

STATE HEALTH PLANNING BOARD
January 17, 2019

CERTIFICATE OF NEED
LEVEL II TRAUMA CENTER DESIGNATION IN UNION COUNTY AND
CONTIGUOUS COUNTIES

Department of Health Staff Project Summary, Analysis and Recommendation

CN CALL

On August 17, 2017, the Department of Health (Department) issued a certificate of need (CN) call for applications for designation as a Level II trauma center in Union County and contiguous counties (49 NJR 8(1) see Attachment 1.) The text of the CN call cautioned that “{i}s “Issuance of this call does not constitute a finding of need by the Department for the designation of an additional Level II trauma center in the affected area. Acceptance of applications pursuant to this notice does not constitute a finding of need by the Department for the services proposed in the application(s). The Department reserves the right to disapprove all applications submitted in response to the call if the Department determines that applicants have not satisfactorily demonstrated need or compliance with the requirements of N.J.S.A. 26:2H-8, N.J.A.C. 8:33 and 8:43G.” The CN call also contains provisions for existing trauma centers as well as non-applicants to address the impact that an applicant’s requested designation would have on the trauma services provided by the existing trauma center.

The criteria to determine need is detailed in the CN call. Applicants need to demonstrate the following for major trauma cases in 2015 and 2016:

1. Major traumas involving a Union County resident treated at a hospital in Union County or a contiguous county;
2. Major trauma cases occurring within Union County and treated at a hospital in Union County or a contiguous county;
3. Major trauma cases treated at a hospital in Union County or a contiguous county; and
4. Factors, including demographic and geographic, impacting trauma center access for major trauma cases that occur within Union county or a contiguous county.

Major trauma is defined in the CN call and N.J.A.C. 8:43G as an injury to a trauma patient who sustains a sudden injury, due to violence or other forces, that requires medical/surgical intervention to prevent death or disability. Included patients are those with both injuries in the ICD-9 CM diagnostic or injury code range of 800.00 through 959.9 and an associated E (external cause of injury) code, with the exception of drowning or suffocation or the ICD-10 equivalents. These patients must meet one or more of the following criteria:

1. Transfer to a designated trauma or burn center from another acute care hospital;
2. Admission to intensive or critical care or another monitored setting;
3. Hospitalization for three or more days;
4. Injury score of three or more on the Abbreviated Injury Scale (AIS*);
5. Survival probability of 90 percent or less according to the Trauma Score/Injury Severity Score (TRISS) method; or
6. Death (including deaths in the emergency department).

*AIS Score is a tool used by professionals for grading the severity of injury to trauma patients and is classified as (1) Minor, (2) Moderate, (3) Severe, Non-life threatening, (4) Severe, Life threatening, (5) Critical, Survival Uncertain, (6) Death. ¹

CN APPLICATION REVIEW

On October 31, 2017, Trinitas Regional Medical Center's (Trinitas) submitted an application in response to this CN call (CN# FR17 1101-20-01); no other applicants responded. The Department reviewed Trinitas' application and issued completeness questions which Trinitas responded to on May 30, 2018. In addition to completeness review, the Department's Office of Emergency Medical Services (OEMS) conducted a medical record audit of a sample of cases that Trinitas had submitted and identified as major trauma in its application.

Staff reviewed Trinitas' application and completeness responses as it pertains to the CN criteria for need determination as detailed below:

1. Demonstration of Need for Level II Trauma Center Designation

- a. **CN Call Criteria #1, 2 and 3 - Trauma Cases in Union County:** Major traumas involving a Union County resident treated at a hospital in Union County or a contiguous county; major trauma cases occurring within Union County and treated at a hospital in Union County or a contiguous county; and major trauma cases treated at a hospital in Union County or a contiguous county.

1. The Department requested information from Trinitas during completeness review to satisfy the CN call criteria 1, 2 and 3 that was not included in its CN application. Trinitas stated in its responses that it is unable to produce documentation to determine need stating no data is currently collected (page 2/39 completeness responses.)
2. The Department requested Trinitas provide during completeness review various data to support its application. Trinitas was unable to provide this information stating that the data/information the Department requested is

¹ Greenspan, et al., Abbreviated Injury Scale and Injury Severity Score: A Scoring Chart. *J Trauma*, 25, 1985.

unavailable since it is information that the 2008 American College of Surgeons (ACS) report and the State Trauma System Advisory Committee (STSAC) noted were deficiencies in the New Jersey trauma system. As documentation of its attempt to obtain the requested completeness information, Trinitas provided its Open Public Records Act (OPRA) requests and responses sent to all Department Divisions requesting data to respond to completeness questions.

3. Trinitas stated that much of the information requested by the Department during completeness related to other hospitals was not obtainable. Trinitas stated that data on regional trauma care volume, Emergency Medical Services (EMS) triage and performance data could not be found (page 2/39 completeness responses.)
4. Trinitas was asked during completeness review to provide outcome data to support the need for trauma services in Elizabeth. Trinitas states no such data exists (page 36/39 completeness responses.)

Due to Trinitas' inability to produce data/documentation to support determination of need for a Level II trauma center in Union County, staff finds that Trinitas failed to demonstrate need with regard to the CN call criteria #1, 2 and 3. (See Section 5a for staff discussion on data issue.)

b. CN Call Criteria #4 - Geographic and Demographic Factors

1. To satisfy criteria #4, geographic and demographic factors, Trinitas states its location in a congested travel area and the size of Elizabeth (100,000 or more residents) without a trauma center within city limits supports the geographic criteria (page 46 of CN application.)

The Department staff finds that Trinitas' assertion that a Level II trauma center is needed in Elizabeth does not take into consideration that the CN call is for a regional service involving all of Union County. As discussed in 1a above, Trinitas was unable to provide Union County trauma data in support of its application. Staff also notes there are two other non-trauma hospitals within Union County (Overlook Medical Center and RWJUH at Rahway.)

Additionally, Union County is surrounded by four other counties encompassing 18 hospitals, including University Hospital (University) which is a Level I trauma center located 8 miles away, Robert Wood Johnson University Hospital, a Level I trauma center located 21 miles away and Morristown Memorial Hospital, a Level II trauma center located 23 miles away.

2. To support the demographic factors of CN criteria #4, Trinitas highlights the minority and low-income population it serves (Page 9 & 10 of CN Narrative), its safety-net status and the crime rate of Elizabeth. Trinitas further claims Catholics as a medically underserved population (page 8/39 completeness responses.)
3. Trinitas was asked during completeness about access problems to trauma care, especially for the medically underserved when suffering a major trauma and how Trinitas' proposed designation would improve outcomes. Trinitas provided information to demonstrate its record of serving the medically underserved as documented by its hospital-wide charity care and Medicaid percentages. Trinitas also identified the number of trauma cases currently performed at Trinitas as proof of trauma care access problems by the medically underserved population (page 33-34/39 completeness responses.)

Department staff finds that Trinitas was unable to provide specific information regarding trauma access and outcomes. The questionable amount of cases found in the medical record audit (see Section 3 below) raises questions regarding Trinitas' proof of access problems for medically indigent in Section 1.b.3 above. Staff further finds that Trinitas failed to consider the geographic proximity (8 miles) of University Hospital, a Level I trauma center.

4. Since trauma care is a regional service and the CN call was for Union County, the Department requested documentation as to how Trinitas anticipates providing trauma services to the entirety of Union County.

In response to this request, Trinitas provided 2017 admissions by patient residency. Of the 16,234 hospital admissions, 9,709 or 58% were Elizabeth residents. Of the 56,136 ER visits in 2017, 39,588 or 70% were Elizabeth residents (page 16 & 17/39 completeness responses.) Staff notes that Trinitas erroneously stated all ER visits are trauma care, which artificially inflates Trinitas' claim.

Staff finds that Trinitas did provide information on cases it has classified as major trauma, which is not the full complement of trauma cases in Union County as defined in the CN call; Trinitas only provided cases it classified as major trauma that were treated in its own emergency room (ER.) The Department's medical record audit calls into question the classification of many of the cases Trinitas submitted as major trauma (see Section 3 below.)

Staff finds that overall Trinitas provides access to the medically underserved; however, Trinitas failed to demonstrate that it significantly serves all Union County since the majority of admissions and ER visits were Elizabeth residents. Trinitas was also unable to provide specific information regarding trauma access and outcomes. Staff also

questions the classification of many cases that Trinitas submitted as major trauma cases (see Section 3 below.) Staff further finds that Trinitas failed to consider the geographic proximity (8 miles) of University Hospital, a Level I trauma center.

Staff therefore finds that Trinitas failed to satisfactorily demonstrate a need with regard to CN Call criteria #4.

2. Demonstration that Existing Providers would not be negatively impacted in accordance with N.J.S.A. 26:2H-8

- a. Trinitas claims its proposed Level II trauma designation would not have an impact on existing trauma providers, namely University which is a Level I trauma center. Trinitas states it already exists as a “de facto” trauma center and would continue to make transfers to University as medically appropriate.

