TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH LICENSURE AND REGULATION
OFFICE OF EMERGENCY MEDICAL SERVICES
665 MAINSTREAM DRIVE, 2ND FLOOR
NASHVILLE, TENNESSEE 37243
TELEPHONE: (615) 741-2584

APPLICATION FOR TRAUMA CENTER DESIGNATION

Name of Facility: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Chief Executive Officer: _____

Designation Process Requested For:

Level I ☐ Level II ☐ Level III ☐ Level IV ☐

I certify that this is an accurate and complete representation of the intent of this facility for trauma center designation.

_____
Name of Person Coordinating Application

_____
Signature

_____
Date

Instructions

Complete the application and attach the required documentation. Descriptions of various aspects of your facility's trauma program are requested. The purpose of the descriptions is twofold; to ensure the minimum criteria are in place before the site visit and to allow the site reviewers to become familiar with how your institution manages trauma patients. For these reasons, be brief yet detailed in your descriptions for the required criteria while you address each subject. Please provide an organized binder with appropriate tabs that contain the necessary requested information. Feel free to attach documentation that is not specifically requested if you feel that it will better illustrate or describe a component of your trauma program.

Since this application is for initial designation, it is expected that some of the requested information may not yet be available. In these specific circumstances, criteria deficiencies will not be a barrier to initial designation if it is clear that the facility is making a good-faith effort to implement these elements of the program. Refer to Table 1 for direction as to how to deal with these issues.

Table 1:

Program Criteria	Deficiency	Action	Evaluation
Performance Improvement Data	Hospital has no data with respect to the number of trauma team activations, transfers or diversion occurrences in the last year.	Establish a process to track and collect this data.	Site reviewers will ask to see data on the number of activations, transfers and diversion occurrences since application was made.
Trauma Registry	Hospital is not using a registry; not collecting or reporting trauma data to the state trauma registry.	Contact office of EMS trauma program staff for assistance in submission of trauma registry data.	Site reviewers will ask to see evidence that the facility is using an established registry and submitting appropriately.
Morbidity And Mortality Review and Multidisciplinary Trauma Review Committees	Hospital does not have formal peer review and multidisciplinary review committees established and meeting regularly; no documentation of committee activities.	Establish a process for peer review and multidisciplinary review of trauma care; schedule meetings. (Members may not have had their first meeting at the time of application.)	Site reviewers will ask to see the minutes of the meetings that have taken place since the date of application.

Please provide four (4) binders for review by the site evaluation team. The application binders may be provided in hard copy or electronic copy submitted to the state Trauma System Manager at:

Tennessee Department of Health
Office of Emergency Medical Services
665 Mainstream Drive, 1st Floor
Nashville, TN 37243

If electronic submission is elected please email to: robert.seesholtz@tn.gov.

A. Trauma Center Organization – Tab A

Identify the director (chief) of the following departments or services and attach curriculum vitae detailing medical post graduate training and experience. Indicate the number of medical staff assigned by service and specialty and attach a detailed listing with names, including resident physicians.

LEVEL I Required Trauma Center Departments/Services	Director or Contact Physician	Number of Physicians Assigned to Service
1. Trauma Service		
2. Emergency Department		
3. Intensive Care Unit		
4. Surgical Services:		
a. Cardiothoracic		
b. General		
c. Microsurgery Capabilities		
d. Neurologic		
e. OB-GYN		
f. Ophthalmic		
g. Oral-Maxillofacial		
h. Orthopedic		
i. Orthopedic Sub/Hand		
j. Otorhinolaryngologic		
k. Pediatric		
l. Plastic		
m. Urologic		
5. Medical Services:		
a. Anesthesiology		
b. Cardiology		
c. Gastroenterology		
d. Hematology		
e. Infectious Diseases		
f. Internal Medicine		
g. Nephrology		
h. Pathology		
i. Pediatrics		
j. Psychiatry		
k. Pulmonary		
l. Radiology		
6. Clinical Laboratory Services		

LEVEL II Required Trauma Center Departments/Services	Director or Contact Physician	Number of Physicians Assigned to Service
1. Trauma Service		
2. Emergency Department		

3. Intensive Care Unit		
4. Surgical Services:		
a. Cardiothoracic		
b. General		
c. Neurologic		
d. Orthopedic		
5. Medical Services:		
a. Anesthesiology		
b. Cardiology		
c. Gastroenterology		
d. Hematology		
e. Infectious Diseases		
f. Internal Medicine		
g. Nephrology		
h. Pathology		
i. Pediatrics		
j. Psychiatry		
k. Pulmonary		
l. Radiology		
6. Clinical Laboratory Services		

LEVEL III Required Trauma Center Departments/Services	Director or Contact Physician	Number of Physicians Assigned to Service
1. Trauma Service		
2. Emergency Department		
3. Intensive Care Unit		
4. Surgical Services:		
a. General		
5. Medical Services:		
a. Anesthesiology		
b. Internal Medicine		
6. Clinical Laboratory Services		

LEVEL IV Required Trauma Center Departments/Services	Director or Contact Physician	Number of Physicians Assigned to Service
1. Emergency Department		
2. Intensive Care Unit* (If admitting traumatically injured patients)		
3. Clinical Laboratory Services		

B. Staffing – Tab B

Submit an organizational staffing plan demonstrating 24 hour-a-day coverage in the following specialty areas as listed below. Provide a description of physician and nursing shifts, number of beds/staffing patterns and on-call procedures.

