LOUISIANA

STATEWIDE TRAUMA SYSTEM PLAN

LOUISIANA
EMERGENCY
RESPONSE
NETWORK

2019

ABOUT THIS PLAN

The Louisiana Emergency Response Network (LERN) is an agency of state government created by the Louisiana Legislature in 2004 and charged with the responsibility of developing and maintaining a statewide system of care coordination for patients suddenly stricken by serious traumatic injury or time-sensitive illness (such as heart attack and stroke). It is a system also designated to serve as a vital healthcare resource in the face of large scale emergencies and natural disasters. Getting to the right place at the right time to receive the right care is a matter of life or death for these patients.

LERN's statewide system of trauma care coordination is being developed and continuously refined in accordance with nationally recognized trauma system principles and guidance created by the American College of Surgeons Committee on Trauma (ACS-COT). LERN's charge is to build and maintain a comprehensive system that addresses the daily demands of traumatic injury in Louisiana – a system that is also ever ready to serve as a vital healthcare component of Louisiana's all disasters response infrastructure.

> The care of injured patients requires a system approach to ensure optimal care.
>
> *Resources for Optimal Care of the Injured Patient 2014*
> **Committee on Trauma**
> **American College of Surgeons**

This *Statewide Trauma System Plan* was created as a master guide for understanding LERN's organizational infrastructure and operational components. This guide is organized into nine major sections:

1. Authority and Leadership
2. Trauma System Development
3. Pre-hospital Trauma Care
4. Definitive Care Facilities
5. Statewide Trauma Registry
6. Performance Improvement
7. Injury Research and Prevention
8. All Disasters and Mass Casualty Interface
9. Financial

This plan document describes in detail LERN's current organization and operations. The plan also provides summary descriptions of LERN's work-in-progress and planned next steps in the development of a comprehensive statewide trauma system for Louisiana.

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SECTION ONE: AUTHORITY AND LEADERSHIP

This section defines the basic elements of the Louisiana Emergency Response Network's (LERN) authority and leadership – including enabling legislation, vision and mission, governing board, regional commissions, and staff.

Enabling Legislation

The Louisiana Legislature enacted legislation in 2004 (LA RS 40:2841-2846) to create a "comprehensive, coordinated statewide system for the access to regional trauma and time-sensitive illness emergency care throughout the state." This legislation created LERN – prescribing the development of a volunteer state board to plan, govern, and implement the statewide system. This original LERN legislation also prescribed the development of nine regional commissions populated with volunteers that live and work within the region they represent.

This legislation created LERN – prescribing the development of a volunteer state board to plan, govern, and implement the statewide system.

The LERN legislation was amended in 2006 to add four additional seats to the LERN Board and adjust the Board's quorum rules. The LERN legislation was amended a second time in 2007 to establish liability limitations for provider participation in LERN and designate LERN as a separate budget unit within the Louisiana Department of Health (LDH). Most recently, the LERN legislation was amended in 2010 to:

- Update requirements for Louisiana hospitals to achieve the status of a Level I, Level II, or Level III trauma center – based upon national guidelines, including *Resources for Optimal Care of the Injured Patient* by the American College of Surgeons Committee on Trauma;
- Establish a statewide trauma registry;
- Create the Louisiana Emergency Response Network Fund;
- Provide for a public records exception to support LERN's performance management and improvement efforts;
- Expand the size of the LERN governing board; and
- Initiate a process for development of LERN infrastructure to address time-sensitive illness.

A copy of the current LERN state law is provided in **Appendix A**.

Vision and Mission

LERN's vision and mission statements reflect the intent of our enabling legislation and the Board's commitment to building a comprehensive statewide care coordination systems that meet nationally recognized standards and requirements.

Our Vision

To build and maintain Louisiana's care coordination systems for trauma and time-sensitive illness (stroke & heart attack) and facilitate readiness of healthcare providers during all disaster response.

Our Mission

The mission of the Louisiana Emergency Response Network (LERN) is to defend the public health, safety, and welfare by protecting the people of the state of Louisiana from unnecessary deaths and morbidity due to trauma and time-sensitive illness.

Governing Board

LERN is governed by a 28-member board that represents a diverse set of stakeholders. LERN's enabling legislation specifies a stakeholder organization to nominate qualified candidates for each LERN board seat. Nominees are submitted to the Governor for consideration and appointment to serve a three-year term. The following stakeholder organizations nominate qualified board candidates.

- American College of Surgeons Committee on Trauma
- American Stroke Association
- Governor's Office of Homeland Security and Emergency Preparedness (GOHSEP)
- Louisiana Alliance of Information and Referral Systems (211)
- Louisiana American College of Emergency Physicians
- Louisiana Association of EMS Physicians
- Louisiana Chapter of the American College of Cardiology
- Louisiana Department of Health (LDH)
- Louisiana Medical Association
- Louisiana State Board of Nursing
- Louisiana State Medical Society
- Louisiana Hospital Association
- Louisiana Hospital Association Rehabilitation Constituency Group
- Louisiana House of Representatives
- Louisiana Rural Ambulance Alliance
- Louisiana Senate
- Louisiana State Coroners Association

- Louisiana State University Health Science Center – New Orleans
- Louisiana State University Health Science Center – Shreveport
- Metropolitan Hospital Council of New Orleans
- National Emergency Number Association (911)
- Optometry Association of Louisiana
- Rural Hospital Coalition
- Tulane University Health Sciences Center

A current list of LERN board members is provided on the LERN website – www.lern.la.gov.

Regional Commissions

LERN is organized into nine geographic regions, and our efforts in each region are guided by a Regional Commission – an advisory board of key trauma and time-sensitive illness stakeholders, including (but not limited to) the following organizations.

- American Academy of Pediatric Physicians
- American College of Cardiology
- American College of Emergency Physicians
- American College of Surgeons
- American Stroke Association
- Burn Center
- LDH-OPH Regional Medical Director
- Emergency Medical Response
- GOHSEP
- Hospital < 60 Beds
- Hospitals > 100 Beds
- HHS Designated Regional Coordinator
- Local Ambulance Services
- Louisiana State Medical Society
- Military Hospital
- National Emergency Number Association (911)
- Registered Nurse Practicing in Emergency or Critical Care
- Rural Ambulance Representative
- Service District Hospital
- Trauma Center Representative

A current listing of Regional Commission members for all nine regions can be found on the LERN website – www.lern.la.gov.

The nine LERN geographic regions correspond with the nine administrative regions of the LDH.

Region 1

Jefferson Parish
Orleans Parish
Plaquemines Parish
St. Bernard Parish

Region 2

Ascension Parish
East Baton Rouge Parish
East Feliciana Parish
Iberville Parish
Point Coupee Parish
West Baton Rouge Parish
West Feliciana Parish

Region 3

Assumption Parish
Lafourche Parish
St. Charles Parish
St. James Parish
St. John the Baptist Parish
St. Mary Parish
Terrebonne Parish

Region 4

Acadia Parish
Evangeline Parish
Iberia Parish
Lafayette Parish
St. Landry Parish
St. Martin Parish
Vermillion Parish

Region 5

Allen Parish
Beauregard Parish
Calcasieu Parish
Cameron Parish
Jefferson Davis Parish

Region 6

Avoyelles Parish
Catahoula Parish
Concordia Parish
Grant Parish
LaSalle Parish
Rapides Parish
Vernon Parish
Winn Parish

Region 7

Bossier Parish
Caddo Parish
Claiborne Parish
DeSoto Parish
Natchitoches Parish
Red River Parish
Sabine Parish
Webster Parish

Region 8

Caldwell Parish
East Carroll Parish
Franklin Parish
Jackson Parish
Lincoln Parish
Madison Parish
Morehouse Parish
Ouachita Parish
Richland Parish
Tensas Parish
Union Parish
West Carroll Parish

Region 9

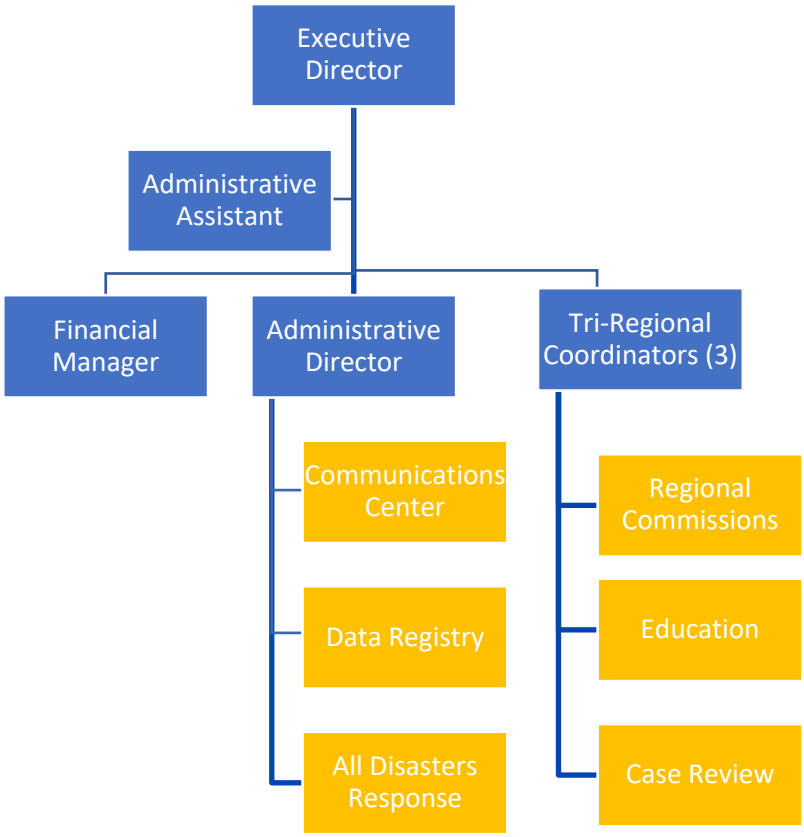
Bienville Parish
Livingston Parish
St. Helena Parish
St. Tammany Parish
Tangipahoa Parish
Washington Parish

Medical Directors

LERN has three medical directors serving as subject matter experts for the three statewide systems of care coordination developed and maintained through LERN's legislative mandate, including trauma, stroke, and STEMI. The medical directors, working collaboratively with LERN's board and executive director, provide valuable professional expertise that guides and facilitates LERN's management and continuous refinement of trauma, stroke, and STEMI systems of care. The medical directors are crucial leaders of LERN's ongoing efforts to expand and strengthen statewide provider networks for trauma, stroke, and STEMI. A current list of LERN medical directors is provided on the LERN website – www.lern.la.gov.

Staff

LERN utilizes a small staff of experienced healthcare professionals to administer state-level operations, manage LERN's Communications Center (including case review) and data registry, offer educational services and outreach, promote expansion of care networks, and support LERN's nine Regional Commissions.



A current list of LERN staff members is provided on the LERN website – www.lern.la.gov.

SECTION TWO: TRAUMA SYSTEM DEVELOPMENT

Louisiana's statewide trauma system is being developed and continuously refined in accord with the nationally recognized trauma system model developed through the work of the federal Health Resources and Services Administration (HRSA) and the American College of Surgeons Committee on Trauma (ACS COT).

The economic burden of trauma is estimated at an astounding **$671 billion** a year, including healthcare costs and lost productivity.

National Trauma Institute, Trauma Statistics

The Need for Organized Trauma Care Systems

The argument for developing and maintaining organized trauma care systems is perhaps best made through a presentation of trauma statistics.

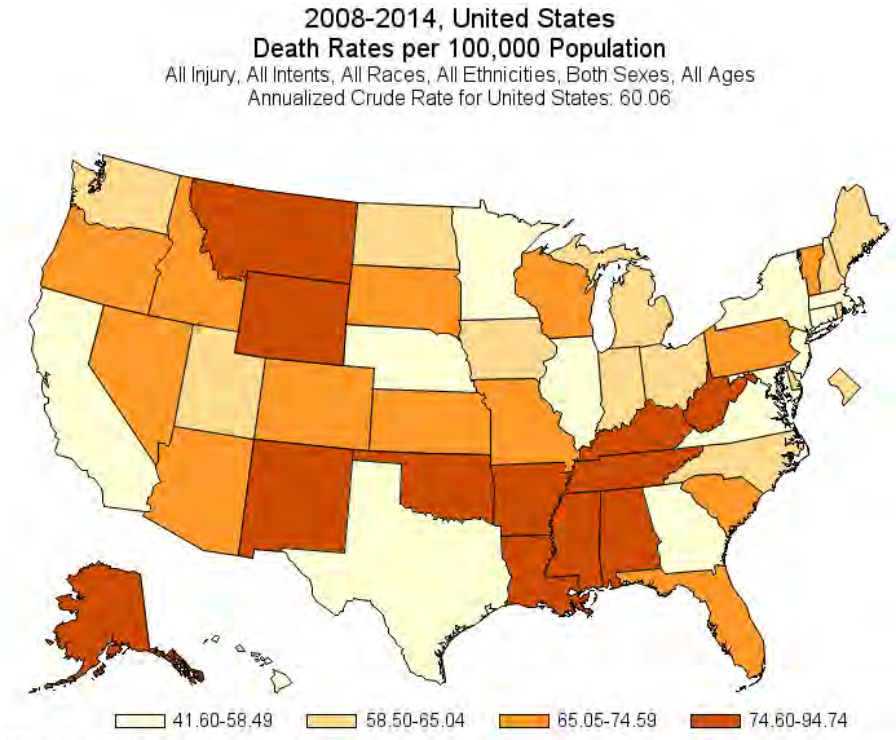
Each year in the US, **trauma** accounts for **41 million** emergency department visits and **2.3 million** hospital admissions.

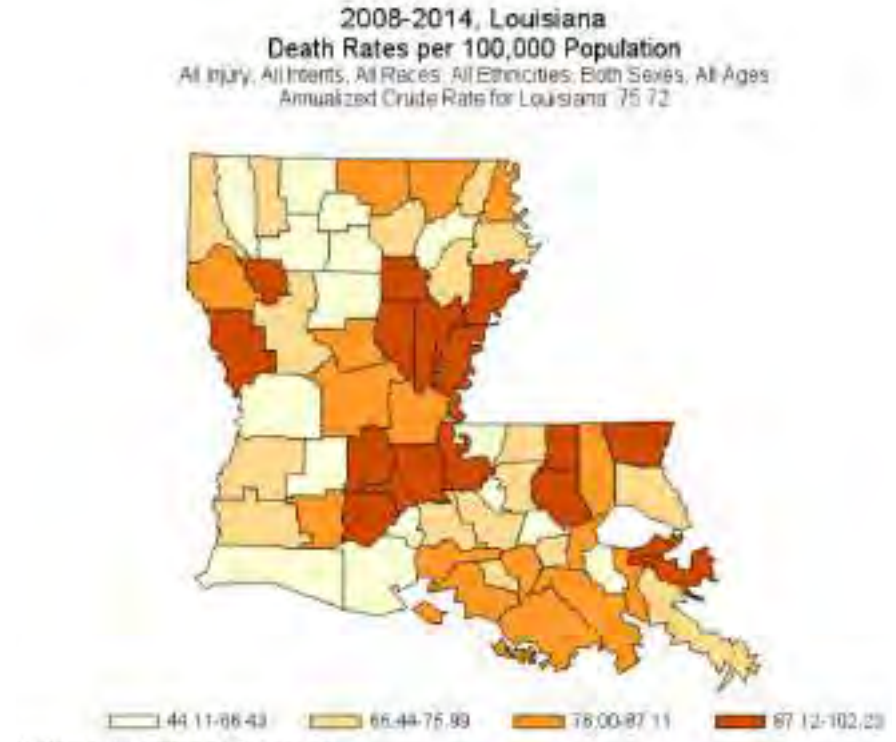
Traumatic injury is the **leading cause of death for children** in the US. In fact, trauma is the **#1 cause of death** for the 1 to 46 years old age group – accounting for 47% of all deaths in this age range. Trauma is the third leading cause of death for the whole US population.

Each year, over **9 million people** are treated in emergency departments for nonfatal **injuries related to falls**.

National Trauma Institute, Trauma Statistics

Louisiana has one of the highest trauma death rates in the nation.





Produced by the Statistics, Programming, and Economics Branch, National Center of Injury Prevention and Control
Data Sources: NCES National Vital Statistics System for Numbers of Deaths,
US Census Bureau for Population Estimates, 2008 – 2014

The highest rates of trauma (86.97 – 102.24 per 100,000) within the state of Louisiana are found in the following parishes.

- Orleans Parish (102.24)
- Caldwell Parish (100.78)
- St. Bernard Parish (99.46)
- Pointe Coupee Parish (99.37)
- LaSalle Parish (99.29)
- Washington Parish (98.19)
- Tensas Parish (97.92)
- Catahoula Parish (96.64)
- Sabine Parish (93.08)
- St. Helena Parish (92.23)
- Evangeline Parish (91.02)
- Red River Parish (90.46)
- Livingston Parish (88.10)
- Concordia Parish (88.09)
- Acadia Parish (87.83)
- St. Landry Parish (87.24)
- Morehouse Parish (86.98)
- Avoyelles Parish (86.97)

History of Trauma System Development in the US

The beginnings of modern trauma systems in the US can be traced to federal legislation, specifically the Highway Safety Act of 1966 and the Emergency Medical Services Systems Act of 1973. These acts represent initial efforts to apply the emergency medical and trauma care lessons learned by physicians serving in the US military during the Vietnam and Korean Wars. Those initial federal acts led to education and training programs for emergency medical technicians (EMTs) and initial model development of regional trauma and emergency medical services.

The early efforts were a huge step forward but the model of trauma care developed was limited, emphasizing hospital-based acute care. A second major step forward in trauma care policy was the development of the *Model Trauma Care Systems Plan* in 1992 by HRSA in collaboration with provider stakeholder groups. The new model that was created called for an *inclusive* trauma care system. This new *inclusive* trauma system model included not only trauma centers, but all healthcare facilities according to availability of trauma resources.

In 2002, HRSA conducted the *National Assessment of State Trauma System Development, Emergency Medical Services Resources, and Disaster Readiness for Mass Casualty Events*. This study demonstrated much progress but also revealed that few states could boast of trauma systems that included all the components of HRSA's *inclusive* trauma system model. Not surprisingly, this assessment also demonstrated that states with the most comprehensively developed trauma systems were better prepared to medically handle disasters of all types.

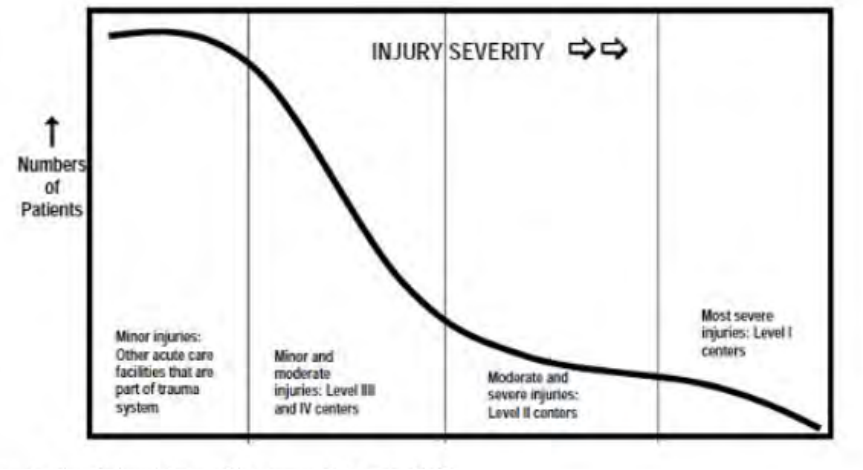
In 2006, HRSA updated its trauma system model with the publication of *Model Trauma Systems Planning and Evaluation*. This update to the model utilizes a public health framework that views traumatic injury as a *disease* that can be prevented or managed in a way that reduces severity and improves ultimate outcome.

Today, the nationally recognized resource for development of trauma centers and statewide trauma systems is *Resources for Optimal Care of the Injured Patient 2014* by the American College of Surgeons Committee on Trauma (ACS COT). This guidebook utilizes the HRSA model and provides detailed descriptions of the organization, staffing, facilities, and equipment needed to provide state-of-the-art treatment for the injured patient at every phase of trauma system participation. It also includes a *Criteria Quick Reference Guide* that identifies the criteria necessary to meet the requirements included in each chapter of the guidebook. A copy of this reference guide is provided on the LERN website at lern.la.gov/trauma/state-designated-trauma-centers/.

Trauma System Model

LERN is using the trauma system material developed by HRSA and ACS to help guide the building of an *inclusive* statewide trauma system in Louisiana. The *inclusive* trauma system model recognizes the full continuum of injury severity and utilizes all acute care facilities to get the injured patient to the **Right Place** at the **Right Time** to receive the **Right Care**.

Inclusive Trauma System Model



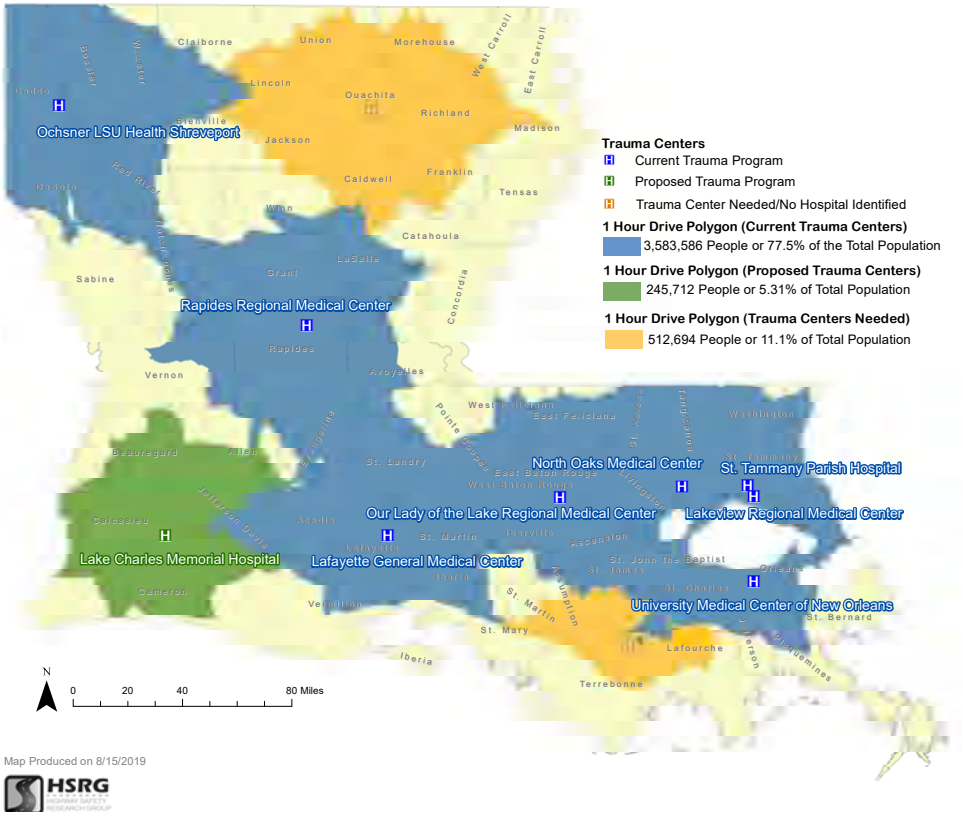
Resources for the Optimal Care of the Injured Patient 2014
American College of Surgeons
Committee on Trauma

A trauma system is a partnership between public and private entities to address injury as a community health problem. A fully-developed statewide trauma care system has many components – requiring a multidisciplinary team approach that allows all involved healthcare providers to function in pre-planned concert. Emergency care providers match patients, through protocols and medical supervision, with the medical facility equipped with the resources to best meet the patient's needs – sometimes bypassing the closest medical facility.

