ARKANSAS STATE BOARD OF HEALTH

Arkansas Department of Health
Trauma and Emergency Response Branch
Trauma Section

Deleted: Injury Prevention and Control

ARKANSAS TRAUMA SYSTEM RULES

Deleted: AND REGULATIONS

Promulgated Under the Authority of Act 559 of 1993
and Act 393 of 2009

Effective September 6, 2014
By the Arkansas State Board of Health
Arkansas Department of Health
Little Rock, Arkansas
Nathaniel Smith, MD, MPH, Director

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AUTHORITY

The following Arkansas Trauma System Rules and (hereafter referred to as the Rules) pertaining to the comprehensive, statewide trauma system are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by Act 559 of 1993, Ark. Code Ann. § 20-13-801 et seq. (The Trauma System Act), Act 393 of 2009, Ark. Code Ann. § 20-13-801 et seq. (An Act to Amend the Trauma System Act), and the laws of the State of Arkansas.

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SECTION I: DEFINITIONS/ACRONYMS

For the purpose of these Rules, the following terms are defined:

Abbreviated Injury Scale: An anatomic injury severity scoring system

ABEM: American Board of Emergency Medicine

ABMS: American Board of Medical Specialties

ABP: American Board of Pediatrics

ABS: American Board of Surgery

ACEP: American College of Emergency Physicians

ACGME: Accreditation Council for Graduate Medical Education

ACLS: Advanced Cardiac Life Support

ACLS-certified: Individuals certified by the American Heart Association in Advanced Cardiac Life Support.

ACOS: American College of Osteopathic Surgeons

ACS: American College of Surgeons

ACS COT: American College of Surgeons' Committee on Trauma

ADH: Arkansas Department of Health (used interchangeably with "Department" as described in Ark. Code Ann. § 20-13-803)

Advanced Pediatric Life Support Course: Jointly developed and sponsored by the American College of Emergency Physicians and American Academy of Pediatrics.

Advanced Trauma Life Support Course: A course certified through the ACS with a four year certification.

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AIS: Abbreviated Injury Scale

Alcohol screening and intervention: A method to screen trauma patients for risky alcohol use or abuse and a plan to assist patients with positive screens. Screening can be in the form of a consumption questionnaire or biological measurements. Assistance can be a provision of appropriate referrals or in-house intervention such as brief motivational interviewing.

~~Alpha~~ OPEN: Dashboard status in which trauma services are provided at a trauma center and open to EMS and transfers. This status only needs updating upon any changes to the system.

ALS: Advanced Life Support

Alternate pathway: ~~Criteria that shall be satisfied by a provider to be a member of a facility's trauma team in a specialty for which he/she does not hold Board certification. The alternate pathway is determined by the ADH and is specific to specialties. Facilities that wish to be designated with physicians who qualify for participation under the alternate pathway shall notify the ADH Trauma Section at least three months prior to the designation visit.~~
Criteria that shall be satisfied by a provider to be a member of a facility's trauma team in a specialty for which he/she does not hold Board certification. Applies to surgeons trained outside of US or Canada. Facilities that wish to be designated with physicians who request to participate under the alternate pathway shall notify the ADH Trauma Section at least three months prior to the designation visit. Alternate Pathway for General Surgeons requires 1) Currency in ATLS, 2) list of patients treated during the past year with accompanying Injury Severity Score and outcome data, 3) Performance improvement assessment by the trauma medical director demonstrating that the morbidity and mortality results for patients treated by the surgeon compare favorably with the morbidity and mortality results for comparable patients treated by the other members of the trauma call panel"

AMA: American Medical Association

AOA/HFAP: American Osteopathic Association/Healthcare Facilities Accreditation Program

AOBEM: American Osteopathic Board of Emergency Medicine

APLS: Advanced Pediatric Life Support

Arkansas Health Data Initiative: Established by Act 1035 of 2003 (Ark. Code Ann. § 20-8-401 et seq.), this initiative is designed to "serve as an access point for studies concerning state and federal health information, to inform and support Arkansas health policy officials." Act 1035 authorizes the Director of the Arkansas Center for Health Improvement to establish and maintain this program.

Arkansas Trauma Communications Center: The Arkansas Trauma System's patient transport coordination center for both prehospital emergencies and for interfacility transfers.

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Staffed with both Paramedics and RNs, it uses the AWIN network and dashboard to coordinate the transport of trauma patients to the closest, most appropriate trauma center or, if appropriate, the closest hospital (used interchangeably with "call center" as described in Ark. Code Ann. § 20-13-817).

Arrival Time: Arrival time is defined as the time that patient presenting by ambulance or helicopter physically enters the emergency department. It does not apply to arrival on the helipad or the EMS loading dock. For patients who are ambulatory and self-present, it is the time they are triaged in the ED. Similarly, departure time is the time that the patient physically leaves the department or the time of death.
Comment: Would like time of presentation to the hospital to be Arrival for all modes of arrival.
After further discussion: **Arrival time is the earliest documented time the patient presents to the ED. It does not apply to arrival on the helipad or the EMS loading dock. Regarding direct admissions enter time patient was admitted to the hospital.**

Asystole: Absence of spontaneous cardiac activity.

ATCN: Advanced Trauma Care Nursing

ATLS: Advanced Trauma Life Support

ATCC: Arkansas Trauma Communications Center

Audit filters: State audit filters are tools that assist with monitoring the process of care relative to standards of care.

AWIN: Arkansas Wireless Information Network

Backfill agreement: A formal, signed agreement between EMS providers with cross-jurisdictional (adjoining county) provision of emergency services from one service to another when existing resources are, or may be, inadequate or depleted.

Basic Life Support: Transportation by ground ambulance vehicle, provision of medically necessary supplies and service, and the provision of BLS ambulance services.

- ***Basic life support (BLS) personnel*** means that the ambulance shall be staffed by an individual who is qualified in accordance with state and local laws as an Emergency Medical Technician (EMT). These laws may vary from state to state. For example, only in some states is an EMT permitted to operate limited equipment on board the vehicle, assist more qualified personnel in performing assessments and interventions, and establish a peripheral intravenous (IV) line.

BLS: Basic Life Support

Board: The Arkansas State Board of Health as provided for in Ark. Code Ann. §20-7-102.

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Board-certified: Physicians certified by appropriate specialty Boards recognized by the ABMS or the AOA.

Board-eligible: The time a candidate has from the end of training to successfully complete a certifying examination. This period is defined by the specialty Board.

~~**Bravo**~~ **Delay:** Dashboard status in which the particular trauma service is provided but the trauma center is at capacity – delay is possible. This status reverts to ~~Alpha~~ Open every two hours and shall be updated by the trauma center if necessary. This represents a capacity rather than a capability issue.

Bypass: Transport of a trauma patient past a receiving trauma center normally used by the EMS provider for the purpose of accessing more readily available or appropriate medical care.

CCRN: Critical Care Registered Nurse

CD: Compact disc

CDC: Centers for Disease Control and Prevention

CE: Continuing education

Centers for Disease Control and Prevention: A federal agency committed to epidemiological surveillance and control of disease processes, particularly those secondary to infection or trauma, and prevention.

CEO: Chief Executive Officer

~~**Charlie**~~ **Not provided:** Dashboard status in which the particular trauma service is never provided at the trauma center. This is a capability rather than a capacity issue. This status never needs updating unless the center begins offering the service.

~~**Charlie Temp**~~ **No Capability:** Dashboard status in which the particular trauma service is normally provided at the trauma center but is temporarily unavailable. This status shall be updated by the trauma center when capability returns to normal. This represents diversion and is characterized by a change in capability rather than capacity.

CME: Continuing medical education

CMS: Centers for Medicare and Medicaid Services

Closed: Dashboard status in which a trauma center has a major internal emergency (structural damage, environmental or utility problems, etc.) and cannot accept any patients including self-referrals or by private vehicle.

Communications system: A collection of individual communication networks, such as

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transmission systems, relay stations, and control and base stations capable of interconnection and interoperation that are designed to form an integral whole. The individual components shall serve a common purpose, be technically compatible, employ common procedures, respond to control, and operate in unison.

Comorbidity: An underlying process present prior to the injury that contributes to the morbidity of the injury and may affect triage decisions. Examples are significant cardiac, respiratory, or metabolic diseases that stimulate the triage of injured patients to trauma centers.

Continuing Medical Education: Defined educational activities for practicing physicians, often resulting in approved credit hours from the AMA, AOA, state medical society, state osteopathic medical association, a medical school, or a hospital.

COO: Chief Operating Officer

~~**Core Surgeon:** On-call panel of surgeons taking greater than 60% of current trauma calls within their specialty. Responsible for all credentialing requirements within their specialty, including at least 50% attendance at Trauma Peer Review Committee meetings.~~

Credentialing: Approval of a physician as a member of the trauma team based on a review of the individual's training and experience by the TMD and the appropriate service chief.

CRNA: Certified Registered Nurse Anesthetist

CT: Computed Tomography or CT Scan

Dashboard: An up-to-date, live computer screen depiction at the ATCC of the capability and capacity to deliver trauma services of:

- every designated trauma center in the Arkansas Trauma System and,
- those hospitals that are "in pursuit of designation."

~~**Delta:** Dashboard status in which the particular trauma service is provided but is at capacity and resolution (e.g., return of services availability) is not expected for at least 12 hours. This represents diversion and is a capacity rather than a capability issue.~~

Demonstrated commitment: Provision of evidence (visible and written) that clearly demonstrates an institution wide commitment to trauma care.

Designation: The process by which a hospital is identified by the ADH as an appropriate trauma center to receive traumatically injured patients.

Desirable characteristic: A component of the trauma center care standards, the presence or availability of which is encouraged but not required for designation.

Disaster: Sudden event with a variable mixture of injury to or sickness of human beings,

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destruction or contamination of property, overwhelming demand on local response resources, and/or disruption of organized societal mechanisms.

Diversion: A procedure put into effect by a trauma center to ensure appropriate patient care when that center is unable to provide its usual and expected capability and capacity, either on a permanent or temporary basis.

Early consultation: "As early as the need is recognized"; the expectation is that if the trauma panel member is requested to be at the bedside, he/she will respond to the bedside within 30 minutes.

ECHO: Echocardiogram

ED: Emergency Department

EM: Emergency Medicine

Emergency Medical Services: The transportation and medical care provided the ill or injured prior to arrival at a medical facility by a certified emergency medical technician or other health care provider. Continuation of the initial emergency care within a medical facility subject to the approval of the medical staff and governing board of that facility (Ark. Code Ann. § 20-13-202[9]).

Emergency Nurse Pediatric Course: Developed and sponsored by the ENA which covers the knowledge and skills necessary for the initial nursing assessment and management of pediatric patients in the ED.

EMR: Electronic medical record

EMS: Emergency Medical Services

EMS Provider: An individual licensed by the ADH's Section of EMS to include, without limitation, EMT, Advanced EMT, Paramedic, and EMS Instructor.

EMTALA: Emergency Medical Treatment and Active Labor Act (42 U.S.C. §1395dd)

ENA: Emergency Nurses Association

Encounter Form: The patient care record approved by the ADH's Section of EMS that fully describes all prehospital care provided. The encounter form shall be left with the receiving hospital at the time of transfer of care or no more than 24 hours after the transfer of care. This form shall include a patient narrative.

ENPC: Emergency Nurse Pediatric Course

ENT: Ear, nose, and throat

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ETT: Endotracheal tubes

Extrication: The services provided by the use of specialized equipment for the purpose of gaining access to, and ultimately extricating, entrapped patients.

FACS: Fellow of the American College of Surgeons

FACOS: Fellow of the American College of Osteopathic Surgeons

FAST: Focused Assessment with Sonography for Trauma

Field triage: Classification of patients according to medical need at the scene of a traumatic injury.

FTE: Full-time equivalent

GCS: Glasgow Coma Scale

General Surgery Residency Program: General Surgical postgraduate training approved by the ACGME or the AOA.

Glasgow Coma Scale: A scoring system that defines eye, motor, and verbal responses in the patient with injury to the brain.

Health Insurance Portability and Accountability Act (45 CFR Parts 160, 162, 164, as amended by the HITECH Act, 78 FR page 5566): Requires that health care organizations standardize patient health, administrative and financial data.

HIPAA: Health Insurance Portability and Accountability Act (see above citation)

Hospital criteria: Required or desirable characteristics that help categorize Level I, II, III, and IV trauma centers.

ICD: International Classification of Diseases

ICP: Intracranial pressure (often monitored in patients with severe injuries to the brain)

ICU: Intensive Care Unit

ICU Capacity: ICU has met capacity. The facility could "flex" and temporarily hold patients elsewhere to include self-presenting, by EMS, or Interfacility Transfers. TraumaComm MAY NOT contact a facility to request they receive an Interfacility Transfer; however they ARE still available for immediate surgical stabilization of self-presenting and EMS patients. System auto reverts to "Open" after 12 hours.
Comment: Facility has process to temporarily hold patients…remove the word Flex

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ICU Max: ICU has exceeded capacity and the facility CANNOT hold or admit ICU patients within the facility, to include self-presenting, by EMS or Interfacility Transfers. **This status DOES NOT auto revert to "Open" at any time, and must be done by the facility.** Hospitals in this category ARE still available for immediate surgical stabilization of self-presenting and EMS patients.
Comments: Recommend adding ICU max is closed to receiving transfers

Immediately available to the patient: Services provided by a trauma center that are in house 24/7.

Inclusive trauma care system: A trauma care system that incorporates various levels of health care facilities in a community in a system in order to provide a continuum of services for all injured persons who require care in an acute facility; in such a system, the injured patient's needs are matched to the appropriate hospital resources.

In-house: Physically present in the hospital

In-pursuit of designation: A hospital's status while it attempts, prior to its designation site survey, to become designated as a trauma center within the Arkansas Trauma System.

Injury: The result of an act that damages, harms, or hurts; unintentional or intentional damage to the body resulting from acute exposure to mechanical, thermal, electrical, or chemical energy or from the absence of such essentials as heat or oxygen (see Trauma).

Injury and Violence Prevention Section: The organization within the ADH responsible for development and promotion of injury prevention programs as set forth in Ark. Code Ann. § 20-13-818.

Injury control: Activities designed to teach decrease the burden of injury

Injury Severity Score: The sum of the squares of the AIS scores of the three most severely injured body regions.

Interfacility transfer: The transfer of a patient from one facility to another facility.

International Classification of Diseases: A standard coding system that includes all injuries and disease processes.

ISS: Injury Severity Score

IVP: Injury and violence prevention (used interchangeably with "injury prevention programs" as described in Ark. Code Ann. § 20-13-818)

Massive transfusion protocol: A written protocol required for Level I, II, and III trauma centers and desired for Level IV trauma centers. The massive transfusion protocol is used to

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identify and manage patients with significant blood loss who require ongoing resuscitation with blood components to maintain intravascular volume and hemostasis.

Mechanism of injury: The source of forces that produce mechanical deformations and physiologic responses that causes an anatomic lesion or functional change in humans. The circumstance in which an injury occurs such as sudden deceleration, wounding by a projectile, or crushing by a heavy object.

Medical control-direct: Direction to prehospital personnel provided by a physician or an authorized communications resource person under the direction of a physician.

Medical control-indirect: The establishment and monitoring of all medical components of an EMS system, including protocols, standing orders, education programs, and the quality and delivery of direct control.

Medical oversight: The assistance given to the TRACs by a physician or group of physicians designated by the TRAC to provide technical assistance in regional system planning

Mid-level practitioner: Physician assistant, RN or an advanced nurse practitioner. Mid-level practitioners may participate in the care of trauma patients. They may initiate trauma resuscitation and perform procedures as long as they are current in ATLS. The supervising physician shall meet the ATLS requirements described within this document. The supervising physician shall be notified of the arrival of trauma patients and be available for assistance. This process and resulting patient outcomes shall be reviewed through the trauma QI program.

Morbidity: The relative incidence of disease

Mortality: The number of deaths in a defined population in a defined unit of time typically represented as mortality rate.

MRI: Magnetic resonance imaging

Multiple or mass casualty triage: Specialized techniques of triage used when large numbers of injured patients are concentrated in one area.

Non-core surgeon: Not part of surgical trauma coverage, taking less than 40% of trauma call of a given specialty. Not responsible for QI meeting attendance, but is required to maintain CME and all other requirements within his/her specialty.

NSA: Non-surgical admission

Occasional failure to meet standards: A temporary or unforeseen circumstance in which a trauma center cannot meet a standard of care (as set forth in Sections VII and VIII) less than 5% of the time annually. This shall be monitored by the center's QI program.

OGME: Osteopathic Graduate Medical Education

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OMFS: Oral and maxillofacial surgery

On-call: Committed for a specific time period to be available and respond within an agreed amount of time to provide care for a patient in the hospital.

OPO: Organ Procurement Organization

OR: Operating room

ORIF: Open reduction internal fixation

Over-triage (two definitions):

- When the trauma team is activated at a level higher than required by the facility's criteria. Example: the facility's Level I criteria calls for activation for a patient with a GCS of < 9. The patient's condition by EMS report is a GCS of 12, yet the facility activates a Level I response.
- When the trauma team is activated appropriately according to the facility's criteria but the patient's condition does not require such services. Example: a facility activates a Level II for all patients in a rollover motor vehicle crash. This is an internal evaluation of appropriateness of the criteria.

PACU: Post-anesthesia care unit

PALS: Pediatric Advanced Life Support

Pediatric Advanced Life Support Course: Developed and sponsored by the American Heart Association and the American Academy of Pediatrics. This course covers the knowledge and skills necessary for the initial management of pediatric emergencies, including trauma.

Pediatric patient: ~~The state defines a pediatric patient as ≤15 years old (cut off at 15 years, 364 days) for the purpose of data collection.~~ Facilities have the discretion to define a pediatric patient differently for the purpose of admission to that facility. The facility is responsible for reporting capability to care for a pediatric patient, as defined by that facility, to the TRAC and to the ATCC. All facilities are required to provide emergency care within their capabilities to all patients regardless of age and shall be compliant with CMS/EMTALA regulations. For the purpose of data collection, ages 14 yrs and under will be monitored.

Recommendation change: pediatric definition to become less than or equal to 14 years old.
Rationale: align with ACS verification standards.
Comments: Opposed to defining pediatric patient. ACS has requirements for hospitals caring for ages 14yrs and under to ensure capability and capacity. But does not define pediatric age group. Recommend removal of pediatric patient definition.

Pediatric trauma center: A pediatric hospital fulfilling the criteria for comprehensive trauma care.

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Pediatric Trauma Score: An injury scoring system used in some centers caring for pediatric patients.

Pediatric trauma surgeon: Certified pediatric surgeon with a commitment to trauma or certified general surgeon with special training and documented CME relevant to pediatric trauma care.

PET: Positron emission tomography

PGY: Post-graduate year

Post-graduate year: Classification system for residents in post-graduate training. The number indicates the year they are in during the post-medical school residency program; for example, PGY 1 is one year after graduation from medical school.

Promptly available to the patient: Services provided by a trauma center that are available to the patient within 30 minutes of patient arrival or notification, whichever comes first.

Protocol: A written procedure to ensure standardization of care.

QI: Quality improvement

Regionalization: The identification of available resources within a given geographic area and coordination of services to meet the needs of a specific group of patients.

Rehabilitation: Services that seek to return a trauma patient to the fullest physical, psychological, social, vocational, and educational level of functioning of which he/she is capable, consistent with physiological or anatomic impairments and environmental limitations.

Required characteristic: A component of trauma center care standards that is required for designation.

Research: Clinical or laboratory studies designed to produce new knowledge applicable to the care of injured patients.

Response time: ~~Interval between notification and arrival of a general surgeon or surgical specialist in the ED or OR.~~ It is expected that the surgeon be in the emergency department at the time of patient's arrival, with adequate notification from the field. The response time is measured as the interval from the patient's arrival to the surgeon's arrival.
Comment: Further discussion. After further discussion, agreed with the change.

Resuscitation: The phase of trauma or specialty care where emergency life support treatment is provided to sustain vital bodily functions.

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Revised Trauma Score: A physiological scoring system, with high inter-rater reliability and demonstrated accuracy in predicting death. It is scored from the first set of data obtained on the patient, and consists of GCS, systolic blood pressure, and respiratory rate.

RN: Registered Nurse

RTS: Revised Trauma Score

RTTDC: Rural Trauma Team Development Course

Short Form: An abbreviated encounter form that is left at the receiving hospital at the time of transfer of care when a completed encounter form is not available. This form does not replace the requirement to provide a completed encounter form to the receiving hospital within 24 hours after the transfer of care.

Staff physician: A physician who is credentialed by a hospital to provide care; he/she may or may not be on the trauma call panel.

TAC: Trauma Advisory Council

TCRN: Trauma Certified Registered Nurse

TIR: Trauma Image Repository

TJC: The Joint Commission (formerly known as JCAHO)

TMCD: Trauma Medical Co-Director

TMD: Trauma Medical Director

TMR: Trauma Multidisciplinary Review

TNATC: Transport Nurse Advanced Trauma Care
Comment: Should be TPATC …. Transport Professional Advanced Trauma Course

TNCC: Trauma Nurse Core Course

TPM: Trauma Program Manager

TRAC: Trauma Regional Advisory Council

TRAC Medical Director: Physician appointed to provide medical oversight and technical assistance within a TRAC.

TRAC MD: TRAC Medical Director

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Transfer agreement: A formal, written agreement between trauma centers for the transfer and acceptance of trauma patients. ***Note: This is not a substitute for the EMTALA transfer forms***.

Trauma: A term derived from the Greek for "wound". For the purpose of these Rules, trauma is strictly defined as a blunt or penetrating injury and certain special considerations such as burns, age, use of anticoagulation medication, and pregnancy > 20 weeks.

Trauma Advisory Council: The body of individuals appointed by the Governor to advise, assist, and make recommendations to the Trauma Section concerning the development and operation of the statewide trauma system (Ark. Code Ann. § 20-13-807).

Trauma band: A wristband applied to trauma patients during transport to the ED or while being treated in the ED. Each band has a unique identifier consisting of an alpha-numeric seven character combination (example: A000001) that will serve as a patient identifier in the EMS and Trauma Registries.

Trauma call panel: The listing of surgeons and physicians assigned to provide trauma care, including date of coverage and alternate surgeons.

Trauma center: A specialized, licensed hospital distinguished by the immediate availability of physicians and equipment on a 24/7 basis to care for severely injured patients or those at risk for severe injury.

Trauma center designation: The process by which the Trauma Section identifies and verifies trauma centers' capability and capacity to care for severely injured patients within a trauma care system.

Trauma Image Repository: A centrally located server that stores images received from trauma centers which participate in the Arkansas Trauma System. The purpose is to share electronic images, such as CT scans, MRIs, X-rays, PET scans, ECHOs, and ultrasounds, with trauma centers where the patient is to be transferred for trauma care. The repository is a secure, Web-based program that allows the physicians and hospital staff access to patients' electronic images. The purpose of the repository is to provide instant electronic access to images so that definitive care can be delivered to the patient immediately upon arrival at the higher level trauma center. It also vastly decreases the likelihood that patients will need to be rescanned at the receiving facility.

Trauma liaison: The designated physician representative or their physician designee within a given specialty.

Trauma Medical Co-Director: Physician in a Level III trauma center designated by the institution and medical staff to coordinate trauma care when the TMD is not a surgeon. All qualifications, duties, and responsibilities required of the TMD are applicable to the TMCD.

Trauma Medical Director: Physician designated by the institution and medical staff to

coordinate trauma care.

Trauma Multidisciplinary Review Process: An active process, led by the TMD and TPM, with representation from all core surgeons, specialties, and services, who participate on the trauma team at the facility, which is authorized to establish, review, and improve the care of the injured. This process shall consist of two distinct committees:

- Trauma Program Operations Review Committee: composed of the full membership of TMR as stated above, that assesses, addresses, and corrects Trauma Program system issues.
- Trauma Peer Review Committee: composed of the TMD, other physician and non-physician members of the trauma service, and sub-specialist involved in patient care in a case under review, that examines sentinel events, including trauma deaths, in a system or hospital.

Trauma patient: The patient who presents with acute bodily injuries secondary to an external force requiring immediate intervention deemed necessary to preserve life and limb (see definition of Trauma). For statistical purposes, the definition will apply to the **traumatically injured patient** who:

- is admitted for observation for a period of time greater than 8 hours; or
- is admitted to the hospital; or
- is transferred to another trauma center; or
- expires.

Trauma Peer Review Committee: Composed of the TMD, other physician and non-physician members of the trauma service, and sub-specialist involved in patient care in a case under review, that examines sentinel events, including trauma deaths, in a system or hospital. The meeting must consist of at least two physicians that are involved in the care of trauma patients.

Trauma Program: An administrative unit that includes the trauma service and coordinates other trauma-related activities; for example, IVP, public education, CME activities, etc.

Trauma Program Manager: The RN who is responsible for the successful operation of the Trauma Program, including data abstraction, QI, internal and community education, and IVP efforts on behalf of the trauma center. The TPM may have other personnel resources to perform the above duties, but retains the ultimate responsibility for their success. The TPM may have a different title, depending on the organizational structure of the facility (such as trauma coordinator), but the FTE allocation and responsibilities remain the same.

Trauma Program Operations Review Committee: Composed of the full membership of TMR as stated above, that assesses, addresses, and corrects Trauma Program system issues.

Trauma Regional Advisory Council: The council formed within a trauma region that develops and oversees the region's trauma system plan, to include, without limitation, QI and IVP activities.

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Trauma Registry: A mechanism for the collection and analysis of trauma data from the trauma system. More specifically, a database of information, submitted to the Trauma Registry Section by the trauma centers, relating to the care of trauma patients as defined in these Rules. The information is used to evaluate the quality of care provided.

Trauma/Injury Severity Score: The likelihood of patient survival based on a regression equation that includes patient age, ISS, RTS, and the type of injury (blunt or penetrating).

Trauma Section: The organization within the ADH responsible for implementation of the trauma system per the Trauma System Act (Act 393 of 2009, Ark. Code Ann. § 20-13-801 et seq.).

Trauma service: The group of providers (physicians, mid-level practitioners such as physician assistants or nurse practitioners, and nurses) who are responsible for the care of the trauma patient and the trauma QI program in the trauma center. In some centers this includes the general surgeons and liaisons from the various specialties. In larger, tertiary facilities, this may be a separate team that provides only trauma care.

