



# IDAHO TIME SENSITIVE EMERGENCY SYSTEM

TRAUMA | STROKE | STEMI

## Level V Trauma Center

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2020 Application & Resource Toolkit



IDAHO DEPARTMENT OF  
HEALTH & WELFARE

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# About the Idaho TSE System

## **Why a TSE program?**

The 2014, Idaho Legislature approved and funded a plan to develop a statewide Time Sensitive Emergency (TSE) system of care that addresses three of the top five causes of deaths in Idaho: trauma, stroke, and heart attack (a.k.a. STEMI). Studies show that organized systems of care improve patient outcomes, reduce the frequency of preventable death, and improve the quality of life of the patient.

## **How does the TSE program work?**

The Idaho Department of Health & Welfare provides oversight and administrative support for the day-to-day operation of the program.

A governor-appointed TSE Council made up of healthcare providers and administrators and EMS agencies representing both urban and rural populations is responsible for establishing Rules and Standards for the Idaho TSE System. The Council is the statewide governing authority of the system.

The state has been divided into six regions. Each of these has a TSE Regional Committee made of EMS providers, healthcare providers and administrators, and public health agencies. The regional committees will be the venue in which a wide variety of work is conducted such as education, technical assistance, coordination, and quality improvement. The TSE Regional Committees will have the ability to establish guidelines that best serve their specific community as well as providing a feedback loop for EMS and healthcare providers.

## **What guiding principles are the foundation of the Idaho TSE System?**

- Apply nationally accepted evidence-based practices to time sensitive emergencies;
- Ensure that standards are adaptable to all facilities wanting to participate;

- Ensure that designated centers institute a practiced, systematic approach to time sensitive emergencies;
- Reduce morbidity and mortality from time sensitive emergencies;
- Design an inclusive system for time sensitive emergencies;
- Participation is voluntary; and
- Data are collected and analyzed to measure the effectiveness of the system.

**How often is a center verified, and how much does it cost?**

A center is verified every three years and an onsite survey is required for every verification process. The onsite survey fee is \$1,500 and must be submitted with the application. Once the center is designated, the designation fee can be paid in three annual payments of \$1,000.

**Whom do I contact about the application process?**

**Idaho Time Sensitive Emergency Program**

P.O. Box 83720

Boise, ID 83720-0036

[tse@dhw.idaho.gov](mailto:tse@dhw.idaho.gov)

<https://tse.idaho.gov>

**Program Supervisor Melissa Ball**

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(208) 334-2124

**Program Specialist Stacy Connolly**

[Stacy.Connolly@dhw.idaho.gov](mailto:Stacy.Connolly@dhw.idaho.gov)

(208) 334-5526

Please do not hesitate to contact us with any questions or concerns. We would be happy to help in any way we can to assist you in meeting these standards.

# Application Process

## State Verification

To apply for a designation as a Level IV Trauma Center in Idaho **using the State of Idaho for verification**, please do the following:

1. Print and complete the application. Submit one application per facility. A completed application includes:
  - a. Facility and Personnel Profile;
  - b. Certification Statement;
  - c. Pre-Survey Questionnaire (PSQ); and
  - d. Required attachments.
2. Obtain the required signatures on the Certification Statement.
3. Use the current edition of the TSE Standards Manual as a reference to understand the designation criteria.
4. Put the application in a binder with labeled, tabbed dividers between each section: Profile, Certification Statement, and verification letter.
5. Mail the completed application and onsite site survey fee (\$1,500) to:

[Make checks payable to Bureau of EMS & Preparedness](#)

Bureau of EMS & Preparedness  
Time Sensitive Emergency Program  
P.O. Box 83720  
Boise, ID 83720-0036

Or for FedEx, UPS, etc.  
2224 E. Old Penitentiary Rd.  
Boise, ID 83712

The TSE Program staff will notify you within 10 business days to confirm the receipt of the application and check.

# Application

Answer every question (circle either yes or no) and label all attachments. If you require additional space, please include a separate sheet. Once completed, print and sign the application (i.e. Certification Statement). Please contact the TSE Program staff if you have any questions or concerns regarding your application (208) 334-2124.

## Personnel Profile:

Facility Name:		
Mailing Address:	City:	Zip:
Physical Address:	City:	Zip:
Phone:	County:	
Application Contact:		
Phone:	Email:	

Hospital Administrator/CEO:	
Phone:	Email:
Trauma Program Manager	
Phone:	Email:
Trauma Medical Director	
Phone:	Email:

## Facility Profile:

Number of ED Beds:

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Number of ED Beds Designated for Critical Patients (Trauma, Stroke, STEMI):

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Number of Inpatient ICU Beds:

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Annual ED Volume:

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Annual Trauma Volume:

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Local Population Size the Facility Supports:

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Name of Nearest Tertiary Facility:

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Number of Miles and Approx. Time by Ground:

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# CERTIFICATION STATEMENT

I, \_\_\_\_\_ (CEO/COO), on behalf of \_\_\_\_\_ (facility), voluntarily agree to participate in the Idaho Time Sensitive Emergency System and Idaho TSE Registry as an Level V Trauma Center. We will work with Emergency Medical Services (EMS) and other facilities in our area to streamline triage and transport of trauma patients and participate in our Regional Time Sensitive Emergency Committee.

I certify that:

- A. The information and documentation provided in this application is true and accurate.
- B. The facility meets the State of Idaho criteria to be designated as a Level IV Trauma Center.
- C. We will notify the Time Sensitive Emergency Program Manager immediately if we are unable to provide the level of service we have committed to in this application.