A trauma system is organized to protect the people from unnecessary deaths and morbidity due to trauma. Mature trauma systems encompass a full continuum of service components – from injury research and prevention, pre-hospital care, and hospital care – to rehabilitative services and performance improvement activities.

Resources for the Optimal Care of the Injured Patient 2006

The LERN Board's vision for trauma includes the establishment of at least one ACS-verified, state-designated trauma center in each region of the state. Represented below is the 2019 version of LERN's "ideal" trauma center network map, which includes existing state-designated trauma centers and LERN's proposed geographic locations for additions to Louisiana's trauma center network.



Updated: August 2019

LERN's Strategic Priorities

LERN's governing board has established a list of strategic priorities to guide organizational planning and decision-making across all four major components of LERN activity – trauma, stroke, STEMI, and all disasters response. The Board reviews the strategic priorities annually and updates the list as necessary to accurately reflect the priority goals and tasks of the organization. LERN's current (2019) trauma system strategic priorities include the following items.

1. Build and Maintain Provider Participation in LERN Care Coordination Networks

Assess and map the adequacy of LERN Care Coordination Networks for trauma, stroke, and STEMI. Facilitate the continuance of provider participation, the addition of new participating providers and the elevation of participation levels as appropriate.

2019: *Twelve-Month Goals (Trauma)*

- Increase the use of the LCC to facilitate transfers for trauma
- Tri-regional engagement with referral centers in regions to educate on the use of the LCC for Transfers
- Regional engagement of EMS providers for system update and burn system education

2019: *Twelve-Month Goals (Stroke)*

- One new PSC in Region 3 and 8
- One new Level III in Regions 4 through 8
- Provide support and remediation to prevent demotion of Level III stroke centers to Level IV
- Engage the State Stroke Workgroup and EMS Stroke Workgroup to participate in updates to existing stroke protocols and guidelines.

2019: Twelve-Month Goals (STEMI)

- Re-engage STEMI Receiving centers in outreach and network building
- Re-engage STEMI Referring Centers in care coordination with partner Receiving Centers.

2019: Twelve-Month Goals (All Disaster Response)

- Utilize the regional commission structure and regional partners to ensure involvement in
  one MCI/Disaster drill annually in each region of the state.
- Engage one new region to participate in MCI Boot Camp
- Conduct EMS TOC tabletop exercise prior to hurricane season.

2. Uphold and Refine Standards for LERN's Care Coordination Networks

Lead network-specific programs designed to assess, uphold, and refine standards for LERN's Care Coordination Networks utilizing the expertise of LERN's medical directors in collaboration national authoritative organizations and LERN-convened expert panels.

2019: *Twelve-Month Goals (Trauma)*

- Further maturation of the Trauma Collaborative to define and implement new Statewide Clinical Care Guidelines or other protocols to improve timeliness and appropriateness of trauma care

2019: Twelve-Month Goals (Stroke)

- Develop Stroke Education Course and engage regional partners to help teach course. Teach course in every region by 2020.
- Develop education module and update Emergency Department physicians on the changes in stroke standard of care – specifically for Large Vessel Occlusions.

2019: Twelve-Month Goals (STEMI)

- Facilitate data sharing between Receiving and Referring Centers and EMS
- Reevaluate existing transfer protocols and facilitate new clinical protocol development (as needed) between Receiving and Referring Centers

3. Leverage Data to Continuously Assess and Improve LERN Networks Performance

Work collaboratively with LERN's participating providers and other stakeholders to refine and expand the data available to LERN for performance improvement initiatives. Lead network-specific programs that leverage available data to assess and improve the performance of LERN's Care Coordination Networks.

2019: *Twelve-Month Goals (Trauma)*

- Recruit and hire a data analyst to facilitate data base utilization and reporting
- Use of the Trauma Collaborative to enhance data reliability in the registry
- Continue development of pre hospital benchmarking and evaluate the reception of this by prehospital providers
- Expand the pilot of the trauma ID band program

2019: Twelve-Month Goals (Stroke)

- Bi-annual aggregation of Level III Stroke Center data for trends in treatment performance
- Initiate pilot LVO variable data submission in all Level III Stroke Centers
- Trend tPA administration rate from LaHIDD data set
- Implement requirements for Level 1 and Level II Stroke Centers to submit Door to Needle metrics to LERN.

2019: Twelve-Month Goals (STEMI)

- Identify optimal STEMI registry for Louisiana, after seeking input from stakeholders across the care spectrum

- Facilitate data collection and submission to afore-identified registry, with aggregate and de-identified individual data sharing with LERN

4. Strengthen LERN's Mission Sustainability

Strengthen the financial sustainability of LERN's mission, including the continuous development and improvement of statewide care coordination systems for trauma and time-sensitive illness, and the effective administration of LERN's state office operations and statewide communications center.

2019: *Twelve-Month Goal*

- Identify and pursue, throughout the first half of 2019, potential dedicated funding options.

SECTION THREE: PRE-HOSPITAL TRAUMA CARE

Pre-hospital providers, protocols, and communication systems are critical to the effective delivery of pre-hospital care and transport services for trauma patients.

EMS Providers

Fifty-six percent of Louisiana EMS providers participate in LERN's trauma care provider network– utilizing LERN's pre-hospital protocols and collaborating with LERN's Communications Center (LCC) to efficiently deliver trauma patients to the most appropriate hospital-based resources that can best address their specific injuries. This amount of participation provides coverage to 85% of the state's population.

EMS participation in LERN's trauma care network is voluntary – the terms of EMS provider participation are captured in a written agreement. Through the participation agreement, EMS providers agree to utilize LERN entry criteria and destination protocols, coordinate with the LCC, provide relevant data, and participate in LERN's efforts to manage and improve the quality of the statewide trauma system.

A sample copy of LERN's EMS Provider Agreement form is provided in **Appendix B**.

Visit lern.la.gov/trauma for region-specific lists of LERN's participating EMS providers.

Protocols

LERN has adopted the tagline – ***Right Place. Right Time. Right Care.***

The tagline brings to mind two basic trauma facts – first, not all injuries are equal in severity, and second, not all hospitals have equal resources available to care for trauma patients. The tagline also alludes to one of the most basic trauma system goals – to evaluate and expeditiously deliver each trauma patient to a hospital facility capable of providing the level of care needed.

The successful management of trauma patients requires the accurate identification of specific injuries or mechanisms likely to cause severe injury. Protocols are used to identify patients with injuries and mechanisms that warrant pre-hospital (EMS) coordination with the LCC to consistently deliver those patients to the *Right Place* at the *Right Time* to receive the *Right Care*.

The LERN Board has approved a protocol labeled the *LERN Destination Protocol: Trauma* to support the pre-hospital evaluation and expeditious delivery of trauma patients. This protocol is based on the CDC Field Triage Scheme developed by the Committee on Trauma, American College of Surgeons with input from an expert panel representing EMS, emergency medicine, trauma surgery, and public health. A copy of the *LERN Destination Protocol: Trauma* is provided in **Appendix C**.

The LERN Board has approved a protocol labeled the LERN Hospital Interregional Transfer Guidelines and LERN Hospital Interregional Transfer Protocol. The protocol aims to facilitate timely transfers to definitive care hospitals.

LERN Communications Center

The LERN Communications Center (LCC) is a key element of Louisiana's statewide trauma system. LERN's participating hospitals provide the LCC with real-time capacity and capability updates – producing all the information the LCC needs to maintain an accurate inventory of what hospital resources are available, and where, 24/7/365.

When a pre-hospital provider (EMS) or a hospital determines a patient meets trauma criteria, as indicated in the *LERN Destination Protocol: Trauma*, the LCC is engaged to match the patient to the appropriate level of care/hospital resources available. The LCC is staffed 24/7/365 by nationally registered paramedics with in-depth knowledge of the LERN network design, function, and protocols.

The LCC is equipped with an emergency resources information system that provides LERN with a continuous real-time functional status display of all LERN network hospitals. Each participating hospital has a real-time functional status display of their regional network hospitals resources. This system provides an information grid listing of:

- Individual hospitals;
- Each hospital's resource capability as it relates to General Surgery, Orthopedic Surgery, Neurosurgery, Pediatric Trauma, OB Trauma, MRI, CT, etc.; and
- The hospital's primary trauma resource components – indicating, in real time, the availability or non-availability of these individual components (i.e., the availability of surgery and surgical subspecialties).

The LCC also facilitates emergency department to emergency department (ED to ED) transfers through this information system.

> It is important to note that the LCC **DOES NOT FUNCTION** as EMS Medical Control and it **IS NOT** a 911 Public Service Access Point (PSAP). **The LCC only handles patients who meet the Standard LERN Entry Trauma Criteria.**

The LCC communications infrastructure is designed to interface with the State's current communication technology systems – to support LERN's day-to-day network operations and the statewide interoperability mission in times of natural disasters and manmade emergencies.

Call volume handled by the LCC has steadily grown since the first call in 2008. More information on LCC call volume can be found on the website – www.lern.la.gov.

SECTION FOUR: DEFINITIVE CARE FACILITIES

The network of definitive care facilities that participate in LERN's trauma care system represents approximately 98% of all hospitals in Louisiana that possess an emergency department.

Trauma Centers

Louisiana law (LA RS 40:2171-2173) states that the "trauma center" label shall be reserved exclusively for hospitals with state-issued trauma center designation. The Health Standards Section of LDH is charged with the responsibility of designating a hospital as a Level I, Level II, or Level III trauma center. A copy of LA RS 40:2171-2173 is provided in **Appendix D**.

To receive LDH designation as a Level I, Level II, or Level III trauma center, Louisiana hospitals must successfully complete the trauma center verification process of the ACS COT. Level I is the highest level of trauma center – requiring the greatest commitment of hospital resources.

Hospitals that want to seriously explore the trauma center verification process should purchase *Resources for Optimal Care of the Injured Patient 2014* by the ACS COT. To order a copy of this text, visit www.facs.org/trauma/publications.html. To learn more about the ACS COT trauma center verification process, go to www.facs.org/trauma/verificationhosp.html.

Trauma centers in Louisiana are required to contribute data to the statewide trauma registry, participate in LERN's Regional Commissions, and participate in LERN regional and state level performance improvement and injury prevention activities.

Louisiana's designated trauma centers include:

- Region 1: Norman E. McSwain, Jr. MD Spirit of Charity Trauma Center – University Medical Center – New Orleans (Level I)
- Region 2: Our Lady of the Lake Regional Medical Center – Baton Rouge (Level II)
- Region 4: Lafayette General Medical Center – Lafeyette (Level II)
- Region 6: Rapides Regional Medical Center – Alexandria (Level II)
- Region 7: LSU Health Sciences Center/University Health – Shreveport (Level I)
- Region 9: North Oaks Medical Center – Hammond (Level II), Lakeview Regional Medical Center – Covington (Level III) and St. Tammany Parish Hospital (Level III)

State Trauma Center Designation Process

RS 40: 2173 provides for the rules, regulations, and standards for licensure as a trauma center. The Department of Health, specifically the Health Standards department, designates a healthcare facility as a trauma center upon verification from the American College of Surgeons that the facility has met its criteria for a Level I, II, or III Trauma Center. These are the three levels of trauma centers currently recognized in the Louisiana State Trauma System. The "trauma center" label shall be reserved exclusively for hospitals with state-issued trauma center certification.

The Health Standards Section of LDH issues standard forms for applications. Instructions and forms issued by Health Standards are designed to assist providers in submitting the required information to add a trauma center. These forms are:

- HSS-HO-34 Application & Checklist for Hospital Trauma Center Designation
- HSS-PR-02 Plan Review Attestation

- HSS-HO-09 Attestation

Designated Trauma Centers must be re-verified by the ACS COT every three years. Upon re-verification by the ACS COT, trauma centers must request a renewal of the state designation from the Health Standards Section at LDH. The required Health Standards forms are included in the Hospital Trauma Center Licensing Renewal Packet:

- HSS-HO-034b Application & Checklist for Hospital Trauma Center Renewals
- HSS-HO-09 Attestation

These forms are provided in **Appendix E**, and can be downloaded directly from the LDH website at http://dhh.louisiana.gov/index.cfm/page/1809. Questions related to these forms or the application process should be directed to Health Standards (225) 342-6194.

Trauma Programs

A goal of the LERN Board is to establish a statewide trauma system that includes at least one verified trauma center in each of the nine LDH regions of the state. The LERN Board recognized the opportunity to reduce the morbidity and mortality of trauma patients in Louisiana in areas without an existing Level I or Level II trauma center by adopting a Trauma Program process.

The Trauma Program process recognizes achievement of specific benchmarks by hospitals that are actively pursuing Level II or Level III Trauma Center verification through the ACS. Louisiana's Trauma Program criteria are drawn from the *Resource for the Optimal Care of Injured Patients 2014* published by the ACS. *Trauma Program recognition is distinct and different from the Trauma Center certification/designation by the state. To be certified as a trauma center in Louisiana, a hospital must fully satisfy the requirements of R.S. 40:2172 and 2173.*

Qualification for LERN Trauma Program recognition requires the hospital be in a LERN region that does not have an existing Level I or Level II ACS verified trauma center or a recognized Level II or Level III trauma program. If there is a LERN-recognized Level II or Level III trauma program already in the region, the hospital must complete the most current version of the ACS needs based assessment of trauma systems tool (ACS NBATS). If the number of trauma centers allocated by the tool is less than or equal to the number of existing trauma programs and trauma centers in the region, the hospital is not eligible for trauma program recognition.

LERN's Procedure for Trauma Program Recognition

A. A hospital must complete the LERN-approved form, "Application for Recognition of Trauma Program."

B. The hospital CEO must complete and sign the LERN-approved trauma program checklist/attestation for the applicable trauma program level.

    1) By this attestation, the hospital CEO ensures 24/7/365 availability of the resources listed.

    2) The attestation must be validated by a site visit by LERN staff.

    3) Upon CEO attestation and/or site visit, if it is determined by the LERN executive committee in conjunction with the LERN Trauma Medical Director, that the required benchmarks are not in place the hospital will not be eligible for trauma program verification.

C. After satisfying the requirements of A. and B. above, the hospital will be recognized as a trauma program and such recognition will be added to the LERN resource management screen for the purpose of routing trauma patients.

D. To maintain trauma program recognition, the hospital must schedule an ACS verification or consultation site visit for "the desired trauma level within 12 months of LERN acceptance of the trauma program checklist/attestation.

    1) If an ACS verification or consultation site visit is not scheduled within 12 months of the signed checklist/attestation, the "trauma program" indicator on the LERN resource management screen will be removed.

E. After a consultation visit for the desired trauma level, the hospital has one year to achieve verification by the ACS or the trauma program indicator will be removed on the LERN resource management screen.

    1) If the hospital fails the ACS verification visit and a focused review visit, the hospital will lose trauma program status. The trauma program indicator will be removed from the LERN resource management screen.

    2) If the hospital fails the ACS verification visit and a focused review visit, the hospital will lose trauma program status. The trauma program indicator will be removed on the LERN resource management screen.

F. After loss of trauma program status for failing the ACS verification visit and focused review visit, trauma program status may be regained provided the following conditions are met:

    1) A LERN designee and either the LERN trauma medical director or a trauma surgeon must review the deficiencies and findings of the ACS at a site visit;

2) The hospital must develop a remediation plan and apply to the LERN board for approval of trauma program status;

3) The LERN board will review the LERN team assessment of deficiencies and the hospital's remediation plan;

4) The LERN board must vote to approve the trauma program status request.

The documents referenced in this section can be found in the following appendices.

Appendix F: Attestation Requirements Level II Trauma Program
Appendix G: Attestation Requirements Level III Trauma Program
Appendix H: Trauma Program Application
Appendix I: Needs Based Assessment of Trauma Systems Tool (NBATS)
Appendix J: Rule: LAC 48:I, Chapter 197, §19701-§19707
Appendix K: Ammendment to Trauma Program Rule
Appendix L: Attestation Requirements Pediatric Level I and II Trauma Program

Participating Hospitals

The clear majority of hospitals that participate in the LERN provider network are not designated as trauma centers. Hospital participation in LERN is voluntary – the terms of hospital participation are captured in a written agreement.

> Optimally, all acute care facilities with emergency departments should be formally prepared and designated to care for injured patients at a level commensurate with their resources, their capabilities, and community's needs..
>
> *Resources for Optimal Care of the Injured Patient 2014*
> American College of Surgeons Committee on Trauma

Through the participation agreement, hospitals define the level of trauma care resources typically available at their facility and agree to routinely notify LERN of changes in the availability of their trauma care resources using the Resource Management System. The agreement also requires hospitals to utilize LERN protocols, coordinate with the LERN Communications Center, provide relevant data, and participate in LERN's efforts to manage and improve the quality of the trauma system.
A sample copy of the LERN hospital agreement form (including LERN trauma, STEMI, stroke, and interregional transfer protocols) is provided in **Appendix M**.

See the Trauma page of the LERN website (www.lern.la.gov/trauma) for region-specific lists of LERN's participating hospitals.

Rehabilitation

Fully developed trauma center programs and trauma systems include resources and processes to support rehabilitation of the trauma patient.

Louisiana's state-designated trauma centers are required to offer rehabilitation services consistent with ACS-COT trauma center verification requirements, including, but not limited to:

- In Level I and II trauma centers, rehabilitation services must be available within the hospital's physical facilities or as a freestanding rehabilitation hospital, in which case the hospital must have transfer agreements.

- In Level I and II trauma centers, these services [physical therapy, social services, occupational therapy and speech therapy] must be available during the acute phase of care, including intensive care[1].

SECTION FIVE: STATEWIDE TRAUMA REGISTRY

A statewide trauma registry is a data collection system that includes a file of uniform data elements that describes the injury event, demographics, pre-hospital information, care, outcomes, and costs of treatment for injured patients. The purpose of such a registry is to mine the data for what it can tell us – registry data can be coded, compiled, analyzed, and reported. A trauma registry is an important management tool that is used for performance management and improvement, research, and injury prevention.

Individual trauma centers that are verified by the ACS COT must develop and maintain their own trauma registries and submit their data to the National Trauma Data Bank (NTDB). In Louisiana, hospitals must successfully complete the ACS COT verification process as a condition of state designation as a trauma center.

> The rehabilitation of injured patients should begin the first hospital day. Acute care should be consistent with the preservation of optimal functional recovery. The ultimate goal of trauma care is to restore the patient to preinjury status. Not only is this effort best for the patient; it also is less costly. When rehabilitation results in independent patient function, there is a 90% cost saving compared with costs for custodial care and repeated hospitalizations.
>
> *Resources for Optimal Care of the Injured Patient 2014*
> American College of Surgeons
> Committee on Trauma

[1] Criteria Quick Reference Guide, Resources for Optimal Care of the Injured Patient 2014

Louisiana's statewide trauma registry was authorized by the Louisiana Legislature in 2010. The legislation charges the LERN Board to "establish and maintain a statewide trauma registry to collect and analyze data on the incidence, severity, and causes of trauma, including traumatic brain injury. The registry shall be used to improve the availability and delivery of pre-hospital or out-of-hospital care and hospital trauma care services."

This legislative act also includes a requirement that all state-designated trauma centers contribute their relevant trauma data to the statewide trauma registry (when adequate funding is provided to cover the relevant trauma center administrative costs).

Technology

LERN has acquired the information technology needed to establish and maintain a statewide trauma registry. The technology vendor is Image Trend and the registry technologies utilized by LERN include EMS State Bridge and Patient Registry.

Data Dictionary

LERN has developed data dictionaries that include lists of specific data elements and outline reporting requirements for the hospital patient registry and the EMS patient registry. The data dictionaries include:

> *"Trauma systems are needed to implement an organized system of care that meets all needs of injured pateints. Such a system cannot exist without data collection and analysis."*
>
> *Resources for Optimal care of the injured Patient 2014*
> **American College of Surgeons**
> **Committee on Trauma**

- Hospital: Facility-Based Data Dictionary (For Image Trend Users – explains how to enter data into the web-based statewide trauma registry)
- Hospital: Non-Facility-Based Data Dictionary (For other vendors – technical requirements to upload to the Louisiana State Trauma Registry)
- EMS: Facility-Based EMS Users (For Image Trend Users – Explains how to enter data into the web-based statewide EMS registry)
- EMS: Non-Image Trend Users (For other vendors – technical requirements to upload to the Louisiana State Trauma Registry)

See the Trauma Registry page of the LERN website (lern.la.gov/trauma/trauma-registry) for access to LERN's trauma registry data dictionaries.

Trauma Registry Participation

Current hospital participation in the statewide trauma registry is limited to Louisiana's state-designated trauma centers, the trauma programs, and Children's Hospital New Orleans. EMS participation includes 30 providers across the state. A complete list of participating entities as of 6/20/2017 is included in **Appendix L**.

Louisiana's goal, which is the ideal stated by the ACS, is for all acute care facilities that treat injured patients to contribute to the state trauma registry. Receiving injury data from all facilities treating trauma patients would inform public health decision making based on comprehensive injury data regarding: incidence, care, cost, and outcome of injuries. Once stratified, population-based injury prevention programs could be targeted to specific regions.

