Natividad
MEDICAL CENTER

Trauma Implementation Timeline

Submitted November 15, 2013

Natividad
MEDICAL CENTER

November 14, 2013

Kirk Schmitt
EMS Agency Director
County of Monterey Health Department
1270 Natividad Road
Salinas, CA 93906

Dear Mr. Schmitt:

Natividad Medical Center is pleased to present the accompanying documents as part of our ongoing proposal for designation as a Level II trauma center. We have attached the following documents for your review:

1. Responses to IRP conditions with attachments.
2. Revised Trauma Center Minimum Standards (section 5) from original proposal.

We look forward to working with you and your staff to develop the County's first Trauma Center. Please let us know if you have any questions.

Sincerely,

Harry Weis
Chief Executive Officer

Gary R Gray, DO
Chief Medical Officer

CC: Michael R Derr, Contracts/Purchasing Officer

1441 Constitution Boulevard
. Box 81611
Salinas, CA 93912-1611
PH 831.755.4111

www.natividad.com

IRP

Conditions

Natividad
MEDICAL CENTER

Responses to IRP Conditions

IRP Condition	Action Plan
Neurosurgery. 24 hour neurosurgical coverage must be demonstrated. There must be training for operating room staff of neurosurgical procedures. There must be training for ICU staff regarding Neurosurgical monitoring (ICP)	***Natividad Medical Center is negotiating contracts with several neurosurgeons with significant neurotrauma experience. These agreements will require Board of Supervisors approval and will be submitted for approval no later than 07/31/14. Natividad will go live with Neurosurgical coverage no later than 10/1/2014.*** ***Natividad Medical Center is proceeding with the purchase of required equipment to establish our Neurotrauma service. These purchases do not require Board of Supervisors approval. These items are listed in attachment A and will be onsite no later than 5/31/2014.*** ***Operating room, Emergency Department, Medical Surgical and Intensive Care Unit staff will begin training by 5/1/2014. NMC will be partnering with other trauma facilities to facilitate nursing education and training. They have agreed to provide staff resources, materials and simulation exercises for implementation in our facility.***
Angiography: 24 hour angiography must be demonstrated. This includes facility equipment, physician availability, and workforce training and availability.	***Natividad Medical Center will ensure that conventional catheter angiography will be available 24 hours per day no later than 11/30/2014. Key implementation steps Include:*** 1. ***Mobile angiography Lab will be onsite no later than June 30, 2014 and has already been approved by the Board of Supervisors. Plans for required ancillary construction covered walkways and electrical connections will be submitted for approval to Board of Supervisors by 3/1/2014. Construction will not exceed 60 days allowing ample opportunity for training.*** 2. ***We will begin angiography training of our current staff no later than May 1, 2014. Natividad Medical Center will hire per diem staff as necessary to provide training and education of radiology staff. Per Diem positions do not require Board of Supervisors approval. Permanent support and technician positions will be approved by the Board of Supervisors no later than 3/1/2014. Attachment B outlines additional staff required before designation.***

	3. ***Natividad Medical Center already contracts with Salinas Valley Radiologists to provide interventional physician services. We are currently meeting with the group to ensure that coverage meets ACS Trauma standards. If a contract amendment is required it will be presented to the Board of Supervisors before 9/30/2014***
The minimum CME requirements must be met for physicians in the specialties of general surgery, emergency medicine, neurosurgery, and orthopedic surgery.	***A variety of trauma-specific CME opportunities have been identified and information provided to department directors. Additionally, trauma CME's are being offered to physicians and nurses at NMC on a regular basis to assist in meeting the CME requirements per ACS guidelines. The ED Medical Director, ED trauma liaison have currently met the necessary CME requirements per ACS guidelines. The department medical directors, in cooperation with the Trauma Program manager, have been charged with ensuring physician compliance with CME requirements.*** ***Natividad Medical Center will ensure that both the TMD and all trauma surgeons meet required trauma related CME hours no later than 12/31/2014. Contracted Neurosurgeons will be required to meet CME hours congruent with contract execution. The Orthopedic liaison and Orthopedic surgeons will complete required trauma related CME hours no later than 11/30/2014.***
Improved mechanism for physician to physician contact	***An interfacility patient transfer committee has been developed. A dedicated transfer line will be established to facilitate direct physician to physician communication. Policies and procedures for***

for arranging patient transfers	***facilitating patient transfer, identifying available beds and arranging transport are in progress. Our call center will go live at time of designation though all infrastructure will be in place by 11/30/2014.***
Trauma Medical Director and Trauma Program Manager should attend the Trauma Outcome Performance Improvement Course (TOPIC). Ideally, these individuals should attend this course together.	***The Trauma Medical Director and Trauma Program Manager will attend one of the two currently available TOPIC's courses in March or May 2014.***
Representation from emergency medical services should be included on the facility's trauma performance committee. Additionally, a representative from trauma service (preferably the Trauma Medical Director) should participate with EMS performance improvement.	***Each of the respective program managers will be attending regularly scheduled meetings as per the recommendation.***

IRP

Attachments

Natividad
MEDICAL CENTER

IRP Attachments

Attachment A: Operating Room Equipment List

Attachment B: Staffing by Department

Attachment A

OR Equipment

Cost Estimate	Function
$ 345,666.21	The Zeiss Pentero 900 is a state of the art microscope used by neurosurgeons when working in the brain or on spines. Due to the delicate nature of the work and the size of the vessels in the brain, a microscope is necessary for the neurosurgeon and their assistant for visualization.
$121,837.00	The Jackson table is an OR table designed for back and neck procedures and for procedures done to the back of the head. The patient is positioned on their stomach using this table.
$ 47.398.50	The Midas Rex High Speed Surgical drill is light weight and compact allowing for maneuverability when operating in tight spaces such as the head or spine.
$195,000.00	CUSA stands for Cavitron Ultrasonic Surgical Aspirator and is used for aspirating brain tumors. While not necessarily used in Trauma it's expected that Neurosurgeons might add this volume to Natividad.

$150,000.00	Multiple trays of instruments must be added to the OR's instrumentation for trauma ranging from surgical procedures such as a craniotomy for epidural hematomas (blood clots) to fractured spine cases.
$18,645.00	The OMNI retractor is a self retractor for abdominal surgeries. It eliminated the number of hands that are necessary when performing surgery in the abdomen to retract abdominal contents.
$14,123.00	NMC has one vascular set designed for large cases. This will provide a back up in the event we would have back to back trauma cases
$12,299.53	NMC has one "rib" tray which is necessary if chest surgery is performed. This will give NMC a second tray.

$4,155.23	As with the Vascular and Rib trays, NMC has one complete thoracotomy tray in the OR. This is not adequate if the tray should be used or contaminated. It also isn't adequate if more than one victim arrives. Due to the weight of the trays, Thoracotomy trays are divided into A and B. Trays can not weigh more than 25 lbs according to AAMI standards.
$4,603.70	See Thoracotomy A.

Total $857,570.74

Attachment B

Staffing by Department

Natividad Medical Center will request Board of Supervisors approval of the core positions by March 1, 2014. Positions will be filled as needed in order to meet the training and go-live timelines.

Radiology Staffing Augmentation

Position	FTE
Radiology Technologist	4.0
RN	2.8
Interventional Radiology Supervisor	1.0
CT Coverage	2.6
MRI Coverage	0.4
Clerk	1.0
TOTAL	11.8

Laboratory Staffing Augmentation

Position	FTE
CLA	1.2

OR Staffing Augmentation

Position	FTE
RN	7
Surg Tech	4.2
Central Sterile Tech	1.4
Housekeeper	2.8
Anesthesia Tech	1.4
TOTAL	16.8

Emergency Department Augmentation

Position	FTE
Trauma RN	8.4
Triage RN	2.8
TOTAL	11.2

ICU/Medical Surgical Unit/ARU Augmentation

Position	FTE
RN ICU	4.2
RN Med Surg	8.4
RN ARU	4.2
TOTAL	16.8

Trauma Services

Position	FTE
Trauma Program Manager	1.0
Trauma Prevention/Outreach RN	1.0
Trauma Registrar	1.0
Trauma Nurse Practitioners	5.0
Admin Assistant	1.0
TOTAL	9.0

Revised Trauma Standards

Natividad
MEDICAL CENTER

Revised Trauma Center Minimum Standards, Section 5

State of California, Title 22		American College of Surgeons		Natividad Medical Center
Trauma Center Requirements				
(a)	A Level II trauma center is a licensed hospital which has been designated as a Level I or II trauma center by the local EMS agency. While both Level I and II trauma centers are similar, a Level I trauma center is required to have staff and resources not required of a Level II trauma center. The additional Level I requirements are located in Section 100260. Level I and II trauma centers shall have appropriate pediatric equipment and supplies and be capable of initial evaluation and treatment of pediatric trauma patients. Trauma centers without pediatric intensive care unit, as outlined in (e)(1) of this section, shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care. A Level I or Level II trauma center shall have at least the following:	5-5	The trauma medical director (TMD) must be a board-certified surgeon or an ACS Fellow, (usually a general surgeon) with special interest in trauma care.	*Exceeds standard – The Trauma Medical Director, Alex Di Stante, MD, FACS, has completed board certifications in not only General Surgery but Surgical Critical Care as well. He is fellowship-trained from a Level I trauma center, has experience at a Level II trauma center, and a current ACS Fellow.*
		5-6	The trauma medical director must participate in trauma call.	*Meets standard – Dr. Di Stante actively participates in trauma call.*
		5-7	The trauma medical director must be current in Advanced Trauma Life Support.	*Meets standard – Dr. Di Stante completed his most recent ATLS course in 2010.*
		5-8	Membership and active participation in regional or national trauma organizations is essential for the trauma medical director.	*Meets standard – NMC is a member of The Trauma Center Association of America as well as TMAC.*
(1)	A trauma program medical director who is a board-certified surgeon, whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care such as:	5-9	The trauma medical director must have the authority to correct deficiencies in trauma care and exclude from trauma call the trauma team members who do not meet specified criteria.	*Meets standard – Per the Trauma Policies and Procedures, the Trauma Medical Director has the authority to correct deficiencies in trauma care or exclude from trauma call the trauma team members who do not meet specified criteria.*

