

# Level 3 Trauma Hospital Designation Criteria

FULL IMPLEMENTATION DEADLINE 01.01.2027

Revision 12.2025

## Level 3

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### Institution - Criterion 1.1

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#### Definition

The board of directors, administration, and medical staff shall demonstrate a commitment to provide the resources and support necessary to sustain the trauma designation. This commitment shall be signed and dated within one year of designation expiration.

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#### Measures of Compliance

The following must be submitted with the designation application:

- A signed hospital board resolution letter dated no more than one year prior to designation expiration
  - A signed hospital medical staff resolution letter dated no more than one year prior to designation expiration
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#### Resources / Sample Documents

1.1 Hospital Board Resolution

1.1 Medical Staff Resolution

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#### References

None

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#### Helpful Tips

Resolution should include language such as

“THEREFORE; BE IT RESOLVED that the board of directors of [HOSPITAL] acknowledges the commitment to adherence to the standards required for level [III or IV] trauma designation, as well as commitment to ensuring that the necessary personnel, facilities, and equipment are made available to support adherence to those standards.”

When using templates, be sure they are modified as appropriate including your hospital name and designation level.

Evaluate the appropriate timeline to start this process, as it can take a while to cycle through meetings for the appropriate signature(s).

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## Level 3

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### Institution - Criterion 1.2

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#### Definition

The trauma program shall be established by the facility and represented on the official hospital organizational chart.

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#### Measures of Compliance

The following must be submitted with the designation application:

- An official hospital organizational chart
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#### Resources / Sample Documents

1.2 Organizational Chart

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#### References

None

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#### Helpful Tips

The facility's organizational chart should show where trauma "lives" in the facility in relation to other departments in the hospital. The organizational chart should represent job titles or positions, not specific people.

The trauma program may be located within an existing department, such as the Department of Surgery or Emergency Department, but must appear on the official organizational chart.

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## Level 3

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### Medical Director - Criterion 2.1

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#### Definition

The trauma medical director (TMD) or medical advisor shall be a board-certified or board-eligible physician whose job description defines his or her authority, roles, and responsibilities for the leadership of the trauma program, the trauma performance improvement process, and tertiary case review.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Start month and year for the TMD
  - Expiration date of current board certification
  - Current job description(s) should include
    - Roles and responsibilities for:
      - Leadership of the trauma program
      - Trauma performance improvement
      - Tertiary case review
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#### Resources / Sample Documents

2.1 Trauma Medical Director Job Description- Sample

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#### References

None

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#### Helpful Tips

The trauma medical director (TMD) position may also be titled trauma medical advisor if needed.

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## Level 3

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### Medical Director - Criterion 2.2

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#### Definition

If the trauma medical director (TMD) is not a general surgeon, there must be a co-TMD who is a board-certified or board-eligible general surgeon.

2.2.1 The co-TMD must have a job description that defines the roles and responsibilities for the Trauma Program, including trauma performance improvement and tertiary case review.

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#### Measures of Compliance

If a surgeon co-trauma medical director is required, the following must be submitted with the designation application:

- Start month and year for the co-TMD
  - Expiration date of current board certification for the co-TMD
  - Current job description of the co-TMD
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#### Resources / Sample Documents

2.2 Level 3 Trauma Co-Medical Director Job Description - Sample

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#### References

None

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#### Helpful Tips

The co-TMD position may also be titled co-trauma medical advisor if needed.

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## Level 3

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### Medical Director - Criterion 2.3

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#### Definition

The trauma medical director (TMD) and co-TMD must meet the same trauma training requirements as the Emergency Physician.

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#### Measures of Compliance

The following must be submitted with the designation application:

- The month and year of course completion for the TMD's last training course (ATLS or CALS)
  - Clinician roster including the required educational and certification components
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#### Resources / Sample Documents

Clinician Roster

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#### References

Educational Resources website

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#### Helpful Tips

None.

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## Level 3

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### Program Manager - Criterion 3.1

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#### Definition

The trauma program manager (TPM) must be either a registered nurse or an allied health professional with emergency and trauma care experience.

3.1.1 The TPM job description must define the roles and responsibilities for the management and leadership of the trauma program and the trauma performance improvement process.

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#### Measures of Compliance

The following must be submitted with the designation application:

- The name and credentials of the TPM position
  - Their start date (Month/Year) in the position
  - The TPM job description describing all trauma program roles and responsibilities, including the performance improvement process
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#### Resources / Sample Documents

3.1 Trauma Program Manager Job Description - Sample

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#### References

None

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#### Helpful Tips

The TPM job description will define the roles and responsibilities related to the leadership of the trauma program, including trauma performance improvement.

The TPM position may also be titled coordinator if needed.

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## Level 3

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### Program Manager - Criterion 3.2

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#### Definition

If the trauma program manager (TPM) is not a registered nurse, a registered nurse must assist with:

3.2.1 Primary review of trauma care provided in all areas of the hospital

3.2.2 Function as a liaison between the trauma program and the nursing staff

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#### Measures of Compliance

The following must be submitted with the designation application:

- The name and credentials of the registered nurse assisting the TPM
- Their start date (Month/Year) in the position

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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

The liaison should assist with follow-up/investigation, education, etc. between the trauma program and nursing staff.

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### Level 3

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#### Program Manager - Criterion 3.3

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##### Definition

The trauma program manager (TPM) must have at least a portion of an FTE dedicated for trauma program responsibilities.

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##### Measures of Compliance

The following must be submitted with the designation application:

- The amount of FTE the TPM has dedicated to the trauma program.

This will be validated at site visit.

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##### Resources / Sample Documents

None

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##### References

None

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##### Helpful Tips

The trauma program performance improvement process requires that sufficient resources are invested in order to maintain integrity and support the growth of the trauma program. The time allotted should be dedicated, protected, and uninterrupted.

Dedicated time for trauma program managers\* directly correlates with the success of a facility's trauma program. TPM workloads are extremely dependent on ED and admission volumes. Most successful Level 3 trauma programs have a minimum dedicated 0.6 FTE, which increases rapidly with higher ED and admission volumes. This does not include FTE allocation for registry entry.

Leadership of the trauma program, the PI process and other workload completion/timeliness must be monitored closely to judge whether the FTE assignment is adequate. PI  
and other workload completion and timeliness must be monitored closely to judge whether the FTE assignment should be increased.

If the facility had immediate actions or multiple recommendations in the past designation cycle, reevaluate the FTE allocation and responsibilities of the TPM.

\*Some TPM responsibilities may be delegated to other staff.

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## Level 3

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### Trauma Team Activation - Criterion 4.1

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#### Definition

The hospital must have a trauma team activation (TTA) policy, protocol or guideline that includes:

- 4.1.1 A list of all team members expected to respond, which may include telemedicine providers.
  - 4.1.2 The response time expectation for the team members, including in-house and off-site staff.
  - 4.1.3 The physiologic, anatomic, and clinical indicators that, when met, require the activation of the trauma team.
  - 4.1.4 The person(s) authorized to activate the trauma team.
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#### Measures of Compliance

The following must be submitted with the designation application:

- A list of team member positions (not names) expected to respond to each level of trauma activation
  - The response time expectation for each of the team members listed above
  - The criteria for each level of activation
  - A list of positions authorized to activate the trauma team
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#### Resources / Sample Documents

- 4.1 Level 3 Single-Tier Trauma Team Activation (TTA) Policy - Sample
  - 4.1 Level 3 Multi-Tier Trauma Team Activation (TTA) Policy - Sample
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#### References

None

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#### Helpful Tips

When trauma activation criteria are changed, review and update any associated policy to ensure it matches.

