

# Alabama Trauma System Region Six Plan



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## **I. Goal of the Alabama Trauma System**

The primary goal of the Alabama Trauma System (ATS) and this Regional Trauma Plan is:

**To administer a system which continues to decrease trauma mortality and morbidity in the seven counties in the Gulf Region and complies with or exceeds all Alabama Department of Public Health Office of Emergency Medical Services (ADPH/OEMS) requirements.**

## **II. Region Six Overview**

This system will operate in Baldwin, Clarke, Conecuh, Escambia (AL), Mobile, Monroe, and Washington Counties.

The ATS requires an oversight authority to meet ADPH requirements, as well as project concept, overall responsibility, developmental aspects, implementation, and evaluation of continuing activities. Such an entity is commonly referred to as a lead agency and, in this plan, the lead agency is the Alabama Gulf Emergency Medical Services System Region Six (Gulf). The authority of this agency is derived from specific activity goals and plans approved by the ADPH/OEMS and the State Board of Health. Participation in the ATS is accomplished as follows:

1. The decision to participate or to continue to participate must be a joint effort between hospital administration and medical staff.
2. Hospital administration and the medical staff will carefully re-evaluate the Regional Trauma Program.
3. A joint decision is made (hospital administration and medical staff) that the hospital wishes to apply to participate, continue participation at the current recognized level, or change its level commensurate with its resource capabilities and the revised approved Trauma Center Designation Criteria.
4. Application is provided by ADPH/OEMS, and returned documenting the hospital's desire to participate or to change level of participation. ADPH/OEMS must have an application on file for each hospital if the hospital is going to participate at the same level.
5. An on-site inspection at each facility requesting a change in status is to be held to review system design and function, and to evaluate the hospital based on the criteria for the requested level. The ADPH/OEMS will perform this inspection.
6. The findings of the inspection will be forwarded to the Regional Advisory Council (RAC). The RAC will review the application and on-site inspection report to document compliance with requirements and provide a report and recommendation to the Statewide Trauma and Health Systems Advisory Council (STHSAC) for consideration.
7. The STHSAC will make recommendations to the ADPH regarding hospital participation as a trauma center in the ATS. If approved, the hospital will become part of the system by executing a Memorandum of Understanding (MOU) with the ADPH documenting their

willingness to actively participate in the ATS and maintain trauma center resources according to its chosen and evaluated level.

### **III. Components and Organization**

Hospitals must decide whether to participate in this system or not based upon ability to meet resource standards for a chosen trauma center level, medical staff desire to participate and support this program, and hospital administration's desire to participate in and support the ATS.

#### **A. Communication Component**

The Alabama Trauma Communication Center (ATCC) is staffed 24 hours a day by personnel with specific in-depth knowledge of ATS design, function, and protocols. It is the primary responsibility of the ATCC to coordinate ATS activities by maintaining and providing information whenever needed, on field status and trauma center status, so this data can be used by the prehospital and trauma center personnel in providing care to patients meeting system entry criteria. The ATCC operates through system operation protocols. The ATCC makes no primary decisions, but provides information about patient management and destination as established by protocols for system function. The ATCC serves as a resource for such protocol information to Emergency Medical Service Providers (EMSP) that may not be familiar with the protocols, or the ATCC may simply provide the direction of prehospital and trauma center resource utilization for trauma management. The ATCC performs the following functions:

1. Assigns unique system I.D. number for each patient meeting system entry criteria for tracking throughout the system.
2. Collects brief patient information.
3. Provides information on system entry criteria based on preset protocols as requested by EMSP, when it is not clear if a patient meets trauma entry criteria.
4. Maintains knowledge of the functional status of all system hospitals at all times.
5. Maintains knowledge of the activity status in the prehospital setting at all times.
6. Coordinates patient destination, when patient meets system entry criteria based on preset protocols as to the closest, currently operational designated trauma hospital.
7. Coordinates resources for optimal utilization using pre-established protocols for system function, when there are multiple simultaneous events in the region.
8. Establishes an automatic communications link between the EMSP and the receiving facility, as requested.
9. Records and enters prehospital data for the ATS database.