Trinitas provided data which claims that in 2016, 89 trauma cases bypassed Trinitas from the city of Elizabeth because the hospital does not have trauma designation. Trinitas states this would be a minimal impact on University (Page 21/39 completeness responses.)

Staff finds that Trinitas fails to include in its discussion the fact EMS trauma triage guidelines require the transport of trauma cases to the nearest trauma center. In the event Trinitas were to become a designated trauma center, EMS would then be required to transport to Trinitas those cases from Trinitas’ service area that were historically transported to University (See discussion in Section 4 below.) This shift in transport protocol would reach beyond the 89 cases that Trinitas states bypassed its hospital in 2016, since the service areas of the two hospitals overlap and the distance between them is only 8 miles. Trinitas would see an increase in trauma cases beyond those that currently arrive via walk-in or private transport that historically were transported to University. Staff notes that Trinitas states that its proposed trauma designation “will do little to nothing to affect the distribution of trauma patients between University and Trinitas” (Page 20/39 completeness responses.)

- b. Trinitas states that “...University’s trauma program would still face no significant financial risk because it is subsidized by the State under a statutory funding mandate. The New Jersey Medical and Health Sciences Education Restructuring Act expressly requires that the amount of State funding provided to University Hospital shall be sufficient to maintain the level of community services ...and to maintain University Hospital as an acute care facility and trauma center” (page 22/39 completeness responses.)

Staff finds that Trinitas suggests that New Jersey taxpayers shall subsidize any financial loss that University may experience if Trinitas is approved for trauma services.

Staff further finds that Trinitas' statements regarding University's financial impact suggest that the New Jersey trauma system cannot support a new trauma center designation and that the need for the new trauma designation may not exist.

- c. In response to Trinitas' application, the Department received letters of opposition from interested parties including existing providers, state legislators, county and city officials. Trinitas also received letters of support, the majority of which are found in Trinitas' application and completeness response submission. Below are key points made by commenters. (See Attachments 2A & B for a full list of commenters.)
1. University's Chairman of the Board and the President/CEO submitted their April 12, 2018 response to Trinitas' application. Commenters state that the pool of trauma patients is a fixed percentage of the population. On average, University treats 1,250 trauma patients annually and 87% of University's caseload originates within a ten-mile radius surrounding Trinitas. The addition of a new trauma center 8 miles away from University would destabilize the current trauma system which involves more than merely designation. The trauma system at University encompasses specialty staffing, technology, emergency transport services including air medical dispatch services, all of which are contingent upon maintaining necessary patient volume to support the trauma system. University is also responsible for statewide notification, dispatch and coordination of resources, emergency planning and response at Newark Liberty International Airport and the Port of New York and New Jersey (Attachment 2B, item 1.)
 2. The Chief of Trauma and Surgical Critical Care at Rutgers New Jersey Medical School/Director of University's Trauma Center states that Trinitas' claim of being a de facto trauma center based on volume is misleading. He states volume is one part of an overall verification and designation process by the ACS; Trinitas would need to meet and pass all ACS verification standards. Trinitas has never undergone such a review; therefore, Trinitas cannot claim itself as a de facto trauma center (Attachment 2B, item 16.)

The commenter further states that Trinitas listed 49 cases transferred from its ER to University; however, Trinitas did not include cases within its service area that came directly to University. Designation would be detrimental to University and Robert Wood Johnson University Hospital, neither of which are close to capacity.

Staff note: The commenter's "49" cases is inconsistent with number of cases reported by Trinitas on page 21/30 completeness; of the 135 cases admitted at University from Elizabeth in 2016, 46 were transferred by Trinitas to University. The remaining 89 cases may not go to University if Trinitas receives trauma designation.

3. The Chancellor of Rutgers Biomedical and Health Sciences states in his May 31, 2018 letter that based on University's projections of reduced trauma caseload as discussed in comment #1 above, Trinitas' designation would negatively impact the quality of training for medical students and surgery residents at Rutgers New Jersey Medical School (Attachment 2B, item 24.)
4. The Medical Director of Morristown Medical Center's Level II Trauma Center, who is the Chair of the NJ Chapter of the American College of Surgeons Committee on Trauma and a member of the State Trauma System Advisory Committee states his opposition to any additional trauma center designations until the recommendations of the American College of Surgeons Committee of Trauma and State Trauma System Advisory Committee reports are implemented. Commenter states that to date there have been no findings to confirm a need to expand trauma services in New Jersey and more specifically Union County (Attachment 2B, item 19.)
5. The Department did not receive any letters of support or opposition from Robert Wood Johnson University Hospital (RWJUH), which is also a Level I trauma center approximately 21 miles and 40 minutes travel time from Trinitas.

In response to completeness question #6 regarding pediatric trauma services, Trinitas submitted a newly executed transfer agreement with RWJUH. Trinitas discussed the potential changes at University at the time of completeness response submission in that University submitted a CN to reduce pediatric services as the reason for the RWJUH agreement (page 16/39 completeness responses.) Staff notes that University has since withdrawn its CN application to close its pediatric intensive care unit. Trinitas currently has transfer agreements with University and RWJUH for pediatric trauma cases.

6. Senators Codey and Lesniak and Assemblywoman Quijano and Assemblyman Holley and others support Trinitas' application stating the designation as a Level II Trauma Center "will add immediate life-saving trauma resources to a community in need while elevating preparedness and overall response."

7. Senators Sweeney, Cryan, Vitale and Coughlin, the Mayor of Elizabeth and others support Trinitas' application stating "a trauma designation will formally acknowledge the already existing care that Trinitas is providing to date, confirming the level and quality of life-saving care. In addition, a designation will expand joint disaster planning at the state level and better integrate communication and enhance retention of skilled personnel and its exemplary area-wide EMS services."
8. Assemblyman Greenwald supports Trinitas' application stating "Trinitas Regional Medical Center is also an important part of any emergency plan for mass casualty events. Situated off Exit 13A of the Turnpike, which has been identified as "the two most dangerous miles in America" and adjacent to the largest high school in the country, Trinitas Regional Medical Center is perfectly situated to support prompt triage and surgery needs for surrounding Level I hospitals."

Staff finds that Trinitas did not satisfactorily demonstrate that existing providers would not be negatively impacted by its designation as a Level II trauma center. The rationale for this finding is the potential impact that the EMS trauma triage guidelines would have on the transport of trauma patients in the region and the commenters stated negative impact that Trinitas' proposed trauma designation would have on University's Level I trauma center and the State trauma system overall.

3. Major Trauma Cases

a. Trauma Cases submitted by Trinitas

Trinitas provided patient data (2015, 2016 and 2017) compiled by its consultant deemed to meet the criteria of major trauma as defined in the CN call and N.J.A.C. 8:43G-12. In 2017, Trinitas claims it treated 373 major trauma cases. Of those 373 major trauma cases, 166 (45%) were mechanical falls, with 68 of the mechanical falls (18%) being categorized as moderate or minor cases (AIS Score 1 and 2) and 82 (49%) categorized as severe, non-life threatening (AIS Score 3) (see Attachment 3, Table 1.) The 2015 and 2016 data report similar results.

b. 2017 Medical Record Audit

Staff found insufficient information in Trinitas' application and completeness responses to verify whether the cases as prepared by its consultant met the major trauma criteria. The Department's OEMS conducted a medical record audit to determine whether a sample of cases met the major trauma criteria. OEMS reviewed the medical records of a 184 case sample of the 373 reported CY 2017 cases of which 146 were mechanical falls, 30 motor vehicle crashes and 8 gun-shot wounds. The audit results (See Attachment 6, Table 3)

pertaining to the major trauma criteria as found in the CN call and N.J.A.C. 8:43G-12.13 are as follows:

There were 18 audited cases in need of Level 1 trauma services, burn center or pediatric services which were transferred.

There were 16 cases found not to meet the major trauma criteria: 8 did not have at least one of the 6 trauma criteria, 1 mechanical fall had no documentation of a fall (Case #1), 7 were mechanical falls that were old that did not meet the definition of a major trauma “sudden injury” (Cases 2-8.)

In addition, there are many cases staff found to be questionable, including those mechanical falls with fractures that were discharged with no admission or transfer which had an AIS score of 3 (severe, non-life threatening) as determined by Trinitas’ consultant. OEMS staff were unable to verify the AIS score 3 as assigned by Trinitas’ consultant.

101 cases were transported to Trinitas by EMS which may not be considered major trauma during EMS field triage since these cases would have been transported directly to a trauma center per trauma triage guidelines. (See Section 4. New Jersey Trauma System below for discussion on EMS trauma triage protocol.)

There were 12 motor vehicle crashes and gunshot wound deaths that were transported by EMS to Trinitas and not a trauma center because as OEMS staff found, the deaths already occurred in the field or were imminent with no chance of patient survival.

Staff found that many cases were elderly mechanical fall patients with fractures that may have been admitted for 3 days to Medicare qualify for long term care or rehabilitation admission.

