Level IV Trauma Designation Work Plan

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Hospital Commitment	A decision by a hospital to become a trauma facility requires the commitment of the institutional governing body and the medical staff. **CD 5-1** Documentation of administrative commitment is required from the governing body and the medical staff. **CD 5-1** Because the trauma PI program crosses many specialty lines, it must be empowered to address events that involve multiple disciplines and be endorsed by the hospital governing body as part of its commitment to optimal care of the injured patients. There must be adequate administrative support to ensure evaluation of all aspects of trauma care. **CD 5-1**	Two resolutions are required. One from the hospital board and one from medical executive board. **CD 5-1** The governing board provides a written letter of resolution, indicating the facility's commitment to the hospital's trauma program and desire to provide the resources necessary to become and sustain a level IV trauma hospital designation. A sample of a resolution is on Appendix #2 in the PRQ. **CD 5-1** The medical staff board provides a written letter of resolution, indicating the medical staffs' commitment to the hospital's trauma program and desire to participate as necessary to become and sustain a level IV trauma hospital designation. Contact your facility's risk manager, or administrative office for a "resolution" form. A sample of a resolution is on Appendix #2 in the PRQ.			
Trauma System	Meaningful involvement in state and regional trauma system planning development, and operation is essential for all designated trauma facilities and participating acute care facilities within a region. **CD 1-3** The individual trauma facilities and their health care providers are essential system resources that must be active and engaged participants. **CD 1-1** They must function in a way that pushes trauma facility-based standardization, integration, and PI program out to the region while engaging in inclusive trauma system planning and development. **CD 1-2**	**CD 1-3** The trauma facility staff must demonstrate participation in regional and/or state trauma organizations. Examples are state advisory committees, MCOT, regional committees, and state EMS committees. **CD 1-1, CD 1-2** The trauma facility must demonstrate engagement in communication with other facilities within their region and outside of their region. This can be achieved through feedback letters to sending hospitals on patient transfers, feedback to EMS agencies on patient transports, engaging in conversations with receiving hospitals on patient outcomes, being a resource for other healthcare providers in your region, and providing educational events to all stakeholders in your region.			

Level IV Trauma Designation Work Plan

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Trauma System (continued)	The trauma program must also demonstrate appropriate orientation, credentialing processes, and skill maintenance for advanced practitioners, as witnessed by an annual review by the trauma medical director. **CD 11-87** Sufficient mechanisms must be available to identify events for review by the trauma PI program. Issues that must be reviewed will revolve predominately around (1) system and process issues such as documentation and communication; (2) clinical care, including identification and treatment of immediate life-threatening injuries (ATLS); and (3) transfer decisions. **CD 16-10** Once an event is identified, the trauma PI program must be able to verify and validate that event. **CD 16-11** The best possible care for patients must be achieved with a cooperative and inclusive program that clearly defines the role of each facility within the system. **CD 1-1** The foundation for evaluation of a trauma system is the establishment and maintenance of a trauma registry. Trauma registry data must be collected and analyzed by every trauma facility. The trauma center must demonstrate that all trauma patients can be identified for review. **CD 15-1**	**CD 11-87** Have a written orientation program available, which should include skill maintenance documentation as well. The credentialing process should follow the hospital's credentialing process already in place. Annual review should be documented for each provider. **CD 16-10** Develop a process that will identify events to be reviewed through PI. All patients that meet these three criteria should be reviewed every month with PI program. Comprehensive audit filters (all of ACS and State of Michigan audit filters) should capture any patient's that fall into these three categories. **CD 1-1** The hospital and trauma service should have a clear understanding of what patients are admitted and what patients are transferred out. In addition, the hospital should have clear transfer plans with other hospitals in their region. **CD 15-1** Must have a designated data collection person and state registry system. Data is entered on all trauma patients that meet criteria. Quarterly data submission is required. This data will support the PI program and injury prevention program.			
The Role of a Trauma Facility in a Trauma System	This trauma facility must have an integrated, concurrent performance improvement (PI) program to ensure optimal care and continuous improvement in care. **CD 2-1** The trauma facility must be able to provide the necessary human and physical resources (physical plant, and equipment) to properly administer acute care consistent with their level of verification. **CD 2-3**	**CD 2-1, CD 2-3** Hospital must have the capabilities to treat trauma patients through equipment, human and physical resources and well defined transfer plans. This is demonstrated through the documentation of the care of the patient, policies, and protocols, as well as through a strong PI program.			

