Western Virginia Emergency Medical Services Council, Inc.

WESTERN VIRGINIA EMS COUNCIL PREHOSPITAL AND INTERHOSPITAL REGIONAL TRAUMA TRIAGE PLAN

This plan is written to coordinate with and supplement Virginia's State Trauma Triage Plan. Revised and Adopted by WVEMS Board of Directors March 13, 2025.

Western Virginia EMS Council, Inc.
1944 Peters Creek Road NW
Roanoke VA 24017
800.972.4367
www.wvems.org

Table of Contents

Executive Summary

Under the *Code of Virginia* § *32.1-111.3*, The Virginia Office of Emergency Medical Services acting on behalf of the Virginia Department of Health has been charged with the responsibility of maintaining a Statewide Trauma Triage Plan. Emergency Medical Services (EMS) Agencies are required by EMS Regulation 12 VAC 5-31-390 to follow specialty care hospital triage plans. This regional plan was developed for use by agencies and hospitals in the Western Virginia EMS region, and follows the guidelines set forth in the Statewide Plan and addresses prehospital and inter-hospital patient transfers.

The Statewide Trauma Triage Plan establishes minimum criteria for identifying trauma patients and the expectation that these patients shall enter the "trauma system" and receive rapid definitive trauma care at appropriate hospitals. This regional trauma triage plan augments the Commonwealth's minimum trauma triage standards by providing additional point of entry and resource information. This regional plan set forth standards equivalent to those proscribed by the state trauma triage plan.

The Virginia Department of Health, Office of Emergency Medical Services (OEMS), the state Trauma System Oversight and Management Committee and this regional EMS council endorse the 2021 Centers for Disease Control (CDC) *Field Triage Decision Scheme: The National Trauma Triage Protocol* and it accompanies document *Guidelines for Field Triage of Injured Patients*. The CDC is now home to the national trauma program and has assumed responsibility for establishing the national standard for trauma triage in cooperation with the American College of Surgeons (ACS) who has traditionally developed these criteria. The 2021 CDC documents have been endorsed by the following organizations:

The Joint Commission (JCAHO)
National Association of State EMS Officials (NASEMSO)
American College of Surgeons (ACS)
American Academy of Pediatrics (AAP)
National Association of EMS Physicians (NAEMSP)
National Association of EMS Educators
National Native American EMS Association
Commission on Accreditation of Medical Transport Systems (CAMTS)
American Medical Association (AMA)
The American Public Health Association (APHA)
American Pediatric Surgical Association
American College of Emergency Physicians (ACEP)
National Association of EMT's (NAEMT)
International Association of Flight Paramedics (IAFP)
Air Medical Physician Association (AMPA)
National Ski Patrol

The Virginia Trauma System is an inclusive system and therefore all hospitals are required to participate in the Trauma Triage Plan. Establishing a comprehensive statewide emergency medical care system, incorporating healthcare facilities, transportation, human resources, communications, and other components as integral parts of a unified system serves to improve the delivery of emergency medical services and thereby decrease morbidity, hospitalization, disability, and mortality. This document provides uniform guidelines for prehospital and inter-hospital triage and transport of trauma patients.

The Virginia Trauma System defines a "trauma victim" as a person who has acquired serious injuries and or wounds brought on by either an outside force or an outside energy. These injuries and or wounds may affect one or more body systems by blunt, penetrating or burn injuries. These injuries may be life altering, life threatening or ultimately fatal wounds.

Trauma patient recognition and Triage is a Two-tiered System:

- Initial Field Triage in the prehospital environment (pre-hospital criteria) and;
- Secondary triage or trauma patient recognition and appropriate timely triage by all Virginia hospitals.

