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Time Sensitive Emergency System

State of Idaho

Authority: Sections 46-914 through 46-922, Idaho Code

Time Sensitive Emergency Council
Effective date July 1, 2025

IDAHO TIME SENSITIVE EMERGENCY SYSTEM
TRAUMA | STROKE | STEMI

Available Monday through Friday

(Except holidays designated by the State of Idaho)

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I. DEFINITIONS

The following terms are used in this manual as defined below:

EMS Agency. Any organization licensed by Department under Sections 46-901 through 46-922, Idaho Code, and IDAPA 15.06.07 – *Emergency Medical Services*, that operates an air medical service, ambulance service, or non-transport service.

Facility. A health care organization that is voluntarily seeking designation from the Idaho Time Sensitive Emergency Council. A facility may be any of the following:

> **Center.** A facility designated by the Idaho Time Sensitive Emergency Council is known as a center.
>
> **Freestanding Emergency Department.** Is owned by a hospital with a dedicated emergency department; is located within thirty-five (35) miles of the hospital that owns or controls it; provides emergency services twenty-four (24) hours per day, seven (7) days per week on an outpatient basis; is physically separate from a hospital; and meets the staffing and service requirements in Code of Federal Regulations (CFR) Title 42, Section 482.55.
>
> **Hospital.** As defined in Section 39-1301, Idaho Code, is a facility which is primarily engaged in providing, by or under the daily supervision of physicians, concentrated medical and nursing care on a twenty-four (24) hour basis to inpatients experiencing acute illness; and diagnostic and therapeutic services for medical diagnosis and treatment, psychiatric diagnosis and treatment, and care of injured, disabled, or sick persons; and rehabilitation services for injured, disabled, or sick persons; and obstetrical care. Provides for care of two (2) or more individuals for twenty-four (24) or more consecutive hours. Is staffed to provide professional nursing care on a twenty-four (24) hour basis.
>
> **Rural Clinic.** A health care clinic in a rural area that is located more than thirty-five (35) miles from a hospital via maintained roads and is capable of providing emergency care to patients.

Heart Attack. STEMI, which is a common name for ST-elevation myocardial infarction, a more precise definition for a type of heart attack that is caused by a prolonged period of blocked blood supply that affects a large area of the heart and has a substantial risk of death and disability calling for a quick response.

Regional Time Sensitive Emergency (TSE) Committee. A regional TSE committee established under Section46-918, Idaho Code.

Stroke. An interruption of blood flow to the brain causing paralysis, slurred speech and/or altered brain function usually caused by a blockage in a blood vessel that carries blood to the brain (ischemic stroke) or by a blood vessel bursting (hemorrhagic).

Trauma. The result of an act or event that damages, harms, or hurts a human being resulting in intentional or unintentional damage to the body resulting from acute exposure to mechanical, thermal, electrical or chemical energy, or from absence of such essentials as heat or oxygen.

TSE Designated Center. A facility that has voluntarily applied for TSE designation; has met designation criteria; remains in compliance with the designation criteria and standards of these rules; and which the TSE Council has designated as one (1) or more of the following:

a. Trauma
   (1) Level I Trauma Center;
   (2) Level II Trauma Center;
   (3) Level III Trauma Center;
   (4) Level IV Trauma Center;
   (5) Level V Trauma Center;
   (6) Pediatric Level I Trauma Center; or
   (7) Pediatric Level II Trauma Center.
b. Stroke
   (1) Level I Stroke Center (Comprehensive);
   (2) Level II+ Stroke Center (Thrombectomy Capable);
   (3) Level II Stroke Center (Primary); or
   (4) Level III Stroke Center (Acute Stroke Ready).
c. STEMI (Heart Attack)
   (1) Level I+ STEMI Center (Cardiogenic Shock Capable);
   (2) Level I STEMI Center (Receiving); or
   (3) Level II STEMI Center (Referring).

TSE Designated EMS Agency. An EMS agency that has voluntarily applied for TSE designation; has met designation criteria; remains in compliance with the designation criteria and standards of these rules; and which the TSE Council has designated as one (1) of the following:

a. TSE Basic Life Support (BLS) EMS Agency;
b. TSE Intermediate Life Support (ILS) EMS Agency; or
c. TSE Advanced Life Support (ALS) EMS Agency.

II. TSE STANDARDS MANUAL AUTHORITY

The Idaho Time Sensitive Emergency System Council is authorized under Section 46-916, Idaho Code, to promulgate rules for the purpose of establishing standards and for the administration of a voluntary time sensitive emergency system of care.

III. REFERENCED DOCUMENTS

- American College of Surgeons, Resources for the Optimal Care of the Injured Patient
- American College of Cardiology, Chest Pain Accreditation Standards
- DNV Healthcare, Inc., Primary Stroke Center Certification Standards
- DNV Healthcare, Inc., Comprehensive Stroke Center Certification Standards
- Joint Commission, Advanced Disease Specific Care Manual

IV. TSE REGIONS

There are six TSE regions.

- **Region 1 – North.** The counties of Benewah, Bonner, Boundary, Kootenai, and Shoshone.
- **Region 2 – North Central.** The counties of Clearwater, Idaho, Latah, Lewis, and Nez Perce.
- **Region 3 – Southwest.** The counties of Ada, Adams, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Valley, and Washington.
- **Region 4 – South Central.** The counties of Blaine, Camas, Cassia, Gooding, Jerome, Lincoln, Minidoka, and Twin Falls.
- **Region 5 – Southeast.** The counties of Bannock, Bear Lake, Bingham, Caribou, Cassia, Franklin, Minidoka, Oneida, and Power.
- **Region 6 – East.** The counties of Bonneville, Butte, Clark, Custer, Fremont, Jefferson, Lemhi, Madison, and Teton.

The specific procedures to request realignment of regions can be found in IDAPA 15.06.07 – *Emergency Medical Services*. Refer to Section 46-918, Idaho Code, for detailed description of the Regional TSE Committee.

V. APPLICATION PROCESS

General Information

A facility applying for initial designation as a TSE designated facility must apply for each designation by:

- Submitting a completed application for each designation being sought to the TSE Branch via the Bureau of Emergency Medical Services;
- Submitting a non-refundable TSE site survey fee as applicable to the TSE Branch; and
- Scheduling a site survey as applicable.

The Idaho TSE Council, upon review of appropriate documentation, may provide reciprocity for facilities in Idaho that also choose to operate under a designation in a neighboring state's system.

Fees

The designation fees are for a three (3) year designation and are payable on an annual basis.

	Designation Fee 3-years/Annual (Not to exceed)	**TSE Site Survey Fee (Not to exceed)**
Trauma Designations		
Level I	$45,000/$15,000	$3,000 (Not applicable with national or acceptable State verification)
Level II	$36,000/$12,000	$3,000 (Not applicable with national or acceptable State verification)
Level III	$24,000/$8,000	$3,000 (Not applicable with national or acceptable State verification)
Level IV	$12,000/$4,000	$1,500 (Not applicable with national or acceptable State verification)
Level V	$3,000/$1,000	$1,500
Pediatric Level I and Level II	$36,000/$12,000	No fee. Must be ACS verified
Stroke Designations		
Level I	$21,000/$7,000	$3,000 (Not applicable with national or acceptable State verification)
Level II and Level II+	$12,000/$4,000	$3,000 (Not applicable with national or acceptable State verification)
Level III	$1,500/$500	$1,500 (Not applicable with national or acceptable State verification)
STEMI Designations		
Level I and Level I+	$21,000/$7,000	$3,000 (Not applicable with national or acceptable State verification)
Level II	$1,500/$500	$1,500 (Not applicable with national or acceptable State verification)

Site Survey

An Idaho TSE site survey may include:

- A review of the facility's application;
- A chart review based on the facility's application;
- A review of the facility's QI process;
- An inspection of equipment pertaining to the designation being sought;
- A review of policies and procedures pertaining to the designation being sought;
- A physical inspection of the facility;
- Interviews with facility staff and review of staff credentials;
- A review of the facility's protocols and call schedules;
- A review of transfer documentation and written agreements; and
- A review of the facility's planned interaction with prehospital transport.

Survey Team

A TSE Council approved site survey team may include:

Physician surveyor who:

- Is certified by the American Board of Medical Specialties or the American Board of Osteopathic Medicine;
- Is board-certified in the specialty area being represented on the review team;

- Is currently active or active within the last twelve (12) months in trauma, stroke or emergency cardiac care at a center that is at or above the level being reviewed;
- Is from outside of the region of the center being verified; and
- Has no conflict of interest with the center under review.

Nurse surveyor and/or Program Manager who:

- Is currently active or active within the last twelve (12) months in trauma, stroke or emergency cardiac care at a center that is at or above the level being reviewed;
- Is from outside of the region of the center being verified; and
- Has no conflict of interest with the center under review.

The procedures to notify the Idaho TSE Council of a potential conflict of interest with a specific reviewer can be found in IDAPA 15.06.07 – *Emergency Medical Services*, Section 631 *TSE Site Survey – General Requirements*.

Provisional Designation, Waiver, Denial, Modification, Revocation and Suspension

Procedures for applying for a waiver or for submitting an appeal can be found in IDAPA 15.06.07 – *Emergency Medical Services*, Section 640 *Waivers* and Section 647 *Designation At A Lesser Level*.

VI. TRAUMA DESIGNATION

Level I, II, III & Level IV Trauma Center

A hospital seeking Level I, II, III or Level IV Trauma Center designation have the choice to use an approved national accreditation body or the State of Idaho to verify their compliance.

To apply for Level I, II, III or Level IV Trauma Center using the ACS to verify compliance, the following is required:

- Hospital Profile and Certification Statement; and
- A copy of the pre-review questionnaire (PRQ) from the national accreditation body; and
- A copy of the final site survey report.

To apply for Level I, II, III or Level IV Trauma Center using the Idaho TSE Council to verify compliance, the following is required:

- A completed application; and
- A non-refundable site survey fee; and
- A scheduled site survey.

A hospital applying for initial designation using the Idaho TSE Council to verify compliance must have a TSE Council approved survey team evaluation prior to initial designation. The hospital must meet or exceed the designation criteria in Appendix A.

After completion of the site survey, the center must then pay either the annual designation fee or the entire three (3) year designation fee. The center will be designated for three (3) years, unless the designation is rescinded by the TSE Council for non-compliance with the TSE Council's rules. The TSE Council will send a certificate of designation and confirmation of the designation period. Annual designation fees for those facilities paying yearly are due to the Department within thirty (30) days of the date of the invoice in order to maintain designation.

Any TSE designated center that has a loss of certification or licensure will immediately notify the TSE Council by contacting TSE Branch staff.

A TSE designated Level I, II, III or Level IV Trauma Center requesting renewal of their designation must:

- Submit a renewal application six (6) months prior to the expiration date of the previous designation; and
- Submit a non-refundable site survey fee, if applicable; and
- Submit a copy of the full accrediting body report detailing the results of the site visit; or
- Schedule a site visit from a TSE Council approved survey team.

Designation will not lapse due to a delay in scheduling the site visit, if the delay is through no fault of the facility.

Level V Trauma Center

A hospital, freestanding emergency department, or rural clinic seeking Level V Trauma designation must undergo the Idaho TSE Council verification to demonstrate compliance with the standards incorporated by the TSE Council.

To apply for Level V Trauma Center, the following is required:

- A completed application; and
- A non-refundable site survey fee; and
- A scheduled site survey.

A facility applying for initial designation must have a TSE Council approved survey team evaluation prior to initial designation. The facility must meet or exceed the designation criteria in Appendix A.

After completion of the site survey, the center must then pay either the annual designation fee or the entire three (3) year designation fee. The center will be designated for three (3) years, unless the designation is rescinded by the TSE Council for non-compliance with the TSE Council's rules. The TSE Council will send a certificate of designation and confirmation of the designation period. Annual designation fees for those facilities paying yearly are due to the Department within thirty (30) days of the date of the invoice in order to maintain designation.

Any TSE designated center that has a loss of certification or licensure will immediately notify the TSE Council by contacting TSE Branch staff.

A TSE designated Level V Trauma Center requesting renewal of their designation must:

- Submit a renewal application six (6) months prior to the expiration date of the previous designation; and
- Submit a non-refundable site survey fee; and
- Schedule a site visit from a TSE Council approved survey team.

Designation will not lapse due to a delay in scheduling the site visit, if the delay is through no fault of the facility.

Pediatric Trauma Center

A hospital seeking Pediatric Level I or II Trauma Center designation must undergo the American College of Surgeons' (ACS) verification to demonstrate compliance with the corresponding standards published in the ACS document *Resources for Optimal Care of the Injured Patient* as applicable.

To apply for Pediatric Level I or II Trauma Center designation, the following is required:

- Hospital Profile and Certification Statement; and
- A copy of the pre-review questionnaire (PRQ) from the ACS; and
- A copy of the ACS site survey report.

Once verified by the ACS and approved by the TSE Council, the center must then pay the annual designation fee or the entire three (3) year designation fee. The center will be designated for three (3) years unless the designation is rescinded by the TSE Council for non-compliance with the TSE Council's rules. The TSE Council will send a certificate of designation and confirmation of the designation period. Annual designation fees for those facilities paying yearly are due to the Department within thirty (30) days of the date of the invoice in order to maintain designation.

Any TSE designated center that has a loss of certification or licensure will immediately notify the TSE Council by contacting TSE Branch staff.

A TSE designated Pediatric Level I or II Trauma Center requesting renewal of their designation must:

- Submit a renewal application; and
- Be verified by the ACS three (3) months prior to the expiration date of previous designation; and
- Submit a copy of the full ACS report detailing the results of the ACS site visit.

Designation will not lapse due to a delay in scheduling the site visit if the delay is through no fault of the facility.

VII. STROKE DESIGNATION

Level I, II+ Thrombectomy, II, & III Stroke Center

A hospital, freestanding emergency department, or rural clinic seeking Level I, II, II+ Thrombectomy, or III Stroke Center designation has the choice to use an approved national accreditation body or the State of Idaho to verify their compliance.

To apply for Level I, II, II+ Thrombectomy, or III Stroke Center using an approved national accreditation body, the following is required:

- Hospital Profile and Certification Statement; and
- A copy of the full accreditation report detailing the results of the site visit.

To apply for Level I, II, II+ Thrombectomy, or III Stroke Center using the Idaho TSE Council to verify compliance, the following is required:

- A completed application; and
- A non-refundable site survey fee; and
- A scheduled site survey.

A facility applying for initial designation using the Idaho TSE Council to verify compliance must have a TSE Council approved survey team evaluation prior to initial designation. The facility must meet or exceed the designation criteria in Appendix A.

After completion of the site survey, the center must then pay either the annual designation fee or the entire three (3) year designation fee. The center will be designated for three (3) years, unless the designation is rescinded by the TSE Council for non-compliance with the TSE Council's rules. The TSE Council will send a certificate of designation and confirmation of the designation period. Annual designation fees for those facilities paying yearly are due to the Department within thirty (30) days of the date of the invoice in order to maintain designation.

Any TSE designated center that has a loss of certification or licensure will immediately notify the TSE Council by contacting TSE Branch staff.

A TSE designated Level I, II, II+ Thrombectomy, or III Stroke Center requesting renewal of their designation must:

- Submit a renewal application six (6) months prior to the expiration date of the previous designation; and
- Submit a non-refundable site survey fee, if applicable; and
- Submit a copy of the full accrediting body report detailing the results of the site visit; or
- Schedule a site visit from a TSE Council approved survey team.

Designation will not lapse due to a delay in scheduling the site visit if the delay is through no fault of the facility.

VIII. STEMI DESIGNATION

Level I+ Cardiogenic Shock, I, & II STEMI Center

A hospital, freestanding emergency department, or rural clinic seeking Level I+ Cardiogenic Shock, I or II STEMI Center designation has the choice to use an approved national accreditation body or the State of Idaho to verify their compliance.

To apply for Level I+ Cardiogenic Shock, I or II STEMI Center using an approved national accreditation body, the following is required:

- Hospital Profile and Certification Statement; and
- A copy of the full accreditation report detailing the results of the site visit.

To apply for Level I+ Cardiogenic Shock, I or II STEMI Center using the Idaho TSE Council to verify compliance, the following is required:

- A completed application; and
- A non-refundable site survey fee; and
- A scheduled site survey.

A facility applying for initial designation using the Idaho TSE Council to verify compliance must have a TSE Council approved survey team evaluation prior to initial designation. The facility must meet or exceed the designation criteria in Appendix A.

After completion of the site survey, the center must then pay either the annual designation fee or the entire three (3) year designation fee. The center will be designated for three (3) years, unless the designation is rescinded by the TSE Council for non-compliance with the TSE Council's rules. The TSE Council will send a certificate of designation and confirmation of the designation period. Annual designation fees for those facilities paying yearly are due to the Department within thirty (30) days of the date of the invoice in order to maintain designation.

Any TSE designated center that has a loss of certification or licensure will immediately notify the TSE Council by contacting TSE Branch staff.

A TSE designated Level I+ Cardiogenic Shock, I or II STEMI Center requesting renewal of their designation must:

- Submit a renewal application six (6) months prior to the expiration date of the previous designation; and
- Submit a non-refundable site survey fee, if applicable; and
- Submit a copy of the full accrediting body report detailing the results of the site visit; or
- Schedule a site visit from a TSE Council approved survey team.

Designation will not lapse due to a delay in scheduling the site visit if the delay is through no fault of the facility.

IX. APPENDIX A: DESIGNATION REQUIREMENTS

Level I Trauma Center

Designation Criteria for Level I Trauma Center

Criteria for designation are in place to verify the services and systems to ensure optimal care of the trauma patient. The following elements must be met for designation as a Level I Trauma Center in Idaho.

Type I criteria must be in place at the time of the verification site visit to achieve designation. Type II criteria are also required but are less critical. If three or fewer Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of designation is issued. During the following 12 months, if the trauma center successfully corrects the deficiencies, the period of designation will be extended to 3 years from the date of the initial verification visit. If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital may not be designated.