In addition to the above functions, in the event of a mass casualty situation, the ATCC would serve as an established vital coordination link between on-site control and all ATS hospital

resources in the region for the most rapid and efficient patient distribution in such circumstances.

## **B. Emergency Response Display (ERD)**

The Emergency Resource Display (ERD) is part of the communication component. The ERD provides each participating hospital and the ATCC with the status display of all trauma centers. Each system hospital will maintain the status notation of the primary trauma resources in that hospital. Trauma centers will be able to change their status and activity level at any time.

## **C. Continuous Quality Assurance (QA)**

The ATS 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, information for use in determining and developing trauma teaching programs, information for use in potential trauma studies, and utilization in evaluation of system function in the QA Program. The basic QA process involves numerous specific steps to be performed by each individual entity. These steps are:

1. Assign a QA manager to oversee the process in the organization.
2. Develop a written QA program to evaluate patient care with regard to appropriateness, quality, and quantity. 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 hospitals, this may be a combination of Advanced Trauma Life Support (ATLS) protocols, plus additional standards as necessary or an individual set of patient care standards (protocols) developed by that hospital. These programs are reviewed and approved by the Regional QA Committee and the ADPH/OEMS, and as part of becoming an ATS participating hospital under the direction/extension of the QA activities of ADPH/OEMS.
3. Establish a method for QA data collection by ADPH/OEMS.
4. Evaluate QA activities undertaken by the individual system participants i.e., EMSP or trauma centers. This first involves the determination of specific audit filters. Mandatory trauma center audit filters include major trauma (Injury Severity Scale greater than 15) and others as may be determined by the ADPH/OEMS. Other appropriate audit filters may also be evaluated. For trauma centers, external outcome comparisons are part of the evaluation process.
5. Determine the presence of QA issues through the data evaluation process.
6. Discuss QA issues at the formal QA conference of each individual system participant (EMSP or trauma center).
7. Develop a corrective action plan. In general, action activities can be placed under the categories of professional resolution or administrative resolution.

8. Re-evaluate to document the results and effectiveness of the corrective action plan. This is commonly called "closing the loop."

#### **D. Regional Advisory Council (RAC)**

The RAC was established by the STHSAC for the purpose of operation of the Regional Trauma Plan and to fulfill the legislative and rules requirements of a statewide trauma system. This is done under the authority of the ADPH/OEMS with action plans developed and recommendations presented. RAC appointments will occur in the following manner:

1. The RAC shall have a minimum of 10 members.
2. Four representatives of hospitals, who shall be appointed by the Board of Trustees of the Alabama Hospital Association. Two of the appointees shall be from hospitals located in urban areas and two shall be from hospitals located in rural areas of the state. At least two of the appointees shall be from hospitals that will be designated as trauma centers.
3. Four representatives who shall be licensed physicians appointed by the Medical Association of the State of Alabama (MASA).
4. One member who shall be a licensed EMSP from the region who shall be appointed by the State Health Officer.
5. The State Health Officer or his designee.
6. Additional members may be appointed pursuant to rules promulgated by the State Board of Health.
7. The Chair and Vice Chair of the RAC shall be elected by the members to serve for 4 years.
8. All members of the council shall be appointed for a term of 4 years, except initial members shall be appointed to terms of from 1 to 4 years and shall serve such staggered terms so that members appointed by the Alabama Hospital Association and MASA may be appointed subsequently each year. The membership of the council shall be inclusive and reflect the racial, gender, geographic, urban/rural, and economic diversity of the state. Vacancies shall be filled in the manner provided for the original appointments. Persons appointed to fill vacancies shall serve the unexpired portions of the terms.
9. The RAC shall meet at least twice a year, but may meet more frequently upon the call of the Chair. The RAC may meet by electronic means and shall establish rules of procedure for its meetings.
10. The RAC may appoint subcommittees and workgroups. Subcommittees shall consist of council members and workgroups may consist of non-council members.
11. All other governance requirements of the RAC shall be established by rule of the State Board of Health.
12. Regional trauma advisory council members shall be entitled to reimbursement for expenses incurred in the performance of their duties at the same rate as state employees.

