available at:  
www.facs.org/quality-programs/trauma/vrc/resources
Clarification & Verification Document Updates

The updates for the monthly Verification Change Log and Clarification Document for January have been completed.

These documents may be accessed through the VRC webpage at www.facs.org/quality-programs/trauma/vrc/resources.

Going forward, changes to the criteria will be published in the Verification Change Log, and clarifications to any criteria will be published in the Clarification Document.
Clarification Document

Updates sent to participants monthly
## Verification Change Log

Updates sent to participants monthly

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<th>Level II</th>
<th>Level III</th>
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### Resources 2014 Orange Book Description of Criteria

- **Chapter 1 - 1-1**: The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1-1).
- **Chapter 1 - 1-2**: 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).
- **Chapter 1 - 1-3**: 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).
- **Chapter 2 - 2-1**: 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).
- **Chapter 2 - 2-2**: Surgical commitment is essential for a properly functioning trauma center (CD 2-2).
- **Chapter 2 - 2-3**: 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).
- **Chapter 2 - 2-5**: 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).
Recording of Webinars

The webinars are recorded during the session and will be posted within one week on the ACS YouTube channel.

You may also access them via the VRC resources webpage at:

https://www.facs.org/quality-programs/trauma/vrc/resources.
Disclaimer

• All questions are pulled directly from the question submissions. There have been no edits made to the contents.

• If your question is not answered today, the question may require more information, and will receive a response from ACS staff within one week after the webinar.
Announcements
Next Verification Q&A Webinar

Deadline to submit questions: Thursday, March 30, 2017

Webinar date: Friday, March 10, 2017

Webinar time: 12:00pm - 1:00pm CST
2017 TQIP Annual Scientific Meeting and Training

Save the date! November 11-13, 2017
HILTON CHICAGO | CHICAGO, IL
Stop the Bleed website is live!
Last Call! TQIP Call for Data

- The next TQIP quarterly Call for Data opened February 1st.

- Please submit your 4th quarter of 2016 data as well as any updates to previous submissions dating back to the 3rd quarter of 2015.

- The Call for Data will close on Wednesday, March 1st.
Speaking of data.....
The Stakeholder Public-Comment website is live:

https://www.facs.org/quality-programs/trauma/vrc/public-comment

We strongly encourage everyone to review and comment on the standards. Your input will help guide the revision process to add, modify or retire requirements.
Scheduling Reminders
Site Visit Application

• The application must be received at least 13-14 months in advance of the requested time frame or current expiration date.
  ▪ This will hold your spot and in addition, provide centers plenty of time to prepare and complete the online PRQ.
• The lead time is required due to the multitude of applications received.
• All of 2017 and up to March 2018 are closed to scheduling:
  • [https://www.facs.org/quality-programs/trauma/vrc/site-packet](https://www.facs.org/quality-programs/trauma/vrc/site-packet)
**Pre-Review Questionnaire (PRQ) Online Access**

- The VRC office will provide you with an email receipt when the application is received.
  - Logins to the online PRQ will be provided within the context of the email.
  - The online PRQ can be accessed at: [http://web2.facs.org/traumasurvey5/](http://web2.facs.org/traumasurvey5/).
Site Visit Application Payment

- Do not submit payment with the application.
- Your center will be billed annually for the Trauma Quality Program fee
  - This annual fee will not include any additional visit-related fees, such as additional reviewers
- The fee structure is located at: https://www.facs.org/quality-programs/trauma/vrc/fees
Scheduling Site Visits

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

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

- When a lead reviewer is available for your site visit, contact will be made to the TPM prior to confirm the dates.
Scheduling Site Visits

“What happens if a facility is due for a reverification visit, but the visit can’t be scheduled until after the due date (i.e., the visit is due in April but can’t be scheduled until July due to difficulties on the part of the ACS, such as not enough reviewers or overbooked schedule)? Does the center remain verified past its due date? How is that handled, and how long after the due date will the center remain verified?” (Level Unidentified)

Applications are due 13-14 months prior to the expiration date in which, the visit will be scheduled prior to, and within the timeframe requested. In the rare event, there are challenges with securing a review team, the visit will be scheduled within 30 days from either the expiration date or from the center’s preferred timeframe. If the former, the center’s verification status will not be affected and will remain verified until the final report is released.
General Questions
PRQ: Implementation of New Standards

“In our last PRQ that we completed, there were some questions about PTSD. Going forward will PTSD be incorporated into any CD deficiencies for Level II or Level III Trauma Centers?” (Level III Center)

There are currently no plans to develop deficiencies for Post Trauma Stress Disorder (PTDS).

