



Colorado Department
of Public Health
and Environment

TRAUMA CENTER DESIGNATION SCORING TOOL LEVEL III

January 2007

CDPHE
HFEMSD-Trauma Program
4300 Cherry Creek Drive South
Denver, CO 80246-1530
(303) 692-2983

Facility Name: _____

Review Date: _____

Reviewers: _____

State Observer: _____

SITE REVIEWER INSTRUCTIONS

The Colorado Department of Public Health and Environment (CDPHE), Health Facilities and Emergency Medical Services Division, is requesting your assistance in meeting two goals during trauma center designation review.

- The first goal is to determine whether the facility has the required resources and commitment for trauma center designation.
- The second goal is to provide information so the facility may improve trauma patient care.

We designed the following scoring tool to assess a facility's ability to meet the minimum state standards. The facility must show commitment to providing the necessary resources for trauma patient care. It must develop and maintain a trauma service demonstrated by organizational structure, personnel, a trauma quality improvement program, and program documentation. To fully assess whether a facility has met the minimum standards for trauma center designation, the following sources of information may be used: 1) the facility's application; 2) facility staff interviews; 3) a physical tour of the facility; 4) patient medical records, quality improvement documents, and/or peer review minutes, 5) CME and credentialing files; and 6) other pertinent documents related to the facility's trauma program.

CDPHE will use your information and recommendations in its trauma center designation decision. These legal decisions may be controversial and could result in appeal and/or further review. Careful documentation is imperative, as your descriptions will validate CDPHE decisions. Whenever possible, please refer specifically to people (by name or title), locations, documents or medical records.

1. Familiarize yourself with this document before the review date.
2. Print legibly.
3. Read each standard carefully, and ask the state observer for clarification when necessary.
4. Check either **Met**, **Met with Reservations**, or **Not Met** for each standard. Document the rationale for any Met with Reservation or Not Met ratings. Include evidence to substantiate your findings. Comments must be objective and concise. Met with reservations should be used in cases where performance is acceptable with improvement recommended, i.e., where there is evidence of some degree of compliance with standards, but a plan of action/correction is required for full compliance. Reviewers may then recommend a plan of correction or a re-review to document compliance.

NOTE: The Department expects compliance with all essential criteria as defined in rule. The designation decision process provides time and opportunity, prior to the Department's final decision, for facilities to institute corrective action in response to deficiencies identified during the site review.

NOTE: This scoring tool will NOT be returned to the facility. You will be asked, during the exit interview, to provide detailed verbal feedback to the facility staff based on this scoring tool. Please be prepared to refer back to the state standards to explain any items scored "met with reservations" or "not met." Please also feel free to provide comments to the facility about strengths of its current trauma program or suggestions about the future development of its program.

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. A trauma program with: a. An administrative organizational structure that identifies the institutional support and commitment. The program's location within that structure must be placed so that it may interact with at least equal authority with other departments providing patient care within the facility.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. A trauma program with: b. Medical staff commitment to support the program demonstrated by a written commitment to provide the specialty care needed to support optimal care of the injured patient and specific delineation of surgical privileges.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION				
1. A trauma program with: c. Policies that identify and establish the scope of trauma care for both adult and pediatric patients, including but not limited to:	MET	MET W/ RES.	NOT MET	Comments or Explanation
1) Initial resusciation and stabilization				
2) Admission and inter-facility consultation and transfer criteria				
3) Surgical capabilities				
4) Critical care capabilities				
5) Rehabilitation capabilities if available				
6) Neurosurgical capabilities if available				
7) Spinal cord surgical capabilities if available				
8) Other specialist capabilities if available				
9) Written procedure for receipt and transfer of patients by fixed and rotary wing aircraft				

A. HOSPITAL ADMINISTRATION AND ORGANIZATION				
1. A trauma program with:	MET	MET W/ RES.	NOT MET	Comments or Explanation
d. A Trauma Medical Director who is a board-certified general surgeon, or is board-qualified working toward board certification. A facility may have another physician as a co-trauma medical director.				
The Trauma Medical Director is responsible for:				
1) Service leadership, overseeing all aspects of trauma care, with administrative authority for the hospital trauma program including:				
a) Trauma multidisciplinary program				
b) Trauma quality improvement program				
c) Provision of recommendations for physician appointment to and removal from the trauma service				
d) Policy and procedure development and enforcement				
e) Peer review				
2) Participates on a local or statewide basis in trauma educational activities for healthcare providers or the public.				
3) Functions as trauma medical director at only one facility.				
4) Participates in the on-call schedule.				
5) Participates in regional trauma system development.				

