Utah Department of Public Safety
Bureau of Emergency Medical Services
Level IV Trauma Center Designation Criteria

Rev 1/2025

Criteria for designation of Level IV trauma centers are based upon ***Resources Optimal Care of the Injured Patient, COT/American College of Surgeons, 2014.*** Criteria to verify that services and systems are in place to insure optimal care of the trauma patient are defined in that document. The following elements are referenced by chapter and must be met for designation as a Level IV trauma center in Utah.

FACILITY: REVIEW DATE:

Chapter	Criteria Element	Met	NOT Met
1	**Trauma System Participation**		
Type II	1. There is evidence that the trauma program staff is involved in trauma system planning, development and operation within the state and the region. (CD 1-1)		
Type II	2. The individual trauma center and health care providers are essential system resources and engaged participants (CD 1-2)		
Type II	3. The trauma center and its providers function in a way to support trauma center based standardization, integration and PIPS out to the region while engaging in inclusive trauma system planning and development. (CD 1-3)		
** **Type II** **	4. TMD and TPM Attendance and participation threshold at regional and State Trauma Systems meetings of 75% is required. (State Criteria) • Provide evidence of attendance (at time of survey).		

CH 2	The Role in the Trauma System		
Type I	1. The trauma center must have an integrated, concurrent performance improvement and patients safety (PIPS) program to ensure optimal care and continuous improvement in care. (CD 2-1)		
Type II	2. The trauma center must provide the necessary human and physical resources (plant and equipment) to properly administer acute care consistent with their level of designation (CD 2-3)		
Type I	3. The 80% compliance of the surgeon's (when available) or physician's presence in the emergency department within 30 minutes of notification/patient arrival is confirmed and documented in the PI process. Surgeon response requirements must be defined specifically for your trauma program. (CD 2-8)		
Type II	4. Well-defined transfer plans are essential and in place and current (CD 2-13). Collaborative treatment and transfer guidelines reflecting Level IV center capabilities must be developed and reviewed regularly, with input from higher-level centers (CD 2-13)		
Type II	5. The hospital has 24-hour ER coverage by a physician or qualified Advanced Practice Provider. (CD 2-14)		
Type II	6. The emergency department at **Level IV** centers must be continuously available for resuscitation with coverage by a registered nurse and physician or midlevel provider, and it must have a physician director (CD 2–15).		

Type II	7. These providers must maintain current Advanced Trauma Life Support® certification as part of their competencies in trauma (CD 2–16). **(All Non-ED Boarded Providers in Level IV Centers)**		
**	8. Treatment and transfer of pediatric trauma patients are reviewed as part of the trauma PI process.		
Type II	9. There is evidence that the Trauma Program Director and the Trauma Program Manager are knowledgeable and work together with guidance from the trauma peer review committee to identify events, develop corrective action plans and ensure methods of monitoring and benchmarking (CD 2-17).		
Type II	10. Level I, II, III and IV trauma centers the multidisciplinary trauma peer review committee must meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured (CD 2–18).		
Type II	11. Level I, II, III and IV trauma centers, a PIPS program must have audit filters to review and improve pediatric and adult patient care (CD 2–19).		
Type II	12. Because of the greater need for collaboration with receiving trauma centers, the Level IV trauma center must also actively participate in regional and statewide trauma system meetings and committees that provide oversight (CD 2–20).		

Type II	13. The Level IV trauma center must also be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers (CD 2–21).		
Type II	14. Level I, II, III and IV trauma centers the facility must participate in regional disaster management plans and exercises (CD 2–22).		
CH 3	**Pre-hospital Trauma Care**		
Type II	1. The trauma program must participate in the training of pre-hospital personnel, the development and improvement of pre-hospital care protocols and PIPS. (CD 3-1) II		
Type II	2. The protocols that guide prehospital trauma care must be established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies, and basic and advanced prehospital personnel (CD 3–2). II		
Type II	3. When a trauma center is required to go on bypass or to divert, the center must have a system to notify dispatch and EMS agencies (CD 3–7). The center must do the following: • Prearrange alternative destinations with transfer agreements in place 1. • Notify other centers of divert or advisory status 2. • Maintain a divert log 3. • Subject all diverts and advisories to performance improvement procedures		
CH 4	**Inter-hospital Transfer**		
Type II	1. Direct physician-to-physician contact is essential (CD 4–1).		

