

The background is a dark blue field filled with various shades of blue gears of different sizes, some overlapping. On the left side, there is a vertical strip with a colorful, abstract, and somewhat pixelated pattern in shades of orange, yellow, and brown.

# STAC ATCC OPERATIONS REPORT

October 27, 2009

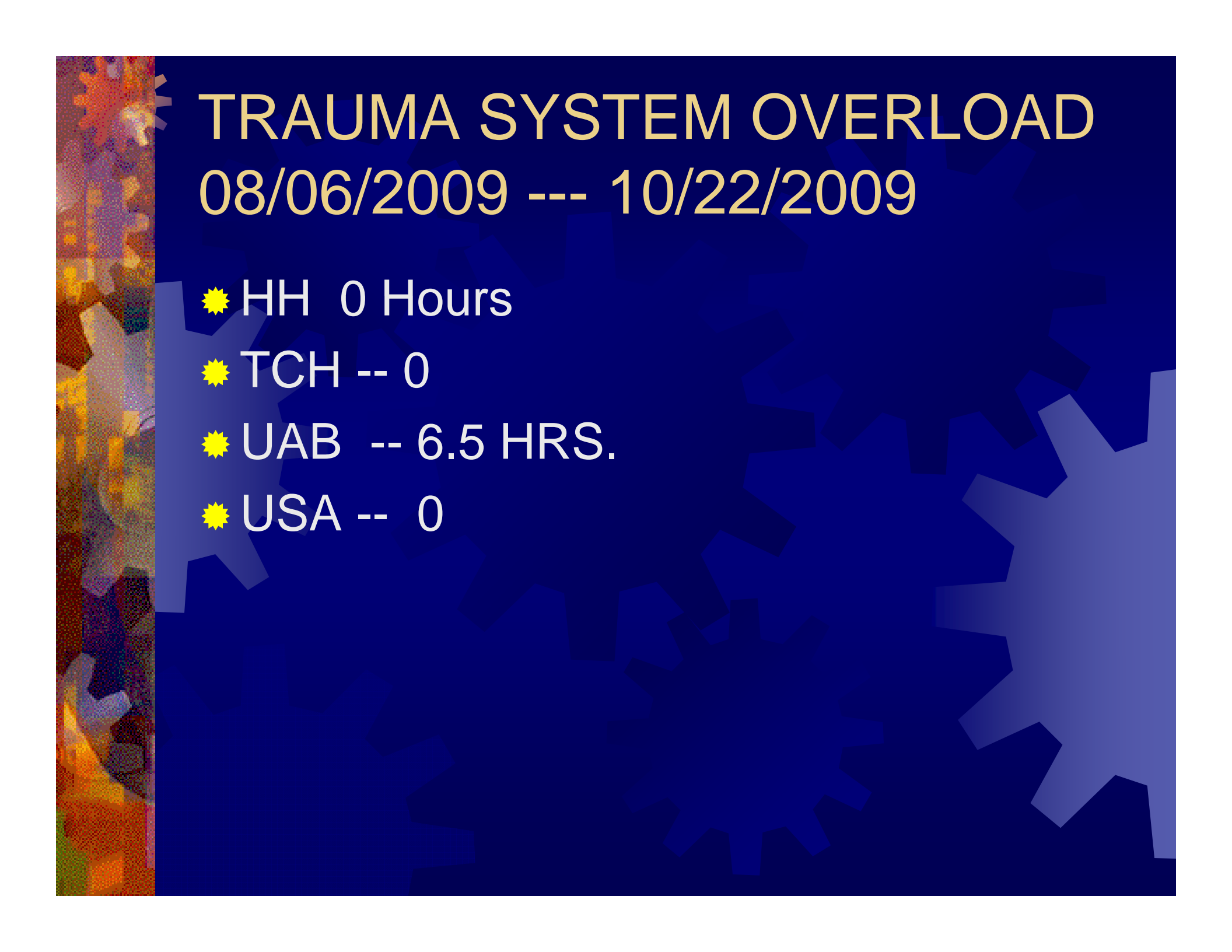
# Trauma System --- Volume --- 08/06/2009 --- 10/22/2009

- ★ Total System Volume –
- ★ NATS 482 --HH 303 ,DGH 21,  
Three's 107 , Erlanger 3 , NMMC 0
- ★ BREMSS 875 – UAB 647, TCH 54,  
Three's 153
- ★ EAST 12, -- Two 6, Three's 6
- ★ GULF 188, -- USA 145 , Three's 34



# TRAUMA SYSTEM VOLUME

- ✱ 10/22/2008 to date 10/22/2009
- ✱ NATS 1748
- ✱ BREMSS 3662
- ✱ 07/08- patients - 3588
- ✱ 06/07 - patients - 3610



# TRAUMA SYSTEM OVERLOAD

08/06/2009 --- 10/22/2009

- ★ HH 0 Hours
- ★ TCH -- 0
- ★ UAB -- 6.5 HRS.
- ★ USA -- 0



# Trauma System --- Overload

## TBO 8/06/2009 10/22/2009

- ★ HH --- 0 Hours
- ★ TCH--- 0 Hours
- ★ UAB --- 46.4 Hours .
- ★ USA --- 0 Hours
- ★ Patients rerouted - 0