State of California, Title 22	American College of Surgeons		Natividad Medical Center
(A) recommending trauma team physician privileges; (B) working with nursing and administration to support the needs of trauma patients; (C) developing trauma treatment protocols; (D) determining appropriate equipment and supplies for trauma care; (E) ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect; (F) having authority and accountability for the quality improvement peer review process; (G) correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet standards; (H) coordinating pediatric trauma care with other hospital and professional services; (I) coordinating with local and State EMS agencies; (J) assisting in the coordination of the budgetary process for the trauma program; and (K) identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program.	2-4	Through the trauma Performance Improvement and Patient Safety (PIPS) program and hospital policy, the TMD must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review.	*Exceeds standard – The Trauma Medical Director is personally involved in selecting the surgeons to participate in trauma care at the Medical Center. He is also directly involved in the monthly trauma call schedule. The Trauma Policy and Procedures further describes the Trauma Medical Director's responsibility as well as his contract and authority for determining each general surgeon's (as well as other physician specialists who care for trauma patients) ability to participate on the trauma panel based on performance review. In addition, there is continuous evaluation of processes and outcomes through the trauma PIPS program, which is supported by the trauma registry.*
	6-1	The TMD must have the responsibility and authority to ensure compliance with verification requirements for the trauma surgeons on the call panel (board certification, clinical involvement, education and regional or national commitment).	*Meets standard – As per the Trauma Policy and Procedures, the Trauma Medical Director has the responsibility and authority to ensure compliance with verification requirements for the trauma surgeons on the call panel.*
	16-10	The trauma program must have a trauma medical director with the authority and administrative support to lead the program.	*Meets standard – The Trauma Policy and Procedures allow Trauma Services and the Trauma Medical Director to have the authority to lead the program. There is considerable administrative support with utilizing the trauma policy's authority.*
	16-11	The trauma medical director must have sufficient authority to set the qualifications for the trauma service members.	*Meets standard – As per the Trauma Policy and Procedures, the Trauma Medical Director has the authority to set the qualifications for the Trauma Services' members and to recommend changes for the trauma panel based on performance review.*
	16-12	The TMD must have sufficient authority to recommend changes for the trauma panel based upon performance reviews.	*Meets standard – As per the Trauma Policy and Procedures, the Trauma Medical Director has the authority to set the qualifications for the Trauma Service members and to recommend changes for the trauma panel based on performance review.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		5-20	The core group of trauma surgeons must be defined by the trauma medical director.	*Exceeds standard – The Trauma Medical Director is personally involved in selecting the surgeons to participate in trauma care at the Medical Center. He is also directly involved in the monthly trauma call schedule. The Trauma Policy and Procedures further describes the Trauma Medical Director's responsibility as well as his contract and authority for determining each general surgeon's (as well as other physician specialists who care for trauma patients) ability to participate on the trauma panel based on performance review.*
		7-5	The roles and responsibilities of the emergency physicians and trauma surgeons are defined, agreed on, and approved by the director of the trauma service.	*Exceeds standard – Not only are the roles and responsibilities of the ED physicians and trauma surgeons clearly defined by the Trauma Policies and Procedures, but they also have significant experience performing their roles. All policies and procedures are approved by the Trauma Medical Director.*
		5-17	The trauma program manager must show evidence of educational preparation and clinical experience in the care of injured patients.	*Exceeds standard – The job description for the Trauma Program Manager, Chelsi Mettler, RN, TNCC, lists all of these responsibilities and more. A copy of the job description is included as Exhibit 9. Chelsi is an experienced ED Charge Nurse who has also visited other trauma centers in the region. She is a member of TMAC.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		5-12	Seriously injured patients must be admitted to or evaluated by an identifiable surgical service staffed by credentialed trauma providers.	*Exceeds standard – The Trauma Policies and Procedures require all patients who have a traumatic injury requiring admission will be evaluated by the trauma service. In addition, these patients will be admitted to a surgical service (preferentially Trauma Services). This is monitored daily and monthly (per registry report). The trauma service is rounded on by the Trauma Medical Director at least twice weekly, who also oversees all aspects of the multidisciplinary care delivered to trauma patients. The trauma surgical service panel consists of nine general surgeons (six of whom have completed trauma/surgical critical care fellowships). Seven are current on ATLS certification; the remaining two are willing to take/retake it. There are currently no residents or mid-level providers participating on the trauma service. The credentialing criteria/qualifications for being a member of the trauma surgical service panel are detailed within the Trauma Policies and Procedures.*
		5-13	Sufficient infrastructure and support to ensure adequate provision of care must be provided for this service.	*Exceeds standard – The Medical Center, constructed in 1998, is a state-of-the art, earthquake-compliant building designed to absorb and flex with seismic vibrations. Trauma surgery has 24/7 coverage supported by in-house anesthesiology, operating suites, and promptly available OR teams. There is a dedicated ED ultrasound and two, brand new CT scanners that will be in place prior to designation.* *The Medical Center has a massive transfusion policy with blood product stock levels and a documented mutual aid agreement, and point of care testing in the ED and ICU for instant lab results. NMC Trauma Services offers a continuum of care from the time the patient presents in the ED through physical rehabilitation. The Medical Center has the only acute rehabilitation unit in Monterey County.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		11-47	Physician coverage of critically ill trauma patients must be promptly available 24 hours per day.	*Exceeds standard – The trauma surgeon is immediately available 24 hours per day to cover critically ill trauma patients. In addition, a hospitalist is immediately available in-house during the day and at least one board certified emergency medicine physician is on duty at all times.*
		11-48	Physicians must be capable of a rapid response to deal with urgent problems as they arise in critically ill trauma patients	*Exceeds standard – The trauma surgeon is either immediately available or in-house 24 hours a day to cover critically ill trauma patients.*
(2)	A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of the adult and/or pediatric trauma patient, administrative ability, and responsibilities that include but are not limited to: (A) organizing services and systems necessary for the multidisciplinary approach to the care of the injured patient; (B) coordinating day-to-day clinical processes and performance improvement as it pertains to nursing and ancillary personnel; and (C) collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program.	11-53	The trauma service must retain responsibility for patients and coordinate all therapeutic decisions appropriate for its level.	*Meets standard – As per the Trauma Policies and Procedures, Trauma Services retains responsibility for patients and coordinates all therapeutic decisions.*
(3)	A trauma service which can provide for the implementation of the requirements and provide for coordination with the local EMS agency.			
(4)	A trauma team, which is a multidisciplinary team responsible for the initial resuscitation and management of the trauma patient.			

State of California, Title 22		American College of Surgeons		Natividad Medical Center
(5)	Department(s), division(s), service(s) or section(s) that include at least the following surgical specialties, which are staffed by qualified specialists: (A) general; (B) neurologic; (C) obstetric/gynecologic; (D) ophthalmologic; (E) oral or maxillofacial or head and neck; (F) orthopaedic; (G) plastic; and (H) urologic			
(6)	Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists: (A) anesthesiology; (B) internal medicine; (C) pathology; (D) psychiatry; and (E) radiology	2-7	With adequate notification from the field the trauma surgeon is expected to be in the emergency department on patient arrival. The maximum acceptable time is 15 minutes for trauma care facilities. The program must demonstrate that the surgeon's presence is in compliance at least 80% of the time.	*Will meet standard – The Trauma Policies and Procedures describe the expected trauma surgeon response times (and defines the criteria) for Code Trauma (15 minutes from notification), Trauma Alert (30 minutes from notification) and Trauma Consult (1 hour from notification). The PIPS Program, utilizing trauma registry data, will review monthly prior to designation. Any individual who does not meet 100 percent compliance will receive a letter reminding them of the standards.*
(7)	An emergency department, division, service or section staffed with qualified specialists in emergency medicine who are *immediately available*.	2-8	The trauma surgeon on call must be dedicated to the trauma center while on duty.	*Meets standard – As per the Trauma Policies and Procedures, the trauma surgeon on-call is dedicated (i.e., unencumbered by conflicting duties or responsibilities) to the trauma center while on duty.*
(8)	Qualified surgical specialist(s) or specialty availability, which shall be available as follows[1]: (A) general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be *immediately available* for trauma team activation and *promptly available* for consultation; (B) On-call and promptly available:	2-9	A published back-up call schedule for trauma surgery must be available.	*Will meet standard – Due to the fragmented trauma volume, there has not been a need for back-up coverage to date. However, there is a policy in place should a second trauma surgeon be necessary to assist or cover when the primary surgeon is encumbered for greater than one hour. Before designation, the Medical Center will formalize a back-up call schedule for trauma surgery.* ***Timeline: General surgeon will be on back-up call at time of designation.***

State of California, Title 22		American College of Surgeons		Natividad Medical Center
	1. neurologic; 2. obstetric/gynecologic; 3. ophthalmologic' 4. oral or maxillofacial or head and neck; 5. orthopaedic; 6. plastic; 7. reimplantation/microsurgery capability. This surgical service may be provided through a written transfer agreement; and 8. urologic (C) Requirements may be fulfilled by supervised senior resident as defined in Section 100245 of this Chapter who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon: 1. the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care; 2. a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available; 3. a staff trauma surgeon or a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.	2-14	Trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body.	*Exceeds standard – All trauma surgeons are credentialed for pediatric trauma care by the Medical Center's credentialing body. Due to the large percentage of pediatric ED visits (roughly 25 percent) and sizeable L&D program, the emergency medicine physicians are very competent to assist the trauma surgeons with pediatric trauma care and there is typically a pediatrician in-house. In addition to general pediatrics, there are two board certified pediatric gastroenterologists and two board certified pediatric cardiologists on the NMC medical staff and available for consults.*
		6-12	The TMD must accrue and average of 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.	*Will meet standard – The Trauma Medical Director has completed a number of CME hours; however, not enough are related to trauma. Through a combination of external classes, courses, and conferences, Dr. Di Stante will meet or exceed the 16 annual hours of required external CME. All trauma surgeons and Medical Center physicians responding to Trauma Services will be encouraged to attend the trauma-related CME. Prior to designation, the Trauma Medical Director will complete at least 16 external hours in the next 12 months.* ***Timeline: Natividad Medical Center will ensure that the TMD completes required trauma related CME hours no later than 12/31/2014.***
		6-2	Board certification is essential for general surgeons who take trauma call in trauma care facilities.	*Exceeds standard – The trauma surgical service panel consists of nine general surgeons who are all currently board certified in General Surgery. In addition, six trauma surgeons have completed trauma/surgical critical care fellowships and board certifications in Surgical Critical Care, including the Trauma Medical Director.*
		5-21	The core group of trauma surgeons must take at least 60% of the total trauma call hours each month.	*Exceeds standard – 100 percent of the trauma call panel is covered by the core trauma surgeons.*
		6-3	The trauma surgeon must have privileges in general surgery.	*Meets standard – All of the trauma surgeons have privileges in general surgery.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		6-8	The trauma surgeon is expected to be present in the operating room for all trauma operations. A mechanism for documenting this presence is essential.	*Meets standard – Trauma surgeons are present in the OR for all trauma operations. Residents are not used to fulfill this requirement. The operating record document the surgeon's 100 percent attendance during any surgical procedure.*
		6-11, 17-7	All general surgeons on the trauma team must have successfully completed the ACS ATLS® course at least once.	*Exceeds standard –Eight of the nine trauma surgeons have successfully completed ATLS at least once. Currently, one is a course director, two are instructors, and four are providers. The remaining two trauma surgeons have committed to taking/updating their ATLS prior to designation. ATLS expiration dates are included with Exhibit 13.*
		6-13	The trauma surgeons who take trauma call must accrue the documented 16 hours annually or 48 hours in 3 years of trauma-related CME, or may meet this requirement by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.	*Will meet standard – Six of the trauma surgeons have from 55 to over 100 CME hours related to trauma during the last two years (August 2011-July 2013). All of these have been extramural. The three remaining trauma surgeons have committed to meeting or exceeding the number of trauma-related CME hours required by ACS prior to designation. A 12-month calendar of trauma-related CME is included as Attachment 9.21. Along with external trauma classes and courses, these monthly topics will ensure all trauma surgeons achieve the required CME hours. All physicians responding to Trauma Services will be encouraged to attend the trauma-related CME.* ***Timeline: Natividad Medical Center will ensure that the all trauma surgeons will meet required trauma related CME hours no later than 12/31/2014.***

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		11-64	The trauma center (TC) must have the following surgical specialists available. (orthopaedic surgery, neurosurgery, thoracic surgery, plastic surgery, obstetric and gynecologic surgery, ophthalmology, otolaryngology, and urology)	*Will meet standard – The Medical Center has all of the surgical specialists listed currently available, except neurosurgery. The local neurosurgical group has committed to supporting whichever hospital is designated as the trauma center for Monterey County. However, NMC has taken the further, proactive step to identify neurosurgeons through a posted RFP who are available to join the medical staff and provide on-call trauma services. A letter of commitment is enclosed with Attachment 9.13 and current curriculum vitae of the four neurosurgeons who are willing to contract with NMC are available in Attachment 9.2. All have significant trauma center experience. The selected group will be in place prior to designation.* ***Timeline: (see 8-1,8-2,8-3,8-5)***

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		8-1	A neurosurgeon must be designated as the liaison to the trauma service. Neurotrauma care should be organized and ideally run by a neurosurgeon who is highly experienced and devoted to the neurosurgical care of injured patients. If this surgeon is not the director of the neurosurgery service, a neurological surgeon liaison must be designated.	*Will meet standard – The Medical Center will designate a neurosurgeon as a liaison to Trauma Services. The liaison will be approved by the Trauma Medical Director and highly experienced and devoted to the neurosurgical care of injured patients. This will occur before designation of the trauma center.* *The liaison will be a neurosurgeon with* *1) The local neurosurgical group, who has committed to participate with the Medical Center, or* *2) Four contracted neurosurgeons who have worked at Level I and II trauma centers, a letter of commitment is provided in Attachment 9.13.* *The liaison will be selected prior to designation of the trauma center.* ***Timeline: Natividad Medical Center is negotiating contracts with several neurosurgeons with significant neurotrauma experience. These agreements will require Board of Supervisors approval and will be submitted for approval no later than 07/31/14.*** ***Natividad Medical Center is proceeding with the purchase of required equipment to establish our Neurotruama service. These purchases do not require Board of Supervisors approval. These items as listed attachment A and will be onsite no later than 3/31/2014.***

