Statewide Trauma Advisory Council Meeting

October 6, 2008
1:00 p.m. – 3:00 p.m.

Alabama Department of Public Health
The RSA Tower
Conference Room 1586
Montgomery, Alabama

Members Present	Dr. Loring Rue, Dr. Rony Najjar, Dr. Alzo Preyear, Chief Billy Pappas, Beth Anderson, Gary Gore, Dr. John Campbell, Dr. Donald Williamson
Member Absent	Dr. John Mark Vermillion
Members by Phone	Allen Foster, Bryan Kindred
Staff Present	Dennis Blair, Choona Lang, Verla Thomas, Tammie Yeldell, Robin Moore, Brian Hale
Guest	Joe Acker, Danne Howard, Denise Louthain, E. Allan Pace, Alex Franklin (by phone)

Welcome

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

Consideration of Minutes of August 21, 2009

The Council recommended approval of the minutes of August 21, 2008, as distributed; the motion carried unanimously.

RTAC Meeting Rules/Standard Proxy Form

The Council recommended approval of the Standard Proxy Form for the Regional Trauma Advisory Council (RTAC), as distributed; the motion carried unanimously.

RTAC Appointees/Meeting Updates

Dr. Campbell gave brief update on the RTAC appointees and scheduled meetings.

The Council recommended approval of each RTAC appointee list by electronic vote; the motion carried unanimously.

Beth Anderson	approved	09/03/2008
Gary Gore	approved	09/02/2008
Dr. Rony Najjar	approved	09/02/2008
Bryan Kindred	approved	08/28/2008
Dr. Loring Rue	approved	09/04/2008

Dr. John Campbell	approved	09/04/2008
Dr. Alzo Preyear	approved	09/04/2008
Dr. Donald Williamson	approved	09/15/2008

Regional Trauma Advisory Meeting Update

North Region	To Be Announced Pediatric surgeons Dr. James Gilbert (North Region) and Dr. Celeste Holland (Gulf Region) were added to the appointees list at the request of the STAC members.
East Region	October 30, 2008 1:30 p.m. East Alabama EMS Office Lincoln, AL
BREMSS Region	October 28, 2009 5:00 p.m. Birmingham Botanical Gardens Birmingham, AL
Southeast Region	November 12, 2008 5:00 p.m. Adams/Trojan Center Ballroom A & B Troy State University Troy, AL
Gulf Region	Tentative date November 20, 2008 6:00 p.m. Location to be announced

All appointees terms started after the STAC voted electronically.

Regional Trauma Plan Template

Dr. Campbell discussed the regional trauma plan template designed from the two regions where trauma systems are operating.

Trauma Registry

Dr. Campbell discussed the Injury Case Criteria for the State Trauma Registry. The registry that is currently being used only captures head and spinal cord injuries.

The Council recommended approval of the Injury Case Criteria for State Trauma Registry with the modification of adding ICD-9 codes 905-909.9 (late effects of injury), as distributed; the motion carried unanimously. (See attached)

Trauma System Update

Dr. Campbell gave a brief update of the trauma system statistics from North and BREMSS Regions. (See attached)

West Town Hall meeting is still on hold at this point.

Trauma Funding

The Trauma Funding Workgroup conducted its first meeting to discuss the distribution of trauma dollars for the trauma system. The next meeting to be announced.

QI Workgroup

Dr. Campbell gave a brief update of some issues that the QI Committee is currently reviewing. STAC suggested QI workgroup bring reports of various issues to the STAC to review on ongoing basis.

Dr. Williamson suggested QI specific report updates at every STAC meeting.

Pediatric Workgroup

Dr. Campbell gave a brief update of the issues the Pediatric Workgroup is currently working on.

1. Pediatric equipment
2. Educational programs
3. Pediatric entry criteria
4. Alabama Pediatric facility map

Trauma Rules

Dr. Campbell gave a brief update of the Trauma Rules Process.

New Business

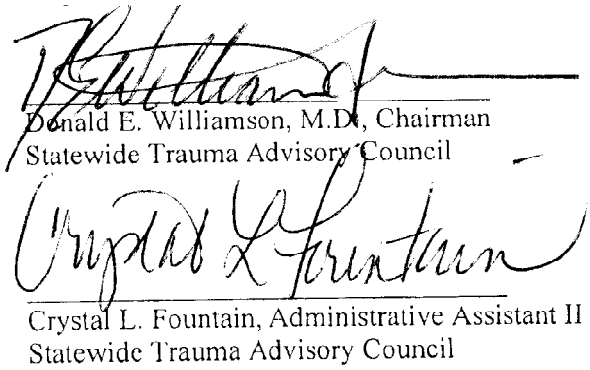
Dr. Najjar has a situation in North with increasing problems of traumatic brain injuries being transferred from all over the state to Huntsville Hospital. The expressed concern is that the selected surgeons will be overwhelmed in the neuro-area with the overloads then eventually run away.

The Council recommended establishing a Neurosurgeon Task Force; the motion carried unanimously. Dr. Campbell will coordinate the neurosurgeon task force.

Blue Cross/Blue Shield needs to be included in the trauma funding process.

Next meeting November 17, 2009

Adjourned 2:45 p.m.



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

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

Approved December 3, 2008

Proxy Resolution for Trauma Advisory Council

WHEREAS, The Alabama Legislature has permitted the passage of House Bill 448, the establishment by the chair, with the consent of the majority of the members, a procedure for proxy representation, voting and quorum; and

WHEREAS, the committee determines that such procedures are necessary to the proper functioning of the committee;

NOW THEREFORE, BE IT RESOLVED BY THE ALABAMA REGIONAL TRAUMA ADVISORY COUNCIL:

1. All members of the Regional Trauma Advisory Council may select his/her proxy designee. The proxy statement shall name the members to whom the proxy is given, shall state whether the proxy is a general proxy or limited to a certain question and shall be signed by the members giving the proxy.

2. The council meeting shall be held at least twice a year and more frequently if needed. The council may meet by electronic means and voting shall be accepted electronically.

3. Voting privileges are extended only to members of the council who have attended in person or by proxy a minimum of 50 percent of the regular and called meetings of the committee during the last twelve months. Members who do not qualify for voting privileges regain such qualifications upon meeting the attendance requirements set forth herein.

4. The quorum to transact business at any regular or called meeting shall be 50 percent of the current membership. Members sending proxies shall be counted as present.

Done this _____ Day of _____ 2008

Dr. Donald Williamson
Chair

.

REGIONAL TRAUMA ADVISORY SCHEDULE MEETINGS

Region 1 Meeting

November 20, 2008 10:30 a.m.
Tentative Location: Huntsville Botanical Gardens

Region 2 Meeting

October 30, 2008 1:30 p.m.
East Alabama EMS
58 Speedway Industrial Drive
Lincoln, AL 35096

Region 3 Meeting

October 28, 2008 5:00 p.m.
Birmingham Botanical Gardens Auditorium 1st Floor
2612 Lane Park Road
Birmingham, AL 35223

Region 5 Meeting

November 12, 2008 5:00 p.m.
Adams/Trojan Center Ballroom A & B
Troy State University
Troy, AL 36082

Region 6 Meeting

November 18, 2008 6:00 p.m.
The Magnolia Ballroom
Mobile, AL

REGIONAL TRAUMA ADVISORY COMMITTEE (RTAC)

AlaHA Appointees

Region 1	William Anderson	Helen Keller Hospital	4 years
	Tom Lackey	Highlands Medical Center	3 years
	Christine Stewart	Russellville Medical Center	2 years
	Pam Hudson	Crestwood Medical Center	1 year
Region 2	Peter Selman	Dekalb Regional	4 years
	Judy Gould	Northeast Alabama Regional	3 years
	Tim Harlin	Randolph Medical Center	2 years
	Steve Gautney	Citizens Baptist	1 year
Region 3	Mike Waldrum	UAB	4 years
	Mike Warren	Children's Hospital	3 years
	Christine Stewart	Lakeland Community	2 years
	Terrell Vick	St. Vincent's St. Clair	1 year
Region 5	Russ Tyner	Baptist Health	4 years
	Jennie Rhinehart	Community Hospital	3 years
	Ron Owen	Southeast Alabama	2 years
	Bobby Ginn	LV Stabler Memorial	1 year
Region 6	Chris Griffin	DW McMillan	4 years
	Phil Cusa	Thomas Hospital	3 years
	Becky DeVillier	USA Children & Women	2 years
	Alan Whaley	Mobile Infirmary	1 year