\_\_\_\_\_  
Chair, Governing Entity

\_\_\_\_\_  
Date

\_\_\_\_\_  
Chief Executive Officer

\_\_\_\_\_  
Date

\_\_\_\_\_  
Trauma Medical Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
Trauma Program Manager

\_\_\_\_\_  
Date

# 1. Trauma System

## Time Sensitive Emergencies (TSE)

1.1 Do you participate in your Regional Time Sensitive Emergency (TSE) Committee? YES NO

## Center Mission

1.2 Attach a copy of the current resolution supporting the trauma center from the medical staff.

Refer to the *Toolkit* for sample.

*Medical Staff Resolution (attachment)*

1.3 Attach a copy of the current resolution supporting the trauma center from the hospital board.

Refer to the *Toolkit* for sample.

*Hospital Board Resolution (attachment)*

1.4 Is the center a health care facility (as defined in section 10 of the TSE Rules) with the commitment, medical staff, personnel, and training necessary to provide initial care and stabilization of the trauma patient? YES NO

EXPLAIN:

# 2. Description of Trauma Center

## Description of the Trauma Center

2.1 Is your trauma program empowered to address issues that involve multiple disciplines? YES NO

EXPLAIN:

2.2 Can you provide initial resuscitation of the trauma patient and immediate intervention to control hemorrhage and to assure maximum stabilization prior to referral to an appropriate higher level of care? YES NO

EXPLAIN:

## Trauma Leadership

### **Trauma Medical Director**

2.3 Do you have a Trauma Medical Director with the authority and administrative support to lead the program? YES NO

Attach a copy of the Trauma Medical Director's job description.

*Trauma Medical Director's Job Description (attachment)*

2.4 Is your Trauma Medical Director current in ATLS? YES NO

2.5 Provide your Trauma Medical Director's CV supporting their personal involvement in patient care, staff education, and professional organizations.

Attach supporting documentation.

*Trauma Medical Director's CV & ATLS Card (attachment)*

2.6 Are your trauma team providers reviewed by the Trauma Medical Director and credentialed by the medical staff and governing board? YES NO

2.7 Is your Trauma Medical Director responsible for developing and directing the quality improvement program? YES NO

2.8 Is your Trauma Medical Director accountable for all trauma care and does he or she exercise administrative authority for the trauma program? YES NO

2.9 Does your Trauma Medical Director participate in the internal trauma QI process by attending at least 50% of meetings? YES NO

Attach supporting documentation.

*TMD PIPS Attendance (attachment)*

### **Trauma Program Manager**

2.10 Do you have a Trauma Program Manager? YES NO

Does he or she show evidence of educational preparation and clinical experience caring for injured patients? YES NO

Attach the Trauma Program Manager's CV.

*Trauma Program Manager's CV (attachment)*

2.11 Is your Trauma Program Manager responsible for the use of internal trauma registry data for quality improvement and trauma education? YES NO

Refer to the *Toolkit* for sample.

Attach a copy of the Trauma Program Manager's job description.

*Trauma Program Manager's Job Description (attachment)*

2.12 Does your Trauma Program Manager work with your Trauma Medical Director to address the multidisciplinary needs of the trauma program? YES NO

EXPLAIN:

2.13 Does your Trauma Program Manager serve as a liaison to local EMS agencies and accepting centers? YES NO

This may be satisfied by participating in your Regional TSE Committee.

EXPLAIN:
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### 3. Clinical Functions

3.1 Is the criteria for activation (priority level) clearly defined?  
YES NO

Refer to the *Toolkit* for TSE Field Trauma Triage Guidelines.

Attach a copy of the criteria for activation.

*Criteria for Activation (attachment)*

3.2 Is the center staffed to ensure immediate and appropriate care to trauma patients during hours of operation? YES NO

3.3 Do you have written protocols determining which types of patients (i.e. adult and pediatric) are admitted and which are transferred? YES NO

Refer to the *Toolkit* for sample.

Attach the transfer protocols.

*Patient Transfer and Admit Protocol (attachment)*

3.4 Do you have local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers?  
YES NO

3.5 Do you have established protocols to ensure immediate and appropriate care of adult and pediatric trauma patient? YES NO

### Trauma Team

3.6 Do you have a policy and procedures describe the role of all personnel on the Trauma Team?      YES              NO

Refer to the *Toolkit* for sample.

Attach supporting documentation.

*Trauma Team Policy (attachment)*

3.7 At a minimum, does the Trauma Team consists of:

- a. A physician or midlevel provider?      YES              NO
- b. A registered nurse or licensed practical nurse?      YES              NO

3.8 Do your Trauma Team members participate in multi-disciplinary trauma committee and the quality improvement process?      YES              NO

3.9 Addressed in 2.6.

### Emergency Department

3.10 During hours of operation, do you have a health care provider(s) (MD, DO, FNP, PA) available?      YES              NO

If yes, is the provider on-site within 30 minutes of patient arrival with an 80% achievement rate?

Data point: Percentage of provider response less than 30 minutes. \_\_\_\_\_

Data point: Average provider response time. \_\_\_\_\_

3.11 During hours of operation, do you have RN/LPNs staffed at levels necessary to meet the needs of the trauma patient?      YES              NO

3.12 Does your trauma providers have documentation of training and knowledge of care for the trauma patient?      YES              NO

3.13 Does your midlevel providers (Nurse Practitioners or Physician Assistants) have documentation of training and knowledge of care for the trauma patient?

YES NO

### Collaborative Clinical Services

#### **Radiology**

3.14 Do you have written policy to delineate the availability of CT services (if available) to the trauma patient? YES NO

#### **Other Surgical Specialists**

3.15 Do you have a posted list of specialists who are promptly available from inside and outside of the center? YES NO

## 5. Interhospital Transfer

5.1 Does the decision to transfer an injured patient rest with the attending provider and is based solely on the needs of the patient? YES NO

Attach supporting documentation.

*Transfer Guidelines (attachment)*

5.2 Do you have written transfer agreements in place with higher level trauma centers? YES NO

Refer to the *Toolkit* for sample.