The question in the PRQ is solely asking if the hospital has a screening process. Because this is a yes/no question, we are unable to collect best practice data.

Take a moment to visit the Stakeholder Public-Comment website to review and comment on the current standards. The committee will use the feedback to guide the revision process. https://www.facs.org/quality-programs/trauma/vrc/public-comment
PRQ: Pediatric Population

“Our center recognizes peds patients as under 18. For review should we pull under 18 patients or under 15 patients since under 15 is what ACS recognizes?”
(Level II Center)

For pediatric verification purposes and completion of the PRQ, only report data for patients who were admitted and captured in your trauma registry under the age of 15. Do not include data for those patients older than 15 years old in the PRQ.

For the medical case review, we recommend you pull a few cases for those patients older than 15 years of age. These cases may be kept in its own stack.
PRQ: Appendix 2 for Operative Cases

“More than one procedure can be done on PRQ appendix #2 trauma surgeons are you asking for # of OR cases or # of procedures?” (Level I Center)

We are asking for the number of operative cases (OR cases).
Site Visit: Reviewing Research Articles

“How does a surveyor evaluate research articles? It seems surveyor dependent?” (Level I Center)

Reviewers are looking to ensure the research articles meet the following:

- Approved within 36 months, ending the last day of the “reporting year” for the upcoming visit or ending the first day of the last site visit;
- Subject is related to the management of trauma patients;
- Work was related to your trauma center;
- Authored/co-authored by required disciplines.

More information and the Summary Form for Research Articles is located at:
https://www.facs.org/quality-programs/trauma/vrc/resources.
Site Visit: Implementation of a Criterion

“If you have a deficiency in subspecialty coverage, how long should the deficiency be corrected prior to a verification survey?” (Level II Center)

At minimum, between 6-9 months of documentation demonstrating the specialty requirement was implemented and monitored through PIPS to ensure compliance and that there were no adverse outcomes.
Isolated Hip Fractures and Same Level Falls

“What is Orange citation and exact language for rule ‘old pt, fall, only fx hip’: can admit to medicine without penalty?” (Level III Center)

The admission policy for elderly patients with single level falls and isolated hip fractures should be set at each individual institution. If these patients meet the NTDS inclusion criteria, they should be captured in your trauma registry, and if the center includes them in the volume admission numbers (on the PRQ), then you must follow the rules as any other trauma admission such as, reviewing nonsurgical admissions, PI, etc. (CD 5-18). Refer to page 121.

Note: This may differ from your state inclusion criteria. Therefore, you may have to capture 2 sets of data points.
Isolated Wrist or Ankle Fractures

“Do patients with single injuries like wrist or ankle fractures that are admitted be admitted to trauma or orthopedics?” (Level III Center)

The admission policy for isolated foot and ankle injury should be set at each individual institution. There’s the high speed MVC with a negative work up except an ankle fracture versus the truly isolated injury to the foot or ankle. An option would be for orthopaedics to be initially consulted on patients with any significant mechanism and if they wish, they can have podiatry consult if it is truly an isolated injury.
Organizational Reporting Structure

“What are the reporting requirements for the program manager as it applies to organizational structure?” (Level II Center)

Refer to the next few slides on some examples. What the ACS is looking to see is that the reporting structure allows the Trauma Medical Director (TMD) and Trauma Program Manager (TPM) the ability to run their program and that their reporting structure allows them to address issues across the spectrum of the hospital.
Example of a Trauma Program Organizational Chart: Level I Trauma Centers

Vice President
Clinical Operations

Service Line Director
Department of Surgery

Chair
Department of Surgery

Trauma Medical Director

Trauma Program Manager

Trauma PI RN, Injury Prevention Coordinator

Trauma Registrars
Example of a Trauma Program Organizational Chart: Level I Trauma Centers

Vice President & Chief Nurse Executive

Service Line Director
ER, Critical Care, Burn & Flight Programs

Trauma Program Manager

Trauma PI RN, Injury Prevention Coordinator, Trauma Registrars

Chair
Department of Surgery

Trauma Medical Director
Example of a Trauma Program Organizational Chart: Level II Trauma Centers

President & CEO

Senior VP Pt Care Services, COO

Pt Care Director / Surgical Services

Trauma Med Director

Endo  OS, NS  Anesth  TPM
Example of a Trauma Program Organizational Chart: Level III & IV Trauma Centers