Trauma Registry Submission Schedule

Calendar Year Quarter		Submission Deadline
January - March Admissions		June 1
April - June Admission		September 1
July - September Admission		December 1
October - December Admission		March 1

Trauma Registry Reports

LERN compiles annual state trauma registry reports that include standard dataset information established by the National Trauma Database (NTDB). These reports are used to compare Louisiana to national metrics published in the annual NTDB Report. Cause of injury reports help guide injury prevention efforts. Without a comprehensive registry it is difficult to make broad assumptions based on the data. LERN began publishing annual state trauma registry reports began in 2012 and current reports include:

- Patient Age Distribution
- Cause of Injury
- Cause of Injury by Survivability
- Received Pre-Hospital/Transfer
- Trauma Type by Gender
- Facility Traumatic Deaths by Trauma Type
- Blood Alcohol Testing
- Drug Screening

- Injury Severity Score (ISS) by Age
- ISS Range
- Fatalities by ISS
- Hospital Length of Stay
- Intensive Care Unit (ICU) Length of Stay
- Emergency Department/Acute Care Dispositions
- Hospital Discharge Disposition
- Top Dispositions (Hospital and Emergency Department)
- Hospital Admissions by Trauma Type
- Paid/Not Paid Annual Comparison

LERN's annual trauma registry reports are available on the Trauma Registry page of the LERN website (lern.la.gov/trauma/trauma-registry).

SECTION SIX: PERFORMANCE IMPROVEMENT

Today, performance improvement efforts in hospitals (and other healthcare providers) include formal organizational structures and activities focused on a continuous process of recognition, assessment, and correction. A basic tenet of performance improvement is that the opportunities for improving the efficaciousness, safety, and cost-effectiveness of care are ongoing.

In other words, performance improvement is focused on improving the *value* of care. The value equation includes three variables – quality of process, quality of outcome, and cost.

$$\text{Value of Care} = \frac{\text{Quality Process + Quality of Outcome}}{\text{Cost}}$$

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In Louisiana, hospitals must successfully complete the ACS COT verification process as a condition of state designation as a trauma center. Individual trauma centers that are verified by the ACS COT must include a structured trauma program effort to demonstrate a continuous process for improving care for injured patients. The ACS COT does not dictate methodology for this performance improvement requirement, but its guidance is consistent with the Institute of Medicine's six quality aims for patient care: safe, effective, patient centered, timely, efficient, and equitable.

Statewide trauma systems also commonly pursue trauma care performance improvement at the regional (within a state) and statewide levels – utilizing the resources of the statewide trauma registry and the expertise of their regional trauma commissions. LERN is actively promoting and building hospital participation in Louisiana's statewide trauma registry to reach a critical mass of participation necessary to facilitate trauma care performance improvement efforts at the regional and statewide levels. The ACS COT requires verified trauma centers to use a risk-adjusted benchmarking program as part of the performance improvement requirement, and encourages all trauma centers (of all levels) to participate in regional and statewide performance improvement and patient safety (PIPS) programs.

LERN's current performance improvement efforts are limited to evaluating the operations of the LERN Communications Center. The evaluation process is two-fold: 1) provider-related issues pertaining to the LCC operations staff and 2) system-related issues between the communications center and LERN stakeholders. Sample audit filters include the following.

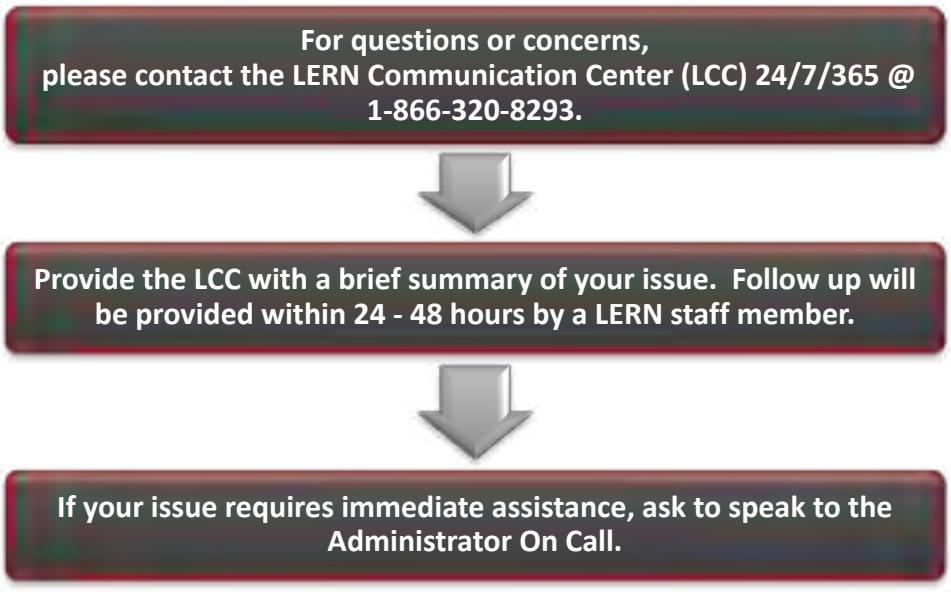
LCC Provider Audit Filters

- Length of call
- Timely answer
- Professional language
- Introduced self
- Triaged correctly
- Routed correctly
- Script followed
- Standard operating procedure (SOP) followed

LCC Operations and System Audit Filters

- Patient routing refused by hospital
- Hospital resources not updated by hospital
- EMS did not contact LERN
- Administrator on call contacted
- No resources in region (note lack of … i.e., ortho, neuro, etc.)
- Secondary transfers

In addition to directing patients and resource management tracking, the LERN Communications Center serves as a single point of entry to report all questions, concerns, and issues. This allows stakeholders the opportunity to report issues concurrently, 24/7/365. When a query is reported to the LCC, a case review is initiated and directed to the LERN operations staff for investigation and loop closure. The following schematic illustrates this process.



SECTION SEVEN: INJURY RESEARCH AND PREVENTION

The *2014 American College of Surgeons Resources for Optimal Care of the Injured Patient* manual requires Level I and Level II Trauma Centers to implement at least two programs that address one of the major causes of injury in the community. Given that the ongoing development of Louisiana's trauma system is aligned with the ACS guidelines and trauma center verification program, injury prevention efforts in the state are led and mostly funded by the designated trauma centers.

LERN collaborates with the state-designated trauma centers in injury prevention efforts and fosters replication of programs via the state Trauma Program Managers Group. LERN anticipates the day when hospital participation in the statewide trauma registry will reach a critical mass to support the design and implementation of regional and statewide injury research and prevention initiatives.

SECTION EIGHT: ALL DISASTER AND MASS CASUALTY INTERFACE

Louisiana's Department of Health, Center for Community Preparedness coordinates the State's response to public health threats of all types, including natural disasters (hurricanes, floods, and pandemics) and man-made emergencies (industrial spills and explosions, other large-scale accidents, and terrorist attacks).

LERN's Communications Center (LCC) supports the Center for Community Preparedness by serving as the "first call" helpdesk for the state's ESF-8 Portal, and 24/7/365 information coordinator for unfolding disaster/mass casualty events. In this role, LERN provides timely information that helps Louisiana's hospitals, other healthcare providers, and relevant stakeholder agencies prepare for and manage response to the emergency events they face.

Regional Coordinators

Louisiana's All Disasters Response effort utilizes regional coordinators including:

- Designated Regional Hospitals
- Hospital Designated Regional Coordinators
- EMS Designated Regional Coordinators

Designated Regional Hospitals (DRH) are larger acute care facilitates with emergency room capabilities and many subspecialty services. They serve voluntarily and have agreed to provide additional capacity and resources in the initial emergency response of a mass casualty or event.

Designated Regional Coordinators (DRC) leadership for each region is provided through Hospital designated regional coordinators and EMS designated regional coordinators. Primary responsibilities for the DRCs include:

- To serve as the liaison with other health-related entities and on behalf of the industry they represent and to provide liaison with non-health related entities such as the Parish Office of Homeland Security and Emergency Preparedness.
- To support the patient transfer process during a declared state of emergency.
- To facilitate the identification of a medical evacuation queue during a declared state of emergency.
- To facilitate the development and implementation of regional and inter-organization/facility emergency preparedness plans for designated regions in the State of Louisiana.
- To lead the region's process for planning, training, exercises, development of, testing of, continuous improvement of, and management of regional hospital response to emergency situations.
- To be the leader for the region during a statewide emergency in which ESF-8 is tasked to respond.

LERN works collaboratively with the Designated Regional Hospitals and Coordinators – critical resources on the ground and across the state that are key to coordinating all disasters response.

Lists of current Designated Regional Hospitals and Coordinators are available on the LERN Disaster Response: Regional Coordinators page of the LERN website (www.lern.la.gov).

Mass Casualty Incident (MCI) Levels

A mass casualty incident (often shortened to MCI and sometimes called a multiple-casualty incident or multiple-casualty situation) is any incident in which emergency medical services resources, such as personnel and equipment, are overwhelmed by the number and severity of casualties. Depending on the geographic area and hospitals surrounding even small numbers of patients can tax the local emergency system. In an effort to streamline processes with ensuring appropriate routing of patients involved, LERN will follow the following guidelines for MCI patient distribution:

MCI Level 1 – Incident will require local resources and responding agencies. Incident may require additional resources within the region.

- Size – 5 to 10 patients
- Hospitals – notification to local hospitals in area near location of incident
- Triage – patients identified as **RED**, **YELLOW**, **GREEN** following START Triage guidelines and primary injury/service needed ***(LERN may be able to direct patients to specific area emergency departments with appropriate resources in small scale event)***
- Communications – primary: phone; secondary: radio. LERN Communications Center will assign a LERN Regional Tactical channel for transport operations when necessary.

MCI Level 2 – Incident will require local resources and responding agencies. Incident may require additional resources within the region.

- Size – 10 to 20 patients
- Hospitals – notification to local hospitals in area near location of incident and/or adjacent city or parishes
- Triage – patients identified as **RED**, **YELLOW**, **GREEN** following START Triage guidelines and primary injury/service needed ***(LERN may be able to direct patients to specific area emergency departments with appropriate resources in small scale event)***
- Communications – primary: phone; secondary: radio. LERN Communications Center will assign a LERN Regional Tactical channel for transport operations when necessary.

MCI Level 3 – Incident will require multiple regional resources and responding agencies. Incident may require additional resources in adjacent regions.

- Size – 20 to 100 patients
- Hospitals – initial notification to all regional hospitals and/or adjacent regions
- Triage – patients identified as **RED**, **YELLOW**, **GREEN** following START Triage guidelines
- Communications – Phone and radio communications. Incident command, operational officers, and area hospitals should monitor HRSA __ during incident. LERN Communications Center will assign a LERN Regional Tactical channel for transport operations when necessary.

MCI Level 4 – Incident will require multiple regional resources and responding agencies. Incident may require additional resources in adjacent and/or multiple regions.

- Size – 100 to 1000 patients or casualties
- Hospitals – initial notification to all hospitals statewide
- Triage – patients identified as **RED**, **YELLOW**, **GREEN** following START Triage guidelines
- Communications – Phone and radio communications. Incident command, operational officers, and area hospitals should monitor HRSA __ during incident. LERN Communications Center will assign a LERN Regional Tactical channel for transport operations when necessary.

MCI Level 5 – Incident will require statewide resources.

- Size – greater than 1000 patients
- Hospitals – initial notification to all hospitals statewide
- Triage – patients identified as **RED**, **YELLOW**, **GREEN** following START Triage guidelines
- Communications – Phone and radio communications. Incident command, operational officers, and area hospitals should monitor HRSA __ during incident. LERN Communications Center will assign a LERN Regional Tactical channel for transport operations when necessary.

A copy of the current MCI procedure (process flowchart) for EMS is available on the LERN Disaster Response: Mass Casualty Incident Levels page of the LERN website (www.lern.la.gov).

Response Planning and Preparation

LERN participates in a wide variety of local, regional, and statewide All Disaster Response preparatory activities ranging from active shooter drills to emergency drills to system testing and planning. These practice efforts builds streamlined response capabilities that can operate under difficult circumstances and in the worst of times.

LERN has been tasked with the management and operations of the EMS Tactical Operations Center (EMS TOC) during disasters. The EMS TOC is responsible for the following Emergency Support Functions Health and Medical (ESF 8), Ambulance Surge Plan which is designed to support the following operations:

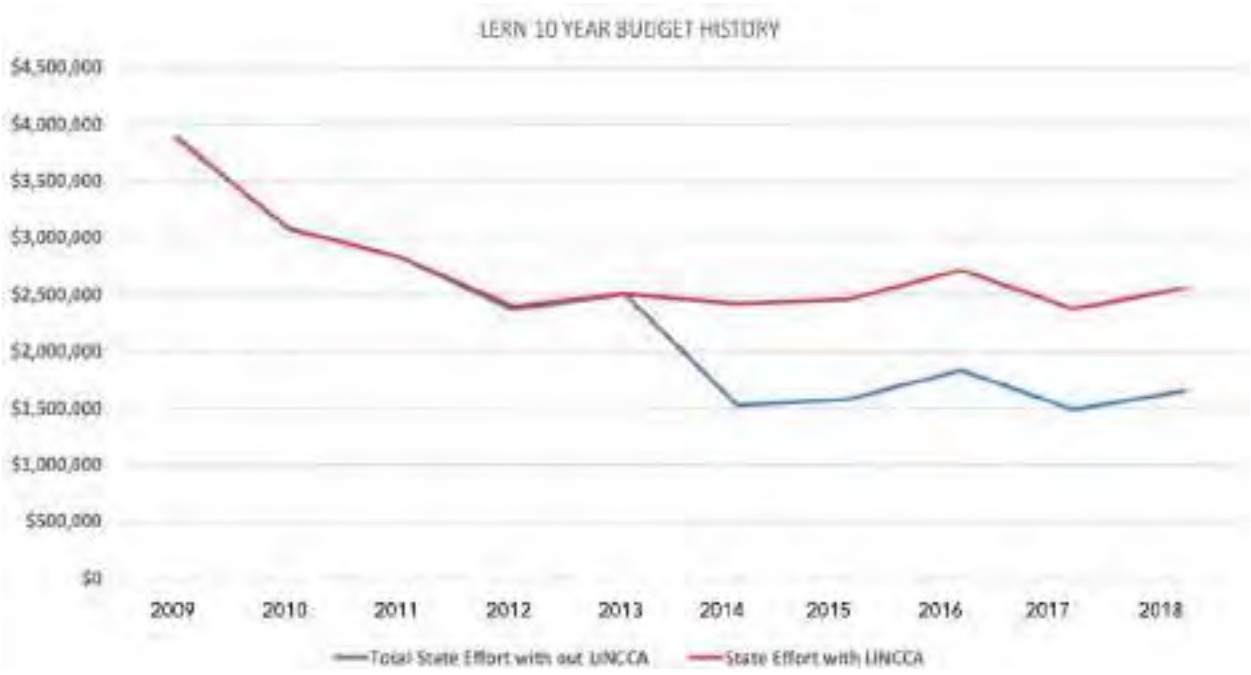
- Support the hospital evacuation process, referred to as the medical Institution Evacuation Plan (MIEP) with Emergency Medical Services (EMS) surge assets.
- Support the nursing home evacuation process with EMS surge assets, secondary to nursing home contracts and plans.
- Augment community 9-1-1 services with EMS surge assets.
- Support Medical Bus Triage Operations with EMS personnel and assets.
- Support staff augmentation and EMS assets at state operated Medical Special Needs Shelters (MSNS), Critical Transportation Need Shelters (CTNS), Federal Medical Stations (FMS), and other designation locations.
- Support repatriation of designated evacuees with transportation assets.

SECTION NINE: FINANCIAL

State funding for LERN's Communications Center, state-level administration, educational services, and regional trauma networks support began in 2006. During the initial years of operational funding, LERN existed as a program inside the Louisiana Department of Health (LDH). LERN became a separate budget unit under LDH effective Fiscal Year (FY) 08-09. Since that time, LERN has consistently demonstrated the ability to successfully manage an independent budget, partner with LDH, maximize the state's investment, and maintain steady growth and development.

LERN Funding: Sources and History

Funding for LERN comes from two relatively unstable sources – the state general fund (SGF) and federal LINCCA (Low-Income and Needy Care Collaboration Agreement) funds. Since fiscal year ending 2009, total LERN funding has decreased by 36% from approximately $3.9 million in FYE 09 to approximately $2.5 in FYE 17. During that same time, state general funds to LERN have decreased 59% from approximately $3.9 million to $1.6 million. The following chart illustrates these declines.



Current funding supports operations across LERN's four distinct areas of focus – trauma, stroke, STEMI (the deadliest form of a heart attack) and all disasters response.

Louisiana Emergency Response Network Fund

LERN's research of statewide trauma systems in other states indicates that many states have established one or more funding mechanisms to provide direct financial incentives for hospitals to establish and maintain a designated trauma center status.

In some states, a special statewide trauma system fund has been established to receive and distribute dedicated state funding to designated trauma centers. Consistent with this trend, the Louisiana Legislature established the Louisiana Emergency Response Fund in the 2010 Regular Session. This legislation states "the source of monies deposited into the fund may be any monies appropriated annually by the legislature, including federal funds, any public or private donations, gifts, or grants from individuals, corporations, nonprofit organizations, or other business entities which may be made to the fund, and any other monies which may be provided by law." The legislation also requires that any monies in the fund shall be used as directed by the LERN Board for grants, projects, and services which address the goals and objectives of the LERN Board.

LERN is continuously exploring opportunities to secure monies for this new trauma fund and is collaborating with LDH to explore potential opportunities to pursue dedicated trauma funding.

APPENDIX A

LERN State Law

Attachment III

La. R.S. 40:2841-2846 LOUISIANA EMERGENCY RESPONSE NETWORK (LERN)

§2841. Legislative purpose

The legislature declares that in order to safeguard the public health, safety, and welfare of the people of this state against unnecessary trauma and time-sensitive related deaths and incidents of morbidity due to trauma, a comprehensive, coordinated statewide system for access to regional trauma-patient care throughout the state be established. This system shall be compatible and interfaced with the Governor's Office of Homeland Security and Emergency Preparedness.

Acts 2004, No. 248, §1, eff. June 15, 2004; Acts 2006, 1st Ex. Sess., No. 35, §4, eff. March 1, 2006; Acts 2006, No. 442, §3, eff. June 15, 2006.

§2842. Definitions

As used in this Chapter the following terms shall have the following meanings:

(1) "Board" means the Louisiana Emergency Response Network Board.

(2) "Department" means the Department of Health and Hospitals.

(3) "Louisiana Emergency Response Network" (LERN) means the statewide system of regional trauma-patient care that is an organized, seamless, coordinated effort among each component of care including pre-hospital, acute care, post-acute care, rehabilitation, and injury prevention in a defined geographic area which provides access to local health systems for time-sensitive patient care treatment and is integrated with local public health systems and the Governor's Office of Homeland Security and Emergency Preparedness.

(4) "Network" means the Louisiana Emergency Response Network.

Acts 2004, No. 248, §1, eff. June 15, 2004; Acts 2006, 1st Ex. Sess., No. 35, §4, eff. March 1, 2006; Acts 2006, No. 442, §3, eff. June 15, 2006.

§2843. Louisiana Emergency Response Network; creation; domicile

A. The Louisiana Emergency Response Network is hereby created as a network which, through its board, shall direct the efforts to decrease trauma-related deaths and incidents of morbidity and mortality due to trauma in Louisiana. By maximizing the integrated delivery of optimal resources for patients who ultimately need acute trauma care, the network shall address the daily demands of trauma care and form the basis for disaster preparedness. The resources required for each component of the system shall be clearly identified, deployed, and studied to ensure that all injured patients gain access to the appropriate level of care in a timely, coordinated, and cost-effective manner.

B. The domicile of the network shall be Baton Rouge, Louisiana.

Acts 2004, No. 248, §1, eff. June 15, 2004.

§2844. Governing board; membership, appointment, terms, compensation, vacancies

A. There is hereby established within the department the Louisiana Emergency Response Network Board.

B. The network shall be governed by a board of twenty-eight members which shall include:

(1) One cardiologist from nominees submitted by the Louisiana Chapter of the American College of Cardiology.

(2) One member from nominees submitted by the Rural Hospital Coalition to represent hospitals with fewer than sixty beds.

(3) One member from nominees submitted by the Metropolitan Hospital Council of New Orleans to represent hospitals with one hundred beds or more.

(4) One member from nominees submitted by the Louisiana Hospital Association to represent a service district hospital.

(5) Two members from nominees submitted by the Department of Health and Hospitals which shall include a member from the office of mental health.

(6) One member from nominees submitted by the Governor's Office of Homeland Security and Emergency Preparedness.

(7) Two members from nominees submitted by the Louisiana State Medical Society which shall include a member specializing in pediatric surgery.

(8) One member from nominees submitted by the Louisiana Medical Association.

(9) One member from nominees submitted by the Committee on Trauma or American College of Surgeons.

(10) One member from nominees submitted by the Louisiana American College of Emergency Physicians.

(11) One member from nominees submitted by the Louisiana State University Health Sciences Center at Shreveport.

(12) One member from nominees submitted by the Louisiana State University Health Sciences Center at New Orleans.

(13) One member from nominees submitted by Tulane University Health Sciences Center.

(14) One member from nominees submitted by the Louisiana State Coroners Association.

(15) Two members from the Louisiana House of Representatives.

(16) Two members from the Louisiana Senate.

(17) One 211 member of the Louisiana Alliance of Information and Referral Systems.

(18) One member of the Louisiana Rural Ambulance Alliance.

(19) One 911 member of the National Emergency Number Association.

(20) One member of the Louisiana Hospital Association rehabilitation constituency group.

(21) One physician from nominees submitted by the American Stroke Association.

(22) One registered nurse practicing in emergency or critical care from nominees submitted by the Louisiana State Board of Nursing.

(23) One medical director of an emergency medical services agency from nominees submitted by the Louisiana Association of EMS Physicians.

(24) One optometrist from nominees submitted by the Optometry Association of Louisiana.

C. (1) The members listed in Paragraphs (B)(1) through (14) and (17) through (24) of this Section shall be appointed by the governor from a list of qualified candidates nominated by the respective organizations.

(2) The organizations listed in Paragraphs (B)(1) through (14) and (17) through (24) of this Section shall each submit a list of at least four nominees for the respective board position to the governor.

(3) The members listed in Paragraphs (B)(15) and (16) of this Section shall be appointed by the speaker of the House of Representatives and the president of the Senate, respectively.

D. All members of the board shall serve terms of three years, except for initial terms beginning on the effective date of this Chapter, and determined by lot at the first meeting of the board as follows:

(1) Six shall serve until July 1, 2005.

(2) Seven shall serve until July 1, 2006.

(3) Seven shall serve until July 1, 2007.

E. The chairman shall be elected by the board for a term to be determined by the board and no member shall serve more than two consecutive terms as chairman.

F. Each appointment by the governor shall be subject to Senate confirmation.

G. Each board member shall serve without compensation. Legislators shall receive the same per diem and travel reimbursement for attending meetings of the board as is normally provided for members of the legislature. Nonlegislative board members may receive reimbursement for expenses in accordance with the guidelines of the entity they represent.