Do you have written transfer agreements in place with specialty referral centers (e.g. burn, pediatric, and rehabilitation centers)? YES NO

[Transfer agreements must be available at the time of the on-site survey.](#)

5.3 Is there a mechanism for direct provider-to-provider contact for arranging patient transfer? YES NO

EXPLAIN:

5.4 Do you have written transfer protocols with a referral burn center to refer burn patients to a designated burn center? YES NO

5.5 Addressed in 3.3.

## 6. PIPS

Visit the TSE website at <http://tse.idaho.gov/> to download a copy of *Developing a PIPS Program*.

6.1 Do you have a PIPS program to ensure optimal care and continuous improvement of care? YES NO

[This can be fulfilled by participation in Regional QI case reviews.](#)

Attach a copy of your PIPS policy.

*PIPS Policy (attachment)*

[If your PIPS policy does not address each item 6.2 to 6.12, please provide supporting documentation addressing each criterion with your PIPS Policy attachment.](#)

6.2 Is your PIPS program supported by a reliable method of internal data collection that consistently gathers valid and objective information necessary to analyze and identify opportunities for improvement? YES NO

6.3 Does your PIPS process of analysis occur at regular intervals to meet the needs of the program? YES NO

6.4 Are you able to separately identify the trauma patient for review? YES NO



- e. Has a peer review process that includes prehospital providers?  

YES            NO
- f. Has a method for comparing patient outcomes with computed survival probability?  

YES            NO
- g. Evaluates autopsy information on all trauma deaths?  

YES            NO

## 8. TSE Registry

8.1 Is your trauma data submitted to the Idaho TSE Registry within 180 days of treatment at least 80% of the time?      YES            NO

Attach a letter from the Idaho TSE Registry supporting your answer.

*Idaho TSE Registry Letter (attachment)*

8.2 Addressed in 8.1.

8.3 Does your trauma program ensure that registry data confidentially measures are in place? YES            NO

## 9. Outreach & Education

9.1 Are you engaged in public and professional education specific to trauma?  

YES            NO

Attach a list of public and professional trauma educational opportunities from the past 12 months.

*Trauma Education Documentation (attachment)*

## 10. Prevention

10.1 Do you participate in traumatic injury prevention and bases activities on local data?            YES            NO

Attach supporting documentation for all activities in the past 12 months.

*Injury Prevention Documentation (attachment)*

## 11. Disaster Planning and Management

11.1 Do you have a disaster plan described in your Disaster Manual? YES NO

Refer to the *Toolkit* for sample.

[Disaster Manual must be available at the time of the on-site survey.](#)

# Medical Staff Resolution

WHEREAS, traumatic injury is the leading cause of death for Idahoans between the ages of 1 and 44 years; and

WHEREAS, [HOSPITAL] strives to provide optimal trauma care; and

WHEREAS, treatment at a trauma hospital that participates in a standardized system of trauma care can significantly increase the chance of survival for victims of serious trauma; and

WHEREAS, participation in the Idaho Time Sensitive Emergency System will result in an organized and timely response to patients' needs, a more immediate determination of patients' definitive care requirements, improved patient care through the development of the hospital's performance improvement program and an assurance that those caring for trauma patients are educationally prepared:

THEREFORE; BE IT RESOVED that the medical staff of [HOSPITAL] resolves to support the hospital's trauma program and to participate with initiatives in the furtherance of the standards published by the Idaho Time Sensitive Emergency System for Level IV Trauma Centers.

IN WITNESS THEREOF, I have hereunto subscribed my name this [DAY] day of [MONTH], [YEAR].

---

Chief of Staff

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Date

SAMPLE

# Hospital Board Resolution

WHEREAS, traumatic injury is the leading cause of death for Idahoans between the ages of 1 and 44 years; and

WHEREAS, [HOSPITAL] strives to provide optimal trauma care; and

WHEREAS, treatment at a trauma hospital that participates in a standardized system of trauma care can significantly increase the chance of survival for victims of serious trauma; and

WHEREAS, participation in the Idaho Time Sensitive Emergency System will result in an organized and timely response to patients' needs, a more immediate determination of patients' definitive care requirements, improved patient care through the development of the hospital's performance improvement program and an assurance that those caring for trauma patients are educationally prepared:

THEREFORE; BE IT RESOVED that the medical staff of [HOSPITAL] resolves to support the hospital's trauma program and to participate with initiatives in the furtherance of the standards published by the Idaho Time Sensitive Emergency System for Level IV Trauma Centers.

IN WITNESS THEREOF, I have hereunto subscribed my name this [DAY] day of [MONTH], [YEAR].

---

Chairman of the Board

---

Date

SAMPLE

# Trauma Medical Director Job Description

**Job Title:** Trauma Program Medical Director

**Reports to:** Chief of Medical Staff

**Qualifications:**

1. MD, PA, or NP
2. Member in good standing of the hospital or clinic medical staff
3. Currently certified in Advanced Trauma Life Support (ATLS)
4. Three years clinical experience in emergency/trauma care
5. Two years administrative experience
6. Ability to establish and maintain effective interpersonal relationships
7. Ability to accept and implement change
8. Ability to solve problems and make decisions
9. Demonstrated history of positive relations with colleagues, support staff, hospital-based providers, administrators, and patients

**Nature and Scope:** The Trauma Medical Director is responsible for the ongoing development, growth and oversight/authority of the Trauma Program. The Trauma Medical Director is responsible for promoting high standards of practice through development of trauma policies, protocols, and practice guidelines; participating in performance improvement monitoring; and oversee staff education. He/she has authority to act on all trauma performance improvement and administrative issues and critically review trauma deaths and complications that occur within the center. Decisions affecting the care of trauma patients will not be made without the knowledge, input and approval of the Trauma Medical Director.