13. The members shall represent the demographic composition of the state to the extent possible.
14. The State Board of Health may designate the trauma care regions as the regions for planning and coordination of emergency medical and hospital care for other illnesses. The trauma advisory councils shall advise, consult with, and make recommendations on coordination of systems of care by health care centers for other illnesses as may be determined necessary by the State Board of Health.

#### **E. RAC QA Committee Make Up**

The Regional Medical Director and Chair of each RAC will determine and select the RAC QA membership to assure all stakeholders are represented. The Vice-Chair of the RAC is to be the Chair of the RAC QA Committee.

#### **IV. System Operation/Communication**

The ATCC will note the closest hospital for the EMSP and the database. After determination that a patient meets system entry criteria, the highest level EMSP should contact the ATCC at the earliest practical time to enter the patient into the system. The reporting EMSP should identify himself/herself and provide the following information:

1. Basic patient data (number of victims, age, and sex).
2. Injury mechanism data.
3. Major anatomic injuries.
4. Current primary survey status (airway, breathing, circulation, level of consciousness, and vital signs).
5. Incident location.
6. Estimated scene departure time.
7. Proposed mode of transport (if ground, state transporting unit number).

If communication failure should occur, direct contact between the EMS unit and its dispatch should be established with relay of information to the ATCC.

#### **V. Secondary Triage**

Secondary triage involves a determination of the severity status once a decision has already been made that a patient is to be entered into the system (primary triage). Secondary triage is used in conjunction with estimated transport time and current trauma center activity status to determine trauma center destination. The ATCC coordinates the application of the approved secondary triage protocols utilizing the patient assessment, and transport time estimated by the field EMSP combined with the current trauma center activity status, as noted on the ERD to determine the trauma center destination. Secondary triage is based on physiologic status, mechanism of injury, and anatomic



criteria, the potential use of EMSP discretion, and evaluation of co-morbid factors. Secondary triage standards are:

#### **A. Physiological Entry Criteria**

1. Physiologic entry criteria take precedence over other criteria, except Glasgow Coma Score (GCS), even if patients also meet mechanism and/or anatomic criteria.
2. Any patient entered into the system meeting physiologic criteria is to be transported to the closest available Level I trauma center if the total transport time is under 60 minutes. If the Level I trauma center is yellow because of no trauma surgeon (backup surgeon green), the patient should still be taken there unless a closer Level II trauma center is within 20 minutes transport time. If the Level I trauma center is yellow due to neurosurgical services or computed tomography (CT) is red, then transport the patient to the closest Level II trauma center or Level III trauma center enrolled in the trauma system with green neurosurgical services and CT.
3. Any patient with head trauma with a GCS < 9 is to be transported to the closest available Level I trauma center if transport time is < 60 minutes, or the closest available Level II or Level III trauma center if transport time is > 60 minutes. Any patient with head trauma with a GCS ≥ 9 and stable vital signs, or head trauma with any neurologic changes in a child ≤ 5 years of age with stable vital signs, may be transported to the closest Level II or Level III trauma center.
4. In the following situations, the patient should be transported IMMEDIATELY to the closest hospital with full-time emergency physician coverage (trauma center preferably) as coordinated by the ATCC:
  - a. Loss of airway
  - b. Hemodynamic instability (with not vascular access)
  - c. Uncontrolled bleeding (external)

Hospital transfer to an adult or pediatric specialty center can proceed as soon as the patient is stable enough for transport (not necessarily full and complete resuscitation or evaluation/initial care). For expediency, data collection purposes, and adherence to ATS standards, ADPH/OEMS prefers that hospital transfers be directed by the ATCC.

