

Statewide Trauma Advisory Council Teleconference

March 23, 2009

10:00 a.m. – 12:00 p.m.

Alabama Department of Public Health
The RSA Tower, Suite 1554
Montgomery, Alabama

Members Present	Dr. Loring Rue, Dr. John Mark Vermillion, Dr. Rony Najjar, Dr. Alzo Preyear, Ms. Beth Anderson, Mr. Bryan Kindred, Dr. John Campbell, Dr. Donald Williamson
Member Absent	Mr. Gary Gore
Staff Present	Choona Lang, Verla Thomas, Tammie Yeldell, Robin Moore, Brian Hale, Dr. William Crawford
Guest	Joe Acker, David Garmon, Danne Howard, Denise Louthain, John Blue, Dr. Sherry Melton

Welcome

Dr. Williamson called the meeting to order with a welcome and roll call.

Consideration of Minutes of December 3, 2008

The Council recommended approval of the minutes of December 3, 2008, as distributed; the motion carried unanimously.

New Member

John Rainey, CEO of Wiregrass Medical Center, will replace Allen Foster CEO of Mizell Memorial Hospital, on the Statewide Trauma Advisory Council (STAC).

Rehab Transfer Procedure

Hospitals cannot get patients transferred on the weekend to rehab hospitals. The self-pay patients are more difficult to transfer than patients who have insurance coverage. Dr. Campbell and Danne Howard will coordinate an informal workgroup of STAC members and rehab facility personnel to discuss the rehab transfer issues.

DeKalb County/Regional Trauma Advisory Council (RTAC) Membership Adjustment

DeKalb County moved from Region 2 to Region 1. Dr. Steve Isbell and Peter Selman, CEO, were changed from Region 2 to Region 1.

X-ray Pack Update

Joe Acker reviewed the problems related to hospital transfers of trauma patients (and other patients) and how frequently the CDs containing the imaging studies of the transferred patients cannot be opened by the receiving hospital. This requires the receiving hospital to repeat the procedures which results in delays, increased costs, and more x-ray exposure for the patients. The X-ray Pack is an internet based software solution that translates any form of digitalized image into a form that can be opened by any hospital. The MASA-appointed physicians on the STAC strongly supported the X-ray Pack which they felt would provide an important contribution to improved patient care as well as to enhanced capabilities of a statewide trauma system. The cost of the system would be about \$140,000 initially with any ongoing yearly cost of about \$20,000. Currently, there are no funds to purchase such a system, but Dr. Williamson will look into the possibility of Stimulus Funds for such a project. Joe will request input for several radiologists and will generate a report to share with the STAC before the next meeting.

Trauma System Update

Dr. Campbell gave a brief update on the Trauma System planning and implementation activities.

New Business

Gulf Region RTAC Revision

The Council recommended approval of changes made to the Gulf Region RTAC, as distributed; the motion carried unanimously.

Trauma Center Designation Revision Recommendation

Dr. Campbell is working on a recommended revision to the hospital criteria for the Trauma System. Currently the criteria does not state that a surgeon is required for the facility to be a Level III in the Trauma System. This issue must be corrected. During Dr. Campbell's review of the hospital criteria, he found several other things that could also be stated more clearly. Dr. Campbell has sent the draft document to the physicians on the STAC for their review and will then send it to the entire advisory council before the next STAC meeting.

University of South Alabama (USA) Evaluation Report

Dr. Najjar and Dr. Crawford gave a brief summary of the on-site survey visit to USA in Mobile, Alabama. The Gulf RTAC recommended that USA be approved as a Level I Trauma Center, by STAC.

The Council recommended approval of USA as a Level I Trauma Center for the Gulf Region as distributed; the motion carried unanimously.

Office EMS & Trauma and Mrs. Beth Anderson will coordinate a press release pertaining to the designation of USA as a Level I Trauma Center.

Alabama Trauma System QI/Status Report

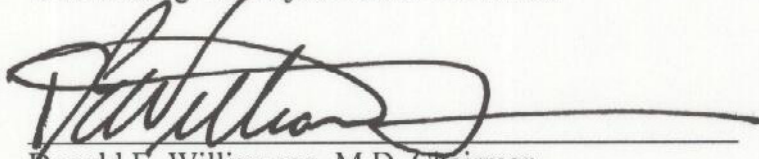
Joe Acker gave a brief update of the Trauma System from December 2, 2008, through March 19, 2009.

