MINIMUM REQUIREMENTS FOR CERTIFICATION AS AN OTA TRAUMA CENTER (level I)

1. HOSPITAL commitment
    a. The hospital has the commitment of the institution's governing body and the medical staff to maintain an orthopaedic trauma unit, as demonstrated by resolution or letter.
    b. There is sufficient infrastructure and support to the trauma service to ensure adequate provision of care,
    c. There should be an agreement document which provides stability of support over a period of time (recommended minimum of 3 years). In many settings, this may be a contract for services; in others it may take the form of a memorandum of understanding. It should be specific and enforceable.
    D. There should be recognition by the system that provision of on-call coverage for the hospital Emergency Department represents substantial work on the part of physicians and that work should be compensated by the hospital or institution in some manner which is acceptable to the physician workforce. In some situations, this will involve a call pay stipend; in others it may involve other forms of compensation.

2. ***STAFFING***
    a. There should be a specifically identified orthopaedic trauma director, who:
        i. Is adequately trained and experienced in orthopedic trauma. Fellowship training is preferred.
        ii. Actively participates in trauma call.
        iii. Functions as liaison to the trauma team
        iv. Has responsibility and authority for determining each orthopaedist's ability to participate on the trauma panel based on an annual review.
        v. Has the authority to correct deficiencies in orthopaedic trauma care or exclude from trauma call any team members who do not meet criteria.
        vi. Has protected time and support to discharge his/her administrative duties
    b. There should be at least one fellowship trained orthopaedic traumatologists on staff

    c. Mid-level providers should be provided by the hospital or system, with the number of such to be determined by the orthopaedic trauma director and hospital administration. A suggested level of support would be at least one P.A./A.R.N.P dedicated per orthopaedic trauma surgeon FTE.

    d. There should be a full time cast/traction technician dedicated to orthopaedic trauma service. These services should be available 24 hours a day, 7 days a week on a call schedule.

e. There should be a dedicated hospital floor/nursing team in order that support staff can be consistent.

f. There should be a hospital-supported transfer center to facilitate physician to physician communication and arrangement of transfers

g. There must be in-house call room facilities for attending orthopaedic traumatologist

h. The system should provide sufficient resources to maintain an orthopaedic trauma database (at least 0.5 FTE for data entry or research support).

i. There must be a guaranteed annual equipment budget line item, including OR, ED and ward components specifically for orthopaedic trauma.

3. ***SUPPORT SERVICES - TRAUMA***

a. Physician specialists:
   i. General surgeon(s) dedicated to trauma care must work in hospital.
   ii. Fellowship trained microvascular surgeon must be willing to perform flap surgery.
   iii. Fellowship trained vascular surgeon must be available for trauma cases.
   iv. Neurosurgeon must be available for trauma cases.
   v. Spine surgeon (orthopaedic or neurosurgeon) is available for spine injuries.
   vi. Medical specialists available to consult on infectious disease, cardiac, pulmonary, dermatologic, psychiatric, and rehabilitation issues

b. MRI, CT, and angiography suites must be in house. Radiologist consultation should be available at least locally, if not in house, 24/7/365.

c. Dedicated or identified social worker or case manager for discharge planning services

4. ***OPERATING ROOM REQUIREMENTS***

a. The hospital must provide sufficient resources, including instruments, equipment, and personnel, for modern musculoskeletal trauma care, with readily available operating rooms for musculoskeletal trauma procedures.

b. Operating rooms must be promptly available to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization and compartment decompression (24/7 - mandatory)

c. Adequate protected OR time must be available for managing orthopaedic injuries and trauma patients on an urgent, semi-urgent and elective basis, in addition to the "emergent" procedures mentioned above.

d. There should be a defined mechanism and protocol for providing additional staff for a second operating room when the first operating room is occupied.

e. There should be a "No bumping" policy of orthopaedic trauma cases for other cases except for other orthopaedic trauma cases (schedule re-arrangement) or life threatening emergencies.

f. There should be dedicated ortho trauma OR staff teams 2 out of 3 shifts (trained staff that understand equipment and procedures on days and evenings)

g. There must be availability of modern x-ray fluoroscopic equipment with dedicated OR radiology technician(s).

h. There must be a radiolucent O.R. table(s) acceptable to the orthopaedic trauma director.

i. There must be a Fracture table acceptable to the Orthopaedic Trauma Director

j. There should be adequate equipment and implant storage near the orthopaedic trauma room.

5. ***OPERATING ROOM EQUIPMENT (IN HOUSE)***

a. Long bone intramedullary nailing system
b. Ex fix system (mini, small, large, pelvic)
c. Plating system (mini, small, large, locked, and standard)
d. Hip fracture fixation system (plates, and nails)
e. Hemiarthroplasty systems for hip and shoulder
f. Pelvic and acetabular system
g. Femoral distractors
h. Cannulated screw sets (large, small)
i. Power drills, saws, burrs, reamers
j. Bone reduction clamps system
k. Midas Rex type high speed drill/cutting tool system
l. Screw removal sets
m. Arthroscopy system

MINIMUM REQUIREMENTS FOR CERTIFICATION AS AN OTA TRAUMA CENTER (level I)

n. General orthopaedic tools (osteotomes, curettes, clamps, retractors, lamina spreaders, etc) which are dedicated to the orthopaedic trauma service and not shared with other orthopaedic services.

Each of these systems should be selected by the orthopaedic trauma director for the most appropriate components and features necessary in his/her center with the goal of optimizing high quality, cost-effective patient care.

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