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		8-2	Neurotrauma care must be promptly and continuously available for severe traumatic brain injury and spinal cord injury and for less severe head or injuries to the spine, when necessary.	*Will meet standard – The Medical Center will establish neurotrauma care that is promptly and continuously available for severe traumatic brain injury and spinal cord injury and for less severe head or injuries to the spine.* *Care will be provided by either* *1) The local neurosurgical group, who has committed to participate with the Medical Center, or* *2) Four contracted neurosurgeons with significant trauma center experience, a letter of commitment is provided in Attachment 9.13.* *Neurotrauma services will occur before designation of the trauma center.* ***Timeline: Natividad Medical Center will implement Neurosurgical services prior to designation and is currently negotiating contracts. Natividad will go live with Neurosurgical coverage no later than 10/1/2014***

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		8-3	The TC must provide a reliable neurotrauma on-call schedule with formally arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed. A published back-up call schedule is ideal, but is not essential when the volume of neurotrauma is low (i.e. - fewer than 25 emergency craniotomy procedures are done within 24 hours of admission per year)	*Will meet standard – The Medical Center will establish reliable neurotrauma on-call schedule with formally arranged contingency plans. This will include a formal back-up call schedule initially. If the neurotrauma volume does not warrant this level of commitment based on ACS standards, alternative coverage plans may be considered. Neurosurgeons on-call will be dedicated to the Medical Center.* *Reliable coverage will be available through either* *1) The local neurosurgical group, who has committed to participate with the Medical Center, or* *2) Four contracted neurosurgeons, a letter of commitment is provided in Attachment 9.13. All have significant experience at Level I and II trauma centers.* *Neurotrauma call schedules will be in place prior to trauma center designation.* ***Timeline: Natividad Medical Center will implement Neurosurgical services prior to designation and is currently negotiating contracts. Natividad will go live with Neurosurgical coverage no later than 10/1/2014***

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		8-5	When neurosurgical consultation is requested, an attending neurosurgeon must be promptly available to the hospital's trauma service.	*Will meet standard – Upon request, a neurosurgeon will be promptly available to Trauma Services based on the on-call schedule provided.* *Consultations will be provided by either* *3) The local neurosurgical group, who has committed to participate with the Medical Center, or* *4) Four contracted neurosurgeons, all with Level I and II trauma center experience; a letter of commitment is provided in Attachment 9.13.* *Neurosurgical consultations will be established prior to trauma center designation.* ***Timeline: Natividad Medical Center will implement Neurosurgical services prior to designation and is currently negotiating contracts. Natividad will go live with Neurosurgical coverage no later than 10/1/2014***
	(D) Available for consultation or consultation and transfer agreement for adult and pediatric trauma patients requiring the following surgical services: 1. burns; 2. cardiothoracic; 3. pediatric 4. reimplantation/microsurgery, and 5. spinal cord injury	8-9	Board certification is essential for neurosurgeons who take trauma call.	*Will meet standard – All neurosurgeons considered for the on-call schedule will be board certified.* ***Timeline: (see 8-1,8-2,8-3,8-5) All contracted neurosurgeons taking trauma call will be board certified.***
		8-10	Qualified neurosurgeons should be regularly involved in the care of head- and spinal cord- injured patients and must be credentialed by the hospital with general neurosurgical privileges.	*Will meet standard – The board certified neurosurgeons who cover call for trauma patients will have documented experience managing traumatic neurologic injuries and will be regularly involved in the management of head and spine injuries. Whichever neurosurgical group is selected, it will be credentialed by the Medical Center with general neurosurgical privileges prior to designation as a trauma center. As an example, the four contract neurosurgeons all have significant experience at Level I and II trauma centers.* ***Time line: (see 8-1,8-2,8-3,8-5)***

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		8-11	The neurosurgery service must participate actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.	*Will meet standard – The neurosurgical service, through the appointed liaison, will participate in all aspects of Trauma Services, including the PIPS program and Trauma Services Improvement Committee.*
		8-12	The neurosurgery representative to the multidisciplinary peer review committee must attend a minimum of 50% of these meetings.	*Will meet standard – All members, including the neurosurgical representative, must attend at least 50 percent of the meetings as required by the Medical Staff Bylaws.* ***Timeline: Standard will be met upon service implementation.***
		8-13	The liaison representative from neurosurgery must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.	*Will meet standard – The neurosurgical liaison will meet or exceed the required trauma-related CME hours as defined by ACS.* ***Timeline: Standard will be met upon service implementation.***
		8-14	The neurosurgeons who take trauma call must have the documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME, or, may meet this requirement by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.	*Will meet standard – The neurosurgeons on the trauma on-call panel will meet or exceed the required trauma-related CME hours or equivalent as defined by ACS.* ***Timeline: Standard will be met upon service implementation.***
		9-6	Orthopaedic team members must have dedicated call at their institution or have an effective back-up call system. If the on-call orthopaedic surgeon is unable to respond promptly, a back-up consultant on-call surgeon must be available.	*Exceeds standard – The on-call schedule includes the 13 orthopaedic surgeons who have all completed board certifications in Orthopaedic Surgery. One is always assigned dedicated call and promptly available to Trauma Services. There are procedures in place should there be a need for a second orthopaedic surgeon consult.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		9-7	An orthopaedic team member must be promptly available in the trauma resuscitation area when consulted by the surgical trauma team leader for multiply injured patients.	*Meets standard – An orthopaedic surgeon is promptly available to the trauma resuscitation area when requested by the trauma surgeon or designee.*
		9-8	The design of the back-up call system is the responsibility of the orthopaedic trauma liaison, but must be approved by the TMD.	*Exceeds standard – The current on-call schedule provides a dedicated orthopaedic surgeon who is not encumbered by call to other hospitals.*
		9-14	Board certification is essential for orthopaedic surgeons who take trauma call in a Level II trauma care facility.	*Exceeds standard – All 13 orthopaedic surgeons have completed board certification and the majority have at least 17 years of experience.*
		9-15	Orthopaedic surgeons must have privileges in general orthopaedic surgery.	*Meets standard – all orthopaedic surgeons have privileges in general orthopaedic surgery.*
		9-16	The liaison representative from orthopaedic surgery must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.	*Will meet standard – The orthopaedic liaison will meet or exceed the required trauma-related CME hours as defined by ACS.* ***Timeline: Natividad Medical Center will ensure that Orthopedic Liaison completes required trauma related CME hours no later than 11/30/2014.***
		9-17	The orthopaedic surgeons who take trauma call must have the documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME, or, may meet this requirement by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.	*Will meet standard – The orthopaedic surgeons on the trauma on-call panel will meet or exceed the required trauma-related CME hours or equivalent as defined by ACS.* ***Timeline: Natividad Medical Center will ensure that Orthopedic Surgeons participating on the trauma call panel complete required trauma related CME hours no later than 11/30/2014. Natividad Medical Center has developed an internal CME program to support trauma education.***
		9-13	The orthopaedic representative to the trauma PIPS program must attend a minimum of 50% of the multidisciplinary peer review meetings.	*Meets standard – All members, including the orthopaedic surgeon representative, must attend at least 50 percent of the meetings as required by the committee bylaws.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
(9)	Qualified non-surgical specialist(s or specialty availability, which shall be available as follows: A. Emergency medicine, in-house and immediately available at all times. This requirement may be fulfilled by supervised senior residents, as defined in Section 100245 of this Chapter, in emergency medicine, 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 specialists in emergency medicine and are board certified in emergency medicine shall not be required by the local EMS agency to complete an advanced trauma life support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialist in a specialty other than emergency medicine. B. Anesthesiology, Level II shall be promptly available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives. This requirement may be	7-1	The emergency department must have a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients.	*Exceeds standard – Craig Walls, MD, PhD, FACEP is the ED Medical Director and a CEP. He is very familiar with trauma as he completed his emergency medicine residency at Johns Hopkins Hospital's Level I trauma center as well as working at Cook County Hospital's Level I trauma center in Chicago. Dr. Walls is actively involved with Trauma Services and uses his experience to improve the trauma program. He is board certified in emergency medicine.* *Dr. Walls is supported by 17 emergency medicine physicians. At least one, usually two, board certified emergency medicine physicians are on duty at all times. To allow these physicians to focus more on critical ED patients, there is a RME® process supported by up to four mid-level providers. This process can diagnose and treat many lesser acute ED patients without utilizing ED beds, freeing up the physicians to immediately care for critically injured patients. RME® is available from 9:00 a.m. until midnight.*
		7-3	Occasionally, emergency physicians cover in-house emergencies. These cases and their frequency must be reviewed by the PIPS program to ensure that this does not adversely affect the care of patients in the emergency department.	*Meets standard – The Medical Center has continuous in-house hospitalist coverage to respond to emergencies thus allowing the ED physician to remain in the ED at all times.* *Though rarely required, any request for an emergency medicine physician to respond to an in-house emergency is captured through a tracking form. The PIPS program reviews this information to ensure that it does not adversely affect the care of ED and trauma patients.*
		7-4	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.	*Exceeds standard – Residents are not used to meet the needs of trauma patients.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
	fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergency situations in trauma patients and of providing any indicated 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. C. Radiology, promptly available; and D. Available for consultation: 1. cardiology; 2. gastroenterology; 3. hematology; 4. infectious diseases; 5. internal medicine; 6. nephrology; 7. neurology 8. pathology; and 9. pulmonary medicine.	7-6	Board certification is essential for emergency physicians who take trauma call.	*Exceeds standard – There are 17 emergency physicians on the medical staff at NMC; 14 are board certified and the remaining three are new residency graduates and active candidates for board certification. Ten of the ED physicians have prior trauma experience including the ED Medical Director.* *All of the emergency medicine physicians have taken ATLS during their careers. Six physicians are current and the remaining have committed to retaking ATLS upon designation. Attachment 9.4 and Exhibit 17 provide a list of the emergency physicians, current schedule, and their curriculum vitae as requested.*
		7-7	Emergency physicians on the call panel must be regularly involved in the care of injured patients	*Exceeds standard – The emergency medicine physicians work an equal number of shifts and are constantly exposed to patients with injuries. The RME® process enables the physicians to spend more time with critically ill and injured patients, while the mid-level providers manage less acute ED patients.*
		7-10	Emergency physicians must participate actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.	*Meets standard – The Emergency Medicine Liaison participates in all aspects of Trauma Services, including the PIPS program and Trauma Services Improvement Committee.*
		7-11	The emergency medicine representative or designee to the multi-disciplinary peer review committee must attend a minimum of 50% of these meetings.	*Meets standard – All members, including the emergency medicine representative, must attend at least 50 percent of the meetings as required by the committee bylaws.*
		7-12	The liaison representative from emergency medicine must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME	*Will meet standard – Craig Walls, MD, PhD, FACEP, the Emergency Medicine Liaison, has accumulated 19 trauma-related CME hours during the last two years. Dr. Walls has committed to meet or exceed the required trauma-related CME hours as defined by ACS.* ***Timeline: Natividad Medical Center will ensure that the EM Liaison completes required trauma related CME hours no later than 12/31/2014.***