- Vice President & Chief Nurse Executive
- Nurse Manager, ED
- Trauma Program Manager
- Trauma Medical Director
Inclusion Criteria: ICD 10 Codes

“What are the ICD 10 codes to be used for the reporting year total ED visits requested in the PRQ?” (Level II Center)

For verification purposes, the trauma center should follow the National Trauma Data Standard (NTDS) dictionary for patient inclusion criteria which can be found at: http://www.ntdsdictionary.org/
Locums

“Level II: Do locum emergency physicians have to maintain the same credentialing & education as our primary EM physicians?” (Level II Center)

For all trauma centers, locums treating trauma patients must meet the credentialing process and same requirements as the other physicians/surgeons, e.g. board certification, CME and/or an Internal Education Process, peer review attendance, etc.
CD-Related Questions
Continuous Rotation (CD 2-6)

“Is there a requirement to have a PGY 1 or greater in house overnight for a Level I Pediatric center to be verified?” (Level I Center)

No, there is no requirement for a PGY inhouse overnight. To clarify, there may be a PGY 4 or 5 who is part of the trauma team that may begin resuscitation while awaiting the arrival of the attending surgeon. The PGY 4-5 cannot independently fulfill the responsibilities of, or substitute for, the attending surgeon (CD 2–6).
Bypass (Diversion) Protocol (CD 3-4)

“Please explain what is expected in a written Bypass Protocol.” (Level I Center)

Refer to page 25. The bypass/diversion protocol must include the following:

- Trauma surgeon involved in the decision process (CD 3-5);
- Identify when the hospital’s resources are not available or the event of an internal hospital disaster;
- Notify the EMS agency and hospital personnel;
  - Provide status updates
- Notify other centers of divert and/or advisory status;
- Review occurrences through the PIPS process (<5%, CD 3-6).
Bypass: Trauma Surgeon Involvement (CD 3-5)

“Is it acceptable that the trauma surgeon is notified when going on ER bypass and not involved with decision to close every time?” (Level I Center)

This is not acceptable. The trauma surgeon must be involved in the decision regarding bypass (diversion) each time the center goes on bypass (CD 3-5).
“Trauma transfers: Does TMD only need to review for appropriateness of transfer? Or do we need to f/u with transfer center?” (Level II Center)

All transfers need to be reviewed for appropriateness by the TMD and the TPM.

The receiving facility should provide feedback to the transferring facility regarding the patient’s condition, plan of care, and any PIPS issues identified.
Trauma Medical Director (CD 5-5)

“Does the TMD have to be full time?” (Level III Center)

The TMD must be dedicated to one trauma center. S/he cannot administer two facilities. The position must be full-time and permanent.
“If trauma surgeons are on the call schedule as backup, i.e., never primary call, are they still required to meet CME requirements?” (Level II Center)

There are no requirements for the back-up trauma surgeons to meet the CME requirement (CD 5-7) or the peer review attendance (CD 6-8).
“Can you discuss/elaborate/define CD 5-8, active participation in regional or national trauma organizations?” (Level II Center)

The TMD must be a member and actively participates in regional (state symposiums, etc.) or in national trauma (AAST, EAST, ACS, etc.) organizations.

For example, Dr. Maxson is a Fellow (member) of the American College of Surgeons and is an active member on the Committee on Trauma.
“OPPE: How in depth or not is the OPPE expected to be and examples of what should be included?”

(Level I Center)

There are a few examples for OPPE on the VRC Resources repository website. The expectation is that the TMD conduct an OPPE and has a process (score card/template/report) available to present on site, if asked.

The depth of the OPPE will vary, but should include the surgeon’s performance activities. This may include attendance to peer review meetings, CME tracking, any corrective action review, etc.
“Our hospital already does OPPE annually. Does an additional one need to be done by the TMD and liaisons?” (Level I Center) Includes Radiology?

It is not required to have a separate OPPE; however, it must be integrated with the trauma program with oversight by the TMD.

The TMD is not expected to perform an OPPE on the specialists, e.g. ED physicians, Neurosurgeons, Orthopaedic Surgeons, Anesthesia, Radiology, etc. The OPPE for these specialists should be performed by their respective directors with oversight by the TMD.
Limited Tier Response (CD 5-16)

“Is the expectation from this criteria that the trauma surgeon comes to the ED on Tier 2 activations within a specified time frame? Or rather, within a specified time frame when admitted to the hospital?” (Level II Center)

For the limited tier team activation, the time expectation for the types of injuries/patients the surgeon will respond to will be determined by the institution and would be based from when the ED activation was called.
Alternate Pathway (CD 6-3)

“I have a non US boarded neurosurgeon taking trauma call. (1) How long must he follow the alternate pathway criteria?” (Level I Center)

To clarify, all surgeon who are non U.S. or Canadian board certified who are or will be participating on trauma call, must be reviewed by the Alternate Pathway Criteria (APC) at their current institution.