Field Trauma Triage Decision Scheme

National Guideline for the Field Triage of Injured Patients

RED CRITERIA
High Risk for Serious Injury

Injury Patterns	Mental Status & Vital Signs
• Penetrating injuries to head, neck, torso, and proximal extremities • Skull deformity, suspected skull fracture • Suspected spinal injury with new motor or sensory loss • Chest wall instability, deformity, or suspected flail chest • Suspected pelvic fracture • Suspected fracture of two or more proximal long bones • Crushed, degloved, mangled, or pulseless extremity • Amputation proximal to wrist or ankle • Active bleeding requiring a tourniquet or wound packing with continuous pressure	**All Patients** • Unable to follow commands (motor GCS < 6) • RR < 10 or > 29 breaths/min • Respiratory distress or need for respiratory support • Room-air pulse oximetry < 90% **Age 0–9 years** • SBP < 70mm Hg + (2 x age in years) **Age 10–64 years** • SBP < 90 mmHg or • HR > SBP **Age ≥ 65 years** • SBP < 110 mmHg or • HR > SBP

Patients meeting any one of the above RED criteria should be transported to the highest-level trauma center available within the geographic constraints of the regional trauma system

YELLOW CRITERIA
Moderate Risk for Serious Injury

Mechanism of Injury	EMS Judgment
• High-Risk Auto Crash – Partial or complete ejection – Significant intrusion (including roof) • >12 inches occupant site OR • >18 inches any site OR • Need for extrication for entrapped patient – Death in passenger compartment – Child (age 0–9 years) unrestrained or in unsecured child safety seat – Vehicle telemetry data consistent with severe injury • Rider separated from transport vehicle with significant impact (eg, motorcycle, ATV, horse, etc.) • Pedestrian/bicycle rider thrown, run over, or with significant impact • Fall from height > 10 feet (all ages)	**Consider risk factors, including:** • Low-level falls in young children (age ≤ 5 years) or older adults (age ≥ 65 years) with significant head impact • Anticoagulant use • Suspicion of child abuse • Special, high-resource healthcare needs • Pregnancy > 20 weeks • Burns in conjunction with trauma • Children should be triaged preferentially to pediatric capable centers **If concerned, take to a trauma center**

Patients meeting any one of the YELLOW CRITERIA WHO DO NOT MEET RED CRITERIA should be preferentially transported to a trauma center, as available within the geographic constraints of the regional trauma system (need not be the highest-level trauma center)

***Prehospital providers should transfer trauma patients with uncontrolled airway, uncontrolled external hemorrhage, or if there is CPR in progress to the closest hospital or free-standing emergency department for stabilization and transfer.**

Trauma Patient Transport Considerations

Regional EMS Patient Care Protocols in the Western Virginia EMS region address transport considerations. Each jurisdiction is unique in its availability of trauma resources. Consideration should be given to the hospital(s) that is/are available in the region and the resources that they have available to trauma patients when developing a point of entry plan. Pre-planning for times when the primary hospital is not available to receive trauma patients because of multiple patients, diversion, loss of resources such as power need to be made in advance of being on scene with a critical trauma patient.

Consideration should also be given to prehospital resources including, the level of care available by the ground EMS crews, and the closest Medevac service available at the time of the incident, and other conditions such as transport time and weather conditions. Use of Medevac (Air ambulances) services can assist with trauma patients reaching definitive trauma care in a timely fashion.

Field transports by helicopter of trauma patients as defined in this plan shall:

1. Lessen the time from on scene to a hospital compared to ground transport
2. Bypassing a non-trauma designated hospital to transport directly to any level trauma center should not be greater than 30 minutes
3. Trauma patients transported by air must meet the clinical triage criteria for transport and be transported to the closest Level I Trauma Center, or when appropriate the closest Level II Trauma Center.
4. Patient requires a level of care greater than can be expected by the local ground provider if the Medevac unit can be on scene in a time shorter than the ground unit can transport to the closest hospital.
5. Extenuating circumstances such as safety, egress/access should be documented similar to other "extraordinary" care scenarios.