1. Trauma System	
Time Sensitive Emergencies (TSE)	
1.1 The center's trauma program staff has sufficient involvement in national, state, and regional trauma system planning, development, and/or operation.	II
Center Mission	
1.2 There is a current resolution supporting the trauma center from the medical staff (See Trauma Toolkit).	II
1.3 There is a current resolution supporting the trauma center from the hospital board (See Trauma Toolkit).	II
1.4 There is sufficient infrastructure, staff equipment, and support to the trauma program to provide adequate care.	I
1.5 The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	II
2. Description of Trauma Center	
Description of the Trauma Center	
2.1 All trauma facilities are on the same campus.	II
2.2 The trauma program is empowered to address issues that involve all applicable disciplines.	I
2.3 The center provides initial resuscitation of the trauma patient and immediate intervention to control hemorrhage and to assure maximum stabilization prior to referral to an appropriate higher level of care or admission.	II
2.4 The center meets volume performance requirements 1,200 trauma patients admissions yearly or 240 admissions with an Injury Severity Score (ISS) of more than 15.	I

2.5 The adult trauma center that admits more than 100 injured children annually has a pediatric Emergency Department (ED) area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma Performance Improvement and Patient Safety (PIPS) program.	II
2.6 The center provides some means of referral and access to trauma center resources.	II
2.7 The center provides a continuous rotation in trauma surgery for senior residents that is part of an Accreditation Council for Graduate Medical Education, accredited program in any of the following disciplines: General surgery, Orthopedic surgery, or Neurosurgery; and supports an acute care surgery fellowship consistent with the educational requirements of the American Association for the Surgery of Trauma.	I
2.8 In teaching facilities, the requirements of the Residency Review Committee are met.	II
Trauma Leadership	
Trauma Medical Director	
2.9 The trauma program has a Trauma Medical Director with the authority and administrative support to lead the program.	I
2.10 The Trauma Medical Director is a board-certified surgeon or an American College of Surgeons (ACS) Fellow.	I
2.11 The Trauma Medical Director is current in Advanced Trauma Life Support (ATLS).	II
2.12 The Trauma Medical Director has accrued 36 hours in 3 years of trauma-related Continuing Medical Education (CME).	II
2.13 The Trauma Medical Director participates in trauma call.	I
2.14 The Trauma Medical Director is a member of and participates in regional or national trauma organizations.	II
2.15 The Trauma Medical Director has sufficient authority to set specified criteria for the trauma panel members.	II
2.16 The roles of emergency physicians and trauma surgeons are defined, agreed on, and approved by the Trauma Medical Director.	II
2.17 The Trauma Medical Director has the authority to correct deficiencies in trauma care and to exclude from trauma call the trauma team members who do not meet specified criteria.	II
2.18 The Trauma Medical Director has the authority to recommend changes for the trauma team based on performance review.	II
2.19 The Trauma Medical Director has the responsibility and authority to determine each general surgeon's ability to participate on the Trauma Team through the PIPS program and hospital policy.	II
2.20 The structure of the trauma program allows the Trauma Medical Director to have oversight authority for care of injured patients who may be admitted to individual surgeons.	II
2.21 The Trauma Medical Director has the responsibility and authority to ensure compliance with designation requirements.	II

2.22 The Trauma Medical Director is involved in the development of the center's bypass protocol.	II
2.23 The Trauma Medical Director ensures dissemination of information to the committees that comprise the PIPS program.	II
2.24 In circumstances when attendance is not mandated, the Trauma Medical Director ensures dissemination of information from the PIPS program.	II
2.25 The Trauma Medical Director is accountable for all trauma care and exercises administrative authority for the trauma program.	I
2.26 The Trauma Medical Director participates in the Performance Improvement and Patient Safety (PIPS) program by attending at least 60% of meetings.	II
2.27 The Trauma Medical Director will approve the design of any sub-specialty backup call system.	II
2.28 The Trauma Medical Director will approve all sub-specialty liaisons for the program.	II
2.29 The PIPS program, comprised of at minimum the Trauma PI and Trauma Operations Committees, is chaired by the Trauma Medical Director or their designee. In the Trauma Medical Director's absence, a designee must be identified.	II
Trauma Program Manager	
2.30 The Trauma Program Manager must have 1.0 full-time equivalent (FTE) commitment to the trauma program.	II
2.31 The Trauma Program Manager has accrued 36 hours in 3 years of trauma-related continuing education.	II
2.32 The Trauma Program Manager is responsible for the use of trauma registry data for quality improvement and trauma education.	II
2.33 The Trauma Program Manager works with the Trauma Medical Director to address the multidisciplinary needs of the trauma program.	I
2.34 The Trauma Program Manager serves as a liaison to local Emergency Medical Services (EMS) agencies and referring/accepting centers.	II
3. Clinical Functions	
3.1 The criteria for graded activation must be clearly defined by the center and reviewed annually, with the highest level of activation including the seven required criteria listed in Table 1.	II
3.2 The center is staffed to ensure immediate and appropriate care of trauma patients during hours of operation.	I
3.3 The trauma service retains responsibility for its patients and coordinates all therapeutic decisions.	I
3.4 The center must be able to provide the necessary human and physical resources to properly administer acute care consistent with ATLS.	II
3.5 The center has written protocols to determine which types of patients are admitted and which are transferred.	II

3.6 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the Intensive Care Unit (ICU) team.	I
3.7 There is a method to identity injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners.	I
3.8 The center must be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers.	II
3.9 The center has established protocols to ensure immediate and appropriate care of the adult and pediatric trauma patient.	II
Trauma Team	
3.10 The team response to all trauma priority levels must be defined and reviewed annually.	II
3.11 All trauma/general surgeons, emergency physicians, and advanced practice providers who participate as a member of the Trauma Team have completed ATLS at least once.	II
3.12 Trauma Team members participate in both the Trauma PI and Trauma Operations Committees.	II
3.13 Trauma Team physicians and advanced practice providers are credentialed by the medical staff and governing board.	II
Emergency Department (ED)	
3.14 The ED has a designated Emergency Physician Director supported by an appropriate number of additional physicians to ensure immediate care of injured patients.	I
3.15 An emergency physician is present in the ED at all times.	I
3.16 All emergency physicians are board-certified, board-eligible, or meet the Alternate Pathway criteria* (Table 3).	II
3.17 Emergency physicians on the call panel are regularly involved in the care of injured patients.	II
3.18 The emergency medicine PIPS liaison or designee has accrued an average of 12 hours annually or 36 hours in 3 years of external** trauma-related CME, or participate in maintenance of certification.	II
3.19 The emergency medicine PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
3.20 In institutions where there are emergency medicine residency programs, supervision is provided by an in-house attending emergency physician 24 hour per day.	II
3.21 The ED must evaluate its pediatric readiness and have a plan to address any deficiencies.	II
General Surgery	
3.22 All trauma surgeons must have privileges in general surgery.	II
3.23 The trauma surgeons respond promptly to activations and participate in PIPS activities.	II

3.24 Trauma surgeons in adult trauma centers that admit more than 100 injured children annually are credentialed for pediatric trauma care by the center's credentialing body.	II
3.25 The center has general surgical coverage 24/7.	II
3.26 The trauma surgeon on-call is dedicated to the trauma center while on duty.	I
3.27 A published backup call schedule for trauma surgery is available.	II
3.28 Seriously injured patients are admitted to and/or evaluated by the trauma service.	II
3.29 The trauma surgeon is present in the ED within 15 minutes of patient arrival for highest level of activation 24/7 with an 80% achievement rate as monitored by the PIPS program.	I
3.30 The trauma surgeon on-call is involved in decisions regarding diversion.	II
3.31 All trauma surgeons must participate in both the Trauma PI and Trauma Operations Committees, and attend a minimum of 50% of these meetings.	II
3.32 A general surgeon or appropriate substitute is available for major resuscitations in-house 24/7.	I
3.33 A general surgeon covering trauma call is board-certified, board-eligible, meet the Alternate Pathway criteria* (Table 3), or an ACS Fellow.	II
Orthopedic Surgery	
3.34 The center has orthopedic surgery available 24/7.	II
3.35 An orthopedic surgeon is present in the ED within 30 minutes of request with an 80% achievement rate.	II
3.36 The orthopedic surgeon has privileges in general orthopedic surgery.	II
3.37 Orthopedic surgeons who care for injured patients are board-certified, board-eligible, or meet the Alternate Pathway criteria* (Table 3).	II
3.38 Orthopedic team members have dedicated call at their institution and a backup call system.	II
3.39 Orthopedic surgeon's liaison have documented 12 hours annually or 36 hours in 3 years of external** trauma-related CME or participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program. Staying current with their board certification satisfies the CME requirement.	II
3.40 The orthopedic surgery PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
Neurosurgery	
3.41 The center has neurosurgery available 24/7.	II
3.42 The neurosurgeon has privileges in general neurosurgery.	II
3.43 A neurosurgeon is present in the ED within 30 minutes of request with an 80% achievement rate.	II
3.44 Neurosurgeons who care for injured patients are board-certified, board-eligible, or meet the Alternate Pathway criteria* (Table 3).	II

3.45 Neurotrauma care is promptly and continuously available for severe traumatic brain injury and spinal cord injury and for less severe head and spine injuries when necessary.	I
3.46 The ce8nter provides an on-call neurosurgical backup schedule or a formally arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed.	I
3.47 A neurosurgeon PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
3.48 Neurosurgeons who take trauma call have documented 12 hours annually or 36 hours in 3 years of external** trauma-related CME or participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program. Staying current with their board certification satisfies the CME requirement.	-=
Collaborative Clinical Services	
Anesthesia	
3.49 Anesthesia services are on-site within 15 minutes of notification for emergency operations and airway problems 24/7.	I
3.50 An anesthesiologist PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
3.51 The PIPS program reviews the availability of anesthesia services in patient care areas and any delays in care due to lack of anesthesia resources.	II
Operating Room (OR)	
3.52 The Operating Room (OR) is adequately staffed and available within 15 minutes.	I
3.53 Operating rooms are adequately staffed and available within 30 minutes of surgeon decision for emergency operative intervention for musculoskeletal injuries.	I
3.54 There is a mechanism for providing additional staff for a second operating room when the first operating room is occupied.	II
3.55 The OR has all of the following essential equipment:	I
a. rapid infusers;	
b. thermal control equipment and resuscitation fluids;	
c. intraoperative radiologic capabilities;	
d. equipment for fracture fixation;	
e. equipment for endoscopic evaluation (bronchoscopy and gastrointestinal endoscopy);	
f. equipment necessary for craniotomy;	
g. cardiopulmonary bypass available 24/7; and	
h. an operating microscope available 24/7.	
3.56 A mechanism is in place to ensure OR availability without undue delay for patients with semi-urgent orthopedic injuries.	II

3.57 A mechanism is in place for documenting the attending surgeon's presence in the OR for all trauma operations.	II
3.58 The PIPS program evaluates OR availability and delays.	II
Post-Anesthesia Care Unit (PACU)	
3.59 The PACU has the necessary equipment to monitor and resuscitate patients.	I
3.60 The PACU has qualified nurses available 24/7 as needed during the patient's post-anesthesia recovery phase.	I
3.61 If the PACU is covered by a call team from home, there is documentation by the PIPS program that nurses are available and delays are not occurring.	II
Radiology	
3.62 Conventional radiography and CT services are available in-house 24/7.	I
3.63 MRI capability is available in-house 24/7 or on-call within 60 minutes. There is documentation by the PIPS program that technicians are available and delays are not occurring.	I
3.64 Conventional catheter angiography and sonography services are available in-house 24/7.	I
3.65 The center has staff available on-site or via telemedicine within 30 minutes of notification for the interpretation of radiographs and performance of complex imaging studies 24/7 with an 80% achievement rate. The center has staff available on-site within 60 minutes of request for the performance of interventional procedures 24/7.	I
3.66 The center has an in-house radiographer.	I
3.67 Critical information is verbally communicated to the Trauma Team.	II
3.68 Diagnostic information is communicated in a written form and in a timely manner.	II
3.69 Changes in interpretation are monitored by the PIPS program.	II
3.70 Final reports accurately reflect communications, including changes between preliminary and final interpretations.	II
3.71 The center has policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the Radiology Department.	II
3.72 A radiologist PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
Intensive Care Unit (ICU)	
3.73 The ICU has the necessary equipment to monitor and resuscitate patients.	I
3.74 Intracranial pressure monitoring equipment is available.	I
3.75 A qualified nurse is available 24/7 to provide care during the ICU phase.	I
3.76 The patient/nurse ratio does not exceed 2:1 for critically ill patients in the ICU.	II
3.77 The center has in-house physician coverage for ICU at all times.	II
3.78 Physician coverage of critically ill trauma patients is available 24/7.	I

3.79 Physicians covering critically ill trauma patients respond rapidly to urgent problems as they arise.	II
3.80 The trauma surgeon remains in charge of patient in the ICU.	I
3.81 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team.	II
3.82 The surgical director or co-director of the ICU has appropriate training and experience for the role.	I
3.83 The surgical director of the ICU has obtained critical care training during residency or fellowship and has expertise in perioperative and post-injury care of injured patients.	II
3.84 The surgical director of the ICU has added qualifications in surgical critical care from the American Board of Surgery or meets the Alternate Pathway criteria* (Table 3) for critical care.	II
Other Surgical Specialists	
3.85 The center has a list of specialists who are promptly available from inside and outside of the center.	II
3.86 The center has the following surgical specialists:	I
a. Orthopedic surgery;	
b. Neurosurgery;	
c. Cardiac surgery;	
d. Thoracic surgery;	
e. Hand surgery;	
f. Plastic surgery;	
g. Obstetric and Gynecological surgery;	
h. Ophthalmology;	
i. Otolaryngology;	
j. Urology; and	
f. Microvascular surgery.	
Medical Consultants	
3.87 The center has a list of specialists who are promptly available from inside and outside of the center.	II
3.88 The center has the following medical consultants and their respective support teams:	II
a. Cardiology;	
b. Infectious disease;	
c. Pulmonary medicine;	
d. Gastroenterology; and	
e. Nephrology.	
Respiratory Therapy	
3.89 A respiratory therapist is available in-house 24/7 to care for trauma patients.	I

Laboratory	
3.90 Laboratory services are available 24/7 for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate. The blood bank is capable of blood typing and cross-matching.	I
3.91 The center has the capability for coagulation studies, blood gases, and microbiology.	I
3.92 The blood bank has an adequate amount of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, or appropriate coagulation factors to meet the needs of injured patients.	I
3.93 The center must have a transfusion protocol developed collaboratively between the trauma service and the blood bank.	I
3.94 The center must have a rapid reversal protocol in place for patients on anticoagulants.	II
Nutrition	
3.95 Nutrition support services are available.	II
Social Services	
3.96 The center has social services.	II
3.97 The center must screen all admitted trauma patients for alcohol misuse and provide a brief intervention if appropriate.	II
3.98 The center must have a protocol to screen patients at high risk for psychological sequelae with subsequent referral to a mental health provider when required.	II
3.99 The center must have a process in place to assess pediatrics for nonaccidental trauma (NAT).	II
Dialysis	
3.100 Acute hemodialysis is available.	II
Rehabilitation	
3.101 Rehabilitation consulting services, occupational therapy, speech therapy, and physical therapy are available during the acute phase of care.	I
3.102 The center has either rehabilitation services within its facility or a transfer agreement to a freestanding rehabilitation hospital.	II
4. Prehospital Trauma Care	
4.1 The center collaborates with EMS agencies and provides feedback on patient care.	II
5. Interhospital Transfer	
5.1 The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient.	II
5.2 There are transfer agreements in place with specialty referral centers.	II
5.3 A mechanism for direct physician-to-physician contact is present for arranging patient transfer.	II
5.4 The center must have guidelines addressing which patients should be transferred and the safe transport of those patients.	II

6. Process Improvement and Patient Safety (PIPS)	
6.1 The trauma PIPS program has a clearly defined relationship with the hospital's Performance Improvement/Quality Improvement Department.	II
6.2 The center must have a written and clearly defined PIPS plan that is updated annually. The program must ensure optimal care through continuous clinical review as well as operational procedures and must:	II
a. outline the organizational structure of the PIPS process;	
b. specify the processes of event identification;	
c. include audit filters;	
d. define levels of review; and	
e. specify the members of the PIPS Committee.	
6.3 The PIPS program is supported by a reliable method of internal data collection.	II
6.4 The PIPS program is, at minimum, comprised of two committees: Trauma Performance Improvement (PI) and Trauma Operations.	II
6.5 The Trauma PI Committee is a multidisciplinary committee that meets regularly to:	II
a. address patient care processes and outcomes;	
b. identify patient care opportunities for improvement; and	
c. reduce variability in care.	
6.6 The Trauma Operations Committee is a multidisciplinary committee that meets regularly to:	II
a. correct program deficiencies and optimize patient care;	
b. addresses system and processes issues; and	
c. includes all program-related services.	
6.7 The process of multidisciplinary review and analysis occurs at regular intervals to meet the needs of the program, takes attendance, and records minutes. All major disciplines within the center that are caring for trauma patients must be represented in the process.	II
6.8 The process demonstrates effective use of audit filters, problem identification, analysis, proposed corrective actions, resolution, and loop closure.	II
6.9 All trauma team activations must be categorized by priority of response and reported by number and percentage of total trauma patients.	II
6.10 The center must use a risk adjusted national benchmarking system to measure performance and outcomes against peers.	II
6.11 The PIPS program must use evidence-based clinical practice guidelines and protocols.	II
6.12 Deaths are categorized as mortality with opportunity for improvement or mortality without opportunity for improvement.	II
6.13 The PIPS program reviews the organ donation process and rate.	II
6.14 The center must work with sending and receiving facilities to provide and obtain feedback on transferred patients.	II

6.15 The center must work with EMS agencies to provide and obtain feedback on transported patients.	II
6.16 The PIPS program monitors and confirms the requirement for 80% compliance of surgeon's presence in the ED within 30 minutes of patient's arrival.	II
6.17 The center must have a diversion policy that provides notification for dispatch centers and EMS agencies when on divert and must track the occurrence of diversions.	II
6.18 The PIPS program must review the following metrics to ensure appropriateness of care, rationale, adverse outcomes, and identify opportunities for improvement:	II
a. delay of timely access to care, equipment, or interventions in all care areas;	
b. admissions;	
c. transfers;	
d. non-surgical services (NSS) with a goal of <10%; and	
e. over/under triage.	
6.19 There must be at least 0.5 FTE dedicated Performance Improvement (PI) personnel when the volume of registry patient entries exceeds 500 patients. When annual volume exceeds 1,000 registry patient entries, the trauma center must have at least 1.0 FTE PI personnel.	II

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8. Time Sensitive Emergency (TSE) Registry

8.1 Data is submitted to the Idaho TSE Registry per Idaho Code 46-920. At least 80% of cases are submitted within 180 days of hospital discharge.	I
8.2 There is a process in place to verify that TSE Registry data is accurate and valid.	II
8.3 The trauma program ensures that registry data confidentiality measures are in place.	II
8.4 There must be at least 0.5 FTE dedicated to the trauma registry per 200 to 300 annual patient entries.	II
8.5 Staff members who have a registry role in data abstraction and entry, injury coding, ISS calculation, data reporting, or data validation for the trauma registry must fulfill all of the following requirements:	II
a. participate in and pass the most recent version of the AAAM's Abbreviated Injury Scale (AIS) course;	
b. participate in a trauma registry course that includes all of the following content: abstraction, data management, reports/report analysis, data validation, and HIPPA; and	
c. participate in an ICD-10 course or an ICD-10 refresher course every five years.	
8.6 The Trauma Registrars must accrue at least 24 hours of trauma-related continuing education during the verification cycle.	II

9. Outreach & Education

9.1 The center is engaged in trauma-related public outreach and education.	II

9.2 The center provides a mechanism for trauma-related education for clinical staff involved in trauma care.	II
9.3 The center provides an ATLS course at least annually.	II
10. Prevention	
10.1 The center participates in traumatic injury prevention and bases activities on local data. It is recommended to have a fall prevention program, but not required.	II
10.2 The center must have someone in a leadership position that has injury prevention as part of their job description.	II
10.3 The center demonstrates collaboration with or participation in national, regional, and/or state injury prevention programs.	II
11. Disaster Planning and Management	
11.1 The center has a disaster plan described in its Disaster Manual.	II
11.2 A surgeon from the trauma panel is a member of the center's disaster committee.	II
11.3 Drills that test the individual hospital's disaster plan are conducted at least every 6 months.	II
12. Organ Procurement	
12.1 The center has an established relationship with a recognized Organ Procurement Organization (OPO).	II
12.2 There are written policies for triggering notification of the OPO.	II
12.3 The center has written protocols for declaration of brain death.	II
13. Research	
13.1 The center meets the research requirements of one of the two options listed in Table 2.	II
13.2 The administration of the trauma center demonstrates support of the research program.	II

** External continuing education does not include in-house: in-service, case-based learning, grand rounds, internal trauma symposia, and/or publications disseminating information gained from a local conference.