Type II	2. A very important aspect of interhospital transfer is an effective PIPS program that includes evaluating transport activities (CD 4–3).		
Type II	3. Perform a PIPS review of all transfers (CD 4–3).		
CH 5	**Hospital Organization/Trauma Program**		
Type I	1. There is a demonstrated commitment of the hospital governing body and medical staff to the trauma center. (CD 5-1)		
Type I	2. There is a current resolution supporting trauma center designation for the governing board (3 yrs) (CD 5-1)		
Type II	3. The criteria for a graded activation must be clearly defined by the trauma center, with the highest level of activation including the six required criteria listed in Table 2 (CD 5–13).		
Type II	4. In Level III and IV trauma centers the team must be fully assembled within 30 minutes (CD 5-15).		
Type II	5. Other potential criteria for trauma team activation that have been determined by the trauma program to be included in the various levels of trauma activation must be evaluated on an ongoing basis in the PIPS process (CD 5-16) to determine their positive predictive value in identifying patients who require the resources of the full trauma team.		

** **Type II** **	6. The trauma medical director must be current in ATLS (State Recommended Only)		
** **Type II** **	7. The trauma director must have authority to correct deficiencies in trauma care and exclude from trauma call trauma team members who do not meet specified criteria. (State Recommended Only)		
** **Type II** **	8. The TMD must attend and chair a minimum of 50% of the multidisciplinary trauma peer review committee meeting. (State Recommended)		
** Type II **	9. Is TPM a Registered Nurse? (State requires this position to be filled by a Registered Nurse). If not, please list License/Certification: *** Current (non-RN) TPM will be "grand-fathered" until the position is vacated. TPM Position must be filled by RN thereafter.		
CH 6	**Clinical Functions: General Surgery**		
Type I	1. The maximum response time for Level I activations is 30 minutes with an attendance threshold of 80%. The 80% compliance of the surgeon's (when available) or physician's presence in the emergency department within 30 minutes of notification/patient arrival is confirmed and documented. Surgeon response requirements must be defined specifically for your trauma program. (CD 2-8)		
Type I	2. There must be multidisciplinary trauma peer review chaired by the TMD with representatives from general surgery, orthopedic surgery, neurosurgery, emergency medicine, ICU and anesthesia as available in the facility. (State Recommended Only)		
Type I	3. For Level I and II trauma centers, the maximum acceptable response time is 15 minutes; for Level III and Level IV trauma centers, the maximum acceptable response time is 30 minutes. Response time will be tracked from patient arrival rather than from notification or activation. An 80 percent attendance threshold must be met for the highest-level activations (CD 2–8).		

CH 7	**Clinical Functions: Emergency Medicine**		
**	1. There is a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients for the size of the facility. (State Recommendation Only)		
**	2. The emergency physicians should be represented in the trauma PI program multidisciplinary committee. (State Recommended Only)		
Type II	3. All board certified emergency physicians must have successfully completed the ATLS program at least once. (For all Level Trauma Centers) CD 7-14, CD 17-5 Noted in Change Log.		
CH 8	**Clinical Services: Neurosurgery (if available)**		
**	1. If neurosurgery is provided, there must be a trauma director-approved plan to determine which types and severity of neurological injury patients should remain at the facility when no neurosurgery coverage is present.		
**	2. There must be a PI program that convincingly demonstrates the appropriate care of neurological patients treated.		
**	3. There must be appropriate transfer agreements with Level I or Level II trauma centers.		
CH 9	**Clinical Services: Orthopedic Surgery (if available)**		
**	1. There must be operating rooms available to allow for emergency operations on musculoskeletal injuries including open fracture debridement and stabilization, external fixator placement, and compartment decompression.		