MASA Appointees

Region 1	Dr. Rony Najjar	4 years
	Dr. Ginger Bryant	3 years
	Dr. Larry Sullivan	2 years
	Dr. Bill Vermillion	1 year
Region 2	Dr. Gordon Hardy	4 years
	Dr. Charles Newman	3 years
	Dr. Lucian Newman	2 years
	Dr. Steven Isbell	1 year
Region 3	Dr. Sherry Melton	4 years
	Dr. Patrick Prithcard	3 years
	Dr. Steven Baldwin	2 years
	Dr. Christopher Rosko	1 year
Region 5	Dr. John Mark Vermillion	4 years
	Dr. John Moorehouse	3 years
	Dr. F. Donovan Kendrick	2 years
	Dr. Todd Michael Sheils	1 year
Region 6	Dr. Richard Gonzalez	4 years
	Dr. Jorge Alonso	3 years
	Dr. John McMahon	2 years

	Dr. Jimmie Gavras	1 year

Dr. Williamson Appointees

Region 1	Don Webster, EMT-P	4 years
Region 2	Johnny Warren, EMT-P	4 years
Region 3	David Waid, EMT-P	4 years
Region 5	Larry Williams, EMT-P	4 years
Region 6	Chief Billy Pappas, EMT-P	4 years

Regional Medical Director

Region 1	Dr. Sherrie Squyres	4 years
Region 2	Dr. Neil Christen	4 years
Region 3	Dr. Adam Robertson	4 years
Region 5	Dr. Rick Weber	4 years
Region 6	Dr. Frank Pettyjohn	4 years

Hospital Representatives

Region 1	Mark Dooley	Athens Limestone	4 years
	James Weidner	Cullman Regional	3 years
	Dean Griffin	Decatur General	2 years
	Carl Bailey	Eliza Coffee	1 year
	Jeff Rains	Hartselle Medical Center	4 years
	David Spillers	Huntsville Hospital	3 years
	Thomas Dunning	Lawrence Baptist	2 years
	Cheryl Hayes	Marshall North	1 year
	John Anderson	Marshall South	4 years
	Sherry Jones	Parkway Medical	3 years
	Niles Floyd	Red Bay Hospital	2 years
	Jody Pigg	Shoals Hospital	1 year
	David Fuller	Woodland Medical Center	4 years
Region 2	Jeff Noblin	Cherokee Medical	4 years
	Linda Jordan	Clay County	3 years
	Glenn Sisk	Coosa Valley Medical Center	2 years
	Doug DeGraaf	Gadsden Regional	1 year
	Roger Collins	Jacksonville Medical Center	4 years
	Agnes Wages	Lake Martin	3 years
	Kelli Powers	Lanier Health Service	2 years
	Matt Hayes	Riverview Regional	1 years
	Jim Peace	Russell Medical Center	4 years
	Linda Burdette	Stringfellow Memorial	3 years
	Richard Daniel	Wedowee Hospital	2 years
Region 3	Keith PArratt	Princeton Baptist	4 years
	Timothy Thornton	UAB Medical Center West	3 years

	Bill Heburn	Trinity Medcial Center	2 years
	Garry Gause	Brookwood Medical Center	1 year
	Robert Bernstein	Carraway Methodist	4 years
	Debra Richardson	Chilton Medical Center	3 years
	Dr. Sandral Hullett	Cooper Green	2 years
	Dr. Bo Cofield	UAB Highlands	1 year
	Sean Tinney	St. Vincent's Blount	4 years
	Todd Kennedy	St. Vincent's East	3 years
	David Wilson	Shelby BMC	2 years
	Curtis James	St. Vincent's Hospital	1 year
	Joel Tate	Walker Baptist	4 years
Region 5	Libby Kennedy	John Paul Jones	4 years
	Barry Keel	Vaughn Regional	3 years
	Mark Dooley	Andalusia Regional	2 years
	Lynne Parker	Baptist Medical Center South	1 year
	Mindy Burdick	Baptist Medical Center East	4 years
	Ben Busbee	Bullock County	3 years
	Jim McKnight	Crenshaw Baptist	2 years
	Vernon Johnson	Dale Medican Center	1 year
	Terry Andrus	East Alabama Medical Center	4 years
	Rusty Eldridge	Troy Regional	3 years
	Ellen Briley	Elba General	2 years
	Gordon Faulk	Elmore Community	1 year
	Blair Henson	Florala Memorial	4 years
	L. Keith Granger	Flowers Hospital	3 years
	Harry Cole, Jr.	Georgiana Hospital	2 years
	Don Henderson	Jackson Hospital	1 year
	Allen Foster	Mizell Memorial	4 years
	Ralph Clark	Medical Center Barbour	3 years
	Jeff Brannon	Medical Center Enterprise	2 years
	James Matney	Jack Hughston	1 year
	Ginger Henry	Prattville Baptist	4 years
	John Rainey	Wiregrass Medical Center	3 years
Region 6	Beth Anderson	USA Medical Center	4 years
	Douglas Tanner	Washington County	3 years
	Bob Gowing	Atmore Community	2 years
	Bob Humphrey	Evergreen Medical	1 year
	Doug Sewell	Grove Hill	4 years
	Terese Grimes	Jackson Medical Center	3 years
	Vince DeFranco	Monroe County	2 years
	Williams McLaughlin	North Baldwin	1 year
	Clark Christianson	Providence Hospital	4 years
	Michael Neunendorf	South Baldwin	3 years
	Kevin Bierschenk	Southwest Alabama	2 years
	Bill Mason	Springhill Memorial	1 year

Physicians

Region 1	Rhett Murray, MD	4 years
	Joel Pickett, MD	3 years
	Randolph Buckner, MD	2 years
	James Thomas, MD	1 year
	Daniel Spangler, MD	4 years
	Stephan Moran, MD	3 years
	Jeff Johnson, MD	2 years
	David Garvey, MD	1 year
	Deepak Katyl, MD	4 years
	Robert Echols, MD	3 years
	Michael Samotowka, MD	2 years
	Scott Warner, MD	1 year
	John Markushewski, MD	4 years
	James Gilbert, MD	
Region 2	James White, MD	4 years
	Ron Shiver, MD	3 years
	John Valente, MD	2 years
	Tony White, MD	1 year
	Michelle Gold hagen, MD	4 years
	Rodney Snead, MD	3 years
	David Roberts, MD	2 years
	Lewis Sellers, MD	1 year
	Henry Ruiz, MD	4 years
	Howard McVeigh, MD	3 years
	Buddy Smith, MD	2 years
Region 3	Loring Rue, MD	4 years
	Thomas Arnold, MD	3 years
	Bryan Balentine, MD	2 years
	David Elliott	1 year
	Thonas Francavilla, MD	4 years
	Oliver Muensterer, MD	3 years
	Keith Funderburk, MD	2 years
	Rena Stewart, MD	1 year
	Jeremy Rogers, MD	4 years
	Peter Ray, MD	3 years
	Annalissa Sorrention, MD	2 years
	Bart Guthrie, MD	1 year
	Wm. Kirkland Hawley, MD	4 years
Region 5	Carl Barlow, MD	4 years
	Allen Lazenby, MD	3 years
	Alan Moore, MD	2 years
	James York, MD	1 year
	Wallace Falero, MD	4 years
	Sam Sawyer, MD	3 years

	John Drew, DO Andy Gammill, MD Roland Hester, MD Adolfo Robledo, MD Jonathan Vukovich, MD Alzo Preyear, DO Clay Harper, MD James Jones, DO Jonathan Skinner, MD Mark McDonald, MD Jeffrey Whitehurst Fleming Brooks, MD Steven O'Mara, MD Danny Hood, MD Allen Hicks, MD Ronald Shaw, MD	2 years 1 year 4 years 3 years 2 years 1 year 4 years 3 years 2 years 1 year 4 years 2 years 1 year 4 years 3 years 3 years
Region 6	Melissa Costello, MD Arnold Luterman, MD Keith A. Scott, MD John Meade, MD Kenneth Brewington, MD Albert Simmons, MD Steve Bowden, MD Anthony Martino, MD William Farmer, MD Michael Sternberg, MD Eugene Quindlen, MD Mark Mitchell, MD Celeste Holland, MD	4 years 3 years 2 years 1 year 4 years 3 years 2 years 1 year 4 years 3 years 2 years 1 year

