

# 2010 Trauma Report

*Good Samaritan Hospital Emergency Services Annual Report to Our Community*

## Just in Time for Christmas, Tyrin Daniels is back to being a cowboy

The month of December often finds us surrounded by friends and family, giving and receiving gifts, baking and decorating for the holidays. It also provides time for reflection on the year's many blessings. For one northcentral Nebraska family, the hustle and bustle of holiday preparations were halted by the quick turn of events on December 15, 2010.

For Roni and Nuly Daniels, their son Tyrin and Tyrin's grandfather Chuck Daniels, the day was progressing as any other "normal" day on the ranch in Ainsworth. Loading calves to haul to the sale barn was one of the activities of the day. Nuly and Chuck were loading calves onto a semi-truck, while four-year-old Tyrin watched from behind a metal gate. During this process, one 750-pound calf turned back and ran full-force into the metal gate that Tyrin was standing behind. The calf hit the gate so hard that he bent it in the middle and bent the latch so the gate swung open and hit Tyrin.



He was facing the gate with his head turned to the side; the gate hit him in the side of the head, slamming the other side of his head into the frozen ground, rendering him unconscious. Tyrin's dad and grandfather quickly rushed to his side.

*"Cowboy" continued on page 4*

Healthcare you can *believe in.*

† CATHOLIC HEALTH  
INITIATIVES

**Good Samaritan Hospital**

Kearney, Nebraska

[www.gshs.org](http://www.gshs.org)

*The medical center, centered on you.*

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## Drill Puts Wheels in Motion for Back-Up Communications Center

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On April 15, 2010, Good Samaritan Hospital (GSH) participated in a community-wide disaster drill made possible by a federal grant. The exercise was based around a mock explosion that specifically tested GSH's policies and procedures for a mass influx of patients.

Following the disaster drill, Good Samaritan Hospital joined other community agencies in identifying areas for further development and worked through the drill's other intended purpose—improving processes that aren't used every day. Currently, GSH is working to revise the triage tag system used by our EMS service and those of surrounding communities. Vests in an array of colors have also been purchased to help differentiate the many departments responding to the Emergency Department (ED) during a disaster to further reduce confusion.

Another urgent need identified in the drill was a back-up communication center in the event of a disaster that affects our ED. The day-to-day communication center at GSH is located within the ED, but the drill quickly demonstrated that a mass influx of

patients creates increased phone and radio traffic as well as foot traffic in the form of disaster responders. Due to the important role the communication center plays in these situations, it needed to be moved where there would be less commotion. Work had already taken place toward the implementation of such a center to support our GSH incident command center, but this drill demonstrated our need to finalize those plans.

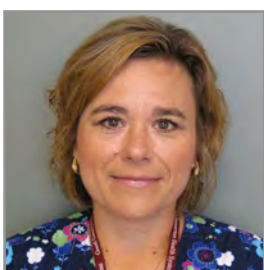
Final touches are now being made to a communication center in the basement of Good Samaritan Hospital. This center is designed to quickly become active and house both our hospital switchboard and Emergency Services communication specialists. The back-up communication center will become the hub of most incoming phone calls during a disaster as well as the location of our hospital's internal communications staff. Good Samaritan AirCare and our long distance ambulance service will be dispatched from this location, and it will also serve as a tertiary back-up communications center for some of the activities of the Buffalo County Communications Center if that need becomes necessary. Our back-up communication center is expandable and secured to allow for a multitude of potential needs and for prolonged activation.

In all, the April 2010 disaster drill was a tremendous learning experience not without its challenges. However, putting our response skills to the test in this community-wide exercise laid the groundwork for a better approach to an actual disaster. While we hope our community never experiences a disaster event, we hone our skills to ensure the best response if one arises.

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## Nebraska ENA Chapter Receives State Council Achievement Award

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**Karla Hosick, RN, BSN, CEN**, GSH's trauma nurse coordinator, also serves as the president of the Nebraska Emergency Nurses Association State Council, that received the ENA State Council Achievement Award on February 25, 2011, in Portland, Ore., at the national ENA Leadership Conference. The Nebraska Council was recognized for their efforts to effectively network among members, promote professional development for members, and conduct its affairs in a sound business manner. Congratulations to Karla and all the members of the Nebraska ENA State Council!

## Safe Kids Platte Valley Joins Cribs for Kids' Initiative

Good Samaritan Hospital Safe Kids Platte Valley became the first Safe Kids chapter in the state of Nebraska to enter into an agreement with Cribs for Kids®. Cribs for Kids® was established as a national infant safe sleep initiative in 1998.