# TRAUMA SYSTEM ---- RED

- ★ HH 2.5 Hrs
- ★ TCH – 0
- ★ UAB -- .2
- ★ USA -- 0
- ★ Patients Rerouted – 0

# ANY OTHER REPORTS ?

LifeTrac™ Version 4.0 © 1996- 2008 by LifeTrac Technologies - Observer- Status

Status Patients Bio/Chemical Reports
EPI Disaster About
ALL

Systems **Cardiac, Stroke & Trauma System Resources**

	T	S	C	ED-T	ED	ANES	OR	X-RAY	TICU	TS	SS	OS	NS	CT	SICU	Neuro	CCU	Card	CLab
Brookwood	3	1																	
Carraway	3	1																	
Childrens	1																		
Cooper Green	4																		
St Vincents East	3	1																	
Princeton	3																		
Shelby	3	1																	
St. Vincents																			
Trinity	3																		
UAB Highlands		1																	
UAB Medical West	3																		
University	1																		
VA Bham	4																		
Walker	3	1																	
Athens-Limestone	3																		
Crestwood Med Center	3																		
Cullman Regional	3																		
Decatur General	2																		
Eliza Coffee	3																		
Huntsville Hospital	1																		
Marshall North	3																		
Marshall South	3																		
Parkway Medical	3																		
Russellville Hospital	3																		

System Started: 03/07/2008 08:07:38 03/07/2008 08:09:19

## APPENDIX C

### CONTINUOUS QUALITY IMPROVEMENT

- A. Quality improvement is a vital part of a Trauma System. It is used to document continuing proper function of the system and evaluation of that function to implement improvements in system function and trauma victim management. In a Trauma System patients have virtually no time to make specific choices regarding acute and critical medical care and therefore, the system itself has a moral responsibility to evaluation functions to assure that the highest level of care is being provided and that improvements are implemented whenever possible in a timely manner. All CQI activities are to be provided in compliance with and under the auspices of the ADPH/OEMS&T and this plan is automatically revised when any changes in rules, process or contract is provided.
- B. Such a program is system wide. There is to be individual agency efforts on the part of all participating agencies, plus a Regional Oversight Committee is necessary for overall review of system function. Every participating trauma hospital or organization will be represented on the Regional QI Committee and continuing participation of all the various entities involved in trauma care is mandatory.
- C. The appropriateness, quality, and quantity of all activities of the system must be continuously evaluated.
1. Medical Care
  2. Prehospital care
  3. System function (dispatch activities, scene time, triage process and destination, response level, etc.)
- D. Prehospital Inter-Hospital Care
1. Items evaluated
    - a. patient assessment
    - b. protocol adherence (when applicable)
    - c. procedures initiated/completed
    - d. on-scene time
    - e. medical control interaction
    - f. transport-mode (ground/air)



**Appendix taken from original Trauma Plan**

- g. resource availability/needs match
  - h. arrival report
  - i. record/documentation
  - j. inter-trauma hospital care/transport
2. Process - primarily performed by EMS organizations
- a. Each organization assigns QI person to oversee process
  - b. Standards established - regional/authorized
  - c. Determine audit filters
  - d. Collect data
  - e. Evaluate data
  - f. Determine QI issues present
  - g. Develop corrective action plan
    - 1) professional resolution
    - 2) administrative resolution
  - h. Re-evaluation to document results/effectiveness of corrective action plan
- E. Hospital Care QI inclusive of participation in the statewide trauma registry
- 1. Medical care
    - a. Complications
    - b. Deaths
    - c. Outcome Review
      - 1) internal review
      - 2) external comparison

## Appendix taken from original Trauma Plan

- d. Process for medical care QI (performed by each institution)
  - 1) Establish written care standards
  - 2) Collect data
    - a) trauma data elements
    - b) complications or events lists
  - 3) Data QI evaluation
    - a) establish audit filters (indicators)
    - b) determine presence of potential QI issues
    - c) primary review (permissible)
    - d) multi-disciplinary peer review of QI issue
  - 4) Corrective action
    - a) professional resolution
    - b) administrative resolution
  - 5) Re-assess for effectiveness of corrective action
  - 6) Documentation essential utilizing QI tracking flow sheet
2. Trauma Hospital Function
  - a. Trauma Hospital operations via audit filter review
    - 1) Continuous
    - 2) Intermittent
    - 3) Focused audit filter review
  - b. Specific event evaluation when event problem noted by trauma team member
  - c. Medical nursing audit
  - d. Utilization review

## Appendix taken from original Trauma Plan

- e. Tissue review
  - f. Divert utilization review
  - g. Process same as for Medical Care Review with the addition of some form or method for noting events that occur that need evaluation to try to improve Trauma Hospital functions.
- F. Regional System Function
- 1. Primarily performed by Regional EMS staff QI individual
  - 2. Evaluation of overall Regional System function
  - 3. Process
    - a. Establish standard
    - b. Collect data
    - c. Evaluate data - determine audit filters
    - d. Devise plan of corrective action for QI issues
    - e. Re-evaluate to determine effectiveness of corrective action
    - f. participation on Regional Trauma QI Committee
- G. Regional QI Committees (staffed by BREMSS)
- 1. Goals - review entire Regional Trauma Program
    - a. System administration/organization/activities
    - b. Prehospital care
    - c. Hospital care
  - 2. Members
    - a. ADPH/OEMS&T
      - 1) Regional EMS Off-Line Medical Director
      - 2) Regional EMS Executive Director

## Appendix taken from original Trauma Plan

- 3) Regional EMS Office QI Coordinator
- 4) Regional EMS Office Data Coordinator
- b. Prehospital provider representation - the designated QI coordinator for each county, (from an EMS organization)
- c. Participating hospital representation
  - 1) Trauma Director
  - 2) QI Coordinator
- d. Coroner
3. Process
  - a. Brief report of QI activities from each participating county/EMS organization and hospital
  - b. General system information
  - c. Focused review of items of major concern/impact including selected cases
  - d. Develop consensus of issues that represent QI concerns
  - e. Develop action plan
  - f. Have re-evaluation process to determine effectiveness of action plan results
  - g. Complete documentation of all activities including any recommendations for change or action to the RTAC and the ADPH/OEMS&T.
4. Hospital Medical Care Review Sub-Committee
  - a. Members
    - 1) Trauma Director from each participating Trauma Hospital
    - 2) Emergency Department Medical Director from each active Trauma Hospital
    - 3) Regional EMS Medical Director
    - 4) Coroner/Medical Examiner