Provide nurse and provider education when any activation criteria or policy change occurs.

Anatomic criteria refer to specific injuries and injury patterns.

Physiologic criteria refer to disturbances in vital signs, such as low GCS, decreasing GCS, or hypothermia.

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## Level 3

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### Trauma Team Activation - Criterion 4.2

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#### Definition

The trauma team activation (TTA) criteria must be readily available in locations where a trauma patient is likely to be initially encountered.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Trauma team activation (TTA) poster

Locations of posted criteria will be validated at site visit.

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#### Resources / Sample Documents

4.2 Level 3 Single-Tier Trauma Team Activation (TTA) Poster - Sample

4.2 Level 3 Multi-Tier Trauma Team Activation (TTA) Poster - Sample

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#### References

None

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#### Helpful Tips

Criteria should be readily available in the ED triage area, trauma bays, and any other ED rooms where injured patients may receive care.

Ensure that any wall posters match the trauma activation policy, protocol, or guideline.

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## Level 3

### Tier-One Trauma Team Activation Criteria - Criterion 5.1

#### Definition

When one of the following tier-one trauma activation criteria is met, the emergency department provider must promptly communicate with the general surgeon and details of the discussion must be documented in the medical record:

5.1.1 Sustained GCS  $\leq$  8 secondary to trauma

5.1.2 Respiratory distress, airway compromise, or intubation

5.1.3 Penetrating trauma to head, neck, chest, abdomen, or pelvis

5.1.4 Evidence of shock/hypoperfusion indicated by:

5.1.4.1 Systolic blood pressure  $\leq$  90 mmHg at any time or age-specific hypotension in pediatrics

*Table 1: Age-specific hypotension*

Age (years)	SBP (mmHg)
< 1	< 70
1-2	< 75
2-5	< 80
6-17	< 90

5.1.4.2 Persistent tachycardia in a patient  $\leq$  17 years old

*Table 2: Age-specific heart rate*

Age (years)	HR (bpm)
0-1	< 80 or > 180
1-2	< 70 or > 180
2-5	< 60 or > 180
6-17	< 60 or > 160

5.1.4.3 Provider impression of hypoperfusion (consider absent distal pulses, agitation, anxiety, confusion, delayed capillary refill, diaphoresis, pallor, persistent heart rate > 120 in a patient > 14 years old, tachypnea)

5.1.5 Arterial tourniquet indicated

5.1.6 Pregnancy > 20 weeks with vaginal bleeding or contractions attributed to a traumatic mechanism

5.1.7 Discretion of the emergency department provider:

- Positive eFAST exam
  - Those patients not meeting any of the tier-one trauma team activation criteria
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### **Measures of Compliance**

The following must be submitted with the designation application:

- TTA policy

This will be validated through case reviews at site visit.

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### **Resources / Sample Documents**

4.1 Level 3 Single-Tier Trauma Team Activation (TTA) Policy – Sample

4.1 Level 3 Multi-Tier Trauma Team Activation (TTA) Policy - Sample

4.2 Level 3 Single-Tier Trauma Team Activation (TTA) Poster – Sample

4.2 Level 3 Multi-Tier Trauma Team Activation (TTA) Poster - Sample

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### **References**

None

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### **Helpful Tips**

None

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## Level 3

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### General Surgeon Response - Criterion 6.1

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#### Definition

The general surgeon must arrive within 60 minutes when requested. The general surgeon may be canceled when the patient has left the facility, and this must be documented.

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#### Measures of Compliance

This is validated through case reviews at site visit.

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#### Resources / Sample Documents

None

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#### References

Criterion 21.3.10

Criterion 22.1.3

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#### Helpful Tips

Request may come from the Emergency Department or Inpatient setting.

Response time should be measured from the time requested until the surgeon arrival.

In the event the patient is transferred (left the facility) prior to surgeon arrival, the surgeon can be cancelled.

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## Level 3

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### General Surgeon Response - Criterion 6.2

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#### Definition

The general surgeon must be consulted upon discovery of any of the following conditions resulting from trauma:

- 6.2.1 Serum lactate > 5.0 mmol/L and not improving
  - 6.2.2 High grade solid organ injury (grade 3 – grade 5)
  - 6.2.3 Fluid in the abdomen, without solid organ injury
  - 6.2.4 Untreated hemothorax or pneumothorax requiring thoracostomy
  - 6.2.5 Cardiac or major vessel injury
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#### Measures of Compliance

This is validated through case reviews at site visit.

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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

The consultation between the general surgeon and the ED provider may be by telephone if documented promptly in the medical record and the providers can determine if and how quickly the surgeon may need to respond in person.

Elevated serum lactate indicates poor tissue perfusion and should be measured soon after arrival in patients with significant injury. A level > 5.0 is concerning for tissue hypoxia and should prompt aggressive resuscitation. The lactate level should be repeated in 2-4 hours, and if it remains over 5 or is increasing, should prompt a surgical consultation.

High grade solid organ injuries are more likely to bleed or develop complications, and surgical evaluation should determine if intervention or transfer is needed.

Free fluid without solid organ injury may indicate a hollow viscus injury, requiring examination by the surgeon to determine proper investigation.

“Untreated” is defined as a patient with a hemothorax/pneumothorax that requires a chest tube be placed and does not have one in place. If the ED provider is able to place the tube, the surgeon would not be required to respond.

If the ED Provider is unable or unsuccessful to place the tube, the surgeon is required to respond.

Patients with a suspicion of cardiac or major vessel injury may require intervention or temporizing measures by the surgeon.

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## Level 3

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### General Surgery and Operating Room - Criterion 7.1

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#### Definition

The operating room must be continuously available for emergent surgery.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Attestation

This will be validated through case reviews at site visit.

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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### General Surgery and Operating Room - Criterion 7.2

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#### Definition

A general surgeon must be continuously available, either on-site or on-call, and able to respond to the hospital within 60 minutes. A schedule identifying the general surgeon on-call must be readily available to the emergency department and operating room staff.

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#### Measures of Compliance

The following must be submitted with the designation application:

- General surgeon coverage schedule (Up to 12 months' worth of schedules may be requested.)

Schedule accessibility in the ED/OR will be validated during site visit tour.

Response time from the surgeon will be validated through case reviews at site visit.

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#### Resources / Sample Documents

None

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#### References

Criterion 22.1.3

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#### Helpful Tips

Track this in the PI process

For the purposes of general surgeon coverage, "continuously" means seamless coverage 350 days of the calendar year.

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## Level 3

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### General Surgery and Operating Room - Criterion 7.3

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#### Definition

The operating room team must arrive at the hospital within 30 minutes from the time requested.

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#### Measures of Compliance

Validated through case reviews and review of PI documents at site visit.

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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

Track this in the PI process.

The operating room team is defined as minimum staff needed to begin the case.

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## Level 3

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### General Surgery and Operating Room - Criterion 7.4

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#### Definition

The hospital must establish a written plan addressing:

7.4.1 How the trauma patient will be managed should the usual surgical coverage be temporarily unavailable for any reason (e.g., the surgeon is already in surgery).