For those required surgical specialties that are allowed availability substitution from outside the hospital, please provide a current signed transfer agreement that indicates coverage of the required specialty.

LEVEL I & LEVEL II - Organizational Staffing Plan

1. Trauma Service
2. Anesthesiology
3. General Surgery
4. Neurologic Surgery
5. Orthopedic Surgery
6. Emergency Department
7. Intensive Care Unit
8. Recovery Room
9. Radiological Special Procedures
10. Hemodialysis
11. Clinical Laboratory Services
12. Burn Care Unit

LEVEL III - Organizational Staffing Plan

1. Trauma Service
2. Anesthesiology
3. General Surgery
4. Emergency Department
5. Intensive Care Unit
6. Recovery Room
7. Hemodialysis
8. Clinical Laboratory Services
9. Burn Care Unit

LEVEL IV - Organizational Staffing Plan

1. Emergency Department
2. Intensive Care Unit (if admitting traumatically injured patients)
3. Clinical Laboratory Services

C. Trauma Service – Tab C

1. Describe the organization of the Trauma Service and attach the organizational chart that reflects the administrative reporting structure of the trauma program.
2. Include procedures and requirements for the following:
    a. Physician credentialing
    b. Procedures for activating the service and the responsibilities of the trauma surgeon in caring for patients from the emergency department to discharge from the hospital.

3. Include information on the hospital's trauma data collection system and participation in the state trauma registry.
4. Attach a narrative description of how the trauma team members are activated when a trauma patient presents to the Emergency Department. Please include:
    a. Written graded activation criteria
    b. Responsibilities of members of the trauma team in trauma resuscitation
    c. Preparation for transfer to a higher level of care if applicable
5. A copy of policies, procedures, and guidelines for the care of the trauma patient must be available at the time of site review.

D. Trauma Program Manager (TPM) – Tab D

1. Attach a copy of the TPM's Curriculum Vitae with job description. Indicate if position is full time, if not, please describe other duties.
2. Attach an organizational chart depicting the TPM's reporting structure.

E. Operating Suites – Tab E

State the number of available suites and cite special suites for the following:

1. Dedicated, or scheduled, for the Trauma Service
2. Cardiopulmonary Bypass
3. Microsurgery
4. Other dedicated suites for subspecialties

F. Programs for Quality Assurance – Tab F

1. Outreach Programs - Indicate outreach to community physicians and out-lying facilities
2. Trauma Performance Committee – List members of the committee, a description of the committee, and the committee's role in process improvement.

G. Outreach/Training Programs – Tab G

1. Trauma Training Programs - Indicate training plans for medical/surgical staff, nursing, prehospital providers, community physicians and the availability of training to all applicants
2. Public Education - Specifically directed towards trauma, i.e. injury prevention, first aid, etc. Indicate focus and audience of education efforts

H. Special Facilities/Resources/Capabilities – Tab H

1. Submit specific plans or procedures demonstrating compliance with these standards:
    a. Organ Donor Protocol - Note organ retrieval experience and linkage with organ donor organizations
2. Trauma Research (if applicable) - Indicate areas of interest and expertise

In a supplemental narrative report, you may describe any unique services or special features, such as hospital-based helicopter ambulance operations, crisis counseling, pastoral care or family assistance program, rehabilitation, disaster preparedness, radiological incident plans, or poison control and treatment capabilities.

The foregoing information shall be submitted with the application. Upon receipt of the application, the Office of Emergency Medical Services - Trauma Program will review the application. Any deficiencies noted in the application must be corrected prior to scheduling of the site visit.

All costs of the application process, including costs incurred for the site visit will be borne by the applicant facility, payable upon invoice from the Department.

The following signatures certify the review and endorsement of this application by the medical staff for trauma center designation.

Chief of Staff (Type Name and Title)

Signature Date Signed

Chief of Surgery (Type Name and Title)

Signature Date Signed

Chief of Medicine (Type Name and Title)

Signature Date Signed

Director of Trauma Services (Type Name and Title)

Signature Date Signed

Director of Emergency Medicine (Type Name and Title)

Signature Date Signed

Administrator or Chief Executive Officer (Type Name and Title)

Signature Date Signed