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## Level I

The Level I facility is a regional resource trauma center that is a tertiary care facility central to the trauma care system. Ultimately, all patients who require the resources of the Level I center should have access to it. This facility must have the capability of providing leadership and total care for every aspect of injury, from prevention through rehabilitation. In its central role, the Level I center must have adequate depth of resources and personnel.

Because of the large personnel and facility resources required for patient care, education, and research, most Level I trauma centers are university-based teaching hospitals. Other hospitals willing to commit these resources, however, may meet the criteria for Level I recognition.

In addition to acute care responsibilities, Level I trauma centers have the major responsibility of providing leadership in education, research, and system planning. This responsibility extends to all hospitals caring for injured patients in their regions.

Medical education programs include residency program support and postgraduate training in trauma for physicians, nurses, and prehospital providers. Education can be accomplished through a variety of mechanisms, including classic continuing medical education (CME), preceptorships, personnel exchanges, and other approaches appropriate to the local situation. Research and prevention programs, as defined in this document, are essential for a Level I trauma center.

## Level II

The Level II trauma center is a hospital that is also expected to provide initial definitive trauma care, regardless of the severity of injury. Depending on geographic location, patient volume, personnel, and resources, however, the Level II trauma center may not be able to provide the same comprehensive care as a Level I trauma center. Therefore, patients with more complex injuries may have to be transferred to a Level I center (for example, patients requiring advanced and extended surgical critical care). Level II trauma centers may be the most prevalent facility in a community, managing the majority of trauma patients.

The Level II trauma center can be an academic institution or a public or private community facility located in an urban, suburban, or rural area. In some areas where a Level I center does not exist, the Level II center should take on the responsibility for education and system leadership.

## Level III

The Level III trauma center serves communities that do not have immediate access to a Level I or II institution. Level III trauma centers can provide prompt assessment, resuscitation, emergency operations, and stabilization and also arrange for possible transfer to a facility that can provide definitive trauma care. General surgeons are required in a Level III facility. Planning for care of injured patients in these hospitals requires transfer agreements and standardized treatment protocols. Level III trauma centers are generally not appropriate in an urban or suburban area with adequate Level I and/or Level II resources.

## Level IV

Level IV trauma facilities provide advanced trauma life support prior to patient transfer in remote areas where no higher level of care is available (see Chapter 13: Rural Trauma). Such a facility may be a clinic rather than a hospital and may or may not have a physician available. Because of geographic isolation, however, the Level IV trauma facility is the de facto primary care provider. If willing to make the commitment to provide optimal care, given its resources, the Level IV trauma facility should be an integral part of the inclusive trauma care system. As at Level III trauma centers, treatment protocols for resuscitation, transfer protocols, data reporting, and participation in system performance improvement (PI) are essential.

A Level IV trauma facility must have a good working relationship with the nearest Level I, II, or III trauma center. This relationship is vital to the development of a rural trauma system in which realistic standards must be based on available resources. Optimal care in rural areas can be provided by skillful use of existing professional and institutional resources supplemented by guidelines that result in enhanced education, resource allocation, and appropriate designation for all levels of providers. Also, it is essential for the Level IV facility to have the involvement of a committed health care provider, who can provide leadership and sustain the affiliation with other centers.

An inclusive system should leave no facility without direct linkage to a Level I or II trauma center. This association should facilitate expeditious transfer of seriously injured patients who require a higher level of care. Exchange of medical personnel between Level I/II and Level III/IV facilities may be an excellent way to develop this relationship. The Level I and II trauma centers have an obligation to extend their educational outreach to the rural areas in the form of professional education, consultation, or community outreach. A mechanism should deliver feedback about individual patient care and outcome analysis to the referring hospital.