#### **B. Anatomic Entry Criteria – for stable patients (for unstable patients see Physiological Entry Criteria above)**

1. Flail chest
  - a. Closest available Level I if < 60 minutes total transport time
  - b. Closest available Level II or III if > 60 minutes total transport time to Level I
2. Long bone fracture
  - a. Closest available Level I if < 60 minutes total transport time
  - b. Closest available Level II or III if > 60 minutes total transport time to Level I

3. Penetrating trauma to the head, neck, torso, or extremities proximal to the elbow or knee
    - a. Closest available Level I as long as patient remains stable
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I
  4. Combination of trauma and burns (partial and full thickness) of 15 percent or greater
    - a. Closest available Level I with Burn Center as long as patient remains stable
    - b. Closest available Level I or II if > 60 minutes total transport time to Level I with Burn Center
    - c. Closest Level III if > 60 minutes total transport time to Level I or II
  5. Amputation proximal to the wrist or ankle (amputated part recovered and not mangled)
    - a. Closest available Level I with Replantation Service if < 60 minutes total transport time
    - b. Closest available Level I or II without Replantation Service if > 60 minutes total transport time to Level I with Replantation Service
    - c. Closest Level III if > 60 minutes total transport time to Level I or II
  6. Amputation proximal to the wrist or ankle (amputated part NOT recovered or IS mangled)
    - a. Closest available Level I if < 60 minutes total transport time
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I
  7. One or more limbs with acute paralysis
    - a. Closest available Level I if < 60 minutes total transport time
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I
  8. Pelvic fracture, as evidenced by a positive "pelvic movement" exam
    - a. Closest available Level I if < 60 minutes total transport time
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I
  9. Crushed, degloved, mangled, or pulseless extremity
    - a. Closest available Level I if < 60 minutes total transport time
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I
  10. Open or depressed skull fracture
    - a. Closest available Level I if < 60 minutes total transport time
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I
- C. Mechanism of Injury Criteria – for stable patients (for unstable patients see Physiological Entry Criteria above)**
1. A patient with the same method of restraint as a deceased victim

- a. Closest available Level I if < 60 minutes total transport time
  - b. Closest available Level II or III if > 60 minutes total transport time to Level I
2. Ejection from an enclosed vehicle
    - a. Closest available Level I if < 60 minutes total transport time
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I
  3. Motorcycle/bicycle/ATV crash with the patient being thrown at least 10 feet from the motorcycle/bicycle/ ATV
    - a. Closest available Level I if < 60 minutes total transport time
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I
  4. Auto versus pedestrian with significant impact with the patient thrown, or run over by a vehicle
    - a. Closest available Level I if < 60 minutes total transport time
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I
  5. Unbroken fall of 20 feet or more onto a hard surface
    - a. Closest available Level I if < 60 minutes total transport time
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I
  6. Unbroken fall of 10 feet or 3 times the height of the **child** onto a hard surface
    - a. Closest available Level I if < 60 minutes total transport time
    - b. Closest available Level II or III if > 60 minutes total transport time to Level I

**D. EMSP Discretion**

If a patient has been entered into the system and does not meet specific secondary triage criteria or the EMSP has a specific reason to upgrade the triage decision, the EMSP may do so and transport the patient to the closest available Level I, II, or III trauma center if there is less than 60 minutes transport time. The EMSP is to specifically note on the e-PCR the reason for utilization of this discretion process. The EMSP is to specifically inform the ATCC at the time the decision is made using the EMSP discretion criteria.

Any patient entered into the ATS who is stable but has any of the following factors may have a change in protocol-based destination as listed below. Unstable patients follow the unstable physiologic criteria (see A above).

1. < 15 years of age
  - a. Closest available pediatric Level I trauma center if < 60 minutes total transport time
  - b. Closest available Level I or II trauma center if > 60 minutes total transport time to pediatric Level I trauma center

- c. Closest available Level III trauma center if > 60 minutes total transport time to a Level I or II trauma center
2. EMSP's suspicion of severity of trauma/injury may be raised by the following factors:
    - a. Age > 55
    - b. Age < 5
    - c. Environment (hot/cold)
    - d. Patient's previous medical history
    - e. Insulin dependent diabetes or other metabolic disorder
    - f. Bleeding disorder or currently taking anticoagulant medication (e.g., coumadin, heparin)
    - g. COPD/Emphysema
    - h. Renal Failure on dialysis
    - i. Pregnancy
    - j. Child with congenital disorder
    - k. Extrication time > 20 minutes with heavy tools utilized
    - l. Motorcycle crash
    - m. Head trauma with history of more than momentary loss of consciousness

#### *EMSP Discretion Notes*

1. Transport time is the time which the field EMSP estimates considering the mode of transport, weather, traffic, and other variables and incorporates the time from scene departure to hospital arrival.
2. Transport mode (ground versus air) will be determined by the field EMSP. Medical Direction may wish to modify the transport mode.
3. Based on prehospital trauma activity, transport needs, and resource availability, the ATCC will assist in direction of patient destinations as well as ground and air transport between the onsite EMSP, trauma centers, and the helicopter service.
4. Should a hospital destination be changed from the original destination chosen at the time of ATCC contact, a QA will be initiated. A quarterly report of all of these issues will be made to the RAC.

