

## FREQUENTLY ASKED QUESTIONS

### Admission of trauma patients to non-trauma service

- Can a trauma patient be admitted to a non-trauma service, i.e., a hospitalist? A trauma patient that also has significant medical issues/co-morbidities should be admitted to a trauma service (general surgery, orthopedics, neurosurgery) for at least the first 24 hours, and the hospitalist can be consulted for the other conditions. If the trauma is stabilized after 24 hours, the patient can be transferred to the care of the hospitalist, internal medicine, etc., as their condition warrants. If the surgeon determines there is no traumatic injury, and the only reason to admit is complications from existing conditions, then the hospitalist could be the attending physician. However, it must be the trauma surgeon, not the ER physician, who physically examines the patient (no telephone consults or at-home image reads) and determines that there is no traumatic injury, and directs the downgrade and transfer of the patient's care to a hospitalist. This is especially difficult in Bravo cases where EMS makes a Bravo determination in the field based on mechanism; MVC with significant intrusion, no visible signs of injury, only complaints of pain, and the patient has significant co-morbidities that preclude them from being discharged to home for follow-up at a later time. While there is no absolute answer, it would be more appropriate for the ED physician to admit the patient to a trauma service for at least 24 hours, or call in a trauma service physician to direct the admission.
- How many trauma patients can be admitted to a hospitalist? Monitoring the trauma patients who are admitted to a non-trauma service is a key component of Performance Improvement. If you are able to explain the reasoning behind this decision for appropriate and good patient care, you should meet the expectation of the surveyors. ACS predicts about a 10% admit rate to services other than trauma, so you could use this as a benchmark in comparison to your rate.

### Education Requirements

- If a physician extender is assigned to another department within the hospital and is called to the ED to assist in the care of a trauma patient (ED is full), is that practitioner required to have ATLS? **No.**
- Are Nurse-Practitioners working in the emergency department required to take Advanced Trauma Life Support (ATLS) training? **Nurse-Practitioners (mid-level providers) assigned to the ED must have either ATLS or the Rural Trauma Course (RTC).** If a NP is assigned to a "fast-track" area that is physically separated from the ER, they do not have to have ATLS or RTC. However, if everyone works out of the same general ED, regardless if certain rooms are designated as "fast-track," then they must have either ATLS or RTC.

## EMTALA

- Are the destination guidelines accepted under EMTALA? [The State Trauma Plan, which includes the system regulations, the regional trauma plans, and the EMS destination guidelines, is recognized as a community plan by CMS.](#)
- Would it be a violation of EMTALA for the ED physician to assist the EMS provider in establishing an airway (intubation) without admitting the patient to the ED? [Yes.](#)
- For example, EMS provider diverts to closest facility due to unsecured airway, ED physician goes outside and intubates the patient in the ambulance and directs EMS to continue transport to a higher level of care? [If EMS brings the patient to a hospital en route for stabilizing care, whether or not removed from the ambulance stretcher, that patient has “come to the emergency department” under the definition of the EMTALA law. As such, that hospital has an obligation under EMTALA to medically screen and stabilize the patient within the capability and capacity of the facility. The patient could then be appropriately transferred under the EMTALA law if the physician made the judgment that immediate transfer was in the best interests of the patient and certified that the benefits of immediate transfer outweighed the risks of further delay in higher level care and that the mode of transport and personnel were appropriate.](#)
- [EMTALA Interpretive Guidelines can be found at: <http://www.cms.gov/RegulationsandGuidance/Legislation/EMTALA/index.html>](#)
- If a general surgeon, orthopedic surgeon (or other physician specialty) is on call and the ED physician requests that he/she responds, are they required to do so? [Yes.](#)
- Is it acceptable, or required, to delay the transport of the patient to complete any hospital documentation? [If it were not in the interests of the patient to delay transfer pending completion of paperwork, the assisting hospital could fax or otherwise securely transmit \(electronically, etc\) the records of care to the final receiving hospital trauma center. It is perfectly acceptable to “stabilize and ship” if the medical determination is that the benefits outweigh the risks. The focus in any decision is the best interest of the patient. The patient should be logged in as a hospital ER visit and medical treatment documented. Evidence that the benefits outweighed the risks of immediate transfer should be documented.](#)
- Is EMS required to leave a run-sheet with the assisting hospital? [Although not required by EMTALA, the safest course would be to complete a run sheet for each leg of the trip.](#)

## Field Triage

- Is EMS required to be compliant with the guidelines? [Yes.](#)

- Who determines compliance? State, Region, both? Compliance starts with the EMS provider. Additionally, a hospital that receives a patient that should have gone to a higher level of care, i.e., an Alpha trauma patient being transported to a Level IV Trauma Center, has the obligation to notify both the EMS provider and the region of the incident. The Bureau of EMS has a full-time compliance officer to investigate violations of the regulations, including destination guidelines.
- Is it acceptable for the EMS provider to transport a patient meeting Alpha or Bravo criteria to a Level IV if the facility has the resources needed to provide definitive care to the patient? (This question excludes patients meeting the following criteria: cardiac arrest, unsecured/non-patent airway and EMS provider safety at risk.) No. The destination guidelines state that Alpha and Bravo patients should be transported to Level III or higher Trauma Centers.