If previously approved, the following slide will outline what will be required on subsequent visits.
Alternate Pathway (CD 6-3)

If the surgeon was previously approved by the alternate pathway criteria process at the current institution, an onsite visit will NOT be required; however, the following criteria will be required at the time of the subsequent visit:

1. A list of 48 hours of trauma-related CMEs during the past 3 years. This can be met by participation in the center’s Internal Education Process;
2. Documentation that the surgeon is present at least 50% at the trauma performance improvement meetings;
3. Documentation of membership or attendance at local and regional or national trauma meetings during the past 3 years;
4. Performance improvement assessment by the Trauma Medical Director (TMD) to ensure that patient outcomes compare favorably to other members of the trauma call panel.
“Please define the CD’s that need to be met for Level III Trauma Centers with Neurosurgery capabilities. (Other than the ones already established as required for Level III TC) (Chapter 8).” (Level III Center)

At this time, Level III trauma centers with Neurosurgery capabilities are required to meet the already established requirements noted in Chapter 8.
Neurosurgery Contingency Plans (CDs 8-3, 8-4, 8-5)

“Can you describe appropriate neurosurgical plans for rural programs as identified in CD 8-4 and CD 8-5?” (Level II Center)

ACS does not differentiate rural versus urban. The requirements would be the same.

Neuro Contingency Planning (CD 8-5) Level I, II

- Published backup call schedule (CD 8-3)
- Diversion plan: primary & backup Neurosurgeon is encumbered (CD 8-4)
- EMS notification of diversion
- PIPS review of each instance & process
“Can you please clarify if a neurosurgery/orthopedic NP/PA can respond within the 30 minute window for site specific criteria?” (Level II Center)

It is acceptable if there are agreed upon guidelines between the TMD and the Neurosurgeon/Orthopaedic liaison for the types of injuries the Resident or Physician Assistant will respond to. There must be clear documentation with the attending specialist surgeon on the plan of care.
“What is an effective PIPS process to monitor that an OR is always immediately available?” (Level I Center)

Assure there are policies and procedures established to adequately review and measure outcomes relative to this requirement.

Demonstrate this process by having, for example:

- Adequate ORs during various times throughout the day so that an emergency procedure can “bump” a case,
- Audit filters to track delays/notification system,
- Surveillance reports that show periodic analysis and rate trending.
“What time are most Level III Trauma Centers using to start the clock ticking for the 30 minutes to OR for emergent cases (CD9-2)? (Decision of need for OR? ED arrival time? CT read time?, etc.).” (Level III Center)

The clock starts from the time the OR is notified a case needs to be done.
"Is there a recommended x-ray discrepancy rate for films which are read initially by a non-radiologist (such as, EC physician)?" (Level III Center)

No, there is not a discrepancy rate for films. The radiology reports can be highly variable. The expectation is that changes in interpretation and missed injuries are monitored through the PIPS process. The radiology department should have a systematic process for monitoring revisions and missed injuries.
ICU Coverage (CD 11-51)

“CD 11-51 is this referring to the Trauma Surgeon? Should this measure be tracked? If so, in what incidences?” (Level II Center)

Appropriately trained physicians must be available in-house within 15 minutes to provide care for the ICU patients 24 hours per day (CD 11-51). This must be tracked and documented. This coverage may be performed by an appropriately supervised Senior Surgery Resident or an in-house Trauma Attending credentialed to provide critical care.