MDHHS Michigan Department of Health & Human Services

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Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
The Role of a Trauma Facility in a Trauma System (continued)	Multidisciplinary trauma peer review committee must meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured. **CD 2-18** A PI program must have audit filters to review and improve pediatric and adult patient care. **CD 2-19** Because of the greater need for collaboration with receiving trauma facilities, the Level IV trauma facility must also actively participate in regional and statewide trauma system meetings and committees that provide oversight. **CD 2-20**	**CD 2-18, CD 2-19** Trauma service must set regular multidisciplinary peer review meetings, with a set agenda, in order to review resuscitations, trauma systems issues, provider issues, and recommendations for improvement. All audit filters are reviewed and evaluated at this meeting. Facility must have documentation of their involvement in any statewide trauma meetings, as well as regional trauma meetings. Maintain a log of meetings, dates, attendees from your facility, etc.			
Pre-hospital Trauma Care	The protocols that guide pre-hospital trauma care must be established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies and basic and advanced pre-hospital personnel. **CD 3-2** The level IV facility must also be the local trauma authority and assume the responsibility for providing training for pre-hospital and hospital based providers. **CD 2-21** When a trauma facility is required to go on bypass or divert, the facility must have a system to notify dispatch and EMS agencies. The facility must do the following: • Prearrange alternative destinations with transfer agreements in place • Notify other facilities of divert or advisory status • Maintain a divert log • Subject all diverts and advisories to performance improvement procedures **CD 3-7**	**CD 3-2** The protocols that guide pre-hospital care for trauma patients must be collaboratively developed by all stakeholders. **CD 2-21** Must provide the education to pre-hospital providers on the Level IV center's activation systems, trauma systems, etc. Maintain documentation of all education provided to pre-hospital providers, such as speaking at the UP EMS conference. Loop closure, such as memos, to pre-hospital providers for educational purposes should be well documented in meeting minutes. **CD 3-7** Documentation must show all of the required information in CD 3-7. The PI program must discuss, and show in the minutes, every occurrence of the hospital going on diversion, along with any and all affected trauma patients.			

Level IV Trauma Designation Work Plan

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Inter-hospital Transfers	Transfer guidelines and plans between facilities are crucial and must be developed after evaluating the capabilities of rural hospitals and medical transport agencies. Collaborative treatment and transfer guidelines reflecting the facilities' capabilities must be developed and regularly reviewed, with input from higher-level trauma facilities in the region**.** Well defined transfer plans are essential. **CD 2-13** Direct physician to physician contact is essential. Direct contact of the physician or midlevel provider with a physician at the receiving hospital is essential. **CD 4-1** A very important aspect of interhospitall transfer is an effective PI program that includes evaluation transport activities. **CD 4-3** All transfers must be evaluated as part of the receiving trauma facility's performance improvement (PI) process and feedback should be provided to the transferring facility. **CD 4-3**	**CD 2-13** Establish a transfer protocol that is approved by the trauma medical director and monitored by PI program which includes: • Anatomical and physiological characteristics identifying a patient in need of transfer • List of transfer services w/contact information • List of supplies/equipment that will accompany patient • List of records/documentation that will accompany patient • Personnel needed to accompany patient **CD 4-1** Transfer protocols must be developed that required physician to physician communication. **CD 4-3** All transfers are to be reviewed through PI program. Develop a process to provide feedback to transferring facilities. Develop a process to disseminate feedback from receiving facilities to staff, physicians, EMS, etc.			