Pre-Hospital EMS Representatives

Region 1	Mike West, EMT-P David Gardner, EMT-P	4 years 3 years
Region 2	Shane Parker, EMT-P Matt Knight, EMT-P	4 years 3 years
Region 3	James Robinson, EMT-P Rickey Vest, EMT-P	4 years 3 years
Region 5	Michael Whaley, EMT-P Steve Kennedy, EMT-P	4 years 3 years
Region 6	Michael Lambert, EMT-P Lee Rumbley, EMT-P	4 years 3 years

Trauma System Stats 2008

Trauma Regions	**Patients Entered**						
	March	**April**	**May**	**June**	**July**	**August**	**September**
BREMMS Total	321	314	333	324	358	341	314
UAB	232	252	258	230	242	230	228
TCH	29	22	14	19	36	38	27
Level II Hospitals							
Level III Hospitals	62	42	67	69	70	65	55
NATS Total	66	73	178	197	192	155	139
Huntsville Hospital	60	64	134	138	124	104	99
Level II Hospital	2	1	11	10	4	10	5
Level III Hospitals	4	6	39	34	51	31	26

RULES
OF
ALABAMA STATE BOARD OF HEALTH
ALABAMA DEPARTMENT OF PUBLIC HEALTH

CHAPTER 420-2-2

ALABAMA STATEWIDE TRAUMA SYSTEM

EFFECTIVE: FEBRUARY 18, 2009

STATE OF ALABAMA
DEPARTMENT OF PUBLIC HEALTH
MONTGOMERY, ALABAMA

ALABAMA STATE BOARD OF HEALTH
ALABAMA DEPARTMENT OF PUBLIC HEALTH

CHAPTER 420-2-2

ALABAMA STATEWIDE TRAUMA SYSTEM

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420-2-2-.01 General.

(1) Legal Authority for Adoption of Rules. Under and by virtue of authority vested in it by the Legislature of Alabama, Act 299, Regular Session, 2007(§22-11D-1,et seq. *Ala. Code 1975*), the State Board of Health does hereby adopt and promulgate the following rules to govern the Alabama Statewide Trauma System.

(2) Definitions.

(a) The Board. The Alabama State Board of Health.

(b) The Council. The Statewide Trauma Advisory Council.

(c) The Department. The Alabama Department of Public Health.

(d) Designated Trauma Center. A hospital that has met all the standards for trauma center designation as set out in these rules and that has been certified by the Department.

(e) Designation. A formal determination by the Department that a hospital is capable of providing designated trauma care.

(f) ED. Emergency Department.

(g) EMT. Emergency Medical Technician.

(h) The Fund. The Statewide Trauma System Fund.

(i) Hospital. A health institution that has been licensed pursuant to the Board's Hospital Rules, Chapter 420-5-7, *Ala. Admin. Code* and that has a functioning ED.

(j) ICU. Intensive Care Unit.

(k) May. This indicates permissive requirements.

(l) Office of EMS and Trauma. The Department's Office of Emergency Medical Services and Trauma.

(m) OR. Operating Room.

(n) QA/QI. Quality Assurance/Quality Improvement.

(o) Regional Councils. The regional trauma advisory councils.

(p) Regions. The trauma care regions.

(q) The Registry. The Statewide Trauma Registry.

(r) These Rules. Rules 420-2-2-.01 through 420-2-2-.14, Chapter 420-2-2, Alabama Statewide Trauma System, *Ala. Admin. Code*.

(s) Shall. This indicates mandatory requirements.

(t) Alabama TCC Operations Director. Trauma Communication Center Director.

(u) Alabama TCC. Alabama Trauma Communication Center.

(v) Pre-hospital Trauma Patient. A pre-hospital patient who meets trauma system entry criteria (see appendix E) and is entered into the trauma system by calling the Alabama Trauma Communications Center and obtaining a unique identification number.

(w) Hospital Trauma Patient. A hospital patient who meets trauma system entry criteria (see appendix F) and is entered into the trauma system by calling the Alabama Trauma Communications Center and obtaining a unique identification number.

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D, et seq.
History:

420-2-2-.02 Trauma Center Standards: Verification

Upon the receipt of advice and approval of the council, the board had adopted rules for verification and certification of trauma center status as set out in Appendix A.

Author: John Campbell, M.D.
Statutory Authority: Alabama Legislature, Act 299, Regular Session, 2007 (*Code of Alabama 1975,* §22-11D-1, et seq.*)*
History: Filed March 20, 2008; Effective April 24, 2008

420-2-2-.03 Trauma Center Designation.

(1) Types of Designation.

(a) Regular Designation. A regular designation may be issued by the Board after it has determined that an applicant hospital has met all requirements to be

designated as a trauma center at the level applied for and is otherwise in substantial compliance with these rules.

(b) Provisional Designation. At its discretion, the Board may issue a provisional designation to an applicant hospital that has met all requirements to be designated as a trauma center at the level applied for, with exception to minor deviations from those requirements that do not impact patient care or the operation of a trauma region.

1. The provisional designation may be used for an initial designation or for an interim change in designation status to a lower level due to a trauma center's temporary loss of a component necessary to maintain a higher designation level.

2. A trauma center must submit a written corrective plan and interim operation plan for the provisional designation period including a timeline for corrective action to the Office of EMS and Trauma within 30 days of receiving a provisional designation.

3. A provisional designation shall not extend beyond 15 months.

4. A trauma center may submit a written request to the Office of EMS and Trauma that a provisional designation be removed once all components of its corrective plan have been achieved. Following its receipt of such a request, the Department will conduct a focused survey on the trauma center. A regular designation shall be granted in the event it is confirmed that all components of the corrective plan have been achieved.

(2) Levels of Designation. There shall be three levels of trauma center designation. The criteria of each level is set out in Appendix A.

(3) Application Provision. In order to become a trauma center, a hospital must submit an application (attached to these rules as Appendix B) and follow the application process provided in paragraph (4) below.

(4) The Application Process. To become designated as a trauma center, an applicant hospital and its medical staff shall complete the Department's "Application for Trauma Center Designation". An applicant hospital shall submit the completed application via mail or hand delivery to the address listed on the application. Within 30 days of receipt of the application, the Department shall provide written notification to the applicant hospital of the following:

(a) That the application has been received by the Department;

(b) Whether the Department accepts or rejects the application for incomplete information;

(c) If accepted, the date scheduled for hospital inspection;

(d) If rejected, the reason for rejection and a deadline for submission of a corrected "Application for Trauma Center Designation" to the Department;

(e) Upon receipt of a completed application by the Department, an application packet containing a pre-inspection questionnaire will be provided to the applicant hospital. The pre-inspection questionnaire must be returned to the Department one month prior to the scheduled inspection.

(f) The trauma center post-inspection process will proceed as listed below:

1. The inspection report will be completed two weeks after completion of the inspection.
2. A State and Regional review of the inspection report and a recommendation for or against designation will be made thirty days after completion of the inspection.
3. A final decision will be made known to the applicant hospital within x weeks of the completion of the inspection.
4. Focus visits may be conducted by the Department as needed.

(5) The Inspection Process. Each applicant hospital will receive an onsite inspection to ensure the hospital meets the minimum standards for the desired trauma center designation level as required by these rules. The Department's Office of EMS and Trauma staff will coordinate the hospital inspection process to include the inspection team and a scheduled time for the inspection. The hospital will receive written notification of the onsite inspection results from the Office of EMS and Trauma.

(6) Designation Certificates.

(a) A designation certificate will be issued after an applicant hospital has successfully completed the application and inspection process. The designation certificate issued by the Office of EMS and Trauma shall set forth the name and location of the trauma center, and the type and level of designation. The form of the designation certificate is attached to these rules as Appendix C.

(b) Separate Designations. A separate designation certificate shall be required for each hospital when more than one hospital is operated under the same management.