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. A trauma program with: e. A facility-defined trauma team, with an identifiable team leader	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. A trauma program with: f. A facility-defined trauma team activation protocol that includes who is notified and the response requirements. The protocol shall base activation of the team on the anatomical, physiological, mechanism of injury criteria and co-morbid factors as outlined in the pre-hospital trauma triage algorithms as set forth in 6CCR 1015-4, Chapter 2, Exhibit A.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. A trauma program with: g. A facility-defined trauma service with the personnel and resources identified as needed to provide care for the injured patient.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. A trauma program with: h. A registered nurse identified as the Trauma Nurse Coordinator with educational preparation and clinical experience in care of the injured patient as defined by the facility. This position is responsible for the organization of services and systems necessary for a multidisciplinary approach to care of the injured patient.	
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. A trauma program with: i. Multidisciplinary trauma committee with specialty representation. This committee is involved in the development of a plan of care for the injured patient and is responsible for trauma program performance. (See below for specifics from section 304.B.2)	
MET	MET WITH RESERVATIONS	NOT MET
<p>The trauma multidisciplinary committee, is responsible for trauma program performance at each trauma center. Membership will be established by the facility, and the committee will establish attendance requirements. Responsibilities include, but are not limited to:</p> <ol style="list-style-type: none"> a. The review of all services essential to the care and management of the trauma patient; b. Meeting on a regular basis, but not less than every two months for Level III Facilities, to assure timely review and corrective action. c. Performance management functions include but are not limited to: <ol style="list-style-type: none"> 1) Establishing and enforcing policies and procedures; 2) Reviewing process issues, e.g., communications; reviewing systems issues, e.g., response times and notification times; and promoting educational offerings; and 3) Reviewing and analyzing trauma registry data for program evaluation and utilization, with defined intervals for data collection and analysis. Level III facilities shall maintain a trauma registry as required by regulation in Chapter 1 of the trauma rules. 4) Maintaining a system (such as a log) for tracking patient disposition and deaths. 		

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. A trauma program with j. A quality improvement program as defined in Section 304. All designated Level III –V trauma centers shall have an organized, trauma quality improvement program that demonstrates a plan, process and accountability for continuous quality improvement in the delivery of trauma care. It is the responsibility of the trauma medical director in coordination with the trauma nurse coordinator to oversee the program. The plan should address the criteria as described in 6 CCR 1015-4, Chapter 3, 304.B.1 – see below.	
MET	MET WITH RESERVATIONS	NOT MET
<p>Definition: A defined plan for the process to monitor and improve the performance of a trauma program is essential. This plan shall address the entire spectrum of services necessary to ensure optimal care to the trauma patient, from pre-hospital to rehabilitative care. This plan may be parallel to, and interactive with, the hospital-wide quality improvement program as defined in CRS 25-3-109 but may not be replaced by the facility process. The plan should identify:</p> <ol style="list-style-type: none"> 1) The facility-defined standards of medical care for the trauma patient; 2) A process for corrective action, to include problem identification, action plan, resolution or outcome for loop closure; 3) The method for documentation and maintenance of minutes on site and readily available of special death audits, trauma multidisciplinary committee, or any other committees used in this process; 4) The process for prehospital trauma care review; 5) The data sources to support an effective monitoring system, to include but not be limited to retrospective and concurrent medical record review; 6) A process for the identification and review of facility-defined patient sentinel events, complications and trends. 		