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Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Trauma Program Coordinator/ Manager (TPM)	TPM is knowledgeable and involved in trauma care, working with TMD with guidance from trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking. **CD 2-17**	**CD 2-17** This person shall be a RN with clinical experience in trauma care. Alternatively, other qualified allied health personnel with clinical experience in trauma care may be appropriate. It is expected that the Coordinator/Manager has allocated time for the trauma program. The TPM does not have to be dedicated full time to the trauma program.			
Trauma Program Medical Director (TMD)	The TMD and the TPM knowledgeable and involved in trauma care must work together with guidance from trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking. **CD 2-17** The trauma medical director and the trauma program manager must have the authority and be empowered by the hospital governing body to lead the program. **CD 5-1**	**CD 2-17** Trauma Medical Director must work closely with the Trauma Program Manager. This is evidenced through minutes, memos, documentation containing loop closure.			
General Surgery	For Level III and Level IV facilities the maximum acceptable response time is 30 minutes. Response time will be tracked from patient arrival rather than from notification or activation. An 80 percent attendance threshold must be met for the highest-level activations. **CD 2-8** The successful completion of the ATLS® course, at least once, is required in all levels of trauma facilities for all general surgeons, on the trauma team. **CD 17-5**	**CD 2-8** **Note: This CD refers to trauma facilities that have trauma surgeons on their trauma team (24/7).** Response time is tracked from patient arrival rather than from notification or activation. An 80 percent attendance/ threshold must be met for the highest-level activations. This should be an audit filter. **CD 17-5** Maintain documentation of each general surgeon and the date of ATLS completion.			

Level IV Trauma Designation Work Plan

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Emergency Medicine	Must have 24 hour physician coverage by a physician or midlevel provider. **CD 2-14** Emergency department must be continuously available for resuscitation with coverage by a registered nurse and physician or midlevel provider, and it must have a physician director. **CD 2-15** The emergency department providers must maintain current ATLS certification as part of their competencies if the provider is not Board Certified in Emergency Medicine. **CD 2-16** Advanced practitioners who participate in the initial evaluation of the trauma patients must demonstrate current verification in ATLS. **CD 11-86** It is expected that the physician or midlevel provider will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 30 minutes for the highest level of activation, tracked from patient arrival. The PI program must demonstrate that the physician's presence is in compliance at least 80 percent of the time. **CD 2-8**	**CD 2-14** Provide published schedule showing physician or midlevel provider availability 24/7 for ED coverage. **CD 2-15** Must have a schedule of nursing and physician 24/7 coverage. Identify a Medical director for the emergency department that is a physician. **CD 2-16** Maintain documentation for ATLS certification, or Board certification. If the emergency department provider is Board Certified in emergency medicine then the provider must take ATLS at least once. **CD 11-86** Must maintain documentation for ATLS certification for these advanced practitioners. **CD 2-8** This (response times of ED provider) must be an audit filter in the PI to be reviewed by PI program.			