Update on Trauma Funding

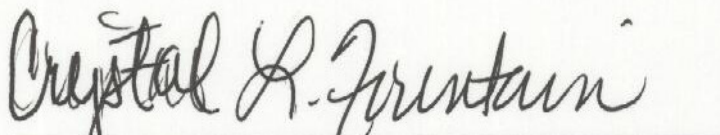
The date of the Physician Trauma Funding Workgroup is to be announced.

The next STAC Meeting is scheduled at 10 a.m. on April 24, The RSA Tower, Suite 1586; 201 Monroe Street; Montgomery, Alabama.

The meeting was adjourned at 11:00 a.m.



Donald E. Williamson, M.D. Chairman
Statewide Trauma Advisory Council



Crystal L. Fountain, Administrative Assistant II
Statewide Trauma Advisory Council

Approved April 24, 2009

**REGIONAL TRAUMA ADVISORY COMMITTEE (RTAC)
GULF REGION (6)**

Dr. Donald Williamson **State Health Officer**

AlaHA APPOINTEES

Mr. Chris Griffin **D.W. McMillan Memorial Hospital**

Mr. Phil Cusa **Thomas Hospital**

Ms. Becky DeVillier **USA Children's & Women's Hospital**

Mr. Alan Whaley Mobile Infirmery Medical Center Replaced by Dr. Kenneth Brewington, who currently is in a physician position on the committee.
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MASA APPOINTEES

Dr. Richard P. Gonzalez **Trauma Surgeon**

Dr. Jorge E. Alonso **Orthopedics/Trauma Surgeon**

Dr. John M. McMahan, Jr. **Emergency Medicine**

Dr. Jimmie George Gavras **General Surgery**

DR. WILLIAMSON APPOINTEE

Mr. Billy Pappas, EMT-P **Mobile Fire Rescue Department**

REGIONAL MEDICAL DIRECTOR

Dr. Frank Pettyjohn **USA Medical Center**

RTAC APPOINTEES BY STAC

HOSPITAL REPRESENTATIVES (13)

In order to balance the hospital representatives with the physicians with 13 each and also because this hospital was left off the list, we should add:
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Mr. Ormand Thompson Infirmery West 5600 Girby Road Mobile, AL 36693
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Mrs. Beth Anderson **USA Medical Center**

Mr. Doug Sewell	Grove Hill Memorial Hospital
Mr. Clarke Christianson	Providence Hospital
Mr. Douglas Tanner	Washington County Hospital
Ms. Terese Grimes	Jackson Medical Center
Mr. Michael Neuendorf	South Baldwin Regional Medical Center

Mr. Bob Gowing Replaced by Mr. Bill Perkins	Atmore Community Hospital
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Mr. Vince DeFranco	Monroe County Hospital
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Mr. Kevin Bierschenk Replaced by Ms. Lisa Sims	Southwest Alabama Medical Center
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Mr. Bob Humphrey	Evergreen Medical
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Mr. William McLaughlin	North Baldwin Infirmary Hospital
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Mr. Bill Mason Replaced by Mr. Jeff St. Clair. Jeff St. Clair wishes for Mr. Paul Read to serve as the RTAC representative (permanent proxy) for Springhill. Paul is the “Vice President/Chief Nursing Executive” for Springhill.	Springhill Memorial Hospital
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PHYSICIANS (13)

Dr. Melissa W. Costello	Emergency Medicine
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Dr. William Admire Replaces Dr. Kenneth Brewington who now serves as the administrator of Mobile Infirmary	Emergency Medicine
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Dr. William Farmer	Emergency Medicine
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Dr. Arnold Luterman	Trauma Surgery/Burns
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Dr. Albert G. Simmons	General Surgery
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Dr. Michael L. Sternberg	Emergency Medicine
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Dr. Keith A. Scott	Family Practice
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Dr. Steve Bowden	Emergency Medicine
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Dr. Eugene A. Quindlen

Neurosurgery

Dr. John Meade

Emergency Medicine

Dr. Anthony M. Martino

Neurosurgery

Dr. Mark Mitchell

Emergency Medicine

Dr. Celeste M. Hollands

Pediatric Surgery

PREHOSPITAL EMS REPRESENTATIVES

Mr. Michael Lambert EMT-P

Conecuh County EMS

Mr. Lee Rumbley, EMT-P

Baptist LifeFlight

PURPOSE:

The following are criteria for entering a patient who has been involved in a trauma incident into the Alabama Trauma System.