Trauma-Specific Internal Education: A facility may develop an internal education program related to trauma to include but not limited to educational meetings, in-service, case-based learning, educational conferences, grand rounds, internal trauma symposia, in house publications, web based education, and provision of articles from the trauma literature to be read by participants. This has to be a documented educational experience~~, not a routine peer case review meeting~~. CME awarded should be commensurate with the time spent in the activity and in line with national standards for such education. The program is responsible for monitoring the individual's participation in the program. This can be done through maintenance of certification questions, email read receipts, etc. by the learner. Facilities must have copies of applicable CME certificates. In the case of review courses, the facility must be able to demonstrate how many of the total hours are trauma-related.

Trauma system: An integrated network that ensures that acutely injured patients are expeditiously taken to facilities appropriate for their level of injury and receive the best possible care. Licensed ambulance services shall appropriately triage all traumatically injured patients using the Field Triage Decision Scheme: The Arkansas Trauma Triage Protocol . The lead EMSP will make the destination decision considering the ATCC recommendation, patient's condition, distance of travel, patient preference and system status.

Trauma team: A group of health care professionals organized to provide care to the trauma patient in a coordinated and timely fashion.

Triage: The sorting of patients in terms of priority, treatment, transportation, and destination, so that the patient can be transported to the most appropriate trauma center or, when appropriate, hospital based upon established criteria.

TRISS: Trauma Score/Injury Severity Score

Under-triage (two definitions):

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- When the trauma team is activated at a lower level than required by the facility's criteria. Example: the trauma center's Level I criteria calls for activation for a patient with a GCS of < 9. The patient's condition by EMS report has a GCS of 6, yet the facility activates as Level II response.
- When the trauma team is activated appropriately according to the facility's criteria but the patient's condition does not require such services. Example: a facility activates a Level II for all patients in a rollover motor vehicle crash. This is an internal evaluation of the appropriateness of the criteria.

SECTION II: ADMINISTRATIVE

A. Purpose

The purpose of these Rules is to establish the procedures and standards for a statewide, comprehensive trauma system in order to decrease morbidity and mortality which results from trauma.

B. The Board may conduct public meetings consistent with the Administrative Procedures Act (Ark. Code Ann. § 25-15-201 et seq.) to modify provisions of these Rules in order to meet state, regional, or community needs regarding trauma care.

C. All communications concerning these Rules shall be addressed to the Arkansas Department of Health, Trauma Section, 4815 West Markham, Slot 4, Little Rock, Arkansas 72205-3867 or emailed to: adh.trauma@arkansas.gov

D. Only providers currently meeting trauma grant deliverables are eligible to:

1. serve in an official capacity on the ~~TAC,~~ TRAC, or their committees; and,

2. receive supplemental funding, such as system enhancement, pay for performance, and special project funding.

SECTION III: PUBLIC INFORMATION AND EDUCATION

A. Purpose

Trauma is a preventable disease; therefore, public information and education are important components of the Arkansas Trauma System. ~~The Trauma and IVP Sections~~ The Trauma Section shall ~~provide easily accessible public information and~~ actively promote and encourage trauma system and IVP education throughout Arkansas. Recommended change -Potentially dictate volume of IVP per size of facility.

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Comment: Recommend no qualifier on volume

B. Information and Resources

~~The Trauma and IVP Sections shall utilize the ADH website and other appropriate means to provide public information and resources, post notices, and reference other documents and information relevant to trauma system and IVP providers.~~ The Trauma Section shall utilize the ADH website and other appropriate means to provide public information and resources, post notices, and reference other documents and information relevant to the trauma system.

C. Trauma Center Standards for Public Education and IVP

It shall be the responsibility of all designated trauma centers to implement public information and IVP programs as outlined in Section VII.

D. No hospital may represent itself as an Arkansas-designated trauma center ~~or advertise its expertise in the care of injured patients~~ without a certificate of trauma center designation from the ADH.

SECTION IV: PREHOSPITAL TRIAGE AND TRANSPORT

A. Purpose

Emergency care of the traumatically injured patient is best accomplished using an inclusive, multi-level trauma care systems approach. Triage, transport, and transfer protocols have been developed to ensure that trauma patients shall receive prompt and potentially lifesaving treatment.

B. Prehospital Trauma Treatment Standard

1. Assessment

Traumatically injured patients shall be appropriately triaged using the *Field Triage Decision Scheme: The Arkansas Trauma Triage Protocol* as defined in Section IV. C.

2. Initiate resuscitation

BLS interventions (establishment of patent airway, hemorrhage control, spinal immobilization, fracture immobilization, etc.) will be initiated by the EMS provider following ~~established state protocols~~ at least state minimum guidelines. If there are no state-mandated

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protocols established, the agencies shall follow local protocols.
Recommended change from EMS committee: Delete above paragraph And add - Resuscitation will be immediately initiated by the EMS provider following
established state ~~protocols~~ state minimum guidelines.
Comment: Remove word protocol and change to state minimum guidelines.

3. Rapid transport to the most appropriate trauma center, following contact with the ATCC ~~when appropriate~~ and their recommendations.
Recommended change from EMS committee: Rapid transport to the most appropriate trauma center, following contact with the ATCC.
Comment: need to include recommendation of ATCC. Further discussion
Patient transport will be initiated by the EMS provider following established guidelines using the *Field Triage Decision Scheme: The Arkansas Trauma Triage Protocol.*

4. Notify the receiving trauma center

~~Contact with the receiving trauma center shall be made at least 15 minutes prior to patient arrival. If transport time is less than 15 minutes, contact shall be made as far in advance of arrival as possible. An accurate description of the incident, injuries, current medical interventions based upon established protocols, and patient status will be relayed to the trauma center. Further management guidance will be requested from the receiving hospital medical control as required during transport. The trauma center shall monitor the state-mandated EMS channel and EMS unit in a timely manner.~~ Upon recommendation from the ATCC, contact with the receiving trauma center must be made immediately. For all major trauma patients ~~s~~, the ATCC shall make this contact for the transporting unit. An accurate description of the incident, injuries, current medical interventions based upon established ~~protocols~~ guidelines, and patient status will be relayed to the trauma center. Further management guidance ~~will~~ may be requested from the receiving hospital medical control as required during transport. The trauma center shall continuously monitor the state mandated EMS channel.
Recommended change: Further management "maybe" requested not "will" be requested.
Comment: accept 'may' rather than 'will'

5. Treatment during transport

~~Patient care shall follow established local protocols unless state-~~

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~~mandated protocols exist that address a specific issue.~~ Patient care must meet or exceed the state minimum guidelines for all trauma patients. ~~shall follow established local protocols unless state minimum guidelines exists that address a specific issue.~~

~~6. EMS providers shall not initiate transport procedures as set forth in the *Field Triage Decision Scheme: The Arkansas Trauma Triage Protocol* when the following patient conditions occur:~~

~~a. Decomposition~~

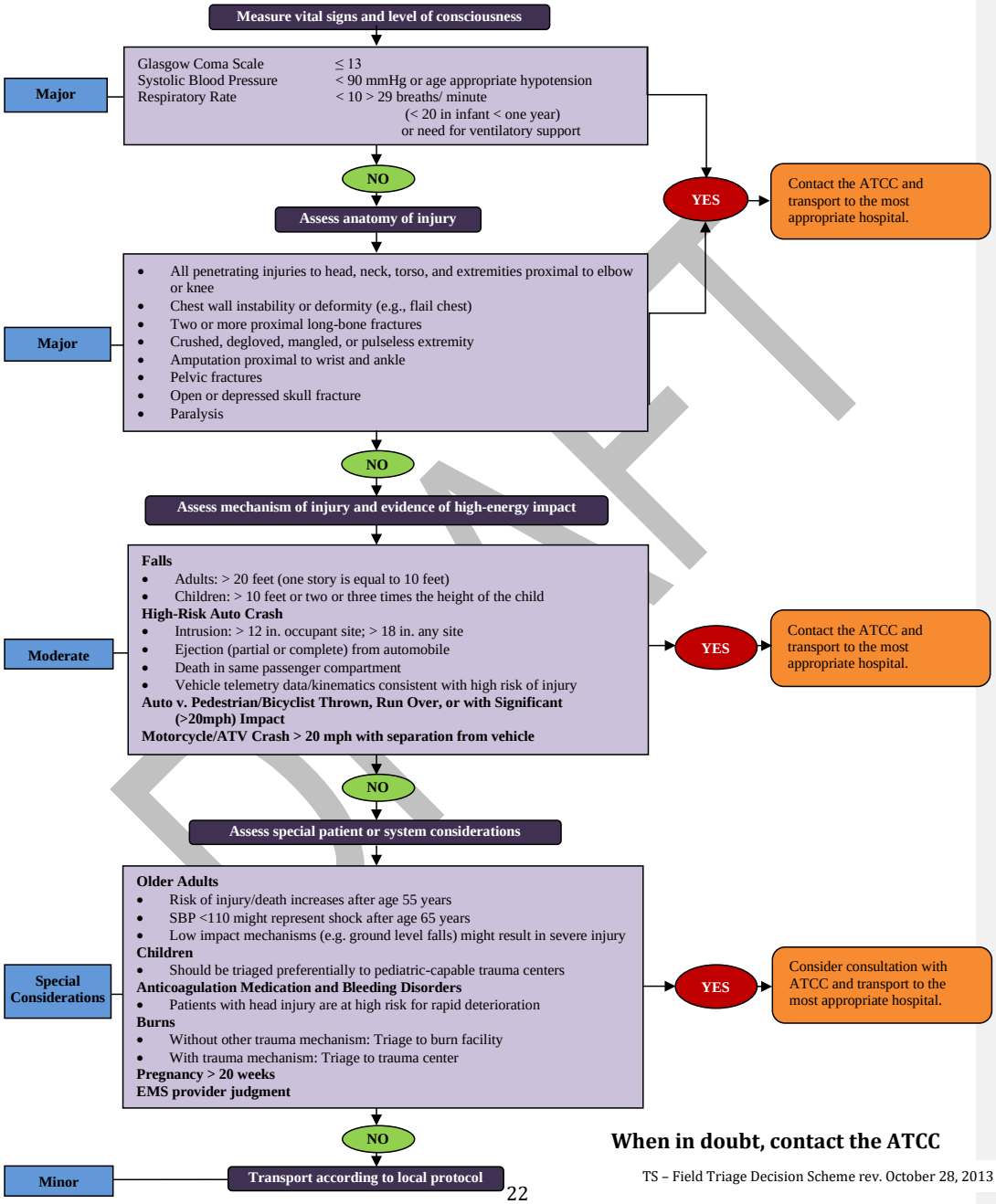
~~b. Rigor mortis~~

~~c. Normothermic asystole secondary to trauma (as determined by ALS providers only; does not apply to BLS providers).~~

~~These patients may be transported according to local protocol.~~

Recommended Changes to the Field Triage Decision Scheme:
For patients on anticoagulation medication and bleeding disorders will be elevated from special consideration to Moderate.
For older adults (age 65 and greater) SBP <110 and/or HR > 90 will be elevated from special consideration to Major
Comment: Recommend adding HR greater than 90 for older adults as a Major
*__Note__ that geriatric is referred to as > 65 (and not 65 and greater as listed above) in other areas of the rules and the prehospital field triage decision scheme. Need to make an update in all areas to be 65yrs and greater.

C. Field Triage Decision Scheme: The Arkansas Trauma Triage Protocol



When in doubt, contact the ATCC

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D. Trauma System Transport Standard

1. Patients meeting trauma criteria

   Patients who meet the trauma criteria as outlined in Section IV. C. shall be transported to the most appropriate trauma center based on ATCC recommendation unless:

   a. the EMS provider is unable to establish or maintain an adequate airway or control excessive hemorrhage; in these cases, the patient shall be transported to the nearest hospital able to provide the appropriate care; or,

   b. the ATCC recommends a specific trauma center and the patient refuses to be transported to that facility; in this case, the EMS provider shall fully inform the patient of the limited capacity and capability of the patient's chosen facility. The EMS provider has the discretion to transport the patient to the most appropriate trauma center to treat the patient's specific injuries (Act 553 of 2009, Ark. Code Ann. § 20-13-1003). Licensed ambulance services shall appropriately triage all traumatically injured patients using the Field Triage Decision Scheme: The Arkansas Trauma Triage Protocol . The lead EMSP will make the destination decision considering the ATCC recommendation, patient's condition, distance of travel, patient preference and system status. If the patient refuses to be transported to the ATCC recommended trauma center and the EMS provider decides to take him/her to the patient's facility of choice, the EMS provider shall document the patient's refusal. ~~Recommended Changes: 1)Pre-hospital triage major activation should conform with hospital major activation 2) Need to elude to prehosp report launching the level of trauma activation per the facility's criteria~~ 3) Would change wording of D. 1. b. Wording to "shall fully inform patient their chosen facility has not been recommended by ATCC "

   Comment: Do not support recommend changes 1 & 2 pre-hospital activation conforming to hospital activation. Agree with #3 recommendation regarding D. 1. b

2. Trauma bands shall be placed on all trauma patients who will be transported to a trauma center. Once applied to a trauma patient, the trauma band number shall be recorded on the patient care record.

~~3. An EMS provider shall complete a radio report to the trauma center at least 15 minutes prior to patient arrival. If transport time is less~~

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~~than 15 minutes, contact shall be made as far in advance of arrival as possible.~~
Recommended change from EMS committee: Remove above paragraph
Comment: Agree with EMS Committee regarding removal of #3

~~4. The EMS provider shall, at the time of transfer of care, leave a completed Encounter Form or a completed Short Form. If a Short Form is left with the receiving trauma center, the ambulance service shall submit a completed Encounter Form within 24 hours of transfer of care.~~ The EMS provider shall, at the time of transfer of care, leave a completed patient care record or a state approved Short Form. If a Short Form is left with the receiving trauma center, the ambulance service shall submit a completed patient care record within 24 hours of transfer of care.
Comment: Agree

~~5. An EMS provider shall maintain a minimum of two backfill agreements to be utilized in order to maintain service area coverage should the provider need to leave its service area for emergency trauma responses.~~ An EMS provider shall maintain mutual aid agreements to be utilized in order to maintain service area coverage should the provider need to leave its service area for emergency trauma responses.
Comment: Agree

EMS providers shall participate in all QI reviews that involve care provided by the EMS service. These may occur at any level of the trauma system (e.g., the trauma center, the TAC QI/TRAC Committee, or the TRAC QI Committee).

SECTION V: TRIAGE REQUIREMENTS FOR TRAUMA CENTERS

A. Purpose

The role of the Level I and Level II (comprehensive) trauma centers shall be to provide the highest level of definitive care for the severely injured adult and pediatric patient with complex, multi-system trauma. In the event of the availability of a specialized pediatric trauma center, the Level I or Level II centers may elect to arrange for transfer of care to that center for pediatric patients. Level I and Level II trauma centers shall have the capability of providing total patient care for every aspect of injury from prevention through the arrangement of rehabilitative services. The role of the Level III (general) trauma center is to provide initial evaluation and stabilization, including surgical intervention, of the severely injured adult or pediatric patient. Critically injured patients who require specialty care may be transferred to a higher level trauma

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center in accordance with established criteria. The role of the Level IV (basic) center is to provide resuscitation and stabilization of the severely injured adult or pediatric patient prior to transferring the patient to a higher level trauma center. ~~Recommended Change: All pediatric traumas should be taken directly to ACH via prehospital protocols unless hemorrhage or airway issues are a consideration. What are the "established criteria "that allow for transfer from level 3 trauma centers. Do all level 1 and 2 centers provide rehabilitative services to pediatric patients.~~

Comment: Do not agree with recommendation

B. Standards for Level I-IV Trauma Centers

1. ~~Prehospital (EMS) radio report~~ Prehospital Communication and ATCC Dashboard

   The trauma center shall monitor the EMS communications system at all times. ~~In the event of a trauma patient being transported, the EMS report shall be transmitted by the EMS provider to the ED of the receiving hospital 15 minutes prior to arrival at the facility. If transport time is less than 15 minutes, contact shall be made as far in advance of arrival as possible.~~ The trauma center is required to maintain an up-to-date, accurate, and complete representation of capability and capacity on the ATCC dashboard.

2. Implementation of a trauma activation protocol

   ~~Based upon the information received, the trauma facility triage nurse or other appropriate medical control officer shall activate the trauma activation protocol for that facility as outlined in Section V. C.~~ Based upon the information received, the appropriate emergency department staff shall activate the trauma activation protocol for that facility as outlined in Section V. C.

   Comment: Agree

3. Trauma patients not meeting the trauma triage criteria

   These patients shall undergo appropriate ED screening and evaluation as prescribed by state protocol and CMS/EMTALA requirements.

4. Re-evaluation of trauma patient and activation

   A trauma patient whose condition deteriorates or is found to have significant injuries not detected in the initial evaluation shall be reclassified, and the trauma team shall be activated.

5. Trauma patients requiring transfer shall be identified as soon as possible, and the ATCC shall be contacted for transfer as soon as it is evident that the patient's needs exceed the capability and capacity of the facility. Ongoing stabilization may be required following the request to transfer. A decision to transfer shall not be dependent upon a complete/partial patient workup.

6. A transferring hospital shall utilize telemedicine when requested to do so by the receiving facility or the ATCC.

C. Triage Standards for Level I-IV Trauma Centers

1. Receive the EMS provider radio report.

2. Use the predetermined multi-tiered activation plan to activate the trauma team based on prehospital information when available.

3. Assure placement of a trauma band on the patient (if not already placed on the patient by the EMS provider).

4. At a minimum, centers shall include in the highest level of activation criteria the following:

   a. confirmed hypotension (<90mmHg adults or age appropriate for children) attributed to trauma;

   b. GCS < 9 with a mechanism due to trauma (general surgeon response can be at the discretion of the ED physician) (for Levels I, II, and III); GCS < 13 with a mechanism due to trauma (for Level IV);

   c. respiratory distress attributed to trauma;

   d. gunshot wound to the neck, chest, or abdomen;

   e. transfer of a patient from another facility receiving blood or pressure support to maintain vital signs; and,

   f. any patient for whom the ED physician feels the highest level of activation is warranted.

5. Trauma patients who meet none of the above criteria shall undergo appropriate ED evaluation and management. The facility shall have a protocol in place for the rapid assessment and treatment of patients taking anticoagulant medication with injury above the clavicles.

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6. The highest level of activation must require activation of the entire trauma team including operating room (OR) and the general surgeon on call. The only exceptions to this is blunt force trauma with cardiac arrest (CPR in progress); ~~b.) An isolated head injury with a GCS <9 with a mechanism due to trauma (general surgeon response can be at the discretion of the ED physician) (for Levels I, II, and III); c.) An isolated head injury with a GCS <13 with a mechanism due to trauma (for Level IV). Respiratory distress attributed to trauma (if no other criteria for highest activation are met) does not require activation of the OR, but does require activation of the general surgeon on call.~~ Activation of the general surgeon and OR for hanging, drowning, isolated penetrating injury to the head and inhalation injury can be at the discretion of the Emergency Department (ED) physician.

Comment: would like to remove discretion of ED physician with GCS <9. Reword paragraph. Further discussion. Further discussion had, changes made as above.

D. High Risk Criteria for the Consideration of Early Transfer

(These guidelines are not intended to be hospital-specific.) The following patients, when identified, shall be given consideration for early transfer to a facility with specific expertise in their care:

~~1. Comorbidities~~

1. A trauma patient presenting with any one of the following ~~comorbidities~~ shall be considered a candidate for rapid transfer:

   a. age < 10 years or ≥ 55 years;

   b. patients taking anticoagulation with any head or brain injury; or,

   c. pregnancy when obstetrics monitoring is unavailable.

   Recommended Change: D. 1. a. To < 18 I'm not sure we need an upper age limit. I would define pediatric patients and "children and infants" by age
   Comment: do not agree with the recommended change

2. Burn patients

   A trauma patient presenting with any one of the following criteria shall be considered a candidate for rapid transfer to a specialized burn center (all centers transferring burn patients shall utilize telemedicine when requested by the burn center):

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a. second and third degree burns >10% body surface area in patients <10 years or > 50 years;

b. second and third degree burns >20% body surface area in other age groups;

c. second and third degree burns involving face, hands, feet, genitalia, or perineum, or which involve skin overlying major joints;

d. third degree burns > 5% body surface area;

e. high voltage electrical burns, including lightning injury;

f. significant chemical burns;

g. inhalation injury;

h. burn injury in patients with pre-existing conditions that could complicate management, prolong recovery, or affect mortality;

i. any burn patient in whom concomitant trauma poses an increased risk of morbidity or mortality may be initially treated in a trauma center until stable before appropriate transfer to a burn center;

j. infants and children with burns who were seen initially in centers without qualified personnel or proper equipment for burn care shall be transferred to a burn center with those capabilities; or,

k. burn injury in patients who will require special social and emotional or long-term rehabilitative support, including cases involving suspected abuse and neglect.

3. Pediatric patient

A hemodynamically unstable pediatric patient not responsive to standard resuscitative techniques mandates immediate operative intervention. Nonoperative care is safe only in an environment that provides both close clinical observation by a surgeon experienced in the management of childhood trauma and promptly available medical care. A pediatric patient presenting with any one of the following criteria shall be considered a candidate for rapid transfer to a facility capable of providing specialized pediatric care:

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a. GCS of ≤ 13 or GCS deterioration of two or more;

b. infants and children with injuries requiring complex or extensive reconstruction;

c. infants and children with polysystem trauma requiring organ system support;

d. infants or children who meet any of the adult transfer criteria as outlined in Section V. E.; or,

e. hemodynamically stable infants and children with documented visceral injury being considered for observational management.

E. Standards for Transfers between Trauma Centers

1. The decision to transfer an injured patient to a facility for specialty care in an acute situation shall not be based on the patient's ability to pay or insurance status.

2. Qualified physicians on-call for a facility shall participate actively in the assessment of an injured patient and in the decision to transfer based on the patient's best interest.
Recommended Change: This section needs work in my opinion. Urgent ill defined. Also we should require a conversation between like specialists/ "qualified physicians", ortho to ortho, CV surgeon to CV surgeon, etc ... see section E. 2. I would further define " participate actively " as requiring these conversations
Comment: Do not support recommended change

3. Conducting a hospital-to-hospital transfer

a. The sending ED shall contact and inform the ATCC of the need to transfer an injured patient.

b. The ATCC shall gather pertinent information.

c. The ATCC shall evaluate both sending and potential receiving facilities' dashboard status and compare this to the patient's needs.

d. The ATCC shall then contact the closest, most appropriate trauma center, considering all known factors, such as recent

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volume to the facility, the patient's actual needs, distance, and weather.

e. The ATCC shall facilitate the conversation between the sending and receiving trauma centers and will remain on the recorded line to provide needed assistance until the transfer is accepted.

4. Urgent trauma patient transfers

The need for an urgent trauma transfer exists when, in the opinion of the treating physician, the following two conditions are met:

a. the immediate needs of the patient cannot be met in the sending facility due to lack of capability or capacity; and,

b. the patient's condition is such that failure to meet the immediate needs will likely result in loss of life, limb, fertility, or permanent impairment that transfer to a higher level of care could potentially ameliorate.

The facility seeking the urgent trauma transfer shall contact the ATCC to provide patient condition information and to obtain concurrence with the urgent trauma transfer classification. All urgent trauma transfers shall prompt the involvement of the ATCC medical director in real time. The medical director shall verify the urgent nature of the transfer and concur there is reasonable evidence the two conditions of an urgent trauma transfer are met. If the above conditions are met and concurrence from ATCC is obtained, this transfer qualifies as an urgent trauma transfer.

Once the ATCC confirms the patient meets the criteria for urgent trauma transfer, the ATCC shall contact the EMS provider identified by the transferring hospital to coordinate pickup. The ATCC shall confirm with the transferring hospital the time the patient will be ready for pickup and communicate this information to the EMS provider. The sending hospital should contact the EMS provider designated on the ATCC dashboard early in the process to allow the provider as much advance notice as possible of the impending urgent transfer.

If the EMS provider cannot be at the transferring hospital by the agreed upon time, a backfill provider shall be contacted by the EMS provider. The backfill provider must be within the boundaries of the service area before coverage is considered in place. If the service is unable to secure a backfill agreement acceptance, the ATCC shall be

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available to assist with the backfill, but not assume responsibility. The EMS provider shall have ten minutes to accept the transfer request and shall arrive at the hospital at the time agreed upon between the transferring hospital and the EMS agency. The patient and paperwork should be ready for transfer at that time.

Recommended Change: If the EMS provider cannot be at the transferring hospital by the agreed upon time, the transferring hospital shall have the autonomy to contact other, qualified EMS providers to locate the EMS provider that can be at the transferring facility in the shortest amount of time in support of best practice for transferring the trauma patient. Rationale for change: In current state, it reads as if the first contacted EMS agency is somehow "guaranteed" the transfer as we, as the hospital, are now to wait on the EMS agency to work out their own backfill or staffing challenges. We have several EMS entities in our region, most of which are fully capable and qualified to take these transfers. We have also had some issues with "primary" EMS agency being very delayed in call backs to accept or decline transfer. (greater than alotted 10 minutes), we have also had much difficulty with EMS "accepting" a transfer, and then not arrive at hospital for the transfer sometimes as much as an hour and 51 minutes AFTER accepting the transfer. This is absolutely unacceptable for a trauma patient needing a higher level of care than we can currently provide. Re-writing this section will give the transferring facility more ability to call several EMS agencies in the region to find the one that can get the patient out in the shortest possible time. Our facility has absolutely no preference as to which EMS agency transports our trauma patients, we only want the first appropriate, qualified agency to be at our facility as quickly as is possible. Also, clarification on the 2 hour rule for all trauma transfers out. EMS have staffing issues like every other healthcare entity, and in an area with 2 large hospitals, there have been times that both facilities may have transfers waiting to go at the same time. If one hospital's transfer is in need of Neurosurgery and the other is a "stable" acetabular injury, BOTH facilities are forced to operate on the 2 hour mandate. This scenario, which is completely fictional, could potentially transport the acetabular fracture first, thus delaying the much more urgent neurosurgery pt.. Due to staffing, this could literally be a several hour delay. If hospitals could be given some concise guidance on differentiating "Urgent" vs. non"urgent" transfers out in regards to the 2 hour trauma transfer out rule, this would allow for medically appropriate decision making for the betterment of the trauma patient. But when all trauma centers are held to rigid 2 hour transfer out rule for every trauma transfer out, this can put unnecessary pressure on the EMS agency for transfer.