(7) Designation for Contract.

(a) A designation contract will be completed after the hospital has successfully completed the application and inspection process. The designation contract shall be issued by the Office EMS and Trauma. It shall set forth the name and location of the trauma center and the type and level of designation.

(b) Separate Designation Contracts. A separate designation contract shall be required for each hospital when more than one hospital is operated under the same management.

(c) The form of the designation contract is attached to these rules as Appendix D.

(8) Basis for Denial of a Designation.

The Department shall deny a hospital application for trauma center designation if the application remains incomplete after an opportunity for correction has been made, or if the applicant hospital has failed to meet the trauma center designation criteria as determined during the inspection.

(9) Suspension, Modification, and Revocation of a Designation.

(a) A trauma center's designation may be suspended, modified, or revoked by the Board for an inability or refusal to comply with these rules.

(b) The Board's denial, suspension, modification or revocation of a trauma center designation shall be governed by the Alabama Administrative Procedure Act, §41-22-1, et seq., *Ala. Admin. Code.*

(c) Hearings. Contested case hearings shall be provided in accordance with the Alabama Administrative Procedure Act, §41-22-1, et seq., and the Board's Contested Case Hearing Rules, Chapter 420-1-3, *Ala Admin. Code.*

(d) Informal settlement conferences may be conducted as provided by the Board's Contested Case Hearing Rules, Chapter 420-1-3, *Ala. Admin. Code.*

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority*: Code of Alabama, 1975*, §22-11D-5
History:

420-2-2-.04 Statewide Trauma Advisory Council. There is established a Statewide Trauma Advisory Council. The Council assists in the development of these rules and serves as a consultant to the Board on matters related to the Statewide Trauma System.

Authors: John Campbell, M.D., and Choona Lang

Statutory Authority*: Code of Alabama, 1975*, §22-11D-5
History:

420-2-2-.05 Trauma Care Regions. Trauma Care Regions will be the same as the EMS Regions as approved by the State Board of Health.

Authors: John Campbell, M.D.
Statutory Authority: Alabama Legislature, Act 299, Regular Session, 2007(*Code of Alabama, 1975*, §22-11D-1, et seq.)
History: Filed May 21, 2008; Effective June 25, 2008

420-2-2-.06 Regional Trauma Advisory Councils.

(1) Creation. Regional councils are established to advise, consult with, and accommodate specific regional needs. Each regional council shall provide data required by the Department or the Council to assess the effectiveness of the statewide trauma system

(2) Membership. Each regional council shall have a minimum of 10 members. The membership of the regional councils shall be appointed in the same manner as the Council is appointed and shall be composed of representatives of the same groups. The chair of each regional council shall be elected by its members to serve for four year term. The members shall represent the demographic composition of the region served, as far as practicable. Regional trauma advisory council members shall be entitled to reimbursement for expenses incurred in the performance of their duties as the same rate as state employees.

(3) Responsibilities. The regional trauma council is responsible for direct oversight and management of its specific regional trauma system. The regional council shall review the entire regional trauma program activities for appropriateness, quality, and quantity to include pre-hospital and hospital care. The regional trauma council shall decide the appropriate secondary patient care triage criteria for their specific region to ensure patients are routed to the closest and most appropriate hospital according to their injuries.

In addition, the regional council shall fulfill the responsibilities as listed below:

1. Maintain standards;
2. Collect data;
3. Evaluate data-determine audit filters;
4. Re-evaluate to determine effectiveness of corrective action;
5. Participate on Regional Trauma QI Committee;
6. Devise plan of corrective action for QI issues;

(4) Committees.

1. QA/QI Committees. The regional trauma advisory councils shall document the effectiveness of hospital and emergency medical service QA/QI evaluations through routine reports of these QA/QI activities provided by each trauma system entity in their specific region. The regional trauma council will routinely perform focused review of specific QA/QI items of pre-hospital and hospital trauma care activities as determined appropriate by the regional trauma council. Recommendations for action will be developed by the committee based on analysis of data/information evaluated during committee function. The regional trauma council will submit quarterly compliance reports to the Office of EMS and Trauma for review to ensure the system process is followed.

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

420-2-2-.07 Patient Entry Criteria for hospitals. Patients shall be entered into the Alabama Trauma System according to the criteria set out in Appendix F.

Appendix F

Authors: John Campbell, M.D. and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

420-2-2-.08 Patient Entry Criteria for pre hospital providers. Refer to EMS Alabama Patient Care Protocols 8.5

Appendix H

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

420-2-2-.09 Statewide Trauma Registry

(1) Creation. There is established a Statewide Trauma Registry to collect data on the incidence, severity, and causes of trauma, including traumatic brain injury. The registry shall be used to improve the availability and delivery of pre-hospital or out-of-hospital care and hospital trauma care services.

(2) Data Elements. Each designated trauma center shall furnish the following data to the registry. *See Appendix G for data elements.*

(a) Injury Case Criteria for State Trauma Registry.
1. ICD-9 diagnosis code 800.00 – 959.9 and
2. Assigned an ATCC number
3. Admitted to hospital for 24 hours or greater or
4. Transferred from one hospital to another hospital or
5. Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status

(b) Excludes the following isolated injuries:
1. 905 – 909.9 (late effects of injury)
2. 910 – 924.9 (superficial injuries-including blisters, contusions, abrasions, and insect bites)
3. 930 – 939.9 (foreign bodies)

(3) Reporting. All cases of traumatic injuries meeting the trauma admission criteria, diagnosed, assigned an ATCC number or treated and admitted to a level I, II, or III trauma facility shall report to the Alabama Trauma Registry within 90 days of ED visit or facility admission or diagnosis as prescribed by these rules. Reports are to be submitted on a monthly basis.

(4) Confidentiality. All registry data shall be held confidential pursuant to state and federal laws, rules, and policies.

Authors: John Campbell, M.D. and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

420-2-2-.10 Centralized Dispatch and Communications System. Communications are critical to the function to the Trauma System.

(1) The Alabama TCC will be staffed 24-hours-a-day by personnel with specific in-depth knowledge of the Trauma System design, function, and protocols.

(2) It will be primary responsibility of the Alabama TCC to coordinate the Trauma System activities by maintaining, providing information and recommendations whenever needed to the field staff and hospital personnel in providing care to patients meeting the trauma system entry criteria. Oversight of day-to-day operations of the Alabama TCC will be responsibility of the Alabama TCC Operations Director.

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

420-2-2-.11 Air Ambulance Activation Requirements. Refer to Guidelines for Early Activation of Helicopter Emergency Medical Services 7.9

Appendix I

Guidelines for Helicopter Transport of Trauma System Patients 7.10

Appendix J

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

420-2-2-.12 Quality Assurance/Quality Improvement. Quality Assurance and Quality Improvement (QA/QI) activities are a vital component of the Trauma System. They are used to document and foster continuous improvement in performances and the quality of patient care. In addition, they will assist the Department in defining standards, evaluating methodologies, and utilizing the evaluation results from continued system improvement. The department shall develop guidelines for the state and regional level trauma staff in regarding QA/QI activities.

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

420-2-2-.13 Confidentiality

(1) State and Regional Trauma QA/QI members shall be provided access to all information, reports, statements, or memoranda reviewed by or furnished to the State and Regional Trauma QA/QI workgroups members; and any discussion, findings, conclusions or recommendations resulting from the review of the records by the State and Regional Trauma QA/QI workgroups are declared to be privileged and confidential. All information, reports, statements, or memoranda reviewed by or furnished to the State and Regional Trauma QA/QI workgroups shall be used only in the exercise of proper functions and duties of the State and Regional Trauma QA/QI workgroups.

(2) All information furnished to the State and Regional QA/QI workgroups shall include pertinent safety and health information associated with the case summary. All identifying patient information will be removed before preparing case summary.

(3) All information and records acquired or developed by the State and Regional Trauma QA/QI workgroups shall be secured and have restricted access and shall be destroyed when no longer of use.

(4) Statistical information and data may be released by the State and Regional Trauma QA/QI as long as no identifying patient information is provided.

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

420-2-2-.14 Statewide Trauma System Fund.