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		7-13	The emergency physicians who participate on the trauma team must accrue the documented 16 hours annually or 48 hours in 3 years of trauma-related CME, or participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.	*Will meet standard – The emergency medicine physicians will meet or exceed the required trauma-related CME hours or equivalent as defined by ACS* ***Time line: Natividad Medical Center will ensure that that EM physicians complete required trauma related CME hours no later than 12/31/2014.***
		7-15	Physicians who are certified by boards other than emergency medicine who treat trauma patients in the emergency department are required to have current ATLS status.	*Exceeds standard – All of the emergency medicine physicians are board certified in Emergency Medicine, except for the new residency graduates who are active candidates. In addition, everyone has completed ATLS at some point during their careers. Six physicians are current and the remaining have committed to retaking ATLS upon designation.*
		11-1	Anesthesiology services must be promptly available for emergency operations.	*Exceeds standard – At least one board certified/eligible anesthesiologist is in-house and immediately available 24 hours a day, 7 days a week. CRNAs are utilized to primarily manage the L&D needs, allowing the physicians to focus on critical patients. An anesthesiologist is in the operating suite upon patient arrival or responds to the ED upon request.*
		11-2	Anesthesiology services must be promptly available for airway problems.	*Exceeds standard – At least one board certified/eligible anesthesiologist is in-house and immediately available 24 hours a day, 7 days a week. The Trauma Policies and Procedures document that anesthesiology services are promptly available for airway issues.*
		11-3	An anesthesiologist liaison to the trauma program must be designated.	*Meets standard – Amish Shah, MD is the anesthesiologist liaison. Dr. Shah is board certified in Anesthesiology.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		11-5	When anesthesiology chief residents or CRNAs are used to fulfill availability requirements, the staff anesthesiologist on-call must be advised, promptly available at all times, and present for all operations.	*Exceeds standard – Only anesthesiologists are used to meet this requirement, not residents or CRNAs. However, CRNAs are utilized for less acute anesthesia procedures allowing the physicians to be immediately available for trauma patients.*
		11-7	Anesthesia services must be available 24 hours a day and present for all operations. When local conditions permit, anesthesia providers may take call from outside the hospital.	*Exceeds standard – At least one board certified/eligible anesthesiologist is in-house and immediately available 24 hours a day, 7 days a week. An anesthesiologist is in the operating suite upon patient arrival or responds to the ED upon request.*
		11-8	Without in-house anesthesia services, protocols must be in place to ensure the timely arrival of the anesthesia provider at the bedside at the time of need.	*Exceeds standard – NMC has in-house anesthesia services.*
		11-11	All anesthesiologists taking call must have successfully completed an anesthesiology residency.	*Exceeds standard – All 12 of the anesthesiologists completed anesthesia residencies and 10 are board certified in Anesthesiology, the remaining two are board eligible. The last two are newer residency graduates and active candidates.*
		11-13	The anesthesia representative must participate in the trauma PIPS program.	*Meets standard – Dr. Shah is the Anesthesia Liaison and representative at the trauma PIPS program.*
		11-14	The anesthesiology representative to the trauma program must attend at least 50% of the multidisciplinary peer review meetings.	*Meets standard – All members, including the anesthesia representative, must attend at least 50 percent of the meetings as required by the committee bylaws.*
		11-67	Specialists from internal medicine and pulmonary medicine must be available on staff.	*Meets standard – There are six Internal Medicine physicians on staff, all completed board certifications in Internal Medicine.* *Five physicians comprise the Pulmonary/Critical Care Medicine Department, all completed board certifications in Pulmonary Disease and some accomplished a second board certification in either Critical Care Medicine or Internal Medicine.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		11-68	Specialty consultation for problems related to internal medicine, pulmonary medicine, cardiology, gastroenterology, and infectious disease must be available.	*Meets standard – Internal Medicine, Cardiology, and Gastroenterology have formal call schedules; a copy is available in Attachment 9.2. Consults for pulmonary medicine and infectious disease are available as needed.*
(b) (1)	Radiological service. The radiological service shall have *immediately available* a radiological technician capable of performing plain film and computed tomography imaging. A radiological service shall have the following additional services *promptly available*; A. angiography, and B. ultrasound.	11-28	Radiologists must be promptly available in person or by teleradiology, when requested, for the interpretation of radiographs, performance of complex imaging studies, and interventional procedures	*Exceeds standard – Eleven active radiologists are on staff with at least one in-house from 7:00 a.m. until 7:00 p.m. every day and on-call after hours. All have completed board certifications in Diagnostic Radiology. Teleradiography equipment enables immediate consultation with a contracted radiologist on-call through NightHawk or the NMC radiologist as needed.*
		11-29	Radiological diagnostic information must be communicated in a written form and in a timely manner.	*Exceeds standard – Not only is radiological diagnostic information communicated in a written form and in a timely manner, but the timeliness is also tracked by the Radiology Department. A turnaround time report, including written report completed, is included as Attachment 9.20.*
		11-30	Radiological critical information that is deemed to immediately affect patient care must be verbally communicated to the trauma team.	*Meets standard – There is a procedure in place to verbally report any critical radiology results to the trauma team immediately. This is documented in Exhibit 4.*
		11-31	The preliminary report should be permanently recorded. The final report must accurately reflect the chronology and content of communications with the trauma team, including changes between preliminary and final interpretations	*Meets standard – All radiology reports are permanently recorded. The final report accurately reflects the chronology and content of communications with the trauma team, including changes between preliminary and final interpretations.*
		11-32	Changes in interpretation must be monitored through the PIPS program	*Exceeds standard – Not only are changes in interpretation monitored through the PIPS program, but also through the Radiology Department's internal review process.*
		11-33	At least one radiologist must be appointed as liaison to the trauma program.	*Meets standard – The Medical Center designated, Dr. Gary Falkoff, to serve as the radiologist liaison to Trauma Services. Dr. Falkoff is highly experienced and devoted to the radiologic needs of trauma patients.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		11-34	Participation in the trauma PIPS program process is essential. At a minimum, radiologists should be involved in protocol development and trend analysis that relate to diagnostic imaging.	*Meets standard – The Radiology Department, through the appointed liaison, Dr. Gary Falkoff, participates in all aspects of Trauma Services, including the PIPS program and Trauma Services Improvement Committee. This includes protocol development and trend analysis related to diagnostic imaging at a minimum.*
		11-35	The TC must have 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.	*Meets standard – When a trauma patient requires transfer to radiology, the Trauma Policies and Procedures clearly outline the accompanying personnel, equipment, and supplies for continuous monitoring and possible resuscitation. The trauma team remains with the patient until return to the trauma resuscitation bay or other appropriate disposition, such as OR suite.*
		11-36	Conventional radiography and CT must be available in all TCs 24 hours per day.	*Meets standard – All radiology equipment is located within the Medical Center and available at all times. Additional CT and portable X-ray capacity is being added shortly with two new CT scanners being installed within the next year.*
		11-37	An in-house radiographer is required.	*Exceeds standard – Currently, there is at least one (and up to eight) CT/X-ray technologist in-house at all times. Prior to designation, this will increase to a minimum of two, cross-trained CT/X-ray technologists.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		11-40	Conventional catheter angiography and sonography must be available 24 hours per day.	*Will meet standard – NMC is in the process of adding an angiography suite. It is fully anticipated and scheduled for comprehensive angiography services to be available prior to designation.* ***Timeline: Natividad Medical Center will ensure that conventional catheter angiography will be available 24 hours per day no later than 11/30/2014. Key implementation steps Include:*** 1. ***Mobile angiography Lab onsite no later than June 30 , 2014. Lease already approved by the Board of Supervisors.. Plans for required ancillary construction (power and awnings) will be submitted to Board of Supervisors by 3/1/2014.*** 2. ***We will begin angiography training of our current staff no later than May 1, 2014. Natividad Medical Center will hire per diem staff as necessary to provide training and education of radiology staff. Per diem positions do not require Board of Supervsiors approval. Permanent support and technician positions will be approved by the Board of Supervisors no later than3/1/2014.*** 3. ***24 hour angiography coverage will be instituted no later than 11/30 /2014. Salinas Valley Radiologists are already under contract to provide interventional procedures.*** *Sonography is immediately available to trauma patients through the dedicated ED Sonosite ultrasound machine. The emergency medicine physicians have been utilizing FAST training to perform ultrasound exams for the last five years without having to wait for a technologist. The trauma surgeons are similarly trained in FAST, except Dr. Weinstein, who has committed to taking FAST training prior to designation.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
(2)	Clinical laboratory service. A clinical laboratory service shall have: A. a comprehensive blood bank or access to a community central blood bank; and B. clinical laboratory services immediately available	11-75	Laboratory services must be available 24 hours per day for the standard analyses of blood, urine, and other body fluids, including micro sampling when appropriate, in all levels of trauma care facilities.	*Meets standard – Laboratory services are available 24 hours a day for the standard analyses of blood, urine, and other body fluids, including micro sampling when appropriate.*
		11-76	The blood bank must be capable of blood typing and cross matching to meet the needs of injured patients.	*Exceeds standard – The blood bank is capable of blood typing and cross matching. In addition, two units of uncrossmatched blood are brought to the trauma bay for all Code Trauma activations.*
(3)	Surgical service. A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has: A. operating staff who are promptly available unless operating on trauma patients and back-up personnel who are promptly available; and B. appropriate surgical equipment and supplies as determined by the trauma program medical director.	9-2	Operating rooms must be promptly available to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization and compartment decompression.	*Meets standard – An OR suite is promptly available for trauma surgery. Sufficient resources, including instruments, equipment, OR suites and personnel are readily available for musculoskeletal trauma care. This includes open fracture debridement and stabilization and compartment decompression. The priority of trauma cases is documented in the Trauma Policies and Procedures.*
		9-3	A system must be organized so that semi-urgent musculoskeletal trauma cases can be scheduled without undue delay and at not inappropriate hours that might conflict with more urgent surgery or other elective procedures.	*Meets standard – A system for the scheduling of all OR cases, including trauma, is available within the Trauma Policies and Procedures. It clearly defines how semi-urgent musculoskeletal trauma cases can be scheduled without undue delay and at not inappropriate hours that might conflict with more urgent surgery or other elective procedures.*
		11-17	If the first operating room is occupied, a mechanism for providing additional staff must be in place to staff a second operating room.	*Meets standard – The operating department has a defined process for providing additional staff to support a second OR suite when necessary. Trauma equipment is organized on mobile carts to facilitate trauma cases in any OR suite.*
		11-18	An operating room must be adequately staffed and readily available.	*Meets standard – The OR suites are adequately staffed and readily available at all times. There is at least one board certified/eligible anesthesiologist in-house and immediately available at all times. One or more OR teams are in-house or on-call and promptly available at all times.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		11-20	The operating room must have the essential OR equipment for the patient populations that they serve.	*Will meet standard – The OR suites have the essential equipment needed for trauma surgery, including ligasure, harmonic scalpel, argon beam, Level I Infuser, Bare Hugger, orthopaedic equipment, general, cardiac, thoracic, vascular, and urological equipment, and bypass capabilities. Prior to designation, additional neurosurgical equipment will be acquired to fully complement the neurosurgical service.* *Surgical trays and essential equipment are stored on mobile carts to expedite set up and allow any OR suite to handle trauma surgical cases.* ***Timeline: See attachment A. Board of Supervisors approval is not required.***
		11-21	The TC must have the necessary equipment for craniotomy.	*Will meet standard – The operating department has some, but not all, of the necessary equipment for craniotomies. Prior to designation, all neurosurgical equipment will be purchased as directed by the neurosurgical group.* ***Timeline: See attachment A. Board of Supervisors approval is not required.***
		11-24	The postanesthesia care unit (PACU) with qualified nurses must be available 24 hours per day to provide care for the patient if needed during the recovery phase.	*Exceeds standard – The PACU has qualified nurses available 24 hours a day to provide care for the patient if needed during the recovery phase. All PACU nurses are ACLS and PALS certified.*
		11-45	A surgeon must serve as co-director or director of the ICU and be responsible for setting policies and administration needs related to trauma ICU patients.	*Exceeds standard – The Trauma Medical Director serves as the Surgical Critical Care Medical Director for the ICU. As such, Alex Di Stante, MD, FACS has the responsibility for setting policies and administration needs related to trauma ICU patients. With his fellowship training in surgical critical care at the UCI Medical Center's Level I trauma center, Dr. Di Stante is the appropriate surgeon to serve in this role.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		11-54	The trauma surgeon must be kept informed and concur with major therapeutic and management decisions made by the ICU team.	*Exceeds standard – As per the Trauma Policies and Procedures, the trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team. In addition, the Trauma Medical Director, who is also the Surgical Critical Care Medical Director, is regularly involved in the care of these patients through regular ICU rounding.*
(c) (1) (2) (3)	A Level I or Level II trauma center shall have a basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall: designate an emergency physician to be a member of the trauma team; provide emergency medical services to adult and pediatric patients; and have appropriate adult and pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director.			*Exceeds standard* 1. *A board certified emergency medicine physician is a core member of the trauma team and is always immediately available. Residents and recent emergency medicine residency graduates are not used to satisfy this requirement.* 2. *Board certified (14) or active candidate (3) emergency medicine physicians attend to the care and treatment of all ED adult and pediatric patients. Due to the high volume of pediatric ED patients (roughly 25 percent), there is a high pediatric competency within the ED staff. In addition, all trauma patients under the age of 15 are seen by a pediatrician as requested by the trauma surgeon per the Trauma Policies and Procedures. Pediatric trauma cases requiring a PICU will be transferred pursuant to the transfer agreement with Lucile Packard Children's Hospital, see Attachment 9.10.* 3. *The ED is fully equipped with the necessary equipment and supplies for trauma patients. The Trauma Medical Director and Program Manager have worked with the ED Medical Director and Nurse Manager to ensure all of the resources needed are in place.*
(d)	In addition to the special permit licensing services, a trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code	11-58	A qualified nurse must be available 24 hours per day to provide care during the ICU phase.	*Exceeds standard – Qualified nurses are available 24 hours a day to provide care during the ICU phase. Further, the Trauma Program Manager rounds daily, when possible, on all trauma cases in the ICU.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
	of Regulations, the following approved supplemental services:	11-59	The patient/nurse ratio must not exceed 2:1 for critically ill patients in the ICU.	*Exceeds standard – The ratio of patients to nurses does not exceed 2:1 for critically ill patients in the ICU. The Medical Center ICU has the ability to move to 1:1 staffing, if needed.*
(1)	Intensive Care Service: A. the ICU shall have appropriate equipment and supplies as determined by the physician responsible for the intensive care service and the trauma program medical director; B. The ICU shall have a qualified specialist promptly available to care for trauma patients in the intensive care unit. The qualified specialist may be a resident with two (2) years of training who is supervised by the staff intensivist or attending surgeon who participates in all critical decision making; C. and the qualified specialist in (B) above shall be a member of the trauma team.	11-60	The ICU must have the necessary equipment to monitor and resuscitate patients.	*Meets standard – The ICU has all of the necessary equipment and supplies to support trauma patient care. This includes, but is not limited to, cardiac output monitors, pulmonary function measuring devices, thermal controls, and intracranial pressure monitoring. The dedicated ultrasound unit provides additional capabilities immediately available for the trauma surgeon or intensivists.*
		11-46	The trauma surgeon must remain in charge of directing the care of patients while in the ICU.	*Exceeds standard – As per the Trauma Policies and Procedures, the trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team. In addition, the Trauma Medical Director, who is also the Surgical Critical Care Medical Director, is regularly involved in the care of these patients through regular ICU rounding.*
		11-61	Intracranial pressure monitoring equipment must be available	*Meets standard – Intracranial pressure monitoring equipment and supplies are readily available.*
(2)	Burn Center. This service may be provided through a written transfer agreement with a Burn Center.	B-1	Burn in-house management or transfer	*Meets standard – A written transfer agreement for burn patients is in effect with the Santa Clara Valley Medical Center. NMC has a written transfer agreement already established with this facility. It is available in Attachment 9.7.* *During July 2013, the monthly trauma CME was "Initial Management of Burns." It was taught by a regional burn center director from a Level I trauma center.*
		B-2	Burn stabilization/treatment guidelines	*Meets standard – The Trauma Policies and Procedures contains guidelines for the initial stabilization and treatment of burns.* *During July 2013, the monthly trauma CME was "Initial Management of Burns." It was taught by a regional burn center director from a Level I trauma center.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
(3)	Physical Therapy Service. Physical therapy services to include personnel trained in physical therapy and equipped for acute care of the critically injured patient.	9-1	Physical and occupational therapists and rehabilitation specialists are essential.	*Exceeds standard - All patients receive their physical and occupational therapy and rehabilitation during their acute hospitalization. The Sam Karas Acute Rehabilitation Center at NMC, the only acute Medicare-certified rehabilitation center in Monterey County, is available to patients requiring additional inpatient therapy before returning home. All trauma patients are closely followed throughout the acute Medical Center process and evaluated prior to discharge to an appropriate discharge destination (home, acute rehabilitation, sub-acute, skilled nursing facility, board and care, outpatient, or other post-acute care setting).* *Early rehabilitation assessment of all trauma patients is an important part of optimal trauma patient recovery; all trauma patients admitted to NMC receive an initial evaluation within four hours of request by the trauma team. Once admitted to the unit, a complete assessment of the patient's rehabilitation requirements is generally made within 24 hours and is supervised by two physiatrists who are board certified in Physical Medicine and Rehabilitation and have 47 years of combined experience. Daily medical physician visits ensure medical stability and optimal functional recovery.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		12-2	Physical therapy must be provided.	*Exceeds standard – Upon discharge from acute care and after consultation with patient and family, trauma patients requiring inpatient rehabilitation are moved to NMC's 20-bed acute inpatient rehabilitation unit or an appropriate rehabilitation facility depending on the needs of the patients, where they benefit from an interdisciplinary program geared to their special needs. Along with social work and case management services, this includes a complete range of rehabilitative therapies, including physical, speech, occupational, respiratory, music, recreational and pet therapy. Other specialty services available through consultation or referral are psychiatry, psychiatry, orthotics/prosthetics, swallow assessments, vocational rehabilitation counseling, audiology, learning disabilities education, and pastoral counseling. One-on-one and group therapy sessions help patients reach a high level of functional independence to return home safely and confidently. Most services, including physical therapy, are available on an outpatient basis as well.*
(4)	Rehabilitation Center. Rehabilitation services to include personnel trained in rehabilitation care and equipped for acute care of the critically injured patient. These services may be provided through a written transfer agreement with a rehabilitation center.	9-9	The TCF must provide sufficient resources, including instruments, equipment, and personnel, for modern musculoskeletal trauma care, with readily available operating rooms for musculoskeletal trauma procedures.	*Meets standard – The Medical Center has sufficient resources, including instruments, equipment, operating suites, and personnel readily available for musculoskeletal trauma procedures. The priority of trauma cases within the operating department is documented in the Trauma Policies and Procedures.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		12-1	Rehabilitation services must be available within the hospital's physical facilities or as a freestanding rehabilitation hospital, through a transfer agreement.	*Exceeds standard - All patients receive their physical and occupational therapy and rehabilitation during their acute hospitalization. The Sam Karas Acute Rehabilitation Center at NMC, the only acute Medicare-certified rehabilitation center in Monterey County, is available to patients requiring additional inpatient therapy before returning home. All trauma patients are closely followed throughout the acute Medical Center process and evaluated prior to discharge to an appropriate discharge destination (home, acute rehabilitation, sub-acute, skilled nursing facility, board and care, outpatient, or other post-acute care setting).* *Early rehabilitation assessment of all trauma patients is an important part of optimal trauma patient recovery; all trauma patients admitted to NMC receive an initial evaluation within four hours of request by the trauma team. Once admitted to the unit, a complete assessment of the patient's rehabilitation requirements is generally made within 24 hours and is supervised by two physiatrists who are board certified in Physical Medicine and Rehabilitation and have 47 years of combined experience. Daily medical physician visits ensure medical stability and optimal functional recovery.*
(5)	Respiratory Care Service. Respiratory care services to include personnel trained in respiratory therapy and equipped for acute care of the critically injured patient.	11-70	A respiratory therapist must be available to care for trauma patients 24 hours per day.	*Exceeds standard – Three to four respiratory therapists are in-house and available to care for trauma patients 24 hours a day. In addition, a respiratory therapist is part of the trauma team and responds to all Code Trauma activations as identified in the Trauma Policies and Procedures.*
(6)	Acute hemodialysis capability.	11-73	The facility must have either dialysis capabilities or a transfer agreement in place.	*Exceeds standard – NMC has acute hemodialysis capability in-house.*
(7)	Occupational therapy service. Occupational therapy services to include	12-4	Occupational therapy must be provided.	