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. A trauma program with j. A quality improvement program as defined in Section 304. All designated Level III –V trauma centers shall have an organized, trauma quality improvement program that demonstrates a plan, process and accountability for continuous quality improvement in the delivery of trauma care. It is the responsibility of the trauma medical director in coordination with the trauma nurse coordinator to oversee the program. The process should include the elements described in 6 CCR 1015-4, Chapter 3, 304.B.1 - see below.	
MET	MET WITH RESERVATIONS	NOT MET
1) A special audit of all trauma deaths with: <ul style="list-style-type: none"> a) Written documentation of the process to include the assessment, any corrective action and resolution; and b) The deaths shall be identified as: preventable, potentially preventable, or non-preventable, and c) Reporting a summary of the audit findings to the trauma multidisciplinary committee; 2) Prehospital trauma care review; 3) Collection of data to support an effective monitoring system, to include but not be limited to retrospective and concurrent medical record review; 4) Identification and review of facility-defined patient sentinel events, complications and trends; 5) Institution-specific nursing audits with: <ul style="list-style-type: none"> a) Evidence that nursing performance improvement issues are reviewed as part of the trauma program; b) Clinical filters for nursing documentation; and c) Ongoing monitoring and/or trending. 6) Multidisciplinary peer review to include a process of peer review as defined in C.R.S. § 12-36.5-104 et.seq. This process shall monitor compliance with, or adherence to facility-defined standards of medical care for the trauma patient. All trauma centers shall have a policy that includes the process and criteria for utilization of a resource outside the facility for peer review. Documentation of findings and recommendations must be maintained with an identified reporting process for loop closure. Qualifications of outside peer reviewer must be identified by the facility as defined in C.R.S § 12-36.5-104; 7) Case presentations of interest for educational purposes to improve overall care to the trauma patient to include: <ul style="list-style-type: none"> a) All aspects and contributing factors of trauma care from prehospital to discharge or death; and b) A review of any event that deviates from an anticipated outcome; and c) Documentation of the review shall include date, reason for review, problem identification, recommendations, resolution and education. 		

A. HOSPITAL ADMINISTRATION AND ORGANIZATION	1. A trauma program with j. A quality improvement program as defined in Section 304. All designated Level III –V trauma centers shall have an organized, trauma quality improvement program that demonstrates a plan, process and accountability for continuous quality improvement in the delivery of trauma care. It is the responsibility of the trauma medical director in coordination with the trauma nurse coordinator to oversee the program. Accountability can be demonstrated by meeting criteria described in 6 CCR 1015-4, Chapter 3, 304.B.1 – see below.	
MET	MET WITH RESERVATIONS	NOT MET
<ol style="list-style-type: none"> 1) The trauma center [has an] organizational structure responsible for the administration of the [trauma quality improvement] plan, to include a description of who has the authority to change policies, procedures or protocols related to trauma care; 2) The trauma service director in coordination with the trauma nurse coordinator demonstrates responsibility for: <ol style="list-style-type: none"> a) The identification of and responsibility for the oversight of the plan; b) Initiation of corrective action as needed; c) A process for corrective action, to include problem identification, action plan, resolution or outcome for loop closure; 3) The development and evidence of on-going reporting and trending of institution-specific audit filters to facilitate the quality improvement program to identify at a minimum, but not limited to: <ol style="list-style-type: none"> a) Program structure (systems issues) with all trauma transfers in or out, except those with isolated extremity fractures; b) Program process (medical issues) with provider response times when the trauma team is activated; and c) Program outcomes with compliance with initial resuscitation and stabilization as defined in facility policy. 		

A. HOSPITAL ADMINISTRATION AND ORGANIZATION				
k. Divert protocols, to include:	MET	MET W/ RES.	NOT MET	Comments or Explanation
1) Coordination with the RETAC.				
2) Notification of pre-hospital providers.				
3) Reason for divert.				
4) A method for monitoring times and reasons for going on divert.				
Definition: Redirection of the trauma patient to a different receiving facility. Redirection shall be in accordance with the prehospital trauma triage algorithm, as set forth in Chapter 2. Reasons for going on divert are limited to lack of critical equipment or staff; operating room, emergency department, or intensive care unit saturation; disaster or facility structural compromise.				