Comment: Accept this proposed change. Further discussion needed.

All urgent trauma transfer requests shall prompt a review at the local TRAC's QI Committee to ensure that the system is being used appropriately, that the urgent trauma transfer is accomplished in a timely manner, and that each segment of the system performed its responsibilities. Potential abuses of the system shall be elevated to the QI/TRAC Committee of the TAC for review and recommendation of action steps, if required, to the ADH in order to prevent future abuses.

5. Non-urgent trauma patient transfers

   If the transfer request does not meet the two criteria for an urgent transfer, yet the patient's injury requires a higher level of care, the transferring trauma center shall call the ATCC to coordinate

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acceptance with the receiving center. The transferring center shall notify its EMS provider and coordinate an appropriate time for patient pickup. The EMS provider shall have no less than one hour to arrive at the transferring facility. The transferring center shall have the patient ready for pickup by the agreed upon time.

SECTION VI: TRAUMA CENTER DESIGNATION

A. Purpose

Any hospital that desires authorization to provide trauma care services within the Arkansas Trauma System shall request designation from the Trauma Section. No hospital may be represented to the public as an Arkansas-designated trauma center unless that facility holds a certificate of trauma center designation issued by the ADH. Hospitals may choose to seek an additional trauma center designation offered by the ACS.

B. Trauma Center Designation Process

1. Application

Application for trauma center designation shall be made on forms provided by the ADH.

2. Site survey

Upon the review and approval by the Trauma Section of the application materials submitted pursuant to Section VI. B. 1., an on-site survey of the facility shall be scheduled. All costs associated with conducting an on-site survey shall be the responsibility of the applicant. The on-site survey shall be conducted based upon the standards described in Sections VII or VIII, as applicable. All requirements, including CMEs, meeting attendance (e.g., operations, peer review, TRAC), and certifications (e.g., TNCC, ATLS, RTTDC) shall be verified as met or not met at the time of the site survey visit. No additional documentation will be accepted after the visit and used in consideration of the determination of compliance with criteria. The survey team and the ~~TAC~~ Hospital Designation Committee of the TAC shall not consider any activities or certifications that may occur after the site survey. The survey team shall consist of members approved by the Trauma Section as outlined in Section VI. B. 3. The survey team shall submit a comprehensive report to the Trauma Section and the ~~TAC~~ Hospital Designation Committee. ~~which will review the findings and report its recommendation to the TAC. The TAC, in turn, shall submit the recommendation to the Trauma Section.~~ The Trauma Section shall review the survey findings, in

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conjunction with the recommendation, and issue a decision to implement one of the following options:

a. Full designation - Designation level requested by the applicant for a period of three years.

b. Provisional designation - Temporary approval issued for one year in which the hospital enjoys all the rights and privileges of operating as a designated trauma center. The facility is required to submit a corrective action plan to address the deficiencies within 90 days of the date of the designation letter to the Trauma Section for approval. It shall be the hospital's responsibility to correct the deficiencies and complete a focused review prior to the end of the provisional year.

   The focused review and subsequent approval process requires at least six weeks; therefore, the facility shall submit all paperwork and undergo an on-site visit (if one is required) at least six weeks prior to the expiration of its provisional designation at one year. All requirements, including CMEs, meeting attendance (e.g., operations, peer review, TRAC) and certifications (e.g., TNCC, ATLS, RTTDC) shall be met at the time of the site survey visit. There will be no automatic extension of the provisional designation while awaiting the outcome of a focused review. During the focused review, all deficiencies and weaknesses will be addressed by the review team. Additional deficiencies and weaknesses may be cited if discovered and verified during the focused review process. At the conclusion of the provisional term, if the facility has not met the ADH's requirements, the provisional designation shall be revoked and the facility shall reapply for trauma center designation.

   At the conclusion of the first provisional approval, the facility may request, and the Trauma Section may consider, a second and final provisional approval for up to one year. Consideration will be given to facilities for which the failure to meet the corrective action prescribed is beyond their immediate control. At the conclusion of the second provisional term, if the facility has not met the ADH's requirements, the provisional designation shall be revoked and the facility shall reapply for trauma center designation.

   A hospital that is not designated cannot represent itself as a trauma center but may apply to be "in-pursuit of designation"

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with an action plan in place approved by the Trauma Section. It does not have to repay previously received funding but is not eligible for continued funding unless designated at a later date. Recommended Change: and may be placed on the ATCC dashboard if deemed appropriate by ADH trauma section Comment: Do not agree with recommended change

c. Designation at a different level - Full or provisional designation at a different level of designation as recommended by the Trauma Section based upon the facility's current capabilities as determined by the Trauma Section's review of the on-site survey.

d. Approval denied or suspended/revoked - The facility shall resubmit a new application. This cannot be done earlier than six months after the denial or suspension/revocation. The facility has the option to designate at a lower level with the approval of the ADH at the time of suspension/revocation.

If an application for designation is denied or not approved at the desired level, please see Section VI. C. for the appeal process.

3. Trauma center site survey team

a. Purpose

As part of the trauma center designation process, following a successful application, an on-site survey of the prospective trauma center shall be conducted to evaluate the quality of the applicant's compliance with the standards outlined in Sections VII and VIII.

The survey of hospitals for trauma center designation shall include interviews with designated hospital staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary to assure compliance with the requirements of the Rules set forth in this document. The cost of the site survey shall be paid by each applicant hospital or renewing trauma center unless otherwise stated by the Trauma Section.

b. The survey team will be selected by the Trauma Section and consist of individuals who are disinterested both politically and financially from the facility to be surveyed. Each team member shall have past experience and/or special training related to trauma designation site surveys.

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c. The following individuals shall comprise the survey team. As noted in Section VI. B. 3. d., the actual composition of the team is dependent upon the level of trauma center designation sought by the hospital.

1) General surgeon (pediatric surgeon for pediatric specialty facility) who currently works in a designated trauma center and who is a FACS or a member of the ACOS.

2) Emergency physician (pediatric emergency physician for pediatric specialty facility) who currently works in a designated trauma center and who is Board-certified in EM or approved by the Trauma Section.

3) ~~TPM who is a RN with responsibility for monitoring and evaluating nursing care of trauma patients and for the coordination of the QI and patient safety programs of the trauma center in conjunction with the TMD.~~ An RN with TPM with responsibility for monitoring and evaluating nursing care of trauma patients and for the coordination of the QI and patient safety programs of the trauma center in conjunction with the TMD
Comment: RN with TPM experience currently working in a designated trauma program and involved in the care and/or oversight of trauma patients

4) Trauma Section representative who has a regular working relationship with the TAC.

d. The survey team shall be comprised of the following for the designation levels set forth below:

1) Level I - two physicians, one of whom shall be a surgeon, a TPM, and a Trauma Section representative. The majority of the clinical review team shall be out-of-state reviewers;

2) Level II - two physicians, one of whom shall be a surgeon, a TPM, and a Trauma Section representative. At least one member of the clinical review team shall be an out-of-state reviewer;

3) Level III - one physician, one TPM, and a Trauma Section representative. Both clinicians may be from within the state but shall be from another region(s) of the state; and,

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4) Level IV - one physician or one TPM and a Trauma Section representative. The clinician reviewer shall be from another region of the state.

In the event that in-state reviewers are not available, out-of-state reviewers may be substituted at the facility's cost.

e. All team members, with the exception of the Trauma Section representative, shall be active in the management of trauma patients.

f. Additional team members may be assigned at the discretion of the Trauma Section, based on previous performance, concerns, or complaints. The additional cost shall be the responsibility of the facility.

g. The survey team shall evaluate the quality of each applicant's compliance with the standards set forth in Sections VII and VIII by:

1) conducting interviews with hospital personnel;

2) examining equipment, touring the physical plant; and,

3) reviewing medical records, staff rosters and schedules, operations and peer review committee meeting minutes, Trauma Registry data, and other documents relevant to trauma care.

h. Findings of the survey team shall be forwarded to the Trauma Section within two weeks of the survey date.

i. An out-of-state hospital shall be surveyed under the same criteria by which in-state facilities are verified. However, if the out-of-state applicant is designated as a trauma center in an adjacent state with an established trauma system, the standards of review meet or exceed Arkansas' standards, and there is no competition for designation at that level, the Trauma Section may use the administrative findings, conclusions, and decisions of the adjacent state's or ACS's verification process to make the decision to designate. Additional information may be requested by the Trauma Section to make a final decision. Out-of-state facilities wishing to exercise this option shall notify the ADH Trauma Section at least six months prior to the anticipated site survey.

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4. Certification of an approved trauma center

   Upon approval by the Trauma Section of all application requirements as set forth in Section VI. B. 1. and 2., a certificate of trauma center designation shall be issued identifying the facility as an Arkansas-certified provider of trauma care. This certificate shall be enforced for a time period not to exceed three years from the date of issue or, if provisional, shall be reviewed by the end of the one year provisional period.

5. Trauma centers are required to notify the Trauma Section of administrative and trauma team staff changes.

   a. Notification of administrative changes include the facility's President, CEO, COO, and/or Administrator. Trauma centers are required to notify the Trauma Section within 30 days of a status change by submitting the administrative/trauma team staff change notification form.

   b. Notification of trauma team staff changes include the TMD, TPM, and/or Registrar. Trauma centers are required to notify the Trauma Section immediately of a status change by submitting the administrative/trauma team staff change notification form.

   c. The Trauma Section reserves the right to perform an on-site evaluation of the facility if the changes are felt to be substantial, may change the commitment to the Trauma Program, or change the clinical or administrative performance of the program.

6. Denial of trauma center designation

   A trauma center's designation may be denied for, but not limited to, any one of the following reasons:

   a. failure to comply with applicable sections within these Rules and/or the Rules for Hospitals and Related Institutions in Arkansas;

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   b. failure to provide care consistent with the facility's capability and capacity;

   c. willful preparation or filing of false reports or records;

   d. fraud or deceit in obtaining or attempting to obtain

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designation status;

e. failure to submit data to the Trauma Registry as described in Section XI;

f. failure to have appropriate staff or equipment required for designation as described in Sections VII or VIII, as applicable;

g. unauthorized disclosure of medical or other confidential information;

h. alteration or inappropriate destruction of medical records; or,

i. refusal to render care because of a patient's race, ethnicity, sex, creed, national origin, sexual preference, gender identity, age, disability, medical problem, or inability to pay.

C. Appeal Process

Any hospital that fails a trauma center designation site survey may file an appeal under the following guidelines:

1. A hospital that files an appeal shall submit a written request for re-review to the Trauma Section within 30 calendar days of denial. The request shall state the specific point(s) of disagreement with any deficiencies noted and provide support for reconsideration of the ruling. The Trauma Section shall send the hospital's request to the TAC's Designation Committee for consideration. The hospital may make a request to present its case to the TAC Designation Committee in person. Within one week of considering the request, the TAC Designation Committee shall make a recommendation to the Trauma Section, which shall retain the authority to either uphold or modify the previous decision regarding designation.

2. Should a hospital continue to disagree with the ruling of the Trauma Section, it may continue the appeal process. A hospital wishing to do so shall submit a written petition to the Director of the ADH for a hearing. The petition shall clearly set forth the nature of the appeal.

3. Hearings may be conducted before the entire Board, one or more members of the Board, an examiner or referee, or one or more members of the ADH. The Director of the ADH shall recommend to the President of the Board the composition of the hearing committee and the hearing officer to preside at the hearing. The President of the Board shall appoint the hearing officer and other hearing committee members.

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4. All administrative enforcement and hearing procedures hereunder, in which a final order is issued by the ADH, shall be conducted in accordance with the Administrative Procedures Act (Ark. Code Ann. § 25-15-201 et seq.) and amendments thereto.

D. Suspension/Revocation of Designation

1. The Trauma Section may, at its discretion, authorize a random site survey to review a trauma center for compliance with these Rules at the expense of the ADH.

2. A trauma center's designation may be suspended/revoked at any time for, but not limited to, any one of the following reasons:

   a. failure to comply with applicable sections within these Rules and/or the Rules for Hospitals and Related Institutions in Arkansas;

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   b. failure to provide care consistent with the facility's capability and capacity;

   c. willful preparation or filing of false reports or records;

   d. fraud or deceit in obtaining or attempting to obtain designation status;

   e. failure to submit data to the Trauma Registry as described in Section XI;

   f. failure to have appropriate staff or equipment required for designation as described in Sections VII or VIII, as applicable;

   g. unauthorized disclosure of medical or other confidential information;

   h. alteration or inappropriate destruction of medical records; or,

   i. refusal to render care because of a patient's race, ethnicity, sex, creed, national origin, sexual preference, gender identity, age, disability, medical problem, or inability to pay.

3. Reapplication for designation after suspension/revocation

   Six months after a suspension/revocation of designation

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as outlined in Section VI. B. 2. d., the facility may reapply for designation at the discretion of the Trauma Section in Sections VI. B. 1. and 2.

At the time of the suspension/revocation, the facility has the option to designate at a lower level with the approval of the Trauma Section.

4. Occasional failure to meet standards

   Occasional failure (less than 5% of the total time in a three month period) of a trauma center to meet its obligations shall not be grounds for suspension or revocation by the Trauma Section if the circumstances under which the failure occurred:

   a. do not reflect an overall deterioration in the quality of and commitment to trauma care; and,

   b. are corrected within a reasonable time frame by the facility as determined by the Trauma Section.

5. Complaints

   Upon receipt of a complaint describing an alleged violation as described in Section VI. D. 2 above, the Trauma Section shall:

   a. notify the trauma center of the complaint;

   b. initiate a review of the complaint, which may consist of an on-site review by the Trauma Section;

   c. develop a written report of the review; and,

   d. notify the trauma center of the results of the review.

6. Notification of action

   If the Trauma Section proposes to suspend/revoke a designation, the Trauma Section shall notify the trauma center by registered or certified mail at the last address shown in the Trauma Section records. The notice shall state the alleged facts that warrant the action and state that the trauma center has an opportunity to request a hearing in accordance with the Administrative Procedures Act, § 25-15-201 et seq.

   a. The trauma center shall request a hearing within 15 calendar days after the date of the suspension/revocation notice. This

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request shall be in writing and submitted to the Trauma Section. If a hearing is requested, the hearing shall be held in accordance with the Administrative Procedures Act as noted above. The trauma center shall continue to function at the level of its designation until the process is completed.

b. If the trauma center does not request a hearing in writing within 15 calendar days from the date of notice, it is deemed to have waived the opportunity for a hearing and the suspension/revocation decision shall stand.

E. Random Site Survey

The Trauma Section reserves the right to perform a focused or full site survey based on a reason to believe a trauma center is not in compliance with the Rules. Should such a survey be conducted, it shall be done at no expense to the facility.

F. Joint Trauma Service Applications

1. Trauma centers may apply for joint designation as a Level I, II, or III trauma center. The plan for multiple trauma centers to operate as a single trauma center shall be endorsed by the TRAC. Once the decision has been made to work cooperatively to achieve a level of designation, each facility shall submit an application for the given level. The Trauma Section shall follow the same process of evaluating the application as it would for a single facility application with the exceptions listed below:

a. cooperative trauma oversight with one TMD and a joint trauma service is preferred;

b. a cooperative multidisciplinary committee with representation from all the participating facilities;

c. a coordinated set of policies and procedures to deliver optimal trauma care;

d. a predetermined trauma center rotation schedule shall be made available to the TRAC and Trauma Section;

e. trauma centers seeking joint designation shall serve the same primary service area;

f. a coordinated QI program for trauma, including joint peer review and joint system review; and,

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g. trauma centers shall maintain individual trauma registries; however, the centers shall have the capability to create joint reports.

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SECTION VII: TRAUMA CENTER CRITERIA

Criteria for Level I and II Trauma Centers

Purpose: To define and clarify the criteria necessary for a comprehensive care facility to become a Level I trauma center, for a major care facility to become a Level II trauma center, and to ensure optimal care of the injured.

Definition: Level I and Level II trauma centers provide comprehensive care to patients following injury. Services include both medical and surgical specialties coordinated to achieve the best outcomes for the most severely injured patients. These comprehensive care facilities are also involved in professional and community education as well as IVP. Level I centers have the additional responsibilities and requirements to provide sub-specialty services, such as cardiac, hand, and reconstructive surgery, and have a commitment to trauma research and graduate medical education.

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Level I and II Criteria			
Level	**Section**	**Required (R) or Desirable (D)**	**Criteria**
	TRAUMA PROGRAM		
	1. Support/Infrastructure		
I, II	**Institutional Support**	R	(1.1) Clear evidence of hospital board, administrative, and medical staff support in the form of a written resolution to attain and maintain the level of designation; the resolution shall be updated and signed at least every three years. (1.2) Financial support of additional FTEs, space, and/or equipment, as required. (1.3) Authorization for the trauma program's leadership and committees to perform their required duties. (1.4) Clearly defined lines of reporting for the TMD and TPM within the organization.
I, II	**Trauma Program Administration and Infrastructure**	R	(1.5) Program within an acute care facility with defined leadership (TMD, TPM) with the authority to develop, oversee, and improve the care of the injured within the facility, and is integrated into the local, regional, state, and national system of trauma care. (1.6) The trauma program shall participate in the development and improvement of prehospital care protocols and patient safety programs.
	2. Staffing		
I, II	**Trauma Medical Director (TMD)**	R	***Requirements and qualifications for the TMD:*** (2.1) A general surgeon in good standing in the institution with state licensure, has membership in professional organizations, possesses clinical knowledge and expertise, actively participates in the care of injured patients, and has a personal interest and the time to be the champion for trauma patient care to the medical staff and the trauma center. (2.2) Board-certified/Board-eligible in general surgery (pediatric surgery in a pediatric facility). (2.3) Current in ATLS as either a provider or an instructor. ~~or attendance and documentation of self-assessment CME at an ADH-approved national trauma meeting.~~ In addition, 17 hours of verifiable trauma CMEs including any state mandated education. Comment: Accept (2.4)The TMD cannot be a locum or itinerate. Comment: Accept ***Responsibilities and duties of the TMD:*** (2.5)The TMD must have the responsibility and authority to ensure compliance with above requirements and may not direct more than one

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			trauma center. Comment: Accept (2.4) Participate in trauma call. (2.5) Lead the trauma QI and patient safety programs within the trauma center. (2.6) Have a method to identify injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners. (2.7) Perform a written annual review of the performance of all the surgeons on the call panel. Documentation of such shall be available for review at the designation site survey. (2.8) Have the ability to contribute to the TPM's performance evaluation. (2.9) Demonstrate with his/her signature awareness of the facility's invoices to the ADH for payment. (2.10) There shall be a verifiable, written job description that clearly identifies expectations of leadership and authority to perform the duties required, including the authority to conduct trauma-specific peer review, place members on and take members off of a trauma *call schedule* **, be involved in the development of the trauma center's bypass protocol and the decisions regarding bypass and ~~"Charlie Temp"~~ "No Capability" status, and affect process changes identified in the trauma multidisciplinary meetings. Comment: Accept (2.11) Have responsibility and authority for determining each call panel member's ability to participate on the trauma call schedule based on a periodic review. (2.12) Have responsibility and authority to ensure compliance with verification requirements; and report changes in the program that would affect the designation of the facility to the ADH. (2.13) The TMD or his or her respective physician designee shall attend at least 50% of both Trauma Program Operations Review Committee and Trauma Peer Review Committee meetings. Comment: Accept *** The ability to grant or remove a provider's privileges to practice in an area is reserved for the facility's board and Medical Staff Committee. There should be a distinction of a provider's privileges to participate in care of the trauma patient and participation in a trauma call schedule. The facility's board and Medical Staff Committee shall take into consideration the input of the TMD when considering trauma privileges, while the TMD shall have the discretion of which providers participate in the trauma call schedule. A decision by the TMD to place or remove a provider from the trauma call schedule shall not be viewed as affecting or restricting a provider's hospital privileges, as that decision is reserved for the facility's board and Medical Staff Committee.*
I, II	**Trauma Program Manager (TPM)**	R	***Requirements and qualifications for the TPM:*** (2.13) A RN with responsibility for monitoring and evaluating nursing care of trauma patients and the coordination of QI and patient safety programs for the trauma center in conjunction with the TMD.

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			(2.14) He/she shall be well trained and knowledgeable in trauma. The TPM shall also obtain CE so as to remain up to date in regard to trauma. (2.15) ATCN, TNCC, TPATC or ADH-approved equivalent course certifications shall be current. (2.16) The training of a TPM new to this position shall include a TPM course, a QI course, and an AIS coding course or state sponsored coding course. ***Responsibilities and duties of the TPM:*** (2.17) There shall be a verifiable, written job description for the TPM that clearly identifies expectations of leadership and authority to perform the duties required. (2.18) Dedicate at least 1.0 FTE to trauma programs having a trauma patient record volume of 500 or greater. (2.19) The time and resources allocated shall be sufficient for the TPM to be effective in the job of QI, community education, clinical education, IVP, and research as required. (2.20) The TPM or his or her nursing designee shall attend at least 50% of both Trauma Program Operations Review Committee and Trauma Peer Review committee meetings. Comment: Accept
I, II	**Trauma Registrar**	R	(2.20) There shall be a verifiable, written job description for the Trauma Registrar, who is separate from but supervised by the TPM and who has appropriate training (e.g., the AAAM course ~~or state sponsored coding course~~ and the ATS, Trauma Registrar Course ~~in injury severity scaling~~). Comment: Accept ~~Recommended Change: who has appropriate training in AAAM Abbreviated Injury Scaling course, American Trauma Society's Trauma Registry course, and annual attendance at the Arkansas Trauma Registry Users Conference by at least one registrar.~~ Comment: do not accept recommended change (2.21) The facility shall have adequate resources to maintain accurate and timely collection, evaluation and submission of trauma data.
I, II	**Trauma Program Staff**	R	(2.22) Trauma Program staff shall have adequate support resources to efficiently and effectively oversee and administer the trauma program and remain engaged in an effective QI process.
I, II	**Trauma Liaisons**	R	(2.23) Official physician liaisons shall be named for EM, orthopedics, neurosurgery, anesthesia, critical care, and radiology. Liaisons are responsible for the accurate dissemination of information from the trauma committee meetings to their service members. (2.24) ~~Liaisons are responsible for attending the Trauma Program Operational Review Committee meetings and at least 50% of Trauma Peer Review~~

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			~~Committee meetings. The liaison responsibilities may be shared by physician members of the specialty~~. Comment: Accept change
I, II	**Trauma Team**	R	(2.25) A predetermined set of care providers and ancillary personnel (physicians, mid-level practitioners, nurses, X-ray technologists, laboratory, respiratory therapists, etc.) needed to provide resuscitation, rapid triage, and transfer of the severely injured.
I, II	**Consultant Coverage**	R	(2.26) Trauma centers shall have an internal policy identifying the expectations for consultant responses. Deviations to the policy shall be tracked in the QI process. ~~(2.27) If a consultant is unable to provide the service indicated by the ATCC dashboard, the consultant shall be involved in the transfer process with ATCC.~~ Comment: Do not support the addition. Recommend Strike
	3. Participation		
I, II	**General Surgery Participation**	R	***Requirements of the general surgeon(s):*** (3.1) Shall provide 24/7 general surgical coverage. (3.2) Shall have privileges in general surgery. (3.3) Shall be Board-certified/Board-eligible in general surgery, or a FACS, or a FACOS. (3.4) ~~Shall have taken ATLS at least once or shall be current in ATLS within one year of hire.~~ Shall have taken ATLS at least once or shall be current in ATLS within one year of hire. If a general surgeon who is new to a facility has never taken ATLS, he or she will have a one year grace period during which they must obtained ATLS certification. This period will begin ~~commensurate~~ with their participation on the call panel. Comment: Accept (3.5) ~~Shall obtain the required verifiable 18 17 hours of Category I trauma-specific CME, or 18 17 hours of trauma-specific internal education every three years.~~ **Trauma specific CME is not required for General Surgeons boarded in their specialty and current in their maintenance of certification (MOC) for their board unless State mandated education is required by the Department of Health. Hospital TMD can mandate specific CME for PI or loop. Those not boarded or not current in their board MOC shall obtain verifiable 17 hours of Category I trauma specific CME or 17 hours of trauma specific internal education every 3 years and must obtain any mandated education as required by the Department of Health.** Further discussion needed. (3.6) ~~Core surgeons~~ Call panel surgeons shall participate in at least 50% of the Trauma Peer Review Committee meetings. ~~and disseminate information back to all non-core surgeons.~~ Comment: Accept

Commented [CJ2]: Comment from Dr. Maxson: At National level the requirement for CME has gone away for those boarded in their specialty and current in their maintenance of certification for their board (MOC). Only group required is Trauma Medical Director and debating regarding Liaisons. Does the group believe that the TMD needs verifiable CME? **Would like to see state mandated requirements for everyone id'd thru State PI process or PMR. What about adding state mandated education when required or published, etc. Would like language that a hospital TMD can mandate specific CME for loop closure or PI.**
Comment from Dr. Olivi: Believes it is beneficial if they are on trauma call panel.
Red bold was agreed upon by Dr. Maxson, Dr. Robertson, Dr. Olivi. Will need to establish an education committee

Or state mandated education as required by the department of health. Hospital TMD can mandate specific CME for PI or loop closure.