Staff found many instances that while a case may have had one or more of the trauma criteria as defined in the CN call and N.J.A.C. 8:43G, the case could be properly treated by any hospital ER and not need treatment at a trauma center.

c. Discharge data (UB) analysis 2014, 2015 and 2016

In addition to the 2017 medical record audit, staff analyzed Trinitas’ patient discharge data for calendar years 2014, 2015 and 2016 and were able to approximate the number and classification of cases that Trinitas claims as major trauma by including those emergency room patients with ICD trauma codes(s) through the 13th position and an external cause of injury (E-Code) that were admitted for 3+ days. Deaths in the ER and transfers out of the ER were also included (Attachment 5, Table 2.)

The staff's discharge data analysis in Attachment 5 calls into question Trinitas' classification of major trauma cases. In many cases, a trauma code was not in the first few diagnosis positions on the patients' discharge (UB) record, meaning the trauma was not a primary reason for admission. Also, in each year 3-8% of cases found as trauma were readmissions into Trinitas for a 2nd time within 7 days, which calls into question whether these cases met trauma criteria.

In terms of patient age distribution, approximately 60% of all trauma cases were age 66 and over, 20% were age 85 and over in each of the 3 years. In each year 2-4.5% of cases were transferred directly from a skilled nursing center. Also, many of the trauma cases were discharged to a skilled nursing facility.

The above analysis reinforces staff's 2017 medical record audit findings that many trauma cases may be elderly mechanical fall patients with fractures that were admitted for 3 or more days in order to Medicare qualify for long term care admission.

While staff's analysis of discharge data is limited in that it could not verify Trinitas' submitted major trauma cases, it does raise additional questions regarding Trinitas' classification of cases, and Trinitas' ability to meet the minimum 350-volume requirement.

Department staff questions Trinitas' ability to meet the minimum volume requirement of 350 cases based on the results of the 2017 medical record audit, the 2014-2016 discharge data analysis and the number of cases that could be excluded as major trauma. Staff notes that the 350 major trauma cases specified in N.J.A.C. 8:43G-12.14(b) represents a minimum number with which existing trauma centers must comply for licensing purposes and is set as a floor to assure quality standards; it is not intended to be a specific indicator of need for additional trauma centers.

4. New Jersey Trauma System

New Jersey EMS are required by Department regulation (N.J.A.C. 8:41, Appendix E and F) to follow the "Trauma Triage Guidelines" protocol which requires the transport of trauma patients to an appropriate level trauma center. Due to the triage protocol, EMS currently bypasses Trinitas when transporting trauma patients and those patients that Trinitas claims are trauma cases may arrive by means other than EMS transport (walk-in, private transport.) Also, the 2017 medical record audit found 101 of 184 cases arrived by EMS, including 12 motor vehicle crashes and gunshot wounds with no chance of survival, which calls into question Trinitas' classification of these cases as major trauma. Due to the EMS bypass, Trinitas does not distinguish itself from any other non-trauma hospital in the cases it currently treats and claims as major trauma.

5. Other Issues Raised by Trinitas

- a. P.L. 2013 Ch. 223 directs the Commissioner of Health to: (1) appoint a State Trauma Medical Director to oversee the planning, development, ongoing maintenance and enhancement of the formal state trauma system; (2) establish a State Trauma Advisory Committee (STSAC) on the development of a formal statewide trauma plan that defines the roles of all health care facilities in the state and (3) promulgate regulations establishing and implementing a state trauma system plan.

As Trinitas states, data requested by the Department to determine need was unproduceable by Trinitas. Therefore, absent such data, staff finds that while the planning of a formal statewide trauma system is underway, the designation of a Level II trauma center at Trinitas is premature. This data effort is one of the legislative mandates of the STSAC.

- b. Trinitas claims that trauma center designation is needed for disaster preparedness and mass casualty incidences (page 1 & 4 of Project Narrative.)

Department staff points out that New Jersey's responses to such incidents are coordinated by the State of New Jersey Office of Emergency Management within the Office of Attorney General. The Department of Health, as well as all health care entities in the State, participate in this crucial endeavor. Staff therefore finds Trinitas' linking emergency response to trauma designation unfounded since Trinitas is not required to be trauma designated to participate in statewide disaster preparedness.

- c. Trinitas states that an agenda item of the State Trauma System Advisory Committee (STSAC) to discuss need methodology implicitly acknowledges such a need exists (page 15/39 completeness responses.)

Staff finds discussion of need methodology for possible long-range planning purposes at an advisory committee meeting does not equate to an actual finding of need.

- d. Trinitas states that trauma designation will permit data collection, which Trinitas states is a goal of the American College of Surgeons (ACS) report (page 3/39 completeness responses.)

Staff notes that the ACS report titled "Trauma System Consultation, State of New Jersey, New Brunswick, New Jersey, August 4-7, 2008" is found in Trinitas' completeness responses, under Tab 2. Staff finds that on page 88 of its report, the ACS recommends that non-trauma centers also report trauma data and be involved in the trauma system. Since trauma designation is not necessary for Trinitas' participation in data collection, staff does not agree with this argument.

- e. Trinitas uses the term “inclusive” trauma system found in the ACS report to support their trauma designation (page 5/39 completeness responses.) The legislation (P.L. 2013 Ch 223) that was enacted based upon the ACS report removes the term “inclusive” and replaces with “formal” state trauma system (Legislation is found at Attachment 4.)

Staff finds Trinitas’ argument that its trauma designation would create an inclusive trauma system is unfounded since this language was not included in the enabling legislation.

STAFF RECOMMENDATION

Department staff has reviewed all information related to Trinitas’ CN application for Level II Trauma Designation and is recommending denial of Trinitas’ application based on:

- (1) Trinitas’ inability to satisfactorily demonstrate a need for Level II trauma center designation at Trinitas based upon the criteria found in the CN call including the ability to demonstrate need in Union County and geographic and demographic factors;
- (2) Trinitas’ inability to satisfactorily demonstrate compliance with N.J.S.A. 26:2H-8 in that existing providers would not be negatively impacted by its designation as a Level II trauma center;
- (3) Trinitas’ inability to satisfactorily demonstrate that Trinitas would meet and maintain the minimum volume standard of 350 major trauma cases per year in accordance with N.J.A.C. 8:43G-12.14(b) as a result of the medical record audit findings and discharge data analysis which call into question the classification of a number of trauma cases; and
- (4) The 350-volume standard for Level II trauma centers is the minimum volume requirement to have an efficient/effective trauma center; it is not a number that indicates a need for more trauma centers.

ATTACHMENT 1

49 NJR 8(1)
August 7, 2017
Filed August 18, 2017

PUBLIC NOTICE

HEALTH

THE COMMISSIONER

Notice of Invitation for Certificate of Need Applications for Designation as a Level II Trauma Center in Union County, pursuant to N.J.A.C. 8:33-4.1 (a)2

Take notice that, in compliance with N.J.S.A. 26:2H-1 et seq., and the provisions of N.J.A.C. 8:33-4.1 (a), Cathleen D. Bennett, Commissioner, New Jersey Department of Health (Department), is inviting certificate of need applications on a full review basis for designation as a Level II trauma center in Union County in accordance with the provisions of N.J.A.C. 8:43G-12.12 and N.J.S.A. 26:2H1 et seq. The Department is initiating this call because an acute care hospital has presented documentation indicating

that there may be a potential need for a Level II trauma center in Union County. Certificate of need applications in response to this notice will be accepted for processing in accordance with N.J.A.C. 8:33-4.5.

Issuance of this call does not constitute a finding of need by the Department for the designation of an additional Level II trauma center in the affected area. Acceptance of applications pursuant to this notice does not constitute a finding of need by the Department for the services proposed in the application(s). The Department reserves the right to disapprove all applications submitted in response to the call if the Department determines that applicants have not satisfactorily demonstrated need or compliance with the requirements of N.J.S.A. 26:2H-8, N.J.A.C. 8:33 and 8:43G.

On January 1, 2015, the American College of Surgeons (ASC) Committee on Trauma Systems Evaluation and Planning Committee, issued a Statement finding that "[r]egional trauma system implementation has been shown to improve mortality and reduce complications. The number, level, and location of trauma centers are critical elements of trauma system function and disaster response. The importance of controlling the allocation of trauma centers, as well as the need for a process to designate trauma centers based upon regional population need, has been recognized as an essential component of trauma system design since the 1980s." The ASC Committee on Trauma recommends that trauma system needs be assessed based on access, quality of patient care, population mortality rates, and trauma system efficiency, rather than the needs of individual health care organizations or hospital groups.

In addition to the information required in Application Form CN-3, N.J.S.A. 26:2H8 and N.J.A.C. 8:33-4.9(a), each applicant shall demonstrate the following for major trauma cases in 2015 and 2016:

1. Major traumas involving a Union County resident treated at a hospital in Union County or a contiguous county;
2. Major trauma cases occurring within Union County and treated at a hospital in Union County or a contiguous county;
3. Major trauma cases treated at a hospital in Union County or a contiguous county; and
4. Factors, including demographic and geographic, impacting trauma center access for major trauma cases that occur within Union County or a contiguous county.