Level IV Trauma Designation Work Plan

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Radiology	Conventional radiography must be available in all trauma centers 24/7. **CD 11-29**	**CD 11-29** Published schedule must show that conventional radiology is available 24/7.			
Lab and Blood Bank	24-hour availability of a laboratory capable of: • Standard analysis of blood, urine and other body fluids, including micro sampling • Blood typing and cross matching **CD 11-80, CD 11-81** Must have a massive transfusion protocol developed collaboratively between the trauma service/program and the blood bank. **CD 11-84**	**CD 11-80, CD 11-81** Ensure lab has these capabilities, along with policy and procedures. **CD 11-84** Inventory number of O negative units in-house. Ensure access to a blood bank. Written policy and protocol on obtaining blood from blood bank for emergent use on trauma patient. Develop a policy specific to Massive Transfusion for trauma patients. The implementation of the Massive Transfusion policy must also be an audit filter to review through PI program.			
Burn Patients	Trauma facilities that refer burn patients to a burn center must have a written transfer agreement with the referral burn center. **CD 14-1**	**CD 14-1** Have written transfer agreement with a specific burn center.			
Trauma Team Activation	The criteria for a graded activation must be clearly defined by the trauma facility, with the highest level of activation including the six required criteria listed in Chapter 5; Table 2 of the ACS' "Resources for the Optimal Care of the Injured Patient, 2014". **CD 5-13** Other potential criteria for trauma team activation that have been determined by the trauma program to be included in the various levels of trauma activation must be evaluated on an ongoing basis in the PI process to determine their positive predictive value in identifying patients who require the resources of the full trauma team. **CD 5-16**	**CD 5-16, CD 5-13** If your trauma activation policy contains additional criteria, beyond the six state required criteria, then these specific, additional, criteria must be included in the monthly performance improvement data. This will ensure the validity of these criteria. For example, additional criteria for your institution may be to initiate a trauma activation for all ground level falls in patients the age of > 70 years old. These patients must be reviewed in the monthly performance improvement data. The activation policy should specify when the team must be assembled, who is to respond and how they are to be notified. The policy should build upon existing facility-specific internal operating procedures, staffing resources and established minimum state criteria.			

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Trauma Team Activation (continued)	The criteria for a graded activation must be clearly defined by the trauma facility, with the highest level of activation including the six required criteria listed in Table 2. **CD 5-13**	Most trauma facilities have a multi-tiered trauma team activation protocol. Even though facilities may have different nomenclature to identify various activation levels, the intent is that there will be levels commensurate with "full" and "limited" activation levels described in Table 2, Chapter 5. The limited activation criteria should be based on high-risk mechanisms of injury. The field triage decision scheme, as outlined in Figure 1, Chapter 3, should be used. **CD 5-13** Establish a trauma team activation policy which includes activation criteria, responders and roles. Activation criteria must include the six required criteria for highest level of activation : • Confirmed blood pressure less than 90 mm Hg at any time in adults and age specific hypotension in children • Gunshot wounds to the neck, chest, or abdomen or extremities proximal to the elbow/knee • Glasgow Coma Scale score less than 9 with mechanism attributed to trauma • Transfer patients from other hospitals receiving blood to maintain vital signs • Intubated patients transferred from the scene or patients who have respiratory compromise or are in need of an emergent airway (Includes intubated patients who are transferred from another facility with ongoing respiratory compromise (does not include patients intubated at another facility who are now stable from a respiratory standpoint) • Emergency physician's discretion			
	The protocols that guide prehospital trauma care must be established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies, and basic and advanced prehospital personnel. **CD 3-2**	**CD 3-2** Develop the trauma activation protocols in collaboration with physicians, medical director for EMS agencies. Provide education to all surgeons, emergency physicians, and EMS personnel on these protocols.			
	The trauma team must be fully assembled within 30 minutes. **CD 5-15**	Ensure trauma activation billing codes are implemented, following current MCR rates and guidelines. (Medicare)			
	All trauma team activations must be categorized by the level of response and quantified by number and percentage, as shown in Chapter 5; Table 2 of the ACS' "Resources for the Optimal Care of the Injured Patient, 2014". **CD 5-14, CD 5-15**	**CD 5-15** Trauma facilities must develop an activation system that pages out all members of the trauma team for trauma activations. Trauma team arrival times must be monitored in monthly PI.			