**Principal Duties and Responsibilities:**

Administration:

- Participate in the research, development, and writing of trauma policies, protocols and practice guidelines.
- Implement all trauma program policies and procedures as they pertain to patient care.
- Organize, direct and integrate the trauma program with all other departments and services within the hospital.
- Promote a cooperative and collaborative working environment among the clinical disciplines involved in trauma care.
- Maintain an effective working relationship with the medical staff, trauma service staff, administration and other departments.
- Assess need for equipment, supplies, and budget.
- Assist the Trauma Program Manager in developing and meeting the trauma program budgetary goals.
- Oversee, participate in, and develop projects that ensure the cost-effectiveness of care provided by physicians and hospital.

Program Initiatives:

- Develop and provide input on the development and maintenance of practice guidelines, policies, and methodologies for medical/surgical trauma care.
- Participate in site review by regulatory agencies.

- Organize, direct, and implement departmental practices to assure continued compliance with applicable laws including the guidelines established by the Idaho Time Sensitive Emergency System.
- Demonstrate positive interpersonal relationship with colleagues, referral MDs, hospital personnel, and patients/families in order to achieve maximum operational effectiveness and customer satisfaction.
- Assure transfer agreements are in place and in good standing; maintain relationship with receiving facilities; and foster collaborative relationships.
- Make appropriate referrals for specialty services and communicate regularly with referring physicians as appropriate.
- Provide trauma care leadership and consultation for emergency, surgery, and intensive care unit departments.
- Participate in regional and statewide activities affecting the trauma program.
- Attend local and national meetings and conferences to remain current regarding issues relevant to the performance of duties.
- Demonstrate consistent, efficient, cost effective, and quality trauma care at all times.
- Participate in trauma patient/family satisfaction projects as developed by hospital.

#### Performance Improvement:

- Determine and implement PI activities appropriate to the trauma program.
- Oversee the trauma PI program and participate in other quality initiatives that deal with the care of injured patients.
- Review and investigate all trauma PI inquiries in collaboration with the Trauma Program Manager and refer to the appropriate committees.
- Monitor compliance with trauma treatment guidelines, policies, and protocols.
- Assure that the quality and appropriateness of patient care are monitored and evaluated and that appropriate actions based on findings are taken on a consistent basis.
- Report quality of care issues promptly to appropriate individuals including Trauma Program Manager and hospital administration.
- Identify and correct deficiencies in trauma care policies, guidelines, and protocols.
- Consult with appropriate medical staff and administration regarding quality care issues and adverse outcomes; identify areas to improve patient care.
- Coordinate, schedule, and facilitate the PI peer review process.
- Assist the Trauma Program Manager in evaluating the effectiveness of corrective actions resulting from PI processes.

#### Clinical Education:

- Support the requirements for trauma CME by participating and assisting in the education and training of center personnel physicians and specialists.
- Provide education for hospital staff regarding trauma program policies and appropriate medical practices.

#### Community Outreach:

- Maintain relations with community organizations and legislative bodies whose activities relate to trauma care and injury prevention.
- Participate in hospital outreach activities as requested by administration.
- Develop and participate in trauma community education and injury prevention activities.
- Function as a liaison to other centers within the region.

# Trauma Program Manager Job Description

**Job Title:** Trauma Program Manager

**Department:** Trauma Services

**General Summary:** Maintains responsibility and accountability for trauma services strategic development, regulatory compliance, and associated activities related to trauma care throughout the organization and within the community.

## **Principal Duties and Responsibilities:**

- Adheres to the general [FACILITY] standards to promote a cooperative work environment by utilizing communication skills, developing interpersonal relationships and team building; following the hospital's and departmental policies and procedures contributing to the overall quality of services; staying informed of changes in policies and procedures.
- Establishes effective networks with colleagues throughout [FACILITY] and referral region; maintains interaction with all members of the healthcare team, administration, management, community, patients, and families; develops and supports forums for discussion and resolution of product line issues; defines annual goals and objectives for the trauma services.
- Ensures that trauma services are provided in accordance with [FACILITY] mission, strategic initiatives and all internal and external regulatory standards; implements the mission of the trauma services line; maintains accreditation, regulatory, and professional standards impacting trauma services.
- Monitors financial viability of department through operational and capital budget input, expense control, and quality improvement.
- Ensures clinical progression toward defined quality outcomes, patient and family satisfaction, cost effectiveness, and systems efficiency.
- Enhances commitment to teach and education within the referral area.
- Serves as a driving force to achieve trauma services goals and overall organizational strategic commitments to care; recognizes and responds to contemporary healthcare trends and reimbursement issues impacting healthcare delivery practices.
- Ensures age developmentally appropriate care is provided in accordance with care guidelines for specific age groups served.

## **Principal Duties and Responsibilities:**

In addition to the job-specific responsibilities listed above, all employees are expected to support and model [FACILITY] mission, vision, values, fundamentals of teamwork, service philosophy (CREDO), and other organizational competencies e.g. quality management, fiscal responsibility, safety, and continuous learning. Employees will be held accountable for knowledge and effective application of these principles.

## **Required Qualifications:**

### Education:

- Associates degree in nursing.

### Experience:

- 5+ years in trauma, emergency or critical care services (or equivalent education and/or experience).

Certification/Licensure:

- ID State RN licensure, certification from Trauma Nursing Core Course (TNCC), Basic Life Support (BLS) for Healthcare Providers, Advanced Cardiac Life Support (ACLS), and Pediatric Advanced Life Support (PALS).

Skills:

- Excellent oral, written, and interpersonal communication skills; strong analysis/problem solving skills; computer skills; proven leadership ability; excellent planning, budgeting and fiscal management; exceptional skill and nursing practice in the trauma environment facilitating identification of potential clinical situations impacting trauma outcomes; ability to analyze data abstraction relations to trauma registry; ability to educate; excellent presentation skills.

**Preferred Qualifications:**

Bachelor's degree in nursing or health related field with a minimum of 5 years emergency, trauma and/or critical care nursing experience; previous management, strategic planning, program development, and budgetary experience.