For purposes of this notice, "major trauma" means an injury to a trauma patient who sustains a sudden injury, due to violence or other forces, that requires medical/surgical intervention to prevent death or disability. Patients included are those with both injuries in the ICD-9 CM diagnostic or injury code range of 800.00 through 959.9 and an associated E (external cause of injury) code, with the exception of drowning or suffocation, or the ICD-IO equivalents. Patients must also meet, as a result of such injury rather than another disease or condition, one or more of the following criteria:

1. Transfer to a designated trauma or burn center from another acute care hospital;
2. Admission to intensive or critical care or another monitored setting;
3. Hospitalization for three or more days;
4. Injury score of three or more on the Abbreviated Injury Scale;
5. Survival probability of 90 percent or less according to the Trauma Score/Injury Severity Score (TRISS) method; or
6. Death (including deaths in the emergency department).

N.J.A.C. 8:43G-12.13.

The Department invites existing designated Level I and Level II trauma centers, as well as any other non-applicants, to file a written submission with the Department in response to any certificate of need applications submitted pursuant to this notice.

Copies of submitted applications may be obtained upon request using the following link:

https://www16.state.nj.us/NJ_OPRA/opraRequest.jsp?deptname=Health&divisionChoice=46:Health:HCS:Certificate%20of%20Need%20and%20Licensina:dhcsacustodian@doh.nj.gov.

In accordance with N.J.S.A. 26:2H-8 and N.J.A.C. 8:33-4.9(a), a written statement submitted by an existing designated Level I or Level II trauma center may address the impact that an applicant's requested designation as a Level II trauma center would have on the trauma services provided by the existing trauma center.

Geographic areas to be served: Union County and contiguous counties.

Date application is due: November 6, 2017

Date completeness review decision is anticipated to be issued: February 6, 2018

Date State Health Planning Board is anticipated to review the applications and submit recommendations to the Commissioner: May 3, 2018

Prospective applicants may obtain a certificate of need application (Form CN-3) for full review on the Department's website at www.nj.gov/health/forms and shall submit the completed application using electronic media and 35 paper copies of the application to:

Certificate of Need and Healthcare Facility Licensure Program
New Jersey Department of Health
PO Box 358
Trenton, NJ 08625-0358
(609) 292-6552 or 292-7228

ATTACHMENT 2A
LETTERS OF SUPPORT IN CN APPLICATION AND COMPLETENESS RESPONSES

	Date	Organization/Title, Name	OPPOSE	SUPPORT
1	4-23-2018	Stephen M. Sweeney, Senate President, NJ Senate		X
2	10-27-2017	Richard Codey, State Senator, NJ Senate		X
3	4-18-2018	Joseph Cryan, Senator, District 20		X
4	4-18-2018	Joseph Vitale, Senator, District 19		X
5	10-3-2017	Raymond J. Lesniak, Senator		X
6	4-18-2018	Craig Coughlin, Assembly Speaker District 19		X
7	4-18-2018	Annette Quijano, Assemblywoman, District 20		X
8	4-18-2018	Jamel Holley, Assemblywoman, District 20		X
9	3-19-2018	Sergio Granados, Chairman, Union County Board of Chosen Freeholders		X
10	3-19-2018	Bette J. Kowalskii, Vice Chairman, Union County Board of Chosen Freeholders		X
11	3-19-2018	Bruce H. Bergen, Freeholder, Union County Board of Chosen Freeholders		X
12	3-19-2018	Linda Carter, Freeholder, Union County Board of Chosen Freeholders		X
13	3-19-2018	Angel G. Estrada, Freeholder, Union County Board of Chosen Freeholders		X
14	3-19-2018	Angela R. Garretson, Freeholder, Union County Board of Chosen Freeholders		X
15	3-19-2018	Christopher Hudak, Freeholder, Union County Board of Chosen Freeholders		X
16	3-19-2018	Mohamed S. Jalloh, Freeholder, Union County Board of Chosen Freeholders		X
17	3-19-2018	Alexander Mirabella, Freeholder, Union County Board of Chosen Freeholders		X
18	10-17-2018	Cardinal Joseph Tobin, Archdiocese of Newark		X
19	9-26-2017	J. Christian Bollwage, Major City of Elizabeth		X
20	9-20-2017	Andrew Moran, County of Union Dept of Public Safety		X
21	9-20-2017	Denise Palazzo, General Manager, The Mills at Jersey Gardens		X
22	9-27-2017	Joseph Cryan, Union County Sherriff's Offices		X
23	9-20-2017	Catherine Hart, Housing Authority of the City of Elizabeth		X
24	9-20-2017	James Coyle, President, Gateway Regional Chamber of Commerce		X
25	9-20-2017	Sidney Blanchard, Executive Director, Community Access Unlimited		X
26	9-20-2017	Teresa Soto Vega, Executive Director, PROCEED, Inc.		X
27	9-20-2017	George Haas, CEO/President, Greater Elizabeth Chamber of Commerce		X
28	10-12-2017	Janice C. Lilien, CEO, YWCA Union County		X
29	9-20-2017	Steven Karp, Executive Director, Jewish Educational Center		X
30	10-6-2017	Dura Arias, Founder & Executive Direcotr, Curemonos		X
31	10-25-2017	Elizabeth Fritzer, President, Springfield First Aid Squad, Inc.		X

32	9-20-2017	Charles Haliar, Cranford First Aid Squad		X
33	9-20-2017	Paul Mucha, Roselle Fire Dept.		X
34	9-20-2017	Karen Dinsmore, Acting Director, Dept. of Human Services, County of Union		X
35	9-20-2017	Woody Philippe, Executive Director, Jefferson Park Ministries Inc.		X
36	10-2-2017	David Fletcher, President, Elizabethtown Healthcare Foundation		X
37	10-29-2017	James Masterson, Executive Dir/CEO, Union Township Chamber of Commerce		X
38	9-20-2017	Thomas Beck, Executive Director, Jewish Family Service of Central New Jersey		X
39	10-30-2017	Roderick Spearman, Chairman, Union County Fatherhood Initiative Coalition		X

ATTACHMENT 2B
Supplemental Letters of Support/Opposition

	Date	Organization/Title, Name	OPPOSE	SUPPORT
1	4-12-2018	University Hospital Board Chairman Robert Johnson, M.D. and President & CEO John Kastanis	X	
2	3-26-2018	Newark Mayo Ras. J. Baraka	X	
3	4-10-2018	NJ Legislators: Ruiz, Gill, Jasey, Tucker, Caputo, Rice, Marin, Giblin, Speight, Timberlake	X	
4	4-18-2018	U.S. Congress House of Representatives District 10, Donald M. Payne, Jr.	X	
5	4-19-2018	Essex County Executive, Joseph N. DiVincenzo, Jr.	X	
6	4-6-2018	NJ Assembly 21 st District, Nancy F. Munoz	X	
7	4-20-2018	Essex County Board of Chosen Freeholders, Brendan W. Gill, President	X	
8	4-11-2018	City of Newark, Municipal Council, Mildred C. Crump, President	X	
9	4-11-2018	City of Newark, Health Committee, West Ward Council Member, Joseph A. McCallum Jr., Chairman	X	
10	4-12-2018	Newark/North Jersey Committee of Black Churchman, Inc., Bishop Jethro James, Jr., Pastor, Paradise Baptist Church	X	
11	4-12-2018	New Community Corp., Richard Rohman, CEO	X	
12	4-20-2018	Urban League of Essex County, Vivian Cox Fraser, President & CEO	X	
13	4-48-2018	NJ Association of Black Educators, James E. Harris, President	X	
14	5-1-2018	Responders 2-14 under cover letter from Robert MacFadyen, Director, Regulatory Affairs & Accred., University Hospital	X	
15	5-2-2018	UH United Union Coalition, CIR/BEIU. CWA, HPAE, Operating Engineers	X	
16	-	Rutgers-NJ Medical School, Chief Division of Trauma and Director Trauma Center, University Hospital, David H. Livingston, MD FACS	X	
17	-	NJ Trauma Center Council, Chairman, John M. Porter, MD. FACS	X	
18	3-19-2018	Union County Board of Chosen Freeholders, Chairman, Sergio Granadas		X
19	6-25-2018	Louis DiFazio, MD Medical Director, Level II Trauma Center, Morristown Medical Center	X	
20	5-29-2018	Municipal Council, Office of the City Clerk, Newark, NJ	X	
21	5-30-2018	Connie Dwyer Breast Cancer Foundation		X
22	6-5-2018	Louis Greenwald, Majority Leader, NJ General Assembly		X
23	3-19-2018	Sergio Granados, Chairman, on behalf of Union County Board of Chosen Freeholders		X
24	5-31-2018	Rutgers Biomedical & Health Sciences, Brian Strom, MD, MPH, Chancellor	X	

ATTACHMENT 3

**Table 1: Trinitas CY 2017 Trauma Cases by
Category and AIS Score**

A.I.S. SCORE	1	2	3	4	5	6	Total
Category	Minor	Moderate	Severe, Non-Life Threatening	Severe Life Threatening	Critical Survival Uncertain	Death	
Mechanical Falls	1	67	82	9	3	4	166
% of total cases		18%	22%				45%
Assaults	0	15	57	2	0	0	74
Gunshots	0	0	5	0	0	3	8
Stab Wounds		0	11	1	1	0	13
Motor Vehicle	0	3	14	5	0	8	30
Sports	0	15	24	0	0	0	39
Burns	0	17	2	0	0	0	19
Miscellaneous	0	1	17	3	0	3	24
Totals	1	118	212	20	4	18	373
% of total cases	0.3%	31.6%	56.8%	5.4%	1.1%	4.8%	

Source: Trinitas completeness responses dated May 30, 2018

ATTACHMENT 4

Title 26.

