

**Facility Designation Criteria - Minimum Critical Elements Summary
DTC2.1**

PURPOSE: As outlined in West Virginia (WV) §64-27-6, standards and criteria for designation as a WV Trauma Center are those standards outlined by American College of Surgeons, Committee on Trauma (ACS-COT) with specific modifications or additions as established by the Office of Emergency Medical Services (OEMS). Six (6) critical elements have been set forth by OEMS and **MUST** be in place and functional at a facility prior to granting initial provisional Trauma Center designation OR in order to maintain Trauma Center designation.

PROCEDURE: Prior to the granting of initial provisional Trauma Center designation OR in order to maintain Trauma Center designation, the following six (6) critical elements **MUST** be in place and functional.

1. **Trauma Center MUST utilize, at a minimum, OEMS Priority 1 (P1) Trauma Team Activation (TTA) criteria.** These criteria were established by State Trauma Advisory Council (STAC). Minimum P1 TTA criteria are:

- a. CONFIRMED blood pressure <90 mmHg at any time in adults or age specific hypotension in children;
- b. Respiratory compromise or in need of an emergent airway;
-Includes intubated patients who are transferred from another facility with ongoing respiratory compromise
- c. Intubated patients transferred from the scene;
- d. Transfer patients from other hospitals receiving blood to maintain vital signs;
- e. Gunshot wounds to abdomen, neck, chest or extremities proximal to the elbow/knee;
- f. Glasgow Coma Score (GCS) < 9 (less than 9) with mechanism attributed to trauma;
- g. Emergency physician discretion.

Note: Facilities which choose to implement a multi-tier TTA/Response may develop their own Priority 2 (P2) TTA criteria.

2. **Trauma Center MUST implement and maintain an active Trauma Performance Improvement (PI) Program.** There must be an active Local Medical Review Committee (LMRC) which meets on a regular basis and no less than bi-monthly (every other month). This committee must actively review, discuss cases and maintain written documentation of their discussion, activity, and loop closure. This written documentation must include attendance, written minutes, and documented activities.

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3. **Trauma Center MUST use State Trauma Registry (STR).** A facility specific Trauma Registry must be continually maintained based on following requirements:
- a. All patients presenting to a facility who meet WV Trauma Registry inclusion criteria must be entered into the registry.
 - b. Trauma Registry patient data entry should be complete within two (2) weeks of patient discharge (to assure data availability for PI activities).
 - c. Trauma Registry patient data entry should be complete (including identification of system issues, morbidity and mortality determinations, and loop closure documentation) within two (2) months of patient discharge.
 - d. Steps must be taken to assure reliable and valid Trauma Registry data.

Note: If Trauma Registry data entry falls outside these guidelines Trauma Center designation will be subject to suspension.

4. **Trauma Center MUST have a functioning organized Trauma Program.** This program must be utilized on a continuous basis and have the following minimum components:
- a. Specific, defined, and identified personnel who respond regularly and routinely to all Trauma Team Activations (TTAs). This includes general surgeon response to P1 TTAs when applicable. The attending surgeon's response to P1 TTAs will be according to expectations established by the ACS-COT (1999, 2000, 2004, 2014) and additional modifications established by OEMS.
 - i. For Level I, II, and III Trauma Centers, it is expected that the trauma surgeon be in the emergency department (ED) upon patient arrival, with adequate notification from the field. For Level I and II centers, the maximum acceptable response time is fifteen (15) minutes. For Level III Trauma Centers, the maximum acceptable response time is thirty (30) minutes.
 - ii. For Level IV Trauma Centers, a resuscitation team will be organized for the severely injured trauma patient. If the Level IV Trauma Center has a surgeon as part of their trauma team response then the surgeon will respond promptly within thirty (30) minutes for the resuscitation of the injured patient.
 - iii. Response time to be tracked from patient arrival or P1 TTA if after patient arrival with an 80% threshold for each trauma surgeon.
 - iv. Trauma surgeon response to P1 TTA should be included in each facility's Trauma Performance Improvement (PI) plan.

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- b. Trauma Program must be supported, both operationally and financially, by the institution and medical staff.
 - c. Trauma Program personnel (Trauma Medical Director, Trauma Program Manager / Trauma Program Coordinator, and Trauma Registrar) must be empowered to carry out their responsibilities.
5. **Trauma Center's Trauma Program MUST include policies which assure patient oriented utilization of resources.** Facilities must have Trauma Program policies in place which assure that physicians, who are on-call for the ED, provide a reasonable amount of service to the Trauma Program to justify liability protection, which they receive as a result of Trauma Center designation. Facility policies must have the following minimum components:
- a. **Level I, II, and III Centers:** ACS-COT specialty coverage guidelines must be followed.
 - b. **Level IV facilities without general surgery, orthopedic surgery, or neurosurgery physicians on staff and taking emergency call:** ACS-COT coverage guidelines must be followed.
 - c. **Level IV facilities with general surgery, orthopedic surgery, and/or neurosurgery physicians on staff and taking emergency call:**

Level IV General Surgery:

- If the facility has at least five (5) general surgeons on staff and taking emergency call, then the facility must have full-time general surgery call coverage for the ED in order for the facility to maintain Trauma Center designation.
- If the facility has less than five (5) general surgeons on staff and taking emergency call, then facility policy must assure each staff physician provides an average of at least seven (7) days of ED call coverage per month in order for the facility to maintain Trauma Center designation. In this situation, policy must assure ED call schedule clearly identifies which days of the month ED coverage by a general surgeon is NOT available and a protocol for management of patients.

Level IV Orthopedic Surgery:

- If the facility has at least five (5) orthopedic surgeons on staff and taking emergency call, then the facility must have full-time orthopedic call coverage for the ED in order for the facility to maintain Trauma Center designation.
- If the facility has less than five (5) orthopedic surgeons on staff and taking emergency call, then facility policy must assure each

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staff physician provides an average of at least seven (7) days of ED call coverage per month in order for the facility to maintain Trauma Center designation. In this situation, policy must assure ED call schedule clearly identifies which days of the month ED coverage by an orthopedic surgeon is NOT available.

Level IV Neurosurgery:

- If the facility has at least five (5) neurosurgeons on staff and taking emergency call, then the facility must have full-time neurosurgery call coverage for the ED in order for the facility to maintain Trauma Center designation.
- If the facility has less than five (5) neurosurgeons on staff and taking emergency call, then facility policy must assure each staff physician provides an average of at least seven (7) days of ED call coverage per month in order for the facility to maintain Trauma Center designation. In this situation, policy must assure ED call schedule clearly identifies which days of the month ED coverage by a neurosurgeon is NOT available.

6. Trauma Center's general surgeons, emergency medicine physicians and general surgery/emergency medicine advanced practice providers (APPs) MUST complete Advanced Trauma Life Support (ATLS) credentialing requirements. These requirements include:

- a. All general surgeons must have successfully completed ATLS provider course at least once.
- b. All emergency medicine physicians must have successfully completed ATLS provider course at least once.
- c. Current ATLS provider verification is required for all emergency medicine physicians who work in the ED and are not board certified through American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM).
- d. Current ATLS provider verification is required for all general surgery and ED advanced practice providers (APPs) that **may** function as a member of the team caring for a trauma team activated patient via assessment, ongoing evaluation and/or interventions. In facilities with single physician ED coverage and expected physician response to an in-house (out of ED) emergency, all ED APPs scheduled for single physician covered periods must demonstrate currency as an ATLS provider.