State of California, Title 22		American College of Surgeons		Natividad Medical Center
	personnel trained in occupational therapy and equipped for acute care of the critically injured patient.	12-6	Rehabilitation consultation services, occupational therapy, speech therapy, physical therapy, and social services must be available during the acute phase of care (including intensive care).	*Exceeds standard – All patients receive rehabilitation consultation services, occupational therapy, speech therapy, physical therapy, and social services during their acute hospitalization. The Sam Karas Acute Rehabilitation Center at NMC, the only acute Medicare-certified rehabilitation center in Monterey County, is available to patients requiring additional inpatient therapy before returning home. All trauma patients are closely followed throughout the acute care process, including the ICU phase, and evaluated prior to discharge to an appropriate discharge destination (home, acute rehabilitation, sub-acute, skilled nursing facility, board and care, outpatient, or other post-acute care setting).* *Early rehabilitation assessment of all trauma patients is an important part of optimal trauma patient recovery; all trauma patients admitted to NMC receive an initial evaluation within four hours of request by the trauma team. Once admitted to the unit, a complete assessment of the patient's rehabilitation requirements is generally made within 24 hours and is supervised by two physiatrists who are board certified in Physical Medicine and Rehabilitation and have 47 years of combined experience. Daily medical physician visits ensure medical stability and optimal functional recovery.*
(8)	Speech therapy service. Speech therapy services to include personnel trained in speech therapy and equipped for acute care of the critically injured patient.	12-5	Speech therapy must be provided.	*Exceeds standard – Speech therapy is readily available during the acute phase of care through the Sam Karas Acute Rehabilitation Center at NMC, the only acute, Medicare-certified rehabilitation center in Monterey County. All trauma patients are closely followed throughout the inpatient stay and evaluated prior to discharge for an appropriate discharge destination (home, acute rehabilitation, sub-acute, skilled nursing facility, board and care, outpatient, or other post-acute care setting). Speech therapy is available on an outpatient basis as well.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
(9)	Social Service	12-3	Social services must be provided.	*Exceeds standard – As a designated public Safety Net hospital, NMC has unparalleled social services' expertise. The Medical Center never discharges or transfers a patient due to financial status. Three social services staff and three case managers are available during weekdays and promptly available after hours. They have an excelled cadre of referral solutions for chemical dependency, palliative care, victims of violence, DUI arrests, and homeless population. NMC staff has the ability to admit people to board-and-care homes through the County General Assistance Fund, which help ensure follow-up care happens. Furthermore, A MediCal representative is in-house Monday through Friday meeting with patients and enrolling them as needed.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
(e) (1)	A trauma center shall have the following services or programs that do not require a license or special permit. Pediatric Service. In addition to the requirements in Division 5 of Title 22 of the California Code of Regulations, the pediatric service providing in-house pediatric trauma care shall have: A. a pediatric intensive care unit approved by the California State Department of Health Services' California Children Services (CCS); or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care; and B. a multidisciplinary team to manage child abuse and neglect.	2-15	There must be a pediatric emergency department area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma PIPS.	*Meets standard – Due to the large percentage of pediatric ED visits (roughly 25 percent) and sizeable L&D program, the emergency medicine physicians are very competent to assist the trauma surgeons with pediatric trauma care and there is typically a pediatrician in-house. All trauma surgeons are credentialed for pediatric trauma care by the Medical Center's credentialing body. The ED maintains appropriate pediatric resuscitation equipment and area within the ED. Pediatric-specific trauma is reviewed by the PIPS program.* *Pediatricians are promptly available for Trauma Services. Per the Trauma Policies and Procedures, all trauma patients under the age of 15 are seen by a pediatrician as requested by the trauma surgeon. There are currently five active pediatricians with 15 years of experience on average. In addition to general pediatrics, there are two board certified pediatric gastroenterologists and two board certified pediatric cardiologists on the NMC medical staff and available for consults.* *The Medical Center maintains a 12-bed, inpatient pediatric unit. For pediatric ICU needs, there is a transfer agreement in place with Stanford University Hospital/Lucile Packard Children's Hospital; it is contained in Attachment 9.10.*
		2-16	For adult TCs admitting fewer than 100 injured children younger than 15 years, these above listed resources are desirable. These hospitals must, however, review the care of their injured children through their PIPS	*Meets standard – Currently, the Medical Center is admitting fewer than 100 injured children younger than 15 years. It is unknown whether the combined trauma volume of Monterey County will impact this. However, NMC pledges to meet or exceed the ACS pediatric requirements for a Level II adult trauma center. Pediatric-specific trauma is part of the PIPS program review process.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
(2)	Acute spinal cord injury management capability. This service may be provided through a written transfer agreement with a Rehabilitation Center			*Exceeds standard – Comprehensive spinal cord injury management is provided through the Sam Karas Acute Rehabilitation Center at NMC, the only acute, Medicare-certified rehabilitation center in Monterey County. All trauma patients are closely followed throughout the acute care process, including the ICU phase.* *All trauma patients admitted to NMC receive an initial evaluation within four hours of request by the trauma team. Once admitted to the unit, a complete assessment of the patient's rehabilitation requirements is generally made within 24 hours and is supervised by two physiatrists who are board certified in Physical Medicine and Rehabilitation and have 47 years of combined experience. Daily medical physician visits ensure medical stability and optimal functional recovery.*
(3)	Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code;	21-1	The TC must have an established relationship with a recognized organ procurement organization.	*Exceeds standard – The Medical Center not only has a protocol in place to identify potential organ donors, it received a national award in 2008 for its efforts. NMC CCD nurses were invited by One Legacy to work on its 2009 Rose Parade "Stars of Life" float. One Legacy coordinates the organ donation process and the recovery of organs and tissues for transplant. These CCD nurses are members of the NMC team that were recognized by One Legacy with a special award for their excellent work in caring for patients after a declaration of brain death, which resulted in the gift of life to 23 recipients in 2007.*
(4)	An outreach program, to include: A. capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and B. trauma prevention for the general public;	21-2	A written policy must be in place for triggering notification of the Organ Procurement Organization	*Meets standard – A written policy is established for triggering notification of the Organ Procurement Organization; it is available with the Trauma Policies and Procedures.*
		21-4	It is essential that each TC have written protocols defining clinical criteria and confirmatory tests for the diagnosis of brain death.	*Meets standard – The Trauma Policies and Procedures offer written protocols defining clinical criteria and confirmatory tests for the diagnosis of brain death.*
		17-3	All TCs must be involved in prevention activities, some of which	*Exceeds standard – NMC's public education on trauma-related issues is exemplified in its participation*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
			involve public educational activities.	*in the "Every 15 Minutes" program focused on adolescent drunk driving.* *The Trauma Medical Director, Trauma Program Manager, Community Health Education Director, and Medical Center leadership are considering a number of injury-prevention topics. A partial list of the topics is provided below.* ➢ *Horseback Riding Safety* ➢ *Securing Heavy Furniture and Objects* ➢ *DUI Prevention Summit* ➢ *Operation Cease Fire for Gang Violence* ➢ *DUI and Distracted Driver Programs* ➢ *On Point Balance for Senior Fall Prevention* ➢ *AARP Driving Safety Program* ➢ *Coaches Clinic for Youth Sports* ➢ *Helmet Use for Anything with Wheels* ➢ *Senior Fairs* ➢ *Rotary and Kiwanis Club Presentations* *Due to its significant role as a designated public Safety Net hospital and community provider, the Medical Center has a significant campaign for illness-related issues as well. These include prenatal care, immunizations, healthy nutrition and exercising, diabetes initiative, preventive health, health screenings, and many senior programs. Healthcare education is shared through the website as well. There is a catalog of services presented by the NMC Education Department related to eating right, diabetes, weight loss, and events sponsored by the Natividad Medical Foundation. Injury prevention education will follow a similar format and be shared through the website, community fairs, public outreach, and sponsored events.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		18-1	All TCs, regardless of resources, must participate in injury prevention.	*Meets standard – NMC's public education on trauma-related issues is exemplified in its participation in the "Every 15 Minutes" program focused on adolescent drunk driving.* *The Trauma Medical Director, Trauma Program Manager,* Community Health Education Director, *and Medical Center leadership are considering a number of injury-prevention topics. A partial list of the topics is provided below.* ➢ *Horseback Riding Safety* ➢ *Securing Heavy Furniture and Objects* ➢ *DUI Prevention Summit* ➢ *Operation Cease Fire for Gang Violence* ➢ *DUI and Distracted Driver Programs* ➢ *On Point Balance for Senior Fall Prevention* ➢ *AARP Driving Safety Program* ➢ *Coaches Clinic for Youth Sports* ➢ *Helmet Use for Anything with Wheels* ➢ *Senior Fairs* ➢ *Rotary and Kiwanis Club Presentations*
		18-2	A TC must be able to demonstrate evidence of a job description and salary support for a prevention coordinator. The trauma care facility must have a prevention coordinator.	*Will meet standard – Prior to designation as a Level II trauma center, the Medical Center will establish and resource a prevention coordinator position. This coordinator will increase the breadth and depth of injury prevention activities.* ***Timeline: The Trauma Prevention Coordinator job description has been developed. The position will be submitted for Board of Supervisors no later than 3/1/2014. The Trauma Prevention Coordinator position will be filled no later than 11/30/2014.***