Physiological criteria:

1. A systolic BP < 90 mm/Hg in an adult **or child 6 years or older < 80 mm/Hg in a child five or younger.**
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.**

Anatomical Criteria:

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 fifteen percent or greater.
5. **See Burn Protocol 4.7 for criteria to enter burned patient into trauma system**
6. The patient has an amputation proximal to the wrist or ankle.
7. The patient has one or more limbs which are paralyzed.
8. The patient has a pelvic fracture, as evidenced by a positive “pelvic movement” exam.

Mechanism of the patient injury:

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 or 10 feet or 3 times the height of the child onto a hard surface.**

EMT Discretion:

1. If, the EMT is convinced the patient could have a severe injury which is not yet obvious, the patient should be entered into the trauma system.
2. The EMTs suspicion of severity of trauma/injury may be raised by the following factors:
 - a. Age > 55
 - b. **Age < five**
 - c. Environment (hot/cold)

- d. Patient's previous medical history
 - i. Insulin dependent diabetes or other metabolic disorder
 - ii. Cardiac condition
 - iii. Immunodeficiency disorder
 - iv. Bleeding disorder
 - v. COPD/Emphysema
 - vi. Renal failure on dialysis
- e. Pregnancy
- f. **Child with congenital disorder**
- g. Extrication time > 20 minutes with heavy tools utilized
- h. Motorcycle crash
- i. Head trauma with history of more than momentary loss of consciousness.

ENTERING A PATIENT INTO THE TRAUMA SYSTEM:

1. Regions that are not yet operating under the Alabama Trauma System

Patients should be transported to a hospital with a trauma response program if such is available in the region, per the region's Medical Control and Accountability Plan.

2. Regions that are currently operating under the Alabama Trauma System should call the Trauma Communications Center (TCC) to determine patient destination:

TCC contact numbers:

Toll-Free Emergency: 1-800-359-0123, or
Southern LINC EMS Fleet 55: Talkgroup 10/Private 55*380, or
Nextel: 154*132431*4

After assessing a trauma situation and making the determination the patient should be entered into the Trauma System, the EMT licensed at the highest level should contact the Trauma Communications Center (TCC) at the earliest time which is practical, and provide the following:

1. Identify yourself and your agency by name, unit number and county. If on-line medical direction is necessary, the receiving trauma center becomes medical direction. TCC will help coordinate on-line medical direction with a physician immediately.
2. Give your geographic location.
3. Give age and sex of patient (patient name is not necessary).
4. Assign patient number if more than one patient.
5. Give criteria for entry into Trauma System.

Administrative

TRAUMA SYSTEM PROTOCOL (continued)

8.5

6. Give vital signs: Blood Pressure, Pulse rate, Respiratory rate, GCS
7. TCC Communicator will offer available trauma centers based on information given above.
8. Give unit number of transporting unit, mode of transport, and time of transport from the scene.
9. You will be given a unique identification number that must be entered into the chart when you generate your e-PCR. The Office of EMS and Trauma will use this to identify the charts for quality improvement studies.

Notify the TCC of any change in the patient's condition. The receiving trauma center (or TCC, who can relay to trauma center) should be updated by the transporting unit 5-10 minutes out. This update need only consist of any patient changes and patient's current condition. A repeat of information used to enter the patient into the Trauma System is not necessary since this information will be relayed by the TCC to the receiving trauma center. After the patient is delivered to the trauma center, the transporting provider should call the TCC with the Patient Care Report times.

NOTE: If you are considering helicopter transport of the trauma patient, you should follow Protocol 7.10: Guidelines for Helicopter Transport of Trauma Patients

Alabama Trauma Center Designation

Trauma Facilities Criteria: APPENDIX A Trauma Rules

*The following table shows levels of categorization and their **essential (E)** or **desirable (D)** criteria necessary for designation as a Trauma Facility by the Alabama Department of Public Health*