**Working Conditions:**

Physical Requirements:

- Work requires moderate physical exertion up to 33% of the time with ability to lift objects weighing 50lbs. or less.

Environmental Conditions:

- Work is performed under normal working conditions with adequate lighting and ventilation; reasonably anticipated exposure to blood and body fluids once per month or more.

Mental/Visual Requirements:

- Job duties frequently require intense concentration or attention to detail (35-65% of work time).

# Criteria for Consideration of Transfer

## Central Nervous System

- Penetrating injury/open fracture, with or without cerebrospinal fluid leak
- Depressed skull fracture
- GCS <14 or deterioration
- Spinal cord injury or major vertebral injury

## Chest

- Major chest wall injury or pulmonary contusion
- Wide mediastinum or other signs suggesting great vessel injury
- Cardiac injury
- Patients who may require prolonged ventilation

## Pelvis/Abdomen

- Unstable pelvic ring disruption
- Pelvic fracture with shock or other evidences of continuing hemorrhage
- Open pelvic injury; Solid organ injury

## Major Extremity Injuries

- Fracture/dislocation with loss of distal pulses
- Open long-bone fractures
- Extremity ischemia

## Multiple-System Injury

- Head injury combined with face, neck, abdominal, or pelvic injury
- Burns with associated injuries
- Multiple long-bone fractures
- Injury to more than two body regions

## Co-morbid Factors

- Age >55 years; children <5 years of age
- Cardiac or respiratory disease
- Insulin-dependent diabetes; morbid obesity
- Pregnancy
- Immunosuppression

## Secondary Deterioration (Late Sequelae)

- Mechanical ventilation required
- Sepsis
- Major tissue necrosis
- Single or multiple organ system failure (deterioration in central nervous, cardiac, pulmonary, hepatic, renal, or coagulation systems)

# Transfer Agreement Example

This agreement is made and entered into by and between [YOUR FACILITY NAME, CITY, STATE], a nonprofit corporation (hereinafter called [YOUR FACILITY]) and [RECEIVING FACILITY NAME, CITY, STATE], a nonprofit cooperation, (hereinafter called [RECEIVING FACILITY]):

WHEREAS, both [YOUR FACILITY] and [RECEIVING FACILITY] desire, by both means of this Agreement, to assist physicians and the parties hereto in the treatment of trauma patients (e.g. burn, traumatic brain injuries, spinal cord injuries, pediatrics); and whereas the parties specifically wish to facilitate: (a) the timely transfer of patients and information necessary or useful in the care and treatment of trauma patients transferred, (b) the continuity of the care and treatment appropriate to the needs of trauma patients, and (c) the utilization of knowledge and other resources of both facilities in a coordinated and cooperative manner to improve the professional healthcare of trauma patients.

IT IS, THEREFORE, AGREED by and between the parties as follows:

PATIENT TRANSFER: the need for transfer of a patient from [YOUR FACILITY] to [RECEIVING FACILITY] shall be determined and recommended by the patient's attending physician in such physician's own medical judgement. When a transfer is recommended as medically appropriate, a trauma patient at [YOUR FACILITY] shall be transferred and admitted to [RECEIVING FACILITY] as promptly as possible under the circumstances, provided that beds and other appropriate resources are available. Acceptance of the patient by [RECEIVING FACILITY] will be made pursuant to admission policies and procedures of [RECEIVING FACILITY].

[YOUR FACILITY] agrees that it shall:

Notify [RECEIVING FACILITY] as far in advance as possible of transfer of a trauma patient.

Transfer to [RECEIVING FACILITY] the personal effects, including money and valuables and information relating to same.

Make every effort within its resources to stabilize the patient to avoid all immediate threats to life and limbs. If stabilization is not possible, [YOUR FACILITY] shall either establish that the transfer is the result of an informed written request of the patient or his or her surrogate or shall have obtained a written certification from a physician or other qualified medical person in consultation with a physician that the medical benefits expected from the transfer outweigh the increased risk of transfer.

Affect the transfer to [RECEIVING FACILITY] through qualified personnel and appropriate transportation equipment, including the use of necessary and medically appropriate life support measures.

[YOUR FACILITY] agrees to transmit with each patient at the time of transfer, or in the case of emergency, as promptly as possible thereafter, pertinent medical information and records necessary to continue the patient's treatment and to provide identifying and other information.

[RECEIVING FACILITY] agrees to state where the patient is to be delivered and agrees to provide information about the type of resources it has available.

Bills incurred with respect to services performed by either party to the Agreement shall be collected by the party rendering such services directly from the patient, third party, and neither party shall have any liability to the other for such charges.

This Agreement shall be effective from the date of execution and shall continue in effect indefinitely. Either party may terminate this Agreement on thirty (30) days notice in writing to the other party. If either party shall have its license to operate revoked by the state, this Agreement shall terminate on the date such revocation becomes effective.

Each party to the Agreement shall be responsible for its own acts and omissions and those of their employees and contractors and shall not be responsible for the acts and omissions of the other institutions.

Nothing in this Agreement shall be construed as limiting the right of either to affiliate or contract with any hospital or nursing home on either a limited or general basis while this agreement is in effect.

Neither party shall use the name of the other in any promotional or advertising material unless review and written approval of the intended use shall first be obtained from the party whose name is to be used.

This Agreement shall be governed by the laws of the State of Idaho. Both parties agree to comply with the Emergency Medical Treatment and Active Labor Act of 1986, and the Health Insurance Portability and Accountability Act of 1996 and the rules now and hereafter promulgated thereunder.

This Agreement may be modified or amended from time to time by mutual agreement of the parties, and any such modification or amendment shall be attached to and become part of the Agreement.