7.4.2 How surgeon call will be covered when scheduled gaps in the usual coverage occur (e.g., vacations).

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#### Measures of Compliance

The following must be submitted with the designation application:

- Operating Room plan/document
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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### General Surgery and Operating Room - Criterion 7.5

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#### Definition

A surgeon must be present at all operative procedures performed in the operating room.

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#### Measures of Compliance

This will be validated through case reviews at site visit.

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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### Emergency Medicine - Criterion 8.1

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#### Definition

An emergency physician must be continuously available, either on-site or on-call.

If the emergency department physician is off-site, an on-call schedule must identify the physician(s) covering the emergency department.

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#### Measures of Compliance

The following must be submitted with the designation application:

- ED schedule demonstrating continuous coverage (Up to 12 months' worth of schedules may be requested)

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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### Emergency Medicine - Criterion 8.2

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#### Definition

When called, the emergency physician must arrive at bedside within 15 minutes of the patient's arrival.

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#### Measures of Compliance

This will be validated through case reviews at site visit.

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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### Anesthesia - Criterion 9.1

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#### Definition

An anesthesiologist or certified registered nurse anesthetist (CRNA) must be continuously available, either on-site or on-call.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Attestation
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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### Orthopedic Surgery - Criterion 10.1

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#### Definition

If the hospital provides emergent orthopedic surgery, a schedule of the orthopedic surgeon on-call must be maintained and accessible by the emergency department and inpatient staff.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Orthopedic surgery on-call schedule (Up to 12 months' worth of schedules may be requested)
- Orthopedic Worksheet

This will be validated through case reviews at site visit.

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#### Resources / Sample Documents

10.1 Level 3 Orthopedic Worksheet

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#### References

None

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#### Helpful Tips

Ensure consistency between the transfer policy, admission policy, and the facility's practice related to orthopedic care.

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## Level 3

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### Orthopedic Surgery - Criterion 10.2

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#### Definition

If the hospital admits patients for the care of surgical orthopedic injuries, a schedule/document outlining the orthopedic surgeon coverage must be maintained and accessible by the emergency department and inpatient staff.

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#### Measures of Compliance

The following must be submitted with the designation application:

- A schedule/document to outline the orthopedic surgical coverage (Up to 12 months' worth of schedules may be requested)
  - Orthopedic Worksheet
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#### Resources / Sample Documents

10.1 Level 3 Orthopedic Worksheet

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#### References

None

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#### Helpful Tips

Ensure consistency between the transfer policy, admission policy, and the facility's practice related to orthopedic care.

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## Level 3

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### Post-Anesthesia - Criterion 11.1

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#### Definition

A registered nurse capable of recovering a post-anesthesia patient must be continuously available.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Attestation
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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### Respiratory Therapy - Criterion 12.1

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#### Definition

A respiratory therapist, registered nurse, or other allied health professional trained in ventilator management must be continuously available.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Attestation
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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

If RN or other allied health professional fills this role, ensure training is provided.

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## Level 3

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### Blood Bank - Criterion 13.1

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#### Definition

There must be an in-house blood bank stocked with type-O blood.

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#### Measures of Compliance

The following must be submitted with the designation application:

- The number of units of each blood product that is typically stocked in-house.

This will be validated at site visit.

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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### Blood Bank - Criterion 13.2

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#### Definition

There must be a policy establishing a procedure for the emergent release of uncross-matched blood that:

13.2.1 Ensures that uncross-matched blood can be released to the appropriate staff immediately

13.2.2 Includes a provision to release uncross-matched blood to the appropriate staff in the absence of the blood bank staff if they are off-site

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#### Measures of Compliance

The following must be submitted with the designation application:

- Emergent Blood Release policy

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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

Existence of a Massive Transfusion Protocol (MTP) is beneficial to patient care but not required.

If the hospital has an MTP, submit with the designation application.

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## Level 3

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### Radiology - Criterion 14.1

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#### Definition

A computed tomography (CT) technologist must be continuously available, either in-house or on-call.

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#### Measures of Compliance

The following must be submitted with the designation application:

- A description of CT technologist coverage
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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### Radiology - Criterion 14.2

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#### Definition

A radiologist must be continuously available, either in-house or off-site.

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#### Measures of Compliance

The following must be submitted with the designation application:

- A description of radiologist coverage

This will be validated at the site visit.

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#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

None

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## Level 3

### Admission - Criterion 15.1

#### Definition

If admitted, one hundred percent of patients with conditions represented in Table 3, must be admitted by or receive a consultation from an appropriate surgeon (Ortho, Neuro, General, Spine, etc.).

- General Surgeon consultations are required to be at bedside.
- Surgical subspecialist (Ortho, Neuro, Spine, etc.) consults can be remote.

All consultations/evaluations for traumatic injury must be performed within 18 hours of discovery of the injury.

- The consultation/admission may be accomplished by the surgeon's appointed Nurse Practitioner (NP)/Physician Assistant (PA) on behalf of the surgeon.

Table 3: Mandatory surgeon admit or consult

Hemothorax or pneumothorax requiring a thoracostomy
Sternum or scapula fracture
Pelvic fracture (not isolated ramus fractures)
Five or more rib fractures with a Practice Management Guideline in place
Pulmonary contusion with the need for oxygen to maintain SpO2 > 90%
Significant fall: <ul style="list-style-type: none"> <li>▪ &gt; 10 feet</li> <li>▪ &gt; 65 years old and fall from elevation or down stairs</li> </ul>

Patients with conditions represented in table 4 may be admitted without surgical consultation.

Table 4: Surgeon consult not required

Concussion
Subarachnoid hemorrhage involving one hemisphere no more than 3 mm thick, subdural or intraparenchymal hemorrhage < 8 mm thick, GCS > 13, in a patient not taking anticoagulant or antiplatelet agents (aspirin and NSAIDs are allowed) *
Diminished level of consciousness attributed to a non-traumatic cause
Thoracic or lumbar transverse or spinous process fracture
One or two rib fractures
Three or four rib fractures with a Practice Management Guideline in place
Pneumothorax that does not require a thoracostomy

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## Measures of Compliance

The following must be submitted with the designation application:

- Admission Policy
- Practice Management Guideline (PMG) for rib fractures

Validated through case reviews and review of PI documents at site visit

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## Resources / Sample Documents

### 15.1 Level 3 Admission Policy - Sample

### 15.1 Level 3 Rib Fracture Practice Management Guideline

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## References

Criterion 21.3 (PI Process)

Criterion 22.1 (PI Measures)

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## Helpful Tips

Consider tracking this using a PI filter for Table 3 conditions.

Admission policy must include the conditions in Table 3 that the hospital admits.

Surgeon consultation is expected to be 100%, if not the hospital should have documented PI activities to remedy the situation.

Providers should exercise judgement in obtaining consults sooner if warranted by the injury mechanism or acuity.

If consultations/evaluations for trauma care are by telephone, it must be documented in the medical record.

Pelvic fractures include all sacral fractures.

Elevation or “down stairs” is any elevation, any number of steps.

PMG must be approved by the hospital Medical Executive Committee or equivalent and monitored by the trauma PI program.