Pending

Authors: John Campbell, M.D., and Choona Lang
Statutory Authority: *Code of Alabama, 1975*, §22-11D-1, et seq.
History:

Alabama Trauma Center Designation

Trauma Facilities Criteria: APPENDIX A Trauma Rules

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

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

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

	Level I	Level II	Level III
Multidisciplinary committee attendance	E	E	-
FACILITIES/ RESOURCES/ CAPABILITIES			
Volume Performance			
Trauma admissions 750/ year	E	-	-
Presence of surgeon at resuscitation	E	E	D
Presence of surgeon at operative procedures	E	E	E
Emergency Department (ED)			
Personnel - designated physician director	E	E	D
Equipment for resuscitation for patients of all ages			
Airway control and ventilation equipment	E	E	E
Pulse oximetry	E	E	E
Suction devices	E	E	E
Electrocardiograph-oscilloscope-defibrillator	E	E	E
Internal paddles	E	E	-
CVP monitoring equipment	E	E	D
Standard IV fluids and administration sets	E	E	E
Large-bore intravenous catheters	E	E	E
Sterile surgical sets for:			
Airway control/ cricothyrotomy	E	E	E
Thoracostomy	E	E	E
Venous cutdown	E	E	E
Central line insertion	E	E	-
Thoracotomy	E	E	-
Peritoneal lavage	E	E	D
Arterial catheters	E	D	D
Ultrasound	D	D	D
Drugs necessary for emergency care	E	E	E
X-ray available 24 hours/ day	E	E	D
Cervical traction devices	E	E	D
Broselow tape	E	E	E
Thermal control equipment:			
For patient	E	E	E
For fluids and blood	E	E	D

	Level I	Level II	Level III
Rapid infuser system	E	E	D
Qualitative end-tidal CO_2 determination	E	E	E
Communications with EMS vehicles	E	E	E
OPERATING ROOM			
Immediately available 24 hrs/day[7]	E	D	D
Operating Room Personnel			
In house 24 hrs/ day[8]	E	-	-
Available 24 hrs/ day		E	E
Age Specific Equipment			
Cardiopulmonary bypass	E	-	-
Operating microscope	D	D	-
Thermal Control Equipment			
For patient	E	E	E
For fluids and blood	E	E	E
X-ray capability, including c-arm image intensifier	E	E	E
Endoscopes, bronchoscopes	E	E	D
Craniotomy instruments	E	D	-
Equipment for long bone and pelvic fixation	E	E	D
Rapid infuser system	E	E	D
Post Anesthetic Recovery Room (SICU is acceptable)			
Registered nurses available 24 hours/day	E	E	-
Equipment for monitoring and resuscitation	E	E	E
Intracranial pressure monitoring equipment	E	D	-
Pulse oximetry	E	E	E
Thermal control	E	E	E
Intensive or Critical Care Unit for Injured Patients			
Registered nurses with trauma education	E	E	-
Designated surgical director or surgical co-director	E	E	D
Surgical ICU service physician in-house 24 hours/day Emergency physician will satisfy this requirement	E	D	-
Surgically directed and staffed ICU service	E	D	-
Equipment for monitoring and resuscitation	E	E	-
Intracranial monitoring equipment	E	-	-
Pulmonary artery monitoring equipment	E	E	-

	Level I	Level II	Level III
Respiratory Therapy Services			
Available in-house 24 hours/day	E	E	D
On-call 24hrs/day	-	-	D
Radiological services (available 24 hours/day)			
In house radiology technologist	E	E	D
Angiography	E	D	-
Sonography	E	E	D
Computer Tomography (CT)	E	E	D
In house CT technician	E	-	-
Magnetic Resonance Imaging (Technician not required in house)	E	D	-
Clinical laboratory services (Available 24hours/day)			
Standard analyses of blood, urine, and other body fluids, including micro sampling when appropriate			
Blood typing and cross-matching	E	E	E
Coagulation studies	E	E	E
Comprehensive blood bank or access to a community central blood bank and adequate storage facilities	E	E	E
Blood gasses and pH determinations	E	E	
Microbiology	E	E	E
Acute Hemodialysis	E	E	E
In-house (staff not required in-house 24 hours)	E	-	-
Transfer agreement (written document not required)	--	E	E
Burn Care – Organized			
In house or transfer agreement with Burn Center (See above)	E	E	E
Acute Spinal Cord Management			
In-house or transfer agreement with Regional Acute Spinal Cord Injury Rehabilitation Center (See above)	E	E	E
REHABILITATION SERVICES			
Transfer agreement to an approved rehabilitation facility (See above)	E	E	E
Physical therapy	E	E	D
Occupational therapy	E	D	D
Speech therapy	E	D	-
Social Service	E	E	D

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

	Level I	Level II	Level III
Identifiable IRB process	D	-	-
Extramural educational presentations	D	D	-
Number of scientific publications	D	-	-

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

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

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

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

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

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

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

[8]An operating room must be adequately staffed and immediately available in a Level I trauma center. This is met by having a complete operating room team in the hospital at all times, so if an injured patient requires operative care, the patient can receive it in the most expeditious

manner. These criteria cannot be met by individuals who are also dedicated to other functions within the institution. Their primary function must be the operating room.

An operating room must be adequately staffed and available when needed in timely fashion in a Level II trauma center. The need to have an in-house OR team will depend on a number of things, including patient population served, ability to share responsibility for OR coverage with other hospital staff, pre hospital communication, and the size of the community served by the institution. If an out-of-house OR team is used, then this aspect of care must be monitored by the performance improvement program.

APPENDIX B Trauma Rules	*Alabama Department of Public Health* *Office of EMS and Trauma* *Page 1 of 2*

ALABAMA TRAUMA CENTER CLASSIFICATION / DESIGNATION APPLICATION

(Instructions on page 2)

Section A. LEVEL OF CLASSIFICATION / DESIGNATION

Name of Hospital to appear on Certification:

Classification / Designation Level (Check)	None	Level I	Level II	Level III
Current level:	☐	☐	☐	☐
Level being applied for:		☐	☐	☐

Section B. FACILITY IDENTIFYING INFORMATION

Facility Name:			
Mailing Address (include street address):			Telephone Number
City	State	Zip	County
Trauma Medical Director (Name, Title)			
E-mail	Telephone ( )		Fax ( )
Trauma Program Coordinator/ Manager (Name, Title)			
E-mail	Telephone ( )		Fax ( )
Physician Director of Emergency Medicine (Name, Title)			
E-mail	Telephone ( )		Fax ( )
Chief of Surgery (Name, Title)			
E-mail	Telephone ( )		Fax ( )

Contact Person (Name, Title)		
E-mail	Telephone ( )	Fax ( )

