Chapter 23 – Trauma Center Criteria Specific to Level IV Trauma Centers			
2014 Criteria Quick Reference Guide			
The preceding chapters of *Resources for Optimal Care of the Injured Patient* are designed to clearly define the criteria to verify that trauma centers have resources for optimal care of injured patients.		**This chapter is included as a quick reference to identify the criteria to meet the requirements as stated in each chapter.**	
Chapter	**Level**	**Criterion by Chapter and Level**	
Chapter 1: Trauma Systems			
1	IV	The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1–1).	
1	IV	They must function in a way that pushes trauma center–based standardization, integration, and PIPS out to the region while engaging in inclusive trauma system planning and development (CD 1–2)	
1	IV	Meaningful involvement in state and regional trauma system planning, development, and operation is essential for all designated trauma centers and participating acute care facilities within a region (CD 1–3)	
Chapter 2: Description of Trauma Centers and Their Roles in a Trauma System			
2	IV	This trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care (CD 2–1).	
2	IV	Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification (CD 2–3).	

2	IV	For Level IV trauma centers, it is expected that the physician (if available) or midlevel provider will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 30 minutes for the highest level of activation, tracked from patient arrival. The PIPS program must demonstrate that the physician's (if available) or midlevel provider's presence is in compliance at least 80 percent of the time (CD 2–8).	
2	IV	Well-defined transfer plans are essential (CD 2–13).	
2	IV	Collaborative treatment and transfer guidelines reflecting the Level IV facilities' capabilities must be developed and regularly reviewed, with input from higher-level trauma centers in the region (CD 2–13).	
2	IV	A Level IV facility must have 24-hour emergency coverage by a physician or midlevel provider (CD 2–14).	
2	IV	The emergency department at Level IV centers must be continuously available for resuscitation with coverage by a registered nurse and physician or midlevel provider, and it must have a physician director (CD 2–15).	
2	IV	These providers must maintain current Advanced Trauma Life Support® certification as part of their competencies in trauma (CD 2–16).	

2	IV	For Level I, II, III and IV trauma centers a trauma medical director and trauma program manager knowledgeable and involved in trauma care must work together with guidance from the trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking. (CD 2-17).	
2	IV	Level I, II, III and IV trauma centers the multidisciplinary trauma peer review committee must meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured (CD 2–18).	
2	IV	Level I, II, III and IV trauma centers a PIPS program must have audit filters to review and improve pediatric and adult patient care (CD 2–19).	
2	IV	Because of the greater need for collaboration with receiving trauma centers, the Level IV trauma center must also actively participate in regional and statewide trauma system meetings and committees that provide oversight (CD 2–20).	
2	IV	The Level IV trauma center must also be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers (CD 2–21).	
2	IV	Level I, II, III and IV trauma centers the facility must participate in regional disaster management plans and exercises (CD 2–22).	
Chapter 3: Prehospital Trauma Care			
3	IV	The trauma program must participate in the training of prehospital personnel, the development and improvement of prehospital care protocols, and performance improvement and patient safety programs (CD 3–1).	
3	IV	The protocols that guide prehospital trauma care must be established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies, and basic and advanced prehospital personnel (CD 3–2).	

3	IV	When a trauma center is required to go on bypass or to divert, the center must have a system to notify dispatch and EMS agencies (CD 3–7). The center must do the following: • Prearrange alternative destinations with transfer agreements in place • Notify other centers of divert or advisory status • Maintain a divert log • Subject all diverts and advisories to performance improvement procedures	
Chapter 4: Interhospital Transfer			
4	IV	Direct physician-to-physician contact is essential (CD 4–1).	
4	IV	A very important aspect of interhospital transfer is an effective PIPS program that includes evaluating transport activities (CD 4–3).	
4	IV	Perform a PIPS review of all transfers (CD 4–3).	
Chapter 5: Hospital Organization and the Trauma Program			
5	IV	A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff (CD 5–1).	
5	IV	Documentation of administrative commitment is required from the governing body and the medical staff (CD 5–1)	

		in 3 years) (CD 5–7)	
5	IV	The criteria for a graded activation must be clearly defined by the trauma center, with the highest level of activation including the six required criteria listed in Table 2 (CD 5–13).	
5	IV	In Level III and IV trauma centers the team must be fully assembled within 30 minutes (CD 5-15).	
5	IV	Other potential criteria for trauma team activation that have been determined by the trauma program to be included in the various levels of trauma activation must be evaluated on an ongoing basis in the PIPS process (CD 5-16) to determine their positive predictive value in identifying patients who require the resources of the full trauma team.	

Chapter 6: Clinical Functions: General Surgery			
6	IV	Level IV trauma centers, the maximum acceptable response time is 30 minutes. Response time will be tracked from patient arrival rather than from notification or activation. An 80 percent attendance threshold must be met for the highest-level activations (CD 2–8).	

Chapter 7: Clinical Functions: Emergency Medicine			
Chapter 8: Clinical Functions: Neurosurgery			
Chapter 9: Clinical Functions: Orthopaedic Surgery			
Chapter 11 Collaborative Clinical Services			
Chapter 13: Rural Trauma Care			
13	IV	Direct contact of the physician or midlevel provider with a physician at the receiving hospital is essential (CD 4–1).	
13	IV	Transfer guidelines and agreements between facilities are crucial and must be developed after evaluating the capabilities of rural hospitals and medical transport agencies (CD 2–13).	