H. The board shall adopt rules and regulations to provide for the governance of the board. Such rules and regulations shall include but not be limited to:

(1) Procedures for the election of board officers, including terms of office and methods and grounds for removal.

(2) Procedures and grounds for the removal of any board member. Grounds for removal shall include conviction of a felony or may include failure to meet board attendance rules as provided by rule.

I. Procedures for filling a vacancy created by the removal, resignation, or death of any board member prior to the end of the board member's term shall follow those used for initial appointments.

J. The number of board members necessary to constitute a quorum for the transaction of business shall never be less than one third of the entire membership of the board. A majority vote of the board members constituting a quorum shall be necessary for any action taken by the board.

Acts 2004, No. 248, §1, eff. June 15, 2004; Acts 2006, 1st Ex. Sess., No. 35, §4, eff. March 1, 2006; Acts 2006, No. 442, §3, eff. June 15, 2006; Acts 2006, No. 426, §1; Acts 2010, No. 934, §1.

§2845. Board; functions, powers, and duties

A. The board shall:

(1) Establish and maintain a statewide trauma system that shall include a centralized communication center for resource coordination of medical capabilities for

participating trauma centers as defined by R.S. 40:2171 and emergency medical services.

(2) Provide for implementation of a network and plan designed to achieve:

(a) A reduction of deaths and incidents of morbidity caused by trauma and time-sensitive illnesses.

(b) A reduction in the number and severity of disabilities caused by trauma.

(c) Measures to demonstrate a return on investment for the LERN system.

(d) Implementation of regional injury prevention programs.

(3)(a) Establish and appoint nine regional commissions that correspond with the nine administrative regions of the department. These regional commissions shall implement and manage each regional component of the network. The board shall promulgate rules and regulations to provide for the duties and responsibilities of the nine regional commissions.

(b) The membership of each commission shall consist of the following members including but not limited to:

(i) A representative from the Governor's Office of Homeland Security and Emergency Preparedness.

(ii) The Department of Health and Hospitals, office of public health regional medical director.

(iii) A representative of local ambulance services.

(iv) A representative of emergency medical response.

(v) A hospital chief executive officer or administrative representative from a hospital with less than sixty beds.

(vi) A hospital chief executive officer or administrative representative from a hospital with more than one hundred beds.

(vii) A hospital chief executive officer or an administrative representative from a service district hospital.

(viii) A representative of the local component society of the Louisiana State Medical Society.

(ix) A representative of the local chapter of the Louisiana Medical Association.

(x) A specialist from the American College of Emergency Physicians.

(xi) A specialist from the American College of Surgeons.

(xii) A representative from the Louisiana Chapter of the National Emergency Number Association.

(4)(a) Enter into interagency agreements with the department, the Governor's Office of Homeland Security and Emergency Preparedness, and such other entities, public or private, as may be necessary to assure continuity of care during emergencies.

(b) Agreements between the board and these entities shall provide for the protocols of mandatory data collection and shall include provisions regarding the specific data to be shared among the entities, the individual or individuals allowed by each party to have access to the other party's data, and the security arrangements between the parties to ensure the protection of the data from unauthorized access that would threaten the privacy of individuals and the confidentiality of the data.

(c) The parties shall not agree to share data pursuant to a specific agreement if any law would otherwise prohibit the sharing of such data by the parties.

(d) The parties shall protect all individually identifiable health information to the extent of their ability within the context of the mission of the Louisiana Emergency Response Network.

(5) Hold regular quarterly meetings and special meetings as necessary for the conduct of its business. Special meetings may be called upon forty-eight-hour notice by the chairperson, or in his absence, upon the written authorization of a majority of the members of the board.

(6) Establish and maintain a statewide trauma registry to collect and analyze data on the incidence, severity, and causes of trauma, including traumatic brain injury. The registry shall be used to improve the availability and delivery of pre-hospital or out-of-hospital care and hospital trauma care services.

(a) The board shall promulgate rules and regulations according to the Administrative Procedure Act to do the following:

(i) Define specific data elements required to be furnished to the registry by every health care facility certified by the department as a trauma center.

(ii) Define trauma data elements that all other health care facilities shall be required to furnish to the registry.

(iii) Establish a process for submission, analysis, and reporting of registry data.

(b) Required reporting to the state trauma registry is contingent on LERN providing adequate financial support through the Louisiana Emergency Response Network fund to cover administrative costs.

(7) Work with the department to develop stroke and ST segment elevation myocardial infarction (STEMI) systems that are designed to promote rapid identification of, and access to, appropriate stroke and STEMI resources statewide.

B. In addition to its function as provided in Subsection A of this Section, the board shall have the following powers and duties:

(1) To enter into any contract related to its responsibilities in compliance with this Chapter and other state laws.

(2) To employ an executive director and necessary staff to oversee the operations of the network and to be responsible to the board for the administration and coordination of all aspects of the network.

(3) To standardize and review performance indicators that evaluate the quality of services delivered by the network and to ensure that improvement in the quality of services delivered is accomplished and documented.

(4) Shall apply for all available appropriate public and all available appropriate public* and private federal grants, donations, or gifts of money or services from any available source.

C.(1) The board shall submit an annual written report to the Senate and House Committees on Health and Welfare at least thirty days prior to each regular session. The report shall include a summary of the data relevant to the goals set forth in Paragraph (A)(2) of this Section and all other information relevant to trauma-patient care and its delivery in Louisiana through the network.

(2) The board shall submit any additional reports or information to the secretary of the department upon request of the secretary and the Senate and House Committees on Health and Welfare upon request of the chairman of either committee.

D. (1) The board may accept grants, donations, or gifts of money or services

from public or private organizations or from any other sources to be utilized for the purposes of the board.

(2) There is hereby created in the state treasury, a special fund called the Louisiana Emergency Response Network Fund. The source of monies deposited into the fund may be any monies appropriated annually by the legislature, including federal funds, any public or private donations, gifts, or grants from individuals, corporations, nonprofit organizations, or other business entities which may be made to the fund, and any other monies which may be provided by law.

(3) Monies in the fund shall be invested in the same manner as monies in the state general fund, and interest earned on investment of monies in the fund shall be credited to the state general fund. Unexpended and unencumbered monies in the fund at the end of the fiscal year shall remain in the fund.

E. Subject to any appropriation by the legislature, monies in the fund shall be used as directed by the board solely to fund grants, projects, and services which will address the goals and objectives of the board as authorized in this Chapter.

F. In addition to annual reports to the legislature, the board may publish documents and materials intended to further the mission or purpose of the board.

Acts 2004, No. 248, §1, eff. June 15, 2004; Acts 2006, 1st Ex. Sess., No. 35, §8, eff. March 1, 2006; Acts 2006, No. 442, §3, eff. June 15, 2006; Acts 2010, No. 934, §1.

§ 2845.1. Public records exception

Patient and peer review data or information submitted or transmitted pursuant to this Chapter to the trauma registry, the board, any committee acting on behalf of the board, any hospital or pre-hospital care provider, any physician or other direct care provider, any regional commission, any emergency medical services council, emergency medical services agency, or other group or committee whose purpose is to monitor and improve quality care pursuant to this Chapter, shall be confidential and exempt from the provisions of law relative to public records as provided in R.S. 44:4.1(B)(24).

Acts 2010, No. 934. §1, eff. Aug. 15, 2010.

§2846. Rules and regulations; Department of Health and Hospitals

A. The board shall adopt and revise such rules and regulations as may be necessary to enable it to carry into effect the provisions of this Chapter. Such rules and regulations shall be promulgated in accordance with the Administrative Procedure Act.

B. The rules and regulations shall be submitted to the House and Senate Committees on Health and Welfare.

C. Upon request of the board, the department shall provide advice, information, and assistance to the board concerning rules to be promulgated by the board.

Acts 2004, No. 248, §1, eff. June 15, 2004.

APPENDIX B

Pre-Hospital-Provider-Agreement-Sample-Fillable

AGREEMENT FOR PARTICIPATION IN LOUISIANA EMERGENCY RESPONSE NETWORK
BY AND BETWEEN
LOUISIANA EMERGENCY RESPONSE NETWORK BOARD
AND
PRE-H0SPITAL AGENCY

THIS AGREEMENT FOR PARTICIPATION (sometimes hereinafter referred to as ("Agreement") is entered into this ____ day of_____, 2017 by and between Louisiana Emergency Response Network Board ("LERN") and Pre-hospital Agency ("Participating Pre-Hospital Provider") to facilitate participation of Participating Pre-Hospital Provider in Region(s) __ of the Louisiana Emergency Response Network.

WHEREAS, it is incumbent upon the State of Louisiana and public and private healthcare partners and allies to work in concert to safeguard the public health and welfare of Louisiana residents against unnecessary trauma and time-sensitive related deaths and incidents of morbidity;

WHEREAS, La. R.S. 40:2841-2846 establishes the Louisiana Emergency Response Network as a public/private cooperative effort between healthcare providers and the Louisiana Department of Health and Hospitals to maximize the integrated delivery of optimal resources for patients who ultimately need acute care for trauma or time-sensitive illness, or for a disaster within the state;

WHEREAS, LERN is responsible for improving access to regional care for trauma and time-sensitive illness or a disaster within the state by developing, implementing, and supporting systems in nine administrative regions within the State of Louisiana;

WHEREAS, LERN is charged with the responsibility to obtain, aggregate, and utilize data related to the integrated and uniform delivery of emergency care resulting from trauma, time-sensitive illness or for a disaster within the State;

WHEREAS, the State of Louisiana has facilities and healthcare partners available to support the initial management and/or definitive treatment of the severely injured, those with time-sensitive illness, or those effected by a disaster within the State;

WHEREAS, pre-hospital providers and other healthcare providers agree to use best efforts to support and cooperate with LERN in its efforts to implement a system of improved medical response for emergency care resulting from trauma, time sensitive-illness, or a disaster within the State;

WHEREAS, Region 1 of the Louisiana Emergency Response Network is the defined geographical area that includes the parishes of Orleans, St Bernard, Jefferson, and Plaquemines; and

WHEREAS, Region 2 of the Louisiana Emergency Response Network is the defined geographical area that includes the parishes of East Baton Rouge, West Baton Rouge, East Feliciana, West Feliciana, Pointe Coupee, Ascension, and Iberville; and

WHEREAS, Region 3 of the Louisiana Emergency Response Network is the defined geographical area that includes the parishes of St. Mary, Terrebonne, Lafourche, Assumption, St. James, St John the Baptist, and St. Charles; and

WHEREAS, Region 4 of the Louisiana Emergency Response Network is the defined geographical area that includes the parishes of Evangeline, Acadia, St. Landry, Lafayette, St. Martin, Vermillion, and Iberia; and

WHEREAS, Region 5 of the Louisiana Emergency Response Network is the defined geographical area that includes the parishes of Beauregard, Allen, Calcasieu, Jefferson Davis, and Cameron; and

WHEREAS, Region 6 of the Louisiana Emergency Response Network is the defined geographical area that includes the parishes of Vernon, Rapides, Avoyelles, Grant, LaSalle, Winn, Catahoula, and Concordia; and

WHEREAS, Region 7 of the Louisiana Emergency Response Network is the defined geographical area that includes the parishes of Caddo, Bossier, Webster, Claiborne, DeSoto, Red River, Bienville, Sabine, and Natchitoches; and

WHEREAS, Region 8 of the Louisiana Emergency Response Network is the defined geographical area that includes the parishes of Union, Morehouse, West Carroll, East Carroll, Lincoln, Ouachita, Richland, Madison, Jackson, Caldwell, Franklin, and Tensas; and

WHEREAS, Region 9 of the Louisiana Emergency Response Network is the defined geographical area that includes the parishes of St. Helena, Washington, Livingston, St. Tammany, and Tangipahoa; and

WHEREAS, Participating Pre-Hospital Provider is a pre-hospital provider located within Region(s) 1 of the Louisiana Emergency Response Network that desires to participate in the Louisiana Emergency Response Network pursuant to the terms of this agreement.

NOW THEREFORE, in consideration of the premises and mutual understandings herein contained, the Parties to this Agreement acknowledge and agree as follows.

1. LERN Entry Criteria and Destination Protocols. When people are in need of time-sensitive medical care and treatment as a result of trauma, stroke, STEMI or other emergencies or disasters, Participating Pre- Hospital Provider and LERN, acting through the LERN Communication Center ["LCC"] will use best efforts to facilitate the movement of patients from the pre-hospital setting to the most appropriate definitive care facility

by following "LERN Destination Protocol: Trauma", attached hereto as Attachment A, "STEMI Triage Protocol for Pre-Hospital Providers," attached hereto as Attachment B, or "LERN Destination Protocol: Stroke" attached hereto as Attachment C, to the extent these protocols are applicable to a particular situation. Regional borders do not apply in the pre-hospital setting as the goal is to transport to the most appropriate definitive care facility. In regions with preexisting protocols (or agreements) involving verified trauma centers, LERN will consider these protocols when directing transport of pre-hospital patients.

2. LERN Data.

a. Participating Pre-Hospital Provider understands that data, as currently defined in Attachment D, will be used and shared in order to move LERN patients from the scene of traumatic injuries, time-sensitive illness, or disaster to local emergency departments, or other sites to definitive care. LERN network data will also be used to track and evaluate the performance of LERN in real time to the extent possible or within seven (7) days of patient entry into LERN.

b. The protocol for network data collection is part of the LCC standard operating procedure and will include data sets pertinent to LERN's ability to ensure continuity of care and timely access to Definitive Care. LERN data will be shared in summary form with all agencies and institutions participating in or providing oversight to LERN. It is not the intention of LERN Board to identify any activity or data related to participating pre-hospital provider; LERN data will be disseminated in aggregate form.

3. Patient Information and LERN Communications.

a. Each patient entered into EMS State Service Bridge, the comprehensive pre-hospital care data collection and analysis reporting system used by LERN for data collection, will be assigned a unique numerical identifier for the purpose of facilitating the movement of LERN patients. LERN will use unique patient identifiers in data collection and data evaluation. LERN intends that any and all identifiable patient information shall be afforded protection related to confidentiality, privacy, and security of protected health information.

b. Participating Pre-Hospital Provider will complete patient records, emergency transfer forms, and other necessary patient-specific documentation sufficient to maintain regulatory compliance with HIPAA, and other applicable laws, rules and regulations, and to facilitate standard physician and nursing communication for the transfer of patients and safe and appropriate patient care.

c. The activities of LERN assist Participating Pre-Hospital Provider with the movement of a specific subset of patients, i.e., those who need emergency care resulting from trauma, time sensitive illness or a disaster within the State. LERN Board

establishes no additional legal or regulatory requirements for Participating Pre-Hospital Provider other than as set forth herein.

4. Planning. Participating Pre-Hospital Provider agrees to be engaged in activities related to development, cooperative planning, and coordination of patient care. Participating Pre-Hospital Provider will work with LERN Board to facilitate continuous quality improvement of the Network and the care available to patients within the State. Participating Pre-Hospital Provider agrees to support attendance at LERN education and training seminars by having appropriate personnel attend those seminars. The parties understand that need for LERN Data requirements may increase as LERN develops over time, and that Participating Pre-Hospital Provider may be requested to sign addenda to this Agreement of Participation to facilitate the need for increased data.

5. Term of Agreement. This Agreement is in effect for the period commencing on the date first noted above and terminating five years thereafter. The Agreement will continue and will automatically renew for a successive five year period unless either the contracting party advises the other of intent to not renew in writing within 30 days before the end of the term. Either party shall also have the right to cancel this Agreement, with or without cause, by giving the other party thirty (30) days written notice forwarded to their respective address by certified mail. LERN Board has the right to cancel this contract upon less than thirty (30) days due to budgetary reductions and changes in funding priorities by the Board.

THUS DONE AND SIGNED by the Louisiana Emergency Response Network Board and Pre-hospital Agency, Participating Pre-Hospital Provider in Region(s) __.

LOUISIANA EMERGENCY RESPONSE NETWORK BOARD

BY:_____ _____
DATE

PRINT NAME _____

PARTICIPATING PRE-HOSPITAL PROVIDER
PRE-H0SPITAL AGENCY

BY: _____ _____
DATE

PRINT NAME _____

TITLE _____

Call LERN Communication Center at 1-866-320-8293 for patients meeting the following criteria:

- Unmanageable airway
- Traumatic cardiac arrest
- Burn patient > 40 % BSA without IV
- Tension pneumothorax
- Burn patient without patent airway

YES → **Closest ED/Trauma Center**

NO

Measure vital signs and level of consciousness

- GCS ≤13
- SBP <90mmHg
- RR <10 or >29 breaths per minute, or need for ventilator Support (<20 in infant aged <1 year)

NO

Assess anatomy of injury

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g. flail chest)
- Two or more proximal long-bone fractures
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis
- Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture)

YES → **Transport to Trauma Center/Trauma Program** These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program. ** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.*

NO

Assess mechanism of injury and evidence of high-energy impact

- **Falls**
  - -- Adults: >20 feet (one story is equal to 10 feet)
  - -- Children: >10 feet or two or three times the height of the child
- **High-risk auto crash**
  - -- Intrusion, including roof: > 12 inches occupant site; > 18 inches any site
  - -- Ejection (partial or complete) from automobile
  - -- Death in the same passenger compartment
  - -- Vehicle telemetry data consistent with a high risk of injury
- **Auto vs. pedestrian/bicyclist/ATV thrown, run over, or with significant (>20 mph) impact**
- **Motorcycle crash >20mph**

YES → **Transport to Trauma Center/Trauma Program** which, depending upon the defined trauma system, need not be the highest level trauma center/program. If no Trauma Center/ Trauma Program in the region, LCC may route to the most appropriate resourced hospital.

NO

Assess special patient or system considerations

- **Older Adults**
  - -- Risk of injury/death increases after age 55 years
  - -- SBP <110 may represent shock after age 65
  - -- Low impact mechanisms (e.g. ground level falls) may result in severe injury
- **Children**
  - -- Should be triaged preferentially to pediatric capable trauma centers
- **Anticoagulants and bleeding disorders**
  - -- Patients with head injury are at high risk for rapid deterioration
- **Burns**
  - -- With trauma mechanism: triage to trauma center
- **Pregnancy >20 weeks**
- Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls
- Major joint dislocations (hip, knee, ankle, elbow)
- Open Fractures
- **EMS provider judgment**

YES → **Transport to Trauma Center/Trauma Program** or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.

NO

Multi / Mass Casualty Incident

NO → **Transport according to local protocol**

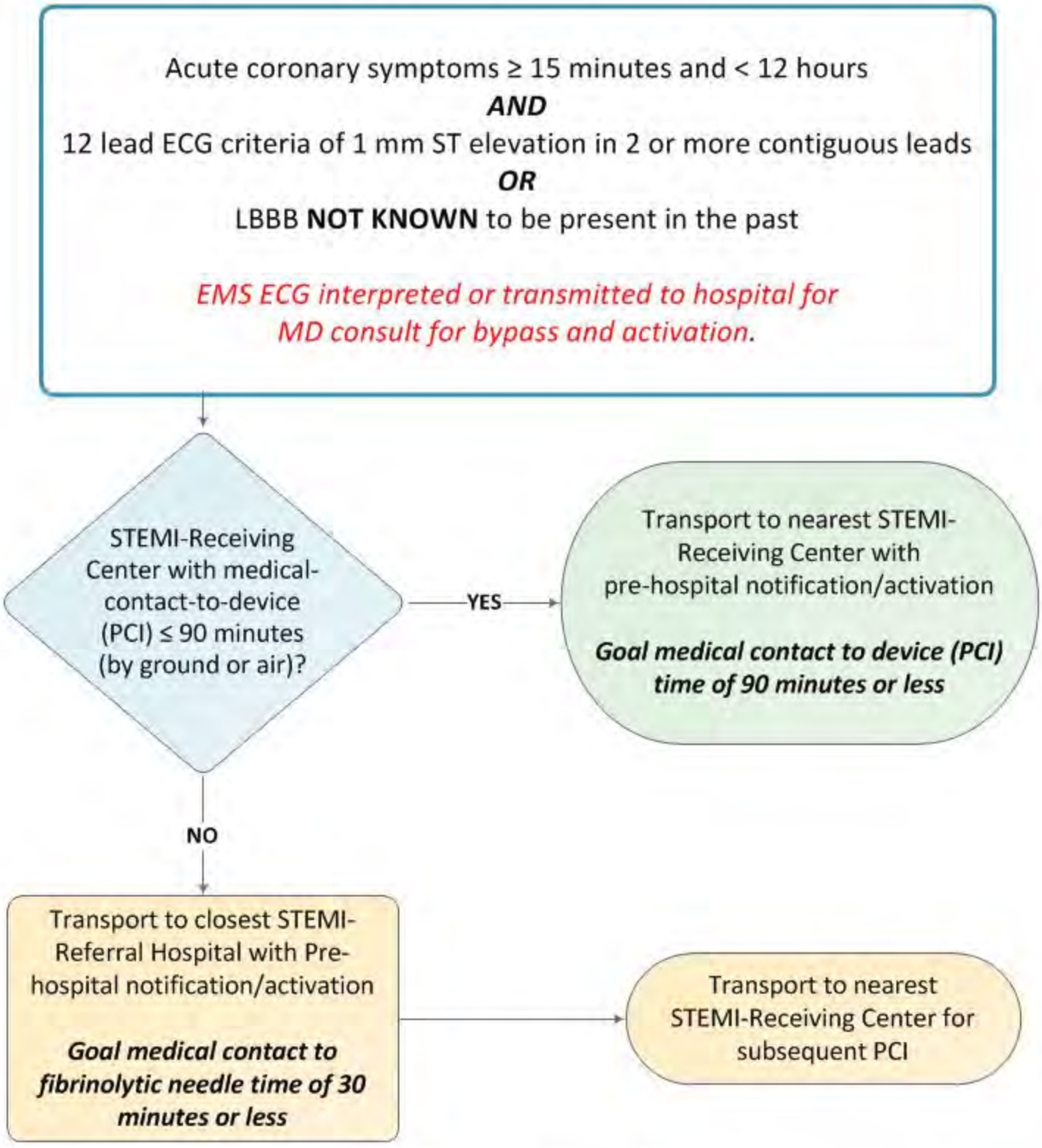
LOUISIANA EMERGENCY RESPONSE NETWORK

Destination Protocol
TRAUMA

When in doubt, transport to a trauma center.