Designation Criteria for Level II Trauma Center

Criteria for designation are in place to verify the services and systems to ensure optimal care of the trauma patient. The following elements must be met for designation as a Level II Trauma Center in Idaho.

Type I criteria must be in place at the time of the verification site visit to achieve designation. Type II criteria are also required but are less critical. If three or fewer Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of designation is issued. During the following 12 months, if the trauma center successfully corrects the deficiencies, the period of designation will be extended to 3 years from the date of the initial verification visit. If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital may not be designated.

1. Trauma System	
Time Sensitive Emergencies (TSE)	
1.1 The center's trauma program staff has sufficient involvement in national, state, and regional trauma system planning, development, and/or operation.	II
Center Mission	
1.2 There is a current resolution supporting the trauma center from the medical staff (See Trauma Toolkit).	II
1.3 There is a current resolution supporting the trauma center from the hospital board (See Trauma Toolkit).	II
1.4 There is sufficient infrastructure, staff equipment, and support to the trauma program to provide adequate care.	I
1.5 The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	II
2. Description of Trauma Center	
Description of the Trauma Center	
2.1 All trauma facilities are on the same campus.	II
2.2 The trauma program is empowered to address issues that involve all applicable disciplines.	I
2.3 The center provides initial resuscitation of the trauma patient and immediate intervention to control hemorrhage and to assure maximum stabilization prior to referral to an appropriate higher level of care or admission.	II
2.4 The adult trauma center that admits more than 100 injured children annually has a pediatric Emergency Department (ED) area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma Performance Improvement and Patient Safety (PIPS) program.	II
2.5 The center provides some means of referral and access to trauma center resources.	II

Trauma Leadership	
Trauma Medical Director	
2.6 The trauma program has a Trauma Medical Director with the authority and administrative support to lead the program.	I
2.7 The Trauma Medical Director is a board-certified surgeon or an American College of Surgeons (ACS) Fellow.	I
2.8 The Trauma Medical Director is current in Advanced Trauma Life Support (ATLS).	II
2.9 The Trauma Medical Director has accrued 36 hours in 3 years of trauma-related Continuing Medical Education (CME).	II
2.10 The Trauma Medical Director participates in trauma call.	I
2.11 The Trauma Medical Director is a member of and participates in regional or national trauma organizations.	II
2.12 The Trauma Medical Director has sufficient authority to set specified criteria for the trauma panel members.	II
2.13 The roles of emergency physicians and trauma surgeons are defined, agreed on, and approved by the Trauma Medical Director.	II
2.14 The Trauma Medical Director has the authority to correct deficiencies in trauma care and to exclude from trauma call the trauma team members who do not meet specified criteria.	II
2.15 The Trauma Medical Director has the authority to recommend changes for the trauma team based on performance review.	II
2.16 The Trauma Medical Director has the responsibility and authority to determine each general surgeon's ability to participate on the Trauma Team through the PIPS program and hospital policy.	II
2.17 The structure of the trauma program allows the Trauma Medical Director to have oversight authority for care of injured patients who may be admitted to individual surgeons.	II
2.18 The Trauma Medical Director has the responsibility and authority to ensure compliance with designation requirements.	II
2.19 The Trauma Medical Director is involved in the development of the center's bypass protocol.	II
2.20 The Trauma Medical Director ensures dissemination of information to the committees that comprise the PIPS program.	II
2.21 In circumstances when attendance is not mandated, the Trauma Medical Director ensures dissemination of information from the PIPS program.	II
2.22 The Trauma Medical Director is accountable for all trauma care and exercises administrative authority for the trauma program.	I
2.23 The Trauma Medical Director participates in the Performance Improvement and Patient Safety (PIPS) program by attending at least 60% of meetings.	II

2.24 The Trauma Medical Director will approve the design of any sub-specialty backup call system.	II
2.25 The Trauma Medical Director will approve all sub-specialty liaisons for the program.	II
2.26 The PIPS program, comprised of at minimum the Trauma PI and Trauma Operations Committees, is chaired by the Trauma Medical Director or their designee. In the Trauma Medical Director's absence, a designee must be identified.	II
Trauma Program Manager	
2.27 The Trauma Program Manager must have 1.0 full-time equivalent (FTE) commitment to the trauma program.	II
2.28 The Trauma Program Manager has accrued 36 hours in 3 years of trauma-related continuing education.	II
2.29 The Trauma Program Manager is responsible for the use of trauma registry data for quality improvement and trauma education.	II
2.30 The Trauma Program Manager works with the Trauma Medical Director to address the multidisciplinary needs of the trauma program.	I
2.31 The Trauma Program Manager serves as a liaison to local Emergency Medical Services (EMS) agencies and referring/accepting centers.	II
3. Clinical Functions	
3.1 The criteria for graded activation must be clearly defined by the center and reviewed annually, with the highest level of activation including the seven required criteria listed in Table 1.	II
3.2 The center is staffed to ensure immediate and appropriate care of trauma patients during hours of operation.	I
3.3 The trauma service retains responsibility for its patients and coordinates all therapeutic decisions.	I
3.4 The center must be able to provide the necessary human and physical resources to properly administer acute care consistent with ATLS.	II
3.5 The center has written protocols to determine which types of patients are admitted and which are transferred.	II
3.6 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the Intensive Care Unit (ICU) team.	I
3.7 There is a method to identity injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners.	I
3.8 The center must be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers.	II
3.9 The center has established protocols to ensure immediate and appropriate care of the adult and pediatric trauma patient.	II

Trauma Team	
3.10 The team response to all trauma priority levels must be defined and reviewed annually.	II
3.11 All trauma/general surgeons, emergency physicians, and advanced practice providers who participate as a member of the Trauma Team have completed ATLS at least once.	II
3.12 Trauma Team members participate in both the Trauma PI and Trauma Operations Committees.	II
3.13 Trauma Team physicians and advanced practice providers are credentialed by the medical staff and governing board.	II
Emergency Department (ED)	
3.14 The ED has a designated Emergency Physician Director supported by an appropriate number of additional physicians to ensure immediate care of injured patients.	I
3.15 An emergency physician is present in the ED at all times.	I
3.16 All emergency physicians are board-certified, board-eligible, or meet the Alternate Pathway criteria* (Table 3).	II
3.17 Emergency physicians on the call panel are regularly involved in the care of injured patients.	II
3.18 The emergency medicine PIPS liaison or designee has accrued an average of 12 hours annually or 36 hours in 3 years of external** trauma-related CME, or participate in maintenance of certification.	II
3.19 The emergency medicine PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
3.20 The ED must evaluate its pediatric readiness and have a plan to address any deficiencies.	II
General Surgery	
3.21 All trauma surgeons must have privileges in general surgery.	II
3.22 The trauma surgeons respond promptly to activations and participate in PIPS activities.	II
3.23 Trauma surgeons in adult trauma centers that admit more than 100 injured children annually are credentialed for pediatric trauma care by the center's credentialing body.	II
3.24 The center has general surgical coverage 24/7.	II
3.25 The trauma surgeon on-call is dedicated to the trauma center while on duty.	I
3.26 A published backup call schedule for trauma surgery is available.	II
3.27 Seriously injured patients are admitted to and/or evaluated by the trauma service.	II
3.28 The trauma surgeon is present in the ED within 15 minutes of patient arrival for highest level of activation 24/7 with an 80% achievement rate as monitored by the PIPS program.	I
3.29 The trauma surgeon on-call is involved in decisions regarding diversion.	II

3.30 All trauma surgeons must participate in both the Trauma PI and Trauma Operations Committees, and attend a minimum of 50% of these meetings.	II
3.31 A general surgeon covering trauma call is board-certified, board-eligible, meet the Alternate Pathway criteria* (Table 3), or an ACS Fellow.	II
Orthopedic Surgery	
3.32 The center has orthopedic surgery available 24/7.	II
3.33 An orthopedic surgeon is present in the ED within 30 minutes of request with an 80% achievement rate.	II
3.34 The orthopedic surgeon has privileges in general orthopedic surgery.	II
3.35 Orthopedic surgeons who care for injured patients are board-certified, board-eligible, or meet the Alternate Pathway criteria* (Table 3).	II
3.36 If orthopedic surgery is not dedicated at their institution, a backup call system must be in place.	II
3.37 Orthopedic surgeon's liaison have documented 12 hours annually or 36 hours in 3 years of external** trauma-related CME or participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program. Staying current with their board certification satisfies the CME requirement.	II
3.38 The orthopedic surgery PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
Neurosurgery	
3.39 The center has neurosurgery available 24/7.	II
3.40 The neurosurgeon has privileges in general neurosurgery.	II
3.41 A neurosurgeon is present in the ED within 30 minutes of request with an 80% achievement rate.	II
3.42 Neurosurgeons who care for injured patients are board-certified, board-eligible, or meet the Alternate Pathway criteria* (Table 3).	II
3.43 Neurotrauma care is promptly and continuously available for severe traumatic brain injury and spinal cord injury and for less severe head and spine injuries when necessary.	I
3.44 The center provides an on-call neurosurgical backup schedule or formally arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed.	I
3.45 A neurosurgeon PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
3.46 Neurosurgeons who take trauma call have documented 12 hours annually or 36 hours in 3 years of external** trauma-related CME or participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program. Staying current with their board certification satisfies the CME requirement.	-=

Collaborative Clinical Services	
Anesthesia	
3.47 Anesthesia services are on-site within 15 minutes of notification for emergency operations and airway problems 24/7.	I
3.48 An anesthesiologist PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
3.49 The PIPS program reviews the availability of anesthesia services in patient care areas and any delays in care due to lack of anesthesia resources.	II
Operating Room (OR)	
3.50 The Operating Room (OR) is adequately staffed and available within 15 minutes.	I
3.51 Operating rooms are adequately staffed and available within 30 minutes of surgeon decision for emergency operative intervention for musculoskeletal injuries.	I
3.52 There is a mechanism for providing additional staff for a second operating room when the first operating room is occupied.	II
3.53 The OR has all of the following essential equipment:	I
a. rapid infusers;	
b. thermal control equipment and resuscitation fluids;	
c. intraoperative radiologic capabilities;	
d. equipment for fracture fixation;	
e. equipment for endoscopic evaluation (bronchoscopy and gastrointestinal endoscopy);	
f. equipment necessary for craniotomy;	
g. cardiopulmonary bypass available 24/7; and	
h. an operating microscope available 24/7.	
3.54 A mechanism is in place to ensure OR availability without undue delay for patients with semi-urgent orthopedic injuries.	II
3.55 A mechanism is in place for documenting the attending surgeon's presence in the OR for all trauma operations.	II
3.56 The PIPS program evaluates OR availability and delays.	II
Post-Anesthesia Care Unit (PACU)	
3.57 The PACU has the necessary equipment to monitor and resuscitate patients.	I
3.58 The PACU has qualified nurses available 24/7 as needed during the patient's post-anesthesia recovery phase.	I
3.59 If the PACU is covered by a call team from home, there is documentation by the PIPS program that nurses are available and delays are not occurring.	II
Radiology	
3.60 Conventional radiography and CT services are available in-house 24/7.	I

3.61 MRI capability is available in-house 24/7 or on-call within 60 minutes. There is documentation by the PIPS program that technicians are available and delays are not occurring.	I
3.62 Conventional catheter angiography and sonography services are available in-house 24/7.	I
3.63 The center has staff available on-site or via telemedicine within 30 minutes of notification for the interpretation of radiographs and performance of complex imaging studies 24/7 with an 80% achievement rate. The center has staff available on-site within 60 minutes of request for the performance of interventional procedures 24/7.	I
3.64 Critical information is verbally communicated to the Trauma Team.	II
3.65 Diagnostic information is communicated in a written form and in a timely manner.	II
3.66 Changes in interpretation are monitored by the PIPS program.	II
3.67 Final reports accurately reflect communications, including changes between preliminary and final interpretations.	II
3.68 The center has policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the Radiology Department.	II
3.69 A radiologist PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
Intensive Care Unit (ICU)	
3.70 The ICU has the necessary equipment to monitor and resuscitate patients.	I
3.71 Intracranial pressure monitoring equipment is available.	I
3.72 A qualified nurse is available 24/7 to provide care during the ICU phase.	I
3.73 The patient/nurse ratio does not exceed 2:1 for critically ill patients in the ICU.	II
3.74 The center has in-house physician coverage for ICU within 15 minutes of notification.	II
3.75 Physician coverage of critically ill trauma patients is available 24/7.	I
3.76 Physicians covering critically ill trauma patients respond rapidly to urgent problems as they arise.	II
3.77 The trauma surgeon remains in charge of patient in the ICU.	I
3.78 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team.	II
3.79 The center has a surgical director or co-director for the ICU who is responsible for setting policies and administration related to trauma ICU patients.	II
3.80 The surgical director of the ICU has obtained critical care training during residency or fellowship and has expertise in perioperative and post-injury care of injured patients.	II
Other Surgical Specialists	
3.81 The center has a list of specialists who are promptly available from inside and outside of the center.	II

3.82 The center has the following surgical specialists:	I
a. Orthopedic surgery;	
b. Neurosurgery;	
c. Cardiac surgery;	
d. Thoracic surgery;	
e. Hand surgery;	
f. Plastic surgery;	
g. Obstetric and Gynecological surgery;	
h. Ophthalmology;	
i. Otolaryngology; and	
j. Urology.	
Medical Consultants	
3.83 The center has a list of specialists who are promptly available from inside and outside of the center.	II
3.84 The center has the following medical consultants and their respective support teams:	II
a. Cardiology;	
b. Infectious disease;	
c. Pulmonary medicine; and	
d. Gastroenterology.	
Respiratory Therapy	
3.85 A respiratory therapist is available in-house 24/7 to care for trauma patients.	I
Laboratory	
3.86 Laboratory services are available 24/7 for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate. The blood bank is capable of blood typing and cross-matching.	I
3.87 The center has the capability for coagulation studies, blood gases, and microbiology.	I
3.88 The blood bank has an adequate amount of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, or appropriate coagulation factors to meet the needs of injured patients.	I
3.89 The center must have a transfusion protocol developed collaboratively between the trauma service and the blood bank.	I
3.90 The center must have a rapid reversal protocol in place for patients on anticoagulants.	II
Nutrition	
3.91 Nutrition support services are available.	II
Social Services	
3.92 The center has social services.	II

3.93 The center must screen all admitted trauma patients for alcohol misuse and provide a brief intervention if appropriate.	II
3.94 The center must have a protocol to screen patients at high risk for psychological sequelae with subsequent referral to a mental health provider when required.	II
3.95 The center must have a process in place to assess pediatrics for nonaccidental trauma (NAT).	II
Dialysis	
3.96 The center has either dialysis capabilities or a transfer agreement with a facility that has dialysis capabilities.	II
Rehabilitation	
3.97 Rehabilitation consulting services, occupational therapy, speech therapy, and physical therapy are available during the acute phase of care.	I
3.98 The center has either rehabilitation services within its facility or a transfer agreement to a freestanding rehabilitation hospital.	II
4. Prehospital Trauma Care	
4.1 The center collaborates with EMS agencies and provides feedback on patient care.	II
5. Interhospital Transfer	
5.1 The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient.	II
5.2 There are transfer agreements in place with higher level trauma centers as well as specialty referral centers.	II
5.3 A mechanism for direct physician-to-physician contact is present for arranging patient transfer.	II
5.4 The center must have guidelines addressing which patients should be transferred and the safe transport of those patients.	II
6. Process Improvement and Patient Safety (PIPS)	
6.1 The trauma PIPS program has a clearly defined relationship with the hospital's Performance Improvement/Quality Improvement Department.	II
6.2 The center must have a written and clearly defined PIPS plan that is updated annually. The program must ensure optimal care through continuous clinical review as well as operational procedures and must:	II
a. outline the organizational structure of the PIPS process;	
b. specify the processes of event identification;	
c. include audit filters;	
d. define levels of review; and	
e. specify the members of the PIPS Committee.	
6.3 The PIPS program is supported by a reliable method of internal data collection.	II

6.4 The PIPS program is, at minimum, comprised of two committees: Trauma Performance Improvement (PI) and Trauma Operations.	II
6.5 The Trauma PI Committee is a multidisciplinary committee that meets regularly to:	II
a. address patient care processes and outcomes;	
b. identify patient care opportunities for improvement; and	
c. reduce variability in care.	
6.6 The Trauma Operations Committee is a multidisciplinary committee that meets regularly to:	II
a. correct program deficiencies and optimize patient care;	
b. addresses system and processes issues; and	
c. includes all program-related services.	
6.7 The process of multidisciplinary review and analysis occurs at regular intervals to meet the needs of the program, takes attendance, and records minutes. All major disciplines within the center that are caring for trauma patients must be represented in the process.	II
6.8 The process demonstrates effective use of audit filters, problem identification, analysis, proposed corrective actions, resolution, and loop closure.	II
6.9 All trauma team activations must be categorized by priority of response and reported by number and percentage of total trauma patients.	II
6.10 The center must use a risk adjusted national benchmarking system to measure performance and outcomes against peers.	II
6.11 The PIPS program must use evidence-based clinical practice guidelines and protocols.	II
6.12 Deaths are categorized as mortality with opportunity for improvement or mortality without opportunity for improvement.	II
6.13 The PIPS program reviews the organ donation process and rate.	II
6.14 The center must work with sending and receiving facilities to provide and obtain feedback on transferred patients.	II
6.15 The center must work with EMS agencies to provide and obtain feedback on transported patients.	II
6.16 The PIPS program monitors and confirms the requirement for 80% compliance of surgeon's presence in the ED within 30 minutes of patient's arrival.	II
6.17 The center must have a diversion policy that provides notification for dispatch centers and EMS agencies when on divert and must track the occurrence of diversions.	II
6.18 The PIPS program must review the following metrics to ensure appropriateness of care, rationale, adverse outcomes, and identify opportunities for improvement:	II
a. delay of timely access to care, equipment, or interventions in all care areas;	
b. admissions;	
c. transfers;	
d. non-surgical services (NSS) with a goal of <10%; and	
e. over/under triage.	