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Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Trauma Registry	All healthcare facilities with an emergency center shall participate in data submission. **MI-CD 1-1**	**MI-CD 1-1** Must submit data into state trauma registry system/data bank.			
	All data which meets inclusion criteria, as defined in the most current version of "National Trauma Data Standard: Data Dictionary", is submitted electronically into the State Trauma Registry (ImageTrend). Twelve months of data must be submitted into the State Trauma Registry prior to applying for designation as a Michigan trauma facility for the first time. **MI-CD 1-2**	**MI-CD 1-2** Must follow the inclusion criteria as defined in the Data Dictionary. This data is entered electronically into the State Trauma Registry. Twelve months of data must be entered before applying for designation.			
	To maintain designation as a Michigan Trauma facility, data is to be submitted electronically into the State Trauma Registry quarterly. **MI-CD 1-3**	**MI-CD 1-3** Data must be submitted electronically into ImageTrend and submitted to the State of Michigan quarterly.			
	Each healthcare facility is required to designate a person responsible for trauma registry activities. This person should have minimal training necessary to maintain the registry. This need not be a dedicated position. **MI-CD 1-4**	**MI-CD 1-4** Must have a person with the responsibilities of entering data into the state registry.			
	The trauma facility must demonstrate that all trauma patients can be identified for review. **CD 15-1**	**CD 15-1, CD 15-3** Identify a designated data collection person and implement a trauma registry. Obtain access to ImageTrend or other trauma data registry system used in-house. Data must be directly entered or uploaded from another registry system into the state trauma registry as required. PI program is supported by this trauma registry data.			
	The trauma registry is essential to the performance improvement (PI) program and must be used to support the PI process. **CD 15-3**				
	Furthermore, these findings must be used to identify injury prevention priorities that are appropriate for local implementation. **CD 15-4**				
	Trauma registries should be concurrent. At a minium, 80 percent of cases must be entered within 60 days of discharge. **CD 15-6**				

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Trauma Registry (continued)	The trauma program must ensure that appropriate measures are in place to meet the confidentiality requirements of the data. **CD 15-8** Strategies for monitoring data validity are essential. **CD 15-10** All process and outcome measures must be documented within the trauma PI program's written plan and reviewed and updated at least annually. **CD 16-5**	**CD 16-5** All processes and outcome measures must be included in the PI written plan and reviewed annually. All events must be identified, verified, and validated by the PI program and documented.			
Performance Improvement	Develop a performance improvement plan based on standards that are incorporated by reference to Administrative Rule 325.135 and the ACS "Resources for the Optimal Care of the Injured Patient 2014". The standards include: 1. Have a written performance improvement plan which addresses the following: a. Have a process of event identification and levels of review which result in the development of corrective action plans, and methods of monitoring, re-evaluation, risk stratified benchmarking must be present and this process must be reviewed and updated annually. b. Problem resolution, outcome improvements and assurance of safety (loop closure) must be readily identifiable through methods of monitoring, re-evaluation, benchmarking and documentation.	Develop PI plan which is supported by facility's data that has been entered in the state trauma registry. The plan must demonstrate levels of review (i.e. trauma coordinator, trauma medical director, peer review, administration). Documentation must demonstrate resolution and loop closure. The plan must include the five specific State of Michigan criteria. The plan must include Michigan and ACS audit filters. **Michigan Audit Filters:** 1. Any system and process issues 2. Trauma deaths in house or in the emergency department 3. Any clinical care issues, including identifying and treatment of immediate life threatening injuries 4. Any issues regarding transfer decision 5. Trauma team activation times to trauma activation **Additional Michigan Audit Filters:** 1. Trauma patients with more than one inter-hospital transfer prior to definitive care 2. Ground transport trauma patients with an ED RTS less than or equal to 5.5 and scene transport times (scene departure to ED arrival) greater than 20 minutes 3. Trauma patients with EMS scene times (EMS scene arrival to EMS scene departure) greater than 20 minutes 4.			