Chapter 26:2KK.

(New) State Trauma System.

C.26:2KK-1 to
26:2KK-5

P.L.2013, CHAPTER 223, approved January 17, 2014
Senate, No. 3027 (First Reprint)

1 AN ACT concerning trauma care and supplementing Title 26 of the 2 Revised Statutes.
3

4 BE IT ENACTED by the Senate and General Assembly of the State 5 of New Jersey:
6

7 1. The Legislature finds and declares that:

8 a. Injury is the leading cause of death for New Jersey citizens
9 aged one to 44, the fourth leading cause of death for all age groups,
10 and accounts for more than 60,000 emergency department visits in
11 the State each year, with direct medical costs estimated to be in
12 excess of \$2 billion;

13 b. At the request of the Department of Health, the American
14 College of Surgeons Trauma Systems Evaluation and Planning
15 Committee assessed the State's trauma system and made numerous
16 recommendations for its improvement. The committee found that,
17 while the provision of trauma care in New Jersey has many
18 dedicated trauma professionals, a sufficient number of¹ ten trauma
19 centers strategically located in the State, and 100 percent
20 emergency medical services coverage, the trauma care system faces
21 many challenges. Among the challenges noted by the committee
22 are the absence of one lead State agency to oversee and ensure the
23 coordination of a Statewide trauma system and the absence of
24 systematic data collection concerning the various aspects of trauma
25 care in the State;

26 c. Among the recommendations made by the committee to 27 address the challenges to the State trauma
system were:

28 establishment of a statutorily authorized lead agency to oversee the
29 development of ¹an inclusive a formal ¹State trauma system,
30 appointment of a designated leader to coordinate stakeholders
31 involved in all aspects of providing trauma care in the development,

32 maintenance, and ongoing evaluation of a formal ¹[inclusive] ¹
33 State trauma system, the creation of an advisory body to formulate

EXPLANATION — Matter enclosed in bold-faced brackets [thus] in the above bill is not enacted and is intended to be omitted in the law.

Matter underlined thus is new matter.

Matter enclosed in superscript numerals has been adopted as follows: Senate SIKH committee amendments adopted December 12, 2013.

1 policies that address all aspects of patient care, and the development
2 of prevention strategies to help control injury as part of ¹[an
3 inclusive] a formal State ¹trauma system;
4 d. While there currently exists a Trauma Center Council in
5 New Jersey which represents multidisciplinary trauma care within
6 the State-designated trauma centers, this Council is focused on the
7 activities and operations of New Jersey's State-designated trauma
8 centers, with limitations in developing an effective trauma system
9 for the State of New Jersey; and
10 C. In order to more effectively prevent injury, improve the care
11 and ¹[outcome] outcomes ¹of individuals who are injured in New
12 Jersey, and save lives, it is appropriate to ensure the development
13 and implementation of ¹[an inclusive] a formal State ¹trauma
14 system to serve injured patients in the State along the continuum of
15 their care, and establish means for ongoing data collection and input 16 from relevant stakeholders in
the State's trauma care system to 17 inform policies concerning trauma care in the State.

18
19 2. The Department of Health shall serve as lead agency for the
20 development of ¹[an inclusive] a formal ¹State trauma system that
21 defines the roles of all health care facilities in the State, taking into 22 account their resources and
capabilities, allowing for the provision 23 of care to injured patients in the State along the continuum of care.
24

25 3. a. The Commissioner of Health shall appoint a State
26 Trauma Medical Director, to oversee the planning, development,
27 ongoing maintenance, and enhancement of ¹la Statewide inclusive
28 the formal State ¹trauma system, consistent with the
29 recommendations of the American College of Surgeons Committee
30 on Trauma, and, to the extent applicable, consistent with the
31 processes outlined in the State Trauma System Planning Guide
32 issued by the National Association of State Emergency Medical
33 Services Officials. The State Trauma Medical Director shall be a
34 physician who is licensed pursuant to Title 45 of the Revised
35 Statutes, is experienced in the provision of surgical critical care and 36 trauma care, and is otherwise
qualified to perform the duties of the 37 position.

38 b. The State Trauma Medical Director shall, in collaboration
39 with the State Trauma System Advisory Committee (STSAC)
40 established pursuant to section 4 of this act, oversee the
41 development of a Statewide trauma system plan, and once the plan
42 has been adopted through regulations promulgated by the

43 department in compliance with the provisions of this act, shall be
44 responsible for implementing, maintaining, and providing ongoing
45 evaluation of the plan. The director shall additionally ensure that
46 the development and implementation of the plan involves broad-
47 based collaboration with stakeholders representing disciplines 1 relevant to trauma care in the State and
interested citizens, 2 including the commissioner, the director, or any other stakeholders 3 that the STSAC
determines may inform the process.

4

5 4. a. The commissioner shall establish a multidisciplinary
6 State Trauma System Advisory Committee (STSAC) to advise the
7 commissioner and the State Trauma Medical Director on the
8 development of a (formal)¹ Statewide trauma system plan. In order
9 to enable maximum input from stakeholders, the ST SAC shall
10 include, to the extent feasible, representatives of all aspects of
11 trauma care. The members of the committee, who shall be 12 appointed by the Governor, shall include,
but need not be limited to, 13 representatives of the following trauma care providers in the State:

14 (1) the medical director of each State-designated trauma center,
15 provided that the trauma program managers of each State
16 designated trauma center may serve as alternates for the medical
17 director of each State-certified trauma center;

18 (2) the medical director of a State-certified burn treatment
19 facility;

20 (3) the chairperson of the New Jersey Emergency Medical
21 Services Council;

22 (4) the medical director of a rehabilitation facility in the State
23 that treats patients with traumatic injuries, including traumatic brain
24 injuries and traumatic spinal cord injuries;

25 (5) three representatives of pre-hospital care providers in the
26 State, including an advanced life support provider as recommended
27 by the State mobile intensive care advisory council, a volunteer
28 basic life support provider as recommended by the New Jersey State
29 First Aid Council, and a paid basic life support provider;

30 (6) The New Jersey licensed physician chairperson of the New
31 Jersey Chapter of the American College of Surgeons Committee on
32 Trauma; .

33 (7) a New Jersey licensed physician recommended by the New
34 Jersey Chapter of the American College of Emergency Physicians;

35 (8) a New Jersey licensed nurse recommended by the New
36 Jersey Chapter of the Emergency Nurses Association;

37 (9) one individual with expertise in the prevention of injury; and 38 (10) one medical director of the
emergency department of a New 39 Jersey hospital that is not a State-designated trauma center.

40 b. (l) The STSAC shall have an executive committee appointed
41 by the commissioner from among the members of the STSAC,

42 consisting of ¹ [the] !yyg ¹ medical directors ¹ [of each] from ¹ State43 designated Level One trauma ¹
[center, one medical director of al

44 centers• two medical directors from ¹ State designated Level Two
45 trauma ¹ center] centers ; one medical. director of an emergency
46 department from a New Jersey hospital that is not the site of a
47 State-designated trauma center ¹l,] .1 one representative of pre-hospital care providers in the State ¹ L]
. 1 and the State Trauma 2 Medical Director, who shall serve ex officio as chair of the 3 executive committee
of the STSAC.

4 (2) The executive committee of the STSAC shall set forth the
5 times and agenda of the meetings of the ST SAC, coordinate the 6 policy recommendations of the
STSAC, and draft the ST SAC's 7 initial and subsequent reports.

8 c. (1) Each member of the STSAC shall serve for a term of
9 three years and may be reappointed to one or more subsequent
10 terms, except that of the members first appointed, one third shall
11 serve for a term of three years, one third for a term of two years,
12 and one third for a term of one year. Vacancies in the membership 13 of the committee shall be filled
in the same manner provided for the 14 original appointments..

15 (2) The ST SAC shall organize as soon as practicable following 16 the appointment of its members and
shall hold its initial meeting no 17 later than 90 days after the effective date of this act.

18 (3) The members of the ST SAC shall select a chairperson and 19 vice chair. The vice chair shall conduct
the committee meetings 20 when the chairperson is unable to attend.

21 (4) The members shall serve without compensation, but shall be 22 reimbursed for necessary expenses
incurred in the performance of 23 their duties and within the limits of available funds.