A. HOSPITAL ADMINISTRATION AND ORGANIZATION		
1. A trauma program with:		l. A trauma registry as required in Chapter 1 of these rules, and trauma data entry support.
Data must be submitted by the facility within 60 days of discharge or death as required by the rule 6CCR 1015-4, Chapter 1, 1.2.		
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION		
1. A trauma program with:		m. Participation in the RETAC and statewide quality improvement programs as required in rule.
MET	MET WITH RESERVATIONS	NOT MET

A. HOSPITAL ADMINISTRATION AND ORGANIZATION				
2. Hospital departments/divisions/sections	MET	MET W/ RES.	NOT MET	Comments or Explanation
a. Surgery				
b. Emergency Medicine				
c. Anesthesia				

B. CLINICAL CAPABILITIES	1. Emergency Medicine in-house 24 hours a day		
MET	MET WITH RESERVATIONS	NOT MET	

B. CLINICAL CAPABILITIES	2. This service available in person 24 hours a day within 20 minutes of trauma team activation: a. General Surgery. Coverage shall be by the attending board-certified surgeon or board-qualified surgeon working toward certification, who may only take call at one facility at one time		
MET	MET WITH RESERVATIONS	NOT MET	

B. CLINICAL CAPABILITIES	2. This service available in person 24 hours a day within 20 minutes of trauma team activation: a. General Surgery. The surgeon will meet those patients meeting facility-defined trauma team activation criteria upon arrival, by ambulance, in the emergency department. For those patients meeting trauma team activation criteria were adequate prior notification is not possible, the surgical response shall be 20 minutes from notification.		
MET	MET WITH RESERVATIONS	NOT MET	

B. CLINICAL CAPABILITIES	3. This service is on-call and available within 30 minutes of request by the trauma team leader: a. Anesthesia. Coverage shall be by 1) A board-certified anesthesiologist or board-qualified anesthesiologist working toward certification OR 2) A certified registered nurse anesthetist (CRNA)	
MET	MET WITH RESERVATIONS	NOT MET

B. CLINICAL CAPABILITIES	3. This service is on-call and available within 30 minutes of request by the trauma team leader: a. Orthopedic Surgery. Coverage shall be by a board-certified or board-qualified orthopedic surgeon working toward certification.	
MET	MET WITH RESERVATIONS	NOT MET

B. CLINICAL CAPABILITIES	4. The following non-surgical specialists on call, credentialed and available in person or by tele-radiology for patient service upon request of the trauma team leader: a. Radiologist.	
MET	MET WITH RESERVATIONS	NOT MET