Coordinated Approach to Related Plans

Both prehospital and hospital providers should become familiar with other related local, regional and statewide plans. These plans represent a tiered response to a growing number of patients, and can include:

- Applicable MCI Plans
- Disaster/WMD Plans
- Surge Capacity Plans

This Trauma Triage Plan is intended for incidents that occur during normal EMS operations.
The plans build upon one another. This Trauma Triage Plan is intended to guide treatment for a smaller number of patients that can be managed by resources available during normal day-to-day operations. MCI Plans provide additional guidance to agencies, municipalities and medical facilities when their normal resources are being strained. Surge plans are developed to meet the need of large scale events that may require caring for hundreds even thousands of patients.

During a mass casualty incident, point-of-entry into the trauma care system could be altered. Additional guidance should be obtained in the prehospital setting using medical control, and by medical facilities using the Near Southwest Preparedness Alliance's Regional Healthcare Coordinating Center (RHCC). The RHCC is a resource that is available to hospitals in the region and may be contacted by calling 866-679-7422.

INTER-HOSPITAL TRIAGE CRITERIA

Hospitals not designated by the Virginia Department of Health as a Trauma Center should enter injured patients that meet the below physiological and/or anatomic criteria into the trauma system (rapid transfer to an appropriate level designated Trauma Center)

Adult Patient	Pediatric Patient
	All pediatric patients with Pediatric Trauma Scores ≤ 6 * See pediatric trauma score below
Respiratory • Bilateral thoracic injuries • Significant unilateral injuries in pt's >60 (e.g. pneumothorax, hemo-pneumothorax, pulmonary contusion, >5 rib fractures) • Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease • Respiratory compromise requiring intubation • Flail chest	**Respiratory** • Bilateral thoracic injuries • Significant unilateral injuries in patients with pre-existing cardiac and/or respiratory disease • Flail chest
CNS • Unable to follow commands • Open skull fracture • Extra-axial hemorrhage on CT, or any intracranial blood • Paralysis • Focal neurological deficits • GCS ≤ 12	**CNS** • Open skull fracture • Extra-axial hemorrhage on CT scan • Focal neurological deficits
Cardiovascular • Hemodynamic instability as determined by the treating physician • Persistent hypotension • Systolic B/P (<100) without immediate availability of surgical team	
Injuries • Any penetrating injury to the head, neck, torso or extremities proximal to the elbow or knee without a surgical team immediately available. • Serious burns/burns with trauma (see below) • Significant abdominal to thoracic injuries in patients where the physician in charge feels treatment of injuries would exceed capabilities of the medical center	**Injuries** • Any penetrating injury to the head, neck, chest abdomen or extremities proximal to the knee or elbows without a surgical team immediately available • Combination of trauma with burn injuries • Any injury or combination of injuries where the physician in charge feels treatment of the injuries would exceed the capabilities of the medical center
Special Considerations • Trauma in pregnancy (≥ 24 weeks gestation)	

- Geriatric
- Bariatric
- Special needs individuals

PEDIATRIC TRAUMA SCORE

COMPONENT	+2	+1	-1
Size	Child/adolescent, >20 Kg.	Toddler, 11-20 Kg.	Infant, <10 Kg.
Airway	Normal	Assisted O2, mask, cannula	Intubated: ETT, EOA, Cric
Consciousness	Awake	Obtunded; loss of consciousness	Coma; unresponsiveness
Systolic B/P	>90 mm Hg; good peripheral pulses, perfusion	51-90 mm Hg; peripheral pulses, pulses palpable	<50 mm Hg.; weak pr no pulses
Fracture	None seen or suspected	Single closed fracture anywhere	Open, multiple fractures
Cutaneous	No visible injury	Contusion, abrasion; laceration <7 cm; not through fascia	Tissue loss; any GSW/Stabbing; through fascia

BURN RELATED INJURIES

The American Burn Association has identified the following injuries that usually require referral to a burn center.