6.19 There must be at least 0.5 FTE dedicated Performance Improvement (PI) personnel when the volume of registry patient entries exceeds 500 patients. When annual volume exceeds 1,000 registry patient entries, the trauma center must have at least 1.0 FTE PI personnel.	II
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8. Time Sensitive Emergency (TSE) Registry	
8.1 Data is submitted to the Idaho TSE Registry per Idaho Code 46-920. At least 80% of cases are submitted within 180 days of hospital discharge.	I
8.2 There is a process in place to verify that TSE Registry data is accurate and valid.	II
8.3 The trauma program ensures that registry data confidentiality measures are in place.	II
8.4 There must be at least 0.5 FTE dedicated to the trauma registry per 200 to 300 annual patient entries.	II
8.5 Staff members who have a registry role in data abstraction and entry, injury coding, ISS calculation, data reporting, or data validation for the trauma registry must fulfill all of the following requirements:	II
a. participate in and pass the most recent version of the AAAM's Abbreviated Injury Scale (AIS) course;	
b. participate in a trauma registry course that includes all of the following content: abstraction, data management, reports/report analysis, data validation, and HIPPA; and	
c. participate in an ICD-10 course or an ICD-10 refresher course every five years.	
8.6 The Trauma Registrars must accrue at least 24 hours of trauma-related continuing education during the verification cycle.	II
9. Outreach & Education	
9.1 The center is engaged in trauma-related public outreach and education.	II
9.2 The center provides a mechanism for trauma-related education for clinical staff involved in trauma care.	II
10. Prevention	
10.1 The center participates in traumatic injury prevention and bases activities on local data. It is recommended to have a fall prevention program, but not required.	II
10.2 The center must have someone in a leadership position that has injury prevention as part of their job description.	II
10.3 The center demonstrates collaboration with or participation in national, regional, and/or state injury prevention programs.	II
11. Disaster Planning and Management	
11.1 The center has a disaster plan described in its Disaster Manual.	II
11.2 A surgeon from the trauma panel is a member of the center's disaster committee.	II

11.3 Drills that test the individual hospital's disaster plan are conducted at least every 6 months.	II
12. Organ Procurement	
12.1 The center has an established relationship with a recognized Organ Procurement Organization (OPO).	II
12.2 There are written policies for triggering notification of the OPO.	II
12.3 The center has written protocols for declaration of brain death.	II

** External continuing education does not include in-house: in-service, case-based learning, grand rounds, internal trauma symposia, and/or publications disseminating information gained from a local conference.

Designation Criteria for Level III Trauma Center

Criteria for designation are in place to verify the services and systems to ensure optimal care of the trauma patient. The following elements must be met for designation as a Level III Trauma Center in Idaho.

Type I criteria must be in place at the time of the verification site visit to achieve designation. Type II criteria are also required but are less critical. If three or fewer Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of designation is issued. During the following 12 months, if the trauma center successfully corrects the deficiencies, the period of designation will be extended to 3 years from the date of the initial verification visit. If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital may not be designated.

1. Trauma System	
Time Sensitive Emergencies (TSE)	
1.1 The center's trauma program staff has sufficient involvement in regional trauma system planning, development, and operation.	II
Center Mission	
1.2 There is a current resolution supporting the trauma center from the medical staff (See Trauma Toolkit).	II
1.3 There is a current resolution supporting the trauma center from the hospital board (See Trauma Toolkit).	II
1.4 There is sufficient infrastructure, staff equipment, and support to the trauma program to provide adequate care.	I
1.5 The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	II
2. Description of Trauma Center	
Description of the Trauma Center	
2.1 All trauma facilities are on the same campus.	II
2.2 The trauma program is empowered to address issues that involve all applicable disciplines.	I
2.3 The center provides initial resuscitation of the trauma patient and immediate intervention to control hemorrhage and to assure maximum stabilization prior to referral to an appropriate higher level of care or admission.	II
2.4 The adult trauma center that admits more than 100 injured children annually has a pediatric Emergency Department (ED) area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma Performance Improvement and Patient Safety (PIPS) program.	II
2.5 The center provides some means of referral and access to trauma center resources.	II

Trauma Leadership	
Trauma Medical Director	
2.6 The trauma program has a Trauma Medical Director with the authority and administrative support to lead the program.	I
2.7 The Trauma Medical Director is a board-certified surgeon or an American College of Surgeons (ACS) Fellow.	I
2.8 The Trauma Medical Director is current in Advanced Trauma Life Support (ATLS).	II
2.9 The Trauma Medical Director has accrued 36 hours in 3 years of trauma-related Continuing Medical Education (CME).	II
2.10 The Trauma Medical Director participates in trauma call.	I
2.11 The Trauma Medical Director maintains personal involvement in patient care, staff education, and professional organizations.	II
2.12 The Trauma Medical Director has sufficient authority to set specified criteria for the trauma panel members.	II
2.13 The roles of emergency physicians and trauma surgeons are defined, agreed on, and approved by the Trauma Medical Director.	II
2.14 The Trauma Medical Director has the authority to correct deficiencies in trauma care and to exclude from trauma call the trauma team members who do not meet specified criteria.	II
2.15 The Trauma Medical Director has the authority to recommend changes for the trauma team based on performance review.	II
2.16 The Trauma Medical Director has the responsibility and authority to determine each general surgeon's ability to participate on the Trauma Team through the PIPS program and hospital policy.	II
2.17 The structure of the trauma program allows the Trauma Medical Director to have oversight authority for care of injured patients who may be admitted to individual surgeons.	II
2.18 The Trauma Medical Director has the responsibility and authority to ensure compliance with designation requirements.	II
2.19 The Trauma Medical Director is involved in the development of the center's bypass protocol.	II
2.20 The Trauma Medical Director ensures dissemination of information to the committees that comprise the PIPS program.	II
2.21 In circumstances when attendance is not mandated, the Trauma Medical Director ensures dissemination of information from the PIPS program.	II
2.22 The Trauma Medical Director is accountable for all trauma care and exercises administrative authority for the trauma program.	I
2.23 The Trauma Medical Director participates in the Performance Improvement and Patient Safety (PIPS) program by attending at least 60% of meetings.	II

2.24 The Trauma Medical Director will approve the design of any sub-specialty backup call system.	II
2.25 The Trauma Medical Director will approve all sub-specialty liaisons for the program.	II
2.26 The PIPS program, comprised of at minimum the Trauma PI and Trauma Operations Committees, is chaired by the Trauma Medical Director or their designee. In the Trauma Medical Director's absence, a designee must be identified.	II
Trauma Program Manager	
2.27 The Trauma Program Manager must have 1.0 full-time equivalent (FTE) commitment to the trauma program.	II
2.28 The Trauma Program Manager has accrued 36 hours in 3 years of trauma-related continuing education.	II
2.29 The Trauma Program Manager is responsible for the use of trauma registry data for quality improvement and trauma education.	II
2.30 The Trauma Program Manager works with the Trauma Medical Director to address the multidisciplinary needs of the trauma program.	I
2.31 The Trauma Program Manager serves as a liaison to local Emergency Medical Services (EMS) agencies and referring/accepting centers.	II
3. Clinical Functions	
3.1 The criteria for graded activation must be clearly defined by the center and reviewed annually, with the highest level of activation including the seven required criteria listed in Table 1.	II
3.2 The center is staffed to ensure immediate and appropriate care of trauma patients during hours of operation.	I
3.3 The trauma service retains responsibility for its patients and coordinates all therapeutic decisions.	I
3.4 The center must be able to provide the necessary human and physical resources to properly administer acute care consistent with ATLS.	II
3.5 The center has written protocols to determine which types of patients are admitted and which are transferred.	II
3.6 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the Intensive Care Unit (ICU) team.	I
3.7 There is a method to identity injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners.	I
3.8 The center must be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers.	II
3.9 The center has established protocols to ensure immediate and appropriate care of the adult and pediatric trauma patient.	II

Trauma Team	
3.10 The team response to all trauma priority levels must be defined and reviewed annually.	II
3.11 All trauma/general surgeons, emergency physicians, and advanced practice providers who participate as a member of the Trauma Team have completed ATLS at least once.	II
3.12 Trauma Team members participate in both the Trauma PI and Trauma Operations Committees.	II
3.13 Trauma Team physicians and advanced practice providers are credentialed by the medical staff and governing board.	II
Emergency Department (ED)	
3.14 The ED has a designated Emergency Physician Director supported by an appropriate number of additional physicians to ensure immediate care of injured patients.	I
3.15 If emergency physicians cover in-house emergencies, a PIPS process must be in place demonstrating the efficacy of this practice.	II
3.16 All emergency physicians are board-certified, board-eligible, or meet the Alternate Pathway criteria* (Table 3).	II
3.17 Emergency physicians on the call panel are regularly involved in the care of injured patients.	II
3.18 The emergency medicine PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
3.19 The ED must evaluate its pediatric readiness and have a plan to address any deficiencies.	II
General Surgery	
3.20 All trauma surgeons must have privileges in general surgery.	II
3.21 The trauma surgeons respond promptly to activations and participate in PIPS activities.	II
3.22 Trauma surgeons in adult trauma centers that admit more than 100 injured children annually are credentialed for pediatric trauma care by the center's credentialing body.	II
3.23 The center has general surgical coverage 24/7.	II
3.24 The trauma surgeon on-call is dedicated to the trauma center while on duty.	I
3.25 Seriously injured patients are admitted to and/or evaluated by the trauma service.	II
3.26 The trauma surgeon is present in the ED within 30 minutes of patient arrival for highest level of activation 24/7 with an 80% achievement rate as monitored by the PIPS program.	I
3.27 The trauma surgeon on-call is involved in decisions regarding diversion.	II
3.28 All trauma surgeons must participate in both the Trauma PI and Trauma Operations Committees, and attend a minimum of 50% of these meetings.	II
3.29 A general surgeon covering trauma call is board-certified, board-eligible, meet the Alternate Pathway criteria* (Table 3), or an ACS Fellow.	II

Orthopedic Surgery	
3.30 The center has orthopedic surgery available 24/7.	II
3.31 An orthopedic surgeon is present in the ED within 30 minutes of request with an 80% achievement rate.	II
3.32 The orthopedic surgeon has privileges in general orthopedic surgery.	II
3.33 Orthopedic surgeons who care for injured patients are board-certified, board-eligible, or meet the Alternate Pathway criteria* (Table 3).	II
3.34 If orthopedic surgery is not dedicated at their institution, a backup call system must be in place.	II
3.35 The orthopedic surgery PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
Collaborative Clinical Services	
Anesthesia	
3.36 Anesthesia services are on-site within 30 minutes of notification for emergency operations and airway problems 24/7.	I
3.37 An anesthesia PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees, and attends a minimum of 50% of these meetings.	II
3.38 The PIPS program reviews the availability of anesthesia services in patient care areas and any delays in care due to lack of anesthesia resources.	II
Operating Room (OR)	
3.39 The Operating Room (OR) is adequately staffed and available within 30 minutes.	I
3.40 Operating rooms are adequately staffed and available within 30 minutes of surgeon decision for emergency operative intervention for musculoskeletal injuries.	I
3.41 The OR has all of the following essential equipment:	I
a. rapid infusers;	
b. thermal control equipment and resuscitation fluids;	
c. intraoperative radiologic capabilities;	
d. equipment for fracture fixation; and	
e. equipment for endoscopic evaluation (bronchoscopy and gastrointestinal endoscopy).	
3.42 A mechanism is in place for documenting the attending surgeon's presence in the OR for all trauma operations.	II
3.43 The PIPS program evaluates OR availability and delays.	II
Post-Anesthesia Care Unit (PACU)	
3.44 The PACU has the necessary equipment to monitor and resuscitate patients.	I
3.45 The PACU has qualified nurses available 24/7 as needed during the patient's post-anesthesia recovery phase.	I

3.46 If the PACU is covered by a call team from home, there is documentation by the PIPS program that nurses are available and delays are not occurring.	II
Radiology	
3.47 Conventional radiography and CT services are available in-house 24/7 or on-call within 30 minutes. There is documentation by the PIPS program that technicians are available and delays are not occurring.	I
3.48 The center has staff available on-site or via telemedicine within 30 minutes of notification for the interpretation of radiographs 24/7 with an 80% achievement rate.	I
3.49 Critical information is verbally communicated to the Trauma Team.	II
3.50 Diagnostic information is communicated in a written form and in a timely manner.	II
3.51 Changes in interpretation are monitored by the PIPS program.	II
3.52 Final reports accurately reflect communications, including changes between preliminary and final interpretations.	II
3.53 The center has policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the Radiology Department.	II
3.54 A radiologist PIPS liaison or designee participates in both the Trauma PI and Trauma Operations Committees.	II
Intensive Care Unit (ICU)	
3.55 The ICU has the necessary equipment to monitor and resuscitate patients.	I
3.56 If the center admits neurotrauma patients, intracranial pressure monitoring equipment is available.	I
3.57 A qualified nurse is available 24/7 to provide care during the ICU phase.	I
3.58 The patient/nurse ratio does not exceed 2:1 for critically ill patients in the ICU.	II
3.59 When a patient is critically ill, there is a mechanism in place to provide prompt availability of ICU physician coverage 24/7.	I
3.60 The trauma surgeon remains in charge of patient in the ICU.	I
3.61 The center has a surgical director or co-director for the ICU who is responsible for setting policies and administration related to trauma ICU patients.	II
Other Surgical Specialists	
3.62 The center has a list of specialists who are promptly available from inside and outside of the center.	II
3.63 The center has the following surgical specialists:	I
a. Orthopedic surgery.	
Medical Consultants	
3.64 The center has a list of internal medicine specialists who are promptly available from inside and outside of the center.	II

Respiratory Therapy	
3.65 There is a respiratory therapist available in-house or on-call 24/7.	I
Laboratory	
3.66 Laboratory services are available 24/7 for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate. The blood bank is capable of blood typing and cross-matching.	I
3.67 The center has the capability for coagulation studies, blood gases, and microbiology.	I
3.68 The blood bank has an adequate amount of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, or appropriate coagulation factors to meet the needs of injured patients.	I
3.69 The center must have a transfusion protocol developed collaboratively between the trauma service and the blood bank.	I
3.70 The center must have a rapid reversal protocol in place for patients on anticoagulants.	II
Nutrition	
3.71 Nutrition support services are available.	II
Social Services	
3.72 The center has social services.	II
3.73 The center must screen all admitted trauma patients for alcohol misuse and provide a brief intervention if appropriate.	II
3.74 The center must have a protocol to screen patients at high risk for psychological sequelae with subsequent referral to a mental health provider when required.	II
3.75 The center must have a process in place to assess pediatrics for nonaccidental trauma (NAT).	II
Dialysis	
3.76 The center has either dialysis capabilities or a transfer agreement with a facility that has dialysis capabilities.	II
Rehabilitation	
3.77 The center has physical therapy services.	I
3.78 The center has either rehabilitation services within its facility or a transfer agreement to a freestanding rehabilitation hospital.	II
Additional Capabilities	
3.79 Centers offering services beyond those required for their level of designation must have a written plan for provision and monitoring of those services.	II
4. Prehospital Trauma Care	
4.1 The center collaborates with EMS agencies and provides feedback on patient care.	II
5. Interhospital Transfer	
5.1 The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient.	II

5.2 There are transfer agreements in place with higher level trauma centers as well as specialty referral centers.	II
5.3 A mechanism for direct physician-to-physician contact is present for arranging patient transfer.	II
5.4 The center must have guidelines addressing which patients should be transferred and the safe transport of those patients.	II
6. Process Improvement and Patient Safety (PIPS)	
6.1 The trauma PIPS program has a clearly defined relationship with the hospital's Performance Improvement/Quality Improvement Department.	II
6.2 The center must have a written and clearly defined PIPS plan that is updated annually. The program must ensure optimal care through continuous clinical review as well as operational procedures and must:	II
a. outline the organizational structure of the PIPS process;	
b. specify the processes of event identification;	
c. include audit filters;	
d. define levels of review; and	
e. specify the members of the PIPS Committee.	
6.3 The PIPS program is supported by a reliable method of internal data collection.	II
6.4 The PIPS program is, at minimum, comprised of two committees: Trauma Performance Improvement (PI) and Trauma Operations.	II
6.5 The Trauma PI Committee is a multidisciplinary committee that meets regularly to:	II
a. address patient care processes and outcomes;	
b. identify patient care opportunities for improvement; and	
c. reduce variability in care.	
6.6 The Trauma Operations Committee is a multidisciplinary committee that meets regularly to:	II
a. correct program deficiencies and optimize patient care;	
b. addresses system and processes issues; and	
c. includes all program-related services.	
6.7 The process of multidisciplinary review and analysis occurs at regular intervals to meet the needs of the program, takes attendance, and records minutes. All major disciplines within the center that are caring for trauma patients must be represented in the process.	II
6.8 The process demonstrates effective use of audit filters, problem identification, analysis, proposed corrective actions, resolution, and loop closure.	II
6.9 All trauma team activations must be categorized by priority of response and reported by number and percentage of total trauma patients.	II
6.10 The PIPS program must use evidence-based clinical practice guidelines and protocols.	II

6.11 Deaths are categorized as mortality with opportunity for improvement or mortality without opportunity for improvement.	II
6.12 The PIPS program reviews the organ donation process and rate.	II
6.13 The center must work with sending and receiving facilities to provide and obtain feedback on transferred patients.	II
6.14 The center must work with EMS agencies to provide and obtain feedback on transported patients.	II
6.15 The PIPS program monitors and confirms the requirement for 80% compliance of surgeon's presence in the ED within 30 minutes of patient's arrival.	II
6.16 The center must have a diversion policy that provides notification for dispatch centers and EMS agencies when on divert and must track the occurrence of diversions.	II
6.17 The PIPS program must review the following metrics to ensure appropriateness of care, rationale, adverse outcomes, and identify opportunities for improvement:	II
a. delay of timely access to care, equipment, or interventions in all care areas;	
b. admissions;	
c. transfers;	
d. non-surgical services (NSS) with a goal of <10%; and	
e. over/under triage.	
6.18 There must be at least 0.5 FTE dedicated Performance Improvement (PI) personnel when the volume of registry patient entries exceeds 500 patients. When annual volume exceeds 1,000 registry patient entries, the trauma center must have at least 1.0 FTE PI personnel.	II

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8. Time Sensitive Emergency (TSE) Registry

8.1 Data is submitted to the Idaho TSE Registry per Idaho Code 46-920. At least 80% of cases are submitted within 180 days of hospital discharge.	I
8.2 There is a process in place to verify that TSE Registry data is accurate and valid.	II
8.3 The trauma program ensures that registry data confidentiality measures are in place.	II
8.4 There must be at least 0.5 FTE dedicated to the trauma registry per 200 to 300 annual patient entries.	II
8.5 Staff members who have a registry role in data abstraction and entry, injury coding, ISS calculation, data reporting, or data validation for the trauma registry must fulfill all of the following requirements:	II
a. participate in and pass the most recent version of the AAAM's Abbreviated Injury Scale (AIS) course;	
b. participate in a trauma registry course that includes all of the following content: abstraction, data management, reports/report analysis, data validation, and HIPPA; and	

c. participate in an ICD-10 course or an ICD-10 refresher course every five years.	
8.6 The Trauma Registrars must accrue at least 24 hours of trauma-related continuing education during the verification cycle.	II
9. Outreach & Education	
9.1 The center is engaged in trauma-related public outreach and education.	II
9.2 The center provides a mechanism for trauma-related education for clinical staff involved in trauma care.	II
10. Prevention	
10.1 The center participates in traumatic injury prevention and bases activities on local data. It is recommended to have a fall prevention program, but not required.	II
10.2 The center must have someone in a leadership position that has injury prevention as part of their job description.	II
10.3 The center demonstrates collaboration with or participation in national, regional, and/or state injury prevention programs.	II
11. Disaster Planning and Management	
11.1 The center has a disaster plan described in its Disaster Manual.	II
11.2 A surgeon from the trauma panel is a member of the center's disaster committee.	II
11.3 Drills that test the individual hospital's disaster plan are conducted at least every 6 months.	II
12. Organ Procurement	
12.1 The center has an established relationship with a recognized Organ Procurement Organization (OPO).	II
12.2 There are written policies for triggering notification of the OPO.	II
12.3 The center has written protocols for declaration of brain death.	II

** External continuing education does not include in-house: in-service, case-based learning, grand rounds, internal trauma symposia, and/or publications disseminating information gained from a local conference.

