Alabama Trauma System Designation Criteria- page 9-10

[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. Promptly available for Level I facilities will be 15 minutes response time for 80 percent of trauma system patients except for EMT Discretion. Levels II and III response time will be 30 minutes. Compliance with these requirements will be monitored by the hospital's quality improvement program and the ATS Trauma Registry.

[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] Anesthesiologist will be available in-house 24 hours a day for Level I trauma centers. In Level II and III trauma centers anesthesiologist or CRNA will be available within 30 minutes response time. In Pediatric Level I trauma centers, anesthesiology will be available in-house 24-hours a day. Requirements may be fulfilled by a Pediatric Emergency Attending Physician, Pediatric Emergency Fellow, or a Senior Anesthesia Resident CA-2/CA-3 (PGY-3/PGY-4).

[4]Alabama 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. An average of three of the 18 hours should focus on pediatrics.

[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. *Level I and II trauma centers may have an affiliation with pediatric hospitals to fulfill added pediatric requirements.

[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 in 30 minutes or readily available 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, prehospital 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.

[9]All levels of trauma centers should monitor prehospital trauma care. This includes the quality of patient care provided, patients brought by EMS and not entered into the trauma system but had to be entered into the trauma system by the hospital (under triage), and patients entered into the trauma system by EMS that did not meet criteria (over triage).

[10]Hospital must complete and return to the RAC 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.

[11]Level III X-ray services will be available promptly after hours and on weekends.

[12]Level I director of surgical critical care team will be surgical critical care board certified except for pediatric facilities that have 24 hours in- house pediatric intensivist.

[13]Some portion of education should be pediatrics based.

[14]Includes adults and pediatrics.

_____I have read and understand the requirements for coverage under the Alabama Trauma System.

Collaborating Physician Signature: _____

Print Name : _____