- Partial thickness and full thickness burns greater than 10% of the total body surface area (BSA) in patients under 10 or over 50 years of age.
- Partial thickness burns and full thickness burns greater than 20% BSA in other age groups.
- Partial thickness and full-thickness burns involving the face, eyes, ears, hands, feet, genitalia or perineum of those that involve skin overlying major joints.
- Full thickness burns greater than 5% BSA in any age group.
- Electrical burns, including lightning injuries; (significant volumes of tissue beneath the surface may be injured and result in acute renal failure and other complications).
- Significant chemical burns.
- Inhalation injuries.
- Burn injury in patients with pre-existing illness that could complicate management, prolongs recovery, or affects mortality.
- Any burn patient in whom concomitant trauma poses an increased risk of morbidity or mortality may be treated initially in a trauma center until stable before transfer to a burn center.

- Children with burns seen in hospitals without qualified personnel or equipment for their care should be transferred to a burn center with these capabilities.
- Burn injury in patients who will require special social and emotional or long-term rehabilitative support, including cases involving child abuse and neglect.

Inter-hospital Transports by Helicopter

1. All trauma patients transported by air must meet the clinical trauma triage criteria for transport to the accepting Level I or Level II trauma center or burn center

2. Patient requires a level of care greater than can be provided by the local hospital.

3. Patient requires time critical intervention, out of hospital time needs to be minimal, or distance to definitive care is long.

4. Utilization of local ground ambulance leaves the local community without ground ambulance coverage.

Air Medical Resources Potentially Available to Areas in the WVEMS Region	
Helicopter Air Medical Service	***Contact Number***
Carilion Lifeguard 10 (Westlake), 11 (Radford) and 12 (Lexington)	888.377.7628
AirLife Virginia (Martinsville, VA)	800-336-6224
Wake Forest Baptist AirCare (Elkin, NC; Martinsville, VA)	833-925-3247
Centra One (Lynchburg)	866.924.7633
Pegasus (University of Virginia, Charlottesville)	800.552.1826
VSP Med-Flight 1(Richmond)	804.674.2400
VSP Med-Flight 2 (Abingdon)	276.223.4250
PHI AirCare (Weyers Cave, Fredericksburg, Front Royal, Leesburg, Manassas)	800.258.8181
LifeEvac of Virginia (Dinwiddie, Mattaponi)	877.902.7779
Highlands Emergency Air Rescue & Transport (Marion, VA; Elizabethton, TN; Greeneville, TN; Jenkens, KY)	800.946.4701
HealthNet (Beckley, WV; Lewisburg, WV)	800.346.4206
Duke Life Flight (Durham NC; Smithfield, NC)	800.362.5433
UNC Air Care (Siler City, NC; Goldsboro, NC; Fayetteville, NC)	800.247.6264

Trauma Triage Quality Monitoring

The Office of EMS is responsible for monitoring and ensuring the quality of trauma care and trauma triage in the Commonwealth. Quality monitoring and assurance is accomplished through several means including, but not limited to, the trauma center designation process, analysis of data from the Emergency Medical Services Patient Care Information System (EMS and Trauma Registries) and from other existing validated sources, the

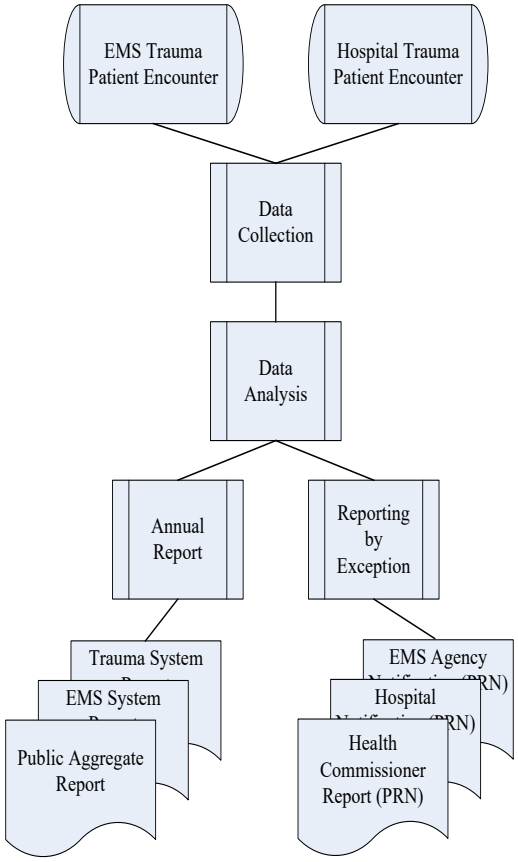
trauma performance improvement committee, feedback mechanisms, and regional Trauma Performance Improvement Committees.

