

**ABBREVIATED REQUEST FOR PROPOSAL (RFP)
FOR COMBINED NORTH CAROLINA DESIGNATION &
AMERICAN COLLEGE OF SURGEONS (ACS) VERIFICATION
VISIT AS A TRAUMA CENTER**

**The North Carolina Office of
Emergency Medical Services
Division of Health Service Regulation
Department of Health and Human Services**

Legal Name of Hospital Seeking Designation:

Level of Review: Level I Level II Level III

Name and Telephone Number of Contact Person for this Application:

Date of Submission: _____

Date current designation ends: _____

5-12-10

GENERAL INFORMATION AND INSTRUCTIONS

PURPOSE OF THE TRAUMA CENTER REQUEST FOR PROPOSAL (RFP)

The North Carolina Office of Emergency Medical Services (OEMS) is actively involved in the process of identifying, as well as renewing, Level I, II and III trauma centers in North Carolina. Although North Carolina has been involved in Level I and II designation since 1982, criteria for Level III designation were not approved until January 1991. The most current criteria for all three levels are written in rule in the North Carolina Administrative Code effective January 1, 2009.

This Request for Proposal (RFP) has been prepared by OEMS in order to assist in ascertaining whether a hospital seeking initial or renewal trauma center designation meets the state's trauma center criteria. The criteria are based upon guidelines developed by the American College of Surgeons (ACS) and approved by the State EMS Advisory Council. Each hospital in North Carolina interested in applying for initial or renewal designation must complete an RFP document and submit it for consideration by the state. This process has been a requirement since January 1, 1985.

This RFP has been designed primarily to allow each facility the opportunity to demonstrate its sincere commitment to meet North Carolina's criteria and to provide quality trauma care to the citizens of North Carolina. Any commitments required of a hospital, as pertain to staffing, equipment or other resources at the time of designation, must remain intact throughout the hospital's designation period.

INSTRUCTIONS FOR COMPLETION OF THE RFP

Need Help?

Questions relating to initial or renewal designation procedures, trauma center criteria or the RFP should be directed to Ms. Nadine Pfeiffer, Assistant Chief, Health Systems, North Carolina Office of Emergency Medical Services. She can be reached at (919) 855-3960; FAX # (919) 733-7021; or nadine.pfeiffer@dohhs.nc.gov. The trauma center designation policy and procedures can also be accessed via internet at <http://www.ncdohhs.gov/dohsr/EMS/trauma/guidelines.html>.

Format of RFP

The RFP will be mailed to an applicant via CD, to be utilized by the hospital in the final typing of answers to the RFP questions.

Typing and Collating Instructions

Single-spaced typing should be utilized to respond to all questions.

Since the application is utilized for all three levels of designation, some questions may be irrelevant for the designation being sought, requiring no response, or a "No" or "NA" for not applicable.

Under no circumstances is any question or section to be deleted from the document.

The yes/no questions in the document have been set up to allow for a simple click of the yes or no box () , by double-clicking on the box itself and selecting "checked" (from the pop-up table) as the default value.

Questions requiring a narrative response should be answered in the space immediately following the question. While unlimited space is provided, it is best to keep answers succinct.

In the event an answer can best be supplied by providing the copy of an existing policy or other document, it is acceptable to include a notation to this effect and to include this item in the appendix. It is

up to each hospital to determine formatting of attachments to the RFP. It is best to avoid attaching an entire document or manual then refer to it as “the manual” numerous times in reference.

Answers that refer the reader to another section of the RFP should clearly identify this location. In turn, appendices should clearly identify the question being answered and contain the same page number as the initial question. An “a” through “z” can be provided to indicate sequential pages (i.e., page 40a, 40b, 40c, etc.). There is no need to delete page numbers or to replace each page number throughout when including a copied document.

Prior to forwarding the completed applications to OEMS and ACS, the applicant must ensure the RFP is correctly repaginated and bound in some manner.

Before the RFP is mailed, the required signatures must be obtained on the sign-off page. Please note all situations where someone is serving in an “acting” capacity.

Please do not include the general information and instruction pages with the completed RFP.

Required Copies, Transmittal Letter and Mailing Instructions

A letter from the Chief Executive Officer of the hospital should accompany the RFPs. At a minimum, the letter must indicate the action that is being requested of the state.