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			(3.7) Shall respond to the ED promptly (Level I – 15 minutes, Level II – 30 minutes) an aggregate of 80% of the time when on-call and when the highest level of trauma is activated. (3.8) Trauma panel surgeons shall respond promptly to activations, remain knowledgeable in trauma care principles, whether treating patients locally or transferring them to a center with more resources, and participate in QI activities. (3.9) Level I facilities shall have a surgeon in house 24/7. This requirement can be fulfilled by a general surgical senior resident (PGY-3 or greater). Recommended Change: Require in house 24/7 surgery for Level I & II facilities. Comment: No comment made
I, II	**Orthopedic Surgery Participation**	R	***Requirements of the orthopedic surgeon(s):*** (3.10) ~~Shall provide 24/7 orthopedic coverage. On-call and promptly available when requested by the trauma surgeon or EM specialist.~~ Orthopedic surgeons shall have privileges in general orthopedic surgery, providing 24/7 orthopedic coverage, on-call and promptly available when requested by the trauma surgeon or EM specialist, and expected to provide care within the scope of general orthopedic practice. Comment: Accept (3.11) Shall obtain the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17 hours of trauma-specific internal education every three years, **and must obtain any mandated education as required by the Department of Health and hospital TMD.** ~~Comment:~~ ~~Opinion 1: National if boarded in specialty and current in board and MOC status then the only required to have CME are the medical director and liaison in certain services. Gen surgery, EM, ortho, & nsgy did not require. Those physicians working in ED that are not boarded in EM must have CME.~~ ~~Opinion 2: CME requirement should remain~~ ~~Opinion 3: Develop an AR Trauma System educational course for the CME requirement~~ (3.12) A liaison shall participate in at least 50% of the Trauma Peer Review Committee meetings and Trauma Program Operations Review Committee and disseminate information back to all orthopedic surgeons on the call panel. (3.13) ~~Orthopedic surgeons shall have privileges in general orthopedic surgery.~~ (3.14) In the cases where the orthopedist is not dedicated to the facility 24/7, an orthopedic backup plan is required and shall be approved by the TMD. (3.15) The following orthopedic-specific QI filters shall be in place and tracked (other filters may be added at the discretion of the ADH Trauma Section): 1. time from injury to washout for open fractures; 2. time from injury to ORIF for femur fracture; and, 3. appropriateness and timing of IV antibiotics for all open fractures.

Commented [CJ3]: All liaison's need to be updated with this language

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I, II	**Neurosurgical Participation**	R	***Requirements of the neurosurgeon(s):*** (3.16) Shall provide 24/7 neurosurgical coverage. On-call and promptly available when requested by the trauma surgeon or EM specialist. (3.17) Shall obtain the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17 hours of trauma-specific internal education every three years. (3.18) The liaison shall participate in at least 50% of the Trauma Peer Review Committee meetings and Trauma Program Operations Review Committee and disseminate information back to all neurosurgeons on the call panel. (3.19) In the case where the neurosurgeon is not dedicated to the facility 24/7, a neurosurgical backup plan is required and shall be approved by the TMD. (3.20) The following neurosurgical specific QI filters shall be tracked (others may be developed at the discretion of the ADH Trauma Section): 1. all cases requiring the backup to be called in, or the trauma center is ~~Charlie Temp~~ "No Capability" or bypassed due to unavailability of the neurosurgeon on-call; and, *2.* neurotrauma care shall be reviewed for compliance with the Brain Trauma Foundation Guidelines. ~~*https://www.braintrauma.org/pdf/protected/Guidelines_Management_2007w_bookmarks.pdf*~~ *https://www.braintrauma.org/uploads/11/14/Guidelines_Management_2007w_bookmarks_2.pdf*
I, II	**Anesthesiology Participation**	R	***Requirements of the anesthesiologist(s):*** (3.21) Anesthesia services in Level I trauma centers are available in-house 24/7. This may be fulfilled by an anesthesiologist, PGY4 or greater anesthesia resident, or a CRNA. If a CRNA is utilized, an anesthesiologist shall be promptly available. If a CRNA is utilized, it shall be with the approval of the Chief of Anesthesiology. (3.22) Anesthesiology services in a Level II are on-call and promptly available for emergency operations. (3.23) Anesthesiology services are promptly available for airway problems. (3.24) A fully credentialed anesthesia provider shall be present for all trauma operations. (3.25) There is an anesthesiologist liaison designated to the trauma program. (3.26) The availability of the anesthesia services and the absence of delays in airway control or operations are documented by the trauma QI program. (3.27) In a Level II trauma center without in-house anesthesia services, protocols are in place to ensure the timely arrival at the bedside of the anesthesia provider.

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			(3.28) In a Level II trauma center without in-house anesthesia services, there is documentation of the presence of physicians skilled in emergency airway management. (3.29) The anesthesia liaison participates in the trauma QI program. (3.30) The anesthesiology representative or designee to the trauma QI program attends at least 50% of both the Trauma Peer Review Committee meetings and Trauma Program Operation Review Committee meetings. Comment: Liaison doesn't have to be at both meetings, could use a designee that is not a physician at the operations meeting. Would like to see this updated in all specialty
I, II	**Emergency Medicine Participation**	R	***Requirements of emergency medicine physician (s):*** (3.31) There is a liaison from the EM Service to the Trauma Program who effectively disseminates information back to the EM service. (3.32) The EM liaison has the required verifiable ~~18~~ 17 hours of Category I trauma- specific CME, or ~~18~~ 17 hours of trauma-specific internal education every three years. (3.33) The EM liaison regularly attends the trauma QI meeting and has documented 50% attendance at the Trauma Peer Review Committee meetings. Recommended Change: Need to require EM Board eligibility by all EM providers. Comment : Grandfather the current EM providers and require future EM providers to be boarded
I, II	**Medical Specialty Support**	R	(3.34) The following medical specialties shall be on-call and promptly available at the request of the trauma service: • critical care medicine • pathology • internal medicine/pulmonary (family medicine can substitute for internal medicine at a Level II) • interventional radiology • pediatrics • cardiology • ~~nephrology~~ Comment: Accept The following medical specialties shall be on staff and available at the request of the trauma service: •pathology •nephrology and their respective support staff (e.g., respiratory therapy, dialysis team, and nutritional support) •gastroenterology •infectious disease Comment: Accept

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I	**Surgical Specialty Support** **(Level I)**	R	(3.35) The following surgical specialties shall be on-call and promptly available at the request of the trauma service: • ~~urology~~ • ~~cardiac surgery with pump capability~~ • ~~hand surgery with microvascular capability~~ • ~~maxillofacial coverage~~ • ~~plastics/reconstructive~~ • ~~ophthalmology~~ • orthopedic surgery • neurosurgery • cardiac surgery • thoracic surgery • vascular surgery • hand surgery • microvascular surgery • plastic surgery • obstetric and gynecologic surgery • ophthalmology • otolaryngology • urology • interventional radiology • peripheral vascular
II	**Surgical Specialty Support** **(Level II)**	R	(3.36) ~~Required staff with a facility plan for care of the patient admitted to the facility by the specialists in a timely manner. The surgical specialist need not be on-call. Patients should not be sent out of the community because of lack of these resources available to the patient (90% compliance is expected).~~ • ~~cardiac surgery~~ • ~~urology~~ • ~~maxillofacial coverage (any specialty, such as plastics, ENT, and OMFS)~~ • ~~ophthalmology~~ • ~~plastics/reconstructive surgery~~ • ~~~~ The following surgical specialties shall be on-call and promptly available at the request of the trauma service: •interventional radiology •orthopedic surgery •neurosurgery •cardiac surgery •urology •obstetric and gynecologic surgery •peripheral vascular

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			Required staff with a facility plan for care of the patient admitted to the facility by the specialists in a timely manner. The surgical specialist need not be on-call. Patients should not be sent out of the community because of lack of these resources available to the patient (90% compliance is expected). •maxillofacial coverage (any specialty, such as plastics, ENT, and OMFS) •ophthalmology •plastics/reconstructive surgery
	TRAUMA FACILITY AND OPERATIONS		
	4. Emergency Department (ED)		
I, II	**Leadership**	R	(4.1) The ED has a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients. This may be different from the trauma liaison. (4.2) An ED nursing liaison shall be identified and available to the trauma team.
I, II	**Communication with ED Physicians and Nurses**	R	(4.3) A reliable method shall exist to communicate changes in trauma process to all staff members caring for injured patients in the ED. An example of this would be a communication book in the ED, requiring a signature by nurses and physicians when changes or other important updates to the trauma process are determined through the QI program.
I, II	**Physician, Mid-level Practitioners and Nursing Availability**	R	(4.4) ED shall have 24/7 in-house emergency coverage by physicians and nurses. (4.5) Level I facilities shall have EM providers who are Board-certified/Board-eligible recognized by ABEM, AOBEM and ABP in the ED 24/7. (4.6) A tracking mechanism shall be in place and reviewed in the QI program. The QI program shall review all times the ED physician leaves the ED uncovered in order to respond to an emergency in-house. (4.7) EM physicians on the call panel are regularly involved in the care of injured patients. (4.8) The EM representative or designee to the Trauma Peer Review Committee attends a minimum of 50% of these meetings. (4.9) There is EM physician participation with the overall trauma QI program and the Trauma Program Operational Process Performance Committee (dealing with systems issues).

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I, II	**CME Requirements for Providers**	R	(4.10) Category I CME is necessary to maintain knowledge in the field. The physicians or mid-level practitioners caring for trauma patients in the ED shall obtain the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17 hours of trauma-specific internal education every three years.
I, II	**Trauma Educational Certification for Physicians and Mid-Level Practitioners**	R	(4.11) Maintaining current ATLS certification for physicians and mid-level practitioners is ~~essential~~ required for those who cover the ED as participants on the trauma team who are not Board-certified/Board eligible in EM. Physicians Board-certified/Board eligible in EM, as recognized by ABEM, AOBEM, or ABP, shall have completed ATLS at least once, and are encouraged but not required to be current.
I, II	**Trauma Nursing Educational Preparation**	R	(4.12) Current certification in one of the trauma nursing courses is essential for nurses who assist in trauma resuscitations. ATCN, TNCC, TPATC or ADH-approved equivalent course shall be obtained. 80% of ED trauma nurses shall be certified and newly hired ED trauma nurses shall be certified within their first year of hire. (4.13) 80% of nurses working in the ED shall be current in ACLS and PALS or ENPC.
I, II	**Paramedic Educational Preparation**	R	(4.14) All paramedics working in the ED, who participate in trauma resuscitation, must be certified in PHTLS. May audit TNCC as a substitution for PHTLS (4.15) All paramedics working in the ED shall be current in ACLS and PALS. Comment: Recommend 80% requirement (same as nursing). Remove PHTLS and allow for audit of TNCC or ATLS
I, II	**Paramedic Continuing Education**	R	(4.16) It is necessary that paramedics who assist with trauma resuscitations continue to be educated on trauma treatment and issues and shall obtain 12 hours of trauma - specific CE or 12 hours of trauma-specific internal education every three years.
I, II	**Nursing Trauma Continuing Education**	R	(4.14) It is necessary that nurses who assist with trauma resuscitations continue to be educated on trauma treatment and issues and shall obtain 12 hours of trauma-specific nursing CE or 12 hours of trauma-specific internal education every three years.
I, II	**Activation Criteria**	R	(4.15) The criteria for the highest level of trauma team activations shall be clearly defined and evaluated by the QI program. (4.16) A patient ≤ 15 years of age who meets a center's criteria for the highest level of activation or is classified as either a major or moderate trauma patient under the Arkansas Trauma Triage Protocol and requires transfer, shall be transferred to a designated pediatric trauma center. Recommended Change: pediatric definition to become less than or equal to 14 years old. Rationale: align with ACS verification standards. Comment: Not accepted

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			(4.17) The facility shall activate the entire trauma team to include the operating room (OR) and general surgeon, based on a set of written activation criteria unless otherwise excluded in section V. C. 6 to include: ~~predetermined trauma team based on a set of written activation criteria that include~~: 1. confirmed hypotension (< 90mmHg adults or age appropriate for children) attributed to trauma; 2. GCS < 9 with a mechanism due to trauma (general surgeon response can be at the discretion of the ED physician); 3. respiratory distress attributed to trauma; 4. gunshot wound to the neck, chest or abdomen; 5. transfer of a patient from another facility receiving blood or pressure support to maintain vital signs; and, 6. any patient for whom the ED physician feels the highest level of activation is warranted. (4.18) Activation of the trauma team for the highest level shall be based on prehospital notification when available. (4.19) Facilities may create a tiered activation system with variable response from hospital and physician personnel, but shall have the above criteria in the highest level of activation. For the program's highest level of activation, the surgeon shall be in the ED on patient arrival, with adequate notification from the field. Activation occurs based on prehospital criteria when available. The program shall demonstrate that the surgeon's presence is in compliance at least 80% of the time. Demonstration of the attending surgeon's prompt arrival for patients with appropriate activation criteria shall be monitored by the hospital's trauma QI program. (4.20) The facility shall be able to demonstrate under and over-triage rates based on its activation criteria. (4.21) The facility shall be able to track the arrival of the physicians who should respond to a given level of activation.
I, II	**Helipad or Landing Zone**	R	(4.22) Shall have a helipad or landing zone.
I, II	**Trauma Image Repository**	R	(4.23) Availability to send and receive images to and from TIR in the ED. (4.24) Utilization of TIR when appropriate for expediting trauma patient care.
I, II	**Roles and Responsibilities in the Trauma Bay**	R	(4.25) Written protocol for roles and responsibilities of all team members during trauma team resuscitations.
I, II	**Safe Transport of Patients Within and Out of the Emergency Department**	R	(4.26) A policy is required describing the level of resources required for the safe movement of patients out of the trauma bay, either within the ED or to other departments in the trauma center.

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	5. Essential Equipment (shall include but not be limited to)		
I, II	**Airway Control and Ventilation Equipment (Adult and Pediatric)**	R	(5.1) Neonatal to adult oxygen masks, ambu bags, and ETTs (5.2) Every facility shall have equipment and a plan for difficult intubations. (5.3) Cricothyrotomy supplies and drugs necessary for emergency intubation
I, II	**Airway Monitoring**	R	(5.4) Pulse Oximetry (5.5) Qualitative End-tidal CO2 Determination – Color Change Detectors (5.6) Continuous End-tidal CO2 Monitoring **Recommended Change: Remove 5.5, or change to qualitative CO2 needed only if quantitative monitoring is not available in the facility** Comment: Accept recommendation of "qualitative CO2 determination only if quantitative monitoring is not available in the facility"
I, II	**Hemorrhage Control**	R	~~(5.7) Junctional tourniquet capable of occluding the aorta~~ Comment: add CAT tourniquets or equivalent and pelvic binders
I, II	**Thermal Regulation**	R	(5.8) The ability to regulate the room temperature in the trauma bay in a reasonable amount of time. (5.9) Fluid warming devices (5.10) Thermal control blankets
I, II	**Large Bore IV Catheters**	R	(5.11) 14 – 18 gauge IVs (5.12) Interosseous catheters
I, II	**Focused Assessment with Sonography for Trauma (FAST)**	R	(5.13) Machine available to the trauma team and members of the trauma team trained in its use.
I, II	**Standard Procedure Trays**	R	(5.14) Thoracotomy (adult and pediatric) (5.15) Tube thoracostomy tray with tubes (adult and pediatric) (5.16) Surgical tray with airway equipment (adult and pediatric)
I, II	**Standard Airway Equipment**	R	Ensure equipment is available in both adult and pediatric sizes. (5.17) Oral and nasal airway (5.18) Ambu bags (5.19) ETT - with cuffed ETT down to size 4.0

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I, II	**Pediatric Resuscitation Equipment**	R	(5.20)	Color-coded, length-based resuscitation tape Weight-based, color-coded resuscitation cart Pediatric equipment available as listed in the American Academy of Pediatrics Joint Policy Statement-Guidelines for Care of Children in the Emergency Department (2009). ~~http://pediatrics.aappublications.org/content/early/2009/09/21/peds.2009-1807.citation~~ http://pediatrics.aappublications.org/content/124/4/1233
I, II	**PACS and Lab Results Computer**	R	(5.21)	Shall be in reasonable proximity to the trauma bay for ease of access by the trauma team.
	6. Operative Services			
I, II	**Operating Room (OR)**	R	(6.1)	~~The OR is adequately staffed and immediately available (Level I) and promptly available (Level II) for emergency procedures.~~ The OR is adequately staffed and immediately available for emergency procedures.
			(6.2)	The OR has provision for the timely completion of semi-urgent cases so as not to cause delay to the patient (orthopedic cases).
			(6.3)	The OR has the essential equipment for trauma care.
			(6.4)	There is a mechanism in place for providing additional staff for a second OR when the first OR is occupied.
			(6.5)	The QI program evaluates OR availability and delays when an on-call team is used.
I, II	**Post-anesthesia Care Unit (PACU)**	R	(6.6)	The PACU has qualified nurses available 24/7 as needed during the patient's post-anesthesia recovery phase.
			(6.7)	The PACU is covered by a call team from home with documentation by the QI program that PACU nurses are available and delays are not occurring.
			(6.8)	The PACU has the necessary equipment to monitor and resuscitate adult and pediatric patients. In facilities where pediatric patients are cared for, this equipment shall include ambu bags, ETTs and oral airways appropriate to the age of the patients.
			(6.9)	The QI program ensures that the PACU has the necessary equipment to monitor and resuscitate patients.
			(6.10)	If the PACU acts as an overflow area for the ICU and trauma patients are housed there while waiting for an ICU bed, the nurses in the PACU shall have similar qualifications as the ICU nurse for the care of trauma patients.
	7. Intensive Care Unit			
I, II	**Intensive Care**	R		

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	Unit (ICU)		(7.1)	Physicians, properly trained, experienced and credentialed are available to the injured patient in the ICU 24/7.
			(7.2)	There is a provision for immediate, in-house 24/7 physician response to a patient emergency.
			(7.3)	The trauma center has a surgical director or co-director for the ICU, who is a core surgeon, who participates in setting policies and administration related to trauma ICU patients, and participates in the QI program.
			(7.4)	Coverage of emergencies in the ICU does not leave the ED without an appropriate physician coverage plan.
			(7.5)	The trauma surgeon remains in charge of trauma patients in the ICU and is kept informed of and concurs with major therapeutic and management decisions.
			(7.6)	The nurse caring for a trauma patient has appropriate initial training in the care of injured patients and maintains competency in the care of injured patients.
			(7.7)	A qualified nurse is available 24/7 to provide care during the ICU phase.
			(7.8)	The patient/nurse ratio does not exceed 2:1 for critically ill trauma patients in the ICU.
			(7.9)	The ICU has the necessary equipment to monitor and resuscitate patients.
			(7.10)	There are written protocols for declaration of brain death.
			(7.11)	When ICU patients are held in other locations (PACU, ED) due to temporary lack of bed space, all requirements for ICU care would apply.
			(7.12)	The ability to perform intracranial pressure (ICP) monitoring is required. Guidelines for the use of ICP monitoring shall follow the Brain Trauma Foundation Guidelines. ~~*https://www.braintrauma.org/pdf/protected/Guidelines_Management_2007w_bookmarks.pdf*~~ *https://www.braintrauma.org/uploads/11/14/Guidelines_Management_2007w_bookmarks_2.pdf*
			(7.13)	A pathway for the care of the patient with a severe traumatic brain injury shall exist (see above link for the Brain Trauma Foundation Guidelines). Recommended Change: Need to have dedicated surgical ICU Comment: agree- has been shown to improve outcomes
	8. Other Trauma Care Areas and Services			
I, II	**Pediatric Care**	R	(8.1)	Any adult trauma center that annually admits 100 or more injured children ≤ 14 15 years of age shall fulfill the following additional criteria demonstrating its capability to care for injured children: trauma surgeons shall be credentialed for pediatric trauma care by the hospital's credentialing body, and there shall be a pediatric ED area, pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma QI program. Recommended Change: pediatric definition to become less than or equal to 14 years old. Rationale: align with ACS verification standards. Comment: Do not accept

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			(8.2) Hospitals admitting fewer than 100 injured children annually, ≤ ~~15~~ 14 years of age, shall review and document the review of all pediatric patients in the QI program. Recommended Change: pediatric definition to become less than or equal to 14 years old. Rationale: align with ACS verification standards. Comment: Do not accept (8.3) Pediatric resuscitation equipment shall be available in all pediatric care areas.
I,II	**Geriatric Care/Special Needs**	R	(8.4) The facility shall have a protocol for the admission and care of geriatric/special needs patients (age > 65 years). (8.5) There shall be a protocol in place in the facility for the rapid evaluation of patients with head injuries who are on anticoagulants, which shall include a component addressing the rapid reversal of such agents when possible. The protocol may exclude patients who are on aspirin only.
I, II	**Laboratory Services Available 24/7**	R	(8.6) Standard analysis of blood, urine, and other body fluids, including micro-sampling for pediatric patients when appropriate. Blood gases and pH determination is required. (8.7) The capability for coagulation studies including viscoelastic testing, blood gases, and microbiology shall be available 24/7. ~~(8.8) Thromboelastography is required at Level I trauma centers.~~
I, II	**Blood Bank/Ability to Transfuse Blood 24/7**	R	(8.9) The blood bank shall be capable of blood typing and cross matching. (8.10) The blood bank shall have an adequate supply of red blood cells available with additional red blood cells, fresh frozen plasma, platelets and cryoprecipitate to meet the needs of injured patients through a regional source and tracked through the QI program. (8.11) Mass transfusion protocol that results in a balanced resuscitation with red cells, plasma, and platelets. (8.12) Prompt availability of universal donor blood. (8.13) Facilities shall have a protocol for the rapid reversal of anticoagulants when available. Facilities may develop their own protocol until such time that state guidelines are adopted.
I, II	**Radiological Services Available 24/7**	R	(8.14) Radiologists shall be promptly available, in person or by teleradiology, when requested for the interpretation of radiographs. (8.15) X-ray technologists shall be promptly available 24/7 upon activation of the trauma team. (8.16) Diagnostic information shall be communicated in a written form and in a timely manner. (8.17) Critical information shall be verbally communicated to the trauma team.

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			(8.18) Final reports are timely and accurately reflect communications, including changes between preliminary and final interpretations. (8.19) Changes in interpretation shall be monitored through the QI program. (8.20) The trauma center has policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the radiology department. (8.21) Conventional radiography and CT are available in-house 24/7. (8.22) MRI and interventional radiology are available 24/7. When the MRI or interventional radiology technologist responds from outside the hospital, the Trauma Program documents the response time. (8.23) Radiologists shall over-read trauma films sent from referring facilities and render written reports when requested. (8.24) The TIR is utilized to expedite care of patients being transferred in and out when appropriate.
I, II	**Respiratory Therapy Services**	R	(8.25) There shall be a respiratory therapist available in-house 24/7 and available to the trauma patient.
I, II	**Rehabilitation Services**	R	(8.26) Rehabilitation services shall be available during the acute phase of care. (8.27) Protocol development and consultation shall be available from a physician with training in physical medicine and rehabilitation or with a physician whose practice focuses on rehabilitation. (8.28) Protocols shall be in place for the timely consultation with rehabilitation and therapy services. (8.29) Transfer agreements shall be in place for in-patient rehabilitation services if they do not exist within the facility. (8.30) Patients with spinal cord injury shall be reported to the Spinal Cord Commission within five business days of patient arrival? (8.31) Functional outcome measurements made on discharge shall be obtained per institutional protocol until such time when there are state protocols adopted.
I, II	**Therapy Services**	R	(8.32) Physical therapy (8.33) Occupational therapy (8.34) Speech therapy
I, II	**Social Services**	R	(8.35) Social work Case management Chaplain services Child life (pediatric hospitals and hospitals admitting more than 100 pediatric patients annually)

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	9. Effective Transfer of Patients		
I, II	**Coordinate All Trauma Transfers Through the ATCC**	R	(9.1) All trauma transfers shall be coordinated through the ATCC. ~~Compliance shall be 95% of the time as an aggregate (average) over the reporting period (this does not apply to out-of-state hospitals transferring to out-of-state hospitals).~~ The program shall monitor transfers in its QI program and be able to demonstrate compliance. If the program transfers out more than 40 patients in a review period, then 95% compliance with ATCC coordination is expected (this does not apply to out-of-state hospitals transferring to out-of-state hospitals). The decision to accept ~~or not accept~~ a patient to the facility shall be made within 10 minutes of contact by the ATCC at least 90% of the time. The exception to this 10 minute requirement is for stable, single system orthopedic, ophthalmologic, or maxillofacial injuries where discussion with the specialist would be beneficial (all communication shall still come though ATCC and an answer given as to acceptance within 20 minutes). The acceptance time shall be tracked in the facility's QI program. ~~A direct physician-to-physician contact is not required essential for acceptance of a transfer.~~ The acceptance may be granted by anyone designated by the facility to accept a patient on behalf of the facility, including an ED nurse. A direct physician-to-physician contact is desirable but should not delay the transfer process. Recommended Change: Propose that anyone can accept the patient but that a provider-to-provider report is necessary. Do not accept the recommended change in green. (9.2) Denials for acceptance of transfers shall be tracked through the trauma program's QI process. Utilization of the ATCC shall be actively tracked in the facility's QI program with a list of all patients transferred out with the corresponding trauma band number. (9.3) ~~All diversions (Bravo, Charlie Temp, and Delta) shall be documented and tracked in the hospital's trauma QI program. Diversions that exceed 5% of the time for required services shall be reported quarterly with a corrective action plan to the TRAC and the ADH.~~ All diversion, dashboard discrepancies, double transfers, and ATCC reports shall be documented and tracked in the hospital's trauma QI program. A trauma facility ~~shall~~ should not be on diversion for any required category listed on the ATCC dashboard more than 5% of the time during the review period. Reports of all diversions shall be available at all designation site surveys.
I, II	**Appropriate Documentation of Patient Records for Transferred Patients**	R	(9.4) Transferring facilities shall send a copy of the patient's pertinent medical record (to include full EMS patient care records or EMS short form) along with radiographic studies (by the TIR or a cloud based image transfer 80% of the time or CD when the TIR is not available) (9.5) Final readings by the referring facility's radiologists shall be sent to the receiving facility as soon as available when requested by the receiving

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				facility. Transfer shall not be delayed waiting on this final reading report.
			(9.6)	Copies of original ~~run sheets~~ patient care record and readings of the X-ray studies shall be sent to the receiving hospital no later than the next business day.
I, II	**Well-defined Transfer Plans are Essential**	R	(9.7)	The plan shall be codified in the facility, approved by the Trauma Program Operations Review Committee, and disseminated to the ED physicians and surgeons in the program. All transfers out shall be reviewed in the review committee by the TMD and TPM and documented as appropriate or inappropriate. The decision to transfer an injured patient to a specialty facility in acute situation shall be based solely on the need of the patient; for example, the method of payment is not considered.
I, II	**Teletrauma**	R	(9.8)	The hospital shall have collaborative agreements with ~~referral trauma centers~~ Centers for Distance Health and demonstrate successful use. Recommended Change: Teletrauma requirements not be imposed on centers with similar capabilities. Consider asking the proposed change for Level II centers only. Comment: Need clarification of the recommendation in green
	10. Quality Improvement and Peer Review Process			
I, II	**Quality Improvement (QI)**	R	(10.1)	The center shall have a clearly defined QI program for the trauma patient population. The QI program shall be supported by a reliable method of data collection that consistently gathers valid and objective information necessary to identify opportunities for improvement. The results of analysis shall define corrective strategies, the results of which shall be documented. The trauma program shall be empowered to address issues in multiple disciplines.
			~~(10.2)~~	~~The TMD (or his/her respective physician designee), the TPM (or his/her respective nurse designee), and specialty representatives in EM, orthopedics, neurosurgery, anesthesia, critical care, and radiology shall attend at least 50% of the Trauma Peer Review Committee meetings.~~
I, II	**Audit Filters**	R	(10.3)	Use of the current Arkansas State QI Audit Filters is mandatory.
			(10.4)	The facility shall track and trend the cases that trigger one of the state audit filters. The trauma center may add additional filters to suit its specific needs. The facility shall use the trended information gathered from review of the audit filters to guide the QI program.
			(10.5)	Identified problem trends shall undergo review in the multidisciplinary QI meetings with action plans generated, documented, and followed by loop closure.