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Performance Improvement (continued)	c. All criteria for trauma team activation have been determined by the trauma program and evaluated on an ongoing basis in the PI process. d. The PI program identifies and reviews documents, findings, and corrective action on the following audit filters: • Any system and process issue • Trauma deaths in house or in emergency department • Any clinical care issues, including identifying and treatment of immediate life threatening injuries • Any issues regarding transfer decision • Trauma team activation times to trauma activation **Rule 325.135, MI-CD 2-3** 2. Have a policy in place to review issues that revolve predominately around (1) system and process issues such as documentation and communication; (2) clinical care including identification and treatment of immediate life threatening injuries (ATLS); and (3) transfer decisions. Demonstrate participation in the RTN PI as described in the Regional Trauma Network work plan. Minimally, this includes demonstrating that the healthcare facility is participating in regional data collection, analysis and sharing. A brief description of planned or ongoing participation in the RTN PI initiatives must be submitted with the designation application. **MI-CD 2-1** The PI program must be supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement. **CD 15-1**	**Additional Michigan Audit Filters continued:** 5. Transferred trauma patients with an ISS greater than 15 and transfer time (ED admit to definitive hospital admit) greater than 6 hours for rural place of injury or 4 hours for urban place of injury 6. Trauma patients with an ISS > 15 and ED time (ED admit to ED discharge) greater than 2 hours 7. Trauma patients who die with a probability of survival (TRISS) >50% 8. Trauma patients transported by EMS without an associated ambulance report in the medical record 9. Trauma patients 14 years of age or younger (children) who either had an ED GCS less than or equal to 8, intubation, or ISS greater than 15 and not transferred to a regional pediatric trauma center 10. Pediatric Trauma Patients 11. General surgeon response times to trauma activation. **Note: This audit filter applies to trauma facilities that have trauma surgeons on their trauma team (24/7).** 12. Bypass and diversion events 13. All "other" criteria that requires trauma team activation **ACS Audit Filters:** 1. All trauma deaths in house or in the emergency department 2. All pediatric trauma admissions 3. General surgeon response times to trauma activation. **Note: This audit filter applies to trauma facilities that have trauma surgeons on their trauma team (24/7).** 4. Emergency provider response time to trauma activation 5. Trauma team response times to trauma activation 6. All bypass and diversion events 7. All trauma transfers			

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Performance Improvement (continued)	For all levels of trauma facilities, the PI program must document that timely and appropriate ICU care and coverage are being provided. **CD 11-60** Peer review must occur at regular intervals to ensure that the volume of cases is reviewed in a timely fashion. **CD 2-18** Trauma surgeon response to the emergency department. Trauma surgeon on-call response for the highest level of activation must be continuously monitored and variances documented and reviewed for reason for delay, opportunities for improvement and corrective actions. The minimum threshold is within 30 minutes. Response times will be tracked from patient arrival. An 80 percent attendance threshold must be met for the highest level activations. **CD 2-8** The process of event identification and levels of review must result in the development of corrective action plans, and methods of monitoring, reevaluation, and benchmarking must be present. **CD 2-17**	**CD 2-8** **Note: This CD refers to trauma facilities that have trauma surgeons on their trauma team (24/7).** The response time for the trauma surgeon's arrival to the emergency department is an audit filter. Response times for all trauma activations are reviewed through PI program. The policy may be written with quicker response times for higher level trauma activations. All variances to trauma surgeons' response times to trauma activations are reviewed with corrective action and loop closure. Any additional criteria that your facility includes in the trauma activation must be included in your PI program.			