Section C. REGIONAL TRAUMA ADVISORY COUNCIL (RTAC) NAME

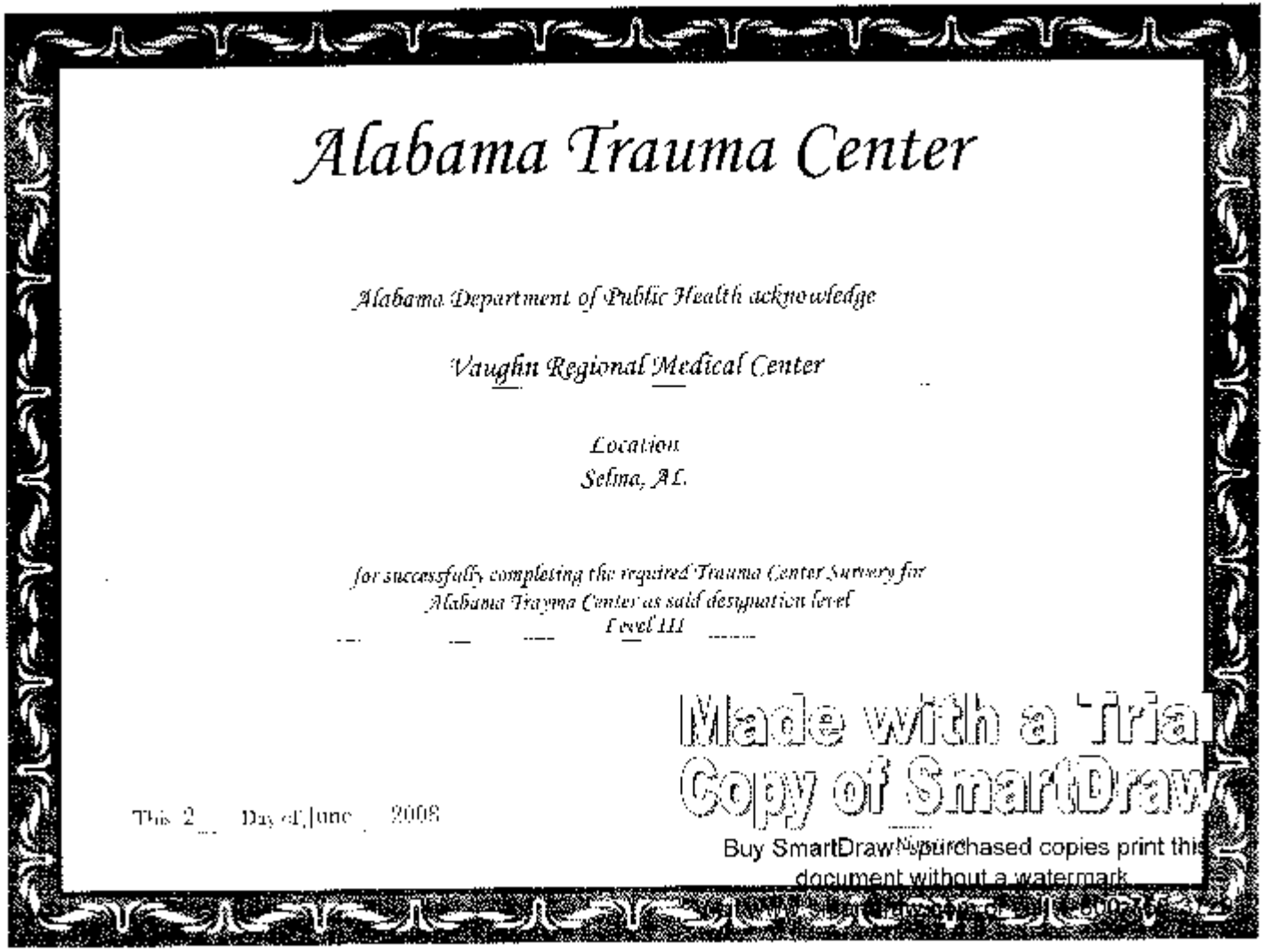
( )North
( )East
( )BREMSS
( )West
( )Southeast
( )Gulf

Section D. ACKNOWLEDGEMENT AND SIGNATURE(S)

Signature of CEO	Date Signed
Signature of Chief of Staff	Date Signed
Signature of Chief of Surgery	Date Signed

In accordance with the requirements of the Trauma System Administrative Rules, the hospital listed above agrees to abide by the State Trauma System Hospital Classification / Designation Criteria.

Appendix C Certificate (Sample)



Alabama Trauma Center

Alabama Department of Public Health acknowledge

Vaughn Regional Medical Center

Location
Selma, AL

for successfully completing the required Trauma Center Survey for Alabama Trauma Center as said designation level
Level III

This 2 Day of June 2008

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Contract Appendix D Trauma Rules

This contract is for the purpose of establishing the responsibilities of the Alabama Statewide Trauma System and_____ hospital to injured patients within *(insert list of counties)* counties.

Alabama Department of Public Health agrees to coordinate through the Alabama Trauma Communications Center (TCC) and the triage protocols (Appendix A), a process which assures _____ will receive only those trauma patients from the Emergency Medical Services (EMSS), which _____ has the resources to provide effective trauma care.
(***Listed as Appendix E to the State Committee of Public Health Statewide Trauma System Trauma Rules)***

_____agrees to participate in the trauma system as a level___and to meet all the requirements as set forth in Appendix B of this document.
(***Listed as Appendix A to the State Committee of Public Health Statewide Trauma System Trauma Rules)***

_____agrees that at any time that resources, personnel, or facilities are unavailable as required for a level____ as defined in Appendix B, that notification will be immediately made to the TCC.
(***Listed as Appendix A to the State Committee of Public Health Statewide Trauma System Trauma Rules)***

_____ agrees to support the function of the Alabama Statewide Trauma System & TCC to assure the proper triage and transport of trauma patients as well as the collecting of data to support QA and QI. Also_____ agrees that it will maintain the system-required computer linkage.

Nothing in this contract shall cause a trauma patient to be transported to a trauma hospital contrary to the patient's **expressed intent**.

The following is the process which will be followed if _____ breaches any of it required performance levels as contained in this contract, which are incorporated into and made a part of this contract.

(1) The first breach of an activity standard will result in a letter of explanation indicating there has been a breach of an activity standard with an explanation and an indication that there is a need for corrective action. A one-month period for corrective action implementation will be allowed.

(2) If a second breach of the same activity occur a letter to the responsible entity indicating that a second breach has occurred with a warning that a third breach in that activity standard will result in suspension from the Trauma System from a 30-day period of time. A one-month period for corrective action implementation will occur.

(3) A third breach of the same activity will result in contract failure and suspension of that facility from the Trauma System for a period of 30 days as per decision of the Alabama Statewide Trauma System with the suspension time doubled from subsequent deviations of the same standard.