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			~~(10.6) Orthopedic, neurosurgical and geriatric/special needs-specific audit filters shall be tracked (see orthopedic, neurosurgical and geriatric/special needs sections).~~ (10.7) Non-surgical admission (NSA) Trauma centers may admit more than 10% of the admitted trauma patients to a non-surgical service. If a trauma service admits more than 10% of injured patients to a non-surgical service, the trauma program shall: 1. be able to run a Trauma Registry report of all patients admitted to a non-surgical service (total number of NSAs); 2. determine the number of NSAs that had an appropriate surgical service consult; 3. determine the number of NSAs resulting from same level falls; 4. determine the number of NSAs resulting from drowning and hanging; and, 5. determine the number of NSAs with ISS ≤ 9. (10.8) All NSA patients not meeting criteria 2-5 shall be reviewed in the QI meeting for appropriateness of admission to a non-surgical service.
I, II	**Trauma Chart Reviews**	R	(10.9) Review charts on all trauma patients meeting state Trauma Registry inclusion criteria, including deaths, unexpected outcomes, all pediatric patients, and other patients who meet state QI audit filter criteria. (10.10) Review of the entire patient's encounter with the trauma system, from EMS through hospital treatment and discharge, transfer, or death, with identification of opportunities for improvement in any and all aspects of care. (10.11) Identified opportunities for improvement shall be followed by an action plan and loop closure documenting the effect of the action plan.
I, II	**Trauma-Specific QI Program**	R	(10.12) This program shall be a structured process, led by the trauma program, to demonstrate continuous evaluation to improve care for injured patients that is coordinated with the hospital-wide QI program. The components of an organized trauma QI program shall be: (10.13) a reliable method of identifying trauma patients presenting to and/or admitted to the facility; (10.14) the infrastructure to abstract patient information from the hospital and prehospital records in order to identify quality of care issues that is reliable and consistently obtains valid and objective information necessary to identify opportunities for improvement; (10.15) a clearly defined set of data points and audit filters to be abstracted from the patient's record; (10.16) proper identification and ICD-9, ICD-10 (or newer version), and AIS coding of all injuries; (10.17) selection of facility-specific process and outcome measures that are

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			related to patient care and can be benchmarked to national standards; (10.18) a functional trauma registry that supports the QI program; (10.19) validation of data abstraction, injury identification, and ISS coding is mandatory; ~~(10.20) a multidisciplinary review process that occurs at frequent, regular intervals and analyzes trauma care in the institution in order to identify opportunities for improvement;~~ (10.21) multidisciplinary involvement as evidenced by both meeting an attendance threshold and submission of case reviews in specialty areas; (10.22) the results of this multidisciplinary review process leads to corrective actions that are documented which may include a letter to inform the responsible party with or without response, an educational offering related to the identified issue, a policy change or development of new policy, counseling of the responsible person, or removal from the trauma call panel; (10.23) when a consistent problem or inappropriate variation is identified, corrective actions are taken and documented; (10.24) tracking and trending of identified performance issues is necessary to ensure compliance to process changes; (10.25) the TMD and TPM shall be empowered by the hospital's administration to address issues that involve multiple disciplines and perform loop closure for issues identified; (10.26) the TMD and TPM shall be aware of current national standards of trauma care and hold their call panel physicians to this expectation; (10.27) creation of protocols, guidelines, or pathways based on the findings from multidisciplinary meetings; and, ~~(10.28) the QI program reviews the appropriate referral of patients to the regional organ procurement organization and subsequent organ donation rate.~~
I, II	**Trauma Multidisciplinary Review (TMR) Process**	R	(10.29) This process shall be led by the TMD and the TPM with representation from all core surgeons, specialties, and services, participates on the trauma team at the facility, which is authorized by the facility to establish, review, and improve the care of the injured. The TMR process shall: 1. establish trauma treatment protocols; 2. oversee compliance with these protocols; 3. identify opportunities for improvement; 4. develop plans for resolution and ensures improvement of identified issues; and, 5. monitor loop closure of issues identified in the process. (10.30) While there may be a single multidisciplinary meeting in a facility, this multidisciplinary process shall consist of two distinct parts. Meeting attendance is required at 50% for each meeting: 1. Trauma Program Operations Review Committee; and, 2. Trauma Peer Review Committee.

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			(10.31) The minutes and sign in sheets of these discussions shall be recorded separately. (10.32) The peer review portion shall report through the hospital's trauma QI program to assure protection and continuity of practitioner data for credentialing processes. The conduct of the peer review meeting shall be compliant with state and federal law to ensure confidentiality and patient protection. (10.33) Meetings shall occur with a frequency that ensures timely resolution of issues identified through the trauma QI program. Trauma centers with few trauma patients may accomplish this on a quarterly basis while centers with more trauma volume may need to hold such meetings on a more frequent basis. ~~(10.34) Attendance by the ED director or EM liaison, TMD, all core surgeons, specialties (including, but not limited to, neurosurgical, orthopedic, radiology, and critical care liaisons), and services is required and they shall attend at least 50% of the Trauma Peer Review Committee meetings.~~ ~~(10.35) In circumstances when attendance is not mandated (non-core members), the TMD ensures dissemination of information from the trauma peer review committee. The TMD shall document the dissemination of information from the trauma peer review committee.~~
	11. Responsibility to the Arkansas Department of Health (ADH)		
I, II	**Trauma Registry Data and Submission to the Trauma Registry**	R	(11.1) Timely abstraction of the charts of injured patients who meet inclusion criteria; data shall be entered into the Trauma Registry and closed within 60 days of discharge 80% of the time during the 3 year review period. (11.2) Data shall be submitted to the Trauma Registry when requested by the ADH. (11.3) At the time of submission of the designation site survey pre-review questionnaire, the trauma center shall submit all trauma patient records to the Trauma Registry even if the submission is not within the standard reporting period. (11.4) Trauma Registry data are collected and analyzed.
I, II	**Accuracy of the Trauma Data Submitted to the Trauma Registry**	R	(11.5) The trauma center shall create and implement a verifiable process to ensure accuracy and completeness of the data submitted to the Trauma Registry. (11.6) Trauma centers are required to document complete and accurate data for all trauma patients meeting state Trauma Registry inclusion criteria.
I, II	**Participation in Trauma Regional Advisory Council (TRAC)**	R	At least 50% of the required (to be determined by the TRAC) regional meetings shall be attended by the: (11.7) TMD or physician designee; and, (11.8) TPM or nurse designee.

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I, II	**Active Participation in the Regional and State QI Review Process**	R	(11.9) The TMD (or his/her respective physician designee) and TPM (or his/her respective nurse designee) shall attend 50% of the regional peer review meetings. (11.10) The TMD (or his/her respective physician designee) and TPM (or his/her respective nurse designee) shall attend 100% of the regional and state peer review meetings when the facility's cases are discussed. (11.11) The trauma center shall provide adequate clinical patient information for meaningful discussion in the protected QI meetings sanctioned by the ADH. (11.12) The Trauma Program shall provide data and participate meaningfully in the regional and state QI meetings as required by the chair of the committee, TRAC MD, or state TMD.
I, II	**Community Outreach and Education in Trauma-specific Opportunities Sponsored by the Hospital**	R	(11.13) The facility shall provide opportunities for staff and community physicians, nurses, allied health personnel, and prehospital providers to receive CME credits. The facility may satisfy this requirement by working independently or with other facilities, the TRAC, regional organizations, or ADH-approved educational foundation to provide this education. The facility's contribution to education and outreach shall be verifiable at review.
I	**Accredited Residency Education Program (Level I)**	R	(11.14) A Level I trauma center shall provide a continuous rotation in trauma care for residents (PGY 2 or higher) that is part of an accredited (adult or pediatric) graduate medical education program in any of the following disciplines: general surgery, orthopedic surgery, EM, or neurosurgery; or support an acute care surgery fellowship consistent with the educational requirements of the American Association for the Surgery of Trauma. ~~http://www.aast.org/acutecaresurgery/programrequirements.aspx~~ www.aast.org/curriculum Pediatric Level I trauma centers requires PGY 3 or higher). In circumstances in which the primary residency program is not housed in the facility, the rotation should lead to increasing the number of trained graduates in that specialty.
	12. Trauma Research		
I	**Trauma Research (Level I)**	R	(12.1) The Level I trauma center shall meet one of the following research requirements: • minimum of 10 peer-reviewed articles published or accepted in journals included in *Index Medicus* in 3 years; or 4 peer-reviewed articles published in journals included in *Index Medicus/Medline* http://www.nlm.nih.gov/bsd/aim.html in 3 years; • meet the criterion of 3 of 7 scholarly activities as defined below by ACS in *Resources for Optimal Care of the Injured Patient 2006* :

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			1. "Leadership in major trauma organizations. There must be evidence of this leadership for a Level I organization. Evidence includes membership in trauma committees of any of the regional and national trauma organizations such as the American Association for the Surgery of Trauma (AAST), Western Trauma Association, Eastern Association for the Surgery of Trauma, and the ACS Committee on Trauma. 2. Peer-reviewed funding for trauma research. There should be demonstrated evidence of funding of the center from a recognized government or private agency or organization. 3. Evidence of dissemination of knowledge to include review articles, book chapters, technical documents, Web-based publications, editorial comments, training manuals, and trauma-related course material. 4. Display of scholarly applications of knowledge as evidenced by case reports or reports of clinical series in journals included in MEDLINE. 5. Participation as a visiting professor or invited lecturer at national or regional trauma conferences. 6. Support of resident participation in institution-focused scholarly activity, including laboratory experiences, clinical trials, or resident trauma paper competitions at the state, regional, or national level. 7. Mentorship of residents and fellows, as evidenced by the development of a trauma fellowship program or successful matriculation of graduating residents into trauma fellowship programs." (12.2) The research shall represent work related to the trauma center or as part of a national research consortium. (12.3) The articles shall include authorship or co-authorship by a member of the general surgery trauma team, and at least two of the following six disciplines: EM, neurosurgery, orthopedics, radiology, anesthesia, and rehabilitation.
	13. Other Responsibilities of Comprehensive Trauma Centers		
I, II	**Injury and Violence Prevention (IVP)**	R	(13.1) The facility shall have an identified staff member who is the point of contact for IVP activities ~~and notify the Trauma Section and the TRAC IVP Committee regarding the identity of the designated person~~. (13.2) ~~The facility shall demonstrate involvement with the TRAC in regional IVP planning efforts.~~ (13.3) The facility shall work with the ADH-affiliated IVP programs by participating in evidence-based prevention programs, either alone or in collaboration with other facilities, such as the regional Hometown Health Initiative and local EMS agencies~~, or the TRAC~~.

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			(13.4) ~~The facility shall demonstrate participation in ADH-affiliated IVP programs and shall participate in evaluation efforts for regional IVP programs.~~
I, II	**Alcohol Screening and Intervention**	R	(13.5) The facility shall have a method to screen admitted trauma patients for alcohol use or abuse and have a plan to assist patients with positive screens. Screening can be in the form of a consumption questionnaire or biological measurements. Assistance can be provision of appropriate referrals or in-house intervention, such as brief motivational interviewing.
I, II	**Disaster Management**	R	(13.6) The hospital shall participate in regional disaster planning and drills. (13.7) The hospital shall meet the disaster-related requirements of TJC, the AOA/HFAP or an equivalent licensing body. (13.8) A trauma panel surgeon or clinical member of the trauma team shall be involved in the hospital's disaster committee. (13.9) As an emergency response exercise, the hospital shall activate its Emergency Operations Plan twice a year at each site included in the plan. If the hospital activates its Emergency Operations Plan in response to one or more actual emergencies, these emergencies may serve in place of emergency response exercises. Regional participation would be accepted. One of the exercises should include an influx of patients. After action review should be recorded and verifiable. Tabletop sessions, though useful, are not acceptable substitutes for these exercises. (13.10) The trauma center shall have an Emergency Operations Plan described in the hospital disaster manual.
I, II	**Organ Procurement Organization (OPO)**	R	(13.11) The trauma center shall have an established relationship with a recognized OPO. (13.12) The trauma center shall have written policies for triggering notification of the OPO. (13.13) The trauma center shall track its percentage of referral of eligible patients and track the percentage of successful donors from the pool of referred patients.

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Criteria for Level III Trauma Centers

Purpose: To define and clarify the criteria necessary for a general care facility to become a Level III trauma center and ensure optimal care of the injured.

Definition: The Level III trauma center (general) 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, stabilization, and also arrange for transfer to a facility that can provide definitive trauma care. General surgeons and orthopedic surgeons are required in a Level III facility.

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Level III Criteria			
Level	**Section**	**Required (R) or Desirable (D)**	**Criteria**
	TRAUMA PROGRAM		
	1. Support/Infrastructure		
III	**Institutional Support**	R	(1.1) Clear evidence of hospital board, administrative, and medical staff support in the form of a written resolution to attain and maintain the level of designation; the resolution shall be updated and signed at least every three years. (1.2) Financial support of additional FTEs, space, and/or equipment, if required. (1.3) Authorization for the trauma program's leadership and committees to perform their required duties. (1.4) Clearly defined lines of reporting for the TMD/TMCD and TPM within the organization.
III	**Trauma Program Administration and Infrastructure**	R	(1.5) Program within an acute care facility with defined leadership (TMD/TMCD and TPM) with the authority to develop, oversee and improve the care of the injured within the facility, and is integrated into the local, regional, state, and national system of trauma care. (1.6) The trauma program shall participate in the development and improvement of prehospital care protocols and patient safety programs.
	2. Staffing		
III	**Trauma Medical Director (TMD)/Trauma Medical Co-Director (TMCD)**	R	***Requirements and qualifications for the TMD/TMCD:*** (2.1) ~~A facility may have a co-director who is a general surgeon. If a facility has a director and a co-director, one shall be a general surgeon.~~ A facility may have a director and a co-director. The director shall be a general surgeon. (2.2) A physician in good standing in the institution with state licensure, has membership in professional organizations, possesses clinical knowledge and expertise, actively participates in the care of injured patients, and has a personal interest and the time to be the champion for trauma patient care to the medical staff and the trauma center. (2.3) Board-certified/Board-eligible in his/her specialty or a FACS, or a FACOS. (2.4) Current in ATLS as either a provider or an instructor. (2.5) The TMD cannot be a locum or itinerate. ***Responsibilities and duties TMD/TMCD:***

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(2.6) The TMD must have the responsibility and authority to assure compliance with above requirements and may not direct more than one trauma center.

Comment: Please clarify/elaborate on the purpose of requiring that a TMD only direct one facility. If a surgeon TMD at a level 3 facility also provides care at a nearby level 4 facility, wouldn't it be reasonable for that surgeon to also act as TMD for that level 4 facility. It would seem that a level 3 surgeon TMD would likely be the most qualified to direct a level 4 facility. Should it be limited to state that a TMD may only direct a single Level 1, 2 ,or 3 facility. Comment: Level 1 and 2 should only be dedicated to the facility. No strong opinion on a Level 3 also being the TMD for Level 4. Recommend adding the caveat that the TMD have the time and resources to be effective in the role at both facilities.

(2.5) Participate in trauma call.

(2.6) Lead the trauma QI and patient safety programs within the trauma center.

(2.7) Have a method to identify injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners.

(2.8) There shall be a verifiable, written job description that clearly identifies expectations of leadership and authority to perform the duties required, including the authority to conduct trauma-specific peer review, place members on and take members off of a trauma *call schedule* **, be involved in the development of the trauma center's bypass protocol and the decisions regarding bypass and ~~"Charlie Temp"~~ "No Capability" status, and affect process changes identified in the trauma multidisciplinary meetings.

(2.9) Have responsibility and authority for determining each call panel member's ability to participate on the trauma call schedule based on a periodic review.

(2.10) Have responsibility and authority to ensure compliance with verification requirements; and report changes in the program that would affect the designation of the facility to the ADH.

(2.11) Have the ability to contribute to the TPM's performance evaluation.

(2.12) Demonstrate with his/her signature awareness of the facility's invoices to the ADH for payment.

(2.13) TMD ~~or TMCD (shall be a surgeon)~~ shall perform a written annual review of the performance of all the surgeons on the call panel. Documentation of such shall be available for review at the designation site survey.

(2.14) The TMD or his or her respective physician designee shall attend at least 50% of both Trauma Program Operations Review Committee and Trauma Peer Review committee meetings.

** *The ability to grant or remove a provider's privileges to practice in an area is reserved for the facility's Board and Medical Staff Committee. There should be a distinction of a provider's privileges to participate in care of the trauma patient*

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			and participation in a trauma call schedule. The facility's Board and Medical Staff Committee shall take into consideration the input of the TMD or TMCD when considering trauma privileges, while the TMD or TMCD shall have the discretion of which providers participate in the trauma call schedule. A decision by the TMD or TMCD to place or remove a provider from the trauma call schedule shall not be viewed as affecting or restricting a provider's hospital privileges, as that decision is reserved for the facility's Board and Medical Staff Committee.
III	**Trauma Program Manager (TPM)**	R	***Requirements and qualifications for the TPM:*** (2.15) A RN with responsibility for monitoring and evaluating nursing care of trauma patients and the coordination of QI and patient safety programs for the trauma center in conjunction with the TMD/TMCD. (2.16) He/she shall be well trained and knowledgeable in trauma. The TPM shall also obtain continuing education so as to remain up to date in regard to trauma. (2.17) ATCN, TNCC, TPATC or ADH-approved equivalent course certifications shall be current. (2.18) The training of a TPM new to this position shall include a TPM course, a QI course, and an AIS coding course or state-sponsored coding course. ***Responsibilities and duties of the TPM:*** (2.19) There shall be a verifiable, written job description for the TPM that clearly identifies expectations of leadership and authority to perform the duties required. (2.20) Dedicate at least 1.0 FTE to trauma programs having a trauma patient record volume of 500 or greater. (2.21) The time and resources allocated shall be sufficient for the TPM to be effective in the job of QI, community education, clinical education, and IVP. (2.21)The TPM or his or her nursing designee shall attend at least 50% of both Trauma Program Operations Review Committee and Trauma Peer Review committee meetings.
III	**Trauma Registrar**	R	(2.22) There shall be a verifiable, written job description for the Trauma Registrar that clearly identifies expectations. (2.23) The facility shall have adequate resources to maintain accurate and timely collection, evaluation and submission of trauma data. (2.24) After passing 500 trauma patient records, there shall be an identified Trauma Registrar, who is separate from but supervised by the TPM and who has appropriate training in injury severity scaling (e.g., AAAM course ~~or state-sponsored coding course,~~ ATS Trauma Registrar Course). Recommended Change: …who has appropriate training in AAAM Abbreviated Injury Scaling course, American Trauma Society's Trauma Registry course, and annual attendance at the Arkansas Trauma Registry Users Conference. Comment: or designee (word it the same as Level 1 and 2s)

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III	**Trauma Program Staff**	R	(2.25) Trauma programs shall have adequate support resources to efficiently and effectively oversee and administer the trauma program and remain engaged in an effective QI process.
III	**Trauma Liaisons**	R	(2.26) Official physician liaisons shall be named for EM, orthopedics, anesthesia, critical care, and radiology (if available in-house). In addition, if a neurosurgery service is provided, a liaison shall be named. Liaisons are responsible for the accurate dissemination of information from the trauma committee meetings to their service members. (2.27) ~~Liaisons are responsible for attending the Trauma Program Operational Review Committee meetings and at least 50% of Trauma Peer Review Committee meetings. The liaison responsibilities may be shared by physician members of the specialty.~~ Recommended Change/Question: does the liaison need to be a physician or the director of the specialty group? Comment: change to wording of Level 1s and 2s
III	**Trauma Team**	R	(2.28) A predetermined set of care providers and ancillary personnel (physicians, mid-level practitioners, nurses, X-ray technologists, laboratory, respiratory therapist, etc.) needed to provide resuscitation, rapid triage, and transfer of the severely injured.
III	**Consultant Coverage**	R	(2.29) Trauma centers shall have an internal policy identifying the expectations for consultant responses. Deviations to the policy shall be tracked in the QI process. If a consultant is unable to provide the service indicated by the ATCC dashboard, the consultant shall be involved in the transfer process with ATCC. Comment: If the consultant is to be involved in transfer, it needs to be specified what involvement means. A consulting phone call in discussion with the ED regarding the results of the images as read by Radiology or ED physician should suffice. Or will it be required to see the patient resulting in a delay of transfer? Comment: Medical Record documentation as to why service was not able to be provided and the consultant should be available to speak to the referring physician.
	3. Participation		
III	**General Surgery Participation**	R	***Requirements of the general surgeon(s):*** (3.1) Shall have 24/7 general surgical coverage. (3.2) Shall have privileges in general surgery. (3.3) Shall be Board-certified/Board-eligible in general surgery or a FACS, or a FACOS or satisfy the criteria for an alternate pathway if deemed necessary by the ADH.

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			(3.4) ~~Shall have taken ATLS at least once or shall be current in ATLS within one year of hire.~~ Shall have taken ATLS at least once or shall be current in ATLS within one year of hire. If a general surgeon who is new to a facility has never taken ATLS, he or she will have a one year grace period during which they must obtained ATLS certification. This period will begin commensurate with their participation on the call panel (3.5) Shall obtain the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17 hours of trauma-specific internal education every three years. (3.6) ~~Core~~ Call panel surgeons shall participate in at least 50% of the Trauma Peer Review Committee meetings. ~~and disseminate information back to all surgeons.~~ (3.7) Surgeons shall respond to the ED promptly (within 30 minutes) an aggregate of 80% of the time when on-call and when the highest level of trauma is activated. (3.8) Trauma panel surgeons shall respond promptly to activations, remain knowledgeable in trauma care principles, whether treating patients locally or transferring them to a center with more resources, and participate in QI activities.
III	**Orthopedic Surgery Participation**	R	***Requirements of the orthopedic surgeon(s):*** (3.9) Level III trauma centers shall have 24/7 orthopedic coverage. ~~In a designation or re-designation year, Level III trauma centers that do not have 24/7 orthopedic coverage may attain the classification in one of two ways:~~ ~~1. In the first year, the Level III trauma center shall not transfer more than 50% of all trauma patients for treatment at another facility; in the second year, the center shall not transfer more than 45% of trauma patients; in the third year and thereafter, the center shall not transfer more than 40% of trauma patients. If the Level III trauma center fails to meet these thresholds in any year, the Level III trauma center must submit a Corrective Action Plan for approval to the Arkansas Department of Health to be implemented within one year of the approval date. If neither the threshold nor the Corrective Action Plan is attained, the Level III designation shall be suspended and the center must reapply for designation; or~~ ~~2. The Level III trauma center must transfer 5% fewer trauma patients for treatment at another facility than the center transferred in the previous year (the "index year"); 10% fewer than the index year in the second year; and 15% fewer than the index year in the third year. Facilities that remain above the 40% standard for transfers of trauma patients subsequent to year three shall continue to decrease by 5% annually until the 40% standard is met. If the Level III trauma center fails to meet these thresholds in any year, the Level III trauma center must submit a Corrective Action Plan for approval to the~~

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			~~Arkansas Department of Health to be implemented within one year of the approval date. If neither the improvement threshold nor the Corrective Action Plan is attained, the Level III designation shall be suspended and the center must reapply for designation.~~ Orthopedic surgeons shall have privileges in general orthopedic surgery, providing 24/7 orthopedic coverage, on-call and promptly available when requested by the trauma surgeon or EM specialist, and expected to provide care within the scope of general orthopedic practice. Must meet the requirement 95% of the time. Comment: Transfer percentage should be removed as a requirement. (3.10) Shall obtain the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17 hours of trauma-specific internal education every three years. (3.11) A liaison shall participate in at least 50% of both the Trauma Peer Review Committee and Trauma Program Operation Review Committee meetings ~~the Trauma Peer Review Committee meetings~~ and disseminate information back to all orthopedic surgeons on the call panel. Add the same language here as is in Level 1 and 2 (3.12) ~~Orthopedic surgeons shall have privileges in general orthopedic surgery.~~ (3.13) In the cases where the orthopedist is not dedicated to the facility 24/7, an orthopedic backup plan is required and shall be approved by the TMD. (3.14) The following orthopedic specific QI filters shall be in place and tracked (other filters may be added at the discretion of the ADH Trauma Section): 1. time from injury to washout for open fractures; 2. time from injury to ORIF for femur fracture; and, 3. appropriateness and timing of IV antibiotics for all open fractures.
III	**Neurosurgical Participation**	D	***Neurosurgical coverage is not required in a Level III facility.*** However, if a Level III facility represents itself as having neurosurgical capability and capacity on the ATCC dashboard, the following applies and is required of the neurosurgeons at the facility: (3.15) Shall obtain the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17hours of trauma-specific internal education every three years. (3.16) The liaison shall participate in at least 50% of both the Trauma Peer Review Committee and Trauma Program Operation Review Committee meetings ~~the Trauma Peer Review Committee meetings~~ and disseminate information back to all neurosurgeons on the call panel. Add the same language here as is in Level 1 and 2 (3.17) The following neurosurgical-specific QI filters shall be tracked (others may be developed at the discretion of the ADH Trauma Section):