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Performance improvement (continued)	Criteria for all levels of TTA must be defined and reviewed annually. Minimal acceptable criteria for the highest level of activation include the following (institutional criteria may be included): 1. Confirmed systolic blood pressure less than 90 mmHG at any time in adults and age-specific hypotension in children. 2. Gunshot wounds to the neck, chest, or abdomen. 3. Glasgow Coma Scale Score less than 8, with mechanism attributed to trauma. 4. Transfer patients receiving blood to maintain vital signs. 5. Intubated patients transferred from the scene or patients with respiratory compromise or obstruction, including intubated patients who are transferred from another facility with ongoing respiratory compromise 6. Emergency physician's discretion **CD 5-13** It is essential that each trauma facility have written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death. **CD 21-3** Transfers to a higher level of care within the institution. **CD 16-8** All trauma patients who are diverted or transferred during the acute phase of hospitalization to another trauma facility, acute care hospital, or specialty hospital or patients requiring cardiopulmonary bypass or when specialty personnel are unavailable must be subjected to individual case review to determine the rational for transfer, appropriateness of care, and opportunities for improvement. Follow-up from the facility to which the patient was transferred should be obtained as part of the case review. **CD 9-14, CD 3-4, CD 4-3**	**CD 5-13** Develop a Trauma Team Activation (TTA) policy. This TTA is implemented to activate appropriate staff for incoming trauma patients. The highest level of TTA must, at a minimum, incorporate the six listed criteria. This policy is reviewed annually and documentation shows this annual review (committee meeting minutes). **CD 21-3** Written protocols that identify clinical criteria and confirmatory tests for the diagnosis of brain death. **CD 16-8** All transfers must be tracked, documented, and reviewed through PI.			

Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Performance Improvement (continued)	For Level IV trauma centers, it is expected that the surgeon will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 30 minutes for the highest-level activation tracked from patient arrival. The minimum criteria for full trauma team activation are provided in Table 2 in Chapter 5. The program must demonstrate that the surgeon's presence is in compliance at least 80 percent of the time. **CD 2–8** The trauma PI program must be supported by a registry and a reliable method of concurrent data collection that consistently obtains information necessary to identify opportunities for improvement. **CD 15-3**	**Note: This CD refers to trauma facilities that have trauma surgeons on their trauma team (24/7).** **CD 2-8** Response time is tracked from patient arrival rather than from notification or activation. An 80 percent attendance/threshold must be met for the highest-level activations. This should be an audit filter.			
Outreach and Education	There must be someone in a leadership position that has injury prevention as part of his or her job description. **CD 18-2** Must have an organized and effective approach to injury prevention and must prioritize those efforts based on local trauma registry and epidemiologic data. **CD 18-1** The trauma program must participate in the training of pre-hospital personnel, the development and improvement of pre-hospital care protocols, and performance improvement programs. **CD 3-1**	**CD 18-2, CD 18-1** Injury prevention needs to be written into a leadership position's job description. This person may be the trauma program manager, the ED manager, etc. This person must document all injury prevention activities, as well as an injury prevention plan based on local registry data.			

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Program Component	Criteria Description	Action Required	Responsible person(s)	Targeted Deadline	Complete √
Outreach and Education (continued)	Participate in coordinating and implementing Regional Trauma Network injury prevention work plans and initiatives. **MI-CD 3-1** All verified trauma facilities must engage in public and professional education. **CD 17-1** Universal screening for alcohol use must be performed for all injured patients and must be documented. **CD 18-3**	**MI-CD 3-1** The facility's injury prevention plan must incorporate regional SMART objectives. The regional injury prevention plans were developed and written by the RTAC subcommittees. **CD 17-1** Maintain records and documentation of any public and professional outreach/education. An example is bicycle helmet safety, children car seat education, participation in regional advisory education subcommittee events. **CD 18-3** Develop a universal screening of alcohol tool. This must be documented on all injured patients in the medical record.			
Disaster Plan	All hospitals must have a hospital disaster plan described in the hospital's policy and procedure manual or equivalent. **CD 20-4** Trauma facilities must meet the disaster-related requirements of the Joint Commission. **CD 20-1** Hospital drills that test the individual hospital's disaster plan must be conducted at least twice a year, including actual plan activations that can substitute for drills. **CD 20-3** The facility must participate in regional disaster management plans and exercises. **CD 2-22**	**CD 20-4** Review the hospital disaster plan. TPM and risk management must review JC disaster plan and update in regard to trauma systems. **CD 2-22** Document trauma service participation in regional disaster plans and exercises.			