## Appendix taken from original Trauma Plan

- 5) Trauma Coordinator from Level I Trauma Hospital as recorder
  - 6) The chairman of this committee will be the chairman of the RTAC.
- b. Activities are to review the trauma medical care issues including specific death audit review and major complications review as determined by the committee chairman. Other CQI issues will be reviewed as deemed appropriate.
  - c. The process used will be the same process as outlined in the CQI Section of the Regional Trauma System Plan.
  - d. Reports of a summary nature will be made to the Regional CQI Committee. Individual physician medical care issues will initially only be reported to the trauma director of the trauma hospital providing care in that situation and be made by personal communication. In general, discussions at the sub-committee meeting will fulfill this notification requirement. If a persistent individual problem trend occurs, this situation will be referred to the appropriate hospital CQI Committee.
5. All members are expected to attend at least 75% of the Regional CQI Committee meetings and the Hospital Medical Care Review

#### IV. DATA/CONTINUING QUALITY IMPROVEMENT COMPONENT

This component is absolutely essential for function of the Trauma System. In virtually any serious trauma/injury situation, the patient has a very limited ability to meaningfully select Prehospital, hospital and physician care. The efficacy of the initial care in these patients may have a pivotal role in determining their outcome. Therefore, there is a system responsibility to evaluate the system function to determine continuing effectiveness in the management of these major trauma victims. The Trauma Plan is designed with this component to be able to generate an overall system-wide trauma database which would provide an overall look at Trauma incidents, significance, care and outcomes, provide information for use in determining and developing trauma teaching programs, provide information able to be used in potential trauma studies, and utilization in evaluation of system function in the CQI Program. **This portion of the trauma plan must remain compliant with STAC and State Board of Health directives, thus this portion of the plan accepts any such changes automatically for all aspects of continuous Quality Improvement.** There are three basic elements of this component. The first is a standard trauma dataset that will be used to establish a regional trauma database at ATCC. The second element is the continuous quality improvement program of the trauma system at ATCC. The third element is the trauma registry data at each hospital. All data from these three data sources is available to ADPH/OEMS&T to use in statewide trauma QI activities.

The Trauma CQI Dataset for Trauma Hospitals is that set forth in ADPH/OEMS&T rules requiring each Trauma Hospital's collection and reporting of data for the trauma registry.

The second entity in this component is the continuous quality improvement (CQI) program for the Trauma System. This program is necessary to the Trauma System to document continuing function and allows the implementation of improvements in a system where the patients may not have the ability to make their own personal medical care choices and depend on the system for adequacy and completeness of care. This program will be system-wide with the individual agencies basically doing their own CQI evaluations and reporting to a regional oversight committee as well as the ADPH/OEMS&T. The appropriateness, quality and quantity of all activities in the system must be continuously monitored in the areas of Prehospital care, medical care of the patients in the Trauma Hospitals and overall system function.

The basic CQI process involves numerous specific steps to be performed by each individual trauma hospital their CQI effort. These steps are:

1. Assignment of a CQI manager to oversee the process in the organization.
2. Develop a written CQI program to evaluate patient care with regard to appropriateness, quality and quantity and as part of that program, patient care

standards are established for use in the evaluation process. For Prehospital programs, this simply may be the regional Prehospital protocol. For Trauma Hospitals this may be a combination of ATLS protocols, plus additional standards as deemed necessary or an individual set of patient care standards (protocols) developed by that hospital. These programs are reviewed and approved by the Regional CQI Committee and the ADPH/OEMS&T and as part of becoming a Trauma System participating Trauma Hospital under the direction/extension of the CQI activities of ADPH/OEMS&T.

3. A method for CQI data collection is established by ADPH/OEMS&T.
4. CQI evaluations are undertaken by the individual system participants - EMS providers or Trauma Hospital hospitals. This first involves the determination of specific audit filters. Mandatory Trauma Hospital audit filters include major and others as may be determined by the ADPH/OEMS&T. Other appropriate audit filters may also be evaluated. For Trauma Hospitals, external outcome comparisons are part of the evaluation process.
5. Determine the presence of CQI issues through the data evaluation process.
6. Discussion of CQI issues at the formal CQI Conference of each individual system participant - EMS provider or Trauma Hospital.
7. Develop a correction action plan. In general, action activities can be placed under the categories of professional resolution or administrative resolution.
8. Re-evaluation must occur to document the results and effectiveness of the corrective action plan. This is commonly called "closing the loop".

Adequate documentation of these activities is essential. In Trauma Hospitals a multi-disciplinary peer review process must occur. In Trauma Hospital CQI programs both medical care and Trauma Hospital function must be evaluated.

The Regional CQI Committee has the goal of review of the entire Regional Trauma Program activities for appropriateness, quality, and quantity of activities and report such to all participants and ADPH/OEMS&T. That review is to include system administration/organization activities, plus Prehospital care and hospital care review. The Regional Committee will document effectiveness of hospital and EMS CQI evaluations through routine reports of these CQI activities provided by each participating trauma hospital to the Regional Committee. The Regional Committee will perform focused review of specific items as determined appropriate, but these reviews will include evaluation of both Prehospital and hospital activities. Death audit review is mandatory. It is expected that most issues will be resolved by developing an action plan in conjunction with the various Trauma System entities. A re-evaluation for results is to be undertaken. If it is determined that a change in system configuration or standard function should occur, a recommendation will be sent to the Regional Trauma Advisory Council (RTAC) for evaluation and report to ADPH/OEMS&T.

## ALABAMA TRAUMA SYSTEM PATIENT ENTRY CRITERIA FOR HOSPITALS

The following are criteria for hospital emergency department medical personnel to enter into the Alabama Trauma System a patient who has been involved in a trauma or burn incident. Any hospital in Alabama may utilize this protocol and is encouraged to use the Alabama Trauma Communications Center (ATCC) to expedite appropriate trauma patient transfer.