SAMPLE

YOUR  
FACILITY:

RECEIVING  
FACILITY:

SIGNED  
BY:

SIGNED  
BY:

DATE:

DATE:

# Trauma Transfer Protocol

**PURPOSE:** Trauma patients who will be transferred out of this facility to a definitive care facility emergently must be identified early, assessed, treated quickly and transferred efficiently in order to provide them the best possible outcome.

**POLICY:** Patients to be transferred can often be identified before they arrive in the emergency department. Arrangements for emergency transfer can often begin the moment the emergency department staff is notified by EMS that they are en route with a major trauma patient. Other patients may require evaluation by the emergency department physician before the decision to transfer is made.

Once the decision to transfer has been made, it should not be delayed to obtain x-rays, CT scans, or laboratory results that do not immediately impact the resuscitation. At this point, the focus of the emergency department staff is on resuscitation and stabilization with the goal of minimizing the patient's length of stay in the emergency department.

Consideration should be given to whether the patient will be transferred via ground or air. Generally, seriously injured trauma patients should be transferred by air when possible. Consideration should be given to ground transport if the patient can be received by the definitive care facility sooner than if transported by air or if aero medical transfer is significantly delayed or unavailable for any reason.

Transport vehicles should be staffed by paramedics and/or nurses whenever possible. Trauma patients on whom invasive procedures have been performed or who have received medications must be transferred under the care of personnel who are adequately trained to manage their resulting condition. If necessary, a physician or nurse from this hospital may accompany the patient.

The following are conditions that should immediately activate emergency transfer procedures:

## **Central Nervous System**

- Penetrating injury, open fracture, with or without cerebrospinal fluid leak
- Depressed skull fracture
- GCS  $\leq$  14 on decontamination
- Spinal cord injury or major vertebral injury

## **Chest**

- Major chest wall injury or pulmonary contusion
- Wide mediastinum or other signs suggesting great vessel injury
- Cardiac injury
- Patients who may require prolonged ventilation

## **Pelvis/Abdomen**

- Unstable pelvic ring disruption
- Pelvic fracture with shock or other evidences of continuing hemorrhage
- Open pelvic injury; Solid organ injury

## **Major Extremity Injuries**

- Fracture/dislocation with loss of distal pulses
- Open long-bone fractures
- Extremity ischemia

### **Multiple-System Injury**

- Head injury combined with face, chest, abdominal, or pelvic injury
- Burns with associated injuries
- Multiple long-bone fractures
- Injury to more than two body regions

### **Co-morbid Factors**

- Age >55 years; children <5 years of age
- Cardiac or respiratory disease
- Insulin-dependent diabetes; morbid obesity
- Pregnancy
- Immunosuppression

### **Secondary Deterioration (Late Sequelae)**

- Mechanical ventilation required
- Sepsis
- Major tissue necrosis
- Single or multiple organ system failure (deterioration in central nervous, cardiac, pulmonary, hepatic, renal, or coagulation systems)

The following are conditions that should be considered for immediate transfer:

### **Central Nervous System**

- GCS >10 and <14

### **Chest**

- >2 unilateral rib fractures
- Patients who may require prolonged ventilation

### **Abdomen**

- Solid organ injury

### **Major Extremity Injuries**

- Open long-bone fractures
- Extremity ischemia

### **Multiple-System Injury**

- Injury to more than two body regions

### **Co-morbid Factors**

- Age >55 years; children <5 years of age
- Cardiac or respiratory disease
- Insulin-dependent diabetes; morbid obesity
- Pregnancy
- Immunosuppression

### **Secondary Deterioration (Late Sequelae)**

- Mechanical ventilation required

SAMPLE

**PURPOSE:**

Before patient arrival:

1. After becoming aware that a trauma patient is en route who likely will require emergent transfer, the emergency department staff activates the trauma team and notifies the emergency department physician of the likelihood of transfer. Ascertain from EMS if they have already ordered aero medical transportation.
2. The physician identifies the appropriate mode of transfer (i.e. aero medical vs. ground) and qualifications of transferring personnel.
3. HUC contacts the appropriate aero medical and/or ground transportation, obtains ETA:  
[INSERT CONTACT INFORMATION]  
[INSERT CONTACT INFORMATION]  
[INSERT CONTACT INFORMATION]

After patient arrival:

1. The physician identifies and contacts the receiving facility and requests the receiving physician to accept the transfer. The two should discuss the current physiological status of the patient and the optimal timing of transfer.
2. Before transfer, the physician should:
  - a. Ensure chest tubes are placed in presence of pneumothorax
  - b. Ensure at least two IV lines are established
  - c. Consider securing the airway with an endotracheal tube, LMA, or surgical airway if GCS <11
  - d. Consider sending additional blood, equipment, and supplies (i.e. medications, fluids, etc.) that the patient may need en route if not available in the transporting vehicle.
3. The HUC copies of all available documentation to accompany the patient:
  - a. EMS report
  - b. Resuscitation record
  - c. X-rays, CT scans
  - d. Lab results

SAMPLE

# Criteria for Consideration of Transfer

Taken from *Resources for Optimal Care of the Injured Patient, COT/American College of Surgeons, 2014.*

- Pulse oximetry
- End-tidal carbon dioxide detection
- Arterial pressure monitoring
- Pulmonary artery catheterization
- Patient rewarming

# Trauma Diversion Policy

**PURPOSE:** Occasions may arise when one or more essential hospital resources are functioning at maximum capacity or otherwise unavailable and it is in the best interests of the trauma patient to be directed to an alternative facility for care.

**POLICY:** The need to go on “trauma divert” is a rare situation, but might occur in the following circumstances:

- The emergency department is saturated; demand for critical patient care resources exceeds availability.
- Emergency department resources are fully committed due to an external disaster/multiple-casualty event.
- Emergency department resources are unavailable due to an internal disaster or catastrophic mechanical failure.

In such rare cases, the emergency department physician may make the decision to divert trauma patients for a short period of time. The need to remain on divert status should be reviewed at least hourly to provide for the shortest possible time on divert.