An example may include, a patient who recently came out of the OR and has severe bleeding.
ICU Director (CD 11-53)

“Can the Surgical Director of the ICU be an informal role or does it need a job description and formal appointment?” (Level II Center)

It must be a formal appointment. Meaning that the ICU director must meet the qualifications, e.g. board certified General Surgeon, CME, peer review attendance, etc. The expectation is that the ICU director must be involved in the care of the trauma patients.
“Does ICU co-directorship have to be formally written for a level III trauma center or can it be understood and monthly communication shown between trauma and medical directors?” (Level III Center)

There must be a formal process. A Level II and III trauma center must have a surgeon that serves as the co-director or director of the ICU, be actively involved in, and responsible for, setting policies and administrative decisions related to trauma ICU patients.
**ICU Credentialed Providers Response (CD 11-60)**

“Is sub-specialist arrival time tracking necessary for those patient who are not considered emergent/urgent?” (Level I Center)

The requirement is for the trauma program to track the time the trauma surgeon or consultant (sub-specialist) was paged/called to the ICU for emergent issues related to the trauma patient, and document the response time at the bedside. Any issues or delays in care must be reviewed through the PIPS process by the trauma program.
“Does the ICU Rep for Trauma committee have to be a physician?” (Level III Center)

Yes. All peer review attendees, excluding the TPM, must be surgeons/physicians.
**Microvascular Capabilities (CD 11-71)**

“For CD 11-71, is a Level 2 required to have 24/7 coverage for hand surgery? For CD 11-71, what is the expectation for microvascular surgery? Does this surgeon need to do free flaps and trams? For CD 11-71, will transfer agreements suffice for a Level 2 for intermittent coverage?”  (Level II Center)

A Level II trauma center must have a Hand Surgeon and Microvascular Surgeon. Microvascular coverage may be satisfied by having a surgeon who uses an operating microscope for nerve repair, free tissue transfer, etc. These specialists are not required to be inhouse 24/7, but must be available to consult, in person, when requested by the attending surgeon. May have transfer agreements for complex injuries.
Advanced Practitioners (CD 11-86)

“Could you please clarify whether APP's in ED need ATLS if they do not have any role in caring for the trauma alert patient?” (Level II Center)

The APRNs/PAs who are not involved in the trauma team activation are not required to be current in ATLS.

Those APRNs/PAs that function as a member of the trauma team activation and are caring for trauma activation patients via assessment or interventions must be current in ATLS. If the Trauma and/or ED APP’s only role is as a scribe or entering orders they would not need to meet the ATLS requirement.
“Where is the risk adjusted benchmarking template that is marked as pending on the PRQ list of attachments and Appendices?” (Level I Center)

With the change in CD 15-5 (Effective January 1, 2017, all trauma centers must be enrolled in TQIP), the benchmarking template is no longer necessary. The list of attachments will be updated to remove the ‘pending’ language.
Registrar (CD 15-9)

“Is there any talk about moving the charts per registrar from 500-750/year to 500?” (Level I Center)

At this time, there are no revisions to decrease the number of cases. As mentioned earlier in this webinar, we are encouraging everyone to visit the Stakeholder Public-Comment website to provide feedback on the current standards.
Mortality Review (CD 16-6)

“Do all hospice cases have to be presented at monthly trauma M and M, or just a case review?” (Level I Center)

Yes, if the death occurred while under hospice care at your facility, then that case will be reviewed.

If the patient is transferred to another facility/hospice care center, those cases would not be reviewed.
“Do all death cases need committee (M&M) review? Or can they be vetted by TMD & TPM if there are no issues?” (Level I Center)

Not all death cases need to go to the Morbidity & Mortality Committee. Deaths with opportunity must undergo review.
Trauma Systems/Operations Committee (CD 16-12)

“Multi-disciplinary Operations Meeting, Can it be held as often as you want? With no physician attendance requirement?” (Level II Center)

The Trauma Systems/Operations Committee may be held as often as deemed necessary. The manual states it should be held quarterly with physicians, prehospital personnel, nurses, technicians, administrators, and other ancillary personnel.
Prevention Activities (CD 18-1)

“What are they looking for in a fall prevention program for the elderly? How have other facilities handled this?” (Level III Center)

Level I, II and III trauma centers must use their trauma registry and epidemiologic data to drive the center’s injury prevention activities (CD 18-1). The program and intervention strategies should then be selected based on the data. Examples may include, going out to venues and provide education to senior citizens on preventing falls and risk factors.
Prevention Program Partnership (CD 18-6)

“What type of community organizations are acceptable to partner with for a prevention program?”
(Level III Center)

Refer to page 141. A trauma center’s prevention program must include and track partnerships with other community organizations (CD 18-6) such as, law enforcement agencies, schools, churches, county health departments, and any other organizations. This may also include, other trauma centers in your region or consortium.
"If adult trauma surgeons are caring for pediatric trauma patients, do they have to demonstrate pediatric trauma education hrs?" (Level I Center)

No. The CME pediatric requirement is for Level I or II pediatric trauma centers that are seeking verification.
Thanks for your participation!