A resident can respond and perform any role in the resuscitation that the surgeon deems fit. However, the trauma system response requirements refer to the attending surgeon. The resident cannot respond in his/her place or supplant his/her role

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## Level 3

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### Admission - Criterion 15.2

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#### Definition

For all trauma patients admitted to the hospital for trauma care, a surgeon should be the admitting or consulting physician at least 70% of the time.

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#### Measures of Compliance

Validated through case reviews and review of PI documents at site visit

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#### Resources / Sample Documents

None

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#### References

Criterion 21.3.11

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#### Helpful Tips

Track this in the PI process

Multi-system injury trauma cases should be admitted to the general surgeon. Single-system injury trauma cases may be admitted to a primary care physician if consultations are obtained from the appropriate surgeon (i.e., orthopedic surgeon for isolated orthopedic injuries, neurosurgeon for isolated neurological injuries and general surgeon for all other injuries). Traumatic injury cases exclusively orthopedic in nature may be admitted to the orthopedic surgeon.

#### Excluding patients admitted with:

- Conditions listed in 15.1 Table 4
  - Isolated pubic ramus fractures
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## Level 3

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### Admission- Criterion 15.3

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#### Definition

The hospital must have a policy describing:

15.3.1 The types of trauma patients considered for admission.

15.3.2 The specialists responsible for admitting and providing consults.

15.3.3 The expectations for monitoring patients for deterioration. Elements should include:

15.3.3.1 Fluctuating or increasing heart rate

15.3.3.2 Fluctuating or decreasing blood pressure

15.3.3.3 Fluctuating or worsening level of consciousness or mental status

15.3.3.4 Increasing work of breathing, shortness of breath, or tachypnea

15.3.3.5 Increasing agitation or anxiety

15.3.3.6 Diaphoresis or pallor

15.3.3.7 Indications for provider notification

15.3.4 The considerations of the admission decisions, in the event of patient deterioration, must include:

15.3.4.1 Weather

15.3.4.2 Distance

15.3.4.3 Transport resource availability

15.3.4.4 Timeliness of specialty resources/definitive interventions

15.3.5 The emergent transfer procedures in the inpatient setting.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Admission Policy

This will be validated through case reviews at site visit.

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## **Resources / Sample Documents**

### 15.1 Level 3 Admission Policy - Sample

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#### **References**

None

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#### **Helpful Tips**

Provide education to staff with any trauma policy change.

The policy should reflect all provider types involved in the care of the admitted patient. i.e. hospitalists, internal medicine, family medicine, general surgeons, ortho, neuro, etc.

Clarify when coverage is provided by NP/PA vs. Physician.

Cross reference admission and transfer policies to ensure they do not contradict each other.

Encourage proactive considerations to limit the number of reactive responses needed.

The impact of delays in transfer, or increased time to arrival at definitive care could impact patient outcome and should be considered prior to admission.

The goal for patient arrival at definitive care is 120 minutes from the time deterioration is discovered.

The inpatient emergent transfer procedures can either be outlined in the admission policy or similar document.

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## Level 3

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### Transfer - Criterion 16.1

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#### Definition

The hospital must have a policy directing the internal processes to emergently implement the transfer of a trauma patient from the emergency department or an in-patient area to definitive care that lists:

16.1.1 The anatomic and physiologic criteria that, when present, must result in the decision to transfer;

16.1.2 The orthopedic surgical conditions that, when present, must result in the decision to transfer. The policy must specifically address how time-sensitive orthopedic conditions such as a threatened limb, compartment syndrome, dislocated knee, and dislocated native hip (i.e., not arthroplasty) will be managed while awaiting transport.

16.1.3 The primary ground and aeromedical transfer services to be used, with contact information for each.

16.1.4 A listing of the supplies, records, and personnel accompanying the patient.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Trauma Transfer policy

This will be validated through case reviews at site visit.

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#### Resources / Sample Documents

16.1 Level 3 Trauma Transfer Policy - Sample

---

#### References

None

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#### Helpful Tips

Definitive care includes any designated trauma hospital with the resources to treat all injuries the patient has sustained. If all injuries can be definitively managed at this hospital, transfer is not needed.

Anatomic criteria refer to specific injuries and injury patterns.

Physiologic criteria refer to disturbances in vital signs, such as low GCS, decreasing GCS, or hypothermia.

---

## Level 3

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### Transfer - Criterion 16.2

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#### Definition

Designated trauma hospitals may not transfer adult or pediatric patients to undesignated hospitals.

Exception: Due to regulatory limitations, patients may be transferred to a Veterans Administration medical center when medically appropriate.

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#### Measures of Compliance

This will be validated through case reviews at site visit.

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#### Resources / Sample Documents

None

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#### References

Trauma System Hospitals website

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#### Helpful Tips

None

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## Level 3

---

### Transfer - Criterion 16.3

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#### Definition

The hospital must have transfer agreements with trauma hospitals capable of providing definitive care for trauma patients, including:

16.3.1 At least one agreement with a primary referral hospital

16.3.2 At least two agreements with hospitals capable of caring for burn patients

16.3.3 At least one agreement with a designated Level 1 or Level 2 Pediatric Trauma Hospital

---

#### Measures of Compliance

The following must be submitted with the designation application:

- Transfer Agreement with primary referral hospital
  - Transfer Agreement with two hospitals capable of caring for burn patients
  - Transfer Agreement with Level 1 or Level 2 Pediatric Trauma Hospital
- 

#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

One agreement can fulfill multiple categories.

Most transfer agreements renew automatically. If they do not, be sure to update before they expire.

Transfer agreements are required, even if the transferring and receiving hospitals are part of the same system.

The primary referral hospital may be within the hospital's own health system.

---



## Level 3

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### General Surgeon Training - Criterion 17.1

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#### Definition

General surgeons must have successfully completed ATLS and/or CALS Trauma & Provider Course within the last four years. General surgeons must re-take their ATLS or CALS Trauma & Provider Course before or during the month in which it is due.

---

#### Measures of Compliance

The following must be submitted with the designation application:

- Clinician Roster
  - Current ATLS or CALS certification cards
- 

#### Resources / Sample Documents

Clinician Roster

---

#### References

None

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#### Helpful Tips

Collaborate with the credentialing office.

There is no grace period for either ATLS or CALS training.

Dates of course completion should be documented on the Clinician Roster, not expiration dates.

If the general surgeon is using their instructor status to meet this requirement, current instructor status must be validated.

This requirement does not apply to those who are called in to assist the attending provider during an unusual and rare event, such as a Mass Casualty Incident (MCI).

---

## Level 3

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### Emergency Physician Training - Criterion 18.1

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#### Definition

If the emergency department physician is currently board-certified or board-eligible with an American Board of Emergency Medicine (ABEM)-approved or American Osteopathic Board of Emergency Medicine (AOBEM) certification, or is board-certified in Pediatric Emergency Medicine by the American Board of Pediatrics, then the physician is required to have successfully completed an ATLS or CALS Trauma & Provider Course once.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Clinician Roster
- 

#### Resources / Sample Documents

[Clinician Roster](#)

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#### References

None

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#### Helpful Tips

Physicians scheduled to work in the emergency department as a second provider must meet the training requirements of the trauma system.

Collaborate with the credentialing office.

This requirement does not apply to those who are called in to assist the attending provider during an unusual and rare event, such as an MCI.