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		18-4	[Prevention]The TC must demonstrate collaboration with or participation in national, regional, or state programs.	*Will meet standard – A number of the injury-prevention topics under consideration include partnerships with national, regional, and state programs. Examples include AARP Driving Safety, Rotary and Kiwanis Club presentations, DUI Prevention Summit, and Operation Cease Fire. Trauma Services will continue to identify prevention opportunities that will deliver a local impact.* ***Timeline: See 18-2.***
		18-5	TCs must have a mechanism to identify patients who are problem drinkers.	*Exceeds standard –Social Services is charged with not only identifying substance abuse patients, including alcohol, but also referring them to in and outpatient services. NMC has a history of doing this better than other hospitals due to its Safety Net mentality. It also has access to the County General Assistance Fund to admit homeless patients to board-and-care facilities that helps ensure follow-up care happens.*
(5)	Written interfacility transfer agreements with referring and specialty hospital;	4-1	A mechanism for direct physician to physician contact is essential for arranging patient transfers.	*Exceeds standard – The Medical Center is a regional tertiary center for L&D, NICU, as well as acute rehabilitation. As such, there is an established mechanism for direct physician to physician contact for patient transfers. NMC has pre-existing transfer relationships and agreements with other specialty centers, such as burns and pediatrics, for transferring patients out of NMC. This is documented in Attachments 9.7 and 9.10.*
		4-2	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 and not on the requirements of the patient's specific provider network or the patient's ability to pay (i.e. – payment method is not considered).	*Exceeds standard –As a designated public Safety Net hospital, NMC never discharges or transfers a patient due to financial status or provider network. Furthermore, Social Services works diligently to identify payment solutions for all patients, including trauma cases. A MediCal representative is in-house Monday through Friday meeting with patients and enrolling them as needed.*
(6)	Continuing education. Continuing education in trauma care; and shall be provided for: (A) staff physicians; (B) staff nurses;	17-6	The hospital must provide a mechanism to offer trauma-related education to nurses involved in trauma care.	*Meets standard – NMC makes numerous hours of CE available for nurses, some of which are related to trauma. Good examples of this are the TNCC courses recently taught. There are additional programs, including mock trauma codes, open to all staff*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
	(C) staff allied health personnel; (D)EMS personnel; and (E) other community physicians and health care personnel.			*members. The dedicated ED and Critical Care Educators coordinate mandatory skills testing for all ICU and ED nurses. The Nursing Education Department will work collaboratively with Trauma Services to further increase the amount of trauma-related education to all nursing units and ancillary staff. In addition, all staff completes annual reorientation for key subject areas. For a list of educational classes related to trauma, see Attachment 9.21. It is the responsibility of each department's management staff to audit the required information as part of the nurse's annual evaluation. This review must reveal a minimum of 30 CE hours biannually as well as other required training.* *Future educational opportunities at the Medical Center will include TCAR course for the nursing staff in the telemetry, medical/surgical, and acute rehabilitation units. Additional trauma-specific training will include Advanced Trauma Nursing and other trauma topics related to the care of the trauma patient provided by the Trauma Medical Director, trauma surgeons, and trauma liaisons. As topics are identified using the trauma registry and by request of ancillary departments, they will be added to the CE calendar. The Trauma Medical Director and Trauma Program Manager participate in departmental staff development programs upon request. Topics include an overview of the trauma program and trauma system implementation, traumatic shock, respiratory issues in trauma, maternal trauma, and trauma 101.* *The Medical Center educators work in conjunction with the Trauma Program Manager and the Trauma Medical Director to conduct monthly mock trauma activations. The nature of each mock trauma is based on the areas for improvement noted during the chart review process as well as the multidisciplinary Trauma QRC.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		17-1	All verified TCs must be engaged in public and professional education.	*Exceeds standard – In addition to the professional education described in the prior section (ACS 17-6), NMC's public education on trauma-related issues is exemplified in its participation in the "Every 15 Minutes" program focused on adolescent drunk driving.* *The Trauma Medical Director, Trauma Program Manager, Community Health Education Director, and Medical Center leadership are considering a number of injury-prevention topics. A partial list of the topics is provided below.* ➢ *Horseback Riding Safety* ➢ *Securing Heavy Furniture and Objects* ➢ *DUI Prevention Summit* ➢ *Operation Cease Fire for Gang Violence* ➢ *DUI and Distracted Driver Programs* ➢ *On Point Balance for Senior Fall Prevention* ➢ *AARP Driving Safety Program* ➢ *Coaches Clinic for Youth Sports* ➢ *Helmet Use for Anything with Wheels* ➢ *Senior Fairs* ➢ *Rotary and Kiwanis Club Presentations* *Due to its significant role as a designated public Safety Net hospital and community provider, the Medical Center also has a significant campaign for illness-related issues as well. These include prenatal care, immunizations, healthy nutrition and exercising, diabetes initiative, preventive health, health screenings, and many senior programs. Healthcare education is shared through the website as well. There is a catalog of services presented by the NMC Education Department related to eating right, diabetes, weight loss, and events sponsored by the Natividad Medical Foundation. Injury prevention education will follow a similar format and be shared through the website, community fairs, public outreach, and sponsored events.*
Trauma Center Quality Improvement				