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			1. all cases requiring the backup to be called in or the patient to be diverted or transferred due to unavailability of the neurosurgeon on-call; and, ~~2.~~ neurotrauma care shall be reviewed for compliance with the Brain Trauma Foundation Guidelines. ~~https://www.braintrauma.org/pdf/protected/Guidelines_Management_2007w_bookmarks.pdf~~ https://www.braintrauma.org/uploads/11/14/Guidelines_Management_2007w_bookmarks_2.pdf
III	**Anesthesiology Participation**	R	***Requirements of the anesthesiologist(s):*** (3.18) Anesthesiology services are promptly available for emergency operations. (3.19) Anesthesiology services are promptly available for airway problems. This may be fulfilled by an anesthesiologist or a CRNA. If a CRNA is utilized an anesthesiologist shall be promptly available. If a CRNA is utilized it shall be with the approval of the Chief of Anesthesiology. (3.20) There is an anesthesiologist liaison designated to the trauma program. (3.21) The availability of the anesthesia services and the absence of delays in airway control or operations are documented by the trauma QI program. (3.22) In trauma centers without in-house anesthesia services, protocols are in place to ensure the timely arrival at the bedside of the anesthesia provider. (3.23) In a center without in-house anesthesia services, there is documentation of the presence of physicians skilled in emergency airway management. (3.24) The anesthesia liaison participates in the trauma QI program. (3.25) The anesthesiology representative or designee to the trauma program attends at least 50% of both the Trauma Peer Review Committee meetings and Trauma Program Operations Review Committee meetings.
III	**Emergency Medicine Participation**	R	***Requirements of emergency medicine physician (s):*** (3.26) There is a liaison from the EM Service to the Trauma Program who effectively disseminates information back to the EM service. (3.27) The EM liaison has the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17 hours of trauma-specific internal education every three years. (3.28) The EM liaison regularly attends the trauma QI meeting and has documented 50% attendance at both the Trauma Peer Review Committee meetings and the Trauma Program Operations Committee meetings. Add the same language here as is in Level 1 and 2
III	**Medical Specialty Support**	R	(3.29) The following specialty shall be on-call and promptly available at the request of the trauma service:

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			• Internal medicine (family practice may be substituted for internal medicine)
	TRAUMA FACILITY AND OPERATIONS		
	4. Emergency Department (ED)		
III	**Leadership**	R	(4.1) The ED has a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients.
III	**Communication with ED Physicians and Nurses**	R	(4.2) A reliable method shall exist to communicate changes in trauma process to all staff members caring for injured patients in the ED. An example of this would be a communication book in the ED, requiring a signature by nurses and physicians when changes or other important updates to the trauma process are determined through the QI program.
III	**Physician, Mid-level Practitioners and Nursing Availability**	R	(4.3) ED shall have 24/7 in-house emergency coverage by physicians and nurses. (4.4) A tracking mechanism shall be in place and reviewed in the QI program. The QI program shall review all times the ED physician leaves the ED uncovered in order to respond to an emergency in-house. (4.5) EM physicians on the call panel are regularly involved in the care of injured patients. (4.6) The EM representative or designee to the Trauma Peer Review Committee attends a minimum of 50% of these meetings. (4.7) There is EM physician participation with the overall trauma QI program and the Trauma Program Operational Process Performance Committee (dealing with systems issues).
III	**CME Requirements for Providers**	R	(4.8) Physicians who cover the ED in rural trauma centers may not see enough trauma to stay abreast of current treatment protocols. Category I CME is necessary to maintain knowledge in the field. The physician or mid-level practitioner caring for trauma patients in the ED shall obtain the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17hours of trauma-specific internal education every three years.
III	**Trauma Educational Certification for Physicians and Mid-Level Practitioners**	R	(4.9) Maintaining current ATLS certification for physicians and mid-level practitioners is ~~essential~~ required for those who cover the ED as participants on the trauma team who are not Board-certified in EM. Physicians Board-certified/Board-eligible in EM, as recognized by ABEM, AOBEM or ABP, shall have completed ATLS at least once, and are encouraged but not required to be current. Comment: ATLS current for all providers. Comment: re-word the paragraph

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			to separate out the mid-level vs the EM physicians. For all Level 3 the mid-levels are required to be current in ATLS.
III	**Trauma Nursing Educational Preparation**	R	(4.10) Current certification in one of the trauma nursing courses is essential for nurses who assist in trauma resuscitations. ATCN, TNCC, TPATC or ADH-approved equivalent course will be obtained. 80% of ED trauma nurses shall be certified and newly hired ED trauma nurses shall be certified within their first year of hire. (4.11) 80% of nurses working in the ED shall be current in ACLS and PALS or ENPC.
III	**Trauma Nursing Continuing Education**	R	(4.12) It is necessary that nurses who assist with trauma resuscitations continue to be educated on trauma treatment and issues and shall obtain 12 hours of trauma-specific nursing CE or 12 hours of trauma- specific internal education every three years.
III	**Paramedic Educational Preparation**	R	(4.14) All paramedics working in the ED, who participate in trauma resuscitation, must ~~be certified in PHTLS. May~~ audit TNCC ~~as a substitution for PHTLS~~ or ATLS. Word as it is in the Level 1 and 2 (4.15) All paramedics working in the ED shall be current in ACLS and PALS 80%. Word as it is in the Level 1 and 2
III	**Paramedic Continuing Education**	R	(4.16) It is necessary that paramedics who assist with trauma resuscitations continue to be educated on trauma treatment and issues and shall obtain 12 hours of trauma - specific CE or 12 hours of trauma-specific internal education every three years.
III	**Activation Criteria**	R	(4.13) The criteria for the highest level of trauma team activations shall be clearly defined and evaluated by the QI program. (4.14) A patient ≤ 15 years of age who meets a center's criteria for the highest level of activation or is classified as either a major or moderate trauma patient under the Arkansas Trauma Triage Protocol and requires transfer, shall be transferred to a designated pediatric trauma center. (4.15) ~~The facility shall activate the predetermined trauma team based on a set of written activation criteria that include:~~ The facility shall activate the entire trauma team to include the operating room (OR) and general surgeon, based on a set of written activation criteria, unless otherwise excluded in section V.C.6: 1. confirmed hypotension (< 90mmHg adults or age appropriate for children) attributed to trauma; 2. GCS < 9 with a mechanism due to trauma (general surgeon response can be at the discretion of the ED physician Comment: Add after ED physician in an isolated head injury with GCS <9); 3. respiratory distress attributed to trauma; 4. gunshot wound to the neck, chest or abdomen; 5. transfer of a patient from another facility receiving blood or pressure support to maintain vital signs; and, 6. any patient for whom the ED physician feels the highest level of activation is warranted.

Commented [CJ4]: Comment: Recommend 80% requirement (same as nursing).
Remove PHTLS and allow for audit of TNCC or ATLS

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			(4.16) Activation of the trauma team for the highest level shall be based on prehospital notification when available. (4.17) Facilities may create a tiered activation system with variable response from hospital and physician personnel, but shall have the above criteria in the highest level of activation. For the program's highest level of activation, the surgeon shall be in the ED on patient arrival, with adequate notification from the field. The maximum acceptable response time is 30 minutes tracked from time of activation. Activation occurs based on prehospital criteria when available. The program shall demonstrate that the surgeon's presence is in compliance at least 80% of the time. Demonstration of the attending surgeon's prompt arrival for patients with appropriate activation criteria shall be monitored by the hospital's trauma QI program. (4.18) The facility shall be able to demonstrate under and over-triage rates based on their activation criteria. (4.19) The facility shall be able to track the arrival of the physicians who should respond to a given level of activation.
III	**Rural Trauma Education ~~Team Development Course (RTTDC)~~**	R	(4.20) Rural facilities shall demonstrate participation by members of the trauma resuscitation team, including physicians, nurses and allied health personnel within a regional facility by attending once during a review period. Rural facilities shall demonstrate participation by members of the trauma resuscitation team, including physicians, nurses and allied health personnel within a regional facility by attending once during a review period. (e.g., RTTDC or ADH approved equivalent).
III	**Helipad or Landing Zone**	R	(4.21) Shall have a helipad or a written, organized plan for getting the trauma patient to a safe landing zone with alternative sites should the primary landing site be unavailable.
III	**Trauma Image Repository**	R	(4.22) Availability to send and receive images to and from TIR in the ED. (4.23) Utilization of TIR when appropriate for expediting trauma patient care.
III	**Roles and Responsibilities in the Trauma Bay**	R	(4.24) Written protocol for roles and responsibilities of all team members during trauma team resuscitations.
III	**Safe Transport of Patients Within and Out of the Emergency Department**	R	(4.25) A policy is required describing the level of resources required for the safe movement of patients out of the trauma bay, either within the ED or to other departments in the trauma center.
	5. Essential Equipment (shall include but not be limited to)		
III	**Airway Control**	R	

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	and Ventilation Equipment (Adult and Pediatric)		(5.1) Neonatal to adult oxygen masks, ambu bags, and ETTs (5.2) Every facility shall have equipment and a plan for difficult intubations. (5.3) Cricothyrotomy supplies and drugs necessary for emergency intubation
III	**Airway Monitoring**	R	(5.4) Pulse Oximetry (5.5) Qualitative End-tidal CO2 Determination – Color Change Detectors (5.6) Continuous End-tidal CO2 Monitoring if neurosurgery services are provided
III	**Hemorrhage Control**		(5.7) ~~Junctional tourniquet capable of occluding the aorta~~ Comments: add CAT tourniquets or equivalent and pelvic binders
III	**Thermal Regulation**	R	(5.7) The ability to regulate the room temperature in the trauma bay in a reasonable amount of time. (5.8) Fluid warming devices (5.9) Thermal control blankets
III	**Large Bore IV Catheters**	R	(5.10) 14 – 18 gauge IVs (5.11) Interosseous catheters
III	**Focused Assessment with Sonography for Trauma (FAST)**	R	(5.12) Machine available to the trauma team and members of the trauma team trained in its use.
III	**Standard Procedure Trays**	R	(5.13) Thoracotomy (adult and pediatric) (5.14) Tube thoracostomy tray with tubes (adult and pediatric) (5.15) Surgical tray with airway equipment (adult and pediatric)
III	**Standard Airway Equipment**	R	Ensure equipment is available in both adult and pediatric sizes. (5.16) Oral and nasal airway (5.17) Ambu bags (5.18) ETT - with cuffed ETT down to size 4.0
III	**Pediatric Resuscitation Equipment**	R	(5.19) Color-coded, length-based resuscitation tape Weight-based, color-coded resuscitation cart Pediatric equipment available as listed in the American Academy of Pediatrics Joint Policy Statement-Guidelines for Care of Children in the Emergency Department (2009) ~~*http://pediatrics.aappublications.org/content/early/2009/09/21/peds.2009-1807.citation*~~ *http://pediatrics.aappublications.org/content/124/4/1233*

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III	**PACS and Lab Results Computer**	R	(5.20)	Shall be in reasonable proximity to the trauma bay for ease of access by the trauma team.
	6. Operative Services			
III	**Operating Room (OR)**	R	(6.1) (6.2) (6.3) (6.4) (6.5)	The ORs are promptly available within 30 minutes of notification of the need for an urgent case to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization and compartment decompression. The OR is adequately staffed and promptly available. The OR has the essential equipment. There is craniotomy equipment available in trauma center that offers neurosurgery services. The QI program evaluates OR availability and delays when an on-call team is used.
III	**Post-anesthesia Care Unit (PACU)**	R	(6.6) (6.7) (6.8) (6.9) (6.10)	The PACU has qualified nurses available 24/7 as needed during the patient's post-anesthesia recovery phase. The PACU is covered by a call team from home with documentation by the QI program that PACU nurses are available and delays are not occurring. The PACU has the necessary equipment to monitor and resuscitate adult and pediatric patients. In facilities where pediatric patients are cared for, this equipment shall include ambu bags, ETTs and oral airways appropriate to the age of the patients. The QI program ensures that the PACU has the necessary equipment to monitor and resuscitate patients. If the PACU acts as an overflow area for the ICU, and trauma patients are housed there while waiting for an ICU bed, the nurses in the PACU shall have similar qualifications as the ICU nurse for the care of trauma patients.
	7. Intensive Care Unit			
III	**Intensive Care Unit (ICU)**	R	(7.1) (7.2) (7.3)	When a critically ill trauma patient is treated locally, there shall be a mechanism in place to provide prompt availability of a physician, who has the ability to care for critically ill patients 24/7. The surgical director or the surgical co-director shall be a surgeon, who is credentialed by the hospital to care for ICU trauma patients, and who participates in the QI program. Coverage of emergencies in the ICU does not leave the ED without an appropriate physician coverage plan.

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			(7.4) The trauma center has a surgical director or co-director for the ICU who participates in setting policies and administration related to trauma ICU patients. (7.5) The trauma surgeon remains in charge of trauma patients in the ICU and is kept informed of and concurs with major therapeutic and management decisions. (7.6) A qualified nurse is available 24/7 to provide care during the ICU phase. (7.7) The patient/nurse ratio does not exceed 2:1 for critically ill patients in the ICU. (7.8) The ICU has the necessary equipment to monitor and resuscitate patients. (7.9) There are written protocols for declaration of brain death. (7.10) When ICU patients are held in other locations (PACU, ED) due to temporary lack of bed space, all requirements for ICU care would apply. (7.11) Intracranial pressure monitoring in facilities with neurosurgical coverage. Guidelines for the use of ICP monitoring shall follow the Brain Trauma Foundation Guidelines. https://www.braintrauma.org/uploads/11/14/Guidelines_Management_2007w_bookmarks_2.pdf
	8. Other Trauma Care Areas and Services		
III	**Pediatric Care**	R	(8.1) Any adult trauma center that annually admits 100 or more injured children ≤~~15~~ 14 years of age shall fulfill the following additional criteria demonstrating its capability to care for injured children: trauma surgeons shall be credentialed for pediatric trauma care by the hospital's credentialing body, and there shall be a pediatric ED area, pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma QI program. (8.2) Hospitals admitting fewer than 100 injured children annually, ≤15 14 years of age, shall review and document the review of all pediatric patients in the QI program. (8.3) Pediatric resuscitation equipment shall be available in all pediatric care areas.
III	**Geriatric Care/Special Needs**	R	(8.4) The facility shall have a protocol for the admission and care of geriatric/special needs patients (age > 65 years). (8.5) There shall be a protocol in place in the facility for the rapid evaluation of patients with head injuries who are on anticoagulants, which shall include a component addressing the rapid reversal of such agents when possible. The protocol may exclude patients who are on aspirin only.
III	**Laboratory Services Available 24/7**	R	

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			(8.6) Standard analysis of blood, urine, and other body fluids, including micro-sampling for pediatric patients when appropriate. Blood gases and pH determination is required. (8.7) The capability for coagulation studies, blood gases, and microbiology shall be available 24/7.
III	**Blood Bank/Ability to Transfuse Blood 24/7**	R	(8.8) The blood bank shall be capable of blood typing and cross matching. (8.9) The blood bank shall have an adequate supply of red blood cells available with additional red blood cells, fresh frozen plasma, platelets and cryoprecipitate to meet the needs of injured patients through a regional source and tracked through the QI program. (8.10) Mass transfusion protocol that results in a balanced resuscitation with red cells, plasma and platelets. (8.11) Prompt availability of universal donor blood. (8.12) Facilities shall have a protocol for the rapid reversal of anticoagulants when available. Facilities may develop their own protocol until such time that state guidelines are adopted.
III	**Radiological Services Available 24/7**	R	(8.13) Radiologists are promptly available, in person or by teleradiology, when requested for the interpretation of radiographs. (8.14) X-ray technologists shall be promptly available 24/7 upon activation of the trauma team. (8.15) Diagnostic information is communicated in a written form and in a timely manner. (8.16) Critical information is verbally communicated to the trauma team. (8.17) Final reports accurately reflect communications, including changes between preliminary and final interpretations. (8.18) Changes in interpretation shall be monitored through the QI program. (8.19) The trauma center shall have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the radiology department. (8.20) Conventional radiography and CT are available 24/7. (8.21) When the CT technologist responds from outside the hospital, the Trauma Program documents the response time. (8.22) TIR is utilized to expedite care of patients being transferred in and out when appropriate.
III	**Respiratory Therapy Services**	R	(8.23) There shall be a respiratory therapist available and on-call 24/7.
III	**Rehabilitation Services**	R	(8.24) Facilities shall be required to provide rehabilitation services or have transfer agreement(s) signed with rehabilitation facilities to ensure the timely transfer of patients requiring these services.

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III	**Therapy Services**	R	(8.25) Facilities are required to provide these services or have transfer agreement(s) signed to ensure the timely transfer of the following services: • Physical therapy • Occupational therapy • Speech therapy
III	**Social Services**	R	(8.26) Social work Case management Chaplain services
	9. Effective Transfer of Patients		
III	**Coordinate All Trauma Transfers Through the ATCC**	R	~~(9.1)~~ All trauma transfers out shall be coordinated through the ATCC. Compliance shall be 95% of the time as an aggregate (average) over the reporting period (this does not apply to out-of-state hospitals transferring to out-of-state hospitals). The program shall monitor transfers in its QI program and be able to demonstrate compliance. The decision to accept or not accept a patient to the facility shall be made within 10 minutes of being contacted by the ATCC at least 90% of the time. The exception to this 10 minute requirement is for stable, single system orthopedic, ophthalmologic, or maxillofacial injuries where discussion with the specialist would be beneficial (all communication shall still come though ATCC and an answer given as to acceptance within 20 minutes). The acceptance time shall be tracked in the facility's QI program. for acceptance of a transfer. The acceptance may be granted by anyone designated by the facility to accept a patient on behalf of the facility, including an ED nurse. A direct physician-to-physician contact is desirable but should not delay the transfer process. Recommended Change - the requirement for accepting inbounds transfers within 10 minutes of the initial call. This is often times unrealistic if we need to view radiology images, ask for other referrals or clarifying patient current condition and needed services. Our facility desires to take all appropriate inbound transfers, however we need to ensure we have the capability to care for them and our facility is the most appropriate facility to meet their needs. We are requesting amendment to the 10 minute turnaround requirement. Receiving facility should insist that all transfers be coordinated by ATCC. (9.2) Denials for acceptance of transfers shall be tracked through the trauma program's QI process. Utilization of the ATCC shall be actively tracked in the facility's QI program with a list of all patients transferred out with the corresponding trauma band number. ~~(9.3) All diversions (Bravo, Charlie Temp, and Delta) shall be documented and tracked in the hospital's trauma QI program. Diversions that exceed 5% of the time for required services shall be reported quarterly with a~~

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			~~corrective action plan to the TRAC and the ADH.~~ All diversion, dashboard discrepancies, double transfers, and ATCC reports shall be documented and tracked in the hospital's trauma QI program. A trauma facility shall not be on diversion for any required category listed on the ATCC dashboard more than 5% of the time during the review period. Reports of all diversions shall be available at all designation site surveys. Comments: 5% is rarely met by the Level 3, would like to see all diversions are tracked and corrective action plans are developed. Specifically regarding ICU.
III	**Appropriate Documentation of Patient Records for Transferred Patients**	R	(9.4) Transferring facilities shall send a copy of the patient's pertinent medical record (to include full EMS patient care records or EMS short form) along with radiographic studies (by the TIR or a cloud based image transfer 80% of the time or CD when the TIR is not available). (9.5) Final readings by the referring facility's radiologists shall be sent to the receiving facility as soon as available when requested by the receiving facility. Transfer shall not be delayed waiting on this final reading report. (9.6) Copies of original ~~run sheets~~ patient care records and readings of the X-ray studies shall be sent to the receiving hospital no later than the next business day.
III	**Well-defined Transfer Plans are Essential**	R	(9.7) The plan shall be codified in the facility, approved by the Trauma Program Operations Review Committee, and disseminated to ED physicians and surgeons in the program. All transfers out are reviewed in the review committee by the TMD/TMCD and TPM and documented as appropriate or inappropriate. The decision to transfer an injured patient to a specialty facility in an acute situation shall be based solely on the needs of the patient; for example, the method of payment is not considered.
III	**Teletrauma**	R	(9.8) The hospital shall have collaborative agreements with referral trauma centers and demonstrate successful use.
	10. Quality Improvement and Peer Review Process		
III	**Quality Improvement (QI)**	R	(10.1) The center shall have a clearly defined QI program for the trauma patient population. The QI program shall be supported by a reliable method of data collection that consistently gathers valid and objective information necessary to identify opportunities for improvement. The results of analysis shall define corrective strategies, the results of which shall be documented. The trauma program shall be empowered to address issues in multiple disciplines. ~~(10.2) The TMD/TCMD (or his/her respective physician designee), the TPM (or his/her respective nurse designee), and specialty representatives in EM, orthopedics, neurosurgery, anesthesia, critical care, and radiology (if~~

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			~~available in-house) shall attend at least 50% at the Trauma Peer Review Committee meetings.~~
III	**Audit Filters**	R	(10.3) Use of the current Arkansas State QI Audit Filters is mandatory. (10.4) The facility shall track and trend the cases that trigger one of the state audit filters. The trauma center may add additional filters to suit its specific needs. The facility shall use the trended information gathered from review of the audit filters to guide the QI program. (10.5) Identified problem trends shall undergo review in the multidisciplinary QI meetings with action plans generated, documented, and followed by loop closure. (10.6) ~~Orthopedic, neurosurgical and geriatric/special needs-specific audit filters shall be tracked. (see orthopedic, neurosurgical and geriatric/special needs sections). Shall track neurosurgical audit filters in facilities when neurosurgery is available~~. (10.7) Non-surgical admission (NSA) Trauma centers may admit more than 10% of the admitted trauma patients to a non-surgical service. If a trauma service admits more than 10% of injured patients to a non-surgical service, the trauma program shall: 1. be able to run a Trauma Registry report of all patients admitted to a non-surgical service (total number of NSAs); 2. determine the number of NSAs that had an appropriate surgical service consult; 3. determine the number of NSAs resulting from same level falls; 4. determine the number of NSAs resulting from drowning and hanging; and, 5. determine the number of NSAs with ISS ≤ 9. (10.8) All NSA patients not meeting criteria 2-5 shall be reviewed in the QI meeting for appropriateness of admission to a non-surgical service.
III	**Trauma Chart Reviews**	R	(10.9) Review charts on all trauma patients meeting state Trauma Registry inclusion criteria, including deaths, unexpected outcomes, all pediatric patients, and other patients who meet state QI audit filter criteria. (10.10) Review of the entire patient's encounter with the trauma system, from EMS through hospital treatment and discharge, transfer, or death, with identification of opportunities for improvement in any and all aspects of care. (10.11) Identified opportunities for improvement shall be followed by an action plan and loop closure documenting the effect of the action plan.
III	**Trauma-Specific QI Program**	R	(10.12) This program shall be a structured process, led by the trauma program, to demonstrate continuous evaluation to improve care for injured patients that is coordinated with the hospital-wide QI program.

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			The components of an organized trauma QI program shall be: (10.13) a reliable method of identifying trauma patients presenting to and/or admitted to the facility; (10.14) the infrastructure to abstract patient information from the hospital and prehospital records in order to identify quality of care issues that is reliable and consistently obtains valid and objective information necessary to identify opportunities for improvement; (10.15) a clearly defined set of data points and audit filters to be abstracted from the patient's record; (10.16) proper identification and ICD-9, ICD-10 (or newer version), and AIS coding of all injuries; (10.17) selection of facility-specific process and outcome measures that are related to patient care and can be benchmarked to national standards; (10.18) a functional trauma registry that supports the QI program; (10.19) validation of data abstraction, injury identification, and ISS coding is mandatory; (10.20) a multidisciplinary review process that occurs at frequent, regular intervals and analyzes trauma care in the institution in order to identify opportunities for improvement; (10.21) multidisciplinary involvement as evidenced by both meeting an attendance threshold and submission of case reviews in specialty areas; (10.22) the results of this multidisciplinary review process leads to corrective actions that are documented may include a letter to inform the responsible party with or without response, an educational offering related to the identified issue, a policy change or development of new policy, counseling of the responsible person, or removal from the trauma call panel; (10.23) when a consistent problem or inappropriate variation is identified, corrective actions are taken and documented; (10.24) tracking and trending of identified performance issues is necessary to ensure compliance to process changes; (10.25) the TMD/TCMD and TPM shall be empowered by the hospital's administration to address issues that involve multiple disciplines and perform loop closure for issues identified; (10.26) the TMD/TCMD and TPM shall be aware of current national standards of trauma care and hold their call panel physicians to this expectation; (10.27) creation of protocols, guidelines, or pathways based on the findings from multidisciplinary meetings; (10.28) there is a QI program that convincingly demonstrates appropriate care in the facility that treats neurotrauma patients; and, ~~(10.29) the QI program reviews the appropriate referral of patients to the regional organ procurement organization and subsequent organ donation rate.~~
III	**Trauma Multidisciplinary Review (TMR) Process**	R	(10.30) This process shall be led by the TMD/TCMD and the TPM with representation from all core surgeons, specialties, and services,

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			participates on the trauma team at the facility, which is authorized by the facility to establish, review, and improve the care of the injured. The TMR process shall: 1. establish trauma treatment protocols; 2. oversee compliance with these protocols; 3. identify opportunities for improvement; 4. develop plans for resolution and ensures improvement of identified issues; and, 5. monitor loop closure of issues identified in the process. (10.31) While there may be a single multidisciplinary meeting in a facility, this multidisciplinary process shall consist of two distinct parts: 1. Trauma Program Operations Review Committee; and, 2. Trauma Peer Review Committee. (10.32) The minutes and sign in sheets of these discussions shall be recorded separately. (10.33) The peer review portion shall report through the hospital's trauma QI program to assure protection and continuity of practitioner data for credentialing processes. The conduct of the peer review meeting shall be compliant with state and federal law to ensure confidentiality and patient protection. (10.34) Meetings shall occur with a frequency that ensures timely resolution of issues identified through the trauma QI program. Trauma centers with few trauma patients may accomplish this on a quarterly basis while hospitals with more trauma volume may need to hold such meetings on a weekly basis. ~~(10.35) Attendance by the ED director or EM liaison, TMD/TCMD, all core surgeons, specialties, services when available, and radiology when available in-house, is required and they shall attend at least 50% of the Trauma Peer Review Committee meetings.~~ ~~(10.36) In circumstances when attendance is not mandated (non-core members), the TMD/TCMD ensures dissemination of information from the trauma peer review committee. The TMD/TCMD shall document the dissemination of information from the trauma peer review committee.~~
	11. Responsibility to the Arkansas Department of Health (ADH)		
III	**Trauma Registry Data and Submission to the Trauma Registry**	R	(11.1) Timely abstraction of the charts of injured patients who meet inclusion criteria; data shall be entered into the Trauma Registry and closed within 60 days of discharge 80% of the time during the three year review period. (11.2) Data shall be submitted to the Trauma Registry when requested by the ADH. (11.3) At the time of submission of the designation site survey pre-review questionnaire, the trauma center shall submit all trauma patient records to the Trauma Registry even if the submission is not within the standard reporting period. (11.4) Trauma Registry data are collected and analyzed.