**	2. There is a PI process which demonstrates the appropriateness of care orthopedic care provided in the facility.		
**	3. There is a PI process which documents the appropriateness of the decision to transfer or retain major orthopedic trauma.		
CH 10	**Pediatric Trauma Care**		
**	1. Trauma care provided to pediatric patients must have a pediatric specific PI program that reviews trauma care for all pediatric trauma patients.		
**	2. Appropriate equipment, policies and PI must be in place for pediatric patients.		
CH 11	**Collaborative Clinical Services**		
Type I	1. Conventional Radiology and CT services must be available 24 hours per day either in house or on call. (CD 11-29)		
**	2. Critical information deemed to immediately affect patient care must be communicated to the trauma team. (CD 11-35)		
**	3. There must be 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.		
**	4. When the CT technologist responds from outside the hospital, the PI program documents response time and any delays to patient care.		

Type II	5. The PIPS program must review all ICU admissions and transfers to ensure appropriate patients are selected to remain at a Level IV center vs. being transferred to a higher level of care. (CD 11-60)		
**	6. A qualified nurse must be available 24/7 and the nurse patient ratio in the ICU (when provided) must not exceed 2:1		
Type I	7. Laboratory services must be available 24/7 for the standard analysis of blood, urine, and other body fluids, including coagulation, blood gasses microbiology and micro-sampling when appropriate. (CD 11-80)		
Type I	8. The blood bank must be capable of typing and cross matching and have an adequate amount of red cell, fresh frozen plasma (when available), platelets and other products necessary to meet the needs of the trauma patient. (CD 11-81)		
Type I	9. There must be a massive transfusion protocol. (CD 11-84)		
Type II	10. Emergency Department midlevel/advance practitioner/physician assistant providers that function as a member of the team caring for trauma activation patients via assessment or interventions must be current in ATLS. If the ED midlevel's only role is as a scribe or entering orders they would not need to meet the ATLS requirement. (CD 11-86)		
Type II	11. Advanced practitioners who participate in the **initial evaluation** of trauma patients must demonstrate current verification as an Advanced Trauma Life Support® provider. (11-86)		
Type II	12. The trauma program must demonstrate appropriate orientation, credentialing processes, and skill maintenance for advanced practitioners as witnessed by an annual review by the trauma medical director. (CD 11-87).		

CH 12	**Rehabilitation (If available)**		
**	1. Physical Therapy should be available.		
**	2. Social Services should be available.		
CP 13	**Rural Trauma Care**		
Type II	1. Direct communication of the physician or midlevel provider with a physician at the receiving hospital is required. (CD 4-1)		
Type II	2. All transfers must be evaluated as part of the PIPS program. (CD 4-3).		
Type II	3. The foundation for evaluation of a trauma system is the establishment and maintenance of a trauma registry (CD 15–1).		
Type II	4. Issues that must be reviewed will revolve predominantly around (1) system and process issues such as documentation and communication; (2) clinical care, including identification and treatment of immediate life- threatening injuries (ATLS®); and (3) transfer decisions (CD 16-10).		
Type II	5. The best possible care for patients must be achieved with a cooperative and inclusive program that clearly defines the role of each facility within the system (CD 1–1).		
CP 14	**Guidelines for the Operation of Burn Centers**		
Type II	1. Trauma centers that refer burn patients to a designated burn center must have in place written transfer agreements with the referral burn center (CD 14–1)		
CP 15	**Trauma Registry**		
Type II	1. Trauma registry data must be collected and analyzed as part of the PI process. (CD 15-1).		

Type II	2. The trauma registry is essential to the performance improvement and patient safety (PIPS) program and must be used to support the PIPS process (CD 15–3).		
Type II	3. Furthermore, these findings must be used to identify injury prevention priorities that are appropriate for local implementation (CD 15–4).		
Type II	4. Trauma registries should be concurrent. At a minimum, 80 percent of cases must be entered within 60 days of discharge (CD 15–6)		
Type II	5. The trauma program must ensure that appropriate measures are in place to meet the confidentiality requirements of the data (CD 15–8).		
Type II	6. Strategies for monitoring data validity are essential (CD 15–10).		
CH 16	**Performance Improvement and Patient Safety**		
Type II	1. The PIPS program must be supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement (CD 15–1).		
Type II	2. The processes of event identification and levels of review must result in the development of corrective action plans, and methods of monitoring, reevaluation, and benchmarking must be present (CD 2–17).		
Type II	3. Peer review must occur at regular intervals to ensure that the volume of cases is reviewed in a timely fashion (CD 2–18).		
Type I	4. Because the trauma PIPS program crosses many specialty lines, it must be empowered to address events that involve multiple disciplines and be endorsed by the hospital governing body as part of its commitment to optimal care of injured patients (CD 5–1).		