13	IV	All transfers must be evaluated as part of the receiving trauma center's performance improvement and patient safety (PIPS) process (CD 4–3), and feedback should be provided to the transferring center.	
13	IV	The foundation for evaluation of a trauma system is the establishment and maintenance of a trauma registry (CD 15–1).	
13	IV	Issues that must be reviewed will revolve predominately around (1) system and process issues such as documentation and communication; (2) clinical care, including identification and treatment of immediate life-threatening injuries (ATLS®); and (3) transfer decisions (CD 16-10).	
13	IV	The best possible care for patients must be achieved with a cooperative and inclusive program that clearly defines the role of each facility within the system (CD 1–1).	
Chapter 14: Guidelines for the Operation of Burn Centers			
14	IV	Trauma centers that refer burn patients to a designated burn center must have in place written transfer agreements with the referral burn center (CD 14–1)	
Chapter 15: Trauma Registry			
15	IV	Trauma registry data must be collected and analyzed by every trauma center (CD 15–1).	
15	IV	The trauma registry is essential to the performance improvement and patient safety (PIPS) program and must be used to support the PIPS process (CD 15–3).	
15	IV	Furthermore, these findings must be used to identify injury prevention priorities that are appropriate for local implementation (CD 15–4).	
15	IV	Trauma registries should be concurrent. At a minimum, 80 percent of cases must be entered within 60 days of discharge (CD 15–6)	
15	IV	The trauma program must ensure that appropriate measures are in place to meet the confidentiality requirements of the data (CD 15–8).	

15	IV	Strategies for monitoring data validity are essential (CD 15–10).	
Chapter 16: Performance Improvement and Patient Safety			
16	IV	The PIPS program must be supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement (CD 15–1).	
16	IV	The processes of event identification and levels of review must result in the development of corrective action plans, and methods of monitoring, reevaluation, and benchmarking must be present (CD 2–17).	
16	IV	Peer review must occur at regular intervals to ensure that the volume of cases is reviewed in a timely fashion (CD 2–18).	
16	IV	Because the trauma PIPS program crosses many specialty lines, it must be empowered to address events that involve multiple disciplines and be endorsed by the hospital governing body as part of its commitment to optimal care of injured patients (CD 5–1).	
16	IV	There must be adequate administrative support to ensure evaluation of all aspects of trauma care (CD 5–1).	
16	IV	The trauma medical director and trauma program manager must have the authority and be empowered by the hospital governing body to lead the program (CD 5–1).	

16	IV	The trauma center must demonstrate that all trauma patients can be identified for review (CD 15–1).	
16	IV	The trauma PIPS program must be supported by a registry and a reliable method of concurrent data collection that consistently obtains information necessary to identify opportunities for improvement (CD 15–3).	
16	IV	All process and outcome measures must be documented within the trauma PIPS program's written plan and reviewed and updated at least annually (CD 16–5).	
16	IV	Trauma surgeon response to the emergency department (CD 2–9). See previous detail.	
16	IV	Trauma team activation (TTA) criteria (CD 5–13). See previous detail.	
16	IV	All Trauma Team Activations must be categorized by the level of response and quantified by number and percentage, as shown in Table 2 (CD 5–14, CD 5–15).	

16	IV	Acute transfers out (CD 9–14). All trauma patients who are diverted (CD 3–4) or transferred (CD 4–3) during the acute phase of hospitalization to another trauma center, acute care hospital, or specialty hospital (for example, burn center, reimplantation center, or pediatric trauma center) or patients requiring cardiopulmonary bypass or when specialty personnel are unavailable must be subjected to individual case review to determine the rationale for transfer, appropriateness of care, and opportunities for improvement. Follow-up from the center to which the patient was transferred should be obtained as part of the case review.	
16	IV	Transfers to a higher level of care within the institution (CD 16–8).	
16	IV	Trauma registry (CD 15–6). See previous detail.	
16	IV	Sufficient mechanisms must be available to identify events for review by the trauma PIPS program (CD 16–10).	
16	IV	Once an event is identified, the trauma PIPS program must be able to verify and validate that event (CD 16–11).	
Chapter 17: Outreach and Education			
17	IV	All verified trauma centers, however, must engage in public and professional education (CD 17–1).	
17	IV	The successful completion of the ATLS® course, at least once, is required in all levels of trauma centers for all general surgeons (CD 6-9), emergency medicine physicians (CD 7-14) and midlevel providers (CD 11-86) on the trauma team.	
Chapter 18: Prevention			
18	IV	Trauma centers must have an organized and effective approach to injury prevention and must prioritize those efforts based on local trauma registry and epidemiologic data (CD 18–1).	

18	IV	Each trauma center must have someone in a leadership position that has injury prevention as part of his or her job description (CD 18-2)	
Chapter 19: Trauma Research and Scholarship			

Chapter 20: Disaster Planning and Management			
20	IV	Trauma centers must meet the disaster-related requirements of the Joint Commission (CD 20–1).	
20	IV	Hospital drills that test the individual hospital's disaster plan must be conducted at least twice a year, including actual plan activations that can	

		substitute for drills (CD 20–3)	
20	IV	All trauma centers must have a hospital disaster plan described in the hospital's policy and procedure manual or equivalent (CD 20–4).	
Chapter 21: Solid Organ Procurement Activities			
21	IV	It is essential that each trauma center have written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death (CD 21–3).	
Chapter 22: Verification, Review, & Consultation Program			
Chapter 23: Criteria quick Reference Guide			
All reference documents will be available at: *https://www.facs.org/quality-programs/trauma/vrc/resources*			