The Office of EMS, acting on behalf of the Commissioner of Health, will report aggregate trauma triage findings annually to assist the EMS and Trauma Systems to improve local, regional and statewide trauma triage programs. A de-identified version of the report will be available to the public and will include, minimally, as defined in the statewide plan, the frequency of (i) incorrect triage in comparison to the total number of trauma patients delivered to a hospital prior to pronouncement of death and (ii) incorrect interfacility transfer for each region.

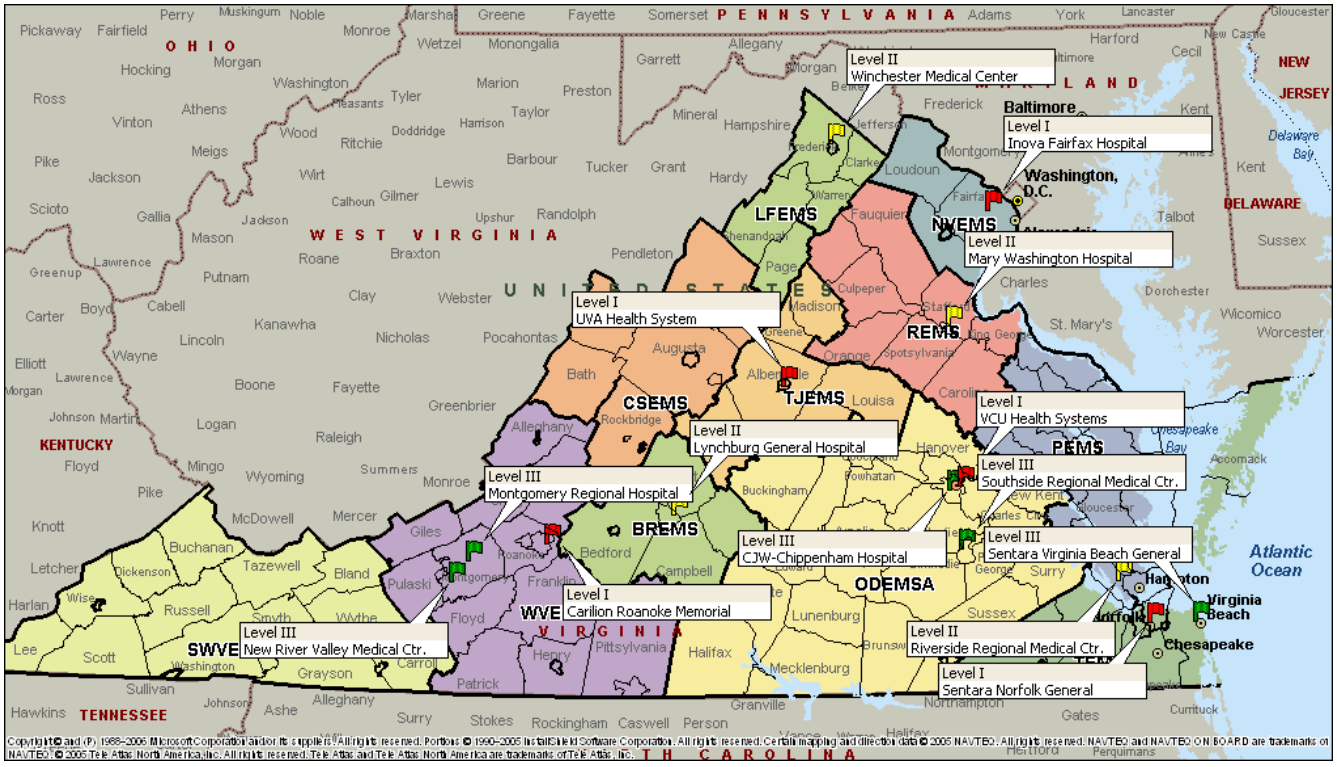
The program will ensure that each emergency medical services director or hospital is informed of any patterns of incorrect prehospital or interfacility missed triage, delayed or missed interfacility transfer as defined in the statewide plan, specific to the provider and will give the entity an opportunity to correct any facts on which such a determination is based, if the entity or its providers assert that such facts are inaccurate.