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III	**Accuracy of the Trauma Data Submitted to the Trauma Registry**	R	(11.5) The trauma center shall create and implement a verifiable process to ensure accuracy and completeness of the data submitted to the Trauma Registry. (11.6) Trauma centers are required to document complete and accurate data for all trauma patients meeting Trauma Registry inclusion criteria.
III	**Participation in Trauma Regional Advisory Council (TRAC)**	R	At least 50% of the required (to be determined by the TRAC) regional meetings shall be attended by the: (11.7) TMD/TCMD or physician designee; and, (11.8) TPM or nurse designee.
III	**Active Participation in the Regional and State Peer Review Process**	R	(11.9) The TMD/TCMD (or his/her respective physician designee) and TPM (or his/her respective nurse designee) shall attend 50% of the regional peer review meetings. (11.10) The TMD/TCMD (or his/her respective physician designee) and TPM (or his/her respective nurse designee) shall attend 100% of the regional and state peer review meetings when the facility's cases are discussed. (11.11) The trauma center shall provide adequate clinical patient information for meaningful discussion in the protected QI meetings sanctioned by the ADH. (11.12) The Trauma Program shall provide data and participate meaningfully in the regional and state QI meetings as required by the chair of the committee, TRAC MD, or state TMD.
III	**Community Outreach and Educational Programs in Trauma-specific Opportunities Sponsored by the Hospital**	R	(11.13) The facility shall provide opportunities for staff and community physicians, nurses, allied health personnel, and prehospital providers to receive CME credits. The facility may satisfy this requirement by working independently or with other facilities, the TRAC, regional organizations, or ADH-approved education foundation to provide this education. The facility's contribution to education and outreach shall be verifiable at review.
	12. Other Responsibilities of General Trauma Facilities		
III	**Injury and Violence Prevention (IVP)**	R	(12.1) The facility shall have an identified staff member who is the point of contact for IVP activities. ~~and notify the Trauma Section and the TRAC IVP Committee regarding the identity of the designated person.~~ ~~(12.2) The facility shall demonstrate involvement with the TRAC in regional IVP planning efforts.~~ (12.3) The facility shall work with the ADH-affiliated IVP programs by participating in evidence-based prevention programs, either alone or in

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			collaboration with other facilities, such as the regional Hometown Health Initiative and local EMS agencies., ~~or the TRAC.~~ Recommended Change: Would like to see metric to amount of IVP, perhaps one per year, 3 per cycle. ~~(12.4) The facility shall demonstrate participation in ADH-affiliated IVP programs and shall participate in evaluation efforts for regional IVP programs.~~
III	**Alcohol Screening and Intervention**	R	(12.5) The facility shall have a method to screen admitted trauma patients for risky alcohol use or abuse and have a plan to assist patients with positive screens. Screening can be in the form of a consumption questionnaire or biological measurements. Assistance can be provision of appropriate referrals or in-house intervention, such as brief motivational interviewing.
III	**Disaster Management**	R	(12.6) The hospital shall participate in regional disaster planning and drills. (12.7) The hospital shall meet the disaster-related requirements of TJC, the AOA/HFAP or an equivalent licensing body. (12.8) A trauma panel surgeon or clinical member of the trauma team shall be involved in the hospital's disaster committee. (12.9) As an emergency response exercise, the hospital shall activate its Emergency Operations Plan twice a year at each site included in the plan. If the hospital activates its Emergency Operations Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. Regional participation would be accepted. One of the exercises should include an influx of patients. After action review should be recorded and verifiable.Tabletop sessions, though useful, are not acceptable substitutes for these exercises. (12.10) The trauma center shall have an Emergency Operations Plan described in the hospital disaster manual.
III	**Organ Procurement Organization (OPO)**	R	(12.11) The trauma center shall have an established relationship with a recognized OPO. (12.12) The facility shall have written policies for triggering notification of the OPO. (12.13) The facility shall track its percentage of referral of eligible patients and track the percentage of successful donors from the pool of referred patients.

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Criteria for Level IV Trauma Centers

Purpose: To define and clarify the criteria necessary for a rural acute care facility to become a Level IV trauma center and ensure optimal care of the injured.

Definition: The Level IV trauma center (basic) is a rural medical treatment facility without continuous surgical availability that has a commitment to excellence in trauma care. Level IV centers have an organized program that defines the trauma patient and activates a multidisciplinary treatment team that is rapidly available to treat the injured patients using pre-determined clinical guidelines developed by the trauma system. A Level IV trauma center is expected to function at its clinical capability, which may exceed the minimum "essential" categorization criteria. For example, if a general surgeon is sometimes available, he/she shall be an active member of the trauma team. If he/she is on-call for the hospital and responsible for patient care, then the surgeon shall also be responsible for trauma patient care.

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Level IV Criteria			
Level	**Section**	**Required (R) or Desirable (D)**	**Criteria**
	TRAUMA PROGRAM		
	1. Support/Infrastructure		
IV	**Institutional Support**	R	(1.1) Clear evidence of hospital board, administrative, and medical staff support in the form of a written resolution to attain and maintain the level of designation; the resolution shall be updated and signed at least every three years. Comments: Agree (1.2) Financial support of additional FTEs, space, and/or equipment, as required. (1.3) Authorization for the trauma program's leadership and committees to perform their required duties. (1.4) Clearly defined lines of reporting for the TMD and TPM within the organization.
IV	**Trauma Program Administration and Infrastructure**	R	(1.5) Program within an acute care facility with defined leadership (TMD, TPM) and authority to develop, oversee, and improve the care of the injured within the facility, and is integrated into the local, regional, state, and national system of trauma care. (1.6) The Trauma Program shall participate in the development and improvement of prehospital care protocols and patient safety programs. Recommended Change: More specific on volume of what prehosp protocol program or safety programs. This area is grey, and facilities unaware of what this means. Comments: Discussion--Recommend to stay consistent with how this rule is written for the other levels. Consider to change to read that the Trauma Program is aware of the prehospital care protocols. Consider EMS agencies are required to bring their protocols to the TRACs yearly. **Recommendation is to add a sentence that says this can be done collectively at the TRAC**
	2. Staffing		
IV	**Trauma Medical Director (TMD)**	R	***Requirements and qualifications for the TMD:*** (2.1) A physician in good standing in the institution with state licensure, has membership in professional organizations, possesses clinical knowledge and expertise, actively participates in the care of injured patients, and has a personal interest and the time to be the champion for trauma patient care to the medical staff and the trauma center. (2.2) Current in ATLS as a provider or an instructor. ***Responsibilities and duties of the TMD:*** (2.3) Lead the trauma QI and patient safety programs within the trauma center. (2.4) Have the ability to contribute to the TPM's performance evaluation.

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			(2.5) Demonstrate with his/her signature awareness of the facility's invoices to the ADH for payment. (2.6) Have a method to identify injured patients, monitor the provision of health care services, and hold formal and informal discussions with individual practitioners. (2.7) There shall be a verifiable, written job description that clearly identifies expectations of leadership and authority to perform the duties required, including the authority to conduct trauma-specific peer review, place members on and take members off of a trauma *call schedule* **, be involved in the development of the trauma center's bypass protocol and the decisions regarding bypass and ~~"Charlie Temp"~~ "No Capability" status, and affect process changes identified in the trauma multidisciplinary meetings. (2.8) Have responsibility and authority for determining each call panel member's ability to participate on the trauma call schedule based on a periodic review. (2.9) Have responsibility and authority to ensure compliance with verification requirements; and report changes in the program that would affect the designation of the facility to the ADH. (2.10) The TMD or his or her respective physician designee shall attend at least 50% of both Trauma Program Operations Review Committee and Trauma Peer Review Committee meetings. *** The ability to grant or remove a provider's privileges to practice in an area is reserved for the facility's board and Medical Staff Committee. There should be a distinction of a provider's privileges to participate in care of the trauma patient and participation in a trauma call schedule. The facility's board and Medical Staff Committee shall take into consideration the input of the TMD when considering trauma privileges, while the TMD shall have the discretion of which providers participate in the trauma call schedule. A decision by the TMD to place or remove a provider from the trauma call schedule shall not be viewed as affecting or restricting a provider's hospital privileges, as that decision is reserved for the facility's board and Medical Staff Committee.*
IV	**Trauma Program Manager (TPM)**	R	***Requirement and qualifications for the TPM:*** (2.11) A RN with responsibility for monitoring and evaluating nursing care of trauma patients and the coordination of QI and patient safety programs for the trauma center in conjunction with the TMD. (2.12) He/she shall be well trained and knowledgeable in trauma. The TPM shall also obtain continuing education so as to remain up to date in regard to trauma. (2.13) ATCN, TNCC, TPATC or ADH-approved equivalent course certifications shall be current. (2.14) The training of a TPM new to this position shall include a TPM course and a QI course. ***Responsibilities and duties of the TPM:***

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			(2.15) There shall be a verifiable, written job description for the TPM that clearly identifies expectations of leadership and authority to perform the duties required. (2.16) Dedicate at least 1.0 FTE to trauma programs having a trauma patient record volume of 500 or greater. (2.17) The time and resources allocated shall be sufficient for the TPM to be effective in the job of QI, community education, clinical education, and IVP. (2.18) The TPM or his or her nursing designee shall attend at least 50% of both Trauma Program Operations Review Committee and Trauma Peer Review Committee meetings.
IV	**Trauma Registrar**	R	(2.19) There shall be a verifiable, written job description for the Trauma Registrar that clearly identifies expectations. (2.20) The facility shall have adequate resources to maintain accurate and timely collection, evaluation, and submission of trauma data. (2.21) The training of a Trauma Registrar new to this position shall include a course approved by the ADH. Recommended Change: The training of a trauma registrar new to this position shall include a course approved by the ADH and annual attendance at the Arkansas Trauma Registry Users Conference. Comments: Add or designee
IV	**Trauma Program Staff**	R	(2.22) Trauma Program staff shall have adequate support resources to efficiently and effectively oversee and administer the trauma program and remain engaged in an effective QI process.
IV	**Trauma Liaisons**	R	(2.23) Official physician liaisons shall be named for EM. In addition, if a neurosurgery, orthopedics, anesthesia, critical care, and in-house radiology service is provided, a liaison shall be named. Liaisons are responsible for the accurate dissemination of information from the trauma committee meetings to their service members. ~~(2.24) Liaisons are responsible for attending the Trauma Program Operational Review Committee meetings and at least 50% of Trauma Peer Review Committee meetings. The liaison responsibilities may be shared by physician members of the specialty.~~
IV	**Trauma Team**	R	(2.25) A predetermined set of care providers and ancillary personnel (physicians, mid-level practitioners, nurses, X-ray technologists, laboratory, respiratory therapist, etc.) needed to provide resuscitation, rapid triage, and transfer of the severely injured.
IV	**Consultant Coverage**	R	(2.26) Trauma centers shall have an internal policy identifying the expectations for consultant responses. Deviations to the policy shall be tracked in the QI process.

Commented [CJ6]: Dr Maxson asks that the topic of attendance of Operational meetings needs to be further discussed. Propose that it doesn't necessarily have to be the physician. Look at this in every case where the attendance is listed as required in the rules

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			(2.27) If a consultant is unable to provide the service indicated by the ATCC dashboard, the consultant shall be involved in the transfer process with ATCC **Comment: Medical Record documentation as to why service was not able to be provided and the consultant should be available to speak to the referring physician.**
	3. Participation		
IV	**General Surgery Participation**		***General surgery coverage is not required at a Level IV facility.*** However, if a hospital represents itself as having general surgical capability and capacity on the ATCC dashboard, the following applies and is required of the general surgeon(s): (3.1) Shall have privileges in general surgery. (3.2) Shall be Board-certified/Board-eligible in general surgery or a FACS, or a FACOS or satisfy the criteria for an alternate pathway if deemed necessary by the ADH. (3.3) ~~Shall have taken ATLS at least once or shall be current in ATLS within one year of hire.~~ Shall have taken ATLS at least once or shall be current in ATLS within 1 year of hire. If a general surgeon who is new to a facility has never taken ATLS he or she will have a 1 year grace period during which they must obtain ATLS certification. This period will begin commensurate with their participation on the call panel. Comment: Add Locum coverage are expected to have ATLS certification at the beginning of their service. (3.4) Shall obtain the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17 hours of trauma-specific internal education every three years. ~~(3.5) Core surgeons~~ Call panel surgeons shall participate in at least 50% of both the Trauma Peer Review Committee and Trauma Program Operations Review meetings. ~~and disseminate information back to all surgeons.~~ ~~(3.6) Shall respond to the ED promptly (within 30 minutes) on an aggregate of 80% of the time when on-call and when the highest level of trauma is activated.~~ (3.7) Surgeons shall respond promptly to activations, remain knowledgeable in trauma care principles, whether treating patients locally or transferring them to a center with more resources, and participate in QI activities.
IV	**Orthopedic Surgery Participation**		***Orthopedic surgery coverage is not required at a Level IV facility.*** However, if a hospital represents itself as having orthopedic surgical capability and capacity on the ATCC dashboard, the following applies and is required of the orthopedic surgeon(s): (3.8) Shall obtain the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17 hours of trauma-specific internal education every three years. (3.9) A liaison shall participate in at least 50% of both the Trauma Peer Review Committee and Trauma Program Operations meetings and disseminate information back to all orthopedic surgeons on the call panel. ~~(3.10) Orthopedic surgeons shall have privileges in general orthopedic surgery.~~

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			(3.10) Orthopedic surgeons shall have privileges in general orthopedic surgery, ~~providing 24/7 orthopedic coverage,~~ when on call and promptly available when requested by the trauma surgeon or EM specialist, and expected to provide care within the scope of general orthopedic practice. (3.11) The following Orthopedic specific QI filters shall be in place and tracked (other filters may be added at the discretion of the ADH Trauma Section): 1. time from injury to washout for open fractures; 2. time from injury to ORIF for femur fracture; and, 3. appropriateness and timing of IV antibiotics for all open fractures.
IV	**Anesthesiology Participation**		***Anesthesiology coverage is not required at a Level IV facility.*** However, if a hospital has anesthesiology on-call to assist with urgent surgical cases, the following applies and is required of the anesthesiologist(s): (3.12) Anesthesiology services are promptly available for emergency operations; (3.13) Anesthesiology services are promptly available for airway problems if on-call for urgent surgical cases; This may be fulfilled by an anesthesiologist or a CRNA. If a CRNA is utilized, the supervising physician shall be promptly available. If a CRNA is utilized, it shall be with the approval of the chief anesthesiologist or supervising physician if the facility does not have a chief anesthesiologist; (3.14) There is an anesthesiology liaison designated to the trauma program; (3.15) The availability of the anesthesia services and the absence of delays in airway control or operations is documented by the trauma QI program; (3.16) In trauma centers without in-house anesthesia services, protocols are in place to ensure the timely arrival at the bedside of the anesthesia provider; (3.17) In a center without in-house anesthesia services, there is documentation of the presence of physicians skilled in emergency airway management; (3.18) Availability of anesthesia services and the absence of delays in airway control or operations are documented in the trauma QI program; (3.19) The anesthesia liaison participates in the trauma QI program; and, (3.20) The anesthesiology ~~representative or designee~~ liaison to the trauma program attends at least 50% of both the Trauma Peer Review Committee and Trauma Operations Review Committee meetings.
	TRAUMA FACILITY AND OPERATIONS		
	4. Emergency Department (ED)		
IV	**Leadership**	R	(4.1) As with the TMD, a physician leader is essential. The TMD may also be the ED Director. The ED Director shall be an active liaison to the trauma program.

IV	**Communication With ED Physicians and Nurses**	R	(4.2) A reliable method shall exist to communicate changes in trauma process to all staff members caring for injured patients in the ED. An example of this would be a communication book in the ED, requiring a signature by nurses and physicians when changes or other important updates to the trauma process are determined through the QI program.
IV	**Physician, Mid-level Practitioners and Nursing Availability**	R	(4.3) ED that is available 24/7 with physicians and nurses rapidly available (within 10 minutes of notification of the highest level of activation) to resuscitate the injured patient. This has to be met 80% of the time. (4.4) A tracking mechanism shall be in place and reviewed in the QI program.
IV	**CME Requirements for Providers**	R	(4.5) Physicians who cover the ED in rural trauma centers may not see enough trauma to stay abreast of current treatment protocols. Category I or II CME is necessary to maintain knowledge in the field. The physician or mid-level practitioner caring for trauma patients in the ED shall obtain the required verifiable ~~18~~ 17 hours of Category I trauma-specific CME, or ~~18~~ 17 hours of trauma-specific internal education every three years.
IV	**Trauma Educational Certification - Physician and Mid-Level Practitioners**	R	(4.6) Maintaining current ATLS certification for physicians and mid-level practitioners is essential for those who cover the ED as participants on the trauma team who are not Board-certified in EM. Physicians Board-certified/Board-eligible in EM, as recognized by ABEM, AOBEM, and ABP shall have completed ATLS at least once, and are encouraged but not required to be current. Recommend Change: ATLS should be current for all ED providers Comment: Would not recommend making ATLS required as current for all ED Providers.
IV	**Trauma Nursing Educational Preparation**	R	(4.7) Current certification in one of the trauma nursing courses is essential for nurses who assist in trauma resuscitations. ATCN, TNCC, TPATC or ADH-approved equivalent course will be obtained. 80% of ED trauma nurses shall be certified and newly hired ED trauma nurses shall be certified within their first year of hire. (4.8) 80% of nurses working in the ED shall be current in ACLS and PALS or ENPC.
IV	**Trauma Nursing Continuing Education**	R	(4.9) It is necessary that nurses who assist with trauma resuscitations continue to be educated on trauma treatment and issues and shall obtain 12 hours of trauma-specific nursing CE or 12 hours of trauma-specific internal education every three years.
IV	**Paramedic Educational Preparation**		(4.14) All paramedics working in the ED, who participate in trauma resuscitation, must be certified in PHTLS. May audit TNCC as a substitution for PHTLS (4.15) All paramedics working in the ED shall be current in ACLS and PALS

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			Comment: Recommend 80% requirement (same as nursing). Remove PHTLS and allow for audit of TNCC or ATLS
IV	**Paramedic Continuing Education**		(4.16)It is necessary that paramedics who assist with trauma resuscitations continue to be educated on trauma treatment and issues and shall obtain 12 hours of trauma - specific CE or 12 hours of trauma-specific internal education every three years.
IV	**Activation Criteria**	R	(4.10) The criteria for the highest level of trauma team activations are clearly defined and evaluated by the QI program. (4.11) A patient ≤ ~~15~~ 14 years of age who meets a center's criteria for the highest level of activation or is classified as either a major or moderate trauma patient under the Arkansas Trauma Triage Protocol and requires transfer, shall be transferred to a designated pediatric trauma center. (4.12) The facility shall activate the predetermined trauma team based on a set of written activation criteria that include: 1. confirmed hypotension (< 90mmHg adults or age appropriate for children) attributed to trauma; 2. GCS < 13 with a mechanism due to trauma (general surgeon response, if provided, can be at the discretion of the ED physician Comment: Add after ED physician" IN AN ISOLATED HEAD INJURY WITH GCS < 13"); 3. respiratory compromise or obstruction or an intubated patient from the scene; 4. gunshot to the neck, chest, or abdomen; and, 5. any patient that the ED physician feels the highest level of activation is warranted. (4.13) Activation of the trauma team for the highest level shall be based on prehospital notification when available, regardless of the ultimate decision to transfer. (4.14) Facilities may create a tiered activation system with variable response from hospital and physician personnel but, at a minimum, shall have the above criteria in the highest level of activation. The facility shall determine the expectation for physician response to the various levels of activation and be able to track this as part of the QI program. (4.15) The physicians on-call for the ED shall be notified for patients' meeting the highest level of activation when the trauma team is activated and is expected to be present in the ED within 10 minutes of team activation. ~~(4.16) Level IV facilities are not required to have surgical capability; however, if general surgeons are participating on the Level IV facility's trauma call panel and are on-call, they are expected to be promptly available (30 minutes) upon notification of activation of the highest level of trauma.~~ (4.17) Level IV facilities are not required to have surgical capability; however, 1) if general surgeons are participating on the Level IV facility's trauma call panel and are on-call, they are expected to be promptly available (30 minutes) upon notification of activation of the highest level of trauma. 2) The facility shall activate the entire trauma team to include the operating

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			room (OR) and general surgeon, based on a set of written activation criteria, unless otherwise excluded in section V.C.6 (4.18) The facility shall be able to demonstrate under and over-triage rates based on their activation criteria. (4.19) The facility shall be able to track arrival of the physicians who should respond to a given level of activation.
IV	**Rural Trauma Education**	R	~~(4.20) Rural facilities shall demonstrate participation by at least three members of the trauma resuscitation team, including physicians, nurses, and allied health personnel, three times per review period.~~ Rural facilities shall demonstrate participation by members of the trauma resuscitation team, including physicians, nurses and allied health personnel within a regional facility by attending once during a review period. (e.g., RTTDC or ADH approved equivalent). Recommended Change: Once per review period Comment: Rural Trauma Team Development Course. It will be difficult for some Level IV Trauma Centers to meet this criteria due the attrition rates of personnel who have taken this course. There has not been a RTTDC class in Arkansas in about 3 years and the closest classes are in Texas or Kansas. If the course were taught in Arkansas this would not be an issue.
IV	**Helipad or Landing Zone**	R	(4.21) Shall have a helipad or a written, organized plan for getting the trauma patient to the ED from an established safe landing zone with alternative sites should the primary landing site be unavailable. Exceptions may be made by the ADH on an individual facility basis for urban Level IV facilities.
IV	**Trauma Image Repository**	R	(4.21) Availability to send and receive images to and from TIR in the ED. (4.22) Utilization of TIR when appropriate for expediting trauma patient care.
IV	**Roles and Responsibilities in the Trauma Bay**	R	(4.23) Written protocol for roles and responsibilities of all team members during trauma team resuscitations.
IV	**Safe Transport of Patients Within and Out of the Emergency Department**	R	(4.24) A policy is required describing the level of resources required for the safe movement of patients out of the trauma bay, either within the ED or to other departments in the trauma center.
	5. Essential Equipment (shall include but not be limited to)		
IV	**Airway Control and Ventilation Equipment (Adult and**	R	(5.1) Neonatal to adult oxygen masks, ambu bags, and ETTs (5.2) Every facility shall have equipment and a plan for difficult intubations.

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	Pediatric)		(5.3) Cricothyrotomy supplies and drugs necessary for emergency intubation
IV	**Airway Monitoring**	R	(5.4) Pulse Oximetry (5.5) Qualitative End-tidal CO2 Determination – Color Change Detectors (5.6) Continuous End-tidal CO2 Monitoring (**Desired**)
IV	**Hemorrhage Control**		(5.7) ~~Junctional tourniquets capable of occluding the aorta~~ Comments: Add CAT tourniquet or equivalent and pelvic binders.
IV	**Thermal Regulation**	R	(5.7) The ability to regulate the room temperature in the trauma bay in a reasonable amount of time. (5.8) Fluid warming devices (5.9) Thermal control blankets
IV	**Large Bore IV Catheters**	R	(5.10) 14 – 18 gauge IVs (5.11) Interosseous catheters
IV	**Focused Assessment with Sonography for Trauma (FAST)**	D	(5.12) Machine available to the trauma team and members of the trauma team trained in its use.
IV	**Standard Procedure Trays**	R	~~(5.13) Thoracotomy (adult and pediatric) if general surgical capabilities~~ (5.14) Tube thoracostomy tray with tubes (adult and pediatric) (5.15) Surgical tray with airway equipment (adult and pediatric)
IV	**Standard Airway Equipment**	R	Ensure equipment is available in both adult and pediatric sizes. (5.16) Oral and nasal airway (5.17) Ambu bags (5.18) ETT - with cuffed ETT down to size 4.0
IV	**Pediatric Resuscitation Equipment**	R	(5.19) Color-coded, length-based resuscitation tape Weight-based, color-coded resuscitation cart Pediatric equipment available as listed in the American Academy of Pediatrics Joint Policy Statement-Guidelines for Care of Children in the Emergency Department (2009) ~~*http://pediatrics.aappublications.org/content/early/2009/09/21/peds.2009-1807.citation*~~ *http://pediatrics.aappublication.org/content/124/4/1233*
IV	**PACS and Lab Results Computer**	R	(5.20) Shall be in reasonable proximity to the trauma bay for ease of access by the trauma team.
IV	**Suction Devices**	R	

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			(5.21) Oral and tracheal suction devices for adult and pediatric patients, as well as tubing required for connection, shall be present in the trauma bay and CT scanner.
	6. Operative Services		
IV	**Operating Room (OR)**		***Level IV facilities are not required to have surgical capability;*** however if a hospital represents itself as having OR capability and capacity on the ATCC dashboard, the following applies and is required: (6.11) The ORs are promptly available within 30 minutes of notification of the need for an urgent case to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization and compartment decompression. (6.12) The OR is adequately staffed and promptly available. (6.13) The OR has the essential equipment. (6.14) There is craniotomy equipment available in trauma center that offers neurosurgery services. The QI program evaluates OR availability and delays when an on-call team is used.
IV	**Post-Anesthesia Care Unit (PACU)**		***Level IV facilities are not required to have PACU capability;*** however if a hospital represents itself as having OR capability and capacity on the ATCC dashboard, the following applies and is required: (6.15) The PACU has qualified nurses available 24/7 as needed during the patient's post-anesthesia recovery phase. (6.16) The PACU is covered by a call team from home with documentation by the QI program that PACU nurses are available and delays are not occurring. (6.17) The PACU has the necessary equipment to monitor and resuscitate adult and pediatric patients. In facilities where pediatric patients are cared for, this equipment shall include ambu bags, ETTs and oral airways appropriate to the age of the patients. (6.18) The QI program ensures that the PACU has the necessary equipment to monitor and resuscitate patients. If the PACU acts as an overflow area for the ICU, and trauma patients are housed there while waiting for an ICU bed, the nurses in the PACU shall have similar qualifications as the ICU nurse for the care of trauma patients.
	7. Intensive Care Unit		
IV	**Intensive Care Unit (ICU)**		***Level IV facilities are not required to have ICU capability;*** however if a hospital represents itself as having ICU capability and capacity on the ATCC dashboard, the following applies and is required: (7.11) When a critically ill trauma patient is treated locally, there shall be a mechanism in place to provide prompt availability of a physician, who has the ability to care for critically ill patients 24/7. (7.12) The surgical director or the surgical co-director shall be a surgeon, who is credentialed by the hospital to care for ICU trauma patients, and who participates in the QI program. (7.13) Coverage of emergencies in the ICU does not leave the ED without an appropriate physician coverage plan.