B. CLINICAL CAPABILITIES	4. The following non-surgical specialists on call, credentialed and available in person or by tele-radiology for patient service upon request of the trauma team leader: b. Internal Medicine.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	1. An Emergency Department with: a. Personnel, to include: 1) A designated physician director (for the emergency department) who is board-certified in emergency medicine, family practice, internal medicine or surgery, and whose primary practice is in emergency medicine.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	1. An Emergency Department with: a. Personnel, to include: 2) Physician(s) designated as member(s) of the trauma team: a) Physically present in the Emergency Department 24 hours/day.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	1. An Emergency Department with: a. Personnel, to include: 2) Physician(s) designated as member(s) of the trauma team: a) For all physicians hired by December 31, 2005: board-certified in emergency medicine, family practice, internal medicine or surgery; d) For all emergency department physicians taking trauma and hired on or after January 1, 2006: board-certified in emergency medicine or board-qualified in emergency medicine working toward certification.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	1. An Emergency Department with: a. Personnel, to include: 2) Physician(s) designated as member(s) of the trauma team: b) Who are CURRENTLY Advanced Trauma Life Support (ATLS) verified unless board-certified in emergency medicine. C. 13. c. If board-certified in emergency medicine, documentation of successful completion of an ATLS course (at some point in time.)	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	1. An Emergency Department with: a. Personnel, to include: 2) Physician(s) designated as member(s) of the trauma team: c) Whose primary practice is in emergency medicine.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	1. An Emergency Department with: a. personnel, to include: 3) Registered Nurses in-house 24 hours/day who: a) Provide continuous monitoring of the trauma patient until release from the Emergency Department, and	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	1. An Emergency Department with: a) personnel to include: 3) Registered Nurses in-house 24 hours/day who: b) At least one Registered Nurse in the Emergency Department 24 hours/day who maintains current verification in Trauma Nurse Core Course (TNCC) or equivalent.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/ CAPABILITIES	1. Emergency Department			
b. Equipment for the resuscitation of patients of all ages shall include but not limited to:	MET	MET W/ RES.	NOT MET	Comments or Explanation
1) Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitators, and oxygen				
2) Pulse oximetry				
3) End-tidal CO ₂ determination				
4) Suction devices				
5) Electrocardiograph-oscilloscope-defibrillator				
6) Internal paddles – adult and pediatric				
7) Apparatus to establish central venous pressure monitoring				
8) Standard intravenous fluids and administration devices, including large bore intravenous catheters				
9) Sterile Surgical sets for:				
a) Airway control/cricothyrotomy				
b) Thorocostomy – needle and tube				
c) Thoracotomy				
d) Vascular access to include central line insertion and interosseous access				
e) Peritoneal lavage				
10) Gastric Decompression				
11) Drugs necessary for emergency care				
12) X-ray availability, 24 hours a day				
13) Two-way communication with emergency transport vehicles				
14) Spinal immobilization equipment / cervical traction devices				
15) Arterial catheters				
16) Thermal control equipment for: a) patients				
16) Thermal control equipment for: b) blood and fluids				
17) Rapid infuser system;				
18) Medication chart, tape or other system to assure ready access to information on proper dose per-per-kilogram for resuscitation drugs and equipment sizes for pediatric patients.				

C. FACILITIES/RESOURCES/CAPABILITIES	2. An operating room available 24 hours/day with: a. Facility-defined operating room team on-call and available within 30 minutes of request by the trauma team leader.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES				
2. An operating room available 24 hours/day with: b. Equipment for all ages shall include, but not be limited to:	MET	MET W/ RES.	NOT MET	Comments or Explanation
1) Thermal control equipment for: a) patients,				
1) Thermal control equipment for: b) blood and fluids;				
2) X-ray capability, including c-arm image intensifier				
3) Endoscope, broncoscope,				
4) Equipment for fixation of long bone and pelvic fractures,				
5) Rapid infuser system,				
6) Equipment for the continuous monitoring of temperature, hemodynamics and gas exchange.				

C. FACILITIES/RESOURCES/CAPABILITIES				
3. Post-anesthetic recovery room (surgical intensive care unit is acceptable) with:	MET	MET W/ RES.	NOT MET	Comments or Explanation
a. Registered nurses available within 30 minutes of request, 24 hours/day,				
b. Equipment for the continuous monitoring of temperature, hemodynamics, and gas exchange,				
c. Thermal control equipment for: 1) patients,				
c. Thermal control equipment for: 2) bloods and fluids.				

C. FACILITIES/RESOURCES/CAPABILITIES	4. Intensive Care Unit for injured patients with: a. Personnel, to include: 1) A director or co-director who is a surgeon with facility privileges to admit patients to the critical care area, and is responsible for setting policies and oversight of the care related to trauma ICU patients.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	4. Intensive Care Unit for injured patients with: a. Personnel, to include: 2) A physician, approved by the trauma director, who is available within 30 minutes of notification to respond to the needs of the trauma ICU patient.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	4. Intensive Care Unit for injured patients with: a. Personnel, to include: 3) Registered Nurses.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	4. Intensive Care Unit for injured patients with: b. Equipment for the continuous monitoring of temperature, hemodynamics and gas exchange,	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES				
5. Radiological Services, available 24 hours/day, with:	MET	MET W/ RES.	NOT MET	Comments or Explanation
a. A radiology technician available within 30 minutes of notification of trauma team activation;				
b. A computed tomography technician available within 30 minutes of request;				
c. Computed Tomography (CT);				
d. Ultrasound.				