The Commissioner shall ensure the confidentiality of patient information, in accordance with § 32.1-116.2. Such data or information in the possession of or transmitted to the Commissioner, the EMS Advisory Board, or any committee acting on behalf of the EMS Advisory Board, any hospital or prehospital care provider, or any other person shall be privileged and shall not be disclosed or obtained by legal discovery proceedings as is written in the *Code of Virginia*, unless a circuit court, after a hearing and for good cause shown arising from extraordinary circumstances, orders disclosure of such data.

To initiate a prehospital trauma case review in the Western Virginia EMS Region, you may contact the Western Virginia EMS Council, or visit the **Performance Improvement Medical Incident Review** section of our website at www.wvems.org/performance-improvement.



Virginia Designated Trauma Centers and Designation Level Description



Trauma Center Designation Levels Defined

Centers highlighted in blue (or shaded) are located in the WVEMS region

Level I Trauma Centers

Level I trauma centers have an organized trauma response and are required to provide total care for every aspect of injury, from prevention through rehabilitation. These facilities must have adequate depth of resources and personnel with the capability of providing leadership, education, research, and system planning.

Carilion Roanoke Memorial Hospital (Adult/Pediatric Trauma)
1906 Belleview Ave, Roanoke

Chippenham Medical Center
7101 Jahnke Road, Richmond

Inova Fairfax Hospital
3300 Gallows Road, Falls Church

Sentara Norfolk General Hospital
600 Gresham Drive, Norfolk

University of Virginia Health System
1224 West Main St., Charlottesville

VCU Health (Adult/Pediatric)
1213 E Clay Street, Richmond

Level II Trauma Centers

Level II trauma centers have an organized trauma response and are also expected to provide initial definitive care, regardless of the severity of injury. The specialty requirements may be fulfilled by on call staff, that are promptly available to the patient. Due to some limited resources, Level II centers may have to transfer more complex injuries to a Level I center. Level II centers should also take on responsibility for education and system leadership within their region.

Centra Lynchburg General Hospital
1901 Tate Springs Road, Lynchburg

LewisGale Medical Center
1900 Electric Road, Salem

Henrico Doctors' Hospital
1602 Skipwith Road, Richmond

Mary Washington Hospital
1001 Sam Perry Blvd, Fredericksburg

Naval Medical Station Portsmouth
620 John Paul Jones Circle. Portsmouth

Reston Hospital Center
1850 Town Center Pkwy, Reston

Riverside Regional Medical Center
500 J. Clyde Morris Blvd, Newport News

Virginia Hospital Center in Arlington
1701 N George Mason Dr., Arlington

Winchester Medical Center
1840 Amherst Street, Winchester

Level III Trauma Centers

Level III centers, through an organized trauma response, can provide prompt assessment, resuscitation, stabilization, emergency operations beyond the capabilities of a non-designated facility, and can also arrange for the transfer of the patient to a facility that can provide definitive trauma care. EMS providers who routinely transport to the Level III Trauma Centers in the region should become familiar with the capabilities of these facilities and should use medical control when deciding whether to transport trauma patients to these Level III centers.

Level III centers should be active in EMS education and system leadership within the region.