**NOTE: THIS IS FOR PATIENTS PRESENTING TO ANY EMERGENCY DEPARTMENT, NOT FOR PATIENTS ALREADY ADMITTED TO A HOSPITAL**

**Physiological criteria present on arrival or develop during evaluation and observation:**

1. A systolic BP < 90 mm/Hg in an adult or child 6 years or older < 80 mm/Hg in a child Less than 6 years old.
2. Respiratory distress - rate < 10 or >29 in adults, or <20 or >60 in a newborn < 20 or > 40 in a child three years or younger <12 or >29 in a child four years or older.
3. Head trauma with Glasgow Coma Scale score of 13 or less or head trauma with any neurologic changes in a child five or younger. The level of trauma center to which this patient would be transferred would depend on regional secondary triage criteria. Generally only GCS scores of 9 or less are triaged to a Level I Trauma Hospital.

**Anatomical Criteria (patient with normal physiologic signs):**

1. The patient has a flail chest.
2. The patient has two or more obvious proximal long bone fractures (humerus, femur).
3. The patient has a penetrating injury of the head, neck, torso, or groin, associated with an energy transfer.
4. The patient has in the same body area a combination of trauma and burns (partial and full thickness) of 15% or greater.
5. The patient has an amputation proximal to the wrist or ankle.
6. The patient has one or more limbs which are paralyzed.
7. The patient has a pelvic fracture demonstrated by x-ray or other imaging technique.
8. Significant internal injuries are found during hospital evaluation and the referring hospital does not have the surgical resources to manage them.

**Mechanism of Injury Criteria (patient with normal physiologic signs):**

**This should not be used as criteria for entering a patient into the trauma system except by hospitals that lack the resources and/or expertise to properly evaluate a patient for internal injuries.** Patients put into the system for this reason could adequately be evaluated by a Level II or Level III trauma hospital.



1. A patient with the same method of restraint and in the same seating area as a dead victim.
2. Ejection of the patient from an enclosed vehicle.
3. Motorcycle/bicycle/ATV crash with the patient being thrown at least ten feet from the motorcycle/bicycle.
4. Auto versus pedestrian with significant impact with the patient thrown, or run over by a vehicle.
5. An unbroken fall of twenty feet or more onto a hard surface. **Unbroken fall of 10 feet or 3 times the height of the child onto a hard surface.**

### **Burn Criteria:**

Indications for entering the patient into the trauma system and transferring to a burn center include the following:

1. Partial thickness burn of greater than 10% of the total body surface area.
2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
3. Third-degree burns in any age group.
4. Electrical burns, including lightning injury.
5. Chemical burns.
6. Inhalation injury.
7. Burn injuries in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
8. Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient's condition may be stabilized initially in a trauma center before transfer to a burn center.
9. **Burned children in hospitals without qualified personnel or equipment for the care of children.**
10. Burn injury in patients who will require special social, emotional, or rehabilitative intervention.

### NOTES:

1. Patients entered into the system for Physiologic criteria may be transferred by calling the Alabama Trauma Communications Center (ATCC) 1-800-359-0123. **Note: hospitals unable to care for these patients should transfer them immediately.**
2. Patients entered into the trauma system for Burn criteria may be transferred by calling the ATCC for availability of appropriate bed (floor vs. ICU) at ready burn center. When availability of a bed is confirmed, the ATCC will connect the transferring physician with the receiving surgeon (if immediately available) at the ready burn center to discuss any stabilization that should be done prior to transfer.
3. Hospitals wishing to enter a patient into the trauma system for Anatomic criteria should call the ATCC who can identify the appropriate ready hospital and can facilitate the transferring physician consulting with a receiving physician to discuss the transfer.