C. FACILITIES/RESOURCES/CAPABILITIES				
6. Clinical Laboratory Services, to include:	MET	MET W/ RES.	NOT MET	Comments or Explanation
a. Standard analysis of blood, urine and other body fluids;				
b. Blood typing and cross matching;				
c. Coagulation studies;				
d. Blood and blood components available from in-house, or through community services, to meet patient needs and blood storage capability;				
e. Blood gases and pH determination;				
f. Microbiology;				
g. Serum alcohol and toxicology determination;				
h. A clinical laboratory technician in-house.				

C. FACILITIES/RESOURCES/CAPABILITIES		
7. Respiratory therapy services, in-house.		
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	8. Neuro-trauma management a. acute spinal cord management with: 1) Neurosurgeons or orthopedic surgeons with special qualifications in acute spinal cord management, on-call and available within a facility-defined time of request of the trauma team leader.	
MET	MET WITH RESERVATIONS	NOT MET

OR

C. FACILITIES/RESOURCES/CAPABILITIES	8. Neuro-trauma management a. acute spinal cord management with: 2) Written transfer guidelines for patients with spinal cord injuries.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	8. Neuro-trauma management b. acute brain injury management with a: 1) Neurosurgeon on-call and available within 30 minutes of the request of the trauma team leader.	
MET	MET WITH RESERVATIONS	NOT MET

OR

C. FACILITIES/RESOURCES/CAPABILITIES	8. Neuro-trauma management b. acute brain injury management with: 2) Written transfer guidelines for patients.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	9. Organized burn care for those patients identified in Section 306 of this chapter, with transfer guidelines with a burn center.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES				
10. Rehabilitation services with:	MET	MET W/ RES.	NOT MET	Comments or Explanation
a. A physician who is credentialed by the facility to provide leadership for physical medicine and rehabilitation;				
b. Policies and procedures for the early assessment of the rehabilitation needs of the injured patient;				
c. Physical therapy;				
d. Occupational therapy;				
e. Speech therapy; and				
f. Social services.				

OR

C. FACILITIES/RESOURCES/CAPABILITIES	g. Transfer guidelines for access to rehabilitation services	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	11. Injury Prevention/Public Education, with: a. Outreach activities and program development;	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	11. Injury Prevention/Public Education, with: b. Information resources for the public; and,	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	11. Injury Prevention/Public Education, with: c. Facility-developed or collaboration with existing national, regional and state programs.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	12. In-house trauma-related continuing education, for: a. Non-physician trauma team members, and,	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	12. In-house trauma-related continuing education, for: b. Nurses in the Emergency Department and Intensive Care Unit with facility-defined competency testing and orientation programs.	
MET	MET WITH RESERVATIONS	NOT MET

C. FACILITIES/RESOURCES/CAPABILITIES	13. CME requirements for surgeons, orthopedic surgeons, emergency physicians, anesthesiologists/CRNA's and neurosurgeons, if providing trauma care, to include: a. 10 hours of trauma-related facility-defined CME annually or 30 hours over the three-year period preceding any site review.	
MET	MET WITH RESERVATIONS	NOT MET

C.13.b is scored above in C.1.a.2). b)

C. FACILITIES/RESOURCES/CAPABILITIES	13. CME requirements to include: c. Documentation of successful completion of an ATLS course for surgeons. (Requirement for boarded emergency physicians is scored in C.1.a.2)b) above.)	
MET	MET WITH RESERVATIONS	NOT MET

INTERFACILITY CONSULTATION AND TRANSFER	Adult-Critical Injuries as defined in 6CCR 1015-4, Chapter 2, 202.C.1 require mandatory consultation with a Level I trauma surgeon, for consideration of transfer of the patient within 6 hours after recognition of condition. The attending trauma surgeon of the referring facility shall initiate the consultation (See Chapter 2).	
MET	MET WITH RESERVATIONS	NOT MET
Consultation is defined as telephone or telemedicine to determine the necessity of transfer and the circumstances of transfer including but not limited to: additional diagnostic/therapeutic issues; availability of resources; and weather conditions. Consultation occurs between the attending trauma surgeon of a referring facility and an attending trauma surgeon (who is a member of the attending staff) at a receiving facility. Trauma consultation shall include written documentation completed by the trauma surgeon. Patient disposition disagreements will be documented at both facilities.		