24 d. (1) Consistent with the recommendations of the American
25 College of Surgeons Committee on Trauma, and, to the extent
26 applicable, consistent with the processes outlined in the State
27 Trauma System Planning Guide issued by the National Association 28 of State Emergency Medical
Services Officials, the ST SAC shall:

29 analyze data related to trauma care in the State; design ¹ [an
30 inclusive] @ formal ¹ system of trauma care in the State with system-
31 wide standards of pre-hospital triage and hospital-based care and
32 policies; evaluate the State trauma system on an ongoing basis, and
33 identify strategies to ensure optimal coordination of the Statewide
34 trauma system. In fulfilling these responsibilities, the STSAC shall 35 seek input from stakeholders
representing all aspects of trauma care 36 the State.

37 (2) Within one year following the date of enactment of this act,
38 the STSAC shall prepare and submit a report to the commissioner
39 and the State Trauma Medical Director, which shall include a 40 recommended comprehensive State
trauma system plan. The plan 41 shall address:

- 42 (a) Best practices and standards for all trauma care providers;
- 43 (b) Development and implementation of protocols for the
44 stabilization and transfer of patients;
- 45 (c) Training requirements for acute care hospital personnel with
46 respect to identifying, stabilizing, and arranging for the transfer of a
47 patient whose condition is beyond the scope of the hospital's

48 capabilities;
1 (d) Mandatory trauma triage practices to be performed by
2 emergency medical service providers;
3 (e) Any other issues that the STSAC determines to be 4 appropriate for inclusion in the plan.
5 (3) Subsequent to the receipt of the initial report and
6 recommendation submitted by the ST SAC pursuant to this 7 subsection, the commissioner shall
promulgate regulations 8 establishing and implementing a state trauma system plan.
9 (4) Subsequent to the preparation and issuance of its initial
10 report pursuant to this subsection, the ST SAC shall: systematically
11 review strategies to maintain and improve the State trauma system;
12 submit an annual report to the commissioner and the State Trauma
13 Medical Director on its activities; and provide any 14 recommendations it
determines are necessary to improve the State 15 trauma system.
16
17 5. The Commissioner of Health, pursuant to the
18 "Administrative Procedure Act," P.L.1968, c.410 (C52: 14B-1 et 19 seq.), shall adopt rules and
regulations necessary to effectuate the 20 purposes of this act.
21
22 6. This act shall take effect immediately.
23
24
25
26
27 Provides for development and implementation of State trauma 28 system.

ATTACHMENT 5, TABLE 2: TRINITAS TRAUMA DISCHARGE DATA (UB) ANALYSIS 2014-2017

Unique Observations with ICD 9 Trauma Code in Diagnosis (DX1 - DX13) and						
	2014		2015		2016	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Inpatient	430	98.62	363	97.84	339	98.55
ER Outpatient	6	1.38	8	2.16	5	1.45
Total	436	100.0	371	100.0	344	100.0
Readmission Into an Acute Care Facility for a Second Time within 7 Days						
	2014		2015		2016	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
No	392	89.9	328	88.4	316	91.9
Yes	38	8.7	34	9.2	23	6.7
Unknown	6	1.4	9	2.4	5	1.5
Total	436	100.0	371	100.0	344	100.0
Age						
	2014		2015		2016	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
00 - 01	5	1.2	2	0.5	5	1.5
02 - 10						
11 - 17			1	0.3	2	0.6
18 - 25	10	2.3	11	3.0	12	3.5
26 - 45	39	8.9	50	13.5	31	9.0
46 - 65	122	28.0	89	24.0	88	25.6
66 - 85	170	39.0	151	40.7	116	33.7
> 85	90	20.6	67	18.1	90	26.2
Total	436	100.0	371	100.0	344	100.0
Point of Origin for this Admission						
	2014		2015		2016	
	Frequency	Percent	Frequency	Percent	Frequency	Percent
Non-Health Care Facility Point of Origin	407	93.4	352	94.9	323	93.9
Transfer from Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)	15	3.4	7	1.9	16	4.7
Transfer from another Health Care Facility	2	0.5	1	0.3	1	0.3
Information Not Available	11	2.5	11	3.0	4	1.2
Transfer from Inpatient in Same Facility Resulting in Separate Claim to Payer	1	0.2				
Total	436	100.0	371	100.0	344	100.0
Source: Department of Health analysis of 2014 to 2016 discharge (UB) data.						

ATTACHMENT 6: Table 3 Key

(D) AIS Scores

- 1 = Minor
- 2 = Moderate
- 3 = Severe, Non-Life Threatening
- 4 = Severe, Life Threatening
- 5 = Critical, Survival Uncertain
- 6 = Death

(E) Trauma Category

- 1 = Mechanical Falls
- 2 = Motor Vehicle Crash
- 3 = Gun Shot Wounds
- 4 = Stabbing
- 5 = Sports Related Injury
- 6 = Other

(F) Mode of Arrival

- 1 = Self
- 2 = EMS
- 3 = Unknown

(G) Disposition

- 1 = Admission
- 2 = Discharge
- 3 = Transferred
- 4 = Dead
- 5 = AMA/Elopement

(I) Unit Admitted To

- 1 = Med/Surg
- 2 = ICU
- 3 = Telemetry
- 0 = Dead/Transfer/Discharge

(K) Trauma Criteria Met

- 1 = Transfer to a designated trauma or burn center
- 2 = Admission to intensive or critical care or another monitored setting
- 3 = Hospitalization for three or more days
- 4 = Injury score of 3+ on the Abbreviated Injury Scale
- 5 = Survival probability of 90% or less on the Trauma Score/Injury Severity Score (TRISS) method
- 6 = Death (including deaths in the ER)

ATTACHMENT 6

TABLE 3. TRINITAS TRAUMA AUDIT 2017 CASES

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Case #	Discharge Diagnosis	Age	AIS/ISS Score	Trauma Category	Mode of Arrival	Disposition	Days Admitted	Unit Admitted To	Audit Comments	Trauma Criteria
1	Pneumonia, rib fx, pleural effusion	45	2	1	1	1	3	1	Left AMA X2 days prior w/pneumonia, rib fx, pleural effusion - No evidence of fall in chart - MD confirmed in our presence chart not clear	3
2	R shoulder dislocation - glenoid fx.	54	2	1	1	1	4	1	Fell 2 weeks prior - went to OR	3
3	L5 and sacral fx.	60	2	1	1	1	8	1	Fell X3 weeks ago	3
4	Sacral Fx.	76	2	1	1	1	4	1	Fell backwards X6 days ago	3
5	Transverse Fx of third & fourth phalanges, cellulitis of L foot	47	2	1	1	1	3	1	In police custody - fall X2 days ago	3
6	R sacral sufficiency fx, R superior pubic fx rami	75	3	1	1	1	3	1	Mult. Falls over the weekend and came to ED for eval	3, 4
7	L1 Burst Fx	79	3	1	1	1	5	1	Fell yesterday on wet floor	3, 4
8	Fx Humerus	66	3	1	1	2	0	0	Tripped - 5 days old	4
9	T1 fx	82	3	1	1	1	5	1	Fell down 3 steps off ladder	3, 4
10	Rib Fx. - 7,8,9	82	3	1	1	1	4	1	Nursing home pt. fell in bathroom	3, 4
11	Subarachnoid Hematoma	97	3	1	1	1	4	2	Fell X1 hour prior, small hemorrhage in right temporal lobe	2, 3, 4
12	Fx Humerus - old due to mult. Falls	90	3	1	1	1	3	1		3, 4
13	Fx tibia	97	2	1	1	1	3	1		3
14	Fx R acetabulum, Fx inferior R ramus	87	2	1	1	1	5	1	Fell landed on R side	3
15	Fx hip & pelvis	84	2	1	1	1	3	1	Fell	3
16	L Elbow Fx.	87	2	1	2	1	7	1	Walking in bathroom when fell	3
17	Subdural Hematoma - 5mm	84	3	1	2	1	9	3	Pt. had alt. mental status and was recently released from rehab. Pt. had hx.of mult. falls.	3, 4
18	Open Ankle Fx.	89	3	1	2	1	4	1	Tripped on slippers	3, 4
19	Displaced Fx of humeral neck	92	2	1	2	1	5	1	Slipped fell in kitchen	3