**REGIONAL TRAUMA ADVISORY COMMITTEE (RTAC)  
NORTH REGION (1)**

DR. WILLIAMSON

**AlaHA APPOINTEES**

William Anderson, President/ CEO, Helen Keller Hospital  
4 years

Kim Bryant, CEO, Highlands Medical Center  
3 years

Christine Stewart, CEO, Russellville Medical Center  
2 years

Pam Hudson, CEO, Crestwood Medical Center  
1 year

**MASA APPOINTEES**

Dr. Rony Najjar-Huntsville Hospital      Trauma Surgery  
4 years

Dr. Ginger Bryant-Huntsville Hospital      Orthopedic Surgery  
3 years

Dr. Larry Sullivan-Decatur General      Emergency Medicine  
2 years

Dr. Bill Vermillion- Eliza Coffee      Emergency Medicine  
1 year

**DR. WILLIAMSON APPOINTEE**

Don Webster EMT-P  
HEMSI  
Huntsville  
4 years

**REGIONAL MEDICAL DIRECTOR**

Sherrie Squyres, M.D.      Emergency Medicine  
4 years

**RTAC APPOINTEES BY THE STAC  
HOSPITAL REPRESENTATIVES (14)**

Cary Payne, Administrator-Athens Limestone  
4 years

James Weidner, CEO-Cullman Regional Medical Center  
3 years

Dean Griffin, CEO-Decatur General Hospital  
2 years

~~Carl Bailey~~, **Jody Pigg**, Hospital Director-Eliza Coffee  
1 year

G.F. Naylor CEO-Hartselle Medical Center  
4 years

David Spillers, Administrator - Huntsville Hospital  
3 years

Thomas Dunning, Administrator-Lawrence Baptist  
2 years

Cheryl Hayes, Administrator-Marshall North  
1 year

John Anderson, Administrator-Marshall South  
4 years

Tim McGill, CEO-Parkway Medical  
3 years

Niles Floyd, Administrator-Red Bay Hospital  
2 years

~~Jody Pigg~~, **Kathy Harrison**, Administrator-Shoals Hospital  
1 year

~~James Weidner, CEO-Woodland Medical Center~~  
~~4 years~~

Jeff Rains, Administrator-DeKalb Regional Medical Center  
3 years

**PHYSICIANS (13)**

Rhett Murray, M.D.  
Huntsville  
4 years

Neurosurgery

Joel Pickett, M.D.  
Huntsville  
3 years

Neurosurgery

Randolph Buckner, M.D.  
Decatur General  
2 years

General/Vascular Surgery

James Thomas, M.D.  
Huntsville  
1 year

Emergency Medicine

Daniel Spangler, M.D.  
Florence  
4 years

Emergency Medicine

Stephan Moran, M.D.  
Huntsville  
3 years

Trauma Surgery

Jeff Johnson, M.D.  
Huntsville  
2 years

Emergency Medicine

David Garvey, M.D.  
Huntsville  
1 year

Emergency Medicine

Deepak Katyl, M.D.  
Huntsville  
4 years

Trauma Surgery

Robert Echols, M.D.  
Cullman  
3 years

Emergency Medicine

Michael Samotowka  
Huntsville  
2 years

Trauma Surgery

Scott Warner, M.D.  
Cullman  
1 year

Critical Care/Pulmonary/Emergency  
Medicine

John Markushewski, M.D.  
Huntsville  
4 years

Emergency Medicine

James Gilbert, M.D.  
Huntsville  
3 years

Pediatric Surgery

**PREHOSPITAL EMS REPRESENTATIVES (2)**

Mike West, EMT-P  
Athens Limestone EMS  
4 years

David Gardner, EMT-P  
AirEvac LifeTeam  
3 years

Statewide Trauma Advisory Council Meeting  
October 27, 2009  
The RSA Tower, Suite 1586  
10 a.m.-12 p.m.  
Call in Information# 1-888-776-3766 Enter \*3251726\*

Welcome.....Dr. Williamson

*New member Dr. Richard Gonzalez, USA Medical Center; Mobile, Alabama*

Adoption of August Meeting Minutes.....Dr. Williamson

Unfinished Business

Trauma System Activation Updates for Gulf/East/Southeast Regions.....Dr. Campbell  
Alabama Trauma System Operation Report.....Joe Acker  
Out of State Trauma System Designation Process.....Dr. Campbell  
Trauma Imaging Transmission and Receive.....Dr. Campbell

New Business

Interfacility Transfer process (Stable Patients).....Dr. Campbell  
RTAC Membership Revisions.....Dr. Campbell  
Regional Trauma Plans Revision

Other Issues

Next Meeting.....December 10, 2009

Meeting Adjourn.....12 p.m.

# PATIENT CRITERIA FOR HOSPITALS TO ENTER PATIENTS INTO THE TRAUMA SYSTEM

# THE ALABAMA TRAUMA SYSTEM IS UNIQUE

- NOT ONLY ARE THE TRAUMA HOSPITALS INSPECTED AND CERTIFIED BUT ALSO THEIR CRITICAL RESOURCES ARE CONSTANTLY MONITORED BY COMPUTER AT THE ALABAMA TRAUMA COMMUNICATIONS CENTER (ATCC)
- ONLY PATIENTS WITH LIFE-THREATENING OR POTENTIALLY LIFE-THREATENING INJURIES ARE PUT INTO THE SYSTEM (about 10% of injured patients)
- AMBULANCES ARE DIRECTED TO THE RIGHT TRAUMA CENTER BY A SINGLE COMMUNICATIONS CENTER (ATCC) THAT CAN IMMEDIATELY SEE THE STATUS (**RED - UNAVAILABLE** OR **GREEN - AVAILABLE**) OF EVERY TRAUMA CENTER



# HOW DOES THE SYSTEM WORK?

- THE EMTS IN THE FIELD HAVE BEEN TRAINED IN THE INJURY CRITERIA TO PUT PEOPLE INTO THE TRAUMA SYSTEM
- WHEN THEY FIND A PATIENT THAT MEETS ENTRY CRITERIA THEY CALL THE ATCC AND ENTER THE PATIENT INTO THE SYSTEM
  - EACH PATIENT IS GIVEN A UNIQUE IDENTIFIER NUMBER
  - NAMES ARE NEVER USED
- THE ATCC AND THE EMT DECIDE WHICH READY HOSPITAL WOULD BE RIGHT FOR THE PATIENT USING THE SECONDARY CRITERIA IN THE REGIONAL TRAUMA PLAN AND THE SCREEN SHOWING AVAILABLE TRAUMA CENTERS

	Systems			Trauma, Stroke and Cardiac System Resources																
	T	S	C	ED-T	ED	ANES	OR	X-RAY	TICU	TS	SS	OS	NS	CT	SICU	Neuro	CCU	Card	CLab	
Athens-Limestone	3				█	█	█	█	█	█	█									
Crestwood Med Center	3				█	█	█	█	█	█	█									
Cullman Regional	3				█	█	█	█	█	█	█									
Decatur General	2				█	█	█	█	█	█	█		█							
Eliza Coffee	3				█	█	█	█	█	█	█		█							
Huntsville Hospital	1			█	█	█	█	█	█	█	█	█	█	█						
Marshall North	3				█	█	█	█	█	█	█									
Marshall South	3				█	█	█	█	█	█	█									
Parkway Medical	3				█	█	█	█	█	█	█									
Russellville Hospital	3				█	█	█	█	█	█	█									

WHAT IF THE PATIENT  
COMES BY PRIVATE  
VEHICLE OR THE PATIENT  
COMES BY EMS BUT THE  
EMT DID NOT REALIZE THE  
PATIENT WAS BAD ENOUGH  
TO BE PUT INTO THE  
SYSTEM?