State of California, Title 22		American College of Surgeons		Natividad Medical Center
	Trauma centers of all levels shall have a 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. In addition the process shall include: A detailed audit of all trauma-related deaths, major complications and transfer (including interfacility transfer); A. A multidisciplinary trauma peer review committee that includes all members of the trauma team; B. Participation in the trauma system data management system; C. Participation in the local EMS agency trauma evaluation committee; and, D. A written system in place for patients, parents of minor children who are patients, legal guardian(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child. E. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.	5-11	Trauma programs that admit more than 10% of injured patients to nonsurgical services must demonstrate the appropriateness of that practice through the PIPS process.	*Exceeds standard – Currently, less than 10 percent of injured patients are admitted to a nonsurgical service. However, all trauma cases are reviewed by the Trauma Medical Director, Trauma Program Manager, and the PIPS program.*
		7-8	A representative from the emergency department must participate in the prehospital PIPS program.	*Exceeds standard – Dr. Michael Moeller is an NMC emergency medicine physician and the Medical Center's representative for the County's prehospital PIPS program. Not only does he participate with the Emergency Medical Care Committee (EMCC), but he also represents the interests of all Monterey County emergency departments on the Medical Advisory Committee (MAC).*
		7-9	A designated emergency physician must be available to the trauma director for PIPS issues that occur in the emergency department.	*Meets standard – As the ED liaison to Trauma Services, Dr. Walls is available to the Trauma Medical Director for ED issues identified through the PIPS program.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		8-4	There must be a PIPS review of all neurotrauma patients who are diverted or transferred.	*Will meet standard – While it is the Medical Center's goal to never divert or transfer a trauma case, the PIPS program reviews any trauma diversion or transfer. This review is superficial currently for neurotrauma and will become comprehensive in nature once the Neurosurgical Service is in place. This will occur prior to designation.* ***Timeline: Standard will be met upon service implementation.***
		9-10	The PIPS process must review the appropriateness of the decision to transfer or retain major orthopaedic trauma.	*Meets standard – While it is the Medical Center's goal to never transfer a trauma case, the PIPS program reviews any trauma transfer, including those related to orthopaedics.*
		P-4	Pediatric-specific PI program	*Will meet standard – Prior to designation, Trauma Services will develop a pediatric-specific PI program. It will follow the same guidelines as the PIPS, Trauma Services Improvement and other trauma-related committees.* ***Timeline: PIPs process already in place. Pediatric standard will be met upon service implementation.***
		11-6	The availability of the anesthesia services and the absence of delays in airway control or operations must be documented by the hospital PIPS process.	*Meets standard – The current PIPS program tracks the availability of anesthesia services and the absence of delays in airway control or operations.*
		11-19	If an on-call team is used, availability of the operating room personnel and timeliness of starting operations must be evaluated by the hospital PIPS process and measures implemented to ensure optimal care.	*Meets standard – The PIPS program currently evaluates the current on-call OR team performance to ensure optimal care. To date, this has not been identified as an issue for the optimal care of the injured patient. Anesthesia is in-house and immediately available.*
		11-25	If the availability of the PACU is met by a team on-call from outside the hospital, the availability of the PACU nurses and absences of delays must be documented by the PIPS program.	*Meets standard – The availability of the on-call PACU team is monitored and documented by the PIPS program. Any absences or delays are tracked, discussed, and corrective action plans implemented by the operating department.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		11-26	The PACU must have the necessary equipment to monitor and resuscitate patients, consistent with the process of care designated by the institution and monitored by the PIPS program.	*Meets standard – The PACU has the necessary equipment to monitor and resuscitate patients. It is consistent with the process of care designated by the institution and monitored by the PIPS program.*
		11-27	The PIPS program must, at a minimum, address the need for pulse oximetry, end-tidal carbon dioxide detection, arterial pressure monitoring, pulmonary artery catheterization, patient rewarming, and intracranial pressure monitoring.	*Meets standard – The PIPS program addresses the need for pulse oximetry, end-tidal carbon dioxide detection, arterial pressure monitoring, pulmonary artery catheterization, patient rewarming, intracranial pressure monitoring, and other processes critical to Trauma Services.*
		11-39	If the CT technologist responds from outside the hospital, the PIPS program must document the technologist's response time.	*Exceeds standard – Currently, there is at least one (and up to eight) CT/X-ray technologist in-house at all times. Prior to designation, this will increase to a minimum of two, cross-trained CT/X-ray technologists.*
		11-56	The PIPS program must document that the physician coverage of emergencies in the ICU is available and does not leave the emergency department without appropriate physician coverage.	*Exceeds standard – Emergencies in the ICU are managed by one of three resources,* *1) Medical Director – Weekdays* *2) Internist Group – 24-hour patient care* *3) Hospitalists – 07:00-19:00 & on-call* *The ICU Medical Director is board certified in Pulmonary Medicine and all of the hospitalists are board certified Intensivists. The trauma surgeon is also immediately available for ICU emergencies of trauma patients. It would be unusual for an emergency medicine physician to leave the ED and the event would be flagged and reported to the PIPS program.*
		15-3	The trauma registry must be used to support the PIPS program.	*Exceeds standard – The Trauma One Registry has over three years of trauma data to support the PIPS program.*
		16-2	The PIPS program must be supported by a reliable method of data collection that consistently obtains valid and objective information necessary to identify opportunities for improvement.	*Meets standard – Through the Trauma Policies and Procedures, there is a clearly defined Trauma PIPS program, which includes a reliable method for gathering valid and objective data to identify opportunities for improvement. This process is further supported by the trauma registry, which is audited on a regular basis by the Trauma Program Manager.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		16-4	The performance improvement process of analysis must include multidisciplinary review.	*Meets standard – The Trauma QRC. This multidisciplinary committee is chaired by the Trauma Medical Director and has representatives from Trauma Services (i.e., the core trauma surgeons), physicians who were directly involved in the care of the patient being discussed, and liaisons for orthopaedics, emergency medicine, anesthesia, and radiology.*
		16-5	The performance improvement process of analysis must occur at regular intervals to meet the needs of the program.	*Meets standard – The QRC meets monthly.*
		16-6	The results of analysis in the performance improvement process (peer review committee) must define corrective strategies.	*Meets standard – The results of analysis define corrective strategies. Corrective action or improvement plans are created to address the issue.*
		16-7	The results of analysis and the corrective strategies identified in the PI process (peer review committee) must be documented.	*Meets standard – The results of analysis define corrective strategies, which are documented. In addition, the results of these corrective strategies (e.g., loop closure) are documented.*
		16-8	The trauma program must be empowered to address issues that involve multiple disciplines.	*Meets standard – Through the Trauma Policies and Procedures, the trauma program is empowered to address issues that involve multiple disciplines and to ensure comprehensive evaluation of all aspects of trauma care.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		16-9	The trauma program, including trauma PIPS, should be approved by the hospital governing body as part of its commitment to optimal care of injured patients. This commitment must include adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	*Meets standard – The Board of Trustees, which includes a County Board Supervisor, is fully informed and enthusiastically approved the creation of Trauma Services, including the related programs such as PIPS. They reviewed the feasibility analysis, including comprehensive pro forma and cash flow spreadsheets, before providing a letter of support that is included as Exhibit 2.* *As part of the Board and senior leadership commitment, NMC has hired a Trauma Medical Director, Trauma Program Manager, Trauma Registry Coordinator, and Trauma Administrative Assistant. Senior leadership, including the CEO, meets with trauma and ancillary staff weekly at the Trauma Implementation Committee. The Administrative Assistant to the CMO provides additional support for physician meetings, scheduling of meetings, travel and some clerical.* *The Trauma Services organizational chart in Section 4.4 demonstrates that the trauma staff has direct access and defined lines of authority to the CNO. The Trauma Medical Director reports directly to the CMO.*
		16-14	The TC must be able to demonstrate that the trauma patient population can be identified for separate review regardless of the institutional PIPS process. This is usually done through the trauma registry.	*Exceeds standard – The Trauma One Registry was purchased to specifically demonstrate that the trauma patient population can be identified for separate review. The registry has over three years of trauma data to support the PIPS program. Sample registry reports are available in Exhibit 12.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		16-26	When a consistent problem or inappropriate variation is identified, corrective actions must be taken and documented.	*Meets standard – The Trauma Medical Director is responsible for implementing, maintaining, monitoring, and evaluating the care and service provided by the trauma service. Monitoring activities are administered in accordance with the overall NMC quality assessment and performance improvement plan. Care of the injured patient is continually assessed and evaluated. Important aspects of care that are high volume, high risk, or problem prone are the highest priority for monitoring. The Trauma Medical Director and the Trauma Program Manager are empowered and work closely with department directors/managers and physicians across multiple disciplines to implement actions and solve identified problems. All performance improvement action plans are monitored, evaluated, and re-evaluated for effect and resolution. Corrective actions are documented in action plans and presented to the appropriate committee, department, or service with recommendations for improvement. A response is mandatory and a timeline for corrections required on any significant issue.*
		21-3	The PIPS process must review the organ donation rate.	*Meets standard – The current PIPS program reviews the organ donation rate. Any negative change in the rate prompts a review of organ donation processes for corrective action, including staff education.*
		15-1	Trauma registry data must be collected and analyzed by every trauma care facility. The registry is an essential management tool that contains detailed, reliable, and readily accessible information needed to operate a TCF.	*Exceeds standard – The Trauma One Registry by Lancet was purchased to specifically demonstrate that the trauma patient population can be identified for separate review. The registry has over three years of trauma data to support the PIPS program. Sample registry reports are available in Exhibit 12.*
		15-2	The trauma registry data must be submitted to the National Trauma Data Bank (NTDB).	*Will meet standard – The Medical Center pledges to share trauma registry data with the NTDB as part of designation.*
		15-4	The trauma registry should be concurrent. At a minimum, 80% of the trauma cases must be entered within 60 days of discharge.	*Meets standard - There is more than 36 months of available data in the registry. Data collection and entry is concurrent. NMC pledges to enter all trauma cases within 60 days of discharge and openly share the results with the Monterey County EMS Agency.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		15-5	The trauma program must ensure that appropriate measures are in place to meet the confidentiality requirement of the trauma registry data.	*Meets standard – The trauma registry software is in compliance with the Medical Center's policy for the confidentiality and security of patient information. This includes appropriate measures are in place to assure Health Insurance Portability and Accountability Act (HIPAA) privacy compliance as well.*
		15-6	There must be strategies for monitoring data validity for the trauma registry.	*Meets standard – The Trauma One registry is audited on a regular basis by the Trauma Program Manager.*
		16-19	There must be a trauma 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 improve trauma care by reviewing selected deaths, complications, and sentinel events with the objectives of identification of issues and appropriate responses.	*Will meet standard – There is a multidisciplinary trauma performance improvement and peer review committee, known as the Trauma QRC, which meets every month. This committee is chaired by the Trauma Medical Director and has representatives from Trauma Services (i.e., the core trauma surgeons), physicians who were directly involved in the care of the patient being discussed, and the liaisons for orthopaedics, emergency medicine, anesthesia, and radiology. As soon as a neurosurgical liaison is identified, NMC will fully meet this standard. This will occur prior to designation.* *The committee is charged with improving trauma care by reviewing selected deaths, complications, and sentinel events with the objectives of identification of issues and appropriate responses.* ***Timeline: Committee already in place. Neurosurgery will be added upon service line activation.***
		16-13	Trauma patient care may be evaluated initially by individual specialties within their usual departmental PIPS review structures; however, identified problem trends must undergo multidisciplinary peer review by the Trauma Peer Review Committee.	*Meets standard – Most specialties have individual quality improvement processes within their usual departmental PIPS review structures that may evaluate the care provide to trauma patients. Identified problem trends undergo a multidisciplinary peer review by the Trauma QRC.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		16-25	All deaths must be systematically reviewed, and categorized as preventable, non-preventable, or potentially preventable through a peer review process.	*Meets standard – Per the Trauma Policies and Procedures, all deaths are reviewed at the monthly Trauma QRC meeting and are categorized as preventable, non-preventable, or potentially preventable.*
		16-20	[Multidisciplinary Peer Review Committee] The attendance by the TMD and the specialty representatives is at least 50%.	*Meets standard – All members, including the specialty representatives, must attend at least 50 percent of the meetings as required by the Medical Staff Bylaws.*
		16-1 5-10 6-10	The core general surgeon attendance at the trauma peer review committee is at least 50%.	*Meets standard – All members, including the core general surgeons, must attend at least 50 percent of the meetings as required by the Medical Staff Bylaws.*
		16-22	In circumstances in which attendance is not mandated (non-core members), the TSMD ensures dissemination of information from the trauma peer review committee.	*Meets standard – Minutes are kept for all quality improvement meetings, regardless whether the meeting is mandatory for non-core members; this includes the Trauma QRC. Through the Trauma Program Manager, the Trauma Medical Director ensures the meeting summary and key findings are disseminated via email to all committee members.*
		5-22	The TSMD must ensure and document dissemination of information and findings from the peer review meetings to the non-core surgeons on the trauma call panel.	*Meets standard – Minutes are kept for all quality improvement meetings, including the Trauma QRC. Through the Trauma Program Manager, the Trauma Medical Director ensures the meeting summary and key findings are disseminated via email to all committee members, including the non-core surgeons.*
		16-23	The TSMD must document the dissemination of information from the trauma peer review committee.	*Meets standard – Email records document that meeting summaries, key findings, and corrective action strategies for all meetings, including the trauma peer review committee, are disseminated to all committee members.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		16-24	Evidence of appropriate participation and acceptable attendance must be documented in the PIPS process.	*Meets standard – All committee minutes, including the PIPS program, provide the documented evidence of actual attendance. This information is tracked within a spreadsheet by Trauma Services to monitor compliance and ensure an acceptable level of attendance is maintained. A percentage of attendance is calculated and compared to the minimum percentage set by the committee bylaws for compliance. Any discrepancies are brought to the attention of the Trauma Medical Director, the representative below the standard, and possibly that person's medical director or department manager.*
		16-15	There must be a process to address trauma program operational issues.	*Meets standard – The Trauma Services Improvement Committee meets one to two times per month to discuss the trauma program's operational issues.*
		16-16	Documentation (minutes) must reflect the review of operational issues and, when appropriate, the analysis and proposed corrective actions.	*Meets standard – Minutes from the Trauma Services Improvement Committee meetings reflect the review of operation issues and, when appropriate, the analysis and proposed corrective actions. Corrective actions may include some or all of the following:* ➢ *The implementation/revision of policies, procedures, or processes,* ➢ *The purchase or upgrade of equipment, and* ➢ *The education and training of staff and providers.*
		16-17	The process to address trauma program operational issues must identify problems.	*Meets standard – Trauma Services Improvement Committee members and all staff who have contact with Trauma Services are encouraged to communicate issues to Trauma Services Improvement Committee. The process to identify problems comes by review of all trauma patient care, daily rounding, trauma registry review, and staff development meetings. Employees and physicians are encouraged to contact Trauma Services either via phone, email, or in person.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		16-18	The process to address trauma program operational issues must demonstrate problem resolutions (loop closure).	*Meets standard – Loop closure is complete once the problem has been corrected and the person identifying the issue is informed of the resolution. Loop closure may also include continual monitoring to ensure the problem does not reappear. Follow up on process and operational changes are communicated in writing to the Trauma QRC.*
Interfacility Transfer of Trauma Patients				
(a)	Patients may be transferred between and from trauma centers providing that: (1) any transfer shall be, as determined by the trauma center surgeon of record, medically prudent; and (2) in accordance with local EMS agency interfacility transfer policies.	4-1	A mechanism for direct physician to physician contact is present for arranging patient transfers.	*Exceeds standard – The Medical Center is a regional tertiary center for L&D, NICU, as well as acute rehabilitation. As such, there is an established mechanism for direct physician to physician contact for patient transfers. NMC has pre-existing transfer relationships and agreements with other specialty centers, such as burns and pediatrics, for transferring patients out of NMC. This is documented in Attachments 9.7 and 9.10.*
(b)	Hospitals shall have written transfer agreements with trauma centers. Hospitals shall develop written criteria for consultation and transfer of patients needing a higher level of care.	4-2	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.	*Exceeds standard –As a designated public Safety Net hospital, NMC never discharges or transfers a patient due to financial status or provider network. Furthermore, Social Services works diligently to identify payment solutions for all patients, including trauma cases. A MediCal representative is in-house Monday through Friday meeting with patients and enrolling them as needed.*
(c)	Hospitals which have repatriated trauma patients from a designated trauma center shall provide the information required by the system trauma registry, as specified by local EMS agency policies, to the transferring trauma center for inclusion in the system trauma registry	8-4	There is a PIPS review of all neurotrauma patients who are diverted or transferred.	*Will meet standard – While it is the Medical Center's goal to never divert or transfer a trauma case, the PIPS program reviews any trauma diversion or transfer. This review is superficial currently for neurotrauma and will become comprehensive in nature once the Neurosurgical Service is in place. This will occur prior to designation.* ***Timeline: Committee already in place. Neurosurgery case review will be added upon service line activation.***