ATTACHMENT 6

TABLE 3. TRINITAS TRAUMA AUDIT 2017 CASES

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Case #	Discharge Diagnosis	Age	AIS/ISS Score	Trauma Category	Mode of Arrival	Disposition	Days Admitted	Unit Admitted To	Audit Comments	Trauma Criteria
20	Displaced L Rib Fx (8,9), non-displaced fx R rib fx (5,6,7), Fx L scapula	96	3	1	2	1	8	1	Fell getting out of bed	3, 4
21	Subarachnoid hemorrhage	93	3	1	2	1	5	1	Fell at home multiple times - hx. Dementia	3
22	Fx. L radius, L patella, comminuted transverse patella	88	3	1	2	1	6	1	Fell carrying laundry	3, 4
23	Fx R acetabulum, R superior pubic rami fx, R sacrum fx	87	3	1	2	1	6	1	Fell at home	3, 4
24	R Knee Fx, R elbow Fx	86	2	1	2	1	4	1	Tripped & fell while walking X1 hour ago	3
25	Small tissue trauma w possible subarachnoid hematoma	96	3	1	2	1	4	1	Fall in bathroom, could not exclude hemorrhage	3, 4
26	Vertebral compression fx, T7 and T8 Fx	93	2	1	2	1	7	1	Found on floor by son - unknown down time	3
27	Comminuted scapula fx	88	2	1	2	1	4	1	Fall getting out of bathtub	3
28	L inferior pubic rami and bilateral unstable sacral fx	86	3	1	2	1	4	1	Fell at home	3, 4
29	Bilateral nasal fx, L middle finger fx, scalp laceration	92	2	1	2	1	6	1	Fell attempting to go to bathroom - hit head on dresser	3
30	Comminuted L Humerus FX	80	2	1	2	1	9	1	Trip and fell went to OR - tuberosity reconstruction	3
31	SAH, R sinus Fx, R orbit fx	80	3	1	2	1	6	2	Was walking and fell	2,3,4
32	Pelvic Fx.	80	2	1	2	1	6	1	Fell off porch	3
33	Fx T12, L2	83	2	1	2	1	9	1	Fell yesterday	3
34	L pubic rami fx	89	2	1	2	1	4	1	Tripped & fell at home	3
35	SAH	84	3	1	2	1	6	2	Fell	2,3,4
36	L2 fx, Rib fx (1)	80	2	1	2	1	4	3	Syncope/fall - hit dresser	2,3
37	Bilateral sacral fx, L5 transverse fx	82	3	1	2	1	3	1	Fell off chair and hit door	3,4
38	Fx Humerus - old due to mult. Falls	90	3	1	2	1	3	1		3,4

ATTACHMENT 6

TABLE 3. TRINITAS TRAUMA AUDIT 2017 CASES

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Case #	Discharge Diagnosis	Age	AIS/ISS Score	Trauma Category	Mode of Arrival	Disposition	Days Admitted	Unit Admitted To	Audit Comments	Trauma Criteria
39	Fell - Fx L1	81	2	1	2	1	3	1		3
40	Fx C2, C3, C4	99	3	1	2	1	3	1	Fell down 3 steps	3,4
41		84	2	1	2	1	3	1	Fell	3
42	SAH	85	3	1	1	1	4	2	Fell while in bathroom	3,4
43	Fx. Acetabulum	91	2	1	2	1	3	1	Fell	3
44	Fx C5	90	3	1	2	1	3	1		3,4
45	Intercerebral hemorrhage	96	3	1	2	1	3	1	Fell down stairs	3,4
46	Fx C2	93	3	1	2	1	Unk.	2	Fell	2,4
47	Fx Pubic Rami	86	3	1	3	1	3	1		3,4
48	Subdural Hematoma	81	3	1	3	1	Unk.	1	Lightheaded and fell	4
49	SAH	85	3	1	2	1	3	1	Fell	3,4
50	Fx C1	85	3	1	2	1	3	1	Fell	3,4
51	Fx Humerus	86	3	1	2	1	3	1		3,4
52	Fx Ankle	85	2	1	2	1	Unk.	2		2
53	Displaced L ankle fx	52	2	1	1	1	1	1	Went to OR after falling	0
54	Fx orbit, nose, maxilla	82	3	1	2	1	3	1	Fell	3,4
55	S2 fx w/buckling, S3 Fx	70	2	1	2	1	4	1	S/P fall ETOH, Hematoma L frontal above eye	3
56	Subdural Hematoma	74	3	1	2	1	4	1	Fell in driveway	3,4
57	Distal femoral fx	69	3	1	2	1	6	1	Fell reaching for walker - ETOH intoxic	3,4
58	Intraventricular hemorrhage	70	3	1	2	1	2	2	Fell in nursing home	2,4
59	Bilateral Nasal Bone Fx	78	3	1	2	1	20	1	Fell on wet floor yesterday	3,4
60	Fx Rib X4	67	3	1	2	1	3	1		3,4
61	Fx Fibula & femur	67	2	1	2	1	3	1	Fell	3
62	Fx Ankle	74	2	1	2	1	3	1		3
63	Fx Rib x2	76	3	1	1	2	0	0	Fell in shower	4
64	Compression fx - L7	67	3	1	1	2	0	0	Slip & fell from step stool	4

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TABLE 3. TRINITAS TRAUMA AUDIT 2017 CASES

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Case #	Discharge Diagnosis	Age	AIS/ISS Score	Trauma Category	Mode of Arrival	Disposition	Days Admitted	Unit Admitted To	Audit Comments	Trauma Criteria
65	Fx. Of R 10th rib, possible 11th rib	66	3	1	1	2	0	0	Fall at work - hit wood, had small pleural effusion	4
66	C2 Fx.	68	2	1	2	1	13	2	Hangman's fx - fell walking down stairs	2,3
67	Subdural Hematoma	68	3	1	1	1	8	1	Small convexity, fell mult. Times in past X3 days	3,4
68	Pelvic Fx.	75	2	1	1	1	3	1	Fell out of car onto curb	3
69	Depressed comminuted Fx of L frontal sinus	67	3	1	2	2	0	0	Fell and hit face	4
70	Skull Fx. - Subdural Hematoma	71	3	1	2	1	6	2	Fell down 5 steps - linear non-displaced skull fx. - posterior or temporal hematoma	2,3,4
71	Rib fx (5,6), Displaced L clavicle fx	69	3	1	1	1	4	3	Fell down 3 steps	2,3,4
72	Fx wrist	74	2	1	1	1	3	1		3
73	Fx clavicle, small subdural	67	3	1	1	1	3	1		3,4
74	Fx L1	78	0	1	1	1	3	1	Fell off step ladder	3
75	Fx radius	78	2	1	2	1	Unk.	3	Fell down 3 stairs	2
76	Fx maxilla, nasal bone	75	3	1	2	1	3	1	Fell	3,4
77	Fx orbit, maxilla, nasal bone	77	2	1	2	1	3	1	Fell	3
78	Fx pelvis	69	3	1	2	1	1	1	Fell on ice	4
79	Subdural	74	3	1	1	1	Unk.	1		4
80	Fx Sacrum	66	2	1	3	1	3	1	Fell	3
81	Concussion	78	3	1	2	5	0	0	Refused adm - syncopal episode at airport	4
82	mult rib fx (9, 10, 11)	71	3	1	1	5	0	0	Fell on floor	4
83	Distal tibia Fx	45	2	1	1	1	5	1	Fell down while walking - went to OR	3
84	Ankle Fx.	45	2	1	2	1	2	1	Went to OR	0
85	Displaced patella fx.	18	2	1	1	1	3	1	Fell down 10 steps - distracted comminuted displaced patella - went to OR	3
86	Humerus/ankle Fx.	63	2	1	2	1	6	1	Went to OR	3
87	Ankle, tib/fib Fx	41	2	1	3	1	4	1	Fell in snow - went to OR - got 2 screws	3

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TABLE 3. TRINITAS TRAUMA AUDIT 2017 CASES

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Case #	Discharge Diagnosis	Age	AIS/ISS Score	Trauma Category	Mode of Arrival	Disposition	Days Admitted	Unit Admitted To	Audit Comments	Trauma Criteria
88	Transverse Fx of tibial metaphysis	4	2	1	1	2	0	0	Child fell down 8 steps - autistic	0
89	Contusion on unspec. Injury to head	17	3	1	1	2	0	0	Child tripped fell w syncopal episode 6 hrs. prior to coming to ED	4
90	Nondisplaced Fx of L tibia spiral	1	2	1	1	3	0	0	Child "twisted" and fell on floor - Child abuse case	1
91	Skull Fx.	10	3	1	1	3	0	0	Fell from a high chair - non-displaced fx. at base of skull - no hemorrhage - Transf. to University Hospital	1,4
92	Deep puncture wound near anus	8	2	1	1	3	0	0	Fell in shower	1
93	Nondisplaced parietal Fx	1	2	1	1	3	0	0	Fell out of crib 2 days ago	1
94	Displaced fx distal 3rd of radius & ulna	5	2	1	1	5	0	0	Fell off Hover Board - wanted to transfer to Univ. - parent signed out AMA	0
95	Fx Tib-Fib	1	2	1	1	3	0	0	Fell	1
96	Parietal bone skull fx	1	3	1	2	3	0	0	Child is 4 mo. - sister carrying child and dropped	1,4
97	Fx Tibia	7	2	2	1	3	0	0		1
98	Lung contusion, displaced clavicle fx	8	3	2	1	3	0	0	Child pedestrian struck	1,4
99	Fx radius and ulna	12	2	1	1	3	0	0		1
100	Myolysis Left Flank area	49	3	1	1	3	0	1	Fell 4 ft. off ladder X3 days prior	1,4
101	Fx Humerus, Patella	86	2	1	2	3	0	0	Fell	1
102	Fx. Glenoid/Humerus	75	2	1	1	3	0	0	Fell	1
103	Fx ankle, talus	60	3	1	1	3	3	0	Fell 5 feet	1,4
104	L Clavicle Fx	58	3	1	1	2	0	0	Conminuted unstable Left Clavicle Fx.	4
105	Fx Ribs (7,8,9)	60	3	1	1	2	0	0	S/P fall last week	4
106	Conminuted Fx of L calcaneous w/ smal fragments	50	3	1	1	2	0	0	Fell down 10 steps on ladder	4
107	T12 Fx	60	3	1	1	2	0	0	Fall on the job backwards	4