# SCENARIO #1

- You are a community hospital and don't have the resources to care for a trauma patient, or
- You are a trauma center but:
  - You don't have the critical resources needed to take a new patients (are “RED”) or
  - The patient needs a higher level of care than you can provide

IN THIS SITUATION YOU  
SHOULD RAPIDLY EVALUATE  
THE PATIENT TO SEE IF  
HE/SHE MEETS CRITERIA  
FOR A HOSPITAL TO ENTER  
HIM/HER INTO THE SYSTEM

INJURY CRITERIA FOR  
HOSPITAL EMERGENCY  
DEPARTMENT PERSONNEL  
TO ENTER A PATIENT INTO  
THE TRAUMA SYSTEM

**NOTE: THIS CRITERIA IS FOR  
PATIENTS PRESENTING TO ANY  
EMERGENCY DEPARTMENT, NOT  
FOR PATIENTS ALREADY  
ADMITTED TO A HOSPITAL**

**ALL HOSPITALS, NOT JUST TRAUMA  
CENTERS, CAN ENTER PATIENTS INTO THE  
TRAUMA SYSTEM**

- **PHYSIOLOGICAL CRITERIA IS PRESENT ON ARRIVAL OR DEVELOPS DURING EVALUATION**

- A systolic BP < 90 mm/Hg in an adult **or child 6 years or older**
  - < 80 mm/Hg in a child Less than 6 years old.
- Respiratory distress - rate < 10 or >29 in adults, **or**
  - <20 or >60 in a newborn
  - < 20 or > 40 in a child three years or younger
  - <12 or >29 in a child four years or older.
- Head trauma with Glasgow Coma Scale score of 13 or less **or head trauma with any neurologic changes in a child five or younger.**
  - The level of trauma center to which this patient would be transferred would depend on regional secondary triage criteria. Generally only GCS scores of 9 or less are triaged to a Level I Trauma Hospital unless the CT scan reveals intracranial bleeding.



THESE PATIENTS ARE  
GENERALLY TRANSFERRED  
TO A LEVEL ONE TRAUMA  
CENTER IF THEY ARE  
STABLE ENOUGH FOR  
TRANSFER

IN SOME CASES YOUR  
SURGEON MAY HAVE TO  
OPERATE TO CONTROL THE  
BLEEDING IN ORDER TO  
STABILIZE A PATIENT FOR  
TRANSFER

# IF YOU NEED TO TRANSFER THE PATIENT:

- CALL THE ATCC (1-800-359-0123)
- DESCRIBE THE PATIENT'S INJURIES TO THE ATCC (get the ATCC number and place on chart)
- TELL THEM IF YOU DON'T HAVE THE RESOURCES TO CARE FOR THE PATIENT
- THE ATCC WILL TELL YOU THE CLOSEST READY HOSPITAL (GREEN) WITH THE NEEDED RESOURCES
- YOU CAN SEND THEM DIRECTLY THERE
  - YOU DO NOT HAVE TO TALK TO THE RECEIVING SURGEON (THE HOSP HAS SIGNIFIED ACCEPTANCE BY TURNING ITSELF GREEN)
  - THE ATCC CAN HELP ARRANGE TRANSPORT

- **ANATOMIC CRITERIA IS PRESENT ON ARRIVAL OR IS FOUND DURING EVALUATION (STABLE VITAL SIGNS)**

- The patient has a flail chest.
- The patient has two or more obvious proximal long bone fractures (humerus, femur).
- The patient has a penetrating injury of the head, neck, torso, or groin, associated with an energy transfer.
- The patient has in the same body area a combination of trauma and burns (partial and full thickness) of 15% or greater.
- The patient has an amputation proximal to the wrist or ankle.
- The patient has one or more limbs which are paralyzed.
- The patient has a pelvic fracture demonstrated by x-ray or other imaging technique.
- Significant internal injuries are found during hospital evaluation and the referring hospital does not have the surgical resources to manage them.

THESE PATIENTS ARE  
GENERALLY TRANSFERRED  
TO A LEVEL ONE OR LEVEL  
TWO TRAUMA CENTER  
UNLESS THE LEVEL THREE  
TRAUMA CENTER HAS THE  
RESOURCES TO TREAT  
THEM

# IF YOU NEED TO TRANSFER THE PATIENT:

- CALL THE ATCC (1-800-359-0123)
- DESCRIBE THE PATIENT'S INJURIES TO THE ATCC (get the ATCC number and place on chart)
- TELL THEM IF YOU DON'T HAVE THE RESOURCES TO CARE FOR THE PATIENT
- THE ATCC WILL TELL YOU THE CLOSEST READY HOSPITAL (**GREEN**) WITH THE NEEDED RESOURCES
- THE ATCC WILL CONNECT YOU WITH A RECEIVING DOCTOR TO DISCUSS THE PATIENT'S TRANSFER
  - **SINCE THE PATIENT HAS STABLE VITAL SIGNS THE RECEIVING DOCTOR MUST OK THE TRANSFER**
  - **IF THE TRAUMA CENTER REFUSES THE TRANSFER YOU WILL HAVE TO GO THROUGH REGULAR EMTALA TRANSFER PROCEDURES AND NOT THE ATCC**
  - **ALL CONVERSATIONS ARE RECORDED AND ALL TRANSFERS AND REFUSED TRANSFERS ARE REVIEWED BY THE REGIONAL QI COMMITTEE**

- **Burn Criteria:**

- Indications for entering the patient into the trauma system and transferring to a burn center include the following:

- 1. Partial thickness burn of greater than 10% of the total body surface area.
- 2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
- 3. Third-degree burns in any age group.
- 4. Electrical burns, including lightning injury.
- 5. Chemical burns.
- 6. Inhalation injury.
- 7. Burn injuries in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
- 8. Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient's condition may be stabilized initially in a trauma center before transfer to a burn center.
- **9 Burned children in hospitals without qualified personnel or equipment for the care of children.**
- 10. Burn injury in patients who will require special social, emotional, or rehabilitative intervention