Designation Criteria for Level IV Trauma Center

Criteria for designation are in place to verify the services and systems to ensure optimal care of the trauma patient. The following elements must be met for designation as a Level IV Trauma Center in Idaho.

Type I criteria must be in place at the time of the verification site visit to achieve designation. Type II criteria are also required but are less critical. If three or fewer Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of designation is issued. During the following 12 months, if the trauma center successfully corrects the deficiencies, the period of designation will be extended to 3 years from the date of the initial verification visit. If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital may not be designated.

1. Trauma System	
Time Sensitive Emergencies (TSE)	
1.1 The center's trauma program staff has sufficient involvement in regional trauma system planning, development, and operation.	II
Center Mission	
1.2 There is a current resolution supporting the trauma center from the medical staff (See Trauma Toolkit).	II
1.3 There is a current resolution supporting the trauma center from the hospital board (See Trauma Toolkit).	II
1.4 There is sufficient infrastructure, staff, equipment, and support to the trauma program to provide adequate care.	I
2. Description of Trauma Center	
Description of the Trauma Center	
2.1 The trauma program is empowered to address issues that involve all applicable disciplines.	I
2.2 The center provides initial resuscitation of the trauma patient and immediate intervention to control hemorrhage and to assure maximum stabilization prior to referral to an appropriate higher level of care or admission.	II
Trauma Leadership	
Trauma Medical Director	
2.3 The trauma program has a Trauma Medical Director with the authority and administrative support to lead the program.	I
2.4 The Trauma Medical Director is current in Advanced Trauma Life Support (ATLS).	II
2.5 The Trauma Medical Director maintains personal involvement in patient care, staff education, and professional organizations.	II

2.6 The Trauma Medical Director must work with trauma team providers' (physicians and advanced practice providers) to ensure appropriate orientation, qualifications, and skill maintenance.	II
2.7 The Trauma Medical Director has the responsibility and authority to ensure compliance with designation requirements.	II
2.8 The Trauma Medical Director is accountable for all trauma care and exercises administrative authority for the trauma program.	I
2.9 The Trauma Medical Director participates in the Performance Improvement and Patient Safety (PIPS) program by attending at least 60% of meetings.	II
2.10 The PIPS program, comprised of at minimum the Trauma PI and Trauma Operations Committees, is chaired by the Trauma Medical Director or their designee. In the Trauma Medical Director's absence, a designee must be identified.	II
Trauma Program Manager	
2.11 The center has a Trauma Program Manager. The Trauma Program Manager shows evidence of educational preparation and clinical experience caring for injured patients.	II
2.12 The Trauma Program Manager is responsible for the use of trauma registry data for quality improvement and trauma education.	II
2.13 The Trauma Program Manager works with the Trauma Medical Director to address the multidisciplinary needs of the trauma program.	I
2.14 The Trauma Program Manager serves as a liaison to local Emergency Medical Services (EMS) agencies and referring/accepting centers.	II
3. Clinical Functions	
3.1 The criteria for graded activation must be clearly defined by the center and reviewed annually, with the highest level of activation including the seven required criteria listed in Table 1.	II
3.2 The center is staffed to ensure immediate and appropriate care to trauma patients during hours of operation.	I
3.3 The center must be able to provide the necessary human and physical resources to properly administer acute care consistent with ATLS.	II
3.4 The center must have written protocols outlining which types of trauma patients the facility is capable of providing inpatient services.	II
3.5 The center must be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers.	II
3.6 The center has established protocols to ensure immediate and appropriate care of the adult and pediatric trauma patient.	II
Trauma Team	
3.7 The team response to all trauma priority levels must be defined and reviewed annually.	II
3.8 All trauma/general surgeons, emergency physicians, and advanced practice providers who participate as a member of the Trauma Team have completed ATLS at least once and should remain current in ATLS.	II

3.9 Trauma Team members participate in both the Trauma PI and Trauma Operations Committees.	II
3.10 Trauma Team physicians and advanced practice providers are credentialed by the medical staff and governing board.	II
Emergency Department (ED)	
3.11 The physician or advanced practice provider will be in the Emergency Department (ED) on patient arrival for the highest level of activation, provided there is adequate notification from the prehospital providers. The maximum acceptable response time is 30 minutes from patient arrival in the ED. The PIPS program must demonstrate that the provider's presence is in compliance at least 80% of the time.	I
3.12 The center must have emergency coverage by a physician or advanced practice provider 24/7.	I
3.13 ED providers must have completed ATLS at least once.	II
3.14 Advanced practice providers who direct/lead the initial evaluation of trauma patients must maintain current ATLS certification.	II
3.15 The ED must evaluate its pediatric readiness and have a plan to address any deficiencies.	II
Collaborative Clinical Services	
Radiology	
3.16 Conventional radiography and CT services are available in-house 24/7 or on-call within 30 minutes. There is documentation by the PIPS program that technicians are available and delays are not occurring.	I
Other Surgical Specialists	
3.17 The center has a list of specialists who are promptly available from inside and outside of the center.	II
Laboratory	
3.18 Laboratory services are available 24/7 in-house or able to respond within 30 minutes for the standard analysis of blood, urine, and other body fluids, including microsampling when appropriate. The blood bank should be capable of blood typing and cross matching.	I
3.19 The center must have a transfusion protocol developed collaboratively between the trauma service and the blood bank.	I
3.20 The center must have a rapid reversal protocol in place for patients on anticoagulants.	II
Nutrition	
3.21 Nutrition support services are available.	II
Social Services	
3.22 The center has social services.	II
3.23 The center must screen all admitted trauma patients for alcohol misuse and provide a brief intervention if appropriate.	II

3.24 The center must have a protocol to screen patients at high risk for psychological sequelae with subsequent referral to a mental health provider when required.	II
3.25 The center must have a process in place to assess pediatrics for nonaccidental trauma (NAT).	II
Additional Capabilities	
3.26 Centers offering services beyond those required for their level of designation must have a written plan for provision and monitoring of those services.	II
4. Prehospital Trauma Care	
4.1 The center collaborates with EMS agencies and provides feedback on patient care.	II
5. Interhospital Transfer	
5.1 The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient.	II
5.2 There are transfer agreements in place with higher level trauma centers as well as specialty referral centers.	II
5.3 A mechanism for direct physician-to-physician contact is present for arranging patient transfer.	II
5.4 The center must have guidelines addressing which patients should be transferred and the safe transport of those patients.	II
6. Process Improvement and Patient Safety (PIPS)	
6.1 The center must have a written and clearly defined PIPS plan that is updated annually. The program must ensure optimal care through continuous clinical review as well as operational procedures and must:	II
a. outline the organizational structure of the PIPS process;	
b. specify the processes of event identification;	
c. include audit filters;	
d. define levels of review; and	
e. specify the members of the PIPS Committee.	
6.2 The PIPS program is supported by a reliable method of internal data collection.	II
6.3 The PIPS program is, at minimum, comprised of two committees: Trauma Performance Improvement (PI) and Trauma Operations.	II
6.4 The Trauma PI Committee is a multidisciplinary committee that meets regularly to:	II
a. address patient care processes and outcomes;	
b. identify patient care opportunities for improvement; and	
c. reduce variability in care.	
6.5 The Trauma Operations Committee is a multidisciplinary committee that meets regularly to:	II
a. correct program deficiencies and optimize patient care;	
b. addresses system and processes issues; and	

c. includes all program-related services.	
6.6 The process of multidisciplinary review and analysis occurs at regular intervals to meet the needs of the program, takes attendance, and records minutes. All major disciplines within the center that are caring for trauma patients must be represented in the process.	II
6.7 The process demonstrates effective use of audit filters, problem identification, analysis, proposed corrective actions, resolution, and loop closure.	II
6.8 All trauma team activations must be categorized by priority of response and reported by number and percentage of total trauma patients.	II
6.9 The PIPS program must use evidence-based clinical practice guidelines and protocols.	II
6.10 Deaths are categorized as mortality with opportunity for improvement or mortality without opportunity for improvement.	II
6.11 The center must work with sending and receiving facilities to provide and obtain feedback on transferred patients.	II
6.12 The center must work with EMS agencies to provide and obtain feedback on transported patients.	II
6.13 The center must have a diversion policy that provides notification for dispatch centers and EMS agencies when on divert and must track the occurrence of diversions.	II
6.14 The PIPS program must review the following metrics to ensure appropriateness of care, rationale, adverse outcomes, and identify opportunities for improvement:	II
a. delay of timely access to care, equipment, or interventions in all care areas;	
b. admissions;	
c. transfers;	
d. non-surgical services (NSS) with a goal of <10%; and	
e. over/under triage.	
6.15 There must be at least 0.5 FTE dedicated Performance Improvement (PI) personnel when the volume of registry patient entries exceeds 500 patients. When annual volume exceeds 1,000 registry patient entries, the trauma center must have at least 1.0 FTE PI personnel.	II
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8. Time Sensitive Emergency (TSE) Registry	
8.1 Data is submitted to the Idaho TSE Registry per Idaho Code 46-920. At least 80% of cases are submitted within 180 days of hospital discharge.	I
8.2 There is a process in place to verify that TSE Registry data is accurate and valid.	II
8.3 The trauma program ensures that registry data confidentiality measures are in place.	II
9. Outreach & Education	
9.1 The center is engaged in trauma-related public outreach and education.	II
9.2 The center provides a mechanism for trauma-related education for clinical staff involved in trauma care.	II

10. Prevention	
10.1 The center participates in traumatic injury prevention and bases activities on local data. It is recommended to have a fall prevention program, but not required.	II
10.2 The center must have someone in a leadership position that has injury prevention as part of their job description.	II
11. Disaster Planning and Management	
11.1 The center has a disaster plan described in its Disaster Manual.	II
11.2 The Trauma Medical Director is a member of the center's disaster committee.	II
11.3 The center must participate in regional disaster management plans and exercises.	II
12. Organ Procurement	
12.1 The center has written protocols for declaration of brain death.	II

Designation Criteria for Level V Trauma Center

Criteria for designation are in place to verify the services and systems to ensure optimal care of the trauma patient. The following elements must be met for designation as a Level V Trauma Center in Idaho.

Type I criteria must be in place at the time of the verification site visit to achieve designation. Type II criteria are also required but are less critical. If three or fewer Type II deficiencies are present at the time of the site visit and no Type I criteria are cited, a 1-year certificate of designation is issued. During the following 12 months, if the trauma center successfully corrects the deficiencies, the period of designation will be extended to 3 years from the date of the initial verification visit. If any Type I deficiency or more than three Type II deficiencies are present at the time of the initial verification site visit, the hospital may not be designated.

1. Trauma System	
Time Sensitive Emergencies (TSE)	
1.1 The center must participate in their Regional Time Sensitive Emergency (TSE) Committee.	II
Center Mission	
1.2 There is a current resolution supporting the trauma center from the medical staff (See Trauma Toolkit).	II
1.3 There is a current resolution supporting the trauma center from the facility board (See Trauma Toolkit).	II
1.4 The center is a health care facility (as defined in section 10 of the TSE Rules) with the commitment, medical staff, personnel, and training necessary to provide initial care and stabilization of the trauma patient.	I
2. Description of Trauma Center	
Description of the Trauma Center	
2.1 The trauma program is empowered to address issues that involve all applicable disciplines.	I
2.2 The center provides initial resuscitation of the trauma patient and immediate intervention to control hemorrhage and to assure maximum stabilization prior to referral to an appropriate higher level of care.	II
Trauma Leadership	
Trauma Medical Director	
2.3 The trauma program has a Trauma Medical Director with the authority and administrative support to lead the program.	I
2.4 The Trauma Medical Director is current in Advanced Trauma Life Support (ATLS).	II
2.5 The Trauma Medical Director maintains personal involvement in patient care, staff education, and professional organizations.	II

2.6 The Trauma Medical Director will review the trauma team providers' (physicians and advanced practice providers) performance and qualifications.	II
2.7 The Trauma Medical Director has the responsibility and authority to ensure compliance with designation requirements.	II
2.8 The Trauma Medical Director is accountable for all trauma care and exercises administrative authority for the trauma program.	I
2.9 The Trauma Medical Director participates in the Performance Improvement and Patient Safety (PIPS) program by attending at least 60% of meetings.	II
Trauma Program Manager	
2.10 The center has a Trauma Program Manager. The Trauma Program Manager shows evidence of educational preparation and clinical experience caring for injured patients.	II
2.11 The Trauma Program Manager is responsible for the use of trauma registry data for quality improvement and trauma education.	II
2.12 The Trauma Program Manager works with the Trauma Medical Director to address the multidisciplinary needs of the trauma program.	I
2.13 The Trauma Program Manager serves as a liaison to local Emergency Medical Services (EMS) agencies and referring/accepting centers.	II
3. Clinical Functions	
3.1 The criteria for activation must be clearly defined by the center. At minimum, this must include the seven required criteria listed in Table 1.	II
3.2 The center is staffed to ensure immediate and appropriate care to trauma patients during hours of operation.	I
3.3 The center must be able to provide the necessary human and physical resources to properly administer acute care consistent with ATLS.	II
3.4 The center has written protocols to determine which types of patients are admitted and which are transferred.	II
3.5 The center must be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers.	II
3.6 The center has established protocols to ensure immediate and appropriate care of the adult and pediatric trauma patient.	II
Trauma Team	
3.7 The center's policy and procedures describe the role of all personnel on the Trauma Team.	I
3.8 At a minimum, the Trauma Team consists of:	I
a. a physician or advanced practice provider; and	
b. a registered nurse or licensed practical nurse.	
3.9 Trauma Team members participate in the multidisciplinary trauma committee and the PIPS program.	II
3.10 Trauma Team physicians and advanced practice providers are credentialed by the medical staff and governing board.	II

Emergency Department (ED)	
3.11 During hours of operation, the center has a health care provider(s) (MD, DO, FNP, PA) available. The provider must be on-site within 30 minutes of patient arrival with an 80% achievement rate.	I
3.12 The center is staffed by RN/LPNs during hours of operation at levels necessary to meet the needs of the trauma patient.	I
3.13 Trauma providers must have documentation of training and knowledge of care for the trauma patient.	I
3.14 Where advanced practice providers (Nurse Practitioners or Physician Assistants) staff the Emergency Department (ED), there must be documentation of training and knowledge of care for the trauma patient.	I
3.15 The ED must evaluate its pediatric readiness and have a plan to address any deficiencies.	II
Collaborative Clinical Services	
Radiology	
3.16 The center has a written plan to access radiology services either in their location or through a transfer agreement.	I
Other Surgical Specialists	
3.17 The center has a list of specialists who are promptly available from inside and outside of the center.	II
3.18 The center must have a process in place to assess pediatrics for nonaccidental trauma (NAT).	II
4. Prehospital Trauma Care	
4.1 The center collaborates with EMS agencies and provides feedback on patient care.	II
5. Interhospital Transfer	
5.1 The decision to transfer an injured patient rests with the attending provider and is based solely on the needs of the patient.	II
5.2 There are transfer agreements in place in higher level trauma centers as well as specialty referral centers.	II
5.3 A mechanism for direct provider-to-provider contact is present for arranging patient transfer.	II
5.4 The center must have guidelines addressing which patients should be transferred and the safe transport of those patients.	II
6. Performance Improvement and Patient Safety (PIPS)	
6.1 The center must have a written and clearly defined PIPS plan that is updated annually. The program must ensure optimal care through continuous clinical review as well as operational procedures and must:	II
a. outline the organizational structure of the PIPS process;	
b. specify the processes of event identification;	
c. include audit filters;	

d. define levels of review; and	
e. specify the members of the PIPS Committee.	
6.2 The PIPS program is supported by a reliable method of internal data collection.	II
6.3 The process of multidisciplinary review and analysis occurs at regular intervals to meet the needs of the program, takes attendance, and records minutes. All major disciplines within the center that are caring for trauma patients must be represented in the process.	II
6.4 The process demonstrates effective use of audit filters, problem identification, analysis, proposed corrective actions, resolution, and loop closure.	II
6.5 The PIPS program must use evidence-based clinical practice guidelines and protocols.	II
6.6 Deaths are categorized as mortality with opportunity for improvement or mortality without opportunity for improvement.	II
6.7 The center must work with sending and receiving facilities to provide and obtain feedback on transferred patients.	II
6.8 The center must work with EMS agencies to provide and obtain feedback on transported patients.	II
6.9 The center must have a diversion policy that provides notification for dispatch centers and EMS agencies when on divert and must track the occurrence of diversions.	II
6.10 The PIPS program must review the following metrics to ensure appropriateness of care, rationale, adverse outcomes, and identify opportunities for improvement:	II
a. delay of timely access to care, equipment, or interventions in all care areas;	
b. admissions;	
c. transfers;	
d. non-surgical services (NSS) with a goal of <10%; and	
e. over/under triage.	
6.11 There must be at least 0.5 FTE dedicated Performance Improvement (PI) personnel when the volume of registry patient entries exceeds 500 patients. When annual volume exceeds 1,000 registry patient entries, the trauma center must have at least 1.0 FTE PI personnel.	II
7. This Section Left Intentionally Blank	
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8. Time Sensitive Emergency (TSE) Registry	
8.1 Data is submitted to the Idaho TSE Registry per Idaho Code 46-920. At least 80% of cases are submitted within 180 days of hospital discharge.	I
8.2 There is a process in place to verify that TSE Registry data is accurate and valid.	II
8.3 The trauma program ensures that registry data confidentiality measures are in place.	II
9. Outreach & Education	
9.1 The center is engaged in trauma-related public outreach and education.	II

10. Prevention	
10.1 The center participates in traumatic injury prevention and bases activities on local data. It is recommended to have a fall prevention program, but not required.	II
11. Disaster Planning and Management	
11.1 The center has a disaster plan described in its Disaster Manual.	II
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X. APPENDIX B: TABLES

Table 1. Minimum Criteria for Full Trauma Team Activation
Confirmed blood pressure less than 90 mm HG at any time in adults and age-specific hypotension in children;
Penetrating injury to the head, neck, chest, or torso;
Glasgow Coma Scale (GCS) score less than 9 with mechanism attributed to trauma;
Any patient receiving blood/vasopressors;
Intubated/Supraglottic airway/BVM; OR
Patients who have respiratory compromise or are in need of emergent airway;
Included 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); and
Emergency physician's discretion.

Table 2. Research Requirements for a Level I Trauma Center
Option 1
20 trauma-related, peer-reviewed articles in journals listed in Index Medicus or PubMed in a 3-year period.
At least one article with a general surgery author or co-author; and
Trauma-related activities from at least three of the following disciplines:
a. Basic sciences
b. Neurosurgery
c. Emergency medicine
d. Orthopedics
e. Radiology
f. Anesthesia
g. Vascular surgery
h. Plastic surgery or maxillofacial surgery
i. Critical care
j. Cardiothoracic surgery
k. Rehabilitation
l. Nursing

Option 2
10 trauma-related, peer-reviewed articles in journals listed in Index Medicus or PubMed in a 3-year period.
The same specialty authorship requirements as in Option 1; and
Demonstration of trauma-related scholarly activity in at least four of the following areas:
a. Leadership in major trauma organizations.
b. Peer-reviewed funding for trauma research.
c. Evidence of dissemination of knowledge.
d. Published trauma-related case reports.
e. Visiting professorships or invited lectures.
f. Resident participation in scholarly activity.
g. Trauma, critical care, or acute surgery fellowship.