State of California, Title 22		American College of Surgeons		Natividad Medical Center
(d)	Hospitals receiving trauma patients shall participate in system and trauma center quality improvement activities for those trauma patients who have been transferred.	8-6	When there is no neurosurgical coverage, the program must have a plan, approved by the trauma director, that determines for which types and severity of neurologic injury patients should remain at the facility.	*Meets standard – The Trauma Medical Director has established a plan for determining which types and severity of neurologic injury patients should remain at the facility. This plan is part of the Trauma Policies and Procedures.* *This standard will not be applicable with the incoming neurosurgical service, which will be fully deployed prior to designation.*
		8-8	Transfer agreements must exist with appropriate Level I and Level II trauma centers.	*Meets standard – NMC has written and fully executed transfer agreements with the trauma centers at not only Santa Clara Valley Medical Center , but also Stanford University Hospital. Copies are available in Attachments 9.7 and 9.10.*
	No Comparable Regulations	1-1	All trauma care facilities (TCFs) must participate in trauma system planning, development, or operation.	*Meets standard – Senior leadership has supported the planning, development, and operation of Monterey County's own trauma system using internal trauma centers. NMC participated in the 2011 trauma feasibility study, which ultimately led to this RFQ process.* *NMC and Trauma Services fully commits to being a partner with the County in the future development and refinement of the trauma system. This will include full access to the NMC trauma registry that may be used to identify coordinated prevention campaigns, prehospital training, and changes to EMS policies.*
		5-2	There must be a current written resolution (reaffirmed every three years) supporting the TCF from the hospital board.	*Meets standard – The Board of Trustees, which includes a County Board Supervisor, is fully informed and enthusiastically supports becoming a trauma center. They reviewed the feasibility analysis, including comprehensive pro forma and cash flow spreadsheets, before providing a letter of support that is included as Exhibit 2. The Board of Trustees is willing to reaffirm this commitment every three years by Board resolution.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		5-3	There must be a current written resolution (reaffirmed every three years) supporting the TCF from the medical staff.	*Exceeds standard – The medical staff is very supportive of the Medical Center becoming the trauma center for Monterey County. As such, a number have written letters pledging their individual departments' support, which are available in Exhibit 11. In addition, the Chief of Surgery statement provided as Attachment 9.12 strongly advocates the strengths of NMC over other options. Lastly, all of the department medical directors have quickly agreed to sign the required "Statements of Commitments to Perform and Fulfill Responsibilities Arising from Designation" document provided in Section 7.* *The medical staff is willing to reaffirm this support every three years through written resolution.*
		11-74	Nutrition support services must be available.	*Meets standard – Nutritional Services is fully committed to meeting the unique dietary needs of every patient, including trauma patients.*
		20-1	TCFs must meet the disaster-related requirements of the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). [AKA:TJC]	*Exceeds standard – As the busiest ED in Monterey County, NMC is a critical partner during any disaster and must meet and exceed the Joint Commission disaster standards. The Medical Center participates in disaster planning drills on a regular basis and constantly tests medical surge through the ED. The Emergency Management Committee is led by the Director of Engineering and Safety, Jim Kari. He utilizes his military background and experience to develop a level of "combat readiness" to the Medical Center's preparedness efforts. NMC completed a HVA with a probability risk matrix to determine planning and exercise priorities. The Medical Center adopted the HICS system several years ago and has a minimum of two planned disaster drills each year that meet or exceed the requirements of Joint Commission. There is a Code Saturation Policy that is tested regularly for decompressing the ED due to influenza, disaster, or other reason. Six recent exercises that tested medical surge included:* ➢ *02/29/12, Contaminated water*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
				➢ *06/15/12, Hazardous material spill* ➢ *10/19/12, Table top exercise* ➢ *11/08/12, Table top exercise* ➢ *11/15/12, Med/health CA exercise* ➢ *01/30/13, Patient surge exercise* *Fortunately, the Medical Center campus was built in 1998 and the entire facility meets SB 1953 earthquake standards for seismic stability. NMC will be available to care and treat Monterey County residents following a major earthquake. Rather than just life safety and critical electrical loads typically protected at other hospitals, the entire Medical Center is connected to an emergency generator that is tested regularly. The ED has a portable tent to increase its capacity as well as permanent decontamination showers and equipment for hazardous material events. NMC is also fortunate to have the County EOC located on the same campus; even if communications are severely affected, the EOC is only 500 feet away. Many department managers have also completed 16 hours of training for Emergency Preparedness and Disaster Management: ICS 100, ICS 200, IS 700, and IS 800. Key personnel have attended additional training including ICS 300 and ICS 400 for larger incident management.*
		20-2	A trauma panel surgeon must participate on the hospital's disaster committee.	*Meets standard – The Trauma Medical Director is part of the Environment of Care Committee, which encompasses the Emergency Management Committee.*
		20-4	TCF must have a hospital disaster plan described in the hospital's policy and procedure manual or equivalent.	*Exceeds standard –In total, there are over 60 emergency response plans. The Emergency Operations, Mass Fatality, and Evacuation Plans as well as Business Continuity Branch Job Action Sheets are provided with Exhibit 23. NMC utilizes the HICS model; many of the incident specific procedures that fall under the all hazards approach are reflected in these plans.* *NMC has the capability to continue operations in the*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
				event of a broad range of emergencies or disasters, ranging from earthquakes and floods to terrorist attacks and pandemics. Emergency supplies of fuel, potable water, food, medical gases, pharmaceuticals, sterilization supplies, and other emergency response supplies and equipment are maintained by the Medical Center. The facility is also the local site of the SNS cache of medical countermeasures for nerve agents. The Medical Center has built-in redundancy for all critical systems and equipment as well as the ability to obtain outside resources quickly. *The Medical Center meets earthquake standards, which fully comply with the requirements set forth in SB 1953. The earthquake joints and other structural features of the buildings allow it to withstand a sizeable earthquake and sustain little, if any, physical damage. In a disaster, NMC is well positioned to continue operations. In an unforeseen emergency of the magnitude that requires all hospitals to work together, NMC would not only support any hospital but also any facility necessary to ensure victims and their families receive the proper care and attention.*
		3-1	The TSMD must be involved in the development of the TCF's bypass protocol.	*Meets standard – The Trauma Medical Director was part of the team that developed the trauma diversion policy. A copy is available in Exhibit 3.*
		3-2	The trauma surgeon must be involved in the decision regarding bypass.	*Exceeds standard – While it is the goal of the Medical Center to never divert a trauma case, the Trauma Medical Director or on-duty trauma surgeon is part of the decision process as described by the trauma diversion policy (Exhibit 3). In addition, the Trauma Program Manager (or designee), Administrator on-call, Nursing Supervisor, and OR Director are part of the process.* *If a trauma diversion occurs, it is reviewed within 24 hours by Trauma Services and further reviewed by the Trauma QRC on the next monthly meeting for the cause analysis and identification of corrective actions.*

State of California, Title 22		American College of Surgeons		Natividad Medical Center
		3-3	The trauma program must participate in the development and improvement of prehospital care protocols and patient safety programs.	*Will meet standard – As a base hospital and busiest ED in Monterey County, NMC is a regular participant in the development and improvement of prehospital care protocols and patient safety programs.* *Moving forward, NMC and Trauma Services fully commit to being a partner with the EMS agency and continuing to support all prehospital needs. This will include full access to the NMC trauma registry that may be used to identify coordinated prevention campaigns, prehospital training, and changes to EMS policies. In addition, Trauma Services staff will teach trauma topics to EMS staff.*
		5-10	The criteria for a graded activation must be clearly defined by the TCF and continuously evaluated by the performance improvement and patient safety program.	*Meets standard – Activation protocols are clearly defined by the Trauma Policies and Procedures. The levels of activation are continuously evaluated by the PIPS program. If a deficiency is noted, the activation criteria within the trauma policy will be updated.*
		6-7	The criteria for the highest level of activation must be clearly defined by the TCF and evaluated by the PIPS program and the patient safety program.	*Meets standard – The criteria for the highest level of activation is clearly defined by the Trauma Policies and Procedures. All levels of activation, including "Code Trauma" (the highest), are continuously evaluated by the PIPS program. If a deficiency is noted, the activation criteria within the trauma policy will be updated.*