**Indiana Department of Homeland Security**

**One Year Progress Report for “in the process” Level III Trauma Center**

Hospitals that were granted status as an “in the process” Level III Trauma Center are asked to provide sufficient documentation for the Indiana State Department of Health and the Indiana Department of Homeland Security to demonstrate that your hospital continues to comply with the following requirements:

1. **Submission of trauma data to the State Registry**. The hospital must be submitting data to the Indiana Trauma Registry following the Registry’s data dictionary data standard within 30 days of application and at least quarterly thereafter.

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| Has your hospital submitted trauma data to the State Registry at least two out of the last four quarters? | YES  NO |

1. **Trauma Surgeon response times.** Evidence must be submitted that response times for the Trauma Surgeon are as defined by the Optimal Resources document of the American College of Surgeons. Also, there must be a written letter of commitment, signed by the Trauma Medical Director, that is included as part of the hospital’s application. There must be evidence that a trauma surgeon is a member of the hospital’s disaster committee.

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| Have your Trauma Surgeon’s maintained a response time as defined by the Optimal Resources document of the American College of Surgeons since granted “in process” Level III Trauma Center status?  *Provide your hospital’s Trauma Surgeon response times including number of responses, response times and percentage within the required timeframe per Trauma Surgeon (documentation tool attached).* | YES  NO |

1. **Diversion policy**. The hospital must provide a copy of its diversion policy and affirm that it will not be on diversion status more than 5% of the time. The hospital’s documentation must include a record for the previous year showing dates and length of time for each time the hospital was on diversion.

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| Has your hospital maintained a diversion status of less than 5% of the time since granted “in process” Level III Trauma Center status?  *Provide your hospital’s diversion documentation showing reason for diversion and dates and length of time for each time the hospital was on diversion (documentation tool attached).* | YES  NO |

1. **Orthopedic Surgery.** There must be an orthopedic surgeon on call and promptly available 24 hours per day. There must also be a written letter of commitment, signed by orthopedic surgeons and the Trauma Medical Director, for this requirement.

**Critical Care Physician coverage.** Physicians must be capable of a rapid response to deal with urgent problems as they arise in critically ill trauma patients. There must be prompt availability of Critical Care physician coverage 24 hours per day. Supporting documentation must include a signed letter of commitment of proof of physician coverage 24 hours a day.

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| Have your Orthopedic Surgeons and Critical Care Physicians maintained coverage 24 hours per day since granted “in process” Level III Trauma Center status?  *Provide your hospital’s monthly Orthopedic and Critical Care physician call schedules since granted “in process” Level III Trauma Center status.* | Orthopedic Surgeons:  YES  NO  Critical Care Physicians:  YES  NO |

1. **Operational process performance improvement committee**. There must be a trauma program operational process performance improvement committee and documentation must include a roster of the committee and meeting times for the previous year.

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| Has your Trauma Program Operational Process Performance Committee met at least quarterly since granted “in process” Level III Trauma Center status?  *Provide your hospital’s committee meeting dates and times along with a roster of the committee members and their attendance (documentation tool attached).* | ☐ YES ☐ NO |

1. **Trauma Peer Review Committee.** There must be a multidisciplinary peer review committee with participation by the trauma medical director or designee and representatives from General Surgery, Orthopedic Surgery, Neurosurgery, Emergency Medicine, and Anesthesia to improve trauma care by reviewing selected deaths, complications, and sentinel events with the objectives of identification of issues and appropriate responses.

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| Have the trauma medical director or designee and representatives from General Surgery, Orthopedic Surgery, Neurosurgery, Emergency Medicine, and Anesthesia attended your multidisciplinary peer review committee at least 50% of meetings since granted “in process” Level III Trauma Center status?  *Provide your hospital’s committee meeting dates and times along with a roster of the committee members and their attendance (documentation tool attached).* | Trauma Medical Director:  ☐ YES ☐ NO  General Surgeon:  ☐ YES ☐ NO  Orthopedic Surgeon:  ☐ YES ☐ NO  Neurosurgeon:  ☐ YES ☐ NO  Emergency Medicine:  ☐ YES ☐ NO  Anesthesia:  ☐ YES ☐ NO |

**Additional Information Necessary**

Hospital Name and Mailing Address (no PO Box):

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Previously known as (if applicable):

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Date the “In the Process” status was granted:

Level Three Adult \_\_\_\_\_\_\_\_\_\_\_ Level One Pediatric \_\_\_\_\_\_\_\_\_\_\_\_\_

Level Two Pediatric \_\_\_\_\_\_\_\_\_\_\_\_\_

Hospital’s status in applying for ACS verification as a trauma center (including Levels being pursued and date of scheduled ACS verification visit)

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Trauma Medical Director:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Pgr #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Trauma Program Manager/Coordinator:

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Office Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Pgr #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ATTESTATION**: In signing this application, we are attesting that all information contained herein is accurate and that we and our attesting hospital agrees to be bound by the rules, policies and decisions of the Indiana Emergency Medical Services Commission and the Indiana State Department of Health regarding our status under this program.

Chief Executive Officer Signature Printed Date

Trauma Medical Director Signature Printed Date

Trauma Program Manager Signature Printed Date

01/22/2014