#### **Level IV evaluations conducted by Region Director (Rule 1.5.10)**

- Is this required? Yes.
- If required, what criteria should be evaluated? The primary purpose of this visit will be to ensure compliance with the regulations, with particular emphasis on practitioner training; protocols and procedures; and performance improvement (Rule 1.5.10).

#### **Partial Capability (Rule 1.2.17)**

- Is compliance required? Yes.
- If compliance is required, who is responsible for monitoring compliance? State, Region, both? Compliance starts with the hospital PI process. From there, it goes to the region for review. If the region is satisfied that the standards of care have been met, no further review is required. If the region recommends further review, the case will go to the State Trauma PI Committee. If the committee determines that the standard of care has been met, no further review is required. If the committee determines that there has been a violation of the regulation, the case will be referred to the Division of Trauma for investigation.
- If Region is responsible for monitoring trauma center compliance, what is the Department's expectation of the Trauma Region in efforts to promote compliance? The expectation is that the region will comply with, and enforce the regulations of the system and the statutes of the state in accordance with their contract with the Department of Health. Every region has developed a compliance policy and is expected to enforce that policy. When a region finds that it cannot promote compliance from a hospital, it has the obligation to inform the Division of Trauma.
- Would the Department seek corrective action measures from a Trauma Center that is noncompliant with the rule? Yes.

- What are the specific policies, procedures, guidelines, protocols, equipment, education that would be required? In general, a Level IV Trauma Center would have to comply with the policies, procedures, guidelines, protocols, equipment, education, etc., required of a Level III Trauma Center if they kept surgical/orthopedic trauma patients. A Level III Trauma Center would be required to comply with the policies, procedures, guidelines, protocols, equipment, education, etc., of a Level II Trauma Center, if they kept neurosurgical trauma patients.
- Are Level IV Trauma Centers expected to meet the physician response times that are outlined in the Level III regulations, if those services are utilized? Yes.
- If utilized, when does the measurement of response time begin? EMS notification or patient arrival, whichever is sooner (Rule 4.2.1).

### **Pediatric Trauma Centers**

- Is it permissible to admit pediatric trauma patients to Level IV trauma centers? No.
- If so, are there any special conditions? Pediatric trauma patients with isolated orthopedic injuries may only be kept at Secondary Pediatric Trauma Centers; to qualify as a Secondary Pediatric Trauma Center, the hospital must be designated as a Level III or higher adult Trauma Center (Rule 6.2.1).
- Does partial capability rule apply? No.
- Is it permissible to admit pediatric trauma patients to a Level III Trauma Center if the patient has injuries other than isolated orthopedic injuries? Yes, surgical patients may be kept.
- If so, are there any special conditions? Yes, the hospital must be designated as a Secondary Pediatric Trauma Center and all pediatric trauma admissions will be reviewed by the PI process.
- Does partial capability rule apply? No.

### **Physician call at multiple Trauma Centers**

- Can physicians take trauma call at multiple trauma centers? Level I and II trauma centers are required to have Trauma/General Surgeons “unencumbered” when on call; this means they cannot take call at more than one trauma center at the same time. Anesthesia must be in-house 24/7, which also precludes call at multiple facilities. The regulations state that it is desirable that Orthopedic surgeons and Neurosurgeons be dedicated to a single trauma center, or there must be a published back-up schedule. Practically, we hold orthopedics and neurosurgery to the same standard as the trauma surgeon and anesthesia: they must be dedicated to one facility per day while on call. This does not mean that

they cannot practice or take call at multiple facilities, but that they cannot take call at more than one facility at the same time.

The reason for this is very simple: Generally speaking, there is only one physician of each specialty on trauma call at each hospital. When a physician is treating a trauma patient, that particular trauma center essentially goes on “trauma divert” for a period of time, depending on the severity and complexity of the patient’s injuries. If a physician is taking simultaneous call at multiple trauma centers, the system loses two (or more) trauma centers due to lack of physician coverage, not just one. With only 23 Level I-III trauma centers in the entire system, allowing physicians to take multiple call is a risk the system cannot accept.

Level III trauma centers do not have the same restrictions on physician call coverage as do Level I and II trauma centers, however, we strongly discourage multiple call.