---

## Level 3

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### Emergency Physician Training - Criterion 18.2

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#### Definition

If the emergency department physician is not board-certified or board-eligible with an ABEM-approved or AOBEM certification, the physician must have successfully completed ATLS and/or CALS Trauma & Provider Course the last four years. Emergency physicians must re-take their ATLS or CALS Trauma & Provider Course before or during the month in which it is due.

---

#### Measures of Compliance

The following must be submitted with the designation application:

- Clinician Roster
  - Current ATLS or CALS certification cards
- 

#### Resources / Sample Documents

Clinician Roster

---

#### References

None

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#### Helpful Tips

There is no grace period for either ATLS or CALS training.

Collaborate with the credentialing office.

Physicians scheduled to work in the emergency department as a second provider must meet the training requirements of the trauma system.

This requirement does not apply to those who are called in to assist the attending provider during an unusual and rare event, such as an MCI.

---

## Level 3

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### ED Nurse Practitioner (NP)/Physician Assistant (PA) Training - Criterion 19.1

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#### Definition

Emergency department Nurse Practitioners (NP)/Physician Assistants (PA) must have successfully completed ATLS and/or CALS Trauma & Provider Course within the last four years. Providers must re-take their ATLS or CALS Trauma & Provider Course before or during the month in which it is due. Other NP/PAs who respond to the ED may be required to complete ATLS and/or CALS Trauma & Provider Course at the discretion of the hospital's trauma leadership.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Clinician Roster
  - Current ATLS or CALS certification cards
- 

#### Resources / Sample Documents

[Clinician Roster](#)

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#### References

None

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#### Helpful Tips

If the urgent care is co-located in the emergency department, the NP/PAs must meet this criterion.

Other NP/PAs could include general surgery or other subspecialties.

Collaborate with the credentialing office.

There is no grace period for either ATLS or CALS.

This requirement does not apply to those who are called in to assist the attending provider during an unusual and rare event, such as a Mass Casualty Incident (MCI).

---

## Level 3

---

### Registered Nurse Training - Criterion 20.1

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#### Definition

Registered nurses scheduled or expected to cover the emergency department must:

20.1.1 Review the hospital's trauma team activation, trauma admission, and trauma transfer policies **and**

20.1.2 have successfully completed Trauma Nursing Core Course (TNCC), Comprehensive Advanced Life Support (CALS) Trauma & Provider Course, Advanced Trauma Care for Nurses (ATCN), or in-house training that meets the following objectives:

- Identify the common mechanisms of injury associated with blunt and penetrating injuries.
  - Describe and demonstrate nursing trauma assessment to identify typical injuries associated with common mechanisms of injury.
  - List appropriate interventions for injuries identified in the nursing assessment.
  - Associate signs and symptoms with physiological changes in the patient.
  - Describe the ongoing assessment to evaluate the effectiveness of interventions.
- 

#### Measures of Compliance

The following must be submitted with the designation application:

- Attestation
  - Job description or similar educational requirements document
  - Training documentation
- 

#### Resources / Sample Documents

MDH has created a series of 12 online eLearning modules for hospitals who wish to use them to satisfy part of the required learning objectives.

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#### References

Educational Resources website

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**Helpful Tips**

Job description or similar educational requirements document should include trauma training requirement and timeline (e.g. required within 12 months of hire).

Identify which MDH e-Learning modules are required by the hospital.

Explain how the hospital's trauma team activation, trauma admission, and trauma transfer policies are reviewed as part of this training.

This requirement does not apply to those who are called in to assist during an unusual and rare event, such as an MCI.

---

## Level 3

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### Registered Nurse Training - Criterion 20.2

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#### Definition

If the hospital admits patients to treat an injury or to monitor the patient for deterioration, registered nurses assigned to patient floors where those patients are admitted must:

20.2.1 Review the hospital's trauma admission and trauma transfer policies **and**

20.2.2 Have successfully completed Trauma Nursing Core Course (TNCC), Comprehensive Advanced Life Support (CALS) Trauma & Provider Course, Advanced Trauma Care for Nurses (ATCN), Trauma Care After Resuscitation (TCAR), Course in Advanced Trauma Nursing (CATN), or in-house training relating to the conditions treated or monitored that meets the following objectives:

- Identify the common mechanisms of injury associated with blunt and penetrating injuries.
  - Describe nursing trauma assessment to identify typical injuries associated with common mechanisms of injury.
  - List appropriate interventions for injuries identified in the nursing assessment.
  - Associate signs and symptoms with physiological changes in the patient.
  - Describe the ongoing assessment to evaluate the effectiveness of interventions.
- 

#### Measures of Compliance

The following must be submitted with the designation application:

- Attestation
  - Job description or similar educational requirements document
  - Training documentation
- 

#### Resources / Sample Documents

MDH has created a series of 12 online eLearning modules for hospitals who wish to use them to satisfy part of the required learning objectives.

---

#### References

Educational Resources website

---

**Helpful Tips**

Job description or similar educational requirements document should include trauma training requirement and timeline (e.g. required within 12 months of hire).

Identify which MDH eLearning modules are required by the hospital.

Explain how the hospital trauma admission and trauma transfer policies are reviewed as part of this training.

This requirement does not apply to those who are called in to assist during an unusual and rare event, such as an MCI.

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## Level 3

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### Performance Improvement Process - Criterion 21.1

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#### Definition

The performance improvement process must outline (in a written document), the following elements:

- 21.1.1 Case Finding: The steps to identify cases that meet the trauma registry inclusion criteria.
- 21.1.2 \*Primary Review: The process to provide critical nurse level review to identify potential clinical care issues and deviations from standards of care and/or practice.
- 21.1.3 \*Secondary Review: The process to provide critical provider level review to identify potential clinical care issues and deviations from standards of care and/or practice.
- 21.1.4 Tertiary Review
  - 21.1.4.1 Provider Case Review: The established method for a provider level committee case review to identify potential clinical care issues that are identified by trauma program leaders.
    - 21.1.4.1.1 Define committee members and attendance expectations/requirements.
    - 21.1.4.1.2 Results of tertiary case reviews that identify opportunities to improve clinical care must be communicated with the medical providers.
  - 21.1.4.2 Multidisciplinary Review: The established method for multidisciplinary committee review to identify potential operational issues that are identified by trauma program leaders.
    - 21.1.4.2.1 Define disciplines to be represented and attendance expectations/requirements.
    - 21.1.4.2.2 Meeting minutes must be shared with committee members not in attendance at the meeting.
- 21.1.5 Trauma Registry: The established steps for data entry into the trauma registry.
- 21.1.6 Performance Improvement: The method to identify and document performance related issues and steps for improvement.
- 21.1.7 Performance Measures: Identify where and how state and/or local measures are monitored and tracked.

\* The scope of primary and secondary case review includes care provided in the prehospital setting, emergency department, inpatient units, and all areas and departments of the hospital that provide or

affect trauma care, as well as performance related information from a receiving hospital about transferred patients.

---

### **Measures of Compliance**

The following must be submitted with the designation application:

- Performance Improvement Process document
- 

### **Resources / Sample Documents**

21.1 Level 3 Performance Improvement (PI) Process Flowchart- Sample

21.1 Level 3 Provider Case Review Attendance Guideline

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### **References**

None

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### **Helpful Tips**

Primary Review: Outline who will review the TPM's cases.