The diversion of trauma patients only pertains to incoming ambulance patients and not to walk-in patients. A patient incoming via ambulance while on “trauma divert” will be accepted if the EMS provider and monitoring physician determine that the patient is experiencing a condition such that transport to the next closest appropriate trauma hospital could reasonably result in increased morbidity or death. “Trauma divert” status is a request to EMS personnel to transport the patient to another facility. The patient or EMS personnel may decline the request to divert provided they have been properly apprised of the potential for delayed treatment affecting the care of the patient.

Ambulance patients who have arrived on hospital property will be admitted to the emergency department and evaluated by a physician regardless of the hospital’s diversion status.

## **PROCEDURE:**

### Going on divert:

1. The emergency department physician will decide on the need to go on “trauma divert”. The physician will notify the emergency department charge nurse.
2. The charge nurse notifies the following of “trauma divert” status:
  - a. Emergency department nursing staff
  - b. EMS dispatch center(s) (e.g. sheriff departments); request EMS personnel to call hospital early with patient information.
  - c. [NEIGHBORING HOSPITAL(S)]
3. The emergency department charge nurse begins a “Trauma Divert Tracking Log”.

When contacted by EMS with information regarding a seriously injured trauma patient, the emergency department staff person taking report notifies EMS crew that the hospital is on “trauma divert” and immediately puts the crew in contact with the emergency department physician. The physician will determine if the patient is to be seen in the emergency department or diverted to a nearby facility. The decision whether or not to divert must be accomplished very quickly in order to minimize the amount of time the patient spends in transit.

Going off divert:

1. The emergency department physician who initiated the closure must:
  - a. Continuously evaluate the need to remain on “trauma divert”.
  - b. Make the decision as to when the hospital is no longer on “trauma divert”.
  - c. Notify the emergency department charge nurse when no longer on “trauma divert”.
2. The charge nurse notifies:
  - a. Emergency department nursing staff
  - b. EMS dispatch center(s) (e.g. sheriff departments)
  - c. [NEIGHBORING HOSPITAL(S)]
3. The emergency department charge nurse completes the “Trauma Divert Tracking Log” and forwards it to the Trauma Program Manager.

SAMPLE

# Creating a Disaster Plan

1. Establish a hospital disaster committee consisting of the following:
  - a. Chair representative;
  - b. Vice-chair administrative representative;
  - c. Trauma surgeon representative;
  - d. Trauma service administrative representative;
  - e. Security representative;
  - f. Medical staff representation from surgery, anesthesiology, pathology, radiology, infectious disease, medicine, pediatrics, and emergency medicine;
  - g. Radiation safety officer;
  - h. Nursing staff representatives (ED, OR, inpatient);
  - i. Medical records representative;
  - j. Information technology representative;
  - k. Communications representative(s);
  - l. Social service representative;
  - m. Public relations representative;
  - n. Supply representative; and
  - o. Pastoral care representative.
  
2. Document potential disasters for the region.
  - a. Evaluate local geography, demographics, industry, and epidemiologic data for hazards.
  - b. Determine the regional history of natural hazards.
  - c. Sources of information about hazards could include fire department, law enforcement agencies, National Oceanic and Atmospheric Administration, US Army Corps of Engineers, and Department of Transportation (hazardous material on highways and railroads).
  
3. Establish interagency and inter-institutional agreements.
  
4. Determine realistic institutional capacity and capability.
  - a. Determine maximum number of beds, categories (i.e. ICU, ward, adult, pediatric, burn, etc.)

- b. Develop a protocol to assess inpatients for potential early discharge or relocation to make beds available for casualties.
  - c. Plan a mechanism to place a hold on elective and non-urgent surgery.
5. Determine desired and available basic and disaster supplies including inventory and emergency stockpile.
- a. Blood supply arrangements should be made with the Red Cross and other suppliers of blood and included in simulation exercise.
  - b. Stockpiles of reinforcement supplies available on a 24-hour basis should be located among commercial sources, other institutions, the military, and FEMA, so that they can be obtained readily by telephone.
  - c. Food, water, and energy needs should be considered for specific disasters: consider sources, amounts, and length of time.
6. Develop a flow chart of mass casualties through hospital areas ensuring the following:
- a. Patient flow is unidirectional (to avoid bottlenecks in ED and radiology).
  - b. Patient traffic does not enter and leave any area through the same door.
7. Designate hospital space for the following:
- a. Patient unloading area.
    - i. Ground vehicles require careful traffic control with provision for buses and trucks.
    - ii. Helicopters need a designated landing area.
  - b. Triage criteria should be developed according to types of injured patients seen and number of victims involved in the disaster.
  - c. A triage area should be designated. Depending on the configuration of the hospital, access to the triage area, and the number of patients involved, this area may or may not use the ED. Note; For mass casualties, an area other than the ED should be used. The ED should be reserved for patient care.
  - d. Critical stabilization area (usually the ED).
  - e. Preoperative area – immediate and delayed.
  - f. Operative area.
  - g. Postoperative area.
  - h. Burn treatment area.
  - i. Minor surgery area.