Since 1998, through the donation of thousands of cribs, Cribs for Kids® has been making a positive impact on the rates of babies dying of Sudden Infant Death Syndrome (SIDS) and accidental suffocation. This safe-sleep education program was especially designed for low-income families to help reduce the risk of injury and death of infants due to unsafe sleep environments. Cribs for Kids® currently has more than 260 partner programs in 47 states throughout the country that provide a GRACO Pack N Play® crib, educational materials and other important safety tips to protect infants.



Good Samaritan Hospital Safe Kids Platte Valley program is coordinated by Karen Triplett. To learn more about the program, please contact Karen at 308-865-2011.

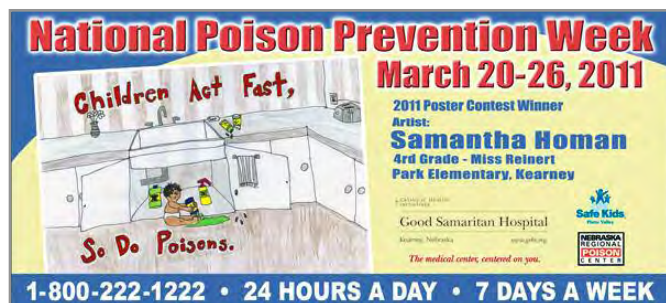
## Preventing Accidental Poisoning—One Poster at a Time

Every day in America, nearly 82 people die as a result of unintentional poisoning, another 1,941 are treated in emergency departments. Between 2004 and 2008, poisoning was the fourth leading cause of unintentional injury death in Nebraska.

The Nebraska Regional Poison Center is one of the first calls made when caring for an individual exposed to a poison. The center operates 24/7, and is staffed by a nationally certified team of registered nurses and physicians. Its primary function is to assess and quickly make treatment recommendations during poisonings.

National Poison Prevention Week, the third week in March, is designated to build awareness about accidental poisonings and how to prevent them. Congress intended this event for local communities to raise awareness of this all-too-common issue.

Good Samaritan Hospital also strives to reduce the number of injuries and deaths due to accidental poisonings by engaging young and old.



We partner with the Nebraska Regional Poison Center to host an annual poster contest. This contest is an optional activity for 3rd through 5th grade students; they are welcome to create a poster that conveys a safety message regarding poison prevention. The students' creations are sent to the Nebraska Regional Poison Center where a winner is chosen. The winning poster is then displayed on a billboard in our community during National Poison Prevention Week. This initiative gets the word out in two ways—the billboard serves as a visual reminder for passers-by, and the contest participants talk about poison prevention with their families.

Good Samaritan Hospital (GSH) Emergency Department cares for a variety of patients ranging from elderly to pediatric and medical to trauma. Children below the age of 16 accounted for 2,705 visits in 2010 compared to 2,877 visits in 2009. A decrease of 172 pediatric patients.

### GSH Emergency Dept. Visits

<b>2009:</b>	
Medical	10,624
Trauma	3,725
Outpatient	219
Direct Admit Hold	75
<b>Average per month</b>	<b>1,220</b>
<b>2010:</b>	
Medical	10,746 (+122)
Trauma	3,708 (-17)
Outpatient	247 (+28)
Direct Admit Hold	71 (-4)
<b>Average per month</b>	<b>1,231 (+11)</b>

### Average Length of Stay in GSH Emergency Dept.

<b>2009:</b>	
Treated & Released	1.58 hours
Treated & Admitted	2.74 hours
<b>2010:</b>	
Treated & Released	1.52 hours (-.06)
Treated & Admitted	2.69 hours (-.05)
<b>Average door-to-Doc</b>	<b>13.82 minutes</b>

## 2010 GSH Emergency Department Trauma Patients Admitted to GSH

Type Trauma	Age Groups						Total
	0-15	16-30	31-45	46-60	61-75	76+	
4 Wheeler/ATV	5	4	5	4	4	1	23
Accident	25	23	20	28	9	7	112
Accidental GSW							*
Animal	4	2	0	3	0	1	10
Assault	2	6	5	4	0	0	17
Bicycle							*
Burn							*
Fall	41	10	22	68	75	231	447
Horse	3	5	1	4	6	0	19
Machine							*
MVC	8	42	18	24	12	8	112
Motorcycle	1	10	1	1	1	0	14
Pedestrian/MVC							*
Power Saw							*
Sports							*
Stab Wound							*
Others*	8	9	7	5	2	1	32
<b>Totals</b>	<b>97</b>	<b>111</b>	<b>79</b>	<b>141</b>	<b>109</b>	<b>249</b>	<b>786</b>

\* to protect patient confidentiality traumas with less than 10 patients are not individually listed, however, they are included in the final total as others

## Back to Being a Cowboy *continued from page 1*

When he didn't respond after a few minutes, they scooped him up and drove him to Brown County Hospital in Ainsworth 22 miles away. Twenty-two miles is normally a short ride into town, but for this father on this day, it was one of the longest rides of his life.