Submit one original and three copies directly to OEMS to the attention of Ms. McKenzie L. Cook at least 30 days prior to the survey date at the address listed below:

USPS delivery:

OEMS
Attn: McKenzie Cook
2707 Mail Service Center
Raleigh, NC 27699-2707

UPS or similar carrier:

OEMS
Attn: McKenzie Cook
701 Barbour Drive
Raleigh, NC 27603

*Electronic copies are no longer accepted by the states email system due to the inability of encryption of the state email system.

Submit one copy and one electronic copy directly to the ACS at least 30 days prior to the survey date.

KEY PERSONNEL SIGN-OFF SHEET

We, the undersigned, understand that this application has been prepared as part of a trauma center designation request. We have reviewed the contents of this document and certify that, to the best of our knowledge, it is an accurate representation of our facility with respect to current trauma care capabilities and future intentions.

1. HOSPITAL ADMINISTRATION:

Executive Officer:

Name: _____

Signature: _____

Administrator Responsible for Emergency Services:

Name: _____

Signature: _____

2. PHYSICIANS:

Chief of Staff:

Name: _____

Signature: _____

Chief, Department of Surgery:

Name: _____

Signature: _____

Physician Responsible for Trauma Program or Chief of Trauma Service:

Name: _____

Title: _____

Specialty: _____

Signature: _____

Physician Director, Emergency Department:

Name: _____

Specialty: _____

Signature: _____

3. NURSING:

Trauma Nurse Program Manager (or Trauma Nurse Coordinator):

Name: _____

Signature: _____

Trauma Service

1. Do triage criteria exist for the use of helicopters for scene response in your service area? Yes No

If "Yes," please provide a copy of this document.

2. Describe the EMS providers that serve your facility (i.e., level of care, primarily paid, volunteer, etc.), their governing body and medical leadership.

(Insert Text Here)

3. Provide a description on the history of your trauma service, (i.e., initial designation, growth of service, etc.). Be sure to address how the trauma medical director oversees all aspects of the multidisciplinary care from the time of injury through discharge.

(Insert Text Here)

4. Please provide names for all the following that apply and attach a copy of their job descriptions and curricula vitae:

Trauma Service Medical Director: (Insert Text Here)
Trauma Program Manager: (Insert Text Here)
Trauma Nurse Coordinator: (Insert Text Here)
Trauma Registrar: (Insert Text Here)

5. Does the Trauma Medical Director, in addition to being a board certified general surgeon, have a minimum of three year's clinical experience on a trauma service or have trauma fellowship training? Yes No

6. Do any of the other surgeons who participate on the trauma call panel have any other specialized trauma training (i.e., a fellowship in trauma; previous experience as a director/member of a trauma service at other designated trauma center(s); military experience, etc.)? Yes No

If yes," please specify name of individual and type of training.

(Insert Text Here)

7. Does the trauma medical director review the performance of the members on the trauma panel annually? Yes No

(Insert Text Here)

8. Is the hospital's trauma registrar designated as full-time? Yes No

If "No," please specify percentage of time devoted to registry activities

(Insert Text Here)

9. Provide documentation to verify that the trauma registrar has completed sixteen hours of trauma registry related or trauma-related continuing education during the last two year cycle (please define). A list of courses, etc. with dates and hours will suffice.

(Insert Text Here)

10. Please provide documentation from Department of Surgery as to credentialing process/criteria for any mid-level practitioners. Mid-level practitioners on trauma service not used

(Insert Text Here)

11. Mid-level practitioners routinely caring for trauma patients must have a minimum of sixteen hours of trauma-related continuing education every two-years. Please provide documentation of compliance for the last two-year cycle (please define) for each of these individuals. A review of the CME certificates may be requested at the time of the visit.

(Insert Text Here)

12. Is evaluation and treatment of a trauma patient started by a trauma team that includes, at a minimum, a PGY4 or senior general surgical resident who is a member of the hospital's surgical residency program? Yes No

13. Do you have a protocol manual for trauma? Yes No

If "Yes," have available at time of visit.

14. Are there standard written protocols that are routinely updated with respect to trauma care management? Yes No

If "Yes," please attach copies (or if trauma manual is provided, refer to section).

15. How does the trauma service know who gets admitted to make sure each patient is picked up by the service?

(Insert Text Here)

16. Are all the hospital's multiply traumatized patients admitted to the trauma service? Yes No

17. If your trauma system allows for the routine transport (from the scene or trauma center) of injured patients to an affiliated hospital, describe the criteria for this to occur.