Table 3. *Alternate Pathway Criteria

Emergency Physicians

In rare circumstances a non-board-certified emergency physician may be included in the trauma service. This situation may arise when a limited number of qualified emergency physicians are available to a hospital that wants to establish a verified trauma program. To assist these programs in providing optimal care to injured patients with existing physician resources, the following alternative to board certification is available. All of the following criteria must be met:

1. A letter by the Trauma Medical Director indicating this critical need in the trauma program because of the physician's experience or the limited physician resources in emergency medicine within the hospital trauma program;
2. Evidence that the emergency physician completed an accredited residency training program in that specialty. This completion must be certified by a letter from the program director;
3. Documentation of current status as a provider or instructor in Advanced Trauma Life Support (ATLS);
4. A list of the 36 hours of trauma-related continuing medical education (CME) during the past three years;
5. Documentation that the emergency physician is present for at least 50% of the trauma performance improvement and educational meetings;
6. Documentation of membership or attendance at local and regional or national trauma meetings during the past three years; and
7. Performance improvement assessment by the Trauma Medical Director and the director of the Emergency Department (ED) demonstrating that care provided by the emergency physician compares favorably with care of the other members of the ED on the trauma call panel.

General Surgery

In rare circumstances a non-board-certified surgeon may be included in the trauma service. This situation may arise when a limited number of qualified surgeons are available to a hospital that desires to establish a verified trauma program. To assist these programs in providing optimal care to injured patients with existing surgical resources, the following alternative to board certification is available. This option cannot be used for the director of a trauma program:

1. A letter by the Trauma Medical Director indicating this critical need in the trauma program because of the physician's experience or the limited physician resources in general surgery within the hospital trauma program;
2. Evidence that the surgeon completed an accredited residency training program in that specialty. This completion must be certified by a letter from the program director;
3. Documentation of current status as a provider or instructor in Advanced Trauma Life Support (ATLS);
4. A list of the 36 hours of trauma-related continuing medical education (CME) during the past three years;
5. Documentation that the surgeon is present for at least 50% of the trauma performance improvement and educational meetings;
6. Documentation of membership or attendance at local and regional or national trauma meetings during the past three years;
7. A list of patients treated during the past year with accompanying Injury Severity Score (ISS) and outcome data;
8. Performance improvement assessment by the Trauma Medical Director demonstrating that the morbidity and mortality results for patients treated by the surgeon compares favorably with the morbidity and mortality results for comparable patients treated by other members of the trauma call panel; and
9. Licensed to practice medicine and approved for full and unrestricted surgical privileges by the hospital's credentialing committee.

Neurosurgery

In rare circumstances a non-board-certified neurosurgeon may be included in the trauma service. This situation may arise when a limited number of qualified neurosurgeons are available to a community that desires to establish a verified trauma program. To assist neurological services, the following alternative to board certification is available. All of the following criteria must be met:

1. A letter by the Trauma Medical Director indicating this critical need in the trauma program because of the physician's experience or the limited physician resources in neurosurgery within the hospital trauma program;
2. Evidence that the neurosurgeon completed an accredited residency training program in that specialty. This completion must be certified by a letter from the program director;
3. Documentation of current status as a provider or instructor in Advanced Trauma Life Support (ATLS);
4. A list of the 36 hours of trauma-related continuing medical education (CME) during the past three years;
5. Documentation that the neurosurgeon is present for at least 50% of the trauma performance improvement and educational meetings;
6. Documentation of membership or attendance at local and regional or national trauma meetings during the past three years;
7. A list of patients treated during the past year with accompanying Injury Severity Score (ISS) and outcome data;
8. Performance improvement assessment by the Trauma Medical Director demonstrating that the morbidity and mortality results for patients treated by the neurosurgeon compares favorably with the morbidity and mortality results for comparable patients treated by other members of the trauma call panel; and
9. Licensed to practice medicine and approved for full and unrestricted surgical privileges by the hospital's credentialing committee.

Orthopedic Surgery

In rare circumstances a non-board-certified orthopedic surgeon may be included in the trauma service. This situation may arise when a limited number of qualified orthopedic surgeons are available to a community that desires to establish a verified trauma program. To assist these programs in providing optimal care to injured patients with existing surgical resources, the following alternative to board certification is available. All of the following criteria must be met:

1. A letter by the Trauma Medical Director indicating this critical need in the trauma program because of the physician's experience or the limited physician resources in orthopedic surgery within the hospital trauma program;
2. Evidence that the orthopedic surgeon completed an accredited residency training program in that specialty. This completion must be certified by a letter from the program director;
3. Documentation of current status as a provider or instructor in Advanced Trauma Life Support (ATLS);
4. A list of the 36 hours of trauma-related continuing medical education (CME) during the past three years;
5. Documentation that the orthopedic surgeon is present for at least 50% of the trauma performance improvement and educational meetings;
6. Documentation of membership or attendance at local and regional or national trauma meetings during the past three years;
7. A list of patients treated during the past year with accompanying Injury Severity Score (ISS) and outcome data;
8. Performance improvement assessment by the Trauma Medical Director demonstrating that the morbidity and mortality results for patients treated by the orthopedic surgeon compares favorably with the morbidity and mortality results for comparable patients treated by other members of the trauma call panel; and
9. Licensed to practice medicine and approved for full and unrestricted surgical privileges by the hospital's credentialing committee.

XI. APPENDIX C: STROKE DESIGNATION REQUIREMENTS

Level I Stroke Center (Comprehensive)

Designation Criteria for Level I Stroke Center

1. Personnel
1.1 The center has a Stroke Program Coordinator that is at minimum an RN.
1.2 The center has a Stroke Program Medical Director who is a Neuro-Specialist (i.e. Neurosurgeon, Neurologist, or Neuro-Intensivist) with extensive experience in Neurology and cerebrovascular disease.
1.3 The center has an acute stroke team on-site (as designated by the Stroke Program leadership) 24/7 within 15 minutes of activation with an 80% achievement rate.
1.4 The Stroke Program Coordinator and Stroke Program Medical Director are responsible for program design, education, protocols, Performance Improvement (PI), program development, outreach, etc.
1.5 The center has a Neurologist 24/7 that is contracted to be on-site or available via telemedicine within 15 minutes of stroke team activation.
1.6 The center has a board-certified Vascular Neurologist; or the center has an ABPN-certified Neurologist who has completed 12 months of formal training in Vascular Neurology, or who devotes a minimum of 25% of practice time to Vascular Neurology.
1.7 The center has a Vascular Surgeon available 24/7 that is contracted to be on-site within 30 minutes when requested.
1.8 The center has Neuro-Interventional physicians available 24/7 that are contracted to be on-site within 30 minutes when requested.
1.9 The center has Critical Care or Neurocritical Care physicians, or advanced practice providers, available 24/7 that are contracted to be on-site within 30 minutes when requested.
1.10 The center has Physical Medicine and Rehabilitation physicians.
1.11 The center has a Neurosurgeon available 24/7 that is contracted to be on-site within 30 minutes when requested.
1.12 The center has organizational and administrative support.
1.13 The center has clinical Emergency Department (ED) personnel trained in diagnosing and treating acute stroke on-site 24/7.
2. Training and Education
2.1 The Stroke Program Medical Director has a minimum of 8 hours of annual stroke-related education.
2.2 The Stroke Program Coordinator has a minimum of 8 hours of annual education on stroke diagnosis and treatment.

2.3 All center staff are educated annually on the signs and symptoms of stroke and the process to activate emergency systems.
2.4 The Emergency Department (ED) and Stroke Unit's clinical staff demonstrate evidence of initial and annual training in the care of acute stroke patients.
2.5 The center provides annual public education on stroke-related topics such as disease prevention, risk factors, signs and symptoms, and 911 activation.
2.6 The center provides stroke education to stroke patients and their caregivers.
2.7 The center offers disease prevention for its employees at least annually.
3. Stroke Services
3.1 The center has Neuro-Radiology services available 24/7.
3.2 The center has Diagnostic Radiology services available 24/7.
3.3 The center has:
a. an Intensive Care Unit (ICU);
b. Physical Therapy;
c. Occupational Therapy; and
d. Speech Therapy.
3.4 The center has staff stroke nurses available 24/7.
3.5 The center has a CT tech on-site 24/7.
3.6 The center initiates CT or MRI within 20 minutes of patient arrival 24/7 with an 80% achievement rate.
3.7 The center has staff on-site or via telemedicine to interpret CT or MRI results within 45 minutes of patient arrival 24/7 with an 80% achievement rate.
3.8 The center has a diffusion-weighted MRI available 24/7.
3.9 The center has MR angiography/MR venography available 24/7.
3.10 The center has CT angiography available 24/7.
3.11 The center has digital subtraction cerebral angiography available 24/7.
3.12 The center has transcranial doppler available 24/7.
3.13 The center has transesophageal and transthoracic echo.
3.14 The center has carotid artery duplex ultrasound imaging.
3.15 The center has 12-lead ECG and chest x-ray capability 24/7.
3.16 The center has laboratory or point-of-care testing 24/7 with:
a. blood glucose results that are obtained and documented prior to initiation of thrombolytics;
b. results for CBC and coagulation labs are available in a median of 45 minutes or less from patient arrival; and
c. testing results do not delay initiation of thrombolytics.

3.17 The center has IV thrombolytic therapy, as endorse by current evidence-based guidelines, for stroke available 24/7.
3.18 The center reviews mechanical thrombectomy metrics, it will collect data on the following items:
a. arrival at Interventional hospital to skin puncture;
b. symptomatic intracranial hemorrhage within 36 hours of the procedure;
c. mortality within 72 hours of the procedure (all cause);
d. door-to-device;
e. ischemic stroke patients with large vessel occlusion (LVO) who achieve TICI 2b or higher for the primary vessel occlusion less than or equal to 60 minutes from the time of skin puncture;
f. a process for internal and external benchmarking to drive PI; and
g. tracks 90-day modified Rankin scores for patients receiving mechanical thrombectomy and thrombolytics.
3.19 The center has Intra-Arterial (IA) recanalization capability available 24/7.
3.20 The center performs carotid endarterectomy 24/7.
3.21 The center provides surgical treatment of intracranial cerebrovascular disease 24/7.
3.22 The center provides placement of intracranial pressure transducer 24/7.
3.23 The center provides placement of ventriculostomy 24/7.
3.24 The center performs endovascular treatment of intracranial aneurysms/arterial venous malformations 24/7.
3.25 The center performs endovascular treatment of vasospasm 24/7.
3.26 The center performs stenting and/or angioplasty of extracranial vessels 24/7 or has a referral protocol in place.
3.27 The center performs stenting and/or angioplasty of intracranial vessels 24/7 or has a referral protocol in place.
3.28 The center has operating room coverage 24/7 and is ready within 30 minutes of notification with an 80% achievement rate.
3.29 The center has Interventional services available 24/7 on-site within 30 minutes of notification with an 80% achievement rate.
3.30 The center has post discharge stroke services.
3.31 The center must have written stroke protocols, order sets, procedures, and/or algorithms for assessment and treatment of ischemic and hemorrhagic strokes which include:
a. stroke team activation process;
b. initial diagnostic tests;
c. administration of medication;
d. swallowing assessment prior to oral intake;

e. evaluation and treatment by Physical Therapy, Occupational Therapy, and/or Speech Therapy. Consider as a required reporting to state registry;
f. discharge order set, protocol, or process that includes consideration for antithrombotic therapy, statin therapy, or anticoagulants as needed for patients with atrial fibrillation (AFib) and toward patient education on secondary prevention and risk factors; and
g. referral to post discharge rehabilitation services if need identified.
3.32 The center's pharmacy is adequately staffed by qualified personnel to ensure effective medication management services including emergency services available 24/7.
3.33 The center has transfer protocols or guidelines specific to stroke patients; however, there should be no reason to transfer stroke patients from a Level I Stroke Center other than in extreme circumstances.
3.34 The center provides assistance with training and clinical education for Emergency Medical Services (EMS) agencies in coordination with the EMS Medical Directors, as needed and upon request.
3.35 The center collaborates with EMS agencies on stroke care.
3.36 The center has a process for initiation of palliative care and/or comfort care.
4. Minimum Requirements
4.1 The center cares for a minimum of 12 non-traumatic subarachnoid hemorrhage (SAH) patients per year.
4.2 The center performs a minimum of 15 clippings or endovascular procedures per year for aneurysmal disease.
4.3 The stroke program has an organized process, or a designated response team, for rapid evaluation and treatment of inpatients that develop stroke symptoms.
4.4 NIH Stroke Score is used in the Emergency Department (ED) and the inpatient setting as the primary neurologic assessment tool.
5. Performance Measurement and Quality Improvement
5.1 The center participates in the Idaho TSE Registry. At least 80% of cases are submitted within 180 days of hospital discharge.
5.2 The center meets the benchmark of door-to-needle time of less than 60 minutes with a 75% achievement rate and 45 minutes with a 50% achievement rate.
5.3 The center participates in their Regional TSE Committee.
5.4 The center must have a Performance Improvement (PI) program to ensure optimal care and continuous improvement of care.
5.5 The PI program is supported by a reliable method of internal data collection that consistently gathers valid and objective information necessary to analyze and identify opportunities for improvement.
5.6 System and process issues, clinical care issues, and all admission and transfer decisions must be reviewed by the PI program.

5.7 The center must use current clinical practice guidelines derived from evidence-based validation resources to achieve benchmark goals.
5.8 All process and outcome measures must be documented in a written PI plan.
5.9 The process of analysis occurs at regular intervals (at least quarterly) to meet the needs of the program.
5.10 The process demonstrates problem resolution (loop closure).
5.11 The center is able to identify the stroke patient population for review.
5.12 The center's PI program must work with transferring facilities to provide and obtain feedback on all transferred patients.
5.13 The PI program evaluates delays in availability of the Interventional suite.
5.14 Delays in Surgeon/Interventionalist response time must be monitored and reviewed for cause of delay and opportunities for improvement. Corrective actions must be documented.
5.15 Transfers within 24 hours to a higher level of care must be reviewed to determine the rationale for transfer, adverse outcomes, and opportunities for improvement.
5.16 The PI review is inclusive of all stroke admissions and transfers.
5.17 The center must have a policy to notify dispatch and EMS agencies when on divert status.

Designation Criteria for Level II Stroke Center Plus Thrombectomy Capable

1. Personnel
1.1 The center has a Stroke Program Coordinator that is at minimum an RN.
1.2 The center has a Stroke Program Medical Director who is a Neuro-Specialist (i.e. Neurosurgeon, Neurologist, or Neuro-Intensivist) with extensive experience in Neurology and cerebrovascular disease.
1.3 The center has an acute stroke team on-site (as designated by the Stroke Program leadership) 24/7 within 15 minutes of activation with an 80% achievement rate.
1.4 The Stroke Program Coordinator and Stroke Program Medical Director are responsible for program design, education, protocols, Performance Improvement (PI), program development, outreach, etc.
1.5 The center has a Neurologist 24/7 that is contracted to be on-site or available via telemedicine within 15 minutes of stroke team activation.
1.6 The center has a Vascular Surgeon available 24/7 that is contracted to be on-site within 30 minutes when requested.
1.7 The center has Neuro-Interventional physicians available 24/7 that are contracted to be on-site within 30 minutes when requested.
1.8 The center has Critical Care or Neurocritical Care physicians, or advanced practice providers, available 24/7 that are contracted to be on-site within 30 minutes when requested.
1.9 The center has a Neurosurgeon available 24/7 that is contracted to be on-site or emergent transfer protocols that enable access to Neurosurgery within 2 hours.
1.10 The center has organizational and administrative support.
1.11 The center has clinical Emergency Department (ED) personnel trained in diagnosing and treating acute stroke on-site 24/7.
2. Training and Education
2.1 The Stroke Program Medical Director has a minimum of 8 hours of annual stroke-related education.
2.2 The Stroke Program Coordinator has a minimum of 8 hours of annual education on stroke diagnosis and treatment.
2.3 All center staff are educated annually on the signs and symptoms of stroke and the process to activate emergency systems.
2.4 The Emergency Department (ED) and Stroke Unit's clinical staff demonstrate evidence of initial and annual training in the care of acute stroke patients.

2.5 The center provides annual public education on stroke-related topics such as disease prevention, risk factors, signs and symptoms, and 911 activation.
2.6 The center provides stroke education to stroke patients and their caregivers.
2.7 The center offers disease prevention for its employees at least annually.
3. Stroke Services
3.1 The center has Neuro-Radiology services available 24/7.
3.2 The center has Diagnostic Radiology services available 24/7.
3.3 The center has:
a. an Intensive Care Unit (ICU);
b. Physical Therapy;
c. Occupational Therapy; and
d. Speech Therapy.
3.4 The center has staff stroke nurses available 24/7.
3.5 The center has a CT tech on-site 24/7.
3.6 The center initiates CT or MRI within 20 minutes of patient arrival 24/7 with an 80% achievement rate.
3.7 The center has staff on-site or via telemedicine to interpret CT or MRI results within 45 minutes of patient arrival 24/7 with an 80% achievement rate.
3.8 The center has a diffusion-weighted MRI available 24/7.
3.9 The center has CT angiography available 24/7.
3.10 The center has digital subtraction cerebral angiography available 24/7.
3.11 The center has transesophageal and transthoracic echo.
3.12 The center has carotid artery duplex ultrasound imaging.
3.13 The center has 12-lead ECG and chest x-ray capability 24/7.
3.14 The center has laboratory or point-of-care testing 24/7 with:
a. blood glucose results that are obtained and documented prior to initiation of thrombolytics;
b. results for CBC and coagulation labs are available in a median of 45 minutes or less from patient arrival; and
c. testing results do not delay initiation of thrombolytics.
3.15 The center has IV thrombolytic therapy, as endorse by current evidence-based guidelines, for stroke available 24/7.
3.16 The center reviews mechanical thrombectomy metrics, it will collect data on the following items:
a. arrival at Interventional hospital to skin puncture;
b. symptomatic intracranial hemorrhage within 36 hours of the procedure;

c. mortality within 72 hours of the procedure (all cause);
d. door-to-device;
e. ischemic stroke patients with large vessel occlusion (LVO) who achieve TICI 2b or higher for the primary vessel occlusion less than or equal to 60 minutes from the time of skin puncture;
f. a process for internal and external benchmarking to drive PI; and
g. tracks 90-day modified Rankin scores for patients receiving mechanical thrombectomy and thrombolytics.
3.17 If Neurosurgical services are provided, the center performs surgical treatment of intracranial cerebrovascular disease 24/7.
3.18 If Neurosurgical services are provided, the center has a fully functioning operating room 24/7 and appropriate qualified Neurosurgical staff within a maximum of 2 hours when determined to be immediately needed for a patient.
3.19 The center has Interventional services available 24/7 on-site within 30 minutes of notification with an 80% achievement rate.
3.20 The center has post discharge stroke services.
3.21 The center must have written stroke protocols, order sets, procedures, and/or algorithms for assessment and treatment of ischemic and hemorrhagic strokes which include:
a. stroke team activation process;
b. initial diagnostic tests;
c. administration of medication;
d. swallowing assessment prior to oral intake;
e. evaluation and treatment by Physical Therapy, Occupational Therapy, and/or Speech Therapy. Consider as a required reporting to state registry;
f. discharge order set, protocol, or process that includes consideration for antithrombotic therapy, statin therapy, or anticoagulants as needed for patients with atrial fibrillation (AFib) and toward patient education on secondary prevention and risk factors; and
g. referral to post discharge rehabilitation services if need identified.
3.22 The center's pharmacy is adequately staffed by qualified personnel to ensure effective medication management services including emergency services available 24/7.
3.23 The center has transfer protocols or guidelines specific to transferring stroke patients to a Level I Stroke Center for non-traumatic subarachnoid hemorrhage management including clipping and coiling.
3.24 The center provides assistance with training and clinical education for Emergency Medical Services (EMS) agencies in coordination with the EMS Medical Directors, as needed and upon request.
3.25 The center collaborates with EMS agencies on stroke care.
3.26 The center has a process for initiation of palliative care and/or comfort care.