	Level I	Level II	Level III
INSTITUTIONAL ORGANIZATION			
Trauma Program	E	E	E
Trauma Service	E	E	-
Trauma Team	E	E	E
Trauma Program Medical Director	E	E	D
Trauma Multidisciplinary Committee	E	E	D
Trauma Coordinator/ TPM	E	E	E
HOSPITAL DEPARTMENTS/ DIVISIONS/ SECTIONS			
1 Surgery	E	E	-
Neurological Surgery	E	-	-
Neurological trauma liaison	E	-	-
Orthopedic Surgery	E	E	-
Orthopedic trauma liaison	E	E	-
Emergency medicine	E	E	-
Anesthesia	E	E	-
CLINICAL CAPABILITIES			
Published on-call schedule	E	E	E
2 General Surgery (attending surgeon promptly available ¹ 24 hours/day to maintain green status)	E	E	E D
3 Published back-up schedule or written back-up method ²	E	D	D
4 Dedicated to single hospital when on-call	E	D	D
5 Anesthesia (promptly available ³ 24 hours/day to maintain green status)	E	E	E D
Emergency Medicine (Immediately available in-house 24 hours/day)	E	E	E
6 On-call and promptly available 24 hours/ day to maintain green status			
Cardiac surgery	E	-	-
Hand surgery (does not include micro vascular/re implantation)	E	D	-
Micro vascular/replant surgery	D	-	-
Neurologic Surgery	E	D	-
Dedicated to one hospital or back-up call	E	D	-

	Level I	Level II	Level III
Obstetrics/gynecologic surgery ⁴	E	D	-
Ophthalmic surgery	E	D	-
Oral/maxillofacial surgery	E	D	-
Orthopedic	E	E	D
Dedicated to one hospital or back-up call	E	D	-
Plastic surgery	E	D	D
Critical care medicine	E	D	-
Radiology	E	E	D
Thoracic surgery	E	D	-
CLINICAL QUALIFICATIONS			
General/ trauma surgeon			
7 Current board certification or eligible	E	E	-
8 Average of 6 hours of trauma related CME/year ⁵	E	D	D
ATLS completion	E	D E	E
Peer review committee attendance > 50%	E	E	-
Multidisciplinary committee attendance	E	E	-
Emergency Medicine			
9 Board certification ⁶ or eligible	E	D	D
ATLS completion ⁷	E	E	E
10 Average of 6 hours of trauma related CME/year ⁵	E	E D	E
Peer review committee attendance > 50%	E	E	-
Multidisciplinary committee attendance	E	E	-
Neurosurgery			
11 Current board certification or eligible	E	-	-
Average of 6 hours of trauma related CME/year ⁵	E	D	D
ATLS completion	D	D	D
Peer review committee attendance > 50%	E	E	-
Multidisciplinary committee attendance	E	E	-
Orthopedic surgery			
Board certification	E	D	-
Average of 6 hours of trauma related CME/year ⁵	E	D	D
ATLS Completion	D	D	D
Peer review committee attendance > 50%	E	E	D
Multidisciplinary committee attendance	E	E	-

	Level I	Level II	Level III
FACILITIES/ RESOURCES/ CAPABILITIES			
Volume Performance			
Trauma admissions 750/ year	E	-	-
Presence of surgeon at resuscitation	E	E	D
Presence of surgeon at operative procedures	E	E	E
Emergency Department (ED)			
13 Personnel - designated physician director	E	E	E D
Equipment for resuscitation for patients of all ages			
Airway control and ventilation equipment	E	E	E
Pulse oximetry	E	E	E
Suction devices	E	E	E
Electrocardiograph-oscilloscope-defibrillator	E	E	E
14 Internal paddles	E	E	E
15 CVP monitoring equipment	E	E	E D
Standard IV fluids and administration sets	E	E	E
Large-bore intravenous catheters	E	E	E
Sterile surgical sets for:			
Airway control/ cricothyrotomy	E	E	E
Thoracostomy	E	E	E
Venous cutdown	E	E	E
Central line insertion	E	E	-
16 Thoracotomy	E	E	E
17 Peritoneal lavage	E	E	E D
Arterial catheters (should we be more specific?)	E	D	D
18 Ultrasound	E D	E D	D
Drugs necessary for emergency care	E	E	E
19 X-ray available 24 hours/ day to maintain green status	E	E	D
Cervical traction devices	E	E	D
Broselow tape	E	E	E
20 Thermal control equipment:			
For patient	E	E	E
For fluids and blood	E	E	D
Rapid infuser system	E	E	D
Qualitative end-tidal CO ₂ determination	E	E	E
Communications with EMS vehicles	E	E	E