Rev. 12/10/15
Eff. 1/1/2016

STEMI TRIAGE PROTOCOL FOR PRE-HOSPITAL PROVIDERS*

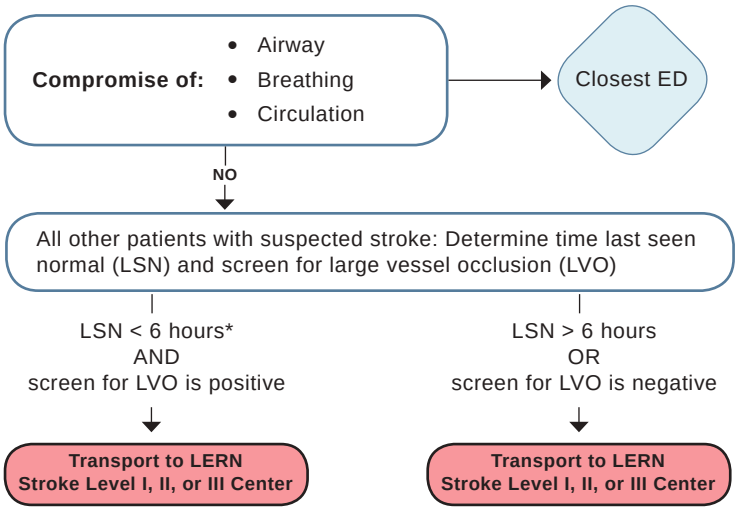


*O'Gara PT, Kushner FG, Ascheim DD, et all. 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infraction: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Journal of the American College of Cardiology. 2013;61(4):e78.

LOUISIANA EMERGENCY RESPONSE NETWORK

STROKE DESTINATION PROTOCOL

The following protocol applies to patients with suspected stroke:



If < 15 minutes of additional transport time to reach Level I or endovascular capable Level II Center, transfer to the Level I or endovascular capable Level II Center

If > 15 minutes of additional transport time to reach Level I, II, or III Center than to reach stroke capable Off Site ED, it is acceptable to transport to a stroke capable Off Site ED

* the LSN < 6 hours should include patients without a definite time of LSN, but who could reasonably be assumed to be within 6 hours of onset, including patients who wake-up with stroke symptoms

Guiding Principles:

- Time is the critical variable in acute stroke care
- Protocols that include pre-hospital notification while en route by EMS should be used for patients with suspected acute stroke to facilitate initial destination efficiency
- Treatment with intravenous tPA is the only FDA approved medication therapy for hyperacute stroke
- EMS should identify the geographically closest hospital capable of providing tPA treatment
- Transfer patient to the nearest hospital equipped to provide tPA treatment
- Secondary transfer to facilities equipped to provide tertiary care and interventional treatments should not prevent administration of tPA to appropriate patients

Adopted 4/20/2017

LERN Communication Center: 1-866-320-8293

LERN Network Data Set*

Following are the LERN Network data variables that will be collected on each patient encounter by the LERN Call Center. This will be done by the LERN Communication Center during initial call and performing follow up calls with EMS agencies.

- Hospital Name
- Hospital Staff name
- EMS dispatch date
- EMS dispatch time
- EMS unit arrival on scene date
- EMS unit arrival on scene time
- EMS unit scene departure date
- EMS unit scene departure time
- ED/hospital arrival date
- ED/hospital arrival time
- Patient age and sex
- Transport mode
- Patient condition on arrival at Hospital Emergency Department
- Patient's Mechanism of injury
- Patient Hospital Emergency Department departure time
- Specific injuries sustained
- LERN Entry Criteria met by patient's presentation
- Patient treatment in pre-hospital setting in reference to:
    - Airway Control
    - Breathing support
    - Circulatory support and control
    - Initial field systolic blood pressure
    - Initial field pulse rate
    - Initial field respiratory rate
    - Initial field oxygen saturation
    - Initial field GCS total
    - Splinting
    - Medications
- Stroke/STEMI Related
    - Time of onset
    - Duration
    - Initial cardiac rhythm

*American College of Surgeons Committee on Trauma (2006) Table 2. National Trauma Data Bank Data Elements: Pre-Hospital Information *Resources for Optimal Care of the Injured Patient 2006* (pp. 94-95)

APPENDIX C

LERN Trauma Protocol

Call LERN Communication Center at 1-866-320-8293 for patients meeting the following criteria:

- Unmanageable airway
- Traumatic cardiac arrest
- Burn patient > 40 % BSA without IV
- Tension pneumothorax
- Burn patient without patent airway

YES → **Closest ED/Trauma Center**

NO

Measure vital signs and level of consciousness

- GCS ≤13
- SBP <90mmHg
- RR <10 or >29 breaths per minute, or need for ventilator Support (<20 in infant aged <1 year)

NO

Assess anatomy of injury

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g. flail chest)
- Two or more proximal long-bone fractures
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis
- Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture)

YES → **Transport to Trauma Center/Trauma Program** These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program. ** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.*

NO

Assess mechanism of injury and evidence of high-energy impact

- **Falls**
  - -- Adults: >20 feet (one story is equal to 10 feet)
  - -- Children: >10 feet or two or three times the height of the child
- **High-risk auto crash**
  - -- Intrusion, including roof: > 12 inches occupant site; > 18 inches any site
  - -- Ejection (partial or complete) from automobile
  - -- Death in the same passenger compartment
  - -- Vehicle telemetry data consistent with a high risk of injury
- **Auto vs. pedestrian/bicyclist/ATV thrown, run over, or with significant (>20 mph) impact**
- **Motorcycle crash >20mph**

YES → **Transport to Trauma Center/Trauma Program** which, depending upon the defined trauma system, need not be the highest level trauma center/program. If no Trauma Center/ Trauma Program in the region, LCC may route to the most appropriate resourced hospital.

NO

Assess special patient or system considerations

- **Older Adults**
  - -- Risk of injury/death increases after age 55 years
  - -- SBP <110 may represent shock after age 65
  - -- Low impact mechanisms (e.g. ground level falls) may result in severe injury
- **Children**
  - -- Should be triaged preferentially to pediatric capable trauma centers
- **Anticoagulants and bleeding disorders**
  - -- Patients with head injury are at high risk for rapid deterioration
- **Burns**
  - -- With trauma mechanism: triage to trauma center
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- Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls
- Major joint dislocations (hip, knee, ankle, elbow)
- Open Fractures
- **EMS provider judgment**

YES → **Transport to Trauma Center/Trauma Program** or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.

NO

Multi / Mass Casualty Incident

NO → **Transport according to local protocol**

LOUISIANA EMERGENCY RESPONSE NETWORK

Destination Protocol
TRAUMA

When in doubt, transport to a trauma center.

Rev. 12/10/15
Eff. 1/1/2016

APPENDIX D

Trauma Center Law

§2171. Definitions

As used in this Part:

(1) "Department" means the Louisiana Department of Health.

(2) "Trauma case" means any injured person who has been evaluated by prehospital personnel according to policies and procedures established by the Louisiana Department of Health and who has been found to require transportation to a trauma center.

(3) "Trauma center" means a health care facility which is capable of treating one or more types of potentially seriously injured persons and which has been certified as a trauma center by the Louisiana Department of Health.

Acts 1987, No. 358, §1.

§2172. Certificates; applications; fees

A. All health care facilities offering trauma care services may be certified on a voluntary basis.

B. Application for certification shall be made by a health care facility to the department upon forms furnished by the department. Upon determination that the facility is in compliance with the minimum requirements for certification as established by the department, the department shall issue a certificate for such period as may be provided for in the published regulations of the department.

C. There shall be a certification fee of two hundred dollars for any certificate issued in accordance with the provisions of this Part, renewable every three years.

Acts 1987, No. 358, §1.

§2173. Rules, regulations, and standards for licenses

A. The department shall promulgate rules and regulations to carry out the provisions of this Part in accordance with the provisions of the Administrative Procedure Act. The department shall consult with the Louisiana Emergency Response Network (LERN), the Louisiana Hospital Association, and the Louisiana State Medical Society in the development of rules and regulations.

B. The department shall promulgate minimum standards for trauma centers as defined in this Part which shall:

(1) Specify the number and types of trauma patients for whom such centers must provide care in order to ensure that such centers will have sufficient experience and expertise to be able to provide quality care for victims of injury.

(2) Specify the resources and equipment needed by such centers.

(3) Include standards and guidelines for triage and transportation of trauma patients prior to care in designated trauma centers.

(4) Specify procedures for the certification and evaluation of designated trauma centers.

(5) Include procedures for the receipt, recording of, and disposition of complaints.

(6) Provide for the right of appeal for those health care facilities for which certification has been refused.

(7) Provide for the verification and certification of trauma center status which assign level designations based on resources available within the applicable facility. Rules shall be based upon national guidelines, including but not limited to those established by the American College of Surgeons in Hospital and Pre-Hospital Resources for Optimal Care of the Injured Patient and any published appendices thereto.

(8) Provide that LERN may fund the provision of data to the state trauma registry in accordance with the registry's adopted rules, requirements, and reporting cycle.

(9) Provide that certified trauma centers participate in LERN regional commissions and LERN regional and state-level trauma system performance improvement and injury prevention activities per American College of Surgeons guidelines once adequate funding has been secured by the certified trauma center.

C. The regulations promulgated under this Section shall be consistent with the guidelines for designation of trauma centers specified by the American College of Surgeons.

D. The regulations promulgated under this Section shall require health care facilities applying for certification as a trauma center to obtain a consultation site visit through the Committee on Trauma of the American College of Surgeons.

E. The department shall designate a health care facility as a trauma center when the requirements of this Section have been fulfilled and upon verification from the American College of Surgeons that the facility has met its criteria for Level I, II, or III. The "trauma center" label shall be reserved exclusively for hospitals with state-issued trauma center certification.

F. The department shall issue standard forms for applications and for inspection reports, after consultation with LERN and other appropriate organizations.

Acts 1987, No. 358, §1; Acts 2010, No. 934, §1.

APPENDIX E

LDH Health Standards

DEPARTMENT OF HEALTH AND HOSPITALS

Health Standards Section

Application & Checklist for Hospital Trauma Center Designation

Instructions for Completing the Application & Checklist for Hospital Trauma Center Designation

1. Please fill out all information.
2. Please identify a designated contact person of the hospital for all information to be communicated through.
3. Please place all attachments behind this checklist in the order listed on the checklist.
4. Please submit the packet in its entirety with this checklist on top of all documents.

All packets will be reviewed by the administrative assistant. **If the packet is determined to be incomplete, the entire packet will be sent back to the facility for completion.** Once a packet is determined to be complete by the administrative assistant, it will be placed in line for processing. Please keep in mind that with the large volume of work being requested by hospitals, the wait time can be lengthy. The forms, fees and information should be submitted to the state office approximately **6 to 10 weeks prior to your anticipated opening date.**

The Department of Health and Hospitals shall not process any packet until all forms, required applicable accompanying information and fees are received.

Payment Information	
Check or Money Order Number:	
☐ Mail Payment & Payment Transmittal Form To	☐ Mail License Application Payment To
DHH Licensing Fee PO Box 62949 New Orleans, LA 70162-2949	Department of Health & Hospitals Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821-3767

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING•HEALTH STANDARDS SECTION
BOX 3767 • BATON ROUGE, LOUISIANA 70821-3767
PHONE #: (225) 342 • *0138* • FAX #: (225) 342-0157 www.dhh.louisiana.gov

Application & Checklist for Hospital Trauma Center Designation

Administrator:		**Designated Contact Person:**	
Administrator Phone:		**Designated Contact Phone:**	
Administrator Email:		**Designated Contact Email:**	
Hospital Name:			**Hospital License #:**
Hospital Address:			
Hospital Phone:		**Hospital Fax:**	

Letter of Intent

Are you applying to be designated as a licensed Trauma Center ☐ Yes ☐ No

Trauma Center Level you are applying for:

- **☐ Primary Level 1: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level I Trauma Centers**
- **☐ Primary Level II: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level II Trauma Centers**
- **☐ Secondary Level III: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level III Trauma Centers**

Geographical location of the trauma center:

Name of the Building where the trauma center will be located:

Trauma Center Director:

Date of the American College of Surgeons approval as a Trauma Center:

Other Details:

Criteria (Each of these must be attached in order for your application to be processed):	Yes	No	Describe

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING•HEALTH STANDARDS SECTION
P.O. BOX 3767 • BATON ROUGE, LOUISIANA 70821-3767
PHONE #: (225) 342 • *0138* • FAX #: (225) 342-0157 www.dhh.louisiana.gov

Application & Checklist for Hospital Trauma Center Designation

HSS-HO-34 Application & Checklist for Hospital Trauma Center Designation	☐		
Licensing Fee of $200.00 for the 3 year certification (please submit a copy of the transmittal form and copy of the check).	☐		Attach
Health Facility Plan Review Approval Letter from the Office of State Fire Marshal (OSFM) for the Health Standards Plan Review that is titled DHH FACILITY LICENSING RECOMMENDATION. The OSFM can NOT exempt this review. For information on this plan review, please visit our website at http://dhh.louisiana.gov/index.cfm/directory/detail/740.	☐		Attach
HSS-PR-02 Plan Review Attestation. Please ensure that the PO number matches the one on the DHH FACILITY LICENSING RECOMMENDATION letter.	☐		Attach
Site Map showing where the trauma center is located on the campus relative to other buildings, parking and streets. Please demarcate the trauma center area on the site plan.	☐		Attach
11 x 17 copies of the architecturally scaled floor plans for each floor of each building designated as the trauma center to include the green stamp of approval from the Office of state Marshal, dimensions, and identification of service areas (i.e. nurse's station, exam rooms, etc.). Please ensure that the number stamped on the floor plans by the Office of State Fire Marshal matches the number stamped on the DHH FACILITY LICENSING RECOMMENDATION letter. Please ensure that all areas of the floor plan can be read once printed. You can submit additional sheets for areas as long as the area is identified on the overall floor plan.	☐		Attach
Office of State Fire Marshall Inspection Report Approvals (Fire/Architectural/Sprinkler): Please submit the recent inspection reports for each building/area being licensed. The forms must indicate the name of the building/areas inspected, list the correct name and address of the hospital and must indicate that it is acceptable for occupancy.	☐		Attach
Office of Public Health Inspection Report Approval: Please submit the recent inspection reports for each building/area being licensed. The form must indicate the name of the building/areas inspected, list the correct name and address of the hospital and must indicate that it is acceptable for occupancy.	☐		Attach
Letter on hospital letterhead stating that either the hospital owns the space and it is not leased/subleased to anyone or that the hospital is the owner of the space through a lease/sublease.	☐		Attach
HSS-HO-09 Attestation Form	☐		Attach
Copy of the notification of Trauma Center verification by the American College of Surgeons, Committee on Trauma.	☐		Attach

Attestation & Signature

I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership or change in geographical address. It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section in writing of any changes in the information provided in this application in a separate packet. I attest that the Rural Health Clinic currently complies with the requirements of the Office of State Fire Marshal and Office of Public Health. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

Authorized Representative's Printed Name & Title:

Authorized Representative's Signature Authorized Representative's Signature:	Date:

For DHH Use Only	Date	Yes	No	Comments
Incomplete Packet Sent Back To Facility along with an instructional letter:		☐	☐	
Packet ready for Program Manager Review		☐	☐	
Routed for licensing survey, Licensing Survey Completed & Approved		☐	☐	
ACO Updated (notes, buildings, cert kit application)		☐	☐	
CMS 1539s distributed		☐	☐	
POPS updated		☐	☐	
License & Letter distributed		☐	☐	
Logs Updated		☐	☐	
Prepped and submitted for filing		☐	☐	
Additional Comments:				

OFFICE OF MANAGEMENT & FINANCE • BUREAU OF HEALTH SERVICES FINANCING•HEALTH STANDARDS SECTION
P.O. BOX 3767 • BATON ROUGE, LOUISIANA 70821-3767
PHONE #: (225) 342 • *0138* • FAX #: (225) 342-0157 www.dhh.louisiana.gov

Health Standards Section

Attestation for Compliance with Plan Review Directives

Plan Review Tracking Number:	
Project Being Attest To:	
Project Location Being Attested To:	
Purpose of the Plan Review Being Attested To:	
Hospital's License Number or DBA Name:	
Administrator:	**Designated Contact Person:**
Administrator Phone:	**Designated Contact Person Phone#:**

This attestation form must be signed by the Administrator/Designee of the Facility. You must return this form as part of your DHH Licensing Application.

Attention: Read the Following Carefully Before Signing.

Statements of Entries Generally: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes false, fictitious or fraudulent statement or entry, shall be fined or imprisoned or both. (18 U.S.C., Sec. 1001).

I certify that I have reviewed the directives issued by the Plan Review Department relative to Plan Review Number P . Based upon my personal knowledge and belief, I attest that this facility has made all corrections (see next page) and met all directives on the letter issued for the date of . I attest that this facility meets and will continue to meet the applicable requirements set forth in the State of Louisiana Rules, Regulations and Minimum Standards, Standards of payment, all applicable Conditions of Participation/Conditions of Coverage found in the Code of Federal Regulations, and the current applicable Guidelines for Design and Construction of Health Care Facilities. I agree that if the facility fails to meet any of these requirements, I will notify the Health Standards Section of DHH of the changes immediately in order to permit a valid determination of the facility's compliance to the regulations. I understand that the Health Standards Section of DHH, Centers for Medicare and Medicaid Services (CMS), or its representatives, has the right to conduct an on-site survey at any time to validate whether the information provided is true.

Administrator/Designee Signature: _____ Date: _____
Architect Signature (mandatory): _____ Date: _____

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Health Standards Section

Attestation for Compliance with Plan Review Directives

Plan Review Comments Listed on the "DHH FACILITY LICENSING RECOMMENDATION"
(Please also include comments from any amendment pages)

Item # on Plan Review Letter	FGI #	Explanation of how the hospital corrected/complied with this requirement
Example: #3	**2.2-3.4.1.3 documentation from certified physicist detailing radiation protection within new CT scan room and X-ray room.**	**The hospital complies with this requirement by (explain how you comply with this requirement). The physicist report is attached showing compliance with this requirement (you may attach the reports but you must explain here how you comply with this requirement).**

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DEPARTMENT OF HEALTH AND HOSPITALS

Health Standards Section

Application & Checklist for Hospital Trauma Center Renewal

Instructions for Completing the Application & Checklist for Hospital Trauma Center Renewal

1. Please fill out all information.
2. Please identify a designated contact person of the hospital for all information to be communicated through.
3. Please place all attachments behind this checklist in the order listed on the checklist.
4. Please submit the packet in its entirety with this checklist on top of all documents.

All packets will be reviewed by the administrative assistant. **If the packet is determined to be incomplete, the entire packet will be sent back to the facility for completion.** Once a packet is determined to be complete by the administrative assistant, it will be placed in line for processing. Please keep in mind that with the large volume of work being requested by hospitals, the wait time can be lengthy. The forms, fees and information should be submitted to the state office approximately **6 to 10 weeks prior to your anticipated opening date.**

The Department of Health and Hospitals shall not process any packet until all forms, required applicable accompanying information and fees are received.

Payment Information	
Check or Money Order Number:	
☐ Mail Payment & Payment Transmittal Form To	☐ Mail License Application Payment To
DHH Licensing Fee PO Box 62949 New Orleans, LA 70162-2949	Department of Health & Hospitals Health Standards Section P.O. Box 3767 Baton Rouge, LA 70821-3767

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PHONE #: (225) 342 • *0138* • FAX #: (225) 342-0157 www.dhh.louisiana.gov

Application & Checklist for Hospital Trauma Center Renewal

Administrator:		**Designated Contact Person:**	
Administrator Phone:		**Designated Contact Phone:**	
Administrator Email:		**Designated Contact Email:**	
Hospital Name:			**Hospital License #:**
Hospital Address:			
Hospital Phone:		**Hospital Fax:**	

Letter of Intent

Are you applying to renew your designation as a Trauma Center ☐ Yes ☐ No (If this is for the initial licensing of a Trauma Center please use form HSS-HO-034)

Trauma Center Level you are renewing:

- ☐ **Primary Level 1: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level I Trauma Centers**
- ☐ **Primary Level II: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level II Trauma Centers**
- ☐ **Secondary Level III: Must meet the criteria of the American College of Surgeons, Committee on Trauma for Level III Trauma Centers**

Geographical location of the trauma center:

Name of the Building where the trauma center is located:

Trauma Center Director:

Date of the American College of Surgeons most recent approval as a Trauma Center:

Other Details:

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Application & Checklist for Hospital Trauma Center Renewal

Criteria (Each of these must be attached in order for your application to be processed):	Yes	No	Describe
HSS-HO-34b Application & Checklist for Hospital Trauma Center Renewal	☐		
Licensing Fee of $200.00 for the 3 year certification (please submit a copy of the transmittal form and copy of the check).	☐		Attach
Site Map showing where the trauma center is located on the campus relative to other buildings, parking and streets. Please demarcate the trauma center area on the site plan.	☐		Attach
Office of State Fire Marshall Inspection Report Approvals (Fire/Architectural/Sprinkler): Please submit the recent inspection reports for each building/area being licensed. The forms must indicate the name of the building/areas inspected, list the correct name and address of the hospital and must indicate that it is acceptable for occupancy.	☐		Attach
Office of Public Health Inspection Report Approval: Please submit the recent inspection reports for each building/area being licensed. The form must indicate the name of the building/areas inspected, list the correct name and address of the hospital and must indicate that it is acceptable for occupancy.	☐		Attach
Letter on hospital letterhead stating that either the hospital owns the space and it is not leased/subleased to anyone or that the hospital is the owner of the space through a lease/sublease.	☐		Attach
HSS-HO-09 Attestation Form	☐		Attach
Copy of the notification letter of Trauma Center verification by the American College of Surgeons, Committee on Trauma and a copy of the certificate of verification.	☐		Attach

Attestation & Signature

I understand that if the agency license is granted, it is granted for one year and shall become void upon change of ownership or change in geographical address. It is my responsibility to notify the Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section in writing of any changes in the information provided in this application in a separate packet. I attest that the Rural Health Clinic currently complies with the requirements of the Office of State Fire Marshal and Office of Public Health. I certify that the information herein is true, correct and supportable by documentation to the best of my knowledge. Documentation of the information above is available upon request by the Department of Health and Hospitals.

Authorized Representative's Printed Name & Title:

Authorized Representative's Signature Authorized Representative's Signature:	Date:

For DHH Use Only	Date	Yes	No	Comments
Incomplete Packet Sent Back To Facility along with an instructional letter:		☐	☐	
Packet ready for Program Manager Review		☐	☐	
Routed for licensing survey, Licensing Survey Completed & Approved		☐	☐	
ACO Updated (notes, buildings, cert kit application)		☐	☐	
CMS 1539s distributed		☐	☐	
POPS updated		☐	☐	
License & Letter distributed		☐	☐	
Logs Updated		☐	☐	
Prepped and submitted for filing		☐	☐	
Additional Comments:				

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Health Standards Section

Attestation for a Licensed & Certified Hospital

Instructions for Completing the Attestation Form

We have recently revised the format of the Attestation form. Please review these instructions before filling out the Attestation Form.