# IF YOU NEED TO TRANSFER THE BURN PATIENT:

- CALL THE ATCC (1-800-359-0123)
- DESCRIBE THE PATIENT'S INJURIES TO THE ATCC (get the ATCC number and place on chart)
- TELL THEM IF YOU DON'T HAVE THE RESOURCES TO CARE FOR THE PATIENT
- THE ATCC WILL TELL YOU THE CLOSEST **GREEN** BURN CENTER WITH THE NEEDED RESOURCES
- THE ATCC WILL CONNECT YOU WITH A RECEIVING DOCTOR TO DISCUSS THE PATIENT'S TRANSFER
  - **SINCE THE PATIENT HAS STABLE VITAL SIGNS THE RECEIVING DOCTOR MUST OK THE TRANSFER**
  - **IF THE TRAUMA CENTER REFUSES THE TRANSFER YOU WILL HAVE TO GO THROUGH REGULAR EMTALA TRANSFER PROCEDURES AND NOT THE ATCC**
  - **ALL CONVERSATIONS ARE RECORDED AND ALL TRANSFERS AND REFUSED TRANSFERS ARE REVIEWED BY THE REGIONAL QI COMMITTEE**



MECHANISM OF INJURY AND  
EMERGENCY MEDICINE  
PHYSICIAN DISCRETION ARE  
NOT CONSIDERED REASONS  
FOR TRANSFER OF STABLE  
PATIENTS

IF THE PATIENT IS STABLE  
YOU SHOULD NOT NEED TO  
TRANSFER HIM/HER UNLESS  
YOU FIND AN OCCULT LIFE-  
THREATENING INJURY

SCENARIO #2  
YOU ARE A TRAUMA CENTER  
AND ARE READY FOR A NEW  
PATIENT (STATUS “GREEN”)

IN THIS SITUATION YOU SHOULD RAPIDLY EVALUATE THE PATIENT TO SEE IF HE/SHE MEETS CRITERIA FOR A HOSPITAL TO ENTER HIM/HER INTO THE SYSTEM

- **PHYSIOLOGICAL CRITERIA IS PRESENT ON ARRIVAL OR DEVELOPS DURING EVALUATION**

- A systolic BP < 90 mm/Hg in an adult **or child 6 years or older**
  - < 80 mm/Hg in a child Less than 6 years old.
- Respiratory distress - rate < 10 or >29 in adults, **or**
  - <20 or >60 in a newborn
  - < 20 or > 40 in a child three years or younger
  - <12 or >29 in a child four years or older.
- Head trauma with Glasgow Coma Scale score of 13 or less **or head trauma with any neurologic changes in a child five or younger.**
  - The level of trauma center to which this patient would be transferred would depend on regional secondary triage criteria. Generally only GCS scores of 9 or less are triaged to a Level I Trauma Hospital unless the CT scan reveals intracranial bleeding.

- **ANATOMIC CRITERIA IS PRESENT ON ARRIVAL OR IS FOUND DURING EVALUATION (STABLE VITAL SIGNS)**

- The patient has a flail chest.
- The patient has two or more obvious proximal long bone fractures (humerus, femur).
- The patient has a penetrating injury of the head, neck, torso, or groin, associated with an energy transfer.
- The patient has in the same body area a combination of trauma and burns (partial and full thickness) of 15% or greater.
- The patient has an amputation proximal to the wrist or ankle.
- The patient has one or more limbs which are paralyzed.
- The patient has a pelvic fracture demonstrated by x-ray or other imaging technique.
- Significant internal injuries are found during hospital evaluation.

# IF YOU DON'T NEED TO TRANSFER THE PATIENT:

- CALL THE ATCC (1-800-359-0123)
- DESCRIBE THE PATIENT'S INJURIES TO THE ATCC (get the ATCC number and place on chart)
- TELL THEM YOU HAVE THE RESOURCES TO CARE FOR THE PATIENT AND WILL ADMIT HIM/HER
- **NOTE: IT IS VERY IMPORTANT TO ENTER THE PATIENT INTO THE SYSTEM AND RECORD THE ATCC IDENTIFICATION NUMBER FOR BOTH QI REASONS AND FINANCIAL REASONS**

- **Burn Criteria:**

- Indications for entering the patient into the trauma system and transferring to a burn center include the following:

- 1. Partial thickness burn of greater than 10% of the total body surface area.
- 2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
- 3. Third-degree burns in any age group.
- 4. Electrical burns, including lightning injury.
- 5. Chemical burns.
- 6. Inhalation injury.
- 7. Burn injuries in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
- 8. Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient's condition may be stabilized initially in a trauma center before transfer to a burn center.
- **9 Burned children in hospitals without qualified personnel or equipment for the care of children.**
- 10. Burn injury in patients who will require special social, emotional, or rehabilitative intervention



# IF YOU DON'T NEED TO TRANSFER THE PATIENT:

- **THIS IS UNLIKELY UNLESS YOU ARE A BURN CENTER**
- CALL THE ATCC (1-800-359-0123)
- DESCRIBE THE PATIENT'S INJURIES TO THE ATCC (get the ATCC number and place on chart)
- TELL THEM YOU HAVE THE RESOURCES TO CARE FOR THE PATIENT AND WILL ADMIT HIM/HER
- **NOTE: IT IS VERY IMPORTANT TO ENTER THE PATIENT INTO THE SYSTEM AND RECORD THE ATCC IDENTIFICATION NUMBER FOR BOTH QI REASONS AND FINANCIAL REASONS**

IF THERE ARE QUESTIONS  
YOU MAY CALL ME OR EMAIL ME

JOHN CAMPBELL, MD  
MEDICAL DIRECTOR, EMS &  
TRAUMA

PHONE: 334-206-5383

EMAIL:

[john.campbell@adph.state.al.us](mailto:john.campbell@adph.state.al.us)

## **420-2-2-0--- Trauma Center Designation For Out-of-State Hospitals**

### **(1) Types of Designation.**

#### **(a) Regular Designation For Out-of-State Hospitals That Have Been Inspected and Certified by Their States Using American College of Surgeons (ACS) Level I, II, or III Trauma Center Standards**

A regular designation may be issued by the Board after it has determined that an applicant hospital has been certified by ACS standards at a level of I, II, or III trauma center by the state in which the hospital is located and the hospital is otherwise in substantial compliance with these rules. The designation will be at the same level as certified by the state in which the hospital is located. If the Out-of-State hospital wishes to be certified at a higher level than their state has certified them or if their state did not use ACS standards when certifying them, the hospital must follow the same certification procedure as In-State hospitals.