- j. Hazardous chemical or radioactive material decontamination areas and receptacles for contaminated materials.
  - k. Expectant area (for dying patients).
  - l. Morgue.
  - m. Psychiatric area within the institution or at nearby schools, hotels, or motels for psychiatrically trained medical, nursing, social service, and security personnel to work with the following:
    - i. People from the disaster area including rescue personnel;
    - ii. People disturbed by the news generated by the disaster; and
    - iii. Family, friends, and others.
  - n. Press conference room with space for many telephones and for minor amenities outside the patient-care perimeter.
  - o. Record and evidence area.
  - p. Recruitment and assignment office to assist in assessing and assigning volunteers.
  - q. Disaster support center including the following:
    - i. Administrative control center; and
    - ii. Communications center.
8. Develop a system to summon and assign personnel to designated patient-care areas. Call-up needs should consist of internal and external call-up. ED and other in-hospital personnel will be assigned as hospital first responders for key posts until external call-up can be affected. Keep assignments flexible and updated. Do quarterly updates of telephone number rosters. A designated reporting area, away from the ED, for sign-in should be established.
9. Personal Resources:
- a. Hospital disaster commander and emergency operating center liaison plus at least two alternates based in the disaster support center.
  - b. The triage officer should be a physician who has the knowledge necessary for optimally using the resources required to care for severely injured patients. Physicians need to be available for field triage as part of a disaster site medical team and for in-house triage as assigned by the disaster commander. Non-physician medical personnel may serve in this role in certain settings if properly trained.

- c. Physicians, nurses, a radiation safety officer, and administrative staff are assigned to specific patient-care areas. Develop an instruction packet for use in each patient-care area describing their specific functions during a disaster.
- d. A chief security officer in charge of the perimeter and other security to assist identifying various people, control the press, act as morgue officer under the pathologist's supervision, and inventory victims' valuables and evidentiary materials.
- e. Public relations-media person: One person using the press conference technique should be the sole communication link with the press.
- f. Patient transport personnel.

10. Provision for food and rest for disaster personnel:

- a. Shift schedules to allow regular rotations to equalize workload and prevent provider fatigue; and
- b. Critical incident stress management program to recognize and treat providers who show signs of stress, exhaustion, and/or emotional disability.

11. Communications system compatible with other EMS elements. Note: Consider the possibility that the present system might be overwhelmed or disrupted):

- a. Intra-agency operating center:
  - i. Emergency operating center.
  - ii. Fire department, law enforcement agencies, and ambulance and helicopter services.
  - iii. Predetermined method of radio frequency selection to be used by each agency.
  - iv. Provision for "secondary distribution" of casualties from overloaded facilities to those with more capacity to assure maximal casualty treatment.
- b. Inter-hospital system.

12. Establish medical record and patient identification systems including identification of triage category.

13. Define institutional and staff security.

- a. Secure perimeter of hospital.
- b. Secure perimeter of patient-care area.
- c. Provide for ready access to all areas of hospital through elevator control and in-hospital crowd control.

- d. Ensure personnel security – control and identification.
- e. Identify a designated area for members of the press.
- f. Perform regional hazard assessment.
  - i. Radiation protection.
  - ii. Hazardous material protection.
  - iii. Emphasis of neutrality in riot situations.

14. Debrief and counsel disaster and rescue personnel on a routine basis.

15. Critique each disaster response and modify the plan to reduce future errors within 24 hours of disaster.

16. Transfer agreements.

- a. Protocols should include the flexibility needed for disasters.

# TSE Field Trauma Triage Guidelines

## Priority 1 (Focus: Physiology)

### Airway/Breathing

- Actual or potential airway compromise:
  - Acute Hypoxia
  - RR < 10 or > 29 (adult)
  - Severe maxillofacial injuries
- Intubated/Supraglottic Airway/BVM
- Suspected inhalation injury

### Event/Injuries/Findings

- Penetrating injury to head, neck, or torso
- High voltage electrical injury
- Bilateral femur fractures
- Complete amputation above the wrist or ankle
- Open skull fracture
- Child: Flail chest/Pelvic fracture/Pulseless extremity

### Circulation

- CPR by medical provider
- Hypotension:
  - Adult: SBP < 90mmHg, HR > 130
  - Child: Age 1-9yrs: SBP ≤ 70 + (2x age in years)
  - Age < 1yr: SPB ≤ 70mmHg
  - Child HR: 0-12mths: > 180 or < 80bpm
  - ≥ 12mths-5yrs: > 160 or < 60bpm
  - 6-10yrs: > 140 or < 60bpm
  - ≥ 11yrs: > 120 or < 60bpm
- Any patient receiving blood/vasopressors

### Disability

- GCS ≤ 12 attributable to trauma
- Bilateral extremity paralysis or suspected spinal cord injury

## Priority 2 (Focus: Anatomy)

### Event/Injuries/Findings

- Penetrating injury proximal to elbow/knee
- Unilateral motor deficit
- 2 or more broken extremities (any)
- Application of a tourniquet
- Open or displaced pelvic fracture
- Open femur or humerus fracture
- Crushed or mangled extremity
- Flail chest and/or palpable crepitus
- Burn involvement of face, airway, hands, feet, genitalia; **OR**
  - Adult: ≥ 20% TBSA
  - Child: ≥ 10% TBSA
- Pregnant(≥ 20wks) with vaginal bleeding
- Submersion with traumatic mechanism

Child \*Pediatric is considered age ≤ 14yrs

## Consider UPGRADING one level if:

- Pediatric: age ≤ 14yrs
- Adult: age ≥ 65yrs
- Significant co-morbidities

## Priority 3 (Focus: Mechanism)

### Event/Injuries/Findings

- Penetrating injury distal to elbow/knee
- Closed isolated femur fracture
- Loss of consciousness after injury
- GCS 13-14 after injury
- Pregnant(≥ 20wks) without vaginal bleeding
- Burn: Adult: ≤ 20% TBSA
- Child: ≤ 10% TBSA
- Amputation of one or more digits
- Sensory deficit of an extremity

### Mechanisms

- Motor vehicle crash with
  - Death of co-occupant
  - Broken/bent steering wheel
  - Rollover
  - Extrication time > 20 minutes
  - > 12" intrusion into occupant space
  - Non-enclosed transport accident > 20mph
- Ejection from enclosed vehicle
- Motor vehicle vs. pedestrian/bike
- Fall 2x patient's height
- Significant animal-related injury

- Anti-coagulation other than Aspirin
- Hypothermia/Hyperthermia
- EMS DISCRETION