#### **E. Hospital Destination**

Hospital destination will be determined by secondary triage evaluation and the current activity status of hospitals in the system at the time the injury occurs. Trauma centers will usually be either Green (Available), Yellow (Conditional), or Red (unavailable).

Green status means the trauma center has all service line resources available and may receive trauma patients based on location and secondary triage criteria at that time. Green status requirements involve the following:

1. All levels of trauma centers must have the following resources (which are on the ERD grid) active and available at that time as pertains to their trauma center level: emergency department (if Level I), anesthesia, operating room, X-ray, ICU, and orthopedic surgery (orthopedic surgery not required for Level III).
2. For Level I trauma centers, the neurosurgical services and CT must be actively available.
3. The primary call trauma surgeon must be actively available at that time for all levels of trauma center.
4. If a hospital has a secondary surgeon call schedule (backup surgeon), the lack of the primary trauma surgeon will only change the trauma center to "yellow." Yellow status can occur under certain circumstances.

Yellow status means, at that moment, some service line resources are not available and patients should be triaged to that facility only under certain specific conditions. Criteria for yellow status include:

1. A Level I trauma center that does not have neurosurgical services or a CT scanner available.
2. A hospital with a secondary surgeon backup call schedule may be at yellow status if the primary trauma surgeon is unavailable, but the secondary backup surgeon is available. A hospital that does not have a secondary backup surgeon call schedule cannot be at a yellow status based on trauma surgeon availability.

Red status indicates at least some primary trauma care service line resources in that trauma center are not actively available and the hospital is not to receive trauma patients at that time. Red status criteria are:

1. If any of the following resources are unavailable: emergency department (ED-T if Level I), anesthesia, operating room, X-ray, ICU, and orthopedic surgery (Level I).
2. Trauma surgeon is unavailable and there is no secondary surgeon backup call schedule or secondary surgeon is also unavailable.
3. Patients with neurologic injuries will not be triaged to a Level I center with no neurosurgical services or a CT scanner not actively available at that time (neurosurgical services or CT red status).

#### *Hospital Destination Notes*

1. Hospital destination for patients entered into the system will be the closest available appropriate trauma receiving facility based on secondary triage and trauma center availability.
2. When a hospital is on yellow status for the trauma surgeon/secondary backup surgeon status, trauma patients are directed to that hospital only when equivalent facilities are unavailable or beyond the routine 60-minute transport time, or there are multiple casualties requiring care at that level.

3. A yellow status due to the unavailability of neurosurgical services or a CT scanner at a Level I or II facility, means patients with neurologic trauma are to be transported to another facility.
4. No facility should receive more than one unstable patient at one time if there are other Level I trauma centers on green status within a reasonable transport time.
5. In the event a patient or family member requests transport to a specific facility that does not meet system guidelines, efforts will be made to clarify and encourage the advantage of using the ATS and a specific request to follow the established ATS plan will be made of the family. The patient's wishes will, however, ultimately prevail.
6. If an event occurs where there are multiple patients meeting ATS entry criteria, the patient who is most critically injured (yet potentially salvageable) should go to the nearest appropriate green trauma center based on secondary triage criteria. The other patients should go to appropriate green and yellow trauma centers as coordinated through the ATCC.

## **VI. Guidelines**

### **A. Trauma System Overload (TSO)**

1. When USA Health University Hospital (USA) is on TSO, USA will accept all trauma system patients from the scene within Region Six.
2. If USA is on TSO, all hospitals within Region Six will speak directly to the on-call trauma surgeon regarding patient transfer from their facility.
3. If USA is on TSO and a trauma system patient transfer is requested through ATCC, ATCC will link the requesting hospital with the USA Transfer Center and the requesting physician will speak directly to the on-call trauma surgeon regarding patient transfer from their facility.