Tyrin was quickly assessed and treated in Ainsworth, where staff rapidly determined that he would need transport to Good Samaritan Hospital (GSH) via their AirCare helicopter. He had suffered a traumatic brain injury that left him semi-conscious and unable to cooperate or follow directions. By this time, Tyrin's mom was also by his side and accompanied him to GSH.

Prior to Tyrin's arrival at GSH, the trauma team was assembled and waiting. They performed another rapid assessment and Tyrin received a CT scan within 14 minutes of his arrival. Indeed, he had suffered an injury to his brain as well as fractures to his skull that would require surgical intervention and placement on a ventilator. Receiving this news from the physicians, his parents were extremely calm and determined to be strong and think positively for their son. Their valiant efforts at maintaining their composure and strength are a testimony to the strength and will they passed onto their son for his recovery.



# Burn Wound Guide

*An educational tool compliments of Good Samaritan Hospital in partnership with Saint Elizabeth Regional Medical Burn Center. Designed to detach from this report for reference and/or posting in your work area.*

## Complex Wound Management

*All burn case photos compliments of Saint Elizabeth Regional Medical Burn Center, Lincoln, NE.*



Stomach Burn



Infected Stomach Burn

**Necrotizing Fasciitis** is a life-threatening infection of subcutaneous tissue and fascial planes and can result from minor trauma or in surgical wounds.



Buttocks Ulcer



Leg Ulcer

**Lower Extremity Ulcers** can be caused from either cardiovascular insufficiency or poorly controlled diabetes— or a combination. Often what you see is minor compared to the total damaged tissue.



Legs with TENS



Flame Burn—Before Debridement



Flame Burn—After Debridement

**Toxic Epidermal Necrolysis (TENS)** is a life-threatening skin disorder characterized by blistering and peeling of the skin. This condition can be caused from a drug reaction, but in a third of the cases there is no identifiable cause.

# TELETRAUMA CONSULT WITH BURN CENTER

## AIRWAY

### Assess Inhalation

Indications include:

- ◆ Sputum with carbon particles
- ◆ Hoarseness
- ◆ Air hunger
- ◆ Singed nasal/facial hair
- ◆ Burns involving face or neck

### Breathing

If breathing seems to be compromised by tight extensive chest burns, consult Burn Center immediately!

### Circulation

Assess cardiac status

- ◆ Assess peripheral pulses frequently—consult Burn Center immediately if pulses change or diminish

### Disability

- ◆ Most burn patients are alert and oriented—if not, determine cause of CNS impairment
- ◆ Expose and examine the entire body for injury

# EMERGENCY BURN CARE

## FLUIDS

- ◆ Determine percent of burned [TBSA]—first degree burns are not included in estimation + Rule of nines + Berkow chart

- ◆ Obtain IV access
- ◆ Initiate fluid resuscitation, consult Burn Center for help:

### PARKLAND FORMULA

$$\begin{aligned} & - (2-4\text{ml of LR}) \\ & \times (\text{weight of pt in kg}) \\ & \times (\% \text{ TBSA burned}) \\ & = \text{amount of fluid given in} \\ & \text{1st 24-hours post-burn} \\ & (1/2 \text{ of this amount is given in} \\ & \text{the first 8 hours after burn}) \end{aligned}$$

- ◆ Assess urine output
- ◆ Insert Foley catheter in patients with burns >25% TBSA

## WOUND MANAGEMENT

- ◆ Use a clean, dry sheet or dressing—no wet dressings (they can cause hypothermia in large burns)
- ◆ Tetanus status—give booster if not current in last 5 years
- ◆ For pain control, give morphine—consider sedation also

† CATHOLIC HEALTH INITIATIVES

Saint Elizabeth Regional Medical Center

Burn and Wound Care Center®

† Good Samaritan Hospital

# REFERRAL CRITERIA of the American Burn Association

Burn injuries that should be referred to a burn unit include the following:

- ◆ Second degree burns greater than 10% total body surface area (TBSA)
- ◆ Burns involving the face, hands, feet, genitalia, perineum and major joints
- ◆ Electrical burns including lightning injury
- ◆ Third degree burns in any age group
- ◆ Chemical burn
- ◆ Inhalation injury
- ◆ Burn injury in patient with preexisting medical disorders that could complicate management, prolong recovery or affect mortality
- ◆ Any patient with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient may be treated initially in a trauma center until stable before being transferred to a burn center.
- ◆ Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
- ◆ Hospitals without qualified personnel or equipment for the care of children should transfer children with burns to a burn center with these capabilities. Burn injury in patient who will be requiring special social/emotional and/or long-term rehabilitative support, such as cases involving suspected child abuse, substance abuse, etc, should be transferred to a burn center.

## REFERRING HOSPITAL

Trauma patient presents to Emergency Department

Teletrauma educational reference or video report desired  
Obtain consent from patient  
Turn on power to camera and monitor

## Call 1-800-877-2876

Saint Elizabeth Regional Medical Burn Center has two burn surgeons available for consultation

Request Teletrauma Educational References:

- ◆ Your name
- ◆ Facility name
- ◆ Phone number
- ◆ Patient name
- ◆ Patient DOB
- ◆ Report when MD is in attendance

Discuss patient assessment and known injuries.

For interventions, guidance must be provided by burn surgeon.

## Disposition:

- ◆ Decision to transport to trauma center—call appropriate transportation service. Call terminated when patient transported or guidance no longer required.
- ◆ If patient is to be transferred, call registration desk at 402-219-7121 and provide patient's name, DOB, and disposition. Fax face sheet to 402-219-8773.

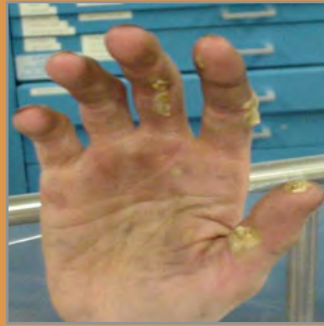
**Good Samaritan Hospital's trauma team is always available for teletrauma consults, just call 1-800-474-7911.**

For questions or more information about teletrauma at GSH, call Karla Hosick, trauma nurse coordinator at 308-865-7684 or Dr. Pam Westerling, ED medical director at 308-865-7512.

## State-of-the-Art Burn Wound Management



Chemical Burn—cement work



Electrical Burn-Hand



Electrical Burn-Foot

### Electrical Burns

What you see on the surface of the skin may not accurately reflect the total injury. You should consult the Burn Center with all electrical injuries.



Foot Burn



Arm Burn



Partial Thickness Scald-Before



Partial Thickness Scald-After

## Nebraska Catholic Health Initiatives Organizations Form Single System

Catholic Health Initiatives (CHI), a national nonprofit health organization, operates in 19 states and includes 73 hospitals, 40 long-term care, assisted- and residential-living facilities and home health agencies. Four of those hospitals are in Nebraska, and have operated independently of one another since Catholic Health Initiatives was formed in 1995.

With changes in healthcare on the horizon, the leaders of those four hospitals—Good Samaritan (Kearney), Saint Elizabeth (Lincoln), Saint Francis (Grand Island) and St. Mary's (Nebraska City)—recently came together as one health system to serve a large region of Nebraska and Kansas residents. The new organization also includes

The Physician Network, a group of 140 physicians, and HealthConnect at Home, a home health agency.

By forming one organization, this becomes the second largest healthcare organization in Nebraska. The advantages are many:

- ◆ It is easier to share best practices and service line expertise with each other.
- ◆ We can care for more patients while at the same time reducing costs for those patients by reducing duplication of work.
- ◆ We can develop statewide service lines that improve Nebraskans' access to high quality healthcare. Staff from the six entities are already working together to improve care across the state for cancer, cardiac and strokes.



### A call to 1-800-474-7911 does it all!

Good Samaritan Hospital services can be even closer to you and your patients. One call truly does it all—connecting you with teletrauma, Physician referral, AirCare transport, ambulance transport and patient placement at Good Samaritan Hospital. And now with FREE direct dial phones, caregivers can reach a member of the Good Samaritan trauma team by simply picking up the receiver.