4. Minimum Requirements
4.1 The center performs a minimum of 15 thrombectomies annually, or 45 in 3 years.
4.2 The stroke program has an organized process, or a designated response team, for rapid evaluation and treatment of inpatients that develop stroke symptoms.
4.3 NIH Stroke Score is used in the Emergency Department (ED) and the inpatient setting as the primary neurologic assessment tool.
5. Performance Measurement and Quality Improvement
5.1 The center participates in the Idaho TSE Registry. At least 80% of cases are submitted within 180 days of hospital discharge.
5.2 The center meets the benchmark of door-to-needle time of less than 60 minutes with a 75% achievement rate and 45 minutes with a 50% achievement rate.
5.3 The center participates in their Regional TSE Committee.
5.4 The center must have a Performance Improvement (PI) program to ensure optimal care and continuous improvement of care.
5.5 The PI program is supported by a reliable method of internal data collection that consistently gathers valid and objective information necessary to analyze and identify opportunities for improvement.
5.6 System and process issues, clinical care issues, and all admission and transfer decisions must be reviewed by the PI program.
5.7 The center must use current clinical practice guidelines derived from evidence-based validation resources to achieve benchmark goals.
5.8 All process and outcome measures must be documented in a written PI plan.
5.9 The process of analysis occurs at regular intervals (at least quarterly) to meet the needs of the program.
5.10 The process demonstrates problem resolution (loop closure).
5.11 The center is able to identify the stroke patient population for review.
5.12 The center's PI program must work with receiving and transferring facilities to provide and obtain feedback on all transferred patients.
5.13 The PI program evaluates delays in availability of the Interventional suite.
5.14 Delays in Surgeon/Interventionalist response time must be monitored and reviewed for cause of delay and opportunities for improvement. Corrective actions must be documented.
5.15 Transfers within 24 hours to a higher level of care must be reviewed to determine the rationale for transfer, adverse outcomes, and opportunities for improvement.
5.16 The PI review is inclusive of all stroke admissions and transfers.
5.17 The center must have a policy to notify dispatch and EMS agencies when on divert status.

Designation Criteria for Level II Stroke Center

1. Personnel
1.1 The center has a Stroke Program Coordinator that is at minimum an RN.
1.2 The center has a Stroke Program Medical Director that must be a physician; a Neurologist or Neurosurgeon preferably but not required.
1.3 The Stroke Program Coordinator and Stroke Program Medical Director are responsible for program design, education, protocols, Performance Improvement (PI), program development, outreach, etc.
1.4 The center has organizational and administrative support.
1.5 The center has clinical Emergency Department (ED) personnel trained in diagnosing and treating acute stroke on-site 24/7.
2. Training and Education
2.1 The Stroke Program Medical Director has a minimum of 8 hours of annual stroke-related education.
2.2 The Stroke Program Coordinator has a minimum of 8 hours of annual education on stroke diagnosis and treatment.
2.3 All center staff are educated annually on the signs and symptoms of stroke and the process to activate emergency systems.
2.4 The Emergency Department (ED) and Stroke Unit's clinical staff demonstrate evidence of initial and annual training in the care of acute stroke patients.
2.5 The center provides annual public education on stroke-related topics such as disease prevention, risk factors, signs and symptoms, and 911 activation.
2.6 The center provides stroke education to stroke patients and their caregivers.
2.7 The center offers disease prevention for its employees at least annually.
3. Stroke Services
3.1 The center has a Neurologist or physician experienced in cerebrovascular care available 24/7 on-site or via telemedicine within 20 minutes of patient arrival with an 80% achievement rate.
3.2 The center has:
a. an Intensive Care Unit (ICU);
b. Physical Therapy;
c. Occupational Therapy; and
d. Speech Therapy.
3.3 The center has a CT tech on-site 24/7.

3.4 The center initiates CT or MRI within 20 minutes of patient arrival 24/7 with an 80% achievement rate.
3.5 The center has staff on-site or via telemedicine to interpret CT or MRI results within 45 minutes of patient arrival 24/7 with an 80% achievement rate.
3.6 The center has intracranial and extracranial vascular imaging.
3.7 The center has transesophageal and transthoracic echo.
3.8 The center has carotid artery duplex ultrasound imaging or other non-invasive vessel imaging.
3.9 The center has 12-lead ECG and chest x-ray capability 24/7.
3.10 The center has laboratory or point-of-care testing 24/7 with:
a. blood glucose results that are obtained and documented prior to initiation of thrombolytics;
b. results for CBC and coagulation labs are available in a median of 45 minutes or less from patient arrival; and
c. testing results do not delay initiation of thrombolytics.
3.11 The center has IV thrombolytic therapy, as endorse by current evidence-based guidelines, for stroke available 24/7.
3.12 Centers offering services beyond those required for their level of designation must have a written plan for provision and monitoring of those services consistent with the highest level of standards requiring that service.
3.13 The center has post discharge stroke services.
3.14 The center must have written stroke protocols, order sets, procedures, and/or algorithms for assessment and treatment of ischemic and hemorrhagic strokes which include:
a. stroke team activation process;
b. initial diagnostic tests;
c. administration of medication;
d. swallowing assessment prior to oral intake;
e. evaluation and treatment by Physical Therapy, Occupational Therapy, and/or Speech Therapy. Consider as a required reporting to state registry;
f. discharge order set, protocol, or process that includes consideration for antithrombotic therapy, statin therapy, or anticoagulants as needed for patients with atrial fibrillation (AFib) and toward patient education on secondary prevention and risk factors; and
g. referral to post discharge rehabilitation services if need identified.
3.15 The center's pharmacy is adequately staffed by qualified personnel to ensure effective medication management services including emergency services available 24/7.
3.16 The center has transfer protocols or guidelines that include criteria specific to transferring stroke patients including hemorrhagic stroke patients, stroke patients outside of the IV thrombolytic/endovascular treatment window, patients at high risk for decompensation, malignant edema or death, etc.

3.17 The center must have a written transfer protocol with at least one Level I Stroke Center. The transfer protocol must include communication with and feedback from the receiving center.
3.18 The center provides assistance with training and clinical education for Emergency Medical Services (EMS) agencies in coordination with the EMS Medical Directors, as needed and upon request.
3.19 The center collaborates with EMS agencies on stroke care.
3.20 The center has a process for initiation of palliative care and/or comfort care.
4. Minimum Requirements
4.1 The stroke program identifies clinical practice guidelines that are used to facilitate evidence-based clinical care.
4.2 The stroke program has an organized process, or a designated response team, for rapid evaluation and treatment of inpatients that develop stroke symptoms.
4.3 The stroke program will collect data on door-in-door-out times for patients transferred for endovascular therapy and hemorrhagic strokes.
4.4 NIH Stroke Score is used in the Emergency Department (ED) and the inpatient setting as the primary neurologic assessment tool.
5. Performance Measurement and Quality Improvement
5.1 The center participates in the Idaho TSE Registry. At least 80% of cases are submitted within 180 days of hospital discharge.
5.2 The center meets the benchmark of door-to-needle time of less than 45 minutes with a 50% achievement rate.
5.3 The center participates in their Regional TSE Committee.
5.4 The center must have a Performance Improvement (PI) program to ensure optimal care and continuous improvement of care.
5.5 The PI program is supported by a reliable method of internal data collection that consistently gathers valid and objective information necessary to analyze and identify opportunities for improvement.
5.6 System and process issues, clinical care issues, and all admission and transfer decisions must be reviewed by the PI program.
5.7 The center must use current clinical practice guidelines derived from evidence-based validation resources to achieve benchmark goals.
5.8 All process and outcome measures must be documented in a written PI plan.
5.9 The process of analysis occurs at regular intervals (at least quarterly) to meet the needs of the program.
5.10 The process demonstrates problem resolution (loop closure).
5.11 The center is able to identify the stroke patient population for review.
5.12 The center's PI program must work with receiving and transferring facilities to provide and obtain feedback on all transferred patients.

5.13 If available, the PI program evaluates OR availability and delays.
5.14 If available, delays in Surgeon/Interventionalist response time must be monitored and reviewed for cause of delay and opportunities for improvement. Corrective actions must be documented.
5.15 Transfers within 24 hours to a higher level of care must be reviewed to determine the rationale for transfer, adverse outcomes, and opportunities for improvement.
5.16 The PI review is inclusive of all stroke admissions and transfers.
5.17 The center must have a policy to notify dispatch and EMS agencies when on divert status.

Designation Criteria for Level III Stroke Center

1. Personnel
1.1 The center has a Stroke Program Coordinator (may use a system coordinator). The Stroke Program Coordinator shows evidence of educational preparation and clinical experience caring for stroke patients.
1.2 The center has a Stroke Program Medical Director (may use a system Medical Director). The Medical Director can be an advanced practice provider (APP), a medical doctor (MD), or a Doctor of Osteopathic (DO) and must have sufficient knowledge of cerebrovascular disease to provide administrative leadership, clinical guidance, and input to the program.
1.3 The Stroke Program Coordinator and Stroke Program Medical Director are responsible for program design, education, protocols, Performance Improvement (PI), program development, outreach, etc.
1.4 The center has organizational and administrative support.
2. Training and Education
2.1 The Stroke Program Medical Director has a minimum of 4 hours of annual stroke-related education.
2.2 The Stroke Program Coordinator has a minimum of 4 hours of annual education on stroke diagnosis and treatment.
2.3 All center staff are educated annually on the signs and symptoms of stroke and the process to activate emergency systems.
2.4 The Emergency Department (ED) and Stroke Unit's clinical staff demonstrate evidence of initial and annual training in the care of acute stroke patients.
2.5 The center provides annual public education on stroke-related topics such as disease prevention, risk factors, signs and symptoms, and 911 activation.
2.6 The center provides stroke education to stroke patients and their caregivers.
2.7 The center offers disease prevention for its employees at least annually.
3. Stroke Services
3.1 The center has a Neurologist or physician experienced in cerebrovascular care available 24/7 on-site or via telemedicine consult within 15 minutes of patient arrival with an 80% achievement rate.
3.2 The center has a CT tech available 24/7.
3.3 The center has staff on-site or via telemedicine to interpret CT results within 45 minutes of patient arrival 24/7 with an 80% achievement rate.
3.4 The center has 12-lead ECG and chest x-ray capability 24/7.

3.5 The center has laboratory or point-of-care testing 24/7 with:
a. blood glucose results that are obtained and documented prior to initiation of thrombolytics;
b. results for CBC and coagulation labs are available in a median of 45 minutes or less from patient arrival; and
c. testing results do not delay initiation of thrombolytics.
3.6 The center has IV thrombolytic therapy, as endorse by current evidence-based guidelines, for stroke available 24/7.
3.7 The center must have written stroke protocols, order sets, procedures, and/or algorithms for assessment and treatment of ischemic and hemorrhagic strokes which include:
a. stroke team activation process;
b. initial diagnostic tests;
c. administration of medication (including consultation with a Neurologist or with a Level I or II Stroke Center); and
d. swallowing assessment prior to oral intake.
e. if the center admits stroke patients for inpatient care, must also have written protocols, order sets, procedures, and/or algorithms for assessment and treatment of ischemic and hemorrhagic strokes which include:
i. process that is overseen and operationalized by Stroke Program leadership to ensure appropriateness of admission for inpatient management of non-thrombolytic, and if applicable, thrombolytic-eligible patients;
ii. evaluation and treatment by Physical Therapy, Occupational Therapy, and/or Speech Therapy. Consider as a required reporting to state registry;
iii. discharge order set, protocol, or process that includes consideration for antithrombotic therapy, statin therapy, or anticoagulants as needed for patients with atrial fibrillation (AFib) and toward patient education on secondary prevention and risk factors;
iv. referral to post discharge rehabilitation services if need identified; and
v. clinical staff providing inpatient care for stroke patients have evidence of initial and annual education on the care of stroke patients.
3.8 The center has transfer protocols or guidelines that include criteria specific to transferring stroke patients including hemorrhagic stroke patients, stroke patients outside of the IV thrombolytic/endovascular treatment window, patients at high risk for decompensation, malignant edema or death, etc.
3.9 The center must have a written transfer protocol with at least one Level I Stroke Center and one Level II Stroke Center. The transfer protocol must include communication with and feedback from the receiving center.
3.10 The center provides assistance with training and clinical education for Emergency Medical Services (EMS) agencies in coordination with the EMS Medical Directors, as needed and upon request.

3.11 The center collaborates with EMS agencies on stroke care.
4. Minimum Requirements
4.1 The stroke program has an organized process, or a designated response team, for rapid evaluation and treatment of inpatients that develop stroke symptoms.
4.2 NIH Stroke Score is used in the Emergency Department (ED) as the primary neurologic assessment tool.
5. Performance Measurement and Quality Improvement
5.1 The center participates in the Idaho TSE Registry. At least 80% of cases are submitted within 180 days of hospital discharge.
5.2 Door-to-needle time equal to or less than 60 minutes with a 50% achievement rate with progression toward a goal of equal to or less than 45 minutes in 50% of cases.
5.3 The center participates in their Regional TSE Committee.
5.4 The center must have a Performance Improvement (PI) program to ensure optimal care and continuous improvement of care.
5.5 The PI program is supported by a reliable method of internal data collection that consistently gathers valid and objective information necessary to analyze and identify opportunities for improvement.
5.6 System and process issues, clinical care issues, and all admission and transfer decisions must be reviewed by the PI program.
5.7 The center must use current clinical practice guidelines derived from evidence-based validation resources to achieve benchmark goals.
5.8 All process and outcome measures must be documented in a written PI plan.
5.9 The process of analysis occurs at regular intervals (at least quarterly) to meet the needs of the program.
5.10 The process demonstrates problem resolution (loop closure).
5.11 The center is able to identify the stroke patient population for review.
5.12 The center's PI program must work with receiving facilities to provide and obtain feedback on all transferred patients.
5.13 The PI review is inclusive of all stroke admissions and transfers.
5.14 The center must have a policy to notify dispatch and EMS agencies when on divert status.

XII. APPENDIX D: STEMI DESIGNATION REQUIREMENTS

Level I+ STEMI Center (Cardiogenic Shock Capable)

Designation Criteria for Level I STEMI Center Plus Cardiogenic Shock Capable

1. Personnel
1.1 The center has organizational and administrative support for the program.
1.2 The center has a Cardiac Care Coordinator that has sufficient resources to complete required tasks.
1.3 The center has a defined rapid response team that responds to cardiac emergencies within the facility.
1.4 The center has a defined cardiac care team that responds to cardiac emergencies within the Emergency Department (ED).
1.5 The center has a Cardiac Care Medical Director that is board-certified in cardiology or emergency medicine.
1.6 The center has physicians in the ED 24/7 who are board-certified or board-eligible in emergency medicine.
1.7 The center has an interventional cardiologist on-site within 30 minutes of STEMI activation.
1.8 The center has cardiac catheterization (cath) lab staff on-site within 30 minutes of STEMI activation.
2. Training and Education
2.1 The physicians, advanced practice providers, and registered nurses (RNs) on the rapid response and cardiac care teams are current in Advanced Cardiac Life Support (ACLS) or equivalent.
2.2 All center ED RNs are current in ACLS training or equivalent.
2.3 All center staff must complete annual education on the signs and symptoms of Acute Coronary Syndrome (ACS) and the process to activate emergency systems.
2.4 The Cardiac Care Medical Director must have a minimum of 18 hours in 3 years of cardiac-related continuing education.
2.5 The Cardiac Care Coordinator must have a minimum of 18 hours in 3 years of education addressing ACS.
2.6 RNs on the cardiac care team complete annual education or training in identifying dysrhythmias, symptoms of ACS, and current American Heart Association (AHA) ACS guidelines.

2.7 The center offers tobacco cessation, nutrition, and other heart-healthy education for its employees and the community at least annually.
2.8 The center provides annual public education on cardiovascular disease prevention, risk factors, the signs and symptoms of heart attack, and the importance of learning CPR and 911 activation.
2.9 The center provides assistance with training and clinical education for Emergency Medical Services (EMS) agencies in coordination with the EMS Medical Directors, as needed and upon request.
3. STEMI Services
3.1 The center's pharmacy is adequately staffed by qualified personnel to ensure effective medication management services 24/7.
3.2 The center has Food and Drug Administration (FDA)-approved fibrinolytic therapy available 24/7.
3.3 The center has a Targeted Temperature Management (TTM) process that follows current AHA guidelines.
3.4 The center has a process for activating the cardiac care team for patients who arrive via EMS and patients who "walk-in".
3.5 The center has a written process for: ACS, STEMI, triage for "walk-ins" presenting with symptoms of ACS, fibrinolytic therapy, initiation of post arrest care based on current AHA guidelines, and transfer guidelines.
3.6 The center has cardiac surgery capabilities or a transfer process with a cardiac surgery center via an appropriately trained EMS agency.
3.7 The center collaborates with EMS agencies on ACS care.
3.8 The center has an intensive or critical care unit.
3.9 The center has a process map outlining the flow from patient's first medical contact for EMS, ED "walk-ins", and transfer through cath lab arrival.
3.10 The center has written agreements or an auto-accept process to accept all STEMI referrals.
3.11 The center has a no-divert policy for all patients who meet STEMI activation criteria and a backup plan with a communication strategy for situations when the hospital's cardiac care resources are temporarily unavailable.
4. Minimum Requirements
4.1 The center performs the minimum procedural volume:
a. annual PCI institutional volume equal to or greater than 400;
b. annual primary PCI institutional volume equal to or greater than 36;
c. annual PCI provider volume equal to or greater than 50; and
d. annual primary PCI provider volume equal to or greater than 11.
4.2 The center has the following support resources:

a. advanced hemodynamic resources with biventricular support;
b. cardiac surgery on-site;
c. cardiogenic shock support team;
d. comprehensive post arrest care including TTM;
e. intensive care units that support cardiothoracic and coronary patients;
f. locally available cardiac rehabilitation services; and
g. agreement with an air medical agency trained in the transport of advanced circulatory support patients or processes to support hospital staff assisted transport.
5. Performance Measurement and Quality Improvement
5.1 The center participates in the Idaho TSE Registry. At least 80% of cases are submitted within 180 days of hospital discharge. Participation in a national registry and CARES is recommended, but not required.
5.2 The center participates in their Regional TSE Committee.
5.3 The center must have a Performance Improvement (PI) program to ensure optimal care and continuous improvement of care.
5.4 The PI program is supported by a reliable method of internal data collection that consistently gathers valid and objective information necessary to analyze and identify opportunities for improvement.
5.5 System and process issues, clinical care issues, and all admission and transfer decisions must be reviewed by the PI program.
5.6 The STEMI program must use current clinical practice guidelines derived from evidence-based validation resources to achieve benchmark goals.
5.7 All process and outcome measures must be documented in a written PI plan.
5.8 The process of analysis occurs at regular intervals (at least quarterly) to meet the needs of the program.
5.9 The process demonstrates problem resolution (loop closure).
5.10 The center is able to identify the STEMI patient population for review.
5.11 The center's PI program must work with transferring facilities to provide and obtain feedback on all transferred patients.
5.12 The PI review is inclusive of all STEMI admissions and transfers.
5.13 Delays in cath lab team response time must be monitored and reviewed for cause of delay and opportunities for improvement.
5.14 The center achieves first medical contact-to-device time in less than 90 minutes in 85% of EMS and "walk-in" cases. This excludes cases with a transport time more than 30 minutes.
5.15 The program has a goal for transfer patients of door-to-door-to-device (D2D2D) in less than 120 minutes with processes in place to work with transferring EMS agencies.