(Insert Text Here)

18. With respect to trauma patients being transported from the scene by pre-hospital providers, do triage criteria exist in your primary service area that call for bypassing local community hospitals? Yes No

If "Yes," provide a copy of this document.

19. Is there a defined policy to accept the transfer of trauma patients from referring hospitals? Yes No

20. Describe the factors considered in the decision as to whether a trauma patient should/should not be transferred from a referring facility

(Insert Text Here)

21. Who can accept incoming trauma transfers and how is this information then relayed to the trauma team?

(Insert Text Here)

22. Is there a written document that defines what constitutes a neurosurgical emergency? Yes No

If "Yes" to the above, please enclose a copy.

23. An attending orthopaedist must be promptly available (as defined by the hospital's trauma system) to the hospital's trauma service. How is the in-house requirement being fulfilled?

- An in-house attending orthopaedic surgeon
 An in-house orthopaedic resident (PGY2 or higher); or
 An in-house trauma surgeon or emergency physician.

24. Is there a written document that defines what constitutes an orthopaedic emergency? Yes No

If "Yes," please provide a copy.

Emergency Department Equipment

Please indicate whether the following capabilities or items of equipment are available in the emergency department for patients of all ages:

- | | | | |
|-----|---|------------------------------|-----------------------------|
| 1. | Airway control and ventilation equipment (including laryngoscopes and endotracheal tubes of all sizes, bag-mask resuscitators, pocket masks, and sources of oxygen) | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. | Pulse oximetry | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 3. | End-tidal CO ₂ determination equipment | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 4. | Suction devices | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 5. | Electrocardiograph-oscilloscope-defibrillator w/internal paddles | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 6. | Apparatus to establish central venous pressure monitoring | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 7. | All standard intravenous fluids and administration devices, including large-bore intravenous catheters and intraosseous infusion devices | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 8. | Sterile surgical sets for: | | |
| | Airway control/cricothyrotomy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Thoracotomy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Vascular access | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Thoracostomy | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Peritoneal lavage | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | Central line insertion | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 9. | Apparatus for gastric decompression | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 10. | X-ray availability, 24 hours a day | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 11. | Two-way communication equipment for communication with emergency transport system | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 12. | Skeletal traction devices, including capability for cervical traction | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 13. | Arterial catheters | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

- | | | | |
|-----|---|------------------------------|-----------------------------|
| 14. | Thermal control equipment (e.g., warming blankets, lights, etc.): | | |
| | a) for patients | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| | b) for blood and fluids | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 15. | Rapid infuser system | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 16. | Pediatric length measurement system | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 17. | Diagnostic Ultrasound | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 18. | Doppler | Yes <input type="checkbox"/> | No <input type="checkbox"/> |

Radiologic Capacities

1. What priority is given to trauma patients needing X-rays? Attach documentation of any policy relating to this matter.

(Insert Text Here)

2. Define how the trauma team has access to emergency computed tomography, arteriography, and MRI.

(Insert Text Here)

3. Who interprets the radiographs after hours

(Insert Text Here)

4. Who accompanies and monitors the trauma patient to the radiology suite?

(Insert Text Here)

Rehabilitation Medicine

1. Describe the extent of your rehabilitative services (including physical, occupational and speech therapies) for trauma patients (including head and spinal cord injuries). Describe how the center ensures that major trauma patients have a functional assessment and recommendations regarding short and long-term rehabilitation needs within one week of the patient's admission to the hospital or as soon as hemodynamically stable.

(Insert Text Here)

Pediatric Trauma

1. What is your definition of a pediatric patient?

(Insert Text Here)

2. Describe how you care for pediatric trauma patients which are admitted to the hospital.

(Insert Text Here)

3. Is there a separate pediatric trauma service? Yes No

If Yes, describe how pediatric trauma patients and trauma surgeons are included in the PI process and required committee structures and meetings.

(Insert Text Here)

4. Are there separate pediatric resuscitation rooms in the ED? Yes No

If "Yes," how many are there?

(Insert Text Here)

5. What percent of your pediatric patients are transferred out and what criteria are utilized for this decision?

(Insert Text Here)

Please send the documents to the attention of: Ms. McKenzie L. Cook
OEMS
2707 Mail Service Center
Raleigh, NC 27699-2707