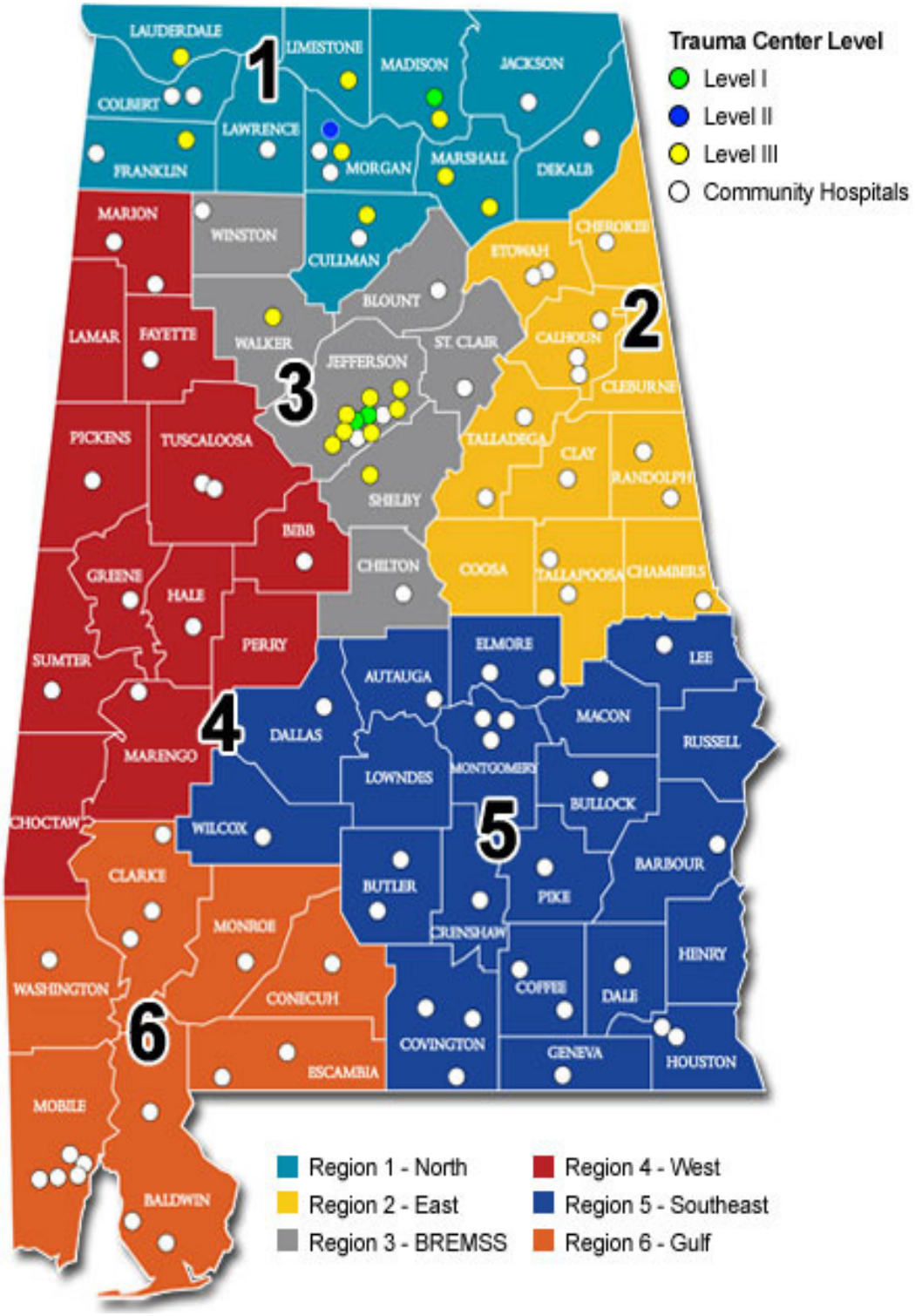
_____ _____

Hospital CEO State Health Officer

_____

State EMS/Trauma Medical Director

Appendix E


Trauma Center Level
Level I
Level II
Level III
Community Hospitals
1
2
3
4
5
6
LAUDERDALE
LIMESTONE
MADISON
JACKSON
COLBERT
LAWRENCE
MORGAN
MARSHALL
DEKALB
FRANKLIN
MARION
WINSTON
CULLMAN
CHEROKEE
ETOWAH
BLOUNT
LAMAR
FAYETTE
WALKER
JEFFERSON
ST. CLAIR
CALHOUN
CLEBURNE
PICKENS
TUSCALOOSA
TALLADEGA
CLAY
RANDOLPH
SHELBY
BIBB
CHILTON
COOSA
TALLAPOOSA
CHAMBERS
GREENE
HALE
PERRY
SUMTER
AUTAUGA
ELMORE
LEE
MACON
RUSSELL
DALLAS
MARENGO
LOWNDES
MONTGOMERY
BULLOCK
CHOCTAW
WILCOX
BARBOUR
CLARKE
BUTLER
PIKE
CRENSHAW
MONROE
HENRY
WASHINGTON
CONECUH
COFFEE
DALE
COVINGTON
GENEVA
HOUSTON
ESCAMBIA
MOBILE
BALDWIN
Region 1 - North
Region 2 - East
Region 3 - BREMSS
Region 4 - West
Region 5 - Southeast
Region 6 - Gulf

Appendix F

PATIENT ENTRY CRITERIA FOR HOSPITALS

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

Physiological criteria present on arrival or develop during evaluation and observation:

1. A systolic BP < 90 mm/Hg in an adult **or < 80 mm/Hg in a child five or younger.**
2. Respiratory distress - rate < 10 or >29 in adults, **or < 20 or > 40 in a child one year or younger.**
3. Head trauma with Glasgow Coma Scale score of 13 or less. The level of trauma center to which this patient would be transferred would depend on regional secondary triage criteria. Generally only GCS scores of 9 or less are triaged to a Level I Trauma Hospital.

Anatomical Criteria (patient with normal physiologic signs):

1. The patient has a flail chest.
2. The patient has two or more obvious proximal long bone fractures (humerus, femur).
3. The patient has a penetrating injury of the head, neck, torso, or groin, associated with an energy transfer.
4. The patient has in the same body area a combination of trauma and burns (partial and full thickness) of 15% or greater.
5. The patient has an amputation proximal to the wrist or ankle.
6. The patient has one or more limbs which are paralyzed.
7. The patient has a pelvic fracture demonstrated by x-ray or other imaging technique.
8. Significant internal injuries are found during hospital evaluation.

Mechanism of Injury Criteria:

This should not be used as criteria for entering a patient into the trauma system except by facilities that lack the resources and/or expertise to properly evaluate a patient for internal injuries. Patients put into the system for this reason could adequately be evaluated by a Level II or Level III trauma hospital.

1. A patient with the same method of restraint and in the same seating area as a dead victim.
2. Ejection of the patient from an enclosed vehicle.
3. Motorcycle/bicycle/ATV crash with the patient being thrown at least ten feet from the motorcycle/bicycle.
4. Auto versus pedestrian with significant impact with the patient thrown, or run over by a vehicle.
5. An unbroken fall of twenty feet or more onto a hard surface.

Burn Criteria:

Indications for entering the patient into the trauma system and transferring to a burn center include the following:

1. Partial thickness burn of greater than 10% of the total body surface area.
2. Burns that involve the face, hands, feet, genitalia, perineum, or major joints.
3. Third-degree burns in any age group.
4. Electrical burns, including lightning injury.
5. Chemical burns.
6. Inhalation injury.
7. Burn injuries in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
9. Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient's condition may be stabilized initially in a trauma center before transfer to a burn center.
9. Burned children in hospitals without qualified personnel or equipment for the care of children.
10. Burn injury in patients who will require special social, emotional, or rehabilitative intervention.

NOTES:

1. Patients entered into the system for Physiologic criteria may be transferred by calling the Alabama Trauma Communications Center (ATCC).
2. Patients entered into the trauma system for Burn criteria may be transferred by calling the ATCC for availability of appropriate bed (floor vs. ICU) at ready burn center. When availability of a bed is confirmed, the ATCC will connect the transferring physician with the receiving surgeon (if immediately available) at the ready burn center to discuss any stabilization that should be done prior to transfer.
3. Facilities wishing to enter a patient into the trauma system for Anatomic or Mechanism of Injury criteria should call the ATCC who can identify the appropriate ready hospital and can facilitate the transferring physician consulting with a receiving physician to discuss the transfer.

Appendix G

Injury case criteria for State Trauma Registry

1. ICD-9 diagnosis code **800 - 959.9** *(per National Trauma Data Standard Version 1.2.2, revised April 2008)*
   And
2. Hospital admission for 24 hours or greater **or**
3. Transferred from one hospital to another hospital **or**
4. Death resulting from the traumatic injury (independent of hospital admission or hospital transfer)
5. Assigned an **ATCC number** **

Exclusions:

1. 910 – 924.9 (superficial injuries, including blisters, contusions, abrasions and insect bites)
2. 930 – 939.9 (foreign bodies)

Reporting Schedule:

1. Within **90 days** of ED visit, admission, or diagnosis as above
2. Reports are to be submitted to ATR on a monthly basis

** Anyone assigned an ATCC number will be reported to Trauma Registry

*** Approved per STAC on 10/06/08

Appendix H
Administrative

TRAUMA SYSTEM PROTOCOL	**8.5**

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

Physiological criteria:

4. A systolic BP < 90 mm/Hg in an adult **or < 80 mm/Hg in a child five or younger.**
5. Respiratory distress - rate < 10 or >29 in adults, **or < 20 or > 40 in a child one year or younger.**
6. Head trauma with Glasgow Coma Scale score of 13 or less.

Anatomical Criteria:

10. The patient has a flail chest.
11. The patient has two or more obvious proximal long bone fractures (humerus, femur).
12. The patient has a penetrating injury of the head, neck, torso, or groin, associated with an energy transfer.
13. The patient has in the same body area a combination of trauma and burns (partial and full thickness) of fifteen percent or greater.
14. The patient has an amputation proximal to the wrist or ankle.
15. The patient has one or more limbs which are paralyzed.
16. The patient has a pelvic fracture, as evidenced by a positive “pelvic movement” exam.

Mechanism of the patient injury:

6. A patient with the same method of restraint and in the same seating area as a dead victim.
7. Ejection of the patient from an enclosed vehicle.
8. Motorcycle/bicycle/ATV crash with the patient being thrown at least ten feet from the motorcycle/bicycle.
9. Auto versus pedestrian with significant impact with the patient thrown, or run over by a vehicle.
10. An unbroken fall of twenty feet or more onto a hard surface.

EMT Discretion:

1. If, the EMT is convinced the patient could have a severe injury which is not yet obvious, the patient should be entered into the trauma system.
2. The EMTs suspicion of severity of trauma/injury may be raised by the following factors:
   a. Age > 55
   b. **Age < five**
   c. Environment (hot/cold)
   d. Patient’s previous medical history
      i. Insulin dependent diabetes
      ii. Cardiac condition
      iii. Immunodeficiency disorder
      iv. Bleeding disorder

v. COPD/Emphysema

e. Pregnancy
f. Extrication time > 20 minutes with heavy tools utilized
g. Motorcycle crash
h. Head trauma with history of more than momentary loss of consciousness.