Designation Criteria for Level I STEMI Center

1. Personnel
1.1 The center has organizational and administrative support for the program.
1.2 The center has a Cardiac Care Coordinator that has sufficient resources to complete required tasks.
1.3 The center has a defined rapid response team that responds to cardiac emergencies within the facility.
1.4 The center has a defined cardiac care team that responds to cardiac emergencies within the Emergency Department (ED).
1.5 The center has a Cardiac Care Medical Director that is board-certified in cardiology or emergency medicine.
1.6 The center has physicians in the ED 24/7 who are board-certified or board-eligible in emergency medicine.
1.7 The center has an interventional cardiologist on-site within 30 minutes of STEMI activation.
1.8 The center has cardiac catheterization (cath) lab staff on-site within 30 minutes of STEMI activation.
2. Training and Education
2.1 The physicians, advanced practice providers, and registered nurses (RNs) on the rapid response and cardiac care teams are current in Advanced Cardiac Life Support (ACLS) or equivalent.
2.2 All center ED RNs are current in ACLS training or equivalent.
2.3 All center staff must complete annual education on the signs and symptoms of Acute Coronary Syndrome (ACS) and the process to activate emergency systems.
2.4 The Cardiac Care Medical Director must have a minimum of 18 hours in 3 years of cardiac-related continuing education.
2.5 The Cardiac Care Coordinator must have a minimum of 18 hours in 3 years of education addressing ACS.
2.6 RNs on the cardiac care team complete annual education or training in identifying dysrhythmias, symptoms of ACS, and current American Heart Association (AHA) ACS guidelines.
2.7 The center offers tobacco cessation, nutrition, and other heart-healthy education for its employees and the community at least annually.
2.8 The center provides annual public education on cardiovascular disease prevention, risk factors, the signs and symptoms of heart attack, and the importance of learning CPR and 911 activation.

2.9 The center provides assistance with training and clinical education for Emergency Medical Services (EMS) agencies in coordination with the EMS Medical Directors, as needed and upon request.
3. STEMI Services
3.1 The center's pharmacy is adequately staffed by qualified personnel to ensure effective medication management services 24/7.
3.2 The center has Food and Drug Administration (FDA)-approved fibrinolytic therapy available 24/7.
3.3 The center has a Targeted Temperature Management (TTM) process that follows current AHA guidelines.
3.4 The center has a process for activating the cardiac care team for patients who arrive via EMS and patients who "walk-in".
3.5 The center has a written process for: ACS, STEMI, triage for "walk-ins" presenting with symptoms of ACS, fibrinolytic therapy, initiation of post arrest care based on current AHA guidelines, and transfer guidelines.
3.6 The center has cardiac surgery capabilities or a transfer process with a cardiac surgery center via an appropriately trained EMS agency.
3.7 The center collaborates with EMS agencies on ACS care.
3.8 The center has an intensive or critical care unit.
3.9 The center has a process map outlining the flow from patient's first medical contact for EMS, ED "walk-ins", and transfer through cath lab arrival.
3.10 The center has written agreements or an auto-accept process to accept all STEMI referrals.
3.11 The center has a no-divert policy for all patients who meet STEMI activation criteria and a backup plan with a communication strategy for situations when the hospital's cardiac care resources are temporarily unavailable.
4. Minimum Requirements
4.1 The center must have performed a minimum of 36 percutaneous coronary intervention (PCI) procedures for STEMI during the most recent rolling 12-month period.
5. Performance Measurement and Quality Improvement
5.1 The center participates in the Idaho TSE Registry. At least 80% of cases are submitted within 180 days of hospital discharge. Participation in a national registry and CARES is recommended, but not required.
5.2 The center participates in their Regional TSE Committee.
5.3 The center must have a Performance Improvement (PI) program to ensure optimal care and continuous improvement of care.
5.4 The PI program is supported by a reliable method of internal data collection that consistently gathers valid and objective information necessary to analyze and identify opportunities for improvement.

5.5 System and process issues, clinical care issues, and all admission and transfer decisions must be reviewed by the PI program.
5.6 The STEMI program must use current clinical practice guidelines derived from evidence-based validation resources to achieve benchmark goals.
5.7 All process and outcome measures must be documented in a written PI plan.
5.8 The process of analysis occurs at regular intervals (at least quarterly) to meet the needs of the program.
5.9 The process demonstrates problem resolution (loop closure).
5.10 The center is able to identify the STEMI patient population for review.
5.11 The center's PI program must work with transferring facilities to provide and obtain feedback on all transferred patients.
5.12 The PI review is inclusive of all STEMI admissions and transfers.
5.13 Delays in cath lab team response time must be monitored and reviewed for cause of delay and opportunities for improvement.
5.14 The center achieves first medical contact-to-device time in less than 90 minutes in 85% of EMS and "walk-in" cases. This excludes cases with a transport time more than 30 minutes.
5.15 The program has a goal for transfer patients of door-to-door-to-device (D2D2D) in less than 120 minutes with processes in place to work with transferring EMS agencies.

Designation Criteria for Level II STEMI Center

1. Personnel
1.1 The center has organizational and administrative support for the program.
1.2 The center has a Cardiac Care Coordinator that has sufficient resources to complete required tasks.
1.3 The center has a defined rapid response team that responds to cardiac emergencies within the facility.
1.4 The center has a defined cardiac care team that responds to cardiac emergencies within the Emergency Department (ED).
1.5 The center has a board-certified emergency room physician or an Advanced Cardiac Life Support (ACLS)-certified physician who oversees cardiac care.
2. Training and Education
2.1 The physicians, advanced practice providers, and registered nurses (RNs) on the rapid response and cardiac care teams are current in Advanced Cardiac Life Support (ACLS) or equivalent.
2.2 All center ED RNs are current in ACLS training or equivalent.
2.3 All center staff must complete annual education on the signs and symptoms of Acute Coronary Syndrome (ACS) and the process to activate emergency systems.
2.4 The Cardiac Care Medical Director must have a minimum of 18 hours in 3 years of cardiac-related continuing education.
2.5 The Cardiac Care Coordinator must have a minimum of 18 hours in 3 years of education addressing ACS.
2.6 RNs on the cardiac care team complete annual education or training in identifying dysrhythmias, symptoms of ACS, and current American Heart Association (AHA) ACS guidelines.
2.7 The center offers tobacco cessation, nutrition, and other heart-healthy education for its employees and the community at least annually.
2.8 The center provides annual public education on cardiovascular disease prevention, risk factors, the signs and symptoms of heart attack, and the importance of learning CPR and 911 activation.
2.9 The center provides assistance with training and clinical education for Emergency Medical Services (EMS) agencies in coordination with the EMS Medical Directors, as needed and upon request.
3. STEMI Services
3.1 The center's pharmacy is adequately staffed by qualified personnel to ensure effective medication management services 24/7.

3.2 The center has Food and Drug Administration (FDA)-approved fibrinolytic therapy available 24/7.
3.3 The center has a Targeted Temperature Management (TTM) process that follows current AHA guidelines.
3.4 The center has a process for activating the cardiac care team for patients who arrive via EMS and patients who "walk-in".
3.5 The center has a written process for: ACS, STEMI, triage for "walk-ins" presenting with symptoms of ACS, fibrinolytic therapy, initiation of post arrest care based on current AHA guidelines, and transfer guidelines.
3.6 The center has a transfer process in place for rapid transfer of patients requiring a higher level of care.
3.7 The center collaborates with EMS agencies on ACS care.
3.8 The center has a process map outlining the flow from patient's first medical contact to transfer for any STEMI patient that arrives at their facility.
4. This Section Left Intentionally Blank
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5. Performance Measurement and Quality Improvement
5.1 The center participates in the Idaho TSE Registry. At least 80% of cases are submitted within 180 days of hospital discharge.
5.2 The center participates in their Regional TSE Committee.
5.3 The center must have a Performance Improvement (PI) program to ensure optimal care and continuous improvement of care.
5.4 The PI program is supported by a reliable method of internal data collection that consistently gathers valid and objective information necessary to analyze and identify opportunities for improvement.
5.5 System and process issues, clinical care issues, and all admission and transfer decisions must be reviewed by the PI program.
5.6 The STEMI program must use current clinical practice guidelines derived from evidence-based validation resources to achieve benchmark goals.
5.7 All process and outcome measures must be documented in a written PI plan.
5.8 The process of analysis occurs at regular intervals (at least quarterly) to meet the needs of the program.
5.9 The process demonstrates problem resolution (loop closure).
5.10 The center is able to identify the STEMI patient population for review.
5.11 The center's PI program must work with receiving facilities to provide and obtain feedback on all transferred patients.
5.12 The PI review is inclusive of all STEMI admissions and transfers.
5.13 The center must have a policy to notify dispatch and EMS agencies when on divert status.

XIII. TSE EMS DESIGNATIONS

Application Process

A licensed Idaho Emergency Medical Services (EMS) agency seeking a TSE designation must undergo the Idaho TSE Council verification to demonstrate compliance with the standards incorporated by the TSE Council.

To apply for a TSE EMS Designation as a BLS, ILS, or ALS level of licensure, the following is required:

- The EMS agency must be currently licensed in Idaho and must have at least one of the following 911 response agency:
  a. Prehospital-Transport
  b. Prehospital-Support
  c. Prehospital-Non-transport
  d. Air Medical-Transport
- Submit a completed application in IGEMS at the level of licensure; and
- Consent to verification site visits as determined by the TSE Council.

Once verified by the TSE Council, the agency will be designated for three (3) years, unless the designation is rescinded by the TSE Council for non-compliance.

Revocation and Negotiated Probationary Status

Any TSE designated EMS agency that has a loss of licensure or is found to no longer meet the standards for verification shall be reported to the TSE Council by contacting the Bureau of Emergency Medical Services staff. The TSE Council may elect to revoke the EMS agency's TSE designation or place on negotiated probationary status. If the EMS agency's TSE designation is placed on negotiated probationary status, the EMS agency must cooperate with the TSE Council to develop and implement the following:

- The agency's plan to achieve compliance;
- The timeline required for the agency to achieve compliance; and
- The methods by which the agency's progress to achieve compliance will be verified by the TSE Council.

Negotiated probationary status shall be valid for a maximum of one year.

- If an EMS agency is found to have achieved compliance, the agency's TSE designation will be removed from negotiated probationary status and restored in good standing.
- If an EMS agency is found to remain noncompliant at the end of one year, the TSE designation of that agency will be rescinded.
- A licensed EMS agency which has their TSE designation rescinded by the TSE Council will be eligible to reapply for TSE designation one year from the date the TSE designation was rescinded. Completion of the initial application process for TSE designation will be required.
- TSE EMS designations in negotiated probationary status will be kept confidential.

Fees

There are no designation fees associated with TSE EMS Designations. This designation will be voluntary and free to any qualified agency. Once verified, the TSE Council will send a certificate of designation and a set of stickers to be placed on the agency's emergency vehicles. The agency may purchase additional stickers by contacting the Bureau of Emergency Medical Services.

XIV. APPENDIX E: TSE EMS DESIGNATION REQUIRMENTS

TSE BLS EMS Agency

Designation Criteria for TSE BLS EMS Agency

Criteria for designation of a TSE Basic Life Support (BLS) EMS Agency are the recommendations based upon the EMS Advisory Committee. Criteria verify the services and systems are in place to ensure optimal care of a patient exhibiting either trauma, stroke or heart attack (a.k.a. STEMI) symptoms. Each standard must be met for approval as a TSE EMS designated agency.

Criteria Element
1. The agency must be in compliance with all requirements for EMS agency licensure by the Bureau of Emergency Medical Services as specified in IDAPA 15.06.07.
2. The agency must have policies, protocols, and/or procedures addressing trauma, stroke, and STEMI care including transport to the closest appropriate facility and provide annual training on such.
3. The agency must be an active and participating member of their TSE Regional Committee and participate in the regional QI process. An agency representative or designee must attend 50% of these meetings either by call-in or in-person.
4. The agency must demonstrate their local QI process that clearly evaluates trauma, stroke, and STEMI patients.
5. The agency must demonstrate collaborative relationships with a local facility and/or regional TSE designated facilities.
6. The agency must demonstrate consistent medical director involvement working to achieve TSE standards.
7. The agency must collect, track, and provide TSE with the following data annually to their TSE Regional Committee. The agency must create a QI process that demonstrates compliance with the following goals:
a. documented use of a recognized stroke scale on patients with primary impression of CVA at least 90% of the time;
b. documented “Last Known Well” time for patients with primary impression of CVA at least 90% of the time;
c. aspirin administration or documentation of contraindications, within 10 minutes of patient contact, for cardiac-related chest pain (suspected MI) at least 75% of the time;
d. on scene times less than 15 minutes or documented delays with cardiac-related chest pain (suspected MI) at least 90% of the time; or acquisition of a 12-lead EKG, within 10 minutes of patient contact, at least 75% of the time for cardiac-related chest pain (suspected MI) *applicable for transport agencies only;
e. on scene times less than 15 minutes or documented delays for full trauma activations at least 75% of the time *applicable for transport agencies only;

f. on scene times less than 15 minutes or documented delays for stroke activations at least 90% of the time *applicable for transport agencies only;
g. documentation that field providers are notifying receiving facility/agency of trauma, stroke, and STEMI activation at least 90% of the time; and
h. obtain and document blood glucose level in suspected stroke patients at least 90% of the time.
8. The agency must provide documentation that all EMS personnel obtain CPR training at least once every two years.

Designation Criteria for TSE ILS EMS Agency

Criteria for designation of a TSE Intermediate Life Support (ILS) EMS Agency are the recommendations based upon the EMS Advisory Committee. Criteria verify the services and systems are in place to ensure optimal care of a patient exhibiting either trauma, stroke or heart attack (a.k.a. STEMI) symptoms. Each standard must be met for approval as a TSE EMS designated agency.

Criteria Element
1. The agency must be in compliance with all requirements for EMS agency licensure by the Bureau of Emergency Medical Services as specified in IDAPA 15.06.07.
2. The agency must have policies, protocols, and/or procedures addressing trauma, stroke, and STEMI care including transport to the closest appropriate facility and provide annual training on such.
3. The agency must be an active and participating member of their TSE Regional Committee and participate in the regional QI process. An agency representative or designee must attend 50% of these meetings either by call-in or in-person.
4. The agency must demonstrate their local QI process that clearly evaluates trauma, stroke, and STEMI patients.
5. The agency must demonstrate collaborative relationships with a local facility and/or regional TSE designated facilities.
6. The agency must demonstrate consistent medical director involvement working to achieve TSE standards.
7. The agency must collect, track, and provide TSE with the following data annually to their TSE Regional Committee. The agency must create a QI process that demonstrates compliance with the following goals:
a. documented use of a recognized stroke scale and LVO assessment on patients with primary impression of CVA at least 90% of the time;
b. documented “Last Known Well” time for patients with primary impression of CVA at least 90% of the time;
c. aspirin administration or documentation of contraindications, within 10 minutes of patient contact, for cardiac-related chest pain (suspected MI) at least 75% of the time;
d. on scene times less than 15 minutes or documented delays with cardiac-related chest pain (suspected MI) at least 90% of the time; or acquisition of a 12-lead EKG, within 10 minutes of patient contact, at least 75% of the time for cardiac-related chest pain (suspected MI) *applicable for transport agencies only;
e. on scene times less than 15 minutes or documented delays for full trauma activations at least 75% of the time *applicable for transport agencies only;
f. on scene times less than 15 minutes or documented delays for stroke activations at least 90% of the time *applicable for transport agencies only;

g. documentation that field providers are notifying receiving facility/agency of trauma, stroke, and STEMI activation at least 90% of the time; and
h. obtain and document blood glucose level in suspected stroke patients at least 90% of the time.
8. The agency must provide documentation that all EMS personnel obtain CPR training at least once every two years. Advanced '85s must be trained in aspirin administration optional module.

Designation Criteria for TSE ALS EMS Agency

Criteria for designation of a TSE Advanced Life Support (ALS) EMS Agency are the recommendations based upon the EMS Advisory Committee. Criteria verify the services and systems are in place to ensure optimal care of a patient exhibiting either trauma, stroke or heart attack (a.k.a. STEMI) symptoms. Each standard must be met for approval as a TSE EMS designated agency.

Criteria Element
1. The agency must be in compliance with all requirements for EMS agency licensure by the Bureau of Emergency Medical Services as specified in IDAPA 15.06.07.
2. The agency must have policies, protocols, and/or procedures addressing trauma, stroke, and STEMI care including transport to the closest appropriate facility and provide annual training on such.
3. The agency must be an active and participating member of their TSE Regional Committee and participate in the regional QI process. An agency representative or designee must attend 50% of these meetings either by call-in or in-person.
4. The agency must demonstrate their local QI process that clearly evaluates trauma, stroke, and STEMI patients.
5. The agency must demonstrate collaborative relationships with a local facility and/or regional TSE designated facilities.
6. The agency must demonstrate consistent medical director involvement working to achieve TSE standards.
7. The agency must collect, track, and provide TSE with the following data annually to their TSE Regional Committee. The agency must create a QI process that demonstrates compliance with the following goals:
a. documented use of a recognized stroke scale and LVO assessment on patients with primary impression of CVA at least 90% of the time;
b. documented “Last Known Well” time for patients with primary impression of CVA at least 90% of the time;
c. aspirin administration or documentation of contraindications, within 10 minutes of patient contact, for cardiac-related chest pain (suspected MI) at least 75% of the time;
d. acquisition of a 12-lead EKG, within 10 minutes of patient contact, at least 75% of the time for cardiac-related chest pain (suspected MI);
e. on scene times less than 15 minutes or documented delays for full trauma activations at least 75% of the time *applicable for transport agencies only;
f. on scene times less than 15 minutes or documented delays for stroke activations at least 90% of the time *applicable for transport agencies only;

g. documentation that field providers are notifying receiving facility/agency of trauma, stroke, and STEMI activation at least 90% of the time; and
h. obtain and document blood glucose level in suspected stroke patients at least 90% of the time.