Type I	5. There must be adequate administrative support to ensure evaluation of all aspects of trauma care (CD 5–1).		
Type I	6. The trauma medical director and trauma program manager must have the authority and be empowered by the hospital governing body to lead the program (CD 5–1). I		
Type I	7. The trauma center must demonstrate that all trauma patients can be identified for review (CD 15–1).		
Type II	8. The trauma PIPS program must be supported by a registry and a reliable method of concurrent data collection that consistently obtains information necessary to identify opportunities for improvement (CD 15–3).		
Type II	9. All process and outcome measures must be documented within the trauma PIPS program's written plan and reviewed and updated at least annually (CD 16–5).		
Type II	10. Trauma surgeon response to the emergency department (CD 2–9). See previous detail.		
Type II	11. Trauma team activation (TTA) criteria (CD 5–13). See previous detail.		
Type II	12. All Trauma Team Activations must be categorized by the level of response and quantified by number and percentage, as shown in Table 2 (CD 5–14, CD 5–15). II		

Type II	13. Acute transfers out (CD 9–14). All trauma patients who are diverted (CD 3–4) or transferred (CD 4–3) during the acute phase of hospitalization to another trauma center, acute care hospital, or specialty hospital (for example, burn center, reimplantation center, or pediatric trauma center) or patients requiring cardiopulmonary bypass or when specialty personnel are unavailable must be subjected to individual case review to determine the rationale for transfer, appropriateness of care, and opportunities for improvement. Follow-up from the center to which the patient was transferred should be obtained as part of the case review.		
Type II	14. Transfers to a higher level of care within the institution (CD 16–8).		
Type II	15. Sufficient mechanisms must be available to identify events for review by the trauma PIPS program (CD 16–10).		
Type II	16. Once an event is identified, the trauma PIPS program must be able to verify and validate that event (CD 16-11)		
CH 17	**Outreach and Education.**		
Type II	1. The trauma center must be engaged in public and professional education activities. (CD 17-1)		
Type II	2. The successful completion of the ATLS® course, at least once, is required in all levels of trauma centers for all general surgeons (CD 6-9), emergency medicine physicians (CD 7-14) and midlevel providers (CD 11-86) on the trauma team.		

Type II	3. Trauma and/or Emergency Department Advanced Practice Providers (APPs) that function as a member of the team caring for trauma activation patients via assessment or interventions must be current in ATLS. This does not include the consult tier or Fast-Track. (rv 4/14/16) It does not include orthopaedic and neurosurgery practitioners who are consulting. (rv 6/8/15)		
Type II	4. Level IV physicians working in the ED must be current in ATLS (refer to CD 2-16). (rv 6/8/15)		
CH 18	**Injury Prevention**		
Type II	1. Trauma centers must have an organized and effective approach to injury prevention and must prioritize those efforts based on local trauma registry and epidemiologic data (CD 18–1).		
Type II	2. Each trauma center must have someone in a leadership position that has injury prevention as part of his or her job description (CD 18-2)		
Type II	3. Universal screening for alcohol use must be performed for all injured patients and must be documented (CD 18–3)		
CH 19	**Research/Scholarships Left BLANK**		
Ch 20	**Disaster Planning and Management**		
Type II	1. The hospital must meet the disaster related requirements of JACHO. (CD 20-1) II		
Type II	2. Hospital drills that test the individual hospital's disaster plan must be conducted at least twice a year, including actual plan activations that can substitute for drills (CD 20–3). II		

Type II	3. All trauma centers must have a hospital disaster plan described in the hospital's policy and procedure manual or equivalent (CD 20–4). II		
21	**Organ Procurement Activities**		
Type II	1. It is essential that each trauma center have written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death (CD 21–3). II		