1. List the date of the license application this form is associated with.

2. List the effective date of the attestation.

3. List the hospital's DBA name as it appears on the license.

4. List the geographical address of the hospital.

5. List the telephone number (direct line, no voice mail) and fax number of the hospital.

6. List the name of the location being attested to. Example ABC Hospital – EFJ Off-Site Campus (Medical Surgical 4th floor, rooms 401, 402, 403, & 404)

7. List the address of the location being attested to.

8. List the phone number of the area being attested to.

9. Document the purpose of the areas of the attestation.

10. Please review all State of Louisiana Rules, Regulations and Minimum Standards (LAC 48:I, Chapter 93) governing hospitals to ensure the areas being attested to are in compliance. Please be ready to discuss compliance issues with Health Standards Section Program Managers and Division of Engineering personnel.

11. Please review all applicable Conditions of Participation found in the current Code of Federal Regulations to ensure the areas being attested to are in compliance. Please be ready to discuss compliance issues with Health Standards Section Program Managers and Division of Engineering personnel.

12. Please review the current version of the American Institute of Architects Guidelines for Design & Construction of Health Care Facilities to ensure that the areas being attested to are in compliance. Please be ready to discuss compliance issues with Health Standards Section Program Managers and Division of Engineering personnel.

13. All decisions regarding the acceptance of attestations in lieu of on-site surveys are made on a case-by-case basis.

Health Standards Section

Attestation for a Licensed & Certified Hospital

Application Date:	**Effective Date:**
Administrator:	**Designated Contact Person:**
Hospital Name:	
Hospital Address:	
Hospital Phone:	**Hospital Fax:**
Name of Location Being Attested To:	
Address of Location Being Attested To:	
Phone Number of Location Being Attested To:	
Purpose of Location Being Attested To:	

This attestation form must be signed by the Administrator/Designee of the Hospital and each page of the Attestation Form must be initialed and dated.

Attention: Read the Following Carefully Before Signing.

Statements or Entries Generally: Whoever, in any matter within the jurisdiction of any department or agency of the United States knowingly or willfully falsifies, conceals or covers up by any trick, scheme or device a material fact, or makes false, fictitious or fraudulent statement or entry, shall be fined or imprisoned or both. (18 U.S.C., Sec. 1001)

I certify that I have reviewed the hospital licensing requirements and based upon my personal knowledge and belief, I attest that _____ (hospital location being attested to), effective (requested effective date), meets and will continue to meet the applicable requirements for hospitals set forth in the State of Louisiana Rules, Regulations and Minimum Standards (LAC 48:I, Chapter 93) governing Hospitals, all applicable Conditions of Participation found in the Code of Federal Regulations for hospital, and the current applicable guidelines found in the American Institute of Architects Guidelines for Design & Construction of Health Care Facilities. I agree that if the hospital fails to meet any of these requirements, I will notify the Health Standards Section of DHH of the changes immediately in order to permit a valid determination of the hospitals' compliance to the regulations. I understand that the Health Standards Section of DHH, Centers for Medicare and Medicaid Services (CMS), or its representative, has the right to conduct an on-site survey at any time to validate whether the information provided is true.

Signature: _____ (Administrator/Designee) _____ (mo/dd/yr)

APPENDIX F

Trauma Program Checklist Attestation Level I

LOUISIANA EMERGENCY RESPONSE NETWORK

Adult Level II – Trauma Program Checklist/Attestation

To reduce the morbidity and mortality of trauma patients in Louisiana, the LERN Board authorized an evaluation process which recognizes the achievement of specific benchmarks in hospitals actively pursuing Levels II or III Trauma Center verification through the American College of Surgeons (ACS). The criteria are drawn from the Resource for the Optimal Care of Injured Patients 2014 published by the ACS. In addition to these criteria, a site visit is required to validate attestation. It is highly suggested that prior to attesting, the hospital engage the LERN Trauma Medical Director or LERN designee with program development.

Check "Yes" or "No" to indicate achievement of the following Trauma Program Requirements:

A. Trauma Medical Director with Job Description	The Trauma Medical Director is a general surgeon who leads the multidisciplinary activities of the trauma program.		
	Yes	**No**	**Indicate Name and Contact Information for Medical Director**

B. Trauma Medical Director Requirements			
The Trauma Medical Director must meet the following standards:	**Yes**	**No**	**Comments or Explanation**
a. Current board certified general surgeon (or a general surgeon eligible for			

certification by the American Board of Surgery according to current requirements) or a general surgeon who is an American College of Surgeons Fellow with a special interest in trauma care.			
b. Participates on trauma call panel			
c. Must be current in Advanced Trauma Life Support			
d. Must chair multidisciplinary trauma peer review committee meetings.			

C. Trauma Program Manager (TPM) with Job Description.	The Trauma Program Manager is fundamental to the development, implementation, and evaluation of the trauma program. In addition to administrative ability, the TPM must show evidence of educational preparation and clinical experience in the care of injured patients.		
Requirements	**Yes**	**No**	**Indicate Name and Contact Information for the TPM**
a. In a level II trauma program, the TPM must be full-time and dedicated to the trauma program and in TPM role for 3 months.			

D. Functioning Trauma Registry		
Trauma registry requirements:	**Yes**	**No**
a. Trauma Registry Software purchased and operational.		
b. Trauma Registrar hired and actively entering patient data into the registry.		

c. 3 months of trauma registry data must be collected and available for review upon request.		

E. General Surgery Coverage		
General Surgery Coverage Requirements:	**Yes**	**No**
a. 24/7/365 coverage by board certified/eligible General Surgeons credentialed to treat trauma patients.		
b. Respond to the established criteria for full trauma team activation.		
c. Evidence of participation/attendance in PI Meetings.		
d. Evidence that the surgeon is in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 15 minutes for the highest level of activation tracked from patient arrival. This is currently tracked via the PIPS process.		
e. The trauma surgeon on call must be dedicated to a single hospital while on duty.		
f. All general surgeons on the trauma team must have successfully completed the Advanced Trauma Life Support (ATLS) class at least once.		

F. 24/7/365 Specialty Coverage		
Neurosurgery:	**Yes**	**No**
a. Neurotrauma care must be continuously available for all TBI and spinal cord injury patients and as evidence by a published neurotrauma call schedule.		
b. If one neurosurgeon covers two centers there is a published backup schedule.		
Orthopaedic Surgery	**Yes**	**No**
a. Dedicated call schedule at the hospital or an effective back up call system. If the on-call orthopaedic surgeon is unable to respond promptly, a backup consultant on-call surgeon must be available.		
b. The orthopaedic surgeon must be available in the trauma resuscitation area within 30 minutes after consultation has been requested by the surgical trauma team leader for multiply injured patients based on institutional specific criteria.		
Anesthesiology	**Yes**	**No**
a. Anesthesia services must be available in-house 24 hours a day.		
b. When anesthesiology senior residents or CRNAs are used to fulfill availability requirements, the attending anesthesiologist on call must be advised, available within 30minutes at all times, and present for all operations.		

G. Required departments to have appropriate staffing/capability		
Emergency Medicine:	**Yes**	**No**
a. Designated emergency physician director.		
b. All board-certified emergency physicians or those eligible for certification by an appropriate body according to their current requirements must have successfully completed the ATLS course at least once.		
c. Physicians who are certified by boards other than emergency medicine who treat trauma patients in the emergency department are required to have current ATLS status.		
Operating Room:	**Yes**	**No**
a. An operating room must be adequately staffed and available within 15 minutes.		
b. Availability of the operating room personnel and timeliness of starting operations must be continuously evaluated by the trauma PIPS process, and measures must be implemented to ensure optimal care.		
Post Anesthesia Care Unit (PACU)	**Yes**	**No**

a. A PACU with adequate staffing must be available 24 hours a day to provide care for the patient if needed during the recovery phase.		
Radiology:	**Yes**	**No**
a. Radiologists are available within 30 minutes in person or by teleradiology for the interpretation of radiographs.		
b. An in-house radiology technologist and CT technologist are required.		
Intensive Care Unit:	**Yes**	**No**
a. The ICU director or co-director must be a surgeon who is currently board certified or eligibility for certification by the current standard requirements.		
Clinical Laboratory	**Yes**	**No**
a. Must be available 24 hours per day for standard analyses of blood, urine, and other body fluids, including micro-sampling when appropriate.		
b. Capable of blood typing and cross matching.		
c. Must have a massive transfusion protocol developed collaboratively between the trauma service and the blood bank.		
Performance Improvement and Patient Safety	**Yes**	**No**
Adequate meeting minutes (redacted) that reflect discussion of the following:		

a. Issue Identification		
b. Discussion		
c. Loop closure		

Attestation: The undersigned hereby attests that the facility meets all of the standards identified in the Trauma Program Requirements document and ensures 24/7/365 availability of the resources and requirements indicted. The undersigned also attests that the hospital can provide verification of the accuracy of the responses and will immediately notify the Louisiana Emergency Response Network if they no longer meet the requirements. The undersigned understands that the "trauma center" label shall be only be used as provided by La.R.S.40:2171-2173.

_____ _____

Print Name of Hospital CEO **Date**

_____

Signature: Hospital CEO

APPENDIX G

Trauma Progam Checklist Attestation Level II

LOUISIANA EMERGENCY RESPONSE NETWORK

Adult Level III – Trauma Program Checklist/Attestation

To reduce the morbidity and mortality of trauma patients in Louisiana, the LERN Board authorized an evaluation process which recognizes the achievement of specific benchmarks in hospitals actively pursuing Levels II or III Trauma Center verification through the American College of Surgeons (ACS). The criteria are drawn from the Resource for the Optimal Care of Injured Patients 2014 published by the ACS. In addition to these criteria, a site visit is required to validate attestation. It is highly suggested that prior to attesting, the hospital engage the LERN Trauma Medical Director or LERN designee with program development.

Check "Yes" or "No" to indicate achievement of the following Trauma Program Requirements:

A. Trauma Medical Director with Job Description	The Trauma Medical Director is a general surgeon who leads the multidisciplinary activities of the trauma program.		
	Yes	**No**	**Indicate Name and Contact Information for Medical Director**

B. Trauma Medical Director Requirements			
The Trauma Medical Director must meet the following standards:	**Yes**	**No**	**Comments or Explanation**
a. Current board certified general surgeon (or a general surgeon eligible for			

certification by the American Board of Surgery according to current requirements) or a general surgeon who is an American College of Surgeons Fellow with a special interest in trauma care.			
b. Participates on trauma call panel			
c. Must be current in Advanced Trauma Life Support			
d. Must chair multidisciplinary trauma peer review committee meetings.			

C. Trauma Program Manager (TPM) with Job Description.			
Requirements	**Yes**	**No**	**Indicate Name and Contact Information for the TPM**
a. A TPM must be hired in role for a minimum of 3 months.			

D. Functioning Trauma Registry		
Trauma registry requirements:	**Yes**	**No**
a. Trauma Registry Software purchased and operational.		
b. Trauma Registrar identified and actively entering patient data into the registry.		
c. 3 months of trauma registry data must be collected and available for review upon request.		

E. General Surgery Coverage		
General Surgery Coverage Requirements:	**Yes**	**No**
a. 24/7/365 coverage by board certified/eligible General Surgeons credentialed to treat trauma patients.		
b. Respond to the established criteria for full trauma team activation.		
c. Evidence of participation/attendance in PI Meetings.		
d. Evidence that the surgeon is in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 30 minutes for the highest level of activation tracked from patient arrival. This is currently tracked via the PIPS process.		
e. The trauma surgeon on call must be dedicated to a single hospital while on duty.		
f. All general surgeons on the trauma team must have successfully completed the Advanced Trauma Life Support (ATLS) class at least once.		

F. 24/7/365 Specialty Coverage		
Neurosurgery:	**Yes**	**No**
a. Neurosurgery is not required. All Level III Adult Trauma Programs must have evidence of transfer agreements with appropriate Level I and Level II Trauma Centers.		
b. If neurosurgical services are provided at the Level III trauma program, there must be a written plan approved by the trauma medical director that determines which types of neurosurgical injuries may remain and which should be transferred.		
c. In all cases, whether patients are admitted or transferred, the care must be timely, appropriate, and monitored by the PIPS program.		
Orthopaedic Surgery	**Yes**	**No**
a. Must have an orthopaedic surgeon on call and promptly available 24 hours a day.		
b. If the orthopaedic surgeon is not dedicated to a single facility while on call, then a published backup schedule is required.		
Anesthesiology	**Yes**	**No**
a. Anesthesiologists or CRNAs must be available within 30 minutes.		
b. In Level III programs without in-house anesthesia services, written protocols		

must be in place to ensure the timely arrival at the bedside by the anesthesia provider within 30 minutes of notification and request.		

G. Required departments to have appropriate staffing/capability		
Emergency Medicine:	**Yes**	**No**
a. Designated emergency physician director.		
b. All board-certified emergency physicians or those eligible for certification by an appropriate body according to their current requirements must have successfully completed the ATLS course at least once.		
c. Physicians who are certified by boards other than emergency medicine who treat trauma patients in the emergency department are required to have current ATLS status.		
Operating Room:	**Yes**	**No**
a. An operating room must be adequately staffed and available within 30 minutes.		
b. If an on call team is used, availability of the operating room personnel and timeliness of starting operations must be continuously evaluated by the trauma PIPS process, and measures must be implemented to ensure optimal care.		

Post Anesthesia Care Unit (PACU)	**Yes**	**No**
a. A PACU with adequate staffing must be available 24 hours a day to provide care for the patient if needed during the recovery phase.		
Radiology:	**Yes**	**No**
a. Radiologists are available within 30 minutes in person or by teleradiology for the interpretation of radiographs.		
b. In a level III program, if the CT technologist takes call from outside the hospital, the PIPS program must document the technologist's time of arrival at the hospital.		
Intensive Care Unit:	**Yes**	**No**
a. The ICU director or co-director must be a surgeon who is currently board certified or eligibility for certification by the current standard requirements.		
b. In a Level III trauma program, the PIPS program must review all ICU admissions and transfers of ICU patients to ensure that appropriate patients are being selected to remain at the Level III center vs. being transferred to a higher level of care.		
Clinical Laboratory	**Yes**	**No**
a. Must be available 24 hours per day for standard analyses of blood, urine, and		

other body fluids, including micro-sampling when appropriate.		
b. Capable of blood typing and cross matching.		
c. Must have a massive transfusion protocol developed collaboratively between the trauma service and the blood bank.		
Performance Improvement and Patient Safety	**Yes**	**No**
Adequate meeting minutes (redacted) that reflect discussion of the following:		
a. Issue Identification		
b. Discussion		
c. Loop closure		

Attestation: The undersigned hereby attests that the facility meets all of the standards identified in the Trauma Program Requirements document and ensures 24/7/365 availability of the resources and requirements indicted. The undersigned also attests that the hospital can provide verification of the accuracy of the responses and will immediately notify the Louisiana Emergency Response Network if they no longer meet the requirements. The undersigned understands that the "trauma center" label shall be only be used as provided by La.R.S.40:2171-2173.

_____ _____

Print Name of Hospital CEO **Date**

_____

Signature: Hospital CEO

APPENDIX H

Trauma Program Application Recognition

Louisiana Emergency Response Network
Application for Recognition of Trauma Program

Date of Application: _____

Hospital Name and Address: _____

_____

_____

Contact Person: _____ Phone Number: _____

I. Request for Recognition Trauma Program seeking (Circle):

Level II Adult Trauma Hospital

Level III Adult Trauma Hospital

Level I Pediatric Trauma Hospital

Level II Pediatric Trauma Hospital

II. Hospital Information Packet

1. Submit a letter from the hospital board indicating commitment of the institutional governing body and medical staff to the establishment of a level _____ Trauma Center.
2. Submit a copy of the Trauma Medical Director Job description and CV.
3. Submit a copy of the Trauma Program Director job description.
4. How many patients have been entered into the trauma registry? _____
5. How many PI Meetings have been held? _____
6. (Level 3 applicants ONLY) Please define the demographic of patients that the program plans to transfer out for care – ex: pediatric trauma, neuro trauma.

III. Physician Information

1. How many General Surgeons are board certified/Board Eligible with ATLS certification? _____

2. How many Emergency Medicine Physicians are Board Certified/Board Eligible in Emergency Medicine? _____

3. How many in Emergency Medical Physicians not board certified/Board Eligible in Emergency Medicine are current with ATLS? _____

4. How many Orthopaedic Surgeons are Board Certified/Board Eligible? _____

5. How many Neurosurgeons are Board Certified/Board Eligible (Level II applicant only)? _____

6. If applying for Level III Trauma Program and the hospital plans to treat neurosurgery injuries, how many Neurosurgeons are Board Certified/Board Eligible? _____

Signature of CEO _____

Date _____

The hospital must submit this completed form with requested documents to:

Paige Hargrove
Louisiana Emergency Response Network
14141 Airline Highway, Suite B, Building 1
Baton Rouge, LA 70817

Questions regarding this application should be addressed to Paige Hargrove (225)756-3440 or paige.hargrove@la.gov.

APPENDIX I

ACS NBATS Tool

American College of Surgeons Committee on Trauma

Needs Based Assessment of Trauma Systems (NBATS) Tool

Developed by the Needs-Based Trauma Center Designation Consensus Conference convened by the American College of Surgeons Committee on Trauma[1]

August 24-25, 2015

Introductory Notes

The Needs-Based Trauma Center Designation Consensus Conference was held in Chicago on August 24-25, 2015. The conference was convened by the American College of Surgeons Committee on Trauma, and was comprised of a broad group of people involved in the process of trauma center designation in the context of an inclusive regional trauma system. The group was unanimous in support of the principle that trauma center designation within a regional trauma system should be based upon the needs of the population served, as outlined in the recent position statement put forward by the American College of Surgeons Committee on Trauma. The group was also unanimous in its opinion that there is immediate need for a practical tool, based upon data that is currently available, that can be used to assist regions currently struggling with this issue of new trauma center designation.

The group worked to develop such a model tool to assist regions in the performance of an assessment and the determination of the number of trauma centers needed in a region. The conference workgroup was fully cognizant of the challenges involved in this process, not the least of which is a lack of proven metrics of need. The goal was to produce a pragmatic and relatively simple tool that could be used based upon data currently available, while also starting the process that would lead to future improvements and refinements in the approach. This was constructed to aid in the performance of an assessment of the number of trauma centers needed in a specified geographical region, which will be called a Trauma Service Areas (TSA). This tool presumes that the TSA to be evaluated has already been defined, and could range in size from a small county to a multi-state region. In Louisiana, the TSA is the Louisiana Department of Health Region. There are 9 LDH Regions. The tool is designed to evaluate the number of centers needed within the TSA, starting from a clean slate and then making adjustments for existing trauma centers (Level I, II, and III) in the TSA. In Louisiana, This tool is being used to determine if another trauma program is needed in a defined region. A trauma program is distinct and different from the Trauma Center certification by the state which requires verification by the American College of Surgeons. This tool does not attempt to specifically assess the impact of adding an additional center to a TSA, nor does it attempt to determine the relative merit of a particular facility becoming a trauma center within the TSA.

The tool assigns points based upon four elements: population, transport time, community support, and number of severely injured patients (ISS > 15) discharged from centers in the

[1] The participants in the conference are listed in Appendix 1.

TSA that are not Level I, Level II, or Level III trauma centers. This raw score is then adjusted based upon the number of existing Level I, Level II, and Level III centers, and based upon the volume of severely injury patients seen at those existing centers. The final score provides a guideline for the number of trauma centers needed in the TSA.

The conference working group acknowledges that there is no clear evidence to support the use of any of the specific measures proposed, and as a result all recommendations reflect the expert opinion of the convened group, derived through a deliberative group process. The tool itself, along with point assignments for each element, and the point totals to determine trauma center need in this draft are for initial evaluation purposes only. It is anticipated that both the individual element scores as well as the final target ranges will vary depending upon the demographics of the particular TSA (e.g. population, population density, size, geography) and will also reflect the balance of priorities within the specific trauma system. The tool is being circulated to a larger audience of people and groups involved in the trauma center designation process for comment and for initial testing in a range of existing systems; as proof of concept and to begin to collect data that can be used to improve and refine the tool.

Please review the tool and try it out in your particular circumstances. You may modify any of the parameters used if you feel this will improve the accuracy of the model in your region. Please feel free to submit any comments, as well as any trial data generated, to the conference working group through the Feedback Form. Please also feel free to contact Maria Alvi, Manager, Trauma Systems and Quality Programs (malvi@facs.org) with any additional questions or concerns.

Thank you for your interest and your willingness to participate in this important project.

Robert J. Winchell, MD FACS
Chairman
Trauma Systems Evaluation and
Planning Committee

Ronald M. Stewart, MD FACS
Chairman
Committee on Trauma

On behalf of the Needs-Based Trauma Center Designation Consensus Conference working group.

ACS NBATS Tool
Preliminary Draft 1 – September 4, 2015

1. Population

a. total TSA population of less than 600,000 received 2 point
b. total TSA population of 600,000 to 1,200,000 received 4 points
c. total TSA population of 1,200,000 to 1,800,000 received 6 points
d. total TSA population of 1,800,000 to 2,400,000 received 8 points
e. total TSA population of greater than 2,400,000 received 10 points

Points Assigned: _____

2. Median Transport Times (combined air and ground – scene only no transfer)

a. Median transport time of less than 10 minutes received 0 points
b. Median transport time of 10 – 20 minutes receives 1 points
c. Median transport time of 21- 30 minutes receives 2 points
d. Median transport time of 31 – 40 minutes receives 3 points
e. Median transport time of greater than 41 minutes receives 4 points

Points Assigned: ____

3. Lead Agency/System Stakeholder/Community Support

Lead agency support for a trauma center (if none exist) or an additional trauma center or trauma program in the TSA – 5 points.

Trauma System Advisory Committee (or equivalent body) statement of support for a trauma center (if none exist) or an additional trauma center or trauma program in the TSA – 5 points.