Carilion New River Valley Medical Center
2900 Lamb Circle, Christiansburg

Inova Loudon Hospital
44045 Riverside Pkwy, Leesburg

LewisGale Hospital Montgomery
3700 South Main Street, Blacksburg

Sentara Virginia Beach General Hospital
1060 First Colonial Road, Virginia Beach

Southside Regional Medical Center
200 Medical Park Blvd, Petersburg

Sentara Northern Virginia Medical Center
2300 Opitz Boulevard, Woodbridge

Minimum Surgical & Medical Specialties for Trauma Designation

Surgical Clinical Capabilities: (On call and promptly available)	**Level of Designation**		
	I	**II**	**III**
Trauma/General Surgery	**X**	**X**	**X**
Anesthesiology	**X**	**X**	**X**
Orthopedic Surgery	**X**	**X**	**X**
Thoracic Surgery	**X**	**X**	
Cardiac Surgery	**X**		
Pediatric Surgery	**X**		
Hand Surgery	**X**		
Microvascular/Replant Surgery	**X**		
Neurological Surgey	**X**	**X**	
Plastic Surgery	**X**	**X**	
Maxillofacial Surgery	**X**	**X**	
Ear, Nose & Throat Surgery	**X**	**X**	
Oral Surgery	**X**		
Ophthalmic Surgery	**X**	**X**	
Gynecological Surgery/Obstetrical Surgery	**X**	**X**	

Medical Clinical Capabilities: (On call and promptly available)	**Level of Designation**		
	I	**II**	**III**
Cardiology	**X**	**X**	
Pulmonology	**X**		
Gastroenterology	**X**		
Hematology	**X**		
Infectious Disease	**X**		
Internal Medicine	**X**	**X**	**X**
Nephrology	**X**		
Pathology	**X**	**X**	**X**
Pediatrics	**X**		
Radiology	**X**	**X**	**X**
Interventional Radiology.	**X**		

Western Virginia EMS Region Defined and its Resources

EMS regions are defined by the Virginia Board of Health, which enters into a contract with a private, non-profit regional EMS organization to provide various planning and coordination functions within each region. The Western Virginia EMS Council, Inc., is the contracted agency within the Western Virginia EMS region. The Code of Virginia, §32.1-111.11 charges regional EMS councils with the development and implementation of an efficient and effective regional emergency medical services delivery system. A board of directors representing the localities served and other related organizations provides leadership and governance for the council.

Geography and Demographics

The Western Virginia EMS region encompasses the seven cities and twelve counties of Virginia's Planning Districts 4, 5 and 12. The region extends from the West Virginia border to the north, to the North Carolina border to the south. The region encompasses the urban and suburban areas of the Roanoke and Danville MSA's, as well as many rural and remote areas such as those in Patrick, Floyd and Giles counties. The region's total population (based on 2023 estimates) is 698,264. The region encompasses 5,661 square miles.

The region encompasses the counties of Alleghany, Botetourt, Craig, Floyd, Franklin, Giles, Henry, Montgomery, Patrick, Pittsylvania, Pulaski, and Roanoke, and the cities of Covington, Danville, Martinsville, Radford and Salem.

Hospitals and Free-Standing Emergency Departments in the Western Virginia EMS Region

Hospitals in the Western Virginia EMS Region *(operating 24-hour emergency departments)*	
Hospital	**Location**
Carilion Franklin Memorial Hospital	Rocky Mount
Carilion Giles Memorial Hospital	Pearisburg
Carilion New River Valley Medical Center **(Level III TC)**	Christiansburg
Carilion Roanoke Memorial Hospital **(Level I TC)**	Roanoke
Centra Gretna Medical Center (Free Standing ED)	Gretna
Sovah Health-Danville	Danville
LewisGale Medical Center	Salem
LewisGale Hospital Alleghany	Low Moor (Clifton Forge)
LewisGale Hospital Montgomery **(Level III TC)**	Blacksburg
LewisGale Hospital Pulaski	Pulaski
Sovah Health-Martinsville	Martinsville
Lewis Gale Medical Center – Cave Spring (Free Standing ED)	Cave Spring
Lewis Gale Medical Center – Blue Hills (Free Standing ED)	Bonsack
LewisGale Montgomery–Christiansburg ER (Free Standing ED)	Christiasburg

EMS Agencies

The region includes 98 state-licensed EMS agencies. Of the 91 agencies, 74 are considered emergency transport agencies, and 17 others are licensed as first responder agencies and the remainder as basic and/or advanced life support care and transportation agencies. These EMS agencies comprise a mix of commercial basic and advanced life support transport agencies, air ambulance (two rotary wing units), specialized transport, industrial-based services and governmental umbrella agencies. The focus in this trauma triage plan will be on "9-1-1" emergency provider agencies, commercial advanced life support, rotary wing air transport and specialized transport providers.