	Level I	Level II	Level III
OPERATING ROOM			
21 Immediately available 24 hrs/day ⁷ to maintain green status	E	D	D
Operating Room Personnel			
22 In house 24 hrs/ day ⁸ to maintain green status	E	-	-
23 Available 24 hrs/ day to maintain green status		E	E
Age Specific Equipment			
Cardiopulmonary bypass	E	-	-
Operating microscope	D	D	-
Thermal Control Equipment			
For patient	E	E	E
For fluids and blood	E	E	E
X-ray capability, including c-arm image intensifier	E	E	E
Endoscopes, bronchoscopes	E	E	D
Craniotomy instruments	E	D	-
Equipment for long bone and pelvic fixation	E	E	D
Rapid infuser system	E	E	D
Post Anesthetic Recovery Room (SICU is acceptable)			
24 Registered nurses available 24 hours/day to maintain green status	E	E	-
Equipment for monitoring and resuscitation	E	E	E
Intracranial pressure monitoring equipment	E	D	-
Pulse oximetry	E	E	E
Thermal control	E	E	E
Intensive or Critical Care Unit for Injured Patients			
Registered nurses with trauma education	E	E	-
25 Designated surgical director or surgical co-director	E	D E	D
Surgical ICU service physician in-house 24 hours/day Emergency physician will satisfy this requirement	E	D	-
26 Surgically directed and staffed ICU service	E	D	-
Equipment for monitoring and resuscitation	E	E	-
Intracranial monitoring equipment	E	-	-
Pulmonary artery monitoring equipment	E	E	-
Respiratory Therapy Services			
27 Available in-house 24 hours/day to maintain green status	E	E	D
28 On-call 24hrs/day to maintain green status	-	-	D
29 Radiological services (available 24 hours/day)			

	Level I	Level II	Level III
30 In house radiology technologist to maintain green status	E	E	D
Angiography	E	D	-
Sonography	E	E	D
Computer Tomography (CT)	E	E	D
In house CT technician	E	-	-
Magnetic Resonance Imaging (Technician not required in house)	E	D	-
31 Clinical laboratory services (Available 24 hours/day to maintain green status)	E	E	E
32 Standard analyses of blood, urine, and other body fluids, including micro sampling when appropriate	E	E	E
Blood typing and cross-matching	E	E	E
Coagulation studies (should we be more specific?)	E	E	E
Comprehensive blood bank or access to a community central blood bank and adequate storage facilities	E	E	E
33 Blood gasses and pH determinations	E	E	E
Microbiology	E	E	E
Acute Hemodialysis	E	E	E
34 In-house (staff not required in-house for green status 24 hours)	E	-	-
35 Transfer agreement (written document not required)	--	E	E
Burn Care – Organized			
36 In house or transfer agreement with Burn Center (written document not required) (See above)	E	E	E
Acute Spinal Cord Management			
37 In-house or transfer agreement with Regional Acute Spinal Cord Injury Rehabilitation Center (See above written document not required)	E	E	E
REHABILITATION SERVICES			
38 Transfer agreement to an approved rehabilitation facility (See above written document not required)	E	E	E
Physical therapy	E	E	D
Occupational therapy	E	D	D
Speech therapy	E	D	-
Social Service	E	E	D
PERFORMANCE IMPROVEMENT			
Performance improvement programs	E	E	E
Trauma registry			

	Level I	Level II	Level III
39 In house	E	E	D
40 Participate in state, local or regional registry	E	E	E
41 Orthopedic database	D	-	-
42 Audit of all trauma deaths	E	E	E
Morbidity and mortality review	E	E	E
Trauma conference-multidisciplinary	E	E	D
Medical nursing audit	E	E	E
43 Review of pre-hospital trauma care ⁹	E	E	E D
44 Review of times and reasons of trauma-related bypass for trauma status being red	E	E	E
Review of times and reasons for transfer of injured patients	E	E	E
Performance improvement personnel dedicated to care of injured patients	E	D	D
CONTINUING EDUCATION/OUTREACH			
General Surgery residency program	D	-	-
ATLS provide/ participate	E	D	D
Programs provided by hospital for:			
Staff/community physicians (CME)	E	E	D
Nurses	E	E	D
Allied health personnel	E	E	-
45 Pre-hospital personnel provision/ participation ¹⁰	E	E	D
PREVENTION			
Collaboration with other institutions for injury control and prevention	E	D	D
Designated prevention coordinator-spokesman for injury control	E	D	-
Outreach activities	E	D	D
Information resources for public	E	D	-
46 Collaboration with existing national, regional and state programs	E	E D	E
47 Coordination and/or participation in community prevention activities	E	E	E D
RESEARCH			
Trauma registry performance improvement activities	E	E	E
Research committee	D	-	-
Identifiable IRB process	D	-	-
Extramural educational presentations	D	D	-
Number of scientific publications	D	-	-

¹ In both Level I and Level II facilities 24-hour in-house availability is the most direct method for the attending surgeon to provide care. In hospitals with residency programs, a team of physicians and surgeons that can include the Emergency Department Physicians, Surgical Residents, or Trauma Residents may start evaluation and treatment allowing the attending surgeon to take call outside the hospital if he/she can arrive. For hospitals without residency programs, the attending surgeon may take call from outside the hospital but should be promptly available. Compliance with these requirements must be monitored by the hospital's quality improvement program.