ENTERING A PATIENT INTO THE TRAUMA SYSTEM:

1. Regions that are not yet operating under the Alabama Trauma System
Patients should be transported to a hospital with a trauma response program if such is available in the region, per the region's Medical Control and Accountability Plan.

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

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

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

1. Identify yourself and your agency by name, unit number and county. If on-line medical direction is necessary, the receiving trauma center becomes medical direction. TCC will help coordinate on-line medical direction with a physician immediately.

2. Give your geographic location.

3. Give age and sex of patient (patient name is not necessary).

4. Assign patient number if more than one patient.

5. Give criteria for entry into Trauma System.

6. Give vital signs: Blood Pressure, Pulse rate, Respiratory rate, GCS

7. TCC Communicator will offer available trauma centers based on information given above.

8. Give unit number of transporting unit, mode of transport, and time of transport from the scene.

9. You will be given a unique identification number that must be entered into the chart when you generate your e-PCR. The Office of EMS and Trauma will use this to identify the charts for quality improvement studies.

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

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

Appendix I

Operations Guidelines **June 25, 2008**

GUIDELINES FOR EARLY ACTIVATION OF HELICOPTER EMERGENCY MEDICAL SERVICES **7.9**

PURPOSE: Helicopter EMS services (HEMS) offer speed of transport and ALS personnel experienced in managing critical patients. These guidelines are to assist EMS responders in determining when early activation of HEMS would likely be in the critical patient's best interest. Early Activation means initiation of a helicopter response prior to arrival of the EMS responders to the scene. Early Activation may be based on pre-arrival information regarding the incident or a suspicion by EMS that specialty care may be needed. Early Activation is initiated at the request of the first responding EMS providers or in conjunction with Dispatch and the EMS service. It is recognized that pre-arrival information may be misleading and the activated HEMS may be cancelled. The HEMS service that can respond to the scene in the shortest time should be called. If a HEMS service cannot answer a call and a second service is requested, the requesting agency must notify the second service that the call has already been refused and why.

Situations in which Early Activation of HEMS may be needed includes, but are not limited to:

1. Report of severe collision involving one or more vehicles
2. Multiple victim incidents with severe illness or injuries
3. Report of person being ejected from a vehicle
4. Pedestrian vs. vehicle with reported injuries
5. MVC with reported death and other injured persons
6. Report of severe burns
7. An unbroken fall of twenty feet or more onto a hard surface
8. Penetrating injury to head, neck, torso, or groin
9. Report of injury with paralysis
10. Sickness with new onset focal weakness or paralysis (suspected stroke)
11. Severe chest pain thought to be of cardiac etiology
12. Near drowning
13. Report of amputation proximal to wrist or ankle
14. Report of serious injury in a patient whose location would be difficult to access by ground ambulance but is more accessible by helicopter
15. Severe shortness of breath or airway problems
16. There is no available ground ambulance to respond
17. Report of patient with symptoms of shock
18. Report of patient with history of trauma and altered mental status
19. Discretion of Medical Direction or responding EMS personnel

HEMS are most appropriately used when their use would **SIGNIFICANTLY** reduce the time required to get the patient to the appropriate hospital or when potentially lifesaving prehospital interventions may be needed that that cannot be provided by the responding EMS service. The Regional Aeromedical Plan must be followed when approved. Quality Improvement monitoring is important and is best done in partnership with the responding helicopter service.

Appendix J

Operations Guidelines **June 25, 2008**

GUIDELINES FOR HELICOPTER TRANSPORT OF TRAUMA SYSTEM PATIENTS	**7.10**

Purpose

Helicopter EMS services (HEMS) offer speed of transport and ALS personnel experienced in managing critical patients. The purpose of this Air Evacuation Protocol is to provide EMS personnel who are on scene, with guidelines for utilizing HEMS for transporting trauma system patients.

Process

Several factors must be considered before summoning HEMS for a trauma scene response. Stable patients who are accessible by ground vehicles and are within a reasonable distance from the designated trauma center are best transported by ground vehicles. Often, patients can be transported by ground ambulance and delivered to the appropriate trauma center before a helicopter can reach the scene. You must follow your Regional Aeromedical Plan when approved. If a question exists as to whether HEMS transport would be appropriate, Medical Direction should be consulted before summoning a helicopter for a scene response.

HEMS are best used to transport critical trauma patients such as those entered into the trauma system because of physiologic or anatomic criteria. Those patients entered into the trauma system because of mechanism of injury or EMT discretion criteria are often more appropriately transported by ground ambulance.

The primary determinant should be to get the patient to the most appropriate facility in the shortest amount of time.

Emergency Medical Services personnel should request HEMS when transportation by air will SIGNIFICANTLY reduce actual transport time to the receiving facility and/or the patient needs potentially lifesaving prehospital interventions that cannot be provided by the responding EMS service. The following are some criteria when HEMS transport should be considered.

1. Transport time to the designated trauma center by ground ambulance is significantly greater than the response time and transport to the designated Trauma Center by air.

2. Ambulance access to the scene or away from the scene is significantly impeded by road conditions and/or traffic.

3. Prolonged patient extrication when a Level I facility is needed. Understand that some extricated patients are not injured and/or have sustained minor injuries and may not need HEMS.

4. Multi-system blunt or penetrating trauma with unstable vital signs.

5. Severe burns that require transport to a burn center (See Protocol 4.7).

6. Patients with severe respiratory distress or airway problems.

7. Multiple patient incidents that exceed ground ambulance service resources.

8. No ambulance available to transport the patient and/or no ALS service (if needed) within 30 minutes.

9. Discretion of Medical Direction or the on-scene EMS personnel.

When use of HEMS is not specifically defined by the protocol, the on-scene EMS personnel can establish communication with Medical Direction for advice.

Once the decision is made to use HEMS for a trauma patient, the service that can respond to the scene in the shortest time should be called. Because helicopters must go through a preflight protocol before lift-off, the shortest response time should be obtained by calling the HEMS first and then calling the TCC to decide on the proper destination hospital. When a decision is made on a destination hospital, the helicopter service should be immediately notified so they may develop their flight plan. If Early Activation was utilized, the responding HEMS service should be notified of the patient destination as soon as possible. If a HEMS service is unable to answer a call and a second service is requested, the requesting agency must notify the second service that the call has already been refused and why.

An EMS service should not wait on the scene or unduly delay transport waiting for HEMS to arrive. If the patient is packaged and ready for transport, the EMS service should reassign the landing zone to a mutually agreeable site that is closer to the hospital, and should initiate transport. The helicopter may intercept an ambulance at an agreed upon alternate landing site.

Cancellation

When EMS personnel arrive on scene, they should assess the situation. If HEMS has already been called and it is the professional judgment of the HIGHEST LEVEL LICENSED EMS PERSONNEL ON THE SCENE that the helicopter will not provide a significant benefit, it should be cancelled as soon as possible. A HEMS request by a BLS agency may be cancelled by the responding ALS agency only after an appropriate patient assessment has been conducted. A HEMS request by an ALS agency may be cancelled only by the agency making the initial request. If HEMS cancels a flight, they must inform the requesting agency ASAP.

If HEMS arrives on scene and determines that the patient does not meet criteria for helicopter transport or that patient, weather, or aircraft issues preclude use of the helicopter for transport, they may request ground transport of that patient. The request for ground transport does not preclude the HEMS crew from boarding the ground ambulance and continuing to provide advanced care as would be provided in flight. In situations where the HEMS crew determines that the patient does not have a medical need for HEMS transport, the transfer of this patient

to a ground ambulance shall not constitute abandonment as defined by EMS regulations.

Quality Assurance/Improvement
As with all EMS responses in which HEMS is utilized, there should be QA/QI done in partnership with the responding helicopter service. Follow the Regional Aeromedical Plan when approved.

THIS IS A GUIDELINE AND IS NOT ALL INCLUSIVE. EMS PERSONNEL SHOULD USE GOOD CLINICAL JUDGEMENT AT ALL TIMES. IF THERE ARE ANY QUESTIONS, OLMD SHOULD BE CONSULTED.

[i] 11/06/2008 c.f.