Primary Review: If the TPM is not a RN, an RN must assist with the review of the trauma care and function as a liaison between the trauma program and the nursing staff (criterion 3.2).

Secondary Review: Outline who will review the TMD's cases.

Clearly outline who is responsible for reviewing each level of care (including EMS, inpatient, etc.).

Tertiary Case Review committee: Define which providers and other staff are expected and/or required to participate.

---

## Level 3

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### Performance Improvement Process - Criterion 21.2

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#### Definition

The performance improvement process must demonstrate the following elements:

##### 21.2.1 Case Finding:

21.2.1.1 must occur within three weeks of patients' discharge

21.2.1.2 identify trauma cases that meet the trauma registry inclusion criteria

##### 21.2.2 Primary Review:

21.2.2.1 must occur within three weeks of patients' discharge.

21.2.2.2 identify potential clinical care issues and care issues that are inconsistent with trauma standards of care (e.g. Comprehensive Advanced Life Support [CALs], Trauma Nursing Core Course [TNCC] and Rural Trauma Team Development Course [RTTDC] principles).

21.2.2.3 the scope of case review includes care provided in the pre-hospital setting, emergency department, inpatient units, and all areas and departments of the hospital that provide or affect trauma care, as well as performance related information from a receiving hospital about transferred patients.

##### 21.2.3 Secondary Review (if required):

21.2.3.1 must occur within six weeks of patients' discharge

21.2.3.2 identify potential clinical care issues and care issues that are inconsistent with trauma standards of care (e.g. Advanced Trauma Life Support [ATLS], Comprehensive Advanced Life Support [CALs], and Rural Trauma Team Development Course [RTTDC] principles).

21.2.3.3 the scope of case review includes care provided in the pre-hospital setting, emergency department, inpatient units, and all areas and departments of the hospital that provide or affect trauma care, as well as performance related information from a receiving hospital about transferred patients.

##### 21.2.4 Tertiary Review (if required):

Provider Case Review

21.2.4.1 Provider case review is to be facilitated by the trauma medical director (TMD)/Co-TMD.

21.2.4.2 Learnings from provider case review must be provided to medical providers who are not in attendance at the meeting.

#### Multidisciplinary Review

21.2.4.3 Meeting minutes must be shared with committee members not in attendance at the meeting.

21.2.5 Performance Improvement documentation will include:

21.2.5.1 Evaluation of performance measures

21.2.5.2 Findings from all levels of case reviews

21.2.5.3 Actions undertaken to correct clinical care and process issues identified during case reviews

21.2.5.4 Appropriate steps towards improvement or resolution of identified issues

21.2.6 Demonstrate resolution of at least two clinical care or care process issues.

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### Measures of Compliance

Validated through case reviews and review of PI documents at site visit.

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### Resources / Sample Documents

Minnesota Trauma Registry Inclusion Criteria

Trauma Performance Improvement Case Review Guide

Trauma Standards of Care

#### 21.2 Level 3 Case Review PI Worksheet

21.2 Level 3 Case Review PI Spreadsheet

21.2 Level 3 Inpatient Review Form

21.2 Level 3 PI Tracking Form

23.2 Level 3 Provider Case Review Attendance Spreadsheet

23.2 Level 3 Provider Case Review Meeting Minutes

24.2 Level 3 Multidisciplinary Attendance Spreadsheet

24.1 Level 3 Multidisciplinary Meeting Minutes

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### References

None

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### Helpful Tips

Timely (concurrent) primary and secondary review yields the most effective PI results

“All medical providers” include any provider who may give care to an injured patient in the emergency department (21.2.4.3):

- ED physicians
- ED NP/PAs
- General surgeons
- Surgical NP/PAs
- Other facility specific providers who respond to the ED for trauma care

Learnings can be shared in a variety of forms, including but not limited to meeting minutes, newsletter, feedback document, and/or case review summary (21.2.4.3).

Investigative follow up, from primary and secondary review, should be included in PI documentation (21.2.5.2).

Tertiary Level Provider Case Review meeting attendance: formal leave of absences are allowed, document on attendance sheet (military or medical leave).

Document evidence of event identification, effective use of audit filters, demonstrated loop closure, attempts at corrective actions, and strategies for sustained improvement measured over time (21.2.6)

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## Level 3

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### Performance Improvement Process - Criterion 21.3

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#### Definition

The hospital must establish and monitor performance improvement filters that include:

21.3.1 Case category: TTA, Transfer, Admit, Death

21.3.2 Delay in decision to transfer (> 30 min.) once the immediate transfer criteria/policy is met

21.3.3 Patient met transfer conditions and admitted locally

21.3.4 Admitted and then transferred

21.3.5 Delays in care

21.3.6 Deviation from Practice Management Guidelines

21.3.7 At least one hospital-specific filter that focuses on improving clinical care or care process

General surgeon non-compliance with response time and communication requirements:

21.3.8 Tier-1 TTA & general surgeon did not promptly communicate with ED provider (phone or in-person)

21.3.9 Tier-1 TTA & general surgeon promptly communicated with ED provider and did not document in the medical record

21.3.10 General surgeon did not respond within 60 minutes when requested

21.3.11 Trauma patient admitted to a non-surgeon without surgeon consult

21.3.12 General surgeon did not arrive at bedside within 18 hours

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#### Measures of Compliance

The following must be submitted in the designation application:

- Performance Improvement filters
- 

#### Resources / Sample Documents

21.2 Level 3 Case Review PI Worksheet

21.2 Level 3 Case Review PI Spreadsheet

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## References

### PI Filter Examples

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### Helpful Tips

Any filter that yields a “yes” answer, requires further investigation.

If trauma leadership identifies trends with the monitored filters, consider implementing formal PI project.

Any deviation from hospital trauma policies (TTA, Transfer, Admission) should undergo PI review.

Any deviation in standards of care should lead to further PI review.

- General surgeon responses include Tier-One TTA, ED, Table 3, etc. (21.3.10)
  - Any patient being taken from the ED to the OR will be considered an admission.
-

## Level 3

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### Performance Improvement Process- Criterion 21.4

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#### Definition

The Emergency Department must:

21.4.1 Perform a Pediatric Readiness Assessment within each designation cycle

21.4.2 Have a plan to address at least one of the identified gaps

21.4.3 Identify a pediatric point of contact

---

#### Measures of Compliance

The following must be submitted with the designation application:

- Pediatric Readiness Assessment Score
- Pediatric point of contact name and email

Validated through PI discussion at site visit

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#### Resources / Sample Documents

Resources to address deficiencies:

<https://emscimprovement.center/domains/pediatric-readiness-project/readiness-toolkit/>

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#### References

Pediatric readiness assessment:

<https://www.pedsready.org/>

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#### Helpful Tips

Incorporate findings into the PI process.

Pediatric point of contact is a person to receive communication related to pediatric care.

“Pediatric Readiness” refers to infrastructure, administration and coordination of care, personnel, pediatric-specific policies, equipment, and other resources that ensure the hospital is prepared to provide care to the injured child.