Community support demonstrated by letters of support from 25- 50% of city and county governing bodies within the TSA – 1 points

Community support demonstrated by letters of support from over 50% of city and county governing bodies within the TSA – 2points

Points Assigned: ____

4. Severely injured patients (ISS > 15) discharged from acute care facilities not designated as Level I, II, or III trauma centers.

a. Discharges of 0-200 severely injured patients receives 0 points
b. Discharges of 201 – 400 severely injured patients receives 1 points
c. Discharges of 401 – 600 severely injured patients receives 2 points
d. Discharges of 601- 800 severely injured patients receives 3 points
e. Discharges of greater than 800 severely injured patients receives 4 points

Points Assigned: ____

5. Level I Trauma Centers

a. For the existence of each verified Level I trauma center already in the TSA assign 1 negative point
b. For the existence of each verified Level II trauma center already in the TSA assign 1 negative point
c. For the existence of each verified Level III trauma center already in the TSA assign 0.5 negative points

Points Assigned: ____

6. Numbers of severely injured patients (ISS > 15) seen in trauma centers or trauma programs (Level I and II) already in the TSA

The expected number of high-ISS patients is calculated as:

500 x (# of Level I and Level II centers or programs in the

TSA) = _____

a. If the TSA has more than 500 severely injured patients above the expected number assign 2 points
b. If the TSA has 0-500 severely injured patients above the expected number assign 1 point
c. If the TSA has 0-500 fewer severely injury patients than the expected number assign 1 negative point
d. If the TSA has more than 500 fewer severely injured patients than the expected number assign 2 negative points

Points Assigned: ____

The following scoring system shall be used to allocate trauma centers within the TSAs:

1. TSAs with scores of 5 points or less shall be allocated 1 trauma center
2. TSAs with scores of 6-10 points shall be allocated 2 trauma centers
3. TSAs with score of 11-15 points shall be allocated 3 trauma centers
4. TSAs with scores of 16-20 points shall be allocated 4 trauma centers

If the number of trauma centers allocated by the model is greater than the existing number of trauma centers in the TSA, efforts should be undertaken to recruit and designate additional trauma centers.

If the number of trauma centers allocated by the model is greater than the number allocated by the model, the lead agency should not designate additional trauma centers in the TSA.

Appendix 1: List of Participants

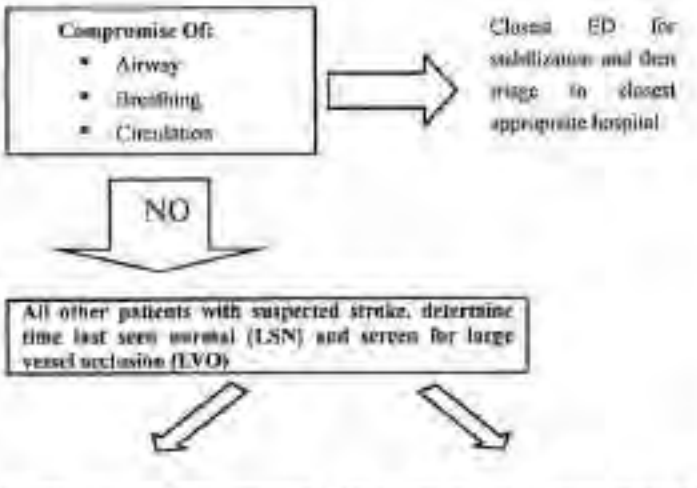
Eileen Whalen, MHA, RN	President and COO; Acting CNO	The University of Vermont Medical Center
Michele Ziglar, RN, MSN	Vice President of Trauma Services	HCA Healthcare
Betty J Bartleson, MSN	Vice President of Nursing and Clinical Services	California Hospital Association
Robert Gfeller	Executive Director	Childress Institute for Pediatric Trauma
Robert Fojut	Editor	Trauma System News
Charles William Mains, MD, FACS	Surgeon	Surgical Specialists of Colorado
Dennis Maier, MD	Medical Director	Surgical Associates PC
Robert Todd Maxson, MD	Pediatric Surgeon	Arkansas Children's Hospital
Debra Perina, MD, FACEP	Director	American College of Emergency Physicians (ACEP); NAEMSP
N. Clay Mann, PhD, MS	Professor of Surgery	NEMSIS TAC PI, University of Utah
Ellen Mackenzie, PHD	Fred and Julie Soper Professor and Chair	Johns Hopkins Bloomberg School of Public Health
Robert Mackersie, MD	Professor of Surgery and Director of Trauma Services	University of California San Francisco; San Francisco General Hospital and Trauma Center
Eric Chaney, MBA	Representing the Deputy Director (Acting), Workforce Health and Medical Support Division	US Department of Homeland Security (DHS)
Gregg S Margolis, PhD, NRP	Director of the Division of Health System Policy, Office of the Assistant Secretary for Preparedness and Response	US Department of Health and Human Services (HHS); ASPR
Brendan G Carr, MD, MA, MS	Director of ECCC; Division of Health System Policy	US Department of Health and Human Services (HHS); ASPR
Beth Edgerton, MD, MPH	Director of the Division of Child, Adolescent and Family Health (DCAFH)	Health Resources and Services Administration (HRSA)
Cathy Gotschall, ScD	Senior Health Scientist	National Highway and Traffic Safety Administration (NHTSA)
Drew Dawson	Director, Office of EMS	National Highway and Traffic Safety Administration (NHTSA)
Fergus Laughridge, Captain, CPM	Professional Services and Compliance Officer	Humbolt General Hospital EMS and Rescue, State of Nevada
Eric Epley	Executive Director	Southwest Texas Regional Advisory Council (STRAC); Regional Structure
Robert Jex, RN	Specialty Care Program Manager	Utah Dept. of Health, Bureau of EMS; Utah Office of Rural Health
John Armstrong, MD	Surgeon General; Secretary of Health	Florida Department of Health
Chuck Kearns, MBA	President	NAEMT
Ronald M Stewart, MD, FACS	Chair COT	ACS Trauma
Leonard J Weireter, MD, FACS	Vice Chair COT	ACS Trauma
Robert J Winchell, MD, FACS	Chair TSEPC, COT	ACS Trauma
Jean Clemency	Administrative Director of ACS Trauma Programs	ACS Trauma Programs
Nels D Sanddal, PhD, REMT	Manager of Trauma Systems and Trauma Centers Verification Programs	ACS Trauma Programs
Maria Alvi, MHA	Manager of Trauma Systems and Quality Programs	ACS Trauma Programs
Jane Ball, RN, DrPH	ACS Trauma Consultant	ACS Trauma Programs
Justin Rosen	State Affairs Associate; COT Advocacy Committee	ACS Advocacy and Health Policy
Molly Lozada	Manager of Trauma Centers Quality VRC Programs	ACS Trauma Programs
Matt Coffron	Manager of Policy Development	ACS Advocacy and Health Policy
Melanie Neal	NTDB Manager	ACS Trauma Programs
Scott Matthews	Graphic Recorder, Company Co-founder	Tremendousness

APPENDIX J

Rule: LAC 48:I, Chapter 197, §19701-§19707

LERN Call Center: (866) 320-8293

The following protocol applies to patients with suspected stroke:



* The LSN < 6hrs should include patients without a definite time of LSN, but who could reasonably be assumed to be within 6 hrs of onset, including patients who wake-up with stroke symptoms

Guiding Principles:

- Time is the critical variable in acute stroke care
- Protocols that include pre-hospital notification while en route by EMS should be used for patients with suspected acute stroke to facilitate initial destination efficiency.
- Treatment with intravenous tPA is the only FDA approved medication therapy for hyperacute stroke.
- EMS should identify the geographically closest hospital capable of providing tPA treatment.
- Transfer patient to the nearest hospital equipped to provide tPA treatment.
- Secondary transfer to facilities equipped to provide tertiary care and interventional treatments should not prevent administration of tPA to appropriate patients.

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 43:1758 (September 2017).

Chapter 195. STEMI Protocols

§19501. STEMI Triage Protocol for Pre-Hospital Providers

A. On November 21, 2013, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "STEMI Triage Protocol for Pre-Hospital Providers," as follows.

Acute coronary symptoms ≥ 15 minutes and < 12 hours AND 12 lead ECG criteria of 1 mm ST elevation in 2 or more contiguous leads OR LBBB NOT KNOWN to be present in the past EMS ECG interpreted or transmitted to hospital for MD consult for bypass and activation		
↓		
STEMI-Receiving Center with medical contact-to-device (PCI) ≤ 90 minutes (by ground or air)?	YES→	Transport to nearest STEMI-Receiving Center with pre-hospital notification/activation Goal medical contact to device (PCI) time of 90 minutes or less
NO ↓		
Transport to closest STEMI-Referral Hospital with Pre-hospital notification/activation Goal medical contact to fibrinolytic needle time of 30 minutes or less	→	Transport to nearest STEMI-Receiving Center for subsequent PCI

*O'Gara PT, Kushner FG, Ascheim DD, et al. 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Journal of the American College of Cardiology. 2013;61(4):e78.

B. This protocol was published at LR 50:197 (January 20, 2014).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:146 (January 2015).

Chapter 197. Trauma Program Recognition

§19701. Generality

A. The goal of the Louisiana Emergency Response Network Board is to establish a trauma system that includes one verified trauma center in each region of the state. Trauma program recognition in excess of this goal will be determined utilizing a needs based assessment. The LERN communication center coordinates access to the trauma system by providing accurate and professional routing of patients experiencing time sensitive illness to the definitive care facility, which includes trauma programs recognized according to these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1931 (November 2016).

§19703. Purpose

A. LERN recognizes the opportunity to reduce the morbidity and mortality of trauma patients in Louisiana in areas without an existing level I or level II trauma center or an existing level II or level III trauma program through this process which recognizes the achievement of specific benchmarks in hospitals actively pursuing levels II or III trauma center verification through the American College of Surgeons (ACS).

B. The purpose of this Chapter is to define the qualifications, procedure, and requirements for hospitals seeking trauma center verification by the ACS to be recognized by LERN as achieving the core components of a trauma program and thus qualified for recognition as a trauma program.

C. The criteria for trauma program recognition are drawn from *Resources for Optimal Care of Injured Patient 2014* published by the ACS.

D. Trauma program recognition is distinct and different from the trauma center certification by the state. To be certified as a trauma center, a hospital must satisfy the requirements of R.S. 40:2172 and 2173.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:193) (November 2016).

§19705. Qualifications for LERN Trauma Program Recognition

A. The hospital must be located in a LERN region that does not have an existing ACS verified level I or level II trauma center.

B. A hospital providing care to trauma patients in a LERN region without an existing ACS verified level I or level II trauma center or without an existing level II or level III trauma program is eligible for trauma program recognition upon meeting the requirements of this rule.

C. If there is an existing LERN recognized level II or Level III trauma program in the LERN region, the hospital must complete the most current version of the ACS needs based assessment of trauma systems tool (ACS NBATS). If the number of trauma centers allocated by the tool is less than or equal to the number of existing trauma programs in the region, the hospital is not eligible for trauma program recognition.

D. A hospital must be in the process of working toward ACS verification to be eligible for trauma program recognition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1932 (November 2016).

§19707. Procedure for Trauma Program Recognition

A. A hospital must complete the LERN approved form, "application for recognition of trauma program".

B. The hospital CEO must complete and sign the LERN approved trauma program checklist/attestation for the applicable trauma program level.

1. By this attestation, the hospital CEO ensures 24/7/365 availability of the resources listed.

2. The attestation must be validated by a site visit by LERN staff.

3. Upon CEO attestation and/or site visit, if it is determined by the LERN executive committee in conjunction with the LERN trauma medical director, that the required benchmarks are not in place the hospital will not be eligible for trauma program verification.

C. After satisfying the requirements of A. and B. above, the hospital will be recognized as a trauma program and such recognition will be added to the LERN resource management screen for the purpose of routing trauma patients.

D. To maintain trauma program recognition, the hospital must request an ACS verification or consultation site visit at the time of the attestation or within 30 days thereafter, with the consultation or survey to occur within 12 months of the attestation or as close to 12 months as the ACS schedule allows. Written documentation of the request and scheduling must be submitted to LERN.

1. If an ACS verification or consultation site visit is not requested within 30 days and does not occur within 12 months or as close to 12 months as the ACS schedule allows, the trauma program indicator on LERN resource management screen will be removed.

E. After a consultation visit for the desired trauma level, the hospital has 30 days to schedule the verification survey by the ACS to occur within 12 months of the consultation or as close to 12 months as the ACS schedule allows. Written documentation of the request and scheduling must be submitted to LERN.

1. If documentation of scheduling per required parameters is not submitted to LERN and the ACS verification survey is not scheduled to occur within 12 months of the consultation or as close to 12 months as the ACS schedule allows, the trauma program indicator will be removed on the LERN resource management screen.

2. If the hospital fails the ACS verification visit and a focused review visit, the hospital will lose trauma program status. The trauma program indicator will be removed on the LERN resource management screen.

F. After loss of trauma program status for failing the ACS verification visit and focused review visit, trauma program status may be regained provided the following conditions are met:

1. a LERN designee and either the LERN trauma medical director or a trauma surgeon must review the deficiencies and findings of the ACS at a site visit;

2. the hospital must develop a remediation plan and apply to the LERN board for approval of trauma program status;

3. the LERN board will review the LERN team assessment of deficiencies and the hospital's remediation plan;

4. the LERN board must vote to approve the trauma program status request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1932 (November 2016), amended LR 44:63 (January 2018), LR 45:436 (March 2019), repromulgated LR 45:573 (April 2019).

Subpart 17. Personal Assistance Services

Chapter 201. State Personal Assistance Services Program

Editor's Note: This Chapter, formerly LAC 67:VII.Chapter 11, was moved to LAC 48:I.Chapter 201.

§20101. Mission
[Formerly LAC 67:VII.1101]

A. General Statement. The legislature of Louisiana recognizes the right of people with significant physical disabilities to lead independent and productive lives and further recognizes that persons with significant disabilities require personal assistance to meet tasks of daily living and, in many cases to avoid costly institutionalization. The creation of the State Personal Assistance Services Program, hereafter referred to as the SPAS Program, is to provide state personal assistance services to persons with significant disabilities in order to support and enhance their employability and/or to avoid inappropriate and unnecessary institutionalization. The mission of the SPAS Program is to provide for an orderly sequence of services to these persons who are determined eligible for the program.

B. Program Administration. The Department of Health and Hospitals, through Office of Aging and Adult Services (OAAS), is responsible for the administration of the SPAS Program.

C. Purpose of this Rule. This Rule sets forth the policies of OAAS in carrying out the agency's mission, specifically as this mission relates to the SPAS Program.

D. Exceptions. The secretary or secretary's designee shall have the sole responsibility for any exceptions to this policy manual.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), repromulgated LR 19:1436 (November 1993), amended LR 33:1146 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:385 (February 2015).

§20103. Enabling Legislation
[Formerly LAC 67:VII.1103]

A. House Bill Number 1198, Act 939 of the 2010 Regular Session, LAC Title 48, Chapter 201, *Revised Statute* 46:2116.2.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:2116.2.

HISTORICAL NOTE: Promulgated by the Department of Social Services, Rehabilitation Services, LR 17:611 (June 1991), amended LR 19:1437 (November 1993), LR 33:1146 (June 2007), amended by the Department of Health and Hospitals, Office of Aging and Adult Services, LR 41:385 (February 2015).

§20105. Definitions
[Formerly LAC 67:VII.1105]

A. The following terms, when used in this manual shall have the meaning, unless the context clearly indicates otherwise.

Self-Directed—the participant or legal/personal representative will direct, supervise, hire and discharge his/her personal attendant and be able to *self-direct* all goods/services needed.

Management Contractor/Fiscal Agent—contracted entity which may be responsible for day to day program activities including but not limited to eligibility requirements, etc.

Department—the Department of Health and Hospitals.

Individual with Significant Disabilities—an individual with loss of sensory or motor functions interfering with activities of daily living to the extent that the person requires assistance with non-medical personal care needs, domestic or cleaning needs, dressing and undressing, moving into and out of bed, transferring, ambulation, related services including but not limited to meal preparation, laundry, and grocery shopping, and/or other similar activities of daily living.

PA—personal assistance.

Secretary—the *secretary* of the Department of Health and Hospitals.

State Personal Assistance Services (SPAS) Program—services means goods and services which are required by a person with significant disabilities age 18 eighteen or older to increase a person's independence or substitute for a person's dependence on human assistance.

Intentional Program Violation—made a false or misleading statement, or misrepresented, concealed or withheld fact; or committed any act that constitutes a violation of the SPAS Program or SPAS policy and/or procedures.

AUTHORITY NOTE: Promulgated in accordance with 46:2116.2.

APPENDIX K

Ammendment to Trauma Program Rule

Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH
Secretary

1903#048

RULE

Department of Health
Bureau of Health Services Financing

Telemedicine—Claim Submissions
(LAC 50:I.503)

The Department of Health, Bureau of Health Services Financing has amended LAC 50:I.503 in the Medical Assistance Program as authorized by R.S. 36:254 and pursuant to the Title XIX of the Social Security Act. This Rule is promulgated in accordance with the provisions of the Administrative Procedure Act, R.S. 49:950 et seq. This Rule is hereby adopted on the day of promulgation.

Title 50
PUBLIC HEALTH—MEDICAL ASSISTANCE
Part I. Administration
Subpart 1. General Provisions
Chapter 5. Telemedicine
§503. Claim Submissions

A. Medicaid covered services provided via an interactive audio and video telecommunications system (telemedicine) shall be identified on claim submissions by appending the Health Insurance Portability and Accountability Act (HIPAA) of 1996 compliant place of service (POS) or modifier to the appropriate procedure code, in line with current policy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:2032 (August 2005), amended by the Department of Health, Bureau of Health Services Financing, LR 45:436 (March 2019).

Implementation of the provisions of this Rule may be contingent upon the approval of the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS), if it is determined that the submission to CMS for review and approval is required.

Rebekah E. Gee MD, MPH
Secretary

1903#049

RULE

Department of Health
Emergency Response Network Board

Trauma Program Recognition (LAC 48:I.19707)

In accordance with the provisions of R.S. 49:950 et seq., and the Administrative Procedure Act, the Louisiana Emergency Response Network Board amends LAC 48:I.Chapter 197, Section 19707, a Rule as revised by the Louisiana Emergency Response Network Board in a meeting of August 16, 2018, the following "Trauma Program Recognition", adopted as authorized by R.S. 9:2798.5. The Rule clarifies timeliness and requirements for hospitals seeking Trauma Program recognition. This Rule is hereby adopted on the day of promulgation.

Title 48
PUBLIC HEALTH—GENERAL
Part I. General Administration
Subpart 15. Emergency Response Network
Chapter 197. Trauma Program Recognition
§19707. Procedure for Trauma Program Recognition

A. - E. ...

F. After loss of trauma program status for failing the ACS verification visit and focused review visit, trauma program status may be regained provided the following conditions are met:

1. A LERN designee and either the LERN trauma medical director or a trauma surgeon must review the deficiencies and findings of the ACS at a site visit;

2. The hospital must develop a remediation plan and apply to the LERN board for approval of trauma program status;

3. The LERN board will review the LERN team assessment of deficiencies and the hospital's remediation plan;

4. The LERN board must vote to approve the trauma program status request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1932 (November 2016), LR 45:436 (March 2019).

Paige Hargrove
Executive Director

1903#004

RULE

Department of Health
Professional Counselors Board of Examiners

Requirements, Fees and Exemptions
(LAC 46:LX.705, 801, 803, 901 and 1701)

In accordance with the applicable provisions of the Louisiana Administrative Procedures Act (R.S. 49:950 et seq.) and through the authority of the Mental Health Counselor Licensing Act (R.S. 37:1101 et seq.), the Louisiana Licensed Professional Counselors Board of Examiners has added to rules clarification on licensure requirements, fees and exemptions. This Rule is hereby adopted on the day of promulgation.

Title 46
PROFESSIONAL AND OCCUPATIONAL STANDARDS
Part LX. Licensed Professional Counselors Board of Examiners
Subpart 1. Licensed Professional Counselors
Chapter 7. Application and Renewal Requirements for Licensed Professional Counselors
§705. Renewal

A. - D.1. ...

APPENDIX L

Attestation Requirements Pediatric Level I and II Trauma Program

LOUISIANA EMERGENCY RESPONSE NETWORK

Pediatric Level I or II – Trauma Program Checklist/Attestation

To reduce the morbidity and mortality of trauma patients in Louisiana, the LERN Board authorized an evaluation process which recognizes the achievement of specific benchmarks in hospitals actively pursuing Levels I or II Pediatric Trauma Center verification through the American College of Surgeons (ACS). The criteria are drawn from the Resource for the Optimal Care of Injured Patients 2014 published by the ACS. In addition to these criteria, a site visit is required to validate attestation. It is highly suggested that prior to attesting, the hospital engage the LERN Trauma Medical Director or LERN designee with program development.

Check "Yes" or "No" to indicate achievement of the following Trauma Program Requirements:

A. Trauma Medical Director with Job Description	The Trauma Medical Director is a pediatric surgeon who leads the multidisciplinary activities of the trauma program.		
	Yes	**No**	**Indicate Name and Contact Information for Medical Director**

B. Trauma Medical Director Requirements			
The Trauma Medical Director must meet the following standards:	**Yes**	**No**	**Comments or Explanation**
a. In a Level II pediatric trauma center, the pediatric trauma medical director should be a board-certified pediatric surgeon or a surgeon eligible for certification by the American Board of Surgery according to current requirements for pediatric surgeons.			

b. When the pediatric TMD is not a BC/BE pediatric surgeon, the individual must be a BC/BE general surgeon and must: • Be privileged to provide pediatric trauma care, • Be a member of the adult trauma panel • Accrue ACS required trauma CME, at least 9 hours must be related to clinical pediatric trauma care • Be current in PALS Society of Critical Care Medicine Fundamentals of Pediatric Critical Care course. • Formal relationship with a pediatric TMD at another verified level I PTC.			
c. Participates on trauma call panel			
d. Must be current in ATLS			
e. Must chair multidisciplinary trauma peer review committee meetings.			
C. Trauma Program Manager (TPM) with Job Description.	The Trauma Program Manager is fundamental to the development, implementation, and evaluation of the trauma program. In addition to administrative ability, the TPM must show evidence of educational preparation and clinical experience in the care of injured patients.		
Requirements	**Yes**	**No**	**Indicate Name and Contact Information for the TPM**
a. In a level II trauma program, the TPM must be full-time and dedicated to the trauma program and in TPM role for 3 months.			
D. Functioning Trauma Registry			
Trauma registry requirements:	**Yes**		**No**

a. Trauma Registry Software purchased and operational.		
b. Trauma Registrar hired and actively entering patient data into the registry.		
c. 3 months of trauma registry data must be collected and available for review upon request.		
E. General Surgery Coverage		
General Surgery Coverage Requirements:	**Yes**	**No**
a. 24/7/365 coverage by board certified/eligible General Surgeons credentialed to treat trauma patients. b. In a Level II pediatric trauma center, there must be at least one pediatric surgeon who is board–certified or eligible for certification by the American Board of Surgery according to current requirements in pediatric surgeon (CD 10-21). The remainder of the call panel may be general surgeons with demonstrated interests and skills in pediatric trauma care		
c. Evidence that the surgeon is in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 15 minutes for the highest level of activation tracked from patient arrival. This is currently tracked via the PIPS process.		

d. The trauma surgeon on call must be dedicated to a single hospital while on duty.		
F. 24/7/365 Specialty Coverage		
Neurosurgery:	**Yes**	**No**
a. Neurotrauma care must be continuously available for all TBI and spinal cord injury patients and must be present and respond within 30 minutes based on institutional–specific criteria.		
b. If one neurosurgeon covers two centers there is a published backup schedule.		
c. There must be one surgeon who is board–certified or eligible for certification by the appropriate neurosurgical board (CD 10-23) identified with demonstrated interests and skills in pediatric trauma care.		
Orthopaedic Surgery	**Yes**	**No**
a. There must be one surgeon who is board–certified or eligible for certification by the appropriate orthopaedic board (CD 10-22) identified with demonstrated interests and skills in pediatric trauma care.		
b. Dedicated call schedule at the hospital or an effective back up call system. If the on-call orthopaedic surgeon is unable to respond promptly, a backup consultant on-call surgeon must be available.		

c. The orthopaedic surgeon must be available in the trauma resuscitation area within 30 minutes after consultation has been requested by the surgical trauma team leader for multiply injured patients based on institutional specific criteria.		
Anesthesiology	**Yes**	**No**
a. Anesthesia services must be available in-house 24 hours a day.		
b. When anesthesiology senior residents or CRNAs are used to fulfill availability requirements, the attending anesthesiologist on call must be advised, available within 30minutes at all times, and present for all operations.		
G. Required departments to have appropriate staffing/capability		
Emergency Medicine:	**Yes**	**No**
a. Designated emergency physician director.		
b. All board-certified emergency physicians or those eligible for certification by an appropriate body according to their current requirements must have successfully completed the ATLS course at least once.		
c. Physicians who are certified by boards other than emergency medicine, or pediatric emergency medicine, who treat trauma patients in the emergency department are required to have current ATLS status.		