(b) Provisional Designation. At its discretion, the Board may issue a provisional designation to an applicant hospital that has met all requirements to be designated as a trauma center at the level applied for, with exception to minor deviations from those requirements that do not impact patient care or the operation of a trauma region.

1. The provisional designation may be used for an initial designation or for an interim change in designation status to a lower level due to a trauma center's temporary loss of a component necessary to maintain a higher designation level.
2. A trauma center must submit a written corrective plan and interim operation plan for the provisional designation period including a timeline for corrective action to the Office of EMS and Trauma within 30 days of receiving a provisional designation.
3. A provisional designation shall not extend beyond 15 months.
4. A trauma center may submit a written request to the Office of EMS and Trauma that a provisional designation be removed once all components of its corrective plan have been achieved. Following its receipt of such a request, the Department will conduct a focused survey on the trauma center. A regular designation shall be granted in the event it is confirmed that all components of the corrective plan have been achieved.

**(2) Levels of Designation.** There shall be three levels of trauma center designation. The criteria of each level is set out in Appendix A.

**(3) Application Provision.** In order to become a trauma center, a hospital must submit an application (attached to these rules as Appendix B) and follow the application process provided in paragraph (4) below.

**(4) The Application Process.** To become designated as a trauma center, an applicant hospital and its medical staff shall complete the Department's "Application for Trauma

Center Designation **by Inspection**” or “**Application for Trauma Center Designation by Previous Certification**” An applicant hospital shall submit the completed application via mail or hand delivery to the address listed on the application. Within 30 days of receipt of the application, the Department shall provide written notification to the applicant hospital of the following:

- (a) That the application has been received by the Department;
- (b) Whether the Department accepts or rejects the application for incomplete information;
- (c) If accepted, the date scheduled for hospital inspection **by the Department or an MOU if application is by documented previous certification by ACS standards**;
- (d) If rejected, the reason for rejection and a deadline for submission of a corrected “Application for Trauma Center Designation” to the Department;
- (e) Upon receipt of a completed application **for inspection** by the Department, an application packet containing a pre-inspection questionnaire will be provided to the applicant hospital. The pre-inspection questionnaire must be returned to the Department one month prior to the scheduled inspection.
- (f) The trauma center post-inspection process will proceed as listed below:
  1. The inspection report will be completed two weeks after completion of the inspection.
  2. A State and Regional review of the inspection report and a recommendation for or against designation will be made thirty days after completion of the inspection.
  3. A final decision will be made known to the applicant hospital within x weeks of the completion of the inspection.
  4. Focus visits may be conducted by the Department as needed.

**(5) The Inspection Process.** Each hospital **that applies for designation by inspection by the Department** will receive an onsite inspection to ensure the hospital meets the minimum standards for the desired trauma center designation level as required by these rules. The Department’s Office of EMS and Trauma staff will coordinate the hospital inspection process to include the inspection team and a scheduled time for the inspection. The hospital will receive written notification of the onsite inspection results from the Office of EMS and Trauma.

#### **(6) Designation Certificates.**

- (a) A designation certificate will be issued after an applicant hospital has successfully completed the application and **Alabama** inspection process or **upon application and proper documentation of previous certification by their state using ACS standards**. The

designation certificate issued by the Office of EMS and Trauma shall set forth the name and location of the trauma center, and the type and level of designation. The form of the designation certificate is attached to these rules as Appendix C.

(b) Separate Designations. A separate designation certificate shall be required for each hospital when more than one hospital is operated under the same management.

**(7) Designation Memorandum of Understanding (MOU).**

(a) A designation MOU will be completed after the hospital has produced documentation that the state in which they are located has certified them as a level I, II, or III trauma center using ACS standards or the hospital has successfully completed the application and Alabama inspection process. The designation MOU shall be issued by the Office EMS and Trauma. It shall set forth the name and location of the trauma center and the type and level of designation.

(b) Separate Designation MOUs. A separate designation MOU shall be required for each hospital when more than one hospital is operated under the same management.

(c) The form of the designation MOU is attached to these rules as Appendix D.

**(8) Basis for Denial of a Designation.**

The Department shall deny a hospital application for trauma center designation if the application remains incomplete after an opportunity for correction has been made, or if the applicant hospital has failed to meet the trauma center designation criteria as determined during the inspection.

**(9) Suspension, Modification, and Revocation of a Designation.**

(a) A trauma center's designation may be suspended, modified, or revoked by the Board for an inability or refusal to comply with these rules.

(b) The Board's denial, suspension, modification or revocation of a trauma center designation shall be governed by the Alabama Administrative Procedure Act, §41-22-1, et seq., *Ala. Admin. Code*.

(c) Hearings. Contested case hearings shall be provided in accordance with the Alabama Administrative Procedure Act, §41-22-1, et seq., and the Board's Contested Case Hearing Rules, Chapter 420-1-3, *Ala Admin. Code*.

(d) Informal settlement conferences may be conducted as provided by the Board's Contested Case Hearing Rules, Chapter 420-1-3, *Ala. Admin. Code*.

**Authors:** John Campbell, M.D., and Choona Lang

**Statutory Authority:** *Code of Alabama, 1975, §22-11D-5*

**History:**