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TABLE 3. TRINITAS TRAUMA AUDIT 2017 CASES

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Case #	Discharge Diagnosis	Age	AIS/ISS Score	Trauma Category	Mode of Arrival	Disposition	Days Admitted	Unit Admitted To	Audit Comments	Trauma Criteria
108	Mult. Rib fx (9, 10)	45	3	1	1	2	0	0	Slipped and fell in bathroom	4
109	Bilateral mandible fx	57	3	1	1	2	0	0	Slipped and fell down 5 concrete steps, ETOH	4
110	Fx Rib X4	52	3	1	1	2	0	0		4
111	Fx nose, concussion	31	3	1	1	2	0	0	Fell in shower	4
112	L rib fx (8) w bibasilar atelectasis	44	2	1	1	2	0	0	Fell 8ft onto concrete	0
113	R mid radius fx	33	2	1	1	2	0	0	Fell on arm earlier in day	0
114	Mult Rib fx (6 &7)	56	3	1	1	2	0	0	Slip and fall on stairs	4
115	Fx Humerus	51	3	1	1	2	0	0	Fell	4
116	Fx Ribs x2	60	3	1	1	2	0	0	Fell down stairs	4
117	Fx Rib X3	58	3	1	1	2	Unk.	0	Walk-in	4
118	Rib Fx.	59	3	1	2	1	5	1	Mult. Rib fx. X4, pneumothorax, (sm. Right apical), chest tube	2,4
119	Acute trimalleolar Ankle Fx w/mild tibiotalar dislocation	51	2	1	2	1	5	1		2
120	Spiral Fx R Ankle	59	2	1	1	1	4	1	Tripped and fell on sidewalk	2
121	SAH	32	3	1	1	1	Unk.	2	Fell	2,4
122	Fx Humerus	26	3	1	1	1	3	1	Fell out of bed	3,4
123	Fx Humerus	61	3	1	1	1	Unk.	1	Fell	4
124	Fx elbow	30	3	1	1	1	3	1	Fell down stairs	3,4
125	Fx Ankle	23	2	1	1	1	3	1		3
126	Fx Ankle	51	2	1	1	1	3	1		3
127	Fx Ribs	68	3	1	1	1	1	1		4
128	Subdural	74	3	1	1	1	Unk.	1		4
129	Fx ribs, L1	62	2	1	1	1	Unk.	1	Fell and tripped	0
130	Comminuted distal radial fx of L wrist ("Smith Fx")	62	2	1	2	1	8	1	Fell rolled off hood of car w/ETOH consumption	3

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TABLE 3. TRINITAS TRAUMA AUDIT 2017 CASES

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Case #	Discharge Diagnosis	Age	AIS/ISS Score	Trauma Category	Mode of Arrival	Disposition	Days Admitted	Unit Admitted To	Audit Comments	Trauma Criteria
131	Subdural Hematoma	62	3	1	2	1	Unk.	2		2,4
132	Subdural Hematoma	48	3	1	2	1	Unk.	2		2,4
133	Cerebella Hemorrhage	51	3	1	2	1	3	1	Fell	3,4
134	Fx Acetabulum	61	2	1	2	1	3	1	Trip and fell	3
135	Fx Hip & wrist	58	2	1	2	1	3	1	Fell off ladder	3
136	Fx Acetabulum	62	3	1	2	1	Unk.	3	Fell	2,4
137	Fx C6	61	3	1	2	1	3	1	Fell	3,4
138	Fx Ankle	46	2	1	2	1	3	1		3
139	SAH	61	3	1	2	1	3	1		3,4
140	Fx orbit, nasal bone	51	2	1	2	1	3	1		3
141	Fx elbow	60	2	1	2	1	3	1		3
142	Fx orbit	41	3	1	2	1	1	1	Fell, Hx of CA	4
143	Fx Humerus	61	3	1	2	1	1	1	Fell	4
144	Fx radius and ulna	62	2	1	2	1	3	1	Tripped and fell	3
145	Fx radius and ulna	61	2	1	2	1	3	1		3
146	Fx ankle	56	2	1	2	1	3	1	Tripped	3
147	Fx Humerus, Hip	57	2	1	2	1	Unk.	1	Fell	0
148	Rib. Fx.	52	3	1	1	5	0	0	Fell on ice - Fx. Of 3, 4, 5,6 rib fx. - no pneumo	4
149	Traumatic arrest	54	6	2	2	4	0	0	Pedestrian vs. MV	6
150	Traumatic arrest	37	6	2	2	4	0	0		6
151	Traumatic arrest	25	6	2	2	4	0	0	Arrest in field	6
152	Traumatic arrest	29	6	2	2	4	0	0	Arrest in field	6
153	Traumatic arrest	48	6	2	2	4	0	0	Arrest in field	6
154	Traumatic arrest	34	6	2	2	4	0	0	Motorcycle accident	6
155	Traumatic arrest	116	6	2	2	4	0	0	Arrest in field	6
156	Traumatic arrest	66	6	2	2	4	0	0	Arrest in field	6

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TABLE 3. TRINITAS TRAUMA AUDIT 2017 CASES

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Case #	Discharge Diagnosis	Age	AIS/ISS Score	Trauma Category	Mode of Arrival	Disposition	Days Admitted	Unit Admitted To	Audit Comments	Trauma Criteria
157	Traumatic arrest	54	6	2	2	4	0	0	Pedestrian struck - threw himself under car	6
158	GSW chest	22	6	3	2	4	0	0	Cardiac arrest	6
159	GSW chest	27	6	3	2	4	0	0	Alive at arrival then died	6
160	GSW chest	24	6	3	2	4	0	0	Cardiac arrest	6
161	Open wounds	39	2	2	1	3	0	0	Motorcycle accident	1
162	Large head laceration, concussion	20	3	2	1	3	0	0	Passenger in car	1,4
163	Fx femur	26	3	2	2	3	0	0	Pedestrian vs. MV	1,4
164	Fx pelvis, ribs, L-5	71	3	2	2	3	0	0	Pedestrian vs. MV	1,4
165	Back pain, bilateral wrist fx, abdomen	27	3	2	2	3	0	0	Pedestrian struck	1,4
166	Compression fx - T7-8	21	3	2	2	1	3	1		3,4
167	Subdural Hematoma	54	3	2	2	1	Unk.	2		4
168	Fx ribs X3, pneumo, pulm. Contusion	26	3	2	2	1	Unk.	2		2,4
169	Fx tibia	22	3	2	2	1	Unk.	1	Motorcycle accident	4
170	Concussion	18	3	2	2	1	3	1	Pedestrian vs. motorcycle	3,4
171	Renal contusion, fx scapula	72	3	2	2	1	11	2		2,3,4
172	Nasal fx	25	3	2	2	1	0	1	ETOH - Admin to floor then left same day AMA	4
173	Frontoparietal subdural hemorrhage	63	3	2	2	1	1	3	Passenger in car	2,4
174	Small R convexity subdural hematoma, nondisplaced fx L transverse C7	77	3	2	2	1	6	2	Restrained driver	2,3,4
175	Contusion chest wall	39	3	2	3	1	Unk.	2		2,4
176	Fx elbow	37	2	2	3	1	3	1	Motorcycle accident	3
177	Fx hip/dislocated	31	3	2	3	1	3	1	To OR	3,4
178	ORIF Rt index finger	28	3	2	3	1	3	1	Finger in field	3,4
179	GSW leg/calf	25	3	3	1	2	0	0		4
180	GSW lower leg - 4 days old	27	3	3	1	2	0	0	Came to ED for antibiotics	4
181	GSW upper arm	19	3	3	1	2	0	0		4

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TABLE 3. TRINITAS TRAUMA AUDIT 2017 CASES

(A)	(B)	(C)	(D)	(E)	(F)	(G)	(H)	(I)	(J)	(K)
Case #	Discharge Diagnosis	Age	ALS/ISS Score	Trauma Category	Mode of Arrival	Disposition	Days Admitted	Unit Admitted To	Audit Comments	Trauma Criteria
182	GSW - foot - Fx metatarsals x3	17	3	3	2	2	0	0		4
183	GSW lower leg	61	3	3	2	2	0	0		4
184	Concussion	18	3	2	1	2	0	0	Pedestrian vs. MV	4