Operating Room:	**Yes**	**No**
a. An operating room must be adequately staffed and available within 15 minutes.		
Post Anesthesia Care Unit (PACU)	**Yes**	**No**
a. A PACU with adequate staffing must be available 24 hours a day to provide care for the patient if needed during the recovery phase.		
Radiology:	**Yes**	**No**
a. Radiologists are available within 30 minutes in person or by teleradiology for the interpretation of radiographs or to perform complex imaging studies or interventional procedures.		
b. Board certification or eligibility for certification by the current standard requirements is essential for radiologists who take trauma call in Level I and II trauma centers (CD 11-43).		
c. An in-house radiology technologist and CT technologist are required.		
Intensive Care Unit:	**Yes**	**No**
a. The surgical director of the pediatric intensive care unit should be board certified in surgical critical care.		
Clinical Laboratory	**Yes**	**No**
a. Must be available 24 hours per day for standard analyses of blood, urine, and other body fluids, including micro-sampling when appropriate.		

b. Capable of blood typing and cross matching.		
c. Must have a massive transfusion protocol developed collaboratively between the trauma service and the blood bank.		
H. Pediatric Specific Measures		
A Level II pediatric trauma center must annually admit 100 or more injured children younger than 15 years.		
All pediatric trauma centers must have the following programs: pediatric rehabilitation, child life and family support programs, pediatric social work, child protective services, pediatric injury prevention, community outreach, and education of health professionals and the general public in the care of pediatric trauma patients.		
All centers must be enrolled in TQIP and/or TQIP–Peds or commit to doing so upon achieving Trauma program status.		

Attestation: The undersigned hereby attests that the facility meets all of the standards identified in the Trauma Program Requirements document and ensures 24/7/365 availability of the resources and requirements indicted. The undersigned also attests that the hospital can provide verification of the accuracy of the responses and will immediately notify the Louisiana Emergency Response Network if they no longer meet the requirements. The undersigned understands that the "trauma center" label shall be only be used as provided by La.R.S.40:2171-2173.

_____ _____ _____

Signature: Hospital CEO **Print Name of Hospital CEO** **Date**

APPENDIX M

Hospital Participation Agreement

AGREEMENT FOR PARTICIPATION IN LOUISIANA EMERGENCY RESPONSE NETWORK

BY AND BETWEEN

LOUISIANA EMERGENCY RESPONSE NETWORK BOARD

AND

IN REGION

THIS AGREEMENT FOR PARTICIPATION (sometimes hereinafter referred to as Agreement) is entered into this 1st day of July, 2014 by and between Louisiana Emergency Response Network Board (LERN) and (hereinafter referred to as Participating Hospital) to facilitate participation of Participating Hospital in Region of the Louisiana Emergency Response Network.

WHEREAS, it is incumbent upon the State of Louisiana and public and private healthcare partners and allies to work in concert to safeguard the public health and welfare of Louisiana residents against unnecessary trauma and time-sensitive related deaths and incidents of morbidity;

WHEREAS, La. R.S. 40:2841-2846 establishes the Louisiana Emergency Response Network (LERN) as a public/private cooperative effort between healthcare providers and the State of Louisiana to maximize the integrated delivery of optimal resources for patients who ultimately need acute care for trauma or time-sensitive illness, or for a disaster within the State;

WHEREAS, LERN is responsible for improving access to regional care for trauma and time-sensitive illness or a disaster within the state by developing, implementing, and supporting systems in nine administrative regions within the State of Louisiana;

WHEREAS, LERN is charged with the responsibility to obtain, aggregate, and utilize data related to the integrated and uniform delivery of emergency care resulting from trauma, time-sensitive illness, or a disaster within the State;

WHEREAS, the State of Louisiana has facilities and healthcare partners available to support the initial management and/or definitive treatment of the severely injured, those with time-sensitive illness, or those affected by a disaster within the State;

WHEREAS, hospitals and other healthcare providers agree to use best efforts to support and cooperate with LERN in its efforts to implement a system of improved medical response for emergency care resulting from trauma, time-sensitive illness, or a disaster within the State;

WHEREAS, Region «REGION» of the Louisiana Emergency Response Network is the defined geographical area that includes the parishes of _____, _____, _____, _____, and _____.

WHEREAS, Participating Hospital is a hospital located within Region «REGION» of the Louisiana Emergency Response Network and desires to participate in the Louisiana Emergency Response Network pursuant to the terms of this agreement.

NOW THEREFORE, in consideration of the premises and mutual understandings herein contained, the Parties to this Agreement acknowledge and agree as follows.

1. LERN Entry Criteria and Destination Protocols. When people are in need of time-sensitive medical care and treatment as a result of trauma, illness, or other emergencies or disasters, Participating Hospital and LERN, acting through the LERN Communication Center [LCC] will use its best efforts to facilitate the movement of patients from the pre-hospital setting to the most appropriate definitive care facility by following "LERN Destination Protocol: Trauma," attached hereto as Attachment A, "STEMI Triage Protocol for Pre-Hospital Providers," attached hereto as Attachment B, and "LERN Destination Protocol: Stroke" attached hereto as Attachment C, to the extent these protocols are applicable to a particular situation. Regional borders do not apply in the pre-hospital setting as the goal is to transport to the most appropriate definitive care facility. In regions with preexisting protocols (or agreements) involving verified trauma centers, LERN will consider these protocols when directing transport of pre-hospital patients.

2. Emergency Department Transfer to Definitive Care. When an individual requires specific services or medical treatment not available at the initial facility Participating Hospital and LERN, acting through the LCC, will use its best effort to facilitate transfer to the more appropriate definitive care facility by following "LERN Hospital Interregional Transfer Guidelines" and "LERN Hospital Interregional Transfer Protocol", both attached hereto as Attachment D, for an individual whose condition exceeds the regionally available resources provided by local area hospitals.

3. Resource Management.
    a. Participating Hospital agrees to use the LERN screen within Resource Management, a secure web-based system, as a communication component within LERN.

    b. Hospital information entered into Resource Management will include, but is not limited to, availability of select medical specialties and other information about the hospital's ability to respond and treat LERN patients according to identified protocols.

    c. Participating Hospital will use best efforts to provide real-time information about the hospital's available resources and will take reasonable steps to update the information twice daily at 7 a.m. and 7 p.m. If resources change significantly during the day, Participating Hospital agrees to use best efforts to change resource availability status and activity level in Resource Management at that time.

    d. The information entered into Resource Management will be used by the LCC to direct the flow of patients according to the established Protocols. Participating Hospital understands that Resource Management information is available to the LCC and LERN participating hospitals within the region.

4. LERN Data.
    a. Participating Hospital understands that data, as currently defined in Attachment E, will be used and shared in order to move individuals meeting LERN Entry Criteria from the scene of traumatic injuries, time-sensitive Illness, disaster, local emergency departments, or other sites to Definitive Care.

    b. Data collected will include data sets pertinent to LERN's ability to ensure continuity of care and timely access to Definitive Care. LERN data will be accumulated and organized in summary form. It is not the intention of LERN to identify any activity or data related to a participating hospital; LERN data will be disseminated in aggregate form.

5. Patient Information and LERN Communications.
    a. Each patient entered into EMS State Service Bridge, the comprehensive pre-hospital patient care data collection and analysis reporting system used by LERN for data collection, will be assigned a unique numerical identifier for the purpose of facilitating the movement of the individual through the LERN network. LERN will use the unique numerical identifiers in data collection and data evaluation. LERN intends that any and all identifiable patient information shall be afforded protection to the extent of LERN's ability within the context of the mission of LERN.
    b. Participating Hospital will complete patient records, emergency transfer forms, and other necessary patient-specific documentation sufficient to maintain regulatory compliance with the Emergency Medical Treatment and Labor Act (EMTALA), HIPAA, and other applicable laws, rules and regulations, and to facilitate standard physician and nursing communication for the transfer of patients and safe and appropriate patient care.
    c. The activities of LERN assist Participating Hospital with the routing to and from the hospital of a specific subset of patients, i.e., those who need emergency care resulting from trauma, time sensitive illness or a disaster within the State. LERN establishes no additional legal or regulatory requirements for Participating Hospital other than as set forth herein.

6. Planning. Participating Hospital agrees to be engaged in activities related to development, cooperative planning and coordination of patient care. Participating Hospital will work with LERN to facilitate continuous quality improvement of the Louisiana Emergency Response Network and the care available to patients within the State. Participating Hospital agrees to support attendance at LERN education and training seminars by having appropriate hospital personnel attend those seminars. The parties understand that need for LERN data requirements may increase and Participating Hospitals may be requested to sign addenda to this Agreement of Participation to facilitate the need for increased data.

7. Term of Agreement. This Agreement is in effect for the period commencing on the date first noted above and terminating five years thereafter. The Agreement will continue and will automatically renew for a successive five year period unless either the contracting party advises the other of the intent to not renew in writing, within 30 days before the end of the term. Either party shall also have the right to cancel this Agreement, with or without cause, by giving the other party thirty (30) days written notice forwarded to their respective address by certified mail. LERN has the right to cancel this contract upon less than thirty (30) days due to budgetary reductions and changes in funding priorities.

THUS DONE AND SIGNED by the Louisiana Emergency Response Network Board and «HOSPITAL» Participating Hospital in Region «REGION».

LOUISIANA EMERGENCY RESPONSE NETWORK BOARD

_____ _____

DATE

PRINT NAME: **Paige Hargrove**

PARTICIPATING HOSPITAL

HOSPITAL: «HOSPITAL»

BY: _____ _____

DATE

PRINT NAME _____

TITLE: _____

Call LERN Communication Center at 1-866-320-8293 for patients meeting the following criteria:

- Unmanageable airway
- Traumatic cardiac arrest
- Burn patient > 40 % BSA without IV
- Tension pneumothorax
- Burn patient without patent airway

YES → **Closest ED/Trauma Center**

NO

Measure vital signs and level of consciousness

- GCS ≤13
- SBP <90mmHg
- RR <10 or >29 breaths per minute, or need for ventilator Support (<20 in infant aged <1 year)

NO

Assess anatomy of injury

- All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Chest wall instability or deformity (e.g. flail chest)
- Two or more proximal long-bone fractures
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Pelvic fractures
- Open or depressed skull fracture
- Paralysis
- Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture)

YES → **Transport to Trauma Center/Trauma Program** These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program. ** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.*

NO

Assess mechanism of injury and evidence of high-energy impact

- **Falls**
  - -- Adults: >20 feet (one story is equal to 10 feet)
  - -- Children: >10 feet or two or three times the height of the child
- **High-risk auto crash**
  - -- Intrusion, including roof: > 12 inches occupant site; > 18 inches any site
  - -- Ejection (partial or complete) from automobile
  - -- Death in the same passenger compartment
  - -- Vehicle telemetry data consistent with a high risk of injury
- **Auto vs. pedestrian/bicyclist/ATV thrown, run over, or with significant (>20 mph) impact**
- **Motorcycle crash >20mph**

YES → **Transport to Trauma Center/Trauma Program** which, depending upon the defined trauma system, need not be the highest level trauma center/program. If no Trauma Center/ Trauma Program in the region, LCC may route to the most appropriate resourced hospital.

NO

Assess special patient or system considerations

- **Older Adults**
  - -- Risk of injury/death increases after age 55 years
  - -- SBP <110 may represent shock after age 65
  - -- Low impact mechanisms (e.g. ground level falls) may result in severe injury
- **Children**
  - -- Should be triaged preferentially to pediatric capable trauma centers
- **Anticoagulants and bleeding disorders**
  - -- Patients with head injury are at high risk for rapid deterioration
- **Burns**
  - -- With trauma mechanism: triage to trauma center
- **Pregnancy >20 weeks**
- Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls
- Major joint dislocations (hip, knee, ankle, elbow)
- Open Fractures
- **EMS provider judgment**

YES → **Transport to Trauma Center/Trauma Program** or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.

NO

Multi / Mass Casualty Incident

NO → **Transport according to local protocol**

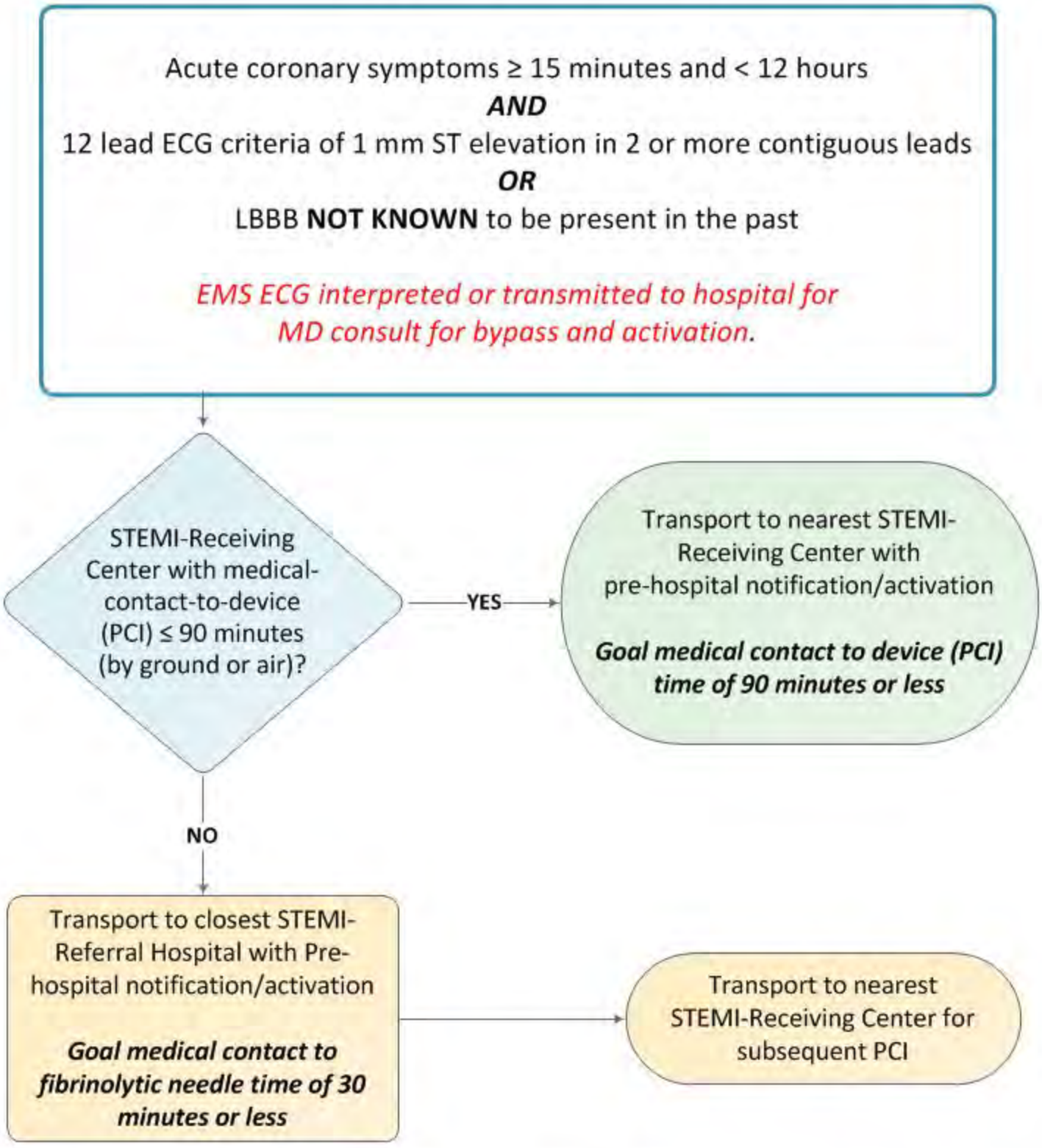
LOUISIANA EMERGENCY RESPONSE NETWORK

Destination Protocol
TRAUMA

When in doubt, transport to a trauma center.

Rev. 12/10/15
Eff. 1/1/2016

STEMI TRIAGE PROTOCOL FOR PRE-HOSPITAL PROVIDERS*

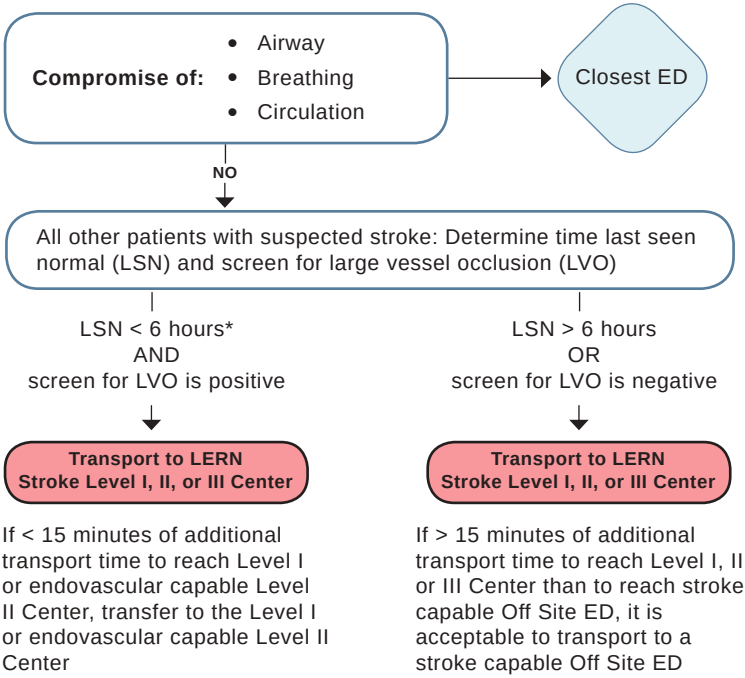


*O'Gara PT, Kushner FG, Ascheim DD, et all. 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infraction: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Journal of the American College of Cardiology. 2013;61(4):e78.

LOUISIANA EMERGENCY RESPONSE NETWORK

STROKE DESTINATION PROTOCOL

The following protocol applies to patients with suspected stroke:



* the LSN < 6 hours should include patients without a definite time of LSN, but who could reasonably be assumed to be within 6 hours of onset, including patients who wake-up with stroke symptoms

Guiding Principles:

- Time is the critical variable in acute stroke care
- Protocols that include pre-hospital notification while en route by EMS should be used for patients with suspected acute stroke to facilitate initial destination efficiency
- Treatment with intravenous tPA is the only FDA approved medication therapy for hyperacute stroke
- EMS should identify the geographically closest hospital capable of providing tPA treatment
- Transfer patient to the nearest hospital equipped to provide tPA treatment
- Secondary transfer to facilities equipped to provide tertiary care and interventional treatments should not prevent administration of tPA to appropriate patients

Adopted 4/20/2017

LERN Communication Center: 1-866-320-8293

LERN Hospital Interregional Transfer Guidelines

- All patients whose conditions exceed the regionally available resources provided by local area hospitals may be transferred from one region to another following LERN Interregional Hospital Transfer Protocol.
- The LERN Hospital Interregional Transfer Protocol only applies to hospitals that are participating in the LERN network.
- Regions or individual parishes that have MOU's (which include medical control & destination guidelines), between an ACS verified Level 1 trauma center and a local parish medical society (ies) will be incorporated into the LCC standard operating procedure for the effected region(s).

LERN Hospital Interregional Transfer Protocol

1. Patients transferred via the LERN Hospital Interregional Transfer Protocol must:
    a. Meet Standard LERN Entry Trauma Criteria that requires resources &/or capabilities not available in that region.
    b. Be assessed and stabilized to the best of their ability at a local area hospital prior to transport to the closest appropriate hospital.
    c. The treating physician /nurse must contact LERN to request a transfer. The LERN Communications Center (LCC) will determine the closest and most appropriate facility available following the Standard LERN Trauma Criteria Destination Protocol.

LERN Network Data Set*

Following are the LERN Network data variables that will be collected on each patient encounter by the LERN Call Center. This will be done by the LERN Call Center performing follow up phone calls with EMS agencies and/or hospitals.

Hospital Name
Hospital Staff name
Hospital Call back number
Patient Hospital Emergency Department arrival time
Patient condition on arrival at Hospital Emergency Department
Patient's Mechanism of injury
Patient Hospital Emergency Department departure time
Patient's unique Hospital visit ID number
LERN Entry Criteria met by patient's presentation
Patient treatment in Hospital Emergency Department in reference to:

- Airway Control
- Breathing support
- Circulatory support and control
- Splinting
- Medications

_____

*American College of Surgeons Committee on Trauma (2006) Table 2. National Trauma Data Bank Data Elements: Pre-Hospital Information *Resources for Optimal Care of the Injured Patient 2006* (pp. 94-95)