Vehicles

Within the region, there are approximately 490 licensed ambulances, first response vehicles, air and other specialized transport vehicles. (This figure excludes wheelchair vans.)

Licensed EMS Vehicles in the Region	
By Type	***Number of EMS Vehicles***
Air Ambulance	4
Ground Ambulance	332
Non-Transport Vehicle	144

The licensure and designation of these vehicles does not imply they are constantly manned and ready for response. Some of these vehicles are considered "reserve," some are unmanned during certain segments of the day and a portion are generally unmanned except for volunteer response.

Rotary wing transport in this region is provided, primarily by the Carilion Lifeguard 10 helicopter, based in Westlake in northeastern Franklin County; Carilion Lifeguard 11, based at the Carilion New River Valley Medical Center, a Level III trauma center; AirLife Virginia 1 and Wake Forest Baptist AirCare 3 both based at Blue Ridge Airport in Henry County. Other rotary wing services, convenient to but located outside the region, include hospital-based helicopters in Lexington, VA; Charlottesville, VA; Richmond, VA; Lynchburg, VA; Winston-Salem, NC; Durham, NC; Marion, VA; and Lewisburg, WV.

Personnel

Within the region there are a total of 3,733 pre-hospital EMS providers. Each of these technicians is certified by the Commonwealth, and has met specific course, continuing education and recertification requirements.

Certified EMS Providers in the Region	
Level of Certification	***Number of Providers***
Emergency Medical Responder (EMR)	52
Emergency Medical Technician (EMT)	2362
Advanced EMT (AEMT)	193
Intermediate	228
Paramedic	760
ALS-C and Education Coordinator	138

External Resources

Other Trauma Centers (outside the WVEMS region)

In addition to Carilion Roanoke Memorial Hospital (Level I) and LewisGale Medical Center (Level II), these other designated trauma centers should be considered as needed for major trauma patients:

- University of Virginia Health System, **Level I** (Charlottesville, VA)
- Wake Forest Baptist Medical Center, **Level I** (Winston-Salem, NC)
- UNC Healthcare, **Level I** (Chapel Hill, NC)
- MedStar Washington Hospital Center, **Level I** (Washington, DC)
- Inova Fairfax Hospital, **Level I** (Falls Church, VA)
- Charleston Area Medical Center, **Level I** (Charleston, WV)
- Lynchburg General Hospital, **Level II** (Lynchburg, VA)
- VCU Health, **Level I** (Richmond, VA)

Burn Resources

These facilities are considered for transport of severely burned patients:

- Wake Forest Baptist Medical Center (Winston-Salem, NC)*
- VCU Health (Richmond, VA)*
- Chippenham Hospital (Richmond VA)*
- UNC Healthcare (Chapel Hill, NC)*
- MedStar Washington Hospital Center (Washington, DC)*
- Shriners Hospital for Children (Cincinnati, OH)*
- Sentara Norfolk General Hospital (Norfolk, VA)*

* ABA Designated Burn Center: http://www.ameriburn.org/verification_verifiedcenters.php

Additional Trauma Triage Information

Virginia Office of EMS Trauma Web page: http://www.vdh.virginia.gov/emergency-medical-services/trauma-critical-care/

Centers for disease Control and Injury Prevention
CDC Field Triage Guidelines: https://www.cdc.gov/mmwr/pdf/rr/rr6101.pdf
CDC Field Triage PowerPoint: https://stacks.cdc.gov/view/cdc/23038/Share

American College of Surgeons – Committee on Trauma
http://www.facs.org/trauma/index.html

Western Virginia EMS Council – See Performance Improvement Website Section
www.wvems.org