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## Welcoming New Emergency and Pediatric Physicians

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**Dr. C.L. Bosley,**  
*Emergency Medicine*

In February 2011, Good Samaritan Hospital warmly welcomed Craig L. Bosley, MD as the newest addition to our Emergency Department staff. Dr. Bosley earned his medical degree at the University of Colorado Medical Center in Denver. He is board certified in emergency medicine

and spent the past 30 years as an emergency physician at Portneuf Medical Center in Pocatello, Idaho.



**Dr. A.J. Kratochvil-Stava,**  
*Pediatric Medicine*

In July 2010, Dr. Angela Kratochvil-Stava joined the Good Samaritan Hospital medical staff. Dr. Kratochvil-Stava received her undergraduate degree from the University of Kansas and her medical degree from UNMC in Omaha. She completed her residency at Creighton-Nebraska Universities Health Foundation in 2009, and joined Kearney Clinic's pediatrician group.

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## Trauma's Impact Necessitates Designated Care Systems

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**By Dr. L.E. Bragg,**  
*Trauma Medical Director*

According to the Centers for Disease Control and Prevention, about 116 million patients seek emergency care every year in the United States with almost 27 million visits attributed to injuries resulting from trauma. Trauma is the leading cause of death for younger people and is the fourth leading

cause of death overall. The cost of injuries to society each year, including both medical costs and loss of productivity, is in the neighborhood of \$500 billion.

Trauma Center designation requires that healthcare systems meet rigorous standards defined by the American College of Surgeons. Meeting these standards ensures that the emergency trauma center has the full range of specialists, nurses, ancillary personnel, and all the necessary equipment to take care of the severely injured patient. It's well established that trauma centers—like the Level II Trauma Center found at Good Samaritan Hospital—decrease morbidity and mortality for injured patients of all ages. The survival and remarkable recovery of Tyrin\*, and many others like him, illustrates how well emergency trauma systems work.

*\*See Tyrin's story on the front page of this report.*

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## Ensuring Advanced Trauma Care in Our Region

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**By Dr. D.M. Huebner,**  
*Orthopedic Trauma Medical Director*

Good Samaritan Hospital continues its role as lead hospital in Region III of the Nebraska Statewide Trauma System; I also serve as medical director for this region. In Region III, we have nearly reached our goal of designating all of the hospitals as Basic, General or Advanced Level Trauma Centers.

In fact, all but two have completed the initial designation process, which is active for four years. We are now beginning to re-designate hospitals. This ongoing process ensures that our region's hospitals remain up-to-date so we can bring the region cutting-edge trauma care. I am pleased to report that Good Samaritan also takes a leading role in trauma education and performance improvement with the regional hospitals.

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## Performance Improvement—Massive Transfusion Protocol (MTP)

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Massive transfusion is defined as replacement approximating or exceeding the patient’s blood volume within a 24 hour interval. In children, it can be viewed as the need for at least four units of blood within four hour’s time with continued hemodynamic instability in children. The purpose for adopting a Massive Transfusion Protocol (MTP) is to expedite the rapid restoration of circulating blood volume and the prevention of coagulopathies and other complications associated with hypovolemic shock.

Considering this information, it is recommended that all trauma centers develop a protocol for transfusion of blood products of this magnitude. Working in concert with the blood bank, the existing protocol was revised utilizing recommendations from the latest literary publications. One of the recommendations that created the most change in our protocol was to transfuse fresh frozen plasma (FFP) and platelets simultaneously with the packed red blood cells (PRBCs), progressing to an addition of cryoprecipitate when in the later phase of the protocol.

Initiating our MTP occurs when hemodynamic instability persists after transfusion of four units of PRBCs and the trauma surgeon determines that hypovolemic shock is the source of the instability.



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### Back to Being a Cowboy *continued from page 5*

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Tyrin’s caregivers say there is no greater reward than seeing a critically injured patient fully recover.

Today, when asked how Tyrin is doing, his parents say he is back to being a cowboy “as if nothing ever happened.” They reflect on the care that Tyrin received in Ainsworth, Kearney and Lincoln, and acknowledge that it was nothing but top notch. They are particularly grateful for the AirCare and ICU staff, stating they were “an AMAZING group of individuals.”

And they are quick to mention Tyrin’s recovery when listing their many blessings—no matter what time of year. “Tyrin is and always will be our Christmas miracle.”