### **B. Trauma Red**

1. When USA is on Trauma Red status, all trauma patients should be routed to another trauma system hospital per the Region Six Trauma Plan.
2. If USA is on Trauma Red Status and an EMS Provider chooses to transport a trauma system patient to USA, a QA form will be initiated and the recordings will be sent by the ATCC to the AGEMSS Acute Health Systems Director for follow-up.
3. When USA is on Trauma Red status and a trauma system patient transfer is requested directly to the USA Transfer Center, the USA Transfer Center will re-direct the caller to the ATCC where the ATCC will assist the transferring hospital in securing the patient transfer to the most appropriate, available trauma system hospital.

### **C. Pediatric Trauma Destination**

1. A pediatric trauma patient is defined as an age less than 15 years old.

2. All pediatric trauma system patients meeting Physiologic, Anatomic, or Mechanism of Injury criteria that are transported by ground will be taken to USA unless the ground service can transport to a pediatric Level 1 trauma system hospital in 60 minutes.
3. All pediatric trauma patients transported by air will be transported to USA or Ascensions Sacred Heart in Pensacola, FL.

EMSPs entering patients into the ATS will receive their medical direction from the receiving Trauma Center. On scene times should be kept at a minimum. Initiation of transport should occur within 10 minutes in most cases of major trauma.

## **VII. System Compliance, Evaluation, and Action**

### **A. Maintaining System Function**

Failure of compliance with contract performance criteria or requirements, standards, or adherence to system function protocols, as stated in the most current version of the written Region Six Trauma Plan, will result in specific actions to be taken by the RAC. Questions of compliance will be generated by system oversight review by the RAC. Issues regarding a question of compliance, when brought to the attention of RAC, may be directed to the ADPH/OEMS for evaluation. The RAC will evaluate questions of compliance and, if a compliance infraction has occurred, a report will be forwarded to the ADPH/OEMS.

### **B. Prehospital Participation**

The prehospital component requirements, standards, and system function protocols are part of the Regional Medical Control Plan and deviation from that plan may result in the following actions by the ADPH/OEMS:

1. First breach of activity standards will result in a call and letter of explanation to the prehospital service indicating there has been a breach of activity standards with an explanation of the situation and an indication of the need for corrective action to be taken. There will be a 1-month time period for implementation of the corrective action.
2. The second breach of the same activity (or failure to respond to the first breach) will result in another letter to the prehospital service with a copy to the ADPH/OEMS indicating that a second breach has occurred and again allowing a 1-month period for corrective action.
3. A third breach of the same activity will result in investigation and action by the OEMS. The OEMS will send a report of findings and action to the RAC.

### C. Hospital Participation

Hospital participation in the system is governed by the contract between the ADPH/OEMS and each hospital. Deviations from requirements, standards, or system function protocols governed by the contract may result in the following actions by the ADPH/OEMS upon the advice of the RAC:

1. The first breach of an activity standard will result in a call and/or letter of explanation indicating there has been a breach of an activity standard with an explanation and an indication that there is a need for corrective action. A 1-month period for corrective action implementation will be allowed.
2. If a second breach of the same activity occurs a letter to the responsible entity indicating that a second breach has occurred with a warning that a third breach in that activity standard will result in suspension from the ATS for a 30-day period of time. A 1-month period for corrective action implementation will occur.
3. A third breach of the same activity will result in contract failure and suspension of that facility from the ATS for a period of 30 days as by decision of the RAC with the suspension time doubled for subsequent deviations of the same standard. It will be the duty of the ADPH/OEMS to carry out these predetermined actions in cases of violation of requirements, standards, or failure of adherence to system function protocols.

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The patient care guidelines contained in this document are not intended to be an inflexible, mandatory plan of treatment and are not substitutes for independent clinical judgment with respect to the care and treatment of individual. It is understood by the hospital that all care is individualized based upon the patient's current condition, assessment, and the clinical judgment of the health care provider.