---



## Level 3

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### Performance Improvement Measures - Criterion 22.1

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#### Definition

The following performance measures must be maintained or exceeded:

22.1.1 Trauma team activated when criteria met: 80%

22.1.2 ED provider and general surgeon promptly communicate: 90%

22.1.3 Surgeon response time when requested within 60 minutes: 90%

22.1.4 Patient admitted with a Table 3 condition and received a consult/evaluation by a surgeon within 18 hours: 100%

22.1.5 Trauma patients admitted to or consulted by a surgeon (all patients) within 18 hours: 70%

22.1.6 At least one hospital-specific measure that focuses on improving clinical care and meeting the hospital's set goal

*Compliance with performance measures are calculated based on the most recent 12 months of data.*

---

#### Measures of Compliance

The following must be submitted in the designation application:

- L3 PI Measures spreadsheet or similar document that includes required performance measures (submit previous full calendar year and current year to date data)

Validated through case reviews at site visit

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#### Resources / Sample Documents

22.1 Level 3 Trauma PI Measures Spreadsheet

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#### References

Criterion 15.1

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#### Helpful Tips

Previous 12 months of data are typically requested with the application; however, additional months may be requested.

For each measure, provide the monthly raw data, including the numerator and denominator.

The hospital must submit documentation of PI for any metric that is below goal to demonstrate activities to improve the measure.

The general surgeon or their appointed NP/PA must respond to the hospital and assess the patient within 18 hours of discovery.

“All admitted patients” excludes patients admitted with:

- Conditions listed in criterion 15.1 Table 4
  - Isolated pubic ramus fractures
-

## Level 3

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### Tertiary Level Provider Case Review - Criterion 23.1

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#### Definition

The hospital must establish a mechanism by which all physicians, nurse practitioners (NP) /physician assistants (PA) that care for trauma patients review cases identified by the trauma program leaders in a committee format to identify opportunities to improve trauma care and prescribe remedies.

---

#### Measures of Compliance

The following must be submitted in designation application:

- Attestation
  - PI policy (and flowchart, if applicable)
  - Tertiary level provider case review meeting minutes
  - Attendance tracking spreadsheet
- 

#### Resources / Sample Documents

Trauma Performance Improvement Case Review Guide

21.1 Level 3 Provider Case Review Attendance Guideline

23.1 Level 3 Provider Case Review Meeting Minutes

23.2 Level 3 Provider Case Review Attendance Spreadsheet

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#### References

None

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#### Helpful Tips

The Clinician Roster is used to cross reference the provider list/attendance tracking.

The TMD should facilitate case review discussions to align with leadership expectations (2.1)

The minimum number of meetings expected is four per year or quarterly. This should be increased as needed to meet the needs of the facility.

---

## Level 3

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### Tertiary Level Provider Case Review - Criterion 23.2

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#### Definition

General surgeons, general surgery nurse practitioners (NP)/physician assistants (PA) involved in trauma care, emergency department physicians, and emergency department nurse practitioners (NP)/physician assistants (PA) on staff must attend a minimum of 50% of the scheduled meetings.

23.2.1 If liaisons attend as a representative of their disciplines, other members of the discipline must attend a minimum of 50% of their disciplines' case review meetings

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#### Measures of Compliance

The following must be submitted with the designation application:

- PI policy (and flowchart, if applicable)
  - Tertiary level provider case review meeting minutes
  - Attendance tracking spreadsheet
- 

#### Resources / Sample Documents

Trauma Performance Improvement Case Review Guide

21.1 Level 3 Provider Case Review Attendance Guideline

23.1 Level 3 Provider Case Review Meeting Minutes

23.2 Level 3 Provider Case Review Attendance Spreadsheet

---

#### References

None

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#### Helpful Tips

The Clinician Roster is used to cross reference the provider list/attendance tracking.

The PI policy should clearly outline the expectations for engagement at Tertiary Case Review meetings (Provider Case Review and Multidisciplinary Review) for providers who cover frequently and infrequently. Refer to *Provider Attendance at Tertiary Case Review Meeting Guideline* for attendance expectations.

Attendance of hospital system wide meetings will only be counted if the individual hospital's cases are discussed.

If a liaison attends case review meetings as a representative of their discipline, the remaining members from that discipline are still required to attend 50% of their own disciplines' case review meetings.

- The liaison will discuss the case with their colleagues.
  - Meeting minutes and attendance should be maintained for the specific disciplines' meetings.
-

## Level 3

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### Tertiary Level Multidisciplinary Review - Criterion 24.1

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#### Definition

The hospital must establish a mechanism through which clinical disciplines involved in trauma care review operations and opportunities for improvement as identified by trauma program leadership. The concerns should be discussed within a structured committee format to formulate remedies.

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#### Measures of Compliance

The following must be submitted with the designation application:

- Attestation
- PI policy (and flowchart, if applicable)
- Tertiary level multidisciplinary review meeting minutes
- Attendance tracking spreadsheet

Validated through case reviews and PI discussion at site visit.

---

#### Resources / Sample Documents

21.1 Level 3 Provider Case Review Attendance Guideline

24.1 Level 3 Multidisciplinary Meeting Minutes

24.1 Level 3 Multidisciplinary Meeting Agenda

24.2 Level 3 Multidisciplinary Attendance Spreadsheet

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#### References

None

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#### Helpful Tips

This is usually outlined in the PI policy/PI flowchart.

The TMD should facilitate tertiary level reviews to align with leadership expectations (2.1)

Incorporating a case review may be beneficial to draw on the diverse perspectives of all members involved in trauma care

---

## Level 3

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### Tertiary Level Multidisciplinary Review - Criterion 24.2

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#### Definition

The following disciplines must be represented, and participate at 75% in multidisciplinary review:

24.2.1 Emergency medicine

24.2.2 General surgery

24.2.3 Orthopedic surgery

24.2.4 Neurosurgery

24.2.5 Radiology

24.2.6 Laboratory

24.2.7 Blood bank

24.2.8 Critical care

24.2.9 When required by the trauma program manager and/or the trauma medical director, representatives from other surgical subspecialties, anesthesia, administration, nursing, emergency medical services, and ancillary service personnel must also attend.

---

#### Measures of Compliance

The following must be submitted with the designation application:

- Attendance tracking spreadsheet

Validated through case reviews and PI discussion at site visit.

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#### Resources / Sample Documents

21.1 Level 3 Provider Case Review Attendance Guideline

24.1 Level 3 Multidisciplinary Meeting Minutes

24.2 Level 3 Multidisciplinary Attendance Spreadsheet

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#### References

None

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**Helpful Tip**

At least one representative of each discipline/department of the tertiary level multidisciplinary review.

- The goal is to always have a representative at each meeting.
- Individual department representatives can vary from meeting to meeting.
- If the hospital does not have inhouse neurosurgery services or orthopedic services, they are not required to attend.

Tracking spreadsheet must include department represented.

The minimum number of meetings expected is four per year or quarterly. This should be increased as needed to meet the needs of the facility.

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## Level 3

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### Diversion - Criterion 25.1

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#### Definition

The hospital must establish a policy that:

25.1.1 Identifies the circumstances that may require trauma patients to be diverted to another hospital.

25.1.2 Lists the hospital personnel responsible for the decision to divert trauma patients.

25.1.3 Establishes the procedure to notify hospital departments, EMS agencies, and other area hospitals of the need to divert trauma patients and when the need to divert patients has ended.

---

#### Measures of Compliance

The following must be submitted in designation application:

- Diversion Policy
- 

#### Resources / Sample Documents

None

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#### References

None

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#### Helpful Tips

“Diversion” is a temporary status when a health care facility informs local emergency medical services (EMS) and neighboring hospitals of a temporary inability care for trauma patients.