**The protocol is divided into four sections, physician order set includes:**

**1. Laboratory Studies**

*(a Clot to bank, Hgb & Hct, Platelet count, PT, PTT, Fibrinogen, and Ionized Calcium level)*

**2. MTP1**

*(includes 6 units PRBCs, 2 units FFP, 1 unit Platelets)*

**3. MTP2**

*(includes 4 units PRBCs, 2 units FFP, 1 unit Platelets)*

**4. MTP Add**

*(includes 4 units PRBCs, 2 units FFP, 1 unit Platelets and optional 2-5 packs cryoprecipitate)*

During the development of the protocol, a gap in communication between the laboratory and the staff attending to the patient was identified. This was addressed by identifying one person to communicate the physician orders to the laboratory, not only eliminating confusion, but multiple phone calls as well.

The trauma department was actively involved in driving this process, but all types of patients suffering from hypovolemic shock have the potential to benefit from this new protocol.

Good Samaritan  
*Emergency Services*

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Kearney, NE 68848-1990

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## 2011 Education

### Advanced Cardiac Life Support Classes (ACLS)

October 18 and 20, Initial Course  
October 19 and 20, Initial Course  
August 9, Renewal Course  
September 19, Renewal Course  
September 20, Renewal Course  
November 1, Renewal Course

### Pediatric Advanced Life Support Classes (PALS)

October 4 and 12, Initial Course  
October 5 and 12, Initial Course  
June 14, Renewal Course  
September 22, Renewal Course

### Neonatal Resuscitation Program (NRP)

September 15, Initial Course  
September 15, Renewal Course

### Trauma Nurse Core Course (TNCC)

September 28 and 29

### Advanced Trauma Life Support Course (ATLS)

September 30-October 1

### Emergency Care Workshop

Fall of 2011

### Maternal Child Education

Advanced Fetal Monitoring Course, October 19  
S.T.A.B.L.E Course, November 11

### EMS

Nebraska Statewide EMS Conference, July 15-17

### Coming in 2012

NEMSA Conference, January 14-15, 2012

## Region III Hospitals and Trauma Centers

Hospital Name	Trauma Center Level	Consultation Visit Status	Destination Visit Status
Ainsworth	Basic	Completed	Completed
Alma	Basic	Completed	Declined Renewal
Benkelman	Basic	Completed	Completed
Broken Bow	Basic	Completed	Completed
Callaway	Basic	Not Completed	Not Completed
Cambridge	Basic	Completed	Renewed 2010
Cozad	Basic	Completed	Completed
Franklin	Basic	Completed	Renewed 2009
Gothenburg	Basic	Completed	Completed
Grand Island	General	Completed	Renewed 2009
Holdrege	Basic	Completed	Completed
Kearney	Advanced	Completed	Renewed 2009
Lexington	Basic	Completed	Renewed 2010
McCook	Basic	Completed	Completed
Minden	Basic	Completed	Completed
North Platte	General	Completed	Completed
Ord	Basic	Completed	Renewed 2010
St. Paul	Basic	Completed	Renewed 2010
Valentine	Basic	Completed	Renewed 2010

Basic Level Trauma Center—The role of the basic trauma center is to stabilize, prepare and transfer all patients with potentially life threatening injuries.

General Level Trauma Center—The role of the general trauma center is to provide initial evaluation and stabilization (surgical if appropriate), to provide general medical and surgical inpatient service to those patients who can be maintained in a stable or improving condition without specialized care. They also need to prepare and transfer patients meeting predetermined criteria to comprehensive or advanced centers.

Advanced Level Trauma Center—In addition to the capabilities of the levels above, the role of the advanced trauma center is to provide definitive care for complex and severe trauma. Emergency physicians and nurses are in-house, 24-hours a day, with personnel who can initiate surgery available. Neurological assessment and stabilization will be started immediately and a neurosurgeon is available. There is a broad range of specialists available for consultation or care, and comprehensive diagnostic capabilities and support equipment are available.

Comprehensive Level Trauma Center—The role of a comprehensive trauma center is to provide the highest level of definitive, comprehensive care for patients with complex traumatic injury. Personnel who can initiate surgery are in-house and immediately available. In addition to direct patient care, comprehensive trauma centers are also responsible for research, education and outreach programs for trauma. Appropriate equipment for pediatrics should be maintained in emergency departments, ICUs, and operating rooms for facilities at the general, advanced and comprehensive trauma center levels.

Please refer to the Nebraska HHS System Web site at [www.hhs.state.ne.us/ems/emstrauma.htm](http://www.hhs.state.ne.us/ems/emstrauma.htm) for more information about the statewide trauma system and how to become a trauma center.