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			(7.14) The trauma center has a surgical director or co-director for the ICU who participates in setting policies and administration related to trauma ICU patients. (7.15) The trauma surgeon remains in charge of trauma patients in the ICU and is kept informed of and concurs with major therapeutic and management decisions. (7.16) A qualified nurse is available 24/7 to provide care during the ICU phase. (7.17) The patient/nurse ratio does not exceed 2:1 for critically ill patients in the ICU. (7.18) The ICU has the necessary equipment to monitor and resuscitate patients. (7.19) There are written protocols for declaration of brain death. (7.20) When ICU patients are held in other locations (PACU, ED) due to temporary lack of bed space, all requirements for ICU care would apply. (7.12) Intracranial pressure monitoring in facilities with neurosurgical coverage. Guidelines for the use of ICP monitoring shall follow the Brain Trauma Foundation Guidelines. https://www.braintrauma.org/uploads/11/14/Guidelines_Management_2007w_bookmarks_2.pdf
	6. Other Trauma Care Areas and Services		
IV	**Pediatric Care**	R	(6.1) Hospitals admitting fewer than 100 injured children annually, ≤15 14years of age, shall review and document the review of all pediatric patients in the QI program. (6.2) Pediatric resuscitation equipment shall be available in all pediatric care areas.
IV	**Geriatric Care/Special Needs**	R	(6.3) The facility shall have a protocol for the admission and care of geriatric/special needs patients (age > 65 years). (6.4) There shall be a protocol in place in the facility for the rapid evaluation of patients with head injuries who are on anticoagulants, which shall include a component addressing the rapid reversal of such agents when possible. The protocol may exclude patients who are on aspirin only.
IV	**Laboratory Services Available 24/7**	R	(6.5) Standard analysis of blood, urine, and other body fluids, including micro-sampling for pediatric patients when appropriate. Blood gases and pH determination is required.
IV	**Blood Bank Ability to Transfuse Blood 24/7**	R	(6.6) The ability to provide oxygen carrying capacity along with volume expansion in an actively bleeding injured patient. The facility shall have the ability to perform a type and cross match or have at least two units of O negative blood available.

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			(6.7)	Facilities shall have a protocol for the rapid reversal of anticoagulants when available. Facilities may develop their own protocol until such time that state guidelines are adopted.
			(6.8)	The facility shall have a Massive Transfusion Protocol developed collaborative between the trauma center and the blood bank.
IV	**Radiological Services Available 24/7**	R	(6.9)	X-ray technologists shall be promptly available 24/7 upon activation of the trauma team.
			(6.10)	The TIR shall be utilized to expedite care of patients being transferred in and out when appropriate.
IV	**Respiratory Therapy**	R	(6.11)	Shall have a respiratory therapist or other personnel trained to fulfill that function (evaluated at the time of verification) who is on-call and promptly available.
IV	**Rehabilitation Services**	R	(6.12)	Facilities shall be required to provide rehabilitation services or have transfer agreement(s) signed with rehabilitation facilities to ensure the timely transfer of patients requiring these services.
IV	**Therapy Services**	D		Physical therapy Occupational therapy Speech therapy
IV	**Social Services**	D		Social work Case management Chaplain services
	7. Effective Transfer of Patients			
IV	**Coordinate All Trauma Transfers Through the ATCC**	R	(7.1)	All trauma transfers shall be coordinated through the ATCC with an expectation of compliance at 95% of the time as an aggregate (average) over the reporting period. The acceptance may be granted by anyone designated by the facility to accept a patient on behalf of the facility, including an ED nurse. A direct physician-to-physician contact is desirable but should not delay the transfer process.
			(7.2)	Utilization of the ATCC shall be actively tracked in the facility's QI program with a list of all patients transferred out and the corresponding trauma band number.
			~~(7.3)~~	~~A trauma facility shall not be on diversion for any required category listed on the ATCC dashboard for more than 5% of the time during any three month period.~~
			(7.3)	All diversion, dashboard discrepancies, double transfers, and ATCC reports shall be documented and tracked in the hospital's trauma QI program. A

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			trauma facility shall not be on diversion for any required category listed on the ATCC dashboard more than 5% of the time during the review period. Reports of all diversions shall be available at all designation site surveys.
IV	**Appropriate Documentation of Patient Records for Transferred Patients**	R	~~(7.4) Transferring facilities shall send a copy of the patient's pertinent medical record along with radiographic studies (by the TIR when available or readable CD when the TIR is not available).~~ (7.5) Transferring facilities shall send a copy of the patient's pertinent medical record (to include full EMS patient care records or EMS short form) along with radiographic studies (by the TIR or a cloud based image transfer 80% of the time or CD when the TIR is not available). (7.6) Final readings by the referring facility's radiologists shall be sent to the receiving facility as soon as available when requested by the receiving facility. Transfer shall not be delayed waiting on this final reading report. (7.7) Copies of original ~~run sheets~~ patient care record and readings of X-ray studies shall be sent to the receiving hospital no later than the next business day. Recommended Change: Add 2-hour transfer out to regulation Comment: Do not favor the recommendation in green.
IV	**Well-defined Transfer Plans are Essential**	R	(7.7) The plan shall be codified in the facility, approved by the Trauma Program Operations Review Committee, and disseminated to the ED physicians and surgeons in the program. All transfers out shall be reviewed in the review committee by the TMD and TPM and documented as appropriate or inappropriate. The decision to transfer an injured patient to a specialty facility in acute situation shall be based solely on the need of the patient; for example, the method of payment is not considered.
IV	**Teletrauma**	R	(7.8) The hospital shall have collaborative agreements with referral trauma centers and demonstrate successful use.
	8. Quality Improvement and Peer Review Process		
IV	**Quality Improvement (QI)**	R	(8.1) The center shall have a clearly defined QI program for the trauma patient population. The QI program shall be supported by a reliable method of data collection that consistently gathers valid and objective information necessary to identify opportunities for improvement. The results of analysis shall define corrective strategies, the results of which shall be documented. The trauma program shall be empowered to address issues in multiple disciplines. ~~(8.2) The TMD (or his/her respective physician designee), the TPM (or his/her respective nurse designee) and, if available, specialty representatives in EM, orthopedics, neurosurgery, anesthesia, critical care, and radiology (if in-house) shall attend at least 50% at the Trauma Peer Review Committee meetings.~~

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IV	**Audit Filters**	R	(8.3) Use of the current Arkansas State QI Audit Filters is mandatory. (8.4) The facility shall track and trend the cases that trigger one of the state audit filters. The trauma center may add additional filters to suit its specific needs. The facility shall use the trended information gathered from review of the audit filters to guide the QI program. (8.5) Identified problem trends shall undergo review in the multidisciplinary QI meetings with action plans generated, documented, and followed by loop closure. (8.6) ~~Orthopedic and geriatric/special needs-specific audit filters shall be tracked (see orthopedic, and geriatric/special needs sections). Applies to level IV if orthopedic services care for injured patients in the facility.~~ (8.7) Non-surgical admission (NSA) Trauma centers may admit more than 10% of the admitted trauma patients to a non-surgical service. If a trauma service admits more than 10% of injured patients to a non-surgical service, the trauma program shall: 1. be able to run a registry report of all patients admitted to a non-surgical service (total number of NSAs); 2. determine the number of NSAs that had an appropriate surgical service consult; 3. determine the number of NSAs resulting from same level falls; 4. determine the number of NSAs resulting from drowning and hanging; and, 5. determine the number of NSAs with ISS ≤ 9. (8.8) All NSA patients not meeting criteria 2-5 shall be reviewed in the QI meeting for appropriateness of admission to a non-surgical service.
IV	**Trauma Chart Reviews**	R	(8.9) Review charts on all trauma patients meeting state Trauma Registry inclusion criteria, including deaths, unexpected outcomes, all pediatric patients, and any other patients that meet state QI audit filter criteria. (8.10) Review of the entire patient's encounter with the trauma system from EMS through hospital treatment and discharge, transfer, or death, with identification of opportunities for improvement in any and all aspects of care. (8.11) Identified opportunities for improvement shall be followed by an action plan and loop closure documenting the effect of the action plan.
IV	**Trauma-Specific QI Program**	R	(8.12) This program shall be a structured process, led by the trauma program, to demonstrate continuous evaluation to improve care for injured patients that is coordinated with the hospital-wide QI program. The components of an organized trauma QI program shall be: (8.13) a reliable method of identifying trauma patients presenting to and/or admitted to the facility;

			(8.14)	the infrastructure to abstract patient information from the hospital and prehospital records in order to identify quality of care issues that is reliable and consistently obtains valid and objective information necessary to identify opportunities for improvement;
			(8.15)	a clearly defined set of data points and audit filters to be abstracted from the patient's record;
			(8.16)	proper identification and ICD-9, ICD-10 (or newer version), and AIS coding of all injuries;
			(8.17)	selection of facility-specific process and outcome measures that are related to patient care and can be benchmarked to national standards;
			(8.18)	a functional Trauma Registry that supports the QI program;
			(8.19)	validation of data abstraction, injury identification and ISS coding is mandatory;
			(8.20)	a multidisciplinary review process that occurs at frequent, regular intervals and analyzes trauma care in the institution in order to identify opportunities for improvement;
			(8.21)	multidisciplinary involvement as evidenced by both meeting an attendance threshold and submission of case reviews in specialty areas;
			(8.22)	the results of this multidisciplinary review process lead to corrective actions that are documented may include a letter to inform the responsible party with or without response, an educational offering related to the identified issue, a policy change or development of new policy, counseling of the responsible person, or removal from the trauma call panel;
			(8.23)	when a consistent problem or inappropriate variation is identified, corrective actions are taken and documented;
			(8.24)	tracking and trending of identified performance issues is necessary to ensure compliance to process changes;
			(8.25)	the TMD and TPM shall be empowered by the hospital's administration to address issues that involve multiple disciplines and perform loop closure for issues identified;
			(8.26)	the TMD and TPM shall be aware of current national standards of trauma care and hold their call panel physicians to this expectation;
			(8.27)	creation of protocols, guidelines, or pathways based on the findings from multidisciplinary meetings; and,
			~~(8.28)~~	~~the QI program reviews the appropriate referral of patients to the regional organ procurement organization and subsequent organ donation rate.~~
IV	**Trauma Multidisciplinary Review (TMR) Process**	R	(8.29)	This process shall be led by the TMD and the TPM with representation from all surgeons/specialties (if available) and services, participates on the trauma team at the facility, which is authorized by the facility to establish, review, and improve the care of the injured. The TMR process shall: 1. establish trauma treatment protocols; 2. oversee compliance with these protocols; 3. identify opportunities for improvement; 4. develop plans for resolution and assure improvement of identified issues; and,

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			5. monitor loop closure of issues identified in the process. (8.30) While there may be a single multidisciplinary meeting in a facility, this multidisciplinary process shall consist of two distinct parts: 1. Trauma Program Operations Review Committee; and, 2. Trauma Peer Review Committee. (8.31) The minutes and sign in sheets of these discussions shall be recorded separately. (8.32) The peer review portion shall report through the hospital's trauma QI program to assure protection and continuity of practitioner data for credentialing processes. The conduct of the peer review meeting shall be compliant with state and federal law to ensure confidentiality and patient protection. (8.33) Meetings shall occur with a frequency that ensures timely resolution of issues identified through the trauma QI program. Trauma centers with few trauma patients may accomplish this on a quarterly basis while centers with more trauma volume may need to hold such meetings on a weekly basis. ~~(8.34) The attendance requirement for physicians (ED director, TMD, and general surgeon liaison (if the facility provides general surgical coverage, even on a part time basis) and mid-level practitioners is at least 50% of the Trauma Peer Review Committee meetings.~~ ~~(8.35) Hospitals that have general surgeons, orthopedic surgeons, radiologists (if in-house), neurosurgeons, EM physicians, anesthesiologists or rehabilitation specialists participating in the trauma team in the facility are required to have a liaison from these specialties participate in at least 50% of the Trauma Peer Review Committee meetings, if those providers participate in the care of trauma patients, even if the level of designation does not require that specialty.~~ (8.36) The TMD shall provide to the non-liaisons the information from the process and peer review meetings. This process of dissemination of information shall be monitored through the QI program and be verifiable at review. If general surgery or orthopedic coverage is less than 33% of the total time, the requirement to have a liaison attend the meetings is waived. The other requirements will remain in force as is the responsibility of the TMD to effectively disseminate information.
	9. Responsibility to the Arkansas Department of Health (ADH)		
IV	**Trauma Registry Data and Submission to the Trauma Registry**	R	(9.1) Timely abstraction of the charts of injured patients who meet inclusion criteria; data shall be entered into the Trauma Registry and closed within 60 days of discharge, 80% during the three year review period. (9.2) Data shall be sent to Trauma Registry when requested by the ADH. (9.3) At the time of submission of the designation site survey pre-review questionnaire, the trauma center shall submit all trauma patient records to the Trauma Registry even if the submission is not within the standard reporting period. (9.4) Trauma Registry data are collected and analyzed.

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IV	**Accuracy of the Trauma Data Submitted to the Trauma Registry**	R	(9.5) The trauma center shall create and implement a verifiable process to ensure accuracy and completeness of the data submitted to the Trauma Registry. (9.6) Trauma centers are required to document complete and accurate data for all trauma patients meeting state Trauma Registry inclusion criteria.
IV	**Participation in Trauma Regional Advisory Council (TRAC)**	R	At least 50% of the required (to be determined by the TRAC) regional meetings shall be attended by the: (9.7) TMD or physician designee; and, (9.8) TPM or nurse designee.
IV	**Active Participation in the Regional and State Peer Review Process**	R	(9.9) The TMD (or his/her respective physician designee) and TPM (or his/her respective nurse designee) shall attend 50% of the regional peer review meetings. (9.10) The TMD (or his/her respective physician designee) and TPM (or his/her respective nurse designee) shall attend 100% of the regional and state peer review meetings when the facility's cases are discussed. (9.11) The trauma center shall provide adequate clinical patient information for meaningful discussion in these protected QI meetings which have been sanctioned by the ADH. (9.12) The program shall provide data and participate meaningfully in the regional and state QI meetings as required by the chair of the committee, TRAC MD, or state TMD.
IV	**Community Outreach and Educational Programs in Trauma-specific Opportunities Sponsored by the Hospital**	R	(9.13) The facility shall provide opportunities for staff and community physicians, nurses, allied health personnel, and prehospital providers to receive CME credits. The facility may satisfy this requirement by working independently or with other facilities, the TRAC, regional organizations or an ADH-approved education foundation to provide this education. The facility's contribution to education and outreach shall be verifiable at review.
	10. Other Responsibilities of Basic Trauma Facilities		
IV	**Injury and Violence Prevention (IVP)**	R	~~(10.1)~~ The facility shall have an identified staff member who is the point of contact for IVP activities. ~~and notify the Trauma Section and the TRAC IVP Committee regarding the identity of the designated person.~~ ~~(10.2) The facility shall demonstrate involvement with the TRAC in regional IVP planning efforts.~~ (10.3) The facility shall work with the ADH-affiliated IVP programs by participating in evidence-based prevention programs, either alone or in

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			collaboration with other facilities, such as the regional Hometown Health group, local EMS agencies. ~~or the TRAC.~~ ~~(10.4) The facility shall demonstrate participation in ADH-affiliated IVP programs and shall participate in evaluation efforts for regional IVP programs.~~
IV	**Alcohol Screening and Intervention**	R	(10.5) The facility shall have a method to screen admitted trauma patients for risky alcohol use or abuse and to have a plan to assist patients with positive screens. Screening can be in the form of a consumption questionnaire or biological measurements. Assistance can be provision of appropriate referrals or in-house intervention, such as brief motivational interviewing.
IV	**Disaster Management**	R	(10.6) The hospital shall participate in regional disaster planning and drills. (10.7) The hospital shall meet the disaster-related requirements of TJC, the AOA/HFAP or an equivalent licensing body. (10.8) A trauma panel surgeon or clinical member of the trauma team shall be involved in the hospital's disaster committee. (10.9) As an emergency response exercise, the hospital shall activate its Emergency Operations Plan twice a year (which may include one table top) at each site included in the plan. If the hospital activates it's Emergency Operations Plan in response to one or more actual emergencies, these emergencies can serve in place of emergency response exercises. Regional participation would be accepted. One of the exercises should include an influx of patients. ~~Tabletop sessions, though useful, are not acceptable substitutes for these exercises.~~ After action review should be recorded and verifiable. (10.10) The trauma center shall have an Emergency Operations Plan described in the hospital disaster manual.
IV	**Organ Procurement Organization (OPO)**	R	(10.11) The trauma center shall have an established relationship with a recognized OPO. (10.12) The facility shall have written policies for triggering notification of the OPO. (10.13) The facility shall track its percentage of referral of eligible patients and track the percentage of successful donors from the pool of referred patients.

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SECTION VIII: PEDIATRIC TRAUMA CENTER STANDARDS

A. Purpose

The highest level of pediatric trauma care is provided in a pediatric trauma center. This center shall be capable of providing comprehensive care for all injured infants and children, particularly the most severely injured. A facility may be designated as a pediatric Level I or II trauma center by meeting the criteria outlined in Section VIII. B. or C., respectively. A facility may obtain a dual designation as a trauma center (Level I or II) by: 1. meeting the requirements for a Level I or II trauma center as set forth in Section VII.; and, 2. meeting the criteria for a pediatric trauma center (Level I or II) as outlined in Section VIII. B. or C., respectively. When no pediatric facility is available, infants and children with multisystem injuries may be treated in an adult trauma center that has demonstrated a significant commitment to pediatric care as determined by the criteria outlined in Section VIII. B. or C.

B. Level I Pediatric Trauma Center:

1. An annual volume of at least 250 admitted pediatric patients (≤~~15~~ 14 years of age).

Comments: Recommend removal of definition.

2. The hospital seeking pediatric Level I designation shall meet all the criteria listed for an adult Level I facility. In addition, a hospital seeking a Level I pediatric trauma center designation shall have:

   a. a pediatric trauma service organized and run by a pediatric surgeon;

   b. a pediatric ED with appropriate personnel, equipment, and facilities;

   c. a pediatric ICU with pediatric surgery and other surgical, medical, and nursing personnel and equipment needed to care for the injured child;

   d. a pediatric surgeon credentialed in trauma care immediately available and present in the OR for any and all operative procedures; and,

   e. a general surgical resident at a minimum PGY 3 or higher resident level may initiate resuscitative care until the attending pediatric surgeon arrives.

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3. A Level I pediatric trauma center shall have, at a minimum, the following specialists active on the trauma call panel and involved in the Trauma Peer Review Committee and the Trauma Program Operations Review Committee:

    a. two pediatric surgeons;

    b. one pediatric orthopedist;

    c. one pediatric neurosurgeon;

    d. one pediatric anesthesiologist;

    e. two pediatric intensivists;

    f. two pediatric EM physicians;

    g. one pediatric radiologist;

    h. one pediatric rehabilitation specialist; and,

    i. one child abuse specialist.

4. A Level I pediatric trauma center shall also have the following:

    a. a pediatric TPM;

    b. a trauma registrar;

    c. a separate and distinct trauma QI program;

    d. pediatric-specific clinical care guidelines and pathways;

    e. a pediatric-specific massive transfusion protocol;

    f. a pediatric-specific IVP program;

    g. a child abuse assessment team;

    h. specific credentialing by the hospital with the agreement of the TMD for any physician serving on the trauma call panel not Board-certified/Board-eligible in a pediatric sub-specialty; and,

    i. a pediatric trauma research program with peer-reviewed publications.

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C. Level II Pediatric Trauma Center:

1. An annual volume of at least 125 admitted pediatric patients (≤~~15~~ 14 years of age).

2. The hospital seeking pediatric Level II designation shall meet all the criteria listed for an adult Level I or II facility. In addition, a hospital seeking a Level II pediatric trauma center designation shall have:

    a. a designated pediatric area in the ED staffed with pediatric trauma personnel and appropriate equipment; and,

    b. a pediatric ICU with appropriately trained personnel and equipment.

3. A Level II pediatric trauma center shall have, at a minimum, the following specialists active on the trauma call panel and involved in the Trauma Peer Review Committee and the Trauma Program Operations Review Committee:

    a. one pediatric surgeon;

    b. one pediatric orthopedist or an orthopedist meeting an alternate pathway if deemed necessary by the ADH;

    c. one pediatric neurosurgeon or a neurosurgeon meeting an alternate pathway if deemed necessary by the ADH;

    d. one pediatric intensivist;

    e. one pediatric EM physician;

    f. pediatricians;

    g. a pediatric TPM;

    h. a trauma registrar; and,

    i. pediatric-trained trauma nurses.

4. All surgeons, intensivists, anesthesiologists and EM providers not formally trained in a pediatric sub-specialty shall:

    a. be credentialed specifically by the facility to care for children of all ages;

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b. have their credentials reviewed and approved by the TMD; and,

c. have pediatric trauma-specific CME.

5. A Level II pediatric trauma center shall also have the following:

a. a separate and distinct trauma QI program;

b. pediatric-specific clinical care guidelines and pathways;

c. ongoing pediatric trauma education for physicians and nurses;

d. a pediatric-specific massive transfusion protocol;

e. a pediatric-specific IVP program; and,

f. a child abuse assessment team or protocols in place for the assessment and treatment of children with known or suspected child maltreatment.

SECTION IX: TRAUMA REGIONAL ADVISORY COUNCILS (TRACS)

A. All participating health care entities shall have representation on their respective TRAC.

B. The TRAC shall develop and oversee a regional system plan which consists of by-laws, a QI plan, and an IVP plan.

C. Each TRAC Chair and/or QI Chair shall serve as ex-officio to the Trauma Advisory Council's QI/TRAC Committee to update and advise the TAC regarding regional concerns.

D. Each TRAC shall be responsible for a peer review program in its region of the state. The peer review process is a component of the overall state peer review process sanctioned by the Trauma Section. A review of trauma patients will be made according to the TAC's Trauma System State QI Plan. All participating health care entities shall participate in the QI process.

E. Other operational and reporting actions of the TRAC dealing with QI and patient safety concerns will be handled in accordance with the TAC's Trauma System State QI Plan.

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SECTION X: REHABILITATION FACILITIES

A. Purpose

A complete trauma system shall include early integration of rehabilitation services into all phases of acute and primary care.

B. Trauma centers shall demonstrate that rehabilitation services are initiated at the earliest possible point after trauma patient admission. Any spinal cord disabled person and any person having a traumatic brain injury resulting in permanent partial, permanent total, or total disability shall be reported to the Arkansas Spinal Cord Commission within five calendar days of identification of the above by the trauma center. This procedure ensures that these patients can be referred to appropriate rehabilitation facilities in a timely manner.

C. Trauma centers shall demonstrate that appropriate transfer agreements are in place with a rehabilitation facility or facilities.

SECTION XI: TRAUMA REGISTRY

A. Purpose

The ADH shall develop a statewide trauma data collection and evaluation system. This data shall be studied in order to improve both the individual and collective care given to trauma patients. Any hospital that is a designated trauma center or is pursuing trauma center designation shall collect and submit data to the Trauma Registry Section. Hospitals that are not pursing designation may still participate in the Trauma Registry.

B. Data collection, submission, and analysis

1. Data shall be collected on all patients who meet the defined state Trauma Registry inclusion criteria in accordance with the standard data set developed by the Trauma Registry Section.

2. Data shall be submitted to the Trauma Registry Section at least quarterly or as required in accordance with the approved data format and processes.

3. The Trauma Registry Section shall provide, at a minimum, annual summary data to the trauma centers.

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4. Trauma Registry data shall be reviewed as part of the trauma center designation process.

5. Data shall be released to the TAC QI/TRAC Committee and the TRAC QI Committee for the purposes of quality or system assessment and improvement of the trauma system. Data released to these entities for QI purposes shall not be subject to disclosure under the Freedom of Information Act of 1967 (Ark. Code Ann. § 25-19-101) [Act 393 of 2009, Ark. Code Ann. § 20-13-819 (a) (1)] and shall be exempt from discovery and disclosure in any legal proceeding [Act 393 of 2009, Ark. Code Ann. § 20-13-819 (b) (1)].

6. For research purposes only, and in accordance in Ark. Code Ann. § 20-8-403, with the written permission of the State Health Officer and pursuant to the provisions of the HIPAA of 1996, as amended, Trauma Registry data may be accessed in order to facilitate the operation of the Arkansas Health Data Initiative.

7. Aggregate, non-confidential data may be provided to the TAC, TRACS, and other entities.

8. The Trauma Registry Section may provide data for the purposes of research and aggregate statistical reporting to research projects approved by the ADH.

C. Data security

1. Data shall be collected in a manner which protects and maintains the confidential nature of patient records.

2. Individual records and reports made pursuant to these rules shall be held confidential within the hospital and Trauma Registry Section and shall not be made available to the public.

3. Any data provided by the Trauma Registry Section shall be released in accordance with rules promulgated by the Board that provide for appropriate data security and confidentiality.

SECTION XII: SEVERABILITY

If any provision of these Rules, or the application thereof to any person or circumstances is held invalid, such invalidity shall not affect other provisions or applications of these Rules which can give effect without the invalid provisions or applications, and to this end the provisions hereto are declared to be severable.

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SECTION XIII: REPEAL

All Rules and Regulations and parts of Rules and Regulations in conflict herewith are hereby repealed.

CERTIFICATION

This will certify that the foregoing Arkansas Trauma System Rules were adopted by the Arkansas Board of Health at a regular session of the Board held in Little Rock, Arkansas on the ____day of _____, 2014.

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Nathaniel Smith, MD, MPH
Secretary, Arkansas Board of Health
Director, Arkansas Department of Health