The diversion of trauma patients should only occur if the emergency department is unable to provide stabilization and timely transfer of the trauma patient.

All trauma diversions must be reviewed through the trauma performance improvement process. (25.2)

---

## Level 3

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### Diversion - Criterion 25.2

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#### Definition

Instances in which the hospital implements divert status must be reviewed through the trauma performance improvement process.

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#### Measures of Compliance

The following must be submitted in designation application:

- Attestation
- 

#### Resources / Sample Documents

MNTrac report

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#### References

Criterion 24.1

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#### Helpful Tips

Diversion of trauma patients should be a rare occurrence and only be considered if the emergency department is unable to provide stabilization and timely transfer of the trauma patient.

Any diversion incident should be discussed at the tertiary level multidisciplinary review committee.

The PI review should be documented.

---

## Level 3

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### Trauma Registry - Criterion 26.1

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#### Definition

The hospital must submit data as defined by the State Trauma Advisory Council within 60 days of the patients' discharge or transfer.

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#### Measures of Compliance

Validated through review of registry data

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#### Resources / Sample Documents

None

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#### References

Minnesota Trauma Registry Inclusion Criteria

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#### Helpful Tips

Confirm validation scores are within acceptable range.

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## Level 3

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### Trauma Registry - Criterion 26.2

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#### Definition

Data imported from other sources must be submitted in a manner and format that is acceptable to MDH.

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#### Measures of Compliance

Validated through review of registry data

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#### Resources / Sample Documents

None

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#### References

Image Trend Data Schema

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#### Helpful Tips

If trauma data is uploaded from third party registry, cases need to be uploaded to MNTrauma registry within 60 days of patient discharge.

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## Level 3

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### Regional Trauma Advisory Committee - Criterion 27.1

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#### Definition

The hospital must actively participate in at least one Minnesota Regional Trauma Advisory Committee (RTAC) or subcommittee of a Minnesota RTAC.

Active participation is defined as attending at least 50% of the scheduled meetings.

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#### Measures of Compliance

The following must be submitted in the designation application:

- Attestation
- 

#### Resources / Sample Documents

None

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#### References

Regional Trauma Advisory Committee (RTAC) website

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#### Helpful Tips

None

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## Level 3

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### Injury Prevention - Criterion 28.1

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#### Definition

The hospital must participate in community injury prevention activities.

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#### Measures of Compliance

The following must be submitted in the designation application:

- Attestation

This will be validated at site visit.

---

#### Resources / Sample Documents

Site Visit Presentation Template (Injury Prevention slide)

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#### References

None

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#### Helpful Tips

Injury prevention activities do not have to be owned by Trauma Program. Any activity that the trauma program works collaboratively with other hospital departments or outside agencies would all be considered trauma program injury prevention, as long as it relates to mitigating future traumatic injuries.

Utilize Trauma Registry and PI data to help inform what injury prevention opportunities exist.

---

## Level 3

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### Required Equipment - Criterion 29.1

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#### Definition

Emergency Department:

- Airway control and ventilation equipment
  - Arterial tourniquet
  - Pulse oximetry
  - Suction devices and supplies
  - EKG monitor and defibrillator
  - Crystalloid IV fluids and administration sets
  - IV catheters from 14-22 Ga.
  - Drugs necessary for emergency trauma care
  - Nasal gastric & oral gastric tubes
  - Cervical collars
  - Pediatric length-based resuscitation tape or reference manual
  - Blanket warmer or overhead radiant heater
  - Warming cabinet for IV fluids or inline IV fluid warmer
  - Rapid IV fluid infuser system (may use pressure bag)
  - Quantitative end-tidal CO<sub>2</sub>
  - Method to communicate with EMS
  - Mechanism for IV flow-rate control
  - Intraosseous needles and administration sets
  - Supplies for surgical airway & thoracostomy
  - Mechanism for pelvic stabilization
- 

#### Measures of Compliance

The following must be submitted with the designation application:

- Required Equipment Checklist and Attestation form

Validated during tour at site visit.

---

### **Resources / Sample Documents**

Required Equipment Checklist and Attestation form

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### **References**

None

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### **Helpful Tips**

For pediatric sizes, ensure that there is at least one size for each age/size category of the pediatric length-based resuscitation tape or reference manual.

Ensure that all resources (i.e. pediatric length-based tape) are the most current.

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## Level 3

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### Required Equipment - Criterion 29.2

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#### Definition

Imaging Department:

- Airway control and ventilation equipment
  - Suction device and suction supplies
- 

#### Measures of Compliance

The following must be submitted with the designation application:

- Required Equipment Checklist and Attestation form

Validated during tour at site visit.

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#### Resources / Sample Documents

Required Equipment Checklist and Attestation form

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#### References

None

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#### Helpful Tips

Emergency airway equipment must be stocked in the CT room(s) to ensure airway management occurs without delay when patient respiratory status changes.

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## Level 3

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### Required Equipment - Criterion 29.3

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#### Definition

Operating Room:

- Blanket warmer or other mechanism for thermoregulation
  - Warming cabinet for IV fluids or inline IV fluid warmer
  - X-ray capabilities including C-arm intensifier
  - Rapid infuser system (may use pressure bag)
- 

#### Measures of Compliance

The following must be submitted with the designation application:

- Required Equipment Checklist and Attestation form

Validated during tour at site visit.

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#### Resources / Sample Documents

Required Equipment Checklist and Attestation form

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### Required Equipment - Criterion 29.4

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#### Definition

Post-Anesthesia Recovery:

- Equipment for monitoring and resuscitation
  - Pulse oximetry
  - Blanket warmer or other mechanism for thermoregulation
  - Warming cabinet for IV fluids or inline IV fluid warmer
- 

#### Measures of Compliance

The following must be submitted with the designation application:

- Required Equipment Checklist and Attestation form

Validated during tour at site visit.

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#### Resources / Sample Documents

Required Equipment Checklist and Attestation form

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#### References

None

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#### Helpful Tips

None

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## Level 3

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### Required Equipment - Criterion 29.5

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#### Definition

Intensive Care Unit:

- Equipment for monitoring and resuscitation
  - Ventilator (transport ventilator is not sufficient)
- 

#### Measures of Compliance

The following must be submitted with the designation application:

- Required Equipment Checklist and Attestation form

Validated during tour at site visit.

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#### Resources / Sample Documents

Required Equipment Checklist and Attestation form

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#### References

None

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#### Helpful Tips

If the hospital admits injured pediatric patients, appropriate equipment should be available in the inpatient unit.

Equipment for monitoring and resuscitating the trauma patient should be available on any unit in which these patients may be admitted.

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## Level 3

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### Required Equipment - Criterion 29.6

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#### Definition

Inpatient Unit:

- Equipment for monitoring and resuscitation
- 

#### Measures of Compliance

The following must be submitted with the designation application:

- Required Equipment Checklist and Attestation form

Validated during tour at site visit.

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#### Resources / Sample Documents

Required Equipment Checklist and Attestation form

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#### References

None

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#### Helpful Tips

If the hospital admits injured pediatric patients, appropriate equipment should be available in the inpatient unit.

Equipment for monitoring and resuscitating the trauma patient should be available on any unit in which these patients may be admitted.

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