² If there is no published back-up, call schedule there must be a written procedure of how to identify or locate another surgeon when needed and this should be monitored by the quality improvement plan.

³ Timeliness of anesthesia response should be monitored by the hospital's quality improvement program.

⁴ AL licensed specialty pediatric facilities, which are PPS exempt under Title 42 USC Section 1395ww(d)(1)(B)(iii) and receive funding under Title 42 USC 256e shall not be required to have an obstetric/gynecologic surgery service but should have a transfer agreement for OB-GYN surgery services.

⁵ An average of 18 hours of trauma CME every three years is acceptable.

⁶ Physicians may be board certified in Emergency Medicine or Pediatric Emergency Medicine by an ABMS- or AOA-recognized board, or may be board certified in a primary care specialty if they have extensive experience in management of trauma patients.

⁷ Physicians not board certified in Emergency Medicine or Pediatric Emergency Medicine by an ABMS- or AOA-recognized board must maintain their ATLS certification. There will be a three-year grace period for emergency department staff to become compliant with this requirement

⁸ An operating room must be adequately staffed and immediately available in a Level I trauma center **to remain available (green) to the trauma system**. This is met by having a complete operating room team in the hospital at all times, so if an injured patient requires operative care, the patient can receive it in the most expeditious manner. These criteria cannot be met by individuals who are also dedicated to other functions within the institution. Their primary function must be the operating room.

An operating room must be adequately staffed and available when needed in timely fashion in a Level II trauma center **to remain available (green) to the trauma system**. The need to have an in-house OR team will depend on a number of things, including patient population served, ability to

share responsibility for OR coverage with other hospital staff, pre hospital communication, and the size of the community served by the institution. If an out-of-house OR team is used, then this aspect of care must be monitored by the performance improvement program.

⁹All levels of Trauma Centers should monitor prehospital trauma care. This includes patient care, patients brought by EMS but entered into the trauma system by the hospital (under triage) and patients entered into the trauma system that did not meet criteria (over triage).

¹⁰Hospital must complete and return to the RTAC the initial patient findings, treatment provided and outcome at the end of the first 24 hours. This should be noted on the ATCC patient record.

TRAUMA SYSTEM PATIENT ENTRY CRITERIA FOR HOSPITALS

The following are criteria for in-hospital medical personnel to enter a patient who has been involved in a trauma or burn incident into the Alabama Trauma System.

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.

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 facilities 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 or 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).
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. Facilities wishing to enter a patient into the trauma system for Anatomic or Mechanism of Injury 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.

STAC ATCC OPERATIONS REPORT

March 23, 2009

Trauma System --- Volume --- 12/02/2008 --- 03/19/2009

- Total System Volume – 1292
- NATS 393 --HH 273 ,DGH 19,
Three's 80 , Erlanger 3
- BREMSS 899 – UAB 643, TCH 60,
Three's 177

TRAUMA SYSTEM VOLUME

- 3/19/08 to date 03/19/09
- NATS 1622
- BREMSS 3547
- 07/08- patients - 3572
- 06/07 - patients - 3498

TRAUMA SYSTEM OVERLOAD 12/02/2008 – 03/19/2009

- HH 0 Hours
- DGH 0 Hours
- TCH -- 0
- UAB -- 106.5 HRS.
- Patients Rerouted -- 6 – Prin.
2, TCH.1, Trinity 2, MW 1
- Pts. to Level 1(UAB) 13

Trauma System --- Overload TBO 12/02/2008 03/19/2009

- HH --- 0 Hours
- DGH --- 0 Hours
- TCH--- 0 Hours
- UAB --- 15.5 Hours
- Patients rerouted - Trinity 1

TRAUMA SYSTEM ---- RED

- HH 7 HRS. (244 &177)
- DGH 660 HRS.35 MIN. (430-8991)
- TCH – 0
- UAB -- 9 HRS. 14 MIN. (17-207)
- Patients Rerouted – 0