INTERFACILITY CONSULTATION AND TRANSFER	Adult-High Risk Injuries as defined in 6CCR 1015-4, Chapter 2, 202.C.2. a-e., require mandatory, timely (within 12 hours after recognition of condition) consultation with a Level I or key resource facility trauma surgeon for consideration of transfer. The primary attending trauma surgeon of the referring facility shall initiate the consultation. Consultation and/or transfer decisions in patients with traumatic injuries less severe than those listed shall be determined by the RETAC based on resources, facilities, and personnel available in the region and shall be made in accordance with RETAC protocols. (See Chapter 2.)	
MET	MET WITH RESERVATIONS	NOT MET
Consultation is defined as telephone or telemedicine to determine the necessity of transfer and the circumstances of transfer including but not limited to: additional diagnostic/therapeutic issues; availability of resources; and weather conditions. Consultation occurs between the attending trauma surgeon of a referring facility and an attending trauma surgeon (who is a member of the attending staff) at a receiving facility. Trauma consultation shall include written documentation completed by the trauma surgeon. Patient disposition disagreements will be documented at both facilities.		

INTERFACILITY CONSULTATION AND TRANSFER	PEDIATRIC-Critical Injuries, Children 0 – 5 as defined in 6CCR 1015-4, Chapter 2, 202.D.1, require mandatory transfer with prior consultation to an RPTC. If an RPTC is not available, then transfer to the highest level trauma center available. (See Chapter 2.)	
MET	MET WITH RESERVATIONS	NOT MET
<p>Consultation is defined as telephone or telemedicine to determine the necessity of transfer and the circumstances of transfer including but not limited to: additional diagnostic/therapeutic issues; availability of resources; and weather conditions. Consultation occurs between the attending trauma surgeon of a referring facility and an attending trauma surgeon (who is a member of the attending staff) at a receiving facility. Trauma consultation shall include written documentation completed by the trauma surgeon. Patient disposition disagreements will be documented at both facilities.</p>		

INTERFACILITY CONSULTATION AND TRANSFER	PEDIATRIC-Critical Injuries, Children 6 – 12 as defined in 6CCR 1015-4, Chapter 2, 202.D.1 require mandatory timely consultation with an attending surgeon at an RPTC within 6 hours after recognition of condition. (See Chapter 2.)	
MET	MET WITH RESERVATIONS	NOT MET
<p>Consultation is defined as telephone or telemedicine to determine the necessity of transfer and the circumstances of transfer including but not limited to: additional diagnostic/therapeutic issues; availability of resources; and weather conditions. Consultation occurs between the attending trauma surgeon of a referring facility and an attending trauma surgeon (who is a member of the attending staff) at a receiving facility. Trauma consultation shall include written documentation completed by the trauma surgeon. Patient disposition disagreements will be documented at both facilities.</p>		

INTERFACILITY CONSULTATION AND TRANSFER	PEDIATRIC-High Risk Injuries, Children 0 – 12 as defined in 6CCR 1015-4, Chapter 2, 202.D.2 require mandatory consultation with an attending trauma surgeon at an RPTC within 6 hours after recognition of condition.	
MET	MET WITH RESERVATIONS	NOT MET
<p>Consultation is defined as telephone or telemedicine to determine the necessity of transfer and the circumstances of transfer including but not limited to: additional diagnostic/therapeutic issues; availability of resources; and weather conditions. Consultation occurs between the attending trauma surgeon of a referring facility and an attending trauma surgeon (who is a member of the attending staff) at a receiving facility. Trauma consultation shall include written documentation completed by the trauma surgeon. Patient disposition disagreements will be documented at both facilities.</p>		